

**THE 3 TS OF LEADERSHIP ENGAGEMENT:
TRUTH, TRUST AND TEAMWORK**

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The single most important ingredient for transformational high performance improvement is leadership; yet we have a leadership vacuum at the frontline. The 3 T's of truth, trust, and teamwork offer a conceptual framework of actions that can be taken to engage trustees, senior administrative leaders, independent and employed physicians as well as frontline nurses and staff who are the servant leaders providing care. The market forces of transparency in hospital performance press the three T's into action.

INTRODUCTION

Truth is the currency of our analytical mind – facts, data, patterns, and metrics drive the critical processes of our industry.

Trust is the currency of our heart – our faith or belief in mission, the value of the common good, the personal and organizational brand of our colleagues and collaborators.

Without truth and trust built into the gears of teamwork, the machinery of our care process, we are individuals, carried along by systems inertia, delivering fragmented and production centered healthcare.

Many have believed that there is active resistance to performance improvement activities.

When we asked **Dr Don Berwick**, the visionary leader of the very successful Institute for Healthcare Improvement (IHI) “100,000 Lives Campaign” that engaged more than 3,000 hospitals and so far has contributed to saving more than 122,000 lives¹ whether there were any surprises. He stated:

"We misinterpret a vacuum as if it were resistance. The campaign participants who have stepped forward as leaders fills this vacuum. Something was missing and now it's supplied with this energy to do better. It wasn't resistance; it was the absence of a clear, articulated, real meaningful opportunity to do something. People seem to focus on resistance in health care - defects, problems, and the slowness of change. We're finding energy in the workforce that even I, and I'm an optimist, didn't know was there. Doctors, managers, therapists, pharmacists are coming out of the woodwork. All they want to do is help and get involved. The energy level is just phenomenal. Executives, too - I've had CEOs call me spontaneously, testifying to the meaning of this, not just in the organizations but for them personally. This is tapping something that I guess was there all along." [Don Berwick, Personal Communication 8/23/06]

Purchasing, quality, and certifying organizations are forcing us to change through their demands for transparency, which is revealing great gaps in performance.

This is occurring against a backdrop of eroding values. An environmental scan of our popular culture reflects decades of a gradual slide of our values that has crept into how we deliver healthcare. Like an invisible operating system, we have fallen into default habits of thinking that can defeat the energy of enthusiasm for improvement. We have become well schooled skeptics, unconsciously practicing distrust bias and ever questioning the motives of others as a result of popular messages.

- **Exploitation versus Value Creation:** It is not lost to us that our business leaders have great incentives to exploit business relationships and infrastructures in the name of shareholder value when in reality the objective is short term gain.
- **Social Darwinism -The Apprentice and Survivor era :** Weekly television programs act out Social Darwinism and individual survival of the fittest. We have few role models of true leadership or teamwork.
- **Moral Relativism and Situational Ethics Replace the Golden Rule:** An end justifies the means. Mentality has led to the art of “positioning” rather than the truth. This pattern is continually reinforced as the norm. Great companies such as Costco, Amazon.com, Fedex, Dell, Southwest Airlines, Fours Seasons Hotels, Enterprise Rent-A-Car, ² on the other hand, distill their success down to one behavior – that they fiercely adhere to the golden rule: *"Do unto others as you would wish them do unto you."*³
- **Failure of Support Systems:** The recent failures of FEMA during the Katrina disaster in 2005 and the apparent impotence of support systems we take for granted do not build confidence in light of the collective national sense of uneasiness after the 9/11 terrorism attack of 2001.

Warren Buffet, the business guru often called ‘the oracle of Omaha,’ has said that

*“the chains of habit are too light to be felt until they are too heavy to break.”*⁴

Our chains of habit and preconceived notions must be considered as we try to engage leaders through truth, trust, and teamwork.

Truth

Truth is a comprehensive term that, in all of its nuances, implies accuracy and honesty.⁵ At a time when challenging the veracity of someone’s position and “stump the star” has become a national blood sport on cable news, we need to leverage the power of consensus on good data and information with our physicians and healthcare leaders.

In a recent conversation with business guru Jim Collins, author of *Good To Great*,⁶ we asked how we can leverage our “resource engine” in healthcare and engage physicians who are not employed by a hospital to become engaged in the performance improvement of that hospital. He simply stated “through data.” He elaborated that the data regarding performance gaps and the impact of improved performance is the way to engage them. We then asked him if there were any models that demonstrate such an approach and suggested we take a look at how data was used to engage teachers in the Roger Biggs story as told in *Good to Great in the Social Sectors*⁷ where performance of children was correlated to the performance of teachers. (See Insert 1) Figure 1 displays the Collins’ Hedgehog concept, utilized by such organizations to transform themselves from good to great; rigorously examining what they are passionate about, what they are best at and what drives their resource engine.

The integrity of collaborators rests with the integrity of their information. It is critical that a bridge of truth be developed between the minds of our trustees, administrators, and physicians. It is a tough job winning healthcare stakeholders with data. Healthcare fraud is estimated to be between 1 and 10% of our industry by dollar volume.⁸ Many have institutionalized pushing the envelope on reimbursement rules, which has come back to haunt them and eroded trust within the ranks. Long term, transparency will have great impact. Gaming the system will become the systems game where we will only gain by improving our systems. Short term, we must make sure that creative approaches to manipulating data to maximize financial performance be abandoned.

We must engage leaders and recruit teammates to our improvement programs by being scrupulous regarding the veracity of the data and information pertaining to our work. **Maureen Bisognano**, the inspirational COO of IHI offers a word of caution:

“We should never hype our results and we should

celebrate our failures as much as our successes because we can learn so much faster from our failures.” [Maureen Bisognano, Personal Communication, 8/22/06]

The data does not have to be perfect, however. Jim Collins also shared with us that, for improvement purposes, the slope of a trend may be more important than the absolute numbers.

In order to engage non-clinical governance leaders who are accountable to the community, as well as investors in for-profit hospitals, we must make sure that we provide the information in a way that is meaningful to them regarding risk, safety, quality, and the allocations of resources important to improve care.

To engage senior administrators who must translate clinical, operational, and financial information into actionable strategies, plans and tactics, we must have an integrated approach to enterprise wide performance.

Physicians who immediately gravitate to pure clinical information must be given a balanced view with clear incentives to get them to play on performance teams. Information must be clear, unbiased, and we must engage the physician leaders who have values consistent with the organization and those consistent with the aim of specific performance improvement efforts being undertaken. To engage physicians without such values, purely with economic enticements is a waste of effort and time.

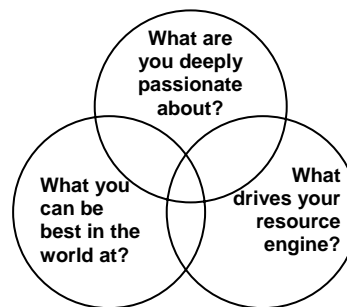
To engage mid-level managers, we must be careful to provide information that is relevant to the scope of their charge while providing real transparency to the organization and context to the overall aims of their initiatives.

Finally, to engage frontline caregivers who often have the purest values, we need to show them how the information will help them better care for their patients.

Insert: Roger Biggs Story from *Good to Great for the Social Sectors*⁷

Roger Biggs, who taught physics at a suburban public high school, had an audacious goal of turning the science department into a great center of scientific education. In order for the department to become great, Roger knew he had to fill the teaching seats with ‘great’ teachers – and not rely on ‘good’ teachers. The data he assessed was the three year teaching history of teachers. If they had not exhibited ‘greatness’ in their teaching, they were not given tenure, which had usually been a ‘given.’ He changed the entire make up of the science department hire-by-hire and tenure by tenure. The science department became nationally famous. Roger accomplished all this with the use of early-assessment mechanisms, rigorously employed.

Figure 1: The HedgeHog Concept



Circle 1: Passion – Understanding what your organization stands for (its core values) and why it exists (its mission or core purpose).

Circle 2: Best at – Understanding what your organization can uniquely contribute to the people it touches, better than any other organization on the planet.

Circle 3: Resource engine – Understanding what best drives your resource engine, broken into three parts: time, money and brand.

Adapted from: *The Hedgehog Concept*, page 19 in *Good to Great in the Social Sectors*⁷

Trust

The patient-physician relationship, as the *Journal of the American Medical Association* policy perspective declared a few years ago, is a “moral enterprise grounded in a covenant of trust.”⁹

We submit that collaborative relationships of performance improvement are also a moral enterprise grounded in a covenant of trust.

For the purposes of this discussion, we shall define trust as having faith in the performance of colleagues and collaborators. We define such faith as

“the belief in things not yet seen.” This means we have faith in our collaborator’s integrity, reliability, honor, loyalty, and support.

David Shore, a trust thought-leader, states that “Trust is an unwritten agreement between two or more parties - for one party to perform a set of agreed-on activities and for the other party to perform a set of agreed-on activities without fear of change from either party.”¹⁰

Faith-based organizations that are truly faithful to their mission have a real strategic edge. They, in Demming’s words have a “constancy of purpose”.¹¹ However, those that do not live their values, and in truth behave with an operating system focused on financial performance while parroting other values, are at a great disadvantage. Hypocrisy drives distrust bias and can defeat a plea to “do the right thing for patients” when the potential recruits know that lurking behind this mask is the face of a production-centered tyrant driven by the bottom line.

In order to engage trustees who are accountable to both the community and their investors, we must appeal to their values. Non-clinical trustees can relate to the dimensions of patient centered care and often develop a deep sense of satisfaction that they are serving their fellow man. We must earn their trust by honestly communicating the nuances of clinical care and call on them to help us make tough decisions regarding the allocation of resources that may compromise financial performance. We must ask them to practice forgiveness for changing or breaking budgets to address previously unknown risks.

It is difficult to generate the trust of senior administrators who may have experienced taking a risk on clinical improvement efforts or adopting technologies that have cost much more than expected and delivered much less than promised. We need to make sure we can deliver on the numbers forecasted for a patient safety program before we propose such a program; we never get a second chance at a first impression.

There are multiple barriers when it comes to earning the trust of physicians – such as physicians’ skepticism and critical thinking, fear for their autonomy, worries of time commitments which translates into income and lifestyle impact, and lack of motivation if the benefits of a program only accrue to the hospital.¹² Fairly or unfairly, physicians and administrators often maintain a baseline level of distrust. Physicians fear hospital centered programs

have hidden “gotcha’s” that may hurt their practices in the long term. Administrators often fear that new technologies or activities proposed by physicians may hurt hospital economics in the long run. A baseline level of uneasiness must be recognized and care must be taken to build the bridge between physicians and administrators.

Dr. Gary Gottlieb, President of Brigham and Women’s Hospital, one of the country’s highest performing hospitals, states:

“A critical element to our success is engaging our doctors in our vision of patient quality and safety. We do this by creating a transparent environment and upon this we build a foundation of trust and truth with our team.” [Dr. Gary Gottlieb, Personal communication, 8/22/06]

To engage mid-level managers, we must be consistent in our behaviors as leaders. We must live up to our commitments and mirror the values of the organization every day. We build a mid-level manager’s faith in our leadership when we give them accountability WITH authority. That is to say that we give them the authority to act on safety issues where the problems occur. When we give them accountability with no authority, they feel victimized when things go wrong and they are powerless to impact the problems. For instance, when we espouse lofty values on the wall and then allow unwritten values of financial performance to trump improvement activities, we lose their trust.

To engage the trust of frontline caregivers, we must “walk the talk.” There is no more clear message to the frontline than daily issues of preventable harm and in many cases, there are no behaviors from above to correct them.

Another powerful and memorable quote from Warren Buffet is:

*“trust is like the air we breathe. When it’s present, nobody really notices. But when it’s absent, everybody notices.”*¹³

It may take a lifetime to earn trust and an instant to lose it.

Teamwork

Successful teams are comprised of people, knowledge, skills, communication, structure, and a systematic method to achieve a stated aim.

As for the people on the team, we need to have the “A players” on the bus, according to Ann Rhoades, industry workforce and leadership expert

from the airline and hospitality industries.

Dr. Michael Leonard, a national leader and gifted educator in teamwork and communication, states that:

"When the right effective teamwork, tools and behaviors are used, it can deliver truly reliable care at the bedside and align the strategic goals of the organization with patient centered care values". [Dr. Michael Leonard, Personal Communication 8/20/06]

All successful performance improvement program methods have at least five activities: education, measurement, skill building, process improvement, and reporting. Such programs come in many flavors; however, the secret and critical ingredient to all of them is leadership.

Dr. David Pryor is an innovator and senior leader of Ascension Health, which is experiencing outstanding results in performance improvement attributes. He told us that these results are due, in part, to their unleashing the untapped power of mutual respect that is being revealed through study and development of their culture. Living the IHI expression of "some is not a number, soon is not a time," Ascension has committed to "excellent clinical care with no preventable injuries or deaths by July 2008." [Dr. David Pryor, Personal Communication 8/22/06]

Dr. Steven Seltzer, Chairman of Radiology at the Brigham and Woman's Hospital, mentioned earlier, has found that institutional efforts to improve quality and safety require the buy-in of every member of the enterprise.

"Organizational leaders, physicians, nurses and administrative staff must all cooperate to achieve optimum results. The enterprise-level quality improvement initiatives catalyzed by our Radiology Department, such as introduction of computerized physician order entry with decision support for ordering and scheduling diagnostic imaging examinations were successful only because the institution's medical staff also found these initiatives to be beneficial in their daily practice (saving time from handwriting radiology orders and avoiding burdensome pre-authorization by telephone by insurers), and because the institution's executive leadership supported the necessary practice changes." [Dr. Steven Seltzer, Personal Communication, 8/20/06]

Dr. Gary Kaplan, the Chairman and CEO of Virginia Mason Medical Center in Seattle, an organization that is experiencing extraordinary performance, led by teams of physician leaders and

professional administrators, was asked what leadership lessons he had learned from their quality journey:

"First, to be the best, you need to be willing to look outside of your own industry for insights and not rely on the usual benchmarking approaches. Virginia Mason is deploying high performance management methods from the Toyota Production System to all aspects of healthcare operations."

"Second, as a leader you must pay careful attention to what signals you are sending to your organization. It is surprising how much impact even simple behaviors of the leader can have on an organization and strong leaders must always be aware and thoughtful about this signal generation." [Dr. Gary Kaplan, Personal communication, 5/5/06]

In order to engage trustees who are accountable to the community and investors, we must make sure that actionable information is provided to them and that we give them an opportunity to play a role. There really is a place for them on our teams.

In the words of **Dr. Dennis O'Leary** the President of JCAHO:

*"There is no room on the sidelines—trustees don't have to know the answers, they just need to know the right questions."*⁴

To engage senior administrators in teamwork, we must continually emphasize the impact that performance improvement can have on enterprise wide performance. Too often we obsess on clinical details and fail to translate the improvement impact on the metrics to which administrators are held accountable.

To engage physicians we must recognize that, in most communities, they are independent small business leaders who are continually in competition—the drivers for success have included the 3 A's - affordability, availability, and ability...in that order of importance. They influence 80% of healthcare costs and make care decisions based on the quality of care to their patients, their habit and training bias, and income and time issues. Their decisions are not necessarily based on the latest best practices. The widely publicized Rand study by Beth McGlynn found that we have surprisingly modest adoption of best practices for which there is substantial evidence and consensus.¹⁴

To engage mid-level managers in teamwork, we must give them focus, direction, and show them "what success looks like".^{15,16} We must fund and

implement teamwork, training and projects that put them in the drivers seat. To engage the trust of frontline caregivers, again we must put them right in the middle of the teams and give them the opportunity to take root and bloom.

In the words of **Dr. Allan Frankel**, a thought leader in high performance cultures:

“The cardinal error currently being made in many organizations is the layering of teamwork initiatives on the status quo where the lattice truth and trust are too weak to support them.” [Dr. Allan Frankel, Personal Communication 8/20/06]

Transparency: The 3 T's In Action

An excellent example of transparency pressing truth, trust, and teamwork into action is the Leapfrog Group public reporting program for the National Quality Forum Safe Practices.

In 2003, the National Quality Forum (NQF) released its report “Safe Practices for Better Healthcare,” that was comprised of 30 safe practices intended to have specificity, benefit, evidence for effectiveness, generalizability, and readiness. In short, the objective was to provide practices that would have life saving impact across many care settings.¹⁷ This work had personal support of Dr. Ken Kizer, the former CEO of NQF, and now continues under the guidance of Dr. Janet Corrigan, a luminary thought leader and champion for quality, who now leads the NQF.

The Leapfrog Group had already been surveying hospitals regarding adoption of three of the practices, including CPOE, evidence based referral, and intensive care unit coverage.

After publication of the 2003 report, Texas Medical Institute of Technology (TMIT) committed to fund research and development in the domains of the safe practices. The specific focus of the R&D was to accelerate adoption, verify clinical, operational, and financial impact of the practices, develop solutions that enable the practices, and to identify opportunities to develop incentives for leaders to become engaged, fund performance improvement, and support transparency. In 2003 TMIT developed a survey, weighting system, and scoring approach with a world class team of safety experts that allowed hospitals to report on adoption of the balance of the 27 practices. The program has been updated each year and in 2005 a total of 1267 hospitals responded to the survey from multiple roll out regions.

The practice entitled “Creating a Culture of Patient Safety” which embodied a number of activities to be orchestrated by leadership was weighted 263 points out of an available 1000 points for importance to healthcare. The remaining practices averaged only 28 points, reflecting the great importance of leadership and culture.

In the near future, TMIT will be publishing detailed findings of its research, including analysis of a number of research topics from surveys, focus groups, input from multiple national task forces of subject matter experts, and direct interviews of hospitals. It has committed to interview 100% of the respondents each year. Early findings of interviews of leaders (comprised of the CEO or his or her designee – typically the safety officer or quality leader) of 260 hospitals reveal some surprises and give solace to those who believe that truth, trust, and teamwork really exists in healthcare.

The research interview review process had five objectives:

- **Submission Clarification:** To make sure the hospital understood the survey, answered accurately, and to allow TMIT to optimize the survey and Frequently Asked Questions (FAQs).
- **Identify Performance Gaps:** To identify areas where TMIT and subject matter experts could help hospitals improve their adoption of practices and improve care.
- **Identify New Practices and Solutions:** Some of the greatest innovations occur at the frontline and the aim is to identify new best practices and solutions that could be shared with the national community. Areas such as imaging and technology adoption are addressed.
- **Identify Networking Opportunities:** Emphasis was placed on identifying how TMIT could establish opportunities for the high performers to help the lower performers and foster collective learning.
- **Knowledge Transfer:** To identify needs so that TMIT could develop and share concepts, tools, and resources with the national community and responders.

The method included a step by step review of their official answers to each of the 161 Leapfrog survey questions. Experienced, clinically trained interviewers, who have deep domain knowledge

regarding the subject matter, conducted the interviews with a carefully constructed internet based system, allowing them to verify answers and cross check validity through carefully constructed decision/question trees of more than 230 questions.

Of 1267 official submitters, 260 interviews of 70-90 minutes were undertaken over late year 2005 and year 2006. A detailed review of each and every survey question was administered.

Although a detailed analysis will be published in the future, early findings reveal that there were very few hospitals found to have improper submissions of any type. If anything, the interviewers found the hospitals very hard on themselves and were conservative in interpretation.

Leader champions and physician engagement were critical to improvement, as were assignments of direct accountability for performance areas. Overall, condition specific practices were most difficult to adopt.

More than 90% of the hospitals have assigned formal accountability to a leader or leaders who monitor progress and drive improvement on an ongoing basis.

More than 97% identified performance gaps that they have targeted for improvement - that became obvious through the process. 100% of those took actions to improve in a formal process.

Only 40% report success in implementing beta blocker use prophylactically for elective surgery; many teams have had false starts.

When hospital leaders were asked what their implementation teams have learned that could help others, the following common themes emerged:

- Maintain your focus on what you are trying to improve.
- Leadership support is vital to your team's success.
- Persistence pays! – Change takes time.
- Anticipate “road blocks” in your improvement journey and plan ahead.
- Always engage the medical staff in what you are trying to improve.
- Communicate improvement results and share what you have learned across the organization.
- Always get those who do the actual work

involved in the change process.

- Standardize processes wherever and whenever possible.
- Step back and celebrate the small successes as well as those big “wins”

Although thorough review of all submitters will be undertaken and reported, early findings are clear. The sharing of truth – performance information, trust – the collective belief that the practices were the right approach to improving care, and teamwork, focused on specific areas of improvement, transparent to the world, drove improvement initiatives.

Probably as importantly, the three T's, spearheaded by transparency, drove budget allocations. It is also safe to say that public reporting drives leaders...leaders drive budgets...and budgets drive safety.

Future Leadership Engagement and Development

We had the opportunity to speak with David Gergen, advisor to four presidents and distinguished educator on the principles of leadership. We asked him what we need to look for in our healthcare leaders and in engaging physician leaders. He said we should look for what we seek in presidents: judgment, curiosity, and character. In his book *Eyewitness to Power*, he states that leaders of the future must have:

*“Inner mastery; a central, compelling purpose rooted in moral values; a capacity to persuade; skills in working within the system; a fast start; a strong, effective team; and a passion that inspires others to keep the flame alive.”*¹⁸

Hayley Burgess, a passionate patient safety leader at Hospital Corporation of America, believes that

“If we trained our future leaders in the domains of truth, trust, and teamwork, the energy that they can bring to the equation will be awesome. Many have the passion; however, we need to invest in their knowledge and skills to improve our culture.” [Hayley Burgess, Personal Communication 8/23/06]

The recurring theme of the need for leadership skills, values, and culture continues to grow and will likely shape the behaviors of our future leaders. In 2005, a Consensus Standards Maintenance Committee was formed by NQF to update the evidence for the 30 safe practices, make recommendations for changes to the practices, and

evaluate new practices. A wide range of subject matter experts was consulted and a careful evidence based review of the practices was undertaken, including input from TMIT's 260 experts and research test bed of more than 3,100 hospitals. The practices were harmonized across the Joint Commission on Accreditation of Health Care (JCAHO), Centers for Medicare & Medicaid Services (CMS), Agency for Healthcare Research and Quality (AHRQ), the Leapfrog Group, and the Institute for Healthcare Improvement (IHI), with the hope of providing a common roadmap for healthcare institutions.¹⁹ Task forces with each of these organizations carefully cross-walked, looked for cross language and cross credit opportunities, and have committed to cross communicate the practices when they become standards.

A major focus of the committee was to develop and refine a practice entitled "Creating and Sustaining a Culture of Patient Safety." It recognized the continued need for emphasis on leadership and is comprised of four elements:

- Leadership Structures and Systems
- Culture Measurement, Feedback and Interventions
- Teamwork and Team-based Interventions
- Identification and Mitigation of Risks and Hazards

This safe practice will likely become a standard in the second half of 2006; however, considerable research is already underway to understand the principles of leadership engagement and adoption of these practice elements as well as impact of incentives. For instance, the *L.E.A.D. Hospitals Program* (Leadership Engagement And Development) is a national multi-year, multi-institutional collaborative effort that has grown out of the TMIT National Harmonization Initiative, which can be found at the Safety Leaders website (www.SafetyLeaders.org). It includes:

- Assessment of leadership engagement and development in quality and safety performance improvement, aligned with the national standards.
- Focus group testing of best practices in leadership engagement.
- Clarify operational definitions for high performance and transformation.

- Research grants and accelerated publication.
- Virtual focus groups, national workshops and webinars.
- Measurement instrument development and internet mediated surveys.
- Development of best practice concepts, tools, and resources to be released to the public domain.

Leadership Engagement and Development Research

Early findings of focus groups of more than 250 respondents at national meetings, through internet surveys, and interviews reveal:

- 4 out of 10 hospitals spend less than 30% of their board meetings discussing quality and safety.
- 3 out of 10 of hospital leaders still believe that their organization is more financially driven than quality driven.
- More than 8 out of 10 believe that healthcare purchaser incentives have an impact on their organization's quality and safety.
- More than 4 out of 10 hospital leaders believe that their physicians are very minimally engaged in hospital improvement programs.

The program explores certain key questions important to engagement of governance boards, senior administrative leaders, independent and employed physician leaders, mid-level managers and frontline caregivers. Such questions include:

- Can we systematize leadership engagement. Is it a matter of nature versus nurture? Is it less about genotype and phenotype of leaders and organizations and more about creating the right environment for engagement to flourish?
- What is the level of readiness for transformational improvement?
- What does transformation look like?
- How do we clearly define patient centered care as an aim of transformation?
- What is the business case for investment in leadership engagement/development and how will we measure enterprise wide performance improvement?
- What are the drivers for informal physician leader engagement in hospital performance improvement?
- Will Pay-For-Performance incentives drive

leadership engagement?

- What are the critical success factors for methods such as gain sharing to engage physicians?
- Will leadership engagement drive transformation at the frontline?
- How can we systematically develop great leaders from the ranks within organizations?
- What are the concepts, tools, and resources that are needed to foster leadership engagement and development?
- How do smaller hospitals develop the resources they need to undertake internal leadership development?
- How do we leverage truth, trust, and teamwork”?

In the words of **Dr. David Hunt**, Medical Officer with CMS, one of the lead collaborators:

“All great performance improvement breakthroughs have three key elements – leadership, resources, and a system for implementation”. [David Hunt, Personal Communication 8/20/06]¹⁶

Clearly, much work needs to be done by many researchers, academic institutions, quality improvement organizations (QIOs), quality payer and certifying organizations to effect change through leadership engagement and development. Such work needs to be placed in the public domain, shared freely, and most importantly be translational so that it can be transformational. We need more than interesting studies. We need real tools for real people to put to real work.

Conclusion

The bridge between the head and the heart may only be an 18 inch journey; however, it may be the toughest road we will need to build. It will be critical to ignite the right mixture of passion and information to fire the action of future leaders.

Warren Buffet, the Forbes business magazine founder, when asked what characteristic he most commonly saw in great leaders, said:

“Enthusiasm – it is the eternal sparkplug of life and the propeller of all progress.”

Our job, it seems, is that we must study how we can leverage the truth to win the minds, trust to win the hearts, and teamwork to harness the energy that will deliver power to that propelle

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