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EFFECTIVE GOVERNANCE FOR QUALITY AND PATIENT SAFETY IN CANADIAN HEALTHCARE ORGANIZATIONS

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A REPORT TO THE CANADIAN HEALTH SERVICES RESEARCH FOUNDATION AND THE CANADIAN PATIENT SAFETY INSTITUTE

G. ROSS BAKER
JEAN-LOUIS DENIS
MARIE-PASCALE POMEY
ANU MACINTOSH-MURRAY

www.chsrf.ca

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Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

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For more information, please contact:

Canadian Health Services Research Foundation

1565 Carling Avenue, Suite 700
Ottawa, Ontario K1Z 8R1

Email: info@chsrf.ca
Telephone: 613-728-2238
Fax: 613-728-3527

Canadian Patient Safety Institute

Suite 1414, 10235 – 101 Street
Edmonton, Alberta T5J 3G1

Email: info@cpsi-icsp.ca
Toll Free: 1-866-421-6933
Telephone: 780-409-8090
Fax: 780-409-8098

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KEY MESSAGES FOR DECISION MAKERS

- **Board chairs and CEOs at both regional and organizational levels (hospitals, long-term care and other settings)**

  Board chairs and trustees should add quality and patient safety expertise to the skills matrices and competency profiles for board members. They should seek to recruit at least one member, and perhaps more, who has expertise in healthcare quality or similar expertise in other industries.

  Board chairs and quality committee chairs should develop a plan for board and quality committee members to broaden their knowledge and skills in quality and patient safety. Boards should also explore other approaches, such as generative governance (engaging in deeper inquiry and exploring root causes).

  Board chairs and CEOs should consider conducting external reviews of their current approaches to the governance of quality and safety, including processes and the adequacy of current quality and patient safety goals.

  Healthcare boards should establish specific quality and patient safety goals as prominent components of the strategic plan and hold CEOs accountable for the achievement of those goals. Boards need to participate as full and informed partners in the development of strategic goals and plans.

  Boards need access to relevant and informative measures of safety and quality to assess current performance and target improvement strategies.

- **Policy makers in provincial and territorial governments**

  Boards need to deepen their expertise in quality and safety, build governance skills, and receive better and more usable information about current performance. Few regions or healthcare organizations have the resources to independently develop these skills and knowledge. Strategic investments by governments in educational development could greatly enhance current governance skills related to improving quality and patient safety. Some educational programs already exist and could be strengthened. New resources could support program development and educational costs borne by boards.

  Governments, together with quality councils and other experts, could help develop a database of measures and sample dashboards – a visual presentation of summarized data used to track performance improvements – that would support regional and organizational boards. Some of this information can be accessed from the Canadian Institute for Health Information (CIHI) and other databases, while other information has to be developed locally using decision support and measurement expertise. Governments should also explore the development of a competency profile for board members that could help inform selection of Regional Health Authority (RHA) and other board members.

  Governments should assess whether targeted resources could help RHAs and delivery organizations develop greater capabilities for improving care and care delivery processes so that these organizations can achieve the goals set by government and local governance.

  Funding should be allocated to research that identifies the ways in which board and leadership activities support improvements in quality of care and patient safety. This research should include longitudinal studies that can assess the impact of new initiatives and interventions over time.

EXECUTIVE SUMMARY

Background. Governing boards of healthcare organizations in Canada are accountable for the performance of their organizations and provide oversight on decisions. Until recently, many boards focused more on financial performance and fundraising than clinical quality and patient safety, leaving these matters to medical staff structures or administration. Growing information on variations in performance in clinical quality, together with an increasing interest by governments in holding boards accountable for quality and safety outcomes, has contributed to efforts to improve board performance. This project gathered information from available literature, along with interviews with key informants, case studies, and a survey of healthcare organization board chairs to identify governance practices and steps to improve governance related to quality and patient safety.

Methods. We reviewed the relevant literature between 1990 and 2007 by searching bibliographic databases and online search engines using relevant key words. We also searched websites of organizations supporting work in this area, and examined literature from the organizational and managerial literatures on determinants of quality and patient safety. Semi-structured interviews were held between February and August 2008 with 15 experts in Canada and the U.S .on governance for quality and safety. Discussions focused on exploring strategies and tools for helping boards set goals, monitor performance and improve quality and safety. Based on these interviews, we selected and developed case studies of four healthcare boards – three in Canada and one in the U.S. – that were identified as using leading practices in the governance of quality and patient safety. For each organization we carried out interviews with key informants and analyzed relevant documents. Finally, based on the issues identified in the interviews and case studies, we designed and carried out a survey of Canadian regional healthcare boards, and samples of hospital and long term care boards.

Results. In both the U.S. and Canada there are growing pressures for healthcare boards to improve their performance in setting goals, monitoring performance and stimulating improvements in clinical quality and patient safety. There is emerging evidence that more effective board oversight is associated with higher quality of care. In addition, there are increasing efforts, especially in the U.S., to regulate the improvement of governance practices in this area.

Interviews with Canadian healthcare leaders, including CEOs of healthcare associations, health region board chairs and others, suggest that current efforts to create effective governance for quality and patient safety in Canada are in the early stages. Many boards have focused largely on financial performance and access issues and are still developing the broader skills needed to assume a more “corporate” role and to develop the specific expertise needed in quality and patient safety. Some Canadian healthcare organizations do not have a quality committee, and the use of a policy governance model has limited the board focus on quality of care, which is seen as an operational rather than strategic issue.

A number of critical levers for creating more effective governance for quality and safety emerged from a review of the literature, as well as from interviews and case studies.

Create better information for the board on quality and patient safety. Such information should be easily interpretable by the board in assessing performance, inform their efforts to set strategic goals, and assist the board in determining current progress toward these goals.

Boards should monitor results for a small number of critical indicators of clinical performance, much as they do when reviewing financial performance. In many organizations, however, reports on clinical quality and patient safety include few high level “big dot” measures. Boards instead receive detailed reports on clinical programs with indicators that vary from program to program. Many organizations have limited support for such measurement and use available measures, instead of determining and developing measures that provide timely and relevant measures of clinical quality and patient safety. Accountability agreements and other requirements sometime determine the measurements provided to

the board, and some boards receive large number of performance measures that are not clearly related to strategic goals. Effective practices seen in some organizations include developing a dashboard with a limited numbers of measures that reflect current strategic goals, incorporating real- time measures of clinical performance, and developing composite measures that "roll up" related indicators for the board, rather than reporting numerous individual measures.

Improve the expertise on the board in quality and patient safety. Many boards have limited expertise available to assess quality reports and must rely on medical staff and management expertise to set goals and monitor outcomes. Healthcare boards need to include quality expertise in their competency profiles, and to ensure that all board members receive orientation and continuing education in these areas. They also need to recruit one or more members with deeper expertise who can provide insight and help the board quality committee and the board as a whole execute their responsibilities in this area. Recruitment of experts in "lean" or other quality disciplines from outside healthcare may also be useful.

Create a quality and safety plan. Boards need to develop quality plans that include specific objectives with clearly defined targets and assigned responsibility for execution. Boards need to be full partners, not passive recipients, in the development of these plans. The quality and safety plan should be an integral part of the larger strategic plan, not just a reaction to targets set elsewhere.

Improve governance skills. Board members' effectiveness in improving quality and patient safety rests on their abilities to interpret the information provided, ask good questions, and maintain a consistent focus on achieving the outcomes endorsed by the board. Strict separation of strategy and policy from operations discussions limits the board's capability to assess current performance and set direction. A number of strategies have been used by leading organizations to help bridge this gap. Boards may benefit from hearing stories about patient experiences, by engaging in "generative governance" that builds board expertise without prompting micromanagement of operations, and by understanding the nature of critical events that have occurred in the organization and the system issues that they uncover. Effective governance for quality and safety is first and foremost based on generic good governance practices where there is an extensive exchange of views before decisions are made and where constructive questions help to shape good decisions. High-performing boards carry out their work in an atmosphere of respect, candor and trust. Better information and deeper knowledge of quality and patient safety must be used by board members who have effective governance skills.

Building effective relationships between the board, medical staff and senior leadership. While boards need to assert their role in setting direction and monitoring progress for the improvement of quality and patient safety, they also need to build strong, trusting relationships with medical staff and senior leadership. New structures for medical staff and better alignment between quality improvement efforts carried out by medical staff and organizational quality departments may facilitate better alignment in quality and patient safety initiatives. Explicit "compacts" that identify roles and expectations may help to establish trust and effective working relationships.

Survey Results: The survey was designed to determine the extent to which Canadian healthcare organizations are engaging in the activities that support effective governance for quality and patient safety. Initial analysis of surveys returned from 79 organizations suggests a number of areas where additional efforts are needed to improve governance. While most board chairs report that their boards receive numerical reports in standard formats, only half rated this information as excellent or good in assessing performance. Less than half of boards reported that they addressed quality and patient safety issues in all meetings, and only one-third of boards spend 25% of their time or more on quality and patient safety issues. More than 80% of boards have formally established strategic goals for quality with specific targets, but a majority of board chairs indicate that their boards did not provide the ideas for strategic direction or initiatives. Finally, in evaluating their effectiveness in carrying out their quality and patient safety oversight functions, roughly half of the chairs rated their boards as extremely or very effective, while 40% rated themselves as somewhat effective.

Creating more effective governance. Based on the data provided in this report, Canadian healthcare boards need to develop greater expertise in quality and patient safety. They need better information on organizational performance in these areas, along with improved skills in helping to create and monitor the strategic quality and patient safety plans of their organizations. Provincial and territorial governments need to create an environment and provide resources that facilitate board development in these areas. Ministers of health need to ensure that boards have the expertise needed to execute accountabilities for quality and patient safety. Resources are also needed to improve educational opportunities and measurement capabilities.

Healthcare board members in Canada are volunteers, often not paid for their participation in difficult and time-consuming reviews of complex issues. Greater investment is needed to support trustees in developing the knowledge and skills related to assessing and improving quality of care and patient safety. There are few forums where board members can interact and few resources that capture leading practices that would inform boards. Governments, provincial and territorial healthcare associations, healthcare regions and individual delivery organizations need to provide resources to improve measurement, build expertise, and support the development of governance skills. Without such initiatives, current attempts to hold boards accountable for performance in quality and safety will lead to frustration and failure.

INTRODUCTION

Governing boards of healthcare organizations in Canada are accountable for the performance of their organizations and provide oversight on their decisions. To achieve their governing responsibilities in regards to quality and safety, boards can perform various functions: develop a vision of quality and safety improvement for their organization; define clear and realistic goals; access, interpret and use valid and appropriate information to monitor performance relevant to these goals; and support initiatives to develop quality and safety culture and capabilities within the organization (adapted from Denis, Champagne, Pomey et al., 2005). However, recent research and policy discussions in Canada and the U.S. suggest that boards often fail to set goals, monitor progress, and to hold CEOs accountable for performance related to the quality and safety of care.

In many cases, boards have deferred to medical staff, assuming that the medical staff will assert responsibility for quality of care. This deferral reflects not only recognition of the expertise of medical and other clinical leaders on these issues, but also the historic separation of responsibilities between the administration and the medical staff organization – the former responsible for financial and operational issues, the latter for quality of care. While chiefs of staff and medical (or professional) advisory committees report to boards, in many organizations these reports have been received with limited discussion. Boards have been satisfied with addressing other issues, such as financial performance and fund-raising. This issue is further complicated by the complexity of judging the quality of clinical care, and, until recently, the paucity of information on clinical performance that was available to boards. Moreover, since most board members are not clinicians, they lack expertise about the care provided and may feel unable to fully question clinical leaders about the quality of the services provided.

A number of recent developments have altered this situation. First is the evidence of problems in the general level of quality and safety of care across healthcare organizations. Among this evidence are the findings of the Canadian Adverse Event Study (Baker, Norton, Flintoft, et al., 2004) as well as reports from research groups (e.g., Bruce, Prior and Katz, 2006), the Canadian Institute of Health Information (e.g., CIHI, 2008), the provincial health quality councils (e.g., Health Quality Council, 2007) and others, outlining problems in the quality of healthcare services. Second is the improvement in the availability and quality of information about such issues at the level of individual hospitals and other healthcare delivery organizations, which has clearly demonstrated wide variations in performance between healthcare organizations. Third is the growing movement to publicly release performance data. Efforts to increase transparency include requirements that organizations post data on their web sites, or participate in various

performance reports. Fourth, ministries of health are linking increased funding to the reporting of performance on quality and safety or, conversely, are establishing explicit accountabilities, using these performance measures to hold CEOs and boards responsible for performance on quality and safety measures (in addition to financial performance). As a result of these pressures, there is growing interest in understanding the strategies, tactics and tools through which boards can establish quality and safety goals and stimulate improvement in healthcare organizations.

This interest has been further accelerated by high-profile efforts such as the Institute for Healthcare Improvement's "Boards on Board" campaign (IHI, 2007). This program focuses on stimulating board involvement and leadership in improving quality of care, making explicit the assumption that performance will be strengthened if the board is active in setting quality goals and holding the CEO accountable, and, through her or him, the organization, for the achievement of these goals. While the IHI focus has been primarily on U.S. hospitals and health systems, its work has captured the attention of leaders in Canada as well.

There is little research evidence to guide healthcare organizations on which board structures and processes promote high performance. Few articles in the healthcare governance literature offer data on the board role in improving quality of care, and only a handful of publications in the quality improvement literature address governance. The literature on board effectiveness and performance has been largely dominated by prescriptive and normative discussions of governance structures and composition based on limited data. Empirical research has focused on issues such as agency theory, and control and its implications for managers and governors (e.g., Dalton et al., 1998). Research on boards' changing structures and their impact on performance suggests that corporate structures are more effective than traditional board structures (Alexander, Ye, Lee, et al., 2006; Weiner & Alexander, 1993). However, there is still limited empirical evidence of how boards fulfill their oversight and monitoring roles, and how these have changed over time (Alexander, Lee, Wang, et al., 2009; Alexander and Lee, 2006).

Evidence of the impact of board involvement in improving care is still limited. Clearly there is a need for additional research on the strategies, tactics and tools that are linked to effective board performance and effective organizational performance.

The goals of this project were to:

1) Identify the structures, processes and tools of governing boards, and the strategies and tactics that can be used by boards in setting goals, monitoring improvements and achieving results in the quality of care and patient safety;

2) Review the evidence of the impact of different structures, processes, strategies and tactics on quality of care and patient safety outcomes and the links with boards involvement;

3) Analyze leading governance practices through case studies; and,

4) Assess the possible governance practices that are relevant and implementable in the context of Canadian healthcare organizations at both regional and local levels that would lead to improvement in quality of care and patient safety.

In this context, we define quality to mean "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Lohr, 1990). Quality includes a number of different dimensions, including safety, timeliness, effectiveness, efficiency, equity and patient centeredness (Institute of Medicine, 2001). Efforts to improve patient safety focus on the "reduction and mitigation of unsafe acts within the healthcare system as well as the use of best practices to improve the overall quality of care" (Canadian Patient Safety Dictionary, 2003, 12).

METHODS

LITERATURE REVIEW

A detailed review was carried out of published literature and accessible grey literature on the current challenges and the structures, processes, strategies and tools used by healthcare boards to improve quality and safety. We reviewed relevant literature between 1990 and 2007 by searching bibliographic databases and online search engines using relevant key words. We also searched websites of a number of organizations supporting work in this area, and supplemented these searches with literature from the organizational and managerial literatures on determinants of quality and patient safety. (Appendix 1, the literature review, includes a description of the search strategy and specific methods used.) Results of the literature review were used to develop a preliminary conceptual framework that provided the basis for the semi-structured interview guides[1] used in the next phases of the study.

INTERVIEWS WITH GOVERNANCE EXPERTS

Semi-structured interviews were held between February and August 2008 with 15 experts in Canada and the U.S. on board performance and strategies and tools for helping boards to set goals, monitor performance, and improve quality and safety. The interviews also aimed to identify potential case study sites. Experts were selected based on the results of the literature review and nominations from key informants.

CASE STUDIES

Based on these interviews, we selected and developed case studies of four healthcare boards – three in Canada and one in the U.S. – that were identified as using leading practices in the governance of quality and patient safety. We selected the case sites to include examples from both academic health centre and general care settings. In June, July and November 2008, between two and four team members paid one visit to each of the four sites. In advance of each visit, the researchers reviewed a range of background documents provided by system informants. These documents included strategic plans, annual reports, terms of reference, improvement reports, and committee minutes. Site visits included meetings and interviews with board chairs and members, CEOs and their executive teams, senior clinical leaders, and support staff.

For each case study, the unit of analysis was the board and its governance practices related to quality and safety, including the interface with the CEO and executive team and the relationships with key external agencies, including governments, accreditors, and other bodies, such as the Institute for Healthcare Improvement. An average of 10 interviews per case was conducted, supplemented by documentary analysis (Kvale, 1996; Lofland and Lofland 1995). Analysis focused on key aspects of governance practices and on the resources, competencies and instruments that support the implementation of such practices. The analysis was based on interpretive methods (Coffey & Atkinson, 1996), to identify key themes and concepts and the relationships between them. The case studies were crafted based on thematic analysis of extensive notes recorded during the interviews, integrating details from the strategic and operational documents from each site (Miles and Huberman, 1994; Yin, 2003). Key interview participants at each of the four sites reviewed the draft reports to ensure factual accuracy.

SURVEY

A number of issues and potential leading practices were identified in the literature review, interviews and case studies. To discover the extent to which Canadian healthcare boards have addressed these issues and adopted these practices, we designed a survey for board chairs. The survey includes some items that were part of an earlier U.S. survey carried out by the Governance Institute in collaboration

[1] The semi-structured interview guides used for the expert and case site interviews are available from the authors.

with the Agency for Health Research and Quality (AHRQ) (Jiang et al, 2008; Jiang et al., 2009). The survey was pilot-tested and translated into French to facilitate its use in Quebec. A copy of the English survey along with a cover letter was mailed on May 28, 2009 to board chairs of all healthcare regions outside Quebec, all Ontario hospitals, and a random sample of long-term care facilities. The French-language version was e-mailed to board chairs of Quebec healthcare institutions, including health and social services centres, university hospitals and institutes[2], in the same time frame. Follow-up reminders were sent on June 15. Results from English-language surveys received by June 29, 2009 are included in this report.

DATA ANALYSIS AND PRESENTATION

Information from the first three components of the study (literature review, interviews with experts and case studies) has been integrated in the first part of the results section. We start with a description of the current environment and the pressures on boards to increase oversight on quality and safety, and then describe their performance in this regard. Based on our data, we identify a number of critical issues facing healthcare boards as they mobilize efforts to provide direction and monitor results for quality of care and patient safety. Next, using our survey data, we assess the extent to which boards have these capabilities and are engaging in the activities needed to fulfill their fiduciary responsibilities for quality and safety of care. We end by presenting a framework outlining the factors that contribute to board performance related to quality and safety, and provide recommendations to address these issues.

RESULTS

THE PRESSURES ON BOARDS TO PROVIDE LEADERSHIP ON QUALITY AND SAFETY

There is a growing literature on the role of boards in improving quality and patient safety, along with an accelerated interest from policy-makers and practitioners. This new interest contrasts with previous tolerance for considerable variation in how governance responsibilities were discharged in hospitals, and other healthcare organizations (Alexander, Weiner and Bogue, 2001; Orlikoff, 2005) and limited attempts to identify and disseminate governance best practices. Contributing to this increased governance focus has been the growing interest in improving governance more generally, in healthcare organizations, other non-profit corporations and for-profit corporations. The increased scrutiny of governance is linked with a trend to greater accountability and a growing capacity to measure organizational performance for clinical, financial and other outcomes.

In the U.S., the growing attention to accountabilities for quality and patient safety stems from several sources. As a result of several governance scandals, the U.S. Congress passed the Sarbanes-Oxley Act in 2002 legislating greater financial accountability for investor-owned corporations. Although not aimed specifically at healthcare organizations, this legislation has influenced the larger environment of organizational reporting and accountability and influenced board practices more broadly (Alexander and Lee, 2006). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has increasingly specified performance standards in quality and patient safety, including revised standards for Governance and Executive Leadership (JCAHO, 2008). The Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services identified governance attention to quality of care as suboptimal, and issued recommendations on how boards should act (CMS, 2006). More recently, the Office of the Inspector General of the U.S. Department of Health and Human Services, together with the American Health Lawyers Association, has published a report identifying the responsibilities of hospital boards for quality of care and warning about the need for increased government

[2] Les Centres de santé et de services sociaux, et les centres de hospitalier universitaires

oversight in this area (Callender, et al., 2007). Added to these pressures, Medicare has identified a list of services for which it will not reimburse hospitals for the additional costs incurred for the patients. This list includes hospital-acquired infections and other adverse events. (Milstein, 2009)

In December 2006, the Institute for Healthcare Improvement launched a campaign, "Boards on Board", inviting U.S. healthcare organizations to implement a series of best practices aimed at improving governance for quality and patient safety. By the fall of 2008, 1,682 hospitals had enrolled in this effort (Conway, Personal communication, September 8, 2008). These hospitals were asked to implement specific practices including: setting specific aims to reduce harm; gathering data and hearing stories of harm; establishing system-level measures of patient safety; changing policies and culture to create an environment to support safer care; creating a learning agenda for the board and the organization; and establishing executive accountability for improving quality and reducing harm with clear targets (IHI, 2008; Conway, 2008).

The pressures to establish greater board accountability for Canadian healthcare organizations are similar, if less visible, than in the U.S. The Broadbent report on Accountability and Governance in the Voluntary Sector (1999) outlined the need to improve governance in non-profit corporations, although the emphasis in this report was not explicitly on hospitals. Accreditation Canada has identified governance as a critical issue that emerges in many accreditation surveys. As well, actions by governments in several provinces, including the removal of hospital or regional boards, have suggested the need to improve governance structures and processes.[3]

However, the lack of public knowledge on the performance of healthcare organizations has limited the scrutiny of the effectiveness of these organizations, and by inference, the quality of governance. Public reporting of quality and safety measures is still in early stages in most Canadian provinces, despite recommendations by Romanow (2002), Kirby (2002) and Fyke (2001), who advocated greater efforts. The release of the Hospital Standardized Mortality Ratio (HSMR) data by CIHI in late 2007 attracted considerable media attention. Accountability agreements between governments and healthcare regions or delivery organizations have focused more on financial performance than on quality of care.

Recent efforts in Ontario, where the Ministry of Health and Long-Term Care has linked additional funding for surgical procedures to reporting of quality measures, including infection rates, suggest that governments may be broadening their focus. In Quebec, the Ministry of Health and Social Services has made accreditation mandatory for all Quebec healthcare organizations and required those organizations to maintain risk management committees. James Orlikoff, a highly respected consultant on governance issues, suggests that Canadian healthcare organizations are lagging behind U.S. organizations in their attention to quality and safety, and that members of Canadian boards may be more deferential and less comfortable with confronting medical staff and administrators on these issues than their counterparts south of the border (Personal communication, March 11, 2008). Whether the sources are structural or cultural, the pace of change in this area has been quicker in the U.S. than in Canada.

Many Canadian healthcare organizations and healthcare regions do not have a quality committee of the board where performance measures can be reviewed, plans developed and policies suggested. Recent data collected in Ontario suggest that while 89% of hospitals had a board committee with a quality of care mandate, only 27% of Ontario Community Care Access Centres (CCACs) and 50% of long-term care organizations had such a committee (Ontario Health Performance Initiative, 2007[4]). Accreditation

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[3] See, for example, Health Quality Council of Alberta's review of the infection control and sterilization lapses in the East Central Health Region of Alberta (HQCA, July 2007). This report pointed to governance failures which undermined accountability for infection control and sterilization procedures.

[4] A 2007 survey on governance done by the Ontario Hospital Association found that only 35% of hospitals listed a patient care and quality committee of the board; however, the authors believe that this result may underestimate the true proportion (Ontario Hospital Association, 2007).

Canada has developed new standards on governance that became effective in January 2009. These standards include defining governance responsibilities for risk management, reviewing of the frequency and severity of near misses and adverse events, making patient safety part of the governance and strategic planning process, reviewing data on quality and safety performance, and tracking the impact of initiatives to address these issues. These standards provide very specific guidance to healthcare organizations and those assessing governance activities in accreditation site visits (Accreditation Canada, 2008).

There are growing pressures on boards of Canadian healthcare organizations to exercise greater oversight on the quality and safety of care. Anne Corbett and Michael Baker, in a recent policy document issued by the Ontario Hospital Association, reviewed the legislative mandates, common law duties and other accountabilities of hospital boards in that province. They note that, "Boards of Trustees in Ontario hospitals are responsible for the quality and safety of patient care and should ensure that they are familiar with the issues and overall directions of this field." (Corbett and Baker, 2008). Other provinces have been less explicit in declaring their expectations of regional or facility boards. In Saskatchewan, for example, there is no explicit requirement for boards with respect to quality of care and patient safety, although *The Critical Incident Regulations* (and the 2004 Reporting Guidelines) and *The Regional Health Services Act/Cancer Agency Act* provide a statutory framework for RHAs and the Saskatchewan Cancer Agency, which implies such a responsibility.[5]

IS THERE A RELATIONSHIP BETWEEN MORE EFFECTIVE BOARD OVERSIGHT AND QUALITY OF CARE?

Efforts to engage boards in improving care are based on the rationale that an "activated board, in partnership with executive leadership, can provide the will and set system-level expectations and accountability for high performance and the elimination of harm. Properly conducted, this leadership work can dramatically and continuously improve the quality of care" (Conway, 2008: 215). The empirical evidence supporting this argument is slim. Two U.S. studies have found correlations between board and senior leader activities and higher quality of care. The first study by Vaughn and colleagues (2006) used data from a survey of hospital leadership in 413 hospitals across eight states on their implementation of quality improvement initiatives. These data were linked to an index of quality performance based on risk-adjusted measures of morbidity, morality and complications. The authors found that better quality outcomes were associated with boards spending more than 25% of their time on quality issues and where boards receive a formal quality performance measurement report. They also found that hospitals that reported a high level of interaction between the board and medical staff in setting quality strategy had better quality outcomes, and that hospitals where compensation of senior executives was based in part on quality performance had better clinical quality outcomes.

A second recent study by Jiang and colleagues (2009) used data derived from a survey of board practices in the oversight of quality linked to administrative data on care processes and data outcomes for heart attack, heart failure and pneumonia. The authors found a statistically significant correlation between process of care and mortality measures and a number of self-reported measures of board activities. These measures included the presence of a board quality committee, the setting of strategic goals for quality improvement by the board, the use of indicators of clinical quality and patient safety by the board, the presence of specific items on the board agenda devoted to quality, the board spending more than 20% of board meeting time on quality issues, and where the CEO's performance evaluation included measures for clinical improvement and patient safety. However, the differences in process of care measures were small for most items (3–4%). Moreover, since the survey results are cross-sectional, it is impossible to judge to what extent the board actions influenced quality of care; perhaps the board, leadership and front-line staff shared a common commitment to delivering high-quality care that would exist even if the board were not spending 25% of its time on the quality agenda.

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[5] Personal communication, Saskatchewan Ministry of Health, June 24, 2009.

The limited empirical data linking board practices to organizational effectiveness goes beyond quality of care issues. Indeed, the research on the influence of boards on all aspects of organizational performance, including financial performance, is surprisingly limited. There is little empirical research showing that boards influence financial performance (Dalton, 1998) or evidence of how boards fulfill their monitoring and oversight roles, and the extent to which these practices have changed over time (Alexander et al., 2009). Clearly, additional research on how and the extent to which boards influence quality of care and patient safety, and the development of longitudinal data on sound measures, would be helpful. Research on this topic is difficult, since it requires valid and reliable metrics of quality of care linked with measures of board structures and processes. The literature is also entirely based on U.S. experience.

In addition to the Vaughn and Jiang studies, it is important to note the considerable reporting of hospital and health system experiences in board engagement. Various case studies (e.g., Slessor Crandall and Nielson, 2008; Rose, Thomas, et al., 2006) and less formal reports on the Institute for Healthcare Improvement (IHI) website (from the "Boards on Board" campaign) and elsewhere have indicated important impacts on clinical process and outcome measures following greater board involvement.

CURRENT PERFORMANCE OF CANADIAN BOARDS IN THE OVERSIGHT OF QUALITY AND PATIENT SAFETY

Not surprisingly, given the recent emergence of quality and patient safety as clear governance responsibilities, our interviews with Canadian leaders, including CEOs of hospitals, health region board chairs and executives of other healthcare organizations, suggested that efforts to improve the governance of quality and patient safety in Canada were still in early stages in many organizations. One of our interviewees, who has worked with boards in several provinces, summarized the current efforts by governance bodies to address quality and safety as "scattered." Elaborating on this, he noted:

> *Each board has dealt with it [quality and safety] from a different perspective. They are not using consistent indicators, they are not using a consistent approach, and they don't really understand what their role is, what their fiduciary responsibility is with respect to quality.... In some cases they are a little mixed up because they think the medical advisory committee (MAC) is responsible for quality and they don't understand what the governors' role in quality is. And if they think they have a role they don't know how to carry it out.*

For much of the last decade most Canadian boards have been concerned with financial and access questions, which have been seen as the most critical issues for Canadian healthcare organizations. Another interviewee remarked:

> *We have no one in the public sector putting pressure on health care [organizations]; no province is doing so. We are doing it through CCHSA[6], [those] standards are going to help. The Saskatchewan Health Department issued a governance manual, but they leave a lot of execution to the boards, they didn't mandate it.*

Many boards are still grappling with the challenges of moving from more traditional board roles of fundraising and community advocacy (sometimes described as the philanthropic model) to roles that focus on setting long-term goals, assessing performance against those goals, ensuring financial health and quality of care, and assessing the board's own performance (the corporate governance model – see Alexander and Weiner, 1998; Pointer and Orlikoff, 2002). The shift in board roles toward explicit accountability for organizational performance has led to a growing recognition that ensuring quality of care is a fundamental requirement of governance and that fiduciary responsibility extends beyond financial performance. A recent report released by the Ontario Hospital Association made this point

[6] Canadian Council on Health Services Accreditation, now Accreditation Canada

clearly. Members of the board must ask, "[b]ased on my skill and judgement, what do I, in good faith, believe our board should be doing to ensure organizational quality and success and sustainability of the hospital" (Corbett and Baker, 2008).

There is no straightforward answer to this question; adopting a greater responsibility for quality and safety performance is challenging for many boards. Few board members have much experience or knowledge of quality activities, in healthcare or other industries. Although many boards target the recruitment of lawyers, accountants and business people to bring necessary skills to the board, few boards have sought members with skills in the quality arena. Moreover, there are few avenues for education on these issues. A former Canadian hospital CEO could not identify any education programs offered by Canadian organizations in this area, and a former board quality committee chair lamented that there is no forum in Canada for board members to learn about quality and safety so that they can discharge their oversight responsibilities. Several health association CEOs noted that there is a growing concern with quality and safety issues in their member organizations, but they also noted the limited responses to prepare board members to address these issues.

When asked to nominate healthcare regions or organizations whose boards represented leading performance, many of our interviewees found it difficult to nominate organizations, or qualified their nominations, saying that "they were making progress, but were still in early stages." Our interviewees did not believe that many boards in Canada are spending 25% or more of their time on quality and safety oversight, a figure cited by U.S. experts (see also Vaughn, Koepke, Kroch, et al., 2006) and identified as a goal by the IHI.[7]

Several factors constrain attempts to change the current skill mix and board activities. In several provinces, board members are appointed by government to regional boards, restricting the ability of regions to recruit members with skills in quality and safety. The Carver model of governance (Carver, 2006), which is popular in many organizations, encourages boards to focus on issues of organizational purpose and policy and to leave decisions on how organizations achieve these policies to management. This model, sometimes termed, "policy governance," makes it awkward for boards to discuss the details of patient safety events or to consider the means by which healthcare organizations are attempting to improve safety. Interviewees in several provinces noted that board's reluctance to "get into management issues" was a frequently cited reason for not discussing patient safety matters. One board member explained that their provincial government had not expected the regional board to create a quality committee: "This was the time that they were talking about policy governance, a Carver [model]," explained one board member, "and they thought that we would be drilling down too much and going into operations by getting into quality."

INFORMATION ON QUALITY AND PATIENT SAFETY

Many healthcare organizations face challenges in creating useful performance measures that can be easily interpreted by lay members of a healthcare board. Such measures need to be timely assessments of current performance in targeted areas. Hundert and Topp (2003) stress that "the board as a whole should routinely monitor results for a small number of critical corporate indicators," and ensure that management and the medical advisory committee are monitoring quality results in a more detailed fashion. Among the challenges are the variability in the measures used, concerns about data quality, and the provision of large numbers of detailed indicators, which may result in board members becoming overwhelmed and confused in judging performance.

[7] This is also the case in the U.S., where a recent survey found only 41% of hospital governing boards reported spending more than 20% of their meeting time on quality issues (Jiang, Lockee, Bass, et al., 2008).

One of our interviewees also noted the frequent variability of measures used in different programs, the lack of longitudinal data necessary to assess whether performance is improving, and the lack of comparisons to other organizations. He noted as well that many board quality committees are unsystematic and unquestioning about the information they receive on quality of care:

> *In many cases what I have seen is that the quality committee of the board will invite various programs to make presentations and in the absence of any overall indicators a program will come and say, "this is what I do and we're taking good care of our patients," and in the next meeting another program will come and say the same thing. I don't think they are intentionally obscuring anything from the board. But there is no formalized process to measure overall quality. So therefore there is no framework for the board members to ask questions.*

In regional authorities, the search for a few good measures to inform the board is even more difficult since these boards need to understand performance for a wider variety of services and types of care. As one regional CEO described it,

> *Part of our challenge in a regional system is it's not just acute care. And so you know you want to keep this [report as a] small two-pager, and yet you've got services in such a broad range of programs that to get some that relate to the other part of the business is a bit of a challenge too, you know mental health and addictions and public health and some of these, so that is still a work in progress*

Some U.S. experts advocate developing dashboards with a small number of quality and safety "big dots." The IHI strategy suggests that boards of hospitals should select a small set of system level measures, which they label "Whole System Measures," as a way to monitor organizational performance. These measures include the rate of harm per 1,000 patient days, Hospital Standardized Mortality Ratio (HSMR), patient satisfaction and other measures (not all these measures address quality and patient safety issues—see Martin, Nelson, Lloyd and Nolan, 2007).

However, not all U.S. organizations have been successful in achieving such a dashboard. A study undertaken by Kroch and colleagues (2006) examined the content and composition of U.S. hospital board dashboards, how these were created and used, and the relationship between dashboards and hospital performance to assess whether the presence of such information contributed to improvements in performance. Dashboards were collected from 139 hospitals in nine states in the U.S., analyzed, and then linked to other information about these hospitals. The researchers found that hospitals had, on average, 29 measures on the dashboard and 70% had between 15 and 45 measures. Most measures were categorized as relating to clinical quality, efficiency and safety (61%), while 9% reported measures from the customer perspective, and 17% were financial measures.

Many Canadian healthcare organizations have struggled to develop useful measurements for board oversight of quality and patient safety. Some organizations have created voluminous reports with dozens of measures across many programs. Even some of the Canadian organizations identified as being among the leaders in current practice have faced challenges in developing useful indicators that would summarize critical measures of quality and patient safety. At the Ottawa Hospital, which is devoting considerable effort and resources to develop a data warehouse, creating appropriate and useful measures for the board continues to be a problem. The board in this organization now receives 75 or more measures. The Director of the Centre for Patient Safety in this organization noted, "There is still not a very sophisticated method of capturing data across the organization in a way that the board can understand it and it's not minutia." New data formats, including a balanced scorecard, are being discussed, but some board members are concerned that this format over-simplifies the complex nature of the hospital's work.

The Saskatoon Health Region uses two dashboards: one developed by the Ministry of Health that includes financial and access measures, and one produced internally that focuses more on quality and safety. Some measures are dictated externally and do not provide sufficient information to assess the

impact of local improvement projects, while some internal measures cannot be compared to other organizations' performance. The board is working to develop a more effective report. The SHR board chair observed that "We were getting too much information. We had an opportunity to say, you know we like this information but it has got to be simpler than this."

Virginia Mason Medical Center (VMMC) in Seattle, WA also sees quality and safety measures as a critical tool for the board, and agrees that finding the right set of measures is a challenge. The VMMC approach incorporates several aspects that help to ensure that the performance measures presented to the board are relevant and informative. The roughly 20 measures are tightly linked to key strategies. Moreover, while the Quality Oversight Committee (QOC) examines the data in detail, the measures are collapsed to three or four measures of quality and patient safety when the performance is reported to the board as a whole. For example, the measure of patient safety includes data on a range of different initiatives and outcomes, including performance on clinical care "bundles" (e.g., the AMI bundle of care process measures), surgical site infections and adverse drug events. This strategy allows the full board to assess the overall patient safety performance, while the QOC can drill down on specific measures and assess whether the work plan for each goal is on track.

VMMC still struggles with an issue that is a growing concern with Canadian organizations: the need to reconcile the demands for external accountability on specified measures (which may vary between different regulatory bodies) with the information needed to assess performance and guide strategic and operational decisions. The external measures are required for accreditation and other oversight activities, but they may not reflect the critical strategic goals for the organization. Gary Kaplan, the VMMC CEO, described the dilemma and the organization's response:

> *Five years ago we had what we called the 54 Must Dos, 54 metrics that were in the public domain from some bodies we respected, Leapfrog, National Quality Forum, IHI, JCAHO. But you realize if you are chasing 54 priorities you are not really chasing any of them adequately. So we've gotten much better at honing in and trying to triangulate …and putting our own work to it, so we've got clear organizational quality and safety goals.*

This challenge of reconciling the information needed for external accountability and that needed to inform local improvement is present in both U.S. and Canadian organizations. Another issue facing Canadian organizations is the extent to which they will make information about their performance available publicly. Most boards have used quality and safety information for internal purposes and have reported only what is required, principally to government. Expectations in this area are changing rapidly. For example, Ontario hospitals receiving additional funding for surgical cases for specified conditions are now required to report on the incidence of *C. difficile*, MRSA and VRE infections, and on measures of ventilator-associated pneumonias, central line infections and compliance with measures to reduce surgical site infections. Some hospitals had made this information publicly available before the Ministry requirements, while others are approaching this issue more cautiously. One of our interviewees noted that, "Our annual report is not really an accountability report to the community about how we are performing on quality and safety. It's a marketing document."

The push to develop external measures needs to be balanced against the types of measure that are useful for boards and senior leadership. James Reinertsen, a former hospital CEO and now an IHI senior fellow, believes that the most useful measures for boards are not the risk-adjusted and highly analyzed comparisons developed by third parties, but raw local hospital data on key counts such as deaths, surgical complications, infections, patient complaints and patient satisfaction. Rather than asking "How do we compare to others?", Reinertsen urges board members to set ambitious goals, and to use more timely hospital data to answer the questions, "Is our care getting better?" and "If not, is the strategy wrong, or is it not being executed effectively?" (Reinertsen, 2007)

KNOWLEDGE OF QUALITY AND PATIENT SAFETY

What skills and knowledge does a board need in order to fulfill its fiduciary responsibilities on quality of care and patient safety? This issue seems to perplex many boards. Few boards have many members who have extensive background in healthcare quality, or skills in industrial quality improvement, lean production and similar techniques. There is a growing call for more education on this topic for board members, and many board members are participating in educational sessions designed for staff of healthcare organizations.

Two critical issues emerge in the discussion of how much background knowledge and skills board members need about healthcare quality and safety. The first is what education is needed to enable members of board quality committees and the overall board to discharge their responsibilities. Jim Conway reports that several U.S. states are now requiring that healthcare board members complete mandatory training that includes education on healthcare quality and patient safety (Conway, 2008). Several healthcare associations in Canada are developing modules on quality and patient safety for board members or developing resource materials, such as the recent report released by the Ontario Hospital Association (Ontario Hospital Association, 2008). And many boards are developing local programs and inviting experts to help them understand quality improvement and the board's role in setting direction, assessing current performance and evaluating the progress in targeted areas.

There is no consensus on the extent to which all board members should be capable of assessing quality and patient safety. At the Ottawa Hospital, there is an ongoing debate about the expertise needed by board members in quality and safety. The chair of the board quality committee believes that orientation and continuing education in this area is essential for all members and has proposed an education plan. However, the chair (now past chair) emphasized the need for board members to rely upon the skills they develop in measuring performance and assessing outcomes in other domains. He did not see a pressing need to develop healthcare quality expertise among all board members. Some U.S. hospital associations, including those in Massachusetts and New Jersey, are developing a curriculum for all board members that focus on their role in healthcare quality (IHI, 2008).

Not all board members are likely ever to be experts in quality of care. Boards need a range of expertise and they need all members to have basic skills in several areas. Not all board members are accountants, for example, but all board members need to be able to read financial statements. Similarly, while not all board members can be experts in quality, they must develop the skills to evaluate reports on quality of care and to ask questions about current performance.

The second issue is whether boards should broaden their recruitment of members who have quality and patient safety knowledge and skills. A number of boards are now targeting members of their community who have quality skills in other industries. One of the key members of the Virginia Mason Medical Centre board is a vice-president of Boeing and an expert in lean production techniques. The Governance Committee at Virginia Mason has developed a skills matrix to guide recruitment of new members. The board chair identified how this is used:

> *So our overall selection grid looks at the expertise that is needed, looks at what we have on the Board presently, looks at when board members are going to be retiring, and matches that all up so that when the governance committee goes out and is charged with looking and selecting the board members, they are looking for somebody specifically with a safety and quality background, for example.*

Similarly, one of our interviewees discussed the approach his region's board is taking to improve the board's assessment and guidance on quality and safety. He noted that the board began by developing a governance committee and creating a skills-based assessment of the board. This analysis helps to establish a foundation for developing a board that is capable of ensuring that patients receive high quality and safe care. In both these cases, the approach to improving board skills on quality and safety rests on the effectiveness of governance committees, board self-evaluations, and the extent to which

boards have identified their needs for orientation and education. Boards with governance committees that develop careful assessment of the skills needed for the board, evaluate the extent to which these skills are present, and then target recruitment to build these skills, are likely to be more successful than boards that act in a more ad hoc fashion. While quality and safety issues are quite topical, there are other critical skills for the board. A number of boards have developed a strategy that ensures that the board has depth in quality and safety in the context of the full skill base needed for the board as a whole.

CREATING A QUALITY AND PATIENT SAFETY PLAN

Timely and relevant information about current performance, together with knowledge on quality of care and patient safety, are important ingredients in creating strategic goals for the organization. The Ottawa Hospital Corporate Quality Plan provides a good example of a quality plan that includes specific objectives, defined measures with clear targets, and assigned responsibility for execution for each element of the plan. For 2007/2008 the objectives included improving patient flow through and access for both emergent and elective patients, improving transitions of care through clinical pathway use, safer medication practices and the patient health record, and improving patient safety through improved adverse event reporting, root cause analysis at system and unit level and mortality and morbidity rounds (along with a number of other objectives). [See Appendix 2 in The Ottawa Hospital Case study.]

Since most board members have limited knowledge about the quality improvement initiatives in the organization, the leadership in developing quality plans often rests with management. However, in the case study organizations, the role of the board or board quality committee was not passive. In Saskatoon Health Region the board participates in the development of the quality plan. One member of the senior management team noted that "[t]he quality plan falls right out of our strategic plan; it drives some of the very specific work and goals." At Virginia Mason Medical Center, the Quality Oversight Committee of the board assumes the responsibility for developing the quality plan. The board chair described the process this way:

> *It was led by the QOC [Quality Oversight Committee], not just by management, and the QOC worked on the goals and objectives. It went back to the larger management teams for review and came back to the QOC. We have gotten to a point where that sort of a quality and safety strategy is being led by the QOC versus management recommending and the QOC simply approving. We had several late nights wherein the total focus of the QOC meeting was, what revisions do we believe are necessary, or what enhancements do we believe will be helpful, to our quality strategy going forward?*

In all our case studies, board and senior managers strove to create a quality plan that was an integral part of the broader strategic agenda. Such plans need to be more than just reactions to targets set elsewhere; they need to be anchored in core metrics of organizational performance, and they need to be aligned with other key aspects of the strategic plan. At the Vancouver Island Health Authority the board works with VIHA staff to set quality and patient safety priorities, taking into account the Ministry of Health's directions in their annual "letter of expectations." Staff provides reports and monitors trends, but board members also identify issues and initiate new directions.

In addition to identifying specific areas for clinical improvement, boards need to ensure that their organizations have created an environment that is conducive to improving the quality and safety of care. Boards can encourage and endorse disclosure policies, the development of a just culture, and effective patient safety reporting and learning strategies that help to create an atmosphere of openness, trust and improvement.

GOVERNANCE SKILLS AND ROLE

The capabilities of boards in meeting their fiduciary responsibilities for quality and safety are dependent upon more than their skills and knowledge about these areas, and their access to information about organizational performance. Board effectiveness relies on the ways in which board members translate this knowledge and information into quality and safety plans with measurable goals, maintain oversight on progress toward these goals, and hold the CEO, and through her or him, the organization, responsible for these goals. Knowledge, skills and information thus must be linked to effective governance processes (Chait, Ryan and Taylor, 2005). And this effectiveness, in turn, rests upon board members' skills in interpreting information, asking the right questions, assessing whether the answers to those questions indicate due diligence to the issues at hand, and maintaining a consistent focus on achieving the specific outcomes endorsed by the board. Excellence in governance for quality and safety relies on broader governance skills. Such skills require substantial experience and expertise.

Highly effective governance processes are challenging to develop and maintain in any area. However, the challenge in quality and safety is increased by the difficulty in maintaining focus on the board's responsibilities for providing oversight and strategic direction, and avoiding the temptations of directing management and reviewing operations. How is this possible when discussions of patient safety inevitably lead to a review of failures in clinical processes, lapses in information transfers and the convergence of unlikely circumstances that result in patient harm? Are attempts to stay focused on "policy", not "management," even desirable in the face of attempts to tell stories about patient experiences with the goal of "putting a human face" on safety and quality efforts?

Our case studies revealed several ways in which effective governance processes allow boards to negotiate the potential conflicts raised by the concurrent need for boards to develop expertise in these areas while not interfering with managerial responsibilities for operations. At the Ottawa Hospital, the board spends time with management in "generative governance," deliberating on organizational challenges such as the need to improve patient flow and reduce the numbers of alternative level of care (ALC) patients (who need to be transferred to other facilities, but for various reasons cannot).

Generative governance permits board members and senior leaders to jointly explore these issues and the underlying dynamics that limit success. Such discussions allow board members to probe the nature of specific operational issues and to build better understanding of hospital systems (Chait, Ryan and Taylor, 2005; Taylor, Chait and Holland, 1996). These sessions allow the board to assess why certain efforts are not proceeding as well as they might. For example, the board of the Ottawa Hospital had set an ambitious target for staff flu vaccination, which was not met. Working in a generative discussion with senior leadership, they jointly explored the barriers to meeting these goals and brainstormed ways to overcome these barriers. Such discussions require trust on both sides. As the CEO noted, "If you're a seasoned CEO, I can understand that you might be hesitant to have the board so involved. If you are a seasoned board member, you might be hesitant to get too involved in operational business. So it's a risk on both sides that can turn into a disaster." The board reduces these risks by being clear about when it is engaging in such discussions, by limiting these to specific and important issues that require such clarification, and by using the expertise of one board member who is experienced in these methods and helps guide the discussions.

The Quality Oversight Committee (QOC) of the board at Virginia Mason Medical Center has also developed a strategy that challenges the traditional division between policy and management responsibilities. Following a visit to Japan, where they were impressed with the delegation of authority to all production line workers to "stop the line" to correct quality problems, VMMC decided to implement a patient safety alert (PSA) system, where any staff member can flag a safety and quality issue. These issues led to immediate situation assessments and root cause analyses, with the goal of making corrections in real time (usually finished within 3 to 18 hours.) The PSAs are categorized as yellow, orange or red based on their severity or potential for harm (Furman and Caplan, 2007).

Initially, the QOC reviewed the numbers, categories and issues involved in the PSAs. However, following a highly public patient safety failure that resulted in the death of a patient, the QOC decided that it could not discharge its fiduciary responsibilities if it did not understand how the most serious PSAs were being addressed. Now the QOC reviews all "red PSAs" (i.e., the most severe events), assessing whether the reports adequately identify the issues and the necessary actions to avoid repetition of these events. The QOC is now the only body authorized to sign off and close a red PSA. On average there are three red PSAs per month.

Many healthcare organizations would find it unacceptable, if not unworkable, to give a board committee the final authority to review patient safety event analyses and recommendations. In contrast, the VMMC board and CEO see this activity as one of the key drivers for improving performance and ensuring accountability for performance in the organization. Their success rests on the skills of the QOC members to take an organized, systematic and disciplined approach that aims at "interrogating the process, rather than the people". The QOC members focus on assuring that due diligence appears to have been paid to the investigation of root causes and the development of effective counter measures. Among the members of the committee is the VP from Boeing, who notes that while she has no healthcare expertise, she understands lean methods and applies the tools that she uses to assess failures in her work to her appraisal of the healthcare systems' report on the red Patient Safety Alert. She notes:

> *So what you are doing is sort of a validation, right, so when they come in and talk about the corrective action that we are taking to address this, I find myself, before I read what that is, asking those questions to ensure that my logic take me to the same place.*

The success of a quality committee such as that at VMMC depends on a clear understanding by committee members that they are focused on assessing the investigation **process**, not the specific **outcomes**. Such a committee needs strong leadership, dedicated and experienced members, and effective work processes. The board chair at VMMC noted that board members were aware of the tension between governance and operations:

> *There are two things here that I would characterize as being different from other places that I have worked. One is that there is a sufficient level of sophistication on the Board from their prior experience that they know where to draw that line [between policy and operations]. Or they learn it quickly in this setting.*

Effective governance for quality and safety is first and foremost based on generic good governance practices. Prybil notes that high-performing hospital boards are those in which there is "'extensive exchange of views before decisions are made," and where "constructive questions and scepticism dominate the boardroom deliberations" (Prybil, 2006). These findings echo the thoughts of Sonnenfield, who noted that the key to exemplary boards is the existence of "robust, effective social systems." Such boards generate "virtuous cycles of respect, trust, and candor" and foster a culture of open and constructive dissent (Sonnefeld, 2002). Board processes related to oversight of quality and patient safety build on their capabilities to act collectively as effective governors.

EFFECTIVE RELATIONSHIPS BETWEEN THE BOARD, MEDICAL STAFF AND SENIOR LEADERSHIP

The capability of boards and board quality committees to function effectively and to move appropriately between fiduciary, strategic and generative modes relies on trust as well as skills. Boards, senior leadership and medical staff need to develop an understanding of each other's roles and create strong collaborative relationships for achieving the organization's goals. David Nadler (2004) notes that "[t]he key to better corporate governance lies in the working relationships between boards and managers, in the social dynamics of board interaction, and in the competence, integrity, and constructive involvement of individual directors." Similarly, healthcare boards need to assert their responsibilities to assure a

high quality of care and to monitor the organization's efforts to continually improve that care. This is new territory for many board members, and requires recognition that the board will take on new activities and ask new questions. One board quality committee chair commented that "We're saying it's the system that needs to improve… It means getting into the issue of are we actually managing and practicing health care in the right way?" He and the board's chair both attend the MAC as members: "We're there and we're involved and we are challenging them."

Effective relationships can require new structures and approaches. When the Vancouver Island Health Authority was established in 2001, the Medical Advisory Committee was composed of 50 members and 80 quality councils and committees. Beyond the cumbersome nature of this structure, the Health Authority MAC was focused on traditional medical quality assurance, and some physicians were hesitant to embrace the shift from a blame culture to a culture that emphasized learning and understanding the broader system contexts for adverse events. The agenda of the Health Authority MAC was focused on credentialing, disciplinary issues, bylaws, and little else. Changes in these structures take time, and leadership is needed to align medical staff structures with new board roles and expectations. To help build trust and communicate new approaches, the VIHA board makes a point of meeting with local physicians at every meeting, rotating its meeting location around the region.

Better alignment between medical staff and administrative structures can mean changing the medical leadership structure and developing new leadership. The Ottawa Hospital has placed considerable emphasis on reorganizing the key roles and committees, reinforcing the quality and patient safety dimensions of the VP Medical role, and integrating structures to facilitate the review of issues related to clinical, financial and operations portfolios.

EXECUTING EFFECTIVE GOVERNANCE FOR QUALITY AND SAFETY

Despite growing agreement that boards need to assume fiduciary responsibilities for quality and safety, there is no clear consensus on exactly how they should do this. While there is a growing acknowledgement that increasing involvement of boards in quality and safety will lead to greater organizational attention to these issues, many boards appear to struggle to execute effectively in assuming these responsibilities. In part, this difficulty reflects the challenges outlined above, including a lack of in-depth board knowledge about quality and patient safety, inadequate information on organizational performance in these areas, non-standardized processes for reviewing current performance, inadequate governance skills, and a lack of trust or poor working relationships between boards, senior management and medical staff leadership. However, it must be recognized that there is limited agreement about what constitutes effective board processes for establishing goals and monitoring quality.

One approach to improving healthcare board performance in quality and patient safety draws on creating structures and processes analogous to financial oversight and performance review. In quality, like finance, goals need to be established, relevant indicators selected, progress monitored, and appropriate action taken if goals are not achieved. Hundert and Topp (2003) outline three activities necessary for discharging board responsibilities that parallel the work of the finance committee:

- Monitoring the quality of the service
- Ensuring that management processes are in place to measure, monitor and maintain the quality of the service, and
- Ensuring quality in all aspects of hospital operations (Hundert and Topp, 2003)

The Saskatoon Health Region, which was one of our case study hospitals, has adopted an approach that incorporates these elements. Board members see their role with respect to quality as setting direction,

monitoring, and asking good questions. They review reports and dashboards, then "ask questions about what kind of processes have changed to prevent this from happening or to keep making improvement" (SHR board member interview). (See Saskatoon Health Region case study, p.4.)

Hundert and Topp (2003) are not advocating that boards become overly familiar with operational details. In fact, they suggest that information from "critical incident reporting, risk management, morbidity and mortality rounds" and similar reports are "unlikely to make the board's list of critical corporate indicators, although the board needs to ensure that such activities are untaken and followed up." The model in this approach derives from an analogy to financial oversight and performance review.

The Institute for Healthcare Improvement's effort to engage trustees to stimulate higher performance in quality and patient safety includes several activities (setting specific aims, establishing and monitoring system-level measures and establishing executive accountability for clear improvement targets), which are similar to the approaches used to deliver effective financial governance (IHI, 2008). However, the IHI "Boards on Board" campaign goes beyond this more traditional governance model to deepen the engagement of board members and encourage more ambitious aims in improving care. In particular, IHI argues that boards not only need to review data on adverse events, but they need to "put a human face" on harm data, reviewing specific cases where patients experienced harm while receiving care. Boards also need to commit to creating and spreading a just culture, and to adopting policies and practices that encourage disclosure of adverse events and resolving issues that led to harm. The suggestion that boards engage in deep learning about quality and patient safety, that they hear stories from individual patients, change the environment to support disclosure and resolution of adverse events, and embrace transparency for all organizational data goes well beyond traditional monitoring roles. Many U.S. hospitals appear to be following this advice. At Allen Memorial Hospital in Waterloo, Iowa, for example, the president of the medical staff begins each board meeting reading a detailed account of a patient case that occurred in the hospital. The hospital intends to hear directly from patients who were injured by the care they received in the hospital. The board also participates in educational sessions on quality and safety of care, which includes patient accounts of injuries received in their care. (Slessor, Crandall and Nielsen, 2008)

IHI is not alone in advocating an expanded role for boards in quality and patient safety. The U.S. National Quality Forum issued a report in 2004 on improving the role of hospital trustees in quality improvement, which they labelled, "a call to responsibility" (NQF, 2004). A recent report from The Governance Institute suggests that boards can contribute to improved quality by holding the CEO accountable for quality and safety goals, participating in the development of explicit criteria to guide medical staff credentialing and privileging, setting the board agenda for quality, and reviewing patient satisfaction and other information (Lockee, Droom, Zablocki, and Bader, 2006).

SURVEY RESULTS

To what extent are Canadian healthcare organizations creating the structures and engaging in the activities in the areas outlined above? Our survey was designed to provide answers to these questions. As of June 29, 2009, 79 completed English-language surveys had been returned and analyzed, representing a response rate of 15%. Returns from hospitals board chairs were proportionally greater (29%) than regional authority board chairs (17%) and board chairs of long- term care facilities (8%)[8]. Given the low response rates, the data need to be interpreted cautiously, as those returning surveys may not be representative of board chairs for similar organizations. In light of the small number of responses, results presented here include data from all three types of organizations.

[8] Hospitals in Ontario and long-term care facilities in a number of provinces continue to have boards, while most hospital in other provinces (and some long-term care facilities) are governed by boards of regional health authorities and do not have separate governance structures.

INFORMATION ON QUALITY AND PATIENT SAFETY

Almost all (89%) of boards indicated that they received numerical reports in a standard format that allowed them to track or review performance on quality and patient safety. However, only 51% of boards rated this information as excellent or good in assessing overall performance. A majority of boards (58%) reported that the board agenda included stories about clients that experienced harm while receiving care within their organizations. As well, most board chairs reported that critical incidents were reported to the full board, 46% saying all critical incidents were reported and 43% saying that selected critical incidents were reported. A majority (56%) of board chairs reported that the board *always* required management to report on the progress of corrective actions in response to incidents, and a further 32% indicated that the board *sometimes* did so.

Only 43% of board chairs reported that *all* board meetings have a specific item on the agenda devoted to the discussion or review of quality and patient safety, while 13% reported that *none* or *few* board meetings included quality and patient safety agenda items. One-third of board chairs indicated that the board spent 25% or more time on quality and patient safety issues, while two-thirds reported that the board spent less than 25% of its time on these issues. Patient safety or quality issues are most commonly reported to the board by the CEO (31%) or by the COO or a VP (24%) and less commonly by the chief of staff (14%) or hospital staff (12%). Seventeen per cent of board chairs reported that it was the board member chairing the Quality Committee who usually presented the report.

DEVELOPING THE QUALITY AND SAFETY PLAN AND PROVIDING OVERSIGHT

The great majority of board chairs (82%) indicated that the board had formally established strategic goals for quality and patient safety, and almost all (85%) indicated that these goals contained specific targets. When asked whether quality and patient safety objectives were as important, less important or more important than financial goals, most (71%) said that quality and patient safety were *equally* important as financial goals, and 23% said that quality and patient safety were *more* important. Only 5% reported that financial goals were more important. At the same time, however, a majority of board chairs (53%) reported that the board *did not* provide ideas for strategic change or initiatives in quality and patient safety, suggesting that management was taking the lead in these organizations. This conclusion is supported by fact that only 18% of board chairs reported that the board occasionally disagreed with senior management with respect to the operations and activity of the organization, while 74% said this happened *rarely*, and 8% said it *never* did. Interestingly, 36% board chairs reported that disagreements between senior management and medical staff happened *frequently or occasionally*, and 24% said disagreements between boards and medical staff were a *frequent* or *occasional* occurrence.

More than half of board chairs reported that they rated the board's effectiveness in carrying out its quality and patient safety oversight function as *extremely effective* (4%) or very effective (51%), while 40% rated the board's effectiveness as somewhat *effective*. The board chair's ratings for the board's effectiveness in achieving quality and safety goals were similar. Most board chairs believed that board policy was *extremely supportive* (32%) or *very supportive* (55%) of a patient safety culture.

BOARD MEMBER KNOWLEDGE OF QUALITY AND PATIENT SAFETY

About half (57%) of board chairs reported that their board recruitment process included the identification and recruitment of individuals with knowledge, skills and experience related to quality and patient safety, and that their board skills matrix included quality and patient safety as one of the competency areas. Nearly all (87%) of board chairs said that new board members received an orientation that described the board's responsibilities for quality and patient safety. However, only 28% of board chairs reported that there were *many* opportunities for education in this area, while 42% reported *some* opportunities, and 30% reported *few* or *none*. Interestingly, 43% of board chairs stated that all board members participate in education on quality and patient safety issues, while 19% said it was *more than half* the board participating, and 23% noted it was *less than one-quarter* of the board. Asked to rate

the full board on its knowledge, skills and experience with respect to patient safety issues, 35% of board chairs gave the board an *excellent* or *very good* rating, while only 20% rated their boards as *fair* or *poor*.

CONCLUSIONS

Based on the information gathered for this report, there appear to be a number of key elements for boards to fulfill their responsibilities for quality and patient safety. These are displayed in Figure 1. All of these elements are critical, but they are also interdependent. Effective performance relies not only on the information available about quality of care, but also on trustees' knowledge of quality and safety and the governance skills of trustees.

Interestingly, much of the advice provided by IHI, NQF and others who wish to strengthen the governance of quality and safety focuses on structures (e.g., creating a board quality committee), expertise (improving knowledge about quality and patient safety) and information (hearing patient stories and reviewing "big dot" measures). These elements are clearly essential, but they may not be sufficient to ensureeffective governance. The board, medical staff and senior leadership need to have a productive working relationship, maintaining clear accountability but also collaborating in the development of strategies and goals, assessing improvements, and developing the skills and knowledge needed to achieve these goals. Trust is important to ensure open conversations, together with the free circulation of information, the joint development of policies and processes to improve quality and safety, clear definition of roles and responsibilities for board, medical staff and senior leadership, and agreement on the improvement plans and ways to track progress.

One critical issue facing boards is the need to clarify their role in improving quality and patient safety versus the roles of leadership and medical staff. Traditionally, boards have delegated responsibilities for quality issues to medical staff, in particular to the Medical Advisory Committee (MAC), which reports to the board. This approach is inconsistent with the board's accountability for setting goals and monitoring performance (Reinertsen, 2008). However, the MAC and senior management have an ongoing responsibility to identify and resolve issues and to support the board. Thus, revision of current structures and the creation of more explicit "compacts" (Silversin & Kornacki, 2002) that clarify the expectations and roles of board, medical staff and management are essential to creating more effective healthcare organization governance. Board leadership and skills are critical elements, but effective governance requires participation of many parties along with the investment of time and new resources to create and sustain high levels of performance.

Canadian healthcare organizations are funded largely by provincial and territorial governments, which provide strategic direction and exert regulatory control. Ministers of health appoint regional health authority board members; indeed, in some provinces they do so without any input from the managers of these regions. While regions maintain some operational autonomy within a broader strategic and fiscal framework (as do hospitals and long-term care organizations in Ontario), these entities are clearly limited in the extent to which they can initiate and fund new strategic directions; thus, governance in Canadian healthcare ultimately reflects the interests and intents of provincial governments. Regional and organizational initiatives to improve quality of care and patient safety occur within a broader policy and financial framework, which may acknowledge the critical nature of these objectives but may not always provide commensurate resources.

Expanded reports of quality and patient safety problems, along with more explicit accountability agreements between governments and healthcare organizations, have created growing pressures for healthcare organizations to improve the quality and safety of care they provide. Recent research coupled with well publicized campaigns suggest that boards can be effective in helping focus attention on these issues, setting strategic aims, monitoring performance, and holding CEOs accountable for this performance.

This broadening of fiduciary responsibilities is neither simple nor easy because it requires important changes in the work and membership of boards. Boards need better information about quality and

safety in their organizations, including a performance dashboard that organizes key measures and provides an ongoing assessment of performance on strategic goals. Boards need to recruit new members whose expertise in this area will guide quality committees and improve the dialogue with senior administrative and clinical leadership. Boards and management also need to support efforts to deepen the knowledge of quality and safety issues for all board members.

In adopting a greater focus on quality and patient safety, board members need to develop knowledge and judgment concerning the factors influencing quality and safety of care, without losing sight of their responsibilities to remain focused on the strategic issues. A more co-operative approach on governance does not exclude the importance of a clear accountability framework and relationships between senior leadership and boards. However, it does underline the need to go beyond monitoring and control to also focus on how boards can help organizations to develop capacities within the organization for continuous improvement.

Excellent organizations in Canada and the U.S. are grappling with these issues in their efforts to make the governance of quality and safety more effective. Their experiences suggest a number of recommendations to strengthen boards in these areas.

For healthcare boards at both regional and organizational (hospitals, long-term care and other settings) levels:

1) Healthcare boards need to establish specific quality and patient safety goals as prominent components of strategic plans and hold CEOs accountable for the achievement of these goals. Boards need to participate as full and informed partners in the development of strategic quality goals and plans, not as passive recipients of plans created outside the board meeting.

2) Boards and board quality committees need access to relevant and informative measures of safety and quality to assess current performance and target improvement strategies. These measures must provide a broad description of organizational performance, but be limited in number. Useful measures will reflect key strategic and operational goals and permit board members to assess whether the organization is on target.

3) Boards need to develop or identify orientation and continuing education opportunities for their members to ensure that all board members are able to interpret information on quality and patient safety performance. Members of board quality committees need additional expertise to be able to critically question performance and provide guidance on improvement strategies.

4) Board governance committees need to explicitly target recruitment of members for the board and board quality committee whose expertise and experience enables them to serve as experts, much as boards target and recruit expertise in financial and other skills. Board governance committees should develop competency profiles or skill matrices that guide such recruitment.

5) Boards need to consider how they can balance the need to understand organizational performance in sufficient detail to fulfill their fiduciary responsibilities while remaining in the governance role. Exploration of generative governance, the use of patient stories, and the application of other techniques that deepen the board's understanding may provide means to balance these roles.

6) Boards need to evaluate the extent to which they are fulfilling their quality and safety responsibilities, using external reviews of their governance processes, including accreditation, peer reviews, and visits to other organizations to identify effective governance practices. Accreditation Canada can assist in this area by sharing best practices that are identified by their surveyors. Other tools, such as the Community for Excellence in Health Governance web site, provide additional means for sharing leading practices.

Federal, provincial and territorial governments also need to ensure that their policies and programs in support of improved governance and strengthen the resources for improving the quality of care and patient safety in the following ways:

7) Greater educational resources need to be developed in Canada that enables trustees to gain expertise in quality and safety and to improve the governance processes of the organization they serve.

8) Provincial or pan-Canadian investments are needed to develop relevant, timely and scientifically sound measures of patient safety and quality of care that will inform and guide governance activities.

9) Governments need to review the current level of support provided to regions and healthcare organizations to improve quality of care. Targeted efforts to provide leading-edge training and to develop a larger cohort of experts in quality improvement and patient safety would help to improve the capabilities of healthcare organizations.

10) Funding should be allocated to research that identifies the ways in which board and leadership activities support improvements in quality of care and patient safety. This research should include longitudinal studies that can assess the impact of new initiatives and interventions over time.

Healthcare board members in Canada are volunteers, often not paid for their participation in difficult and time-consuming reviews of complex issues. Greater investment is needed to support trustees in developing the knowledge and skills related to assessing and improving quality of care and patient safety. There are few forums where board members can interact and few resources that capture leading practices that would inform boards. Governments, provincial and territorial healthcare associations, healthcare regions and individual delivery organizations need to provide resources to improve measurement, build expertise and support the development of governance skills. Without such initiatives, current attempts to hold boards accountable for performance in quality and safety will lead to frustration and failure.

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FIGURE 1: DRIVERS OF EFFECTIVE GOVERNANCE FOR QUALITY AND PATIENT SAFETY