Governance Quality Engagement Diagnostic

Overview

This diagnostic is designed to help boards and organization leaders identify challenges that may be impeding efforts to improve quality. Developed by Jim Conway, this resource draws on 20 years of personal governance experience as well as learning from the literature and the shared experience of trustees, executives, patients, family members, staff, teachers, and students. The tool framework is constructed around six key drivers of engagement as reported initially in the 2006 "Getting Boards on Board" initiative of the Institute for Healthcare Improvement (IHI). It identifies more than 60 challenges that, when addressed, can help boards and leaders create their own pathway to continuous improvement. The tool reflects quality domains identified by the National Academy of Medicine (formerly the Institute of Medicine), which include care that is safe, effective, patient-centered, timely, efficient, and equitable.

How to Use This Tool

Using this tool together (governance and leadership, including medical staff leadership):

- Check for evidence of problems and struggles that could be limiting impact
- Discuss why
- Seek out key resources, examples of best practice, and lessons learned by boards who are "leading the way"
- Develop a plan to address problems and turn them into opportunities for improvement
- Execute following the IHI's Model for Improvement [http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx] or a similar systematic approach

"Boards on Board" Drivers	✓	Board Leadership Barriers (CHECK ALL THAT APPLY)
1. Set aims	❑	1. "Pile it on" strategy; too many aims and priorities set
	❑	2. Lack of urgency/constancy of purpose; looking for "shiny new object"
	❑	3. Aims externally driven; missing internal "losing sleep" issues
	❑	4. External benchmarks set around the mean
	❑	5. No process for selecting and aligning aims against the triple/quadruple aim
	❑	6. "Favorites" get projects resourced; no transparency to justify choices and tradeoffs
	❑	7. Board fails to communicate what's important and why; goals not made public
	❑	8. Lack of will or vision of what is possible; status quo is fine
	❑	9. Failure to consider multiyear targets and timelines where appropriate
	❑	10. Overarching systemwide aims not set and/or achieved in multientity systems

Excerpted from "Governance Leadership of Quality: Confronting Realities and Creating Tension for Change," by Jim Conway (*Trustee Insights,* July 2018).

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2. Get data and hear stories	❑	11. Data and PowerPoint overload with no time for discussion
	❑	12. Patient and staff harm not discussed in the boardroom
	❑	13. Absence of guidelines on time allocated to presentations and discussion
	❑	14. Reports of the same types of errors over and over without improvement
	❑	15. Patient stories shared without discussion of impact or next steps
	❑	16. Data presented in red/yellow/green form and not data over time (run charts)
	❑	17. Same few trustee voices heard in board quality discussions
	❑	18. Lots of opportunities missed; hiding in 8-point font
3. Establish and monitor system-level metrics	❑	19. Stretch goals avoided to stay personally "safe"; courage not visible
	❑	20. Rate-based data, acronyms, and other abbreviations not understood by all trustees
	❑	21. Gaps between bold aims and current realities are not highlighted
	❑	22. Quality domains not in balance (e.g., no focus on equity, timeliness, etc.)
	❑	23. Interconnections among clinical, financial, service, and experience outcomes ignored, leading to unintended consequences
	❑	24. No clarity that the board's focus is on quality assurance and not quality control
	❑	25. Lack of knowledge on the cost implications of current quality performance
	❑	26. Aims chosen are inpatient focused and not reflective of the organization's breadth
	❑	27. Unit variation persists unchallenged; hidden under a "big dot" that is "OK"
	❑	28. Not enough use of leading indicators; performance data is routinely old

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4. Change the environment, policies, and culture	❑	29. "Core values light," with values not publicly verifiable every day
	❑	30. Quality isn't core to the organization values, principles, business strategy
	❑	31. Board hasn't publicly acknowledged its ultimate accountability for care quality
	❑	32. Trustees who have core competencies in quality are not sought out
	❑	33. Clinicians (M.D., R.N., etc.) have a limited role in board meetings
	❑	34. Patients and family advisers not at board quality table
	❑	35. Practices "only invented here"; little, if any, best-practice sharing or learning
	❑	36. Little recognition of, and celebration for, progress
	❑	37. Staff suffer from "projectitis" and drown under project "waterfalls"
	❑	38. Financial issues pushing quality off board agenda
	❑	39. Trustees/leaders speak about quality only when spoken to at board meetings
	❑	40. There are physicians on staff to whom you wouldn't refer family/friends
	❑	41. Credentials recommendations routinely approved by board without discussion
	❑	42. Quality is not represented at every board and committee table
	❑	43. Trustees' competencies and passions untapped
	❑	44. Board and trustees' self-assessments not conducted and/or not criteria-based
	❑	45. Trustees not helped to see what they should see
	❑	46. Board out of the loop in oversight of serious patient and staff harm
	❑	47. Leaders struggle with transparency and only positive outcomes are reported
	❑	48. Board follow-up loops routinely not closed
	❑	49. Board finds it difficult to do the work with 2 to 4 board quality meetings a year

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5. Learn from others and from each other	❑	50. Board quality role not well understood by trustees or key stakeholders
	❑	51. No one's asking "Could it happen here?" when a serious event occurs elsewhere
	❑	52. Evaluations of board meetings are not conducted
	❑	53. Trustees never go to where the work is done (i.e., rounding in units and clinics)
	❑	54. Staff perceives trustees and leaders don't have a "clue" of work at the front line
	❑	55. No ongoing board orientation, continuing education, and/or coaching
	❑	56. Trustees not trained or assessed for knowledge about quality improvement and their role
6. Establish executive accountability	❑	57. Lack of clarity in governance/management roles and responsibilities
	❑	58. Lack of sustained leadership engagement over time
	❑	59. Absence of partnership among the board, chair, and CEO
	❑	60. Targets set without probing resource capacity to execute
	❑	61. Theory of work ahead unclear: What are key drivers? What is the evidence?
	❑	62. No succession planning to ensure continuous function of quality committee and board role in quality oversight
	❑	63. Trustees and leaders haunted by question: "If you knew, why didn't you do?"

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