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## IHI Calls on Boards to Lead on Quality and Safety

*An Interview with Jim Conway, Senior Vice President,  
Institute for Healthcare Improvement*

By Elaine Zablocki

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**When hospitals in the 100,000 Lives Campaign, through their work on multiple improvement initiatives, exceeded their goal by more than 20 percent, what did they do for an encore?**

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For the Institute for Healthcare Improvement, Cambridge, MA, the answer is to up the ante.

In December, IHI announced a national campaign to dramatically reduce incidents of medical harm in U.S. hospitals. The 5 Million Lives Campaign hopes to enroll 4000 hospitals to protect patients from five million incidents of medical harm over a 24-month period (December 2006 to December 2008). It targets a dozen specific interventions and goals (see sidebar).

Most of the initiatives address patient care, but for the first time, IHI is emphasizing a non-clinical goal:

Get boards on board by defining and spreading the best-known leveraged processes for hospital boards of directors, so they can become far more effective in accelerating organizational progress toward safe care.

Measurable indicators:

Boards in all hospitals will spend at least 25% of their meeting time on quality and safety issues.

Boards will have a conversation with at least one patient (or family member of a patient) who sustained serious harm at their institution within the last year.

“When you look at the literature on change, it’s clear that engaged leadership always plays an essential role,” says Jim Conway, an IHI senior vice president actively involved in governance leadership for IHI and with the 5 Million Lives Campaign. “When I began working with IHI, I had an opportunity to visit many hospitals, and I heard over and over again that governing boards face increased expectations today, and find themselves ill-trained to perform their new roles.”

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Great Boards editor Elaine Zablocki interviewed Conway about the specific steps hospital boards are taking now to engage more effectively in leadership on quality and safety issues.

**Q.** The 5 Million Lives Campaign encourages boards to set specific targets for reducing unnecessary mortality and harm, and to make an explicit, public commitment to measurable quality improvement. Why is this important?

**A.** You need to decide what you want to be. What defines a good year for you? You might decide that by 2010 you want to be the safest public hospital system in the country.

**Q.** Actually, that strikes me as an intimidating goal. Couldn't the hospital do something incremental? Couldn't it review the dozen IHI goals and decide to focus on three or four of them?

**A.** So, how many people dying is okay with you? How much harm is okay with you?

The Ascension Health System, which has 74 hospitals, set a goal a few years ago that by July 2008 they would eliminate all preventable errors within

their system. Talk about big, hairy, audacious goals!

When a system sets a goal like that, the first thing we notice is that everybody in their system is aware of it. Secondly, we see spectacular levels of improvement in that system.

When you work on quality improvement, you notice that a goal of making something 5 percent better doesn't get anyone excited. When you say you want to make it 50 percent better, everyone says, "oh God, this is really going to change the way we do things." We've learned that in fact it is easier – it's certainly more disruptive, but it's also easier – to focus and engage people around substantial goals. You absolutely need to set specific aims, and those aims should be a stretch for you.

Research tells us that when we pull 100 charts at a typical U.S. hospital, we'll find 40 instances of harm. The best we've seen anywhere is 20 instances in 100 charts. There are hospitals with 120 examples of harm in 100 charts. The reason for pushing this goal is, even if you do improve 50 percent, there are still people going home who've experienced avoidable harm, suffering, tragedy, at your hospital.

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## 5 Million Lives Campaign Targets Twelve Interventions

During the Institute for Healthcare Improvement's 100,000 Lives Campaign, 3,100 participating hospitals reduced inpatient deaths by about 122,000 over an 18-month period through overall improvements in care, including improvements associated with six interventions recommended by the IHI initiative.

Now, IHI has launched an even more ambitious effort. The 5 Million Lives campaign continues working to save lives through six interventions from the first campaign, and aims to prevent avoidable injuries through six additional interventions.

### Six interventions from the 100,000 Lives Campaign:

- ◆ Deploy rapid response teams at the first sign of patient decline.
- ◆ Deliver reliable, evidence-based care for acute myocardial infarction to prevent deaths from heart attack.
- ◆ Prevent adverse drug events (ADEs) by implementing medication reconciliation.
- ◆ Prevent central line infections by implementing a series of interdependent, scientifically grounded steps.
- ◆ Prevent surgical site infections by reliably delivering the correct perioperative antibiotics at the proper time.
- ◆ Prevent ventilator-associated pneumonia by implementing a series of interdependent, scientifically grounded steps.

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“Engaged leadership always plays an essential role.”

**Q.** The campaign goal is that hospital boards will spend at least 25% of their meeting time on quality and safety issues. You suggest they should gather data on harms and potential harms, and listen to detailed, specific stories about harm that has occurred in their hospital.

**A.** While our formal goal is that at every meeting the board should spend 25 percent of its time on quality and safety issues, Children’s Hospital in Cincinnati spends 60 percent of its board time on these issues.

This is an effort to put a “human face” on the data. You hear about a grandmother who was going home; she slipped and fell, and died at the hospital.

She never saw her grandchildren again. You listen to what the statistics *mean*.

We suggest that the CEO should investigate the story behind an important medical error, interviewing patient, family, and staff. At a minimum, the CEO should tell the story in detail at a board meeting. Ideally, you bring in the patient, family and staff. I was present at a board meeting at an academic center, where the staff associated with a medical error told their story to the board. It was difficult. It was deeply emotional. But out of that presentation, the board reached an extraordinary resolve to put more focus on this area.

“This is an effort to put a ‘human face’ on the data.”

What this is about is confronting the reality. You’ve set your aim, now you look at your data. Peter Senge, in *The Fifth Discipline*, introduced the notion of creative tension. He says, “first you set your vision, then you confront your

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### Six additional interventions to prevent harm:

- ◆ Prevent harm from high-alert medications, starting with a focus on anticoagulants, sedatives, narcotics, and insulin.
- ◆ Reduce surgical complications by reliably implementing all of the changes in care recommended by SCIP, the Surgical Care Improvement Project ([www.medqic.org/scip](http://www.medqic.org/scip)).
- ◆ Prevent pressure ulcers by reliably using science-based guidelines for their prevention.
- ◆ Reduce methicillin-resistant staphylococcus aureus (MRSA) infection by reliably implementing scientifically proven infection control practices.
- ◆ Deliver reliable, evidence-based care for congestive heart failure, to avoid readmissions.
- ◆ Get boards on board by defining and spreading the best-known leveraged processes for hospital boards of directors, so they can become far more effective in accelerating organizational progress toward safe care.

**For more information** on how the Campaign defines medical harm see the FAQs tab in the Campaign area of IHI.org at <http://www.ihl.org/IHI/Programs/Campaign/Campaign.htm?TabId=6>.

reality; out of that will come the tension for change.”

We also suggest that the board talk about quality as the first item on its agenda. There is nothing that’s more important. This conversation should not be cut short due to lack of time.

**Q.** It isn’t an easy conversation. I can picture boards putting it off.

**A.** It is hard. As the chief operating officer at Dana-Farber Cancer Institute, every two

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months I had to tell the board stories of the patients we had hurt since their last meeting. That's absolutely hard. You don't present a single case in great detail at every meeting, but at each meeting you should talk about the patients who've suffered and/or died. At each meeting, you review your progress towards improved care.

**Q.** Before we leave this topic, what does the hospital legal department say when management and staff stand up at a board meeting to discuss in detail how things went wrong? Doesn't this increase the hospital's legal liability?

**A.** As we look at other industries, we observe that the only risk greater than disclosure is to know something and not disclose it. Think about WorldCom, about Enron, about Bridgestone Tire. When you try to cover up problems, you're dead in the water. We are also learning that errors don't erode trust (people know they happen). What erodes trust is what you do after the error.

"Errors don't erode trust (people know they happen). What erodes trust is what you do after the error."

**Q.** You encourage hospitals to establish and monitor a small number of organization-wide "roll-up" measures such as medical harm per 1,000 patient days or risk-adjusted mortality rates over time. They should be continually updated and transparent to the entire organization and its customers. Why should they do this?

**A.** When you walk into a hospital these days, everyone's gathering data on hundreds of items, to meet regulatory requirements and national patient safety goals and so on. You could be doing a hundred things without actually knowing whether care is getting better or worse. We're saying organizations should closely monitor their overall mortality and morbidity. You should monitor organization-wide harm. If you're unbelievably busy, and you're doing a thousand things, and that line isn't moving, that tells you you're not focused on the aspects of your system that actually create harm, suffering and waste.

Sometimes I look at a quality dashboard, and the trustees say to me, "Jim, I see so much I don't know what I'm seeing. There's too much information." Recently I helped review a hospital whose dashboard was a sea of green. It was comparing itself to standard external measures. We said, "we want to know how you're doing on the issues you're losing sleep over."

"How many people dying is okay with you? How much harm is okay with you?"

**Q.** Are you saying a dashboard ought to have some red or orange markers, because those will be the issues you're working on?

**A.** Yes. You have to push yourself. In the best hospitals, if we get things right 80 or 90 percent of the time, we think we're doing great. In fact, we need to look at the 10 to 20 percent of patients who aren't getting the care they need.

It's a real temptation to sit down with your board and present good statistics. You want to tell them everything's wonderful. Then something happens. Let's say the failure of your systems kills a patient, and the regulatory agencies come

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in. At Dana-Farber a patient died from to a chemotherapy overdose, just before I was hired. I recall how the board chair said to me, “never again will we be duped.”

It happens in other organizations; it’s happening now. The board of trustees thinks there are no problems, because no one wants to tell them the difficult truth. Governing boards today are held accountable for the quality of care and services by everybody from Standard and Poor’s to the IRS. They have to hear the truth.

**Q.** Are any hospitals already taking the steps you’ve described?

**A.** There are many. MemorialCare Medical Centers, in southern California, has developed a series of system-wide “bold goals” linked directly to their overall strategic plan. Their system board has issued specific “what-by-when” aims in five key areas. By June 2007, they aim to reduce inpatient mortality by 15 percent and avoidable infections by 50 percent. They expect to see complete adherence

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to all evidence-based protocols for acute heart attacks, heart failure, and community-acquired pneumonia, 95 percent of the time. They intend to reduce codes outside intensive care units by 50 percent.

Cambridge Health Alliance (CHA), in Massachusetts, has been reporting performance metrics for years as part of its balanced scorecard, including data on adverse drug events, heart attack care, and patient satisfaction. Now the board is requesting explicit, detailed information on safety-related issues, including patient complaints, readmissions and staff injuries. The board has set a specific goal of eliminating all “never events” such as wrong-site surgery, mismatched blood transfusions, and severe bed-sores.

At Virginia Mason Medical Center, in Seattle, the board quality oversight committee oversees situations where patients could potentially have been harmed. At each monthly meeting the committee reviews a dozen minor or moderate incidents, and focuses in detail on one or two situations where there was a strong likelihood of harm, or actual harm occurred. The hospital doesn’t consider these more serious incidents resolved until all committee members have signed off on their root causes and remedies.

**For more information:**

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Elaine Zablocki, editor of Great Boards, is a freelance healthcare journalist whose work has appeared in Physician Practice, Internal Medicine News, Medicine on the Net, and numerous other publications.