M16: Engaging Physicians to Transform Care

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Presenters in this session have nothing to disclose

Session Objectives

• Describe how urgency, shared vision, change sponsorship, a compact (reciprocal expectations between doctors and their organization), and a comprehensive method facilitate physician engagement in improvement efforts
• Address the loss of autonomy that often blocks physician engagement
• Draw lessons from VMMC’s experience that can be applied to their own organization
Virginia Mason Medical Center

- Integrated health care system
- 501(c)3 not-for-profit
- 336-bed hospital
- Nine locations
- 500 physicians
- 5,500 employees
- Graduate Medical Education
- Research Institute
- Foundation
- Virginia Mason Institute

Our Strategic Plan

Vision
To be the Quality Leader and transform health care

Mission
To improve the health and well-being of the patients we serve

Values
Teamwork | Integrity | Excellence | Service

Strategies
People
We attract and develop the best team

Quality
We relentlessly pursue the highest quality outcomes of care

Service
We create an extraordinary patient experience

Innovation
We foster a culture of learning and innovation

Virginia Mason Team Medicine® Foundational Elements
- Strong Economics
- Responsible Governance
- Integrated Information Systems
- Education
- Research
- Virginia Mason Foundation

Virginia Mason Production System
Seeing with our Eyes
Japan 2002

Team Leader
Kaplan reviewing
the flow of the
process with
Drs. Jacobs and
Glenn at Hitachi Air
Conditioning plant

Take-Aways

How are air conditioners, cars, looms and airplanes like
health care?

• 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
The VMMC Quality Equation

\[ Q = A \times (O + S) \]

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

New Management Method: The Virginia Mason Production System

We adopted the Toyota Production System philosophies and practices and applied them to health care because health care lacks an effective management approach that would produce:

- Customer first
- Highest quality
- Obsession with safety
- Highest staff satisfaction
- A successful economic enterprise
VMPS Tools in Action

- Value Stream Development
- RPIW  (Rapid Process Improvement Workshop)
- 5S  (Sort, simplify, standardize, sweep, self-discipline)
- 3-P  (Production, Preparation, Process)
- Standard Work
- Daily Work Life

“Nursing Cells” – Results > 90 days

RN time available for patient care = 90%!

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
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<tbody>
<tr>
<td>RN # of steps = 5,818</td>
<td>846</td>
</tr>
<tr>
<td>PCT # of steps = 2,664</td>
<td>1256</td>
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<tr>
<td>Time to the complete am cycle of work = 240’</td>
<td>126’</td>
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<tr>
<td>Patients dissatisfaction = 21%</td>
<td>0%</td>
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<tr>
<td>RN time spent in indirect care = 68%</td>
<td>10%</td>
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<tr>
<td>PCT time spent in indirect care = 30%</td>
<td>16%</td>
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<tr>
<td>Call light on from 7a-11a = 5.5%</td>
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<tr>
<td>Time spent gathering supplies = 20’</td>
<td>11’</td>
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Lindeman Surgery Center Throughput Analysis

<table>
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<tr>
<th></th>
<th>Before</th>
<th>Today</th>
<th>% Change</th>
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</thead>
<tbody>
<tr>
<td>Time Available (10 hr day)</td>
<td>600 min</td>
<td>600 min</td>
<td>0%</td>
</tr>
<tr>
<td>Total Case Time (cut to close plus set-up)</td>
<td>107 min</td>
<td>65.5 min</td>
<td>39%</td>
</tr>
<tr>
<td>Case Turnover Time (pt out to pt in)</td>
<td>30 min</td>
<td>15 min</td>
<td>50%</td>
</tr>
<tr>
<td>Cases/day</td>
<td>5 cases/OR</td>
<td>8 cases/OR</td>
<td>60%</td>
</tr>
<tr>
<td>Cases/4 ORs</td>
<td>20 cases</td>
<td>32 cases</td>
<td>60%</td>
</tr>
</tbody>
</table>

Primary Care – Flow Stations
Creating MD Flow Reduces Patient Wait Times

VMPS Concepts of a Flow Station
- Waste of motion (walking)
- Continuous flow
- Visual control (Kanbans)
- External setup
- Water strider
- U-Shaped Cell
"Stopping the Line"

**Organization-wide Involvement**

- Staff identify and report issues and concerns using the Patient Safety Alert System
- Leadership involvement with investigation and resolution
- Board Quality Committee review and approve closure of high-severity issues (Red PSA’s)
Categorizing Patient Safety Risk Events

3 Basic Risk Sources
- Evaluation
- Treatment
- Critical interactions

27 Specific Risk Categories

3 of the top 5 risks
- Direct Patient Care
- Medication
- Laboratory Order & Collection

Overall staff response rate
Virginia Mason Medical Center

We look “different” since 2009. Why?
What might be the benefit and lesson if we go higher?
Reduction of Hospital Professional/General Liability Premiums

% change from previous year, with 74% overall reduction in premium since 2004-05

Maintain a Successful Economic Enterprise

Shared Success Program

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Virginia Mason Medical Center
Hospital of Decade: Efficiency and Effectiveness

Quality and Resource Use Comparison

Tuesday Morning “Stand Up”
Our Quality & Safety Journey

1st IOM Report
Toyota Production System Introduced to VMMC

1st Culture of Safety Work Plan
Virginia Mason Production System established

1st Safety Culture Survey
Patient/ Family Engagement

Mary L. McClinton
Fatal medical error
CPOE Go Live

1st PSA for clinical events
PSA for non-clinical events

CEO Mandates PSA System

Strategic Quality Plan
IIHS. 100.00 Lives

1st Patient Safety Alert (PSA) for clinical events
2nd Safety Culture Survey
MD Disclosure Training

Patient Safety Alert (PSA) Q4Q Site Visits
2nd PSA Culture Survey

Just Culture

Leapfrog Governance Award
IHIs 5 Million Lives

Leapfrog Top Hospital of the Decade
AHRQs Safety Culture Survey: 81% Participation

Staff & Patient Leader Rounds
MDM RPIW: Time Out ST-PRA

2010 HealthGrades Patient Safety Award
AHRQs Safety Culture Survey: 82% Participation (fully electronic)

Employee Safety Risk Registry
Just Culture

2010 Organizational Goals
Delivering Patient-Centered Coordinated Primary Care
Optimizing Care Transitions
Smoothing Patient Flow
Eliminate Healthcare Associated Infections
Glycemic Control
Prevention of Hospital Associated Delirium

Patient Experience

Service: Patient Experience
Integration of the Patient Experience

People: Team Engagement
Transformational Leadership
Organizational Training & Education

Strong Economies
Growth

Integrated I.S.: Technology and Care Delivery Partnerships
Realizing the Potential of Our Electronic Health Record
Update the Enterprise Orders and Documentation Framework
Ambulatory CPOE
Measure and Improve our Results

2013 Organizational Goals

Quality and Safety: Care Delivery Innovations
- Delivering Patient-Centered Coordinated Primary Care
- Optimizing Care Transitions
- Smoothing Patient Flow
- Eliminate Healthcare Associated Infections
- Glycemic Control
- Prevention of Hospital Associated Delirium

Quality, Safety, Service, People, Innovation
- Respect for People

Service: Patient Experience
- Integration of the Patient Experience

People: Team Engagement
- Transformational Leadership
- Organizational Training & Education

Strong Economies
- Growth

Integrated I.S.: Technology and Care Delivery Partnerships
- Realizing the Potential of Our Electronic Health Record
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How Have We Gotten Here?

With engaged and committed staff and physicians!

Not Accurate to Say Physicians Resist Change

- Physicians embrace new technologies and new treatment approaches they believe benefit them, their patients
- BUT…engaging them in change is challenging when benefits are not apparent and, in their experience, there is no problem with current practices. Are often skeptical that a change will be an improvement
Socialization Process via “Hidden Curriculum”
Contributes to Current State

- Autonomy in the service of quality patient care is core to medical professionalism
- Efforts to standardize care run counter to professional identity – hence viewed pejoratively
- Ambivalence toward viewing medicine as a business
- Often little appreciation for contribution of colleagues in other disciplines, nurses and administrators
- Difficulty trusting the work of colleagues and other staff undermines effective teamwork
A Helpful Perspective on Change

Two Kinds of Challenges
Ronald Heifetz

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

Adaptive
- Challenge is complex
- To solve requires transforming long-standing habits and deeply held assumptions and values
- Involves feelings of loss, sacrifice (sometimes betrayal to values)
- Solution requires learning and a new way of thinking, new relationships
An Easily Adopted Technical Change

Technical not because it’s technological but because:

- Its use involves no angst or challenge to personal identity
- Adoption is intuitive or similar to other successful changes. Past experience provides a “road map” or sense for how it works
- There’s always the Genius Bar – someone does know what to do.

An Adaptive Challenge

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia

TIME OUT
- Confirm all team members have introduced themselves by name and role
- Surgeon, anaesthesia professional and nurse verbally confirm patient
  - Site
  - Procedure
- Anticipate critical events
- Surgeon reviews: what are the critical, unanticipated, non-operative, unplanned risks?
- Anaesthesia team reviews: are there any patient-specific concerns?
- Nursing team reviews: has sterility (excluding indicator results) been confirmed? Are there equipment issues or any concerns?
- Has antibiotic prophylaxis been given within the last 60 minutes?
  - Yes
  - No
  - Not applicable
- Is essential imaging displayed?
  - Yes
  - No
  - Not applicable

Before skin incision

Before patient leaves operating room

SIGN OUT
- Nurse verbally confirms with the team
- The name of the procedure recorded
- That instruments, sponge and needle packets are correct for this 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
Wisdom from Ronald Heifetz

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

Technical fixes
- New payment scheme for doctors
- Incentives or bonuses
- Reorganization
- Issuing new vision statement

Adaptive solutions
- Giving authority to solve problems to the implementers
- Discussion that allows respectful airing of difference
- Bringing conflict to the surface and constructively resolving it

Adaptive Work

“Solutions are achieved when ‘the people with the problem’ go through a process together to become ‘the people with the solution.’ 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
Engagement is Essential When Change is Adaptive

To move from distrust to neutrality:
- Meet legitimate needs
- Increase transparency
- Demonstrate empathy
- Engage in humble inquiry
- Apologize if appropriate

To engage doctors:
- Invest time necessary for deep conversation
- Don’t rush to (superficial) agreement
- Help others reflect on conflict among colleagues as well as between doctors and management

Transformation Requires Technical Tools and Attention to Human/Adaptive Dimension

Lean tools

Transformation

Necessary but not sufficient
Transformation Requires Technical Tools and Attention to Human/Adaptive Dimension

- Lean Tools
- Adaptive Change
- Transformation

Requirements for Transformation

- Single, organization-wide method
- Urgency to improve
- Shared vision of the organization's future
- Doctor leaders step up as change sponsors
- Committed, aligned leadership & management
- New compact: reciprocal expectations & accountability
Discussion #1

In your organization:

- Identify one or more operational changes that affected doctors that didn’t go well.
- How did each involve some—or all—of the following:
  - Loss (what of?)
  - Need to learn new skills or develop new relationships
  - Lack of clear road map for implementation
  - Stress, discomfort or frustration

Requirements for Transformation

Urgency to improve

Shared vision of the organization's future

Doctor leaders step up as change sponsors

Committed, aligned leadership & management

New compact: reciprocal expectations & accountability

Single, organization-wide method

Commitment, aligned leadership & management
**It All Starts With Urgency**

“When people have a true sense of urgency, they think that action on critical issues is needed *now*, not eventually, not when it fits easily into a schedule.”

- John Kotter, *A Sense of Urgency*

**The Status Quo is Like Gravity**

- The invisible hold of the status quo is *very* strong:
  - The current way is known
  - The “new way” raises fear and anxiety
- For change:
  - Make the current way uncomfortable
  - Build a compelling case for change
“Distress” and Adaptive Work

- Adaptive challenge
- Limit of tolerance
- Productive range of distress
- Threshold of learning

Time

Disequilibrium


Making Colleagues Uncomfortable is NOT Easy

- Too often leaders see their role as protecting colleagues from harsh realities
- “Asbestos booties” handed out during difficult times

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Gary Kaplan and Jack Silversin
Urgency: Make the Invisible Visible

• HOW
  - “Self-discovery” – experiential
  - More than facts: John Kotter’s see/feel/change approach

• WHAT
  - Cost of doing nothing exceeds cost of change
  - Cold, hard facts on performance and lack of sustainability
  - Gap between aspiration and reality
  - The personal impact of incidents

• ASKING vs. TELLING
  - Typical format: Tell, Ask, Tell
  - Alternative: Ask and listen, Tell, Ask

Time for a Change – VMMC 2000

• Issues
  - Survival
  - Retention of the Best People
  - Loss of Vision
  - Build on a Strong Foundation

• Leadership Change
• A Defective Product
Urgency for Change at VMMC

“We change or we die.”

– Gary Kaplan, VMMC Professional staff meeting, October 2000

November 23, 2004

Investigators: Medical mistake kills Everett woman

Hospital error caused death

Mary L. McClinton
The Challenge of Ongoing Urgency

• In a time of constant and tumultuous change, avoid complacency

• Shift focus from pain and fear (sources of urgency) to aspiration, affirmative view of future
Leaders Calibrate Heat As Needed

- Leaders need to turn UP heat to get attention and communicate urgency
- Leaders can also dial DOWN heat if there is counter-productive anxiety leading to disengagement. Offer clear vision, provide clear guidance, take some work off plate

Leaders’ Role in Signal Generation

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

— Charles O’Reilly III
Discussion #2: Urgency for Improvement

- What signals do leaders in your organization send regarding urgency for care improvement? Are their signals consistent?
- What is the impact of the signals sent on physicians’ engagement in improvement?
- In your own area of responsibility, what actions do you take to raise the heat for improvement?
- What actions on your part tend to lower needed heat (when you don’t intend to)?

Requirements for Transformation

- Urgency to improve
- Shared vision of the organization’s future
- Doctor leaders step up as change sponsors
- Committed, aligned leadership & management
- New compact: reciprocal expectations & accountability
- Single, organization-wide method
Explicit Shared Destination Creates Focus and Alignment

Lack of Shared Vision Reflects Silo Mentality and Distrust
Challenges to Having Vision that Is Shared

- Often relationships between administration and physicians are strained or dysfunctional
- For their part, physicians don’t acknowledge their own interdependence
- Power of vision under-leveraged
  - Vision process is often superficial; an exercise with a narrow purpose (e.g., for PR)
  - Little connection between vision on paper and daily life
  - No clear method to achieve vision

Requirements for Developing Shared Vision

- Doctors develop deep appreciation of interdependence (to provide best, safest patient care)
- There is a process to develop vision – not a one-off meeting:
  - Deepens understanding of the various imperatives the organization must respond to including quality, value, safety
  - Challenges myths (e.g., Triple Aim not possible)
  - Encourages different points of view to be heard
  - Builds commitment
- Vision is:
  - Strategic and granular
  - Perceived as a stretch, but not a fantasy
Basis of Vision is Shared Interests

- Organization’s Interests
- Doctors’ Interests

**SHARED INTERESTS**
- Commitment to patients’ care and safety
- Positive reputation
- Economic success
- Recruit and retain talent

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**The Vision as Practical Guide**

- Keep it front and center. Use it to open meetings, reference it when introducing change
- Connect the dots for people so they can see how what they are doing and what you ask them to do relates to this vision....don’t assume they will make all the connections themselves
- Find ways to measure progress toward the vision
- Use it as a guide to board decisions and policy choices
- Align rewards – tangible and intangible with effort toward the vision
- Use it to recruit and hire talent who will contribute toward it
Discussion #3
Shared Vision

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

Little 1 2 3 4 5 Great

- Why did you choose the number you did?
- What impact does this have on doctor engagement?
Engage Doctors to Transform Care

Urgency to improve

Shared vision of the organization’s future

Doctor leaders step up as change sponsors

Committed, aligned leadership & management

New compact: reciprocal expectations & accountability

Single, organization-wide method

Typical Views Doctors Hold of Their Leaders

• Advocate
• Protector
• Communicator – go to meetings to represent our views and keep us informed of important news
• First among equals, “not one millimeter above”
Consider Two Mental Models

The diagram illustrates the range of leadership activity from the manager's view of role (Advocate For Peers) to the chief's view of role (Advocate for my Peers). The other leader actions are highlighted within the range of leadership activity.

What’s the Downside When Leaders Protect?

- Innovation
- External change
- New initiative
- Disappointing performance …“bad news”

The diagram shows a layer of protection for front line doctors, with arrows pointing to various factors that leaders protect to avoid negative feedback or consequences.
Reinforcement of Traditional Physician Leadership Role

- Preference for leadership that doesn’t threaten personal autonomy
- There are times when advocacy or protection is appropriate
- Physicians make leaders pay a price for stepping out of advocate/protector role
- Election to management roles
- Short tenure in role limits development of a wide range of leadership skills

Caught in the Middle

Organization needs doctors to sanction change

Doctors don’t easily accept legitimacy of leaders’ authority
Culture Determines What is Acceptable in a Leader – Ed Schein

“Leadership now is the ability to step outside the culture that created the leader to start evolutionary change processes that are more adaptive.”

An Expanded View of Clinical Leadership

• A new mental model – courageous leadership
• Sponsor change
  ▪ Demonstrate personal commitment to quality and safety improvement
  ▪ Be a role model and among the first to adopt the new way
  ▪ Provide encouragement and acknowledgment to those who get on with change
  ▪ Hold colleagues accountable to engage in quality and safety initiatives
• Engage colleagues – apply fair process
• Make practice life more efficient and professionally satisfying for colleagues
• Make and keep commitments on behalf of doctors
VMMC Physician Leader is a Real Job

- Appointed, not elected
- Clear expectations/job descriptions
- Performance feedback
- Training and development
- Succession planning

Everyone Changes

- It’s not just physician leaders who shift mindset and actions
- Working collaboratively with physicians 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”
Leadership at Every Level

• At the local level, to engage physicians and improve care, takes effective leadership from physicians (and other clinical colleagues)
• Executives’ mindset and skills also critical to engaging physicians…to developing an enterprise that values physician input, to building trust, respect and accountability for everyone

Discussion #4
Physicians as Leaders

• What model of physician leadership is most common in your organization:
  ▪ Advocate and protector of status quo for physician-colleagues?
  ▪ Facilitator of change and skilled at engaging colleagues?
• What is the impact of this model of physician leadership on the organization’s ability to change?
Engage Doctors to Transform Care

- Urgency to improve
- Shared vision of the organization’s future
- Doctor leaders step up as change sponsors
- Committed, aligned leadership & management
- New compact: reciprocal expectations & accountability

World Class Management

Elements of Management by Policy

- Reflection
  - vision
  - feedback (including barriers)
  - customer and supplier data
  - breakthrough

- Check and Review
  - compare performance to plan
  - must not be punitive
  - occurs at all company levels (crew to top management)

- Policy Deployment
  - understanding / awareness
  - develop strategies for
    - entire organization
    - departments
    - individuals

- “Catchball”
  - formal discussions
  - idea exchange
  - set priorities
  - identify resources / roles
  - set measurement criteria
We attract and develop the best team.

People

We foster a culture of learning and innovation.

Innovation

We create an extraordinary patient experience.

Service

We relentlessly pursue the highest quality outcomes of care.

Quality

Vision

To be the Quality Leader and transform health care.

Mission

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Values

Teamwork | Integrity | Excellence | Service

Strategies

Virginia Mason Team Medicine

SM

Foundational Elements

Patient

Economic

Governance

Education Virginia Mason

Foundation

Integrated Information Systems

Research

Virginia Mason Production System

Patient

Long Term Vision

Set Priorities that Align with the Vision

5 Year Plans

Annual Goals

Quality and Safety

KPO Priorities

Hospital

Corporative

Clinic

Ambulatory Prevention Bundles

Optimize Care Transitions

Zero Nosocomial Infections

Fall Prevention

Patient Safety

Innovative Clinic

KPO Priorities

Quality and Safety

2013 Organizational Goals

Quality and Safety: Care Delivery Innovations

- Delivering Patient-Centered Coordinated Primary Care
- Optimizing Care Transitions
- Smooth Patient Flow
- Eliminate Healthcare Associated Infections
- Glycemic Control
- Prevention of Hospital Associated Delirium

Quality: Safety, Service, People, Innovation

- Respect for People

Service: Patient Experience

- Integration of the Patient Experience

People: Team Engagement

- Transformational Leadership
- Organizational Training & Education

Strong Economics

- Growth

Integrated I.T.: Technology and Care Delivery Partnerships

- Realizing the Potential of Our Electronic Health Record
- Update the Enterprise Orders and Documentation Framework
- Ambulatory GPQOE
- Measure and Improve our Results
Explicit Goals and Work Plans

• Clearly Defined Activities and Deliverables
• Identified Executive Sponsors
• Established Guidance Teams
• Goals Approved by Board

A3 Divisional Goals
Management by Policy - Check and Review

- regular checks and reviews are critical
- determines current status of goal achievement
- conducted regularly (e.g., daily, monthly, quarterly)
- includes intensive, objective study of data
- joint problem-solving, planning, and follow-up may be required

“If there is a place where blame for silos and politics belong, it is at the top of an organization.”

-Silos, Politics and Turf Wars (p.177) by Patrick Lencioni
World-Class Management
Cross Functional Management
Orthopedic Value Stream

**Orthopedic Model Line**: Hospital Clinic & Corporate KPOs

**World-Class Management**

**Daily Management**: Leaders Have Two Jobs

1. Run your business
2. Improve your business
There are four principal elements of Daily Management:

1. Leader standard work
2. Visual Controls
3. Daily Accountability
4. Process Discipline

Clinic Supervisor & Director Daily List:
- Standard work for leaders specifies the actions to be taken each day to focus on the processes in each leader's area of responsibility.
Observations Across Many Organizations

Principles that support high levels of alignment

• Ownership of goals
• Alignment of unit with enterprise goals
• Discipline and execution
• Feedback and learning regarding results

Engage Doctors to Transform Care

- Single, organization-wide method
- Urgency to improve
- Shared vision of the organization's future
- Doctor leaders step up as change sponsors
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- New compact: reciprocal expectations & accountability
Compact

- Expectations members of their organization have that are:
  - Unstated yet understood
  - Reciprocal
    - The give
    - The get
  - Mutually beneficially

Traditional Physician Compact

**GIVE**
- Treat patients
- Provide quality care (personally defined)

**GET**
- Autonomy
- Protection
- Entitlement
Clash Of “Promise” And Imperatives

Traditional “Promise”
Legacy Expectations

• Autonomy
• Protection
• Entitlement

Imperatives

• Improve safety/quality
• Implement electronic records
• Improve efficiency and value
• Be patient-focused
• Improve access

Consequences When Compact is Out of Synch with Strategy

• Erosion of morale
• Slow improvement
• Mistrust of leaders who sponsor change
Compact Process Recalibrates Expectations

- Journey as important as destination
- Iterative process for understanding and buy-in
- Mutual accountability (2-way street)

Sequencing Compact Development

Context → Strategic Vision → Dialogue to co-create new Compact

- Societal needs
- Local market
- Competition
- Organization’s strengths

Aspirational statement describing organization’s future – broadly & deeply owned

- Medical Staffs’ Responsibilities: What med staff will give the org to achieve shared vision
- Organization’s Responsibilities: What the org will give the med staff to support them keep their commitments
Old Compact at VMMC Not Working

• Despite the fact things weren’t working, most physicians clung to the fundamental “gets” they felt due them
  ▪ Protection
  ▪ Autonomy
  ▪ Entitlement
• Physician-centered world view prevailed

VMMC Compact Process

Physician Retreat
(Fall 2000)

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

VMMC Compact Process

Physician Retreat
(Fall 2000)

Compact committee
drafts compact
(Winter 2001)

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

Departmental
meetings for input
(Spring 2001)
Virginia Mason Medical Center
Physician Compact

<table>
<thead>
<tr>
<th>Organization’s Responsibilities</th>
<th>Physician’s Responsibilities</th>
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<tbody>
<tr>
<td><strong>Foster Excellence</strong></td>
<td><strong>Focus on Patients</strong></td>
</tr>
<tr>
<td>• Recruit and retain superior physicians and staff</td>
<td>• Practice state of the art, quality medicine</td>
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<tr>
<td>• Support career development and professional satisfaction</td>
<td>• Encourage patient involvement in care and treatment decisions</td>
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<tr>
<td>• Acknowledge contributions to patient care and the organization</td>
<td>• Achieve and maintain optimal patient access</td>
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<tr>
<td>• Create opportunities to participate in or support research</td>
<td>• Insist on seamless service</td>
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<tr>
<td><strong>Listen and Communicate</strong></td>
<td><strong>Collaborate on Care Delivery</strong></td>
</tr>
<tr>
<td>• Share information regarding strategic intent, organizational priorities and business decisions</td>
<td>• Include staff, physicians, and management on team</td>
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<tr>
<td>• Offer opportunities for constructive dialogue</td>
<td>• Treat all members with respect</td>
</tr>
<tr>
<td>• Provide regular, written evaluation and feedback</td>
<td>• Demonstrate the highest levels of ethical and professional conduct</td>
</tr>
<tr>
<td><strong>Educate</strong></td>
<td><strong>Behave in a manner consistent with group goals</strong></td>
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<tr>
<td>• Support and facilitate teaching, GME and CME</td>
<td><strong>Participate in or support teaching</strong></td>
</tr>
<tr>
<td>• Provide information and tools necessary to improve practice</td>
<td><strong>Listen and Communicate</strong></td>
</tr>
<tr>
<td><strong>Reward</strong></td>
<td>• Communicate clinical information in clear, timely manner</td>
</tr>
<tr>
<td>• Provide clear compensation with internal and market consistency, aligned with organizational goals</td>
<td>• Request information, resources needed to provide care consistent with VM goals</td>
</tr>
<tr>
<td>• Create an environment that supports teams and individuals</td>
<td>• Provide and accept feedback</td>
</tr>
<tr>
<td><strong>Lead</strong></td>
<td><strong>Take Ownership</strong></td>
</tr>
<tr>
<td>• Manage and lead organization with integrity and accountability</td>
<td>• Implement VM-accepted clinical standards of care</td>
</tr>
<tr>
<td></td>
<td>• Participate in and support group decisions</td>
</tr>
<tr>
<td></td>
<td>• Focus on the economic aspects of our practice</td>
</tr>
<tr>
<td></td>
<td><strong>Change</strong></td>
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<tr>
<td></td>
<td>• Embrace innovation and continuous improvement</td>
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<tr>
<td></td>
<td>• Participate in necessary organizational change</td>
</tr>
</tbody>
</table>

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 “sides” are living up to compact commitments
Hardwiring Compact

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

VMMC Leadership Compact

Organization Responsibilities

- Foster Excellence
  - Recruit and retain the best people
  - Acknowledge and reward contributions to patient care and the organization
  - Provide opportunities for growth of leaders
  - Continuously strive to be the quality leader in health care
  - Create an environment of innovation and learning
- Lead and Align
  - Create alignment with clear and focused goals and strategies
  - Continuously measure and improve our patient care, service and efficiency
  - Manage and lead organization with integrity and accountability
  - Resolve conflict with openness and empathy
  - Ensure safe and healthy environment and systems for patients and staff
- Listen and Communicate
  - Share information regarding strategic intent, organizational priorities, business decisions and business outcomes
  - Clarify expectations to each individual
  - Offer opportunities for constructive open dialogue
  - Ensure regular feedback and written evaluations are provided
  - Encourage balance between work life and life outside of work
- Educate
  - Support and facilitate leadership training
  - Provide information and tools necessary to improve individual and staff performance
- Recognize and Reward
  - Provide clear and equitable compensation aligned with organizational goals and performance
  - Create an environment that recognizes teams and individuals

Leader Responsibilities

- Focus on Patients
  - Promote a culture where the patient comes first in everything we do
  - Continuously improve quality, safety and compliance
- Promote Team Medicine
  - Develop exceptional working-together relationships that achieve results
  - Demonstrate the highest levels of ethical and professional conduct
  - Promote trust and accountability within the team
- Listen and Communicate
  - Communicate VM values
  - Courageously give and receive feedback
  - Actively request information and resources to support strategic intent, organizational priorities, business decisions and business outcomes
- Take Ownership
  - Implement and monitor VM approved standard work
  - Foster understanding of individual/team impact on VM economics
  - Continuously develop one’s ability to lead and implement the VM Production System
  - Participate in and actively support organization/group decisions
  - Maintain an organizational perspective when making decisions
  - Continually develop oneself as a VM leader
- Foster Change and Develop Others
  - Promote innovation and continuous improvement
  - Coach individuals and teams to effectively manage transitions
  - Demonstrate flexibility in accepting assignments and opportunities
  - Evaluate, develop and reward performance daily
  - Accept mistakes as part of learning
  - Be enthusiastic and energize others
Discussion #5
Organization-Physician Compact

• In what ways does the unwritten compact between your organization and doctors:
  ▪ Support change and improvement?
  ▪ Serve as an impediment to change and improvement?

Engage Doctors to Transform Care

- Urgency to improve
- New compact: reciprocal expectations & accountability
- Shared vision of the organization's future
- Doctor leaders step up as change sponsors
- Committed, aligned leadership & management
- Single, organization-wide method
Transformation: Where To Start?

Three areas of inquiry:
- Do we insist on a single method of improvement? If not, why not? What’s the effect?
- How shared is a sense of urgency to improve? Why is it as it is?
- To what degree are your physicians committed to a common vision? To what degree is it one administration shares?

Flu Vaccination “Fitness for Duty”

- Do we put patient first?
- Compelling science
- Staff resistance
- Staying the course
- Organizational Pride
LEADERSHIP MUST CHANGE ITS MENTALITY.

SCARCITY: You are not paying us enough.

ABUNDANCE: We have more than enough.
“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

Readings