Summary of the
Maryland Patient Safety Center
Boards on Board Roundtable

Engaging Boards in Patient Safety:

A Working Paper for Hospitals from the Maryland Patient Safety Center & Maryland Healthcare Education Institute

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Engaging Boards in Patient Safety: One Facility's Story

Lee Carter, a Board member at Cincinnati Children's Hospital Medical Center, speaks matter-of-factly about winning the 2006 American Hospital Association (AHA)-McKesson Quest for Quality Prize. Ten years earlier, the Board of the 511-bed academic medical center had committed itself to improving quality and patient safety and to providing family-centered care. To some, the prize could have been seen as a testament to the medical center's success. But not to the Board of Cincinnati Children's – and definitely not to then-Board Chair Carter.

The prize came at a time when the Board had begun to take a different look at patient safety data and was starting to ask pointed questions of the executive team. "We didn't allow ourselves to be satisfied with a 97 percent patient satisfaction score," Carter explains. "We wanted to know what the 3 percent 'gap' represented." And the Board didn't like the answer: At Cincinnati Children's, which has 900,000+ patient encounters each year, 3 percent translates into 27,000 bad experiences.

Shortly after winning the Quest for Quality Prize, the Board held its annual retreat and saw other data it didn't like. At Cincinnati Children's, 17 children were harmed each year. An average number, says Carter, but an unacceptable number to the Board. So, in 2006, the Board set a goal of zero incidents of preventable harm by 2010.

Cincinnati Children's mantra is "measure, measure, measure." Everyone in the organization is 200 percent accountable, says Carter – 100 percent for themselves, and 100 percent for everyone around them. Run charts are posted in real time on the hospital's Intranet, where 11,500 employees also see the word "safety" mentioned 10 or more times on the home page; system-wide outcome measures and performance data are on public display on the hospital's Web site; and quality, not finances, is the first agenda item at Board meetings.

So, what progress is the pediatric facility, which recently made U.S News & Word Reports' 2009 Honor Roll for Best Children's Hospitals, making toward eliminating preventable harm by 2010? "Our goal in 2007 was 12, but we only made it to 14," Carter acknowledges. "Last year, we aimed for eight and got to seven. We were shooting for four this year, but only made it to five " (The hospital's fiscal year ended on June 30.) The hospital is clearly making progress but, cedes Carter, it's very hard work.

The important change from 2006, he says, is Cincinnati Children's has created a culture of trust within the organization that allows for transparency regarding patient safety. Over time, says Carter, we've become "ardent about transparency."

Is your hospital ready? Is your Board?

Engaging Boards in Patient Safety: The Maryland Boards on Board Roundtable

Carter shared many of the strategies Cincinnati Children's used to get its Board more engaged in patient safety at a recent roundtable sponsored by the Maryland Patient Safety Center (MPSC) and Maryland Healthcare Education Institute (MHEI) in Savage, Maryland. Presidents/Chief Executive Officers (CEOs) and Board members from nine Maryland hospitals and health systems participated in the day-long, by-invitation-only, event. James L. Reinertsen, MD, Senior Fellow at the Institute for Healthcare Improvement (IHI) and President of The Reinertsen Group, framed, guided, and facilitated the discussion.

This MPSC/MHEI "working paper" is a synthesis of the day's presentations and discussions. It also contains 10 practical, "actionable" strategies for engaging hospital Boards in patient safety and seven questions healthcare Board members shouldn't hesitate to ask the executive team.

Steal the good ideas and share them with your colleagues. Then share your successes, challenges, and best practices at local, state, regional, and national forums on quality and patient safety, such as MHEI's 34th Annual Medical Staff and Governance Leadership Conference, which will be held on October 18-20, 2009, at the Hotel Hershey in Hershey, Pennsylvania, and MPSC's 6th Annual Maryland Patient Safety Conference, which will be held on March 19, 2010, at the Baltimore Convention Center.

Boards of trustees and healthcare executives play a critical role in patient safety. The Joint Commission recently issued a Sentinel Event Alert that urges healthcare leaders to step up efforts to prevent errors and to take specific steps to improve patient safety. This reinforces the MPSC dedication to providing healthcare leaders with the tools and resources to be successful and proactive in their efforts to address and improve the quality of care for patients.

Help the Board "See" the Data

When Boards become activated about hospital quality – and patient safety ranks high on that list – it makes the CEO and administration sweat over the next Board quality committee meeting as much as they sweat over the finance meeting, says James L. Reinertsen, MD, a leading hospital medical staff and governance consultant. One way to get their attention, he suggests, is by telling stories. Reinertsen urges hospitals to start each Board quality meeting with a recent, real-time story about patient care in the facility – ideally told by the patient or the patient's family and the staff who cared for the patient. "And not just the miracle moments," he adds.

Telling patient stories to the Board is one of the techniques Anne Arundel Medical Center staff learned last fall at an IHI meeting. Chief Operating Officer (COO) Victoria Bayless, BS, MHSA, says it's helping her organization become more transparent. Ideally, patient stories also help "put a face" on data that the Board will discuss in the meeting.

Reinertsen and Carter recommend hospitals take a serious look at the data themselves. Neither suggests moving away from run charts. Quite the contrary, "the currency for communication in an organization is the run chart," says Reinertsen – although he thinks the more sophisticated CUSUM (cumulative sum) control chart provides a better early warning signal in many cases. But run charts don't help Boards see the patients behind the numbers.

Samuel L. Ross, MD, MS, CEO of Bon Secours Baltimore Health System, wholeheartedly agrees. "All of our healthcare decision making should be patient centric. But we break data about our patients into so many pieces – a run chart for patient falls, another for infection rates – that we lose track of the individual."

When reviewing patient safety data, Cincinnati Children's Board members now ask: "how many patients is that?" Carter describes one meeting during which the Board was reviewing the rates of ventilator-associated pneumonia (VAP). While he acknowledged the importance of the data, Carter wanted to know how many kids went home because they didn't get VAP. "Telling me how many patients this means is information I can understand," says Carter. Cincinnati Children's now routinely converts "rates/thousand" or "rates/patient days" into real patient numbers and adds those numbers to its run charts.

Reinertsen has examples of other ways hospitals are helping their Boards "see" the data. He cites one hospital that showed the number 514 on a PowerPoint slide. No title, no text. Just the number 514 "The Board, of course, wanted to know what 514 meant," he says. The next slide was a pie chart that broke down the number of patients harmed during that reporting period – 514 – into seven categories of harm (198 infections, 137 adverse drug events, 39 codes, 49 surgical complications, 53 falls, and 27 "other").

Delnor Hospital, a 159-bed, Planetree-designated hospital for patient-centered care in northeastern Illinois, gives its Board two views of its patient safety indicators.

It first projects a slide that contains a table showing the hospital's performance against nine patient safety indicators, such as the number of accidental punctures or lacerations, over several consecutive reporting periods and a run chart for one of the indicators. Then it clicks on a slide that "builds" in PowerPoint. On this slide, patients' first names and the first initial of their last names appear – some changed to protect their privacy – one name at a time along with the date of their adverse event and type of event. The patient information is also color coded.

Most of the 16 names on the slide Reinertsen showed at the roundtable were colored red. The names of the six patients who died from their adverse events at Delnor during that reporting period appeared in blue. "Talk about getting the Board's attention," says Reinertsen. (The 22 people who saw Reinertsen present this slide at the roundtable were themselves speechless.)

Reinertsen also suggests eliminating denominators altogether from many Board reports. "You don't need them to compare yourself to yourself over time," he insists.

While Boards do need to know how their organization compares to best-in-class hospitals, those data don't need to be reviewed at every meeting. A thorough review of important benchmark data once a year may suffice, allowing the Board to focus its attention at every other meeting on those charts and reports that show whether the organization is on track to achieve its strategic goals.

Richard "Chip" Davis, PhD, Vice President, Innovation & Patient Safety at Johns Hopkins Hospital, concurs. "Early on, we were drowning our Board with data," says Davis, "until the Board Chair said: 'This is too much. Give me five metrics.'" Make sure the metrics you choose align with the organization's strategic goals, cautions Carter.

Rather that talking about infection rates or surgical complication rates, Reinertsen urges the executive team and the Board to take the discussion to a higher plane.

Boards need to start asking the really tough questions, he says, such as: "How many people did we harm here last month?" Engaging in these conversations will send a clear signal throughout the organization that the Board is committed to patient safety.

Lessons Learned from Two Forward-Thinking Organizations

"Getting the Board 'on board' is hard work," says Anne Arundel Medical Center COO Victoria Bayless, BS, MHSA, echoing Cincinnati Children's Board member Lee Carter. "The IHI staff made it sound easy and clear," says Bayless of the IHI meeting she and Board member Patricia Roche attended last fall.

Anne Arundel staff have started telling patient stories to its Board. It is working on creating quantifiable strategic aims, expanding committee membership to some younger physicians on the medical staff, and retooling its quality dashboard. "We aimed for 10 leading measures and wound up with 20", said Bayless. " We're still working on scaling them back. Knowing what our baseline is has been a problem."

"We're struggling with credentialing," adds Board member Roche. "We need to figure out how to marry the quality and credentialing reports, how to find balance in celebrating successes and recognizing harm."

To Anne Arundel Medical Center and other healthcare organizations that are taking the lead in patient safety, Lee Carter offers the following advice:

- You are never as good as you think.
- Audacious goals are required to achieve transformational change (otherwise you're just managing incrementally).
- Transformational change is very hard.
- It always takes longer than you think.
- With perseverance, you can reach the "tipping point" and succeed!

Going Public with Patient Safety Data

Hopkins' Davis recounts a dinner meeting he had in Boston with Reinertsen and IHI President Donald Berwick, MD. "I was clearly underwhelming Berwick," Davis admits, "only to have Jim suddenly ask if I knew what Hopkins' hearse rate was. Jim was asking if I knew how many patients leave Hopkins each week in a hearse."

It was a sobering moment for Davis, who resolved to return to Baltimore and become a Hopkins champion for full disclosure of real-time, patient safety incidents, including the number of patients the hospital has harmed each week. A key first step: Gaining buy-in from Hopkins' senior leadership team and legal counsel. The result: each Friday afternoon at 3:00, Davis' staff e-mails The Johns Hopkins Weekly Report of Harm to 300 people, starting with the Board Chair and going down through the organization to mid-level management, not just to board members, executives and clinical chiefs. And it's Davis' expectation that many who receive the email will forward it to colleagues and friends in and out of the hospital.

The Weekly Report of Harm is part of a new quality culture at Hopkins. "Our staff knows where we are in any week," says Davis.

After going 80+ weeks without a blood stream infection, Hopkins recently had one, and when it appeared on the weekly report, says Davis, "the staff responded as if the sky had fallen."

The Board, however, had a more nuanced response – one that is indicative of its commitment to a culture of trust and transparency. Hopkins' Board believes the hospital's blood stream infection should be zero, and that's the goal it set. "It's achievable," says Davis.

At the same time, notes Reinertsen, everyone involved in patient care acknowledges that "stuff happens." And the Hopkins Board's reaction to the one blood stream infection wasn't accusatory, says Davis. No one asked who the physician of record was. Instead, the Board wanted to figure out how to fix the system to achieve the goal it had set.

Asked if he thinks Hopkins has been sued because of its Weekly Report of Harm, Davis says "no." Seen any embarrassing front-page stories in the Sun or Post? "Maybe," he replies.

There are definite tradeoffs, says Davis. You solve the problem of your Board not knowing about quality problems. In the process, you choose to live with potential lawsuits and media backlash. Regardless, he says, "Hopkins' execs and staff feel it's the right thing to do."

"He Assembled a Meeting and a Riot Broke Out"

That, says T. Michael White, MD, Chief Medical Officer at Washington County Hospital (WCH), is how first-time attendees at the hospital's monthly Quality Forum often describe the meeting – including Maryland Patient Safety Center Executive Director Bill Minogue. "It can look like chaos," White concedes.

Like Carter, White traces his involvement with Board quality and patient safety to the late 1990s. He devised the construct of the Quality Forum when he was Vice President of Value and Education/Chief Medical Officer at the University of Pennsylvania Medical Center (UMPC) McKeesport, the position he held before joining WCH in 2008. The Quality Forum was an immediate hit at McKeesport and was considered a best practice by UPMC, an academic medical center conglomerate of 20 Pennsylvania hospitals. Payers like HighMark Blue Cross Blue Shield of Pennsylvania also gave the Quality Forum high marks. Upon his arrival in Hagerstown, White told WCH President and CEO James Hamill that his hospital needed to have a Quality Forum, too. Within two months, White convened the first meeting.

WCH's Quality Forum includes the Board, administration, nursing and medical staff leadership, and department heads, but anyone who is interested can attend. "It's not unusual for us to have 90 attendees," says White.

The group meets once a month and reviews 70+ pages of run charts, reports, and other documents pertaining to the hospital's progress toward its mission and its key strategic quality initiatives along with highly sensitive data on patient safety, quality, and satisfaction – all in the span of 90 minutes. The Quality Forum provides a data-driven assessment of the organization that acknowledges WCH's successes against the backdrop of opportunities for improvement, action plans, and continuous improvement feedback loops.

The first two or three meetings were hard on the staff, admits White. "We jump back and forth through three large packets of paper. But we've since established a rhythm for the meeting. The staff now knows exactly where in each packet to look for the information they are interested in. They come prepared, particularly if they have something to say. And staff who do have something to say, frequently champions for one of the hospital's quality improvement initiatives, seldom speak for more than two minutes. We talk 'New York fast,'" he adds.

White says WCH's Board definitely "sees" the hospital's patient safety issues. Everyone on the Board has passed the "Patient Safety 101" course. "They are ready for a master's-level course," he says. "Stuff happens and we tell them about it. The Board assumes we do something about the issues we bring to their attention." White wants them to know that's actually happening. "It is," he insists, "their fiduciary obligation."

To that end, and partly as an outgrowth of his participation at the MPSC/MHEI roundtable, White wants to hold a day-long leadership orientation this fall for the administration, Board, and medical and nursing staffs. His goal is to expose hospital leadership and trustees to the steps WCH takes after it brings quality issues to the Board's attention.

"The Board knows about incident reports and root cause analyses," he says. "They don't know where or how we separate process issues and people issues. They need to know how we determine accountability and how we handle peer review. We need to show them how we close the circle on patient safety incidents. The Board needs to be able to speak to issues like these if asked about patient safety by regulators like the Joint Commission."

Would your hospital be able to? Would your Board?

Three Useful Strategies to Get the Board's Attention

- Tell stories
- Put a face on the data
- Eliminate denominators

Seven Effective Strategies for Solving Patient Safety Problems

- Adopt clear strategic safety aims
  - As measured by [fill in the blank]?
  - By when?
  - (Remember "some" is not a number; "soon" is not a time)
- Develop a strong quality committee
  - Involve patients and/or family members
- Oversee a useful, timely dashboard
  - Make sure the metrics align with the organization's strategic aims
- Adopt bold stances on transparency
- Go public – immediately – with bad news
- Have courageous conversations *at* Board meetings (not in the parking lot *after* the meeting)
- Marry your quality and re-credentialing reports

Adapted from James L. Reinertsen, MD, The Reinertsen Group

Where to Next? Setting Goals

In his work as a governance consultant, Reinertsen offers a different slant on the 80/20 rule many quality improvement teams frequently cite: 20% of hospital Boards in the U.S. are "on board," he estimates – meaning some 4,800 of the nation's hospital Boards, the other 80%, are not.

Nevertheless, Reinertsen says he hasn't yet seen many sophisticated Boards begin to wrestle with two challenging issues that need to be addressed:

- What mechanism can hospitals put in place to give their Boards as much confidence about the quality report as they place in the organization's routine financial audit?
- How will the Board handle the discomfort that likely will arise if it sets an "audacious" performance goal – one like Cincinnati Children's zero incidents of preventable harm by 2010 – that might not be achievable? What message does it send to the organization? (And tangentially: How does the Board then tie a potentially unachievable goal to its CEO's annual compensation package, which is tied to performance?)

Quality audits and CEO compensation vis-à-vis goals of zero incidents of patient harm may be topics for a future MSPC/MHEI roundtable.

But Cincinnati Children's Carter doesn't skip a beat when asked about setting "stretch" patient safety goals. "Audacious goals," he insists, "are required to achieve transformational change."

Is your hospital ready? Is your Board?

Some Questions ANY Board Member Can Ask

- Are we on track to achieve the organization's aim?
- Are we executing our strategy to achieve our aim?
- Are we "off the rails" on any regulatory or compliance issues? (Any time the "Check Engine" light comes on, the executive team and Board must take immediate action.)
- Does this set of re-credentialing recommendations fully support the organization's mission, aims, and strategies?
- How many patients is that?
- Who is best in the world?
- Were patients and families involved?

Adapted from James L. Reinertsen, MD, The Reinertsen Group

Boards on Board Roundtable Participants

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