New Leadership Skills for Better Health and Health Care

Middle East Forum on Quality and Safety in Healthcare 2014

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Derek Feeley

Moderator: Ms. Liz Thiebe
The Leader’s Role:
A Trilogy of Assurance, Improvement, and Innovation

- You are juggling a lot

  - Leaders are responsible for running their organizations and producing reliable outcomes
  - New program ideas surface and need activation
  - Expectations from patients, families, and staff rise and we need to do better to meet them
  - There are increasing needs to access the care system
The Quality Trilogy

- Assuring quality
- Improving quality
- Innovating quality

The Trilogy: Assurance

Assurance is inspecting to ensure that safe and effective standards of care are in place every day

- Joint Commission International and other accreditation
- Leadership rounds and triggers
- Listening to staff and patients
Assurance

- What happens when assurance is not in place and the patient/staff voice is not heard?
Don Berwick’s Four Principles for the NHS as a Learning Organisation

- Place the quality of patient care, especially patient safety, above all other aims.
- Engage, empower and hear patients and carers at all times.
- Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in the area in which they work.
- Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

The Trilogy: Improvement

- **Four Leadership Questions:**
  - *Do you know how good you are?*
  - *Do you know where you stand relative to the best?*
  - *Do you know where the variation exists?*
  - *Do you know the rate of improvement over time?*

- **Building improvement capability**

- **Chartering and supporting teams to close gaps**

- **High-Impact Leadership**
Interdependent Dimensions of High-Impact Leadership

New Mental Models
How leaders think about challenges and solutions

High-Impact Leadership Behaviors
What leaders do to make a difference

IHI High-Impact Leadership Framework
Where leaders need to focus efforts

“Leadership is about getting people to want to do the right thing.”

“Good leaders make people feel that they’re at the very heart of things, not at the periphery. Everyone feels that he or she makes a difference to the success of the organization. When that happens, people feel centered and that gives their work meaning.”
How will you know what is the right thing?

- If you don’t think about your values?
- If you don’t think about how your values impact on others?
- If you don’t behave in accordance with those values?
Design and Nurture the Culture

Your Calendar?
“New Mental Models”

- “How leaders think about challenges and solutions”
- "The only thing that works is management by values. Find people who are competent and really bright, but more importantly, people who care exactly about the same things you care about." – Steve Jobs
Vince Lombardi and Leadership Behaviors

“Perfection is not attainable, but if we chase perfection we can catch excellence.”

“The quality of a person’s life is in direct proportion to their commitment to excellence, regardless of their chosen field of endeavor”
High-Impact Leadership Behaviors

1. Person-centeredness
   Be consistently person-centered in word and deed

2. Front Line Engagement
   Be a regular authentic presence at the front line and a visible champion of improvement

3. Relentless Focus
   Remain focused on the vision and strategy

4. Transparency
   Require transparency about results, progress, aims, and defects

5. Boundarilessness
   Encourage and practice systems thinking and collaboration across boundaries

“The source of energy at work is not in control, it is in connection to purpose.”
High-Impact Leadership

Driven by Persons and Community
- Include patients on improvement teams
- Start meetings with patient stories and experience data
- Use leadership rounds to model engagement with patients and families

Develop Capability
- Teach basic improvement at all levels
- Invest in needed infrastructure and resources
- Integrate improvement with daily work at all levels

Shape Culture
- Communicate and model desired behaviors
- Target leadership systems and organizational policies with desired culture
- Take swift and consistent actions against undesired behaviors

Create Vision and Build Will
- Boards adopt and review system-level aims, measures, and results
- Channel leadership attention to priority efforts
- Transparently discuss measures and results

Deliver Results
- Use proven methods and tools
- Frequently and systematically review efforts and results
- Devote resources and skilled leaders to high-priority initiatives

Engage Across Boundaries
- Model and encourage systems thinking
- Partner with other providers and community organizations in the redesign of care
- Develop cross-setting care review and coordination processes
IHI’s Theory of Change

- Will
- Ideas
- Implementation
Will-building at the Senior Level

- Colones’ rounds
- Walk of shame
- O’Brien’s breakfast meeting
- Transparency
- Sharp end knowledge
Root Cause Analysis: Learning From Our Mistakes

Nobody likes it, but mistakes do happen. If a mistake harms a Munson Medical Center patient or employee, or even has the potential to cause significant harm, a Root Cause Analysis (RCA) is conducted to pinpoint what went wrong and to plan for prevention of future injuries.

RCAs have been performed at Munson for more than five years as part of a renewed focus on patient safety. Among the 35 RCAs conducted so far this year, incidents included a near electrocution of an employee, combative patients, medication errors, and plant facility issues.

One lesson learned over the years is that it’s crucial for everyone involved in an incident to participate and felt the process improvement measure instituted to prevent similar mistakes would improve patient care overall.”

Physician participation in the RCA process is vital, according to a recent issue of RiskRx, a national risk management newsletter. “In addition to lending clinical expertise, physician participation adds credibility and facilitates medical staff implementation of improvement strategies. The Joint Commission has gone so far as to say that, ‘An RCA will usually not be accepted by the Joint Commission if the analysis did not include physician participation.’”

New guidelines call for a Root Cause Analysis to be scheduled within 72 hours of an incident, and conducted within two weeks. All action assignments are to be completed within 30 days. “So far, B3 South holds the record for the quickest response,” McGuire said. “They had a full RCA completed and sent back within 24 hours.”
What’s the matter?

What matters to you?

Ideas: Build the Capacity for Innovation

- Design a system to scan the research literature and to get the latest information into action in real time
- Build an R+D (innovation) engine to reach to other countries and industries for better answers
Ideas with Potential

- Minimally Disruptive Medicine
- Design Council diabetes visit cards & Cedars Sinai Visit Cards
- Lauren’s List
- New ways to see and connect with patients and staff
Minimally disruptive medicine

Health care delivery designed to reduce the burden of treatment on patients while pursuing patient goals
Work of being a chronic patient

Sense-making work

Organizing work and enrolling others

Doing the work

Reflection, monitoring, appraisal
Medication Choice Cards

Other Cards

Low Blood Sugar (hypoglycemia)

Blood Sugar (A1c Reduction)

Side Effects

Daily Routine

Daily Sugar Testing

Cost

These figures are estimates and are for comparative reference only. Actual out-of-pocket costs vary over time, by pharmacy, insurance plan coverage, preparation and dosage. While some plans name brands may be comparable in cost to generics.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Generic Available</th>
<th>Cost/Duration</th>
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<tbody>
<tr>
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<td>$0.10 per day</td>
<td>$10 / 3 months</td>
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<tr>
<td>Insulin</td>
<td>(No generic available)</td>
<td>Price varies by dose</td>
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<td>Glitazones</td>
<td>$7.20 per day</td>
<td>$650 / 3 months</td>
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<tr>
<td>Exenatide</td>
<td>(No generic available)</td>
<td>Price varies by dose</td>
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<td>Sulfonylureas</td>
<td>$9.00 per day</td>
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<tr>
<td>Glitins</td>
<td>$6.20 per day</td>
<td>$560 / 3 months</td>
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</table>
Diabetes Visit Cards

- Developed in England by the Design Council to improve the effectiveness of chronic care visits at physicians’ offices
- The patient sorts the cards to select issues that form the agenda for the visit
- Satisfaction is improved and patients report more control of their disease
Diabetes Visit Cards
Trust the Young
What Matters To Me

My name is Kendra
I am 7
I don't like medicine by myself

I can dress myself with some help.
I can do my homework.
I love noisy toys.

24.10.2013
Implementation: Delivering Results

- Achieve breakthrough goals
- Spread and sustain
- Provide day-to-day leaders for microsystems
- Develop human resources
- Manage local improvement
- Provide leaders for large system projects
What Can You Do By Next Tuesday?

Learn the Improvement Model

![Model for Improvement Diagram]

Source: The Improvement Guide
What Can You Do By Next Tuesday?

Build a Ramp Model

Changes That Result in Improvement

DATA

A P S D

Hunches Theories Ideas

A P S D

A P S D

D S P A
Multiple PDSA Cycle Ramps

Change Concepts
What Improvement Skills are Needed for Each Role?

Everyone
(Staff, Supervisors, UBT lead triad)
• Setting goals and measures
• Identifying problems
• Mapping process
• Testing change
• Simple waste reduction
• Simple standardization
• Team behaviors

Change Agents
(Middle Managers, Stewards, project leads)
• Setting goals and measures
• Identifying problems
• Mapping process
• Sequencing tests of change
• Simple understanding variation
• Implementation and spread
• Simple waste reduction
• Simple standardization

Operational Leaders
(Executives)
• Setting direction and big goals
• Results leadership
• Portfolio selection and management
• Managing oversight of improvement
• Being a champion and sponsor
• Understanding variation to lead
• Managing implementation and spread

Experts
• Analysis, prioritization of portfolios
• Deep statistical process control
• Deep improvement methods
• Leadership team advisory re portfolio selection, process
• Effective plans for implementation and spread
Building PI Capability and Skills

Develop and Test the System at a Facility level
- Improvement Advisor
- Leadership
- First project
- Oversight responsibility
- Several teams
- 90 days

Expand improvement system to more departments
- Several Improvement Advisors
- Prioritization and portfolios
- Oversight groups
- Sponsor and champion accountability by service
- Team development and alignment of goals

Deepen improvement knowledge within services and units
- Service line IA’s
- All leaders know role and skills
- Prioritization and oversight in operations
- Alignment of portfolios
- Standard work
- Teams know goals and test change

Learning and sharing systems regionally and program-wide Improvement Institute

Project
Portfolio
Whole system
Continuous improvement

Mentors

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Progress on Key Indicators: 2008 - 2012

<table>
<thead>
<tr>
<th>Hospital Standardized Mortality Ratio</th>
<th>BSI Rolling 12 Mo. Rate</th>
<th>Cdiff</th>
<th>SRAES</th>
<th>HAPUS</th>
<th>Readmissions</th>
<th>Inpatient Utilization</th>
<th>RFO</th>
<th>Worker Injury Rates</th>
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<td>52%</td>
<td>35%</td>
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<td>82%</td>
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<td>30%</td>
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Dramatic Reduction in Risk Adjusted Hospital Mortality

Hospital Standardized Mortality Ratios

NOTE: Data above reflects rolling twelve month observed/expected ratio

Ratio of observed to expected mortality

Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2008 2009 2010 2011 2012 2013

KP - All Facilities
US Medicare Overall
Kaiser Foundation Hospital
Significant Reduction in Use of Inpatient Bed National Patient Day Rate

Inpatient Days per 1000, 2009Jan-2013Mar
All Lines of Business, All Regions, Unadjusted

All Regions

Source: Inpatient Days per 1000 report, National
All Kaiser Permanente Medicare Plans Receive 5 out of 5 Stars

October 15, 2013

TOPICS: EXPERT MEDICINE, PRODUCTS AND BENEFITS | REGIONS: NATIONAL | KEYWORDS: MEDICARE STARS

OAKLAND, Calif. — Kaiser Permanente has announced that all of its Medicare health plans have earned 5 stars — the highest overall rating for quality and service from the Centers for Medicare & Medicaid Services. The 5-star rating applies to Kaiser Permanente’s 2014 Medicare health plans that operate in California, Oregon, Washington, Hawaii, Colorado, the Mid-

Atlantic States and Georgia.
The Dancing Guy
3 Things You Will Need

1. Leaders, followers and momentum
2. A framework that you can fall back on
3. To pay some attention to culture and values
From Kaiser Permanente

- Start with why
- Ask the right questions
- Measure what matters
- Drive the change
From Scotland

- A compelling vision
- A story
- Actions/stepping stones
- Engaging and enthusing the workforce
- Creating momentum by securing improvements
- Never letting up and making it stick
Leadership in Complex Systems

- Destabilize the existing system
- Leaders as “sense makers”
- Allow solutions to emerge
- Beware the “aye been”
- Accept paradox and contradiction
Implementing improvement in messy environments… can it be done?

- **Will** = destabilize the status quo
- **Ideas** = sense making
- **Implementation** = allow emergence
“Creating a Culture of Excellence” is Well-Understood

- Well-studied (Schein, Singer, for example)
- Key Steps in Culture Change
  - Set aim – “Never again will patients be harmed in our care”
  - Identify the behaviors that would reflect such a culture – *Standard work, ask for help, offer help*
  - Build the supports for these behaviors (*information systems, learning systems, human resource policies, training, leadership incentives*)
  - Leaders at all levels consistently promote the behaviors and the message
Edgar Schein on Culture

- Culture is a result of what an organization has learned from dealing with problems and organizing itself internally.

- Your culture always helps and hinders problem solving.

- Solve problems by identifying and resolving associated discrepancies between values and behavior.

- Do not oversimplify culture. It’s far more than “how we do things around here.”

- Leaders should not focus on culture change. Focus on a business problem.

- Culture is a group phenomenon. Engage focus groups to define how the culture is helping and hindering work on a problem.
Thank You!

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  President and CEO

- Derek Feeley
  Executive Vice President

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