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Program Evaluation • Consultation • Market Research

Process and Outcomes Evaluation of the *Trustee Advantage* Program

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EXECUTIVE SUMMARY

While hospital Boards of Trustees are legally responsible for the quality of patient care in their institutions, their traditional focus has been on fiscal oversight and business strategy rather than on quality and safety. Despite increasing emphasis on the role of hospital Boards of Trustees in governance of quality and safety, Boards have been slow to take up the challenge, likely because many hospital Board members are uncertain of their role in quality and safety governance, what constitutes governance excellence, and what specific steps to take to achieve excellence.

Blue Cross Blue Shield of Massachusetts (BCBSMA) developed and sponsored Trustee Advantage, a 15-month grant program designed to help Boards of Trustees at five Massachusetts hospitals advance their governance of clinical quality and patient safety improvement. Goals were for trustees to understand their accountability with respect to quality performance, embrace their role as quality champions, and ensure that their hospitals' compensation systems and resource allocation reflect this commitment to quality and safety.

The three educational components of the program were: (1) an ongoing peer learning community, (2) a six-month engagement with a coach expert in both governance and hospital quality and safety, and (3) an in-depth experiential practicum of the hospital's choosing. Trustee Advantage provided \$50,000 in funding to each of five BCBSMA network hospitals: Beth Israel Deaconess – Needham (BID-Needham), Emerson Hospital, Harrington Hospital, Lowell General Hospital, and Winchester Hospital. The hospitals agreed to commit an additional \$25,000 to the Trustee Advantage effort, along with other hospital resources beyond funding.

METHODS

GRG's evaluation activities were designed to assess both process and intermediate outcomes of the Trustee Advantage program for the five participating hospitals. The process evaluation examined the context in which the Trustee Advantage operated, how the three components of the Trustee Advantage program unfolded, and participant experiences of the program. The outcomes evaluation tracked participant knowledge and attitude changes, the extent to which they have implemented governance plans in the service of these goals, and the facilitators of and barriers to such efforts going forward.

GRG used multiple methods, including document review, observation, online surveys, data forms, phone interviews, and learning community rating forms to collect data from program participants in various roles: CEOs, Board Chairs, Trustee Advantage Project Coordinators, trustees, and coaches. Response rates were quite good. All five CEOs, Chairs, Project Coordinators, and coaches provided all requested data. At the learning community sessions, response rates on the rating forms averaged 86%, and responses to the online surveys for trustees and CEOs were 88% on the pre-program survey and 78% on the post-program survey. These response rates are higher than are typically seen.

KEY FINDINGS

- The program was well designed and unfolded smoothly. The learning community allowed participants to learn from other hospitals and build a network; the coaches brought expertise, credibility, and perspective; and the experiential learning galvanized participants and enabled them to focus and bond.
- The three program components operated synergistically, building on and reinforcing each other. However, participants rated experiential learning activities as higher in impact on knowledge and governance practices.
- The Trustee Advantage program led to dramatic knowledge gains in participants' reported quality and safety knowledge, especially about general quality and safety issues, the Board's role, and specific steps, tools, and strategies. There was also some evidence of dissemination to nonparticipants.
- The program had a favorable impact on attitudes, with more participants at program's end ranking quality and safety at the top of the list of areas for Board oversight, reporting greater Board-executive agreement on quality and safety goals, reporting a modest but significant gain in physician engagement, and identifying more champions, especially the Board of Trustees.
- The hospitals made governance improvements due to their participation in the Trustee Advantage program and planned more in the coming year, especially in terms of performance monitoring and quality and safety improvement goals.
- A number of governance improvements hospitals made were in areas linked in past research to better quality and safety outcomes, such as putting quality performance on the agenda at more Board meetings and spending more time at each meeting on quality, among other improvements.
- The quality and safety journey is facilitated by factors allowing continued focus and momentum. Financial stability and CEO tolerance of Board activism are likely necessary precursors to progress. Other facilitators include reinforcing the link between quality and lower cost; having champions and good relationships among executives, Board, and medical staff; openness to discussion of defects; setting up systems to keep Board focus on quality and safety; and infusing resources into hospitals that lack them.
- Participants were so pleased with the program and their progress in quality and safety governance that they planned to continue certain aspects of it on their own and would like to see it scaled up to other hospitals.
- The Trustee Advantage program is one step in a longer quality journey for hospitals. Participants saw the program as accelerating their journeys significantly, but also indicated that this process is ongoing.

KEY RECOMMENDATIONS

- The learning community can be used to help maintain focus and momentum by scheduling sessions closer together and keeping the hospital teams limited to five or six representatives of management and the Board of Trustees.
- GRG recommends examining the feasibility of making the learning community self-sustaining past the end of the Trustee Advantage program. Participating hospitals could rotate responsibility for sessions, or perhaps there could be a few less formal follow-up sessions for participants to report on their progress and new lessons learned.
- The structuring of the coaching engagement should be refined by specifying that there be at least three sessions, one for fact-finding, one to deliver recommendations, and one to check in on the hospital's implementation of the recommendations, perhaps adding a "booster shot" session 12 to 18 months later. It is worth considering formulating explicit guidelines for future coaches while still allowing flexibility for customization.
- If it became necessary to scale back the program significantly, a stripped-down model could be built around the experiential learning with guidance from a facilitator or coach. It is likely that this model would not have as much impact as a stand-alone in the absence of the reinforcing learning community and coaching components, but results suggest a lot of "bang for the buck" with experiential learning.
- Knowledge transfer to non-participants can be enhanced by involving more trustees in the experiential learning and coaching components, by supporting participants in disseminating the knowledge they gain throughout their hospitals, and by considering the creation of a physician leadership training component.
- Choosing hospitals that are in the best position to benefit from Trustee Advantage will maximize gains. Facilitating conditions include adequate financial stability; a CEO who is a champion, welcomes increased personal accountability for quality and safety, and is comfortable dealing with an increasingly activist Board; additional champions on the Board and medical staff; a non-defensive and open culture willing to confront deficiencies; and a certain degree of progress already demonstrated on quality and safety improvement.

INTRODUCTION

Trustee Advantage is a 15-month grant program designed and sponsored by Blue Cross Blue Shield of Massachusetts (BCBSMA) to help Boards of Trustees at five Massachusetts hospitals advance the governance of clinical quality and patient safety improvement at their institutions. BCBSMA sought to support the hospitals in making transformative, rather than merely incremental, change in quality and safety. To make this happen, the Trustee Advantage program provided \$50,000 in funding to each of five BCBSMA network hospitals: Beth Israel Deaconess – Needham (BID-Needham), Emerson Hospital, Harrington Hospital, Lowell General Hospital, and Winchester Hospital. The hospitals agreed to commit an additional \$25,000 to the Trustee Advantage effort, along with other hospital resources beyond funding.

The Trustee Advantage program included three components:

- **Learning Community:** Hospitals participated in an ongoing peer learning community with the other grant recipients. Each hospital was represented at the sessions by a team consisting of the CEO, Board Chair, two trustees, and the designated Trustee Advantage Project Coordinator.
- **Coaching:** Hospitals had a six-month engagement with a coach who was an expert in both governance and hospital quality and safety. Executive team members and Board members participated in the coaching activities; in some cases, members of the medical staff also participated.
- **Experiential Learning Activity:** Hospitals participated in an in-depth experiential practicum of the hospital's choosing. The intention was that the full Board would participate in this activity; however, as described in the Results section, this did not occur in practice.

THE ROLE OF HOSPITAL BOARDS OF TRUSTEES IN QUALITY AND SAFETY GOVERNANCE

Hospital Boards of Trustees are legally responsible for the quality of patient care in their institutions, as has been established by court rulings, state statutes, and Joint Commission accreditation.^{1,2} Traditionally, however, hospital Boards have focused primarily on fiscal oversight and business strategy, delegating the governance of quality and safety to the medical staff or to a Board Quality Committee.³

During the last decade, organizations including the Centers for Medicare & Medicaid Services (CMS), the American Hospital Association, the National Quality Forum,⁴ and the Institute for

¹ Lister, E., & Cameron, D.L. (2001). The role of the board in assuring quality and driving major change initiatives — Part 1: Maintaining organizational integrity. *Group Practice Journal*, 50, 13-20.

² Jiang, H.J., Lockee, C., Bass, K., Fraser, I., & Norwood, E.P. (2009). Board oversight of quality: Any differences in process of care and mortality? *Journal of Healthcare Management*, 54, 15-29.

³ Levey, S., Vaughn, T., Koepke, M., Moore, D., Lehrman, W., & Sinha, S. (2007). Hospital leadership and quality improvement: Rhetoric versus reality. *Journal of Patient Safety*, 3, 9-15.

⁴ National Quality Forum. (2004). *Hospital Governing Boards and Quality of Care: A Call to Responsibility*. Washington, DC: Author.

Healthcare Improvement^{5,6} have called on hospital Boards to take a much stronger role in quality and safety governance and have promulgated specific recommendations for doing so. Some examples of best practices in quality and safety governance are the Board being involved in setting the hospital's quality agenda, there being a dedicated Board-level Quality Committee, quality being on the agenda at every Board meeting, CEO compensation being linked to quality and patient safety indicators, and so on. Such leadership on the part of the Board is appropriate given that Boards set and monitor the mission of their organizations, and quality of care is fundamental to every hospital's mission of providing safe, cost-effective, and affordable health care.⁷

Boards have been slow to take up this challenge, as reflected in the suboptimal governance practices that still prevail at many U.S. hospitals.^{8,9,10} This is likely because many hospital Board members remain uncertain about their role in the governance of quality and safety, about what constitutes governance excellence in this area, and about exactly what steps to take to achieve such excellence. One 2007 study of community hospitals like those that participated in the Trustee Advantage program found that:

Board members felt unprepared, reactive, and unwilling to challenge the hospital culture in the clinical realm. Although board respondents felt confident in nonclinical matters, [they] tended to defer to physicians for clinical quality issues. However, board interviewees expressed a need for further education on quality.¹¹

It is important to note that the hospitals that chose to apply for BCBSMA Trustee Advantage grants to work on improving Board governance of quality and safety are somewhat further along than is the typical hospital. The choice to apply for this grant, along with the fact that BCBSMA described all of the hospitals as demonstrating a strong commitment to improvement as well as a receptive culture, particularly at the Board and executive levels, indicates that the Trustee Advantage hospitals had already bought into the idea that Boards of Trustees should take a strong leadership role in governing quality and safety.

⁵ Reinertsen, J.I., Pugh, M.D., & Bisognano, M. (2005). *IHI Innovation Series Paper: Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*. Cambridge, MA: Institute for Healthcare Improvement.

⁶ Institute for Healthcare Improvement. (2007). *Getting boards on board*. Cambridge, MA: Author. Available at <http://www.ihl.org/IHI/Programs/Campaign/BoardsonBoard.htm>

⁷ Quality Curriculum for Trustees. Chicago, IL: The Center for Healthcare Governance, American Hospital Association. Available at <http://www.americangovernance.com/americangovernance/education/QC.pdf>

⁸ Jiang et al. (2009).

⁹ Jha, A., & Epstein, A. (2010). Hospital governance and the quality of care. *Health Affairs*, 29, 182-187.

¹⁰ Vaughn, T., Koepke, M., Kroch, E., Lehrman, W., Sinha, S., & Levey, S. (2006). Engagement in leadership in quality improvement initiatives: Executive Quality Improvement Survey results. *Journal of Patient Safety*, 2, 2-9.

¹¹ Levey et al., 2007, p. 11.

RATIONALE AND GOALS OF THE TRUSTEE ADVANTAGE PROGRAM

The Trustee Advantage program is part of BCBSMA’s Community Transformation Initiative, which aims to improve the quality of medical care their members receive by working with various partners to help improve the health-care delivery system to achieve higher, more affordable access to the right services at the right time.¹² Specifically, engaging hospital Boards is part of the initiative’s “governance” lever of change,¹³ which has the following strategic objectives:

- Trustees understand their accountability with respect to quality performance.
- Trustees embrace their role as quality champions, mandating safe, effective, and efficient care.
- Trustees ensure their organizations’ compensation systems and resource allocation reflect this commitment to quality and safety.

Trustee Advantage was designed to provide three focused and interrelated experiences — a peer learning community, expert coaching, and an experiential learning activity, as noted above — to assist hospital Boards in taking significant concrete steps toward excellence in quality and safety governance. BCBSMA articulated the following goals for the Trustee Advantage program:

- Stimulate participating hospitals to develop a trustee-supported audacious goal or statement of aim to dramatically improve quality and safety.
- Accelerate progress of the participating hospital toward improved safety and quality through greater Board attention and focus.
- Deepen and reinforce Board commitment to safety and quality in the participating hospitals, so as to ensure safety and quality remain central strategic objectives for the organization over time — even in the face of a changing financial context or changes in executive leadership.
- Build personal leadership effectiveness around the governance of quality and safety for a critical nucleus of Board members through shared learning across hospitals and from other external experts.
- Distill lessons learned that can help guide other organizations seeking to strengthen their own Board governance of quality and safety as well as the future efforts of sponsors like BCBSMA.
- Develop participating organizations as potential champions for a strengthened Board role in pursuing quality and safety.
- Demonstrate the potential for a significant expansion of the Trustee Advantage program and the learning community element, where the expected impact would merit a major funding investment from sponsoring organizations seeking to promote hospital quality and safety.

¹² Killingsworth, C.L. (2010, March 1). *Health care in Massachusetts*. Presentation to students at the Harvard School of Public Health. Available at http://www.qualityaffordability.com/pdf/CLK_HSPH_Website_Presentation.pdf.

¹³ The other three levers of change are financing and payment, legislative and regulatory, and public engagement.

GRG'S EVALUATION OF THE TRUSTEE ADVANTAGE PROGRAM

The evaluation plan for Trustee Advantage included examinations of both process and outcomes. In the process evaluation, Goodman Research Group (GRG) assessed the participating hospitals on the three program components (learning community, coaching, and experiential learning). Interim reports on the learning community meetings also allowed for mid-course corrections in this program component. Process questions included:

- What was the context in which the Trustee Advantage operated?
- How did the three components of the Trustee Advantage program unfold?
- What were participants' experiences of the three components of the program?

Ultimately, BCBSMA hopes that Trustee Advantage will facilitate improved clinical outcomes for participating hospitals. However, this more distal outcomes goal was not feasible to measure in the initial implementation of the program. Rather, GRG's evaluation tracked intermediate outcomes, such as the hospitals' commitment to transformative change in quality and safety governance, the extent to which they have implemented governance plans in the service of these goals, and the facilitators of and barriers to such efforts going forward. Outcomes questions included:

- Did participants gain knowledge and improve their attitudes about quality and safety improvement over the course of participating in the Trustee Advantage program?
- Did participating hospitals improve their quality and safety governance practices, especially those linked with objective quality and safety outcomes? Do they attribute those changes to their participation in the Trustee Advantage program?
- Did the Trustee Advantage program give participants the tools they need to move forward in their quality and safety journey? What are the facilitators and barriers on this journey?
- How successful were the three program components — and the Trustee Advantage program as a whole — at changing knowledge, attitudes, and governance practices?

METHODS

GRG’s evaluation activities were designed to assess the process and intermediate outcomes of the Trustee Advantage program for the five participating hospitals. GRG’s evaluation used a multi-method approach to track changes and progress toward goals over the 15 months of the program. From June 2009 to August 2010, we collected four types of data: online surveys, hospital data forms, phone interviews, and learning community rating forms (see Appendix A for copies of all evaluation measures). Table 1 shows the instruments completed by each respondent and the timing of data collection. GRG also reviewed two secondary data sources, the grant proposals and the final reports completed by each hospital and submitted to BCBSMA. One exception was Harrington’s final report, which was not submitted to BCBSMA during the evaluation period.

Table 1
Data Sources

Respondent Role	Timing	Online Survey	Hospital Data Form	Phone Interview	LC Rating Form
CEO	<i>Before TA</i>	✓			✓
	<i>After TA</i>	✓		✓	
Chair	<i>Before TA</i>	✓			✓
	<i>After TA</i>	✓		✓	
Project Coordinator	<i>Before TA</i>		✓		✓
	<i>After TA</i>		✓		
LC delegate trustees	<i>Before TA</i>	✓			✓
	<i>After TA</i>	✓			
Other trustees	<i>Before TA</i>	✓			
	<i>After TA</i>	✓			
Coach	<i>Before TA</i>			✓	
	<i>After TA</i>			✓	

LC = learning community; TA = Trustee Advantage.

LEARNING COMMUNITY SESSION RATING FORMS

GRG evaluators attended and observed all five learning community sessions. At the end of the three content sessions and the wrap-up session, brief 5-minute surveys were passed out asking attendees to rate the benefit of each component of the session as well as to provide logistical feedback. The response rates for each rating form are shown in Table 2.

Table 2
Response Rates for Learning Community Session Rating Forms

	Number of Respondents	Response Rate
#1: Setting audacious Board goals for safety and quality	24	89%
#2: Board roles and responsibilities in creating a culture of safety	22	92%
#3: Board role in engaging physicians around quality and safety	17 ^a	71%
Wrap-up session	24	92%

^aAt this session, participants were asked to fill in the rating form at the end of dinner, at which point a number of participants had already left.

ONLINE SURVEYS OF TRUSTEES AND CEOS

Survey Administration

GRG received email addresses for all current trustees and CEOs from the Project Coordinator of each hospital. A 15-minute pre-program survey assessing baseline knowledge and attitudes toward hospital quality and safety was launched to these individuals in June 2009. The survey remained online for three weeks, and non-respondents were emailed three reminders.

In May 2010, a 15- to 20-minute post-program survey was launched to current trustees and CEOs at four of the hospitals (Lowell General Hospital took a three-month extension on the grant, so the survey was launched to the Lowell trustees and CEO three months later). Questions addressed changes in knowledge and attitudes toward quality and safety issues, experiences with the three components of the Trustee Advantage program where applicable, and suggestions for program modifications.

After three weeks and three reminders to non-respondents, initial response rates at the four hospitals were not very good. Therefore, GRG engaged in additional efforts to boost the response rate among non-respondents who had completed the baseline survey; they received an additional reminder from GRG, one from their hospital's Project Coordinator, one from BCBSMA, and a final reminder from GRG. In all, the post-program survey for the first four hospitals remained online for seven weeks. In July 2010, the survey was launched to Lowell participants. It remained online for three weeks, and non-respondents were emailed three reminders.

Response rates for the pre-program and post-program surveys at each hospital are shown in Table 3. There were 61 respondents who took both surveys.¹⁴ Of these 61, 10% were CEOs and 90% were trustees (10% Board Chairs, 15% trustees delegated to represent their hospitals at the learning community sessions, and 65% other trustees).

¹⁴ There were unmatched surveys for 16 respondents who took the pre-program survey only and for 10 respondents who took the post-program survey only.

Table 3
Response Rates for the Pre-Program and Post-Program Surveys

	Pre-Program Survey		Post-Program Survey	
	Number of Respondents	Response Rate	Number of Respondents	Response Rate
BID-Needham	20	100%	14	74%
Emerson	18	95%	16	89%
Harrington	8	67%	7	58%
Lowell	13	81%	17	77%
Winchester	18	86%	17	85%
TOTAL	77	88%	71	78%

On the post-program survey, almost half (47%) of respondents were 56–65 years of age, 17% were over 65, and the rest were 35–55. The most commonly represented field was the financial industry (banking, finance, investment; 27%), followed by health care (22%) and high tech or computers (15%). More than half (55%) had served on their hospital’s Board for five years or fewer; 18% for up to 10 years, and 27% for more than 10 years.

Retrospective Pre-Test Items

We judged it likely that responses to some of the most important outcome measures on the survey might be prone to response shift bias. Response shift is a change in the way respondents answer questions before and after a program because, after participating in the program, they have a different, often more sophisticated, understanding of the concepts being assessed than they had beforehand. Response shift is particularly likely in transformative educational programs such as Trustee Advantage, in which many participants “don’t even know what they don’t know” before participating in the program.

One strategy to address response shift bias is to ask retrospective pre-test (RPT) questions on the post-program survey. An RPT question asks respondents after they have completed the program — knowing what they know now — to rate their situation at the beginning of the program. Thus, many outcome measures were asked in three different ways: (1) about the respondent’s current situation on the pre-program survey, (2) about the respondent’s past situation via an RPT item on the post-program survey, and (3) about the respondent’s current situation on the post-program survey.

As an illustration, before beginning the Trustee Advantage program, trustees and CEOs rated their knowledge on a six-item measure of quality and safety knowledge quite highly — 3.81 on a 5-point scale, or just under *very knowledgeable*. However, when asked at the end of the program to rate their starting level of knowledge, they rated it significantly lower, averaging 2.82, or just under *somewhat knowledgeable*. They rated their post-program knowledge at 3.99.

Research reviewed by Klatt and Taylor-Powell¹⁵ suggests RPT items are more valid than traditional pre-test items in that they are more consistent with objective and behavioral measures of the same constructs without being any more susceptible to biases such as social desirability (the desire to

¹⁵ Klatt, J. & Taylor-Powell, E. (2005, October). *Synthesis of literature relative to the retrospective pretest design*. Paper presented at the Joint CES/AEA Conference, Toronto, Canada.

present oneself in a positive light) or demand (responding in the direction the question seems to “pull” for).

RPTs may, however, be susceptible to effort justification (underestimating on the RPT to justify effort expended on program participation). Given the wealth of converging evidence suggesting that participants learned a great deal from the Trustee Advantage program — including responses to direct questions about learning; interviews with coaches, who represent a more objective outside opinion, as well as with CEOs and Board Chairs; and the fact that Boards actually changed their governance practices — our considered interpretation is that responses to the traditional pre-test items on the trustee-CEO survey were, in fact, inflated, while responses to the RPT items represent a more accurate assessment of respondents’ pre-program state. Thus, the most appropriate comparison for assessing program-related changes is the difference between RPT and post-program ratings.

HOSPITAL DATA FORMS

In June 2009, GRG sent hospital data forms with questions about hospital quality and safety governance practices to the Project Coordinator at each hospital; the forms took about 45-60 minutes to complete. In June 2010, GRG sent the forms completed the previous year back to each Project Coordinators and asked them to indicate any areas of actual, planned, or considered change in governance practices and to indicate the extent to which such changes were due to the hospital’s participation in the Trustee Advantage program. The post-program updates took about 30-40 minutes to complete.

INTERVIEWS WITH COACHES

From October 2009 to December 2009, GRG conducted 20- to 30-minute pre-program phone interviews with each of the five selected coaches. Due to delays in several hospitals’ initial selection and engagement of a coach, the timing of the baseline interview varied by hospital. The interviews asked for coaches’ expert opinions on each hospital’s status on their quality and safety journey, potential facilitators and barriers to progress, and the anticipated focus of their work.

Post-program phone interviews were conducted from July 2010 to August 2010. Coaches were asked to discuss their work with the hospital and to give their expert opinions on the hospital’s progress on quality and safety governance over the course of the program.

INTERVIEWS WITH CEOS AND BOARD CHAIRS

GRG conducted 30-minute post-program phone interviews with each hospital’s CEO and Board Chair from July 2010 through August 2010. Lowell transitioned to a new Board Chair over the course of the Trustee Advantage program, so both the incoming and outgoing Chairs were interviewed. Likewise, Winchester transitioned to a new CEO, so both the incoming and outgoing CEOs were interviewed. The CEOs and Board Chairs were asked to discuss their experiences with all three components of the Trustee Advantage program, assess their progress throughout the program, and offer suggestions for improving the program model.

PROCESS EVALUATION: HOW DID THE TRUSTEE ADVANTAGE PROGRAM UNFOLD?

In order to better understand the impact of the Trustee Advantage program on hospital Board governance of clinical quality and patient safety, it is first necessary to understand the context in which the program operated as well as the details of how the program unfolded over the course of 13 months. Context includes factors such as the location and type of hospital, where the hospital is in its quality and safety journey, what other quality and safety initiatives the hospital has participated in, and other variables such as idiosyncratic histories, medical staff bylaws, CEO characteristics, and other factors that affect the organization's ability to move toward excellence in quality and safety governance.

For example, suburban and rural community hospitals are generally not able to devote the same resources — financial and otherwise — to improving quality and safety governance as are, say, urban teaching hospitals with access to faculty and students from highly selective medical schools. On the other hand, the latter hospitals may be less able to convince their elite physician corps that they need to change the way they practice medicine. Hospitals that are just beginning their journey toward governance excellence have very different needs and very different capabilities for change than do hospitals that are further along in the journey. Hospitals with fraught histories of management-physician relations have special challenges in engaging their physicians in new quality and safety initiatives.

Partly to address such inter-hospital differences, the Trustee Advantage program was designed to be customizable to each hospital's individual needs and capacities. All hospitals participated in the learning community together, but each hospital chose its own coach, what to focus on during the coaching engagement, and which experiential learning activity or activities to do.

TRUSTEE ADVANTAGE PROGRAM PARTICIPANTS

All of the grantees are community hospitals in the BCBSMA network; they are non-profit, short-term, acute-care facilities. One of the hospitals, BID-Needham, is affiliated with Beth Israel Medical Center (BIDMC) in Boston, a Harvard Medical School teaching hospital. The five participating hospitals vary significantly in size and in how busy they are, as shown in Table 4.

Table 4
Descriptive Data on Participating Hospitals

	Staffed Beds	Discharges	Patient Days
BID-Needham ^{1,2}	41	2,332	7,504
Emerson ¹	168	6,395	46,704
Harrington	126	3,179	15,282
Lowell General ^{1,3}	179	13,302	53,450
Winchester ^{1,2}	205	14,721	54,439

Note: All information from the American Hospital Directory (www.amd.com). Data on beds, discharges, and patient days updated July 2010; data on cancer program, teaching hospital status, and trauma program updated May 2010.

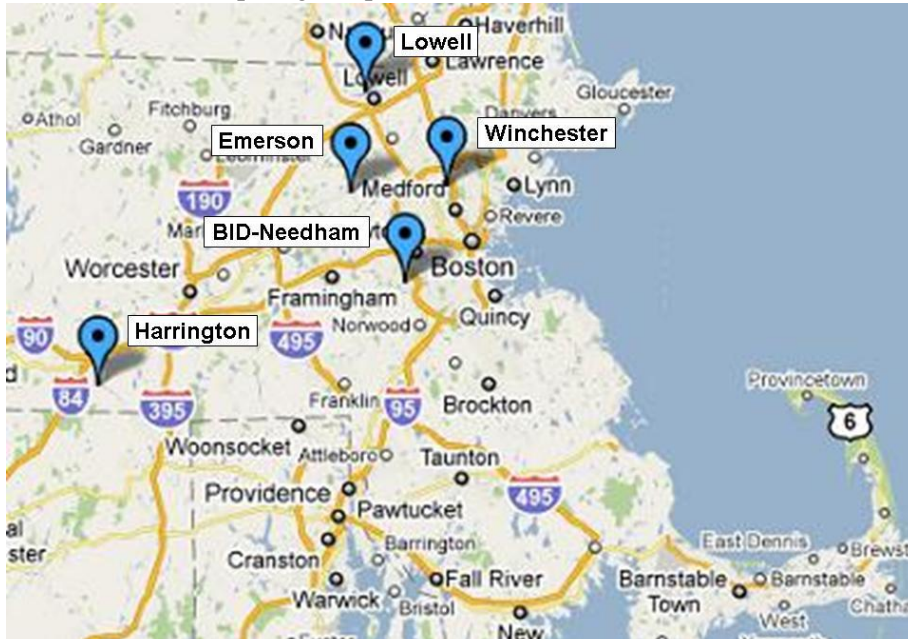
¹Approved Cancer Program: Community Hospital Comprehensive Cancer Program.

²Teaching hospital.

³Verified Trauma Program: Level III Trauma Center.

Four of the hospitals are in the Boston metropolitan area, and one, Harrington Hospital, is in the Worcester metropolitan area, about 60 miles from Boston, as shown in Figure 1.

Figure 1
Locations of Participating Hospitals



As noted above, all five participating hospitals were committed to improvement and had a receptive culture at the Board and executive levels, as determined by BCBSMA. For example, one of the hospitals had already been working with a coach before the Trustee Advantage program began, and two had developed audacious quality and safety improvement goals, one as part of BCBSMA’s earlier two-year Leading Edge Acceleration of Delivery and Design (LEAD) program, in which CEOs met in a community of practice to set audacious quality improvement goals. Another hospital participated in a safety initiative with the Massachusetts Coalition for the Prevention of Medical Errors and belonged to the IHI Passport Program, a fee-based service providing hospitals with tools, resources, and access to expert support on health-care improvement. Several hospitals also mentioned participating in the Trustee Insight program sponsored by BCBSMA and the Massachusetts Hospital Association, a speaker series featuring national experts on hospital governance of quality and safety.

However, the hospitals were at very different stages in their journey toward excellence in quality and safety and in governance of quality and safety, as shown in Table 5. To quantify these differences, GRG examined publicly available quality and safety data on the *Hospital Compare* website operated by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS). We examined the hospitals’ ratings on process-of-care measures for the Surgical Care Improvement Project, heart attack, heart failure, and pneumonia and counted areas where the hospital deviated by 5% or more in either direction from the Massachusetts state average. As shown in the table, these objective quality and safety assessments were quite consistent with assessments by the coaches, whose expertise and experience allowed them to provide a broader and more objective perspective than that provided by hospital leaders themselves.

Table 5
Quality and Safety of Participating Hospitals

	Percentage of CMS <i>Hospital Compare</i> Process-of-Care Measures ¹ That Are:		Coach Assessment at Baseline of Where Hospital Started Its Quality and Safety Governance Journey
	≥5% <u>Below</u> Massachusetts Average	≥5% <u>Above</u> Massachusetts Average	
Hospital A	0%	12%	“Well down the road.”
Hospital B	12%	12%	“Earlier in their journey.”
Hospital C	16%	4%	“They have made significant progress.”
Hospital D	20%	4%	“Early in their journey.”
Hospital E	40%	8%	“Beginning [their journey].”

Note: Because this information is sensitive, hospitals were given an alias to maintain their confidentiality. The alias refers to the same hospital throughout the report.

¹Includes CMS *Hospital Compare* process-of-care measures for the Surgical Care Improvement Project, heart attack, heart failure, and pneumonia as of March 10, 2010. Information by hospital is publicly available at <http://www.hospitalcompare.hhs.gov/>.

LEARNING COMMUNITY

The first component of the Trustee Advantage program was a peer learning community. As noted earlier, each hospital was represented at the five learning community sessions by its CEO, the Board Chair, two trustees who had been delegated to attend the sessions, and the designated Trustee Advantage Project Coordinator.

TruePoint, a research-based management consulting firm, was hired by BCBSMA to facilitate the learning community sessions. TruePoint's design principles for building an effective learning community were to:

- Evolve the aspirations and agenda of the community through an explicit dialogue between sponsor expectations and participant interests.
- Create the conditions for trust and openness: minimum participation levels, confidentiality; personal chemistry.
- Build up from participants' own cases in order to:
 - Build ownership.
 - Ensure tight linkage to the real leadership agenda.
 - Understand effective practices in the context of an integrated organizational system.
- Focus on applied knowledge and its link to desired outcomes of improved Board governance:
 - Share practical tools, not just concepts.
 - Assess ideas and approaches by the practical difference they can make.

There were five meetings of the learning community, as shown in Table 6. The working part of each session was two hours long. The content and wrap-up sessions also included two hours for a reception and dinner afterwards to allow for more informal interaction and building of rapport among participants. The three content session topics were based on initial discussions the hospitals had with the consultants from TruePoint and with BCBSMA.

Table 6
Learning Community Sessions

Date	Topic
March 2, 2009	Launch session
June 24, 2009	#1: Setting audacious Board goals for safety and quality
September 15, 2009	#2: Board roles and responsibilities in creating a culture of safety
December 7, 2009	#3: Board role in engaging physicians around quality and safety
March 31, 2010	Wrap-up session

The TruePoint consultants developed a framework for each of the three content areas showing in some detail the typical stages of hospital progress toward quality and safety governance excellence in that area (see Appendix B). The frameworks and additional reading materials were distributed to the hospitals in advance to be used in session preparation; they also served as a guide to discussion during the sessions. Two expert facilitators from TruePoint guided both the advance preparation and the session discussions.

At the launch session, each team briefly introduced their hospital’s strategic context, quality and safety governance journey, and goals for participation in the Trustee Advantage program. TruePoint described the learning community approach and detailed the preparation requirements and agenda for the first content session.

At the content and wrap-up sessions, seating was arranged so each table included representatives from all five hospitals. The content sessions shared a similar agenda. First, three hospitals gave brief initial perspectives on their experiences with the session topic. Then the other two hospitals gave more detailed case presentations describing their experiences working to improve quality and safety, including context, key issues, and lessons learned. After the case presentations, the facilitator summed up and offered some guiding questions to be discussed in small groups at the tables and then shared with the larger group. The case presentations and the ensuing discussions constituted the heart of the session.

At the wrap-up session, each hospital gave a presentation on their goals, their progress on the three session content areas, lessons learned and advice for other hospitals, and suggestions for improving the Trustee Advantage program. Afterwards, TruePoint facilitated discussions on cross-cutting themes and lessons for other hospitals first in small groups at the tables and then in the larger group.

What Were the Most Valuable Aspects of the Learning Community?

Feedback from the learning community session rating forms was used to make several mid-course corrections to subsequent sessions (see Appendix C for a full set of annotated session rating forms). The corrections were all based on the developing consensus among the program’s designers, the management and evaluation consultants, and the attendees that the most valuable aspect of the learning community was the rare chance for hospital leaders to exchange information, engage in discussions, and build relationships across hospitals.

Thus, agenda items allowing for such cross-hospital interaction were expanded, while items that involved less cross-hospital interaction were trimmed. For this reason, although the expert dinner speaker at the second content session was quite well received, a decision was made to forgo additional speakers. There are a number of other venues for hospital leaders to hear expert speakers, including the Trustee Insight program mentioned above, but they do not have as many opportunities for meaningful interaction with leaders from other hospitals.

GRG identified a number of themes in CEO and Board Chair comments about the learning community, and particularly the cross-hospital interaction component. Valuable aspects of the learning community included:

- **Participating in the learning community allowed participants to assess their own hospital’s progress compared to others.** This could be both encouraging and motivating; as one Chair said, *“Actually, we are well on our way; we were surprised that we were a little more advanced than we thought we were, but there were also areas that we thought we could develop.”* Such comparisons also made trustees feel that their issues and challenges were more common than they had realized; as one CEO noted, trustees *“got to understand that all Boards are coming to grips with these kinds of issues.”*

- **The case presentations and discussion enabled participants to learn from other hospitals' successes and mistakes.** One Chair mentioned that *“We saw the opportunity to learn from the experiences of other people in other organizations and hopefully learn from that so we wouldn't run down plan A and find out plan B is a lot better and we should've done it that way.”* Other participants mentioned specific ideas they had heard about from other hospitals and were implementing at their own.
- **The learning community meetings encouraged participants to build a network of other hospital leaders.** *“There's personal contacts... you're purposefully set up where you're not with your own group. There's an awful lot that takes place at that table...a lot of it takes place with the interaction and the way that [sessions were] organized...so that there was interchange with other hospitals...The typical exchanging of cards and the contacts made and calls made and interaction about things you'd say that they would say, 'Can I touch base with you about that?' I think that's kind of a hidden part of this.”*

Another part of the learning community sessions that a number of attendees found useful were TruePoint's frameworks showing the stages in hospital progress toward governance excellence in the three content areas of goal setting, creating a culture of safety, and physician engagement (see Appendix B).

How Could the Learning Community Be Improved?

Participants made logistic suggestions related to the timing of the learning community sessions. Although the difficulty of planning a meeting time that worked for a large group of people was acknowledged, some participants felt that the resulting lag between the sessions was too long. One CEO suggested increasing the number of Board participants to relieve the stress of ensuring trustee representation: *“We might increase the size of the potential Board participants so instead of three, we make it five or six, so that way we can always be assured that there's going to be a few more there.”*

Other suggestions include extending the learning community sessions beyond the end of the Trustee Advantage program, allowing more time for discussion during the sessions, increasing or enhancing the pre-reading materials, and inviting CEOs from outside hospitals to speak and share their relevant experiences.

COACHING ENGAGEMENT

The second component of the Trustee Advantage program was a coaching engagement. Each hospital had a six-month engagement with a governance and quality expert chosen by the hospital with guidance from BCBSMA. The coaches worked with the hospital's CEO, Board, and Quality Committee to increase their effectiveness as champions for quality care. Descriptions of the coaches and their work with the hospital are shown in Table 7.

Table 7

Trustee Advantage Coaches and Their Work with the Hospitals

BID–Needham	<p><i>Eric Lister, MD:</i> Managing Director for Ki Associates, an organizational consulting firm with expertise in executive performance, quality and safety, and physician relations for healthcare initiatives. Also a Senior Consultant for HealthSure, a healthcare consulting firm. Prior to his current positions, Lister served as a faculty member at a number of renowned medical institutions.</p> <p>Dr. Lister participated in several Board meetings, attended a Medical Executive Committee Meeting, and corresponded regularly with the CEO. Throughout his work with the hospital, Dr. Lister suggested several potential process modifications, including changes to the re-credentialing process; consulted on facilitating physician engagement towards accomplishing the hospital's LEAD goals to eliminate preventable harm; and discussed the hospital's goal to move away from a results reporting approach.</p>
Emerson	<p><i>James Reinertsen, MD:</i> Head of the Reinertsen Group, a consulting firm that works with hospital and health system boards, CEOs, physician leaders, and senior executive teams to improve clinical quality and safety. Prior to founding the Reinertsen Group, Reinertsen held leadership positions at a number of healthcare centers, including Park Nicollet Medical Center and Beth Israel Deaconess Medical Center.</p> <p>Mr. Reinertsen held four conference calls and two retreats and collaborated with Alice Gosfield, JD, to engage the Board, medical staff, and management in developing an audacious goal. During the conference calls, the coaches helped to debrief from the experiential learning site visit to McLeod and plan the two retreats. The first retreat was used to discuss Board and medical staff roles in quality improvement, and the second retreat was used to set Emerson's audacious goal. Physicians, Board members, and senior staff attended both retreats.</p>
Harrington	<p><i>Joseph Bujak, MD:</i> Vice President, Medical Affairs for Kootenai Medical Center in Coeur d'Alene, Idaho, and speaker, author, facilitator, and consultant on issues related to healthcare organization–physician relationships, clinical quality and patient safety, and leading and managing transformational change.</p>

Dr. Bujak held three sessions with Harrington Hospital centering on issues of re-credentialing and physician engagement. Dr. Bujak met with several leaders and physicians and was crucial in getting physicians on board with quality and safety initiatives.

James Conway, MS: Senior Vice President at the Institute for Healthcare Improvement and Senior Consultant at the Dana-Farber Cancer Institute (DCFI). Prior to taking on his current positions, Conway was the CEO of DCFI. Areas of expertise include executive leadership, patient safety, change management, and patient/family-centered care.

Lowell General

Mr. Conway observed and shared his observations at a Patient Care Assessment Committee Meeting (PCAC) and participated in an off-site retreat, where Board members and senior leaders discussed best practices and formulated an audacious goal. As a follow-up to the themes discussed with Mr. Conway, the PCAC met with Ann Cavagnaro, RN, who made targeted recommendations to make structural changes to the PCAC.

David Nash, MD: Professor and Dean at Jefferson School of Population Health in Philadelphia and consultant to healthcare organizations within both the public and private sectors. Internationally known for his work in outcomes management, medical staff development, and quality-of-care improvement.

Winchester

Dr. Nash interviewed Board members and medical staff leaders, held two coaching sessions with the Board, the Board Quality Committee, and invited hospital and medical staff leaders. The coaching sessions stressed the importance of the Board's governance responsibilities. As a result of their work with Dr. Nash, the hospital decided to add physician leadership and reducing unexplained or unsupported medical variation to their strategic goals for 2011.

Note: Information on coaches' qualifications and specialties was compiled from the coaches' websites. Information on what the hospitals worked on with the coaches was obtained from the hospitals' final reports to BCBSMA; for Harrington, information on Dr. Bujak's work was obtained from interviews with the CEO and Board Chair.

The coaching process was intended to conclude with the development of an audacious, trustee-supported goal, or statement of aim, to dramatically improve the quality and safety of the hospital. However, in practice, the hospitals tailored their work with the coaches to their own particular needs. Two of the hospitals already had audacious quality and safety goals, and one did not finish the goal-setting process, although it is on the path to doing so (see Table 8).

Table 8
Hospitals' Audacious Goals

Hospital	Goal Was Set	Audacious Goal
BID-Needham	Before TA	Eliminate preventable harm by 2012.
Emerson	As a result of TA	Reduce five HAIs ¹ by 50% by end of 2010.
Harrington	Goal not yet set	N/A
Lowell General	As a result of TA	Eliminate preventable harm by 2012.
Winchester	Before TA	Eliminate preventable harm by end of 2011.

Note: Information compiled from coach, CEO, and Board Chair interviews, trustee-CEO survey, and final reports.

TA = Trustee Advantage; HAI = hospital-acquired infection; N/A = not applicable.

¹Ventilator-associated pneumonia (VAP), central line-associated bloodstream infections (CLABSI), surgical site infections (SSI), catheter-associated urinary tract infections (CAUTI), and hospital-acquired Clostridium difficile (C. diff).

What Were the Most Valuable Aspects of the Coaching?

GRG identified four primary benefits of the coaching, as described by the CEOs and Board Chairs:

- **The coaches brought technical expertise that the hospitals lacked.** For example, one CEO said *“He helped us in a lot of ways. He set up our quality Board committee, how often they met, what a dashboard looks like, how often it should be updated, should it be mixed with your finance dashboard.”* Others described various ways in which their coaches educated their Board members, executive leadership, and medical staff on specific quality and safety topics.
- **The credibility of the coaches helped get various constituencies on board.** The coaches have credibility not just because of their expertise, but also by virtue of their position as an objective voice coming from outside the institution. As one Board Chair noted, *“He was viewed as somebody who was really there to help us and didn’t have a personal axe to grind.”* Other hospitals worked with their coaches on engaging their physicians in quality and safety, and they noted that in these cases, the fact that these coaches were physicians themselves lent them more credibility with the medical staff in particular: *“[Our coach] had a lot of credibility, and when he spoke, the doctors listened because he was a doctor.”*
- **The coaches were able to offer a broader outside perspective by virtue of their work with many hospitals.** As one CEO noted, *“The thing that [our coach] brings to the table is seeing a whole bunch of different places.”* Another CEO offered a more specific example: *“I think hearing from him some good examples of how physicians, and, in particular, physician leaders, have been able to transform different organizations was helpful.”*
- **Some of the coaches challenged and provoked in order to create change.** Leaders from two of the hospitals appreciated their coaches’ provocative approaches. It is probably easier to take such an aggressive approach as an expert and an outsider. One CEO said, *“I wouldn’t call him controversial, but he made people and our physician leaders think differently...He threw some controversial stuff out there that made people think, so I think he was very helpful.”* Another noted, *“[Our coach’s] style by nature tends to be provocative, and he does it intentionally...He began to plant some seeds there that were very effective, and*

we began to engage around that issue in a way that we hadn't before we had him here." A third hospital found their coach's style problematic, but in that case, the issue was more that he was perceived by the medical staff as lecturing or hectoring them, not that he was provocative.

How Could the Coaching Be Improved?

Several coaches and participants mentioned that additional coaching would have been beneficial, particularly a follow-up session. One coach suggested three visits: one for fact-finding, one to deliver recommendations, and one to check in on the hospital's implementation of the recommendations. Another wished *"that there was some ability to follow up at a much longer interval to help them stay on track because, while I left them with a lot of education and recommendations...there is nothing structurally built in for me to either challenge them around their commitments or...to give them a booster shot."* This sentiment was echoed by a Board Chair, who suggested *"going back and reviewing with the coach again, maybe on a once-a-year basis, about these goals and make sure we're meeting them on target."*

Two of the five coaches reported that it may have been advantageous for them to have more support. Specific suggestions mentioned included setting up a meeting for coaches and formulating guidelines or a model for coaches in the program.

EXPERIENTIAL LEARNING ACTIVITIES

Finally, the third component of the Trustee Advantage program was an experiential learning activity. Each hospital Board selected an experiential learning activity intended to build Board expertise in — and commitment to — improvement in clinical quality and patient safety. These activities were chosen by each hospital with input from BCBSMA and, in some cases, from the hospital’s coach. The selected activities are shown below in Table 9. Although the intent was that the full Board would participate in the experiential learning activities, in practice, this only occurred at Lowell General.

Table 9
Trustee Advantage Experiential Learning Activities at Each Hospital

BID–Needham	<p><i>Institute for Healthcare Improvement, 21st Annual National Forum on Quality Improvement in Health Care:</i> The Institute for Healthcare Improvement works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action. Every year, the National Forum refuels the tanks of leaders of change, from executives to the front line. Attendees participate in workshops, speaker presentations, and exhibits over the course of four days on the issue of quality improvement in health care. A delegation of 10 Board members and members of the management team attended the conference.</p>
Emerson	<p><i>1. Site visit, McLeod Regional Medical Center, Florence, SC:</i> Visitors to the medical center participate in a variety of activities, including a tour of the facility, patient rounds, goal-setting workshops, physician engagement presentations, and one-on-one meetings with the Patient Care Assessment Committee. A combination of senior staff (CEO, CMO), Board Quality Committee members, Board members, and medical staff leaders attended.</p> <p><i>2. Value Capture:</i> The organization facilitates leader observations on the hospital floor of how work is done, how problems occur, and how the organization tries to solve them. After structured discussions, leaders design and test improvements to strategy, structure, and daily management. Finally, the leadership team does operational planning toward embedding in the DNA of the organization the structures and strategies they have self-discovered may be necessary to reach transformational levels of performance. A combination of senior staff (CEO, CMO), Board Quality Committee members, Board members, and medical staff leaders attended.</p>
Harrington	<p><i>Site visit, Johns Hopkins Hospital, Center for Innovation in Quality Patient Care, Baltimore, MD</i></p> <p>Attendees of this one- to three-day session meet with Johns Hopkins staff, nurses, and faculty physicians as part of a customized workshop tailored to individual hospitals’ needs and designed to lead a quality revolution. A group who represented the three constituencies — senior management, the Board of trustees, and the medical staff — traveled to Johns Hopkins.</p>
Lowell General	<p><i>Value Capture:</i> See description above. At Lowell, a total of 17 members of the PCAC, Board of Trustees, and senior administration participated. A second session was conducted several months later for those trustees who were unable to attend the first session.</p>

Winchester

Value Capture: See description above. At Winchester, the officers of the Board participated later shared their experiences with the Board members who were unable to participate.

Note: All information about the experiential activities was compiled from the organizations' websites. Information on who participated in the activities was obtained from the hospitals' final reports to BCBSMA; for Harrington, information on Harrington's site visit was obtained from interviews with the CEO and Board Chair.

What Were the Most Valuable Aspects of the Experiential Learning Activities?

GRG noted five valuable aspects of the experiential learning activities, as discussed by the CEOs and Board Chairs:

- **The experiential learning activities offered a perspective that was different from the one the trustees usually see.** Whether they were observing practices at model, best-in-class hospitals, shadowing front-line staff at their own hospitals, or hearing a variety of expert presentations on relevant topics, all of the experiential learning activities offered an alternative perspective and new ideas to participants. Chair and CEO comments included *"It really speaks the need for senior people and Board members to have front-line experience to see what's really going on"* and *"We got to learn from [model hospital], which had a great program and were very open about confessing that they didn't necessarily have everything down; they still make mistakes and are trying to improve things."*
- **The experiential learning activities were vivid and intense and, therefore, memorable.** As one Chair said, *"I think that was very impactful because it was very hands on and you could touch it and see it and feel it."* A CEO noted that the Value Capture experience *"was a real eye opener for the Board members. So it took a lot of what they had been hearing about in a rather abstract fashion and helped it make very real, very substantive, very concrete for them, and they began to appreciate just how difficult it is to change a process, change a workflow or a system, because there are so many interdependencies."*
- **The experiential learning activities could be galvanizing to participants.** One CEO said *"It was an 'aha' moment where we all said, wow, there's so much more we can and need [to] and will be doing, and who are the leaders that are going to take us there...in the medical staff, Board, and lead management."* A Chair described a site visit as *"really impactful on two people in particular. One was the Chair of the Quality Committee, who had been frustrated in his ability to get things going, so I think he felt energized in the visit and the subsequent activities."*
- **The experiential learning activities took participants away from their daily routine.** This allowed participants to devote more time, attention, and focus to what they were learning. One CEO described it this way: *"If you're caught up in the same old, same old every day, you don't have the focus sometimes, and this allowed them to have the focus to listen, learn, ask questions in an environment where they didn't have to worry if they were seeing patients in ten minutes."*

- **Because experiential learning activities were conducted as a group, they allowed for bonding.** This was likely especially important when members of different constituencies — management, the Board, and medical staff — were participating in the activities. A CEO noted, *“Much more importantly [than the specific takeaways], we sat as a group, we learned together, we bonded, we had dinners together, we had lunch, we had interactions, we had memorable occasions. There was a value and a gain and an upside to all that alone.”* Similarly, a Board Chair said, *“A lot of us went together as a group, so we had this off-campus, away-from-the-pressures-of-the-office stance to just be together and talk about things.”*

How Could the Experiential Learning Activities Be Improved?

Several CEOs and Board Chairs would have liked to see the experiential learning component extended or expanded upon. A CEO of one of the participating hospitals suggested, *“I would almost make job shadowing part of the program — the nurses and the docs, I would make that a mandatory part of the program. I would have a little bit more on the experiential learning.”* A Chair of one of the hospitals felt that the experiential learning component would have had a bigger impact if the entire Board had been able to participate, as intended by BCBSMA in its design of the Trustee Advantage program.

Finally, one of the Project Coordinators noted important conditions facilitating the success of experiential learning: *“The experiential learning component had the most powerful impact on the Board, management and physicians who participated. But it was important to do [the activity] within a planned process designed to culminate with setting a system-level aim. This made the experiences more relevant and actionable.”*

THE TRUSTEE ADVANTAGE PROGRAM MODEL

Overall, the three components of the Trustee Advantage program unfolded smoothly and operated well with only one or two bumps in the road. There were some small mid-course corrections to the learning community model to enhance opportunities for cross-hospital interaction. Overall, however, participants were pleased with all components of the program and had only a few relatively minor suggestions for improving the various components of the model, as discussed above. Participants also had a few suggestions that went beyond tweaks to the individual components of the program model, many involving extending the impact of the Trustee Advantage program.

How Could the Overall Trustee Advantage Program Model Be Improved?

Several participants suggested continuing the learning community sessions beyond the end of the Trustee Advantage program. Others suggested incorporating more of the medical staff into the program by involving them in the learning community sessions and in more of the activities. Another participant noted that *“Physicians are critical to success in quality. And it’s hard to find well-qualified physician leaders. If the program could add a physician leadership training component, it could make a difference in their level of engagement and their understanding of their role.”* The same participant also suggested involving the entire Quality Committee *“to keep [them] in sync with what*

the core group was learning [and] become a team that was learning and developing their quality leadership skills together.”

Suggestions were also made to extend the reach of the program to other hospitals, in line with BCBSMA’s goal to scale the program up if it proves successful. One trustee said, *“I wish all hospitals could do this — I would like to see groups of hospitals, perhaps by region, get together to continue the quality and safety conversation. We can all learn from each other, and the goals of patient safety should be common to all of us and should be a non-competitive discussion.”*

Two Board Chairs also mentioned they would have liked the opportunity to tour the other hospitals participating in Trustee Advantage, extending both the learning community and experiential learning aspects of the program. One stated, *“It’s one thing for people to put on a presentation...but actually to go to the hospital and sit through an actual Board meeting with them to see their procedures.”* Another said, *“I don’t know why visits or the meetings couldn’t have occurred in conjunction with at least one of the visits to the hospital.”*

OUTCOMES EVALUATION: WHAT WAS THE IMPACT OF THE TRUSTEE ADVANTAGE PROGRAM?

This section examines outcomes including:

- Knowledge gains,
- Favorable attitude changes,
- Reported physician engagement gains,
- Improvements in quality and safety governance practices, especially those linked to objective quality and safety outcomes,
- Hospital self-assessments of progress, and
- The extent to which the Trustee Advantage program gave participants the tools they need to move forward.

The section also discusses:

- Facilitators and barriers in the quality and safety governance journey, and
- The absolute and relative impact of each of the three components of the Trustee Advantage program.

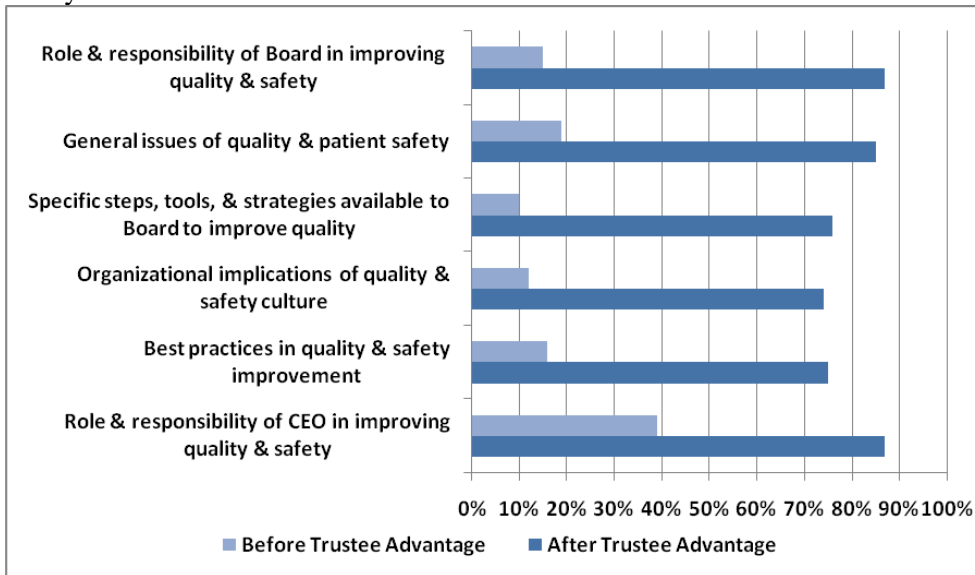
The primary data for the outcomes evaluation come from the trustee-CEO surveys (see Appendix D for annotated trustee-CEO surveys) and the hospital data forms.¹⁶ Illustrative quotes from trustees, CEOs, Board Chairs, Project Coordinators, and coaches are also included throughout.

¹⁶ Blank copies of the hospital data forms are included in Appendix A: Instruments. However, completed forms are not included as an appendix to maintain hospital confidentiality.

KNOWLEDGE GAINS

The Trustee Advantage program resulted in significant gains in scores on a six-item measure of knowledge of quality and safety. Scores increased by over a point on a 5-point scale, to an average rating of *very knowledgeable* across the six items. As shown in Figure 2, these gains were remarkably large, averaging a fivefold increase in the number of respondents describing themselves as *very* or *extremely* knowledgeable in those areas. These gains were especially notable for knowledge of Board’s role in quality and safety, general quality and safety issues, and specific steps, tools, and strategies for Boards to improve quality.

Figure 2
Change in Percentage Rating Themselves as *Very* or *Extremely* Knowledgeable about Quality and Safety Issues

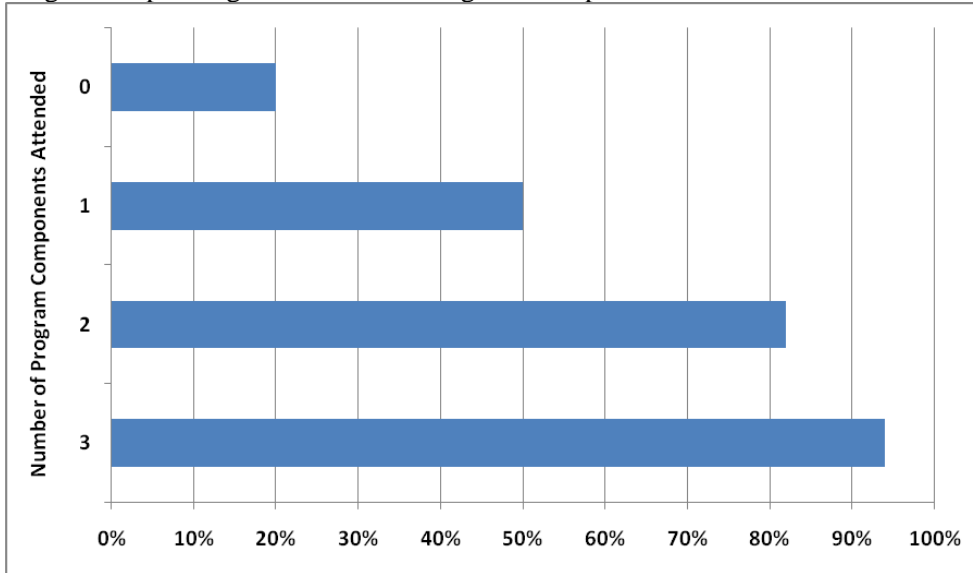


N = 58-61 respondents who took both pre-program and post-program surveys.

Another item asked more directly about the Trustee Advantage program. Almost two-thirds (64%) of respondents described themselves as having learned *quite a bit* or *a great deal* as a result of the Trustee Advantage program. As one trustee noted, s/he had “*learned more re: patient safety/quality from program than in previous three years on the B[oard] o[f] D[irectors].*”

Not surprisingly, as shown in Figure 3, the more program components — learning community, coaching, or experiential learning activity — the respondent attended, the more s/he learned. Interestingly, however, 20% of those who did not directly participate in the Trustee Advantage program still reported learning *quite a bit* or *a great deal* as a result of the program, indicating that those who did participate were disseminating the knowledge they gained to other trustees at their hospitals.

Figure 3
Percentage Reporting Learning *Quite A Bit* or *A Great Deal* as a Result of Trustee Advantage Program Depending on Number of Program Components Attended

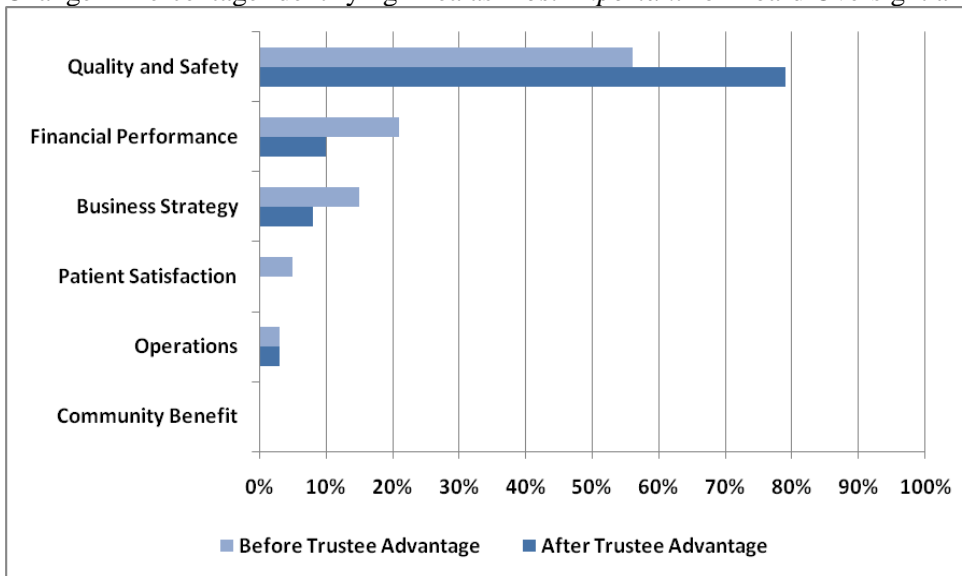


N = 58-61 respondents who took both pre-program and post-program surveys.

ATTITUDE CHANGES

In addition to knowledge gains, the Trustee Advantage program also resulted in several favorable attitude changes. The number of respondents saying that quality and safety was *the most important area* for Board oversight and governance rose from 56% to 79%, as shown in Figure 4. Ten percent of respondents continue to rank financial performance first, down from 21%.

Figure 4
Change in Percentage Identifying Area as *Most Important* for Board Oversight and Governance

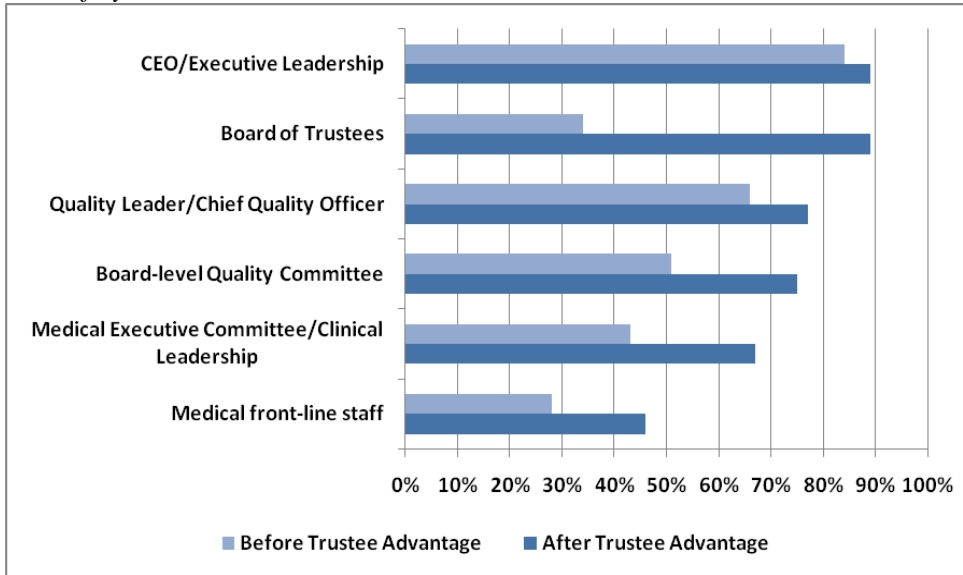


N = 61 respondents who took both pre-program and post-program surveys.

Respondents also perceived a significant increase in agreement between the Board and executive leadership on the hospital's quality and safety improvement goals. The rating before the Trustee Advantage program began was still fairly high, averaging *general consensus*, but the percentage reporting *unanimity* more than doubled, from 23% to 58%.

In terms of champions, respondents identified a significantly larger number of key players and constituencies as being among *the strongest advocates of quality and safety* at their hospital. As shown in Figure 5, the greatest increase, from 34% to 89%, was in the percentage naming the Board of Trustees — that is, themselves, because most survey respondents were trustees — as champions. Importantly, the CEOs were perceived as strong champions even before the program began, which is likely related to the hospital’s willingness to apply for the Trustee Advantage grant as well as being an explicit criterion in BCBSMA’s decision to award the grant.

Figure 5
Change in Percentages Naming Key Players and Constituencies as *Strongest Advocates of Quality and Safety*



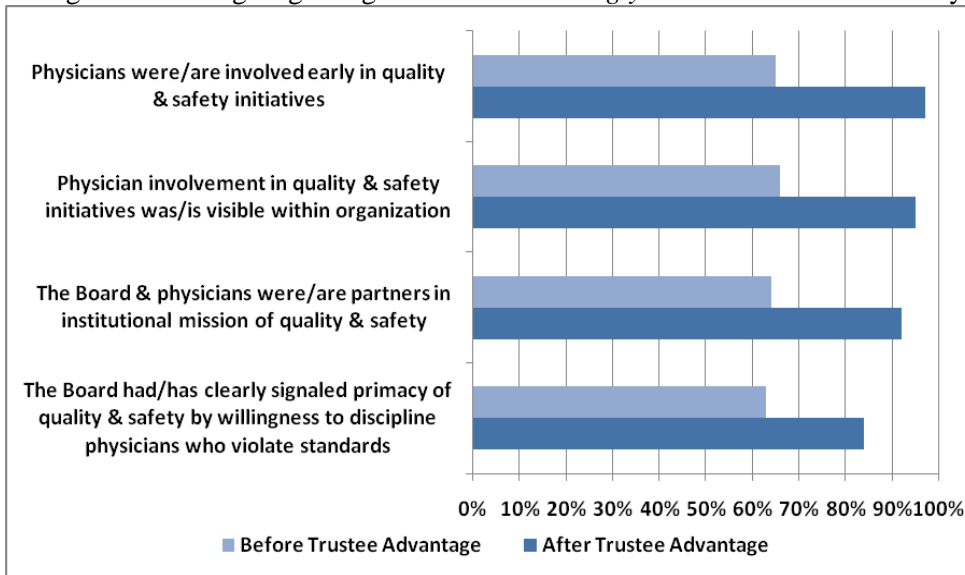
N = 61 respondents who took both pre-program and post-program surveys.

CHANGES IN PHYSICIAN ENGAGEMENT

Respondents perceived a modest but significant increase on a four-item measure of physician engagement, with the average rating moving from a point just under *agree somewhat* to a point midway between *agree somewhat* and *strongly agree* on a 4-point scale. Increases ranged from 21% to 32% in the percentage agreeing *somewhat* or *strongly* with each statement, as shown in Figure 6. Thus, in a familiar pattern, this measure indicates that the participating hospitals were already doing fairly well before beginning the Trustee Advantage program, but that they were doing significantly better afterwards.

Figure 6

Change in Percentage Agreeing *Somewhat* or *Strongly* with Statements about Physician Engagement



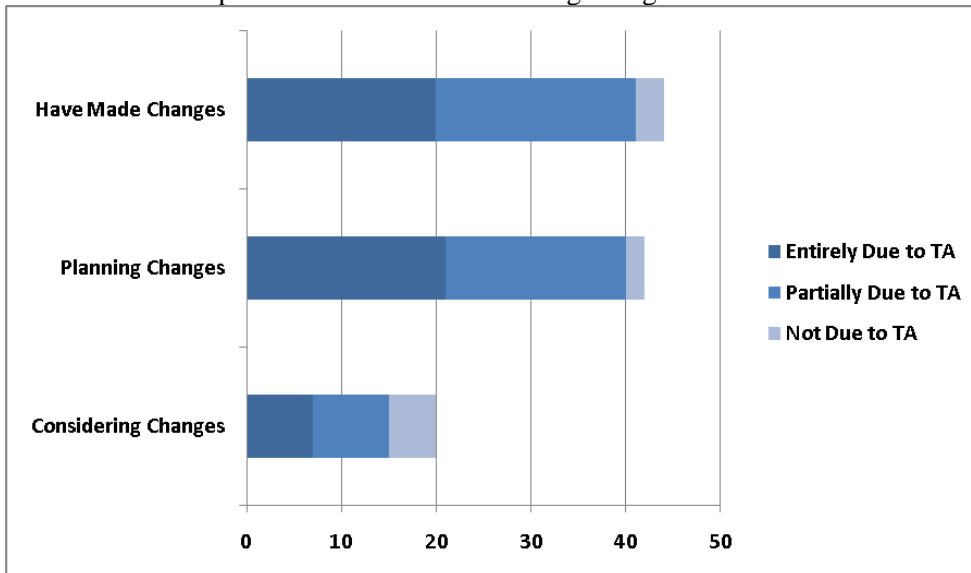
N = 57-60 respondents who took both pre-program and post-program surveys.

QUALITY AND SAFETY GOVERNANCE PRACTICES

One of the most important desired outcomes of the Trustee Advantage program is for hospital Boards to actually make changes in the direction of best practices in their governance of quality and safety. As shown in Figure 7, not only did participating hospitals make an average of close to nine such changes apiece, but they attributed the vast majority of those changes either entirely or partially to their participation in the Trustee Advantage program. The hospitals were planning to make almost as many changes in the next 12 months, and an average of four additional changes were under consideration at each hospital.

Figure 7

Total Number of Changes in the Direction of Governance Excellence and the Extent to Which They Are Due to Participation in the Trustee Advantage Program

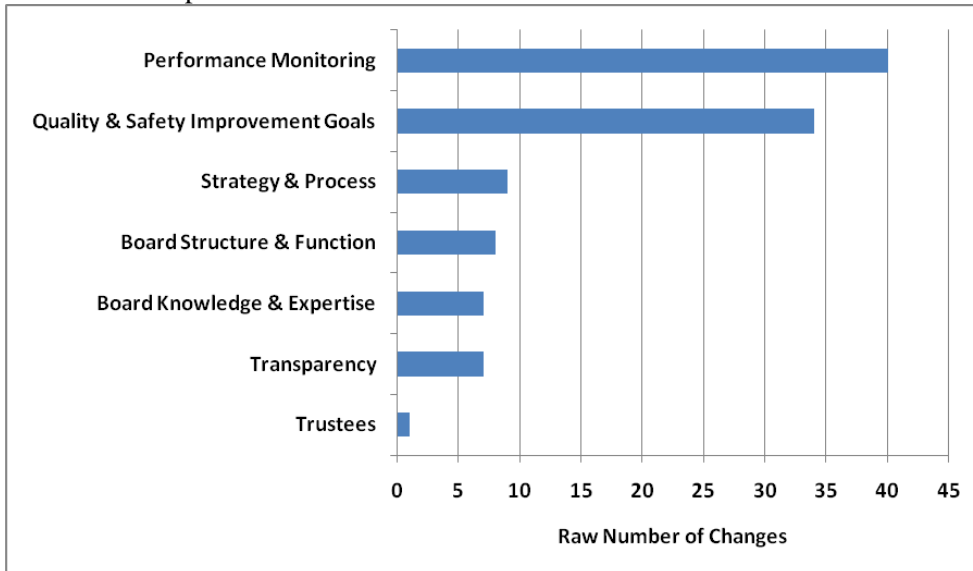


Note: All data on governance changes and the extent to which they were due to the Trustee Advantage program came from hospital data forms filled out by the Project Coordinators.

What Kinds of Governance Changes Did the Hospitals Make?

Not surprisingly given the content of the Trustee Advantage program, most of the governance changes the hospitals made, planned to make in the next 12 months, or were considering fall into the areas of performance monitoring and quality and safety improvement goals (see Figure 8). Under performance monitoring, several of the hospitals are now putting quality and safety on the agenda at more Board meetings, devoting a greater percentage of the meeting to quality and safety, and including more — or more vivid — patient safety stories. Under quality and safety improvement goals, several of the hospitals are now increasing medical staff involvement in setting and approving these goals, setting target dates for achieving the goals, and, in general, moving toward goals that are more measurable, time-bound, realistic, and ambitious.

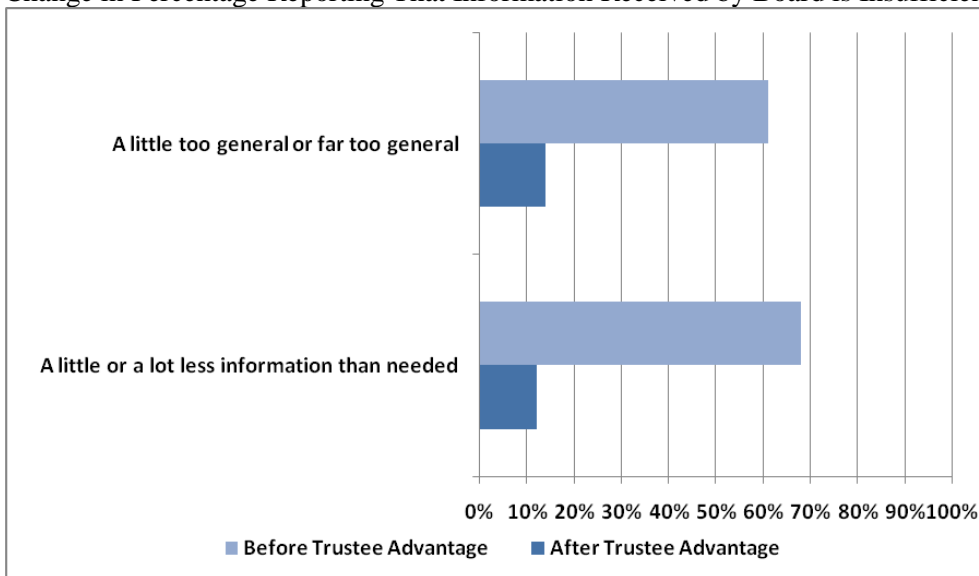
Figure 8
 Content Areas of Actual, Planned, or Considered Changes in the Direction of Governance Excellence Across All Hospitals



Note: All data on governance changes and the extent to which they were due to the Trustee Advantage program came from hospital data forms filled out by the Project Coordinators.

All of the participating hospitals made changes in the direction of best practices in terms of the quality and safety information presented to the Board. Therefore, it is not surprising that, as shown in Figure 9, the percentage of respondents reporting that the information the Board receives is insufficient dropped precipitously after the Trustee Advantage program. Correspondingly, the percentages tripled of those who reporting receiving *just the amount of information that is needed* (14% to 58%) and *just the right level of detail* (24% to 75%).

Figure 9
 Change in Percentage Reporting That Information Received by Board is Insufficient

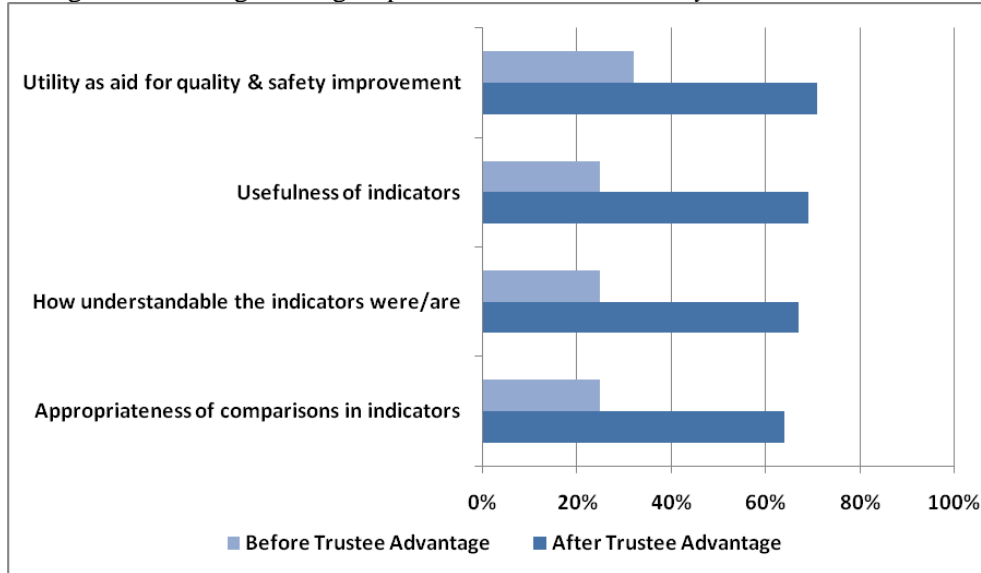


N = 57-61 respondents who took both pre-program and post-program surveys.

Three of the hospitals made changes to their quality and safety dashboards, one was planning to make changes in the next 12 months, and one was on the verge of instituting a dashboard at the end of the Trustee Advantage program. Excluding the latter hospital, respondents reported a significant increase on a four-item measure of dashboard quality, from just below *good* to just below *very good*, on average, on a scale ranging from *poor* to *excellent*. Changes for specific items are shown in Figure 10.

Figure 10

Change in Percentage Rating Aspects of Dashboard as *Very Good* or *Excellent*



N = 44-45 respondents who took both pre-program and post-program surveys, excluding respondents from the one hospital that did not have a dashboard during the course of the Trustee Advantage program.

To What Extent Did the Hospitals Make Governance Changes That Have Been Linked to Objective Quality and Safety Outcomes?

Despite the growing literature on best practices in hospital governance of quality and safety, studies empirically linking governance practices to objective quality and safety outcomes remain quite scarce. Three exceptions are studies conducted by Thomas Vaughn and his colleagues in 2006, H. Joanna Jiang and her colleagues in 2009, and Ashish Jha and Arnold Epstein in 2010.¹⁷ Importantly, even these studies only show a link between governance and safety outcomes at a single time point and do not demonstrate that the governance practices *cause* the quality and safety effects, a crucial

¹⁷ Vaughn et al. (2006) surveyed 413 hospitals in eight states and linked their reported governance practices to CareScience Quality Index scores, an inpatient quality rating system based on risk-adjusted measures of morbidity, mortality, and medical complications. Jiang et al. (2009) surveyed 490 CEOs nationally and linked reported governance practices to performance on CMS process-of-care measures and Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI), which are hospital-level risk-adjusted mortality rates. Jha & Epstein (2010) surveyed 722 Board Chairs nationally and tested which of their reported governance practices differentiated high- and low-performing hospitals on Hospital Quality Alliance outcomes reported to that are reported to CMS.

question to be addressed in future research. Presently, though, these studies provide our best evidence of which governance practices are likely consequential for quality and safety performance.

Figure 11 lists the governance practices assessed in the evaluation that were linked to quality and safety outcomes in at least one of the three studies.¹⁸ The figure also includes the prevalence of that practice in those studies; these percentages can be used as a benchmark in assessing the quality of the governance practices of the hospitals participating in the Trustee Advantage program. For each practice, the figure shows the state of the five participating hospitals — each represented by one dot — before and after the program. In cases where hospitals improved their governance practices, the right column shows the extent to which improvements were attributed to the hospital’s participation in the Trustee Advantage program. There were a total of 15 improvements in safety-linked linked governance practices, all of which were attributed either entirely or partially to Trustee Advantage.

Figure 11
Changes in Empirically Safety-Linked Governance Practices at Participating Hospitals

Governance Practice (Benchmark)	Before TA Program	After TA Program	Changes Due to TA?
Hospital has formal training program covering clinical quality for Board (32% ^a)	● ● ● ● ●	● ● ● ● ●	●
Board is involved in setting quality agenda for the hospital (63% ^b)	● ● ● ● ●	● ● ● ● ●	—
Board has quality subcommittee (59% ^a , 60% ^b)	● ● ● ● ●	● ● ● ● ●	—
Board receives formal quality performance measurement report (80% ^c)	● ● ● ● ●	● ● ● ● ●	—
Quality performance on agenda at every Board meeting (63% ^a , 75% ^b)	● ● ● ● ●	● ● ● ● ●	● ● ¹
At least 20 ^{a,b} –25% ^c of Board time spent on quality issues (42% ^a and 40% ^b at least 20%, 28% more than 25% ^c)	● ● ● ● ●	● ● ● ● ●	● ● ●
Board reviews a quality dashboard regularly (72% ^a)	● ● ● ● ●	● ● ● ● ●	—
Board uses dashboard with national benchmarks (65-75% ^b)	● ● ● ● ●	● ● ● ● ●	●
Board reviews JCAHO Core Measures at least quarterly (57% ^a)	● ● ● ● ●	● ● ● ● ●	● ●
Board reviews infection rates at least quarterly (69% ^a)	● ● ● ● ●	● ● ● ● ●	● ●
CEO compensation linked to quality and safety indicators (66% ^c , 56% ^b , 44% ^a)	● ● ● ● ●	● ● ● ● ●	—
Hospital establishes strategic goals for quality improvement (80% ^b)	● ● ● ● ●	● ● ● ● ●	● ● ²
	● ● ● ● ●	● ● ● ● ●	● ● ³

Key

● Below Standard ● Close to Standard ● Meets Standard ● Exceeds Standard
 ● Entirely Due to TA ● Partially Due to TA

¹⁸ The studies also found evidence linking other governance practices that were not assessed in the evaluation to objective quality and safety outcomes; these practices are not presented here.

TA = Trustee Advantage.

^aJha & Epstein (2010). ^bJiang et al. (2009) ^cVaughn et al. (2006).

¹One green dot remained green, but there was a change indicated in the right-hand column. That hospital had quality on the agenda at every meeting, but they were only meeting quarterly, well below the standard. They doubled the number of meetings, keeping quality on the agenda at all of them, and attributed this change entirely to their participation in the Trustee Advantage program.

²Extent to which goals have dimensions needed for effective improvement: measurable, time-bound, realistic, and ambitious.

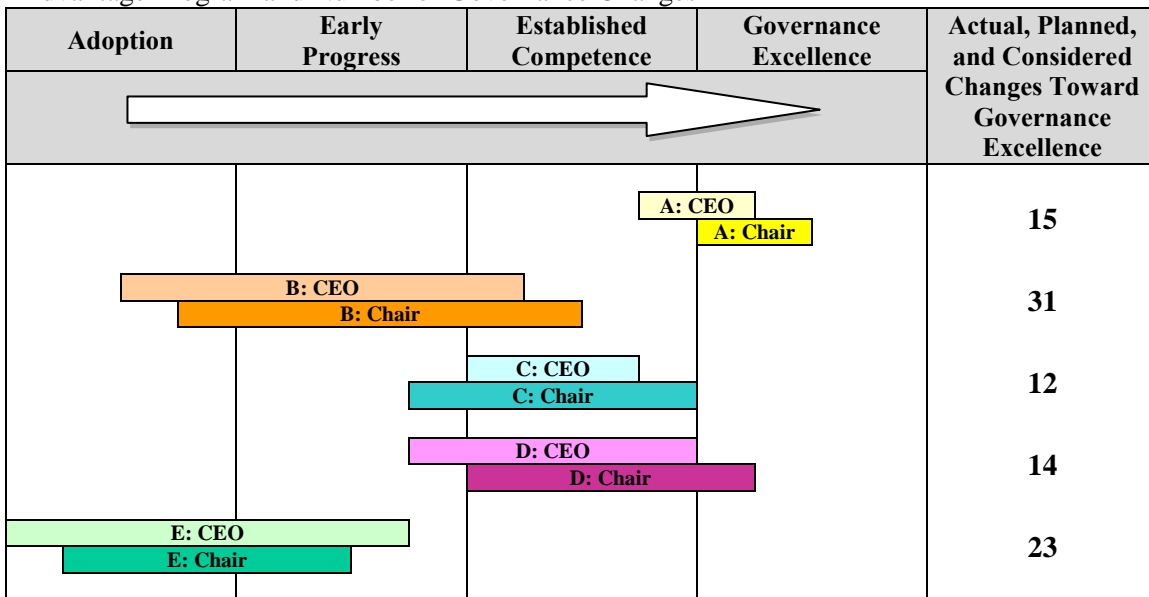
³Whether the hospital has an audacious quality and safety improvement goal with a target for completion.

HOSPITAL ASSESSMENTS OF PROGRESS

CEOs and Board Chairs were asked to assess their hospital’s starting and ending point along the TruePoint developmental framework continuum over the course of the Trustee Advantage program, as shown in Figure 12. The length of each bar is an indication of the amount of self-reported progress that each hospital made over the course of their participation in the program.

Figure 12

CEO and Board Chair Self-Assessments of Governance Stage at Beginning and End of Trustee Advantage Program and Number of Governance Changes



Note: All self-assessment data came from interviews with the Chairs and CEOs. A rater examined transcripts and coded the responses. At one hospital, both the incoming and outgoing CEOs had participated in the Trustee Advantage program; at another, both the incoming and outgoing Board Chairs had participated. In both cases, ratings were averaged for presentation in the figure above. All data on governance changes came from hospital data forms filled out by the Project Coordinators.

Again, it is apparent that the hospitals started at very different points on their quality and safety journeys, although the CEO and Chair assessments do not track perfectly with the more objective

assessments of quality and safety performance presented earlier in the Process Evaluation section, particularly for the “mid-pack” hospitals.¹⁹

However, Hospital A had the highest objective and coach-rated quality and safety performance in the earlier table, and, as shown in the figure, that hospital’s CEO and Board Chair described themselves as starting out at a very high level and making little additional progress during their participation in Trustee Advantage. This is consistent with their governance practices at baseline: On the hospital data form, Hospital A was already at governance excellence in almost every area measured even before the Trustee Advantage program began. The other hospitals simply had more room for improvement.

Interestingly, as shown in the rightmost column of the figure, across all hospitals, the CEO and Chair progress assessments track fairly closely with the number of changes that hospital reported making, planning to make in the next 12 months, or considering making to their governance practices. Unlike Hospital A, Hospitals C and D made relatively few changes compared to other hospitals despite the fact that their baseline governance practices did leave room for improvement, especially in the case of Hospital C.

Hospital A, although it was farther along than the other hospitals in its quality and safety governance journey on both subjective and objective measures, still gained from the Trustee Advantage program. When asked to discuss the return on investment of participating in the program, the CEO said, *“To the extent that we’ve bought into this idea and it’s helped us to affirm and maintain a path that we were already on as opposed to having the interest and the support for this drop off...then, in a sense, it was priceless.”* The Board Chair said, *“What I found interesting was the fact that a lot of [the other hospitals] were saying that, ‘You’re so far ahead here; we’re learning a lot from what you’re doing.’ That’s all well and good, but you can’t stop; you need to constantly work. We are an award-winning hospital for a lot of reasons, [but] there are always things that we can improve. I think the reason we are award winning is, we always improve.”*

TOOLS TO MOVE FORWARD

Respondents rated a series of seven statements about whether the Trustee Advantage program had given them the tools they need to move forward in their quality and safety journey. The majority gave the highest rating on the seven-point scale, *strongly agree*, to all of the items, as shown in Table 10. If the top two categories, *somewhat agree* and *strongly agree*, are combined, almost all respondents agree with the statements, with percentages ranging from 93–98%.

Table 10
Agreement with Statements about Trustee Advantage Program Effects

AS A RESULT OF MY HOSPITAL’S PARTICIPATION IN THE TRUSTEE ADVANTAGE PROGRAM, MY HOSPITAL:	Percentage Agreeing Strongly
...can effectively improve clinical quality and patient safety through Board governance.	83%
...has a greater commitment to improving Board governance of	80%

¹⁹ This may be partially due to the fact that we were restricted to publicly available quality indicators. CEO and Board Chair assessments are also likely prone to some degree of bias, particularly given that hospitals ordinarily have little opportunity to observe each other’s governance practices and, therefore, may not be fully aware of their relative standing in that regard.

quality and safety.	
...is more effective in carrying out its quality and safety oversight function.	75%
...will make changes in the direction of best practices in the Board's governance of quality and safety in the next 12 months.	74%
...understands what steps need to be taken to improve Board governance of quality and safety.	70%
...has gotten greater buy-in from various stakeholders in the hospital for improving Board governance of quality and safety.	66%
...has a more concrete plan for improving Board governance of quality and safety.	60%

N = 59-61 respondents who took both pre-program and post-program surveys.

Respondents also made a number of comments about what their hospitals had gained from their participation in the Trustee Advantage program. Several commented that participation had heightened awareness of quality and safety at their hospitals and contributed to progress in quality and safety governance:

Raised the level of awareness and action!

Trustees now understand their leadership role in quality and safety and are no longer giving "rubber stamp" approval of administrative policy.

It was always a priority at the hospital, but, in my opinion, it has made it the #1 priority, and it has caused us to focus and plan more effectively.

The program helped to focus our efforts by setting a one-year plan in place with specific deliverables and timetables.

Overall, participants were so pleased with the Trustee Advantage program and their progress in quality and safety governance that they planned to continue certain aspects of it on their own. For example, one hospital plans to incorporate an experiential learning activity much like Value Capture as part of the orientation for all new trustees. Participants also wanted other hospitals to be able to get the same benefits they did from the Trustee Advantage program, so would like to see it scaled up.

FACILITATORS AND BARRIERS

GRG noted a number of themes in discussions with coaches, CEOs, and Board Chairs about facilitators and barriers in the quality and safety journey. One of the biggest challenges is remaining focused over an extended period of time and in the face of multiple compelling distractions.

As one of the trustees noted, *"The presentations at the final session showed exciting promise but [there is] much more opportunity for learning and improvement across organizations. Premature declaration of victory is to be avoided. Changing a culture takes much more than a year or two."* Many observers believe that organizational transformation is required in order to make significant inroads in improving hospital quality and safety. Jim Reinertsen notes that such transformation can

take 10 to 15 years, quoting one hospital leader as saying that “*transformation is at least a 3-CEO problem.*”²⁰

Hospital Boards also face myriad distractions from a quality and safety focus, including financial and market forces, which can easily consume all of a Board’s attention. In fact, having adequate financial stability is probably a necessary precursor to making any progress at all in quality and safety governance. However, as one of the coaches and several of the CEOs noted, Boards can be reminded that quality and safety improvements can translate into financial benefits: “*With so much focus on the money right now, the challenge of remembering that critical outcomes — financial outcomes, service outcomes — different outcomes are all part of a whole. With a tremendous focus on cutting costs and saving a buck, it’s easy to be distracted by that digression and to forget that improvements in safety and quality can save costs.*”

When asked to name facilitators of quality and safety improvement, almost all of the coaches mentioned specific individuals or entities in the hospital who were committed champions of quality and safety. Champions can maintain forward momentum by serving as models and by bringing the focus back to quality when it begins to wander. Ideally, there should be champions in each of the three major constituencies within the hospital — executive leadership, the Board, and the medical staff — as each has a different role to play in driving quality and safety improvement.

One study²¹ found better quality and safety outcomes when the CEO was identified as the person with the greatest impact on quality improvement. The Board of Trustees can “*function as a deep reservoir of constancy of purpose,*”²² even in the face of leadership transition. Physician leaders have more credibility with other physicians, who can be challenging to get on board given that they are usually not employed by the hospital.

Good, functional relationships among members of these three groups are also key to forward progress. Several coaches and CEOs mentioned that CEOs must be able to tolerate a more activist Board than they may have been used to as part of getting Boards on board as quality champions:

- *[The CEO]’s been around for a while, and he’s part of the culture that the Board reported to the CEO, not that the CEO reported to the Board. I think that [now] he may have a new boss or a stronger boss in his Board. [The CEO] has been very supportive, welcomed this...there was no pushback. The Board of Trustees was getting their two legs and are assuming much more of their accountability and responsibility.*
- *I think it was a really good return [on investment] because, if anything, I feel like I created a lot of monsters. I just had lunch with one of my Board members, and he said, “Well, I don’t know how you feel to be setting up the Trustee Advantage thing,” and I said, “I love it; why?” and he said, “Well, we keep coming back with questions.”... I think that Trustee Advantage is fabulous because my Board came back asking all the right questions.*

²⁰ Reinertsen, J. L. (2007). *Hospital boards and clinical quality: A practical guide*. Toronto, ON: Ontario Hospital Association. Available at <http://www.reinertsegroup.com/publications/documents/Boards%20and%20Clinical%20Quality%20Ontario%20Hospital%20Association%202007.pdf>

²¹ Vaughn et al. (2006).

²² Reinertsen (2007).

One of the coaches noted that not all CEOs would welcome this: *“My biggest surprise was the willingness of the CEO to put it on the line...He didn’t duck from the fact that if we raised the expectations around the Board on safety and quality, it could reflect badly on him...I would’ve expected most CEOs to want to hedge their bets...He would be willing to say, if we can’t get it done, shame on me, shame on us. I thought that was courage, real leadership.”*

On a related note, two coaches mentioned some degree of defensiveness on the part of executive leadership and the Board as a barrier: *“There’s still some hesitance on the part of people to bring up [hospital]’s defects, and it’s absolutely necessary for them to bring up [hospital]’s defects for them to get better...I think the real issues are, culturally, this kind of inability to squarely face up to the current performance, both in administration and, lesser, on the Board.”* And *“I’m a consultant; I’m in there to help, and I met a bit of defensiveness...what I’m worried about is that they were concerned that this needs to be a thoughtful, not-too-accelerated, purposeful journey, and I think it needs to be quicker than that.”*

Progress is also facilitated by good relationships with the medical staff, and hampered by dysfunction or a negative past history, as mentioned by several of the coaches: One noted as a barrier that *“They’ve got a lot of cowboys on their medical staff.”* Another discussed a toxic past history between administration and the medical staff from many years ago that remained as a *“longstanding simmering problem”* with the potential to *“completely hijack the agenda.”* In contrast, good physician leaders can *“sustain the momentum...it would be really nice if they could identify a core set of physician champions, sort of like the apostles...I think that would be the most pivotal thing they could do.”*

Of course, momentum can also be maintained by making a number of the changes to Board structure and functioning that were made as part of the Trustee Advantage program in terms of improved dashboards, better performance monitoring, and so on. As one Chair noted in reference to these governance changes, *“I think we’ve established a good foundation for good, serious, ongoing work on quality.”* A coach said of another hospital, *“They have good data...With the dashboard much more focused, they’ll get a stronger sense and a clearer sense of what the issues are, and that’ll allow them to focus more and address these issues.”*

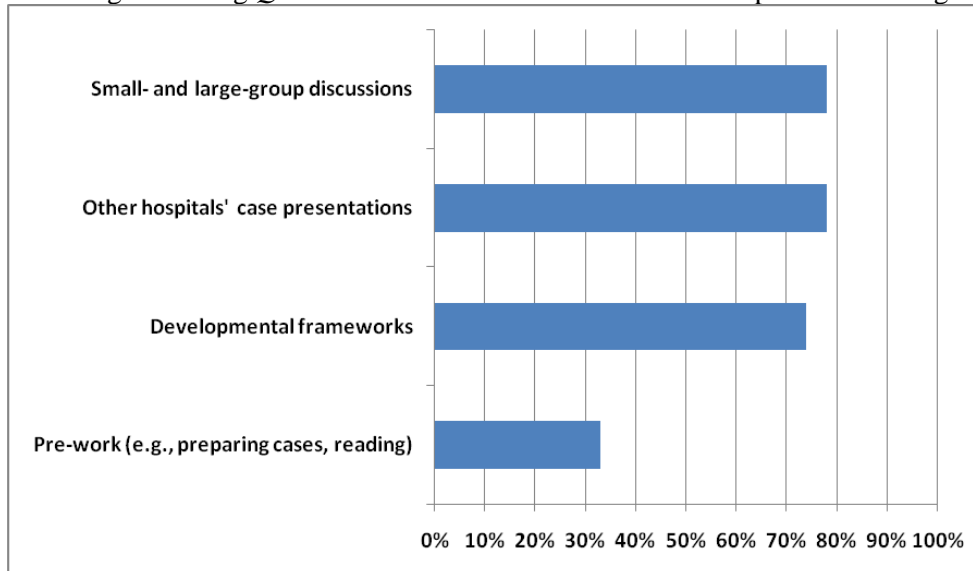
Finally, several of the participants also mentioned the lean resources a community hospital typically has to devote to efforts like this. As one coach said, *“This is not a gigantic hospital with all types of resources...I mean, [the quality lead] is it. He doesn’t have a deep staff, he doesn’t have research assistants...They’re a typical community hospital; they bring the typical amount of resources to bear that this type of hospital can on this issue.”*

IMPACT OF THE THREE PROGRAM COMPONENTS ON OUTCOMES

Nearly four in ten of respondents had attended at least one learning community session. Of those, 74% reported gaining *quite a bit* or *a great deal* of actionable information, and 64% reported that the learning community had *quite a bit* or *a great deal* of impact on Board governance of quality and safety at their hospitals. As shown in Figure 13, the majority of respondents rated the discussions, case presentations, and frameworks quite highly.

Figure 13

Percentage Learning *Quite A Bit* or *A Great Deal* from Each Aspect of Learning Community Sessions



N = 27 respondents who took both pre-program and post-program surveys.

Almost two-thirds (62%) of respondents had participated in coaching. Of those, 71% reported gaining *quite a bit* or *a great deal* of actionable information, and 71% reported that the coaching had *quite a bit* or *a great deal* of impact on Board governance of quality and safety at their hospitals.

Thirty-nine percent of respondents had attended one of the experiential learning activities that their hospital chose. Of those, 94%²³ reported gaining *quite a bit* or *a great deal* of actionable information, and 80% reported that the learning community had *quite a bit* or *a great deal* of impact on Board governance of quality and safety at their hospitals.

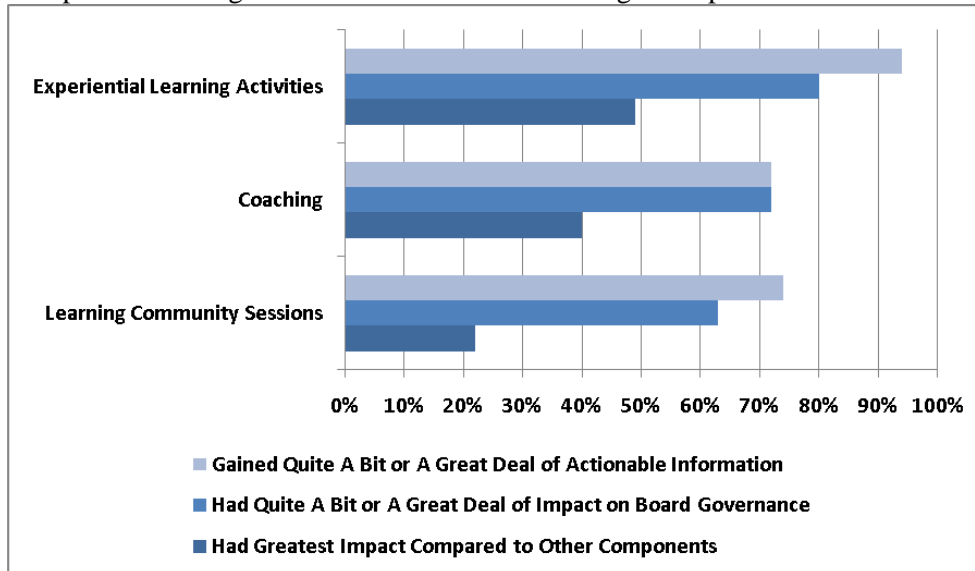
Which Program Component Had the Greatest Impact on Outcomes?

As noted above, respondents were asked to rate the amount of actionable information they gained from each of the three Trustee Advantage components and their impact on Board governance of quality and safety at their hospital. They were also asked to rank each of the three components as having the greatest, second greatest, and third greatest impact on governance. Responses to all of these assessments converged on the experiential learning activities as having the greatest impact of

²³ This represents the weighted average across the four different experiential learning activities.

the three (see Figure 14), although it is important to note that all three components of the program were well-received.

Figure 14
Comparative Ratings for the Three Trustee Advantage Components



For actionable information rating, N = 32 for experiential learning, 50 for coaching, and 24 for learning community. For impact ratings: N = 39 for experiential learning, 42 for coaching, and 38 for learning community. All respondents took both pre-program and post-program surveys.

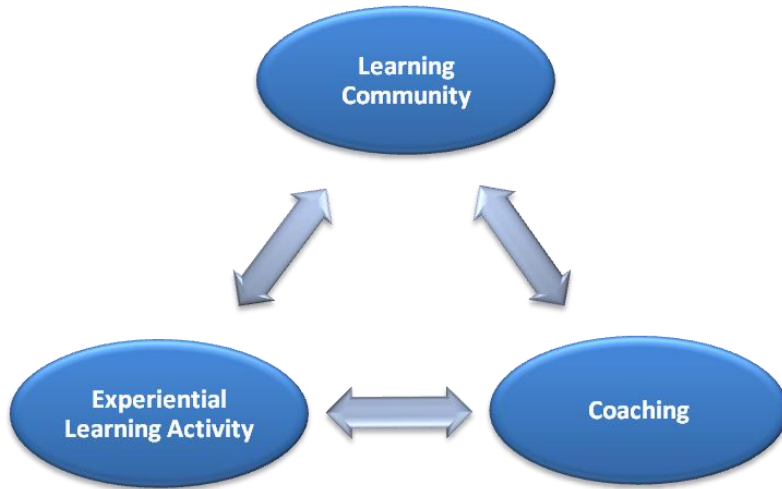
As noted in the process evaluation section, the experiential learning activities were vivid and dramatic; open-ended descriptions of these activities from the survey and interviews with participants included language like “wow,” “eye-opening,” and “‘aha’ moment.” This may account for respondents’ choice of it as the most impactful component. Coaching was rated as having the second greatest impact, and the learning community was rated as having the third greatest impact.

Because those who had personally participated in all three components were in the best position to judge relative impact, we examined their ratings separately. Interestingly, these participants gave higher ratings to the learning community than did those who were exposed to fewer program components, ranking it approximately equal to the coaching in terms of having *quite a bit or a great deal* of impact. This finding should be interpreted with some caution because participating in all three components was linked to hospital role — that is, these respondents were more likely to be CEOs, Board Chairs, and quality leaders — but it nevertheless suggests that the learning community was valuable.

Further, the survey forced respondents to rank the components. In the interviews with CEOs and Board Chairs, four of 12 refused to choose, saying things like, “*I wouldn’t separate them that way...I really think they’re all important parts of it and they built upon each other, so I’d hate to pull out one of the bricks in that wall. I think I would recommend them all.*” Others detailed the specific things their hospitals had gained from each component; for example: “*They all had different contributions. The [experiential learning] gave people hands-on, on-the-ground experience, and it was very helpful and gave people perspective. The coaching, which included advice and facilitating sessions, was very successful because we had these goals and we were able to get these done by having an expert coach.*”

The learning communities were good because those helped us get perspective.” Figure 15 illustrates the synergistic effect of the three components.

Figure 15
The Trustee Advantage Components Work Synergistically



CONCLUSIONS

THE TRUSTEE ADVANTAGE PROGRAM WAS WELL DESIGNED

Overall, the three components of the Trustee Advantage program unfolded smoothly and operated well. The learning community allowed participants to assess their own hospital's progress compared to others, learn from other hospitals' successes and mistakes, and build a network of other hospital leaders. The coaches brought technical expertise, credibility, and a broader outside perspective. For the three hospitals that didn't already have an audacious quality and safety improvement goal, the coaches helped two hospitals set such a goal and the third hospital make significant progress in that direction. The experiential learning activities offered a new perspective, were memorably dramatic, galvanized participants, and allowed hospital teams to focus and to bond.

THE THREE PROGRAM COMPONENTS OPERATED SYNERGISTICALLY

Although participants gave a slight edge to the experiential learning activities over the coaching and the learning community in terms of their impact on trustee knowledge and governance practices in their hospitals, a number of participants noted — and GRG's assessment confirmed — that the three components operated in a synergistic, mutually reinforcing manner. Each component had some unique features and was helpful in a different way, and content derived from one component was often reinforced by another component.

THE TRUSTEE ADVANTAGE PROGRAM LED TO DRAMATIC KNOWLEDGE GAINS

The Trustee Advantage program resulted in remarkable increases — averaging fivefold — in participants' reported quality and safety knowledge, particularly with regard to general quality and safety issues, the Board's role, and specific steps, tools, and strategies. There was also evidence that, to some degree, participants disseminated their knowledge to other trustees who did not participate directly in the program.

THE TRUSTEE ADVANTAGE PROGRAM HAD A FAVORABLE IMPACT ON ATTITUDES

The program resulted in several favorable attitude changes. The number rating quality and safety as the most important area for Board oversight rose from just over half to four out of five. Agreement between the Board and executive leadership on quality and safety improvement goals started fairly high, but rose even higher. More quality and safety champions were identified after the Trustee Advantage program, with the greatest increase in those identifying the Board of Trustees as a champion. Importantly, CEOs were already champions before participating in the Trustee Advantage program, likely accounting for their hospitals' willingness to participate. Respondents also perceived a modest but significant increase in physician engagement.

PARTICIPATING HOSPITALS MADE GOVERNANCE IMPROVEMENTS AS A RESULT OF PARTICIPATING IN THE TRUSTEE ADVANTAGE PROGRAM

Participating hospitals made a number of improvements to their quality and safety governance practices, the vast majority of which they attributed either entirely or partially to their participation in the Trustee Advantage program. On average, each hospital made almost nine changes in the direction of governance excellence, and planned to make a similar number of additional changes in the year following the end of the program. Most of the changes the hospitals made, planned, or considered were in the areas of performance monitoring and quality and safety improvement goals. The performance monitoring improvements were further reflected in increased reports that trustees were receiving the right amount of information at the right level of detail and — for the four hospitals with dashboards — that the dashboards were useful.

A NUMBER OF THE GOVERNANCE IMPROVEMENTS HOSPITALS MADE WERE IN AREAS LINKED TO BETTER QUALITY AND SAFETY OUTCOMES

The hospitals made a total of 15 improvements to governance practices that have been linked in past research to better objective quality and safety outcomes. All of these changes were attributed either entirely or partially to the hospitals' participation in the Trustee Advantage program. These changes include, but are not limited to, instituting a formal quality and safety training program for Board members, putting quality performance on the agenda at more Board meetings, and spending more time at each meeting on quality.

THE QUALITY AND SAFETY JOURNEY IS FACILITATED BY FACTORS ALLOWING FOR CONTINUED FOCUS AND MOMENTUM

One of the biggest challenges in the quality and safety journey is sustaining focus and momentum in the face of multiple competing demands for attention. Financial stability — and perhaps CEO buy-in and tolerance of an activist Board — are probably necessary precursors to making progress. Other facilitators include continual reinforcement of the idea that better quality can equal lower cost, having champions among the Board and medical staff as well as executive leadership, the existence of good relationships among those three constituencies, being open to discussing “bad news” and deficiencies in the service of improvement, setting up a self-sustaining system that keeps the Board's focus squarely on quality and safety, and, where possible, infusing resources such as the Trustee Advantage program's financial and technical assistance into hospitals that lack the resources to address quality and safety on their own.

PARTICIPANTS ARE CONTINUING SOME ASPECTS OF THE TRUSTEE ADVANTAGE PROGRAM ON THEIR OWN

Participants were so pleased with the Trustee Advantage program and their progress in quality and safety governance that they planned to continue certain aspects of it on their own. Further, they also wanted other hospitals to be able to get the same benefits they did from the Trustee Advantage program and so would like to see it scaled up.

THE TRUSTEE ADVANTAGE PROGRAM IS ONE STEP IN A LONGER QUALITY JOURNEY FOR HOSPITALS

Transformative change in quality and safety governance cannot be accomplished overnight. Participants saw the Trustee Advantage program as accelerating their quality and safety journey significantly, an assessment that is supported by improvements in trustee knowledge and attitudes and in actual governance practices. Because of their prior commitment to improvement, most of the hospitals had participated in other quality and safety improvement and governance initiatives prior to or concurrently with the Trustee Advantage program, and all indicated that their quality and safety journeys were still ongoing.

RECOMMENDATIONS

USE LEARNING COMMUNITY TO MAINTAIN FOCUS AND MOMENTUM

Although it will be logistically challenging, learning community sessions should be scheduled closer together, perhaps every six weeks, to maintain focus and momentum. Although some participants wanted to see larger teams and more involvement of medical staff in the learning community, GRG recommends keeping the teams at five to six people per hospital so that the overall group size remains manageable and the focus remains on the role of Boards of Trustees in quality and safety governance. Further, opportunities for cross-hospital sharing and discussion should be maximized, which might be more difficult if the group size got too unwieldy.

CONSIDER CONTINUING THE LEARNING COMMUNITY BEYOND THE LIFE OF THE PROGRAM

GRG recommends examining the feasibility of making the learning community self-sustaining past the end of the Trustee Advantage program to keep the hospitals on track. Participating hospitals could rotate responsibility for logistics, and session topics and activities could be tailored to participant needs and interests. If meetings were every six weeks, each hospital would only have to run a session every seven months or so; alternatively, sessions could be spaced further apart after the end of the Trustee Advantage program proper. However, it would be important to consider whether the right balance could be struck between the commitment of time and effort involved and the value of continuing the learning community. A less time-intensive model might be to just have follow-up meetings twice a year for a few years after the end of the program so that participating hospitals could share their progress and lessons learned as they continued to move along the path toward quality and safety governance excellence.

REFINE THE STRUCTURING OF THE COACHING ENGAGEMENT

GRG recommends following one of the coach's suggestions for coaches to schedule at least three sessions with the hospitals: one for fact-finding, one to deliver recommendations, and one to check in on the hospital's implementation of the recommendations, and then perhaps adding a "booster shot" coaching session 12 to 18 months later. It is also worth considering the idea of having the coaches who participated in the program formulate some guidelines for future coaches, although it is

important not to impose so much structure that participating hospitals lose the ability to tailor the coaching to their own particular needs and context.

THE PROGRAM COULD BE SCALED BACK BY BUILDING A MODEL AROUND EXPERIENTIAL LEARNING

The experiential learning activities produced a lot of “bang for the buck,” especially in terms of the short time commitment required of the hospital leaders. It is likely that this component had a larger effect as part of the Trustee Advantage program than it might have had on its own because it built on and was reinforced by the learning community and the coaching. If it were necessary to scale back the program significantly, a model could be built around the experiential learning piece. However, it would be very important for the hospitals to have the guidance of a coach or facilitator in planning the activity and in debriefing afterwards in order to extract the maximum value from it. In fact, because the full Trustee Advantage model was so successful, it would be preferable to scale it up with all three components intact.

ENHANCE KNOWLEDGE TRANSFER TO NON-PARTICIPANTS

To address concerns about involving more trustees directly in the program, GRG recommends increasing the emphasis on all trustees participating in the experiential learning component and perhaps in the coaching. There was some degree of transfer of knowledge from participants to nonparticipants at their hospitals, but participants could be given more support around how best to disseminate the knowledge they gain to those who are not participating directly in the program. It is also worth considering creating a physician leadership training component, as suggested by one of the Project Coordinators, whether this is added to the Trustee Advantage program or is a stand-alone program.

CHOOSE HOSPITALS THAT CAN BENEFIT MOST FROM TRUSTEE ADVANTAGE

One consideration in scaling up the model is that hospitals should be vetted for their readiness to benefit from the program, as BCBSMA did with these five hospitals. The hospital must have sufficient financial stability that finances do not become a distraction from the focus on quality and safety. Hospitals whose CEOs are champions of quality of safety are in the best position to benefit from a program like Trustee Advantage. The CEO should welcome increased personal accountability for quality and safety and be comfortable dealing with a Board that becomes increasingly activist around quality and safety issues. Additional champions on the Board and among medical staff would also enhance a hospital’s ability to make progress, as would a culture of openness and willingness to confront the hospital’s deficiencies in the service of improvement.

The hospital should have demonstrated some progress on quality and safety improvement; otherwise, as one CEO pointed out, there would be potential for embarrassment on the part of the Board and the management team. A mix of hospitals at different points in the quality and safety journey worked well for Trustee Advantage. Hospitals that are farther along in their quality and safety journey can serve as models for the others. Although their own improvement may not be dramatic because they have a shorter road to travel to excellence, they can make gains as well, as discussed above.

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