

“Driving for Quality in Acute Care: A Board of Directors Dashboard” Government-Industry Roundtable

*A Report on the Office of Inspector General and Health Care Compliance Association
Roundtable on Hospital Board of Directors’ Oversight of Quality of Care*

Introduction

On November 10, 2008, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the Health Care Compliance Association (HCCA) co-sponsored a government-industry roundtable called Driving for Quality in Acute Care: A Board of Directors Dashboard. The meeting was the most recent in a series of government-industry discussions designed to foster dialogue between the various stakeholders that are committed to improving compliance to Federal health care program rules and requirements and promoting the care of beneficiaries.

This roundtable focused on how a hospital’s board of directors can use performance scorecards, or dashboards as a tool to promote quality of care in its institution. Dashboard reports use graphics to concisely present critical data in summary form. The goal of the meeting was to encourage a dialogue among hospitals that have successfully implemented dashboards, as well as hospitals that are just beginning the effort. The meeting also provided a forum for government representatives (including staff members of OIG and the Centers for Medicare & Medicaid Services (CMS)) to share their perspectives on the issues and challenges surrounding quality of care. This article reports on the day’s proceedings and summarizes the participants’ views on information dashboards as well as their suggestions for using them to improve quality of care.

Why Hospital Boards? Why Dashboards? Why Now?

The core mission of a hospital is to provide quality care to its patients. Quality of care has many dimensions, ranging from access to health care and professional competence to the appropriate environment for care. Shortcomings can result in direct harm to patients because of substandard care or indirect harm because of a lost opportunity to receive higher quality care. These institutions are governed by boards of directors and, whether elected or appointed, boards are often composed of members of a community who may know very little about health care delivery or what constitutes quality care. Nonetheless, the boards have a fiduciary duty to their institutions as a whole, and

Medicare places the responsibility for quality in hospitals squarely on the shoulders of the boards.¹

The challenge is to provide the board with the tools it needs to effectively meet its responsibilities to the hospital and its patients. Information dashboards have emerged as a vital tool for hospital boards committed to promoting quality improvement within their organizations. Research has shown that there is a correlation between dashboard implementation and quality performance.² For example, a well-designed dashboard can raise awareness of areas in which the hospital is underperforming. This enables the board to determine what needs to be done to improve performance. Although many larger urban hospital systems are familiar with the dashboard concept, smaller community hospitals would benefit from this tool as a way to connect systems, jump-start quality improvement initiatives, and align incentives of all stakeholders.

There are many questions about the creation and use of the dashboard. For example, how do hospitals determine the quality measures to be used? Should the board's quality committee or medical staff be involved with the creation of the measures? Who, in addition to the board, should be given the dashboard? How frequently should the dashboard be updated? What actions should the board take in response to the information presented in the dashboard? How can the dashboard be linked to the organization's strategic plans or objectives? These questions formed the basis of the roundtable presentations and discussions.

The Structure of the Meeting

Fifty-five hospital professionals and government representatives attended the roundtable. They represented a wide spectrum of hospital organizations and professionals, including not-for-profit and for-profit organizations, academic medical centers, public and community hospitals, clinicians, administrators, compliance officers, and other leaders in the acute care industry.

The day began with remarks from Herb Kuhn, CMS Deputy Administrator, who discussed CMS's role in promoting quality and the value-based purchasing initiative, which includes pay for performance, never events, gainsharing, and competitive bidding. After these introductory remarks, Michael Pugh, a hospital quality and governance expert, set the stage for the day by discussing how a dashboard can help a

¹ See, 42 CFR § 482.21(e), CMS's Conditions of Participation for Hospitals, the governing body of the hospital is responsible for quality of care.

² See, Eugene Kroch et al., "Hospital Boards and Quality Dashboards," vol. 2 Journal of Patient Safety, pp. 10-19 (2006)

board promote quality of care. Then, a panel of representatives from three hospital systems described the design and use of their quality dashboards and responded to questions from the audience.

The afternoon session began with a presentation by another panel of hospital representatives, who discussed the challenges of engaging their boards in implementing robust quality dashboards. The roundtable participants then separated into four discussion groups designed around the main themes of the day: 1) the boards' engagement and commitment to quality, 2) the measuring and reporting of quality indicators, 3) promoting transparency of quality information and results, and, 4) accountability at all levels of the organization to high-quality patient care.

This "brainstorming" exercise enabled participants to share their insights on quality dashboards and to identify best practices and pitfalls. The objective was not to reach consensus on a model dashboard or specific best practices, but rather to foster a collegial exchange of ideas on ways to effectively engage a board of directors in improving quality of care.

At the conclusion of the day, the participants agreed that the roundtable was very productive and that a written summary would be beneficial. The following synopsis is based on the notes taken by scribes provided by HCCA. Themes and topics common to more than one discussion have been consolidated. The views expressed in these summaries do not necessarily represent the views of OIG or HCCA.

Keynote Speaker

The keynote speaker of the roundtable was Michael D. Pugh, President and CEO of Verisma Systems, Inc., and a Senior Faculty member of the Institute for Healthcare Improvement, an independent not-for-profit organization committed to helping lead the improvement of health care throughout the world. Mr. Pugh works on national quality improvement efforts, including the "Boards on Board" project, a campaign aimed at getting hospital boards to engage in promoting quality and safety within their organizations. Mr. Pugh presented strategies for increasing accountability for quality at the board level and best practices for pursuing quality initiatives. The main points in the presentation are summarized below.

Use dashboards: Hospital boards should use performance dashboards so that they can quantify and determine the quality of care provided in their hospitals. All hospital boards need to be able to answer these questions: "How good is your hospital?" and "How do you know?" Dashboards can be useful in interpreting the mounds of data presented to boards and quality committees. Although a high level dashboard is best

for the full board, it would be wise to use topic-specific scorecards to drill down at a board committee level (finance, strategy, planning, quality, and safety). To be most effective, the dashboards should be reviewed at every board meeting.

Put a human face on the data: Dashboards should focus on the patient by using actual accounts of harm, not rates of harm. For example, instead of reporting a metric that the medication error rate was .004%, the data should be reported as the actual number of incidents—(e.g., 35 patients experienced adverse medication events last month). By looking at specific patient impact, the scorecard will begin to tell a story often hidden by traditional reporting about the quality of the care practiced at the facility. High profile events, such as wrong-site surgery and other sentinel events, should be reported to the board: not just what happened, but what impact it had on that patient, effectively putting a human face on the data.

Set ambitious targets: The board should drive organizational progress toward safe and effective quality care. Dashboards are excellent tools for monitoring system-level improvement by showing performance measures, specific targets for reducing harm, and specific processes for increasing quality. The board should set all-or-none target levels for clinical care and safety measures (100% or 0%), e.g., it is not acceptable to have a single accidental overdose. Because it is impossible to achieve target levels overnight, it is useful to set interim measures that show the hospital's progress towards closing the gap between actual performance and targets.

Avoid color coding to low expectations: In many dashboards, the performance metrics are color-coded to illustrate how a public entity's performance compares with a selected benchmark. The colors are typically green, yellow, and red and are coded in reference to industry averages, such as the "75th percentile" or other standardized national comparative data. Although using color-coding is simple, it is often deceptive because without numbers it can mislead the board if tied to targets that have been set too low. For example, a dashboard could be predominately green, indicating that targets are being met, but a closer examination might reveal that targets have been set inappropriately low. An incorrect assumption can be made that only the "red" blocks need attention. If color-coding is used, then boards need to frequently ask how the targets are set.

Simple is better: The ideal dashboard format is simple — charts and data graphed over time. This is the most useful format because it shows whether the hospital is heading in the right direction. A dashboard should reflect what the board thinks is important about quality. The board should establish and monitor a small number of system-level

“roll-up” measures that are updated continually and are transparent to the entire organization and its stakeholders.

Align goals with the activities of stakeholders: Creating alignment in organizations is a critical leadership function. For an organization to function at its best, there has to be alignment between a compelling vision for the future and the day-to-day work of the staff. The board, senior leadership, executive committee, management teams, and medical staff must all buy into an initiative to promote quality improvement and work towards the target. Data from a quality dashboard could lead to quality improvement projects and operational decisions — successful implementation depends on clear delineation of responsibility for each measure, including the frequency of reporting. Dashboards can be used to align the goals of stakeholders at all levels.

Quality and compliance leaders play a key role: By presenting topic-specific scorecards (safety, mortality, infection control, etc.) quality and compliance leaders can help the board understand large amounts of data and encourage board members to ask questions about the data. Quality and compliance leaders can separate indicators that are simply being monitored from those that they want to improve. By doing this, they can focus the board’s discussion on the improvement efforts, instead of just reporting the data. Compliance leaders must also help quality leaders ensure that the data reported to the board are accurate and consistent. When patient harm events occur, the compliance and quality officers should ensure that the organization follows its internal policies, completes any external reporting requirements, and takes the appropriate actions, when required by regulation, policy or contract, not to charge the patient for care provided as a result of the harm event.

Boards and Dashboard Case Studies

After Mr. Pugh’s presentation, a three-person panel gave their insights into the process of developing quality of care dashboards in their hospitals. The distinguished presenters included:

- Dr. Darrell A. Campbell, Jr., Chief of Clinical Affairs, University of Michigan Health System, a 913-bed academic medical center of the University of Michigan in Ann Arbor, Michigan;
- Jim Bross, Vice President and Chief Financial Officer, Rutherford Hospital, a 143-bed private, not-for-profit acute care hospital in Rutherfordton, North Carolina; and
- John Falcetano, Chief Audit and Compliance Officer, University Health Systems of Eastern Carolina, a regional health system with seven hospital serving 29 counties in North Carolina.

The speakers were asked to present “case studies” of their facilities that described the evolution of quality measurement and reporting in their organizations. The presenters also were asked to describe how their organization created and instituted their dashboards. The insights gleaned from the presentations are summarized below.

Statistics are important: Statistics measuring quality are vital to the successful operation of a hospital. They must be communicated to the physicians and staff to enable them to improve quality practices. The data also must be presented to the board to foster its engagement in quality issues. By viewing the cold facts, the board can begin to build a sense of urgency and understand that “we have to do this.” The board must be behind quality initiatives if they have any chance of succeeding.

Consolidate and package data: A dashboard enables all data to be consolidated into one central location instead of multiple reports that present only a fragmented view of the organization. The dashboard should highlight what the board needs to know because the hospital’s quality strategy is dictated by information given. For example, data presented about nosocomial infection rates will affect decisions about housekeeping disinfection protocols.

Do a quality self-assessment: Every hospital faces quality challenges specific to its facility. Before selecting quality indicators to monitor, the board should identify its facility’s key quality risk areas. Often a hospital’s standard audit process can help identify quality issues and weaknesses. It is often best, for the quality audit to focus on internal controls, quality process, and high-volume services.

Pick the right dashboard metrics: There should be a balanced approach to dashboard metrics. A balanced dashboard should measure financial strength, operational effectiveness, clinical quality, patient satisfaction, and market share. The board must understand that there is a key relationship between payment and quality. A balance of dashboard metrics can help to establish a link between quality and finances. Dashboards that emphasize this link can help senior leaders realign priorities to meet quality goals and achieve desired financial returns.

Use benchmarks: One way to measure quality is to compare a facility’s performance to those of other regional and national hospitals. Some speakers felt that using standardized measures with national comparative data was an excellent way to get a sense of the broader issues. The speakers indicated that it is most useful to focus on risk-adjusted benchmarks and recommended using observed-to-expected ratios (O/E ratios) in selecting areas a hospital intends to investigate.

Set annual quality goals: The hospital should conduct an annual review of key services, stakeholder expectations, regulatory standards, and customer feedback to determine priorities for patient safety and quality improvement efforts. Specifically, it should compare its current performance with the previous year's performance, as well as benchmarks and theoretical test performance measures.

Monitor results: Is the hospital effectively using quality data? Dashboard metrics are not merely data points but rather measures of what changes need to be made to improve quality in a facility. Instead of monitoring only outcomes, hospital staff should consider monitoring quality improvement processes.

Emphasize the bad as well as the good: The key message to the board is that lots of good things happen and sometimes bad things happen. There must be regular emphasis on negative outcomes or shortfalls to help the board understand the costs and risks of not focusing on quality. The board needs to understand when and how the hospital has harmed patients and to look at the sentinel event process and root-cause analysis. There should be sufficient analysis to explain to the board what caused the harm.

Panel Discussion

The afternoon session began with a second panel discussion, which included a dialogue between the audience and the panelists. The distinguished panelists included:

- Kathryn D. Beattie, M.D., Sr. Vice President for Medical Affairs and Chief Medical Officer, Valley Medical Center, a 300-bed Level III trauma center in Renton, Washington;
- Heather N. Caldwell, Corporate Compliance Officer, St. Mary's Medical Center, a 393-bed not-for-profit hospital providing care to the West Virginia, Kentucky, and Ohio tristate region; in Huntington, West Virginia; and
- Sandra A. Marshall, Sr. Vice President, Organizational Effectiveness and Clinical Outcomes, Covenant Health, a community-owned health care system that includes five acute care hospitals in eastern Tennessee.

The panel addressed topics including how each of their organizations engaged their boards in quality-of-care issues. Each panelist described her organization's practices for collecting and distributing quality data and the resources allocated to monitoring the quality data on their dashboards. Audience members were interested in whether the panelists' boards had begun to monitor "never events" and whether they had developed methods to compare the reported data to data on under reported events.

Although each type of organization presents unique challenges (e.g., an elected board that changes members frequently versus lifetime appointments), there were many points of agreement on the challenges faced in each institution and excellent insights were shared regarding the methods used to address those challenges.

Breakout Sessions

Following the panel discussion, participants had an opportunity to provide direct input via breakout sessions. The group divided into four roundtables. Each discussed a different aspect of the challenges and best practices for creating and instituting a quality dashboard. The discussions are summarized below.

Boards' Engagement and Commitment to Quality:

This group discussed how the board could increase its commitment to delivering the highest quality of care. Indicators of a board committed to quality included: how much time was spent discussing quality at board meetings and whether the board members talked to patients, conducted chart reviews, or created incentives for self-reporting of quality problems. The group discussed ways that a board could empower every employee to make quality his or her first priority:

Support outside the hospital: Some outside organizations, such as state hospital associations, can be great resources for boards. In some cases, outside groups offer education for board members or collaborative opportunities to explore quality issues. In other cases, a state hospital group sets certain quality goals or otherwise champions the cause of quality across the State.

Support inside the hospital: A committed management team can help the board become engaged in quality. For example, the management team should nurture any demonstration of courage or leadership on quality by a board member, thus encouraging more such demonstrations.

Support from within the board: Hospital boards often have various subcommittees charged with delving more deeply into certain issues. If the board has a quality committee, it can support quality by ensuring that enough time is devoted to the quality agenda items in board meetings. Some boards solicit direct input from patients by offering them seats on the board or by establishing a quality of care subcommittee comprising patients and/or their families. Figuring out how to structure these types of board committees and how much information to provide them are challenges. No one right way exists.

Educate the board: Board members must understand their legal duties and learn how to oversee clinical issues and quality. They need to be educated not only to understand the quality reports they receive but also to ask good questions. Board members need time, education, and encouragement to become adept at understanding and addressing quality issues.

Narrative matters: Even though no hospital is entirely free of problems, the negative attention garnered by adverse events affects the hospital's reputation. Telling stories with happy endings is easy. It is much harder to explain that something went wrong. The hospital should appeal to the board members' sense of what is right by inviting patients to present their stories at board meetings. This can put a human face on the pages of reports and indicators.

Measuring and Reporting of Quality Indicators:

This group discussed approaches to assessing quality of care by measuring identified quality indicators and effectively communicating the results of those assessments to boards of directors. The group pondered how a hospital should decide which measures to monitor and what data should be included on the quality dashboard. The group also discussed the benefits of comparing an entity's outcomes and measures to those of other providers.

Pick the right measures: The participants discussed which measures they tracked in their own dashboards. Although participants keep abreast of published measures such as CMS Core Measures, most used these as a starting point for individually tailored measures. Participants rely on measures related to safety and those that are evidence based. A facility should continually scrutinize its measures and refine them as necessary to remain current with emerging research and respond to the demands of its organization.

Involve patients: Often the best way to identify a hospital's weaknesses is to hear from patients and their family members. Establishing mechanisms for patients to tell their stories will provide a clear picture of opportunities for improvement. In response to patient input, one participant developed a patient-activated urgent response mechanism so that the patient or the patient's family could call for a "rapid response" team themselves (rather than limiting that capability to medical or nursing staff). Other participants established patient advisory boards to facilitate patient input. Meaningful patient involvement enhances a provider's identification and reporting of specific weaknesses and potential improvements.

Share data with peers: Some providers are hesitant to share data with other entities because of concerns about reputation or competition. Participants noticed a greater willingness to share quality measurement data where payors offered rewards for participating in peer group programs. Participants discussed how sharing quality measurement and reporting information with peers can present an opportunity for enhancing their own measurement and reporting programs. Working with peers enables entities to share ideas about identifying appropriate measures and improving outcomes. Members of the board often ask how their organization's performance compares to that of their peers.

Promoting Transparency of Quality Information and Results:

This group discussed what quality data a hospital should disclose and with whom it should share the data. This roundtable addressed the degree to which hospitals share quality data internally and what quality data are publicly disseminated. This session revealed that many hospitals do risk assessments, balancing the need for transparency against protecting the hospital from liability, in determining how much information should be shared in a particular situation.

Full disclosure to a harmed patient: When there is an adverse event resulting in patient harm, most participants indicated they would tell the patient and family as much information as is known at the time of the event. The group discussed many best practices for reporting the event to the patient, including how to tell the family, what information to share, and the appropriate timing of the discussion. The group felt that it was important that the hospital and physician work as partners when communicating errors and informing the patient of the required followup as a result of the error. Both the occurrence of the event and the analysis of why the event occurred are critical pieces of information that the board can use to monitor the quality of care.

Circulate quality data within the organization: It is essential to share quality data with the board. There was agreement that the quality data on adverse events should be published within the organization to raise awareness of quality issues. When data are distributed to all medical staff in all clinical departments, a learning opportunity is created. At some institutions, systems are in place to ensure that a multidisciplinary team addresses quality concerns. For example, at one hospital, when a medical error is identified, the performance improvement, risk management, compliance, and billing departments are all notified so that each department can evaluate the event. Most entities report that quality data are shared during peer review sessions and a physician's individual quality data results may be used in the recredentialing process.

Determine the appropriate level of dissemination to the public: Many hospitals have started publishing their quality data. Some facilities have posted a hyperlink to CMS Hospital Compare (www.hospitalcompare.hhs.gov), whereas others have posted their quality data directly on their Web sites. Most participants agreed that consumers of health care should have access to quality of care data, (i.e., specific factual data versus public relations reporting). Participants also saw a number of challenges inherent in making quality data available to the public, such as making sure that the data results were accurate and were presented in a manner that would not confuse a lay person. They also discussed whether the hospital would need to provide context (i.e., case mix index and risk adjustments) in order to make the data useful in making comparisons to other entities.

Accountability for Quality Outcomes:

This breakout group discussed how to achieve accountability for quality at all levels of an organization. Strategies for encouraging accountability and ways the board could hold practitioners and management accountable for quality issues were also explored.

Board Accountability: The group recognized the board's legal accountability for quality, but it noted that it is difficult to hold the board truly accountable because many boards either are not aware of what is going on in the facility on a daily basis or do not understand the clinical data given to them. The goal is to educate the board about quality issues, and, ideally, have independent board expertise in the area so that board members are able to ask tough questions about the organization's quality. The group recognized that many hospitals are in financial straits, which makes it difficult for boards to focus attention away from financial viability of the organizations. However, sentinel events and state-mandated public reporting typically shift the attention of the board to quality.

Executive Accountability: It was the general consensus that executive management can play a pivotal role in getting the board engaged in quality issues. Some organizations provide financial incentives to executives to meet certain quality goals. Some participants raised concerns as to whether financial incentives related to core quality measurement data would affect the validity of the data in areas where subjectivity is a factor of the measure. At least one member believed that an organization should hold the CEO directly accountable for quality, such that his or her job is hinged on the achievement of quality goals. Although others disagreed with that approach, there was consensus that executive job descriptions and compensation structures that emphasize quality of care would be beneficial.

Physician Accountability: The group agreed that most physicians feel responsible for the quality of care that they deliver to their patients. In organizations in which physicians are directly employed by the hospitals, accountability for the quality of care delivered at the hospital level can be built into the physician contracts as an incentive for meeting certain quality goals. However, in organizations with nonemployed physicians, getting a physician engaged in the hospital's system-level quality endeavors can be difficult because the current insurance reimbursement system provides no financial incentives a physician to participate in the quality outcomes of a hospital. Additionally, physicians may view hospital data with skepticism and question the data's validity and value. Because core measures are generally reported several months after the reporting time period, they are too remote to be of interest to physicians. However, patient-level live quality measurements (i.e., quality information presented during rounds) could drive physician engagement as well as innovative and appropriate hospital and physician alignment strategies.

Staff Accountability: Successful quality initiatives require the support of all personnel. Some organizations report the organizational and department goals in such a manner that the information gets to all levels of staff. This approach keeps the staff engaged and helps drive individual accountability. This engagement is evidenced in the area of patient safety. All staff generally know they are accountable to report adverse events or medical errors. Hospital leadership should communicate that errors are ultimately the failure of the entire organization and its systems in order to foster a nonpunitive environment focused on a culture of safety.

Conclusions and Main Takeaways

Measuring quality presents challenges: There is a lot of work on quality of care in hospitals being done. Participants agreed that one of the difficulties in addressing quality issues is that no one really knows exactly how to define or measure it. As a rule, you cannot manage what you cannot measure and you cannot measure what you cannot define. Although organizations work to get data on a timely basis, getting data that are accurate, valid, and reliable involves multiple complex processes. Financial measures tend to be concrete (e.g., days of cash on hand) and, therefore, easier to manage. How to measure the quality of care in an institution is not clear cut.

The board must lead the way: The board sets the tone for an institution and must communicate a commitment to quality to all levels of the organization. Quality improvement initiatives cannot succeed if the board does not create momentum and build organizational will to achieve certain results. Management and medical staff must adhere to the organization's commitment to quality.

Dashboards can be an important strategic tool: The board of directors should not just passively receive reports on quality. Even a well-constructed dashboard is not useful if it is not used as a tool for change. The board must establish specific system-level goals and use dashboards to help ensure that those goals are met.

Establish the business case for quality: With the advent of CMS's value-based purchasing (including pay for performance, never events, gainsharing, and competitive bidding), the business case for quality has become more obvious. Nonetheless, focusing primarily on finances often represents a board member's comfort zone. Thus, tying quality and patient safety directly to the financial health of the hospital will likely get board members' attention. For example, presenting the board with a financial analysis of patients with hospital-acquired infections, such as MRSA, should help the board see quality through a financial lens.

Educate the board on quality: It is important that when quality indicators are being reported to the board, members of the board understand the information presented. Participants found that boards appreciated explanations of issues such as the clinical elements of the quality indicators and measurements, the basis for selecting the slate of indicators reported on the dashboard, and what the measures reveal about the provider's risk areas or strengths. One of the most powerful ways to explain data to the board is to put a human face on the data by using specific patient case studies as examples. Participants observed that providing detailed explanations to board members provides background information and context, builds trust, and demonstrates management's grasp of the issues.

Accountability should permeate the hospital: When the board receives quality and core measure information and questions the data it receives, the board ensures responsibility for quality outcomes. However, in some organizations, it is not entirely clear where responsibility lies between medical staff, management, and the board over various areas of quality. Some noted that there can be "organizational silos of interest" in place, which can impact the ability to have true accountability.

Establish a culture of quality: The board needs to ensure that each individual feels that his or her job contributes to the hospital's core quality goals. Participants stressed the importance of incorporating the entire community into the effort, including medical staff, interns in teaching institutions, and peers. Each individual in the facility should be able to articulate how his or her job ties into the quality goals of the hospital, especially when quality issues, such as infection control, permeate multiple departments.

Transparency is essential: An organization's stance on transparency can impact the quality of care delivered. Organizations benefit when quality information is routinely shared to raise awareness and create learning opportunities. Participants championed practices in which a multidisciplinary team addresses quality concerns and reports the resulting process changes or improvements within the organization. All agreed that direct full disclosure about patient harm was critical. Sharing information with patients about the care provided was identified as a best practice.

Sharing data is helpful: As voluntary demonstrations and payor programs bring increased attention to measuring quality indicators, providers are improving and refining their systems for evaluating and reporting on quality of care. Some areas of the country have state or regional systems that share best practices in quality and patient safety among organizations. Comparisons within a locality or community are useful as well as comparisons to providers in that are of a similar size and complexity.

Conclusion

Participants were very pleased with the results of this collaborative effort between OIG, HCCA, and acute care hospital industry representatives. Thanks to the collective efforts of all participants, the roundtable was judged to be a resounding success. Participants explored many issues confronting hospital boards in their oversight of the quality of patient care. Both government and industry participants gained new insights into the challenges and opportunities created by using dashboards as tools to provide boards of directors with means to assess and oversee their organizations' performance on certain quality-of-care metrics. We believe that the roundtable discussions will foster a greater understanding of how the government and hospital industry can work together to improve the quality of care provided to Federal health care program beneficiaries.