

## BOARDROOM BASICS

### Creating a Culture of Safety

The board sets the tone for quality and patient safety throughout a hospital or health system. While all organizations should be monitoring quality metrics, it is the board's approach that should determine how quality is viewed and progress is made. Boards that encourage transparency, prioritize learning from mistakes, and assess challenges from a "systems view" set the stage for major strides to be made.

**P**hysicians, health care providers, hospitals, and health systems have been working to improve quality and reduce errors in health care since health care began. A bedrock of providing medical care is the intention of caring for sick patients to be useful and protect them from harm. But since *To Err is Human* was first published in 1999, strategies and systematic approaches to improve quality and patient safety have moved to the forefront.

#### What is a Culture of Safety?

According to the Institute for Healthcare Improvement, in a culture of safety "people are not merely encouraged to work toward change; they take action when needed."<sup>1</sup> A culture of safety encourages everyone in the organization to identify

opportunities for improvement and make a change. In contrast, punitive organizations may still review quality metrics, but leaders and peers feel threatened when a failure or near miss occurs. This results in covering up mistakes, rather than viewing them as an opportunity for learning and improvement.

#### Humans Make Mistakes

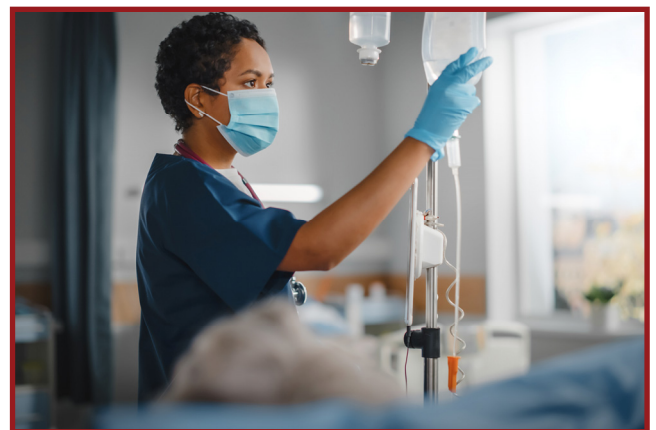
Humans make mistakes. It is up to organizations to create systems that minimize human error and prevent missteps from reaching patients.

**Human Factors.** The people aspects of evaluating safety are called "Human Factors." For example, nurses may

place medications in their uniform pockets because it takes too long to get medications using the proper channels, or a patient is asleep and they are saving it for when the patient wakes up. Hospital and health system leaders must continually evaluate human factors to determine when systems are preventing errors and when they allow for human factors to unknowingly create the potential for errors. A good starting question for boards to consider is: How is our staff working around unsafe or cumbersome systems to provide patient care?

**Negligence.** While many errors are caused by systems that are ineffective, there are instances where an employee or physician is truly negligent, such as being unwilling to see a patient when asked to do so. Negligent providers need to be held accountable and told their actions are not acceptable. At the

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## Our Perspective

### PROVIDING ACCESS TO QUALITY INFORMATION FROM A TRUSTWORTHY SOURCE IS A KEY MISSION FOR SDAHO

Member driven benefits is a key focus for the South Dakota Association of Healthcare Organizations (SDAHO). Our members are very vocal on what they need from SDAHO to help them succeed. This includes educational offerings, networking, advocacy, quality, and safety.

SDAHO has always been at the forefront in communicating with members about the latest regulatory changes, improvement resources, and safety quality metrics on a larger scale. All aimed at helping our members create a culture of safety. SDAHO works as a liaison between our South Dakota Department of Health, federal agencies, and members sharing information quickly and efficiently. Earlier this spring, a [Revision to State Operations Manual \(SOM\), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.21, Quality Assessment & Performance Improvement \(QAPI\) Program](#) ([www.cms.gov/files/document/qso-23-09-hospital.pdf](http://www.cms.gov/files/document/qso-23-09-hospital.pdf)) was shared through the South Dakota Office of Licensure and Certification. This revision is for all general and specialty hospitals that are required to use Appendix A. Please note that critical access hospitals (CAHs) are excluded. There is a large component in the surveyor guidance that looks at board and leadership involvement with quality. Putting this information in front of healthcare leadership is part of our mission as is helping all members understand these latest changes and how it may impact their work and their patients is key.

The updated interpretive guidance is to provide surveyors with a consistent approach for assessing whether a hospital's QAPI (Quality Assessment & Performance Improvement) fully complies with CoP (Conditions of Participation) requirements to improve performance, patient safety, and overall quality of care, including the involvement of the hospital's governing body.

Leadership oversight in the development and ongoing planning of a hospital's QAPI activities is an essential component. The hospital governing body is responsible for:

- Oversight of the QAPI program through its periodic review of the program;
- Review of the progress of QAPI projects;
- Determination of annual QAPI projects; and
- Evaluation of the effectiveness of improvement actions that the hospital has implemented.

The Centers for Medicare and Medicaid Services (CMS) recently shared the latest [Administrative Information Memos to the States and CMS locations](#) ([www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Administrative-Information-Memos-to-the-States-and-Regions](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Administrative-Information-Memos-to-the-States-and-Regions)). This included CMS Quality Safety and Oversight memoranda, guidance, clarifications, and instructions to State Survey Agencies and CMS locations.

Last, through SDAHO's [Quality and Integration webpage](#) ([www.sdaho.org/quality-integration/](http://www.sdaho.org/quality-integration/)), members can access the [CMS Quality, Safety & Education Portal \(QSEP\)](#) (<https://qsep.cms.gov/welcome.aspx>). The QSEP provides a full curriculum of surveyor training and guidance on health care facility regulations. In addition, [SDAHO's education portal](#) ([www.sdaho.org/2023-education-opportunities/](http://www.sdaho.org/2023-education-opportunities/)) provides both live and on-demand educational opportunities to ensure members are equipped with the resources to create and maintain a quality and safe work environment. Visitors can learn more about webinars focusing on:

- Leadership / Governance
- Regulatory / Compliance
- Workforce Development
- Patient / Resident Care
- Self-care

## Upcoming Education

- May 11 \***Metabolic Syndrome** (Patient/Resident Care)
- May 16 \***Utilizing the QAPI Process to Implement a Pressure Injury Program** (Patient/Resident Care)
- May 18 \***F812: An All-Encompassing Food Service Tag: Breaking Down the Federal Tag and Understanding What Surveyors are Looking For** (Regulatory & Compliance)
- May 23 \***Changes to Home Health Now and into the Future** (Regulatory & Compliance)
- May 25 \***Loneliness: Feeling Lonely in a Crowded Room** (Self-Care)
- May 30 \***Workplace Violence Prevention and Response Strategies** (Workforce Development)
- May 31 \***Residents with a Schizophrenia Diagnosis: Now What?** (Patient/Resident Care)
- June 1 \***How I Can Win the Uphill Battle of Change** (Leadership/Governance)
- June 6 \***Tipping the Scales: Managing Weight Changes in Senior Living** (Patient/Resident Care)
- June 8 \***Nursing Services Condition of Participation** (Regulatory & Compliance)
- June 13 \***What Does Advanced Care Planning Look Like in a Residential Care Setting?** (Patient/Resident Care)
- June 20 \***Prevention of Pressure Injuries for the Caregiver and Front-Line Staff** (Patient/Resident Care)
- June 22 \***Driving Down into Operations (Home Health Specific)** (Regulatory & Compliance)
- June 29 \***How Best to Recruit, Retain & Reward Top Level Talent in Today's Healthcare Industry (Part 1)** (Workforce Development)

To learn more about SDAHO's upcoming education, visit us online at [www.sdaho.org/calendar/](http://www.sdaho.org/calendar/).

### Do you have ideas for future issues of *The Trustee Quarterly*?

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'd like to see in future issues of *The Trustee Quarterly*.

#### Write or call:

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same time, hospital and health system leaders must continually seek out opportunities to improve systems that do not promote safe, reliable care. While organizations cannot remove the “human factor,” they can minimize the potential for error by placing “defenses” into systems and processes.

### The Triple Aim vs. the Quadruple Aim

The Institute for Healthcare Improvement’s (IHI) Triple Aim framework was developed in 2008 as an approach to optimize the health system. The Triple Aim consists of three components:

1. Improving the patient experience of care (including quality and patient satisfaction)
2. Improving the health of populations
3. Reducing the cost of care

In recent years, experts have proposed adding a fourth aim to the IHI framework: prioritizing the well-being of the health care workforce and striving to attain joy in the workplace.<sup>3</sup>



The Quadruple Aim recognizes the growing challenge of burnout among physicians and other health care providers, a concern that has been growing for decades but has become even more poignant in the wake of the COVID-19 pandemic. Whether an organization is pursuing the original Triple Aim or the more recently defined Quadruple Aim, workforce well-being is a central component. Studies show that provider burnout impacts all three facets: it is associated with lower patient satisfaction, it negatively impacts health outcomes, and it may increase costs.<sup>3</sup>

### Workforce Well-Being is Critical to a Culture of Safety

The board sets the tone for a culture of safety by prioritizing workforce well-being. A key component of this culture is a partnership between the board, senior leadership, and medical staff to establish aligned goals for how the organization will deliver safe, high quality care. Mutual respect and strong communication between the board and medical staff are critical, as is physician involvement in strategic planning. When the patient safety plan is discussed or updated, it is important to engage physicians early, clearly communicating that physicians

will be instrumental in developing and implementing the plan.

Workforce well-being extends well beyond the board’s partnership with the medical staff to maintain a strong patient safety plan. In addition, the board must continually strive to build employee and provider loyalty and satisfaction, employee empowerment and joy in the workplace while addressing concerns about provider burnout and workplace

violence. Board actions that aid in these goals include:

- Valuing employee input. No one has better insight into potential improvement opportunities than the employees doing the everyday hard work. Employees must feel valued and heard, and have opportunities to impact meaningful change in the organization.
- Investing in technology that strengthens systems, minimizes errors, lessens employees’ workload, and improves the patient care experience.
- Ensuring organizational transparency. Transparent organizations allow employees to see and share information and make suggestions. They communicate strategies and objectives to employees, and provide regular updates about progress toward achieving those objectives.

**Whether an organization is pursuing the original Triple Aim or the more recently defined Quadruple Aim, workforce well-being is a central component.**

- Ensuring employees are valued and appreciated. While feedback from co-workers is important, positive feedback from management and the executive team plays a crucial role in ensuring that employees feel appreciated.
- Seeking opportunities for providers to practice at the top of their license, shifting from physician-centric to team-based models that combine physicians with registered nurses, nurse practitioners, physician assistants, and others.
- Providing ongoing educational opportunities for all employees.
- Ensuring meaningful performance evaluation methods that encourage two-way dialogue, provide positive and constructive feedback, and provide fair and equitable review and compensation.
- Prioritizing employee safety, including an organization-wide zero tolerance policy for workplace violence.

### Leadership Commitment to Ensuring a Culture of Safety

Every board must define what a culture of safety means for their hospital or

health system. This begins with a commitment from the board, senior leadership, and medical staff to continually focus on improvements in patient safety, error reduction, and zero harm as an explicit organizational priority.

**Board Accountability.** Boards can actively show accountability by committing to ongoing education about patient safety, setting and monitoring goals, and ensuring that executives and all levels of management prioritize

patient safety (for example, sharing patient safety stories at board meetings).

**A “Just Culture.”** The 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.” This means creating a culture that: 1)

addresses systemic issues with the potential to lead to unsafe behaviors (for example, medication that is too cumbersome to access properly), and 2) holds individuals accountable for reckless behavior (for example, failure to wash hands regularly).

A “just culture” moves beyond saying that human error is unacceptable. This only hides errors and prevents learning. Instead, it sets the tone for a culture where mistakes, regardless of severity, are reported with lessons learned.

### Commitment to a Culture of Safety

- ✓ Dedication to patient safety, error reduction and zero harm as an explicit organizational priority
- ✓ Board accountability and commitment to learning
- ✓ Ensure a “just culture”
- ✓ Reporting with the goal of learning
- ✓ Encourage teamwork and collaboration
- ✓ Prioritize patient and family engagement
- ✓ Implement a quality dashboard
- ✓ Address adverse events appropriately

### Expectations for Reporting.

Employees must view patient safety as an integral part of their jobs, with the expectation that they will internally report safety concerns, broken systems and processes, actual errors, and “near misses.” Reporting with the intention of improving patient safety creates an environment of trust so that blame is not automatically placed when an error occurs.

**Teamwork.** Leaders and employees should be trained in team skills and job-specific competencies, encouraging providers to work in a collaborative manner in which each individual has a responsibility to identify and/or act to prevent potential safety errors.

### Patient and Family Engagement.

Patients and their families should be involved in decisions about their care, including open communication about

risk factors and potential consequences of care options. In addition, hospitals and health systems using best practices ask patients to provide feedback to the board about quality, patient safety, and the patient experience.

**Implementing a Quality Dashboard.** A hospital or health system’s dashboard is a clear, straightforward approach for boards to understand what level of quality they are providing. Data should be presented in easy-to-understand graphs, allowing boards to interpret the information and ask probing questions without feeling overwhelmed by hard-to-understand details. A comprehensive quality dashboard ensures that the board knows:

- How the organization’s quality and patient safety compares to other organizations;
- Whether quality performance is trending in the right direction over time, and which metrics are trending which direction;
- If quality data is impacted by seasonal fluctuations or other fluctuations the board should be aware of; and
- How quality and patient safety compares for various ethnic and racial groups, and if care equity is being addressed.

**Addressing Adverse Events.** There are times when things do go wrong. Management has the responsibility for immediately looking at what happened and documenting the causes and effects of the adverse or serious safety/sentinel event. The general approach for board notification and discussion revolves

### Board Components of Patient Safety Success

- The board is engaged and reviews quality data at each board meeting
- There is recognition that patient safety errors occur in all health care settings
- There is agreement that the current error rate is unacceptable and zero harm is the goal
- There is a culture of fixing the “system” when errors are identified and discussed
- A CEO with a strong track record of results is actively engaged in quality and safety and understands and acts on opportunities for improvement
- The CEO’s compensation is linked to quality and safety results to at least the same degree as financial success
- The organization and its leaders hold physicians accountable for undesirable behavioral and clinical practice variations
- 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 areas of the organization
- The board allocates resources for quality improvement and error prevention
- Physicians are engaged and active partners in achieving quality aims
- The board is committed to ongoing education about quality and patient safety, workplace improvement, systems approaches, and patient and family engagement

around the severity, breadth, and impact of the event.

For example, an active shooter who kills staff and/or patients requires urgent board notification. A medication error that does not injure a patient is usually included in incident reports and summarized for the board (or the quality and safety committee of the board) at their next meeting.

Even if there is no harm to a patient, all patients (or in the case of pediatric patients, their parents) need to be informed about an adverse event. It is understandable to be hesitant to tell a patient about an adverse event due to fear that they may pursue litigation or because the physician is embarrassed. Admitting an error is never pleasant, but transparency remains essential for improving future patient care.

### Sources and More Information

1. Develop a Culture of Safety. Institute for Healthcare Improvement. Accessed March 2, 2023. [www.ihi.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx](http://www.ihi.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx).
2. Institute for Healthcare Improvement. The IHI Triple Aim. Accessed March 2, 2023. [www.ihi.org/Engage/Initiatives/TripleAim](http://www.ihi.org/Engage/Initiatives/TripleAim).
3. Bodenheimer T, Sinsky C. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med*. 2014 Nov-Dec;12(6):573-6. doi: 10.1370/afm.1713. PMID: 25384822; PMCID: PMC4226781.
4. Free from Harm. Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human. National Patient Safety Foundation. 2015.

BOARDROOM BASICS

# CMS Expectations for Board Oversight of Quality and Patient Safety

In March 2023, the Centers for Medicare and Medicaid Services (CMS) updated its guidance for the Quality Assessment and Performance Improvement (QAPI) program. The guidelines provide clear expectations for the board’s leadership in ensuring quality and patient safety, including creating a hospital-wide culture of safety for all services provided.

**C**onditions of Participation (CoPs) define specific requirements that hospitals and health systems must meet in order to participate in Medicare and Medicaid programs. CMS recently updated its guidance to help surveyors use a consistent approach when assessing whether a hospital or health system’s QAPI program complies with CoPs. According to CMS, “QAPI CoP deficiencies are the third most frequently cited of the 24 CoPs for Medicare-certified hospitals.” That means hospitals have a lot of room for growth in this area, and boards of trustees are responsible for ensuring that happens.

The updated guidance from CMS emphasizes that engagement by the hospital’s governing body is necessary to ensure high quality of care. Specifically, CMS outlines that boards should conduct regular reviews of quality and patient safety programs, including:

- **The development of a plan** to implement and maintain the QAPI program;
- **Review of progress** of QAPI projects;

- **Determination of annual QAPI** projects; and
- **Evaluation of the effectiveness** of improvement actions that the hospital or health system has implemented.

In addition to oversight of quality programs, the board is responsible for:

- **Establishing clear expectations** for safety;
- **Communicating safety expectations**, including informing all staff of their specific roles and responsibilities in QAPI; and
- **Allocating adequate resources** to carry out the functions of the QAPI program requirements.

When being evaluated, CMS also expects hospitals and health systems to provide evidence of how the board initiated performance improvement projects because of adverse events.

In addition, CMS specifies that there will be a review of the board’s

## Condition of Participation

The QAPI CoP requires a hospital to “maintain and demonstrate evidence of its QAPI program for review by CMS, as well as the **governing body oversight of the program in an effort to deliver safe, quality patient care and prevent adverse events and patient harm.**” (42 CFR 482.21)

processes related to the QAPI program and the board’s expectations for a culture of safety that is hospital-wide in its scope. The culture of safety must encompass all locations of the hospital (onsite and off-site inpatient and outpatient services and departments) and all services provided directly by the hospital as well as those services provided under arrangement or contract.

## Sources and More Information

1. CMS. Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. Memo Subject: Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.21, Quality Assessment & Performance Improvement (QAPI) Program. March 9, 2023. [www.cms.gov/files/document/qso-23-09-hospital.pdf](https://www.cms.gov/files/document/qso-23-09-hospital.pdf).
2. American Hospital Association. CMS Issues QAPI Program Interpretive Guidance Specifying Boards’ Roles. Special Bulletin. March 13, 2023.

GOVERNANCE INSIGHTS

# National Governance Trends: Ten Board Practices For Discussion

The American Hospital Association recently published its *2022 National Health Care Governance Survey Report*, providing a comprehensive picture of what hospital and health system boards look like across America. Comparing your board to industry standards for composition, structure, and processes is an important step to maximizing the impact of your board.

**T**he American Hospital Association's (AHA) national governance survey is a comprehensive resource that outlines board practices and trends in eight areas: 1) Board composition; 2) Board diversity; 3) Board structure; 4) Board selection; 5) Board orientation and education; 6) Board evaluation; 7) Performance oversight; and 8) Board culture.

In each area, the AHA provides an analysis of trends that are occurring and a detailed break-down of data points such as board composition, use of term limits, standing committees, use of a board portal, education

requirements, whether the board conducts a board self-assessment, approaches to CEO succession planning, and more.

The depth of the board practices measured is impressive, but can also be overwhelming. When reviewing the numbers, it is important to remember that the report is a representation of current dynamics in health care governance, and the results should not be viewed as benchmarks. What's best for each hospital and the communities they serve varies. However, knowing how your board compares in key practices can help guide your board to be more impactful in achieving your mission.

Below are ten governance practices boards can use as a starting point to identify potential areas in need of improvement. High level national comparisons are listed below each item. The full AHA report includes additional information, including a full comparison in each area by board type.



## Board Practices: Job Descriptions, New Member Orientation and Continuing Education

1. **Our board has job descriptions for board members, the board chair, and for the committee chair(s).** 62 percent of boards report having job descriptions for their board members. Job descriptions for the board chair (54%) and committee chairs (23%) are less common.
2. **Our board has a formal new board member orientation.** 87 percent of boards provide new board member orientations. The most common components included in new board member orientations are meeting with the CEO and/or senior leadership, health care governance orientation, and health care orientation. The least common components included are an overview of the community served and offering formal mentoring with a senior board member.
3. **Our board members have a continuing education requirement.** Only 39 percent of boards report having a continuing education requirement.
4. **Our board periodically receives an educational briefing with legal counsel.** Boards report providing briefings with legal counsel in the following areas:
  - Compliance issues (89%)
  - Trustee conflict of interest/

independence and how they should be disclosed (75%)

- Legal fiduciary duties of loyalty, care, and obedience (73%)
- The need for trustees to keep board matters confidential (62%)
- Director and officers liability insurance (42%)

### Board Evaluation

5. **Our board conducts a full self-assessment and uses the results to create an action plan to improve performance.** 61 percent of boards report using a full board self-assessment. Of the boards that conduct an assessment, 91 percent use the results to create an action plan to improve board performance.
6. **Our board evaluates individual board member performance using the criteria listed below.** Boards report evaluating individual performance in the following areas:
  - Meets the board and committee attendance requirement (86%)
  - Actively engages in board discussion (76%)
  - Arrives fully prepared to participate in meetings (66%)
  - Offers valuable insights and demonstrates a high degree of competence (65%)
  - Fosters a culture of mutual respect (65%)

### Board Accountability and Organizational Performance Oversight

7. **Our board has an authority matrix or policy that defines management oversight and accountability versus governance oversight and accountability for spending limits, signature authority, and when certain actions require board approval.** 75 percent of boards report using an authority matrix. System boards are more likely to report using an authority matrix (90%) compared to subsidiary boards (63%) and freestanding boards (68%).
8. **Our board uses precise and quantifiable metrics and objectives to evaluate organizational performance.** Boards report the following:
  - Clinical quality (95%)
  - Service quality/patient satisfaction (93%)
  - Financial/capital allocation/investment performance (92%)
  - Patient safety (90%)
  - Employee satisfaction (83%)
  - Achievement of strategic priorities (75%)
  - Physician engagement/satisfaction (60%)
  - Community/population health (54%)
  - Diversity & health equity (44%)



### Board Leadership Through Discussion, Deliberation and Debate

9. **An executive session is included on every board meeting agenda.** 66 percent of all boards routinely include executive sessions. Executive sessions are more routine amongst system boards (91%) compared to subsidiary boards (42%) and freestanding boards (56%).
10. **What percentage of time does our board spend in active discussion, deliberation, and debate?** Nationally boards report the following times:
  - Zero—25% (22%)
  - 25% —50% (43%)
  - 50% —75% (19%)
  - 75% —100% (16%)

*To download the AHA 2022 National Health Care Governance Survey Report, go to <https://trustees.aha.org/aha-2022-national-health-care-governance-survey-report>.*