

The Board's Role in Quality and Patient Safety Performance Measurement

BY DENISE M. MURPHY, RN, M.P.H., CIC, FAAN, MAIN LINE HEALTH SYSTEM

Evidence tells us that healthcare organizations are safer if their boards commit to the following responsibilities: 1) spend more than 25 percent of board meeting time focused on quality and patient safety (QPS); 2) receive a QPS measurement report; 3) maintain high interaction with the medical staff on QPS strategy; 4) base senior executive compensation, in part, on QPS performance; and 5) identify the CEO as having the greatest impact on QPS, especially when identified as such by the chief quality officer.¹ This special section will focus on two board quality committee

responsibilities: the review and related follow up on quality and patient safety measurement/performance. Whether your organization has a balanced scorecard that incorporates QPS metrics or a dashboard specific to these indicators, your role must include a deep understanding of the measurement and improvement activities that will move the organization in the desired direction and sustain reliable performance.

Similar to any key leadership position, board members should have (or request) a position description or committee charter outlining the roles and responsibilities of the committee on which they serve. In such

a position description, responsibility for performance measurement oversight could be explained through statements such as the following:

- The board delegates responsibility for oversight of quality and patient safety performance to the board QPS committee, which meets six times per year.
- At least 25 percent of the board's agenda will focus on QPS issues identified by the QPS committee.
- A dashboard outlining goals, baseline performance, targets, and other comparative metrics will be reviewed and

Exhibit 1: Sample System Dashboard Report*

System Dashboard Year to Date

Year to Date Apr 2013–Dec 2013 (9 Months), except where footnoted

Baseline Period Jan 2012–Dec 2012, except where footnoted

Data for illustration purposes ONLY
NO actual hospital values used

| Focus Area Indicator | Desired Direction | System Goals for Apr 2013–Mar 2014 | | | Results for YTD Compared to System Goals | | | | | | | | | | | |
|---|-------------------|------------------------------------|---------------|---------|--|------------|------------|-----------|------------|-----------|------------|-----------|------------|-----------|------------|-----------|
| | | Threshold | Annual Target | Maximum | System | | Hospital A | | Hospital B | | Hospital C | | Hospital D | | Hospital E | |
| | | | | | Baseline | YTD 9 Mo. | Baseline | YTD 9 Mo. | Baseline | YTD 9 Mo. | Baseline | YTD 9 Mo. | Baseline | YTD 9 Mo. | Baseline | YTD 9 Mo. |
| Safe | | | | | | | | | | | | | | | | |
| Patient Safety | | | | | | | | | | | | | | | | |
| Mislabeled Specimens | ▽ | 128 | 64 | 0 | 107 | 68 | 32 | 20 | 21 | 17 | 26 | 18 | 20 | 13 | 8 | 0 |
| Pressure Ulcers - Unit Acquired Stage II or worse - Acute Critical Care | ▽ | 5.66% | 5.51% | 4.89% | 5.18% | 2.59% (17) | 0.32% | 1.36% (3) | 4.95% | 2.00% (5) | 18.18% | 7.53% (7) | 2.78% | 2.15% (2) | N/A | N/A |
| Pressure Ulcers - Unit Acquired Stage II or worse - Rehab | ▽ | 0.23% | 0.21% | 0.18% | 0.26% | 0.00% (0) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0.26% | 0.00% (0) |
| Ⓢ Preventable Harm Events SSE1-5 ** | ▽ | 0.12 | 0.06 | 0.00 | 0.07 | 0.07 (3) | 0.00 | 0.00 (0) | 0.08 | 0.08 (1) | 0.12 | 0.12 (1) | 0.13 | 0.14 (1) | 0.00 | 0.00 (0) |
| Device Associated Infections | | | | | | | | | | | | | | | | |
| Central Line Assoc. BSI per 1,000 line days - Acute Critical Care | ▽ | 1.10 | 0.66 | 0.00 | 0.98 | 0.40 (5) | 0.56 | 0.25 (1) | 0.44 | 0.18 (1) | 2.46 | 1.44 (2) | 2.35 | 0.59 (1) | N/A | N/A |
| Cath. Assoc. Symptomatic UTI per 1,000 cath. days - Acute Med/Surg/Tele | ▽ | 0.80 | 0.48 | 0.00 | 0.94 | 0.44 (11) | 0.98 | 0.40 (2) | 0.20 | 0.42 (3) | 3.10 | 0.46 (2) | 0.42 | 0.48 (4) | N/A | N/A |
| Cath. Assoc. Symptomatic UTI per 1,000 cath. days - Rehab | ▽ | 0.78 | 0.74 | 0.69 | 0.99 | 1.02 (1) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0.99 | 1.02 (1) |

For measures not reported as counts, the actual count of incidents is reported in parentheses where applicable.
**Preventable = Serious Safety Events with deviation from Generally Accepted Performance Standards (GAPS)

N/A - Not Applicable

| | | | |
|-------------------|---------------|------------|---------------------------|
| Threshold Not Met | Threshold Met | Target Met | Maximum Achieved/Exceeded |
|-------------------|---------------|------------|---------------------------|

Note: Only Threshold Not Met and Maximum Achieved (0) are colored for the Patient Safety Counts and Standardized Infection Ratio with Expected Infections Greater than one (1)

Ⓢ Fiscal Year Baseline: Jul 2012–Jun 2013 YTD: Jan 2013–Dec 2013

*This is only part of the dashboard. If you would like the full sample dashboard, contact Kayla Wagner at kwagner@GovernanceInstitute.com.

1 T. Vaughn, M. Koepke, and E. Kroch, et al., "Engagement of Leadership in Quality Improvement Initiatives: Executive Quality Improvement Survey Results," *Journal of Patient Safety*, Vol. 2, No. 1, March 2006, pp. 2–9.; G. Rollins, "Getting Boards On-Board: Leadership Engagement Key to Reaching Quality Goals," *The Safety Net*, Institute for Healthcare Improvement, Fall 2008, pp. 8–9.

discussed at every QPS committee meeting.

- Summary reports will be presented to the full board at quarterly directors' meetings. These reports will highlight areas where performance is above and/or below the desired target.

Some states are required by law (e.g., Pennsylvania's MCARE Act) to include certain types of reports to be shared with the board of directors with specified frequency, such as adverse events leading to harm or death. This type of mandate underscores the importance of board member orientation to their role with targeted education about measurement interpretation. Orientation to dashboards or scorecards that graphically display progress against goals at a glance (i.e., so called "stoplight" dashboards with red, yellow, and green indicators) is critical to members fulfilling their oversight role. **Exhibit 1** on the previous page provides an example of Main Line Health System's stoplight dashboard.

The governance role as it relates to QPS performance measurement must begin with an understanding of how the organization selects the work of QPS, prioritizes that work, and allocates resources to improvement activities. Patient care priorities are often tied to executive compensation with incentive payments increasing as threshold, targeted, or superior/maximum performance is achieved. Main Line Health System's dashboard displays several pages of priority goals and "monitored" goals that are under consideration for the next performance year. The QPS dashboard is published monthly in hard copy and available electronically on the organization's intranet, to be accessed by leadership and management, staff, and committee members. QPS committee members, as well as the full board, receive an electronic copy of the dashboard at least a week before every meeting for their review. The "Dashboard Drilldown" is conducted in depth for the committee while higher-level summaries are shared at the full board meeting.

Publicly reported measures are also available on Main Line Health's Web site for review by the community. Definitions and examples are explained simply for the public's understanding (e.g., central line bloodstream infection rates begin with an explanation of what a central venous catheter/central line is and why many hospitalized patients benefit from



this level of venous access). Despite the fact that this information can be visualized on CMS' Hospital Compare Web site (www.hospitalcompare.gov), Main Line's online organizational dashboard contains metrics that are much more timely (a three- to six-month lag) versus data that is over a year old.

In addition to the monthly QPS dashboard, the QPS committee selects "Annual Team Goals" that are tied to incentive compensation for department directors and above, and include selected medical staff programs (i.e., hospital medicine service dashboard). All staff members at every level of the organization receive an annual bonus payment if target or maximum performance is achieved for the overall hospital patient satisfaction score (HCAHPS). "Long-Term Goals" (stretch goals) are tied to senior executive compensation only. The finance/compensation committee of the board makes decisions collaboratively with management about incentive payments tied to QPS, service, financial, and growth opportunities. Examples of the Annual Team Goals and Long-Term Incentive Plan Goals are found in **Exhibits 2** and **3**.

Routine review and updates on activities driving team and long-term goals must include setting expectations for desired behaviors to improve performance or sustain improvement. So in addition to reviewing and monitoring the QPS

dashboard, the board also engages in dashboard drilldowns that include discussions with clinical and administrative leadership on performance improvement strategies, non-financial incentives, barrier removal, and accountability for safe, high-quality patient care.

How Is Quality Measured?

Released in March 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*, prepared by the Institute of Medicine's (IOM) Committee on the Quality of Health Care in America, reported on the status of patient care quality in U.S. hospitals.

The committee already spoke to the state of patient safety in its 1999 report, *To Err Is Human: Building a Safer Health System*. Concluding that tens of thousands of Americans die each year as a result of preventable mistakes in their care, the report laid out a comprehensive strategy by which government, healthcare providers, industry, and consumers can reduce medical errors.

Crossing the Quality Chasm focused more broadly on how we can redesign the healthcare system to foster innovation and improve the delivery of care. The IOM presented a comprehensive strategy and action plan organized into the following six aims: that we measure the quality of care to ensure that it is **Safe, Timely, Effective, Efficient, Equitable, and Patient-centered (STEEEP)**.

Arranging QPS indicators on dashboards/scorecards using the IOM's six aims helps organize Main Line's work into priority outcomes for patients that are easily understandable. In addition to using the IOM framework for the organizational dashboard, the QPS department is currently developing service/program-specific STEEEP reports. These reports contain metrics that are nominated by Main Line Health experts in their specialty and vetted across clinical stakeholders for acceptance as a means of measuring excellence in their particular clinical care arena. An example of the STEEEP report assembled by Main Line's Emergency Medicine service leadership is found in **Exhibit 4**.

The review of service or the programmatic metrics fosters accountability for improvement at the front line where physician, nurse, and administration leaders care for specific populations. Learning to measure population health in collaboration with preventive/well-care, post-acute care, and community services partners is the

Exhibit 2: Sample Annual Team Goals

**MAIN LINE HEALTH
ANNUAL TEAM GOALS
FISCAL YEAR '14**

| STRATEGIC INITIATIVE | | CY 2012 | Quality Year 2014 (April 2013–March 2014) | | | YTD RESULTS | WEIGHT |
|---|--|--------------|---|-----------------------------|-----------------------------|---------------------------------|--------|
| | | BASELINE | THRESHOLD | TARGET | SUPERIOR | | |
| <u>SUPERIOR PATIENT EXPERIENCE</u> | | | | | | | |
| <u>Improving Measures</u> | | | COTH 60th %tile | COTH Top Quartile | COTH Top Decile | Quality Year YTD (Apr–Mar 2014) | 22.5% |
| J | ▼ Overall Hospital Mortality (Index) | 0.87 | 0.86 | 0.79 | 0.67 | | |
| J | ▼ Overall Hospital Readmissions Index | 0.98 | 0.97 | 0.94 | 0.83 | | |
| <u>Nursing Measures</u> | | | 7.5% reduction from baseline | 10% reduction from baseline | 20% reduction from baseline | | |
| J | ▼ Inpatient Falls per 1,000 inpatient days - Excludes Rehab, Psych & ED - HARM Score E-I (PSN/UHC) | 0.029 | 0.027 | 0.026 | 0.024 | | |
| J | ▼ NDNQI: Critical Care Acquired Pressure Ulcers Stage II & Above | 6.1% | 5.7% | 5.5% | 4.9% | | |
| <u>Infection Measures</u> | | | Median | ~ NHSN 60 %tile | NHSN Top Decile | | |
| J | ▼ CLABSI Med Surg ICU | 0.98 | 1.00 | 0.66 | 0.00 | | |
| J | ▼ CAUTI Med Surg and Telemetry, non ICU | 0.97 | 0.80 | 0.48 | 0.00 | | |
| <u>Patient Satisfaction - HCAHPS</u> | | | CMS 60th %tile | CMS Top Quartile | CMS Top Decile | | |
| J | ▲ Rate Hospital (%-9's & 10's) | 75.2% | 70.8% | 74.0% | 80.0% | | |
| J | ▲ Communication with Doctors (% *Always*) | 80.4% | 81.9% | 84.0% | 87.0% | | |
| J | ▲ Communication with Nurses Domain (% *Always*) | 81.0% | 79.0% | 80.0% | 84.0% | | |
| <u>Sustaining Measures</u> | | | HQID 60th %tile | HQID Top Quartile | HQID Top Decile | | 10% |
| J | ▲ Heart Failure - Appropriate Care Measure | 98.6% | 95.6% | 97.6% | 99.0% | | |
| J | ▲ Pneumonia - Appropriate Care Measure | 96.3% | 96.3% | 97.3% | 98.4% | | |
| J | ▲ AMI - Appropriate Care Measure | 98.5% | 96.9% | 98.9% | 100.0% | | |
| J | ▲ SCIP - Appropriate Care Measure | 98.0% | 92.8% | 94.6% | 97.1% | | |
| M | ▼ SSI - Hip Prosthesis (HPRO) SIR | 0.57 | 1.00 | 0.75 | 0.50 | | |
| M | ▼ SSI - Knee Prosthesis (KPRO) SIR | 0.52 | 1.00 | 0.75 | 0.50 | | |
| <u>New Measures</u> | | | CMS 60th %tile | CMS Top Quartile | CMS Top Decile | | 5% |
| J | ▲ HCAHPS Hospital Environment (% *Always*) | 59.4% | 83.3% | 72.0% | 78.0% | | |
| J | ▲ HCAHPS Staff Responsiveness (% *Always*) | 67.2% | 66.8% | 70.0% | 78.0% | | |
| | ▼ SSI - Cardiac Surgery (not incl CABG) | 1.54 | 1.00 | 0.75 | 0.50 | | |
| FY '13 | | | | | | | |
| STRATEGIC INITIATIVE | | | THRESHOLD | TARGET | SUPERIOR | YTD RESULTS | |
| <u>HIGHLY ENGAGED PEOPLE</u> | | | | | | | |
| | ▲ Employee Engagement Survey (Accountability Index)* | 4.59 | 4.59 | 4.65 | 4.68 | | 15% |
| <u>FINANCIAL PERFORMANCE</u> | | | | | | | |
| | ▲ Operating Margin | 9.50% | 5.25% | 5.45% | 5.65% | | 37.5% |
| | ▲ Fund Development | \$23,853,474 | \$13,430,727 | \$16,221,391 | \$17,352,800 | | |
| <u>CLINICAL EDUCATION & RESEARCH</u> | | | | | | | |
| | ▲ Clinical Publications | N/A | 253 | 289 | 331 | | 5.0% |
| | ▲ IRB Approval of New Protocols | N/A | 75 | 80 | 85 | | 5.0% |

J Jefferson Health System Goal
M JHS Monitored Goal
▲ increase better
▼ decrease better

* FY '13 goals & results were adjusted to a Gallup score; FY '14 goals are not adjusted

| |
|-----------------------|
| Threshold Not Met |
| Threshold Achieved |
| Target Achieved |
| Superior |
| Baseline Not Achieved |

Exhibit 3: Sample Long-Term Incentive Plan Goals

**Main Line Health
Senior Executive
Long-Term Incentive Plan (LTIP)**

Cycle VI (7/1/2010 to 6/30/2013)

| Performance Measures | Baseline | Weight | Threshold (50%) | Target (100%) | Superior (150%) | YTD Result |
|---|--|--------|---|--|--|------------|
| Performance Gate: Achieve budgeted financial performance over cycle (July 1, 2010 to June 30, 2013) | | | | | | |
| Superior Patient Experience <u>The Journey to Zero Events of Harm</u> In pursuit of the ultimate goal to eliminate errors, reduce preventable errors causing serious harm by x from baseline (SSER) percentage | 0.34/10,000 adj PD (15 events) Jul 09–Jun 10 | 100% | 30% reduction (10 events or 0.24/10,000 adj PD) | 40% reduction (9 events or 0.20/10,000 adj PD) | 50% reduction (8 events or 0.17/10,000 adj PD) | |

Cycle VII (7/1/2011 to 6/30/2014)

| Performance Measures | Baseline | Weight | Threshold (50%) | Target (100%) | Superior (150%) | Result |
|---|----------|--------|----------------------|----------------------|----------------------|--------|
| Performance Gate: Achieve budgeted financial performance over cycle (July 1, 2011 to June 30, 2014) | | | | | | |
| Diversity <u>Train Main Line Health Employees on Cultural Competency:</u> Supports AHA goal of eliminating Health Care Disparities. Metric is percentage of staff hired by 12/31/2013 trained by end of Cycle VII | | 100% | 70% of staff trained | 80% of staff trained | 90% of staff trained | |

Cycle VIII (7/1/2012 to 6/30/2015)

| Performance Measures | Baseline | Weight | Threshold (50%) | Target (100%) | Superior (150%) | Result |
|---|-------------------------------|--------|--|---|---|--------|
| Performance Gate: Achieve budgeted financial performance over cycle (July 1, 2012 to June 30, 2015) | | | | | | |
| Clinical Performance Reduce mortality related to sepsis by x percentage of baseline | 1.07 | 50% | 7.5% Reduction from Baseline (0.99) | 10% Reduction from Baseline (0.96) | 20% Reduction from Baseline (0.86) | |
| Superior Patient Experience Further progress on the attainment of "Meaningful Use" for Electronic Patient Records | Stage 1 met; payment received | 50% | Sustain Stage I criteria for 1 year (Oct '12–Oct '13); receive payment (approx. \$8.3MM) | Become compliant with Stage 2 by Oct '14; receive payment (approx. \$5.5MM) | Become compliant with Stage 3 by Oct '15* (approx. \$2.8MM) | |

*Stage 3 compliance would be announced subsequent to committee meeting (expected September 2015) and prior to payment for LTIP awards expected in November 2015.

| |
|------------------------|
| Threshold Not Achieved |
| Threshold Achieved |
| Target Achieved |
| Superior |

current challenge quality leaders and their boards must address.

Benchmarking: Using Comparative Data

Wherever possible, metrics should be comparable to nationally reported benchmarks where standardized definitions and data collection methodologies have been utilized. For example, the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network has collected, analyzed, and reported data on hospital-acquired infections, beginning with standardized surveillance programs in 300 hospitals in the 1970s, expanding to more than 12,000 medical facilities across the U.S. today.²

Other common sources of benchmarking information include the Council of

Teaching Hospitals and Health Systems (COTH®) and University Healthcare Consortium (UHC). COTH® is composed of approximately 400 major teaching hospitals and health systems, including 64 Veterans Affairs medical centers. COTH® was established in 1965 to provide representation and services related to the special needs, concerns, and opportunities facing major teaching hospitals in the U.S. and Canada. It serves as the principal source of hospital and health system input into overall Association of American Medical Colleges (AAMC) policy and direction (see www.aamc.org/members/coth). UHC, formed in 1984 and located in Chicago, is an alliance of 120 academic medical centers and 302 of their affiliated hospitals representing the nation's leading academic medical centers (see www.uhc.edu). This is not an exhaustive

list of comparative data sources, but the message to boards and their committees is that there are several data sources that are important to be familiar with in order to assess credibility, validity, and reliability of an organization's measurement work. The organization should use both national and regional benchmarks to provide a more complete picture of how the hospital(s) perform against others in the area.

However, benchmarking alone does not fully inform the organization as to how well it is doing or how much it is improving quality and patient safety. In addition to comparing the organization against national and regional benchmarks, the QPS committee and board must also compare the organization against its own historical performance to track the rate of improvement over time. The Main Line QPS

Exhibit 4: STEEP Executive Summary Report

Quarter: Jul-Sep 2013

Baseline Year: Jan-Dec 2012

| IOM Dimension | Measure | System | | Hospital 1 | | Hospital 2 | | Hospital 3 | | Hospital 4 | | Desired Direction | System Goals for Apr 2013-Mar 2014 | | |
|--------------------------|--|----------|--------------|------------|--------------|------------|--------------|------------|--------------|------------|--------------|-------------------|------------------------------------|--------|----------|
| | | Baseline | Curr Qtr | Baseline | Curr Qtr | Baseline | Curr Qtr | Baseline | Curr Qtr | Baseline | Curr Qtr | | Threshold | Target | Superior |
| Safe | | | | | | | | | | | | | | | |
| | Unscheduled Returns to ED within 72 hrs (admitted patients only) | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | ↓ | 0 | 0 | 0 |
| | Left the emergency department before being seen (LWBS) (OP-22) | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% | ↓ | N/A | 1.6% | N/A |
| | Completion of Culture of Safety Training within 90 days of staff hire | 60% (10) | 60% (10) | 60% (10) | 60% (10) | 60% (10) | 60% (10) | 60% (10) | 60% (10) | 60% (10) | 60% (10) | ↑ | N/A | 100% | N/A |
| Timely | | | | | | | | | | | | | | | |
| Treat and Release | | | | | | | | | | | | | | | |
| | Time from Door (Arrival) to Diagnostic Evaluation by a Qualified Medical Professional (OP-20) | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | ↓ | 20 | 15 | N/A |
| | Time from Disposition to Departure | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | ↓ | N/A | 16 | N/A |
| | Time from ED Arrival (Door) to ED departure (OP-18b) | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | ↓ | 190 | 180 | N/A |
| | Time to ECG (AMI and Chest Pain) (OP-5) | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | ↓ | 7 | 5 | 3 |
| Admitted | | | | | | | | | | | | | | | |
| | Time from Arrival (Door) to Qualified Medical Practitioner | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | ↓ | 20 | 15 | N/A |
| | Time from Qualified Medical Professional to Disposition | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | ↓ | N/A | 143 | N/A |
| | Time from Admit (Disposition) Decision to time of departure from ED (ED-2b) | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | ↓ | 105 | 79 | 58 |
| | Time from ED Arrival (Door) to physician decision to admit (ED-1b minus ED-2b) | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | 150 | ↓ | 160 | 155 | N/A |
| | Time from ED Arrival (Door) to ED Departure (ED-1b) | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | ↓ | 220 | N/A | N/A |
| Effective | | | | | | | | | | | | | | | |
| | ED visits where patient was admitted as inpatient or observation ^^ | 25% | 25% | 25% | 25% | 25% | 25% | 25% | 25% | 25% | 25% | ↓ | 26.7% | 21.0% | 15.5% |
| Efficient | | | | | | | | | | | | | | | |
| | Time to Primary PCI in minutes (AMI-8) | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | ↓ | 90 | 60 | 47 |
| | Diversion Hours in hh:mm (Quarter / Annualized) ^ | 300:30 | 30:00/120:00 | 300:30 | 30:00/120:00 | 300:30 | 30:00/120:00 | 300:30 | 30:00/120:00 | 300:30 | 30:00/120:00 | ↓ | N/A | 387:42 | N/A |
| | Diversion Occurrences (Quarter / Annualized) ^ | 30 | 2 / 8 | 30 | 2 / 8 | 30 | 2 / 8 | 30 | 2 / 8 | 30 | 2 / 8 | ↓ | N/A | 54.7 | N/A |
| Equitable | | | | | | | | | | | | | | | |
| | Ratio of Time Door (Arrival) to Departure (ED LOS) for behavioral health diagnosis vs other diagnosis - Treat and Release (excludes transfers) | 1.77 | 1.77 | 1.77 | 1.77 | 1.77 | 1.77 | 1.77 | 1.77 | N/A | 1.77 | 1 | 1 | 1 | 1 |
| Patient Centered | | | | | | | | | | | | | | | |
| | Response to question "Overall rating ER care" on Press Ganey ED Survey - treated and released patients only | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | ↑ | 89.3% | 89.7% | 90.5% |
| | Response to question "Courtesy of Emergency Room Staff" on Press Ganey Inpatient Survey | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | ↑ | 91.2% | 91.3% | 91.6% |

Threshold Not Met Threshold Met Target Met Superior Met

Where only Target is available, goal will either be met (green) or not (red).

² Emerging Infectious Diseases, Vol. 7, No. 2, March-April 2001; and FAQ about National Healthcare Safety Network (available at www.cdc.gov/nhsn).

Exhibit 5: Top MLH Performance Improvement Initiatives

(FY 2014–2015)

| CLINICAL QUALITY | PROCESS/OPERATIONS |
|--|---|
| 1. Eliminate Preventable Harm | 1. Improve ED Flow (decision to admit through arrival in bed) |
| 2. Reduce Unexpected Mortality* | 2. Evaluate Pre-Admission Testing Process for Standardization |
| 3. Improve Transitions in Care and Coordination Process | 3. Improve OR Flow/Utilization |
| 4. Improve the Patient Experience (Increase HCAHPS/PG Scores) | 4. Support Initiatives to Reduce Cost Per Case and LOS |
| 5. Decrease Healthcare Associated Infections (HAIs) (Device related, SSI) | 5. Improve Outpatient Registration Process |
| 6. Achieve Top Decile Core Measure Performance | |
| 7. Decrease Falls with Harm | |
| 8. Decrease Pressure Ulcers | |
| 9. Decrease Hospital Acquired VTE | |
| 10. Establish Clinical Environment Work Groups (CEWs) and Improve Microsystem Accountability | |

1–4 Top Board QPS Priorities

*Focus: Inpatient Sepsis, Palliative Care/Hospice Services, Respiratory Conditions, and Clinical Documentation Improvement (CDI)

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dashboard has a page of definitions that points to the source for indicator definitions as well as which benchmarking data has been used to set performance targets. Simple explanations shared during board committee orientation are important to ongoing understanding of data and evaluation of progress against goals. There will be measures that cannot be compared to a large national database because accurate comparisons do not exist. In that case, measuring progress to one's own organizational trends over time is the most appropriate strategy.

For example, many organizations report data to the National Database of Nursing Quality Indicators (NDNQI®), a repository for nursing-sensitive indicators such as pressure ulcers and patient falls. This is the only database containing data collected at the nursing unit level. If executive-level reports strive to review organization-wide performance, NDNQI data cannot be used as an organizational benchmark since data is reported by type of nursing unit only. In such a case, a hospital's goal might be to reduce pressure ulcers or falls by 20 percent year over year; therefore, using internal trend data for comparison is most appropriate.

Exhibit 5 illustrates how the Main Line Health board and senior team select national standards and internal strategic goals, along with supporting program and committee infrastructure. *Transforming Systems of Care*, Main Line's quality and patient safety framework, is used to provide a strategic view of the organization's priorities, support systems, and accountability structure (see **Exhibit 6**).

Understanding performance measurement often requires some basic knowledge of clinical conditions (e.g., heart failure, sepsis), tests, and procedures (e.g., cardiac catheterization, total joint replacement).

Clinician members of administration that attend board or committee meetings, invited guests (e.g., performance improvement team leaders), and physician board members spend significant time defining, describing, and even visually demonstrating how things should work and how/why something went wrong. Photographs, videos, technology, and equipment demonstrations are part of the meetings at Main Line Health. This interaction is not only critical to comprehension and discussion but helps keep clinicians and board members engaged in a more meaningful way. Rules banning routine use of abbreviations and acronyms supports better understanding as well.

Silence doesn't translate to understanding. Most often, the inverse is true. Encouraging lay board members to speak up, ask tough questions, and challenge hospital leaders is part of management's role.

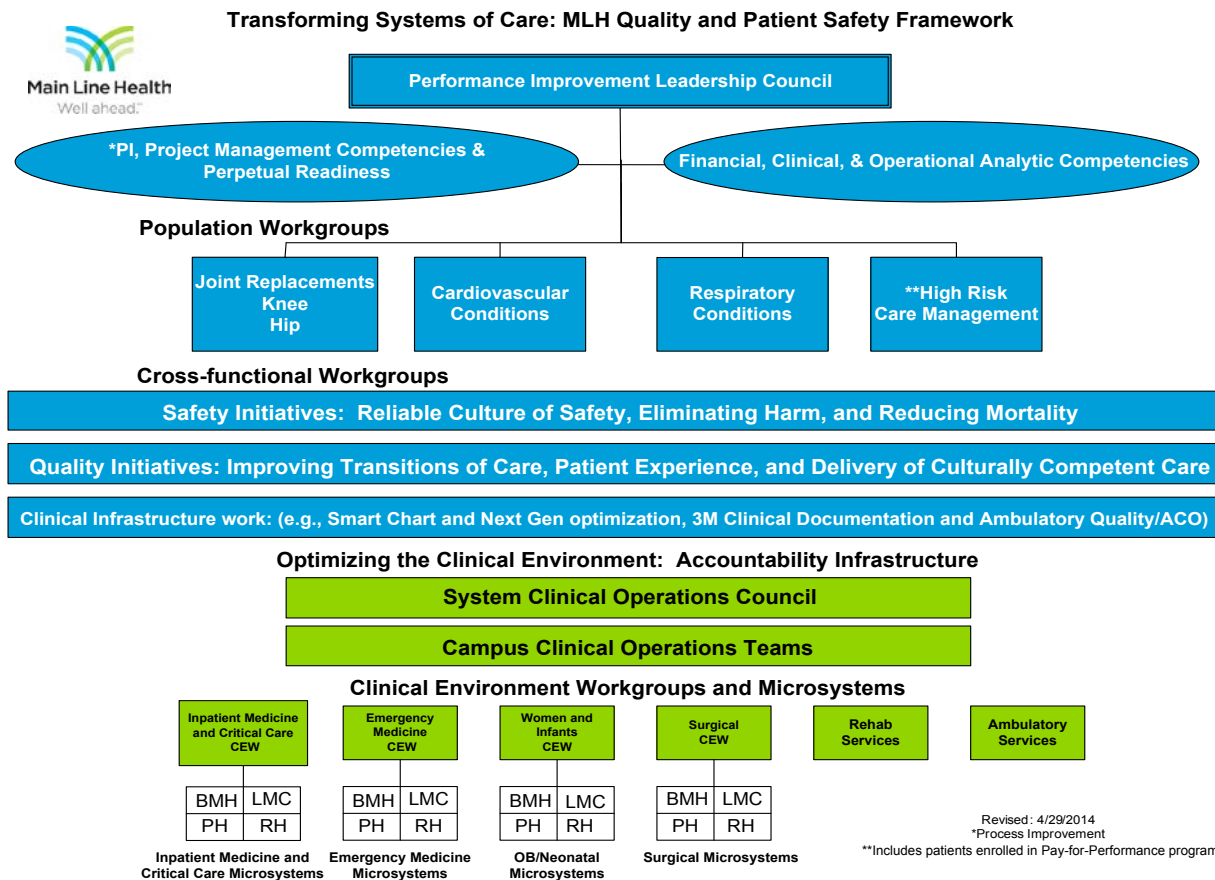
The Most Important Role of Board Members: Ask Tough Questions

Beyond looking at measurements and indicators, board members must drill down and ask tough questions of management to ensure that they are being held accountable to targets and that the metrics continue to be meaningful. Below is a sample list of questions asked by directors and QPS committee members at Main Line Health:

1. Why aren't we aiming for zero or 100 percent all the time?
2. What makes achieving zero or 100 percent (or top decile) hard?
3. What are we doing to sustain improvement gains?
4. What percent of errors/undesired outcomes are preventable?
5. Do we know how our (local) competitors are doing?
6. Are our populations comparable? How do we know?
7. Have we involved patients or family members in our improvement initiatives?



Exhibit 6: Transforming Systems of Care



8. Does staff have what they need to keep patients safe?
9. Do we know if and/or how staffing has affected (will affect) our outcomes (pertinent especially if budget issues or reductions are also being discussed with the board)?
10. Is the medical staff engaged?
11. How do we know that recommended change has been adopted? How do we know that recommended change is being sustained?

Summary

Performance measurement and analytics may possibly be the toughest aspect of quality and safety program work. Effective programs often have database managers, programmers, and analysts (or some combination) whose job is to ensure that measurement is valid, reliable, and reported in a way that is easily understood by key stakeholders. Translating data into actionable information for frontline improvement teams, managers, leadership,

and the board is one of the most critical responsibilities of QPS program leaders. The exhibits in this special section represent a few graphics that have helped Main Line Health orient new board members to their role in performance measurement and helped to make those measurements more meaningful. With a rigorous measurement and review process that is updated on a continual basis, along with providing board and committee members with the tools and resources they need to develop a deep understanding of the metrics used and how they work, boards and QPS committees can make a meaningful and measurable difference in the quality of care delivered at the bedside. ●

The Governance Institute thanks Denise M. Murphy, RN, M.P.H., CIC, FAAN, Vice President of Quality and Patient Safety at Main Line Health System in Bryn Mawr, PA, for contributing this special section. She can be reached at MurphyD@mlhs.org.

