IHI, essentially, is a community of communities. Of patient communities taking charge of their own treatment, of hospital communities driving continuous improvements, of health care systems innovating, of counties, cities and countries rethinking health care delivery. We have an amazing network of communities and individuals worldwide that are part of IHI. We’re inspired by what they do daily and how they use and leverage everything we’ve learned over the past 23 years, how they create and measure new approaches to persistent problems, how they effect change and improve health for so many.
Of patient communities taking charge of their continuous improvements, of health care rethinking health care delivery. We have an worldwide that are part of IHI. We’re and leverage everything we’ve learned over approaches to persistent problems, how they
A Common Gift
The theme of this year’s progress report is community. As we compiled the stories you’ll read in the following pages, we were struck by an overwhelming gratitude, and a little pride, that IHI has the privilege to act as convener for all the communities described in this report. The word “community” derives from Latin — *cum* meaning “with” or “together,” and *munis* meaning “gift” — and the IHI “community” is indeed our common gift. In the last few years, health care has been held up as an example of what’s not working in modern society. While the systems we work in are still fragmented, still costly, and in many instances, still unsafe, improving health care can be our gift. As 2011 ends and 2012 begins, health care is in a unique and perhaps historic position to improve society as a whole. A redesigned health care system can help us improve our health, balance our budgets, and strengthen our communities. We know how to do it — the stories in this report are just a handful of countless examples of inspiring progress. What’s needed now is to leverage the collective strength of our community so that all patients, everywhere, can benefit. IHI has always sought to enrich and leverage our collective experience and expertise through a broad network of collaborators, and through smaller networks of strategically aligned organizations, learning communities, and fellows. This year’s progress report highlights just some of the extraordinary work of these partners. From the students and faculty changing health professions education through the IHI Open School, to the patients and nurses in Sweden changing the culture in their dialysis clinic, to the network across the US working to reduce hospital readmissions, to the IHI Fellows returning home to improve their organizations, communities everywhere are helping to redesign health care into the system patients need and deserve. We could not be prouder to play our part. IHI is still a small organization — about 125 people — and working with the IHI staff is a gift for me every day. But we could never succeed without our brilliant and inspired faculty. Every day, these individuals who teach and guide improvement work all over the world share their gifts of ingenuity, courage, and resolve. The dedication of this amazing group of professionals is the reason IHI remains a potent force. These stories are their stories, and we can never say thank you enough. The future of health care is, like our economies, fraught with uncertainty. But whatever happens, the IHI community will continue to doggedly pursue a redesigned health care system that fulfills all the promises we make to our patients. To everyone who has asked whether we can do better, and to everyone who has demanded we do better, thank you.

Sincerely,

Maureen Bisognano
President and CEO, Institute for Healthcare Improvement
YOU HAVE TO HELP ME TREAT MYSELF.
I NEED TO HAVE CONTROL IN MY LIFE.

CHRISTIAN FARMAN
Christian Farman was diagnosed with renal failure at age 25. An athletic man in good shape, he recalls, “It was a big shock for me to get into dialysis.” When he started treatments, Farman quickly experienced side effects such as nausea, edema, and extreme thirst. “It was horrific,” he remembers.

Farman received a kidney transplant, but in 2005 he was back on dialysis. On the first day of treatment, he spoke with Britt-Mari Banck, a nurse in the Ryhov County Hospital hemodialysis clinic in Jönköping, Sweden. Farman said to her, “You have to help me treat myself. I need to have control in my life.” He had researched self-dialysis and became convinced that if he could manage his own treatment, the side effects would disappear.

In many dialysis centers, the story would have ended there. But Farman’s unusual request was met with an unusual response. “I said, ‘Yes, how shall we start?’” recalls Banck, now acting head nurse for the hospital’s self-care dialysis unit.

Banck showed Farman how to use the dialysis machine, read and interpret lab results, and document his care in his chart. Within five weeks, Farman was managing his dialysis independently. He discovered that self-dialysis resulted in fewer side effects.

Before long, Banck was training other renal patients to manage their own treatment. As more patients performed their own dialysis, and had dialysis more often because it was a less burdensome process, infection rates fell. “We were a community,” Farman says, “and we didn’t feel we were sick anymore, because the treatment was so good.”

Today, nearly 60 percent of the hospital’s peritoneal dialysis and hemodialysis patients are managing their own treatments. The hospital aims to increase that number to 75 percent. Banck says, “It’s a very joyful thing.”

As for Farman, he left his job with Saab Avitronics and went to nursing school. He’s now a registered nurse in Ryhov County Hospital’s ear, nose, and throat clinic. “I have a big advantage, because I see the patient as a resource,” he says.

TODAY, NEARLY 60% OF THE HOSPITAL’S DIALYSIS PATIENTS ARE MANAGING THEIR OWN TREATMENTS.
“WHEN YOU SEE A VENTILATED PATIENT UP AND WALKING, YOU CAN’T HELP BUT GET EXCITED.”

KAREN MONTGOMERY
A patient in her eighties had come to Sunnybrook Health Sciences Centre in Toronto for an elective procedure, but after a seizure she was put on a ventilator in the critical care unit.

Things didn’t look good. Even so, on Day 3, her care team started to wean her off sedation and helped her sit up in bed. Three days later, she was walking around the unit.

“When you see a ventilated patient up and walking, you can’t help but get excited,” says Karen Montgomery, a critical care physiotherapist at Sunnybrook.

Montgomery learned how to get the patient moving by participating in an IHI “live case study” visit at Intermountain Healthcare in Salt Lake City, Utah. The program grew out of pioneering work by IHI faculty Terry Clemmer and Vicki Spuhler of Intermountain, and Wes Ely of Vanderbilt University School of Medicine.

During the visit, Intermountain ICU staff performed delirium assessments, used protocols for early removal of sedation, and mobilized ventilated patients. “I was shocked,” remarks Genny Ng, a Sunnybrook respiratory therapist who attended the program. “We saw a lot of ventilated patients, and instead of getting bed baths they were walking to the shower.”

Patients in critical care are usually kept immobile and heavily sedated, but there’s growing evidence that these practices can seriously damage patients’ long-term recovery.

After their Intermountain visit, the Sunnybrook team began identifying patients who were good candidates for early mobility — as well as nurse and physician champions.

“We needed to take baby steps initially,” says Linda Nusdorfer, an advanced practice nurse. “One nurse kept refusing to help mobilize her patient,” Montgomery recalls. “We got someone else to help, and eventually the nurse came around when she saw how the patient benefited.”

Although it’s too early to see the effect of the protocol on outcomes, it’s clear that Sunnybrook’s culture is changing. “We expect our patients to get up and walk or sit,” observes Montgomery. “The nurse says, ‘Okay, what are we doing to get this patient moving?’”

**THERE IS GROWING EVIDENCE THAT MOBILITY CAN HELP A PATIENT’S LONG-TERM RECOVERY.**
According to Medicare data, one in five Americans aged 65 and older who are hospitalized will return to a hospital within 30 days for an unplanned readmission. To reverse this trend, some hospitals have begun to reduce readmissions as part of IHI’s STAAR (State Action on Avoidable Rehospitalizations) initiative. One of the most successful STAAR participants is Baystate Medical Center, a 650-bed hospital in Springfield, Massachusetts. According to Dr. Evan Benjamin, Senior Vice President for Health Care Quality at Baystate, the financial element was never a concern. Not only is reducing readmissions the right thing to do for patients, he asserts, it’s also a way to stay vital in the changing health care landscape. “We were looking at really transforming health care,” says Benjamin, “in the context of improving care for our community, decreasing overall costs, and beginning to understand our role in providing a more accountable and integrated health system.” In 2009, Baystate joined STAAR with the goal of reducing readmissions by 30 percent, starting on a general medicine unit and a cardiac unit. At the time of admission, nurses and case managers now identify patients at risk of readmission, complete a care needs assessment, and draft a customized discharge plan that is subsequently reviewed and revised. After discharge, low- and moderate-risk patients receive a follow-up call within 1 to 2 days; visiting nurses see high-risk patients at home the next day (for home care visits not covered by Medicare, Baystate pays the costs). The result of these efforts is a 25 percent drop in readmissions for cardiac patients, in addition to a hospital-wide decline of 10 to 15 percent, between October 2010 and June 2011. IHI Vice President Pat Rutherford calls Baystate’s work a “pioneering effort,” adding, “This new way of working across organizational boundaries with patients and staff is creating the foundation for accountable care organizations and health care reform.”
THE EFFORTS RESULTED IN A HOSPITAL-WIDE DECLINE IN READMISSIONS OF 10 TO 15%.
A Hospital
Takes Aim at VTE
In 2008, Blessing Hospital — a 435-bed facility in rural Quincy, Illinois — decided to examine their system for preventing venous thromboembolism (VTE). Their findings were unsettling: physicians’ compliance rate with the prophylaxis order sets was only 7 percent. “It was unbelievable how many times those order sets were not touched by the physician,” recalls Debbie Lewis, the VTE project leader.

As a charter member of IHI’s Passport Program, Blessing had access to a wealth of improvement resources including IHI’s Preventing VTE Expedition. Expeditions are interactive, web-based programs designed to help frontline teams make rapid improvements. Through active participation in the Expedition, Blessing completely retooled their processes. “We knew the evidence-based guidelines and we knew what we needed to do,” says Dr. Robert Merrick, Blessing’s Medical Director of Quality, “but what we got from the Expedition was how.” They worked with a pharmacist to design a more user-friendly order set and built it into physicians’ admission orders. After transitioning to an electronic record, compliance became easier to track. Doctors began to receive individual reports on their performance. Merrick credits the structure of the Expedition as a “significant contributor to our success.” Having sessions every two or three weeks “kept us making progress.” The results have been remarkable. From 2008 to 2010, compliance with appropriate pharmacologic prophylaxis rose from 33 percent to above 80 percent, and the number of hospital-acquired VTE cases dropped from 71 to 49 — a 37 percent decrease. In recognition of these accomplishments, Blessing won the 2011 Illinois Hospital Association’s Quality Excellence Achievement Award.

The goal of an Expedition is to give participants enough content, ideas, tools and coaching to set them on a path to success. According to Fran Griffin, IHI faculty on the Expedition, “This is a great example of what we hope to achieve with everybody.”
When Interim Healthcare in Greenville, South Carolina, first learned about IHI’s Hospital Inpatient Waste Identification Tool while participating in the Impacting Cost + Quality initiative, they knew it was a way to drive out waste in hospitals. No one dreamed that this home health agency would end up using the tool to identify waste in home care.

But, especially in light of changes in Medicare & Medicaid reimbursement policies, the team at Interim’s Greenville franchise was determined to find new ways to identify and reduce waste — and its associated cost — throughout the system. Perhaps the Waste Identification Tool could be adapted for use in more places than the hospital.

“When we started learning about waste in health care, it was obvious that some waste in hospitals is also waste in home care,” says Connie McCammond, Greenville’s Executive Director of Patient Services.

The first place Greenville staff found potential waste was in complex wound care. For example, clinicians sometimes continued care for wounds when the prognosis for full recovery was poor. The team realized that with fewer visits, staff could help the patient and caregiver independently care for the wound to prevent infection, while continuing to provide palliative wound treatments. “It doesn’t change the quality of the care you’re providing, but it does impact the cost,” McCammond says.

Interim also used the tool to improve efficiencies in certain office processes, for instance, to enhance office staff productivity. McCammond estimates they will save $1 million dollars through 2012 by introducing the IHI tools and strategies.

IHI Vice President Katharine Luther considers Interim’s unexpected adaptation noteworthy. First, it demonstrates the broad applicability of the Waste Identification Tool — beyond the hospital focus that IHI’s R&D team imagined when they first developed the tool in 2009. Second, Interim’s ability to tailor the tool to their needs “speaks to the talent in their organization that will guide them well as they must find ways to provide higher quality care at a lower cost, as we all do.”
COLLABORATION WAS OUR MANTRA.

STEVE GALEN

OUR COUNTY GOVERNMENT UNDERSTANDS THE TRIPLE AIM. THE WHOLE COMMUNITY IS MOVING TOWARD A POPULATION HEALTH FOCUS.

STEVE GALEN
Steve Galen, President and CEO of Primary Care Coalition (PCC) of Montgomery County, Maryland, has lots of experience setting up health care delivery systems and making them work. He is also very good at bringing people together to solve big problems. In 2007, PCC was one of 15 organizations chosen to prototype IHI’s Triple Aim, which seeks to transform health systems by simultaneously pursuing three aims: enhancing the experience of individual patients, improving the health of a population, and reducing the cost of care. That experience, Galen said, moved PCC toward a “grander vision.” PCC soon became an “integrator” — an organization that builds connections among health care, government, and social service organizations so they can improve health more efficiently. “Collaboration was our mantra,” he says.

First, PCC worked with local emergency departments to ensure that patients automatically receive a referral to a safety net clinic for primary care. They also persuaded specialty care providers to treat patients for free. Finally, they worked with local organizations to expand capacity for low-cost mammograms and established patient navigation services at clinics to make it easier for women to get mammograms.

Galen says this work required a completely new way of thinking about health care. “The Triple Aim provides us with a framework that we can share with other people — our county government understands the Triple Aim. The whole community is moving toward a population health focus.” With support from Montgomery County Executive and County Council, PCC is now working to apply the Triple Aim principles to all 120,000 of the county’s low-income, uninsured residents. PCC believes that by bringing together many agencies and data sources, the county can reduce per capita health care costs by 20 percent while improving the health of the population beyond expectations. “Steve has a deep understanding of the operational role of an integrator,” says Tom Nolan, IHI Senior Fellow and a statistician at Associates in Process Improvement. This enables PCC to initiate more ambitious projects than any one organization could pursue on its own. Galen says it’s exciting to help hospitals, county agencies, and community organizations work together. “Normally there are levels of competition among all these players, and we’ve figured out how to work with all of them. It’s what I call magic.”
PATIENT SAFETY IS YOUR NUMBER-ONE PRIORITY. IF YOU CAN’T LIVE UP TO THAT, DON’T WORK HERE.

DR. JAMES LEDERER
In 2004, Paul Wiles, Novant Health’s CEO, was devastated. A MRSA outbreak in the neonatal intensive care unit caused the death of a premature infant. “This shouldn’t have happened,” Wiles said. Aware that poor hand hygiene was the likely culprit, he disregarded the risks to Novant’s reputation and began telling “Samuel’s story” [not the child’s real name].

Novant set an ambitious three-year goal of a 90 percent hand hygiene compliance rate throughout their system, which serves more than five million people from Virginia to South Carolina. Novant also made an unusual investment, spending nearly $300,000 on what Wiles calls an “in-your-face” internal communication campaign. Screensavers and videos exhorted staff to wash their hands. Posters showing a child in a hospital gown, with the words “You could kill him with your bare hands,” went up on nearly every available wall.

More importantly, Novant rigorously enforced hand hygiene compliance. Nurses designated as monitors gathered about 2,500 observations per month. When they observed lapses, they often intervened directly — and reported physician non-compliance immediately to a VP. Physicians with poor hand hygiene records risked probation or the denial of credentials.

Novant quickly exceeded its 90 percent hand hygiene compliance goal. In 2005, the entire system had 234 cases of MRSA. Since beginning the campaign, Novant has prevented some 539 MRSA cases, at an estimated savings of $5.39 million.

Honoring Samuel’s memory goes beyond Novant’s patients. Embracing IHI’s “all teach, all learn” spirit, Novant serves as an IHI hand hygiene Mentor Hospital, offering informal coaching and making their campaign materials — posters, screensavers, etc. — freely available to others.

The commitment to safety and quality that started with hand hygiene has become a comprehensive philosophy. “You come into Novant knowing that [patient] safety is your number-one priority,” says Dr. James Lederer, Novant’s Medical Director of Clinical Improvement. “If you can’t live up to that, don’t work here.”
WORKING WITH PEOPLE WHO ARE WILLING TO PUSH THE LIMITS AND DO THINGS DIFFERENTLY IS REALLY EXCITING.

TANYA MALONEY
Four years ago, Geraint Martin, CEO of Counties Manukau District Health Board (CMDHB) in Auckland, New Zealand, had a vision. He wanted to maximize improvement in the health system by supporting learning and innovation across the district and bringing together a variety of health-related services under one roof.

Meanwhile, almost 9,000 miles away, IHI was developing a new concept called Quality and Innovation Centers (QICs) to help innovative organizations play a leadership role, similar to that of IHI, in advancing quality and safety in their regions. QICs would develop the capability to offer professional development programming and improvement expertise, convene key stakeholders, spread best practices, conduct evaluation and data analysis, and undertake R&D for innovation.

CMDHB’s aspirations and IHI’s new QIC strategy dovetailed perfectly. The result is Ko Awatea, a new learning center in Auckland that opened in June 2011 — a partnership between IHI and CMDHB to establish a QIC for the region. According to Dr. Jonathon Gray, Ko Awatea Director and a former IHI Fellow, the name means “dawning of the first light” in Maori and reflects the resolve “to capture the opportunity of that moment at the beginning of a new day, just as the first light appears and perhaps anything is possible.”

Ko Awatea, attached to a hospital, features 25 classrooms, a library, and an innovation space. IHI Senior Vice President Penny Carver describes it as “a warm, engaging environment that stimulates conversations, networking, and learning.” About 300 students come through the center each day to attend professional development programs, modeled after IHI’s, for executives, frontline improvement teams, and managers. Inspired by IHI’s Campaigns, Ko Awatea is running several campaigns of its own, the most ambitious of which is Saving 20,000 Bed Days with the goal to reduce hospital bed days by 5 percent.

According to Tanya Maloney, Ko Awatea’s General Manager, “The learning opportunities for us, being able to partner with IHI, are fantastic. Working with people who are willing to push the limits and do things differently is really exciting.” They also benefit from IHI’s expertise grounded in longstanding experience. “There’s the excitement of doing new things,” says Maloney, “and having the solid methodology.”
Malawi, a predominantly rural country in southeastern Africa, has one of the highest rates of maternal mortality in the world: 810 deaths per 100,000 live births. Neonatal mortality is similarly high, at 30 deaths per 1,000 live births. "MaiKhanda, a program launched in 2006 with funding from the UK-based Health Foundation, aims to lower these staggering mortality rates. In partnership with IHI, Women and Children First, and University College London’s Centre for International Health and Development, MaiKhanda serves three districts in Malawi comprising two million people. The program employs a unique two-pronged approach: a quality improvement (QI) initiative in health facilities, and community outreach with women’s groups. At nine hospitals and 61 health centers, frontline workers formed QI teams and, using the Model for Improvement, implemented changes to identify high-risk pregnant women, prevent and manage post-partum hemorrhage, and enlist appropriate blood donors in advance of labor. MaiKhanda also established 729 women’s groups to discuss pregnancy and birth issues, and to brainstorm solutions to problems. “This is meant to empower women to make better-informed decisions,” says MaiKhanda Director Martin Msukwa. For example, the women who highlighted anemia as a problem began growing iron-rich vegetables in community kitchen gardens. Through community outreach, “We work at creating demand for maternal and neonatal health,” Msukwa explains. But it’s equally crucial to address the supply side — “to make sure that the facilities are equipped to take care of these pregnant women.” The program was designed as a randomized controlled trial: some areas received the QI program, others the community outreach, still others had both, while the remaining had none. Where only the QI program or outreach was introduced, no statistically significant results emerged. In the areas where both were introduced, there was a 22 percent reduction in newborn mortality (though still no reduction in maternal mortality). "Each on its own was not able to achieve improvement,” remarks IHI Senior Vice President Pierre Barker, “yet when you put them together they achieved this significant result. It underscores the synergy of the two approaches.” “We’ve learned from this project that results take time,” Barker notes. “And we’ve learned a tremendous amount about how to adapt our methods to resource-constrained settings.”
DRIVING DOWN
INFANT MORTALITY RATES
THEY WERE ABLE TO ACHIEVE
A STUNNING 87% DECLINE IN
HOMELESSNESS IN TIMES SQUARE.

ED: SKID ROW HOUSING TRUST (LOS ANGELES, CA)
BILL: DIRECTIONS HOME (FORT WORTH, TX)
JAMES: PROJECT H3 (PHOENIX, AZ)
ANGELA: OCEAN PARK COMMUNITY CENTER (SANTA MONICA, CA)
In 2005, Common Ground tried a counterintuitive approach to getting homeless people in New York City into housing. They targeted the individuals who had been on the streets the longest. By focusing intensively on this contingent, they were able to achieve a stunning 87 percent decline in homelessness in Times Square over a two-year period.

Galvanized, the organization sought a broader impact. In 2010, Community Solutions, a spinoff of Common Ground, launched the 100,000 Homes Campaign, with a goal of housing 100,000 people by July 2013.

Staff involved in the initial Common Ground efforts had been working with IHI Senior Fellow Tom Nolan for years, so they knew about IHI’s 100,000 Lives and 5 Million Lives Campaigns. “There was this kind of ‘aha’ moment,” says Becky Kanis, Director of the 100,000 Homes Campaign. “Maybe we could do something like that.”

Like the IHI Campaigns, 100,000 Homes is ambitious and large in scale, with a structure linking field organizers throughout the country to central objectives. Over 100 communities are now participating, and they have collectively housed over 10,000 people.

According to Christina Gunther-Murphy, IHI Director of Hospital Portfolio Operations, who advises the 100,000 Homes Campaign, this project is “not just teaching us about large-scale change, but how to improve health, how to work with partners to achieve that change.”

Kanis is enthusiastic about the relationship with IHI. “There’s not an interaction I’ve had with anyone at IHI where I haven’t left that interaction feeling smarter and happier,” she says. “There’s no way that this could possibly be happening across the country without IHI’s support and mentorship.”
IHI launched the Open School for Health Professions in 2008 as an initiative focused primarily on offering free online health care improvement and patient safety courses for students. Soon, however, it blossomed into a community of learners that now consists of 68,839 students, 368 interprofessional Chapters on campuses in 46 US states and 50 countries.

One of IHI’s goals in developing a Chapter network was to accelerate the integration of improvement and safety content into the health professions curricula, and evidence indicates this integration is on the rise. A majority of users (74 percent, on average) report they are taking IHI Open School courses for a required class or training, and Chapters — like the one at the University of California, San Francisco (UCSF) — are helping to get quality and safety into the curriculum. Last year, UCSF’s Departments of Medicine and Pharmacy co-sponsored a one-day elective, “Quality Improvement and Patient Safety: Introduction to the Principles,” that attracted over 120 students from the Schools of Medicine, Nursing, Pharmacy, and Dentistry.

“I’ve been involved in interprofessional activities since my first year and I’ve seen a pretty dramatic difference in just three years,” says Jennifer Samore, a UCSF pharmacy student and Chapter leader. “This year, for our fall weekly elective, we have basically 20 percent representation from all of the schools.”

Samore also attended the IHI Open School Student Leadership Academy in June. By featuring sessions led by world-class health care leaders and bringing together 75 students from different disciplines and geographic areas, the IHI Open School is responding to the growing need to develop leaders committed to becoming change agents in health care.
If you ask IHI Fellowship program alumni to name the most valuable part of their fellowship year, they tend to respond the way Anna Roth, CEO of Contra Costa Regional Medical Center and Health Centers in Martinez, California, does. “I was fundamentally changed by the experience, and so was my organization,” she recalls. “It’s hard to name just one thing.”

Every July, a group of mid-career professionals from the US and the UK arrive at IHI to spend a year immersing themselves in learning about health care improvement. With funding from the family of George W. Merck, the Health Foundation (UK), and Kaiser Permanente, the fellows plunge into projects, gain technical improvement skills, meet the world’s foremost improvement leaders, and tour innovative health care systems. When they return home, they often take on new leadership roles at work.

IHI Fellowship Director Joelle Baehrend reports that many of the 57 people who have passed through the program since 1998 discovered their own leadership potential. “They have more head space here because they aren’t doing their day-to-day jobs,” she contends. “They can think about the impact they really want to make, and they start to see things more globally.”

Malcolm Daniel, a consultant in anesthesia and intensive care at Glasgow Royal Infirmary in Scotland, says that, since he finished his fellowship, his colleagues have begun to see him as a resource for improving health care on a national scale. “I think much more about the bigger picture now,” he says. “Previously, I worked on improvement projects in my ICU. Now I think more about what I can do in my region and my country.”
A reporter once asked Jim Conway, former IHI Senior Vice President, if hospital boards could just “do something incremental” to improve safety.

Conway’s response was sharp. “So, how many people dying is okay with you?” he said. “How much harm is okay with you?”

That kind of straight talk is a hallmark of Conway’s work. For the past six years, Conway has traveled the world to bring patient voices into the design of health care and educate hospital boards about their role in improving safety.

“Jim has probably saved thousands of lives in the work he’s done,” said Maureen Bisognano, IHI’s President and CEO. Conway recently retired from IHI to spend more time with his family. He’ll also be serving as an adjunct lecturer at the Harvard School of Public Health, a board member for several local health care organizations, and a principal at the consulting firm Pascal Metrics.

Conway, who was Chief Operating Officer at the Dana-Farber Cancer Institute for ten years before coming to IHI in 2005, is widely seen as the nation’s leading champion of patient- and family-centered care. To honor this, IHI will be awarding an annual scholarship in Jim’s name to fund a patient and family advisor’s attendance at IHI’s National Forum.

Along with IHI faculty James Reinertsen and James Orlikoff, Conway has also helped redefine the work of hospital boards. “In the past, board meetings focused on finances — and maybe at the end, there would be a quality report,” said Bisognano. “Jim’s leadership has turned that around.”
One of the enduring lessons of IHI’s work over the past two decades has been the crucial importance of capable and effective governance. Organizational boards of directors are the stewards of our health care system and when a board is engaged and informed about quality of care, patients will benefit. In this area, IHI has been privileged to be led by its own remarkable board — a group of world-renowned leaders who volunteer their time to play a vital role in achieving IHI’s mission. Our board has always been defined by an unwavering commitment to knowledge and improvement. We are doubly lucky that many of our past board members continue to devote themselves by contributing to various Board Committees and projects. This growing network of luminaries, with an exceptional breadth of experience and wisdom, is at the heart of IHI’s effectiveness and success. We can never thank them enough.
A grateful team says thank you
HAVING THE IHI COMMUNITY TO TURN TO FOR ADVICE AND SUPPORT IS INVALUABLE AS I WORK TO FURTHER THE GOAL OF IMPROVING QUALITY AT MY INSTITUTION AND EMBEDDING QI IN MY MEDICAL SCHOOL CURRICULUM.

LAKSHMAN SWAMY, MD/MBA STUDENT, WRIGHT STATE UNIVERSITY