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Leading change and value

An alternative approach to leadership

Diabeter employs a leadership style which incorporates value into all its clinics. Prof. Henk-Jan Aanstoot explains how he keeps a motivated, coherent team and what his future plans are.

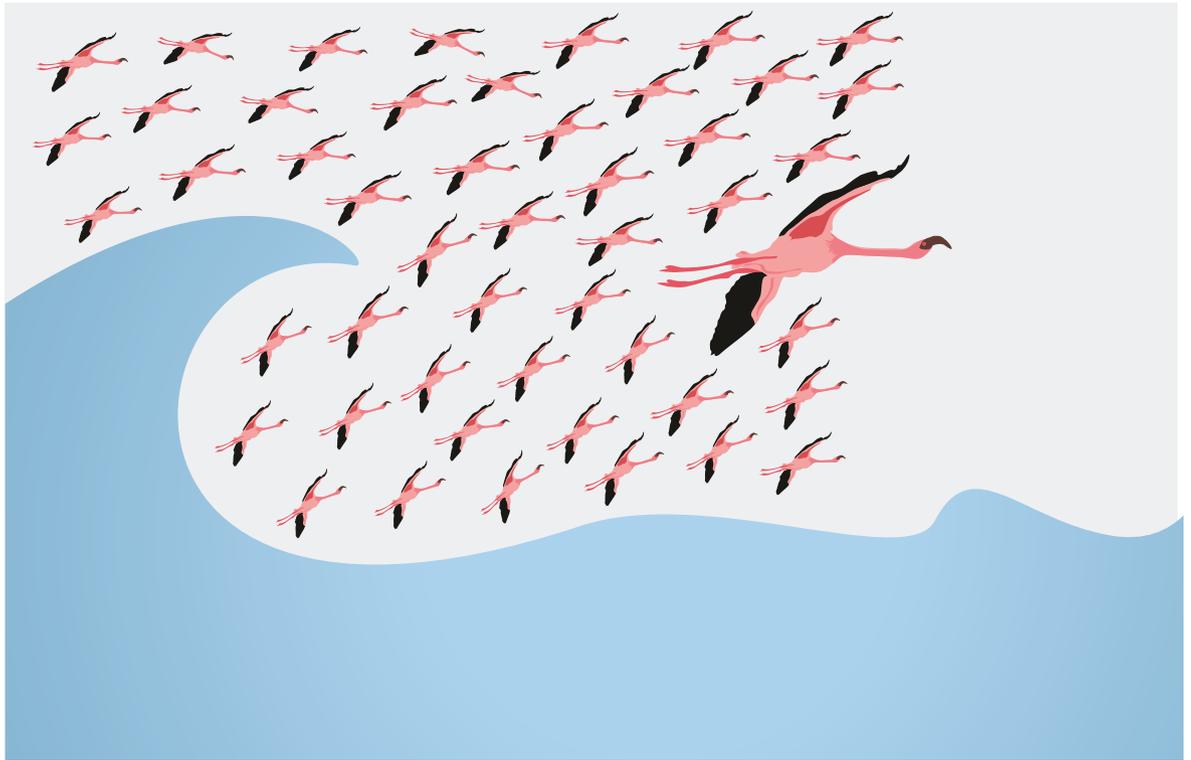


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Within Diabeter, we have developed a value-based healthcare (VBHC) model that transforms healthcare delivery by providing a combination of innovative technologies, patient-centric care delivery, and reimbursement on the basis of outcomes rather than volume. One of the most important aspects of the VBHC agenda (Porter and Teisberg, 2006) is to create an integrated practice unit (IPU), including a coherent team. The staff are a hugely important asset here, impacting on our care delivery, and we are aware that our new value-based system brings changes that challenge staff. This is why it is important that our staff share our values and goals, settle into this shared belief system, and that we continue to support and motivate them accordingly.

When it comes to developing a VBHC model, I think two things that are hugely important are

leadership style and the possibility to adapt to new things and developments. Of course, the leadership style has to carry that philosophy across the organisation. We have been doing this now for 12 years, and that has had an important effect on leadership style. Leaders should have their feet on the ground somewhere close to where care takes place.

We also realised something else in previous years. There's a famous saying from Dutch abstract expressionist artist Willem de Kooning, "you have to change to stay the same", and I think that says it in some way. We have to adapt ourselves to new technology but we still have to be caregivers, listening to the needs of patients. So it's an issue of high touch, high care and high tech.

That being said, the leadership in healthcare is often quite stable and not able to bring changes quickly. So, the leadership should not only lead the

clinic, but should also have a very clear vision of what's happening around the clinics in the world. For us, Henk Veeze and myself, that was the main reason to leave the hospital we previously worked in; we couldn't create the IPU and transfer the knowledge that we had on how the disease would develop and what's happening in the world, thus getting what was needed done. Moreover, we could not create a small but highly efficient loop of information from patient care through providers to leadership, and towards new decisions for change. Right now, we need rapid changes, alternative leadership and change management. In my view, leadership is absolutely important to have this flexibility. Rather than be in the board room, be on the floor. As we see how quickly traditional care changes in the next three years, enabling improvements in the outcomes of patients with diabetes, it is also our duty to 'change and stay the same'.

Collective leadership

In our leadership model, we are further developing the combination of medical leadership working with 'chiefs of staff'. This model comes from successful big clinics like the Mayo Clinic and the Cleveland Clinic. At the top, there are two people: one is medical, and the other is an expert in organisational aspects. I think that a leadership model is a basis for future healthcare development, so a model with strong medical vision and medical leadership combined with optimal chiefs of staff who run the show on HR, finances etc. is important. In my country of the Netherlands, a lot of hospital boards don't have a lot of medical experience, so if you look at developments in medicine, they usually start low on the ground or somewhere in the field, and when you bring it into the hospital, somewhere they get stuck.

Support and motivate staff using outcome data

I think if you have a VBHC model where people can see that improvements take place and patients like the care, it's very motivating. You don't need to apply effort in that area. The biggest problem that we see is that sometimes things change rapidly and you need to give some time for people to adapt—that matter of change management again. In addition, the jobs will change in the next generation of healthcare: diabetes nurses will either become 'diabetes technologists' focusing on technological solutions, or become more involved in motivation and support. Similarly,

education will change from a full-diabetes-curriculum to modern teaching, focusing on situation awareness and problem solving. As most people trained in healthcare come with a traditional background in care and have to switch to a 'high tech, high touch' environment, we've learned that when people come to work with us, we need to, what we call 'Diabetarise' them: no paper, lots of technologies, no electronic patient charts but a disease management system that helps and checks your work etc.

“ LEADERS SHOULD HAVE
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One of the things we introduced this year is to deliver outcome data not only at a clinical or patient level, but also at a healthcare provider level. As in a lot of industries, staff members now have their own data, their own results presented every month, so that they and others can learn from this. We saw, for example, that some nurses were excellent at implementing technology, but the number of patients they offered this to was limited. Conversely, we do see HCP's that prescribe technology but are behind in achieving better outcome with it. Discussing and sharing such data and experiences helps towards making improvements. By being transparent with personal outcome, group outcome, team outcome, and clinic outcome data, staff are stimulated. At the beginning it can be frightening, with staff saying: "Oh my god, they're looking at my data." But eventually it works. The whole strategy requires good leadership—not only to implement it, but also so that you don't misuse it and cause staff to become frightened about data and outcome etc.

In a VBHC model, if you talk about outcome constantly, then you also have to talk about personal outcome and learn from it, including HCP individual outcomes. Currently, we have introduced this in 80% of our staff members and when seeing what you can do, share and improve, they look at it in a positive way. Their interest has even extended to an eagerness to get involved with its further development, such as personal dashboards on outcomes. So, it's working out, and that's a fairly new step in healthcare. At least we don't see it happening often. It's hugely stimulating and promising.

Of course, if you have very bad outcomes, you ask yourself: why is it? Did I follow the patient? Did I follow the protocol? Do I need more training? What can I do about it? You can compare with others and begin to see how better outcomes could be achieved. Learning through the system in one of our centres this year caused an enormous drop and improvement in A1C outcome. So this scheme looks very promising. We were very careful when we started it, and we are now very happy with it. Our clinic is actually the leader in our field, which is great to see. It's interesting to see that outcome discussions go that way.

Outcome data as a training tool

We learned from our studies and publications with the Hvidoere Study Group that three aspects of chronic diabetes care are key: a) frequent contacts, b) agreed treatment goals and targets with patients and c) a clear coherent 'one-voice' view from the team of HCP's. As this last one is very important, we are changing our HCP education to e-modules, which start with teaching about our vision and VBHC model with innovative technologies and patient-centric care delivery. The history behind Diabeter, the goals that we have, the key learning that will be achieved via the outcome scheme are now part of the introduction. They re-emerge in discussions, in schedules and in evaluations, providing staff with many opportunities to learn from what we have done in the past. It also provides openings to ask for input and information about new systems and changes.

With this new HCP training, the next step is to include that in our patient education. We are moving much more towards situation awareness education. Situation awareness education can be utilised to reveal potential issues in healthcare quality and increase patient safety. Through training, HCPs can learn to be fully engaged and aware of their environment and minimise or deal with any current or potential distractions or dangers. With education, so can more and more patients. To develop this further we decided to split our team efforts and create a separate technology team that include nurses that are good with technology that can handle all the technology developments with a patient. We already use a 'closed-loop' data system with our patients (called ther@pymail), which uses patient data as a bridge between the team and the patient. The new 'cloud care' approach is required to create the next step, using new insulin pump and glucose sensor technologies, together with automated contacts and a control

room. A great new area of technology we are looking into is virtual reality. Here, the candidate would put on virtual reality goggles, see how the clinic works via a virtual world, and participate.

Finding suitable, coherent staff

Finding the right kind of person to join your organisation is an important part of building a strong and effective team. Rather than the right qualifications, knowledge and experience, it is important to ask potential colleagues how they feel they could add to VBHC and how they can combine technology with empathy, compassion, working style and vision.

What we currently do after somebody applies for a job is we ask them in for an interview as well as to be on our clinic for half a day or a whole day. It is key that this experience fits with their expectations, and also with ours. There is a considerable shortage in healthcare staff here in the Netherlands and in other countries, but we do see that people are motivated to work with us when they see it's all about outcome and that we can add to that. Although there are people who in the process say, "I'm not equipped for this job. I want to be in clinics where I just see people. I don't want to have email or data and things around me", there are others who have been looking for exactly this kind of model and clinic to join. Some who were averse to the idea to start with have later seen the huge value it delivers. ■

KEY POINTS



- ✓ Right now, we need rapid changes, alternative leadership and change management
- ✓ Leadership is important for providing flexibility and meeting value-based healthcare goals
- ✓ Effective leadership involves transferring knowledge on the disease and learning from outcome data
- ✓ By offering a coherent team, patients believe in and understand what we're doing



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