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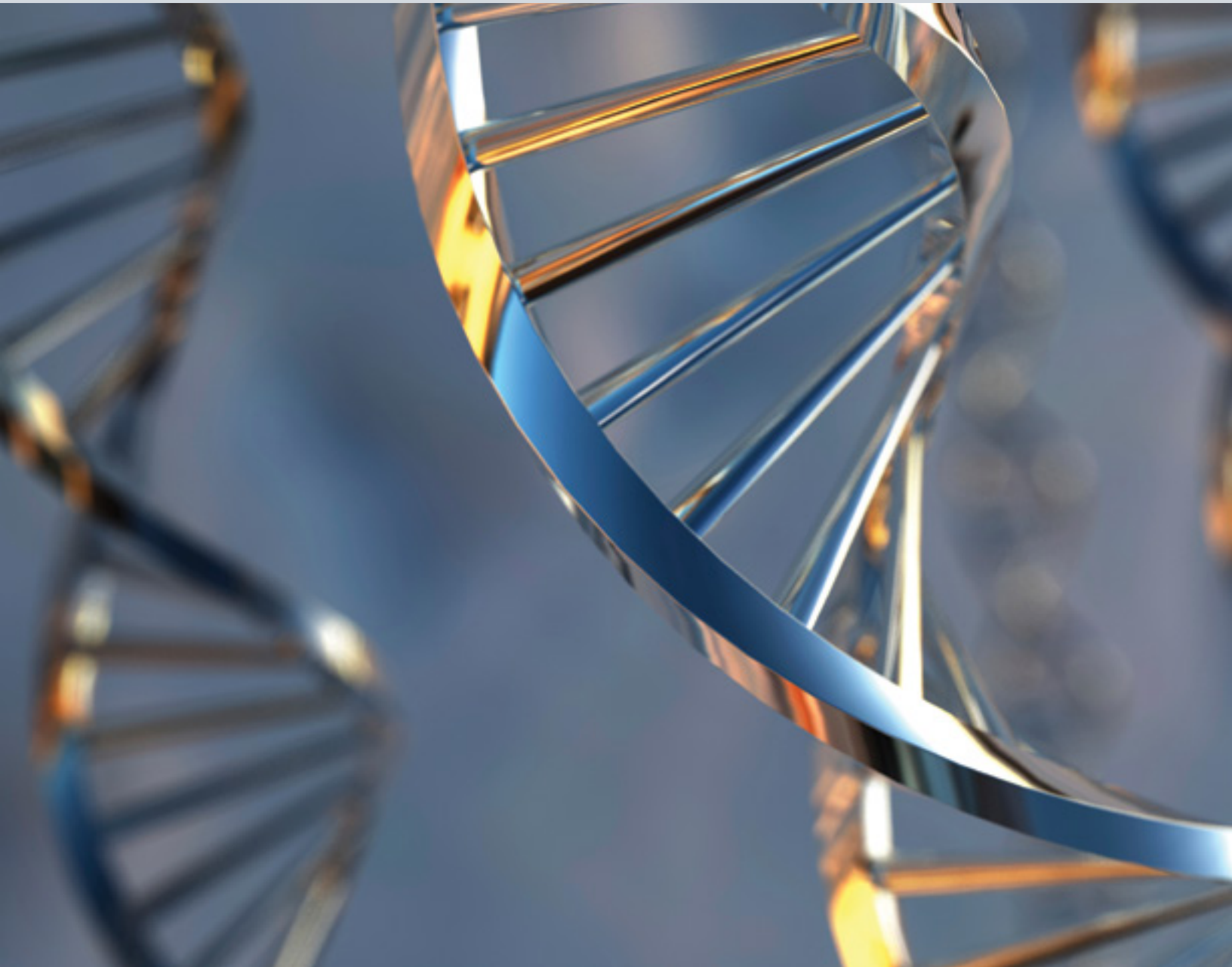

MOVING THE CULTURE FROM INDIVIDUAL HEROICS TO SYSTEMIC VALUE CREATING A CULTURE OF VALUE – PART 2

This is the second piece in a series of articles about creating a "Culture of Value" in your organization.

Although the direction of US healthcare policy remains uncertain, the need to improve quality and experience while driving down cost remains a priority. The value equation [defined as (quality + experience)/cost] touches every aspect of healthcare, and, while simple to define, it can be difficult to translate into action. Building value into organizational culture holds tremendous potential. In this series, we have defined a *Culture of Value as one where everyone, from frontline staff to C-Suite leadership, understands what it means to create value for patients, providers, and the system, including how to act in ways that enhance value from each of their respective roles*.

Here, we share a case depicting a common healthcare challenge: how to orient the culture from volume to value.

Creating a culture of value: The case of cardiovascular surgery

Why a culture change? Why now?
A leading academic medical center's cardiovascular surgery program had grown quickly, across a large regional system. The program was committed to cutting-edge therapies, giving patients a chance to live and thrive when others had turned them away. Clinicians cared deeply about their patients, and surgeons worked long and erratic hours to serve them.

In 2015, the program identified several deaths the chief believed were avoidable. At the same time, public rankings declined. The chief engaged the CMO for help.

Cultural assessment to understand practice, not just policy
Experienced in influencing quality, the CMO saw the need to look at the organizational dynamics that contributed to the mortality issues. We were asked to conduct a separate cultural assessment which cast a wide net to understand day-to-day practices. We partnered with the program to look into the work of the team members across all levels.

We found patterns of behavior that had worked when the program was small, but with growth, were no longer reliable. The program needed to move from reliance on heroic behavior by individuals to a systemic approach to quality.

Changing the culture: No one silver bullet
We knew that changing the culture would **require as much attention to how** initiatives were put in place **as to what** initiatives were begun. It would require a focus on the day-to-day behavior of hundreds of people across multiple geographically separate hospitals—and their ambulatory counterparts. No one action would have sufficient impact across the system. We focused on leadership, prioritized focus areas, and broad engagement.

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Leadership: Making change visible—We knew that to shift so much within a program of this size and scope, having executive clinical and administrative alignment, and the broad clinical perspective of stakeholders responsible for the quality of care, was essential. That meant demonstrating the backing of leadership in these ways:

- Leadership commitment from the system—An executive group was in place to ensure that leaders of entities and their clinical leaders were on board with our learning and the necessary changes. One of the operational reviews recommended increasing staff; the leadership group made the case for that intervention.
- Leadership commitment from the chief—The chief's commitment to a focus on quality was visible and consistent. In the same way that he had led the program in growth and commitment to cutting edge treatment, he began to lead in quality.
- Interprofessional governance—Organizational interventions could not be scaled by surgeons alone. We supported development of an interprofessional, inter-entity clinical leadership team to deliver on changes that made sense for each role and entity. Team members were able to push each other to work on what they needed to do, not just in the room, but also with the stakeholders they represented.

Focus: Understanding the variables—The clinical leaders identified a quality goal for the program. To accomplish this goal, they prioritized change work that could accelerate impact by vetting the cultural assessment findings and recommendations against their experience on the ground. Specifically, the team advanced these areas of focus:

- Developing standardized protocols—In programs where many patients are not "typical," it is challenging to get physicians to agree on protocols. After several false starts, the leadership team felt it had the momentum to develop and reach acceptance of key protocols, pulling from broad expertise.
- Negotiating role clarity—The program's rapid growth had led to widespread confusion about who (what role) should do what when with regard to patient safety issues. With unclear expectations, conflict was inevitable. The program leadership team negotiated clear and transparent ways to escalate problems.
- Infrastructure for accountability—Without ways to track protocol adherence, sustained quality change is difficult. The clinical leaders developed methods to gain commitment and adherence to specific metrics which became transparent dashboards for the entities and the surgeons.

Engagement: Bringing the culture of value to life—Along with regular formal communications, the executive group developed, with our support, a program retreat. Beyond showcasing the work of the clinical leaders and many other efforts, the retreat also connected the specific changes to all program stakeholders and to drive the pace of work, since it served as a deadline for milestones. Leaders across the system understood the plan—and a real and consistent commitment to change.

The results of a value orientation

A year later, the program has seen gains in the goals of reducing morbidity and mortality, five of six dashboard measures, and launched its journey toward a culture of value—where individuals can see the impact of their choices. These results reinforce the significance of the hard work that went into creating a culture of value—from developing over a dozen clinical protocols to reinforcing psychological safety of staff.

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The improvement in metrics had important implications for the value of care. For example, decreased ALOS increased access for more very sick patients, contributing to both the mission and the revenue of the department. Cultural change supported both quality and value.

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200 or visit our website at www.cfar.com.