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Prescriptions for Excellence in HEALTH CARE

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

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Editorial

All Boards Aboard the Quality Train!

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

Welcome back to *Prescriptions for Excellence in Health Care,* a second volume of supplements to our *Health Policy Newsletter* devoted exclusively to the quality improvement agenda in the United States. This special issue focuses on a relatively new but increasingly important aspect of health care quality – namely, the governing board's leadership role and responsibilities vis-à-vis quality assurance and improvement throughout their organization.

Until recently, hospital and health system boards were comprised mainly of businessmen and meetings focused primarily on a "bottom line" defined solely in financial terms. The policy debates that followed in the wake of the Institute of Medicine's report, *Crossing the Quality Chasm,* brought about changes in the 21st century boardroom as well as at the point of care.

Today, the Centers for Medicare and Medicaid Services (CMS) and professional oversight organizations require private and nonprofit institution boards to demonstrate leadership in quality and patient safety. Board composition is changing, with growing numbers of medical professionals taking seats at the table. Quality, which rarely made an appearance at board meetings in prior years, is often at the top of the agenda.

The articles in Section I of this issue discuss governance from 6 different perspectives. The first article, "The Governing Board's Role in the Quality Agenda: An Overview," serves as a primer and lays the groundwork for other articles in the section. The second article, "Hospital Boards: Bringing Quality to the Table," highlights the important steps that must be taken and offers practical advice for incorporating quality at the board level.

Finance remains a primary responsibility of the board, and in the third article, "Quality Improvement and the Bottom Line," Dr. Carpenter discusses quality improvement with an eye toward expenses, revenue, and income. The fourth article, "Ethics, Culture, and the Board," examines these and associated

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behavioral elements that present challenges for today's governing boards.

"Nonprofit Community Health System Board Engagement in CEO and Board Evaluation," reports on the results of a large-scale, comprehensive study of the structures, practices, and cultures of community health system governing boards with respect to accepted definitions of good governance. The final article on governance, "The Future of Boards: White Water Ahead," serves as a reminder that change – even for the better – is never without turbulence and points out some submerged rocks downstream.

The 3 articles in Section II call attention to other important work being accomplished in the health care quality arena. The first, "Reforming Camden's Health Care System – One Patient at a Time," is an amazing success story from the front lines of medicine and a valuable lesson in how, even in a marginalized community, health quality can be improved through intelligent use of health information technology tools, communication, cooperation, and application of the principles of population health.

"Physician Quality Performance Initiative (PQRI): Theory and Practice" provides valuable insight into CMS' pay-for-performance program via the experience of 1 large hospital. The final article, "Improving Quality and Safety through Convenient Care Clinics," recounts the process by which retail clinics made quality and patient safety a top priority.

I am very proud of this information-rich issue and the work of these talented authors. For readers who would like more detail on governance, a number of contributors to this issue also authored chapters for a text on the subject (*Governance for Health Care Providers: The Call to Leadership.* Nash DB, Oetgen WJ, Pracilio VP, eds., Taylor & Francis, Inc., 2008).

As always, I am interested in your feedback; you can reach me by email at: david.nash@jefferson.edu or visit my blog at: nashhealthpolicy@blogspot.com.

David B. Nash, MD, MBA is Founding Dean and the Dr. Raymond C. and Doris N. Grandon Professor, Jefferson School of Population Health.

A Message from Lilly

In Pursuit of a Quality Culture

By Fionnuala Walsh, PhD

Being in the business of discovering, developing, manufacturing, and marketing medicines is a privilege. At Eli Lilly and Company, we understand that we must earn this privilege—and the trust of our customers—every day.

A relentless focus on quality is one of the most important ways we earn this trust. While historically our quality organization has been associated mainly with manufacturing, in recent years we have set a course to establish quality systems throughout our enterprise.

Our goal is nothing less than making quality an integrated and permanent part of our culture in every part of our business. Key to this transformation is the widespread use of science-based principles such as risk management and quality by design.

For a pharmaceutical company, quality by design can be described in 2 steps. First, you must design your products to meet specific targets—in this case, targets of clinical performance as defined by your customers and patients. Then, you must design all of your processes, from R&D through post-marketing, to consistently deliver a product that meets the attributes necessary for this performance.

It is not hard to see how the use of quality tools in a truly integrated fashion can result in improved patient safety and better outcomes. In fact, we are implementing a Safety and Efficacy Quality System to span clinical development, marketing, and pharmacovigilance. Our goal with this system is to create global quality standards wherever possible, then integrate them across boundaries. While this effort is still relatively new, already many organizations and hundreds of people are involved, from clinical research physicians to the leaders of our marketing affiliates to business partners and vendors to regulators.

Of course, manufacturing remains integral to providing products that are safe and high quality. Within our global manufacturing network, which includes more than 20 sites, 10,000 employees, and numerous contract manufacturing organizations, we have moved beyond "basic"

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quality practices and into a continuous improvement mode. Having seen tangible improvements among the metrics for manufacturing excellence (these metrics include deviations, backlog items, and factory losses), we have demonstrated effectiveness. Now, we are challenging ourselves to achieve efficiency as well.

More than 30 years ago, a Lilly advertisement appearing in popular magazines depicted a bottle of pills beneath the headline, "The one you take is never tested." This rather provocative statement was our way of expressing confidence in the quality of every step we take leading to the moment when our products reach their intended audience.

Today we are working to reinstill this same level of confidence by building a quality culture. The key differences between then and now are that we have better tools at our disposal, a stronger commitment to enterprise-wide quality, and, perhaps most important, the knowledge that quality can and does lead to better outcomes for patients.

Fionnuala Walsh is Vice President, Quality, Eli Lilly and Company.

The Governing Board's Role in the Quality Agenda: An Overview

By William J. Oetgen, MD, MBA

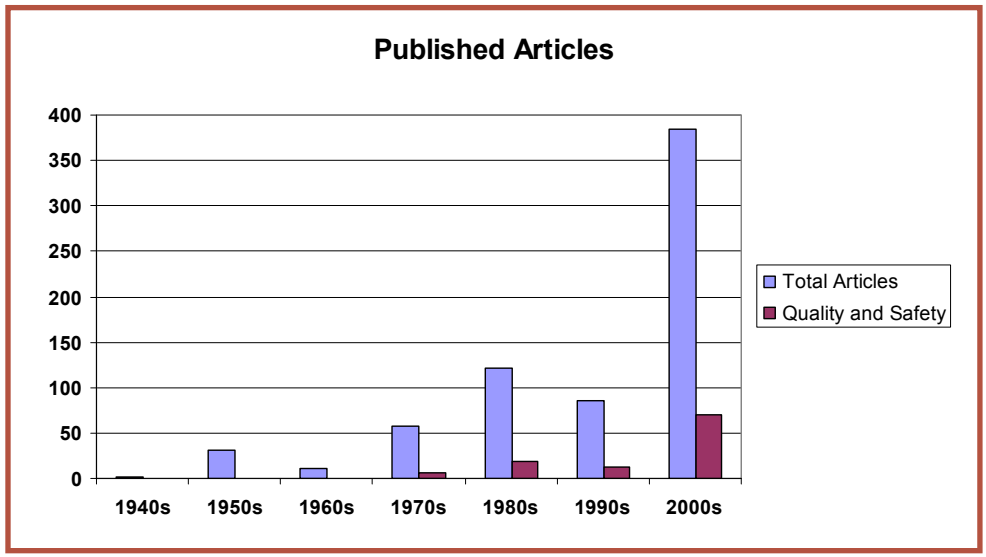
The responsibility of the governing board in setting the quality agenda is a subject of wide currency among health care organizations. Today's hospital and health system boards are continually reminded that their responsibility for quality care and patient safety – often viewed as a specific subset of quality care – is foremost on the minds of patients, payers, providers, and regulators. But quality care and patient safety have not always been so prominent on the agendas of health care boards. It is instructive to review this ascending responsibility from a historical perspective, from the viewpoint of current mandates, and from a speculative look into the future.

Historical Perspective: In a recent report, Joshi and Hines[1] discussed governance board issues of quality and safety. A query of articles related to this report produced a sample list of 699 references. While these articles were all related to board governance functions and responsibilities, not all of them were specifically concerned with quality and patient safety.

Figure 1 shows the publication dates of these articles by decade and the proportion of the articles that were concerned with quality or patient safety. These data reveal a surge in the publication of board governance-related articles in the current decade and a modest rise in the proportion of papers that are specifically concerned with the topics of quality and patient safety.

In the decade following the 1980 publication of Donabedian's classic book on health care quality *(Explorations in Quality Assessment and Monitoring, Volume I. The Definition of Quality and Approaches to its Assessment)*, there was only a modest increase in the number and proportion of quality-related articles listed in our sample. Figure 1 shows that the proportion of

Figure 1. Published Articles Related to Governance Board Functions and Responsibilities



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quality-related articles in the sample was 12.3% in the 1970s, 14.9% in the 1980s, and 14.1% in the 1990s.

A closer look at the publications from the 2000s shows the interest in quality and safety rising sharply over the decade (Figure 2). In the first 2 years of the decade, fewer than 20% of articles were concerned with quality and patient safety, whereas nearly half of the publications were devoted to these topics in the last 2 years. This suggests a growing interest in governance boards' functions concerning quality of care and patient safety.

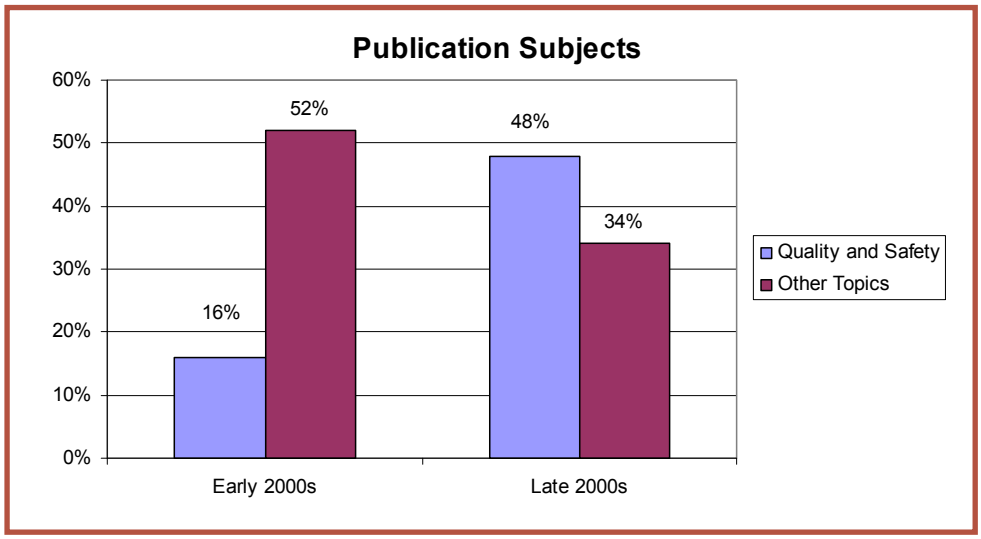
The evolution of board function over the past half century can be traced by reviewing the titles of the 699 publications chronologically. In the 1950s, articles were concerned with topics such as hospital décor, board responsibilities, hospital food service (perhaps one of the first board "quality" functions), and the board's relationship with nurses. A 1954 article suggested that all hospital boards should include physicians as members, and the concept of boards' interest in quality first appears in the 1960s. In our sample, specific mention of incorporating quality committees within board structures occurs in 1977, and it is apparent that the "quality buck" stops with the board by the late 1970s.

From 1980 through the 1990s, the concepts of board responsibility, quality of care, and patient safety underwent refinement. In particular, the concept of quality care was broadened to include more stakeholders; nurses were invited to participate as board members; and patient satisfaction became a governance concern. During this period, the concept of quality assurance evolved from total quality management to continuous quality improvement. Boards' responsibility for all of these processes continued to be reflected in the published literature.

Since the publication of the Institute of Medicine report in 2000 (Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err is Human: Building a Safer Health System*), board attention has become focused on patient safety and medical error reduction. Other current quality-related topics of board interest are public reporting of quality data and the logical nexus of finance and quality care, the pay-for-performance movement.

Over the 60-year span of the 699 publications in the sample, the concept of board responsibility for health care quality has evolved from relatively trivial concerns (eg, hospital décor) to the revolutionary concept of pay for performance with its potentially adverse financial implications.

Figure 2. Publication Subjects: Growth in Fields of Quality and Safety



Current Mandates: Three national organizations provide mandates for board involvement in quality and patient safety: the Joint Commission, the National Quality Forum, and the Institute for Healthcare Improvement.

The Joint Commission requires that governing boards promote a culture of quality and safety in their organizations. Boards must assure that their organizations participate in measurement and improvement efforts for quality and safety indicators, allocate resources so that these functions can be accomplished, and hold management accountable for that accomplishment. Moreover, the Joint Commission requires that care quality and patient safety be specifically addressed in board meetings.[2]

The National Quality Forum asserts that governing boards are responsible for ensuring the quality of health care provided in their institutions. To that end, boards should enable evaluations of their own effectiveness in: enhancing quality; developing a "quality literacy" of safety, clinical care, and outcomes; and overseeing their institutions' participation in national quality measurement and improvement programs.[3]

The Institute for Healthcare Improvement recommends that health care governing boards set and communicate specific organizational improvement goals, integrate those improvement goals with strategic goals, and regularly review key metrics and adverse events. Governing boards should provide resources for the achievement of these goals and hold management accountable for the attainment of these goals.[4]

The common ground of mandates from these 3 organizations for governing board responsibilities for quality is to:

- promote a culture of quality and safety
- make quality and safety prominent on the board agenda and promote board education

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- ensure organizational measurement and improvement activities and participate in nationally based projects
- monitor the activities and their results
- review adverse events
- provide financial resources
- hold management accountable
- hold themselves accountable

The Future: Based on a review of the past and a look at the current mandates, what might the future hold for governing boards regarding the issues of quality and patient safety? Future governing boards will be required to lead by example. They will be expected to educate themselves and to achieve a sophisticated knowledge of the principles of quality care and patient safety. This will be accomplished by upgrading the knowledge of individual board members and by adding board members with professional expertise in quality management and in safety processes.

Future boards will spend proportionately more time on issues of quality of care and patient safety. They will assess themselves more rigorously in these efforts to assure that all their organizations' functions are of the highest possible quality. As boards become subject to increasing scrutiny from outside agencies and other parties, they also stand to reap the benefits – or suffer the consequences – of increased public disclosure.

While financial oversight will continue to be of paramount importance to future boards, its relative importance will diminish. "Increasingly, the role of the governing body in quality and patient safety oversight is being viewed as a fiduciary responsibility at least equal to its financial oversight role."[4]

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References:

1. Joshi MS, Hines SC. Getting the board on board: engaging hospital boards in quality and patient safety. *Jt Comm J Qual Patient Saf.* 2006;32(4):179-187.
2. Berman S, ed. *Getting the Board on Board: What Your Board Needs to Know About Quality and Patient Safety.* Oakbrook Terace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2007.
3. National Quality Forum. *Hospital Governing Boards and Quality of Care: A Call to Responsibility.* Washington, DC: National Quality Forum; 2004.
4. Botwinick L, Bisognano M, Haraden C. *Leadership Guide to Patient Safety.* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2006.

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

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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 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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Quality Improvement and the Bottom Line

By Caryl E. Carpenter, MPH, PhD

Do improvements in quality of care result in improvements in the bottom line? To answer this question, we need to know the impact of quality improvement (QI) on costs and revenues, plus the net effect on profits. Although the positive impact of quality on the bottom line has been documented in other industries, there is little recent empirical evidence in the health care industry.

The business case for health care QI (ie, that investments in QI will result in better clinical outcomes and better financial performance) is primarily based on anecdotal evidence from case studies. Larger empirical work is about 10 years old; for example, a study[1] of more than 1700 hospitals in the late 1990s concluded that effective implementation of QI could improve financial and cost performance. This study and others predate quality incentive systems such as pay for performance (P4P) and nonpayment for preventable complications or never events.

Perhaps one of the most important breakthroughs in health services research in the last 20 years has been the growing body of evidence that better quality is not necessarily more expensive. In consumer product markets, we have traditionally assumed that higher priced products are better quality products. This assumption carried over into the health care industry until recently, when numerous outcomes studies documented that it is possible to improve quality and reduce costs at the same time. What has not always been clear is whose costs have been reduced – the provider's, the payer's, and/or the consumer's. This article considers only the impact of quality improvement on the hospital provider's costs.

The impact of better outcomes on revenues has not been examined. For example, the Premier P4P demonstration project documented improvements in processes, reductions in mortality rates, and decreases in associated costs in the demonstration hospitals.[2] However, no data were collected to measure the impact of the P4P incentives on revenues or the net effect on profits.

The Income Statement Perspective: To determine the relationship between QI and profitability, it is necessary to take an income statement perspective. The income statement represents a summary of financial activity over a period of time. The bottom line (net *income*) results from subtracting expenses from revenues. Although the terms *expense* and *cost* are often used interchangeably, in the language of accounting they have different meanings. Studies that examine the impact of quality of care on hospital *costs* may actually mean hospital *expenses*. From an income statement perspective, the question becomes, "How do QI programs impact expenses (costs) and revenues, and what is the resulting impact on income (profits)?" In this context, the relevant costs (or expenses) are those incurred by the provider of care, not the payer or the consumer.

Impact on Expenses: We start with the impact of QI strategies on costs for hospitals (ie, the expenses reported on the income statement) (Figure 1). First, there are expenses associated with designing and implementing a QI program or complying with quality guidelines from a payer. If an inpatient hospital QI program results in shorter stays, fewer ancillaries, or the use of less expensive drugs for a given condition, hospital expenses will decrease, particularly the variable expenses associated with patient care. Fixed expenses, primarily staff salaries, decrease only if the reduction in utilization leads the hospital to downsize. On the other hand, if better quality of care results in longer stays, more ancillaries, and more expensive drugs, variable expenses for the hospital will increase. Fixed expenses also could increase if higher utilization required additional staffing or a state mandated a lower nurse-to-patient ratio to improve quality.

Figure 1. Impact of Quality Improvement on Hospital Expenses

+	Expense of designing and implementing QI programs
–	Expense from shorter stays, fewer ancillaries, or less costly drugs
+	Expense from longer stays, more ancillaries, or more costly drugs
+	Expense from changes in nurse staffing ratios
–	Expense from avoiding "never events"
+	Expense from increased utilization resulting from enhanced reputation???

The recent advent of nonpayment for preventable complications or "never events" raises questions about the impact of these payer policies on hospital expenses. Presumably, complications and never events result in higher expenses for the hospital than if the complication or event had been avoided. Does that imply that a QI or patient safety program that targets preventable complications or never events would result in lower expenses for the hospital? The answer is not clear, although it should be yes.

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Impact on Revenues: While estimating the impact of QI on expenses can be difficult, estimating the impact on revenues is even more complex. The impact on revenues depends on the payer (Figure 2). Under a case-based reimbursement system such as the diagnosis-related groups (DRG) system used by Medicare, reducing hospital expenses does not result in higher revenues. Medicare pays a fixed rate per admission based on the diagnosis. That rate does not decrease when a hospital reduces length of stay or services per admission.

Figure 2. Impact of Quality Improvement on Hospital Revenues

	No change under DRG reimbursement
–/+	Under per diem payment (depending on change in length of stay)
+	Under pay for performance
	No loss of revenue from "never event" denials
+	Revenue from increased utilization resulting from enhanced reputation???

DRG = Diagnosis Related Groups

Revenues from payers that use per diem reimbursement methods will decrease if QI methods result in shorter inpatient stays, whereas revenues from these payers will increase if QI results in longer stays. QI programs that result in more or fewer services per day will not affect revenues from per diem payers.

Under a P4P system, revenues should increase as a hospital complies with quality standards and improves outcomes of care. The impact of nonpayment for never events is more ambiguous. Although avoiding preventable complications or never events will avoid nonpayment and a loss of revenues, it will not increase revenues.

Many hospital managers believe that improvements in quality will result in a better reputation for the hospital in the community. It could also result in better ratings through programs like HospitalCompare (www.hospitalcompare.hhs.gov) and HealthGrades (www.healthgrades.com). If such improvement in reputation results in increased utilization of a hospital's services and increased market share, the hospital's QI efforts could increase revenues. Unfortunately, it is costly and time consuming to measure the increase in utilization that can be attributed to QI or an enhanced reputation, so these measurements are rarely done.

Impact on Income: Hospitals earn operating income when their revenues exceed expenses. Therefore, the question of the impact of QI on profitability depends on its net effect on expenses and revenues (Figure 3). The effect will depend, again, on the method of reimbursement. QI that reduces expenses will increase income under DRG payment; QI that increases expenses will decrease income under DRG payment. However, the net effect of QI on profits under per diem payment or P4P is unclear. The reduction in expenses must be greater than the reduction in revenues under per diem payment for QI to increase net income. This would be most likely to occur if the hospital reduced fixed as well as variable expense. Similarly, the increased revenue from P4P may or may not exceed the reduction in hospital expense, so the net effect on profits is ambiguous.

Figure 3. Impact of Quality Improvement on Income (Profits)

+/–	Under DRG reimbursement
+/–	Under per diem payment
+/–	Under pay for performance
+	Income from avoiding "never event" denials
+/–	Income from increased utilization resulting from enhanced reputation???

DRG = Diagnosis Related Groups

Conclusion: Do improvements in quality of care result in improvements in financial performance? It depends on the impact of QI on hospital expenses and revenues. That depends, in turn, on the type of QI intervention, its impact on utilization, and the reimbursement method. Conceivably, QI could increase net income for some payers and decrease it for others. There is a clear need to measure the effects of QI carefully in order to answer this crucial hospital management question.

Caryl E. Carpenter, MPH, PhD is a professor in the Department of Management, Health, and Human Resources in the School of Business Administration at Widener University. She can be reached at: cecarpenter@widener.edu.

References:

1. Alexander JA, Weiner BJ, Griffith J. Quality improvement and hospital financial performance. *J. Organiz. Behav.* 2006;27:1003-1029.
2. Lindenauer PK, Remus D, Roman S, et al. Public reporting and pay for performance in hospital quality improvement. *N Engl J Med.* 2007;356:486-496.

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Ethics, Culture, and the Hospital Board

By P. Michael Peterson, EdD

Culture is the cornerstone of any health care organization. It defines how people behave, think, and organize themselves to achieve success. The essence of culture is rooted in the underlying assumptions and beliefs that have been jointly learned and taken for granted as the organization has evolved.[1] These assumptions function much like a software operating system, guiding behavior and thought within the organization, often below our level of awareness but broadly and deeply stabilizing how we work, perform, behave, communicate, relate, and think. Schein identifies various deep underlying assumptions that define a culture: the nature of human nature ("Is it good or is it evil?"); the nature of human relationships ("How should we best relate to achieve success?"); the nature of time and space ("How do we look at time? How does our physical layout reflect work style and status?"); and the nature of reality and truth ("Are you more moralistic or pragmatic in your decision making?").[1] The answers health care providers and hospital board members give to these questions determine how the organization is structured and organized, what it values, how it works and behaves, what it rewards and punishes, what it considers to be acceptable or ethical, and ultimately how healthy the organization will be.

Ethics is defined as the body of moral principles or values governing a particular culture or group.[2] Within health care organizations, ethics is the outcome of cultural values and assumptions related to the practice of medicine and patient care. Although some people perceive ethics as a religious artifact, in reality it is an essential part of doing business because ethical principles and codes of conduct provide a framework for good decision making and organizational behavior. Ethics serve to link the personal beliefs of employees with the corporate cultural values and beliefs. Typically cultures value honesty, integrity, trust, hard work, loyalty and commitment, and respect for one another[3] - traits that are learned through education (eg, the organization publicly declares them as values) and through observed behavior (eg, we see what others do and don't do and the consequences of those actions). However, these attributes can be compromised if the competing values of profit, market share, competition, and individualism are also espoused by the organization. Within any health care providing organization, a culture may promote competing values that serve to create ethical dilemmas for employees.

> "Do I provide the patient with all available medical options if it means costing the hospital money and time?"

> "Do I bring the misconduct of a coworker to management, or do I let it slide to protect the unit or team?"

In addition, pressure can be placed on employees to compromise ethics in an effort to achieve a greater good (or value).[4]

In a 2003 National Business Ethics Survey conducted by the Ethics Resource Center,[5] the most common types of misconduct observed were abusive or intimidating behavior toward employees, and lying to employees, customers, suppliers, and the public. These types of misconduct can be reinforced culturally and thus perpetuate a counterproductive work environment. For example, a nurse supervisor who regularly berates new nurses as a means of controlling staff and achieving quality care creates a hostile work environment (unethical conduct) in the process of achieving corporate goals (quality care). If she is rewarded by management for her performance (quality care), her unethical management practices are reinforced simultaneously.

Employees quickly learn what is "acceptable behavior" within the greater corporate culture and what is truly valued. Mistreatment (perceived or real) of employees acts as a catalyst for unethical workforce behaviors such as retaliatory responses (eg, stealing supplies, less productive use of time, backbiting, noncompliance). In a study conducted by Harris Interactive on behalf of Deloitte & Touche USA,[6] 91% of employed adult workers stated that they would more likely behave ethically on the job when they have a good work/life balance, and 60% said that job dissatisfaction is a significant reason for people to make unethical decisions at work. In fact, people do care about ethics and consider it an important criterion for a healthy workplace.[7]

When an organization's culture drifts toward unethical practices, the work environment becomes less professional, productive, satisfying, and safe.[8,9] Unethical cultures (or those with weak ethics) create conditions in which ethical dilemmas are more common and in which personal values are consistently challenged. The resulting emotional stress among workers contributes to ill health, increased turnover, and decreased productivity and service quality.[10-12]

What Can the Hospital Board Do?:

Employees listen to their leadership's messages and observe their behavior;

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therefore, it is incumbent on any health care board to define, both in word and deed, ethical conduct and to determine the degree to which ethics are a part of the organization's culture.

Communication about ethics should become a regular part of performance reviews, staff meetings, and personal conversations. Consistent enforcement and reminders of ethical standards serve to strengthen the cultural value and create a safe environment that encourages employees to ask ethics questions and get the right answers.

Creating an Ethical Hospital Board Culture:

Understanding the existing culture is paramount to creating an ethical hospital board culture.[13] It is difficult to know where to go without knowing where you are. By taking a close, critical, objective look at his or her own cultural assumptions and how they influence the organization, a board member can identify areas for growth, improvement, and change. To avoid preconceptions and potential biases, a cultural assessment should be conducted by an external consultant (or agency). Internal cultural assessments often fail to recognize problems and the underlying assumptions.

Internal systems can be put in place to monitor for signs and symptoms of an unhealthy organization or workforce. Measures that should be consistently monitored include absenteeism rates, turnover rates, work stress level, grievances, communication problems, sickness and illness rates, short- and long-term disability, accident and safety problems, ethics violations, patient care quality, and medical mistakes. Mandating these actions at the organizational level can serve to prevent more chronic corporate "diseases." Regular reports to the board on these matters should be requested and subject to discussion from a cultural and ethical perspective.

Leadership is vital for an ethical and healthy organization. Therefore board members should self-monitor their own behaviors, decisions, and practices to assure that they align with healthy standards of conduct and cultural assumptions that promote a healthy organization and employee well-being.

Hospital board members should not be afraid to challenge long-held cultural assumptions. The tendency is to perpetuate a given culture because it is known, stable, and comfortable. However, the culture could be the prime cause of institutional problems. They should ask themselves, "How is our culture impacting our success or contributing to ethical problems within the organization?"

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References:

1. Schein EH. *The Corporate Survival Guide*. San Francisco: Jossey-Bass; 1999.
2. Merriam-Webster Dictionary. Available at: http://www.merriamwebster.com/dictionary/ethics. Accessed February 16, 2009.
3. Joseph J. Ethics in the workplace. ASAE and the Center for Association Leadership. Available at: http://asaecenter.org/PublictionsResources/articledetail.cfm?ItemNumber=13073.
4. Ambrosio E, Walkerley S. Broadening the ethical focus: a community perspective on patient autonomy. Available at: http://www.humanehealthcare.com/Article.asp?art_id=619.
5. Ethics Resource Center. *2003 National Business Ethics Survey*. Arlington, VA: Ethics Resource Center; 2003.
6. Worthington B. Work/Life balance influences workplace ethics. Available at: http://hreonline.com/HRE/printstory.jsp?storyId=12614425.
7. Peterson M. What men and women value at work: implications for workplace health. *Gender Medicine.* 2004;1(2):106-124.
8. Gillett G. Medical science, culture, and truth. Available at: http://www.peh-med.com/content/1/1/13.
9. Baker L, Sara S, Gaba D, et al. Patient safety culture in hospitals. *Abstr AcademyHealth Meet*. 2003;20: abstract no. 706.
10. Bates DW, Gawande AA. Error in medicine: what have we learned? *Ann Intern Med.* 2000;132(9):763-767.
11. Pugliesi K. The consequences of emotional labor: effects on work stress, job satisfaction, and well-being. *Motivation and Emotion.* 1999;23(2):125-154.
12. Sexton JB, Thomas EL, Helmreich RL. Error, stress, and teamwork in medicine and aviation: cross sectional surveys. *BMJ*. 2000;320:745-749.
13. Peterson M, Wilson JF. The culture-work-health model and work stress. *Am J Health Behav.* 2002;26(1):16-24.

Nonprofit Community Health System Board Engagement in CEO and Board Evaluation

By Lawrence Prybil, PhD

The demand for more accountability, greater transparency, and better performance by the boards that govern our nation's investor-owned and nonprofit organizations is growing at the federal, state, and local levels. This heightened interest in the performance of nonprofit organizations and their governing boards has stimulated serious examination of governance practices.

Except for requirements established by state statutes, the Internal Revenue Service, and The Joint Commission, formal standards for governance of nonprofit health care organizations have not been adopted in the United States. However, in recent years substantial efforts have been made by voluntary commissions, panels, and others (eg, the American Governance and Leadership Group, The Governance Institute, and the National Center for Healthcare Leadership) to describe good governance practices and to provide guidance for boards and chief executive officers (CEOs) to consider as benchmarks in evaluating and improving governance performance.

The recent emergence of community-based health networks or systems has transformed the health care delivery environment in the United States. In various forms – from loose affiliations to highly integrated systems with centralized governance and management – these community-

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based networks or systems encompass a substantial and growing proportion of the nation's hospitals and provide a considerable volume of inpatient and outpatient services.

The governing board of a nonprofit hospital or health care system is legally and morally responsible for the organization, its operations, and the services it provides. The board serves as the steward of the organization – its mission, its assets, and its integrity. The basic duties of the board include:

1. Establishing, preserving, and reshaping the organization's mission as necessary.
2. Setting the organization's overall direction by assessing the environment, adopting a strategic plan, and monitoring the organization's progress toward its goals.
3. Setting quality measures and standards and assessing the organization's performance in relation to them.
4. Adopting operating and capital budgets and exercising financial stewardship.
5. Ensuring that the organization's charitable and community benefit obligations are met.
6. Ensuring that the organization is well managed and complies with applicable laws and regulations.
7. Appointing CEOs, setting expectations for them, and evaluating their performance objectively and regularly.
8. Ensuring that the board has the collective knowledge, skills, and commitment to do its job properly and that board self-evaluation is performed objectively and regularly.

While the body of knowledge regarding governance in general has expanded substantially in recent years, there is relatively little information about governing boards and governance practices in community-based health care systems. This fact – in combination with the heightened interest in the duties and performance of governing boards and advances in formulating benchmarks of good governance – provided the impetus for a study of governance in community health systems.

Study of Governance in Community Health Systems: An Overview

The purpose of this study was to examine the structures, selected practices, and cultures of community health system governing boards and to compare them with contemporary benchmarks of good governance. The intent was to identify areas where system governance can be improved, and to provide helpful insights for systems' CEOs and board leaders to assess and enhance board effectiveness. For the purposes of the study, "community health systems" were defined as: *"Nonprofit healthcare organizations that (1) operate two or more general-acute and/or critical access hospitals and other healthcare programs in a single, contiguous geographic area and (2) have a chief executive officer and a system-level board of directors who provide governance oversight over all of these institutions and programs."*

The study was designed in 3 phases.

- **Phase I:** Identify a set of nonprofit community health systems that meet the definition, and build a "Community Health System Database."
- **Phase II:** Conduct a survey of system CEOs to: 1) verify that their systems meet the definition; 2) obtain the CEOs' perspectives on several aspects of their boards' structures, practices, and cultures; and 3) compare the findings to current benchmarks of good governance, and prepare a report.
- **Phase III:** Make on-site visits to a subset of the systems to conduct in-depth interviews with CEOs and board leaders.

After pretesting with several CEOs, a survey was mailed to 210 CEOs of community health systems via US Postal Service Priority Mail in February, 2007. The survey questions were limited to those the team believed could be answered accurately by CEOs without extensive investigation. A follow-up mailing sent to nonrespondents in March, 2007, offered the CEOs the option of completing the survey electronically. Follow-up phone calls were made in April and June of 2007 to encourage study participation.

The final study population of 201 nonprofit community health systems included 131 independent organizations (65%) and 70 organizations that were part of larger regional or national organizations (35%). (The 9 CEOs whose systems did not meet the definition of "community health system" were excluded.) The number of hospitals in these systems ranged from 2 to 9, with an overall average of 3.5 general acute and critical access hospitals per system. Usable survey forms were completed and returned by 123 systems (61%). Survey data were analyzed in the fall of 2007 and an initial report was published in February of 2008. A summary of the findings follows.

Summary of Findings Regarding CEO and Board Evaluation:

Evaluating the CEO's performance fairly, objectively, and regularly is

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beneficial for the CEO, the board, and the organization as a whole, and has become accepted as a fundamental benchmark of good governance. The survey data showed that performance expectations are established for over 90% of the CEOs who participated in this survey, either by their community health system board or – for those with parent organizations – at the corporate level. As expected, 100% of the CEOs reported that *financial targets* were regularly included in their performance expectations.

Responses in other critical areas were surprising in a positive sense. Monitoring and evaluating the quality of patient care and ensuring safety of patients, staff, and visitors is one of the governing board's most important responsibilities. Close to 99% of the CEOs surveyed reported that patient quality and safety targets were regularly included in their performance expectations.

Leadership and team building targets were included in 68.2% of CEOs' performance expectations, with those who head independent systems reporting 70.6% compared with 60% of those who head systems that are part of parent organizations.

Establishing clear expectations for the CEO regarding *community benefit programs* is a good governance practice. Ninety percent of the CEOs who lead systems that are part of parent organizations reported performance targets in this area compared with only 49% of the CEOs of independent systems – a statistically significant difference. It is possible that the parent corporations encourage or require their subsidiary system boards to establish specific expectations for their CEOs in this important area.

More than 90% of the CEOs reported that their community health system board or parent organization formally evaluates their actual performance in relation to the established targets on a regular basis – 77.5% annually and 18.9% every 2 years. When asked their opinions about the effectiveness of the CEO evaluation process currently in place, 95% of the CEOs of systems that are part of parent organizations perceived that the performance evaluation process was fair and effective compared with only 66% of CEOs of independent systems. Most surprising was the finding that, although 90.2% of CEOs reported that their community health systems' boards engaged in formal assessments of how well they carry out their own duties on a regular basis, only 55.9% reported that the findings were employed to make changes intended to improve their boards' structures, practices, or culture.

The next steps will include a further analysis of the survey findings and an evaluation of the systems' 3-year operating performance data. On-site visits will be made to 10 community health systems, and 1-on-1 interviews will be conducted with board leaders. Following these steps, a complete data analysis and final study report will be published. The full initial report in which these findings are discussed in detail is as follows:

Prybil L, Levey S, Peterson R, et al. *Governance in Nonprofit Community Health Systems*. Chicago, IL: Grant Thornton LLP; 2009.

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The Future of Boards: White Water Ahead

By Gary Filerman, PhD

As previous articles in this newsletter have shown, there are clear indications that turbulence lies ahead on the governance path. Although the signs warn us to heed them and act accordingly, health care boards are slow to adapt, and providers who serve on boards are not known for their willingness to lead change. To survive and prosper in a constantly changing environment, health care delivery organizations must be adaptive systems. This requires leadership from the top – the board level – and there has never been a time when provider board members have had a more critical role to play…*if* they are well prepared.

Can it get more turbulent? Yes, because of the diverse pressures that buffet organizations, including:

- Tensions over appropriate medical staff representation in governance
- Misaligned economic interests between the hospital and some physicians – or among different physician groups
- Increasing understanding of the determinants of quality of care that mandates hands-on board involvement and response

Other changes also impinge on the future of boards; for example:

- Medical work. Tasks and competencies are being redistributed within the medical profession and among health care workers.
- Workforce organizations. The traditional adversarial relationship

between management and workers will dissipate as unionization expands and everybody joins the patient-centered team.

- Transparency. It may be a private organization, but tax exemption will bring the same kind of accountabilities (ie, rules) that the Sarbanes-Oxely Act of 2002 brought to publicly traded companies.

Physician membership on boards has been increasing in recent years. I say "membership" rather than "representation" because members of the board have a primary responsibility to the interests of the organization. It is a confusing picture that will be sorted out – hopefully by the boards themselves, but more likely by regulation.

Medical Staff Representation in Governance: The relevant questions include: 1) how autonomous is the hospital medical staff, and 2) what is effective medical staff representation on the board? Interests, responsibilities, and relationships keep changing and the structure of the organization must adapt to the changes. It was relatively simple when most of the doctors were independent users of the facility whose interests were managed through the medical staff organization that they controlled. Now there is a substantial subset of physicians whose financial ties to the institution differentiate them from those who maintain the traditional relationship. The real or perceived differences in interests may lead to conflict.

The ramifications of the quality of care revolution on all aspects of health professions practice have just begun to be felt. It is hard for some organizations and practitioners to imagine greater impact, or intrusion, depending on the perspective. Outcomes assessment-driven research continues to reveal more ways in which the system must change, and increases the onus on governance to craft and enforce the changes. In simple terms, this means changing provider behavior, for which the board carries unequivocal responsibility. There may be a "partnership" with the medical staff but, in the eyes of the law and the patient, it is an unequal partnership. The physician on the board shares responsibility with the other members to support a culture of quality, to ensure that the by-laws adequately address quality, and to enforce the by-laws by putting the interests of the patient first.

Medical Work: There are profound changes under way in how medical work gets done. Outcomes research is an important factor, but so are the shortages of professionals – particularly primary care providers – and the increases in the burden of chronic disease and the elderly population. There is no prospect that expanding the number of doctors, nurses, and other providers while following the present work rules (commonly called scope-of-practice) will meet the need.

It is clear that tasks will have to be redistributed among providers according to the needs of the patient and the competencies of providers, and not according to the economic interests of the professions. How well it works will be assessed in terms of patient safety, outcomes, and cost-effectiveness – not by conformity with outmoded licensure laws.

The Workforce: The expansion of organized labor in health care is an important trend with implications for the board. Unions are becoming more sophisticated in their appeal to health workers and have raised moral questions about wages and benefits in the not unsympathetic public arena.

It is also important to recognize that all of the health professions are turning to collective negotiation for economic leverage. Unions clearly have a stake in quality of care and the strength of the institution. Looking forward – a key role of the board – a new social compact is likely to emerge that goes beyond traditional relationships. The challenge lies in getting there.

Transparency: Demands for the release of "inside" information about quality of care, charges, and costs are becoming more insistent and duplicative. This "production transparency" will continue as pay for performance becomes the general pattern and the number and scope of quality measures continues to expand. Governance transparency is another matter.

Both for-profit and nonprofit hospitals are being swept into the growing regulation of the governance function. The rationales are different but the results are the same. Shareholders' rights are the issue in publicly traded systems and the public's rights are the issue in tax exemption. Abuses, rising costs, and issues of access and quality of care all converge to encourage regulators to press for more transparent and predictable governance processes.

More Regulation, Not Less: The mandate will be for boards to proactively meet the public policy objectives of greater accountability and transparency. Boards will have less privacy as they wrestle with the tensions of interprofessional economics and with how to achieve greater clarity of responsibility for provider competence.

Boards, especially tax-exempt boards, are entrusted with the stewardship of resources in the service of the mission, whether on behalf of stockholders or patients. It is a social compact built on trust that has diminished. The emerging social compact will depend much more on regulatory processes. The sources will probably be a mix of federal, state, local, and even "voluntary" agencies (eg, the Joint Commission).

Mandated transparency will be but one aspect of greater public accountability. Increasingly, boards will be required

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to define their own operating rules and held accountable for playing by those rules. This trend has serious implications for physician board members whose representative function and participation will come under scrutiny. Boards must be very sensitive to this trend and proactive in addressing all identifiable questions of real or apparent conflict of interest.

Steering through the coming white water demands the deliberate, proactive attention of boards. In particular, clinician board members will be expected to clarify their roles and provide expert guidance as the board engages the rapids.

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Reforming Camden's Health Care System – One Patient at a Time

By Jeffrey Brenner, MD

We are faced with the challenges of an aging population, increasing numbers of patients with chronic illnesses, continually rising health care costs, growing numbers of uninsured, constrained public budgets, and the growing recognition that many Americans receive unsafe and ineffective care. Our health care system stands at the crossroads of access, quality, and cost without an obvious path forward. Systemic health care reform will require new and innovative approaches to long-standing problems. In Camden, New Jersey, an organization called the Camden Coalition of Healthcare Providers (CCHP) has begun to reframe the questions and look for better answers. Camden, a small city with 3 hospitals in 9 square miles, has the dubious distinction of being at the top of 2 lists: it is the poorest city in the United States according to 2005 census data,[1] and it was named the "most dangerous city in the United States" by the Morgan-Quitno report in 2003. Once a thriving center of manufacturing and industrial commerce, the city's economy and social infrastructure have collapsed over the last 50 years. Currently, 44% of families live below the federal poverty level and the city's population of 79,000 is quite young (median age = 27 years).[1] The city government, police department, and school system are under varying levels of state takeover due to a history of corruption and poor performance. Ironically, a place like Camden may hold the keys to reinventing the health care delivery system – to make it safer, more cost-effective, and more patient-centered.

Five years ago, CCHP began building a citywide health database using claims data from the 3 local hospitals. The database now contains the name, address, date of birth, date of admission, insurance status, diagnosis codes, charges, and receipts for every Camden City resident who has been to a local hospital or emergency room (ER) from 2002 through 2007. From these data we have learned that, in a single year, 50% of the city's residents use an ER or hospital - twice the national rate. The leading utilizer averaged 113 visits a year. The vast majority of these visits are for acute and chronic problems that could be prevented with better access to primary care.

According to internal data collected from 2002 to 2007, 13% of the patients accounted for 80% of the costs (mostly to Medicaid and Medicare) and 20% of the patients generated 90% of the costs. The most expensive patient had $3.5 million in receipts. The top 1% of patients (1035 residents) went to the ER and hospital between 24 and 324 times. The $46 million that hospitals received for the care of these patients would be sufficient to fund approximately 100 primary care nurse practitioners (NP), with each NP caring for just 10 patients.

The database was a crucial first step in galvanizing support for CCHP from local stakeholders and foundations. Currently, CCHP has 3 main projects: a Citywide Care Management Project targeting "super utilizers" of the local ERs and hospitals; a Primary Care Capacity Building Project to assist local offices with practice improvement efforts; and a Web portal to improve efficiency and coordination of care.

Implemented in September 2007, the *Citywide Care Management Project* now has 60 patients enrolled. Patients are referred by physicians, nurses, and social workers at the local hospitals, and by several Medicaid health maintenance organizations (HMOs). A family physician, NP, community health worker, and social worker staff the project, which provides "transitional" primary care to patients because most have no existing relationship with a primary care provider. These patients have significant barriers to care including: homelessness, substance abuse, severe chronic illnesses, physical disability, and mental health problems. Project staff help patients fill their prescriptions, apply for long-term disability, enroll in a medical day program, find appropriate housing, get a bed in the homeless

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shelter, coordinate legal issues, find transportation, treat depression, manage chronic illnesses like diabetes, and coordinate appropriate testing/specialty care. The patients are monitored wherever they go: hospital, nursing home, medical day program, street corner, or homeless shelter.

The chief advantage of a citywide coalition is its ability to encourage collaboration and data sharing among hospitals, to identify common challenges, and to address the challenges with coordinated solutions. One successful strategy has been to organize a monthly Citywide Care Management Coordinating Meeting that is attended by social workers, ER physicians, hospitalists, and community-based physicians from across the city. An electronic health record (EHR) system is used to systemically track the care of our patients. Eventually, local ERs, hospital-based physicians, and Medicaid HMO care management staff will have access to the system as well.

We are currently managing 90 patients and have enough data on 36 patients, before and after the project, to begin analyzing outcomes. The citywide health database allows us to track 5 years' worth of hospital and ER claims prior to the intervention. Our system of soliciting referrals from local physicians and social workers has correctly identified and enrolled very expensive, high-utilizing patients in our project (Figure 1). Our project tracking data shows an initial decrease in their utilization parameters and an improvement in their collections rate. Once we have a year of data we can begin the statistical analysis necessary to correct for problems in data like regression to the mean.

Like any maladaptive health behavior, it takes time and compassion to effect positive change in patterns of utilization. These patients don't want to go to the hospital – they just don't know how to get their needs met. After a few months of twice-weekly outreach visits, hospital utilization often drops significantly. Patients like these are not unique to Camden. Such patients are well known to every hospital and ER in every city in the country.

For much of Camden's population, reducing ER and hospital utilization will require transforming local primary care offices into high-performing, modern, patient-centered medical homes, with features like multidisciplinary care teams, EHRs, open-access scheduling, and patient registries. The primary care providers and clinics that operate in underserved communities struggle to keep their offices open. Unsafe communities, break-ins, low reimbursement rates, complex patients, and difficult insurance requirements create monumental challenges to providing high-quality care. Our Coalition has begun laying the groundwork for transitioning local practices into NCQA-certified medical homes[2] through monthly office manager meetings, provider education programs, individual practice assessments, and technical assistance.

Political scientists observe that systems in urban communities (ie, public health, safety, education) become insular, self-perpetuating, and resistant to change. A study of the education performance and civic capacity of 11 cities found that sustained improvements were achieved as a result of many years of sustained efforts by a stable group of stakeholders. The CCHP exemplifies the type of local multi-stakeholder coalition that

Figure 1. Initial Project Outcomes for Patients in Citywide Care Management Project

Measured as rates per month before and after intervention at a 1:1 ratio
N=36 patients

Outcome Measure	Before	After	Absolute Change	Percent Change
Charges	$1,218,009.69	$531,202.91	–$686,806.78	–56.39%
Receipts	$83,992.29	$55,641.94	–$28,350.35	–33.75%
Collections rate	6.90%	10.47%	3.58%	+51.90%
Emergency Visits	43.532	29.363	–14.169	–32.55%
Inpatient Visits	18.063	7.850	–10.214	–56.54%

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will be critical to nationwide reform of our health care system. There are multiple efforts across the country to build similar organizations.

A small, poor city like Camden is an excellent laboratory for understanding what is broken in our health care delivery system and for piloting practice-level, hospital-level, and community-wide solutions.

Unnecessary utilization and poor health outcomes in urban communities represent a systemic failure to build a well-funded, accessible, high-quality, proactive, coordinated, data-driven health care delivery system with a strong primary care base that is connected to the local network of community-based social services. We are working to build such a system – one "super utilizer" at a time.

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References:

1. Camden Facts 2008. Available at: http://www.camconnect.org/fact/documents/Camden_Facts_08_3-20-08_demographics.pdf.
2. National Committee for Quality Assurance. Physician Practice Connections – Patient-Centered Medical Home. Available at: http://www.ncqa.org/tabid/631/Default.aspx.

Physician Quality Reporting Initiative (PQRI): Theory and Practice

By Bettina Berman, RN

Background: Medicare, the nation's single largest health care purchaser, pays for health care services for almost 45 million beneficiaries[1] – a number that is expected to swell in the coming decade. Current Medicare expenditures represent 14% of federal spending, and the projected annual growth rate is 7.5% between 2008 and 2017.[1] In light of this, the financial viability of Medicare and payment reform will likely continue to dominate future health policy discussions in the United States.

For several years, research has demonstrated that more, and more expensive, health care is not necessarily better health care. A recent policy brief issued by the Dartmouth Institute for Health Policy and Clinical Practice reported that the geographical variations in Medicare spending are almost entirely explained by differences in the volume of Medicare services rendered to beneficiaries. Perhaps more compelling are findings that a higher volume of services and higher spending do not produce better outcomes of care.[2]

In 2005, the Centers for Medicare and Medicaid Services (CMS) issued its Quality Roadmap with strategies for achieving higher health care quality for Medicare beneficiaries while curtailing skyrocketing health care costs. One of these strategies – Value-Based Purchasing (VBP) – sought to transform Medicare from a passive payer to an active purchaser of high-quality efficient care. CMS considers VBP to be the basis for all future Medicare reimbursement and payment systems.

The cornerstones of VBP are: development of clinical, evidence-based measures; resource utilization measurement; and payment system redesign.[3]

Physician Quality Reporting Initiative (PQRI): The Tax Relief and Health Care Act of 2006 formed the legislative background for the PQRI program, one of several VBP initiatives implemented by CMS. Officially launched on July 1, 2007, PQRI consists of processes, outcomes, and structural measures used to assess evidence-based standards of clinical care. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the PQRI program permanent and required that, by 2010, CMS develop a more comprehensive plan for VBP that includes measures, incentive methodology, data strategy and infrastructure, and public reporting.

Currently a voluntary pay-for-reporting quality initiative, PQRI is widely regarded as a precursor to a federal pay-for-performance (P4P) program for individual Medicare providers. Now in its third year, the program offers physician and nonphysician providers a financial incentive in return for submitting quality-based G-codes (ie, Medicare-specific codes) or Current Procedural Technology-II claims codes.

The 2009 PQRI consists of 153 unique quality measures and 7 quality measures groups related to patient care provided in both the inpatient and outpatient settings. In 2009, new individual measures were introduced in the areas of HIV, back pain, and preventive care, and options for reporting on measures groups were expanded to include preventive care, coronary artery bypass graft, rheumatoid arthritis, perioperative care, and back pain.

Eligible professionals include physician and nonphysician providers who accept Medicare Part B payment and hold an active National Provider Identifier. The payment incentive for 2009 is 2% of total allowed charges for covered services furnished during a reporting period (ie, January 1-December 31, 2009 for all measures,

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and a July 1-December 31, 2009 option for registry and measures group-based reporting).[4]

In 2009, the measure for electronic prescribing (e-Rx) became a separate VBP-P4P initiative under CMS, offering an additional 2% financial incentive to physicians who utilize e-Rx in the outpatient setting. Providers who fail to meet e-Rx requirements will be faced with a reduction in payment starting in 2012.[5]

In addition to the small financial incentive, early adopters of PQRI have benefited from their experience with the program's structure and have provided CMS and the measure developers with feedback on the quality measures and the program methodology. Such an understanding of the framework for a national quality-reporting program prepares providers for future programs.[6] Although the release of the initial provider report from CMS revealed some systemic and methodologic issues, providers are likely to gain useful benchmarking data from future reports.

Experience with the PQRI Program at Jefferson University Physicians (JUP) Faculty Practice Plan: JUP is a faculty practice plan of 450 primary care and specialty physicians in 19 practices. Recognizing the need to measure and improve quality of outpatient care, the JUP Clinical Care Subcommittee (CCS) focuses on creating a JUP-wide quality and safety culture, monitoring national and local trends in quality management and P4P, selecting and developing quality measures and initiatives in alignment with nationally endorsed measures, and stimulating performance improvement.

The CMS PQRI program was implemented as a JUP-wide performance project in 2006. Primary care practices were the first to identify measures for reporting, and practice participation grew as additional subspecialty measures became available. Of 200 physicians (15 practices) who participated in the 2007 program, approximately 50% qualified for a bonus payment. The CCS expects that all 19 practices will have submitted PQRI measures to CMS by late spring of 2009.

Implementing the PQRI program across 19 faculty practices was a complex undertaking that required strong efforts from interdisciplinary teams. Barriers were abundant; for example:

- Professional and nonprofessional education was needed regarding the program concept and the new lexicon of quality codes.
- Complex measure specifications presented difficulties.
- The existing infrastructure was insufficient to support reporting requirements and changes to current workflow processes.
- Physician buy-in issues were related to the size of the financial incentive, the increase in workload, and acceptance of quality measures as accurate indicators of quality patient care.
- Lack of transparency of the algorithm used for reporting compliance and lack of timely feedback reports from CMS created delays in providing meaningful feedback to practices.

While many of the barriers encountered by the JUP practices were similar to the nationwide findings by CMS, a key factor to successful PQRI implementation across JUP has been the collaboration between representatives from the practices, JUP administration, and the JUP performance improvement team. Continued support from CMS in terms of national provider calls, information posted on the CMS Web site, and clarification of questions via email has been invaluable to the success and the expansion of the program across the faculty practices.

It will be interesting to see where the CMS Quality Roadmap will lead us in the future. The CMS plan for a VBP program for Medicare payment for professional services, required by MIPPA legislation, is due in less than a year (May 2010).

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References:

1. Kaiser Family Foundation. Medicare spending and financing fact sheet. Publication #7305-03. Available at: http://kff.org/medicare/upload/7305_03.pdf.
2. Fisher E, Goodman D, Skinner J, Bronner K. *Health care spending, quality, and outcomes. More isn't always better.* The Dartmouth Institute for Health Policy and Clinical Practice. Available at: http://www.dartmouthatlas.org/atlases/Spending_Brief_022709.pdf.
3. Centers for Medicare and Medicaid Services. *Roadmap for quality measurement in the traditional Medicare fee-for-service program.* Available at: http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf. Accessed April 9, 2009.
4. Centers for Medicare and Medicaid Services. *Physician quality reporting initiative.* Available at: http://www.cms.hhs.gov/pqri/. Accessed April 3, 2009.
5. Centers for Medicare and Medicaid Services. *Electronic prescribing incentive fact sheet.* Available at: http://www.cms.hhs.gov/ERxIncentive/Downloads/erx_incentive_program_simple_factsheet.pdf. Accessed April 3, 2009.
6. Gaspar KG, Sherellen G, Weygandt P. Physicians as stakeholders in health care: PQRI is an opportunity to participate. *Primary Care Reports.* 2008;14(2):13-24.

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Improving Quality and Safety Through Convenient Care Clinics

By Tine Hansen-Turton, MGA, JD

The need for accessible, affordable, quality health care in the United States has never been greater. Convenient Care Clinics (CCCs) were created in response to challenges faced by the current health care delivery system – a shortage of primary care providers, decreased access to basic primary health care, and high costs – all of which compromise quality.

CCCs are small, consumer-driven, retail-based clinics that provide basic and preventive health care services to all populations and sociodemographic segments 7 days a week, including evenings and holidays. Practicing evidence-based medicine, CCCs' staff – usually nurse practitioners (NPs) or physician assistants (PAs) and physicians – diagnose and treat common health problems, triage patients to appropriate levels of care, advocate for a medical home for all patients, and reduce unnecessary visits to emergency rooms.

CCCs strive to integrate their services with those of the local medical community. In particular, they actively work to connect CCC patients with a primary care physician (PCP). To date, more than 1000 CCCs across the country have provided care to more than 3.5 million patients. Because nearly one third of CCC patients – and 40 million Americans overall – report not having a PCP, CCCs are in a position to improve the quality of public health by facilitating proactive and prevention-minded health care.

Quality care and quality assurance are critical to the long-term survival of CCCs. Standardized protocols and nationally accepted evidence-based guidelines generally are built in to the electronic heath records (EHRs) that CCC providers use as tools to enhance the clinical decision-making process. Among the professional organizations whose guidelines are incorporated by CCCs are the American Academy of Pediatrics, the American Medical Association, and the American Academy of Family Physicians.

CCCs incorporate rigorous quality assessments in their evaluative structures including formal chart reviews by collaborating physicians, peer review by NPs and PAs, and standard coding audits. Most clinics use proprietary software systems, EHRs, and other technology to optimize the patient experience and facilitate continuity of care within the medical community.

In general, CCCs follow established protocols to ensure a high level of care and patient satisfaction. On arrival at a clinic, patients register to be seen, sometimes using a touch-screen computer terminal (similar to an airline self-check-in kiosk) into which they enter basic demographic information and the reason for their visit. This sign-in process is the beginning of the patient's EHR. In some cases, this information is transmitted electronically to a computer terminal inside the treatment room, where a provider is notified that a patient is waiting to be seen. Once the patient is escorted to the exam room, the provider validates the information provided by the patient at check-in and enters additional medical information about the patient's symptoms and conditions, as well as any pertinent medical history.

In October 2006, industry leaders formed the Convenient Care Association (CCA), a nonprofit corporation that brings CCC providers and business leaders together with the goal of assuring that this new model of care remains focused on quality service, accessibility, and affordability. The CCA launched industry-wide quality and safety standards in March of 2007. Developed with the guidance of a clinical advisory board and with direct input from the leadership of medical and nursing groups, these standards were designed to be more stringent than those adopted by key medical associations. Mandatory adherence to these common standards for operation helps ensure uniform quality across all CCCs.

The ongoing training and process improvement required by CCA standards help CCCs to maintain quality and continuity of care and to foster activities (eg, communication of clinical outcomes and satisfaction rates) that improve continuity and quality. The standards are built on the foundation that creating synergies with traditional medical service providers also will improve continuity and overall quality. The following is an excerpt from the CCA quality and safety standards:

- All providers are credentialed and follow state licensing requirements.
- CCA members are committed to monitoring quality on an ongoing basis.
- CCA members build relationships with traditional health care providers and hospitals, and, when permitted, share patient information and ensure continuity of care.
- CCA members encourage patients to have a regular source of primary care.
- CCA members are in compliance with state and federal regulations (Occupational Safety and Health Administration [OSHA], Clinical Laboratory Improvement Amendments [CLIA], Health Insurance

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Portability and Accountability Act [HIPAA], Americans with Disabilities Act [ADA], Centers for Disease Control [CDC]).

- CCA members provide an environment that is conducive to quality patient care and meet standards for infection control and safety.

In Table 1, the CCA standards are compared to retail-based CCC guidelines developed by key medical professional associations.

CCA has contracted with the Jefferson School of Population Health to establish a process whereby CCA members who demonstrate adherence to quality standards may become certified. The certification process entails an initial assessment of written policies and procedures and subsequent reviews of CCA member operations to assure continued adherence to quality standards. CCA recognizes member clinic certification awarded by other national accrediting bodies (eg, The Joint Commission).

Collectively, CCCs have reported positive outcomes. A recent study published in the *American Journal of Medical Quality* showed an overall 99.05% adherence by CCC providers to clinical guidelines for treating acute pharyngitis, a rate that is significantly higher than adherence rates reported elsewhere.[1] A May, 2008 Harris Interactive poll published in the *Wall Street Journal* reported that 90% of CCC patients are satisfied with the quality of their care.[2]

In conclusion, CCCs have evolved at a time when our health care system is floundering. CCCs focus on quality, convenience, and consumer choice. Competent professional health care providers, use of evidence-based practices in patient care, established quality standards, and ongoing quality improvement mechanisms are central to the CCC concept. Because of this, CCCs are proving to be an accessible, affordable, and high-quality health care choice.

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References:

1. Woodburn JD, Smith KL, Nelson GD. Quality of care in the retail health care setting using national clinical guidelines for acute pharyngitis. *Am J Med Qual*. 2007; 22: 457-462.
2. The Wall Street Journal Online/Harris Interactive Healthcare Research. New WSJ.com/Harris Interactive study finds satisfaction with retail-based health clinics remains high. Available at: http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=1308.

Table 1. Comparison of CCA Standards with Other Professional Association Standards

Category	Quality Standards Comparison	AAFP	AAP	AMA	CCA
Scope of Practice	Well-defined	●		●	●
	Limited	●		●	●
Practice Guidelines	Evidence-based	●	●	●	●
	Continuity of care	●		●	●
Team-based Approach	Compliance with practitioner oversight requirements	●	●	●	●
	Out of scope	●		●	●
	Follow-on care	●		●	●
Referrals	Encourage medical home	●	●	●	●
	Emergency response procedures	●			●
Electronic Health Record	Data aggregation	●		●	●
	Integration	●		●	●
Provider Credentialing	All practitioners			●	●
	Peer review				●
	Collaborating physician review				●
Quality Monitoring	Compliance with evidence-based guidelines	●			●
	Quality and safety outcome analysis				●
	Patient satisfaction analysis				●
	Occupational Safety and Health Administration			●	●
	Clinical Laboratory Improvement Amendments				●
Compliance	Health Insurance Portability and Accountability Act				●
	Americans with Disabilities Act				●
	Centers for Disease Control Infection Control Guidelines		●	●	●
Consumer Empowerment Price	Health care choices				●
	Consumer transparency				●

AAFP = American Association of Family Practitioners AAP = American Academy of Pediatrics AMA = American Medical Association CCA = Convenient Care Association

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