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Ten Ways to Improve the Board's Use of Quality Measures

By Elaine Zablocki

Hospital and health system boards are being overwhelmed by hundreds of quality indicators from numerous sources. Many are required or linked to payment incentives, but some are part of voluntary improvement programs. Amidst the deluge of numbers, leaders could miss valuable, potentially actionable information.

“... while pursuing quality and patient safety the industry has tended to go a mile wide and an inch deep.”

—Christine Goeschel, RN, Director of Patient Safety and Quality Initiatives, Quality and Safety Research Group, Johns Hopkins School of Medicine

Christine Goeschel, RN, director of patient safety and quality initiatives at the Quality and Safety Research Group at the Johns Hopkins School of Medicine, is completing a doctoral thesis on the role of hospital boards in improving quality and safety. “Boards are often handed a template or scorecard that lists hospital performance on many externally

determined measures of care,” she finds. “While those measures are in fact important, often there aren’t sufficient resources to focus on all of them. My colleagues and I are concerned that while pursuing quality and patient safety the industry has tended to go a mile wide and an inch deep.”

“Both governance and management have to focus on the vital few,” says Maulik S. Joshi, DrPH, president of the Health Research and Educational Trust (an affiliate of the American Hospital Association). “Monitor the few measures that are most important to your organizational performance, where you have the greatest level of accountability, of leverage, of the ability to improve. In some cases the data may be limited, and the measures may be imperfect, but we can still use that data to look at where we are, and where we want to be.”

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How can a hospital or health system cut the tidal wave of measures to a manageable, improvable, and critical few? And how can boards use quality measures to drive improvements? We put these questions to leaders at five hospitals and healthcare systems and to several industry experts. They offered these ideas:

1. Align measures with the organization's strategic goals. Joshi says that each hospital's strategic plan, and its major pillars related to quality and safety, should form the basis for establishing measures for board oversight of quality.

"You can't report 200 quality measures to your board of trustees."

—Stephen R. Grossbart, PhD,
Chief Quality Officer,
Catholic Healthcare Partners,
Cincinnati, Ohio

Michael D. Pugh, president and CEO of Verisma Systems, Inc., in Pueblo, Colo., and a senior faculty member at the Institute for Healthcare Improvement, says, "It's the board's job to ensure that they're looking at quality measures that together create a picture of the whole organization and its effectiveness. I find that at the board level, organizations need an overarching strategy that knits things together. For example, the strategy might be 'no needless deaths' or 'no harm to patients' or 'every patient gets the right care every time.' Once

you have a high-level theme for your quality efforts, it becomes easier to clarify priorities and to link specific measures to your vision of what you want care to be for your patients."

2. Look at the big dots. Boards are replacing narrow measures with composite indexes and "big dots," designed to capture a great deal of information in a single number.

"We've embraced the concept that we will report and hold people accountable at a very high level," says Stephen R. Grossbart, PhD, chief quality officer for Catholic Healthcare Partners, Cincinnati, Ohio. "We recognize each 'big dot' includes many different projects and activities and sub-measures, but you can't report 200 quality measures to your board of trustees."

Bellin's "All or None" measure looks at the percentage of patients who received all appropriate aspects of care, not just some—no ifs, ands, or buts.

Bellin Health System, Green Bay, Wisc., monitors its five key strategic initiatives—effectiveness, efficiency, engaging with the community, growth, and teamwork—with just 18 measures, many of them representing "big dots" (see Figure 1). For example,

for clinical effectiveness, Bellin's scorecard includes an "appropriate care index" for the outpatient setting which rolls up 11 measures, such as effective testing and control of cholesterol and blood sugar levels.

Other effectiveness measures include the risk-adjusted mortality rate, the number of days between serious patient safety events, and "All or None," which measures the percentage of patients who received *all* appropriate aspects of care, not just some—no ifs, ands, or buts.

"We decided to use a very simple formula: How many inpatients did you have in a given period of time, and how many of them died? That is the number that we're going to report, because we want to challenge ourselves to understand any death in our hospitals."

—Susan D. Keiler,
Chair of the Quality Task Force,
Covenant Health System,
Lexington, Mass.

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3. Focus on reducing preventable injuries and deaths.

Increased emphasis is being placed on reducing preventable injuries and deaths. Over the past few years 27-hospital Providence Health System has been using two indices to summarize clinical quality, one of them based on the CMS core measures. “During the course of 2009, as we looked at our performance, we realized we needed to put more emphasis on reducing preventable deaths and eliminating injuries,” says Keith Marton, MD, chief medical and quality officer and senior vice president at Providence Health, Renton, Wash. “We concluded that simply focusing on the clinical reliability index wasn’t getting us where we needed to be, so we’ve moved to a more direct focus on mortality.”

“We knew our board members wanted to know about mortality, but there is a great deal of controversy over the exact indicator to use,” explains Susan D. Keiler, chief operating officer of St. Mary’s Health System, Lewiston, Maine, and chair of Lexington, Mass.-based Covenant Health System’s quality task force. After “healthy debate . . . in the end, we decided to use a very simple formula: How many inpatients did you have in a given period of time, and how many of them died? That is the number that we’re going to report, because we want to challenge ourselves to understand any death in our hospitals.”

One reason Covenant decided not to risk-adjust mortality is that it wanted dashboard data to be available as close to real time as possible. “Whenever you turn to an external resource to risk-adjust data you lose valuable time,” Keiler says. System-wide data for all measures from the month of January will be entered and available by mid-February.

Other systems have grappled with this issue and reached different decisions. Providence has chosen to use risk adjustment as a way to compare itself to other top-performing systems; it is addressing the time delay issue by finding ways to speed up turnaround time for this metric. “A hospital or system needs to look at both raw mortality and risk-adjusted rates,” says healthcare quality consultant Steve Durbin, formerly system director for quality at Providence. “Tracking raw mortality is important, since it links to the drive to have fewer patients die in hospital. On the other hand, there are strong seasonal patterns in mortality rates, and the rate can vary substantially over time. Risk adjustment helps us understand these underlying patterns and see any unusual trends that need focused attention to improve.”

4. Think about the big picture. To choose measures of overarching performance, Joshi says leaders can look to the six “Aims for Improvement” detailed in the Institute of Medicine’s report, “Crossing the Quality Chasm.” These are safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. “This is a great framework, and since it exists, we don’t have to reinvent it,” he says.

Joshi says boards should think not only about currently required metrics, but also about emerging issues. “Even though we may not have well-defined metrics or great trend data, we need to look at issues such as preventable readmissions, because we can already tell that this will be essential information in the foreseeable future.”

“An airplane has to constantly monitor wind speed, position of rudder, altitude, and fuel levels. That doesn’t mean the pilot has to pay attention every minute to each dial, except to confirm that they’re all green, not red.”

— Thomas L. Garthwaite, MD,
Chief Medical Officer, Catholic Health East

5. Build powerful, simple dashboards around big dots and other key measures. Boards are asking for quality measures displayed in more powerful dashboards that combine increased information with a simpler graphic format. “A hospital is a complex organization that must measure an enormous number of things,” says Thomas L. Garthwaite, MD, chief medical officer at Catholic

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Health East. “It’s just like an airplane, which has to constantly monitor wind speed, position of rudder, altitude, and fuel levels. That doesn’t mean the pilot has to pay attention every minute to each dial, except to confirm that they’re all green, not red.”

Bellin monitors thousands of measures, says president and CEO George Kerwin, but when it comes time to report to the board, those metrics are summarized in a few measures, related to every aspect of the organization. “This scorecard has been an incredible tool. It is so simple, and board members love it,” Kerwin says. Bellin’s scorecard also clearly indicates whether variation from the target is statistically significant or within normal “control limits.”

The Covenant Health System board specifically requested a redesigned quality dashboard. They felt that our current dashboard was too busy, with too many indicators, too many reds and greens,” says Keiler. The new dashboard, which took effect in January 2010, displays each metric as an individual graph, with six data points of trend in the initial view. Trend lines are oriented so an upward line always indicates a positive direction. This enables board members to instantly identify a metric that isn’t showing improvement. Each system-wide metric includes a “drill down” function where individual facility performance can be viewed.

The Covenant Health System dashboard workgroup was an ad-hoc team comprised of system members plus outside experts, including Joshi. The group started out with a list of about 40 possible metrics for the dashboard, and eventually boiled it down to about 20. “We are a diverse system, including nursing facilities as well as hospitals,” explains Keiler. “We agreed to do a common system-wide dashboard, with some measures that are unique to hospitals, some that apply to nursing facilities, and some that apply system-wide.”

“When you discuss a financial report, you talk about certain aspects that require explanation; we do exactly the same thing with our quality report.”

—George Kerwin, President and CEO,
Bellin Health System

6. Discuss quality measures actively in committee and with the full board. Boards shouldn’t passively listen to quality reports and move on—they should actively discuss and constructively challenge what’s presented.

At Bellin Health System, “we’re not just going to toss out a bunch of weird numbers that people don’t understand,” says Kerwin. “When you discuss a financial report, you talk about certain aspects that

require explanation; we do exactly the same thing with our quality report.” At a recent board meeting, a primary care physician and a nurse discussed their frontline work, and the board questioned them closely about whether Bellin’s metrics really captured the essence of primary care quality.

Providence Health System “consciously chose to eliminate” its system-wide board quality committee several years ago and instead “make the board a quality committee of a whole,” says Marton. “When the board meets these days they spend more time discussing quality than they do finances.” At the same time, the chair has asked an ad hoc group of Providence board members with particular expertise in quality and safety to meet regularly to review quality issues in greater detail than the board can do. By doing this they are able to refine the ensuing full board presentation and discussion to meet the board’s needs.

CHE’s Garthwaite, who also serves on the board of Catholic Healthcare West, suggests boards ask three questions about quality measures:

- Is what they’re telling me the whole story? Are we just hearing the good news?
- Are we honest with ourselves about our performance relative to other hospitals?
- Is there anything additional we could be doing to improve performance?

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7. Be sure the board has members who can really understand and discuss quality.

Over the past four years Catholic Health East has expanded and revamped the board's Quality Committee, inviting new members with strong clinical backgrounds, including external quality experts. The committee now includes two members of the full board, and has frequent participation by the board chair. This committee meets face-to-face for two full days each quarter, has the time and expertise to review numerous quality metrics in detail, and then reports to the board.

"Consistent reporting of summary measures and comparisons to other health systems are the best-received reports," Garthwaite says. "Boards tend to focus on assuring that action is taken to improve below-average performance."

8. Set stretch goals. Organizations that aspire to excellence, not just average performance, need to set "stretch goals" that test their capacity to improve.

For example, in 2010, Catholic Healthcare Partners is focusing on four major quality goals: reducing length of stay, maintaining already low mortality rates, improving patient experience, and reducing patient harm by 25 percent. "That's a substantial stretch goal for us, and we are excited about it," comments Grossbart.

The system analyzed its own data and identified five areas with substantial opportunities to reduce harm to patients: falls, post-surgery sepsis, central-line infections, pulmonary embolisms/deep vein thrombosis following surgery, and pressure ulcers. The measures were chosen based on high volume, strong evidence available on how to reduce the incidence of harm, and a significant impact on both mortality and cost. When they are reported to the board, they will be rolled up into a single measure: reducing patient harm.

9. Set "developmental" goals for measures the organization is just beginning to understand.

Executives and clinicians are often reluctant to commit to stretch goals or even incremental improvements when they don't fully understand the factors that affect performance. For example, hospitals are facing pressure to reduce readmissions, and may face financial penalties if they don't, but readmissions have multiple causes and many hospitals are still developing improvement strategies.

Catholic Healthcare Partners addresses this by setting what it calls a "developmental goal." This is a softer goal, explains Grossbart. For readmissions, he says, "we are developing the capacity to manage this aspect of the care delivery system and improve our performance, but we don't know enough at this time to set targets. At this point, we are working to develop measurement systems, set a target, and experience some reduction."

The system is currently writing program code to identify its current baseline readmission rates. At some point in the future, perhaps one or two years down the road, this developmental objective will become an operational objective. "At that point we'll be able to define processes and set targets for reducing readmissions," Grossbart says.

10. Tie executive bonuses to key quality measures.

Four years ago Catholic Health East put 20 percent of top executive pay "at risk" based on quality, but over the past two years that has been increased to 50 percent financial indicators, 50 percent quality. Until recently the CMS core measures were used as the basis for CHE quality incentives, but not anymore. "First, everybody is doing reasonably well on the core measures, and since they're made public, there's plenty of incentive to continue working on them," says Garthwaite. Starting in 2010, CHE is basing executive bonuses on nine clinical measures (with a lower threshold set at meeting at least three targets and a maximum incentive based on meeting all nine targets.) The measures include ventilator-associated pneumonia, catheter-associated urinary tract infections, falls, readmission rates for selected illnesses, and improved patient satisfaction.

As the hospitals profiled in this article demonstrate, today's health systems operate within a shifting economic and political framework. The pressure to improve quality, and to publicly report quality measures, will only increase.

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In addition, improving the quality of care and avoiding harm to patients is at the core of every hospital's mission. By focusing on the most essential quality measures, by summarizing many measures in a single index, and by using simple but powerful graphic displays, boards can fulfill their responsibility to maintain high quality, and to probe deeply into areas where quality can be improved.

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