Getting Started Kit:
Governance Leadership
"Boards on Board"

How-to Guide

A national initiative led by IHI, the 5 Million Lives Campaign aims to dramatically improve the quality of American health care by protecting patients from five million incidents of medical harm between December 2006 and December 2008. The How-to Guides associated with this Campaign are designed to share best practice knowledge on areas of focus for participating organizations. For more information and materials, go to www.ihi.org/IHI/Programs/Campaign.

This How-to Guide is dedicated to the memory of David R. Calkins, MD, MPP (May 27, 1948 – April 7, 2006) -- physician, teacher, colleague, and friend -- who was instrumental in developing the Campaign's science base. David was devoted to securing the clinical underpinnings of this work, and embodied the Campaign's spirit of optimism and shared learning. His tireless commitment and invaluable contributions will be a lifelong inspiration to us all.

How to cite this material:
5 Million Lives Campaign. Getting Started Kit: *Governance Leadership "Boards on Board" How-to Guide*. Cambridge, MA: Institute for Healthcare Improvement; 2008. (Available at www.ihi.org)

The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. IHI helps accelerate change by cultivating promising concepts for improving patient care and turning those ideas into action. Thousands of health care providers participate in IHI's groundbreaking work.

Campaign Donors

The 5 Million Lives Campaign is made possible through the generous leadership and support of America's Blue Cross and Blue Shield health plans. IHI also acknowledges the support of the Cardinal Health Foundation, and the support of the Blue Shield of California Foundation, Rx Foundation, the Aetna Foundation, Baxter International, Inc., The Colorado Trust, and Abbott Point-of-Care.

This initiative builds on work begun in the 100,000 Lives Campaign, supported by Blue Cross Blue Shield of Massachusetts, the Cardinal Health Foundation, the Rx Foundation, the Gordon and Betty Moore Foundation, The Colorado Trust, the Blue Shield of California Foundation, the Robert Wood Johnson Foundation, Baxter International, Inc., The Leeds Family, and the David Calkins Memorial Fund.

Contributors

The work of several leading governance organizations has informed the development of this guide. These include Center for Healthcare Governance, Centers for Medicare & Medicaid Services, Estes Park Institute, Great Boards, Joint Commission, National Association of Public Hospitals and Health Systems, National Center for Healthcare Leadership, National Quality Forum, and The Governance Institute. We thank them and all the individuals and organizations who have contributed.

"*I think that we should declare 2007 'The Year of Governance' and start to put back on the table of the boards not just a request, but an absolute sense of obligation, that learning who does better and then doing at least that well is central to proper stewardship of health care. Until leaders own that problem, I don't think spread is going to happen. The buck stops in the board room*."

--An Interview with Donald Berwick, *Joint Commission Journal on Quality and Patient Safety*. 2006;32(12):666.

"Leaders are responsible for everything in the organization, especially everything that goes wrong."

--Paul O'Neill, Former Secretary of the Treasury and Chairman and CEO of Alcoa

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Goal

Boards of Trustees in all hospitals will undertake the six key governance leadership activities to improve quality and reduce harm in their hospitals recommended in this Guide (pp. 14-20). At a minimum, boards should start by spending more than 25% of their meeting time on quality and safety issues and by conducting, as a full board, a conversation with at least one patient, or family member of a patient, who sustained serious harm at their institution within the last year.

Six Things All Boards Should Do

1. **Setting Aims:** *Set a specific aim to reduce harm this year. Make an explicit, public commitment to measurable quality improvement (e.g., reduction in unnecessary mortality and harm), establishing a clear aim for the facility or system.*
2. **Getting Data and Hearing Stories:** *Select and review progress toward safer care as the first agenda item at every board meeting, grounded in transparency, and putting a "human face" on harm data.*
3. **Establishing and Monitoring System-Level Measures:** *Identify a small group of organization-wide "roll-up" measures of patient safety (e.g., facility-wide harm, risk-adjusted mortality); update the measures continually and make them transparent to the entire organization and all of its customers.*
4. **Changing the Environment, Policies, and Culture:** *Commit to establish and maintain an environment that is respectful, fair, and just for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error.*
5. **Learning… Starting with the Board:** *Develop your capability as a board. Learn about how "best in the world" boards work with executive and MD leaders to reduce harm. Set an expectation for similar levels of education and training for all staff.*
6. **Establishing Executive Accountability:** *Oversee the effective execution of a plan to achieve your aims to reduce harm, including executive team accountability for clear quality improvement targets.*

Introduction: A New Kind of Intervention

After the first 18 months of the 100,000 Lives Campaign (December 2004-June 2006), the team at the Institute for Healthcare Improvement (IHI) paused to study the participating hospitals that had the most success over the course of the initiative. We wanted to learn more about those facilities that had introduced Rapid Response Teams and seen precipitous drops in codes outside of the ICU; we wanted to understand the clinical insights and operational breakthroughs that had allowed other organizations to go more than a year without a single ventilator-associated pneumonia or central-line infection.

In hospitals across the country, we uncovered innovations and local adaptations for each of the six 100,000 Lives Campaign interventions (documented in detail in the "Tips and Tricks" sections of the updated How-to Guides for each). We also noticed several core characteristics of facilities whose work was outstanding, no matter what intervention they were trying to introduce. These exceptional hospitals seemed to have created an organizational context better able to support change of any kind, whether it involved providing reliable care for acute myocardial infarction, reducing adverse drug events through effective medication reconciliation, or introducing other best practices to make patients safer and care more trustworthy. These highest-achieving organizations shared in common a small set of foundational properties, including clear aim setting and prioritization, transparent measurement, investment in building quality improvement capacity, and mindfulness of the role that every stakeholder in the care process has in driving improvement. These common elements were the basis for our previously issued How-to Guide on Running a Successful Campaign in Your Hospital, and what we learned from this research molded our thinking about senior leadership, itself, as we designed the 5 Million Lives Campaign.

We were also informed by the innovative work of a number of national and regional associations and agencies seeking to determine essential executive and board activities to help hospitals and health care systems deliver care with the quality characteristics

explored by the Institute of Medicine in its seminal report, *Crossing the Quality Chasm*. Our driving question is clear and important: What is the proper role of the people at the senior-most levels of the organization in the pursuit of better quality? How can senior leaders and boards exert the greatest positive influence on change?

As we move forward in the 5 Million Lives Campaign, an extraordinarily ambitious effort to radically reduce patient injuries in American hospitals, we have decided to augment our six original and five new clinical interventions (11 in total) with an intervention of a different type: a non-clinical intervention. This intervention, Governance Leadership (commonly referred to as "Boards on Board" after the article by M. Joshi and S.C. Hines), focuses on one of the most crucial attributes of those organizations that have demonstrated the greatest sustained progress in patient safety: *deeply engaged leadership, starting with the Board of Trustees.*

Background: The Power of Engaged Leadership and Governance

One primary function of senior leaders in health care is to support their "followers" in developing behaviors, skills, habits, processes, and technologies that lead reliably to dramatically improved performance. This influence has elements of both "push" (making the status quo uncomfortable) and "pull" (making the future attractive). The previously published IHI Framework for Leadership for Improvement suggests five core leadership activities relevant to improvement:

1. ***Establish the Mission, Vision, and Strategy*** as a "relentless drumbeat" for communicating the direction of the organization to all stakeholders.
2. ***Build the Foundation for an Effective Leadership System*** by choosing, developing, and aligning a leadership team capable of transformational tasks, and then ensure that, throughout this team, improvement capability is exceptional.
3. ***Build Will*** in the form of visible, constant, unrelenting, and well-explained commitment, starting with the organization's leaders, to make measurable systemic improvement as quickly as possible.

4. ***Ensure Access to Ideas*** about the clinical best practices and support processes, and insights about how to introduce them, so that the organization has readily available designs and concepts that are superior to the *status quo*.
5. ***Attend Relentlessly to Execution***, integrating improvement deeds and review in the daily work of the organization, and ensuring that better results are effective, sustained, and spread throughout the organization.

In many of our programs, we at IHI have witnessed the powerful impact that skilled and committed senior leaders can have in driving the improvement of care; we've seen that in Breakthrough Series Collaboratives, Pursuing Perfection, Transforming Care at the Bedside, the IMPACT Network, New Health Partnerships, the 100,000 Lives Campaign, and now the 5 Million Lives Campaign. Every organization achieving exceptional results appears to have activated senior leaders in each of the five elements in the Leadership Framework: *Vision, Foundation, Will, Ideas,* and *Execution*. Moreover, if any one of these elements is missing, the process of change can easily stall. Deficient will is a common culprit. Without it, senior leadership will be insufficient even where innovations and best practices are plentiful, and even where energetic project managers and clinicians show thrilling resourcefulness in testing, adapting, and implementing new ideas. Leaders who ignore improvement activity, or fail adequately to support it, send a strong implicit message that improving the quality of care is of secondary importance to other considerations (e.g., financial concerns), a message that we have seen destroying energy and driving resources into activities that have far less impact on patient outcomes. When that happens, in the longer term, the energy for improvement, even if it starts off high, dissipates.

Highly engaged executive leadership teams working with highly engaged boards in a trusting partnership can be the source of will for the entire organization. As hospitals try to drive rapid improvement, boards have an opportunity—we believe, indeed, a significant responsibility—to make better quality of care the organization's top priority.

Outmoded views of hospital governance sometimes suggest that hospital boards are responsible only—or primarily—for the organization's financial health and reputation. Board duties in these areas are unquestionably important, especially in light of heightened community benefit standards, changing reimbursement formulas from payers, increased consumer expectations, and the alarming increase in the number of uninsured. But the board's duties do not end with financial stewardship. Boards oversee mission, strategy, executive leadership, quality, and safety on behalf of the owner—whether the hospital is community-, government-, or investor-owned. As noted consistently in Joint Commission accreditation standards, boards especially guard quality of care; they are expected to fulfill an oversight role in the credentialing of the medical staff, quality assurance, and the continuous improvement of the care provided by the health care organization. In the modern view, boards bear direct responsibility for the organization's mission to provide the best possible care and to avoid harm to patients. The board's responsibility for ensuring and improving care cannot be delegated to the medical staff and executive leadership; ensuring safe and harm-free care to the patients is the board's job, at the very core of their fiduciary responsibility. An activated board, in partnership with executive leadership, can set system-level expectations and accountability for high performance and the elimination of harm, and, properly conducted, this leadership work can dramatically and continually improve the quality of care in the hospital.

Both Standard and Poor's and Moody's Investors Service released opinions in 2006 on the importance they attach to the leadership of clinical quality outcomes and safety in making determinations of hospital bond rating decisions. This has drawn further attention to the stewardship of improvement by health care Boards of Trustees and senior leaders.

In the last 10 years, management research by Alexander, Berwick, Chaitt, Joshi, McDonagh, Shortell, Weiner, and others has been replete with articles underscoring the responsibility and impact of health care boards on quality and safety. In 1999 the Institute of Medicine (IOM) made this responsibility explicit in its landmark study, *To Err*

Is Human, and reinforced it again in *Crossing the Quality Chasm* in 2001 and in subsequent reports. Over the last five years many assessment tools, publications, and presentations have emerged through IHI and leadership organizations working in the area of governance, including the Center for Healthcare Governance, Centers for Medicare & Medicaid Services, the Estes Park Institute, Great Boards, the Healthcare Research and Educational Trust, the Joint Commission, the National Center for Healthcare Leadership, the National Quality Forum, and The Governance Institute (see the Annotated Bibliography and Additional Resources: Governance and Leadership of Quality Reference List). Recent research on the role of governance in high-performing organizations (Lockee, Kroom, Zablocki, Bader, 2006; Vaughn, Koepke, Kroch, Lehrman, Sinha, Levey, 2006) shows a direct correlation between high performance in hospitals and specific attributes of their boards.

Boards can make an enormous difference when:

- The CEO is held accountable for quality and safety goals;
- The board participates in the development of explicit criteria to guide medical staff credentialing and privileging;
- The board quality committee annually reviews patient satisfaction scores;
- The board sets the board agenda for quality; and
- The medical staff is involved in setting the agenda for the board's discussion surrounding quality.

Lockee, Kroom, Zablocki, Bader, 2006.

Better outcomes are associated with hospitals in which:

- The board spends more than 25% of its time on quality issues;
- The board receives a formal quality performance measurement report;
- There is a high level of interaction between the board and the medical staff on quality strategy;
- The senior executives' compensation is based in part on quality performance; and
- The CEO is identified as the person with the greatest impact on quality, especially when so identified by the executive in charge of quality.

Vaughn, Koepke, Kroch, Lehrman, Sinha, Levey, 2006.

But best practices among boards remain uncommon. Proceedings from an invitational meeting hosted by the Centers for Medicare & Medicaid Services (Department of Health and Human Services, 2006) summarize and reinforce much of the work on how boards and leaders who accept responsibility for the quality of care should act. Those proceedings include data from the National Patient Safety Foundation, Estes Park Institute, and AIG Insurance suggesting there is a significant gap between how the governing board, executive leadership, and middle management view organizational and cultural elements of quality and safety.

With all of the focus on the board's role in driving quality, an IHI scan, with the help of governance experts, of the 5,000-plus hospitals in the country suggests that the current state of health care governance activity is, at best, highly variable. Our analysis suggests that boards fall into four general categories with respect to their level of engagement in improving quality and safety, their effectiveness in doing so, and their understanding of quality principles:

- Actively engaged and capable; already leading a high-performance organization, and wondering how they can do their board work even better;
- Actively engaged; often showing that commitment through a high-profile event, but needing a much stronger foundation for continual work on improvement;

- Not fully engaged, but having strong, latent capabilities and talent on the board; looking to light a fire with the full board, but not sure how to proceed; and
- Neither engaged nor capable; feeling quality is just fine; viewing quality of care as not the board's proper business, but rather that of the medical and executive leadership.

Our aim with this How-to Guide and other 5 Million Lives Campaign Board on Board publications (Conway, 2008) is to offer insight into the behavior of the most effective boards, to apply what is being learned about governance to the IHI Framework for Leadership for Improvement, and to suggest several straightforward steps for developing effective governance activity in your organization.

Applying the *IHI Framework for Leadership for Improvement* to Governance

A way to think about the work of effective boards is to use the previously referenced IHI Framework for Leadership for Improvement to recommend specific actions for governing boards to take within each of the framework's five categories:

1. ***Establish the Mission, Vision, and Strategy***
    a. Set direction and monitor performance.
        i. Integrate strategy and quality.
        ii. Monitor the culture of quality and safety.
        iii. Establish aims for safety and quality improvement.
2. ***Build the Foundation for an Effective Leadership System***
    a. Establish an interdisciplinary Board Quality Committee.
    b. Bring knowledgeable quality leaders onto the board.
    c. Set and achieve educational standards for the board members.
    d. Build a culture of real (not pro forma) conversations about improving care at board and committee meetings, with physician and nursing leaders, and with administration.
    e. Allocate adequate resources to ongoing training of employees and medical staff about quality improvement.

3. ***Build Will***
    a. Establish a policy of full transparency about data on quality and safety.
    b. Insist on the review of both data and stories from patients and families.
    c. Help patients and families tell their stories directly to staff, senior leaders, and the board.
    d. Establish policies and practices with respect to errors and injuries that emphasize through communication, respectful practice, disclosure, apology, support, and resolution.
    e. Understand both the current performance of your organization and the performance levels of the best organizations in the world.
    f. Show that you own the problem and are driving the agenda by placing quality first on the board agenda and devoting 25% or more of the board's agenda to it.
    g. Show courage: don't flinch.
4. ***Ensure Access to Ideas***
    a. Boards should ask management four idea-generating questions, when reviewing progress against quality and safety aims:
        i. "Who is the best in the world at this?"
        ii. "Have you talked to them to find out how they do it?"
        iii. "How many ideas have you tried out?"
        iv. "What ideas did our patients and families and front-line staff have for improvement?"
5. ***Attend Relentlessly to Execution***
    a. Establish executive accountability for achievement of aims.
    b. Establish an effective oversight process, including:
        i. Devoting 25% of board meeting time to quality and safety.
        ii. Monitoring your own system-level measures for improvement (rather than being comforted by benchmarks).
        iii. Reviewing data generated weekly, or, at a minimum, monthly.
    c. Ask hard questions, including:

i. Are we on track to achieve the aim?
ii. If not, why not? What is the improvement strategy? What are key steps planned toward full-scale execution?

Alignment with Regulation, Standards, and Advancing Practices

In developing this How-to Guide, and the specific Governance Leadership intervention, we consulted the current and proposed standards and regulations of the Joint Commission and the Medicare Conditions of Participation to make sure the intervention was aligned with their intent. As the National Quality Forum prepared the *Safe Practices for Better Healthcare: 2006 Update – a Consensus Report (2007),* there was a comprehensive effort to ensure "harmonization" of the practices among the Centers for Medicare & Medicaid Services, the Agency for Healthcare Research and Quality, the Leapfrog Group, the Joint Commission, and the Institute for Healthcare Improvement. The Governance Leadership Intervention is fully aligned with the comprehensive *Safe Practices.* (NQF has made available to IHI through TMIT a copy of the practices summary, "Table 1 Safe Practices, Care Settings, and Specifications," which can be found on IHI's website at http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Literature/.) The recommendations of the 2007 joint report from the Department of Heath and Human Service Office of the Inspector General and the American Health Lawyers Association, titled "Corporate Responsibility and Health Care Quality," are directionally consistent with this intervention. Similarly aligned and anchored in the Campaign, the National Business Group on Health (2008), a coalition of the largest national employers, has announced an initiative focused on an engaged board and the education of the executives of their organizations who sit on hospital boards about quality and safety issues.

The Governance Intervention: Six Things All Boards Should Do to Improve Quality and Reduce Harm

The 5 Million Lives Campaign asks governance leadership of participating organizations to begin, at a minimum, by focusing on the following six activities:

1. **Setting Aims:** *Set a specific aim to reduce harm this year. Make an explicit, public commitment to measurable quality improvement (e.g., reduction in unnecessary mortality and harm), establishing a clear aim for the facility or system.*

Organizations should develop a specific statement of aims for improvement, with quality effectively integrated into strategy. For example, the leaders at Ascension Health, the largest not-for-profit health system in the US, formulated three strategic aims; they promise to provide:

- Health Care That Is Safe;
- Health Care That Works; and
- Health Care That Leaves No One Behind.

Ascension's senior leaders and board spelled out each aim in detail, including quantitative goals. For example, for the aim, "Health Care That Is Safe," the specific goal statement is: "No preventable injuries or deaths by July 2008." Ascension's board and leaders review progress toward this aim regularly, and they have created a transparent system to transfer learning among hospitals all across the system. The aim, itself, is system-wide; it applies to all hospitals.

Another strategic aim of this type, with an associated goal (among others), from a different organization, is:

- "We will offer all the care and only that care that we know will help you. We will do nothing that will harm you."
- "One specific goal is to achieve zero central line infections for the entire institution across all services by August 31, 2008."

On the 5 Million Lives Campaign Action Day in June 2007, IHI asked organizations to declare and share their aims and many did.

2. **Getting Data and Hearing Stories:** *Select and review progress toward safer care as the first agenda item at every board meeting, grounded in transparency, and putting a "human face" on harm data.*

   Many boards are now starting their meetings with a case review of a patient who experienced harm at their hospital in the prior month. These cases provoke new and different conversations, and provide added will to move to safer systems. At a board Clinical Quality Committee meeting of the Seton Family of Hospitals in Austin, TX, operational leaders reviewed a patient safety problem and their plans to prevent a recurrence. One of the lay board members pushed harder for a reliable plan. She noted that the plans proposed were not likely to produce reliability at best known levels, and that employing reliability science would be a better solution than working harder. That meeting was an important step toward creating a culture of reliability, and it began with informed questioning by a board member.

   IHI recommends two very specific steps in initial assessment for every board and organization in the Campaign. Although both are challenging, we know of no steps more powerful than these two to accelerate commitment from the senior leader level:

   - **An Initial Chart Audit for Harm**: The board should commission a review of 20 randomly chosen patient charts from the prior month to document all types and levels of injury. We suggest that this review, and the subsequent report to the board, be conducted by a team of clinicians with the help of the IHI Global Trigger Tool (although other supports can be helpful, as well). Specifications, examples, and brief training for the use of this tool can be found on IHI's website. In the longer run, organizations may choose monthly chart review of this size and type to become one of their key, system-level safety monitoring systems. Note:

Findings from the field suggest that, to best learn about patterns of harm, organizations may choose to start their review with a focus on 20 charts from the medical surgical services, or 20 readmissions, or 20 deaths, rather than routine obstetrics cases (which may not contain many instances of harm).

- **An In-Depth Case Study:** The CEO, with the assistance of the CMO and CNO, should conduct a detailed, personal investigation of a significant patient injury in the hospital, including interviewing the involved patient, family, and staff. The purpose is to understand in great depth the "story," in all of its complexity, to illuminate the nature and sources of hazard in a complex health care organization. The CEO should personally present that case to the board in a session of no less than one hour in length. If possible and desirable, the affected patient and family should be there at the board meeting to add their accounts and view in person. (In preparation for this review, the CEO and board may wish to read the book on "high-reliability organizations" by Karl Weick and Kathleen Sutcliffe, *Managing the Unexpected: Assuring High Performance in an Age of Complexity.)*

3. **Establishing and Monitoring System-Level Measures:** *Identify a small group of organization-wide "roll-up" measures of patient safety (e.g., facility-wide harm, risk-adjusted mortality) that are continually updated and are made transparent to the entire organization and all of its customers.*

It is not enough for the executive leadership group and the medical staff to frame an aim. The board must know about the aim, understand it, care about it, and oversee its achievement. This is critical, because board engagement is essential to building the will needed to drive change at the scale and pace intended in the 5 Million Lives Campaign. When they receive reports on quality of care, many boards find themselves lost in the hundreds of minute but important measures at the patient level. It is not unusual for a board report on quality to contain several hundred measures and benchmarks, and yet not to contain metrics that can help the board to

see quality or improvement at the system level. Boards of hospitals in IHI's IMPACT Network now view a small set of system-level measures, called "Whole System Measures," including benchmarks against the best in the nation—sometimes the best in the world—as a way to monitor organization-wide progress. (See IHI's Whole System Measures White Paper.) One such system-level metric—of particular relevance to the Campaign—is the rate of medical harm per 1,000 patient days, which can also be expressed as a rate per 100 admissions (see Appendix A for more information on these measures). Another is the Hospital Standardized Mortality Ratio (HSMR), which allows boards to compare their organization's risk-adjusted mortality rate to others and to track it within the institution over time (download an IHI White Paper that describes how to use the HSMR here).

4. **Changing the Environment, Policies, and Culture:** *Commit to establish and maintain an environment that is respectful, fair, and just for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error.*

   To become safer, health care organizations need to build cultures of quality and safety that are bound in respect and communication and committed to full disclosure, apology, support, and resolution for patients and families when there is harm. As organizations around the country struggle with this critical element of a culture of safety and patient and family partnership, other organizations are providing leadership and courage to draw from. The Harvard hospitals have issued their seminal work, *When Things Go Wrong (2006)*, and the University of Michigan and other organizations are writing powerful stories of learning, respectful practice, and results from a multi-year journey of communication, transparency, disclosure, support, and rapid case resolution. One option for boards, which we recommend strongly, is to study the courage demonstrated in the documents cited above and adopt the guidelines articulated in *When Things Go Wrong*.

5. **Learning… Starting with the Board:** *Develop your capability as a board. Learn about how "best in the world" boards work with executive and MD leaders to reduce harm. Set an expectation for similar levels of education and training for all staff.*

   Modules for board education should answer the questions:

   a. What is the Board of Trustees' responsibility and accountability for quality and safety?
   b. What is the current state of quality improvement and safety in health care overall, in your community, and in your health care organizations? How does prevailing practice stand up to best practice?
   c. How can board members effectively leverage their roles and experiences to affect the pace of quality improvement in their organization?
   d. What are the best strategies to sustain the gain and drive continuous improvement?

   In our experience, most boards and leaders overestimate the front-line staff's ability to improve. In such cases, even with sufficient will and great ideas that have worked elsewhere, execution stalls. Boards can work to ensure that all physicians, nurses, and all staff know how to make performance changes, and leaders are able to help diffuse the new performance levels reliably across the entire system and to hold the gains over time. The IHI White Paper, Engaging Physicians in a Shared Quality Agenda (2007), provides extensive guidance. Some health care organizations have set up "colleges" to build the new skills with staff, and to ensure that the adequate skills and staff are aligned to make progress. One measure of adequacy of the educational and resource systems is the pace of change. If the tempo is too slow, and change is taking many months, the board should reconsider the effectiveness of the developmental support systems.

   Trends in new approaches to trustee education are emerging. The Tennessee Hospital Association has begun a program of voluntary board certification across the spectrum of board responsibilities, including quality and safety. In New Jersey, a bill

was passed by both Houses that mandates all new board of trustee members in the state will have one full day of education on their responsibilities as board members. It would include their duties, understanding finances, quality indicators, etc. The curriculum will be designed by the Commissioner of Health in partnership with NJHA, the Council on Teaching Hospitals (COTH), and the Alliance. In June 2006, the Mass. Hospital Association Board approved a recommendation to proceed with the development of a BCBSMA-funded curriculum for health care organizations trustees, focusing on their role in health care quality. The development of this curriculum was guided by MHA's *ad hoc* Trustees Steering Committee along with Dr. John Combes, President of the Center for Healthcare Governance. The program has been piloted by nine organizations and the next round is prepared. In addition to a curriculum tailored to each board, additional deliverables include a Quality Resource Guide to supplement the curriculum and a toolkit that offers board members a series of action steps that support their fiduciary responsibility for their hospital's quality performance. The AHA Center for Healthcare Governance is offering this program to others.

6. **Establishing Executive Accountability:** *Oversee the effective execution of a plan to achieve your aims to reduce harm including executive team accountability for clear quality improvement targets.*

Boards should oversee the effective execution of a plan to achieve their aims to reduce harm, just as they oversee finance. The board can set the agenda for improvement through the linkages in performance review and compensation systems for all top leaders. The feedback to these leaders in reviews can create energy around a patient-focused safety agenda, or it can focus more exclusively on financial performance. The board's choice about these messages tends to have a lasting impact on the day-to-day priorities and focus for the leader team's daily work. A review on how boards are incenting CEOs and senior executives to provide will and ensure successful execution has been published (Rice, 2008).

If each facility in the nation could make a commitment to these practices, we predict enormous improvement in introducing the best practices at the heart of the 5 Million Lives Campaign and a dramatic national transformation in the quality and safety of health care organizations care.

Topical Discussions in Governance and Quality

Since the introduction of the Governance Intervention, seven specific issues have emerged:

1. Dashboards: A number of excellent references are included in the How-to Guide and new materials are being assembled. The 2006 Forum presentation by Lloyd, Martin, Nelson, and Stiefel is a comprehensive resource http://www.ihi.org/ihi/files/Forum/2006/Handouts/C12_BLloyd_LMartin_GNelson_MStiefel_Dashboard.pdf as is the 2007 article by Pugh and Reinertsen.
2. Involving Patients and Families: Requests have come in for information on how to effectively integrate patients and families at the time of error or unanticipated outcomes, as well as more routinely in the work of the board. In addition to the IHI's article on boards and executives working closely with patients and families (Conway, 2008), and the review articles out of a recent expert meeting (Conway et al., 2006; Johnson et al., 2008), other key resources include:
    a. Institute for Family Centered Care www.familycenteredcare.org
    b. IHI Patient-Centered Care www.ihi.org/IHI/Topics/PatientCenteredCare/
    c. Planetree Organization www.planetree.org

    Concern has been expressed about legal and risk issues associated with sharing information around medical error and care experiences directly with patients and families when they become aware of the care of others. Clearly, HIPAA and the rights of patients and staff must be respected. Each of the organizations above has specific experiences in this area and can provide counsel. In sum, that errors happen is not a surprise to patients and families; patient and family advisors respect confidentiality when they volunteer and are asked to sign confidentiality agreements; and patients and families share the same overall

goals as the organization—they want to know what happened, why it happened, and what's being done to prevent it from happening again. It is their care system, too.

3. System-Level Boards: The role of the system-level board is a frequent topic of interest. The referenced paper by Orlikoff and Totten (2006) on *The Challenges of System Governance* is a strong resource.
4. Public Boards: Information around optimizing the unique challenges of the public board is a routine request. Resources are being assembled and will be posted on www.ihi.org. The National Association of Public Hospitals and Health Systems is also a valuable go-to place www.naph.org.
5. Rural and Critical Access Hospitals: Multiple organizations and communities are effectively scaling the Boards on Board to this environment. In turn, rural and critical access hospitals are providing courage and leadership to the Campaign. The Campaign website is a strong resource for current efforts in this area. http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=2#RuralHospitalsAffinityGroup
6. Governance / Leadership Assessments. Across the governance community there has been a search for assessment tools that governing boards, executive leaders, and middle managers can use to understand where they are, monitor improvement, and consider leadership in the context of outcomes. The Oklahoma Foundation for Medical Quality (OFMQ), under contract with the Centers for Medicare & Medicaid Services (CMS), is leading a major national initiative to align health care leadership with clinical performance improvement. This public-private collaboration, including advisors from 55 industry organizations and over 130 supporting partners, is developing an assessment tool to help health care organizations identify and adopt quality-oriented leadership systems and ultimately improve clinical care processes and outcomes. The Hospital Leadership and Quality Assessment Tool (HLQAT) is now in pilot. http://www.ofmq.com/hospital-leadership-collaborative
7. Disruptive Behaviors. Increasingly, discussions of "crucial conversations" among boards and executive leaders are focusing on disruptive behaviors among staff,

their impact on quality and safety, and the role of the board and executive leadership. The Joint Commission has set new standards in this area and content is emerging. A few representative general articles are included in the bibliography (Leape and Fromson, 2006; Smetzer and Cohen, 2005; Hickson et.al, 2007; Rosenstein and O'Daniel, 2005).

8. Engaging Physicians in Quality and Safety. Throughout the Campaigns, we have been struck with the tremendous commitment of physicians and all clinician staff, as well as the enormous demands on their time. Organizations often struggle with how to respectfully and effectively engage physicians. The previously referenced IHI White Paper, "Engaging Physicians in a Shared Quality Agenda," presents a strong model for consideration. http://www.ihi.org/IHI/Results/WhitePapers/EngagingPhysiciansWhitePaper.htm

Getting Started on the Governance Intervention

How does a health care organization move forward?

1. Distribute the How-to Guide to the board and executive administrative and clinical staff immediately.
2. Put the 5 Million Lives Campaign on the agendas of the next meetings of the Board of Trustees and the Board Quality Committee, along with those of the executive leadership and the Medical Executive Committee.
3. Open these meetings with a short narrative of an actual patient event, illustrating a type or pattern of harm that occurred within the last month in that institution. This is most effective when connected to the organization's harm reduction strategy, including lessons learned from the event and specific actions being asked of the board.
4. Present the *Six Things All Boards Should Do to Improve Quality and Reduce Harm,* and develop an action plan to move forward on each item within the next month.
5. Place your organization's system-level harm metrics on the board and senior leadership dashboards.

Annotated Bibliography

Alexander JA, Lee SD. *Does governance matter? Board configuration and performance in not-for-profit hospitals.* The Milbank Quarterly. 2006;84(4):733.

The article is valuable not only for showing how differences in governance mechanisms can be conceptualized and measured, but also for providing evidence that governance makes a difference on certain outcomes. It provides strong evidence that more attention is indeed warranted to the relationship between governance and performance, particularly in areas that are distinctive to the role of nonprofit institutions.

Bisognano M, McCannon J, Botwinick L. *A campaign for 100,000 lives: The time is now for boards to lead quality and safety efforts*. *Trustee*. 2005;58(8):12-14,19,1.

The board has a major role in the Institute for Healthcare Improvement's plan for saving 100,000 patient lives by 2006 through implementation of six proven quality interventions. This article underscores the role, the approach, and the outcomes.

Bjork D, Fairley JD. *Creating a Culture of Collaborative Leadership Between Boards and CEOs: A Practical Guide for Trustees*. Center for Healthcare Governance; 2006.

This publication is one in a series of recent monographs issued by the Center that can be accessed at http://www.americangovernance.com/americangovernance/publications/monographs.html; it is designed to be a resource for both new and seasoned board members and CEOs. It should be included in new board member orientation materials and used as a primer in board leader and officer education programs. Understanding the nature and importance of the board-CEO relationship and how to work together effectively can help both parties get the most out of this critical leadership partnership and can also help pave the way for establishing a board culture of active, engaged governance. As Bjork and Fairley conclude, "…if the board accepts and acts on its responsibility to nurture this relationship, it will make the CEO's job easier, the board's job easier, and the organization more successful."

Building an Exceptional Board: Effective Practices for Health Care Governance. Report of the Blue Ribbon Panel on Health Care Governance (2007). HRET and Center for Healthcare Governance. http://www.americangovernance.com/americangovernance/resources/blueribbon.html

The report examines key issues in governance and offers practical guidance for how board chairs and members can improve their performance and accountability. Comprised of hospital trustees, CEOs, governance experts, and researchers, the panel focused its efforts on five areas it determined were critical to effective governance: Being an Accountable Board: Earning and Maintaining the Public's Trust; Building and Sustaining a Proactive and Interactive Board Culture; Laying a Foundation for Effective

Decision-Making: Board Meetings and Information for Governing; Focusing the Board on Key Governance Priorities; and Clarifying Authority and Responsibility: The Buck Stops Where? The report includes the panel's recommendations in each of these areas, as well as sample tools and resources to implement them. It is intended to foster broader dialogue and sharing, among health care organizations and their boards, of perspectives and resources to further strengthen and improve health care governance.

Chait R, Ryan W, Taylor B. *Governance as Leadership: Reframing the Work of Nonprofit Boards*. BoardSource and John Wiley and Sons: Hoboken NJ; 2005.

Written by noted consultants and researchers attuned to the needs of practitioners, *Governance as Leadership* redefines nonprofit governance. The book sheds light on the traditional fiduciary and strategic work of the board and introduces a critical third dimension of effective trusteeship: generative governance. It provides a powerful framework for a new covenant between trustees and executives: more macrogovernance in exchange for less micromanagement.

Clough J, Nash, DB. *Health Care Governance for Quality and Safety: The New Agenda.* American Journal of Medical Quality 2007 22: 203-213.

A comprehensive bibliography of publications on governance and executive leadership for quality and safety.

Conway J, Johnson B, Edgman-Levitan S, Schlucter J, Ford D, Sodomka P, Simmons L. *Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future. A Work in Progress.* Institute for Family-Centered Care and Institute for Healthcare Improvement; web manuscript, June 2006. http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/

This paper provides background information to facilitate the development of an action plan to ensure that sustained, meaningful partnerships with patients and families are in place in hospitals and health systems; in community clinics and other ambulatory settings; in schools educating the next generation of health care professionals; in national associations; in federal, state, and community agencies; in foundations and advocacy organizations; and among payers. The paper was drafted at the request of The Robert Wood Johnson Foundation in preparation for a one-day invitational meeting convened by the Institute for Family-Centered Care and the Institute for Healthcare Improvement in June 2006.

Conway J. Patients and families: Powerful new partners for health care and for caregivers. *Healthcare Executive*. 2008 Jan/Feb;23(1):60-62.

This article, the third in a series on IHI's 5 Million Lives Campaign intervention on governance leadership, focuses on key leadership strategies that can improve patient safety. The author describes engaging patients and families as partners for health care and for caregivers.

Conway, J. Getting Boards on Board: Engaging Governing Boards in Quality and Safety. *Jt Comm J Qual Patient Saf*. 2008 Apr;34(4):214-20.

This article profiles in detail the evidence behind and the elements of the Boards on Board intervention. It is the sixth and final article in the series on the 5 Million Lives Campaign, the Institute for Healthcare Improvement's national initiative that aims to protect patients from five million incidents of medical harm in United States hospitals between December 2006 and December 2008.

Department of Health and Human Services Office of Inspector General (OIG) and the American Health Lawyers Association (AHLA). *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors.* June 27, 2007. http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf

This educational resource is a co-sponsored document by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the American Health Lawyers Association (AHLA). It seeks to assist directors of health care organizations in carrying out their important oversight responsibilities in the current challenging health care environment. Improving the knowledge base and effectiveness of those serving on health care organization boards will help to achieve the important goal of continuously improving the U.S. health care system.

Department of Health and Human Services. Centers for Medicare and Medicaid Services. *Hospital Leadership Summit: Moving from Good to Great*. CMS Headquarters, September 28, 2006.http://www.ofmq.com/cms-leadership-summit

This is a summary of proceedings of an invitational conference representing a broad range of constituents, including health system and hospital executives, clinical leaders, representatives of public agencies, national and state hospital associations, and QI organizations, academicians, researchers, and consultants. The program presented in two areas: the review of recent research on the relationship between hospital leadership and institutional high performance; and case studies describing how hospital leaders have been successful in taking steps to address quality within their organizations.

Getting the Board on Board: What Your Board Needs to Know about Quality and Patient Safety. Joint Commission Publishing.
http://store.trihost.com/jcaho/product.asp?dept%5Fid=34&catalog%5Fitem=787

This books shows how board members can play a leading role in improving the quality and safety of the care, treatment, and services provided at their organizations. This book addresses growing demands for boards to take responsibility not just for the organization's financial integrity but for quality and patient safety. Case studies and examples from hospitals and health care leaders across the United States demonstrate effective boards' best practices in promoting a culture of quality and safety; participating in measurement and improvement; addressing quality and safety in board meetings; and holding management accountable for change.

Hickson GB, Pichert JW, Webb LE, Gabbe S. A complementary approach to promoting professionalism: identifying, measuring and addressing unprofessional behaviors. *Academic Medicine*. November 2007;82(11).

Vanderbilt University School of Medicine (VUSM) employs several strategies for teaching professionalism. This article, however, reviews VUSM's alternative, complementary approach: identifying, measuring, and addressing *un*professional behaviors. The key to this alternative approach is a supportive infrastructure that includes VUSM leadership's commitment to addressing unprofessional/disruptive behaviors, a model to guide intervention, supportive institutional policies, surveillance tools for capturing patients' and staff members' allegations, review processes, multilevel training, and resources for addressing disruptive behavior.

Hospital Governing Boards and Quality of Care. A Call to Responsibility. National Quality Forum; 2004.

As follow-up to a March 2004 meeting, "A Call to Responsibility" was developed to call on hospital governing boards to review their policies and practices to make sure that they are consistent with four principles fundamental to delivering quality health care.

Johnson B, Abraham M, Conway J. Simmons L, Edgman-Levitan S, Sodomka P, Schlucter J, Ford D. *Partnering with Patients and Families to Design a Patient and Family-Centered Health Care System Recommendations and Promising Practices*. Institute for Family-Centered Care and Institute for Healthcare Improvement; web manuscript, January 2008.
http://www.familycenteredcare.org/pdf/PartneringwithPatients.pdf

A one-day invitational meeting was convened by the Institute for Family-Centered Care (IFCC) in collaboration with the Institute for Healthcare Improvement (IHI) on June 2, 2006, with the goal to "explore how to enhance efforts to collaborate with patients and families in the redesign of health care and to realize the enormous potential of patient and family partnerships." This meeting brought together 26 patient and family advisors, 59 administrative and clinical leaders from hospitals and other health care organizations and foundations, IHI, and other leadership. This report is based on the deliberations that took place at that meeting and on the recommendations that emerged from it. Many of the report's recommendations are illustrated by examples drawn from health facilities and other organizations that are making exemplary progress in partnering with patients and families.

Joshi MS, Hines SC. Getting the board on board: Engaging hospital boards in quality and patient safety. *Joint Commission Journal on Quality and Patient Safety*. 2006;32(4):179-187.

The authors identified a series of steps by boards to improve a hospital's overall performance that include: (1) increasing education on quality to increase the board's quality literacy; (2) improving the framing of an agenda for quality; (3) more quality

planning, focus, and incentives for leadership and governance for quality improvement; and (4) greater focus on the patients.

Kroch E, Vaughn T, Koepke M, Roman S, Foster D, Sinha S, Levey S. Hospital boards and quality dashboards. *Journal of Patient Safety*. 2006;2(1):10-19.

This study found much variation in dashboard content and in the implementation practices associated with them. The suggested relationship of dashboard content, development, and implementation practices to observed hospital performance is worth noting. Further research relating these preliminary findings to quality performance would enable the identification of characteristics of dashboards that are most useful in supporting hospital leadership in its QI activities.

Leape LL. Fromson JA. Problem Doctors: Is There a System-Level Solution? *Ann Intern Med.* 2006;107-115.

In this article the authors review definitions, underlying causes, the extent of the problem, an ineffective system, identifying physicians whose performance may endanger patients, a model for improvement, and a plan for moving ahead.

Lockee C, Kroom K, Zablocki E, Bader B. *Quality*. The Governance Institute; 2006.

This publication is designed to give boards the insights and the tools they need to make a difference in the organization's quality journey towards understanding the fundamentals of quality, the importance of board engagement, the findings from research on best practices, measurement, building a culture of safety, the business case, resource allocation, and the power of oversight.

McDonagh K. Hospital governing boards: a study of their effectiveness in relation to organizational performance. *Journal of Healthcare Management*. 2006;51:6. Umbdenstock R. Practitioner Application.

This article describes the development and evolution of governing boards and summarizes critical findings from a research study on hospital governing boards. The factors that measure governing board performance were found to be consolidated into one single factor of collaborative board functioning consistent with emerging governance theory.

Moody's Investor Service. *Improving clinical quality and patient safety of greater importance to not-for-profit hospitals*. Special Comment. Moody's Investor Service; May 2006.

This article reflects the growing importance of clinical quality and patient safety in the eyes of multiple stakeholders: patients, physicians, payers, employers, and hospitals. In the Summary Opinion, the authors write, "Moody's anticipates that in the short-term, strategies to improve quality and patient safety will likely reduce operating results for many hospitals as the tools and steps to implement the strategy may require adding

costs faster than benefits are realized. However, hospitals that eventually demonstrate a sustainable link between quality investments and better clinical outcomes will likely gain competitive advantage, thereby improving financial performance and possibly their bond ratings.

National Business Group on Health. *A Toolkit for Action: Ensuring Patient Safety Across Health Care.* 2007. www.businessgrouphealth.org/healthtopics/patientsafety/toolkit/index.cfm.

The Board of Directors of the National Business Group on Health adopted a position statement on patient safety in November 2006, Recommendations to Employers on Essential Actions to Improve the Quality and Safety of Health Care. To reinforce its commitment to the issue, the Business Group has developed **A Toolkit for Action: Ensuring Patient Safety Across Health Care** specifically for employers. Many organizations and individuals provided input for this product.

Orlikoff JE. Building better boards in the new era of accountability. *Frontiers of Health Services Management* (American College of Healthcare Executives). 21:3.

Health care boards are entering a new era of heightened accountability, scrutiny, and reform. The authors note the structure, composition, and specific required functions of boards can be legislated or mandated, but the effective function of boards cannot. At the same time that governance faces this new era of accountability, it is also being bombarded with the legions of monumental challenges in the tumultuous health care field. Chief executive officers and their boards must be willing to recognize the challenges and risks to the field of governance in general and to their boards in particular. Furthermore, they must be willing to implement new strategies and approaches for successful governance, including becoming compliant with Sarbanes-Oxley requirements; conducting a comprehensive audit of the structure, function, composition, and culture of the board; and seeking board members from outside the community, among many others.

Orlikoff J, Totten MK. *The Challenges of System Governance*. Trustee Workbook. April 2006.

Prybil L, Levey S, et.al. *Governance In Nonprofit Community Health Systems: An Initial Report on CEO Perspectives*. Grant Thornton LLP
Chicago, Illinois. February 2008. http://www.public-health.uiowa.edu/news/pdf/021508-release.pdf

This report on CEO perspectives reports most nonprofit community health systems' governing structures and practices are consistent with established benchmarks of good governance while noting there is room for improvement. The report examines the structure and composition of community health systems' governing boards as well as their practices, procedures and underlying culture, based on a survey of 123 health system CEOs.

Pugh M, Reinertsen JL. Reducing harm to patients. *Healthcare Executive*. 2007;22(6):62, 64-65.

This article by Michael Pugh and James Reinertsen is the second in a series on key leadership strategies that can improve patient safety. Inspired by IHI's 5 Million Lives Campaign, the authors lay out the principles and merits of dashboards to track specific and whole system quality improvement.

Reinertsen JL, Gosfield AG, Rupp W, Whittington JW. *Engaging Physicians in a Shared Quality Agenda.* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org)

This white paper presents a framework on which hospital leaders might build a written plan for physician engagement in quality and safety. The paper includes tools to help hospital leaders assess organizational factors that will inform the degree of difficulty in engaging physicians, as well as to identify and prioritize initiatives for which physician engagement is essential. While the principal focus of the paper is on American hospitals and their organized medical staffs, the framework might also be applied to many other types of health care systems and in settings outside the United States.

Reinertsen J. Boards, administrators, medical staffs and quality: Sorting out the roles. *Trustee*. 2003;1-11.

The purpose of this article is to address the roles of hospital boards, administrators, and medical staff leaders in clinical quality, with the emphasis on clarifying the key responsibilities of trustees in overseeing the core work of their institutions—caring for the sick. The board's roles can be summarized as follows: Understand the important things your community expects from your hospital; See that a few system-level measures of those things are established, understood and monitored (the "Big Dots."); Aim to improve the Big Dots, and link the improvement of those things to your main strategic goals; Build the hospital's will to achieve these aims; Maintain constancy of purpose for the long-term quality transformation of the hospital; and Promote collaboration across the community for redesign of care.

Rice, J. *Executive Pay and Quality: New Incentive Links*. Integrated Healthcare Strategies, 2008. http://www.ihstrategies.com/pdf/NewIncentiveLinks.pdf

A survey of hospital CEOs and senior human resource executives in 119 organizations provides evidence that the national attention to improve the quality and safety of patient care has taken root in over 80% of the hospitals, and is growing. Boards and senior executives are building explicit measures for quality improvement into their incentive pay plans. This survey explores patterns in the motivations, levels, metrics, and methods of incentive pay for hospital physician and administrative leaders during the summer of 2007.

Rosenstein AH, O'Daniel M. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. *Am J Nurs*. 2005;105:54-64; quiz 64-65.

This study examined the impact of work relationships on clinical outcomes. Investigators surveyed more than 1500 nurses, physicians, and administrators to elicit their perceptions on disruptive behavior and its consequences. Most providers perceived a negative effect of such behavior on adverse events, medical errors, and the overall quality of care provided. The authors suggest greater emphasis on improving working relationships and offer a number of strategies to consider.

Safe Practices for Better Healthcare—2006 Update: A Consensus Report. Washington, DC: National Quality Forum; 2006.

In 2003, the National Quality Forum (NQF) endorsed a set of 30 safe practices to reduce the risk of harm to patients. They serve as a tool for health care providers, purchasers, and consumers to identify and encourage practices that will reduce errors and improve care. The practices were updated in 2006 and "Table 1: Safe Practices, Care Settings, and Specifications" (included here) is excerpted from the full report to provide a snapshot of the entire set of practices. Governance and Executive Leadership receive considerable reference in the Chapter on Culture of Safety. The full report is available on the NQF website.
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Literature/SafePracticesforBetterHealthcare2006Table1.htm

Schyve PM. What you can do: the trustee, patient safety, and JCAHO. *Trustee.* 2003;56(2):19-21.

The Joint Commission has developed patient safety standards that hospital leaders, including trustees, are responsible for implementing, along with National Safety Goals and recommendations. The author examines these standards through the lens of the board.

Smetzer,JL, Cohen, MR. Intimidation: Practitioners speak up about this unresolved problem. *Joint Commission Journal on Quality and Patient Safety*. October 2005. [Available online at http://www.ismp.org/Survey/surveyresults/Survey0311.asp]

This survey, conducted by the Institute for Safe Medication Practices, captured more than 2000 health care providers' views to assess the prevalence of intimidation in patient care settings. Results suggested widespread experiences with a variety of intimidating behaviors such as condescending language, impatience with answering questions, or refusal to answer questions or a telephone call. Findings were not limited to physicians; pharmacists seemed more affected than nurses, and nearly half of respondents felt the behaviors countered necessary patient safety efforts. The authors conclude with recommendations to promote cultural change.

Standard and Poor's. Sweeney L, editor. *Quality And Transparency Could Transform U.S. Not-For-Profit Health Care*. Standard and Poor's; 2006.

S&P is modifying its credit rating process to incorporate an assessment of quality programs and outcomes in health care organizations and the role of leadership at the Board and executive levels to drive those outcomes. In this report, S&P outlines the questions they are asking as well as their plan for increasingly intensive scrutiny in the future.

Taylor B, Chait R, Holland T. *The New Work of the Nonprofit Board*. Harvard Business Review. Reprint 96509; 1996.

Too often, the board of a nonprofit organization is little more than a collection of high-powered people engaged in low-level activities. But that can change, the authors say, if trustees are willing to discover and take on the new work of the board. When they perform the new work, a board's members can significantly advance the institution's mission and long-term welfare. The authors give many examples of boards that have successfully embraced the new work. The stakes are high: if boards demonstrate that they can change effectively, the professional staff at the institutions they serve just may follow suit.

Vaughn T, Koepke M, Kroch E, Lehrman W, Sinha S, Levey S. *Engagement of leadership in quality improvement initiatives: executive quality improvement survey results*. Journal of Patient Safety. 2006;2(1):2-9.

The results of the survey show that hospital leadership is engaged in quality, but in a manner that can be enhanced. Several changes in leadership structures and systems relating to boards and senior administrative management teams are recommended so that the pace of improvement that Americans want can be realized in the hospital industry.

Weiner BJ, Alexander JA, Shortell SM*. Leadership for quality improvement in health care: Empirical evidence on hospital boards, managers and physicians*. Medical Care Research and Review. 1996;53:397-416.

Weiner B, Shortell S, Alexander JA. *Promoting clinical involvement in hospital quality improvement efforts: The effects of top management, board, and physician leadership.* Health Services Research. 1997;32:491-510.

An examination of the effects of top management, board, and physician leadership for quality on the extent of clinical involvement in hospital CQI/TQM efforts. Measures of top management leadership for quality and board leadership for quality showed significant, positive relationships with measures of clinical involvement in CQI/TQM. Active-staff physician involvement in governance showed positive significant relationships with clinical involvement measures, while physician-at-large involvement in governance showed significant negative relationships. Study results suggest that leadership from the top promotes clinical involvement in CQI/TQM. Further, results indicate that leadership for quality in health care settings may issue from several sources, including managers, boards, and physician leaders.

When Things Go Wrong: Responding to Adverse Events. A Consensus Statement of the Harvard Hospitals. Burlington, Massachusetts: Massachusetts Coalition for the Prevention of Medical Errors; March 2006.

This consensus paper of the Harvard-affiliated hospitals proposes full disclosure, including an apology to the patient, when adverse events or medical errors occur. The paper represents the collaborative effort of a group of clinicians, risk managers, and patients participating from several Harvard teaching hospitals and the Risk Management Foundation.

Zablocki E. IHI calls on boards to lead on quality and safety. *Great Boards*. Summer 2007;7(2):1-5.
http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Literature/IHICallsonBoardstoLeadQualitySafetyConway.htm

Jim Conway, Senior Vice President at the Institute for Healthcare Improvement (IHI), discusses the essential role of hospital boards in leading and accelerating safety and quality efforts. "Get the Board on Board" is one intervention in IHI's 5 Million Lives Campaign.

Additional Resources: Governance and Leadership of Quality

(Available at IHI.org: http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Literature/)

Bader B. Best Practices for Board Quality Committees. Great Boards. Accessed April 20, 2006. Available at http://www.greatbrds.org/newsletter/reprints/Board_quality_committees_best_practices.pdf

Bader B. 7 Things Your Board Can Do to Improve Quality and Patient Safety. Great Boards. Spring 2006. Available at http://www.greatboards.org/newsletter/reprints/GBspring06-reprint-quality.pdf

Bader B. *Quality and Patient Safety: Engaging Your Board to Take the Lead*. ACHE Journal, March-April 2006. Available at http://www.greatboards.org/resources/pdf/Healthcare_Executive_Bader_article_patient_safety.pdf

Bader B. The right stuff, the right way: 10 ways to improve board meetings. Great Boards. Winter 2005. Available at http://www.greatboards.org/newsletter/reprints/Ten_Ways_to_Improve_Board_Meetings.pdf

Bibby J, Reinertsen J. Leading for Improvement: Whose Job Is It Anyway? Pursuing Perfection and the NHS Modernisation Agency; October 2004. (Unpublished Manuscript).

Botwinick L, Bisognano M, Haraden C. *Leadership Guide to Patient Safety*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006. (Available on www.IHI.org)

Gautam KS. A call for board leadership on quality in hospitals. *Qual Manag Health Care*. 2005;14(1):18-30.

Gosfield AG, Reinertsen JL. The 100,000 Lives Campaign: Crystallizing standards of care for hospitals. *Health Affairs*. 2005;24(6):1560-1570.

Great boards ask tough questions: What to expect from management on quality. *The Governance Institute*. 2005;16(2).

Joshi MS, Hines SC. Getting the board on board: Engaging hospital boards in quality and patient safety. *Jt Comm J Qual Patient Saf*. 2006;32(4):179-187.

Move Your Dot™: Measuring, evaluating, and reducing hospital mortality rates. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

Patient safety survey. *Trustee.* 2005;58(1):8-9.

Reinertsen J, Pugh M, Bisognano M. *Seven Leadership Leverage Points for Organization-level Improvement in Health Care*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2005. (Available on www.IHI.org)

Reinertsen J. *A Theory of Leadership for the Transformation for Health Care Organizations*. The Reinertsen Group; May 2003. (Unpublished manuscript, revised January 2004.)

Governance Institute Publications:

(Available at IHI.org: http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Literature/)

Board Quality Committees: The Governance Institute's Fax Poll Results. Dec 2002.

Getting on Board with Quality. *Board Room Press*. February, 2005.

Taking a Strong Stance on Quality Oversight. *Board Room Press*. October, 2006.

The Board's Role in Quality Oversight: Not a Responsibility That Can Be Delegated. *Board Room Press*. October, 2004.

Total Quality Management: A Committee Takes the Reigns. *Board Room Press*. April, 2006.

IHI National Forum Presentations:

Bader B, Joshi M. *Hospital Boards: No Pain, No Gain*. IHI National Forum, Dec. 2005. Accessed April 20, 2006. http://www.delmarvafoundation.org/html/content_pages/presentations/Maulik/ihidecember2005.pdf

Bader B. *Follow the Leaders*. IHI National Forum, Dec. 2005. Accessed May 14, 2007. http://www.ihi.org/ihi/files/Forum/2006/Handouts/C9_BBader_Follow_the_Leaders_Handout.pdf

Joshi M, Christian D. *How Governance Makes a Difference in the Quality of a Hospital's Performance*. IHI National Forum, Dec. 2004. Accessed Apr 20, 2006. http://www.delmarvafoundation.org/html/content_pages/presentations/Maulik/forihi11_27_2005newbackground.pdf

Publications from the AHA Center for Healthcare Governance:
(To order copies, call 888-540-6111 or e-mail bladewski@americangovernance.com)

Does Excellent Health Care Governance Lead to Excellent Performance? (Or, can a Great Board make a Difference?)

Hospital Patient Safety and Quality Monitoring: A Resource for Governing Boards and Trustees

Patient Safety and Quality Reporting for Governance: Data Reporting Guide for Hospital Staff

Major Associations in Governance Leadership:

Center for Healthcare Governance http://www.americangovernance.com/

CMS http://www.cms.hhs.gov/

Estes Park Institute http://www.estespark.org/

Great Boards http://www.greatboards.org/

Joint Commission http://www.jointcommission.org/

National Association of Public Hospitals and Health Systems www.naph.org

National Center for Healthcare Leadership http://www.nchl.org/

National Quality Forum http://www.qualityforum.org/

The Governance Institute http://www.governanceinstitute.com/

Appendix A: Recommended Intervention-Level Measures

The following measures are relevant for this intervention. The Campaign recommends that you use some or all of them, as appropriate, to track the progress of your work in this area.

Outcome Measure(s):

Rate of Medical Harm per 100 Admissions
Owner: **IHI** Owner Measure ID: **N/A** Measure Information: **[Campaign MIF]** Comments: • This measure is almost identical to Rate of Medical Harm per 1000 Patient Days; the only difference is the denominator used. The main benefit of looking at harm per 100 admissions (rather than per 1000 patient days) is that it is more accessible, especially to non-clinical audiences, and so might be better for building will.

Rate of Medical Harm per 1000 Patient Days
Owner: **IHI** Owner Measure ID: **N/A** Measure Information: **[Campaign MIF]** Comments: • This measure is almost identical to Rate of Medical Harm per 100 Admissions; the only difference is the denominator used. The main benefit of looking at harm per 1000 patient days (rather than per 100 admissions) is that your results will be more comparable to other hospitals' results (useful, for example, if the hospital is participating in a collaborative or system-wide improvement project), because the use of patient days in the denominator serves as a crude risk-adjustment mechanism.