How good is your hospital or healthcare organization?
How Good…?

- What is the right number of medication errors if you are the patient?
- How many infections would you like to take home with you from your hospital stay?
- How do you explain to your mother that it is perfectly normal and acceptable to spend 8 hours in the ED?
- Why is it ok to discharge a patient from the ED without any real arrangements made for follow-up care?

Are we seeing all the harm? Inpatient Surgical Record Review of 854 patients in 11 US hospitals…

- Found 14.6% of patients had a Surgical Adverse Event (SAE)
- 44% of SAEs caused increase LOS or readmit
- 8.7% required life-saving intervention or resulted in permanent harm or death
- “…Most of the events identified by Trigger Tool review had not been detected or reported via any other existing mechanism.”
Global Trigger Tool shows that adverse events in hospitals may be ten times greater than previously measured

“This study compared three methods to detect adverse events in hospitalized patients, using the same patient sample set from three hospitals: voluntary reporting, the Agency for Healthcare Research and Quality's Patient Safety Indicators, and the IHI Global Trigger Tool. The IHI Global Trigger Tool found at least ten times more confirmed, serious events than these other methods. The authors submit that reliance on voluntary reporting and Patient Safety Indicators could produce misleading conclusions about the current safety of US health care and misdirect safety improvement efforts.”


Basic Board Responsibilities

- Set and periodically review the mission, values and goals
- The only employee who reports to the board is the CEO. The board must hire, fire and evaluate his/her performance.
- The board ensures the quality of patient care.
  - The board ensures the organization’s financial performance.
  - The board has shared responsibility for the health of their community.
  - The board must assume responsibility for itself.

Two Key Truths About Boards

- As a general rule, boards think quality is a lot better than the administrators, doctors, and nurses do.
  - “But you never told us in a way we could understand it.”
- Boards make a big difference in quality
  - 25% time, interaction with medical staff, CEO compensation…

Board Dashboards and Scorecards

- The most common question boards ask about dashboards: “What should be on it?”
- Our response:
  - What is your aim?
  - How do you intend to use the data?
A Place to Start Thinking About Quality Aims

Don’t hurt me
Help me
Be Nice to Me

Don Berwick, MD

IHI Triple AIM

Define “Quality’ from the perspective of an individual member of a defined population

- Core organizational strategy
- Success is “Leadership Dependent”
The Role of the Board in Quality and Safety

Quality Aims

- **Quality:** Deliver everything that will help, and only what will help. The goal is 100%
- **Safety:** Do no harm. The goal is 0 Events

A Health Care System’s Core Work

- **Inputs**
  - Patients
  - Staff
  - Supplies
  - Equipment
  - Facilities

- **Care Processes**
  - Diagnosing
  - Treating
  - Explaining
  - Teaching
  - Monitoring
  - Documenting

- **Outputs**
  - Care Outcomes
  - Harm Rate
  - Patient Satisfaction
  - Cost per Case

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The Role of the Board in Quality and Safety

How This Looks to Many Board Members

Inputs
- Patients
- Staff
- Supplies
- Equipment
- Facilities

Care Processes
- Diagnosing
- Treating
- Explaining
- Teaching
- Monitoring
- Documenting

Outputs
- Care Outcomes
- Harm Rate
- Patient Satisfaction
- Cost per Case

What Is this Award Winning Hospital Perfectly Designed to Produce?

- Outcomes/System-level Measures
  - Excellent patient experience
    - 95% willingness to recommend
  - Risk-adjusted inpatient mortality rates that track with US “average”
    - 30-day AMI mortality is 13.0% (better than the US average 16.6%)
  - Low overall costs of care for Medicare population
    - 30-day readmission rates for AMI (16.9%) and CHF (19.5%) better than US norms

4/13/2012
But It Is Also Designed to Produce…

- Safety events each year
  - 6 sentinel events
  - 12 deaths associated with "occurrences"
  - 9 permanent injuries associated with "occurrences"
  - 12 CLAB infections 10 VAP
  - 40-50 MRSA infections (12 in Q4 2009)
  - ~100 CA-UTI
  - 32 surgical "occurrences" (2 deaths, 2 sentinel events, 6 temporary harms)

- Process measures: all or none
  - 9% defect rates in CHF care
  - 5% defect rates in pneumonia care
  - 1% defect rate in AMI care
  - 4% defect rates in SCIP measures

Seven Leadership Leverage Points*

- Set measured system-level aims and oversee at the Board level
- Align aims, measures and strategies in a leadership learning system
- Channel leadership attention to aims
- Get the right team engaged, including the patient
- Engage the CFO in this work
- Engage with physicians
- Build deep improvement capability

*ihi.org White Paper: Reinertsen, Pugh and Bisognano, 2009
Is Your Board Dashboard/Scorecard Confusing?

- Too many measures?
- Trying to answer two questions at once?
  - How do we compare to others?
  - Are we on track to achieve our quality aims?
- Columns of numbers instead of graphs?
- Color coding—everything is green?
- Look like eye charts?

How to Measure Harm

- Try to eliminate the denominator…
  - You don’t need denominators to compare yourself to yourself, over time
  - Denominators are often part of the problem (ADEs per 1000 doses, SSEs per 1000 patient days)
- “Rates” make the problem abstract, rather than personal
What makes more sense… if the right answer is 0?

<table>
<thead>
<tr>
<th>Traditional Display (Rates)</th>
<th>Actual Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>.005 ADEs /1000 doses</td>
<td>35 ADEs last month</td>
</tr>
<tr>
<td>2.67 infections/1000 patient days</td>
<td>220 hospital acquired infections last quarter</td>
</tr>
<tr>
<td>.003 Falls with harm per/1000 patient days</td>
<td>65 Patient falls—16 with harm last month</td>
</tr>
</tbody>
</table>

Risk Management Report?

<table>
<thead>
<tr>
<th>Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>488</td>
</tr>
<tr>
<td>Medication Error</td>
<td>725</td>
</tr>
<tr>
<td>Readmission for proc/surgery site infection</td>
<td>11</td>
</tr>
<tr>
<td>Birth Injury</td>
<td>9</td>
</tr>
<tr>
<td>Difficult Delivery</td>
<td>42</td>
</tr>
<tr>
<td>Fetal Resuscitation</td>
<td>47</td>
</tr>
<tr>
<td>Maternal transfer to critical care</td>
<td>3</td>
</tr>
<tr>
<td>Delay in diagnosis</td>
<td>456</td>
</tr>
<tr>
<td>Delay in treatment</td>
<td>291</td>
</tr>
<tr>
<td>Mislabeled labs</td>
<td>327</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>3</td>
</tr>
<tr>
<td>Trauma to healthy tissue</td>
<td>117</td>
</tr>
<tr>
<td>Pressure sore</td>
<td>79</td>
</tr>
<tr>
<td>Complications during surgery</td>
<td>56</td>
</tr>
<tr>
<td>Return to OR</td>
<td>79</td>
</tr>
<tr>
<td>Unexpected change in condition</td>
<td>101</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2834</strong></td>
</tr>
</tbody>
</table>
Put a face on the data
The Role of the Board in Quality and Safety

24 Patients & Events – CY 2012 vs 46 Total for 2010

Louenee D. 9/23/09 Fall
Beverly S. 2/4/09 Med Error
Robert D. 5/12/09 Post Procedure Death
Karen C. 9/28/09 Delay in Treatment
Peggy P. 7/1/09 Burn
Sharenda W. 2/15/09 Med Error
Edward R. 4/23/09 Wrong Side Procedure
Brenda R. 10/14/09 Delay in Treatment
James H. 10/25/09 Post Procedure Death
Lilliam C. 4/3/09 Retained foreign object

Dorothy R. 1/28/09 Delay in Treatment
Monroe K. 5/18/09 Post Procedure Death
Juanita A. 5/14/09 Delay in Treatment
Michael F. 8/20/09 Retained foreign object
Jerry Y. 11/7/09 Fall
Johnny B. 11/9/09 Fall
Willie B. 11/8/09 Med Error

47% Reduction SSER from Dec. 08 Baseline
48% Reduction in # of events year to year

Yoland C. 7/7/09 Delay in Treatment
Scott G. 9/5/09 Delay in Treatment
Yolanda C. 7/7/09 Delay in Treatment
Alma M. 11/6/09 Fall
Pauline M. 11/2/09 Fall

Used with Permission IHI 2012

A 78% reduction through Nov. 2013

Lois R. 4/16/10 Surgical Fire
Mary B. 5/22/10 Post Procedure Cx
Lamar A. 6/3/10 Med Error
Bruce C. 5/25/10 Delay In Dx
Marilyn C. 1/21/10 Med Error

Sylvia L. 3/31/10 Delay In Dx
Frank S. 2/22/10 Surgery Cx
Ruby B. 5/30/10 Fall
Doyle L. 7/22/10 Med Error

Used with Permission IHI 2012
The Role of the Board in Quality and Safety

Color Coded Dashboards Only As Good As Your Targets

- Simple, and sometimes too simple
- Color coding without numbers can mislead
- Tendency is to assume that only the “red” blocks need attention
- If used, boards need to frequently ask how the targets are set

The Case For All-or-None Measurement

Governance Question: “What % of Patients Got the Right Care?”

Report to the Board Quality Committee

“Our MI Core Indicators were greatly improved last quarter. Only one measure requires corrective action.”

<table>
<thead>
<tr>
<th>Evidence-Based Care Measure</th>
<th>EBC Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBC 1</td>
<td>80%</td>
</tr>
<tr>
<td>EBC 2</td>
<td>100%</td>
</tr>
<tr>
<td>EBC 3</td>
<td>100%</td>
</tr>
<tr>
<td>EBC 4</td>
<td>60%</td>
</tr>
<tr>
<td>EBC 5</td>
<td>80%</td>
</tr>
<tr>
<td>EBC 6</td>
<td>90%</td>
</tr>
</tbody>
</table>
The Role of the Board in Quality and Safety

### The Case For All-or-None Measures
Only 30% of Patients Received the Right Care*

<table>
<thead>
<tr>
<th>EBC 1</th>
<th>EBC 2</th>
<th>EBC 3</th>
<th>EBC 4</th>
<th>EBC 5</th>
<th>EBC 6</th>
<th>Total</th>
<th>EBC Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient 10</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per Patient Totals</th>
<th>6</th>
<th>6</th>
<th>4</th>
<th>5</th>
<th>5</th>
<th>6</th>
<th>4</th>
<th>6</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Care Elements Received by Patient</td>
<td>83%</td>
<td>100%</td>
<td>67%</td>
<td>83%</td>
<td>83%</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>83%</td>
</tr>
</tbody>
</table>

*Right Care defined as receiving all of the required EBC elements (based on clinical eligibility)

### The Case for Measuring Against Standards/Expectations

- **Door to Intervention time** proven to be critical to Heart Attack outcomes
- **Standard**=30 minutes from presentation to (Thrombolytics or 90 minutes to Angioplasty)

**Great Report or Not?**

- **Quality Committee Report**
  - “Our data indicates that we are exceeding the national standard. Our average time for thrombolytics is 29.5 minutes.”
Not: What about the 25% of patients with delayed care?

![Door to Therapy-MI chart](image)

**Door to Therapy-MI**

- Average = 29.5 Minutes
- 30 Minute Standard
- 25% of All Patients Beyond the Standard

What Might Be On the Hospital Board’s **Balanced Scorecard**?

*Board performance measures should at minimum include expected aims and results for:*

- Employee Satisfaction or Engagement
- Operating Margin %
- Cost per Discharge
- Days Cash on Hand
- Waiting Time/Access Measure
- New: Triple Aim Measures
- Mortality Rate
- Re-admission Rate
- Patient Experience
- % of Patients Receiving Care According to the Evidence
- Number of Patient Harm Events
Current Measurement Systems

- Current system is silo-specific:
  - Site-, provider-, payer-, disease-
  - Hospital care measures
  - HEDIS preventive measures
- Measurement areas are important, however, they do not measure integrated and accountable care

Three Dimensions of Value

- Population Health
- Experience of Care
- Per Capita Cost
Future of Quality Measurement must Integrate

- Outcomes that matter to patients
- Processes/experiences
- Service
- Costs
- Think episodically and comprehensively
- Think “Triple Aim”

Potential Triple Aim Measures: Population Health

- Health outcomes
  - Mortality: Years of potential life lost; Life expectancy; Standardized mortality rates
  - Health/functional status: Single question (e.g. from CDC HRQOL-4) or multi domain (e.g., SF-12)
  - Healthy life expectancy (HLE): Combines life expectancy and health status into a single measure, reflecting remaining years of life in good health
- Disease burden
  - Incidence and/or prevalence of major chronic conditions
- Risk status
  - Behavioral: Smoking, alcohol, physical activity, diet
  - Physiological: Blood pressure, BMI, cholesterol, blood glucose
Potential Triple Aim Measures: Experience of Care

- Standard questions from patient surveys
  - Global questions from US CAHPS or How’s Your Health
  - Experience questions from NHS World Class Commissioning or Care Quality Commission
  - Likelihood to recommend
- Set of measures based on key dimensions (e.g., US IOM Quality Chasm Aims: Safe, effective, timely, efficient, equitable, and patient-centered)

Potential Triple Aim Measures: Per Capita Cost

- Total cost per member of the population per month
- Hospital and ED utilization rate and/or cost
- Medicare cost per beneficiary
- Total cost of care
### Patient-reported Outcomes

- **Definition:** Any report of the status of a patient’s health condition that comes directly from the patient, without interpretation of the patient’s response by a clinician or anyone else.
- **PRO tools:** Measure what patients are able to do and how they feel by asking questions.
  - Enable assessment of patient-reported health status for physical, mental, and social well-being.
- **A wide variety of patient-level instruments to measure PROs:**
  - Examples: How’s Your Health, SF-36, CDC HRQOL, PROMIS.

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### Dashboards

- “Findings…dashboards are generally used to create general awareness rather than used to guide operations and performance management…Greater hospital quality was linked to shorter, more focused dashboards, active use of dashboards for operations management, and strong influence of board quality committees in dashboard content and implementation.”

  Kroch et al., Journal of Patient Safety 2 (1) 10-19, March 2006
### Boards Often Find It Useful to Employ Two Types of Dashboards

<table>
<thead>
<tr>
<th><strong>Comparison Dashboard</strong></th>
<th><strong>Strategic Dashboard</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- How do we compare to…</td>
<td>- Are we on track to achieve our aims?</td>
</tr>
<tr>
<td>- Other hospitals?</td>
<td>- Reduce harm</td>
</tr>
<tr>
<td>- Regulatory standards?</td>
<td>- Improve outcomes</td>
</tr>
<tr>
<td>- Benchmarks?</td>
<td>- Improve satisfaction</td>
</tr>
<tr>
<td>- P4P measures?</td>
<td>- Reduce costs</td>
</tr>
<tr>
<td>- Hundreds of measures</td>
<td>- Grow</td>
</tr>
<tr>
<td>- Processes</td>
<td>- A few key measures</td>
</tr>
<tr>
<td>- Measures are typically</td>
<td>- Outcomes, Drivers</td>
</tr>
<tr>
<td>- risk-adjusted</td>
<td>- Measures are typically</td>
</tr>
<tr>
<td>- apples to apples (rates per procedure e.g.)</td>
<td>- Close to real time</td>
</tr>
<tr>
<td>- slow</td>
<td>- “Good enough”</td>
</tr>
</tbody>
</table>

The Strategic Dashboard Answers the Questions

- Are we on track to achieve our aims?
- Is our strategy working?
- To answer these questions…
  - The board dashboard should parallel the organization’s aims
  - The measures should be weekly or monthly, real time, and displayed as run charts.
  - Measures do not necessarily need to be risk adjusted, or displayed as rates. You can eliminate the denominator in many instances.
  - Management and the board should review the key system-level measures at every meeting.
What questions did the Board ask of management and medical staff leaders at this meeting?

229 Infections Avoided Thus Far!
2011 Midwest Health System Board Quality Dashboard

<table>
<thead>
<tr>
<th></th>
<th>FY 2010</th>
<th>20%</th>
<th>FY 2011</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mortalities</td>
<td>1,254</td>
<td>251</td>
<td>1,003</td>
<td></td>
</tr>
<tr>
<td>Inpatient All-Cause Readmissions</td>
<td>10,392</td>
<td>2,078</td>
<td>8,314</td>
<td></td>
</tr>
<tr>
<td>Harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related to Medical Management</td>
<td>679</td>
<td>136</td>
<td>543</td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Infections</td>
<td>1,549</td>
<td>310</td>
<td>1,239</td>
<td></td>
</tr>
<tr>
<td>Related to Patient Care</td>
<td>905</td>
<td>181</td>
<td>724</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>3</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3,147</td>
<td>629</td>
<td>2,518</td>
<td></td>
</tr>
<tr>
<td>Sentinel Events</td>
<td>162</td>
<td>32</td>
<td>130</td>
<td></td>
</tr>
<tr>
<td>with harm</td>
<td>75</td>
<td>15</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Perfect Care</td>
<td>81%</td>
<td>16</td>
<td>97%</td>
<td></td>
</tr>
</tbody>
</table>

2011 Midwest Health System Board Detail Report

- Status: Steady Improvement

Hospital Acquired Conditions (All)

- Current Focus
  - Infections and Falls
Linking Strategy and Execution

- Leverage Point 2:
  Build an executable strategy to achieve the aims, and oversee the execution at the highest levels of administration

- One of the biggest disconnects in hospitals is that quality efforts are often not aligned with overall aims and strategy

- It might be a good project, but will it help move the Dots?

Tracking is not enough…

- It’s not enough to have a dashboard that tracks your system-level aims and drivers.

- If you are to achieve your goals, the board and senior management must review the key data on big dots and drivers, and respond if needed with changes in strategy or improvements in execution, quickly.
Your Strategic Theory Drives the Creation of the Board “Strategic Quality Dashboard”

<table>
<thead>
<tr>
<th>Big Dots (Pillars, BSC…)</th>
<th>Drivers (Core Theory of Strategy)</th>
<th>Projects (Ops Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are your key strategic aims? How good must we be, by when?</td>
<td>• Down deep, what really has to be changed, or put in place, in order to achieve each of these goals?</td>
<td>• What set of projects will move the drivers far enough, fast enough, to achieve your aims?</td>
</tr>
<tr>
<td>• What are the system-level measures of those aims?</td>
<td>• What are you tracking to know whether these drivers are changing?</td>
<td>• How will we know if the projects are being executed?</td>
</tr>
</tbody>
</table>

Example: A Strategic Theory for the Aim “Reduce Mortality Rate”

<table>
<thead>
<tr>
<th>Big Dot Aim</th>
<th>Drivers (Core Theory of Strategy)</th>
<th>Projects (Ops Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce mortality rate by 20% in 24 months, as measured by Hospital Standardized Mortality Rate (from 105 to 85)</td>
<td>• Culture of teamwork as measured by monthly survey of key nursing units</td>
<td>What set of projects will move the drivers far enough, fast enough, to achieve your aims? How will we know if the projects are being executed?</td>
</tr>
<tr>
<td></td>
<td>• Reliable recognition and early treatment of sepsis as measured by % of septic patients on protocol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improved end of life care as measured by % deaths in home care or hospice</td>
<td></td>
</tr>
</tbody>
</table>
The Ideal Strategic Dashboard Parallels the Strategic Theory

Are we on track with the mortality Aim?
Are we executing our strategy?

The Role of the Board in Quality and Safety
The Ideal Strategic Dashboard Parallels the Strategic Theory

Are we on track with the mortality Aim?
Are we executing our strategy?
What is your diagnosis?

Summary: The Strategic Dashboard

- The Board Dashboard should parallel the organization’s aims and strategic theory.
- The measures should be weekly or monthly, real time, and displayed as run charts.
- Measures do not necessarily need to be risk adjusted, or displayed as rates. You can eliminate the denominator in many instances.
- Management and the board should review the key system-level measures at every meeting.
What About the Other Important Type of Quality Question?

- How does our quality measure up…
  - To other hospitals like ours?
  - To standards and regulatory requirements?
  - To industry “benchmarks?”
  - …etc.

External Comparative Data Need to Knows

<table>
<thead>
<tr>
<th>Upside</th>
<th>Downside</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often risk adjusted</td>
<td>Time lag (months)</td>
</tr>
<tr>
<td>Apples to apples can be useful</td>
<td>Static (no data over time)</td>
</tr>
<tr>
<td>Source of pride</td>
<td>If you look bad, energy is wasted on “the data must be wrong”</td>
</tr>
<tr>
<td>Source of energy for improvement</td>
<td>If you look good, you become complacent</td>
</tr>
<tr>
<td>Necessary “staying in business” requirement (licensure, deemed status…)</td>
<td>How you look depends on how others perform</td>
</tr>
<tr>
<td></td>
<td>Standards and benchmarks are full of defects (“The cream of the crap”)</td>
</tr>
</tbody>
</table>
Recommendations for Board Use of Comparative Dashboards

- Don’t use comparative reports to oversee and guide improvement at each meeting.
- Do ask for an “exception report” for any measures that are “off the regulatory and compliance rails.”
- Create a separate dashboard with all your publicly reported ‘compared to others’ data and review it annually.
- Compare to the best, not the 50th %tile.
- Always make sure you know how “green” is determined.

Summary: Good Board Practices for Dashboards

- Separate the “comparison” and “strategic” questions into two dashboards.
- Use the “comparison” dashboard to take stock from time to time, not to steer by.
- Set a few system-level, specific aims, and develop a Strategic Dashboard with timely, “good enough” data that is based on your theory of what needs to happen to achieve the aims.
- Spend time on your strategic dashboard: If you’re not on track to achieve your aims, start asking hard questions.
Dashboard Workshop

- Assess your own quality dashboard.
  - Are major aims crystal clear on the dashboard? (how good, by when, as measured by...)
  - Do you have a clear drivers and “strategic theory” of how to accomplish your aims, evident on the dashboard?
  - Which measures belong on the “how do we compare to others/standards?” dashboard, and which belong on the “Are we on track to achieve our aims?” dashboard?
  - How timely are the measures? How could you improve the time delay in getting feedback on performance?
  - For harm-related measures, does the dashboard answer the question “How many patients was that?”

- List three specific improvements you intend to make in your board’s quality dashboard.

Thank you!

Q&A