

The Triple Aim of improving the experience of care, improving the health of populations and reducing per capita costs of health care is a nationally recognized goal that provides context for much of the work now underway to redesign existing systems for care, payment and collaboration to achieve better health outcomes for all Americans.

Board members of hospitals and health systems across the country are having discussions about population health, value-based care, bundled payments and greater engagement of patients, families and clinicians in improving care processes and health outcomes, within and outside of their health systems. They understand that this transformational work is core to their organization's mission and central to the board's responsibility and accountability as stewards of community health. What is beginning to set leading organizations and their boards apart from the rest, however, goes beyond their willingness to systematically define, implement and oversee the work necessary to achieve the Triple Aim. These organizations also recognize the importance of connecting the dots among key elements of the work and its impact at all levels of the organization, including governance.

During my four years on the board of Penn Medicine Lancaster General Health, I have seen the evolution of our organization's Triple Aim work and framework to help the board comprehensively oversee what our system is doing to achieve it.

Our journey has encompassed many steps that help our organization deliver greater quality and value to our communities. Among these are:

- our merger with Philadelphia-based Penn Medicine;
- a commitment to high reliability and continuous improvement through a Lean Management System;
- implementation and expansive operationalization of a powerful health information system and the data analytics necessary to understand and monitor performance at the individual patient, outpatient practice, hospital unit and population levels; and
- appointment of a Physician Executive for Quality working with other clinical leaders in areas such as quality and safety, health information and population health.

These important relationships and expanded resources have enabled our board and leadership to ask key questions and implement further operational changes and investment needed to continue our journey.

Our organization and board have made significant strides in connecting our health system's work to its governance. Much of the impetus for enhanced board involvement in overseeing efforts to achieve the Triple Aim came from deep discussions between our board and management to answer the deceptively simple question, "So what?" In other words, "What does all this work mean for the board's role?" Like many boards, we have reviewed significant amounts of data and been briefed and provided guidance on activities underway to help our hospital, physician practices and accountable care organization operate successfully in the changing environment. We looked for a context and framework to connect the dots for governance. We decided to use the Triple Aim as our context and worked with executive leadership to enhance the board's understanding of the work our organization was doing to achieve it and the impact of that work. This focus has further enabled how our board monitors organizational performance.

Beginning in July 2017, our board began to regularly review 32 indicators of performance linked to the Triple Aim. The 32 metrics are based on Penn Medicine's Blueprint for Quality and Patient Safety: Engagement, Continuity and Value (see Penn Medicine Lancaster General Health's framework and performance metrics on page 4). The board also reviews goals established for each category. For example, one of our engagement goals is to implement two continuous improvement ideas per month.

Prior to its meetings, the full board frequently listens to a patient story related to one of our performance indicators. For example, our health information system allows us to identify high users of the hospital's emergency department (ED)—some with as many as 30 visits per year. These individuals are assigned to a multidisciplinary team who looks at both health and social factors that may be affecting their ED use. With our Care Connections team, one of our frequent ED users found a new place to live and adopted healthy behaviors that significantly improved her life and reduced her visits to the ED. This individual was present and celebrated at our annual meeting dinner this year.

Board oversight of quality and safety performance has broadened, as we work to link measures of patient care performance to population health issues to get an expanded view of community health. Beyond the hospital and physician practices, our board also follows progress within our accountable care organization, which includes 100,000 patients, our direct-to-employer self-insured solution and within our post-acute network. Key metrics are included in the board's review of executive performance and compensation. Quality and safety goals also are part of Penn Medicine Lancaster General Health's strategic plan.

At each of its meetings, the board's Quality Committee has a deep conversation about one or two issues and then provides a high-level overview of that discussion to the full board. The board also is presented with one performance indicator for more detailed review at each meeting. While our board often focuses on indicators where performance can be improved, we take the time to review performance improvement success stories to celebrate these accomplishments as well.

Helping to enhance our contribution to advancing Triple Aim work also has required additional education for board members. For example, when we implemented a Lean Management System organization-wide, the board participated in “deep dive” learning so we could understand this approach to process improvement and how it results in improved performance. This foundational learning also helps our board better engage with staff and ask meaningful questions when we review the results of Triple Aim problem-solving projects and Plan-Do-Check-Act cycles.

Together with executive and clinical leadership, all governing boards can take important steps to expand their contribution to achieving Triple Aim goals. Key conversations about bridging ongoing work to improve inpatient and outpatient care and reduce costs with new work to address population health and community needs can begin at the board committee level. At Penn Medicine Lancaster General Health, these conversations start at the board’s Mission and Community Service Committee.

When an expanded perspective on health, such as that expressed in the Triple Aim, guides formation of the organization’s strategic priorities, boards and executives can then resource the work and develop and track new metrics that provide a broader view of the performance necessary to achieve them.

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Penn Medicine

Lancaster General Health

Quality/Patient Safety Indicators - FY 2018

ENGAGEMENT
Likelihood to Recommend, LG Health (Top Box %)
Overall Rating of Care, LGH (Top Box %, HCAHPS)
Responsiveness of Hospital Staff (Top Box %, HCAHPS)
Communication with Nurses, LGH (Top Box %, HCAHPS)
Communication with Doctors, LGH (Top Box %, HCAHPS)
Communication with Doctors, LGHP (Top Box %, CG-CAHPS)
Continuous Improvement: ideas implemented per month per board (#)
CONTINUITY
7-day Unplanned Readmissions (%)
30-day Unplanned Readmissions (%)
7-day ECF Unplanned Readmissions (%)
ED patients that left waiting room without being seen (%)
ED "Decision-to-Admit" to "transferred out of ED" ≤ 60 minutes (%)
Hospital Discharges by noon (%)
LGHP Post-Discharge Visits - seen within 7 days after discharge (%)
Access to Care, LGHP (Top Box %, CG-CAHPS)
Timely Initiation of Care, Affilia (% seen within 48 hours of referral/return home)
Return to Acute Care, Lancaster Rehabilitation Hospital
VALUE
Risk-adjusted mortality index (observed/expected by UHC/Vizient)
Never Events (National Quality Forum: Serious Reportable Events)
Healthcare Associated Infections per 1000 discharges
Surgical Site Infections: Wound Class I (rate per 100 procedures)
Catheter-Associated Urinary Tract Infections (rate per 1000 urinary catheter days)
Sepsis 3 hour bundle compliance (%)
Hospital-acquired pressure injuries (all stages) per 1,000 discharges
Postop PE or DVT per 1,000 surgical discharges (PSI 12)
Hemorrhage per 1,000 surgical discharges (PSI 9)
Inpatient Falls per 1,000 patient days+B12:B33B38B14B12:B33
C-section rate (nulliparous and term, PC-02)
Colorectal cancer screening (%)
Breast cancer screening (%)
Diabetes: A1c < 8 (%)
Depression: PHQ-9 screening with follow-up plan (%)