

# Kentucky Trustee

For Kentucky Hospital Governing Board Members

June 2015

## BOARDROOM BASICS

### Moving Beyond Quality Measurement: A Culture of Safety Begins with the Board

Providing high-quality, safe care begins with a culture of safety. The board is responsible for setting the tone for the hospital, providing the tools necessary for employees to carry out the quality and patient safety vision, and encouraging a safe environment by regularly measuring and monitoring quality measures. Boards should expect transparency, continual improvement, and measurable results from the medical staff and administration in a way that promotes safe and constructive conversations about success and failure. If the administration feels threatened each time a failure occurs, failure will become hidden from the board and buried deep in the organization where there is no opportunity for learning and improvement.

**H**umans make mistakes. It is up to organizations to create systems that prevent errors from reaching patients. These are called "Human Factors." To address this, hospital and health system leaders should ask questions such as: What is the next error that is likely to occur? How will our systems prevent it? How is our staff working around systems to provide needed care to patients? A common example is placing medications in pockets because it takes too long to get them from the pharmacy. Another example is providing care at night and then asking for an order in the morning because the physician on-call is angry at the nurse if he or she is awakened.

Most errors are caused by systems that do not work when an employee or physician is truly negligent, such as being abusive toward fellow care providers. Negligent providers need to be held accountable and

told their actions are not acceptable. At the same time, hospital and health system leaders must continually seek out opportunities to improve systems that remove the "Human Factor."

#### Creating a Culture of Safety

Boards must define what a culture of safety means to their hospital, including the following critical components:

- **Open Communication:** Patient involvement in decisions about their care, informing patients of the consequences of the care they receive, and ensuring language that supports the patient safety effort.
- **Engaged Patients:** Hospitals and health systems using best practices have patients provide feedback to the board about quality, patient safety, and the patient experience. This communication enhances the board's discussion.
- **Reporting:** Create an environment of trust to address accountability in a fair and just manner so blame is not automatically placed when an error occurs; encourage employees to view patient safety as an integral part of their jobs, and to internally report errors, "near misses" and other opportunities to improve safety.
- **Informed Action:** Understand and analyze data, including near misses that could have impacted patients but were averted.

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## PRESIDENT'S NOTEBOOK

**K**entucky has emerged as a national leader in expanding health coverage through the implementation of the Affordable Care Act (ACA). Under the strong leadership of Governor Beshear, the online marketplace where consumers can buy health insurance, Kynect, and the expansion of Medicaid in Kentucky have resulted in more than 400,000 Kentuckians being enrolled in new health coverage. While Kentuckians should be proud of this achievement, it is also important to understand another part of the story: The government's success in expanding health coverage has come at a significant cost to Kentucky hospitals.

Just a few weeks ago, KHA released a report titled, "*Code Blue: Many Kentucky Hospitals Struggling Financially Due to Health System Changes*." The report highlights how rural hospitals in Kentucky have been the hardest hit. It recognizes that Kentucky hospitals have received an additional \$506 million in payments for treating patients covered by Medicaid expansion; however, it underscores that it cost hospitals \$617 million to actually deliver the care, leaving a \$111 million gap in unpaid costs.

The KHA report also discusses how Medicare payments to hospitals will be cut by \$4.6 billion from 2010 to 2024 to help finance health reform. The intent of the ACA was that the cuts would be offset, for the most part, by health care payments from people who had previously been uninsured. The original estimates by the Congressional Budget Office projected that half of the newly insured would be covered by private insurance and the other half by expanded Medicaid. That has not been the case in Kentucky, however. Because Kentucky is a low-income state, ranking 46<sup>th</sup> in per-capita income, the actual enrollment statistics reveal that 75 percent of the newly insured in the commonwealth are covered by Medicaid, and only 25 percent have bought a private health plan. This is important because private health insurance pays health providers at a much higher rate than the Kentucky Medicaid program, which pays hospitals approximately 82 percent of what it actually costs to care for the Medicaid patients. The difference between Medicaid payments and the actual cost is known as the "Medicaid shortfall," which was estimated to be more than \$300 million in Kentucky in 2013.

Additionally, nearly 12 percent of Kentuckians (approximately 521,000 people) remain uninsured. Hospital bad debts have doubled in the past five years and Kentucky hospitals had \$2.3 billion in total uncompensated costs in 2013, which far outstrips the disproportionate share hospital (DSH) payments that are in place to offset the cost of treating patients who are uninsured, or covered by Medicaid (since payments only cover 82 percent of a hospital's cost — not charges).

Lastly, the KHA *Code Blue* report outlines how the statewide implementation of Medicaid managed care, in which private managed care organizations (MCOs) provide coverage to Medicaid patients, continues to cause a concern among Kentucky hospitals. While state government cannot reverse cuts in federal payments to hospitals, it can improve the state Medicaid program, on which hospitals heavily rely. Kentucky's hospital community strongly urges Governor Beshear to continue his strong leadership in health care by directing changes to the state Medicaid program. There are six actions outlined in the report that can work to the benefit of the patients, hospitals and the communities they serve.

For a copy of the report, please visit <http://www.new-kyha.com/Portals/5/NewsDocs/Code%20Blue%20Report%20Web.pdf>.

Despite the uncertainty surrounding health care today, KHA's vision will remain steadfast. We will continue to represent all of Kentucky's 129 hospitals, related health care organizations and integrated health care systems dedicated to sustaining and improving the health status of the citizens of Kentucky.

Sincerely,



Michael T. Rust, FACHE  
President  
Kentucky Hospital Association



Michael T. Rust  
President

## Governance Notebook

**Request a copy of the KHA *Code Blue* Report and the report on *Kentucky Hospitals Actions to Reduce Costs***

The report details an analysis of the impact federal payment cuts will have on the financial bottom line of Kentucky hospitals. The analysis found Kentucky hospitals will lose more money than they gain in new revenue from expanded health insurance coverage. KHA supports the governor's decision to expand Medicaid and the significant revenue it generates; however, the new expansion revenue is less than the cuts Kentucky hospitals will experience in order to finance the ACA. While the amount of charity care will be reduced as a result of expanded Medicaid coverage, the Medicare and Medicaid DSH cuts will be greater than the amount of new revenue. **The bottom line: Kentucky hospitals will have higher losses and lower operating margins, with a projected net loss of \$1 billion from 2014 to 2020.**

**Learn more about how health care reform and other legislative issues will affect your hospital by attending the KHA Health Care Leadership Conference on November 13, 2015**

Please join us at the Marriott Louisville East on Friday, November 13 for the annual KHA Health Care Leadership Conference. The Health Care Leadership Conference is a great way for hospital chief executive officers, board chairmen, trustees, other hospital administrators, government relations staff and medical staff members to stay informed of legislation that may affect their facilities.

The conference will present the latest in state and federal legislative issues and regulatory concerns from the Kentucky General Assembly. Please talk with your hospital CEO about attending.

**Do you have ideas for future issues of the *Kentucky Trustee*?**

Our goal is to provide you with the information and knowledge you need to lead your hospitals forward in today's rapidly changing environment. Tell us what you think, and what you would like to see in future issues of the *Kentucky Trustee*.

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## GOVERNANCE INSIGHTS

## The Transformative Board: Rethinking Governance

Holding on to the status quo, no matter how successful it might have been, will not propel today's hospitals into the future. Communities across the nation depend on hospitals for health care, employment and economic stability. As their leaders, boards of trustees should embrace governance changes that will enable them to guide their organizations in a complex, competitive health care world that will not be the same tomorrow as it is today.

In their report “Redefining the H,” the American Hospital Association (AHA) highlights five paths for hospital transformation:<sup>1</sup>

- Becoming a high-performing specialty provider (such as a children's hospital or rehabilitation center);
- Strategic partnering for greater horizontal or vertical reach, efficiency and access to resources;
- Redefining to a different delivery system (oriented toward more ambulatory or long-term care);
- Experimenting with new payment and delivery systems (such as bundled payment, accountable care organizations (ACOs), clinically integrated networks or medical homes); or
- Integrating with other services across the continuum of care.

Determining which path or combination of paths might be right for the organization cannot be accomplished with the same meeting agendas, the same reports, the same presentations, the same thinking or the same expectations that may have served the board well until now. For example, one of the driving forces of the Affordable Care Act (ACA) is the shift from fee-for-service to a payment system based on the delivery of high quality care at an efficient cost. Yet the 2014 National Health Care Governance Survey conducted by the AHA indicates that nearly one-quarter of hospital boards are either “not

engaged” or are only “somewhat engaged” in quality and safety issues. In addition, one in five CEOs are not held accountable by their board for the organization's quality performance.<sup>2</sup>

### Advancing Governance

As hospital and health system leaders, boards need to be thinking ahead to the future. Advancing the pace of board leadership means:

- **Advancing trustee knowledge** about health care transformation and its implications not only for health care in general, but for their hospital and health system in particular;
- **Advancing boardroom discussions, deliberations and respectful confrontation** about the challenges and issues confronting the organization not only today, but also future concerns that need to be anticipated and planned for now;
- **Advancing trustee thinking**, engaging in visionary and creative scenario planning for the organization's future and how to achieve it;
- **Advancing the board's leadership skill** in adapting to change, organizational complexity, and uncertain futures as it strives to overcome barriers and improve the health of the community; and
- **Advancing organizational progress** toward delivery of the

best quality, best outcomes, best service, best cost and fulfillment of the hospital or health system's mission.

### What Do We Need to Rethink?

Members of highly effective boards are able to walk away from a board meeting with the knowledge that the meeting was a valuable use of their time and expertise, and that their leadership is guiding the organization closer to its vision and contributes to the fulfillment of the mission. These become the fundamental standards by which board members can assess the board's function and value. Do meetings represent time well-spent? Is the organization advancing on its vision? Are the board's discussions and decisions aligned with the mission? In today's rapid fire, complex health care environment, the following considerations are good starting points for rethinking and advancing governance.

**Rethinking Performance Priorities.** As health care evolves, the board's performance in the following areas becomes critical. Boards should rethink and assess their strengths in these high priority areas: 1) knowledge of the ACA, its objectives, and the forces and trends it has set in motion; 2) knowledge and understanding of quality, patient safety and other clinical care issues; 3) systems thinking and leadership of complex organizations; 4) understanding and responsiveness to community needs; 5) cultural competency; and 6) visionary and

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## LEADERSHIP PERSPECTIVES

## The Supply Chain: A Strategic Ally for Hospital and Health System Leadership

Health care organizations across the nation are in the midst of transforming the delivery of care as they respond to forces for change that include the Patient Protection and Affordable Care Act (ACA), changes in payment and reimbursement structures, and intense government, media and public scrutiny. Expanded insurance coverage, including expansion of Medicaid in some states, and an aging population have meant an uptick in patient volume for many health care organizations; however, as more patients receive care in outpatient settings, not-for-profit hospital revenue is down and inpatient acuity is increasing. As revenue growth has slowed, hospital costs have continued to rise, squeezing operating margins.

**C**harged with the responsibility of managing a hospital or health system's non-labor costs, supply chain professionals are well-positioned to contribute the expertise needed to help hospitals and health systems do more than just address rising costs. Supply chain professionals have well-established, long-term working relationships with administrators, clinicians and departments that cut across organizations. Few other departments in an organization are as well-situated as the supply chain to assist the organization to address the challenges, achieve objectives and meet the requirements of health care transformation.

As hospitals continue to face financial challenges in the midst of a rapidly changing environment, it is no surprise that credit rating agencies cited rising costs and slim operating margins as key concerns in their 2015 outlooks for not-for-profit hospitals.<sup>1</sup> Cost-cutting and improved productivity are two means of providing some relief in a traditional sense. But for boards willing to think outside the box, supply chain professionals believe that real success will come not with simply negotiating lower costs, but with an all-encompassing movement that takes quality and outcomes into consideration along with costs. Supporting this premise,

supply chain experts point out that pay-for-performance quality measures, which originated as pay-for-reporting, continue to evolve. To-date, core quality measures on the CMS Hospital Compare website have been focused on improving clinical processes, such as delivery of timely and effective care for heart attack, stroke, emergency care and more. Supply chain professionals are collaborating with clinicians on new measures that are increasingly dependent on supplies, such as vascular central line-associated infections, catheter-associated urinary tract infections, pressure ulcers and more.

### The Convergence of Cost, Quality and Outcomes (CQO)

The Association for Healthcare Resource & Materials Management (AHRMM), personal membership group of the American Hospital Association (AHA), is the leading organization for health care supply chain professionals. In 2013, AHRMM introduced its Cost, Quality and Outcomes (CQO) movement. CQO represents the intersection or convergence

between health care costs, quality and outcomes. It is a holistic view of the correlations between cost, quality and outcomes. AHRMM defines:



cost in its equation as “all costs associated with delivering patient care and supporting the care environment”;

quality represents “patient-centered care aimed at achieving the best possible clinical outcomes”; and

outcomes are defined as “the financial reimbursement driven by outstanding clinical care at the appropriate costs.”

The CQO movement was developed not as a tool, but as an encompassing and permeating effort to equip the health care supply chain profession for health care transformation. The movement has been designed to strengthen supply chain

**Supply chain management represents more than simply a means for negotiating lower costs. Hospital and health system leaders should consider supply chain professionals their strategic allies.**

professionals' skills and expertise, and ensure their readiness to successfully navigate and provide leadership through health care transformation, using CQO as a framework for strategic decision-making.

The CQO movement provides education, training, products and services for supply chain professionals. In 2013, the movement's first year, AHRMM focused its CQO education and training to the supply chain professional at

the provider level. In 2014, the focus was to move beyond the provider setting to engage the broader healthcare field. In 2015, AHRMM continues focusing CQO on the engaging the supply chain professional and thought leaders at both the provider and healthcare field levels.

The supply chain represents more than simply a means for negotiating lower costs. Internally and externally, it is



executive representatives from many of the key industry stakeholders for a vibrant and engaged dialogue about the future of supply chain in health care. Stakeholders included group purchasing organizations (GPOs), suppliers/manufacturers, distributors, health insurance companies, solution providers and government agencies. The group of thought leaders discussed factors critical to

interwoven with more hospital and health system functions than any other department or function in an organization, placing it in the best position to develop strategic responses that will strengthen hospital finances and help to improve quality of care. With the CQO movement as a resource, AHRMM's goals have been "to prepare supply chain executives and professionals to:"<sup>2</sup>

- Decipher and leverage complex analytics;
- Understand the impact of various payment policies on reimbursement, including accountable care, bundled payments, value-based purchasing and other programs;
- Create discussion, build consensus, and when appropriate, motivate change around clinical preference items;
- Anticipate and swiftly respond to disruptions in the supply chain (such as drug shortages) to ensure that patient care is not compromised; and
- Understand the impact of all medical supplies, devices, and pharmaceuticals on patient outcomes and reimbursement.

### CQO Isn't Just a Supply Chain Issue...It's a Health Care Issue

In an effort to broaden the CQO constituency and collaboration with others in the health care field, in August 2014 AHRMM brought together thought leaders from the supply chain profession with

CQO success, such as strengthening trustful collaboration and partnership among stakeholders, and the development of meaningful metrics. They recognized that a critical element in finding cost savings will be working with clinicians to better understand what materials or products are used with which patients, by which clinicians, in what facility, and linking that data and information to costs and clinical and financial outcomes. Collaborations such as this would contribute to the development of demand forecasting models.

Thought leaders discussed the fact that outcomes will be the greater cost driver of the future, not supply costs. It was emphasized to thought leaders that unlike other industries, the health care field does not view supplies as assets. One thought leader observed that comparative effectiveness research focusing on products will be essential to changing that viewpoint, and can be facilitated by operationalizing unique device identification to track and trace supplies and their impact on outcomes.

Themes that emerged from thought leaders' CQO discussions, included:<sup>3</sup>

- The vital need for effective collaboration and solutions-based engagement between providers and suppliers;
- The importance of engaging physicians and surgeons in cost, quality and outcomes efforts; and
- The critical role that cloud-based technology can and will have in

### CQO: Questions for Boards of Trustees

Although the board of trustees is not intimately involved in the details of supply chain management, the board should understand the high-level challenges and implications. As the board sets the tone, determines the strategic direction and allocates resources, the supply chain management and its implications should be incorporated. Boards should start with questions such as:

- ✓ Does your board understand the implications of the supply chain on cost and quality?
- ✓ Does your board understand current supply chain challenges impacting the organization? What about projected trends in the future?
- ✓ Is collaboration encouraged between supply chain leaders, physicians and surgeons?
- ✓ Has your board considered incorporating supply chain leaders into strategic discussions toward an all-encompassing movement that takes quality and outcomes into consideration along with costs?

supply chain and health care transformation solutions.

Supply chain management represents more than simply a means for negotiating lower costs. Hospital and health system leaders should consider supply chain professionals their strategic allies as they develop plans and initiatives for successfully navigating health care transformation and fulfilling the organization's mission to serve patients and their communities.

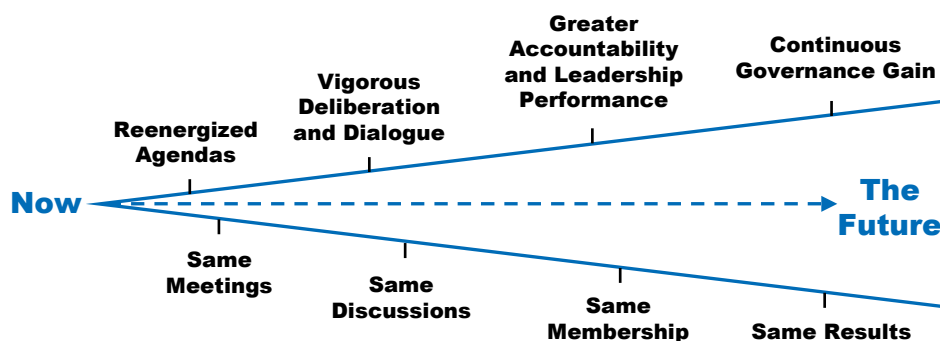
*To download a full copy of the 2014 AHRMM Thought Leader Summit white paper, which highlights the key trends identified as the leading drivers for healthcare supply chain success, go to [www.ahrmm.org/AHRMM14-Thought-Leader-Summit](http://www.ahrmm.org/AHRMM14-Thought-Leader-Summit).*

### Sources and More Information

1. Respaat, Robin. Grim Outlook for Healthcare, Hospital Sector in 2015: Rating Agencies. *Reuters*. December 16, 2014.
2. AHRMM. [www.ahrmm.org](http://www.ahrmm.org). Accessed 3-6-15.
3. AHRMM14 Executive Thought Leader Summit White Paper: Cost, Quality, and Outcomes: The Future of Healthcare Supply Chain. August 2014.



## What Direction Do You Want Your Board to Take?



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strategic thinking. If a frank and forthright assessment of strengths comes up short in these areas, rethinking governance education, trustee performance expectations and targeted succession planning is needed to advance the caliber of the board's performance.

**Rethinking Board Composition.** The board should be comprised of individuals who display a diversity of opinions, independence and objectivity in their thoughts and actions. Oftentimes, professional diversity is the first focus of board succession planning. Yet, with accountability for mission fulfillment, board members are called upon to address their community's health care disparities and to strengthen cultural competency. To eliminate disparities and inequities of all kinds, and to gain from new and different perspectives, insights, and understanding, rethinking the board's composition should extend to encompass not only diverse professional expertise, but also race, ethnicity, gender and age.

Many boards would also benefit by advancing from representational composition to a board composition based on competency. Competency-based boards provide the overarching expertise, experience and perspectives needed to successfully govern into the future while still reflecting the community or communities served.

**Rethinking Board Meetings and Agendas.** Active discussion, inquiry, deliberation and debate are the board's best tools for engaged governance and leadership. Yet just over 40 percent of boards report that

they spend more than half their board meeting time in active discussion, deliberation or debate rather than listening to reports and presentations.<sup>2</sup> A consent agenda should be used to free up time for board members to deliberate over issues, ask penetrating questions, envision various scenarios and ultimately reach well-considered decisions. If board meetings and discussions have become routine and monotonous, re-energize them with retreat style round-table or small group discussions. If decisions are rote and "rubber stamp", encourage board members to challenge assumptions. If needed, the board chair or other member of the board should take the role of "Devil's Advocate," posing contrarian views for the sake of prompting deeper thought and consideration of issues.

A quick scan of board meeting agendas should indicate if the board is spending its time where it's needed most. Studies of evidence-based governance best practices show that high-performing community health systems spend nearly three-quarters of their time equally on strategic thinking and planning (24 percent), financial performance (24 percent) and patient care quality and safety (25 percent). Remaining time on high performing board agendas is also devoted to oversight of community benefit programming (10 percent) and board development (e.g., education, performance evaluation, succession planning, recruitment) (10 percent).<sup>3</sup>

**Rethinking Board Committees.** Board performance can benefit from sound delegation practices and strong committee work in several ways. Appropriate delegation of work to committees can free

## "Jump Start" Your Governance Rethinking

Trustees should consider the following questions to "jump start" their rethinking:

- ✓ What are the greatest challenges your organization will face in the next three to five years?
- ✓ What potential scenarios has the board envisioned for the organization's future? What initiatives have been undertaken to prepare the organization for those scenarios?
- ✓ Are you personally ready to provide the leadership required to navigate the trends and health reform implications shaping the health care environment? Is your board ready?
- ✓ Does your current governance structure best position your entire organization for long-term success? If the board were to develop its governance structure today, would it be the same or different? What would you change and why?
- ✓ Does the board continually incorporate new information and new ideas to reshape its strategic thinking?
- ✓ What does your board need to rethink?

up limited board meeting time, allowing more opportunities for the board as a whole to focus on strategy, policy and vision. High performing committees can present the board with evidence-based recommendations and rationale that enable the board to hone in on the crux of an issue, deliberating only on the most relevant concerns and making timely, nimble decisions. Many boards also benefit from engaging individuals who are not on the board to serve on committees. If carefully selected, these individuals can fill gaps in needed committee expertise, but also serve as potential candidates for future board service.

## Sources and More Information

1. American Hospital Association. Hospitals in Pursuit of Excellence. Redefining the H. 2015. [www.aha.org/research/cor/redefiningH](http://www.aha.org/research/cor/redefiningH).
2. American Hospital Association's Center for Healthcare Governance. 2014 National Health Care Governance Survey Report. 2014. [www.americangovernance.com](http://www.americangovernance.com).
3. Prybil, Lawrence Ph.D., et. al. Governance in High-Performing Community Health Systems: A Report on Trustee and CEO Views. Grant Thornton LLP. 2009.

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- **Teamwork:** Continually train in both team skills and job specific competencies, encouraging caregivers to consistently work in a collaborative manner in which each individual has a responsibility to identify and/or act to prevent potential medical errors.
- **Focus on Improving Systems and not Blaming Individuals:** The focus should continually be on fixing systems so that the error cannot occur again.

### Engaging Physicians and Building Medical Staff Partnerships for Quality and Patient Safety

The board is responsible for setting direction, goals, and oversight. This accountability cannot be delegated to the medical staff. High performing organizations have common, aligned goals set by the board and jointly developed by the administration and physicians. The medical staff plays an important role in the delivery of safe, high quality care to patients and in achievement of the organization's goals.

One way to build the relationship is by establishing clear expectations that physicians should anticipate of the organization, and expectations that the organization anticipates of physicians. This is called a "compact." A clearly defined compact can help build alignment with existing physicians and also aid in future recruitment efforts—physicians looking for a partnership and shared vision may be drawn to organizations with a clearly defined compact, while others may be deterred by the concept.

**Strengthening Board and Physician Communication.** The contrasting cultures of physician independence and autonomy and board shared-decision making may be difficult to overcome, but can be achieved through board-medical staff

communication, relationship-building and mutual respect. The board sets the tone for the hospital by creating a "practice friendly environment" through strategic understanding of the clinical and medical staff issues, ensuring adequate staffing, quality employees, efficient and effective processes, and providing adequate resources.

Board/medical staff relationships can also be enhanced through additional efforts, such as retreats and workshops, one-on-one meetings or focus groups that allow both groups to understand one another's viewpoints. Conducting a medical staff needs assessment can also help the

board to understand physician needs, and physician involvement in strategic planning allows mutual understanding of long-term issues and a shared long-term vision.

**The End Goal: Improved Care.** If boards struggle to get physicians on board with a quality and patient safety plan, explaining how implementing the plan will provide their patients with better care will build and sustain physician support. Make sure providers know that the changes will result in fewer errors and less harm to their

### Ensuring a "Just Culture"

The board's actions set the tone or "culture" for their organization, including setting patient safety guidelines and priorities and dedicating the resources necessary to provide appropriate, effective, safe care.

Physicians and clinical staff must be held accountable for providing superior quality. For example, a physician who does not wash his or her hands or has a high rate of infections needs to be supported and held accountable for improving his or her care.

**This matching of the board's role and fixing systemic issues as the cause for patient harm, while simultaneously holding staff accountable when there is reckless behavior, is called a "Just Culture."**

A "Just Culture" advances organizations beyond simply saying that human error is unacceptable, which only hides errors and prevents learning. It is important to have a culture where mistakes, regardless of severity, are reported and learned from. Mistakes should be viewed as a learning opportunity, bringing to light systems to fix, unless an obvious lack of judgment is a primary cause.

For more information about the Just Culture concept, see: *Patient Safety and the 'Just Culture': A Primer for Health Care Executives.* Marx D. New York, NY: Columbia University. Agency for Healthcare Research and Quality. April 2001. <http://psnet.ahrq.gov/resource.aspx?resourceID=1582>.

patients, itemizing the specific desired outcomes as a result of the changes. In addition, demonstrate how the change will take them equal or less time. Engage physicians early with a physician champion playing an integral role in the decision-making and implementation process, clearly communicating that physicians will be instrumental in developing and implementing the patient safety plan. The reward will come for the physicians when they see their patients are receiving the very best care possible.

### Implementing a Quality Dashboard

It is important that hospital trustees understand the quality of care provided at their hospital or health system. A hospital's dashboard is a clear, straight-forward approach for boards to understand if they are providing good, really good, or top-tier quality. A robust dashboard will typically include the following measurements:

- Quality measures posted on the CMS Hospital Compare website;
- Joint Commission Data (maternity measures, accreditation, patient safety goals);

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- Patient satisfaction measures posted on the CMS Hospital Compare website;
- Mortality and Sepsis Mortality;
- Readmissions all-cause, and for Critical Access Hospitals, transfers after the first 24 hours;
- Cesarean rate for low risk, first birth women (NTSV);
- Opioid and broad spectrum antibiotic usage;
- Infection measures from the National Healthcare Safety Network (NHSN), including surgical infections, urinary catheter infections, ventilator infections, central line infections, MRSA, and C. diff infection rates;
- Employee injuries;
- Radiation dosage in children;
- Outpatient measures;
- Nursing measures, including falls and ulcers;
- Physician measures (Physician Quality Reporting System (PQRS)), such as aspirin for heart attack and diabetic control with Hemoglobin A1c;
- Adverse events;

- Medication adverse events, such as hypoglycemia, anticoagulation, opioids;
- State-specific reported measures;
- Nurse staffing plans; and
- Other facility specific topics, such as: emergency department (diversion, boarders, waiting time, patients who come more than five times in rolling 12 months); incident reports; medical malpractice claims (open, closed); and community health measures (examples may include diabetes, asthma, and obesity).

### ***“Safety Across the Board” Dashboard.***

Some hospitals combine their comprehensive quality dashboard measures together into what is called a “safety across the board” measure. The amount and complexity of data can be daunting, and interpretation of the information is important for board members to understand.

Data should be presented in trended graphs. They can either be rates or counts. When interpreting quality data, boards should think about:

- How do we compare with other organizations? Are we in the top 25% of performance? The top 10%?
- Are there five points on a trend graph going in the direction of improvement? One or two points do not show a trend.
- How is the data impacted by seasonal variation?
- Has care improved for all patients, or do certain ethnic groups have different results?

Although staff have the best intentions, too often reports are too detailed and board members either do not have the opportunity or do not feel comfortable asking basic questions about quality reports. When this happens, the opportunity for strategic discussion is lost.

To maximize the impact of quality reporting, graphs should be labeled with

### **Ensuring Success in Patient Safety Programs**

- ✓ The board is engaged and reviews quality data at each board meeting
- ✓ A CEO with a strong track record (results) is in engaged in quality and safety
- ✓ The CEO’s compensation is linked to quality and safety results to at least the same degree as financial success
- ✓ There is recognition that patient safety errors occur in the hospital
- ✓ There is agreement that the current error rate is unacceptable
- ✓ There is a culture of fixing the “system” when errors are identified and discussed
- ✓ The organization holds physicians accountable
- ✓ Data is posted on units so that care delivery staff see and can participate in progress
- ✓ Accountability for quality and safety reporting to the board is in place in all corners of the organization
- ✓ The board allocates resources for quality improvement and error prevention
- ✓ Physicians are engaged and active partners in achieving quality aims

terminology that board members understand, and should clearly highlight the trends and information they were designed to communicate.

### ***Staff, Patient and Family Dashboards.***

Transparency builds trust and a sense of partnership with employees as well as patients and families. Hospitals and health systems should post quality and patient safety data in units relevant to the care provided. Examples of data to post on nursing units are hand hygiene results, pressure ulcers, falls, and infection rates. In addition, if asked, employees, patients and families will often have improvement suggestions. The board should encourage leaders to have a process in place to gather and respond to suggestions for improvements to the patient care experience.

