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Crossing the Quality Chasm: A Moral or Financial Imperative?

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Today, more than ever, health system boards are faced with an unprecedented level of uncertainty. While issues such as sharp increases in labor and supply chain costs need management attention, these issues can be distracting to the board's basic responsibilities of obedience, duty, and loyalty, especially in the realm of quality and safety. Over the last two years, the federal government appropriately relaxed regulations to give hospitals and health systems more flexibility to manage the COVID-19 pandemic. An unintended consequence of a relaxed regulatory environment could mean a step backward in the healthcare industry's long quest to improve quality and safety. To better understand the context for our current position and to plot our future course, it is helpful to examine the history of quality and safety in healthcare.

The Evolution of Quality Improvement

Since the early 1900s, the healthcare industry found itself on a gradual path of quality improvement. Before 1970, much of the improvement focus was on eradicating epidemic diseases such as polio, rubella, smallpox, cholera, and a host of other communicable diseases. However, in the mid-1960s, boards and healthcare leaders began to altruistically adopt quality agendas influenced by leaders such as Avedis Donabedian, considered by many to be one of the founders of the contemporary healthcare quality movement. Donabedian understood healthcare as a system. He stated, "People have a big problem understanding the relationship between quality and systems." Donabediam also recognized that "system management doesn't get taught in medical school or nursing school."[1]

1 M. Best and D. Neuhauser, "Avedis Donabedian: Father of Quality Assurance and Poet," *BMJ Quality & Safety*, Volume 13, Issue 6, 2004.

While work to eliminate disease continued, Donabedian suggested a three-component approach for evaluating the quality of care that included structure, process, and outcomes. Donabedian believed that structure measures affect process measures, which in turn affect outcome measures. For years following the "Donabedian era," healthcare systems embedded structure, process, and outcomes cycles into everyday practice. Quality reports became commonplace on executive and governance agendas.

Then, in 1999, the Institute of Medicine (IOM) released the landmark report *To Err Is Human: Building a Safer Health System*. The report, in a shocking fashion, shed light on failures within our healthcare system that resulted in an estimated 100,000 annual deaths due to medical errors. The self-assured hubris of healthcare leaders and boards was disrupted as a century of work to eliminate disease and improve quality was now in question. Were we doing more harm than good? Following the release of the IOM report, the healthcare industry used the report as a battle cry for improvement.

Just 10 years later, with the passing of the Affordable Care Act (ACA), the U.S. health system's journey towards enhanced quality accelerated by tying enhanced payment for services to quality improvement. With the passing of the ACA, emphasis on quality began to shift from just a line item on the governing board's agenda to an essential operational strategy. For the first time, the board's basic duty of care took on an additional meaning as improved quality outcomes became a meaningful financial strategy.

However, the vision of the ACA legislation has waned in recent years. A recent white paper titled *The Future of Value-Based Payment: A Road Map to 2030*, suggests that "while participation in value-based payments continues to grow, the adoption of advanced forms of value-based payment through alternative payment models lags behind both the goals set by the Secretary of Health and Human Services in 2015 and the threshold required for widespread practice transformation. Furthermore, the complexity of the current suite of alternative payment models and the allure of traditional fee-for-service prevent the widespread adoption of full risk-bearing contracts. The high costs of care with the impending insolvency of the Medicare trust fund, persistence of poor quality of care and health disparities along racial and socioeconomic lines, and mixed success of alternative payment models indicate the need for a revamped vision for the 2020s."[2]

2 Rachel M. Werner, et al., *The Future of Value-Based Payment: A Road Map to 2030*, Leonard Davis Institute of Health Economics, University of Pennsylvania, 2021.

The pandemic has also created new challenges related to providing high-quality care. In general, the quality of care has suffered during the COVID era. Resources for typical care shifted to meet the demand of new COVID cases and many quality improvement activities took a back seat. According to an article by Jeffrey Braithwaite, Ph.D., from the International Society for Quality in Health Care, "The downstream consequence of the prioritization of COVID by health systems is that many routine, non-COVID-19 patients have failed to receive appropriate care. Out of fear, lockdown restrictions, or insufficient availability of staff and resources at health facilities, many patients stayed away from emergency departments; others missed their scheduled check-up, screening, test, or procedure. Others could not be admitted or had delayed or rushed care—the individual or population effects of which have yet to play out. In the case of cancer patients, for example, there are legitimate and very real concerns for the lethal outcomes that will result from lack of timely treatment."[3] Boards and senior leaders now need to recalibrate, and shift focus back to quality improvement efforts.

➜ Additional Resources

Improving Quality in Health Systems: How Do They Do It? (Toolbook)

The MUST Dos for Excellent Governance of Quality (Webinar)

The Board's Role in Quality, Second Edition (Elements of Governance)

"All Quality Is Local" (System Focus Article)

The Board's Role

Now, more than ever, boards have a variety of motivating factors to support a continuous quality improvement journey for their health systems. While there are abundant opportunities over the next decade to improve our organization's quality and financial effectiveness, strong leadership, wisdom, and a steady approach will be crucial competencies for healthcare governing boards. The following is a simple checklist to ensure your healthcare system's quality agenda stays on a well-lit path:

3 Jeffrey Braithwaite, "Quality of Care in the COVID-19 Era: A Global Perspective," IJQHC Communications, 2021.

1. Continuously update strategic plans and include the system's current quality position relative to strategic aims. Ensuring the quality agenda is firmly rooted in strategy will position your healthcare system for long-term improvement and balanced success.
2. Assess board competencies annually through a comprehensive board assessment. The annual board assessment provides a good check of the board's alignment to the three fiduciary duties (care, loyalty, and obedience) along with core responsibilities, such as quality oversight, etc. The board assessment is a vital tool to identify areas of strength and weakness, especially in quality oversight.
3. Emphasize board education to remain current on the ever-changing payer and regulatory environment. The Governance Institute provides a variety of information and education applicable to governing boards.

Regardless of the motivation, quality improvement is a vital component of a governing board's obligations. Communities rely on the board's ability to avoid distractions and remain vigilant to the continuous quality improvement journey.

The Governance Institute thanks Chuck Mantooth, President and CEO, Appalachian Regional Healthcare System, for contributing this article. He can be reached at cmantooth@apprhs.org.