Spring 2006 Vol. VI, No. 1 REPRINT

GREAT BOARDS

Published by Bader & Associates Governance Consultants, Potomac, MD

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.

"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."

*See **quality,** page 2*

quality *from page 1*

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 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 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:

*See **quality**, page 3*

7 Board Tools

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

quality from page 2

• 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 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 a board reviews goes a long way in determining whether it's focused on the big picture or the micro-environment.

• 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 death in hospitals once considered an unavoidable complication of critical care. According to reports on the IHI's Web site, *www.ihi.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,

*See **quality**, page 4*

quality, from page 3

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 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 pneumonic, "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.

> *"The board has to encourage management to think in a more strategic way about quality and to view quality as a competitive advantage."*
>
> David B. Nash, M.D., M.B.A.
> Jefferson Medical College

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, 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

*See **quality**, page 5*

GREAT BOARDS

The online newsletter for healthcare boards

Publisher: Barry S. Bader
Editor: Sharon O'Malley

For a free subscription,
log onto www.GreatBoards.org
E-mail: info@GreatBoards.org

quality, from page 4

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**

Barry S. Bader is publisher of Great Boards and president of Bader and Associates, a Maryland-based governance consulting firm. Sharon O'Malley is editor of Great Boards.

*See **succession**, page 6*

Quality and Patient Safety

Engaging Your Board to Take the Lead.

Patient safety became a rallying cry in 1999 when the Institute of Medicine (IOM) released its finding in “To Err Is Human” that as many as 98,000 people in American hospitals die annually as a result of preventable medical errors. These deaths represent the tip of the iceberg in terms of the opportunity to make healthcare safer. For example, with every medication error that results in death, another 10 errors cause non-fatal harm and 100 cause no harm.

The study has brought about many activities, including the JCAHO’s national patient safety goals, the Institute for Healthcare Improvement’s (IHI) 100,000 Lives Campaign, sentinel event reporting, and a plethora of other patient safety activities. Clinical improvement initiatives also have increased, most notably pay-for-performance programs.

Board trustees support the push for patient safety. Sentinel events are out of the closet, reported and discussed by board committees. Boards receive patient safety indicators and monitor improvement projects. Trustees want to do the right thing, and without question they are making our hospitals safer.

Yet the evidence indicates that progress has been incremental rather than systemic. An analysis conducted by R.M. Wachter, titled “The End of the Beginning: Patient Safety Five Years After To Err Is Human” (*Health Affairs*, Nov. 30, 2004), found greater awareness but few changes in resources, culture and information technology to make a measurable dent in medical errors. Patients count on hospitals to provide safe care and facilities, but preventable deaths equivalent to a jumbo jet crashing every day does not fulfill their trust.

In a *Harvard Business Review* article, “Fixing Healthcare From the Inside, Today,” published September 2005, S.J. Spear, a senior fellow at IHI, describes why the root causes of preventable errors are deeply embedded in the traditional culture and processes of the healthcare system. Healthcare professionals are resistant to the standardization of safe practices and mandatory checklists, which typically are accepted practices in other complex industries, such as air transportation. Hospitals have been slow to adopt fail-safe information systems to prevent medication mishaps and diagnostic errors, impeded by insufficient funding and physician resistance to integrating new information technology into their work habits. Hospital staff respond to flawed processes—to broken processes, such as delaying getting drugs for patients, and with work-arounds such as stockpiling medications—because they lack the time, resources or management directive to redesign the processes to work better.

These engrained cultural barriers will not change quickly or easily, but rather will require sustained effort and resources. Fundamental change cannot be accomplished without the engagement of board and senior executive leadership.

Why Boards Are Not Leading

Boards and executives need to adopt a deliberate leadership strategy to develop the board’s quality competency and engage its full potential. Most executives try to educate their boards about quality and patient safety and involve them in these initiatives, but CEOs voice frustration that their boards “are supportive but passive, don’t really understand clinical information, get mired in the details and can’t see the big picture.”

Contrast that with how many boards tackle their financial responsibilities. They adopt a laser-like focus on key measures of performance, demand understandable explanations of variances and do not ease up until performance improves. They ask probing questions and support tough decisions.

Copyright Healthcare Executive, March/April 2006, pgs 64 to 67. **ache.org**

They bring relevant perspective from private industry. In short, they lead, they do not just follow.

Why are boards not equally tenacious with regard to patient safety and quality? First, there has been an over-reliance on educating trustees in patient safety issues. Education is vital, but to expect that education can transform a group of well-intentioned volunteers into expert quality overseers is simply unrealistic. Just as the Sarbanes-Oxley Act calls for financial experts on corporate board audit committees, healthcare boards need a few members with quality expertise on the quality committee.

Second, there is an almost mystical belief that dashboards will spur improved performance. Performance metrics are important, but as Robert Lloyd, executive director of Performance Improvement at IHI, commented, measures alone are not self-actualizing and thus do not automatically trigger improvement. Many dashboards have so many indicators that trustees lose sight of the vital few measures of mission success which really matter. Dashboards need to be linked to accountability.

Third, a lack of transparency still keeps boards unaware of deep-rooted quality and safety problems. Fear of liability and punishment contribute to a culture in which errors and problems are not openly discussed and solutions are not sought. Board quality committees need to become a forum for candid discussion and exploration of improvement needs.

Finally, and perhaps most importantly, many boards and executives have failed to distinguish a governance role that adds value to quality and patient safety. Boards have been told they must be the super cops of quality and safety or risk loss of accreditation. Consequently board and quality committees are drowning in detailed reviews of quality-related operations that lead to tedious meetings and occasional meddling.

Instead healthcare boards should refocus their work around the overarching goal of redesigning their part of the healthcare world to be the safest, best quality, most efficient and best-managed organization it can possibly be. The board should approve a limited number of high-level performance goals; require management to redesign the dashboard reports around those goals; support significant investments in culture development, quality measurement and information technology; and truly hold management and physicians accountable for results.

Optimizing the Board's Engagement in Quality and Safety

A board that wants to fully harness its potential to advance quality can build its competency through five stages of development:

1. **Recruitment.** The board explicitly recruits several members for their competencies in quality, safety and customer satisfaction in both industry and healthcare. Clinicians with a passion for and training in quality improvement and patient safety should be sought. In addition, individuals who can quickly grasp complex issues and ask probing questions—attorneys, college and university presidents, and corporate executives come to mind—can help a board understand quality and safety issues.

2. **Awareness.** Education is not a panacea, but it is the foundation of effective governance. The board has a formal orientation and continuing education process that makes board members aware of:

   - External quality and patient safety requirements in an era of increased governance accountability and transparency.
   - The board's responsibilities for clinical quality, patient safety, customer service and (for hospital boards) physician credentialing.
   - The need and opportunity to improve quality and safety communicated through objective data (such as the IOM medical errors study) and through powerful stories of real errors made on real patients.
   - The organization's programs to measure and improve quality and safety.

3. **Literacy.** Board education can develop trustee literacy on such issues as:

   - How to read scorecards and spot red flags for clinical outcomes, patient/customer satisfaction and employee satisfaction.
   - National trends in healthcare quality, such as pay for performance and IHI's 100,000 Lives Campaign.

4. **Application.** The board abandons passive tendencies and actively engages on quality issues. Examples include:

Copyright Healthcare Executive, March/April 2006, pgs 64 to 67. **ache.org**

- Asking when a problem involving a care process will be fixed and when the board (or board quality committee) can expect a report back.

- Ensuring the annual quality and patient safety improvement plans have sufficient resources and are integrated with the organization's strategic and financial plans.

- Challenging a medical staff recommendation that falls short of the board's expectations.

- Incorporating quality and safety goals into the CEO's performance evaluation and incentive compensation.

5. **Work that adds value.** The board makes a distinctive, substantive contribution to the organization through its work. Examples will vary among organizations but may include:

- Challenging the organization to raise the bar—for example, winning the Malcolm Baldrige National Quality Award or, as one health system has done, setting a goal of zero deaths due to errors by 2008.

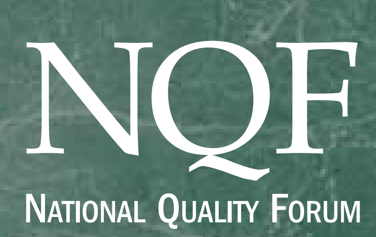
- Inspiring management to rethink its approach to integrating information technology into care delivery.

- Communicating the hospital's quality initiatives and results to key stakeholders.

Boards have long represented the best and brightest of the community. Tremendous potential lies in those communities, boards and medical staffs. An intentional approach to board engagement can reap rewards for the entire organization. ▲

Barry S. Bader is a governance consultant based in Potomac, Maryland. He is one of The Governance Institute's governance advisors and counsels boards on practices to enhance their effectiveness. Bader can be reached at bbader@greatboards.org.

Copyright Healthcare Executive, March/April 2006, pgs 64 to 67. **ache.org**



Hospital Governing Boards and Quality of Care: A Call to Responsibility

December 2, 2004

Background

It is well established that hospital governing boards (e.g., boards of trustees) have responsibility for the quality of care provided in the institutions they govern.[1] However, hospital boards generally have been rather passive in their approach to quality improvement, leaving this responsibility to the medical staff or delegating it to a quality committee of the board.

The board's role in ensuring quality of care is of increasing importance as public reporting of quality data and rewarding performance activities become more prevalent; however, board members often express confusion and uncertainty about what exactly they need to do to fulfill their responsibilities in this regard. Indeed, the specific responsibilities of hospital governing boards for improving quality and the most effective methods by which boards can assure that facility management is fulfilling its obligation regarding quality of care are not well defined. More clearly defining these responsibilities would likely benefit hospital quality of care.

At present, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) sets forth a set of expectations and responsibilities for hospital boards, and various hospital governance experts promote algorithms detailing board responsibilities. However, there is no comprehensive, consensually produced guidance available for trustees who wish to measure the quality of their governance against objective standards. This is especially so in the area of clinical quality improvement.

National Quality Forum Workshop on the Role of Hospital Trustees in Quality Improvement

During the past two years, the National Quality Forum (NQF) has been approached by multiple entities about whether it would be willing to articulate specific expectations of boards of trustees regarding their roles and responsibilities and the degree of their oversight for quality improvement.

On March 30, 2004, the NQF convened a meeting to help determine how it might best help hospital trustees monitor their governance of and accomplish their obligations for quality improvement. In light of recent reports raising concerns about patient safety and healthcare quality, the meeting especially focused on three questions:

1. What strategies and tactics should hospital governing boards employ to best fulfill their responsibility of improving the quality and safety of care in their facilities?
2. How can hospital governing boards assure that facility management is fulfilling its obligations regarding quality improvement?
3. How can the NQF help motivate and support hospital trustees in the accomplishment of their obligations regarding healthcare quality improvement? More specifically, what role might the NQF play in articulating expectations, strategies, or standards regarding the role and responsibility of boards of trustees in improving quality and safety?

One of the recommendations of the participants at the NQF Workshop on Hospital Governance and Quality Improvement was that the NQF should issue a "Call to Responsibility" for hospital governing boards.

Following the workshop, the NQF prepared a draft statement, which then underwent review by the workshop participants. The statement then was reviewed and amended per widespread public and NQF Member comment before its ultimate approval by the NQF Board of Directors.

[1] Lister E, Cameron DL. The role of the board in assuring quality and driving major change initiatives—part 1: maintaining organizational integrity. *Group Practice Journal.* 2001;50:13-20.

A Call to Responsibility

The NQF, representing nearly 300 consumer, healthcare provider, healthcare payer, and other organizations, approved the following "Call to Responsibility" for hospital governing boards on December 2, 2004.

Principles for Hospital Boards of Trustees

The NQF strongly encourages hospital governing boards to become actively engaged in quality improvement. The NQF calls upon hospital governing boards to review their policies and practices to make sure that they are consistent with the following principles. The NQF recognizes that hospital boards vary widely in composition and governance authority, but believes that these principles are intended to apply to all boards:

1. Hospital governing boards play a vital role in monitoring and improving hospital care to ensure that it is safe, beneficial, patient centered, timely, efficient, and equitable.[2] Indeed, hospital governing boards are responsible for ensuring the quality of healthcare provided in their institutions.[3]

   To fulfill their role in ensuring quality, hospital governing boards should:

   a) Ensure that healthcare quality is a paramount priority and a primary focus of board activities. Pragmatically, boards may wish to take a more active role in ensuring quality by beginning with a focus on patient safety, recognizing that safety is a subset of quality and that the infrastructure needed to ensure safety is materially the same as that needed to ensure high quality.

   b) Prominently place patient safety and quality issues (e.g., reviewing errors and their impact on hospital resources) on board meeting agendas to ensure that the treatment by board chairs accorded to these issues equals—or exceeds—that accorded to finances.

   c) Proactively oversee and evaluate patient safety and healthcare outcomes and the creation of a culture of safety by engaging in patient safety and quality improvement projects, establishing governance practices that support a system of performance measurement and quality improvement, and holding management accountable for poor performance, adverse outcomes, and their remedies.

   d) Ensure that a system of performance measurement and quality improvement is in place and that credible results enable the evaluation of the organization's effectiveness.

   e) Recognize physicians' roles, the role of the medical staff within the hospital, and the roles of nursing executives and other clinical leaders (e.g., pharmacists, infection control professionals) in achieving quality by engaging them in quality improvement efforts.

   f) Assure that hospital leadership adopts human resource policies and physician staff bylaws that articulate specific expectations of staff's involvement in quality improvement, adheres to hospital policies designed to ensure the safety of patients and staff, and receives adequate training (e.g., educational preparation, technical competency, and continuing education) in quality-related content areas (e.g., performance measurement, quality improvement).

   g) Ensure that hospital management is capable of and focused on the analysis and improvement of organizational design that supports the ongoing, systematic assessment and optimization of patient safety and quality of care, including the facilitation of internal reporting mechanisms between management and line staff, and that resources are made available for this purpose.

   h) Align budget development and financial resources with the organization's quality and patient safety goals to ensure dynamic and ongoing review and consideration of such priorities—and plans for continuous improvement—when developing and executing capital budgets and other financial strategies and decisions.

   i) Actively support management's negotiation of payment contracts that do not penalize the organization for its investment in quality and safety, recognizing that such investments are equal to, if not more important than, those designated for service capacity and/or facility improvements.

2. To enable effective evaluation of their own role in enhancing quality, hospital governing boards should:

   a) Advocate for diverse board composition with specific expertise in quality, patient safety, and clinical areas including, but not limited to, physicians, nurses, industrial engineers, pharmacists, consumers, and others with qualifications in modern business management, organizational design, and healthcare administration.

   b) Review their own performance—individually and collectively through established measures developed for this purpose—in improving hospital care by assessing the extent to which the board's oversight and leadership influences quality and safety in the facility.

[2] In *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), the Institute of Medicine identifies six aims of the healthcare quality system: that it should be safe, effective, efficient, timely, patient centered, and equitable. In 2002, the NQF endorsed the consensus document, *A National Framework for Healthcare Quality Measurement and Reporting,* which lays out similar aims for the healthcare system but states that one aim should be beneficial, which encompasses but also goes beyond effectiveness.

[3] This responsibility can be delegated to a hospital-level committee that reports directly to the board in those cases where an institution is part of a larger multihospital system.

3. Hospital governing boards should develop a "quality literacy" regarding patient safety, clinical care, and healthcare outcomes. This literacy should:
   a) At a minimum, include education in the infrastructure of patient safety, healthcare quality, and performance measurement, incorporating clinical education, as appropriate, as well as the business case for quality.
   b) Recognize the role of the board of trustees in representing consumers and the community it serves.
   c) Be comparable and akin to their knowledge and understanding of the institution's financial health and well-being vis-á-vis the Sarbanes-Oxley Act.[4]
   d) Where appropriate, utilize existing organizations (e.g., Quality Improvement Organizations, the Governance Institute, the Healthcare Trustee Institute, the American Governance & Leadership Group, JCAHO) and their resources to provide courses, training, and information to assist in fulfilling these expectations for quality literacy. In instances where existing tools and resources are not available, hospital boards should collaborate with organizations to develop and commission such tools.
4. Hospital governing boards should oversee and be accountable for their institutions' participation and performance in national quality measurement efforts and subsequent quality improvement activities:
   a) Hospital boards should ensure that their participation in national quality improvement activities focus on nationally agreed-upon priorities[5] and those that are critical to their own institution.
   b) Participation in one or more existing efforts, including, but not limited to, the Hospital Quality Alliance,[6] NQF-endorsed national voluntary consensus standards,[7] JCAHO National Patient Safety Goals,[8] the Leapfrog Group, and other national performance reporting/benchmarking systems,[9] should be realized.
   c) Performance data derived from participation in national quality improvement efforts and presented by appropriate hospital personnel (e.g., chief medical officer, nurse executives, pharmacists) need to be consistently reviewed by the board, no less frequently than the board reviews the institution's financial metrics, to determine performance and drive improvements in patient safety and healthcare quality.
   d) Based on such data, a determination of the cost implications of adverse events and poor performance that impact profitability and compromise organizational performance—and an understanding that quality improvements can result in cost savings—should be calculated, including, but not limited to, legal, personnel, regulatory, and marketing costs.
   e) Performance should be evaluated in the context of the six NQF aims (i.e., safe, beneficial, patient centered, timely, efficient, and equitable) for quality improvement.
   f) Hospital boards should hold accountable and require full and complete explanations from management when safety and quality performance levels differ significantly from national benchmarks or fall below expectations, with specific attention devoted to the organization's plan for improvement (e.g., its development, performance expectations, and the basis on which expectations are established). Boards should then monitor management's progress with these plans at least quarterly and consider action if shortfalls are not eliminated in a timely manner.
   g) In the context of these performance levels, hospital boards should facilitate the adoption of incentive programs for hospital executives and management based on explicit rewards for results and related quality improvements.

[4] On July 30, 2002, President George W. Bush signed into law the Sarbanes-Oxley Act of 2002, which added many new—and revised many existing—provisions of the federal securities laws. To protect the interests of investors and, more generally, the public, this federal law establishes the status, duties, composition, powers, rules, and reporting of boards for all public companies that are subject to securities law. See www.sec.gov/divisions/corpfin/forms/exchange.shtml. Last accessed January 30, 2005.

[5] NQF. *National Priorities for Healthcare Quality Measurement and Reporting.* Washington, DC: NQF; 2004.

[6] The Hospital Quality Alliance was initiated in December 2002 by the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges. Since that time, a number of additional organizations have joined this effort to make critical information about hospital performance accessible to the public: the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), NQF, the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality, the American Medical Association, the Consumer-Purchaser Disclosure Group, the AFL-CIO, AARP, the National Association of Children's Hospitals and Related Institutions, the American Nurses Association, and others.

[7] To date, NQF has endorsed national voluntary consensus standards for acute care hospitals, nursing homes, cardiac surgery, nursing, and diabetes, and has endorsed national consensus standards on safe practices for better healthcare and serious reportable events in healthcare. Additionally, NQF has endorsed frameworks for a national healthcare quality and measurement and hospital performance evaluation.

[8] As of January 1, 2004, all JCAHO-accredited healthcare organizations began to be surveyed for the implementation of the 2004 National Patient Safety Goals.

[9] National performance reporting/benchmarking systems include those operated by JCAHO, CMS, the American College of Cardiology, the Society for Thoracic Surgeons, the Vermont Oxford Network, the American College of Surgeons, the Leapfrog Group, and others.

Principles for Other Hospital Stakeholders

Although hospital governing boards play a pivotal role in improving patient safety and healthcare outcomes, it should be recognized that other hospital stakeholders influence successful hospital governance. To this end, the NQF calls upon other hospital stakeholders to support boards of trustees and hospitals in this enterprise.

1. Policymaking organizations responsible for establishing standards and/or developing regulations in this area should ensure currency with scientific evidence and federal and/or state regulations:
   a) Policymakers should ensure that any regulations in this area address the highest standards for the role of hospital governing boards in quality improvement.
   b) Specifically, JCAHO and CMS should continue to review and update their hospital accreditation standards to ensure currency, consistency, and alignment.
2. Consumers—both individually and in organized forums—should expect hospitals' boards of trustees to represent their interests in overseeing quality of care:
   a) Consumers should expect to be represented on boards and/or be vocal to the board about their experiences and expectations with hospital care.
   b) Consumers should urge and encourage hospitals in their community to participate in local, regional, and national public reporting initiatives.
3. Payers (i.e., public and private entities) should align payment systems with hospital quality and safety improvements:
   a) Purchasers and health insurance plans should consider the role of hospital governing boards in quality improvement, including public accountability, in their contracting and purchasing arrangements (e.g., "shared savings" arrangements).
   b) They should also consider the impact of improvements in safety and quality on payment mechanisms (e.g., analyzing and evaluating the quality and safety ramifications of all major financial negotiations, rewarding for performance).

Future Action

In approving this document, the NQF Board of Directors agreed that it should be distributed widely with the expectation that hospital trustees exert their appropriate role in quality improvement. This document will be reviewed periodically for the need to update it.

National Quality Forum

601 Thirteenth Street, NW - 500 North, Washington, DC 20005
Ph 202.783.1300 Fax 202.783.343
www.qualityforum.org

Hospital Governance and Quality Improvement

Washington, DC ■ March 30, 2004

Workshop Participants

Kenneth W. Kizer, MD, MPH (Co-Convener)
National Quality Forum, Washington, DC

Eric D. Lister, MD (Co-Convener)
Healthcare Trustee Institute and Ki Associates, Portsmouth, NH

Daniel T. Roble, Esq. (Co-Convener)
Ropes & Gray LLP, Boston, MA

Harris Berman, MD
Tufts University School of Medicine, Boston, MA

Carmella Bocchino, RN, MBA
America's Health Insurance Plans

Frank E. Carlton, MD
Memorial Health University Medical Center, Savannah, GA

Gordon R. Clark, MBA
The Governance Institute, San Diego, CA

Carmela Coyle
American Hospital Association, Washington, DC

Robert M. Dickler
Association of American Medical Colleges, Washington, DC

Richard de Filippi, PhD
Cambridge Health Alliance, Cambridge, MA

Irene Fraser, PhD
Agency for Healthcare Research and Quality, Rockville, MD

John R. Griffith
University of Michigan, School of Public Health, Ann Arbor, MI

Neil Jesuele
American Hospital Association, Washington, DC

Charles N. Kahn, III
Federation of American Hospitals, Washington, DC

James R. Knickman, PhD
The Robert Wood Johnson Foundation, Princeton, NJ

David J. Lansky, PhD
FACCT-Foundation for Accountability, Portland, OR

Russell Massaro, MD
Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL

Catherine E. McDermott
National Committee for Quality Health Care, Washington, DC

Linda Miller
Volunteer Trustees of Not-for-Profit Hospitals, Washington, DC

Woodrow A. Myers, Jr., MD, MBA
WellPoint Health Networks, Thousand Oaks, CA

Debra L. Ness
National Partnership for Women & Families, Washington, DC

James E. Orlikoff, MA
Orlikoff & Associates, Inc., Chicago, IL

Karen Titlow, MA, PT
Leapfrog Group, Washington, DC

Susan Van Gelder
Federation of American Hospitals, Washington, DC

NQF Staff

Ellen T. Kurtzman, RN, MPH
Senior Program Director

Christine M. Page-Lopez
Research Assistant

© 2004 by the National Quality Forum. All rights reserve.