Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders

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EXECUTIVE SUMMARY

Hospital governing boards assume an important role in improving delivery of quality care in the hospital. More knowledge about the prevalence and impact of particular board activities can help them perform this role more effectively. This study draws from a survey of hospital and system leaders (presidents/chief executive officers [CEOs]) that was conducted in the first six months of 2006 with a total of 562 respondents. The survey contained 27 questions on various aspects of board engagement in quality. More than 80 percent of the responding CEOs indicated that their governing boards establish strategic goals for quality improvement, use quality dashboards to track performance, and follow up on corrective actions related to adverse events. The adoption of other practices was reported less frequently. Only 61 percent of the respondents indicated that their governing boards have a quality committee. The existence of a board quality committee was associated with higher likelihoods of adopting various oversight practices and lower mortality rates for six common medical conditions measured by the Agency for Healthcare Research and Quality's Inpatient Quality Indicators and the State Inpatient Databases.

Hospital governing boards appear to be actively engaged in quality oversight, particularly through use of internal data and national benchmarks to monitor the quality performance of their organizations. Having a board quality committee can significantly enhance the board's oversight function. Other potentially useful activities—such as board involvement in setting the agenda for the discussion on quality, inclusion of the quality measures in the CEO's performance evaluation, and improvement of quality literacy of board members—are currently performed infrequently.

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The Institute of Medicine (2001) report *Crossing the Quality Chasm* calls for improving healthcare systems and organizations as an important step in improving quality and patient safety. By law and regulation, hospital governing boards are ultimately responsible for quality of patient care (Gautam 2005; Marren, Feazell, and Paddock 2003). The accreditation standards set by the Joint Commission (1995) also clearly state that the board is responsible for maintaining quality patient care. No transformational change will happen unless hospital leaders make quality a top priority and are firmly engaged in quality improvement (CMS 2006). In recent years, hospital governing boards have acquired growing responsibility and potential to help lead hospitals in the direction of improved quality. Governing boards that demonstrate commitment and engagement in significant and sustained quality-of-care improvement convey seriousness of purpose to everyone in their organization. When the board sets the priorities and looks at the numbers, providers at every level in the organization know that their efforts to improve care are an organizational priority and that the board pays attention to results. They also know the board is committed to providing resources to improve and sustain quality.

Anecdotal reports have shown the importance of board leadership to the success of quality and patient safety initiatives (Meyers 2004; Paine et al. 2004; Sandrick 2005). Results of several surveys of hospitals in a number of states also revealed that hospital leadership is engaged in quality, yet variation exists in the adoption of those board practices shown to be associated with better patient outcomes (Kroch et al. 2006; Vaughn et al. 2006). For our study, we drew from a recent survey of hospital and system leaders that has a broader geographic representation and that contains a more comprehensive set of questions than previous surveys. Besides covering board practices commonly addressed in other surveys, this survey also asks hospitals about the existence and composition of board quality committees, thus allowing us to examine this important structural feature in board oversight of quality. Having a board committee that focuses primarily on quality communicates a high level of board attention to quality of care. The board quality committee can thus enhance the visibility of the board's leadership on quality issues and provide an effective mechanism for organizing and directing internal resources to address quality of care.

With the unique features of this survey, we sought to explore the following questions:

- How frequently were various board practices adopted among hospitals?
- Are there any differences in the adoption of these practices and in quality of care between boards with a quality committee and boards without a quality committee?
- What hospital characteristics are associated with the likelihood of having a board quality committee?
- What are the major differences in board practices between boards at the hospital level and those at the system level?

The findings of this study can help inform hospital leaders, accreditation

entities, and public policymakers about board leadership in quality and the particular features in board structure and operation that may be significantly associated with board oversight of quality.

METHODS

Data for this study were drawn from multiple sources, including primary data collection on board practices and secondary databases on hospital characteristics and patient outcomes.

Survey on Board Practices

Between January and May 2006, the Governance Institute (TGI) conducted a survey of hospital leaders on practices in board oversight of quality. The survey was mailed to 3,898 hospitals (28 percent were public hospitals and nearly all others were nonprofit hospitals) and to 302 systems (18 percent were church sponsored and the rest were secular). The TGI survey contained 27 questions on various aspects of board engagement in quality, including structure of the board quality committee, if there is one; specific practices in oversight of quality; and perceived effectiveness of the board oversight function. Questions on specific board practices were grouped into six categories:

1. Policy, goals, and agenda setting
2. Information monitoring and reporting
3. Discussion of quality at board meetings
4. Quality literacy of board members
5. Accountability of senior executive management
6. Alignment of key stakeholders on quality issues

Quality Measures

Quality of care was measured by the Inpatient Quality Indicators (IQI) developed by the federal Agency for Healthcare Research and Quality (AHRQ 2007). Twelve mortality indicators were selected that cover six medical conditions (heart attack, congestive heart failure, pneumonia, stroke, hip fracture, and gastrointestinal bleeding) and six surgical procedures (abdominal aortic aneurysm repair, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, craniotomy, hip replacement, and carotid endarterectomy). The IQI software incorporates risk adjustment by all-patient refined diagnosis-related groups (APR-DRG), age, and gender. After generating hospital-level risk-adjusted rates for individual mortality indicators, composites were constructed for each hospital as a weighted average of selected indicators, with weights equal to the proportion of patients for each condition or procedure. Three composites were developed: the first included all 12 indicators, the second included the six medical conditions, and the third included the six surgical procedures. Hospital-level data for these composite measures were produced by applying the IQI to the State Inpatient Databases (SID) of the Healthcare Cost and Utilization Project (HCUP) sponsored by AHRQ. The SID includes all-payer data on inpatient stays from virtually all community hospitals in each participating state.

Hospital Characteristics

Data on a number of hospital structural characteristics, including size (number of beds), ownership, location (urban/ru-

ral, region), teaching status, and system affiliation, were obtained from the American Hospital Association's (AHA) Annual Survey of Hospitals. Teaching status was defined as meeting any one of the following criteria: (1) being a member of the Council of Teaching Hospitals and Health Systems, (2) having a residency program approved by the American Medical Association, or (3) having a resident-to-bed ratio greater than 0.25.

Analyses

Descriptive statistics were obtained for each survey question. For questions where the answer was not dichotomous but on a Likert scale (e.g., none, few, some, most, all), responses were recoded for analytic purposes by collapsing the categories into two or three (e.g., most or all versus others). Bivariate analysis was conducted to compare differences in board practices and quality measures between boards with a quality committee and those without. Differences in board practices between hospital boards and system boards were also examined. A χ^2 test was used to assess the statistical significance of differences in board practices and a t-test was used to determine the significance of differences in quality measures. Multivariate logistic regression was performed to estimate the likelihood of having a board quality committee in relation to hospital characteristics.

RESULTS

Results were based on 562 hospital leaders who responded to the survey. These hospitals and systems were spread across all 50 states, which provided a much broader geographic representation than that covered in previous studies. Among the respondents, 490 were presidents/chief executive officers (CEOs) of individual hospitals and 72 were presidents/CEOs of multihospital systems. These 72 systems represent a total of 387 hospitals. Based on data from the AHA Annual Hospital Survey, hospitals included in this study reflect different structural characteristics in terms of size, ownership (except for for-profit hospitals), teaching status, urban/rural location, and region. However, if compared with the universe of U.S. community hospitals, the study sample appears to overrepresent large, nonprofit, and teaching hospitals as well as hospitals in the Midwest (see Appendix for details).

Overview of Survey Results

Table 1 summarizes responses to the survey questions. Overall, 61 percent of the responding CEOs reported that their hospitals have a single board committee that focuses exclusively or primarily on quality. Also, 88 percent indicated that their governing boards believe the board is as responsible for the quality of patient care as for the financial performance of the organization. The survey results reveal a number of commonly adopted board practices: 81 percent reported that the board establishes strategic goals for quality improvement for the organization; 86 percent reported the use of quality dashboards or scorecards at the board committee or the full board level to track and review performance; more than 80 percent indicated inclusion of measures on clinical quality, patient safety, and patient satisfaction in quality dashboards; and 83 percent said that the board requires

management to report on the progress of corrective action in response to quality-related adverse events or trends.

Although 65 percent of the respondents said that the board is involved in setting the quality agenda for the organization, less than half of the respondents reported that the board is also involved in setting the agenda for the board's discussion on quality. According to 67 percent of the responding CEOs, their governing boards participate in the development and/or approval of explicit criteria to guide physician credentialing. However, less than a third of the respondents indicated that the board has issued a written policy on quality for the organization and has formally communicated the policy to the senior executive team, physician leadership, and all hospital staff.

With regard to discussion of quality at board meetings, 75 percent of the responding CEOs reported that most to all of the board meetings have a specific agenda item devoted to quality. Nonetheless, only 41 percent indicated that the board spends more than 20 percent of its meeting time on the specific item of quality. As for quality literacy of board members, about half of the respondents indicated that all board members participate in education on quality annually and that orientation for new board members includes an overview of the organization's definition of quality, information on how to understand quality reports, and rationales of why the organization focuses on specific quality priorities.

Slightly more than half of the respondents stated that the CEO's performance evaluation includes objective measures of quality and patient safety. About one-third of the respondents reported that their governing boards mandate alignment on quality initiatives among the key stakeholders in the organization. Finally, less than half of the respondents rated the quality oversight performance of their governing boards at 5 to 6 on a scale of 1 to 6 (with 1 being "not effective" and 6 being "very effective").

Comparisons Between Boards With and Boards Without a Quality Committee

Table 1 also presents a comparison of board practices between boards with a quality committee and those without. Overall, boards with a quality committee were more likely than boards without a quality committee to adopt almost all of the practices examined in the survey. For example, 91 percent of boards with a quality committee use quality dashboards or scorecards, compared with 79 percent of boards without a quality committee. Moreover, boards with a quality committee are more likely to include indicators for clinical quality, patient safety, and patient satisfaction, as well as national benchmarks, in their quality dashboards or scorecards. However, no significant difference was found between boards with and boards without a quality committee in how frequently board meetings include quality on the agenda and how much board meeting time is devoted to the quality item.

Much greater differences were revealed in practices related to several other areas, including policy, goals, and agenda setting; orientation of new board members; accountability of senior

TABLE 1
Reported Practices in Board Oversight of Quality, and Comparisons Between Boards With and Boards Without Quality Committee

Board Practices	All Respondents (n = 562)	Boards With Quality Committee (n = 344)	Boards Without Quality Committee (n = 218)
Structure			
Having a single board committee that focuses exclusively on quality	61.2%	—	—
Policy, goals, and agenda setting			
Believing that the board is as responsible for the quality of patient care as for the financial viability of the organization	87.7%	91.0%	82.5% **
Issuing a written resolution or policy on quality for the organization and formally communicating it to the senior executive team, physician leadership, and all hospital employees	30.8%	33.8%	25.9% *
Establishing strategic goals for quality improvement	81.3%	89.5%	68.2% **
Being involved in setting the quality agenda for the organization	64.7%	72.4%	53.2% **
Being involved in setting the agenda for the board's discussion on quality	42.4%	48.8%	32.6% **
Participating in the development and/or approval of explicit criteria for physician appointments, reappointments, and clinical privileges	67.4%	71.2%	61.3% *
Information monitoring and reporting			
Using a quality dashboard or scorecard to track/review performance	86.4%	91.3%	78.6% **
Including the following indicators in the dashboard, among others			
Clinical quality			
Internal data	84.9%	90.4%	77.1% **
National benchmarks	75.7%	82.6%	65.6% **
State benchmarks	48.8%	52.3%	43.6% *
Patient safety			
Internal data	81.6%	86.3%	74.8% **
National benchmarks	63.7%	68.6%	56.4% **
State benchmarks	35.6%	38.1%	32.1%

Patient satisfaction			
Internal data	81.4%	87.2%	72.9% **
National benchmarks	66.8%	74.1%	56.0% **
State benchmarks	31.2%	33.7%	27.5%
Reporting sentinel events at the full board level	65.6%	59.1%	75.1% **
Reporting on the progress of corrective action related to serious or adverse incidents or trends	82.7%	84.8%	79.3%
Discussion of quality at board meetings			
Most to all board meetings have a specific item on the agenda devoted to quality	75.1%	77.3%	71.6%
Percentage of board meeting time spent on the specific item devoted to quality			
> 20%	40.8%	40.2%	41.7%
10% to 20%	46.9%	50.3%	41.3% *
< 10%	12.4%	9.5%	17.0% *
Quality literacy of board members			
Orientation for new board members includes all three components: the organization's definition of quality, how to understand quality reports, and why the organization focuses on specific quality priorities	55.9%	60.0%	49.5%*
All board members participate in education on quality issues on an annual basis	48.9%	49.3%	48.4%
Accountability of senior executive leaders			
The CEO's performance evaluation includes measures for achieving clinical improvement and patient safety goals	54.6%	60.8%	45.4%**
The executive team members' performance evaluation includes measures for quality and patient safety	70.7%	78.5%	59.2%**
Alignment of key stakeholders on quality issues			
Mandating alignment on quality initiatives among key stakeholders in the organization	37.7%	43.4%	28.6%**
Key stakeholders being aligned around definition of quality, quality indicators, and issues related to quality improvement (5 to 6 on a scale of 1 being not aligned to 6 being very well aligned)	53.5%	55.7%	50.0%
Perceived effectiveness of the board function			
Effectiveness of the board in carrying out its quality oversight function (5 to 6 on a scale of 1 being not effective to 6 being very effective)	48.1%	53.2%	40.1%**

Level of statistical significance for differences between boards with quality committee and those without:

* $p < .05$, ** $p < .01$

executive leaders; and alignment of key stakeholders in the organizations. Compared with boards without a quality committee, boards with a quality committee are more likely to issue a written policy on quality and formally communicate it throughout the organization (34 percent versus 26 percent); to establish strategic goals for quality improvement (90 percent versus 68 percent); and to be involved in setting the quality agenda for the organization (72 percent versus 53 percent) as well as for the board's discussion on quality (49 percent versus 33 percent). Likewise, boards with a quality committee are more likely to include measures for both quality and patient safety in the executives' performance evaluation (61 percent versus 45 percent for CEO's evaluation, and 79 percent versus 59 percent for executive team members' evaluation). Mandated alignment on quality initiatives among key stakeholders in the organization is also a lot more common for boards with a quality committee than for boards without a quality committee (43 percent versus 29 percent). In terms of perceived effectiveness of the board in fulfilling its quality oversight function, boards with a quality committee are more likely to receive a higher rating of performance by the respondents (53 percent versus 40 percent).

Table 2 compares quality outcomes as measured by the risk-adjusted mortality composites between boards with a quality committee and those without. Among the responding hospitals, 439 (90 percent if the 72 system respondents are excluded) were successfully linked to the HCUP SID for calculating the mortality composites. Significantly lower mortality rates for medical conditions were found for hospitals whose governing boards have a quality committee. No difference was found in the composite mortality rate for surgical procedures between these two types of hospitals. The lack of significant association between board quality committee and surgical mortality rates could be attributable to a number of factors. The surgical indicators cover only six high-tech procedures that are mainly performed in medium to large hospitals and capture a much smaller patient population than the medical indicators. The average mortality rate is also much lower for the surgical procedures than for the medical conditions. Hospital care for patients that undergo those major surgical procedures could be more standardized across hospitals, compared with the care for medical patients.

Table 2 also shows comparisons in the mortality composite for medical conditions between hospitals with a board quality committee and those without by each hospital type. Lower mortality rates in association with the presence of a board quality committee were found for small hospitals, nonteaching hospitals, rural hospitals, and public or nonprofit hospitals. Some of the differences did not reach statistical significance because of the relatively small sample sizes.

Table 3 presents the likelihood of having a board quality committee in relation to individual hospital characteristics. Only hospital size and region were found to be significantly associated with the presence of a board quality committee. If subtracting the odds ratio from 1, compared with large hospitals,

TABLE 2
Comparisons in Clinical Quality Between Boards With and Boards Without Quality Committee

Risk-Adjusted Mortality Composites	Boards With Quality Committee	Boards Without Quality Committee
Overall mortality (n = 417)	4.6%	5.2%**
Mortality for medical conditions (n = 423)	5.4%	6.0%**
Mortality for surgical procedures (n = 238)	1.9%	2.0%
Mortality for medical conditions		
Size		
Small hospital (n = 142)	6.1%	6.7%
Medium hospital (n = 162)	5.3%	5.3%
Large hospital (n = 119)	5.1%	5.3%
Ownership		
Nonprofit hospital (n = 324)	5.3%	5.9%*
Public hospital (n = 91)	5.7%	6.4%
For-profit hospital (n = 8)	—	—
Teaching status		
Teaching hospital (n = 111)	5.2%	5.0%
Nonteaching hospital (n = 312)	5.5%	6.2%*
Location		
Urban hospital (n = 273)	5.2%	5.2%
Rural hospital (n = 150)	6.0%	6.9%

Note: Only 439 hospitals can be linked to the HCUP data for calculating the mortality measures. After excluding outliers and missing values, only 417 hospitals are available for the overall mortality composite, 238 hospitals for the surgical mortality composite, and 423 hospitals for the medical mortality composite. For details on the mortality composites, see the Methods section in the article.

*$p < .05$, **$p < .01$

the odds of having a board quality committee were 76 percent lower for small hospitals (i.e., 1 – 0.243 = 0.757) and 47 percent lower for medium-sized hospitals (i.e., 1 – 0.531 = 0.469). The odds of having a board quality committee were nearly two times higher for hospitals in the Northeast than for hospitals in other regions (i.e., 2.793 – 1 = 1.793).

Differences Between Hospital Boards and System Boards

Figure 1 and Figure 2 highlight significant differences found between hospital boards (n = 490) and system boards (n = 72). First, system boards are much more likely than hospital boards to have a single quality committee that focuses primarily on quality (86 percent versus 58 percent). Second, the composition

TABLE 3
Likelihood of Having a Board Quality Committee in Relation to Hospital Characteristics

Hospital Characteristics	Odds Ratio	95% Confidence Interval
Small size (1–99 beds)	0.243**	0.119–0.496
Medium size (100–299 beds)	0.531*	0.296–0.953
Public ownership	0.765	0.479–1.222
Teaching status	1.017	0.576–1.795
Urban location	0.843	0.517–1.372
Northeast	2.793**	1.523–5.123
South	0.707	0.436–1.149
West	1.199	0.703–2.045

Note: Reference categories include large, nonprofit, nonteaching, rural, and Midwest. An odds ratio less than 1.0 suggests that a particular hospital characteristic is associated with decreased likelihood of having a board quality committee, and vice versa.
*$p < .05$, **$p < .01$

of the board quality committee is also different. For system boards, nonclinical board members are most likely to be on the quality committee (94 percent), followed by vice president of medical affairs or chief medical officer (87 percent), clinical board members (86 percent), and members of the medical staff (86 percent). For hospital boards, both the CEO and the chief nursing officer are most likely to be on the quality committee (89 percent), followed by quality improvement department representative(s) and nonclinical board members (87 percent) and members of the medical staff (83 percent). The likelihood for chief of staff, board chair, or chief operating officer to join the quality committee is much lower (around 50 to 60 percent), with no significant difference shown between system boards and hospital boards. The chief financial officer is the least likely to be on the quality committee in both hospital and system boards.

Survey results also reveal significant differences between hospital boards and system boards in several other board practices. Compared with hospital boards, system boards are more likely to establish strategic goals for quality improvement for the organization (90 percent versus 80 percent), to include national benchmarks for clinical quality in quality dashboards or scorecards (85 percent versus 74 percent), and to mandate alignment on quality initiatives among key stakeholders in the organization (47 percent versus 36 percent).

DISCUSSION

The results of this study demonstrate that hospital governing boards appear to be actively engaged in quality oversight, particularly in reviewing and tracking the organization's performance through

FIGURE 1
Differences in Board Practices Between Hospital Boards and System Boards

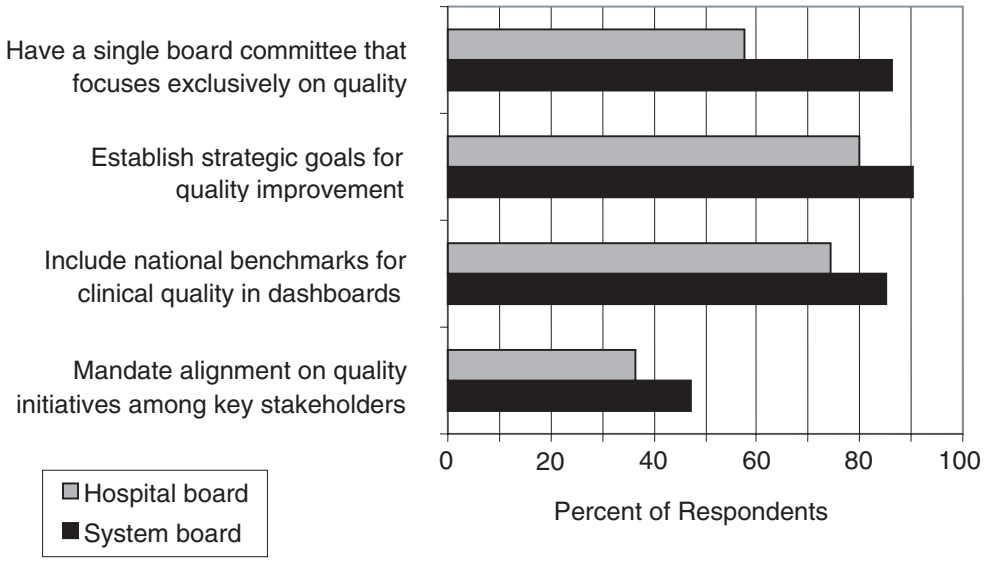
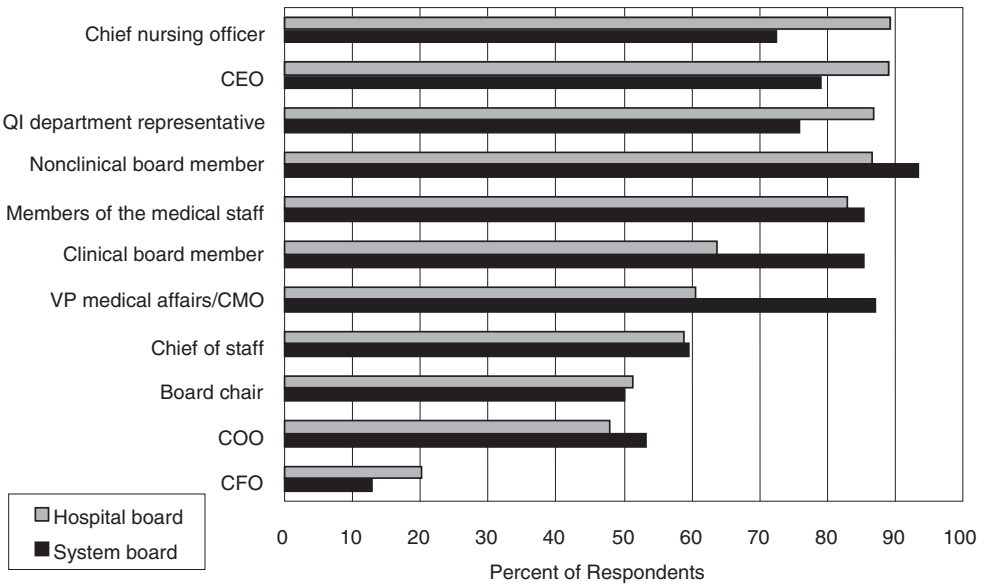


FIGURE 2
Representatives on the Board Quality Committee



QI: quality improvement; CMO: chief medical officer; COO: chief operating officer; CFO: chief financial officer

use of internal data and national benchmarks. Most of the responding hospitals (more than 80 percent) use a quality dashboard or scorecard and include measures on both clinical quality and patient safety, which is consistent with what has been reported in previous studies (Kroch et al. 2006; Vaughn et al. 2006). Another positive finding is that most governing boards are aware that they are responsible for the quality of care as much as for the financial viability of the organization. This alleviates a general concern that hospital leadership may not view these two performance areas as equally important. Most governing boards were also reported to have established strategic goals for quality improvement.

Nonetheless, the survey results reveal that less than half of the responding CEOs regarded the governing board of their organization as very effective in its quality oversight function. Specifically, improvements can be made in a number of areas to enhance the board's quality oversight function:

- Being effective in communicating the written policy on quality to all staff
- Being involved in setting the agenda for the board's discussion on quality
- Allocating appropriate share of board meeting time to the quality item
- Including measures for quality and patient safety in the CEO's performance evaluation
- Improving the quality literacy of board members
- Achieving alignment on quality initiatives among key stakeholders in the organization

This study also highlights the importance of having a board quality committee. Hospital governing boards that have a single committee that focuses exclusively or primarily on quality were found to be more likely to adopt various oversight practices and to have better clinical outcomes. These findings suggest that the board quality committee is particularly effective in enhancing the board's oversight function. But only about 60 percent of the responding CEOs confirmed the existence of a board quality committee in their hospitals or systems. Small or medium-sized hospitals were much less likely than large hospitals to have a board quality committee. Hospitals that currently do not have such a committee in their governing boards may want to consider establishing one. A typical arrangement is to include board members, the hospital CEO, nursing leadership, and physician leadership on the board quality committee. Hospitals that are members of a multihospital system also seem to benefit from having a board quality committee at the system level, especially in the area of clinical expertise and data resources.

The findings of this study were drawn from a sample of hospitals that voluntarily responded to the survey. These hospitals do not necessarily represent the universe of community hospitals in the United States, even though they were spread across different regions, sizes, ownerships, and locations. It is also possible that responding hospital leaders may be more attentive to quality issues or may consider themselves more engaged in quality oversight than those who did not respond.

Despite this limitation, the results of this study provide valuable information about some particular board structural and operational features that have not been examined in prior research.

In summary, hospital governing boards were found to be engaged in quality oversight, primarily through monitoring the quality performance of their organizations. Having a board quality committee was particularly important to the effectiveness of the board's oversight function. There is room for improvement for a number of less frequently performed but potentially useful activities, such as board involvement in setting the agenda for the discussion on quality, inclusion of the quality measures in the CEO's performance evaluation, and improvement of the quality literacy of board members.

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APPENDIX

Descriptive Characteristics of Hospitals Represented in the Study

Hospital Characteristics	Hospitals that Responded to the Survey at the Hospital Level (n = 490)	Hospitals Within the 72 Systems that Responded to the Survey at the System Level (n = 387)	All U.S. Community Hospitals (per AHA Annual Survey)
Size[a]			
Small	28.6%	38.4%	46.3%
Medium	26.2%	26.1%	24.2%
Large	45.2%	35.5%	29.5%
Ownership			
Public	23.1%	11.8%	21.2%
Nonprofit	75.1%	86.1%	54.4%
For-profit	1.8%	2.1%	24.4%
Teaching status			
Teaching	22.1%	22.1%	14.7%
Nonteaching	77.9%	77.9%	85.3%
Service type			
General hospital	96.3%	92.9%	80.2%
Specialty hospital	3.7%	7.1%	19.8%
Location			
Urban	59.1%	71.3%	63.4%
Rural	40.9%	28.7%	36.6%
Region			
Northeast	18.4%	7.5%	13.2%
Midwest	37.8%	48.9%	28.1%
South	25.6%	31.5%	40.7%
West	18.2%	12.1%	18.1%

[a]Hospital size was defined by number of beds within the categories that were stratified by region, urban/rural location, and teaching status. Details are available from www.hcup-us.ahrq.gov/db/vars/hosp_bedsize/nisnote.jsp.

PRACTITIONER APPLICATION

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The findings detailed in this article are at once reassuring and disturbing. It is encouraging that more than 80 percent of the hospitals surveyed report that their governing boards are actively engaged in establishing strategic goals for quality improvement, using dashboards to track performance, and following up on corrective actions related to adverse events. Yet only 61 percent of respondents indicate that their governing bodies have a quality committee. As a further indicator of the work that still needs to be done, fewer than one-third of the respondents reported that the board has issued a written policy on quality and formally communicated the policy to the senior executive team, physician leadership, and all hospital staff.

In an era marked by demands for increased transparency and accountability, it is unthinkable that a hospital or healthcare system would not have a finance, audit, or executive compensation/governance committee particularly. And it strikes me as equally unthinkable that a hospital board would not have a quality committee. As the authors clearly point out, hospital governing boards are ultimately responsible for the quality of care provided in the institution, a responsibility that was confirmed by the courts decades ago. For reasons that are well documented, the past ten years have been marked by increasing attention on quality improvement, error reduction, patient safety enhancement, and patient satisfaction measurement. Quality literacy at all levels of the organization is of paramount importance, and the board must lead by example in making sure that an effective mechanism is in place for executing the quality agenda at the governing body level. The study findings that correlate the breadth of quality oversight with the presence of a board quality committee are encouraging and should serve as a positive reinforcement of the net worth of quality committees. So too should these findings be an important motivator for all hospital boards to adopt a formal structure at the board level for carrying out the quality and patient safety agendas of the organization. Perhaps the about-to-be widespread adoption of pay-for-performance programs will serve as a final stimulus to boards who have heretofore failed to raise quality and patient satisfaction to the same level as financial integrity, physical plant oversight, and employee relations.

The federal government, state regulators, private payers, patients, and families are demanding that meaningful quality information be available so that consumers may make more informed choices regarding hospital care. The veil of protection that long characterized hospital quality and performance information has been lifted. Boards that have resisted or failed to embrace an organized quality committee are exposing their institutions and the patients they serve to needless risks. The authors make a compelling case for decisive action.