

CONCLUSION

IT HAS BEGUN...

SANDY SHEAHAN

ASSISTED BY TOM BIGDA-PEYTON



INSTITUTE OF PUBLIC
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The HLTP project is an innovation project in the health care area which involves the transformation of three health care organization using organizational transformation techniques including the development of balanced scorecards, strategy maps, accountability agreements and process improvements using LEAN methodologies. The results of these processes will be tracked, documented and the learnings harnessed and shared through publications and workshops. The project is supported by the Ontario government.

The views expressed in this report are the views of IPAC and the authors and do not necessarily reflect those of the Ontario government.”

It has begun.....

Over the last two decades, there have been endless initiatives rolled out across Ontario as patchwork attempts at healthcare reform. Despite these initiatives, little changed and as Dr. Ray Gaiardo, Chief of Emergency Medicine at **Guelph General Hospital** puts it....***“We were a group of really good people trapped in a really bad process.”*** Today, there is no doubt that the *“quality by design”* theory behind ED PIP, where leadership engages the front-line in problem-solving and nurtures capabilities and mindsets in their people to enhance resilience, reliability and results is definitely here to stay.

PIP was a Catalyst

A number of key themes rise to the surface when contemplating the journey and stories of the first five ED PIP sites. At the top of the list is the understanding that PIP built capacity into these organizations and was a catalyst for a number of new initiatives to take hold and spread. In addition and interestingly enough, PIP also provided the impetus for many other ideas and programs that had been incubating in Ontario hospitals for some time to mature to the next level. PIP wasn't just another *“hamster wheel”* as Ruth Mück RN feared it might be at the beginning of the process (**Cambridge Memorial Hospital Story**) but turned out to be *the “grand unifying theory”* according to Dr. Blair Egerdie VP-Medicine (**St. Mary's General Hospital Story**) *“.... an attitudinal shift, a new way of looking at and dealing with problems applicable to the entire organization from a unified approach.”*

PIP was an Irritant

A common sentiment for all 5 Wave 1 sites was that PIP was an ‘annoyance’ right from the start as staff tried to back-fill positions, rearrange schedules, add new types of meetings and grasp innovative approaches to work and change. It was not long however into the 8 month journey when things began to change. *“It's funny”* says Dr. Ian Digby, ED Physician at Guelph General Hospital *“how PIP was seen as such an irritant at the beginning and then it ended up saving the whole place.”* No one could have anticipated the true test of PIP would come right at the end of Wave 1 in the form of the H1N1 flu pandemic. Dr. Ian reflects on the merging of newly acquired process improvement skills by staff informed by timely and relevant data (the DART) and a new spirit of collegiality in the organization that empowered them to switch gears with little warning, make decisions and implement changes on the fly.

PIP met with Resistance

Expect Resistance! If you aren't getting resistance, you probably aren't doing anything different. Push-back will come in many different forms from many places and at various times in the change journey. Sometimes it's about nothing more than *“We've always done it that way,”* explains Dr. Ray.

Change and culture shift take time and early adopters need to work with their colleagues whether clerk, physician, nurse or other to educate, inform and encourage them along the way. The value of ‘champions with credibility,’ in the eyes of those resistant to change can go a long way in transformation work. *“Perhaps initially we are just asking them to put one egg into the basket. It’s usually not long before they decide they want to jump into the basket themselves”* adds Eileen Bain – Vice President of Patient Services at Guelph General Hospital. The experience of all Wave 1 sites in some respects has revealed stories of “nay-sayers,” “skeptics” and “status quo junkies” whose doubts and resistance at the beginning of the process gradually yielded to organizational resilience, improved reliability of process redesigns and better outcomes for patients and staff.

PIP improved Communication

Resoundingly, one of the greatest successes of PIP has been improved communication across organizational levels at all sites and between staff and patients, families and caregivers. Initiatives like bullet rounds and white boards have significantly improved interdisciplinary communication. The use of patient white boards and other visual cueing methods around predictive discharge has enhanced communication between staff, patients, family members and caregivers. Improved teamwork at all five sites has brought people together to diagnose, design, test and implement changes with front-line personnel closest to the action leading the charge. Working through ED PIP with the application of its lean tools, quality improvement frameworks and PDSA cycles has created a new *“common language”* in varying degrees across all organizations laying the foundation for emerging *“quality by design”* cultures.

Redesigning of roles, processes and even physical workspace at Wave 1 sites has reduced negative communication in and across many units. For example, at **Grand River Hospital**, the former bed allocator role as described by Colleen Backewich (Interim Access and Flow Coordinator) was a *“disabled”* function located in the heart of the ED. Hampered by crying babies, constant interruptions, endless phone calls and a lot of negative communication between the ED and Inpatient units, this role has been redesigned and re-located as an important component of a more integrated and coordinated bed management system at Grand River.

PIP encouraged Innovation

Another theme that we heard in the stories of the Wave 1 sites was how the combination of supportive executive leadership encouraging a culture focused on quality improvement was aligned with early success in organizations where these factors were present. Susan Peters – General Electric Vice President of Executive Development believes that, *“Time spent learning should never be perceived to be in conflict with operations. This is about being ambidextrous.”* She emphasizes that when you are a learning organization, you have to balance the creative tension of striving for operational excellence with taking the time to innovate and learn. Being an adaptive leader requires carving out time to learn (Harvard Business Review, January 2009, p. 103). As Ontario hospitals continue down the road of

system redesign and quality process improvement, the ability of senior leaders to support discovery, incubation and acceleration of new ideas in their people will differentiate an innovative, learning culture from all of the others. A learning culture allows for experimentation and failure (within the context of fail-safe design) while making every opportunity to harvest the learning.

PIP produced Results

At all five Waterloo Wellington hospitals, PIP produced results, the extent of which varied depending on the presence of other factors like:

- supportive leadership
- physician engagement
- communication and information flow
- a learning culture focused on quality improvement, innovation and the use of IT
- credibility of PIP leaders and champions
- the use of timely and relevant data and tools (eg. the Daily Access Reporting Tool or DART) to inform performance and process improvement
- organizational strategy, structure and skills training focused on quality improvement

The design, testing and implementation of more effective and efficient processes has led to improved patient access and flow demonstrated by movement in 3 key ED metrics 1) ED patients admitted in 8 hours or less, 2) non-admitted patients (CTAS 1 and 2) processed in 8 hours or less and 3) non-admitted 4's and 5's processed in 4 or less hours. Other important indicators of change have been a decrease in the number of patients that leave the ED without being seen (LWBS), a decrease in the average length of stay (ALOS) of patients from the time they are admitted to the time of discharge and an increase in the number of discharges by 11:00 a.m. Again, all organizations have experienced varying degrees of movement in any number of these indicators depending on the presence or absence of other quality improvement criteria listed above.

Less tangible than quantitative data results, was the fact that PIP became a vehicle for “champions of change” to shine and brought many new leaders to the forefront of each organization. Supporting and developing these new front-line leaders will be essential to sustaining current quality improvement work as well as the designing and piloting of new initiatives.

PIP is Sustainable

As with all major change, maintenance and transfer of new knowledge remains an issue. Some slippage has occurred at all five sites in the early days post-PIP but a number of actions have been taken by these organizations to uphold and spread change as documented at the end of each Wave 1 story.

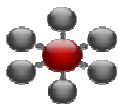
The “ED to Every Department” philosophy at **Groves Memorial Hospital** is slowly spreading with the use of a continuous quality improvement framework and PDSA (Plan-Do-Study-Act) cycles originally used in the ED (to develop a See and Treat pathway) and now being applied to other process improvement initiatives across the organization. As more and more hospitals across Ontario continue to work at embedding a “quality by design” framework into their organizational cultures, it will not be long before we begin to see fundamental change taking place across our greater system. Identifying change is an easy task. Implementing and sustaining these changes in a large and complex system is a challenge. As the system integrator, funder and accountability agent, the Waterloo Wellington Local Health Integration Network continues to play a valuable role in supporting these five Wave 1 ED PIP sites.

On March 10th 2010, one year after the start of PIP, members of the WW LHIN met with ED PIP Wave 1 representatives, physicians and the Waterloo Wellington Community Care Access Centre (WW CCAC) to collaborate on tactical ways to support and sustain local improvement efforts.

The dialogue that ensued revealed that most sites regretted not involving more staff in the PIP initiative from the beginning. All sites also acknowledged that although they had made incredible strides in learning from the Ministry, external coaches, site visits and one another, there was still a keen interest in seeing more of their staff trained in ‘lean’ tools and methodology. The discussion also hi-lighted that although all Wave 1 sites achieved impressive gains with PIP and were very positive about the impact of the program, as PIP came to an end and both dedicated staff resources and coaches were removed, all organizations faced similar concerns around the issue of sustainability. Through ongoing collaboration with Wave 1 sites, the WW LHIN has agreed to support sustainability efforts through:



Tracking of **results** to support problem-solving and sharing



Supporting collaboration and sharing across the network to enhance **resilience**



Helping to build lean capabilities and skills in more staff to improve overall system **reliability**

MacLeod, Deane, Bell and Baker (2008) have identified three pillars of supporting change that will need to be secured by Ontario hospitals in the days ahead to ensure sustainable transformation (**see Introduction**); creating a “learning” culture that strengthens employee **resilience**, designing and redesigning processes to create more effective and efficient operating systems with improved consistency and **reliability** and providing a supportive management / leadership infrastructure that encourages and defines the desired **results** of the transformation.

ED PIP is probably the greatest transformation initiative that the Ontario hospital system has seen to date. Most people recognize this; some understandably are still figuring it out. As we near the end of the completion of Wave 2 (May 2010), it will be exciting to see the results of 20 more organizations embarking on this journey. One thing we know - that on the road to excellence, these ***'high-performers in the making'*** have started to embrace ***'quality'*** as a system property and are beginning to understand the pursuit of quality and safety as a core competency of everyone's job. With a strategic focus on patient needs, they have shown by example how high quality, sustainable care can be delivered every day – not by chance but rather by design. Committed to a spirit of persistent crafting and sustaining of robust strategies and improvements in care, their stories and 'lessons learned' influence, inspire and dare us to consider what is possible as we continue the journey of healthcare reform in the province of Ontario.

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