On the Mend: Changing a healthcare organizational culture to continuous improvement

Follow-up Q&A

The lean healthcare webinar "*On the Mend*: Changing a healthcare organizational culture to continuous improvement" drew an engaged audience that submitted hundreds of questions, many more than we could address during the hour-long session. We selected questions that represented the major topics you wanted to know more about for a follow-up Q &A with our presenters. Here are your questions and their replies.

John Toussaint, CEO of the ThedaCare Center for Healthcare Value, former president and chief executive officer of ThedaCare**:**

Q. How did senior leaders come to the conclusion that adopting lean was the most effective strategy for operations improvement?

A. It was clear that what we were doing wasn't working. We scoured the country looking for manufacturing organizations with world class quality defined as 3.4 defects/million. We found it in a snow blower company 40 miles from ThedaCare. We went out on the shop floor and observed workers committed and trained in solving problems. We said to each other that this was what we were looking for in healthcare.

Q. Physician engagement — can you give details about how to do it?

A. The most important learning we had was to fix issues that the doctors had. Most of their biggest headaches had never been addressed so with the lean tools we fixed many headaches and by doing so started to prove to the docs that the lean method could help them. As they saw that, they became more and more engaged and today there are many physician leaders who may not use all the words of the ThedaCare Improvement System but are clearly committed to improvement using these tools.

Q. Is there an effective lean healthcare assessment tool that you prefer for gauging the lean level of a healthcare organization?

A. We are experimenting with the Shingo Prize assessment tool applied to healthcare. At the Healthcare Value Leaders Network we now have trained a number of examiners from healthcare organizations in the networks. Organizations that have received the full assessment have found it very valuable.

Q. Can you summarize A3 thinking? I have heard it used but don't know what it is.

A. An A3 is two 11-by-17 sheets of paper on which a story is told with words, pictures, and data about a problem in the organization. The story starts with the background and current condition, a problem statement, then goals, gap analysis, and finally countermeasures and a plan. It is a changing document, and it stimulates dialogue among all individuals involved in a process. The fundamental principle of A 3 thinking is

that people focus on the problem first then solutions, realizing that the best solutions will come from the people directly involved in the work.

Q. As the leader of ThedaCare, how did you learn how to be a lean leader? Did you have a sensei guiding you?

A. I had several mentors but I wouldn't say I had a personal sensei. The mentors I chose were from manufacturing, had been CEOs, and had many years of experience in implementing lean. They all were willing to help at every step of the way, and I didn't pay any of them a dime. They were committed to fixing healthcare using lean.

Q. Is there an organization in ThedaCare that oversees the lean implementation process? Where is this organization reporting?

A. There is one ThedaCare Improvement System and all resources report to the senior vice president of the ThedaCare Improvement System, who reports to the CEO.

Q. What were some of the challenges that you faced that you consider unique to lean in healthcare?

A. The autocracy of healthcare professionals is a big barrier to implementing a continuous improvement methodology. This problem has its roots in the shame-and-blame guild training system in medical schools and nursing schools which is fatally flawed. There is no training or understanding of fundamental quality improvement principles including standard work and plan-do-study-act cycles.

Q. You mentioned that senior management wanted to go much faster, but you realized you had to have dialogue with people to bring them along and this takes time. How did you deal with these expectations to deliver quickly?

A. The A3 thinking tool is the best and fastest way to achieve consensus on change. Read John Shook's book *Managing to Learn* and use this powerful tool to create a change environment.

Q. How do you sustain the visual management boards?

A. The template is established and the staff fills out the data. The manager’s job is to facilitate the discussion every day or every hour whatever the case may be and keep staff and physicians focused on what is important for the unit then visually display it.

Q. How do you handle absence from the job to do kaizen events?

A. Kaizen is scheduled months ahead of time so positions can be back-filled during the week. This is especially important when physicians are participating.

Q. How is standardization maintained across the organization while allowing multiple lean process designs? Do you provide guidelines for lean improvement but allow different groups to create their own solutions?

A. Standard work is not etched in stone. It should change based on new learnings. If one unit has learned something new they change standard work. The challenge is how to spread the learnings quickly to other units and, as everyone knows who has implemented lean, spreading it is the hardest part.

Q. How do you specifically deal with people who are very resistant to change?

A. Everyone is resistant to change. The question is, what is in it for people to change: is my work life going to be better; are the patients going to be safer; is the staff going to get more engaged? Until we train people on the fundamental components of lean we can't expect them to have a clue about it. Most "resistance" is actually our fault for not figuring out what are the benefits of change for people.

Q. Where is the best place to start for quick wins?

A. It doesn't matter. All processes in healthcare are in chaos so in all areas processes need to be stabilized then standardized then improved.

Q. How do you integrate your office of patient safety, quality department, etc. ... with your efforts around lean?

A. It starts with a single improvement methodology which is fundamentally based on the Toyota Production System. All improvements whether in patient safety, surgery, outpatient care, etc. are based on using the ThedaCare Improvement System methodology. We have been careful to not have competing improvement methods as this does nothing but confuse staff and doctors and ourselves.

Q. How did you deal with compliance/legal requirements that don't really add value but force you to put in redundant "nonvalue- added" checks and balances?

A. We comply with all regulations and have compliance teams like everyone else. It's nonvalue added to patients but there is no choice. It is interesting to note however, that when staff and managers claim we can't change a process because we won't be in compliance, most of the time it is simply not true. We might not be in compliance with one of our managers understanding of a regulation but that understanding is usually what is flawed, not the process being out of compliance.

Q. Do you consider patients' families to be stakeholders?

A. Absolutely, and it's the reason when we admit a patient in the collaborative care unit that an exam is done within the first 90 minutes with the nurse, the doctor, the pharmacist, and the family present.

Q. About how much time do your staff members (RN, CNA, etc.) spend on improvement efforts in addition to their "standard" RN or CNA duties?

A. There is still a great deal of firefighting every day, if that is what is meant by standard duties. The goal is that more time is spent on improvement than firefighting and as more and more standard work is put in place this begins to happen. Contrary to popular belief standard work actually frees time for staff and doctors to do improvement.

Q. During the webinar, you mentioned a video of a team problem-solving around an issue on the pick list that you described. Can we access the video?

A. Yes. You can see the video on the YouTube channel of the Healthcare Value Leaders Network.

Roger Gerard, chief learning officer, ThedaCare**:**

Q. With a "no layoff" policy, you still need to move "extra" staff to new positions and new departments. How do you make this a positive experience? For most people in my organization, this is still seen as negative. Due to union agreements, there is a "bumping" process that is somewhat chaotic and impacts anyone less senior than the displaced staff member.

A. We have a career transitions process within the human development value stream. This mapped-out process anticipates, well in advance of any value stream activity, what may occur in the way of staff displacement or the possible elimination of functional positions. Because this happens at least eight to 10 weeks in advance of any event, we have time to recognize and then support the transition of an employee into a new role in the organization. There is still turbulence in this process, but we have minimized that turbulence and very successfully helped people move into new roles, and in some cases, new careers in the organization.

Q. What are some examples used to create dialogue during the resistance period? Are leaders trained in advance to deal with these conversations?

A. We use the dialogic process before and during resistance in a number of ways. Early in the consideration of changing work processes or tasks, we often will enter a workgroup to consider what the group's observations are, focus on opportunities and concerns, and then sometimes generate the "hard questions" that staff might have. We know that the earlier we have these conversations with staff, the more effective we are in dispelling difficulties. Later when changes are underway, we very often revisit the departments undergoing change and take very deliberate steps to cause conversation about what's occurring, how they are experiencing what's occurring, and what can be done to help them make the transition more effective and more positive. Taking the time to do this allows us to anticipate problems that that are occurring or may occur,

demonstrates that leadership is responsive to their needs and is willing to consider all of their criticisms, their concerns, and their anxieties as we go through the process. This is very powerful.

Q. How did you conduct the employee engagement survey, e.g. through Gallop?

A. Our employee engagement survey is conducted by the Advisory Board, and we are currently undertaking our third iteration of that survey. We survey annually with a very comprehensive survey that all employees are invited to take, and we generate somewhere in the neighborhood of a 60% to 80% response rate. In addition we collect data three times during the course of the year (every three months) between the comprehensive surveys, using a randomized pulse survey. This pulse survey enables us to detect early any changes that are going on in overall employee engagement in between the comprehensive surveys. All of this is done online and all of the data is assembled by the Advisory Board in the case of the comprehensive survey, or by the Organizational Development Department in the case of the pulse survey. Once the data is collected, it is analyzed by the organizational development staff and information about survey results is brought back to the executives, managers and the staff of the organization through a series of staff forums in each of the departmental or divisional areas.

Q. Is the engagement survey conducted on all staff and physicians to achieve the 80%-plus results?

A. The engagement survey is available to all staff throughout the system, including full-timers, part-timers, and occasional part-time employees. We do treat the provider survey separately from the staff survey because of special factors we want to pulse with our provider community. Therefore, they are not participants in the Advisory Board comprehensive survey. However, the provider survey and the Advisory Board indicators have significant overlap, and essentially are measuring many of the same overall engagement factors.

Q. How did you motivate people to think and act lean?

A. As John and I stated in the *On the Mend* , motivating people is not something that we accomplished directly in order to generate an engaged employee or physician. Rather we trusted that the professionals working for ThedaCare are already motivated to do the right thing for the patient and to do the right thing professionally. Our energies were focused on aligning that intrinsic motivation that our professionals already bring to their work, with the needs of the ThedaCare organization, to provide a very patient- focused, provider-focused, and friendly waste-free care delivery process. When you begin thinking about “motivating” other people, you are going down a trail that, over the long haul, can only be construed as *manipulation,* and we are very sensitive to that in our culture. Rather, we would prefer to err on the side of assuming intrinsic motivation that already exists. Where we find that intrinsic motivation to do what is needed does not

exist in a specific individual, it's possible that that individual is the wrong talent for our culture.

Q. How do/did you handle "individual contributors" who were good at their particular role but did not or would not buy in or participate in teamwork and change management?

A. This is always a significant concern when you bring about massive change in an organization. There are at times some individuals who are very good technically or clinically, in their particular role or profession, but who are for some reason unwilling or unable to work effectively as part of a team, and unable to adapt to the new changes that are increasingly a requirement of work in the organization. Unfortunately, we have to understand that some of these people, if they do not change themselves, will fail. And we have to be prepared to support them when they fail, either in selecting new work for them to do where they do have an interest, or at times helping them find a career position outside of ThedaCare, so that, from a career standpoint, they can move on effectively and helpfully to their next assignment.

Q. Who developed the curriculum to develop leaders in the 18 core competencies? Who offers the training? Besides training, are there any other development activities included in the development process? How long before leaders go through their leadership development?

A. The human development value stream is parsing out the 18 core competencies that have been defined in the research within ThedaCare as the leadership competencies that predict success. As we do this, the senior leadership of the organization has defined four of them as core, and the first wave of development focus. These four are: building effective teams, developing people, the ThedaCare Improvement System, and business acumen. Our early work to build core curriculum for all of our executives and managers in the organization is organizing around these core competency areas.

In addition, our individual development planning process is grounded in the same four competencies, and all of the work of individual leader development starts with these four. Every manager has a customized individualize development plan and access to the core curriculum. We understand that most of the learning and development does not occur in the classroom or in a training environment, but rather most of the development occurs through mentoring and coaching, and even more importantly, through stretch assignments. The best way to learn coaching is to coach and mentor somebody with guidance from a mentor. The best way to learn teamwork and building effective teams is to build one with effective coaching and mentoring from an advise, The best way to learn business acumen is to run a business or a portion of a business with coaching and mentoring from a couple of good mentors. That is our philosophy of learning within ThedaCare. We have a classroom-based curriculum, but that is not considered to be the primary source of learning.

Q. How much do you require, encourage, or use value-stream analysis with value-stream mapping to guide improvement work?

A. We are using value-stream analysis and value-stream mapping for much of our improvement work and certainly for much of our leadership development and training work. In addition, we are reorganizing much of our on-boarding, selection and hiring of new managers and staff through processes that have been remapped through the human development value stream. Through this rigorous work, we are trying to make sure that every manager, supervisor or lead that we bring into the organization, or promote from within the organization, is properly prepared to do the work that they are being asked to do. The methodologies of lean ensure that we have sufficient operational input into the redesign of these processes and a very rich array of learning methodologies, so that people have the ability to learn what they need to learn to be successful.

Q. Have the job descriptions of employees changed to support the lean culture? Is the compensation system linked to lean efforts addressing waste reduction, flow improvement, etc.?

A. We are presently redesigning job descriptions of employees affected by the adoption of lean in the workplace on an “as needed” basis and, as of yet, have not developed a core set of lean job descriptions for the organization as a whole. As we begin to understand the business performance system as a subset of our lean activities, it is becoming increasingly apparent that we will have to move this up on our work plan schedule within the human development value stream, so that there is clarity across different divisions and elements of the ThedaCare system about what is expected for different job classes. As it stands now, we have not yet gotten to that point in the delineation of specific job duties at different levels of leadership.

The compensation system is not linked directly to our lean efforts, and we do not have what is commonly known as a pay-for-performance appraisal system in this organization. We do have a managerial bonus system and an employee gainsharing system, both of which are tied to the financial performance of the organization, the quality and safety performance of the organization, and to the overall engagement of the people working in the organization. However these plans are more *communications processes* to keep people focused on what's important in the organization than they are compensation systems, even though they use a discretionary compensation as their framework for communications. Much of the work defining all of this has been done by using the tools and methodologies of lean.

Q. What are the four key drivers you've selected for leadership development?

A. As stated earlier, the four key competencies that we've selected as the driving key competencies for leadership development are (1) business acumen, (2) the ThedaCare Improvement System methodologies, (3) developing and coaching people, and (4)

building effective teams. We selected these because they are considered by our senior leadership as the core competencies upon which all of the other competencies are built. Without this focus, many of the other competencies will be less than effective at bringing about a long-term and large-scale change in the organization. So these are the four that we will likely be organizing much of our leadership development framework around for the next 12 to 24 months. As we do that, we are also looking at the crossover effect of these for competencies on the other 14 in the research, and we are almost serendipitously developing a framework for each of those as well due to their interconnection.

For More Information:

- Download excerpts from *On the Mend* and watch a video of John Toussaint sharing a personal anecdote about how to change healthcare's shame-and-blame culture.
- Explore the resources provided by the Healthcare Value Leaders Network, a partnership between two nonprofits — the ThedaCare Center for Healthcare Value and the Lean Enterprise Institute — with a mission to fundamentally improve healthcare delivery through lean thinking.
- Examine a curriculum of Lean Healthcare Workshops, specialized training with the practical exercises, examples, and case studies that show you how to apply lean management concepts to healthcare.
- Hear the latest best practices from leaders in the lean healthcare movement at the Lean Healthcare Transformation Summit.
- Visit the *Webinar Library* for concise insights into the technical and "people" challenges of a lean transformation.
- To get first notice of LEI's free webinars and follow-up postings, make sure you receive our e-letters. Log in, then click the "My Profile" link at the top right on the homepage. Check the box "LEI Newsletters."