

Workbook

Governing for Quality in a 'No-Outcome, No-Income' World

"The large differences in board activities between high-performing and low-performing hospitals we found suggest that governing boards may be an important target for intervention for policymakers hoping to improve care in U.S. hospitals."

—Ashish Jha and Arnold Epstein, *"Hospital Governance and the Quality of Care,"* Health Affairs, January 2010

There's hardly a health care board member, past or present, who hasn't heard of the age-old governance mantra "no margin, no mission." For years this simple phrase captured what most trustees came to believe was their primary obligation: to ensure the financial viability of their hospital or health system. Days cash on hand, debt coverage ratio and net operating margin were key measures that defined high or low performance. The board finance committee was where the action was; and when it came time to recruit new trustees, the board typically would look for a banker or businessman to fill the opening. Today, however, oversight for quality and safety takes its place beside—or some would argue ahead of—financial viability as top priority for health care governing boards.

Evidence of alarming quality and safety performance has been in the public spotlight for more than a decade. Yet, despite notable efforts by some hospitals and systems to set big aims for quality and safety improvement and make great strides toward achieving them, medical

errors remain the fourth leading cause of death in America. As a nation we have not yet been able to do enough to move that "big dot" in the right direction.

The quality and safety imperative for boards cannot be clearer. And, a growing number of studies are reinforcing the board-quality improvement connection. Research tells us that when boards are engaged in quality and safety issues, their hospitals are more likely to have quality improvement programs, lower mortality rates and better performance on other quality-related outcomes. However, despite these compelling findings and a variety of national and local efforts to get boards on board, the big dot of board engagement has been tough to pin down, let alone move in the right direction.

THE GOVERNANCE-QUALITY CONNECTION

IN THEIR RECENT STUDY, Harvard researchers Ashish Jha and Arnold Epstein surveyed 922 board chairs overseeing

1,000 nonprofit U.S. hospitals about their board's expertise, views and practices related to clinical quality. Their findings largely were discouraging. Nearly half of the board chairs did not view quality as a top priority for board oversight. Just 59 percent of the hospitals had a board quality committee. Only 32 percent reported that their boards received formal training in clinical quality. Quality performance was on every board meeting agenda at 63 percent of the hospitals, while financial performance was on every agenda for 93 percent.

The study also showed significant differences in governance perspectives and practices in organizations with different levels of performance related to quality. Ninety-one percent of high-performing organization boards regularly reviewed a quality dashboard compared with 62 percent of boards of low-performing hospitals. Some 58 percent of respondents from hospitals that were low performers in quality said their organization performed better or much better than the typical U.S. hospital.

Jha and Epstein concluded that "Major

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opportunities exist to shift the knowledge, training and practices of hospital boards to promote a focus on improved clinical quality. Yet, nearly half of hospital board chairs did not see quality as a top priority, which points to the difficult road ahead.”

Questions for Discussion

1. Is overseeing our hospital’s quality and safety performance a top priority for our board? If so, what have we done to make it a priority? If not, why not?
2. Does our board have a quality and safety committee?
3. What level of training in overseeing quality and safety has our board received?
4. Do we review a quality performance dashboard at every board meeting? On what quality measures do we focus?
5. Does our board use quality performance as a top criterion in rating our CEO’s performance?

MOVING DOWN THE ROAD

SAD TO SAY, sticks often work better than carrots.

In his recent article, “Applying Sarbanes-Oxley to Healthcare Quality,” governance expert Barry Bader makes a compelling argument that while government regulation may not be the best way to improve board oversight of quality, the SOX legislation emphasizes many good governance principles that could have a positive impact. These include:

- Accountability to the public and responsibility for representing stakeholders’ interests in delivery of safe, quality care
- Transparent disclosure of information about quality performance and outcomes
- A board committee dedicated to quality and safety oversight
- Selection of board members with expertise and competence in quality performance assessment and improvement
- Active board member engagement in learning about quality and in questioning and discussing hospital quality performance
- An audit of quality performance conducted by an outside, independent expert and the opportunity for the board to meet with the auditor without senior management present

- Attestation that the organization has made a good-faith effort to assure the accuracy of quality data

Whether or not you support this approach for improving board oversight of quality, there’s no denying that the SOX legislation has set a higher standard for governance performance and accountability. Of course, when it comes to lawmaking, hospitals are not playing a waiting game. Reform legislation reinforces already accelerating pay-for-performance trends. These initiatives require boards to step up to the plate today to ensure their hospitals’ quality and safety performance can meet stricter standards that will go into effect over the next three to five years.

Before health care reform was enacted, boards may have been interested to learn about nonpayment events or the need for greater cooperation among hospitals and physicians. However, the current reform environment has brought us:

- Unprecedented public scrutiny requiring performance transparency and hospital accountability for outcomes
- Growing requirements, such as the Physician Quality Reporting Initiative and state-level error reporting, for providers to submit their performance data to payers and regulators
- Payment increasingly tied to quality and safety reporting, and process and performance improvement in both inpatient and ambulatory settings
- A growing number of events for which payers are denying reimbursement
- New delivery models, such as accountable care organizations, and different approaches to reimbursement, such as bundling of payments, that require high levels of teamwork among hospitals and physicians
- Concerns about shortages of physicians, nurses and other health professionals that will be needed to provide care for more patients in the new delivery system
- Growing requirements for hospital boards to participate in education about their role in overseeing quality and safety performance to comply with state law or to become eligible for financial incentives

For boards, these shifts mean that a “when we get to it” focus on quality and safety no longer is viable. Board engage-

ment around quality and safety performance must shift from an interest to a necessity. Anything less will lead to ongoing risk to patients and economic peril for health care providers, rendering them unable to compete effectively in the emerging health care delivery system. Welcome to the world of “no outcome, no income.”

Questions for Discussion

1. What are the pros and cons of a SOX-like solution to improving board effectiveness in overseeing hospital quality and safety performance?
2. Does our board understand which nonpayment events most affect our hospital and what our hospital is doing to prevent them?
3. How would we assess our organization’s ability today to partner with physicians to participate in new models of care delivery?
4. Overall, how well prepared is our organization to thrive in a no-outcome, no-income world? (See Are You Ready for Health Reform?)

ACTIONS FOR BOARDS

THE GOOD NEWS IS that a growing number of boards understand it is time to do more than merely put a toe in the water when it comes to their hospital’s quality and safety performance. They are educating themselves about reform’s challenges, and they also realize it’s time to jump in the pool. Hospital trustees around the country are asking for guidance and direction, not just about what they need to know, but also about what they need to do.

The governance road map for effective leadership under reform still is being drawn; some pieces will get clearer as we move forward. And, boards likely will face obstacles along the way. One of these could be not having all the timely information they need to make decisions. Hospital executives who are worried about working with their medical staffs in the current climate may choose not to bring thorny issues to their board until they have figured them out. But the stakes are too high to preserve illusions about being in control or knowing exactly how to proceed. Gutsy, progressive boards and

executives will pave the way for collaborating with physicians by sitting down with them, as partners should, to talk about the best ways to move forward.

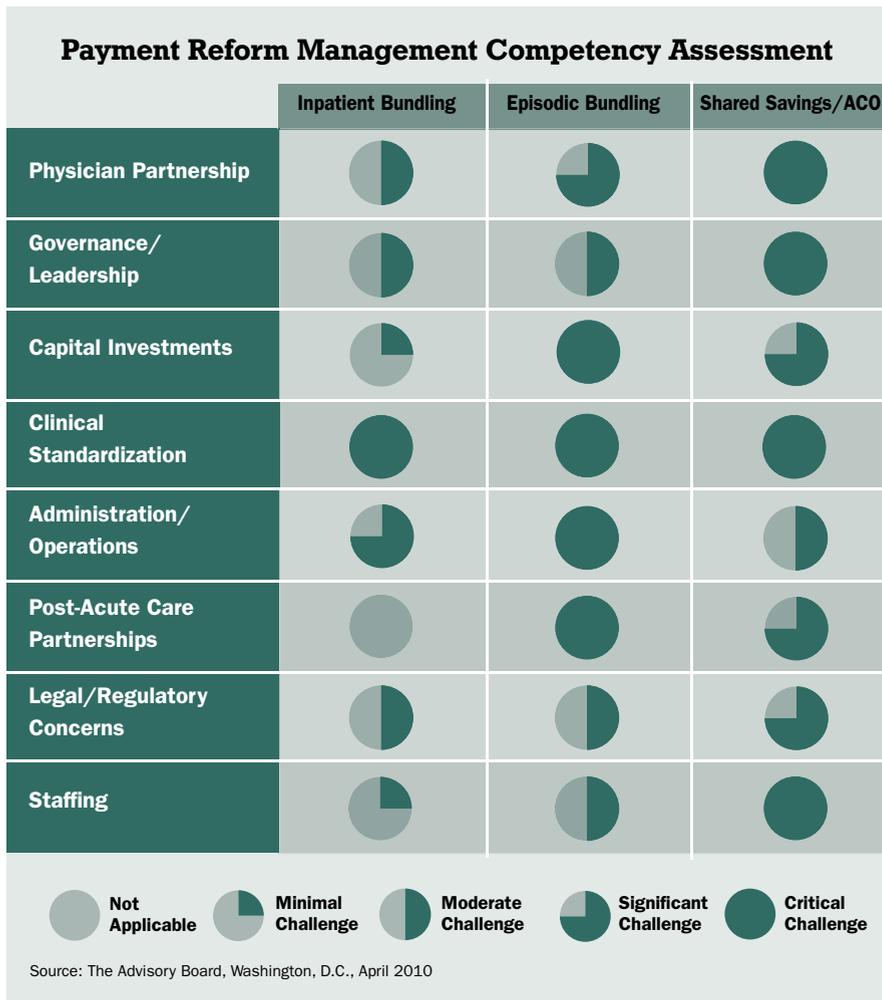
Imagine that today is the first meeting of your hospital's task force on bundled payment for congestive heart failure. Who would be in the room? What would be on the agenda? What diagnoses and treatments will need to be considered? What practice standards should be put in place? What performance feedback tools will be most effective? Most hospitals are not having these conversations today, but they should be, given that the Centers for Medicare & Medicaid Services has already launched its demonstration project on bundling hospital and physician payments for 28 cardiac and nine orthopedic diagnosis-related groups.

Boards can play an important role both in providing focus and direction for their organizations and in preparing themselves to govern more effectively in a no-outcome, no-income world. Here are a few destinations on the governance road map.

Climb quickly up the learning curve. Find out all you can about accountable care organizations, bundled payment approaches, new quality and safety reporting requirements, and key provisions of the reform legislation, and when new requirements are scheduled to take effect. Make this learning the focus of board meeting education sessions or your upcoming board retreat and invite your hospital's physician leaders to attend.

Ask questions. How are our hospitals and physicians working together to prepare for new delivery and payment models? Are we following the results of pilot projects around the country? What has been learned that we can apply? How will our hospital's performance need to improve in such key areas as cost, quality and access to services? What are we doing to get better? How will we gain access to the clinical and other personnel we need to provide care under new delivery models? What are our hospitals' plans for addressing these issues?

Review what the board measures and monitors. Hospital boards seriously engaged in quality and safety oversight focus on a dashboard of key performance indicators. These typically include such selected measures of clinical quality as the



hospital's overall mortality rate, health care-associated infections and unplanned readmissions. Medication errors or patient slips and falls are examples of typical measures related to patient safety. Patient, physician and employee satisfaction also are monitored frequently.

However, in the current climate of reform, boards must help their hospitals focus on making significant strides in improving quality and safety over the next two years. One way for boards to contribute is to require their hospitals to set big aims for improvement. Another is to set and enforce penalties for noncompliance with standards. For example, a significant aim might be to reduce by 50 percent over the next two years unexplained clinical variation in two DRGs treated in the hospital's intensive care unit. Another might be to reduce medication errors by half on four medical-surgical floors within the same time period. The board also might ensure that the hospital adopt the Institute for

Healthcare Improvement's ventilator-associated pneumonia and central line protocols or that practitioners follow standards for treating acute myocardial infarctions. The board also could agree to support the hospital in denying admitting privileges for nonconformers.

Boards also need to broaden their focus on performance review beyond outcomes for inpatient care. They should be aware of how many clinical departments are participating in the Physician Quality Reporting Initiative. As care delivery moves more into ambulatory settings, so must review of quality and safety outcomes. Hospitals need to work with their clinical department chairs and employed physicians to identify key performance measures for care related to their specialty that is provided in a clinic or physician's office. Then, they should monitor performance on these measures throughout the organization.

The move toward ambulatory care also requires boards to better understand how

well their hospitals and health systems are providing access to care and service. While access has many dimensions, including affordability and convenience, one way to define and measure it involves speed to care. The time it takes for patients to get an appointment for a primary care visit or how long they have to wait to see a clinician after arriving at a clinic or office are examples of access measures that boards or their quality committees might monitor.

Trustees also should understand their hospital's plans for ensuring adequate staffing if more patients seek care as they become insured under reform. Entering into a joint venture with a retail clinic, supporting medical school loan forgiveness for primary care practitioners or expanding use of doctors of nursing practice, clinical nurse specialists or nurse practitioners to provide more clinical support are some ideas under consideration by leading health care organizations.

Some hospitals are considering whether to become trauma certified to provide greater access for patients to a broader range of care and treatment options. They are also re-examining how referral processes will work under new approaches to reimbursement. For example, should a patient with prostatitis have his first appointment with a primary care physician, rather than with a urologist, to increase efficiency and optimize revenue?

Focus on the important issues.

More and more boards are moving away from traditional agendas that are heavy on management and committee reports and adopting consent agendas to deal with routine board decisions up front. Because one of the most important resources trustees have is the time they spend together, boards should broaden their meeting consent agendas to leave as much time as possible to discuss strategic issues.

Expand clinician participation.

Most hospital boards today have two or three physicians on the board. But who are they? Most often, physician board members include the chief of the medical staff and perhaps a retired surgeon or a physician practicing outside the hospital's service area. Today boards also need to seek clinicians with broader backgrounds, such as training in health services research, public health or quality measurement and management. Hospitals also need to bring onto boards more nurses who can provide critical input about patient needs and concerns as well as the quality of their care experiences.

Broaden trustee skill sets. Hospitals have much to learn from other industries. Health care boards can benefit by expanding the skill sets of their members to include experts in industrial approaches to quality and safety improvement, such as Six Sigma or lean manufacturing. Boards will need educators who are skilled in approaches to adult learning and experts conversant in change management processes to reframe their thinking and beliefs. Board members with information system expertise can help guide hospitals through adopting inpatient and ambulatory electronic medical records, expanded clinical support systems and compliance with meaningful use of information technology and other regulatory requirements.

Require continuous learning.

Leadership retreats and visits to organizations further along the learning curve can help boards, executives and physician leaders develop and apply new ideas and perspectives. Providing adequate resources to support ongoing learning will be essential. Creating goals and a follow-up plan prior to a retreat or education session also can extend the benefits of these activities.

Provide staff support for governance. Boards need solid staff support for

all their governance activities, but especially for those focused on quality and safety. The chief medical officer or chief nursing officer should be responsible for bringing quality and safety data to the board's quality committee, just as the chief financial officer staffs the board's finance committee.

Expand scrutiny of board performance. Boards should adopt a 360-degree approach to assessing both board and committee performance at least every other year and consider including not only executive staff but selected external stakeholders in the evaluation.

Strengthen board practices.

Establishing and adhering to both board member and board leader term limits helps to ensure fresh perspectives and avoid member burnout. Establishing solid board leadership succession-planning processes that provide enough time and learning opportunities will be critical to adequately developing junior board members. And adopting a competency-based approach to governance that goes beyond recruiting board members with diverse professional backgrounds to seeking people adept at managing complexity, strategic orientation, innovative thinking and other skills can bring a new level of contribution from a board. This deeper expertise will be needed to address successfully the new challenges facing health care organizations. **T**

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CONCLUSION

In today's environment, boards can tip the scales between success and failure for their organizations. However, to make a difference, boards need to do more than just get on board; they need to get out front and lead by expanding their knowledge and expertise and upping their level of productive engagement. The risk of governance as usual or simply watchful waiting is significant. What's at stake is the future viability and mission of our nation's hospitals.