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# A Call to Action; a Time for Leadership

by Mary K. Totten

It's been a decade since the Institute of Medicine identified care that is "equitable" as one of its "Six Aims" for health care delivery in America. While it is easier to grasp the meaning and significance of the other aims, such as care that is timely and efficient, "equity of care" has been more elusive.

Progress has been made but ample evidence indicates that differences persist in the way care is delivered, that certain health needs of racial and ethnic minorities and other subgroups remain unmet, and that the health status of these populations varies from that of other subgroups. Data show, for example, higher rates of infant mortality, hypertension, death from heart disease and stroke, and preventable hospitalizations among blacks compared with other populations. When hospitals look at their patient diagnoses data by race and ethnicity they also can uncover less obvious health needs. That's what prompted Heywood Hospital in Gardner, Mass., to dig deeper after noting the hospital had treated a small group of Asian patients for chemical exposure. As reported in the July/August Trustee magazine, by working with a community minority coalition the hospital discovered that many Asians in the area worked in environments that put them at risk for chemical exposure and needed education about the health risks they faced (see links to Trustee article and other resources in the Equity of Care Resources sidebar on page 3).

Health care disparities are being addressed by a growing number of our nation's hospitals, not just because it is the right thing to do, but because it is essential for performance excellence and improved quality. Therefore, health care disparities demand attention and action at the highest levels of health care leadership, including the governing board.

## A National Call to Action

A number of national organizations have partnered to establish the Equity of Care initiative, which provides resources to help hospitals eliminate disparities. In July, these organizations, including the American Hospital Association, American College of Healthcare Executives, the Catholic Health Association of

the United States, the National Association of Public Hospitals and Health Systems and the American Association of Medical Colleges, issued a national "Call to Action" urging hospital and health system leaders to take three steps to help eliminate disparities and improve quality of care for all. These steps include:

- Increasing the collection and use of race, ethnicity and language preference data;
- Increasing cultural competency training; and
- Increasing diversity in governance and leadership.

A variety of resources to help hospitals and their leaders address these issues also are available through its website, [www.equityofcare.org](http://www.equityofcare.org).

## Action Steps for Boards

One way boards can have a positive impact on health care disparities is to review and discuss hospital performance data profiled by race, ethnicity and language preference (REAL data). Massachusetts General Hospital (MGH) in Boston shares such data with its board and posts it on the MGH website. This commitment to performance and transparency is longstanding at MGH.

"After the IOM published its 2002 report *Unequal Treatment*, our hospital's leadership took a very progressive stance on dealing with disparities," said Joe Betancourt, M.D., director of the Disparities Solution Center at MGH. "Rather than adopting a position of 'innocent until proven guilty', we assumed we had disparities in care delivery and made a commitment to addressing them."

MGH brought together leaders from nursing and other patient care and quality functions who established the Disparities Solution Center to better monitor care and identify and reduce disparities. While MGH had been collecting REAL data about its own care delivery for some time, the organization established a disparities dashboard and worked with other area hospitals to strengthen data collection and use.

“We also broadly delivered the message that equity of care was an essential element of our organization’s commitment to quality,” Betancourt said. “Since 2003, we have presented disparities data in a detailed report which is discussed twice each year by the full board (click onto MGH 2011 report on Great Boards site). We also share with the board the interventions we have taken to address disparities and the improvements MGH has made.”

During the first few years, the board focused on understanding equity of care issues and becoming acclimated to MGH data, reporting and performance. At the same time, the overall focus of the board’s work began to shift more strongly toward quality. Betancourt also joined the MGH board’s Quality Committee, where disparities data are routinely presented and discussed.

“Once this shift occurred,” Betancourt said, “our board began to ask the tough questions all boards should focus on, such as:

- Why do we deliver care that varies in quality?
- What are the reasons for this variation?
- How is our hospital monitoring disparities?
- What are we doing to eliminate them?
- How are we integrating our work around disparities with our hospital’s broader quality and safety efforts?”

Board members also helped the hospital recruit members for a Multicultural Advisory Committee, which includes patients and acts as a sounding board and “litmus test” for MGH activities.

“Our hospital’s work to address disparities in care has become a touch point of pride for our organization,” Betancourt said. “It is part of our commitment to improving care quality for all, being transparent about our performance, and striving toward organizational excellence by fixing what is broken.”

Gregg S. Meyer, M.D., senior vice president for quality and safety at MGH, points to the power of the IOM Six Aims as a framework for helping boards understand equity of care and its overall relationship to quality.

“Reviewing equity as part of the IOM aims helped our board understand that if our organization is not providing quality care to everyone it’s not really taking great care of patients,” he said. “The IOM framework also helped us move beyond the obstacles many organizations experience in addressing care disparities.”

Meyer related the disparities journey to the five stages of grief and loss articulated by psychiatrist Elisabeth Kübler-Ross, M.D., in her work on death and dying.

hospitals realize they are contributing to the problem but may become depressed or uncertain about what they can do to change things. Finally, with acceptance comes the capacity to deal with the issue head on and take action to positively address it.”

Meyer also encourages hospitals to recognize the limits of documentation when it comes to addressing disparities.

“You can spend a great deal of effort documenting care disparities,” he said. “While that effort is valuable, hospitals need to expend equal or greater resources to actually deal with the issues that documentation and analysis of the data reveal.”

Another way boards can better understand health care disparities is to make the membership of the board itself more diverse. University Hospitals Health System (UH), a seven-hospital system based in Cleveland, Ohio, has built a focus on diversity into its board’s structure and practices.

“Our Governance & Community Benefits Committee has established a protocol that includes diversity as one of the elements considered in identifying and recruiting new members for its boards of directors. Each year, an analysis

is undertaken to identify the skills and characteristics that will be needed at the board level to effectively oversee implementation of our strategic plan,” explained Janet Miller, the organization’s chief legal officer and corporate secretary. “We compare our progress on diversity with best practice benchmarks published by Diversity, Inc., and seek candidates that reflect the patients our hospitals care for, which include Latino, African American and Amish populations.”

The UH system board has a Cultural Diversity Committee, which not only includes representatives of racial and ethnic groups the system serves, but also employees and other stakehold-

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Chief Legal Officer and Corporate Secretary

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“In coming to terms with equity of care issues, hospitals and their leaders often start out in the denial stage, believing that while disparities exist at other hospitals, they do not exist at their hospital,” Meyer said. “Then they enter the second stage, where they blame disparities in the care their hospital provides on other factors such as socioeconomic status, poor housing or other causes unrelated to the way care is being delivered. In stage three, they rationalize that while the hospital’s care delivery or failure to meet the health needs of certain populations are in fact contributing to health disparities, the organization is good at doing other things besides providing care at the same level of quality to all patients. In stage four,

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ers. This committee reviews data on the diversity of the UH employee population and the vendors and suppliers the system works with.

“Our board realizes that diverse voices make a difference and that a more diverse board is empowered to look at issues from a broader range of perspectives,” Miller said.

Sharon Rossmark is a trustee on the board of the three-hospital Sinai Health System located on the west side of Chicago. She believes that her organization’s diverse board creates a broader, richer conversation in the board room that is more sensitive to the issues facing the multicultural populations her hospital serves.

“In reviewing the results of our customer service surveys, our board’s Quality, Safety and Operations Committee noted

that the meals our hospital serves are among the top factors affecting the care experience for our patients,” she said. “We wanted to provide some of the comforts of home and, based on patient feedback, decided to change our meals to reflect the interests of our Hispanic patients. Early reaction has been positive—a nice result for a small cost to the hospital.”

“Our board also looked at data on care provided to patients whose second language is English and determined that our hospital needed to increase availability of translation services and resources in our Emergency Department,” she said. “This was especially important for elderly patients accompanied by children who could not sufficiently communicate with hospital personnel.”

Rossmark emphasized the importance of incorporating diversity into the

board’s governance practices and the value of including diverse members from within and outside of the communities the hospital serves. She also encouraged boards to provide training for new diverse members.

The AHA, along with its Center for Healthcare Governance and the Institute for Diversity in Health Management, provides an education program for diverse individuals who would like to serve on health care boards. Participants have the option of joining a registry the Center maintains to match interested individuals with health care boards seeking diverse candidates for board service ([www.americangovernance.com](http://www.americangovernance.com)).

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## EQUITY OF CARE RESOURCES

- “Quality Care for All,” Trustee magazine, July/August 2011 is available at [http://www.trusteemag.com/trusteemag\\_app/jsp/articledisplay.jsp?dcrpath=TRUSTEEMAG/Article/data/07JUL2011/1107TRU\\_COVERSTORY&domain=TRUSTEEMAG](http://www.trusteemag.com/trusteemag_app/jsp/articledisplay.jsp?dcrpath=TRUSTEEMAG/Article/data/07JUL2011/1107TRU_COVERSTORY&domain=TRUSTEEMAG).
- Free resources and shared best practices to help hospitals eliminate disparities are available at [www.equityofcare.org](http://www.equityofcare.org).
- “Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders” presents and discusses key strategies for collecting and using patient race, ethnicity and language (REAL) data. This report is available at <http://www.hret.org/health-equity/index.shtml>.
- A Disparities Toolkit to help hospitals put data strategies into action can be accessed at <http://www.hretdisparities.org>.
- “Building a Culturally Competent Organization: The Quest for Equity in Health Care” explores how hospitals and health systems can increase their cultural competency to ensure that care delivery is respectful of all patients’ diverse values, beliefs and behaviors. This publication offers seven recommendations for improving cultural competencies, self-assessment checklists, a list of cultural competency resources and case studies from high-performing hospitals and is available at <http://www.hret.org/quality/projects/cultural-competency.shtml>.
- Massachusetts General Hospital (MGH) in Boston posts performance data profiled by race, ethnicity and language preference on the MGH Web site at <http://qualityandsafety.massgeneral.org/measuresequitable.aspx?id=4>.
- A copy of the MGH Racial and Ethnic Disparities Dashboard report is available on the Great Boards site at <http://greatboards.org/pubs/disparities-dashboard-shell-2011.doc>.
- MGH also offers additional resources on equity of care issues through its Disparities Solutions Website. *Improving Quality and Achieving Equity: A Guide for Hospital Leaders*, *Assuring HealthCare Quality: A Healthcare Equity Blueprint*, and *Creating Equity Reports: A Guide for Hospitals* are available at <http://www2.massgeneral.org/disparitiessolutions/resources.html>.
- The charter for the system board Cultural Diversity Committee of the University Hospitals Health System in Cleveland, Ohio is available on the Great Boards website at <http://greatboards.org/pubs/cultural-diversity-committee-charter.doc>.

# Avoiding Bad Big Decisions

by Barry S. Bader

Times of transformational change inherently call for big decisions about corporate strategy and financial investments. With provider payments under attack and the payment system shifting from volume based to value-based care, hospital and health system boards can anticipate a decision-rich agenda in coming years:

- Should we form/join with a larger system or entity, and if so, which alternative offers the best fit?
- How and how fast should we align with physicians in order to accept accountability for the costs, outcomes and efficiency of patient care?
- How aggressively should we pursue value-based payment arrangements that carry the risk of losses as well as incentives?
- Should we invest in an organization-wide quality management model applied to healthcare, such as the Baldrige process, the Toyota Production System, LEAN/Six Sigma, or ISO-9000?
- Should we modernize or expand the inpatient hospital campus or focus more on a distributed network of ambulatory sites?
- How heavily should we invest in a strategy to improve community health and reduce health disparities when the financial payoff, if any, may be more long- than short-term?

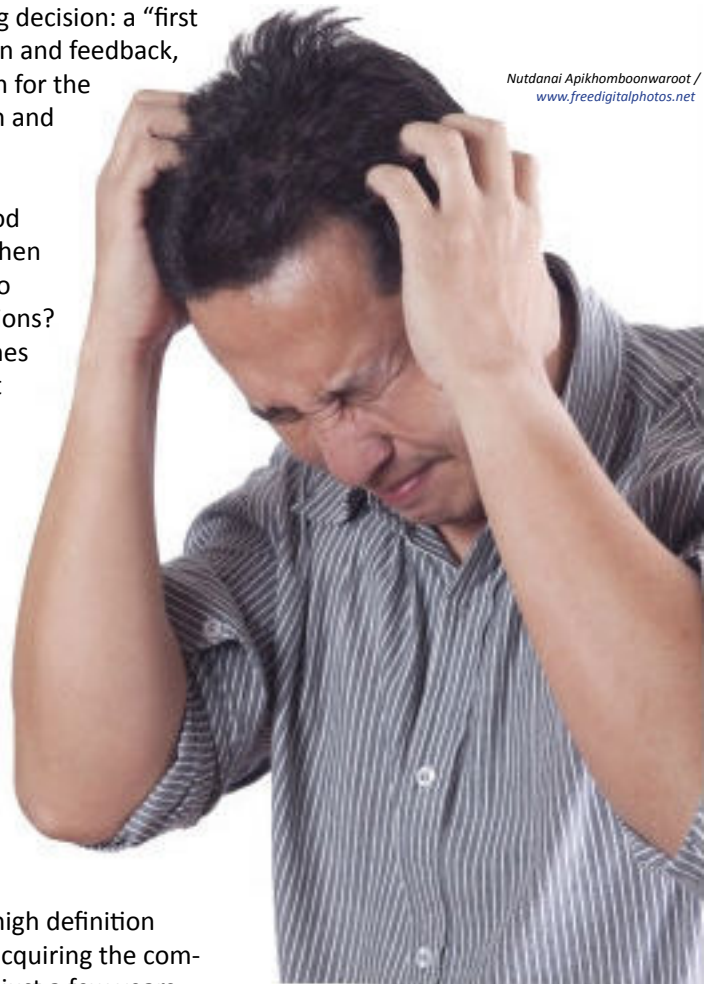
Many boards of private corporations as well as healthcare organizations would say with some legitimacy that these are management questions better left to the professionals who know the business. The governing board, they say, should engage in discussing and approving a high-level, compelling vision and strategic plan based on management's recommendations. Subsequently, management should bring major decisions to the board with good supporting documentation. The "no surprises" rule applies. The board should get at

least two bites of a big decision: a "first reading" for discussion and feedback, and a second occasion for the final recommendation and decision.

That's all well and good on the surface – but then why do companies too often make bad decisions? Just check the headlines for examples. Hewlett Packard announced it was getting out of the smart phone and personal computer businesses, after making billion dollar deals to acquire Palm and Compaq to pursue exactly these businesses in recent years. A few months earlier, Cisco Systems announced it was discontinuing the Flip camera, a handheld high definition movie camera, after acquiring the company for \$590 million just a few years earlier. Hospitals aren't immune: Many wrote off tens of millions of dollars spent acquiring physician practices in the 1990s in hopes of generating managed care contracts that never emerged.

As David Garvin and Michael Roberto wrote in *Harvard Business Review* in 2004, "our research over the past several years strongly suggests most leaders get decision making all wrong." They assert that leaders often employ "advocacy oriented" decision practices that lock in a preferred course early on and then advocate for their choice at each level en route to the board, with too little objective analysis or genuine openness to reconsideration at each step.

Writing this summer in *Harvard Business Review*, Daniel Kahneman, Dan Lovallo, and Olivier Sibony assert that



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common biases often creep unseen into decision making processes, causing good leaders to make bad decisions. Citing research from McKinsey Co. on 1,000 business investments, they assert that organizations that actively worked to reduce bias in decision making achieved returns up to seven percentage points higher.

## Avoiding the Three Biggest Mistakes in Decision Making That Boards and Management Make

In my experience, when facing big decisions, hospital and health system boards, along with their CEOs and senior physician leaders, are prone to three common mistakes:

1. **Paying too little attention to the process for formulating a major decision for board approval.** Typically,

when a major decision reaches the board level for approval, the discussion revolves around the rationale, costs and anticipated benefits of the action. Management places one option on the table that it has carefully developed and vetted up the ladder, and it needs board action *now*.

Kahneman and his colleagues identify a 12 question checklist that executives can use to “unearth the biases” that teams making recommendations can fall into. These include: Is there any reason to suspect self-interest has motivated the recommendation? Has the team ‘fallen in love’ with its proposal? Were dissenting opinions and credible options candidly raised and fully explored along the way? Where did the numbers underlying key assumptions such as revenue growth, operational costs and market share come from – and could they be based on historic trends that will change in the future? If you had another year to prepare a decision, what additional information would you want – and could you get that now?

**Board implications:** Boards should ask in advance about the decision process management will employ to develop a major recommendation such as a new strategic course or large transaction. The board’s purpose is not to micro-manage, but rather to encourage a sound, inquiry-oriented decision process that explores alternatives, tests assumptions, engages key constituents such as physician partners, obtains input from a board committee and knowledgeable directors at key intervals, and prevents biases from blinding leaders to errors that in retrospect will seem avoidable.

**2. Anchoring too long in existing strategic assumptions – and thus failing to respond quickly to environmental changes.** Holding true to a long-term vision and multi-year strategy through turbulent times is a mark of courageous leadership. However, leaders can get so caught up in the vision that they are blind to changes in underlying assumptions that are critical to achieving the vision. Compounding the problem, underlying assumptions are often couched

in flowery phrases about future megatrends, but are not explicitly stated so they can be regularly reassessed and adjustments made.

For example, many hospitals are employing physicians and readying Accountable Care Organizations and medical homes based on anticipated shifts in the payment system. The underlying assumption is that Medicare, Medicaid and private health plans will transition to value-based payment models such as bundled payments and capitation in the next several years. Therefore, health systems are making big, multi-year investments to integrate with physicians, and upgrade information technology in order to manage shared payments. But what if, as Yogi Berra would say, “the future ain’t what it used to be?” What if, for instance, the payment system changes more slowly or differently than expected, or regulatory barriers to sharing gains with physicians aren’t removed, or other unexpected events occur (as they always do)? What adjustments will need to be made in the strategic plan or the pace of implementation?

**Board implications:** Strategic planning and implementation are an ongoing process. Like a downhill skier simultaneously scanning the slope ahead and watching for nearby peril, the board should be mindful of the long-term vision but also alert to changes in near-term assumptions. As the guardian of the mission, the board’s role in strategic planning, oversight and decision making should be clearly defined in a written policy statement (see [www.greatboards.org](http://www.greatboards.org) for an example) that describes its involvement at a number of key intervals in the strategic planning process:

- When the strategic plan is developed and approved, usually every 3-4 years
- Annual updates of the plan, to review whether underlying assumptions have changed and the plan needs to be “tweaked” or altered
- When major strategic decisions must be made, such as whether to acquire a facility, integrate with a new partner, invest in a new busi-

- ness or service line, or divest/close an existing service line or facility
- Ongoing monitoring of strategic implementation.

**3. Taking the short view.** Many boards continue to spend too much time listening to reports and engaging in short-term oversight, and not enough time in active discussion and deliberation on long-term trends and strategic initiatives affecting their organization’s mission and business model. This is borne out by every survey on how hospital and health system boards allocate meeting time.

**Board implications:** Boards should plan their work to focus the majority of their limited board meeting time on the defining and transformational issues they face, such as the implications of:

- focusing on the health of the community and not only individual patients
- embracing the continuum of care and not mainly acute inpatient care
- fully accepting physicians as full partners in decision making.

An annual set of board goals or “Topic A” issues, incorporated into an annual board and committee work plan can help the board and CEO get more effective board engagement on matters that truly count.

A football coach at Notre Dame once explained that if you wanted to give him advice, “do it on Saturday afternoon between 1 and 4 p.m., in the 20 seconds between plays.” He added: Don’t tell me on Monday morning the right thing to do. By then I know the right thing to do.”

For boards, their 20 seconds to make a difference and add value is at key intervals in the strategic planning process, not after the fact. Careful attention to the board’s role in the decision making process can lead to better decisions in the end.

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