

THE CHARACTERISTICS OF EFFECTIVE QUALITY COUNCILS

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I will share with you some of what I have learned about the characteristics of effective health quality councils and similar organizations. I draw much of my evidence from my experience since 2002 as a founding board member of the Health Quality Council of Saskatchewan, the first one in Canada and, on a per capita basis, the best-funded of any that I know about in any country. I also draw on my direct observation of quality councils and council-like organizations in several states as well as in Australia, England and Scotland.

Most of these quality improvement organizations have been created by government, usually states, by Canadian provinces and, in the UK, countries with devolved government. But several very effective council-like organizations have other auspices. By my informal count about 8 states and 5 Canadian provinces have established quality councils of some sort.

All these organizations are part of a significant international development in health affairs that I call the convergence of science and governance. This development has been in the making for about half a century, but it is only in the past decade or so that it moved from wishful thinking or demonstration projects to become formalized in health policy.

The convergence of science and governance in health affairs has several causes that you know quite well:

- Perhaps most important, convergence is a response to unsustainable increases in spending for health services, much of it attributable to the introduction of new technology, some it a result of the growing burden of chronic disease.
- Second, convergence also responds to a growing array of persuasive findings about the effectiveness of interventions to prevent and treat disease. These findings are persuasive because of advances in the methods of measuring quality and safety and in the different methods for evaluating the effectiveness and efficiency of health services.
- Third, convergence responds to the increasing documentation of problems in the quality and safety of health services; particularly documentation of unwarranted variation in the utilization of health services and studies of the misuse, overuse, and underuse of services.

There is considerable evidence that the convergence of science and health policy is occurring, especially in state government and in large health plans and provider systems. The organizations that best exemplify convergence are evaluating evidence about the effectiveness of interventions and the quality and safety of providing them. No less important, these organizations have established formal processes by which evidence informs clinical, institutional, and financing policy. To some extent, these processes insulate quality improvement organizations from the politics of interest and advocacy groups. I am in danger of saying more than you want to know today on this subject because I have a book about it in press; enough context for now.

The quality or quality and cost councils that have been established by the public sector are an important part of the story of this convergence of science and governance.

So are similar organizations that have other auspices. Here are three examples of such similar organizations: In Minnesota leading medical groups and provider organizations established the Institute for Clinical Systems Improvement (called ICSI); it is financed by major non-profit health plans in the state. The Wisconsin Collaborative for Health Care Quality originated among private sector purchasers. A third example is Kaiser Permanente, which I sometimes describe as a mid-size EU country that offers universal coverage. KP calls its equivalent of a quality council the Care Management Institute.

The work of quality councils and similar organizations varies considerably in both scope and effectiveness. Here are my impressions of the characteristics of high performing quality councils and council-like organizations. I will list five of these characteristics, offer more detail about each of them, and then add a sixth about which I am more tentative. The five characteristics are:

- Stakeholder involvement that is broad, deep and profoundly committed
- Commitment to rigorous and sophisticated measurement and dedication to extensive public reporting of the results of measuring
- Expert boards of directors that work closely with staff to shape what is measured, how information about quality, safety and cost is reported and, no less important, how and by whom information obtained by measurement and its potential significance is explained
- The conviction that effective quality improvement goes beyond the avoidance of blaming and shaming members of the healthcare workforce to include as well genuine concern for both their professional satisfaction and the satisfaction of their patients

- Skillful use of what I call the regulatory shadow to persuade health professionals and provider organizations that voluntary action to improve quality and to spend more efficiently is in their best interests

Now for a few examples.

STAKEHOLDER INVOLVEMENT

Successful quality councils listen hard to stakeholders, involve them in setting priorities for the work they do and, no less important, insist on using a collaborative approach to carrying out and then evaluating their projects.

In Saskatchewan we have held public forums, each attended by more than 200 invited stakeholders. Several of these forums informed our priorities for what to measure and what care processes to improve. We have also convened forums to stimulate broad debate about the difficult issues raised by increasingly granular reporting of data about the quality and safety of care in hospitals and by medical practices.

Evidence of stakeholder involvement in the province is mounting. About 30% of the physicians in the province have participated in learning collaborative and we have a waiting list for subsequent collaborative. Every health region, professional association, and even the Ministry of Health is participating in a collaborated called Quality as a Business Strategy. The Saskatchewan Medical Association, which also negotiates the province's fee schedule with the Ministry of Health, is sponsoring 25 of its members who are attending the annual meeting of the Institute for Health Improvement (IHI) in Nashville this week.

Other examples. In Minnesota, ICSI's reports and guidelines are prepared by volunteer physicians. These guidelines have become the standard of care throughout the state. ICSI also works closely with Minnesota Community Measurement, an organization established by provider organizations, medical groups and the state's medical society with strong encouragement from state government. In Scotland there has also been broad stakeholder involvement, though the quality agency is being reorganized. Quality improvement in the English NHS, in contrast, has been more top down than participatory. But Don Berwick of IHI has been influential in establishing learning collaboratives in England. A recent initiative in the English NHS called the Productive Ward is led by nurses, but engages many other stakeholders. The Minister of Health of Saskatchewan recently led a delegation of stakeholders from that province to England for a week in order to learn more about the Productive Ward and how it is being implemented. One member of the delegation described it "as the Toyota LEAN system without the jargon."

Next, RIGOROUS MEASUREMENT AND DETERMINED PUBLIC REPORTING.

Each of the more successful quality councils has had some success in insisting that it is in the public interest to engage in rigorous measurement of and reporting about the quality of care in hospitals and medical practices. In Saskatchewan we involved the media in the discussion of what to report and held many meetings with community leaders and officers of associations of health professionals. In England and Scotland public policy links measurement and the reporting of results to incentive pay for primary care physicians. Australia expanded measurement and reporting of quality at the urging of the official of the central government responsible for maintaining appropriate market

competition in the general economy. Kaiser Permanente is reporting increasing amounts of information on quality to its members in accessible formats. All of this requires highly competent staff with a variety of research, analytical and communications skills.

The third characteristic of effectiveness in councils is THAT THEY ARE GOVERNED BY EXPERT BOARDS THAT COLLABORATE WITH STAFF IN CRITICAL DECISIONS, especially decisions about measurement, reporting, and explaining the significance of data about quality and its absence. The first use I know of the phrase “expert boards” was by a past-president of the Canadian Medical Association with whom I serve on the HQC in Saskatchewan. He used it in exasperation at our former CEO who wanted a rigid separation between the board as policymaker and the staff as executor of policy. I subsequently noticed that other effective councils have boards whose members are experts who are also deeply engaged in their professions and communities. These experts include persons in health affairs, and representatives of significant community groups, including minorities. Some effective boards have members who are expert in improving quality in business, in labor relations, and in communications. Expert boards discuss policy and significant operational issues with staff until either consensus is reached or the CEO says that he or she has enough information to make the decision down the road and communicate it to the board chair.

The fourth characteristic of effective councils is a COMMITMENT THAT QUALITY IMPROVEMENT REQUIRES MORE THAN AVOIDING BLAMING AND SHAMING HEALTH PROFESSIONALS; A COMMITMENT THAT EFFECTIVE QI ALSO

REQUIRES GENUINE CONCERN FOR THE JOB SATISFICATION OF HEALTH WORKERS AS WELL AS THE SATISFACTION OF PATIENTS. This characteristic has, I think, been more evident outside the United States than within it and it is worth considering here. How front line workers feel about their jobs affects the quality of the care they provide. For example, Ascension, the largest non-profit health system in this country, dramatically reduced falls in its hospitals through a project, organized by its equivalent of a quality council, that identified patients at the greatest risk and then involved employees in every job description in making sure that identified patients (who wore red slippers attached to socks) were joined by an employee whenever they were seen to be walking unaided. The Productive Ward project in England increases nurses' job satisfaction and the quality of care because nurses in each ward redesign care processes and then implement changes in order to allocate more of their time direct care. I should add that councils often acknowledge that disciplining health professionals is sometimes in the public interest—but that discipline is the job of regulatory bodies, not of councils.

The fifth characteristic of effective councils is the productive use of THE REGULATORY SHADOW, which can include professional discipline. Each council or council-like organization, whether based in a jurisdiction or a provider system, emphasizes voluntary action in order to progress toward achieving what QI jargon calls a culture of quality. But each successful council or council-like organization is sponsored by or is relied on by organizations that have regulatory authority or its functional equivalent; that is, they are sponsored by states or countries, by health plans and provider organizations. In Minnesota ICSI doesn't appear to have such

sponsorship; until, that is, you talk to the chairs of the House and Senate Health Committees.

This regulatory shadow helps councils do their work because it attracts the attention and time of professionals and provider organizations. The shadow is particularly effective when it is positive rather than potentially punitive. For example, regulators can allocate payments to health professionals, especially physicians, who have many demands on their time in addition to improving quality. In the UK, as I mentioned primary care doctors are paid for reporting and meeting targets. In Saskatchewan we pay doctors a token fee, but not an insignificant token, for participating in learning collaboratives. Moreover, Quality Council staff assist physicians in adapting and using IT. Last year the Medical Society and the Ministry of Health in the province negotiated a special fee as an incentive to physicians to measure the quality of care their patients with chronic disease receive. Australia has implemented payment rules that reimburse primary care practices for coordinating care for patients with chronic disease.

I now add a sixth, more tentative, generalization about the effectiveness of quality councils. It is controversial in some rooms. The generalization is that we may be able to learn from our colleagues in other countries the importance of considering access to care a dimension of quality. We have usually excluded access from the quality conversation in this country. The famous Institute of Medicine list of the 7 attributes of quality doesn't use the word access; and "equitable care" which some people use as a proxy for access is near the end of that list. Moreover, most of the people I have heard talk about equitable care as a dimension of quality in this country

apply the concept to people who have coverage—who are in the system. In countries with universal coverage, on the other hand, there is considerable evidence that many people who have coverage still lack effective access. As a result, quality organizations in these countries subsume the concept of equity under the broader concept of access. They ask whether each person who needs health services gets the right care at the right time in the right place from the right persons on healthcare teams.

It may be useful to ask this question in the US, despite all the familiar problems of financing expanded access. It could become impossible for quality councils and their equivalents in this country to duck the question of what care is available or is denied to whom, when and, most important, using what criteria. We know that much of our current reimbursement policy is unsustainable.

What can quality councils contribute to the access conversation? One important contribution will be documenting how much care is ineffective and even harmful and the costs that can be averted and reallocated by improving quality. Quality councils, that is, can be important players in building support for spending better; including spending to improve access for persons who have coverage and persons who have no coverage. Although many quality councils and their sponsors in this country may prefer, for reasons of political convenience, to keep the discussion of quality separate from the discussion of access, I suggest when a council starts to address disparities it soon becomes illogical to avoid a broader conversation about access.

I can summarize this talk in an equation:

Good Governance + Good Evidence + Modest Resources from Leverage and/or Appropriations = A Quality Council that can Accelerate Effectiveness, Efficiency and Quality Improvement.