

## A Theory of Leadership for the Transformation for Health Care Organizations

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The history of health care quality improvement is replete with examples of projects in which a team aims for and achieves improvement in one or more dimensions of quality, in a particular ward, unit, or office, for a particular disease or condition. There are fewer examples of such projects in which the improvement is dramatic—breaking through the current levels of performance to achieve something close to the theoretical ideal. Rarer still are examples of dramatic improvements that have been scaled and spread across entire organizations. And there are simply no examples of the transformation of the system of care for entire organizations and communities, in which care approaches the theoretical ideal for every condition, across the whole system, for all dimensions of quality.

Transformation of entire organizations and systems is a leadership task requiring an extraordinary depth and breadth of change. Since it hasn't been done before, no one can claim to have a "recipe" for how to achieve it. But for those leaders who want to take on this daunting task, it would be better to proceed with *some* theory of what it would take to lead such a transformation than to simply muddle along. This paper is written to provide such a theory, in the hopes that it will be helpful to health care leaders as they plan their transformational work, and to the advisors who coach them. And it is clearly offered in the spirit of "All theories are wrong, but some are useful."

The primary basis for the theory presented below is the experience of the thirteen health care organizations that are participating in the Pursuing Perfection project: seven hospitals and care systems in the United States, four communities in England's National Health Service, a teaching hospital in the Netherlands, and a 3-hospital county health care system in Sweden. The brave leaders of these systems have taken on the challenge of transforming their entire health care systems—first for a few conditions, then for a few more, and eventually for all. It is a long-term agenda, and at this writing they are only about two years into the process. Nevertheless, the early learning from that experience is distilled into the theory presented below. I have had the privilege of functioning as a leadership coach and advisor for them, and I am grateful to the CEOs of these organizations for sharing their successes and their failures with me, and to the Institute for Health Care Improvement for giving me the assignment of working with such an extraordinary group of executives.

Other important sources for this theory include the blueprint for a redesigned care system contained in the *Crossing the Quality Chasm* report from the Institute of Medicine, the distilled experience of transformational change in other industries (e.g. Toyota's work over decades with W. Edwards Deming and others), and my own personal experience over 15 years as the CEO of two health care systems, Park Nicollet in Minneapolis and CareGroup in Boston.

In an eloquent paper in 2002, Mark Chassin issued a call for health care leadership in order to implement the outline of the *Chasm* report. But his paper provided no blueprint for what leaders should do—how they should go about leading this transformative set of changes. This paper outlines what leaders should do.

### **The Aim: What would a transformed organization look like?**

The first task in a theory of transformation would be to develop some clear, widely accepted idea about what transformation is. Only after leaders understand the goal can they begin to posit the steps that it might take to reach the goal. Don Berwick offered a way to frame the goal when he suggested in a speech to the Pursuing Perfection leaders that they imagine their future organizations as "Places with no needless deaths, pain, waits, helplessness, and waste." In a subsequent conversation with Pursuing Perfection leaders, I asked them to fill in details about what a transformed organization would be like. Their picture of a transformed state includes the following elements:

*A transformed organization will be a place where...*

- The “Big Dots” (system-level measures of performance on the major dimensions of quality) have moved, and are continuing to improve, with conscious competence, toward the theoretical ideal of...
  - No needless deaths
  - No needless pain
  - No needless helplessness
  - No needless delays
  - No needless waste
  - (Note: in quality improvement, one of the first tools learned is to “plot the dots” i.e. to chart data over time. At a project level, we routinely use run charts of performance data (“small dots”) to measure progress. The term “Big Dots” is simply used to refer to the similar measures at the level of the whole system. Examples of Big Dots include overall hospital mortality rate, cost per case-adjusted admission, and nurse turnover rates.)
- Each patient has the opportunity to design her goals for care, her care team, and her plan of care, in partnership with nurses, physicians, and other professionals.
- The front line staff members, particularly physicians, function as leaders in initiating and driving improvement, rather than simply reacting to and implementing changes suggested by managers.
- The CEO is “master teacher” of quality, which is an operational *line management* responsibility throughout the organization, rather than delegated to a few quality staff professionals.
- The Dots, both Big and Small, are connected: strategic goals, system-level measures, and project-level measures have a logic—a “Theory of the Strategy” deployed rigorously through a method such as Balanced Score Card, or Strategy Maps
- The organization has “square root of n” expert improvers, where n is the total number of employees (this indicator has been posited by Brent James M.D. as an indicator of critical mass in cultural change)
- All Staff seek innovation and ideas worldwide
- “Our Board couldn’t imagine a new CEO who wasn’t an even better champion of QI” (transformation is built into succession management)
- There is full transparency to patients, staff, and community on all measures, using industry-wide standards
- Physicians are “captains of the teams,” rather than highly autonomous “captains of the ship” (a critical element in the evolution of real cross-professional teams)
- All teach, all learn
- You cannot be promoted unless you’re a star quality improver (note: human resources policies and systems are a vital element of this transformation—this is just one example of the kinds of policies that would need to be implemented in order to transform a culture)
- There is a waiting list to get on staff
- Improvement is often through radical re-design, in addition to incremental process improvement
- Improvement Cycles are part of everyone’s daily work life, not thought of as “projects”
- Cycles of Improvement are so many that they are “uncountable”
- Projects cross many organizations, engage the entire community, (as opposed to staying within competitive silos and other boundaries)
- Improvement occurs at the process, system, and “interface of many systems” levels simultaneously
- Quality is the strategy, rather than something that is nice to do, but which can be jettisoned if the organization comes under pressure. (As Charles Buck, retired General Electric executive described it, “Transformed means that when times are tough, we invest more, not less, in Quality.”)
- Everyone in the organization can explain how his/her work is integrated with strategy, logically and quantifiably
- >50% of key committees have patient majorities (an indicator of the sharing of our care design processes to with our patients and families).

These glimpses of elements of a transformed organization help to make the goal less fuzzy, and also make it clear that transformation is probably a long-term aim—a 10 to 20-year goal. Once this long-term aim is framed, the key question then becomes “What theory do we have about what an organization would need to do in order to produce this future?” Such a theory would provide a blueprint for the CEO’s agenda for change.

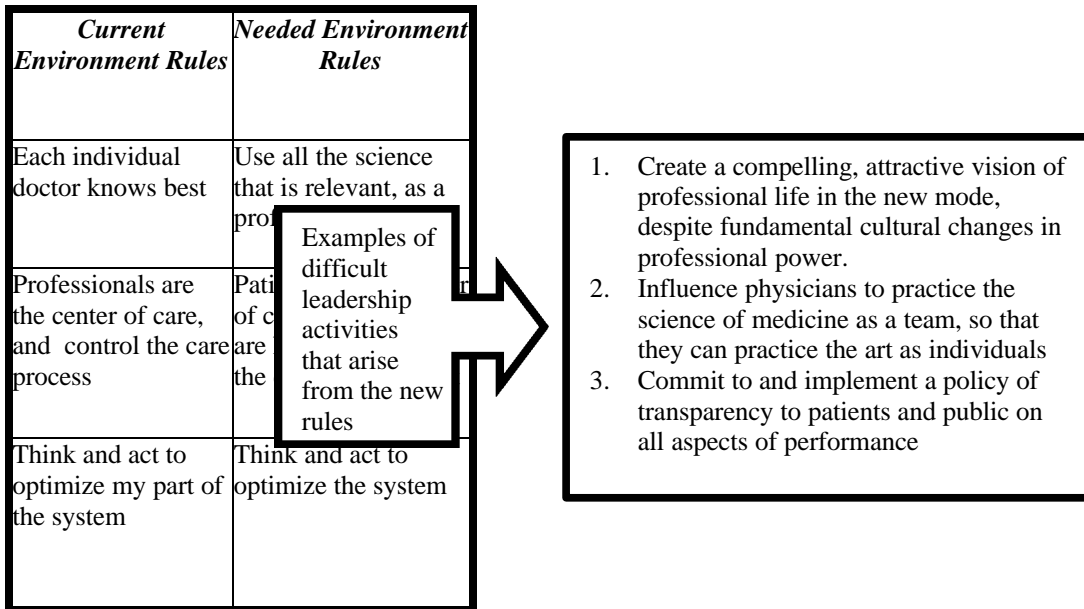
### **The Leadership Challenges of Transformation**

The central work of leadership is to bring about needed change. Becoming “a place with no needless deaths, pain, helplessness...” will require at least six major types of change, and it is these six changes that frame the leadership challenge.

#### *Leadership Challenge 1: Reframe core cultural values*

This task can best be understood by contrasting the current health care system’s cultural rules with those proposed for the envisioned system. (see diagram below) If the old rules are to be replaced by the new rules, leaders will need to guide those whom they lead through a fundamental reframing of values, habits and beliefs. For example, health professionals are selected and conditioned to regard health care quality as an individual responsibility, and therefore to value individual professional autonomy more highly than almost any other professional cultural attribute. Reframing this value (autonomy) and other core professional values is a *transformational* task, rather than a *transactional* one. (Note: “Transactional” changes can be accomplished without changing the participants’ framework of values and beliefs, through well-understood methods such as negotiation, and politics. Transformational tasks require the participants to change core values, and require both a different sort of leader, and a different kind of leadership system).

Transformational change—needing to change core values and beliefs, not just processes of care—becomes very important when considering the personal attributes of key leaders—particularly, that combination of traits and behaviors which generate *authenticity* in a leader—that would seem to be necessary for success. For this reason, I do not believe it would suffice to simply describe what leaders should know how to *do* (how to run an effective meeting, or manage a budget, for example.) It will also be necessary for CEOs, CMOs and VPs of Human Resources to address the difficult problem of what leaders throughout their system, at all levels, must *be*, i.e. what intrinsic traits they should have driven their selection of leaders, so that they will possess the desired values, and the personal *authenticity* necessary to influence their colleagues to change deeply held values. The diagram below illustrates how changing from the old to the new rules require reframing of core values.



*Leadership Challenge 2: Create Improvement Capability*

This challenge is brought about not so much by the nature of the changes themselves, as by the sheer breadth and depth of the changes required. The goals in the transformational vision are so much higher (i.e. not just incremental improvement, but theoretical ideal performance!) and across so many more conditions, that the magnitude and pace of required change will strain existing leaders and leadership teams, and will expose weaknesses in components of the current system of leadership in areas such as communication, spread, workforce development, and development of new leaders. Senior leadership will need to frame and execute an aggressive, comprehensive plan to create improvement capability both at the level of project leadership, and at the level of organizational leadership.

*Leadership Challenge 3: Collaborate across competitive boundaries*

The vision of transformation outlined above will not be achieved if health care systems work in isolation from the larger community. Many current problems result from the fragmentation of care as patients move from one provider to another in the course of treatment. For example, the lack of community-wide clinical data sharing is a significant cause of waste and duplication in testing, medication errors, and missed opportunities for important clinical and preventive care. Similarly, leaders will need to cooperate with their competitors to establish transparent, credible, useful systems of public performance reporting, if whole communities are to transform. Leaders of successful transformation will need to be break out of old patterns of competitive and “proprietary” behavior, and develop truly collaborative relationships around the best interests of their patients and communities. This is not a natural act for leaders, who are charged with the financial and strategic stewardship of their own organizations, and are held to account by their Boards of Trustees for the performance of their part of the system, not the whole community care system.

*Leadership challenge 4: Create a business environment that simultaneously drives business results and community benefit*

For many current health care systems, there is no clear relationship between improved quality and improved business results. The tangle of mismatched and contradictory payment methods, regulatory constraints, and organizational business models that constitutes the American health care system does not provide an obvious way to “do well by doing good.” While it may be true that some attributes of quality such as safety are simply fundamental principles (First Do No Harm), and therefore should not be put to

some calculus of business value, it is also true that if health care organizations bankrupt themselves, they cannot perform the services needed by the community. It will therefore be necessary for leaders in this transformation, in collaboration with purchasers, payers, and regulators, to develop new business environments that keep pace with and support the improvements in quality they are achieving within their organizations.

*Leadership challenge 5: Drive system-level, rather than project-level results.*

Improvement capability is far too often left to a project-by-project approach, and seldom is linked consciously to a plan to drive far-reaching system-wide improvement in outcomes of interest to the community and patients. Leaders will need to organize improvement in order to move organization-wide performance, not boutique projects. Typical measures of system-wide performance might include hospital standardized mortality rates, costs per case-mix-adjusted admission, adverse drug events per 1000 doses, and functional status outcomes for the major common diseases treated in the hospital. This challenge is analogous to that faced by WWII leaders considering the invasion of Normandy. It would be one thing to prove at a “project” level that you could land a boat on the coast of Normandy and unload some troops and weapons. It is quite another thing to commit to a full-scale invasion. That’s what has been missing from far too many health care organizations’ approach to quality. We’ve proved over and over that we can do small projects—to land a boat on the coast. It’s now time that we mounted a concerted invasion on a large scale—to move a Big Dot.

*Leadership challenge 6: Maintain constancy of purpose over the long-term transformational journey.*

Transforming an organization will take time. Given the turnover rates of CEOs in health care, it is highly likely that the transformational agenda will play out over the tenure of at least 2 CEOs, if not more. How will constancy of purpose be maintained over the long term? How will the transformational agenda become so deeply engrained in the culture, leadership succession, and other organizational systems that it would be difficult, if not impossible, for a new CEO to derail it? This is a serious problem in health care. Far too often, performance improvement is viewed as a pet project of the current CEO, rather than embedded into the DNA of the organization itself.

## **Roadmaps to Transformation**

“A place where...” describes an organization so different from the ones in which we now work, that getting there would seem to require a fundamental state change, like going from water to steam. In my conversations with health care leaders, I get the impression that this sort of state change in health care will not be evolutionary, but revolutionary. Or, to put it into *Crossing the Quality Chasm* terms, the gap between our current organizations and “all” is a chasm that cannot be crossed in two steps. All of these ideas—state change, revolution, crossing a chasm—suggest that when transformation does occur, it will be an emergent event—a surprise, something that comes about in the complex adaptive system that is health care not as a result of a finely detailed plan, but because of the convergence of multiple factors, some planned, others completely unplanned. The roads that lead to that convergence might come from multiple directions. Some of those roads can be built and traveled by leaders of hospitals and group practices, but these leaders, by themselves, can neither design nor build all the roads that might be required. The most robust plan to achieve transformation would require health care leaders to work on a plan to achieve those things that are within their control, and simultaneously to influence as much as possible the building of the other roads toward transformation that are out of their direct control. What might these various roads to the tipping point to “all” be?

### **Route 1: Revolution (Leadership from Below)**

Looking at the list of characteristics of “a place where...” it is apparent that one critical factor in transformation of organizations will be a dramatic change in the culture of the professional workforce. The central themes of that cultural change are three:

1. From individual physician autonomy to shared decision-making
2. From professional hierarchies to teamwork
3. From professional disengagement in system aims to “system citizenship”

Why label this route to transformation “revolution?” If these changes were to occur in the health professions, particularly in medicine and nursing, and the organizations in which those nurses and doctors worked did not change responsively, it seems to me that tensions between the workforce and their organizations would eventually kindle a “peasants at the gates with torches” sort of revolution, with the health care professionals demanding dramatic change from the leaders of health care organizations. For example, imagine 15 years of profound cultural changes taking place in newly trained physicians as a result of the recently revised competency requirements of the Accreditation Council on Graduate Medical Education (ACGME), without any corresponding change in the way hospitals and group practices function. It would seem to me that the new generation of physicians will revolt against the old systems, and constitute a powerful force for dramatic change in all types of health care delivery. Hence, “revolution.”

Paul Batalden and David Leach, through the ACGME, have already started us moving down Route 1. Note that this route is particularly important for two of the three main strategies of the *Chasm* report: use all the science we know, and cooperate as a system. Health leaders cannot simply wait for this cultural change to move through medicine, but should be aware of it, and take steps both within and without their organizational boundaries to support and accelerate the cultural change. When possible, hospital and physician leaders should harness the energy from this slow tidal shift in the culture of medicine, and use it to drive needed changes inside their organizations. Route 1 is clearly one of the main highways to the emergent surprise called transformation.

### **Route 2: Friendly Takeover (Leadership from Outside)**

“A place where...” depicts another sort of cultural change, the impetus for which *could* come from outside the health care organizational culture: a profound shift in power from the professional and the organization to the patient and the family. In many ways, we are already well down the road on Route 2. For example, patients and families have broken into the medical “Holy of Holies,” the special knowledge that has defined our source of professional power. They watch open heart surgery on Channel 58, and bring printouts of the latest scientific articles to office visits. They now can see various reports on the performance of nursing homes, hospitals, and physicians, and soon will be seeing many more such reports. The power of information is already in the hands of the public.

This shift in power needs to drive a broad range of changes, from how the aims of care plans are defined, to radical redesign of how care is delivered, paid for, measured, and reported. Ultimately, this power shift to patients and families will result in them having as much control of their care as they wish to have. They will lead the design of their own care, and make important decisions about resources. It is necessary to go down Route 2 in order to implement the “center the care on the patient” strategy of the *Chasm* report.

Just as for Route 1, organizational leaders can not make Route 2 happen by themselves. But they can be aware of its importance, its necessity for the transformation of their own organizations, and its power to help leaders drive needed change. A lot of patients are driving down Route 2 right now, and the job of health care leaders is to find them and use their energy, and their leadership, to invite a “friendly takeover” of their hospitals and clinics.

### **Route 3: Intentional Organizational Transformation (Leadership from Above)**

This route to transformation should be the one most familiar to CEOs and other senior executives. It is the set of leadership strategies that, implemented with constancy of purpose over some years, would be likely to drive organizational transformation. Because Route 3 is the one for which organizational leaders are most directly responsible, it is described in some detail below. It's important to reiterate that, since transformation is likely to be an emergent property of a complex adaptive system, it would be an error for leaders to assume that a well-built and traveled Route 3 will bring about transformation of their own organizations without some convergence from the other routes, (which aren't entirely within the control of leadership.)

Why "leadership from above?" Route 3 contrasts with Route 1 in that Route 1 sees the principal drive for change coming from those working at the front lines, whereas Route 3 envisions the push coming from visionary leaders who want to place their organization change agendas at the leading, rather than the trailing edge, of transformation. From a traditional hierarchical organization perspective, this is "leadership from above."

#### **Route 4: Intentional Macrosystem Transformation (Leadership from High Above)**

A fourth route that might be described does not begin with diffused, perhaps even "unorganized," cultural changes in professions and patients as in Routes 1 and 2. Neither does it arise from within health care delivery organizations as an intentional act of leadership. Route 4 is a way to transformation that arises out of intentional acts of policymakers, regulators, and others in positions of authority outside the health care delivery system itself. Many of the characteristics of "A place where..." would be accelerated by, and perhaps even dependent on, such macrosystem changes.

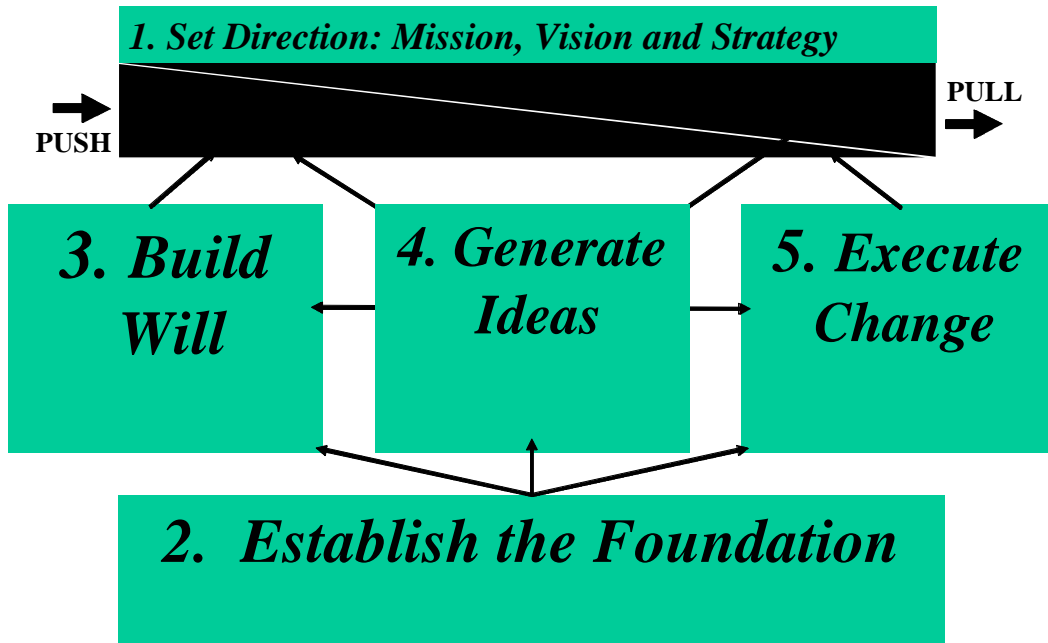
For example, it is not a natural act of organizations to publicly disclose data on their performance, especially when the performance is sub-optimal. Without public policy that requires transparency on the Big Dots, it is likely that widespread transparency would not be the norm in health care, aside from a few brave pioneers. In general, measurement, payment, and accountability regulations that would encourage and reward those who demonstrate evidence-based practices, patient-centeredness, and system-wide cooperation would be a powerful driver of deep organizational change. This policy/regulation highway, Route 4, can not be directly designed or traveled by health leaders, but it might be influenced, and its power harnessed, in order to accelerate the changes they want to bring about inside their organizations. The role of leaders in Route 4 might be analogous to the military situation of "calling in fire on your own position." If such regulatory fire could be sensibly guided by what healthcare executives are learning, and trying to accomplish, it might be exceptionally powerful in getting their organizations through some difficult spots on their own routes to transformation. Route 4 is "leadership from high above."

#### **A Theory of Health Care Organization Transformation: (the MapQuest printout of Route 3)**

With the understanding that in a complex system any detailed plan, for any of the routes above, is likely neither to be correct, nor individually predictive of success, it is nevertheless helpful to posit a theory of how healthcare leaders might frame their own work, as a guide to their travels down Route 3.

A good general framework for this theory is provided by the Institute for Health Care Improvement model of leadership, shown below:

## A Framework for Leadership



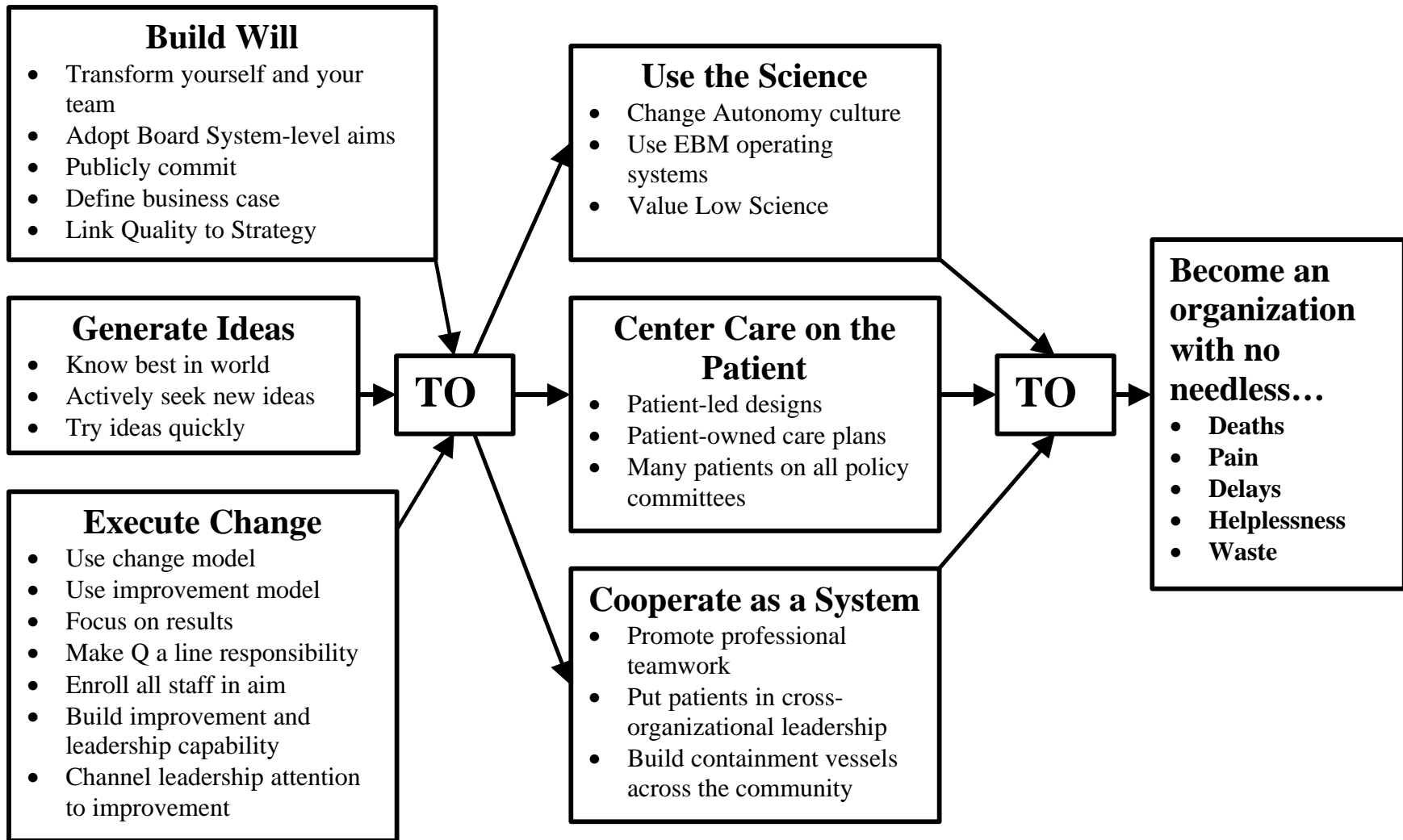
Any general framework such as the one above is useful, but doesn't give much guidance regarding the specific content of the work. For example, for what purposes should leaders be building will, and under what broad themes should they be generating ideas, if transformation of health care organizations is to be successful? Answers to these questions must be part of any theory of transformation. The *Chasm* report's three themes—Use the Science We Know, Center Care on the Patient, and Cooperate as a System—provide a useful additional set of organizing themes under which specific actions essential to transformation might be place.

Using the IHI leadership model as an overall guide for leadership actions, and the three *Chasm* themes as drivers of content, what specific elements would need to go into each of the boxes, if leaders were to successfully navigate their way down Route 3? Put another way, what are the key things that leaders must make happen, if they are to get to the first way-station, and eventually, to "all?" The answers to these questions constitute a theory of what transformational leaders must do to achieve both the near and long-term aims of transformation.

What follows is a description of those leadership activities which, in concert, would appear to me to be essential to transformation of health care organizations. The activities are listed either under one of the "boxes" in the IHI leadership model, or under a *Chasm* theme, but it should be clear to any leader that there is a great deal of overlap among these categories. Suffice it to say that the placement of the activities in one box or another is not important. Neither are the activities necessarily sequential. They are, however, *necessary*, if transformation is to occur.

The diagram on the following page attempts to give a visual representation of Route 3. A more detailed description of each element of the theory then follows.





## **Summary of Theory of Transformation: The CEO's agenda, if organizations are to get to "all."**

1. Set Direction:
  - State the aim, the "commander's intent"
2. Build the Foundation
  - Transform yourself (the CEO)
  - Transform, and remake, if necessary, the senior executive team
  - Build organizational improvement capability
3. Build Will
  - Obtain Board adoption of system-level aims for performance
  - Publicly declare your aims to improve system-level measures
  - Define the business case, and make the financial linkages between projects and financial performance
  - Make a logical, quantitative connection between quality work and key strategic goals
4. Generate Ideas
  - Know the best performance in the world
  - Actively seek new ideas
  - Develop the ability to try new ideas quickly
5. Execute Change
  - Use a well-grounded improvement method, such as the "Model for Improvement" to lead project-level change
  - Use a solid change leadership model to spread and scale useful improvements
  - Focus on results
  - Make improvement results a line management responsibility
  - Make sure everyone in the organization knows her part in achieving the strategic aims
  - Channel leadership attention to improvement projects
6. Use the Science we Know
  - Take intentional action to achieve local change in MD culture: practice the science of medicine as a team, practice the art of medicine as individuals
  - Ensure that administrators and physicians know improvement science ("Low Science")
  - Develop and use evidence-based "operating systems"
7. Center Care on the Patient
  - Put patients in the lead on care design committees
  - Develop and use care plans that incorporate the patients' goals
  - Place patients on your senior executive team, and on all major policy committees
8. Cooperate as a System
  - Promote a culture of teamwork among physicians and nurses
  - Put patients on your "cross-institutional" working groups
  - Build containment vessels across the community
  - Give permission to staff to work cooperatively outside the boundaries of your system

### **Set Direction: State the aim, the "Commander's Intent"**

An essential early task of transformational leaders would be to make a very clear communication of the aim of transformation to the entire leadership team, and to the organization as a whole. In essence, the CEO would need to generate and transmit two descriptions, by some process within the organization.

1. Long term vision of transformation: "A place where...." This description would need to be made in terms specific to each individual organization's culture and environment.
2. Near-term aim: e.g. "By April of 2005, our projects in (Diabetes, CHF, Asthma, Flow...) will have brought about (significant improvement—described specifically by IOM dimensions for

these projects) for thousands of patients and families in our community. Moreover, the designs and methods by which we will achieve those aims will be surprising to us, our patients, and the entire health care world.”

Most important, the CEO would need to declare that aim personally, publicly, repeatedly, and irrevocably—in other words, to authentically transmit a commitment to the aim. In order to do this well, leaders must have initiated their own individual transformative journeys (see “establish the foundation” below). Although the emphasis on these sorts of communications is usually on the “Pull,” i.e. the attraction that nurses, physicians, and administrators might feel to a desirable future vision—it is also important that the leaders communicate in words and deeds a certain amount of “Push” i.e. that the status quo is no longer going to be acceptable in the organization.

### **Establish the Foundation**

There are a number of interrelated tasks that might fall under this headline. All of them would seem critical to successful transformation. Note that in the diagram of Route 3, these have been placed under the boxes for Build Will and Execute Change.

*Transform yourself:* It’s difficult to imagine a transformed organization without a transformed leader. The tough changes required will not be brought about by leaders who are not personally committed to the long-term process, and willing to take significant risks to drive out needless deaths, pain, waste, delays, and helplessness. Furthermore, the front line staff will immediately detect any lack of authenticity in their leaders. CEOs and other leaders should take steps to make and reinforce their personal commitment to the aims; in Deming’s words, to “adopt the new philosophy.”

Specific actions that might be taken to make and improve personal commitment include:

- Interview some nurses, doctors and pharmacists who have been at the sharp end of a needless death or serious injury in your hospital, and listen carefully to their emotions (anguish, embarrassment, fear, anger, bitterness) and their insights into how your organization makes their work difficult. If you don’t know whom to interview, you might ask whomever is in charge of risk management. It’s usually not too hard to find a recent example of harm. Note: this is a difficult process, because it almost invariably results in a profound shift in the way CEOs see such events. The shift is from “They killed that patient” to “I killed that patient,” and one never returns to normal after making that realization.
- Listen, in a similarly deep way, to patients and families experiencing care in your institution. Make it a habit to do this for an hour a day.
- Tell the stories of what you hear to your management team, your physician staff, and your Board. Stories carry both the emotions and the content, and telling them is also a good way of publicly declaring commitment. A specific suggestion: start every Board meeting with a story about an actual patient injury or needless death that occurred in your institution within the previous month. The stories won’t be hard to find, once you start looking. This will “put a face” on the quality problem.
- Read both IOM reports, cover to cover, underlining and paraphrasing them. Read them as if it were a matter of life and death. (It is.)
- Learn and use the Model for Improvement (Langley et al, *The Improvement Guide*, Jossey Bass 1996) in your own work. If you don’t really understand quality theory and methods, attend a good training program with your doctors, nurses, and middle managers. Even though you’re the CEO or other high official, you can still learn—and might learn a lot about improvement from those “below” you in the organization.

*Transform your team:* The senior team and its commitment are just as important to the transformation as is your own personal transformation. You will not achieve either your first way-station, or your long term goals, if any members of the senior executive team are not primary drivers of the transformation. And if any senior executive team members show absence of shared values, half-hearted efforts, lack of deep knowledge of quality philosophy and methods, or cynicism and undermining of the transformation, you will undoubtedly fail.

Specific steps that might be taken to transform the senior management team include:

- View “First, Do No Harm” (an unusually powerful videotape depicting actual errors in a composite of malpractice cases from the Harvard Risk Management collaborative, available from [www.p4pf.org](http://www.p4pf.org)) together as a team, and talk about what you have seen.
- Bring an articulate patient onto your team, not as a passive observer, but as a full member.
- Learn together: attend conferences and courses to learn quality methods, visit the best in the world as a team to find out new ideas and methods...
- As the CEO, ask a very hard question, and take action on the answer: “Do I have the necessary values and skills in the people on this team, to reach either the first way-station or the long-term goal of transformation?” Note: it might be necessary to change some members of the team.

*Build capability:* There is no question that health care organizations generally don’t have a broad cadre of capable improvers in their ranks. All too often, I find that a few quality champions and zealots have “gone to school,” but widespread knowledge and training are absent, with the resulting lack of a critical mass of staff who know the philosophy and tools of improvement. This sort of learning is probably best structured as “just in time” opportunities in the course of improvement work, rather than a big investment in sending people to training programs. But it still requires investment in an intentional, measured plan to build capability, and a solid plan to make use of that growing capability as it is created. A good target is the “Square root of  $n$ ” as Black Belt level improvers, where  $n$  is the total number of employees.

Leadership capability is just as important as improvement knowledge, and so the other half of the “build capability” requirement is for the CEO to implement a plan to create widely distributed leaders throughout the organization, in all ranks. These leaders must understand the commander’s intent, see the organization as a system, and possess the right combination of personal leadership attributes and leadership skills to be able to execute your change agenda despite all sorts of technical, political, and cultural barriers. Just as in the development of quality improvers, leaders will not appear simply because they have gone to leadership school. The CEO and Human Resources executive must put together a comprehensive plan involving hiring methods, performance measurement and feedback, consequences management (a disciplined system for dealing with behaviors that simply don’t fit the desired culture), training systems, and compensation programs, in order to develop a large group of capable leaders.

## **Build Will**

*Get the Board engaged in system-level aims for performance:* Boards are the highest authority in the organization, and if CEOs expect to make the extraordinary changes necessary to get to “all,” they will need more than passive support from the Board. Boards must be actively engaged, and channel the attention of the organization to moving its Big Dots. The first job is for the Board to understand and set aims for the organization’s system-level performance measures. Trustees must understand these Big Dots at least as well as they understand financial numbers such as “days cash on hand,” and “current ratio.”

If leadership of major change is in fact a mix of Will, Ideas, and Execution, it isn’t likely, or even appropriate, that Board leaders would be responsible for *Ideas* for how to reduce mortality rates, or the *Execution* of changes in clinical processes to improve their reliability and safety. But Boards do, and must, have a powerful role in establishing institutional *Will* for improvement. If hospitals are to improve mortality rates, for example, their Boards are going to have to support CEOs and Medical Staff Executive Committees as they work through some highly controversial issues such as how ICUs are organized and staffed, how nurse staffing levels are determined, and how the medical staff organization can assure evidence-based medicine across all the practices of a diverse physician staff. This will require that the Board demonstrate backbone, and send a clear set of signals to the organization that you intend to achieve your quality aims, even if the required changes are painful. There are at least five ways in which trustees can send these signals.

- *Attention:* The currency of leadership is attention. If the board reviews the financial performance monthly, but reviews mortality, Adverse Drug Events, and other quality data annually, the organization’s attention is not being channeled toward quality. Your Board can build *Will* by

channeling at least as much attention to the big quality dots as to capital projects and the bottom line.

- *Accountability:* Other than the overall stewardship of the mission of the institution, the four main jobs of the Board are oversight of quality, finances, strategy, and management. Boards can build *Will* by establishing clear accountability for the CEO for achieving quality aims.
- *Resources:* Organizations watch resources, not words, to determine whether you are really serious about your aims. Boards can and do allocate resources, in their approvals of capital and operating budgets. Boards can build *Will* for quality by making sure that you don't flinch at budget time.
- *Policy:* Boards don't usually decide which managers get promoted, and which physicians are appointed to key positions. But Boards can and should establish policies about these things, policies that would help to drive the quality transformation of your hospital. How quickly would your hospital begin to improve its quality if you established the policy that a demonstrated ability to improve quality is an absolute requirement for any candidate for promotion or new appointment? You can build *Will* into your policies.
- *Courage:* As stated above, when organizations start to move your Big Dots, they face resistance. What will hospitals do when the Medical Staff President reports that one of its busiest referrers and admits refuses to adopt the medical staff's recommended best practices, and threatens to leave the hospital? An institution that is undergoing the quality transformation will face many such issues. The Board can establish *Will* by acting steadfastly and courageously in response to these predictable challenges.

*Publicly declare your aims to improve system-level measures:* It isn't enough that your aims be known to your staff, and to your Board. One of the best strategies for sustaining *Will* is to make your commitment public and permanent. CEOs must not only make their aims transparent, but also their performance measures. This might be painful, but it is essential because the pressure of your community citizens is far more powerful as a driver for change in your organization than any exhortations you might make as CEO.

*Define the business case:* Some quality goals are intrinsically valuable in their own right, and need no business case. For example, it makes little sense to spend a lot of effort calculating the business impact of reduced mortality, because if your care system is causing needless deaths, you should reduce them. Period. And everyone inside and outside the organization will understand the importance of that work.

But other improvement activities such as flow management, and waste reduction, and even planned care of chronic diseases, don't always have such an obvious built-in value-driven case. *Will* to improve can be strengthened considerably by making linkages between improvement and financial results. This is especially true when the improvement requires capital investments to facilitate the implementation of significant redesign, or when waste reduction is critical to organizational success. It is good practice to have finance staff engaged on all major improvement activities

*Make a logical, quantitative connection between quality work and key strategic goals:* The single greatest criticism of quality improvement work in health care during the past 15 years is that it has rarely been connected to the strategy of the organization. For example, most organizations have a strategic plan, and a quality plan. There is some overlap between the two, but seldom are they the same plan.

When asked, "What is the one main thing that your organization must accomplish, or your job is in jeopardy?" health care CEOs can usually give a crisp response, with backup details. Typical answers include:

- Grow 15 %
- Reduce costs by \$20 million
- Diversify our patient base so that we can decrease our dependence on government payers
- Return to profitability

The harder question for CEOs is, "Can you describe to your staff, logically and quantifiably, how improvement work such as specific projects in diabetes, asthma, CHF, or flow management is driving you

toward your main strategic imperatives?” If quality improvement is not clearly part of the principal strategies of the organization, it is likely to be thought of as a “nice, but not absolutely necessary” activity, and therefore will be vulnerable to decreased attention and resources when times are tight. The difference between organizations that *increase* their quality work when times are tight, and those that decrease it, is that in the former, quality *is* the strategy.

## **Generate Ideas**

Transformation requires a dramatic depth and breadth of improvement, which cannot be achieved without surprising innovations and designs. It is inconceivable that this level of innovation will be reached without a serious, intentional set of activities designed to expose the organization to a wide range of ideas, and to encourage innovation. Some markers for those activities might be the following:

*Know the best performance in the world:* A simple test of each improvement activity might be these questions, best asked by the CEO: “What is the best performance in the world in this area? Have you visited them? What did you learn?” For example, if your teams are working to improve Adverse Drug Events (ADEs), their creativity and energy (and their aims) would likely be much higher if they knew that 3 hospitals were regularly achieving ADE rates of 0.5 per 1000, compared to usual rates of 5 per 1000.

*Actively seek new ideas:* Idea generation is not passive. You must work at it. The best organizations know that in tight times, they need more, not fewer ideas. So they do two things:

- Ask internal staff the question, “What ideas do you have?” This can not be a token, or patronizing activity. It must be serious, and sustained, and get a lot of attention from senior management.
- Send their people and teams to improvement meetings, inside and outside of health care, all over the world. In short, they aren’t willing to be trapped into the notion that “if it hasn’t been done in health care, in my country, then it isn’t relevant.”

*Develop the ability to try new ideas quickly:* It isn’t enough to learn about your staff’s suggestions, or bring back ideas from a meeting, and put them in a trophy case. You must translate them to your situation, and try them out on a small scale, preferably within a week of learning about them. How else will you be able to process the thousands of ideas you’re going to generate from the above activities? And more important, how else will your staff know that you are serious about your transformational aims?

There is an interesting tension embedded in the ideas issue: trying out staff members’ ideas tends to reinforce the generation of ideas, and becomes self-perpetuating. But there is a limit—not every idea can be tested, and staff might become discouraged if their ideas aren’t chosen for testing. Generally, however, it would appear that most health care organizations are so far from a “ceiling” on either the generation of ideas, or the testing capacity of ideas, that this tension is in most cases a distant concern.

## **Execute Change**

*Use a good change leadership model:* Organizational change on the scale envisioned by “a place where...” does not come about without a common change language, and a sensible approach to leadership of change. John Kotter’s *Leading Change* (Harvard Business School Press, 1996) provides an excellent example of such a model. It seems unlikely that care systems will succeed if their leaders, broadly distributed throughout the organization, are not conversant with, and skilful users of, this or some other change model. A key element of the change model should be the anticipation of, and the design for, spread of good improvements across the organization.

*Use a good improvement model:* Getting to “all” will require that organizations know and use a framework for improvement in order to drive rapid learning, and to achieve spectacular levels of performance. The “Model for Improvement,” as outlined in *The Improvement Guide*, or some equally effective framework, widely understood and deployed, would seem to be an absolute essential for transformation.

*Focus on results:* One of the commonly observable phenomena in hospitals and group practices is a tendency to be satisfied with good effort, even if such efforts have produced tepid results. A marker of

those organizations that will successfully become “a place where...” is that their leaders will have a relentless focus on results, at both process and system levels, and will accept no other measure of performance. Note that “results,” in this context, requires both *scale* and *degree* of improvement. Being satisfied with nice results of the first pilot project, without spread to any other parts of the system, will not get you to “all.”

*Make improvement results a line management responsibility:* Another common problem with the current quality programs in many organizations is that they are just that: programs. This is the natural structural result of having two plans—a strategic/operational plan that is developed, owned and operated by line managers, and a quality plan that is filed in a different file cabinet, owned by the “quality staff,” and pulled out by the CEO from time to time to prepare for Board meetings and JCAHO evaluations. The deep changes in culture, process, and system design envisioned by “all” will not be brought about by staff leaders, no matter how expert. Unless quality results become a line management responsibility, quality will continue to be a nice sidebar in the annual report—a chance to give out some recognition, and for the organization to win some awards—but deep transformation will not result.

*Make sure everyone in the organization knows her part in achieving the strategic aims:* It isn’t enough to integrate quality and strategic planning, and to make quality results the responsibility of line managers. Without every person in the organization working toward the aims of “a place where...,” health care organizations won’t get there. The process of engaging your entire staff, of enrolling them as citizens in the enterprise, depends on your ability to connect the work of each individual to the broad strategic aims of the institution. This must be a conscious, planned effort. It cannot be coercive, and it must be authentic. There are a number of methods by which leaders can accomplish this task. For example, one organization asks each individual to complete a fairly detailed description of the specific work he or she will do during the following year to help the organization accomplish its transformational goals. The process of engaging each individual starts with the CEO, and is “cascaded” through the organization in hundreds of conversations between managers and their direct reports. The result is that each person has had an opportunity to understand the aims of the organization, and consider what he or she can do to help achieve those aims.

Ultimately, it matters less which method of broad enrollment in the vision is used, than that the task be done. If every person in the institution cannot explain her part on the path to “all,” you won’t get there.

*Channel leadership attention to improvement projects:* The currency of leadership is attention. If this is true, then leaders who wish to transform their organizations should channel their attention to the key leverage points for the quality transformation, and use their chosen leverage points well.

Improvement projects are important processes in the overall transformation of institutions. Well-chosen projects, with high aims for improvement, capable project leadership and teamwork, and good organizational support, can raise the standard of care in the project area or department, promote spread throughout the organization, and demonstrate the values and behaviors that will drive the transformation. If a project produces real results—i.e. sustained improvement of a breadth and depth that makes both patients and caregivers notice—it sends a signal that will be heard throughout the organization that quality improvement is not just a sidebar activity. If, on the other hand, projects produce superficial results, or tepid results are over-praised, or those working in projects cannot connect them to overall organizational strategies, this also sends a signal—one that will hinder, rather than accelerate the transformation. For these reasons, projects are key leverage points—high visibility moments—in the long-term transformation process. Health leaders, particularly CEOs, should learn how to channel attention through project reviews and other methods. The “Primer for Executive Reviews of Projects” (available at [www.qualityhealthcare.org](http://www.qualityhealthcare.org)) provides an outline for how to carry out a good review.

Another method of channeling attention is to put senior executives directly on the project teams. Not only can they often break down barriers to implementation and spread of that particular project, but they can also notice barriers in systems such as human resources, information technology, and budgeting, and recommend deep changes in those infrastructural elements that will help hundreds of future projects to succeed.

## Use the Science We Know

Health care executives need to generate Will, Ideas, and Execution in order to make changes in three broad thematic areas. The first theme is “Use the Science We Know,” and this theme covers two broad categories of activities:

1. Use available scientific evidence about what works and what doesn't, so that we design care plans which deliver all the care that will help, and only the care that will help the patient.
2. Use both types of science—the science of medical evidence, and the science of improvement (sometimes called “Low Science” to distinguish it from the classical “High Science” pathway of laboratory research and randomized clinical trials)—to achieve optimal performance. Low Science has more impact on the safe and reliable implementation of care design plans than on the designs themselves.

Both of these categories require massive change in professional cultures. Three essential activities of health care leaders are described below.

*Take intentional action to achieve local change in MD culture: practice the science of medicine as a team, practice the art of medicine as individuals:* A fierce attachment to individual autonomy is the most prominent barrier to reliable use of evidence in care designs throughout health care. While training programs have initiated new programs to instill a new set of professional values, it will be a decade or more before this cultural change is widespread in medicine. If organizations wish to achieve their aggressive aims in a faster time frame, they must actively work on MD autonomy now. The methods by which leaders take on this problem must be customized to the specific cultural features of each organization. One approach is to show physicians how practicing the science of medicine as a team (e.g. by adopting staff-wide standing order sets for common conditions and situations) can actually give them benefits such as less wasted time, fewer hassles, and better results. In essence, they can give up some autonomy for the science of medicine, so that they can get more time to practice the art of medicine. A marker of those organizations slated for success would be an intentional, sustained effort to bring about such changes in MD culture.

*Ensure that administrators and physicians know “Low Science:”* Your organization cannot use the science of improvement if your staff doesn't know it. One indicator of likely success in the transformation to “a place where...” would be the degree to which knowledge and daily use of improvement science is embedded in the work of all administrative and physician leaders. It's hard to imagine getting to “all” without making a significant and sustained investment in this learning.

*Develop and use evidence-based “operating systems:”* A marker of the effectiveness with which organizations are in fact using all the science they know would be the extent to which “operating systems” driven by evidence are in place. This term is intended to provide the clinical operations equivalent of the operating systems inside one's computer—systems that don't have to be turned on—they just happen. An example in clinical terms would be sterile technique in surgery—it doesn't have to be ordered for each patient, and no physician can exercise individual autonomy to ignore or modify this evidence-based practice. The question for health care organizations, and their medical staffs, is “What additional evidence-based operating systems could we add to the list, beyond sterile technique?” This would be an extremely solid indicator of Using all the Science We Know.

## Center Care on the Patient

Many of the features of “a place where...” depend on a deep shift in power, from professionally dominated systems, to a sharing of power with our patients and their families. Three actions should be on the agenda of every CEO, if their organizations are to transform.

*Put patients in the room on care design committees:* We are already learning that patients will have a profound impact on the design of care systems, if their voice is heard, and better yet, if they are in the same



room as the professionals, working as equals, to come up with better designs. Those organizations who have been using this method have noted at least three reasons why this is a good idea:

- When the patient is sitting at the same table as doctors, and nurses, and pharmacists, and CEOs—it tends to stifle self-serving, organization- or profession-centric discussions. Such discussions simply sound unseemly when patients are present.
- Patients experience care across multiple departments, and physicians' offices, and institutions. When patients are in the room, they'll surface the whole system of care, and demand that you cooperate across boundaries to make that system work better for them.
- Patients have innovative ideas. The design of the shared care plan at St. Joseph's PeaceHealth ([www.patientpowered.org](http://www.patientpowered.org)) would never have looked like it does, if patients hadn't stopped the designers and said "No, that's not going to work for us. Let's do it THIS way."

If this is not the norm on your project and design teams, it is unlikely that you will develop "surprising and innovative methods" that drive extraordinary results.

*Develop and use care plans using the patients' goals, not professionals' goals:* Patient-centered designs are meaningless unless the care plans that are implemented for individual patients are driven by those individual patients' personal values, fears, and preferences. Hospitals and clinics will not achieve the aims of "a place where" if this level of patient-centeredness—working on *their* agenda, as well as yours—is not a feature of every improvement plan.

*Place patients on your senior executive team, and on all major policy committees:* The most visible signal of the shift in power from professionals to patients that CEOs could send to the organization would be to put patients in positions of authority, literally, in key policy and leadership groups throughout the organization. This change is not simply symbolic. The presence of "the customer in the room" will alter every conversation, especially those in which you might be tempted to waver from the long-term transformational agenda.

### **Cooperate as a System**

One of the most difficult challenges of health care leaders is to understand their organizations (and their larger communities) as systems, and to work for the optimization of the performance of the system, rather than for the optimization of their part of the system. The CEO's agenda for transformation should probably include the following, if his organization is to become "A place where...."

*Promote a culture of teamwork among physicians and nurses:* What evidence we have suggests that exceptional performance on system-level results such as hospital mortality rates is powerfully influenced by the level of teamwork across professional disciplines, particularly among physicians and nurses. Exceptional teamwork is not a random event. It is modeled at the top of the organization, hired for, promoted for, and held up as a fundamental organizational value. In particular, persistent problems with lack of teamwork must be dealt with visibly, promptly, and unambiguously, if this value is to take root and thrive. There is no question that teamwork, and the building of a culture and values teamwork, must be on the agenda of the successful organization.

*Put patients on your "cross-institutional" working groups:* If dramatic performance improvement is to occur, it will often require cooperation across several organizations in a community—even with competitors. Probably the single most important indicator of whether a multi-organizational effort will succeed in the long term is whether the customer is literally in the room, in all major policy and leadership groups. Self-interest, petty jealousies, and other common dynamics that tend to destroy cooperation are far less likely to be voiced when patients are in the room. Bringing patients into the room, and keeping them there throughout the journey, will be a major indicator of those organizations that are destined to succeed.

*Build containment vessels across your community:* CEOs and Board leaders will need to reach out across many organizational boundaries, in order to design and implement community-wide improvements. What methods might predict success, rather than just an endless succession of frustrating meetings, without results? (This is an experience that is far too common for health executives who have tried to work on community-wide improvement).

One idea is to consider the conscious building of “containment vessels” within which leaders of otherwise independent, wary, and perhaps even hostile organizations can learn together how to resolve problems for their patients. Containment vessels need to be constructed using three ingredients:

1. Authority structures. This poses a particular challenge when no single organization in the community has “plenary” authority over all the others. In other words, cooperation is a voluntary act, unenforceable by any organizational authority. I have found that those communities who appear to be making progress, despite the absence of an overarching authority structure, often have taken the trouble to document their commitment to each other in some way, and have obtained the authorization of their boards to engage in the work of redesign. Even more importantly, the leaders in such communities have sent a strong signal to their managers that cooperation with their counterparts in other organizations is not only desirable, it is necessary.
2. Relationships. The relationships that are built among the key leaders are critical to cooperation. This is a severe challenge when such relationships are strained each year in processes such as negotiation of health plan payment rates in the USA, or “commissioning” by primary care trusts of hospital and specialty services in the UK. Leaders must consciously work at building relationships capable of taking the heat of truly transformational work.
3. Common purpose. It is critical that leaders develop and share a common aim, a vision of what a transformed health care community would look like. Without it, cooperation will break down as leaders work to optimize their own part of the system, rather than the overall system of care across the community. In a way, this last task brings us full circle to where we started in this theory—describing a picture of a transformed community as “A place where....”

(Note: see *Leadership Without Easy Answers*, Ronald Heifetz, Belknap, Cambridge (MA) 1994 for a more complete description of the concept of containment vessels.)

## **Next Steps**

Rather than write a “conclusion,” it seems more appropriate that I describe the next steps in the development of this theory, since this is clearly an ongoing, dynamic process. First, I invite feedback, suggestions, and critical review of the theory from all readers. Where is it helpful? What aspects seem completely off target? What’s missing? Please let me know.

Second, I will continue to build the learning from the Pursuing Perfection work in Europe and the US into the theory, and readers can expect that the next versions of the theory will be different.

At some point, when enough real results have accumulated so that the theory can rest on a more solid platform, I intend to expand this into a book. In the meantime, given that all theories are wrong, but some are useful, I hope that this early version proves useful to leaders who are working on the difficult task of transformation

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