Hospital Boards and Clinical Quality: A Practical Guide

James L. Reinertsen, M.D.

Introduction

Hospital Boards vary widely in size, composition, and how members are appointed. But most Boards have one thing in common: the majority of the members are typically not health care professionals, such as doctors or nurses. Instead, they tend to be community leaders who have expertise in banking, or politics, or engineering, or real estate…almost anything but the delivery of health care. It is therefore no surprise that Boards have historically focused most of their attention on the hospital's finances, facilities, and strategic plans—things the trustees believe they know something about—and have delegated responsibility to the medical staff for assuring the quality and safety of care.

During the last 5 to 10 years, there has been a dramatic increase in public awareness of quality and safety problems in hospitals. Stories of medication errors, hospital acquired infections, wrong-site surgeries, and needless deaths have dominated the headlines. Hospital performance reports on reliability of evidence-based medicine, safety, and mortality rates for various procedures have become widely available on the internet. Those who live in each hospital's community—the "shareholders" or "owners" whom the Board represents—are putting pressure on the Boards to make the hospital safer. And governmental leaders—the regulators to whom the Board is ultimately accountable—are placing ever higher levels of regulatory and legal pressure on hospitals for improvement.

The result is that many hospital Boards are learning that they cannot continue to simply delegate the responsibility for quality and safety to the medical staff. Rather, the Boards themselves must set more aggressive aims, review better data, ask harder questions, and establish higher levels of accountability for performance in clinical care. In essence, Boards must now perform the same high level of oversight for quality and safety that they have done for finance.

This realization has caused many Boards—and particularly the lay members of those Boards—to ask, "How can we more effectively oversee clinical quality and patient safety when we don't know anything about the technical and professional issues in health care?" This paper is intended as a practical guide in answer to that question.

How Boards Can Make a Difference in Clinical Quality

At its core, successful leadership of improvement requires generation of a strong *Will* to improve, good *Ideas* for improvement, and effective *Execution* of those ideas.[1] Because the majority of Board members are not clinically trained, Boards tend not to be primary sources of specific *Ideas* for how clinical care might be improved. But Boards do play a strong role in *Will* and *Execution*—and in another function essential for the long-term transformation of hospitals—*Constancy of Purpose.*

> *Will*: As the highest authority in hospitals, governing Boards play a vital role in the generation of the will to improve. When organizations are weak-willed, and lack the "spine" to push through fear of change and other barriers to improvement, the failure to improve is often traceable to the Board, and specifically, to the signals that may have been sent (in many instances, unwittingly) saying, in effect, "The Board is not really serious about making this change." For example, when Boards adopt good policies such as "mandatory safety timeouts before all surgical and other interventional procedures" but then hesitate to act when they learn that the policies are being routinely ignored by some staff members, they are signaling the absence of will to improve safety.
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> *Execution*: It is not the responsibility of Board members to go out into their hospitals and make changes happen. But it is the Boards' responsibility to *expect* the changes to happen, and to hold executive teams to account for results. Boards can drive effective execution through rigorous oversight of management teams' performance, and in particular, by paying close attention to key performance data on quality and safety.
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> *Constancy of Purpose*: It has become painfully clear to all those working to improve quality and safety that what hospitals require are not quick fixes, but rather, complete transformations. The lessons from Toyota and other quality leaders outside of health care indicate that organizational transformations require time—10 to 15 years, or even more. In other words, given the turnover rate of hospital executives, "transformation is at least a 3-CEO problem" as one US hospital leader phrased it. The quality and safety transformation cannot be the pet project of any one CEO. The Board must function as a deep reservoir of constancy of purpose, if hospitals are to reach dramatic levels of improvement.

[1] Provost, L, D Miller, and J Reinertsen: IHI Framework for Leadership of Improvement. http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/AFrameworkforLeadershipofImprovement.htm accessed October 23, 2007

The good news is Boards *can* do this job. And when hospital Boards change their governing practices, and start to generate will, drive execution, and establish constancy of purpose, it makes a difference in measured quality results.[2,3] The Institute for Healthcare Improvement has recognized this in the 5 Million Lives Campaign to reduce harm in hospitals, by placing major emphasis on the role of the Board in safety.[4]

What do the best Boards do to oversee quality and safety, and more practically speaking, *how* do they do it?

How Boards Generate and Sustain *Will*

Put a face on the problem.

When Jim Conway was the COO of Dana Farber Cancer Institute, he visited another hospital to tell the story of Betsy Lehman, a Boston Globe health reporter who died in 1996 after a massive overdose of chemotherapy at Dana Farber. This experience catalyzed the transformation of Dana Farber's approach to patient safety. After Conway's presentation, a Board member in the other hospital said, "I'm glad that those sorts of things don't happen here." At that point the CEO of that hospital said, "Oh, but they do!" The Board member replied: "But you never told us." The CEO insisted that he had showed the Board regular reports on the incidence of safety events and other quality data. At which point the Board member said, "But you never told us in a way we could understand it."

Perhaps the most powerful way to "tell it so that trustees can understand it" is to make sure that patient's *stories* are told to the Board. Many Boards now make it a standard practice to start every Board Quality Committee meeting (and some full Board meetings) with a brief patient story—often a story about harm—to put a face on the data that the committee will be reviewing during the meeting. The story can be told by a nurse, doctor, or administrator, but is most powerful if told in person by the patient or family member. To avoid various pitfalls (e.g. spending the entire meeting discussing arcane medical details, or getting bogged down in ad-hoc problem solving), here are some good guidelines for how to tell stories at Board meetings:

- Make sure it's a story about an event in *your* hospital (to avoid the perception that this is someone else's problem)
- Make it a recent event (to avoid the perception that "We used to have that problem but we fixed it."
- Avoid use of patients or staff names (to avoid any temptation to blame individuals)

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[2] Alexander JA, Lee SD. Does governance matter? Board configuration and performance in not-for-profit hospitals. *The Milbank Quarterly*. 2006;84(4):733

[3] Joshi MS, Hines SC. Getting the board on board: Engaging hospital boards in quality and patient safety. *Joint Commission Journal on Quality and Patient Safety*. 2006;32(4):179-187.

[4] 5 Million Lives How To Guide: Governance Leadership. http://www.ihi.org/nr/rdonlyres/95eadb8f-3ad6-4e09-8734-fb7149cfdf14/0/boardhowtoguide.doc accessed October 31, 2007

- If staff is telling the story, use a script (to keep the story short, and avoid unneeded medical details)
- If you invite a family member or patient to tell the story, meet with them in advance to make sure they focus on their experience of the event, rather than the medical details
- If possible, juxtapose the telling of the story and the display of relevant data. For example, if the story is of a patient with a hospital-acquired central line infection, show the run chart of the number of such infections over the past year or two.

  Example: Delnor-Community Quality Committee: Delnor-Community Hospital in Geneva, Illinois has adopted the practice of telling a patient story at the start of every Quality Committee meeting. The Committee invited an 81-year-old patient who had undergone 3 months of procedures treatments for an infection that occurred after a June hip replacement. In just ten minutes, this delightful retired machinist described his experience, ending with *"I would call the last 3 months my 'lost summer.' And I'm 81. I don't have many summers left."*

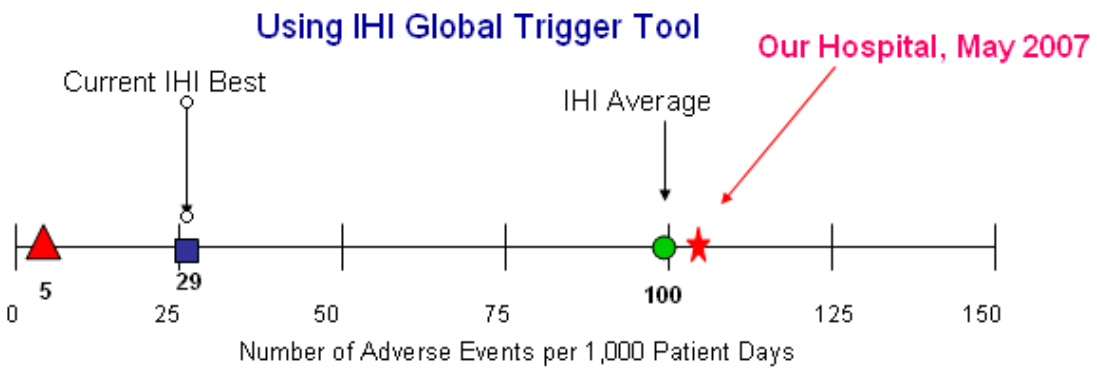
  The next item of the Committee's agenda was a review of surgical site infection rates. With the story of the "lost summer" ringing in their ears, the Committee members started asking very pointed questions about surgical site infections, with an invigorated sense of *Will* to improve performance.

Mind the gap

Another way in which Boards can generate Will is to ask that administrators bring them the answer to the question "Who is the best in the world at this?" The gap between current performance and "best in the world" is a strong source of energy for improvement.

There is an important difference between this "best in the world" inquiry and simply asking "How do we compare to others?" Too often, the answer to the second type of question is comfortingly framed, in reference to deciles of performance, or the median. Statements such as "We're better than the average performance for hospitals like us," or perhaps "We're in the top 25% of hospitals in this dimension of safety" tend to be soothing answers to the Board, and reinforce the status quo. On the other hand, statements such as "We may be better than average, but the best hospitals in the world have 10 times fewer infections than we do!" drive the Board to ask the question "Why can't we do that?"

One excellent practice is to put the "best in the world" line on every run chart or other graphic display of performance, so that the Board sees the gap at every opportunity. The following display from the Institute for Healthcare Improvement's "Toyota Specifications for Healthcare" is a good example of how "minding the gap" can build and maintain the Will to make necessary changes.



Go transparent

It is good to be aware of a quality or safety "gap" in the boardroom. But it is even better to extend that awareness throughout the organization, and to the patients and community you serve. There is no more powerful method to create Will to improve than to bare the hospital's performance to the world. After all, "If you're going to be naked, it's good to be buff."[5]

It takes courage to adopt policies of real transparency. Boards (and executive leaders) often express fear that if they go public with their less-than-optimal data, patients will leave them and go to competitors, or malpractice lawyers will pounce on the data, or regulators will descend on the organization. It's therefore common for hospitals to show only their best data, the performance they're proud of, on billboards and brochures.

But there is no evidence that patients leave hospitals when they forthrightly report *all* their quality and safety data—whether good, bad, or ugly—nor is there evidence that these reports invite lawsuits and regulatory inspections. There is good evidence, however, that transparency drives hospitals to improve, especially in areas of performance that don't look so good.

Cincinnati Children's Hospital offers a dramatic example of transparency. When Lee Carter, Chair of the Board, learned along with the rest of the Board that children in the hospital's care experienced serious harm once every 21 days, Mr. Carter and the Board set an aim to reduce this rate dramatically, and quickly—an 80% reduction, within 18 months. As one of the strategies to achieve that aim, the Board approved a policy of complete transparency about patient safety and harm. As a result, the screen saver on every computer in the hospital now prominently displays the "Number of Days Since a Child Was Last Harmed." All staff, as well as patients and families, see this number each time they look at a computer. And when the number goes to zero, as it does now and then when a new harm event has occurred, a new box appears on the screen saver that allows staff and parents to read a short description of what happened, so that all can learn about

[5] Tapscott, D and D Ticoll. *The Naked Corporation. How the Age of Transparency Will Revolutionize Business*. Simon and Schuster, New York NY, 2003

the mishap, and be better prepared to avoid that sort of harm event. Needless to say, *everyone* in the Cincinnati Children's, (including parents) are acutely aware of CCHMC's effort to reduce harm to children in their care, and safety has improved dramatically. The "Days Since Last Harm" ticker returns to zero far less often today than it did a year ago.

Courageous Boards that encourage management to show quality and safety performance data to all staff, patients, and community, will find that they have harnessed a potent force for improvement: the Will to shape up!

How Boards Drive Execution

The Achilles heel of most major change efforts is not a failure of Will or Ideas. It is the failure to Execute. How can Boards drive successful execution?

Set clear aims

Boards usually set very clear financial aims. For example, if the hospital will be going to the bond market in 2 years, the Board might state an aim to "achieve 140 days cash on hand within 18 months" because they know this will be an important factor in the hospital's bond rating.

The best Boards are now setting quality and safety aims with similar clarity, by declaring how safe or how good the hospital needs to be, by when, and how it will be measured. The Cincinnati Childrens' example is excellent: "We will become 80% safer, as measured by the Serious Safety Event rate, within 18 months." The 5-hospital WellStar system in Atlanta offers another example: "Wellstar's hospital-acquired infections will drop by 50% in FY 2008." The 70+ hospitals of the Ascension system have been driving toward a stunningly clear aim, adopted in 2003 by their Board: "Zero preventable deaths and harm within 5 years."

The value of aims like these for execution can best be appreciated by re-framing them as their opposites: vague, general statements of hoped-for goodness, such as "Ascension will work towards higher levels of safety, someday." How do murky aims hamper execution, whereas clear aims improve it?

- *Murky aims beget murky accountability*. If the Board can't state and measure what it wants the executive team to achieve, it's very difficult to hold them to account.
- *Murky aims beget murky plans*. "We hope to be better, someday" allows the plan to be "somehow." On the other hand, clear, crisp aims tend to drive the creation of well-prioritized, well-resourced plans with the necessary scale, pace, and depth to achieve real results.

So a good step Boards can take to drive execution is to make sure that quality and safety aims are framed in "how good, by when, measured how" terms.

Channel attention to quality

Boards that are serious about quality spend at least 25% of the Board's time on it. For those Boards, the Quality Report is not on the "consent agenda," but is a major feature of each meeting, often the first item on the agenda. Through this basic practice, the Board sends a powerful signal: "We're paying attention to quality." What the Board pays attention to gets the attention of management. And what management is paying attention to tends to be noticed throughout the organization. And then execution becomes more likely, because when everyone knows that "The Board is really serious about this," previously insurmountable barriers melt away, resources somehow become available, and things get done.

It is an excellent practice to do an audit of how the Board spends its time. This can be done as a rough estimate based on memory of past meetings, but it is even better if a prospective actual time measurement is made. If you find that the full Board is not spending at least 25% of its time overseeing quality and safety, consider revising your allocation of the Board's time. After all, "the currency of leadership is attention."[6] How are you spending it?

Spend quality time on quality: watch your own dots

It helps execution when Boards spend at least 25% of their time on quality. It is even better when Boards spend that time well, in activities such as hearing patients' stories, performing probing reviews of quality performance, and asking hard questions of management and medical staff leaders. Unfortunately, that has not been the experience for many trustees, who find that their Boards waste the time listening to lengthy reports on specific quality projects (mostly those that have gone particularly well), sitting passively while a few medical staff leaders get sidetracked in a technical discussion about the evidence base for a particular practice, or hearing detailed excuses explaining why their hospital's quality performance ranking versus other hospitals in the nation is unfair, because of various inadequacies in risk adjustment.

How do the best Boards avoid these traps, and make sure they spend *quality time* on quality? The key lies in the overarching question that these Boards ask about quality performance—the question which guides the design of their data reports, and frames many of their conversations. Instead of repeatedly asking the question "How good are we?" these Boards focus on the question "Are *we* getting better?"

When Boards ask "How good are we?" the answer is almost always framed in comparative terms:

- "Our central line infection rate is better than the average for the University Health Consortium"
- "We rank above the 75th decile for US hospitals in our CMS Core Measures of evidence-based care"

[6] Heifetz, Ronald A. *Leadership Without Easy Answers*. Belknap Press (Cambridge) 1994

These "compared to others" measures are perfectly fine for annual stock-taking, but are usually not helpful for the regular Board reviews that drive execution, because they almost always involve a 4-6 month delay in the feedback loop, during which data is pooled from many hospitals, processed, and then sent back to individual hospitals as percentile rankings, comparisons to average, and so forth. If the Board (and therefore management) is focusing on measures that are 6 months old, how can they respond to stagnant results with timely changes in strategy, key project leadership, or other needed adjustments?

For their regular reviews of performance, the best Boards focus on data *on their own hospital's performance over time*, designed to answer questions such as "Are we on track to achieve our aim of 80% reduction in Serious Safety Events?" and "Are we reducing the number of hospital-acquired infections in our system?" These reports can be current (no more than a month old), do not need to be risk-adjusted (your patient population is pretty much the same from month to month) and don't even need to be expressed as rates (per thousand ICU days, per 1000 drug doses…). This last point is important, especially when the Board's quality aim is expressed relative to the "theoretical ideal" (usually zero or 100%). When the aim is zero hospital-acquired infections, the Board can simply track the number of infections rather than seeing an abstract figure expressed as "x infections per 1000 line-days." Not only is this easier for lay Board members to understand, but it also encourages them to ask far more rigorous questions. And when lay Board members ask management and medical leaders "Why are we still having these infections? The best hospitals in the world have essentially eliminated them," it tends to drive execution of needed changes in hand-washing, along with higher levels of rigor in other preventive practices.

One of the best ways to drive quality and safety execution is to *watch your own dots*, constantly asking yourselves the question "Are we getting better—are we on pace to achieve our aims?"

How Boards Maintain Constancy of Purpose

If it is true that the quality transformation of health care systems will take at least 10-15 years, how do Boards dig in for the long term?

Establish a Quality Committee

It sounds very basic, but Boards that intend to take quality seriously for the long haul establish a committee that oversees quality with the same rigor that the Finance Committee oversees finances. Embedding this review process in the committee structure of the Board makes a strong statement about the permanence of quality as a key organizational strategy, and reduces the likelihood that the Board's attention will stray to other matters as the months and years go by. The design and processes of the best hospital Board Quality Committees, such as those at Allina in Minneapolis, and Delnor-Community in Geneva, Illinois, include the following features:

- The Board appoints its best trustees to the Quality Committee (i.e. this is a "prestigious" assignment for a Board member)
- The Chair or Vice-Chair of the Board is a lead member of the Quality Committee (another strong signal about the importance of this work)
- Lay trustees with expertise in quality (e.g. a manufacturing executive whose company has a long history of using Lean Production methods) are specifically recruited to the Board and appointed to the Quality Committee
- The agenda of the committee meetings is driven primarily by the Board members rather than by the administration
- The committee meets monthly
- Every meeting begins with a brief patient story to illustrate the data being considered during that meeting
- The committee regularly reviews data focusing on the question "Are we on track to achieve our aims?"
- The committee meetings are characterized by vigorous conversations with medical staff leaders and administrators about policies and strategies to achieve the aims.
- The committee considers and approves policies and strategies to improve the likelihood of achieving the quality and safety aims (i.e. the Quality Committee doesn't just listen and discuss—it acts)
- The Quality Committee reports to the Board at every Board meeting, with the Chair of the Quality Committee in the lead (i.e. the Quality Committee report is not given by the "quality staff" but by the lead director)

Send strong cultural signals

Structures and processes are important. But an even more enduring force—one with the staying power to maintain constancy of purpose over many years—is *the hospital's culture*—that set of habits and patterns of behavior and the underlying beliefs and values that prevail in the hospital. For example, one widespread cultural pattern among nurses might be stated as "We nurses follow the safety policies such as hand-washing…unless we're really busy." Another example, common among doctors, is "These safety guidelines are good for everyone else, but they don't apply to me." How do the best Boards send signals that start replacing these widespread, but hazardous cultural rules with a new, better set of habits and patterns? Here are some excellent examples:

- *What do you do when times are tough?* One unwritten cultural rule in many hospitals is "when times get tough, financial concerns trump quality and safety." A good illustration is nurse staffing. Since nurses are the single largest expense of any hospital, when financial pressures arise nurse staffing ratios are often squeezed. And charge nurses—who traditionally act as a vital backup resource for nurses who are struggling with a difficult patient load, or a new procedure—are seen as a luxury in tight times, and are asked to assume direct patient care responsibilities in the interest of "productivity." In other words, in most hospitals, hard financial times lead to higher nurse workloads and lower levels of

experienced backup for nurses—a combination with leads directly to higher safety risks.

But not at Inova Health System in Fairfax, Virginia. Inova has adopted a policy that "Nurse staffing will be at least at the median level of staffing nationally, and a charge nurse without direct patient care responsibilities will be present on each shift." The policy, which is dramatically different from most nurses' experience in most hospitals, has sent a clear, new cultural signal to the managers and staff at Inova: *this Board is putting safety above finance*. This signal will provide unambiguous cultural "guidance" for many other decisions made throughout Inova for years to come, when the tension between money and safety arises. Interestingly, this particular policy also helps to deal with the "I can't follow the safety rules because I'm too busy" pattern of behavior, because if solid staffing and flexible backup systems are in place, it then becomes reasonable to expect front line nurses to follow the safety rules.

- *Give patients and families a seat in the power structure*. A long-standing cultural rule in many hospitals might be stated something like this: "Patients and families have their place, and it's in the waiting room." Dana Farber Cancer Institute in Boston and St. Joseph's PeaceHealth in Bellingham Washington have been leading a break away from that rule, by inviting patients and families into all the decision-making processes and committees of the hospital, including all the powerful committees of the Board such as Finance, Strategic Planning, and Quality. Recently, St. Joseph's PeaceHealth has even taken the unprecedented step of *asking a patient to become a member of the Medical Executive Committee*, (MEC) the body that carries out credentialing, peer review, and other professional activities of the organized medical staff. Somewhat nervous about this radical change, the members of the MEC initially asked the patient to leave the room whenever they discussed sensitive matters having to do with physician quality. As the months wore on, however, they stopped asking the patient to leave. After a year of this experience, the doctors asked to make the patient a full member of the committee, with full voting rights on every issue. The physicians report that the patient's presence has had a remarkable effect on their conversations. What was once considered "routine squabbling among departments" and "strong advocacy for physician autonomy" now sounds unseemly, and of minor importance, because the patient's presence in the room reminds the doctors that the primary purpose of the MEC is to improve professional care for patients, not to protect incomes, habits or physician convenience.

  Boards can make a dramatic impact on the culture of an organization by welcoming patients and families into key committees, design groups, and improvement teams. And the beauty of this step is that it is lasting: once Boards set a course down this road, there seems to be no going back. As Dana Farber's leaders would say, "We can't imagine how we ever ran the institution without them."

- *Don't flinch*. Almost every Board is regularly tested on its commitment to quality and safety. The most common circumstance arises when the Medical Executive Committee reports to the Board on something like "medical record delinquencies" (when doctors haven't completed operative notes, or discharge summaries in a timely manner—which can have an impact on quality of care.) Such delinquencies are annoyingly common in many hospitals, and MECs and Boards usually regard suspending privileges of the physician(s) involved as a rather drastic step. The Board's inaction sends a cultural signal: "The hospital adopts policies on quality and safety, but there won't be consequences if you don't adhere to those policies." It should come as no surprise then, that when other new safety policies are adopted by the Board, they might also be ignored by some medical staff under the twin cultural rules of "that must not apply to me" and "there won't be any consequences, anyway." As a result, *really* important safety policies such as full barrier precautions for central line insertions, and mandatory timeouts before surgery, are followed by most, but not all doctors, without apparent consequence—except to the patients who suffer hospital-acquired infections and wrong site surgeries.

  Boards of hospitals such as McLeod Regional in Florence, South Carolina have started to send different signals to drive long-term cultural changes. When a prominent doctor was persistently delinquent in timely medical records completion, the Board suspended his operating privileges, even though it meant that a major surgical program essentially had to shut down for 2 weeks. The doctor got his charts up to date, the program re-started, and everyone in McLeod realized that the Board had sent a strong new signal: *This hospital is serious about quality and safety*. As a result, observance of *all* safety policies and practices—hand-washing, barrier precautions, time-outs—improved.

  Every Board faces these kinds of tests, at almost every meeting. The question is not *whether* the Board will send a cultural signal. The question is whether you will send the *right* signal. Don't flinch.

Conclusion

Hospital Boards are beginning to realize that they can no longer regard the quality and safety of care in the hospital as the responsibility of the doctors and nurses. Even though most hospital Board members are not clinically trained, they are nevertheless ultimately responsible for everything that goes on in the hospital, including the quality of clinical care.

The best Boards are learning more and more about how lay trustees can do an effective job of quality and safety oversight. This short paper describes three arenas of work for Boards—building the will to improve, driving execution of changes, and creating constancy of purpose for the long haul—and more importantly, offers a practical guide to *how* the best Boards work in these three arenas.

Boards can build will by putting a face on safety and quality problems, by becoming and staying aware of the gap between current performance and the best in the world, and by being transparent—displaying all their quality data to the public, whether good, bad, or ugly.

Boards can drive execution by setting clear "how good by when how measured" quality and safety aims, by spending at least 25% time on quality, and by spending that time well—in particular, by constantly asking for data on the question "are we on track to achieve our aims?"

Finally, Boards can create constancy of purpose for the long haul by establishing a structural foundation in a strong Board Quality Committee, and by being conscious of the Board's role in transforming the organization's culture by the signals sent out by the Board. The best Boards send signals that safety is more important than productivity, that patients and families are full members of the care team, perhaps most powerful of all, that when tested, the Board will be steadfast in its support of quality and safety.