MHA Massachusetts Hospital Association

The leading voice for hospitals.

Leading on Quality and Safety: Briefing for Hospital Trustees

Quality and Patient Safety Division,
Board of Registration in Medicine and
Massachusetts Hospital Association

June 3, 2013 8:00-11:15 AM
MHA Conference Center
5 New England Executive Park
Burlington, MA 01803

Welcome

Pat Noga, Ph.D., RN
V.P. Clinical Affairs

Tracy L. Gay, JD, MSHA
Director, Quality & Patient Safety Division
Massachusetts Board of Registration in Medicine

MHA Massachusetts Hospital Association
The leading voice for hospitals.

Board of Trustees' Role in Quality and Patient Safety

What are the Recommended Practices for Governance Leaders to Improve Quality Outcomes

James B. Conway, MS FACHE

MHA Massachusetts Hospital Association

The leading voice for hospitals.

Leading on Quality and Safety: Briefing for Hospital Trustees, Executives and Physician Leaders

Les Selbovitz

Jim Conway

Our Overview of Session

Anchored in Discussion

- Overview of the Board of Trustees' Role in Quality and Patient Safety—Jim
- What are the Recommended Practices for Governance, Executive, Physician Leaders to Improve Quality Outcomes—Jim
- Engaging and Partnering with Physician Leaders—Les
- Creating Alignment for Quality—Les & Jim
- Disrespectful Practice Case Discussion—Les

What do YOU want to make sure we cover?

Leading on Quality and Safety

Briefing for Hospital Trustees

Overview

Jim Conway
Adjunct Faculty, HSPH
jconway@hsph.harvard.edu

For your service to your patients, families, staff, and communities.

At the State Level, Leadership from the Top

- Mass Hospital Association
  - State Wide Performance Improvement Agenda
  - 100% Board participation

MHA'S STATEWIDE PERFORMANCE IMPROVEMENT AGENDA ACHIEVES 100% HOSPITAL BOARD OF TRUSTEE ENDORSEMENT

TRUSTEE LEADERS SAY HOSPITALS "COMMITTED TO DOING MORE"

One hundred percent (100%) of MHA's acute care, long-term acute care and rehabilitation hospital members have endorsed the association's Statewide Performance Improvement Agenda (SPIA) through their boards of trustees. The SPIA initiative was spurred by MHA's Trustee Advisory Council (TAC) and approved by MHA's Board of Trustees.

SPIA is a commitment to move beyond public reporting to make measurable, concrete improvements in hospital performance. Specifically, the goals are to improve quality by reducing preventable mortality;

Why Do Boards Exist?

To represent the owners

Fiduciary Responsibilities Boards of Directors

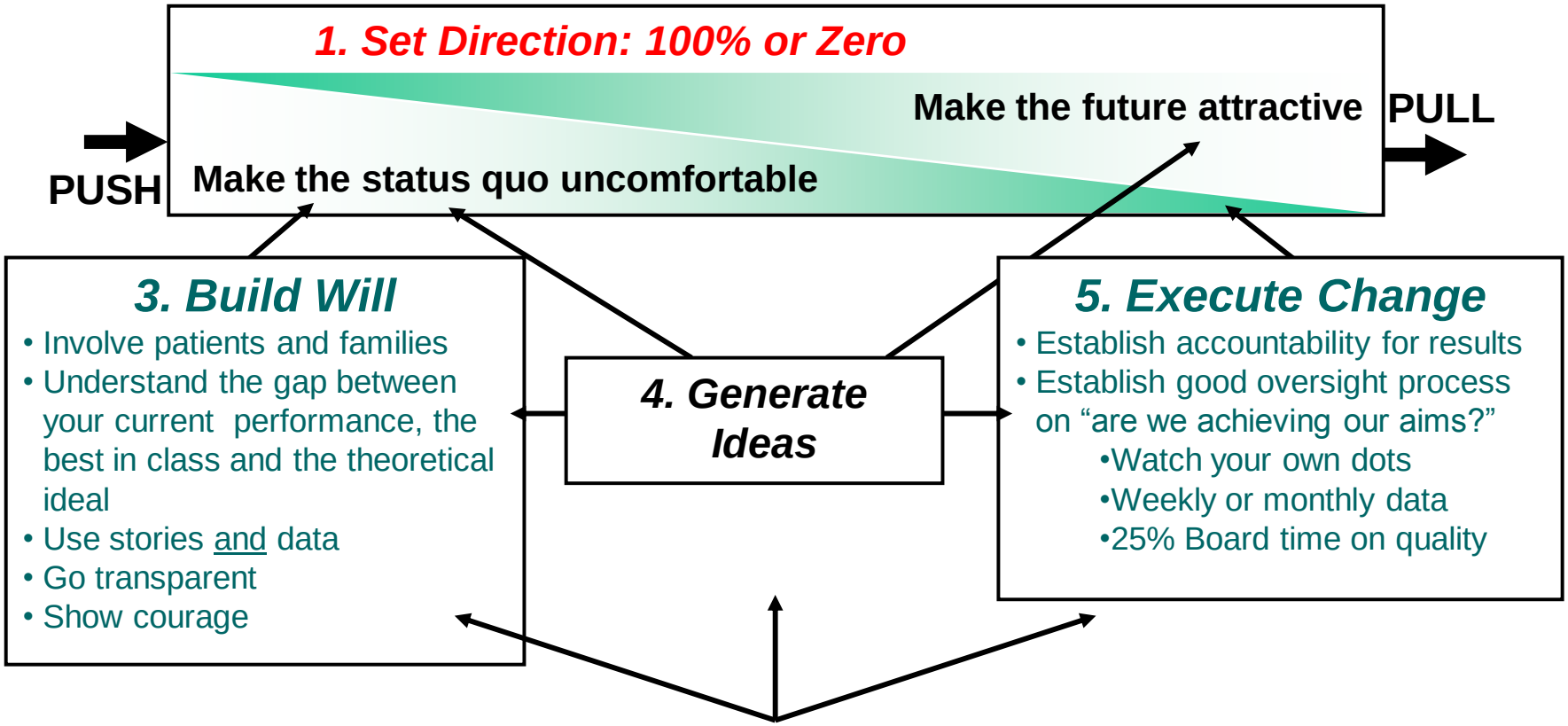
- Non-profit and for-profit
  - Duty of Care
    - Directors carry out their duties in good faith with the duties of care, attention, and skill that a person in a like position would reasonablly believe appropriate
  - Duty of Loyalty
    - Directors are obligated to act solely in the interest of the corporation and to place the organizations interest above their personal gain
- Non Profit
  - Duty of Obedience
    - Directors are obligated to act in a manner that preserves the mission of the corporation.

Miller TE, Gutmann VL. Changing expectations for board oversight of healthcare quality: the emerging paradigm. J Health Life Sci Law. 2009 Jul;2(4):31, 33-77. Center for Health & Pharmaceutical Law & Policy, Seton Hall Law School, USA. millertr@shu.edu

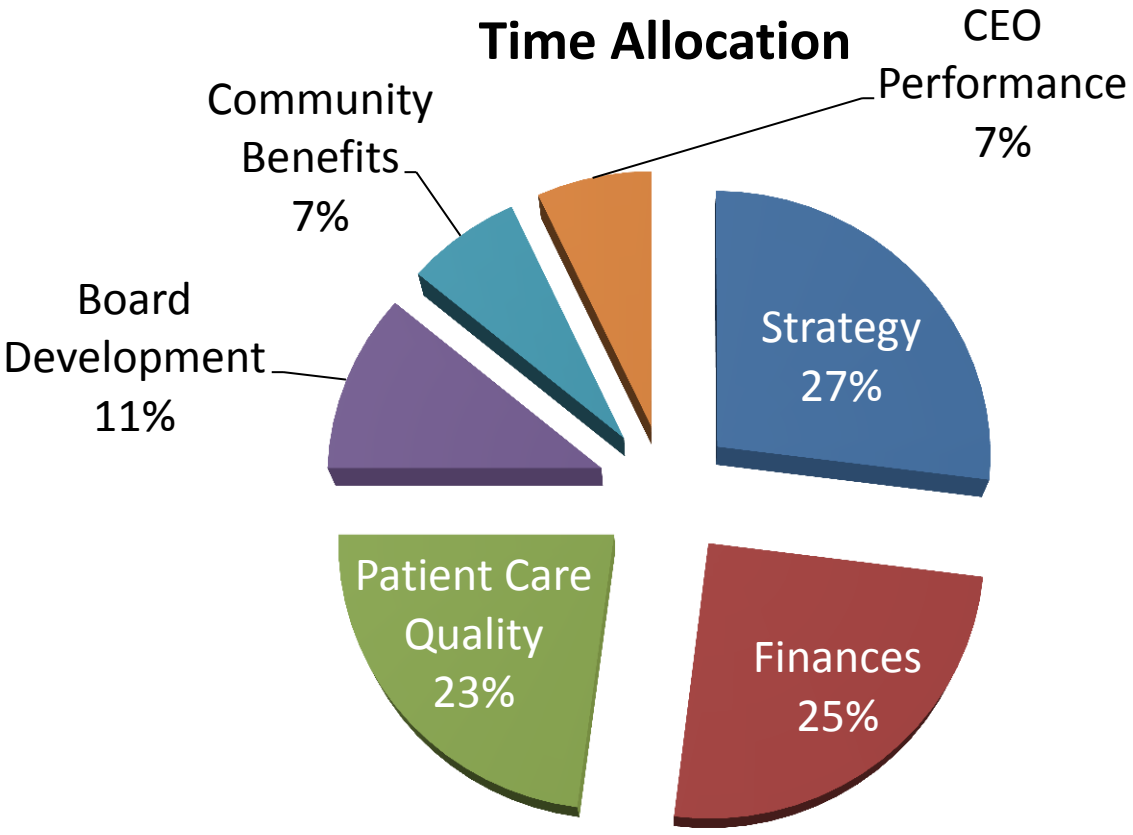
Boards Oversee,
On the Owner's Behalf…

- Mission
- Strategy
- Executive leadership
- Financial stewardship
- Quality of care and service

IHI Framework: Board Leadership of Quality



How Is The Time Of The Community Health System Board Allocated?



Prybil LD, et. al. Board oversight of patient care quality in community health systems. 2010. http://www.ncbi.nlm.nih.gov/pubmed/20042764

Functions of a Board Quality Committee

- Recommend annual quality and safety aims to the board
- Integrate the patient and family into the committee
- Oversee achievement of quality and safety aims
- Oversee credentialing process integrity and reliability
- Oversee compliance with quality/safety regulatory requirements
- Recommend new/improved quality and safety policies to the full board for adoption, as needed
- Signal to management and medical staff desired quality and safety culture in the organization
- Build the team and provide locus for crucial conversations among board, executive and clinical leaders

Trustee-Basic Agenda
Board Quality Committee

- Begin with a brief story of a patient experience
- Review the major quality and safety aims for the year, and the current “strategic dashboard” on performance toward those aims.
- Review sentinel events and reports of harm
- Review the “regulatory dashboard” for any exceptions—anything that is falling out of compliance, and hear the plan for getting back into compliance
- Consider any policy recommendations that need to be brought to the full Board, and vote on them
- Review the meeting itself. Did we talk about the important things? Did everyone get a chance to be heard? What could we improve?

Board Quality Committee Report to the Full Board

- Every board meeting
- First item on agenda
- Assume 25% of board time
- Trustee leads with management support.
- Always use language that allows trustees to apply their personal learning.
- Review the big dots in simple language.
- Highlight key issues that the committee is dealing with.
- Solicit feedback and questions.
- Make recommendations for policy changes.

Board and Board Quality Committee Struggles Observed

- Full Board disengagement
  - "The Committee will look at it"
- Board moves from governance to operations
  - Into the weeds / No time for generative thinking
- Report overload
  - No time for discussion or questions
- The "Quality" trustee
  - "If it is about quality, Paul will catch it"
- The struggle of the lay board member
  - "What can I say? I'm not a clinician."
- The Board member in the community
  - Transparency and confidentiality
- This can't be done quarterly
  - No, many are meeting 10 to 12 times a year

Hot Topics:

- Growing board accountability CMS, OIG
- Overload / waterfall
  - Resourced systematic improvement
- Value/Waste:
  - Measuring & linking: quality, cost, service, satisfaction
  - Driving out waste
- Engaging physicians
  - Competence, disruptive behaviors, credentialing
- Serious reportable events / never events
- Boards: system, public, rural, critical access hospitals
- Dashboards
- Involving patients and families
- Governance and leadership assessment
- Forming a quality committee of the board

Comments, Questions, Answers

Leading on Quality and Safety: Briefing for Hospital Trustees, Executives and Physician Leaders

More on recommended best practices for Governance and Executive Leaders?

ACHE Policy Position: The Healthcare Executive's Role in Ensuring Quality and Patient Safety

- Equipping the board with tools and information to provide appropriate oversight of the patient safety/quality strategy.
- Involving the entire executive leadership team in the patient safety/quality strategy.
- Engaging the medical staff as meaningful partners in the development and implementation of the patient safety/quality strategy.
- Developing processes to hear the voices of patients and families and applying their input in the design and improvement of care processes.
- Cascading a patient safety/quality orientation throughout the organization.
- Developing a culture of improvement that includes an organization-wide commitment to continuous learning.
- Rigorously seeking out and applying best practices.
- Providing open communication and demonstrating a commitment to transparency.
- Adopting information systems that support the patient safety/quality strategy.
- Encouraging organizational involvement in voluntary collaboratives. healthcare organization, active participation is encouraged.

Approved By the Board of Governors of the American College of Healthcare Executives on November 10, 2008

Built off IHI Boards on Board Plank

2013: Some Recommended Best Practices

- Setting aims
  - Know your aims. Strategic as well as compliance
- Getting data and hearing stories
  - Focus is on all harm (patient and staff) and not just the tip
  - Data is transparent
  - Understand variation at the practice and practitioner level
- Establishing and Monitoring System-Level Measures
  - Don't get lost in the weeds of core and process measures
  - Value: Clinical, financial, service, and experience "dance"
  - Measure across care continuum (and not just inpatient)
- Changing the Environment, Policies, and Culture
  - Allocate significant time to quality, safety, risk
  - Measure and evolve cultural variation within organization
  - Respectful Management of Serious Adverse Events
  - Active engagement in and management of credentialing
  - Team building processes
- Learning
  - Conduct in-service and continuing education
- Establishing Executive Accountability
  - Clinical, financial, service, experience outcomes

Board Practices Impacting Outcomes

A Growing Statistically Significant Evidence Base

Practices by Boards	% Practicing
At most board meetings, devotes a significant amount of time to quality issues/discussion	68.5
Has a standing quality committee of the board	65.2
Requires management to base at least some of the hospital's quality goals on the "theoretical ideal"	63.2
Requires the hospital to report its quality/safety performance to the general public	39.3
Both the board and the medical staff are at least as involved or more involved than management in setting the agenda for the board's discussion on quality	49.0
Reviews quality performance measures using dashboards, balanced scorecards, run charts, etc., at least quarterly to identify needs for corrective action	93.7

Jiang, et. al. Enhancing board oversight on quality of hospital care http://www.ncbi.nlm.nih.gov/pubmed/21712722

Questions That Every Board Member Can Ask About Clinical Quality

- Are we on track to achieve our aim?
- Are we executing our strategy to achieve our aim?
- Are we “off the rails” on any regulatory or compliance issues?
- How many patients is that?
- Who is the best in the world?

MD Engagement & Credentialing

What are Governing Boards and Executive Leaders Doing?

Credentialing

- Setting behavior expectations
- Setting peer review expectations:
  - measures and process
  - “report cards”
- Re-education on process
- Receiving segmented recommendations @ Board
- Discussing high risk cases
- Sitting on Credentials Cmte.
  - Permanent or “audit”

MD Engagement

- Active participation @ Board
  - Updates of activities
  - Time allocated for Q&A
- Retreats / Joint Education
- Partnerships
  - Agenda setting
  - Strategy setting
- Enhancing office based practice
- Compacts
- Coaching / consulting

What are your
recommended practices?

Comments, Questions, Answers

Appendix

v03
03/01/08

PROTECTING 5 Million lives FROM HARM IHI.org

Getting Started Kit:
Governance Leadership "Boards on Board"

How-to Guide

A national initiative led by IHI, the 5 Million Lives Campaign aims to dramatically improve the quality of American health care by protecting patients from five million incidents of medical harm between December 2006 and December 2008. The How-to Guides associated with this Campaign are designed to share best practice knowledge on areas of focus for participating organizations. For more information and materials, go to www.ihi.org/IHI/Programs/Campaign.

This How-to Guide is dedicated to the memory of David R. Calkins, MD, MPP (May 27, 1948 – April 7, 2006) – physician, teacher, colleague, and friend – who was instrumental in developing the Campaign's science base. David was devoted to securing the clinical underpinnings of this work, and embodied the Campaign's spirit of optimism and shared learning. His tireless commitment and invaluable contributions will be a lifelong inspiration to us all.

The Joint Commission Journal on Quality and Patient Safety

5 Million Lives Campaign

Getting Boards on Board: Engaging Governing Boards in Quality and Safety

James Conway, M.S.

This article is the sixth and final in the series on the 5 Million Lives Campaign, the Institute for Healthcare Improvement's national initiative that aims to protect patients from five million incidents of medical harm in United States hospitals between December 2006 and December 2008.

The Institute for Healthcare Improvement (IHI)'s 5 Million Lives Campaign has set a target of reducing five million incidents of harm in hospitals from December 2006 to December 2008. To that end, the campaign has recommended 12 interventions. The only nonclinical intervention is to fully engage the governance leadership in quality and safety, more commonly known as "Getting Boards on Board."

Our goal is for boards of trustees in all hospitals to undertake the recommended six key governance leadership activities to improve quality and reduce harm in their hospitals. At a minimum, at every meeting, boards should spend more than 25% of their meeting time on quality and safety issues and should conduct, as full boards, a conversation with at least one patient, or family member of a patient, who sustained serious harm at their organizations within the previous year.

As hospitals seek to drive rapid quality improvement, boards have an opportunity, indeed a significant responsibility, to make better quality of care the organization's top priority. Outmoded views of hospital governance suggest that hospital boards are responsible primarily for the organization's financial health and reputation. Board duties in these areas are unquestionably important, but the board's duties do not end with financial stewardship. Boards oversee mission, strategy, executive leadership, quality, and safety on behalf of the owner—whether the hospital is a nonprofit, government, or investor-owned facility. For nonprofit and government facilities, this owner is the

Article-at-a-Glance

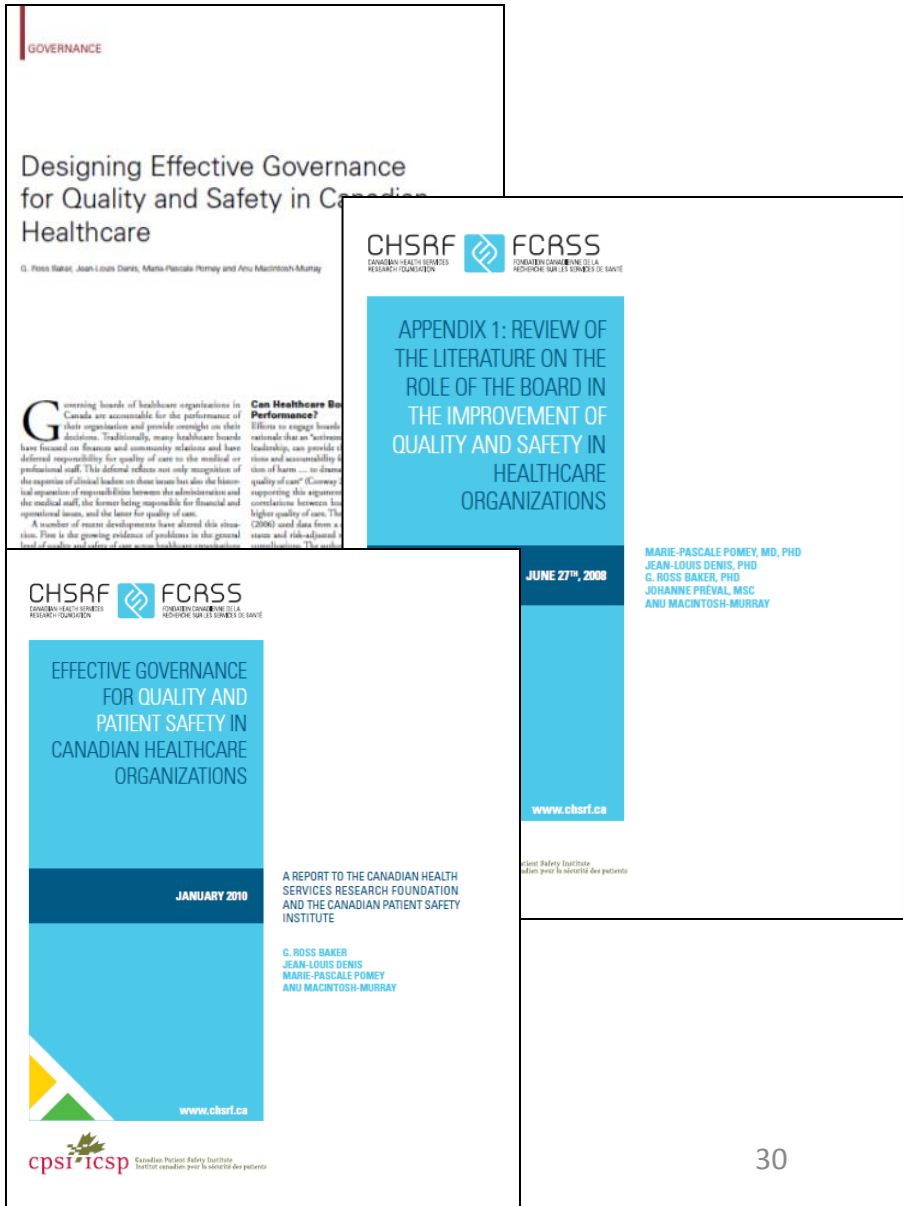
Background: As hospitals seek to drive rapid quality improvement, boards have an opportunity—and a significant responsibility—to make better quality of care the organization's top priority.

Intervention: "Six things all boards should do to improve quality and reduce harm" are recommended: (1) setting aims—set a specific aim to reduce harm this year; make an explicit, public commitment to measurable quality improvement; (2) getting data and hearing stories—select and review progress toward safer care as the first agenda item at every board meeting, grounded in transparency—and putting a "human face" on harm data; (3) establishing and monitoring system-level measures—identify a small group of organizationwide "roll-up" measures of patient safety that are continually updated and are made transparent to the entire organization and its customers; (4) changing the environment, policies, and culture—commit to establish and maintain an environment that is respectful, fair, and just for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error; (5) learning, starting with the board—develop the board's capability and learn about how "best-in-the-world" boards work with executive and medical staff leaders to reduce harm; (6) establishing executive accountability—oversee the effective execution of a plan to achieve aims to reduce harm, including executive team accountability for clear quality improvement targets.

http://www.ihi.org/knowledge/Pages/Publications/GettingBoardsonBoard.aspx

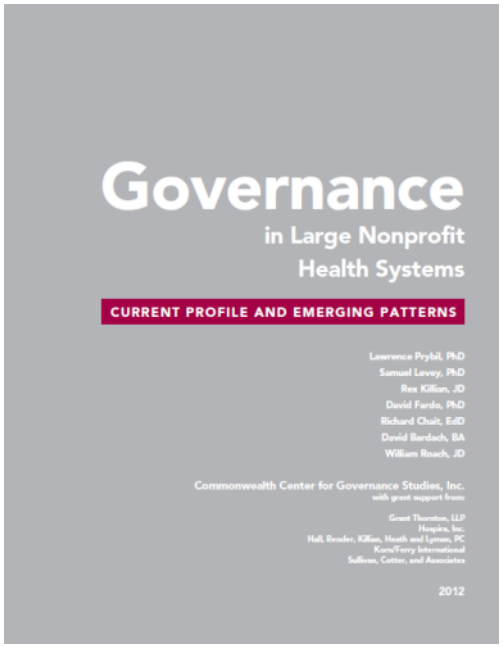
Outstanding Canadian Resources

- Effective Governance For Quality And Patient Safety In Canadian Healthcare Organizations
- Effective Governance for Quality and Patient Safety: A Toolkit for Healthcare Board Members and Senior Leaders
- Designing Effective Governance for Quality and Safety in Canadian Health-care



Quality and Safety Recommendation: Governance in Large Non-Profit Health Systems

Mount concerted initiatives — in partnership with their clinical leadership teams, other health systems, voluntary associations, and independent experts in this area — to define more clearly the roles that boards and board committees can and should play in today's environment with respect to patient care quality and safety.



Prybil L, et.al. Governance In Large Nonprofit Health Systems: Current Profile and Emerging Patterns. 2012. Commonwealth Center For Governance Studies, Inc., P. O. Box 250, Lexington, Kentucky, 40588

GreatBoards
The American Hospital Association's
Promoting Excellence in Health Care Governance

Issue 03
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Managing Editor
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Editor
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Q&A: Physicians on Hospital Boards: Prepare to Challenge Traditional Wisdom

by Mary K. Totten

Editor's note: Relationships are changing between hospitals and physicians as they work more closely together to implement new models of care delivery and lead value-driven, integrated care systems. These changes also will affect physician board members, as traditional approaches to their selection and role are likely to migrate beyond ex-officio representation of medical staff needs and views toward broader competency-based, mission- and vision-focused participation. However, change rarely occurs without challenge. To help sort through some of these challenges, Great Boards asked John Combes, MD, President and Chief Operating Officer of the AHA's Center for Healthcare Governance, and Barry S. Bader, governance consultant and contributing editor to this newsletter, to share their views on the implications of health care transformation for physicians on boards.

Great Boards: *What are the traditional roles physicians have played on hospital boards, and how have physicians come to serve on the board?*

Bader: Physicians have been and should continue to be valued for bringing clinical knowledge to help the board understand patient care, and for their connection to the medical staff's perspective on hospital matters. Imagine planning an ambulatory care center or approving a quality improvement plan without clinical expertise, and the value that physicians could bring is clear. Many physician trustees I've met are smart, collegial and committed to the hospital. They make boards more effective in numerous ways.

On the other hand, some medical staffs traditionally viewed physician trustees as their "representatives" on the board, an outdated perspective that contradicts the fiduciary duty all trustees have to act in the best interest of the entire organization, not a single stakeholder. One traditional means of selecting physician trustees — *ex-officio* seats for medical staff officers such as the medical staff president, president elect and past president — perpetuate the notion that physician trustees are there to represent doctors.

Combes: The traditional practice has been to have the chief of staff serve on the hospital board in an *ex-officio* capacity without vote to represent medical staff issues and concerns. Over time, however, as hospitals began to view physicians as their "customers," more physician members were added to boards, but their role was not well-defined and often they were not oriented or developed to be effective board members. Today, more boards realize that the true value of having physicians at the board table lies in tapping their clinical and patient care expertise to advance the hospital's mission. Savvy boards understand that the distinction between "lay" and "physician" board members is becoming more of an artificial one and that all board members should be selected for the competencies they can bring to effective governance.

Great Boards: *Why has the matter of physicians serving on hospital boards become more challenging today?*

Combes: As the workload for boards increases, finding the time to prepare and participate effectively is a challenge, not only for physicians on boards, but for all trustees. Financial relationships between hospitals and physicians are becoming more varied and complex, which will make it more difficult to find physicians who can serve as truly independent, stakeholder- and mission-focused board members. Few boards are conflict-free, and boards have processes for managing conflicts. However, some boards are seeking physicians who are retired, or who work in industry or for non-competing health care organizations to avoid the conflicts that exist when physicians have a financial relationship with the hospital.

Bader: Board service today obviously is time-consuming, and that's challenging for busy physicians. The requirements for board independence and objectivity also run counter to allocating "representational seats" for single stakeholders such as the medical staff.

More important, though, the fundamental relationship between the hospital and its medical staff is changing. The medical staff once was a quasi-independent, self-governing entity of private practitioners who used the hospital's facilities as a workshop.

Today, hospitals need physicians to function as full care team partners in order to become integrated

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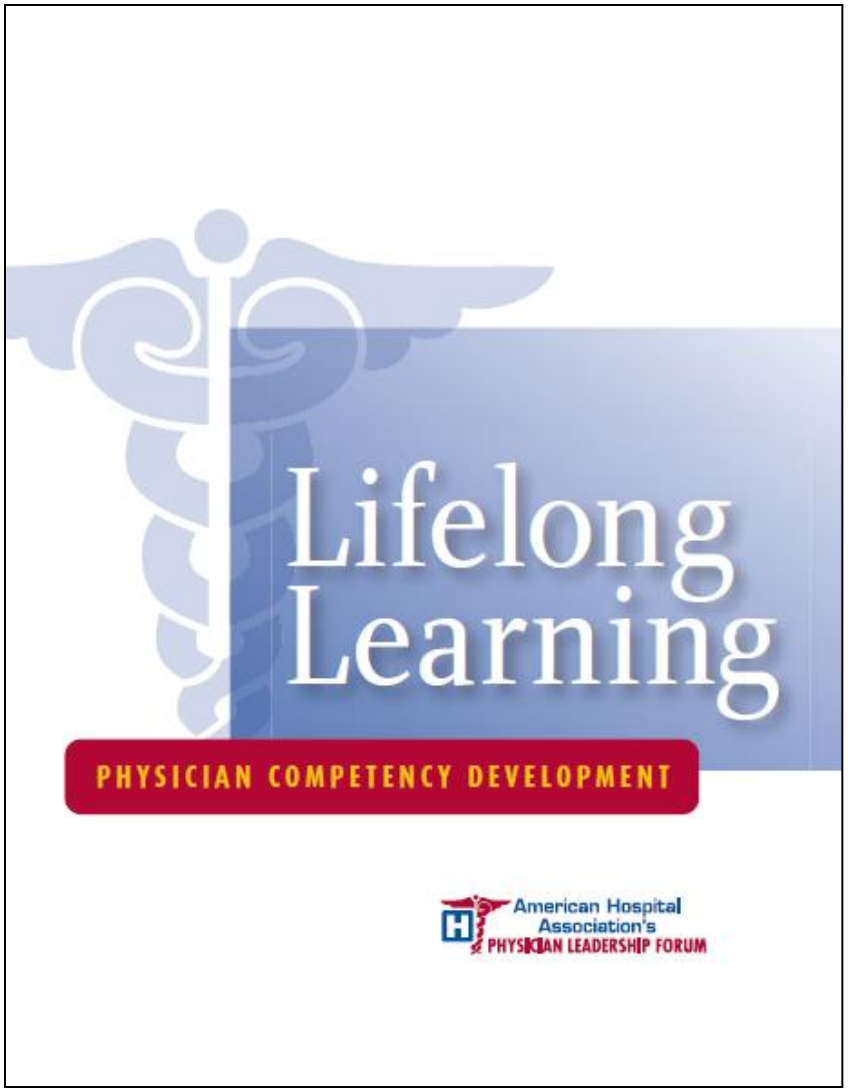
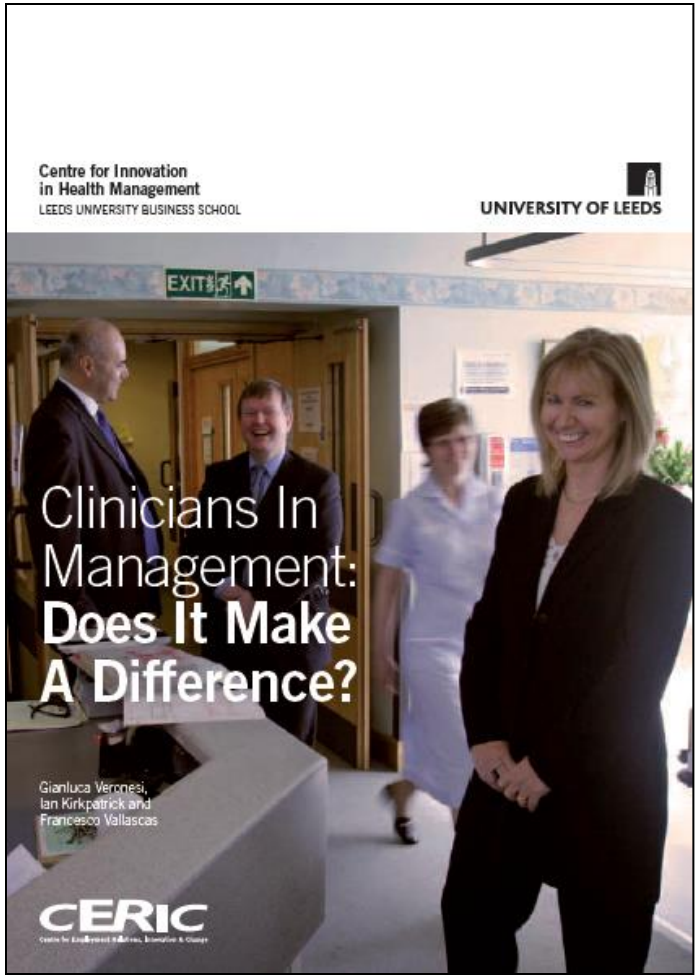


http://www.greatboards.org/newsletter/2011/GreatBoards-reprint-2011-Physicians-on-Hospital-Boards.pdf

http://www.ahaphysicianforum.org/files/pdf/physician-competency-development.pdf

Interesting 2012 Governance and Medical Staff Research Finding in the UK

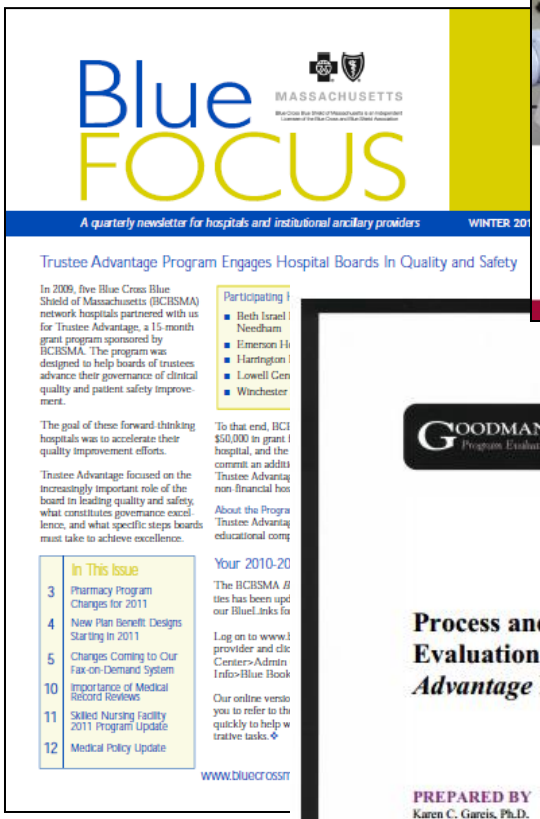


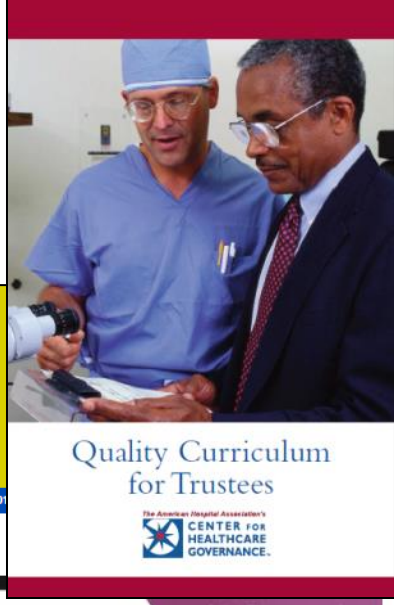
" Increasing the number of doctors on boards significantly increases quality assessed in terms of Health Commission trust ratings, lower morbidity rates and increased patient satisfaction."

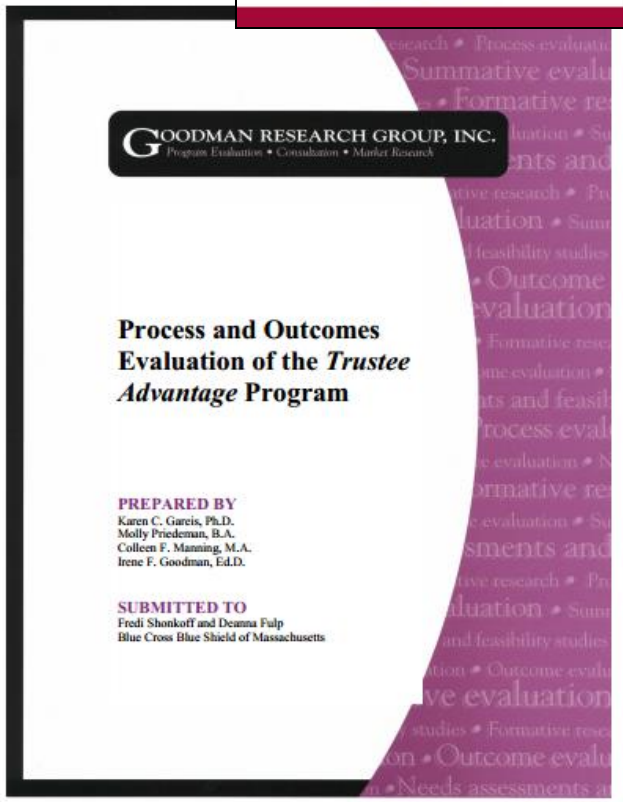
http://www.cihm.leeds.ac.uk/new/2012/05/clinicians-in-management-does-it-make-a-difference/

Trustee Advantage Facilitating Conditions

- Adequate financial stability;
- A CEO who is a champion, welcomes increased personal accountability for quality and safety, and is comfortable dealing with an increasingly activist board;
- Additional champions on the board and medical staff;
- a non-defensive and open culture willing to confront deficiencies; and
- a certain degree of progress already demonstrated on quality and safety improvement.



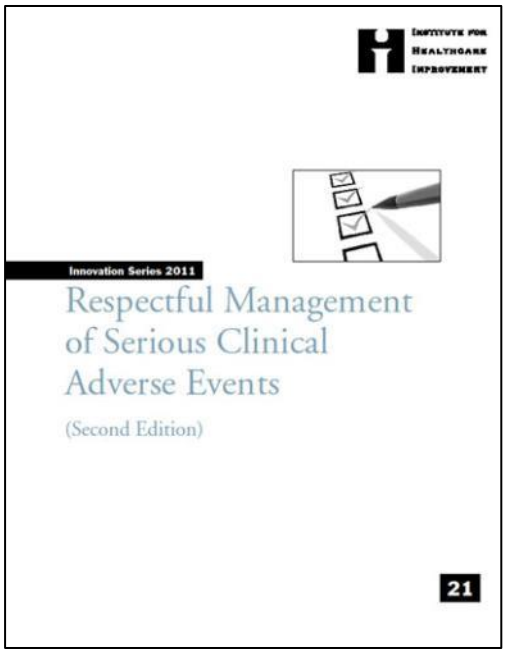




http://www.grginc.com/documents/1GRGBCBSTrustAdvFinalReportTEXT01-27-11rev.pdf

An IHI Resource Center

Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management



"In the aftermath of a serious adverse event, the patient/family, staff, and community would all say, 'We were treated with respect.'"

http://tinyurl.com/IHIEffectiveCrisisMgmt

Additional Resources Noted During Presentation

- Bohmer RM. Leading clinicians and clinicians leading. N Engl J Med. 2013 Apr 18;368(16):1468-70. doi: 10.1056/NEJMp1301814.

- Bunnell CA, Gross AH, Weingart SN, Kalfin MJ, Partridge A, Lane S, Burstein HJ, Fine B, Hilton NA, Sullivan C, Hagemeister EE, Kelly AE, Colicchio L,Szabatura AH, Winer EP, Salisbury M, Mann S. High performance teamwork training and systems redesign in outpatient oncology. BMJ Qual Saf. 2013 May;22(5):405-13. doi: 10.1136/bmjqs-2012-000948. Epub 2013 Jan 24.

NEWTON-WELLESLEY HOSPITAL

Quality and Patient Safety Division of the Board of Registration in Medicine and the Massachusetts Hospital Association

Engaging and Partnering with Physician Leaders

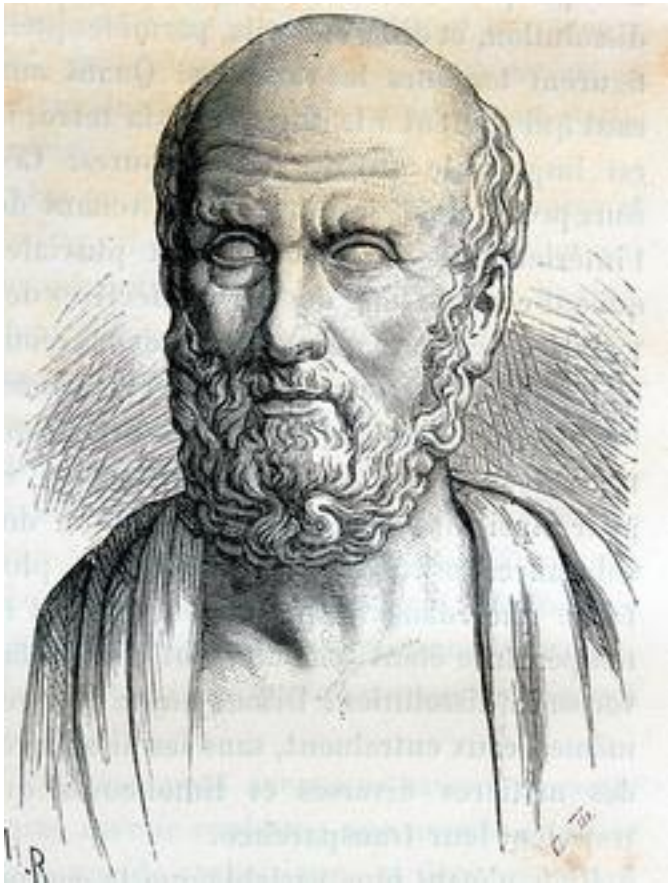
Conference on Quality and Safety
June 3, 2013

Leslie G. Selbovitz, MD

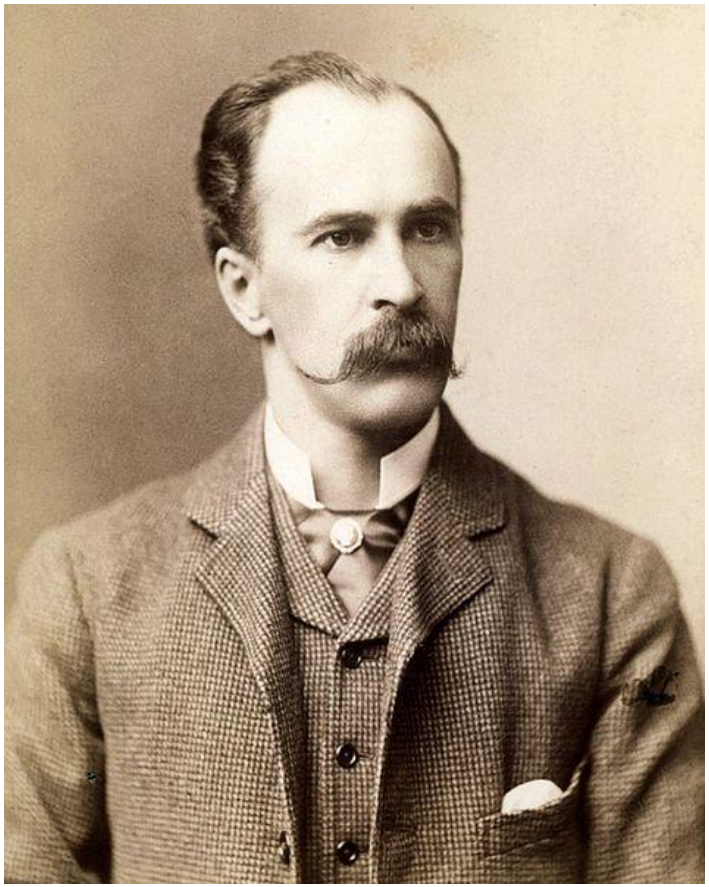
Chief Medical Officer and Senior Vice President for Medical Affairs
Newton-Wellesley Hospital
Clinical Professor of Medicine
Tufts University School of Medicine

Rest of the Agenda

- Engaging and Partnering with Physician Leadership
  presented by Les
- Creating Alignment for Quality
  presented by Jim and Les
- Disrespectful Practices: Case Discussion
  presented by Les



Hippocrates- 400 B.C.



Sir William Osler- 1884

Engaging and Partnering with Physician Leaders: Principles and Practices

Principles:

1. What are the personality characteristics and motivations that drive individuals to become physicians?
   Corollary: How do physicians think?

2. The Vision

3. The Values

4. The Mirror

5. The evolution of professionalism

6. The imbalance between rugged individualism and team membership

7. Risk of trivialization of quality and safety: the importance of words and language
   -Transactional derivatives

Engaging and Partnering with Physician Leaders: Principles and Practices (continued)

Principles (continued):

8. Do physician leaders passively emerge or are they actively created? Common characteristics? Clinical credibility, respectful behaviors, living in a culture of safety zone, approachable, more equanimity than lability, language, tone, careful framing of issues, collective medical I.Q.

-Influence, do not order

-Use power wisely → correlated with erosion

9. Physician culture can be created or derived from these common leadership characteristics

- Totally ignore the physician business practice models
- All principles of professionalism are uniformly distributed

10. Trust and respect of physician leaders is the *sine qua non* of a high performance and aligned medical staff.

11. It's about CULTURE and ETHICS:

-Duty, Altruism, Respect

- George Engel, MD patient and institutional approach

Engaging and Partnering with Physician Leaders: Principles and Practices (continued)

Practices:

1. Time and attention to make credible, and in reliable fashion, the words and deeds that honor a culture of respect: the physician role model recognized and rewarded

   -Integrate physician leader(s) into Executive Management Team

2. Provide adequate resourses to build 360 relationships!

3. Support the quadruple mission of physician leaders:
   - **PATIENT CARE EXPERTS**
   - Educators
   - Discoverers
   - Citizens of the community

4. Create a supporting structure for the most powerful force to motivate physician introspection and desire to change:

   PEER REVIEW

5. Appreciative Inquiry, coupled with accountability, fosters a respectful culture

Engaging and Partnering with Physician Leaders: Principles and Practices (continued)

Practices (continued):

6. Non-punitive peer review in an embracing environment: both safe and mandatory to participate
    * Energy
    * Commitment
    * Optimism
7. Tools and methods to assure validity and reliability of peer review process to analyze care and then improve, measure, feedback, and adjust perpetually
8. Embody physician knowledge into *a priori* construct to guide care (eg, order set guidelines)
9. Blend inpatient and outpatient quality and safety accountability
10. Create a steering, operating and accountable committee structure for quality and safety programs that engages the Board of Trustees on a monthly basis
    - DEAL WITH THE HIDDEN CURRICULUM
    - TRANSPARENCY VS. THE HIDDEN AGENDA

Engaging and Partnering with Physician Leaders: Principles and Practices (continued)

Practices (continued):

11. Allocate dollars to reflect your hierarchy of values internally and externally:

Physician compensation for leadership

VBP and P4P incentives

NWH DEFINITION OF MEDICAL PEER REVIEW

Practices (continued):

12. A process to improve the quality and safety of medical care by which physicians are collegially, but formally, organized to review or investigate professional performance with attention to the applicable standards expected to be incorporated in the doctor-patient relationship and as an accountable member of the health care team.

Engaging and Partnering with Physician Leaders: Principles and Practices (continued)

Practices (continued):

13. THE TEACHING PRINCIPLE

Unless each and every component of care

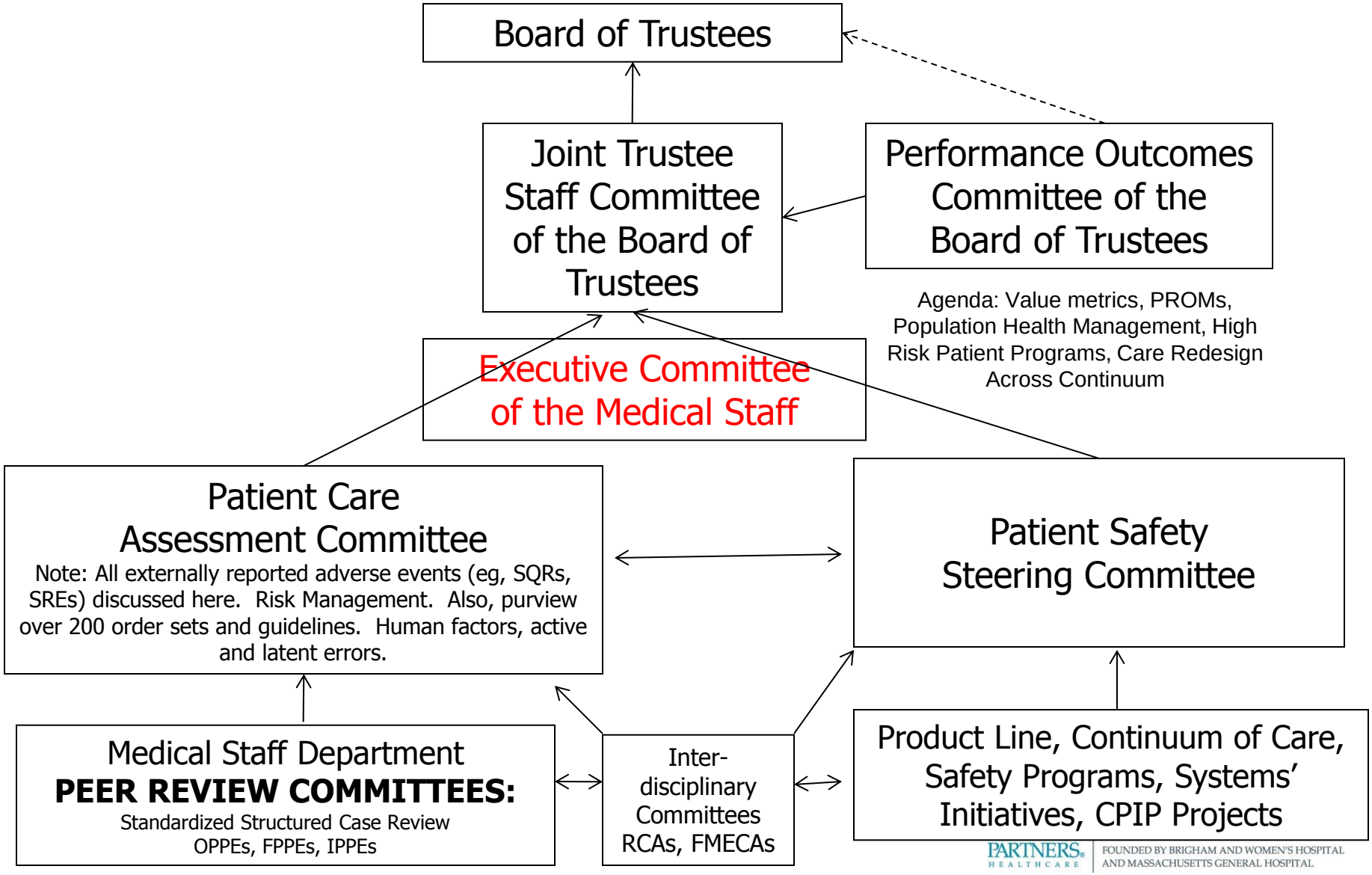
is delivered in the exact fashion in which you would teach it,

there is opportunity for improvement.

This defines the culture to allow all members of the medical staff to be leaders.

Engaging and Partnering with Physician Leaders: Principles and Practices (continued)

14. Practices (continued): Structure of Non-Punitive Peer Review Culture



NON-PUNITIVE PEER REVIEW vs. ARTICLE VIII (Corrective Actions) (Qualified Patient Care Assessment Plan)

Non-Punitive

◇ Peer Review around Teaching Principle
- Feedback
- Scholarship
- FPPEs , OPPEs

(may include various methods of monitoring and/or proctoring)

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Potentially Punitive (Disciplinary)

◇ Article VIII:

"Preliminary Investigation"

and

Corrective Actions

CHAIR (CHIEF)
in collaboration with Chief Medical Officer

◇ External Peer Review as appropriate

◇ All activities go into credentialing/privileging files

◇ No disciplinary authority
- Refer to Chair/Chief

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◇ May result in career altering actions around privileges and Medical Staff membership including reports to Board of Registration in Medicine and/or National Practitioner Data Bank

Engaging and Partnering with Physician Leaders: Principles and Practices (continued)

SUMMARY

LEAD EXISTENTIALLY AND STRATEGICALLY AS YOU WOULD TEACH IT

A doctor tends to a mortally ill child in
Sir Luke Fildes's 1891 painting 'The Doctor.'

Disrespectful Practice Case Discussion

Final Q&A

Thank You

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