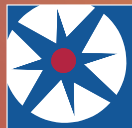
Transforming Care Delivery to Focus on Patient Outcomes: Why Boards Matter

The American Hospital Association's



CENTER FOR HEALTHCARE GOVERNANCE™

Monograph Series

About the Author

Christine Izui is Executive Director Quality, Office of Clinical Affairs, at the Blue Cross and Blue Shield Association, Chicago, IL. She can be reached at Christine.Izui@bcbsa.com.

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Backed by the knowledge and resources of the American Hospital Association, the Center for Healthcare Governance provides state-of-the-art education, research, publications, tools, and other resources to help members achieve excellence in governance. Our community is dynamic and diverse, representing board members, executives and governance advisors who are nationally recognized as the foremost voices in the practice of hospital and health system governance. We share a common goal—to advocate and support excellence, innovation and accountability in health care governance.

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The American Hospital Association's
CENTER FOR HEALTHCARE GOVERNANCE™

Center for Healthcare Governance
155 North Wacker Drive Suite 400
Chicago, Illinois 60606
Phone: (888) 540-6111
www.americangovernance.com

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Overview: The Business and Patient Imperative

Improving health care quality and safety to create better outcomes and greater value for patients and communities can be a daunting challenge for leaders trying to transform our delivery system. In fact, the challenges are so large that it makes sense for key stakeholders of the health care system to work together to accelerate change. Many Blue Cross and Blue Shield (BCBS) health plans have partnered with hospital associations and hospitals to line up training, toolkits, data reporting and financial incentives to create a new health care delivery paradigm. Small, significant steps are moving us in the right direction under the guidance of hospital leaders and clinical champions.

The financial pressures are well documented in the popular press and annual reports of hospitals, insurance companies, government agencies and the checkbooks of the patients we serve. Annual spending on health care delivery is enormous and rising, representing $2.5 trillion that competes with many other social imperatives in our communities. Insurers, as well as hospital leaders, are alarmed by the constant upward trend in spending.

And the question remains, is the money being well spent? One study estimates that at least 30% of every dollar actually spent on care is funding ineffective or redundant care (Institute of Medicine, 2005). A recent report indicates that 84,000 premature deaths could be prevented if the US performed as well as some other nations (The Commonwealth Fund, 2011). Care is not only expensive, but sometimes actually harms the patient. One study suggests that $17 billion a year is spent on medical errors (Classen, et al., 2011). Our current approach to paying for services focuses on the volume or the number of procedures done to a patient, rather than on a successful outcome.

According to a recent Office of the Inspector General study based on a review of hospital charts, more than 13% of Medicare patients are injured or die from adverse events in medical treatment each year. This translates to 1 in 7 Medicare patients experiencing harm or death from a potentially preventable event (Levinson, 2010 OIG report).

There have been many campaigns and concerted efforts to improve quality and patient safety in individual hospitals, across states and nationally. Efforts to reduce central line associated bloodstream (CLABSI,) catheter-associated urinary tract infections (CAUTI) and other hospital-acquired conditions as well as use of quality and safety improvement tools, such as the surgical safety checklist, are beginning to have a significant and sustained impact in hospitals in several states, yet there is still work to be done. The Blue Cross and Blue Shield Association was a major funder of the Institute for Healthcare Improvement (IHI) 5 Million Lives Campaign. Many organizations joined the campaign to learn and apply quality improvement techniques to every day practices. However, efforts are barely keeping up with the rising complexity of medical procedures and the acuity level of patients.

Insurance companies, purchasers and providers are concerned by quality and safety problems, and want to set goals for improvement. However, quantifying the problem currently is a complex undertaking. In fact, it is difficult even for hospital leaders to fully grasp the extent of quality problems within a hospital. Much of the day-to-day activity to serve patients and the harm that sometimes results lies below the surface of the reports monitored by hospital leaders and trustees. A 2011 study compared various approaches to identifying and counting adverse events in hospitals using three tools on a comparable sample of patients. The study found that many tools underestimate the level of harm. Using only one method alone fails to detect most adverse events (Classen, et al., 2011).

Many reports harking back to the 1999 Institute of Medicine (IOM) Report "To Err is Human" have noted that the health care payment system needs to change to align rewards with the quality of services provided. New payment models will lead to experimentation, such as the Alternative Quality Contracts introduced in Massachusetts. Smaller steps are also being taken to change payment, such as a payment bonus for meeting a certain quality threshold. These new arrangements will result in new work processes focused on patient outcomes and, in the short term, uncertainty of payment that will be difficult for some to navigate.

Nationally there is a movement to pay for performance, rather than for volume of services provided. Centers for Medicare and Medicaid Services (CMS) is implementing a value-based purchasing program (VBP) that puts 2% to 5% of Medicare reimbursement at risk, with the ability to earn the dollars at risk through metrics tied to clinical performance measures, mortality rates, implementation of safety processes, and patient experience data (Buckley, 2011). Private insurers are following suit. Payments are being tied to quality rather than quantity of services offered. Commercial insurers have also 'frozen' reimbursement rates, with any increases tied to performance. In 2011 WellPoint announced a new reimbursement system for about 1,500 hospitals across the country serving Blue Cross Blue Shield patients that focuses on 51 indicators of quality and safety. Outcomes are being stressed, with indicators examining readmission rates, infection rates, and reported patient satisfaction (Bloomberg Businessweek, 2011; California Healthline, 2011).

Health care of the future must include a delivery system that can provide safe, high-quality care; elimination of inefficient spending; and incentives for individuals to take action to improve their health. Leaders within the health care industry are and must continue to step forward if we are to make progress on goals to offer each American care that is safe, affordable, coordinated and based on scientific evidence. Many health plans have started to offer incentives for hospital trustees to obtain training and/or certification that will lead to thoughtful oversight of hospital vision, mission, strategic objectives and overall performance, including quality and safety.

Why Trustees?

In the publication *Healthcare Transformation: A Guide for the Hospital Board Member,* authors Joshi and Horak state that hospital trustees support hospitals' fundamental missions to improve the health of the community. In a climate of growing concerns about the quality of health care and the amount we pay for it, trustees are called upon to oversee the transformation of the culture of the organization (Joshi and Horak, 2009). Trustees need the knowledge and skills to take up the challenge to work with clinical and executive leaders to change the organization.

Although hospital governing boards can have significant influence over setting priorities and stretch goals and can emphasize an agenda for improving quality and safety, little is known about the actual level of engagement by trustees in quality-related issues. A study of 1,000 board chairs was conducted to gain a better appreciation of expertise, perspective and engagement in the hospital's quality agenda. The study revealed that less than half of the boards rated quality of care as a top priority, only a minority of board members received any formal training, and a gap existed between board activities in high-performing hospitals and low-performing hospitals (Jha and Epstein, 2009).

In fact, many believe that until recently hospital boards assumed their organizations to be performing well at clinical care, with limited evidence one way or the other. Jha and Epstein found that many boards delegated oversight of quality to the medical staff. It is understandable that oversight of quality is daunting to board members: "…healthcare is a rapidly changing, technology–and knowledge–intensive industry; thus boards need to hire and rely on managers with high levels of content expertise" (Goeschel, et al., 2010). However, boards are increasingly being held accountable for the hospital's performance and improvement of quality and safety.

Board members need to have an understanding of the issues so that they can discuss quality, set goals, and monitor progress. Jim Conway, a former senior vice president at IHI and an expert on board performance, urges trustees to reach to be 'best-in-the-world boards' if they want to lead best-in-class hospitals (Conway, 2008). Leadership learning for board members, hospital executives and physician champions needs to be embedded in organizational strategy. Many board members need to learn about health care delivery, their role as board members and the current quality and safety challenges. Other experts agree that the "unique challenges and unprecedented opportunities for boards" demand training so that board members can strengthen their role as hospital leaders (Goeschel, et al, 2010; Zablocki, 2010).

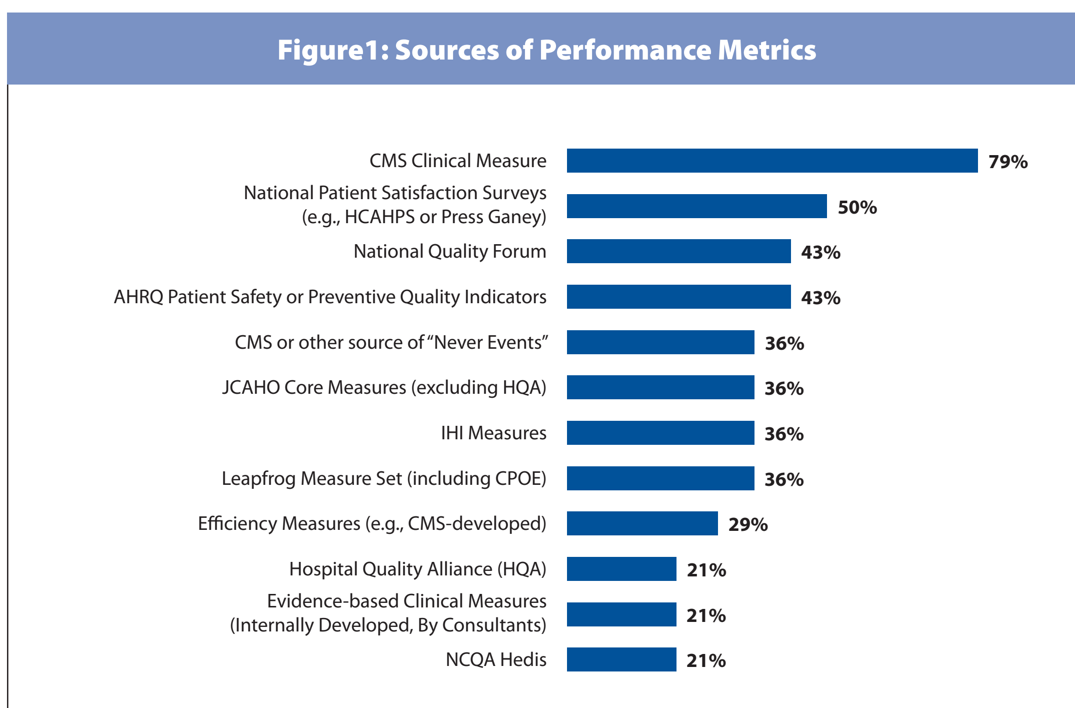
Researchers that evaluated board quality scorecards from hospitals in Michigan and Tennessee found that the most common measures were from CMS and the local Blue Plan (Goeschel, et al., 2011). Insurers can signal important outcomes and work with hospitals to measure and improve them; however, board members need to lead the charge in setting goals and leveraging resources to attain them.

Measuring Quality

There is a movement nationally by CMS and commercial insurers to tie payment to quality metrics, rather than simply paying for the volume of services provided. This is a huge shift away from traditional fee-for-service medicine in which hospitals and physicians billed for each service provided to a patient. Now insurers want to see evidence that services provided actually produced desired results—improved patient function, satisfaction and ultimately health status. Measuring quality is difficult given the complexity of patient conditions, differences in how individuals respond to treatment, and the difficulty in linking interventions to improved health. Nonetheless, the health care payment and delivery system needs to be organized around improving patients' current and long-term health status.

Currently 62% of independent Blue Cross Blue Shield plans across the country have started to tie hospital payment to quality. Many Blue plans have first created financial incentives to report data and participate in improvement initiatives, or pay-for-reporting programs. Over time, the emphasis is being placed on performance rather than reporting. This means that hospitals need a deep understanding of the outcomes being tracked and the work processes required to produce high quality outcomes. For example, if hospitals are to report on and lower infection rates, hospital leaders need to understand the science of infection prevention, internal policies aligning with the science, and barriers to staff compliance with the policies.

Usually national metrics are used when tying performance to payment. A 2011 survey of BCBS Plans (Figure 1) indicates the variety of sources insurers are using to identify measures.



Source: MedVantage, P4P Survey Results, 2011

The majority of the measures come from national organizations that create or endorse clinical measures such as The Joint Commission, Leapfrog, the Institute for Healthcare Improvement, the Agency for Healthcare Research and Quality, and the National Quality Forum. In addition, measures synch up with CMS measures used in the Hospital Compare website and value-based purchasing efforts. Measures typically cover

- important medical conditions such as the CMS-endorsed measures on treatment of heart failure, pneumonia, heart attack or
- hospital-wide efforts to reduce infections or 'never events' or medical errors such as wrong site surgery.

Most hospitals have staff who track national measures and rates that are reported to CMS for the national Hospital Compare website, to state agencies and to insurers. However, trustees may have limited understanding of measures and associated financial incentives or penalties, but need this knowledge to be able to provide guidance on important efforts to improve patient care.

Insurer Support of Trustee Education

Blue Cross and Blue Shield insurers are aware of the need to engage leaders if we are to transform our health care delivery system. Consider the vision and mission statements from several BCBS health plans that provide a foundation to support hospital trustee education.

A few examples below describe how Blue health plans have vision and mission statements that align with hospitals in their markets. These same health plans have incentives in place encouraging local hospitals to educate and engage hospital trustees in improvement priorities.

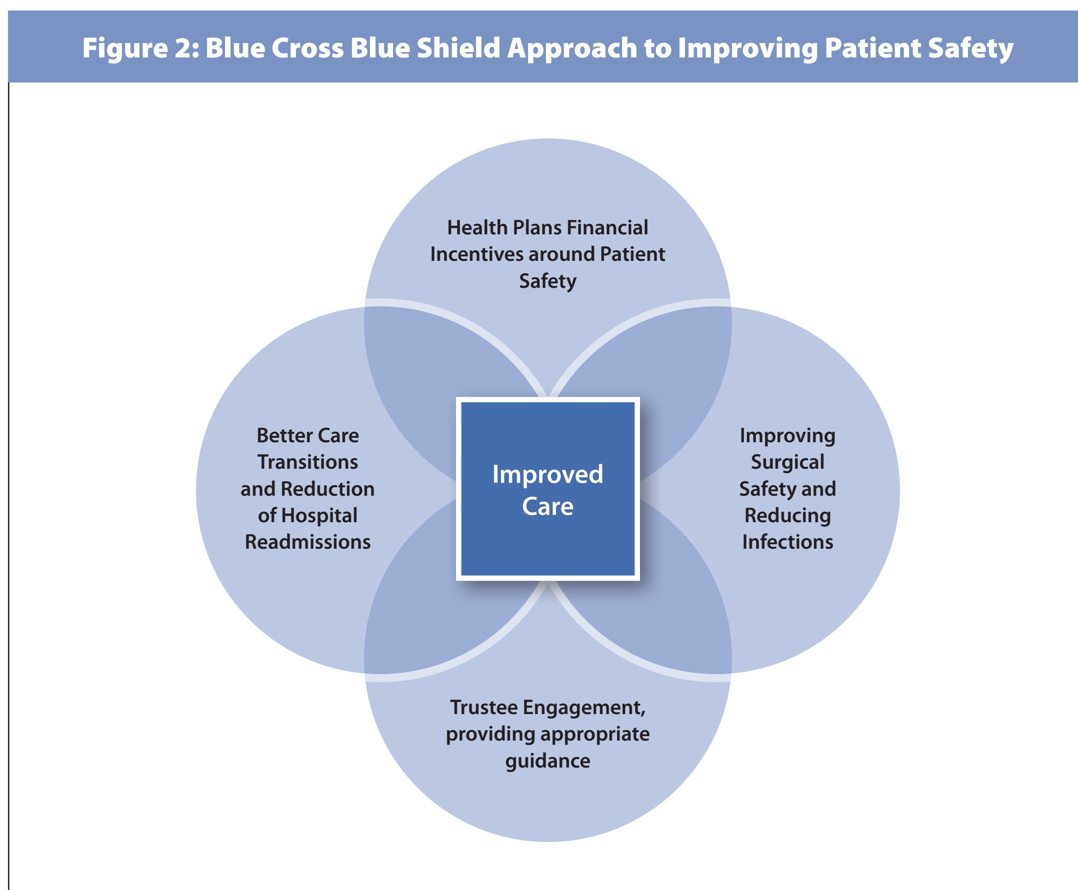
> Blue Cross Blue Shield of **Massachusetts** makes the short and powerful statement about its role in health care. Our Vision—Making Quality Health Care Affordable (Blue Cross Massachusetts, n.d.).
>
> Blue Cross of **Idaho** wants to support and continue to improve the health of the community. Our mission is to provide our members the best value in health insurance and the tools for maintaining and improving their health (Blue Cross of Idaho, n.d.).

The **Arkansas** Blue Cross and Blue Shield Vision is: To be the leading provider of health-care financing solutions, service and information that contribute to improving the health status of those in the communities we serve. (Arkansas Blue Cross, n.d.) Clearly health insurers have a financial obligation to their customers; however, they also have a strong commitment to quality care that improves the health of plan members. The vision and mission of many health plans are similar to those of many community hospitals. Leaders from health insurers and hospitals must work together to create mutual performance goals that align with the goals of supporting and improving the health of community members. Multiple stakeholders must come together to make sure that each is contributing to achievement of these goals.

As health care costs increase, health insurers and hospitals are challenged to invest in quality and patient safety, but they recognize that investment is necessary to create and sustain aggressive goals to protect patients. Hospitals are working to incorporate LEAN, Six Sigma and other approaches to performance improvement into daily care and service delivery. Many Blue plans are putting quality and safety measures into hospital agreements, quality recognition or transparency programs and/or pay-for-performance programs (see sample measures in Figure 1 on page 6). Trustee engagement is a priority for BCBS health plans across the country. The 2012 Blue Cross Blue Shield corporate goals relate to trustee engagement, safer surgery, reduction of infections, and improved care transitions to lower hospital readmissions (see Figure 2).

BCBS plans in several states have a history of supporting trustee education to strengthen the capacity of board members to lead the charge to meet new clinical performance goals.

Figure 2: Blue Cross Blue Shield Approach to Improving Patient Safety



Trustee and leadership engagement are the foundation of sustained and sustainable efforts to improve care.

Some Examples

Work underway in the states discussed below provides a sense of how trustees are being encouraged to attend training and certification courses to ultimately provide more knowledgeable guidance for hospital priorities. Trustees will be essential leaders in efforts to transform health care delivery, community by community.

Massachusetts

The AHA's Center for Healthcare Governance, along with BCBS of Massachusetts (BCBSMA) and the Massachusetts Hospital Association (MHA), designed a training program focused on quality and safety issues for hospital trustees. The Quality Curriculum is an interactive education course which includes simulated learning experiences across six dimensions of governance responsibility:

- mission,
- culture,
- performance,
- leadership,
- strategy, and
- resource allocation.

The course focuses on helping trustees gain practical experience in overseeing hospital quality and safety performance and in planning for and ensuring patient safety and quality care for the future. It concludes with a learning exercise that involves participants in the work of a board Quality Committee and how the committee interacts with the full board.

BCBSMA added this trustee education to their pay-for-performance program, and a payment was received by the hospital after the majority of trustees completed training.

Based on the Quality Curriculum the AHA's Center and MHA created a self-assessment tool that acknowledges that each hospital and each board is different and urges every organization and its board to create a baseline understanding of where they are along the six dimensions of governance responsibility. After the training program, hospital boards are urged to perform a second evaluation along the same dimensions.

Self-evaluation questions are designed to stimulate discussion among board members. Starting with the mission ensures that activity drives performance which supports the organization's purpose. Quality care is central to the mission of health care providers. Sample questions to assess each dimension appear in Figure 3.

Figure 3: Self- Assessment Questions

Mission

- Is quality appropriately addressed in our mission statement?
- Do we review indicators that are linked to the mission quarterly to monitor mission fulfillment?
- Do we deliver a report to the community regarding our mission fulfillment?
- Do we have a statement of aim that commits to quality improvements by a targeted date?

Culture

- Have we defined a desired culture and set of values for our organization?
- Are our organizational values reflected in the practices and attitudes of the organization?
- Do we conduct a cultural assessment?
- Do we devote time on the board agenda to discussing organizational culture?

Performance

- Do we have a quality improvement plan that identifies specific gaps in performance and targets by date certain?
- Do we have the right measures to evaluate our quality performance?
- Do we have the right tools to monitor our progress?
- Are we benchmarking against high-performing organizations and/or the theoretical limit?
- Do we have the right board processes in place for reviewing and evaluating quality performance?
- Do we share our performance with our patients, employees, and the community?

Leadership

- Do we have the right skills and competencies on the Board?
- Do we address gaps in Board skills through education or targeted recruitment?
- Do we have the right mix of incentives for our executives to drive performance improvement?
- Do we have a quality committee in place?
- Does the quality committee appropriately include representation of patients and/or their families as well as medical expertise?
- Does the quality committee report regularly to the Board?
- Do our credentialing and privileging policies support our quality goals?

Strategy

- Are our strategies consistent with the mission of the organization?
- Do our strategies improve the organization's financial and quality performance?
- Are there specific quality objectives and targets included in the organization's strategic plan?

Resource Allocation

- Do we invest the appropriate level of financial support in improving quality and safety?
- Do we devote sufficient Board meeting time to discussing quality and safety performance?

The self-assessment tool is available online at: www.americangovernance.com/americangovernance/education/QA_Self_assessment_tool.pdf.

Once boards have completed the program, they are encouraged to select and adopt over the coming year governance practices they learned about through the training.

Idaho

Blue Cross of Idaho, working directly with Idaho hospitals and the Idaho Hospital Association (IHA) established a hospital quality incentive program that:

- measures patient safety and improved clinical outcomes;
- establishes measures that are based on clinical evidence and industry recognized metrics; and
- establishes indicators that can be precisely and reasonably measured and that minimize administrative efforts by hospitals.

To receive a financial incentive payment, hospitals must meet performance thresholds for five clinical quality metrics and participate in the Boards on Board program, originally created by the Institute for Healthcare Improvement. The IHI created a focus on boards during the 5 Million Lives Campaign to leverage the board's ability to accelerate improvement. Hospitals in Idaho must submit agendas and quality summaries from hospital board meetings to Blue Cross of Idaho. Materials are evaluated to determine if boards are spending a significant amount of time overseeing quality and safety improvement. Best practices found in the agenda and summaries are shared with other hospitals in Idaho to encourage networking and improvement.

Board members also are aware that they are accountable for how the hospital performs on the clinical metrics of the quality incentive program. The issues that are tracked for improvement appear in Figure 4.

Figure 4: Blue Cross of Idaho Quality Measures

- Readmissions to the hospital for a related stay within 30 days of discharge
- Pressure ulcer incidence rates
- Venous thromboembolism (VTE) prophylaxis
- Surgical teams use of the World Health Organization (WHO) surgical checklist
- Bloodstream catheter related infections, prevention efforts

This list is similar to quality measures included in other BCBS pay-for-performance programs. Addressing these clinical quality issues is highly technical, yet these are the types of issues that not only drive hospital quality and safety outcomes, but also financial performance as well. This is why trustees need orientation, training and understanding of tools such as scorecards, report cards and dashboards that report on the clinical outcomes driving new payment arrangements.

The IHA also makes resources available to hospital board members including trustee educational meetings, online education, and a DVD series on the "Boards Role in Quality and Patient Safety", (IHA, n.d.). The DVDs can be used during board meetings, at retreats or at home by individual board members.

South Carolina

Leaders at the South Carolina Hospital Association (SCHA) and BlueCross BlueShield of South Carolina (BCBSSC) are in agreement that training is needed for hospital trustees with diverse expertise and backgrounds that represent the community served (Diamond, 2010). BCBSSC pays a financial reward to hospitals after hospital trustees and executive leaders have taken online or onsite courses and confirmed their learning through testing. This approach is different from an attestation that training has been completed. Board members are being asked to demonstrate an understanding of the materials covered. The training, facilitated by the SCHA and conducted by Best On Board, provides a strong grounding in principals of mission-driven governance and quality improvement. The program contains three levels

- Level 1: Board and Leadership Essentials: successful completion of Essentials of Healthcare Governance course and testing.
- Level 2: Advanced Certification: Successful completion and testing for at least one course in level 2—finance or quality.
- Level 3: Board Leadership: Completion of board leadership learning activities (South Carolina Hospital Association, n.d.).

South Carolina also has been chosen to pilot efforts to improve surgical safety. Operating rooms across the state are tasked with using the World Health Organization's Surgical Safety Checklist (PSQH, 2010). The *New England Journal of Medicine* demonstrated that use of the simple checklist during a time-out period before the start of surgery can reduce major complications following surgery (Haynes, 2009). The simple tool is lauded by many experts. Surgery is an essential component of health care; 234 million operations are performed in the U.S. annually, with a complication rate of three to 17 percent. Data suggest that 50% of all surgical complications are avoidable (Academy Health, n.d). Although tools exist and certainly health care organizations would be pleased to report progress in ending complications, implementation remains daunting.

Leaders from SCHA, BCBSSC and many community organizations are providing oversight for this ambitious undertaking. South Carolina hospital trustees will no doubt be seeing surgical safety measures on their dashboards and report cards as the entire state tracks progress

on this effort. Pairing up hospital board and leadership training that builds capacity with data to track actual improvement efforts is a powerful approach to changing performance.

Additional States

Expect the concept of trustee education to spread. Arkansas Blue Cross Blue Shield provided funding to the Arkansas Hospital Association with additional support provided by the Arkansas Association of Hospital Trustees to enroll at least 80% of Arkansas hospital board members in the Best On Board educational program (Arkansas Blue Cross Blue Shield, 2011). The association has sponsored several programs focusing on the board Essentials and Quality courses. Arkansas BCBS heard about the program from both the Arkansas Hospital Association and the South Carolina Blues. Best practices are being carried from one Blue Cross Blue Shield health plan to another.

The Delaware Healthcare Association, with support from Blue Cross Blue Shield, also has provided the Best On Board course, The Quality Imperative, to the majority of trustees in that state. More than 400 hospital trustees and executives in South Carolina, Arkansas and Delaware have participated in these courses and testing.

Trustees who have participated in these courses also can take the next step to turn their learning into action by adopting a "Quality Compact", which is a commitment to the community to engage in specific best governance practices to improve quality and safety. Establishing a board quality committee, identifying and monitoring a set of quality and safety metrics and including quality and safety goals in executive performance evaluation are key elements of the Compact.

Board Members Can Take Action

The National Quality Forum (NQF) Safe Practices for Better Healthcare describes 34 practices to improve the safety of health care. It is no coincidence that the first safe practice is leadership. Leaders need to make a conscious commitment to making care within their own organizations safer. One model for creating change is the 4A model of adoption described by Denham (2005):

> **Awareness:** Leaders must understand performance gaps, national trends and their own potential for improvement.
>
> **Accountability:** Leaders must be personally accountable for improvement by setting goals with a concrete target by a specific date. Trustees can further instill accountability through setting CEO compensation goals based on hospital performance goals.
>
> **Ability:** Leaders and front-line staff need the education, skills, time, resources and leadership to put changes in place, test the effects, and monitor for long-term results.
>
> **Action:** Leaders must insist on change to prevent harm to patients.

Boards are uniquely poised to take action using this model on behalf of the communities they serve.

Get Educated. Boards that strive to create a world-class hospital also must focus on world-class governance as well. A commitment to ongoing learning and action is necessary to protect patients. In a press release about the Arkansas program Beth Ingram, Vice President for Educational and Membership Services for the Arkansas Hospital Association said, "We are fortunate that Arkansas Blue Cross and Blue Shield shares this vision, this passion for creating the best possible care for the people of Arkansas." Board members should discuss a strategy of partnering with their hospital associations and BCBS health plans on common goals. Education of board members is a start, with early promise that board members will be better informed and comfortable asking tough questions. Boards should also consider creating dashboards or report cards that track the quality and safety metrics in emerging pay-for-performance programs. Goeschel and her colleagues (2010) suggest that boards create a scorecard and select metrics to answer these questions for their health care organizations:

- How often do we do harm?
- How often do we provide evidence-based care?
- How do we know if we have learned from mistakes?
- Have we created a quality and patient safety culture?

Establish a Board Quality Committee. Hospital finances were once the most important focus of many boards. However, performance and finances are becoming intertwined as we enter a "no outcome, no income" era. Joann Reed, Chairperson of the Board of Adirondack Medical Center, indicated that forming a Board Quality Committee changed their focus.

> *Once we learned how to define quality and how to measure it, quality and physician-related issues are now 40 to 50 percent of board meetings. Quality is the thread that goes through all issues, including finances. We couldn't be an effective governing board without this committee (Bader, n.d).*

Set the Bar High. Aligned with their health care organization's vision and mission, the board should set high goals for clinical care. Board members should understand the CMS value-based purchasing metrics and BCBS or other private insurer pay-for-performance goals. These goals are the start of a changing payment system based on performance. Boards need to steer their organizations into this new era of health care finance and delivery focused on improving value through provision of more efficient, higher quality care. The Institute for Healthcare Improvement created a program that linked hospital leadership to transforming care at the bedside. The lessons learned from the project (Pursuing Perfection Initiative) are being transported to other organizations. The goals for hospital and physician organizations involved in the Pursuing Perfection demonstration project were:

- deliver all indicated services at the right time;
- avoid services that are not helpful to the patient or reasonably cost effective;
- avoid safety hazards and errors that harm patients and employees; and
- respect patients' unique needs and preferences (Kabcenell, Nolan, Martin and Gill, 2010).

The Institute for Healthcare Improvement examined the results of this demonstration project. All of the 13 participating health care organizations in the U.S. and Europe were able to make substantial improvements. Two factors that were considered critical to achieving high performance were:

- substantial changes in leadership's approach to quality.
- a steady stream of innovative solutions to persistent challenges such as reducing mortality, harm, and disparities (Kabcenell, et al, 2010).

Board members can drive leadership change and focus their organizations on introducing innovation into protecting patients during the care process.

The American Hospital Association, through its Hospitals in Pursuit of Excellence initiative to support performance improvement, also is engaged in research to improve care outcomes and provides a number of tools and resources to help hospital boards and leaders participate in improvement efforts. As part of this initiative, the AHA's Committee on Performance Improvement published a report titled *Hospitals and Care Systems of the Future* in the fall of 2011. Partnering with payers was among the 10 "Must-Do" strategies and "accountable governance and leadership" one of seven core competencies that the report identified as critical for hospitals' future success. The AHA's winter 2011-12 *Great Boards* newsletter summarized the report's key findings and provided guidance about how boards could use the report to ask the provocative, "edgy" questions that often lead to better governance and organizational performance. For more on these resources visit www.greatboards.org.

Conclusion

The challenges in most of our communities are so large that it makes sense for key stakeholders to work together to set direction for and accelerate change. Many insurers, including Blue health plans, have partnered with national organizations, state hospital associations and individual hospitals to engage trustees in efforts to transform health care.

John Combes, MD, President and Chief Operating Officer for the AHA Center for Healthcare Governance stated: "The new frontier for improving board performance lies not in the structure of the board or its written policies and procedures but rather in its board room culture and the individual and collective behaviors of its members" (Joshi and Horak, 2009, xii). In these times of growing concern about the quality and affordability of health care, trustees are being called upon to model behavior, set the direction for their organizations, and create an environment that fosters culture change at the individual and organizational level. Trustees should strive to attain new knowledge and skills to lead the charge.

References

Academy Health. WHO surgical safety checklist: Surgical Safety Checklist reduces complications, mortality. Retrieved on September 12, 2011 from www.academyhealth.org.

American Hospital Association's Center for Healthcare Governance. *Board Quality Education Program: A Self-Assessment Tool.* Chicago, IL.

Arkansas Blue Cross and Blue Shield. Our Vision. Retrieved on October 26, 2011 from www.arkansasbluecross.com/about/mission.

Arkansas Blue Cross and Blue Shield (2011). Arkansas Blue Cross grant to fund training for hospital board members in Arkansas. News Release. May 23, 2011.

Arkansas Trustee. Arkansas Trustees certified by Best on Board. Summer 2011.

Bader, B.S. Best practices for board quality committees. *Great Boards.* Retrieved on September 26, 2011 from www.greatboards.org.

Bloomberg Business Week. WellPoint ties payment boosts to health outcomes. Bloomberg Businessweek, May 20, 2011. Retrieved on October 26, 2011 from www.businessweek.com/managing/content/may2011.

Blue Cross Blue Shield of Massachusetts. Corporate Promise and Values. Retrieved on October 26, 2011 from www.bluecrossma.com/visitor/about-us.

Blue Cross of Idaho. About Us. Retrieved on October 26, 2011 from www.bcidaho.com/about_us.

Buckley, L. CMS Outlines value-based program: Quality improvement report. *Healthleaders Media,* November 28, 2007. Retrieved from www.healthleadersmedia.com.

California Healthcare Foundation. Wellpoint to adjust hospital payment policy to reflect care quality. California Healthline, May 17, 2011. Retrieved on October 26, 2011 from www.californiahealthline.org/articles.

Classen, DC, Resar, R, Griffin, F, Federico, F, & Frankel, et al. "Global Trigger Tool" shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs* 2011;Vol 30 (4), 1 – 9.

The Commonwealth Fund Commission on High Performance Health System, Why Not the Best? Results from the national scorecard on U.S. health system performance, 2011. The Commonwealth fund, October, 2011.

Conway, J. 5 Million Lives Campaign Getting Boards on Board: Engaging governing boards in quality and safety. *The Joint Commission Journal on Quality and Patient Safety;* April 2008, Vol 34 (4); p 214- 220.

Denham, C. R. Patient Safety practices: leaders can turn barriers into accelerators. *Journal of Patient Safety,* 2005, Vol 1 (1), 43-54.

Diamond, F. Hospital Board members trained on Blues' dime: A unique health plan-provider partnership focuses on giving practical knowledge to those to whom the CEOs report. *Managed Care,* January 2010, 53-54.

George, W.W., Denham, C.R., Burgess, L.H., Angood, P.B. & Keohan, C. Leading in crisis: Lessons for safety leaders. *Journal of Patient Safety,* Vol 6 (1), 24 -30.

Goeschel, C., Wachter, R.M. and Pronovost, P.J. Responsibility for quality improvement and patient safety: Hospital board and medical staff leadership challenges. *Chest,* Vol 138, July 2010, p 170- 178.

Goeschel, C., Berenholtz, S., Culbertson, R., Jin, L., and Pronovost, P. Board Quality Scorecards: measuring improvement. *American Journal of Medical Quality,* July/August 2011, Vol 26 (4), p 254-260.

Great Boards. Board Quality Committees: Best board practices checklists. Retrieved on September 26, 2011 from www.greatboards.org.

Haynes, A.B., et al. A surgical safety checklist to reduce morbidity and mortality in global population. *New England Journal of Medicine,* January 29, 2009, Vol 360 (5), 491-99.

Institute for Healthcare Improvement. 5 Million Lives Campaign. *Getting Started Kit: Governance Leadership "Boards on Board" How-to Guide.* Cambridge, MA: Institute for Healthcare Improvement; 2008.

Institute of Medicine, National Academy of Engineering (NAE). *Building a Better Delivery System: A new Engineering/Health Care Partnership.* Washington, DC: The National Academies Press; 2005.

Jha, A.K, and Epstein, A.M. Hospital governance and the quality of care. *Health Affairs- Web Exclusive,* November 6, 2009, p 1-9.

Joshi, M.S., and Horak, B.J. *Healthcare Transformation: A Guide for the Hospital Board Member.* Boca Raton, FL, CRC Press; 2009.

Kabcenell, A., Nolan, T.W., Martin, L.A., and Gill, Y. The Pursing Perfection Initiative: Lessons on Transforming Health Care. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement, 2010. Available from www.IHI.org.

Levinson, DR. *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries.* Department of Health and Human Services, Office of Inspector General. November, 2010; OEI-06-09-00090.

MedVantage. P4P Survey Results, 2011. Retrieved on February 1, 2012 from www.medvantage.com.

National Quality Forum Safety Practices – 2010 Update. Available at www.qualityforu.org/projects/ongoing/safe-practices.

PSQH. South Carolina Chosen as Pilot for national effort to improve surgical safety: Efforts expected to reduce patient deaths by hundreds each year. PSQH, September 2010. Retrieved on September 12, 2011 from www.psqh.com/news/current-news.

South Carolina Hospital Association. Best On Board South Carolina. Shaping Hospital Governance & Leadership.

Zablocki, E. Ten ways to improve the board's use of quality measures. *Great Boards,* Spring 2010, Vol X. (1).

Organizations as Resources for Board Members

AHA Center for Healthcare Governance
http://www.americangovernance.com/americangovernance/BRP/files/BRP_final.pdf

Best On Board
http://www.bestonboard.org/website/home.html

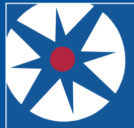
AHA's Great Boards
http://www.greatboards.org/resources

Institute for Healthcare Improvement
http://www.ihi.org/offerings/initiatives/PastStrategicInitiatives/5MillionLivesCampaign/Pages/default.aspx

Many state hospital associations also provide quality and safety resources.

For additional copies of this publication call the Center for Healthcare Governance at (888) 540-6111.

The American Hospital Association's



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