Leading the Transformation of Healthcare Systems

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Patient Safety Colloquium
Ontario, CA
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Outline

- Why “Transformation?”
- Six Leadership Challenges
- Transformation as a Surprise
- The Transformational Tasks of Leadership
Disclaimer

• What you are about to hear is not based on a “normative” theory.
• (But then, neither is anything you buy in the leadership section of the bookstore)
“Transformation?”

• Volume drives success
• Overuse of lucrative services is a particularly strong driver of success
• Potentially avoidable harm and complications are common
• Care is episodic and uncoordinated
• Systems are designed for convenience of providers

• Value drives success
• Neither over-nor under-use is rewarded
• No needless waste
• No needless harm
• No needless waiting or uncertainty
• No needless pain
Every system is perfectly designed to produce the results it gets.

Paul Batalden
Systems

Structures

Processes

Patterns of Behavior
Example: Transformed Surgical Procedure

- Decision to operate is driven by evidence and informed patient decision-making, not $.
- Correct information about patient and procedure is shared between office and O.R.
- All and only the necessary imaging and testing is done.
- Pre-op preventive procedures highly reliable.
- 100% handwashing.
- REAL Checklists led by surgeon at each critical stage in process.
- Coordinated, team-based post-op care.
- Zero complications, readmissions, re-do’s…
- Patient outcome is excellent.
Patterns of Behavior That Must Undergo Transformation if Healthcare is to become Safer

- “Normalized deviance” from safety rules
- “Willful flaunting” of safety rules
- “Check the boxes” approach to safety rules
- “I must show that I’m strong and don’t need to ask for help” approach to teamwork
- “I don’t dare to speak against the authority gradient” even if something is obviously wrong
Forces Driving Transformation

• Business Model Shift: Volume to Value
  – US indebtedness, and healthcare’s options:
    • Plan for ever-declining reimbursement rates or...
    • Reduce potentially avoidable complications and overuse

• Unpredictable Powers:
  – Patients, technology, social media, workforce…

• No longer a 3-CEO Problem?
Per episode
Per enrolled life
Per community cost profile

Danger!
Cross
Quickly!

A la carte
Per RVU
Per admission
Six Leadership Challenges in Transforming Healthcare Systems

1. Reframe core cultural values
2. Create improvement capability
3. Collaborate across competitive boundaries
4. Create a business environment that drives both community benefit and delivery system sustainability
5. Produce system-level results, not science projects
6. Maintain constancy of purpose
Transformation and Surprise

• Complex Adaptive Systems
  – “A collection of individual agents that have the freedom to act in ways that are not predictable and whose actions are interconnected such that one agent’s actions changes the context for other agents.”
    • Contain adaptable elements
    • Can be described by simple rules
    • Exhibit nonlinearity
    • Display surprising, novel behavior
    • Are seldom predictable in detail
    • Often display inherent order, without apparent controls
    • Are context-dependent, embedded in other systems
Routes to Transformation

- Revolution (Leadership from Below)
- Friendly Takeover (Leadership from Outside)
- Intentional Organizational Transformation (Leadership from Above)
- Intentional Macrosystem Transformation (Leadership from High Above)
Routes to Transformation

- Revolution
  (Leadership from Below)

- Friendly Takeover
  (Leadership from Outside)

- Intentional Organizational Transformation
  (Leadership from Above)

- Intentional Macrosystem Transformation
  (Leadership from High Above)
The Transformational Tasks of Leadership

Build Will

Generate Ideas

Execute Change

Build the Foundation

To

Doctors Use Improvement Science

Center Care on Patients

Cooperate as a System

To

Become a System With No Needless...

• Deaths
• Pain
• Delays
• Helplessness
• Waste
• Frame a focused, system-level aim
  • How good
  • By when
  • Whole system
• Test: Can everyone in the organization explain the aim, personal role in achieving it, and current status of performance against it?
• Example: “In the next 12 months, we will reduce healthcare acquired infections by 50%, as measured by the sum of C. diff, MRSA, central line, ventilator pneumonia, and surgical site infections.”

Become a System With No Needless…
• Deaths
• Pain
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• Helplessness
• Waste
Project Zero - Hospital Acquired Infections
Cdiff MRSA SSI and VAP

AIM STATEMENT: Reduce the number of hospital acquired infections in half by the end of 2010.

Set 1: UCL = 16.6, Mean = 8.1, LCL = none (2006/01 - 2006/12)
Set 2: UCL = 9.3, Mean = 3.6, LCL = none (2007/01 - 2009/11)
Set 3: UCL = 6.9, Mean = 2.3, LCL = none (2009/04 - 2010/07)

Desired Direction

MRSA screening for high risk patients started
MRSA screening for all inpatients started
Antibiotic stewardship started

Order of individual counts: Cdiff, MRSA, SSI, VAP

Project Zero Goal = 2
• Transform yourself
• Transform (remake?) the senior exec team
• Build improvement capability
  • Commit to framework and method
  • Hardwire to human resources system

• Tests:
  • Have you personally interviewed staff who were at the sharp end of an error that killed a patient?
  • Is improvement a “line management” responsibility?
• Example: All Virginia Mason leaders must complete 3 weeks of intensive training in Japan on Toyota Production System
• Adopt and oversee aim at Board level
• Start every meeting with a story
• Display data in human terms
• Make aims and performance public
• Safety is a primary value, not a strategic option
• Tests:
  • “How many patients is that?”
  • “Can we do that safely?”
• Example: WellStar Board Quality Committee and “Precursor Events” with crash carts.
<table>
<thead>
<tr>
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<th>Date</th>
<th>Event Description</th>
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<td>John B.</td>
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**Our Baseline, January-December, 2008**
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<td>Robert M.</td>
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A 78% reduction through Nov. 2010

Lois R.
4/16/10
Surgical Fire

Mary B.
5/22/10
Post Procedure Cx

Lamar A.
6/3/10
Med Error

Bruce C.
5/25/10
Delay In Dx

Marilyn C.
1/21/10
Med Error

Sylvia L.
3/31/10
Delay In Dx

Frank S.
2/22/10
Surgery Cx

Ruby B.
5/30/10
Fall

Doyle L.
7/22/10
Med Error

WELLSTAR
Generate Ideas

• Know “best in the world” performers
• Actively seek new ideas, inside and outside the organization
• Try out lots of ideas, quickly
• Tests:
  • When you visit safety improvement teams, do you ask them how many ideas they’ve tried?
  • Is it easy to try something new, or does it take 5 committees to approve?
• Example: Scripted “reality rounds” on critical safety practices
• Focus your aims!!!
• Create a coherent, logical portfolio of projects with the necessary scale and pace to achieve the aim
• Resource the projects with the time of capable leaders
• Establish a culture focused on accountability for results, not activities

Tests:
• How many aims do you have?
• How many **breakthrough** results did you achieve last year?
• When did the CEO last come to a safety team meeting to review results?
• Example: McLeod and 3 projects every 90 days
Doctors Use Improvement Science

- Ask them what they want to improve
- Expect them to take the lead
- Teach them improvement and safety science ($\sqrt{n}$)
- Make it easy for them to do this work
- Recognize their results
- Tests:
  - How many of your medical staff are “capable improvers?”
  - When you start a new initiative, do you always go back to the same 4 doctors?
- Example: After the annual retreat, have the board Chair ask the MEC “What is the medical staff’s plan to accomplish the safety goals we just adopted?”
• Put two patients on the Quality Committee
• Include patients or family members as full members of safety project teams
• Name patients to search or promotion committees for key executive roles

Tests:
• Do you have a “Patient and Family Advisory Committee?”
• Are any patients full voting members of the Quality Committee?

Examples:
• St. Joseph PeaceHealth, retired army nurse a voting member of MEC
• Build “containment vessels” for whole communities
  • Authority, relationships, common purpose
• Put patients on your cross-organizational teams
• Understand and use a key rule of systems:
  • If each part of a system is optimized, the whole system will be sub-optimized.
  • In order to optimize the whole, one or more parts must be sub-optimized.
• Test: Would your conversations about parts of your community care system sound unseemly if patients were in the room?
• Example: Jonkoping County Council and cardiac surgery
The Transformational Tasks of Leadership

- Build Will
- Generate Ideas
- Execute Change

Doctors Use Improvement Science

Center Care on Patients

Cooperate as a System

Become a System With No Needless...
- Deaths
- Pain
- Delays
- Helplessness
- Waste

Build the Foundation
Leaders must emerge who regard themselves as defenders not of organizations but of the underlying purposes that have temporarily created those organizations in their current forms. Leaders will have to be willing to unmake the very organizations they hold in trust. That’s a big job. It requires a kind of courage that is rare among human beings, including organizational leaders.”

Don Berwick MD
“Seeking Systemness,”
Healthcare Forum Journal, March/April 1992
Summary

• Transformational leadership is different
  – Values, habits, beliefs must change
  – Authenticity is essential

• Six Leadership Challenges
  – Values, capability, macrosystem, collaborate, Big Dots, constancy of purpose

• Transformation as a Surprise
  – Complex adaptive systems, 4 Roads

• The Transformational Tasks of Leadership
This is the true joy in life, to be used for a purpose you consider a mighty one, to be a force of nature, rather than a feverish, selfish clod of ailments and grievances, complaining that the world will not devote itself to making you happy.

GB Shaw