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A PROGRAM OF HRET

Enhancing the Board's Role in Quality

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ENHANCING THE BOARD'S ROLE IN QUALITY

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Project Description

This project seeks to develop practical knowledge about how to enhance the board's role in quality. Through in-depth case studies of five health systems, the project will generate theoretically informed, empirically grounded knowledge of governance principles and best practices for enhancing the board's role in quality. The five health systems participating in the project will gain a detailed understanding of the strengths and limitations of their own current governance practices, and obtain a set of tailored "implementable" recommendations. In addition, health systems will learn about the "best practices" observed in the other health systems participating in the research project.

Project Period

October 2005 – June 2007

Project Costs

$100,000

A. Executive Summary

This project aimed to develop practical knowledge about how to enhance the board's role in quality. This report identifies three purposes for board involvement in quality: oversight, leadership, and service. The oversight purpose emphasizes the board's role as fiduciary or steward of the organization's mission and assets. The leadership purpose emphasizes the board's role as strategic partner with management. The service purpose emphasizes the board's role as advisor and sounding board for management.

Building on earlier progress reports and Richard Chait's (2005) book, *Governance as Leadership,* the report offers specific recommendations for enhancing the board oversight, leadership, and service in the quality arena. In response to Project Advisory Board members' requests, the report also includes a list of questions that board members can ask that would stimulate more sophisticated discussions about quality in board meetings and increase board engagement in oversight, leadership, and service for quality. Finally, the report emphasizes the unique role that system boards can play in strengthening the governance practices of affiliate boards.

Recommendations are presented in tabular format to increase the report's readability. The system board chair, the system CEO, and the system executive responsible for quality are the most appropriate audience for these recommendations. These individuals have the legitimate authority, expert power, and credibility/reputation to introduce change in board composition, structure, activity, and relationships.

B. Project Background

With the release of the Institute of Medicine's (2000) report, *To Err is Human: Building a Safer Health System*, quality and patient safety have re-emerged as sentinel issues in healthcare delivery. Hospital quality and patient safety remain in the national spotlight despite some controversy over the number of preventable deaths that occur in America's hospitals. The Institute's report prompted renewed effort to identify and implement interventions to decrease medical errors and enhance patient safety. It also rekindled attempts to hold healthcare organizations accountable for quality. Government agencies, accrediting bodies, employer groups, and other organizations have developed an ever growing number of quality indicators and patient safety goals against which they intend to measure hospital quality performance and improvement [1-5]. Some states have implemented mandatory reporting systems [3]. Hospital quality is likely to remain under intense scrutiny for some time.

As the organizational entity legally accountable for quality of care, governing boards have an important role to play in overseeing quality improvement efforts and patient safety initiatives. Beyond simply fulfilling their oversight responsibilities, boards could potentially play a leadership role by establishing quality and safety as organizational priorities, allocating resources to support quality improvement efforts and patient safety initiatives, revising executive compensation and performance evaluation criteria, and fostering a corporate culture that values quality and safety. Recognizing this potential, many have called for greater board leadership for quality [6-9].

Although boards have a potentially valuable role to play, several features of board composition, structure, process, and context conspire to make the board's fulfillment of its responsibility for quality a challenge. First, few board members possess healthcare backgrounds or clinical expertise. Board members are often selected on the basis of their business experience,

professional skills (e.g., legal, marketing, finance), community ties, personal values, time availability. Although board members from manufacturing and service industries may be well versed in quality issues, board members report feeling confused about their responsibility for quality of care, ill prepared to evaluate quality of care, and uncomfortable taking action to rectify a quality problem (e.g., denying physician reappointment or disciplining an incompetent physician). Second, boards face a disjointed quality committee system, with both hospital committees and medical staff committees charged with improving quality of care and service. This dual committee structure, some argue, complicates the board's ability to perform effective quality oversight [7, 10]. Third, many boards do not possess adequate *governance information systems*—that is, information systems designed to support governance work [11]. Board members receive either too much information or too little to monitor quality effectively [7, 12, 13]. Moreover, they do not receive information in a format that makes it easy to discern what action they should take to rectify a quality problem or improve quality [8, 14]. Finally, board members spend much of their precious meeting time reviewing what has happened since the last board meeting rather than engaging in forward-looking discussion and decision-making [15-18]. Further, boards spent much of their meeting time focused on financial issues; quality may not even appear as a regular agenda item in every board meeting [6].

Despite these formidable challenges, healthcare organizations face mounting pressure for improved quality and safety performance and increased public accountability. A pressing need exists, therefore, to identify the organizational structures and practices that enhance the board's ability to fulfill its oversight responsibility and leadership potential in the quality arena. Although little empirical research exists on the board's role in quality, there exists a substantial practitioner-oriented literature on the subject. Much of this writing appears in trade journals such as *Trustee, Modern Healthcare,* and *Healthcare Executive*. Based on familiarity and experience working with hospitals and health systems, healthcare consultants and trade journal staff writers have produced a steady stream of articles offering guiding principles and "best practices" for enhancing the board's role in quality. These principles and "best practices" represent valuable contributions to the knowledge base. However, three limitations exist that create a significant knowledge gap and practical need.

1. The evidence base supporting these principles and lessons is limited and ill-defined. Support for proposed principles and "best practices" generally takes the form of anecdote and argument, not comparative data and systematic analysis. Consequently, the extent to which these principles and lessons apply generally remains unknown.

2. The current knowledge base lacks sufficient detail to provide practical guidance to an implementation effort. For example, how exactly does one create a climate of trust and candor in the boardroom that encourages the frank exchange of differing points of view yet preserves a sense of teamwork? Which strategies work? Which do not?

3. The current knowledge base is not context-sensitive. Health systems and hospitals vary widely in organizational size, complexity, resources, and culture. Governance principles and "best practices" appropriate for small health systems, for example, might not be appropriate for large health systems. Developing context-sensitive knowledge is critical for generating tailored guidance to health systems seeking to enhance the board's role in quality.

C. Project Aims

This research project will address these knowledge gaps and practical needs by conducting in-depth case studies to generate theoretically informed, empirically grounded knowledge of governance principles and best practices for enhancing the board's role in quality. The specific research questions driving the project are: (a) how can the governing board best fulfill its responsibility for quality, and (b) how can healthcare delivery organizations with multi-tiered governance structures best define and coordinate the role of the system board and the hospital board in quality?

D. Research Methods

D1. Conceptual Framework

The project's conceptual framework drew upon the notion that boards influence quality through the performance of three critical roles. In the strategic role, boards identify the organization's values, formulate policies, and shape strategic choices made by executives. In the control role, boards evaluate organizational and chief executive officer performance. In the service role, boards enhance the organization's reputation, establish contacts with the external environment, and advise and counsel the chief executive officer. The board's performance of these three roles, in turn, is influenced by board composition (e.g., board member backgrounds), structure (e.g., committee characteristics), and process (e.g., meeting characteristics). I used this conceptual framework to focus the data collection and analysis effort, the formulation of recommendations, and the identification of "best practices."

D2. Research Design and Study Population

The project employed a multiple, embedded case study design in which the system board served as the primary unit of analysis and the hospital board served as the secondary unit of analysis [19]. Three health systems affiliated with the Center for Health Management Research (CHMR) participated in this project. An additional health system affiliated recruited through the Health Research and Educational Trust (HRET) also participated in the project: Trinity Health, a catholic health system with 44 hospitals located in seven states. All four systems possessed multi-tiered governance structures. For each health system, I focused on the system board and two hospital boards. To increase the homogeneity of the project sample, I tried to recruit hospitals that are roughly comparable in size, as measured by the number of hospital beds, and geographic location (e.g., urban location). In sum, the project examined 12 boards: four system-level boards and eight hospital-level boards.

D3. Data Collection Strategy

Between January 2006 and December 2006, I conducted 69 one-hour individual interviews with system-level and hospital-level board members and executives. The Appendix to his report shows the number and type of persons interviewed at each system. Briefly, I interviewed 25 system-level board members and executives and 44 hospital-level board members and executives. I interviewed 15 to 21 persons per system. I used semi-structured interview guides to elicit information about board member expertise, quality metrics, data displays, decision-making dynamics, information flows, facilitators, barriers, challenges, and opportunities for improvement. I conducted most interviews by telephone. With permission, I digitally recorded the interviews and transcribed them verbatim. I also sent a questionnaire to the administrative

assistant for each board to collect factual information about the board. I also looked up hospital's quality performance on CMS Core Indicators by accessing www.hospitalcompare.gov.

D4. Data Analysis Strategy

I carefully read each transcript and made notations in the margin, using the conceptual framework to identify potentially relevant themes. I used the constant comparative method to identify themes across interviews and across boards. I looked for at least two mentions of a theme by interview participants who, in principle, could speak to the theme. I then produced brief reports for each board highlighting the strengths and opportunities for improvement in terms of the board's current role in quality. I also offered tailored recommendations to each board that reflected what I learned from that board, from the other boards in the study, and from the broader literature on governance. I sought feedback on these reports from each board contact.

E. Project Findings

Descriptive Findings

The Appendix to this report includes several tables that describe:

- Hospital organizational characteristics
- Hospital performance on CMS Core Indicators
- Hospital board composition, structure, and activity related to quality
- System board composition, structure, and activity related to quality

Since the purpose of this report is to summarize study findings and offer actionable recommendations, I offer no further comment on these descriptive data.

Analysis

The fundamental question that hospital- and system-level board members and executives are grappling with is: What is the role of the board in quality? From a legal standpoint, the board is ultimately accountable for quality of care. Yet, this statement does not clarify what board can and should do to meet this accountability. Practical advice about how to strengthen the board's role in quality depends first on defining the purpose(s) of the board involvement in quality.

Borrowing from Richard Chait's work [20], *Governance as Leadership,* we can identify three purposes of governance that pertain to quality:

- Oversight – The board acts as a fiduciary. Key tasks include evaluating the organization's quality performance, keeping management focused on quality, and ensuring that the organization has an effective quality improvement effort (and medical staff credentialing process). In this role, the board focuses internally and emphasizes what has happened (the past).

- Leadership – The board acts as a strategic partner with management. Key tasks include identifying the organization's purposes, shaping the organization's agenda, helping management to position the organization in its market, and helping management to prepare the organization for the future. In this role, the board focuses externally and emphasizes what will happen (the future).

- Service – The board acts as a "sounding board" and advisor to management. Key tasks include surfacing assumptions, raising deeper and more fundamental questions, and testing conclusions. In this role, the board focuses on itself (and management) and emphasizes what is happening (the present).

The table below highlights how board roles and activities differ across these three purposes.

Three purposes of Governance

	Oversight/Fiduciary	Leadership/Strategic	Service/Generative
Board's Role	Steward	Strategic partner	Co-leader
Key Question	What's wrong?	What's the plan?	What's the question?
Problems are to be…	Spotted	Solved	Framed
Way of Deciding	Reaching resolution	Reaching consensus	Grappling and grasping
Way of Knowing	It stands to reason	The pieces all fit	It makes sense
Performance Metrics	Facts and figures, finances and reports	Strategic indicators Competitor analysis	Signs of learning and insight

Adapted from Chait (2005)

Hospital and health system boards are under greater scrutiny than ever before when it comes to quality oversight. For example, many of the principles articulated in the 2004 National Quality Foundation's statement [21], *A Call to Responsibility*, focus on the strengthening board's capacity to evaluate the organization's quality performance and hold management accountable for improving quality. A similar emphasis on the fiduciary role of boards can be found in the Board on Board component of the Institute for Health Care Improvement's Five Million Lives Campaign (www.ihi.org/IHI/Programs/Campaign). Much of the advice offered by governance experts also focuses on this purpose of governance.

As indicated in earlier progress reports, significant opportunities exist for strengthening the oversight capabilities of system-level and hospital-level boards in the quality arena. In fact, many of the "actionable" recommendations listed in these progress reports focused on this aspect of governance. These recommendations emphasized enhancing the means, motives, and opportunities for board to exercise effective oversight of quality. The table below lists the recommendations offered in earlier reports.

Recommendations for Strengthening Board Oversight of Quality

Means	• Recruit and appoint board members who have experience/expertise with Six Sigma, Lean Production, or other quality improvement approaches • Provide targeted/focused board education and training to improve fit between needed and actual knowledge and skills. • Begin every board quality committee meeting with board education. • Cease the practice of appointing medical staff leaders to the board in an *ex-officio* capacity. Only appoint physicians to the board if they have a passion for quality • Appoint physician board members who have a passion for quality to the role of chair of the board's quality committee • Develop a standard set of "drill down" questions that affiliate boards can ask regarding their affiliate's performance on specific indicators or indicator sets. • Engage the board (and its committee) in discussion about what it needs to know about quality in order to govern. Such information is unlikely to be the

	sort of fine-grained "operational" measures of quality being publicly reported • Use a report card to summarize quality performance indicators • Display performance indicators relative to industry benchmarks and national standards, not just internal trends • Requiring regular updates on quality initiatives or corrective actions • Linking CEO incentive compensation to quality performance
Motives	• Orient new members about the board's responsibility for quality • Reinforce the message about the importance of quality (and the board's responsibility for quality) through ongoing board education • Clearly define the expectations that individual board members must meet regarding board meeting attendance and preparation • Get individual board members involved by giving them tasks that make use of their KSAs and require them to contribute to the whole
Opportunity	• Use a consent agenda to free up time for more important issues • Putt quality on every board meeting agenda • Create a written charter that defines explicitly each committee's roles, responsibilities, and major activities • Create an infrastructure that supports the board's work (e.g., budget for governance operations and staff support for governance activities) • Move quality to the top of the board's meeting agenda • Institute an "80/20" rule: eighty percent of board time will be spent on discussion and decision-making, with only 20 percent spent on presentations. Then, redesign the board meeting package to make this rule feasible.

While much attention has focused on board oversight of quality, far less attention has focused on board leadership for quality. The academic and trade literature offers little discussion of what boards currently do, or could do, to provide leadership for quality. In earlier progress reports, I offered a few recommendations for strengthening the strategic role that boards could play in setting the quality agenda and positioning the organization in the market and for the future. Yet, this governance purpose received less attention in those earlier reports than the oversight purpose, in large part because study data revealed few clear-cut examples of boards providing leadership for quality. In most cases, management set the quality agenda. The board listened and learned, commented on and approved management's plans, and then monitored progress and performance as fiduciaries do. The table below summarizes the few actionable recommendations offered in earlier reports for strengthening the board's leadership capability.

Recommendations for Strengthening Board Leadership for Quality

Means	• Provide board members with benchmarking data, competitor analysis data, insights from futurists and other experts • Developing educational materials and training opportunities for board members to sharpen their strategic thinking skills (e.g., scenarios) • Create board-level task forces organized around strategic issues
Motives	• Clearly define the expectations that board members will participate in strategy formulation • Assess board members contributions to strategy discussions
Opportunity	• Incorporate forward-looking issues and discussion into every board meeting rather than reserving these activities for periodic retreats • Annually analyze board meeting agendas and meeting minutes to assess

	how board *actually* spent its time (relative to desired allocation of time). Assess whether the board spends as much time talking about quality as it does finance. • Develop an annual calendar that links the board's work to the organization's strategic priorities • Get board members involved earlier in the strategy formulation process

Even less attention has been given to the board's service role in quality. Admittedly, the board's opportunity to act in a service capacity occurs less routinely. It also declines over time. That is, the best time for boards to add value as advisors and sounding boards is when a problem or ambiguous situation first arises and before decisions get made about "what is" the problem or situation and what could or should be done about it. Yet, board involvement is often the lowest at these times. This is unfortunate. As generalists and outsiders, board members can raise "naïve" questions, challenge traditional assumptions, and offer alternative framings and perspectives that executives and clinical leaders might not consider on their own precisely because they are so acculturated to health care, so immersed in day-to-day work, and so grounded in their past experiences. The table below offers a few actionable recommendations for strengthening the board's capability to act as servants, advisors, and sounding boards.

Recommendations for Strengthening Board Service for Quality

Means	• Provide board education and skills-building opportunities around Peter Senge's (1990) five learning disciplines, especially those pertaining to mental models and team learning
Motives	• Bring board members into contact with external stakeholders for whom quality is a high priority (e.g., payers, employers, community groups, accrediting bodies, improvement organizations) • Bring board members into contact with internal stakeholders so that they can understand what quality looks like on the ground (e.g., conduct "executive walk-arounds" for board members, present "case studies" in board meetings)
Opportunity	• Bring ill-defined or emerging problems and opportunities to the board early before the management team has reached consensus on "what is" the problem or opportunity and what solutions the management team is considering • Use earlier suggestions to free up time during board meetings to talk in a less structured format about ill-defined or emerging problems and opportunities

The study's Project Advisory Board members reported that they found the tailored reports that I provided to each system and hospital board very helpful in terms of stimulating change and contributing to internal discussions about enhancing the board's role in quality.

In follow-up conversations, several Project Advisory Board members asked me to formulate specific questions that board members could ask in board meetings that would stimulate a higher level of discussion and a greater degree of board engagement. In particular, Project Advisory Board members asked me to elaborate on the board's leadership (strategic) role. The following table responds to this request.

Questions that Board Members Can Ask that Create Higher Engagement in Quality

Oversight/Fiduciary Questions

- Why is the board looking at these quality measures? Why were these measures chosen? Are these measures really telling us anything about our quality performance?
- What measures are we not looking at but should be looking at? Are we searching for our keys under the lamppost?
- How good is our quality improvement system? How do we know that? What evidence do we have that it's as good as we think? What can we do to improve our QI system?
- How good are the data that we are looking at? How do we know that? What evidence do we have that they are as good as we think? What can we do to improve data quality?
- What are the quality implications of this financial, strategic, operational, construction, human resources decision? Do we have a "quality impact report" on this decision?
- What have we done to create a culture of safety? How well is this working? How do we know that? What evidence do we have that it's working as well as we think?
- What have we done to balance a culture of accountability with a culture of learning? How well is this working? How do we know that? What evidence do we have that it's working as well as we think?

Leadership/Strategic Questions

- Why are we focusing on these quality goals?
- Why are these goals more important than other goals that we could have chosen?
- Are these quality goals strategically important? Does pursuing these goals offer any competitive advantage?
- Have we set the bar high enough?
- What big, hairy audacious goals (BHAGs) have we set for ourselves in quality?
- How can we leverage our higher quality to better position us in the marketplace?
- How can we leverage our higher quality to increase customer (patient/physician) loyalty?
- How can we leverage our higher quality to improve community health?
- How do we position ourselves to be ahead of the pack in terms of quality improvement and performance measurement?
- Who in our marketplace has better quality performance? How do they do it? What can we learn? How can we do it even better than they do?
- Who in the nation has better quality performance? How do they do it? What can we learn? How can we do it even better than they do?
- Ask the question: "This strategic priority would not have been achieved if the board had not _____."

Service/Generative Questions

- What if CMS tied hospital payment to quality performance starting tomorrow? What would happen to our financial health?
- What if everyone in our market, including us, achieved 100 percent scores on the CMS core indicators? How would we compete?
- What if we didn't have any governing boards? Would anyone notice?
- What if a single physician or two were standing in the way of achieving perfect scores on CMS core indicators quarter after quarter after quarter? Would we do anything?
- What if a hospital affiliate board was unwilling or unable to exercise effective governance for quality, no matter how much the system tried to help it?
- What will be most strikingly different about this organization in five years?
- What will be most different about the board or how we govern in five years?
- What is the biggest gap between what the organization claims and what it actually is?
- What external factors will most affect the organization in the next year? The next five years?

- Who sees this situation differently?
- What are we missing?
- What problems might the proposed solutions create?
- What is the best / worst possible outcome?

Finally, Project Advisory Board members asked me to help them think through the role of the system board vis-à-vis the role of the hospital board in terms of quality. I have encouraged them to identify those governance tasks that only the system board can do by virtue of their position within the system. Anything the hospital board could do (or should do) better than the system board should be delegated. This could include providing each hospital affiliate with information about how it performs on quality indicators relative to other affiliates within the system. Hospital boards are just as capable as system boards in assessing comparative quality performance across affiliates. Delegating quality oversight tasks to hospital affiliate boards would free up time for system boards to spend on quality leadership and service tasks.

System boards can take on the responsibility of strengthening affiliate-level governance for quality oversight, quality leadership, and quality service. For example, system boards can work with system executives to (a) develop a process for annually or biannually assessing affiliate board capabilities, performance, and needs; (b) develop systems for identifying and transferring best practices in governance within the system; and (c) support affiliate boards by developing high-quality education materials, "internal consultants," and technical assistance so that these costs can be born collectively rather than by individual affiliates.

Audience for Recommendations

The system board chair, the system CEO, and the system executive responsible for quality are the most appropriate audience for these recommendations. These individuals have the legitimate authority, expert power, and credibility/reputation to introduce change in board composition, structure, activity, and relationships.

F. Dissemination of Project Findings

Each participating system received a written report that described the strengths and limitations of the board's current role in quality, and offered specific actionable recommendations for enhancing the board's role.

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APPENDIX

Table 1. Description of Interview Participants

	System-Level	Hospital-Level	Total
Sharp	5	9	14
Spectrum	4	11	15
Sutter	7	11	19
Trinity	9	12	21
Total	25	44	69

Table 2. Description of Hospitals in Study

	Sharp HealthCare		Sutter Health		Spectrum Health		Trinity Health	
	Grossmont	Memorial	Alta Bates	CPMC	Grand Rapids	United Memorial	Holy Cross	St. Alphonsus
State	CA	CA	CA	CA	MI	MI	MD	ID
Rural Location	Urban	Urban	Urban	Urban	Urban	Urban	Urban	Urban
Hospital Beds	463	670	551	521	924	95	400	392
Discharges	22205	23334	21663	24163	48138	2337	23316	17300
Occupany Rate	69	63	79	79	77	63	87	60
ALOS*	4.2	4.8	5.0	4.6	5	3	4.5	4.2
Case Mix Index	-	1.73	1.46	1.70	1.68	1	1.45	1.74
% Medicare	95	26	20	25	36	49	27	38
% Medicaid	2	8	14	8	12	18	15	10
% Outpt Revenue	-	24	24	30	36	65	30	38
Operating Revenue	65	463	416	782	790	41	268	315
Profitability Decile*	2	5	7	1	6	8	5	3
Medicare ID	50026	50100	50305	50047	230038	230035	210004	130007

Source: Solucient, 2006.

* ALOS = Average length of stay

** Ranked against all US hospitals

Table 3. Hospital Performance on CMS Core Indicators

	All US	Sharp HealthCare		Sutter Health		Spectrum Health		Trinity Health	
	Hospitals*	Grossmont	Memorial	Alta Bates**	CPMC***	Grand Rapids	United Memorial	Holy Cross	St. Alphonsus
Acute Myocardial Infarction Care									
% given ACE Inhibitor or ARB for LVSD	80	84	98	NA (89)	NA (83)	89	80	86	100
% given aspirin at arrival	92	96	98	99 (99)	NA (96)	100	97	90	99
% given aspirin at discharge	89	95	99	99 (99)	NA (96)	100	100	92	99
% given beta blockers at arrival	86	96	98	98 (96)	NA (92)	100	95	88	99
% given beta blockers at discharge	88	96	99	100 (99)	NA (97)	100	NA	93	99
% given PCI within 120 minutes of arrival	65	52	64	NA (80)	NA (72)	91	NA	NA	85
% given smoking cessation advice	82	99	99	NA (97)	NA (89)	98	NA	NA	98
% given thrombolytics within 30 minutes of arrival	90	NA	NA	NA (NA)	NA (NA)	NA	NA	NA	NA
Congestive Heart Failure Care									
% given ACE inhibitors or ARB for LVSD	81	89	80	89 (79)	100 (90)	86	81	89	98
% given assessment of left ventricular function	81	91	92	95 (90)	98 (97)	98	93	95	100
% given dicharge instructions	54	50	68	55 (50)	55 (54)	80	59	68	88
% given smoking cessation advice	76	98	93	100 (95)	NA (78)	93	NA	97	94
Pneumonia Care									
% given pneumococcal vaccination	59	35	43	30 (35)	16 (35)	83	68	64	87
% given initial antibiotics within 4 hours after arrival	77	80	73	61 (61)	72 (75)	87	89	69	92
% given oxygenation assessment	99	100	100	100 (100)	100 (100)	100	99	100	100
% given smoking cessation advice	73	84	88	(81) 94	83 (NA)	75	76	80	94
% given most appropriate local antibiotics	79	74	71	88 (89)	76 (79)	92	85	84	84
% with blood culture performed prior to first antibiotic	82	81	86	90 (94)	81 (89)	85	87	86	83
Surgical Infection Prevention									
% receiving preventive antibiotic one hour before incision	75	ND	ND	ND (ND)	ND (ND)	ND	89	72	90
% preventive antibiotic stopped 24 hours after surgery	68	ND	ND	ND (ND)	ND (ND)	ND	92	75	68

*US Average of approximately 4,000 hospitals. Source: hospitalcompare.gov (accessed November 1, 2006)

Reporting Period: January 2005 - December 2005

** First score is for Alta Bates Campus; second score (in parentheses) is for Summit Campus

*** First score is for Davies Campus; second score (in parentheses) is for Pacific Campus. Data for California Campus not reported.

NA = The number of cases is too small (< 25) for purposes of reliably predicting hospital's performance.

ND = No data reported for this hospital

Table 4. Description of Hospital Governance Practices

	Sharp HealthCare		Sutter Health		Spectrum Health		Trinity Health	
	Grossmont	Memorial	Alta Bates**	CPMC***	Grand Rapids	United Memorial	Holy Cross	St. Alphonsus
Board Size and Composition								
Number of Board Members	18	17	21	24	14	11	15	15
Percent Management Members	11	18	9	0	14	18	13	33
Percent Physician Members	11	29	48	42	43	18	20	13
Percent Outside Members	78	53	43	71	43	64	67	54
Percent with training/credentials in QI	11	47	14	0	0	0	0	13
Percent with experience implementing QI	0	0	5	0	0	0	53	0
Board Operations								
Number of board meetings in 2005	12	6	8	12	6	6	4	7
Average board meeting length (minutes)	120	150	150	120	120	90	180	150
Meeting packet sent in advance (days)	5	4	5	5	7	3	7	5
Board uses consent agenda	YES	YES	YES	YES	NO	NO	YES	YES
Board evaluates meeting effectiveness	YES	NO	YES	YES	YES	NO	YES	YES
Board Quality Committee								
Number of committee members	8	0	21	12	25	0	9	9
Percent physician/nurse members	38	0	62	58	64	0	44	44
Percent management members	50	0	19	33	36	0	56	56
Number of committee meetings	6	0	?	?	11	0	4	6
Board Infrastructure								
Board has separate budget?	NO	NO	NO	YES	NO	NO	YES	YES
Board has administrative support	YES	NO	YES	YES	YES	YES	YES	YES
Board has formal orientation program?	YES	YES	YES	YES	YES	YES	YES	YES
Mandatory?	YES	YES	YES	YES	YES	NO	YES	YES
Receive written role description?	YES	NO	YES	YES	YES	NO	YES	YES
Receive orientation to quality?	YES	YES	YES	YES	YES	YES	YES	YES
Board education requirement (hours)	NO	0	0	10	0	0	4	0
Board-Management Relations								
CEO role on board	VM	VM	VM	VM	VM	NV	VM	VM
CEO compensation tied to quality performance	YES	YES	YES	YES	YES	YES	YES	YES

Source: Questionnaire administered during study. Completed by executive or administrative assistant supporting the board

Table 5. Description of System Governance Practices

	Sharp	Sutter	Spectrum	Trinity
Board Size and Composition				
Number of Board Members	25	14	13	15*
Percent Management Members	4	7	8	14
Percent Physician Members	28	14	15	7
Percent Outside Members	68	79	77	67
Percent with training/credentials in QI	?	?	0	20
Percent with experience implementing QI	?	?	23	33
Board Operations				
Number of board meetings in 2005	12	6	4	4
Average board meeting length (minutes)	120	330	360	480
Meeting packet sent in advance (days)	5	7	7	7
Board uses consent agenda	YES	YES	NO	YES
Board evaluates meeting effectiveness	YES	YES	NO	YES
Board Quality Committee				
Number of committee members	8	7	0	4
Percent physician/nurse members	25	43	0	100
Percent management members	13	57	0	25
Number of committee meetings	4	4	0	3
Board Infrastructure				
Board has separate budget?	NO	NO	NO	YES
Board has administrative support	YES	?	YES	YES
Board has formal orientation program?	YES	YES	YES	YES
Mandatory?	NO	YES	YES	YES
Receive written role description?	YES	NO	YES	YES
Receive orientation to quality?	YES	YES	YES	YES
Board education requirement (hours)	0	0	4	0
Board-Management Relations				
CEO role on board	VM	VM	VM	VM
CEO compensation tied to quality performance	YES	YES	YES	YES

Source: Questionnaire administered during study. Completed by executive or administrative assistant supporting the board.
* Includes 2 open positions