Institute for Healthcare Improvement

INSTITUTE FOR HEALTHCARE IMPROVEMENT
SUMMARY REPORT: 90-DAY PROJECT

A Review of Leadership Teaching and Support
Wave 52
September 30, 2019

I. Research and Development Team:

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II. Intent:

The intent of this project is to help IHI engage, teach, and support health care leaders who see the strategic importance of quality for their organizations. We will look internally initially to learn about success and opportunities regarding our leadership support.

III. Background:

We recognize that any work we do on quality within health care needs leadership support. When we analyze projects, collaboratives, and partner relationships we often conclude that one characteristic of successful outcomes is organizations that have high levels of leadership engagement and support. Therefore, anything we can do to engage, teach, and support health care leaders with practical methods, tools, and behaviors to plan for, improve, and maintain quality is important.

To get a quantitative sense of how important leaders are to us, we used the search term "leader" on the IHI website[1] and found 2,436 hits. As a benchmark, we searched on the word "quality" and found 4,678 hits. In analysis of our 39 White Papers, we found the term "leader" or "leadership" mentioned in all but three of the papers. Twenty-one of the White Papers use the term "leader" or "leadership" at least 20 times with the highest total being 293. Since multiple authors wrote the papers over a 16-year period, we wondered how cohesive and consistent were the recommendations to leaders over the years. We will discuss that and the result of multiple interviews in the proceeding sections.

IV. Description of Work to Date:

[1] Search done on October 10, 2019

In support of the following three deliverables:

1. Understand and describe the main challenges that IHI has faced with teaching and supporting leaders.
2. Better understand our market for leadership, such as what level of leadership we are trying to help in an organization and what types of organizations we are specifically trying to work with.
3. Identify the unique value proposition that IHI will bring to leadership.

We interviewed the following IHI people who touch various aspects of our leadership content, teaching, support, relationships, coaching, and programming, past and present, to get a wide perspective in this exploratory phase:

- Pierre Barker
- Carol Beasley
- Don Berwick
- Cindy Betti-Sullivan
- Maureen Bisognano
- Amelia Brooks
- Jill Duncan
- Frank Federico
- Derek Feely
- Tejal Gandhi
- Carol Haraden
- Ninon Lewis
- Trissa Torres
- David Williams
- Faith Yuh

We read the following IHI White Papers:

1. Nolan TW. Execution of Strategic Improvement Initiatives to Produce System-Level Results.
   IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007.

2. Scoville R, Little K, Rakover J, Luther K, Mate K. Sustaining Improvement. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

3. Reinertsen JL, Bisognano M, Pugh MD. Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition). Cambridge, Massachusetts: Institute for Healthcare Improvement; 2008.

4. Kabcenell A, Nolan TW, Martin LA, Gill Y. The Pursuing Perfection Initiative: Lessons on Transforming Health Care. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2010.

5. Swensen S, Pugh M, McMullan C, Kabcenell A. High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. (Available at ihi.org)

6. Martin LA, Neumann CW, Mountford J, Bisognano M, Nolan TW. Increasing Efficiency and Enhancing Value in Health Care: Ways to Achieve Savings in Operating Costs per Year. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2009.

7. Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. Framework for Effective Board Governance of Health System Quality. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

8. Botwinick L, Bisognano M, Haraden C. Leadership Guide to Patient Safety. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006

9. Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017

10. Leading a Culture of Safety: A Blueprint for Success 2017[2]

11. Hilton K, Anderson A. IHI Psychology of Change Framework to Advance and Sustain Improvement. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018

V. Results of the 90-Day Scan:

[2] This paper was produced by NPSF/IHI and is not an official White Paper, but we have included it with the rest of the White Papers reviewed.

Observation from interviews

Based on our interviews, the following themes emerged for IHI:

- Define our overall theory and approach for working with leaders.
- Rationalize and unify our content.
- Create a learning system to study and improve the effectiveness of our framework, content, project and program designs, approaches, and activities with leaders to achieve greater reach and impact.
- Create a rational and engaging portfolio of "products" for leaders.
- Develop a community of committed faculty to support, deliver, learn, and improve our work together.

If we are truly focused on impact and results, and know leaders are key to achieving results, then we must commit to a rigorous focus on leadership because it is a/the pathway to impact. There was general agreement that we desire to work with leaders who are leading or wish to lead transformative change using quality as their strategy. This includes leaders at all levels – anyone planning for, improving, and/or managing and sustaining quality.

There was general agreement that we need one common, simple framework that can be adapted for various levels of leaders and is used as the foundation in all our leadership content and work with leaders. This framework could be adapted for different levels of leadership and contexts with supporting resources. We can use this as an opportunity to "demystify" leadership for quality.

Currently, we have many frameworks across various content areas, especially in improvement science and safety but also in equity and joy-in-work, which should be brought together. We probably have all the "ingredients" now; the immediate task is to bring the pieces together into a unifying framework that all representing IHI embrace and commit to using and improving.

We must continue to do the technical aspects of improving quality – i.e., the practical how-tos based on a theory – *and* we must include the adaptive side of change and the relational aspects of leadership tied to key behaviors and actions that support these tactics.

We want to continue to push the edge and provoke new thinking on what leading for quality means (e.g., leading for equity, expanding our definition of results that require reaching beyond the walls of traditional health care, becoming social justice change agents). We have an opportunity to incorporate new thinking around equity and power (both in what and how we teach) and in social justice.

A common framework and related content serve as the basis of our learning system and need to reduce variation in approaches within IHI. Several of those interviewed discussed variation in our level of engagement with senior leaders in current key partnerships – as an example, some partnerships have regular (i.e., weekly and monthly) contact with the C-suite and others only quarterly or annually at best. There is a mismatch between our aspirations and the level of leadership commitment and involvement we believe is necessary to achieve transformative results and the design of relationships and expectations for leadership engagement. By building a learning system, we should know with certainty what approaches are superior and what context enabled success (the inputs, assumptions, assets – it's not all technique and tactics), allowing us to thoughtfully test changes to improve our activities and impact.

Market research should help us to narrow our focus for programming and customized services, and prioritize target audiences and content we offer and deliver. We need to consider new ways to teach and deliver content, including role modeling the behaviors we teach in our programming and relationships, meeting leaders where they are in their personal leadership development, and considering partnerships with other organizations where leaders "show up." We should have an intentional plan to know the market, our unique contribution, and build the market over a defined time period.

We will need mechanisms to engage, co-develop this content and curriculum, and build a community for learning with existing faculty, as well as establishing methods for identifying, vetting, and onboarding new faculty, and processes to hold faculty, internal or external to IHI, accountable for using and improving our leadership framework, content, and approaches.

Observation from reading

Based on our reading of over 100,000 words that IHI has written about leadership, the following ideas were prominent:

There is a general set of high-level advice in IHI white papers for leaders that can be described by the following set of words or phrases: vision, priorities, focus, communication, attention, systems-thinking, will-building, champion, culture, authentic, trust, psychological safety, inclusion, teamwork, engage stakeholders, behaviors, accountability, transparency, and results-oriented. For experienced leaders, these words are familiar. A question for IHI is whether this high-level advice really helps leaders or if our advice should be more granular as we will now illustrate.

Besides the high-level general advice for leaders, there are specific recommendations in the White Papers. One example from *Execution of Strategic Improvement Initiatives to Produce System-Level Results*:

- Set breakthrough aims.
- Develop a portfolio of projects to support aims.
- Deploy resources to the projects that are appropriate for the aim.
- Establish an oversight and learning system to increase the chance of producing the intended results.

Another example from *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*:

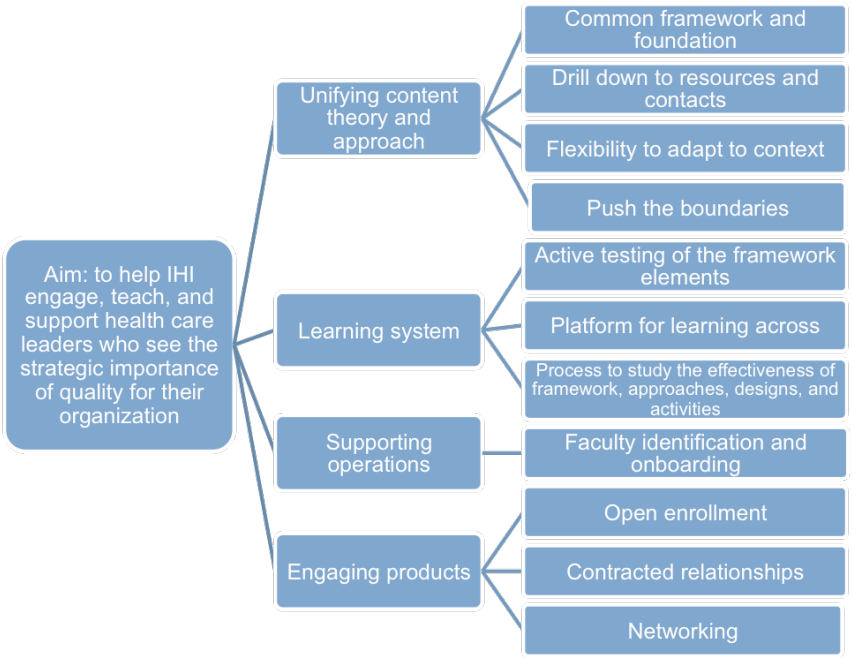
- Put patients and families on the improvement team.
- Make the chief financial officer (CFO) a quality champion.
- Engage physicians.
- Build improvement capability.

Synthesis from our research this wave.

Every piece of work that we do at IHI with organizations involves some level of leaders, and often the work requires the highest level of leaders within an organization to be part of it. Our approach to leaders and the topic of leadership has been inconsistent with each person from IHI who works with leaders introducing variability into the process. Because of this variability in approach on leadership we have no way to compare, learn, and improve a specific model. Additionally, it creates confusion amongst our customers and partners. Contrast this with our teaching on quality improvement in which we consistently base our work on the Model for Improvement[3] as the foundation. We lack the same consistent approach to leadership and hence lack a learning system for our leadership content and supporting programming and activities. We used the following first draft of drivers to further our discussion about leaders and leadership. See Figure 1.

Figure 1: Driver Diagram for IHI support of leadership

[3] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.



Discussion of the four primary drivers

1. Underlying content, theory, and approach

What we have learned so far is that individuals at IHI would like a simple and consistent approach to leadership at all levels of an organization. Just as we approach quality improvement by using the Model for Improvement generally, they would like a similar consistent approach for leadership for quality content. In this 90-day wave of research we are not going to attempt to create a new innovation model, but highlight some considerations for that future model and reintroduce an old model as a potential starting place.

At IHI we need to keep in focus that our connection to leaders is primarily in relation to strategic quality work. We see quality as one of the strategic focuses that leaders need. Leaders sometimes separate their business strategy from quality, but we believe that is a mistake. A quality strategy is not separate from a business strategy. A quality-focused operating model is not separate from a health system's operating model. For IHI, we suppose quality is our business, it is our strategy, and it is our operating model.

It would be good at this point to define quality and some ideas that influence our unifying theory.

1. The IOM defined health care quality as: safe, effective, patient-centered, timely, efficient, and equitable[4].
2. Quality health care should be in pursuit of the Triple Aim.
3. Dr. W. Edwards Deming's System of Profound Knowledge: appreciation for a system, knowledge of variation, theory of knowledge, and psychology[5].
4. Dr. Juran's Trilogy: Quality Planning, Quality Control/Management, and Quality Improvement.[6]
5. Most quality improvement projects require people to take new approaches to both technical and adaptive challenges[7].

Figure 2 is a serviceable model for overall strategic guidance for quality from past IHI work.

Figure 2: Framework for Leadership for Improvement[8]

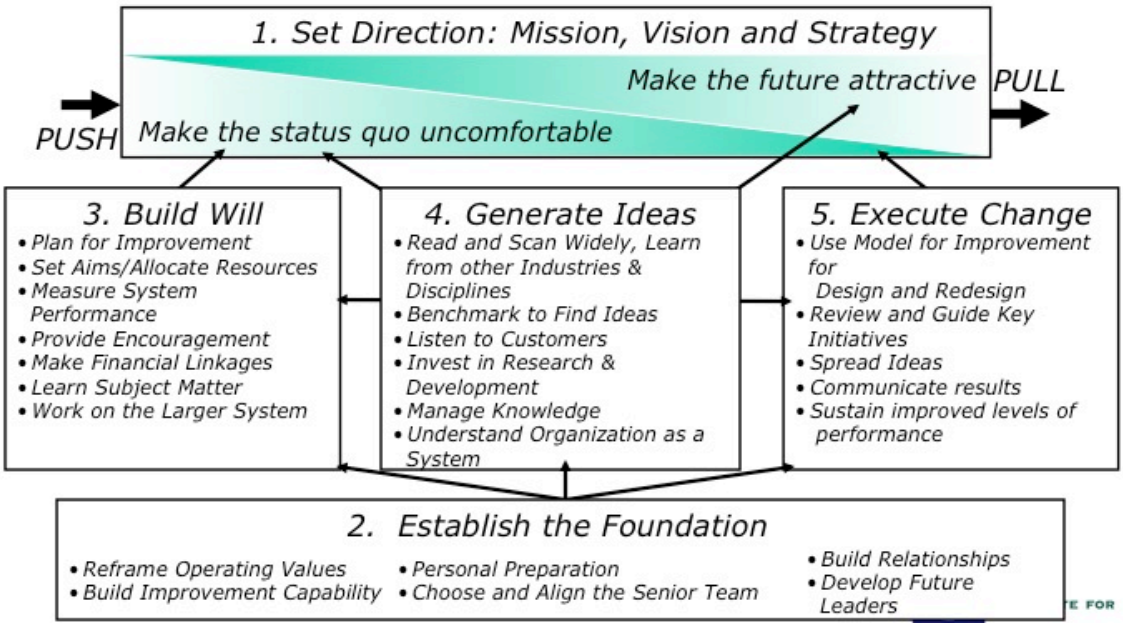
[4] Crossing the Quality Chasm: A New Health System for the 21st Century

[5] Deming WE. The New Economics for Industry, Government, Education. 3rd edition. The MIT Press; 2018.

[6] INSERT citation

[7] Hilton K, Anderson A. IHI Psychology of Change Framework to Advance and Sustain Improvement. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

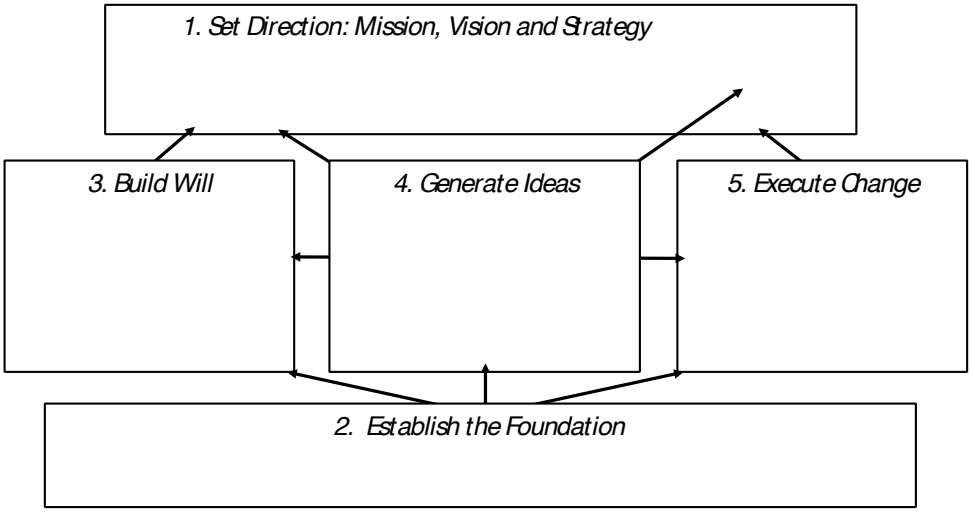
[8] ProvostL,MillerD,ReinertsenJ.AFrameworkforLeadershipofImprovement.Cambridge, Massachusetts: Institute for Healthcare Improvement; February 2006. Online information retrieved February 19, 2008. http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/AFramew orkforLeadershipofImprovement.htm.



There are two key criticisms of this model, Figure 2. First, it was developed with a focus on quality improvement and we recognize we need a model that supports whole system quality – i.e., planning, improving, and managing. A second criticism of this model is its complexity for leaders.[9] However, the concept of Will, Ideas, and Execution is one of the few leadership frameworks that has been consistent at IHI over many years. Thus, we recommend we to continue to use the high-level framework but not the present detailed content, which will be the focus of our next cycle of research. See Figure 3.

[9] Reinertsen JL, Bisognano M, Pugh MD. Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition). Cambridge, Massachusetts: Institute for Healthcare Improvement; 2008.

Figure 3. Leadership Framework for Quality



In the next cycle of research, we plan to collaboratively fill in this framework – i.e., the five boxes. Some of the detailed content will probably look similar to Figure 2, but we also think there will be revision. For example, inclusion of details from the IHI Psychology of Change Framework to Advance and Sustain Improvement,[10]should be considered along with other work that the innovation team is doing now on quality planning and quality control and management.

2. Learning system considerations

The learning system for this work should consider: explicit theory, measures, context such as different types of organizations and different levels of leadership positions within an organization, testing of these ideas, and periodic review.

Before we get into the specifics, one key aspect of the learning system is that IHI leadership endorse and commit to use any theory that we create. Without leadership endorsement and commitment, we will continue to experience the variation in teaching on leadership in our speaking, coaching, and writing at IHI, and we will not be able to have a learning system on leadership for quality.

[10] Hilton K, Anderson A. IHI Psychology of Change Framework to Advance and Sustain Improvement. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.

As stated earlier we are proposing we use the Leadership Framework for Quality as illustrated in Figure 3, to be built out further in Wave 53, resulting in our overall leadership framework for quality. By declaring a model for IHI and using it consistently, we have the opportunity to decrease the amount of variation in support of leaders and achieving results. Decreasing the variation provides us with a chance to learn and improve this model and accelerate results.

The next step in our learning system is to develop a set of proposed measures. As a starting point, we propose the following, to be explored further in the next wave.

- Qualitative feedback of the model after being used
- Number of teams in a collaborative that get to 4 out of 5 or results on prioritized outcomes
- Number of organizations that use the Leadership Model for Quality
- Number of faculty that use the model for teaching
- Number of views of this Leadership Model on the web site
- Number of organizations that incorporate this work into their strategy
- others TBD

Another aspect of a learning system is the target audience. In this case we are targeting health care leaders in general, from the C-suite to point-of-service management. It is a challenge to have one comprehensive model that can meet the needs of all. But to develop learning, we need some consistency to get feedback and improve what we are doing. Thus, we advocate for one model that is the foundation that can then be modified according to the level of leadership and additional contextual considerations. Any modifications should be known for each level of leadership and taught with that level. We could start with three levels of leadership: executive level, middle management, and point-of-service management and design support for those three levels.

Theory, measures, and target audiences need to be tested with organizations with whom we work. Any adaptations to the foundational model should be explicitly articulated and tested, and fed-back for learning and modification when appropriate. Additionally, we need to develop a mechanism for feedback to continuously review and learn from the work. We might add this to evaluation meetings that IHI has periodically on our work with organizations, both in collaborative settings as well as individual grants and contracts. We should also consider digital tools for feedback.

3. Supporting Operations

A few related operational areas were raised repeatedly in our research that should be explored further in subsequent support and development activities. These areas include market intelligence/market insights, product development, new business development, and faculty. This innovation project did not explore these areas explicitly but recognizes the importance of these functions in creating and supporting new products for leaders. A coordinated effort should occur in the subsequent innovation cycle and if this content area is prioritized through a mechanism like a Growth Portfolio to:

- Gather market intelligence as to where IHI can make a unique contribution in the field aligned with our aim, theory, approach, and framework.
- Explore partnerships with organizations to which leaders already belong.
- Grow the market.
- Explore and test new ways to teach, deliver content, coach, build capacity/capability, and learn.
- Train and co-design subsequent offerings and customized services with existing faculty.
- Identify, onboard, and mentor new faculty.
- Create and support faculty community, accountability, and learning.

4. Engaging Products

Based on our research, we have captured some "design principles" for subsequent product development in this content area. We classified these recommendations into three categories based on previous leadership content market research and the current IHI.org structure – trainings (open enrollment programs), customized services (contracted relationships), and networks.

<u>Trainings (Open Enrollment)</u>

- Develop a rational suite of programs that support our theory and framework for identified priority audiences based on market insights and need.
  - Some key questions: How much do we focus on CEOs in programs? Is there a place for teaching quality by role (e.g., a CNO quality course)? This aim and approach is not for all leaders – how do we attract those who share our vision?
- Organize programs in a logical way based on market research, – for example, we could organize around strategies for boards, C-suite, middle managers or core leaders, and point-of-service leaders and the tactics and behaviors to support quality planning, quality management, and quality improvement.
- Explore how to incorporate new ways to teach and learn; role model and incorporate into program design the behaviors we expect leaders to learn and exhibit.

<u>Customized Services (Contracted Relationships)</u>

- Develop or improve our process to assess readiness for this level of change and commitment. This could be included in our diagnostic process.
- Be very clear on our pre-requisites for engaging in a deep relationship and be very clear with the partner about requirements and expectations around such an engagement with IHI (e.g., results orientation, C-suite commitment (CEO commitment is vital to transformative change), regular contact, they own and drive with our support).
- Role model relationship building, honesty, and trust behaviors we expect these leaders to learn and exhibit.

Networks

- Attract and have a place for innovative, aspirational, inspirational, bold leaders to work together on the cutting edge.
- Use our networks to influence the field at large.
- Create examples from these networks to use in other programming, relationships, and publications.
- Use our networks to identify and build the next generation of leaders.

VII. Conclusions and Recommendations:

We conclude that there is an opportunity to continue this work in a subsequent innovation wave with the intent to explore the five-box Leadership Framework for Quality and update it based on our current leadership content and past and present leadership-related programming. This exploration provides the opportunity to connect related innovation projects on quality planning and quality management for total system quality, identify deficiencies in our framework, and develop learning questions and measures for a learning system.

Additionally, an objective of a subsequent innovation wave is to start connecting with our supporting areas, such as market insights and product development (including program development and new business), to begin developing and planning for a cohesive market strategy and more closely linking this innovation work to operations. By connecting with supporting areas now, our aim is to expedite the timeline from innovation to "products in market." This may include starting to explore these concepts with select organizations and leaders in the field.

Finally, we should begin to bring together internal IHI faculty, at a minimum, around this framework to further develop it and create a plan for testing it in programming and projects.

VI. Open Questions:

1. How do we best integrate the innovation work on quality planning and quality management into one cohesive model and market strategy going forward?

2. Can we use the same basic model for all leadership levels? Consider the Will, Ideas, and Execution model, but not all parts of that framework, apply to everyone.
3. If we are going to have one model, what is the teaching package that we need to develop for this work? Going back to Question 2, we probably will need several modules for teaching.
4. Can we develop teaching modules for IHI use on the web?
5. What type of digital platforms will support this work?
6. Who should we talk with in the next wave? Think about both organizations and different levels of management within the organization.
7. How can we get the market research for this work?
8. How do we best involve/identify/onboard/train faculty – new and existing?
9. How do we best involve our staff in this work globally?

VIII: Appendices:

Appendix A: Interview Questions

- What is your definition of leadership?
- What is you approach to leadership?
- Is it based on a particular theory?
- Name one article or book that influenced you.
- If you teach leadership, what are your main points?
- What has IHI done well on leadership? What would you like to see improved?
- What should IHI teach about leadership? What is the best that IHI has taught?
- What needs to be done?
- What else would you ask? Anything else you want to be sure we know?

Appendix B: Initial Assessment Questions

Potential Questions when Considering Projects with Leaders

These questions are intended to help us (IHI) consider a customer's/partner's current leadership commitment to quality and transformative change. We do not intend to use all of these questions. During the next cycle of research, we will shorten this list down to five to eight key questions.

- What is the quality strategy for the health system?
- How is quality brought into strategic planning?
- Describe the most recent strategic clinical quality initiative.
- How did they manage change for this initiative?

- Think back to a strategic project from five years ago. How well were those results sustained?
- Describe the CFO's relationship to quality planning, improvement, and maintenance.
- What is the process for reviewing strategic initiatives?
- Describe the quality infrastructure of the organization and the reporting relationships.
- What does leadership do to gain new ideas?
- How well does leadership understand their political, financial, and social environment?
- Do leaders do front line walk rounds?
- What is the vision for the future of quality patient outcomes?
- What role does the Triple Aim play in this vision?
- How do they communicate the vision?
- How long has the present CEO been at the organization? How about the rest of the leadership team?
- Are the organization's values and vision aligned with IHI's values and vision?
- Does the CEO understand the expectations for working with IHI – monthly meetings with CEO, weekly meetings with CQO, etc.?
- What other key leaders are on board?
- Is there a named key contact with the authority to drive change?
- What red flags do you see?