

Prescriptions for Excellence in Health Care Newsletter Supplement

A collaboration between Jefferson School of Population
Health and Eli Lilly and Company

Volume 1

Issue 19 *Prescriptions for Excellence in Health Care*

Article 1

Issue #19 Spring 2013

May 2013

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(2013) "Prescriptions for Excellence in Health Care Spring 2013 Download Full PDF," *Prescriptions for Excellence in Health Care Newsletter Supplement*: Vol. 1 : Iss. 19 , Article 1.

Available at: <http://jdc.jefferson.edu/pehc/vol1/iss19/1>

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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

Editor-in-Chief: David B. Nash, MD, MBA • Managing Editor: Janice L. Clarke, RN, BBA • Editorial Staff: Deborah C. Meiris, Alexis Skoufalos, EdD

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This newsletter was jointly developed and subject to editorial review by Jefferson School of Population Health and Lilly USA, LLC, and is supported through funding by Lilly USA, LLC. The content and viewpoints expressed are those of the individual authors, and are not necessarily those of Lilly USA, LLC or the Jefferson School of Population Health.

Editorial

Leadership: The Secret Ingredient in Delivery System Reform

By David B. Nash, MD, MBA
Editor-In-Chief

In their recent article, *The Era of Delivery System Reform Begins*, authors Zirui Song, PhD, and Thomas H. Lee, MD, trace the evolution of health care reform in a series of phases. In phase 1, the insurance reform mandated by the 2010 Affordable Care Act (ACA) spurred insurers toward payment reform (eg, bundled payments) as an antidote for unsustainable health care spending. In response, phase 2 saw reform at the hospital, health system, and physician group level as they consolidated into Accountable Care Organizations (ACO) with the goal of improving efficiency and quality while reducing costs for specific patient populations.

Phase 3 – delivery system reform – is where things get very interesting for those of us who work in or around the clinical sphere. This phase focuses on changing the very culture of medicine, challenging ACO physician leaders to shift their organizations away from high-volume/high-cost health care to lower-cost/higher-value health care.

Although organizations like Kaiser Permanente and Geisinger Health System were designed with cultures that are compatible with the ACO model, we lack experience with changing the

culture of organizations that began life differently. So, recognizing the formidable challenges inherent in culture change, where do we focus our approach to reforming – and transforming – our health care provider organizations?

The authors suggest 3 important – and, to my mind, sequential – areas:

- **Leadership:** With bundled payments, all providers in an organization become a “team” – like it or not. When one physician avoids an unnecessary test and another prevents an unnecessary visit to a hospital emergency room, it translates into savings for everyone. It follows that leaders must understand and be able to motivate teamwork and complementary organizational and professional ethics within the organization – physician-physician

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relationships as well as physician-patient relationships.

- **Incentives:** Under health reform, leaders must shift the organization's focus from optimizing individual physicians' patient portfolios to improving the collective value of the care they provide. A focus on collective value leads to an increase in collaboration and consultation within the organization. It falls to the organization's leaders to design incentives that reward value through teamwork (eg, measuring and motivating team performance on common clinical scenarios).
- **Role of the patient:** In effect, ACOs put physicians and patients on the same team. When the organization invests in its patients and integrates their care, both the physicians and the patients benefit. Savvy leaders motivate patients to be active participants in the organization's mission.

I could not agree more with the authors' conclusion that modern

provider organizations must provide leadership for culture change and a health care system with a common vision. With the help of patients, payers, and a legal system that protects physicians who refuse to prescribe unnecessary products or deliver unnecessary services, organization leaders and governing boards will see us through phase 3 and into a transformed US health care system.

As I reviewed the articles for this issue of *Prescriptions for Excellence in Health Care*, I was struck by the common thread of leadership. In essence, all governing board members commit to a leadership role that creates and maintains a culture of quality and safety throughout their organizations.

The first article, "*Staffing the Board Quality and Patient Safety Committee: One Health System's Experience*," is an in-depth account of how a small, forward-looking health system has gone about building a strong connection between its governing board and the quality of care across its multiple settings.

With the ACA firmly in place and the ACO model gaining traction, the second article "*Corporate Governance, Health Care Quality, and Accountable Care*," takes a look at the complexities of multi-organization boards and the additional oversight challenges they pose. The author of the third article shares keen insights into the payer perspective on governance and offers thoughtful answers to the question, "*Why Insurers Are Investing in Hospital Trustees*."

The final article, "*The Future of Governance: Accountability for Customer-Centered Care and Population Health Oversight*," is a compelling narrative that describes the evolving role of boards as care moves outside of hospital walls and becomes more patient-centric over the coming decade.

As always, I look forward to hearing from our readers. I can be reached at: david.nash@jefferson.edu.

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Staffing the Board Quality and Patient Safety Committee: One Health System's Experience

By Denise Murphy, RN, MPH

Introduction

The *Getting Boards On-Board* guideline published by the Institute for Healthcare Improvement (IHI) in 2008¹ encouraged health organization governing bodies to create committees focused exclusively on quality of care and patient safety (QPS). In partnership with the chief executive officer (CEO) and chief medical officer (CMO), an organization's QPS executives often bear responsibility for

staffing the board's QPS Committee. This article relates the experience of Main Line Health (MLH), a 6-hospital nonprofit health system serving portions of Philadelphia and its western suburbs. MLH and its hospitals consistently achieve industry recognition for quality and safety excellence.

The MLH Board of Governors delegates oversight for QPS to a 15-member

committee comprised of governors, medical staff leaders, and senior executives, and is chaired by a physician QPS expert from Jefferson's School of Population Health. The board and its QPS Committee meet 6 times annually. Committee responsibilities include:

- Ensuring high-quality health care through oversight of quality assurance and risk management

processes and results, monitoring patient satisfaction, and approving new programs and services

- Approving strategies for health care provision
- Ensuring medical staff accountability and oversight of credentialing processes
- Approving medical staff bylaws, rules, and regulations, and confirming administrative appointments
- Evaluating medical executive committee recommendations to the board
- Evaluating medical staff roles in meeting community health needs
- Evaluating issues pertaining to consolidation and integration of clinical services
- Evaluating future clinical service needs
- Advising the board on other issues relating to QPS.

Orientation of New QPS Committee Members

Each year, the QPS Committee chair, CMO, and vice president for QPS orient new committee members to their roles in the context of the health care quality environment that encompasses both external elements (eg, standards, regulations, economics) and internal drivers for improvement (ie, performance metrics, patient safety events, results of cause analyses, staff perceptions about safety culture, patients' responses to satisfaction surveys). The QPS Committee reviews national, state, regional, and internal infrastructures as well as priorities and major initiatives aimed at improving patient care quality, safety, and satisfaction.

QPS Committee members invest significant time in preparing for and attending meetings, and they are gratified by evidence that their intense focus on and active involvement in QPS yields positive results. The literature suggests that organizations produce better outcomes when they: (1) spend more than 25% of their time on QPS, (2) receive a formal measurement report, (3) tie executive compensation to QPS performance metrics, (4) have a high level of interaction with medical staff, and (5) identify their CEO as the person having the greatest impact on QPS.² Relevant articles and the IHI's *Boards On-Board* document are included in the orientation electronic materials packet.

Orientation leaders present the IHI's "Six Things All Boards Should Do" (Table 1) and discuss how

management will go about meeting its responsibilities related to joint goal setting, agenda priorities, the process for metric review, and selection of board education topics. QPS Committee members receive an iPad and instructions on how to use the Board Effect (BoardEffect Inc., Philadelphia, PA) application where materials are posted 2 weeks prior to each meeting. Issues of confidentiality and sensitivity related to patient-level information and peer-review protection are covered. Also, MLH's commitment to a safety culture requires that the board meet periodically with a patient, family, and/or staff member who was involved in a recent harm event.

Setting Goals and Priorities on the Annual Agenda

The most challenging governance functions we have encountered include

Table 1. Six Things All Boards Should Do

1. Set a specific aim to reduce harm this year and make an explicit, public commitment to measurable quality improvement (eg, reduction in unnecessary mortality or harm).
2. Select and review progress toward safer care as the first agenda item at every meeting. (Get data on harm and hear stories; put a "human face" on data.)
3. Establish and monitor a small number of organization-wide "roll-up" measures that are updated continually and are transparent to the entire organization.
4. Commit to establish and maintain an environment that is respectful, fair, and just for all who experience pain and loss from avoidable harm.
5. Develop the capability of the board:
 - Learn how "best in the world" boards work with executive and physician leaders to reduce harm.
 - Set an expectation for similar levels of education/training for all staff.
6. Oversee the effective execution of a plan to achieve the board's aims to reduce harm, including executive team accountability for clear QPS targets.

Source: Conway J. (Institute for Healthcare Improvement, Cambridge, Massachusetts, USA) 2008.

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(1) acquiring sufficient understanding of performance metrics to enable diligent oversight, and (2) setting annual goals. MLH's QPS dashboard, with its stoplight format aligned with the Institute of Medicine's (IOM) 6 aims for quality (ie, safe, timely, effective, efficient, equitable, patient-centered),³ is first presented in depth at orientation. The goal selection process and source data for targets and benchmarks are among the topics reviewed.

Goals are specific, measurable, and achievable (the "threshold"), timely based on current national comparisons (the "target"), and challenging. Top decile performance against national comparisons ("maximum performance") is the stretch goal for all measures. With over 40 QPS indicators routinely monitored, the management team assumes responsibility for facilitating the board's selection of its own priority focus for quality ("performance") improvement initiatives.

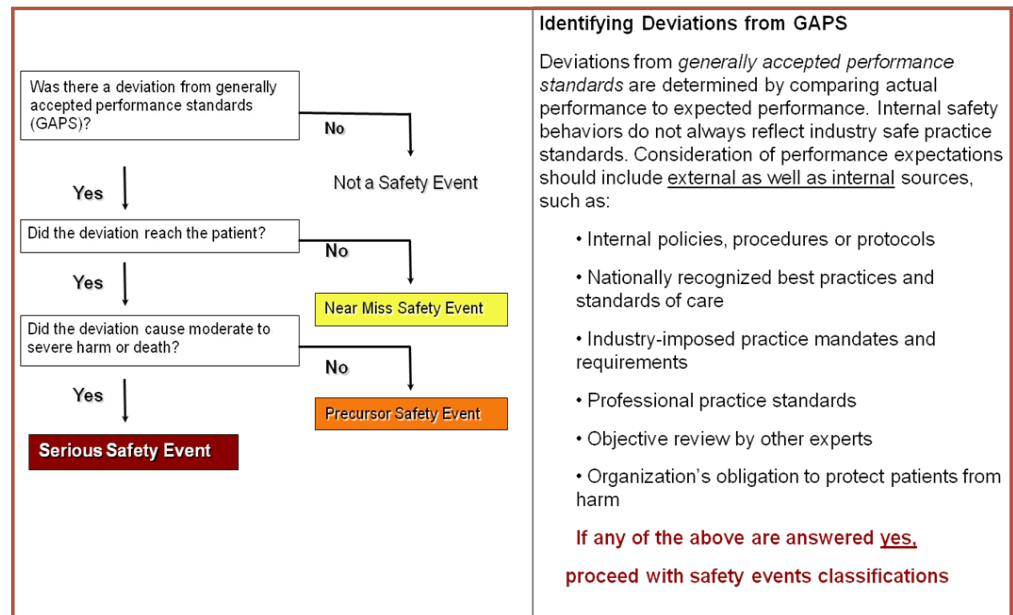
Of MLH's top 10 performance improvement priorities (eg, harmful events such as health care-associated infections, falls, pressure ulcers, adverse obstetrical events), the QPS Committee selected the following for intense focus in 2012: (1) eliminating preventable serious safety events, (2) reducing sepsis-related mortality, (3) reducing avoidable readmissions, and (4) improving patient satisfaction. These 4 strategic priorities are aligned with executive compensation; some are aligned with medical staff incentive programs. For example, hospitalists are now incented to drive efforts to reduce avoidable admissions, ensure compliance with the sepsis protocol, and to improve patient satisfaction scores; specifically, the "Communication with Physicians" component. Managers and frontline

staff also receive monetary rewards if patient experience/satisfaction targets are met.

The top priority, eliminating preventable harm, emerged from an organizational commitment to embed a reliable culture of safety, measured by a 50% reduction in preventable harm

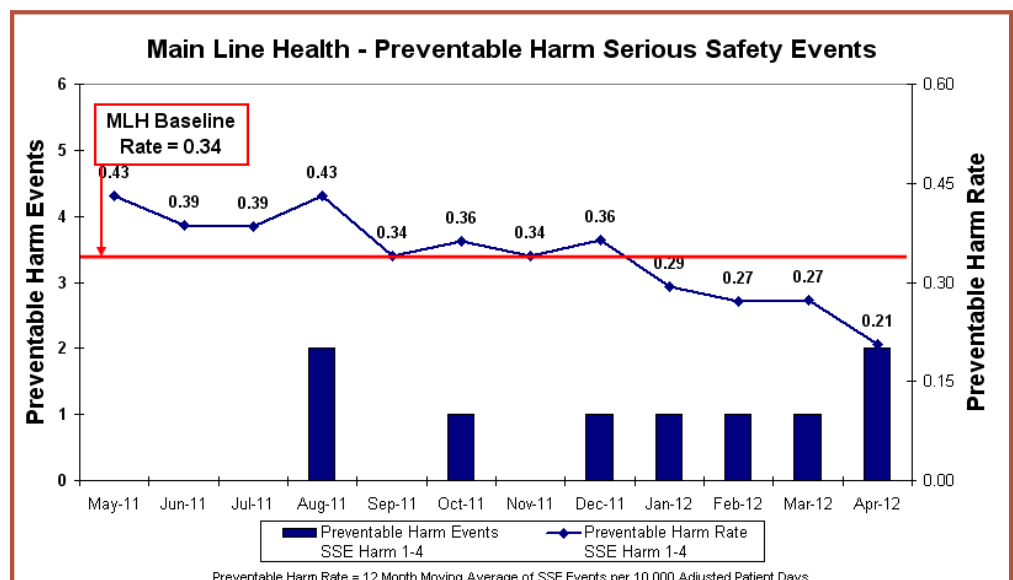
each year until zero harm events are achieved and sustained for at least 12 months. Because there is no nationally accepted definition for *preventable*, MLH defines it as "harm resulting from a deviation in generally accepted practice standards" and classifies serious safety events (SSE) in terms of level of harm. The algorithm used

Figure 1. Algorithm for Determining Preventability of Safety Events



Source: Modified from algorithm provided by Healthcare Performance Improvement (HPI, Virginia Beach, VA 2011).

Figure 2. Main Line Health Preventable Harm Serious Safety Events, May 2011 – April 2012



to determine preventability (Figure 1) is explained during committee orientation and included in each meeting packet thereafter to promote sustained knowledge about safety event designations.

The SSE rate is displayed as both a 12-month rolling rate per 10,000 adjusted patient days, as well as a bar graph designating the number of patients harmed (Figure 2). The SSE rate is presented at each QPS Committee meeting along with results of cause analyses and action plans to prevent similar events in the future. Patient stories are coupled with each data point.

The CEO hosts annual retreats with the full board to engage in strategic planning, review accomplishments against goals, discuss opportunities for improvement, and set the QPS agenda for the upcoming year. This retreat also sets the direction for bimonthly meeting agenda planning.

Prevention and Performance Improvement: Where the Rubber Meets the Road

As part of a Pennsylvania Safety Culture Collaborative, MLH engaged with Healthcare Performance Improvement, LLC to better understand reliability science, to conduct more informative accident causation analyses, and to calculate an SSE rate to track preventable harm. Training on leader methods for reliability and safety behaviors supported by error prevention tools involve all direct and indirect care providers, physician and administrative leaders, as well as the board (Tables 2a and 2b).

Physicians, nurses, and executive leaders present patient safety stories,

Table 2a. The Main Line Health Reliability Culture Toolkit for Leaders

Behaviors	Tools
Make Safety a Core Value <i>We put patient safety first by using our first words for patient safety. We ask the safety question first, and we ensure that good things always happen to those who speak-up for safety.</i>	<ol style="list-style-type: none"> 1. Start every meeting with a safety topic or story 2. Recognize & support people who ask the safety question or “stop the line for safety” 3. Transparency in sharing safety events 4. Embed safety in hiring and performance reviews 5. Encourage and reward reporting of safety events – eliminate fear of reporting
Find & Fix System Problems <i>We improve patient care every day by fixing system problems before they find us. We are sensitive to operations, identify problems that make safe patient care difficult to deliver, and solve the causes of those problems.</i>	<ol style="list-style-type: none"> 1. Daily Check-In 2. Start the Clock for Safety 3. Brief / Execute / Debrief
Build Accountability <i>We make reliability a reality by building sound practice habits in our staff. We reinforce sound practice habits, we discipline those who make risky choices, and we never punish those who experience honest mistakes.</i>	<ol style="list-style-type: none"> 1. 5:1 feedback 2. Rounding to Influence 3. Just Culture 4. Red Rules

sharing event details, results of cause analyses, “Great Catches,” and action plans for prevention with the board. Explanations of harm or near miss events include use of reliability methods, safety behaviors, and error prevention tools that would have prevented an event occurrence. Direct discussion with those involved in safety events results in better understanding for committee members and a deeper sense of shared accountability for quality of care and patient/staff safety.⁴

The CMO and vice president for QPS meet routinely with the chair of the QPS Committee of the board to plan meeting agendas and, more importantly, to identify timely topics of interest for board education. For example, a recent presentation highlighted the MLH strategy to prepare for bundled payments through creation of “clinical excellence bundles” for total joint and cardiac procedures, as well as for patients with heart failure and respiratory

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conditions. Review of implementation progress and sustainability of patient safety action plans and performance improvement initiatives are also part of these planning meetings. Lean Six Sigma teams are invited to share results with board members during the “deep dive” into dashboard metrics that fall short of target goals. Teams that have achieved maximum performance goals also are invited to celebrate their accomplishments and lessons learned with the board.

Denise Murphy, RN, MPH, is Vice President for Quality and Patient Safety at Main Line Health System. She can be reached at: MurphyD@MLHS.org.

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Table 2b. The Main Line Health Error Prevention Toolkit

<i>I commit to the following...</i> Safety Behavior Expectations	<i>By Practicing the Following...</i> Error Prevention Tools
Attention to Detail <i>We focus our attention to always think before we act, especially in high risk situations.</i>	<ul style="list-style-type: none"> ▪ Self Checking Using STAR Stop Think Act Review
Communicate Clearly <i>We're responsible for professional, clear, and complete verbal and written communications.</i>	<ul style="list-style-type: none"> ▪ 3-Way Repeat Back & Read Back ▪ Phonetic & Numeric Clarifications ▪ Clarifying Questions
Handoff Effectively <i>We provide effective handoffs of patients, tasks, and materials by taking the time to give appropriate information and ensuring understanding and ownership.</i>	<ul style="list-style-type: none"> ▪ Use SBAR to handoff: Situation Background Assessment Recommendation
Speak up for Safety <i>We use good judgment at all times to ensure our actions are the best. We use an assertion and escalation technique to act on our responsibility to protect patients & co-workers in a manner of mutual respect.</i>	<ul style="list-style-type: none"> ▪ Crucial Conversations ▪ Question & Confirm ▪ Use ARCC to escalate safety concerns <ul style="list-style-type: none"> – Ask a Question – Make a Request – Voice a Concern – Use Chain of Command ▪ Stop the line for immediate risk!
Got Your Back! <i>We make reliability a reality by building our own sound practice habits and in our co-workers. We're accountable not just for our own actions but for our teammates' as well.</i>	<ul style="list-style-type: none"> ▪ Peer Checking ▪ Peer Coaching

Corporate Governance, Health Care Quality, and Accountable Care

By Douglas A. Hastings

Corporate Governance Developments

The past decade has seen a revolution in corporate governance and in the expectations set for corporate directors. Fiduciary duty has come to mean that directors must be active participants in oversight, not mere passive recipients of information. A good director must engage in active inquiry and be

demanding enough to rattle cages when necessary; be knowledgeable enough to set direction; be bold enough to add value through hard questions; and be vigorous enough to assure that the organization's plans yield results. Yet, a director must not lose sight of the difference between oversight and day-to-day management.

Fiduciary Challenges and Opportunities in the Accountable Care Era

Health care provider organizations face a variety of challenges and opportunities in the accountable care era. As fiduciaries, board members must address several key issues in this period of payment reform. Fee-for-service payments are likely to

decline steadily in the years ahead, challenging financial performance. Additional payment changes will further reduce reimbursement to providers who score poorly on quality measures or who evidence inefficiencies such as above-average readmissions. The shift to various forms of pay for performance, bundled payments, global- or population-based payments, and other value-based reimbursement methodologies will require infrastructure investments by providers that may or may not be reimbursed, further threatening financial solvency.

With the increasing focus on quality measurement and reporting, boards are faced with the prospect that these initiatives may uncover indications of fraud and abuse and trigger judgments against providers making claims to public and private payers for care that is ultimately deemed substandard.¹ Expanded quality data reporting and transparency requires board oversight to assure that the reports are accurate and that compliance plans are enhanced to address these expanded concerns. It is the responsibility of a provider entity board to review the organization's committee structure to ensure that the board and/or board committee's charter specifically requires attention to effectiveness, efficiency, and patient-centeredness in addition to patient safety.

Finally, Accountable Care Organization (ACO) boards and ACO sponsoring organization boards must ensure that appropriate and effective management of clinical personnel and protocols are in place to meet the Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and other requirements and to achieve the ACO's quality and financial goals. Health systems and physician organizations seeking to create ACOs

must consider which entity – one that currently exists or one to be formed – will serve as the ACO (including how many ACOs it may want to form or work with) and how to coordinate the ACO board or boards with other boards within the health system.

Medicare Shared Savings Program Final Rule – Structure and Governance²

The formation of a new entity to serve as a Medicare ACO is not required if an existing entity (or entities) meets all of the applicable requirements set forth in the rule. The ACO governing body nevertheless must include participating ACO providers and suppliers (or representatives) and Medicare beneficiaries (or representatives) – at least 75% control of the governing body must be held by ACO participants (providers and suppliers).

The Final Rule removed the Proposed Rule's controversial requirement that each ACO participant must have "appropriate proportionate control over governing body decision making."³ The Pioneer Model includes an additional requirement that the ACO board include a "consumer advocate." These governance representation requirements raise questions about the fiduciary duty of ACO governing boards (ie, governing board members' allegiances generally will be to the ACO rather than to the particular providers or groups they represent).

NCQA ACO Accreditation Guidelines – Governance⁴

NCQA scores an ACO on the effectiveness of the role, structure, and functions of its governing body, including, "how well the governing body provides leadership, establishes accountability and provides the structure to align the functions of an ACO." NCQA criteria state that the

designated physician or clinician leader of the ACO "must participate on or advise the board" or "have a substantial management function." NCQA also requires an ACO to have a documented process for annually reviewing the ACO's performance and the ACO governing body's performance. ACO governing bodies also must assure that the following stakeholder groups are involved in its oversight functions: primary care practitioners and specialists who provide care for the ACO's patients; hospitals that provide care for the ACO's patients; consumers (eg, individual patients, consumer organizations) who do not have a financial or business stake in the health care system; and purchasers.³

Balancing Representational Requirements

ACO boards must balance stakeholder representation (required by CMS or NCQA) with Internal Revenue Service (IRS) requirements related to community representation, when applicable, as well as with both IRS and good governance recommendations related to the need for a reasonable number of "independent" directors on boards. Ultimately, the director's job is not to "represent" a particular faction or constituency in exercising oversight in accord with the duty of care; rather, a director must act in the overall best interest of the organization for which he or she is a fiduciary. This differs from duty on an advisory board or duty as a provider representative viewing a contract negotiation with a payer or another provider. ACO sponsoring organization board members and ACO board members must clarify their respective missions, visions, and goals – and understand the differences between them.

Governance in the Accountable Care Era

Focused, intentional governance in the accountable care era calls for

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board members to be both educated and proactive. This requires robust recruiting and educating of directors with the right skill sets; providing ongoing information that is incisive and detailed enough to allow for effective oversight without excessive, unnecessary detail; and having in place evaluation mechanisms that allow the board to continuously improve its performance. Key areas of board oversight in the accountable care era include measuring and managing value, maximizing patient and physician stakeholder engagement, enhancing outcomes reporting transparency, strengthening internal pay-for-performance programs while remaining legally compliant, and making the board's work more intentional.

Making the Board's Work More Intentional

It will not be easy to attract, engage, and retain superior board members in this new era of high-performance governance. For board members to believe their time and talents are being maximized, new cultures and systems must be developed to govern tomorrow's integrated and accountable care delivery systems.

High-performance boards must continuously explore and practice intentional governance that embraces attributes such as:

1. Competency-based governance by means of recruiting and educating diverse and talented board members to achieve a balanced set of skills, attitudes, and experience within the board and its committees, advisory councils, and task forces.
2. Information for governance decision making that is driven by data from electronic health records, episodes of care cost profiles, and satisfaction scores of patients, physicians, employees, and purchasers.
3. Fewer but smarter meetings with agendas that encourage meaningful conversations with expert speakers, clinicians, middle managers, and industry analysts about strategic challenges and future opportunities, rather than reviewing past statistics.
4. Patient stories that ground and inform the board's deliberations about the reality of clinical

frontline challenges and the continuous call for value from care that is convenient, comfortable, customized, and cost-effective.

5. Governance processes and structures that are evaluated each year to develop "governance enhancement plans."

Accountable care demands accountable governance. Great boards must engage in critical conversations about governance best practices in their journey toward continuous governance improvement in the accountable care era.

Douglas A. Hastings is Chair, Board of Directors at EpsteinBeckerGreen. He can be reached at: Dhastings@ebglaw.com.

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Why Insurers Are Investing in Hospital Trustees

By Christine Izui

Trustees are positioned to lead sustainable delivery system transformation to advance the organization's mission. Insurers can help promote such transformation by modifying external incentives and payment levers. Insurers, such as Blue Cross and Blue Shield (BCBS) health plans, invest in trustee education as a step toward effective dialogue and eventual progress on mutual goals to improve the health care delivery system.

Mutual goals, robust data, and a trusting relationship are essential for

experimentation with payment and delivery system change. The realm of patient safety, with its well-understood aims and specific performance metrics, is an excellent starting point for leadership discussions between insurers and health care providers to align goals for payment and system reform.

Although current payment approaches and corresponding educational needs of leaders are evolving rapidly, calls for payment reform to promote higher quality of care are hardly new. More

than a decade ago, the Institute of Medicine's *Crossing the Quality Chasm* series of reports recommended removing payment barriers to quality improvement through experimentation and pilot programs.¹ More recently, the 2012 National Quality Forum's Report to Congress indicated that substantial changes are needed to care delivery and payment if we are to meet the National Quality Strategy aims of "healthy people and communities, better care, and more affordable care."²

Removing barriers to make way for new care processes is daunting work. Invariably, new payment models result in anticipated (and unanticipated) changes in the roles and performance of health care providers along the continuum of the health delivery system. The dynamics of such change must be understood by insurers and hospital leadership alike to assure that the welfare of patients remains central to processes that promote high-quality care. Motivated trustees must have rich clinical-financial information and the appropriate skills to create strategic goals and internal incentives to transition the delivery system to one that meets the needs of the larger public served by the organization.

Historically, the health care industry has not invested in its leaders. In a 2008 article, Conway describes how hospital boards can mobilize to create an agenda for the ambitious aims of the Institute for Healthcare Improvement's 5 Million Lives Campaign.³ In addition to numerous goals focused on changing care at the bedside, the campaign stressed education and engagement to "get 'boards on board.'" BCBS health plans made financial investments to support the campaign and also urged hospitals to join.

Some remarkable results have been achieved in addressing quality and safety issues, such as widespread adoption of methods to end infections.⁴ However, there is evidence that these practices are not being disseminated throughout organizations. For example, a successful intervention in an intensive care unit is not always disseminated to other areas of the hospital where a central line infection may occur. Checklists used in one operating suite may not be adopted by surgical teams in other surgical suites within the same hospital. It is incumbent upon leaders to create a strong message

and a clear path to institutionalize a successful campaign activity and create a sustainable safe patient environment and a culture of continual quality improvement.

Educated trustees are critical to creating an environment of positive change within the organization. A number of BCBS health plans have worked with local hospital associations to provide education as a step in heightening awareness about patient safety, quality, and payment incentives. For example:

- BC of Idaho adopted contract language around specific quality metrics such as readmissions, pressure ulcer rates, and surgical safety, as well as trustee education. Education provided by the hospital association is open to the hospital leadership team, with an emphasis on bringing hospital trustees up to speed on their roles in changing the organization. To leverage this education, BC of Idaho requires that hospitals submit board agendas and quality summaries from meetings to BC of Idaho quality staff. In addition, best practices are disseminated from one hospital to other hospitals in Idaho.⁵
- In South Carolina (SC), the educational model "Best on Boards" includes training, testing, and certification.⁵ BCBS of South Carolina supported this program by underwriting the cost of those attending the training and providing a financial incentive for hospitals with a high percentage of board members certified. Of note, SC embarked on a statewide surgical improvement effort with many stakeholders involved in dialogue and oversight.⁶ Trustees must develop their abilities to understand performance data, statewide goals,

individual hospital goals, available tools, and barriers to improvement.

- BCBS of Massachusetts supports trustee education and also is working to change financial incentives through Alternative Quality Contracts, which link a hospital's rate of pay to demonstrated performance on quality and cost benchmarks.⁷

Trustee education is just a starting point. Trustees must become highly engaged in understanding new metrics of success in payment approaches. As we move into an era of "No Outcome, No Income,"⁸ organizations must understand the new expectations. The pace of experimentation is picking up with the creation of smaller center-of-excellence networks that exclude many hospitals; implementation of episode-of-care processes and payments that span time periods and provider settings; growth of the patient-centered medical home model; introduction of pathways for oncology and other complex, expensive treatments; and transfer of financial risk to providers who are in a position to manage the care.⁹

Insurance companies are increasingly aware of the waste created by poor quality. Several organizations are trying to quantify the amount of waste and the dollars that could be saved if adverse events were avoided.^{10,11} The numbers are staggering, with one organization identifying \$600 billion in potential cost savings by eliminating unexplained variation in the intensity of medical and surgical services (eg, end-of-life care, percutaneous coronary procedures) without adversely impacting quality of care.¹² Opportunity exists for trustees, executive leadership, and insurers to collaborate on ambitious but responsible performance goals and financial rewards aimed at reducing medication errors,

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surgical complications, readmissions, infections, and other problems that arise during medical care.

Organization leadership must prioritize the need for and the direction of change to assure alignment with its mission, staff motivation, and dissemination of best practices. Insurers can help by suggesting changes, requiring performance reporting, and tying financial incentives to performance. Well-informed trustees can guide organizational change using robust intelligence on financial and clinical performance, an understanding of changing payment incentives, and an appreciation of the organization's competencies. In an evaluation of major reasons for joining an organization's board, Martin concluded that the "only worthy motivation" comes from a desire to perform public service.¹³ Trustees are ideally positioned to keep patient and community needs front and center as financial and delivery system changes

unfold. Insurers can be valuable partners in setting appropriate incentives for achieving performance goals and demonstrating a commitment to improvement.

Christine Izui is the former Executive Director of Quality and Safety in the Office of Clinical Affairs Division of the Blue Cross and Blue Shield Association. She can be reached at: izuichris@gmail.com.

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The Future of Governance: Accountability for Customer-Centered Care and Population Health Oversight

By Kathryn C. Peisert

To prepare for new payment models, hospitals and health systems must intensify their focus on improving quality while reducing costs. As care becomes more integrated and reimbursement becomes more closely linked to patient outcomes at the "end" of the care continuum, boards must expand the scope of their oversight to include care settings outside the hospital. Such expansion adds to the complexity of governance, with implications for redefining the board's role in coordination with medical groups, post-acute care organizations, and other nonhospital providers.

Three premises address the question of how hospital and health system boards will be required to govern and oversee quality of care over the coming decade as the transition to value-based care is more fully realized:

- 1) Boards will influence care provided outside of the hospital setting.
- 2) As new research yields evidence for effective governance, boards will be able to practice evidence-based governance.
- 3) Increasingly, boards will govern care that is centered on the customer

and, in effect, will oversee the health of the populations they serve.

A Transitioning Market Moving Care Outside the Hospital

Essentially, care delivery transformation is being dictated by new federal government payment models and new arrangements with private payers that reward value and include varying degrees of shared risk, (eg, bundled payments, pay for performance, accountable care models). These changes provide a compelling business case for the board to be deeply involved in quality of care. Consider the bundled payment model wherein a single payment is generated

for an entire episode of care. The single payment must be distributed among all providers who “touched” the patient. If the hospital provides effective care for a given patient, and that patient receives inappropriate care at a post-acute facility that negatively affects the outcome, the single payment is lower. This example demonstrates the pressure on boards to examine quality and cost, and to create accountability for how care is delivered in other settings. The business case for focusing on quality has never been clearer.

Care delivery must focus on wellness and prevention, increased quality and safety, and reduced costs. Examples include allowing more care to be provided on an outpatient basis, using physician extenders and other nonphysician providers, reducing unnecessary/duplicative tests and treatments, increasing the use of evidence-based processes and protocols, improving care coordination (transitions within the hospital and transitions from one care setting to another), and improving the management of patients with chronic diseases. Organizational integration/alignment (via employment, partnerships, or other accountable arrangements) with physicians will be critical. The new culture at the bedside will dictate changes in the information boards use to assess quality of care and will exert pressure on boards to ensure that their governance practices make a clear difference at the front lines of care.

Board Practices That Affect Outcomes

Increasing calls from the industry for standardized provider protocols and evidence-based practice beg the question of whether evidence can be found to connect board activities to quality outcomes. The small amount of research on this topic, dating back to 2005, shows statistical correlations between board practices in quality oversight and

care outcomes.¹ However, results have been inconsistent and studies have been limited to board practices in the area of quality oversight.

A new study conducted by The Governance Institute and National Research Corporation Healthcare Analytics² matches responses regarding adoption of board practices from The Governance Institute’s biennial survey of hospitals and health care systems to performance on the inpatient process-of-care quality measures included in the Centers for Medicare and Medicaid Services Value-Based Purchasing program. Of 101 board practices, the analysis identified 14 with a statistically significant difference in the proportion of high-performing hospitals adopting the practice versus low-performing hospitals. Examples of those practices are:

- The board requires major hospital clinical programs or services to meet quality-related performance criteria, such as volume requirements, effective staffing levels, and accreditation.
- The board has adopted a policy concerning reporting the organization’s quality/safety performance to the general public.
- The board uses competency-based criteria when selecting new board members.
- The board uses an explicit process of board leadership succession planning to recruit, develop, and choose future board officers and committee chairs.
- The board participates in the development and/or approval of explicit criteria to guide medical staff appointments, reappointments, and clinical privileges.
- The board spends more than half of its time during most board meetings discussing strategic issues as opposed to hearing reports.
- The board has adopted policies and procedures that define how strategic plans are developed and updated, such as who is to be involved, time frames, and the role of the board, management, physicians, and staff.

Although this research sheds some light on practices that seem to affect process-of-care measures, future studies are needed to replicate these results, demonstrate improvement over time, and delve into reasons why these specific practices are revealed in this analysis rather than others. With increased understanding, boards can restructure their work over time to enhance specific areas of oversight. As we ask physicians to practice evidence-based medicine, we also should consider the possibility of practicing evidence-based governance.

Governing Customer-Centered Care and Population Health Management

Along with research leading to evidence-based governance, continuing studies also must explore the expansion of the board’s role into customer-centered care and population health management.

Boards must lead hospitals and health systems into the new realm of value, a key component of which is customer-centered care. Care that supports patients’ needs and preferences also supports patient compliance and improved outcomes.³ Beginning in October 2012, 30% of Medicare reimbursement became tied to certain Hospital Consumer Assessment of Healthcare Providers and Systems patient satisfaction measures. As care becomes centered on the customer, organizational strategy and mission must broaden to encompass actions that target improved

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access points, care coordination, medical homes, and staff training on customer experience issues. Likewise, the quality measures used by boards must evolve along with credentialing and privileging policies.

Beyond physician employment and integration, fewer physicians will continue to practice in hospitals and physician extenders and nurses will take on more hospital care. Again, outcomes-based reimbursement will be based on the quality of care delivered across all settings. Governance considerations include updating criteria and process for physician reappointment to the medical staff, evaluating physician adherence to standardized protocols and procedures, and assessing individual providers' care delivery and outcomes in various settings.

Another component in addressing quality and cost, population health management will be a key element in

redirecting focus toward coordinating and improving care for populations at highest risk of poor health and those with costly chronic diseases. With this in mind, boards must: identify and focus on improving the health status of key patient populations, create interdisciplinary care teams to coordinate this care, engage physician leaders in this effort, and create a new culture centered around customer-centered care and population health.

The Future of Governance

Going forward, new best practices will emerge related to overseeing care delivered outside the hospital setting. Accountable governance models will develop and evolve as accountable care organizations take shape. New and enhanced roles for physicians and nurses will be created in leadership and governance to provide oversight and clinical expertise – and also to help define this new model of governance.

As a result, there may be a rise in joint, collaborative governing boards that contain a mix of clinicians, population health specialists, and nonclinician quality experts to oversee hospitals, clinics, medical groups, and medical homes. As continued research evidence informs improvement and supports governance practices, boards eventually will be able to practice evidence-based governance.

Kathryn C. Peisert is Managing Editor of The Governance Institute. She can be reached at: kpeisert@governanceinstitute.com.

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