Making a Difference in the Boardroom:

Updated Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems

THE GOVERNANCE INSTITUTE

A service of NATIONAL RESEARCH Corporation

A Governance Institute White Paper | Fall 2014

About the Author

Larry Stepnick is Vice President and Director of The Severyn Group, Inc., a Virginia-based firm that specializes in conducting qualitative and quantitative research, and writing and producing publications on a wide range of healthcare management issues. In addition to printed materials, The Severyn Group creates Web site content and electronic presentations for training and education purposes. Severyn's clients include a broad spectrum of organizations that represent virtually all aspects of healthcare, including financing, management, delivery, and performance measurement. The Severyn Group assists clients in resolving their most critical strategic concerns.

Prior to cofounding The Severyn Group in 1994, Mr. Stepnick served as Senior Vice President and an elected officer of The Advisory Board Company, a for-profit membership of more than 1,000 hospitals and health systems. Mr. Stepnick received his bachelor's degree from Duke University, where he graduated summa cum laude. He also holds an M.B.A. from the Wharton School of the University of Pennsylvania, where he graduated with honors.

Mr. Stepnick can be reached at (703) 723-0951 or via email at larry@severyngroup.com.

Acknowledgements

Deron Ferguson, Ph.D., Senior Director of Research and Analytics at National Research Corporation (NRC), conducted the statistical analysis for this study and contributed comments to the white paper. Dr. Ferguson manages the research and custom analytics teams and provides strategic direction for NRC with respect to developing its research capability and agenda. With an academic background rooted in economics (B.A., M.A.) and economic geography (Ph.D.), Dr. Ferguson has gained expertise in health services research, including healthcare utilization and outcomes, predictive modeling, analysis of patient experience, validation of survey instruments, and development of standardized health outcome metrics.

The Governance Institute

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

The Governance Institute is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.

A service of NATIONAL RESEARCH *Corporation*

The Governance Institute®

The essential resource for governance knowledge and solutions®

9685 Via Excelencia • Suite 100 • San Diego, CA 92126
Toll Free (877) 712-8778 • **Fax** (858) 909-0813
GovernanceInstitute.com

The Governance Institute is a service of National Research Corporation. Leading in the field of healthcare governance since 1986, The Governance Institute provides education and information services to hospital and health system boards of directors across the country. For more information about our services, please call toll free at (877) 712-8778, or visit our Web site at GovernanceInstitute.com.

The Governance Institute endeavors to ensure the accuracy of the information it provides to its members. This publication contains data obtained from multiple sources, and The Governance Institute cannot guarantee the accuracy of the information or its analysis in all cases. The Governance Institute is not involved in representation of clinical, legal, accounting, or other professional services. Its publications should not be construed as professional advice based on any specific set of facts or circumstances. Ideas or opinions expressed remain the responsibility of the named author(s). In regards to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this publication. The Governance Institute is not responsible for any claims or losses that may arise from any errors or omissions in our publications whether caused by The Governance Institute or its sources.

Table of Contents

Executive Summary

The Governance Institute administers a Biennial Survey of Hospitals and Healthcare Systems covering board structure, composition, and practices.

BEGINNING WITH THE 2011 SURVEY, RESULTS HAVE BEEN compared to performance on standardized quality measures in an attempt to identify board practices that lead to better quality of care.[1] In the most recent phase of this research, The Governance Institute matched, where possible, hospital-specific responses from its 2013 survey to the most recent publicly reported performance on measures included within the fiscal year 2014 Centers for Medicare & Medicaid Services (CMS) Value-Based Purchasing (VBP) program. This analysis includes data from 540 boards that responded to the 2013 survey; collectively, these boards oversee the operations of 763 hospitals.

Of 95 practices included in the survey, the analysis identified 27 distinct board practices that significantly correlated with better performance on the overall VBP score and/or the process-of-care (POC) and clinical outcomes components of that score.[2] Two of these practices were significantly correlated with better performance on all three components (overall VBP, POC, and clinical outcomes), nine were significantly correlated with better performance on two of the three, and 16 were significantly correlated with better performance on one of the three. Overall, 16 practices were significantly correlated with higher overall VBP scores, 14 with higher POC scores, and 10 with higher clinical outcomes scores. For each of these practices, a statistically significant difference exists in the proportion of high-performing hospitals (defined as the top quartile) adopting the practice than low-performing hospitals (defined as the bottom quartile), with high performers being more likely to adopt the practice. **Table 1** on page 4 in the main body of the white paper lists the 27 distinct practices, organized into four categories that group together practices related to similar themes: quality oversight, community health, audit/compliance, and other "good governance" practices. For each practice, an "X" indicates which component(s) of the VBP score (overall, POC, and/or clinical outcomes) the practice appears to influence. Practices with "Xs" in more than one column, therefore, are correlated with better performance on multiple components, suggesting they may have broad value in promoting higher quality.

As an adjunct to this analysis, The Governance Institute conducted interviews with the leaders of four organizations that scored highly on the total VBP measure. These interviews confirmed that high-performing organizations follow most if not all of the identified practices, and that some of these practices currently serve as drivers of quality and safety performance and/or will likely do so in the future as managing defined patient populations and community health become more important. (Other identified practices may not directly be responsible for better performance, but rather are indicative of strategies that forward-thinking boards routinely employ.)

The full report includes case studies that outline how system and local boards within these organizations promote quality, along with a more detailed discussion of the research findings. As a whole, this analysis raises a set of questions for system- and hospital-level boards to consider:

- Has the board sent strong, unmistakable signals to the rest of the organization (including those on the front lines of patient care) about the importance of quality and safety? For example, has it adopted a clear resolution making quality and safety the organization's most important priorities?
- Does the board set and/or require aggressive targets with respect to quality and safety performance throughout the organization? Are these targets based on the theoretical ideal, such as eliminating all preventable harm? Do these targets tie into the strategic planning process? Has the board set target dates for achievement of these goals and setting new goals (while recognizing that quality improvement work is a continuous process)?
- Does the quality committee of the board closely monitor progress in meeting targets, and does performance on quality-related metrics tie into incentive compensation systems in a meaningful way?
- Does the board require and/or strongly encourage development and implementation of formal plans, policies, and strategies related to identifying and addressing the health needs of local communities served by the organization?
- Does the board have processes and/or criteria in place to identify and recruit directors with a passion for and/or experience in quality and quality improvement?
- When appropriate, does the board challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff?
- Does the board encourage liberal sharing of quality-related performance data both within the organization and to the public at large? Does the organization create opportunities for low performers to learn from high performers?

1 The first iteration of this research was presented in Larry Stepnick, *Making a Difference in the Boardroom: Preliminary Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2012.

2 These practices were found to be statistically significant, as defined by a p value less than .10, meaning that there is less than a 10 percent chance that the practice in fact has no relationship to performance.

Background and Introduction

Facing intense pressure to curb costs and improve quality, hospital and health system leaders continue to search for ways to promote evidence-based, efficient care, with a focus on managing the health of populations over time.

MANY OF THESE ORGANIZATIONS NOW DERIVE AT LEAST some portion of their revenues from value-based payment systems that create accountability for quality and costs across the care continuum, something that they have little prior experience in managing. This task becomes even more difficult in an environment where a meaningful portion of revenues still come from fee-for-service (FFS) payments, which tend to penalize providers for investing in the infrastructure needed to improve quality and manage population health.

Given these complexities and calls from outside organizations (such as the Institute for Healthcare Improvement and the National Quality Forum) to become more engaged in quality,[3, 4] time-constrained senior executives and board members are increasingly looking for guidance on board practices that lead to better performance. Prior research on this topic, including several studies conducted by The Governance Institute, has identified some specific practices associated with better quality.[5] This white paper adds to this body of research by reporting on new findings from The Governance Institute's ongoing research into board practices that improve performance on quality measures included in the Centers for Medicare and Medicaid Services (CMS) Value-Based Purchasing (VBP) program, which adjusts payments to hospitals based on their performance on process, outcome, efficiency, and patient experience measures.

In fall 2012, The Governance Institute published preliminary findings from this research, reporting on 14 board practices that significantly correlated with better performance on process-of-care measures contained within the VBP score. Since 2012, The Governance Institute has continued this effort by conducting a similar, more comprehensive exercise that matched federal fiscal year (FY) 2014 VBP scores to board practices as reported in *Governing the Value Journey,* its 2013 Biennial Survey of Hospitals and Healthcare Systems.

3 Institute for Healthcare Improvement, "Getting Boards on Board" (Web page): www.ihi.org/resources/Pages/Tools/HowtoGuideGovernanceLeadership.aspx.

4 National Quality Forum, *Hospital Governing Boards and Quality of Care: A Call to Responsibility,* Washington, D.C., December 2, 2004.

5 The first iteration of this research was presented in Larry Stepnick, *Making a Difference in the Boardroom: Preliminary Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2012.

Research on Board Practices Associated with Higher Quality: Updated Findings

Study Methodology

The Governance Institute's biennial survey covers board structure, composition, and practices. For this most recent research, The Governance Institute matched, where possible, hospital-specific responses from the 2013 survey to the most recent publicly reported performance on measures included within the FY 2014 CMS VBP program, which calculates four separate scores:

- **Process-of-care (POC):** This score is determined by performance on a standard set of measures in four different areas of care—acute myocardial infarction (two measures), pneumonia (two measures), heart failure (one measure), and healthcare-associated infections (seven measures).
- **Patient experience of care:** This score is based on performance in eight different areas measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey related to patient experience: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, hospital cleanliness and quietness, discharge information, and overall hospital rating.
- **Clinical outcomes:** This score is based on performance on three measures: mortality rates within 30 days of patient discharge for heart attack, heart failure, and pneumonia.
- **Total VBP:** This composite score is calculated by giving a 45 percent weighting to the POC scores, 30 percent to patient experience scores, and 25 percent to clinical outcomes scores.

The analysis includes data from 540 boards that responded to the 2013 biennial survey; collectively, these boards oversee the operations of 763 hospitals. Board responses for these hospitals were matched against the FY 2014 VBP scores (the federal FY 2014 began October 1, 2013). Adequate quality data were available for 486 of the 763 hospitals. The publicly reported scores are based on performance during two separate periods—a baseline period and performance period—that differ depending on the VBP component being measured. For the POC and patient experience components, the baseline period ran from April–December 2010, while the performance period ran from April–December 2012. For the clinical outcomes component, the baseline period ran from July 2009 to June 2010, while the performance period ran from July 2011 to June 2012.

The VBP scoring methodology rewards both absolute performance and improvement over time. For the POC and outcomes domains, scores are calculated as the higher of an "achievement" or "improvement" score, with achievement being measured as the score in the performance period, and improvement as the change in score between the baseline and performance periods. For the patient experience domain, the bulk (80 percent) of the VBP score is calculated as the higher of the achievement or improvement score, with the remaining 20 percent being a "consistency" score designed to reward organizations based on their ability to score well across all eight measures within the domain.

Summary of Key Findings

Of 95 practices included in the 2013 biennial survey, the analysis identified 27 distinct board practices that significantly correlated with better performance on the overall VBP score and/or the POC and clinical outcomes components of that score.[6] Two of these practices were significantly correlated with better performance on all three components (overall VBP, POC, and clinical outcomes), nine were significantly correlated with better performance on two of the three, and 16 were significantly correlated with better performance on one of the three. Overall, 16 practices were significantly correlated with higher overall VBP scores, 14 with higher POC scores, and 10 with higher clinical outcomes scores. For each of these practices, a statistically significant difference exists in the proportion of high-performing hospitals (defined as the top quartile) adopting the practice than low-performing hospitals (defined as the bottom quartile), with high performers being more likely to adopt the practice. **Table 1** lists the 27 distinct practices, organized into four categories that group together practices related to similar themes: quality oversight, community health, audit/compliance, and other "good governance" practices. For each practice, an "X" indicates which component(s) of the VBP score (overall, POC, and/or clinical outcomes) the practice appears to influence. Practices with "Xs" in more than one column, therefore, are correlated with better performance on multiple components, suggesting they may have broad value in promoting higher quality.

Table 1. 27 Board Practices Associated with Higher VBP Scores

Board Practice	Total Score	Process-of-Care Score	Clinical Outcomes Score
PRACTICES RELATED TO QUALITY OVERSIGHT			
The board requires major hospital clinical programs and services to meet quality-related performance criteria.*	☑		
The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation.	☑	☑	
The board requires that major strategic projects specify both measurable criteria for success and who has responsibility for implementation of the projects.	☑	☑	
The board requires management to base at least some of the organization's quality goals on the "theoretical ideal" (e.g., no central line infections, no sepsis).		☑	
The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff.		☑	☑
PRACTICES RELATED TO COMMUNITY HEALTH			
The board provides oversight with respect to organizational compliance with IRS requirements to maintain its tax-exempt status that pertain to community benefit and other related issues.	☑	☑	☑
The board considers how the organization's strategic plan addresses community health status and needs before approving the plan.	☑	☑	
The board has adopted a policy or policies on community benefit that include all of the following: a statement of its commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, measurable goals for the organization, a financial assistance policy, and a commitment to communicate transparently with the public.	☑	☑	
The board ensures the adoption and implementation of strategies to meet the needs identified in the community health assessment.		☑	
The board requires that management report each year on the community benefit value provided by the organization to the general public (i.e., the community).		☑	
The board ensures that a community health needs assessment is conducted at least every three years to understand the health issues of the communities being served.	☑	☑	

6 These practices were found to be statistically significant, as defined by a p value less than .10, meaning that there is less than a 10 percent chance that the practice in fact has no relationship to performance.

Table 1. 27 Board Practices Associated with Higher VBP Scores (continued)

Board Practice	Total Score	Process-of-Care Score	Clinical Outcomes Score
PRACTICES RELATED TO AUDIT AND COMPLIANCE			
The board has established a direct reporting relationship with the compliance officer.		☑	
The board has a written external audit policy that makes the board responsible for approving the auditor and the audit oversight process.			☑
The board has adopted a policy that specifies that the audit committee (or other committee/subcommittee with primary responsibility for audit oversight) must be composed entirely of independent persons who have appropriate qualifications to serve in such a role.			☑
The board seeks expert advice and information on industry comparables from independent (i.e., third party) sources before approving executive compensation.	☑	☑	☑
Board members responsible for audit oversight meet with external auditors, without management, at least annually.	☑		☑
The board delegates its executive compensation oversight function to a group (committee, *ad hoc* group, task force, etc.) composed solely of independent directors of the board.	☑		☑
The board (directly or through a dedicated committee) ensures that the compliance plan is properly implemented and effective.		☑	
The board has created a separate audit committee, audit/compliance committee, or another specific committee/subcommittee to oversee the external and internal audit functions.			☑
The board works closely with legal counsel to ensure all advocacy efforts are consistent with tax-exempt status requirements.	☑		
OTHER "GOOD GOVERNANCE" PRACTICES			
The board uses competency-based criteria when selecting new members.*	☑	☑	
The board reviews the sufficiency of the organizational structure every five years.	☑		
The board assists the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).	☑		
The board has a written policy establishing its role in fund development and/or philanthropy.			☑
The board assesses its own bylaws/structure at least every three years.	☑		
Board members complete a full conflict-of-interest disclosure statement annually.			☑
The board receives important background materials within sufficient time to prepare for meetings.	☑		

*These practices also appeared in the 2012 white paper as being associated with higher POC scores.

Inconclusive Findings on Board Practices That Influence Patient Experience Scores

The analysis of patient experience scores did not yield many conclusive findings related to specific board practices that positively affect performance; in fact, 16 of the 24 practices identified were associated with worse (not better) performance. The Governance Institute does not believe that these 16 board practices actually undermine performance on HCAHPS measures. Given these counterintuitive findings, however, The Governance Institute cannot be confident that the eight practices associated with better performance on HCAHPS measures in fact are responsible for those higher scores. In interviews with high-performing organizations, board members and administrative leaders expressed surprise at these findings, and generally rejected the notion that boards somehow are less familiar with or have less influence over performance on patient satisfaction/patient experience measures. Instead, they felt that the findings could be the result of several factors:

- **Greater challenges in improving performance:** Interviewees believe that improving patient experience scores can be very difficult, likely more so than improving performance on CMS core measures and other long-established POC and clinical outcomes measures. In the complex environment that exists in most hospitals and health systems, the patient has many "touch points" with the healthcare system, and ensuring that each of them goes smoothly can be a herculean task. For example, an older facility that scores poorly in terms of noise levels can likely solve that problem only by investing significant money in soundproofing and in new communication technologies to replace out-of-date paging systems. Hospitals that score poorly on communication between physicians and patients may have to convince skeptical doctors of the importance of changing their habits and help them in doing so. In addition, ratings given by patients and/or family members on their experience are more subjective than are POC or clinical outcomes scores, and hence it may be difficult for hospital leaders to understand precisely what needs to be done to improve performance. In some cases, it may not be clear why a patient gave the hospital a particular score (good or bad), making it impossible to use the information to boost performance.
- **More compressed distribution of scores:** Interviewees believe that the distribution of performance scores on patient experience measures may be more compressed than with other categories of measures. In particular, many of these measures use a 1–4 scale, where "1" means a hospital "never" does a certain thing and "4" means that it "always" does. As a practical matter, very few patients give out either 1s or 4s, and hence variations in performance can become more compressed. As a result, a very small difference in absolute score between one hospital and the next can translate into the difference between top-tier and poor performance. For example, one interviewee shared the story of a children's hospital that scored in the top decile of performance one month, only to drop to the bottom 1 percent the following month because of a relatively small change in its score. For this reason, hospitals may be better off tracking their own performance over time on patient experience measures (instead of comparing themselves to others).

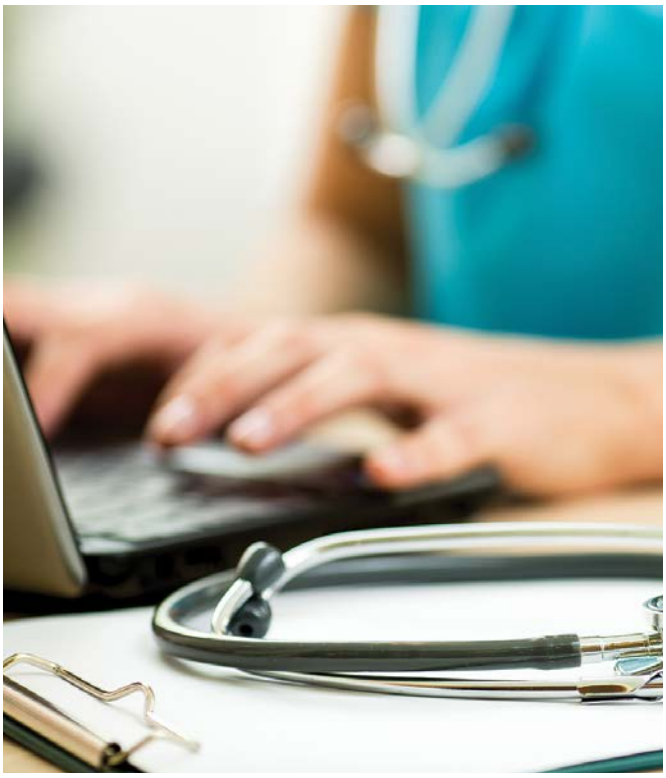
Whatever the reason(s) for the counterintuitive findings in this year's analysis, additional research will be needed before any definitive conclusions can be reached about the impact of boards on patient satisfaction/experience and on any specific board practices that might make a difference in these areas.

Relatively Little Overlap with 2012 Research

Only two of the 27 practices that came out of this year's analysis appeared in The Governance Institute's earlier, preliminary analysis published in the fall of 2012:

- The board requires major hospital clinical programs or services to meet quality-related performance criteria, such as volume requirements, effective staffing levels, and accreditation.
- The board uses competency-based criteria when selecting new board members.

Those involved in this research at The Governance Institute are not surprised by the lack of overlap between the current analysis and the previous findings, for several reasons. First and foremost, the performance scores being used have been calculated somewhat differently. In 2012, researchers had to use a "simulated" score based on VBP specifications, since CMS' timeframe for its public reporting did not correlate with the timeframe used by The Governance Institute in its analysis. Second, governance practices have likely changed to some degree during the two-year period between the analyses. Finally, The Governance Institute biennial survey changed to a minor degree during this time; in particular, one practice identified as being significantly associated with better POC scores in 2012 dropped off the most recent version of the survey.[7]



7 This practice is: *The board has a written policy outlining the organization's approach to physician competition/conflict of interest.*

Detailed Review of Key Findings

To build on the summary information in Table 1, the sections below provide more detailed information on the categories and the 27 identified practices, including the proportion of high- and low-performing hospitals within each VBP component that have adopted them.

Practices Related to Quality Oversight

Five practices directly related to the board's role in overseeing quality were significantly associated with higher scores; the first three (designated in bold) may be particularly important contributors to better performance, as the adoption gap between high and low performers is greater than 10 percentage points. In addition, three of the practices have a positive impact on more than one component of the VBP score:

- **The board requires major clinical programs and services to meet quality-related performance criteria** (93.0 percent of high performers on total VBP score, 81.4 percent of low performers).
- **The board includes objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO's performance evaluation** (93.8 percent of high performers on total VBP score, 81.0 percent of low performers; 91.2 percent of high performers on POC score, 81.9 percent of low performers).
- **The board requires that major strategic projects specify both measurable criteria for success and who has responsibility for implementation of the projects** (98.2 percent of high performers on total VBP score, 86.3 percent of low performers; 95.6 percent of high performers on POC score, 86.2 percent of low performers).
- The board requires management to base at least some of the organization's quality goals on the "theoretical ideal," such as having no central line infections and/or sepsis cases (89.6 percent of high performers on POC score, 80.3 percent of low performers).
- The board is willing to challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff (96.9 percent of high performers on POC score, 90.1 percent of low performers; 96.9 percent of high performers on clinical outcomes score, 88.0 percent of low performers).

Practices Related to Ensuring Organization's Commitment to Community Health

Six practices related to ensuring the organization's commitment to community health have a positive association with better performance, with the first five (designated in bold) having 10 percentage point or greater differences in adoption rates. Four practices are positively associated with better performance on more than one component, including one practice (the first one listed below, designated in italics) associated with better performance on all three components:

- ***The board provides oversight with respect to organizational compliance with IRS requirements to maintain tax-exempt***

status that pertain to community benefit and other related issues (94.6 percent of high performers on total VBP score, 84.3 percent of low performers; 95.5 percent of high performers on POC score, 85.7 percent of low performers; 95.5 percent of high performers on clinical outcomes score, 87.3 percent of low performers).

- **The board considers how the organization's strategic plan addresses community health status and needs before approving the plan** (92.8 percent of high performers on total VBP score, 82.1 percent of low performers; 92.1 percent of high performers on POC score, 80.2 percent of low performers).
- **The board has adopted a policy or policies on community benefit that include all of the following: a statement of its commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, measurable goals for the organization, a financial assistance policy, and a commitment to communicate transparently with the public** (78.2 percent of high performers on total VBP score, 63.0 percent of low performers; 83.0 percent of high performers on POC score, 62.4 percent of low performers).
- **The board ensures the adoption and implementation of strategies to meet the needs identified in the community health assessment** (88.9 percent of high performers on POC score, 78.3 percent of low performers).
- **The board requires that management report each year on the community benefit value provided by the organization to the community/public** (87.9 percent of high performers on POC score, 75.8 percent of low performers).
- The board ensures that a community health needs assessment is conducted at least every three years to understand the health issues of the communities being served (95.3 percent of high performers on total VBP score, 88.2 percent of low performers; 94.4 percent of high performers on POC score, 86.5 percent of low performers).

Practices Related to Audit and Compliance Requirements

Nine practices relate to ensuring the organization meets audit- and compliance-related requirements have a positive association with better performance, with the first three (designated in bold) having 10 percentage point or greater differences in adoption rates. Three practices are positively associated with better performance on more than one component, including one practice (designated in italics) associated with better performance on all three:

- **The board has established a direct reporting relationship with the compliance officer** (82.4 percent of high performers on POC score, 70.3 percent of low performers).
- **The board has a written external audit policy that makes the board responsible for approving the auditor and the audit oversight process** (96.2 percent of high performers on clinical outcomes score, 86.1 percent of low performers).
- **The board has adopted a policy that specifies that the audit committee (or other committee/subcommittee with primary responsibility for audit oversight) must be composed entirely of independent persons who have appropriate qualifications to serve in such a role** (90.6 percent of high performers on clinical outcomes score, 78.9 percent of low performers).
- *The board seeks expert advice and information on industry comparables from independent (i.e., third party) sources before approving executive compensation* (97.2 percent of high performers on total VBP score, 90.8 percent of low performers; 97.3 percent of high performers on POC score, 89.4 percent of low performers; 97.3 percent of high performers on clinical outcomes score, 92.5 percent of low performers).
- Board members responsible for audit oversight meet with external auditors, without management, at least annually (96.1 percent of high performers on total VBP score, 88.1 percent of

low performers; 98.2 percent of high performers on clinical outcomes score, 90.8 percent of low performers).

- The board delegates its executive compensation oversight function to a group (committee, *ad hoc* group, task force, etc.) composed solely of independent directors of the board (95.1 percent of high performers on total VBP score, 87.7 percent of low performers; 96.3 percent of high performers on clinical outcomes score, 89.2 percent of low performers).
- The board (directly or through a dedicated committee) ensures that the compliance plan is properly implemented and effective (98.3 percent of high performers on POC score, 93.0 percent of low performers).
- The board has created a separate audit committee, audit/compliance committee, or another specific committee/subcommittee to oversee the external and internal audit functions (92.4 percent of high performers on clinical outcomes score, 83.6 percent of low performers).
- The board works closely with legal counsel to ensure all advocacy efforts are consistent with tax-exempt status requirements (87.8 percent of high performers on total VBP score, 78.9 percent of low performers).

Other "Good Governance" Practices Related to Board Structure, Activities, and Policies

Seven additional board practices that generally relate to "good governance" also have a positive impact on quality scores, including four with a greater than 10 percentage-point gap in adoption rates between high and low performers, and one (the first listed) that affects more than one component of the score:

- **The board uses competency-based criteria when selecting new members** (80.4 percent of high performers on total VBP score, 68.7 percent of low performers; 81.1 percent of high performers on POC score, 65.4 percent of low performers).
- **The board reviews the sufficiency of the organizational structure every five years** (82.5 percent of high performers on total VBP score, 67.2 percent of low performers).
- **The board assists the organization in communicating with key external stakeholders, such as community leaders and potential donors** (84.9 percent of high performers on total VBP score, 74.5 percent of low performers).
- **The board has a written policy establishing its role in fund development and/or philanthropy** (39.6 percent of high performers on clinical outcomes score, 27.2 percent of low performers).
- The board assesses its own bylaws/structure at least every three years (85.5 percent of high performers on total VBP score, 75.7 percent of low performers).
- Board members complete a full conflict-of-interest disclosure statement annually (100.0 percent of high performers on clinical outcomes score, 97.6 percent of low performers).
- The board receives important background materials within sufficient time to prepare for meetings (100.0 percent of high performers on total VBP score, 97.5 percent of low performers).

Case Examples from High-Performing Organizations

As an adjunct to this analysis, The Governance Institute conducted interviews with the leaders of four organizations that scored highly on the total VBP score. These interviews confirmed that high-performing organizations follow most if not all of the identified practices, and that many of these practices are perceived as drivers of quality and safety performance.

THIS SECTION PROVIDES BRIEF CASE STUDIES THAT OUTLINE how the boards of these organizations promote quality, drawing attention where appropriate to those practices consistent with the research findings presented in the previous section.

Mary Greeley Medical Center

Organization in Brief

Mary Greeley Medical Center is a 220-bed regional referral center located in Ames, IA, that serves a 13-county region throughout the central portion of the state. A publicly owned municipal hospital, the medical center is governed by a five-member board made up of elected public officials who serve four-year terms. The terms are staggered so that several board members come up for election every two years. Even though they are elected positions, board slots have historically been filled by a highly qualified, diverse set of individuals with specific skills and expertise in areas critical to the medical center's success, including finance and quality/safety. Much of this diversity has been achieved by using interim appointments to fill vacancies that arise outside of the election cycle. The governance committee regularly discusses potential candidates in the event a vacancy occurs. At present, four out of the five board members were deliberately selected based on their specific skills and knowledge base (everyone except the board chair). Three of these individuals were originally appointed on an interim basis, and one was deliberately recruited by the chair to run for an open spot on the board.

Board Role in Promoting Quality

The Mary Greeley Medical Center board plays a very proactive, deliberate role in promoting high-quality care. Key elements of that effort include:

- **Maintaining an effective, robust quality and patient safety council:** Two out of the five board members serve on the quality and patient safety council, which also includes senior nursing, physician, and administrative leaders. This council takes the lead in developing quality goals and the strategic plans and action steps for achieving them. At every meeting, the council monitors progress through use of a performance dashboard. The full board receives and reviews the minutes of every council meeting.
- **Spending significant proportion of board time discussing quality:** As a policy, the board dedicates at least 25 percent of its meeting time to issues directly related to quality of care, and often spends significantly more (sometimes as much as 75 percent). Time spent discussing quality is monitored to ensure adherence to this policy. Each meeting focuses on a specific quality-of-care issue, with recent topics including care transitions/coordination (i.e., ensuring that patients return and/or transition successfully after discharge), meaningful use requirements as they relate to quality and patient engagement, and community health. The vice president of quality improvement (QI) often leads these discussions, with outsiders brought in as appropriate. For example, the director of a new community health center recently briefed the board on its operations, including how it coordinates and partners with the medical center to improve community health.
- **Spending only necessary time on presentations:** The Mary Greeley board spends little or no time hearing presentations during meetings, including those related to retrospective financial performance. Relevant financial and other data is included in the packet provided in advance of the meeting, and board members review the information ahead of time, asking questions only if something is unclear or concerning to them. More time is spent on what board members feel is most important—looking forward.
- **Setting aggressive goals, with emphasis on theoretical ideal:** The board approves the annual goals that come out of the quality and patient safety council, along with the strategic plans that relate to those goals. For the organization as a whole, the strategic plan is designed as a compass, with quality and patient safety defined as "true north." Several strategic planning cycles ago, the board of Mary Greeley approved the goal of eliminating all preventable harm within the organization. While the board did not establish an explicit date for achievement of this goal, it set up many processes to monitor progress, including creation of a "preventable harm index" that tracks performance on various metrics, such as preventable falls, central line-associated bloodstream infections (CLABSIs), pressure ulcers, and medication errors. The quality and safety council looks closely at performance on these metrics at every meeting, with the full board receiving a summary dashboard and related narrative highlighting progress. The goal is to make incremental progress every year, and to date substantial improvements have been made on most metrics included in the index. The decision not to set a target date was deliberate,

as the board wanted to create a culture that encouraged staff members to go beyond traditional ways of assessing potential harm. For example, after substantial progress was made in preventing pressure ulcers found in common sites (e.g., the legs), QI staff began to discover additional sites where such ulcers occurred, such as the ears. Now efforts have been put in place to prevent these ulcers as well. Had a target date existed for eliminating preventable harm, staff would have had no incentive to find the additional sites, and would instead have been content with the improvements made in eliminating pressure ulcers at the more traditional sites.

- **Tying significant portion of incentive compensation to quality:** A few years ago, the board approved a shift in the weighting used to allocate incentive compensation throughout the organization. Historically, weighting had been even across all major areas/goals included in the strategic plan. For example, if the strategic plan highlighted eight major areas or goals (one being quality/patient safety), each area received a weighting of 12.5 percent. If it highlighted four areas/goals, each received a 25 percent weighting. Now the patient safety/quality component always accounts for 50 percent of total incentive compensation, with that pool of money being tied to performance on various metrics, including CMS core measures, hospital-acquired conditions, readmissions, and patient satisfaction/experience. The remaining 50 percent of incentive compensation is divided among all the other major goals.

Mission Health

Organization in Brief

Based in Asheville, NC, Mission Health is the state's sixth-largest health system and the region's only remaining not-for-profit, independent community hospital system. Mission Health operates six hospitals, including Mission Hospital (its 763-bed flagship facility), along with numerous outpatient and surgery centers, a post-acute care provider, and the region's only dedicated Level II trauma center. Its medical staff consists of more than 1,000 physicians from more than 50 medical specialties and sub-specialties.

Mission Health was recognized by Truven Health Analytics (formerly Thomson Reuters) in 2012, 2013, and 2014 as one of the nation's Top 15 Health Systems, the only system in the country to receive this designation for three consecutive years (and the only system in North Carolina to ever be named to this list).

The Mission Health System board of directors can have up to 19 members, as well as several *ex-officio* members, with one board position currently open. The board operates as a self-perpetuating entity, with board members serving fixed, staggered terms. For the most part, the board uses a skill-based model for selecting members, with individuals chosen based on their expertise, knowledge, and background, rather than as "representatives" of hospitals or other entities within the system. A focus on diversity is also core to the board. Due to state regulations that go back to the mid-1990s merger of two nearby hospitals to form Mission Health, the system board can include no more than

four practicing physicians. Along with the system board, each of the hospitals and other entities within Mission Health has a local board that plays an important role within its local community.

Board Role in Promoting Quality

The Mission Health system board plays a very active role in promoting high-quality care, with key components of that role outlined below:

- **Setting quality-first vision, with resource and time allocation decisions made accordingly:** The entire board, CEO, and senior management team all buy into a shared vision that puts the quality, safety, and experience of patient care as the number-one priority of the organization. This prioritization not only lives in the hearts and minds of its leaders, but is also summarized in Mission Health's BIG(GER) AIM: to get each patient to the desired outcome, first without harm, also without waste, and with an exceptional experience for every patient and family. It is also reflected directly in the resource allocation decisions that leaders make on a routine basis. For example, over the last four years the amount of money allocated to QI infrastructure (e.g., information technology, dedicated QI staff, patient safety officers) has increased sevenfold, even as reimbursement rates have fallen. In addition, the board allocates significant time to quality, with a target of spending at least a quarter of meeting time on quality. In practice, quality often takes up more than the allocated time.
- **Maintaining symbiotic relationship with senior management:** The members of the Mission Health system board recognize that (with only few exceptions) they are not clinicians and do not work on the front lines of patient care daily, and hence are not in a position to fully understand the nuances of what drives quality and safety. Consequently, they focus on asking the right questions and on setting broad goals related to QI, and they then hold senior management accountable for making measurable progress toward those goals. They rely on the chief quality officer (CQO), chief medical officer (CMO), chief nursing officer (CNO), and others to put forward and execute a robust quality agenda and to develop transparent,

performance-driven metrics to monitor progress in executing that agenda.

- **Setting aggressive goals based on a theoretical ideal:** Several years ago, the Mission Health board adopted the goal of eliminating all preventable harm within the organization. The board recognizes, however, that this goal is aspirational in nature and may never be achieved. In practice, the board wants both leaders and those on the front lines of medicine to never stop working toward the elimination of any preventable harm, because identifying and rooting out such harm is core to the mission and is a never-ending process. Much of the "low-hanging fruit" in this area has already been accomplished, such as the elimination of nearly all CLABSIs, ventilator-associated pneumonia (VAP), and pressure ulcers. But the board recognizes that preventable harm continues to occur in less frequent ways, including those that are more difficult to identify, and consequently sets the expectation that leaders and those on the front lines will continue to look for such harm and develop strategies to eliminate it. For example, significant efforts are now underway to prevent pressure ulcers on the nose, mouth, and ears (the only sites where such ulcers continue to be a problem).
- **Ensuring a robust, effective quality committee:** The quality committee of the board is among the most active of any board committee. Several board members serve on it, including the vice chair, the CEO, and two of the four practicing physicians. Several lay community members also serve on the committee; in some cases this committee experience is used as a "staging ground," with these individuals joining the system board at a later time. The president, CMO, CNO, CQO, and other frontline leaders attend every meeting and play a leadership role in identifying specific QI opportunities, appropriate goals within each of these opportunities, and metrics and monitoring systems to gauge progress toward achieving them. As with the full board, committee members focus on asking the right questions and making sure the organization has the resources it needs to succeed.
- **Tying significant portion of compensation to quality performance:** Twenty percent of incentive compensation is tied to meeting various quality-related goals, including in the areas of patient experience and mortality.

Franklin Woods Community Hospital/ Mountain States Health Alliance

Organization in Brief

Franklin Woods Community Hospital is a not-for-profit, 80-bed hospital serving East Tennessee. The first "green" hospital in the state, it offers a full array of primary care and some specialty services. The hospital opened in 2010 and is part of Mountain States Health Alliance (MSHA), the largest healthcare system in Northeast Tennessee and Southwest Virginia. MSHA operates 13 hospitals, 21 primary/preventive care centers, and numerous outpatient sites, including urgent care and ambulatory surgery centers. MSHA has roughly 9,000 team members, associated physicians, and volunteers who work in its facilities.

MSHA is a locally governed, not-for-profit healthcare organization. Its board of directors consists of local civic and business leaders who have a long-standing commitment to improving the health and supporting the economy of Northeast Tennessee and Southwest Virginia. In addition to the MSHA system board, community boards within local geographic areas work with local facilities and make recommendations to the system board. In Washington County, TN, the local board has responsibility for Franklin Woods Community Hospital and two other facilities—the 445-bed Johnson City Medical Center and a smaller behavioral health hospital.

> "The board sets the expectation that everyone in the organization, from the CEO to those on the front lines of patient care, continuously and relentlessly strives to identify actual or potential problems to improve quality and safety. Our goal is to engrain that belief systematically across the organization, so much so that if someone's DNA is not aligned with this core value, they simply will not fit in here. Just like breathing, taking this approach is what we want everyone here to do naturally, without ever questioning or even thinking about it."
>
> *—Ronald A. Paulus, M.D., President & CEO, Mission Health*

Board Role in Promoting Quality

The MSHA board and the local Washington County board work in partnership to promote high-quality care, with key aspects of that partnership outlined below.

System board role:

- **Setting aggressive goals that take past performance into consideration:** The MSHA system board sets broad, aggressive targets within each of the pillars included on the system's performance dashboard, with quality being one of those pillars (along with people, finance/growth, and innovation). Targets are set to be aggressive and aspirational in nature, with the goal of motivating significant improvements in performance. However, the system board recognizes that performance varies across facilities and adjusts targets to reflect that reality. For high-performing organizations like Franklin Woods, the goal is to be in the top decile of performance on metrics that are part of the Medicare FY 2016 total VBP score. (Typically these facilities have been in MSHA for a significant period of time and hence have benefited from the spreading of best practices across the system.) For other MSHA hospitals (often those newer to the system), a less-ambitious, more realistic threshold goal is set: to perform at the 70th percentile or higher—i.e., within the top 30 percent of all hospitals. The system board expects, however, that all hospitals will become top-decile performers within 24 months of joining MSHA.

- **Tying incentive compensation to meeting performance goals, particularly quality:** The MSHA board approves an incentive compensation plan that ties the performance of all employees to performance in meeting goals across the pillars. For most employees, the incentive is structured as a bonus that can be as high as $500 for frontline staff (e.g., occupational therapists, physical therapists, housekeeping) and $2,500 for supervisors/managers. For senior executives at the system and hospital level (including the CEO), 25 percent of total compensation is at risk based on performance on pillar-related goals. Overall, 30 percent of incentive compensation is tied to meeting quality metrics, while only 10 percent relates to financial performance. (The rest is spread out among the other pillars.)

Local board role:

- **Translating system-level goals to local level:** The Washington County board meets with local hospital executives on a monthly basis to review performance on the metrics included in the various pillars and to develop strategies and plans to ensure that targets are met. As a part of this process, local board members routinely ask questions and provide advice and guidance to senior managers on how to overcome any challenges the organization may be facing in meeting the targets. In some cases, the local board may provide input to the system board on specific support that may be needed, such as an upgrading of the QI infrastructure available to the hospitals. Members of the Washington County board will sometimes be invited to attend system board meetings, and their experience on a local board often serves as a training ground for later joining the system board. Meeting minutes from both boards (the system board and the local board) are made available to each other and to senior leaders at the local facilities.
- **Reviewing and challenging physician hiring/credentialing decisions:** The Washington County board plays a very active role in reviewing information on physician credentialing and hiring decisions. The local board has a strong partnership with the hospital-based medical executive committees (MECs), which proactively ask the board to review information on these doctors. The local board takes this role very seriously, and routinely has robust discussions about the merits of credentialing or hiring a particular physician. The goal of this effort is to ensure that physicians practicing at local MSHA hospitals provide the type of high-quality care that the community expects. At least twice in the past year, the Washington County board review has raised significant "red flags" and the board decided not to recommend sending a physician through for further consideration. The board's ability to play this role effectively stems from its strong partnership with the local MECs, members of which have a trusting relationship with the Washington County board. This good working relationship, in turn, is due in large part to the efforts of the system's physician leadership academy, which serves as an effective vehicle for educating MEC members on what the organization is looking for in its physicians.

Main Line Health

Organization in Brief

Founded in 1985, Main Line Health (MLH) is a not-for-profit health system serving portions of Philadelphia and its western suburbs. The hospital operates four acute-care hospitals, a rehabilitation hospital, a treatment center for recovery from drug and alcohol abuse, a home health service, a large multi-specialty physician network, and a non-profit biomedical research organization. With more than 10,000 employees and 2,000 affiliated physicians, the system's four hospitals have received numerous awards for offering high-quality care and service.

MLH hospitals include Bryn Mawr Hospital, Bryn Mawr Rehabilitation Hospital, Lankenau Medical Center, Paoli Hospital, and Riddle Memorial Hospital. Bryn Mawr and Lankenau are nationally recognized community teaching hospitals located just outside Philadelphia. Offering a full range of services, these hospitals have been named among *U.S. News & World Report's* Best Hospitals in the Philadelphia metropolitan area in 2012. All MLH hospitals have received numerous other honors and awards, including recognition from Press Ganey, Truven Analytics, The Joint Commission, and others for their high-quality care. MLH hospitals have also received Magnet® designation by the American Nurses Credentialing Center, the nation's highest award for recognizing excellence in nursing care.

As a not-for-profit organization, MLH is overseen by a volunteer board of directors made up of men and women who live and work in the system's service area, including several physicians from the medical staff.

Board Role in Promoting Quality

The MLH system board takes an active role in promoting the quality of care and the patient experience, with key components of that role highlighted below:

- **Ensuring quality expertise exists on board and relevant board committees:** A national expert on quality improvement and population health sits on the MLH system board and also serves as chair of its quality and patient safety (QPS) committee. Also, several physicians with QPS experience sit on the system board, including a family physician with expertise in outpatient care and patient-centered medical homes. These individuals have the ability to explain complex issues in terms that their peers on the board can understand. In addition, every board member is expected to attend a meeting of the quality and patient safety committee at least once each year. (The board chair proactively enforces this requirement.) Finally, board members who are on the QPS committee are asked to attend interactive learning sessions focused on leader methods for reliability and error prevention tools. For example, MLH holds a "Walk the Talk" safety fair where board members go through eight interactive learning stations with clinicians role playing and quizzing participants.
- **Dedicating significant time to—and demanding engagement in—quality issues, both at full board and committee levels:** The full system board dedicates significant time at

each board meeting to discussing quality and safety issues, and board members are expected to be actively engaged in these conversations. By policy, more meeting time is spent on QPS than on financial issues. Each full board meeting begins with a patient safety story presented by the system CEO. In addition to discussing this story, the full board spends ample time at each meeting reviewing progress toward key short- and long-term performance metrics related to quality, safety, and patient experience. In addition, the quality and patient safety committee of the board (which includes several board members and other health system leaders) meets six times a year, with each session lasting two-and-a-half to three hours. During these meetings, the committee hears several patient safety stories, including "Great Catches," reviews performance on dashboard metrics, and "drills down" into specific metrics where performance is suboptimal or exemplary. In many instances, staff members who are directly involved in providing patient care (e.g., physicians, nurses) tell the stories and share performance data. Board members who sit on the committee routinely engage in these conversations, often asking detailed questions. Overall, the full board typically devotes 25 percent or more of its meeting time to quality; factoring in all board committee meetings, board members spend nearly half their meeting time discussing quality and patient safety.

- **Approving aggressive, realistic performance goals:** The vice president of quality and patient safety heads up a team that takes charge of developing priority initiatives along with recommendations for annual and long-term goals related to performance in these areas. The board approves the priority areas and the associated goals, which are set at three distinct levels of performance (threshold, target, and superior). The targets are meant to be aggressive but realistic, with threshold performance representing real improvement in new priority areas and in established priorities where performance remains suboptimal. (Targets for areas where performance has reached optimal levels focus on maintaining this performance.) Long-term goals look out three years and tend to be ambitious in nature, often based on theoretical ideas, such as eliminating all preventable patient harm and sepsis-related mortality, etc. As with the annual goals, threshold, target, and superior levels of performance are set to gauge incremental progress toward achieving long-term goals. For example, with respect to eliminating all severe sepsis-related death, annual threshold, target, and superior performance goals might call for 30, 40, and 50 percent reductions per year.
- **Tying significant portion of incentive compensation to quality performance:** The system board has approved a plan that ties a significant portion of incentive compensation to performance on quality-related metrics. Every staff member in the system has his/her compensation tied to annual performance on patient experience metrics, while those at the management level have incentive compensation tied to performance on all annual quality, safety, and patient experience goals, as well as other priority areas (e.g., financial performance, employee engagement). This incentive system can add up to 22 percent to an individual's total compensation. In addition, the hospital presidents and the system CEO have additional incentive compensation tied to the achievement of long-term goals, as described above.

- **Charging health system CEO with accountability for quality and safety:** Unlike other organizations where the chief quality and safety officer is the primary individual held accountable for QPS performance, the MLH system board charges the CEO with this responsibility, one that he readily embraces. As part of building a culture of safety and high reliability, the board made it clear that it expected the CEO and hospital presidents to be able to share detailed information at board meetings about quality and safety events and to answer questions about performance with as much knowledge as the chief QPS officer.
- **Holding regular off-site retreats focused in large part on QPS:** Every 12 to 18 months, the board, senior administrators, and medical staff leaders come together for two-and-a-half days to engage in interactive sessions focused on problem-solving in key priority areas, including safety, quality of care, and the patient experience. Breakout sessions focus on identifying barriers and facilitators to getting to the next level of performance, along with recommendations on specific strategies for doing so. After the breakout sessions, the group meets as a whole to prioritize strategies and integrate them into annual operating plans. Board members unanimously praise these retreats as being highly valuable to them as individuals and to the organization as a whole.

Discussion of Findings

This section reviews the general consensus among interviewees about the 27 identified practices, including the role these practices play within their organizations.

Practices Related to Quality Oversight

Interviewees generally believed that the five board practices related to quality oversight that were identified in the research contribute significantly to better performance on quality metrics, and that their boards routinely employ all of these practices. These boards insist on the establishment of concrete performance targets and on monitoring progress toward them. Interviewees emphasized the value of setting "stretch" targets based on the theoretical ideal. As noted earlier, the boards of Mary Greeley and Mission Health have both set the explicit target of eliminating all preventable harm within their organizations.

> "If you don't believe zero is possible, then you will never get to zero. For many years, no one believed a runner could run a mile in under four minutes. But the year after someone did it, dozens of other runners did the same. Similarly, years ago the idea of eliminating VAP was foreign to most doctors and hospital administrators. Now the opposite is the case—they do not expect to see VAP cases in the hospital."
>
> *—Brian Dieter, CEO, Mary Greeley Medical Center*

Practices Related to Ensuring Organization's Commitment to Community Health

Interviewees were skeptical that the community health-related practices highlighted in the research were currently having a major impact on quality-related performance, as it likely remains too early for such practices to influence scores in a meaningful way. That said, they were not at all surprised that boards that have succeeded in promoting high-quality care also tend to be at the forefront when it comes to improving community health, since forward-looking organizations need to turn their attention to this area. As the transition from FFS to value-based payment systems continues, highly engaged boards are proactively focusing on managing population health and community health status. Some of these early efforts may already be paying dividends, such as programs to improve transitions from the hospital after discharge, both to the home and to long-term care facilities. These programs (such as care coordination and medication reconciliation programs) may be having a modest impact on quality scores, and they will undoubtedly pay dividends in the future by significantly improving performance on various metrics, such as hospitalization and readmission rates within a defined population.

Practices Related to Audit and Compliance and Other "Good Governance" Practices

Interviewees were also skeptical that the practices related to audit/compliance requirements and other "good governance" practices are having a direct, significant impact on quality performance today. Rather, as with the board practices related to community health, they believe that the best-performing boards in the area of clinical quality oversight also tend to be very proactive in terms of overseeing audit and compliance activities. For example, as a municipal public hospital, Mary Greeley Medical Center is not subject to the requirements of Sarbanes-Oxley (SOX). Yet after SOX passed, the medical center's board spent six months going over the legislation line by line and subsequently adopted a variety of new policies to ensure compliance with it. The board has explicitly stated that Mary Greeley should operate as if it is a private, not-for-profit hospital, and hence adhere to all SOX requirements.[8]

In addition, interviewees noted that the practices outlined in the audit/compliance, good governance, and quality oversight sections are all representative of a general approach to governing that the best boards adopt. This approach consists of taking concrete steps to ensure the board holds senior management accountable for performance, and that it judges that performance in an independent, objective manner. Consequently, interviewees were not at all surprised to find many of these practices on the list, such as holding routine meetings with external auditors (without management being present), using competency-based criteria to choose board members, gathering external data for benchmarking purposes, and having an independent audit committee. These practices are consistent with that forward-thinking mindset and approach to governance.

8 According to the American Bar Association, "Although most provisions of Sarbanes-Oxley apply only to public [for-profit] companies, at least two criminal provisions apply to non-profit organizations: provisions prohibiting retaliation against whistleblowers and prohibiting the destruction, alteration, or concealment of certain documents or the impediment of investigations." (See http://apps.americanbar.org/legalservices/probono/nonprofits_sarbanes_oxley.html for more information.) In The Governance Institute's experience, most of its members have voluntarily adopted most or all SOX provisions.

Conclusion and Next Steps

The Governance Institute presents this research and the associated case studies as part of an ongoing effort to understand how board structures, policies, and activities influence hospital and health system performance on all aspects of quality, including patient satisfaction/experience, patient safety, care processes, and clinical outcomes.

THE GOVERNANCE INSTITUTE PLANS TO REMAIN AT THE forefront of such research. This effort will also inform future data-collection efforts through the Biennial Survey of Hospitals and Healthcare Systems.

These research findings raise some questions for system- and hospital-level boards to consider as they strive to meet the challenges outlined in the introduction to this paper, including promoting evidence-based, efficient care and managing the health of populations over time. Key questions include the following:

- Has the board sent strong, unmistakable signals to the rest of the organization (including those on the front lines of patient care) about the importance of quality and safety? For example, has it adopted a clear resolution making quality and safety the organization's most important priorities?
- Does the board set and/or require aggressive targets with respect to quality and safety performance throughout the organization? Are these targets based on the theoretical ideal, such as eliminating all preventable harm? Do these targets tie into the strategic planning process? Has the board set a target date for achievement of these goals and setting new goals (while recognizing that QI work is a continuous process)?
- Does the quality committee of the board closely monitor progress in meeting targets, and does performance on quality-related metrics tie into incentive compensation systems in a meaningful way?
- Does the board require and/or strongly encourage development and implementation of formal plans, policies, and strategies related to identifying and addressing the health needs of local communities served by the organization?
- When appropriate, does the board challenge recommendations of the medical executive committee(s) regarding physician appointment or reappointment to the medical staff?
- Does the board have processes and/or criteria in place to identify and recruit directors with a passion for and/or experience in quality and QI?
- Does the board encourage liberal sharing of quality-related performance data both within the organization and to the public at large? Does the organization create opportunities for low performers to learn from high performers?


MIX
Paper from
responsible sources
FSC® C013371
FSC
www.fsc.org