



# Using Portfolios and Execution to Drive Improvement

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# Objectives

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- Organize improvement efforts that drive aims.
- Appraise your organization regarding the use of system level measures of safety.
- Create a portfolio of work that drives to an outcome of interest.





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# DASHBOARDS ARE A TOOL FOR IMPROVING **QUALITY** NOT MEASUREMENT!





# Focus on the Vital Few!

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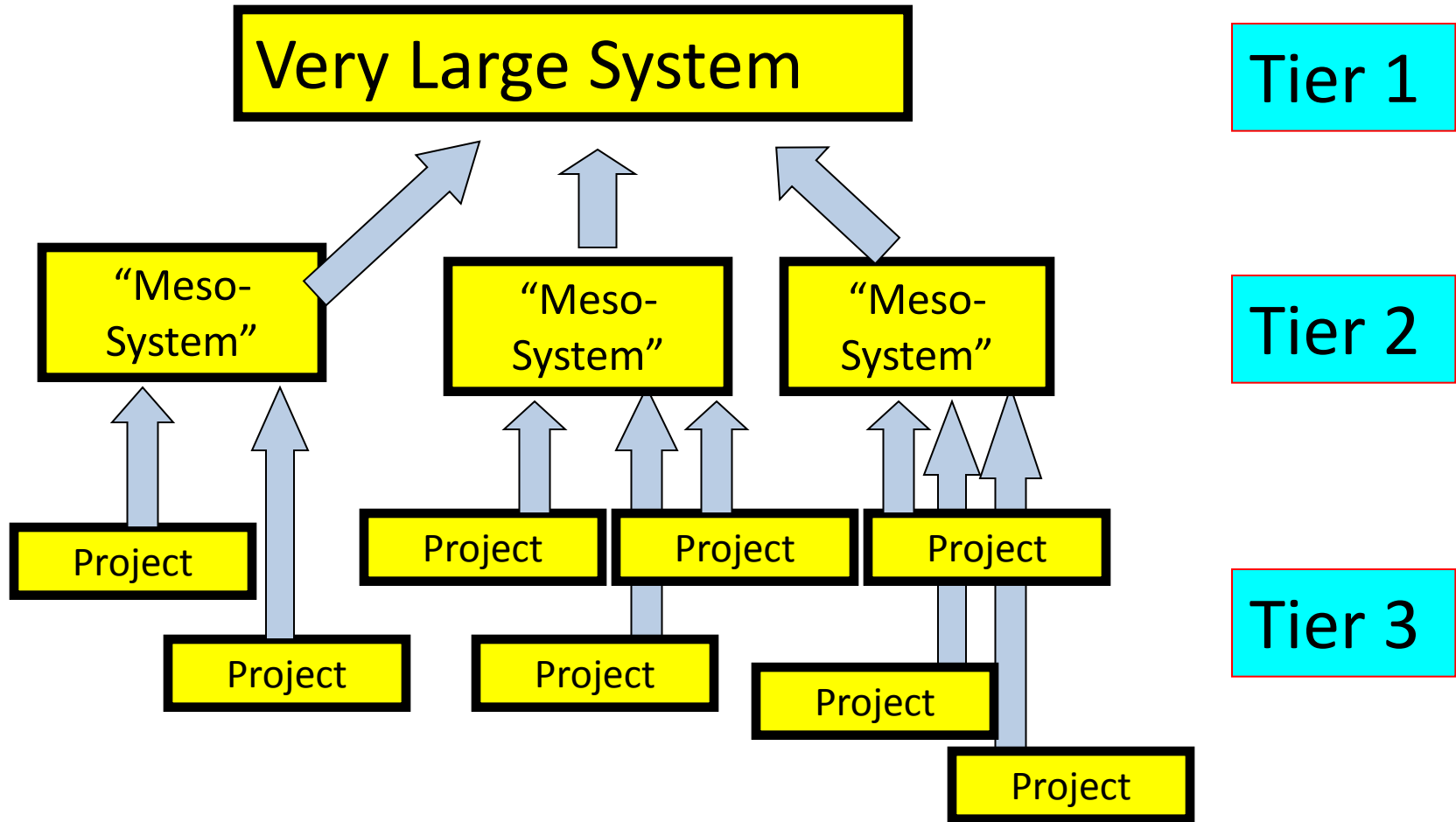
There are many things in life that are interesting to know.

It important to work on those things that are essential to quality.

The challenge, therefore, is to be disciplined enough to focus on the essential, vital few.



# The Intuitive Structure





# A Very Large System Problem

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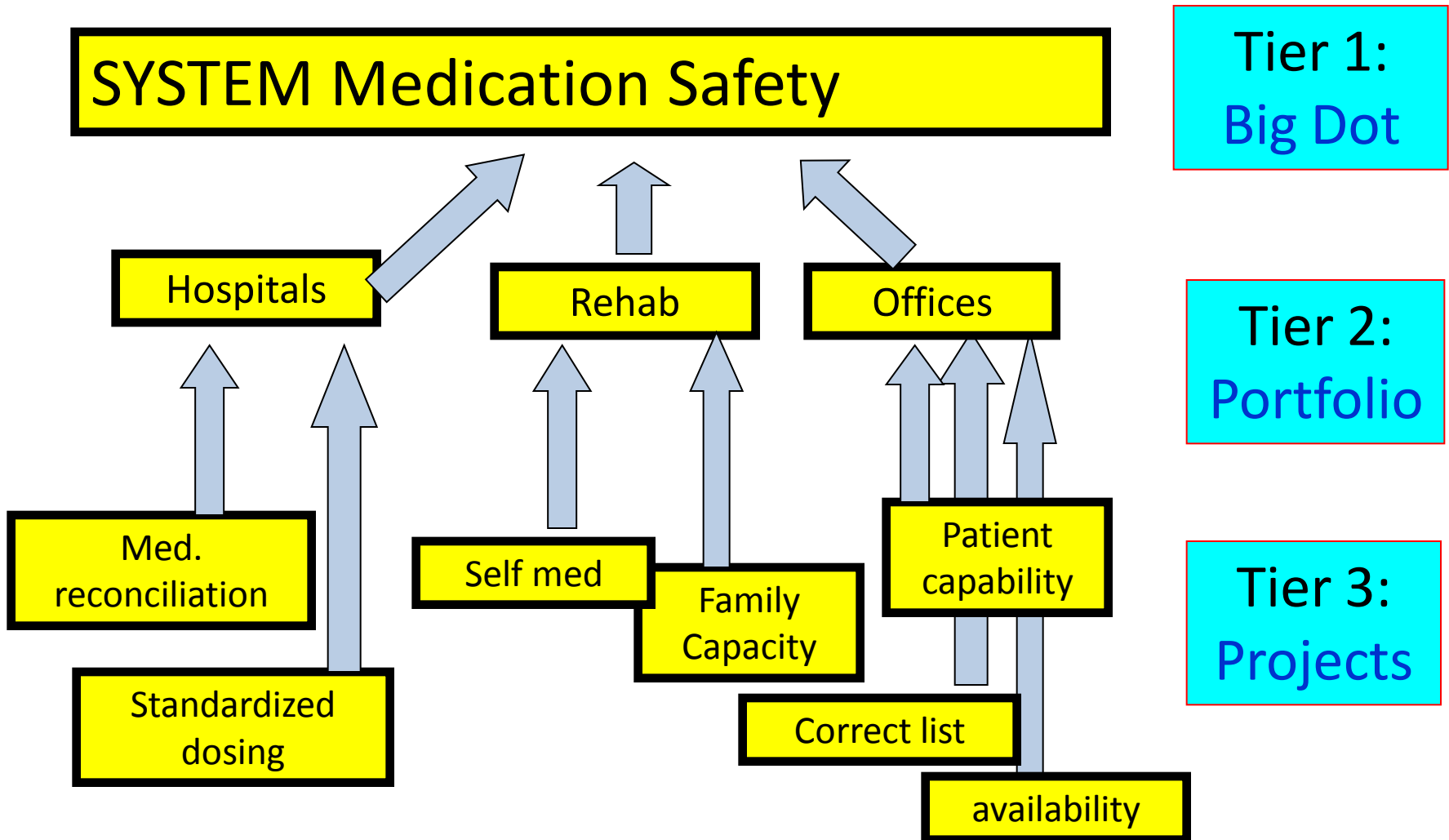
## Medication Safety

# PROBLEM

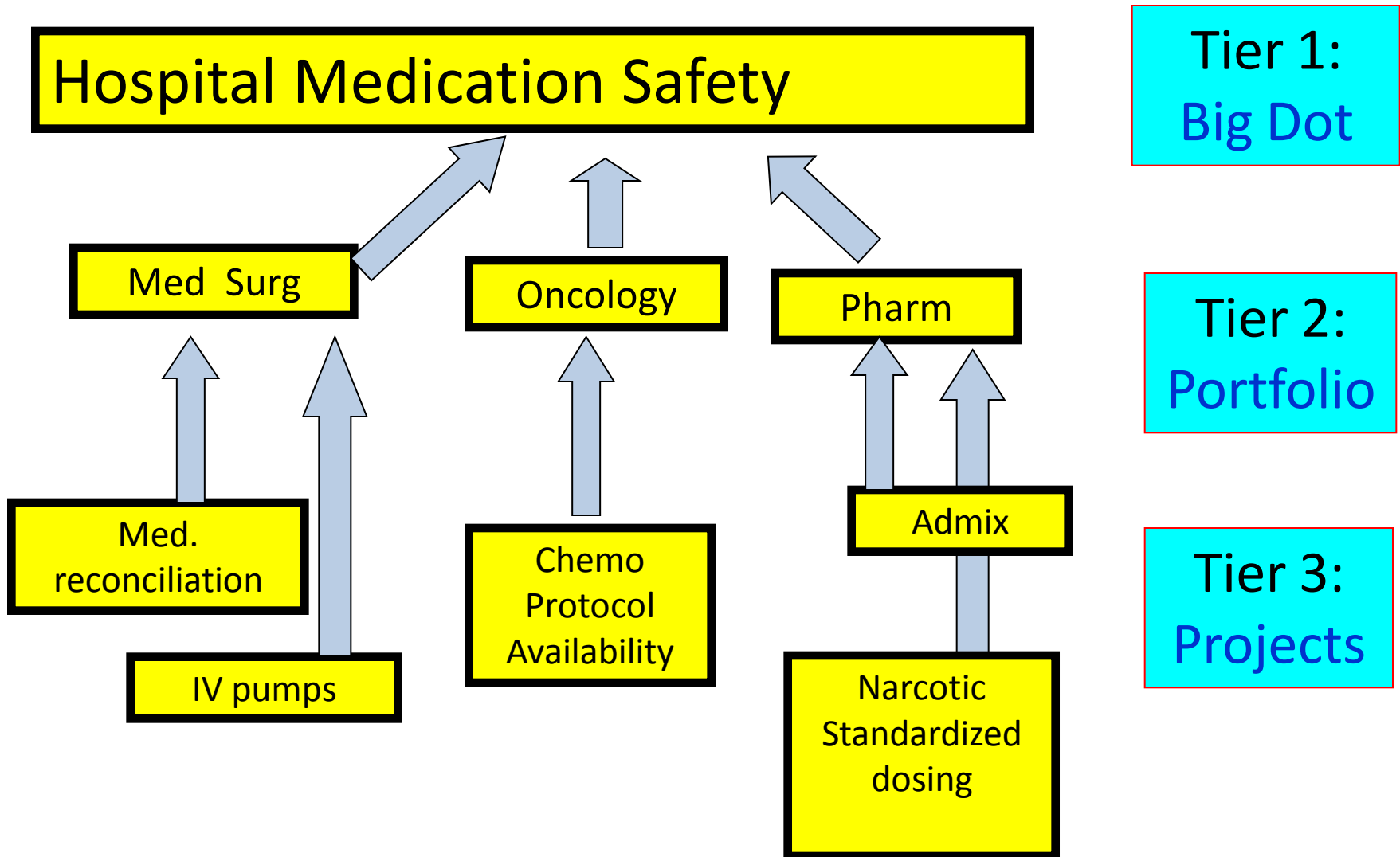
Harm from medications alone occurs in over 25% of all hospitalized patients. Harm to outpatients appears to be much higher.



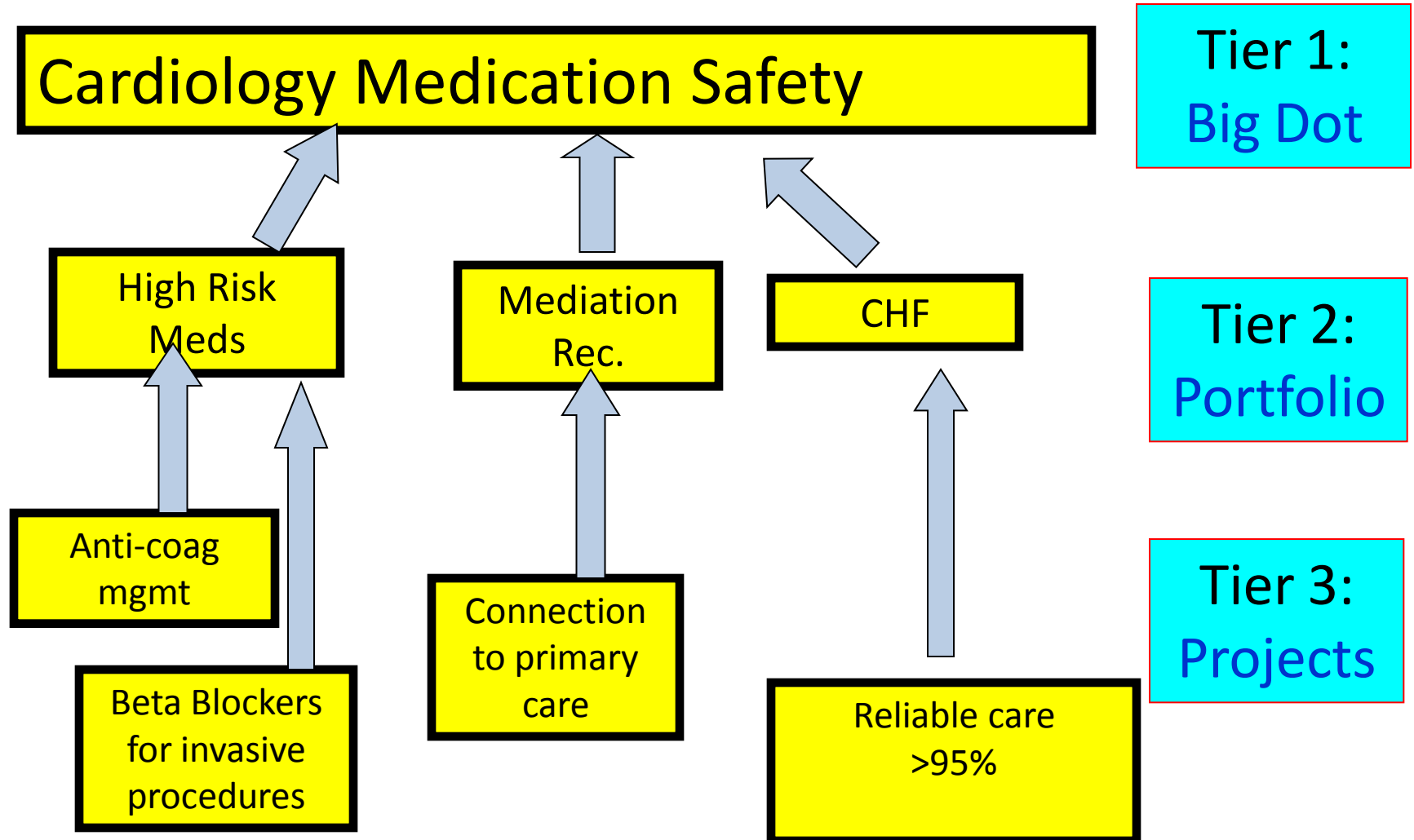
# Example: System Medication Safety





# Example: Hospital Medication Safety



# Example: Department Medication Safety



# The Sequence

<p>System-level Aim</p> 	<p>System-level measures: are you moving toward your aim?</p> 	<p>Ideas about what it would take to move the system level measure</p>
<p>“No needless deaths”</p>	<p>Keep a Run Chart of your monthly mortality percentage</p> <p>Track your HSMR over time</p>	<p>Infection reduction</p> <p>Multi-disciplinary rds.</p> <p>Rescuing failing pts.</p> <p>ADE reduction</p> <p>Community hospice service</p> <p>handovers</p>



# The Differences Are...

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- Level of ambition
- Commitment: hearts pounding
- Core strategy: staying alive
- Clear measure of daily success: territory
- Clear overarching goal: Berlin



# Leading the Whole System to Provide Highly Efficient and Effective Results

## The Ground Level View (Staff)



## The Big Picture View (Management)



# How Will You Know if ... You are Winning or Losing the War or the Battle?

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How Will You Know if ...  
All of Your Efforts to Improve Quality  
and Value are Working?



# What Are We Measuring?

IOM Dimension	Whole System Measures
Safe	<ul style="list-style-type: none"><li>• Adverse events</li><li>• Work days lost</li></ul>
Effective	<ul style="list-style-type: none"><li>• Hospital standardized mortality ratio</li><li>• Unadjusted (raw) mortality</li><li>• Functional outcomes</li><li>• Readmission percentage</li></ul>
Patient-Centered	<ul style="list-style-type: none"><li>• Patient satisfaction</li></ul>
Timely	<ul style="list-style-type: none"><li>• 3<sup>rd</sup> next appointment available</li></ul>
Efficient	<ul style="list-style-type: none"><li>• Patient days during the last 6 months of life</li><li>• Costs per capita</li></ul>
Equitable	



# Start to Think About Moving Beyond Process Measures

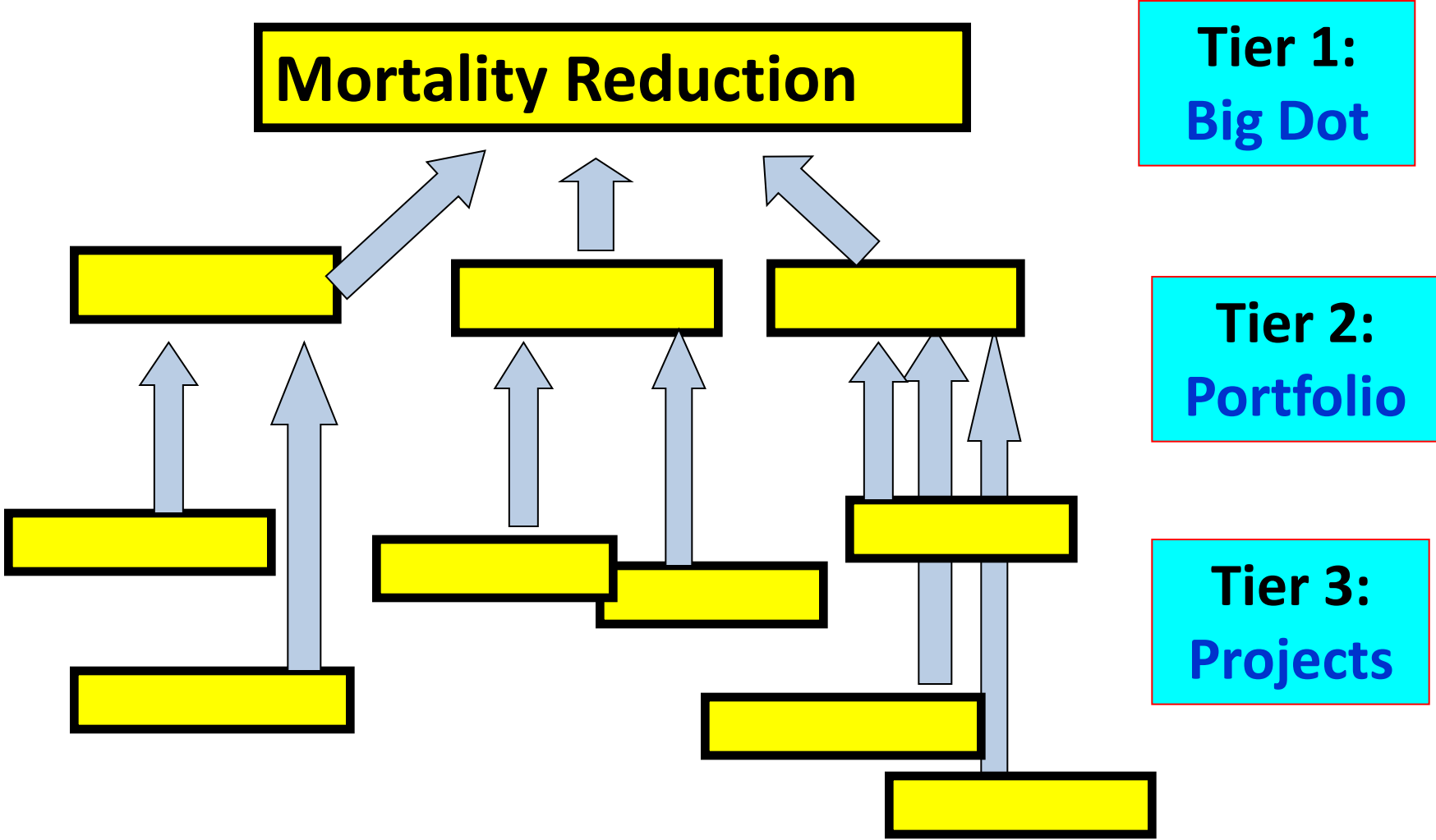
## Process Measures

- AMI Care
  - Time to stent
  - Beta Blockers on arrival
- Pneumonia Care
  - Antibiotic timing
- Immunization Rates
  - Influenza vaccination
- Medication reconciliation

## Whole System Outcome Measures

- Hospital mortality rate
- Adverse event rate
- Days lost to work

# An Example: Reduce Mortality





# Resources & References

1. Kaplan, Norton. "The balanced scorecard: translating strategy into action." Harvard Business School Press, 1996.
2. Lloyd, *Quality Health Care: A Guide to Developing and Using Indicators*. Jones and Bartlett Publishers, 2004.
3. Lloyd, Martin, Nelson. *IHI Whole System Measures Toolkit, Version 2.0*, IHI Boston, 2006.
4. Nelson, Batalden, Ryer. *The clinical improvement action guide*. JCAHO Press, 1998.
5. Nelson, Mohr, Batalden, Plume: "Improving Health Care, Part 1: The Clinical Value Compass." *The Joint Commission Journal on Quality Improvement*, 22(4):243-258, April 1996.
6. Few, Stephen: *Information Dashboard Design, the Effective Visual Communication of Data*. O'Reilly Media Inc. Publishers, 2006.





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**TAKE A MOMENT TO REFLECT  
ON YOUR OWN WORK.  
WHAT WILL YOU INCORPORATE  
FROM THIS SESSION INTO YOUR  
PLANS?**

