Invigorating the Board Quest for Quality Improvement

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For at least two decades, the Dartmouth Atlas has proven that there is great and unexplained variability in clinical practice across the country.

Dr. Glenn Steele, a surgeon and the CEO of Geisinger, has stated that patient care in U.S. is suboptimal 50 percent of the time (where optimal consists of right time, right place, right diagnosis, right treatment, and right price).

The relationship between the board and the medical staff is a key component in the quest for quality improvement. But board and medical staff relationships have gone stale in too many organizations. Little has changed since 1950 and it's time for boards, together with their MECs, to rejuvenate this critical relationship. While most physicians are willing and anxious for this to occur, the ball is in the hands of the board.

Since the Greatest Generation returned home, boards have delegated responsibilities to the MEC for three core functions: credentialing, privileging, and peer review. With one exception (requiring physician specialty board accreditation), boards have allowed their oversight responsibility to largely be reduced to a retrospective, frequently pro-forma review of MEC recommendations in these three core functions. This needs to change.

The Mandate for Change

The American Board of Medical Specialties (ABMS) recognizes 24 distinct specialties (cardiology, neurology, gastroenterology, etc.). Each specialty has at least five areas of subspecialty (ABMS recognizes 148), and many of these physicians treat patients in four distinct venues: emergency room, ambulatory, inpatient, and office. That means there are well in excess of 300 areas (i.e., strategic business units) in which boards are required to exercise policy setting and oversight. Complicating this, most physician/patient encounters are considered a "just in time" event. That is, while an arthroscopic procedure may not technically vary greatly from patient to patient, there are multiple nuances involving each patient, physician, and other clinicians—factors contributing to the clinical variation occurring now.

Providers know that something has to change, and we believe that change should take place at the individual system/hospital level on a specialty-by-specialty (subspecialty) basis.

Every board we know of is working diligently through its quality committee and its MEC to improve clinical outcomes—which can be a complex and often frustrating endeavor. But it doesn't have to be this way. This article describes several steps boards can take to proactively raise the bar in quality improvement and medical staff oversight. These steps will improve outcomes in quality, safety, satisfaction (patient, physician, and employee), and efficiency. They will lead to improved clinical and financial outcomes in all three methodologies by which providers are currently paid: traditional fee-for-service, acute care performance (narrow network), and capitation (HMO and Medicare ACO). Finally, these steps will lead to a rejuvenation of the relationship between the board and medical staff.

Step 1. Enhance the Board Quality Committee's Approach

The first step is to refocus the work of the board quality committee at the appropriate level (i.e., governance, not operations). This means adopting a standard continuous quality improvement approach, which keeps the board focused at the right level: structure, process, and outcomes. In order to be effective, the effort must be led by someone with experience in such an endeavor. This certainly can—but doesn't have to—be a physician. Board members with such experience come from a variety of backgrounds including banking, manufacturing, hospitality, retail, and education.

In addition, boards, working with their executives and MECs, need to revise their approach to granting of privileges and peer review to include utilization of proven best practices and clinical protocols. Physicians must be allowed to exercise clinical judgment and to make decisions outside the bounds of the protocols, but this should occur infrequently. The challenge is to set a standard set of expectations (usually via board policy). Norton Healthcare in Louisville, Kentucky, is an example of one system that has already adopted this approach as a requirement for practice on their staff.

Key Board Takeaways

The board and medical staff must work together proactively to ensure continuous improvement of quality, safety, satisfaction, and efficiency. The following are key steps to take to ensure the board and medical staff relationship is both appropriate and effective:

- Enhance the board quality committee's approach through continuous quality improvement, and establishing standard clinical protocols for privileging/credentialing.
- Use the electronic health record as a quality determinant.
- Link physician compensation to quality outcomes.
- Increase oversight of quality in physician offices.

In some specialties they have adopted national best practices, and for other specialties, physicians have come forward to establish their own.

Step 2. Use the Electronic Health Record As a Quality Determinant

While EHR implementation can be time consuming, costly, and frustrating, we know that in time these systems will simultaneously improve quality, safety, satisfaction, and efficiency. Thus, this is an important area of focus for the board's quality improvement quest.

But IT implementation is just the first step. If boards are to monitor quality improvement, they must also oversee progress in its utilization.[1]

Boards and their executives, together with their MECs, should also require, as a condition of privileging, that physicians utilize an EHR that is interoperable with the system and other physicians (again, Norton

1 The Healthcare Information and Management Systems Society has provided a tool for this, the HIMSS EHR adoption model, which is available from HIMSS Analytics (see www.himssanalytics.org/emram/emram.aspx) and establishes standards for eight stages of adoption. Boards, through their executives, need to work with their medical staffs to establish an approach to reaching the final stage.

Healthcare has already established this policy). This assumes, of course, that the system itself is operating on an appropriate platform. It also requires that this condition be prospectively stated (a requirement for three to five years out) so that physicians have time to plan for the transition.

There are approximately 800 physician office EHRs. We don't know what the right number is (three to five?), but we're certain that even 100 is far too many for a system to support. Working with their IT executives, boards must identify the office platforms that are compatible with the system.

Step 3. Link Physician Compensation to Quality Outcomes

One of the primary roles of any board is the oversight of the physician compensation program. Typically, compensation is tied to quality, but unfortunately most boards don't demand quality *outcomes*. Rather, the requirement tied to compensation is usually just that the physicians and management are working on quality processes.

Today, it is not enough to demand that processes be followed. High-performing boards must focus and incentivize physicians (in a meaningful way) on documented quality outcomes that show improved clinical, operational, and financial performance. Boards should set the tone that it is no longer acceptable for physicians to just be productive. In today's environment, physicians not only need to be productive (which is not just WRVU generation) but must also be following protocols, achieving clinical outcomes, and focusing on managing patient populations rather than individual patient encounters that maximize their productivity.

Step 4. Increase Oversight of Quality in Physician Offices

Every hospital utilizes its MEC to assist in evaluating the quality of inpatient care. A similar group must oversee patient care in the employed physician offices. Boards retain responsibility for the quality of care in these offices just as they do for inpatients. If the equivalent of the MEC for these practices doesn't exist, it needs to be established quickly.

By taking the steps outlined above, boards will ensure that quality improvement is real, and send a clear message to the medical staff that its oversight is diligent and vigorous. Finally and most importantly, these steps will help the board and medical staff work together, at the appropriate levels, to create an ideal care environment for every patient.

The Governance Institute thanks Don Seymour, Executive Vice President, INTEGRATED Healthcare Strategies, and Governance Institute advisor, for contributing this article. Chad Stutelberg, Executive Vice President and Practice Leader, was also a contributor to this article. They can be reached at don@donseymourassociates.com.