



Speaking Remarks

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to

**Issues in Governance: Board's Role in Patient
Safety**

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CHECK AGAINST DELIVERY

- How Ontario's hospitals are governed is an increasingly important issue for the general public, the media, and for our patients.
- And, leading excellence in governance throughout the health care sector is a key strategic direction for the OHA.
- We continue to develop initiatives to strengthen governance among our health care leaders.
- Already, we have created the Governance Centre of Excellence, which provides a broad range of services and educational programs including online resources and tools for health care trustees.
- We have also published the Guide to Good Governance, which is being used extensively by hospital and health care leaders, law firms, health care consultants, LHIN Boards, and other non-profit health care organizations.
- One new initiative that we are particularly excited about is the launch of our comprehensive certification program for health care trustees.

- This educational approach will give board members the tools and expertise to ask the right questions, provide good leadership and effectively monitor a hospital's performance.
- Following through on these and other governance-related initiatives will remain key priorities for the OHA over the next three years.
- My topic this afternoon is at the forefront of these discussions around governance, and that is "The Board's Role in Patient Safety."
- I will attempt to answer two questions.
- First, does a hospital board have a role in patient safety?
- And, second, if so, what would an appropriate role be?
- So, does a hospital board have a role in patient safety?
- The answer is, absolutely.

- A study of adverse events in Canadian hospitals revealed that an estimated 7.5% of patients admitted to acute care hospitals in Canada in 2000 experienced one or more adverse events.
- Of these adverse events, 36.9%, or almost 70,000, were preventable.
- And, although most patients recovered, the human and monetary costs were considerable.
- I think everyone agrees that this performance is not acceptable in a modern, world-class health system, and must be improved.
- In the words of University of Calgary patient safety expert Dr. Peter Norton, “to achieve system level performance improvement, hospitals and systems must have capable, committed leadership in both the executive office and the board room.
- Meaningful and sustainable quality improvement cannot occur in any organization without the full support and engagement of the organization’s trustees.”
- This statement is supported by data.

- As Norton notes, patient outcomes are better in hospitals where:
- The board spends more than 25 percent of its time on quality and safety;
- The board receives a formal quality measurement report on a regular basis;
- There is a high level of interaction between the board and medical staff on quality strategy; and
- Senior executive compensation is based in part on quality and safety performance.

- Given this, it is perhaps no surprise that Dr. Alan Hudson, head of Ontario's Wait Times Strategy, has spoken on several occasions about the need to make hospital boards fully aware of their responsibility for overseeing quality of care in hospitals.

- The latest step toward this was taken on May 5, when the Ministry of Health and Long-Term Care announced its intention to proceed with requiring hospitals to inform patients when errors occur, and with making hospital-level reporting of critical patient safety measures available to the public.

- So, hospital boards, and hospital trustees, as the stewards of their institutions, have a vital public interest role, and increasingly, a legal responsibility, to monitor and improve hospital care, and to ensure that it is safe, beneficial, patient-centred, timely, efficient and equitable.
- The answer to the second question, what is an appropriate role for a board in improving patient safety, is somewhat more involved.
- According to health governance and quality improvement expert Barry Bader, there are five stages of development when working to optimize a board's engagement in quality and safety.
- The first is recruitment – identifying current or prospective trustees with competencies in quality, safety and customer satisfaction in both industry and health care.
- This recommendation is in keeping with current hospital governance best practices, which suggest that boards be skills-based.

- The second is awareness – making trustees aware of that patient safety and quality are issues that they have a responsibility to deal with.
- As I noted a moment ago, Ontario appears to be moving toward making hospital boards legally responsible for safety and quality oversight and improvement.
- The third is developing trustee literacy with respect to patient safety and quality terminology.
- It is impossible to effectively oversee what you don't know about or understand.
- Trustee understanding and comfort with key concepts, like the Hospital Standardized Mortality Ratio, can be improved through specialized board education sessions or the like.
- The fourth stage is application.
- This is when trustees feel are prepared to actively engage on issues of safety and quality.
- This stage is closely linked with the fifth, which is ensuring that the trustees' work on safety and quality adds value.

- I would like to spend some time exploring these last two stages.
- At a recent OHA conference, Dr. Peter Norton began a presentation on patient safety and quality reporting by posing the following questions:
 - Does the board of directors at your hospital discuss finance in more detail than issues of safety and quality?
 - Could your board send a stronger signal to the organization that it is really serious about achieving quality and safety aims?
 - Is your board overwhelmed by quality data and unable to determine what to do with it?
 - These questions really encapsulate the core issue of how hospital trustees can add value and provide leadership on issues of patient safety and quality.
 - Dr. Norton noted that while boards adopt a “laser-like” focus on key measures of performance, demanding understandable explanations of financial variances and asking probing questions, they are often not equally

tenacious with regard to patient safety and quality.

- Why is that?
- Perhaps the role of the board in this area is unclear.
- Norton's recommendations with respect to this issue were fairly straightforward.
- First, make the first agenda item at every board meeting a review of progress toward safer care.
- Second, boards should monitor their meetings and ensure that at least 25% of its time is spent on issue of quality and safety.
- Taken together, these two recommendations would send a very clear signal that hospital boards are making issues of patient safety and quality a key priority, and that the kind of rigour and level of analysis that is applied to issues of funding and spending will now be applied to quality improvement.

- These recommendations give life to the concept of improving patient safety and quality and must begin in the board room.
- The next issue is how to make quality data accessible and meaningful to board members, and how they can, in turn, use it effectively to drive performance improvement.
- The answer, according to Norton, was to adopt what called “Big Dot” indicators.
- Big Dots are those indicators that are relatively easily measurable, and improving performance on those indicators will lead to a major overall performance improvement for a hospital.
- These indicators include hospital acquired infection rates, medication error rates, surgical complication rates and, perhaps most importantly, the Hospital Standardized Mortality Ratio, or HSMR.
- HSMR is a measurement tool that compares a hospital’s mortality rate with the overall average rate.

- Developed in Britain in the mid-1990s, HSMR is used by hospitals in many countries, including Sweden, Holland and the United States.
- The Canadian version of HSMR was developed by the Canadian Institute for Health Information, or CIHI.
- CIHI has calculated Hospital Standardized Mortality Ratios (HSMR) for every acute care hospital in Canada, and plans to publicly release Hospital Standardized Mortality Ratio (HSMR) results in November 2007.
- Some hospitals, including those enrolled in the Canadian Patient Safety Institute's Safer Health Care Now campaign, have been receiving their HSMR reports on a quarterly basis.
- Also, hospitals that participate in Ontario's Wait Times Strategy will be required to report HSMR to their board on a quarterly basis as a condition of their funding.

- One of the major virtues of HSMR is that it is easy to understand, it does a good job of capturing overall hospital patient safety performance, and it can be updated on a near real-time basis.
- The OHA encourages all hospitals to obtain their HSMR as soon as possible, both to become familiar with this indicator before it becomes publicly available later this year, and because it is a useful performance improvement tool.
- As noted by Norton, proactive organizations have successfully used HSMR results to monitor performance and reduce mortality rates.
- By learning more about their HSMR, comparing their performance to their peers, and identifying and implementing improvement strategies, hospitals around the world have been able to make remarkable patient safety and quality gains.
- For example, by tracking HSMR and implementing a range of improvements as a result of what they learned, the UK's Walsall hospital was able to reduce mortality by 40% in only four years.

- Similarly, the Tallahassee Memorial Hospital in Florida was able to use HSMR to drive performance improvements that result in mortality rate reductions of 62% for heart failure, 41% for stroke, and 46% for pneumonia.
- Perhaps more importantly, the use and tracking of HSMR at Tallahassee Memorial helped create a new, positive culture of innovation and improvement.
- As noted by Fain Folsom, the Tallahassee Memorial's Manager of Performance Improvement,

“The best part about this whole process has been watching people get motivated to create change. They have seen dramatic improvements, and now they know not to worry about looking sill when they try something new. We are really improving care, and really making a difference for patients, and that's very motivating.”

- This statement indicates the power of using “big dots” such as HSMR to move improve patient safety and develop a culture of quality improvement.
- The discussion of “big dots” leads directly to another key recommendation by Norton, that boards set organization-wide patient safety improvement goals, such as a significant reduction in HSMR, and hold the executive team accountable for meeting them.
- Studies have shown that after the board, hospital CEOs are the people with the greatest impact on quality improvement.
- As I noted earlier, patient outcomes are better in hospitals where there is a high level of interaction between hospital leaders and medical staff on safety and quality strategy, and where senior executive compensation is based in part on quality and safety performance.
- CEOs drive performance improvement, and foster a culture of patient safety.

- These findings strongly indicate that boards should insist upon making quality improvement a key part of the CEOs mandate.
- Boards can also play a critical role in terms of ensuring that only the best, most qualified health professionals are allowed to practice in their facilities.
- Boards have very important responsibilities with respect to physician credentialing, and monitoring physician performance.
- It may soon become somewhat easier to execute these responsibilities.
- On Saturday, May 5, 2007, the Ministry of Health and Long-Term Care (MOHLTC) announced that it would offer amendments to Bill 171, the *Health System Improvements Act*, an omnibus bill which is currently being considered by Ontario's Legislative Assembly.
- The amendments, which would affect the *Regulated Health Professions Act, 1991*, are intended to enhance patient safety by expanding public reporting on health professionals' credentials and practice records.

- If adopted, the proposed amendments would result in the following changes:
- The posting on a health regulatory college's website of:
 - findings of malpractice and professional negligence against one of its members
 - all matters referred to its discipline committee
 - every suspension or revocation of a member's certificate of registration
- Where a health care professional has been found guilty of any offence, he or she will be required to report this to their regulatory college.
- If the offence relates to the health care professional's suitability to practice, the health regulatory college would then make the subsequent finding of professional misconduct public on its website.
- Ensuring patients have access to information on discipline and incapacity decision a regulatory college makes by requiring the posting of decision summaries on the college's website.

- This information would no longer be automatically removed from the web site after six years.
- These amendments have been introduced and adopted by a legislative committee, and will soon be voted on by the entire legislature.
- Although the OHA's recommendation that Bill 171 be amended to compel the professional colleges, such as the College of Nurses and the College of Physicians and Surgeons, to inform hospital boards when one of their members is under investigation was not accepted, we view these amendments as important steps forward.
- Once this bill passes, this information should be data points for trustees when making decisions about physician credentials.
- To assist trustees, the OHA is currently developing a physician credentialing toolkit.
- We believe that this toolkit, to be released in the weeks ahead, will help trustees ensure that all relevant and important information is considered during the credentialing process.

- These are just a few of the ways that hospital trustees and boards can play a role in improving patient safety.
- And, in today's rapidly changing health care environment, it is important that they do.
- I would like to spend a few moments discussing the environment in which hospitals boards are currently operating.
- Since 2003, almost every one of my speeches has included a line about how Ontario's hospital sector and health sector are working through an era of rapid, root-and-branch change.
- Much of this change has been what technology guru Clayton Christensen has called "disruptive".
- Disruptive change and innovations fundamentally alter the way that an enterprise works.
- In the private sector, disruptive changes – like the introduction of laptop computers and steel mini-mills, for example – changed the way companies were organized and money was made.

- Similarly, in the health sector, the introduction of Hospital Accountability Agreements and the creation of the Wait Times Strategy and Local Health Integration Networks are altering the way that care is organized and delivered.
- I believe that these changes have been – and will continue to be – largely positive.
- But it is no secret that times of transition can be challenging.
- And one of the biggest challenges that we face is governance; specifically, ensuring that Ontario’s hospital trustees have the tools and know-how they need to execute their increasingly heavy responsibilities as stewards of our health care system.
- Ontario’s hospital system is unique in Canada.
- Ours is the last which uses an independent voluntary governance model.
- In this model, the first principle is that local stewardship of our hospitals makes our health system stronger.

- Ontario’s hospital system was founded on this model almost a century ago, and it has served Ontarians well since.
- It may also be fair to say that the success of this governance model influenced the government of Ontario’s thinking when it created Local Health Integration Networks.
- The government has repeatedly called LHINs a “made-in-Ontario” approach to regional health system reform, and really, they are.
- In other provinces, independent, local hospital boards were eliminated with the advent of Regional Health Authorities, in which all decision-making power is vested with the Ministry of Health.
- Ontario took a different approach and created a regionalized system that maintained independent hospital boards.
- This seemingly straightforward decision illustrates the fundamental difference between the way that health care is provided in Ontario as compared to other provinces.

- By maintaining local hospital governance within the LHIN model, the government has acknowledged that the best health system is one built on local experience, local input, and local collaboration.
- By contrast, Regional Health Authorities have at times been criticized by patients and communities for being too top-down, exclusive and centralized.
- So, hospital trustees have been given the opportunity to continue demonstrating the strength and value of local governance.
- But this is also, in some respects, a test of local governance.
- In an era of increasing public scrutiny, expectations and consumerism, hospitals are expected to offer the highest level of services, and provide these services safely.
- The public – and by extension, the media and the government – expect hospital trustees to embrace the patient safety and quality improvement agenda.

- One need look no further for evidence of how prominent issues of patient safety have become than the front page of the Toronto Star, which over the past year has run a number of stories about this issue.
- Hospitals – and hospital trustees – are expected to meet the challenge of improving patient safety.
- If you'll allow me a brief digression, I'd like to add that patient safety is just one challenge to hospital governance.
- And, as many of you know, there are some areas of the province where hospital boards face other significant governance challenges from community activists.
- For the most part, these community activists, who buy memberships in their local hospitals and attempt to exercise direct influence over hospital decision-making, have the best intentions.

- But in some cases, key players may be pushing their own agendas.
- And this has, in some places, resulted in an acrimonious relationship developing between hospital trustees and members of the community and personal attacks on trustees.
- I have written in letters to the editor, and I say this today: these types of attacks sadden me.
- Hospital board members are volunteers who give their time and talents to the service of our communities.
- They welcome community interest, input and debate about the decisions they make.
- Indeed, that very interest is what inspired these individuals to serve their communities on the hospital board.
- I personally believe that no problem can go unsolved if we are willing to respectfully consider the different ideas, perspectives, rights and responsibilities of the people we are working with.

- The OHA is proud to play a role in supporting these members of the community in the important work they do.
- And, I am confident that, even with these challenges, if trustees do make quality improvement and patient safety more of a priority, and are successful in driving other performance improvements, then local, voluntary governance will continue to have a bright future.
- But we should be under no illusions about what could happen should we fail.
- Public demands for change and improvement could compel the government to sweep away our unique governance model in favour of direct control, as has happened in other provinces.
- I am not one for hyperbole, or for fear-mongering.
- However, relatively recent experience in other provinces has shown that there is no guarantee that voluntary governance will continue to exist because it has, until now, been ever thus.

- That is why I believe so strongly that the patient safety and quality agenda must be embraced by trustees.
- For its part, the OHA is planning educational conferences designed to assist Members and the Boards with better understanding their roles and responsibilities with respect to patient safety and quality reporting.
- Information about these sessions is available is available through the OHA's Executive Update and Executive Report, and at www.oha.com.
- I would like to conclude by thanking you for being here today, and thanking you for giving your time and talents to the service of our communities.
- I truly believe that your work strengthens and improves our health care system, and has helped make it one of the best in the world.
- And I know that your efforts and commitment will ensure that Ontario's hospitals meet the challenge of improving patient safety in the time ahead.
- Thank you.