NEJM Catalyst

May 2018

Stories, Strategies, and Solutions in Leadership

A collection of original content from NEJM Catalyst

NEJM GROUP

NEJM Catalyst

May 2018

Dear Colleague,

We are pleased to offer this collection of content from NEJM Catalyst featuring valuable insights, in-depth articles, and selected visuals showcasing innovative ideas in health care leadership from a variety of experts, including our Theme Leaders, Thought Leaders, and NEJM Insights Council.

This collection explores solutions that can be implemented at both the individual and system levels to improve physician learning, organizational culture, and leadership to positively impact health care delivery. We hope it inspires you.

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May 2018

Stories, Strategies, and Solutions in Leadership

Leadership Survey: Why Big Gaps in Organizational Alignment Matter

Insights Report

Stephen Swensen, MD, MMM, FACR & Namita Seth Mohta, MD

Intermountain Healthcare
NEJM Catalyst

Analysis of the NEJM Catalyst Insights Council Survey on Leadership: Providers, Executives, and the Power of Alignment. Qualified executives, clinical leaders, and clinicians may join the Insights Council and share their perspectives on health care delivery transformation.

Advisor Analysis

BY STEPHEN SWENSEN AND NAMITA SETH MOHTA

When people talk about transformation in health care, they tend to focus on the work that needs to be done to move a health care organization forward, such as changing care processes. But that's only half the story. Equally important is an assessment of a team's readiness to take on transformation. And the best gauge of that lies in the question, is everyone in your organization aligned?

When we ask this of NEJM Catalyst Insights Council members — a qualified group of U.S.-based clinical leaders, clinicians, and executives who are directly involved in health care delivery — they return a resounding "no." In our recent Leadership survey, "Providers, Executives, and the Power of Alignment," we observe remarkable gaps in the alignment that respondents consider necessary between key stakeholders and the degree of alignment they perceive within their organizations. For instance, although 91% of respondents say it is extremely or very necessary for frontline clinicians and top executives such as the CEO to be aligned, only 30% consider their own health care organization to be extremely or very aligned among these stakeholders.

These findings from the Insights Council are not an acceptable foundation if you are to successfully transform your organization."

True alignment has numerous positives, not the least of which are better patient outcomes (according to 62% of survey respondents) and organizational stability in a dynamic, changing health care marketplace (56%).

To be clear, we are not conflating alignment with agreement. Not everyone is going to agree with every decision, but they have to understand why certain decisions are made. Our survey results are bleak in this respect — only 21% of respondents say alignment approaches are formally stated in their health care organization, while just under a quarter say the approaches are tacitly understood. Nothing this important should be left unstated.

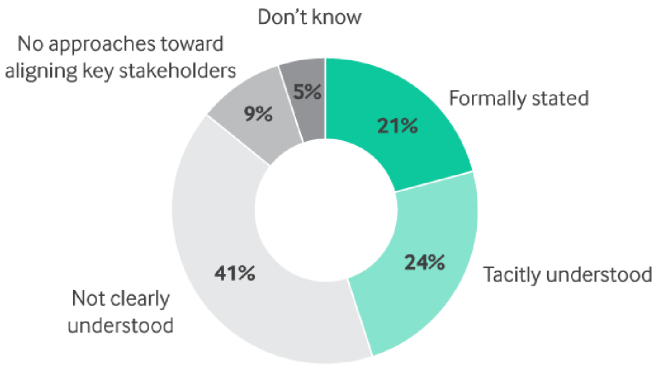
These findings from the Insights Council are not an acceptable foundation if you are to successfully transform your organization.

How to Achieve Alignment

One place to start gaining alignment among key stakeholders is in the definition of the term. The largest share (48%) of our respondents say alignment is achieved when "the organization's mission, vision, and goals are supported by governance, strategy, and incentives." Only 5% label alignment as a "financial model [that] incents providers and executives toward common goals." This result is unsurprising, since the predominant financial models today are not aligned with patients' best interest, physicians' best interest, or even organizations' best interest. There's huge overuse in health care that has at its root a payment system based on more tests and more procedures — a production model that doesn't serve anyone well.

Organizational Alignment Approaches Are Muddled

How transparent are your organization's approaches toward aligning key stakeholders?



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NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

From the Leadership Insights Report: Why Big Gaps in Organizational Alignment Matter.

The next step is figuring out which stakeholders require the most alignment. According to our survey, these are frontline clinicians and clinical leaders such as the Chief Medical Officer; 93% of respondents score their necessity of alignment as extremely or very necessary. At the other end of the spectrum are executives and patients, for which 55% of respondents say alignment between the two is extremely or very necessary.

As you then chart the actual degree of alignment within your own health care organization, in comparison, you'll see what needs to be bridged. In our survey, despite calling alignment between frontline clinicians and clinical leaders a necessity, only 36% of respondents say there is a high degree of alignment in their own organizations. That's an incredible mismatch that must be addressed.

So how can you drive your health care organization toward alignment? We look at it from two different perspectives: within the leadership team, and among the leadership team and clinical providers. For both groups, agreement on vision and strategic plan is most important, according to our survey. Interestingly, Insights Council members find it far more important for administrative leaders to have clinical training/experience than for clinical leaders to have business training/experience. We think this is short-sighted, as new models will require clinical leaders to have business and financial savvy to make the most impact.

"In our survey, despite calling alignment between frontline clinicians and clinical leaders a necessity, only 36% of respondents say there is a high degree of alignment in their own organizations. That's an incredible mismatch that must be addressed."

As you seek to align your own organization, physician compensation models are one place to start. Only a quarter of respondents say physician compensation for employed physicians is extremely or very aligned with organizational strategy, mission, and goals. With so many physicians turning to employment in recent years, the hiring organizations likely expected more alignment in exchange for putting salaries on their books. The situation is even worse with affiliated physicians, where only 10% are highly aligned.

Leaders and clinicians alike must evaluate the degree of alignment at every level of their organizations. Otherwise, as you dive deeper into health care transformation, you will encounter a lot of friction and wasted energy.

VERBATIM COMMENTS FROM SURVEY RESPONDENTS

What single change should your health care organization make to significantly improve provider alignment?

"Address burnout by going to providers to understand their struggles and actively find solutions immediately."

— Clinician at a small nonprofit hospital in the West

"Administration needs to be transparent re: financial challenges, short and long term goals, responsive to physician/clinician concerns."

— Clinician at a small nonprofit hospital in the West

"COMPROMISE. Admin MUST CHANGE their MINDSET to allow willing and able clinical leaders to the real table while clinicians MUST learn to view reform as an OPPORTUNITY to do far better for patients and our profession."

— VP of service line at a large nonprofit health system in the South

"Cultural alignment (values, beliefs, behaviors/processes). Employing providers by a health system constitutes merging two completely different business models. Failure as in most mergers comes from lack of cultural change on both sides. It cannot be the doctor culture or the system culture that prevails. It must be a new culture. Addressing this issue is uncommon if it ever happens."

— VP of a large for-profit community hospital in the South

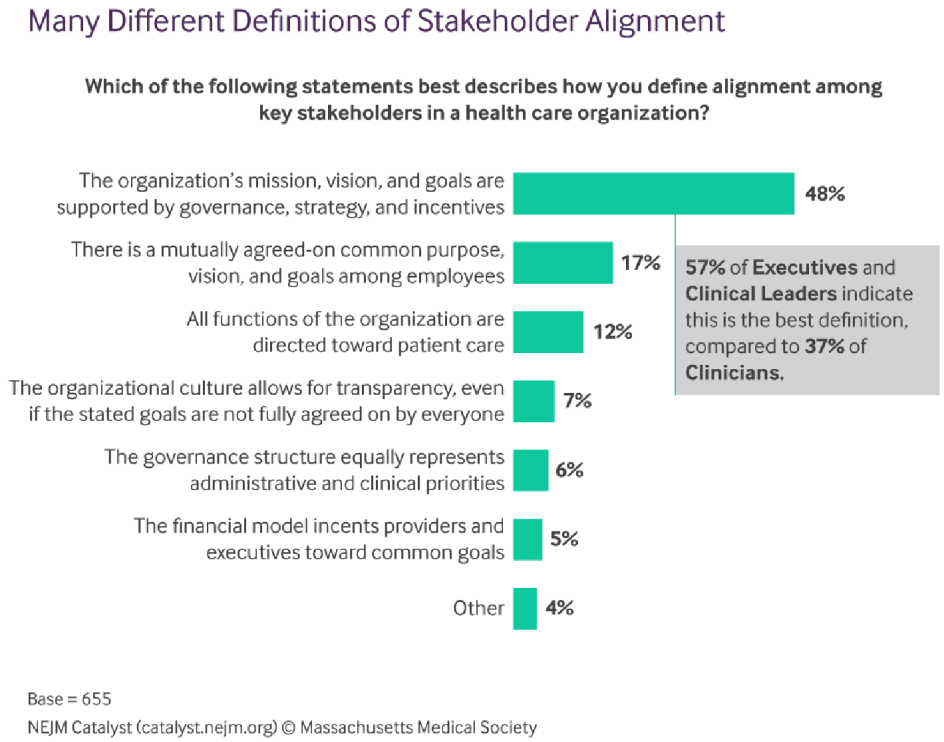
"Leadership opportunities and front line clinical leadership engagement on operational matters that also includes financial metrics."

— Chief of service line at a large nonprofit hospital in the West

Charts and Commentary

BY NEJM CATALYST

In December 2017, we surveyed members of the NEJM Catalyst Insights Council, who comprise U.S.-based clinical leaders, clinicians, and health care executives, about provider-executive alignment. The survey covers the definition of stakeholders' alignment; why organizational alignment is important; the necessity of and degree of alignment among key stakeholders; drivers to improve alignment within the leadership team and among the leadership team and clinical providers; physician compensation alignment with strategy, mission and goals; and the transparency of stakeholder alignment approach. Completed surveys from 655 respondents are included in the analysis.



From the Leadership Insights Report: Why Big Gaps in Organizational Alignment Matter.

With no definitions chosen by more than half of Insights Council members, it is clear they are not in sync on what is meant by health care organization alignment. While 57% of the clinical leaders and executives responding to the survey say alignment is "the organization's mission, vision, and goals . . . supported by governance, strategy, and incentives," only 37% of clinicians choose this definition. More clinicians (17%) than executives (9%) and clinical leaders (7%) say alignment is achieved when "all functions of the organization are directed toward patient care." "The financial model incents providers and executives toward common goals" is scored higher by Council members from for-profit organizations (10%) than those from nonprofits (4%).

Check NEJM Catalyst for monthly Insights Reports not only on Leadership, but also on the New Marketplace, Care Redesign, and Patient Engagement.

Join the NEJM Catalyst Insights Council and contribute to the conversation about health care delivery transformation. Qualified members participate in brief monthly surveys.

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Values-Driven Leadership: A Pathway to Sustained Organizational Success

Article

Jack Gilbert, EdD, FACHE & Barbara Balik, EdD, RN

Arizona State University

As health care CEOs strive to guide their organizations through complex and uncertain times, they face increasing workloads, conflicts between time for care and time to meet regulatory demands, and a sense of loss of control. Burnout is common. Changing payment models make it even more challenging than usual to find a path to positive margins, and many CEOs become preoccupied with that path. However, even though "no margin, no mission" remains as true as it ever was, we believe that it is a mistake to place dominant emphasis on financial performance. Our study of transformational health leaders shows that it is possible to achieve both mission and margin, and avoid burnout, by focusing first on the personal and organizational values that fulfill the Triple Aim of better care, better health, and lower cost. While money is still part of the equation, these leaders keep it in its proper perspective.

One such transformational leader, Sister Mary Jean Ryan, founding CEO and former Chair of multistate system SSM Health, told us, "I worry about finances, capital, and so on. But none of it matters if we can't provide safe care."

> *It is possible to achieve both mission and margin, and avoid burnout, by focusing first on the personal and organizational values that fulfill the Triple Aim of better care, better health, and lower cost."*

We heard this message repeatedly from the 10 CEOs we studied for our book *The Heart of Leadership*. We chose them by polling our contacts, and their contacts, for the names of leaders they considered transformational. The 10 that we chose, all nominated by multiple people, have sustained higher levels of performance than their peers in similar circumstances across a range of measures, including safety, quality, financial health, and public recognition. They came from different kinds and sizes of health care institutions, varied geographies, and a range of backgrounds. By training, four were nurses, three were physicians, and three were non-clinicians. We interviewed them in depth and also spoke to their employees, colleagues, and board members.

We heard the same emphasis on patient-care values even more powerfully from the employees of these organizations. They were just as passionate, committed, and energized as their leaders. All were engaged and felt positive about what they could accomplish together, and they exhibited no signs of burnout.

We were interested in what made these CEOs tick and how they influenced organizational performance. Our interviews showed that they all shared personal values and similar approaches to shaping organizational priorities, culture, and decision-making.

We identified four personal values and five organizational values that all our study subjects share. (The quotes in italics each refer to a different leader.) The personal values are:

1. **Passion for care.** Some of our subjects had been involved in a family member's care, while others had some other type of direct experience with patient care that fired their enthusiasm. Regardless of its origins, these leaders share a personal passion for care that they communicate to those around them: *"The patient matters most to her"; "He is unwavering about the mission — he has a constancy of purpose"; "She has a strong sense of integrity of what's right for patients — she lives and breathes it."*

2. **Hunger for learning and reflection.** These leaders are intelligent, eager for learning, and able to find time to be reflective. They see these priorities as an essential part of their responsibility: *"She continues to expand her personal management toolkit and inspires me to do the same"; "He is a tremendous learner and listener"; "She has a great capacity to integrate information — a student of leadership."*

3. **Authenticity.** These leaders' words match their actions and are marked by authenticity and humility: "'I'm here because of you' is a quote from the CEO to all staff after a major national presentation"; *"She is impeccably true to her words — she is a servant leader"; "I trust him with any decision because he will always do the right thing for patients, the business, employees — and he will not accept otherwise."*

4. **Genuine interest in people.** It is obvious to employees and colleagues that these leaders care about them and trust them: *"There's a 'thereness' when she's with others. She will swivel her chair, move in, and doesn't look at her computer while listening"; "He has a desire to be with and around people to hear what is important to them, what they need."*

The organizational values are:

1. **Relentless patient focus.** The CEOs' personal passion for care translates into an unusually tenacious patient focus in their organizations. This focus drives the organization's strategies and goals: *"She is not distracted by the crisis of the day; she doesn't jump around or vacillate"; "Our strategic plan is alive and well. What is best for the patient? What will make a perfect experience for the patient?"*

2. **Constant drive to improve.** Though these leaders, like all of us, face trying circumstances, they aim high and consistently challenge the status quo: "We can always be better. She's always asking, *'What's the next best?'"; "Restless discontent — he is always looking for bigger impact. 'How can we better serve our community and fulfill our vision and mission?'"; "She thinks above and outside the moment. She frames a more powerful view that offers more daylight."*

3. **Enterprise-wide engagement.** These leaders seek to engage everyone in the organization and make them feel like part of the team. They believe that those closer to the work know best how to make changes that support the organization's goals. This philosophy stems naturally from their care of and trust in others: *"He believes in the wisdom of employees and asks them to be the architects of change"; "There are [people] you'll run into a brick wall for. . . . She's one of those people"; "She has the ability to make people belong and matter and want to work hard for themselves and the institution."*

4. **Team orientation.** Though these leaders acknowledge their full accountability for all decisions, they do not see themselves as "the" decision maker but as a part of the team and part of the solution: *"The toughest decisions are never made hastily or alone — he ensures that others are heard"; "He seeks advice from others and you can see your thoughts reflected in the outcome — he believes you get the best thinking when you get the positives and negatives of a decision"; "She recognizes when the team needs to do the work — she trusts in the team to find the answer."*

5. **A culture of mentorship.** These leaders take great satisfaction in growing others, and consider mentoring an important part of their leadership obligations: *"She finds out what is good in people, exposes it, grows it, and helps you master it in pursuit of the group goal"; "She hired me with no hospital operations experience — she said she was looking for leadership skills and that operations could be taught."*

Particularly in tumultuous times, transformational leaders can bring sustained success to their organizations, fueled by the clarity of their personal and organizational values. "There is a hierarchy: patient, organization, department, individual — all important and in that order," says Gary Kaplan, MD, Chairman and CEO of the Virginia Mason Health System.

> *I worry about finances, capital, and so on. But none of it matters if we can't provide safe care."*

"That hierarchy is now reflected in our strategic plan. That True North has helped guide me and given me resilience in terms of dealing with tough issues. At the end of the day we have to do what's best for patients — they are at the top."

Patricia Gabow, MD, long-time CEO and Medical Director of Denver Health and Hospital Authority, and now a trustee of the Robert Wood Johnson Foundation, adds, "We were determined to raise the bar. We had a commitment to accountability, to adult behavior. And we were determined that those not aligned with the vision would not continue to work here."

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Taking Health Care Governance to the Next Level

Article

Peter J. Pronovost, MD, PhD, C. Michael Armstrong, LHD, Renee Demski, MSW, MBA, Ronald R. Peterson, MHA & Paul B. Rothman, MD

Johns Hopkins Medicine

High levels of preventable harm, poor patient experience, and excess costs permeate our health care industry despite ambitious mission statements to improve patient safety or be the world leader in quality of health care. One reason for these undesirable outcomes is the underdeveloped state of accountability in health care. In most organizations outside health care, the Board of Trustees (or Directors) assumes ultimate accountability for performance. This is rarely the case in health care, where boards have traditionally fixated on financial performance and delegated quality of patient care to the medical staff, often with limited board oversight.

> *If health care is to improve, it will need to ensure the board takes a more systematic and disciplined approach to ensuring quality and patient safety."*

Health care organizations are starting to engage their boards in quality. Many health systems have sought to get "boards on board," encouraging boards to list safety first on the board agenda and to open the board meeting with a story. Though an important start, these efforts can be superficial and will likely do little to improve accountability and provision of care, or to prevent patient harm. Stories are important to engage the heart and spark a lasting memory; yet results matter and boards need to hold health care managers accountable for quality care. While being first on the agenda may signal relative importance, it is paramount that boards create and exercise disciplined processes to monitor performance and ensure accountability, just as they do for financial performance. If health care is to improve, it will need to ensure the board takes a more systematic and disciplined approach to ensuring quality and patient safety.

We recognized that if we were to address health care's ills, namely, to end preventable harm and improve value, we needed to evolve from viewing quality as a project to viewing it as a disciplined and integrated management system with robust governance."

At Johns Hopkins Medicine (JHM), we recognized that if we were to address health care's ills, namely, to end preventable harm and improve value, we needed to evolve from viewing quality as a project to viewing it as a disciplined and integrated management system with robust governance. We sought to ensure that the board quality committee functioned with the same rigor as the board finance committee.

Board finance committees offer a prototype for board quality committees. Board finance committees are disciplined and sticklers for accountability. Despite complex organizational structures in health systems, finance committees oversee every dollar spent and received, and organize this information into a consolidated financial statement. Finance and external auditors routinely review the integrity of their data and ensure systems are in place, such as internal controls and accountability, to deliver accuracy. They have leaders at every level of the organization, from the board to the bedside, who are responsible for financial oversight and transparent reporting. The longer financial targets are missed, the more intense the oversight. Unlike performance on quality goals, months of missing financial goals are not tolerated, and financial misses are addressed with clear improvement plans and frequent monitoring until performance improves.

Strategies to Govern Quality

Strategy	How To
Organization-wide agreement on purpose	Leaders commit to elimination of preventable harm and excellence of patient care.
Map delivery system from Board to bedside	Draw an organization chart of your health system care delivery areas (e.g., inpatient hospital, ambulatory care). Assign a leader to oversee quality for each area.
Align quality work with common framework	Develop a common framework to drive quality work and communicate it to all quality leaders. Johns Hopkins Medicine framework: • Internal risks to patient safety (e.g., culture of blame) • Externally reported measures • Patient experience • Value • Health care equity
Map your quality metrics to remove islands of quality	Examine every place where care is delivered. Ensure standard quality metrics are collected and data reported up through the organization (see Figure).
Ensure integrity of quality data	Ensure that someone is monitoring data accuracy and submitting quarterly audit reports. Expand the role of the financial audit committee to include auditing of quality data.
Make performance transparent	Share quality performance internally with those doing the work and externally with other stakeholders. Report methods used for measures.
Create shared accountability	Higher level leaders give lower level leaders tools to succeed: • Communicate goals and role • Provide resources • Ensure they have quality-related skills • Feedback performance Explicitly define escalating levels of oversight for longer time periods when an area misses its quality goals. After three reporting periods, area is audited and presented to the quality board committee.
Maintain focus on operations	Establish a patient safety and quality subcommittee to handle the operational details. Have representation from board to bedside on subcommittee.

Source: Authors

At JHM we used several strategies to ensure that our board quality committee functioned with the same rigor as the board finance committee. The accompanying table outlines the strategies JHM used to govern quality and offers how to apply these strategies. First, we mapped the entire delivery system into our seven overarching areas of care — inpatient hospitals, ambulatory practices, ambulatory procedures, home care, pediatrics, managed care, and international — and appointed an accountable leader for each area. Also, any organization we purchase or partner with in the future has to be part of this governance system. Then, we meet with the accountable leaders and align all quality-related work along five domains: patient safety, which includes internal risks to patient safety; performance on externally reported quality measures; patient experience; value; and health care equity. A lesson we learned is to not let our focus on the hundreds of measures we must externally report distract us from what clinicians often perceive as the greater risks, which are internal risks, such as a culture that silences rather than supports speaking up about patient safety concerns.

> *"Unlike performance on quality goals, months of missing financial goals are not tolerated, and financial misses are addressed with clear improvement plans and frequent monitoring until performance improves."*

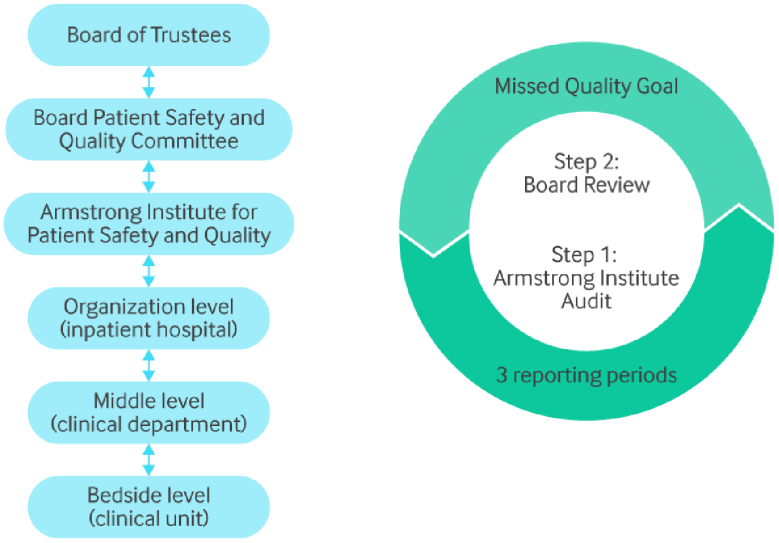
One exercise we conducted started at the bedside in both our hospitals and home care encounters and examined whether all areas and types of care had collected quality measures and reported their data to a higher leadership level. Also, we checked to see whether these data ultimately made it to the board quality committee. Through this exercise, we discovered many islands of quality. In places where quality was either not being measured or was being measured but not reported meant that there was no accountability.

For example, pediatric surgery measures were not reported by the surgery department because they were pediatric patients and were not reported by the pediatrics department because they were surgery patients. This exercise was a valuable approach to identify and eliminate many islands of marooned quality data. We also uncovered that some of the data for our quality measures were of variable quality and implemented internal controls and audits to improve the quality of the data.

> *A lesson we learned is to not let our focus on the hundreds of measures we must externally report distract us from what clinicians often perceive as the greater risks, which are internal risks, such as a culture that silences rather than supports speaking up about patient safety concerns."*

We created a consolidated quality statement that mirrored the finance committee's consolidated statement. Because quality measures vary widely by type of care, we generated separate consolidated statements for the seven areas. Some measures are common across most areas, such as patient experience and preventable health care–acquired infections. A sampling of differences in what some areas measure are emergency department wait times (inpatient hospitals), utilization of health care services (ambulatory practices), use of surgery checklists (ambulatory procedures), process measures for pressure ulcer prevention (home care), and Medicare Advantage star ratings (managed care). Pediatrics and international may measure similar things, such as hand hygiene and infections, but these are very different patient populations. These statements are presented by the president of the entity (e.g., a hospital) at the board quality committee meeting and presented by the JHM Senior Vice President for Patient Safety and Quality at the JHM full board meeting, mirroring the presentation of the consolidated financial statements.

Johns Hopkins Medicine Governance Structure and Accountability Process with Inpatient Hospital Area Example



Source: Authors

Finally, we explicitly defined an accountability plan in which the longer an area misses its quality goals, the greater the degree of oversight. The figure illustrates that after three reporting periods, the area (in this case an inpatient hospital) is audited by the Armstrong Institute for Patient Safety and Quality (the entity that links to the quality board committee and manages quality for Johns Hopkins Medicine) and findings are presented to the board quality committee to explore why quality performance is low and what could be done to improve it. Embedded in this approach is the concept of shared accountability, which means the higher levels of the organization need to hold themselves accountable for giving the lower-level leaders the tools to help them succeed before they can hold a lower-level leader accountable. The tools that lower-level leaders need are knowledge of the goals and their role, performance feedback, the skills, resources, and time for improvement, and regular meetings with the higher-level leader to review performance.

Good governance matters, yet it is too often inconsistent in health care systems. Health care needs to mature their governance by moving the Board of Trustees beyond storytelling and putting safety first on the agenda. A quality board committee can help govern quality if it functions with the rigor as the governance applied by finance committees.

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Action Learning–Based Leadership Development at an Academic Medical Center

Article

Ji Yun Kang, PhD, Mary Ann Djonne, MEd & Joslyn Vaught

Mayo Clinic

Today's health care leaders are tasked with significant challenges in how they deliver patient care and manage the workforce. These challenges have highlighted the need for leadership-development training to enable physicians to transform how health care organizations function. The competencies that are required for a physician to be an effective leader have evolved substantially over the past decade in accordance with a growing view of health care as a complex adaptive system. However, competency-based training in the form of classroom lectures, role modelling, hypothetical practice scenarios, and self-help activities are not sufficient to develop physicians to lead the future of the complex health care industry.

> *"While most leadership-development programs focus on leadership characteristics only, action-learning scholars have come to discover the value of designing programs that recognize the context in which the leaders perform."*

In the current environment of complexity and uncertainty, a different approach is needed. Action learning is a leadership-development process in which small groups work on real-world organizational business problems. As part of this process, individuals and teams reflect on their own work in a supportive environment in which a balance of action and learning is key. While most leadership-development programs focus on leadership characteristics only, action-learning scholars have come to discover the value of designing programs that recognize the context in which the leaders perform. Questioning, reflecting, and listening promote exploration and creativity among team members, thereby generating innovative solutions. Learning happens as an iterative cycle of action-learning-action-learning, and coaching is necessary to guide the group members in reflecting on how they are approaching the problem.

Action learning has been shown to improve broad executive and managerial leadership skills as well as the ability to develop integrative, win-win solutions to challenging situations. As such, it can be an excellent solution to help leaders navigate through the adaptive challenges currently facing health care organizations.

The "Fresh Eyes" Program at Mayo Clinic: A Case Study

In September 2015, Mayo Clinic embarked on an action-learning program called "Fresh Eyes" involving a group of 30 participants comprising physicians, scientists, administrators, and nursing leaders in the leadership succession talent pool. The program objectives were to develop strategic thinkers who would be able to effectively lead in the VUCA (volatile, uncertain, complex, and ambiguous) world of the health care industry.

Program Structure

The program was structured as a 6-month process that started with a 2-day face-to-face kickoff, three subsequent video conference meetings, and a 1-day report-out at the end of the program. Participants were assigned to one of six multidisciplinary teams that were intentionally designed to maximize diversity in terms of roles, functional areas, geographical sites and regions, gender, and ethnicity. Each team was assigned a project that required its members to address a key business challenge related to such topics as physician referrals, test utilization, patient access, integrative medicine, and so on. The team projects were selected by institutional leaders in clinical practice, research, and education based on organizational strategic priorities.

> *Team members were expected to bring a 'fresh eye' perspective that could shine a new light on topics that were both important and challenging for the organization."*

The projects and teams were chosen so that most of the program participants had very limited knowledge of and experience with the subject matter. Team members were thus expected to bring a "fresh eye" perspective that could shine a new light on topics that were both important and challenging for the organization. Each team was assigned two executive sponsors and two project sponsors whose role was to guide the team to information and resources without providing too much direction. Each team was also assigned a team coach whose role was to engage the teams in deliberate reflection for facilitated learning and to meet with the team members on a one-on-one basis to help them to achieve their individual learning goals. The final deliverables were a business plan and a 20-minute presentation to all Fresh Eyes participants and sponsors.

Learning to Work as a Team

Once the projects had been assigned, the team members met as a group once a week or every other week, gathered data and information on the topic; asked each other critical, reflective questions; and moved quickly to propose plans within the given time frame while learning how to work together as a highly functioning team. Thus, the program created a sense of urgency to move forward by letting go of the need to have all information before making decisions.

As the teams had no assigned leader, each team had to identify one or more leaders whose role was to clarify the roles of the various team members and to move them toward the achievement of a common goal. The team leaders had to gauge intuitively how much to step in or step back in group interactions. In the process, the leaders learned to listen to other team members and incorporate their perspectives by acknowledging that there are multiple ways to view a single problem, depending on each member's role, type of practice, or level of knowledge in the subject matter. This was an important part of leadership development because Mayo Clinic is unique in its dyad/triad leadership model in which physicians partner with their administrative and nursing leaders, and the physician participants had to learn how to best leverage the wide range of organizational and business knowledge that their administrative counterparts brought to the project.

> *"The Fresh Eyes action-learning program 'forced' participants to network and to collaborate with team members in ways that would not otherwise have occurred to them."*

During the team meetings, the team coach engaged participants in reflections to question their habitual thinking to expand the range of their consciousness. The coaches challenged the participants to be in their discomfort zone, where actual learning occurs, by asking reflective questions such as "What did I experience?" "What are my reflections?" and "What did I learn?"

One of the main challenges was setting aside time to work on team projects. There was a clear concern among participants at the start of the program about doing project work in the midst of their busy schedules. To find a time that worked for all members, some teams met early in the morning before work or late in the evening despite having to accommodate individuals in three time zones.

Presentation and Implementation of Business Proposals

All business proposals were presented to the sponsors during the report-out portion of the program. Teams were also asked to present their proposals in executive team meetings, committee meetings, and department meetings. Six months after completion, a follow-up email was sent to all project sponsors for updates on the status of the implementation. We

found that some short-term recommendations had been implemented, sub-projects had been identified and were underway, and many participants had expressed interest in taking part in the implementation phase.

Impact of Program

The impact of the program was studied with use of a qualitative case-study method after the completion of the program. Twelve physicians in various specialties who took part in the program agreed to participate in semi-structured interviews, which were recorded and transcribed. The list of the categories in which the program contributed to learning are listed in Table I, and sample testimonials from the participants are provided in Table II.

Learning Categories

Categories	Sub-Categories
Leadership	• Dealing with complexity/uncertainty • Creativity and out-of-the-box thinking • Meeting facilitation • Being open to different perspectives/listening to others • Letting go of control • Expanded perspectives • Team leadership • Business knowledge • Being out of the comfort zone • Strengthening leadership identity • Moving from task orientation to relationship orientation
Team Development	• Working with team members across site/department/function • Physician/Administrator partnership • Leveraging diversity • Building a virtual team • Relationship building
Organizational knowledge	• Enterprise-level thinking • Inefficiency/redundancy of multiple groups working on the same problem
Problem-solving	• Identifying/scoping the problem • Learning how to learn as a team • Collective decision-making • Information and data-gathering • Creating sense of urgency
Coaching and reflection	• Value of reflection • Asking critical questions
Motivators	• Value of working on a real-world institutional problem • Making time for meaningful work • Forming an enterprise network • Executive and project sponsors
Challenges	• Time constraints • Logistical challenges • Lack of structure • Lack of resources

Source: Authors

Table I.

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Sample Testimonials From Participants

As we started to dig into our business challenge, we found that there were 5 different groups enterprise-wide that were working on the same thing, and literally no one knew what the other was doing. So we became the "de facto" group that pooled the information from all of these different groups and presented it in one composite, so that each group would be aware of, and learn from, what other groups were doing.

Variety of perspective is valuable...in group activity, everyone was asked to see the world in different way from their own viewpoint. In surgical practice, we don't see things from multiple perspectives. Something that might seem wonderful to you might seem totally different to others.

Really, the impetus was that Fresh Eyes really forced us. We were told, "Here's your deadline, so you better figure it out quickly." Which is consistent with real life, actually.

I learned to slow down and not be purely task-oriented, to be reflective, and to listen to what others wanted to accomplish, instead of staying focused on getting the job done. Approaching work in this way didn't feel natural to me. This is not what I would have normally done.

The program gave me the skills and strategies for working effectively with individuals across the enterprise. I came to realize how hard it actually is to successfully collaborate with people from different areas. Each member of the group, no matter where they were from, felt like they were a valid member of the team.

Project work was a little bit like doing a jigsaw puzzle. At first, none of the pieces were fitting properly. About one third or half way into the program, I felt, 'Oh, I know where this is going." It was late in the process. We stumbled along the way.

The program absolutely increased my level of engagement in the organization. I have always seen myself as a worker, not a leader, and this was an eye-opener of myself as a leader.

Source: Authors

Table II.

Action Learning: Developing Creative Solutions to Complex Organizational Challenges

Health care organizations are a complex compilation of many different micro-environments. Physician leaders tend to view the world through the lens of their specialty, which has been formed through many years of training and practice, and usually have limited venues for exchanging ideas outside of their area of expertise. Those in leadership positions should understand that what seems to be true may evolve when viewed from a different perspective that they might not have considered.

> *The coaches challenged the participants to be in their discomfort zone, where actual learning occurs, by asking reflective questions such as 'What did I experience?' 'What are my reflections?' and 'What did I learn?'"*

We found that the Fresh Eyes action-learning program "forced" participants to network and to collaborate with team members in ways that would not otherwise have occurred to them. During the course of the program, participants had the opportunity to talk about the guiding values and principles of the organization. Some physicians confessed that they initially felt uncomfortable having to share their individual development goals and engage in open reflection with people they did not know, but they also noted that they eventually became more comfortable as the team members built a level of trust with one another.

The business proposals that resulted from the project were a testament to how much they could accomplish with sense of urgency, teamwork, and commitment. At the end of the program, the participants were amazed at how they could create proposals for seemingly daunting topics within such a limited time frame, with limited resources, and with team members whom they hardly knew.

We found that the Fresh Eyes program successfully achieved a balance of learning and action by stimulating the team members to engage in enterprise-level thinking, to learn how to collaborate as an effective team, and to develop specific proposals designed to improve organizational performance.

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The Importance of Leadership to Organizational Success

Article

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Leadership is an oft-used and sometimes nebulous term, particularly in the field of health care. Although leadership is not traditionally taught in medical schools, physicians possess many qualities that are needed to excel at leadership. For example, medicine requires critical thinking skills that are analogous to those required for effective leadership, such as assessing complex problems, formulating diagnoses, and generating action plans.

> *For leadership to be effective, it must be built on a solid foundation consisting of a clear mission, a vision for the future, a specific strategy, and a culture conducive to success."*

As a result, health care organizations are increasingly recognizing the importance of engaging physicians in their leadership teams, and this engagement will become even more important as the health care environment becomes more challenging. For physicians, leadership can provide an opportunity to strengthen their organizations and positively impact the lives of thousands of people. In this context, what does leadership mean, what are its attributes, and what tools do physician leaders have at their disposal?

Foundations of Leadership

A simple definition of *leadership* is the ability and willingness to take ownership of the organization (or the component of the organization that one is charged with managing), combined with an intrinsic drive to do what is best for the organization. However, for leadership to be effective, it must be built on a solid foundation consisting of a clear mission, a vision for the future, a specific strategy, and a culture conducive to success. New leaders need to understand that these concepts are essential for effectiveness and personal growth.

- **Mission.** Simply put, the *mission* is the reason that an organization exists. For a hospital, the likely mission is to provide high-quality and compassionate medical care. For an academic health center, the mission may be expanded to include producing new knowledge and training the next generation. Having a clear sense of mission is crucial for guiding leadership decisions and choosing between alternatives.

- **Vision.** *Vision* is a conceptualization of a future, and hopefully better, state toward which the leader navigates the organization. Vision should be systematically formulated on the basis of an analysis of demographic trends, scientific advances, and technological innovations in the field. For example, in the field of cardiology, an aging population with an increasing prevalence of calcific aortic stenosis, coupled with innovations in transcatheter aortic valve replacement (TAVR), should motivate a prescient leader to prepare for the introduction of this new technology into the practice and to consider its secondary consequences on surgical volumes, staffing needs, and hospital finances and facilities.

- **Strategy and Tactics.** *Strategy* refers to the plans that the organization follows in order to be successful and competitive, whereas *tactics* refer to the specific steps that the organization takes to achieve and implement the strategy. In other words, strategy is what an organization will do to succeed and compete in its competitive space. A tertiary care hospital (e.g., the Mayo Clinic) may aspire to be the preferred national referral center for complex diseases. The strategy that it follows to achieve this vision may include developing a team of nationally renowned physicians who work in a multidisciplinary manner and broadly developing its reputation (brand). The tactics it may use to achieve this goal may include providing advanced training for its teams, developing cutting-edge treatments, demonstrating the best quality metrics, improving patient experience, and publishing its outcomes, among others.

- **Organizational Culture.** *Organizational culture* is a crucial component that leaders must understand to achieve maximum effectiveness. The best leaders positively impact long-term organizational culture and values through self-modeling of behaviors, creating cultural expectations, and formally communicating cultural expectations. For example, an expectation of maintaining and professing mutual respect at all times can be set and demonstrated by leadership, even in difficult situations. Effectively responding to instances of a breakdown in mutual respect, rather than letting them go unaddressed, are critically important in further solidifying a positive organizational culture.

Leadership Skills and Attributes

In addition to cultivating a conducive environment that is built on a strong foundation, effective leaders must exhibit specific skills and attributes to achieve the goals of the organization. These traits include excellent communication skills, empathy and emotional intelligence, team-building skills, an understanding of the competitive landscape, strategic thinking, and courage, although this list is by no means exhaustive.

- **Communication Skills.** The most important (some would argue the only) tool that leaders possess is communication. Effective communication ensures understanding and is not the same as simply sending out messages or emails. Communication is a two-way interaction, and the ability for the leader to listen is critical. Leaders should practice active listening, rather than just being quiet while others speak. A simple but effective way to practice active listening is to take mental notes while others are speaking or communicating. With time, a leader can become very adept at this skill and others will notice that the leader is actually paying attention. Being heard is important to others, even if final decisions are not what was initially requested.

- **Empathy and Emotional Intelligence.** Empathy and emotional intelligence are key leadership traits that frequently are overlooked. Leaders regularly are called upon to deal with challenging and, at times, unpleasant situations (e.g., conflict situations, crucial conversations, and some annual performance reviews). Having a high degree of emotional intelligence will enable the leader to deal with such situations effectively and objectively while not avoiding the underlying issues. It is important to note that emotional intelligence is a skill like any other and can be developed with practice and coaching. Similarly, an empathic leader who can sense how others feel will be a much more effective communicator and team builder and will be more likely to effectively manage change. Interestingly, this same trait is critical to developing the patient-physician relationship.

- **Team-Building Skills.** The most effective teams (e.g., President Lincoln's "team of rivals") include talented individuals with complementary areas of expertise who are comfortable expressing their opinions. It is the responsibility of the leader not to dominate the conversation and to ensure that teams feel safe speaking up. The effective leader trusts the team members, challenges them, and lets them handle difficult situations. When difficult decisions are required, leaders and their teams will require a high degree of emotional intelligence and courage to make the right decisions for the organization, even if doing so presents challenges in the short term. Courage in leadership is yet another skill that can be developed with practice over time. What is required is a commitment to fairness, transparency, and doing the right thing.

Cultivating Leadership Skills Over Time

Leadership skills are grown over time in a progressive fashion. At the start of one's career, an individual typically works in a technical area and distinguishes himself or herself through technical expertise, outcomes, and innovation. For example, a cardiac surgeon may distinguish himself or herself on successful outcomes, a low mortality rate, and the introduction of new procedures.

"It is important to recognize that leadership skills, like any other type of skill, can be learned and improved.... More challenging, however, is the development of the personal attributes that are necessary for effective leadership."

The next level of leadership is operational. At that level, the individual (e.g., a hospital echocardiography lab director), will gain financial and operational knowledge and quantitative skills (such as understanding costs) that are relevant to the role. If the individual excels at that level, he or she may be tapped to undertake higher-level roles that are more strategic in nature.

A senior leader will be required to understand the competitive environment, macroeconomic trends affecting the practice of medicine, and upcoming regulatory changes. In addition, a strategic leader will need to keep a constant eye on the competition. Positioning the organization for success in a rapidly changing environment with fast-moving competitors is one of the primary responsibilities of the senior strategic leader.

Learning, Improving, and Practicing Leadership Skills

It is important to recognize that leadership skills, like any other type of skill, can be learned and improved. The knowledge-based components of a skill, such as finance or accounting, can be acquired readily in class, online, or with self-directed learning. More challenging, however, is the development of the personal attributes that are necessary for effective leadership. Feedback is a key tool in the development of these attributes. The most common, but sometimes least effective, form of feedback is the annual performance review. More effective methods are structured 360-degree evaluations (which provide the opportunity for honest and frank feedback) and coaching (which can be used to establish and execute individualized developmental plans).

> *Practicing leadership is as much an art as it is a discipline."*

Practicing leadership is as much an art as it is a discipline. A common mistake is for leaders to get too involved in day-to-day operational issues, thereby taking their eyes off the ball and potentially missing new opportunities or emerging threats to the organization. With a team-based mindset, the goal of the leader should not be to make the best decisions for the organization, but rather to ensure that the best decisions *are being made* at all levels. A leader who attempts to make all the decisions will inevitably fail as it is impossible for one individual to be correct all the time. A leader with an engaged team will benefit from a more diverse analysis of challenging situations and will be more likely to make the right call. Team-building, empowerment, and trust with a willingness to listen to suggestions with an open mind are signs of prescient leadership.

Leadership During Constant Change

Because organizations and their environments constantly change, one of the core responsibilities of leaders is initiating and managing the internal changes necessary to adapt to changing circumstances. A thorough discussion on managing change is beyond the scope of this essay; however, it is likely true that without initiating change, one is merely managing and not leading. The ability to effectively institute positive change will stretch and challenge even the best leaders. The attributes discussed above are critical to this process.

Great organizations require great leaders, and the best organizations understand that cultivating leadership skills should be intentional and not left to chance.

THE SHIP MODEL OF LEADERSHIP

A ship can be used as a conceptual model to illustrate several concepts related to organizational behavior and leadership. In this model, the organization may be conceived of as a ship carrying its payload (products or services) to its future destination (vision) through waters (the competitive environment) that at times may be still and at other times may be very choppy (uncertainty, decreasing reimbursements) or may even have icebergs (massive changes in the regulatory environment). It is the responsibility of the leader to be aware of the macroeconomic, government, and regulatory trends that can put the organization at risk and to position the organization not just to avoid these icebergs but to thrive in the future environment. Other ships (competitors) will be engaged in the same enterprise and will compete for the same customers and resources. The leader should have a clear view of the future, the competitive environment, and the direct competitors and should have contingency plans in place to deal with unanticipated events (icebergs). Thus, the primary responsibility of the captain is to chart a pathway through the waters to reach the goal.

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THE SHIP MODEL OF LEADERSHIP (CONTINUED)

In this model, the strategy may be for the ship to go faster and be more maneuverable than its competitors. Tactically, the captain or executive officer will have to determine how the oars will be pulled faster, harder, and more efficiently; how its sails will be trimmed for maximum efficiency; and even how to shed deadwood. If the strategy is implemented successfully, the ship will beat its competitors to the goal, will provide value to its customers, and may be able to charge a premium price for that service. It is important to note that the development of a strategy includes defining what an organization will not do. For example, another potential strategy may be for the ship to be a very large, but slower, purveyor of goods and services. This strategy would enable it to charge low prices but still be profitable. This strategy can work, but it is distinct from the strategy of being fast and maneuverable. In business, it is very difficult for an organization to simultaneously be the low-cost provider and the premium provider. Similarly, in health care, it can be extremely difficult for one organization to master community-based population health as well as resource-intensive destination care simultaneously, unless it is extremely intentional about implementation. Finally, for effective strategy development, a comprehensive understanding of the organization's core competencies and capabilities (e.g., how fast and how efficiently the crew can pull the oars) is critical. Internal expertise, talent, and capabilities will determine what type of strategy can be considered.

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Five Changes Great Leaders Make to Develop an Improvement Culture

Article

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Optimizing leadership skills is more important than ever, given a fast-changing health care environment rife with competitive new services such as CVS MinuteClinics, virtual second-opinion specialty shops, and offshore 24-hour radiology reading services. To adapt, and survive, organizations must take advantage of every bit of institutional talent. But this can happen only if leaders first embrace the need to change.

> *"The qualities of willingness, humility, curiosity, perseverance, and self-discipline have long been leveraged by innovative industries worldwide, yet the health care industry has been slow to catch up."*

But in what ways should a leader change? Many books and scholarly articles describe strategies for leadership improvement. For example, the Lominger Group identified more than 30 key behavioral traits required for outstanding leadership, including "political savvy" and "dealing with ambiguity." At Catalysis, we have distilled important leadership qualities down to five key behavioral dimensions that, together, are essential for fostering a culture of continuous improvement: willingness, humility, curiosity, perseverance, and self-discipline.

Our work with health care leaders has shown us that cultivating these five areas can help improve health system performance. Institutions seeing positive results include St. Mary's General Hospital in Kitchener, Ontario; UMass Memorial Health Care in Worcester; and Zuckerberg San Francisco General Hospital, for which we will present a case study. But first we present our ongoing work with health care leaders.

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The Making of a Continuous Improvement Leader

In 2014, Catalysis invited 40 health care CEOs from across North America to participate in a CEO summit. We organized the leaders into two manageable cohorts, each of which uses a common set of principles and encourages behaviors that build long-term sustainable management systems. Leaders meet twice yearly for half-day learning sessions on such topics as establishing leader standards for supporting frontline workers and developing strategies for understanding customer needs.

The groups achieve common learning objectives through activities based on principles for developing operational excellence. However, the most powerful learning occurs when peers work together, sharing candid stories about personal behavioral change. This open environment of trust allows executives to build strong relationships, including a "buddy" system for tackling topics impossible to discuss within one's organization.

Becoming a continuous improvement leader takes coaching and plenty of practice. Participants become better leaders by 'acting their way into thinking.'"

Becoming a continuous improvement leader takes coaching and plenty of practice. Participants become better leaders by "acting their way into thinking," and our faculty designs opportunities for practice. For example, participants might work together in groups of three on a real-world problem they are facing at their organizations. One person observes, one asks questions, and one answers questions. The learning power comes from the feedback each receives from their peers. Everyone rotates through the three stations to experience each role.

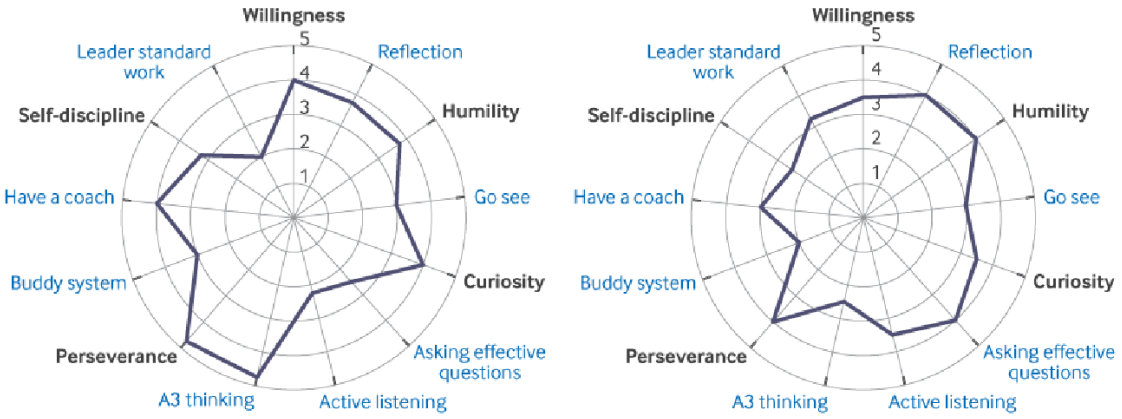
Participants are also coached on actively listening and asking effective, open-ended questions, the latter a reinforcing behavior important to successful cultural change. Back home, they are encouraged to enlist others to observe their daily interactions. Above all, they continuously build on their learning and dare to experiment.

During the course of working with our CEOs, we found that the five important behavioral dimensions we have identified consistently underlie the changes leaders must make.

What Other Industries Can Teach Us

The qualities of willingness, humility, curiosity, perseverance, and self-discipline have long been leveraged by innovative industries worldwide, yet the health care industry has been slow to catch up. Our CEOs are leading the way. Here's why and how these qualities are so critical to their enhancing their leadership skills.

Radar Charts Illustrating Five Behavioral Dimensions, With Associated Reinforcing Behaviors (in blue).



Sample charts such as these serve as powerful visual tools that allow executives to rate their own leadership performance. Each dimension and reinforcing behavior is ranked from 1 to 5 to describe relevant frequency, duration, and intensity: (1) rare, undeveloped, indifferent; (2) irregular, experimental, apparent; (3) frequent, predictable, moderate; (4) consistent, stable, persistent; (5) uniform, mature, tenacious.

Source: Author

Figures 1 and 2.

Willingness

The key factor enabling personal change, and what drives the cultivation of the other behavioral dimensions, is first recognizing that change is required, which then leads to the willingness to do so. Leaders cannot address unproductive organizational traits (redirected blame, autocracy, etc.) without being open to extricating these traits from themselves. We as health care leaders must assume responsibility for poor patient outcomes, as well as staff and physician burnout — much in the way that good teachers can acknowledge how their lessons might not be reaching students. Positive transformation requires a state of readiness for making the personal changes that allow leaders to improve their interactions with others.

To facilitate willingness, we encourage leaders to commit to 10 minutes of self-reflection weekly, telling them to ask themselves, *What in my actions this week led to better thinking on behalf of my team about problems? Did my questions unleash the thinking capacity of my team, or did I blame them for not following up on my specific ideas?*

Humility

In a recent *Journal of Management* study of 105 small-to-medium companies, humility was the best determinant of process and outcome performance in comparative study. In a 2005 *Harvard Business Review* article, renowned business consultant Jim Collins identified personal humility as being the "yin" to the "yang" of will, and an indispensable characteristic for transforming a good company into a great one.

> *The key factor enabling personal change, and what drives the cultivation of the other behavioral dimensions, is first recognizing that change is required, which then leads to the willingness to do so."*

The capacity for humility is essential for leading complex teams, where participants are often more expert than leaders in a particular area. Effective leaders know they do not have all the answers and are willing to "go see" — to be present where the actual work is done — and to respect workers by asking open-ended questions and seeking input.

Many leaders have difficulty setting aside their preconceived ideas to learn from frontline doctors, nurses, and technicians who have firsthand experience in dealing with issues. Leaders should therefore proactively examine their interactions with others and ask themselves, *Did I ask questions that elicited the best thinking of the person or team with whom I interacted? Were there implied answers in my questions?*

Curiosity

When General Motors and Toyota embarked on the New United Motor Manufacturing, Inc. (NUMMI) automobile plant in Fremont, California, in 1984, Japanese executives replaced the struggling US automakers' original management with people hired based essentially on one characteristic: curiosity. They wanted people who were interested in how and why things worked and how to fix what was not working.

> *Effective leaders know they do not have all the answers and are willing to 'go see' — to be present where the actual work is done — and to respect workers by asking open-ended questions and seeking input."*

They also adopted a curiosity-driven problem-solving approach known as "A3 thinking." A3 describes an 11 × 17-inch worksheet that workers use to tell a story, starting with the background and current state of a problem. The method calls for defining the problem, identifying a target condition for the issue, analyzing why the problem exists, and coming up with possible experiments to the root cause of the problem. Conceptually, it is similar to the SOAP note (Subjective-Objective-Assessment-Plan). Physicians are trained to use the scientific method to solve clinical problems and use the SOAP note to manage patients. A3 thinking is like a SOAP note applied to daily problems.

We believe in continuous learning and teach A3 thinking because it forces leaders to exercise their curiosity and think more deeply about a problem before considering a solution. Being curious also means being willing to "go see" and to ask oneself, *Did I unleash the creativity of my team by asking them about how things work and how they should work? Did I see barriers I could remove that would allow them to solve the problems they face?*

Perseverance

Perseverance is the persistence to attack any problem and the belief that no problem is unsolvable — what former SVP of Google's People Operations, Lazlo Bock, calls grit. Collins calls it "ferocious resolve."

> *Is there anything on my calendar this week that will add value to the patients we serve? Have I gone to where value is created to observe, show respect, and encourage the staff?"*

Changing one's behavior requires psychological resilience and the persistence to attack any personal problem. Learning a new skill requires two things: a teacher and practice. Learning to be a continuous improvement leader is no different. Having a coach who observes your daily interactions is invaluable. You must learn to go see, not go tell.

We teach leaders to not let bad days affect their resolve to improve the patient experience. They should reinforce their commitment to change the culture of their organizations by asking themselves, *Did I ask someone to observe my behavior and give me feedback this week? Have I established a confidant with whom I can share my behavioral struggles?*

Self-discipline

In his bestselling book on organizational improvement, *Good to Great*, Collins states that "Sustained great results depend upon building a culture full of self-disciplined people who take disciplined action . . ." Such a culture develops out of effective leader standards. Leaders who follow a system of management that sets expectations for everyone involved and reduces second-guessing regarding what others need allows for better-informed decision-making and problem-solving on the fly.

We encourage our CEOs to condition themselves to a habit of self-discipline in thought and action, and to routinely ask themselves, *Is there anything on my calendar this week that will add value to the patients we serve? Have I gone to where value is created to observe, show respect, and encourage the staff?*

Case Study

When leaders actively pursue and manifest all five behavioral dimensions, we have seen remarkable results occur. Since 2011, Zuckerberg San Francisco General Hospital and Trauma Center (ZSFGH) has been on a transformational journey to provide high-value, patient-centered care. Under the guidance of one of us, ZSFGH's CEO Susan Ehrlich, the hospital has focused on implementing a handful of organizational metrics described as "True North" (equity, safety, quality, care experience, workforce care and development, and financial stewardship).

Efforts began with a pilot project in which a standard daily management system (DMS) developed by Catalysis was established for five "model cells": perioperative services, an inpatient unit, an urgent care clinic, specialty clinics, and the emergency department (ED). The DMS would help engage staff in identifying and solving problems aligned with True North metrics. Training in A3 thinking was simultaneously initiated to teach leaders to identify, define, analyze, and develop plans to solve problems at the frontline level.

> *Institutional problems cannot be effectively managed 'top down.' The old way of autocratic action must cede to processes designed to build a continuous improvement culture."*

Adopting the DMS, as well as executing value stream mapping and improvement events throughout ZSFGH, led to additional measurable improvements, including shorter cycle times for lower-acuity patients in the ED, a greater capacity to see patients in the urgent care clinic, and reduced wait times for prescriptions in the outpatient pharmacy. However, the work also made the team realize that all leaders needed more education, support, and feedback so as to contribute meaningfully to the institution's transformational journey.

In fall 2016, ZSFGH management implemented a second phase focused more deeply on developing leader behaviors that truly supported the principles of "align, enable, and improve" — areas that frame ZSFGH's management of process. This included developing radar charts (see Figures 1 and 2) on the executive team to gauge leadership performance on behaviors aligned with institutional principles and then using the information to improve over time. For example, the characteristic of "humility" aligns with enabling people, whereas "A3 thinking" demonstrates an improvement mindset. Using radar charts also allowed the team to pilot 360 evaluations with one-ups, colleagues, and direct reports — thus facilitating Personal Development Plan (PDP) A3s — as well as to focus on optimizing leader standard work.

This work has recently been expanded from 14 to 53 of the highest-level organizational leaders, including medical staff leaders. The leaders themselves have enthusiastically embraced resources and feedback regarding their individual development, while an "esprit de corps" has infused the group overall. This team approach continues to pay dividends in hospital operations and delivery of the highest quality care to patients.

Conclusion

Institutional problems cannot be effectively managed "top down." The old way of autocratic action must cede to processes designed to build a continuous improvement culture. To achieve a much-needed breakthrough in meaningful cost and quality care results, as well as to promote positive changes in staff members, a leader — whether executive, physician, or clinic leader — must be open to improving how he or she leads. By embracing the five behavioral dimensions of personal change we have outlined, leaders can inspire others and help build a culture that values — and seeks out — the contributions of an organization's greatest asset: the people working at the front lines.

Acknowledgments: Karl Hoover from Karl Hoover & Associates, LLC, Seattle.

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Building a Better Physician Compensation and Performance Model

Case Study

Seth Wolk, MD, MHSA & Doug Apple, MD, FHM

Spectrum Health

KEY TAKEAWAYS

1. Engage physicians early and often. Physician leadership and engagement are essential to successful outcomes.
2. Create and adhere to guiding principles. These foundations provide a "true north" to assist with conflict resolution and to keep everyone moving forward.
3. Think beyond the dollars. Traditional financial incentives can only go so far in driving value-based performance. It is important to recognize physician performance in areas outside wRVU production.
4. Identify the decision-makers. All engagement should be accompanied by a defined process, with the decision-making authorities clearly outlined in advance. Decision-makers will need to align both qualitative and quantitative insights to select the best paths forward.
5. Fail fast. Embrace the nature of the process by creating clear and effective feedback loops—with sufficient breathing room—into all timelines.
6. Create a purposeful communication and change-management strategy. Show that the status quo is not an option, focus on the whys, and support it with communication that is appropriately segmented by audience.

Spectrum Health Medical Group (SHMG), one of the largest multispecialty medical groups in the Midwest, recently redesigned its physician-compensation models to better reflect the fast-changing health care environment that we all face.

Shortcomings of SHMG's Previous Models

Since its formation in 2008, SHMG has grown significantly through a combination of strategic acquisitions, integrations, and national recruitment efforts and now includes nearly 1,000 employed physicians and 500 advanced practice providers. Originally, the group recognized compensation models ranging from a fixed-salary approach to a purely volume-based approach. As in most other health care delivery organizations, physicians represent the highest-paid group of employees. We believe that it's critical for the daily work of these individuals to be aligned with the goals of the organization.

"As in most other health care delivery organizations, physicians represent the highest-paid group of employees. We believe that it's critical for the daily work of these individuals to be aligned with the goals of the organization."

SHMG's previous models were in line with the approaches used in medical groups across the country. However, we found them to be insufficient for a variety of reasons, including the heavy emphasis on individual work relative value unit (wRVU) production, a lack of value-based performance measures, reliance on quarterly reconciliation payments and supplements, and the fact that staff physicians were ineligible to participate in a system-wide incentive compensation plan (ICP).

SHMG's previous models also were tied to an outdated performance-review system that centered mainly on an annual evaluation in which physician leaders were asked to meet with their direct reports to discuss accomplishments and determine goals before assigning a qualitative performance rating (e.g., "meets expectations"). Despite best intentions, this approach was lacking in many respects; for example, conversations between physicians and their physician leaders were infrequent, the physician leaders had received minimal training on effective coaching and feedback approaches, and formal relationships were not always understood across the medical group.

Designing a Comprehensive Model

We were determined to overcome these challenges and create an innovative physician-compensation and performance model that would uphold the guiding principles of being patient-centered, simple, equitable, flexible, balanced, and sustainable. In addition, this new compensation model would need to support physicians in performing what became known as "Job 1 and Job 2." Job 1 for every SHMG physician is to deliver high-quality health care services to their patients. Job 2 is to continually improve upon Job 1. This simple, direct, and powerful message became a rallying point during the entire redesign and implementation process.

After understanding the significant challenge that was at hand, we knew that it was vital to involve the right stakeholders in the redesign process as early as possible. In all, >30 individuals from cross-functional groups were engaged during the 16-month, physician-led redesign process, which began in May, 2015 and was completed in September, 2016.

Creation of the "All-In" Model

The result was the creation of a comprehensive, system-wide compensation and performance model that addresses each of the guiding principles. Financial compensation and rewards within the newly designed "all-in" model involve 3 individual, although related, components: (1) base pay, (2) a department performance incentive, and (3) a physician performance incentive.

The physician-led committee driving the redesign wanted to ensure that all compensation components ultimately would be focused on performance. Therefore, the decision was made to embed a performance-driven element into the base component."

Component 1: Base Pay

A base component, or salary, is an integral part of any physician-compensation model. However, the physician-led committee driving the redesign wanted to ensure that *all* compensation components ultimately would be focused on performance. Therefore, the decision was made to embed a performance-driven element into the base component. Under the new model, each physician is paid a consistent biweekly base salary that is tiered to reflect his or her previous year's performance. Currently, there are 8 standard tiers across the medical group, ranging from 70% to 140% of SHMG's specialty-specific median benchmark for compensation. Departments in which physicians share a group culture and share responsibility for all activities can elect to receive the same base pay department-wide, without tiers.

Because of the varied work environments within individual specialties, departmental leaders were granted some flexibility to select the performance criteria that they believed would best support them in accomplishing their strategic goals. Defined guardrails and governing processes were put in place to help maintain consistency, internal equity, and regulatory compliance. An example of how our primary-care physicians chose to formulate their base pay is shown in the figure below.

Calculating Specialty Specific Base Pay – Primary Health

When it came time to formulate their base pay, our primary-care physicians selected weighted performance criteria that they felt best aligned with the strategic goals of their service line, with an emphasis on wRVUs and panel size and with consideration of advance practice provider (APP) ratios and APP wRVUs. They scored their performance on a sliding scale and then adjusted it by weight to provide a maximum score of 80 points. The physician in this example scored 38 points, which fell within Tier 4 (indicating that this physician's base salary would correspond with 100% of the specialty-specific median salary benchmark). FTE = full-time equivalent.

Weight

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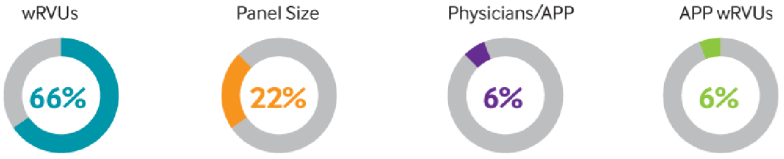
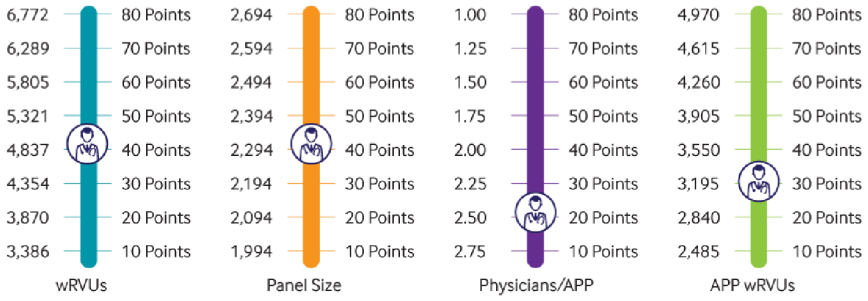


Performance



Calculation

Example Family Medicine Physician (1.0 Clinical FTE)

Metric	A Performance	B Raw Score	C Weighting	D=B x C Adjusted Score
wRVUs	5,013 wRVUs	40 Points	66%	26.4 Points
Panel Size	2,356 Patients	40 Points	22%	8.8 Points
Physician/APP Ratio	2.56 Physicians/APP	20 Points	6%	1.2 Points
APP wRVUs	3,279 wRVUs	30 Points	6%	1.8 Points
			Total Points Earned	38.2 Points

Base Pay (% median)

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	Tier 7	Tier 8
Points	0-14	15-24	25-34	35-44	45-54	55-64	65-74	74-80
Median	70%	80%	90%	100%	110%	120%	130%	140%

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Source: Authors

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Component 2: Department Performance Incentive

Historically, many specialties within SHMG used scorecard-based compensation components to recognize physician performance in areas outside of wRVU production. The results were mixed. Practitioners in some areas, such as primary care, successfully identified high-impact metrics and targets that physicians trusted. Others struggled to identify meaningful non-productivity-related metrics that were reportable and trustworthy. Using lessons learned from previous scorecard iterations, the compensation steering committee created a redesigned scorecard, applicable to all specialties, that became known as the Department Performance Incentive (DPI). To reduce variability and complexity, bounding parameters and reportable metrics were identified to help to guide departments in their DPI scorecard designs. For example, 5 areas—service, access, citizenship/ARTS (administrative, research, teaching, and strategic), value, and clinical activities—must be recognized across all departments. The DPI component is paid out annually in March and is expected to be an average of 5% of specialty-specific median benchmark compensation. An example of how our primary-care physicians chose to calculate their DPI is shown in the table below.

Calculating Department Performance Incentives (Primary Care)

Using a department performance incentive (DPI) template, our primary-care physicians drafted a scorecard to measure departmental performance in 5 areas—service, access, citizenship/ARTS (administrative, research, teaching, and strategic), value, and clinical activities. A maximum of 4 points are awarded for each area, for a maximum of 20 points. The final DPI is calculated as the percentage of points scored, multiplied by the specialty-specific median benchmark compensation. CPC+ = Comprehensive Primary Care Plus, LBP = the number of patients with low-back pain who receive imaging within 28 days after diagnosis divided by the number of patients diagnosed with low-back pain, and HTN referral = the number of hypertensive patients prescribed triple medication therapy prior to referral to a specialist for blood-pressure control.

Area	Metric	Scoring Criteria
Service	Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey	Likelihood to recommend: • >96% = 4 points • >91% = 3 points • >86% = 2 points • >81% = 1 point
Access	Empanelment	• Exceed 110% specialty-specific panel size = 2 points • 50 new patients/yr = 1 point • 100 new patients/yr = 2 points
Citizenship/ARTS	Education, research, or committee involvement	• Minimum 32 hr/yr = 4 points • Minimum 24 hr/yr = 3 points • Minimum 18 hr/yr = 2 points • Minimum 12 hr/yr = 1 point
Value (pick 3)	• Controlled hypertension • Diabetes with A1C >9% • Colorectal cancer screening • Well-child visits	• 2 points for each measure attained (4 points max)
Clinical activities	Utilization metrics that fulfill CPC+ • Choosing Wisely (site chooses 2): LBP, HTN referral (3-drug therapy required), upper endoscopy guidelines adherence) • Saturday/Sunday regularly scheduled hours	• 2 points for each process improvement achieved • 2 points for regularly scheduled weekend hours

Source: Authors

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Component 3: Physician Performance Incentive

Traditionally, select executives and physician leaders throughout Spectrum Health have been eligible for an annual performance incentive based on the achievement of predetermined system-wide goals related to quality, patient experience, cost of care, and so on. This program, known as the Incentive Compensation Plan (ICP), was widely viewed as successful in rewarding system-wide success and performance. However, despite their critical role in helping to achieve ICP success metrics, staff physicians were not eligible to participate in this bonus plan. SHMG leadership used the larger physician-compensation redesign effort to create a convergence of goals by allowing all physicians to participate in a modified version of the ICP known as the physician ICP (P-ICP). The P-ICP closely mirrors the broader ICP while excluding metrics that, for legal and compliance reasons, cannot be tied to physician pay. The P-ICP is paid out annually to eligible physicians in September and is worth up to 5% of specialty-specific median benchmark compensation.

Expected Impact of New Model on Performance Metrics

The new compensation model is being introduced in a phased plan with a 1-year transition period to allow physicians to see how the model works prior to its implementation. Primary care physicians and physicians in Women's Health have been in the transition stage since January 2017. Although the new compensation model is still in its early stages and we do not yet have data to evaluate its impact, we are optimistic that it will positively affect several key performance metrics, including:

- Per-member, per-month cost of care (as measured by payor partners).
- Patient experience (as measured by patient-satisfaction surveys).
- Quality of care (as measured by response times, readmission rates, and registry data, for example).
- Provider satisfaction (as measured by engagement surveys and retention rates).

Where to Start

Medical groups and health care organizations wishing to pursue similar compensation model redesign and transformation processes should undertake several initial steps:

- Assemble a physician-led steering committee that includes leadership representation from all relevant specialty areas.
- Develop a comprehensive work plan that includes an overall timeline, meeting cadence, milestones, decision matrix, and anticipated deliverables.

- Establish clear and documented guiding principles and goals for the new compensation model.
- Assess the effectiveness and limitations of all current compensation models to gauge the magnitude of change that will be required to achieve the determined goals.

At that point, the organization will be ready to begin the redesign process within the established project work plan.

Seth Wolk, MD, MHSA

System Chief Medical Officer, Spectrum Health

Doug Apple, MD, FHM

Chief Medical Officer, Spectrum Health

Tiered Escalation Huddles Yield Rapid Results

Article

Marc Harrison, MD

Intermountain Healthcare

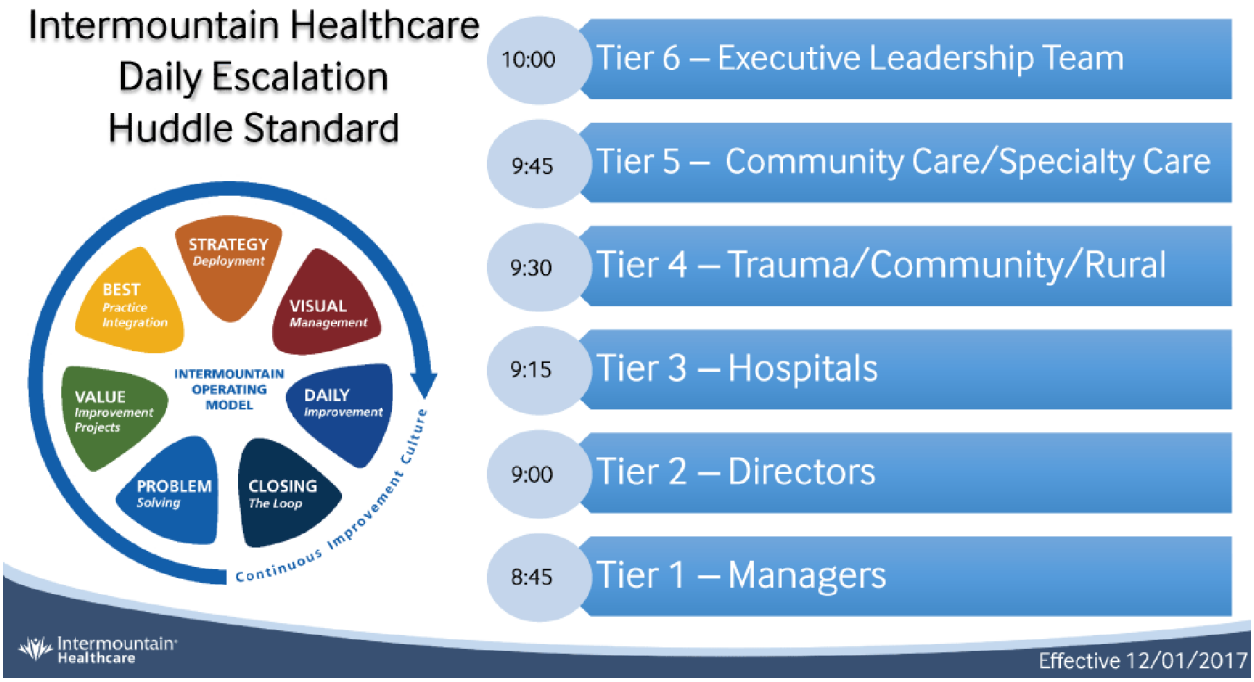
As leaders, we like to think we have all the information we need to address issues effectively and efficiently; but in reality, the information we have is often lagging, coming to us in post-problem, aggregated reports. The information that leaders really need is at the front lines and in real time; and, in just 15 minutes each day, leaders can communicate and align the organization to what is most important.

A significant amount of any health system's knowledge lives in the heads of its caregivers; providing them with a fast and convenient way to escalate that information to leadership can have lasting impacts on response times and critical action plans that resolve safety, practice, access, and stewardship issues.

"A significant amount of any health system's knowledge lives in the heads of its caregivers; providing them with a fast and convenient way to escalate that information to leadership can have lasting impacts."

That communication channel can also build a culture of respect and value within an organization and bridge the age-old "does management care?" gap by showing caregivers that leadership is listening to them and addressing issues proactively.

Intermountain Healthcare learned early on that it is not enough to escalate issues and ideas from front line to manager; there are items that must be escalated even further up the chain of command, including up to the executive level. So the health system has implemented daily, tiered escalation huddles that start with frontline caregivers (Tier 1) and end with the executive leadership team (Tier 6) — all occurring before 10:30 each morning.



15 Minutes a Day at Tier 6

The huddles are brief meetings in which the participants stand around *huddle boards* — whiteboards divided into sections, showing dashboard metrics, charts, lists of new ideas, and other information. In Tier 1, frontline caregivers convene to review safety events and other KPIs, as well as the resources needed to complete their daily tasks or implement new ideas.

> *The health system has implemented daily, tiered escalation huddles that start with frontline caregivers (Tier 1) and end with the executive leadership team (Tier 6) — all occurring before 10:30 each morning."*

Relevant metrics and issues are then reported up through additional tiers based on escalation protocols involving different levels of management, until the most critical information — matters needing system-level attention — reaches the most senior executives in Tier 6. Through this process, Intermountain is able to get data and issues to the CEO within 24 hours, ensuring that leaders are aware of problems and able to resolve them in a timely way.

At the Tier 6 huddle — scheduled for just 15 minutes each day — the executive leadership team stands before its system-level huddle board and receives reports on issues from group leaders, hospital CEOs, and central functions such as information systems, legal, and communications. Some participants are present in person and others call in. The reports concern matters that need the immediate and collective attention of the top executives, with a particular focus on removing barriers that interfere with caregiving.

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Leaders then write action plans and give follow-up reports in subsequent Tier 6 huddles to close the loop on escalated items. The escalation items and the process itself are reviewed quarterly to ensure that the program addresses key organizational priorities and facilitates the ability to adapt to the trends discovered through the escalation process that require additional transparency or focus.

One of the most important benefits of this process is the early identification of trends — which allows for speedy interventions, sometimes leading to an initial corrective action within 24 to 48 hours. Hospital-acquired infections, downtime of information systems or equipment, power outages, caregiver injuries, patient falls, capacity and access issues, and other performance indicators are tracked continuously. For example, senior leaders can address capacity issues at one facility by coordinating diversions to other facilities, keeping patients within the Intermountain system. Safety events can be investigated immediately, with system-wide alerts sent to prevent similar events. Caregivers can detect and quickly address epidemiological issues such as *E. coli* outbreaks.

One of the most important benefits of this process is the early identification of trends — which allows for speedy interventions, sometimes leading to an initial corrective action within 24 to 48 hours."

Intermountain's process helps operations "return to green" much more rapidly compared to the older process in which information came to management's attention on a slower periodic basis, sometimes weeks or even months after events. Issues can be addressed and resolved without reaching the Tier 6 level. For a period of nearly 10 months (April 17, 2017, through January 30, 2018), the program has assigned and closed 305 actions at the Tier 6 level.

The Tier 6 huddle also performs an important secondary function: It allows leaders from across the system to collaborate on issues they might have previously thought they alone were experiencing. Sharing practices that are working well — and those that are not effective — leads to improved consistency, transparency, and performance system wide. Often, great ideas developed in one area can be rapidly replicated in other areas, improving outcomes and reducing inappropriate variation in quality and cost.

After less than 1 year of daily Tier 6 huddles, the gains are measurable, and participants have faster response times, better awareness, and stronger collaboration in solving problems and preventing new problems. Intermountain is addressing safety issues more effectively. Patient and customer service issues are identified and resolved faster. Leaders see capacity more clearly, which allows for more control over transfers out of the system and hospital diversions.

Examples of Success

One of the most compelling examples of the benefit of the escalation huddles is an improvement in the downtime of imaging equipment. The huddles revealed a pattern of delays in repairs to MRI, CT scan, and other imaging devices, and Intermountain discovered the delays were often caused by international shipping processes, where the parts were coming from abroad and were delayed going through customs.

> *The Tier 6 huddle … allows leaders from across the system to collaborate on issues they might have previously thought they alone were experiencing."*

Intermountain discussed the problem with the device manufacturers, who were able to streamline their international shipping processes. The result was significantly faster arrival of needed parts and significantly reduced equipment downtime. And all customers of these suppliers benefited — not just Intermountain.

Other improvements include:

- **Capacity improvement:** We receive daily reports on units at capacity and transfers out of the system. Early in the process, it was evident that we transferred a number of patients out of our system due to capacity issues for behavioral health needs. This led us to: 1) report where we *had* capacity, to help reduce transfers out of the system; and, 2) analyze the out-of-network service requests and approvals our insurance company, SelectHealth, was receiving, as well as the behavioral health network of providers. For example, out-of-network Service Approval Requests declined from 400+ in January 2017 to 147 in August 2017, as access/availability of contracted providers increased.
- **Patient safety:** Rapid training on new bedside rail equipment was implemented system wide when a caregiver experienced a safety issue with patient.
- **Safety alerts:** Safety events are communicated up through the huddles and a safety alert is communicated back down through the organizations for initial corrective action within 24 to 48 hours. Dozens of actions have been communicated through this process, including initiating a number of national recalls.
- **Staff concerns:** Grievances received in the C-suite were down 25% from a year ago after only 3 months into the Tier 6 huddle process.
- **Information alerts:** Pharmacy shortages and alerts are sent out immediately enterprise wide.

- **Patient access:** Medical group clinics reported marked improvements within 3 months; phone access (8-5, M-F) was available at 99% of clinics, up from 53%; appointment availability reached 86%, up from 53%; and extended clinic hours were available at 83% of clinics, up from 49%.
- **Best practices:** Utah Valley Hospital NICU implemented the UCLA Medical Center NICU safety protocol after learning of it from a grandfather visiting the UVU NICU.

Intermountain continues to develop its tiered escalation huddle process; for example, leaders continue to refine the list of key performance indicators that should be reviewed in Tier 6. But the benefits of the process are already clear: faster response, better sharing of best practices, enhanced esprit de corps, and improved safety, quality, access, and efficiency.

It all adds up to better care and service for patients. In just 15 minutes a day, health system leaders can know what frontline caregivers know and how they can support the people who do the work. That may be the most powerful information to have in health care.

Marc Harrison, MD
Intermountain Healthcare

Marc Harrison, MD, is the President and Chief Executive Officer of Intermountain Healthcare. He began serving in this position in October 2016.

Lessons in Leadership: What Makes Me Jealous

Article

Thomas H. Lee, MD, MSc

Press Ganey Associates, Inc.

NEJM Catalyst's Lessons in Leadership series features how health care leaders creatively guide their teams and organizations to make health care better. See all stories here.

There's a saying from Confucius that, if three people are in the street in front of you, two could be your teachers. In other words, you have something to learn from almost anyone, if you are open to it.

Another way of articulating this ancient Chinese wisdom that could help accelerate improvement in the value of health care is this: Almost everyone is doing something that should make you jealous. The goal should be to find it, imitate it, adapt it, and make your care better — so that you can make someone else jealous, too.

> *Almost everyone is doing something that should make you jealous. The goal should be to find it, imitate it, adapt it, and make your care better — so that you can make someone else jealous, too."*

In that spirit, let me describe something that has bothered me since I first learned about it a decade ago: Mayo Clinic physicians have a social norm of answering their beepers immediately. They don't finish driving to their destinations; they pull over to the side of the road. They don't finish an email or a conversation; they pick up their phones, punch in their page number, and are connected directly to the person who paged them.

The people who paged them are holding their phones to their heads, because they know the pagee is going to answer right away. And, within seconds, the two are talking about what to do with their patients.

I learned about this while sharing a taxi ride with Catherine Roberts, MD, a radiologist and clinical informaticist at Mayo's site in Phoenix, Arizona. It is the one and only conversation we have ever had. She was behind me in a long line waiting for taxis on a rainy day, and we were going to the same place. I offered to share my cab, and I have been stewing about what she told me ever since.

She said her colleagues in radiology don't like to recommend additional tests at the end of their radiology reports. They don't want to box other clinicians into having to do tests that might be unnecessary. Instead, they just page them, talk about the patient, and decide what to do. "It makes the radiologists happier," she told me. "Instead of being someone in a dark room processing images, we feel like we're members of the team taking care of patients."

> *Mayo Clinic physicians have a social norm of answering their beepers immediately. They don't finish driving to their destinations; they pull over to the side of the road. They don't finish an email or a conversation; they pick up their phones."*

I told her that I was jealous, but in actuality I found it hard to believe. And when I finally visited Mayo Clinic's original site in Rochester, Minnesota, a few years later, this was one of the first things I asked about — several times, actually. It was true, I learned.

"How do you get people to do it?" I asked. "What happens if you *don't* answer your page right away?"

I swear to you that the first three people all paused, and then answered with the exact same phrase. "You won't do well here," they said.

It was a little scary. I imagined being put outside in the cold in the Minnesota winter, and dying within minutes.

I asked an old friend who had trained with me in Boston before moving to Mayo. "There's no explicit penalty for not answering your page," he said. "But the last thing you want is for people to say 'He's the kind of guy who doesn't answer his page.'"

But another cardiologist told me, "The earth will open up and swallow you" if you didn't answer your page right away.

I have been muttering about the Mayo social norm of answering pages right away for years now, and physicians elsewhere always bring up circumstances in which something might be more important. "What if you are in the middle of doing a procedure?" they say. Or, "What if you are in the middle of talking to a patient?" You won't be surprised to learn that the Mayo folks have figured out ways to deal with these contingencies. Someone answers for them during a procedure. They apologize to the patient, but say they need to talk to a colleague.

> *There's no explicit penalty for not answering your page. But the last thing you want is for people to say, 'He's the kind of guy who doesn't answer his page.'"*

What do they do when they get paged by two different colleagues at the same time? That certainly happens, and I don't know how every Mayo physician handles it. But I do know that we have a tendency in health care to get paralyzed by exceptions, and this social norm seems likely to improve care much more often than worsen it.

Social norms matter, and this one makes me jealous.

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Dr. Lee is the Chief Medical Officer for Press Ganey Associates, Inc., a member of the Editorial Board of the *New England Journal of Medicine,* and the NEJM Catalyst Leadership Board Founder.

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