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

University of Pennsylvania Health System

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Who we are

Victoria Rich, PhD, FAAN, RN
Chief Nursing Executive, University of Pennsylvania Medical Center
Associate Professor, University of Pennsylvania School of Nursing

PJ Brennan, MD
Chief Medical Officer & Senior Vice President
University of Pennsylvania Health System

Elizabeth Riley-Wasserman, PhD
Senior Vice President, HR & Organizational Development, Mercy Health System
(Formerly Chief Learning Officer, University of Pennsylvania Health System)

Linda May, PhD
Principal
CFAR

Larry Hirschhorn, PhD
Principal
CFAR
The frame for today’s discussion

<table>
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<tr>
<th>A new take on accountability</th>
<th>A new take on innovation</th>
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<tbody>
<tr>
<td>Tapping into people’s passions and interests</td>
<td>Helping the organization learn from itself and look for places where pockets of innovation are already beginning to emerge</td>
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<tr>
<td>Developing the everyday work practices — large and small — that make it possible for people to take responsibility</td>
<td>The leader’s job is to develop the strategic radar to identify weak signals and amplify them</td>
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</table>
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

<table>
<thead>
<tr>
<th>Hospital of the University of Pennsylvania #8 US News &amp; World Report/ Magnet</th>
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<tbody>
<tr>
<td>Pennsylvania Hospital</td>
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<tr>
<td>Penn Presbyterian Medical Center</td>
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<tr>
<td>Home Care &amp; Hospice Services</td>
</tr>
<tr>
<td>Good Shepherd Penn Partners</td>
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</tbody>
</table>

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

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UPHS Blueprint for Quality and Patient Safety

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

Today it’s 34 “official” units — and another dozen who are “operating as.”

The job: Today the trios manage Quality on the unit, drawing in others as needed.

UBCLs are ready this year to shoulder Transitions in Care, a major system-wide initiative.
The UBCLs aren’t the answer to “everything”

<table>
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<tr>
<th>UBCLs HAVE THE MOST IMPACT WHEN ...</th>
<th>HERE’S WHY ...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interdisciplinary care coordination</strong> makes a difference</td>
<td>With UBCLs, the team is interdisciplinary from the start</td>
</tr>
<tr>
<td><strong>Physician backup</strong> is especially needed</td>
<td>With UBCLs, the nurse leader can count on backup from the physician leader</td>
</tr>
<tr>
<td>The unit needs the cooperation of another unit or department</td>
<td>With UBCLs, there’s a leadership team to represent the unit in “negotiations”</td>
</tr>
<tr>
<td><strong>Sustaining the gains over time</strong> will be difficult</td>
<td>With UBCLs, accountability is ongoing</td>
</tr>
</tbody>
</table>
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.

INTERNAL

CMO/CNO Alliance focused on Transitions this year

Penn Medicine Leadership Forum “action learning” focused on Transitions this year

New HUP Transitions Committee

CNO Council focused on new roles for Transitions

Unit-based pharmacists

EXTERNAL

Healthcare reform

Pay-for-performance contracts

Public reporting influences patient choice

Vendors looking to partner on tele-health

Insurers looking to reduce readmissions — and willing to negotiate gain-sharing arrangements.

TRANSITIONS IN CARE

for better patient outcomes & reduced readmissions
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

<table>
<thead>
<tr>
<th>Preadmission</th>
<th>Hospital Stay</th>
<th>Follow-up Program</th>
<th>Medical “Landing”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admission</strong></td>
<td><strong>Discharge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Identify candidate patients as early as possible</td>
<td>2 Interdisciplinary care planning from the beginning</td>
<td>7 Hyper-vigilance during the first few days</td>
<td>9 Connect patient with provider within two weeks</td>
</tr>
<tr>
<td>3 Link patient education before, during, and after hospitalization</td>
<td>5 Contact with the follow-up program while still in the hospital to establish the relationship</td>
<td>8 Bi-directional followup</td>
<td></td>
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<tr>
<td>4 Build in psycho-social interventions</td>
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<td></td>
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<tr>
<td>6 Manage medications along the continuum</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Interdisciplinary (electronic) plan of care follows patient after discharge</td>
<td></td>
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</table>
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

<table>
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<tr>
<th>Nursing staff infrastructure</th>
<th>Physician commitment</th>
<th>Aligned metrics &amp; incentives</th>
<th>Making the case</th>
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<td>Budgeting</td>
<td>Leadership development</td>
<td>Other everyday “machinery” of accountability</td>
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Nursing staff infrastructure

Physician commitment

Aligned metrics & incentives

Making the case

Budgeting

Leadership development

Other everyday “machinery” of accountability
Nursing staff infrastructure

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

### Nursing Ratios and Leverage

<table>
<thead>
<tr>
<th></th>
<th>Assistant Nurse Mgr on Off Shift and Weekends</th>
<th>Charge Nurse without Patient Care Duties</th>
<th>Clinical Nurse Specialist/Educator</th>
<th>1:5 RN Ratio</th>
<th>1:10 CNA Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What</strong></td>
<td>One per unit on off shift. Units share on weekends.</td>
<td>One per unit. Rotational assignment.</td>
<td>At least .5 FTE per unit</td>
<td>5 patients per RN</td>
<td>10 patients per Certified Nursing Assistant</td>
</tr>
<tr>
<td><strong>Why</strong></td>
<td>Provides strategic view and continuity on off-shifts</td>
<td>Handles the “air traffic control” that frees the Nurse Leader to partner with Physician Leader</td>
<td>Staff and patient education make the other roles more effective</td>
<td>Allows the unit to focus on quality agenda</td>
<td>Provides leverage for the nursing role</td>
</tr>
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</table>
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
We’re getting out ahead of the budget cycle and speaking with a united clinical voice

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<th>The old way</th>
<th>The new way</th>
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<tr>
<td><strong>First step — set margins for each hospital. Hospitals are locked in.</strong></td>
<td>Discussion of system-wide quality initiatives <strong>before margins are set.</strong></td>
</tr>
<tr>
<td>Hospitals <strong>(separately) submit budgets.</strong></td>
<td>CMOs and CNOs submit a <strong>joint budget</strong> for system-wide quality initiatives they all agreed on.</td>
</tr>
<tr>
<td>Negotiation — across hospitals and with Finance — occurs <strong>after budgets are submitted.</strong></td>
<td>Negotiation occurs <strong>before budgets are submitted.</strong></td>
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We’re making our job **AND the CFO’s job** easier.
Budgeting

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
“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**.

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**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)

**Aligned metrics & incentives**

“Choice within a framework” — we developed targets and worked with each UBCL to pick theirs.
We negotiated to get a Transitions metric in every senior leader’s incentive plan.

**Aligned metrics & Incentives**

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**UPHS Blueprint for Quality and Patient Safety**

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

Focusing the attention of the system

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

First BSI Campaign

2nd BSI Campaign

BioPatch Pilot

BSI Task Force

New Dressing

BioPatch Use Expanded

TheraDoc

BSI Definition Changes

CLC 2000 Removed

Value Capture

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.

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

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.**

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**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 Alliance

Unit Based Clinical Leadership

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

<table>
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<th>Dilemmas of success</th>
<th>Next steps</th>
</tr>
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<td><strong>Everybody wants a piece of the UBCLs</strong></td>
<td><strong>Teaching the UBCLs to be leaders who can get work done through others</strong></td>
</tr>
<tr>
<td>◆ The health system keeps saying, “Give it to the UBCLs.”</td>
<td>◆ Penn Medicine Leadership Forum — traditionally reserved for senior leaders — is <strong>focused this year on the UBCLs</strong></td>
</tr>
<tr>
<td>◆ Many groups are trying to get the UBCLs’ attention — pharmacists, discharge planners, nurse educators, post-acute care providers, …</td>
<td>◆ <strong>It’s organized as “action learning,”</strong> to apply the leadership skills to a Transitions-in-Care project on each unit.</td>
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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

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

A new take on innovation
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

<table>
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<th>INSTEAD ...</th>
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<tr>
<td>Telling and selling</td>
<td>Listening and amplifying</td>
</tr>
<tr>
<td>Pushing people to change</td>
<td>Creating pull for the changes</td>
</tr>
<tr>
<td>Trying to “motivate” or “empower” others</td>
<td>Discovering and freeing up energy and passion</td>
</tr>
<tr>
<td>Thinking your way to new actions</td>
<td>Acting your way to new thinking</td>
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A few resources — Campaign Approach to Change


To be in touch

Victoria Rich, PhD, FAAN, RN
Victoria.Rich@uphs.upenn.edu

PJ Brennan, MD
PJ.Brennan@uphs.upenn.edu

Elizabeth Riley-Wasserman, PhD
ERiley-Wasserman@mercyhealth.com

Linda May, PhD
LMay@cfar.com

Larry Hirschhorn, PhD
LHirschhorn@cfar.com