From a Culture of the Expert to a Culture of Learning

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Health care in the United States is changing in response to unprecedented challenges precipitated by an unsustainable financial model, inconsistent quality of care, eroding patient satisfaction, and unequal access by different socioeconomic groups.

In the traditional model, care was delivered by highly skilled professionals whose authority to provide complex medical care and associated procedures depended upon their having completed prolonged intensive training, followed by state licensure and national certification. But despite laudable attempts to standardize training, performance was as varied as the number of practitioners. The training process emphasized individual accountability and autonomy, often in a stressful environment. To produce a health care expert, the system often sacrificed teamwork, standardization, and collegiality, and focused on episodic care and short term results.

Under a fee-for-service model, health care organizations benefitted from these highly skilled and highly productive physicians, but utilization soared and costs were unsustainable. Changing this model and culture would require a shift from an emphasis on production to an emphasis on quality, from individual patients to community, from individual skills to team performance, and from established experts to a culture of continuous learning and improvement.

When I took my current position in 2008, one of my first tasks was to work with physicians to design and implement a replacement for the voluntary medical staff leadership structure. Everyone, including both physicians and administrative executives, agreed that physician leadership was critical to redesigning the system for delivering care. Yet, there was little connection between clinical and operational "best practices." Physicians lacked time, resources, and support to provide meaningful input and to influence change within the organization.

After a gestation period of eighteen months, the medical staff accepted a structure that included Department Chairs and Division Chiefs jointly selected by the organization and the medical staff with paid administrative time to use for the task of leading change. With the new structure in place, physicians and their operational partners gained traction and momentum by clarifying problems, engaging subject matter experts, designing processes, and measuring outcomes, all with a sense of urgency catalyzed by health care reform.

A growing body of literature in the field informed these deliberations and the resulting changes. Early successes reinforced the clinical legitimacy of these changes in the minds of physicians. Implementation steps paralleled Kotter's steps in *Leading Change*[1] and Shea's view in *Your Job Survival Guide to Change Management*.[2] What we did not anticipate, was how the change in leadership structure and its results would begin to influence the organizational culture. Unlike many adaptive changes described by Heifetz and Linskey,[3] change came from within, fueled by physician energy to influence changes in health care at the local level and provide a legacy to future providers. The milestones reached, and the direction of change, parallel many of the guidelines of the thought leaders in change management, particularly Kotter.[4] This process can amplify those changes beyond the physicians.

It was clear from the beginning that unfreezing the production model would not be easy. Physicians have long endured excessive workloads, declining compensation, bureaucratic intrusions, and eroding professional satisfaction, but they had little time or energy to consider alternatives. Unfortunately misaligned compensation incentives perpetuated a flawed production model. Instead of contemplating another way, physicians responded much like automobile workers did to their unfulfilling jobs; they accelerated production to keep pace with reduced compensation and unfulfilling work. As a result, national data revealed quality gaps; patients increasingly voiced their discontent with access and cost; and health policy experts noted the variable quality of care and inconsistency of access, and the unsustainable financial cost.

Meanwhile, national policy changes that are part of the PPACA (so-called Obamacare) offered a competitive advantage to higher quality results and value-based purchasing. Innovative physician groups around the country were responding to these incentives by providing comprehensive care in a new model, with the result that they were maintaining incomes and working in a more satisfying environment. From the administrative viewpoint of an innovative health care system that wished to remain on the leading edge of change, the first critical step was to communicate this message to its influential physician leaders and to establish the need for change and a vision for what it would look like. Fortunately, the national debate on health care helped to create a "burning platform" sense of urgency. Clearly, without leadership by physicians, change would not occur.

Early discussions emphasized two way communications between the physicians and the administration in an effort to build trust. Key physician leaders with experience in health care reform reinforced the need for a partnership and common purpose between the physicians, the organization, and the community to achieve local solutions. Elements of the new administrative structure's design emphasized cross functional teams to standardize processes and respond to data. The organization's commitment to fund the Chair and Chief positions allowed the medical staff leaders to devote time and resources to the care teams. A common vision of improved quality, efficiency, and satisfaction through data measurement and continuous improvement began to take shape. This could never have been a achieved with predetermined methods, but resulted from group discussions and a collective approach.

The structural changes alone would not have turned this vision into reality. The same competencies that made physicians successful in a system designed to produce experts did not prepare them for working within teams. An introductory Physician Leadership Academy brought in outside experts to provide a curriculum that covered critical components of health care delivery and team performance. This approach helped widen the circle of the "right people" while exposing the new leaders to changes in the industry aside from direct patient care. National organizations for health care education, like the Institute for Health Care Improvement, provided a broad experience that validated our local efforts. The chairs and their operational partners met regularly to establish priorities and to monitor performance data. Committee work and small scale projects provided experience and confidence that change was possible. Education in process improvement, Lean, and Six Sigma provided an additional skill set. Senior executives offered to mentor physician leaders as they made the transition from providers to leaders. Internal communication allowed transparency within the medical staff and shared success.

In the first year, early wins provided confidence and momentum with both the physicians and executive leaders. Key performance indicators, which had not improved under the old system, gradually showed improvement. Statistics for length of stay, hospital acquired infections, birth trauma, and mortality rates improved to top quartile or decile. Implementation of the electronic health record allowed standardization of care protocols and facilitated data retrieval. Physicians were now available to provide cross functional teams with the expertise to change care and engage fellow physicians. Problem areas were identified and resources were attached for improvement. The process of standardization, data, metrics and redesign replaced the individualism of the expert. It was no longer about what we did in the past; it was about what the data showed and could we learn a new way.

The department chairs used their division chiefs and the cross functional care management teams to amplify this approach. The quality department reorganized and simplified data reporting to the teams. Groups that had blamed each other for past inactivity now leveraged collective skills to deliver results. Success broke through long standing organizational silos. Efforts now translated into results that provided both intrinsic and competitive value.

As the new system took hold, these cultural changes were "refrozen" by offering recognition and celebrating success. Providers derived energy from helping others and improving the quality of patient care which they were now empowered to influence. Results met or exceeded national benchmarks which fueled further improvement. Intrinsic rewards and empowerment replaced variable high production care. The process of continuous improvement appealed to the physicians' scientific approach and desire to exceed expectations. Without this intrinsic motivation and passion, structural changes alone would not have resulted in this cultural shift. Without the environmental changes in leadership structure, the status quo would have prevailed. Beyond the intrinsic rewards, solving these issues gives both the physicians and

organization a competitive edge and the prospect of stabilized reimbursement and recognition for crafting a viable solution.

It is still early in the process of change. Barriers and silos still exist. Kotter's steps of clearly communicating problems, urgency, establishing a guiding coalition, and providing an alternative vision will need to be repeated throughout the organization. Two way communication and shared design builds trust; communication and an effective structure to align and empower the teams must follow. Often this requires instruction that is task specific. Peer support can accommodate missteps. Finally, short term wins, achievement, and recognition help provide traction, even while consolidation of gains amplifies the changes. Innovation and creativity propel incremental improvements as well as completely new approaches which are tested with metrics and data. For these new approaches to be deployed system-wide, senior leadership must actively support it and provide the necessary resources, while preventing a retreat into the old system of fragmented care in silos.

As with individuals, organizational behaviors become habits, and with time, habits become culture.

"In times of change, learners inherit the Earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists."

—Eric Hoffer

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