

# Hospital Leadership Summit: Moving from Good to Great

## *Summary of Conference Proceedings*



**CMS Headquarters  
Baltimore, Maryland  
September 28, 2006**

# Hospital Leadership Summit: Moving from Good to Great

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September 28, 2006

Prepared by

Booz | Allen | Hamilton

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## Acknowledgements

The authors wish to thank all of the conference participants, speakers, and panel moderators who so freely shared their knowledge and experiences about the impact of hospital leadership on hospital quality. We would also like to thank everyone who so promptly responded to the post-summit questionnaire for their views and recommendations. Additionally, we are grateful for the assistance provided by the conference planners in making the meeting a success: Shannon Archer, RN, CPHQ; Dale Bratzler, DO, MPH; Jim Conway, MS; Stu Guterman, PhD; Maria Hammel, MA; Rebecca Hudson, MPH; David Hunt, MD; Delphia Johnson; George Karahalios, MHA; Mark Koepke, JD, MA; Eugene Kroch, PhD; Samuel Levey, PhD; Kristine Martin Anderson, MBA; Duncan Moore, PhD; Patricia Payne; and Tom Vaughn, PhD.

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## I. Executive Summary

On September 28, 2006, the Centers for Medicare and Medicaid Services and the Oklahoma Foundation for Medical Quality (OFMQ) sponsored a one-day summit on the impact of hospital leadership on quality and quality improvement. The summit goals were to explore the theoretical, practical, and substantive action that hospital leaders can take to engender, promote, and achieve improvements in clinical performance and to identify tools that might be used or developed to achieve sustained quality. After the summit, participants received a survey that polled views on one of the recommended tools, as well as ideas on topics for further research. For the purposes of this conference, the terms “quality” and “safety” were used interchangeably.

Planning for this summit began in late summer 2006 when the research, academic, and provider communities were invited to submit abstracts outlining the results of studies on the relationships between hospital leadership and high performance or case studies of actions hospital boards and executives had taken to address quality. Invitations to attend the conference were sent to all individuals who submitted abstracts, as well as to several federal and non-profit organizations that provide thought leadership for hospital quality improvement.

A total of 130 individuals attended the summit, representing a broad range of constituencies, including health system/hospital executives (40% of attendees), clinical leaders, and managers (10%); representatives of public agencies (25%); individual from national and state hospital associations and quality improvement organizations (10%); and academicians, researchers, and consultants (15%).

The program included 25 speakers or panelists presenting in two general areas: review of recent research on the relationship between hospital leadership and institutional high performers and case studies describing how hospital leaders had been successful in taking steps to address quality within their organizations. At the conclusion of these presentations, a reactor session generated considerable interaction with the audience.

Although the presenters and audience participants reflected diverse views, a number of common themes emerged.

- **The quality of hospital clinical care needs improvement.** From the seminal Institute of Medicine report, *Crossing the Quality Chasm*, through numerous conferences held on quality issues over the last few years to daily journal and newspaper accounts, evidence exists of that need. Solving the quality problem is essential for the long-term viability of Medicare and, in fact, for the financial viability of hospitals themselves.
- **Hospital leadership can impact quality improvement.** Recent research findings are consistent in identifying the characteristics of high performing institutions: direct executive and board involvement in quality improvement; engaged physician and nursing leaders and staff; active programs to recruit and retain staff committed to quality; the benchmarking and monitoring of progress; and leverage of external resources, such as consumers and outside quality improvement groups. Case study data reinforce these findings, as shown in the examples provided by Providence Health and Services in the West and Mercy Health Partners and TriHealth in the Midwest.
- **Gaps in perceptions exist regarding the commitment to quality improvement across leadership levels.** Thus, clear and direct communications are needed, particularly between the C-suite and both line management and medical staff, to drive quality strategies. In addition, measures are needed to determine whether quality processes have become institutionalized throughout an organization’s culture.
- **Tools and strategies are emerging that measure performance quality and provide data to help drive hospital quality improvement.** Some of the tools discussed include: scenario-based strategic planning; dashboards and balanced, tiered scorecards that measure and report on performance; business reviews of

performance; and organizational partnership structures with physician and nursing staff. In addition, two survey tools hold promise. The Texas Medical Institute of Technology (TMIT) survey of the National Quality Forum (NQF) 30 Safe Practices will assist in identifying hospital performance gaps and uncovering new practices and solutions. The OFMQ Hospital Leadership Culture Assessment tool, based on the critical success factors consistently identified by research, will provide a way for hospitals to assess their quality environments and to take improvement actions in areas showing deficiencies.

- **Hospital leadership must take decisive action to achieve improvements in quality.** These actions include: getting the Chief Executive Officer (CEO) directly involved and taking responsibility for the quality of hospital care; establishing board quality committees that have the tools to succeed; setting clear strategic quality goals and implementing a framework to measure success; providing full transparency and disclosure at the board level; putting into place appropriate procedures and resources; demonstrating the business case for quality and making it clear that productivity and quality are not mutually exclusive; establishing partnerships with physicians and aligning their incentives to quality improvement; sponsoring training in quality and quality improvement for everyone throughout the organization; asking staff whether the institution has an appropriate focus on quality; and holding the CEO and other senior executives accountable for achieving quality goals.
- **More focus is needed on assisting the low performers.** Many resources exist to assist low performing hospitals, including CMS, Quality Improvement Organizations, national and state hospital associations, accrediting organizations, and consultants. As many summit attendees noted, a lot of common knowledge and learning has occurred over time, and now it is a matter of making the information available and disseminating it to decision makers and hospital leaders across the country to help them drive change.

All summit attendees agreed that it will require a complete transformation of leadership, a shift from focusing on the financial state of the organization to focusing on quality, in order to achieve improvements in institutional performance. For this to occur, leadership will need to understand quality metrics and quality improvement and make quality part of their organizational culture. The challenge, then, is to design, implement, and propagate tools that can allow organizations to assess their leadership's commitment to health care quality and performance and their ability to make improvements, achieve transformation, and improve care.

## II. Opening Remarks

1. *Valerie Madison Brown, (MS)  
Deputy Director, (Quality Improvement Group), CMS*

Ms. Brown opened the conference by welcoming the attendees on behalf of the Centers for Medicare and Medicaid Services (CMS). She indicated that CMS has been working on hospital quality for a number of years. Recently CMS has been studying how hospital leadership impacts quality, recognizing that, in other types of industries, leadership engagement is important for achieving the desired improvements in quality. She looked forward to the summit discussions as a way to facilitate and further the dialogue about hospital leadership's role in promoting quality improvement.

2. *Dale Bratzler, DO, MPH  
Medical Director of the Hospital Interventions Quality Improvement Organization Support Center (QIOSC) and the Hospital Quality of Care Measures Special Study of the Oklahoma Foundation for Medical Quality (OFMQ)*

Dr. Bratzler welcomed participants on behalf of the summit planning committee. He described the summit as a day of learning and leadership. He indicated that the summit was intended to inform the work surrounding the role of hospital leadership in the realm of transformational quality improvement. He previewed the topics to be covered, including identifying the core elements of hospital leadership that are most closely related to high performance in clinical quality, defining key common elements that have proven successful in achieving transformational culture change and are reproducible in other facilities, describing a proposed standardized hospital leadership and culture assessment (HLCA) tool, and discussing strategies for incentivizing leaders to engage in the work of transforming their cultures and improving quality. He indicated that the summit was divided into two parts: review of the research and practical examples of successful approaches.

### III. The Case for Leadership: Motive, Method, and Opportunity

*David R. Hunt, MD, FACS*  
*Medical Officer, Quality Improvement Group, CMS*

Dr. Hunt opened his talk by making two main points. First, circumstances in American health care demand accelerated hospital quality improvement and the only way that will happen is through the engagement of hospital leadership. Second, every organization attending the summit has a role to play, but each will face unique pressures and opportunities in meeting our common goals of reliable quality and safety in our hospitals. While CMS has a role because of its fiduciary capacity and responsibility, it cannot work alone in promoting quality. Success in this area is predicated on partnership.

The motive for this endeavor is clear: everyone who provides services to assist the infirm and prevent illness shares a deep commitment and moral dedication to healthcare quality. With the Medicare population expected to double in the next 50 years, however, Medicare expenditures will start to exceed the funds available to serve this population; thus, the fundamentals of how we support healthcare to this population are about to change. We will need to be active in identifying and leveraging the opportunities that will arise as a result of this change. The current statutory framework that provides a start in that it defines three tiers of measures, those used for quality improvement, those self-reported by Medicare plans, and those included in the pay-for-performance (P4P) initiative.

From past history, we know the method for bringing about change relies on leadership. An illustrative case involves the well known physicians Joseph Lister and Theodor Billroth, who each reduced mortality rates by introducing antiseptic surgery practices. Through leadership and organizational/infrastructure change, including leading a clinic that was organized as an integrated system, Billroth was able to get his practices widely adopted and had much greater actual impact on mortality rates.

With the fundamentals about to change in terms of how Medicare population's healthcare needs are met and with the lessons of history on how leadership impacts change, we know that now is the time to lead the building of a reliable system of care. The most recent three years of CMS Quality Improvement Organization (QIO) contracts to assist in improving hospital quality recognize this change. The QIO 6th Scope of Work (SOW) called for developing a national model of quality care; the QIO 7th SOW included an agenda for public reporting of quality measures and performance-based payment; and the QIO 8th SOW provides for developing the roles of leadership and expanding public accountability through P4P.

We recognize there are dangers of developing convoluted processes and procedures in response to these calls for quality improvement; there is also a danger of using process-oriented measures without focusing results-oriented measures. The challenge will be to obtain direct involvement by hospital leadership that has the authority and resources to create straightforward, integrated, well understood, reliable, and accepted processes which show measurable results in outcomes. The average hospital today is better described as the co-location of a number of services, but not a system focused on quality. The question we need to ask ourselves is: In your hospital, can you, can I, can we see focus on patient safety and quality where there were once isolated services?

## IV. Field Research: Measuring the Impact of Leadership on Quality and Safety

### 1. Leadership from the Bedside to the Boardroom

*Diane Pinakiewicz, MBA*

*President, National Patient Safety Foundation*

Ms. Pinakiewicz discussed research conducted by..... into the perceptions, goal conflicts, and dilemmas that hospital managers at all levels face daily relative to..... The research began in 2005 when the National Patient Safety Foundation (NPSF) partnered with AIG Healthcare to sponsor a series of regional meetings entitled “Leadership from the Bedside to the Boardroom”. During these sessions, a survey tool was implemented, seeking the views of middle managers. In the spring of 2006, the Estes Park Institute joined this research by sending the survey tool to hospitals in their network. The Institute asked board chairs, chief executive officers (CEOs), and chief medical officers (CMOs)/ chiefs of staff to complete the survey.

The 28-question survey tool was administered to four groups (board chairs, CEOs/COOs, CMOs/Chiefs of Staff, and middle managers) to assess common ground and gaps in perception. It asked questions relating each respondent’s view of his/her own commitment/engagement in patient safety, organizational operations related to safety, hospital leadership commitment/engagement in patient safety, hospital culture of patient safety, and barriers to patient safety.

This research recognized that optimizing quality and patient safety has garnered high priority and focus across the nation in the last several years, but that, if different perceptions exist regarding a hospital’s patient safety journey, the necessary critical and courageous conversations to move beyond rhetoric are difficult, if not impossible, to have. As the role and importance of leadership engagement has become more evident, the researchers deemed it important to assess potential gaps in perceptions so as to be able to facilitate discussion towards common purpose and priorities and, ultimately, to develop the required common systems, structures, processes, and outcomes for patient safety from the board to the bedside.

In general, most of the 486 respondents are comfortable with their own knowledge of and engagement in patient safety. However, large gaps exist in the perceived engagement between leadership and managers at other levels. The board perceives a very active, visible level of engagement in and culture-readiness for patient safety at all levels of the organization, while mid-level managers and CMOs experience more challenges with keeping safety a priority over production goals. All groups perceive physician engagement as the greatest challenge. Middle management sees a greater opportunity for improved patient safety tools and education. There is consensus at all levels around the opportunity of hardwiring patient/family involvement in patient safety design. In terms of the barriers to patient safety, all groups ranked culture and resources, including information technology (IT) implementation, as common problems. Differences were seen with respect to other barriers. In particular, several board members responded that human error was the major barrier or that no barriers existed, whereas these responses were not found in either the CEO or CMO groups.

The results of this survey demonstrate the need for serious assessment and dialog between the board, C-suite, physician leadership, and middle management and greater visible evidence of leadership involvement in patient safety. In addition, the disconnect in perceptions suggests the need for more objective measurements of patient safety progress within organizations to bridge the gaps. “Flattening the organization” with surveys, such as this one, and candid conversations would go a long way toward obtaining more than a surface commitment for patient safety and quality.

## 2. Best Practices in Board Oversight of Quality

*Karma H. Bass, MPH, CHE*

*Senior Research Executive, The Governance Institute*

Ms. Bass presented the results the first phase of an extensive national study of healthcare system and hospital governing board practices related to oversight of quality. This study was conducted by The Governance Institute and the Solucient Center for Healthcare Improvement with the assumption that a better identification and understanding of the board practices that correlate with higher organizational performance are essential steps in increasing board accountability. The purposes of the study were to (1) determine the prevalence of board quality oversight practices and describe differences identified by hospital type and (2) to determine whether specific practices contribute to better organization-wide performance. The study was based on a January 2006 survey of CEOs of over 4,200 not-for-profit acute care general hospitals across the US to explore board practices in healthcare systems, subsidiary hospitals, and independent hospitals. Phase 1 of the analysis, completed in June 2006, linked each of the 562 responses to the organization's performance on two scorecards: the hospital-wide scorecard measuring quality outcomes, patient safety, efficiency, financial stability, and customer response; and the quality scorecard measuring mortality, complications, patient safety, and length of stay.

The study identified common board quality practices found in at least 80% of surveyed hospitals. These included: formally established strategic goals for quality improvement, monitoring of quality indicators, required progress reports on corrective action on quality/safety problems, investments in new technologies aimed at quality improvement, and board quality committees.

Five board quality practices correlated with a high hospital-wide composite score: CEO performance evaluation that includes objective clinical improvement and patient safety goals; board-established quality agenda; board quality committee review of patient satisfaction scores; board participation in medical staff appointments; and medical staff involvement in setting board quality agenda.

Five board quality practices correlated with a high quality composite score: CEO performance evaluation tied to patient safety goals; time spent during board meetings on quality; board quality committee chair or chief of staff presenting quality report to full board; board participation in medical staff appointments; and medical staff involvement in setting board quality agenda.

These last two areas were significant on both the hospital-wide and quality score cards.

In conclusion, this study suggests that there is a common baseline of traditional board quality practices.

Generally, hospitals that followed these practices have better performance. Thus, it is not always necessary to develop new roles or add-on responsibilities for board members; rather it appears to be more important to improve existing traditional board quality practices.

### 3. Achieving Transformational Change: A Summary of CMS Inspired Research on Leadership

*Eugene A. Kroch, PhD*

*Vice President and Director of Research, CareScience, a Division of Quovadx, Inc.*

Dr. Kroch reviewed recent studies of high performing hospitals. These include studies by Solucient, LLC (“100 Top Hospitals”), Yale University/Agency for Healthcare Research and Quality (AHRQ), The Commonwealth Fund, Vanderbilt Center for Evidence-Based Medicine/Keckley, Mathematica Policy Research, Inc./Delmarva Foundation, Health Sciences Advisory Group (HSAG), Levey Field Study, and Kroch/Vaughn short survey and dashboards.

He identified 12 common characteristics of high performing hospitals across these studies. He grouped them into three areas, leadership (5 characteristics), structure and process (5), and external resources (2). While each study approaches these characteristics from a different perspective and some recognize their interrelationships, all studies recognize their importance in promoting quality improvement. The following summarizes his findings.

#### **Leadership**

1. CEO dedication to quality as job one. CEOs need to exhibit vision and passion, a deep commitment, solid support for quality improvement.
2. Direct board involvement. Boards need to understand the difference between measuring quality and using these measures to promote and reward quality improvement.
3. Leadership understanding and communication of the business case for quality. The key is articulating a compelling case so that these shared goals become understood goals.
4. Support for a culture of quality. In other words, quality improvement pervades the organization’s rituals, traditions, and tools, and is not just another department.
5. Support for evidence-based medicine (EBM) beyond mere lip service. Support includes rewards for higher performance and implementation of EBM.

#### **Structure and Process**

6. Medical and nursing leadership engagement at all levels. This leadership may be coordinated between these two groups or may be demonstrated separately.
7. Attraction and retention of the right people. This characteristic includes clear incentives and signals and does not require significant resources. In fact, small differences in incentive compensation may result in large differences in behavior.
8. Developing effective in-house processes. Key is not only the use of such processes for root cause analysis and feedback, but embedding them into the organization’s daily operations.
9. Monitoring and use of benchmarks. This is the only characteristic across the studies that did not show consistent results in terms of factors correlated with high performing hospitals.
10. Exploitation of the power of IT. Implementation of IT systems is essential to measuring, benchmarking, monitoring, and communicating quality improvement.

#### **External Resources**

11. Engagement with consumers. While there has not been a lot of study in this area, it appears that collaboration with consumers in areas such as EBM is related to high performance.
12. Access to external support and assistance from peers. Again, this is an area where not much study has been done, but preliminarily holds promise for quality improvement.

## V. Moderated Panel Discussion: Applying Field Research to Improving Organization Level Performance

*Moderator: Kristine Martin Anderson, MBA, Principal, Booz Allen Hamilton*

*Panelists: Jean Chenoweth, (degree), Senior Vice President, Center for Performance Improvement, Solucient, LLC; Diane Pinakiewicz, MBA, President, National Patient Safety Foundation; Andrea Silvey, PhD, MSN, Chief Quality Improvement Officer, Health Services Advisory Group; Tom Vaughn, PhD, Associate Professor of Health Management and Policy and Director of Masters Programs, University of Iowa College of Public Health*

Ms. Anderson introduced the panel and asked members to reflect on the application of the research discussed in the earlier presentations, as well as their own other research. Panelists were asked to focus on what board and executive leadership can do to improve quality. To facilitate the discussion, she asked several questions that generated lively dialogue from the panelists and audience alike.

### **Question 1: How have different elements of what you and your colleagues have done reinforce or compete with one another?**

Dr. Vaughn noted the overlap among the study findings, as well as Dr. Hunt's emphasis on the integration of systems. High performing hospitals demonstrated an integrated set of best practices, including board spent time on quality, formal reports on quality made directly to the board, quality-based senior executive compensation, and high levels of board and staff interaction in setting the agenda for quality.

Dr. Silvey remarked that HSAG's research findings were similar to the research discussed by the earlier presenters. In terms the level of involvement required by the CEO, he/she is the one person in the organization with the authority, resources, and expertise to assure that quality improvement is both measured and improved. The board needs to hold the CEO to a high level of accountability for quality improvement. Also, roles and responsibilities for quality improvement (for who?) need to be clearly delineated from the board through the CEO, CMO, physician champions, and other managers.

### **Question 2: How do hospital characteristics impact performance**

Dr. Vaughn indicated that it was hard to compare types of hospitals. He added that he has a doctoral student looking at teaching versus non-teaching hospitals in terms of performance, because there was not a large enough sample of community hospitals in his study to make any definitive judgments.

A member of the audience observed that CEO turnover is often related to medical staff relationships in which the board plays a key role and asked whether any research had examined CEO turnover? Dr. Silvey responded that they had found in high performing hospitals that the lowest CEO tenure was 3 years (Did she say what the average CEO tenure was for all hospitals? Low performers?), but that the range went up to 20 years. The real issue in high performers was sustainability, how well the culture and systems were integrated, rather than a question of a single person or force.

When Dr. Bratzler asked Ms. Pinawkiewicz' whether her study showing the gap between intent and reality has become a tool for change, she said it definitely had that potential. In fact, researchers are currently identifying next steps, including publication and discussions with the organizations. She indicated that discussion was important, given the findings about the perceptions of mid-level management, who have not been taught what quality improvement tools to use, how to use them, how to manage change, and how to manage "up." To achieve sustainability, this training will be critical.

An observation was made that the involvement of CFOs did not appear to make a difference. Ms. Chenoweth indicated that this, indeed, was a weaker finding in their study, but that it requires additional analysis. In

addition, she observed that structures in the hospitals are changing. Organizations are establishing board quality committees that have equal strength and power as the finance committees. As such changes create the forces for integrated systems focused on quality, the result will be increased transparency internally on all quality measures.

One member of the audience asked for the definition of technology used in the research (What research?) and further asked whether technology can really substitute for culture. Dr. Silvey indicated that their study did not have pre-defined indicators for clinical technology and, therefore, asked hospitals what systems they were using. The actual evidence from their studies found highest correlations between high performers and clarity in roles and responsibilities for quality improvement, together with training and skills development related to quality. Some correlation was found related to technology that facilitates communication and coordination of care.

Another questioner said that he has been looking at global measures for financial performance and thinks that bond rating is the best one. He asked whether research has looked at bond ratings and their relationship to quality improvement, because he believes that the ability to garner more resources for quality initiatives would affect the level of performance. He also noted that bond raters are becoming more sophisticated and asking questions about quality measures. Ms. Chenoweth replied that bond ratings do not apply to all hospitals. Using financial measures is problematic, because it is hard to compare hospitals financials. There are changes occurring, however, in standardizing some financial measures so that comparison will be possible in the future. (What is the theory about how bond rating would effect quality? Did they elaborate?)

Another conference participant said that staff want to be safer, but spend time writing policies and procedures around safety, rather than learning how to implement quality improvement. What types of training are recommended? Dr. Silvey responded that training should be provided in change management, communications, individual indicators in use, safety standards, and quality improvement techniques.

### **Question 3: What should be our priorities for additional research in this area?**

Dr. Vaughn replied that we need to find out how to get commitment and action below the leadership. Leadership has access to resources and can establish the vision, goals, direction, and mandates, but these have to filter down to effect change. We need to find out what is actually being done to assign quality improvement responsibilities and tasks to staff at lower levels, and to give them the training, time, and resources to implement change and improve quality. Did Vaughn say anything about medical staff?

Dr. Silvey agreed that more research is needed on the operationalization of achieving high performance. Research needs to look beyond what factors are correlated with performance and understand how they are impacting it. Research questions include: What are staff being trained on? How do we effectively engage physicians in quality improvement activities? What is the interaction between culture and technology and which would accelerate the pace of improvement faster, since both take time? How do we choose among competing priorities?

Ms. Chenoweth agreed with the need to assess the impact of technology. She further indicated that we need to clarify how we talk about measurement (What does this mean? Elaborate or drop). We need to determine how to measure different levels and domains in an organization and how to benchmark performance.

Ms. Pinawkiewicz agreed and added that we need research to determine how to get to the point where safety and quality are design elements, and not discrete goals or separate projects, and how to balance competing priorities.

## **VI. Hospital Leadership Assessment: Activities of the CMS Work Group**

### **1. Transforming Leadership; Transforming Culture**

*Dale Bratzler, DO, MPH*

*Medical Director of the Hospital Interventions QIOSC and  
the Hospital Quality of Care Measures Special Study of the OFMQ*

Dr. Bratzler started by stating that, in the years after the Institute of Medicine (IOM) Report, *Crossing the Quality Chasm*, hospitals have not shown adequate improvement in the most basic measures of quality. According to Dr. Bratzler, governing board, executive, and physician engagement in the quality arena needs significant attention, citing, AHRQ's 2005 *National Healthcare Quality Report* which had four messages: the pace of improvement is modest, improvement is variable, quality has improved, but much remains to be done.

Last spring a group of individuals gathered at the American Hospital Association (AHA) to discuss how to promote the acceleration of hospital quality through the transformation of hospital leadership. Out of this gathering the Hospital Quality Leadership Collaborative Work Group emerged and began meeting to determine what needed to be done to assist QIOs and hospitals engage in this task. One of the actions identified was to develop a validated hospital leadership and culture assessment tool (HLCAT) based on common characteristics that research has associated with high performing hospitals -- a tool that would measure progress toward transformational milestones and focus both comprehensively and specifically on structures and processes related to critical leadership attributes.

The fact is that we really do not know how to fundamentally change systems to deliver consistent quality. We know there is a need to develop new metrics for quality. We are in our infancy in measuring quality: we spend a lot of time counting aspirins, documenting charts, etc., but the measures we use today, while related to better patient outcomes, do not provide explanation.

We know research has shown that engagement of hospital leadership is associated with higher performance in clinical care and that the active involvement and collaborative participation of top-level leaders is essential. Research has also shown us the barriers to transformation. The greatest barrier is the delegation of quality to a department or individual, rather than the promotion of quality throughout the organization's culture through use of quality-oriented tools, active and broad leadership, communication of the compelling case for quality, and prioritization of quality throughout operations. Another barrier is the sense that staff have of feeling overwhelmed by the process and having resources stretched, limited personnel, and competing priorities, combined with physician autonomy and lack training on quality improvement. Another barrier involves the need that hospitals feel to focus on short-term issues, including financial ones.

To assist hospitals in overcoming these barriers, QIOs need reliable and valid measurement tools to assess organizational culture, that is, governance, leadership structure, and processes. QIOs also need intervention tools that will assist low-performing institutions.

## 2. Hospital Leadership: Activities of the Collaborative Workgroup

*Shannon Archer, RN, BSN, CPHQ*

*Hospital Interventions QIOSC Quality Improvement Educator of the OFMQ*

Ms. Archer began her discussion of the evolving HLCAT by describing the project objectives. These are to: identify structures and processes related to leadership engagement in quality improvement that are closely associated with high clinical quality performance; compile the leadership and organizational attributes, functions, and processes associated with high performers into an organizational self-assessment tool; and share the findings in order to facilitate improvements in quality.

Considerable progress has been made in reviewing the research and crosswalking the findings that Dr. Kroch discussed into 12 dimensions around which hospital structures and processes associated with high performers can be measured through the HLCAT. The plan is to field-test the tool with voluntary hospital participants and deploy it as a CMS-endorsed assessment tool. In addition to promoting transformational hospital leadership change, leading to quality improvement, the HCLAT will provide information to support other CMS-sponsored projects such as the development of new metrics for public reporting and P4P, as well as the development of regulatory conditions of participation. The tool will also potentially provide benchmarks for establishing milestones and measuring the progress of quality improvement.

Ms. Archer reviewed the 12 common findings from research discussed by Dr. Kroch and identified specific attributes that could be measured for each of the dimensions. For example, direct board involvement, a characteristic of leadership, could be measured by the percentage of board meeting time dedicated to quality improvement, the existence of a quality subcommittee charged with in-depth analysis and review of quality initiatives, and the requirement for board members to take formal quality improvement education. As another example, medical and nursing leadership engagement, a characteristic of structure and process, could be measured by whether medical staff are provided with information on P4P and whether there is physician and nursing representation on the board. In a final example, engagement with consumers, a characteristic of external resources, could be measured by the existence of satisfaction surveys, leadership walk-arounds, and community outreach efforts.

The HCLAT is formatted using a milestone approach. That is, there will be a series of statements describing various kinds and degrees of behaviors that exhibit different levels or gradations of commitment to quality improvement. The advantage of this approach is that it will provide hospitals with granular data in determining exactly where their leadership and cultural challenges are situated. Hospitals will be able to evaluate their current situations, but will also know which behaviors to aim for in transforming their cultures. The work group has developed benchmarks to set quality improvement goals in terms of “critical,” “below average,” “average,” “above average,” and “exemplary” behaviors. These benchmarks can be used to set quality improvement goals for the organization. While the HCLA tool focuses on assessing internal and relatively tractable aspects of a hospital’s leadership, culture, and processes, ultimately the work group would like to investigate more thoroughly the less tractable factors that can have a determinative influence on performance.

## VII. Leadership Engagement and Development, Transformational Readiness, and P4P Studies

*Charles R. Denham, MD  
Chairman, Texas Medical Institute of Technology (TMIT)*

Dr. Denham began his presentation with some short videos to demonstrate the one can have the greatest tools in the world, but it comes down to leadership engagement to drive improvement. Today, hospitals have clear-and-present-danger challenges to quality care and have to ask themselves how to engage the leaders to tackle these challenges.

Dr. Denham presented his conceptual framework for addressing this issue. Data, “the facts” or “the truth,” are important in order to engage people, because the head responds to data, but is trained to be detached. Trust is the currency of the heart, that is, our faith or belief in mission. It is critical to have leaders with the right mixture of information and passion to ignite action. Teamwork is what brings the two together and harnesses the energy that will deliver power to quality improvement agendas. Without truth and trust built into the gears of teamwork, staff are simply individuals, carried along by systems inertia, delivering fragmented and production-centered health care.

Dr. Denham noted that some believe there is resistance to performance improvement activities. But, according to Dr. Don Berwick, the leader of the Institute for Healthcare Improvement (IHI), “We misinterpret a vacuum as if it were resistance...It wasn’t resistance; it was an absence of a clear, articulated, real meaningful opportunity to do something...We’re finding energy in the workforce that even I – and I am an optimist – didn’t know was there. Doctors, managers, therapists, pharmacists are coming out of the woodwork. All they want to do is to help and get involved.”

Dr. Denham indicated that TMIT has been engaged in a survey involving the National Quality Forum (NQF) Safe Practices, some 30 practices that are intended to have life-saving impact across many care settings. The focus of the TMIT research has been to accelerate practice adoption, verify the impact of the practices, and identify opportunities for leaders to become engaged. In 2003 TMIT developed a survey that allowed hospitals to report on the adoption of 27 of the practices, given that The Leapfrog Group was already studying the other three. The TMIT program has been updated each year, with 1267 hospitals responding in 2005. Late this year TMIT will pilot a new survey of all 30 safe practices and roll it out in early 2007. In administering this survey, TMIT hopes to identify hospital performance gaps, new practices and solutions such as imaging and technology adoption, and networking opportunities for high performers to be matched with lower performers. TMIT also seeks to foster learning, and facilitate knowledge transfer among the survey respondents.

Early findings of the survey include: leader-champions and physician engagement are critical and condition-specific practices are difficult to adopt. Hospital leaders say that they have learned that: maintaining focus is important; persistence pays, and change takes time; roadblocks should be anticipated; medical staff must be engaged in improvement projects; results should be communicated widely; staff at the operational level should get involved in the change process; and processes should be standardized where possible.

In addition to the NQF survey, TMIT polled over 250 hospital CEOs and senior administrators (on what?). The early findings were that 4 out of 10 hospitals spend less than 30% of board meeting time discussion quality and safety; 3 out of 10 hospital leaders believe that their organizations are more financially than quality driven; 80% of leaders believe that healthcare purchaser incentives are impacting their organization’s quality; and 4 out of 10 leaders believe that physicians are minimally engaged in hospital improvement.

## VIII. Leadership in Quality: Profiles in Courage

### 1. Learning to Surf: Strategies for Public Reporting and Beyond

*Steve Durbin, MPH*

*System Director of Quality, Providence Health & Services (PH&S)*

Mr. Durbin opened his presentation by describing Providence Health and Services (PH&S), which provides hospital, long term, and ambulatory care services across five Western states. The 27 PHS hospitals range in size from several beds to over 500 bed tertiary care facilities. With the advent of public reporting and increased public accountability for quality, members of the PH&S Board of Directors and senior managers concluded in August 2004 that a quality strategic plan was needed. The scope of the changes brought on by public reporting and P4P was considered potentially transformational.

The Board undertook a nine-month full-scale strategic planning effort focused on quality and safety. Three scenarios were developed, varying in assumptions about the number of national measures implemented, the degree of national alignment, significance of P4P, and the eventual influence on healthcare consumers and markets. The planning group selected what was considered the most likely scenario-, predicting the development of a large set of national quality measures leading to P4P, but limited direct consumer action.

The IOM Six Aims were adopted as the overarching set of principles for the PH&S Quality Strategic Plan. A quality vision statement – best care and services for every patient, every time – was developed, with measures of success defined. The two key strategies of achieving 90th Percentile on national quality measures and eliminating preventable deaths and injuries, were directly linked to the vision measures of success.

The Quality Strategic Plan has provided leadership with a clear set of quality goals, directions, and messages to enact and drive across PH&S. Dashboard measures, performance objectives, and other action plans are tied to the Plan priorities. Management has clearly articulated that quality is the top strategic priority of PH&S.

The development of metrics is a key focus. While the dashboard contains the Hospital Quality Alliance (HQA) clinical measure sets, leadership needed a more concise set of measures to use in managing the improvement work. In November 2005, the Board adopted a version of the CMS Appropriate Care Measure (ACM), encompassing 18 HQA measures. Goals were established for this measure (termed the Clinical Quality Index) to drive improvements. Also known as an “All or None” measure, the Index is readily understood: Did every patient receive each treatment for which he/she was eligible? This measure links directly with the vision statement, emphasizing reliability in clinical care. The challenge is in evolving from a project-oriented approach which results in achieving 80<sup>th</sup> percentile performance, to a culture-wide integrated systems approach, which calls for the 90<sup>th</sup> percentile and no preventable deaths goals.

One year after adopting the ACM, PH&S understands the transformation, focus, and time these changes will take. The lessons learned include: governance can be a strategic catalyst; strategic planning for quality can create focus on long-range implications and engage leaders at all levels; leaders must see a quality strategy as central to business needs; quality strategy must go beyond national measures to set the broader framework for initiatives and performance across all care processes; and management systems must evolve to include a focus on prioritizing improvement opportunities, setting benchmarks, and measuring execution.

## 2. Transformational Leadership

*Leonard M. Randolph, Jr., MD and Margaret W. Namie, RN, BSN, MPH*

*Dr. Randolph, Senior Vice President and Chief Medical Officer, Mercy Health Partners (MHP)*

*Ms. Namie, Vice President, Chronic Care Management, MHP*

Dr. Randolph started his presentation by observing that the IOM call to transform health—by creating systems of care that are safe, timely, efficient, effective, equitable, and patient-centered—is a challenge to healthcare organizations operating in a reimbursement environment which seems at odds with those aims. Mercy Health Partners (MHP), an integrated health system in Cincinnati, embarked in 2004 on a partnership with its physicians to incorporate these goals in a deliberate way throughout its five hospitals and outpatient sites. The result was an comprehensive strategic plan focused on safety, quality, and clinical transformation. Dr. Randolph believes that its successful implementation is due to five factors.

The first factor is committed leadership with an emphasis on: mission-driven decision making; quality as a core function on equal footing with financials; and progress reporting to promote accountability. System objectives for quality and safety are set annually by the Regional Board and its parent company, Catholic Healthcare Partners (CHP), in alignment with the strategic plan. MHP's leaders are incentivized to both target and stretch goals. Progress towards goals is reported at every organizational level up to the MHP Board through a dashboard. In addition, CEO shares his goals publicly with all managers and provides quarterly updates.

The second success factor is system-wide alignment of strategic initiatives into one overarching strategy, that is, integration of quality into every aspect of operations. Behaviors promoting quality are embedded in operations and include evidenced based medicine (EBM); simplified, standardized processes; and elimination of non-value-added processes.

Active physician involvement is the third factor. MHP is focusing on its physician relationships and a newly formed 22-member Physicians Council guides strategies and policies for implementing EBM across the MHP system. MHP supports the Physician Council by providing staff, resources, and redesigns of care processes. Thus, clinical excellence is clinically, rather than administratively, driven.

A robust information system infrastructure focused on quality and safety is the fourth success factor. Systems that support that framework include digitized radiography, emergency department tracking boards, bar-coded medication administration (unit-dose packaged), smart infusion pump technologies, integrated electronic medical records in physician offices, a citywide simulation center for team training on patient safety, computerized physician order entry, data mining for regular reports of progress on key quality indicators, and full integration with the regional health information organization.

The final success factor is a strong focus on the entire continuum of care. MHP's goal is the transformation from episodic care to supportive care, realizing that the most difficult cases are not necessarily the medically complex ones, but cases that involve chronic care patients who have multiple non-medical issues and require management across the continuum. This focus is particularly mis-aligned with reimbursement mechanisms focused on procedures and episodic illness, rather than on maintaining people at their optimum level of health. However, MHP has been able to demonstrate decreased resource utilization and improved outcomes for people living with chronic illness as a result of its efforts.

### 3. Driving Strategy Execution Using A Balanced Scorecard

*John S. Prout, MHA*

*President and CEO, TriHealth, Inc.*

Mr. Prout described TriHealth as a faith-based integrated health system headquartered in Cincinnati, providing comprehensive services through two tertiary hospitals and over 50 outpatient locations in Ohio, Indiana, and Kentucky. It also operates the region's largest corporate health program and a large Hospice program in cooperation with MHP.

In recent years, TriHealth leadership felt the need to transform their organization. TriHealth had experienced fast growth, but lacked integration. Leadership wanted to improve their quality and become transparent by reporting the quality measures. Following a financial turn around, they also wanted to be able to measure growth and success, to manage both leading and lagging measures (that is, the ones that were not achieving desired goals), and to improve data integrity and accessibility.

Mr. Prout indicated that strategy was important in transforming the organization, but so was the ability to understand how that strategy impacts every aspect of the business. To that end, in 2005 the Board and Mr. Prout decided to implement a business management system using a balanced scorecard to achieve a better alignment between strategy and daily activities, to improve the business review process, and to better communicate strategy and performance throughout the organization. This scorecard ensured a "balanced" focus on quality and service, customers and community, and workforce development.

The scorecard consists of multiple layers of "cascaded" balanced scorecards, which will ultimately align the entire organization to the key top-level strategic objectives and performance measures. The top-level scorecard has been cascaded into scorecards at each hospital, and into other corporate business units and clinical service lines. After each scorecard is built, a model of monthly systematic business reviews is implemented at each level to support exception-oriented, root-cause thinking. The benefits of the balanced scorecard system include the ability to: communicate strategy to all organizational levels; provide alignment and "drill down" visibility into strategic objectives, metrics, and problem areas; ensure that resources get applied appropriately; and, drive accountability and results.

Mr. Prout described the keys to success as top-level leadership that drives the process, management buy-in at all levels, processes that ensure data accuracy and timeliness (What does this mean? Explain or drop), commitment to monthly business reviews, linkages to the strategic planning and budget processes, accountability for performance at all levels, and proactive change/cultural transformation management (Again I'm confused. Clear up or drop). During the course of this initiative, MHP leadership has learned to: standardize language to assure consistency and reliability; devote sufficient, appropriate staff resources; expect data conflicts and involve the IT team early; prioritize corporate initiatives; use scorecards as communications tools; find internal champions and leverage them; and build in rewards and recognition for good performance.

## IX. Moderated Discussion: Leadership in Quality – Profiles in Courage

*Moderator: James B. Conway, MS, Senior Fellow for Healthcare Improvement, Institute for Healthcare Improvement (IHI) and Senior Consultant, Dana-Farber Cancer Institute (DFCI)*

*Panelists: Steve Durbin, MPH, System Director of Quality, PH&S; John A. Hensing, MD, Senior Vice President for Care Management and Quality, Banner Health; Patricia Merryweather, MA, Senior Vice President, Illinois Hospital Association (IHA); John S. Prout, MHA, President and CEO, TriHealth, Inc.; Leonard M. Randolph, Jr., MD, Senior Vice President and Chief Medical Officer, MHP*

Mr. Conway started by reminding the audience of the IHI “100,000 Lives Campaign” that touted the role of engaged leadership. However, he notes that there is evidence of a lack of engagement by leadership, that most change fails, and that error rates continue. In fact, the IOM has concluded that 7,000 – 9,000 people die from preventable medical errors annually, that 1.5 million preventable medication adverse events occur annually, and that, if admitted to a US hospital, a patient will experience one medication adverse event for each day of hospital stay. Additionally, hospital staff satisfaction is rapidly deteriorating, as are staff perceptions of the quality of care they provide. Mr. Conway charged the hospital industry to move from “spray and pray” to driving a strong quality agenda. He said that we need to realize that investing in improving quality is not elective and that we need to provide opportunities and success models for people to draw courage from, similar to those in the just-concluded presentations.

Panelist were asked to focus on barriers and opportunities. To facilitate the discussion, Mr. Conway asked several questions.

### **Question 1: What barriers have you faced (in what?)?**

Mr. Durbin replied that one of the largest challenges involves educating the CEO. Another barrier is the disconnect between primary care and hospital-based care: change can be effected within the hospital, but issues can arise as the patient moves to the next level of care. Additionally, there is the issue of how to communicate with physicians who refer patients to the hospital, but whom are not seen. Mr. Prout added that he sees a challenge in getting focused in terms of the great numbers of measures and in making progress through communication and prioritization. According to Dr. Hensing, there are cultural barriers in terms of how physicians see their roles and view the hospitals as workshops; in fact, he believes that the industry, as a whole, has been slow to grasp the importance of accountability when it comes to care (This is an unclear sentence? Can you clean it up?).

### **Question 2: How can boards and their quality committees can be used effectively?**

Mr. Durbin responded that PH&S had a board quality committee that really was not well informed, partially because it was not getting the information it needed. In addition, the board itself was not tracking quality, so it decided to make quality a full board responsibility and to eliminate the committee. Mr. Prout said that the danger is that the board often thinks it has to do everything and so gets overwhelmed; it is up to the CEO to build a foundation for quality in terms of content, support, and infrastructure and then to involve the board early in the process so that it gets educated on its role.

### **Question 3: Why are there not more hospitals using balanced score cards (raised by Mr. Koepke from the audience)?**

. More widespread use of score cards requires training and resources, such as can be provided by the QIOs and MedQIC. Unfortunately, these resources have not been readily available in the past. However, Ms. Merryweather observed that more hospitals are beginning to use them, motivated by public reporting requirements and P4P. Dr. Randolph concurred that training had been effective at MHP.

**Question 4: How do the panelists view the impact of workforce issues, including nursing and pharmacist shortages, on their quality strategy?**

Mr. Durbin replied that the potential impact is severe; thus, sourcing, recruitment, and retention are major priorities for PH&S. Dr. Randolph stated that over 50% of MHP nursing staff were “travelers” when he started and that they have put in place a worldwide recruitment initiative to stabilize staff and, at the top level, have invited the Chief Nursing Officer (CNO) and the CMO to be members of the physician and nursing councils, respectively. Mr. Prout stated that workforce shortages and the resultant training issues associated with new personnel, especially nurses, are major issues. TriHealth is working collaboratively with its associated nursing school to determine how to bridge theory and practice so nurses understand operational issues related to patient safety. Dr. Hensing added that Banner Health is trying to break down the hierarchy between physicians and nurses and to change bedside relationships as a way of addressing shortages. Mr. Conway commented that nurse turnover at the Dana-Farber Cancer Institute (DFCI) had been reduced by half as a result of DFCI’s focus on quality, including systems to support safe practices and culture of teamwork. He asserted that the quality focus is a differentiator in recruitment.

**Question 5: What challenges exist for community-based hospitals when trying to apply the strategies we have discussed to their unique environment?**

Dr. Hensing responded that Banner Health has a single system board of directors with local hospital advisory groups; thus, there is one system-wide set of measures, definitions, and technologies, with the added advantage that local hospitals can work with professionals outside their communities and can reach consensus on local issues at the community level. Mr. Prout indicated that Catholic Health Initiatives (CHI), one of the sponsors of TriHealth, has many community hospitals and has found that benchmarking against similar peers helps, as does providing local authority to execute quality programs while holding ultimate accountability for quality at the higher CHI level. Ms. Merryweather stated that many Illinois standalone, rural hospitals have slim or no financial margins, and therefore require shared resources and tools. Mr. Durbin observed that many small hospitals take the view that quality goals apply, but do not collect measures, often because they do not have the resources. Dr. Randolph added that MHP takes advantage of a single system board of directors and central credentialing, by-laws, rules, and regulations. Furthermore, it has a metropolitan hospital council reporting quality measures and sponsors physician leadership training programs, making these resources available to all hospitals in the system. Mr. Conway added that, increasingly, the business community is raising the pressure on local hospitals to engage fully in quality improvement programs.

**Question 6: What further research is needed?**

Ms. Merryweather commented that the Illinois Hospital Association (IHA) is examining performance data statewide to identify the low performers (on what?) that are bringing the state scores down. IHA is seeking to share this information with these hospitals in an effort to move them toward targeting their limited resources to achieve some level of improvement. Dr. Hensing indicated a need to know how effective P4P incentives are in changing behavior or whether public and payer pressure is, in fact, the driver for behavior change. Mr. Prout thought that study is needed on how to align hospital-wide incentives with the physicians in the hospitals. He also observed that too much of the quality work is focused on the best performers and more needs to be focused bringing up the bottom 15%. Dr. Randolph noted that research would be useful on how to recruit physicians in today’s world where doctors/residents are no longer willing to work long hours and where several clinicians are often needed to replace one who is leaving. Mr. Durbin made a plea for more research into the leadership characteristics linked to performance.

## X. Reactor Panel: The Path Ahead – Implementing What We’ve Learned

*Moderator: Stuart Guterman, PhD, Senior Program Director for the Program on Medicare’s Future, The Commonwealth Fund*

*Panelists: Thomas E. Hamilton, MA, Director of the Survey and Certification Group, CMS; Stephen F. Jencks, MD, MPH, Senior Fellow, IHI, and Senior Quality Advisor to the Director of the Office of Clinical Standards and Quality, CMS; Duncan Moore, PhD, Executive in Residence, University of Iowa College of Public Health; Stephen R. Mayfield, MBA, MBB, Senior Vice President for Quality and Performance Improvement for AHA and Director of AHA Quality Center*

**Dr. Guterman** started the discussion by summarizing the messages throughout the day:

- Top level involvement is needed.
- Communication between the top level and medical staff is critical to carry out strategy.
- Objectives need to be clear, procedures in place, and resources available.
- Medical staff need to pressure leadership where these things are not in place.

Questions, however, remain. Is it true that the time a board spends reviewing quality issues corresponds to the amount of time staff spend pushing these issues to their attention? How do we get hospitals to perform better? How do we go into low performing hospitals and transform them? How do we take what we know about quality and implement it throughout the healthcare system to achieve high quality care? Dr. Guterman opened the floor to the panelists and audience to address these and other issues they thought salient.

**Dr. Jencks** intimated that the situation is scary. He asked how many in the audience would be comfortable having a loved one in a modern hospital without a family member or other person not associated with the hospital there to make sure things went well. He observed that we have gotten to a point where it is a bold and courageous thing to commit to saying there will be no unnecessary deaths in the hospital.

He recounted that research reviewed today indicated that there are five actions important for a board to undertake:

- Taking responsibility for quality of care in the hospital
- Establishing a board quality committee that has the tools to succeed
- Setting strategic quality and safety goals and implementing a framework to measure success
- Asking professional and non-professional staff whether the institution has an appropriate focus on quality and safety
- Holding the CEO and other senior executives accountable for achieving quality goals.

In addition, he added a few more from his own experience:

- Providing full transparency and disclosure at the board level
- Establishing a just culture where problems can be reported without fear of reprisal
- Dealing with at least one disruptive physician so that the message is clear that such behavior is not acceptable
- Making sure that the business case for quality works at the board level
- Asking whether the institution has the right CEO.

Finally, he noted three factors that external regulators, including CMS, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and bond raters, could look for as markers of a focus on quality:

- Visible evidence that the hospital is taking responsibility for quality of care
- Existence of a quality committee of the board
- Strategic quality goals, a report card, and an overall framework for quality.

He observed that we do not have a knowledge problem, but a “spreading” problem. We need to spread effective leadership practices.

**Dr. Moore** emphasized that CMS should move quickly on the ideas raised in this summit. He pointed out that the summit attendees are not typical of the leadership across industry, and we need to educate those individuals. The deficiencies reported the IOM remain with us. We have the knowledge of what to do, but we are not doing it. The US Secretary of Education yesterday indicated that it is time to overhaul the education system. A week ago a similar message came out from the Food and Drug Administration. We are seeing rising public expectations, rising frustration with the situation, and rising desire for change. In the airline industry there are a variety of players, but the one commonality is they all have to adhere to the same safety rules imposed by the Federal Aviation Administration, whether it involves pilot physicals or the safety belt instructions at the beginning of each flight. He thinks it is time to change from voluntary quality reporting to making it mandatory that hospitals achieve certain quality standards. At the same time it needs to be clear that the QIOs, consultants, and other organizations are available to help institutions achieve change. Finally, he emphasized that the involvement of the CEO is crucial and has been under-recognized, because it has been overshadowed by discussion of the importance of the board.

**Mr. Hamilton** remarked that everyone is engaged in conjuring up the spirit of quality, good data, and engagement, but whether you can make it happen is another story. The challenge is to align large, complex systems to work effectively towards quality. His Survey and Certification Group within CMS conducts accrediting and surveys of facilities across the country, performs complaint investigations, and likes to think of itself as the objective mirror that reflects what is really going on. Some of the best systems have problems, but still see more improvement than those systems at the bottom 15% of the performance spectrum. Mr. Hamilton’s staff is struggling with to bringing the evidence in this bottom 15% to the right people to make a difference and achieve systems change. He admits that true system change is difficult to make in the 90 days allowed by the process, and there is a danger of low performers fixing the presenting, but not the underlying problems. Still, he believes that CMS needs to use its clout as such a major purchaser to drive changes. Rather than just mandate that low-performing hospitals get outside help on their plans of correction, CMS needs to focus on the content of the corrective action plans themselves. Some of the biggest deficiencies his group sees with low performing hospitals are with the quality of the boards.

Separately, he noted that the survey research showed differences in perceptions at various organizational levels regarding safety and operational productivity: the danger is in thinking of quality and finances as opposite issues. There is a need to draw the linkages and demonstrate a business case for quality to debunk the myth that higher quality costs more. The linkage between quality and cost savings is not yet apparent to everyone. On a more positive note, managed care tools can facilitate responsibility and accountability for measures, and true patient-centered care holds the promise of making the patient the unit of funding, not the procedure. Medical systems need to take advantage of these tools and not just wait for P4P or other mandates. The issue then is, What can CMS, other payers in the system, the AHA, and the hospitals themselves do to make sure we have the right resources, linkages, and commitment to make change happen?

**Mr. Mayfield** noted that one of the words used during the summit was “system.” He pointed out that systems engineers and systems thinking are not prevalent across the healthcare/hospital industry, where individuals are trained as physicians, nurses, pharmacists, etc. The problem is that these individuals are being asked to embrace

unfamiliar systems engineering principles. We need to get them the necessary resources, training, and tools to implement quality systems. The AHA is reaching out to hospitals to partner with the private sector to loan systems/process engineers to evaluate and assist in building workable systems. Mr. Mayfield suggested that CMS could assist in this endeavor by encouraging, incentivizing, and providing education to the hospitals.

#### **Comments/Questions from the Audience:**

The first audience comment was that we can actually design in quality and design out failure. We need to stop focusing on measuring the chasms and start design bridges/solutions.

The next comment was from an audience member who observed that CMS has an obligation to mandate change. CMS should invest in these hospitals that are failing, provide them help, and support their efforts to achieve change. One possible idea is to provide tool boxes and physician support. If ways are not found to improve systems, to collect and analyze standardized information, and to standardize care, it was suggested that P4P would fail. Mr. Mayfield responded by saying that the presentations today had demonstrated that behind the success stories were people of vision and passion, not mandates. While CMS is moving toward enforcement and is using a collaborative approach, because mandates would take resources away from one area of the hospital, probably front line staff, and make them focus on reporting, chart reviews, and other administrative activities. Mr. Hamilton agreed with Mr. Mayfield's comments about the need for professional systems engineering. Dr. Jencks observed that there is a need to align many activities and players, not just CMS. He also noted that we need to find ways to assist those institutions, or they will be inclined to deny that their problems exist.

Mr. Moore asked if we are going to actually do the things we have been talking about, or if we are going to continue to rely on voluntary cooperation? He posed that it is time to use the stick. Dr. Jencks replied that enforcement will be effective only if there are drivers other than CMS. These other drivers can include P4P, QIO assistance, data published on Web sites, and standardized measures. Without all drivers pushing the same issues, there will only be more creative reporting and more diverted resources.

Ms. Bass commented that it was gratifying to hear the attention that is being given to the role of governance. This attendee asked for caution, however, in drawing conclusions about the effectiveness of boards in changing quality. More needs to be understood about how boards work. Just as boards need to understand quality in order to make recommendations about quality, we need to understand board operations in making recommendations for boards. This attendee suggested that the audience not generalize today's discussion about boards to boards across the country. Most boards are only at the initial stages of understanding quality and not ready to make major changes in systems related to quality improvement. Dr. Denham responded that the TMIT survey holds hope for better understanding and standardization of terms between quality improvement researchers and boards that will lead to a harmonized set of practices for hospitals.

Dr. Kroch observed that there is a major issue that no one has addressed relating to where CMS is headed. CMS started out as the Health Care Financing Administration. The issue is whether there is a reason behind the name change implying moving from only looking at financing, to becoming a public health organization or whether there is, in fact, ambivalence on the part of the President, Congress, CMS itself, and the public about such a role. Mr. Prout volunteered that some believe that the healthcare system is moving from a cost-based to a value-based competitive model. Mr. Mayfield responded that the market may be creating a value-based model, but that still begged the question as to how healthcare actually operates. Dr. Guterman agreed by pointing out that the healthcare market works differently from other markets and that the impact of market forces needs to be better understood.

Mr. Hamilton posed that it is not possible to have patient-centered care without making the patient truly the center of every endeavor, including finance. Today's patients are serially handed off throughout their care. He

believes that the key to ending this situation is stopping involuntary discharges and tracking voluntary discharges. This solution will pay off in the long run, because patients are in the continuum of care over the long run. Today we cannot predict risk-adjusted trajectories of patient-centered care, because we lack data. If we reorganized the system to be truly patient centric, we would obtain the data needed, and we would also end up changing the incentives for lifetime care. In the absence of this fundamental change, P4P, performance measures, and other initiatives are good to pursue, but not the only requirements needed for change. An audience member responded that there was a naturally occurring experiment of a sort in Europe regarding competition in health care. These countries backed away finding that competition in the aggregate was more expensive and undermined care coordination. Mr. Conway commented that the currency of leadership has changing to a more patient-inspired approach. We need to move out of the mindset of small steps and think about how to address the larger patient care goals. The IOM report states that, until we build a patient centered system, healthcare will not work properly. We need to try to implement some of the existing models of patient-centered care.

## XI. Closing Remarks: What Have We Learned

### ***Dale Bratzler, DO, MPH***

*Medical Director of the Hospital Interventions QIOSC and the  
Hospital Quality of Care Measures Special Study of the OFMQ*

Dr. Bratzler summarized the summit take-aways:

- Research findings are consistent: it is feasible to measure governance and leadership to identify the characteristics of high performing institutions.
- Gaps in perceptions exist regarding the intent versus the reality in quality improvement, so we need measures to determine whether quality processes have become institutionalized throughout an organization's culture.
- Front line staff will focus on what they are accountable for, including quality improvement.
- Physicians need to be involved and need to have their incentives aligned to quality improvement.
- Boards of Directors, and other staff in the hospitals, need training in quality improvement.
- More focus is needed on assisting low performing hospitals in quality improvement.
- We have a spread problem, not a discovery problem. Much common knowledge and learning has been presented, and now it is a matter of taking the information we have and spreading it among the hospitals nationwide.

In conclusion, the QIOs are eager to explore new ways to drive performance improvement. Dr. Bratzler hopes all summit attendees will help drive the process.