An Outsider View: The Journey of Leadership
Part 4: Design, Redesign & Implementation

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Introduction
In our fourth article the focus of our leadership journey will be how leaders impact their organizations through examination and improvement of the processes of the organization. For this part of our leadership journey we will present a series of tools or ideas for the “what” of managing processes of the healthcare system. However, our primary focus will center on the role and opportunity leaders have and your contribution to making this part of the model work best.

If one spends some time searching the literature, the web, and other resources you will find a plethora of different approaches for each of the major topics in this part of our working model. We will offer a very brief overview of some approaches available, but then turn our attention to your role as the leader. Let us begin with some definitions and build the context of managing processes.

What do we mean by a “process”? A process is no more than the steps and decisions involved in the way work is accomplished. Everything we do in healthcare involves processes and lots of them.

Here are some examples:

• Triaging and treating patients in the emergency room
• Taking and recording patient vital signs
• Receiving and dispensing medications
• Moving patients from one ancillary department to another
• Performing surgery
• Conducting quality reviews of the care of patients
• All of the administrative and financial affairs of a hospital
• Meetings of staff
• Coordination and treatment across the various medical/hospital departments
• Post operative care from the recovery room to moving the patient back to his/her hospital room
• Discharge planning and follow-up care
• Financial management of the institution

This is only a small list of the many and complex processes inherent to the hospital environment. It is designed to illustrate that everything we do within the hospital consists of a series of interconnected processes each with defined starting and ending points.

Some processes are more important than the others by virtue of the potential impact they have on the quality and safety of the care we provide. Some are more complex with numerous different technical specialties required to perform the work of the processes. As a result, the more complex the processes of a hospital create greater potential for miscues and/or missteps along the course of treatment. When using the context of a medical specialty, a collection of processes for a given diagnosis and subsequent treatment plan are often referred to as “clinical pathways” or “protocols” for which we can establish “best practice standards” of care. These protocols or pathways, when standardized, offer a good benchmark by which to conduct quality reviews of the care provided.

Who is the process owner?
Everyone has a stake in one or more processes. This is especially true in the hospital environment because patients are “passed” through potentially so many different processes. For the most part, groups of hospital staff usually share in—and “own”—the activities which make up a clinical/administrative process. But the one individual who is ultimately responsible and accountable for the proper working of the process is known as the “process owner.” The process owner of the clinical activities of a hospital and the care provided patients is a physician. He/she holds the ultimate accountability for the safety, will produce a number of excellent examples. For purposes of this paper, we only suggest that hospitals and healthcare organizations should select out and use the one that best fits the needs and management style of the organization if one is not already in place.

Here are only a few we found in a quick search and we should point out many are the same concepts with different titles:

• 6 Sigma
• Hoshin Kanri
• Just in Time Manufacturing
• Total Quality Management
• Process Improvement and Management
• Continuous Quality Improvement
• Quality Improvement
Suffice it to say, each has its own perspective and application. Each model is designed to address most of the following elements with their construct: a focus on organizing and directing the team(s) responsible for examining and improving the processes of the organization; a starting point of defining the problem; measuring the process and analyzing data collected to pinpoint patterns and root causes; design and implementation of improvements; and, most include a monitoring and follow-up procedure to ensure the organization determines the success of the effort. While these are not the only parts of most of the models, they represent the majority of the primary components. Now, we will turn our attention toward our base model to examine the roles of leaders in each part.

Framework for Selecting Processes to Improve
Since healthcare is a very complex and often overlapping series of both clinical and administrative processes, it would be most helpful to have a framework to use in identifying the most valuable processes to examine. Remember, leaders, the goal is to pursue improvements for which there is an excellent return on the investment of time, effort, and expertise of the team tasked with the task. The end-game is all about producing an impact.

Here is one way to look at how to decide which processes will be analyzed for potential improvements.

Leaders can suggest their process improvement team(s) focus on processes in terms of: high volume, high risk, and/or problem prone. For all healthcare organizations, as complex as they are, selecting processes which are repeated many times in the healthcare organization, high volume, will provide an opportunity to make meaningful changes which can have a broad impact across the healthcare organization. If the hospital provides a high volume of normal vaginal deliveries, selecting this clinical pathway (process) will provide a significant potential impact on the quality and safety of this clinical service. Second, we could select processes which carry with them an inherent high risk such as neurosurgery, coronary artery by-pass surgery, or other equally challenging clinical service. Although these clinical services may not have the volume of patients as other areas, their challenging nature regarding the relative risk to the health and well being of the patient, lend themselves to good candidates for review. And third, healthcare leaders may want to encourage formulation of process improvement teams tasked with looking at processes which routinely encounter problems. In healthcare, inherent problems associated with clinical practice generally result in compromising the quality and safety for patients. Using this framework will help leaders and their teams to select out the processes for which the most meaningful and positive outcomes can be achieved.

Now, let us turn our attention to the various sub-parts of the e3 model to learn about each contributes to the focus on managing for process improvement.
Assessment
This part of the e3 model illustrated above usually consists of the following questions to help in defining the root cause of what is not working right or missing:

- What is the problem?
- What is the process associated with the problem?
- What is the focus?
- Who are the key members of the healthcare team who manage the process and what are their roles/contribution to the outcomes?
- What are the steps in the process and how can we measure them?
- What is our target with respect to the process? Is it quality, safety, and efficiency/efficacy? Cost? Outcomes?

In essence, the beginning step of assessment turns out to be the most important because if we do not know what the “real” problem is, our efforts to design a solution will produce results clinical effectiveness, and quality of the care of patients. It should be noted, however, during the clinical care process ownership of the sub-processes, those are the clinical processes bundled together for the entire protocol, does pass to the individual owners of the sub-processes. For example, patients referred to Radiology for x-rays, the technician takes on ownership of the processes associated with the taking of the x-rays. For purposes of the healthcare environment, everyone on the healthcare team assigned to treat an individual patient shares ownership and responsibility for conducting quality improvement reviews.

What is quality improvement?
Quite simply, quality improvement involves healthcare providers in making successful and meaningful changes in the way care is delivered and in improving outcomes of that care. CQI or Continuous Quality Improvement involves a hands-on series of activities and tools used by healthcare professionals and administrators who work toward improving the quality, safety and efficacy of the healthcare services and ancillary support functions for the patients they serve. CQI is a stepwise process designed to collect meaningful data to be analyzed to identify root causes to problems identified in the healthcare system that get in the way of high quality healthcare. CQI includes a variety of tools to assist in the management of this effort. The decisions about what needs to be improved, the possible methods to improve it, and the steps to take after getting results from the charts are all made by staff and based on the reliability and validity of the data collected, experience in the healthcare process, as well as, management wisdom and experience. CQI represents both the science and art of sound management and leadership practice.
What are some underlying principles important to “processes” of healthcare?

There are a number of key factors which help to reinforce the value of leaders who guide their healthcare organizations toward investing time, expertise and effort into exploring and expanding their leadership teams’ abilities and capacities for examining processes. These include:

• Creating, designing, and crafting “standard processes” in healthcare, such as clinical protocols especially using the concepts and tools of benchmarking for best practices, provides standards of care for which assessments of quality, safety and cost effectiveness can be most effectively pursued.

• The healthcare industry by its very nature is a very complex and interconnected “web” of a variety of processes, sometimes overlapping, so having tools to reduce this complex model into “sub-processes” aids in its assessment and improvement.

• Guiding process improvement efforts is an excellent model for leaders who desire to create living and vital “learning organizations” which are always looking for ways to improve.

• Delivering care in resource constrained environments provides an excellent foundation for a call for leadership and involvement across the entire healthcare organization….it creates the opportunity to introduce and implement profound and substantive organizational change!

What is the benefit of critically examining processes for healthcare improvement?

A standardized process improvement methodology allows us to look at how we perform work. When all of the major healthcare staff members are involved in process improvement, they can collectively focus on eliminating waste—of money, people, materials, time, and lost opportunities to improve care. The ideal outcome is that jobs can be done cheaper, quicker, easier, and—most importantly—safer. This is fundamental to leading by looking critically at processes.

A teamwork approach is intrinsic to life in healthcare organizations. Using total quality improvement tools and methods reinforces the intrinsic value of teamwork. Using team members’ collective knowledge, experiences, and efforts is a powerful approach to improving processes. Through teamwork, the whole becomes greater than the sum of its parts.

The Model...e3...Explore, Expand, Excel...Ideas, Relationships, Processes & Systems

Healthcare reform by definition necessitates crafting a new design, a redesign followed by careful implementation of changes to the organizational structure of the healthcare system. In every effort to change the healthcare system, leaders who demonstrate the abilities to perform the following functions will foster environments best suited for potential success. Assessment means leaders are willing and encourage others to develop the ability to critically evaluate current ways of performing activities looking for opportunities for improvement. Process mapping is one method, which we will also explore in a subsequent article, by which to draw picture of how the current system works. It is a stepwise roadmap which can help to identify underlying flaws in the current methods while also stimulating creative energies to find new approaches. Quality improvement, one of the four objectives of healthcare reform in Romania, seeks to address current deficiencies by developing forward thinking and methods to prevent the mistakes made today. The idea behind “after action reviews” is based on
creating an environment of continuous learning as part of the way organizations function. In each of these areas of competencies, leaders will be rewarded for exercising, again, a willingness to challenge their own thinking, as well as, those with whom they work.

Figure 1

Here we go!

Practical models available.
There are a plethora of models available for healthcare leaders to use in the examination of processes. A quick search of the literature and other In essence, the beginning step of assessment turns out to be the most resources which do not fit and ultimately will not “fix” the problem.

Tips for Leaders
For leaders, the challenge is to create an environment where everyone, regardless of their status and/or position, feels the freedom to openly address the questions listed above. So, what can leaders do to promote such an environment? It may take time, but the effort will pay significant dividends. Here are some tips for leaders:

• Always work to provide honest and frank answers to questions raised by staff even if you have an answer they may not like. Honesty with staff will return honesty from them.

• Practice holding brainstorming sessions around key issues or challenges in an effort to uncover creative solutions. Brainstorming sessions will illustrate how leaders are genuinely looking to their staff members for suggestions and recommendations.
• When conducting assessment sessions, ask one of the staff attending to be the facilitator of the session. This will demonstrate how the leader is willing to share the role of “leader” with others, thereby, promoting an open and safe place to share one’s thinking.

• Before starting assessment sessions or first meetings for a process improvement team, brainstorm with the attendees a list of “group agreements” which they and you, the leader, agree to abide by during meetings or gatherings to discuss the processes under review. These group agreements then become “how we agree to behave and interact with one another” as a standard of practice.

• First, and foremost, leaders who encourage and act on the basis of “trust” will reap the rewards of their efforts.

Process Mapping
One the of the critical steps in the process exploring and expanding one’s thinking about a process in an effort to find obstacles, flaws, extra and unnecessary steps, and/or to identify people or groups who do not need to be part of the process is the use of flow charts. A flowchart is a graphical representation of a process. It represents the entire process from start to finish, showing inputs, pathways and circuits, action or decision points, and ultimately, completion. It can serve as an instruction manual or a tool for facilitating detailed analysis and optimization of workflow and service delivery. In healthcare, flow charts can be used to represent clinical protocols or clinical pathways of standards of care upon which quality improvement reviews are based. They can also present a picture of administrative policies and regulations such as supply chain management.

Tips for Leaders
• Use “probe” questions designed to dig deeper into the process problem so that what people see of the surface does not become the final explanation for the problem, but rather provides the avenue to take a deep dive to learn what is really going on.
• Leaders should facilitate a dialogue within the project team to explore where the weak points may be in the process that if corrected will provide much better outcomes. Include everyone in the conversation.

• A leader’s role is to also be the outside/inside objective reviewer of the work and to conduct a cold eye review, one that takes the most critical perspective, to uncover the underlying problem. This requires leaders to be able to balance inquiry with advocacy to move the process improvement team beyond a simple understanding of the process to a place where they can really expose the best opportunities for improvement.

• In the final analysis, there are two key questions for the process improvement team to answer:

  • What patterns or trends emerge?
  • What is the potential root cause?

• During this phase of process improvement efforts, the focus of the leader is to help the team to craft a clear picture of the process and its most critical shortcomings. In reality, finding the root cause is the most difficult, yet, rewarding part of the entire effort.

Quality Improvement

“Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” (1) This quote by Blumenthal suggests two things. First, quality of healthcare and health services have a clear cause and effect relationship so that problems noted in the processes of healthcare which are then corrected will have a measurable and positive impact. Second, improvements are identified by comparing current processes of care with benchmark high quality standards to uncover gaps in performance. Moreover, Drs. Shipon and Nash go on to say that “applying this definition entails measuring health care and implementing interventions based on the measurements as a way to improve care.”(2) For our purposes in this article, quality improvement always involves the examination and assessment of processes associated with the giving the healthcare services. Activities surrounding process quality improvement efforts then fall into three key areas: standards of practice, gaps in performance, and the benefits and impact of meaningful interventions.

Healthcare organizations which commit resources time and effort coupled with solid guidance from its leadership across the organization will be the ones which represent the best in the delivery of high quality, safe, and cost effective healthcare services to its patients and community. Quality improvement activities of healthcare organizations are, in short, the foundation and fundamental core elements of sound process management.

Tips for Leaders

Here are some ideas for healthcare leaders who want to make a difference in their organization’s effort to manage and improve its processes:

• Leaders need to define and clearly state their plans, vision, and direction of the process improvement activities of the healthcare organization. Leaders set the tone and role model for others to emulate.
Take advantage of any opportunity to present your perspective and commitment during staff meetings, any interaction with staff, and larger group gatherings.

- Leaders need to clearly define and set expectations of performance in the action taken in monitoring and managing organizational processes. Incorporate these expectations in staff position descriptions and reward members for best in class behaviors supporting these standards.

- Leaders can encourage and reinforce the value of creating an environment of continuous learning and the commitment to change as a core value of the healthcare organization. Make process improvement a key element of your healthcare organization’s new employee orientation program, part of an on-going agenda for your organization’s education and professional development activities.

After Action Reviews
After Action Reviews were originally created by the U.S. Army as a tool by which the Army could conduct structured de-briefing sessions of the field activities. After action reviews assess and analyze what happened, why did it happen, and how can it be improved so the next event or exercise shows improvement. They can be very formal or informal in their nature, however, they are designed to be done immediately after an event or process so that what has happened is fresh in everyone’s mind. They are also designed to help build a culture of accountability for action in an organization. For healthcare, after action reviews can be used, for example, at the close of a complicated surgical case, in the Emergency Room after a particularly busy or challenging shift, or any other process of a healthcare organization. After action reviews are not a substitute for the more formal quality improvement activities, but rather are short in a timeframe, highly focused de-briefings which serve to draw immediate attention to opportunities for improvement. The results of after action reviews should and can be incorporated into the more formal process improvement activities of the healthcare organization.

Tips for Leaders
Here are some brief ideas to make after action reviews more meaningful and have a clear impact on performance:

- Teach everyone in the healthcare organization what they are and how to conduct an after action review. For example, these sessions can be organized and facilitated using 3 quick questions: what went well? Not so well? And, what can we do better

- Encourage staff members and healthcare teams to plan methodically to routinely conduct after action reviews as a normal part of their management process.

- Report the results of after action reviews at senior leadership or staff meetings to demonstrate how they contribute to the overall performance improvement culture of the organization.

- Celebrate the successes when changes made as a result of an after action review produce improvements.

- Recognize after action reviews are additional tools leaders have available to them and their leadership teams to promote an open and safe environment by which to institutionalize process improvement as part of the core management process.
Some Closing Thoughts
This fourth article has focused on the role of leaders and their contribution to improving the processes of the organizations they lead. As complex of processes there are in healthcare, so are there a plethora of wonderful resources available ready to assist in ensuring that everything that is done, is done with commitment, enthusiasm and the dedication to improving care to patients. Those resources are the people of the entire healthcare team. Here are just a few thoughts for you to consider:

- One of the greatest gifts of leadership is the opportunity to guide, coach and encourage others on the healthcare team to exercise their own leadership roles. Just as healthcare is a multidisciplinary industry, so is management of hospitals and healthcare organizations. No one can nor should consider the role of leadership to be only the senior most person on the team!

- Senior leaders and the rest of the leadership team need to view everything they do in the context of their contribution to managing for success in process improvement. Engaging staff on a routine basis in a dialogue about “processes of healthcare and how to continuously improve” will reinforce staff perceptions of the commitment of senior leadership to the effort as well as embed it as a “this is the way we do things” approach to internal management. Remember, every time you leave your office and go out into the organization you are “on stage”. Staff look toward leaders as role models. Seize the day!

- The senior leader can contribute to crafting this environment of process improvement by setting time aside to work with his/her senior leadership team using management interventions such as leadership retreats to build his/her team. Leadership retreats (1 ½ - 2 day events organized and facilitated by outside expertise) provide an excellent opportunity to work with and build the capacity, capability and confidence of the senior healthcare leadership team.

So, here we close this chapter of our journey. Our next article will focus on leaders of “systems thinking.” But for now, let us end this session with one final thought to ponder.

Leaders...never, never hesitate to reach out to the team for their contribution to the overall effort. You, and only you, hold the keys that will open the doors of creating an environment of sustained superior performance!
