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WSHA CQIP Peer Review and Quality
Improvement Information

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Washington State Hospital Association

MEASURING BOARD
EFFECTIVENES IN
QUALITY AND PATIENT
SAFETY



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Effectiveness

- Making your hospital safer means –
 - Supporting your CEO
 - Setting common expectations for results between hospital and medical staff

Today will challenge your thoughts – it is meant to cause a gap and stimulate thinking

Your role is to help your CEO make it happen.

THE GREAT OBSTACLE TO PROGRESS
IS NOT IGNORANCE BUT THE
ILLUSION OF KNOWLEDGE

DANIEL BOORSTIN

What *is* Quality?

“Quality . . . You know what it is, yet you don’t know what it is. But that’s contradictory . . . But when you try to say what quality is, apart from the things that have it, it all goes poof! . . . If no one knows what it is, then for all practical purposes it doesn’t exist at all. But for all practical purposes it really does exist. What else are grades based on? Why else would people pay fortunes for some things and throw others in the trash pile? Obviously some things are better than others . . . But what’s the ‘betterness’?”

What the hell is quality?

What is it?”

Robert M. Pirsig

Zen and the Art of Motorcycle Maintenance

Pursuing Perfection in Quality and Safety



Pursuing Perfection in Quality and Safety



A BRIEF HISTORY OF QUALITY

THE CODE OF HAMMURABI (CIRCA 2,000 B.C.)

“IF THE SURGEON HAS MADE A DEEP INCISION IN THE BODY OF A FREE MAN AND HAS CAUSED THE MAN’S DEATH OR HAS OPENED THE CARBUNCLE IN THE EYE AND SO DESTROYS THE MAN’S EYE, THEY SHALL CUT OFF HIS FOREHAND.”

- **THE DARLING vs. CHARLESTON COMMUNITY MEMORIAL HOSPITAL CASE - 1965**
- **THE CALIFORNIA MEDICAL INSURANCE FEASIBILITY STUDY – 1977**
- **THE HARVARD MEDICAL PRACTICE STUDY – 1991**
- **THE INSTITUTE OF MEDICINE REPORT - 1999**

Special report



Cover story

Is your doctor bad? You may never know

Limited access to data about medical errors hides potential danger

By Julie Appleby and Robert Davis
USA TODAY

Elsewhere

► Up to 98,000 medical errors happen each year.

Study: U.S. Doctors are not following the guidelines for ordinary illnesses

Medical Care Often Not Optimal

Failure to Treat Patients Fully Spans Range of What Is Expected of Physicians and Nurses

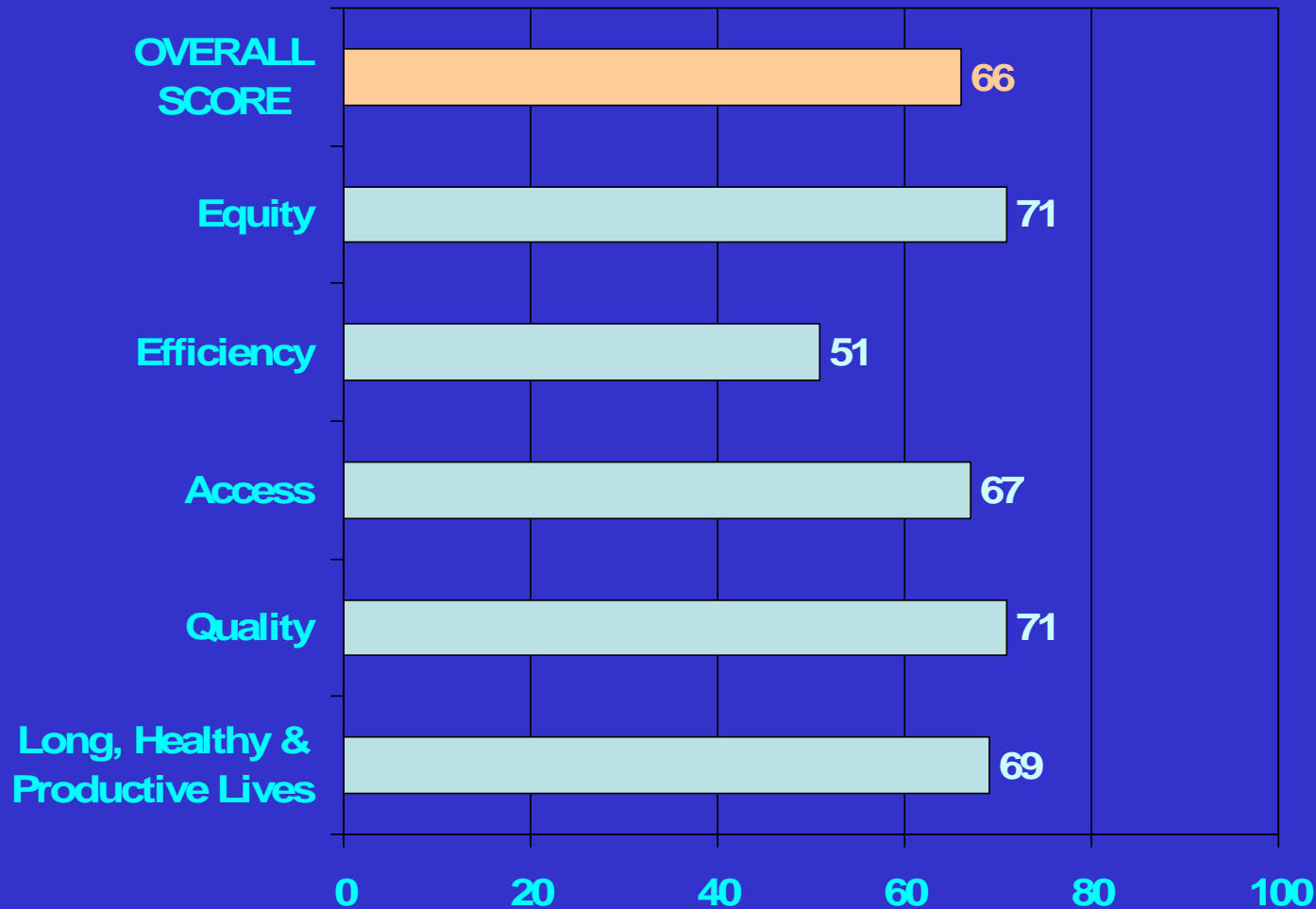
Medical Errors Corrode Health Care Quality

Patients' care often deficient, study says.

Proper treatment given half the time.

On average, doctors provide appropriate health care only half the time, a landmark study of adults in 12 U.S. metropolitan areas suggests.

U.S. SCORES: Dimensions of a High Performance Health System



WHY?

- **ADHERENCE TO THE STATUS QUO**
- **MISALIGNING PAYMENT INCENTIVES**
- **INADEQUATE INFORMATION SYSTEMS**
- **DUPLICATIVE AND COSTLY REGULATORY OVERSIGHT**
- **“INAPPROPRIATE BALANCE BETWEEN AUTONOMY AND ACCOUNTABILITY”**

QUALITY, PATIENT SAFETY AND
GOVERNANCE...

THE PLOT THICKENS

NOT AT MY HOSPITAL!

**Patient Safety Incidents Increased by 3% From
2003 TO 2005**

HEALTHGRADES STUDY, 2007

**67% Of Physicians Have Not Been Involved In
Collaborative Efforts To Improve Quality**

COMMONWEALTH FUND NATIONAL SURVEY OF PHYSICIANS, 2007

NOT AT MY HOSPITAL!

46% Of Physicians Failed To Report At Least One Serious Medical Error, Even Though 93% of Physicians Said They Should Report ALL Significant Medical Errors They Observe.

45% Said They Did Not Report Impaired Or Incompetent Colleague Physicians Even Though 96% Said They Should.

ANNALS OF INTERNAL MEDICINE, DEC. 4, 2007

GOVERNANCE AND QUALITY...

THE NEXT FRAUD FRONTIER?



THE US DEPARTMENT OF JUSTICE ASKS:

- HAS THERE BEEN A SYSTEMIC FAILURE BY MANAGEMENT AND THE BOARD TO ADDRESS QUALITY ISSUES?
- HAS THE ORGANIZATION MADE FALSE REPORTS ABOUT QUALITY, OR FAILED TO MAKE MANDATED REPORTS?
- HAS THE ORGANIZATION PROFITED FROM IGNORING POOR QUALITY, OR IGNORING PROVIDERS OF POOR QUALITY?
- HAVE PATIENTS BEEN HARMED BY POOR QUALITY , OR GIVEN FALSE INFORMATION?

GOVERNANCE AND QUALITY...

THE NEXT CRIMINAL FRONTIER?



HEADLINE: “DEATH AFTER TWO-HOUR ER WAIT RULED HOMICIDE”

- BEATRICE VANCE, 49, DIED OF A HEART ATTACK, BUT THE JURY AT A CORONER’S INQUEST RULED THAT HER DEATH ALSO WAS “A RESULT OF GROSS DEVIATIONS FROM THE STANDARD OF CARE THAT A REASONABLE PERSON WOULD HAVE EXERCISED IN THIS SITUATION.”
- VISTA MEDICAL CENTER, WAUKEGAN, IL; SEPTEMBER, 2006.

Board function ***DOES*** affect quality

Emerging research shows that
Boards can make an enormous
difference in improving quality and
patient safety

MOST COMMON AREAS BOARDS CAN IMPROVE

1. HOLD THE CEO ACCOUNTABLE VIA PERFORMANCE OBJECTIVES AND LINKING COMPENSATION TO SPECIFIC QUALITY AND PATIENT SAFETY GOALS
2. SET THE ANNUAL BOARD AGENDA FOR QUALITY WITH MEDICAL STAFF INPUT
3. SPEND 25% OF BOARD TIME ON QUALITY AND PATIENT SAFETY

MOST COMMON AREAS BOARDS CAN IMPROVE

4. IF ONE DOES NOT EXIST, CREATE A QUALITY COMMITTEE OF THE BOARD
5. FOCUS INTERACTION BETWEEN THE BOARD AND THE MEDICAL STAFF ON QUALITY, PATIENT SAFETY, AND THE QUALITY STRATEGY

MOST COMMON AREAS BOARDS CAN IMPROVE

6. DON'T BE A RUBBER STAMP!
ACTIVELY PARTICIPATE IN THE
OVERSIGHT OF THE MEDICAL STAFF
CREDENTIALING PROCESS,
INCLUDING INVOLVEMENT IN THE
DEVELOPMENT OF CRITERIA
7. REGULARLY RECEIVE AND DISCUSS A
FORMAL QUALITY PERFORMANCE
MEASUREMENT

MOST COMMON AREAS BOARDS CAN IMPROVE

8. THE BOARD QUALITY COMMITTEE
REVIEWS PATIENT SATISFACTION
SCORES
9. PUT A QUALITY EXPERT ON THE
BOARD.
10. EDUCATE ALL BOARD MEMBERS TO
QUALITY LITERACY

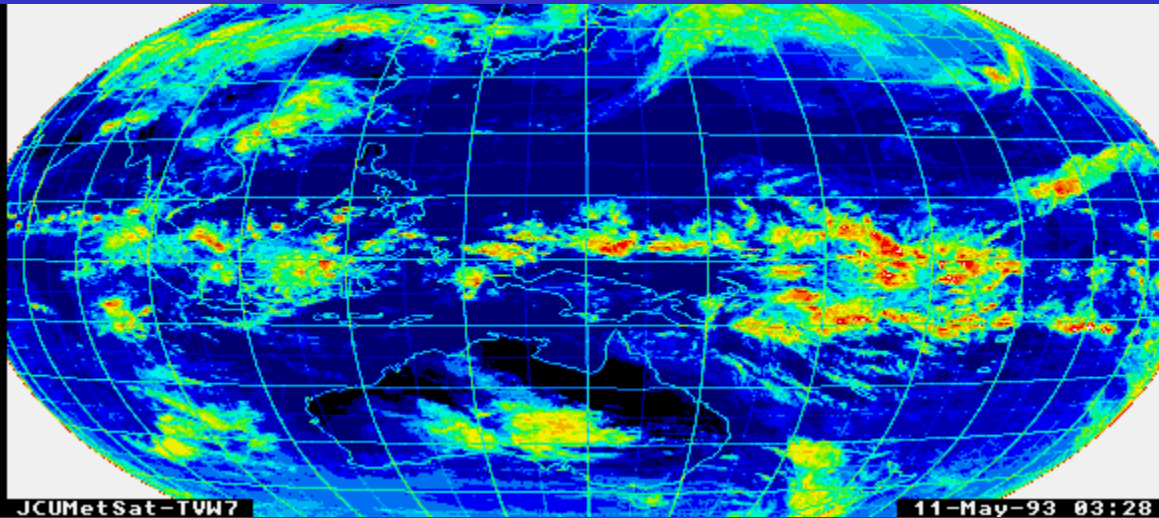
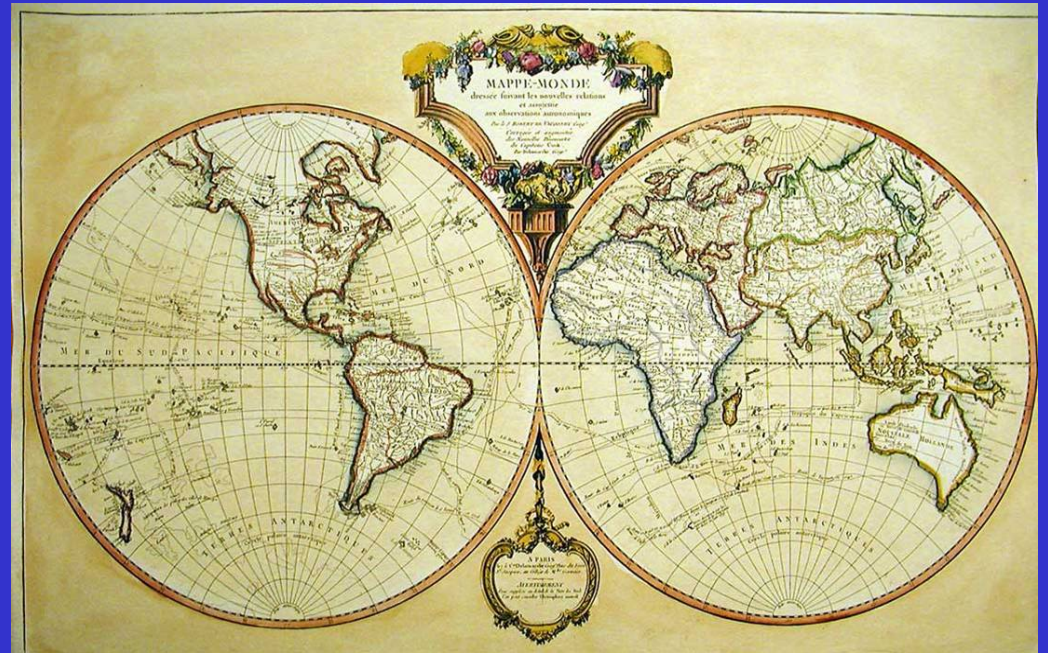
MOST COMMON AREAS BOARDS CAN IMPROVE

11. PRACTICE PROSPECTIVE QUALITY IMPROVEMENT! PLAN QUALITY INTO NEW VENTURES. REFUSE TO APPROVE ANY NEW VENTURE, NEW SERVICE, ETC. UNLESS PROPOSAL CONTAINS A QUALITY PLAN.
12. REQUIRE “POKYOKE”; MISTAKE PROOFING.

DISRUPTIVE GOVERNANCE FOR QUALITY:

- **PUT AN OUTSIDE, “EMPEROR HAS NO CLOTHES” MEMBER ON THE BOARD**
- **DEVELOP AND CONTINUOUSLY REFINE, A BOARD QUALITY INFORMATION DASHBOARD**
- **PUT A QUALITY EXPERT ON THE BOARD – HAVE “QUALITY LITERACY FOR ALL BOARD MEMBERS”**
- **NO “DENOMINATORS” FOR QUALITY DATA; 0% OR 100% TARGETS ONLY!**

**“You Should
Not Use an
Old Map**



**to Explore
a New
World”**

Albert Einstein

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