

Boards, Governance, & Quality of Care in U.S. Hospitals



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Introduction

- Inadequate quality of care an ongoing concern
- Underlying reasons for variation unclear
 - Structural characteristics explain a small amount
 - Don't know why some providers perform better
 - How might we intervene to improve quality?
- Increasing attention on leadership & governance
 - IHI
 - NQF

NQF: What Boards Should Do

- Promote quality as a priority
- Place quality issues at importance to financial ones
- Oversee and evaluate quality outcomes
- Develop systems of performance measurement
- Engage providers and staff in quality improvement

Research Question

- Yet, we know little about what boards do
- How do hospital boards engage in quality?
 - Specifically, how do board chairpersons perceive:
 - Their own familiarity with clinical quality?
 - Their board's training and expertise in clinical quality?
 - Importance of clinical quality for board oversight
 - Importance of clinical quality for CEO performance evaluation?
 - The influence of the board on quality of care delivered
 - Their institution's current level of performance
 - Agenda setting and specific board activities
- How do boards of high and low performing institutions differ?

Methods

4,350 hospitals reporting into HQA

794 for-profit hospitals excluded ←



3,556 non-profit hospitals remaining

146 non-acute care hospitals excluded ←



3,410 hospitals remaining

119 hospitals for which no quality
summary score calculated ←



3,291 hospitals as final sample

Methods

- Random sample of 1,000 hospitals
- Over-sampled:
 - Hospitals in top, bottom deciles of HQA performance

Methods

- Board chairperson identification
- Survey development
 - Literature review
 - Consult with experts in the field
 - Feedback from non-sampled board chairs
 - Formal cognitive testing
- Survey administration
 - Chairs of 1 or 2 hospitals received up to 4 mailings and up to 10 phone calls
 - Chairpersons of 3 or more hospitals in sample received customized approach

Results

- 722 responses out of 922 Chairs sampled
 - Chairperson-level response rate: 78.1%
 - Hospital-level response rate: 76.8%
- Response rate $\geq 70\%$ from each category

Analysis

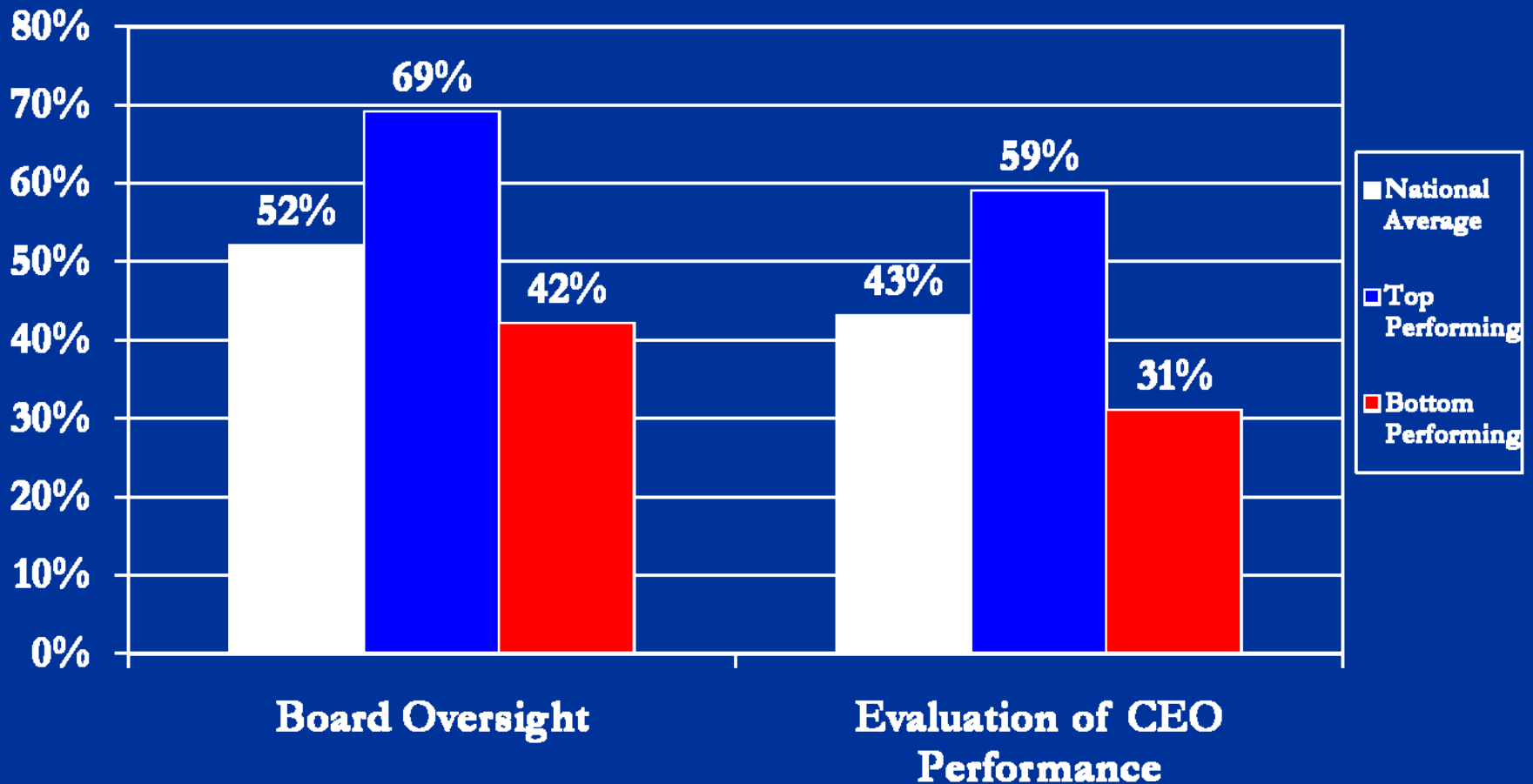
- National averages based upon weighting
- Top vs. bottom-performing hospitals
 - Marked differences in hospital characteristics
 - Multivariable adjustment, stratified analyses, etc.

Board's Expertise with Quality

	National Average	Top Hospitals	Bottom Hospitals
The Board Chair reports that the Board:			
Has moderate or substantial expertise in quality of care	74%	87%	66%
Has a formal training for the board that covers clinical quality	32%	47%	21%

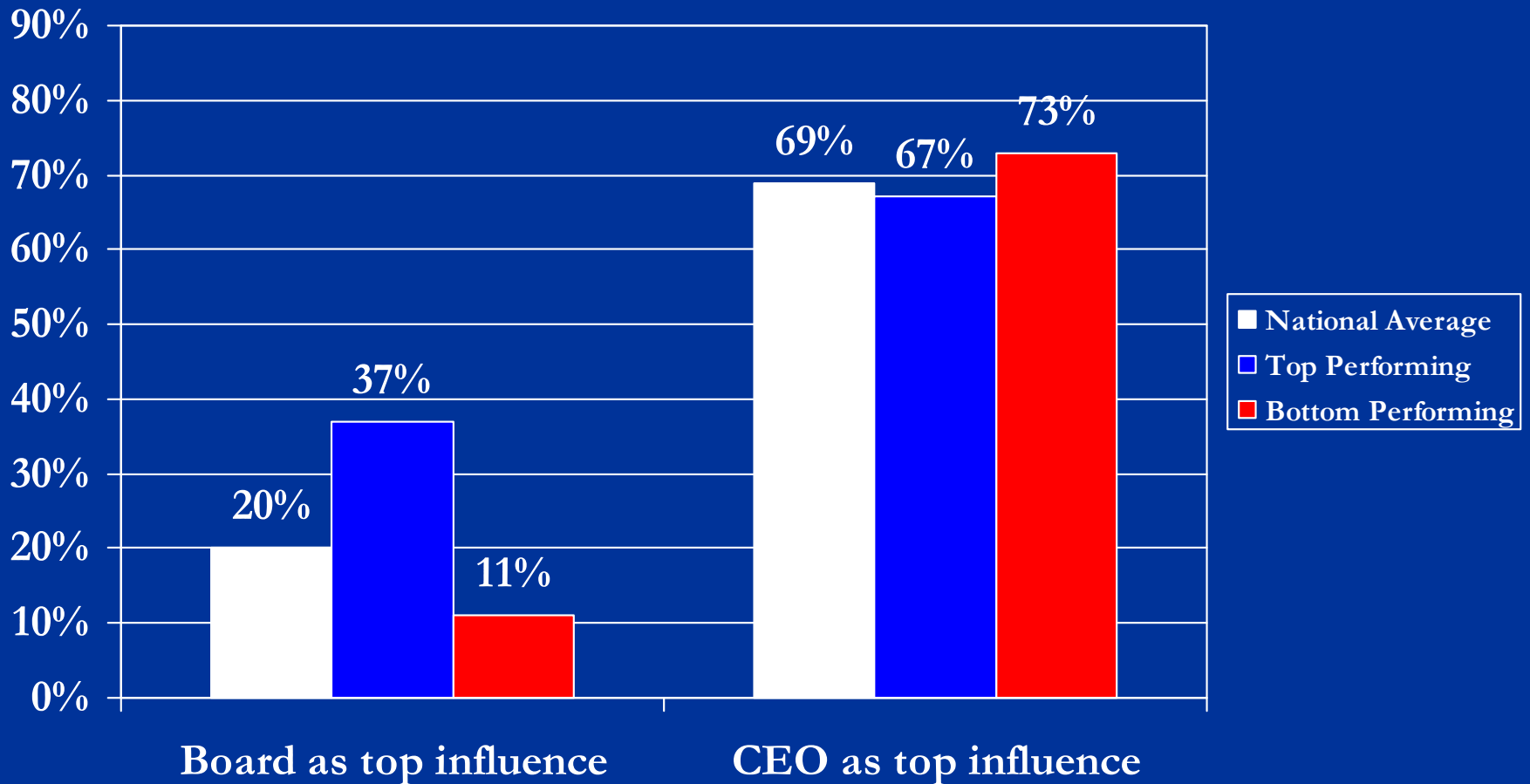
*All p-values<0.001

Quality as a Priority



Percentage of respondents reporting that quality of care is one of the top two priorities for Board oversight or evaluation of CEO performance. P-value <0.001 for comparisons between top and bottom performing hospitals.

Influence of Board and CEO on Quality

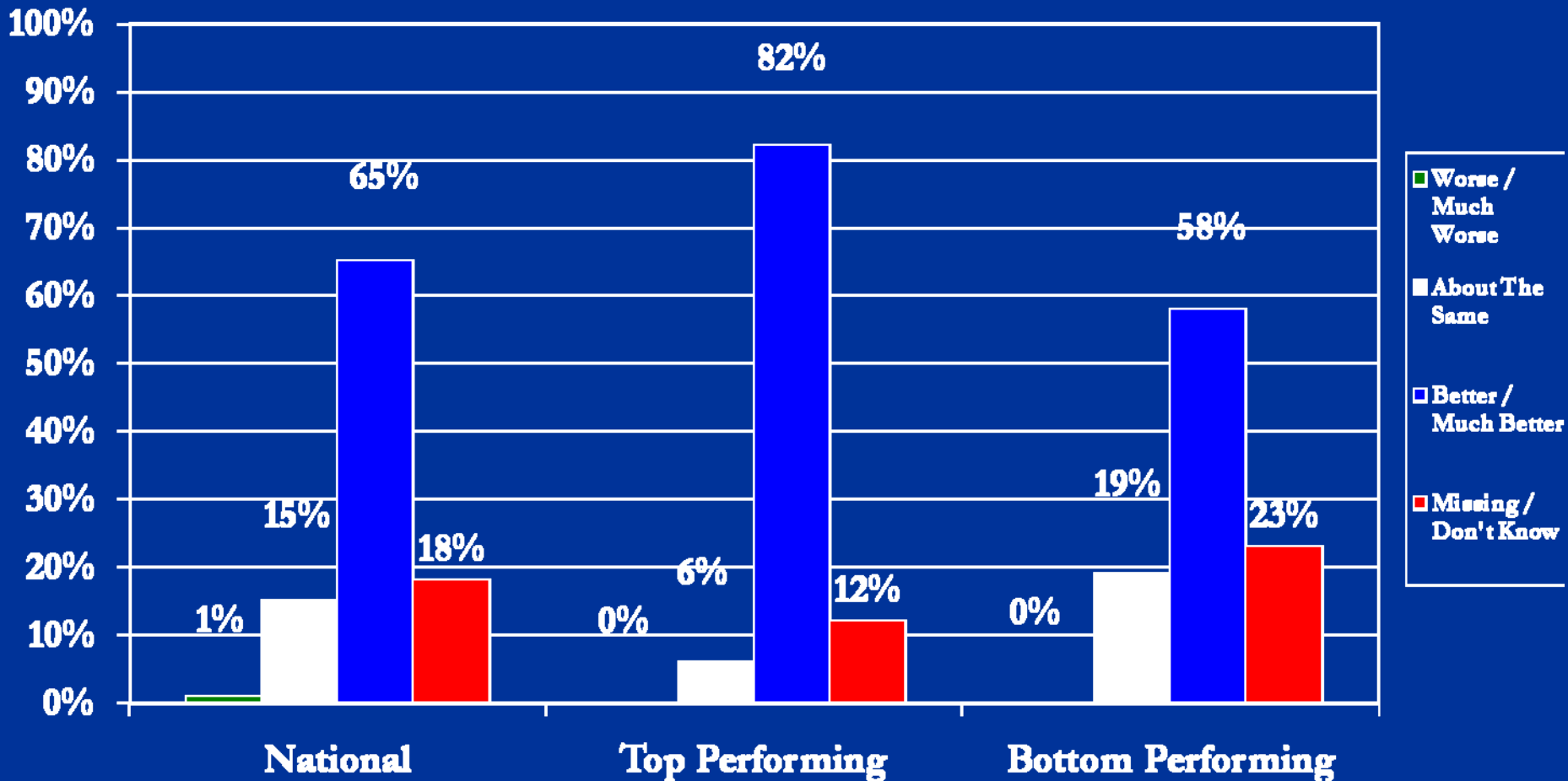


Percentage of respondents who report that the Board or the CEO is one of the top two influences on the quality of care delivered. P-value =0.008 for comparisons between top and bottom performing hospitals for Board comparison.

Chair's Familiarity with Quality

	National Average	Top Hospitals	Bottom Hospitals	P-value
The Board Chair reports personally being somewhat familiar with:				
General issues of Quality and Safety	93%	98%	90%	0.02
TJC core measures / HQA measures	66%	79%	64%	0.002

Perception of performance



Board's Functions Around Quality

	National Average	Top Performers	Bottom Performers	P-value*
Quality on agenda at every meeting	63%	74%	57%	0.003
Finance on agenda at every meeting	94%	90%	95%	0.15
At least 20% of board time on quality	42%	54%	34%	0.001
At least 20% of board time on finance	46%	37%	56%	0.002

Board's Functions Around Quality

	National Average	Top Performers	Bottom Performers	P-value*
Board has a quality subcommittee	60%	73%	52%	0.001
Board has quality dashboard that it reviews regularly	73%	91%	62%	<0.001
Dashboard has trends	81%	84%	74%	0.10
Dashboard has benchmarks	73%	77%	56%	0.003

Board Reviews Data At Least Quarterly

	National Average	Top Performers	Bottom Performers	P-value*
Hospital acquired infections	69%	76%	62%	0.009
Medication errors	70%	76%	62%	0.02
TJC core measures / HQA	57%	68%	45%	<0.001
Patient satisfaction	77%	79%	74%	0.31

Discussion

- National portrait of governance in non-profit hospitals
- Main findings vis-à-vis quality of care:
 - Not as high a priority as ideal
 - Few boards have formal training
 - Few boards think they are highly influential
 - Many boards don't have quality on the agenda regularly, lack a quality subcommittee, or examine dashboards
- Large differences in governance between high and low performers

Limitations

- Response bias
- Self-reported data
 - There may be some socially-acceptable responses
 - No independent verification
- No way to assess causality between Board activity and higher quality

Implications

- *Large number of boards not engaged in quality*
 - Don't know their own performance
 - Don't believe it is a major priority
 - Don't believe they can be effective
- *Ample opportunities for improvement*
 - Targeting information, data
 - Formal training
 - Introduction of a subcommittee, dashboards

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