Getting Boards on Board

The Journey Continues

EVERYWHERE!

Jim Conway

Adjunct Faculty, Harvard School of Public Health
Senior Fellow, Institute for Healthcare Improvement

jconway@ihi.org
Outline

- Governance is IN!
- Key Drivers
- Industry and Organizational Responses
- Core Content
- Crystal Ball
Governance is IN!

Key Drivers

• Outcomes are top of mind
  — Financial, clinical, service, satisfaction
  — Organizational and community
• Boards are ultimately accountable for those outcomes
  — Community as well as organization
  — Not just the money
• An engaged Board can be powerful
• For many organizations, significant gaps remain
• Everyone knows all of this and wants movement, NOW
Breaking News from HealthGrades: When a hospital's board is actively engaged in reviewing quality measures and investing in clinical quality improvement, research shows that reduction in mortality and complications happens at a faster rate. HealthGrades Clinical Excellence senior consultants have found that, among client hospitals, board engagement is one of the primary factors for success in rapidly improving patient care. Among HealthGrades' clients, the reduction in mortality and complication rates for those with engaged boards was statistically significant.
Serious Safety Events
Total Number of SSEs in Comparison to Baseline Rate

Since 7/1/06, we've had 33.6 fewer SSEs than would have resulted from the baseline rate.

At any point on the blue line... if the dashed red line is below it, then the average event rate over the entire time period following that point is less than the baseline rate by a statistically significant margin (p < 0.05). Note: The dashed red line is recalculated each month and moves up or down with the latest point. So the lower the latest point, the lower the dashed red line.

# SSEs Relative to Baseline Rate
Jul 2004 - Jun 2006 Baseline
FY07/FY08/FY09 Goals
Statistical Significance (p < 0.05)
(See Explanatory Note on Chart)

Desired Direction of Change

Source: Legal Dept.

Chart Updated Through 31Aug09 by Art Wheeler, Legal Dept.
Infections per month

HAI Reduction July 08-April 09

VAP, CLBSIs, PH CAUTIs

FY 08 Target
FY 09 target

HAI

Institute for Healthcare Improvement
In a New US Survey of Hospital Governance and the Quality of Care…

• Only 20% of board chairs reported the board chair, board itself, or a subcommittee as one of the two most influential forces on quality.

• Among the low performing hospitals, no respondent reported their performance as worse than the typical US hospital.

• A little over half identified clinical quality as one of the two top priorities for board oversight.

• Fewer than one-third of nonprofit hospitals had formal board training programs that included quality.

The hospital of death

‘Appalling’ care may have led to hundreds of deaths

By Jeremy Laurance, Health Editor

Wednesday, 18 March 2009

Warning signs of poor practice in hospitals across the country are to be urgently reviewed after an investigation uncovered "appalling" standards of care at one hospital which may have led to hundreds of deaths.

The scandal was exposed after monitoring of mortality rates showed that Stafford Hospital, in the West Midlands, had between 400 and 1,200 more deaths than the national average in the three years to 2007-08.

The board of Mid-Staffordshire NHS Trust failed to respond to the warning thrown up by its high death rate, saying there was a problem with the data. It spent more time discussing laundry bills than the
A Range of Approaches

• Expectations and Training:
  — US: JC, NQF, OIG, CMS, Leapfrog, NBGH, BCBS
  — Canada, UK—NHS, Denmark
  — IHI Boards on Board
  — Others: Governance Institute, Center for Healthcare Governance

• Certification
  — Statutory Certification
  — Voluntary Certification

• Surveys and other Tools: HLQAT
NPSA: Seven Questions Every Board Member Should Ask About Patient Safety

1. Does everyone understand the importance of patient safety?
2. Do we really have an open and fair culture?
3. Are we actively encouraging reporting of incidents?
4. Do we get the right information?
5. Are we always open when things go wrong?
6. Do we learn from patient safety incidents?
7. Are we actively implementing national guidance and safety alerts?

http://www.npsa.nhs.uk/nrls/reporting/seven-questions-every-board-member-should-ask-about-patient-safety/
US: Reported Board Voluntary and Other Certification Efforts

- **Georgia** (voluntary)
- **Massachusetts** (BCBSMA Quality Ed. P4P)
- **Minnesota** (voluntary)
- Nebraska (voluntary)
- New Jersey (statutory)
- **Tennessee** (voluntary)
- West Virginia (voluntary)
HLQAT Reports
Gaps are Significant

<table>
<thead>
<tr>
<th>Domain</th>
<th>Board Member</th>
<th>C-Suite</th>
<th>Clinical Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Seeking Organization</td>
<td>66.1%</td>
<td>75.0%</td>
<td>64.8%</td>
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<tr>
<td>Established Quality Goals and Priorities</td>
<td>92.0%</td>
<td>64.5%</td>
<td>93.9%</td>
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<tr>
<td>Effective Communication Processes</td>
<td>63.3%</td>
<td>68.8%</td>
<td>69.7%</td>
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<tr>
<td>Collaboration Across Functions and Levels</td>
<td>90.7%</td>
<td>64.5%</td>
<td></td>
</tr>
<tr>
<td>Clearly Defined QI Leadership Roles</td>
<td>90.3%</td>
<td>79.1%</td>
<td>88.0%</td>
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<tr>
<td>Monitoring and Evaluation of QI Progress</td>
<td>65.6%</td>
<td>51.7%</td>
<td>97.0%</td>
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<tr>
<td>Employee Rewards/Recognition for Achieved Goals</td>
<td>97.8%</td>
<td>80.3%</td>
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<tr>
<td>Adequate Resource Allocation for Clinical Quality Improvement</td>
<td>84.6%</td>
<td>74.8%</td>
<td>65.9%</td>
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<tr>
<td>Quality Improvement Education for All Staff</td>
<td>90.7%</td>
<td>63.8%</td>
<td></td>
</tr>
<tr>
<td>Collaborative, Supportive Culture</td>
<td>92.3%</td>
<td>85.5%</td>
<td>68.3%</td>
</tr>
<tr>
<td>Public Reporting of Quality and Safety Data</td>
<td>95.7%</td>
<td>69.4%</td>
<td>82.5%</td>
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<tr>
<td>Clinical Management Tools, Techniques and Processes</td>
<td>91.8%</td>
<td>76.2%</td>
<td>89.3%</td>
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<tr>
<td>Overall Quality</td>
<td>88.9%</td>
<td>86.0%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Survey Total</td>
<td>82.3%</td>
<td>75.2%</td>
<td>79.2%</td>
</tr>
</tbody>
</table>

Institute for Healthcare Improvement
Core Content

After 5 Years the 6 Elements of the Board on Board Intervention Ring True Around the World
Boards on Board Plank
5 Million Lives Campaign

1. Setting Aims:
   - Set a specific aim to reduce harm this year.
   - Make an explicit, public commitment to measurable quality improvement

2. Getting Data and Hearing Stories:
   - Select and review progress toward safer care as the first agenda item at every board meeting,
   - Ground the work in transparency, and putting a “human face” on harm data
   - Tools: chart audit; case study of a specific case
3. Establishing and Monitoring System-Level Measures:
   ─ Identify a small group of organization-wide “roll-up” measures of patient safety
   ─ Continually update them
   ─ Make them transparent to the entire organization and all of its customers.

4. Changing the Environment, Policies, and Culture:
   ─ Commit to establish and maintain an environment that is respectful, fair and just for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error.
5. Learning:
   - Starting with the Board: Develop your capability as a board.
   - Set an expectation for similar levels of education and training for all staff.

6. Establishing Executive Accountability:
   - Oversee the effective execution of a plan to achieve your aims to reduce harm
   - Include executive team accountability for clear quality improvement targets.
Crystal Ball

- Pressure on Governance will grow
  - Community and organizational outcomes
  - Payers will provide a significant push
  - Great outcomes from others will too.
- Move to mandatory Certification
  - Linked to Directors coverage
- Trustees will know more of reality of practice
  - Effectively fulfill governance responsibilities
- Talented people will seek out board roles
  - Opportunity to improve outcomes and community service
Resources

• 5 Million Lives Campaign, Getting Boards on Board: Engaging Governing Boards in Quality and Safety,
  — How To Guide and Materials
  — Joint Commission Journal on Quality and Patient Safety Conway J. April, 2008

• Quality and Cost
  — IHI White Paper Increasing Efficiency / Enhancing Value
  — Health Foundation Publication
  — RAND Study Strategies for Controlling Cost In Massachusetts.

• Other:
  — NPSA 7 Questions Boards Should Ask