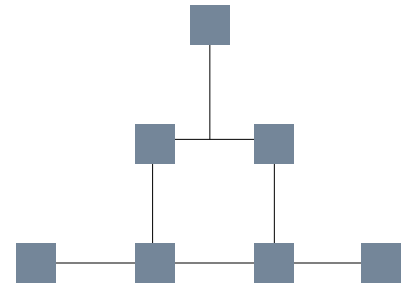


**Innovation Series 2005**

# Seven Leadership Leverage Points

**For Organization-Level Improvement in Health Care**



**100,000 Lives Campaign:** We invite you to join a Campaign to make health care safer and more effective — to ensure that hospitals achieve the best possible outcomes for all patients. The Institute for Healthcare Improvement (IHI) and other organizations that share our mission are convinced that a remarkably few proven interventions, implemented on a wide enough scale, can avoid 100,000 deaths between January 2005 and July 2006, and every year thereafter. Complete details, including materials, contact information for experts, and web discussions, are available on the web at [www.ihl.org/IHI/Programs/Campaign/](http://www.ihl.org/IHI/Programs/Campaign/).

We have developed IHI's Innovation Series white papers to further our mission of improving the quality and value of health care. The ideas and findings in these white papers represent innovative work by organizations affiliated with IHI. Our white papers are designed to share with readers the problems IHI is working to address; the ideas, changes, and methods we are developing and testing to help organizations make breakthrough improvements; and early results where they exist.

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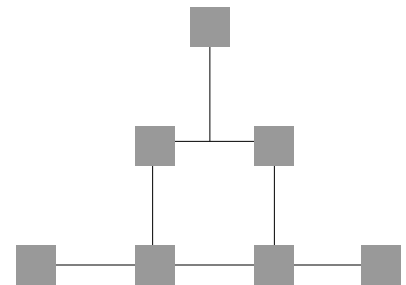
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**For Organization-Level Improvement in Health Care**

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## **Context and Background**

Many leaders of health care delivery systems want to achieve better performance. They are becoming painfully aware of defects in their own organizations and communities—needless deaths, suffering, delays, feelings of helplessness, waste, and inequities—and they have become quite skilled at achieving project-level reductions in these defects. But despite extensive efforts, in some cases over many years of work, we can point to relatively few examples where performance has dramatically improved beyond current benchmarks, across an entire organization or system of care, as measured by a powerful indicator of system-level quality such as mortality rate or cost per capita. Increasingly, it appears that health care CEOs and other leaders *want to make these changes happen, but they don't have a tried-and-true method by which to bring about system-level, raise-the-bar change.*

In IHI's work of supporting and encouraging leaders of innovative health systems, we have observed what we believe to be some important leverage points for leaders who want to achieve dramatic, system-level performance improvement. Together, these leverage points are offered as a sort of hypothesis, framed something like this: *If leaders are to bring about system-level performance improvement, they must channel attention to and take action regarding several, if not all, of these leverage points.* In other words, this set of leverage points is not offered as a tried-and-true method, but as a theory—one that we hope will be useful for individual leaders in planning their work and for us in organizing a support and learning system to share best leadership practices and results across organizations; and from which all of us can learn about what works, and what doesn't, in bringing about large-system change in health care.

The foundation for our hypothesis comes from at least three different sources:

- 1. Complex System Theory:** Complex adaptive systems such as health care organizations and communities cannot be specified and managed in detail. It is highly likely that small changes in certain critical aspects of these systems might bring about surprising and unpredictable amounts of improvement or deterioration in overall system performance. If leaders could choose the right system attributes (“leverage points”) and make small, perhaps difficult, but important changes, very large performance change might result.
- 2. Observed Performance of Leaders and Health Systems:** We have been able to watch the actions of leaders in organizations participating in IHI's Pursuing Perfection and IMPACT programs and other health care systems, and simultaneously to observe the performance of those systems. Where system-level change has occurred, we have attempted to infer from these sources what some of the leadership leverage points for improvement might have been. For example, we have observed that system-level improvement does not occur without a declared aim to achieve it, and that how the aim is declared and adopted by leaders appears to be very important. These leverage points are based largely on qualitative data—more anecdotes and stories about the work of leaders than a solid research base. Nevertheless, these stories are powerful, and serve to support and help refine the theory, and define the agenda for further testing and study.

**3. Hunches, Intuition, and Collective Experience:** The authors come from a variety of backgrounds in health care and have tapped into our collective experience to postulate some of these leverage points—particularly those that surface as recurrent “difficult moments” for leaders. For example, it is our sense that the business case for quality is still tenuous for many health care organizations, and therefore that if the chief financial officer (CFO) were somehow to become a champion for system-level improvement in quality, dramatic improvement would become much more likely.

It might be helpful to note what these leverage points are *not*:

- The leverage points are not intended to be a comprehensive framework for the leadership of organizational transformation. That is a much broader subject, addressed by approaches such as The Baldrige National Quality Program.
- The leverage points are not a substitute for a coherent quality method such as the Toyota Production System or the Model for Improvement. In fact, the organizations in which the leverage points would be applied are assumed to have adopted a coherent quality framework. The question addressed by the leverage points is, “How can leaders lead within that framework (whatever it is) to get *measured system-level results*?”

Finally, we would emphasize that we have framed these as leadership leverage points. In other words, we hypothesize that these are the particular responsibility of the senior leaders of organizations to address effectively in order to bring about system-level change.

This paper has three sections:

1. The first section briefly explains the Seven Leadership Leverage Points.
2. The second section applies the Seven Leadership Leverage Points framework to a current leadership challenge for executives of the more than 1,800 hospitals that have signed on to IHI’s 100,000 Lives Campaign: how to achieve a dramatic improvement, in a short time, in the biggest of all system-level measures—mortality rate.
3. The third section (Appendix A) is a self-assessment tool designed specifically for leaders of hospitals participating in the 100,000 Lives Campaign, but which could easily be adapted for any type of system-level performance improvement.

## **Section One: Seven Leadership Leverage Points**

### **Leverage Point One: Establish and Oversee System-Level Aims for Improvement at the Highest Board and Leadership Level**

A broad quality aim is part of the mission statement of most health care organizations. But if leaders are to actually achieve breakthrough performance at the system level, we believe that they must do the following:

- Establish solid measures of system-level performance — e.g., hospital mortality rate, cost per adjusted admission, adverse drug events per 1,000 doses — that can be tracked monthly, if not more frequently;
- Establish aims for breakthrough improvement of those measures;
- Establish oversight of those aims at the highest levels of governance and leadership; and
- Commit personally to these aims and communicate them to all stakeholders in a way that engenders heartfelt commitment to achieving them.

Establishing system-level performance measures helps to answer the questions, “What are we trying to achieve, and how are we doing at it?” Sometimes referred to as “The Big Dots” (a reference to the visual display of critical data points), the system-level measures collectively define what is ultimately important to the stakeholders of the organization.

### **Leverage Point Two: Align System Measures, Strategy, and Projects in a Leadership Learning System**

Organizational strategy should be linked to moving the performance measures described in Leverage Point One. The traditional focus of strategic planning in health care has been on growth, financial planning, and service planning, often creating a disconnect between those projects which leaders view as *strategic*, and quality improvement work which is viewed as *important, but not necessarily strategic*. As a result, many organizations tend to approach quality on a project-by-project basis without making a clear connection between projects and the overall strategic aims or performance metrics of the organization. Alignment is created when there are clear and explicit linkages between performance measures, strategies, improvement work, and daily work.

To this end, an important role of leaders is to organize the system of improvement work in such a way that all who work in the system know their part, and how it fits into the overall system-level aim. To do this well, leaders must formulate a “Theory of the Strategy” for achieving the aim — that is, a prediction of what will happen if a specific plan is carried out successfully. For example, if the aim is to reduce Hospital Standardized Mortality Rate — mortality rates appropriately adjusted for multiple variables such as population characteristics and diagnoses<sup>1</sup> — from a current level of 129

to a target level of 85 within two years, then a credible, quantitatively sufficient plan to achieve that aim must be framed, and translated into project work and other actions for leaders at every level throughout the system. (Telling people to “go out and do two quality projects in each department” is unlikely to achieve this system-level aim.) Moreover, leaders must monitor progress monthly against the aim and revise their Theory of the Strategy if they are not moving far enough, fast enough.

#### **Leverage Point Three: Channel Leadership Attention to System-Level Improvement**

The currency of leadership is attention. To achieve system-level aims, leaders must actually pay attention to them. All potential resources for channeling leadership attention, whether formal or informal, should be connected to the aim: personal calendars, meeting agendas, project team reviews, executive performance feedback and compensation systems, hiring and promotional practices, membership by patients in design teams and committees. In other words, the signals sent both by the “body language” of individual leaders *and* by the organization’s leadership systems must change, if leaders are to expect system-level results to change. Note: One of the most powerful known methods for channeling attention *inside* your organization is to become transparent about your quality performance *outside* your organization, so some leadership “channel attention” work must be done outside the boundaries of your system.

#### **Leverage Point Four: Get the Right Team on the Bus**

The most common reason for failure of large systems to change is the failure of the senior leadership team to function as an effective team, with the appropriate balance of skills, healthy relationships, and deep personal commitment to achievement of the goal. Achieving a fundamentally different level of performance may be possible with the current team, or it may not be. Getting this difficult judgment correct, and acting on it, is a critical task for the CEO, and is therefore a key leverage point for system-level performance improvement. This requirement for getting the team, and the teamwork, right flows throughout the organization. If it isn’t right at the top of the organization, it tends not to be right anywhere else.

This is more than a matter of getting the appropriate internal staff on the team. An equally critical aspect of this leverage point is to get patients and family members onto the teams — from the executive suite on to the clinical microsystem (the small, interdependent groups of people who work together regularly to provide care for specific groups of patients) and improvement project teams. We simply must make it a routine matter to bring patients’ ideas, perspectives, and insights into the room in which we are redesigning their care.

**Leverage Point Five: Make the Chief Financial Officer a Quality Champion**

One particular member of the senior executive team stands out, in our view, as a critical “leverage point” for large system change: the CFO. The connection between quality improvement and business performance is weakly made in most health care organizations. Traditionally, the successful health care CFO is a master of the revenue stream, able to maximize contracts and payment systems. Cost reduction efforts are generally in reaction to external changes in the market or payment systems and are mostly one-time events focused on reducing the cost of labor, supplies, and vendor contracts. There is little history in health care of the CFO leading a *systematic* focus on improving patient care and support processes with an aim of reducing *per-unit operating cost*. In other industries, CFOs appear to spend proportionately more of their time focused internally on the reduction of waste and the improvement of core operating processes. If CFOs were to become strong drivers of quality-based elimination of waste, and if their commitment were translated deeply into the budgeting, capital investment, and innovation/learning systems of an organization, we believe that health care organizations would be far more likely to achieve dramatic improvement in system-level measures of both financial and quality performance.

**Leverage Point Six: Engage Physicians**

This leverage point requires that leaders reframe the problem. We commonly speak of this challenge in terms of “engaging the physicians in the quality work of the organization,” whereas it might well be a far more powerful leverage point if we thought of it as “engage our organizations in the quality work of physicians.”

Clearly, all professionals need to be engaged, if leaders are to succeed. So why single out physicians? This leverage point arises from the reality that whereas physicians by themselves cannot bring about system-level performance improvement, they are in a powerful position to stop it from moving forward, and therefore their engagement is critical. Simply stated, leaders are not likely to achieve system-level improvement without the enthusiasm, knowledge, cultural clout, and personal leadership of physicians.

How might health system leaders better engage physicians in the effort to achieve measured system-level improvement? The specific answers depend on local structures, processes, and cultural patterns of behavior, but are likely to include elements such as the following:

- Build trust: Say what you do, and do what you say, consistently over time.
- Share power: Equip physicians to lead, and let them do so.
- Reframe the “compact” with physicians in a way that reinforces the cultural values necessary for success.



- Hold discipline: Keep the work of physicians evidence-based and data-driven.
- Avoid “monovoxoplegia,” or “paralysis by one loud voice.” This requires courage, backed by evidence and data and bolstered by the *moral* case for improvement. Courage of this sort is beautifully illustrated by Donna Isgett at McLeod Regional Medical Center, and the question she now asks physicians when they balk at using evidence-based practices: *“Are you saying that you value your individual autonomy more than you value your patients’ outcomes?”*

#### **Leverage Point Seven: Build Improvement Capability**

There is no substitute for knowledge. If superb projects are to spring up throughout an organization, leaders must devote the resources to establishing capable leaders of improvement everywhere. And if successful projects are to scale, spread, and change the performance of the entire system, then leaders must build a system of leaders capable of rapidly recognizing, translating, and locally implementing change concepts and improved designs. The list of capabilities required of senior leaders is long, but includes at minimum the ability to know, use, and teach the following:

- The Model for Improvement<sup>2</sup>
- A coherent improvement strategy such as Toyota Production System<sup>3</sup>
- Concepts and practices of High-Reliability Organizations<sup>4</sup>
- Sophisticated practices in Flow Management<sup>5</sup>
- Concepts and practices in Scale and Spread

Note: This last leverage point provides a good illustration of the interdependence of leverage points. It would do little good to create lots of improvement capability (#7) without establishing an aim (#1) and a strategy by which to guide those who are now capable of doing improvement work (#2). Furthermore, it would be unlikely that capable improvers’ work would scale, spread, and sustain, without some understanding of the impact of that work on financial performance (#5).

## **Section Two: Applying the Seven Leadership Leverage Points to the 100,000 Lives Campaign**

### **Introduction**

As of April 2005, more than 1,800 hospitals and other health care organizations have signed on to the Institute for Healthcare Improvement's 100,000 Lives Campaign. Many of these institutions have started the hard work of implementing the six Campaign interventions, along with other strategies to reduce hospital deaths. But there are only 15 months left, and a lot of improvement remains to be done. Just as "Some is not a number, and soon is not a time," *signing on* to the Campaign is not enough; hospitals must *plan and execute* specific, significant changes in care design and processes.

The early going in implementation has surfaced a number of significant challenges and triggered some early learning for the leadership teams of Campaign organizations. For example, the Campaign timetable requires leaders to plan and execute improvement at a larger *scale* and faster *pace* than ever before. And while hospitals are finding that being part of the national enthusiasm around the Campaign is helpful, enthusiasm alone is not enough to carry any individual hospital through the implementation of the necessary changes.

How might hospital executives map out their approach to achieving their part in the Campaign? The Seven Leadership Leverage Points provide a framework for leaders to answer these questions as they plan to save 121, or 392, or however many lives would represent their contribution to the overall goal of 100,000 fewer deaths in US hospitals.

### **Getting Started: Use this document to guide the development of your agenda for the 100,000 Lives Campaign**

We suggest that the CEO and senior management team start by doing the following:

- Read and understand the 100,000 Lives Campaign documents that describe each of the Campaign interventions, and the evidence base and potential impact of implementing each intervention.<sup>6</sup>
- Individually review this document and complete your own self-assessment (Appendix A).
- Meet and share their assessments and recommended actions.
- Gather the relevant data needed to establish appropriate aims.
- Adopt an aim and create a plan for the local application of the 100,000 Lives Campaign interventions.

It is important to complete this process very quickly (within two weeks), in order to get on with the implementation and steering of the plan. Leaders signal the pace, or tempo, of any major initiative by how they act during the first phases of the work. Your organization cannot work at *allegro* if the downbeat of your leadership baton is *largo*.

**Leverage Point One: Establish and Oversee System-Level Aims for Improvement at the Highest Board and Leadership Level**

*Has the leadership team developed an aim for the number of lives your hospital will save by June 14, 2006?*

Setting an aim for lives to be saved within any one hospital cannot be done with great precision. Nevertheless, it is important to set such an aim, because if your aim is a vague statement about “better,” without any specificity about “how good, by when,” you will have no idea about the scale and pace requirements that you must build into the plan. In other words, if you don’t go through the difficult task of setting an aim for “lives saved by June 14, 2006,” it’s highly likely that your improvement work will lack the urgency and the drive to spread that are necessary for success.

There are several interrelated approaches that you might use to come up with a reasonable target for your hospital. The point of this exercise is not to be exact; it is to wrestle with the question, “What reduction in deaths is possible in our hospital?” and to arrive quickly at a reasonable answer.

- The first approach depends on knowing your hospital standardized mortality rate, or HSMR.<sup>7</sup> If your HSMR is 30 percent higher than the national norm, you probably should set a fairly aggressive goal for overall reduction in deaths — for example, to bring your results to the national norm, or 30 percent lower. On the other hand, if your HSMR is half the national average — for example, because you have already implemented four of the six Campaign interventions — there are probably some further reductions in mortality you could achieve, but it will take some careful planning to identify them, and your aim for improvement might be a 10 percent reduction in HSMR.
- The second approach doesn’t depend on knowing your specific HSMR, but uses your own hospital’s mortality statistics — total yearly deaths — to come up with a reasonable estimate of improvement. There are relatively few hospitals in the US for which a 20 percent reduction in gross mortality would be completely out of reach. So, if your hospital had 1,000 total deaths last year, you could set an aim of about 200 fewer deaths, and do some rough calculations to see if this makes sense with respect to the interventions you might envision. For example, if it is true that a Rapid Response Team alone can reduce gross mortality by 25 to 37 percent,<sup>8</sup> then it seems reasonable (and quite conservative) to estimate a 10 percent reduction, or 100 saved lives, by implementing this key Campaign intervention. Your leadership team would then need to identify interventions that might have the power to save an additional 100 lives, if 200 were your aim.

- A third approach is even less precise, but might be useful. Simply tally the number of beds your hospital is staffing, and estimate that you could save one life for every four beds in the hospital. This is a gross approximation for all US hospitals and might not apply specifically to your situation, but some hospitals have found it helpful.

Probably the most valuable approach would be to use all three methods (HSMR, total deaths, total beds) to triangulate on an aim that makes sense in your context and that will guide the development of a strategy to achieve the aim.

Once you have the answers to these questions, you can come up with a fairly specific statement of aim such as, “At St. Elsewhere, our aim is that 190 fewer patients will die in hospital on an annualized basis by June 14, 2006.”

Leverage Point One posits that it is not enough for the executive leadership group to frame an aim. The Board must know about the aim, understand it, care about it, and oversee its achievement.

This is critical, because Board engagement is essential to building the will needed to drive change at this scale and pace. Consider taking the following steps:

1. Present the 100,000 Lives Campaign, and your proposed aim for number of lives saved, to the Board Quality Committee and ask for their adoption of the aim.
2. Put this item on the full Board’s agenda at the earliest possible date, and ask the Board to adopt the aim and oversee its achievement.
3. Establish and communicate clear accountability for the achievement of the aim, and build that accountability into the Board’s normal mechanisms of executive performance feedback.
4. Show the Board your proposed performance monitoring measurements and the timetable on which they will be displayed and reviewed by the Board.

**Leverage Point Two: Align System Measures, Strategy, and Projects in a Leadership Learning System**

*Now that the hospital has a clear aim, and the leadership team is accountable for achieving it, have you adopted a strategy and a “100,000 Lives Campaign set-up” that you believe has the impact and scale and pace of implementation necessary to achieve the aim?*

Note: It is important to consider this strategy something like a theory: “We predict that if we implement the following changes at these levels of depth, spread, and pace, we will achieve the aim.” You need to ask the same sorts of hard questions about this strategy that you would for any other serious endeavor, e.g., your plan to “improve from 70 days of cash on hand to 90 by the end of the year.”

One important question to ask is, “How big is the opportunity, in your hospital, for each intervention in the 100,000 Lives Campaign?” For example:

**1. What is your acute myocardial infarction (AMI) death rate?** How many actual deaths does that represent? What are your AMI Core Measures? If you have AMI death rates at or above the national norms (~11 percent) and your AMI Core Measures range from 80–99 percent (typical hospitals), then you might be able to expect approximately half the AMI deaths if you were to become an order of magnitude more reliable in the application of evidence-based medicine to AMI. For example, if 94 patients died of AMI in your hospital last year, you could predict perhaps 47 fewer deaths with full implementation of this Campaign intervention.

Note: For this example, and for all the Campaign interventions, it is exceedingly difficult to come up with precise predictions of number of lives that might be saved in any one hospital. Nevertheless, it is important to have SOME idea of the power of each of these interventions. Without such estimates, how would you know whether your strategy (any set of interventions such as the Campaign interventions) has any likelihood of achieving your aim for reduced deaths?

**2. How many patients are currently being harmed by unreconciled medications in your hospital?**

If you haven’t assessed this using the Global Trigger Tool,<sup>9</sup> it would be a good idea to do so, in order to establish a baseline against which to plan, as well as a monthly feedback loop on whether your work on medication reconciliation is producing results. For example, if you are experiencing typical levels of “unreconciled medications per 100 admissions,” then it is reasonable to expect substantial reduction in harm, and death rates, with widespread, effective introduction of medication reconciliation.

**3. How many central line infections, ventilator-associated pneumonias (VAPs), and surgical site infections does your hospital expect to cause this year?** Your current performance on these measures will help you decide how big your opportunity is for reduction in deaths. If you have implemented the ventilator bundle reliably in all your ICUs, and VAP is a rare event now in your hospital, then you can't expect major additional saving of lives in this arena, and should probably consider adding your own local intervention to those of the Campaign (e.g., the reliable application of beta-blockade to all eligible surgical patients).

**4. As noted above, the single biggest opportunity in most hospitals is to implement Rapid Response Teams.** The estimate of lives saved here is fairly simple: at least 10 percent of *the total number of deaths at your baseline*, and perhaps as high as 30 percent or more.

Once you've worked through (and perhaps added to!) the various Campaign interventions, you can get some indication of whether you've got enough power in your proposed changes to achieve your aim. You will now have a "theory of your strategy."

Note: This raises a critical point that cannot be overemphasized. The 100,000 Lives Campaign is aimed at reducing deaths by a significant, specific number in a certain time period. The Campaign is NOT about the implementation of six specific interventions. These have simply been served up as a "prototype strategy to achieve the aim," and each hospital must evaluate them, *as well as other interventions that might be locally more important than the six Campaign interventions*, and devise its own strategy to achieve reductions in mortality.

The senior leadership team also needs to ask some other important questions about the "setup" of the 100,000 Lives work. Again, these questions will sound very familiar, because executives address them regularly for financial plans, market share strategies, and other important business goals. Reducing needless deaths deserves the same rigorous thinking and planning. Examples of such questions include the following:

- Do we have the right leaders in place to take the strategy forward? Have we assigned accountability for each of the specific strategies among the executive team and clinical leadership?
- Working backward from June 14, 2006, do we understand the key milestones within the plan that will tell us whether we are on pace to achieve the aim?
- Looking at all the strategic aims we are working on (not just 100,000 Lives aims), has the management team prioritized and aligned the work so that we can devote the energy and attention necessary to the success of the 100,000 Lives Campaign?

One of the most important questions to answer is, “Is a measurement feedback loop in place that will inform us about progress against the overall aim, and on each Campaign intervention?” A good measurement system will provide reasonably credible data at frequent intervals, perhaps one or two measures for each of the six Campaign interventions (or whatever other interventions you decide are needed locally to achieve your aim), and an overall measure of mortality rate. Ideally, the interval between measurements would be weekly or, at worst, monthly. One cannot steer either the strategy or its implementation with quarterly or annual feedback loops. An example measurement set, displayed on the walls of the Board, Medical Executive Committee, and Senior Management Team meeting rooms, might include the following:

- A monthly run chart of gross mortality rate for the hospital, which can reasonably be converted into “lives saved.” If the baseline mortality rate is 2 percent, and it falls over time to 1.5 percent, and the baseline number of deaths was 1,000 per year, then the approximate number of deaths that didn’t occur at the new mortality rate is 250. Of course, the number of deaths can be counted directly as well. (Note: Should Hospital Standardized Mortality Rate data become available on a weekly or monthly basis, this will be a far more accurate measure of overall impact of your strategy. This sort of data is available to hospital leaders in the National Health Service in England, but is not yet available in the United States.)
- A weekly run chart of the number of “code calls” as an indicator of impact of the Rapid Response Team
- A monthly run chart of a composite score for AMI Core Measures, along with AMI mortality rate
- A monthly run chart of “Unreconciled Medications per 100 Admissions”
- A weekly or monthly run chart of composite score for each of the “bundles”: ventilator-associated pneumonia and central line infection
- As appropriate, for each of the bundles, a run chart or other indicator of rate of events (e.g., VAPs, central line infections)
- Similar measurements for any other interventions that your team has judged to be necessary in order to achieve your targeted reduction in deaths

The last question that you should answer has to do with establishing a learning and action “loop,” using the feedback that comes to the executive team through the measures that you are watching. The question is: “How will the executive team make the necessary changes in either strategy or execution, if the measures aren’t moving far enough, fast enough?”

This is the critical point at which three things come together: the overall aim for number of saved lives, the strategy to achieve this aim, and the measures that allow the management team to predict whether they will succeed on the current course or whether changes need to be made. For example, if the surgical site infection measurements show that the process is bogged down with low implementation of the insulin protocols, then the leadership team needs to diagnose and deal with the situation reasonably quickly. Similarly, if all six Campaign interventions are apparently being implemented across the organization with depth and pace, but the mortality rate isn't budging... then the leadership team might need to revise the strategy.

### **Leverage Point Three: Channel Leadership Attention to System-Level Improvement**

If the currency of leadership is attention, then the Board, Medical Executive Committee (MEC), and executive agendas must give prominent placement to oversight of the 100,000 Lives results. The Board Quality Committee should review progress against the 100,000 Lives aims as a standing agenda item, preferably at the beginning of the agenda. Similarly, the full Board should hear a regular report from the Quality Committee, and the CEO, on the results. Remember that stories can channel attention in ways that run charts cannot, and so it might be a good idea to include a story of needless death in your hospital at each Board meeting. As one Board member said, "Maybe we should keep telling a fresh story each Board meeting until there isn't one to tell."

If your Board is watching closely, it's likely that the executive and MEC teams will also be paying attention to the 100,000 Lives work. Review of the results, and of the ongoing issues in the depth, spread, and pace of implementation of your strategy, must be a standing and prominent agenda item on your key management meetings.

You also channel attention by the choices you make about leadership, and the resources (time, organization focus, energy, staff, etc.) that you free up to allow them to succeed. The key question here is, "Are great performers assigned to this effort and is it seen as an important part of their regular work, not an add-on?" This is part of a larger human resources/leadership development system, through which the organization channels attention by its promotion, hiring, and leadership appointment processes. 100,000 Lives Campaign leaders must ensure that the right signals are being sent by how they've set up the teams that must take these projects forward.

Similarly, you send powerful signals by how you use your own time. For example, have your personal calendars changed to allow executive reviews and walkrounds on 100,000 Lives project teams?



Each senior executive, and most especially the CEO, should schedule visits to the key 100,000 Lives intervention teams, and perform project reviews that send powerful signals about the importance of this work and your focus on results, not on endless activity reports. Informal walkrounds should also be part of your daily and weekly routine. These aren't aimless wanderings and chitchats. Both executive project reviews<sup>10</sup> and more informal walkrounds<sup>11</sup> have been described in some detail and the executive teams should review these papers to make sure that they not only do these activities, but also do them well. All senior executives, including physician leaders, should be included in executive walkrounds.

Finally, you should take the difficult step of becoming transparent about your performance measures, by distributing measures of progress on each 100,000 Lives project, and on the overall aim, widely throughout the organization and the community. Perhaps the single most powerful method by which leaders can channel attention is through adopting and implementing a policy of transparency in performance measures. It's no mystery to your staff and patients that needless deaths and other mishaps occur in your organization. Similarly, the existence of central line or surgical site infections will not come as a surprise to anyone. What *will* surprise and engage your staff, your patients, and your community is if you display *all* your data on these subjects, not just the data you'd give to the marketing department to put on a billboard. The learning from organizations that have gone transparent about performance data, whether good, bad, or ugly, is that it has the following effects:

- Tends to drive a much faster pace of internal improvement
- Allows internal staff to feel respected and trusted by leaders
- Creates an atmosphere of open dialogue about real problems — necessary to get to solutions!
- Doesn't drive patients away — they give you a lot of credit for being honest with them, and for your declared intentions to do something about issues such as hospital deaths.

**Leverage Point Four: Get the Right Team on the Bus**

There is no question that the most common cause of failure in major change initiatives, in any setting, has to do with the absence of an effective, committed leadership team. There are two types of questions that leaders of the 100,000 Lives Campaign hospitals must ask: “Are the right people (right skills, knowledge, attributes) on the team?” and “Is the team really functioning as a team?”

With respect to the question about the right people, executives should first make sure that patients and family members are prominent members of the improvement teams. Direct patient and family engagement in active roles in the design and improvement of care has proven to be a powerful driver of results. The presence of patients and families “in the room” tends to silence self-serving conversations, to surface the whole system, and to bring innovative ideas forward.<sup>12</sup>

Within the leadership team itself, it is important to identify the technical and leadership skills necessary to implement the 100,000 Lives strategy at the required scale and pace, and to know that these skills they present on the team. Leadership behaviors such as the ability to tell stories that engage hearts, the ability to be authentically transparent about performance, and to focus on measured results, are absolute “musts” to be present on the executive team — if not in every member, at least in several of them. Similarly, technical improvement skills such as the ability to spread innovations, to improve reliability, and to manage flow must not only be present, but the senior leadership team must be seen as credible teachers of these and other fundamental quality capabilities. The executive team should build a list of all the skills that should be represented on the senior team, and must ascertain whether the skills are in fact represented. If not, then the CEO needs to build a plan to develop these skills in current executive team members, or to bring the necessary skills onto the team through new or revised membership.

Finally, it is vital that the entire senior executive team be engaged in and committed to achieving the 100,000 Lives aim. This is perhaps the hardest issue of all within this leverage point. If you aren’t sure of your team’s commitment, one suggestion would be for the entire executive team to watch the videotape of Don Berwick’s speech from IHI’s 2004 National Forum, “Some Is Not a Number, Soon Is Not a Time,”<sup>13</sup> and engage in a deep dialogue about the 100,000 Lives initiative and how it fits into each executive’s values, work roles, and other factors. It is critically important that no member of the executive team regard the achievement of the 100,000 Lives aims as “someone else’s problem” or as a “do-good project of little relevance to the overall strategy of this hospital.” Each senior executive on the team should be assigned accountability for one of the 100,000 Lives improvement teams.

**Leverage Point Five: Make the Chief Financial Officer a Quality Champion**

One simple way to connect finance leaders with 100,000 Lives initiatives is related to Leverage Point Four: make them part of each improvement team. If major 100,000 Lives Campaign changes such as Rapid Response Teams are to be implemented on a large scale, it will be critical to understand the financial implications on staffing budgets and other drivers of daily managerial behavior. If members of the finance department work directly on these projects, they can help to make projections, support revisions in budgets, and make the case for investment in resources, as necessary.

Sometimes longstanding, deeply embedded processes such as the annual budget cycle can overwhelm even the most well-planned change initiatives. How will you ensure that changes needed to save lives are not stalled as a result of the current budget planning process? For example, how will you incorporate the impact of full scale and spread of the 100,000 Lives projects as a primary input, not a dependent variable at the end of the budget cycle? If the 100,000 Lives work is truly a top priority, it should be evident in the budget planning process for 2005–2006. Projections of staffing needs, ICU lengths of stay, and other key outputs from the various 100,000 Lives interventions should be incorporated into next year's budget as primary inputs. The analytical work necessary to do this will prove to be a major point of engagement for the CFO, and should be important to establishing the credibility of the “business case” for reducing needless deaths.

As teams go about this work, it will be necessary to develop a set of performance metrics for each 100,000 Lives project that include a unit cost financial measure and a global financial measure. The goal of the 100,000 Lives Campaign is to save lives. If money were not an issue, we could simply throw more resources at the problem. But money is always an issue in organizations, and financial indicators should always be included in a balanced set of project or performance measures. Financial measures should be viewed at two levels, unit cost and organizational impact. Some of the 100,000 Lives projects may increase the per-unit cost of care, but have a positive overall organizational impact due to reimbursement issues. The opposite may also be true. The point is not that the 100,000 Lives Campaign should save money (it might in some organizations), but that leaders must know the impact of decisions. CFO participation and leadership is required.

A final note on this leverage point: Whether there needs to be a business case for the 100,000 Lives Campaign is an interesting question. Some would argue that putting a business calculus to needless deaths is at best, a distraction, and at worst, immoral. We don't wish to take one side or the other in this debate — but simply to acknowledge its existence.

### **Leverage Point Six: Engage Physicians**

The success of several of the 100,000 Lives initiatives will depend on active support and leadership from the medical staff. To get physicians engaged in this agenda, you must reframe your mindset and engage in their quality agenda. The important question is, “Does your executive team truly understand and share the medical staff’s intrinsic motivation for quality?”

In an environment often clouded by battles over issues such as economic credentialing, Emergency Medical Treatment and Active Labor Act (EMTALA) on-call obligations, and departmental turf issues, administrators may lose sight of the strong intrinsic motivation of physicians to improve patient outcomes and reduce wasted time and other inefficiencies in their daily work. The 100,000 Lives Campaign puts the most critical outcome of all — alive or dead — squarely in the center of the agenda. If ever there were an aim around which all parties can gather with unalloyed shared purpose, it is “reduce needless deaths.” It is critical that the shared motivation be articulated and acknowledged, to build the base for making major changes in a short span of time.

Structurally, every hospital has an “organized medical staff,” and its Medical Executive Committee is typically charged by the Board with the delegated responsibility for clinical quality. But it is relatively rare for an MEC to be one of the principal drivers of a major quality initiative such as the 100,000 Lives Campaign. Rather, MECs tend to take a primary role in the credentialing and privileging process for individual physicians, and more often than not play a bystander role to the core administration and its nursing and paid medical directors when major quality initiatives are underway. The MEC (or whatever is the highest leadership group of physicians) must explicitly take the reins of many of the 100,000 Lives projects, regularly review the measures and progress against the aims, and join with senior executives in owning the results.

The right physician leaders must also be chosen for each of the 100,000 Lives interventions. If leaders are chosen badly, projects are likely to flounder. Some characteristics of good physician leaders to consider include the following:

- Has the respect of peers; is seen as “authentic”
- Models the values needed, especially teamwork and respect
- Has courage to take risks, try things
- Has “social skills”: listens well, brings out all voices, articulates well
- Knows and can use the Model for Improvement, reliability principles, and other key skills needed for improvement

Finally, those who work with physicians on making the 100,000 Lives-related changes must know that the organization stands behind them. Are your executive and nurse managers confident of backup and support all the way to the Board, and do they have the courage to engage physicians in difficult conversations to avoid “monovoxoplegia”?

Physicians are strongly aligned, professionally, with the goal of reducing needless deaths. And the vast majority of them will be strongly supportive of the changes that are needed to improve the safety of patients. But it is also highly likely that some of these changes will come up against strong resistance at one or more points in their implementation, and that some of those who oppose the changes will be physicians.

It is important that ALL members of the teams have the courage to face up to strongly negative voices, even in those negative voices are physicians. Otherwise, it’s likely that implementation teams will suffer from “monovoxoplegia” — paralysis by one loud voice — a common condition in hospitals. There are several good antidotes to this problem, but none is more important than courage. Nursing leaders, quality staff, and even senior executives often express hesitance to take on loudly negative physicians, because past history has told them that when the physician takes the issue higher — including to a favorite Board member on the golf course — it is the administrative staff member who pays the consequences.

The Board and senior administrative team must send a very powerful signal about the 100,000 Lives Campaign, and back it up with action. Each manager, team leader, and other participant in this process must know that they have backup — all the way to the Board — if they are to find the courage to speak up in response to loud negativism from powerful individuals.

**Leverage Point Seven: Build Improvement Capability**

Implementing the changes needed to reduce mortality will require that hundreds of capable improvers exist throughout the hospital. *And the requirement for real technical capability includes the senior leadership team.* The question you must answer is, “Does the entire leadership team (including CEO and senior managers) know, use, and teach the technical and change leadership knowledge required to achieve the 100,000 Lives aim?”

Capability for improvement must be developed far and wide throughout the organization. But too commonly, executive leaders exempt themselves from this requirement, and delegate the technical learning about quality to “the quality staff.” But the depth, breadth, and pace of change required to achieve the aims of the 100,000 Lives Campaign demand that executive leadership not only know these skills, but also be the principal practitioners and teachers of these technical capabilities. Although it’s not a comprehensive list, the following technical skills are a starter set of basic requirements for 100,000 Lives executives:

- Basic understanding of the 100,000 Lives interventions and their impact: Executives should have read the Campaign literature thoroughly, and be able to explain and communicate the core rationale for each of the Campaign interventions.<sup>14</sup>
- Model for Improvement and rapid tests of change: The various Campaign interventions generally don’t lend themselves to the “make the perfect design and then implement it everywhere” change model. Executives leading projects need to know and apply the Model for Improvement and many, many rapid tests of change.<sup>15</sup>
- Flow Management: The success of many of the Campaign interventions will depend on a deep quality characteristic — how well the organization manages its flow. Executive leaders need to have a very strong understanding of this core quality body of knowledge.<sup>16</sup>
- Reliability: All of the Campaign interventions will benefit from reliability science and its thoughtful application.<sup>17</sup>
- Scale and Spread: The biggest risk for failure in the Campaign is that organizations will do lots of isolated pockets of nice improvement, but fail to scale, spread, and sustain the changes. This is both a technical and a leadership challenge — but the executive team **MUST** understand and use good spread concepts if the Campaign is to succeed.<sup>18</sup>

**Appendix A:**

**Leadership Leverage Points Self-Assessment Tool for the 100,000 Lives Campaign**

This Self-Assessment Tool is designed to help the administrative, physician, and nursing leaders of a 100,000 Lives Campaign hospital design and plan their work in order to lead to a significant reduction in hospital mortality, in a fairly short time. Ideally, the self-assessment should be done by individual leaders as soon as possible after signing on to the Campaign, by whatever group the hospital feels is its “senior leadership team.” The team should then meet to go over their results, and to plan the actions that will address any Leadership Leverage Points that appear to need particular attention in that hospital.

Leadership Leverage Points	Score 1, 2, 3*	Actions and Behaviors That Support the Score Response	Action Planned	By Whom
<b>1. Establish and Oversee System-Level Aims for Improvement at the Highest Board and Leadership Level</b>	<b>X</b>			
Leadership team has developed a specific aim for # of lives saved, by when				
Leadership team has developed a measurement and reporting system that provides monthly feedback on # of lives saved				
Board has adopted the aim, and is overseeing its achievement using this measurement system				
Accountability for achieving the aim is embedded into the Board’s executive performance feedback system				

[Note: \* 1=not in place, 2=just beginning, 3=established practice]

Leadership Leverage Points	Score 1, 2, 3*	Actions and Behaviors That Support the Score Response	Action Planned	By Whom
<b>2. Align System Measures, Strategy, and Projects in a Leadership Learning System</b>	<b>X</b>			
Leadership team has developed a plan (Campaign interventions plus?) with the necessary scale and pace to achieve the aim				
Monthly (or better, weekly) measures of performance on lives saved, and on individual Campaign interventions, are reviewed by senior leadership team				
These measures are also displayed and reviewed by Medical Staff Exec Committee, and by Board Quality Committee				
The leadership team (administration, Med Exec...) is steering and adjusting both the strategy to achieve the aim, and its execution, based on the measures				

[Note: \* 1=not in place, 2=just beginning, 3=established practice]



Leadership Leverage Points	Score 1, 2, 3*	Actions and Behaviors That Support the Score Response	Action Planned	By Whom
<b>3. Channel Leadership Attention to System-Level Improvement</b>	<b>X</b>			
Board agendas give prominent place to oversight of 100,000 Lives results				
Regular executive and Medical Exec Committee meeting agendas give prominent place to steering 100,000 Lives strategy and its execution				
Personal calendars are changed to allow executive reviews and walkrounds on 100,000 Lives project teams				
Great performers are assigned to this effort and is seen as an important part of their regular work, not an add-on				
Measures of progress on each 100,000 Lives project, and on the overall aim, are widely distributed throughout the organization and the community (transparency)				

[Note: \* 1=not in place, 2=just beginning, 3=established practice]

Leadership Leverage Points	Score 1, 2, 3*	Actions and Behaviors That Support the Score Response	Action Planned	By Whom
<b>4. Get the Right Team on the Bus</b>	<b>X</b>			
Patients and families are deeply involved in each 100,000 Lives project teams				
The entire senior executive team is engaged and committed to achieving the 100,000 Lives aim				
Executive Team: The right technical and leadership skills to implement the 100,000 Lives strategy at the required scale and pace have <i>been identified</i>				
Executive Team: The right technical and leadership skills to implement the strategy at the required scale and pace <i>are present</i>				

[Note: \* 1=not in place, 2=just beginning, 3=established practice]

Leadership Leverage Points	Score 1, 2, 3*	Actions and Behaviors That Support the Score Response	Action Planned	By Whom
<b>5. Make the CFO a Quality Champion</b>	<b>X</b>			
Finance reps are integrated into 100,000 Lives project teams to support business case needs				
Current budget planning incorporates the impact of full scale and spread of the 100,000 Lives projects as a primary input, not a dependent variable at the end of the budget cycle				

[Note: \* 1=not in place, 2=just beginning, 3=established practice]

Leadership Leverage Points	Score 1, 2, 3*	Actions and Behaviors That Support the Score Response	Action Planned	By Whom
<b>6. Engage Physicians</b>	<b>X</b>			
The executive team understands and shares the medical staff's intrinsic motivation for quality (outcomes, wated time...)				
The Medical Executive Committee regards the 100,000 Lives initiative as a core aspect of its delegated responsibility for quality				
Capable leaders have been appointed to physician leadership roles in 100,000 Lives projects				
Executive and nurse managers are confident of backup and support all the way to the Board, and have the courage to engage physicians in difficult conversations and avoid "monovoxoplegia" (paralysis by one loud voice)				

[Note: \* 1=not in place, 2=just beginning, 3=established practice]

Leadership Leverage Points	Score 1, 2, 3*	Actions and Behaviors That Support the Score Response	Action Planned	By Whom
<b>7. Build Improvement Capability</b>	<b>X</b>			
The entire leadership team (including CEO and senior managers) knows and uses the technical and change leadership knowledge required to achieve the 100,000 Lives aim				
<ul style="list-style-type: none"> <li>• Basic understanding of the 100,000 Lives interventions and their impact</li> </ul>				
<ul style="list-style-type: none"> <li>• Model for Improvement and rapid tests of change</li> </ul>				
<ul style="list-style-type: none"> <li>• Flow Management</li> </ul>				
<ul style="list-style-type: none"> <li>• Reliability</li> </ul>				
<ul style="list-style-type: none"> <li>• Scale and Spread</li> </ul>				
Leadership team can, and do, teach the technical and change leadership knowledge to others in the organization				

[Note: \* 1=not in place, 2=just beginning, 3=established practice]

Reference: “What Will It Take to Move Big Dots?” Briefing Paper for IMPACT, Pursuing Perfection, and League of Two Hundred Leaders on “Leadership Leverage Points for System-Level Performance Improvement.” ([www.ihl.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/WhatWillItTaketoMoveBigDots.htm](http://www.ihl.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/WhatWillItTaketoMoveBigDots.htm))

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