# The Board Quality Committee Goes to Work

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A decade ago, it was unusual for boards to have standing committees focused on quality and safety. With leadership from The Governance Institute, the National Quality Forum (NQF), and the Institute for Healthcare Improvement, what was once rare has become commonplace.

WE BELIEVE THAT A ROBUST BOARD QUALITY COMMITTEE is essential, if the governing body is to play its appropriate role in guiding and overseeing a hospital's quality program. Findings from analyses done in 2008 and 2009[1] in fact substantiate this belief: having a standing board quality committee correlates with better performance on quality measures. Previous columns have addressed the distinction between committee work and that which needs to be done by the board as a whole, and the importance of role clarity between system and subsidiary boards. This column is designed to offer the quality committee a blueprint for effectiveness.

## Start with the Right People

Many quality committees are too large, including everyone from the management team who "touches" quality. This is a mistake. It may be helpful to think about composition of the finance committee as a template for the quality committee. The committee should be led by a board member (preferably a non-physician board member) with an interest and background in quality, and include a number of other trustees. It should be staffed by those who direct the hospital's quality efforts, including the VPMA or CMO, physicians representing the work of the medical staff, as well as the management personnel who direct efforts related to quality, risk management, patient satisfaction, and patient complaints.

## Set the Right Goals

On an annual basis, the committee should request an updated and comprehensive quality plan from management, a plan created with input from staff as well as physicians. In the review and modification of this plan, the board quality committee has the prerogative—and in fact the responsibility—to frame serious goals that embody the board's commitment. Complacency, modest ambitions, and defensiveness must be challenged. The plan needs to include an overview of how staff and physicians will work to advance quality, what data will be gathered and how it will be analyzed, and what reports the quality committee will see. Again, think about finance. The board should be knowledgeable and informed in both areas but the entire board does not have to be as steeped in the details as the committee.

1 See Joanna Jiang, Carlin Lockee, Karma Bass, and Irene Fraser, "Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders," *Journal of Healthcare Management*, Vol. 53, No. 2, March/April 2008 (AHRQ analyzed data from The Governance Institute's 2006 quality survey and reported the findings in this article); and Joanna Jiang, Carlin Lockee, and Irene Fraser, "How Hospital Governing Boards Enhance Quality Oversight: An Application of the Agency Theory Perspective," conference paper, International Conference of Academy of Innovation and Entrepreneurship, Beijing, July 2009.

## Select the Right Clinical Measures

There are more quality measures available than any committee could possibly track. The committee needs, through its annual planning ritual, to identify a set of measures that it will track regularly, changing these measures as necessary over time. Some unstructured discussion is necessary as well, allowing unanticipated problems and new ideas to surface.

The measures selected should include some from each of the following categories:

1. Publicly reported measures (such as CMS "core measures"), allowing ready comparison with other institutions.
2. *Trends* in complications, length of stay, readmission, resource utilization, and so forth (trends allow comparison with your own previous performance, enabling the organization to set goals towards "zero" or "perfect" care).
3. Measures addressing safety and efficacy of new or high-risk procedures.
4. Measures addressing effectiveness in treating your most commonly seen conditions and procedures.
5. Measures tracking performance on national initiatives (such as IHI programs).
6. Measures tracking your performance on initiatives launched in response to some particular local finding or experience.
7. Summary results of peer review activity.
8. A log of critical incidents (lawsuits, unanticipated deaths, occurrences reported to regulators or licensing boards, etc.) and staff's analyses of these incidents.
9. Measures of culture (see below).

## Focus on Culture

Through its Safe Practices Guidelines, NQF sets, as its first recommendation, the development of a culture of safety. This tenet is at the top of the list for a reason. The challenge, of course, is that culture is hard to quantify. There are a number of surveys, including one available free of charge from AHRQ, that attempt to quantify culture. Other proxies for culture include physician engagement, employee satisfaction, reten-

*continued on page 2*

*continued from page 1*

tion rates, patient satisfaction, and the results of focus groups with staff or patients.

## Accent the Quality/Operations Interface

The way work is done in a hospital connects in a direct way with its quality and safety results. Are processes efficient or chaotic? Is communication crisp or sloppy? Are methodologies like Lean and Six Sigma employed regularly? In reviewing the analyses and action plans brought forward by physician leaders and management, the committee must assure that activities on the quality front are thoroughly integrated with operational process improvements.

## Drive the Integration of Quality and Finance

All too often, quality and safety work takes place in one "silo," with financial matters overseen completely separately. This process risks sacrificing effectiveness for efficiency. Periodic contact between committee chairs is useful to highlight areas where quality impacts cost (lack of payment for avoidable errors) and cost impacts quality (resources needed to advance quality activities). We suggest that all capital allocation processes include the calculation of a "quality and safety ROI" as a way of integrating these two perspectives.

## Tap the Voice of the Patient

It is important for the committee to spend some time looking past the metrics to touch the human experience of being a patient, whether by inviting patients to the committee to describe their experiences, by studying focus group results, or by viewing videos of focus groups. This activity informs and enriches all of the work described above.

## Conclusions

The board quality committee has critical work to do—setting organizational goals, monitoring performance, overseeing management's action plans, and selecting a set of critical issues to bring to the entire board. The committee's culture must be one of robust engagement, marked by high standards and a willingness to ask the hard questions. The use of dashboards, a commitment to transparency, and attention to the voice of the patient are essential. This work allows board members a deep sense of pride and purpose, as they drive institutional success in the area fundamental to every hospital's identity—it's care of patients.