Bringing the Board on Board

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As the world of health care moves from art to science, with evidence as the basis for decision-making, boards must come along. Increasing, hard data about the effectiveness and outcomes are being used to drive decisions on everything from which procedure to perform to which equipment to purchase. Physicians and other clinicians are guiding patients through selecting treatment based on the most recent comparative clinical evidence about the outcomes of different treatments for individuals.

Boards, which represent the health care institution and its constituencies, must understand the rationale for this approach and use it to make institutional decisions based on evidence about the impact of programs on the community.

In the launch of this new column in the March-April issue, Dr. Kathleen Gillespie wrote, "Evidence-based public health provides a framework for a health care organization to use in assessing community-oriented, population-based activities. With the increased attention to community benefit being paid at the federal and state levels, it becomes all the more imperative that decisions about institutional resource allocation affecting community priorities be based on data – solid, objective evidence."

Many Catholic health care organizations have in their mission statements service to the community. A major function of boards is to provide the link between the institution and the community. In the future, boards need to make decisions using criteria that go beyond financial and clinical attributes to consider as well as the impact on the health of the community.

Health fair screenings offer a typical example. The board may be asked to approve a budget with a line item of $5,000 for screenings at a health fair involving blood pressure and Body Mass Index (BMI) checks. The hospital has sponsored this screening every year for the past 10 years at the same health fair held at the same mall. The $5,000 may cover nurse and nutritionist time, health fair exhibitor fee, supplies and equipment, and educational materials pertinent to the screening.

The seniors who have come to the screening in the past look forward to it because the hospital always offers coffee and cookies, as well as hospital logo items. The screening also maintains goodwill between the staff of the local senior housing facilities and senior centers and the community outreach staff of the hospital. With community goodwill to gain and a modest financial loss, the board is likely to approve the screening.

In addition to the expenses, what if the board was consistently provided information about "evidence about impact on the health of the community?" A blood pressure screening at a community health fair might indeed cost $5,000 in the expenses delineated here. How would the community benefit? How many people would be found who did not already know that they had hypertension or tended toward obesity?

A health fair conducted in a middle-class neighborhood with a high proportion of seniors might not reach anyone who had not been screened previously for these conditions. Nearly 150 people would be screened in a six-hour health fair with two teams of professionals. Of these, perhaps five people would be found who did not know they had high blood pressure or were overweight and thus should be referred to a primary care physician for a first visit for these conditions. The days lost from work or potential disability days saved due to identifying high blood pressure or high BMI would be few, if any.

Let's say the board was asked to approve $5,000 for health fair screenings, but the staff offered a choice between two very different screenings. The above blood pressure and BMI screening for old adults and a new screening – for skin cancer. The new screening would be conducted for a population of postal service and other outdoor workers at a location convenient for the workers so they did not need to miss work, include educational materials that would be distributed by employers, and receive the backing of the local unions.

Both screenings could be recognized as "community benefit" for accounting purposes. The cost of $5,000 is the same. The expenses are slightly different – dermatologists, who are the only clinicians authorized to complete the form for the American Dermatological Association (ADA); a booth with a

privacy screen to conduct partial body screenings; the forms certified and reported to the ADA, and a hospital staff person to follow up with those recommended for referrals to have further testing. Given that screenings take 12 minutes instead of five, with two teams of dermatologists/nurse or support person, 60 people would be screened. However, of the 60, six might be referred for further examination for skin cancer, which is more prevalent among people who work out of doors. Although not statistically probable, one might even be found to have early stages of melanoma.[1]

Comparing evidence about the impact on the community would help the board decide which screening to fund, and thereby, aid the hospital in allocating its resources to make the greatest impact on the community. The skin cancer screening would:

1. bring a screening to people who ordinarily would not have it.
2. offer education about the most common form of cancer, which is surprisingly under-publicized compared to other diseases.
3. refer six people who needed further screening who would lose an average of potentially 30 minutes each getting screened and establishing a baseline record versus a half day or more lost to work for those who wait until a problem is serious, then need to take time off work to go to a doctor and have a biopsy.
4. potentially save the life of one person with melanoma and save more extensive, more expensive treatment for those found to have early stages of skin cancer.

The absence of disabilities days and the value of life can be given economic values and calculated for each screening.

The contrast between the two types of screenings is clear. One makes an immediate difference on health outcomes for the most common form of cancer, saves time lost from work and disability days and thus impacts the economic well-being of the community, and creates the foundation for education about an important subject that is often ignored. The other screening, which assumes a population already well-enmeshed in the health care system, does not immediately change any health outcomes of individuals, offer new education to the community, or have a significant impact on the industry in the community.

The numbers in the above example are taken from the experiences one community hospital, not national averages. Nonetheless, this is just one modest example of how having data about the impact of an activity on the health of the community can influence a board's decisions on an agenda item as modest as a $5,000 expenditure in an annual budget. Magnify this to requests for extraordinary expenditures or thousands of dollars of capital expenditures, and the significance for the health of the community expands.

Moreover, with evidence, the board may be able to make tough decisions that the staff would have a hard time doing. The outreach staff of the hospital, who probably know the staff in the community who works with seniors very well, might have a hard time explaining that the hospital is no longer going to conduct its blood pressure screening for seniors at the health fair. The board can assume the responsibility for the decision, explain the rationale, and hopefully, allow the hospital outreach workers to maintain good relations with those in the immediate community who are working with seniors. Since most of the board members are likely to be community members themselves (and many, perhaps also seniors), the decision is more acceptable to community members than if the hospital staff simply announce the decision or just fail to show up at the health fair.

In brief, our boards have a vital contribution to make in moving our health care institutions toward decision-making based on evidence of impact on the community. On the one hand, the board needs to encourage health institution management to examine the impact on the community as one of the essential elements of decision-making. On the other hand, the board represents the community, so can accept and translate these decisions on behalf of community members. This new approach will require effort by both board and management, but it is consistent with the mission of our institutions and builds on the trust shared between management and boards to act in the community's best interest. ■

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NOTE

1. Although not statistically likely to be found in a screening of 60, melanoma is on the rise and this, or another advanced stage skin cancer, could be found if those participating have not previously been screened.