The Institute for Healthcare Improvement

The Board’s Role in Engaging Leadership & Medical Staff in Performance Improvement

Michael D. Pugh, MPH
April 27, 2013

Basic Board Responsibilities

- Set and periodically review the mission, values and goals.
- The only employee who reports to the board is the CEO. The board must hire, fire and evaluate his/her performance.
- The board ensures the quality of patient care.
- The board ensures the organization’s financial performance.
- The board has shared responsibility for the health of their community.
- The board must assume responsibility for itself

How good is your hospital organization?

Another Way to Think About How Good…
- If you are the patient, what is the right number of medication errors, infections or falls?
- If you are the patient, is it perfectly normal and acceptable to spend 8 hours in the ED?
- If you are the patient, what % of the time should you get the right care?
- If you are the patient, is it OK to transition home from the hospital without a real plan to keep you from needing to come back?

Quality Aims
- Quality: Deliver everything that will help, and only what will help. The goal is 100%
- Safety: Do no harm. The goal is 0 Events
Two Key Truths About Boards

- As a general rule, Boards think quality is a lot better than the administrators, doctors, and nurses do.
  - “But you never told us in a way we could understand it.”
- Boards make a big difference in quality
  - 25% time, interaction with medical staff, CEO compensation…
  - Vaughn T, Koepke M, Kroch et. al. 2006

A place to start thinking about Quality Aims...

Don’t hurt me
Help me
Be Nice to Me

Don Berwick, MD

Outcomes are system results...

“Every system is perfectly designed to produce the results it gets.”

Dr. Paul Batalden
What is this Award Winning Hospital Perfectly Designed to Produce?

- Outcomes/System-level Measures
  - Excellent patient experience
    - 98% willingness to recommend
  - Risk-adjusted inpatient mortality rates that track with US "average"
    - 30-day AMI mortality is 12.9% (better than the US average 16.6%)
  - Low overall costs of care for Medicare population
    - 30-day readmission rates for AMI (16.9%) and CHF (20.5%) better than US norms

But It is Also Designed to Produce…

- Safety events each year
  - 9 sentinel events
  - 9 permanent injuries associated with "occurrences"
  - 90 temporary injuries associated with "occurrences"
  - 27 CLAB infections (9 in Q4 2009)
  - 25-30 VAP (7 in Q4 2009)
  - 50-60 MRSA infections (12 in Q4 2009)
  - 500 CA-UTI (207 in Q4 2009)
  - 700 C. difficile infections (27 in Q4 2009)
  - 32 surgical "occurrences" (2 deaths, 2 sentinel events, 24 temporary harms

- Process Measures
  - 9% defect rates in CHF care
  - 23% defect rates in pneumonia care
  - Nearly perfect AMI care
  - 8% defect rates in SCIP measures

A Hospital’s Core Work

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Care Processes</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>Diagnosing</td>
<td>Care Outcomes</td>
</tr>
<tr>
<td>Staff</td>
<td>Treating</td>
<td>Harm Rate</td>
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<td>Supplies</td>
<td>Explaining</td>
<td>Patient Satisfaction</td>
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<tr>
<td>Equipment</td>
<td>Monitoring</td>
<td>Cost per Case</td>
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<td>Teaching</td>
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From the Top: The Role of the Board in Quality and Safety

How This Looks to Many Board Members

Inputs
- Patients
- Staff
- Supplies
- Equipment
- Facilities

Care Processes
- Diagnosing
- Treating
- Explaining
- Teaching
- Monitoring
- Documenting

Outputs
- Care Outcomes
- Harm Rate
- Patient Satisfaction
- Cost per Case

Seven Leadership Leverage Points*

- Set measured system-level aims and oversee at the Board level
- Align aims, measures and strategies in a leadership learning system
- Channel leadership attention to aims
- Get the right team engaged, including the patient
- Engage the CFO in this work
- Engage with physicians
- Build deep improvement capability

*ih.org White Paper: Reinertsen, Pugh and Bisognano, 2008

How Boards Make a Difference in Quality and Safety

Build Will

Oversee Execution

Maintain Constancy of Purpose

The Institute for Healthcare Improvement
Better Outcomes are Associated with Hospital in Which . . .

- The Board spends more than 25% of its time on Quality Issues
- The Board Receives a Formal Quality Performance Measurement Report
- There is a High Level of Interaction between the Board and the Medical Staff on Quality Strategy
- The Senior Executives' Compensation is based in part on QI Performance
- The CEO is identified as the person with the greatest impact on QI, especially when so identified by the QI Executive

Vaughn C, Koepke M, Kroch et al. 2005

Best Board Practices to Improve Quality for Boards

1. Establish culture and Build Will
2. Establish Bold Performance Goals
3. Promote Leadership Collaboration:
   - The Medical Staff and Administration
4. Empower a Quality Committee
5. Oversee Progress

Transparency and the Board

- If a patient were seriously harmed this week in your hospital, and the initial evaluation of the event indicated that the hospital's culture and systems were probably the underlying cause, would the Board learn of the event?
  - Which Board Members?
  - When?
  - Would the Explanation be "Spun" to make the Hospital Look as Good as Possible?
  - Would Conversations about the Event be Cloaked in Legal and Risk Management mumbo-jumbo?
- Is the Board sending clear signals about transparency to the Management Team?
Quality Committee: Best Practices

- **Structure**
  - Lay Chair, and majority of lay trustees
  - Charter: recommend and oversee achievement of Quality Aims
  - Two patient/family representatives
  - Literacy required

- **Process**
  - Meaningful conversation not PowerPoint
  - **Agenda:**
    - Story
    - Progress toward Aims
    - "Off the rails" exception report
    - Policy recommendation

- **Culture**
  - Everyone’s voice is heard
  - Transparency
  - Ask the important and difficult questions

Quality Committee: Report to the Full Board

- Every meeting
- 1st on the agenda
- 25% of Board time
- Trustee leads with management support
- Review Big Dots with simple language
- Highlight Key Issues committee is dealing with

The Best Quality Committees Have a “Starter Kit” of Good Questions to Ask

- What would be the Right Thing to do for Our Patients?
- Am I the only person who doesn’t understand what you just said?
- Does this set of re-credentialing recommendations fully support our mission, aims, and strategies?
- How many patients is that?
- Who is the best in the world at this?
- Were patients and families involved in making this recommendation?
- Do we have an open and fair culture?
- Do we learn from safety events?
- Do we get the right information?
Setting the Right Aims

Focus on the “Big Dots”
- Mortality
- Infections
- Patient Safety/harm
- Evidence-based care

Examples of “Big Dots”

Delivery system
- Mortality rate
- Hospital Standardized Mortality Rate
- Unadjusted Mortality Rate
- Observed v Expected Mortality Rate per ...
- Harm rate
- Global Trigger Tool
- Serious Safety Events
- Overall Rate of Healthcare Acquired Infections
- Patient Experience
- Staff Satisfaction
- Cost per... (admission) (procedure) (visit) (year of care)

Community/Population
- Cost per capita per year
- Health status of community

System-level measures
(Big Dots)

- Cannot be achieved by a single project on one unit, condition, procedure, disease, or clinic.
- Are important in a fundamental way, i.e. they’re unlikely to be achieved at the expense of something more important, but unmeasured
- Don’t need an arrow saying “down is good” to explain them to the public
Examples of Bold, Specific, System-Level Aims

- "We will achieve a 50% reduction in hospital-acquired infections within 12 months, as measured by the sum of Central Line Bloodstream Infections, Ventilator-Acquired Pneumonias, and Catheter-Associated Urinary Tract Infections."
  WellStar Health System

- "We will cut hospital-acquired infections in half every year, on our way towards zero, as measured by the sum of C Diff, SSI, VAP and MRSA."
  Delnor Community Hospital

- "We will reduce Harm by 80%, as measured by Serious Safety Events, within 3 years."
  Cincinnati Children’s

Not-So-Specific Aims

- “Our hospital strives to achieve the highest levels of quality”
- “Memorial General aims to be in the top tier of hospitals for quality and safety”

As measured by….?
By when…?

The Best Boards (and Medical Staff and Administrative Leaders)

1. Adopt bold, specific, system-level strategic aims
2. Oversee system-level measures of progress toward those aims, using a “strategic dashboard”
3. Develop a strong Quality Committee
4. Build will
   - Eliminate the denominator
   - Put a face on the data
   - Start every meeting with a story
   - Convert data to names, dates, and events
   - Harness the power of transparency
   - Face up to the difficult conversations
1. Examples of Bold, Specific, System-Level Aims

- “We will achieve a 50% reduction in hospital-acquired infections within 12 months, as measured by the sum of Central Line Bloodstream Infections, Ventilator-Acquired Pneumonias, and Catheter-Associated Urinary Tract Infections.” - WellStar Health System
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Not-So-Specific Aims

- “Our hospital strives to achieve the highest levels of quality”
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As measured by….?
By when…?

If your aim is “Pretty Good, Someday,” then your plan can be “Somehow, by Someone, Whenever.”
Sometimes we cannot see what is in front of us…
- When we measure harm, eliminate the denominator…
  - You don’t need denominators to compare yourself to yourself, over time
  - Denominators are often part of the problem (ADEs per 1000 doses, SSEs per 1000 patient days)
- Denominators make the problem abstract, rather than personal

What makes more sense… if the right answer is 0?

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<tr>
<th>Traditional Display (Rates)</th>
<th>Actual Count</th>
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<tr>
<td>.005 ADEs /1000 doses</td>
<td>10 ADEs last month</td>
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<td>2.67 infections/1000 patient days</td>
<td>35 hospital acquired infections last quarter</td>
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<tr>
<td>.003 Falls with harm per/1000 patient days</td>
<td>25 Patient falls—16 with harm last year</td>
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...and whenever possible

Put a face on the data

Jim Reinertsen, MD
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<th>Name</th>
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What Might Be On the Hospital Board's Balanced Scorecard?

Board performance measures should at minimum include expected aims and results for:

- Employee Satisfaction or Engagement
- Operating Margin %
- Cost per Discharge
- Days Cash on Hand
- Waiting Time/Access Measure
- Mortality Rate
- Re-admission Rate
- Patient Experience
- % of Patients Receiving Care According to the Evidence
- Number of Patient Harm Events
- Mortality Rate
- Re-admission Rate
- Patient Experience
- % of Patients Receiving Care According to the Evidence
- Number of Patient Harm Events
- Waiting Time/Access Measure

Color Coded Dashboards Only As Good As Your Targets

- Simple, and sometimes too simple
- Color coding without numbers can mislead
- Tendency is to assume that only the "red" blocks need attention
- If used, boards need to frequently ask how the targets are set

The Case For All-or-None Measurement

Governance Question: “What % of Patients Got the Right Care?”

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<th>Evidence-Based Care Measure</th>
<th>EBC Compliance %</th>
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<td>EBC 1</td>
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<td>EBC 2</td>
<td>100%</td>
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<td>EBC 3</td>
<td>100%</td>
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<td>EBC 4</td>
<td>60%</td>
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<tr>
<td>EBC 6</td>
<td>90%</td>
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Report to the Board Quality Committee

“Our MI Core Indicators were greatly improved last quarter. Only one measure requires corrective action.”
The Case For All-or-None Measures
Only 30% of Patients Received the Right Care*

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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<td>0</td>
<td>0</td>
<td>1</td>
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<td>1</td>
<td>0</td>
<td>0</td>
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<td>1</td>
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<td>1</td>
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<td>0</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>

Per Patient Totals: 5 6 5 5 5 4 5 5 5

Total: 56

Elements Received by Patient:
- Patient 1: 100%
- Patient 2: 100%
- Patient 3: 100%
- Patient 4: 66%
- Patient 5: 80%
- Patient 6: 100%

30% Receiving Perfect Care

*Right Care defined as receiving all of the required EBC elements (based on clinical eligibility)

Caution
- Data should create light, not heat
- Be especially careful when you review physician specific data and correlation
  - Why?, not Who……

Leadership Collaboration
- Ensuring Medical Staff Competency
- Medical Staff Engagement in Quality
- Ensuring Leaders and Medical Staff work together to establish Culture of Safety and Improvement:
  - Multidisciplinary, Team Approach
  - System-based Thinking
  - Standard Work begets Improve Care
Elements of a Framework

- Discover common purpose
- Reframe values and beliefs – board, administration and doctors
- Segment the engagement plan
- Use engaging methods
- Show courage
- Adopt an engaging style

1. Discover Common Purpose:
   1.1 Improve patient outcomes
   1.2 Reduce hassles and wasted time
   1.3 Understand the organization’s culture
   1.4 Understand the legal opportunities and barriers

2. Reframe Values and Beliefs:
   2.1 Make doctors partners, not customers
   2.2 Promote both system and individual responsibility for quality

3. Segment the Engagement Plan:
   3.1 Use the 20/80 Rule
   3.2 Identify and activate champions
   3.3 Educate and inform structural leaders
   3.4 Develop project management skills
   3.5 Identify and work with “laggards”

4. Use “Engaging” Improvement Methods
   4.1 Standardize what’s standardisable, and no more
   4.2 Generate light, not heat, with data
   4.3 Make the right thing easy to try
   4.4 Make the right thing easy to do

5. Show Courage:
   5.1 Provide backup all the way to the Board
   5.2 Work with the real leaders
   5.3 Work with early adopters
   5.4 Make doctor involvement visible
   5.5 Build trust within each quality initiative
   5.6 Communicate candidly, often
   5.7 Value doctors time with your time

6. Adopt an Engaging Style:
   6.1 Involve doctors from the beginning
   6.2 Work with the real leaders
   6.3 Work with early adopters
   6.4 Make doctor involvement visible
   6.5 Build trust within each quality initiative
   6.6 Communicate candidly, often
   6.7 Value doctors time with your time

Where is Common Cause?
The Doctors’ Quality Agenda

- Better outcomes
  - When all was said and done, how did my patient do?
  - Outcomes . . . not process alone
  - Professional reputation
  - Personal sense of excellence
- Less wasted time
  - Hassles, bottlenecks and delays
  - Rework: “My day was going well until..."
Reframing Administrators’ Values, Habits, Beliefs…

**FROM**

- Doctors are customers
- Doctors make care decisions, we run the finances and facilities

**TO**

- The patient is the only customer
- Doctors are our partners in running the system

Teamwork . . . and not a golf team!

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Reframing Doctors’ Values, Habits, Beliefs…

**FROM**

- I must have complete autonomy for everything
- I am personally responsible for the patients I take care of directly

**TO**

- I need autonomy for the art of medicine, but I share it with other doctors for the science of medicine
- I am responsible for the care given broadly throughout the system that I am part of, including my own patients

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**Principles of Engagement**

- Involve doctors from the earliest moment.
- Identify the real leaders, early adopters.
- Make the involvement of the doctors visible.
- Choose both the message and messenger carefully.
- Build and then rebuild trust: do what you say, say what you do, consistently over time.
- Use open, frequent and candid communication.
- Value the process and their time with yours!!
- Pay them for their quality improvement time??

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The Institute for Healthcare Improvement
From the Top: The Role of the Board in Quality and Safety

The Institute for Healthcare Improvement