

Two Days In December

A Report from the Rural Hospital Quality Leadership Summit

Minneapolis, Minnesota
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By Robert J. Hartl and Antoinette J. Pearson

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For questions, concerns, clarification, or technical assistance, please contact:
National Rural Health Resource Center
600 East Superior Street, Suite 404
Duluth, Minnesota 55802
Phone: 218-727-9390
Fax: 218-727-9392
www.ruralcenter.org



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On December 9, 2010, twenty health care experts from across the United States gathered in Bloomington, Minnesota to share and memorialize their best thinking about the status of rural health care quality and leadership. The list of participants was impressive and diverse, including hospital administrators, educators, researchers, consultants, and national health care policy makers. They had in common an impatience with the current state of rural health care and a palpable onus to act. Not a single person invited by the National Rural Health Resource Center, the summit's convener, declined the opportunity. The purpose of this two-day conference was to capture the implicit knowledge of participants, convert it into a meaningful gestalt, and then use it to guide policy makers and those responsible for performance improvements across the continuum of care in rural areas.

The first day of the summit comprised participant presentations about lessons learned during performance improvement initiatives at critical access hospitals across the country. The presentations differed widely in specifics but also converged around key themes that would fuel the second day of the summit. Three primary themes that emerged from the spoken words of presenters were leadership, organizational culture, and the need for patient engagement. In addition, a fourth – perhaps more important – theme became apparent through its conspicuous absence from the presentations: Currently there is no generally accepted strategic framework for organizing the myriad of models, methods and ideas now employed to advance quality improvements in rural health care. Absent such a framework, performance improvement likely will be slow and uneven, relying on the efforts of individuals and progressing one critical access hospital at a time.

First, it was striking to hear all of the presenters – to varying degrees – emphasize the critical nature of effective leadership as the antecedent of successful quality improvements. Some focused on the CEO level and others spoke more broadly of developing leadership at all levels of an organization. The influence of physician leaders, whether exercised intentionally or unconsciously, also was recognized as a relevant factor that affects continuous quality improvement in critical access hospitals. As one summit participant said, “you need a physician leader who brings along the rest.” Perhaps most importantly, developing and retaining effective leadership for a rural hospital actually starts one step further upstream – with the governance board. The board must be fully engaged, playing its critical role in establishing policy and in hiring and evaluating the top organizational leader. Absent the board's commitment to continuous quality improvement, little progress will occur. As one participant put it, “real transformation starts at the top.”

Second, organizational culture was frequently mentioned in the presentations, sometimes as a barrier and sometimes as a key to successful quality improvements. It is unlikely that the health care sector understands the concept of culture better than other industries. Indeed, the anecdotal record is replete with

stories of health care executives who naively attempt to create new cultures by edict. Although well-intended, such leaders often actually cement the status quo and make real change all but impossible. However, it was clear from the presenters at the summit that the pervasiveness and power of culture is well recognized and accorded due respect. As one participant put it, “culture trumps strategy every time.” Another, in discussing the complexity – and perhaps futility – of trying to impose a new culture, quoted culture expert Edgar Schein (2008) who once said: “Culture is a learned thing; it does not result from someone announcing it.”

Driving agendas for change without attention to proper process will increase an organization’s “learning anxiety,” also known as “resistance to change.” Simply put, effective leaders must learn how organizational culture is formed and how it is changed. As one presenter cautioned, “we need to build a framework for change management, not a benchmarking system.” Whereas fixating on the financial bottom line is surely myopic, most presenters likely would agree that the financial health of an organization is related to its capacity to undertake meaningful change initiatives. For that reason, the evolution of an organizational culture that embraces quality must be built on successful business outcomes, not altruism. As Schein (1999) also noted, “culture is the residue of success.” But, as one of the presenters warned, “The time for making wise business decisions is shrinking.”

Woven throughout many of the presentations was a thematic about the need for greater patient engagement in both the delivery of care and in program planning and policy development. This theme includes assuring that patients and their families are able to participate – to the level they choose – in decision-making about personal care options. However, it also means that policy makers and care providers must encourage and embrace collaboration with the end users of health care to develop systems that honor and respond to patient needs. In so doing, rural health care leaders will be better able to positively influence community perceptions about the quality of care in rural versus large, urban systems.

Finally, as the day-one presenters described a wide and generally positive report of change initiatives, it became apparent that this group was composed largely of what sociologist Everett Rogers (1962) described as “innovators” and “early adopters.” While providing inspiration and motivation, the diversity of shared ideas, models, and methods exposed what may be the Achilles heel of those hoping for a more rapid diffusion of quality innovations. That flaw may be that, currently, there is no agreed upon strategic framework or structure to organize the lessons in a way that is understandable, communicable, and actionable by the rest of the statistical spread (the late adopters or those who lag). To that end, the use of the Baldrige framework or some other agreed-upon organizing schematic might be helpful. However, if such an approach is used, it will be important to incorporate flexibility into the structure. Not all organizations face the same challenges, and

cookie cutter approaches are notorious for their inability to recognize and accommodate those guaranteed differences. To assure the proper flexibility in a universal model it will be critical to incorporate the thinking of end users into the basic design.

Based on the reports and discussions that occurred during the summit's first day and evening, the second day sought convergence around common themes and desired future action. Several important outcomes quickly emerged. First, the Executive Director of the National Rural Health Resource Center suggested using the Baldrige framework for promoting and guiding quality improvements in rural health care. This customer-centered model had been mentioned by more than one presenter during the summit's first day, and its value as an organizing structure appeared useful to everyone. Second, the group decided to form what they envision to be a partnership that addresses rural priorities. This coalition of summit participants, and others who will be invited to join them, seek to influence the national agenda for rural health care, align their various organizational strategies with that agenda, and collectively work toward the public policy changes and initiatives they mutually desire. Finally, the group discussed that meaningful comparisons about the quality of care offered by rural versus large urban systems will be impossible until commensurate measures are clearly established. Undoubtedly, that will be an item of importance on the agenda of the newly formed partnership when it next meets.

The summit meeting ended with a "Bohmian Dialogue" (Bohm, 2003), a facilitated process named for the late David Bohm, a heralded quantum physicist who used and popularized this method until his death in 1992. William Isaacs (1999), former director of the Massachusetts Institute of Technology's (MIT) Dialogue Project, has described the process as being "about shared inquiry, a way of thinking and reflecting together." During the MIT project, dialogue was shown to be effective at stimulating collective thinking, organizational learning, and coordinated activity among people with shared interests. It had exactly that effect with the summit's participants who summarized the lessons of the two days in these concluding comments:

- I don't want this to be just voices in the wilderness...we need to engage the policy makers and legislators.
- I have realized this is no longer my world; it is my children's world...I need to help them figure it out.
- Look to the frontline [staff]; they have great ideas.
- We need specific quality indicators across all health care systems, rural and others. so we can make comparisons.

- As we continue this dialogue we need to view hospitals as part of the continuum of care...where all facilities fit into that mix.
- We talked primarily about improving quality in rural hospitals...we need more talk about going beyond that to physicians, clinics, long term care, etc.
- Within our minds we have chosen who we consider early adopters and who is lagging, but I don't think we actually know. We need a process to assess [progress]; our assumptions may not be correct.
- Rural isn't a style of care; it is about location. The fundamental processes are the same.
- We must always remember the end users. We need to know if our recommendations are useful to them.
- For ongoing discussion we should talk about how to create time to continue the dialogue and maintain the enthusiasm of the past two days.
- I hope we keep in mind the balance between the right and left-brainers. I am mindful of hospital administrators who say, "I am not paid for quality." They need to learn to do the right thing.

Although this group of twenty visionaries did not chart a specific strategy for the future, they did establish a context and a framework through which strategic priorities and actions may someday emerge. Perhaps the most significant aspect of the summit was that it happened. The fact is that these busy health care experts traveled to frigid Minnesota for two days during the holiday season – sandwiched between two major snowstorms – to volunteer their thinking about how to improve the quality of health care in rural communities. The nation's needs are obviously monumental, and so too was the dedication of this group of people. One participant said during the concluding dialogue: "I've been re-energized by the last two days on a personal level. When you are an early adopter, there is no path; it is easy to feel beaten down. This summit was re-energizing for me." The other participants likely would agree. Hopefully the outcomes from this important meeting will stimulate others who need to become involved.

In conclusion, the eventual outcome of these Two Days in December is still unknown. However, the group departed from Minnesota invigorated and hopeful. Perhaps they will achieve what one of them wished for on the first day: "We can't be error free, but we can trap our errors before they reach the patient. Do no harm." The members of the new partnership group plan to meet in Washington, DC, during the Rural Health Policy Institute, conducted between January 24 and 26, 2011 to discuss next steps.

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