Engaging Physicians to Transform Care

Objectives

- Describe how urgency, shared vision, change sponsorship, an explicit compact, and a single organization-wide improvement method facilitate physician engagement
- Articulate how to address the unspoken assumptions that become barriers to physician engagement in improvement
Presenter Disclosures

Jack Silversin has no disclosures related to financial or commercial interests
Gary Kaplan has no disclosures related to financial or commercial interests

Where are you from?

What countries are represented here?
Choose one
– USA
– Canada
– UK
– The Netherlands
– Other European countries
– South America
– Asia
– Middle East
– Other
### Professional Groups Represented

What professional groups are represented in the room? Choose one

- Doctors
- Nurses
- Administrators
- Quality Improvement specialists
- Marketing
- Other

### Type of Organization

What kind of organizations are represented? Choose one

- Medical group
- Single hospital
- Health system
- Nursing home/rehab facility
- Insurer/payer
- Government agency
- Other
Virginia Mason

- Integrated health care system
- Became two hospital system in January 2016, with Yakima Memorial affiliation
- 501(c)3 not-for-profit
- 336-bed hospital
- Nine locations
- Graduate Medical Education
- Research Institute
- Foundation
- Virginia Mason Institute

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
What We Learned

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

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
The VMMC Quality Equation

Q = A × \( \frac{O + S}{W} \)

Q: Quality
A: Appropriateness
O: Outcomes
S: Service
W: Waste
Stopping The Line

**Organization-wide Involvement**

- Staff identify and report issues using the Patient Safety Alert System
- Leadership involvement with investigation and resolution
- Board Quality Committee review and approve closure of high-severity issues (Red PSAs)
Effectiveness of Safety Program

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Maintain Successful Economics

Shared Success Program

Reduction of Hospital Professional/General Liability Premiums

% change from previous year, with 75% overall reduction in premium since 2004-05

Expecting at 10% Decrease in this next year
Hospital of Decade: Efficiency and Effectiveness

Our Journey

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**2016 Organizational Goals**

**Quality and Safety**
Protect our patients from infection when they are at Virginia Mason.
- Eliminate healthcare associated infections

**Growth**
Provide access to care when and how people want it.
- Provide patient centered access

**The Virginia Mason Experience: Patients and Team Members**
- Create remarkable experiences for patients and team members

**Many Organisation Have Applied Lean**
At Virginia Mason we recognized that tools alone wouldn’t get us where we wanted to go

**Lean tools**  
**Transformation**  
*Necessary but not sufficient*
How Were We Able to Transform

With engaged and committed staff and doctors!

Individual Physicians and Change

• Physicians embrace new technologies and treatments they believe benefit them and patients
• BUT…change can be challenging when the benefits seem to accrue to the organization but not to them or they don’t have a problem with current practices.
“Hidden Curriculum” during Training Hinders
Organizational Change

• Autonomy in the service of patient care is core to professionalism
• “Standardized” care runs counter to professional identity, is viewed pejoratively
• Ambivalence toward viewing medicine as a business
• Too little appreciation for contribution of colleagues in other disciplines, nurses and administrators
• Not trusting the work of colleagues and other staff undermines effective teamwork

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, anxiety, betrayal to values
• Solution requires learning and a new way of thinking, new relationships
• Triggers avoidance of uncomfortable issues
An Easily Adopted Change: iPhone

Technical not because it's technological but because:

• Its use involves no angst or challenge to personal identity
• Use is intuitive or enough like other tools in use. Other experiences provide a “road map”
• At the Genius Bar – someone does know what to do

An Adaptive Challenge

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia

<table>
<thead>
<tr>
<th>SIGN IN</th>
<th>TIME OUT</th>
<th>SIGN OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PATIENT HAS CONFIRMED</td>
<td>□ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE</td>
<td></td>
</tr>
<tr>
<td>• IDENTITY</td>
<td>• SURGICAL ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM</td>
<td></td>
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<tr>
<td>• SITE</td>
<td>• PATIENT</td>
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<tr>
<td>• CONSENT</td>
<td>• PROCEDURE</td>
<td></td>
</tr>
<tr>
<td>□ SITE MARKED/NOT APPLICABLE</td>
<td>□ ANTICIPATED CRITICAL EVENTS</td>
<td></td>
</tr>
<tr>
<td>□ ANAESTHESIA SAFETY CHECK COMPLETED</td>
<td>□ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS</td>
<td></td>
</tr>
<tr>
<td>□ PULSE KERATOMETER ON PATIENT AND FUNCTIONING</td>
<td>□ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT SPECIFIC CONCERNS</td>
<td></td>
</tr>
<tr>
<td>□ DOES PATIENT HAVE A:</td>
<td>□ NURSING TEAM REVIEWS: HAS STERILITY ENCLOSURE INDICATOR RESULTS BEEN CONFIRMED? ARE THERE EQUIPMENT RELAYS OR ANY CONCERNS</td>
<td></td>
</tr>
<tr>
<td>□ KNOWLEDGE ALLERGIES?</td>
<td>□ HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES</td>
<td></td>
</tr>
<tr>
<td>□ NO</td>
<td>□ YES</td>
<td></td>
</tr>
<tr>
<td>□ YES</td>
<td>□ NOT APPLICABLE</td>
<td></td>
</tr>
<tr>
<td>□ RISK OF ASPIRATION RISK?</td>
<td>□ IS ESSENTIAL IMAGING DISPLAYED?</td>
<td></td>
</tr>
<tr>
<td>□ NO</td>
<td>□ YES</td>
<td></td>
</tr>
<tr>
<td>□ YES AND EQUIPMENT/ASSISTANCE AVAILABLE</td>
<td>□ NOT APPLICABLE</td>
<td></td>
</tr>
<tr>
<td>□ RISK OF Sepsis, BLOOD LOSS ENTRIGE IN CHILDREN?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ NO</td>
<td></td>
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</tbody>
</table>
“The most common cause of failure to make progress is treating an adaptive problem with a technical fix.”

**Technical fixes (aka “magic bullet”)**
- Tend to be imposed and superficial relative to causes of problem
- Example: New payment scheme, incentives or bonuses
- Example: Reorganization 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

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**Technical Solutions Are Good. . .Sometimes**

But not 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*
Transformation Requires Technical Tools and Attention to Human/Adaptive Dimension

Lean Tools

Attention to Adaptive Change

Transformation

Discussion #1: Adaptive Change

In your organization:
- Identify one operational change that affected doctors in your institution that didn’t go well.
- To what extent would you say that the root cause of failure was trying to address an adaptive challenge though only a technical fix?
- What, if anything, would you do differently now seeing that the change doctors were being asked to make was adaptive?
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

Model for Transformation

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Single, organization-wide method
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

The Seattle Times

Hospital error caused death

Mary L. McClinton

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 organization.
The Challenge of Ongoing Urgency

In a time of constant and tumultuous change, avoid complacency

Leaders Need to Send CONSISTENT Signals about the Urgency to Improve

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

— Charles O’Reilly III

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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*

Polling: Is There Urgency?

Consider the physicians who are part of your organisation. What % do you believe feel that it is urgent that the organization improve quality? Choose one

- 10% or less
- About 25%
- About 50%
- More than half but not as much as 75%
- More than 75%
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. The threat of loss looms large

For change – to escape gravitational hold:
- Make the current way uncomfortable
- Build a compelling case for change

“Distress” and Adaptive Work

Adaptive challenge

Limit of tolerance

Productive range of distress
[URGENCY]

Threshold of learning

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

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
John Kotter: “See, Feel, Change”

“People change what they do less because they are given analysis that shifts their thinking than because they are shown a truth that influences their feelings.”

- Kotter and Cohen

To Raise Heat, Create Experiences that Resonate Emotionally

- Provide data and ask others to draw their own conclusions (. . . looks like we’re not nearly as good as I thought)
- Comparing unblinded performance data can prompt visceral reaction and change
- “Go and see.” Visit sites, departments; have conversations with staff. Make consequences of current practice transparent.
- Anything experiential that gets people out of their heads and gives them a new way of looking at existing conditions
- Stories from patients or colleagues that are moving
Discussion #2: Urgency for Improvement

- What signals do your leaders send regarding urgency for care improvement? Are their signals consistent?
- What is the impact of these signals on physician engagement in improvement?
- In your own area of responsibility, what actions do you take to raise the heat for improvement?
- Are there actions you've taken that have resulted in lower heat when more heat was needed?

Model 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
Our Strategic Plan

The Imperative for Alignment

Alignment around picture of the organization in the future that is granular and strategically relevant in your market (shared vision) is a pre-condition for engagement.

“If our goals are different, why would I engage with you around yours – especially if yours seem to be in competition with what I see as my primary aim?”
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
- Physicians and hospitals often compete for business
- For their part, physicians don’t acknowledge their own interdependence
- Historically 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
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

Process for Developing Shared Vision

- Acknowledge baggage and everyone’s contribution to what currently is [relationship-wise]
- Doctors develop appreciation of their interdependence to achieve goals important to them (to provide best, safest patient care; to remain economically viable)
- Doctors understand the various imperatives the organization and medical staff must respond to including quality, value, safety
There is a transparent process to develop vision – not a one-off meeting:
- 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
- Built on shared interests

Vision Serves as Practical Guide

- Keep it front and center. Use it to create context – to open meetings or introduce change
- Connect the dots for people so they can see how a change will support achieving the vision they share. Don’t assume they will make 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 a vision for the organization’s future?
  
  Little
  1  2  3  4  5
  
  - Why did you choose the number you did?
  - What impact does this have on doctor engagement to improve quality and safety?

Polling: Extent of Shared Vision

To what extent do doctors, staff, and management share the same vision for the organization’s future? Choose one

- 1 = little
- 2
- 3
- 4
- 5 = great
Model 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

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”
What's the Downside When Leaders Protect?

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

Layer of protection

Reinforcement of Traditional Doctor Leadership

- Preference for leadership that doesn’t threaten autonomy
- Advocacy or protection is appropriate at times
- Leaders pay a price for stepping out of advocate/protector role
- Election to leadership roles
- Short tenure in role limits skill development
Hospital needs doctor leaders to sponsor change

Doctors don’t easily accept legitimacy of leaders’ authority

Current Dilemma Many Doctor Leaders Face

Evolved Model of Physician Leadership and Management

- Seeks colleagues’ input; discussions lead to understanding of issues, options, risks and consequences
- Addresses stone is shoe issues - help make practice life more efficient for colleagues
- Champions change – serves as role model, early adopter
- Provides feedback to colleagues on performance and behavior. Accountability and positive acknowledgement
- Leader is authorized to lead. Colleagues delegate authority to act on their behalf; he or she is seen as having “legitimate authority”
- Is able to make and keep commitments on behalf of doctors as a partner with administration
At Virginia Mason Physician 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

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 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”
Tuesday “Stand Up” – Example of Leadership in Action

- KPO aligned with operational executive leadership
- Executive sponsorship with accountability for sustained results
- Education
- Standardization of tools, results reporting, and communication

Discussion #4: Doctor Leadership

- What model of doctor leadership is most common in your institution:
  - Advocate for doctor-colleagues and protector of status quo?
  - Sponsor and 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?
Polling: Model of Doctor Leadership

What model of doctor leadership is *more common* in your institution? Choose one

– Advocate for doctor-colleagues and protector of the status quo?
– Sponsor and facilitator of change and skilled at doctor engagement?

Model for Transformation

- Urgency to improve
- Shared vision of the organization's future
- Doctor leaders step up as change sponsors
- Committed, aligned leadership & management
- Single, organization-wide method
- 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

Management by Policy
Set Priorities that Align to the Vision

- Long Term Vision
- 5 year Plans
- Annual Goals
- VMPS Priorities
- Departmental Plan/Goals
- Individual Goals
2016 Organizational VMPS Priorities

Improving the entire patient, family and team experience

Achieve targets aligned with organizational strategies
- Reduce lead time
- Improve quality, eliminate waste
- Ensure/create capacity to meet current and future demand

Coordinate supporting flows to achieve full customer satisfaction
- Achieve skill-task alignment
- Ensure just-in-time inventory
- Use the voice of the customer to inform process design

Consistently apply Daily Management
- Use daily management to know, run, and improve the business
- Engage everyone in daily kaizen


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

<table>
<thead>
<tr>
<th>Orthopedic Value Stream</th>
<th>Recognize</th>
<th>Ready</th>
<th>Restore</th>
<th>Recover</th>
<th>Quarter 6</th>
</tr>
</thead>
</table>

**Orthopedic Value Stream**

- *Integrating Admission Flows*
- *Ortho Model Line 2010 Check In Time to Patients*
- *Ortho Therapeutic Zone*
- *Post-Op Pain Management*
- *End to End Value Stream Diagram*
Daily Management: Leaders have two jobs
1. Run your business
2. Improve your business

Know, Run and Improve Your Business

1. Visual Controls
   Create linked visual systems that drive action

2. Daily Accountability Process
   Establish rounding process at all levels

3. Leader Standard Work
   Leaders routinely complete key activities necessary to run and improve their business

4. Root Cause Analysis
   Asking "why" and using data and analysis to attack problems

5. Discipline
   Leaders consistently verify the health of processes and systems

6. Daily Kaizen
   Coaching staff ideas through Daily Management
Leader Standard Work

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 management alignment throughout the organization

- Discipline and accountability for execution
- Broad and deep ownership of goals
- Unit goals aligned with enterprise goals
- Investment in developing people
- Feedback and learning regarding results – psychological safety allows for learning and improvement
Unstated yet understood
Reciprocal
- The give
- The get
- Mutually beneficially to both the organization and to doctors
Typical “Two Parallel Tracks” in Organizational Life

- One track **administration**, the other track **doctors**
- Admin controls operations, budget and finance. Doctors provide clinical care
- Separated by not just different responsibilities but also by cultures, tribes
- Neither understood nor owned the challenges of the other
- Little experience of collaboration

A Very Long Process to Become a Doctor

- Takes many years
- Delayed gratification
- Hard work
- Personal sacrifice

Medical School...internship...residency year 2, 3, 4... Fellowship
The Light at the End of the Tunnel

Societal Promises/Personal Expectations

• Self-regulated profession
• No boss
• Clinical autonomy
• Job and economic security
• Entitled to respect commensurate with status

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Societal Compact Translates into a “Deal” in Organizations

Doctors Give

• Treat patients
• Provide quality care
  (personally defined)

Doctors Get

• Autonomy
• Protection
• Entitlement

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Clash Of Expectations And Imperatives

Legacy Expectations

- “Light-at-end-of-tunnel” promises
- Autonomy
- Protection
- Entitlement

Imperatives

- Improve safety/quality
- Be patient-focused
- Open up access
- Improve efficiency
- Embrace standard work
- Eliminate non-value added variation

Old Promises Are Eroded

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
A New Compact for a New Era

- Explicit, written down
- Reciprocal – what doctors expect of the organization, what the organization expects of them
- Consistent across age cohorts and tenure with organization. Physicians and administrators accountable to each other
- Supports new delivery models, process improvement
- Potentially leads to greater satisfaction, more resilience, accelerated change

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What a New Compact Is and Isn’t

Compact is:
- Clear and reciprocal expectations
- Written down
- Jointly developed
- Expectations toward a shared aim
- Rules of engagement
- How we will treat each other
- Platform for feedback and mutual accountability

Compact is NOT:
- Legal document
- Code of conduct
- Exhaustive list of behaviors
- Vehicle for “gotcha”

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Compact Work Re-sets the Dynamic

- Everyone changes – doctors and managers
- This is not about “let’s get *them* to change”
- Co-created by management and doctors
- Widespread engagement process
- If “compact” doesn’t resonate, don’t use it! Alternatives: shared agreements; our promises; covenant

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Shared Vision is the Foundation for Compact

**Compact/Shared Agreements**

**Doctors give:**
Behaviors that move the org toward vision

**Organization gives:**
Behaviors that move toward vision and that will support doctors to meet their commitments

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Accountability and Compact Must Go Hand-in-Hand

Written New Compact

Living the agreements with accountability

Old Compact at Virginia Mason
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

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

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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
**Discussion #5**

**Organization-Physician Compact**

What is the unwritten compact between doctors and your organization?

In what ways does this unwritten doctor compact:

- Support change and improvement?
- Serve as an impediment to change and improvement?

---

**Polling: Current Compact**

To what extent does the current informal physician compact hinder improvement in your organization:

Choose one

- 1 = little
- 2
- 3
- 4
- 5 = great
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?

A Couple of Radical Thoughts

Success in change is a function of the quality of your relationships
• Constructive relationships require empathy
• The route to building relationships is having curiosity and investing in conversations
Flu Vaccination “Fitness for Duty”

Do we put patient first?
Compelling science
Staff resistance
Staying the course
Organizational Pride

VMMC Influenza Vaccination Rates

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“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