

Leaders Need Dashboards, Dashboards Need Leaders

Charles R. Denham, MD

Performance dashboards are rapidly evolving hospital leadership decision support tools. In health care, they are not generally designed with direct input by governance boards, administrative, or medical leaders. Few incorporate the stated values or mission of the organization. They have typically been formulated by quality departments and present static trailing indicators of quality metrics required by outside organizations. This is surprising to leaders of other industries who use dynamic dashboards to monitor their progress along their envisioned strategic path.¹

New market forces will require hospital leaders to be directly involved in development of such tools. Most importantly, these leaders must understand that they are accountable for quality in their organizations and that such tools are critical to their success.

As we examine leadership and the use of such tools by hospital leaders in pursuit of quality improvement, we find that there are certain issues that are “givens” in the future:

- Current incremental performance improvement progress is absolutely unacceptable to key health care stakeholders.
- Transformation to high performance will be required for hospitals to survive.
- Leadership has been identified as the *single most important ingredient* to transformational improvement.
- Governance board and physician engagement are critical to high performance in quality and safety.
- Traditional business thinking is *not* the answer for hospitals.
- Harmonization of quality measures, standards, and practices provides a common roadmap for improvement...and competition.
- Pay-for-performance (P-4-P) will be a major driver of the health care market.
- Transparency of quality and safety performance metrics will no longer be an option—this will be tied to reimbursement and, therefore, a given.
- Production-centered command and control silo management models will be replaced by patient-centered integrated systems team models in transforming high performers as suggested in Table 1. This will define new roles for dashboard design team members.

The quality trajectory of typical hospitals using incremental performance improvement initiatives is *unacceptable* to certifying, purchasing, quality, and consumer organizations (Fig. 1, line A). They are moving the bar of required performance (Fig. 1, line B).^{2,3} Systems failures are outstripping our typical rate of gain in improvement. The national standard of care is moving forward and leaving in its wake a zone of unsafe care practices that is currently the status quo.

Now that transformational improvement is beginning to be required by federal payers and quality organizations who advise consumers and employers, such as The Leapfrog Group, access to the precious financial resources that are the lifeblood of solvency is now in the hands of those responsible for hospital quality.⁴

The unfortunate fragmentation of care and the decentralization of physicians’ activities, away from the hospital, have left no one in the quality driver’s seat at most community hospitals. Completely unaware of this, most CEOs are thought, by their boards, staff, and physicians, to be at the controls of quality. Often it takes a series of systems failures or an organizational near-death experience to demonstrate that someone is asleep at the wheel.

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TABLE 1. Proposed Dashboard Design Team Roles

- **Governance boards** should be engaged in input on design, be the keeper of the values flame, and continually seek to provide necessary resources for quality and safety. Trustees must make sure that the organization's values are its compass.
- **CEOs** should chair the design team and spearhead the destination of the quality journey. They must ensure that dashboards are capable of monitoring key systems and progress along their strategic and quality journey. In high performers, this is one and the same.
- **C-suite—senior administrative officers** should make sure that performance dashboards reflect the reality of their own areas and integrate information to optimize enterprise-wide performance. They must make sure that quality, safety, and harmonized P-4-P metrics are adequately communicated through the dashboards. Nursing, pharmacy, radiology, laboratory, and other service-line leaders provide critical insights as to what is important about performance and should be involved in dashboard design.
- **Quality, patient safety, risk management, and performance improvement leaders** will have to integrate their work, information, and progress. They must make sure that senior leaders have the information they need through the instrumentation used to summarize status, patterns, and trends.
- **Employed medical and clinical staff leaders** provide a critical translational role to nonclinical governance board and senior administrative officers and leaders. They must assure that collaboration in development of dashboards is patient centered rather than silo, service, or production centered.
- **Independent medical staff leaders.** Formal or informal leaders in the community who have the respect of the medical staff and or drive significant patient volume can play a huge role in communicating continuity-of-care issues. These are matters that drive readmission and patient flow factors, which significantly impact quality, safety, and financial well-being of hospitals.

Leadership has been found to be the single most important ingredient to transformative improvement in quality. When the CEO is directly and visibly involved in quality activities and has embraced quality as the major strategic focus of their administration, the transformative metamorphosis can occur. As we move from a “no margin—no mission” environment to a “no outcome—no income” reality, such leaders will leave the pack behind.

After the personal dedication of the CEO to quality, engagement of the governance board and formal as well as informal physician leadership is critical to transform a typical hospital into a high performer.

Unfortunately, hospital leaders have been mesmerized by the methods of Wall Street business leaders, only to find that these methods fail miserably in the social sector. Jim Collins, in his recent monograph, “Good to Great in the Social Sectors,” helps us understand that we cannot obsess on financial targets at the expense of our core mission...to bring value to the communities we serve. Traditional business thinking does not apply. By leveraging our full complement of resources, we can harness all of our power and seize the new incentives of the P-4-P movement. In the end, we are not building stockholder wealth; we are building value in our communities.

The external certifying, purchasing, and quality organizations understand the chaos that unsynchronized requests of quality information can have on a hospital. They are seeking to harmonize their requirements, which provide a tremendous advantage to hospitals that are on or ahead of the quality curve.

The P-4-P express has left the station. Historically, P-4-P could have been an abbreviation for “pay-for-perception,” when winning the medical arms race was rewarded with market share. Currently, we are winding our way through the valley of “pay-for-process” however, we will soon arrive at the destination of true “pay-for-performance” because there are no barriers to block this journey. Payment will be tied to quality and safety. High performance hospitals are finding that quality saves lives and saves money to all stakeholders—such hospitals are just not too public about this secret strategic competitive weapon.

If P-4-P is the bait; transparency is clearly the stick. The first stages of incentive programs reward public reporting. Once the data are clearly understood and patterns are recognized, incentives for top performers can be formulated. Unfortunately, in a “zero sum game” world of infinite demand and finite resources, more developed P-4-P programs will penalize poor performers by reductions in reimbursement. This will put them in a doom loop without resources to invest in the very quality initiatives that would have saved them.

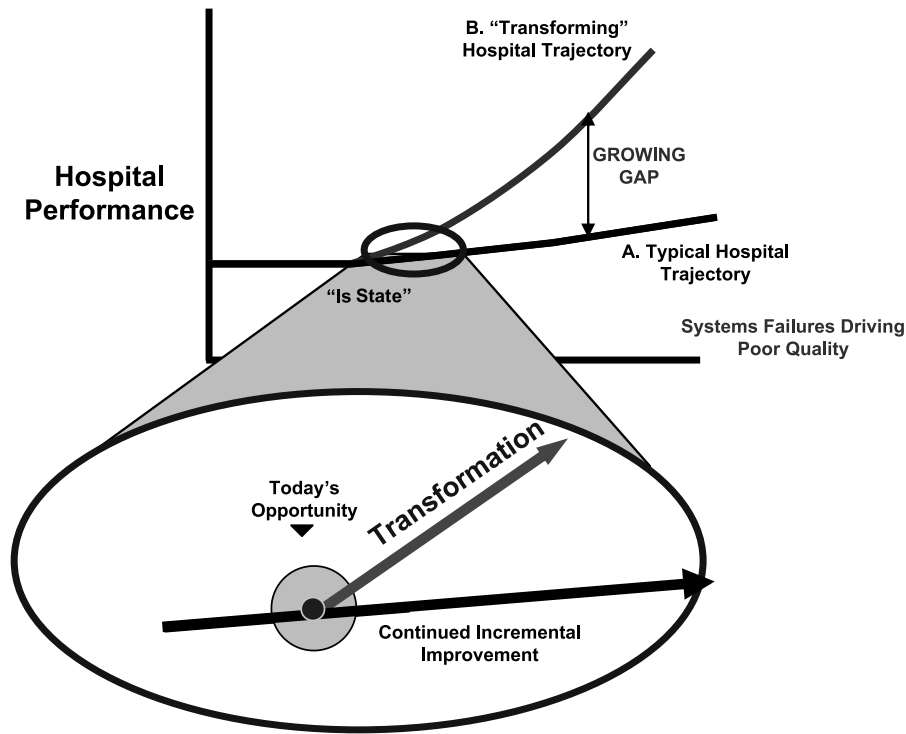
The production-centered command and control silo management models of hospital management that we have inherited will have to give way to patient-centered integrated systems team models for transformation to occur. Risk management, quality, and performance improvement activities will have to become integrated...not just because it is the right thing to do...but because it is the right thing to do to get paid! Our purchasers will demand it.⁵

Interview

David Hunt, MD, FACS; Medical Officer, Centers for Medicare and Medicaid Services (CMS) Quality Improvement Group. Dr. Hunt currently works in the Quality Improvement Group, a division of the Office of Clinical Standards and Quality in the CMS. At CMS, Dr. Hunt is the government task leader for the Medicare Patient Safety Monitoring System, as well as the Surgical Care Improvement Program. He is a general surgeon who continues to practice in parallel with his CMS duties.

Dr. Denham: We understand that CMS has recognized the substantial performance gap related to leadership engagement in safety and quality improvement. Why are leadership and dashboards important areas for CMS?

Dr. Hunt: One thing to highlight is how we actually began to realize how important the performance gap is, particularly in terms of the leadership component. When we looked at our performance in the Quality Improvement Organization (QIO) program, in the sixth scope of work, Dr. Steve Jencks wrote a very good article that identified how we were, where we were, and how we were progressing. It became very, very clear that we were progressing with all-deliberate speed toward our performance measures and that we would probably hit approximately the 90th percentile on our quality performance measures, but that we would not do so before 2025. We realized that we've got to raise the stakes; we've got to improve faster by almost on an order of magnitude. When we look at our infrastructure, our QIOs, and when we look at our performance measures, we really have to



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FIGURE 1. Growing performance gap between typical hospital and transforming hospital.

make some difficult decisions as to how we can drive “transformational change.”

Dr. Denham: So do frontline leaders need to understand that incremental improvement strategies of the past must be displaced by those that will drive transformational change?

Dr. Hunt: Yes. That is the theme of the eighth scope of work and what we are trying to build into the ninth scope of work. We can no longer proceed at a linear pace, but make a quantum leap, above and beyond our incremental improvement path. We looked at all the work, and one thing became appallingly apparent; those hospitals that seem to be doing better in our performance measures, versus those that aren’t, two things clearly stood out: the absolute commitment of the leadership to quality and, second, that they dedicated resources to improvement that they measured and personally monitored. It is a little bit embarrassing that it took all of us so long to begin to focus on this because this is work that so many have highlighted before. It is a commonly held belief in the business community to recognize that, if you want to get something done, leadership is key and has to be on board.

Dr. Denham: Are there key ingredients for transformational change?

Dr. Hunt: History can teach us a lot that current research supports. Take, for example, the change agent, Dr. Joseph Lister, the father of the basic antiseptics we use today. He developed them in the British Isles; however, rapid adaptation did not occur there. It occurred in Austria. The difference was

leadership, resources, and a system. The surgeons in Vienna influenced the operations of the hospitals, could reallocate the necessary resources, and had a system to implement the new practices. In the United Kingdom, the surgeons could not influence the leadership or drive reallocation of the resources. The results of adaptation were absolutely stunning. As good as many of our QIOs are, and as good as many of the quality improvement leaders in the hospital are, we realize that the difference between those who have fair performance and those that do excel is the infusion of significant time and effort of the C-suite, as we call it—the CEO, the CFO, and the governance board. They can focus resources and make sure that there is backing for those who are going to toil away at these measures. This is very, very hard work, and unless the leaders are on board, it is just not going to happen.

Dr. Denham: Why has CMS provided resources to help identify the performance gap in leadership and governance?

Dr. Hunt: CMS recognized this performance gap early on and that, to make serious improvements, we would need to work through the leadership of the hospital. We funded special studies in this regard, and we’re directing QIOs to help assist leaders as well as work through elements of the eighth scope.

Dr. Denham: Were there any surprises from the studies of hospital leaders, trustees, and physicians?

Dr. Hunt: In general, the CEO is perceived by most organizations as the leader or the real chief quality officer of

the hospital—both internally and externally. Those were the perceptions of the governance board as well as the perception of the line workers, particularly in the quality improvement division of most hospitals. CEOs do not see themselves as the chief quality officers. They perceive that quality is a division that reported to them, similar to finance or any other department within the institution. So it was a situation where both sides were pointing in the other direction, and no one is really the effective leader. No one really owns quality systems in the hospitals.

I think the surprise was how different the high performers were compared with typical hospitals. The former embraced quality, that is—and it was infused throughout the institution. The latter had a lack of ownership for quality elements—everyone basically thought it was someone else's job. You could identify those that really believed it was their responsibility by the time that they spent on it and by what they measured in their dashboards. The buck really stops with the CEO and the board of directors.

Dr. Denham: Can you give us detail of the findings of the research regarding leadership engagement, incentives, and accountability?

Dr. Hunt: For hospitals that performed better on our quality measures, there was a true commitment and the realization that quality was not something that happened on its own. That is to say that the boards and the CEOs had specific measures of quality that were important to them. They tied those measures into the performance evaluations of the senior staff as well as the executives of the hospital. In other words, hospitals that seem to perform better are those in which the board and the CEO, the executive leadership, have made a concerted effort to measure and improve quality, and their performance is in some way tied to the results of those measures.

Dr. Denham: Do you think leaders need to be active in the design and development of quality metrics, dashboards, and accountability structures?

Dr. Hunt: The early findings of our research reveal that the high performers have accountability at the board level and at the CEO level for quality. By accountability, they've got to be able to measure and view the data. Many of them are using a dashboard model that allows them to measure the overall quality performance of their institution and tie that back into their own performance evaluation at the board level and at the senior management level, that is, the CEO and the CFO. It is very important that they take responsibility for the elements that are seen on that dashboard.

Dr. Denham: Can you envision a time when such dashboards will be a requirement of CMS for leading organizations?

Dr. Hunt: We are doing developmental work to determine the best role of CMS in leading this effort. We have halves; we are the largest health care payer in the country, and we are also an agency of the federal government. That dual responsibility gives us a little more pause when we say that we're going to require something. But I can tell you that when we do more developmental work and when we expand this research, we are definitely going to find out what is the best way to stimulate and provide incentives for

hospitals. In particular, we should consider insisting that dashboards are a part of their leaders' performance evaluation and to make sure that boards embrace the concept of dashboards in quality measurement as part of their regular fiduciary responsibility. Only after working incredibly hard in other areas and not getting quite the performance that we expected, has CMS started to turn back and look at the role of leaders. So we are definitely investigating what we can do to provide incentives for more institutions to develop and use dashboards.

Interview

Steve Jencks, MD, MPH; Director of the Quality Improvement Group; assistant surgeon general at USPHS, Office of Clinical Standards and Quality, Health Care Financing Administration, Baltimore, Maryland.

Dr. Denham: The majority of hospital staff believes that the CEO is responsible for and the most influential individual in quality, yet surveys of CEOs show that they feel the QI or CMO is in charge of quality. Can you give us your take on this disconnect between the expectations of the staff and the CEO as to who is ultimately responsible for quality?⁶

Dr. Jencks: I think that what this typically reflects is a very loose sense of how quality management is done in a facility. And of course in one sense, the CEO is the chief quality officer, just as he is the chief financial officer. But, in a more realistic sense, if you have a framework for managing quality, it becomes pretty apparent that you've got somebody in charge of it the same way you've got a CFO in charge of the finances or a chief medical officer in charge of the general management of care. So, I'm not surprised because I don't think quality is very well managed.

Dr. Denham: Some feel we are at an inflection point in our national quality trajectory and that quality is coming to center stage. Is that true?

Dr. Jencks: What I think is happening in hospital settings is that we're really showing every sign of having reached a takeoff point or a tipping point. The number of hospitals whose data are being published to the Web as part of the Hospital Quality Alliance and CMS's requirements, and the number of hospitals participating in the Institute for Healthcare Improvement 100,000 Lives Campaign, the number of hospitals following American Heart Association guidelines adds up to almost 1000 participants. All bear evidence of such a shift.

Dr. Denham: Would you say that the leadership structures and systems for governance, leadership, and the frontline in working together on quality are in their infancy?

Dr. Jencks: The structures and systems for governance, leadership, and the frontline are in their infancy in terms of evolution as they begin to work together. As we are in this taking-off point, something fairly radical is happening to the quality community. It has to do with the transformation of frameworks within a facility, trying to get people aware, and the external frameworks which are beginning to set parameters and goals. It is a process of coordination. We are in our infancy in terms of integrating the processes necessary to really deliver within both those frameworks.

Dr. Denham: What is the value of a dashboard to the board, senior management, and the frontline in terms of being able to provide pattern recognition and a routine and a regular way to monitor how we're doing?

Dr. Jencks: That is a very complicated question because what I've observed is that the dashboards take on many different roles. What you want is a dashboard which reflects the culture that you want to have and the aims of that culture. In other words, a dashboard gives you a composite of the "how you're doing with the things that you have declared as 'exceptions' and 'unacceptable'." I think it is very important to have a dashboard that is understandable. There should be agreement as to what areas are critically important, and the board needs to understand what those elements must be.

Dr. Denham: Should the leaders be actively engaged in the dashboard design so that there are indicators along the quality journey, not just something hoisted upon them that they do not understand?

Dr. Jencks: The dashboard design should be based on the aims of the journey, and you really can't take the dashboard off the shelf or from a vendor or anyone else. You need to design the dashboard to provide information that you need to govern. You have to involve the board as well as the CEO in seeing that the dashboard is integrally related to your strategic plan. However, borrowing from other people is not a bad approach at all. In other words, once you've said, "Look, I want something on this dashboard that's telling me how much I'm succeeding in creating a culture of safety and a safe environment," then looking at other organizations who've focused on the same areas is essential. Until you've got your key stakeholders agreeing on what belongs on the dashboards, you can't create a dashboard instrument you want.

Dr. Denham: Are CEOs that are involved in the quality movement aware of the challenges, and do they have the structures and systems in place for quality and safety?

Dr. Jencks: The CEOs I see tend to be an extremely biased sample of high performers. They may have not have figured out how to do it, but they really are starting to get that they are responsible for quality and safety. Five years ago, this might not have been on their radar. They get that this is really on their plate now, and I think many of them hope that it won't be as big an item on their plate in a couple of years because they'll have a system setup that's managing it more effectively. But right now, they've got a transition to make, and most of them do not have a quality and safety system that is even faintly palpable to the quality necessary for ensuring financial integrity.

Dr. Denham: What would your message be to the frontline CEO, their board, and quality leaders? Is the status quo; acceptable?

Dr. Jencks: The first thing I would say is that you do realize that you can't go on like this. It's not going to work. In the not too distant future the status quo; will be unacceptable. It is pretty clear that the public is going to put the pressure on, that the payers are going to put that pressure on the late adapters. They are no longer in the position of having to say, "It is not a good situation, but what can I do?" They will be in the situation of being able to say, "I don't understand why the

hospital in the next town hasn't had a surgical infection or a central line infection this year and we had 32." The real pressure for the late adapters is going to build on safety more than just the broader definition of quality. It is really essential to start to create an environment in which unfixed adverse events that are the result of unsafe practices begin to disappear.

Dr. Denham: Do you have a message regarding dashboards for the CEO and board who are not active in the quality movement?

Dr. Jencks: I think there are 2 parts; First, CEOs and boards really need to understand that safe practices are the key. That's not the same as engaging in a witch hunt when you have an adverse event. A witch hunt will destroy what it means to achieve. Second, what is achievable in many areas is something much closer to perfection than we are accustomed to having. In other words, what we would call extraordinary performance today is really ordinary performance of tomorrow—and a well-designed dashboard will help propel your institution from wherever you are in the quality and safety world today into the required performance of tomorrow.

Interview

Myles Maxfield, PhD; Associate Director, Health Research with Mathematica Policy Research Inc. Dr. Maxfield is a trained economist who has spent the last decade measuring health care quality. He has been involved in hospital quality improvement and transformational change research with a number of federal and national organizations.

Dr. Denham: Doctors Hunt and Jencks have addressed an accountability vacuum for hospital quality. Given that our current trajectory of incremental improvement is unacceptable to certifying, purchasing, and quality organizations, how should we define "transformational change"?

Dr. Maxfield: What we have found in our studies is that transformational change clearly includes both quality and safety; however, we do not, as of yet, have a crisp definition in the hospital industry now. To borrow and modify a phrase from Justice Stewart—"We know it when we see it." We have found patterns among advanced transforming hospitals that we would not put forward as a definition; however, such patterns provide a description. One interesting characteristic that we found is common to many transforming hospitals was the self-realization that their quality has a lot of room for improvement—this is almost independent of the reality of their quality compared with benchmarks. There is clearly an attitude that our quality could be much better. Conversely, if you find the hospital CEO claiming that the quality of their hospital is just fine, it's a reasonably good indicator that this hospital is not transforming.

Dr. Denham: Are there critical success factors or a sequence of events that have been observed that lead to transformational changes that will dramatically improve quality and safety?

Dr. Maxfield: The steps leading to transformation appear to come in a sequence. The first one is the commitment of the CEO to a quality-centered business strategy. A business

strategy such that the hospital views itself as competing with its competitors on the quality of its care is the first goal of the CEO. The second step is that the CEO presents the case for this type of quality-centric strategy to the board and successfully persuades the board to buy into this strategy and then into these transforming hospitals. The board then becomes a supporter. From there, it spreads to the rest of the staff. So it's not so much which one is more important than the others as it is which one comes first. If the C-suite executives are committed, if the board is committed, and frankly the rest of the staff are involved in some way, that is a sign of transformation. One of the characteristics of transformation is the involvement of virtually every person on the staff—from the board to the clinician to the nurses to the technicians.

Dr. Denham: Are there certain events that catalyze or accelerate the transformation?

Dr. Maxfield: A “near-death experience” seems to be a common pattern. However, I wouldn't say it's universal. I don't want to imply that you cannot get there without having this experience. But it does seem to be a common pattern that there is some sort of a bad event, either a financial setback or a patient safety setback of some sort that catalyzes transformation. For example, an adverse event or series of adverse events perceived by the hospital management as very serious, threatening problems gets out into the news and is perceived by the hospital management as a very serious, threatening problem—enough to shake things up, both at the CEO level and the board level. Occasionally, it's enough to generate a change in management.

Dr. Denham: In your experience, does the leadership of transforming organizations see patient safety and quality as 2 discrete characteristics or as part of the same continuum?

Dr. Maxfield: Our experience is that quality and patient safety are not viewed separately. Quality has many dimensions, and patient safety also has many dimensions. I've got the feeling from many hospital administrators that patient safety is probably the most important component. The highest priority component from the hospitals' perspective is the adverse event—which represents substantial cost. Adverse events involve potential legal exposure and potential negative publicity and have a surprisingly strong impact on the financial bottom line, particularly within a diagnostic related group payment system.

Dr. Denham: Should quality and safety be everybody's job in a transforming organization?

Dr. Maxfield: If the locus of responsibility does not extend beyond the QI department, we don't see transformation. Transformational change requires a change in the corporate culture and requires the involvement of virtually everybody who works in the hospital, which includes both employees as well as physicians who are applying their trade in the hospital.

Dr. Denham: What about the “magical thinking” that many organizations have about technology saving the day? We find that technologies are merely enablers of best or better practices. Is that true?

Dr. Maxfield: The way we view it, the transformational change is about corporate culture, working in teams and

clinical redesign. Decision support tools which are often computer based can and do play a very important role in clinical process redesign, but it's a facilitation role. The core of clinical process redesign is what providers do and the decisions that they make. Very often, computers can help that decision-making process, but as several people have told us, it's not about computers.

Dr. Denham: Are there lessons that have been learned regarding adoption of technologies?

Dr. Maxfield: We have found, unfortunately, that some hospitals identify patient safety and quality improvement with their information technology. An unfortunate side effect of that is that it can lead to complacency, thinking that they've solved the problem when they get a fancy decision support tool. It is humans that may cause more of the adverse events.

Interview

Thomas E. Vaughn, MHSA, PhD; Associate Professor, Center for Health Policy and Research, Department of Health Management and Policy, College of Public Health, University of Iowa. He is involved in the study of high-performing hospitals and dashboards.

Dr. Denham: Your team at the Center for Health Policy and Research has conducted significant research regarding hospital governance and administrative leadership and performance dashboards. What was the scope of the effort?

Dr. Vaughn: We are a team that has conducted both qualitative and more traditional survey research on a number of organizations, looking specifically at the role of administrative leadership and board leadership in driving quality, including patient safety. These include a core survey of 18 hospitals in 5 states with 5 to 6 persons in each organization, including board members, medical staff members, quality people, and CEOs. This was followed by an electronic survey of hospitals in 8 states with more than 400 respondents. Based on results of that, we solicited copies of dashboards from about 110 organizations, and we've been trying to analyze the content from those dashboards.

Dr. Denham: Were there clear patterns that were revealed by your work regarding dashboard design engagement of CEO's, boards, and physicians?

Dr. Vaughn: One of the things that is clearly illustrated from our surveys is the importance of the “3-legged stool”—the board, administration, and medical staff all working collaboratively. This underlines the fact that we asked the question, “Who was the most important person in quality in their institution?” The greatest quality was seen in hospitals where the chief quality officer said that the CEO was the primary driver of quality in their organization. This underscores the importance of the CEO being out in front. The CEO has got to set the priorities and then has to work with other folks to put the systems in place that it takes to measure and to improve quality, including staffing and expectations.

Dr. Denham: Jim Collins, who wrote “Good to Great,” said of great organizations that they have “level 5 leaders” who have fierce resolve and deep humility.⁷ The fierce resolve is about the mission, whereas humility lies in

recognition of their own shortcomings and their organization's performance. Tell me about the CEOs of the transformative organizations. Do they have those characteristics?

Dr. Vaughn: The CEOs, in the better performing organizations, are seen as the drivers of quality. They see themselves that way. Also, the chief quality officers and the medical staff folks see them as leading the organization. However, many CEOs, in the face-to-face interview studies, couldn't really define specifics regarding resource allocation or how many FTEs they've got on quality. They are the champions; however, they must rely on their teams. They're also very realistic about their performance. In one of our surveys, we asked people in organizations to grade where they were in terms of quality and safety. The CEOs, as a group, tended to not score their organizations as highly as their staff. So they're very aware of how much needs to be done in addition to being good champions. The CEOs who are successful at transforming their organizations are champions, yet they're humble about their performance.

Dr. Denham: In transformative or high-performing organizations, what are typical board engagement behaviors?

Dr. Vaughn: Boards in high-performing organizations spend much more time at their board meetings discussing quality issues than typical hospitals, and they are more likely to be engaged in strategy development with the medical staff on quality issues.

Dr. Denham: What about the medical staff and the transformational behaviors?

Dr. Vaughn: As seen in the surveys, the medical staff recognizes the importance of the CEO in pushing things, but they also tend to be more likely to want to work directly on transformation. The chief medical officers and the chief quality officers are very strongly committed, with a great deal of enthusiasm and their commitment as champions. They need to be involved in dashboards. The leaders need a role opportunity and a set of instruments to be able to navigate their quality journey, and the most transformative ones want higher performance, quality, and safety. The only way they're going to get there is if they have good instrumentation. On the flip side, a dashboard can't be good unless the leaders design it, so they can use it. The dashboard has got to indicate quality and safety performance, and it must provide that input to the leaders. So leaders need dashboards to do their job, and dashboards, to be good, need leadership design.

Dr. Denham: If you had to describe 3 best design characteristics of a good dashboard, what would they be?

Dr. Vaughn: The dashboard needs to be very focused, as the overarching requirement. It needs to have very targeted metrics that get at what the organization needs but does not require excessive measurements. It needs to be something that they can use to trend things across time. It also needs to include some metrics where they can do comparisons for benchmarking with other organizations. To summarize, the 3 components of a good dashboard are (1) focus and stay out of "drip" (data rich-information poor); the focus would be targeted at what they want to improve; (2) trending capability and some consistency, so they can track internal progress; and (3) being able to benchmark against other organizations, so that they can identify where they are in the scheme of

transformation nationally with other comparatives, so they can learn from other best practices.

Interview

Nancy Foster, Vice President for Quality and Patient Safety Policy, American Hospital Association. Ms. Foster was formerly with the Agency for Healthcare Quality and Research. She is a dedicated champion of the patient safety movement.

Dr. Denham: As one who's steadfastly involved in the patient safety movement and deeply involved in the transparency in public reporting through the Healthcare Quality Alliance and Hospital Compare, how do you see the role of today's hospital CEO changing? Are there greater demands now on today's frontline CEO?

Nancy Foster: It is clear that public reporting of quality data has brought increased scrutiny to hospitals and made even clearer the role of hospital leaders in managing the quality of care in their institutions.

Dr. Denham: Is it reasonable to state that the job description of today's frontline CEO has changed?

Nancy Foster: Absolutely. The job description is changing due to a number of forces. There are 3 main forces that we should allude to. One would be the increasing ability of the public to understand the quality of care being delivered in their local community hospital. Second, it's the increasing interest of payers and employers in getting value for the money they are paying for health care. And third, it is the government and other regulators acting on behalf of the public who are raising the bar for performance.

Dr. Denham: Do hospital CEOs, their leadership team, and governing boards need to be intimately involved in designing their own dashboards?

Nancy Foster: As we listen to hospital leaders from across the country, they increasingly understand the importance of their role in leading quality improvement. As you may know, many hospital CEOs are not clinicians and have felt that quality, in the past, would be better served if it was in the hands of clinicians exclusively. But now, as we learn more about the impact of enterprise-wide systems on delivering high quality, the CEOs, particularly the CEOs at some of the more innovative institutions, are coming to realize that they have a vital role to play, and they are beginning to ask us and many other organizations to help them know how to best perform that function. What they're hungry for are tools that will help them know where they are on their quality journey, and as they make changes, whether those changes are actually helping them makes progress toward their quality targets. That is the role of the dashboard. So they are eager to get their hands on effective dashboards to help them on their quality journey.

Dr. Denham: From your perspective, who are the rest of the players on the quality team who need to be involved in dashboards?

Nancy Foster: The CEOs and the leadership team, including the governance board, clearly have to be at the helm for quality improvement, but they cannot do it alone. They need to be working closely with the whole medical staff, including those that practice outside the hospital; the middle

managers and the frontline folks who understand the day-to-day of what's happening for patients and to patients inside the hospital.

Dr. Denham: Would you say that the will is there, and now they need the execution tools to deliver—such as dashboards?

Nancy Foster: They need a dashboard that helps them effectively identify the opportunities that will work best for their hospital—their opportunities to improve quality—which will include some of the things that are put on there because they're of national interest or statewide interest and many that are on there because they are of particular interest to that hospital and represent particular opportunities given the goals of that hospital.

Interview

Gregg S. Meyer, MD; Chief of Staff, Massachusetts General Hospital. He is cochairman of the National Quality Forum Consensus Standards Maintenance Committee, responsible for maintaining the NQF Safe Practices. He is also a subject matter expert for the TMIT Measures-Standards-Practices Harmonization Program.

Dr. Denham: We're learning that many organizations that are transforming have had a clinical, operational, or financial near-death experience. Is the inertia in health care so great that such a crisis is a requirement for change?

Dr. Meyer: An organization may not have had a near-death experience, but many have carefully reviewed the near-death experience of a like organization and soberly concluded that "there, before the grace of God, go I." And that impels them into powerful action as well.

Dr. Denham: How important is peer-to-peer communication of these experiences between the high performers? Is it important that CEOs talk to CEOs of like organizations, trustees to trustees, and physician leaders to physician leaders?

Dr. Meyer: I think it's essential, and it's something that's just not happening enough yet. That's the kind of discussion that will be spawned by increasing the transparency and increasing the measurement, by collaborating together on a dashboard.

Dr. Denham: How important is it that the leaders who are guiding the organization have an active role in the design of their dashboards?

Dr. Meyer: The leaders have to take the metrics to heart. Dashboards need to speak through their voice. I cannot emphasize that last point enough—when leaders speak to this, they have to be able to speak with conviction and with deep understanding. The truth of the matter is if they're getting something fully baked from their own or other quality and safety experts, they're not going to own it as they do when they put it in their own voice. As a leader, putting your own stamp on it is absolutely essential. That way, it has credibility both within the organization in terms of middle managers and frontline staff and also with the board. The boards know when the CEO is speaking from the heart.

Dr. Denham: Is it fair to say that CEOs have to be actively and personally involved in designing their performance dashboards, visibly lead from them, and communicate their vision and mission through them?

Dr. Meyer: Absolutely. In the end, the CEO has to be willing to dedicate the time, energy, and effort to ensure that the board members and their staff understand what they're measuring and targeting, just like their lay-trustees understand the profit and loss (P and L) statement. They need a P and L statement equivalent for quality and safety.

CONCLUSION

- Hospitals are on a quality journey. To quote Henry Adams, "Leaders need a 'port to seek, a course to steer, and helm to grasp.'"⁸ If we can define our quality destination clearly, then we can put real color, texture, and reality to the image of the port we seek. We can breathe life into our vision for our organizations.
- Our values should define the quality destination and the course we steer. We need finite measurable targets. To quote Don Berwick, the visionary of the tremendously successful 100,000 Lives Campaign, "Some is not a number...soon is not a time."
- If the quality destination determines the performance profile required, and the performance profile determines the instrumentation necessary to monitor systems performance and progress along the journey, then the leaders really do need to be actively engaged in the design of their performance dashboards, especially if they are taking a new transformative trajectory to high performance.
- Production-centered command and control silo management models do not lend themselves to the necessary transformation. These models will be replaced by patient-centered integrated systems team models. In the words of Prof. Samuel Levey of The University of Iowa College of Public Health, "A will to action" will be required at all levels to transform quality improvement from "rhetoric" to "reality" (Levey, personal communication, 2006).
- Some leaders use a typical dashboard of trailing indicators, which is, unfortunately, like driving through the rearview mirror. Others have no one in the quality driver's seat, nor do they have anyone at the controls. Still others, some critics of our industry would say, are CEOs who are so busy looking down at their calculators, making sure that they meet their financial targets that they completely forget the road ahead.
- In aviation, the most important instrument is the compass. Without it, in bad weather, one is soon lost, will run out of resources, and the outcome is absolute. The old-fashioned compass of yesteryear that guided aviation is like our moral compass of today. The internal magnetized needle sought due north like our values seek the common good for our patients.
- Many of our hospital leaders have taken their cues from other US industries far too long. Unfortunately, many of these leaders have lost their moral compasses, as evidenced by Enron, World Com, Arthur Anderson, and the list keeps growing. We must avoid making the same mistakes of other industries who have given up their values compasses for the slicker newer GPS...which is fundamentally a global profiteering system.
- Leaders need dashboards, dashboards need leaders, and both need values.

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