Engaged Physicians Transform Care

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Gary Kaplan, MD

29th Annual National Forum on Quality Improvement in Health Care
December 11, 2017
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

These presenters have nothing to disclose.
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
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
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 \times (O + S)

Q: Quality
A: Appropriateness
O: Outcomes
S: Service
W: Waste
Cumulative Patient Safety Alerts (PSAs)

75,061 PSAs as of April 10, 2017

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Safety Innovation

Patient Safety Risk Register
April 2013

Quality and Safety Outcomes | Quality and Compliance

- 7,469 PSAs reported in 2012
- 1,319 PSAs with recorded injury
- 42% reporting increase over 2011

$865,860 total cost to VM
$564,599 in waived fees
$301,261 in indemnity payments

The top five risks to patients represent
- 70% of recorded injury
- 71% of total costs
- 56% of all reported events

Highlights
1. Coordination & Scheduling
   - Highest volume of harm.
   - Second highest number of events.
   - 115 patients had injury.
   - Most common theme was a defect or delay in responding to an urgent or emergent clinical condition.

2. Medication issues
   - Highest reporting rate.
   - 369 patients had injury.
   - More than half of these events were detected after the medication was given or after the intended delivery time.

3. Direct Patient Care issues
   - 31% of total known costs.
   - 320 patients had injury.
   - Most common themes and reasons for cost were Falls, Aspiration, and Monitoring concerns.
   - Almost all events (89%) occurred either in the hospital ward or at the hospital.”

4. Information Sources
   - Patient Safety
   - Analytics
   - Financial Services
   - Claims

5. Other

Staff Safety Risk Register
April 2013

Quality and Safety Outcomes | Quality and Compliance

- 10,957 reports in 2012
- 1,547 staff exposed to risk
- 497 staff reported physical injury
- 100 staff reported emotional injury
- 2,361 days lost to work

$544,461 in medical treatments

The top five risks to staff represent
- 63% of recorded injury
- 76% of total costs
- 85% of days lost to work

Highlights
1. Lifting
   - Highest cost for treatment ($280,875).
   - Most days lost to work (1,449).
   - 97 staff members reported lifting injuries.
   - Last year also #1 for cost and days lost to work.

2. Physical abuse by patients
   - Mostly involved needles and blades.
   - Largest number of staff injuries (98).

3. Invasive injuries
   - Information sources
     - Employee Health
     - Human Resources
     - Security
     - Patient Safety
     - 3rd Party Providers

4. Other

5. Other

Information sources
- Patient Safety
- Analytics
- Financial Services
- Claims
Effectiveness of Safety Program

PSAs Reported vs Reported Claims

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Maintain Successful Economics

$ (Millions)

$0.0 $5.0 $10.0 $15.0 $20.0 $25.0 $30.0 $35.0 $40.0 $45.0 $50.0 $55.0 $60.0


0.7 3.2 12.0 18.4 29.4 49.4 40.9 35.5 25.6 22.5 37.7 38.0

Shared Success Program

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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
Our VMPS Journey Continues!

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

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

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

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

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

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

- One KPO
- 22 KPO staff members
- First daily management assessment org-wide
- Introduced daily kaizen

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

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

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

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

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

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

- One KPO
- 22 KPO staff members
- First daily management assessment org-wide
- Introduced daily kaizen

- VMPS Priorities focused on improving the patient, family and staff member experience
2017 Organizational Goals

Quality and Safety
Reduce hospital readmissions by ensuring patients safely transition from one care setting to another.

Growth
Ensure patient centered access by providing each patient with the right care, at the right location, at the right time.

The Virginia Mason Experience: Patients and Team Members
Create remarkable experiences throughout our organization for patients and team members.
Many Organisation Have Applied Lean

At VMMC 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!
Physicians embrace new technologies and treatments they believe benefit them and patients.

BUT...change can be challenging when the benefits are not apparent or they don’t see any problem with current practices. Often are skeptical that change is really improvement.
'21st Century Medicine'

Practice of Medicine

Culture of Medicine
Socialization via “Hidden Curriculum” Contributes to Current State

- Autonomy in the service of patient care is core to medical professionalism
- “Standardized” care runs counter to professional identity, is 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
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>
</tr>
</thead>
<tbody>
<tr>
<td>□ Patient has confirmed</td>
</tr>
<tr>
<td>- Identity</td>
</tr>
<tr>
<td>- Site</td>
</tr>
<tr>
<td>- Procedure</td>
</tr>
<tr>
<td>- Consent</td>
</tr>
<tr>
<td>□ Site marked/not applicable</td>
</tr>
<tr>
<td>□ Anaesthesia safety check completed</td>
</tr>
<tr>
<td>□ Pulse oximeter on patient and functioning</td>
</tr>
<tr>
<td>DOES PATIENT HAVE A:</td>
</tr>
<tr>
<td>□ Known allergy?</td>
</tr>
<tr>
<td>- No</td>
</tr>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>□ Difficult airway/aspiration risk?</td>
</tr>
<tr>
<td>- No</td>
</tr>
<tr>
<td>- Yes, and equipment/assistance available</td>
</tr>
<tr>
<td>□ Risk of &gt;500ml blood loss (7ml/kg in children)?</td>
</tr>
<tr>
<td>- No</td>
</tr>
<tr>
<td>- Yes, and adequate intravenous access and fluids planned</td>
</tr>
</tbody>
</table>

### Before Skin Incision

<table>
<thead>
<tr>
<th>TIME OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Confirm all team members have introduced themselves by name and role</td>
</tr>
<tr>
<td>□ Surgeon, anaesthesia professional and nurse verbally confirm</td>
</tr>
<tr>
<td>- Patient</td>
</tr>
<tr>
<td>- Site</td>
</tr>
<tr>
<td>- Procedure</td>
</tr>
<tr>
<td>□ Anticipated critical events</td>
</tr>
<tr>
<td>□ Surgeon reviews: What are the critical or unexpected steps, operative duration, anticipated blood loss?</td>
</tr>
<tr>
<td>□ Anaesthesia team reviews: Are there any patient-specific concerns?</td>
</tr>
<tr>
<td>□ Nursing team reviews: Has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?</td>
</tr>
<tr>
<td>□ Has antibiotic prophylaxis been given within the last 60 minutes?</td>
</tr>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>- Not applicable</td>
</tr>
<tr>
<td>□ Is essential imaging displayed?</td>
</tr>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>- Not applicable</td>
</tr>
</tbody>
</table>

### Before Patient Leaves Operating Room

<table>
<thead>
<tr>
<th>SIGN OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Nurse verbally confirms with the team:</td>
</tr>
<tr>
<td>□ The name of the procedure recorded</td>
</tr>
<tr>
<td>□ That instrument, sponge and needle counts are correct (or not applicable)</td>
</tr>
<tr>
<td>□ How the specimen is labelled (including patient name)</td>
</tr>
<tr>
<td>□ Whether there are any equipment problems to be addressed</td>
</tr>
<tr>
<td>□ Surgeon, anaesthesia professional and nurse review the key concerns for recovery and management of this patient</td>
</tr>
</tbody>
</table>
Adaptive Challenges related to Improvement

- Doctors accepting that lessons from improving manufacturing processes can be applied to improving clinical care
- Following “standard work” or protocols generated by others
- The quality of inter-professional relationships is directly connected to patient outcomes
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”)
- 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
- Bringing conflict to the surface and constructively resolving it
Technical Solutions Are Useful...

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
- Adaptive Change

Transformation
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

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Discussion #1

In your organization:

- Identify an operational change affecting 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
- Any insights about what could have been done differently?
Model for Transformation

Urgency to improve

Single, organization-wide method

Shared vision of the organization’s future

Doctor leaders step up as change sponsors

Committed, aligned leadership & management

New compact: reciprocal expectations & accountability

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• Do those who need to play a role in improvement work believe that a problem even exists?
• Are they eager to “pull in” a new way to solve a problem they acknowledge or will you be “pushing” the change onto an unreceptive audience?
“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 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
- It takes incredible energy to move away from current practices
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.

'Distress' and Adaptive Work

Adaptive challenge

Limit of tolerance

Productive range of distress

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 aim to get their attention. But they may be busy, stressed, not much interested in your change. Expect 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
“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
Visceral-Coupled-With-Rational Ways to Raise Heat

• Share data and ask others to draw conclusions (We’re not nearly as good as I thought)
• Comparing unblinded performance data can prompt visceral reaction and change
• “Go and see.” Site visits. Bring doctors closer to consequences of current practice
• 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
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
Investigators: Medical mistake kills Everett woman

Hospital error caused death

Mary L. McClinton
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
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, how are you raising the heat when more is needed?
• What actions on your part tend to lower heat when more heat is needed?
  • In these situations, what could you do differently?
Model for Transformation

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- Shared vision of the organization’s future
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Single, organization-wide method

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“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?”
Silo Mentality is Default in Most Hospitals
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
- 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**
- Commitment to patients’ care and safety
- Positive reputation
- Economic success
- Recruit and retain talent

**Doctors’ Interests**

**SHARED INTERESTS**
- Commitment to patients’ care and safety
- Positive reputation
- Economic success
- Recruit and retain talent
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
To what extent do doctors, staff, and management share a vision for the organization’s future?

Little 1 2 3 4 5 Great

– Why did you choose the number you did?
– What impact does this have on doctor engagement?
Model for Transformation

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Single, organization-wide method

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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”
Reinforcement of Traditional Doctor Leadership

• Preference for leadership that doesn’t threaten personal autonomy
• Part of leader role is to advocate on behalf of those they lead when necessary
• 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
Consider what is needed from doctor leaders to help the organisation transform

• Sponsor change and engage colleagues
  • 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 the organisation’s quality and safety initiatives

• Help make practice life more efficient for clinical colleagues

• Able to make and keep commitments on behalf of doctors

• Build legitimacy of leader role through overt process that includes discussions with all doctors
VMMC 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
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?
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
World Class Management

Elements of Management by Policy

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

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

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

“Catchball”
- formal discussions
- idea exchange
- set priorities
- identify resources / roles
- set measurement criteria

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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
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

**4/7/2009 6:14:13 PM**

<table>
<thead>
<tr>
<th>Initiative Topic/Name:</th>
<th>Intake Center</th>
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<tr>
<td>Level:</td>
<td>Organizational</td>
</tr>
<tr>
<td>Divisional:</td>
<td>X</td>
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<tr>
<td>Sub Team/Work Group:</td>
<td></td>
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<tr>
<td>Work Unit:</td>
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<tr>
<td>Other Section:</td>
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**Background:** (Brief description of current state and why the work is important)

Currently, there is not a systematic way to collect patient clinical and financial information to set up the hospital care and discharge needs. Patients flow to the hospital through multiple portals including the ED, OR, internal and external facilities, and clinics. This results in the overprocessing of information by multiple staff, multiple moves for patients and inappropriate use of the emergency department. Patient and provider satisfaction is adversely impacted by the complex, multi-step systems.

**Goal Statement and Scope:** (Brief description of what will be accomplished that is specific, measurable and achievable)

Create an intake center integrating the clinical and business processes focusing on the placement of patients who need acute medical, surgical and monitored care. The values stream is from the time the request for hospital/surgical care to the time the patient is admitted for care.

**Tactics:** (Focus areas and key work required to achieve the goal)

- Reduce inappropriate admissions to the emergency department by moving clinical and financial process functions upstream
- Reduce lead time by sorting and simplification of bed control/patient flow supervisor functions
- Achieve a defacto surgical admittance by improving the setup of information preparation at the point closest to the source.
- Link flow of information to outside referral sources to ensure patient needs are matched with the appropriate services.

**Critical Success Factors:** (Additional considerations or key factors)

- Partnership with Corporate KPO and Finance
- Operational and Physician leadership support in the surgical sections, hospitalist services, emergency department, peri-operative services, admitting, social services and utilization review
- Group Health and Pacific Medical Center
- Integration with Regional Referral Services program

**Implementation Considerations:**

<table>
<thead>
<tr>
<th>Check/Act (Next Steps/Reporting Process)</th>
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Management by Policy - Check and Review

Regular checks and reviews are critical to determine the current status of goal achievement. These checks are conducted regularly (e.g., daily, monthly, quarterly) and include an 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
<table>
<thead>
<tr>
<th>Orthopedic Value Stream</th>
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<td>4-3 P Ortho Model line visioning</td>
<td>-19 RPIW, Ortho Therapeutic Zone</td>
<td>1/25 Ortho Prescription Flow &lt;br&gt;4-5 S of Electronic Information &lt;br&gt;Visioning Session Ortho Model</td>
<td>2-26 RPIW Flow of orthopedic to VMMC (ortho flow #2) &lt;br&gt;4 KE Implant Purchasing Process</td>
</tr>
<tr>
<td>24/7 Ortho Model Visioning Session</td>
<td>1 Integrating Kaizen Plans</td>
<td>4-3 P Ortho Model line visioning</td>
<td>1/25 Ortho Prescription Flow</td>
<td></td>
</tr>
</tbody>
</table>

**Recover**

- Ensure patient is ready for D/C
  - Patient teaching

**Cross Functional Management**

- Med Call generates algorithm to schedule patients
- Grey results medical history and need for surgery
- Date, provide information, set appointments for preop, H&P, TJR
- Patient arrives and staff tracks patient progress in case tracking
- General Patient Care, Pain assessment, Mobility event
- Discharge Plan Talk about status of recovery
Daily Management:
Leaders have two jobs
1. Run your business
2. Improve your business
Daily Management

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. Reliability
Leaders consistently verify the health of processes and systems

6. Daily Kaizen
Coaching staff ideas through Daily Management

Management by Policy
Provides focus and direction

World-Class Management System

Cross-Functional Management
Aligns across the organization, award/self/custome satisfaction

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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.
Principles that support high levels of alignment

• Ownership of goals
• Alignment of unit with enterprise goals
• Discipline, focus, follow-through
• Investment in developing people
• Feedback and learning regarding results
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

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Expectations members of an organisation have that are:

• Unstated yet understood
• Reciprocal
  • The give
  • The get
• Mutually beneficially to both the organisation and to doctors
Typical “Two Parallel Tracks” in Organisational 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

Maintaining separate realms and aims does not support alignment, critical to improvement
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
Societal Promises/Personal Expectations

- Self-regulated profession
- No boss
- Clinical autonomy
- Job and economic security
- Entitled to respect commensurate with status
Societal Compact Translates into a “Deal” in Organizations

Doctors Give

• Treat patients
• Provide quality care
  (personally defined)

Doctors Get

• Autonomy
• Protection
• Entitlement
“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
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”
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
Shared Vision is the Foundation for Compact

COMPACT

Doctors give:
Behaviors that move the org toward vision

Organisation leaders give:
Behaviors that move toward vision and that will support doctors to meet their commitments

SHARED VISION
Accountability and Compact go Hand-in-Hand

Written New Compact

Living the agreements & using feedback to build accountability
Phase 2: Compact Implementation

Thoughtful planning regarding opportunities to reinforce new compact agreements

✓ Policies: Modify HR policies to make them consistent with the new compact (including recruitment, hiring, on-boarding).

✓ Performance feedback: Use performance-management conversations with doctors and managers to give feedback on compact agreements.

✓ Development, coaching, mentoring: Provide development activities so that leaders, managers, and doctors have the requisite skills to live compact obligations.

✓ Rewards and acknowledgment: Make heroes of those who become role models of the new expectations. Consider meaningful nonfinancial rewards such as a sincere thank-you from senior leaders.

✓ Compensation: Tie some portion of compensation to meeting the expectations in the new compact.

✓ Resource allocation: Align resources, including budgets and personnel, to ensure that leadership, management, and doctors can live up to commitments in the compact.
## Sample of An Implementation Grid

<table>
<thead>
<tr>
<th>Recruitment</th>
<th>On-boarding for physicians</th>
<th>On-boarding for administrators and managers</th>
<th>Performance reviews – physicians and administrators</th>
<th>Communication</th>
<th>Training: All physicians</th>
</tr>
</thead>
</table>
| Prepare materials that include compact | Changes to existing processes including:  
- Compact in New Physician & New Employee Orientation | Orientation to the compact integrated into existing processes | Change forms for MDs  
Change forms for administrators  
Assure communication through executive chain of command | CEO communication ongoing through what venue  
CMO communication  
COO communication  
“Communication A3” restart – assure all relevant objectives for Compact supported by relevant, coordinated, terse & accessible communications | Quick courses or webinars  
• feedback – giving and getting  
• Communication civility  
• Making a good referral  
• What makes an ACO different? How to succeed in ACO world  
Teamwork |
| Insertion of Compact into candidate flow | Introduction of new specialists to referring PCPs | Standardization of onboarding process across all specialties | | | |
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

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

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Discussion #5
Organization-Physician Compact

• In what ways does the unwritten doctor compact:
  – Support change and improvement?
  – Serve as an impediment to change and improvement?

• If you have done the work to co-create an explicit new compact, has it helped? How?

• If you haven’t, is there enough urgency back home to engage in the work? How could you start?
Flu Vaccination “Fitness for Duty”

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


