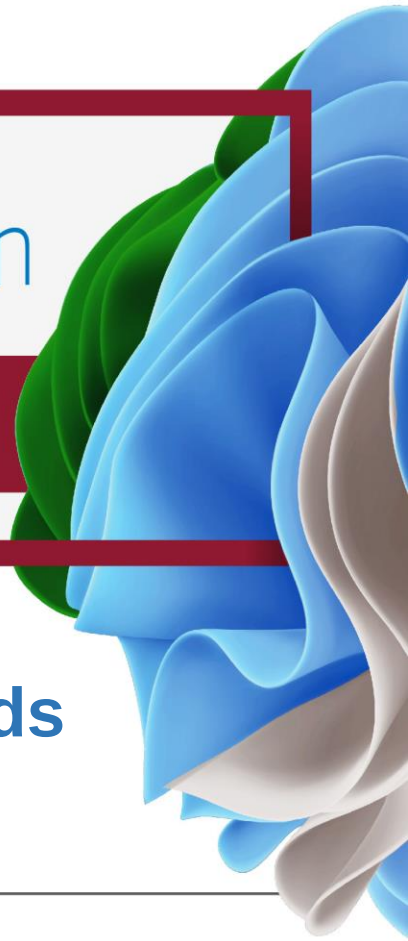
مؤسسة حمد الطبية
Hamad Medical Corporation
HEALTH · EDUCATION · RESEARCH صحة · تعليم · بحوث

In Collaboration with
Institute for Healthcare Improvement

Middle East Forum on Quality & Safety in Healthcare 2023

16-19 March, Doha



Transparency and Building Strategic Dashboards

Saturday, 14th March (10:15-11:15)

Healthcare Resilience in Extraordinary Times

Brought to you by:
Hamad Healthcare Quality Institute

IHI Faculty

Robert Lloyd, PhD

Vice President Improvement Science

Sr. Improvement Advisor

Conflict of Interest

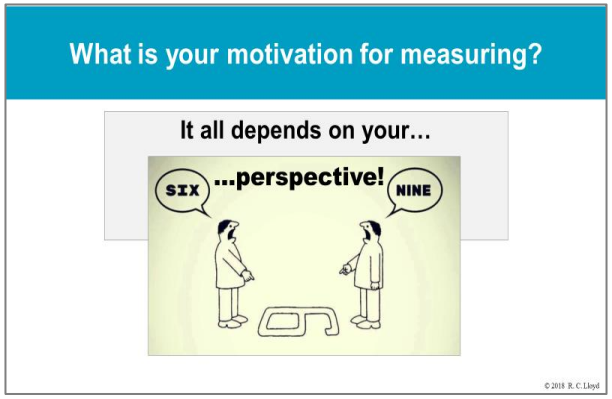
The speaker for this session, Dr. Robert Lloyd, has no conflict of interest or disclosure in relation to this presentation.

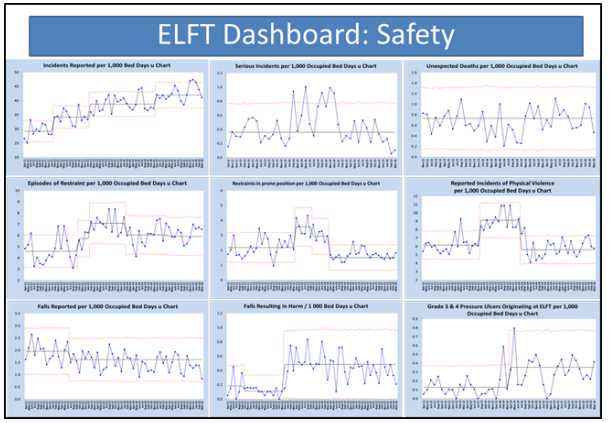
Learning Objectives

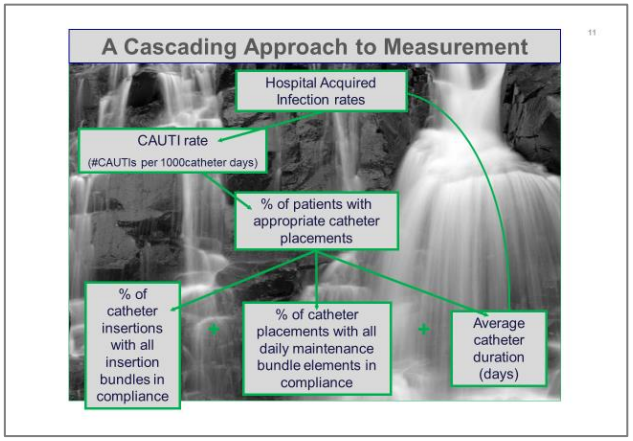
At the end of this session, participants will be able to:

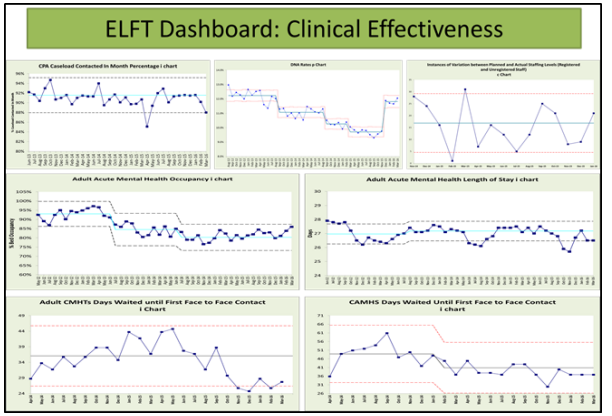
1. **Understand the challenges with evaluating healthcare performance**
2. **Describe the evolution of the Strategic Dashboard**
3. **Explain the components of a Strategic Dashboard**
4. **Clarify the role of Benchmarking**

What is the motivation for developing your Strategic Dashboard(s)?









The Three Faces of Performance Measurement

Aspect	Improvement	Accountability (Judgment)	Research
Aim	Improvement of care **(efficiency & effectiveness)**	Comparison, choice, reassurance, motivation for change	New knowledge **(efficacy)**
Methods: • Test Observability	Tests are observable	No test, evaluate current performance	Test blinded or controlled
• Bias	Accept consistent bias	Measure and adjust to reduce bias	Design to eliminate bias
• Amount of Data	**"Just enough" data,** small sequential samples	Obtain 100% of available, relevant data	**"Just in case" data**
• Flexibility of the hypotheses	Flexible hypotheses, changes as learning takes place	No hypothesis	Fixed hypothesis (null hypothesis)
• Testing Strategy	Sequential tests	No tests	One large test
• Determining if a change is an improvement	**Analytic Statistics (statistical process control)** Run & Control charts	No change focus (maybe compute a percent change or rank order the results)	**Enumerative Statistics** (t-test, F-test, chi square, p-values)
• Confidentiality of the data	Data used only by those involved with improvement	Data available for public consumption and review	Research subjects' identities protected

Adapted from: Lief Solberg, Gordon Mosser and Sharon McDonald, *Journal on Quality Improvement* vol. 23, no. 3, (March 1997), 135-147.

In the name of Quality let’s rate and rank…

So, in the name of Quality let's rate and rank providers using annual or quarterly data!

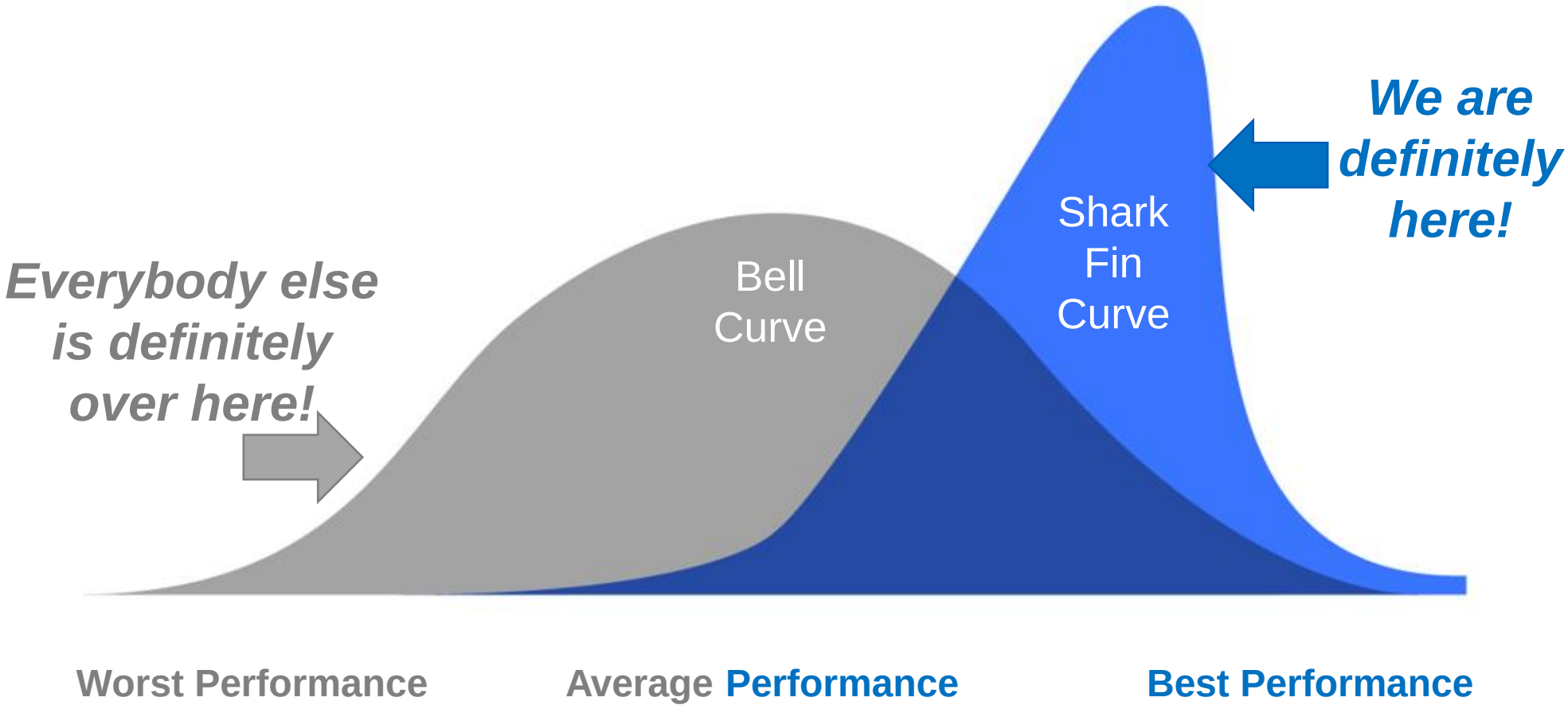
Dr. Atul Gawande, "The Bell Curve" P8

The New Yorker, December 6, 2004

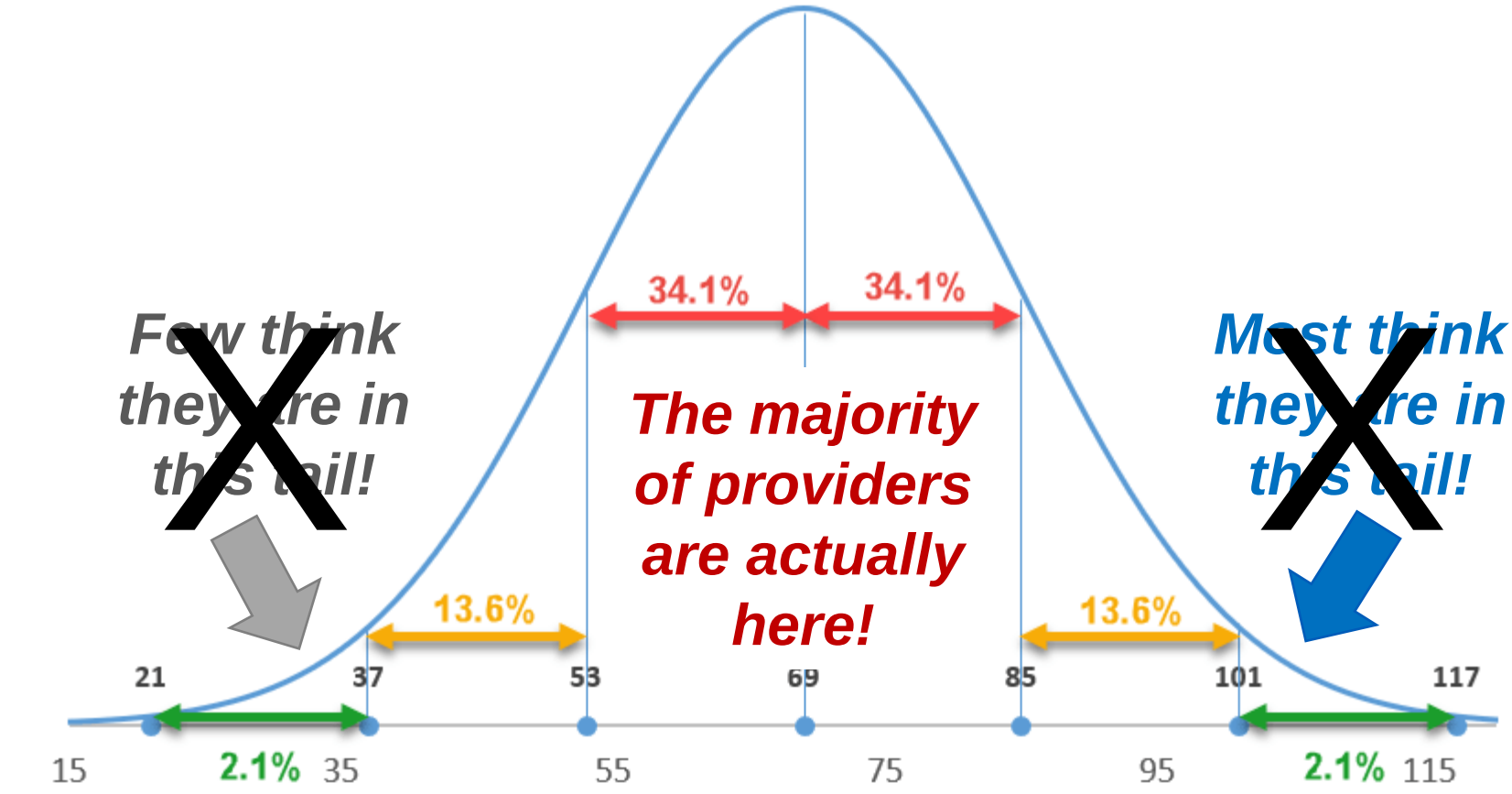
"It used to be assumed that differences among hospitals or doctors were generally insignificant. If you plotted a graph showing the results, people expected that the curve would look something like a shark fin, with most places clustered around the very best outcomes. But the evidence has begun to indicate otherwise.

What you tend to find is a bell curve: a handful of teams with disturbingly poor outcomes for their patients, a handful with remarkably good results, and a great undistinguished middle."

The Bell Curve vs the Shark Fin Curve



But in reality, hospital and doctor distributions look more like this!



The Countries with the "Best" Health Care Systems!

The Health Care Index is a statistical analysis of the overall quality of the health care system, including health care infrastructure; health care professionals (doctors, nursing staff, and other health workers) competencies; cost; quality medicine availability, and government readiness.

It also takes into consideration other factors including, environmental, access to clean water, sanitation, government readiness on imposing penalties on risks such as tobacco use, and obesity.

The ranking looks at 89 countries around the world on five different health variables.

Countries With The Best Health Care Systems, 2021

Rank	Country	Health Care Index (Overall)	Infrastructure	Professionals	Cost	Medicine Availability	Government Readiness
1	South Korea	78.72	87.16	14.23	83.59	82.3	87.89
2	Taiwan	77.7	79.05	13.06	78.39	78.99	65.09
3	Denmark	74.11	90.75	30.01	82.59	92.06	96.3
4	Austria	71.32	86.18	20.25	78.99	88.23	91.8
5	Japan	70.73	78.77	21.6	74.88	74.18	93.2
6	Australia	67.99	92.58	17.37	96.22	67.51	89.91
7	France	65.38	77.86	13.24	71.82	55.1	81.38
8	Spain	64.66	86.28	34.25	75.81	83.82	96.8
9	Belgium	64.63	72.48	24.51	68.68	64.78	94.9
10	United Kingdom	61.73	88.63	14.66	75.61	90.25	88.41

Source: CEOWORLD Magazine – "Top Stories - Stats Gate - Revealed: Countries With The Best Health Care Systems, 2021."

https://ceoworld.biz/2021/04/27/revealed-countries-with-the-best-health-care-systems-2021/

The World Health Organization's last global report ranked these **10 countries** as the most advanced in medicine with the best healthcare in the world:

1. France
2. Italy
3. San Marino
4. Andorra
5. Malta
6. Singapore
7. Spain
8. Oman
9. Austria
10. Japan

Source: World Health Organization, Measuring Overall Health System Performance for 191 Countries

Which country has the best healthcare system in the world?

Switzerland comes top of the Euro Health Consumer Index 2018, and it's firmly above the eleven-country average in the Commonwealth Fund's list too.
Feb 15, 2022

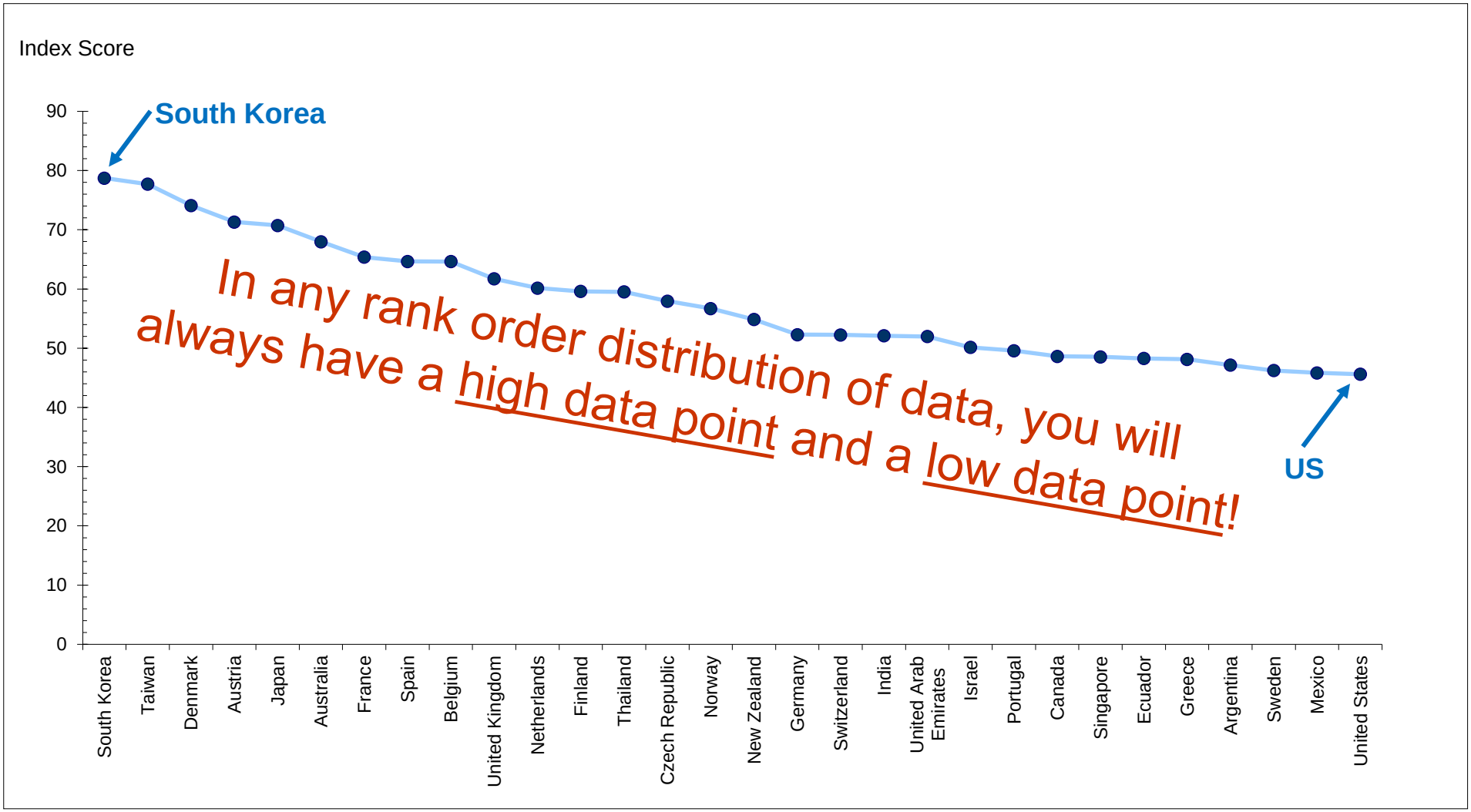
What country is #1 in healthcare?
Best Healthcare in the World 2022

Country	LPI 2020 Ranking	CEO World Ranking
Denmark	1	3
Norway	2	15
Switzerland	3	18
Sweden	4	28

Sooooo, which country is THE BEST?

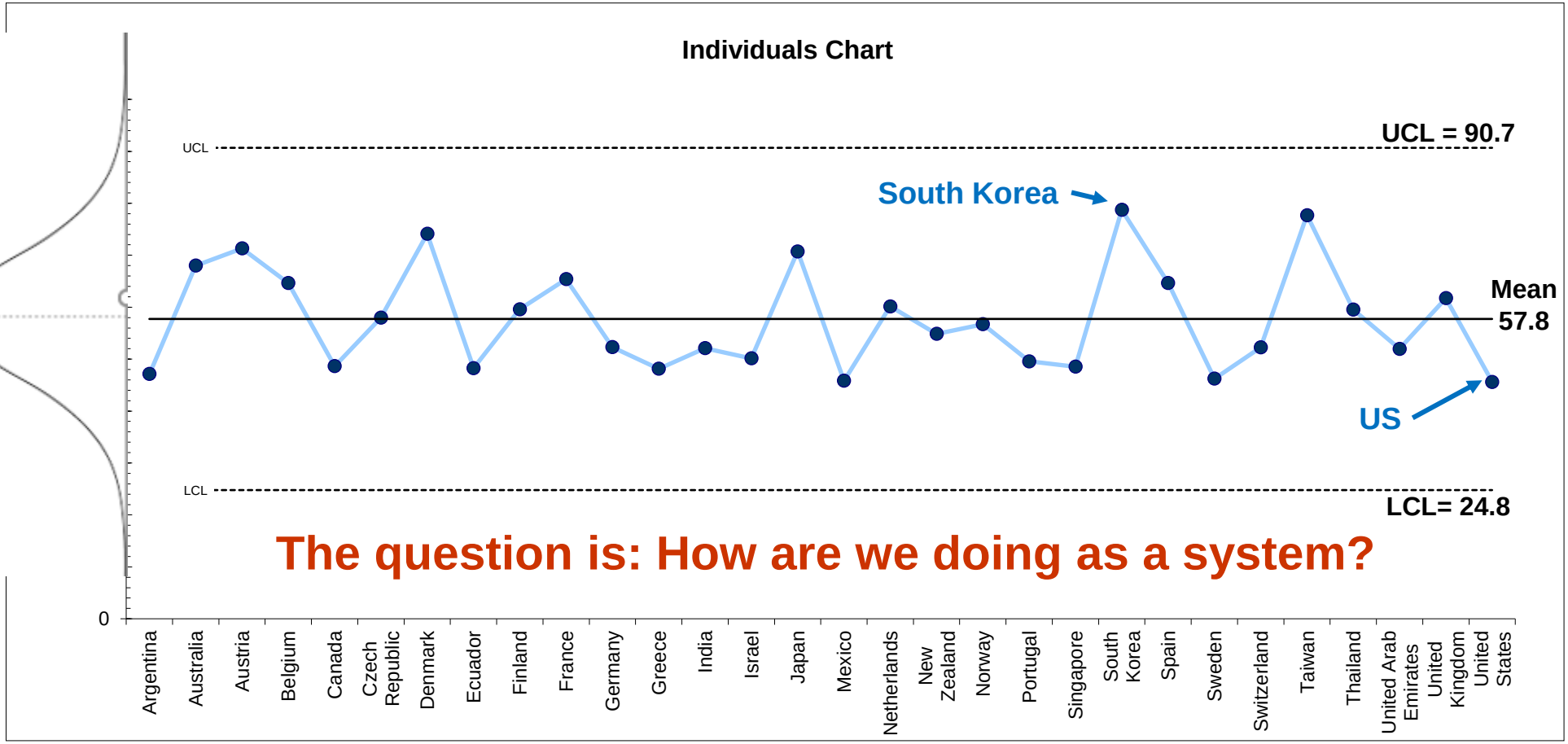
It all depends…

Health Index Scores of the Top 30 Countries



Countries in Descending Order by Index Score

Health Index Scores of the Top 30 Countries



The question is: How are we doing as a system?

Countries in Alphabetical Order by Index Score

This chart reveals that the 30 countries produce a common cause system which is stable and therefore predictable.

Conclusion: No country is better or worse in terms of performance on the Health Index Score.

How long will this measurement madness go on?

The push for measurement will only increase and transparency will serve as a guiding principle!

The Theory and the Prediction

If the staff, the public, the press and political leaders have more data on the performance of healthcare providers then the top performers will be rewarded and serve as exemplars and the poor performers will be motivated to improve.

Do you agree?

If not, then what is your alternative theory and your prediction?

Hospital Profile

About Hospital Compare | About the Data | Resources | Help | PRINT ALL TABS

«Return to Previous Page

General Information | Patient Survey Results | Timely & Effective Care | Readmissions , Complications & Deaths | Use of Medical Imaging | Medicare Payment | Number of Medicare Patients

ADVOCATE GOOD SAMARITAN HOSPITAL

3815 HIGHLAND AVENUE
DOWNERS GROVE, IL 60515
(630) 275-5900

Hospital Type: Acute Care Hospitals
Provides Emergency Services: Yes

Add to my Favorites

Map and Directions

Patient Survey Results

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay. Use the results shown here to compare hospitals based on ten important hospital quality topics.

- More information about patient survey results.
- Current data collection period.

Expanded coverage in the Chicago Tribune Business report

Do hospital ratings bring clarity or confusion?

Patients left to judge credibility of rankings groups — and array of data

By Jordan Rau
Kaiser Health News

How good is St. Mary Mercy Livonia Hospital in Michigan? Depends on whom you ask.

The Leapfrog Group, a nonprofit that promotes patient safety, gave the hospital an A. The company Healthgrades named it one of America's best 50 hospitals.

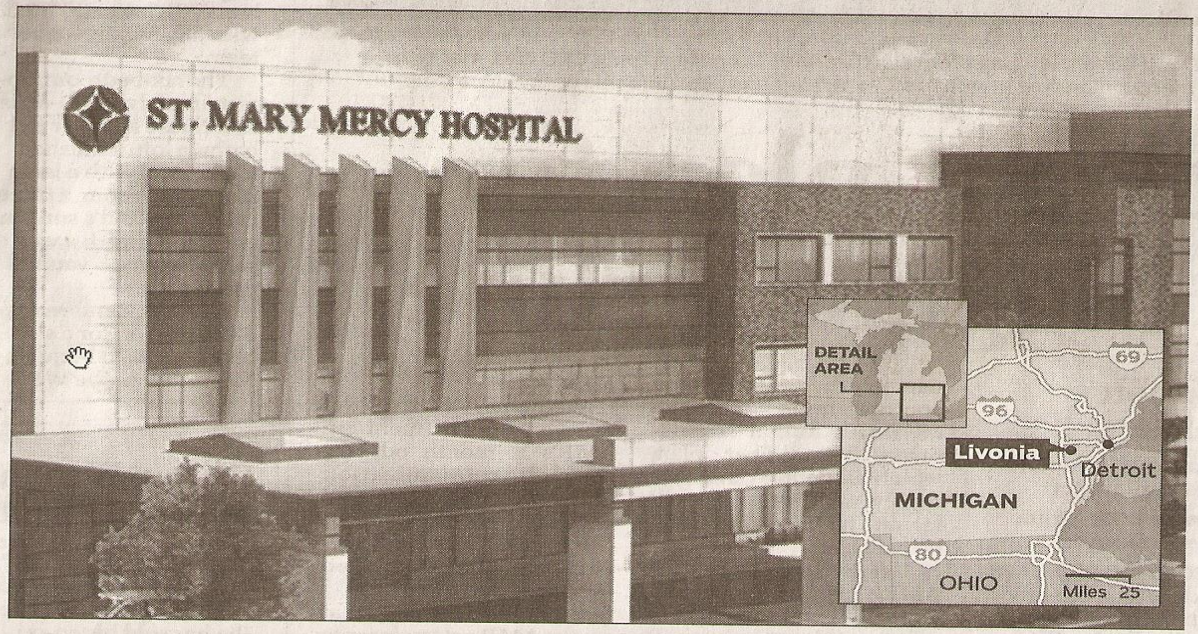
But the Joint Commission, a nonprofit that accredits hospitals, and U.S. News & World Report omitted St. Mary from their best-hospital lists. Consumer Reports gave it an average safety score, 47 points out of 100, citing high numbers of readmissions, poor communication with patients and excessive use of scans. Medicare, which has a new program rewarding hospitals for meeting certain quality measures, is reducing St. Mary's payments by a fraction this year.

Evaluations of hospitals are proliferating, giving patients unprecedented insight into institu-

EXAMPLE:

St. Mary Mercy Hospital

Livonia, Mich.



nia. Consumer Reports examines the number of patients who die or are readmitted, infection rates and Medicare patient surveys of their experiences. Leapfrog looks at data from its surveys of hospitals, the consistency with which hospitals followed safe surgical practices and frequencies of infections and some types of patient harm. Healthgrades analyzes detailed Medicare records to find death and complication rates for 27 procedures and conditions.

"Ratings and ranking programs certainly offer people information they can use to make their hospital selections, but we don't recommend relying on any one of them completely," Jennifer Kennedy, a spokeswoman for St. Mary Mercy, said in an email. "None are able to tell the whole story or paint a complete picture of the care that is delivered."

Opinions and options

Dr. John Santa, who directs Consumer Reports' health ratings, said consumers benefit from different vantages for health care just as they do for cars or electronic devices, and the competition spurs each rating group to get better.

Highly Ranked
A Top 50 Hospital

An Average Hospital

An Unranked Hospital

So, what or who do you believe?

AARP®

American Association of Retired Persons

66 of the "Top" Hospitals in the US.

Leapfrog's April/May 2013 Rankings

Top Hospitals

- **Allegheny General Hospital** *Pittsburgh, Pa.*
- **Baystate Medical Center** *Springfield, Mass.*
- **Bellevue Hospital Center** *New York, N.Y.*
- **Beth Israel Deaconess Medical Center** *Boston, Mass.*
- **Billings Clinic** *Billings, Mont.*
- **Brigham and Women's Hospital** *Boston, Mass.*
- **California Pacific Medical Center** *San Francisco, Calif.*
- **Central Maine Medical Center** *Lewiston, Maine*
- **The Christ Hospital** *Cincinnati, Ohio*
- **Cleveland Clinic Florida** *Weston, Fla.*
- **Detroit Receiving Hospital/University Health Center** *Detroit, Mich.*
- **Dublin Methodist Hospital** *Dublin, Ohio*
- **Englewood Hospital and Medical Center** *Englewood, N.J.*
- **Fairview Southdale Hospital** *Edina, Minn.*
- **Geisinger Medical Center** *Danville, Pa.*
- **Grinnell Regional Medical Center** *Grinnell, Iowa*
- **Hackensack University Medical Center** *Hackensack, N.J.*
- **Harper-Hutzel Hospital** *Detroit, Mich.*
- **Homestead Hospital** *Homestead, Fla.*
- **Indiana University Health La Porte Hospital** *La Porte, Ind.*
- **Inova Fair Oaks Hospital** *Fairfax, Va.*
- **Inova Loudoun Hospital** *Leesburg, Va.*
- **JFK Medical Center of Atlantis** *Atlantis, Fla.*
- **Kaiser Permanente** *Multiple locations*

"Preventable hospital errors are a terrible danger to American families and a huge driver of unnecessary health costs," says Leah Binder, president and CEO of The Leapfrog Group, a Washington, D.C.–based nonprofit that assesses hospitals on national standards of safety, quality and efficiency.

To draw attention to the tragic reality of cases like McClinton's, AARP THE MAGAZINE has teamed up with Leapfrog to showcase what some of the most innovative hospitals are doing to prevent errors. With its Hospital Safety Score, Leapfrog rates institutions on 26 measures of safety—including "never events," infection rates from IV and catheter lines, secondary infections, and hospital-acquired conditions like pressure ulcers and air embolisms—using data it compiles from the Centers for Medicare & Medicaid Services, the American Hospital Association and the Leapfrog Hospital Survey.

One surprising standout: Virginia Mason. In fact, for the past seven years Leapfrog has consistently given the hospital

MAP: CHRIS O'RILEY. SOME CITIES INDICATED ARE HOME TO MULTIPLE TOP HOSPITALS FOR SAFETY

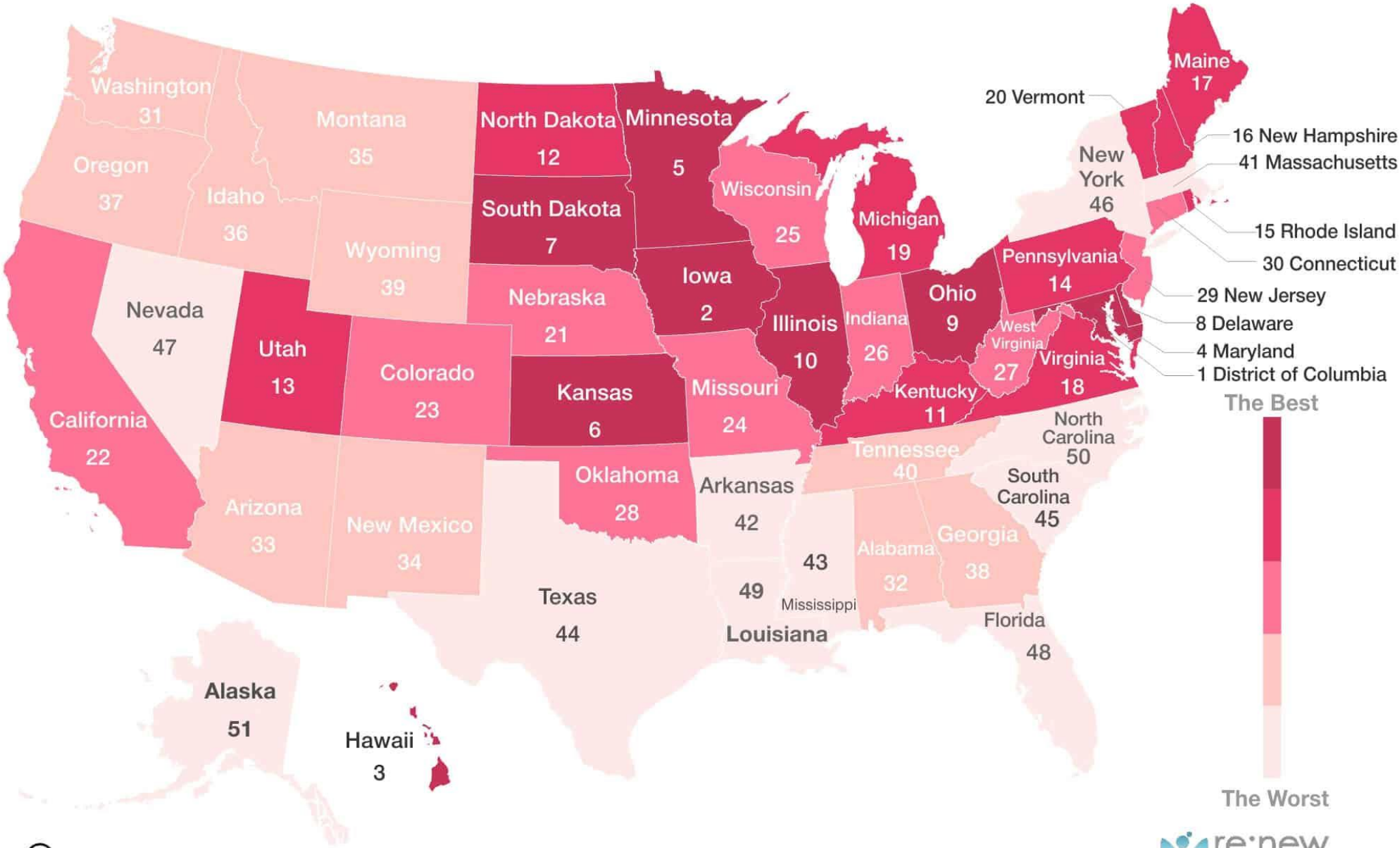
GLOBAL POSSIBILITIES

8 very different rating and ranking methodologies used to create the following composite rankings.

Sources for the Ratings and Rankings

- **U.S. News.** https://money.usnews.com/money/retirement/slideshows/top-10-us-places-for-healthcare?slide=5
- **U.S. News** https://www.usnews.com/news/best-states/rankings/health-care
- **Huffington Post**. https://www.huffingtonpost.com/gobankingrates/10-best-and-worst-states_b_9030422.html
- **Healthcare.** https://www.healthcare.gov/get-coverage/
- **2016 State of Healthcare Quality Table of Content**. http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2016-table-of-contents
- **Center for Medicare and Medicaid Services**. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html
- **Healthcare Quality: How Does Your State Compare? Agency for Healthcare Research and Quality**, September 2015. https://www.ahrq.gov/research/data/state-snapshots/state-snapshots-infographic-txt.html
- **National Healthcare Quality and Disparity Report. Agency for Healthcare Research and Quality**, https://nhqrnet.ahrq.gov/inhqrdr/

Affordability



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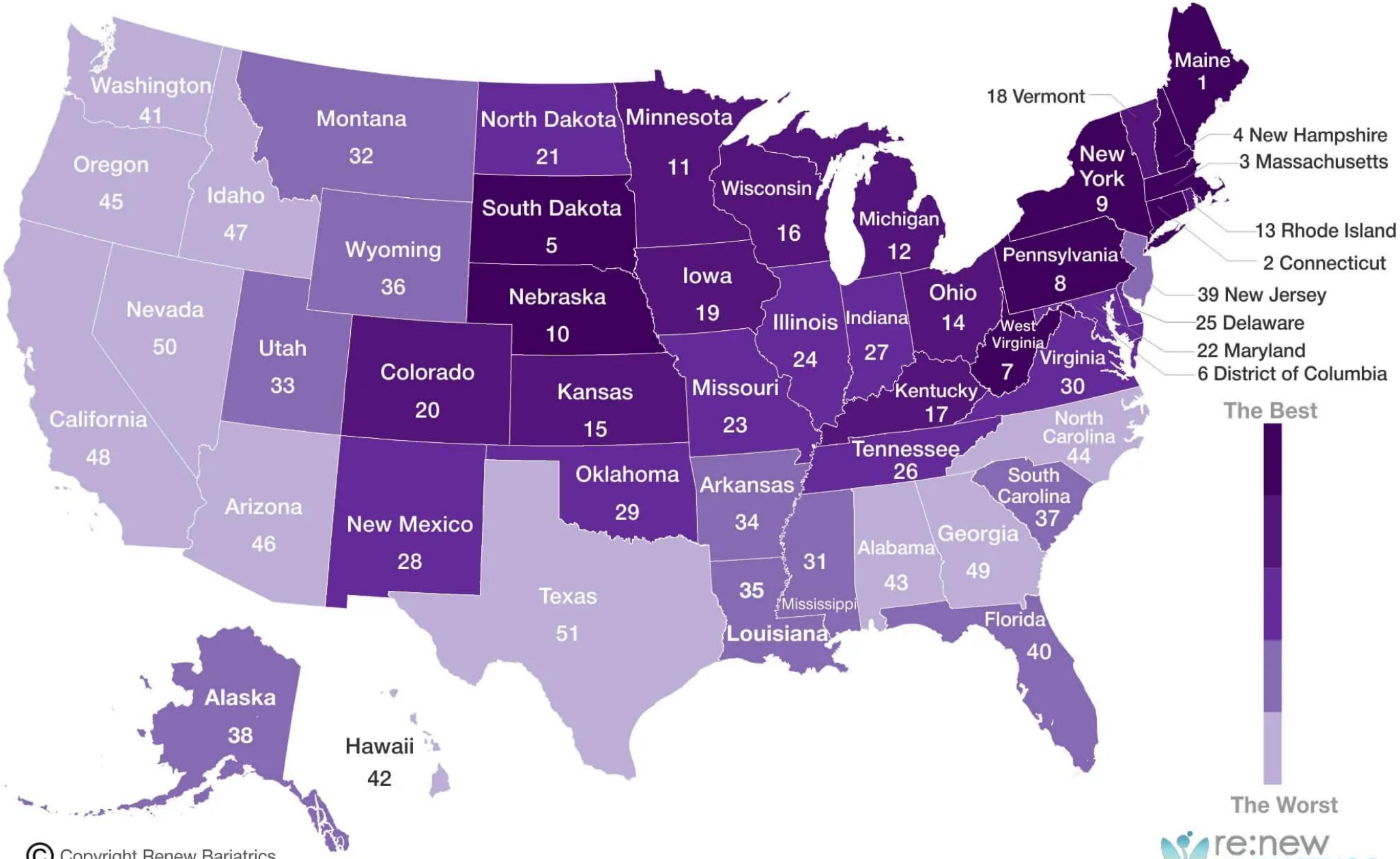
Availability



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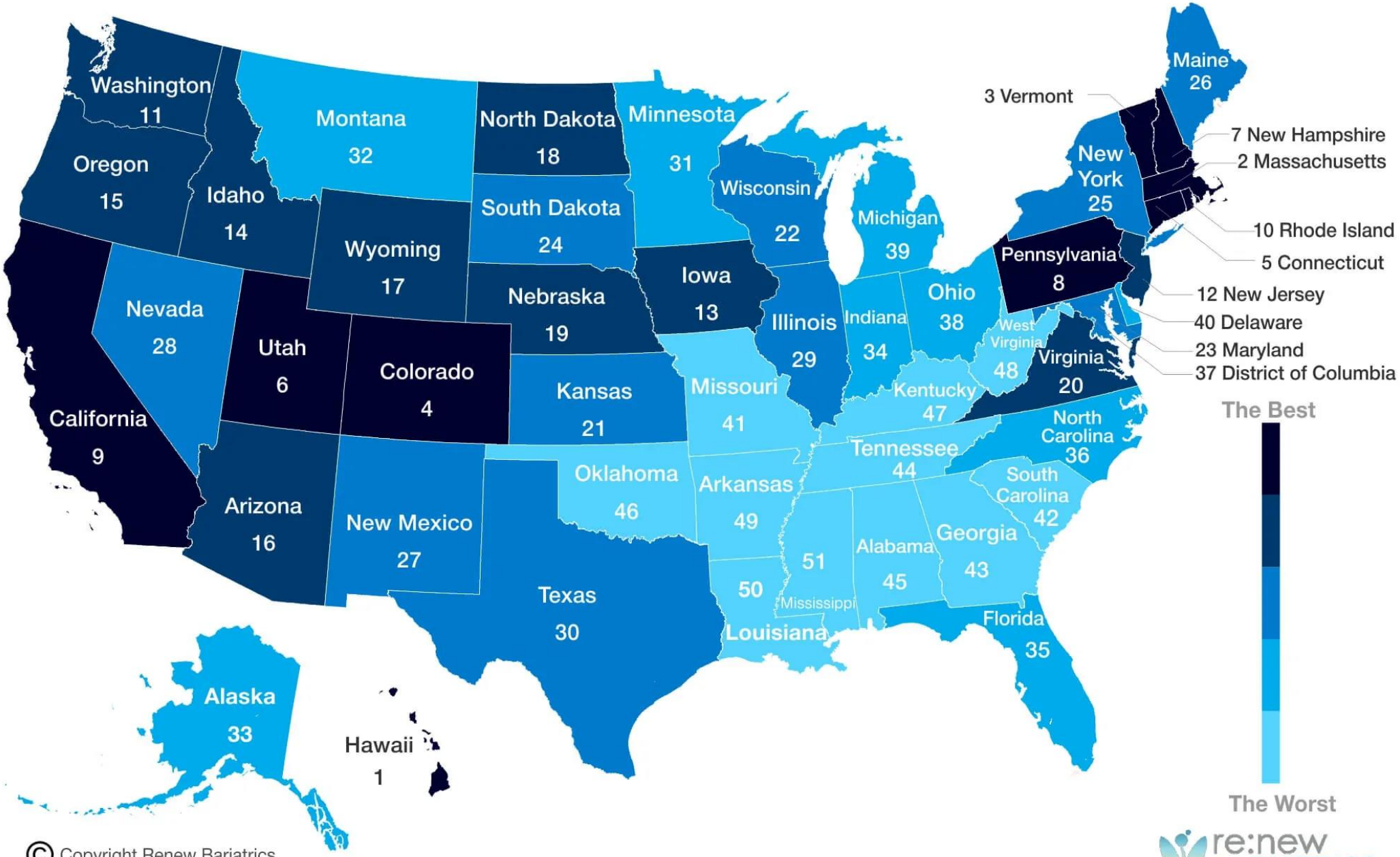
Healthcare Results, Outcomes



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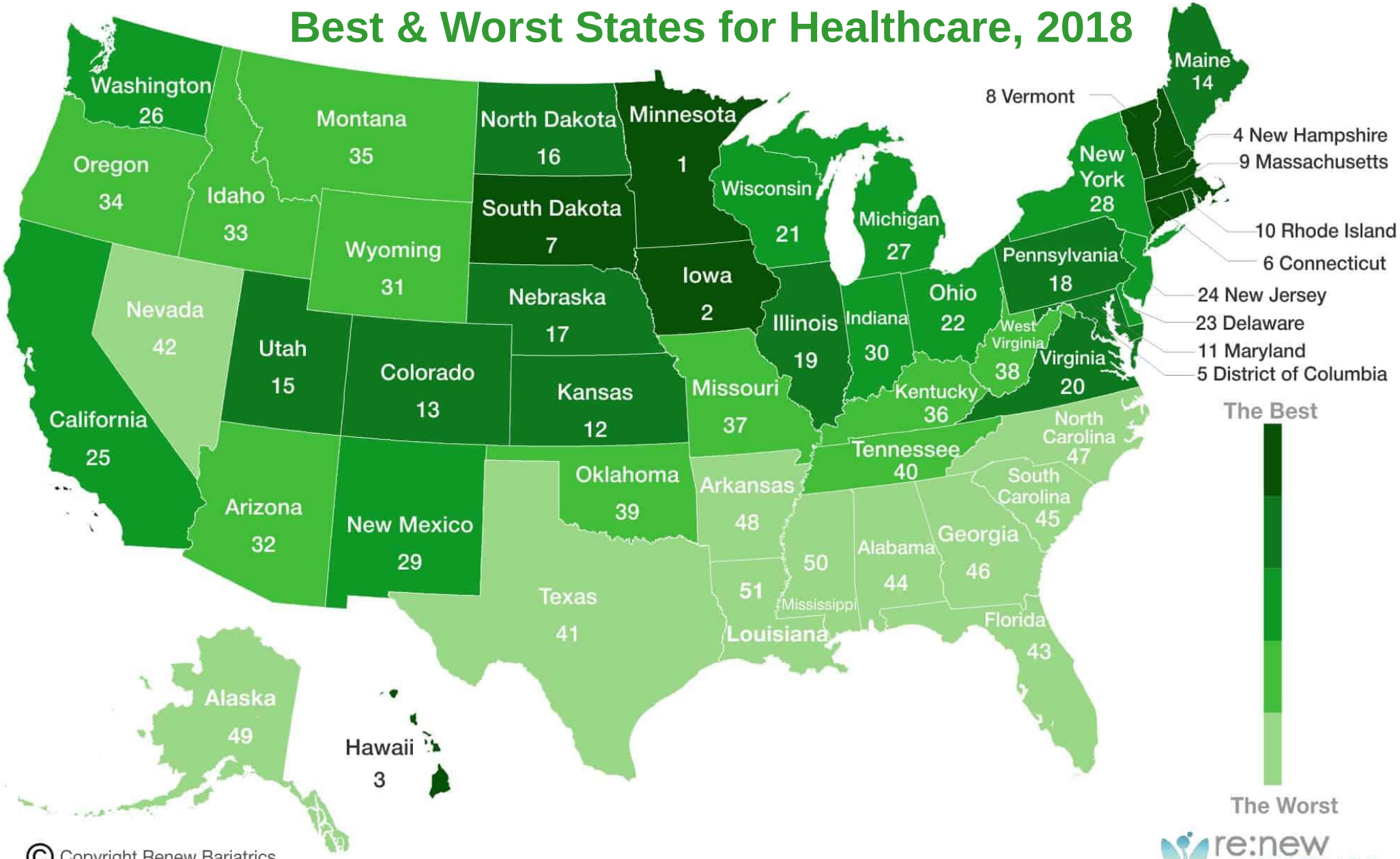
Individual State's Healthcare

Best & Worst States for Healthcare, 2018



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U.S. News 2022-2023 Best Hospitals Honor Roll

1. Mayo Clinic, Rochester, Minnesota.
2. Cedars-Sinai Medical Center, Los Angeles.
3. NYU Langone Hospitals, New York.
4. Cleveland Clinic.
5. (tie) Johns Hopkins Hospital, Baltimore.
5. (tie) UCLA Medical Center, Los Angeles.
7. New York-Presbyterian Hospital-Columbia and Cornell, New York.
8. Massachusetts General Hospital, Boston.
9. Northwestern Memorial Hospital, Chicago.
10. Stanford Health Care-Stanford Hospital, Stanford, California.
11. Barnes-Jewish Hospital, St. Louis.
12. UCSF Health-UCSF Medical Center, San Francisco.
13. Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia.
14. Brigham and Women's Hospital, Boston.
15. Houston Methodist Hospital.
16. Mount Sinai Hospital, New York.
17. University of Michigan Health-Ann Arbor.
18. Mayo Clinic-Phoenix.
19. Vanderbilt University Medical Center, Nashville.
20. Rush University Medical Center, Chicago.

"For more than 30 years, the mission of U.S. News & World Report's annual Best Hospitals rankings has been to help guide patients, in consultation with their doctors, to the right hospital when they need care."

"While disrupting life and health care in many ways, the COVID-19 pandemic has only reinforced U.S. News' long-standing commitment to helping patients across the nation find the best hospital for their needs."

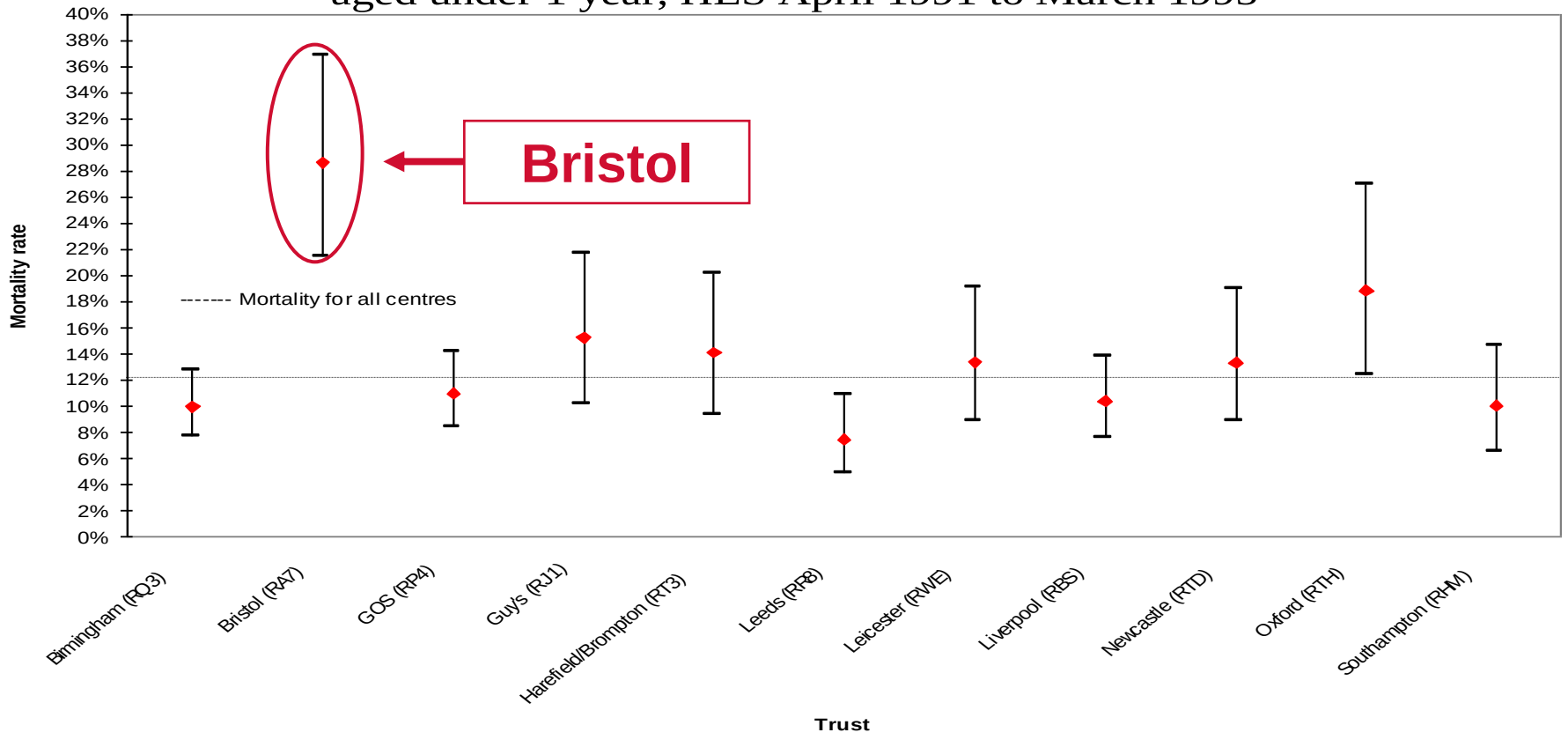
Source: US News & World Report homepage.

So, what does this tell us about quality, safety, efficiency, effectiveness, patient and staff engagement, equity or improvement right now?

The Bristol Inquiry

Death and morbidity rates following surgery were consistently high

Mortality Rate for Paediatric Cardiac Surgery by trust, all open operations, aged under 1 year, HES April 1991 to March 1995



Provisional figures Dr Foster Unit, Imperial College London 2003

2005

80p
Wednesday
March 16 2005
Published in London
and Manchester
guardian.co.uk

The Guardian

Hospitals deny patients facts on death rates

Guardian investigation under freedom of information extracts first data on heart surgeons and reveals successes and failures of system

Sarah Boseley, John Carvel and Rob Evans

Ten years after the Bristol babies scandal, patients are still being denied the information they need to make an informed choice about heart surgery, a Guardian investigation has discovered.

The Kennedy inquiry into the deaths of babies at the Bristol Royal Infirmary, following disciplinary action against two surgeons whose success rates were not as good as colleagues at other children's heart units, prompted the government to demand in 2001 that adult heart surgeons make their death rates public.

The information should have been available by last year, but many hospital trusts are still not collecting adequate data.

The Guardian used 36 simultaneous applications under the Freedom of Information Act to extract for the first time national data about the individual mortality rates of all cardiac surgeons practising in the NHS.

The exercise, unprecedented in its scale, has found:

- One London teaching hospital where trust managers and the cardiac consultants cannot agree among themselves about which surgeon should be assigned responsibility for particular deaths;
- Hospitals which diverted money the government allocated to improve record-keeping and risk assessment;
- Hospitals that are unable to give risk-adjusted data, which would reveal to patients the proportion of high and low risk operations undertaken by surgeons.

The disclosure of individual surgeons' mortality data is the first step towards admitting the public into the secret garden of the medical profession, which would allow patients to exercise informed choice on the basis of knowledge about doctors' clinical record.

Heart surgeons have been in the spotlight because of the Bristol scandal, which led to the striking off of two doctors. The GMC investigated the cases of 53 babies, of whom 29 died.

Choice will be the buzzword of the health debate at the general election, but although patients may be able to choose the hospital with the smarter waiting rooms or larger car park, they are nowhere near getting real information about their consultants results.

Many doctors object to the publication of death rates, for fear that some will be stigmatised as worse than others, when the truth may be that they take the harder cases, where deaths are more likely.

They cite New York, where the publication of heart surgeons' mortality figures caused some to shy away from the riskier cases.

But publication has been inevitable since Alan Milburn, who was then health secretary, told the Society of Cardiothoracic Surgeons in 2001 that he wanted the data in the public domain by last year. The society has worked hard to collect and validate risk-adjusted data that allows for the likelihood of some deaths, but has been frustrated by the low priority given to the exercise by some trusts.

The Guardian's two-month investigation reveals that trust figures show all heart surgeons but one are within the limits of acceptability defined by the society — their death rates do not stray far from the average. Many are excellent. In the case of the one outlier, there are serious questions around the data collected by the trust. The surgeon's own figures — which we have used — put him well within the norm.

It has emerged that the trust, St Mary's in London, has not kept separate figures for the operations carried out by visiting locums, covering for holidays. These have been included in the deaths for consultants who were miles from the operating theatre at the time. St Mary's chief executive, Julian Nettell, acknowledged that their data collection was not as good as it should be.

▸ Page 2

NHS mortality rates, pages 10–11
Leader comment, page 23

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Chaired by Robert Francis QC

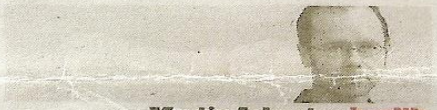
Mid Staffordshire NHS Trust inquiry report published

- Causing death or harm to a patient 'should be an offence'
- 'Duty of candour' should be imposed on NHS staff
- Senior staff who breach code of conduct 'should be disqualified'
- No sacking of 'scapegoats' or reorganising the NHS
- Cameron creates new post of chief inspector of hospitals
- PM apologises for care scandal at Stafford hospital
- Read the key points
- Read the main news story: Report calls for sweeping changes
- Read more: Mid Staffs hospital scandal: explainer
- Read the full report
- Read all our Mid Staffs coverage

2013

Death-rate figures reveal best, worst of our hospitals

Information Act used to obtain data showing hundreds of lives could be saved each year



Martin Johnston health
martin.johnston@nzherald.co.nz

Several hundred lives would be saved each year if some of New Zealand's highest public hospital death rates were brought down to those of the better-performing district health boards.

A *Herald* investigation has found that the Waikato District Health Board has had among the highest in-hospital "standardised" mortality rates in recent years.

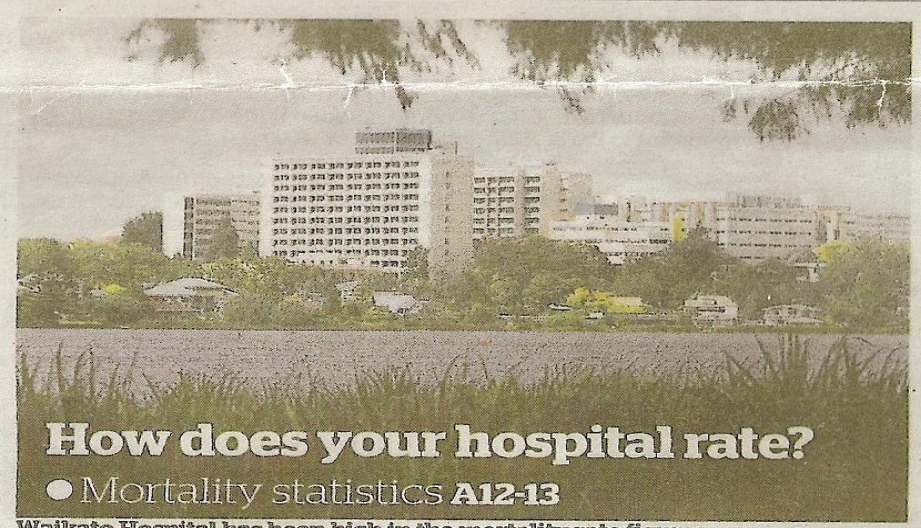
In a five-year period, it had the highest rate for three years.

In those years, its standardised rate — an estimate that gives a fairer comparison than raw data — was significantly higher than the national average.

"Mortality as well as safety, we take it very seriously," said the DHB's chief operating officer, Jan Adams.

The Health Ministry has identified the Waikato rate as a problem, but has also commended the health board for the efforts it is making to get to the root of the issue.

Figures comparing hospital death rates are routinely available to the public in Britain and Canada, and Australia has endorsed using this kind of information as an indicator of healthcare quality and safety.



How does your hospital rate?
● Mortality statistics **A12-13**

Waikato Hospital has been high in the mortality rate figures. Picture / APN

In New Zealand, the details have not been readily available, and the five-year figures for the *Herald* investigation were obtained from the ministry under the Official Information Act.

They show considerable variation between hospitals, but also an overall downward trend.

In the 2010/11 year, just under 8000 admitted inpatients and day patients — 1.48 per cent of total discharges — died within 30 days of admission to hospital.

This was down from 1.68 per cent in 2006/07.

Most hospital deaths cannot be avoided, but overseas research suggests several hundred a year in New Zealand may be preventable.

The ministry said comparing hospital mortality rates with other countries was complicated by different calculation methods, but Australian states tended to have a similar method and rate to New Zealand's.

The Auckland and Waitemata health boards generally had rates at the lower end nationally in the five years of data, while Counties Manukau was mostly in the mid-range.

Rotorua's Lakes DHB was also generally in the middle, while Northland ranged from mid-range to among the lowest. Bay of Plenty tended towards the upper end.

Further south, Capital & Coast was mostly among the lower-rate boards, but Canterbury usually had one of the higher rates.

Experts debate whether standardised hospital mortality rates can be used to evaluate and compare the quality and safety of healthcare in different hospitals.

But in its annual report last year, the ministry made an explicit link between hospital mortality and quality of healthcare.

After an epidemic of healthcare-induced harm was identified in New Zealand a decade ago, numerous schemes to improve the safety and quality of care have slowly taken root.

In a week-long series starting today, the *Herald* looks at some of these life-saving schemes.

Some, such as the surgical checklist, are simple, and some, such as changes to prevent common errors in the prescribing and dispensing of potentially toxic medicines, are more complex.

The *Herald* also talks to families who have lost loved ones to hospital errors that might have been avoidable.

They are bewildered by the paperwork mix-ups and overlooking of clinical information that have contributed to their personal tragedies and feel they have been denied justice.

Full index A2 | **Lotto** A3 | **Family notices** A32-A34 | Business liftout includes: **Puzzles** B11 | **TV** B15

Special report Saving lives: Part one of a five-part series

Life and death on our hospital frontlines

Hospital mortality rates

District Health Board mortality rates for 2010-11.

If all hospitals performed to best-case level, hundreds of lives would be saved each year

Martin Johnston health
martin.johnston@nzherald.co.nz

Hundreds fewer patients would die each year if the death rates at all public hospitals matched the best performers.

But every year several district health boards have a death rate in patients admitted to their hospitals that may be higher than the national rate, and this is regular feature for some, including the Waikato DHB.

So-called "in-hospital" deaths within 30 days of admission number nearly 8000 patients each year, around 1.5 per cent of all people admitted to hospital, including day patients.

Most die from the heart attack, pneumonia or other disorder which landed them in hospital. But in a minority of cases – one in 20 deaths, according to overseas research – it is thought the person's death could have been avoided, by things such as more-careful medicines management or the use of standardised methods to avert falls or infections.

Ministry of Health data obtained by the *Herald* under the Official Information Act shows that although the number of deaths of inpatients in public hospitals has increased by 20 in the five years to June last year, the mortality rate, which takes into account the growing volume of patients treated, has declined to 1.48

The BIG Question is about Value!

"There is a real paradox in American health care today, we spend more than anyone else in the world on health care, though our results are not better... There are growing questions about value. ... Are we really getting a good return on investment?"

Ken Kizer, President National Quality Foundation
Addressing business leaders on March 18, 2004

Where do you stand on transparency?

Level Frequency of Transparency	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. **Greater transparency is needed** across all healthcare settings and providers.					
2. **Patients should be able to compare hospitals as easily as they do cars and other products**.					
3. Results on hospital outcomes (mortality, infections, falls, med errors, etc.) should be made public ***once a year.***					
4. Results on hospital outcomes (mortality, infections, falls, med errors, etc.) should be made public ***twice a year.***					
5. Results on hospital outcomes (mortality, infections, falls, med errors, etc.) should be made public ***four times a year.***					
6. Results on groups of doctors (surgeons, GPs, intensivists, dentist, etc.) should be made public ***once a year***.					
7. Results on individual doctors should be made public ***once a year***.					

Where do you stand on transparency?

Content Topics for Transparency	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
8. All **clinical outcomes on hospital performance** should be made available to the public .					
9. **Operational outcomes on hospital performance** (wait times, referral times, access) should be made available to the public .					
10. **Patient satisfaction results** for each hospital should be made available to the public .					
11. **Financial results** (including salaries) for each hospital should be made available to the public .					
12. **Mortality rates for individual surgeons** should be made available to the public.					
13**. Infection rates for individual physicians** should be made available to the public.					
14. **Errors and harm rates for individual physicians** should be made available to the public.					
15. **Salaries of individual physicians** should be made available to the public.					

The Goal:
To Build a Learning System for Improvement

"An adequate information system has to include information that makes executives question their assumptions about current conditions. It must lead them to ask the right questions, not just feed them the information they expect."

"That presupposes first that the executives know what information they need. It demands further that they obtain that information on a regular basis. It finally requires that they systematically integrate the information into their decision making."

Peter Drucker. "The Information Executives Truly Need" *HBR*, January - February, 1995.

A Learning System Requires both Data or Information

*"**Data** refers to raw facts and figures which are collected as parts of the normal functioning of the hospital. **Information**, on the other hand, is defined as data which have been processed and analyzed in a formal, intelligent way, so that the results are directly useful to those involved in the operation and management of the hospital."*

Charles Austin, *Information Systems for Hospital Administration.* Health Administration Press, 1983.

“How the Right Measures Help Teams Excel”

Christopher Meyer, *HBR*, May - June 1994

“Many managers fail to realize that traditional measures, which focus on results (or outcomes), may help them keep score on the performance of their business but ***do not help a multifunctional team monitor the activities or capabilities that enable it to perform a given process****. Nor do such results measures tell team members what they must do to improve their performance.”*

The Role of Management

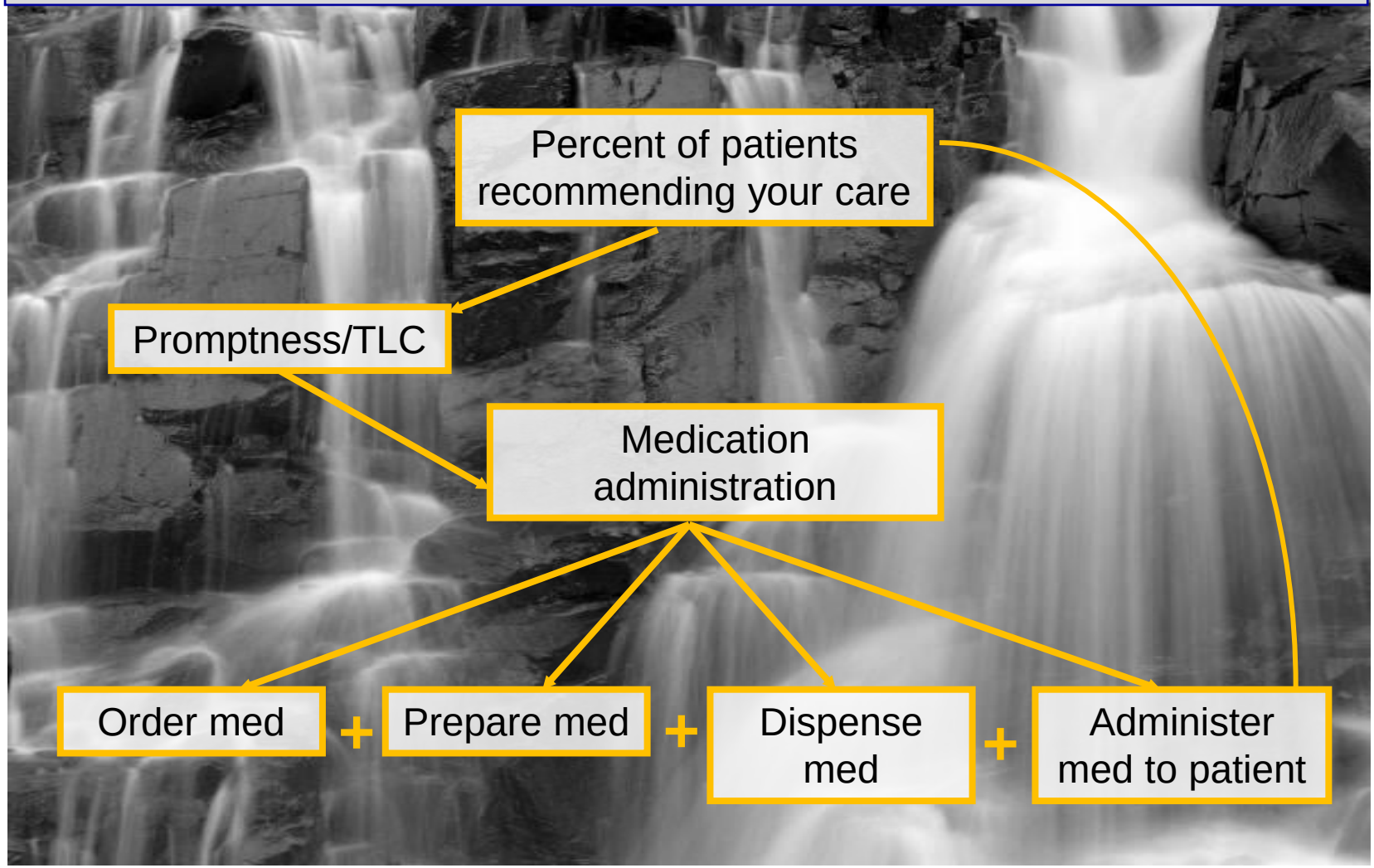
"How the Right Measures Help Teams Excel" Christopher Meyer, *HBR*, May-June, 1994.

Managers should:

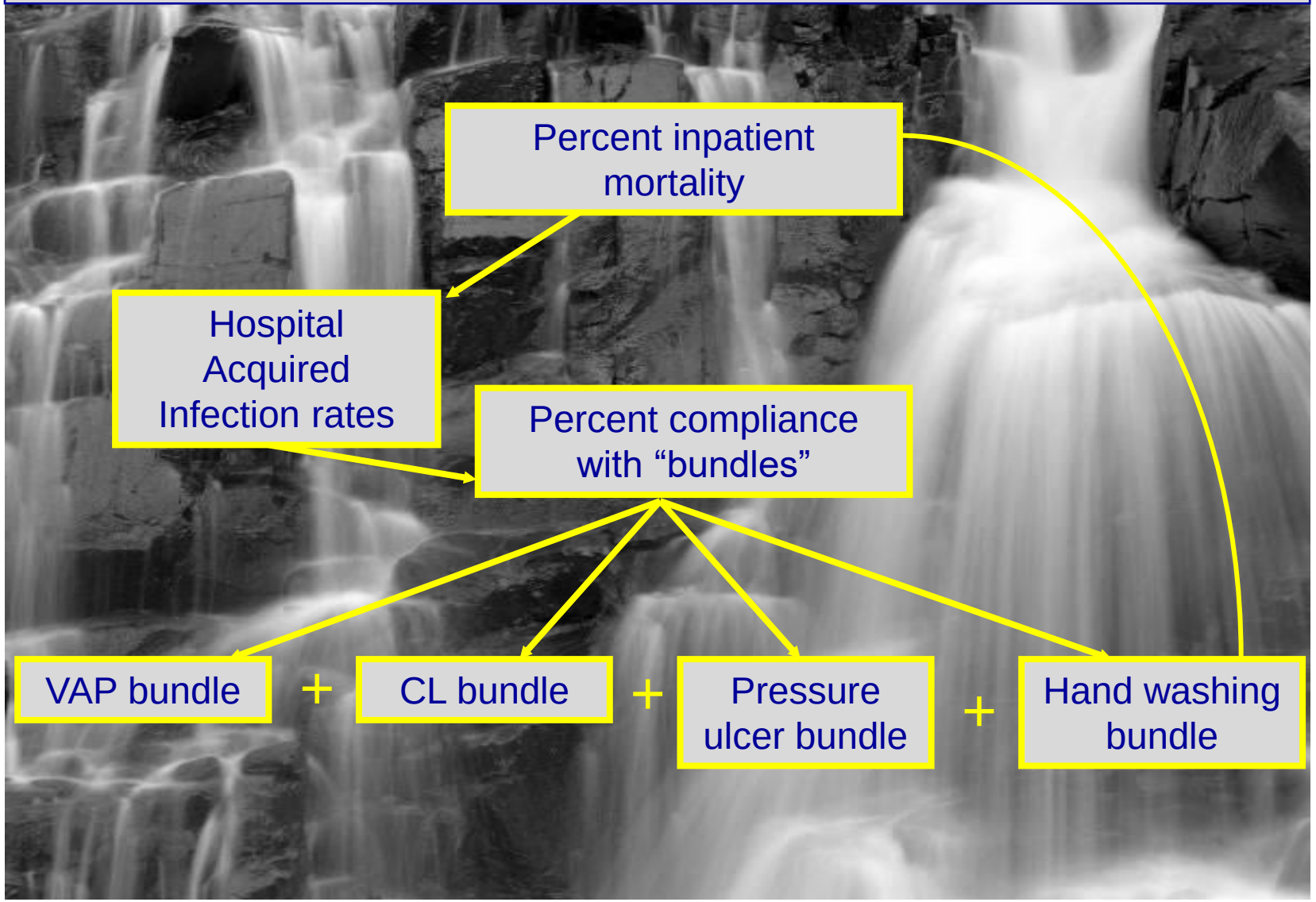
- **Create the strategic context and direction for measurement.**
- **Set strategic goals and boundaries.**
- **Make sure each team understands its purpose and how this purpose fits in with the strategic objectives.**
- **Not dictate what measures a team should use.**
- **Provide training and resources for the teams to accomplish their objectives.**
- **Participate in team reviews.**
- **Not micro-manage the teams through command and control tactics.**

Building a Cascading System of Measures

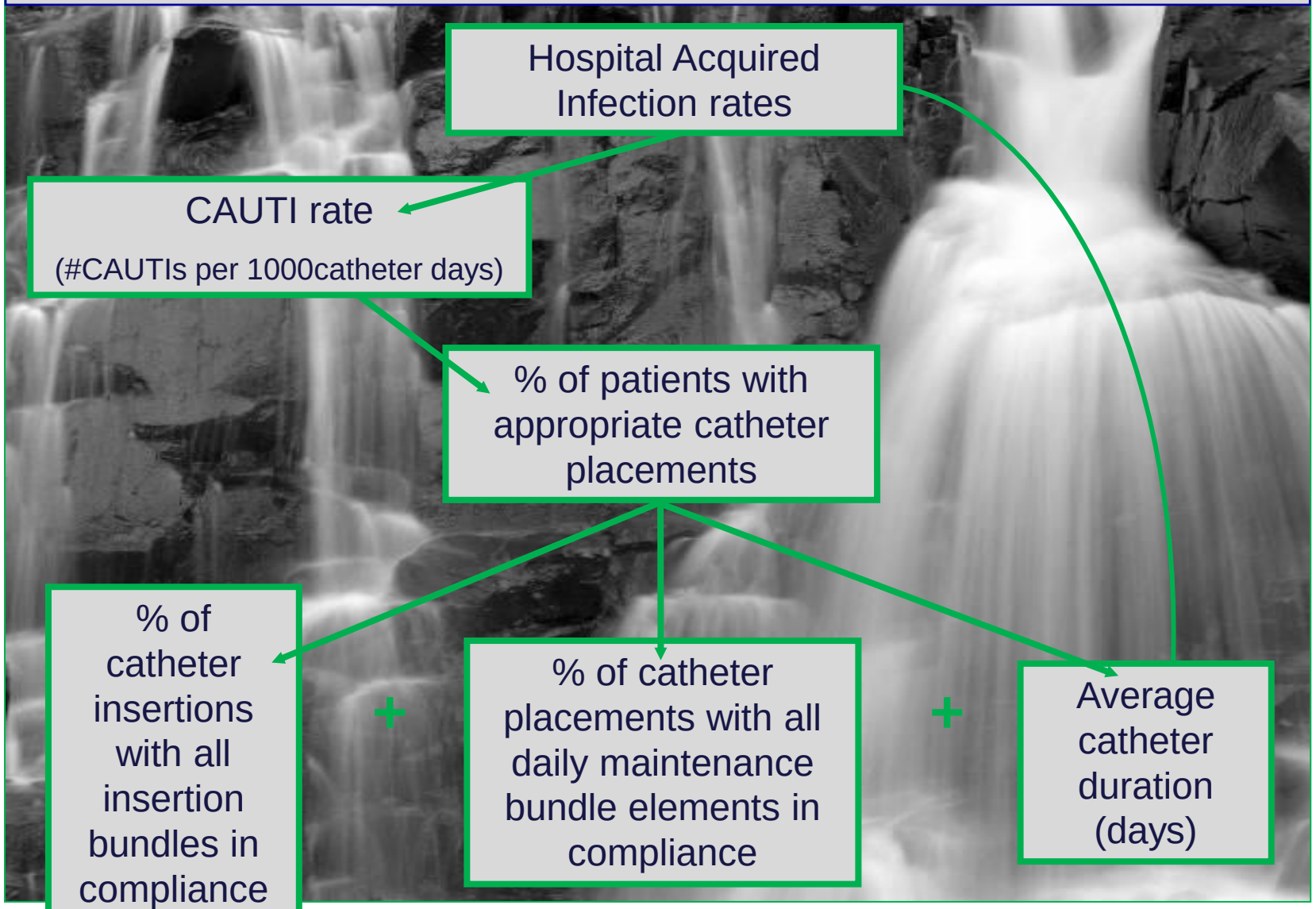
A Cascading Approach to Measurement



A Cascading Approach to Measurement



A Cascading Approach to Measurement

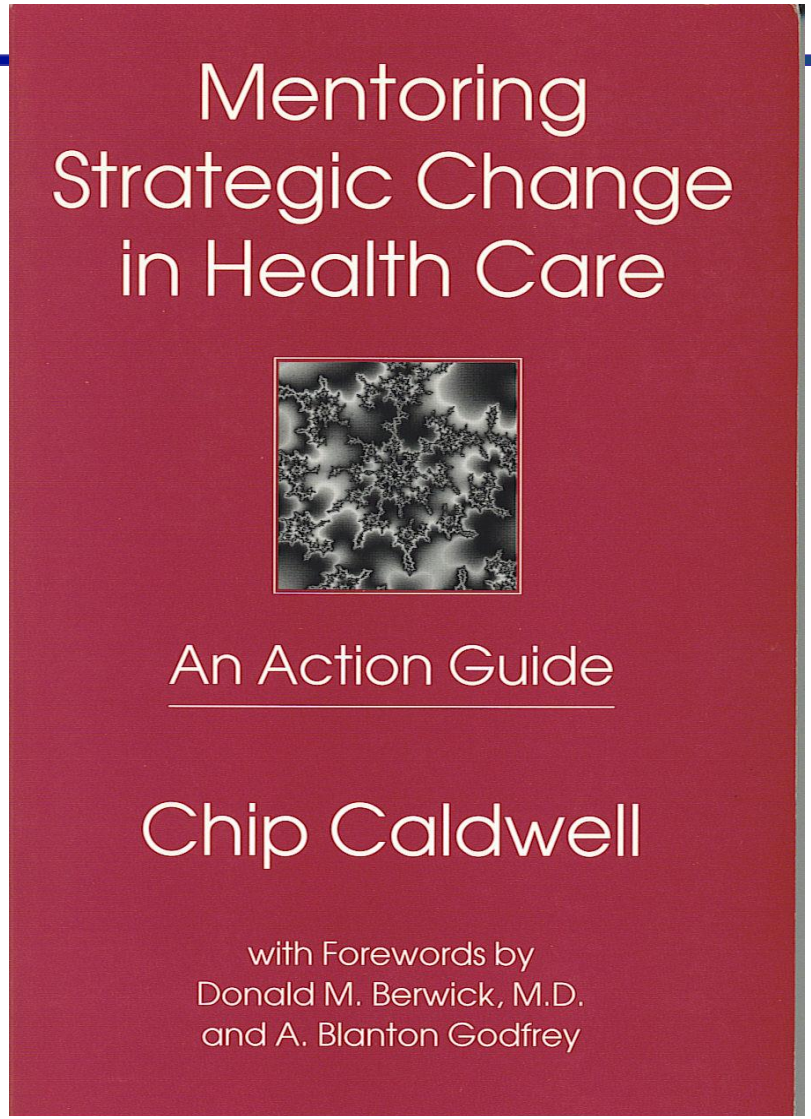


Dialogue #1
Do you have a Cascading System of Measures?

Assess your organization's cascade of dashboards and measures

- Does Corewell Health have a cascading system of measurement? Or, are the measures unrelated and fragmented?
- How long do your dashboards stay in place? Do they have continuity or are they here one day and gone the next?
- Are your dashboards regularly reviewed by an appropriate oversight group? For example, are there dashboards that the Board, senior leaders and managers regularly review? Do staff get to review dashboards?
- Do your dashboards cascade from the top down (macro level) or percolate up from the staff (micro level)?

Building a balanced set of measures



"In spite of a general agreement by most senior leaders of the critical need for a strategic measurement set, ***some organizations stop short of establishing quantifiable measures of all dimensions of their strategies, except financial****.*

They would do well to mimic the same logic they follow in their financial accounting system for their strategic requirements."

Chip Caldwell, 1995, p. 97

Components of a Balanced Set of Measures

S + P + C* = O

Structure + Process + Culture = Outcomes

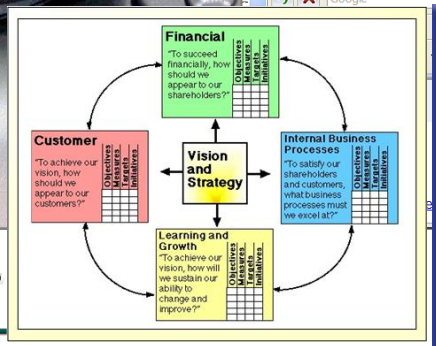
Does your organization's strategic measures reflect a balanced set of measures?

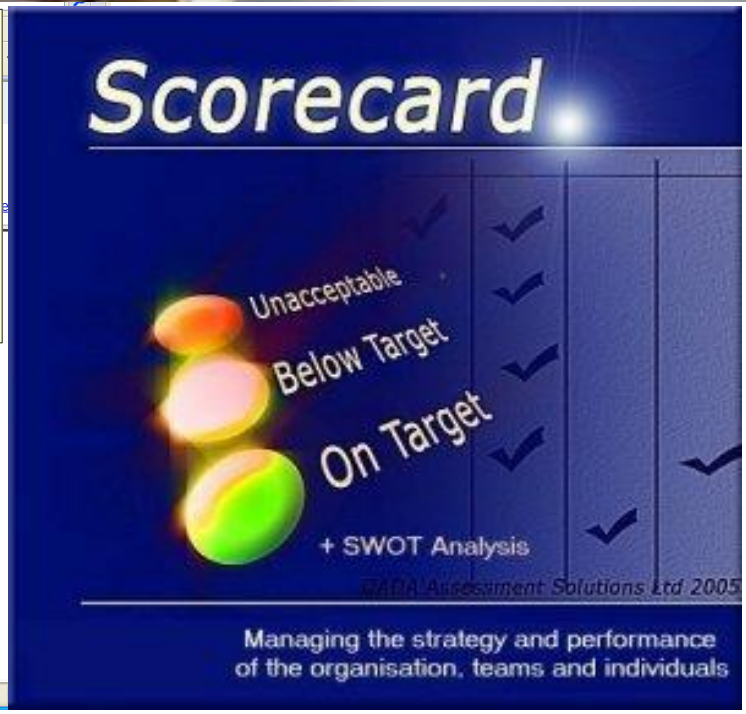
Source: Donabedian, A. *Explorations in Quality Assessment and Monitoring. Volume I: The Definition of Quality and Approaches to its Assessment.* Ann Arbor, MI, Health Administration Press, 1980.

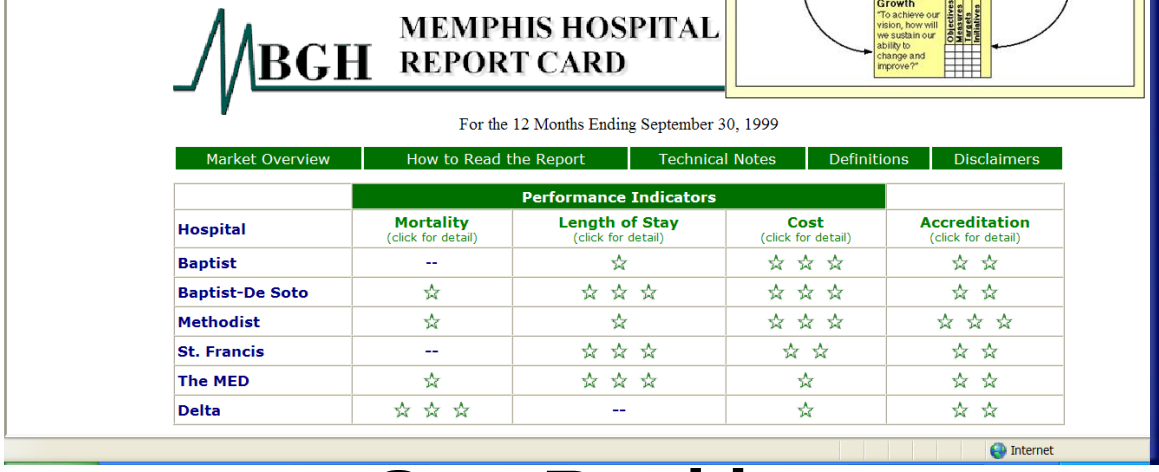
*The Culture component was added by R. Lloyd and R. Scoville to highlight the important role culture plays in driving the Outcomes.

Options for Organizing Your Measures

Dashboards







BGH MEMPHIS HOSPITAL REPORT CARD

For the 12 Months Ending September 30, 1999

Market Overview | How to Read the Report | Technical Notes | Definitions | Disclaimers

Hospital	Performance Indicators: Mortality (click for detail)	Length of Stay (click for detail)	Cost (click for detail)	Accreditation (click for detail)
Baptist	--	☆	☆ ☆ ☆	☆ ☆
Baptist-De Soto	☆	☆ ☆ ☆	☆ ☆ ☆	☆ ☆
Methodist	☆	☆	☆ ☆ ☆	☆ ☆ ☆
St. Francis	--	☆ ☆ ☆	☆ ☆	☆ ☆
The MED	☆	☆ ☆ ☆	☆	☆ ☆
Delta	☆ ☆ ☆	--	☆	☆ ☆

Internet

Star Rankings

Defining Scorecards, Report Cards and Dashboards

- ***Balanced Scorecard*** began as a recommended set of measures that went beyond the traditional management focus on financial measures to answer the question "*What classes of measures should **senior managers** use*?"
- ***Report Cards*** emerged as a variation on the Balanced Scorecard (usually data for judgment).
- ***Dashboards*** provide a means to synthesize key measures. They initially answered the question "*What methods should senior managers use to **interact** with key measures*?"
  - *Show data in graphical displays*
  - *Use drill-downs to deeper levels (disaggregate, stratify)*
  - *Use timely data, relative to your decision-making cycle*
- ***You can use dashboard methods (dynamic approach) to display and structure measures listed in a Balanced Scorecard or Report Card (static approach).***

Appreciation is extended to Kevin Little, Ph.D., IHI Improvement Advisor, for sharing his ideas on this topic.

Background on The Balanced Scorecard

- Balanced Scorecard was developed in the early 1990's by Drs. Kaplan and Norton and first described in the in the *Harvard Business Review*.
- Kaplan and Norton have continued to develop the concept since 1992, extending the initial measurement system into a strategy management system.
- A key aspect in deployment is linking the measures to strategies and actions that will drive improvement in the measures.

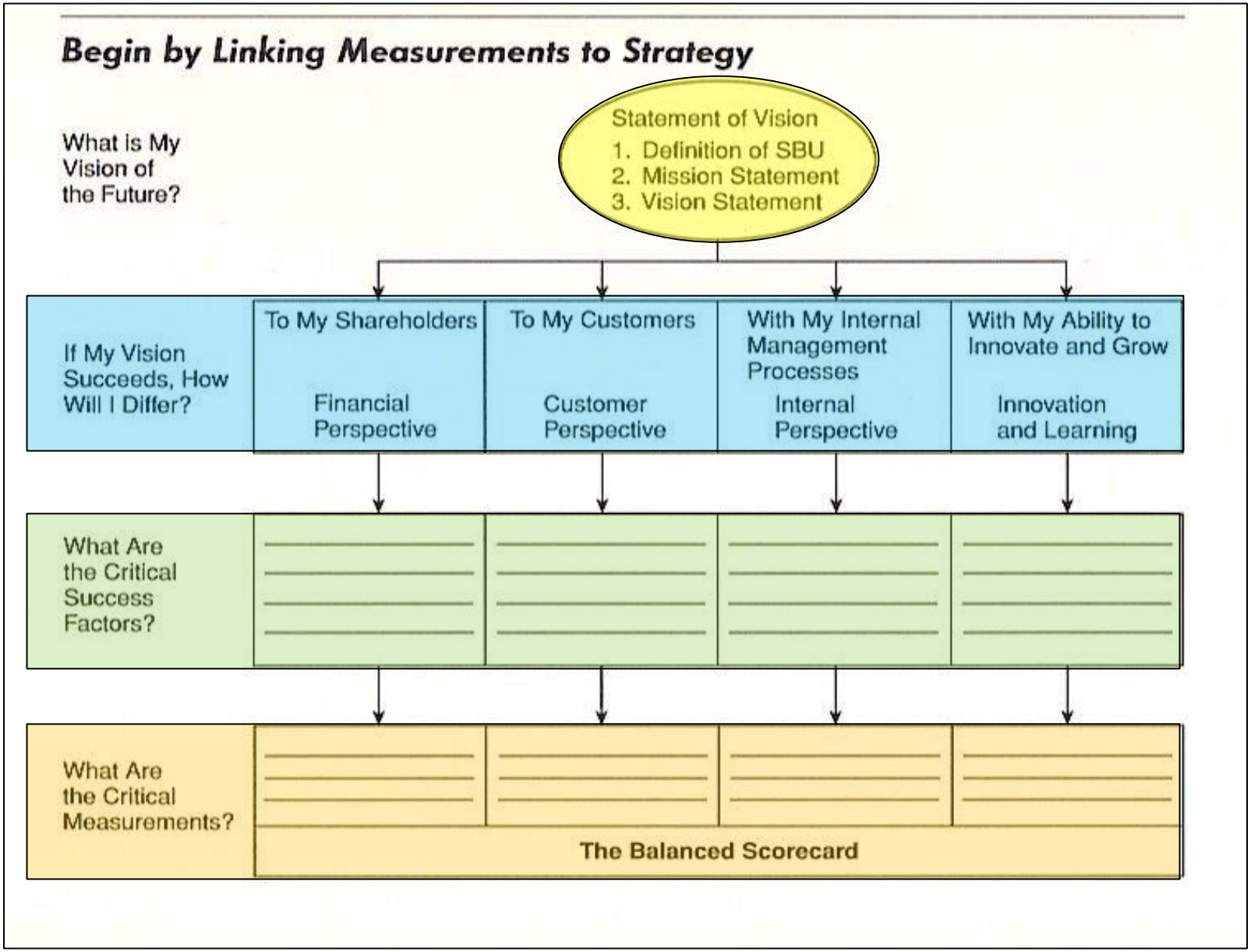
References

R.S. Kaplan and D.P. Norton (1992), "The Balanced Scorecard—Measures that Drive Performance," *Harvard Business Review*, Jan-Feb 1992, pp. 71-79.

R.S. Kaplan and D.P. Norton (1993), "Putting the Balanced Scorecard to Work," *Harvard Business Review* Sept-Oct 1993, pp. 134-137.

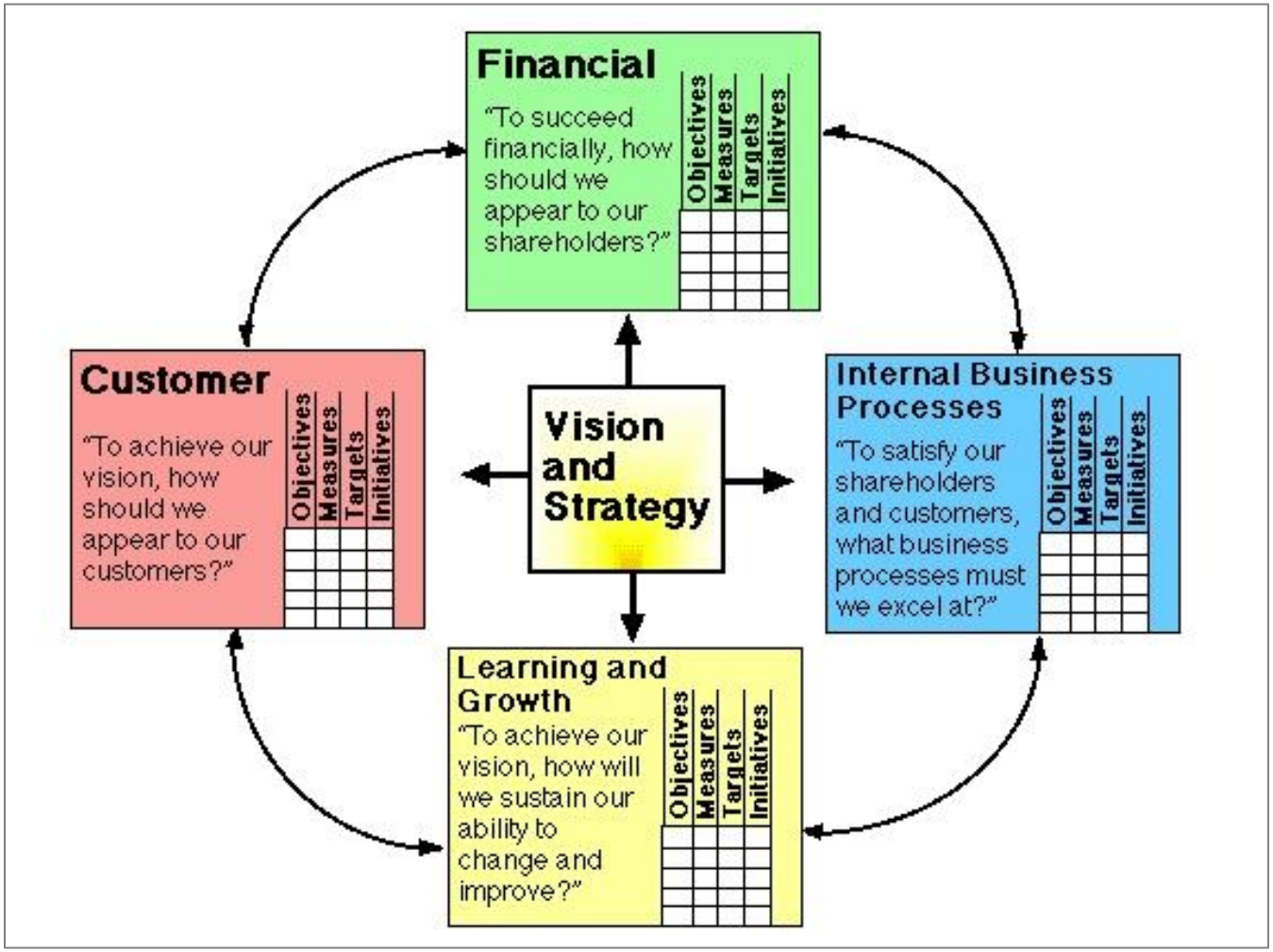
R.S. Kaplan and D.S. Norton (1996), "Using the Balanced Scorecard as a Strategic Management System, " Harvard Business Review, Jan-Feb 1996.

R. S. Kaplan *Conceptual Foundations of the Balanced Scorecard.* Working Paper 10-074, Harvard Business School, Harvard University, 2010. Originally prepared for C. Chapman, A. Hopwood, and M. Shields (eds.), Handbook of Management Accounting Research: Volume 3 (Elsevier, 2009).



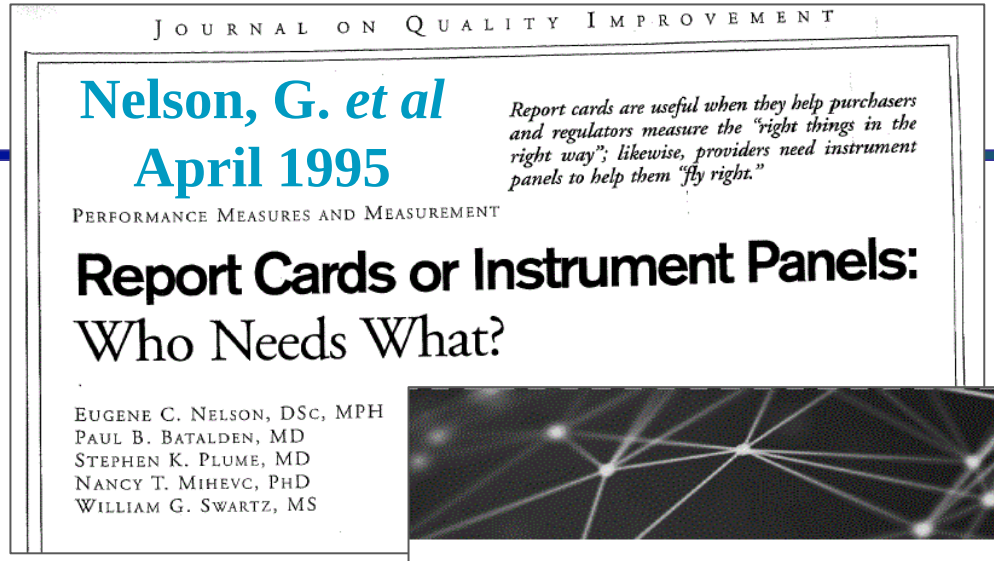
R.S. Kaplan and D.P. Norton (1993), "Putting the Balanced Scorecard to Work," *Harvard Business Review* Sept-Oct 1993, pp. 134-137.

The Kaplan & Norton's Balanced Scorecard



Source: http://www.balancedscorecard.org/basics/bsc1.html

Report Cards and Scorecards can be found in all industries!



JOURNAL ON QUALITY IMPROVEMENT

Nelson, G. *et al*
April 1995

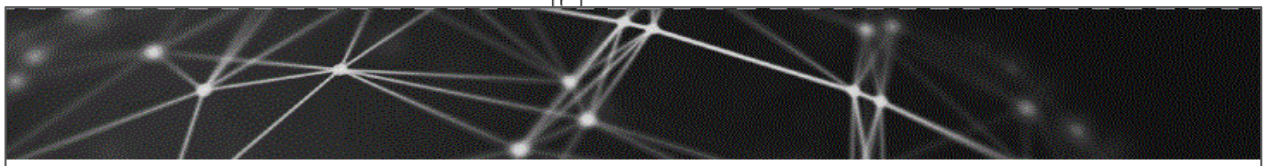
Report cards are useful when they help purchasers and regulators measure the "right things in the right way"; likewise, providers need instrument panels to help them "fly right."

PERFORMANCE MEASURES AND MEASUREMENT

Report Cards or Instrument Panels: Who Needs What?

EUGENE C. NELSON, DSc, MPH
PAUL B. BATALDEN, MD
STEPHEN K. PLUME, MD
NANCY T. MIHEVC, PhD
WILLIAM G. SWARTZ, MS

A great deal of literature has been written on Scorecards, Report Cards and Dashboards.



CHAPTER 5

Lloyd. R.
September 2019

Organizing Indicators into a Strategic Dashboard

Most quality improvement (QI) teams will create more than one indicator. If your organization has 10 to 15 improvement teams this means that you could be looking at managing somewhere between 50 to 120 indicators (assuming that each team creates 5 to 8 indicators, which is usually at the low end of what teams want to track). So, how do you go about organizing multiple indicators? First

Each row in Table 5-1 represents a single indicator. The columns identify the major pieces of information that need to be summarized about each indicator. **TABLE 5-2** provides an example of a completed measurement plan for a team working to improve the medicines management process. Three key concepts provide the focus for the team (i.e., volume, patient safety, and efficiency). Each concept will be captured by:

Instrumental Panel and Dashboard Image

Decision making . . . Dynamic . . . Empowering

- Who uses them? Cockpit crew (pilot, copilot, navigator)
- Who interprets? Cockpit crew
- Focus? Present and future
- Utility? Real-time monitoring, predicting the future and taking action

"The instrument panel or dashboard metaphor has an entirely different aura from that of the report card. It has vitality, timeliness, and a clear-cut utility that is absent from report card thinking. A key feature is providing critical, real-time information to the user to prompt wise decisions and, if need be, make rapid midcourse corrections."

Adapted from "Report Cards or Instrument Panels: Who Needs What?
By Eugene Nelson, et al, *Journal of Quality Improvement,* volume 21, number 4, April, 1995.

What are the benefits of developing and using a Dashboard of Strategic Indicators?

- ✓ It brings together, in a single management report, many of the seemingly disparate elements of an organization's strategic agenda.
- ✓ It helps to reduce information overload, by focusing on the "vital few" indicators.
- ✓ It helps to guard against *suboptimization* by forcing senior managers to consider all the important measures together and lets them see whether improvement in one area may be achieved at the expense of another.
- ✓ It puts strategy and vision, rather than control, at the center of an organization's effort.
- ✓ It is based on an understanding of interrelationships between functions, not on the performance of individual functions or units.
- ✓ It provides an opportunity for organizational learning at the executive level.

But how many measures do you need on your dashboard?

Focus on the Vital Few!

There are many things in life that are *interesting* to know. It far more important, however, to work on those things that are *essential* to quality than to spend time working on what is merely interesting!

"A general rule: If a team has more than 15 measures, it should take a fresh look at the importance of each one."

"How the Right Measures Help Teams Excel" Christopher Meyer, *HBR*, May-June 1994.

Focus on the Vital Few!

"Most companies use too many measures to hold their managers and employees accountable for performance."

"People should be held accountable only for as many diagnostics measures as they can memorize. We would suggest, therefore, that the limit be seven."

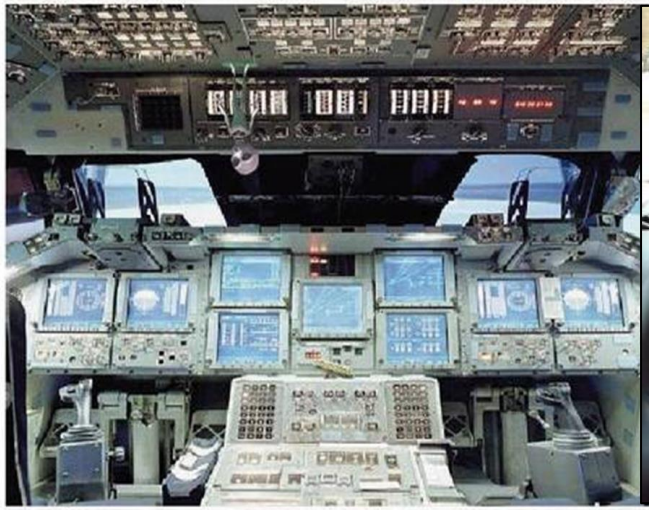
"Why seven? If people are given too few challenges, there won't be enough variety in their work to stimulate creativity. If people are given too many challenges, they quickly suffer from overload."

References

*R. Simons and A. Davila. "*How High Is Your Return on Management?"
HBR, January-February, 1998.

G. Miller. "The Magic Number Seven, Plus or Minus Two: Some Limits in Our Capacity for Processing Information." *The Psychological Review,* Vol. 63, No. 2, 1956, pp. 193-214.

Dialogue #2
So, have you built a stealth bomber, a car, or a motorcycle dashboard?



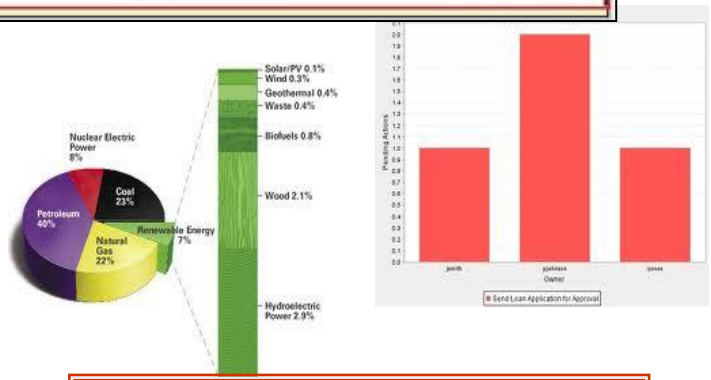
The dashboard challenge, therefore, is to be disciplined enough to focus on the essential (or vital few) things and set aside those things that might be interesting but trivial!

How you display the data will make a big difference.

Data for Judgment (static) versus data for Improvement (dynamic)

You do have a choice!

Data for Improvement



Data for Judgment

Example of Summary Data

(What do you learn from these data?)

Legend for Status of Goals (Based on Annual Goal)
- Goal Met (GREEN)
- Goal 75% Met (YELLOW)
- Goal Not Met (RED)

FY 2009 Hospital System-Level Measures

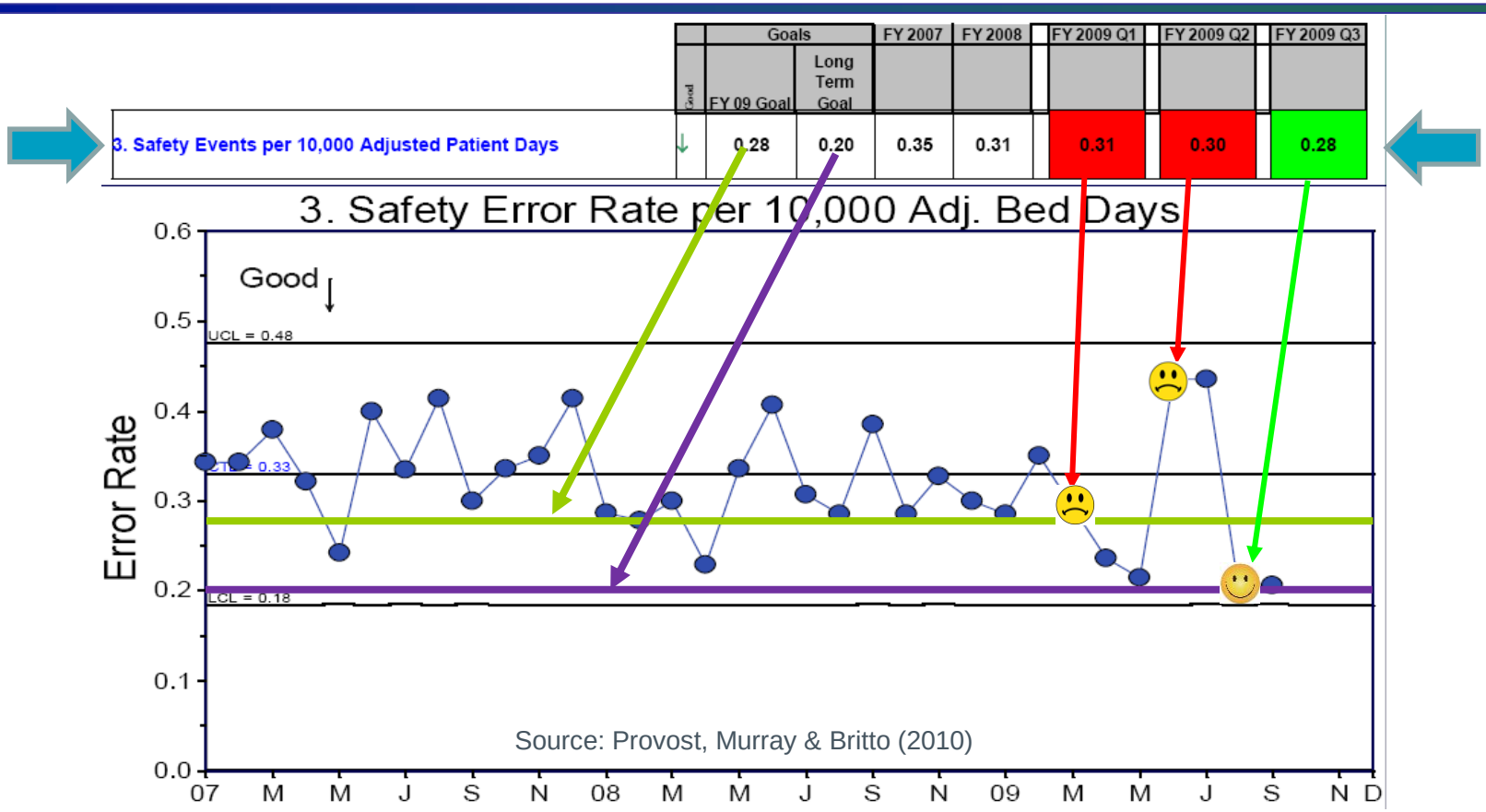
	Good	Goals: FY 09 Goal	Goals: Long Term Goal	FY 2007	FY 2008	FY 2009 Q1	FY 2009 Q2	FY 2009 Q3
Patient Perspective								
1. Overall Satisfaction Rating: Percent Who Would Recommend (Includes inpatient, outpatient, ED, and Home Health)	↑	60%	80%	37.98%	48.98%	57.19%	56.25%	51.69%
2. Wait for 3rd Next Available Appointment: Percent of Areas with appointment available in less than or equal to 7 business days (n=43)	↑	65%	100%	53.5%	51.2%	54.3%	61.20%	65.1%
Patient Safety								
3. Safety Events per 10,000 Adjusted Patient Days	↓	0.28	0.20	0.35	0.31	0.31	0.30	0.28
4. Percent Mortality	↓	3.50	3.00	4.00	4.00	3.48	3.50	3.42
5.Total Infections per 1000 Patient Days	↓	2	0	3.37	4.33	4.39	2.56	1.95
Clinical								
6. Percent Unplanned Readmissions	↓	3.5%	1.5%	6.1%	4.8%	4.6%	4.1%	3.5%
7. Percent of Eligible Patients Receiving Perfect Care--Evidence Based Care (Inpatient and ED)	↑	95%	100%	46%	74.1%	88.0%	91.7%	88.7%
Employee Perspective								
8. Percent Voluntary Employee Turnover	↓	5.80%	5.20%	5.20%	6.38%	6.10%	6.33%	6.30%
9. Employee Best Possibl					3.80	3.96	3.95	3.95
Operational								
10. Percent					84.0%	91.3%	85.6%	87.2%
11. Average					4.90	4.60	4.70	4.30
12. Physician Best Possibl					3.84	3.96	3.80	3.87
Community								
13. Percent					7.00%	6.90%	6.93%	7.00%
14. Percent Programs					0.29%	0.28%	0.31%	0.29%
Financial Perspective								
15. Operating Margin-Percent	↑	1.2%	1.5%	-0.5%	0.7%	0.9%	0.4%	0.7%
16. Monthly Revenue (Million)-change so shows red--but sp cause good related to occupancy	↑	20.0	20.6	17.6	16.9	17.5	18.3	19.2

There is no learning here. This is data for judgment not improvement!

Source: Provost, Murray & Britto (2010)

How Is the Error Rate Doing?

(What do you learn from these data?)



The process reflects common cause variation which means this performance is stable and therefore predictable. But is this current process capable of achieving the short and long terms goals?

Now let's look at another measure

(percent of eligible patients receiving perfect care bundle)

Legend for Status of Goals (Based on Annual Goal)
- Goal Met (GREEN)
- Goal 75% Met (YELLOW)
- Goal Not Met (RED)

FY 2009 Hospital System-Level Measures

	Good	Goals		FY 2007	FY 2008	FY 2009 Q1	FY 2009 Q2	FY 2009 Q3
		FY 09 Goal	Long Term Goal					
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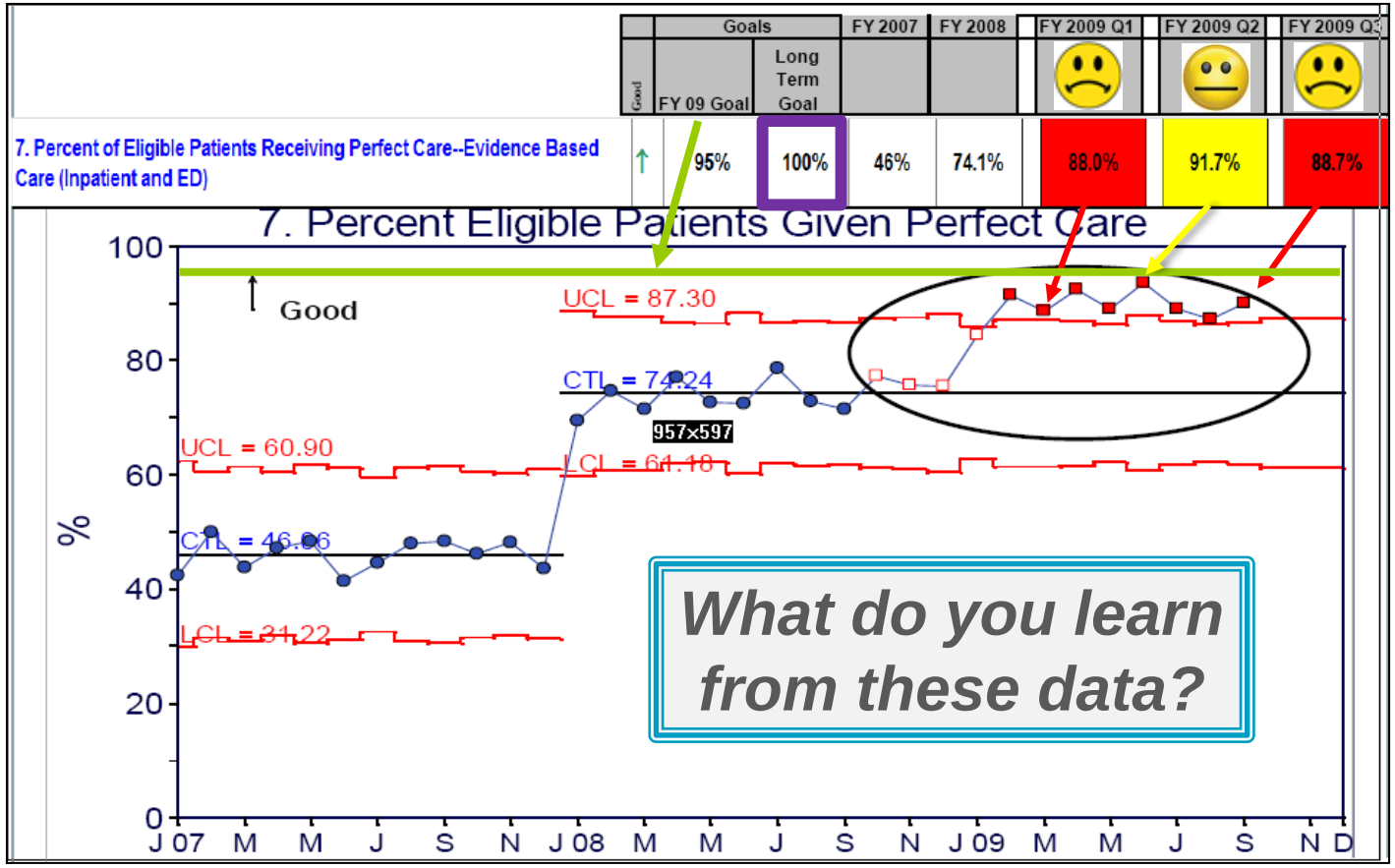
Employee Perspective								
8. Percent Voluntary Employee Turnover	↓	5.80%	5.20%	5.20%	6.38%	6.10%	6.33%	6.30%
9. Employee Satisfaction: Average Rating Using 1-5 Scale (5 Best Possible)	↑	4.00	4.25	3.90	3.80	3.96	3.95	3.95
Operational Performance								
10. Percent Occupancy	↑	88.0%	90.0%	81.3%	84.0%	91.3%	85.6%	87.2%
11. Average Length of Stay	↓	4.30	3.80	5.20	4.90	4.60	4.70	4.30
12. Physician Satisfaction: Average Rating Using 1-5 Scale (5 Best Possible)	↑	4.00	4.25	3.80	3.84	3.96	3.80	3.87
Community Perspective								
13. Percent of Budget Allocated to Non-recompensed Care		7.00%	7.00%	5.91	7.00%	6.90%	6.93%	7.00%
14. Percent of Budget Spent on Community Health Promotion Programs		0.30%	0.30%	0.32%	0.29%	0.28%	0.31%	0.29%
Financial Perspective								
15. Operating Margin-Percent	↑	1.2%	1.5%	-0.5%	0.7%	0.9%	0.4%	0.7%
16. Monthly Revenue (Million)-change so shows red--but sp cause good related to occupancy	↑	20.0	20.6	17.6	16.9	17.5	18.3	19.2

Source: Provost, Murray & Britto (2010)

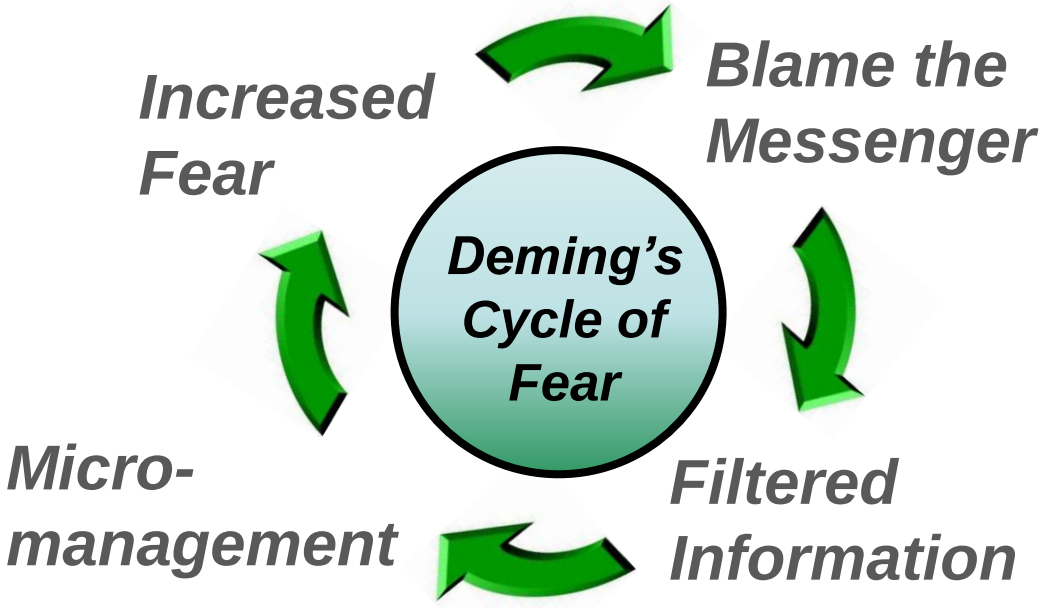
How is Perfect Care Doing Now?



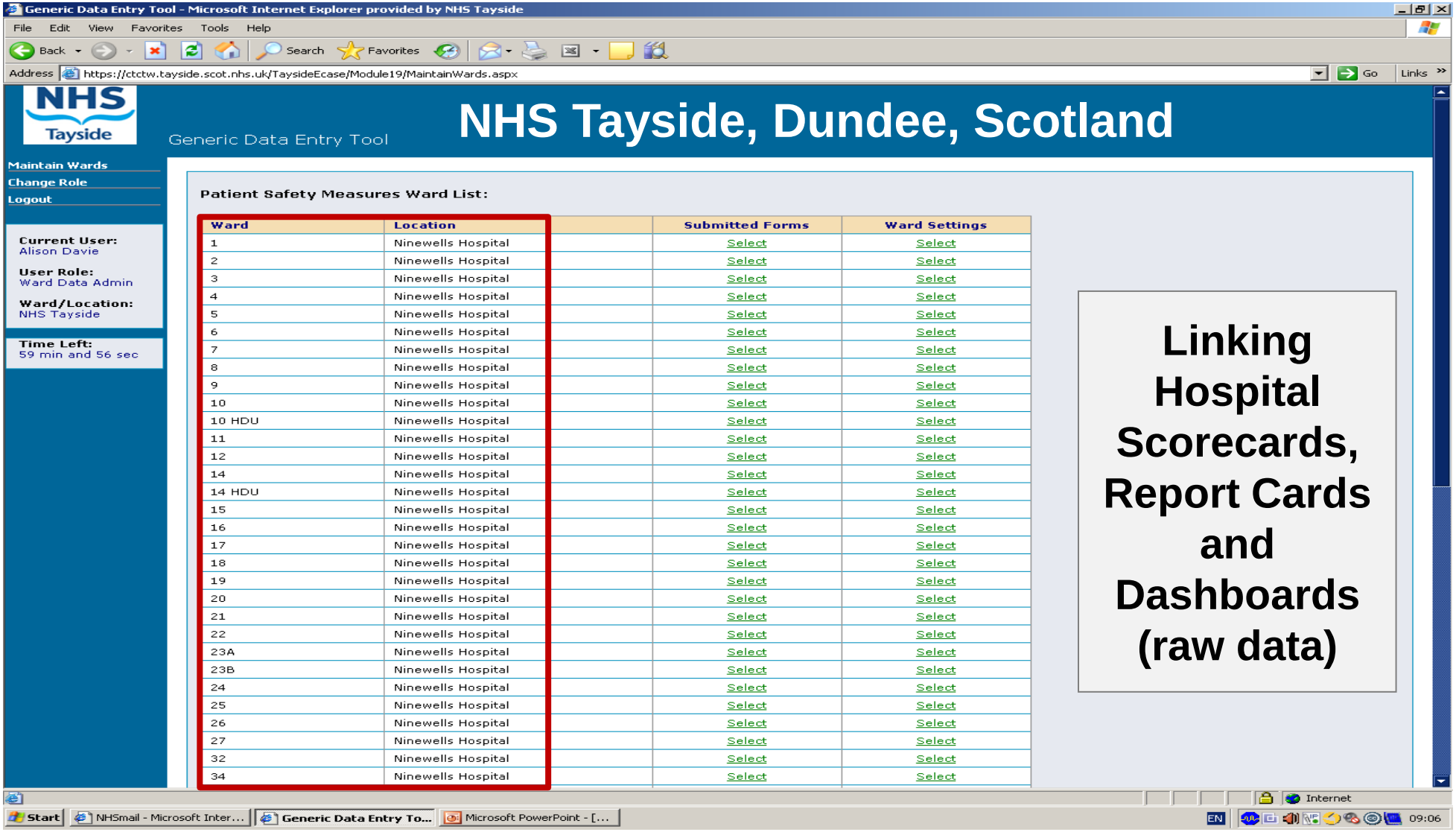
Source: Provost, Murray & Britto (2010)

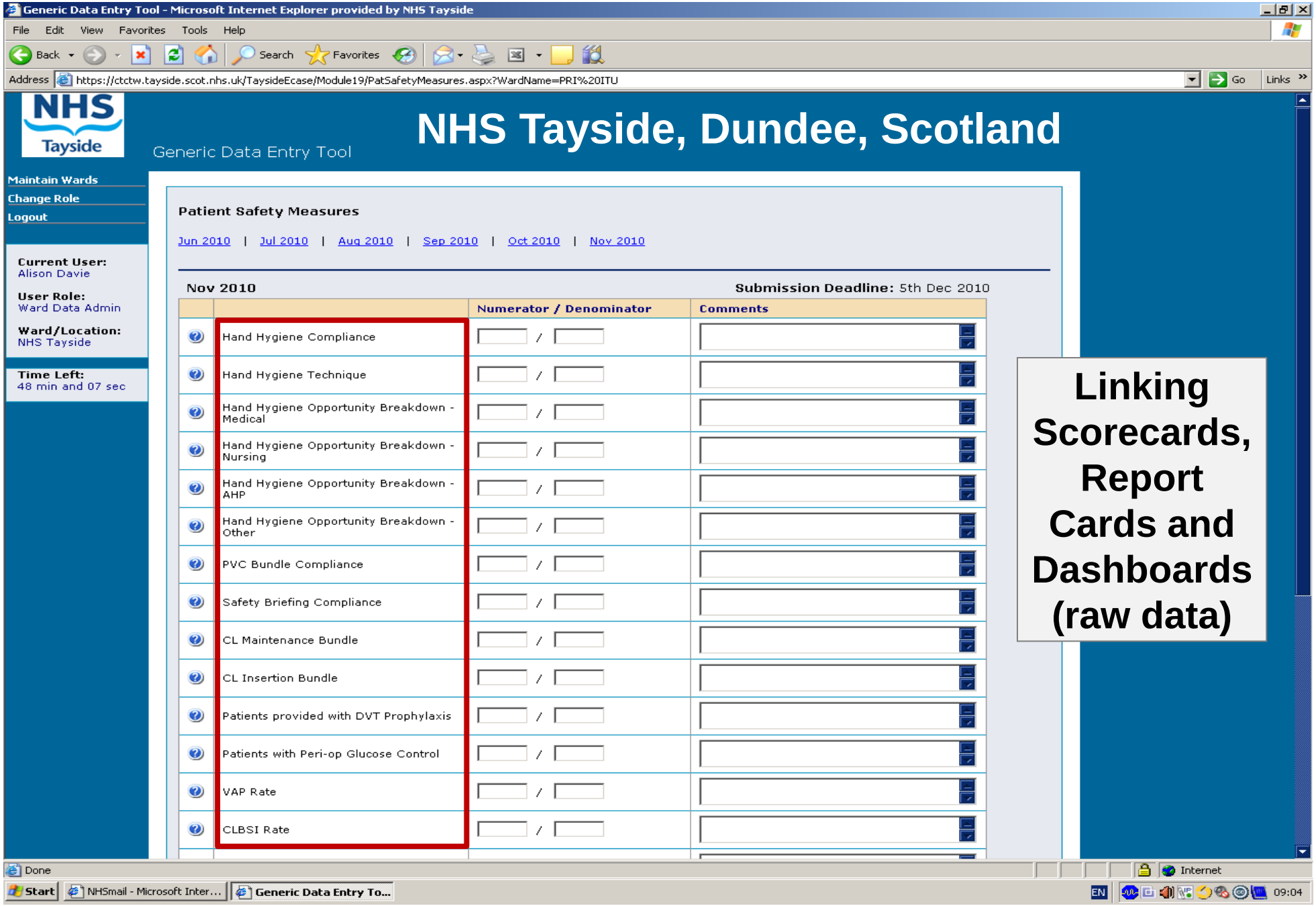
Unintended consequences of using Scorecards and Report Cards

Source: William Scherkenbach. The Deming Route to Quality and Productivity. Ceep Press, Washington, DC, 1990, page 71.

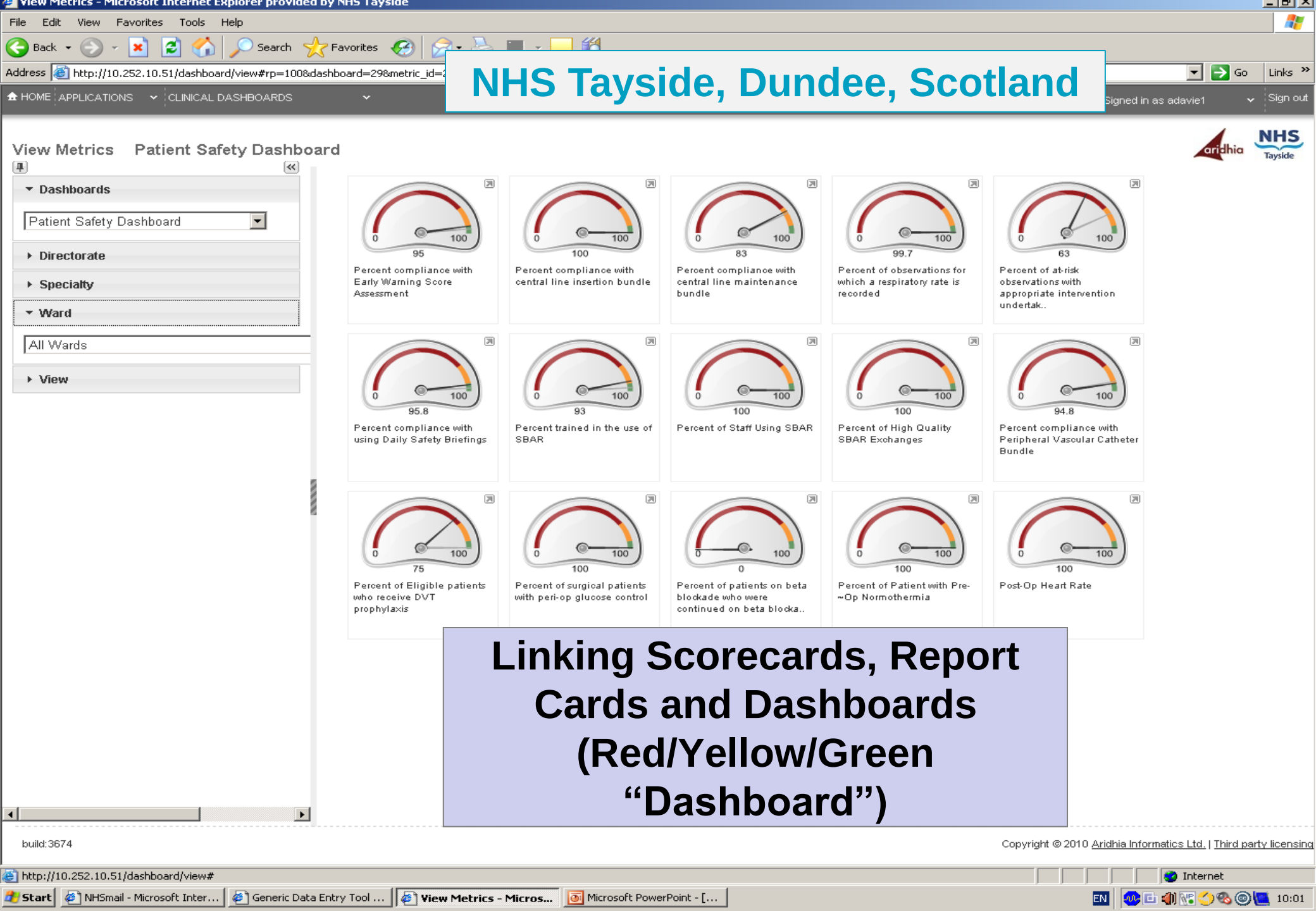


Moving from Data for Judgment to Data for Improvement

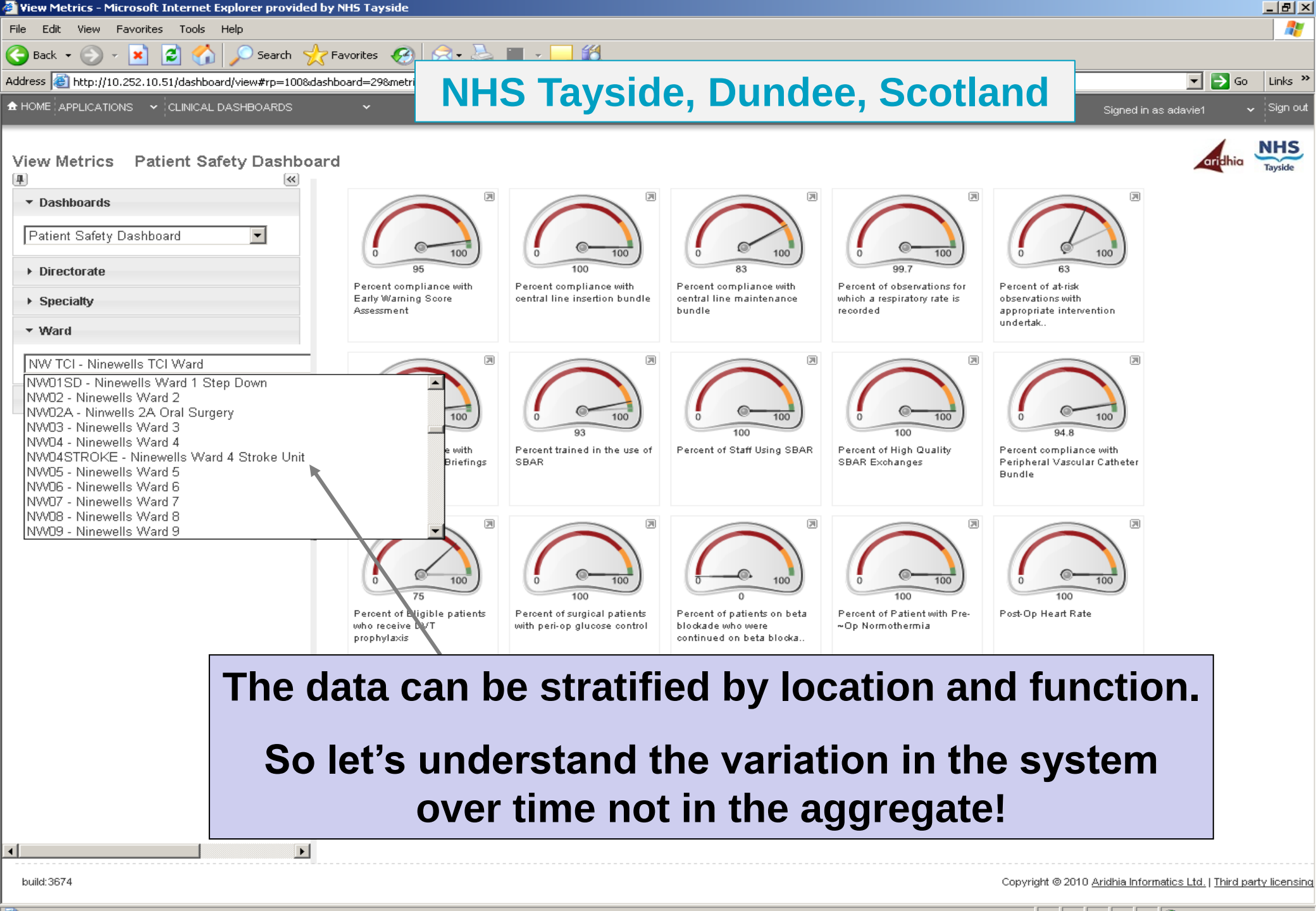




NHS Tayside, Dundee, Scotland



Linking Scorecards, Report Cards and Dashboards (Red/Yellow/Green "Dashboard")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File Edit View Favorites Tools Help
Back Search Favorites
Address http://10.252.10.51/dashboard/view#rp=100&dashboard=29&metri
Go Links
HOME APPLICATIONS CLINICAL DASHBOARDS
Signed in as adavie1 Sign out
NHS Tayside, Dundee, Scotland
View Metrics Patient Safety Dashboard
aridhia NHS Tayside
Dashboards
Patient Safety Dashboard
Directorate
Specialty
Ward
NW TCI - Ninewells TCI Ward
NW01SD - Ninewells Ward 1 Step Down
NW02 - Ninewells Ward 2
NW02A - Ninwells 2A Oral Surgery
NW03 - Ninewells Ward 3
NW04 - Ninewells Ward 4
NW04STROKE - Ninewells Ward 4 Stroke Unit
NW05 - Ninewells Ward 5
NW06 - Ninewells Ward 6
NW07 - Ninewells Ward 7
NW08 - Ninewells Ward 8
NW09 - Ninewells Ward 9
95
Percent compliance with Early Warning Score Assessment
100
Percent compliance with central line insertion bundle
83
Percent compliance with central line maintenance bundle
99.7
Percent of observations for which a respiratory rate is recorded
63
Percent of at-risk observations with appropriate intervention undertak..
93
Percent trained in the use of SBAR
100
Percent of Staff Using SBAR
100
Percent of High Quality SBAR Exchanges
94.8
Percent compliance with Peripheral Vascular Catheter Bundle
75
Percent of Eligible patients who receive DVT prophylaxis
100
Percent of surgical patients with peri-op glucose control
0
Percent of patients on beta blockade who were continued on beta blocka..
100
Percent of Patient with Pre-~Op Normothermia
100
Post-Op Heart Rate
The data can be stratified by location and function.
So let's understand the variation in the system over time not in the aggregate!
build:3674
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Metric Details - Microsoft Internet Explorer provided by NHS Tayside

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Address http://10.252.10.51/dashboard/detail#metric_id=237 Go Links

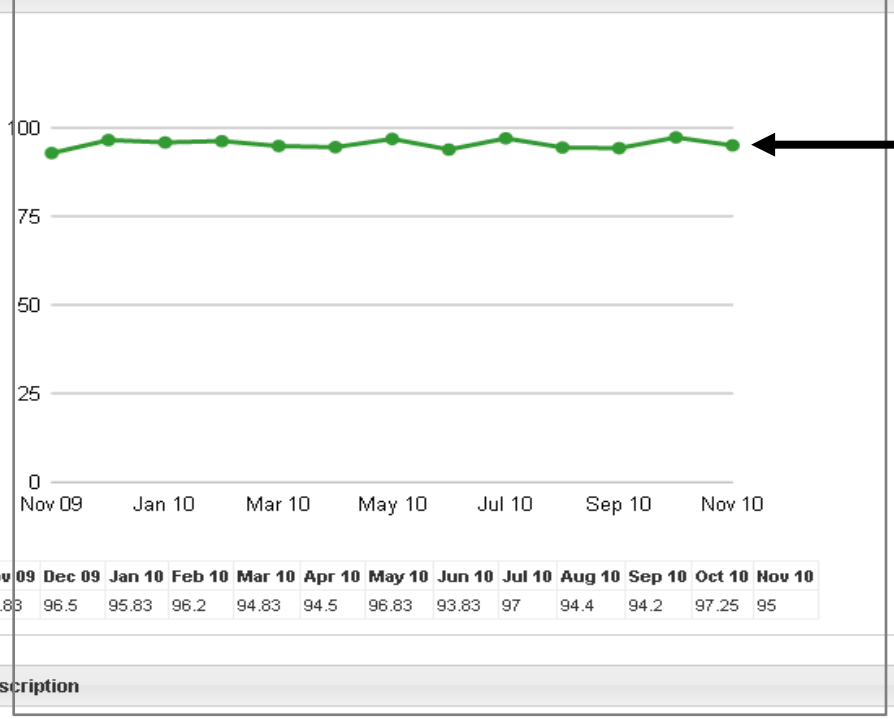
HOME APPLICATIONS CLINICAL DASHBOARDS Signed in as adavie1 Sign out

NHS Tayside, Dundee, Scotland

Metric Details Early Warning Score Assessment compliance

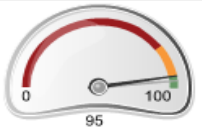
aridhia NHS Tayside

Trendline



Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10
92.83	96.5	95.83	96.2	94.83	94.5	96.83	93.83	97	94.4	94.2	97.25	95

Overview



95
% compli..
-2.3%

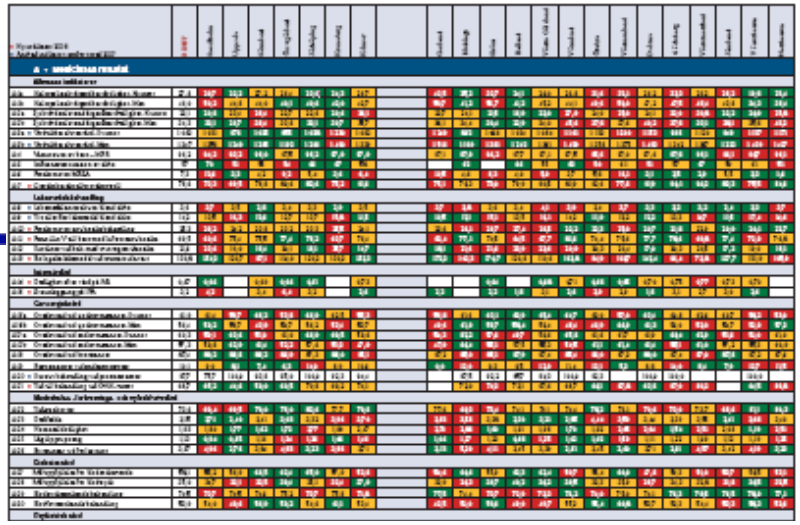
Description

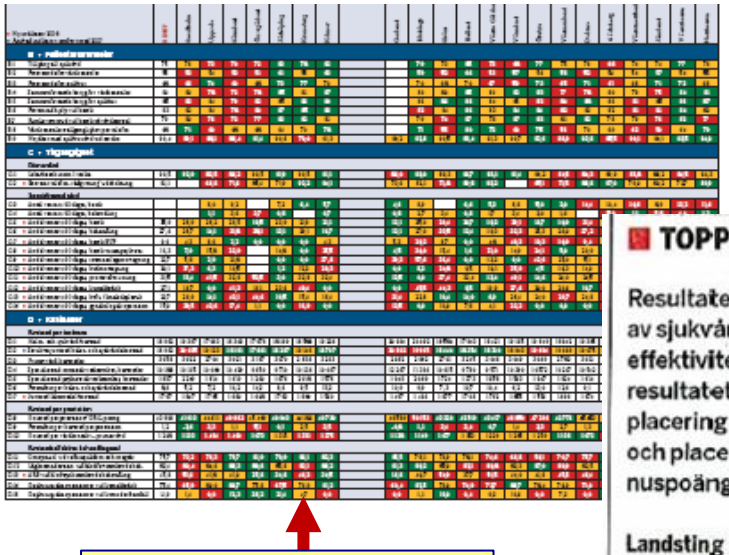
Metric	Early Warning Score Assessment compliance
Group	Patient Safety
Category	Process measure for the Scottish Patient Safety Programme
Description	*No data*
Rationale	Process measure for the Scottish Patient Safety Programme

When you click on a report card dial, up pops a plot of the data over time.

build:3674

Done Internet

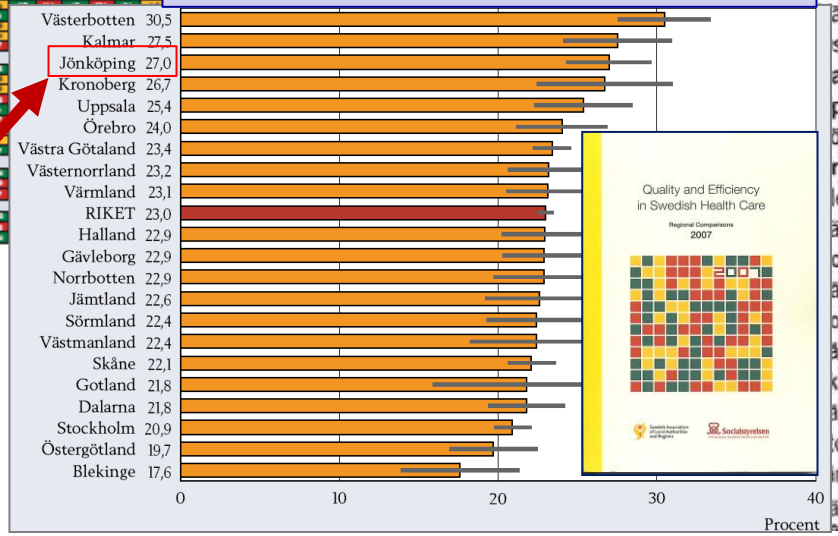




Jonkoping County

Jonkoping County

Swedish Open Comparisons. Is this data for improvement?

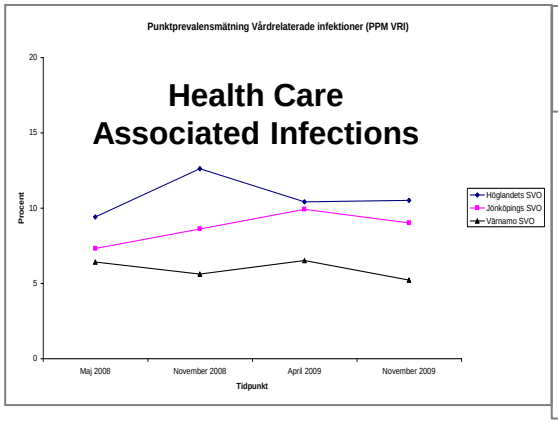


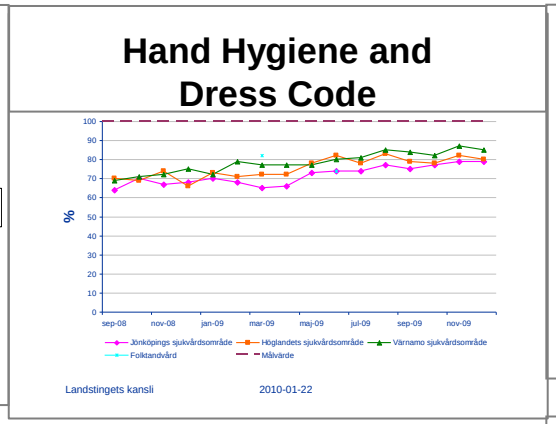
TOPPLISTAN 2008

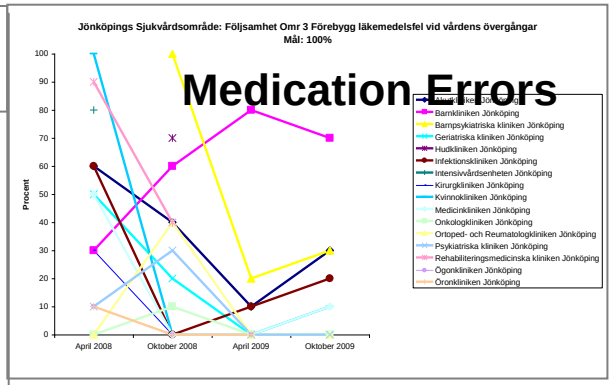
Resultatet av öppna jämförelser av sjukvårdens kvalitet och effektivitet 2008. Summering av resultatet för 101 indikatorer där placering 1–7 ger ett pluspoäng och placering 15–21 ger ett minuspoäng.

Landsting	Poäng –08	Placering –07	–06
Jönköping	29	3	3
Halland	26	5	1
Västmanland	15	4	12
Kronoberg	12	2	2
Kalmar	12	5	6
ästerbotten	11	7	7
stergötland	7	8	9
alarna	7	15	15
ppsala	6	11	19
örmland	6	8	13
rebro	4	10	4
lekinge	0	1	4
ästernorrland	0	14	18
orrbotten	–1	11	7
ävleborg	–3	19	17
otland	–8	20	19
ästra Götaland	–9	16	16
kåne	–11	13	10
ärmland	–12	17	13
ockholm	–15	17	19
mtland	–27	21	11

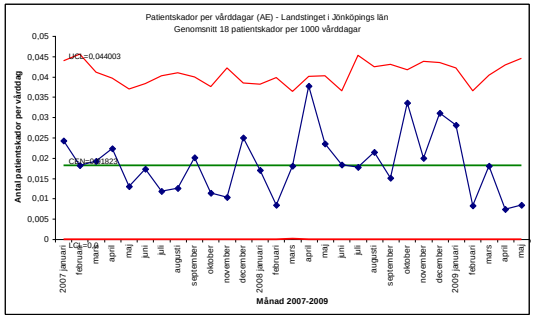
älla: SKL/Socialstyrelsen.
arbetning: Dagens Samhälle

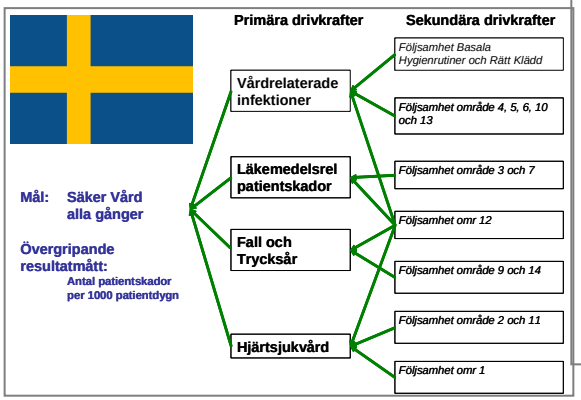


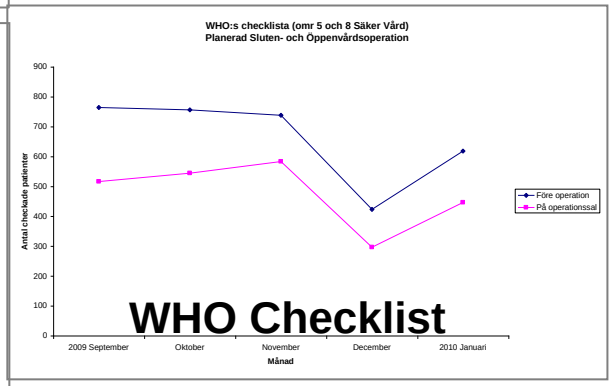




AE rate







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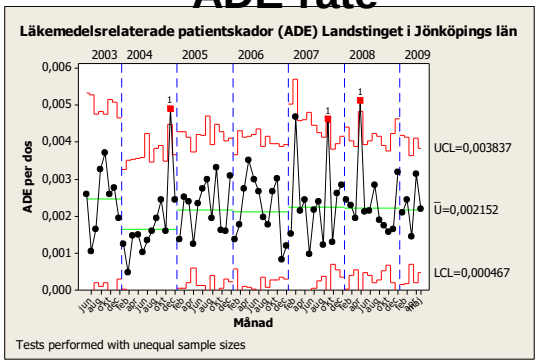
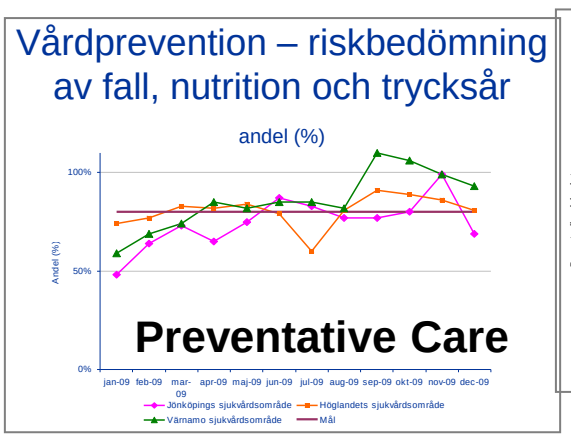
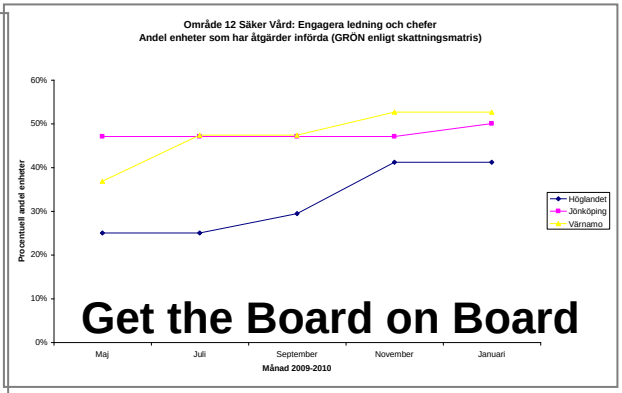
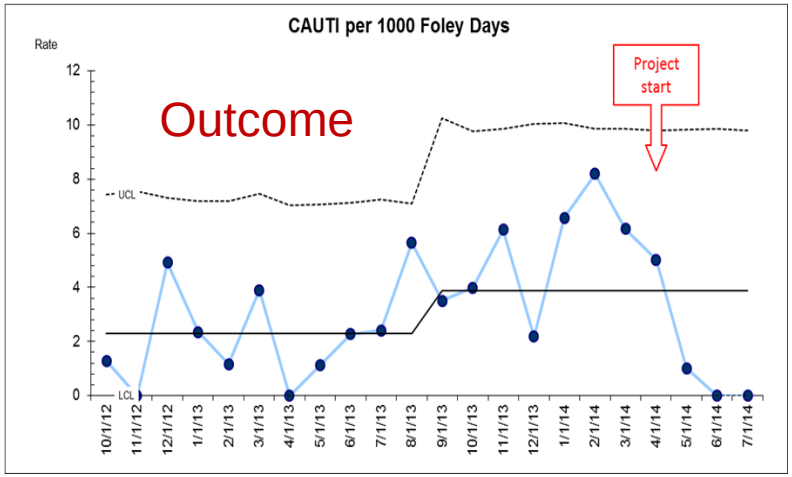


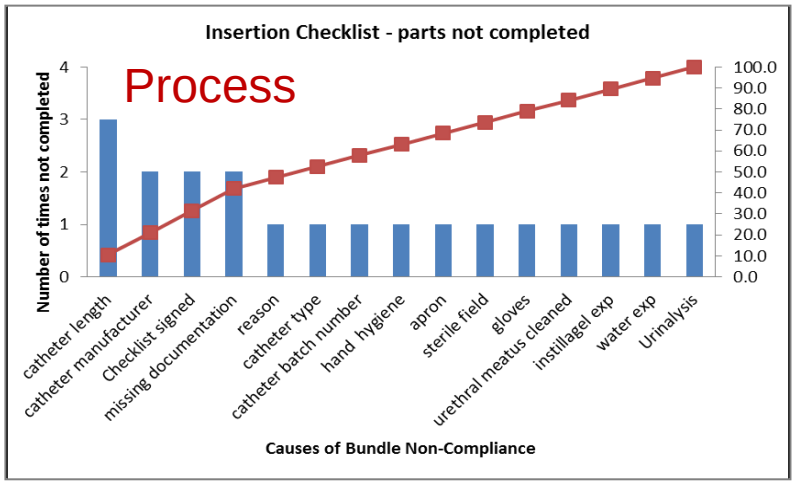


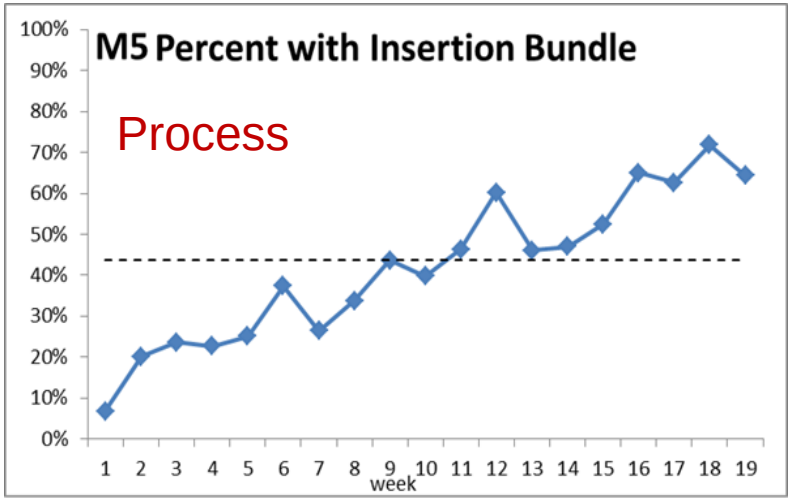


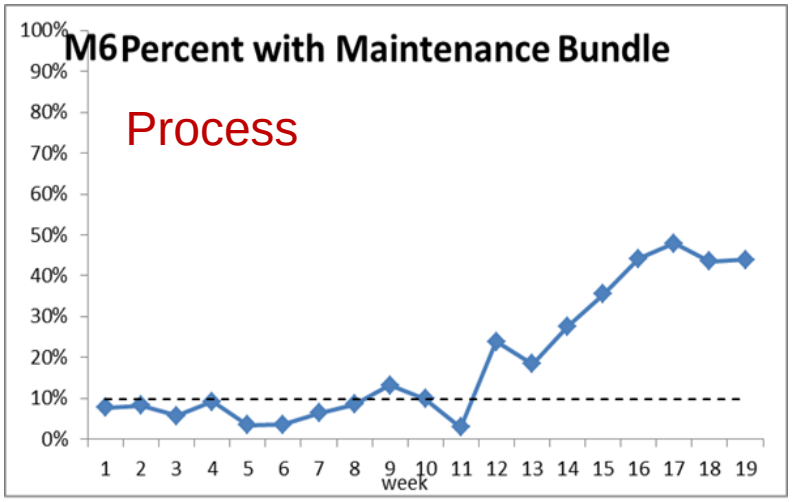
The Alternative to the R/Y/G Charts

Using Small Multiples to Display your Dashboard



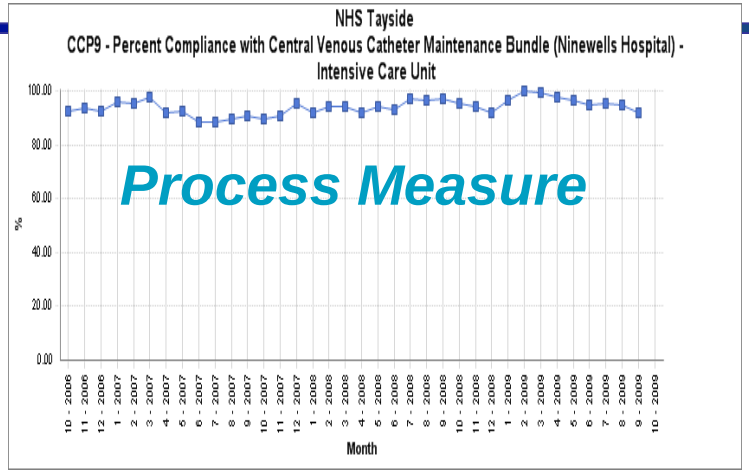


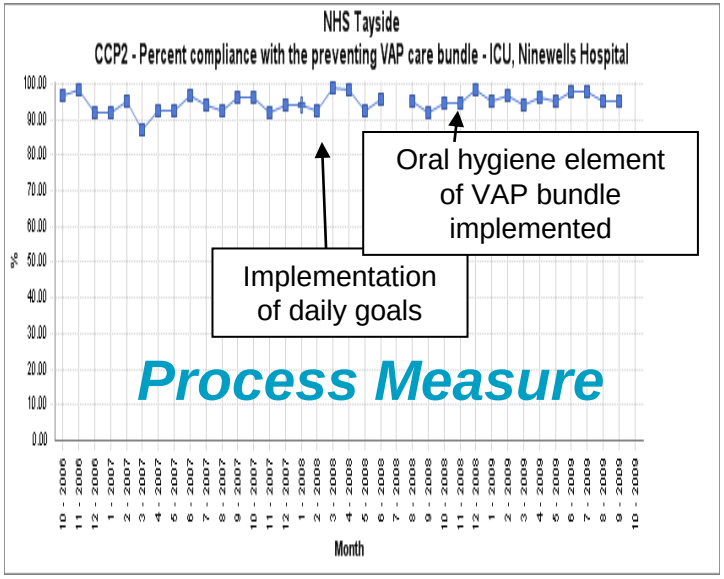




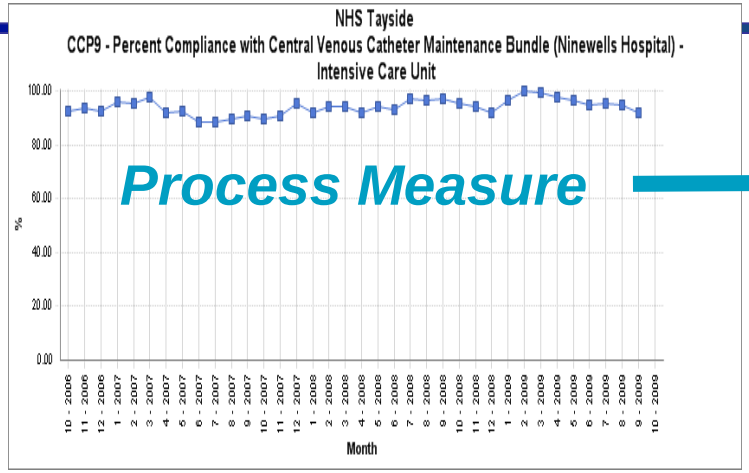
CAUTI Dashboard (Outcome & Process Measures)

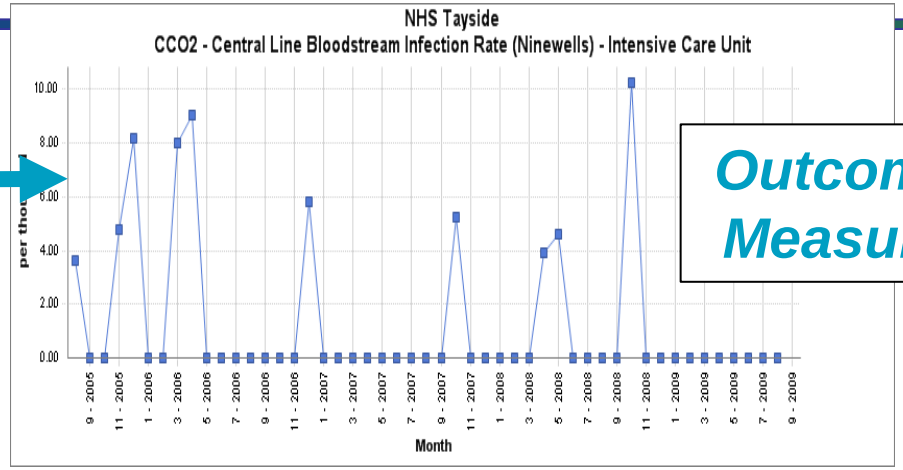
A CRITICAL CARE DASHBOARD allows you to explore relationships

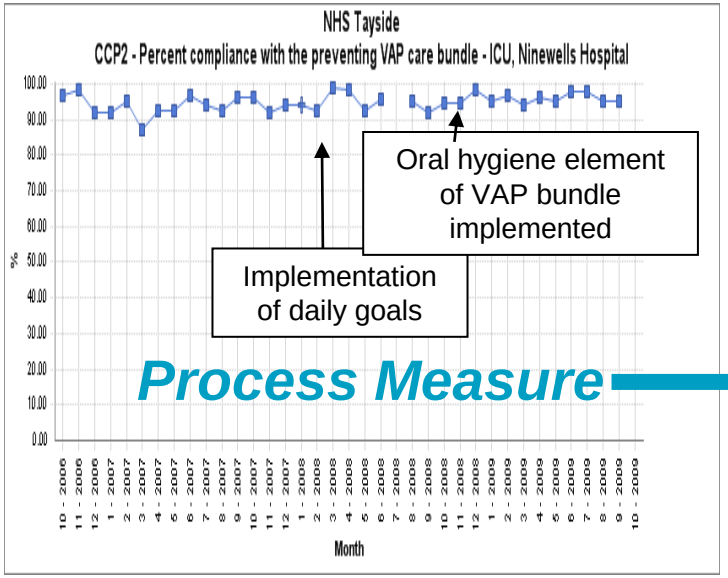


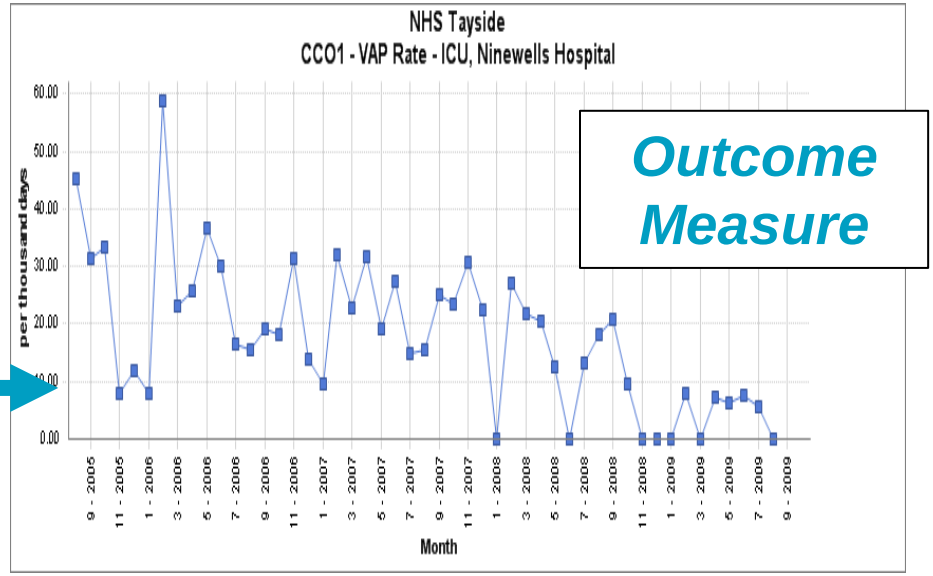


A CRITICAL CARE DASHBOARD allows you to explore relationships





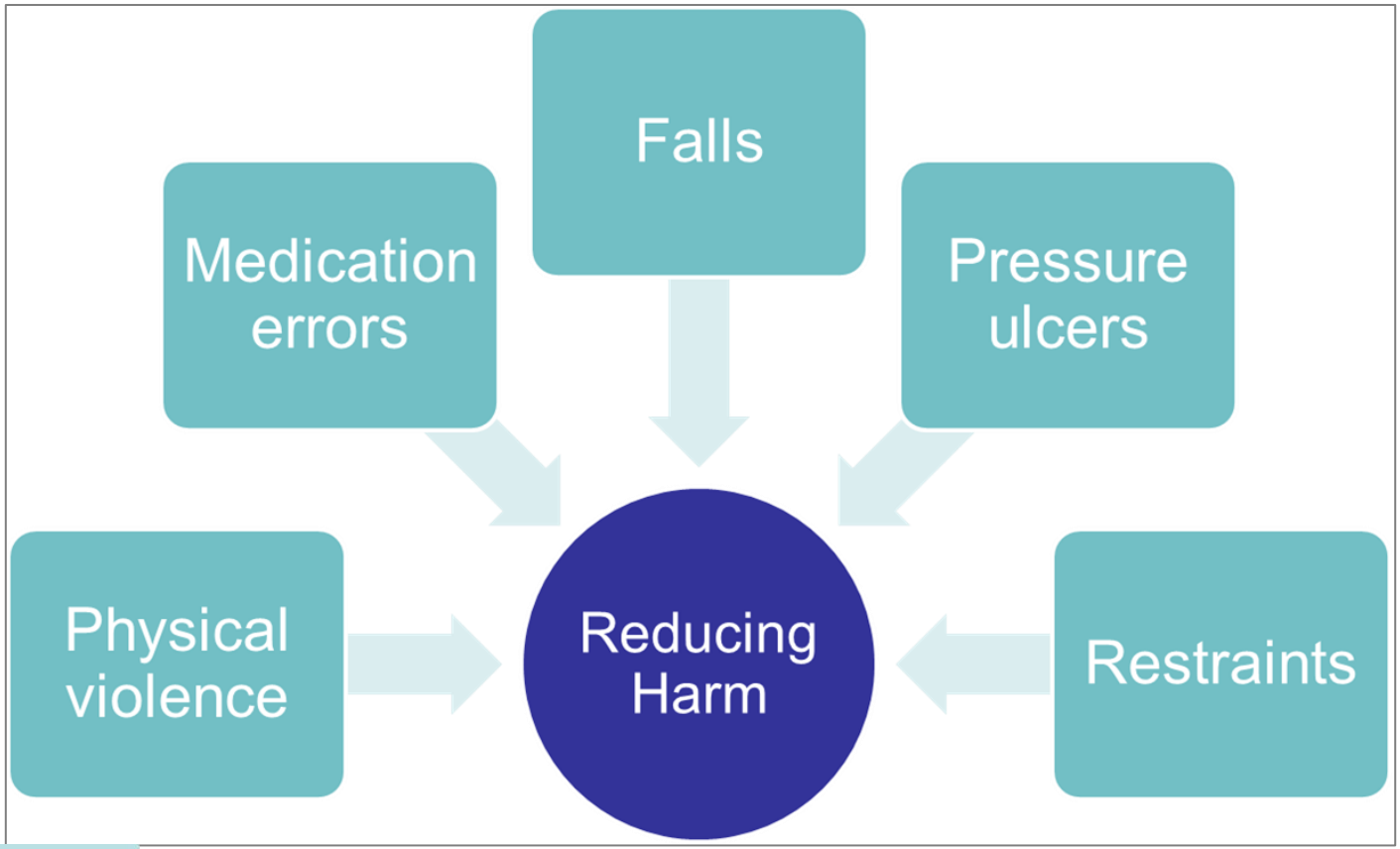




East London NHS Foundation Trust Quality Dashboard

Organisational Level View
QHC Chapter 5, 151-154

East London NHS
NHS Foundation Trust



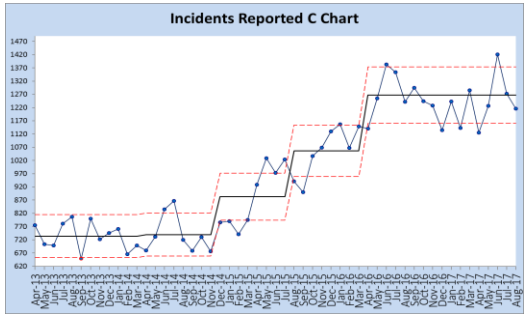
Long-term mission and stretch aims

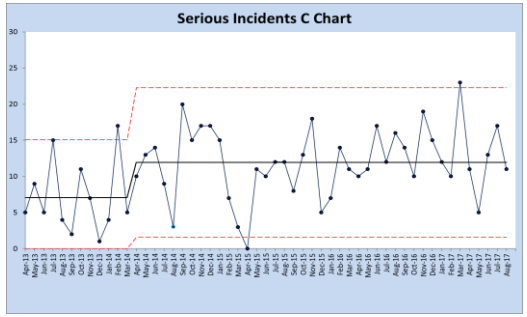
Quality as an Organizational Strategy

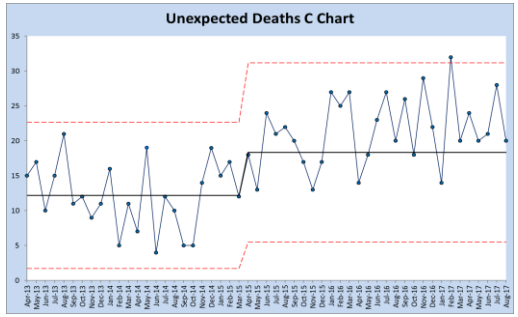
NHS East London NHS Foundation Trust

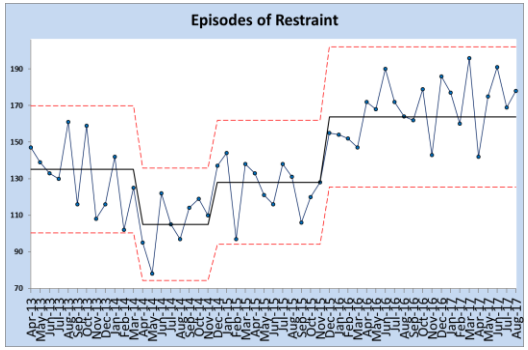
Safety

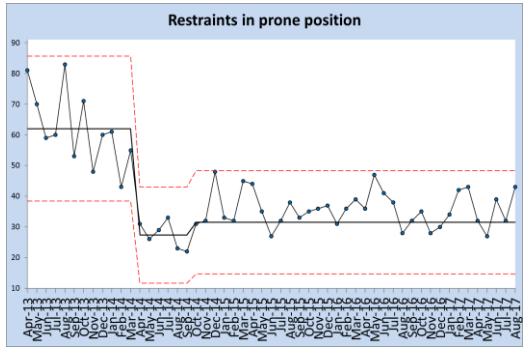
Trust-wide results including Bedfordshire and Luton

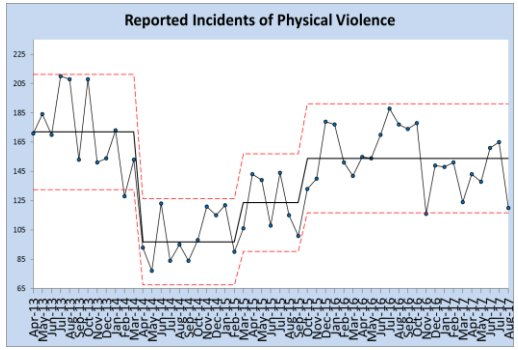


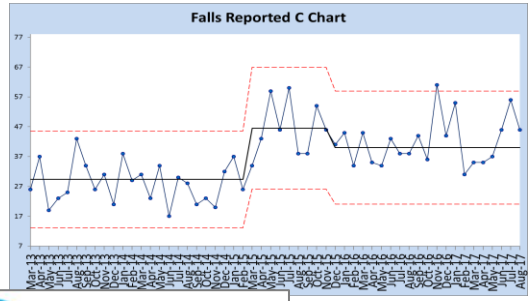


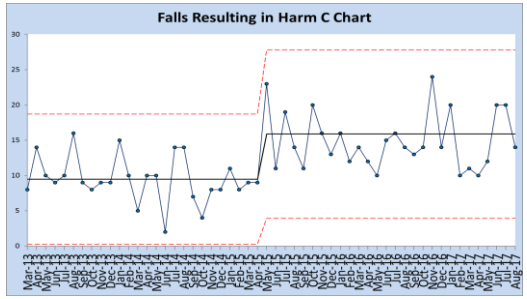


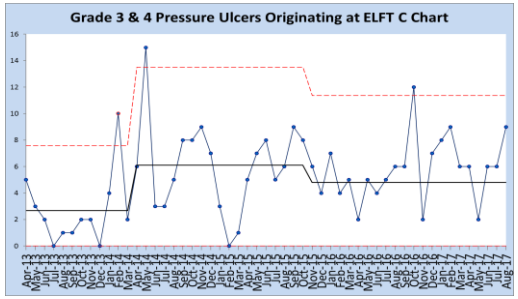






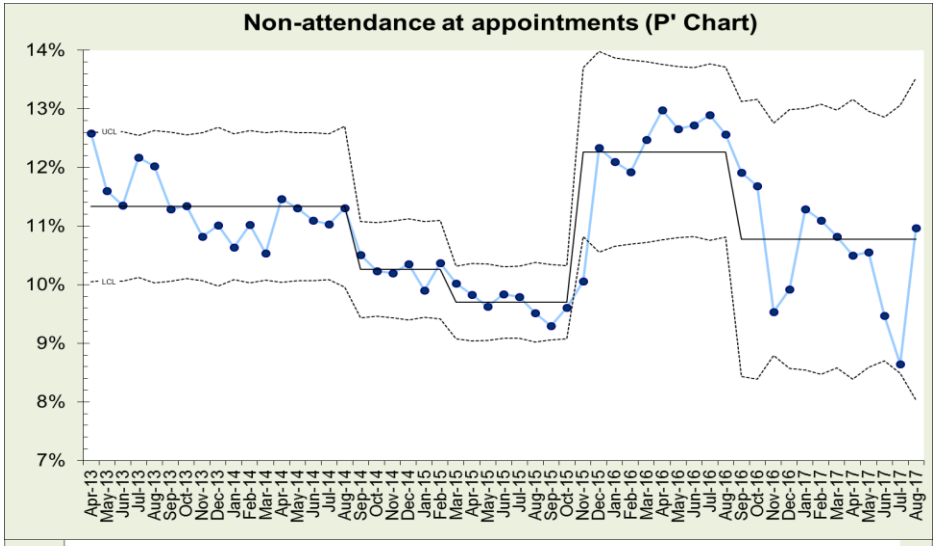


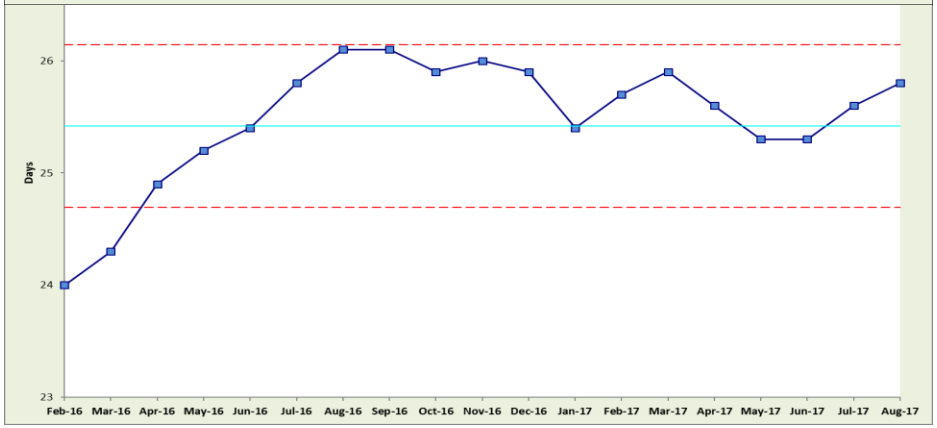


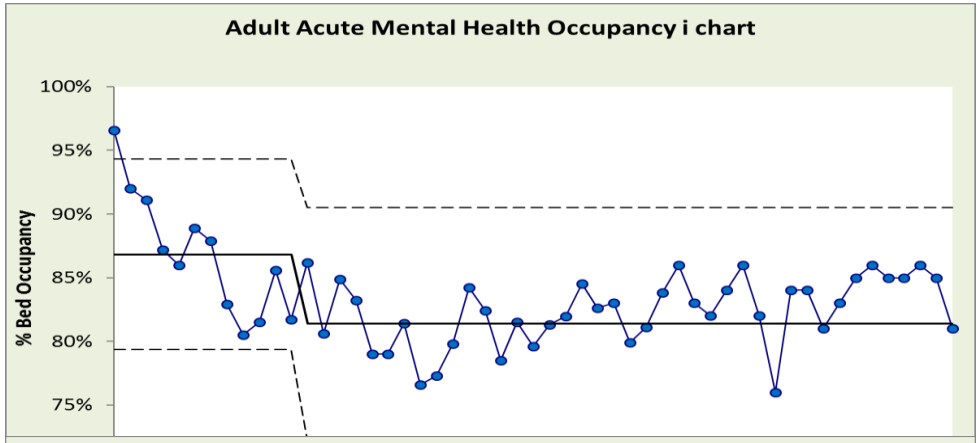


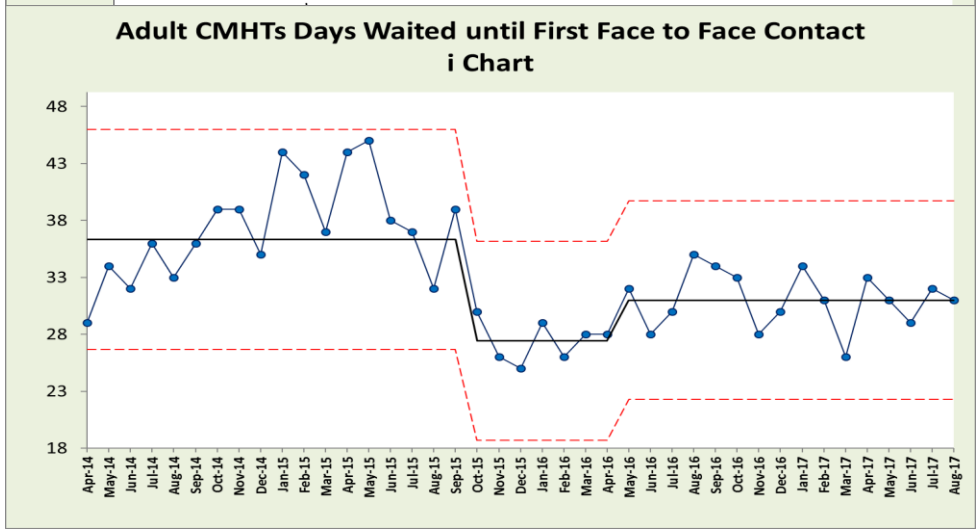
NHS
East London
NHS Foundation Trust

Clinical Effectiveness





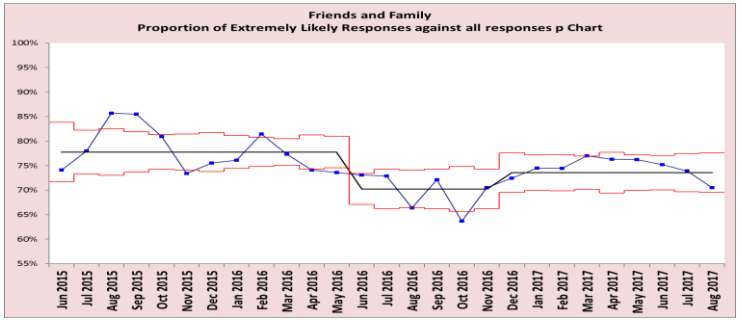


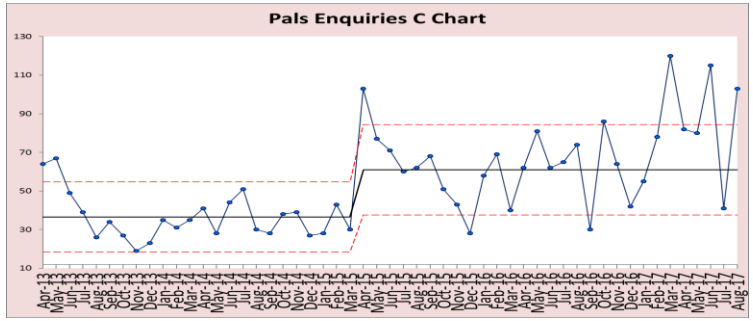


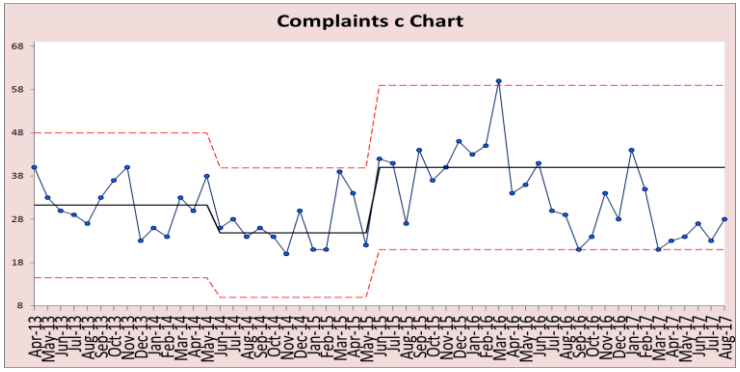
Patient Experience

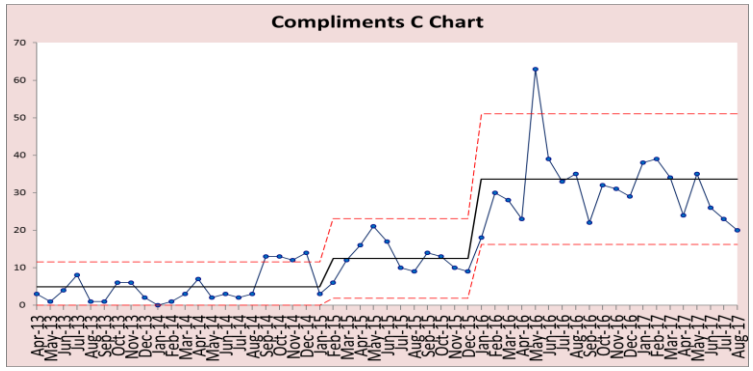
trust wide including Beds and Luton

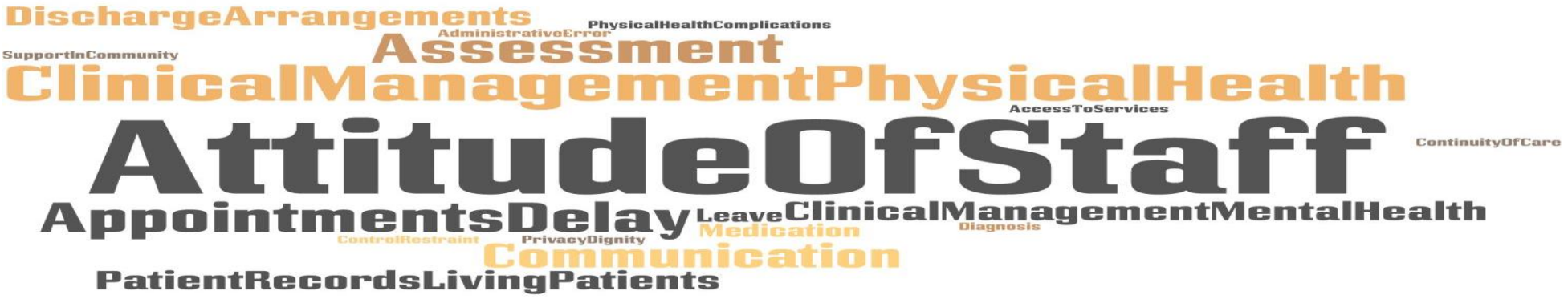
NHS East London NHS Foundation Trust









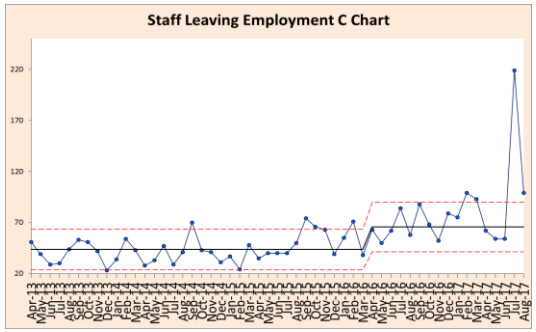


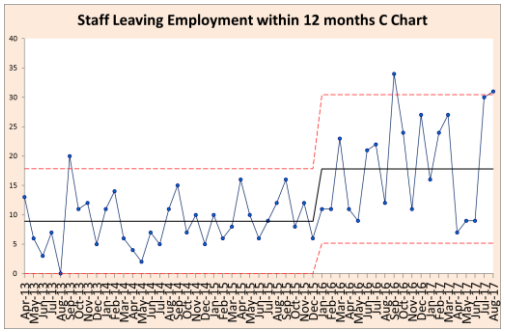
yd

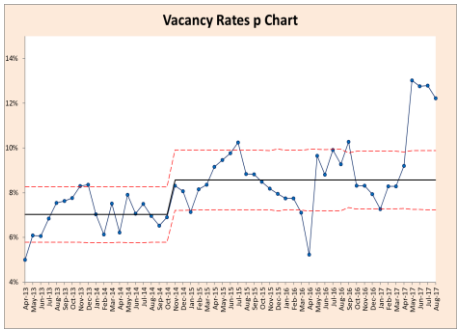
Our Staff

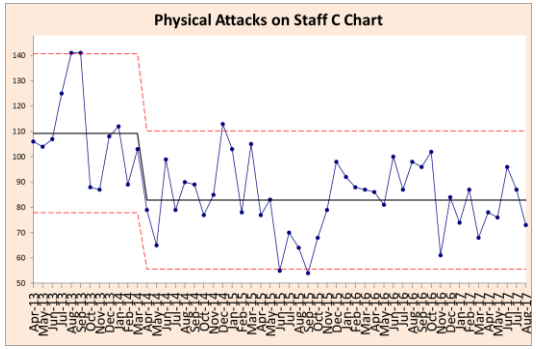
trust wide including Beds and Luton

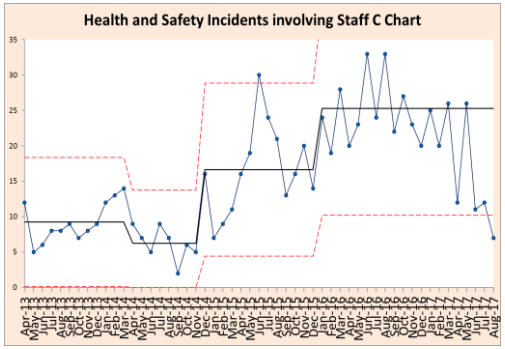
NHS East London NHS Foundation Trust

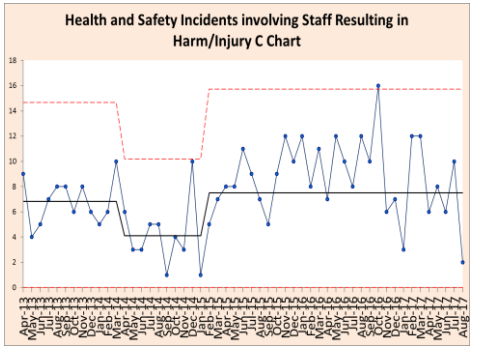


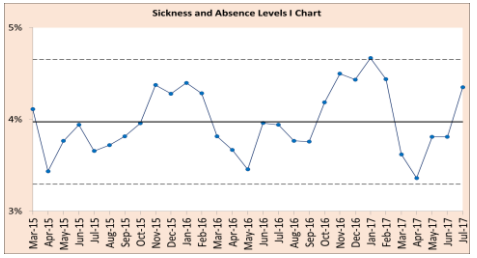












Dialogue #3
So what's on your Dashboard?

Designing the Components of a Dashboard

- Is this a Macro, Meso or Micro level dashboard?
- Which of your strategic objectives will this dashboard address?
- What are the major dimensions captured by this dashboard?
- Does everyone (and I mean EVERYONE) understand the purpose of this dashboard (improvement, judgment, research)?
- Use the ***Dashboard Worksheet*** on the next page.

Dashboard Worksheet (page 1)

Is this a Macro ____ Meso ____ or Micro ____ level dashboard?

The Dashboard is designed to measure the following dimension(s) (mark all that apply):

Patient Satisfaction	____	Information Technology	____
Work Life Quality	____	Infection Control	____
Clinical Excellence	____	Quality Outcomes	____
Appropriateness	____	Financial Viability	____
Availability/Access	____	Growth/Market Share	____
Continuity of Care	____	Respect/Caring	____
Effectiveness	____	Reliability	____
Efficiency	____	Safety	____
Equity	____	Other (specify)	____

Add other dimensions below:

Use this area for notes and comments

Dashboard Worksheet (page 2)

Dashboard Name: _____

Dimension to be captured by this Dashboard	Potential Measures for each Dimension

A Few Closing Thoughts on …

Benchmark as a Noun

- Its only about the numbers!
- Performance to the "best" number(s)!
- Using averages or aggregated numbers is fine!
- National "benchmarks" from the government or consultants must be met!
- Targets and goals are the focal points!

"Occasionally there is some confusion over the correct use of the term "benchmark." A benchmark is a measure of best performance against which an organization's performance is compared. A benchmark, however, is never derived from average or aggregate performance. Because it represents the best, a benchmark must refer to the performance of only one organization."

"When is a Performance Goal a Benchmark?"
The Mihalik Group (Summer, 2003: 2)

Benchmarking as a Verb

- Identifying and understanding best practices.
- Realizing new performance levels.
- Creating a new culture.
- Using numbers to learn, not as an end.
- Focusing on the processes that produce excellence.
- Benchmarking is a beginning not an end!

S + P + C = O ← The outcome of benchmarking

The focus of benchmarking

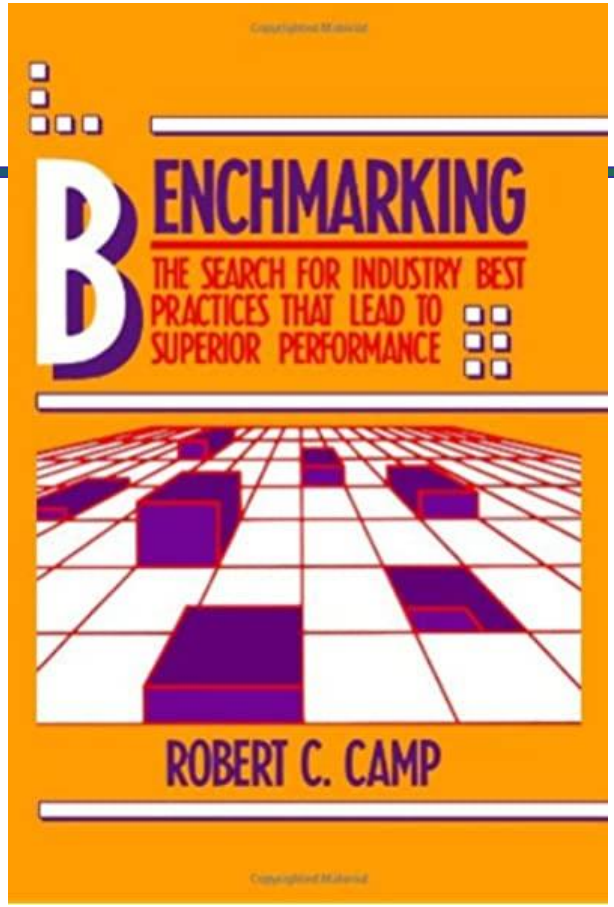
Benchmarking is a Verb

"Benchmarking as a verb, is a way to identify and understand best practices that enable organizations to realize new levels of performance. It is a journey not a destination designed to establish highly reliable structures and processes, create a new culture that is focused on continuous improvement and excellence, and create the conditions that enable a learning organization to emerge."

Source: R. Lloyd. *Quality Health Care: A Guide to Developing and Using Indicators. 2nd edition,* Jones and Bartlett Learning, 2019:155.

Benchmarking Problems

- Look at the current performance of an organization that has been highlighted and quickly pick it as ***THE BENCHMARK***!
- **Give little thought to "how" an organization achieved a top rating.**
- Little consensus on which organization is consistently ***THE BEST*** amongst healthcare organizations or in other industries.



The most widely referenced book on the benchmarking process.

A final thought…

"Measures should not be carved in stone!"

"How the Right Measures Help Teams Excel"
Christopher Meyer, *HBR*, May-June, 1994.

"Measures that were relevant during the early stages in development of a new product (or service) will undoubtedly become irrelevant as the product (or service) nears production."

"Numbers are not explanations; they do not give insight upon which you can build the next step of your reasoning or your next investigation."

Jan Vandenbroucke."Observational Research, Randomized Trials, and Two Views of Medical Science" *PLOS Medicine*, March 2008, vol. 5, issue 3 (www.plosmedicine.org)

So, back to the initial question…

Leadership's Role in Using Data to Drive Change!

- Creating the desire for continuous improvement.
- **Creating an environment that nurtures respect among people.**
- Providing encouragement.
- **Promoting cooperation.**
- Understanding variation!

Additional IHI Resources on the Science of Improvement

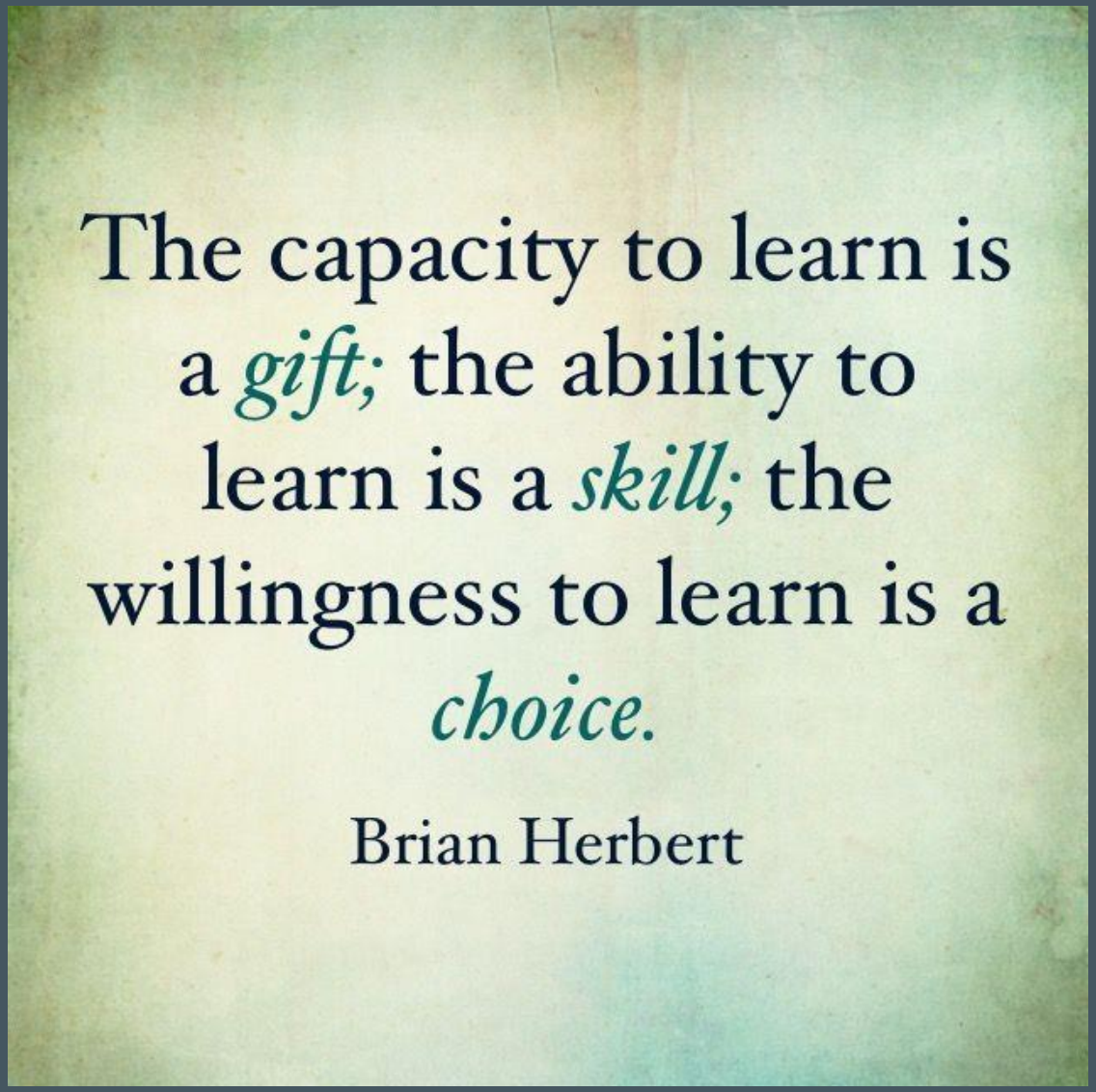
You can access the following free videos from the IHI website:

- Dr. Lloyd has over 20 ***Whiteboard Videos*** that explain the concepts, tool and methods of QI in 4-8 minutes.
  http://www.ihi.org/education/IHIOpenSchool/resources/Pages/BobLloydWhiteboard.aspx

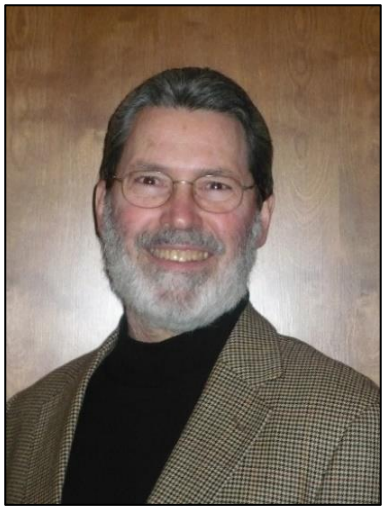
- Also Dr. Lloyd's ***On Demand Videos*** can also be accessed from the IHI Website:
  - Deming's System of Profound Knowledge and the Model for Improvement
    http://www.ihi.org/education/WebTraining/OnDemand/ImprovementModelIntro/Pages/default.aspx
  - Data Collection and Understanding Variation
    http://www.ihi.org/education/WebTraining/OnDemand/DataCollection_Variation/Pages/default.aspx
  - Using Run and Control Charts
    http://www.ihi.org/education/WebTraining/OnDemand/Run_ControlCharts/Pages/default.aspx

Thank you for joining me today.
Best wishes developing and using your Strategic Dashboards!
Dr Bob

The Journey Continues!



Dr. Robert Lloyd Bio



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Robert Lloyd, PhD, Vice President, Institute for Healthcare Improvement provides leadership in the areas of performance improvement strategies, statistical process control methods, development of strategic dashboards and capacity and capability building for quality improvement. He serves as primary faculty for the IHI Improvement Advisor (IA) Professional Development Program, the Improvement Science in Action (ISIA) Program, the Improvement Coach Program and various other IHI initiatives and demonstration projects. Dr. Lloyd works throughout the US, Canada, the UK, Sweden, Denmark, Africa, the Middle East, India, Malaysia, Australia and New Zealand. He is an internationally recognized speaker on quality improvement concepts, methods and tools.

He also advises senior leadership teams and boards on how to create the structures, processes and cultures that will make quality thinking and behaviors part of daily work. He is the author of three leading books on measuring quality improvement in healthcare settings and numerous articles and book chapters on quality measurement and improvement.