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IHI Calls on Boards to Lead on Quality and Safety

An Interview with Jim Conway, Senior Vice President, Institute for Healthcare Improvement

By Elaine Zablocki

When hospitals in the 100,000 Lives Campaign, through their work on multiple improvement initiatives, exceeded their goal by more than 20 percent, what did they do for an encore?

For the Institute for Healthcare Improvement, Cambridge, MA, the answer is to up the ante.

In December, IHI announced a national campaign to dramatically reduce incidents of medical harm in U.S. hospitals. The 5 Million Lives Campaign hopes to enroll 4000 hospitals to protect patients from five million incidents of medical harm over a 24-month period (December 2006 to December 2008). It targets a dozen specific interventions and goals (see sidebar).

Most of the initiatives address patient care, but for the first time, IHI is emphasizing a non-clinical goal:

Get boards on board by defining and spreading the best-known leveraged processes for hospital boards of directors, so they can become far more effective in accelerating organizational progress toward safe care.

Measurable indicators:

Boards in all hospitals will spend at least 25% of their meeting time on quality and safety issues.

Boards will have a conversation with at least one patient (or family member of a patient) who sustained serious harm at their institution within the last year.

“When you look at the literature on change, it’s clear that engaged leadership always plays an essential role,” says Jim Conway, an IHI senior vice president actively involved in governance leadership for IHI and with the 5 Million Lives Campaign. “When I began working with IHI, I had an opportunity to visit many hospitals, and I heard over and over again that governing boards face increased expectations today, and find themselves ill-trained to perform their new roles.”

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Great Boards editor Elaine Zablocki interviewed Conway about the specific steps hospital boards are taking now to engage more effectively in leadership on quality and safety issues.

Q. The 5 Million Lives Campaign encourages boards to set specific targets for reducing unnecessary mortality and harm, and to make an explicit, public commitment to measurable quality improvement. Why is this important?

A. You need to decide what you want to be. What defines a good year for you? You might decide that by 2010 you want to be the safest public hospital system in the country.

Q. Actually, that strikes me as an intimidating goal. Couldn't the hospital do something incremental? Couldn't it review the dozen IHI goals and decide to focus on three or four of them?

A. So, how many people dying is okay with you? How much harm is okay with you?

The Ascension Health System, which has 74 hospitals, set a goal a few years ago that by July 2008 they would eliminate all preventable errors within

their system. Talk about big, hairy, audacious goals!

When a system sets a goal like that, the first thing we notice is that everybody in their system is aware of it. Secondly, we see spectacular levels of improvement in that system.

When you work on quality improvement, you notice that a goal of making something 5 percent better doesn't get anyone excited. When you say you want to make it 50 percent better, everyone says, "oh God, this is really going to change the way we do things." We've learned that in fact it is easier – it's certainly more disruptive, but it's also easier – to focus and engage people around substantial goals. You absolutely need to set specific aims, and those aims should be a stretch for you.

Research tells us that when we pull 100 charts at a typical U.S. hospital, we'll find 40 instances of harm. The best we've seen anywhere is 20 instances in 100 charts. There are hospitals with 120 examples of harm in 100 charts. The reason for pushing this goal is, even if you do improve 50 percent, there are still people going home who've experienced avoidable harm, suffering, tragedy, at your hospital.

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5 Million Lives Campaign Targets Twelve Interventions

During the Institute for Healthcare Improvement's 100,000 Lives Campaign, 3,100 participating hospitals reduced inpatient deaths by about 122,000 over an 18-month period through overall improvements in care, including improvements associated with six interventions recommended by the IHI initiative.

Now, IHI has launched an even more ambitious effort. The 5 Million Lives campaign continues working to save lives through six interventions from the first campaign, and aims to prevent avoidable injuries through six additional interventions.

Six interventions from the 100,000 Lives Campaign:

- ◆ Deploy rapid response teams at the first sign of patient decline.
- ◆ Deliver reliable, evidence-based care for acute myocardial infarction to prevent deaths from heart attack.
- ◆ Prevent adverse drug events (ADEs) by implementing medication reconciliation.
- ◆ Prevent central line infections by implementing a series of interdependent, scientifically grounded steps.
- ◆ Prevent surgical site infections by reliably delivering the correct perioperative antibiotics at the proper time.
- ◆ Prevent ventilator-associated pneumonia by implementing a series of interdependent, scientifically grounded steps.

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“Engaged leadership always plays an essential role.”

Q. The campaign goal is that hospital boards will spend at least 25% of their meeting time on quality and safety issues. You suggest they should gather data on harms and potential harms, and listen to detailed, specific stories about harm that has occurred in their hospital.

A. While our formal goal is that at every meeting the board should spend 25 percent of its time on quality and safety issues, Children’s Hospital in Cincinnati spends 60 percent of its board time on these issues.

This is an effort to put a “human face” on the data. You hear about a grandmother who was going home; she slipped and fell, and died at the hospital.

She never saw her grandchildren again. You listen to what the statistics *mean*.

We suggest that the CEO should investigate the story behind an important medical error, interviewing patient, family, and staff. At a minimum, the CEO should tell the story in detail at a board meeting. Ideally, you bring in the patient, family and staff. I was present at a board meeting at an academic center, where the staff associated with a medical error told their story to the board. It was difficult. It was deeply emotional. But out of that presentation, the board reached an extraordinary resolve to put more focus on this area.

“This is an effort to put a ‘human face’ on the data.”

What this is about is confronting the reality. You’ve set your aim, now you look at your data. Peter Senge, in *The Fifth Discipline*, introduced the notion of creative tension. He says, “first you set your vision, then you confront your

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Six additional interventions to prevent harm:

- ◆ Prevent harm from high-alert medications, starting with a focus on anticoagulants, sedatives, narcotics, and insulin.
- ◆ Reduce surgical complications by reliably implementing all of the changes in care recommended by SCIP, the Surgical Care Improvement Project (www.medqic.org/scip).
- ◆ Prevent pressure ulcers by reliably using science-based guidelines for their prevention.
- ◆ Reduce methicillin-resistant staphylococcus aureus (MRSA) infection by reliably implementing scientifically proven infection control practices.
- ◆ Deliver reliable, evidence-based care for congestive heart failure, to avoid readmissions.
- ◆ Get boards on board by defining and spreading the best-known leveraged processes for hospital boards of directors, so they can become far more effective in accelerating organizational progress toward safe care.

For more information on how the Campaign defines medical harm see the FAQs tab in the Campaign area of IHI.org at <http://www.ihl.org/IHI/Programs/Campaign/Campaign.htm?TabId=6>.

reality; out of that will come the tension for change.”

We also suggest that the board talk about quality as the first item on its agenda. There is nothing that’s more important. This conversation should not be cut short due to lack of time.

Q. It isn’t an easy conversation. I can picture boards putting it off.

A. It is hard. As the chief operating officer at Dana-Farber Cancer Institute, every two

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months I had to tell the board stories of the patients we had hurt since their last meeting. That's absolutely hard. You don't present a single case in great detail at every meeting, but at each meeting you should talk about the patients who've suffered and/or died. At each meeting, you review your progress towards improved care.

Q. Before we leave this topic, what does the hospital legal department say when management and staff stand up at a board meeting to discuss in detail how things went wrong? Doesn't this increase the hospital's legal liability?

A. As we look at other industries, we observe that the only risk greater than disclosure is to know something and not disclose it. Think about WorldCom, about Enron, about Bridgestone Tire. When you try to cover up problems, you're dead in the water. We are also learning that errors don't erode trust (people know they happen). What erodes trust is what you do after the error.

"Errors don't erode trust (people know they happen). What erodes trust is what you do after the error."

Q. You encourage hospitals to establish and monitor a small number of organization-wide "roll-up" measures such as medical harm per 1,000 patient days or risk-adjusted mortality rates over time. They should be continually updated and transparent to the entire organization and its customers. Why should they do this?

A. When you walk into a hospital these days, everyone's gathering data on hundreds of items, to meet regulatory requirements and national patient safety goals and so on. You could be doing a hundred things without actually knowing whether care is getting better or worse. We're saying organizations should closely monitor their overall mortality and morbidity. You should monitor organization-wide harm. If you're unbelievably busy, and you're doing a thousand things, and that line isn't moving, that tells you you're not focused on the aspects of your system that actually create harm, suffering and waste.

Sometimes I look at a quality dashboard, and the trustees say to me, "Jim, I see so much I don't know what I'm seeing. There's too much information." Recently I helped review a hospital whose dashboard was a sea of green. It was comparing itself to standard external measures. We said, "we want to know how you're doing on the issues you're losing sleep over."

"How many people dying is okay with you? How much harm is okay with you?"

Q. Are you saying a dashboard ought to have some red or orange markers, because those will be the issues you're working on?

A. Yes. You have to push yourself. In the best hospitals, if we get things right 80 or 90 percent of the time, we think we're doing great. In fact, we need to look at the 10 to 20 percent of patients who aren't getting the care they need.

It's a real temptation to sit down with your board and present good statistics. You want to tell them everything's wonderful. Then something happens. Let's say the failure of your systems kills a patient, and the regulatory agencies come

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in. At Dana-Farber a patient died from to a chemotherapy overdose, just before I was hired. I recall how the board chair said to me, “never again will we be duped.”

It happens in other organizations; it’s happening now. The board of trustees thinks there are no problems, because no one wants to tell them the difficult truth. Governing boards today are held accountable for the quality of care and services by everybody from Standard and Poor’s to the IRS. They have to hear the truth.

Q. Are any hospitals already taking the steps you’ve described?

A. There are many. MemorialCare Medical Centers, in southern California, has developed a series of system-wide “bold goals” linked directly to their overall strategic plan. Their system board has issued specific “what-by-when” aims in five key areas. By June 2007, they aim to reduce inpatient mortality by 15 percent and avoidable infections by 50 percent. They expect to see complete adherence

“When a system sets a big, hairy, audacious goal, the first thing we notice is that everybody in their system is aware of it. Secondly, we see spectacular levels of improvement.”

to all evidence-based protocols for acute heart attacks, heart failure, and community-acquired pneumonia, 95 percent of the time. They intend to reduce codes outside intensive care units by 50 percent.

Cambridge Health Alliance (CHA), in Massachusetts, has been reporting performance metrics for years as part of its balanced scorecard, including data on adverse drug events, heart attack care, and patient satisfaction. Now the board is requesting explicit, detailed information on safety-related issues, including patient complaints, readmissions and staff injuries. The board has set a specific goal of eliminating all “never events” such as wrong-site surgery, mismatched blood transfusions, and severe bed-sores.

At Virginia Mason Medical Center, in Seattle, the board quality oversight committee oversees situations where patients could potentially have been harmed. At each monthly meeting the committee reviews a dozen minor or moderate incidents, and focuses in detail on one or two situations where there was a strong likelihood of harm, or actual harm occurred. The hospital doesn’t consider these more serious incidents resolved until all committee members have signed off on their root causes and remedies.

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Is **QUALITY** the **Common** Language to **CONNECT** Hospitals & Physicians?

By Don Seymour

Like most segments of the U.S. economy, hospitals and physicians benefited from expanding prosperity after World War II. The Hill-Burton Act helped build hospitals, the Health Manpower Act authorized funds to train physicians, and Medicare and Medicaid ensured payment for at least some of those previously underserved. Federal and state governments in effect entered into a social contract with patients and providers to pay for much of the care providers could offer, and private employers offered comprehensive health coverage for employees.

The social contract that evolved after World War II, what we might call “Greatest Generation Healthcare,” lasted roughly 50 years. Hospitals and physicians both prospered; physicians performed medical staff duties gratis in return for the use of the hospital as a workshop.

However, with unchecked demand, healthcare costs skyrocketed and are quickly becoming unsustainable. A newly emerging contract, what we might call “Boomer Healthcare,” is supported by a different set of concepts, including demand-side economics based on payment constraints and transparent information to compare providers’ quality, safety, customer satisfaction, and prices.

The concepts sustaining Boomer Healthcare substantially alter the mutually beneficial relationship that previously existed between hospitals and physicians. Hospitals face a conundrum: on one hand, they must compete with increasingly entrepreneurial physicians. On the other hand, they need physicians as partners to deliver care based on best practices, participate in quality and patient safety programs, and help meet community needs, especially emergency department coverage. The key question

facing hospital leaders today is how to align hospital and physician interests.

Redefining the hospital/physician relationship will be complex. Money is an important factor but business-based collaboration alone is insufficient. The idea that hospital employment of physicians will guarantee alignment is far too simplistic. Nothing short of a comprehensive approach to realignment will succeed, and then only if it is established on a foundation of quality.

Quality can and should be the common language that brings hospitals and physicians together because:

- (1) Both parties truly believe in quality and know it can be improved.
- (2) The case for improving quality makes increasing sense in business terms, and
- (3) Payers and consumers are entering an era in which they will choose providers based on demonstrated quality.

1. A common interest in better quality

Both hospitals and physicians know the healthcare system could perform much better than our current experience:

- The Dartmouth Atlas and other research studies have documented great variability in patient care — so much so that patients receive “optimal care” only 55% of the time.
- The Institute for Healthcare Improvement’s 5 Million Lives Campaign was developed on the premise that there will be at least that many opportunities to protect patients from “incidents of medical harm” over just two years.¹
- The leading cause of preventable sentinel events is “communications breakdowns” involving physicians, hospital staff and information systems.²
- A recent Boston University study indicated that 40% of consumers think care is worse than it was five years ago.

Increasing evidence shows that when physicians and hospitals work together, they can improve quality and patient safety. For example the IHI’s 100,000 Lives Campaign³ “reduced inpatient deaths by an estimated 122,000 in 18 months” and made “great

— 1 www.ihl.org/IHI/Programs/Campaign

— 2 www.ihl.org, Status Quon’t, Why Healthcare Will Never Be The Same, 2007 Status Report, IHI

— 3 www.ihl.org, IHI Launches National Campaign To Reduce Medical Harm In U.S. Hospitals, Building On Its Landmark 100,000 Lives Campaign

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headway in delivering reliable (best practice) care for acute myocardial infarctions, preventing adverse drug events, and preventing surgical site and central line infections,” as well as inspiring life-saving rapid response teams.

The 266 hospitals participating in the Medicare pay-for-performance (P4P) program managed by Premier Inc. have also steadily improved the quality of patient care.⁴ Among other indicators of

success, it is estimated that these hospitals “experience nearly 1,300 fewer deaths in treating heart attack patients.”

2. The business case for quality is growing stronger

Poor care is costly. It is sad to note that in the past, preventable infections, complications and errors often benefited hospitals financially, since remedial care increased patients’ bills. However, that perverse incentive is changing as Medicare and some private payers

reimburse by diagnosis, not per day or per service rendered. One study estimated that for patients with central line-associated bloodstream infections (a potentially fatal and often avoidable complication) hospitals incurred average expenses of more than \$91,000 per patient, but were paid less than \$65,000, for a loss of more than \$26,000 per patient.⁵ What’s more, under Boomer Healthcare, slim reimbursements mean hospitals need to maximize efficiency by reducing excess capacity and

running at or near full occupancy. Consequently, when patient lengths of stay are extended due to medical error or other glitches, new patients can’t be admitted promptly, and the hospital loses revenues. Physicians grow frustrated over delays and eventually may open their own outpatient facilities.

—4 Bonus Pay by Medicare Lifts Quality, *www.nytimes.com*, January 25, 2007

— 5 "Hospital Acquired Infection: Meeting the Challenge," supplement to *American Journal of Medical Quality*, Nov.-Dec. 2006

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Three Physician Leaders Speak Out:

How our hospitals align with physicians to improve quality

By Elaine Zablocki

Can quality serve as a common interest linking hospitals and physicians?

We asked three physician leaders:

sad to note that in the past **Arthur V. McDowell, III, MD**, chief of cardiology at Middlesex Hospital in Middletown, CT, and chairman of the board of Middlesex Health System, a single-hospital system with several affiliated outpatient facilities.

Loring S. Flint, Jr., MD, senior vice president for medical affairs at Baystate Health, a three-hospital system in Springfield, MA, with about 400 employed physicians plus 1100 community-based physicians.

Gary R. Yates, MD, chief medical officer at Sentara Healthcare, a seven-hospital system in Norfolk, VA, with a 310-physician medical group and over 3000 community physicians.

“There’s no question” quality can be a unifier, says McDowell, “because hospitals are very interested in quality and physicians are equally interested. We are inundated with external organizations demanding not only that

we talk about quality, but that we demonstrate quality.”

Flint agrees, but adds a caveat: “Keeping physicians aligned, or engaged

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We are inundated with external organizations demanding not only that we talk about quality, but that we demonstrate quality.

— Arthur V. McDowell, III, MD, Chairman of the Board Middlesex Health System, Middletown, CT

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If hospitals and physicians can align their interests, both clinical and financial results can improve. A recent study on patient safety from HealthGrades estimated that “if all hospitals had performed at the same level as the top-rated hospitals, about 206,286 patient safety incidents and 34,393 Medicare patient deaths could have been avoided, resulting in \$1.74 billion in savings.”⁶ In addition, preventing sentinel events can reduce

costly malpractice claims and liability insurance costs.

3. Consumer-driven purchasing comes of age with Boomer Healthcare

The most powerful aspect of the business case may well be the empowerment of consumers.

The much-hyped but long delayed era of consumers buying based on value (quality/price), while still in its infancy, appears to be gaining momentum, driven by increased transparency of information as well as financial incentives (e.g.

consumer-directed health plans and P4P payment systems).

Approximately 50 different organizations are currently publishing “quality and patient safety” information in various electronic and print formats. The reliability of this information may vary, but it is all available for public consumption. It includes assessments of not just hospitals but also individual physicians.⁷

No, healthcare providers won’t become Procter & Gambles, and we won’t see

every “consumer” consulting Consumer Reports to choose a hospital or doctor. But there will be enough well-educated, aggressive baby boomers to make the pursuit of quality not just the right ethical thing to do, but the right financial pursuit as well. Given the role Medicare, Medicaid⁸

—6 U.S. Hospital Errors Continue to Rise, www.washingtonpost.com, April 2, 2007 (citing the Fourth Annual HealthGrades Patient Safety in American Hospital’s Study)
—7 America’s Top Doctors (www.castleconnolly.com)
—8 Pay-For-Performance In State Medicaid Programs, The Kuhmerker Consulting Group, The Commonwealth Fund, April 2007

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(that’s the new buzz word) is certainly a key challenge for any healthcare system or hospital. But I don’t think quality alone will be the glue that holds everything together. In addition, physicians want to be involved in key decisions, including annual operating and capital budgets, strategic planning and the development of clinical programs. Employed physicians want a say in their working environment and day-to-day operations.”

“Physicians want to deliver the best possible care to their patients, and so does the system,” Yates says. “We find common ground when we begin to look

beyond care delivered at the individual patient level and look at a comprehensive system of care. When both physicians and the health system can examine and work on processes of care, then significant improvement is possible,

and their interests are very much aligned.”

How they do it
Shared leadership mechanisms. Baystate Health shows its commitment to physicians by engaging them in important leader-

ship processes. The capital planning process begins by asking physicians what they need. Through a series of meetings, each service line sets its priorities; then, service line chairs meet jointly with hospital administrators to prioritize all capital improvements for clinical services, facilities, and information technology, for all three hospitals. “It’s a very open process in which each participant has an equal voice,” Flint says.

Middlesex Hospital has developed a physician-dominated Imperative Oversight Committee that reports regularly to the board and in essence

I don't think quality alone will be the glue that holds everything together. In addition, physicians want to be involved in key decisions.

— Loring S. Flint, Jr., MD, Senior Vice President for Medical Affairs, Baystate Health, Springfield, MA

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and the AARP⁹ appear to be assuming as brokers, over time other segments of the population will join in.

Realignment Based on Quality

A new social contract can align hospitals and physicians around their common quality goals. This realignment has five key components:

1. Clinical Priority

Setting. It has always been unlikely if not impossible for

one hospital to have the best quality outcomes in everything. Today, clinical technology, fellowship training availability and payment algorithms encourage even greater sub-specialization. Clearly, choices have to be made and supported through resource allocation (e.g., facilities, technology and workforce). Hospitals need to engage physicians in a process to identify the clinical specialties they will mutually support at a level of excellence.

2. Customer Support.

Time is a physician's most limited resource. Most hospitals could do a better job of assisting physicians as "customers" by operating efficiently (e.g., procedure rooms that run on time), having competent and sufficient nursing staff, and providing needed information in the chart at the right time. In the most recent Quality of Care Survey by the American College of Physician Executives, 42% of physicians called "patient flow" a major problem, ahead of overuse or under-

use of care (32%), unexplained variances in care (28%), and medical errors (13%).¹⁰ Customer support includes offering physicians appropriate, accurate information regarding variations in patient care. Hospitals can earn physicians' confidence by asking their input on hospital processes and systems that need improvement.

— 9 www.healthcareitnews.com, April 24, 2007

— 10 Doctors say many obstacles block paths to patient safety, Bill Steiger, The Physician Executive, May-June 2007, pp. 6-14.

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serves as a board-level planning committee. The committee meets every two months, and it includes three physician members of the board, past president of the medical staff, and the current (elected) president, vice president, and secretary of the medical staff. In addition, two members are selected from departments that aren't already represented, and the three largest departments (medicine, surgery, and family medicine) are always represented. "This is how we get the most important leaders together in one room," McDowell says.

On occasion the Imperative Oversight Committee will set up a task force that includes all relevant stakeholders to examine major issues. For example, an emergency care task force included emergency physicians, psychiatrists, primary care doctors, other hospital staff, and community members. The end result: a plan to significantly expand the emergency department.

"Once there's a final decision, there is a formal presentation to the board and review by the board finance committee," McDowell says. "But we don't have a board planning committee separate from the administration and medical staff. It's all done in a collaborative way."

Our GI physicians helped take the lead in a national gastroenterology pilot project, and our system was able to play a supportive role to meet their needs.

— Gary R. Yates, MD, Chief Medical Officer
Sentara Healthcare, Norfolk, VA

Meeting physicians' needs as customers.

Sentara has made considerable progress in addressing physicians' needs as customers. For example, the system helped its gastrointestinal physicians

develop the information technology infrastructure and databases needed to begin collecting data on endoscopy indicators that were developed by their

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3. Hospital Clinical Leadership.

In many hospitals the traditional medical staff structure, which relies on decreasingly available volunteer time, is irretrievably broken.

Hospitals and physicians need to develop more sustainable leadership models for the future, designed to meet today's (and tomorrow's) growing demands for proven quality outcomes. Increasingly, department chairmanships will become full time salaried positions,

with appropriate allocations of time between administrative duties and clinical practice.¹¹ Additionally, job descriptions for many Chief Medical Officers and department chairs need significant revisions, with increased emphasis on quality.

4. Physician Recruitment and Employment.

There's an old saw that physicians quote about the importance of the Three A's: Ability (quality), Affability and Availability. Combine this with the fact that today's physicians, as they emerge

from training, seek a balance between lifestyle and work. The era of the physician as an independent, tireless small businessman is just an artifact of Greatest Generation Healthcare. Hospitals today need recruitment plans that offer what modern physicians want out of life. Even in a time of physician shortages, hospitals still must be discriminating, though, looking for physicians who subscribe to the organization's mission and values and bring both strong clinical abilities and interpersonal relationship skills.

Applicant interviews should be rigorous, to find physicians who will be a good fit over the long run.

Hospitals need to develop sustainable structures to employ and retain excellent physicians. They should consider various models, including the benefits of establishing their own physician-governed, professionally managed, multi-specialty groups.

— 11 It is likely hospitalists and employed physicians will be prime candidates for many of these positions.

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specialty societies. "Our GI physicians helped take the lead in a national gastroenterology pilot project, and our system was able to play a supportive role to meet their needs," Yates says.

Special surveys go out to Baystate's high operating room users asking them to evaluate OR equipment as well as support from the anesthesia and surgical teams. There's a quarterly face-to-face meeting with high users of lab and pathology services, and additional surveys and/or focus groups seek input from other groups of high-user physicians.

Common information system.

Baystate also has implemented an ambulatory electronic medical record for all its employed physicians, and the EMR is also available for community doctors who choose to participate (until now at their own cost.) "Because they're part of a larger system, the cost is very competitive," Flint says. Baystate is creating an interface so lab results from various sources will be reported directly into the EMR, and the hospital information system is available to physicians through a secure connection from their homes and offices.

Aligning compensation.

Since the early 1990s Middlesex has reimbursed physicians for time spent in committee work, at a rate that's comparable to other administrative functions – less than they would generate in their offices, but enough to compensate them for time spent away from patients.

At Sentara at least 40 percent of variable compensation for senior executives is based on quality and patient safety performance. The employees' gain-sharing program also includes variable dollars based on quality and safety. "That's one of the ways we align the system," Yates says.

Sentara also has incorporated specific quality and service goals into management contracts with several large community-based specialty groups in the community. This approach has been particularly successful with an area oncology group, Yates says. It led to the development of inpatient and outpatient quality indicators, clinical improvement in those areas, and ultimately a decision to seek accreditation for the cancer program.

"Incorporating quality and service goals in the contract affords an opportunity to get together around the table and focus on

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5. Business

Collaboration. As important as hospital-physician business arrangements are, they are the least important of the five components. However, hospitals should have a clear understanding of what's in the "toolkit" as they enter into risk/reward arrangements with members of their medical staff, such as joint ventures, gainsharing and other endeavors. Quality will improve when physicians

are incented to build volume, increase market share and standardize care.

How Boards Can Help

Boards can do a great deal to support increasing alignment of the hospital and physicians around quality. They can:

- Understand what's driving and troubling physicians – and look for ways the hospital can help
- Pay attention to quality improvement efforts and results

— Engage with physician leaders and senior management in a retreat setting to develop a strategic approach to physician alignment, with initiatives for each of the five components

- Articulate clear policies to support alignment, e.g., to guide the formation of joint ventures, and to address the challenges posed by physicians who directly compete with the hospital or don't accept the responsibilities of staff membership
- Be willing to take prudent risks; to consider

new employment structures, joint ventures and gain-sharing mechanisms; and to learn from experience the best ways to partner with physicians.

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trying to improve care across the specialty," Yates says. "In this case, the group has a presence at all our hospitals, and we can use our relationship with them to develop needed infrastructure. Then we invite other oncologists to participate as well."

Innovative board

structure. Board quality committees are often a sound, top-level approach to aligning organization and physician interests, but Middlesex is finding success going against the grain. About seven years ago, it merged the board quality committee

and the hospital quality committee. In the past, medical and nursing staff reviewed quality data and filtered information to the board. Today one high-level quality committee includes physicians, nursing staff, two administrators — and five board members. Two of the board members are physicians; three are lay board members. This means that out of a twelve-person board, five members attend every quality committee meeting. When quality problems arise, they are able to explain the root causes, and potential solutions, to the rest of the board.

Employment. "We find more and more physicians are interested in exploring alignment through employment, so we anticipate the number of physicians in our medical group will grow, especially in the specialty areas," Yates says. "That will offer us the opportunity to align in an even stronger fashion as we go forward."

As important as all these formal mechanisms are, relationships remain the key. "The most important thing," McDowell says, "is to anticipate potential conflicts and try to defuse them ahead of time."

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Red Rules FOR BOARDS

By Barry S. Bader

In industries where safety is critical and quality must come first, such as airlines and nuclear power, “red rules” refer to protocols that must be followed “to the letter” – all work stops until they are. A commercial airliner doesn’t leave the gate if the pilot spies a possible leak or flat tire; a nuclear plant operator or even a Toyota assembly line worker can “stop the line” when he spots a critical flaw.

The Agency for Healthcare Research and Quality (AHRQ) says one example of a red rule in healthcare might be: “No hospitalized patients can undergo a test of any kind, receive a medication or blood product, or undergo a procedure if they are not wearing an identification bracelet.” The moment a patient is spotted who does not meet this condition, all activity ceases until the patient’s identity has been verified and an identification band is in place.

What differentiates red rules from many “standard rules,” says AHRQ, is that red rules are “always supported by the entire organization. When someone at the frontline calls for work to cease on the basis of a red rule, top management must always support this decision,” notwithstanding any inconvenience, time lost or financial costs.

The concept of red rules can also be applied to governance. There are some practices that are so intrinsic to the effective functioning of a board that they always must be followed and enforced by the board’s leadership and the CEO. Here are seven such practices — or “red rules of governance” — for your board to consider:

1. Never compromise (or lose sight of) the mission and values of the organization, no matter what. If you can’t reconcile a strategy, decision, initiative, or policy with the fundamental mission and values of the organization, stop action and question why you’re doing it. Recommendations to expand or close a service line or community clinic, reduce staffing, redesign benefit packages, or hire physicians to cover the emergency department have major financial implications and may be the right course of action — but only after a thoughtful and disciplined exercise to consider mission and values, weigh options, and make the best choice.

2. Never be passive on a matter of importance. “I’m not convinced the project management is proposing makes strategic or financial sense, but the CEO seems to really want it, so I didn’t question it.” How many times have you heard board members express such comments?

Boards have to put significant trust in management and their board leaders, encourage risk taking, and recognize failures will occur. Good boards do not endlessly nit-pick every management recommendation or shortfall.

But on major decisions and policy matters, if a board member has serious concerns, passivity paves the road to ill-founded decisions. Red rule: speak up. In a famous example of governance abrogation of responsibility, when the CEOs of Time Warner and America Online surprised their directors with a proposed merger, only two board members voiced concern. Later, Ted Turner at Time Warner and Alexander Haig at AOL regretted that they acquiesced so readily; they didn’t try to rally the board to stop the train and allow a full board examination of a “bet the farm” deal that would fail miserably.

The lesson: Directors should never be cowed into silence on a major issue until all legitimate questions have been raised and answered with good data and sound arguments.

3. Never tolerate a disruptive board member. “Disruptive” refers to any behavior that interferes with the orderly and appropriate work of the board. Disruptive board members include those who show disrespect toward their colleagues or management, interfere with management, deliberately violate confidentiality, regularly arrive late or leave early, constantly interrupt or

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harangue at meetings, fail to meet minimum attendance requirements, or come to meetings unprepared.

Conversely, disruption is *not* candid comment, voting with a minority, or raising strong questions of management – those are necessary and appropriate behaviors. Every board can benefit from a contrarian or two, and all directors should on occasion constructively challenge the prevailing wisdom, but effective directors can disagree without being disagreeable.

Too many boards tolerate disruptive behavior that drags down the entire board's performance. The director's position description or a code of conduct should articulate a high standard of performance. When disruptive behavior occurs, the board chair should take action appropriate to the situation. In some cases, a quiet word after the meeting will do, but in other cases a more formal "visit to the woodshed" may be in order. The Executive or Governance Committee may be called to consider the matter. If the behavior continues, the board should not hesitate to remove the disruptive member.

"The concept of red rules can also be applied to governance. There are some that are so intrinsic to the effective functioning of a board that they always must be followed and enforced by the board's leadership and the CEO."

4. Never ignore violations of the conflict of interest policy.

Conflicts of interest involving directors put management in an uncomfortable, even untenable position. They open the board to criticism from the press and government overseers. The board should have a clear definition of what constitutes a conflict and require full disclosure annually and whenever a conflict arises. A committee of independent directors should review all conflicts, determine whether they are acceptable, prescribe action to protect the organization (e.g., competitive bidding process), and submit a report summarizing all conflicts to all board members.

The conflict of interest policy should include a section describing a clear process for any board member to follow if, in the middle of a meeting, they think someone may be conflicted. It takes a bit of the sting away for a director to "invoke paragraph 9b" rather than explicitly discussing a colleague's possible conflicts. The process could include a "stop action" that is called by the chair and an immediate break for the independent directors to confer on the situation.

Even when the board determines a member with a conflict may serve on the board (and many great board members do have appropriately disclosed conflicts), the conflict of interest policy should clearly prohibit directors from using their position or information gleaned as a director for personal gain.

If a board member violates this proscription or inadvertently fails to disclose a conflict, an immediate warning is called for. Repeated or deliberate violations can have only one resolution: removal from the board.

The board should adopt clear rules on sticky situations – such as whether physicians who invest in competitive ventures have a disabling conflict that should bar their continued board membership. Once the rule is set, follow it. Tolerance is worse than having no rule at all.

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5. Never surprise the CEO.

If a director plans to air serious reservations about an upcoming matter or the performance of a program, common courtesy and good board process say to give the CEO a heads-up. Advance notice allows the CEO to come prepared with facts and data and to give thought to the appropriate response. CEOs are not omniscient – they cannot be expected to know every detail of a complex enterprise. Surprising a CEO triggers understandable defensiveness. Even if the board raises good questions, a CEO who feels ambushed can lose objectivity and may be unwilling to reconsider a matter for fear of looking weak.

The intent of a “no surprises” rule isn’t to bar spontaneous questions but to respect management and allow good preparation. If a director deliberately or repeatedly violates the red rule against surprises, the Board Chair should speak with the member and – if the behavior continues – stop the sneak attacks when they occur.

6. Never surprise the board. Similarly, when CEOs bring significant decisions to the board at the eleventh hour, without advance information or thorough committee review, members naturally resent being treated as a rubber stamp. True emergencies requiring expedited board process will occur, but they should be rare.

If a CEO or senior executives fall into a pattern of asking for approval of done deals, the board should apply the red rule and say “No, we’ll consider the matter though the appropriate committee and vote next time.” Once should be enough to send the signal that diligent governance oversight requires sufficient notice.

7. Never bring operational questions or data to the board.

CEOs and senior executives who complain that their boards get into operational details should examine their own practices first to ensure they are providing the right level of information to directors. Is the strategic plan really a management implementation plan that doesn’t focus the board on a few critical strategic success factors? Does the CFO bury critical financial indicators in voluminous financial statements instead of highlighting them on a dashboard? Is the board looking at every

JCAHO core measure instead of rolled-up or bundled measures, such as the percentage of heart attack patients who received “all appropriate care?”

If operational reports are going to the board or a committee, stop the assembly line and ensure that the board gets governance information, not management detail.

For their part, boards should articulate what they want to know, and they should ask for information that’s strategic, trended, contextual, and compared to best practice. If the board doesn’t get a comprehensive performance dashboard or balanced scorecard, invoke the red rule and ask management to work with the board to create one.

If a CEO thinks his board is wandering into operational territory, he should tactfully raise the issue and try to reframe the matter in larger policy or strategy terms. Complaining to subordinates after the fact doesn’t fix the problem. If some board members regularly “get lost in the weeds,” education or discussion of board roles at a retreat may be the remedy.

Following red rules for boards won’t produce results as dramatic as no nuclear mishaps or airline accidents. They will, however, help a board and CEO work as a team, approach tough decisions with candor, and sleep soundly because they’ve protected the mission and provided the organization with sustainability for the long term. *What are your board’s red rules?*

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