

Incentives for Patient Safety: Holding Healthcare Executives Accountable

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Traditionally, governing boards of healthcare facilities have focused more on the business and financial side of operations than on patient safety and quality. More recently, as a result of the patient safety movement, pay-for-performance plans, stricter regulations, and calls to action from organizations such as the Institute for Healthcare Improvement (IHI), the Leapfrog Group, the National Quality Forum, and the Joint Commission, governing boards are receiving education on patient safety and quality issues and becoming responsible for ensuring that their organizations perform well in terms of patient safety and quality. In addition, some facilities are holding chief executive officers (CEOs) and other senior executives accountable for meeting patient safety and quality goals by ensuring that some of their pay depends on it.

This article discusses the responsibility and accountability for quality improvement in healthcare organizations from the top down: from the governing board's responsibility for overseeing patient safety and quality efforts, to CEOs' and other executives' accountability for meeting patient safety and quality goals, and to all other staff's commitment to improving patient safety and quality as part of their job descriptions and performance reviews. In addition, selection of patient safety and quality measures, challenges to implementing such efforts, and the future of governing board involvement and executive accountability are discussed.

IMPROVING QUALITY FROM THE TOP DOWN

Patient safety and quality has only recently become a significant issue for healthcare governing boards. According to Robert M. Wachter, M.D., professor and associate chairman, department of medicine, University of California, San Francisco (UCSF); chief of medical service, UCSF medical center; and editor, Agency

for Healthcare Research and Quality *WebM&M* and PSNet, the 1999 Institute of Medicine (IOM) report *To Err Is Human* got the focus on quality and patient safety started, but governing boards "didn't automatically jump up" and focus their efforts on quality. "What the IOM report did was create a momentum that focused everyone's attention on patient safety and quality," says Wachter. After the IOM report, governing boards were starting to make efforts related to improving patient safety and quality, but they were often unaware of errors occurring in their organizations. However, several factors, including requirements for healthcare facilities to report events publicly, more aggressive efforts by the Joint Commission, and heightened engagement from regulators, "made the traditional board stance of 'hear no evil, see no evil' untenable," says Wachter. He adds that a few healthcare organizations' governing boards

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▶ IN OUR VIEW

Should CEOs Be Paid for Quality?

In the traditional view of hospital governance, governing boards focused more on financial performance than patient safety and quality of care. However, the Institute of Medicine report *To Err Is Human*, published in 1999, initiated some major changes in the ways healthcare organizations operate in terms of patient safety and quality, including the way they are governed.

Within the past few years, governing boards are becoming more responsible for patient safety and quality, more educated on such topics, and more focused on holding chief executive officers (CEOs) and other senior executives accountable for meeting goals. Some healthcare organizations are providing financial incentives to CEOs and senior executives to ensure that patient safety and quality goals are met; for example, a CEO may lose a portion of his or her bonus if the healthcare organization does not meet its goal for reducing healthcare-associated infections.

The lead article of this month's *Risk Management Reporter* discusses responsibility and accountability for patient safety and quality from the top down: from the governing board's oversight responsibility, to the CEO's and other executives' accountability for meeting goals and financial incentives received for doing so, to all staff's commitment to improving patient safety and quality.

So how do risk managers feel about healthcare organizations providing compensation to senior executives for meeting patient safety and quality goals? Results from *Healthcare Risk Control's* survey on executive compensation revealed a lack of consensus among risk managers regarding whether senior executives should receive such compensation. Some survey respondents felt that providing incentive packages to senior executives would result in improvements in patient safety and quality. However, others noted that executives should not receive financial incentives for something that is "part of their job" or that incentive packages "divert from the goal of providing safe quality care, which is our business, to meeting a defined number." Indeed, holding governing boards and senior executives accountable for patient safety and quality presents many challenges that healthcare organizations need to address; some of these challenges are also discussed in the lead article.

As the emphasis on ensuring patient safety and quality care continues to grow, it is likely that governing board and executive accountability will only increase in the future. In addition, will frontline staff someday receive a bonus if they meet a goal such as practicing appropriate hand hygiene? Accountability for patient safety and quality is a growing trend; the *Risk Management Reporter* will continue to cover this topic.

Sincerely,
Cara Nageli

Cara Nageli
Senior Healthcare Writer

were engaged in quality at the time of the IOM report, but it was often because they either had a visionary leader or they had experienced a critical error. For most organizations, the focus on board involvement in quality efforts began about three or four years ago.

In 2006, IHI called attention to board involvement in quality efforts and executive accountability with its 5 Million Lives Campaign. The campaign strives to prevent five million cases of patient harm from December 2006 to December 2008 by recommending 12 interventions for participating healthcare facilities; one of the interventions is “getting the boards on board,” or getting governing boards fully involved in efforts to improve safety and quality. One way boards can do this, according to IHI, is to establish executive accountability for meeting specific quality improvement goals. In its Getting Started Kit for governance leadership, IHI states, “An activated board, in partnership with executive leadership, can set system-level expectations and accountability for high performance and the elimination of harm, and, properly conducted, this leadership work can dramatically and continually improve the quality of care in the hospital.” More information about IHI’s campaign is discussed later in this article.

The importance of the governing board’s involvement in quality efforts and executive accountability has been stressed by other organizations such as the Joint Commission, the National Quality Forum, and the Centers for Medicare & Medicaid Services (CMS). For example, the Joint Commission issued prepublication governance and executive leadership standards that will be used for accreditation in 2009 (Joint Commission).

Some recent studies support the concept that healthcare facilities perform better when the board is involved and when executives are held accountable. According to one study, healthcare facilities that have boards that spend more than 25% of their meeting time on quality issues, that submit a formal quality performance report to the governing board, that tie a portion of senior executives’ compensation to meeting quality improvement goals, and that promote a high level of interaction related to quality issues between the board and medical staff had higher scores on a quality survey than healthcare facilities that did not engage in actions to the same extent (Vaughn et al.). “If you want to see results, it’s going to be at facilities with engaged boards and engaged executive leadership,” says James Conway, M.S., IHI senior vice president, and faculty member, 5 Million Lives Campaign.

Efforts to improve patient safety and quality at healthcare organizations need to start with the governing board and spread to CEOs, senior executives, managers, and frontline staff. All levels of staff within the healthcare organization need to commit to meeting patient safety and quality goals in order to make significant improvements.

It Starts with the Board

Establishing incentives for patient safety and quality improvement cannot be achieved without a commitment from the health system’s governing board. According to IHI, governing boards of healthcare organizations should spend at least 25% of their meeting time on issues related to patient safety and quality and should meet with at least one patient or family member who was involved in a serious unanticipated outcome at their organization during the previous year (Conway). According to a recent study of the structures, practices, and cultures of governing boards in a selection of nonprofit health systems, boards spend an average of 23% of their meeting time on patient safety and quality issues, an indication that healthcare organizations are getting close to meeting IHI’s goal (Prybil et al.).

IHI also recommends six activities that it believes should be performed by all governing boards of healthcare organizations (See “IHI’s Six Activities All Boards Should Do to Improve Quality”).

According to Wachter, until recently, governing boards focused more on fiduciary responsibilities than quality and safety for two reasons: (1) boards had few incentives for focusing on quality and safety and (2) most board members believed that they could not handle quality issues because they were not clinicians and had backgrounds primarily in business or finance. However, Wachter notes that board members who ran chemical businesses, banks, or other organizations should recognize that they have a lot to offer because they know how to run high-reliability organizations and they know how to move information along the system. “Often, they’re surprised about what they have to add to the organization,” he says. Therefore, one of the most important components of educating boards and getting them involved in quality is empowering board members to believe that they can improve quality and safety at their organizations. “It’s about letting them know that they might not know the right drug to treat a heart attack, but they know what safety looks like,” Wachter says.

IHI's Six Activities All Boards Should Do to Improve Quality

As part of its 5 Million Lives Campaign, the Institute for Healthcare Improvement (IHI) outlined the following six activities that the organization believes all boards should be doing, at minimum, to improve quality:

- 1. Set aims.** Each healthcare organization should “set a specific aim to reduce harm this year” and should make a public commitment to meet its goals (e.g., reduce cases of preventable mortality).
- 2. Get data and hear stories.** Every board meeting should begin with a review of quality activities and progress; IHI recommends that patients who have been harmed at the facility during the previous month and their families attend the meeting to put a “human face” on data. IHI suggests two steps that boards beginning the process should take, acknowledging that both steps are challenging:
 - Select 20 patient charts at random, and organize a team of clinicians to review the charts and identify and document all types and levels of injuries. The clinicians should then report results to the board. Organizations can continue to assess performance by conducting similar chart reviews on a monthly basis.
 - Conduct a detailed investigation of a serious case of patient harm at the facility, and interview the involved patient, family, and staff. The chief executive officer (CEO) and chief nursing officer should conduct the investigation and interviews, and the CEO should

present the case to the board (with the patient and family in attendance, if possible) for at least one hour.

- 3. Establish and monitor system-level measures.** Develop a dashboard tool (i.e., tool that sets up information in a format that is clear and easy to read) to provide regular updates and information on a small group of organizationwide quality measures to the board.
- 4. Change the environment, policies, and culture.** Create a culture of quality and safety that supports patients, families, and staff involved in adverse events and promotes full disclosure, apology, and learning from events.
- 5. Learn, starting with the board.** Ensure that boards receive education on quality and safety and learn about what the “best in the world” boards do to improve quality and reduce harm. The board should spread education throughout the system to all leaders and staff.
- 6. Establish executive accountability.** Ensure that compensation and performance reviews for top leaders are tied to meeting clear patient safety and quality goals.

Sources: Conway J. Getting boards on board: engaging governing boards in quality and safety. *Jt Comm J Qual Patient Saf* 2008 Apr;34(4):214-20; Institute for Healthcare Improvement. Getting started kit: governance leadership how-to guide [online]. 2007 [cited 2008 Mar 24]. Available from Internet: <http://www.ihl.org/IHI/Programs/Campaign/BoardsonBoard.htm>. ■

Some governing boards have established subcommittees to focus primarily on patient safety and quality issues. According to the study of the structures, practices, and cultures of nonprofit governing boards, nearly 90% of the organizations have designated a separate board committee responsible for ensuring both quality of care and the safety of patients, staff, and visitors (Prybil et al.).

At Catholic Health Partners (CHP) (Cincinnati, Ohio), the first step in getting its governing board involved in patient safety and quality efforts was creating a board-level quality and safety committee, according to David Nash, M.D., M.B.A., chair, department of health policy, Jefferson Medical College (Philadelphia, Pennsylvania); he is also a member of the board of trustees at CHP and chairs the quality and safety committee. CHP made its governing board responsible for patient safety and quality efforts about 10 years ago and was one of the first organizations to do so because of the visionary leadership and personal commitment of its CEO at that time, Nash says. The quality and safety committee, he adds, “serves as the

conduit for all quality-related information that reaches the board.” It includes a large number of senior level management, meets separately from the governing board, and publishes an annual quality report. Nash notes that healthcare organizations should have a “willingness to have the quality committee report before finance and to have members from the governing board sit on the quality committee.” Nash’s new book, *Governance for Healthcare Providers: The Call to Leadership*, is due to be published in September 2008.

Sentara Healthcare, a health system that serves southeastern Virginia and northeastern North Carolina, has a quality subcommittee, known as the medical affairs committee, that receives reports from the divisions of patient safety and quality, provides oversight on quality issues for the governing board, and makes decisions regarding credentialing and privileges. According to Gary Yates, M.D., chief medical officer, Sentara Healthcare, governing board chairs must first chair the medical affairs committee so that “when they assume the role as [chair], they have a thorough understanding of quality.” Yates adds that the current

governing board has adopted a strategy in which all new members of the board get appointed to the medical affairs committee at the outset to increase knowledge about quality and patient safety among all members of the board.

Other ways board members can be educated about quality and patient safety may include conferences and lectures, retreats at which board members can meet with experts in the healthcare field, or walkarounds to patient care areas with leaders and staff. New Jersey recently passed a bill requiring new board members to receive one full day of education on their duties; most courses offered by New Jersey groups, such as the Health Research and Educational Trust of New Jersey, include quality as part of the course. In addition, the Massachusetts Hospital Association has developed a program, funded by Blue Cross Blue Shield of Massachusetts, in which members of hospital governing boards take courses and receive educational materials on issues such as quality and patient safety; board members who complete the program receive financial incentives. (Conway) The Center for Healthcare Governance plans to offer a similar program throughout the United States in 2008; more information is available online at <http://www.americangovernance.com>.

The Pennsylvania Patient Safety Authority (PSA), a state agency organized to reduce medical errors by identifying problems and recommending solutions that promote safety in hospitals, ambulatory surgical facilities, and birthing centers, is currently developing a curriculum for governing board and executive management education based on Massachusetts's approach. According to Laurene Baker, director of communications, PSA, the agency is collaborating with the Hospital and Healthsystem Association of Pennsylvania and the American Hospital Association to initiate a pilot study of the curriculum; PSA plans to complete pilot studies by December 2008 and begin to fully implement the program in 2009. Educating members of healthcare governing boards and executive management in order to engage them in discussions about patient safety is one of PSA's primary initiatives in its strategic plan for the next several years.

"It's about the board and senior leadership setting clear and challenging expectations and about the board knowing enough so they can ask good and challenging questions," Yates says. "The more the board knows about quality, the better questions they ask."

With the assistance of senior leaders and management, governing boards should establish a set of organizationwide goals for improving patient safety and quality. (See "What Quality Issues Should Be Measured?" for more information.) Each organization chooses its own set of goals or measures based on its needs and modifies the goals as the needs of the organization change. Results and data related to each goal are presented to the governing board by a senior leader or by the quality subcommittee on a regular basis.

Executive Accountability

Once specific goals for organizationwide quality improvement are established, CEOs and other executive leaders should be held accountable for meeting the goals. Indeed, establishing executive accountability for improving patient safety and quality is one of the six actions all boards should follow to improve quality, according to IHI. "The CEO is really the chief safety and quality officer," says Conway. "When the CEO is responsible for quality and safety, you always see better results."

Increasingly, healthcare organizations are tying CEOs' and senior executives' annual performance reviews and compensation packages to meeting the organization's patient safety and quality goals. Results from a 2006 survey of hospital CEOs and senior quality executives indicated that about two-thirds of the hospitals have programs in place to tie executive compensation to meeting patient safety and quality goals (Vaughn et al.). Thomas Vaughn, Ph.D., M.H.S.A., associate professor, department of health management and policy, University of Iowa (Iowa City), and one of the study's authors, compares executives' compensation and review to a report card received in school. "People want to do well and want to know how they're doing," he says.

According to results of a separate survey of hospital CEOs and senior human resources executives conducted in 2007, more than 82% of the organizations have a CEO pay plan established by the board and based on meeting certain performance incentives. About 30% to 35% of the CEOs' base pay is based on achieving certain performance goals, and about 22.5% to 25% of that percentage involves performance goals related to quality. Almost 83% of the surveyed organizations indicated that senior executives, in addition to the CEO, have a pay plan based on incentives, and almost 93% of

What Quality Issues Should Be Measured?

According to the Institute for Healthcare Improvement, healthcare facilities should select a small number of organizationwide patient safety and quality measures that are updated on a regular basis. Such goals may be published quality measures (e.g., Joint Commission National Patient Safety Goals, Centers for Medicare & Medicaid Services' quality measures, National Quality Forum-approved measures, measures from the Agency for Healthcare Research and Quality measures clearinghouse) or areas identified by the organization as needing improvement (e.g., reduction in healthcare-associated infections, reduction in medication errors).

Data on the specified quality measures should be presented to the governing board by a senior leader or by the quality subcommittee and should be organized in a format that is standardized, clear, and concise. Data can then be used to assess the organization's performance and to compare the performance to benchmarks. Boards "need data about their [organization's] performance and need data compared to something else that is meaningful," such as their organization's past performance or the performance of other organizations, says Thomas Vaughn, Ph.D., M.H.S.A., associate professor, department of health management and policy, University of Iowa (Iowa City).

In order to avoid overwhelming or confusing board members with large amounts of measures and statistics, healthcare organizations should select a manageable number of measures that represent the most important patient safety and quality issues at the organization. According to Gary Yates, M.D., chief medical officer, Sentara Healthcare, about 10 to 12 quality measures are selected each long-term

cycle at Sentara. "Each cycle we try to choose the best possible goals," he says. For example, some patient safety and quality measures currently being used include frequency of serious events, behaviors key to preventing serious events, performance in congestive heart failure, pneumonia care, and rates of ventilator-associated pneumonia and catheter-related bloodstream infections.

Sentara also presents data on patient safety and quality measures to the board using a dashboard tool. Many healthcare organizations use dashboards or scorecards to ensure that the information is clear and easy to read. Sentara's dashboard is set up in a red light/green light format: data on measures in red boxes indicates that improvement is needed, and data in green boxes indicates that performance in that area is at an acceptable level.

Catholic Healthcare Partners (CHP) (Cincinnati, Ohio) uses both internal and external quality measures that are updated on an annual basis. According to David Nash, M.D., M.B.A., chair of the department of health policy, Jefferson Medical College (Philadelphia, Pennsylvania), and member of the board of trustees and chair of the quality and safety committee at CHP, measures at CHP are selected at the board level in consultation with management.

Selecting appropriate measures may be difficult for some healthcare organizations. For example, healthcare organizations want to choose a small number of measures, but it may be difficult to choose which areas are most important. This issue is discussed in the main article. ■

those organizations have incentives related to quality. (Integrated Healthcare Strategies)

At Sentara, senior executives in the health system receive bonuses partially based on the organization's performance related to patient safety and quality. Yates explains that executives are eligible for two sets of bonuses—one that is based on meeting short-term (i.e., annual) goals and one that is based on meeting long-term (i.e., three-year) goals. Forty percent of executives' compensation is based on meeting long-term goals related to patient safety and quality.

Henry Ford Health System (Detroit, Michigan) provides compensation for meeting goals such as objectives related to CMS core measures and general achievement of quality objectives to all managers in the health system, including physician executives who are at the director level and above, according to Susan Hawkins, vice president of planning and performance improvement at Henry Ford. Fifteen percent of bonus

eligibility for executives is based on meeting such patient safety and quality goals.

Conway says recent efforts to provide incentives for safety and quality involve putting a portion of executives' salaries at risk rather than providing bonuses for meeting goals in addition to their salary. For example, instead of offering \$300,000 in salary, some healthcare organizations are offering senior executives less money with the opportunity to receive \$300,000 if patient safety and quality goals are met. Conway adds that the financial incentives are just part of the efforts to reward senior executives for meeting goals. "The money is nice, but it's really the celebration of success," he says. "The first thing you love is recognition that a job is done and done well."

Results of a recent poll of *Healthcare Risk Control* (HRC) members indicated that risk managers have mixed responses on whether CEOs and other senior executives should receive compensation based on meeting certain patient safety and quality goals (See

“HRC Poll: Incentives for Patient Safety” for a breakdown of poll results.)

Linking All Employees’ Performance to Quality Improvement

In order to ensure a commitment to patient safety and quality improvement at all levels of the organization, healthcare organizations may want to assess all employees’ performance related to meeting organizationwide patient safety and quality goals at annual performance reviews. In addition, many healthcare facilities include language related to a commitment to patient safety and quality in employee job descriptions.

However, it is less likely that employees other than CEOs or top executives receive compensation or incentive packages related to meeting patient safety and quality goals. The Integrated Healthcare Strategies survey noted above found that almost 83% of organizations provide incentive plans to senior executives in addition to the CEO; significantly less organizations provide incentive plans to directors (58.6%), physicians employed by the organization (47%), service-line managers (37.9%), middle managers (33.9%), and frontline employees (27%). (Integrated Healthcare Strategies)

Sentara Healthcare has a program known as Performance Plus, in which employees receive financial compensation when the health system meets certain goals. At least 50% of the goals have to be related to quality and patient safety, Yates says. Job descriptions for all employees in the Sentara health system include a commitment to patient safety and quality.

Yates adds that an additional method of providing incentives for patient safety to employees that has been very successful is offering employees awards or recognition for their efforts. For example, Sentara gives out four or five CEO awards each year, several of which recognize group efforts to improve quality and patient safety. The awards are presented at Sentara’s semiannual leadership meeting, which is attended by over 700 executives and leaders from the health system. “There is a financial prize, but the real prize is the recognition,” Yates says. Any team in the Sentara health system is eligible to receive the CEO award, and Yates notes that in addition to creating incentives to improve quality and safety in the organization, the awards promote multidisciplinary approaches to quality improvement.

Wachter acknowledges that rewards and recognition for employees are “one of the things in our toolkit” for improving patient safety and quality; however, he emphasizes, “what’s really important is that the

employee of the month is not just the person who made a great save, but also the person who raised a red flag and said, ‘this is funny,’ but it turned out that everything was OK.” In other words, employees should be rewarded for speaking up even if the event turns out to be a false alarm as often as they are rewarded for identifying actual lapses in care. “When rewarding employees for doing well,” Wachter says, “you have to really think about what ‘well’ looks like.”

Conway explains that “flattening the table” is important for getting results in patient safety and quality improvement. In other words, all members of the organization, including the board, executives, midlevel managers, and frontline staff, need to work together to improve quality at the organization. “We used to have a few people in the organization who understand improvement, and we need to have organizations where everyone understands improvement,” he says.

CHALLENGES

Because governing board and senior executive engagement in patient safety and quality is relatively new, many healthcare organizations are encountering challenges and need to identify ways to overcome such issues. Some common challenges are discussed below.

Selecting measures to use. One of the main challenges faced by healthcare organizations is selecting which patient safety and quality measures to use to evaluate progress toward meeting goals. For example, governing boards may be overwhelmed if they are presented with data on a large number of organizationwide measures; however, organizations want to make sure that they cover all important quality issues and do not focus their efforts in one area while neglecting other issues. As stated in “What Quality Issues Should Be Measured?,” healthcare organizations should select a small number of quality measures (e.g., 10 to 12 measures), but many organizations are struggling to identify which patient safety and quality issues are most important or appropriate.

Wachter recommends that healthcare organizations choose relatively broad-based measures that cover several levels of safety and quality. For example, he suggests that as a starting point, organizations divide their measures into three brackets: published quality measures, areas of patient safety (e.g., medication errors), and measures of patients’ experiences. “There is no right answer,” he says, “but you want to cover some elements of safety, some elements of quality, and

some elements of patient experience. It is somewhat experimental; you start somewhere and see how it accomplishes what you want to accomplish.”

According to results of ECRI Institute’s INsight™ survey “Systems Assessment for Quality, Risk, and Safety,” many healthcare organizations are including

performance related to quality improvement activities in performance evaluations for leaders and staff. However, the survey also found that less evidence exists that the targeted goal or purpose is clearly provided to employees and that staff are not always well informed about the organization’s quality goals. Healthcare organizations

HRC Poll: Incentives for Patient Safety

Healthcare risk managers have mixed responses on whether chief executive officers (CEOs) and other senior executives should receive compensation based on meeting certain patient safety and quality goals, according to responses from a recent Healthcare Risk Control System survey on executive compensation. Out of 65 total respondents, 48% believe that CEOs and senior executives should be compensated, 38% believe that they should not, and 14% responded that they did not know (see “Figure 1. Should CEOs and Senior Executives Be Compensated for Meeting Patient Safety and Quality Goals?”). Of those who felt that CEOs and senior executives should not receive compensation, many respondents stated that patient safety and quality are part of their jobs; therefore, they should not receive rewards for such efforts. One respondent noted, “When incentive packages are provided I believe the focus diverts from the goal of providing safe quality care, which is our business, to meeting a defined number.” Others noted that patient safety and quality are team efforts and all staff should be rewarded for meeting goals.

Forty-one percent of respondents are aware of efforts at their organizations to tie CEO compensation to meeting

certain patient safety and quality goals, and 39% indicated that they are aware of other senior executives receiving similar compensation packages. Both published quality measures and areas identified by organizations as needing improvement are used by these respondents’ organizations to measure quality; Centers for Medicare & Medicaid Services’ core measures and Joint Commission National Patient Safety Goals were cited most often. Over three-fourths of the respondents whose organizations tie executive compensation to patient safety and quality believed that such compensation would result in quality improvements at their organizations.

Nearly 50% of organizations’ boards of directors spend at least 25% of their meeting time on quality and safety initiatives (see “Figure 2. Does Your Organization’s Board Devote at Least 25% of Its Meeting Time to Quality and Patient Safety?”). In addition, 64% of organizations include language related to meeting patient safety and quality goals in employee job descriptions, and 69% of organizations include performance related to meeting patient safety and quality goals in employee performance evaluations. ■

Figure 1. Should CEOs and Senior Executives Be Compensated for Meeting Patient Safety and Quality Goals?

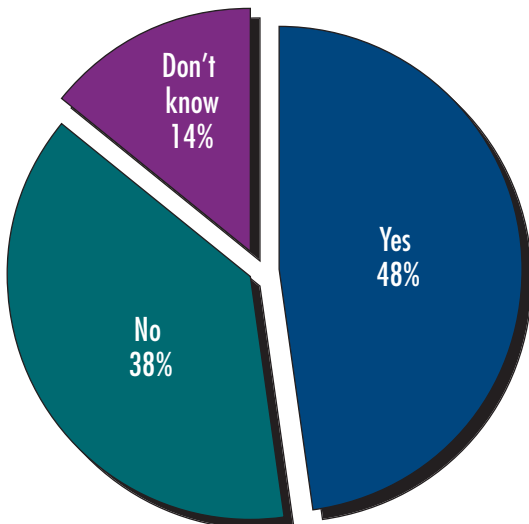
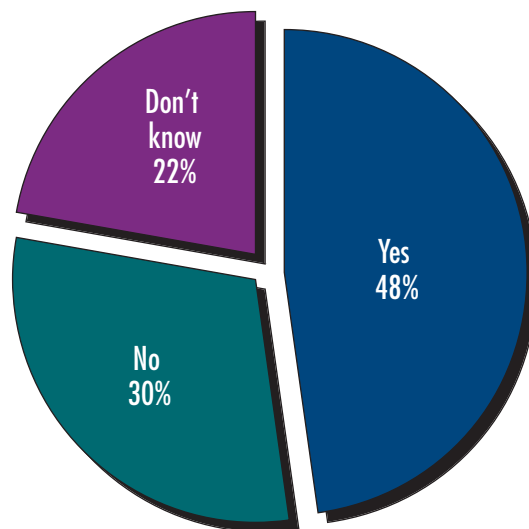


Figure 2. Does Your Organization’s Board Devote at Least 25% of Its Meeting Time to Quality and Patient Safety?



should ensure that quality improvement goals and objectives are clearly defined and conveyed to all employees.

Involving patients and families. Some healthcare organizations are involving patients and families in new ways, such as by inviting patients who have experienced an error at their organizations and their families to attend board meetings and tell their story. “Many organizations are interested in involving patients and families but just don’t know how to do it,” Conway says.

Henry Ford has found that telling stories at board meetings about harmful events involving individual patients has been beneficial in the organization’s efforts to improve quality and patient safety. “We found it to be incredibly powerful,” Hawkins says. She notes that organizations need to find the best way to involve patients and families “so it’s easy for the patient and also so it’s beneficial for the board.” Henry Ford has used methods such as having the board view a video describing the patient event, inviting patients involved in adverse events to board meetings, or including staff representatives to tell the story at board meetings. All three methods have been beneficial, Hawkins says, and organizations need to determine which way works most effectively.

Resources and tools on patient safety advisory councils and other ways to get patients and families involved are available on the Consumers Advancing Patient Safety Web site at <http://patientsafety.org>.

Defining system versus individual institution roles. For some large health systems that have governing boards at the system level and at the individual institution level, it is difficult to define the roles of each. Many organizations establish goals at the system level, and each individual institution works toward meeting those goals. Establishing systemwide goals that are overseen by the governing board and holding executives and leaders accountable for meeting the same goals is an effective way to ensure that goals and incentives are aligned throughout the entire health system.

At Henry Ford, there is a board and corresponding quality committee at the system level and most institutions within the system also have their own board and quality committee. The roles of each board and quality committee are specifically articulated in their charter, Hawkins explains. All of the system’s organizations work toward meeting the same goals; each institution’s results are provided to the system board quality committee every quarter, and the quality committee evaluates each institution’s progress toward meeting patient safety and quality goals.

More information on how one health system aligned patient safety and quality goals systemwide will appear on the *HRC Members’ Web site* and in an upcoming issue of the *Risk Management Reporter*.

Assessing governing board and executive leadership performance. Currently, not many tools are readily available to assess how well governing boards and executive leadership are performing in terms of quality and patient safety efforts. However, ECRI Institute has performed several assessments of patient safety, quality, and risk management systems. These system assessments include evaluation from the board of directors to frontline staff and interdepartmentally across quality, utilization, risk, service, and risk management. Linkages, redundancies, and gaps are identified. “We have found that it is essential for quality, risk, and patient safety goals to be included in the strategic goals of each organization. When the goals and incentives are aligned, outcomes are more effective,” says Barbara G. Rebold, R.N., M.S., CPHQ, director, healthcare quality and INsight assessment services, ECRI Institute.

In addition, a new tool, known as the Hospital Leadership Quality Assessment Tool, is being developed by the Oklahoma Foundation for Medical Quality under contract with CMS. The standardized assessment tool will help governing boards and senior executives assess their organization’s strengths, weaknesses, and ability to facilitate change in terms of quality and patient safety (OFMC).

Engaging physicians in quality and safety. According to Conway, finding ways to engage physicians in efforts to improve patient safety and quality is a very significant issue for healthcare organizations and IHI plans to provide more information on this topic. Wachter adds that healthcare organizations traditionally have created nonpunitive environments and depend on providers to report their own mistakes or lapses; therefore, organizations may send mixed messages to employed providers if their performance evaluations will be “dinged” for not meeting expectations.

While there may not be solutions to some challenges at this time, many healthcare organizations are not halting efforts to improve quality because they encounter such issues, according to Conway. “The exciting thing is that organizations do not look at these challenges as reasons not to go there,” he says. “They’re still going there and looking for ways to overcome the challenges.”

THE FUTURE OF QUALITY INCENTIVES AND ACCOUNTABILITY

As governing boards of healthcare organizations gain experience with quality issues, and as senior executives learn the best way to carry out the organization's goals, healthcare organizations will identify solutions to the challenges identified above as well as any additional challenges or setbacks.

Currently, there is a growing interest among healthcare organizations in getting involved in such efforts. According to Conway, there has been a "tremendous level of interest" in IHI's programs for "getting boards on board." He adds that most participants in IHI's learning events are members of governing boards, which is a big change from the types of personnel who participated in training in the past.

Vaughn notes that boards will continue to become even more involved in quality efforts in the future, "especially because of the evidence that improvements in quality save money." He adds, "there will be so much competition to stay afloat as Baby Boomers reach the age where they're using Medicare more" that healthcare organizations will need to make changes to the way they are governed.

Wachter believes that such initiatives are "only going to grow in importance" in the future. In 5 to 10 years, he says, it will be very easy to figure out if a hospital, physician, nurse, or other employee is providing high-quality care; insurance companies will be going to organizations that provide better care; and physicians will be checking the Web to refer patients to organizations that perform better in quality and patient safety; therefore, boards will have to focus on quality in a completely different way. In addition, quality and patient safety measures and other data will get better. "This is going to involve everyone in the organization," including the board, executives, and other employees, Wachter says.

Those who are involved in such efforts note, however, that governing board involvement and executive accountability are only part of an overall approach to improving quality and patient safety in healthcare organizations. Yates emphasizes, "I wouldn't suggest that just having compensation linked to quality goals is sufficient to create movement in patient safety and quality." He notes that it is a "helpful approach" and that it helps keep the organization focused on improving quality, but it is one of various tools the organization uses in its improvement efforts.

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Tel +1 (610) 825-6000 Fax +1 (610) 834-1275
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