

GREAT BOARDS

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BOARDROOM BRIEFING

7 Things Your Board Can Do to Improve Quality and Patient Safety

By Barry S. Bader
with Sharon O'Malley

Hospitals and physicians are being challenged to improve patient care quality and safety and to demonstrate their results more transparently to consumers, government and health insurers.

Governing boards can choose to be either active leaders or passive overseers in the process. Until now, most boards have been less engaged with quality and safety than with financial and business issues. A lack of clinical expertise limits many directors' ability to raise questions and exercise accountability.

Board leadership is a critical ingredient to achieving better, safer care.

This deferential culture does no harm when the organization's clinical leaders and executives take the initiative to adopt leading-edge approaches to performance measurement and continuous improvement. Leaders of several healthcare winners of the Malcolm Baldrige National Quality Award have said their boards were supportive but not central to their efforts.

In most hospitals and health systems, however, board leadership is a critical ingredient to achieving better, safer care. "We're an organization that wants to be benchmarked with the best," says Alan Newberry, CEO of Peninsula Regional Health System in Salisbury, Md., about his board's posture toward quality.

With an "extraordinarily supportive" board, Peninsula Regional has invested heavily in technology and in the development of a culture of quality and safety, says Newberry. It has been named a Most Wired Hospital and recognized by Solucient as a Top 100 performance improvement hospital, one of only 14 hospitals in America that have won that status twice, he says.

"We talk about the No. 1 responsibility of a board member being quality and credentialing," says Newberry. "They understand the awesome responsibility that the board has—a fiduciary responsibility not only for the economic well being of this organization but for the quality."

Newberry says his board has played a pivotal role over 15 years in the health system's quality advancements.

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“Improving the quality and safety of care in the United States is a public health emergency, and boards have a big responsibility in that regard, says Dr. David B. Nash, chairman of the Department of Health Policy at Jefferson Medical College in Philadelphia and chairman of the board’s Quality Committee for Catholic Healthcare Partners, a Cincinnati-based regional system.

“We have an epidemic of medical errors, and 50 percent of patients in the U.S. don’t get the care they ought to, based on the evidence,” says Nash. “Not that all of this is the board’s responsibility, but an awful big chunk of it is.

“Board members have to be educated about what is going on in the national environment on quality and safety, and then use those newly acquired skills to make sure the organization they are responsible for is measuring and delivering on its quality and safety goals,” says Nash. “Most boards fail on both steps. They don’t devote resources and precious time to education on quality and safety, and thus they lack the fundamentals to hold management’s [and clinicians’] seats to the fire regarding quality and safety.”

The governing board’s abilities have been untapped because it has been misdirected to follow rather than to lead. Here are seven ideas for tapping the board’s full potential to exercise quality leadership.

1. Choose board members with “the right stuff.”

Boards today are becoming more explicit about choosing directors and board quality committee members who can carry out quality

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Board Tools

1. Board recruitment
2. Education
3. Measurement
4. High expectations
5. Culture promotion
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responsibilities collegially but with a dose of knowledge and independence. Some are practicing physicians with a passion for the science of quality and safety enhancement. Others, such as vice presidents of quality or customer service in manufacturing and service industries, bring pertinent business backgrounds. Still others are corporate medical directors, nursing school faculty, pharmacists, public health professionals, and retired physicians and nurses.

Just as every great board should include a few experts in finance, audit and executive leadership, so, too, should every board have a cadre of “quality experts” to lead the rest of the board in raising questions, understanding patient care issues and exercising accountability.

2. Educate the board.

Education is what keeps members—both with and without quality-related backgrounds—up-to-date on new quality requirements and improvement knowledge. The range of approaches to educate directors about quality and patient safety includes:

- Orienting new directors to national trends, external mandates such as pay-for-performance and public reporting of quality results, and to fundamentals such as how to read a quality dashboard and ask questions about improvement initiatives.

- Distributing selected articles and educational materials.

- Sending leadership teams of board members, clinicians and executives to outside conferences such as those sponsored by the Institute for Healthcare Improvement and The Governance Institute.

- Sending leadership teams including board members on benchmarking and learning visits to leading-edge health systems or private companies.

- Inviting the organization’s quality leaders to brief the board on their initiatives as part of board meetings or board education sessions.

- Conducting “director’s rounds” in which board members might shadow a nurse for a shift, spend a weekend night in the emergency department, or accompany the CEO on patient safety rounds to gain first-hand appreciation of quality and safety on the front lines. (Rounds both educate directors and visibly demonstrate their commitment.)

3. Use measures to focus board work on what’s important.

“If we can measure it, we can improve it,” says Newberry. But when he talks about the Peninsula board’s engagement in quality, he stresses, “They’re a governance board, not an

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operational board. They make sure processes are in place to ensure quality and economic viability,” but they don’t dictate details of how to do it.

What a board reviews goes a long way in determining whether it’s focused on the big picture or the micro-environment. To use a financial analogy, an effective board looks at high-level measures, such as overall operating margin, expenses as a percent of patient care revenues, and profitability of major business lines—not at each department’s results, which it expects management to monitor.

Yet in quality and patient safety, some boards and their quality committees review departmental quality reports and small-scale improvement projects. Such efforts are important in a quality culture but they don’t merit much board time.

Rather, boards should aim their sights higher. In a 2005 monograph entitled *10 Powerful Ideas for Improving Patient Care*, quality experts James L. Reinertsen and Wim Schellekens write that the history of improvement in healthcare has focused on “project-level” advancements—what they call the “small dots”—rather than the system-level measures of performance, or the “big dots,” such as:

- Safe medication delivery, measured by reducing adverse drug events per 1,000 doses.
- Workplace safety, measured by reducing work days lost per 100 employees per year.
- Survival after a healthcare experience, measured by reducing the hospital standardized mortality rate, a sophisticated, severity-adjusted measure that was developed in Great Britain.

- Quality of life, measured by improving a patient’s functional status after major procedures.

Small project improvements are a building block in larger-scale improvements, and it’s the job of organizational leaders to set the context in the form of goals for the larger undertaking. For example, Reinertsen and Schellekens cite

What a board reviews goes a long way in determining whether it’s focused on the big picture or the micro-environment.

Tallahassee Memorial Hospital, which markedly reduced its hospital standardized mortality rate. To achieve that goal, the hospital sought a deeper understanding of the patterns preceding patient deaths, particularly those it categorized as “needless deaths.” One pattern was the failure to get resources promptly to patients after nurses identified those whose conditions were deteriorating. As a result, the hospital redesigned critical care processes and created rapid response teams on non-critical care units.

It’s also important to remember that “the indicators are the cheese, not the whole sandwich,” Reinertsen and Schellekens write. “It is wasteful and possibly dangerous to measure indicators without having a purpose for doing so and a plan for the outcomes.” They advise leaders to ask three questions about the measures on dashboards and in other reports:

- What is the aim or purpose we

are measuring? “Reducing post-operative infections” and “making intensive care safer” are examples of aims. The board should understand why these aims were selected—to correct sub-par results; because of external requirements or trends; to achieve “best-in-class” or perfect performance; or perhaps all of the above.

- What will we do differently to improve? The board should ask for explanations that demonstrate understanding of the clinical and operational processes that produce clinical results. Bring data to life with stories that make the numbers relevant and compelling.

- How will we know that changes result in improvement? These are the indicators themselves—“the cheese in the improvement sandwich”—and the board should be able to review them in easily readable formats.

4. Pursue perfection, not improvement.

Healthcare providers too often compare their results to the average and aim for incremental improvement. To achieve breakthrough improvements, quality experts recommend asking, “What is, theoretically, the best performance that a given process or system could achieve?” Since the answer is often “zero defects or perfect performance,” the task becomes redesigning the system to achieve that level.

This isn’t mere rhetoric. For example, hospitals in the IHI’s 100,000 Lives Campaign have identified “bundles” of evidence-based, ideal practices to prevent ventilator-related pneumonia, a chronic cause of

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death in hospitals once considered an unavoidable complication of critical care. According to reports on the IHI's Web site, www.ihl.org, hospitals—such as Owensboro Medical Health System in Kentucky and Swedish Medical Center in Seattle—have dramatically reduced and even eliminated ventilator-related pneumonia cases over sustained periods.

“Set a high bar and work toward that goal,” Nash advises organizational leaders. “Don't tolerate incrementalism. Managers have a lot on their minds. They want to focus on the next building project, the next big doctor recruitment, the opening of the new emergency room, the day-to-day blocking and tackling, which are important. The board has to encourage management to think in a more strategic way about quality and to view quality as a competitive advantage.”

5. Pay more attention to culture.

Data, protocols and information technology all play a part in making care safer and more effective, but hospitals are recognizing that another factor trumps them all.

“When it comes to improvement, culture beats technology hands down every time,” says Nash. “A culture that is non-punitive, open and self-evaluative, and questions tightly held beliefs is a culture that will make progress in improving quality and safety. The board has a responsibility to promote a non-punitive culture. That means the board doesn't penalize its management [for shortfalls or errors]. It devotes sufficient resources and education and time for management to reach mutually agreed-upon goals.”

Sentara Healthcare in Norfolk, Va., has studied how organizations in other high-risk industries, such as airlines and nuclear power plants—where even rare errors have catastrophic results—achieve safety records far surpassing healthcare's. The key ingredient, says Sentara's chief medical officer Dr. Gary Yates, is culture.

From companies such as Duke Power, Sentara has learned “it is necessary to change our behaviors in order to change our culture and to improve our outcomes,” Yates explained in a workshop at IHI's

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David B. Nash, M.D., M.B.A.
Jefferson Medical College

annual forum in December. To change behavior, Sentara is pursuing four initiatives to build a culture of safety:

1. Reinforce safety as our core value.
2. Institute behaviors for error prevention and convert them to habit.
3. Focus and simplify work processes and procedures.
4. Start a state-of-the-art event analysis and lessons learned program.

Sentara is training employees to use a “toolbox” of techniques for making safe care a habit, an automatic behavior. A variety of habit-forming methods are used, such as a “self-checking” routine that's done before

risky procedures. To help employees remember it they're taught a mnemonic, “STAR: stop, think, act, review.” Employees also are trained in use of “repeat backs,” such as, “That's 10 milligrams. Correct, doctor?” Sentara's six hospitals also are using so-called “red rules” that are so critical to patient and employee safety (for example, verifying a patient's identity) that exact compliance must “come before any other consideration.” Consequences for non-compliance are serious.

6. Exercise leaders' powerful influence.

A board can directly affect financial and business results by using its authority to approve budgets and major transactions and oversee performance, but many trustees have difficulty seeing how they can influence patient care quality and service.

In fact, leaders exercise their influence in a variety of roles. Formal authority is just one tool, and it's often the least important. “What [leaders] write and say and how they allocate resources” sends a powerful message throughout an organization,

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Reinertsen and Schellekens write. Above all, “time is what followers pay the most attention to.” They encourage boards and other leaders to visibly channel their attention toward high-level organizational improvements.

Peninsula Regional Health System is a case in point. “We reoriented our board meeting agenda and moved the quality reports to the top when we have full attendance and to emphasize the importance of it,” says CEO Newberry. “We put the financial statements after the quality reports, and we have more time to talk about quality.” Before each monthly meeting, the board has an educational session, the majority of them on quality, patient safety and clinical-related technology initiatives.

Peninsula also created a board-level quality oversight committee that includes nine of 16 board members plus senior management and clinicians. New board members often are assigned to the quality oversight committee because it offers an “excellent opportunity to get them up to speed on what’s going on,” Newberry explains.

Board quality committees should develop annual goals related to quality and safety, lay out quality education and reports on an annual calendar, and design meeting agendas that use time for meaningful discussion of performance and improvement priorities.

“Time is the currency of leadership,” say Reinertsen and Schellekens.

7. Recognize and reward excellence.

The board exerts influence directly when it uses its authority to evaluate

and compensate the CEO and approve compensation for other senior leaders. Traditionally, executives’ incentives have been financially driven, but that needs to change. Along with targets for profitability, a strong balance sheet and market share growth, executives’ bonuses should be based on improving clinical quality, patient safety, customer service and employee satisfaction.

“I have a strong belief that economic incentives for management are a critical part of a board’s toolbox for quality improvement,” says Nash. “You’re going to see boards create a component of management bonus compensation tied to various quality and safety measures. At Catholic Healthcare Partners, the 10th-largest system in the country, we have created a robust economic incentive program for senior leaders across the system, directly tied to various quality and safety measures.”

Similarly, Peninsula Regional’s Newberry says, “Part of my pay and performance objectives are based on patient safety and quality. About 36 to 40 percent of our goals are around safety and quality improvement.”

Optimizing the board’s role in quality won’t be accomplished overnight. Quality is complex, and directors have limited time available. However, the payoff for investments in board recruitment, education and information, along with cultivation of a partnership with executives and clinical leaders, will be worth the wait. Boards do make a difference. **GB**

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Planning for unplanned CEO succession

By Sharon O’Malley

Management guru Peter Drucker said a board’s top job is making sure the organization has an excellent chief executive—continuously.

Governance experts agree, recommending that trustees keep an up-to-date succession plan in the hopper just in case the CEO leaves in a hurry because of a sweeter job offer, a sudden illness, termination, or, in the worst case, death.

Yet, according to The Governance Institute, just 24 percent of hospitals and health systems keep their succession plans current—and some consultants say that’s a rosy figure. More than half of healthcare organizations admit they have no succession plan—20 percent higher than other industries—even though two out of five new corporate CEOs fail in the first 18 months. And just 15 percent of freestanding hospitals know who their next CEO will be, compared with 60 percent of businesses.

“It just hasn’t bubbled up as being that important to them,” says Tom Dolan, president of the American College of Healthcare Executives.

Dolan says boards often believe a young or new CEO is wed to the hospital for a long time, so trustees don’t need to think about a replacement.

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But the median tenure of a hospital CEO is just four years, according to Dolan's group, and the unexpected, of course, can become reality at any time.

So healthcare boards need to prepare for "the-CEO-gets-hit-by-the-bus-scenario," says governance expert Mike Kieffer, chairman of the Chicago-based Quick Leonard Kieffer Group. "They need to keep in mind the unplanned transition. It's what to do if your CEO doesn't show up the next day."

What to do

A plan for the unplanned departure of a CEO covers, at a minimum, three bases.

1. Who will step in to run the place right now? The board has three choices: an executive already on staff; an outsider who can serve as an interim CEO until the board can find a permanent leader, a search that usually lasts at least four months; or a management firm that can keep the hospital running.

Anna Wharton Phillips, senior vice president and Eastern region director for consulting firm Witt/Kieffer, discourages organizations from using outsiders as interim leaders "It sends a message to the senior management team that the board may not have confidence in them," she says.

Besides, she adds, "In most organizations, there's somebody who can hold things together in the period of time it takes to do an executive search."

Many plans say the interim CEO is not expected to become a candidate to fill the job permanently, but Kieffer says that dictum is too specific.

More Tips for Boards

- Update the succession plan at least annually and when CEO or board leadership changes.
- Drive the process. Involve the current CEO in the planning, but not as its leader. The board, not the retiring CEO, after all, will be working with the new leadership.
- Support leadership development. Task the CEO with developing the senior team.
- Plan for the expected, too. If a CEO is expected to retire in a few years, start a comprehensive leadership transition planning process.

"I've seen boards change their mind halfway through the [executive] search," he says. "They might be so impressed with the job [the interim CEO] is doing that they want to consider him for the position. You can't plan for that."

2. How much authority will the interim CEO have? A plan for an unexpected CEO vacancy should outline performance expectations for the interim CEO and any limitations on the stand-in's authority.

Typically, says Kieffer, boards don't empower an interim to refocus the organization's strategic vision or initiatives, or to unilaterally make major financial policy changes and hire or fire senior executives.

"You don't want to saddle your

eventual new CEO with a choice made by an interim," notes Kieffer.

In addition, Kieffer recommends, the board should require the interim to meet weekly with the chair and board executive committee until trustees are comfortable with the stopgap routine.

Finally, the plan should address the interim CEO's compensation. Kieffer suggests the board should seek advice from a compensation specialist to make sure the amount is fair, and then should deliver the extra salary either in a check that's separate from the interim's regular paycheck or as a lump-sum bonus at the end of the service to avoid the perception that the person's regular salary has been raised or cut.

3. How will we choose the permanent CEO? Once the hospital or health system is in the capable hands of a trusted interim administrator, the board must quickly turn its attention to the months-long job of finding a new CEO. A good emergency plan outlines the trustees' first steps: It identifies the executive search firm chosen by the board to handle the task and it might name internal candidates whom the board can consider as possible heirs to the throne.**GB**

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Defining who is an ‘independent director’

By Sharon O'Malley

At St. Francis Hospital and Medical Center in Hartford, Conn., a recently updated conflict-of-interest policy requires that two-thirds of trustees have no significant relationships with the hospital other than their board service.

They are not employed by any of the organization's facilities, and neither are any of their immediate family members. They do not work for companies that do or are seeking to transact substantial business with the organization.

They are, in the parlance of a hot governance trend, “independent directors.”

St. Francis revised its policy, says general counsel Barry Feldman, to make sure all board decisions not only are—but also appear to be—in the organization's, and not any individual's or vendor's, best interest. “We want to make sure that neither the board nor management has such a relationship with the other that it has the potential to cause inappropriate decisions,” he says.

Still, the Internal Revenue Service doesn't say St. Francis or any other not-for-profit healthcare organization has to place such strict limitations on the number of “interested” directors—those who could profit in some way from a relationship with the hospital—who may serve on the board.

That leaves it up to healthcare organizations to craft and enforce their own conflict-of-interest policies. St. Francis is among the strictest in the country when it comes to peopling its 31-member board with independent

directors. But Feldman says others will follow suit as they revisit their conflict-of-interest policies. “They would change their policies if they would consider them now,” he says.

Increasing scrutiny

Those changes would reflect the increasing scrutiny not-for-profit organizations—including healthcare systems and hospitals—are under by Congress, the IRS and state attorneys general since the passage of the Sarbanes-Oxley Act.

You've got to keep your head on a swivel and determine what the law is that pertains to your type of organization.”

*Michael Peregrine
McDermott, Will &
Emery*

Sarbanes-Oxley ushered in a new era of corporate governance accountability and independence. It requires directors responsible for oversight of audit and executive compensation to be independent. The law only covers public companies, but its principles—corporate accountability and transparency—can be applied to charitable organizations that receive tax exemptions and are funded, in part, by donors.

Many not-for-profit boards are voluntarily adopting practices to comply with relevant Sarbanes-Oxley provisions. Among them is stricter vetting of trustees for conflicts of interest—not just on a case-by-case basis as conflicts arise, but proactively.

survey found 64 percent of healthcare boards say they are more aware of conflicts than they were three years ago. Almost 25 percent have established a definition for an independent director, and 14 percent are considering it. And 26 percent have developed “disabling guidelines” that draw clear boundary lines defining when a conflict is great enough to disqualify someone from serving as a director.

Murky area

So exactly who is an “independent director?”

Except in California, the term is not defined under not-for-profit law, explains Michael Peregrine, a partner in the Chicago law firm McDermott, Will & Emery. “You've got to keep your head on a swivel and determine what the law is that pertains to your type of organization,” he notes.

T.J. Sullivan, a partner in the healthcare law firm Gardner Carton & Douglas in Washington, agrees. “Ultimately, the board can decide—within reason—what it wants its definition of an ‘independent director’ to be.”

To develop a workable definition, Sullivan recommends asking two questions:

1. Is the director, a family member or a business entity owned or controlled by the director being paid by the hospital as an employee or consultant?

2. Does the director, a family member or a business entity owned or controlled by the director have a

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financial arrangement—such as ownership, investments or compensation—with the hospital or its subsidiaries, vendors or competitors?

If the answer to either of these questions is yes, the director probably is not independent—but isn't necessarily banned from serving on the board.

At St. Francis, an independent director is “one whose conflict of interest (if any) is of such insignificance, as determined by the Governance and Nominations Committee, that the conflict of interest would not be reasonably perceived to exert an influence on the director's judgment.”

To make that determination objectively, a “material” conflict of interest is further defined as one in which “the contract, transaction or arrangement in question is valued at more than 1 percent of the income or revenues of the director, entity or individual who is the recipient of the benefit, and

(a) the director's direct or indirect actual or potential ownership, investment or other interest is more than 5 percent of the total ownership interest, or

(b) the director's direct or indirect compensation arrangement involves more than \$10,000, or

(c) the director's direct or indirect relationship or arrangement would reasonably be expected to exert an influence on the director's judgment if he or she were called upon to vote on the matter.”

Directors also have a material conflict of interest if they or a family member is on the medical staff or is

an employee, director or officer of a competitor organization, or a family member is employed by St. Francis.

That doesn't mean that otherwise-qualified trustees who have material conflicts of interest can't serve on the board, notes Feldman. But not more than a third of board members may have such conflicts, and those who do may not participate on committees that deal with audit, governance, compensation and finance.

Conflict-free

Peregrine endorses the gravitation by not-for-profits toward conflict-free trustees. “The reason for all this focus on independence is very simple,” he says. “It's to make sure board decisions are made by people who don't have a stake in the game.”

Should a board require a minimum number of directors to be independent? The Panel on the Nonprofit Sector has recommended that at least a third of board members be independent. The New York Stock Exchange revised its definition of “independent director” in 2003 to call for a majority of directors to be free from material conflicts.

Peregrine suggests that healthcare boards use those suggestions as a starting point. “There's no need to reinvent the wheel,” he says, but each health system should adopt a policy that makes sense for that organization.

To that end, he suggests that boards begin their deliberations by asking: Why are we trying to do this? “It should be a thoughtful process for an organization to arrive at a final number,” he says.

Indeed, part of that thought

process should include considering the kinds of potential trustees who might be eliminated if the board is entirely independent.

Eliminate carefully

Boards should weigh the benefit of independent directors against the potential loss of knowledgeable, committed trustees, Peregrine explains. He typically does not recommend that boards require more than 51 percent of members to be independent.

And although the St. Francis board requires that two-thirds of its trustees be independent, Feldman says a wholly independent board would be a bad idea.

“Not-for-profit organizations have a lot of ties to the community,” he explains. “Because of the nature of the constituencies that are important to have on an organization's board—and the competencies that need to be on an organization's board—it's virtually impossible to have a board that is totally without conflict.”GB

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