

# Putting Quality First: How Boards Can Make Quality Improvement a Higher Priority

*The American Hospital Association's*



**CENTER FOR  
HEALTHCARE  
GOVERNANCE™**

# Monograph Series

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The American Hospital Association's Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs.

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## Overview

Boards shape priorities in many ways, but primarily by telling the CEO what's most important. The formal process boards use for this is performance management—goal setting, feedback, performance appraisal, and pay-for-performance. The informal process includes a wide range of interactions, such as setting agendas for meetings, discussing priorities and performance in board and committee meetings, providing informal feedback, asking how performance can be improved, and questioning how proposed operational changes will affect performance.

Boards shape priorities both intentionally and unintentionally. If the first question about a proposed change is how it will affect financial performance, if the incentive plan pays awards only if the budget has been met, or if financial performance is weighted more heavily than other measures in the incentive plan, it signals an overriding concern about profitability. If instead, the first question about a proposed change is how it will affect quality, if board meetings devote as much time to patient safety and quality as to financial performance, and if pay-for-performance depends as much on quality as on financial performance, it signals an overriding concern about quality.

One of the best ways to put quality first is to build it into every facet of the formal performance management process—the job description, the performance appraisal, and the incentive plan. Most hospitals now tie a portion of incentive opportunity to quality improvement, and most job descriptions give lip service, at least, to the CEO's accountability for clinical quality improvement. But job descriptions, performance appraisal, and incentive plans rarely put as much emphasis on quality improvement as on financial performance.

This publication shows boards how to put quality first in all aspects of the performance management process. It gives practical tips on setting good goals for quality improvement, evaluating performance, and rewarding improvements in quality. It gives boards practical suggestions for promoting quality improvement, using processes boards have always used to shape priorities and guide performance. It also reminds boards to use informal approaches, as well, to making quality improvement a higher priority. This publication also includes several tools and resources, such as the box titled Quality Improvement in Action on pages 4-6, to help boards apply the ideas and suggestions included here to improving quality in their own organizations.

## Quality Improvement in Action

*The compensation committee of a large tertiary care hospital is bothered that its quality isn't as good as its financial performance. Its financial performance is near the top of the industry, and has been for the past few years. Its performance on quality measures is above average, but only between median and the 75th percentile. Quality has been improving, relative to its own past performance, but only slowly improving relative to the industry as a whole. The committee wants the hospital to be ranked as one of the country's best hospitals and won't be satisfied with performance below the 90th percentile, relative to its peers. It wants to know how to give a higher profile to quality improvement efforts in its performance appraisal system and its incentive plan.*

## Questions for Discussion

1. Is it realistic to expect a hospital to be at the 90th percentile, relative to its peers, on clinical quality, given that every other hospital is doing its best to improve quality in the same areas?
2. How would you suggest using performance appraisal or the incentive plan to underscore the board's desire to improve quality more quickly? Which is likely to help more?
3. What else could the board do to support the quality improvement program?

*The board of a large community teaching hospital has joined IHI's 5 million lives campaign. It has a quality committee, reviews a clinical scorecard every quarter, reviews a quality failure twice a year and tries to devote at least 15 minutes of every board meeting to discussions related to clinical quality. It recognizes, however, that the process it uses in evaluating the CEO's performance is weak: performance expectations are vague, so it's difficult to figure out how to evaluate her effectiveness in shaping a culture of quality. The board asks the quality committee to develop more explicit performance expectations for the CEO's leadership of quality improvement efforts and a better tool for evaluating her performance on this important measure.*

## Questions for Discussion

1. Should the CEO be the leader of the hospital's quality improvement effort, or is that better left to the Chief Medical Officer or the Director of Quality Improvement?
2. Should the board hold the CEO accountable for results, or only for shaping a culture and process that gets clinicians involved and committed to improving quality?
3. How should performance expectations be defined? Implementing an effective QI process? Developing a culture of quality? Implementing systems that report quality indicators to nurses, physicians, and the board?

*The compensation committee of one of the country's premier academic hospitals wants to raise the bar for earning an incentive award on clinical quality measures. It has an all-employee plan as well as an incentive plan covering executives and mid-level managers, and the quality goals are the same for everyone. Setting goals so high that they may not be reached would mean telling employees who are doing their best to improve quality that they're not doing well enough. Year after year, the hospital beats its goals for financial performance but meets only some of its goals for clinical quality. The hospital compares itself only to other premier academic hospitals and has generally been close to the 75th percentile of this peer group. The chair of the compensation committee, however, sees no reason to reward maintenance of relatively high performance or significant improvement in performance. He's unwilling to reward significant improvements in areas that were weak unless they are at the 75th percentile or above. The committee wants help deciding where to set goals on clinical quality measures.*

## Questions for Discussion

1. Is it appropriate to reward maintenance of good performance, if it's already above average?
2. Is it appropriate to reward significant improvement from a low position (e.g., improvement from the 10th to the 40th percentile)?
3. Does keeping up with improvements elsewhere across the industry require enough effort to deserve commendation and a reward?
4. Should the hospital define its goals as improvements in raw scores or in percentiles, relative to its peer group?

*The compensation committee of a mid-size health system with two community hospitals wants to tie executive pay more closely to clinical quality. It decides, however, that it can't do it by just increasing the weight on quality measures in its annual incentive plan, without de-emphasizing productivity and financial performance. Instead, it introduces a new long-term incentive plan focused solely on clinical quality. It decides that having a separate plan dedicated exclusively to quality improvement will work better than leaving quality as just one of four goals in its annual incentive plan.*

### **Questions for Discussion**

1. Does it make sense to have a separate incentive plan focused only on quality?
2. Should rewards for improving quality reward annual improvements or multi-year improvements?
3. If quality improvement is weighted 25 percent or 35 percent, and incentive opportunity is about average, is that enough emphasis to matter to participants?
4. Would it be better to increase annual incentive opportunity, to make sure that there is enough room to put a lot of emphasis on quality improvement without de-emphasizing productivity and financial performance?

# Introduction

One of the board's most important responsibilities is setting performance expectations and evaluating the chief executive's performance. Boards know this, but they rarely take this responsibility seriously. In the main, they delegate this responsibility to a committee, usually the compensation committee or the executive committee. The committee sometimes asks the board as a whole to participate in evaluating the CEO's performance by filling out a questionnaire, but as often as not, it uses a more informal approach. Too often, performance appraisal is squeezed into a five-minute discussion in executive session focused largely on determining an appropriate salary increase and incentive award. As often as not, there is no formal record of the appraisal—no special performance appraisal form, no written appraisal, nothing much in minutes, little more than a five-minute chat after the meeting, mostly to convey the committee's decisions on compensation. Sometimes, there's nothing more than a written record of the new salary and incentive award.

There's room for debate about whether performance appraisal can be effective, and about the best approach to performance appraisal. There's no question, though, that a lack of emphasis on setting expectations and appraising performance signals something; and the signal isn't good.

When a board doesn't spend time on setting expectations and evaluating the CEO's performance, it neglects one of its most important responsibilities. When it delegates the task to a committee, it misses one of its best opportunities for a broad-ranging discussion of what's going well and what could be better. When it doesn't use the process for setting clear expectations, it lets the CEO decide how to shape expectations. When it doesn't provide careful, thorough feedback to the CEO, it suggests that the board is completely satisfied with performance, or doesn't take this responsibility seriously, or doesn't have time to do it, or doesn't want to do it.

Without a reasonably formal process for performance appraisal, the board does it behind the CEO's back, in informal conversations in the parking lot or grocery store, or reduces it to nothing more than a decision on pay.

Whether or not your board uses a formal process for setting performance expectations and evaluating the CEO's performance and whether or not the board as a whole participates, the performance management and appraisal process is one of the best opportunities a board has for making quality a higher priority, for shaping a culture that's supportive of quality improvement efforts, and for signaling to the CEO (and, by extension, to the management team as a whole) that the board cares as much about clinical quality as about financial performance. The process, after all, involves setting expectations and goals, prioritizing them, evaluating performance, and providing feedback. There's no easier way and maybe no better way for a board to start getting involved in quality improvement. All it requires is making quality improvement one of the most important factors considered in evaluating the CEO's performance.

What boards or their compensation committees generally do reasonably well, and with some formality, is setting performance expectations for the incentive plan(s). They may not set goals, but they do approve them, and they do evaluate performance relative to those goals at the end of the year. These goals are institutional goals, though, more than performance expectations for the CEO. When the board evaluates performance at year end to determine awards, it evaluates performance of the institution and the management team as a whole, more than the performance of the CEO.

Setting performance expectations tied to incentive plans is another obvious opportunity for the board to make quality a higher priority. It may be as simple as putting more weight on quality. It may be as easy as insisting that the quality goals be more clearly defined or that the goals be set at a higher level. For a variety of reasons, incentive plans have typically put more weight on financial performance than on quality, and often even more weight on patient satisfaction than on quality. For years it has been unusual for health care organizations to weight quality in an incentive plan at more than 15 to 20 percent of the total—a signal, and a clear one, about what the board valued, or what it was willing to pay for. Incentive plans that put as much weight on quality improvement as on financial performance clearly signal the board's

support for quality. The process for setting and weighting the goals in the incentive plan is also one of the board's best opportunities for making quality a higher priority, shaping a culture of quality, and signaling to the CEO and the management team as a whole that the board cares as much about quality as financial performance.

The National Quality Forum's "Call to Responsibility" and the Institute for Healthcare Improvement's "Seven Leadership Leverage Points", listed in the box below, both address the board's responsibility for leading the hospital's quality improvement efforts by defining goals, setting expectations, and focusing management's attention on quality and patient safety. The best way to do this is through the performance management process, an approach that's easy for the board to use, and one it should already be familiar with.

### **Implementing NQF's Call to Responsibility Using IHI Leverage Points**

In December 2004 the National Quality Forum issued its Call to Responsibility to guide hospital boards in leading efforts to improve the quality of health care in their institutions. It suggested that boards take the following steps, among others:

- See that quality is a priority and a primary focus of board activities.
- Place patient safety and quality issues prominently on the board's meeting agendas.
- *Oversee the hospital's efforts to improve patient safety and quality, and its efforts to create a culture of quality.*
- *Hold management accountable for poor performance, adverse outcomes, and their remedies.*
- Ensure that a system of performance measurement and quality improvement is in place.
- *See that the hospital adopts human resource policies that articulate specific expectations for staff's participation in quality improvement efforts. . .*

In 2008 the Institute for Healthcare Improvement issued the second edition of its white paper “Seven Leadership Leverage Points for Organization-Level Improvement in Health Care.” The second edition increases emphasis on the importance of board leadership, focusing tightly on just one or two major aims and focusing leadership’s attention on them. The first three steps can be viewed as levers the board can and should use to make quality a higher priority for the organizations they govern:

- Establish and oversee specific system-level aims for the quality improvement effort.
- Develop a strategy to achieve these aims and oversee its execution.
- Focus leaders’ attention on these system-level aims.

What follows is a set of suggestions for making the whole performance management process an effective system for shaping and reinforcing the hospital’s quality improvement agenda.

### **Job Description**

Why start with the job description? Many CEOs don’t even have job descriptions. Everyone knows what the job entails: no one really needs to look at a job description to know what the CEO’s responsibilities are. It usually isn’t even used in performance appraisal or in discussions between the board and the CEO about performance expectations.

The reason to start here is that the job description defines the job and its responsibilities. It is an agreement between the board and the CEO as to what the job entails, what the board views as most important about the job, and what the board intends to hold the CEO accountable for.

If there isn’t a job description, there’s bound to be some ambiguity about the CEO’s accountability for quality, and the degree to which the board should base its evaluation of the CEO’s performance on the hospital’s scores on clinical quality and patient safety.

If there is a job description, and it's old, it may not even mention clinical quality. If the list of the CEO's accountabilities includes clinical quality, it is probably so far down the list that it seems to be an afterthought, not a priority.

If the job description doesn't say that the CEO is accountable for clinical quality, it's hard to make quality one of the principal factors in evaluating the CEO's performance. If clinical quality is one of the last things mentioned, it's hard to make it a priority.

These are some statements from job descriptions describing the CEO's role in leading quality improvement efforts.

“Establish and maintain a process for improving clinical quality and patient safety.”

“Organize, implement, and maintain an effective quality improvement process and promote active participation by the medical staff.”

“Guide efforts to improve quality of care and patient safety.”

None of them is clear enough to tell the board what results the CEO is really accountable for. Is it hiring the right person to lead quality improvement efforts? Setting up a taskforce? Encouraging doctors to participate? Seeing that a system is set up for measuring quality and compliance with quality standards? Setting goals for quality improvement? Or getting results?

If the board wants to hold the CEO accountable for improving quality and patient safety, it should define accountability in terms of results, not in terms of intent or process. The sample statements shown above focus on process and intent. Here are several that focus on results:

Ensure that the hospital meets the highest standards for quality of care and patient safety.

Ensure that the hospital continuously improves the quality of care delivered.

See that the hospital meets or exceeds accepted standards for clinical care and patient safety.

See that the hospital is near the top of its class on quality and patient safety.

All three of the statements listed above from actual job description appear toward the end of the items the CEO is accountable for. Where should they appear? How high a priority should quality improvement be, when the CEO is also accountable for strategic planning, growth, cost-effectiveness, profitability, patient satisfaction, physician relations, external relations, board relations, organizing operations to optimize performance, choosing and developing a good leadership team, and shaping the work environment to make the hospital the “best place to work” and the “best place to practice” as well as a “learning environment”? Perhaps somewhere in the middle?

Making quality improvement a higher priority means putting it closer to the top of the list than it has been. The challenge is deciding where it ranks relative to two other essential metrics—cost per unit of service and revenue per unit of service. Until recently, quality improvement has generally been ranked below patient satisfaction, growth, and market share. To make quality improvement a true priority, it should be ranked above everything other than operating margin (or its determinants, revenue and cost) without which a hospital cannot afford to stay in business.

Whether it ranks first or second depends on whether an organization’s emphasis is on the means or the ends—the mission or the margin that allows the organization to maintain the mission—whether the hospital is a business engaged in clinical care or a provider of clinical care that needs to be paid fairly for the care it delivers. We could argue that there’s no point in staying in business if the hospital can’t deliver care that is at least average in quality, because others can do it better. We could also argue that meeting the community’s need for care is more important than the quality of care, since most care delivered is reasonably good, and the problems are at the margins, not the center. The public debate about health care suggests that cost is more important than quality, and that access may be, too.

Maybe it doesn’t matter whether an organization lists quality first or second among its priorities, so long as quality comes closer to the top of the list than it used to. After all, quality is largely the responsibility of doctors and nurses: administrators don’t decide how to deliver care. Administrators organize care delivery; provide resources to support it; and see that operations are cost-effective, physicians are satisfied enough to admit their patients, and revenue is high enough to cover costs.

The reason to define the CEO's accountability for quality improvement and to move it closer to the top of the list of accountabilities is to make a point, to deliver a message. If the board leaves the CEO's accountability for quality undefined or ill-defined or vague or indeterminate, it can't make quality improvement a higher priority than it has been—unless it wants to work around the CEO, which isn't a good idea.

The effort to clearly define accountability for quality shouldn't stop with the CEO's job description, even though that's the best place for the board to start. Job descriptions for other executives often put any accountability for quality near the end and often define it vaguely. Few organizations worry about keeping job descriptions up-to-date and fewer still invest the time and effort needed to make them clear statements of the job's accountability. They tend to focus on activities, inputs, models, systems, and policies and procedures, rather than outcomes. It's often hard to tell who is accountable for quality, other than the head of the quality improvement program. If job descriptions don't clearly communicate that everyone involved in clinical care is accountable for quality, it's no wonder that quality is just good enough—or maybe not quite good enough.

Why not ask management to ensure that the job description for every employee involved in clinical care includes a clearly worded statement of accountability for the quality of care delivered, for complying with the hospital's standards of care, and, better yet, for identifying ways to improve patient safety and quality of care (see sidebar on job accountabilities below). Why not ask that the statement come near the top of the list of accountabilities, rather than the bottom?

### **Statements of Accountability for Quality For Different Jobs**

**CEO:** Ensure continuous improvement in patient safety and clinical quality by guiding the development and maintenance of an effective quality improvement process, promoting active involvement in quality improvement by physicians and staff, encouraging adoption of evidence-based protocols and best practices developed elsewhere, participating in industry-wide projects to improve quality and develop comparative databases, and allocating

resources to projects with the greatest opportunity for significant improvements. Develop widespread commitment to the hospital's quality improvement efforts by promoting participation, celebrating successes, and encouraging renewed efforts to overcome obstacles. Focus management and board attention on patient safety and clinical quality by regularly reviewing a quality dashboard, results of quality improvement efforts, and sentinel events.

**Vice President-Quality:** Improve patient safety and quality by developing and implementing a plan and process to meet the hospital's quality and patient safety goals, training leaders of QI teams to efficiently and effectively identify ways to make significant improvements, participating in industry-wide projects, and designing and implementing a system to give management, the board and other stakeholders accurate and timely reports on quality and safety.

**Medical Director:** Improve patient safety and clinical quality by increasing the number of physicians actively involved in quality improvement projects, gaining support of the medical staff for industry-wide standards and the hospital's clinical protocols, and achieving universal adoption of the hospital's electronic medical record and physician order-entry system. Promote a respectful, non-punitive culture and learning from experience in implementing reporting systems, dealing effectively with disruptive or intimidating behavior that raises risks, and by leading studies of sentinel events to identify root causes and implement methods for avoiding them in the future.

**Vice President-Nursing:** Develop and maintain enthusiastic support for the hospital's quality improvement efforts across the entire nursing staff. Ensure adoption and consistent use of new clinical protocols by the entire nursing staff. Shape and maintain a respectful, non-punitive culture that allows nurses to report errors and near-misses without fear of retribution. Empower nurses to stop activities or behaviors that violate quality standards or threaten harm or show disrespect for patients. Encourage staff to identify ways to improve patient safety and quality.

**Staff Nurse:** Follow the hospital’s clinical protocols consistently, unless doing so endangers a patient or could delay recovery. Evaluate orders and care plan in light of patient’s condition before administering treatment. Report errors, near-misses, and safety problems to hospital’s patient safety advocate. Stop activities or behaviors that violate quality standards or threaten harm or show disrespect to patients. Identify opportunities to improve quality and/or patient safety.

## Performance Expectations

The most powerful thing a board can do to make clinical quality a higher priority is to set clear performance expectations for quality improvement. Doing so is tantamount to making quality a higher priority, because in many health care organizations performance expectations generally haven’t been clear enough in the past.

What more can the board do to set clear expectations, other than what it is already doing by setting or approving goals for the incentive plan, or shaping goals for the hospital’s quality improvement effort, or asking management to develop a scorecard for clinical quality, and then monitoring performance to show that it is serious about quality improvement?

Let’s recognize that performance expectations can be set in many different ways. The most obvious may be setting goals for the incentive plan, and the place to start may be the job description, by stating clearly what outcomes the job is accountable for achieving. Performance appraisal is another opportunity for setting performance expectations, or clarifying or reinforcing them, so long as the process is taken seriously and encompasses feedback, goal-setting, and coaching on quality.

Another obvious way of setting performance expectations is by shaping the goals for the quality improvement program itself, and by seeing that the goals for each quality improvement initiative are expressed clearly enough so that everyone understands what needs to be done to achieve them. The goals for the program itself have three dimensions—the purpose of the program; the level of quality expected; and the areas of focus:

- The purpose is the reason for dedicating resources to the program, and it ought to be expressed clearly and persuasively.
- The level of quality expected should be realistic, a bit short of perfection, and expressed as striving continuously for improved performance, because standards and benchmarks are likely to be higher in the future than they are today.
- The focus, too, should be realistic, because no hospital can be the best at everything, and lack of focus can make it harder to be really good at a few things.

Focus is important and something the board can insist on. No hospital can achieve world-class quality in every clinical area or 100 percent compliance with every best practice. After all, the National Quality Form has now recognized well over 300 clinical standards or best practices. But every hospital can improve in areas where it isn't as good as it could be or should be, given its circumstances, patient mix, and service mix. Trying to do too many things at once just diffuses attention and effort and makes it harder to make significant progress where it matters most. No hospital can afford to tackle quality improvement in every clinical area or get to 100 percent compliance with every best practice. There's not enough time in the work day; there's not enough staff to work on everything the hospital may want to do; and there's not enough money in the budget to pay for it all. There are too many recognized clinical best practices to achieve them all.

Clarity is also important and something the board can insist on. Defining the purpose of the QI program with a slogan like "best place for care" doesn't help, because it isn't clear enough for anyone to understand what it means or what needs to be done to become the best place for care. It doesn't communicate a performance expectation. Defining the purpose of the program as "finding the best ways to improve the care we provide" or "continuously improving the care we provide" makes it clear and does communicate a performance expectation. So do "eliminating hospital-acquired infections" and "eliminating medication errors" and "reaching and maintaining top-quartile performance on quality and patient safety in all of our major service lines."

Defining the level of performance expected adds clarity. Stating an expectation to achieve "top quartile performance, relative to our peers" is perfectly clear. So are:

- best quality in our service area;
- above average performance;
- no medication errors;
- no wrong-site surgeries;
- 100 percent compliance with x;
- reduce hospital-acquired infections by 10 percent each year; and
- meet CMS patient safety standards.

Defining performance loosely, such as “improve the quality of care we deliver” isn’t likely to inspire the intense effort needed to break through barriers and make significant improvements.

Defining the level of performance expected for the hospital as a whole, as part of defining the purpose of its quality improvement program, can be difficult, because quality is measured in so many different ways. Some measures are comparative, as in top quartile performance; some are absolute, as in 100 percent compliance with a patient safety standard; and others are expressed as improvement over prior performance, as in 10 percent reduction in hospital-acquired infections. Nonetheless, defining general expectations and incorporating different metrics as necessary can establish a framework for decisions about where to focus efforts. Expectations can be expressed as longer-term aspirations, as in “make the *U.S. News & World Report* list of the best hospitals in America in at least two categories” or “reach the top decile performance in cardiology, orthopedics, and oncology,” which can inspire efforts for many years in a row. They can also be expressed as short-term aspirations, as in “reach and maintain at least 90 percent compliance with CMS standards for Acute Myocardial Infarction, Congestive Heart Failure, and Pneumonia within the next three years,” with the understanding that the expectation will be redefined once the short-term goals are met.

It’s easier, but also far more important, to insist on clarity and focus in defining expectations for specific quality improvement initiatives each year. Trustees who are members of the board’s quality committee can shape performance expectations by insisting on the same kind of clarity and focus in selecting and defining goals for quality improvement projects. The most obvious way of shaping expectations is deciding what projects to pursue and what expectations to set. Each hospital and

health system needs to decide which standards, goals or measures to start with. The board can shape expectations by deciding to start with goals that are relatively easy to achieve, so that the program gets off to a good start and participants are likely to get positive feedback for good performance. It can start instead with setting goals in areas where performance is weakest and the opportunity for improvement is greatest. It could start with goals in areas of highest patient volume, or of greatest strategic importance, or of biggest competitive threats. It could also begin by setting goals in areas that are likeliest to affect the hospital's reputation, by focusing on areas in which public rankings of the hospital and its competitors will be readily available to the public and the press.

Another way trustees can shape expectations for quality improvement projects is in shaping or selecting methods for defining expectations. There are three generic approaches to setting expectations:

- defining the goal relative to an absolute standard, as in “99 percent compliance with x;”
- defining the goal relative to performance by peers, as in “performing above average, relative to other hospitals in the local market;” and
- defining the goal in relation to past performance, as in “10 percent reduction in surgical site infections.”

Yet another way trustees can shape expectations is by deciding whether to be realistic or ambitious. Every board wants to see above-average performance; but nowadays it's surprising to see how many health care organizations define the goal as performing in the top quartile or top decile, relative to comparably situated peers, such as mid-sized suburban hospitals or inner-city public teaching hospitals. Others define the goal as reaching perfection, as in 100 percent compliance with particular quality standards. However, if performance in one area is at the 10th or 25th percentile, it is unrealistic to set a goal of getting to the 90th percentile in a year. It may be that the right goal is to get to the 90th percentile over time, and that the best goal for the first year is to get to at least median or average performance.

James Collins, in *Good to Great*, asserts that great performance often comes from setting extraordinarily ambitious goals, what he calls “audacious goals.” An organization that sets goals this way should probably define its expectations as multi-year goals.

It should also decide how it will deal with failure to reach the goal the first year. It may eventually need to compromise, if it can't reach 100 percent compliance with a best practice or the 90th percentile, relative to peers, after trying hard for three or four years.

In the same way, trustees can shape performance expectations by deciding how to set expectations in areas in which the hospital is already performing well. If a hospital is already performing at the 85th percentile, relative to its peers, the quality committee needs to decide whether to set a goal to maintain performance at that level, or to try to improve it, or to shift focus to another measure where performance isn't as good. Trustees can and should shape decisions like this. Recognizing that the hospital has limited resources, it needs to decide whether to invest them in improving quality in an area in which performance is already extremely good. Boards can also gain insight into setting performance expectations by considering how goal-setting for quality improvement has changed over the years (see sidebar titled *A Perspective on Setting Quality Improvement Goals* on pages 19-20).

### **A Perspective on Setting Quality Improvement Goals**

For a long time, quality improvement goals were expressed as figuring out what to do, or getting started, or choosing what to emphasize, because hospitals weren't ready to make a commitment to something more specific. They often didn't know how to get started, or where to start, and wanted to develop a good methodology, or provide training in a particular methodology, or build support from the medical staff before actually setting any specific goals. Those were days of the "not invented here" syndrome, which amounted to rejecting ideas, clinical protocols, and best practices developed elsewhere, because "we know better." Best practices were rejected as "cookie-cutter medicine."

Now we have "evidence-based medicine" and most hospitals and medical staffs have moved far beyond the "not invented here" syndrome. (Wasn't medicine evidence-based before?) The evidence and publicity showing that American medicine isn't as good as we thought it was have captured everyone's

attention, and most doctors now understand that clinical practice patterns need to change to improve clinical outcomes. Younger doctors, in particular, have come to accept the idea that what was long and widely derided as “cookbook medicine” is actually better medicine than the customized medicine worked out in the past by each physician for each patient.

## Performance Appraisal

At its best, performance appraisal is about providing honest feedback, congratulations on what’s gone well, acknowledgment of what hasn’t gone well, clear indications of what’s most important, and encouragement and support for overcoming obstacles and improving performance. At its best, it’s an open, transparent discussion and a two-way conversation that celebrates success, acknowledges failures and the reasons for them, and sets it all in the context of the circumstances, challenges, and obstacles the institution faced over the past year.

At its worst, performance appraisal doesn’t matter, especially when the reviewer doesn’t spend enough time to use the appraisal process to accomplish anything significant. Providing feedback in a compliment or two, a paragraph on “another good year,” a salary increase, and a nice bonus does nothing to clarify expectations or encourage improvement in performance, let alone put a higher priority on quality improvement.

Fortunately most executives are so highly motivated that they’ll do all they can to succeed, if the expectations are clear enough. But providing feedback is one of the most powerful things a board can do to signal what the board cares about.

So, how can the board use performance appraisal to put a higher priority on quality improvement? Here’s a Top 10 List for starters. The board can:

1. ensure that clinical quality is one of the factors used in evaluating the CEO’s performance.
2. place this factor near the top of the list, rather than the bottom.
3. if the appraisal tool weights the factors, increase the weight on quality.

4. define expectations clearly at the beginning of the year, so that it's easy to evaluate performance at the end of the year.
5. establish explicit goals for quality improvement for the coming year, explain them to the CEO, and—a year later—evaluate how well those goals have been achieved.
6. require that some of the feedback on the CEO's leadership for clinical quality matters comes from the board's quality committee, and maybe even from the medical staff, since these are the people most likely to know what the CEO's influence has been.
7. make sure that all board members are fully aware of the institution's clinical quality and patient safety record, as well as the progress made over the past year and the CEO's involvement in promoting progress, so that their evaluations and feedback are well-informed.
8. intentionally highlight clinical quality in the feedback it provides the CEO.
9. take the time needed to make performance appraisal a serious effort; gather comments, not just numerical ratings, from board members, and organize and document the comments in a way that demonstrates that the board takes this process seriously (see Performance Appraisal Questionnaire on pages 21–23).
10. organize and focus performance feedback on a small number of themes, one of which is quality, so that quality is one of just four or five themes, not one of ten or twelve.

None of these things is difficult to do. None of them requires clinical training or expertise. All of them are easy for any board to handle.

## **Performance Appraisal Questionnaire**

*The illustration below shows a portion of a performance appraisal questionnaire with examples of statements of the CEO's accountability for quality improvement and examples of annual goals for quality improvement. Most boards may want to list just one statement of accountability for quality improvement, however the statements listed here illustrate the CEO's accountability for clinical outcomes, creating a culture of quality, gaining medical staff support for quality improvement, and participating in national efforts to improve clinical quality. Most organizations set many more goals than those that get chosen for the annual incentive plan. The goals shown here illustrate a variety that might be appropriate for use in performance appraisal.*

## Assessment of Key Accountabilities

Please evaluate the CEO's performance on each Key Accountability, using the scale below. Explain your evaluation in the space for comments, using examples.

| <b>KEY ACCOUNTABILITIES</b><br>Description of Accountabilities  | <b>Please circle your score on each accountability and explain it in the space for comments</b> |                         |                        |                      |                              |
|---|---|-------------------------|------------------------|----------------------|------------------------------|
|   | Meets some expectations   | Meets most expectations | Meets all expectations | Exceeds expectations | Don't Know or not Applicable |
| <b>Quality of Care and Service</b>  | <b>1</b>  | <b>2</b>                | <b>3</b>               | <b>4</b>             | <b>N/A</b>                   |
| Ensures that ABCMC meets the highest clinical standards for quality of care delivered.  | <i>Comments</i>   |                         |                        |                      |                              |
| Maintains an open, non-punitive and respectful culture that encourages reporting and learning from errors, near-misses, and other events that could harm a patient or delay recovery.     | <i>Comments</i>   |                         |                        |                      |                              |
| Gains commitment from entire clinical staff to support hospital's quality improvement initiatives.  | <i>Comments</i>   |                         |                        |                      |                              |
| Promotes hospital's participation in industry-wide quality improvement programs, including public reporting of hospital's performance on standard measures of quality and patient safety. | <i>Comments</i>   |                         |                        |                      |                              |

## Assessment of FY 2008 Goals

Please evaluate the CEO's performance on each Goal, using the scale below.  
Explain your evaluation in the space for comments, using examples.

| <b>FY 2008 GOALS</b><br>Quality Improvement Goals   | <b>Please circle your score on each goal<br/>                     and explain it in the space for comments</b> |   |  |   |                                    |
|---|--|---|--|---|------------------------------------|
|   | Did not<br>meet goal   | Almost met<br>goal; or met<br>goal with<br>complication | Met goal<br>in fully<br>satisfactory<br>manner | Exceeded<br>goal with no<br>complications | Don't Know<br>or Not<br>Applicable |
| <b>Quality of Care and Service</b>  | <b>1</b>   | <b>2</b>  | <b>3</b>                                       | <b>4</b>                                  | <b>N/A</b>                         |
| Increase compliance with hand washing protocol from 43% in FY to 70% for the last quarter of FY 2008.   | <i>Comments</i>  |   |  |   |                                    |
| Attain a third quartile ranking, relative to the most recent data available from our peer group, on CMS standards for CHF, AMI, and Pneumonia.  | <i>Comments</i>  |   |  |   |                                    |
| Nursing staff responses to employee engagement survey exceed the 65th percentile on question 14, "The hospital's leaders enthusiastically support our efforts to improve patient safety and quality of care." | <i>Comments</i>  |   |  |   |                                    |
| In last quarter of FY 2008, 60% of physician's orders for inpatient care are entered by physicians in the new patient electronic medical record.  | <i>Comments</i>  |   |  |   |                                    |

## Setting Goals

A common weakness of performance expectations and goals is that they aren't clear enough. They may seem clear enough at the beginning of the year, when everyone thinks they know what's meant, but they don't always seem clear at the end of the year, when someone's trying to evaluate performance and figure out whether the goals have been met.

A goal to “develop a system to minimize medication errors,” for example, can be achieved by completing development of a system, without any testing, without any improvement in results, and without any evidence that the newly developed system will actually minimize errors next year. A goal like this can lead to misunderstandings about what was really intended, confusion about how to evaluate performance, and no good basis for evaluating performance.

It's well past time for setting goals that amount to nothing more than deciding what goals to set next year, or deciding what clinical measures to use, or developing new protocols or standards of performance, or choosing a vendor for an electronic health record. There may still be a lot of this to do; but it's nothing but process, and the process is nothing but meetings and discussions. The quality improvement effort in health care began in the 1970s; it's time for results, not more process. Finishing the process is implicit in any goal to improve performance. Setting expectations or goals that amount to nothing but process is just delaying, once more, the hard work of actually improving quality.

Performance expectations do not need to be as explicit as goals, and goals used for performance appraisal do not need to be quite as explicit as goals for an incentive plan. But goals and performance expectations should be defined in terms of outcomes, not inputs—results, not process. Outcomes and results can be defined in terms of ultimate clinical outcomes, such as mortality and morbidity rates, medication errors, and hospital-acquired infections; or in terms of compliance with best practices or clinical protocols or pathways; or in terms of frequency of acceptance and use of a system (e.g., a computerized physician order entry system) intended to prevent mistakes; or even in terms of implementing a system for measuring clinical results that cannot now be measured.

Some goals and expectations need to be defined over a multi-year period, of course. Developing a new system internally is likely to take several years. Reaching a goal of 99 percent compliance with hand-washing protocols may take several years, unless an organization is already almost there.

In the main, however, performance expectations and goals need to be defined in terms of what can be accomplished in a year, since that is the period used for performance appraisal and incentive plans. This doesn't mean things that take more than a year to finish should be ignored, only that these goals should be defined in terms of reaching milestones that can be reached in a year, as well as in terms of the ultimate goal, such as reaching 100 percent compliance or zero defects. The box on pages 25–26 lists examples of useful and vague goals.

### **Examples of Useful and Vague Goals**

*A goal, by definition, is supposed to be clear enough to understand: “an end that one strives to obtain,” according to Webster’s New World Dictionary. A goal is not a good intention, it’s a result to be achieved. A goal that isn’t defined clearly in terms of outcome or result is hardly a goal. Goals that don’t specify the expected outcome don’t lend themselves to evaluation or measurement of performance.*

*Listed below are some examples of goals taken from hospital incentive plans. The first list contains examples of goals that are defined clearly enough that a board would find it easy to determine at year-end whether or not the goal has been met. The second list contains examples of goals that are vague enough that it might be difficult for a board to determine whether or not they were met. The vaguer goals might work for performance appraisal, where there is generally more room for subjective evaluation and no need to determine a dollar value for performance relative to the goal.*

#### **Clear Goals**

- Reach 90 percent compliance with hand-washing guidelines in Q4, as observed by ABC Company.
- Reduce incidence of hospital-acquired infections by 25 percent (2008 vs. 2007).

- Meet all CMS standards for pay-for-performance in 2008.
- Earn five stars from HealthGrades.com in two of these five service lines (a, b, c, d, or e) in 2008.
- Exceed 2007 performance on Congestive Heart Failure (CHF) discharge instructions every quarter in 2008.
- Reach a top decile ranking, relative to most recent 12-months' data reported by the Hospital Quality Alliance, in at least two quarters in 2008 on administering prophylactic antibiotics during the hour before surgery.
- Reduce the overall fall rate to 2.4 falls/1000 patient days for 2008.

### **Vague Goals**

- Implement guidelines for treating patients with acute myocardial infarction by 9/30/08. (What does “implement” mean, introduce or complete training with all nurses or reach 80% compliance with guidelines?)
- Implement new electronic medical record at 10 physician practices. (By when? Do the doctors have to use it to meet the goal?)
- Increase compliance with CHF protocols by 10 percent. (By when? If score is now 53 percent, does this mean an increase to 58.3 percent or 63 percent? What if there are three protocols, and compliance increases by 15 percent on two but not at all on the third, so the average is 10 percent?)
- Establish a board committee on quality and develop its charter. (This is the board's responsibility, not the CEO's. Why wasn't it done last year or the year before? By when? Does it need to meet before year-end?)
- Re-engineer the adult fall prevention program to reduce falls by 15 percent. (What's the goal, to re-engineer the program or to reduce falls? Or both? Over what period are falls measured? What if the program is re-engineered with the goal of reducing falls by 20 percent, but falls for the year are reduced by only 14 percent? What if the program is re-engineered in Q2 and falls in Q4 are down 15 percent, but not in Q3? What if falls in the first quarter of the next year are down 20 percent as a result of re-engineering, and down 15 percent in December, but down only 14 percent in Q4?)

## Incentive Compensation

Most boards have been deeply involved for many years in shaping goals for the incentive plan. This is the arena in which they have most likely influenced the way the CEO and the hospital's leadership team deal with clinical quality. Over the years, most hospitals and health systems have come to emphasize clinical quality as one of the three or four most important measures of performance. Almost all incentive plans now include measures of clinical quality.

Many boards have intentionally increased the weight placed on clinical quality goals in recent years. Ten years ago, it was unusual to see more than a 15 or 20 percent weight placed on clinical quality. Now it is not unusual to see it account for 30 and even 40 percent of the total weight.

The easiest way to make clinical quality improvement a higher priority may be to increase the weight placed on it in the incentive plan. Making it work right isn't all that easy, though. The more weight put on clinical quality, the more important it becomes to set the goals right, because of the amount of money riding on meeting the goals.

When the weight on clinical quality measures is only 10 or 15 percent, the goals don't matter all that much, and neither management nor the board spends a lot of time on refining the goals. When the weight is increased to 30 or 40 percent of the total, though, they do matter a lot, and both management and the board tend to spend a lot more time deciding what the goals should be, how they should be expressed, and how performance should be measured.

Putting more weight on the goals related to clinical quality isn't the only way for the board to use the incentive plan to emphasize clinical quality. Another way would be to set a quality goal as a hurdle or funding criterion for the plan, so that no awards would be paid unless that goal is met, or awards would be reduced to half value if that goal isn't met. Incentive plans in almost any organization start with a premise that no awards should be paid unless there are sufficient funds to pay the awards. This premise gets expressed as a rule that the organization must earn an operating profit big enough to justify paying awards. If a hospital acknowledges that its mission is providing patient care, not generating profits, then the hurdle could just

as well be expressed as not paying awards unless quality is good enough to justify paying them. The emphasis on financial performance in incentive plans has led many nurses and physicians to believe or at least say that “the board cares more about profit than about quality.” Think about the impression made when quality is weighted more heavily than financial performance, as it is at some hospitals, or when the entire incentive plan is focused on quality, as it is at several hospitals. Think about the message delivered when an all-employee incentive plan is tied only to patient satisfaction and clinical quality, as it is at some hospitals.

Another way to focus the incentive plan entirely on quality would be to do as one health system did 20 years ago, when it instituted a new long-term incentive plan focused exclusively on quality improvement. There’s a theory that says that if a business does the right things, and does them well, results will follow. What that implies for a hospital is that focusing on quality and providing better care than other hospitals will lead to all the other business results the hospital wants—lower cost of care, physician satisfaction, growth, increased market share, and a healthy operating margin. Maybe an incentive plan focused exclusively on clinical quality would lead to better business results than one focused largely on business results (e.g., cost-effectiveness, productivity, growth, and operating margin). An exclusive focus on business results would almost certainly do less to improve clinical quality than an exclusive focus on quality would do to improve business results. If the idea seems farfetched, consider a plan that would pay awards if and only if the budgeted operating margin were met, but with award size determined exclusively in relation to clinical quality.

For-profit businesses often base awards strictly on profitability, which is one of their principal reasons for being. Why shouldn’t hospital incentive plans base awards strictly on quality of care, since that is the hospital’s principal reason for being.

Yet another way to focus the incentive program on quality would be to use a more highly leveraged scale for quality than for other measures. If, say, the award for operating margin varies from \$5,000 for acceptable performance to \$10,000 for on-plan performance, to \$15,000 for extraordinarily good performance, the corresponding scale for clinical quality could vary from \$0 to \$20,000—nothing for merely acceptable performance, and a lot more for extraordinarily good performance.

Alternatively, a plan could have a “kicker” for achieving clinical goals two or three years in a row, or for maintaining gains related to last year’s goals while also achieving this year’s goals. The award for achieving this year’s quality goals, for example, could be doubled if the quality goals were also met last year and trebled if the quality goals were met three years in a row. If performance relative to last year’s quality goals was maintained this year, as the hospital also achieved new goals set for this year, the award for this year could be increased by the amount of last year’s award for quality goals—in effect, paying once for achieving the goal, and paying again a year later if performance has been sustained for another 12 months.

## **Informal Approaches**

It’s important to use the formal approaches outlined above to emphasize the CEO’s responsibility for leading quality improvement efforts. These formal approaches persuasively communicate the board’s intent to make quality improvement one of the principal measures of the CEO’s performance. Not using formal approaches may indicate lack of intent or lack of commitment—or lack of discipline in building the expectation into the standard process for managing performance.

Informal approaches can be effective, too, especially when they are used to reinforce formal approaches. Some informal approaches typically recommended include:

- Establishing a separate quality committee of the board, led by a board member, charged with shaping, supporting, and evaluating the hospital’s quality improvement efforts, and required to report regularly to the board as a whole.
- Establishing a quality dashboard with a reasonable set of quality measures (e.g., 12, not 60), which is the basis for regular monthly reports to the board as a whole.
- Setting aside 15 or 20 minutes of every board meeting to focus on quality and safety issues.
- Periodically discussing significant incidents, either at meetings of the quality committee or at meetings of the board as a whole, including explanations from physicians, nurses, and patients about what went wrong; and having the board participate actively in the discussion.
- Having board members visit other hospitals to learn how they deal with quality improvement efforts.

- Having board members actively promote the hospital's participation in national quality improvement projects.
- Asking the CEO to identify other hospitals that can serve as benchmarks to emulate in specific clinical areas, and then seeing what can be learned and applied from their success.
- Asking the CEO to identify ways the hospital could apply lessons learned from other industries to reducing obstacles to quality improvement in the hospital.
- Dealing effectively with physicians whose practice styles hold back the hospital's efforts to improve quality and patient safety.

All of these are good ways for the board to demonstrate its commitment to quality improvement and signal that the board places a high priority on quality and safety. Another way would be for boards to balance the amount of time and attention they give to quality with the amount of time and attention given to financial performance, planning, business development and strategic initiatives.

Some approaches are better than others for shaping priorities and performance expectations. Those that involve active discussions with the board as a whole are most likely to demonstrate to the CEO that the board views quality improvement to be just as important as financial results, patient satisfaction, physician satisfaction, and growth.

Having the quality committee report to the board at each meeting, for example, and using a quality dashboard as the basis for management's report to the board at each meeting is less forceful than having board members discuss quality issues for fifteen or twenty minutes at each board meeting. Listening to reports is passive and only signals patience or tolerance; discussing the issues is active and signals interest and concern.

Active discussion is far more likely to demonstrate the board is serious about improving quality and patient safety. Talking as much about quality and safety as about financial performance would reinforce the formal approaches the board uses for performance management. It would also clearly signal the board's intent to put quality first.

Don't forget, though, that inaction and passivity communicate just as clearly as talking about quality. If the board isn't willing to take responsibility for terminating a physician whose performance is sub-par, or poses a risk to patients, or undermines acceptance by the medical staff of the hospital's efforts to improve quality and patient safety, the effect of whatever else the board does to demonstrate its commitment to quality improvement will be diluted. If the board isn't willing to deal with a physician whose behavior intimidates nurses enough to interfere with quality protocols, or decides that the physician's admissions are more important than the effect of his or her behavior on the hospital's culture of quality, whatever else the board does will be undermined by this failure. If the board decides that it doesn't understand clinical quality issues enough to make a significant contribution, it will have a hard time persuading the CEO that quality is just as important as other things it does understand (like financial performance, growth, or physician relations).

## **Conclusion**

Not every board member can become knowledgeable enough about quality improvement processes to challenge someone who is an expert, but every member should be able to participate in discussions of quality, at least by asking questions or asking for explanations. The discussion, after all, is mostly about a process for improving performance, deciding what goals to set, learning what obstacles get in the way of making progress, and figuring out how to overcome those obstacles. Overcoming obstacles, as often as not, requires insight into human behavior more than any understanding of clinical treatments; and any board member could have an inspiration that could identify a good way to overcome an obstacle. Consider this: passing out coupons for free coffee helped one major medical center get doctors to wash their hands more often. An idea like this doesn't depend on having clinical training.

But boards need at least several members—including independent members who are lay people, not physicians—who will devote enough time to become comfortably conversant with executives and clinicians to raise questions, discuss measurement systems and statistics, and debate management methods for overcoming obstacles to further improvement in quality and patient safety. Otherwise the board will be stuck, unable to challenge excuses, unable to offer alternative interpretations of statistics, unable to propose a better way to focus attention on improvements that matter most, maybe even unable to offer suggestions on overcoming obstacles to change.

Board members don't need to develop clinical pathways, after all, or understand symptoms well enough to diagnose problems, or understand pharmacodynamics enough to explain why one drug is better than another. What they need to understand and be comfortable with are the management approaches used to build organization-wide commitment to clinical protocols, the flaws in measurement systems, and the psychological and behavioral patterns that make it so difficult to go from average to exceptionally good performance. What they need to succeed at this is curiosity, persistence, and a refusal to be intimidated by clinicians, a refusal to let clinical jargon go untranslated into everyday English. What they need is the courage to insist that everything be explained in a straightforward way, so that everyone on the board can grasp what's being said, and an atmosphere so trusting and honest that all board members feel comfortable asking questions and, especially, asking for explanations.

Unless board members get comfortable talking about clinical quality and patient safety issues in some detail, they will have a hard time demonstrating their commitment to quality and a hard time making quality improvement a higher priority than it has been in the past. Active participation in conversing about clinical quality leads to more frequent conversation about it. The more board members who participate, the more comfortable they are participating and the clearer the signal that the board is as committed to quality improvement as it is to other measures of performance.

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## Resources

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