

IHI 5 Million Lives Campaign Board Governance



Colorado Tool Kit: A Guide for Effectively
Engaging Senior Leadership and Board of
Trustees in Quality Improvement

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Introduction

Hospital Board of Trustees and senior leadership have more of an active role in improving quality and patient safety than ever before. Specifically, there has been a large demand for Board of Trustees and CEOs to have greater accountability for quality and patient safety practices, and it has been suggested that quality and patient safety should have equal attention as financial activity and growth in hospital board meetings.

The Colorado Hospital Association has been asked by the The Colorado Trust to take the lead on the "Boards on Board" initiative of the 5 Million Lives Campaign. This project will work to better engage board and senior leadership in quality and patient safety accountability, and provide hospitals with tools and resources to make progress in this important area. CHA is thrilled to be part of this national initiative, and will serve as the main resource to all Colorado hospitals for technical assistance and guidance for the Boards on Board initiative. CHA is identifying ways to engage all of our members in this effort so that all Colorado hospitals can benefit from the resources that will be provided to make progress in this important area. In the coming months, CHA will be offering a series of educational seminars led by board governance experts, who will share best practices and tools for successfully engaging board and senior leadership. In addition, CHA will provide Colorado hospitals with valuable tools and resources to successfully develop and implement their campaign goals related to Board Governance.

The purpose of this tool kit is to provide a framework for the implementation of the Boards on Board initiative in your individual hospitals and health systems. As this initiative moves forward in the coming months, more tools and resources will be made available to help Colorado hospitals advance this initiative and facilitate sustainability of these efforts.

Seven Leadership Leverage Pointsⁱ

Implementation of various Campaign interventions during the 100,000 Lives Campaign has drawn attention to a number of significant challenges and triggered some early lessons for the leadership teams of Campaign organizations. For example, the Campaign timetable requires leaders to plan and execute improvement at a larger scale and faster pace than ever before. While hospitals are finding that being part of the national enthusiasm that surrounds the Campaign is helpful, enthusiasm alone is not enough to carry any individual hospital through the implementation of the necessary changes.

The Seven Leadership Leverage Points provide a framework for leaders to answer these questions as they plan to save 121, or 392, or however many lives would represent their contribution to the overall goal of reducing incidents of harm in hospitals. Use the Seven Leadership Leverage Points to guide the development of your agenda for the 5 Million Lives Campaign. The CEO and senior management team might like to start by doing the following:

- Read and understand the 5 Million Lives Campaign documents that describe each of the Campaign interventions, and the evidence base and potential impact of implementing each intervention.
- Individually review the white paper [Seven Leadership Leverage Points for Organization-Level Improvement in Health Care](#) and complete your own self-assessment (Appendix A of the white paper which is provided with this tool kit).
- Share assessments and recommended actions.
- Gather the relevant data needed to establish appropriate aims.
- Adopt an aim and create a plan for the local application of the 5 Million Lives Campaign interventions.

It is important to complete this process very quickly in order to get on with the implementation and steering of the plan. Leaders signal the pace, or tempo, of any major initiative by how they act during the first phases of the work.

A. Establish System Level Measures

One example of establishing system level measures is to identify Big Dots in the hospital or health system. Big Dots are system level measures that set the expectation for the level of quality in a facility. Through the use of Big Dots, a governing board can measure overall performance, align incentives and measure the effectiveness of

strategies. Governing boards should have a sense of ownership over the Big Dots, especially because the measures should collectively answer the question “How good are we?”. Big Dots should also be transparent, so that everyone in the organization can be aware of their purpose and the level of expectation.

B. Align System Measures, Strategy and Projects

One of the biggest disconnects in hospitals and health systems are that quality efforts are often not aligned with overall aims and strategy. Quality efforts need to be aligned with the Big Dots of the facility to make forward progress in the quality arena. One method to creating alignment is to use the following example:

Big Dots (Board/System Level Measures)	Drivers (Core Strategies and Theories)	Projects (Operating Plan)
<ol style="list-style-type: none"> 1. What are your system level aims and aspirations? 2. What are the system level measures of those aims (i.e. Big Dots)? 3. How good must you be and when? 	<ol style="list-style-type: none"> 1. What are your key organizational strategies for moving your dots? 2. What really has to be changed, or put in order, to achieve each of these goals? 	<ol style="list-style-type: none"> 1. What set of projects will move the Drivers far enough and fast enough to achieve your aims?

C. Channel Board Attention to System-level Improvement

Important questions that hospital and health system boards should be asking themselves include:

1. How often does senior management review progress on quality efforts with the board?
2. How often does the board hold senior level review of measures, strategies and project results?
3. How often does senior management share the results of the review with hospital employees?
4. How often does senior management share efforts, successes, failures and frustrations related to quality efforts with the board?

5. How often does the board and/or senior management look for new opportunities to make improvements related to quality and patient safety?

D. Get the Right Team on the Bus

Each hospital and health system needs to build a quality team that possesses the desire and skill to make advances in quality improvement. Improvements in quality should be a dynamic process; therefore the team members needs to be aware that change needs to occur in the present as well as in the future. Constructing the wrong team for this effort can impede/delay progress and consume valuable time and attention.

Remember that a valuable member of the quality team is the patient!

E. Enlist the CFO as the Quality Champion

Chief Financial Officers (CFOs) can and should be a quality champion. If healthcare CFOs were to become strong drivers of quality in their organizations, it would result in system-level change including:

1. Increase the rate of waste elimination, which would result in better profit margins.
2. Change priorities for capital investment.
3. Change the budgeting and reporting process.
4. Change the learning systems of an organization.
5. Increase the rate of improvement in system-level clinical measures.

There are several ways that CFOs can provide quality leadership to the quality team. CFOs can devote resources to support variation analysis that has identified which areas need work in the hospital. CFOs can also set financial goals tied to clinical goals for improvement efforts as well as provide direct support to the improvement teams that are driving change in the facilities.

F. Engage Physicians

It is important to engage physicians when promoting quality improvement. However, certain methods should be applied for effective engagement.

1. Adopt a new stance: consider physicians your partner, not a customer.
 - Ask physicians to lead this work, and share power and information.
 - Better equip physicians to lead and drive improvement.

2. Uncover a common purpose: the physician quality agenda
 - Physicians are interested in patient outcomes and efficient use of time.
3. Expand the scope: encourage a system view of responsibility
 - Report system measures even if no part of the system is accountable.
4. Use data sensibly: generate light, not heat
 - Do not report system attributes as if they were individual physician results.
5. Reduce variation: standardize effectively with complexity
 - Create bundles and key processes. Avoid the use of complex care pathways.
6. Seek to systemize care around the evidence
 - Allow more time for physicians to practice the art of medicine.
7. Demonstrate backbone: show courage
 - Remember what is best for the patient.

G. Develop Improvement Capability

Key questions for senior leadership include:

1. How much have you invested over the past five years in developing improvement knowledge and capability in your organization?
2. Do you have a method or approach that is *systematically* used to improve processes?
3. Does your senior leadership team actually lead improvement projects?

H. Additional Points

Hospitals should focus on Developing the Right Culture. Organizational culture is an outcome, not an accident. Senior leadership should have a clear vision of a desired organizational culture and leadership actions should drive desired changes.

Remember these key questions when getting started:

1. What are you willing to promise your patients, staff, physicians and your communities about your organization's performance?

2. Are your strategies aligned with the results that you need to achieve?
3. What do you need to do to get your medical staff engaged?

Hospital Board Performance Scorecardⁱⁱ

Hospital boards should use performance scorecards to help focus on specific quality improvement and patient safety indicators, which when combined provide a “state of health” for the level of quality at each individual facility. Performance scorecards should be balanced, addressing a variety of quality and patient safety topics, and should designate a benchmark for facility-specific aims and results. Specific measures that should be on the performance scorecard include:

- Colorado Hospital Report Card Measures
- Re-admission Rate
- Patient Experience/Satisfaction
- Number of Patient Adverse Events
- Number of Patient Never Events
- Employee Satisfaction
- Percentage of Patients Receiving Care According to the Evidence
- Operating Margin Percentage
- Cost per Discharge
- Days Cash on Hand
- Waiting Time / Access Measures

The Colorado Hospital Report Card will report on standardized quality and clinical outcome measures that are endorsed by national organizations, with established standards to measure the performance of healthcare providers and hospitals. The Colorado Hospital Report Card is a dynamic tool, with a long term goal for it to be comprised of a comprehensive set of measures that address various aspects of quality improvement. Measures that have been selected for the 2007 iteration of the Colorado Hospital Report Card include:

1. Agency for Healthcare Research and Quality (AHRQ) Risk-Adjusted Mortality Rate Quality Measures
 - a. Condition Measures
 - Acute Myocardial Infarction (AMI)
 - Congestive Heart Failure (CHF)
 - Gastrointestinal Hemorrhage (GI bleed)
 - Hip Fracture
 - Pneumonia
 - Stroke
 - b. Procedure Measures
 - Carotid Endarterectomy (CEA)
 - Coronary Artery Bypass Graft (CABG)

- Craniotomy
 - Hip Replacement
 - Percutaneous Transluminal Coronary Angioplasty (PTCA)
2. AHRQ Volume Measures
 - Abdominal Aortic Aneurysm Repair (AAA)
 - Carotid Endarterectomy (CEA)
 - Coronary Artery Bypass Graft (CABG)
 - Percutaneous Transluminal Coronary Angioplasty (PTCA)
 3. AHRQ Prevention Quality Measures
 - a. These prevention quality measures represent hospital admission rates (by patient's county of residence) for the following ambulatory care-sensitive conditions:
 - Amputations, lower extremity, diabetic patients
 - Angina, without procedure
 - Appendicitis, perforated
 - Asthma, adult
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Congestive Heart Failure (CHF)
 - Dehydration
 - Diabetes, long-term complications
 - Diabetes, short-term complications
 - Diabetes, uncontrolled
 - Hypertension
 - Low Birth Weight
 - Pneumonia
 - Urinary Tract Infections (UTI)
 4. AHRQ Patient Safety Measures
 - Decubitus Ulcer Rate
 - Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) Rate, postoperative
 - Sepsis Rate, postoperative
 5. Hospital-Acquired Infection Measures
 - Central Line, blood stream
 - Coronary Artery Bypass Graft (CABG), with and without donor site incisions
 - Hip Replacements, total and partial

- Knee Replacements, total and partial

6. Pediatric Inpatient Volume Measures

- Appendectomy
- Asthma
- Births, live
- Diabetes
- Gastrointestinal, non-bacterial
- Respiratory infections and illnesses

Board performance scorecards should specifically address some or all aspects of the Colorado Hospital Report Card. Particular focus should be placed on the AHRQ mortality measures, AHRQ patient safety measures and the hospital-acquired infection measures.

A. Remember the Big Dots

Big Dots are system level measures that set the expectation for the level of quality in a facility. Through the use of Big Dots, a governing board can measure overall performance, align incentives and measure the effectiveness of strategies. Governing boards should have a sense of ownership over the Big Dots, especially as the measures should collectively answer the question “How good are we?”. Big Dots should be transparent, so that everyone in the organization can be aware of their purpose and the level of expectation. Big Dots can vary by individual hospital or health system, but they should focus on the following primary areas: Mortality, Hospital-acquired Infections, Patient Safety and Evidence-based Care.

B. The Usefulness of Separate Scorecards

Performance scorecards should primarily focus on Big Dots at the board level. Therefore, it is useful to utilize topic-specific scorecards to drill down at the board committee level, where individual metrics can be measured and reviewed. For instance, depending on the size of the hospital and ability to have separate board committees for specific topic areas, it may be useful to have separate scorecards for quality, patient safety, finance, strategy & planning, etc. These topic-specific scorecards would then feed into the topic-specific Big Dots that are ultimately presented at the regularly scheduled board meetings.

C. Simple Rules for Hospital Scorecards

Remember the following rules when developing your hospital scorecards:

- Measure what is important
- Review at every board meeting

- Use topic specific scorecards (see section B) to drill down at board committee level (finance, strategy & planning, quality, safety, etc)
- Use simple formats
- Set “all or nothing” target levels for clinical care and safety measures (100% or 0%)
- Avoid using averages; use percentiles measured against standards
- Avoid using color coding, which can lower expectations or send a misguided message (i.e. only red squares deserve attention)
- Data that is graphed over time is the most powerful format.

IHI 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:

- A. **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:

- Healthcare That Is Safe;
- Healthcare That Works; and
- Healthcare 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."

- B. **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 recent 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, IHI knows 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. Specifications, examples, and brief training for the use of this tool can be found on IHI's website. In the long 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 healthcare 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*.)

- C. **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 boards receive reports on quality of care, many 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 Tool Kit.) 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. Another tool 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 (available on IHI’s website)

- D. **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, hospitals 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*, and the University of Michigan is writing a powerful story 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 IHI recommends strongly, is to study and adopt the guidelines articulated in *When Things Go Wrong*.

- E. **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:

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

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](#), provides extensive guidance. Some hospitals 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. 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 precede with the development of a BCBSMA-funded curriculum for hospitals 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 is now being piloted by nine

organizations. In addition to a curriculum tailored to each board, additional deliverables include a Quality Resource Guide to supplement the curriculum and a tool kit that offers board members a series of action steps that support their fiduciary responsibility for their hospital's quality performance. The pilots are expected to be completed by the end of the 2007. In 2008, New England Healthcare Assembly will offer the program to hospitals in the New England region.

- F. **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. Researchers are now collecting a comprehensive view on how boards incentivize CEOs and senior executives to provide will and ensure successful execution.

Annotated Bibliography

Clough J, Nash DB. Health Care Governance for Quality and Safety: The New Agenda. May/June 2007; 22(3): 203-213.

This bibliography is a collection of articles pertaining to governance for quality and safety. The first section of the bibliography contains articles that explain the rationale for board involvement in quality and safety. The second section focuses on the relationship between the board and medical staff. The third section provides strategies that board use to manage quality and safety. The fourth section examines the relationship between the structure of governing board and the organization with regard to quality management and performance. The final section contains commentaries on these issues from experts in the field.

Pugh M, Reinertsen JL. Reducing Harm to Patients. *Healthcare Executive*. 2007;23(6):62-65. (available on www.IHI.org)

This article by Michael Pugh and James Reinertsen, published in *Healthcare Executive*, 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, Pugh MD, Bisognano M. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2005. (available on www.IHI.org)

As part of IHI's work of supporting and encouraging leaders of innovative health systems, this white paper presents some important leverage points for leaders who want to achieve dramatic, system-level performance improvement. This set of leverage points is not offered as a tried-and-true method, but as a theory — one that can be useful for individual leaders in planning their work and for organizing a support and learning system to share best practices and results across organizations; and from which all can learn about what works, and what doesn't in bringing about large-system change in health care.

Additional Resources

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