Lessons from Pursuing Perfection: Leading Organizational Change Through Personal Involvement

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Previous issues of *Transition Watch* described the Robert Wood Johnson Foundation's Pursuing Perfection (P2) program and related evaluation goals and learnings. In this issue we present observations about actions of senior staff in leading their organizations' change processes. A central aspect of the Pursuing Perfection transformations is patient-centeredness. Sites have invested substantial effort in learning more about patients' and families' needs for use in system redesign.[1, 2, 3] These sites recognize that to create a healthcare system that is patient-centered, safe, and of high quality requires leadership that relentlessly pursues these goals. From experienced leaders outside P2, we hear that "leaders play an extraordinary role" and that the "leader's role [is] to be part strategic, part organizational, and part cultural."[4] This article describes senior staff efforts at these sites to better understand patients' needs and patient safety issues and to use this knowledge to drive transformation and redesign efforts.

Leaders as Champions for Organizational Transformation

In the new healthcare environment, senior leaders have key roles as change agents. At a regional medical center, where there has been a long-standing commitment to quality, the CEO himself models the active role that leaders in that organization are expected to undertake. He believes that work focused on improving care should happen daily and that large-scale improvements are initiated by making care perfect for one subset of patients at a time. Because he believes it is critically important to be personally involved in activities to improve care on a daily basis, he has dramatically minimized the time he is away from the office. He tries to facilitate communication and feedback by making it comfortable and easy for staff. He meets with a few people rather than using email to solicit input, eats lunch with employees, facilitates a journal club, and participates in daily walk-arounds. He attends weekly and annual employee orientation sessions, as well as weekly meetings of the clinical effectiveness team and the human resources department. He also reviews senior staff's performance on clinical effectiveness work efforts.

At an academic medical center, quality efforts initially led by the quality improvement leader focused on chartering improvement projects and developing the capability to measure outcomes of their activities. In time, it became clear that this work could not succeed without more organizational support. The CEO responded by communicating that quality and transformation were required because the organization exists to take care of patients; the system was broken, and they needed to fix it. This theme is now part of his daily work – 75% of his time is focused on transformation. His job is to make transformation the organizational imperative and to energize staff to do this. Rather than focusing on increasing volume and revenue, he focuses on transformation and the need for people to talk to each other and support transformation on a daily basis. He attends new staff orientation every two weeks, emphasizing to new employees that the organization will be a great place for them to work, but only if they are interested in transforming care. In fact, he stresses that if they are not interested in transforming care, they should leave, because the organization will not be the right place for them. He serves as a champion on a quality improvement team, and requires all senior executive staff members to do the same. In this role they are expected to demonstrate leadership by really listening, by keeping the team focused, and by breaking down any barriers to work that they may encounter. This year, the CEO challenged each of the organization's 600 managers to conduct at least one quality improvement project, and indicated that this would be reflected in their annual performance evaluation.

At another regional medical center, a senior leader with prior success

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as a change agent was designated as the chair of a task force in the emergency department. Early change efforts led by middle managers had failed, but this more experienced senior leader was able to support the passion for change, teach skills to promote change, and facilitate access to resources that departmental staff would not ordinarily have had.

Walk-Arounds/Walk-Throughs

As described on IHI's qualityhealthcare.org web site, walk-arounds and walk-throughs are two techniques available to senior leaders in healthcare organizations seeking to improve care.[5,6] A walk-through allows employees to better understand the experience of care from the patient's and family's point of view. With the unit staff's knowledge, the staff member pretends s/he is a patient. As the mock patients seek and receive care, they identify and document their thoughts and feelings, and describe changes that would improve the experience for both patients and staff. In walk-arounds, leaders use informal methods to observe and talk with front-line staff about safety issues in the organization.

P2 sites have adopted their own versions of these models. At one site all executive staff start every day by rounding on the floors and talking to patients. They ask questions based on the key drivers of patient satisfaction, such as whether physicians and nurses answered their questions, as well as how the hospital stay has been, if anything could have been done better, and whether there are issues the patient wants to discuss. Senior staff then meet for half an hour to review their observations and to plan next steps.

At another site, the CEO and senior staff are trying to create a culture of patient-centeredness and patient safety with a focus on measurement and accountability. In weekly CEO walk-arounds initiated to talk to staff, quality and risk management staff identify questions to be asked, a manager accompanies each senior leader as scribe, and a database is used to track issues, action steps, and unresolved items. At first, unit staff were wary of this process, making the CEO realize that despite his previous activities in support of quality, he had been less present in the hospital than he had realized. He focused on topics such as "what is the next accident waiting to happen?" and "if you or a person you care about were a patient on this floor, what would you be afraid of?" Issues raised early on included the need for raised toilet seats, pull cords, and other equipment, and, over time, issues such as staffing levels and interactions across departments were identified. By initially focusing on items the manager could quickly fix, a tone was set that change could happen. To ensure continued success, especially for high-priority efforts such as patient identification in medication administration, frequent follow-up was found to be important. Explaining why he and other senior staff make five walk-around visits per week, the CEO at another community hospital described his role as ensuring that ideas are shared, information and expertise are pooled and used, and people lift each other up and grow together.

Conclusion

We believe that the approaches described here provide models that senior staff can use to learn about patient needs and patient safety concerns. These approaches provide a powerful personal context for learning, support cultural and team development among senior staff, and bring senior staff to the organization's front lines. The organizations and executive staff described in this article used these approaches and believe they have led to better patient care, increased patient-centeredness, and improved safety.

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Physician Adherence to Evidence-Based Prescribing Practices: Use of Antipsychotic Medications in the Treatment of Schizophrenia

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As the U.S. experiences rapid growth in the number of new drugs produced, policy makers and leaders in the medical community have been exhorting physicians to be evidence-based in the way they prescribe medications. Not surprisingly, much variation appears to exist in the prescribing patterns of physicians for a wide range of clinical conditions. Existing research suggests that some physicians are more inclined than others to follow the most current evidence available, but the characteristics of such physicians are not well understood.

We examined the characteristics of VA psychiatrists regarding their adherence to evidence-based recommendations for prescribing antipsychotic medications in the treatment of schizophrenia. From a policy perspective, antipsychotics constitute an important class of drugs. They are used to treat schizophrenia, a disabling mental illness affecting more than 2 million persons in the United States alone[1]. In 2001, VHA provided treatment to more than 98,000 patients with schizophrenia at a cost of $1.7 billion[2]. Moreover, this class of drugs, according to a recent report, is a leader in terms of worldwide pharmaceutical sales[3]. VA, as well as other professional organizations, has been involved in disseminating information about best evidence-based prescribing practices for antipsychotic medications in the treatment of schizophrenia.

Survey Overview

A survey was used to obtain information about whether psychiatrists followed evidence-based prescribing approaches for schizophrenia. We selected three best evidence-based practices from the October 2002 issue of *VA Practice Matters*[4]. Recommendations described in *VA Practice Matters* were based on those of the American Psychiatric Association, the Schizophrenia Patient Outcomes Research team (PORT), and from meetings held to develop consensus on controversial issues about schizophrenia treatment, which included VA's Mental Health Quality Enhancement Research Initiative (QUERI) group and representatives from three Mental Illness Research Education and Clinical Centers (MIRECCs)[5].

The three best evidence-based practices selected were:

- Prescribe antipsychotics within the dose ranges.

- Prescribe second-generation antipsychotics before first-generation agents for patients experiencing a first episode of schizophrenia, or for those patients where there is no available history concerning response to antipsychotics.

- Prescribe Clozapine for patients who continue to be symptomatic on their current antipsychotic medications and who have had an adequate trial on at least one second-generation antipsychotic medication.

Although all three practices relate to prescribing antipsychotics, they address different issues of prescribing such medication. The first recommended practice addresses appropriate dosing. The other two recommended practices address the selection of antipsychotic medications – second-generation (or atypical) drugs

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versus first-generation (or conventional drugs) for initial episodes of schizophrenia, and the use of Clozapine for treatment refractive patients.

The questionnaire consisted of three primary parts. Part one was designed to obtain data about adherence to the prescribing practices during recent months. For each of the three prescribing practices, we defined adherence as whether or not the psychiatrist reported following the practice for at least 75 percent of his/her patients who were eligible for the practice. Part two concerned the sources of information that psychiatrists use to stay current with scientific issues and developments in their field. The psychiatrists reported on the extent to which they used scientific journals, medical opinion leaders, continuing medical education programs, and drug company reports as information sources for staying current with scientific developments in psychiatry. Part three of the questionnaire asked respondents to answer a series of questions regarding their demographic characteristics, education and training, and clinical and academic arrangements. The response rate for the survey was approximately 39 percent. Our study sample consisted of 644 VA psychiatrists from the total number of psychiatrists recorded in the VA system.

Discussion

Adherence to recommended prescribing practices was moderately high (from 76 to 81 percent), when compared to what has been reported in the recent literature for physician compliance with evidence-based practices in general. In addition, ten or more years of post-residency experience was positively associated with adherence to two of the three prescribing practices, dosing for antipsychotics and use of second-generation antipsychotics. Our results suggest that the experience of physicians, both in terms of years of practice and type of patients, has some influence on adherence to evidence-based prescribing practices. Perhaps more experienced physicians have better developed information networks or are more expert in searching for and synthesizing relevant prescribing information. We also found that the percent of a psychiatrist's patients who have schizophrenia was positively associated with adherence to the Clozapine prescribing recommendation, pointing to an advantage from the type of experience that comes from repeatedly treating patients whose clinical condition is related to the prescribing practice.

We observed lower levels of adherence for female psychiatrists than we did male psychiatrists for two of the three prescribing practices, use of second-generation antipsychotics and use of Clozapine. Other studies have reported similar differences on this. Our results add to a growing awareness that female physicians may have a more conservative prescribing orientation than do male physicians, although the genesis for this difference in orientation, whether linked to socialization or other factors, is not clear and could also be in part due to response bias, as survey respondents were somewhat more likely to be female.

Our results also point to the role of information sources in promoting adherence to evidence-based prescribing practices. Psychiatrists reporting a higher score on use of published scientific literature were more likely to adhere to both the dosing and use of second-generation antipsychotics recommendations. In addition, a higher score on the drug company report scale was positively associated with adherence to dosing of antipsychotics. Information gleaned from published scientific literature and drug companies appears to have somewhat more influence on evidence-based prescribing behavior than information from medical opinion leaders and continuing education programs.

In sum, we observed a relatively high degree of adherence among VA psychiatrists concerning their prescribing practices in an area where there is at least some consensus in the field regarding best evidence-based practices. More experienced psychiatrists who care for a relatively high proportion of the relevant type of cases tended to be in greater adherence with these practices, as were those psychiatrists who reported greater reliance on the published literature and drug companies as sources of information.

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