C2
From the Top: Engaging the Board in Quality and Safety

APAC Forum on Quality Improvement in Health Care
Auckland, NZ

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President and CEO
IHI

Making Sense of It All
Mid Staffordshire

Board Function **DOES** Affect Quality

Emerging research shows that boards can make an enormous difference in improving quality and patient safety.
The Four Leadership Questions

• Do you know how good you are?
• Do you know where you stand relative to the best?
• Do you know where the variation exists?
• Do you know the rate of improvement over time?

Boards on Board Plank

1. Setting aims
   — Set a specific aim to reduce harm this year.
   — Make an explicit, public commitment to measurable quality improvement.
**The IHI Triple Aim**

- **Health of a Population**
- **Experience of Care**
- **Per Capita Cost**

**Toyota Specifications: System Level**

<table>
<thead>
<tr>
<th>IOM Dimension of Care</th>
<th>Whole System Measure</th>
<th>Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered</td>
<td>Patient Experience Score [Response to the question in the How’s Your Health database, “They give me exactly the help I want (and need) exactly when I want (and need) it.”]</td>
<td>72% of Patients Report, “They give me exactly the help I want (and need) exactly when I want (and need) it.”¹⁵</td>
</tr>
<tr>
<td>Effective and Equitable</td>
<td>Functional Health Outcomes Score</td>
<td>5% of Adults Self-Rate Their Health Status as Fair or Poor¹⁶ [Self-rating will not differ by income]¹⁶</td>
</tr>
<tr>
<td>Efficient</td>
<td>Health Care Costs per Capita [Surrogate measure: Medicare Reimbursement per Enrollee]¹²</td>
<td>$3,150 per Capita per Year¹⁷ $5,026 per Enrollee¹¹</td>
</tr>
</tbody>
</table>
Overview of Whole System Measures

<table>
<thead>
<tr>
<th>Whole System Measure</th>
<th>Definition</th>
<th>Measurement Frequency</th>
<th>Measure Currently in WSM Testing Phase</th>
</tr>
</thead>
</table>
| 1. Rate of Adverse Events (AEs) | Inpatient: AEs per 1,000 Patient Days = \( \text{Total number of AEs} / \text{Total length of stay for all patient records reviewed} \) * 1,000  
Outpatient: Measure in testing phase | Monthly  
Monthly | No  
Yes |
| 2. Incidence of Nonfatal Occupational Injuries and Illnesses | (Number of injuries and illnesses / Total hours worked by all FTEs in a calendar year) * 200,000 | Monthly | No |
| 3. Hospital Standardized Mortality Ratio (HSMR) | (Observed deaths / Expected deaths) * 100 | Annually | No |
| 4. Unadjusted Raw Mortality Percentage | (Number of in-hospital deaths in acute care inpatient population / Number of acute care inpatient discharges) * 100 | Monthly | No |
| 5. Functional Health Outcomes Score: Inpatient and Outpatient | Physical Health Status and Mental Health Status, as measured by % Maximum Achievable Score for each | Monthly | Yes |
| 6. Hospital Readmission Percentage | (Number of discharged patients readmitted to the hospital within 30 days of their discharge / Number of patients discharged) * 100 | Monthly | Yes |

Patient Safety Alliance (PSA) Driver Diagram

**Primary Drivers**
- Scottish Government Sets PSA as Strategic Priority
- Boards Endorse Safety as Key Strategic Priority
- Deliver the programme
- Build a Sustainable Infrastructure for Improvement
- Align SPSP with national improvement programmes and measures

**Secondary Drivers**
- National leaders openly endorse SPSP aims, failure is not an option for execs
  - Time and space given for improvement (not a target)
  - Royal Colleges serve in official capacity
  - Safety is an element of all programmes
- National board development strategy
  - Ownership of agreed upon set of outcomes and measures
  - Quality and safety comprises 25% of agenda
  - Development of infrastructure that supports improvement and measurement
  - Clear improvement aims in strategic plan
- Segment hospitals, customize approach
  - Work with IST, QIS and HES to develop unified improvement approach
  - In-country support for Boards
  - Spread strategy community hosp., primary care One Team
- Develop experts in imp. methods and coaching
  - Safety work migrates to appropriate agency
  - Training programmes developed in Scotland
  - Work with IST, QIS and HES to develop unified improvement approach
- One Team
  - Align aims and measures with national programmes
  - Develop a portfolio and execution model
  - Build connection to safety in national work
  - Define within clinical governance framework
Compliance with Multi-disciplinary Rounds and Daily Goals

[Graph showing compliance data with key points at 74% and 93%]
ICU Mortality Reduction

24% improvement

Ascension Health

CareScience: Observed minus Expected Mortality Rate per 100 Discharges

Baseline
1.05 deaths avoided (Year 2)
1.06 deaths avoided (Year 1)
1.07 deaths avoided (Baseline Period)

Actual Monthly Difference  + 3σ (Center Line for Difference)  UCL  LCL
Boards on Board Plank

2. Getting data and hearing stories
   - Select and review progress toward safer care as the first agenda item at every board meeting.
   - Ground the work in transparency, putting a “human face” on harm data.
   - Engage with patients and families.
   - Tools: chart audit; case study of a specific case

One public hospital saved Gilbert’s life, and another one rebuilt it.
A world of possibility. Found in a world of good.

When Gilbert Selwa was accidentally shot 19 years ago, he was taken to Los Angeles County + USC Medical Center. There, at one of the largest trauma centers in California, doctors treated his injury and kept him alive.

But faced with spending the rest of his life in a wheelchair, Gilbert needed more than life-saving medical care; he also needed life-changing rehabilitation care. And that’s exactly what he found at Rancho Los Amigos National Rehabilitation Center in Downey. Doctors, nurses and therapists there gave him the confidence and the tools he needed to live a productive life, and Gilbert did the rest. Incredibly, Gilbert is now a member of Rancho’s staff, as Director of Patient-Centered Care.

Trauma care. Rehabilitation care. Loving care. We’re California’s public hospitals, and we’re here when you need us.
3. Establishing and monitoring system-level measures

- Identify a small group of organization-wide “roll-up” measures of patient safety.
- Continually update them.
- Make them transparent to the entire organization and all of its customers.

**Boards on Board Plank**

**Serious Safety Event Rate: One View**

Rolling 12-month Serious Safety Events expressed per 10,000 adjusted patient days

- SSER August 2008: 0.41
- Average Days between events:
  - 14 days (CY08 Sept YTD)
  - 19 days (CY07)
  - 37 days (CY06)
### Baseline SSER, Calendar Year 2008, 46 Events

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>John B.</td>
<td>9/6/2008</td>
<td>Delay in Dx</td>
</tr>
<tr>
<td>Shirley H.</td>
<td>12/23/08</td>
<td>Post Proced Death</td>
</tr>
<tr>
<td>Florita H.</td>
<td>7/3/2008</td>
<td>Delay in Tx</td>
</tr>
<tr>
<td>Wade W.</td>
<td>7/16/2008</td>
<td>Wrong Pt. Procedure</td>
</tr>
<tr>
<td>Baby Boy S.</td>
<td>8/1/2008</td>
<td>Delay in Dx</td>
</tr>
<tr>
<td>Joseph R.</td>
<td>9/6/2008</td>
<td>Delay in Dx</td>
</tr>
<tr>
<td>Tamika M</td>
<td>4/21/2008</td>
<td>Med Error</td>
</tr>
<tr>
<td>Andrea M.</td>
<td>6/4/2008</td>
<td>Wrong Procedure</td>
</tr>
<tr>
<td>Nancy H.</td>
<td>6/18/2008</td>
<td>Med Error</td>
</tr>
<tr>
<td>Jimmy P.</td>
<td>7/7/2008</td>
<td>Fall</td>
</tr>
<tr>
<td>Joann E.</td>
<td>9/23/2008</td>
<td>Wrong Site Surgery</td>
</tr>
<tr>
<td>Cynthia M.</td>
<td>10/27/2008</td>
<td>Med Error</td>
</tr>
<tr>
<td>Regina D.</td>
<td>12/9/2008</td>
<td>Wrong Site Surgery</td>
</tr>
<tr>
<td>Baby Girl V.</td>
<td>5/12/2008</td>
<td>Mother's Delay in Tx</td>
</tr>
<tr>
<td>Kyle W.</td>
<td>9/13/2008</td>
<td>Fall</td>
</tr>
<tr>
<td>Teodur C.</td>
<td>1/28/08, 2/12/2008</td>
<td>Delay in Tx</td>
</tr>
<tr>
<td>Alvin G.</td>
<td>8/17/2008</td>
<td>Fall</td>
</tr>
<tr>
<td>Nicole S.</td>
<td>1/4/2008</td>
<td>Delay in Dx</td>
</tr>
<tr>
<td>Margaret H.</td>
<td>2/6/2008</td>
<td>Med Error</td>
</tr>
<tr>
<td>Ursula H.</td>
<td>2/12/2008</td>
<td>Delay in Tx</td>
</tr>
<tr>
<td>Ms. L.</td>
<td>2/14/2008</td>
<td>Delay in Tx</td>
</tr>
<tr>
<td>Sandra M.</td>
<td>12/10/2008</td>
<td>Proced Cx/Delay in Tx</td>
</tr>
<tr>
<td>Karen G.</td>
<td>8/5/2008</td>
<td>Delay in Tx</td>
</tr>
<tr>
<td>Cynthia K.</td>
<td>11/10/2008</td>
<td>Delay in Tx</td>
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<tr>
<td>Lance D.</td>
<td>10/30/2008</td>
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<td>Robert S.</td>
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<td>Mary D.</td>
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<td>Baby Boy G.</td>
<td>3/25/2008</td>
<td>Med Error</td>
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<td>Lorena W.</td>
<td>11/10/2008</td>
<td>Post Procedure Death</td>
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<td>Priscilla W.</td>
<td>8/30/2008</td>
<td>Med Error</td>
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<td>Eugene B.</td>
<td>10/27/2008</td>
<td>Med Error, Fall</td>
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<td>Kathy W.</td>
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<td>Virginia L.</td>
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<tr>
<td>Helene C.</td>
<td>9/5/2008</td>
<td>Fall</td>
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<tr>
<td>Lester J.</td>
<td>9/5/2008</td>
<td>Fall</td>
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<tr>
<td>Chantal E.</td>
<td>6/28/2008</td>
<td>Fall</td>
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<tr>
<td>Gary B.</td>
<td>6/13/2008</td>
<td>Fall</td>
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<tr>
<td>Inapprop Touching</td>
<td></td>
<td>Fall</td>
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<tr>
<td>Sharenda W.</td>
<td>2/15/09</td>
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<tr>
<td>Loueene D.</td>
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<td>Fall</td>
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<td>Beverly S.</td>
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<tr>
<td>Robert D.</td>
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<td>Post Proced Death</td>
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<tr>
<td>Karen C.</td>
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<td>Delay in Treatment</td>
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<tr>
<td>Peggy P.</td>
<td>7/1/09</td>
<td>Burn</td>
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<tr>
<td>Edward R.</td>
<td>4/23/09</td>
<td>Wrong Side Procedure</td>
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<tr>
<td>Brenda R.</td>
<td>10/14/09</td>
<td>Delay In Treatment</td>
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<tr>
<td>James H.</td>
<td>10/25/09</td>
<td>Post Procedure Death</td>
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<tr>
<td>Lilliam C.</td>
<td>4/3/09</td>
<td>Retained foreign object</td>
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<tr>
<td>Dorothy R.</td>
<td>1/28/09</td>
<td>Delay in Treatment</td>
</tr>
<tr>
<td>Monroe K.</td>
<td>5/18/09</td>
<td>Post Procedure Death</td>
</tr>
<tr>
<td>Juanita A.</td>
<td>5/14/09</td>
<td>Delay In Treatment</td>
</tr>
<tr>
<td>Michael F.</td>
<td>8/20/09</td>
<td>Retained foreign object</td>
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<tr>
<td>Johnny B.</td>
<td>11/9/09</td>
<td>Fall</td>
</tr>
<tr>
<td>Willie B.</td>
<td>11/5/09</td>
<td>Med Error</td>
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<td>Helen C.</td>
<td>11/4/09</td>
<td>Delay In Treatment</td>
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<td>Yoland C.</td>
<td>7/7/09</td>
<td>Delay in Treatment</td>
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<tr>
<td>Alma M.</td>
<td>11/6/09</td>
<td>Fall</td>
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<td>Ronnie D.</td>
<td>11/3/09</td>
<td>Delay in Treatment</td>
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<td>Scott G.</td>
<td>9/5/09</td>
<td>Delay in Treatment</td>
</tr>
<tr>
<td>Donna S.</td>
<td>6/4/09</td>
<td>Retained foreign object</td>
</tr>
</tbody>
</table>

**47% Reduction SSER from Dec. 08 Baseline**

48% Reduction in # of events year to year
1 Event January - April 2010 vs 24 Total for 2009

Lois R.
4/16/10
Surgical Fire

Boards on Board Plank

4. Changing the environment, policies, and culture
   - Commit to establish and maintain an environment that is respectful, fair and just for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error.
One particular member of the senior executive team stands out, in our view, as a critical leverage point for large system change: the CFO.

- The connection between quality improvement and business performance is still weakly made in most health care organizations, but that is changing.

- CFOs are finding significant opportunities to improve patient care margins by reducing and eliminating error and clinical waste.
Make the Chief Financial Officer a Quality Champion

Examples:

- McLeod Regional Medical Center in South Carolina
  - eliminated 112 minutes of wasted nursing documentation time per cardiac patient, freeing up nurses to provide higher levels of quality and safety.

- Park Nicollet Health Services in Minnesota
  - By using lean techniques to manage flow, Park Nicollet now routinely processes 64 patients per day through the same endoscopy facility that once struggled to care for 30 to 32 patients per day, with less strain and effort on the part of nurses and physicians. Patients and staff are delighted, and $3 million in capital expenditures were avoided.

- ThedaCare in Wisconsin
  - ThedaCare has seen so much reduction in waste from their first couple of years of widespread application of the lean methodology that the CFO has built a long-range financial plan that does not require any price increases.

Engage Physicians

1. Discover Common Purpose:
   - 1.1 Improve patient outcomes
   - 1.2 Reduce hassles and wasted time
   - 1.3 Understand the organization’s culture
   - 1.4 Understand the legal opportunities and barriers

2. Reframe Values and Beliefs:
   - 2.1 Make physicians partners, not customers
   - 2.2 Promote both system and individual responsibility for quality

3. Segment the Engagement Plan:
   - 3.1 Use the 20/80 Rule
   - 3.2 Identify and activate champions
   - 3.3 Educate and inform structural leaders
   - 3.4 Develop project management skills
   - 3.5 Identify and work with “laggards”

6. Adopt an Engaging Style:
   - 6.1 Involves doctors from the beginning
   - 6.2 Work with the real leaders
   - 6.3 Work with early adopters
   - 6.4 Make physician involvement visible
   - 6.5 Build trust within each quality initiative
   - 6.6 Communicate candidly, often
   - 6.7 Value physicians’ time with your time

5. Show Courage:
   - 5.1 Provide backup all the way to the Board

4. Use “Engaging” Improvement Methods:
   - 4.1 Standardize what’s standardizable, and no more
   - 4.2 Generate light, not heat, with data
   - 4.3 Make the right thing easy to try
   - 4.4 Make the right thing easy to do

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Board on Board Plank

5. Learning
   — Starting with the board, develop your capability as a board.
   — Set an expectation for similar levels of education and training for all staff.

Photos of IHI WalkRounds
Photos of IHI WalkRounds

Build Improvement Capability

The list of capabilities required of senior leaders to drive system-level improvement is long, but includes at a minimum the ability to know, use, and teach the following:

- The Model for Improvement and small-scale rapid tests of change
- A coherent improvement strategy such as the Toyota Production System
- Concepts and practices of high-reliability organizations
- Sophisticated practices in flow management
- Concepts and practices of scale-up and spread of improvements
- Concepts and practices of safety systems
What Improvement Skills are Needed for Each Role?

**Experts**
- Setting direction and big goals
- Execution leadership
- Portfolio selection and management
- Managing oversight of improvement
- Being a champion and sponsor
- Understanding variation to lead
- Managing implementation and spread

**Operational Leaders**
- Setting goals and measures
- Identifying problems
- Mapping process
- Testing change
- Simple waste reduction
- Simple standardization
- Team behaviors

**Change Agents**
- Setting goals and measures
- Identifying problems
- Mapping process
- Testing change
- Simple waste reduction
- Simple standardization
- Team behaviors

**Everyone**
- Setting goals and measures
- Identifying problems
- Mapping process
- Testing change
- Simple waste reduction
- Simple standardization
- Team behaviors

On-boarding

**Develop and Test the System at a Facility level**

Wave III focuses on full deployment and execution and IV on expansion and continuous improvement

February 2008
- 3 Regions
- 6 Improvement Advisors (Medical Center)
- 3 Faculty Mentors (Internal and external)
- Front line staff RIM
- Middle managers PSU
- Reliable design

September 2008
- 5 regions
- 80 Improvement Advisors (Medical Center)
- 11 Faculty Mentors (KP)
- 4 Regional mentor students
- 300 operations managers
- 3,500 Front line RIM+ staff
- Middle manager PSU
- Reliable design

June 2009
- 7 regions
- 150 Improvement Advisors (Medical center, regional, national)
- 12 Faculty Mentors (KP)
- 1000+ Operations managers
- 10,000 Front line RIM+ staff
- Middle manager PSU
- Reliable design

Waves of Improvement Institute

Complete
A Logical Path of Development

1-2 Weeks 6 -12 months 2 years

On-boarding Initial Deployment Expansion Continuous Improvement

Phase BEGINS When...
- National and regional sponsorship commits funding and charters program
- Begins when Mentor deploys to region, which varies on a by region basis
- Regional leadership team identifies the next wave of projects and IA candidates
- Reassessment of processes is ongoing

Starts during Expansion

Phase CONCLUDES When...
- The original 10 Mentors are hired
- Caveat: IA on boarding occurs with each deployment wave, this phase repeats itself
- The first wave of projects is completed within the region
- Organization capabilities are self perpetuating
- Reassessment of processes is ongoing
- Never concludes

End Goal

Hallmarks include:
- Cross site, regional comparisons
- Employ stretch performance goals
- Yearly budget reductions
- Tangible cultural changes (ie, cascading performance contracts)
- Impact metrics
- Organizational capability
- Total value

Board on Board Plank

6. Establishing executive accountability
   —Oversee the effective execution of a plan to achieve your aims to reduce harm.
   —Include executive team accountability for clear quality improvement targets.
To do things differently, we must see things differently. When we see things we haven’t noticed before, we can ask questions we didn’t know to ask before.

John Kelsch, Xerox

Quality Health Care In America Project