MASSACHUSETTS
HEALTH CARE SAFETY & QUALITY
CONSORTIUM

MASSACHUSETTS ROADMAP TO HEALTH CARE SAFETY

Task Force: Leadership and Governance

Final overview July 2023

BETSY LEHMAN CENTER
for Patient Safety

Purpose

The Leadership and Governance Task Force was charged with the task to develop practical recommendations, tools, and policy proposals that support leaders of health care provider organizations across the continuum of care to:

- Make safety a core value and enduring priority
- Continuously act to advance safety culture and operations
- Assume accountability for safety performance

The Task Force defined "leader" as anyone who plays a senior decision-making role in a provider organization across the continuum of health care — from clinician-owners of office practices to executive leaders of hospitals and other large, complex facilities, to members of the governing boards of those organizations.

The recommendations are intended to have potential for high impact, rely on best practices when possible, and include clear objectives and goals. They should support and be applicable to health care organizations of all types and sizes. In addition, recommendations serve to boost the agency and safety of people from communities that experience inequities in medical outcomes, employment, and other health care interactions.

VISION

The Leadership and Governance Task Force envisions a future state in Massachusetts health care where health care leaders feel knowledgeable, supported, and rewarded for their ability to lead transformational culture change to improve safety. This change will require a comprehensive and sustained cultural shift away from the current project-based approach to safety toward a holistic, patient-centered approach. Safety is embraced by health care leaders as a core organizational value. Leaders in this future state recognize that everyone plays a role in safety, that transparency is essential, and that safety requires culture and systems change along with resource investments to be sustainable.

Guiding principles

The Consortium encouraged task force members to apply the following principles when developing their recommendations:

- Move the health care system toward a mindset of zero tolerance for defects that can result in physical or emotional harm to patients, families and staff;
- Support approaches to continuous, proactive safety improvement that break down siloes and enable all stakeholders — including provider organization staff at all levels, patients, payers, and policymakers and regulators — to carry out their respective roles;
- Promote a "just culture" by adopting a fair and consistent approach to safety improvement that fosters psychological safety and holds leadership accountable for breakdowns and shortfalls;
- Advance health equity through the elimination of disparities in safety and quality outcomes on the basis of race, ethnicity, language, age, disability, sex, gender, language, and economic factors;
- Encourage an approach to health care and safety that maximizes the benefits of co-production, recognizing that patients and families provide expertise essential to person-centered care;
- Reduce low-value administrative burdens;
- Remove all forms of waste from work, making it easier to do the right thing.

Background

Since the national movement to improve patient safety catalyzed in the early 1990s[1], considerable gains have been made to improve health care safety, particularly by hospitals[2] whose leaders establish cultures of safety and invest in processes and structures known to support safe operations.[3,4] Because of these efforts, the impact of leadership on the safety of an organization is relatively well understood.

Provider organizations with leaders who demonstrate a commitment to safety perform better on measures of safety and quality than their peers.[5,6] Leaders set the priorities, drive the culture, and are ultimately responsible for outcomes.[7]

A strong safety culture provides a foundation to prevent staff and patient harm and to learn from adverse events when they do happen. The unequivocal commitment of an organization's leadership is required to develop and sustain a strong safety culture. Reliably safe health care will be realized only when all leaders embrace safety as a preeminent core value and make it an enduring priority that is visible in everyday operations and interactions at the highest level of an organization's leadership.[8] Several Massachusetts provider organizations have improved their safety performance through intentional efforts to cultivate a safety culture and prioritize safety improvements. While these success stories are a promising foundation, these improvements have yet to be seen consistently throughout the state.

Challenges

The Task Force discussed a range of challenges and barriers that need to be overcome to achieve the vision of all health care leaders being supported in their ability to lead transformational culture change to improve safety. The Task Force identified barriers in five distinct categories.

Resource constraints

- Financial constraints that impede sustainability of safety efforts
- Time constraints and competing obligations that can lead to drift and only a short-term focus on safety
- Investments in change processes that might not bear fruit for many years are often not rewarded or incentivized
- Other misaligned incentives that discourage investment of time and other resources in safety improvement
- Resources to support leaders in implementing safety systems and culture change are not widely available
- Change management is difficult work that requires leaders to simultaneously address the human and operational drivers of safety improvement. During the period of pandemic recovery, leaders were called upon to address an array of challenges, including workforce staffing issues, that demanded new thinking and approaches

Knowledge and awareness constraints

- Lack of awareness of the essential role of leaders and governing bodies to initiate and embed safety culture and performance
- Lack of commitment to put energy and resources toward safety improvement

- Limited and uneven knowledge and skills among leaders about safety science and their own roles and responsibilities for advancing safety
- Current information gathering and sharing on safety is siloed and haphazard, leading to a fragmented picture of safety for all stakeholders, including leaders
- Failure to recognize who the "leaders" are — not just the CEO/board chairs, but natural thought leaders, owners of small organizations, etc.
- Provider organizations with governing bodies have often not optimized or leveraged the role of board members in safety leadership
- Low awareness of safety risks and events within own organizations and/or overestimation of the degree of competence and level of performance on safety by an organization's leadership
- Inadequate access to information and training on safety principles, practices, and safety leadership, especially for board members who may not be expert in these areas
- Failure to recognize the "business case" — that prioritizing safety and eliminating patient harm reduces health care expenses in the short and long-term

Cultural constraints

- Desire to avoid conflict with colleagues and staff who are resistant to change
- Sense of futility — belief that real change is impossible or that safety is already as good as it's going to get

Governance constraints

- Lack of internal or external accountability systems
- Leaders are not chosen, evaluated, or rewarded based on their safety knowledge or performance

Externally imposed constraints

- Measure sets do not have many effective measures of safety — most are quality focused. This leads to a conflation of quality and safety at the organization/leadership level and a lack of understanding about how to manage safety as an issue
- Payment systems reward for improvements in quality, not safety
- Leaders have not been held accountable for safety by payers, regulators or other stakeholders. Safety improvement has not been a strategic priority.

Discussion points

The Task Force developed discussion points that were prompted by asking what structures, resources, or incentives could contribute to overcoming the above barriers.

A. Hone safety leadership, knowledge, and skills for leaders across the health care continuum

1. A safety curriculum for Massachusetts health care leaders is a key priority. The curriculum could be customized for leaders of varied settings, draw from existing materials, and favor interactive, experiential learning opportunities over didactic lessons. Every version of the curriculum could include:
    - Safety science basics
    - The role of leaders in building a culture of safety and safe operations
    - Understanding inequities in safety and how to overcome them

- Data literacy and the role of transparency

2. Massachusetts could establish a certificate in safety leadership and a credential for executives, and make it widely available to leaders who complete curriculum requirements
3. The state can establish minimum education and training requirements as a condition of licensure for leaders of health care facilities to demonstrate their competence to lead safety
   - Board members of provider organizations might complete a one-time training in health care safety for board members and continuing education in health care safety each year
   - Executive leaders of provider organizations might complete a one-time training in health care safety for executive leaders and continuing education in health care safety each year
4. Institutes of higher education could explore options for clinical program core curriculum (didactic and clinical rotations) to include courses and training in safety, human failure, and mitigation strategies

B. Increase governing board engagement in safety performance and accountability for improvement

1. Board leaders, with the support of executive leaders, can optimize their board's ability to engage in discussions of accountability for safety. This may be accomplished by:
   - Using safety aptitude or willingness to learn as key qualities when recruiting board candidates
   - Ensuring that board members receive education in safety, quality, and improvement concepts at onboarding and periodically thereafter, and that they can demonstrate competencies in safety, equity, and data literacy
   - Establishing a Board Quality and Safety Committee with oversight responsibility for culture change, safety, and performance improvement
   - Incorporating safety as one of the responsibilities of the Audit Committee
   - Using a standardized board assessment that includes inquiry on safety culture knowledge to determine educational opportunities
   - Developing and encouraging participation in a voluntary health care board member certification program, which includes a focus on quality, safety, and improvement
   - Engaging with the board on setting safety goals that are then carried out through contracts, hiring, and compensation decisions
   - Encouraging active participation by board members in safety discussions by providing checklists of relevant questions to ask about their organization's safety performance
   - Including board members on guided leadership rounds and requesting that board members spend time on all floors and units communicating and supporting the safety agenda
2. Safety has a place on the agenda of every board meeting. This may be accomplished by:
   - Beginning each board meeting with a presentation of the organization's safety performance during the previous period. The presentation could note good catches as well as harms because it can be motivating to highlight successes in addition to failure.
   - Presenting and discussing a dashboard that includes patient and workforce safety and culture metrics. Additionally, align the dashboards to show these metrics segmented by categories related to inequities in care.
   - Bringing frontline teams to board meetings to share their success stories and receive recognition.

3. The Attorney General's Office board education materials for non-profit health care board members can include information about board member duties as they relate to organizational safety performance.

C. Ensure ongoing support for leaders throughout their organizational safety journey

1. Health care stakeholders in Massachusetts could collaborate to develop and provide interactive learning activities for Board members, executive leaders of complex health care organizations, and leaders of less complex organizations. The interactive learning activities might include coaching, mentoring, and support networks; safety collaboratives to facilitate peer learning by groups of executive leaders; and simulation-based learning. These interactive learning supports can provide direct implementation support for the fundamentals of Leader Standard Work for Executives and Board Members, including establishing a vision, accepting accountability for safety, developing a culture of safety, and setting metrics, among others.
2. Health care stakeholders in Massachusetts can support the development and implementation of safety planning tools and resources for Board members, executive leaders of complex health care organizations and leaders of less complex organizations.

D. Align financial and regulatory incentives to encourage leaders' prioritization of safety

1. Public and private payers can reward safety performance with incentive payments and other forms of incentives, which could include a Centers of Excellence designation or preferred provider status related to achievement on safety measures.
2. Malpractice carriers can align product pricing incentives and their underwriting process with safety performance. This might include providing a discount incentive to organizations that demonstrate a commitment to participating in activities that improve organizational safety (e.g., by participating in a learning collaborative).
3. The Office of the Attorney General could require greater transparency of nonprofit health care CEO salaries and top paid executive contracts and annual pay. This might include creating easier public access to the executive pay currently reported on IRS Form 990 in addition to seeking and publishing details about incentive bonus structures related to safety and finance, including any gating requirements.
4. The safety review process could include an analysis of leadership and culture issues when doing safety surveys and allocating additional resources for reviewers to examine culture and leadership practices.
5. Medical malpractice carriers can use safety performance as part of their underwriting process.
6. Commercial health plans can use safety performance when contracting with health care providers.
7. With the cost growth benchmark public reporting process, the Health Policy Commission could create a threshold for review of a large health care organization's safety performance and invite leaders to discuss their safety strategy.

E. Ensure regular reporting on safety trends to maximize public understanding of safety data

1. Leaders of health care organizations could collect organizational data and information on safety performance that helps illuminate barriers to culture change and provides meaningful feedback loops for patients, families, and staff.
    - All health care organizations can implement a bi-annual safety culture survey with a minimum required response rate to understand the progress that they have made toward implementing a safety culture and to identify areas for improvement.
    - All health care organizations can collect metrics and establish performance dashboards to monitor the organization's safety performance; develop a method for collecting stories from patients, families, and staff; and institute and establish leadership participation in daily huddles.
    - Leaders of more complex health care organizations can ensure that their patient and family advisory councils operate in a way that creates a true feedback loop between patients and leaders.
2. The Betsy Lehman Center could complete regular, proactive reviews of safety risks by setting, and publish a report that highlights risks that are unique to certain settings and recommends strategies to mitigate these risks.
3. A semi-annual report could be published on practical and implementable safety practices to address top safety concerns. The report can give credit/visibility to organizations that are doing a good job on safety and spotlight safe practices among smaller provider organizations.
4. Health care reporters could receive annual education on safety and leadership's role in safety so they know the right questions to ask.

Next steps

With the final recommendations in the 2023 *Roadmap to Health Care Safety,* Massachusetts can set out to achieve a health care system that delivers safe, quality care in settings across the continuum of care. This begins with leaders of all provider organizations embracing safety as a preeminent core value.

What success looks like

Leaders and governing bodies of Massachusetts health care provider organizations across the care continuum:

- Study, understand and embrace safety principles, systems thinking, and improvement science.
- Strive to eliminate preventable harm to their patients, clinicians and staff.
- Stay informed about their own organization's safety performance.
- Model and reward behaviors that advance safety culture, operations, and outcomes.
- Regularly communicate and demonstrate leadership support for the organization's safety goals to all staff.
- Foster psychological safety and a fair and just culture, eliminating fear that staff will be treated unfairly for speaking up about safety events or risks.
- Actively support and facilitate patient and family participation in safety improvement initiatives.
- Allocate adequate resources to support and sustain safety improvement.
- Ensure that their organizations are fulfilling their safety reporting and transparency obligations.
- Are accountable for organizational expectations and results.

Where do we go from here?

Several existing efforts have provided a foundation for work to come, including resources and materials for leadership curriculum. The goals of the *Roadmap to Health Care Safety* will build on these existing efforts. The next phase of work will set out to develop a Core Curriculum with modules on leadership and governance.

Through these existing efforts and the new ways of thinking offered by the *Roadmap to Health Care Safety,* the Commonwealth can continue moving toward a health care system that routinely and equitably delivers safe, quality care upon which everyone can depend.

Tools and resources

Members of the task force have identified proven tools and resources that can be used or adapted by individual organizations for many of the recommendations in this report. The Betsy Lehman Center will collect, curate, and promote these materials.

Below is a *sample* inventory of tools and resources identified by Task Force members.

	Resources	*Organizations*
Frameworks for safety leadership and governance	Leading a Culture of Safety: A Blueprint for Success	American College of Health Executives and Institute for Healthcare Improvement
	Safer Together: National Action Plan to Advance Patient Safety	Institute for Healthcare Improvement, Agency for Healthcare Research and Quality
	The essential role of leadership in developing a safety culture	Joint Commission
	Patient Safety Leadership WalkRounds	Institute for Healthcare Improvement
	Multiple resources	Press Ganey
	Framework for Safe, Reliable, Effective Care	Institute for Healthcare Improvement
	Multiple resources	Children's Hospital Collaborative
	Multiple case studies	AHRQ Learning Health Systems Case Studies 2019
	Rhode Island Model	Healthcentric Advisors
Leadership curriculum development	Multiple resources	Massachusetts Medical Society
	Multiple resources	Institute for Healthcare Improvement Open School
	Multiple resources	Lucian Leape Institute
	Patient safety curriculum guide: Multi-professional edition	World Health Organization
	Patient safety education program	Healthcare Excellence Canada
	Patient safety curriculum	Patient Safety Movement Foundation

Board education	Multiple resources	Press Ganey
	Eliminating Harm, Improving Patient Care: A Trustee Guide	American Hospital Association
	Getting the Board on Board: What Your Board Needs to Know about Quality and Patient Safety	Joint Commission
	How-To Guide: Governance Leadership (Getting Boards on Board)	Institute for Healthcare Improvement
	Governance for Quality and Patient Safety in Canada	Healthcare Excellence Canada

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Endnotes

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