Dr. Peter Pronovost and the Pathway to Proven Performance

Transcript

00:00 – 01:14

CLAUDIA DOUGLASS: I'm Claudia Douglass, Grant Thornton Healthcare Growth Leader. I'm delighted to have Dr. Peter Pronovost with me from University Hospitals Health System. Peter is a prominent leadership transformation expert and MacArthur Foundation Genius Grant recipient, and his work has earned national recognition, including being named as one of *Time* magazine's 100 Most Influential People.

Thank you for being with us, Dr. Pronovost. I know you like to be called Peter, because I've been fortunate to work with you over the past few years as you have led the transformation at UH. I'm excited to talk about our work together transforming healthcare.

We call our innovative transformation model "The Pathway to Proven Performance: Living and Leading with Love." This methodology can be applied to all industries, including healthcare companies, and it leads to accelerated results that are sustainable over time. I've witnessed this firsthand, and it is different than other top-down models for transformation that I've seen over my 30-year healthcare career.

Thank you for being with us, Peter.

01:16-01:18

PETER PRONOVOST: Thanks for having me, Claudia.

01:19-01:35

CLAUDIA DOUGLASS: So, I'd like to turn back to when you first moved to Cleveland and what was happening in that Ohio area that led to leadership of one of their major healthcare systems, University Hospitals, to conclude that a transformation was needed.

01:36-3:12

PETER PRONOVOST: Yes, thanks, Claudia. You know, the Ohio market, much like the rest of the U.S. healthcare system, was facing some pretty significant headwinds. Compared to the headwinds now with our labor and supply costs, they probably seem very insignificant or maybe a little gentle breeze.

But we weren't focused on value. We largely had an RVU system and success was generally if we made budget and our docs made their RVUs, we were good. But the trends were worrisome. Our only payor mix that was growing is government payors, largely Medicare. We lose money on government payors because of our cost structure, like almost all of America does.

The payments from commercial and other payors were going down and our supply costs were going up. So, all portended a need to do something different. And the only real opportunity wasn't on the fee-for-service side; it was growing value and getting shared savings payments from value. But we at the time didn't have the capabilities to do that yet.

But our board, our leadership, saw that was the future. So that we needed to be able to transform our organization and evolve pretty radically our culture from being one where success is measured generally if your hospital is full, regardless of the patients' needs to be there, towards one where we actually improve value for the people we serve and that we win on both the fee-for-service side and on the value side.

03:13-03:20

CLAUDIA DOUGLASS: Outstanding. Can you talk a bit about your involvement with University Hospitals and the transformation project?

03:21-06:45

PETER PRONOVOST: Sure. I serve as the University Hospitals' Chief Quality and Clinical Transformation Officer, and, so, what that means is I'm responsible for overall quality, safety, service, that portfolio, like many health systems have. I also oversee our ECO and our employee health plan, as well as all of the kind of care management and therapy and home health services that support value.

And, so, with that broad portfolio, it allows me to help drive the organization from a fee-for-service culture and mindset towards a value mindset. And we engage the organization in value by a very simple message of keeping people healthy at home.

We did that with our board by sharing a story of one of our patients, Helen. Helen, at the time was a 63-year-old or 64-year-old woman, who'd been admitted in the last year 15 times for heart failure and 13 times to the emergency department. And every time Helen showed up, the part worked perfectly. She got diarrheased in the ED or was given oxygen, the hospitalist admitted

her, she got more fluid, her blood pressure was controlled, perhaps cardiology consulted her and she was sent out. And she came back. And they took fluid off and controlled her blood pressure and sent her out. And she came back.

You see, because what Helen had was excellent reactive and transactional care, where people looked at the moment she was in front of me. What we missed was relational, proactive care. What we missed was that the main driver of Helen's readmissions was anxiety that wasn't diagnosed. And she missed most of her follow-up appointments because her daughter had died of a narcotic overdose like so many people in Northeast Ohio and America. And she skipped appointments because she was caring for her disabled granddaughter and didn't have anyone to provide respite care.

And what was stunning about Helen's case is all of those defects in value. All of those readmissions and needless ED visits were generally counted in the win column in our P&L, because we just counted our admissions and our stats at the time just looked at how many admissions are discharged do we have this month and if they were going up, it must be good.

We didn't see that some of those embedded hidden in those discharges were defects in value that shouldn't be happening. Helen declared personal bankruptcy. It's the number-one cause of bankruptcy in America. She cost her employer $1.2 million and almost all of it was needless.

And, Claudia, that's the clarion call that we at UH rallied behind, because, you see, the problem that we faced—and heart failure readmissions is one small example—is our inability to solve complex problems collectively, because no one group is going to be able to do that. But, if you break silos, if you align around a common purpose, we have hope that we could.

06:46-07:12

CLAUDIA DOUGLASS: Wow, that is so important —and for so many reasons. Thank you, Peter.

So, one of the things when we're working together, we've been working on this for a while. And, as we look at Living and Leading with Love and the Pathway to Proven Performance, when we look at this, there's a holistic approach to this to deliver sustainable results. Can you talk a little bit about the key components?

07:13-18:45

PETER PRONOVOST: Yeah, Claudia. Thank you. And, you know, we've worked together for a while. So, you know, we've been part of this together, but let me share with you kind of how this model emerged and really synthesizing, you know, a couple decades of work from a variety of different fields that all came together for this Pathway to Proven Performance that is just knocking it out of the park.

You know, as I look around healthcare like the Helen story, or outside of healthcare more broadly, I see the biggest problems that we face in the world today are our inability to solve complex problems collaboratively. And just look at some of the stats in healthcare. Forty years ago, we harmed one in four hospitalized patients. Today, it's the same.

In aviation, that harm rate has been going down exponentially, such that today, it's not one in four people on an airplane are harmed, it's one in 400 million. One in two health systems have negative margins. In healthcare, organizations are going bankrupt in many communities. Indeed, not-for-profit healthcare, the future of it is really threatened and they're the backbone of care in most communities. Half of all clinicians are burnt out because our care models just don't work. Technology isn't helping them. We may build better, but we also add to burnout, and we need a different way of working.

But, you see, Claudia, we understood it didn't need to be that way, that the main reason for the lack of solving problems is a lack of love. And let me explain to you what I mean by that. Love is this energy that is within us all and connects us all. If you're spiritual, you may call that God or grace, or you may call it a universal being. But let's just call it love. And, when you see that goodness in people, when people have innate respect simply because they're born, they don't have to earn it because they have an MD after their name, or they have a fancy title, it fundamentally changes how you work with people.

You see, it allows you to see the brilliance and beauty in everyone, so you can tap their ideas and unleash the capabilities that they have to solve problems. It allows you to learn faster, better, and cheaper, because you bring people together and you trust that their ideas, when brought together, will create new things that we've never dreamed possible. And that is the magic that we sought to draw upon.

But too often in healthcare and in other industries, Claudia, we don't love. We don't see people as innately good. We diminish and we separate people. We say that, if you don't have the right title, your ideas count less or you don't have an MD after your name, that your voice isn't heard, and we're poorer for it. We solve problems much, much slower and we demean, demoralize, and destroy value.

So, in our model, we wanted to tap that energy that is within everybody and leverage that power of love within and between people to radically transform health and healthcare. And the way we do it is not hokey and it's not without accountability. It has profound accountability. It's really three key components, all of which are evidence-based, but none of which have been integrated before.

The first is believing that every employee in the organization needs to see their job is to improve value and that they are empowered to do so. You see, Claudia, the evidence for having a purpose statement is very clear. If I have it and it sits on a wall, it does almost nothing. If I have it and supervisor-level or below connects their behaviors to that purpose, then work flourishes, indeed, like 4X better performance.

So, we didn't let that happen by chance. We systematically met with all of our role types across our, you know, 31,000 people, where everybody has an "I will" statement about what do they need to stop believing and start believing for them to see their job as valued and they are empowered to do so. And, Claudia, it is beautiful, because every one of their comments started with a current lack of love, or, in other words, separation. No matter what role, they all said something like, "I'm going to stop believing my job doesn't matter" or "I'm going to stop believing my voice won't be heard or What I say won't be listened to" and "I'm going to start believing that I matter, that I'm important, that I can contribute to the care team," right? And when you unleash that energy, it is just breathtaking.

The second part of our model is belonging — and that is belonging to a learning community. You see, Claudia, we know that innovation flourishes when you create a structure and culture for diverse ideas to meet and multiply and mature. That's just to have ideas collide. You just like when you and I have conversations where you brainstorm, you bring new ideas, different disciplines, different roles, and you come to have deeper insights in how to solve a problem or you share promising practices.

But that kind of architecture or infrastructure to allow the free flow of ideas doesn't happen by chance. And it sure doesn't happen by sending an email. It happens in our model where we build a fractal structure, where we literally map from board to bedside how are we connecting all the nodes? And fractals, like ferns or flowers or snowflakes or capillaries, operate by simple mathematical rules. And our simple mathematical rules are the following: that whenever you're leading an improvement project, anybody who touches that process has to have a seat at the table. And we cascade down from board to bedside, where every higher level of the organization needs to create a table where every lower level who has a voice in this process, has a seat. And if that table gets too crowded, or the seats get too full, add another branch to the tree, add another node to a flower.

And in this way, you allow three beautiful things, Claudia. You have voice to have co-creation of goals, so people buy in and they're wiser. You have horizontal connections for pure learning where I can say, "Wow, what's Hospital 1 doing compared to Hospital 2, or Floor 1 to Floor 2, or emergency department to another emergency department?" And it sounds messy, but it's majestic, because you just get these beautiful insights into learning from each other and sharing promising practices. And third, it allows us to have vertical connections for accountability. Results matter, and they matter deeply. And love is strong enough and powerful enough for people to be in the spotlight, but also under the spotlight when they're not getting results.

The third part of the model, Claudia, is building disciplined management and accountability systems. You see, good management matters and good management is almost entirely absent in healthcare, almost entirely absent. And that's stunning to some people, but the literature is quite clear about this. Most projects don't have goals or haven't defined roles. They don't have an enabling infrastructure to communicate what's the behavior that we want to change or

measures of those behaviors to clinicians. They don't make it easy to practice those behaviors by tools, training, or technology, and they don't often report ranked performance of how people are doing. They often don't create a fractal peer learning community that allows the free flow of promising practices, and they don't transparently report and have shared accountability.

And I want to take a moment, Claudia, to explain shared accountability, because it grows out of our moral philosophy of "the secret of great care is love." And that is shared accountability operates by the simple notion that a higher-level leader can only hold a lower-level leader accountable if that leader first holds themself accountable to set that team up to be successful. What does that mean? That means they've created a belief system, a belonging system, and built a management system that all these components are in place for that leader to execute through. And, if that isn't in place, it is that lower-level leader's job to make sure that management system, that belief system, the free flow of ideas are all in place.

And, so, what that looks like operationally is when a team's struggling, it's not pointing a bullseye on that person or a finger at them and say, "Claudia, why aren't you performing? I want this fixed by Monday or your job's on the line," right? That's the normal discussion. "You're not going to be around here if you don't solve this." And often the poor person leading that doesn't know the goal, they don't know the roles, they don't have the resources, they have no data, they're floundering.

Say, "Hey, I'm in. Help me, don't judge me." Shared accountability puts that that says, "Okay, Claudia, we're one, we're on the same team here. So, how can I help you? Where do you need resources? Where could we clarify goals? How could we make sure we build that enabling infrastructure? How do we help you engage and create accountability?" And then you cascade that down to the providers or the clinicians or the managers who say, "We're going to achieve this goal, not an option, but we're here to help you." And then, if people are struggling, we go and reach out to say, "Here's the support that you need, but you need to engage in getting this help." Not engaging isn't an option.

We connect them to those who are doing well so they learn from them and say, "Hey, look at this group over here." But we don't say, "Look how good Claudia is." We say "Look how good you could be. You have the same resources to do what they're doing, (you've) just got to be engaged. We're going to help you get there." Now, if people don't engage, we escalate that and say "Yes, okay, you're not engaging. We reached out to you. This isn't an option. Performing or achieving this goal is an organizational priority. We will do it. Reach out." They choose not to escalate. It typically turns into an in-person meeting.

So, love isn't this soft thing, it is the Path to Proven Performance. And, Claudia, what we've seen is when we deploy this approach, in now over 60 projects in our health system, every one of them hits it out of the park. And when we don't, we struggle.

Let me say … about a 50% improvement in multiple med safety measures. So, now that we have about 96% of staff complying with medication best practices, which we've been stagnant for years, a 70% reduction in sentinel events, a 75% reduction in sepsis mortality, a 33% reduction

in annual cost of care in our ACO, and over and over, not because we have one-off projects, because we have a leadership and management system that lives and leads with love.

18:46-20:17

CLAUDIA DOUGLASS: Wow. So, Peter, I've witnessed this as we talked about, and you know we've been dyad partners for a while. And I would say having been a strategy leader for two different health systems and a chief operating officer for another one, this work truly is transformational. I think that there are pockets of it going on in the industry. And what was really helpful when I was working with you and learning this and we've been working together is putting a lot of key words, the rhetoric, the stories, the storytelling is so important, because I think we find people working in this way and in some pieces, but they're not able to fully articulate like you do how to put the recipe together and have this beautiful dish come out.

So, I think that it is just so wonderful to see because people are suffering, patients are suffering, caregivers. Obviously, the economics of this all is we grow in GDP, and I just think it's so important to be able to share this and spread this across healthcare companies, whether they be healthcare systems, companies that are growing, they're small and growing physician practices, life sciences companies, and health plans. So, I can't thank you enough for spending time with us today. We're so grateful.

20:18-21:55

PETER PRONOVOST: Yeah, and, Claudia, if I could just close, because I think you hit on something really powerful. You know, too often in our work to improve, we focus on the technical things, and we think, "I'm being a good leader if I'm tough and I push," and, I mean, you can see we push, but we support, you know, we pull and inspire people before we push them or force them. And the reason is the secret sauce of this work, Claudia, is there's a third dimension in life, in work, that is what religions and mystics and poets and philosophers and Buddhists have understood for years. And that's the dimension of elevating us to a deeper purpose, right?

And it is, it touches your soul, and it elevates you and you illuminate. And we illuminate each other, so that we are able to connect, uplift, and improve faster. And that's not the soft stuff, it's the essential stuff if you want to improve. And it doesn't happen by chance, but with this transformation model, it's built into the way we lead. So, people have this almost effervescence, Claudia, where they're like, they're just bubbling and there's energy in the room and it's palpable. And you walk into a place that's living and leading with love and you feel it. Everything feels differently, and that's when this success flows from there, rather than on beating on people, playing whack-a-mole with one project at a time, wondering why we're not successful.

So, we're really excited about this. We hope it spreads. And it's been an honor to be on with you today, Claudia. Thank you.

21:56-21:59

CLAUDIA DOUGLASS: Thanks for your time, Dr. Pronovost. We appreciate you very much.