

Collaboration, Leadership, and Change in Health Care

• Leadership

- Features of great leaders – an exercise
- What are the characteristics of great leadership?
 - Kouzes and Posner’s “The Leadership Challenge”
- Features of effective teams
- Why is great leadership critical in medicine?
- Evidence that collaboration has value in health care
- Management vs. leadership

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• Change

- Models of change
- An example of implementing change at an academic medical center

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A Leadership Exercise

- Create a 2-column table as follows:
- On the left, write the name *or initials* of a person you have experienced as a **great leader**.
- On the top right, write the name or initials of a person you have experienced as a **poor leader**.
- Under each name/initials, write the characteristics of this individual that informs your impression of her/him.

A Leadership Exercise, cont'd.

A Great Leader I Know	A Poor Leader I Know
Name or Initials:	Name or Initials:

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The Leadership Challenge (Kouzes and Posner)

- Goal to identify the key dimensions of great leadership
 - Administer >2,500 surveys, primarily to managers in middle or senior-level positions
 - Likert scale to identify features most associated with perceived great leadership
 - Conduct >300 interviews



From: Kouzes and Posner. The Leadership Challenge. Jossey Bass, 1995

The 5 Leadership Commitments

- **Challenging the process**
 - Search out challenging opportunities to change, grow, innovate, and improve.
 - Experiment, take risks, and learn from the accompanying mistakes.

From: Kouzes and Posner. The Leadership Challenge. Jossey Bass, 1995

The 5 Leadership Commitments

- **Inspiring a shared vision**
 - Envision an uplifting and ennobling future.
 - Enlist others in a common vision by appealing to their values, interests, hopes, and dreams.

From: Kouzes and Posner. The Leadership Challenge. Jossey Bass, 1995

The 5 Leadership Commitments

- **Enabling others to act**
 - Foster collaboration by promoting cooperative goals and building trust.
 - Strengthen people by giving power away, providing choice, developing competence, assigning critical tasks, and offering visible support.

From: Kouzes and Posner. The Leadership Challenge. Jossey Bass, 1995

The 5 Leadership Commitments

- **Modeling the way**
 - Set the example by behaving in ways that are consistent with shared values.
 - Achieve small wins that promote consistent progress and build commitment.

From: Kouzes and Posner. The Leadership Challenge. Jossey Bass, 1995

The 5 Leadership Commitments

- **Encouraging the heart**
 - Recognize individual contributions to the success of every project.
 - Celebrate team accomplishments regularly.

From: Kouzes and Posner. The Leadership Challenge. Jossey Bass, 1995

Six Leadership Competencies for Health Care Leaders

- **1. Technical knowledge and skills**, e.g.,
 - Operations
 - Finance and accounting
 - Information technology and systems
 - Human resources (including diversity)
 - Strategic planning
 - Policy

Six Leadership Competencies for Health Care Leaders

- **2. Knowledge of health care**, e.g.
 - Reimbursement strategies
 - Legislation
 - Regulation
 - Quality assessment and management
- **3. Problem-solving**, e.g.,
 - To resolve organizational challenges and manage projects

Six Leadership Competencies for Health Care Leaders

- **4. Emotional intelligence**
- **5. Communication**, e.g.,
 - In leading groups
 - In negotiation
 - Conflict resolution
- **6. Commitment to lifelong learning** (in the context of a rapidly changing environment and the need for new skills to cope and manage)

What is Emotional Intelligence (EI)?

- The capacity to **understand** your own and others' emotions, and to **motivate** and **develop yourself and others** in service of improved work performance and enhanced organizational effectiveness
- Essentially having EI means:
 - Understanding yourself
 - Managing yourself
 - Understanding others
 - Managing your relationship with others

The 18 EI Competencies in 4 Domains



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Please List the Features of an Effective Team.

1.
2.
3.
4.
5.
6.
7.
8.
9.

Characteristics of an Effective Team*

- **Has clear purpose**
 - Defined and accepted mission; action plan
- **Informality**
 - Members are comfortable, relaxed
- **Participation**
 - All members engaged; much discussion

*After Glenn Parker

Characteristics of an Effective Team*

- **Listening**
 - Use of effective listening techniques, e.g., questioning, paraphrasing, summarizing
- **Civilized disagreement**
 - Comfortable with disagreement; does not avoid or suppress conflict
- **Consensus decision-making**
 - Thorough discussion; avoidance of voting

*After Glenn Parker

Characteristics of an Effective Team*

- **Open communications**
 - Feelings seen as legitimate; few hidden agendas
- **Clear roles and work assignments**
 - Charter re: roles, goals, responsibilities; even distribution of work
- **Shared leadership**
 - In addition to formal leader, others show effective leadership behavior

*After Glenn Parker

Characteristics of an Effective Team*

- **Attentive to outside relationships**
 - Team attends to outside relationships, resources, and credibility
- **Style diversity**
 - Team has a broad spectrum of group process and task skills
- **Self-assessment**
 - Team attends to process; how well are we doing?

*After Glenn Parker

Special Characteristics of a High-Performing Team

- **Keen sense of purpose**
- **Often ambitious performance goals that are mutually held**
- **Well-developed sense of mutual accountability**
- **Fluid and seamless hand-offs among team members**
- **Interchangeable and complementary skills at the same time**

Katzenbach JR, Smith DK. In: The Wisdom of Teams. Harper, 1999. page 79.

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Why is Great Leadership Critical in Health Care?

- **Physicians’ traits and training discourage collaboration.**
- **The hospital environment challenges teamwork.**

Can Doctors Collaborate?



Doctors are “collaboratively challenged.”

Marvin Weisbord on OD in Health Care,

1978



16 COMPARING ORGANIZATIONS

Relativity Study has been written about the differences to be considered in diagnosing organizations.

Important differences might include:

1. environments

2. work organizations

3. goals

4. structure

5. degree of resource control

Each of these factors will affect each of the boxes, often in ways not well understood or completely predictable. The following article elaborates on these ideas by contrasting academic medical centers with industrial firms. The general analysis would also apply to colleges and universities.

WHY ORGANIZATION DEVELOPMENT HASN'T WORKED (SO FAR) IN MEDICAL CENTERS

Marvin R. Weisbord

“Science-based professional work differs markedly from product-based work. Health professionals learn rigorous scientific discipline as the “content” of their training. The “process” inculcates a value for autonomous decision-making, personal achievement, and the importance of improving their *own* performance, rather than that of any institution.”

Some Think That Collaboration Will Come to Health Care When....



Features of Doctors that Pose Barriers to Their Collaborating

- Medical training and practice conspire against physicians' having basic reflexes for collaboration and teamwork.
 - Training favors individual performance.
 - Training is long and hierarchical.
 - “Extrapolated leadership” conspires against teamwork.
 - Physicians are deficit-based thinkers.

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Extrapolated Leadership in Medicine, cont'd.

- "Physicians do not typically see themselves as followers; therefore, they do not readily acknowledge leaders to have any more authority than that required to call meetings or to represent physicians' interests. Effective leadership among physicians calls for.....recognition on physicians' part of leaders' authority."

From: Silversin and Kornacki. Leading Physicians Through Change, 2000

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Why is Great Leadership Critical in Health Care?

- Physicians' traits and training discourage collaboration.
- **The hospital environment challenges teamwork.**
 - Most hospitals are "silo-based."
 - Component groups (e.g., physicians, nurses, administrators) may have discordant goals.

The Hospital Environment Hampers Teamwork

- The mission of a hospital poses **special organizational challenges to collaboration.**
 - Each **outcome is highly individual** but the volume is high, i.e., "hospitals manage specific processes on a large scale."
 - The **cost of providing care is high** and the **margin is low.**
 - The **populations** involved in providing care are **divergent and have a different focus** (i.e., physicians, nurses, administrators).

Minvielle E. Intl J Quality in Health Care 1997; 9: 189-192

The Hospital Environment Hampers Teamwork, cont'd.

- Hospitals are **highly departmentalized.**
 - Culture focuses on narrow, highly technical areas at the expense of attention to the managerial challenges of the whole.

Minvielle E. Intl J Quality in Health Care 1997; 9: 189-192

Hospitals are Frequently Silo-Based



The Hazard of Silos



The Paradox of Collaboration and Teams in Health Care

- Outstanding outcomes in health care depend on excellent teamwork and collaboration.
- Also, patients judge their care on the human (not technical) aspects of their care, including how well they perceived their providers as working together as a team.
- **But...**
 - Hospitals are traditionally silo-based organizations.
 - Features of medical training conspire against collaboration by physicians.

Top Drivers of Patient Satisfaction (Press Ganey Associates, 2003*)

1. How well staff worked together to care for you	0.79
2. Overall cheerfulness of a hospital	0.74
3. Response to concerns/complaints made during stay	0.68
4. Amount of attention paid to personal/special needs	0.65
5. Staff sensitivity to the inconvenience of hospitalization	0.65
6. How well nurses kept you informed	0.64
7. Staff's effort to include you in treatment decisions	0.64
8. Nurses' attitudes about your requests	0.64
9. Skill of the nurses	0.63
10. Friendliness of the nurses	0.62

* Based on a mail survey of 48 questions driving "most likely to recommend"

Top Drivers of Patient Satisfaction (Gallup Organization, 1999*)

1. Nurses anticipated your needs	0.64
2. Staff and departments worked together as a team	0.64
3. Staff responded with care and compassion	0.62
4. Staff advised you if there was going to be a delay	0.61
5. Nurses explained about meds, procedures, routines	0.60
6. Nurses responded promptly to pain management	0.60
7. Nurses responded in a reasonable amount of time	0.60

* Telephone survey response to 27 questions that correlate most highly with "overall satisfaction"

On the Importance of Collaboration in Medicine

- "Medical care has increasingly become an activity dependent on **team collaboration** and **well-organized systems of care**. Many current deficiencies of medicine relate to **poorly designed systems** and **inadequate communication and coordination**. More than ever, **medicine needs physicians who can collaborate with each other and with other professionals**. It remains uncertain how best to attract such persons to medicine or how best to train medical students so they can work effectively in teams."

From: Mechanic D. "Physician discontent." JAMA 2003; 290: 941

On the Relation of Collaboration to Quality in Medicine

- "...there is increasing understanding that quality of care is embodied in systems as well as in the efforts of conscientious and well-motivated individuals and that improving **quality is a collective challenge requiring collaboration.**"

From: Mechanic D. "Physician discontent." JAMA 2003; 290: 941

Why is Having and Developing Great Leaders Critical in Medicine?: Interim Summary

- Having great outcomes in health care requires teamwork and collaboration.
- Health care organizations are a challenging leadership environment.
- Physicians may be "collaboratively challenged."
- Traditional criteria for advancement to leadership in medicine regard clinical and/or academic prowess rather than having leadership competencies.

Why is Having and Developing Great Leaders Critical in Medicine?: Interim Summary

- Physicians' dedication to mastering medicine may eclipse attention to their developing leadership skills.
- Little attention is given to developing leadership skills in traditional medical school or training curricula.

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The Evidence Supporting the Benefits of Teamwork in Health Care

- Observations by students of systems
- Observational studies (descriptive research)
 - Case reports
 - Observational cohort studies
- Randomized controlled trials
- Your own experience

Process Affects Outcome in Critical Care

- Assess expected vs. actual outcomes in 13 hospital ICUs
 - Then compared process in Hospital 1 where observed hospital survival significantly exceeded APACHE II prediction (mortality ratio 0.59) vs. Hospital 13 where survival fell significantly below prediction (mortality ratio 1.58)
 - Features of Hospital 1: “carefully designed protocols,” “educational programs for staff nurses and for charge nurse as manager,” “excellent communication between physicians and nursing was ongoing”
 - Features of Hospital 13: “admitting physicians and unit nursing staff communicated poorly,” “no policy for routine discussion of patient treatment”
- Knaus WA et al. Ann Intern Med 1986; 104: 410 -418

Teamwork Enhances Outcomes in the Intensive Care Unit

- ICU leaders committed to create an environment “supportive of practice improvement” in the Shock Trauma Respiratory ICU (STRICU) at LDS Hospital
 - Implemented methods to **foster cooperation**
 - **Develop a shared purpose**
 - Create an **open, safe environment**
 - **Include all** who share in the common purpose and **encourage diverse views**
 - Learn to **negotiate agreement**
 - **Insist on fairness and equity in applying rules**

Clemmer TP et al. Cooperation: The foundation of improvement. Ann Intern Med 1998; 128: 1004 – 1009.

Teamwork Enhances Outcomes in the Intensive Care Unit, cont'd.

- **Develop a shared purpose**
 - **Example:** Unit medical director and nurse manager developed workshops for nurses and doctors to improve unit performance and cultivate supportive working relationships.
- **Create an open, safe environment**
 - **Example:** Unit medical director and nurse manager modeled cooperation in their interactions and encouraged same among others.

Clemmer TP et al. Cooperation: The foundation of improvement. Ann Intern Med 1998; 128: 1004 – 1009.

Teamwork Enhances Outcomes in the Intensive Care Unit, cont'd.

- **Include those who share in the common purpose and encourage diverse viewpoints**
 - **Example:** Physicians invite other professionals to express their concerns, ideas, and opinions individually.
- **Learn to negotiate agreement**
 - **Example:** Offer formal sessions on negotiation; physicians who disagree with others are expected to offer alternative solutions.

Clemmer TP et al. Cooperation: The foundation of improvement. Ann Intern Med 1998; 128: 1004 – 1009.

Teamwork Enhances Outcomes in the Intensive Care Unit, cont'd.

- **Insist on fairness and equity in applying the rules**
 - **Example:** In implementing protocols, everyone is asked for their views about the protocol; a time window for comment is established during which everyone's comments are expected with the understanding that non-response implies consent.

Clemmer TP et al. Cooperation: The foundation of improvement. Ann Intern Med 1998; 128: 1004 – 1009.

Teamwork Enhances Outcomes in the Intensive Care Unit, cont'd.

- **Impact of this intervention was that over a 4-year interval during which an ICU committed to establishing a culture of cooperation, costs of ICU care declined by up to 30%, resulting in an overall 19% reduction in total hospital costs.**

Clemmer TP et al. Cooperation: The foundation of improvement. Ann Intern Med 1998; 128: 1004 – 1009.

A Summary of Evidence that Teamwork Enhances Function in Surgery

- **In a study of 16 different surgical teams newly learning minimally invasive cardiac surgery, attention to the elements of teamwork by the surgeon was associated with a steeper learning curve and with substantially shorter procedure times after 40 cases.**
 - **Mean procedure times for the hospital with the second steepest learning curve after 40 cases were 143 minutes vs. 305 minutes for the second slowest curve.**

Pisano GP et al. Management Science 2001; ; 47: 752 – 768.

Lessons from Learning Minimally Invasive Cardiac Surgery

- **Study question:** What are the features of surgical teams that achieve low procedure time for a new surgical technique (minimally invasive cardiac surgery)?
- **Design:** Observational
- **Methods:** Evaluate total procedure time to complete the surgery among 16 hospital teams (660 patients) which were similarly trained by the equipment manufacturer
- **Assess features of those which achieved low procedure times**

Pisano GP et al. Management Science 2001; 47: 752 – 768.

Lessons from Learning Minimally Invasive Cardiac Surgery, cont'd.

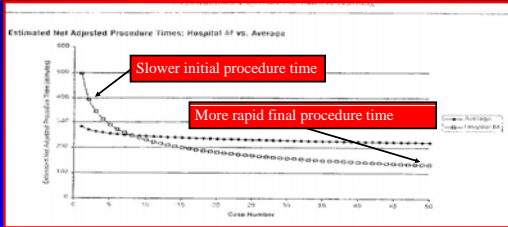
- Of 16 hospitals evaluated, 9 were academic medical centers and 7 community hospitals (all non-profit)
- Mean cardiac cases 1400/year (range 400 – 3500/year)
 - Mean minimally invasive cases = 40 (range 11 – 95)
- Multivariate model with
 - Dependent variable = total procedure time (“skin to skin”)
 - Independent variables
 - Type of procedure (e.g., CABG, valve)
 - Number of grafts in CABG
 - Higgins Score for OHS outcomes
 - Cumulative minimally invasive cases to date

Lessons from Learning Minimally Invasive Cardiac Surgery, cont'd.

- **Model shows that:**
 - **Procedure times fall with experience.**
 - Substantial differences in the slope and intercept of the curves were observed, i.e., the “learning curve” differed greatly and later procedure times varied (sample average of 220 minutes, with the hospital with the second steepest learning curve at 143 minutes for the 40th case vs. 305 minutes for the slowest learner).
 - **Hospitals with lower final procedure times tended to have longer procedure times for first few cases.**

Pisano GP et al. Management Science 2001; 47: 752 – 768.

Procedure Times for a High-Performing Surgical Team vs. All Others



• Hospital M demonstrated the second steepest initial learning curve of all 16.

Pisano GP et al. Management Science 2001; 47: 752 – 768.

Comparison of Surgical Team Practices in a Hospital with Low Procedure Time vs. Others

Team with Second <i>Shortest</i> Procedure Times	Team with Second <i>Longest</i> Procedure Times
Community hospital (1200 operations/year)	Academic medical center
Surgeon hand-picked team to attend training	Team picked by availability and willingness to go to training (on a weekend)
Surgeon explicitly encouraged teamwork as an important success factor	Members of team see themselves as functioning independently

Pisano GP et al. Management Science 2001; 47: 752 – 768.

Comparison of Surgical Team Practices in a Hospital with Short Procedure Time vs. Others

Team with Second Shortest Procedure Times	Team with Second Longest Procedure Times
High cross-department communication regarding the procedure and outcomes (e.g., talk with cardiologists)	No attempt to introduce the technique to other stakeholders
Team meets before the case to discuss (first 10) and after the case to debrief (first 20)	No meetings of team before or after cases

Pisano GP et al. Management Science 2001; 47: 752 – 768.

Comparison of Surgical Team Practices in a Hospital with Short Procedure Time vs. Others

Team with Second Shortest Procedure Times	Team with Second Longest Procedure Times
High communication among surgical team (e.g., perfusionists with nurses, etc.)	No attempt to assure or encourage communication among team members
Surgeon mandated same team for first 15 cases before any new members	No attention to this (only 3 of the 4 individuals who attended training did the first case)
New members were required to watch 4 cases and be proctored in 2 more	Team composition varied for first 7 cases

Pisano GP et al. Management Science 2001; 47: 752 – 768.

Conclusions from this Study

- **The learning curve for surgical teams, even when identically trained in a technique, varies widely, with some teams achieving much lower procedure times than others.**
- **Differences in the high vs. low performers seem to relate to the emphasis on team-building and teamwork of the surgical team.**

Pisano GP et al. Management Science 2001; 47: 752 – 768.

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Leadership vs. Management (After Kotter)

- Different but complementary activities
- Both involve
 - Deciding what needs to be done
 - Creating networks of people to accomplish an agenda
 - Ensuring that the work gets done

Managing vs. Leading (After Kotter)

Managing	Leading
Aim is predictable, orderly results	Aim is to produce change
Involves planning and budgeting	Involves vision and setting direction
Involves organizing and staffing	Involves aligning people
Involves controlling and solving	Involves motivating and inspiring

Kotter JP. What leaders really do. Harvard Business Review

Interim Conclusions Regarding the Need for Great Leadership in Medicine

- Because of features of physicians, of medical training, and of the hospital environment (silo-based), there is a special need for great leadership in medicine.
- Great leadership can foster teamwork, which can confer benefits, especially in multidisciplinary undertakings (like health care).
- By virtue of your responsibilities, each of you faces "The Leadership Challenge."

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- Models of change
- An example of implementing change at an academic medical center

On Change

- “Nothing endures but change.”
 - Heraclitus
- “It is not necessary to change. Survival is not mandatory.”
 - W. Edwards Deming

On Change, cont'd.

- “It’s not the progress I mind, it’s the change I don’t like.”
 - Mark Twain

On Change

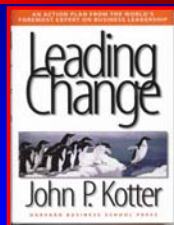
- “Even if you are on the right track, you’ll get run over if you just sit there.”
 - Will Rogers

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8 Stages of Change (after Kotter) From: Leading Change, 1996

- 1. Establishing a sense of urgency
- 2. Creating the guiding coalition
- 3. Developing a vision and strategy
- 4. Communicating the change vision
- 5. Empowering broad-based action
- 6. Generating short-term wins
- 7. Consolidating gains and producing more change
- 8. Anchoring new changes in the culture



Establishing a Sense of Urgency

- Examining the market and competitive realities
- Identifying and discussing crises, potential crises, or major opportunities

Creating the Guiding Coalition

- Putting together a group with enough power to lead the change
- Getting the group to **work together like a team**

Developing a Vision and Strategy

- Creating a vision to help direct the change effort
- Developing strategies for achieving that vision

Communicating the Change Vision

- Using every vehicle possible to constantly communicate the new vision and strategies
- Having the guiding coalition role model the behavior expected of employees

Empowering Broad-Based Action

- Getting rid of obstacles
- Changing systems or structures that undermine the change vision
- Encouraging risk-taking and non-traditional ideas, activities, and actions

Generating Short-Term Wins

- Planning for visible improvements in performance, or “wins”
- Creating those wins
- Visibly recognizing and rewarding the people who made the wins possible

Consolidating Gains and Producing More Change

- Using increased credibility to change all systems, structures, and policies that don't fit together and don't fit the transformation vision
- Hiring, promoting, and developing people who can implement the change vision
- Reinvigorating the process with new projects, themes, and change agents

Anchoring New Changes in the Culture

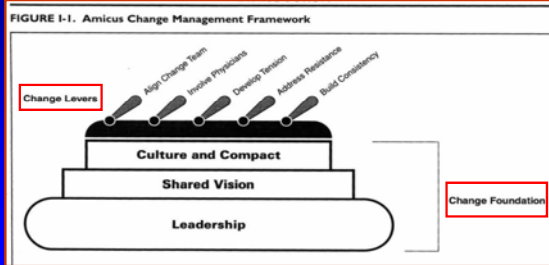
- Creating better performance through customer and productivity-oriented behavior, more and better leadership, and more effective management
- Articulating the connections between new behavioral and organizational success
- Developing the means to ensure leadership development and succession

The 5 Leadership Commitments (Kouzes and Posner) and the 8 Stages of Change (Kotter)

- **Challenging the process** 1. Establishing a sense of urgency
- **Inspiring a shared vision** 2. Creating the guiding coalition
- **Enabling others to act** 3. Developing a vision and strategy
- **Modeling the way** 4. Communicating the change vision
- **Encouraging the heart** 5. Empowering broad-based action
- 6. Generating short-term wins
- 7. Consolidating gains and producing
- 8. Anchoring new changes in the culture

From: Kouzes and Posner. The Leadership Challenge. Jossey Bass, 1995

Framework for Effecting Change in Health Care



From: Silversin and Kornacki. Leading Physicians Through Change, ACPE, 2000.

Some Proposed Steps to Optimize Teamwork in Change Initiatives

- Involve stakeholders early and harvest their ideas and understand their agendas.
- Look for common goals and develop a shared vision.
- Communicate this shared vision.
- Build success through pilot efforts that demonstrate synergies.
- Celebrate small wins.

Characteristics of Physicians Regarding Change Acceptance

- Physicians are:
 - Data-driven
 - Motivated to do the right thing
 - Competitive
 - Generally willing to challenge (the status quo and lots of other things)

Conclusions

- Though challenging, change is a force in our lives and permeates health care.
- Leadership is about leading change.
- Great leadership is critically needed in health care and you have an opportunity, through interest and training, to meet the leadership challenge.

Conclusions, cont'd.

- The change process can be modeled and successfully managed.
- Understanding change management is an asset for the health care leader and is an opportunity for you.

Collaboration, Leadership, and Change in Health Care

- **Change**
 - Types of change
 - “Personal” vs. “external” change
 - Models of change
 - **An example of implementing change at an academic medical center**

Some Caveats Regarding Change Efforts

- Change efforts are neither “clean” nor “linear.”
- Change efforts generally have longer timelines than those of most acute clinical interventions.

A Respiratory Care Challenge

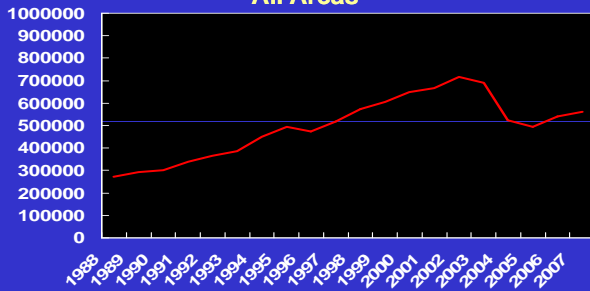
- Under a traditional, physician-directed service, the volume of RT orders is increasing, outstripping the available RTs.
- The frequency of inappropriately ordered RT services is high and increasing.
- You wish to implement an RT Consult Service as a potential solution. How do you lead this change effort to be successful?

Story of the Respiratory Therapy Consult Service (RTCS)

- ~1989 - Emerging awareness that physicians frequently order respiratory therapy services incorrectly (“misallocation”)
 - Orders outstripping the available number of RTs to deliver the ordered care
 - Hence, need to change the paradigm for delivering respiratory care

Gross Service Counts

All Areas

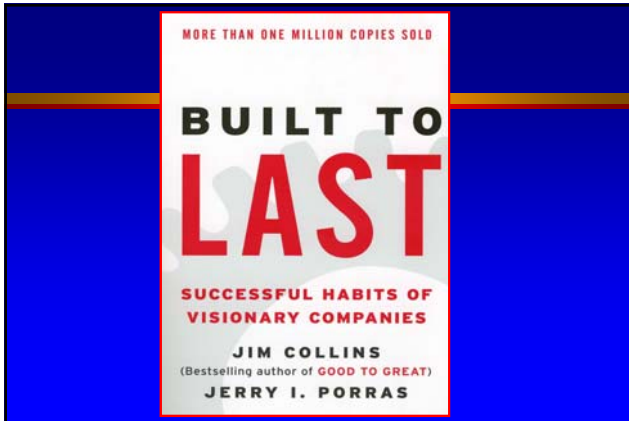


Story of the Respiratory Therapy Consult Service (RTCS), cont'd.

- 2 options:
 - 1. Teach all physicians about appropriate allocation of respiratory care (Staff and trainees)
 - Laudable but tough to reach everyone
 - Not a high priority for some/competing interests
 - 2. Empower RTs to order respiratory care through protocols

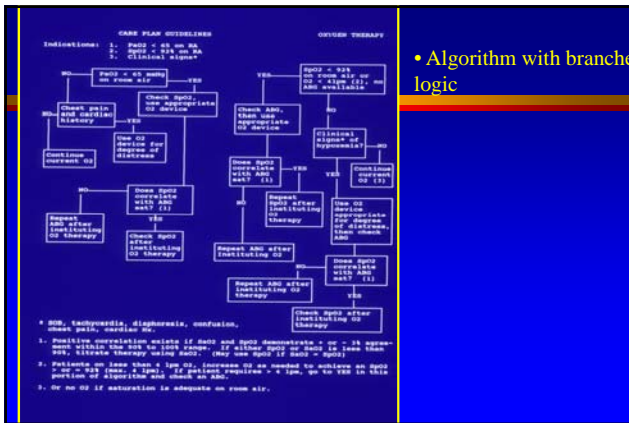
Story of the Respiratory Therapy Consult Service (RTCS), cont'd.

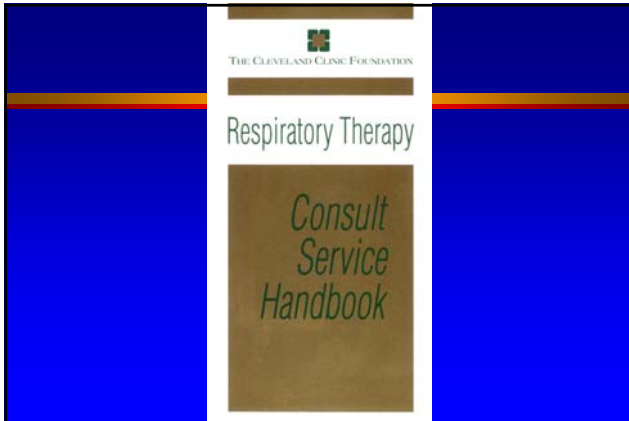
- Appreciate the "Genius of the AND" (after Collins and Porras - "Built to Last")
 - No "Tyranny of the OR"
 - We can empower RTs to order respiratory care services **AND** teach physicians how to order respiratory care



Story of the Respiratory Therapy Consult Service (RTCS), cont'd.

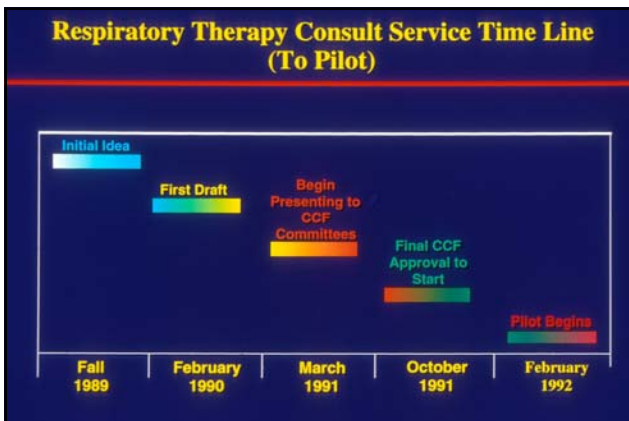
- What we did
 - 1. Engage RTs to help develop evidence-based, branched logic algorithms for respiratory care
 - Lots of idea exchange (giving voice to stakeholders)
 - Engage physicians in design (including some potential resistors)
 - 2. Name the program (Respiratory Therapy Consult Service IRTCS)

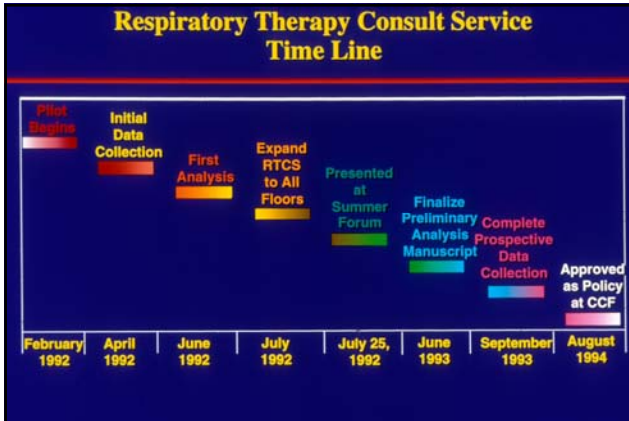




Story of the Respiratory Therapy Consult Service (RTCS), cont'd.

- 3. Once protocols developed, engage in pilot studies of the Respiratory Therapy Consult Service
- 4. Refine the RTCS to optimize
- 5. Publish and distribute the RTCS handbook to all RTs and physicians at CCF
- 6. Perform a randomized controlled trial at CCF of the RTCS vs. usual physician-directed care





Story of the Respiratory Therapy Consult Service (RTCS), cont'd.

- 7. Publish the trial (garner the weight of peer-reviewed endorsement)
- 8. Present the idea to the BOG with a proposal to make RTCS-directed care the default mode of prescribing respiratory care at CCF
- 9. With BOG approval, roll out the RTCS hospital-wide and communicate its availability widely
 - Medical Grand Rounds
 - Other publications

Story of the Respiratory Therapy Consult Service (RTCS), cont'd.

- 10. Current policy is that RT will see patient and perform/implement an RT consult for most non-ICU care at CCF

Assessing the Implementation of the RTCS in the Context of Kotter's Stages of Change

- **1. Establishing a sense of urgency**
 - Demonstrate misallocation of respiratory care
 - Tie the problem to an issue of relevance to CCF and to the stakeholders (RTs), i.e., we need to provide respiratory care to CCF patients and we can appeal to RTs' desire to provide excellent and appropriate care

Assessing the Implementation of the RTCS in the Context of Kotter's Stages of Change

- **2. Creating the guiding coalition**
 - Engage RTs in drafting protocols
 - Work with selected physicians who might resist the idea
- **3. Developing a vision and strategy**
 - Conceive the RTCS program
 - Name it (to capture and communicate the idea succinctly)

Assessing the Implementation of the RTCS in the Context of Kotter's Stages of Change

- **4. Communicating the change vision**
 - Conduct pilot studies to optimize the RTCS (thereby showing the program to physicians whose patients were participating in the studies, i.e., research as a change mechanism appealing to physicians' desire for data)
 - Work with RTs to refine the RTCS

Assessing the Implementation of the RTCS in the Context of Kotter's Stages of Change

- **5. Empowering broad-based action**
 - Seek official sanction at the Board of Governors (rather than "cajole" individual physicians as sole mechanism to implement change [though cajoling/persuading can be an important tool])
- **6. Generating short-term wins**
 - Share the enjoyment of these successes
 - Write papers with RTs as coauthors

A Question for You to Consider

- You are leading this effort.
- What would you do to **assure compliance with handwashing guidelines** and optimize JCAHO preparedness?

JCAHO Preparedness Regarding Handwashing at a Large Academic Medical Center: What Was Done

- Assemble and empower a leadership (handwashing compliance) team consisting of representatives of the stakeholders (e.g., central leadership, physicians, nurses, etc.)
 - Team is given a goal and timeline by institutional leaders.

JCAHO Preparedness Regarding Handwashing at a Large Academic Medical Center: What Was Done, cont'd.

- The team proceeds to systematically measure the frequency of handwashing by provider type, location, department, etc.
- Announce and publicize these results both locally (e.g., within departments) and globally (at institution-wide forums).

JCAHO Preparedness Regarding Handwashing at a Large Academic Medical Center: What Was Done, cont'd.

- Place alcohol “soap stations” widely throughout the hospital (outside all rooms, at elevators, etc.) as visible reminders of the priority given to handwashing.
- Provide regular, predictable and visible interval progress reports, both locally and globally within the institution.

JCAHO Preparedness Regarding Handwashing at a Large Academic Medical Center: Results

- To date, handwashing compliance rates have improved dramatically but remain incomplete, e.g., ~70%.
- Survey and counseling efforts continue.

Assessing the Implementation of the Handwashing Initiative in the Context of Kotter's Stages of Change

- **1. Establishing a sense of urgency**
 - Demonstrate the inadequacy of current practice.
 - Tie the problem to an issue of relevance to and to the stakeholders, i.e., need to pass JCAHO review and comply with goals.

Assessing the Implementation of the Handwashing Initiative in the Context of Kotter's Stages of Change

- **2. Creating the guiding coalition**
 - Create and empower a leadership team.
 - Work individually and intensively with physicians and groups where compliance was poorest.
- **3. Developing a vision and strategy**
 - Conceive the handwashing program.

Assessing the Implementation of the Handwashing Initiative in the Context of Kotter's Stages of Change

- **4. Communicating the change vision**
 - Provide data about compliance levels locally and globally and in multiple forums.
 - By making "soap stations" widely available, there is visible evidence of the effort and its importance.

Assessing the Handwashing Initiative in the Context of Kotter's Stages of Change

- **5. Empowering broad-based action**
 - Publicize the endorsement of the quality committee's authority and responsibility to assure compliance.
- **6. Generating short-term wins**
 - Announce those units with greatest successes and improvements in handwashing practice.

Conclusions

- Though challenging, change is a force in our lives and permeates health care.
- Leadership is about leading change.
- Great leadership is critically needed in healthcare and you have an opportunity, through interest and training, to meet the leadership challenge.

Conclusions, cont'd.

- The change process can be modeled and successfully managed.
- Understanding change management is an asset for the health care leader and is an opportunity for you.



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Consider Classifying Ideas in a “Payoff Matrix”

	Easy To Do	Hard To Do
Big Payoff	Gems	Requires Extra Effort
Small Payoff	Quick Hits	Proceed with Caution

Our Closing Challenge For Today

- Harvest ideas shared today at tables regarding ways to assure sustainability, e.g.,
 - Generating short-term wins
 - Consolidating gains and producing more change
 - Anchoring new changes in the culture
- Look especially for “gems” (in our payoff matrix)



Some Thoughts

- Though challenging, change is a force in our lives and permeates health care.
- Leadership is about leading change.
- The change process can be modeled and successfully managed.
- Understanding change management is an asset for the health care leader and is an opportunity for you.



Our Goals Today

- To understand and (hopefully embrace) the benefits of physician collaboration,
- To identify barriers here to physician collaboration and *more importantly*,
- To develop **actionable, sustainable** strategies by which we can use enhanced physician collaboration and leadership to lead change and solve difficult challenges (such as those to be discussed in table breakouts later this morning)



Our Goals Today, cont'd.

- For **each of you** to develop a personal action plan as to how to advance the goals of better leadership and followership to solve the challenges at Lahey in which you are engaged.
- To design a follow-up plan to sustain the momentum we develop today



Schedule for the Morning

- Introductions and goals for the day
- Can Physicians Collaborate?: Leadership, Collaboration, and Change in Health Care
- **Group work at tables to address current challenges needing physician collaboration and change agency at the Lahey Clinic**
- Report out from table discussions to harvest ideas
- Group conversation to harvest more ideas about how to make today's momentum stick (sustainability)
- Lunch and debrief



Table Discussions: Principles

- The leadership of the Lahey Clinic has articulated near-term institutional goals of:
 - Continued increased patient volume
 - Continued recruitment of high-quality talent (physicians, nurses, administrators, allied health providers)
 - Enhanced patient service and satisfaction



Table Discussions

- One potential organizational tactic to advance these goals is to organize in “service lines.”
- Our goals at tables are to explore the concept of different “service lines” as a way of advancing the Lahey Clinic’s strategic goals.
- Each table has been carefully populated and each of you has a key role at your table.



Table Discussions

- Some (possible) questions to consider:
 - At our best, how do service lines **help advance our goals**?
 - What **advantages** exist?
 - Are there **barriers or disadvantages**?
 - **Honest discussion with great teamwork** is the goal here.
 - What might be an **ideal structure** of our service line?



Table Discussions

- Some (possible) questions to consider, cont'd.
 - What are the **leadership needs** to effect this change?
 - In the context of change models (e.g., Kotter), how can this change effort be organized when we are at our best?



Table Discussions

- Some (possible) questions to consider, cont'd.
 - What **specific, actionable** ideas do we have:
 - To advance the goals of continued, increased patient volume, continued talent recruitment, and enhanced service and patient satisfaction?
 - To implement or to better explore implementing service lines?



Table Discussions

- Some (possible) questions to consider, cont'd.
 - What are **my personal "gotta do's"** to advance my development
 - As a leader?
 - As a collaborator?
 - How do we keep the momentum of today and "make it stick"?



Table Discussions

- Tables convene for 1 hour (take a break PRN).
- Please assign a recorder (flip chart) and a reporter.
- At the end, we will ask each table to “report out” the group’s wisdom (≤ 3 minutes/table).
- Hope is to harvest great ideas to help the Clinic.

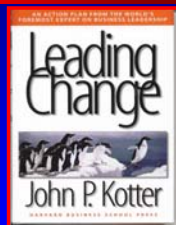


How Do We “Make it Stick”?

- Our closing challenge for today
- Sustainability = “Meeting the needs of the present without compromising the ability of future generations to meet their own needs.”
 - Brundtland Commission, led by the former Norwegian Prime Minister Gro Harlem Brundtland.
- Preserve momentum and develop strategies to maintain progress in these efforts

8 Stages of Change (after Kotter) From: *Leading Change*, 1996

- 1. Establishing a sense of urgency
- 2. Creating the guiding coalition
- 3. Developing a vision and strategy
- 4. Communicating the change vision
- 5. Empowering broad-based action
- 6. **Generating short-term wins**
- 7. **Consolidating gains and producing more change**
- 8. **Anchoring new changes in the culture**



Consider Classifying Ideas in a “Payoff Matrix”

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Our Closing Challenge For Today, cont’d.



- Identify and record a personal “gotta do” regarding personal leadership development and/or regarding an aspect of your work at tables to advance the mission of the Lahey Clinic.

Our Challenge Today and Going Forward

- To understand and (hopefully embrace) the benefits of physician collaboration,
- To identify barriers here to physician collaboration and *more importantly,*
- To develop **actionable, sustainable** strategies by which we can use enhanced physician collaboration and leadership to lead change and solve difficult challenges (such as those to be discussed in table breakouts later this morning)

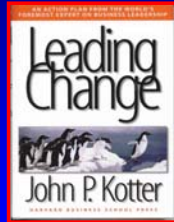
On Teamwork in Critical Care Medicine

- “The abundance of evidence in critical care research demonstrates that **critical care is a team sport**, and the intensivist is the team captain, responsible that each member is proficient in some component of the overall toolbox.....To me, it is evident that intensivists themselves aren’t responsible for better outcomes. Rather, it is the proximity/availability of intensivists to treat at the bedside **and their coordination of other professionals and protocols that save lives.**”

Manthous CA. Respir Care 2006; 51: 1224-1225

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In Support of the Importance of EI

- “181 different positions from 121 organizations worldwide...67% of the abilities deemed essential for effective performance were emotional competencies”
- In a study of more than 2000 managers from 12 large organizations, 81% of the competencies that distinguished outstanding managers were related to EI.

After Boyatzis and Goleman

In Support of the Importance of EI

- “The primary derailer of top executives is a lack of impulse control.”

After Goleman

JCAHO Preparedness Regarding Handwashing at a Large Academic Medical Center: The Baseline State

- **Baseline state:** The JCAHO survey looms, creating a well-recognized sense of urgency.
- **Initial assessment of the rate of handwashing compliance suggests low compliance, i.e., ~35%.**
- **Institution organized to enhance practice in order to meet JCAHO requirements.**
