Executive Briefing & Exchange

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How Do We Learn From Patients' Experiences? (Part IV)

By Dorothy (Dolly) Bellhouse

After last month's column, a colleague asked me for a concrete example using one of the patient experiences I had described. She was interested in what might have been different if staff had been developed to improve their work every day using a scientific method of problem solving. I thought this would be a good way to close this series of columns on learning from patient experiences.

Let's take the experience of my friend waiting to be discharged because staff did not get a wheelchair for her. As you may recall, my friend's physician discharged her at 7:30 in the morning and she was dressed and ready to go at 7:35. She waited until noontime for a consult from a physician who the staff finally discovered was not going to do rounds that day. So, once it was decided that my friend would see her physician at an outpatient visit, she was again ready to leave. The nurse asked her to wait for a wheelchair. My friend waited for more than four hours and ultimately gave up, walking out of the hospital on her own at 4:30 in the afternoon. The table on the following page is a hypothetical comparison of how staff could have learned from one part of this patient experience.

A key part of working adaptively is to harness the knowledge, creativity and problem-solving ability of staff. It is not the problem-solver's role to solve the problem on her own; rather she facilitates the solution by drawing a simple picture of what happened and showing that to staff when they have a minute. She also gets their input for an experiment to make the situation more ideal for patients. Equally as important is that staff know when they have a problem to be solved (instead of just working around it) and to signal when an experiment needs to be redesigned. In this way, real change can be affected and sustained.

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Sheila Keizer
Executive Director
ebe@WomenInHealth.com

Our address is:
20 B Shawnee Way
Bozeman, Montana 59715-7624

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Executive Women in Healthcare
406-586-6400
www.WomenInHealth.com

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How Do We Learn From Patients' Experiences? (Part IV) (Continued...)

Traditionally	Adaptively*
Busy nurse asks an aide to discharge the patient	Busy nurse asks an aide to discharge the patient
Busy aide looks for a wheelchair but cannot find one	Busy aide looks for a wheelchair but cannot find one
	Busy aide knows that she does not have what she needs (a wheelchair) to meet the patient's needs ideally and she knows that this is a problem to be solved
	Busy aide signals her designated "problem-solver" on the unit that she has a problem: she can't find a wheelchair to discharge the patient
Busy aide gets pulled into other duties and forgets to resume search for a wheelchair	The problem-solver observes what is happening now and documents it by drawing a simple stick figure picture of the aide searching for the wheelchair and being pulled into other tasks
The patient waits for 4+ hours and walks out of the hospital without a wheelchair escort	The aide and the problem-solver may "Band-Aid" the problem by getting a wheelchair from another unit to discharge the patient, BUT they don't leave it at that; they work to understand the problem and get to the root cause
	Once the root cause is determined, for example the place for wheelchairs is not specific enough, then the staff devise an experiment designating ONE specific location for the unit's wheelchairs so people know where to get them (without searching all the nooks and crannies of the unit) and they also know exactly where to return them
	The staff decide to make wheelchair parking spaces in the designated location and the wheelchairs are specifically labeled "This is a 5X wheelchair. U take, U return to the parking space beside the green cabinet in the 5X clean utility room." Once these countermeasures are in place the experiment begins
	All staff know that if in the future they cannot find a wheelchair for a patient when they need it, they should signal that the experiment needs to be redesigned

Rapid problem solving in the course of work using the scientific method under the guidance of a teacher.

Hospitals are complex, dynamic environments and most experiments will need to be redesigned sooner or later. The difference in working adaptively is that staff know what to do when the system is not working to deliver what they need to care for their patient ideally. Conversely, just implementing the wheelchair parking spaces as a best practice without helping staff learn to work adaptively leaves them at a loss when the experiment needs to be redesigned. The wheelchair parking spaces just become another good idea that didn't last. Although some experiments seem well-suited to implementing across the hospital, working adaptively is just that-developing the staff's capabilities and skill sets so that they can adapt and continue to learn and improve.

Dorothy (Dolly) Bellhouse is an Associate at the firm of Kenagy & Associates. She left a Senior Vice-President position in the Yale New Haven Health System to join K&A. She holds an MBA in Health Administration and Finance from the University of Chicago. You can share your comments with her at: dbellhouse@kenagyassociates.com

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Practice Beginner's Mind

Paula Butterfield, PhD, PCC

I took up rowing last summer. Not rowboat rowing, but eight-person team rowing in sleek, pencil-slim 65-foot boats. The instructors gave us a few minimal guidelines for how to row together and balance the boat. When we could do both, they gave us a great exercise. They had us row with our eyes closed.

It was a remarkable experience. Without visual cues, we learned to tune in carefully to information from other senses: the sounds of oars clicking in oar locks, breaking water and whooshing from back to front; the physical sensations of being attuned to or out of sync with others' movements; the degree of tension or pressure with which we hold the oars.

Rowing with closed eyes introduced us to an entirely different way of paying attention to the work at hand. It helped us disengage from our thinking brain and operate instead from a new awareness of the moment. Altering our perception created a deeper level of teamwork and greater confidence in our ability to maneuver the boat with ease.

It's hard to work with your eyes closed, but you can create a similar experience in your hospital or healthcare facility by practicing something called beginner's mind. It's a Zen practice of learning to experience *what is* without judgment or preconceptions. When we can anchor ourselves in the moment and openly take in *what is*, we also open ourselves to new possibilities.

For example, pay attention to the things you normally take for granted. Look at a nurses' station or your office or the hospital lobby or cafeteria as if you were seeing it for the first time. What do you notice that you normally overlook? How do your desk, the lobby doors, the nurses' bulletin board look to new eyes? Sit for 20 minutes in the emergency department or surgery waiting room and do the same. What do you hear that you didn't hear before? How do people express their hope and assuage their fear? The purpose here is to see your workplace through the eyes of those you serve. When you can see through their eyes, your world will look much different and options you hadn't seen will come into view.

Beginner's mind is also a powerful way to learn more about yourself. For example, the next time you're in a conversation with someone, pay attention to the silent conversation, the running commentary, that's going on in your mind. Don't try to change it or judge it or stop it. Just observe it. Pay attention to the emotional charge that it generates. *She's really on the ball ... why is he asking me for this?... I should speak up, but....* What are you telling yourself? Notice how the commentary and emotions change depending on your relationship to the other person. A boss saying, "I want to see you right now" will likely evoke a much different internal response than a direct report making the same request. What do the differences tell you about yourself?

Paying attention without judging is what opens the door for new possibilities. It allows us to see our behavior and our world differently, and when we can see things differently, we discover new ways to do things differently. Rowing with our eyes closed helped us discover a world of cues that none of us had noticed before. Working with beginner's mind will open you to a world of cues that you normally overlook.

Try it. The next time you're in a meeting, pay attention to the emotional tenor of the group. What's the energy level like? Does it have a positive or a negative charge? What kinds of exchanges further the group's work and what disrupts or derails it? How are your own feelings serving as a filter? As a source of wisdom?

When you can accurately assess a group's emotional energy, you can shift the emotional tenor of the entire group just by identifying what you hear and acknowledging the group's emotional reality. When you are open to whatever occurs, and can see it through the eyes of wonder, you open the way for new possibilities.

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Paula Butterfield is a leadership coach, professional speaker, and founder of the leadership development firm Butterfield + Laning, LLC. She's a former clinical associate professor at The Ohio State University College of Medicine, and former director of medical education in two academic medical centers. She has a Ph.D. in counseling psychology and an executive MHA from Ohio State. A professional certified coach and an expert on emotionally intelligent leadership, she now works primarily with executive women in healthcare. Visit her website at www.pbutterfield.com or email her at paula@pbutterfield.com.

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END PIECE: The Genie Is Out of the Bottle

After four decades of using computers for business purposes in hospitals, information technology has established its value for clinical purposes. Few would argue that IT contributes to efficiency, safety, convenience, error reduction and evidence-based medicine.

Few would also argue that taking advantage of today's technology disturbs existing behavior patterns, relationships, workflow patterns and habits. For example:

- Many IT systems were introduced as best of breed without regard to interoperability. PC-based computers contributed to fragmentation of information.
- Many IT systems were installed on top of antiquated workflow processes. (It's a little like building modern skyscrapers in New York City on top of century-old water and sewage infrastructures.)
- Most IT systems were designed to function within the walls of the hospital-not in sync with doctor's offices or other hospitals in a region.
- Despite the investment in advanced IT, most hospitals are still largely paper-centric. The demand for retaining paper will be with us for a long time.

What then is changing?

- Central servers are contributing to interoperability.
- The Internet is revolutionizing the way that doctors and hospitals communicate with each other; the way that doctors communicate with each other; and the way doctors and hospitals communicate with patients.
- Inexpensive broadband makes quick communications possible among doctors anywhere-and patients anywhere.
- High quality images can be transmitted instantly.
- Electronic patient records are now a reality.
- Clinical decision support (evidence-based medicine) is another reality.
- Electronic storage, retrieval and distribution of digitized images are now possible.
- Remote diagnosis, treatment and monitoring of care through telemedicine are now possible-along with remote surgery.
- Genomics. Treatment designed for an individual patient-as opposed to a class of patients-demands the use of new IT systems.

What's not changing?

- Silos remain. Collaboration between nurses and doctors is scarce. Collaboration among specialists is difficult because each brings a different perspective to a case.
- Adopting and adapting to IT can vary by age, by institutional culture and mostly by ease of use and benefits derived.
- Enterprise computing is difficult because most hospitals are not enterprises. As one observer put it, "most hospitals have no central nervous system."
- Consideration of outsourcing IT applications has not reached the level of the laundry, measuring patient satisfaction, food service, housekeeping and security services.
- We have no Toyota in healthcare that will force the change of the fundamentals of our industry.

It's time to realize that the genie is out of the bottle. We can never return to the good old days when computers only managed our payrolls, our account receivables and payables and our inventories.

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