Getting the Board on Board to Drive Quality and Safety:
What that means for physicians and other hospital leaders

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What’s the big deal?
Standards to be found in the Joint Commission’s Accreditation Standards dating back several decades have established the Board of Hospitals (and other accredited institutions) as the ultimately accountable group for the quality and safety of care. There is case law dating all the way back to the middle ‘60s holding a hospital corporately liable for a patient’s negligently inflicted injuries for not having exercised sufficient oversight of its physicians’ clinical results for which the board is ultimately responsible. Darling v. Charleston Community Memorial Hospital 33 Ill. 2d 326, (1965).

So why has getting the “Board on Board” become such a catchy phrase, especially among those signing on to the latest 5 Million Lives Campaign promoted by the Institute for Healthcare Improvement (IHI)? Hasn’t the Board always been on board in overseeing the quality and safety of care right along?

Reality may finally be catching up with the theory of board leadership in patient safety and quality
“Trustees traditionally have used their positions on hospital boards for social networking with other business executives and raising money through events such as fashion shows and golf tournaments... Until the last several years, individual hospital boards in Massachusetts and other states had not paid much attention to the issue of preventable deaths, leaving oversight to doctors and administrators. Now, national and local conferences that encourage greater trustee involvement have been packed, healthcare executives say.” Rowland; Hospital Trustees Shift their Focus to Medical Safety”; Boston Globe; March 5, 2007

Donald Berwick, M.D., President and CEO of IHI, in announcing getting the Board on Board as one of his institute’s six new interventions to decrease the incidence of preventable patient injuries by five million during 2007 and 2008, recently stated: “Board seats in American hospitals have traditionally been relatively honorific positions. It is time for hospital boards of directors—along with executives and physicians—to rise from slumber and view safety as an urgent matter.”

Dr. Berwick, by videotape, and Jim Conway, Senior VP of IHI (and former top executive at the Dana Farber Cancer Institute at Harvard) recently addressed a Leadership Summit Meeting on patient safety sponsored by the New Jersey Hospital Association in Princeton. At that meeting, they explained that for hospital boards to participate in IHI’s 5 Million Lives Campaign, they must:

1. Set specific aims to reduce medical injuries annually and make an explicit public commitment to measurable quality improvement;
2. Select and review progress toward safer care as the first agenda item at every board meeting;
3. Establish, continually update and make transparent to the entire organization a small group of enterprise-wide “roll up” measures of patient safety;
4. Commit to establish and maintain an environment that is respectful, fair and just for all who experience the pain and loss associated with avoidable harm and adverse outcomes.
5. Develop their expertise in evaluating quality and safety and set
expectations for a similar level of education and training for all staff; and

6. Hold accountable senior executives for developing and executing a plan to achieve specific quality and safety improvement goals and objectives.

Is there evidence that getting the board on board will make a difference in the quality and safety of care?

Even as committed as physicians are to improving the quality and safety of care, it is perfectly logical for them to ask whether it is really “worth it” for them to help get their institutions’ boards on board to promote the quality and safety of care. A recent landmark study may provide at least an early answer to this important question.

Researchers from the University of Iowa, the Center for Medicare and Medicaid Services (CMS), Care Science, Inc. and the Wharton School of the University of Pennsylvania administered a short Web-based survey of hospital leaders in 2005. The group also consulted with Solucient, the National Committee for Quality Healthcare and eight hospital associations in the preparation and administration of this Executive Quality Improvement (QI) survey.

In particular, the survey examined hospital QI drivers and impediments, quality reporting methods, board and physician participation in QI and the use of senior executive incentives to support QI. A total of 413 hospitals from eight states including Arizona, Colorado, Illinois, Iowa, New Jersey, New York, Pennsylvania and Wisconsin completed the survey. Among other things, the study examined whether leadership involvement in QI (especially of the Board and CEO) was systematically related to observed hospital outcomes, as tracked by the Care Science Quality Index. This is an inpatient quality rating system based on compiling risk-adjusted measures of morbidity, mortality and medical complications into one overall index score. Professionals from Penn’s Medical and Wharton Schools spent many years developing this index with leading hospitals.

Results showed that better quality index scores are associated with hospitals where the board:

1. Spends more than 25 percent of its time on quality issues;
2. Receives a formal quality performance measurement report;
3. Bases the senior executives’ compensation in part on QI performance; and
4. Engages in a high level of interaction with the medical staff on quality strategy.

Better quality index scores were also associated with the chief executive officer being identified as the person with the greatest impact on QI, especially when identified as such by the top hospital QI executive. Those hospitals are more than three times as likely to be in the top third of the quality index distribution as in the bottom third. Vaughn, T, Koepke, M, Kroch, E, Lehrman, W, Sunil, S, Levey, S, Engagement of Leadership in Quality Improvement Initiatives: Executive Quality Improvement Survey Results; Journal of Patient Safety. 2(1): 2-9; March, 2006

Although this is only one study, it is a significant one. Its results are based on the strong systematic associations found between boards taking the leadership on safety and quality and actual, measurable improvements in patient outcomes. In the brave new world of value-driven health care (see the previous issue of Risk Review), such differences in quality index scores may well mean the difference between future success and failure (for hospitals and their staff physicians). This greater financial success will be in addition to the decreases in potentially compensable events from a medical liability perspective likely to occur in these hospitals whose boards drive safety and quality.

So how can physicians contribute?

The study above makes abundantly clear the importance of robust interaction and close alignment between physicians and other hospital leaders in developing a quality strategy for the institution.

“Hospital leaders, including the board, senior executives, and the hospitals’ physicians and other internal stakeholders, need to establish priorities for QI, including both identification and mitigation of risks and hazards and improvement of clinical outcomes.” See Vaughn, et. al. at 7 as well as Denham, CR, Patient safety practices: Leaders can turn barriers into accelerators; J Patient Safety 2005; 1(1):41-55 and Denham, CR, Bagian, J, Daley, J, et.al. No excuses: the reality that demands action. J. Patient Safety 2005; 1(3):170-75

After having completed successfully their own educational curriculum in patient safety, physician leaders should educate both senior management and the boards of their hospitals in patient safety and what they as leaders can and must do to ensure it at their institutions and in their own medical practices. Physicians should be the leaders in the implementations of all types of safety-enhancing technologies. These may include: electronic medical records, computerized physician order entry and integrated mobile systems, computerized adverse event tracking, clinical decision support, risk adjusted outcomes measurement systems, bar coding and radiofrequency identification (RFID) patient tracking systems. Physicians may also lead in less technical, but equally important areas, such as promoting more systematic methods of communication such as the SBAR method (discussing patients’ Situation, Background, Assessment and Recommendations), Rapid Response Teams, and Crew Resource Management efforts. This will be the subject of future Risk Review articles.

How can Princeton Insurance help?

Princeton Insurance is planning to launch several patient safety initiatives over the course of the rest of 2007. The first of these initiatives will concern the main topic of this article, viz.: Getting the Board on Board to Lead Patient Safety and Quality Improvement. This is one of the six new interventions promoted by IHI’s new 5 Million Lives Campaign for 2007-8. The president and CEO of IHI, Donald Berwick, M.D., M.P.P. regards this as the first among equals of these new interventions, having recently called 2007 “The Year of Governance”.

Princeton Insurance looks forward to working with hospital leaders, especially physicians, during the rest of 2007 to help get their Boards on Board to lead patient safety and quality. In addition to the strong evidence cited above of the positive impact that this will have on the quality and safety of care, leaders at Princeton Insurance feel that there is a growing evidentiary base of the positive risk management benefits of doing this, also. This leadership initiative will serve as the foundation for additional safety initiatives such as improving communication among care providers, preventing hospital acquired infections, adverse drug events and surgical complications. How Princeton may join with you to accomplish these goals will be the subject of subsequent Risk Review articles and other communications in the coming months.