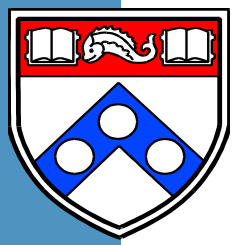
Unit Clinical Leadership Model: A Successful Partnership between Front-Line Clinicians, Quality, and Senior Leaders

University of Pennsylvania Health System

December 8, 2009



IHI 2009 National Forum
on Quality Improvement in Health Care

Who we are

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The frame for today's discussion

A new take on accountability

- Tapping into people's **passions and interests**
- Developing the **everyday work practices — large and small** — that make it possible for people to take responsibility

A new take on innovation

- Helping the organization **learn from itself** and look for places where pockets of innovation are **already beginning to emerge**
- The leader's job is to develop the **strategic radar** to identify weak signals and amplify them

Today's discussion

1. **Unit Based Clinical Leadership — what and why**

2. **Getting there — and sustaining the gains**
   - **Playing with other people's cards**
   - **Learning from ourselves**
   - **Knitting with hard wire**

3. **A "Campaign" approach to change**

1 Unit Based Clinical Leadership — what and why

Penn Medicine

University of Pennsylvania Health System

Hospital of the University of Pennsylvania #8 *US News & World Report/* Magnet
Pennsylvania Hospital
Penn Presbyterian Medical Center
Home Care & Hospice Services
Good Shepherd Penn Partners

Adult admissions — 77,500

Employees — 12,700

University of Pennsylvania Medical School

#2 NIH ranking

Faculty — 1,347

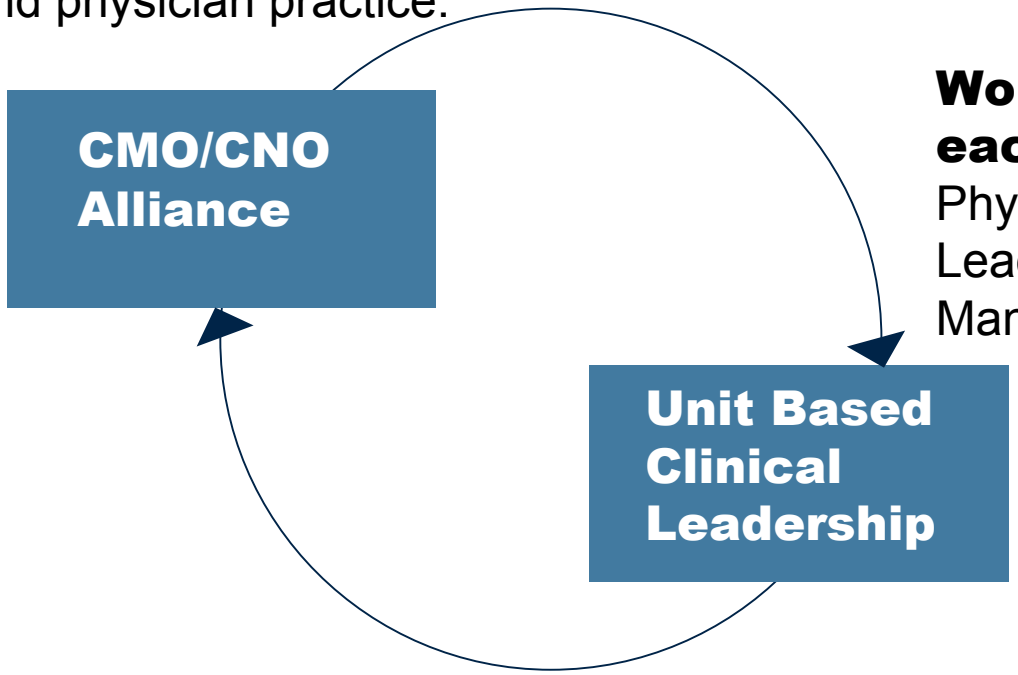
Med students — 741

Grad students — 1,079

Residents/ Fellows — 978

This is the story of a physician/ nurse/ quality partnership at the top and on the frontline

Working alliance of the CMOs and CNOs from all three hospitals, homecare, rehab, and physician practice.



Working alliance on each hospital unit — Physician Leader, Nurse Leader and Project Manager for Quality.

We needed to bring UPHS' clinical strategy to the bedside

UPHS Blueprint for Quality and Patient Safety	
UPHS' overarching quality goal is to **reduce mortality** and **reduce 30-day re-admissions.**	
Four Imperatives	**Priority Actions**
Transitions in care	▪ **Transition planning** ▪ **Medication management**
Reduce variations in practice	▪ **Reduce hospital-acquired infections** ▪ **Reduce medication errors**
Coordination of care	▪ **Interdisciplinary rounding**
Accountability	▪ **Unit clinical leadership**

We discovered we needed a “Swiss Army knife”

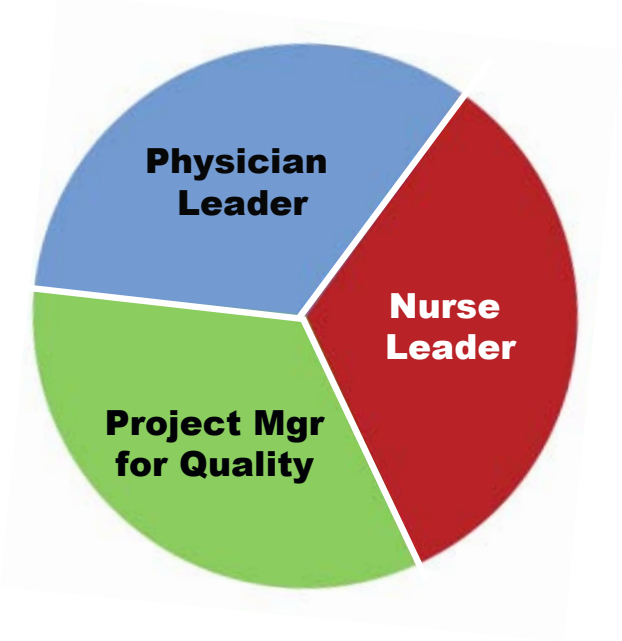
The institution was tired of playing “whack a mole.” Every year we’d develop three or four new initiatives — but then another problem would come along.

We needed a multi-purpose solution on the units to handle almost any Quality problem.

> “This isn’t a project, it’s a way of doing things. You can **bolt different strategies onto it.**”
>
> —UPHS CFO

What our “Swiss Army knife” looks like

Three-Way Partnership Manages Quality on the Hospital Units



Physician Leader and **Nurse Leader** are paired at the unit level — with a **Project Manager for Quality** who brings real-time data and project management skills.

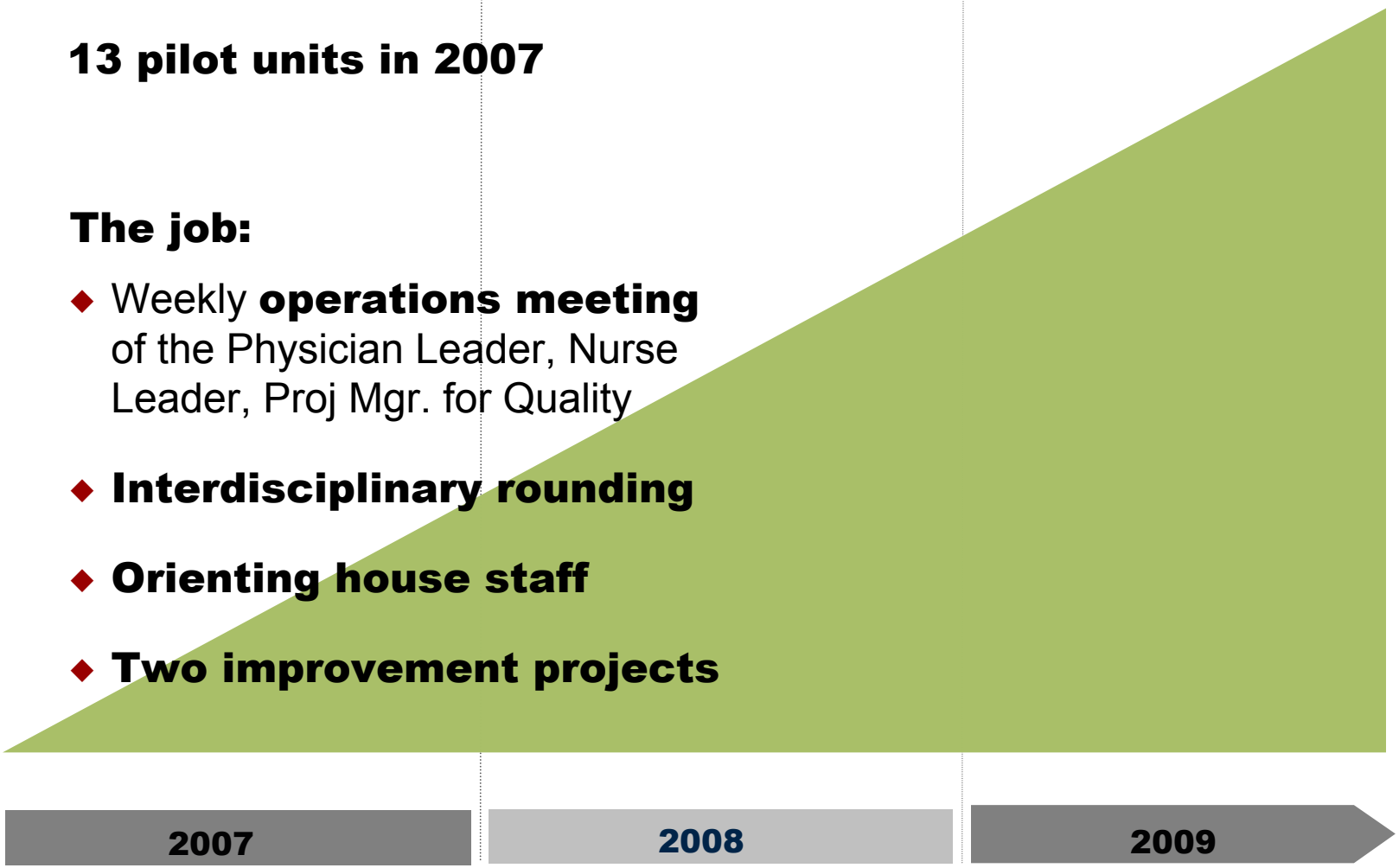
We call these trios “UBCLs,” for “Unit Based Clinical Leadership.”

We started modestly on purpose so the UBCLs could learn to work with each other

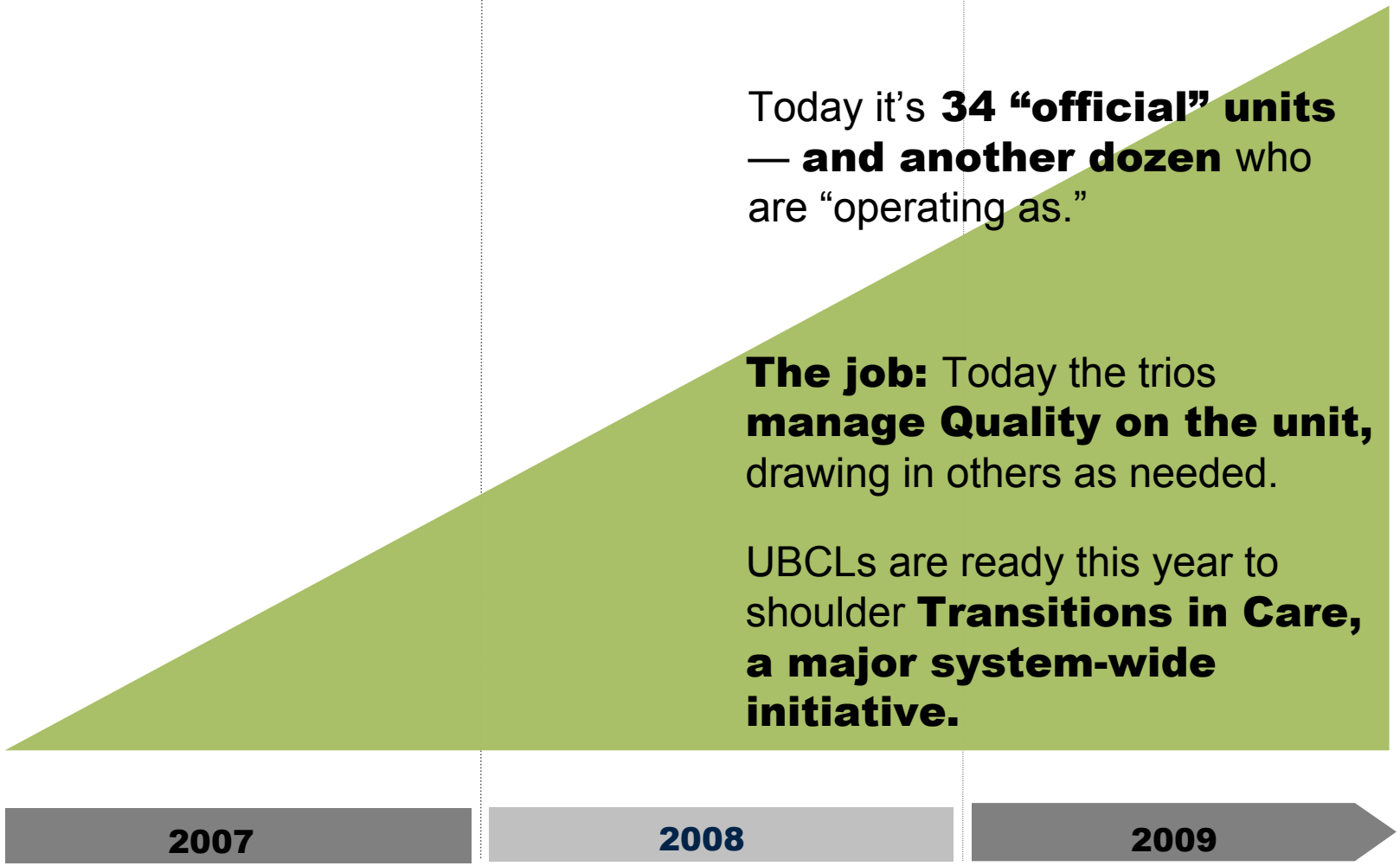
13 pilot units in 2007

The job:

- Weekly **operations meeting** of the Physician Leader, Nurse Leader, Proj Mgr. for Quality
- **Interdisciplinary rounding**
- **Orienting house staff**
- **Two improvement projects**



Today we've covered the house and the UBCLs are ready to take on Transitions, a major system-wide initiative



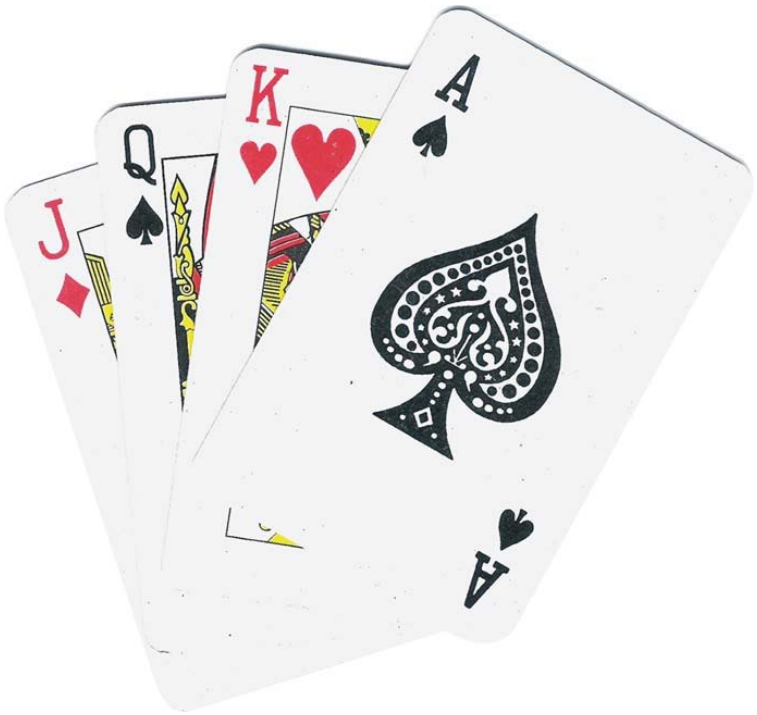
The UBCLs aren't the answer to "everything"

UBCLs HAVE THE MOST IMPACT WHEN …	HERE'S WHY …
Interdisciplinary care coordination makes a difference	With UBCLs, the team is interdisciplinary from the start
Physician backup is especially needed	With UBCLs, the nurse leader can count on backup from the physician leader
The unit needs the **cooperation of another unit** or department	With UBCLs, there's a leadership team to represent the unit in "negotiations"
Sustaining the gains over time will be difficult	With UBCLs, accountability is ongoing

2 How we got there — and what we're doing to sustain the gains

- Playing with other people's cards
- Learning from ourselves
- Knitting with hard wire

Playing with other people's cards



It started with reports of disrespectful behavior, which led to a professionalism self-study

INCIDENT REPORTS

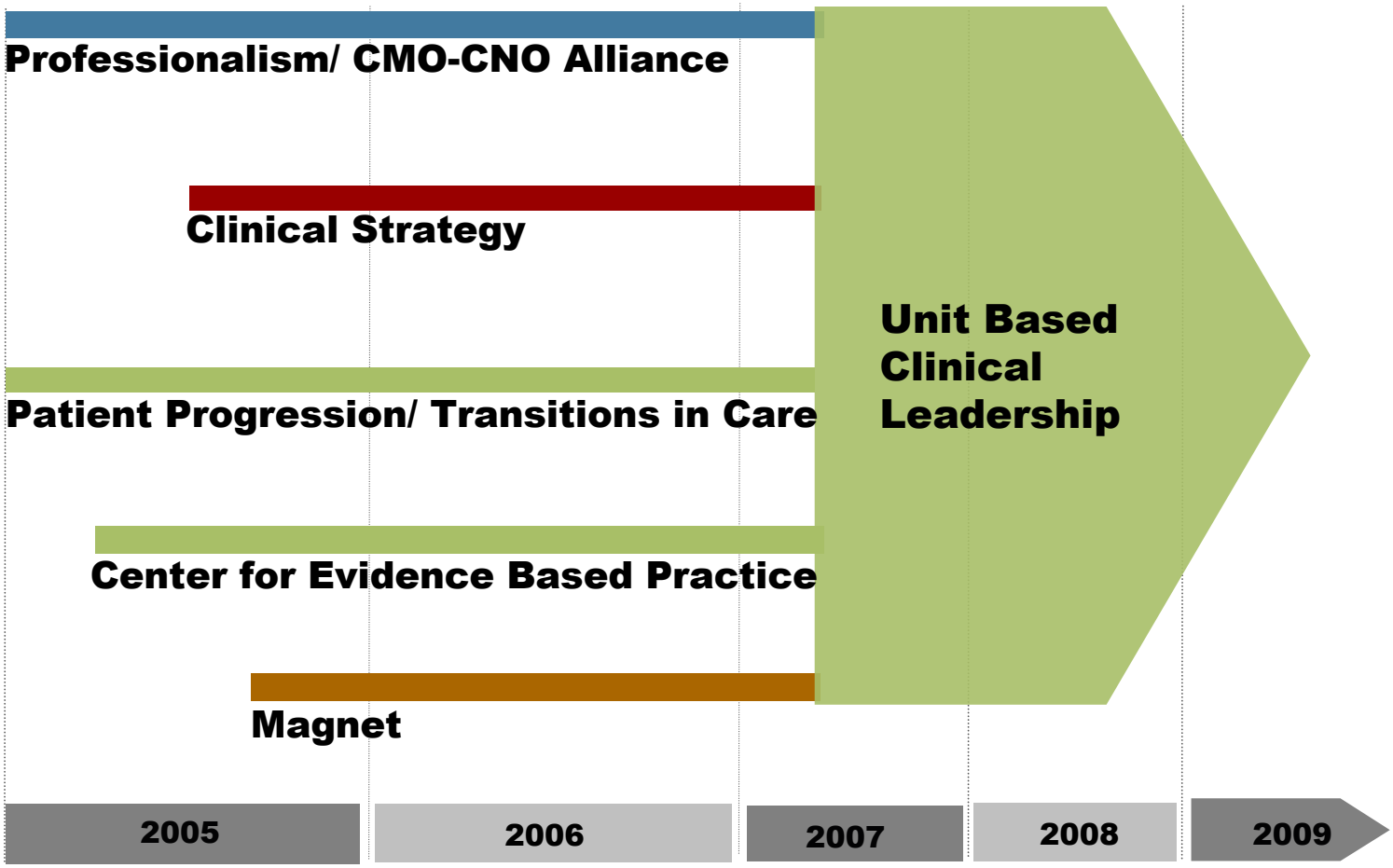
Incident in OR: **Physician lashes out verbally** at nurse during procedure …

… disruptive argument between nurse and house staff …

We convened focus groups to **uncover work practices that foster professionalism:**

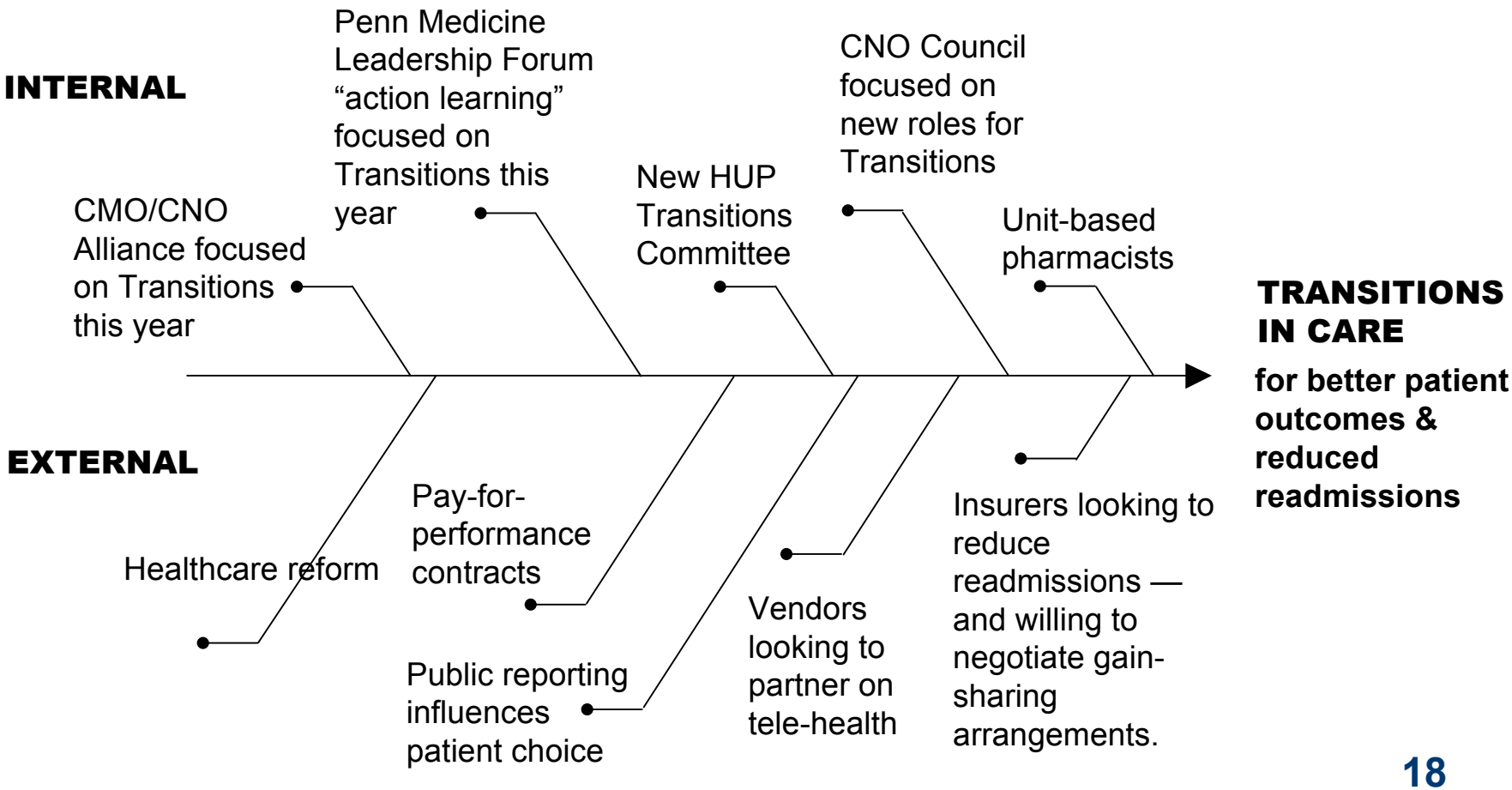
- Nurse/physician partnerships
- Interdisciplinary rounding
- House staff orientation, with senior nurses as one of the teachers
- Daily staff huddles

We began on the blue path, but linked up with the red, green & gold to leverage other people's goals & actions



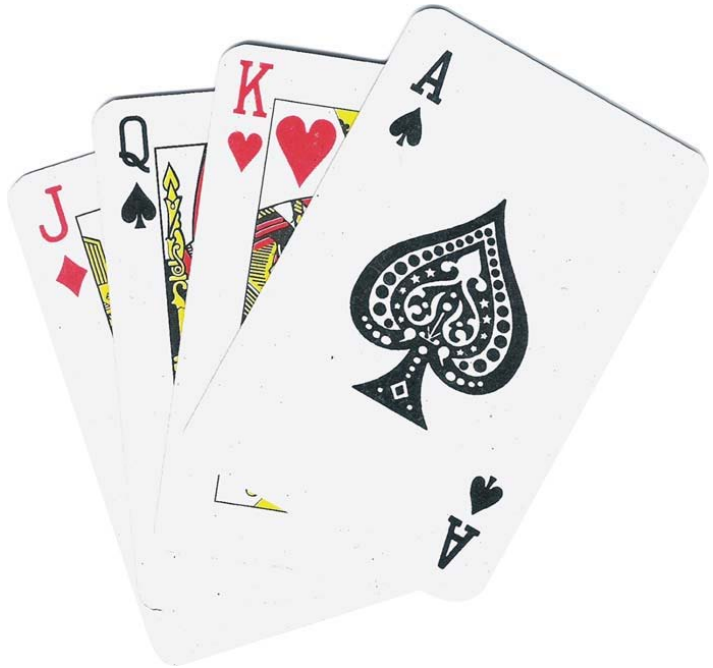
We're tapping into "Other People's Energies." Our biggest job is keeping them aligned.

Transitions in Care is a good example. We have a tiger by the tail.



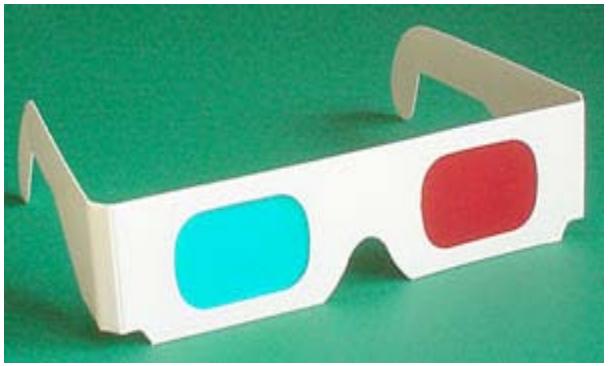
Playing with other people's cards — lessons learned

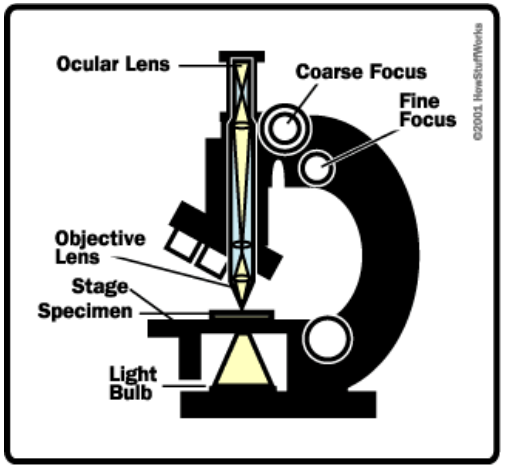
- By tapping into other people's energy and momentum, you can **create results and critical mass** as you go.
- You get **change that sticks,** because people are creating it themselves.
- You **don't have to do all the work** yourself.
- **Your job is to align** what might otherwise work at cross purposes.



Tapping into other people's energy and momentum creates "pull" for the changes you want to make. Other people pull the changes along.

Learning from ourselves





The seeds were there. We turned them into Unit Based Clinical Leadership.

- Pennsylvania Hospital was putting **physician leaders on the units …**
- **Natural nurse manager/ physician pairs** on a few units already …
- Penn Presbyterian Medical Center was looking to **decentralize Quality to the units …**
- **Interdisciplinary rounding,** in various shapes, on many units already …

We took those seeds and helped the organization do something with them:

- **Gave it a name** — "Unit Based Clinical Leadership"
- Pulled people together with **like-minded others** — and gave them **visibility and credit**
- **Tapped into other people's energies,** to pull the changes along
- Created **structures and supports** to make it work

We convened summits to learn from each other, make commitment visible, and create educated consumers

"System-in-the room" summits of 100+ stakeholders each

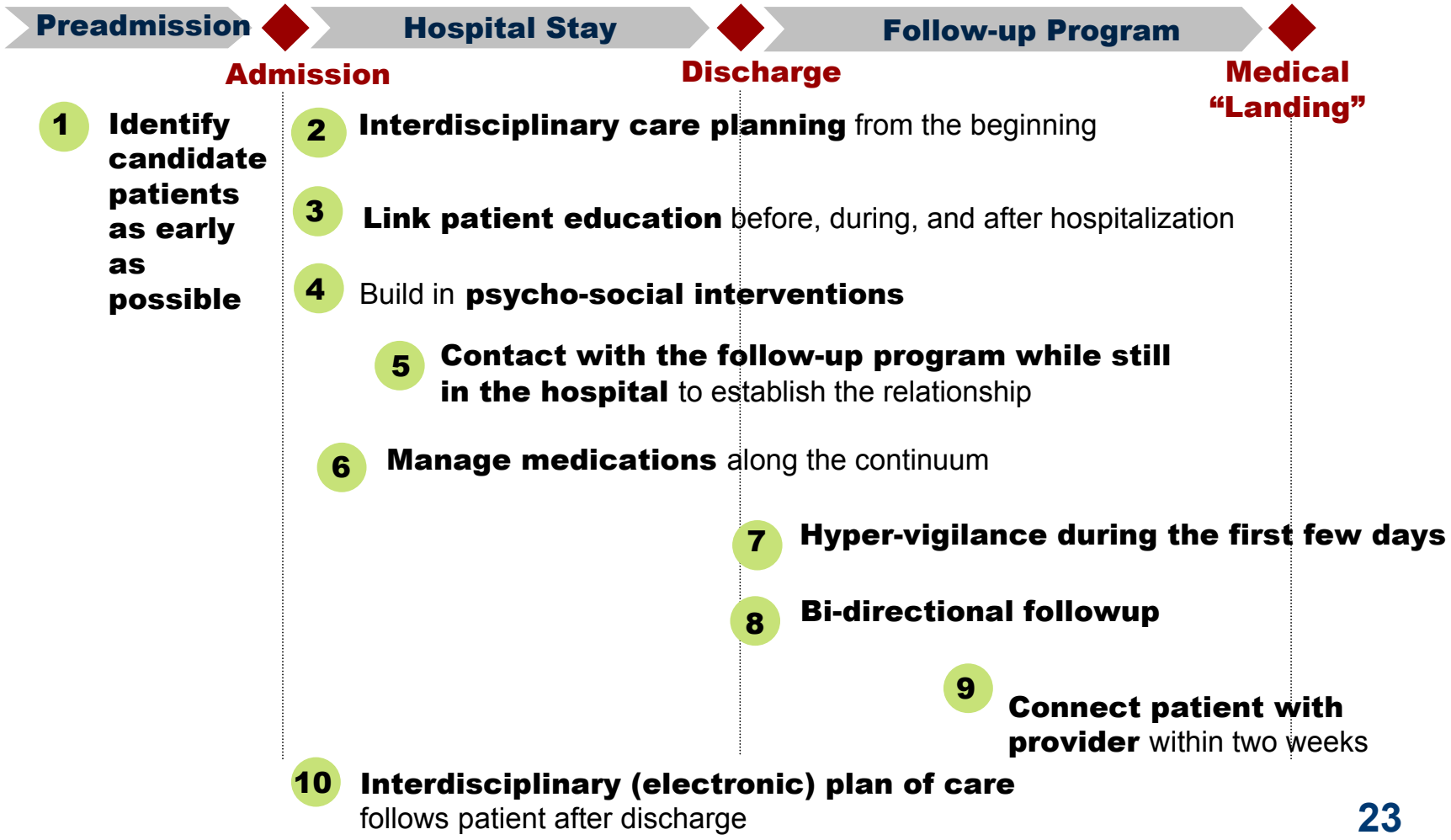
- **Interdisciplinary Rounding Summit**
- **Transitions in Care "Pilots" Conference**
- **Transitions in Care "Marketplace"**

The summits helped us:

- Learn from each other what's **already working at UPHS**
- Make **commitments and momentum tangible**
- Create "educated consumers" for the **changes to come**

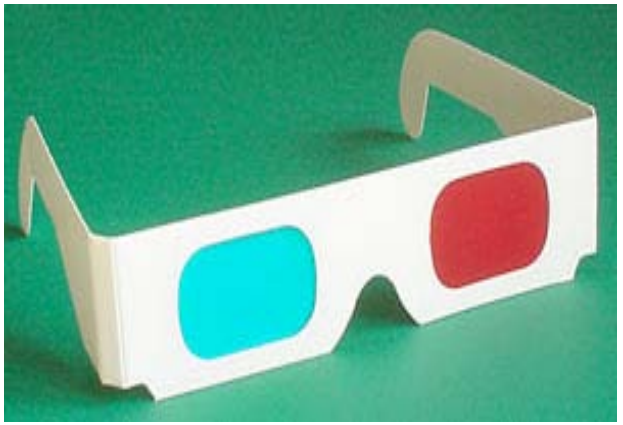
We “discovered” design specs, by looking at what’s already working at UPHS

Design Specs for Transitions Follow-up Programs



Learning from ourselves — lessons learned

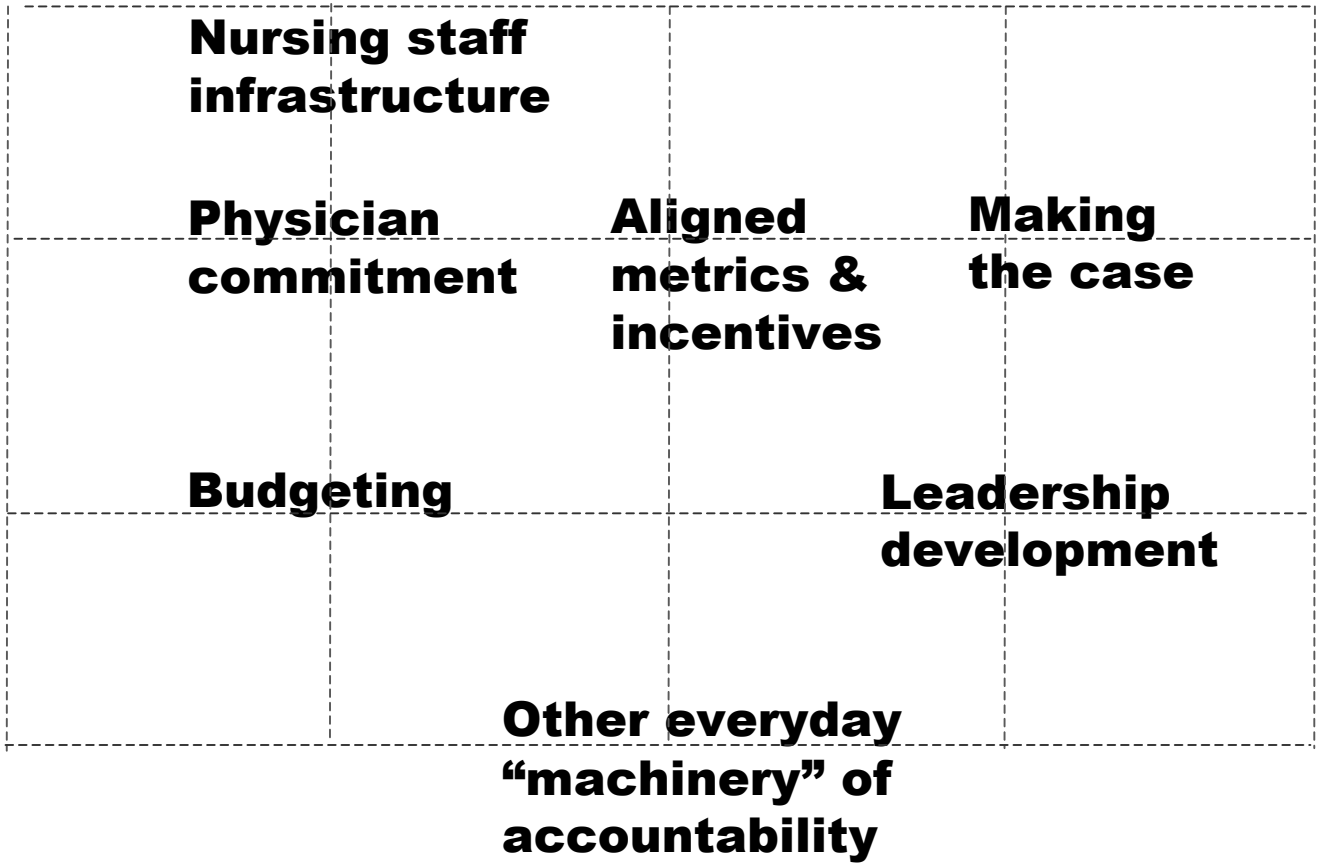
- An organization **learns best when it learns from itself**
- Pockets of innovation are already emerging inside almost every organization — if it knows how to **look and listen**
- These innovations are the **building blocks of culture change.** Your organization's culture is a **"renewable resource."**



Learning from yourself creates "pull" for the changes you want to make. People like to look at themselves in the mirror.

Knitting with hard wire

“Knitting with hard wire” — By that we mean putting in place a scaffold of supports for the new ways of working



Nursing staff infrastructure

Unit leadership alone won't do it. We negotiated the staffing infrastructure to help the unit succeed

Nursing Ratios and Leverage

	Assistant Nurse Mgr on Off Shift and Weekends	Charge Nurse without Patient Care Duties	Clinical Nurse Specialist/ Educator	1:5 RN Ratio	1:10 CNA Ratio
What	One per unit on off shift. Units share on weekends.	One per unit. Rotational assignment.	At least .5 FTE per unit	5 patients per RN	10 patients per Certified Nursing Assistant
Why	Provides strategic view and continuity on off-shifts	Handles the "air traffic control" that frees the Nurse Leader to partner with Physician Leader	Staff and patient education make the other roles more effective	Allows the unit to focus on quality agenda	Provides leverage for the nursing role

Physician commitment

No one believed we could attract enough Physician Leaders, but here's what we did

- **Uncovered** physicians already playing the role
- Looked for **natural affinities and career goals**
- Located up-and-coming physicians who were **flattered to be tapped** for leadership
- **Asked the nurses who they wanted**
- Put **"medical quarterbacks"** on surgical floors
- Focused on **hospitalists** where that made sense

We're going for the **tipping point** where momentum and expectations begin to feed on themselves.

We started building a new alliance with the financial side of the house

The 7:00 am breakfast meeting with the health system CFO

> “We don’t want Finance to set the margins for the hospitals without **first getting input from the Quality strategy.** We want to do that at a system level.
>
> **Can we count on you?**”
>
> — UPHS CMO & CLO

Budgeting

We're getting out ahead of the budget cycle and speaking with a united clinical voice

The old way	The new way
First step — set margins for each hospital. Hospitals are **locked in.**	Discussion of system-wide quality initiatives **before margins are set.**
Hospitals **(separately) submit budgets.**	CMOs and CNOs submit a **joint budget** for system-wide quality initiatives they all agreed on.
Negotiation — across hospitals and with Finance — occurs **after budgets are submitted.**	Negotiation occurs **before budgets are submitted.**

We're making our job **AND the CFO's job** easier.

With the economic downturn, we're looking for creative ways to fund what we need

- Alternative **24/7 coverage strategies**
- Reallocating transfer funds to **physician stipends**
- New uses of **Hospitalists**
- **Gain-sharing arrangements with payers**

Aligned metrics & incentives

"Choice within a framework" — we developed targets and worked with each UBCL to pick theirs

UPHS Blueprint for Quality and Patient Safety

UPHS' overarching quality goal is to **reduce mortality** and **reduce 30-day re-admissions.**

Four Imperatives	Priority Actions
Transitions in care	▪ Transition planning ▪ Medication management
Reduce unnecessary variations in practice	▪ Reduce hospital-acquired infections ▪ Reduce medication errors
Coordination of care	▪ Interdisciplinary rounding
Accountability	▪ Unit clinical leadership

Transitions in Care — FY'10 Targets

1. Post-acute care referrals
2. Use of hospice
3. Med rec on discharge
4. Readmission rate for TCM follow-up program

Reduce Variations in Practice — FY'10 Targets

5. DVTs & PEs
6. BSIs
7. Falls with injury
8. Pressure ulcers
9. VAPs
10. SCIP
11. UTIs

Coordination of Care — FY'10 Targets

12. Interdisciplinary rounding
13. Nurse/physician collaboration (NDNQI)
14. Patient satisfaction (HCAHPS)

We negotiated to get a Transitions metric in every senior leader's incentive plan

Focusing the attention of the system

Every UBCL and every senior leader at UPHS has a **Transitions in Care target this year.**

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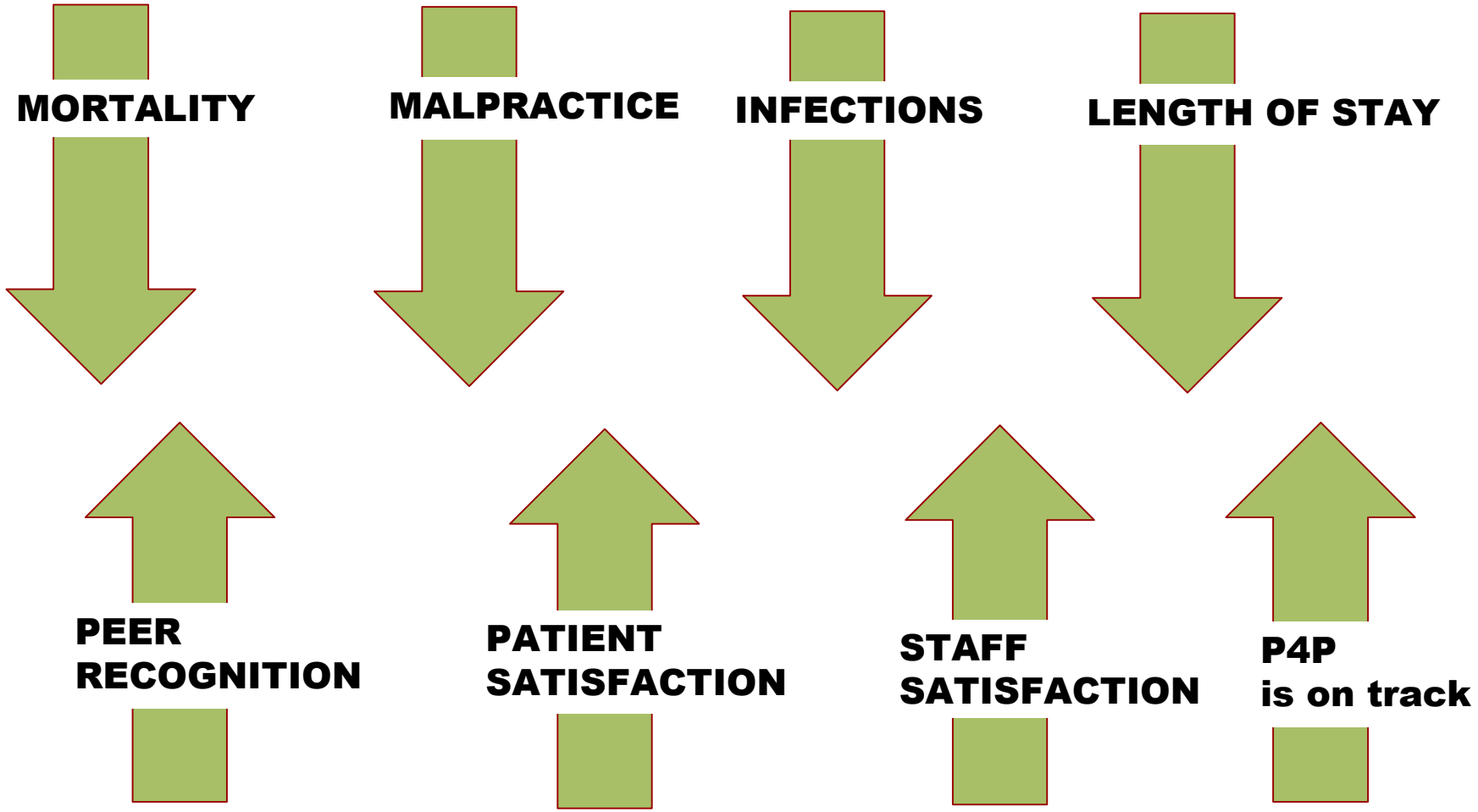
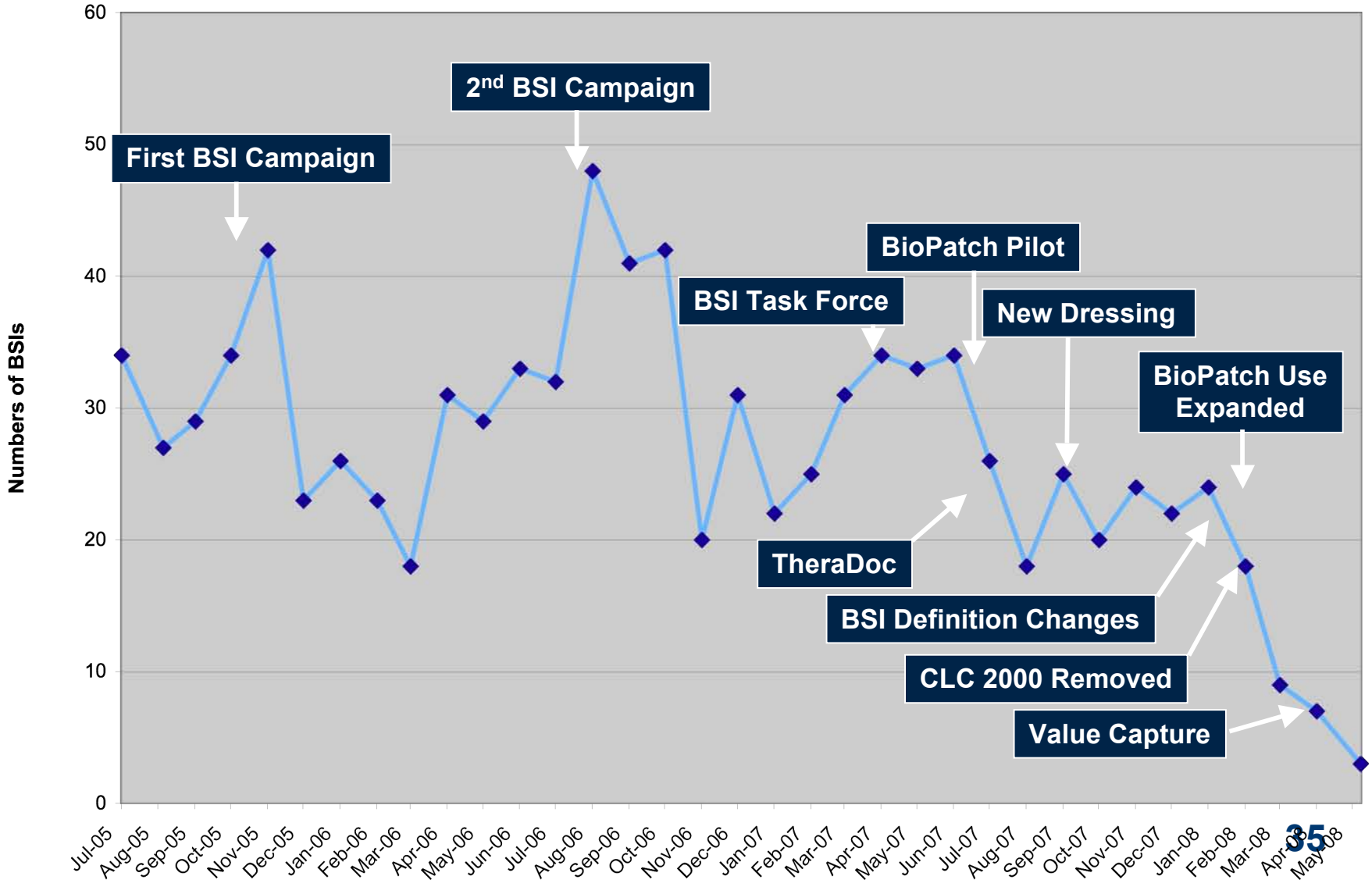
Making the case

Quality-related outcomes at UPHS are moving in the right direction



Making the case

Many efforts over time to reduce bloodstream infections. How to know if the UBCLs were making a difference?



Making the case

We did a study to separate out the impact of the first pilot UBCLs on reducing bloodstream infections

We controlled for the effect of other interventions (Biopatch, TheraDoc, new dressing).

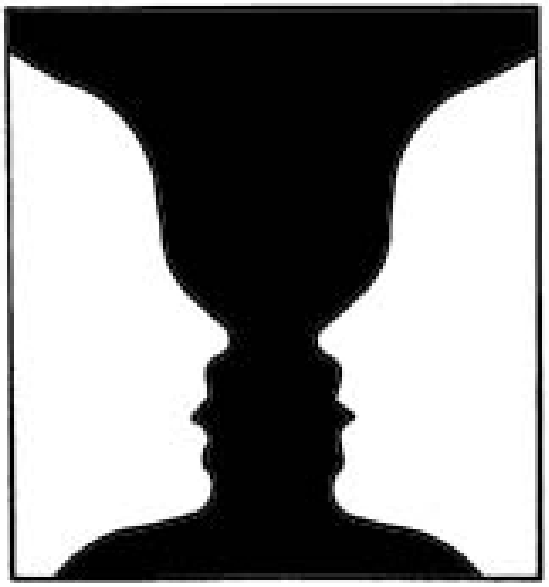
And found that **UBCLs reduce bloodstream infections and save costs.**

Net impact of five pilot UBCLs over nine months (Q3'08 - Q1'09)
33 BSIs avoided
670 hospital days avoided
$477,200 supply cost savings (direct variable supply costs adjusted for age, gender, insurance type and DRG)
$330,000 incremental investment (physician stipends, assistant nurse mgrs)
Total net savings for five units over nine months: $147,200

Figure/ ground

From one perspective, we're **working to improve Quality on the units.**

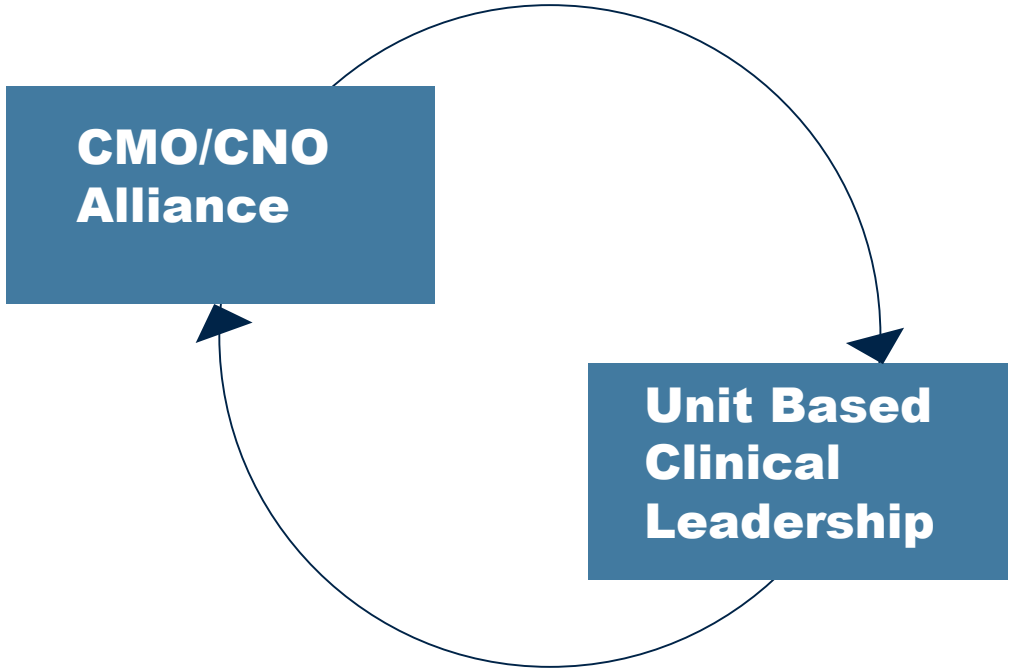
From another perspective, we're **developing the CMOs, CNOs, and UBCLs as leaders.**



Succeeding at the work builds leadership skills.
Leadership skills make it possible to succeed at the work.

Leadership development

We expected to hand off “mentoring” eventually, but discovered we wanted to keep our ears to the ground



CMO/CNO pairs continue to meet monthly with their UBCL teams — to **strategize, troubleshoot, and plan ahead.**

Leadership development

The UBCLs have to learn to be leaders who can get work done through others

Dilemmas of success

Everybody wants a piece of the UBCLs

- The health system keeps saying, **"Give it to the UBCLs."**
- Many groups are trying to **get the UBCLs' attention** — pharmacists, discharge planners, nurse educators, post-acute care providers, …

Next steps

Teaching the UBCLs to be leaders who can get work done through others

- Penn Medicine Leadership Forum — traditionally reserved for senior leaders — is **focused this year on the UBCLs**
- **It's organized as "action learning,"** to apply the leadership skills to a Transitions-in-Care project on each unit.

Everyday "machinery" of accountability

Other structures — big and small — that make it possible for people to take responsibility

- **Staffing & project management for the CMO/CNO Alliance**
- Support for scheduling meetings — **a "small" barrier that can loom very large**
- Communication with UPHS senior leaders **embedded into their regular meetings** — to signal that our issues are central to the work of the institution
- Reallocated an FTE to establish an overall **project manager for the UBCLs**
- **Clinical tools & resources** for improvement targets
- Tools and templates for **managing improvement projects** and running the weekly ops meetings

Knitting with hard wire — lessons learned

- **To change people's behavior,** you have to change their **everyday work practices**
- To change work practices, you have to put in place **supports and infrastructures** — both big and small

The supporting infrastructures create "pull" for the changes you want to make. They attract people to the new ways of working and make them easier, not harder.

Q&A — We welcome your questions, thoughts, & experiences

A new take on accountability

A new take on innovation

- **Playing with other people's cards**
- **Learning from ourselves**
- **Knitting with hard wire**

3 The “Campaign” approach to change

There’s good **social science behind what we’re doing**

CFAR's Campaign Approach to Change

1 Direction and Momentum

The quiet phase — **create "facts on the ground"** before you go broadly public

Results. Early gains and a strong foundation for broader changes.

2 Sweeping People In

Broaden the campaign and create capacities and infrastructures

Results. Spread of new behaviors and the supports to sustain them.

3 Consolidating the Gains

Institutionalize the changes and turn the Campaign back into the mainstream

Results. Change that sticks and the skills to change again as the future demands it.

“Pull” is stronger than “push”

If we create pull, others will do the work of change for us.

New behaviors can’t be legislated. They begin to show up when an organization knows how to create pull for them.

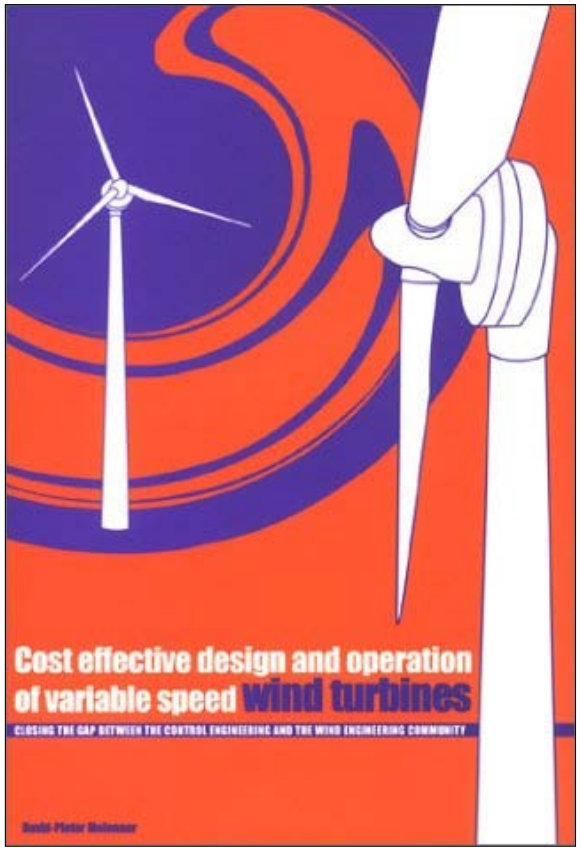
A Campaign creates “pull” for new behaviors.

Your organization's culture is a renewable resource

A useful definition of culture:
"The way we do things around here."

New behaviors are the building blocks of an organization's culture. Each behavior by itself may be small, but **together they can move the organization's culture.**

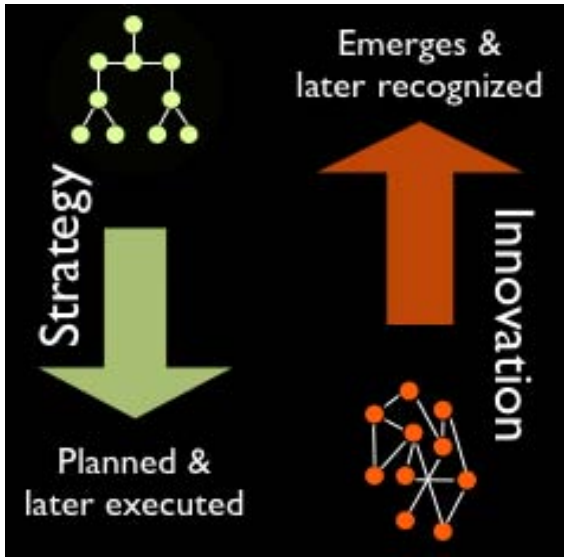
The raw material for a culture change is almost always already emerging in the organization.



A Campaign is top down AND bottom up

Top down, by itself, lacks the **resilience and creativity of grass-roots efforts.**

Bottom up, by itself, lacks **focus, alignment and the commitment of mainstream leaders** who can give resources.



A Campaign taps the **creativity and commitment of the whole system.**

The leadership skills you'll need may seem counterintuitive

NOT …	INSTEAD …
Telling and selling	**Listening and amplifying**
Pushing people to change	**Creating pull** for the changes
Trying to "motivate" or "empower" others	Discovering and **freeing up energy** and passion
Thinking your way to new actions	**Acting your way to new thinking**

A few resources — Campaign Approach to Change

Hirschhorn, Larry and Linda May. **"The Campaign Approach to Change."** *Change,* Vol. 32, No. 3, May-June, 2000.

Hirschhorn, Larry, **"Campaigning for Change,"** *Harvard Business Review,* July, 2002.

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