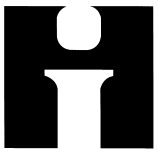

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Reducing Harm to Patients

Using patient safety dashboards at the board level.

As momentum grows across the country for the 5 Million Lives Campaign, board members of hospitals and healthcare systems frequently ask us how they can help or become more involved. We believe it is critically important for boards to set clear expectations and goals for reducing harm to patients and to monitor progress against those goals.

In the Institute for Healthcare Improvement's (IHI) white paper, "Seven Leadership Leverage Points," we hypothesize the first leverage point for driving change is for the board to adopt an aim for improving a few whole-system measures—an enterprise-level set of performance measures sometimes called the "Big Dots"—which the governing board uses to measure overall performance, align incentives and measure the effectiveness of strategies. Big Dot aims are chosen in a balanced set of performance dimensions, such as clinical quality, patient satisfaction, financial performance and organizational effectiveness, and are often presented as a "dashboard" or "balanced scorecard." A typical clinical quality Big Dot aim for hospitals could be "reduce our inpatient mortality rate by 20 percent within two years." With respect to clinical harm and the 5 Million Lives Campaign, a Big Dot aim might be "reduce the likelihood of harm to our patients as measured by the IHI Global Trigger Tool by 50 percent within three years." (*Seven Leadership Leverage Points* and *IHI Global Trigger Tool for Measuring Adverse Events* available at www.IHI.org)

When establishing dashboards, it is important for boards to keep focused on the achievement of whole-system improvement. Most hospital boards routinely see dozens of detailed clinical and improvement measures—Small Dots, if you will—presented to a board quality committee and then forwarded on to the full board in the form of a committee report. While we applaud the increasing transparency of clinical quality data and improvement efforts, Big Dot aims and measures are often lost in the mix of these quality control measures, core measures, improvement project measures and other quality metrics. And because of the sheer volume and complexity of the measures presented in many board committees, time for discussion and hard questions becomes limited. Committees often morph into a nondeliberative report receipt and oversight role, rather than being an active participant in setting the quality and patient safety agenda for the organization.

We believe there is a need for boards to establish a more specific focus with respect to reducing harm to patients above and beyond simple inclusion in the quality report as one of multiple clinical improvement efforts. One idea to create greater focus at the board level is to rethink how quality information is organized and presented to the board and its committees. Hospital management teams should consider breaking down the quality and clinical information they present to the board into a series of logical dashboards. For instance, separate dashboards could easily be created for the following:

- Quality control (measures being tracked for compliance, accreditation or regulatory requirements but for which no active improvement efforts are ongoing)
- Patient safety (falls, complication rates for surgical procedures, adverse drug events and pressure ulcers)
- Improvement projects (core measures, flow projects, patient satisfaction projects or other specific improvement projects)
- And of course, the overall system-level measures, the Big Dots

Another approach is to separate dashboards into two types, reflecting the two questions boards tend to ask: "How do we compare to other hospitals like ours?" and "Are we getting better?" The dashboard needed to answer the first question must be risk-adjusted and often requires extensive processing, which delays getting data by months or even years. The measures needed to answer the second question can be answered with relatively simple, nonrisk-adjusted, close-to real-time measures, often presented as run charts. For example, a simple tracking of the number of new pressure ulcers incurred every month in the hospital, using a rigorous operational definition of "new pressure ulcer," would give a board a good indication of the answer to the question, "Are we getting better at reducing risk of pressure ulcers?" We believe the best boards are spending more and more time on the "Are ***we*** getting better?" question and less time comparing themselves to others.

A well-chosen set of patient safety/reducing harm aims and measures, put together as a dashboard, can drive a more substantive discussion at both board quality committees and full board meetings. (Note: good dashboards not only will show the measures, but also the specific targets for reducing harm and specific process measures linked to the organization's strategy or projects underway for reducing harm.) And when choosing targets or aims, boards and hospital management teams should avoid the trap of setting aims in reference to industry averages such as the "75th percentile" or other comparative data that might exist for some measures. If you consider for a moment the right target from a patient's perspective is zero harm, then the logical extension is the overall goal for patient safety and harm measures should be zero. There are hospitals now operating at zero levels on some harm measures. So the bar is set too low for harm measures if dashboards aim to achieve "75th percentile or better." Zero is the only acceptable aim for many of these indicators.

From a practical standpoint, however, hospitals won't get from current levels to zero overnight. It is, therefore, useful to set interim targets, and one useful method is the gap approach. In this

approach, the hospital sets an interim target to improve a safety indicator by 50 percent (e.g., reduce hospital-acquired infections by half) within a specific time frame (e.g., one year). When the initial target is achieved, then the hospital can use the approach of cutting the gap in half again by a certain date to set a new target. As improvement drives the actual number of incidents to the point where each individual incident can be analyzed, then tracking should transition from looking at a rate of incidence to tracking the actual number of incidents. Some hospitals are experimenting by measuring the number of calendar days between incidents, such as falls or ventilator-associated pneumonia, as another approach to tracking their ability to prevent harm.

Discussions about creating dashboards invariably migrate to the issue of format. Our bias is that simple is better, with key data presented in run charts and graphed over time. Many organizations spend an enormous amount of energy on developing comprehensive and complicated formats, sometimes losing the importance of content in the quest for one-page, eye-appealing, color-coded dashboards. While color coding can be helpful, boards and management need to consider the unintended consequences of using simple color coding to denote progress. In particular, color coding can be deceptive if tied to targets that have been inappropriately set too low. We have seen numerous scorecards and dashboards that are predominately green, indicating that targets are being met, but closer examination reveals that targets have been set at industry average or small incremental levels during past performance rather than significant improvement. For harm indicators, this means that boards can see "green" when significant amounts of harm are still occurring in the hospital. Sometimes it appears that the management objective has shifted from reducing harm to making sure the scorecard blinks green.

The purpose of creating a board-level patient safety and harm measures scorecard is to create a focal point for critical board discussion about the strategies and resources required to get results. Beyond reducing harm from a moral and ethical perspective, there is a strong business case for reducing harm in the current reimbursement environment, which will become even stronger under the proposed changes in the Medicare APDRG payment system.

Reducing harm is a critical strategic imperative for hospitals. A well-chosen dashboard of patient harm measures provides a tool for engaging the board in discussion about patient safety, helps ensure alignment of improvement projects, and lends support for resource allocation decisions to get meaningful, measured results for our patients. ▲

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