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# Hospital Boards: Bringing Quality to the Table

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# Prescriptions for Excellence in HEALTH CARE

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

## Hospital Boards: Bringing Quality to the Table

By Kanak Gautam, PhD

Ever since 1999, when the Institute of Medicine reported an estimate of up to 98,000 preventable hospital deaths annually in its report *Measuring the Quality of Health Care*, there has been a nationwide call for improving quality and patient safety. The ultimate legal responsibility for hospital quality and safety rests with its board. While many hospitals have initiated comprehensive programs for quality improvement in recent years, others - especially smaller or unaffiliated hospitals - have not paid sufficient attention to these critical areas. Although many hospital boards are uncomfortable dealing with quality, preferring to focus on problems of finance and strategy, there is a pressing need for hospital boards to bring quality to the table. The following measures should be taken by boards to place quality at the forefront of their hospitals' agendas.

**Educate Trustees:** Trustee education is critical for board action on quality. Some hospital boards neglect quality because they are unaware of the board's legal responsibility for quality, and others are hesitant to stir up tension between administrative and clinical staff. Many trustees fail to act decisively on quality issues because they believe, incorrectly, that effective quality oversight requires a medical degree. Elements of an effective education program

to build trustees' confidence for leadership in quality include:

- Legal responsibility for quality,
- Administrator-medical staff relations
- Definitions, domains, and indicators of quality

Mandated trustee orientation and continuing education programs must clarify that "oversight of quality" requires goal setting, monitoring, and corrective action—none of which require a medical degree.

**Signal Intent to Lead on Quality:** Once trustees are sufficiently educated about quality, hospital boards must notify the organization of their intent to lead on quality. Initially, the hospital medical staff may contest the board's authority on quality. The board must develop a written statement on quality that defines responsibilities and distinguishes the board's role from that of the medical staff. The statement should clearly describe how the board intends to oversee and direct quality programs. Boards also should specify the types of quality reports they wish to receive (ie, reports with comparative benchmarks, executive summaries that facilitate the board's evaluation of hospital quality). By requesting changes in quality reports, the board signals

its accountability for quality and its intent to refocus priorities accordingly.

**Be Visible on Patient Floors:** Trustees seldom visit patient floors, and tend to confine themselves to the administrative wing of the hospital when participating in board meetings. This creates a barrier between the trustees and patient care departments, and reinforces the perception that trustees are concerned solely with nonclinical issues such as finance and strategy rather than quality.

Leadership in quality requires that trustees become visibly involved in quality activities (eg, visiting hospital floors, talking to patients and care providers to understand quality-related problems). Such involvement underlines the board's commitment to quality and empowers nurses and other clinical staff who previously may have perceived a lack of commitment and support at the board level. Presence on patient floors also gives trustees an opportunity to learn first hand about the problems that must be addressed to help caregivers improve hospital quality.

**Appoint/Empower a Quality Committee:** A hospital board needs a standing committee to monitor quality on its behalf. Close to one third of US hospital boards have no such

*(continued on page 2)*

committee, and many existing quality committees meet infrequently, lack sufficient power, and/or are dominated by members of the medical staff.

Every hospital should have a quality committee with appropriate composition and sufficient, clearly-delineated powers. The quality committee chairperson and members should be drawn from inside and outside the institution, and should represent a variety of backgrounds including medicine, nursing, and industrial quality. Partnership between the quality committee and the hospital's chief medical officer or chief quality officer should be encouraged so that the committee remains in touch with ongoing quality projects. Serving as the eyes, ears, and voice of the board on quality, the quality committee must receive and monitor quality reports on a regular basis and forward recommendations to the board for action.

#### **Establish Goals and Benchmarks:**

Establishing goals and benchmarks is necessary to ensure that quality improvement is directed toward priority areas. The board should oversee the establishment of appropriate quality standards and peer benchmarks for the hospital. The quality committee, physicians and nurses on the board, and other clinical leaders should provide technical advice during goal setting. In the face of preventable deaths, incremental improvement is hardly an appropriate goal. High but achievable goals help establish priority and motivate the organization to greater efforts.

#### **Involve Medical Staff and Other**

**Clinical Staff:** The board needs active cooperation from the medical and clinical staff to fulfill its responsibilities for quality. The board should begin by assessing the adequacy of physician involvement: Are there adequate physicians on the board and its committees? Is there adequate physician representation in addition to medical staff officers? Are forward-thinking physicians being recruited to persuade physicians who are resistant to change? Physicians and other appropriate clinical staff should be appointed to the quality committee and various task forces on quality to benefit from their expertise and to reduce resistance to change.

#### **Ensure that Quality Is Part of Strategic**

**Planning:** Historically, hospital strategic plans have focused almost entirely on financial issues. The board must incorporate quality-related goals in the organization's strategic plan to ensure that quality achievements and failures are discussed at the highest levels and acted upon. Additionally, the board must sanction investment of adequate resources in strategic quality initiatives including staff, facilities, information technology systems, and safety-related technology. To this end, the board also must promote close coordination between the quality and strategic planning committees.

#### **Demonstrate the "Will" to Uphold**

**Quality:** As the ultimate authority on quality in hospitals, the board must

sanction unpopular but effective quality initiatives - even in the face of resistance from the medical staff and others. For example, if a hospital hopes to improve its mortality rate, the board must address controversial issues such as how ICUs are organized and staffed, or how staff levels are determined.

Boards are severely tested when prominent members of the medical staff resist implementing such measures. Backing down in these instances undermines the hard work of physicians and nurses who are trying to create a safer environment for patients. On the other hand, standing by unpopular but effective policies sends a strong message that the board is resolute about advancing patient safety and quality, thus reducing future resistance.

**Conclusion:** Today's health care environment requires hospital boards to play a leadership role in quality. To bring quality to the table and lead on quality, today's boards need self-education, visibility on the patient floor, role clarification on quality, empowered quality committees, involvement of physicians and clinical staff, strategic planning on quality, and a demonstrated will to uphold quality.

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