

Leading the Improvement of Health Care

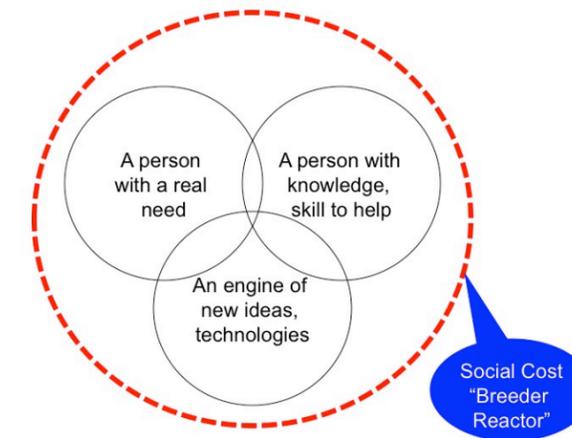
"A one page book"

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May 18, 2011

7. For society and interdependent work to function, we must make promises to each other:

Type of promise	Helpful knowledge, preparation
To Self about professional work	Clarity about personal values, meaning of work
To Patient about system performance	Knowledge of performance, sufficient for prediction...as it might matter to patients
To Patient about professional's own role in system	Knowledge of the way personal performance contributes to the end results experienced by the patient
To Colleagues about own work	Knowledge of the way own work connects to the work of others...and vice versa

1. The American poet, William Stafford, writes: "I call it cruel, perhaps the root of all cruelty to know what occurs, but not recognize the fact." (From "A Ritual to Read to Each Other")



The Swedish poet, Tomas Tranströmer wrote that "every problem seems to cry out in a private language." (From "About History")

Batalden P. "The Leader's Work in the Improvement of Health Care" QSHC (2010) 19:367-368

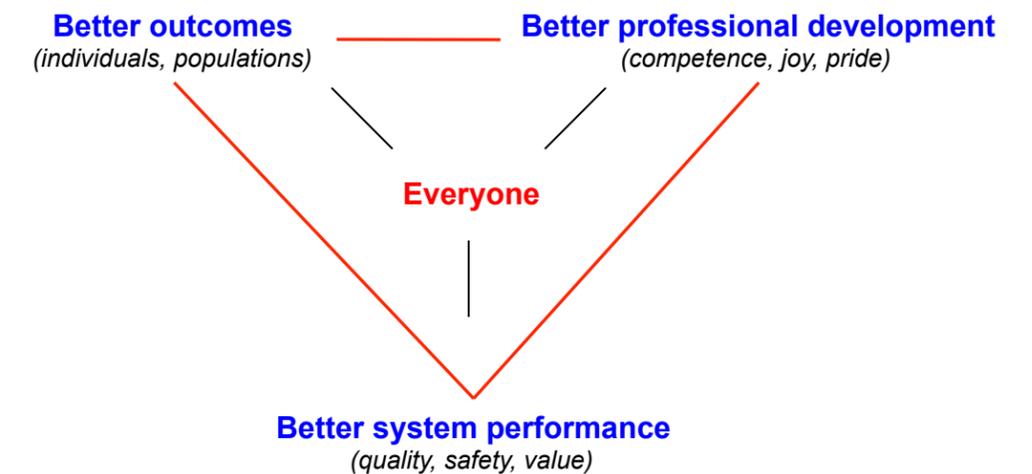
...and in the event of promises not kept, we must be prepared to seek forgiveness.

Arendt H. (1958)
The Human Condition
Chicago: Chicago Univ.

Batalden P, Leach D.
"Sharpening the Focus on Systems-based Practice."
JGME (2009) September

Batalden P. "The Leader's Work in the Improvement of Health Care" QSHC (2010) 19:367-368

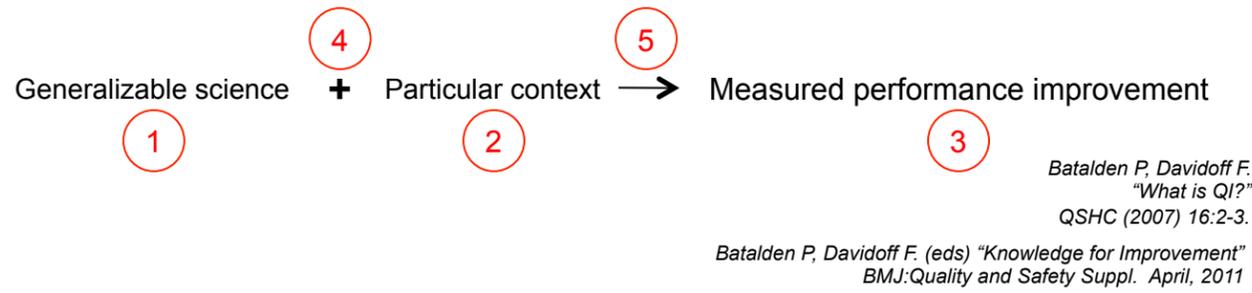
2. At the heart of a sustainable, generative, continually improving health care system are three linked aims.



Batalden P, Davidoff F.
"What is QI?"
QSHC (2007) 16:2-3.

3.Improvement requires bringing multiple knowledge systems together. “Good” science involves more than evidence of effect.

Multiple knowledge systems:



Science

Evidence, assessment

1. Randomized controlled trial
2. Trial without randomization
3. Case control, cohort studies
4. Multiple time series studies
5. Well-described case report

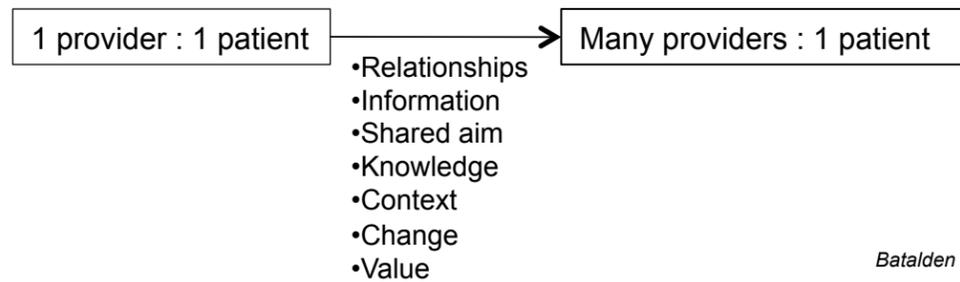
Discovery, explanation

1. Well-described case report
2. Multiple time series studies
3. Case control, cohort studies
4. Trial without randomization
5. Randomized controlled trial

J. Vandenbroucke
 “Observational research, randomized trials and two views of medical science.”
 Public Library of Science. March, 2008

4. Relentlessly reduce waste and add value. Waste lives in needless duplication, delays not required, unnecessary transport, unrecognized information gaps, behaviors from habit, our cherished myths and even the business models that constrain value-based design.

Cherished myth example:



Batalden P, Ogrinc G, Batalden M.
 “From one to many”
 J. Interprof Care (2006) 20(5):549-551

Nelson E, Batalden P, Godfrey M. (2007)
 Quality by Design.
 San Francisco: Jossey-Bass

Flexible business “value” models:

- A. Solution shop—making the diagnosis
- B. Reliable processes—getting effective treatment reliably
- C. Facilitated network—connecting people, resources over time

Stabell, CB, Fjeldstad, ØD.
 “Configuring Value for Competitive Advantage: on Chains, Shops and Networks.”
 Strategic Management Journal (1998) 19:413–437

Nelson E, Batalden P, Godfrey M, Lazar J. (2011)
 Value by Design. San Francisco: Jossey-Bass

5. Match change designs with situation requirements. Health care faces simple, complicated, and complex situations.

Health care situations:

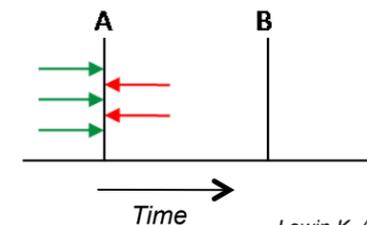
Simple	Complicated	Complex
<ul style="list-style-type: none"> • Baking a cookie • Elements and their interactions known • Recipes help • Forcing functions help 	<ul style="list-style-type: none"> • Rocket to moon • Elements and interactions are knowable • Algorithms help • If, then... 	<ul style="list-style-type: none"> • Raising a child • Elements and interactions are <u>not</u> knowable • Shared aim, relationships matter
Reliability is reasonable	Reliability is possible	Reliability not possible; Resilience is a better aim

Glouberman S, Zimmerman B. (2002) Complicated and complex systems: what would successful reform of Medicare look like? Discussion paper no. 8. Saskatoon: Commission on the Future of Health Care in Canada.

Liu SK, et al. “Improving the Simple, Complicated and Complex Realities of Community-acquired Pneumonia” QSHC (2009) 18: 93-98.

6. Continually inquire into the “unchanged present.” Living systems adapt & respond to their internal and external contexts. They resist intentional change partly because there are competing commitments and assumptions which effectively hold the unchanged present in place. Change mastery requires habits that seek understanding of the daily performance “praxis-space” and its contrast with the *theoretic limits* of what is possible. Fostering the never-ending desire to improve requires social support that appreciates the creativity, the discipline, the courage and the deep satisfaction that comes with understanding and being able to change one’s own work.

Forces:



Lewin K. (1951)
 Field Theory in Social Science.
 New York: Harper.

Commitments:

Desired action	Activities, habits	Competing commitment	Big assumption
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Kegan R, Lahey L. (2009)
 Overcoming the Immunity Barrier to Change.
 Boston: HBS Press.

Supportive work settings:

An organization with the potential for greatness is one where employees can say “yes” to:

1. “I’m treated with dignity and respect everyday by everyone I encounter...and it doesn’t have anything to do with hierarchy.”
2. “I’m given the things I need to make a contribution that gives meaning to my life.”
3. “Someone noticed that I did it.”

Paul O’Neill (2001)
 in Cox T. Creating the Multicultural Organization
 San Francisco: Jossey Bass

Batalden P. (ed) (2010) Lessons Learned Leading Change in Health Care...and How We Learned Them.
 Toronto: Longwoods (www.longwoods.com)