

Podcast 28 - Adaptive Leadership: An Essential Tool for Effecting Change

Transcript

[Voiceover] Michael Konstan: Welcome to Cardi-OH Radio, a podcast of the Ohio Cardiovascular and Diabetes Health Collaborative, also known as Cardi-OH. This is Dr. Michael Konstan from the Case Western Reserve University School of Medicine, and I serve as the principal investigator for Cardi-OH, a statewide network of Ohio 7 medical schools. Cardi-OH is funded by the Ohio Department of Medicaid, and shares best practices to improve cardiovascular health, diabetes outcomes, and to eliminate health disparities in Ohio's Medicaid population. The opinions and recommendations in this podcast are those of the presenters and not those of Cardi-OH and its sponsors and are not intended to be a substitute for medical advice. I hope you enjoy today's podcast.

Aleece Caron: I am Aleece Caron, associate professor of medicine at Case Western Reserve University, co-director of education for the population health research institute at the Metro Health System in Cleveland, Ohio, and a member of Cardi-OH's team best practices. My research focuses on quality improvement and primary care transformation. Today's podcast will explore adaptive leadership in healthcare. We will discuss what it is, why it is important, and characteristics of adaptive leaders. With me today is Dr. Peter Pronovost. Dr. Pronovost is a world-renowned patient safety champion, innovator, critical care physician, a prolific researcher, entrepreneur, and global thought leader. Dr. Pronovost currently serves as the chief quality and clinical transformation officer for University Hospitals in Cleveland, Ohio. His scientific work leverages checklists to reduce central venous line catheter related bloodstream infections and has saved thousands of lives and earned him high-profile accolades including being named one of the hundred most influential people in the world by Time magazine and receiving a coveted MacArthur Foundation Genius Grant in 2008. Thank you for being here today Dr. Pronovost.

Peter Pronovost: Aleece, great to be here with you and please call me Peter.

Caron: Okay, Peter. I'm so pleased to have such a renowned expert here to discuss the topic of adaptive leadership in healthcare. Can you start by telling our audience what exactly adaptive leadership is?

Pronovost: Yeah, Aleece, uh, great question because it sounds like a wonky word, but it's really, really important and and overlooked. We use a change model that breaks change processes up into two types of work. It's a model that comes from Ron Heitz at the Kennedy School of Government. Technical parts of the problem or the opportunity, which is the science or the evidence, you know, how do you make a run chart, how do you do a prao? And then adaptive side, which is how do you get buy in? How do people buy into it? And what we see is one of the biggest mistakes leaders make is we treat adaptive problems with a technical solution, and it never works. And indeed, most of us got where we are because we're really good technically. So, we tend to focus 95% of our efforts

on the technical problems. We're worried about the measurement and the evidence, and we need to be. But 95% of those products that fail fail for adaptive problems. And there's tools to help you prevent those failures. They're just not talked about much in the quality improvement literature or any. And that's why I'm excited to begin to speak with you today about those.

Caron: So, you mentioned the difference between technical leadership and adaptive leadership. Can you talk about the differences between a technical and an adaptive problem?

Pronovost: Sure. Technical problem or at least I would say the technical component of the problem because I believe deeply every problem has both. If you're going to have impact technical problem would be let's say I want to improve annual wellness visits in primary care how am I measuring annual wellness visits what's the denominator who are the docs who are included what do I deal with if patients change enrollment over time or new patients go in how do I deal with them what's the evidence that we're going to say about annual wellness visits. The adaptive side of a problem is when my primary care docs Peter say I'm really busy I'm stressed what are you nuts I'm trying to give me more work with co and the solution for that isn't oh no don't you know the evidence for you know wellness they work really well there's other ways of engaging people and that's what the tools we're going to cover today.

Caron: so, you kind of touched on this a little bit but specifically why do you think adaptive leadership is important?

Pronovost: adaptive leadership not only is important Aleece it's essential if you want an impact right. I mean the literature is quite clear that and you know this better than I do maybe 80% 85% of change projects fail. And given the degree of harm we have and the waste and cost and needless suffering in healthcare, we can't afford to have 85% of our projects fail. So, if you're interested in improving the probability that your project will be successful, be a student of adaptive leadership.

Caron: Great. That was very, very insightful. What are some traits that adaptive leaders have?

Pronovost: Yeah, Aleece, when I think about what are the attributes that adaptive leaders bring, there's what I would say three sets of values or behaviors, an intrapersonal, an interpersonal and an organizational. The first set of traits and by far the most important is I am humble, curious, and compassionate. You can never learn and improve if you're not humble or curious, right? Because we're constantly getting new ideas from other industries, from other people, and and also being compassionate with people about their current suffering that care is hard right now on everybody. And and So those are the first three. The second three, and they're all important, is I respect, appreciate, and help others. And those words are very, very key because I can respect you in my head, but if I don't say to the team, hey, Aleece, really good job when you did this, and it's got to be authentic. And likewise, I can say that, but if I see you struggling and needing help, and I don't roll up my sleeves and get my hands dirty and say, "I'm here with you. I'm here for you." The teams won't work. And the final set is I am accountable to continuously improve myself, my organization, and my community. Put those together and you'll have an adaptive leader.

Caron: That was wonderful. That was very well described. And you know, Peter, you and I have had the pleasure of working together, at least it's been my pleasure for a couple of years now and I've seen you really do a wonderful job in approaching adaptive problems. So, how do you recommend and how do you go about approaching adaptive problems?

Pronovost: Yeah, at least great. There's tools. I may even call them parables for how to address adaptive problems. And if you think about, you know, if you're at all spiritual, why do we use parables in communicating morals or values is because they're often more effective of communicating these complex concepts. And so, I've taken the literature on adaptive and made some of these parables myself. I've published on it a paper called Navigating Adaptive Change.

Caron: Great paper.

Pronovost: And so, let me go through a couple of those. First parable is be unwavering in the hill you climb but humble enough to invite everybody to help you climb it. Now this parable begins after you've decided this is the right problem to solve. So, I'm not want to go upstream to say how do you do that? It's a different podcast I'm happy to do with you. But let me share with you a story where I learned that lesson. I was 18 and we're on a camping trip out in Wyoming and there was about 18 boys trying to decide which hill we climb, and they broke us up into three groups. Each group had a counselor. And the first counselor comes up to the group and says, "Hey guys, you see that hill over there? That's the cir of towers. And that's what we're going to go climb." And described for the next hour to the boys how they're going to get there. No buy in, no co-creating. It was let me tell you how to do it. And they had no buy in and they failed. The second group, the counselor who said, "Hey dude, a lot of cool hills around here. go climb, choose what you want, go have fun." They failed, right? But the sad reality is that's most likely the two types of leaders we have in healthcare, right? The top-down micromanager command and control that demoralizes or the lazy fair no accountability. I was so fortunate to be in the third group. The counselor comes up and says, "You see that hill over there? It's got the most amazing view from the top. It's going to be hard for us to get there. We're going to have to pull together like we never have, but if we work together, I think we're going to get there, right?" And that had a revved up bunch of boys and we made it. And the difference is the great or adaptive leaders clarify why we're doing something and what the goal is but keep their hands off of how to do it. That should live with the people closest to the work. Doesn't mean you don't coach or navigate, but you respect the wisdom of the people doing the work. And so often leaders forget the why and the what and they just dictate how like that first leader and it never works. Second parable that is surface the real and the perceived loss. Now at least let me ask you or readers how many of do you think clinicians resist change?

Caron: Really? You're asking me that they resist change all the time.

Pronovost: Okay. So, they we we see this barriers and we just assume they're resisting change. But let me put on my anthropology hat and dive a little deeper. Let's say I was giving you or clinicians the Ohio State lottery that pays some ungodly like \$800 million or something. That would undoubtedly change almost every clinician's life, right? Unless they were like a tech startup and made a billion dollars. And how many of them do you think would say, "No, no, Peter, you keep that \$800 million. I hate change. I don't want the money. Just take the lottery ticket back." Would never happen. Because if change is positive, we say, "Bring it on. We look forward to it." It's only if change causes a loss, which it often does. And so, what people are resisting is loss. And loss might have a real component. I'm asking you to work a little differently. The reality is though that real loss is often small. But the perceived loss of control, of stature, of power, of budget is what really is the barrier.

But it's invisible unless you are looking for it and could minimize that loss. And because if you don't have a way to communicate that and we'll get to that in our next parable, the perceived loss grows like a cancer over time and people festered and what the hell does Peter think he's doing? You're imposing this stuff on me, and you don't solve that loss with a technical solution. Let me give you

an example of that. When we were spreading the national clabsy, we were going state by state much like this work and I went into one of the states and I was opening up talking about why and every hospital in the state had a team that was representative and there was a trauma surgeon in the back of the room. He was leaning against the wall, and his arms were crossed and he just didn't look like a happy camper. I mean, his body language was was really telling.

And I get two minutes into my talk and he just screams out, "This is just a bunch of crap." And the person hosting it like looks at me stunned and says, "You know, do we get security, Peter? What do we do?" I said, "No, this is the adaptive work we got to go through. Let's just let's let's go with it." So, I said, "Oh, what's your name? Uh, Dr. Jones. Hey, Dr. Jones, help me understand why this is a bunch of crap." And he said, 'I'll tell you why it's a bunch of crap. Is because there's no evidence that a full barrier drape is any better than a three-quarter drape when you're putting a catheter in. And now, because of you, my stupid hospitals making us use this drape.' And I said, "Well, Dr. Jones, you are 100% correct. There's no empiric evidence that between full and 3/4, but we do know that when you use the little quarter square, the little windows, and you use a full or 3/4 much lower infections and indeed when we use the full now in several states, they're down by like 70%."

So if you are putting it in me or my mom please use the full drape but you know let me ask you a question Dr. Jones why does this full versus three quarter bother you so much because from the way I see it the technical difference is you're grabbing the edges and you're flipping it over you know as you unfold a sheet said we've probably spent more time talking than you could flip for the next year. So, I don't really think it's the flip that's gotten to your go, I think there's something else. So, help me understand what that is. And he looks stunned and he said, "Well, you're right. I just wanted you to admit that there's no evidence, but now that you did, I'm happy to use it." Right? And he went on to become a champion. Now, had I approached that doctor by saying, "Here's the evidence, you know, as a technical problem would have failed miserably because it wasn't a technical barrier. That doctor was from an Academic Medical Center.

He needed me to genuflect at before the altar to because I'm in his and I get it, right? He's he and he should be respected. He's a senior doctor, very well respected. It's his turf, right? I'll honor you. Like there's no pride of ownership. This isn't about me. This is about getting infections down. But being able to acknowledge that and approach it with a humble, curious, and compassionate heart allowed us to have that doctor now a zealot for zero harm. Third metaphor, I want to share, it's titled Beware of Monsters in the Bathroom. So, the metaphor, my son's 25 now.

Caron: I'm sure he really appreciates the story.

Pronovost: Yes. Yes, he does. He's a computer scientist, software engineer, but when he was in second grade, he came home from school and said, "Daddy, daddy, I'm afraid to go in the bathroom." And obviously, I was worried what was going on. So, I call a school and said, "Hey, my son comes home and he's seems quite terrified to go in the bathroom. What's going on?" And the teacher chuckled and said, "Oh, we just installed automatic flush toilets and forgot to tell the kids, right?" And I love that because if I think about how we introduce change, we often have management meetings and these great pow-wows, but there's very few frontline people on those meetings. And especially if you're a private practice physician, a night shift nurse, you're almost never in those meetings. And we just magically think that the information about why and what gets convened to all those frontline people from that meeting, but we never or rarely have a structure to ensure that that meeting occurs.

And so, one of the ways to defend against monsters in the bathroom is make sure that you have what I would call a containing vessel, but a structure to say, how are we going to communicate with all the different clinicians who are impacted by this this process? And I mean, I have learned by mistakes so deeply that we always have a communications people embedded in our quality teams. I mean, as you may know, our Kelsey Fuller is our quality lead. So, key to this work, but in all of my roles I ever had, we have our own comm's team that manages the communication because we want to defend against this risk. Two more of these adaptive leadership principles because they're they're so key. One is do the pepperoni pizza exercise. And the idea is whenever I'm going into a change, I try to anticipate what that loss is going to be or what the perceived loss or what people's concerns are.

And so, I map out the pieces of pizza are the various stakeholders, doctors, nurses, administration, finance, and the pieces of pepperoni are what their pet peeves are. And what we try to do is we navigate to say, okay, what are these issues? And this isn't a game. This has to be authentic that we need to be mindful of what the worries are of the team who are going to get brought in and there's a couple themes that come up. Nurses appropriately always worry that the work falls to them because it mostly does right and so being very transparent to say and nurses this will not fall on you alone like yes you have a vital role this will be a team effort physicians care is going to take more time and may impact their billing so docs I get it we got to design a solution that doesn't take time away from you administration always worries about cost is it going to cost more so again okay We have to design a solution, especially where we are in healthcare now, that doesn't add cost.

Indeed, ideally takes away cost. And so, addressing those people's concerns right up, gets people bought in because at least when you look at this adaptive mindset that we have and much of this science of this comes from political science or sociology or social psychology comes from the science of why do we follow others? It's the science of followership. Most of it comes from who you vote for, but It's much broader than that. And people follow others because of two things: Are you like me? And do you care about the things that I care about? To address are you like me? It's often may sound silly, but how you dress, the words you use, like so are you wearing a white coat if you're talking to clinicians? Are you wearing a suit if you're talking to finance? Right? And those sound subtle, but you have to say I'm part of this tribe. And do you care about the things that I do?

Are being authentically addressing their issues and being very very mindful that we use words that imply power with rather than power over people. It's probably one of the most important leadership or adaptive leadership lessons you can do. So, power over people come me coming in and says Aleece you will use this checklist right we're having harm from uncontrolled hypertension you will use this right and not going to work right well right an alternative could be hey you know So uncontrolled hypertension causes the most disability adjusted life years than anything. People suffer needlessly because we could control it. And here's an approach or a guideline or a checklist that seems to have worked at others. Do you think you could revise this and make it your own and create something right? And that subtle wording of language means all the it makes all the difference in the world.

Indeed, when I was spreading the Clamsy checklist to now like 5,000 hospitals, I intentionally told our team, "Do not call it the Peter checklist or at the time it was at Johns Hopkins and do not ask them to use it. Indeed, tell them not to use it. Say, use it as a starting point, but make it better. Make it your own." And my research colleagues at Aleece cringed. I literally had a revolt. They're like, "Peter, you'll never get this published. You how are you going to know what they do?" And I

said, “Well, I could standardize it, but no one will use it. I care more about reducing infections than I could having a more tightly rigorously controlled randomized trial. So, we’re letting it go. Turns out they were all 98% the same, but that 2% difference made it work and they had pride in their own, you know, as they should because they all made it better and they made it fit their local context.

The final metaphor that I would encourage us all to use is what’s called value the dissenter or seek first to understand before we judge. And the the reason This is so important, Aleece, is so many of us in quality and and quite frankly in our society, we see this everywhere. We often believe so much in our cause that we not only think we’re right, we become righteous, right? I mean, we literally think that those who resisting are evil and bad and we’re going to bowl them over because my program is going to save lives and they’re going to do it, and we get this righteousness. But what that does is it then looks at anyone as if they’re morally bad, right? And so, I would encourage us to assume positive intent. That is most clinicians, the very vast majority want to do the right thing. I mean, they’re in this to help patients. And if they’re resisting, rather than assuming that you’re right and they’re wrong, try to understand why they’re resisting, right?

Surface what that loss would be or how it impacts their work because there almost is a always a reason for it. And so, if I have someone resisting that conversation at least almost always goes to, “you know, Aleece, I know you want what’s best for your patients as as do I, but you’re a clinician passionate about safety. So, I was wondering if you could help me understand how you see the world or how you see this project differently because from my lens, I think this would help improve care, which is what you want. So, I must not be seeing something that you are.” And when framed that way, 90% of it is a miscommunication. “Oh, I didn’t know that’s what you wanted, Peter. Of course, I can do that if that’s what you want.” Like, you know, or sometimes they’ll say, well, you know, Peter, I buy this, but if I do this, there’s this other unintended consequence. In economics, we call externalities, right? That and it’s sometimes a time thing. Sometimes it’s a uh another safety issue.

But once we get on the table, we could then solve for that problem, too. It’s not either or. I said, “Okay, at least great. Thanks for serving that up. What if we were to do this to defend against that risk? Could we then try to solve both of these problems at the same time?” And almost always you could come to overcome resistance by approaching it with assuming people have positive intent. So those are the sets of toolkits that I would encourage you to wrestle with to try to get your hands dirty with so that we increase the probability of our projects.

Caron: That was wonderful, Peter, and I love the fact that you made them so relatable and provided such great examples. I want to ask a follow-up question around the pepperoni pizza principle and I know from working in quality improvement and working with you that that’s not just a one-time meeting. How does that actually play out in practice?

Pronovost: Yeah, you’re absolutely right. First, let me take a step back up, please. So often we present quality improvement models as if they’re linear or change management tools like Cotter’s, you know, steps. The reality is these are dynamic and flexible and evolving all the time and new adaptive challenges come in as you evolve your interventions or you learn more. And so, this that’s why I said it’s really the values that you live with. Are you humble and curious and compassionate? So if some somebody raises a new issue and that some you know it there’s resistance you we have

to go back to these over and over again or there's a new team member who got brought into this and you know they need to be engaged and you know at least this is especially important with the power stature on some teams in healthcare where you could have you know an environmental service worker or a transporter who's just as critical as any physician or any senior level person, but they often don't feel that they could give voice because of the statute differences and and creating that culture where everybody is authentically respected for what they bring and your ability to speak up doesn't depend on the letters after your name.

Caron: Wonderful. That that really I think helped clarify things quite a bit. So just to summarize um about approaches to adaptive leadership all change require buy in. Change initiatives have to begin with stakeholders and they all need to be involved in the process. Um we we really need to have a good understanding between the difference between technical and adaptive problems and we have to be able to accept change fatigue and address change fatigue even if we need to make changes taking into account that people just may be tired of doing a lot of different things all the time and that anything we do needs to be widely applied and giving people those skills.

Pronovost: Hey Aleece I want to unpack that word buy in for a second.

Caron: Okay?

Pronovost: Because it's we use it all the time in quality improvement. And let me just kind of reframe because I think there's an opportunity here. Buy in largely implies compliance, right? Not passion, right? And I think what we need to strive for if we're really going to transform care, what we need, we need workers who are inspired, right? That we don't need to motivate people or just even remove resistance. And and yes, there's some who aren't going to be. But when this work is done right, when we align around a purpose, where we acknowledge people's belief systems that you have brilliance in you and we just need to unleash it and we create structures for people to belong to a learning community and so ideas just free flow like whenever we talk. I mean, I love the energy, right? It's just bing bing bing bing bing and and we take thoughts to a new level. People could be unleashed. Let me just give you an example of what I mean by that. You may know that there's been several experiments where if I put fleas in a jar and they'll jump out within a couple minutes. If I then put a lid on that jar, they'll hit their heads for a minute or two, but then they learn to jump less high. When I take that lid off, they don't jump out of the jar. They've been conditioned to lower their performance. Right? And if I think about what we've done in healthcare, that's the vast majority of clinicians who feel that my voice isn't heard that nothing will change that I've been doing this for years that I've spoken up and I try to change it but I was ignored and you know our job as these adaptive leaders is to change that belief system and so that we lead not just by getting people buying but by un-inspiring them and it's got to be authentic. What I think as leaders of this what we need to see is what happened in Death Valley in 2004. Death Valley as you know, is the most desolate, hottest place on Earth. Nothing grows there. Things barely live. And they get preciously little rain. I mean, like 0.01 inches a year. In 2004, they got a freak rainstorm. And a month later, Death Valley, the most desolate place, was a carpet of these brilliant multicolor mountain flowers. I mean, I'll share with you a picture or you can just Google it. Unbelievably beautiful. And what changed? Well, what changed is those seeds needs were already there. They were always there. What they just needed is watering. Right? And I see that if you believe in our employees and staff and quality improvement, those seeds of brilliance and greatness is in every one of those employees. It just needs to be unleashed and let their brilliance bloom.

Caron: Wonderful. I love all of these stories and all of these analogies and I'm definitely going to go Google that picture. I think it'll be really inspiring. We kind of talked about quality improvement a little bit and why quality improvement projects fail and maybe it's a function of adaptive leadership.

Pronovost: It's probably at least you know a and some failure for technical reasons too. I mean I'm an epidemiologist and I spend a lot of my time on the technical side. So, I am by no means saying the technical can't be right. What I'm saying is the technical alone will never work.

Caron: Right. So, what are your thoughts on how adaptive leadership can either help or hinder quality improvement projects?

Pronovost: Yeah. So, great point. Like most things in life, Aleece, it's a balance. I think if it's just like a revival and the evangelism that people feel good, but at the end of the day, you don't move your needle on everything like it's not going to work. And but what when you get it right, Aleece, that these are like a virtuous cycle where people sense that you authentically believe in their capabilities, right? And you have they help co-create something and they move the needle a little bit and then they feel better and it builds more people buy in, more energy and they perform a little bit better, right? And so, I think these things are interdependent. Um, and what I would encourage is these leaders to be mindful of both. Yes, absolutely. Get the technical part right. The reason I'm focusing in this today on adaptive is there's plenty of people who train on the technical side, right? And I'm obviously you do both, but if you look at most of the training in QI, it's all the technical side, right? And and but you don't hear much about unleashing people, right? Inspiring people. people of how do you deal with this resistance, you know, other than docs respond to evidence, right? And like no, docs respond to being listened to, you know, and so I think having this toolkit in your pocket will serve you incredibly well.

Caron: I definitely agree and I've been practicing my adaptive leadership skills and learning quite a bit from you. I imagine many of our listeners are providers who might want to learn how to apply these skills. How might an individual provider learn adaptive leadership?

Pronovost: Yeah, great. So, I would say that start with that being humble and curious and compassionate to learn. There's a couple of books, one a little longer and technical, but the principles and practices of adaptive leadership, but much more importantly, try these things out. And so, be mindful of the words you use, right? When you're starting a project, try drafting the pepperoni pizza. Who's what are the stakeholders? What are they worried about? You know, authentically and then how am I going to minimize their fear or their loss in this project making sure that you communicate the why and the what always and not just jump to telling people how which is a common mistake and so practice these. The other piece at least that I used in my career all the time is I had a uh safe uh colleague when I was at Johns Hopkins uh Laura Morlock was a professor of organizational theory and management and she ran the health policy and management department and She was just brilliant at this stuff and you know so insightful and she would come into meetings uh with me or we sometimes we'd be in the same meetings but she would observe how I behaved right or the words I'd used and when you develop the lenses to see this you could literally say when the words touch people in a positive way or develop antibodies like I'll give you an example I was sitting with some clinicians and one of my physician colleagues was making guidelines there was an academic He's from an academic and there were community hospitals around and he said to all the community doctors, "okay, we're going to make these guidelines down here and we're going to push them out to the community," right? And that word "push out," right? It implies doing thing power over them, not with them. And you can literally just see he lost

everybody. I mean like the like you're done. Nobody was going to do that as opposed to say, "hey, could we co-create what these guidelines are?" So if you have a trusted person, have them observe then after the meeting ask them what did we do that engaged inspired people and what did we do that turned people off because much of what our behaviors are in this side we haven't trained ourselves to see to have lenses to see them but once you open them up and it's almost like you're getting onto the balcony to watch all the different parts or like or like you may have heard the concept metacognition like I'm thinking about my my thinking it is such a powerful tool because like I I'll give you an example once how I applied it we were doing a statewide collaborative as you know they all have very very clear agendas and we all want to be planned and we were in one state and we did the first day's agenda. It was well half of the afternoon because people flew in that morning and it was dead. I mean it nobody resonated. There was no energy. So, I called the team and I said we're throwing away the rest of the agenda. I'm making it up on the fly. You're not touching people. And they're like we can't do that Peter. All the materials, all the handouts said we we lost people. Like who cares if you're going to go through your agenda? It's not going to accomplish our goal of infections. We're starting over and Being comfortable living within that mess and saying, "Okay, let's figure this out together" is a key part of being able to practice this.

Caron: I love that concept, living within the mess. I do that a lot with one of the programs I lead. I really think it helps people come together and it's a really, really good way to get buy in.

Pronovost: Yeah, Aleece, you're spot on because part of I think our hunkering or attachment to the technical is either a fear of vulnerability or this anxiety with messiness, right? And so, I I could have my spreadsheet and all the technical tools that give us comfort and real-world change is a mess. I mean people have emotions they feel lost there's there's could be some conflict. I think what I would say is so much of quality and pe improvement is trained to think that we have the answers to the problem. And what I would ask you to say is have the courage to ask the question and let the answers emerge from the group. Right? That's fundamentally the essence of adaptive leadership is we're just calling the question and convening the people who could have a conversation or dialogue about it. You don't need to know the answers. And if you can get comfortable and be humble enough to say that that's okay. I mean, at university hospitals, the people who can hear, we call groups all the time together, right? And it's not that I know the answers. It's I authentically want to find out what people think the answers are, but we're unwavering in that we're going to solve this problem because it's it needs to be solved.

Caron: This has been a great conversation. I have one last question which could potentially be another podcast in and of itself but how do you pull all of this together to manage a large health care system and if you want to touch on the project that you and I have been working on together with the fractal management system I think people might be interested in hearing a little bit about that too.

Pronovost: Yeah, great question. I call this approach to large scale change leading with love and I use that phrase very intentionally where love in my view is a power that uplifts and connects. A power that uplifts and connects. If you're religious, you may call that power God or grace. If you're spiritual, you may call a universal being or energy. If you're Buddhist, you may just call it energy. But let's just call this love. This power that uplifts and connects. And so many of our problems are when we either don't uplift, we degrade, or we disconnect, where we don't let someone's voice be heard, or we marginalize some group just because for whatever reason, right, that we look at them as othering or less than. So how do we pull this together? Well, we call our change model believe, belong, and build. And let me go through that.

Believe is we work diligently to make sure every member of our organization believes harm is preventable rather than inevitable and believes that they are powerful to do something about it, that it's their job to do that. We also work hard to change leadership beliefs that too often leadership is always command and control and looking for compliance. I mean that's the norm in healthcare, right? By far the norm and trying to get them comfortable with no no your job is to inspire, right? See that seed, water it, but let it go. Get comfortable with the mess. Belonging is this beautiful concept to say we know that if for almost every problem somewhere within a large health system or a state or the country someone's hitting it out of the park, but we don't have a structure or a culture to allow for that free flow of ideas, right? They just don't disseminate. We also know that innovation flourishes when we allow or create a structure and culture for diverse ideas to meet.

As diverse ideas come together, they bump into each other, and you get new deeper insights. And many ways when you and I talk about we come from different perspectives or different trainings, but together the conversation is always generative and takes all of us thinking to that new level. So how do you do that? Well, we call that our fractal system. Fractals are ubiquitous in nature: ferns, flowers, broccoli. They're also in our bodies: alvea, capillary, and glam are fractals. And fractals are identical shape but varying size structures and they operate by simple mathematical rules.

And the simple rule we have is that every higher level in an organization or in a project needs to create a structure where every lower level has a voice and you literally if you need multiple layers you go from board to bedside and what that does Aleece it is a trust built structure because we know change progresses at the speed of trust because when you do that people have a seat at the table to co-create goals they have a way to horizontally share learning like "oh what are you doing at Metro that's really cool could I go borrow it at UH" but we also have vertical linkings for accountability at the end of the day results matter, right? I mean, people are suffering and as an executive of a health system, this isn't just playing research. This is I'm managing and responsible for the care that we provide to patients. So, this fractal is this wonderfully simple concept to say when you're doing a project, make sure you could name the people on each of those nodes in a fractal.

And if you can't name them, you do not have a structure that is going to support trust and communication. And it may sound messy, but you know, let me give you one concrete example from safety. We had an example where we had an error with defibrillation and it happened in one of our cath labs. We made a call and response checklist to solve it. But we're 23 hospitals. So, you say and we do defibrillation in the EDs, in the ICUs, in the OS, in the cath labs, hundreds of places. How on earth would you disseminate that across hundreds of places fast? Well, we were able to do it because we've already connected all of our EDs across the system, all of our OS and anesthesia providers, all of our critical care, all of our hospitalists, all of our acute care surgery. So, we just call those leads and say, "Disseminate against your people.

Make sure you train them and in a week get back to me and show me that you've demonstrated that you've trained these people." So, we took a problem that would have gone on for years within a week solving it. The third part is what we call build and it's our management system part of the fractal and it's based on compelling evidence that good management matters and good management is almost entirely absent. And and by good management, it's not rocket science. It's do we have a defined goal? Do people know their roles? Have we clarified expectations of how we're going to treat each other? Have we built an enabling infrastructure to convert those goals into measures and real-time behaviors and provided feedback on those behaviors and goals and made it easy to do them?

Have we created that peer learning community so that those ideas could spread and promising practices could quickly disseminate and have we reported transparently and created shared accountability where we first seek to ensure team success but if teams don't get on board with it then how do we escalate that because then the day results matter that believe belong and build is what we call leading with love or leading and living with love and it's a transformative powerful concept for healthcare.

Caron: I love the concept of leading and living with love. I think that's really really inspiring and I just want to say thank you so much for being here today and having this wonderful conversation. It's been a pleasure as always. I think we've all learned a lot, and you know have taken away some concepts and some metaphors and some parables that I think will be applicable to the type of work that we're doing in leading adaptive change in healthcare.

Pronovost: Great. And thank you Aleece. It's been wonderful working with and learning from you and I hope the listeners in the audience got something out of this and so they improve their success and their important quality improvement projects. So, thank you.

Caron: Wonderful. And a special thank you to you, our listeners, for tuning in to Cardi-OH Radio.

[Voiceover] Konstan: This concludes today's podcast. Be sure to visit Cardi-OH.org to learn more about the Ohio Cardiovascular and Diabetes Health Collaborative.

[Jazzy instrumental outro music]

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