Don't forget to join in the conversations on twitter
Tweet us at **#quality2019**

D8 #qfd8

Institute *for* Healthcare Improvement

BMJ

Engaged Doctors Transform Care

Gary S. Kaplan, MD, Virginia Mason Medical Center
Jack Silversin, DMD, DrPH, Amicus, Inc.

International Forum on Quality &
Safety in Healthcare
29 March 2019

Disclosures

Gary Kaplan is CEO and Chairman of Virginia Mason Health System

Jack Silversin is President of the consulting firm Amicus, Inc

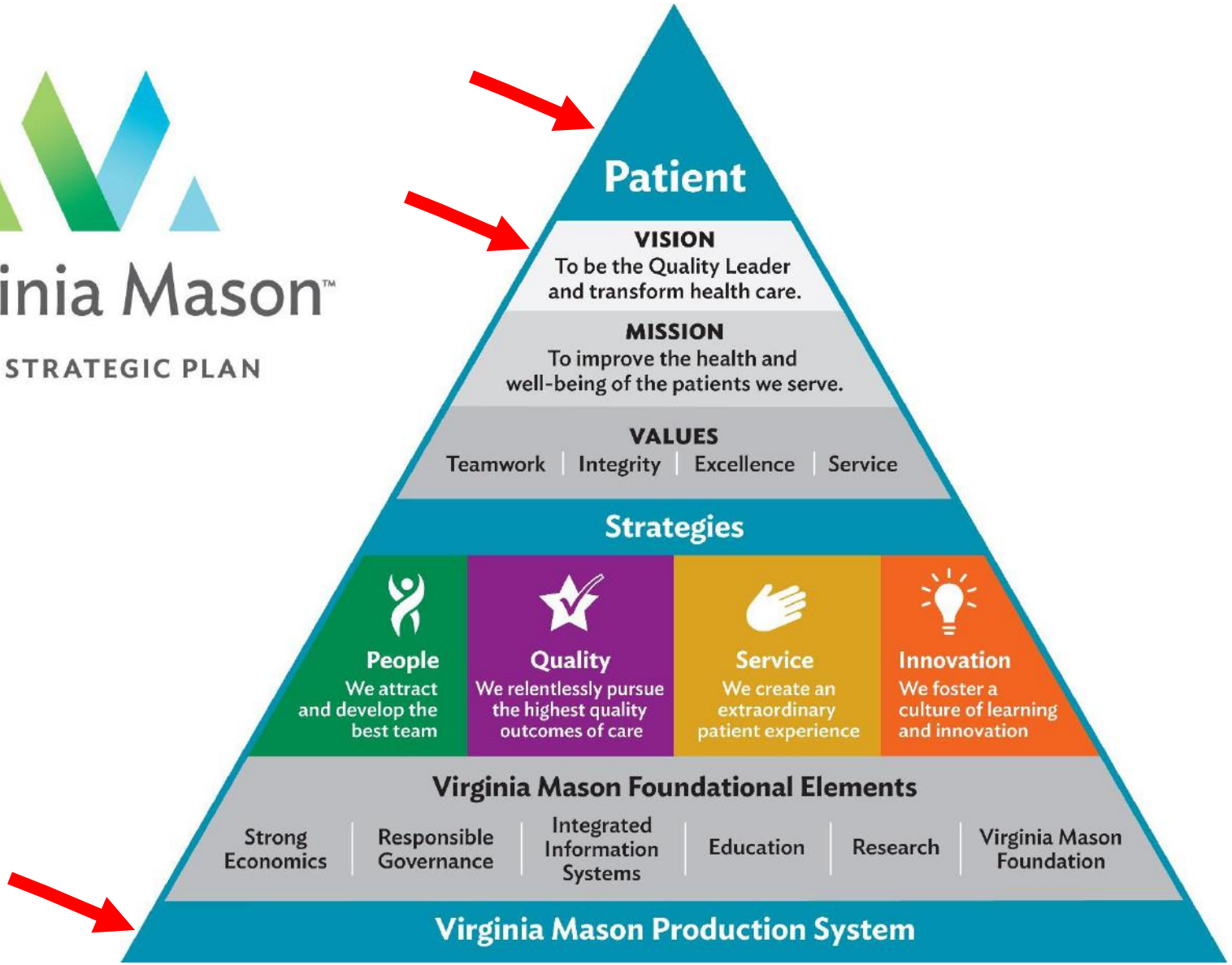
Virginia Mason, Seattle, WA

- Integrated health care system
- 501(c)3 not-for-profit
- Virginia Mason Hospital (Seattle, 336 beds)
- Virginia Mason Memorial (Yakima, 226 beds)
- 38 Clinics
- Graduate Medical Education
- Research Institute
- Bailey-Boushay House
- Virginia Mason Institute

Virginia Mason

Virginia Mason™

OUR STRATEGIC PLAN



Seeing with our eyes – Japan 2002

What We Learned: healthcare and manufacturing have a lot in common

- Every manufacturing element is a production processes
- Health care is a combination of complex production processes: admitting a patient, having a clinic visit, going to surgery or a procedure and sending out a bill
- These products involve thousands of processes—many of them very complex
- All of these products involve the concepts of quality, safety, customer satisfaction, staff satisfaction and cost effectiveness
- These products, if they fail, can cause fatality

Virginia Mason

New Management Method: The Virginia Mason Production System

We adopted the Toyota Production System because it offers a management approach that would produce:

- Customer first
- Highest quality
- Obsession with safety
- Highest staff satisfaction
- A successful economic enterprise

Virginia Mason

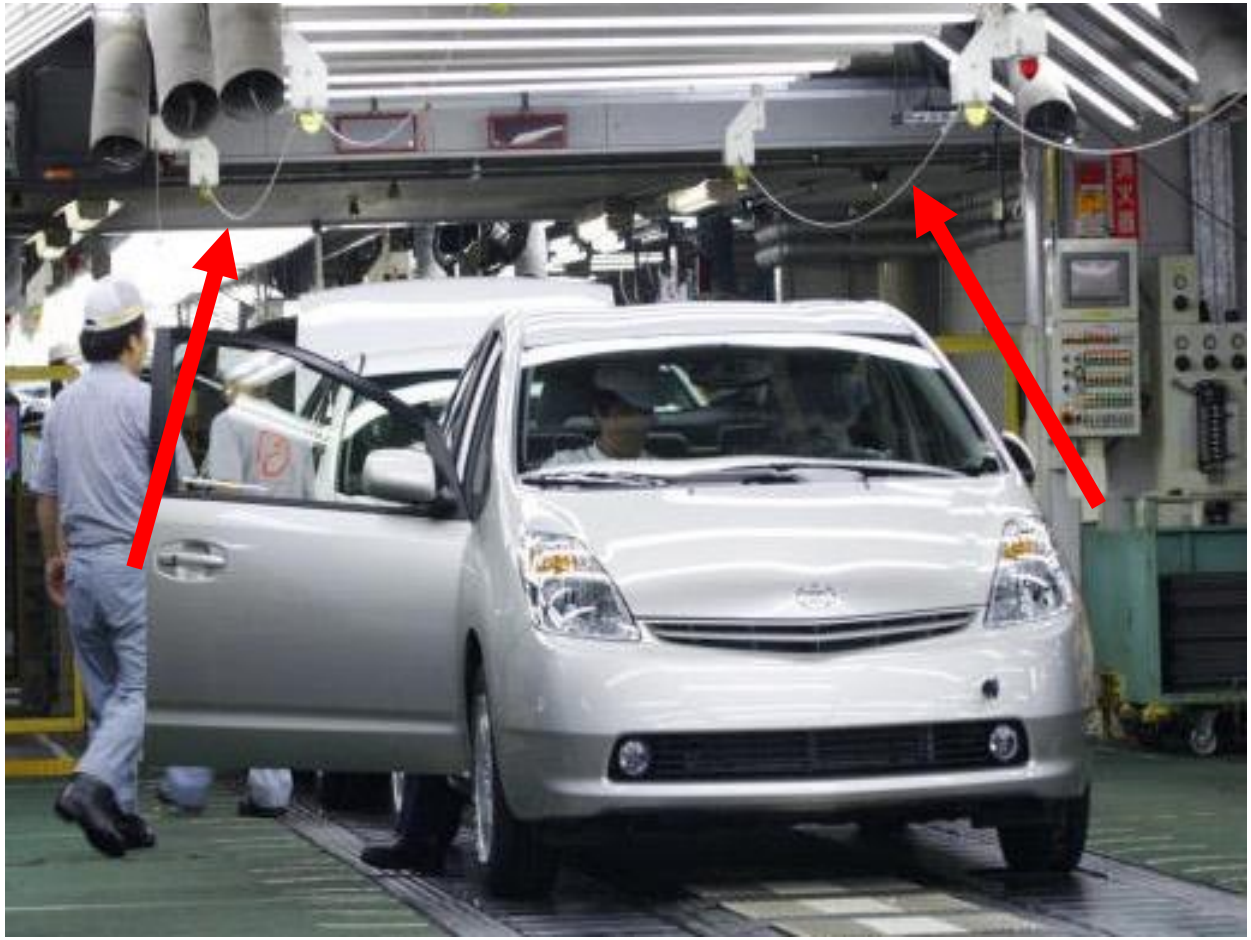
The VMMC Quality Equation

$$Q = A \times \frac{(O + S)}{W}$$

Q: Quality
A: Appropriateness
O: Outcomes
S: Service
W: Waste

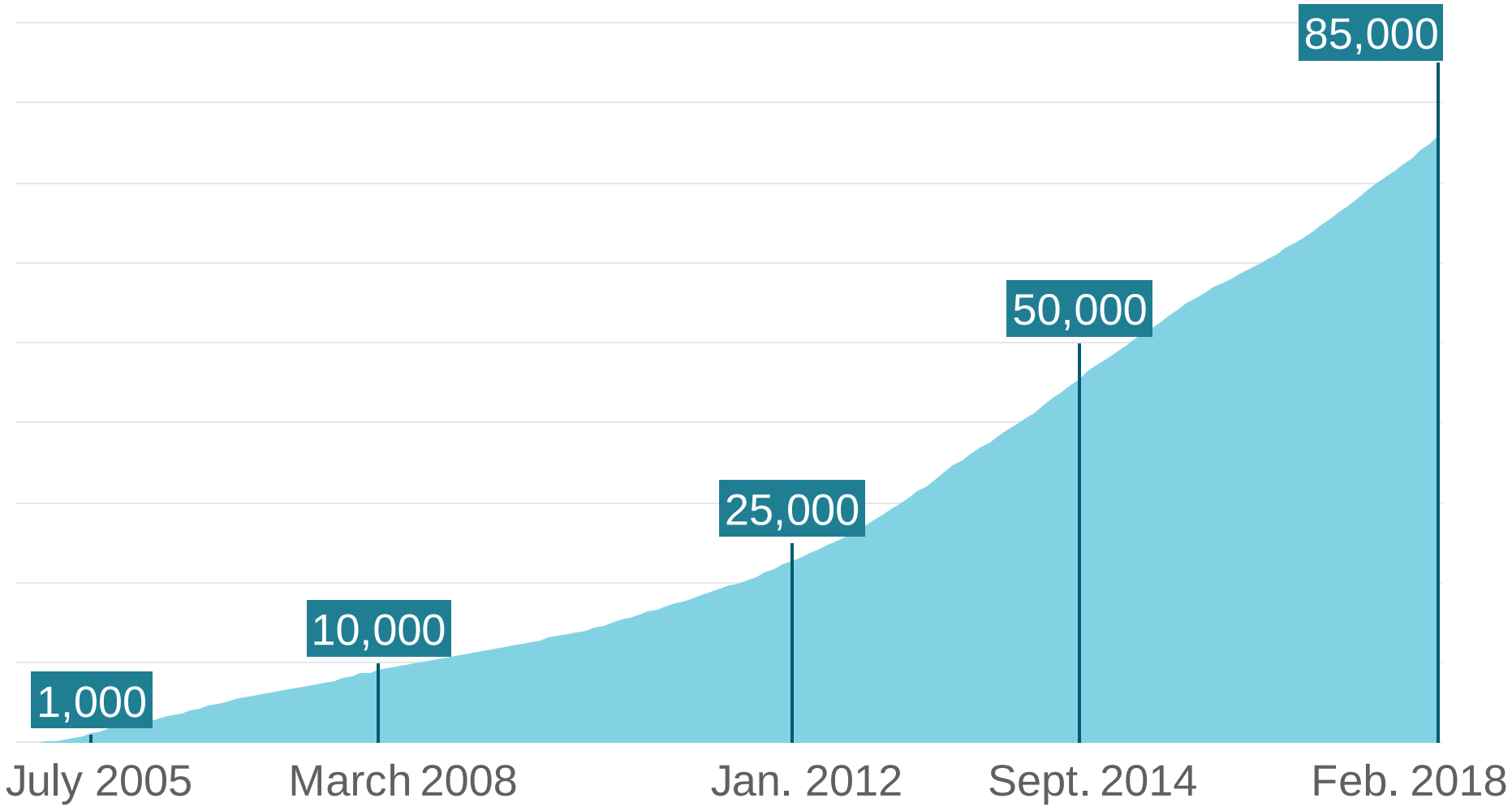
Virginia Mason

Stopping The Line



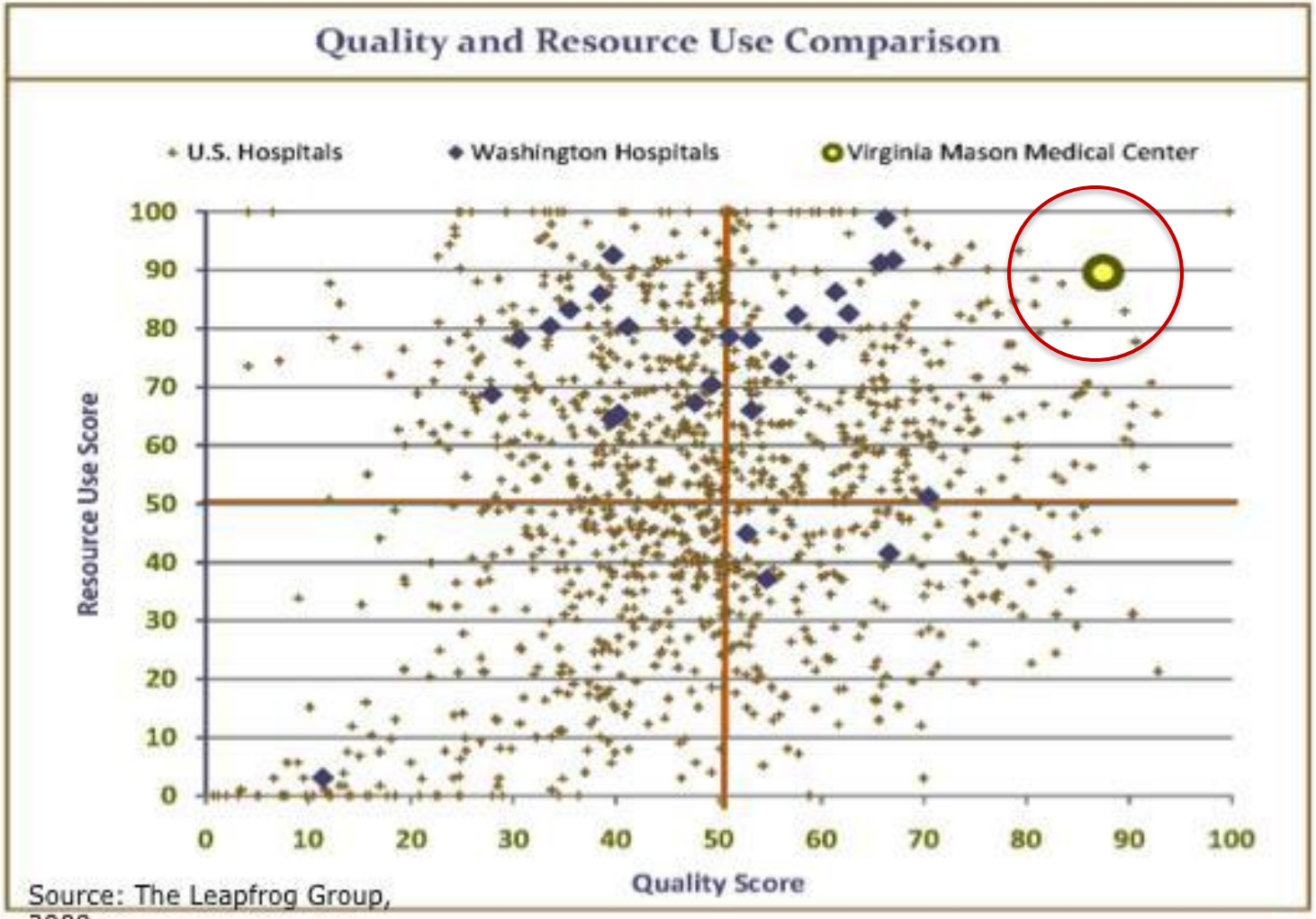
Virginia Mason

Cumulative Patient Safety Alerts (PSAs)



85,000th PSA reported in February 2018

Hospital of Decade: Efficiency and Effectiveness



Source: The Leapfrog Group, 2009.

Virginia Mason

Our VMPS Journey

2002
- -Implemented Strategic Plan with Patient at the top
- -Declared VMPS as our management method
- -Executives to Japan
- -Implemented PSA system
- -49 RPIWs, 3 3Ps

2003
- -Executives & KPO first to be VMPS Certified
- -7 KPO Staff Members

2004
- -Mrs. McClinton

- -All Execs & Admin Directors Certified
- -110 RPIWs, 4 3Ps

2005
- -Kaizen Fellowship program
- -KPO rotational leader position created
- -24 KPO staff members
- -One organizational goal of Quality
- -KPO Goals instituted
- -Tuesday Standup begins

2006
- -HealthGrades Distinguished hospital award
- -Integrated VMPS efforts with supplier partners
- -VMPS training for managers
- -44 RPIWs, 1 3P, 51 Kaizen Events

2007
- -Defined standards for a Model Line
- -Improved VMPS curriculum for all supervisors and above
- -25 KPO staff members

2008
- -Virginia Mason Institute formed
- -Large integrated value streams
- -3P Certification
- -VMPS for Leaders prerequisite for Certification
- -31 KPO staff members

2009

2010
- -Super-flow RPIWs
- -Study & apply Toyota Talent (TWI) training methods
- -66 RPIWs, 6 3Ps, 119 Kaizen Events

2011
- -Top Hospital of the Decade
- -World Class Management system
- -Standard Work for Leaders

2012
- -Experience Based Design training
- -82 RPIWs, 8 3Ps, 238 Kaizen Events
- -26 KPO staff members

2013
- -Respect for People Training
- -Continuing education for VMPS Certified leaders
- -Innovation Events

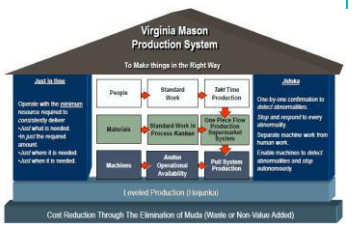
2014
- -Patients as partners with our improvements
- -VMPS for Leaders training becomes "fit for duty" requirement of all admin and physician leaders

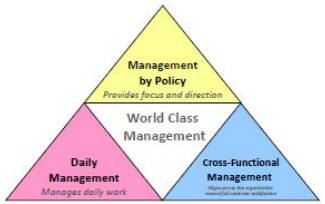
2015
- -One KPO
- -First daily management assessment org-wide
- -Introduced daily kaizen

2016
- -VMPS Priorities focused on improving the patient, family and staff member experience

2017
- -First Advanced VMPS Cohort
- - Memorial partnership & training

2018 - 2020
- -Patient Co-Design next steps
- -Patient/Family Partners required for all RPIWs





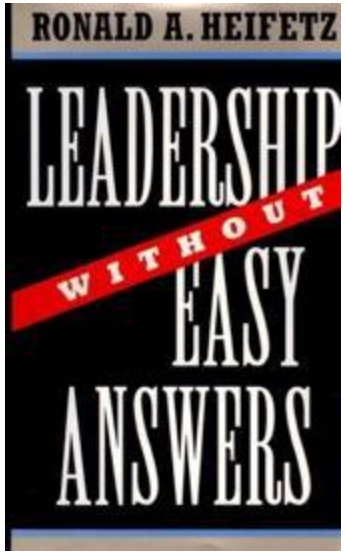
Training's "Hidden Curriculum" Can Hinder Organisational Change

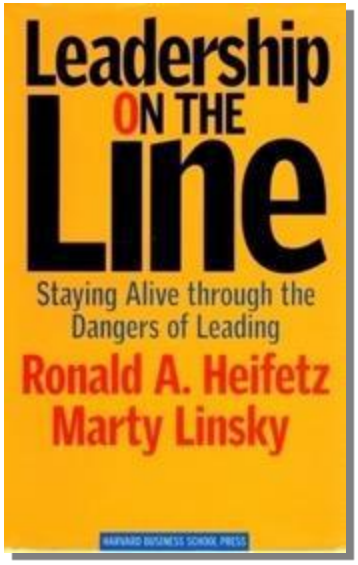
- Autonomy in the service of patient care is core to professionalism
- "Standardized" care runs counter to traditional sense of most doctors' professional identity
- Too little appreciation for contribution of colleagues in other disciplines, nurses and administrators

Two Kinds of Challenges: Ronald Heifetz

Technical

- Problem is well defined
- Solution is known can be found
- Implementation is





Adaptive

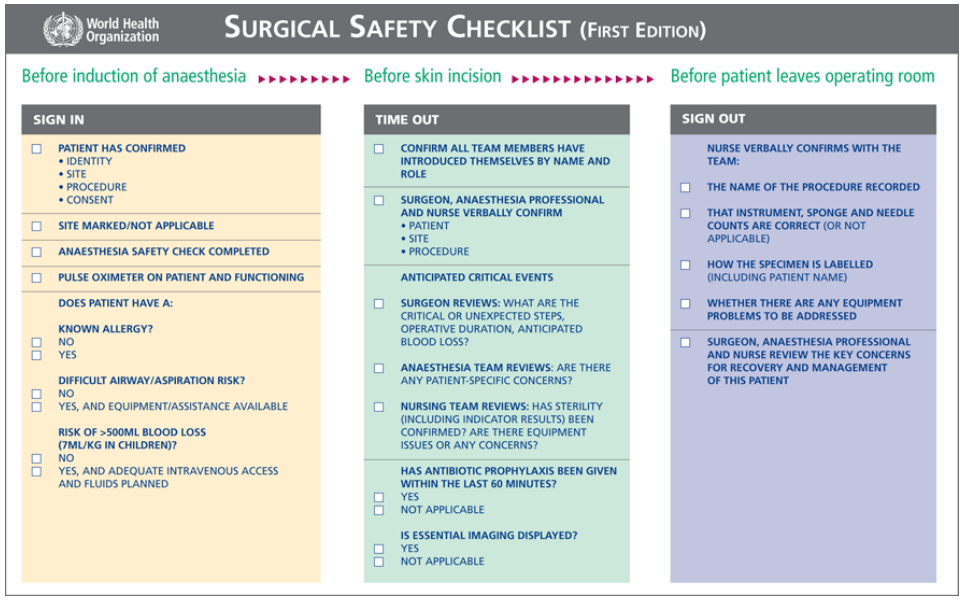
- Challenge is complex
- To solve requires transforming long-standing habits and deeply held assumptions and values
- Involves feelings of loss, sacrifice, anxiety, betrayal to values
- Solution requires learning and a new way of thinking, new relationships
- Triggers avoidance of uncomfortable issues

Amicus

Examples

Technical not because it's technological but because ease of adoption, fast spread

Adaptive ….challenges OR norms and hierarchy



World Health Organization

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia ▸▸▸▸▸▸▸▸▸ Before skin incision ▸▸▸▸▸▸▸▸▸▸▸▸▸ Before patient leaves operating room

SIGN IN

- ☐ PATIENT HAS CONFIRMED
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ SITE MARKED/NOT APPLICABLE
- ☐ ANAESTHESIA SAFETY CHECK COMPLETED
- ☐ PULSE OXIMETER ON PATIENT AND FUNCTIONING
- DOES PATIENT HAVE A:
- KNOWN ALLERGY?
  - ☐ NO
  - ☐ YES
- DIFFICULT AIRWAY/ASPIRATION RISK?
  - ☐ NO
  - ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE
- RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
  - ☐ NO
  - ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT

- ☐ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
  - PATIENT
  - SITE
  - PROCEDURE
- ANTICIPATED CRITICAL EVENTS
- ☐ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?
- HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
  - ☐ YES
  - ☐ NOT APPLICABLE
- IS ESSENTIAL IMAGING DISPLAYED?
  - ☐ YES
  - ☐ NOT APPLICABLE

SIGN OUT

- NURSE VERBALLY CONFIRMS WITH THE TEAM:
- ☐ THE NAME OF THE PROCEDURE RECORDED
- ☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
- ☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
- ☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT

Amicus

Wisdom from Ronald Heifetz

“The most common cause of failure to make progress is treating an adaptive problem with a technical fix.”

Technical fixes (aka “magic bullet”)

- Imposed and superficial relative to causes of problem
- Example: New payment scheme, incentives or bonuses
- Example: Reorganisation or new reporting relationships
- Example: Decreeing new vision is “patients first” without different leadership behaviors

Adaptive solutions

- People get together to find solution to a problem they have
- Discussion that allows respectful airing of difference
- Bring conflict to the surface and constructively resolve it
- PDSA cycles of trying something, studying or measuring and adjusting as needed

Amicus

Technical Solutions Are Good. . . Sometimes

But <u>not</u> sufficient when the problem is adaptive!

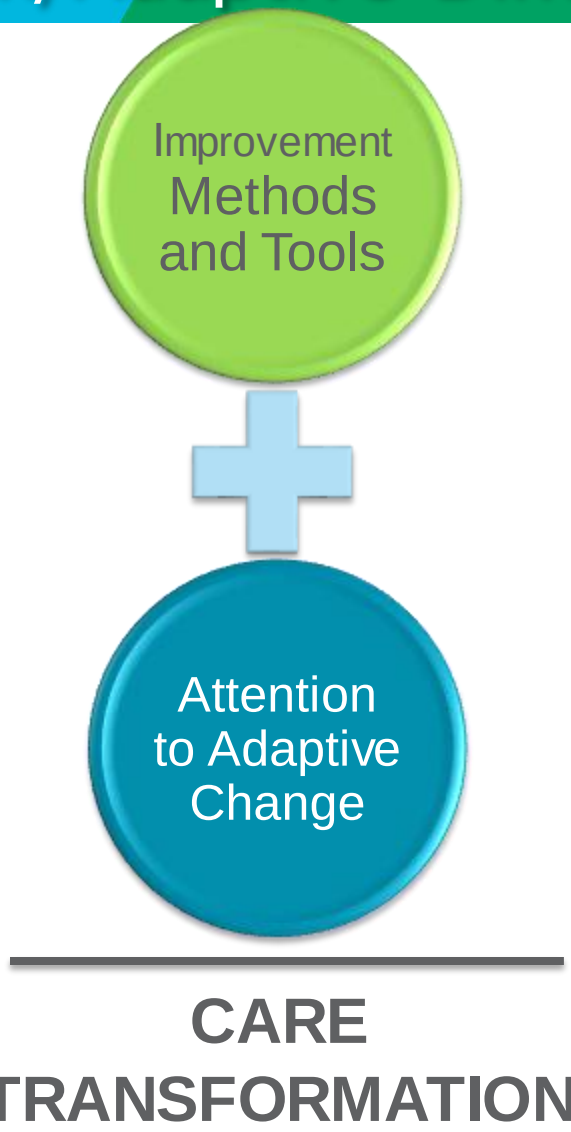
When adaptive . . "The issues have to be have to be internalized, owned, and ultimately resolved by the relevant parties to achieve enduring progress."

- Heifetz and Linsky, *Leadership on the Line*

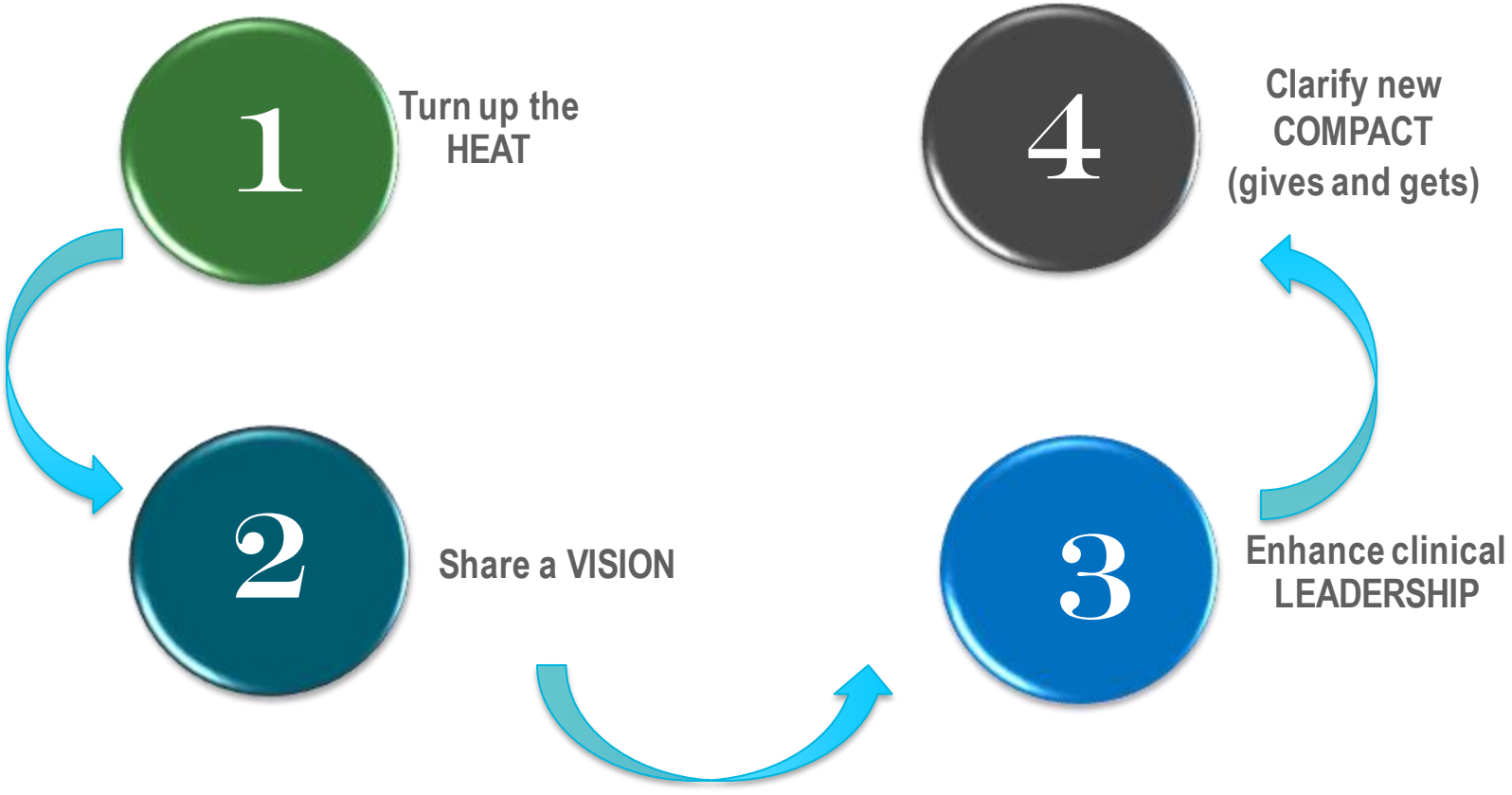
Amicus

Transformation Requires Technical Tools and Attention to Human/Adaptive Dimension

Given the professionalisation of doctors and culture in many hospitals… improvement work and putting patients first is *adaptive change*



Keys to Engage Doctors in Adaptive Change



Virginia Mason

Amicus

To Engage Doctors in Adaptive Change

Turn up the HEAT

Virginia Mason

Amicus

Urgency for Change at VMMC

"We change or we die."

— Gary Kaplan, VMMC Professional
Staff Meeting, October 2000

Virginia Mason

November 23, 2004 – Virginia Mason Medical Center

Investigators: Medical mistake kills Everett woman

KING5.com
K5 Coverage You Can Count On

The Seattle Times

Hospital error caused death

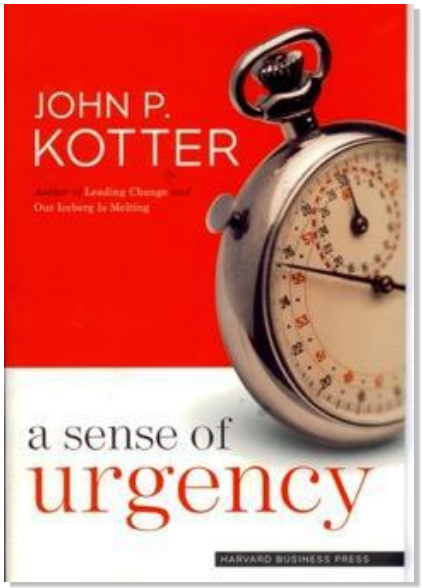
Virginia Mason

A Turning Point for Virginia Mason

- In 2004, a medical error caused the tragic death of Mary L. McClinton, a VM patient.
- This event and the decision for full public transparency was a defining moment for the organisation.

Virginia Mason

Change Has to Start With Urgency

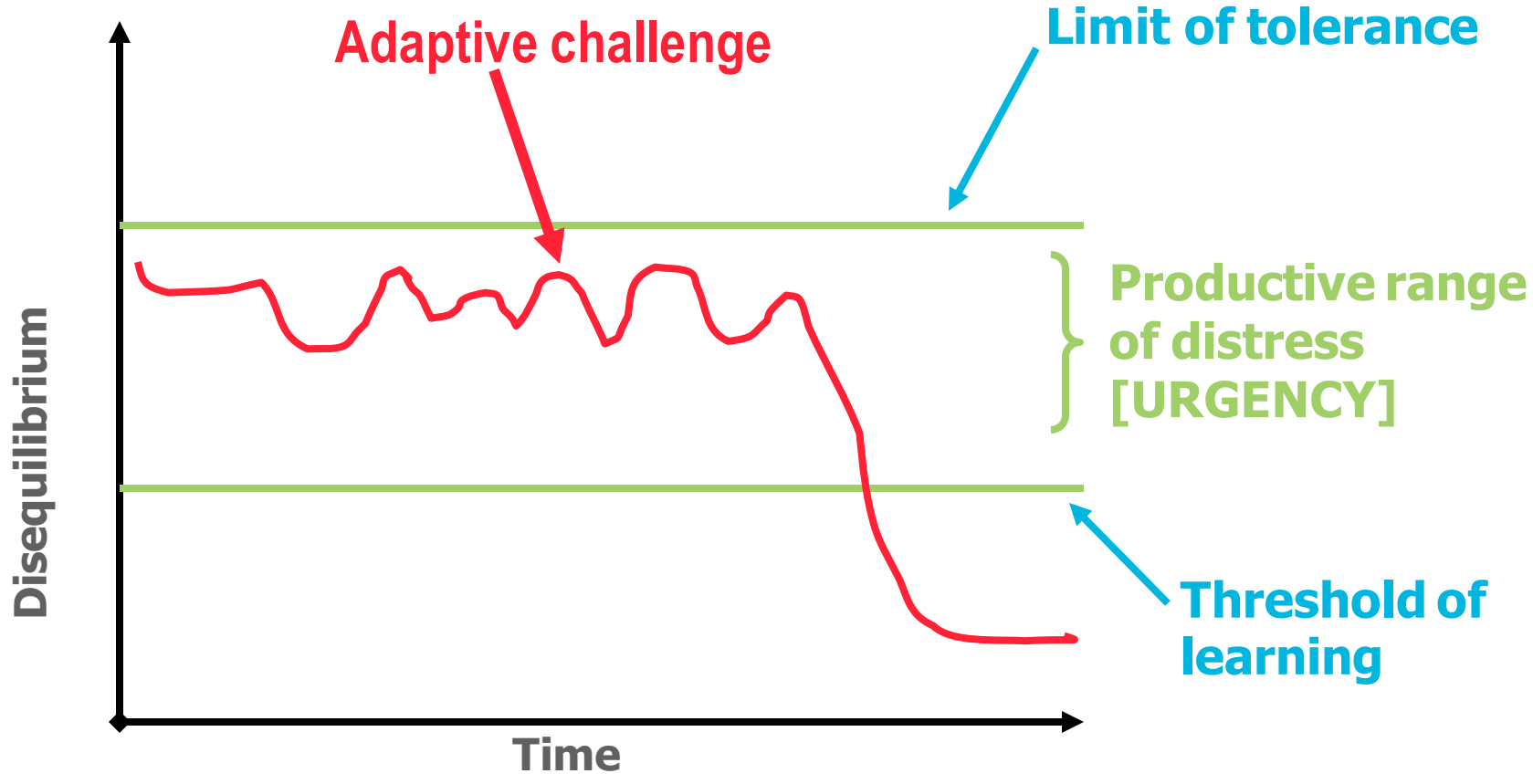


"Establishing a sense of urgency is crucial to gaining needed cooperation. With complacency high, transformation usually fails because few people are even interested in working on the change problem. . .People will find a thousand ingenious ways to withhold cooperation from a process that they sincerely think is unnecessary or wrongheaded."

— John Kotter, *Leading Change*, 1996

Amicus

"Distress" and Adaptive Work



Heifetz, Ronald A. and Marty Linsky. *Leadership on the Line*, Harvard Business School Press, 2002, p 108

Amicus

Making Colleagues Uncomfortable is NOT Easy

Too often leaders see their role as protecting colleagues from harsh realities. Or, are afraid they themselves will become a target if they point out difficult issues.

"Asbestos booties" handed out during difficult times

You CAN Responsibly Raise the Heat

You aim to get their attention. But they may be busy, stressed, not interested in your change which, if adaptive, triggers avoidance.

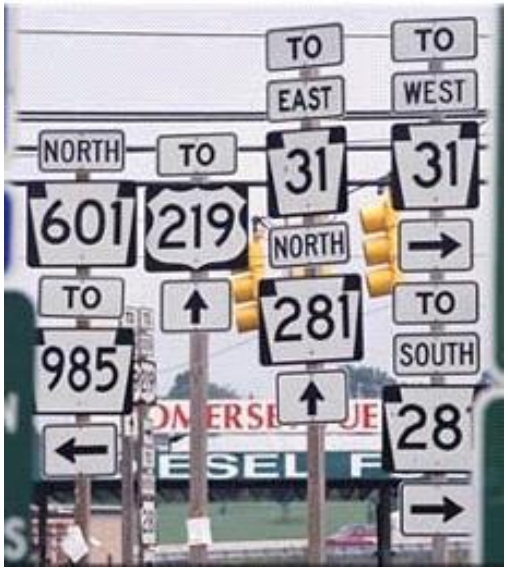
- Bring into the open issues not usually candidly addressed
- Support those who see the need for change but are often silenced or ignored to speak up
- If you can, allow doctors to experience the cost of the status quo by removing protections, work-arounds, that keep heat (and need to change) at bay

Amicus

Leaders Send CONSISTENT Signals about Urgency to Improve

"Leaders are signal generators who reduce uncertainty and ambiguity about what is important and how to act."

— Charles O'Reilly III



OR

Virginia Mason

Back Home Discussion About Urgency

- What signals do senior leaders in our organisation send regarding urgency for care improvement? Are their signals aligned with one another and consistent?

- Based on the signals they get from leaders, what would most frontline doctors conclude about the urgency to improve?

To Engage Doctors in Adaptive Change

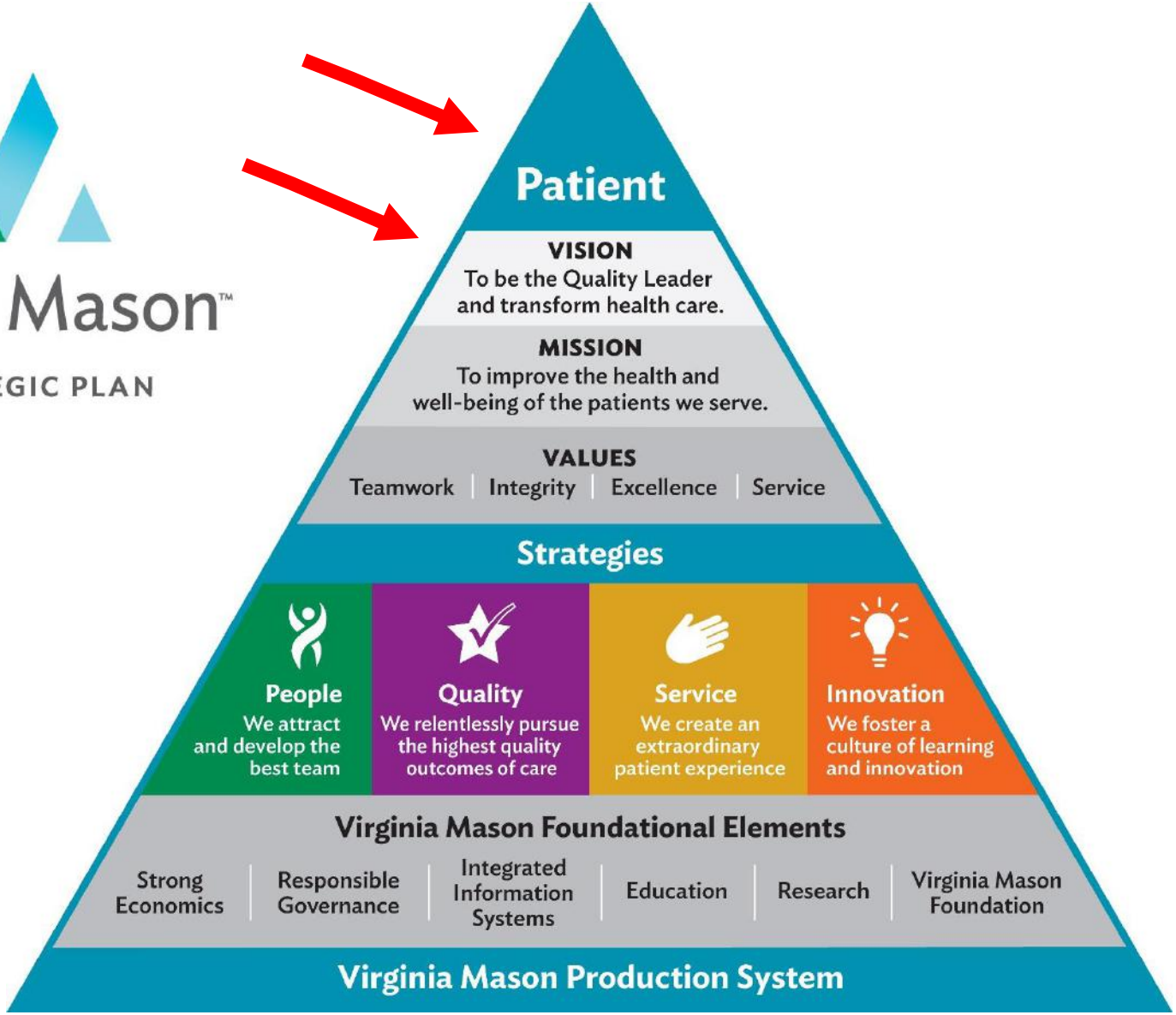
Share a VISION

Virginia Mason

Amicus

Virginia Mason™

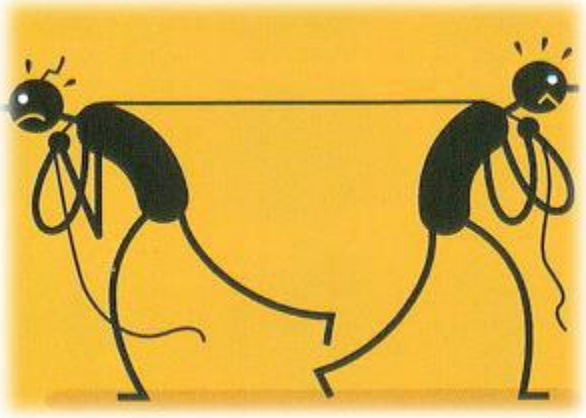
OUR STRATEGIC PLAN



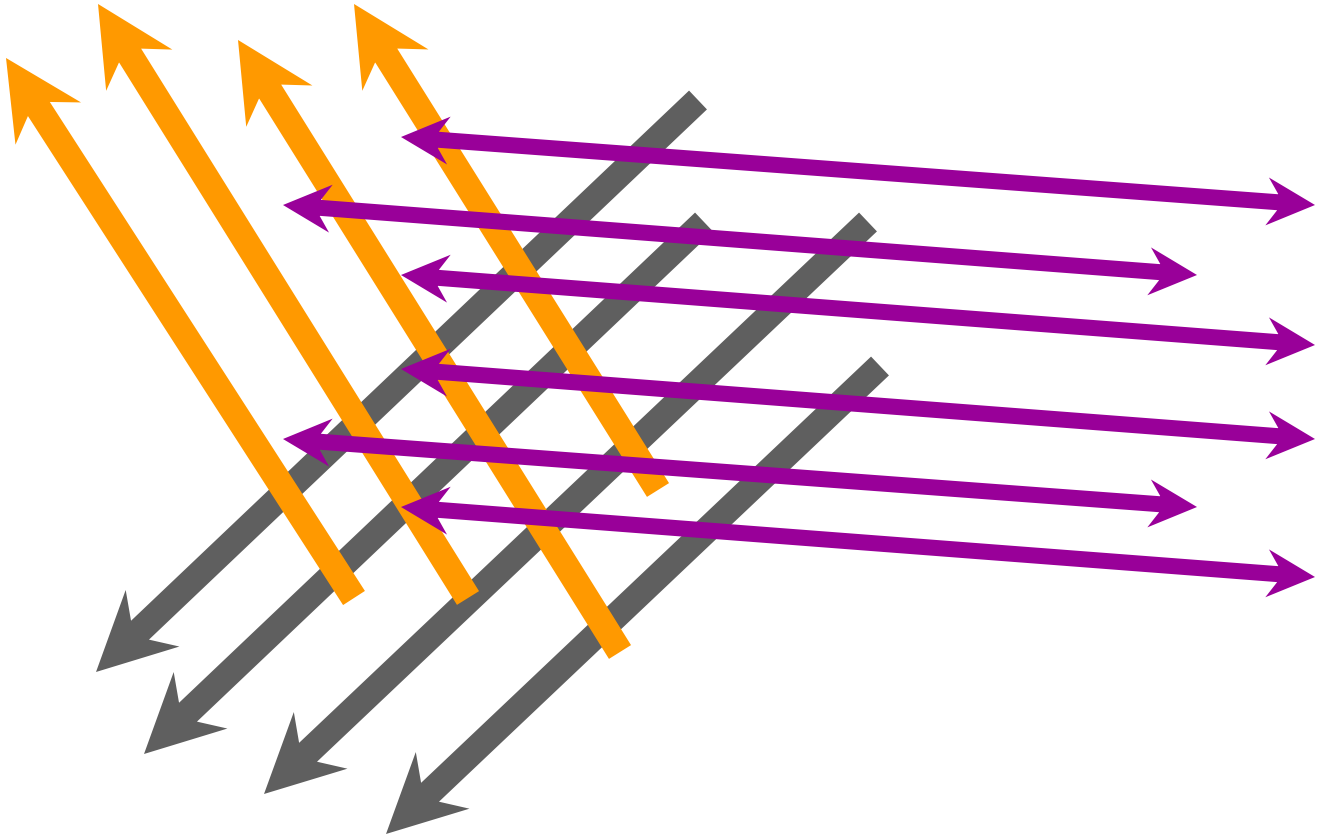
Virginia Mason

Alignment Around A Shared Vision Is Essential

"If our goals are different, why would I engage with you around yours – especially when they seem inconsistent, or in conflict, with what I see as my primary aim or what's in my best interest?"



Lack of Shared Vision Reflects Silo Orientation and Value on Autonomy

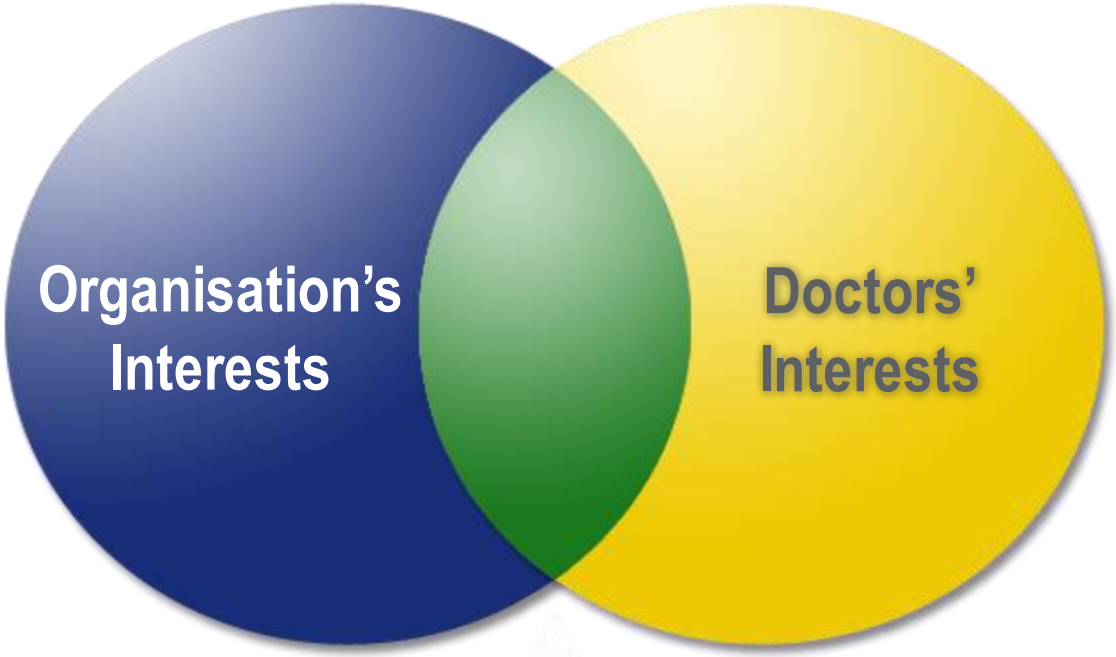


Challenges to Having Vision that Is Shared

- Past success. Good doctors doing their individual best equated with success
- Doctors don't see themselves as interdependent so don't appreciate need to share any vision or destination
- Vision process is often superficial; an exercise with a narrow purpose (e.g.,
- No clear method to achieve vision

Amicus

Basis of Vision is Shared Interests



SHARED INTERESTS

Commitment to patients' care and safety

Positive reputation

Recruit and retain talent

Amicus

Back Home Discussion About Shared Vision

To what extent do doctors, staff, and management share the same vision of where our hospital is heading?

Little Great

1 2 3 4 5

- Why did you choose the number you did?
- What impact does this have on doctor engagement?

To Engage Doctors in Adaptive Change

Enhance Clinical LEADERSHIP

Virginia Mason

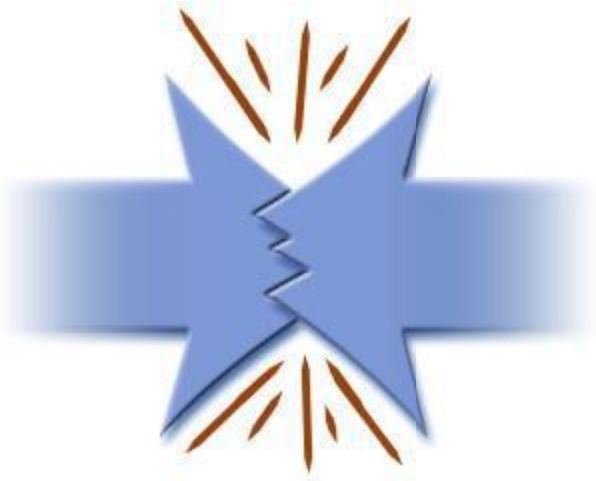
Amicus

Typical Views Doctors Hold of Their Leaders

- Advocate
- Protector
- Communicator – attend meetings, represent our views and inform us of important news
- First among equals, “not one millimeter above”

Current Dilemma Many Doctor Leaders Face

Hospital needs doctor leaders to sponsor change



Doctors don't easily accept legitimacy of leaders' authority

Invest In Developing Clinical Leaders Who

- Seek colleagues' input; discussions lead to understanding of issues, options, risks and consequences
- Provide feedback to colleagues on performance and behavior. Accountability and positive acknowledgement
- Are seen by colleagues as having "legitimate authority" to act on their behalf

Amicus

VMMC Doctor Leader is a Real Job

- Appointed, not elected
- Clear expectations/job descriptions
- Performance feedback
- Training and development
- Succession planning
- Dyad model pairs administrative leader with doctor leader at every level

Virginia Mason

For Doctor Leaders to be Effective, Administrative Leaders Need to Change

- It’s not just physician leaders who shift mindset and actions
- Working collaboratively with doctors represents an adaptive change for many administrative leaders
- Need to move away from language such as: “We need to gain their buy-in” and “We’ll roll it out”

Virginia Mason

Back Home Discussion About Doctor Leadership

- What model of doctor leadership is most common in our hospital:
  - Advocate for doctor-colleagues and protector of status quo?
  - Facilitator of change and skilled at engaging colleagues?
- What is the impact of this model of doctor leadership on our hospital's ability to transform?

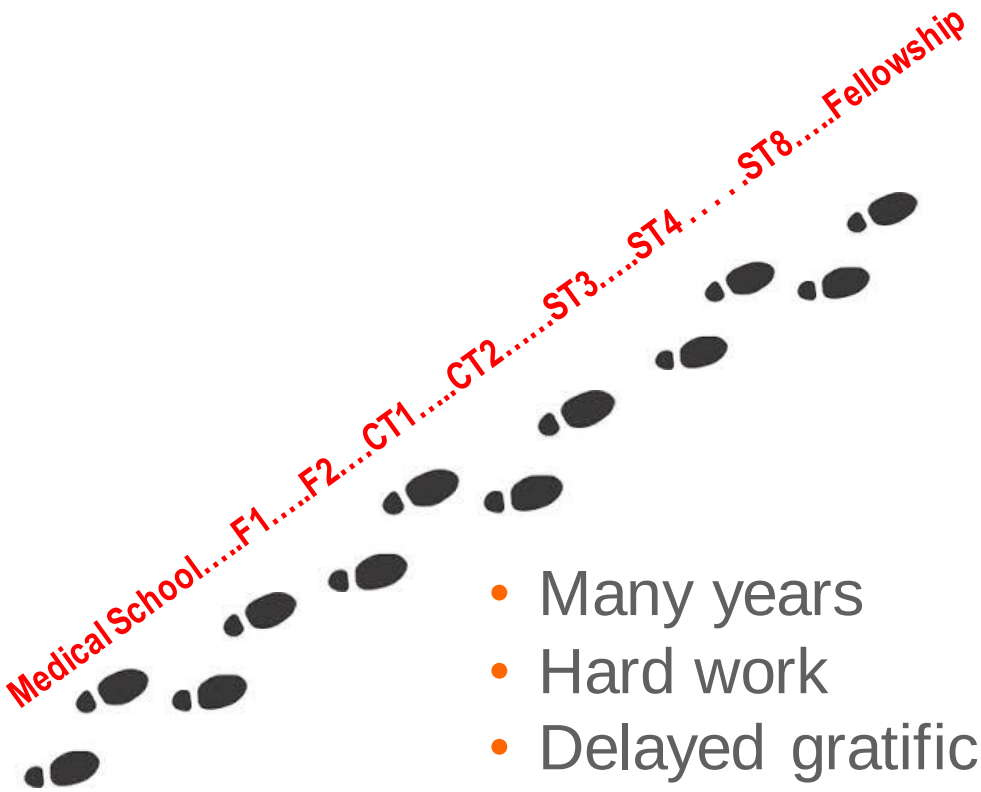
To Engage Doctors in Adaptive Change

Clarify new COMPACT (gives and gets)

Virginia Mason

Amicus

Long Journey with Implicit Promise



- Many years
- Hard work
- Delayed gratification
- Personal sacrifice

- No boss
- Clinical autonomy
- Job and economic security
- Entitled to respect commensurate with status

Amicus

Societal Compact Translates into a "Deal" in Organisations

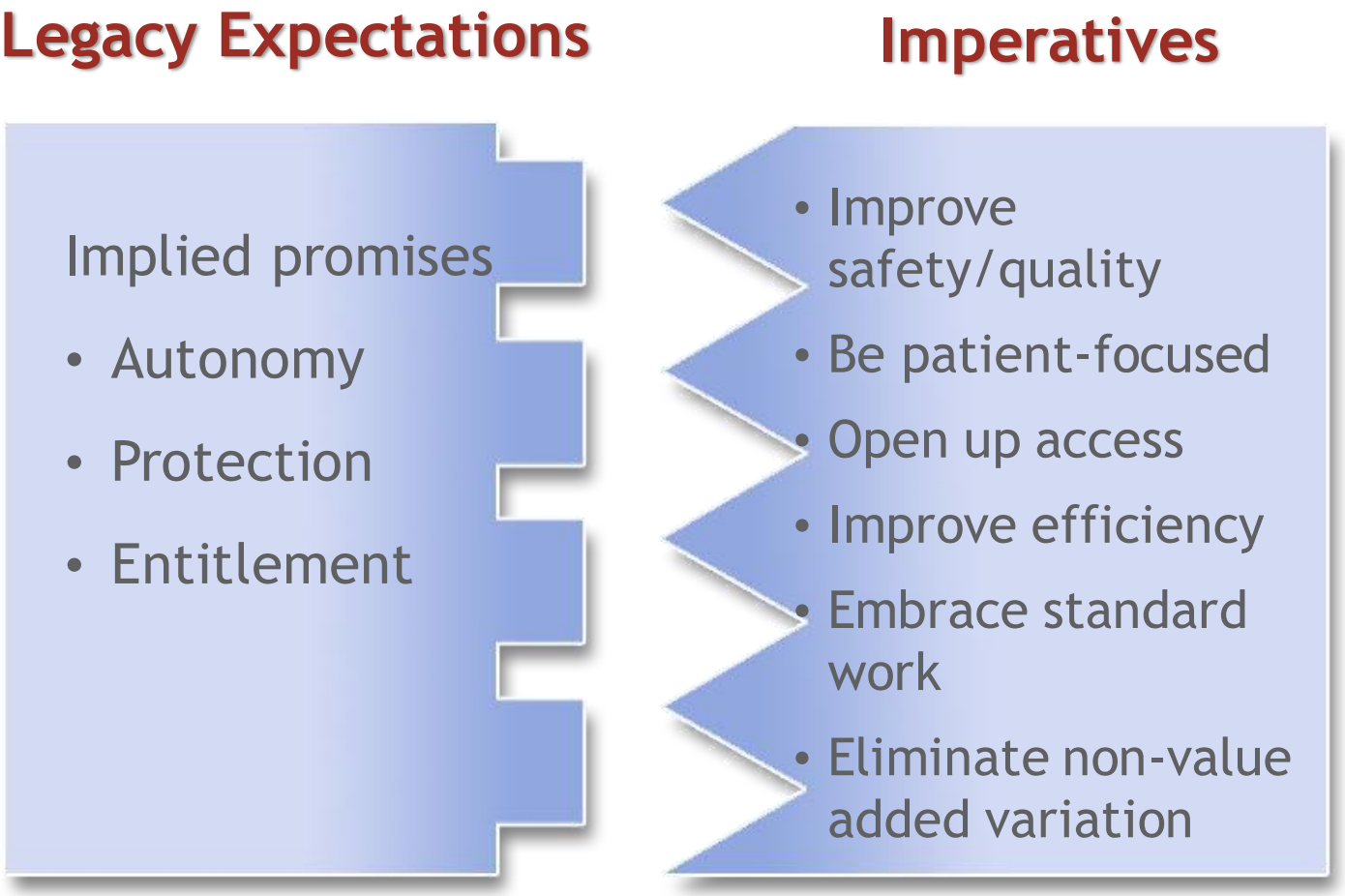
Doctors Give

- Treat patients
- Provide quality care
  (personally defined)

Doctors Get

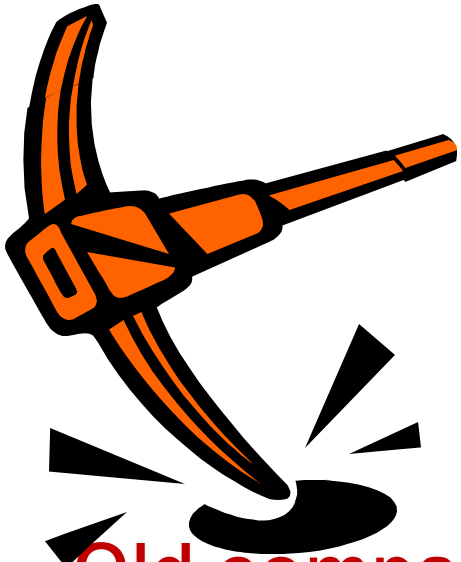
- Autonomy
- Protection
- Entitlement

Clash Of Expectations And Imperatives



Amicus

Old Promises Have Been Eroding



Old compact

Over the years:

- Increased accountability, external review
- More protocols, standard work
- Insistence on real teamwork
- Expectations for service, putting patients first

NO ONE TALKS ABOUT BROKEN "PROMISES" SO PROGRESS IS SLOW AND DOCTORS ARE FRUSTRATED

Amicus

Co-develop a New Compact

- Explicit, written down
- Reciprocal – what doctors expect of the organisation, what the organisation expects of them
- Explicit expectations enable accountability

Shared Vision is the Foundation for Compact

COMPACT

Old Compact at Virginia Mason Not Working

- Despite the fact things weren't working, most doctors clung to the fundamental "gets" they felt due them
  - Protection
  - Autonomy
  - Entitlement
- Doctor-centered world view prevailed

Virginia Mason

VMMC Compact Process

Physician Retreat
(Fall 2000)

- Broad based committee of providers: primary care, sub-specialists
- Focus of retreat: doctors-changing expectations, tools to manage change
- Jack Silversin served as our consultant
- Spent time at VMMC talking to physicians

Virginia Mason

VMMC Compact Process

Physician Retreat
(Fall 2000)

Compact committee drafts compact
(Winter 2001)

- Broad based group of providers
- Administrative Involvement: CEO, JD, HR, Board Member (also a patient)
- Starting point:
  - "Gives" and "gets" from the Retreat
  - Evolving Strategic Plan: patient centered

Virginia Mason

VMMC Compact Process

Physician Retreat
(Fall 2000)

Compact committee drafts compact
(Winter 2001)

Departmental meetings for input
(Spring 2001)

- Committee met weekly
- Reality Checks
  - Management Committee
  - Physicians
- Multiple Drafts until we reached the "final draft"

Virginia Mason

Virginia Mason Medical Center Physician Compact

Organization's Responsibilities

Foster Excellence

- Recruit and retain superior physicians and staff
- Support career development and professional satisfaction
- Acknowledge contributions to patient care and the organization
- Create opportunities to participate in or support research

Listen and Communicate

- Share information regarding strategic intent, organizational priorities and business decisions
- Offer opportunities for constructive dialogue
- Provide regular, written evaluation and feedback

Educate

- Support and facilitate teaching, GME and CME
- Provide information and tools necessary to improve practice

Reward

- Provide clear compensation with internal and market consistency, aligned with organizational goals
- Create an environment that supports teams and individuals

Lead

- Manage and lead organization with integrity and accountability

Physician's Responsibilities

Focus on Patients

- Practice state of the art, quality medicine
- Encourage patient involvement in care and treatment decisions
- Achieve and maintain optimal patient access
- Insist on seamless service

Collaborate on Care Delivery

- Include staff, physicians, and management on team
- Treat all members with respect
- Demonstrate the highest levels of ethical and professional conduct
- Behave in a manner consistent with group goals
- Participate in or support teaching

Listen and Communicate

- Communicate clinical information in clear, timely manner
- Request information, resources needed to provide care consistent with VM goals
- Provide and accept feedback

Take Ownership

- Implement VM-accepted clinical standards of care
- Participate in and support group decisions
- Focus on the economic aspects of our practice

Change

- Embrace innovation and continuous improvement
- Participate in necessary organizational change

Virginia Mason

Compact Supports Alignment with Vision

- Compact discussions as foundational – basic to moving us toward vision
- Compact is revisited, made alive, reinforced
- Periodic assessments/dialogue as to how both parties to the compact are living up to their commitments

Virginia Mason

Hardwiring Compact

- Recruitment
- Orientation
- Job Descriptions
  - Chief
  - Section Heads
  - Physicians
- Feedback

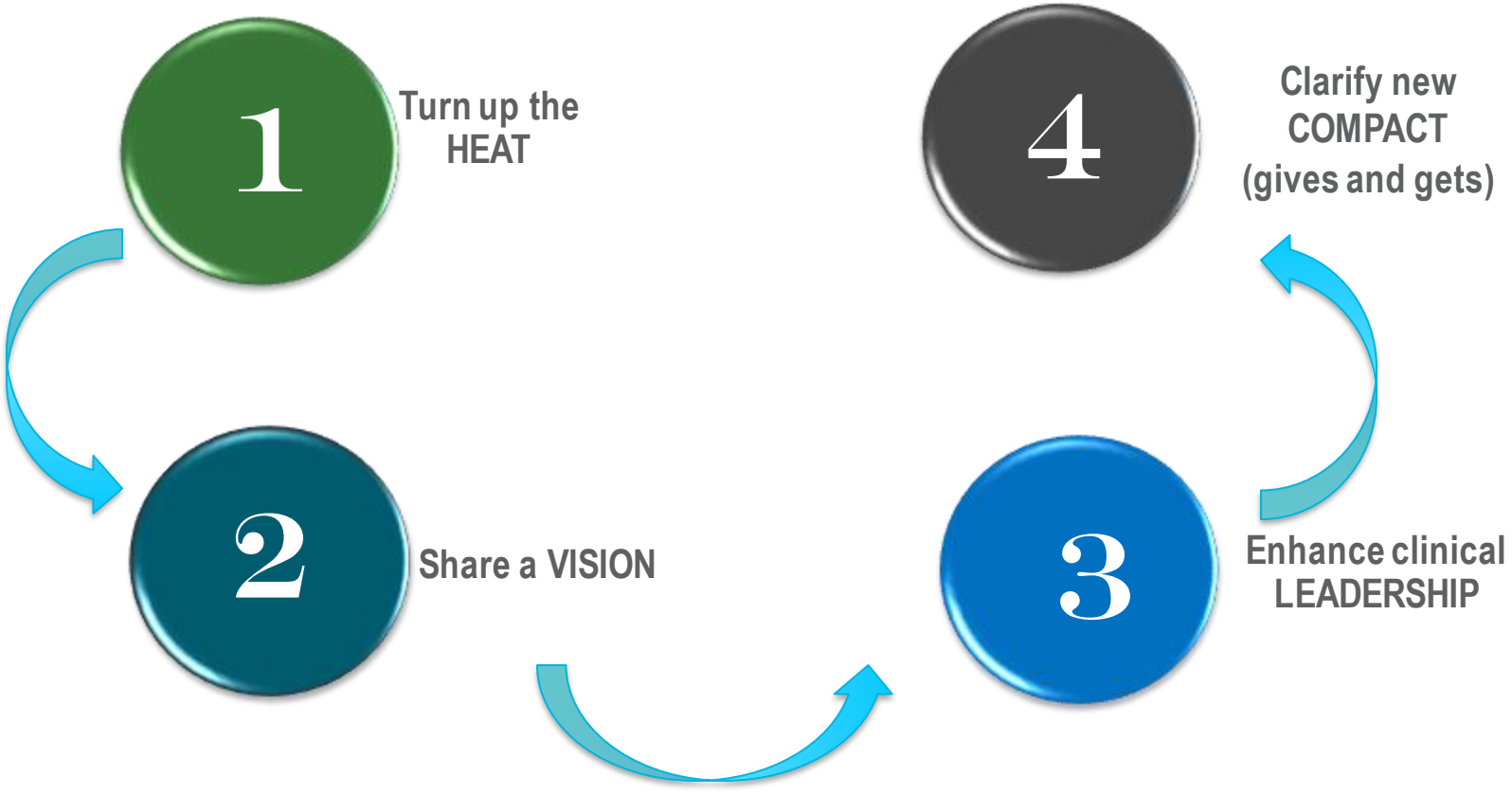
Virginia Mason

Back Home Discussion About Compact

- In what ways does the unwritten compact between our hospital and doctors:
  - Support change and improvement?
  - Serve as an impediment to change and improvement?
- Should we undertake a process to work with doctors to create a new one? Who do we need to involve?

Virginia Mason

Keys to Engage Providers in Adaptive Change



Virginia Mason

Amicus

"In times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists."

- Eric Hoffer

Virginia Mason

Readings

1. Bohmer R. and Ferlins E. Virginia Mason Medical Center – Harvard Business School Case 9-606-044, President and Fellows of Harvard College, 2006
2. Edwards, N, Kornacki, MJ, and Silversin, J. Unhappy doctors: what are the causes and what can be done? *BMJ* 2002; 324: 835-838
3. Heifetz, R. and Linsky, M. *Leadership on the Line*. Harvard Business School Press, 2002
4. Kenny, Charles. Transforming Health Care: Virginia Mason Medical Center's Pursuit of the Perfect Patient Experience. CRC Press, 2011
5. Kenny, Charles. A Leadership Journey in Health Care, Virginia Mason's Story. CRC Press, 2015
6. Kotter, J. *Leading Change*. Harvard Business School Press, 1996
7. Kotter, J. and Cohen, D. *The Heart of Change*. Harvard Business School Press, 2002
8. Kornacki, M.J. and Silversin, J. *Leading Physicians through Change: How to Achieve and Sustain Results*, 2nd edition, American College of Physician Executives, 2012
9. Kornacki, M.J. *A New Compact: Aligning Physician-Organization Expectations to Transform Patient Care*, Health Administration Press, 2015
10. Plsek, Paul. Accelerating Health Care Transformation with Lean and Innovation, The Virginia Mason Experience. CRC Press, 2014