

GREAT BOARDS

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BOARDROOM BRIEFING

7 Things Your Board Can Do to Improve Quality and Patient Safety

By Barry S. Bader
with Sharon O'Malley

Hospitals and physicians are being challenged to improve patient care quality and safety and to demonstrate their results more transparently to consumers, government and health insurers.

Governing boards can choose to be either active leaders or passive overseers in the process. Until now, most boards have been less engaged with quality and safety than with financial and business issues. A lack of clinical expertise limits many directors' ability to raise questions and exercise accountability.

Board leadership is a critical ingredient to achieving better, safer care.

This deferential culture does no harm when the organization's clinical leaders and executives take the initiative to adopt leading-edge approaches to performance measurement and continuous improvement. Leaders of several healthcare winners of the Malcolm Baldrige National Quality Award have said their boards were supportive but not central to their efforts.

In most hospitals and health systems, however, board leadership is a critical ingredient to achieving better, safer care. "We're an organization that wants to be benchmarked with the best," says Alan Newberry, CEO of Peninsula Regional Health System in Salisbury, Md., about his board's posture toward quality.

With an "extraordinarily supportive" board, Peninsula Regional has invested heavily in technology and in the development of a culture of quality and safety, says Newberry. It has been named a Most Wired Hospital and recognized by Solucient as a Top 100 performance improvement hospital, one of only 14 hospitals in America that have won that status twice, he says.

"We talk about the No. 1 responsibility of a board member being quality and credentialing," says Newberry. "They understand the awesome responsibility that the board has—a fiduciary responsibility not only for the economic well being of this organization but for the quality."

Newberry says his board has played a pivotal role over 15 years in the health system's quality advancements.

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“Improving the quality and safety of care in the United States is a public health emergency, and boards have a big responsibility in that regard, says Dr. David B. Nash, chairman of the Department of Health Policy at Jefferson Medical College in Philadelphia and chairman of the board’s Quality Committee for Catholic Healthcare Partners, a Cincinnati-based regional system.

“We have an epidemic of medical errors, and 50 percent of patients in the U.S. don’t get the care they ought to, based on the evidence,” says Nash. “Not that all of this is the board’s responsibility, but an awful big chunk of it is.

“Board members have to be educated about what is going on in the national environment on quality and safety, and then use those newly acquired skills to make sure the organization they are responsible for is measuring and delivering on its quality and safety goals,” says Nash. “Most boards fail on both steps. They don’t devote resources and precious time to education on quality and safety, and thus they lack the fundamentals to hold management’s [and clinicians’] seats to the fire regarding quality and safety.”

The governing board’s abilities have been untapped because it has been misdirected to follow rather than to lead. Here are seven ideas for tapping the board’s full potential to exercise quality leadership.

1. Choose board members with “the right stuff.”

Boards today are becoming more explicit about choosing directors and board quality committee members who can carry out quality

7 Board Tools

1. Board recruitment
2. Education
3. Measurement
4. High expectations
5. Culture promotion
6. Board time
7. Recognition and rewards

responsibilities collegially but with a dose of knowledge and independence. Some are practicing physicians with a passion for the science of quality and safety enhancement. Others, such as vice presidents of quality or customer service in manufacturing and service industries, bring pertinent business backgrounds. Still others are corporate medical directors, nursing school faculty, pharmacists, public health professionals, and retired physicians and nurses.

Just as every great board should include a few experts in finance, audit and executive leadership, so, too, should every board have a cadre of “quality experts” to lead the rest of the board in raising questions, understanding patient care issues and exercising accountability.

2. Educate the board.

Education is what keeps members—both with and without quality-related backgrounds—up-to-date on new quality requirements and improvement knowledge. The range of approaches to educate directors about quality and patient safety includes:

- Orienting new directors to national trends, external mandates such as pay-for-performance and public reporting of quality results, and to fundamentals such as how to read a quality dashboard and ask questions about improvement initiatives.

- Distributing selected articles and educational materials.

- Sending leadership teams of board members, clinicians and executives to outside conferences such as those sponsored by the Institute for Healthcare Improvement and The Governance Institute.

- Sending leadership teams including board members on benchmarking and learning visits to leading-edge health systems or private companies.

- Inviting the organization’s quality leaders to brief the board on their initiatives as part of board meetings or board education sessions.

- Conducting “director’s rounds” in which board members might shadow a nurse for a shift, spend a weekend night in the emergency department, or accompany the CEO on patient safety rounds to gain first-hand appreciation of quality and safety on the front lines. (Rounds both educate directors and visibly demonstrate their commitment.)

3. Use measures to focus board work on what’s important.

“If we can measure it, we can improve it,” says Newberry. But when he talks about the Peninsula board’s engagement in quality, he stresses, “They’re a governance board, not an

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operational board. They make sure processes are in place to ensure quality and economic viability,” but they don’t dictate details of how to do it.

What a board reviews goes a long way in determining whether it’s focused on the big picture or the micro-environment. To use a financial analogy, an effective board looks at high-level measures, such as overall operating margin, expenses as a percent of patient care revenues, and profitability of major business lines—not at each department’s results, which it expects management to monitor.

Yet in quality and patient safety, some boards and their quality committees review departmental quality reports and small-scale improvement projects. Such efforts are important in a quality culture but they don’t merit much board time.

Rather, boards should aim their sights higher. In a 2005 monograph entitled *10 Powerful Ideas for Improving Patient Care*, quality experts James L. Reinertsen and Wim Schellekens write that the history of improvement in healthcare has focused on “project-level” advancements—what they call the “small dots”—rather than the system-level measures of performance, or the “big dots,” such as:

- Safe medication delivery, measured by reducing adverse drug events per 1,000 doses.
- Workplace safety, measured by reducing work days lost per 100 employees per year.
- Survival after a healthcare experience, measured by reducing the hospital standardized mortality rate, a sophisticated, severity-adjusted measure that was developed in Great Britain.

- Quality of life, measured by improving a patient’s functional status after major procedures.

Small project improvements are a building block in larger-scale improvements, and it’s the job of organizational leaders to set the context in the form of goals for the larger undertaking. For example, Reinertsen and Schellekens cite

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Tallahassee Memorial Hospital, which markedly reduced its hospital standardized mortality rate. To achieve that goal, the hospital sought a deeper understanding of the patterns preceding patient deaths, particularly those it categorized as “needless deaths.” One pattern was the failure to get resources promptly to patients after nurses identified those whose conditions were deteriorating. As a result, the hospital redesigned critical care processes and created rapid response teams on non-critical care units.

It’s also important to remember that “the indicators are the cheese, not the whole sandwich,” Reinertsen and Schellekens write. “It is wasteful and possibly dangerous to measure indicators without having a purpose for doing so and a plan for the outcomes.” They advise leaders to ask three questions about the measures on dashboards and in other reports:

- What is the aim or purpose we

are measuring? “Reducing post-operative infections” and “making intensive care safer” are examples of aims. The board should understand why these aims were selected—to correct sub-par results; because of external requirements or trends; to achieve “best-in-class” or perfect performance; or perhaps all of the above.

- What will we do differently to improve? The board should ask for explanations that demonstrate understanding of the clinical and operational processes that produce clinical results. Bring data to life with stories that make the numbers relevant and compelling.

- How will we know that changes result in improvement? These are the indicators themselves—“the cheese in the improvement sandwich”—and the board should be able to review them in easily readable formats.

4. Pursue perfection, not improvement.

Healthcare providers too often compare their results to the average and aim for incremental improvement. To achieve breakthrough improvements, quality experts recommend asking, “What is, theoretically, the best performance that a given process or system could achieve?” Since the answer is often “zero defects or perfect performance,” the task becomes redesigning the system to achieve that level.

This isn’t mere rhetoric. For example, hospitals in the IHI’s 100,000 Lives Campaign have identified “bundles” of evidence-based, ideal practices to prevent ventilator-related pneumonia, a chronic cause of

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death in hospitals once considered an unavoidable complication of critical care. According to reports on the IHI's Web site, www.ihl.org, hospitals—such as Owensboro Medical Health System in Kentucky and Swedish Medical Center in Seattle—have dramatically reduced and even eliminated ventilator-related pneumonia cases over sustained periods.

“Set a high bar and work toward that goal,” Nash advises organizational leaders. “Don't tolerate incrementalism. Managers have a lot on their minds. They want to focus on the next building project, the next big doctor recruitment, the opening of the new emergency room, the day-to-day blocking and tackling, which are important. The board has to encourage management to think in a more strategic way about quality and to view quality as a competitive advantage.”

5. Pay more attention to culture.

Data, protocols and information technology all play a part in making care safer and more effective, but hospitals are recognizing that another factor trumps them all.

“When it comes to improvement, culture beats technology hands down every time,” says Nash. “A culture that is non-punitive, open and self-evaluative, and questions tightly held beliefs is a culture that will make progress in improving quality and safety. The board has a responsibility to promote a non-punitive culture. That means the board doesn't penalize its management [for shortfalls or errors]. It devotes sufficient resources and education and time for management to reach mutually agreed-upon goals.”

Sentara Healthcare in Norfolk, Va., has studied how organizations in other high-risk industries, such as airlines and nuclear power plants—where even rare errors have catastrophic results—achieve safety records far surpassing healthcare's. The key ingredient, says Sentara's chief medical officer Dr. Gary Yates, is culture.

From companies such as Duke Power, Sentara has learned “it is necessary to change our behaviors in order to change our culture and to improve our outcomes,” Yates explained in a workshop at IHI's

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David B. Nash, M.D., M.B.A.
Jefferson Medical College

annual forum in December. To change behavior, Sentara is pursuing four initiatives to build a culture of safety:

1. Reinforce safety as our core value.
2. Institute behaviors for error prevention and convert them to habit.
3. Focus and simplify work processes and procedures.
4. Start a state-of-the-art event analysis and lessons learned program.

Sentara is training employees to use a “toolbox” of techniques for making safe care a habit, an automatic behavior. A variety of habit-forming methods are used, such as a “self-checking” routine that's done before

risky procedures. To help employees remember it they're taught a mnemonic, “STAR: stop, think, act, review.” Employees also are trained in use of “repeat backs,” such as, “That's 10 milligrams. Correct, doctor?” Sentara's six hospitals also are using so-called “red rules” that are so critical to patient and employee safety (for example, verifying a patient's identity) that exact compliance must “come before any other consideration.” Consequences for non-compliance are serious.

6. Exercise leaders' powerful influence.

A board can directly affect financial and business results by using its authority to approve budgets and major transactions and oversee performance, but many trustees have difficulty seeing how they can influence patient care quality and service.

In fact, leaders exercise their influence in a variety of roles. Formal authority is just one tool, and it's often the least important. “What [leaders] write and say and how they allocate resources” sends a powerful message throughout an organization,

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Reinertsen and Schellekens write. Above all, “time is what followers pay the most attention to.” They encourage boards and other leaders to visibly channel their attention toward high-level organizational improvements.

Peninsula Regional Health System is a case in point. “We reoriented our board meeting agenda and moved the quality reports to the top when we have full attendance and to emphasize the importance of it,” says CEO Newberry. “We put the financial statements after the quality reports, and we have more time to talk about quality.” Before each monthly meeting, the board has an educational session, the majority of them on quality, patient safety and clinical-related technology initiatives.

Peninsula also created a board-level quality oversight committee that includes nine of 16 board members plus senior management and clinicians. New board members often are assigned to the quality oversight committee because it offers an “excellent opportunity to get them up to speed on what’s going on,” Newberry explains.

Board quality committees should develop annual goals related to quality and safety, lay out quality education and reports on an annual calendar, and design meeting agendas that use time for meaningful discussion of performance and improvement priorities.

“Time is the currency of leadership,” say Reinertsen and Schellekens.

7. Recognize and reward excellence.

The board exerts influence directly when it uses its authority to evaluate

and compensate the CEO and approve compensation for other senior leaders. Traditionally, executives’ incentives have been financially driven, but that needs to change. Along with targets for profitability, a strong balance sheet and market share growth, executives’ bonuses should be based on improving clinical quality, patient safety, customer service and employee satisfaction.

“I have a strong belief that economic incentives for management are a critical part of a board’s toolbox for quality improvement,” says Nash. “You’re going to see boards create a component of management bonus compensation tied to various quality and safety measures. At Catholic Healthcare Partners, the 10th-largest system in the country, we have created a robust economic incentive program for senior leaders across the system, directly tied to various quality and safety measures.”

Similarly, Peninsula Regional’s Newberry says, “Part of my pay and performance objectives are based on patient safety and quality. About 36 to 40 percent of our goals are around safety and quality improvement.”

Optimizing the board’s role in quality won’t be accomplished overnight. Quality is complex, and directors have limited time available. However, the payoff for investments in board recruitment, education and information, along with cultivation of a partnership with executives and clinical leaders, will be worth the wait. Boards do make a difference. **GB**

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