

Leading the Transformation of Healthcare Systems

**Hospital Association of Southern California
Annual Leadership Meeting
San Diego, CA
May 24, 2012**

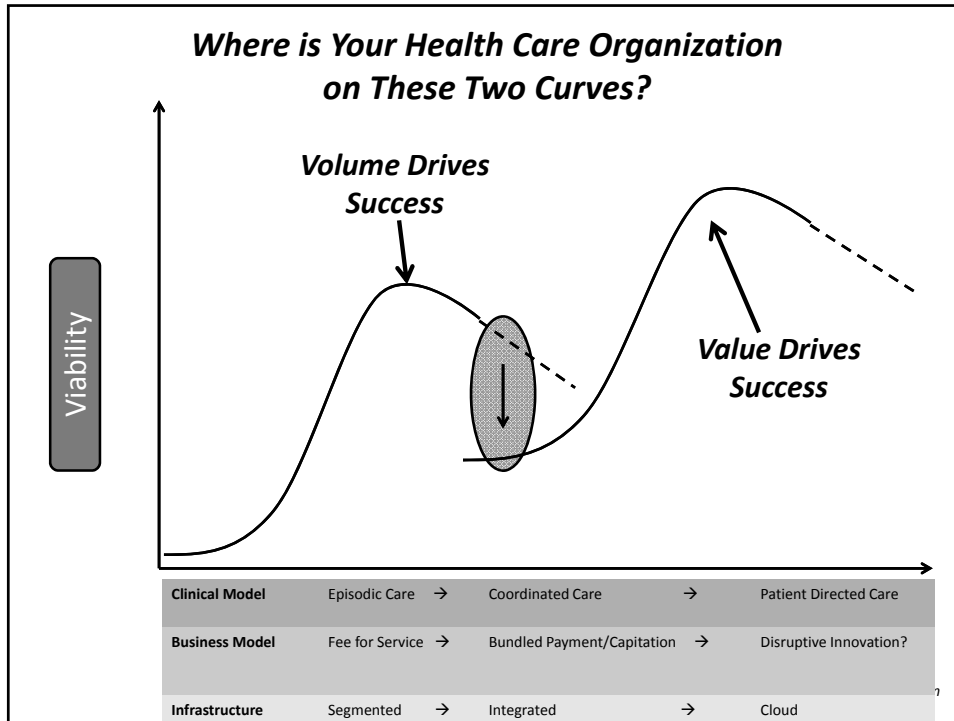
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Outline

- 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 is about more than the business model

- 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



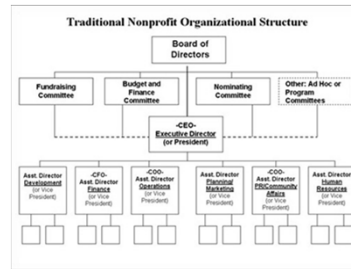
Every system is perfectly designed to produce the results it gets.

Paul Batalden

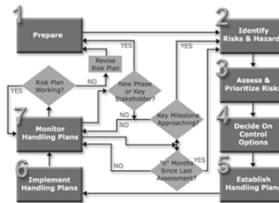


Systems

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





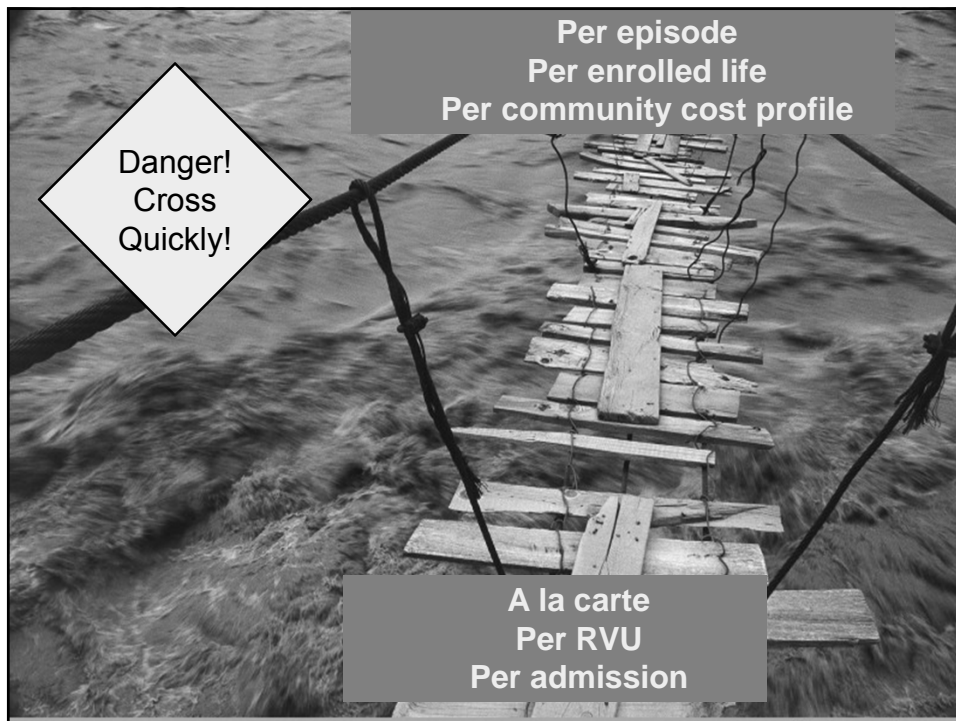
Patterns of Behavior That Must Undergo Transformation if Healthcare is to become Safer

- “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



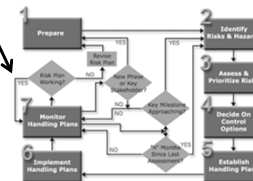
Forces Driving Transformation

- 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, new disruptive sources of competition...
- No longer a 3-CEO Problem?



Six Leadership Challenges in Transforming Healthcare Systems

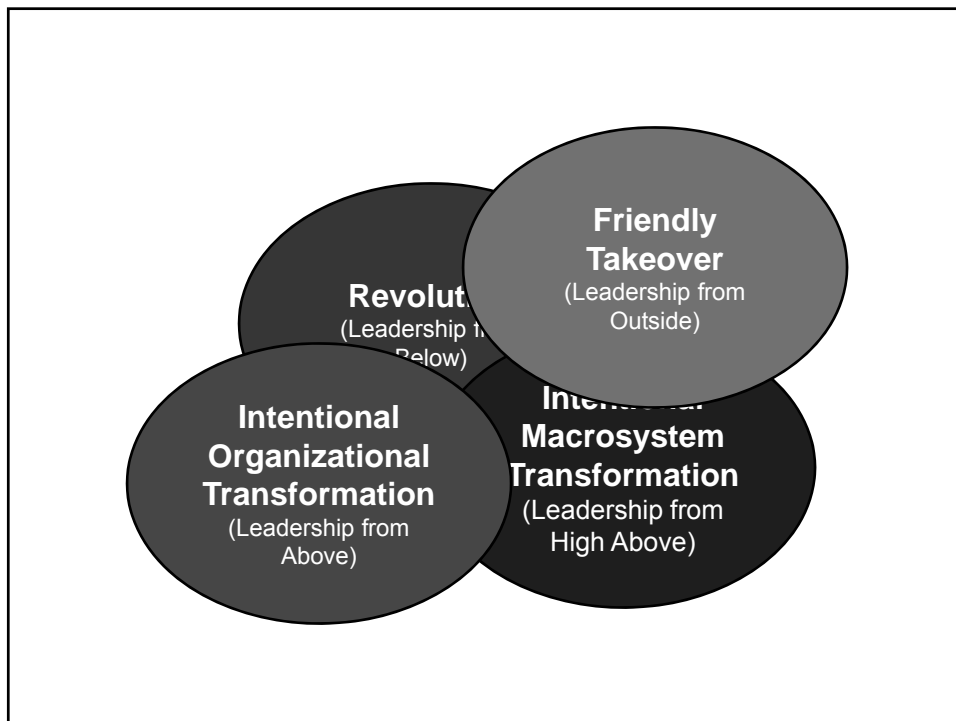
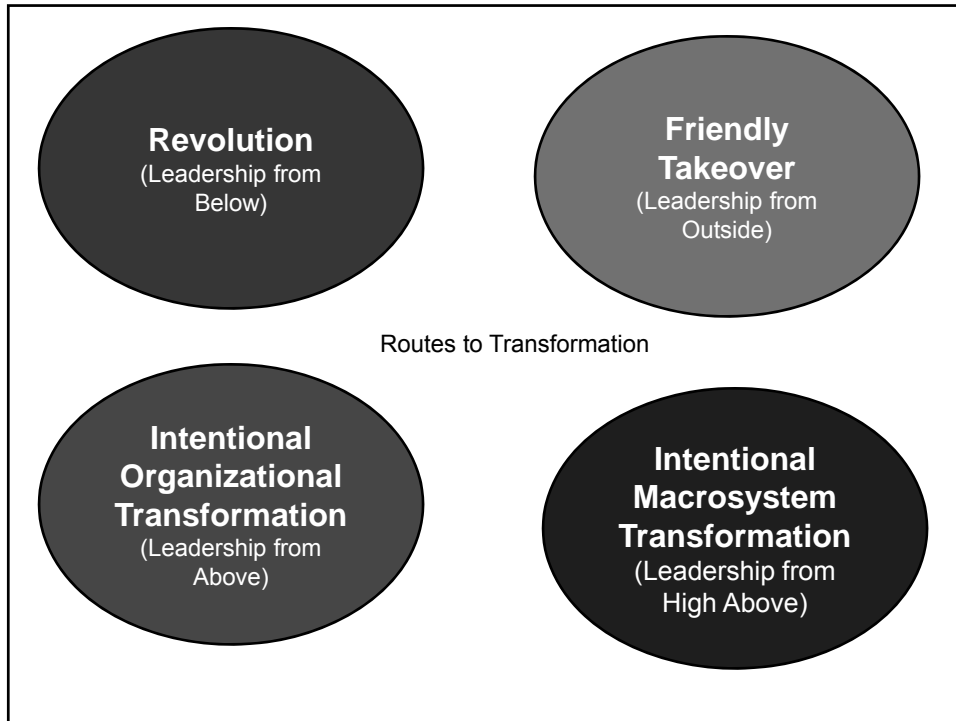
1. Reframe core cultural values
2. Create improvement capability
3. Collaborate across competitive boundaries
4. Create a business environment that drives both community benefit and delivery system sustainability
5. Produce system-level results, not science projects
6. Maintain constancy of purpose

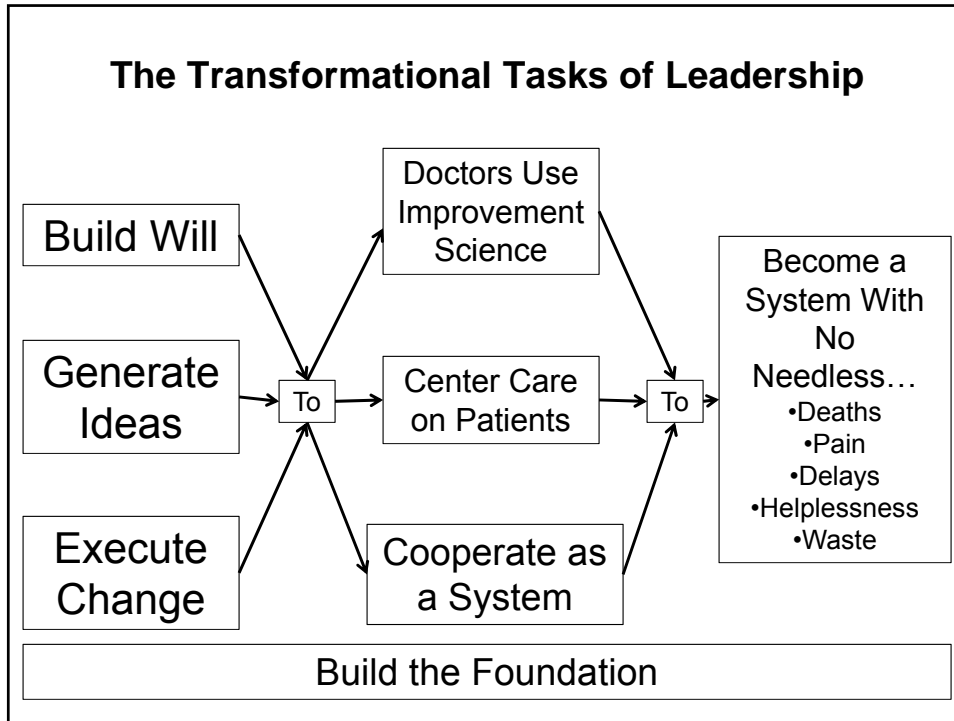


Transformation and Surprise

- 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

Paul Dieck

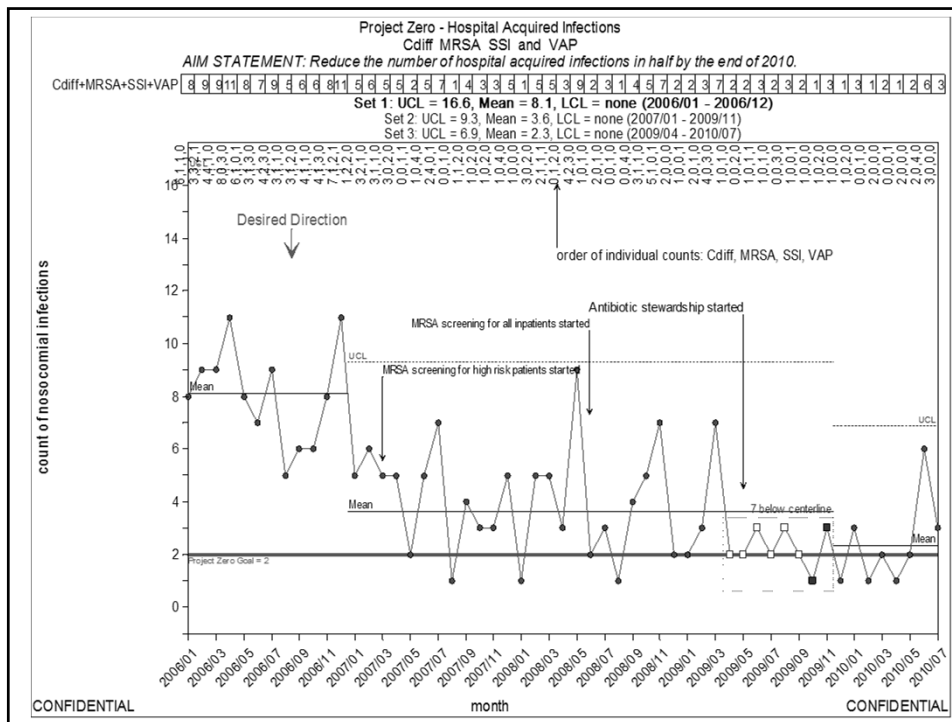




- Frame a focused, system-level aim
 - How good
 - By when
 - Whole system
- Test: Can everyone in the organization explain the aim, personal role in achieving it, and current status of performance against it?
- Example: “In the next 12 months, we will reduce healthcare acquired infections by 50%, as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

Become a System With No Needless...

- Deaths
- Pain
- Delays
- Helplessness
- Waste




- 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

Build the Foundation


Build Will

- 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.

Our Baseline, January-December, 2008


John B. 9/06/2008 Delay in Dx	Shirley H. 12/23/08 Post Proced Death	Florita H. 7/03/2008 Delay in Tx	Wade W. 7/16/2008 Delay in Tx	Baby Boy S. 8/1/2008 Wrong Pt. Procedure	Joseph R. 9/08/2008 Delay in Dx.		
Tamika M 4/21/2008 Med Error	Andrea M. 6/24/2008 Wrong Procedure	Nancy H. 6/18/2008 Med Error	Jimmy P. 7/07/2008 Fall	Joann E. 9/23/2008 Wrong Site Surgery	Cynthia M. 10/27/2008 Med Error	Regina D. 12/9/2008 Wrong Site Surgery	
Baby Girl V. 5/12/2008 Mother's Delay in Tx	Kyle W. 9/13/2008 Delay in Tx	Teodur C. 1/29/08, 2/12/2008 Delay in Tx	Alvin G. 8/17/2008 Fall	Nicole S. 1/4/2008 Delay in Dx	Margaret H. 2/6/2008 Med Error		
Ursula H. 2/12/2008 Fall	Ms. L. 2/14/2008 Delay in Tx	Sandra M. 12/10/2008 Post Procedure Death	Karen G. 8/5/2008 Proced Cx/Delay in Tx	Cynthia K. 11/10/2008 Delay in Tx	Lance D. 10/30/2008 Delay in Tx		
Nicole H. 8/12/2008 Post-proced Cx	Robert S. 10/13/2008 Fall	Mary D. 3/9/2008 Med Error	Baby Boy G. 3/25/2008 Med Error	Lorena W. 11/10/2008 Post Procedure Death	Priscilla W. 8/30/2008 Delay in Tx	Dale W. 10/12/2008 Med Error	
Eugene B. 10/27/2008, 10/28/2008 Med Error, Fall	Kathy W. 12/16/2008 Post Proced Loss of Function				Robert B. 12/2/2008 Post Procedure Death		
Virginia L. 8/12/2008 Delay in Tx	Helene C. 9/5/2008 Fall				Lester J. 9/5/2008 Fall	Calvin P. 4/4/2008 Med Error	Gwendolyn P. 10/28/2008 Wrong Implant
Chantal E. 6/26/2008 Care event	Gary B. 6/13/2008 Fall				Mary C. 12/19/2008 Fall	Douglas T. 10/18/2008 Med Error	
					WELLSTAR		

A 50% Reduction, January-December, 2009

Lois D. 9/23/09 Fall	Beverly S. 2/4/09 Med Error	Robert D. 5/12/09 Post Procedure Death	Karen C. 9/28/09 Delay In Treatment	Peggy P. 7/1/09 Burn	Shara W. 2/15/09 Med Error
Edward R. 4/23/09 Wrong Side Procedure	Brenda R. 10/14/09 Delay In Treatment	James H. 10/25/09 Post Procedure Death	Lillian C. 4/3/09 Retained foreign object		
Dorothy R. 1/28/09 Delay In Treatment	Johnny B. 11/9/09 Fall	Jerry Y. 11/7/09 Fall	Yola C. 7/7/09 Delay in Treatment	Donna S. 6/4/09 Retained foreign object	
Monroe K. 5/18/09 Post Procedure Death	Juanita A. 5/14/09 Delay In Treatment		Alma M. 11/6/09 Fall	Scott G. 9/5/09 Delay in Treatment	
Michael F. 8/20/09 Retained foreign object	Willie B. 11/5/09 Med Error		Pauline M. 11/2/09 Fall	Robert M. 11/3/09 Delay in Treatment	



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				Ruby B. 5/30/10 Fall
Frank S. 2/22/10 Surgery Cx				Doyle L. 7/22/10 Med Error



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

Execute Change

- 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 doctors what they want to improve
- Expect them to take the lead
- Teach them improvement and safety science (√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

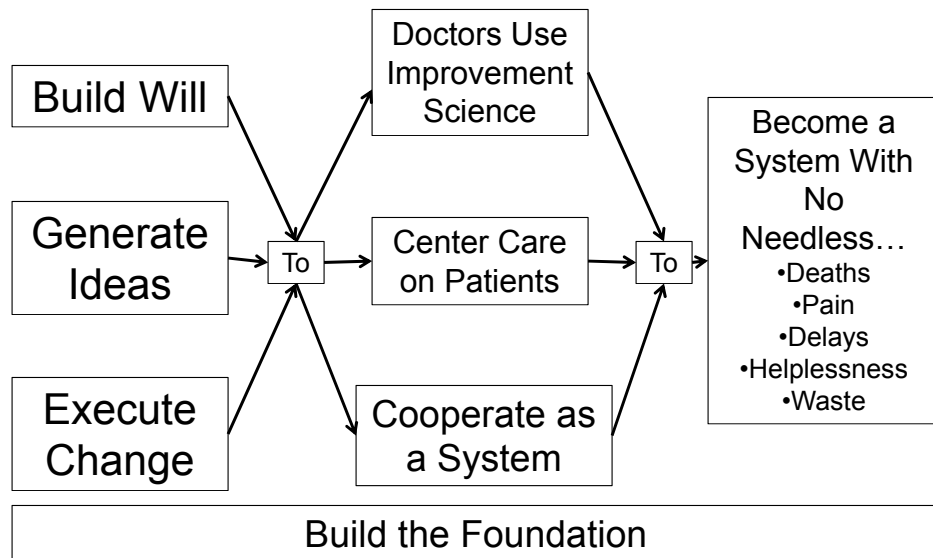
Center Care on Patients

- 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

**Cooperate
as a System**

The Transformational Tasks of Leadership



Checklist For Personal Reflection

What Will It Take To Transform A HealthCare Organization?

A Checklist for Senior Executives

James L. Reinertsen, M.D.
January, 2012

How well are you doing at leading the transformation?

1. Have you set and communicate the direction—the aim, the “commander’s intent?”
 - a. Prepared a one-sentence statement of aim for the entire organization to achieve the theoretically ideal state of performance for one or more dimensions of quality, containing these three key elements:
 - i. How good...
 - ii. By when...
 - iii. As measured by...
 - b. Communicated and understood by all employees...
 - c. Used to align and guide the enterprise...
 - d. Fully integrated into the structure of the organization: everyone can explain his/her role in achieving the aim
2. Have you built the Foundation?
 - a. Transformed yourselves (the senior leaders)



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

