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What Leaders Learn As They Lead Successful Change Efforts

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My OLIT experience has been a seven year journey that I expected to take three. As a result of having to renegotiate the path multiple times, I learned a great deal about time management, over-committing, pacing myself, knowing my limitations, and listening to people who know what is ahead. I am grateful for every insight along the way that friends, colleagues, and family provided that helped to keep me on the right track. The lessons I learned are now treasures I will apply as I continue where my journey is leading now. I found that as a receiver of such support I am now acutely aware of my responsibility not to waste what I learned and not to focus merely on myself, but to remember to watch for those along the way who need the same thing. The result of sharing the experience is far better than I knew.

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For my family, thanks for your encouragement and unlimited support. I hope I can be worthy of the pride I see in your eyes when you look at me now. Perhaps most of all, thanks for letting me take my turns for family dinner at Dion's when my dissertation was spread out all over the dining room. It's almost cleaned up now. I wonder if I can remember how to cook?

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ABSTRACT

As the complexity of change efforts increases in healthcare organizations, the demands on leadership increase, as well. This study examines the experience of the leaders who implemented the Emergency Department Patient Navigation (EDPN) program at Presbyterian Healthcare Services (PHS). Utilizing a case study methodology to interview 12 participants, open-ended questions captured in-depth descriptions of what participants learned as they led a successful change effort.

Findings emerged in three categories: Personal Shift to Agreement, Success Factors, and Leadership Characteristics. Personal Shift to Agreement was used to describe the difference between the prior state and the end state. Terms used to describe what caused the shift include trust, leadership, communication and a focus on the patient. What emerged as significant factors supporting the success of the program are the use of an enterprise approach, leader modeling, the importance of making difficult decisions, the navigator role, and physician involvement. Key Leadership Characteristics identified by

participants as important to have demonstrated personally were adaptability, innovation, and collaboration.

Analysis demonstrates that the program was led utilizing effective change methodology, thus creating transformational changes in patient care, and in transformation in the personal leadership of several participants (Kotter 1996). The role of the physicians in development of the program demonstrated effective use of the social networks, specifically as Opinion Leaders (Rogers, 2002). Effective use of Distributed Cognition (Hutchins, 1995) to develop the solutions allowed the team to create an environment that brought the strength of the enterprise to bear on the national problem of wait times in an Emergency Department (ED).

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Chapter 1

Introduction

In order to produce the best outcomes for patients, to improve efficiency, and to meet regulatory requirements, healthcare organizations must be able to set a clear vision and then efficiently and effectively implement the changes needed to reach that vision. Healthcare is a difficult environment in which to successfully implement changes for many reasons, not the least of which is that there are often numerous change efforts being conducted simultaneously. Success may be assumed without fully knowing what factors played a role in the outcome and further study is needed to understand what contributed to the success.

This program was successful in meeting all functional requirements (See Executive Summary in the Appendix) established. An example of priorities established were an overall cost reduction through a more appropriate venue of care, a mitigation of financial risk due to anticipated lower government reimbursement, and improved customer retention through lower premium. The overall goal to reduce the ED treatment rate by 50% was met.

The purpose of this case study was to utilize qualitative analysis to interview leaders who played a key role in the success of this complex change effort. The study allowed leaders to reflect upon what they learned and how it is influencing their current efforts. They identified best practices and learning others can apply in their leadership endeavors.

The research question is: *"What do leaders learn as they lead successful organizational change efforts?"*

The program. The case study was the Emergency Department Patient Navigation Program at Presbyterian Healthcare Services (Stern, 2010). Presbyterian Healthcare Services (PHS) is an integrated delivery system in Albuquerque, New Mexico comprised of:

- Seven hospitals across the state
- Over 500 primary and specialty care providers
- A Health Plan with 390,000 members across multiple product lines including Commercial, Medicare and Medicaid.

Low-acuity patients, patients with medical issues that are not urgent or severe, seek medical care through the Emergency Departments instead of through a primary care setting for a wide variety of reasons, taking time and space needed for the higher acuity patients for whom an Emergency Department was designed: life-threatening or serious medical conditions. Costs are greater and there is no continuity of care in the ED environment. This results in episodic, sub-optimal medical management of chronic disease and higher overall costs to healthcare. Presbyterian sought to facilitate the delivery of non-urgent care in a venue that facilities the highest quality and lowest cost: the Primary Care setting. (See Appendix for the Lean Six Sigma Project Report Storyboard, Project #1089, 2010)

Presbyterian patients and members, like those in many other healthcare organizations, accessed care in the Emergency Department (ED) for non-emergent conditions, resulting in fragmented and episodic care for the patient and higher health

care costs for all involved. This is a national trend described by Jennifer Brokaw in a May 18, 2010 Washington Post article (Brokaw, 2010):

> *"ER doctors rarely have relationships with the patients we see, and we don't have time for a lengthy dialogue about their ailments. So we often order expensive tests that add to a hospital's already-high fixed costs. As a result non-emergency care delivered in the ER costs almost five times more than in a doctor's office or clinic. Solving the problem of access to care will require new thinking about how to meet all patients' needs, and the first step should be rethinking the role of emergency rooms."*

The original goal of the project was to reduce the cost of care by $10-15 million annually by leveraging the integrated system to deliver care in the most appropriate clinical setting. The solution was a multi-faceted approach using Patient Centered Medical Home, ED Frequent User Program and the subject of this study, the Patient Navigation Program, one of the most ambitious programs ever attempted by PHS.

The program is comprised of three components:

1. Patients received a medical screening exam in the ED to determine the health condition in keeping with the EMTALA requirements.
2. If the condition was non-emergent, patients worked with an experienced member of the Presbyterian's Customer Service Center staff, a Patient Navigator. Knowledgeable of PHS and community services available, the Navigator would schedule appointments within 12-24 hours in a Primary Care, or in some cases, an Urgent Care setting, thus establishing a venue for ongoing care.
3. Navigation was extended to all patients without discrimination, not only PHS Health Plan members, regardless of their ability to pay.

The navigator program itself was developed by a small team of frontline staff and a supervisor who were given the ability to create the system they would implement. The team was formed with enterprise Customer Service Representatives (CSRs) were from areas such as scheduling and benefits and could provide support the patients being navigated. The role of the CSR stayed fundamentally the same, but the location changed to the Emergency Room where their service was provided in-the-moment and for a different purpose: to send patients to Primary Care or Urgent Care instead of the Emergency Department.

Over the course of the program, the navigator role was developed to primarily include the following steps:

1. Provider confirms a non-emergent condition and refers to navigator
2. Navigator educates patient on how to utilize ED and what venue is most appropriate.
3. Navigator explains costs of treatment decision so patients understand why the approach was chosen.
4. Navigator sets up appointment within 12-24 hours to be seen for presenting condition
5. Navigator sets up assignment and appointment with primary care physician if they don't have one.
6. Navigators assist patient within parameters to get to appointment (i.e., Safe Ride, bus pass, etc.)
7. Navigator reporting system ensures patients are being seen.
8. Analysis and follow up ensure system is working as intended and patients are following instructions.

What emerged in the study. The 4-person ICS leadership team was critical because it was very different. It was small and fast and each member was highly experienced - and two of them were very senior leaders who knew the business, and the other two members of the team were a Black Belt (a certification for process improvement professionals with expertise in Lean and 6 Sigma methodology) with a

clinical background and an experienced project manager who was new to PHS. These leaders worked well together with a rare synergy. They were deeply involved in the project - not observing from a distance. They achieved the intended change they set out to do. Without exception, every person interviewed pointed to the leadership team and the way they managed the project as critical to the success, describing the trust that was built, the communication, and an unyielding commitment to the patient as significant. Nobody who began working with this team had experienced anything like it. It was transformational for PHS and for many of the individuals who were closely involved. Some described it as the difference between change leadership versus change management and how this program succeeded at both.

While all leadership participants are extremely proud of the successful outcome, some were fundamentally transformed in their leadership approach. One front-line provider leader talks about how resistant she was at the beginning - like it was not possible to be any more resistant - being quoted as using terms like "over my dead body." The way in which this program was led moved her from the strongest opponent to a committed supporter. She transformed into an advocate and was transformed in the process. She later took on a different leadership role, which she describes as completely outside her area of expertise pointing to this project as how she learned how to lead in a fundamentally different way.

When describing what made it successful, all participants interviewed talked about what it felt like to be in the first meeting when the CEO said "I want you to make me uncomfortable." It was the first time they had been given permission to do something radical with the kind of enterprise backing that could make it happen. That moment was

so profoundly different for most of them that they remember with great clarity. It immediately got their attention that this was profoundly different.

PHS had tried numerous approaches to solve challenges in the Emergency Room and had been successful in making incremental changes. They needed a transformational approach to make a transformational change. They needed the weight of the enterprise to be brought to bear in a new, less traditional management model that could not be fully anticipated or put into a precise project plan at the beginning. They needed a tolerance that allowed the best model to evolve. The tough questions were asked and commitments for support were established to create an overall solution instead of one that worked in one silo, but not in another silo of the organization. What the team developed was a program that determined the care the patient needed through an initial Medical Screening Exam. If it didn't need to be handled in the Emergency Room, patients were navigated to the appropriate venue of care. They changed the paradigm of the "Emergency Room as the community safety net" to the "entire system as the community safety net." This idea was a transformational solution that would require complex and extensive change.

To create a solution of this magnitude, there had to be honest and extensive dialog. The team atmosphere allowed the most fundamentally-opposed ideas to be debated without personal attacks. The senior medical director would say, "We are going to do something, so 'no' is not an option here." In that atmosphere they were allowed to be open, they talked about their real concerns that people are thinking but rarely raise like, "You're asking me to put my career at risk" and "The way you want to do this is actually a financial disincentive for me." "What if this actually creates harm to patients? How will we know they're getting better care?" "It's easy for you to tell me to stand in

front of an angry patient and tell them I'm not going to treat them while you sit in your ivory tower and count the money. I'm the one taking the risk." The ability of the team to bring real concerns forward and to develop a plan to address them together helped to create an atmosphere in which communication was real and effective.

As concerns were raised, they were added to an ongoing mitigation plan that captured how risks would be managed and who would be responsible was maintained. As plans emerged that were viable solutions to those risks, the leaders and team members began to trust the process. Promises were kept and the reality that patients would actually get the "right care in the right setting" became a possibility. The leaders took the time to communicate plans with employees and allow their concerns to be included in the planning. The thinking became "if we're going to do this, let's really do it right" so time was added to make sure everyone involved was given opportunity to express their concerns. People felt heard and respected as their concerns were included into the risk mitigation plan.

At the heart of the conversation was the primary concern for the safety of the patient. The team established that clinical leaders could stop the line immediately if there was a negative impact to a patient. All navigation would stop immediately if they felt the care of the patient was compromised or promises that had been made to gain their agreement were violated. The decision to stop the line created a sense of empowerment and helped the leaders, especially clinical leaders, to trust that the right criteria was driving the program. Without the best interest of the patient at the center of the program, participants indicated that they would never have been engaged, or interested in making such a transformational change to the delivery of care for Emergency patients. The

ability to put the patient first was a significant determinant for providers and gave them confidence that the change was not more important than patient care.

Participants with long-standing history in the organization and healthcare in general had not seen barriers removed with the speed and force they experienced in this program. When it was clear that the revenue to the Emergency Department was going to have a very rapid and continued decline, agreements with the Health Plan were immediately sought to share the revenue savings. This was a radical and ground breaking decision and helped to increase the trust of the participants that the effort was looking from an overall perspective of what was good for the enterprise.

Although trust developed for a wide variety of reasons, the kind of trust that developed was discussed in great detail by participants. They describe it as critical to the success of the program and the engagement of the participants. They would never have undertaken such a radical effort without the ability to trust the team and the intervention they developed.

The Patient Navigation process they developed was allowed to emerge. They investigated what other systems had been doing with navigation and varying levels of success. They did not take best practices in other organizations and try to force-fit a solution into Presbyterian but allowed a new model to develop by creating a vision and allowing the path to develop. This was a fundamentally different approach identified by participants as a key success factor. The ability to allow the individuals at the front line to develop solutions that fit what they were actually experiencing, combined with a leadership team that listened and helped to form solutions was different. There was a

shared ownership of problems that created far more successful solutions, demonstrating a successful utilization of leadership and management.

Presbyterian is a large organization and because the changes proposed were significant to the patients, the employees delivering the care, the organization, and the community, the leaders needed to be adaptable. One way they demonstrated adaptability was by taking a phased approach. The phased approach included gaining buy-in from all the critical stakeholders. As the first phases of the program were launched, an atmosphere of commitment and open communication was established form which the rest of the phases were deployed. An example of the phased approach includes that initial discussions with patients described what was coming before the navigation was implemented, physicians were allowed to continue to treat for awhile before they had to turn patients away, navigation at one location was established before it was launched at each additional location, and the navigators started tele-navigating once protocols and processes were established.

If the leaders needed commitment and open communication, the front line needed it even more. Meetings were filled with stories of how it was working and feedback on how their concerns were being addressed. There were forums and e-mails and feedback loops and huddle boards. They used every communication channel available and then created more if they felt it was needed. There were more face-to-face conversations than any of the leaders had ever experienced. Leaders showed up at the tough times asking how it was going and what they could do to help.

Physician leaders pulled shifts and modeled themselves what they expected their staff to do. They got into the details so that they knew it for themselves. They asked

questions and pushed back on the process requirements until they had solutions they could believe in before they required it others. They demonstrated what they wanted to see side-by-side with the staff they led. They knew the barriers for themselves. Then they went back to the team to determine what it was going to take to remove them.

Innovative solutions were found to address barriers, like the fundamental understanding of EMTLA regulatory requirements that had been the foundation of Emergency care for more than 25 years. Leaders read EMTALA regulations like it was the first time and discovered that long-held myths were surprisingly inaccurate. They worked aggressively with regulatory agencies and others in PHS and created something that helped patients get genuinely better care -- all while still meeting the actual regulatory requirements.

The leaders collaborated to deliver the best care possible. It was the heart and meaning behind everything and all staff could get behind it. Patients could tell and were able to make sense of this radical change because it actually resulted in a better outcome for them. Some patients had never known any other healthcare environment than an Emergency Room -- even if they had insurance -- because that was how it had been done for generations. Ninety-two percent of navigated patients had *never even considered* anything except the Emergency Room to get care. Patients appreciated the help because it gave them what they needed but didn't know how, what or who to ask to get it. When every member of the team was working together, it helped the patients to have confidence in the recommendations.

The central point of collaboration was the Navigator, selected from the Presbyterian Customer Service Center (PCSC). Navigators knew the organization better

than anyone in the system. They knew the financial system, they knew the scheduling system, they knew how to read benefits and make sense of the system and in some cases even other local insurance plans and agencies. They added a value to the customer experience to such an extent that some patients would sneak back into the Emergency Department just to talk to a navigator. They became a GPS system with the compassion of a social worker.

Measures of success are clear and compelling (See Appendix for 12/31/2012 Report). Functional requirements were met and patients were more satisfied as a result. Employees and providers were far more satisfied. Financial savings were achieved because Emergency Room care is the most expensive way to use healthcare and changing that venue of care required a system approach. Patients learned how to interface with the organization as demonstrated by the fact that only 3% of those who started out the Emergency Room for non-emergent issues ever come back after navigation. The program provided a better outcome for the community by encouraging patients to engage in the continuity of their healthcare in ways that were actually cheaper overall.

This was a solution that worked and the people who led it have a story tell that is captured in this case study. It's easy to talk about the statistics and all the ways in which this program is successful. That happens in the monthly report (see Appendix for the 9/5/2010 Report). What is harder to quantify is how the people involved were able to get this level of engagement, trust, and effort to create organization transformation in their approach to a very complex problem: Emergency wait times.

Healthcare organizations are facing unprecedented scrutiny by federal and state governments to implement changes under the Healthcare Reform and other initiatives.

As a result of this intense pressure, change efforts are increasing. It has never been more important to gain a deeper understanding of successful leadership models and approaches that support this imperative for transformational change.

Limitations and Assumptions

Limitations: The primary advantage of the case study approach is that much more detailed information will be available for study (Neale, et al., 2006); however, there are limitations. The time frame is a significant disadvantage in that can be far lengthier than quantitative studies. Additional disadvantages include the limiting factors of interviewing the leaders only. Inclusion of staff would add strength to the study findings, further triangulate the findings, and also increase the time frame in which it could be completed. All interviews, transcription, coding and analysis was done by the researcher and may represent validity and reliability concerns.

Assumptions: The researcher is a Learning Consultant focused on leadership development at Presbyterian and could represent bias as a result of the organizational connection and personal interest in leadership success. Procedures were implemented to remove names of the participants as comments were reviewed. Description of the process used to remove names and protect the participants are more fully described in Methodology section. It is assumed here that the participants trusted the researcher and the program sponsor to deal honestly and respectfully with the information that emerged. Much of the organizational context in which the program occurred was known to the researcher and may limit context for the reader. While this study examines and an integrated approach to successful organizational change, there are many other ways to affect positive change.

Chapter 2: Literature Review

The purpose of this case study was to utilize qualitative analysis to interview leaders who played a key role in the success of a complex change effort. As leaders reflected upon what they learned and how it is influencing their current change efforts, they identified best practices that allow learning for others. The research question was: *"What do leaders learn as they lead successful organizational change efforts?"*

A qualitative study to identify factors that emerge in change efforts in healthcare organizations is supported by a wide range of research and literature. The literature review that follows is organized by: Change Management and Transformational Change, Distributed Cognition, Social Networks, Leadership, articles that support the approach to study successful change efforts, and additional articles for reference.

Change Management. John Kotter is one of the leading writers on change management. His book, Leading Change (Kotter, 1996) and numerous other writings, have provided insight into key factors of change that should be present and should be executed in order. Kotter (1995) also examined the failures of several companies and determined that they did not follow the 8 steps he recommends, which leads him to conclude that the failure to do so was the reason for failure. The eight steps Kotter says are critical to success are:

1) Establish a Sense of Urgency
2) Forming a Powerful Guiding Coalition
3) Creating a Vision
4) Communicating the Vision
5) Empowering Others to Act on the Vision

6) Planning for and Creating Short-Term Wins
7) Consolidating Improvements and Producing More Change
8) Institutionalizing New Approaches.

Kotter (1990) also wrote a foundational article examining the differences between leadership and management. His assertion is that leadership and management are distinctive, yet complementary. Management is about coping with or mitigating complexity where leadership is about coping with or making room for change. If change efforts are championed by individuals whose focus is to manage the complexity rather than to lead through the change, it is anticipated that the effort will be less successful. Kotter believes that change efforts require leadership as he defines it.

Everett Rogers developed the concepts of innovative change in Diffusion of Innovations (Rogers, 2003) after years of agricultural study. His research identified the process of innovation in organizations as:

1) Agenda-Setting: general organizational problems that may create a perceived need for innovation.
2) Matching: fitting a problem from the organization with an innovation.
3) Redefining/Restructuring: the innovation is modified and re-invented to fit the organization, and organizational structures are altered.
4) Clarifying: the relationship between the organization and the innovation is defined more clearly.
5) Routinizing: the innovation becomes an ongoing element in the organization's activities, and loses its identity.

Rogers' steps are similar to those used by Kotter and represent very similar conceptual models. The steps out lined by Rogers broaden understanding the steps in Kotter's model. Rogers' research supports use of opinion leaders.

Margaret Wheatley's discussion of the chaos of change (Wheatley, 1999) supports a study of the success factors in a change effort. Her approach acknowledges that fear of change and a desire to control or minimize it will exist; however, it is what was present that supported and embraced the new change that is of interest:

"In a universe that is on a relentless road to death, we live in great fear. Perhaps we become so fearful of change because it uses up valuable energy and leaves us only with entropy. Staying put or keeping in balance are our means of defense against the eroding forces of nature. We want nothing to rock the boat because only decline awaits us. Any form of stasis is preferable to the known future of deterioration."

And

"Entropy, that fearful measure of a system's demise, was still being produced, sometimes in great quantities. But instead of simply measuring how much *entropy was present, scientists could also note* what happened *to it – how quickly it was produced and whether it was exchanged with the environment. Once it was noted that systems were capable of exchanging energy, taking in free energy to replace the entropy that had been produced, scientists realized that deterioration was not inevitable. Disturbances could create disequilibrium, but disequilibrium could lead to growth."*

Kurt Lewin (Lewin and Gold, 1999) originated field theory with the following central features: 1) Behavior is a function of the field that exists at the time the behavior occurs, 2) Analysis begins with the situation as a whole from which are differentiated the component parts, and 3) The concrete person in a concrete situation can be represented mathematically. Lewin's theory supports the approach of this study in that it takes a situation as whole: the ED Navigation program, and analyses the component parts. It also helps to identify the field that exists at the time of the change. Lewin proposed three stages of change: Unfreeze, Change, and Refreeze.

A study published in October of 2000 (ProSci, 2000) found that top management's biggest contribution to the change management process is to define and communicate the vision. Additionally, the ProSci study found resistance to be the most difficult part of the project, that change agents find that the initiators of the project end up being the biggest obstacles in the end, and that companies often use outside consultants to avoid political agendas and biases within their own companies. The study also found that the three most effective change processes are benchmarking, self-assessment and Six Sigma. Since the ProSci study identifies self-assessment as one of the top three change methodologies, this study is warranted to help PHS develop a repeatable self-assessment tool.

Transformational Learning emerged from Mezirow's (1996) work in adult education - primarily based on a socio-constructivist theory. Mezirow identified 10 phases for a perspective transformation to occur:

1 A disorienting dilemma,

2. Self-examination with feelings of guilt or shame,
3. A critical assessment of assumptions,
4. Recognition that one's discontent & process of transformation are shared & that others have negotiated a similar change,
5. Exploration of options for new roles, relationships, & actions,
6. Planning of a course of action,
7. Acquisition of knowledge & skills for implementing one's plans,
8. Provisionally trying out new roles,
9. Building of competence & self-confidence in new roles & relationships,

10. A reintegration into one's life on the basis of conditions dictated by one's new perspective

Scholars argued that the knowledge from the empirical-analytic tradition served the interests of professionalization and control, and that these interests are not emancipatory. From the perspective of critical theory, it is important to examine the power relationships in which knowledge is produced and whose interests are served. This study interviewed all participants, regardless of their position, in order to understand what they considered to be the success factors. This is a critical component in that the engagement of individuals in major change efforts is rarely motivational in and of itself.

Influenced by Habermas' (1984) view of rationality and analysis toward emancipatory action and Paulo Freire's (1970) process of conscientization Transformational Learning is "the process of effecting change in a *frame of reference*" which relates to assumption that adults have developed, through their life experiences, a whole body of *frames of reference* that in some cases have been uncritically acquired (conditioned responses) as a result of cultural assimilation. A frame of reference is defined as habits of mind, or habitual ways of thinking, feeling, and acting; points of view or beliefs, judgments, attitudes, and feelings that shape a particular interpretation. Transformational learning occurs when adults critically explore their assumptions by engaging in task-oriented problem solving (objective reframing), or self-reflecting to assess their own ideas and beliefs (subjective reframing), that lead to the changes in points of view and/or a transformation of a habit of mind. In this sense, transformational learning can occur either as a result of an acute personal or social crisis (disorienting dilemma) or through series of cumulative transformed meaning schemes.

Distributed Cognition holds that knowledge is socially constructed and occurs in contextual circumstances and is distributed through people, artifacts and social mechanisms. A change effort that occurred across a large organization over a diverse set of departments and that used interfacing software provides a valuable opportunity to demonstrate "people and tools acting in unison to accomplish what no individual alone could." Edward Hutchins (1995) defined cognition as a distributed phenomenon.

Hutchins' theory expands the concept of interaction to include human-human, human-artifacts, and human-artifacts-environment. Even when some division of labor occurs, something more than just the sum of parts is created and that the distributed cognition approach is more collaborative than cooperative. Context is described as a particular circumstance created by a specific arrangement of human-artifacts-environment that take place at a certain point in time. The context is able to modify nature and performance of a system due to change in the arrangements of elements, including the inputs of environment or inclusion/ exclusion of a new artifact. Different elements assume different roles depending on the specific task, activity, or problem encountered. In a distributed cognition view motivation for performance & learning resides in the efficient & successful process of solving a problem toward the effective interaction of the systems' elements.

Social Learning Theory (Bandura, 1977) explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences. Social Learning theory holds that people learn by observing other's behavior and attitudes. The behaviors and attitudes that emerge in this study should inform what needs to be observed by others for successful outcomes to occur. Bandura believed in

"reciprocal determinism", that the world and a person's behavior cause each other. The necessary conditions for effective modeling that Bandura describes are consistent with Kotter's eight steps for change used in the survey:

1) Attention includes distinctiveness, affective valence, prevalence, complexity, functional value. One's characteristics affect attention (e.g., sensory capacities, arousal level, perceptual set, and past reinforcement).

2) Retention is remembering what you paid attention to. It includes symbolic coding, mental images, cognitive organization, symbolic rehearsal, and motor rehearsal.

3) Reproduction is reproducing the image including physical capabilities and self-observation of reproduction.

4) Motivation is having a good reason to imitate and includes motives such as past (i.e. traditional behaviorism), promised (imagined incentives) and vicarious (seeing and recalling the reinforced model).

Building upon John Dewey and Kurt Levin, Kolb (1984) described Experiential Learning as "the process whereby knowledge is created through the transformation of experience." The theory presents a cyclical model of learning in four stages. Learning can begin at any stage, but should follow each stage in the sequence: 1) concrete experience (or "DO"), 2) reflective observation (or "OBSERVE") , 3) abstract conceptualization (or "THINK") , 4) active experimentation (or "PLAN"). Kolb's four-stage learning cycle shows how experience is translated through reflection into concepts, which in turn are used as guides for active experimentation and the choice of new experiences. Presbyterian utilizes the Plan, Do, Study, Act model when considering making an Improvement. The Presbyterian Improvement Model is provided in the Appendix.

Social Learning Theory has sometimes been called a bridge between behaviorist & Cognitive learning theories because it encompasses attention, memory, and motivation.

The theory is related to Vygotsky's Social Development Theory, (1978) which also emphasizes the importance of social learning with experiences "within the zone of proximal development, not so far beyond the learners' current capability that they have great difficulty mastering the experiences." People learn through observing others' behavior, attitudes, and outcomes of those behaviors. "Most human behavior is learned observationally through modeling: from observing others, one forms an idea of how new behaviors are performed and on later occasions this coded information serves as a guide for action." A study to capture key factors of a change effort provides a mechanism to apply Social Learning Theory in the practice of organizational activities. Unfortunately learning the wrong way to go about a change effort happens more than is desired. The study of a successful change effort provides others with information to model the positive behavior, attitudes and hopefully, the outcome.

When referring to Self-Regulated Learning, Zimmerman (2001) states that, "Learning that results from students' self-generated thoughts & behaviors that are systematically oriented toward the attainment of their learning goals". It "involves goal-directed activities that students instigate, modify, & sustain" "attending to instruction, processing information, rehearsing & relating new learning to prior knowledge, believing that one is capable of learning. A systematic approach to learning about change efforts is supported by Self-Regulated Learning Theory.

Operant Theory refers to self-regulation as (a) an attempt to provide a natural science account of phenomena (b) systematic application of behavior change strategies that result in the desired alteration of one's own behavior (Zimmerman, 2001, Pg. 39). The Phenomenological view accepts the primacy of self phenomena in directing learning

behaviors, it favors a person-reference over performance-referenced account of processes & activities (Zimmerman, 2001, pg. 68). Capturing the natural scientific account of a change effort is supported by Operant Theory.

Social Network Analysis. The foundational work of Everett Rogers in Diffusion of Innovation (Rogers, 2003) helped to propel Social Network Analysis as a field. Change Agents are the term coined by Rogers to describe individuals who introduce change from outside the system. They are usually bringing a message of change from an agency and are professional and/or educated. They spark an innovative idea within a communication system that is transmitted to others. It is usually the leaders or outside consultants that are considered Change Agents in organizations.

Rogers identifies Opinion Leaders as the ones who catch the innovative idea and spread it. They do not necessarily hold a position of leadership, but they are a critical part of the informal communication system that diffuses innovations. They can make or break the ability of a new idea to catch on. The combined effect of several Opinion Leaders adopting a new idea can be a tipping point where ideas catch on. Rogers cautions against overusing Opinion Leaders because of the need for Opinion Leaders to maintain the group connectedness. They need to be careful not to deviate too far from the norm of the group. If they begin to appear as professional change agents, they will lose their respect and position as Opinion Leaders.

Several other writers have contributed to the literature which supports this approach. Gladwell (2003) took Rogers concepts of how ideas spread and identified three types of individuals, Connectors, Mavens and Salesmen. These are the ones who make it possible for ideas to catch on to the point of no return – the Tipping Point.

Connectors know a lot of people and can make the linkages between individuals. Mavens are ones who accumulate knowledge – they know what the rest of us don't. Mavens like to help for the sake of helping. Salesmen are persuasive. They have that quality of connecting with people in ways that are often not noticeable or defined – you just like them and tend to agree with them. Gladwell shares stories of how individuals of all three types were able to persuade, inform or connect others from one way of thinking to another.

O'Keefe (2002) discusses how diffusion is more successful when the greatest dissenter becomes the advocate, i.e., that credibility of the source of information is enhanced when you would have expected a different message from this expert. O'Keefe identifies trust and expertise as critical to the persuasive effect of the source.

Rob Cross is a leading researcher on the ways in which social network analysis can be leveraged to business results. In Driving Results Through Social Networks, Cross and Thomas (2009) identified two goals: to teach members how to apply network analysis to critical business issues and to support a series of research programs that yielded actionable insights for measurable business impact. The research was directed toward 1) innovation and top-line revenue growth, 2) client connectivity and sales force effectiveness, 3) large-scale change and post-merger integration, 4) talent management and leadership development, 5) strategy executing and alignment, 6) financial return through effective collaboration, and 7) lateral connectivity in organizations, such as best-practice transfer as is the focus of this study.

Lacayo, et al., (2008) discuss the nature of social change in terms of Chaos Theory and complexity science. Complexity Idea No. 4 is the free flow of diverse and

meaningful information is essential for the system to evolve. The concept is that diversity and participation are critical to effective change. It is important that individuals feel welcome to share their feelings on issues that are taboo or too sensitive to discuss. The greater the variety of participants, the greater the opportunity is to form new associations.

Mato's (2004) insight on how to engage social agents is relevant, setting the expectation that the individuals and groups will generate their own meaning on topics through conflict, transactions and negotiation among "agents". Identified as "constellations" such as grassroots community organizations, workers, student unions, social, political and cultural leaders, teachers, artists, and intellectuals, agents are bound by certain agendas and interpretations "not just by needs or social problems, but by the way in which these needs and problems are subjectively felt and interpreted and the possible solutions and agendas that are put forward." People will generate their own concept of meaning on a topic and the meaning will connect to the group.

Singhal, et al., (2006) provide definitions, sources and measures of social capital. Several definitions are provided, but the one identified as the most cited is: "features of social organization, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions." Sources can be economic, cultural and/or social. Social capital emerges from the ritualistic aspects of cohesive groups as they are "thrown together". Sources are also described as a "resource gained by social relationships with other human beings that can be used for a variety of benefits" with a "bounded solidarity" or principled form of behavior such as the capacity of a group to monitor with "enforceable trust". Groups have a way of creating social capital for

individuals who support the benefit of the group, as well as enforcing the group expectations on the individuals. Measures include interpersonal trust, generalized reciprocity and the density of networks when looking for the degree of social capital that exists in a community. Trust can be measured in willingness to take risks within the group, reciprocity involves the providing of informal mutual services, and civic engagement is the extent to which individuals are involved in their communities and the size of those groups.

Hauser, et al., (2007) hypothesize that social capital plays an important role in diffusion of knowledge and regional innovative capacity. They tested five different dimensions of social capital and determined that associational activity represented the most robust influence on innovation. The key finding is that weak ties provide better bridges to new information than strong ties in that new knowledge is more easily disseminated through loose contacts than close friendships since close relationships usually share the same information.

Literature Supporting Approach. The Elaboration Likelihood Model (ELM), developed by Petty and Cacioppo in 1986, and the Heuristic-Systematic Model (HSM), developed by Chaiken in 1980, claims that there are two meditational routes to persuasion, the central and peripheral (O'Keefe, 2002). ELM and HSM propose that when an individual's capacity and motivation are relatively high, the said individual will carefully consider and evaluate the available information, utilising the central or systemic route. In contrast, when capacity and motivations are low, an individual will process the information on a more trivial level, utilising only the peripheral or heuristic route. This results in the individual retrieving simple schemas or stored decision rules to evaluate the

information being presented. The ELM and the HSM hypothesise that attitude changes resulting from central or systemic processing will show greater persistence, resistance, and will better predict behaviour. The approach of this study will address the need for both the compelling stories and the supporting data to encourage the use and learning across the organization.

In the Harvard Business Review article, *Why Leaders Don't Learn From Success* (Gino and Pisano, 2011) provides a compelling argument for the approach to study a successful change effort. Our desire to prevent failure drives us to learn from mistakes; however, our pride in success keeps us from digging into the details enough to uncover any issues that might become larger problems later. Studying success is an easily overlooked leadership activity with five learning points recommended in the article: 1) Celebrate success, but examine it, 2) Institute systematic project reviews, 3) Use the right time horizons, 4) Recognize that replication is not learning, and 5) If it ain't broke, experiment. This study examines the success as well as identifies processes for learning that with a focus on understanding what deserves replication.

Successful change leaders do things differently that sets them apart from leaders who are not as successful (Miller, 2002). Personal change adaptability is the key determinant, according to Miller, and it appears to be both genetic and learned. The top-line indicators of adaptability include behaviors such as being optimistic, self-assured, innovative, collaborative, purposeful, structured, and proactive. Leaders who adapt well in change are very focused. Their focus tends to be demonstrated in two ways. First "they lead fewer initiatives than their less successful counterparts and ensure that the organization is focused on their agenda." And second, they tend to focus less on the cost

of failure than the benefits of realization. (Miller, 2002 p.365). The best leaders in successful change efforts are very adaptable personally and model the leadership behaviors they want to see.

Sternberg's Successful Intelligence sets forth that there are three aspects of intelligence, Analytical Intelligence, which represents the thinking required to solve problems and to judge the quality of ideas, Creative Intelligence, which is required to formulate good problems and ideas, and Practical Intelligence which is needed to use the ideas and analysis in effective ways in everyday life. Sternberg states that, "The most successfully intelligent people are not necessarily the ones with the greatest degree of intelligence in any of this three forms, they are able to capitalize on their strengths, compensate for their weaknesses, and make the most of their abilities -- all of which require analytical, creative, and practical intelligence." The leadership in this program demonstrated these three keys to successful intelligence.

Literature Supporting Research Methodology. The methodology used was a case study (Stake, 1996). A case study is the appropriate approach in this situation (Neale, et al. 2006) because it provides the opportunity to more deeply understand the impact to the individual leaders of change efforts in organizations. Because the study involved navigating patients away from the Emergency Departments at Presbyterian Healthcare Services (PHS) and into and clinically appropriate care venues that were also more affordable, there was a diverse set of leaders involved across the organization. This allows us to gain insight into what leaders are learning as they lead large scale change efforts, and more specifically, what they learn when the project is successful.

The case study design used qualitative methods collected through individual interviews of the team of approximately 12 leaders who were involved as they successfully sought system-wide solutions to a complex and entrenched problem. The leaders involved were from a cross-functional team, representing the Emergency Department leadership, the physician practice leadership, the health plan leadership, and other representatives of the organization who oversee the system support areas that needed to collaborate in order to execute this effort. It was important to allow this team to explore and reflect upon their experience to determine if this effort required a transformation in their leadership approach in which they accomplished their goals to improve patient care and save the company millions of dollars, thus the methodology was appropriate for the study.

Individuals were asked to identify their role in the change effort as part of the interview. All interviews were conducted in compliance with international and national ethical research standard and were approved by the IRB prior to initiation. The interview instrument is attached as Attachment B.

Representation of the audible and visible data into its written form is an interpretive process which involves making judgments (Bailey, 2002). Although audio and video recording was made of the interviews, only the interviewer's notes are deemed necessary to be transcribed. Audio and video recordings were made for the purpose of clarification in the event review might be required to determine the meaning the interviewee might have intended to convey or to verify exact quotes. Extensive notes were taken by the researcher and transcribed, coded and analyzed. The recordings were used as a back up to the researcher notes. "Decisions about transcribing are guided by the

methodological assumptions underpinning a particular research project, and there are therefore many different ways to transcribe the same data. Researchers decide which level of transcription detail is required for a particular project and how data are to be represented in written form (Bailey, 2002)."

Project documentation was reviewed including, quarterly reports for the initiative, team project meeting minutes, videos, and any other related reports or documents or plans that provide insight into the intention and actions of the change effort. Scorecards and other measurement data that captures the impact and/or success of the project provide triangulation of the data that emerges related to the perceptions and understanding of the interviewees.

A qualitative study to identify factors that emerge in change efforts in healthcare organizations is supported by a wide range of research and literature. The literature review demonstrates the need for further study to understand how application of Change Management and Transformational Change, Distributed Cognition, Social Networks, and Leadership principles could be implemented successfully and if leaders learned from their participating in this effort. The case study approach is an appropriate methodology for this effort and the field is advanced by finding answers to the compelling question of the study "What do leaders learn as they lead successful change efforts?"

Chapter 3: Methodology

A case study was utilized to apply qualitative analysis in the interviews of 12 leaders who played a key role in the success of a complex change effort in a healthcare environment. These leaders reflected upon what they learned and how it is influencing their current change efforts, they identified best practices that allow learning for others. The research question was: *"What do leaders learn as they lead successful organizational change efforts?"* This chapter will describe the methodology utilized for this study.

Rationale. According to a comprehensive review of Transformational Learning research, further study was needed in the field (O'Sullivan, Morrell and O'Connor, 2002), to "explore further the role of adult educators in promoting transformative learning, and the training of "transformative educators", to "broaden the outcomes of transformative learning and to explore the occurrence of 'undesirable' outcomes, to "explicate more clearly the nature of the connection (and eventually the lack thereof) between individual and social transformation." The design of this study broadens the outcomes of transformative learning and informs the development of training for leaders on transformational learning. Any undesirable outcomes identified will be reported and any connection or lack of connection between the individual's transformation and the transformation of the team will also be reported.

Observational data indicate that the subject study was different than standard change efforts initiated within the system and that further study is warranted to understand what was different and if any lessons learned can be applied in additional change efforts. Because the individuals involved are in a wide variety of leadership

positions with varying levels of experience, education, and span of control a qualitative study is warranted in order to understand the effort from the perspective of those closest to it. The design of open-ended questions will allow a free-flowing dialog permitting the participants to share as things come to mind with respect to their experience in the program.

Study Design: Qualitative methods were used to explore what leaders learned as they sought system-wide solutions to a complex and entrenched problem in healthcare that overcrowding highlights: the high cost and lack of continuity of care. The leaders involved were from a cross functional team, representing the Emergency Department leadership, the physician practice leadership, the health plan leadership, and other representatives of the organization who oversee the areas that needed to collaborate in order to execute this organizational transformation effort.

Step 1: **Participant identification:** All leaders of the EDPN program were identified by the program sponsor. Upon gaining approval for the study from the sponsor, the names of the participants were provided.

Step 2: Invitation. The program sponsor , Dr. Mike, sent an e-mail inviting all to participate in the interviews. Solicitation and invitation to participate in the program was requested through the program sponsor. After sending the e-mail, the participants were contacted by phone and/or e-mail by the researcher to determine if they were interested and to arrange for convenient dates for a 1 1/2 hour interview. Of fourteen leaders invited to participate twelve agreed to be interviewed.

Step 3: **Consent**. The participants signed a consent form provided in e-mail to them and either returned it through inter-office mail or signed it as the first step of the interview. A blank copy of the consent is provided in the Appendix.

Step 4: Interview Preparation. Personal interviews were set up with each participant. In preparation for the interviews, the rooms were scheduled, a video camera and an audio tape recorder were obtained to ensure that the interviewer could review the conversation with the least risk to the participants of repeating or impact to their time to call back for clarification. A checklist was developed to ensure that the same interview protocol was employed for each interview.

Step 5: **Interview Process.** Each interviewee was asked the same questions. A copy of the interview questions is provided in the Appendix. An interview template was created for the researcher with the question at the top of the page to allow room for notes to be taken. Video tapes were titled with the date of the interviews and back up audio tapes was used to ensure full capture of the information.

Step 6: **Video recording.** The videos and synopsis documents for each individual were captured and organized for retrieval using a unique identifier and removing names. The files, recordings, synopsis documents, and documentation with the participant names were kept in personal password encrypted devices, and not available in organizational storage systems.

Step 7: Transcription of interviews. All interviews were fully transcribed to capture the text and context of the interviewee statements.

Step 8: Data Analysis Utilizing a slightly modified version of Cresswell's 6 steps for data analysis, a multi-step process of organizing (described in Step 8) and

analyzing data was utilized to find the deeper meanings of the data, to show the data, and interpret the data. Cresswell's six steps to data analysis are: 1) organize and prepare the data; 2) read through all the data; 3) code the data; 4) use the codes to determine categories and themes; 5) determine how the categories and themes will be represented in the qualitative narrative; and, 6) make an interpretation of the data for meaning. The approach taken was one Creswell recommends to report the data as a basic qualitative analysis. The analyzed data revealed the factors that participants identified as significant and were reported in narrative style.

Step 9: Data Coding Process. Written notes captured in the interview template were captured in Microsoft Excel. The key statements were captured in the rows with the columns represented the question they were answering. Each subsequent interview that was conducted was added to the bottom of the spreadsheet and their statements were added until all statements made by each participant to each question were captured in the column for that question within the same page on the spreadsheet. Answers to each question were then captured by the rows as shown in the example below. (See Appendix for sample of Master Interview Notes).

Table 1: Example of Interview Notes

	Question 1	**Question 2**	**Question 3**
Interview 1	comment 1	comment 1	comment 1
	comment 2	comment 2	
	comment 3	comment 3	
		comment 4	
Interview 2	comment 1	comment 1	comment 1
	comment 2		comment 2
	comment 3		comment 3
	comment 4		

Upon entry of all of the interview notes into the spreadsheet, all of the answers to each question captured in the corresponding column were copied into a new page in Excel , i.e., all of the participant answers to the question, "What was your opinion of the outcome?" were copied and pasted into Tab G. Each statement was then coded. Many of the statements contained overlapping contextual meaning and received more than one code. (See Appendix for sample of coded statements).

Table 23: Coding of Statements

QUESTION: What was your opinion of the outcome?				
Line	**Statement**	**Theme 1**	**Theme 2**	**Theme 3**
G1	comment	Code	Code	Code
G2	comment	Code		
G3	comment	Code	Code	
TAB G				

A master list of the codes was kept as each key statement or comment was coded. A sample of the master list of the questions and tabs where the coding of those questions were captured is shown below. (See Appendix for complete document).

Table 3: Sample of Questions and Tabs

Question	**Tab**
1. What was your role in this program?	F
2. What is your opinion of the outcome?	G
3. What is your opinion about the changes that you implemented?	H
4. Please describe the state or context before the change and what is different now.	I
5. What aspects surprised you?	J
6. What do you consider to be critical decision points?	K

A description of each code is included in an aggregated document (See Codes in Appendix). The codes were given headings to establish themes or patterns that emerged. Each statement was given a unique identifier.

Table 4: Sample of Codes

THEMES	**CODE**
Team	
Composition	TCOMP
Provider involvement	TPI
Enterprise collaboration	TEC
Communication	
Extensive dialog	CD
Frequent	CF

Once the coding of all of the statements in each tab was complete, all tabs were combined to create a new complete list with every coded statement on an individual line. Statements with more than one code were given a separate line so that no row in the master list contained more than one coded statement. The individual statement unique identifiers were maintained.

Table 5: Sample of Codes on Individual Lines

Line	**Statement**	**Code**
G31	Positive in what was accomplished - very successful	SO
G32	Positive - this type of change rarely has all barriers removed	SO
G33	Positive - navigation	SO
G34	Positive - lack of complaints	SO
G34	Positive - lack of complaints	SPS
G35	Positive - media response is good	SC
G35	Positive - media response is good	SO

Statements from the question "Please describe the state or context before the change and what is different now" were identified by using a "B" for statements that

related to the previous state and using an "A" for statements that related to the state post intervention.

When combined, the master list contained 3450 individual lines of coded statements. Pivot tables were created to capture all statements that were identified by any specific code. The pivot table also identified the number of statements that were identified by any individual code.

Table 6: Pivot Tables

Code	Count of Line
PSA	218
KL	170
LM	147
CD	143
LD	116
AS	109
LCS	108
LT	104

Upon reviewing the statements in the codes, duplicates were removed and coding similarities were combined to create more clarity for the data represented. These steps included removal of spaces on the original codes and deleting some codes for which other categories of codes were a more accurate capture of the information. Codes that didn't serve a purpose were deleted.

All codes with over 100 statements were reviewed. Upon more thorough review, three categories of themes emerged. The code that was utilized most frequently was whenever a "Personal Shift to Agreement" (PSA) comment was given by participants. By way of explanation of the code, the use of "personal shift to agreement" was used because at the time of the interviews, during the capturing of the codes, it was not yet

clear what the extent of the was. The term was utilized to capture a statement that some change or shift had occurred. The statements coded PSA were reviewed and determined to arrange into four categories: Trust, Leadership, Communication and Patient Focus.

Table 7: Sample PSA Coding

LINE	STATEMENT	PSA	TRUST	LEAD	COMM	PATIENT
M15	(Leaders communicated) how the process would be different and why it's appropriate	1			1	
M16	Listening was key. The team would hear our concerns and then come back with ideas asking "does this fit, would this be enough to make you comfortable?"	1	1		1	
M17	They formulated a plan that would win for all	1	1		1	1
		Total	Total	Total	Total	Total

Once the PSA codes were captured, those that were identified as relating to Trust, Leadership, Communication and Patient Focus were totaled. The percentage of the total number of PSA coded statements in each category were then represented in the findings by the percentage of the total number of PSA coded statements they represented.

The next highest codes were related to Success Factors and grouped together for reporting purposes. Several codes were originally utilized to capture statements reflecting the impact of an Enterprise Solution, however; when all of those codes were combined and duplicates removed, comments reflecting a reference to the Enterprise Solution comprised a higher number of comments than any other single code.

Table 8: Combination of Enterprise Codes

Code	Statement	Number
TEC	(Team) Enterprise Collaboration	55
LE	(Leadership) Enterprise Leader support	53
BLS	(Belief that changed) That leaders would support	23
TA	(Trust) Shared accountability built trust	23
YE	(Yielding) Engagement of all in outcome	40
SOL	(Successful Outcome) Organizational Learning	89
	Starting total	283
	Total after removing duplicates	**243**

The Enterprise Solution was reported as a Success Factor, along with the Leader Modeling, Difficult Decisions, Navigator Role, and Physician Involvement.

The final section of codes relate to the answers provided to the questions about the leader characteristics the participants personally demonstrated. These statements were coded to identify how the questions were answered. The statements of participants described their ability to be Adaptable, Innovative, Collaborative, Optimistic, Purposeful, Confident, Self-Assured, and Proactive and were reported in the summary of Leadership Characteristics.

Step 10: Findings. Upon completion of the coding and development of the descriptive statistics charts that represent the code frequency, the findings from the data was reported in Chapter 4. Actual statements were used in the report to allow for the voice and context of the participants to more thoroughly describe their experience and learning. As participants described their experience, they often used the names of other participants. Not only were all names changed of the participants to pseudonyms, but the names of other participants were also changed as they described their interaction with each other.

Step 11: Analysis. The data from the findings was analyzed to identify what leaders learned to more fully identify how key learning from the program supported themes in related research on change management, transformational change, distributed cognition, social networks, and leadership. The program documentation and themes were compared and validated. See Appendix for program documentation provided.

Human Subjects/Research Sample. No children, prisoners, mentally ill or disabled people were included in this study. Therefore, there are no precautions needed for these vulnerable populations.

Informed Consent. Participation was completely voluntary. Even though management identified the participants and requested their participation, there was no undue duress or implication from management that the survey participation was required, and can be validated by the fact that 2 who were requested to participate declined.. The participants were given an opportunity to select out at the beginning of the survey and to speak "off-the-record" if they wished.

Sample Population. The entire population of leaders in the program were invited. All of them participated except two, who declined, stating that the individual from their area who would participate could speak meaningfully for them, as well. Patton (1990) guidance explains that qualitative research generally uses small sample numbers and asserts that are no rules for sample size in qualitative inquiry. "Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with the available time and resources (p. 184).

Triangulation. In qualitative studies triangulation is essential to ensure that the information gathered can be studied from multiple sources to "confirm the emerging findings (Merriam, 1998). Interviewing all participants garnered information from all participants

created the ability to make interpretations that were credible by exploring consistencies and inconsistencies, similarities and differences across the enterprise (Lincoln & Guba, 1985). Program documents such as reports, presentations and conference papers were also reviewed to determine consistency with participant comments.

The methodology that was utilized was an effective way to capture the participant feedback so that their learning could be identified. The coding was thorough and provided a summarizing framework for the findings. The analysis situated the findings within existing research, and identified further research opportunities and implications for practice.

Chapter 4: Findings

The purpose of this case study was to utilize qualitative analysis to interview leaders who played a key role in the success of a complex change effort. As leaders reflected upon what they learned and how it is influencing their current change efforts, they identified best practices that allow learning for others. The research question was: *"What do leaders learn as they lead successful organizational change efforts?"*

As leaders work in the constantly changing healthcare environment, they are required to implement changes to processes and programs, healthcare protocols, and general management principles every day. There is never-ending pressure to make adjustments and corrections to previously held practices and beliefs to lead their areas and time to reflect upon their experience is rare. Change is an ever-present expectation and forceful taskmaster for leaders that does not always yield benefits as billed. When comparing the change efforts led from a management perspective to reduce variation or improve efficiency, the kind of change discussed in this study was entirely different and demonstrates the importance of the leadership involved. This was a transformational change effort and participants descriptions describe the role that leadership played in the success of the program.

This project was successful by almost anyone's standards as demonstrated by the scorecard and program documentation in the Appendix. The functional requirements were met but what this study seeks to do is to investigate what role the leaders played that supported the success of the program.

The themes that emerged as a result of the interviews provide insight into what supported personal transformation, factors that supported the successful outcome of the

project and the leadership characteristics that supported the participants involved. As leaders reflected on the program and their personal involvement, many of the themes that emerged overlap, support, relate and connect. Not all relationships are described; however, the key themes are presented to demonstrate their relevance, not necessarily to demonstrate how they were interrelated. Representative quotes from participants are provided to demonstrate the language and tenor of the responses.

The first section in this chapter discusses the transformation of the individuals involved in the effort. As they shared their initial state and how they transformed, the term used to describe the change was a personal shift to agreement. The term "Personal Shift to Agreement" comes from a paradigm shift (Kuhn, T. 1962) referring to a change in the basic assumption within the ruling theory of the individuals involved. Because the shift described was personal to the individuals it reflects their transformation from their original paradigm to a profound change in their fundamental model in which emergency care can be successfully delivered. As the participants described their own personal experience, they described four key factors that were related to or responsible for that shift that changed. These four factors are trust, leadership, communication and patient focus as shown in Figure 1 below.

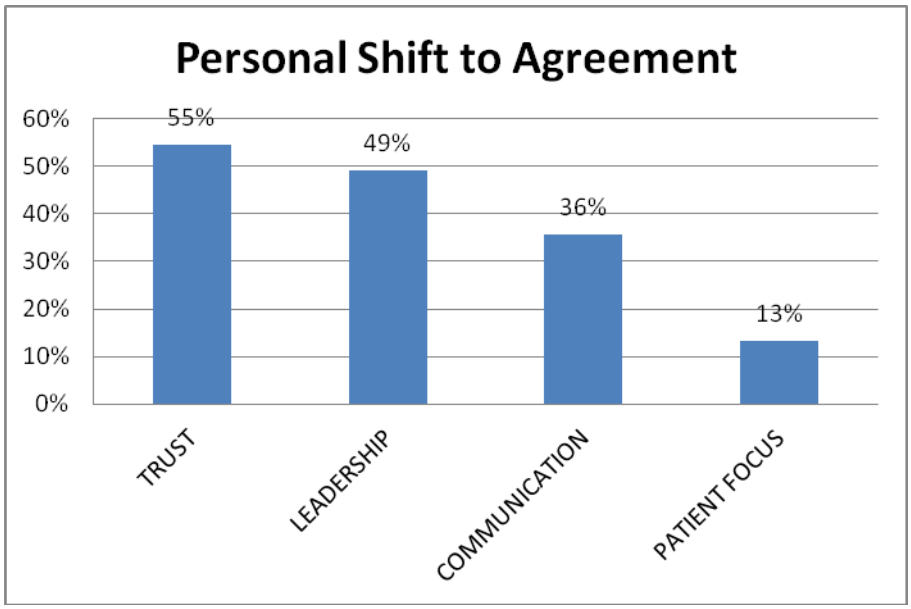


Figure 2: Personal Shift to Agreement

The second section of this chapter discusses what the participants believe made the project successful and what they learned about the importance of that characteristic. As they described their involvement and the impact of the program on their work, the five factors shown in Figure 2 below, emerged as important to the overall success of the program. These factors are an Enterprise Solution, Leader Modeling, making Difficult Decisions, the Navigator Role itself, and Physician Involvement.

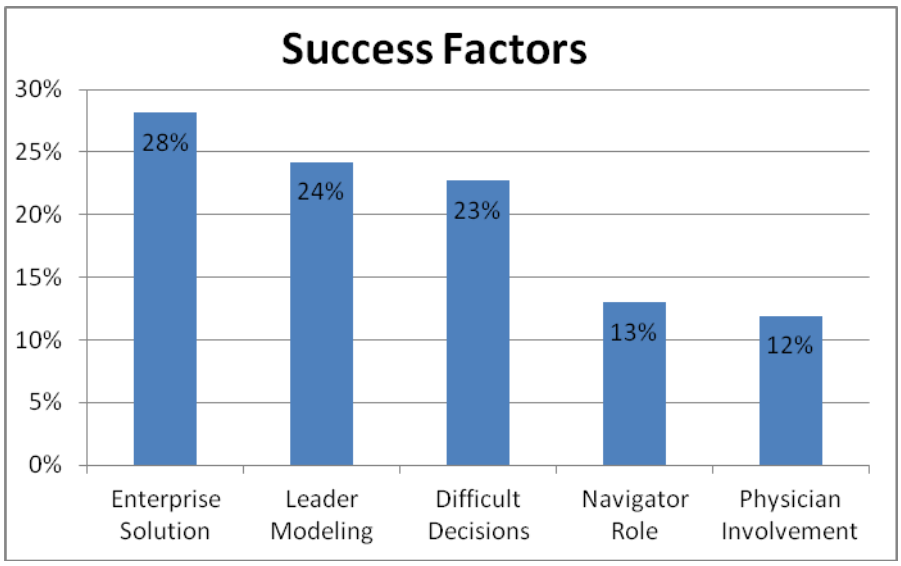


Figure 2: Success Factors

The third section discusses the leadership characteristics participants believe they demonstrated and importance of the characteristic to their personal leadership success. In *"Successful change leaders: What makes them? What do they do that is different" (*Miller, 2002) identifies adaptability as the key determinate of implementation success and the following characteristics of being optimistic, self-assured, innovative, collaborative, purposeful, structured and proactive as indicators of adaptability. When given a list of characteristics that successful leaders tend to demonstrate and asked if they demonstrated any of the characteristics (See Interview Questions in the Appendix), the participants used statements that described themselves as being Adaptable 31% of the time, followed by Innovative 17%, Collaborative 16%, Optimistic 10%, Purposeful 7%, Confident 6%, Self-Assured 6%, and Proactive 6% as shown in the figure below.

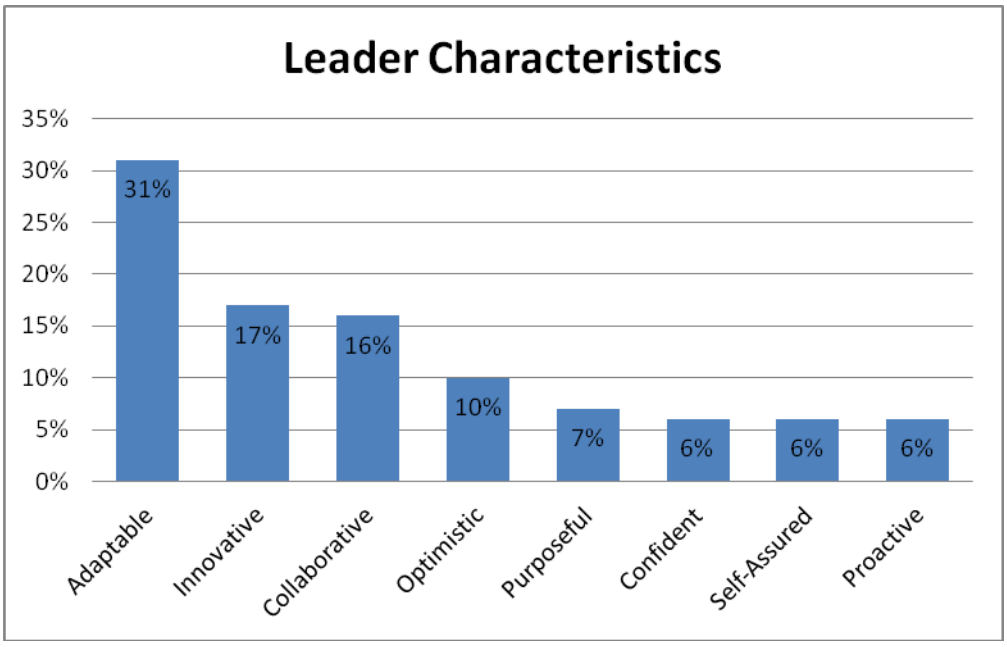


Figure 3: Leader Characteristics

Personal Shift to Agreement.

The code most utilized to describe participant comments was "Personal Shift to Agreement." This topic was the discussed among the leaders interviewed and presented

interesting reflections regarding the point at which they themselves shifted or what they observed as causing others to change. It was interesting to observe that while none of the participants stayed opposed to it, not everyone had to shift to come into agreement with the program. The program itself was radical, changed the way care would be delivered in fundamental ways, and yet there were some who didn't have a transformational experience. There were eight participants who did not experience a shift. These formed into two groups: six who were already in agreement and two who did not need to shift to support it.

Of those the participants interviewed who were already in agreement, four were the initiating core team. Their comments about shifts in agreement were directed toward what they observed as what caused the shift in others because they were watching for it and were working to create the shift to agreement.

In order to provide a background and context for the comments and perspective of the participants, they will be introduced here in relationship to their perspective on the change. The names of the participants have been changed.

Dr. Mike is the Executive Medical Director of Integrated Care Solutions (ICS). ICS was a new group that was formed to address some of the most entrenched and difficult problems facing the organization. The EDPN project was the first large project the team sought to address. Dr. Mike had a long history in emergency room medicine and is well respected by physicians, Emergency Department staff and others within the organization. His belief in and commitment to the EDPN program was evident and often referenced by the others interviewed. As one who started the program, Dr. Mike did not need to shift paradigms as shown in his comment below.

> *(Dr. Mike, Executive Medical Director) I take on a project and I have no thought the project's not going forward and be successful. In this project I felt very confident we could get over a few huge hurdles: getting the docs to trust us and administration to have our backs when things aren't working or there is a bad outcome. The key to success is gaining trust.*

Linda was the Chief Financial Officer of the Presbyterian Health Plan prior to becoming the Vice President of the ICS team and co-sponsor of the EDPN program. As an expert in financing healthcare and how it impacts Presbyterian specifically, Linda's expertise played a critical role in the success of the program. Similar to Dr. Mike's perspective, Linda was convinced that the EDPN program was the right thing to do from the start. When asked if she was excited when she first started on the project, Linda's response was:

> *(Linda, VP ICS) I was. I like knowing that there's something we're going to solve, but we don't have it (figured out yet). And a lot of people get uncomfortable with that here at Presbyterian. It's like they want to know. And it's funny because it's not just people in the project, but I think as an organization, I know there are people who want me to have a 20 page detailed work plan of everything I'm going to do for the next 5 years. I don't know what I'm going to do for the next 5 years. I know that our inpatient utilization is too high. I know that our complex patients don't get the care management they need. I know we do way too many surgeries. Those are the things we know, but I don't know how I'm going to solve it. That would be like me saying 4 years ago that we were going to implement ED Navigation and not treat people in the ER. There's no way I could have known.*

Originally on loan as the Black Belt to the ICS team from the Process Improvement team and having led many Lean and Six Sigma projects at Presbyterian, Phil became one of the original 4 members of the ICS team that launched the EDPN program. His expertise in process improvement efforts at Presbyterian, his capacity to bring clarity to data, and with a deep clinical background, Phil was also in agreement with the program from the beginning as described in his statement below.

(Phil, Black Belt) An aspect that surprised me was the shift of highly resistant people to highly supportive people. Both Dr. Darrell and Dr. Isabella are two of those individuals who were resistant (but became) strong advocates. That was a surprise. I was more impressed. But my state of mind, I was optimistic. That's what I do. I'm a change agent. I design programs. I went in there knowing we would design a new program. I guess I was optimistic that we would do something creative.

Sharon was the only member of the ICS team who was new to Presbyterian. With a deep background in Project Management methodology, Sharon was hired to work specifically on the EDPN project. She stated that she took the job because it was interesting and presented a challenging opportunity to work on a very difficult problem. She was eager to bring her skills to bear on an issue of organizational and national importance and did not have any preconceived understanding that changed as shown in her comment below.

(Sharon, Project Manager) I think I have a different perspective because I had just come to Presbyterian. This was the first project that I was assigned to as a new employee to Presbyterian. I'm not clinical. I have had a project management, Black Belt experience prior to coming here. So one of the things I've always heard is that it's very difficult, a long process, to change things here at Pres. I think I personally was very fortunate for this to be my first project because we had very dedicated people to it. I think a large part of the success, the transformation part of it, is because of the leaders that were involved in this. And I think that if you had people involved that weren't willing to really challenge and research and ask the tough questions that this would have been a very easy effort to say, "Ok, this is too tough. We're not going to go that direction."

(Sharon, Project Manager) (It was) transformational really seeing that change in thinking and ownership. That the project team is very invested and kind of see the big picture and the rest of the people that you pull in to be a part of the team - not quite there yet. You see that shift of "What about this? Can we do that?" with a "No, no, no, no, no." One day they came to the table and started pushing "We could do more." So that was an exciting thing to see as a project manager.

Two other participants in the study did not experience a shift because they were already in agreement in principle. When presented with the program and opportunity to be involved, they quickly accepted the opportunity.

At the time of the program's inception, Joe was the director of the Presbyterian Customer Service Center (PCSC), overseeing more than 200 employees with the responsibility to answer customer questions about their care, billing, and benefits. Joe helped to shape the formation of the PCSC as an enterprise function and was eager to participate on the EDPN implementation team as a Presbyterian Health Plan and Customer Service representative. Joe's enthusiasm was, at least in part, because he was able to recognize that there was something different about this team and that they were going to do something special. He wanted a chance to contribute to help shape Presbyterian for the better. His comment below demonstrates that he was already amenable to the idea and looking for an opportunity.

> *(Joe, Director PCSC) This was a concept that had been talked about for several years. People say now they don't remember where this came from. I do know that having discussions with the President of the Health Plan, probably 18 months prior to this work, where he started talking about the Triple Aim and how the Contact Center really served as the integrator for the Enterprise. When we say an "integrator" somebody who really looks at broad functions that are served from different business units and starts understanding the connection points between those different areas. He and I discussed that actually a program where we could utilize CSRs in a function that would integrate on the delivery system in some manner. We never really specifically discussed the ED, but I when this project kicked off and I was on the invite list for the project team I went in there and did not introduce this concept as, "Hey, I've got this solution for what we can do". But they had innovative leaders on the project team. I think that's one of the other innovative aspects: choosing the right people for the project team. Then allowing the group to actually throw out ideas and discuss. It was amazing how quickly that everybody in the room came to the agreement that in order for this to work there had to be a process solution, technology solution, but most importantly, a people solution, to make this work. That's why the patient navigator was embraced.*

A latecomer to the program, Marcia, stepped into the role of Interim Director of the Emergency Department during a period of leave for the acting director. In that time, Marcia was able to successfully implement the program which had been stalled prior to her involvement. When interviewed, she indicated that she did not experience a paradigm shift because she was already in agreement with the concept and program as shown in the comment below.

> *(Marcia, Interim Director ED) My original state of mind when we started the program was, "This is awesome, this has been needed for a long time." Immediate engagement and immediately onboard with it. Because being that nurse out in the department for many, many years and trying to manage your resources and you know that this patient is non-emergent. That it's something that could have been managed either tomorrow or with their PCP or in Urgent Care. To already have those thoughts and then to have a process (to address it) was great in my opinion.*
>
> *It was just really a fun project for me in process implementation because it was easy to engage in. We were actually providing better care for our patients. At the same time an attempt to alleviate the congestion of the ED. It was a win-win from a nursing perspective based on trying to balance the emergent and the non-emergent. Keeping one alive and one satisfied. (Marcia, Interim Director ED)*

The last group of those who did not experience a shift to agreement are two participants who had oversight of programs that did not require a paradigm shift or change in their duties to support to program. They thought it was an interesting program and they were glad to support the organization's effort, but the impact to them personally was not significant because it didn't really change much in their day-to-day lives.

Tommy was a relatively new leader in the Primary Care and Urgent Care environment. When he first came into the role, the program was already started. He participated in meetings, acted as a liaison for communication, and supported the overall program. He describes his approach as open and interested as shown below.

> *(Tommy, Urgent Care/Primary Care Administrator) My involvement in this program started right as I started my current role. And I came from a business development role into an operations role so I had a very open mindset. I didn't have any biases or anything to that effect, because everything was so new to me, essentially. I probably did experience a shift in thought or feeling after I learned more of how the Urgent Care operates and I would hear comments from providers and from administrators that certainly shaped my thoughts. But it was largely wide open to start with.*

As the manager serving between the director and a front line supervisor in the PCSC, Karen was involved on the implementation team. Karen was excited to be involved and supported the efforts of the frontline supervisor. She maintained the communication to and from the team related to her area of responsibility. Her duties for the EDPN team were not substantially different than it would be with the physician billing group or primary care scheduling groups she oversees. As a result, Karen did not experience a shift as she describes below.

> *(Karen, Manager, PCSC) I actually came on board just after a lot of the work had already been started so I wasn't part of this program from Day 1. A lot of work went into building this team up front and before we actually deployed it. So the time we went go live on that January day, then I was already involved with it, but it took so much just to get to that point. I think, for me it was really exciting and I was real motivated initially, in the very beginning.*

There were four leaders who experienced a paradigm shift to come into agreement with the program. Although all four experienced transformational change, two were more dramatic, one was more gradual change, and one experienced a later phase change.

The two leaders who experienced the dramatic transformational shift were enthusiastic and effusive about the program when interviewed. It would be difficult to find stronger advocates for the program now. Their efforts significantly impacted the success of the program but they did not start from a perspective of agreement. What is common between them is that they both experienced a transformational paradigm shift.

What is different is the willingness to entertain and explore the program when it was first presented as demonstrated in their comments more fully described below.

At the time of program launch Dr. Isabella was the Assistant Medical Director for the Emergency Department. A long-standing ED doctor, Dr. Isabella had a seen-it-all and successfully-resisted-it-all before attitude. Her shift to agreement was dramatic .

> *(Dr. Isabella, Asst. Medical Director ED) We were not going to do it. I think I told Dr. Darrell that we're going to quit. We're going to quit over this. We're not doing it. I've been in the Emergency Departments for 20 years and we can sabotage anything. I have this fond memory of me sitting with my feet up at St. Joe's and there was this administrator I hated and saying, "Well, they'll be gone. I'm just going to do what I do and they'll be gone eventually."*

> *(Dr. Isabella, Asst. Medical Director ED) So I went from I wasn't going to do it to buying in over weeks and months of negotiating to being the queen of the navigation program.*

> *(Dr. Isabella, Asst. Medical Director ED) I've had doctors who, without me prompting them when we recruited new doctors, they say, "We do this incredible thing in our Emergency Department. We navigate patients." These are the same people who were like I was. So it's interesting that now we use it as a recruiting tool. It's a pretty dramatic switch.*

Dr. Isabella's change was dramatic, in part because it was so extremely resistant in the beginning. She wanted no part of the program, believed it was ill-conceived and would never succeed.

> *(Dr. Isabella, Asst. Medical Director ED) We were told that Pres was going to do this project. I was aghast, actually. And I don't know if I said this, but I was quoted as saying "over my dead body." Basically what I said was that I can't sell this to the docs if I don't believe this so somebody better start working on getting me to believe that this is do-able. Because it's not.*

As a highly qualified emergency physician, Dr. Isabella's resistance was not because she was belligerent, as it may have appeared. Change efforts can come and go, but meaningful improvements in patient care are quite rare. Her comments below

demonstrate how she changed to agree with the fundamental way Emergency care is delivered, but also how she changed her view of the organization.

> *(Dr. Isabella, Asst. Medical Director ED) (Now) I'm way more willing to listen, be thoughtful, think it through. Where before, I think coming from the Emergency Room doctor standpoint, I was pretty black and white about how I did things and how we did things. And I think some of it was there's a huge sense of powerlessness in this big institution and in our Emergency Department.*

> *(Dr. Isabella, Asst. Medical Director ED) Having an ability to actually create change that worked was huge. Because people are always trying to do change and 90% of it doesn't work and you're still doing the same thing that you were doing. And people come and go and they hire consultants and they have projects and people come in and it's all the same. And you'll hear that all the time here. I think to be part of something that worked was very exciting. It makes me more willing to try to something else. I think, having done it, the huge amount of effort to make it work is not put into most projects and they don't work. And I think it's because of that. That it takes someone giving, you know, their first born, over and over and over again to make a project work. If you want to make a project work you have to own it, you have to believe in it. You have to eat, sleep and drink it to make it really work. And you have to get people in it.*

When asked what caused her to change her mind, Dr. Isabella's responses include descriptions that other participants also attribute as key to the effective leadership of the team that are more fully described later. Dr. Isabella's interview was especially telling because she had spent time in reflection and understood what happened to her. She openly acknowledged her transformation, knew what caused it and what the personal implications were to her career.

> *(Dr. Isabella, Asst. Medical Director ED) It probably it surprised me more than anything how I came around. I think a lot of it had to do with the Core Team with how they dealt with us.*

> *(Dr. Isabella, Asst. Medical Director ED) The team got it that they had to work with us or it wasn't going to work. I think they understood that they had to have that buy in from us - Dr. Darrell and me and the nurse administrator, who probably never bought in. And then it was sort of our role to get buy-in from the docs. And they helped us with that. They tried*

> *to have barriers, but we saw through that. So we (Dr. Darrell and I) were dogmatic about it like, "The physicians won't do it if you do this." They kept saying, "Ok, so we'll do that." So they not really capitulated, but they heard. Because we were experts on our positions. I felt like they listened.*

When asked if her participation in the project affected her adaptability in general, Dr. Isabella's response was:

> *(Dr. Isabella, Asst. Medical Director ED) It's not too big to say it's because of this project. It may be this project and it may be Dr. Mike. Because I met Dr. Mike because of this project. It totally changed my career. I went from a working Emergency Department Physician, to an Assistant Medical Director to a full-time physician administrator. It's almost too strong to say it's because of this project, but that's sort of where that happened. I've completely switched career paths essentially.*
>
> *(Dr. Isabella, Asst. Medical Director ED) I'm now the director for Case Management. After the navigation program, after he (Dr. Mike) moved on, he hired me to do his job. I ended up taking his job, which I had no experience in. I'm (also) the medical director for the Transfer Center. What I tell people is he comes up with the ideas, somehow I'm the one who has to make it all work.*

By contrast, Barb didn't object to the program when she was presented with it. She quickly came into agreement with the idea. She was a Customer Service Representative (CSR) with a reputation for putting the customer first. When she was approached to explore the role of the navigator, her decision was an easy and quick, "Yes." She was transformed by the experience in the Emergency Room. What she came to understand about the customers she was serving changed her view of her role to be more compassionate and less judgmental as her comments below demonstrate.

> *(Barb, Supervisor PCSC) When we first started it was a pilot program. I'm like, "You want me to be a part of this group? Sure. I'm up for a change. If it gets me off the phones it's awesome - not knowing what I was walking into." Five PCSC reps were chosen from different units within the PCSC. There were two from Scheduling, there was one from Health Plan Services, and there was one who managed the Manage Growth piece of the process from our department and then I was from Patient Financial Services. It was maybe six months into the program, I became a*

> *supervisor. I didn't realize the seriousness and how much we would change the culture in the ER. I think being in that leader role I learned that early on and how important this was...this was special. This was changing culture as we knew it. My director had been a mentor to me. I had it in my mind that there was no way I was going to let him down. And then when I knew how big and special this project was and how many stakeholders were there. I was going to do whatever it took to make this work.*
>
> *(Barb, Supervisor PCSC) This was a big change in the ER. You're talking about a clerical type of position living in the clinical world and it was not accepted. Our background is customer service. We've been here for a long time but we've only provided that service over the phone. It's a totally different experience. We're on the front lines now. We're dealing with patients who were feeling sick and we've never experienced that before. So when we walk them through the process and we get them to where they need to be it's just that sense of helping these patients get to where they need to be. It's like social work, in a way.*

After being asked if she experienced a shift her thoughts, feelings and/or actions, Barb compared her previous view of customer service to how she sees her role now.

> *(Barb, Supervisor PCSC) "Presbyterian provided you a service and we're billing you because your insurance left you this responsibility. How can I help you pay that? This is still your balance. We provided you a service." To me this is a business. "You received your services now you've got to pay us for the services we provided to you." After knowing what walks in and out of the ER - it's a whole different type of customer service that I want to provide to these people. Whether it be a person who is financially stable to a patient who is sleeping under the bridge tonight. It's not just about medical care anymore. It's about helping that person. I don't pass judgment on a patient who could be drug-seeking or who actually really needs to be there. I mean, we see everything. Everybody deserves the same respect regardless of what issues they're going through.*
>
> *(Barb, Supervisor PCSC) I think it was just the whole thing. Being in that environment. Because you see so many different things, the patient just had a baby in the parking lot to somebody coding in the ER and their family grieving. From one extreme to the next. I think it's changed me. And my team.*

As the Medical Director of the Emergency Department, Dr. Darrell, shifted to agreement more gradually. A thoughtful leader, who made it a practice to listen and respond to the physicians, he was being asked to change everything he believed about

how to deliver emergency care. His comments below demonstrate how he learned how to take what he already valued and apply it in a very high-consequence situation. As a result, he came to agreement with the program and is maintaining successful implementation.

> *(Dr. Darrell, Medical Director ED) The role that I played initially was one of a skeptic. In the explanation of the whole process, it became clear that not only was it the right thing to do because we need to make it an affordable and sustainable model, but also the fact that there was a lot of willingness to listen to concerns.*

> *(Dr. Darrell, Medical Director ED) I was surprised by the willingness of Dr. Mike and Linda to listen to our ideas, to understand and to say they accept that if we can't get this in place, for instance if the navigators could not get our patients seen within 12-24 hours, then the whole program would be put on hold. We had a tremendous amount of input, a lot of ability to stop the program - essentially pull the cord and stop the line - if there was a safety issue. That has never, never happened before. They would say here's a program and if there's a problem we'll try to adjust and try to work with it but it will continue. What (this) did was give us control. It gave us the ability to say, "We're going to do this program but under these conditions and if these conditions aren't met, then we can stop the program until they are fixed. That's what enabled...control that I don't think has been there before. There was comfort in knowing that there was a safety valve. That allows you to do a lot more, I think, with pushing people out of their comfort zone when they know in their back pocket they can stop it if they need to.*

> *(Dr. Darrell, Medical Director ED) Prior experience with other programs, where you've had the flavor of the month and you bust your butt and it's quickly forgotten about. We've never been listened to, we've never really had a significant impact on how a program is developed, we're never really brought in early on in the process.*

Dr. Darrell's role became important to give a voice to the providers and to be able to convey concerns and barriers to the leadership team. His ability to articulate the issues in language for both staff and leadership was critical to the team's ability to address the concerns because he fully understood what was at stake for the physicians as well as the organization as shown below.

> *(Dr. Darrell, Medical Director ED) So with that background (flavor of the month) why would this be any different? On top of that, here's this risk - you're actually not going to treat patients. Well, we got into medicine to treat patients. So there was significant risk in my mind in doing that: the safety of the patent, safety of the provider. If you have a physician that ends up in litigation, the impact of that is so significant on every aspect of their life. In their personal life, there's self doubt, there's worry, anxiety, am I going to miss something again? All sorts of stuff. But then there's the work environment. For the next 3-5 years, they're going to cost so much more because of the work up their going to do on every patient because they're worried about litigation. To the point that they're going to order tests that aren't medically necessary because they're going to be worried about the slimmest chance that there might be something going on. It decreases your efficiency. It's huge. So when I say it's a risk to the physician, it's a lot of caveats in there.*

> *(Dr. Darrell, Medical Director ED) When we first implemented the program, for the first 3-6 weeks, we said, "We have this program and this is not considered an emergency. I'm going to treat you this time, but understand that in the future, this is not the appropriate way. I'm going to send you to the navigator who's going to help you get into an appointment." That helped us with some for the frequent flyers to help get them into the program. But it also helped us, more importantly I think, ease ourselves into the dialog with the patient to help them understand the rationale for that.*

Because of his involvement in the program, he was able to see how the program progressed from the very beginning through the implementation which he continues to manage. He describes his transformation as gradual.

> *(Dr. Darrell, Medical Director ED) I don't think it was one thing. I think it was the cumulative effect of all those things. But if you had to nail it down to one thing, I think it was that we were heard and our concerns were addressed. That's a distinction from all the other programs. If you already have your ideas and you're not going to listen and if you're just going to push it forward, I'd rather you just push it forward and not bring me along and make think that I'm going to have some sort of input. But when I actually see things shifting because of different things that I would say, then you come to realize that this is different and it piques your interest, but it also gains your trust.*

The director of the Emergency Department, Denise, openly supported the program during the interview, even to the point of giving a presentation at a conference

on the success of the program in the weeks just prior to the interview. She had been away from the program for more than 6 months, having moved to another job with the organization away from the Emergency Department after having been in leadership there for more than 20 years. Her responses represented a combination of a complete paradigm change with hints of underlying concerns that did not appear to be resolved.

> *(Denise, Director ED) I think that we made some good changes. It's definitely something that we'd never done before. It really did push the limits of tolerability - I don't know if that's a word, but - acceptance as far as providers and nursing staff, particularly in the Emergency Department, being comfortable sending patients elsewhere. We did a lot of checks and balances.*

> *(Denise, Director ED) We did a very extensive risk analysis and risk mitigation plan. We thought up every scenario you could possibly think of which was very time-intense. It was very tedious. Some people thought that we were just stalling and borrowing trouble. But in the end when we all met to talk about we did and were glad we did. That's one of the things that we did. Because we were able to avoid any bad outcomes with patients and had mitigation plans in place if something would happen.*

> *(Denise, Director ED) So the changes that we put in, we knew that if there was poor outcome, we could stop the line right there and re-evaluate. And that ability to stop that was at the level of the charge nurse. So people felt comfortable with being able to keep it safe for patients.*

> *(Denise, Director ED) The changes that we made really embraced the integrated healthcare system that we're a part of. I truly believe that this would not have been possible if we did not have an integrated healthcare system to work with because we were able to work with Finance. We were able to work with the Health Plan. We were able to work with PMG. You know all those different parts of the organization were able to pull together to help pull this off. And to make it work. And again, I believe it was the right thing to do. I really do believe it was the right thing to do.*

When asked if something specific influenced her decision to make the paradigm shift she identified several things that influenced the shift for her shown below.

> *(Denise, Director ED) I think that one thing that was different was that (the CEO), from the very beginning, challenged us with this project. When we came back to him with our suggested solution, he embraced that*

and supported that and made it very clear that all the other leaders would support that as well. And that we as an organization would move forward using our integrated health care system to be able to make this happen.

(Denise, Director ED) I think one of the big changes for me was the conversation I had with Dr. Mike when we were able to reach consensus and agreement on who was going to do the medical screening exam. That was an incredibly important piece and the project was either going to fail or succeed based on that. That was such a huge, huge patient safety issue. And also it was going to (decide if it would) fly with the nursing staff and the providers. So to be able to work that through wasn't easy. Dr. Mike and I had a mutual respect. It was sort of a running joke that he's an ER doc and I'm an ER nurse and so we're not going to agree on some things. Which is true and part of the reason we don't is because nurses tend to be extremely patient centered - not that physicians aren't, but sometimes (nurses are) almost to a fault.

(Denise, Director ED) That was a big change to be able to see that it wasn't it all predetermined and that there was room for negotiation and that when folks could sit back and listen to each other. Sometimes it was hard to listen because part of the issue on this team is that you have non-clinical people and clinical people and one is from Mars and one is from Venus. And often times to get across that communication gap was difficult because sometimes clinical people come off being emotional and you know, not having a lot of data to support what they're saying, but they know it's the right thing and they feel it's the right thing, versus someone who's used to counting numbers and dollars.

(Denise, Director ED) Being able to bring some life into those numbers - looking at that list of acuity codes that we should be able to navigate - going through those one by one and saying, "This is the person that's got a broken ankle and can't walk on it. They've got to have it splinted. They've got to have crutches." I mean sure it's a low acuity code, but you can't send them without treating them. Bringing some of those things to life and saying, "Sure I can send someone that's got burning with urination out for 12 to 24 hours. I'll be miserable, but I can do it." But the other thing was to have the physicians involved, too. Both on the primary care side and the ED side too, to carry that through.

(Denise, Director ED) I think that the trust developed. As we worked together that we were really trying to solve it together. And where for me that trust really melded was when we did the risk mitigation plans. And we'd go to (senior leaders), and say, "Okay, this is what could happen. Are you willing to go to the mat for this?" Are you willing to risk a $50,000 EMTALA fine. And (they'd say) "Yep", so (I'd say), "Ok." So that's the level it was at for some of these decisions. "Are you willing to

deal with a Department of Health complaint?" (They'd say), "Yep." To see that and know that and work through that they were interested in patient safety as much as we were and willing to make it work as much as we were.

(Denise, Director ED) The key thing is that it was the right thing to do for our patients. Because it's getting them to the most appropriate venue of care. And by appropriate, I mean, cost effective. But also where they can get the kind of care, continuity of care, preventive health care. Some of them didn't even know that they need it. And they've never had that level of care before where they had that relationship. I really think the key to this success is the ability to improve the care. And that sounds kind of funny, but by navigating away from the ED, we have improved their care, but we have.

While the direct responses to questions about shifting were affirmative, there were other comments throughout the interview that indicated lingering concerns that didn't appear to be resolved at the time of the interview.

(Denise, Director ED) I don't know that I feel that I received the level of support from my direct leaders as far as the time commitment. On the surface it was given there, but there was no decrease in expectations of what I was supposed to do with other stuff. At times (I) was called out for not being at something when it was because I was doing this.

(Denise, Director ED) There was a hidden agenda that I was trying to figure out what was really going on. And I think it was very uncomfortable because we were told that this would not be a data-driven process. And it was like, "What do you mean? This is Presbyterian. It's not going to be data driven? We have to use data to go to the bathroom around here." And that we would not be using any of our typical process improvement. We wouldn't be using Lean, we wouldn't be using 6 Sigma. We wouldn't necessarily be doing PDSA. We were just going to go do this. Because we were under a strict time frame and we just needed to get it done.

(Denise, Director ED) So that made a lot of us nervous, me included, because it was like, how are you going to know that we're going to do the right thing? We're just going to make something up? How do you know it's really the right thing to do? But I also think, that being said, the importance of what we needed to accomplish was very clear. I think that the urgency and the need for change that was very clear going in. Probably more clear for this project than for any other project I'd worked on.

When describing the leadership characteristics she demonstrated, Denise did not mention adaptability, even though there were follow up questions about it. She was silent when discussing adaptability as being a component of her personal leadership repertoire. She discussed other characteristics she did possess, but perhaps most telling was that she did not appear to believe she was adaptable.

When asked what they believe caused the shift in agreement for themselves or others, the role of trust, the team itself, communication, and patient care as the focus. These themes are very interrelated and often appear in the interview quotes together; however; each theme represents important ways in which project success was achieved and are discussed separately here to highlight the importance of each. Percentages reported are the descriptive statistics representing the number of times statements received the code identified. The totals exceed 100% because many single comments contain a reference to more than one of these themes.

Trust. The trust that participants describe was telling and pointed to the leadership of the effort. When asked why they or others shifted, participants pointed to trust in 55% of their comments.

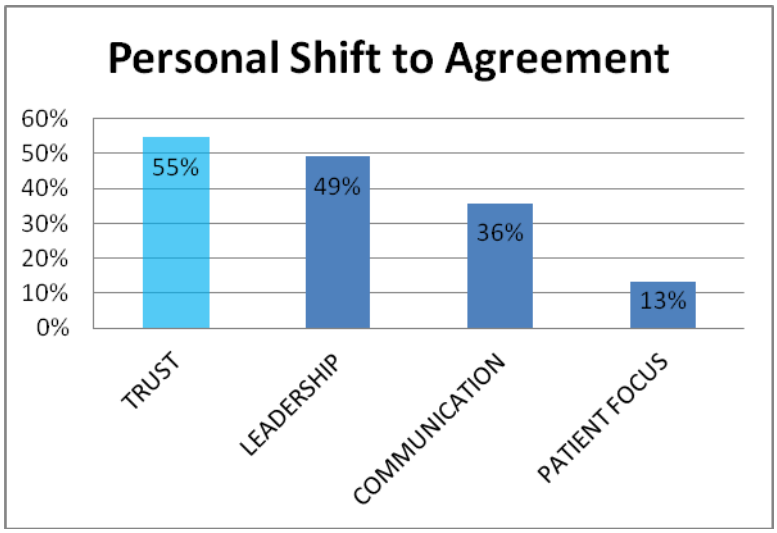


Figure 4: Trust

Trust played a critical role for the leaders. Although they described a number of different reasons for why they came to trust the project and the leaders, participants could describe with great clarity the role that trust played to themselves personally, the importance of trust to the success of the project, and how it critical it was for staff. A sample of their comments are below.

> *(Denise, Director ED) I think that the trust developed. As we worked together we were really trying to solve it together.*
>
> *(Dr. Darrell, Medical Director ED) When I actually see things shifting because of different things that I would say, then you come to realize that this is different and it piques your interest, but it also gains your trust.*
>
> *(Dr. Mike, Executive Medical Director) It's taking time, but they had to see it happen. They didn't trust the system there are other reasons they just didn't trust the system from historical reasons or past experience here and elsewhere that people say one thing then things flip and things turn or people leave. We had to gain their trust by being there every time there was an issue or problem.*
>
> *(Linda, VP ICS) How you communicate to the physicians, if you rely on our standard mechanisms, it doesn't work. One of the things we learned is that we will not rely on anyone else to go talk to the doctors. And there was something where we relied on someone else and it was a disaster and we said we're going to go back to doing it ourselves. I think it's the personal touch. I think it's really knowing a lot about what you're*

explaining to them. I couldn't do it without having a physician partner. He really is the face for the physicians. And that really makes a difference because I can't talk to them in the same way. He can say things I could never say and he can challenge things I could never challenge. So when we talk about communicating we try to fit it in a bin that seems like we have a goal of getting something done by X and we only have this date and we can communicate and we may not know enough about it and we're trying to rush things. I think that because we're in meetings so much that we're not available to people. Not really. We're just in meetings all day long. And so that communication that you get by being out - it doesn't really happen in the same way.

(Linda, VP ICS) The easy thing to say is "it's not affecting you and the data shows it." The hard thing to do is to pull all the data and go out and say, "Ok, this is what it really is." It took a lot of extra time to do that. And I think our normal tendency is to say, "It's not really impacting you" or we really wouldn't address it at all. We'd say we don't see it so we're just going to ignore it. But by going out and sitting down with them and looking at the data and taking all that extra time, it just kind of deflates the emotion around it.

(Dr. Mike, Executive Medical Director) Unfortunately there hasn't been a lot of trust for a lot of reasons. Most emergency physicians don't trust organizations and large administrations because they usually are the ones that get all the issues when things don't work in an Emergency department. I think the key is that you will support them and if they say something isn't working that they recognize it the same way I recognize that administration had my back and that we will have their back. How do you build that? You sit down talk to them and give them your examples. When they bring up issues, you address them in real time, you don't wait 24 or 48 hours you walk down that day (and say,) "I got your thing. It is going to take me a couple of days to get back to you on this, let me look into it." Or, "I disagree, let's talk about it and understand what your issue is. I am not appreciating your issue. Let me understand it so I can address it." If you let things go a week or 2 or 3 weeks it just smolders and it becomes, "These guys don't care." Whatever that issue is, it is 100 times worse and then it becomes that much more to address it. Dealing with things in real time is critical to gain trust as well as to deal with problems.

(Dr. Darrell, Medical Director ED) We've all gotten to know some of the deep seated feelings of physicians. Late adopters and why late adopters and getting through those dialogs and why do you think it's not the right thing to do and let's think about different ways to approach this. Your fears. At that level, that develops a level of trust between the two that are having that conversation. So that gets them to understand that I'm the type of leader that I am. And builds the bonds of trust so that in future

programs they know where I stand and what I'll do to back them up. I think that's significant.

Leadership. The team composition was unusual by Presbyterian standards. This project was started by four highly-skilled, deeply-experienced, and like-minded experts. These four were the founding leaders of the Integrated Care Solutions team which was chartered to develop solutions to difficult organizational problems to deliver better care and reduce costs overall. The subject of this study was the first project they undertook to meet that objective.

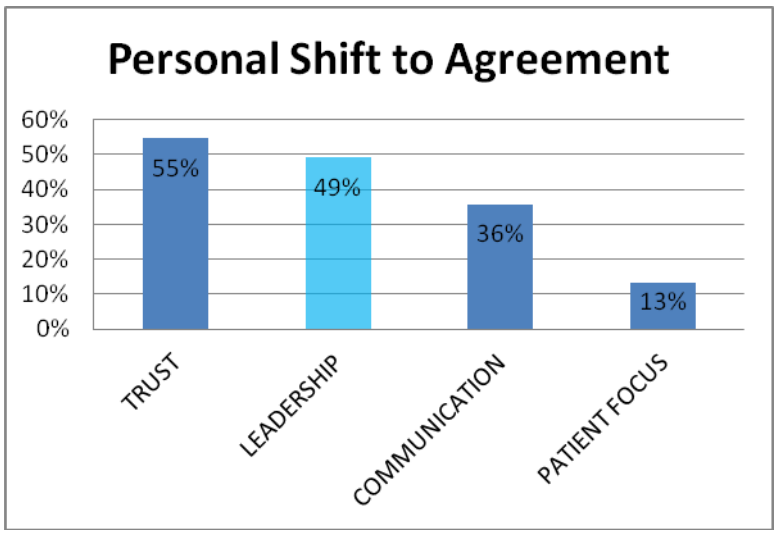


Figure 5: Leadership

When asked why they or others shifted, participants described the team as a driver in 49% of their comments. Themes that relate to the team leadership include the strength of the four originating team members, the role of data, the role of process, speed and enterprise representation.

(Sharon, Project Manager) I would say that selection of leaders to sponsor the project was probably number one - and continues to be - the biggest decision. Dr. Mike and Linda demonstrated sponsorship in every sense of the word. That was important. They were working leaders. They were present. They participated. They understood the clinical and business issues.

(Joe, Director PCSC) I've worked on other programs that involve clinical staff and changing the work flow in the clinical setting. If you don't have physician engagement - which I think was one of the key aspects to the success of the program was having a business leader and a physician leader.

(Linda, VP ICS) I think being successful gave us, not just members of the team, but others, a lot more confidence in really challenging some of the pre-conceived notions around regulatory requirements and other things. So we push a lot more and research a lot more on our own. And then I think it really freed up the providers to say, we don't have to do this (treat patients in the ED). You know there is an alternative way. Seeing the possibilities and seeing all those barriers we create for ourselves can really be removed if we choose to do it. How we approach this type of change is different now.

Delivering health care generates a phenomenal amount of data in complex and sometimes inaccessible systems. In previous projects, data was primary used after the fact and not available in the ways that helped to support a change effort. The role data played in the leadership of this project was that it was available in real time and to those who needed it. It met a statistical rigor that could be trusted as accurate and was verified as appropriate from a clinical perspective.

(Dr. Isabella, Asst. Medical Director ED) It takes a huge amount of effort and then you have support people to make a project work. So that team, more than any team I've ever had, are smart in their support people. I never did data. I don't do data. I hate data. And now I don't do anything without Phil. To have data, to understand how important data was, to have project managers, to have people run meetings, all that support that I had never knew existed and never had was huge. The team Dr. Mike and Linda have created, that's big. You know I didn't have to run the meetings, I didn't have to take the minutes. I don't have to worry about every detail. That's huge as a leader. So it takes an enormous amount of work as a leader and an enormous amount of support. And good support. The first time I gave a navigation talk I called and someone gave me the PowerPoint and I almost passed out like I had no idea that you could have support and someone would call where you went and they'd put the PowerPoint up for you! Oh my God.

(Denise, Director ED) Having Phil as our Black Belt - even though it wasn't a black belt project - what he was able to accomplish with access to data, with data

collection, reports, data analysis, helping us make sense out of some of those things, and bringing in information that we wanted. Because even though it wasn't a data-driven process, we did use data. We just didn't let it slow us down.

(Denise, Director ED) Phil was very valuable in some of the initial chart reviews because there was a lot of tedious work involved in this project. I don't know - I can't even tell you how many patients we navigated. He went back and looked at every single one of those patients, their chart. (He) even looked at days of patients to see if we missed anybody that we could have navigated to give feedback on his statistical analysis of how patients did we really navigate and where are our opportunities.

(Dr. Isabella, Asst. Medical Director ED) A good example was that Primary Care docs said it's really going increase our no-show rate. Because they aren't going to show up. So Phil collected data and found out that 75% of the time these patients do show up. They have a lower no-show rate than regular patients. So that's an example of that he was able to do.

(Denise, Director ED) Their information allowed us to say, yes we do have access. And we are sending X number of patients, and we're not overloading Urgent Care with all these patients. So having that data, considering we didn't have an electronic medical record, we were getting data that's 24 hours old. And docs were getting them weekly. When you consider how un-automated we are, that was really remarkable.

(Joe, Director PCSC) We thought we knew (why patients come to the ED) - because they're lazy, uneducated, don't want to go to take the time to get established with a Primary Care physician - so all these assumptions that the ED is just being used out of convenience. What we came to discover was that our own processes and structure and systems within the organization actually was driving behavior of the patients to go to the ED. You're dealing with someone that's a parent of 2 children that works a job from 8 in the morning to 6 at night and is being told that if you take off from work that you're not going to have a job, where else is that parent going to present? I often go back to one of the CEOs comments that we cannot do better than our community as Presbyterian - meaning that we have to make sure that we are really meeting the needs of the community and for me it just highlighted looking at all the reasons people were coming to the ED. I think one of the key things around this project that was so successful about the changes that we implemented was that it was that it was the first time where we really looked at the data in an intelligent way and built a very robust data collection system so that we asked every patient that we navigated or sent to the patient navigator, "Why did you come here?" And patients were very honest, they were saying, "Well, I work until 6:00 PM and I'd lose my job if I came here and

> *took time off work." " I don't have transportation to get to a primary care physician." Whatever the reason was. "I tried to get into my primary care and they told me the next appointment was going to be 8 weeks from now. I'm sorry, I need medical care now." "I don't have healthcare insurance, but I need to be seen." "My benefit for this medication is cheaper if I come in the ER as opposed to primary care physician." The navigator position is really about interviewing and determining needs and doing a needs assessment and then connecting them with resources. The benefit of doing this at a grassroots level with the patient navigators who are really customer service reps (who) understand how healthcare works and they have access to all the systems. The great thing about this is that as they were doing these interviews, they would identify something like a transportation issue. Now we buy bus passes for folks and we send them to a primary care physician and give them a bus pass to and from the primary care physician office so that they can get established. But really identifying the issue based on the customer and then (the representatives) designed the solution themselves.*

Process management is critical in the delivery of care because it enables consistent actions that have been proven to generate positive clinical outcomes. As a result, the approach to process improvement is rigorous and important to ensuring that the highest standards of quality are met. The process improvement efforts at Presbyterian had become a high priority in the years just prior to the implementation to the EDPN. Teams of process improvement experts had been assigned to study and improve processes in the delivery of care so that it was more consistent, cheaper and streamlined. A standardized approach was established and numerous improvements were made enterprise-wide. The leadership approach for the EDPN program was different in significant ways because they chose a more discontinuous approach. One way this was demonstrated was that if the tool wasn't working, they discarded it and used another tool to serve the project. This was important in the team's ability to move quickly, effectively and successfully to implementation.

> *(Sharon, Project Manager) One of the big things that as a project team was very beneficial for us was having the flexibility to change course. We*

talked about going down a different path that we didn't necessarily project on day 1. We had the flexibility within our group to address those issues whereas if you're following a very strict project management framework, or Black Belt framework, I think often times that they'll say - no that's out of scope. That's scope creep. We can't address that. We'll have to put that on the table for the next initiative. I say this as someone who in the past has followed very rigid expectations. I think that's one of the things that (we) were empowered to do - to navigate the project using the tools that best fit the situation. That also helps us in choosing the right tool for the project. The ability to choose the right tool for the situation - if you're following a project management framework and or a Black Belt project and here are your 40 steps. You can't go to number 4 until you've checked 1, 2 and 3. The ability to say, we talked about step 3 but we can move straight to 5, 6 and 7. Having the ability to tailor the tools to the needs of the effort as opposed to following a very rigid check all of these 40 boxes or you can't have a successful project. I say that consciously in the sense that structure is very important. The ability to have flexibility was very critical - to allow the structure to suit the needs.

(Denise, Director ED) Having a project manager - having Sharon - she was amazing. Absolutely amazing, but just looking at her role at keeping us on track, she was a slave driver. She was very kind, but she sent out that list and you had to update it. But she very gently kept us all on target and kept it all on time. You can imagine this group of people didn't exactly stick to the subject either because we'd all go down little rabbit holes, but having that person there that it was her responsibility to run the project to keep us on time, not only in the meeting, but also on the big timeline. She also could be our go-between with the senior leaders of the project if we needed extra time.

As momentum began to build, the speed with which the leadership team responded and addressed issues increased. Comments below by participants indicate their awareness of the importance of speed, the indicators of the speed that they recognized, and how it affected them personally.

(Phil, Black Belt) Another thing that surprised or impressed me was the speed in which we deployed. The team were really the key drivers of the initiative. There was extensive synergy amongst the 4 of us. We brought a lot of experience to the table. I did not follow the standard approach to deploying so I had more latitude and was able to utilize tools and techniques as they were needed and I didn't have to go through the same level of oversight that other projects have which allowed us to function in a more rapid fashion.

(Phil, Black Belt) (It was) more like (we) used a tool to the extent that it was needed. Once I gleaned enough information using one approach or tool, I could then take that information and move on to the next thing and then I could then progress through that. The decision that we wouldn't have green belts on the project that had to certify because then you have to cross every T and dot every I. Having experience leaders leading these processes we just did what needed to be done at the time. I think that was a critical decision point.

(Phil, Black Belt) (Knowing when to stop using the tools) absolutely allowed the speed. I remember talking to someone else with training as a black belt and showing him my timeline and he couldn't believe the speed from which we were able to go from our first kick off meeting to the pilot. It was like wow! In my mind that speaks to momentum but that also speaks to not having to use every tool in the toolbox and not having to put together PowerPoint slides to show what you did. It's the leadership, the ownership, it's the continued improvements because of their continued oversight.

(Linda, VP ICS) I actually saw the value in taking a step back. I saw value of slowing down, listening. And it doesn't mean I totally changed, but I recognize it more now than I did. I watch for it more in other projects. Presbyterian's Integrated Care model had been in place for many years, but the full force of working as an Enterprise was substantially untapped. Silos exist and little motivation to move beyond them was given. I think it was all around the physicians saying, "Well, we'll do it but only want to do it for 10 diagnoses." And my initial reaction was, "Wow you're limiting it to 10. Why would you do that? It doesn't make sense. There's a lot more stuff." I really wanted to push, push, push. They put so many restrictions on what they were willing to do. And I didn't like it and I was really pushing to have it broader. And it may have been Dr. Mike during that process that said, "I think we're just going to have to let them do this." It slowed it down to make it go faster in the end. Within a week of launching, they came back and said, "Anyone over the age 65 can be navigated." Then a couple of weeks later they said, "Anyone from (age) 5 down to 2". And then a couple of weeks later they said, "Well those 10 diagnoses, we don't want to limit to those. Just let us do them all." To listen to them, to address their needs and to slow down enough - it just accelerated. I wouldn't have predicted that. I thought we were going to fight 10 diagnoses forever.

The team was comprised of leaders representing the enterprise. The ability of the team to work well together, to understand the role and significance of other parts of the

organization to overall success of the project, and to the willingness to support each other was important. There was strong support throughout the project from senior leadership, as well, and that made an impact on the leaders in their ability to lead.

The enterprise leadership, and specifically senior leadership, was described by Linda below as critical to actually getting the program implemented successfully.

> *(Linda, VP ICS) It brought to light that it really takes senior level people to get anything to change around here. That the folks out in the field or manager level, they really can't get it to change. They should be able to, but they can't. The level that we put in, probably should not be required but it is what it is. We shouldn't have had to get involved in the types of things we had to get involved in. Barb should have been able to make things happen without having to call us saying, "I'm not getting anywhere can you guys help me?" People should have been more responsive to her needs without having to come to us. She tried and some of it she was able to do and some of it she had to come and say "Look, I'm just not getting what I need. Can you guys help?"*

Marcia describes how important it was to her that her team could handle the issues without having to call on the senior leadership to step in to solve problems.

> *(Marcia, Interim Director ED) (We used an Administrator on Call process) if a patient was really upset and dissatisfied with the process and there wasn't any way we were able to de-escalate the patient and enable them to understand that we were actually providing better care for them and getting them set up with a primary care, etc.. The staff felt supported, but also the patient (got the message) coming from a higher level. Administrators on Call are senior level leaders. It was interesting because we set up a program for night shift to have support if there was a patient that was very dissatisfied with being navigated. The Administrator on Call would be the one to) talk with the patient. I actually had a bet with (the senior hospital administrator) because I thought, you know, Nursing staff was on board. We've known this for years, I guess. I had a bet that the Administrator on Call would not get any calls from the Night Shift because I knew that my Charge Nurses were so capable in having these discussions with patients. I won. I think for the whole program initially*

> *when we implemented there was one call. One after-hours call. Just one. And it was actually a month and a half into the program initiation.*

Joe describes the team leadership as significant to supporting his ability to lead the way he believed was best.

> *(Joe, Director PCSC) We were sitting in some of these design meetings with directors, and medical directors, and CFOs a VPs, having discussions about how this needed to work. It came along at the right time in my journey of really providing leadership. Being able to voice that opinion with VPs and senior executives in the room to say, "If we want to design this right, we need to get out of our own way and let the people who are doing the work - that know, that are on the ground - design this." For me that was the really the first grassroots level employee-led initiative that I had been involved with where we really let the front line staff design the work and work together. So if something wasn't working with Registration and Patient Navigation, it wasn't directors and VPs trying to work out the issue. It was the two supervisors over the area sitting down with the staff and talking about "Hey, how do we work this out for the patients?"*

Communication. Communication was exceptional on this project. This team communicated extensively with each other, with their teams, and with other parts of the organization. When asked why they or others came to agree with the approach, participants used communication as a primary driver in 36% of their comments. A wide variety of references to communication activities that were given. They didn't delegate it to others; everyone was personally involved regardless of position or title. They didn't leave important things unsaid in meetings and then discuss it behind closed doors separately. Everything was laid out on the table and discussed openly. They used every communication vehicle available to them extensively, fully, and frequently. They valued hearing from employees to such a high degree that they conducted extensive meetings allowing any and all concerns to be brought forward. These concerns were included into a Risk Mitigation Plan. The Risk Mitigation Plan demonstrated the willingness of leaders

to listen to everyone and anyone. Transparency, frequency, involvement at all levels, use of all communication tools and the Risk Mitigation Plan were all described by participants as significant, and in some cases very different from their previous experience.

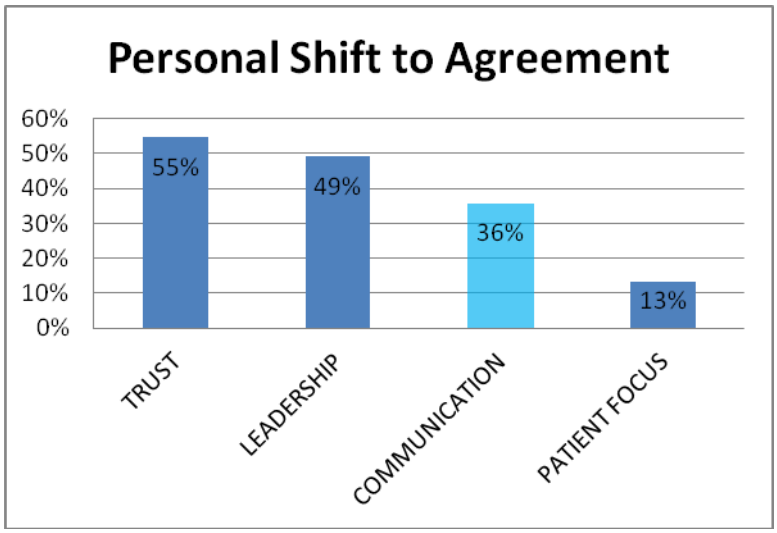


Figure 6: Communication

When asked why they came into agreement, many of the individual comments identified communication as playing the key role in their personal shift. Two critical players in the change effort were the physician leaders. The fact that they point to communication described below as the deciding factor for their change is a substantial finding.

> *(Dr. Isabella, Asst. Medical Director ED) If I had to choose one (reason) it's that we were heard and our concerns were addressed.*

> *(Dr. Darrell, Medical Director ED) In the past I'd want to say if you aren't going to use my feedback, don't waste my time, just tell me what I have to do.*

Openness and honesty characterized the communication of the team. In some cases, participants were not prepared for this level of transparency and found it at first unfamiliar and unnerving and then refreshing.

> *(Denise, Director ED) We all struggled with our own little piece of the world because we were all into each other's business. You could see the support that developed - intolerance may be a strong word - there was a not a tolerance for people saying we can't do it or we won't do it. It was figuring out together how it can work.*

> *(Joe, Director PCSC) It was not offensive, but the meetings were very candid and it was an environment where everybody was encouraged to speak up. This is one project I've been on where there were no "parking lot" discussions outside the project room. Everything was said in the room and we worked on the issues.*

The team was committed to communication because they understood the importance and value of it. One of the ways that was demonstrated was the frequency and amount of communication required of the team in early phases of developing the project as shown in the examples below.

> *(Denise, Director ED) We were meeting 16 hours a week for weeks. We lived with each other. It was incredible. I mean, we met a lot.*

> *(Linda, VP ICS) Once people feel like they're heard they become much more comfortable. Our different personalities, helped too. I think Sharon's personality allowed for a lot more dialog than my personality allowed. So a lot of times we weren't even in some of those meetings - knowing when we didn't have to be there, and letting folks who were more suited to that, do it. I see how Sharon gets things done. People love her. I couldn't get it done the way she gets things done. I don't have the patience to get it done the way she gets it done. She has the ability to listen to every possible scenario they want to throw out. All 200 of them.*

That commitment to communication carried into dialog sessions with the staff before, during and after implementation. Participants frequently mentioned their own commitment and the commitment of other leaders to the project and what it required of them personally to be willing to have the same conversations with different people, to

recognize how important it is that they be involved in it even when they are incredibly busy, and the self-management it took to remain open to it.

> *(Dr. Mike, Executive Medical Director) Sometimes you start a project and before we share (it), we have gone through iterations in our mind. And then you go to your first meeting and everyone comes up with dozens of the same questions. It's very important to recognize that we have been thinking about this for months and now we have a new group. You are going, "Man, we have already established it in our own minds and this is critical." You just need to give people the opportunity to at least voice their opinion.*

> *(Linda, VP ICS) It's amazing to me the personal energy that it takes to do this. It's really challenging because when you get under a tremendous amount of stress you really just want to default back to, "You just need to do it this way." To keep that openness that people can always come to you is really hard.*

> *(Linda, VP ICS) One of the things people say about why this was successful is all the communication we did. No wonder they (people affected by the change) don't feel like they know. The communication piece isn't the first thing we think because it takes so much extra energy. We (typically) don't value communicating and engaging as much as implementing.*

Perhaps it was because of the level of commitment the team had to communication, every participant interviewed considered communication an important part of their role. Nobody was excused from participation. The flattened hierarchical approach allowed for truly effective dialog as demonstrated in Barb's comment about being able to discuss her concerns with the team.

> *(Barb, Supervisor PCSC) I felt like my opinions mattered. I would ask my team for their feedback and what they thought. How it could work better. I was constantly asking them, "What are your barriers? What are you coming across? What are you finding difficult?" Every time I came with a barrier to what we call our core team. I would come with the barriers but I would also come with opinions of how to fix them.*

Every tool available to the team to communicate was exploited. The project was a topic at every existing meeting of any involved group, they discussed it at staff

meetings, a physician meetings, at huddles in shift changes, and they sent e-mail about changes and updates. Most importantly, they rounded. Rounding is a healthcare term used to describe one-on-one conversations between a leader and a staff member. There are prescribed things to ask, but it is intended to allow the staff member to share how things are going and allows the leader to get a first-hand view. All participants rounded on employees extensively. They also used regularly scheduled meetings to understand how things were going.

> *(Denise, Director ED) (In the Emergency Room) We brought it up at the staff meetings. We have the ED section with the docs. We included that leadership from Kaseman and Rio Rancho on the planning teams so we could start that early on. We had have huddles every shift change with the nursing staff and the charge nurses, so the huddles were a good opportunity for them to talk about what we were doing, why we were doing it. We had the white board up or flip chart up so people could write down issues at the time. We had our board in the breakout room that was the issues board where the staff could make a suggestion with their name and stuff on it and stick on the board and there'd be this suggestion and get back to them. So providing different venues for them to be able to provide feedback. And then having the docs round, too and nursing staff really helped a lot, too. (*
>
> *(Dr. Darrell, Medical Director ED) (Physician leadership to physician communications) We have 40 providers, and half of them are working any given day. A third of them are working nights, so there's a lot of difficulty with getting everyone together. A lot of e-mail communication, a lot of phone calls. A lot of face-to-face meetings with either individuals or groups. So it was trying to hit it at every level. We would have meetings - some would start at 7:00 in the morning and some would start at 9:00 at night. So you have your night doctors and just trying to be respectful. It required a lot of flexibility on my part to do that.*
>
> *(Tommy, Urgent Care/Primary Care Administrator) (Urgent Care and Emergency Room team communications) I just remember at one point that Dr. Isabella came in and talked to the providers and it was just really well received. She answered the questions just perfectly. And it gave the Urgent Care providers a chance to really express their concerns and Dr. Isabella listened carefully and addressed it appropriately. Linda, and Phil, and Dr. Darrell and Dr. Isabella were all very, very open to coming to our meetings and did in several cases.*

> *(Marcia, Interim Director ED) (Nurse leader to physician communications) I would round with the providers and the staff and find out what were their barriers were. The nursing staff, for the most part, were easier to adapt and adopt the process. (For) the providers, it was difficult because all of their training is to treat - assess and treat. So there was a major change of practice for them that was difficult. Plus they were primarily responsible for having that conversation with the patient. Which was very uncomfortable because they were essentially giving the patient the news of this is what you have, however, I'm not going to provide treatment, I'm going have you navigated to another facility at a different timeframe. That was hard for them and I completely understood that. (I was) supportive of the providers as well just to provide tips on how that conversation could occur and figuring out role models - providers that were highly capable of doing it - and finding out how they approach the patient. Giving them that opportunity to verbalize it and then (saying), "This is what some of the providers are using that seems to be working well for them that maybe you might want to try." So it seemed to work. They felt like they were supported because it was such a big practice change. Another thing that really helped: giving the bigger picture. Providers felt like they needed to treat the patient that was there, at that time rather than sending them elsewhere, we were actually doing a disservice to that patient. Using examples of not having continuity of care that these patients that potentially have frequent UTIs (Urinary Tract Infections) that really needed to be referred to a Urology physician, would not get that referral because they're seeing so many different physicians in the ED and its fragmented and the ultimate goal of actually fixing what's going on with the patient. We were actually doing the patients a disservice (not to navigate).*

In the early stages, the team began to collect the concerns expressed about what might happen and the implications. The team began to collect these risks, identify solutions to mitigate the risk, and who would take action in the event it occurred. This document was called the Risk Mitigation Plan and it played an important role in communication for many reasons. It represented being heard and that leaders were responsive to concerns and that built trust. Numerous meetings were held to allow concerns to be raised and once it was compiled it could be used by anyone, at any level, to communicate what had been heard and how concerns would be addressed.

(Phil, Black Belt) There was an extensive time period in which we did risk analysis and mitigation planning. More so than we had done in the past. It gave a voice the people who would be more critical, who were more resistant. So they had a forum to raise their concerns. We were able to put in plans to address if any of those concerns came to fruition even though the likelihood may never have been very high. So that deflated those individuals level of resistance. It also gained their support because they could say that all of these concerns that we raised were re-formulated into factual concerns, and we would have a plan in place if we weren't able to meet that need. So now we were able to get the support for those individuals. Concerns were validated and then there was a plan to mitigate.

(Phil, Black Belt) Seeing the people who were resistant become less resistant and seeing their shift - seeing how the investment in the risk analysis and mitigation activities got them to deflate their resistance to become neutral or become supportive. It was the demonstration of buy-in that I got from providers and staff. There's hidden resistance. Oftentimes it's like I'll continue with this long enough and then it'll go away. When the people who were resistant and they become the raving fans and are now out there talking to their colleagues - you know it's not a game.

(Dr. Isabella, Asst. Medical Director ED) Whether it was an EMTALA violation or "that's not how we do things in the ED" or providers will never buy in to this. We came up with different ways of approaching answers to the issues. So it was ok, let's do some scenario planning. Let's come up with all of the scenarios that we can think of for this effort of navigating patients and let's come up with solutions for them. There were a whole lot of action items around that. For example, the EMTALA violation. Let's go investigate it - talk to Legal, do some research. For all of our scenarios, we were actually able to come up with either, "No it's not valid" or "Here's a mitigation plan if this happens." So it's 2:00 in the morning and a patient comes in with her sick child, are we going to navigate? So we had answers to all of those. All of a sudden it became not the project team that said we can do that and you need to buy in. It was let's come up for solutions for a mitigation plan, and if at the end of this we can't come up with a mitigation plan, then we need to truly evaluate whether this was possible. At the end of mitigation scenario planning, there was that shift in thinking and buy in from the team about hey, this is really possible. It was the team that shifted. I think it was the way it was approached. It couldn't have been our leadership (decision) if it had been Dr. Mike or Linda (saying) "That's not an issue. We can take that off the table." It was (that they) allowed the team to come to that resolution - working through and making them responsible for coming up with those mitigation and scenario planning.

Patient Focus. The priority of the project was focused on the best outcome for the patient. The financial benefit was included, but participants never felt it was the driving force. The patient care focus was a unifying theme around which every employee could rally and the driving reason why some were willing to come into agreement with the program. A focus on financial improvements would have disengaged many providers and created resistance. Patient care had to be first - especially for the direct care givers. When asked why they or others shifted, participants used a focus on patient care as a primary driver in 13% of their comments.

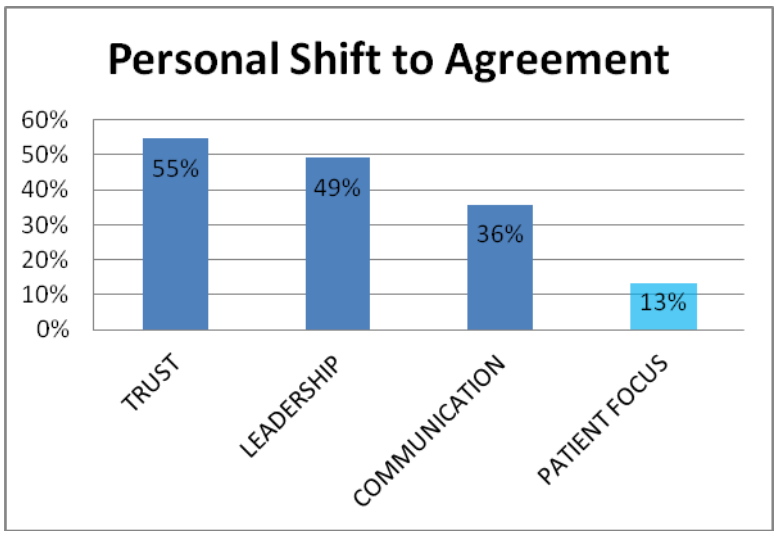


Figure 7: Patient Focus

Comments that demonstrate the importance of the focus on the patients were made by several participants and include the different perspectives each had on what it actually meant to focus on the patient first.

> *(Denise, Director ED) We started out to save $10-$15M, but we never lost sight of patient care. The goals were always the patient safety and continuity of care. Because it would have turned way too many people off. It's like, "I'm not going to listen to one more thing about money. I don't take care of patients because of money. I like to take care of patients." And you can't lose those people because there's lots and lots of those out there, thank goodness, taking care of our patients.*

(Sharon, Project Manager) Patient care was important to everyone that was involved in this effort. So it was important to me as a project manager although I don't interface directly with patients. I think we all had that common goal of we need to do what's best for the patient. We probably all came to interpret and define that differently, but people that pushed back maybe that took longer for them to understand the value or the believe in the value of the patient navigation project I think still had as the basis that patient care at the core of what's important to them.

(Barb, Supervisor PCSC) Patient care is the most important reason we do what we do, whether finance or PCSC or any other view - it's all about patient care.

(Dr. Isabella, Asst. Medical Director ED) Money had to be the afterthought. Patent Safety and continuity of care were foremost because ED providers don't take care of patients for the money.

(Dr. Mike, Executive Medical Director) If anybody asked what are you trying to do long term...making sure that patients were getting taken care of, that patients would not get injured or hurt in any way and the care would at least be equal, if not better.

(Linda, VP ICS) I learned a lot about working with physicians. Because that takes a whole different way of thinking. That you can't approach them from the money standpoint. You really have to take it back to the patient and the benefit to the patient.

(Sharon, Project Manager) (I learned) how passionate people are around patient care. It's the most important reason that we're doing what we're doing. You can look at this effort from a lot of different perspectives: from a financial perspective, from a project perspective, from a clinician standpoint, but in the end it's about how we provide care. Truly for all the different reasons that people had for pushing back in the beginning, we could all probably step back and say, patient care really comes to the top in all of that (and) how we all process that differently.

Success Factors

As with the statements made with respect to what caused a personal shift to agreement, the individual statements in this section also overlap and reflect other factors. In order to identify what contributed to the success of the program, five key success factors emerged that will be discussed here: the project brought an Enterprise solution to

bear on an entrenched national problem; leadership was involved in the trenches and modeled the behavior they wanted to see; the team made the difficult decisions when they needed to be made; the role of the Navigators was well-designed and effective; and the involvement of the physicians was compelling.

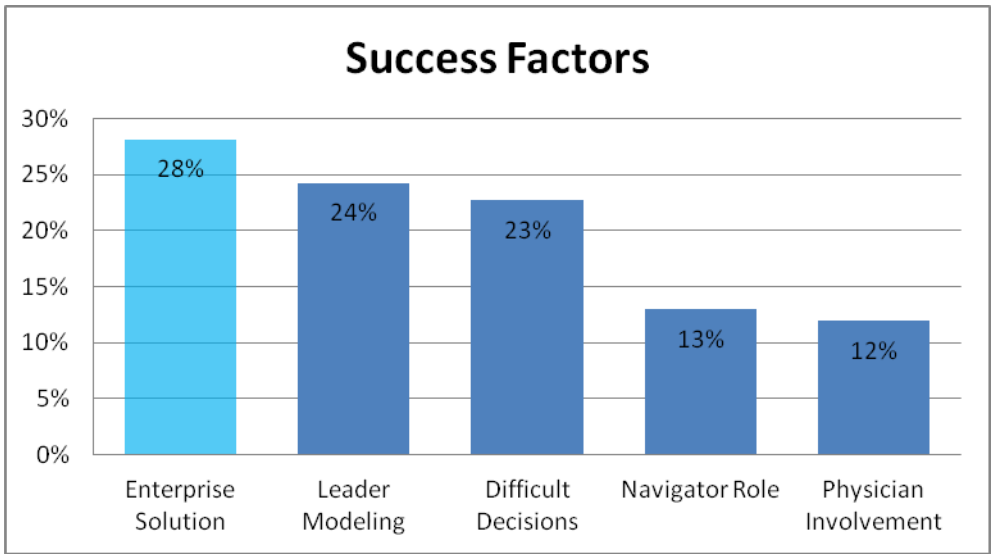


Figure 8: Enterprise Solution

Enterprise Solution. The most frequently referenced success factor was the significance of bringing the Enterprise to bear to find a solution. In past experience, leaders had been able to bring change and improvement to a certain degree, but were often unable to bring resolution to problems that were not within their span of control. Participants commented about the role of bringing the Enterprise to bear to find a solution to the problem 28% of the time when discussing what was critical to the success of the program.

Perhaps the most critical moment at which the difference in the enterprise approach of this program was at the meeting when the idea was launched. The CEO met with the team and told them that he wanted them to "make him uncomfortable". This got

their attention which almost every participant pointed to as significant to helping them to understand that there would be enterprise support.

> *(Joe, Director PCSC) The CEO set down the standard at the time that we will make this work and this will be something that is innovative, outside-the-box, that we need to make him feel uncomfortable with and so I think that set the tone. But the collaboration and the partnership has astounded me in this. Any of the detractors were addressed. We had very strong leaders over the project. When I say that we had strong leaders, I'm talking about the medical director, Dr. Mike, and from the Business Unit of Integrated Care Solutions, Linda.*

> *(Denise, Director ED) I was invited to the initial meeting by (the CEO) where he provided the challenge to transform how we change care in the Emergency Department. He gave us big invitation to make him nervous. We did. He really challenged us to do something that had never been done anywhere.*

> *(Phil, Black Belt) I requested that (The CEO) kick the meeting off. We had resistance to participation on the team. So that was elevated to (the CEO). I asked (The CEO) to kick the meeting off to give his vision and his challenge which provided impetus for participation for those who were resistant. It also elevated the project in the eyes of senior leadership in terms of expectations so that the team knew that their participation was critical and that expectations for the outcomes were very high.*

One point at which the team brought about a significant enterprise solution was regarding how clinicians were paid. Relative Value Units (RVUs) are the method used to bill for physician time. When the program was launched, some physicians were navigating less than others because there was actually a disincentive to navigate: they were paid more to treat than to navigate. This was a significant barrier that the team immediately resolved to align the financial incentives to the program expectations.

> *(Dr. Mike, Executive Medical Director) What we had to do is pay more (RVU's) for navigating a patient than to treat the patient with the same diagnosis. This was critical and that was something that was unspoken for awhile. That was one of those things that people in healthcare don't want to talk about. It's like anything in human nature - people don't want to bring that up. We had to figure out what is really going on here, why aren't people navigating? When we found out about it, we got it changed*

> *within a week which was probably has never been done in a large organization like this. That is where we told senior leadership what was going on and we need to fix it. If this (went) on for six months the program would go down the tubes. Nothing gets changed in a week, especially when it comes to payroll.*
>
> *(Linda, VP ICS) We cleared a lot of the barriers around RVUs - things that allowed physicians, staff and others to not be penalized by the results of the program. In the short term there were certain individuals or departments who saw a negative impact financially, but in the long term as an enterprise, it was something that benefited us significantly.*

The team expected that revenue was going to decline in the Emergency Department. The organizational financial gain would be realized in the Presbyterian Health Plan because they were paying less for member visits. In a demonstration of the Enterprise support of the program, the leaders negotiated a split of the financial gain between the Emergency Department and the Health Plan. This was the kind of silo-breaking effort that demonstrated the reality of the leader support available to bring about success.

> *(Denise, Director ED) The ED revenue may decrease, but the Health Plan is going to be spending less money and we're all Presbyterian and it's going to work out in the end. And you know, it did drop, the revenue in the ED. The decision to allow consequences of the decisions to play out and not be punitive - that might be a little strong term - not getting negative reinforcement. We knew going in that there were going to be things like that that would happen.*
>
> *(Dr. Mike, Executive Medical Director) Before we even pulled the trigger on this program, we sat down with all the key leaders and said to them, "You understand that the Emergency department is going to lose revenue?" "PHP is going to make more money, (it is not going to cost them as much because they're not spending it). You guys are okay about that?"*

The level of change needed for this project had not been possible with previous approaches. Without the ability to bring the enterprise to bear, the likelihood for success would have been diminished because you can only go as far

as you are able to manage within your span of control. Only an Enterprise approach with full leadership support would have worked in this project.

> *(Linda, VP ICS) (A leader) would have never said "turn people away from the ER". It's unnatural for a hospital administrator to say "let's cut my revenue by a couple hundred thousand dollars a month." You're not going to get that. The way we create some of these (process improvement) projects is that it's the business leader defining the project and getting the resource. So you don't get that kind of change. And then you don't have the leadership in the room with the clout to say, "It won't work that way, we're not going to do it that way." The Black Belt sees it but the Black Belt doesn't have the power to make it change. They can't say, "No, we're going to do it this way. We've reached that decision." Because I think they view themselves more as a support versus a driver of change. This would never have happened if we hadn't said, "No, we aren't going to do it this way." And if we had approached it the way we do a lot of other things here, all the barriers that got thrown up, we wouldn't have done it. We would have said, "Let's educate them and not (navigate)." I don't think we would have ever gotten to the place where we said we're not going to treat them. To drive of the kind of change that we need I don't think will ever come within the business unit itself. Because there are too many conflicts to get transformational change. You will get efficiency, which I think is a really critical thing, too. The role of the Black Belts in creating more efficient processes is really critical, but an example of that is the lean track. They created a more efficient solution for something that shouldn't have been happening in the first place. I don't think without Dr. Mike and I coming at it from a totally different angle we would (decide to) just eliminate it at the root.*

> *(Denise, Director ED) I think that the urgency and the need for change was very clear going in. Probably more clear for this project than for any other project I'd worked on. I actually was aware of the urgency and the need, but what I'd never had was the resources to be able to do something about it. Because it's very easy to say fix the ER, but the ER is a symptom of what's wrong in our system. And not just at Presbyterian, but in our country's healthcare system. I mean EDs have been the safety net for the community for a long time. This was the first time that the resources were placed on the table to actually be able to reach into the depths of the organization and have folks that have broader and deeper span of control than I did and actually owned those pieces that could make the changes. As a department director, I had a piece of the pie, but I didn't own a lot of the other stuff out there, nor could I impact it. It was very clear that those resources were there and that they would be called upon to help make this happen. It was very significant … throughout the project to see the support that developed.*

Leader Modeling. A fundamental component to the success of this project was the amount of leadership modeling that was involved. Leader modeling was identified as a factor of success in 209 statements, representing 24% of the comments about success factors.

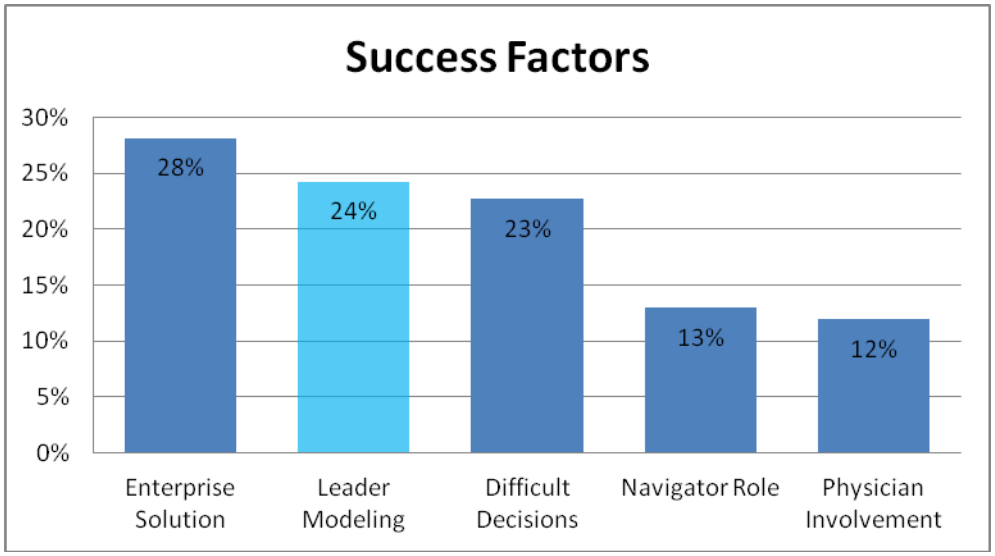


Figure 9: Leader Modeling

The leaders knew firsthand what the difficulties were and became involved in developing solutions when needed because they were experiencing it firsthand. There wasn't an arm's length distance and yet they were able to allow the front line to develop their own solutions.

> *(Linda, VP ICS) I learned that if you put really highly effective people on the team who are really committed to making it work that you just get amazing results. You can see the difference. I'll just be really frank. Joe was not going to be unsuccessful in this. He came really creative with "Let me do this. I'll take it, let me go do this. I'll come back next week and have this done." He created that navigation team. We didn't create how they did it. They created how they approached it. We didn't have to do that.*

> *(Dr. Isabella, Asst. Medical Director ED) I still work two shifts. And I don't have to. It's not like, a part of my job, but it's huge for docs. It's like you're part of a brotherhood.*

(Joe, Director PCSC) One of my cautions during this was that we were going to design the same old thing that we always got and we needed to step out of our way or else we would be our own worst enemy once again. It was a thing that came along at the right time in my journey of really providing leadership - being able to voice that opinion with VPs and senior executives in the room to say, "If we want to design this right, we need to get out of our own way and let the people who are doing the work on the ground design this."

(Barb, Supervisor PCSC) I feel that I had to play several roles. Not only managing my team as a supervisor and doing the regular supervisor stuff, you know you're late, your calling in sick. I played the role as a project manager. We came up with risks. We came up with who is this going to affect and we just kind of planned out our process. Especially when we implemented into different areas, but I also had to be the trainer. And being that we were so spread out and we were there 24/7 and people would have days off too, I would have to put in another process or we had to use another system. So I would have to actually sit there and show them how to enter into a specific system. I mean my navigators are working in today, probably 6 or 7 different systems. I also was part of the Core Team, just little ole me, little ole' supervisor with medical directors with doctors and VPs and directors. It can get a little intimidating at first. It didn't take long though (to adjust).

(Joe, Director PCSC) I worked (as a) patient navigator, but I could not work a swing shift. So I was working 12 hours overnight and coming into the office in the day. It was crazy hours. I actually did that for 2 1/2 days and then that third night it was 1:00 in the morning and I was like, "I'm done. I cannot perform this."

(Barb, Supervisor PCSC) It needed to be a team effort and everybody's opinion was important. Everybody's ideas were important. Even though I thought it may not have been such a great idea or I'm thinking no, that ain't gonna work. I had to remove that piece of me out of it and try. I didn't want to be judgmental. I didn't think this was going to work in the beginning. Especially when we got there and we were in the ER. We're just not accepted here and this is not going to work. I don't see this working. There was a lot of give and take. I'm more than willing to try something and if it's not going to work, I'll try something else. I was given that ability to do so.

(Linda, VP ICS) You have to be really committed to doing it for it to work. And it takes a lot of energy and a lot of patience and sometimes we don't allow for that here. How we started out, we changed along the way. The amount of energy and effort that it took surprised me. How difficult it is to get something done in this organization with something complicated like

this. And how, when you think you're working on one project, you actually end up having to solve a lot of other things along the way to make that one work.

(Dr. Isabella, Asst. Medical Director ED) I actually said this to (the CEO) when they wanted us to do senior leader rounding twice a week, "We rounded 3 times a day to make this (EDPN) work." You know if you want to make a project work you have to own it.

Difficult Decisions. Although it was an important factor that the Enterprise team worked together to bring solutions available within the organization to bear, another key factor was that the team did not delay or avoid making difficult decisions which represented 23% of their comments about the success of the program. They challenged themselves to really understand the EMTALA language, they decided to actually turn patients away, they used scenario planning and risk mitigation, they used a phased approach, and they spent significant time in Community organizations preparing agencies that might be affected by the change.

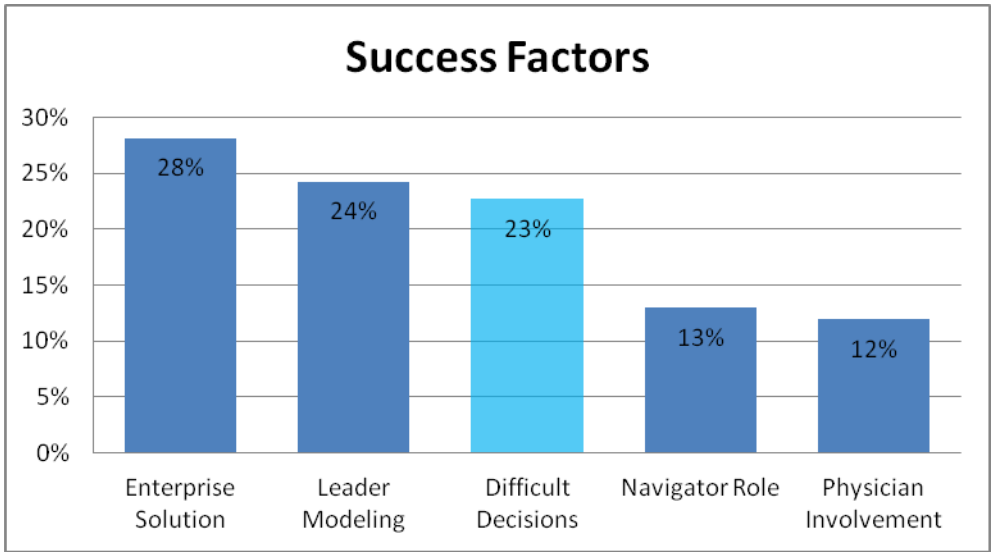


Figure 10: Difficult Decisions

A significant decision made by the team was to read the EMTALA regulations for themselves to fully understand the parameters that they were required to follow. After

this review, they decided to break from a long-standing belief upon which Emergency Departments had based their care model for more than 25 years: that Emergency Departments were required by law to treat every patient that presented there. The team determined that the regulation required a Medical Screening Exam (MSE), which they continue to provide by a physician or a mid-level provider. Treatment was not required and could, therefore, be delivered in the Primary Care setting. This was the fundamental decision upon which all the rest of the navigation program was based. The willingness of the team to view the regulations openly created the opportunity upon which the program was designed.

> *(Linda, VP ICS) Providers never really thought they could not treat. They viewed it more of a safety net, that they were not able to do that. All healthcare, not just us, really take a very black and white view of that. When we went in actually read the reg's ourselves and said, "What does this mean really?" We started asking questions. At the end then it was, "Ok, no it doesn't really mean that." I think the context was really, there isn't a way to solve this, it's just is, and we just have to keep building more and more ER capacity to take care of people that may not need to be taken care of here. We thought, well we can just educate through phone calls and outbound work that the health plan would do. We never thought about intervening at the place where the care got provided. I think that's different now. Being successful gave us, not just members of the team, but others, a lot more confidence in really challenging some of the pre-conceived notions around regulatory requirements and other things. We push a lot more and research a lot more on our own. I think it really freed up the providers to say, "We don't have to do this." You know there is an alternative way.*

> *(Denise, Director ED) The influence that having direct senior leader support and involvement in this project. They were able to remove barriers. An example is we said we have to treat patients all the same and if someone says that they don't have insurance, how can we send them to an Urgent Care when they don't have a co-pay? We can't do that. Linda and Dr. Mike said, "Ok, we'll fix that." And they did. Things like that would have not been possible if we had not had that level of leadership. They would tell us to keep on doing what we're doing - keep on planning and we'll make sure that's taken away. Same with the meeting with all the regulatory agencies, you know, Joint Commission, CMS, Department of*

> *Insurance, Department of Health. All of those bodies that could have a patient complaint or we if missed something and that could have been really serious. Three months after we went live, (we) met with the New Mexico Department of Health - our agent for CMS here in New Mexico - and gave them an update of how many patients we navigated and what the complaints were. They were very interested in what we were doing. They wanted to support us and they wanted to be prepared if there were any complaints. Because they knew as well as we did that there was a potential for some serious complaints and some serious EMTALA accusations even though we were meeting EMTALA. If an accusation is made there's this really painful process that you have to go through. Which nobody wants to do - including them. We were very proactive with them and in turn they were very proactive with us.*

When the team was investigating options, including navigation, they reached out to organizations that already had navigation programs. One organization chose to continue to treat in the Emergency Department. They kept telling the patients to go to Primary Care, but were unwilling to turn the patients away. As a result, the success of that program was greatly limited. There was no motivation for a patient to quit presenting in the Emergency Department if there were no consequences. This was a significant learning for the Presbyterian team and greatly impacted their determination to make difficult decisions as shown below.

> *(Linda, VP ICS) They were never able to do it. They had a navigator but it was more around coordination of follow up and giving materials. They never got to the place where they stopped (providing treatment). Making that decision to say we will not provide care was probably the single biggest turning point. We'll assess them and if they don't need it, we're just not going to do it (treat). There is a lot of fear about taking that step.*

Deciding to implement in a phased approach was another difficult decision. The team began introducing navigation to patients before they ever started doing it. It allowed the patients to have an opportunity to think and really understand options before they came to the Emergency Department the next time. Perhaps more importantly, however, it allowed the staff and providers to get used

to the idea of telling the patients what navigation was before they actually had to do it.

> *(Marcia, Interim Director ED) That we did it in phases was very helpful because we didn't just go from treating these patients to not treating these patients. We did it slowly to provide that education in the future. We treated, and provided education that we were making changes.*

> *(Dr. Darrell, Medical Director ED) People are understanding now that not everything has to be treated as an emergency and if it's not an emergency does it really need to be treated right away in the most expensive area? That has been the biggest change in people's minds. Getting them to understand how to communicate with the patients to help the patients understand. Here's the education, "This is not necessarily an emergency, and we think that you're better served by having continuity of care in this Primary Care setting. We're going to set you up for that. We're going to make sure there is no emergency right now." It's getting that transition going. I'll tell you when we implemented this program we also started off with post-treatment navigation for everyone, meaning to help get ourselves used to the scripting. Because you feel bad when you have someone who is like, "All I have to do is write the script and I'm done with the visit, everything's completed, but I'm going to hold off on doing that?" We started off by giving them the script and saying, "This is not really an emergency and we need you to do this." It helped ease us into it.*

> *(Denise, Director ED) I think that actually doing the phased approach was a critical decision point, because that allowed us to build trust. That allowed us to build adoption, to build safety, to build skills, to build relationships between the docs and navigators, nursing staff and navigators. I think that really enabled our success. To be able to phase it in when we went live at Kaseman and Rio because all of the docs were the same. The nursing staff was different and the patient populations were different. Although it was a little bit shorter time frame, we still did the phased approach in every facility when we went live - and that was huge. That was huge.*

The team took the initiative to take on the difficult task to ensure that everyone in the community knew about the changes in Emergency Room care they were implementing. They were transparent, proactive and thorough in their approach.

> *(Marcia, Interim Director ED) They did Public Service Announcements. Every patient that was on the Presbyterian Health Plan, Pres Health Plan, received information in the mail giving the kind of guidelines of when to*

use your Primary Care, when to use the Urgent Care, when to use the Emergency Department. I got my flyer in the mail. It was really neat, being part of the planning and to see it come to fruition.

(Denise, Director ED) We met with the other hospitals in town to tell them, "This is what we're doing, because what's going to happen is, we won't see them in our ER so they're going to come to yours." Which in the end didn't end up being the problem that we thought it was going to be. We actually were able to get access for these patients to be seen in offices or in Urgent Care. That is another thing that was sort of surprising, that you would go to your competitors and say, "Here's what we're doing and we want your support in this. In turn if you'd like us to support you, if you'd like to do a similar project, we'll be more than willing to." It went well. (A competitor) had actually been doing some (intervention, but) they really weren't doing navigation. What they were doing was bringing the patient in, (the patient would) wait, go through the process, see the doctor. The doctor would see them and say, "Sorry, you don't have an emergency. We're not going to treat you." And just send them away.

(Linda, VP ICS) When we started doing this, Denise says we've got to go meet with Healthcare for the Homeless and we've got to do this and this. It took twice as much energy to go meet with all of these groups. And my initial reaction was, "Why are we doing this?" In the end I understand why. Because it was so smooth and we never had any issues. That part of it takes a lot of time. Thinking about the community, thinking about who are all the people you need to tell what you're doing.

Finally, the decision providers and clinicians point to as extremely critical was the power to "stop the line" that was given to the front line. This authority gave clinicians a level of comfort that at no time would the safety of a patient be overridden by a decision to support the program. Some considered it a safety decision, some considered it a trust-building exercise, but several participants point to it as a critical decision that made the project successful.

(Dr. Isabella, Asst. Medical Director ED) One of the things Dr. Mike said a thousand times is, "If something doesn't go right, we stop it. That day. If it's not (right), we're going to stop right now. We're going to stop right now." I'm like okay, okay. He was pretty passionate about it. We were very much involved.

> *(Dr. Darrell, Medical Director ED) We had a tremendous amount of input in the development of the program and the implementation and the safety factors. (We have) ability to stop the program, essentially, pull the cord and stop the line if there was a safety issue that we recognized. Part of it is that we look at every re-admission that was a navigation or repeat visit to the Emergency Department or an admission from someone who was navigated. We review every case to make sure that we aren't inappropriately navigating. It's kind of our checks and balances to make sure that we're doing the right thing. That's never, never happened before. They would say here's the program and if there's a problem we'll try to adjust and try to work with it but it will continue. What it did was it gave us control. It gave us the ability to say we're going to do this program but under these conditions and if these conditions aren't met, then we can stop the program until they are fixed. Physicians feel like once it's going, it's going, and that's the way it is and there's no options. If there are problems they're just going to have deal with it. And how do you get buy in for something like that? This took care of that unknown aspect. There was a comfort in knowing that there was a safety valve. That allows you to do a lot more, I think, with pushing people out of their comfort zone when they know in their back pocket they can stop it if they need to.*
>
> *(Denise, Director ED) We knew that if there was poor outcome, we could stop the line right there and re-evaluate. And that ability to stop was at the level of the charge nurse. So people felt comfortable with being able to keep it safe for patients.*

Navigator Role. Once the team came determined that they needed navigators, they knew that the navigator role was critical to engaging the patient in the transition of the safety net of the Emergency Department, to the safety net of an integrated system. The navigator program itself was developed by a small team of frontline staff and a supervisor who were given the ability to create the system they would implement. The team was formed with enterprise Customer Service Representatives (CSRs) were from areas such as scheduling and benefits and could provide support the patients being navigated. The role of the CSR stayed fundamentally the same, but the location changed to the Emergency Room where their service was provided in-the-moment and for a different purpose: to send patients to Primary Care or Urgent Care instead of the

Emergency Department. Over the course of the program, the navigator role was developed to primarily include the following steps (See Appendix for diagram):

1. Provider confirms a non-emergent condition and refers to navigator
2. Navigator educates patient on how to utilize ED and what venue is most appropriate.
3. Navigator explains costs of treatment decision so patients understand why the approach was chosen.
4. Navigator sets up appointment within 12-24 hours to be seen for presenting condition
5. Navigator sets up assignment and appointment with primary care physician if they don't have one.
6. Navigators assist patient within parameters to get to appointment (i.e., Safe Ride, bus pass, etc.)
7. Navigator reporting system ensures patients are being seen.
8. Analysis and follow up ensure system is working as intended and patients are following instructions.

Participant comments about the importance of the navigator role to the success of the program represented 13% of the comments.

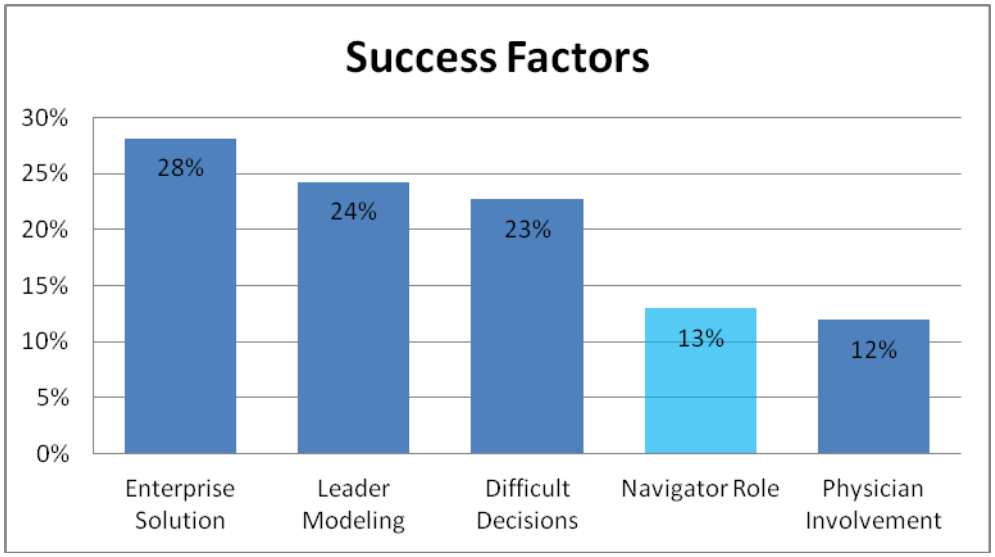


Figure 11: Navigator Role

The Navigator Role itself was developed by the front line team. By allowing the navigators to design their role, it put the decision-making in the hands of the people who

were in the best position to make judgment calls that would limit or increase success.

This was a critical decision and the navigators took that role seriously.

> *(Joe, Director PCSC) I focused on the grassroots, front line, forward facing staff who are actually closest to the issues. They often are the ones who have the innovative answers. It's increased my leadership skill because I now work at a higher level and focus on removing barriers, offering support and guidance, coaching and development and provide minimal oversight. The direct accountability remains on the supervisor, the manager, and the navigators who actually work in that department. When they have staffing issues, they have issues with the form not being completed correctly by physicians, or patients aren't getting navigating correctly, they don't bring those issues to me. They take them directly to the person that can help them make the decision and can help provide the solution.*

> *(Barb, Supervisor PCSC) This was a big change in the ER. It was not really accepted at first. You're talking about a clerical type of position living in the clinical world. And it was not accepted. They felt like they were turning patients away. It can't be done. I think now today, they're very comfortable in what (we) do. I think once we gained their trust, let them know what we were here to do, you know we weren't there to take anybody's jobs. We weren't there to fill in shoes of the provider, the nursing staff or anything like that. We just built trust. It was very uncomfortable in the beginning. We were available on the floor for any questions (before navigation started). as we got to know the staff and we were all the same. You know what I mean, we were new at this and we tried to help. (We helped staff) in their own personal journeys trying to find a medical home, assigning a primary care physician for the staff, getting them appointments next day or following day and helping them get their own situations on a personal level. Because you know there's a lot who didn't have primary care physicians. Or they would come with health plan questions. This was around enrollment time when they didn't know what plan to choose. I can remember just one story specifically of (a staff member) and his wife were trying to have a baby and they were on their own individual plans. I think they were newlyweds or something. All of this family stuff was new to them. He was asking questions about family plans - which one was best for them. He even said, "I have this huge thick (enrollment) book at home." It was actually kind of cool because (it became), "Go ask the navigator because, they'll know." "I don't know, go ask the navigator, maybe they'll know." So we were just like a walking book of knowledge from the business office.*

> *(Barb, Supervisor PCSC) We kind of put ourselves in a social worker shoes. We didn't know what kind of patients we were going to see. We*

> *expected the worst and hoped for the best. We just went over every scenario we thought we'd run into and tried to build resources that way. We talked to City of Albuquerque and their resources like senior programs, transportation programs, free healthcare programs. We talked to United Way. We talked to Human Services. Even if it didn't pertain to our program - we wanted that material.*
>
> *(Barb, Supervisor PCSC) I feel that our work in the ER is to educate our patients and understand the importance of finding a medical home. We educate them on their conditions like they present with flu-like symptoms, sore throats, very minor conditions and we educate them on what the ER should be. These are for life threatening situations. A lot of people don't even know who their doctor is and where their doctor is located. We helped them to understand when they should be using the ER. Sometimes people just don't know.*
>
> *(Dr. Isabella, Asst. Medical Director ED) We (clinicians) got to know the navigators. Then we realized that any patients we saw we could send to the navigators. So then it became this asset, like one of the doctors had a quote that "Navigators were the most important things she'd seen in her whole career in Emergency medicine and she'd be doing this for 20-25 years." She just said it was huge because you could send the patient off and know that someone's going to help them get access to our system. We wasted a lot of time doing that or we spent a lot of time and were very frustrated seeing patients who couldn't access our system. Like I said, it's far from perfect, but the navigators were huge.*

Physician Involvement. The involvement of frontline physicians in leadership was significant to the team's ability to understand the issues. There was a willingness on the part of the physicians to engage and eventually come to trust that their concerns would be heard by leadership. The physician leaders were involved in the design from the start and could visibly recognize their recommendations as the project progressed. Physician Involvement was referenced in 12% of the comments as a success factor.

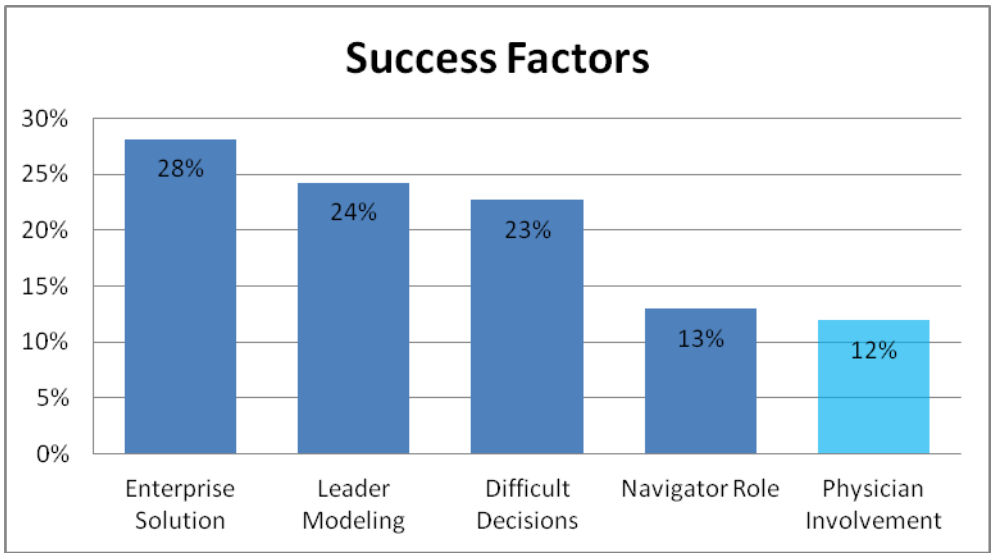


Figure 12: Physician Involvement

(Dr. Isabella, Asst. Medical Director ED) I think the first meeting was sort of top down (but) it was very clear that they wanted to listen to us. Even though it was top down, the project hadn't started. So the project started with us involved in it. Dr. Darrell and I were intimately involved with every detail of the project from the beginning. And they really did listen to us.

(Dr. Darrell, Medical Director ED) It became clear that not only was it the right thing to do because we need to make it an affordable and sustainable model, but also the fact that there was a lot of willingness of Dr. Mike and Linda to listen to the concerns and myself and my Assistant Medical Director, had in terms of making sure that all the bases were covered. And so the main concern for us was, of course, not letting any patients fall through the cracks, or not getting the appropriate treatment. That was one of our main concerns.

(Dr. Isabella, Asst. Medical Director ED) Initially, I didn't want the docs to do it. Even after the first few meetings, I said. "The docs won't do it you'll have to make the nurses do it. These guys can talk big, but we're the ones who have to do it. You know we were scared. It's great for Linda and Dr. Mike to talk about it, but it's like you're the doc with the patient in front of you and you have to somehow tell this patient that you're not going to treat them. The first month was brutal. Our first week we only navigated 3% of patients. And Dr. Mike was down my back. So ED Leadership was in the ED to talk to the docs on every shift. We took turns, three shifts a day. We came in to talk to the docs about the navigation program about what they thought of it, what were the obstacles, what were their concerns. We did that (for) a month! We had outliers. Those outliers had conversations with Dr. Mike about what their issues were.

> *Some just wouldn't do it. We talked to them, we discussed it with them. And now it's like, if you work here, this is part of what you do. And if you feel like you can't do it, then you probably can't work here. I mean that's how much of the culture it is.*
>
> *(Linda, VP ICS) How we approach this type of change, is a little bit different now in terms of how you engage the providers. I think there's lessons learned for sure with our group and I think there are lessons learned across the organization now.*
>
> *(Dr. Darrell, Medical Director ED) So we had a tremendous amount of input in the development of the program and the implementation and the safety factors. (We have) ability to stop the program, essentially, pull the cord and stop the line if there was a safety issue that we recognized. Part of it is that we look at every re-admission that was a navigation or repeat visit to the Emergency Department or an admission from someone who was navigated. We review every case to make sure that we aren't inappropriately navigating. It's kind of our checks and balances to make sure that we're doing the right thing.*

Leader Characteristics.

When given a list of characteristics that successful leaders tend to demonstrate and asked if they demonstrated any of the characteristics (see list of Questions in the Appendix), the percentage of the time participants described themselves as using the characteristics, they used statements that indicated that they were Adaptable 31%, Innovative 17%, Collaborative 16%, Optimistic 10%, Purposeful 7%, Confident 6%, Self-Assured 6%, and Proactive 6%. As each participant reflected on their role in the project and compared it to the characteristics that tend to make leaders successful, they provided examples and stories that demonstrated their belief that they demonstrated the characteristics provided. The characteristics were difficult to separate in describing how they were demonstrated and, as in the previous sections, often were described together. For purposes of highlighting the characteristics individually, they are discussed below.

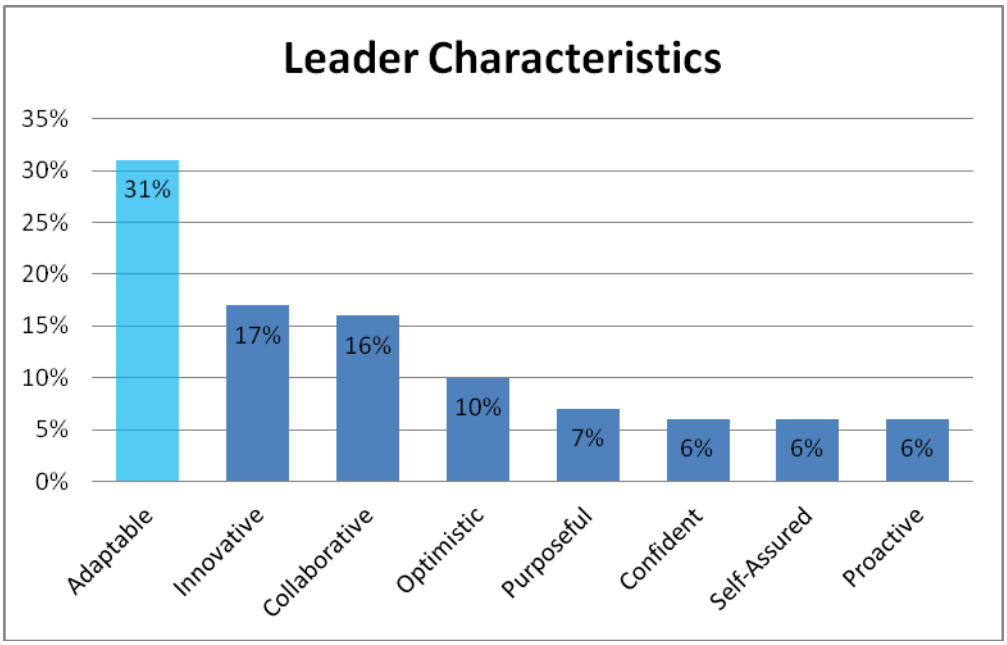


Figure 33: Adaptable

Adaptable. The characteristic most discussed was being adaptable. Participant statements of when they demonstrated adaptability represent 31% of the overall references to successful leadership characteristics. They discussed it as though they expected it of themselves and the other members of the team. They identified the importance of adaptability to the overall success of the program, and shared how they became more adaptable as a result of their participation.

> *(Sharon, Project Manager) I think that all project managers should be highly adaptable, but I guess that's probably not the case, I mean, if you're following your 40 steps and checking every box. I think our success or any success that we think we had with this, we have to attribute to being adaptable. Adapting to all of the challenges and the things that came up that we didn't project. We tried to be as purposeful as possible, however, we had to be adaptable in order to be purposeful. It (adaptability) means taking lessons learned and using those in new efforts. Trying to anticipate but acknowledging that the culture shift is huge. As much as you try to plan for the culture shift, I think it's going to be a little bit different in different situations.*
>
> *(Joe, Director PCSC) It wasn't over-structured but it had the right framework that allowed people the freedom to do the work they needed to*

> *do. My (belief about) adaptability is that anything is possible with the right leadership and the right team and the right approach.*
>
> *(Dr. Mike, Executive Medical Director) Experience is the key (to adaptability). Experience that you learn from. Some people know when to step back and some don't. Maybe I know when to step back because of being burned so many times. I learned from my mistakes - trying to understand that when we come to the table, that I have been thinking about this six months, or 25 years in this particular case, and they are coming to the table hearing concepts they have never heard. Rather than saying, "What, are you stupid?" Just hearing them. Experience that you learn from (teaches you to be adaptable), "How can I get this doc on board? What am I missing in this particular case?" It's the learning process.*
>
> *(Dr. Isabella, Asst. Medical Director ED) I probably wasn't very adaptable or I probably didn't see myself as adaptable. But fairly quickly, once presented with the facts, and once I was invited to collaborate, I think I (became adaptable).*

Innovative. The second characteristic described by participants was being innovative, with 17% of their comments reflecting the importance of it to the success of the project. This project was described in terms that considered it as a highly innovative solution, and yet the leaders did not speak extensively to this characteristic. They discussed how innovative the project was, but described their own innovative characteristics tentatively.

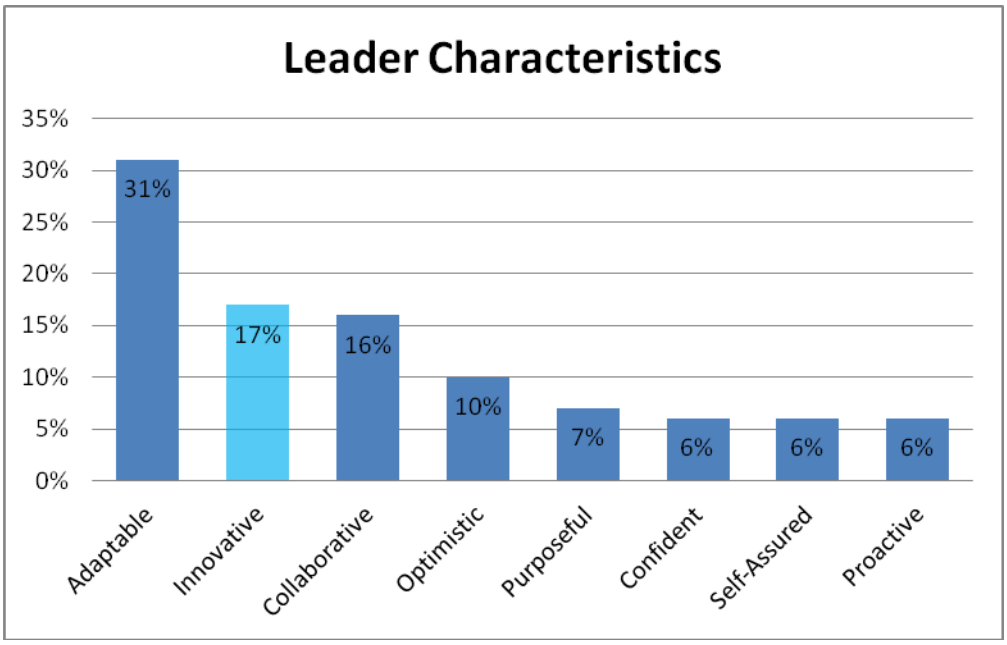


Figure 14: Innovative

(Phil, Black Belt)I think innovation requires adaptability and that's what our part of the organization has been tasked to do. To be innovative. To leverage technology to look for appropriate use of individuals to change paradigms. That's we do.

(Dr. Darrell, Medical Director ED) In terms of (being) innovative I would agree. I think that this program is one demonstration. You could look at Lean and that was very innovative. Lean is essentially an efficiency model of running the department. We're starting up a coaching program. Identifying physicians within the group that are best practice for patient satisfaction, for efficiency, for documentation, for whatever it may be and turning them into coaches for the other physicians. That's a program that I just started up. We've also started a mentoring program for physicians starting just out of residency so that they have what they need to feel solid so that you don't have people leaving the job after a year or two. And so those are some of examples of (being) more innovative.

(Joe, Director PCSC) (The program was) very innovative. We (PHS) are focused on doing the right thing for the patient, the member and the community. This was not about saving money. This was about really connecting the patient with the right venue of care so that they had better continuity of care. I (now) focus on the grassroots, front line, forward facing staff who are actually closest to the issues. Because they often are the ones who have the innovative answers.

(Denise, Director ED) You can be innovative and have it be just a little piece of something that needed solved and ding there it was. It doesn't

have to be like you changed the world. So it's being able to work within those constraints.

(Linda, VP ICS) You know it's funny the whole innovation thing. It's always interesting how we define innovation here. I wouldn't have described myself as being innovative. But I would describe myself as being kind of like a "keep it simple stupid" type. I mean, just kind of cutting out the extra stuff and saying "Why do we have to it that way?" And it's funny because people define some of the things we do as innovative. But I don't define it as innovative. I just define it as common sense, kind of like street sense. I think we get caught up in this innovation word. People perceive what we did with ED Navigation as really valuable but a lot of this efficiency stuff is really valuable, too. They're just different approaches. Somehow we need to figure out the right mix of where to focus on efficiency and where to focus on this type of change and how can we leverage more resources across the organization to affect that broader change versus such a small group doing it. How we use our resources - not letting people kind of come up with ideas for projects but letting our strategy drive the projects and making it really clear going in that we expect that kind of (transformational) change.

(Phil, Black Belt) I've never had a set of champions or process owners engaged to the degree that I had Dr. Mike and Linda. And then in turn have a team members as engaged as Dr. Isabella, Dr. Darrell, Denise, etc. I've never had that. It was more of reporting out versus communicating (in the past), because they didn't have the level of commitment or interest. Here we had, "This is truly affecting how I do my work. I'm truly interested. I want to make sure that my license isn't at risk and my patients aren't at risk." They know it's happening so they'd better get on board. It was happening because (the CEO) says, "Go out there and be innovative." So they were fully engaged. They wanted to consume the communication versus communicating because it's another thing I have to do.

Collaborative. The third leadership characteristic participants discussed was being collaborative. With 16% of their comments attributed to being collaborative, they understood the importance of working together. Participants describe their ability to collaborate as playing a critical role in their ability to lead in this program.

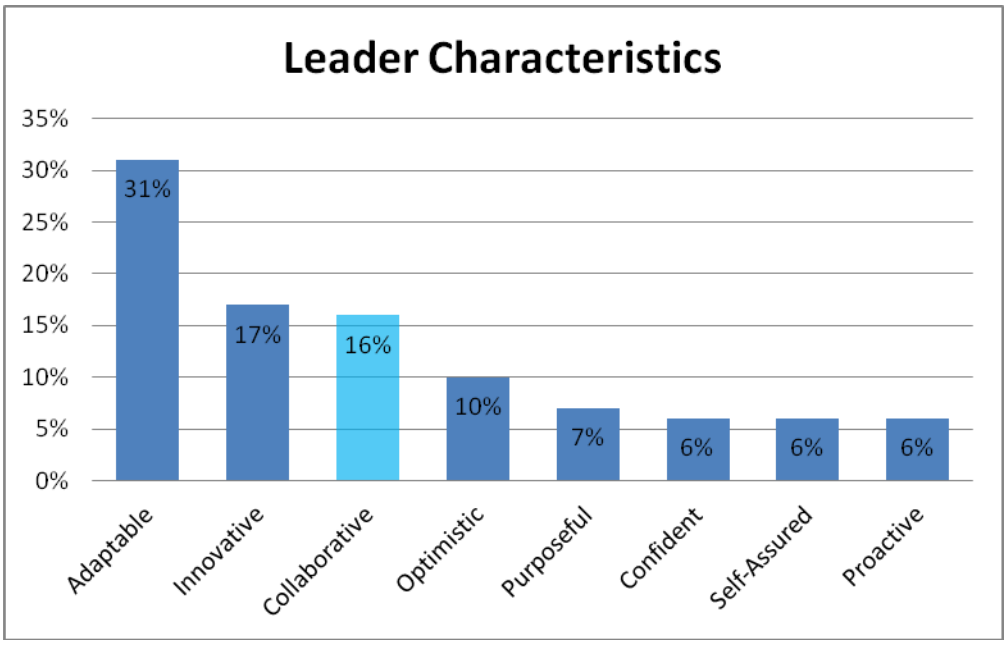


Figure 45: Collaborative

(Dr. Darrell, Medical Director ED) I do think of myself as very flexible and open minded and willing to consider all different aspects of what people are approaching me with (asking), "Does this work, does this not?" I also seek a lot of input. I'm aware that I can have my own flaws in terms of my own thought process. Maybe I'm not seeing something or I'm not communicating in terms that work for someone. I get a lot of input from people that I trust within the group - just regular physicians that I know will be honest with me and that they're passion is for good patient care. I'll seek their input as well.

(Denise, Director ED) Get to know the other people you're working with and you find out who's got strengths that you don't have and you work together and you collaborate and you build off of each other. You work together to combine those strengths because when you combine them, that's huge. You know you have a mind meld and it can be pretty awesome what a group can accomplish together - especially when they're comfortable questioning each other. When you're free to really explore and feel safe in doing that I think is the key, too. And to be able to trust.

(Dr. Isabella, Asst. Medical Director ED) I'm optimistic. I'm self-assured. I'm not innovative, to be perfectly honest. I'm not the rainmaker. I'm pretty collaborative. Doctors tend not to be collaborative at all. I think for a doctor, I'm more collaborative. Partly because as an Emergency Medicine doc you work with nurses all the time. You're not that high on the food chain - or you don't feel like you are - so you tend to be more collaborative.

Optimistic. The fourth leadership characteristic participants discussed, in 10% of their comments about leadership characteristics was being optimistic. Ten percent of their comments reflected the importance of an optimistic approach and how it helped them in the implementation of the program.

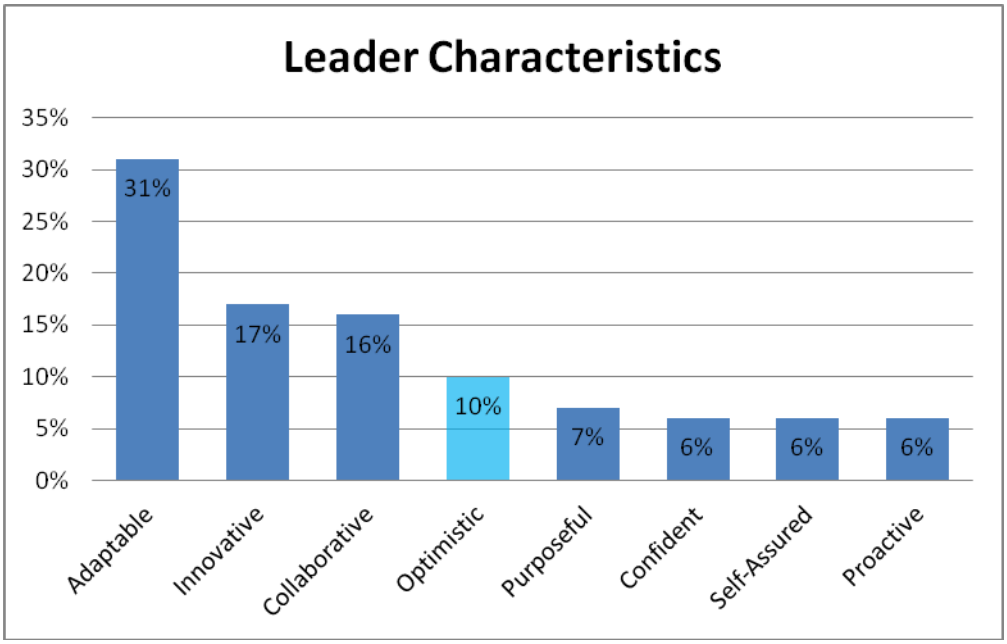


Figure 56: Optimistic

(Barb, Supervisor PCSC) Even though I had reservations in my own mind thinking, "Well I don't know if this is going to work" because of the environment and how people were reacting to us being there. I always tried to come in positive. I tried to be an example instead of having a bad attitude. I tried to come in with a good attitude no matter what kind of day I was having. No matter what barriers I personally was having. I tried not to let my team see that nor anybody on the ED staff.

(Denise, Director ED) Most of the time, I'm pretty optimistic. Because I do look on the bright side of things. I try to see the good in whatever it is.

(Joe, Director PCSC) My personality that such we are going to do it. If it can be done, we will do it. So my role, in addition to providing more of the patient navigator staff and really trying to keep from being our own worst enemy was around cheerleading and saying every reason that we could do this. More of an optimistic team member approach.

(Linda, VP ICS) I think I am pretty optimistic going in to most things. I expected that we would be successful .

Purposeful. The fifth leadership characteristic discussed was being purposeful, with 7% of their comments reflecting their perception of the importance of being purposeful. The participant's demonstration of being purposeful were primarily related to their ability to push through difficult times or times of doubt and how that helped them to succeed.

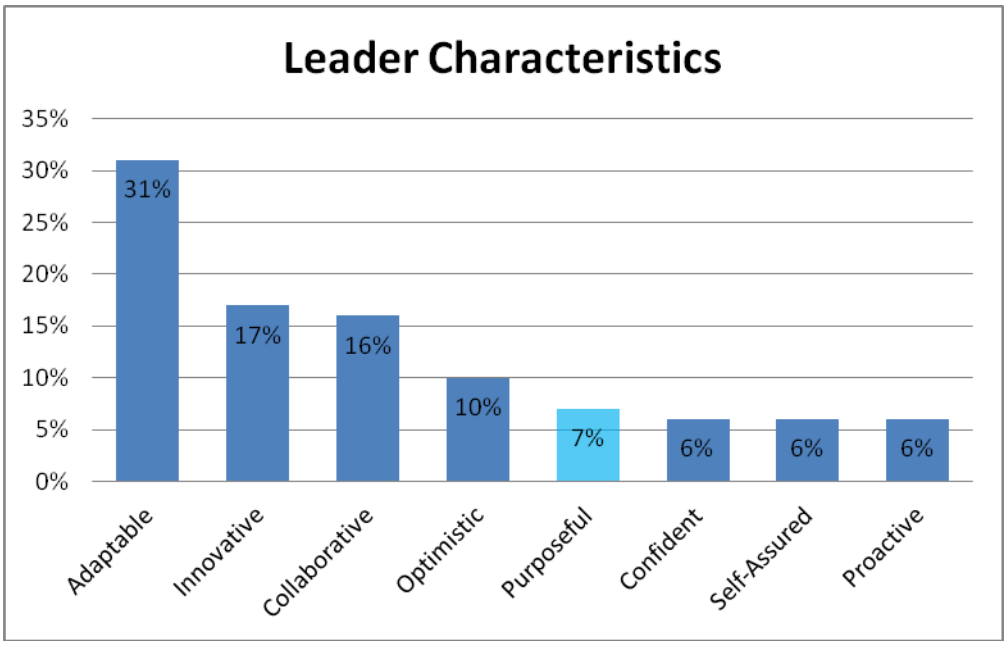


Figure 67: Purposeful

(Barb, Supervisor PCSC) One the biggest things was my director has been a mentor to me. I had it in my mind that there was no way I was going to let him down. When I knew how big and special this project was and how many stakeholders were there, I was not got going to let nobody down. I was going to do whatever it took to make this work. I had passion for this project. And I was determined to make it work.

(Dr. Mike, Executive Medical Director) Am I optimistic? I wouldn't even call it optimism. It was self-determination. It is just optimism that there is no way we are not going to make this happen. We have the support, we have the people. The most important (thing we had was that) the goal was critical: the care going to be better. I really believe it's true. It's kind of facilitating the process and make sure it moves along. The optimism was there. I mean it was optimistic in the sense that we (said), "We're doing this." We felt it was the right thing to do for patients and the organization and cost effectiveness. So we were optimistic, we were self assured. After

many hours and many weeks and days and months of discussion (there was no doubt) that this wasn't the right thing to do. I was self-assured in my belief that this was the right thing to do so there was little waffling on the concept because the concept makes total sense to me. I guess what I am saying is what works for me is I need to believe in what I am doing. I need to absolutely believe in what I am doing and if I put a program in place that I don't believe in, people see it through it immediately and I won't have the energy and fortitude and perseverance, the ability to sit down over and over again to make people to keep pushing the product or service or whatever it is you want to do. I have a purpose.

(Sharon, Project Manager) Sometimes (being) purposeful was the night before, thinking, "How are we going to facilitate this topic tomorrow?" It was a lot of work in that we didn't have a lot of time to really sit and think about it for months, it was something we wanted to keep moving. The purposeful (part) was (being) very quick.

(Joe, Director PCSC) The two areas though that I think highlighted as an opportunity for me was to be purposeful and structured. Those are two attributes that I cannot stand in my past life but I needed to understand to have a balance with that. I think seeing people on the team that have all these attributes, but also have some structure as well and the right level of structure. Really purposeful about what was being done. I think a lot of times we're on project teams, especially in the work place, where things are done as a checklist. This program was very intentional, fact-based, purposeful. Things were done in a very structured manner.

Confident, Self-Assured, and Proactive. The next three leadership characteristics tied for frequency as leaders discussed when they were confident, being self-assured, and proactive. These three characteristics were each discussed 6% of the time and often overlapped in the comments.

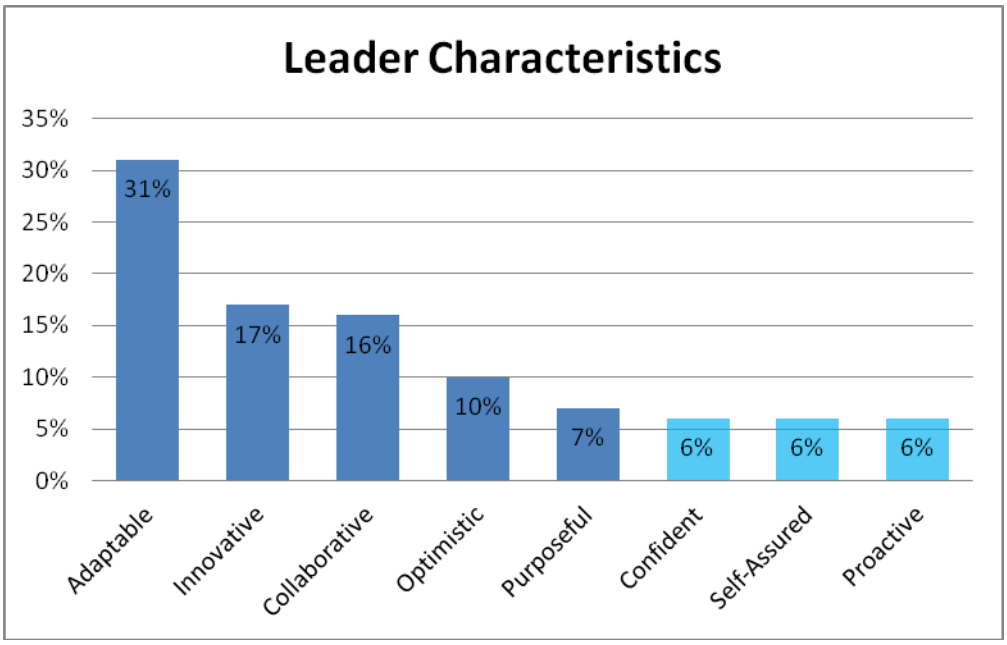


Figure 78: Confident, Self-Assured, and Proactive

Confident. Participants described their confidence as important to their ability to stay engaged and supporting their ability to make adjustments.

> *(Joe, Director PCSC) I was very optimistic. Also innovative, collaborative and proactive. Just being a can-do person and working together to get this done, let's figure out the best solution. I've always worked from an approach that it's not about me. The success is going to be in how the patients receive better care. The thing for me is self-assurance - it really helped increase my self-assurance and confidence. It really helped build upon that.*

Self-Assured. Most participants considered themselves as self-assured and attributed some component of their ability to succeed in this program as related to their self-assurance, as demonstrated by the comments of both Dr. Isabella and Denise below. Their references were tied to their long experience in an Emergency Department and reflect the battles they had already successfully endured.

> *(Denise, Director ED) I think most of the time I'm pretty self-assured. I have been doing what I do for a really long time so I've got the knowledge base of that. That helps with that. And I was comfortable with where I was in the organization. What I thought my role was.*

> *(Dr. Isabella, Asst. Medical Director ED) In terms of thinking that I'm self-assured, once I believed in it and if (doctors) disagreed just because they weren't going to do it, I was pretty willing to take them on. In leading doctors, you have to be enormously self-assured. Emergency Room docs, I mean they're brutal. Now having stepped away from them, I realize how brutal they really were. So you had to be willing to take the hits from them. And be willing to just say, "You know what? I'm willing to talk to you about it, I'm willing to make this work, but you know, this is what were going to do." Emergency medicine docs will do whatever they want. Because we all said, "We'll be here and no-one else is here at 2:00 in the morning. So I get to do whatever I want." You had to monitor that and let them know they weren't going to be able to beat you down and get their way. And once you've got your early adopters and all of that, it worked. I think being self-assured was huge.*

Proactive. Although they did not point specifically to being as proactive when asked this question, many of the interventions, communication, and efforts were undertaken with a proactive approach. One such example was Barb's comment below when she didn't wait to be told what to do, she sought out what would be needed for her team to succeed.

> *(Barb, Supervisor PCSC) I tried to be proactive with my team so if I had to step in to cover a shift and cover the navigator instead of (being) the supervisor. I tried to keep up my skill so that I was able to be efficient and effective helping them because they're the ones who are out there 12 hours a day, 24/7.*

Summary. The design of the study to allow reflection allowed the learning of the leaders to emerge and provided a wide variety of perspectives on what they learned, why it mattered to them personally or professionally and what it meant to the success of the program. Thus it can be concluded that participants were able identify and effectively answer the question "*What do leaders learn as they lead successful organizational change efforts?"*

The findings demonstrate that the participants could articulate with clarity what they learned as a result of participation in the program as they reflected on their

experience. Their comments grouped into themes that demonstrated their Personal Shift to Agreement and underscored the importance of Trust, Leadership, Communication, and Patient Focus to the ability to change form opposition to agreement. Participants validated their belief that the program was a success and could point to what they considered to be the Success Factors as an Enterprise Solution, Leader Modeling, Difficult Decisions, the Navigator Role, and Physician Involvement. Participants also clearly identified the characteristics they demonstrated that supported their ability to lead successfully as being Adaptable, Innovative, Collaborative, Optimistic, Purposeful, Confident, Self-Assured, and Proactive.

Chapter 5: Discussion

This case study set out to answer the question "*What do leaders learn as they lead successful organizational change efforts*?" As participants discussed their involvement in the Emergency Department Patient Navigation Program during the interviews, they were reflected upon their personal learning as well as what they learned and observed by watching others through the implementation of the effort. As reported in Chapter 4, the learning themes emerged in three distinct, but interrelated areas of a personal shift to agreement, success factors and leadership characteristics.

Chapter 4 describes the theme that emerged for a Personal Shift to Agreement and the themes that contributed to their paradigm shift. The themes that emerged were described as significant contributing forces are trust, leadership, communication, and a focus on the patient. Research on change, and more specifically, transformational change, is in keeping with the findings of this study.

Leading Change. Effective change leadership was critical to the success of this program. John Kotter asserts that leadership and management are distinctive yet complementary. He describes management as coping with or mitigating complexity where leadership is about coping with or making room for change (Kotter, *What Leaders Really Do*, 1990). If change efforts are championed by individuals whose focus is to manage the complexity rather than to lead through the change, it is anticipated that change effort will be less successful. This study supports Kotter's theory, and participants supported the idea that the approach was different on this dimension. Participants describe the leadership versus management approach as critical to the transformational change the effort required for a project of this size to be successful.

(Phil, Black Belt) A critical decision point (was) that we wouldn't have green belts on the project that had to certify. (Because) then you have to cross every "t" and dot every "i". Having experienced leaders, Sharon and myself, leading these processes we just did what needed to be done at the time.

(Linda, VP ICS) To drive of the kind of change that we need I don't think will ever come within the business unit itself because there's too many conflicts to get transformational change. You will get efficiency, which I think is a really critical thing too.

(Linda, VP ICS) I think we get caught up in "innovation" as what's valuable. What we did with ED Navigation was really valuable but efficiency is really valuable, too. They're just different approaches. Somehow we need to figure out the right mix of where to focus on efficiency and where to focus on this type of change and how can we leverage more resources across the organization to affect that broader change versus such a small group doing it. Not letting people come up with ideas for projects but letting our strategy drive the projects and making it really clear going in that expect that kind of (transformational) change.

The team successfully utilized Kotter's 8 steps identified as critical to success (Kotter, 1947). When discussing the approach to the study with Dr. Mike, the sponsor of the study, he described his use of Kotter's 8 steps as an important guiding framework for the program. It was not clear that the team took an intentional approach to utilize Kotter's 8 steps, but it was clear that they were all met, as described below.

1) **Establish a Sense of Urgency**: Emergency Department wait times are a national problem. Presbyterian had not be successful in implementing more than incremental changes prior to this effort. The cost of care is the most expensive option in the Emergency Department and does not offer continuity of care for patients. The sense of urgency and what needed to be done was very clear to the participants, as demonstrated by Denise's comment below.

(Denise, Director ED) The importance of what we needed to accomplish was very clear. I think that the urgency and the need for change that was very clear going in. Probably more clear for this project than for any other project I'd worked on.

2) **Forming a Powerful Guiding Coalition:** The formation of an enterprise team was new and foundational to the success of this program as identified in Chapter 4. Senior leadership supported the effort fully aware of the potential risks and the importance of staying focused. Participants had not experienced this kind of support before and tested their assumptions to ensure success, as demonstrated by Dr. Mike's comment below.

(Dr. Mike, Executive Medical Director) Before we even pulled the trigger on this program we wanted to sit down with all the key leaders and say to them," You understand that the Emergency department is going to lose revenue? PHP is going to make more money or it is not going to cost them as much. You guys are okay with that? Legal, there are issues here. We are trying something that we believe no one has done before and we might have a bad outcome. When you see 12,000 patients at some point in time there is going to be a bad outcome. It is just the way it is. Medicine is dynamic and you can't predict everything. If that was the case then you wouldn't need an ER. You would know what to do to with these patients. Are you going to support us (and) support docs on this?" Those types of things. The ability (to know that) when push comes to shove that we are not going to immediately retreat and go back to our old ways, (saying), "Let's just get rid of this thing," after it is up and running and starting to make progress. It will be bumpy at beginning and all of a sudden there will be cuts in Medicaid or something else (comes up). For me for me a critical point was to make sure everybody is hearing the same thing , and ask the question, "Are we all okay with this?"

The comments by Denise below also demonstrate what role the strength of the guiding coalition played in her learning.

(Denise, Director ED) I learned that being part of an integrated healthcare solution can be very powerful. The change you can make is phenomenal when everybody works together, has clear goals, expectations, and are all moving in the same direction. And that when

you have the right individuals at the table, at all the different levels of the project, that also makes a huge difference.

3) **Creating a Vision**. The vision without question was to create a better venue and continuity of care for the patients. Participants pointed to the clarity of the patient focus and articulated the importance of knowing the cost savings would occur, but not at the expense of the patient. Dr. Mike described the vision below.

(Dr. Mike, Executive Medical Director) Our ultimate goal needed to be crystal clear. Making sure that patients were getting taken care of was critical from the Emergency Department, critical from administration, critical across the board that patients would not get injured or hurt in any way and the care would at least be equal if not better.

4) Communicating the Vision: Communication was a significant focus as demonstrated in Chapter 4 (See also Communication Plan in the Appendix). From the very beginning, the team knew what the vision was for the final outcome. Every member of the leadership team was committed to communicating extensively whenever it was needed. When Dr. Isabella describes how she first became aware of the vision, she clearly articulates how different the vision was than the existing state prior to implementation and points to how important it was for all involved to really understand what needed to change.

(Dr. Isabella, Asst. Medical Director ED) In the Emergency Department, we treat everybody. When you become an Emergency Room physician, that's the mantra. You're the safety net. People come in, whether they need to be there or not, whether they can pay or not, based on EMTALA, you see treat everybody. One of the things I often said was that that was what I loved about being in the Emergency Department. I don't want to have to worry about their insurance. I see patients. I treat them. Nobody's ever told me I can't treat them, I can't order a CT, I can't do this. Most people in emergency really like that. So what this program wanted to do was a complete paradigm shift -- as much as you could. We're going to have patients come into the Emergency Department and if they're not emergent, we're going to tell you not to treat them. So that's how it started.

5) **Empowering Others to Act on the Vision.** One of the obvious ways this team empowered others to act on the vision was with the role of the navigator. They understood from the beginning that it was critical to the success of the program to empower navigators to act in real time on the issues that presented.

(Dr. Mike, Executive Medical Director) Giving latitude to the navigators was another big part of this. They were pretty empowered. That word is overused, but they were pretty much empowered to do the things they needed to do. They had the ability to make a lot of real decisions that affected them, how they cared for the patients, and how they ran their shop. It's one of these things we talk about but do we really do it?

6) **Planning for and Creating Short-Term Wins.** The team demonstrated awareness of the importance of short-term wins in many ways, not the least of which was allowing the physicians to gain a sense of comfort with the idea of navigating. By allowing physicians to choose how many diagnoses would be permitted to navigate, it gave them short-term wins that led to ownership. Linda's comments describe how difficult it was to allow the short-term wins when so much as at stake.

(Linda, VP ICS) I think it was all around the physicians saying, "Well, we'll do it but only want to do it for 10 diagnoses." And my initial reaction was, "Wow you're limiting it to 10. Why would you do that? It doesn't make sense. There's a lot more stuff." I really wanted to push, push, push. They put so many restrictions on what they were willing to do. And I didn't like it and I was really pushing to have it broader. And it may have been Dr. Mike during that process that said, "I think we're just going to have to let them do this." It slowed it down to make it go faster in the end. Within a week of launching, they came back and said, "Anyone over the age 65 can be navigated." Then a couple of weeks later they said, "Anyone from (age) 5 down to 2". And then a couple of weeks later they said, "Well those 10 diagnoses, we don't want to limit to those. Just let us do them all." To listen to them, to address their needs and to slow down enough - it just accelerated. I wouldn't have predicted that. I thought we were going to fight 10 diagnoses forever.

7) **Consolidating Improvements and Producing Still More Change.** As the program was fully deployed across the Emergency Departments across the Albuquerque system, there was concern for how much staffing would be needed and how difficult it was to keep Navigators physically present in every location. One way that the team consolidated improvements and produced more change was to collaborate with the Manager of Telecommunications to introduce Telenavigation. Telenavigation allowed the team to work closely with the individual sites to create a comfortable room at each location where patients could interact with the navigators in real time via live video link. This improvement reduced the number of staff needed to support the navigation program without creating any patient concerns. It also introduced a new change to the system that became improvement that could be used in other scenarios within the organization. The importance to the team of the development of Telenavigation was described by Barb.

   (Barb, Supervisor PCSC) It was a struggle because we didn't want to overstaff - we just didn't know how much staff we needed in the beginning. There was a time when we were short-staffed. We didn't think about when people got sick. There was limited PTO granted, especially for the first year. I took that back to my management team. I told them the concerns. We tried different changes at Kaseman where we didn't have the volume in the late night hours. When we moved to the video conferencing equipment and implemented that, we were able to branch out to different facilities not have a full-time staff (physically present) 24/7 at all 3 facilities.

8) **Institutionalizing New Approaches**. Once the organization began to see the success of the program, new ideas for big challenges started looking easier to tackle. Dr. Mike describes how the approach in the EDPN program began to inform approaches to other, very challenging programs.

> *(Dr. Mike, Executive Medical Director) We are taking on the projects that nobody in the country is willing to take on. We are taking on chronic pain. That is huge. The Transfer Center, not quite as huge but the way we did it was huge. We talked about taking on projects that are end of life - things that people are talking about as long as I have been in healthcare. Everybody knows it is a problem but no one takes ownership. That is what we are doing now. It is pretty cool stuff. It is amazingly cool.*

Described in *Resistance To Change: the Rest of the Story* (Ford, Ford and D'Amelio, 2008), agent-recipient relationship conversations are identified as important to understanding resistance negotiation that is taking place. Continued study on the negotiated transactions is important to understand how to apply the learning in additional environments. The negotiated transactions that occurred in this program happened at each stage of the change effort and across a wide range of organizational functions. Further study should be given to what the participants considered to be negotiated and why they agreed to make the transformational changes requested.

Transformational Learning. When describing the statements participants made about whether they changed their minds or not and any causes identified as the reason for the change, codes identified such changes as a "shift" to agreement. The purpose of using the term "shift" instead of "transformation" in the initial documentation of the interviews was because transformation involves much more than just changing from doing one set of tasks to another set of tasks. It involves the broader lens that the design of this study allowed. While eight out of the twelve participants did not experience a personal transformational change, they were aware of the transformational nature of the program. The four original team members actually joined the project or were assigned to it because of its transformational nature, these were Dr. Mike, Linda, Phil and Sharon. Joe and Marcia had been looking for the opportunity to see this kind of transformation and

immediately supported it, encouraged it, and took steps to engage in ways that fundamentally made it possible. Joe's ability to lead his team to develop the Navigator Role was transformational to the program. Marcia's ability to step in to the interim Emergency Department leadership role at the critical time of initial implementation was identified by some participants as pivotal to the program's overall success. Tommy and Karen knew it was transformational and were glad to support it, but did not demonstrate any personal transformational learning with respect to their role or their personal learning.

At least four participants experienced Transformational Learning, Dr. Isabella, Dr. Darrell, Barb, and Denise. Each of them experienced transformation on different dimensions. According to Mezirow's Transformation Theory (Mezirow, 2000) there are four ways in which it occurs: "by elaborating existing frames of reference, by learning new frames of reference, by transforming points of view or by transforming habits of mind."

1. Dr. Darrell experience a transformation in his frame of reference on how Emergency Care should and could be delivered and is successfully sustaining the model as Medical Director of the Emergency Department as.
2. Dr. Isabella experienced the same transformation of her frame of reference on how Emergency care should be delivered and supported the implementation. She also experience a transformation of her frame of reference for leadership and took on a new role she would never have

previously considered. She attributes her participation on this program to transforming her leadership.

3. Barb had been a successful customer service representative prior to the program. She experience a transformation in her frame of reference of Presbyterian customers and what they really needed. Having no leadership experience prior to this program, Barb also transformed her frame of reference to take on a supervisory role that required a fundamental change in her habits of mind about her work and her ability to contribute. Barb and her team transformed the navigator role and by allowing her personal transformation, substantially supported the ability of the team to implement the program.
4. Denise transformed from a frame of reference of absolute opposition to one of support. She did not stay in the Emergency Department, but was able to transform her role within the organization. She successfully learned a new frame of reference and applied it to a leadership role in a different area of care delivery.

Transformation is referred to as a movement through time and restructuring of structures. The EDPN redefine the structure in which care would be delivered and changed the habits of mind of many Presbyterian employees over the course of time and, by its success, convinced them to continue implementing the new process. An interesting component of this program, but not specifically addressed in the study, is that the navigation process was designed to and successfully changed the structures and habits of mind of the patients, as well.

> *(Barb, Supervisor PCSC) Our work (Navigators) in the ER is to educate our patients to understand the importance of finding a medical home. We educate them on their conditions that they present with like flu like symptoms, sore throats - very minor conditions - and educate them on what the environment of the ER should be - for life threatening situations. A lot of people don't even know who their doctor is and where their doctor is located. We helped them to understand when they should be using the ER and when to connect with Primary Care.*

> *(Phil, Black Belt) What surprised me, was that like 92% of the patients we navigated didn't think of going anywhere else. It wasn't a matter of extending our hours or having other venues available to them. They never considered going somewhere else. We're educating the patient. In turn we see a very low percentage of our patients return for repeat navigations which suggests that as longer periods of time go since they were navigated, we can see that we really have an impact in their future behaviors.*

When describing what must be present for organizational transformation to occur, Boverie & Kroth (2001) purport that the organization must be free to question assumptions and to work together to create a new system based on clear assumptions, values and beliefs. The extensive communication efforts undertaken by the participants, and especially during the Risk Mitigation Plan development, had the underlying purpose to provide a forum for assumptions to be questioned or challenged and concerns to be heard. As participants began to see their recommendations appear in the program discussions and documentation, it became clear to participants that a new system was emerging as a result of their work together. Participants pointed to the team approach that allowed for questioning and creating of a new system as critical to developing the trust needed.

> *(Denise, Director ED) I think that the trust developed. As we worked together that we were really trying to solve it together. And where for me that trust really melded was when we did the risk assessment and the risk mitigation plans.*

When describing why participants made a personal shift to agreement, they spoke about trust the most. The title of their book, Transforming Work, Boverie and Kroth identified as having a dual meaning referring to the act of changing the work as well as changing the individual. They identify the keys to transformation as trust, commitment and passion. When describing the approach to change efforts in the past, participants used language - especially body language - that implied resignation or continued personal resistance when identifying how they would comply or even not comply with respect to the work alone. At no time when describing this kind of compliance did they describe a personal change. When they described why they came to agree with changes of the work in this program they also described personal transformation couched in terms that demonstrated the role of trust, commitment and passion in their transformational process. For personal transformation to occur, it needed to be something that mattered to them personally, it had to mean more than just a paycheck. They became invested because their efforts made a difference. Examples below include Barb's transformation in her understanding of the customer's needs and Dr. Isabella's transformation of her leadership.

> *(Barb, Supervisor PCSC) In the past I'd say, "Presbyterian provided you a service and we're billing you because your insurance left you this responsibility. How can I help you pay that? This is still your balance." To me this is business. You received your services now you gotta pay us for the services we provided to you. But after knowing what walks in and out of that ER, it's a whole different type of customer service that I want to provide to these people. Whether it be a person who is financially stable to the patient who is sleeping under the bridge tonight. Get that person the help that they need. Get them a bed to sleep in tonight. Get them a meal to eat tonight. To me it's not just about medical care anymore. It's about helping that person. I don't pass judgment on a patient who could be drug-seeking or who actually needs to be there. I mean we see a lot of everything. And everybody deserves the same respect regardless of what issues they're going through. It's just going that extra mile. Say somebody who's been using drugs and wants to get clean and because of the foundation we've built we don't send these patients over to these facilities,*

> *but we have resources if we need to. Some patients will even just come to the registration area (and say), "I need to talk to a navigator. They told me they were able to help me. They can find me a doctor." Sometimes they'll even make up diagnoses on their own. They're sick because they have this, that and the other. "I need a doctor and the Navigator can get me there."*
>
> *(Dr. Isabella, Asst. Medical Director ED) (Dr. Mike's) incredible drive about it happening but (also) his incredible willingness to listen. I mean it was clear this was going to happen. I don't know if you've ever seen him on a project, but get out of his way. It's not pretty. But he also was never unreasonable. It was going to happen and he was going to make it work, but he always listened. Always, always, always listened. So that was huge. I learned an enormous amount. I certainly had my opinion and I felt really strongly about that opinion and wasn't about to have that opinion changed. And now when someone tells me about something, I try to step back a little and not be quite so, I don't want to use the word virulent, but maybe it's the right word. Aggressive or assertive about my opinions. I'm more willing to listen. Because I think I learned so much that I could take a total paradigm shift that now when someone says something or wants to do something that I think is like, "You're nuts" I think wait a minute, are they nuts? Let's think about this. It really changed how I feel about things like that and how I look at roles. Where before I was pretty black and white and now I'm much more willing to hear about something or listen or be thoughtful."*

As described in Chapter 4, the success factors that emerged were that the program was an Enterprise Solution, there was effective Leader Modeling, Difficult Decisions were made, the Navigator Role was well designed, and there was Physician Involvement. The factors described by participants as important to the success of the program are supported by research in Distributed Cognition, Diffusion of Innovations, and Social Network Analysis.

Distributed Cognition. The goal of the program was to create a navigational system for patients that utilized an enterprise solution engaging expertise from across the organization rather than from the Emergency Department alone. The program launched with a Distributed Cognition perspective that they didn't know what would emerge but

were convinced that if they brought the right people together from across the organization, they would find a solution.

By developing a solution designed for the patient to navigate the Presbyterian system to get a better care outcome, the participants began to learn how to navigate the system themselves to reach a better program outcome. In Cognition in the Wild (Hutchins, 1995), Distributed Cognition is studied as a factor of success for navigating a ship. Of interest is that the key questions answered in navigating a ship are remarkably similar to the navigation questions a patient wants answered as shown in the table below.

Table 9: Navigation Comparison of Ships vs. Patients

Navigation questions for ships	Navigation questions for patients
Where are we?	Where is my entry point to the system?
Given that we are here, how do we get to a different location?	If the ideal entry point is somewhere else, where is it, how do I get there from here and what will it take?
Where will we be if we travel in a particular way for a particular period of time?	Where will I be medically if I follow your advice to take a different route?

In both ship navigation and patient navigation the systems are required to compute data. The human interactions facilitate the process of group learning as Hutchins describes, "Knowledge is intersubjectively shared among the members of the navigation team. This permits the human component of the system to act as a malleable and adaptable coordinating tissue, the job of which is to see to it that the proper coordinating activities are carried out." The EDPN program had a very flat hierarchy and all members of the team considered it a part of the job to share learning so that everyone

was able to function well together. The "connective tissue" of the team was extensive communication, availability of the leaders, and incorporation of the learning into the program, which mirrors successful ship navigation methodology.

One way in which the learning is shared in ship navigation is that the goal hierarchy of the team represents shared goals so that responsibility for meeting the goal can be allocated to specific agents and to provide a control device by identifying the shared goals among the team members.

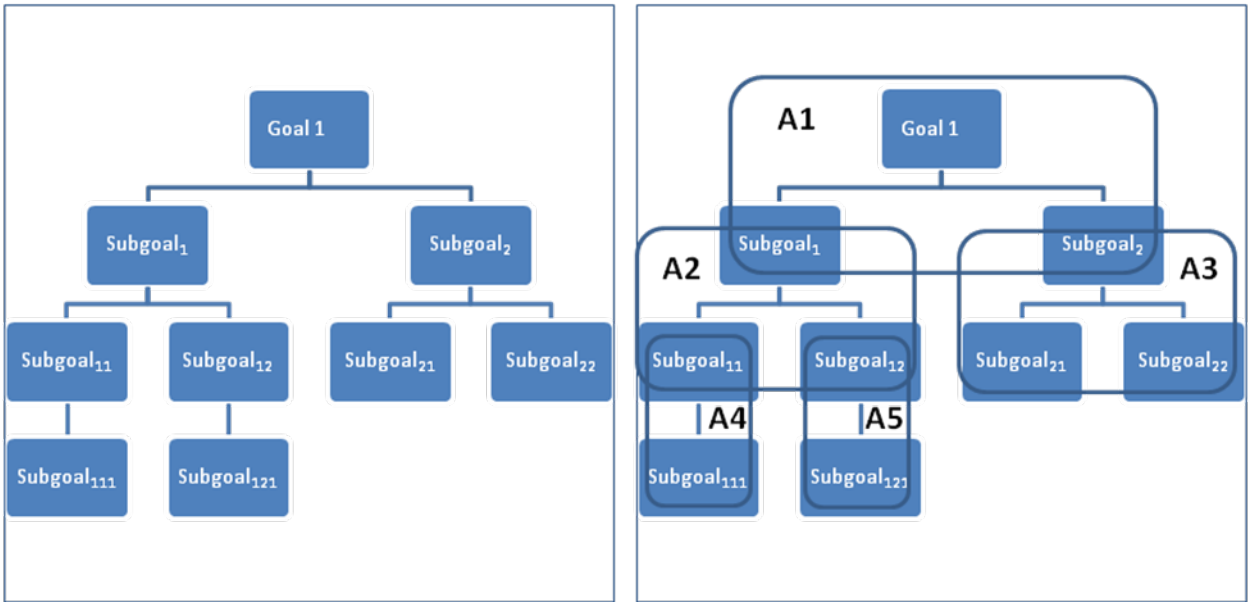


Figure 19: Goal Hierarchy for Goal Satisfaction (Hutchins, 1995)

The EDPN program provided extensive support to the front line teams implementing the program by sharing goals and finding group solutions. When describing the amount of communication and involvement required to remove barriers, Linda refers the difficulty the extensive communication presented. Ship navigation provides a goal structure for the middle leadership that could support the shared goal ownership the team sought without requiring senior leaders to own every level of every goal.

> *(Linda, VP ICS) It really takes senior level people to get anything to change around here. The folks in the field or really can't get it to change. They should be able to, but they can't. Probably the level that Dr. Mike and I put in, probably should not be required but it is what it is. We shouldn't have had to get involved in the types of things we had to get involved in. Like Barb should have been able to make things happen without having to call us saying, I'm not getting anywhere can you guys help me? People should have been more responsive to her needs without having to come to us and saying, no you have to do it.*

Hutchins (1990) discusses using Marr's Vision Model for the computational systems that underlie navigation: Marr's Levels of Description represent computations that are implementation tasks which set constraints upon the performance of the navigation staff. Computation by the system and computation by the individual navigation practitioners are different.

> Level 1: Describes what the system does and why it does it, mapping precisely the abstract properties from one kind of information to another within the system, and the appropriateness and adequacy for the task at hand.
>
> Level 2: Describes a logical organization of the encoding inputs and the transformation of information as it propagates through the system from input to output.
>
> Level 3: Describes the details of how the algorithm and representation are realized physically by recognizing that choices at one level may constrain what will work at other levels.

Level 1 for EDPN: The EDPN program could be compared to a ship's navigational system and the role of the Navigators at Presbyterian appeared to have been highly effective at Level 1 descriptions that supported patients and staff. Participants described understanding what the Patient Navigation program does and why. The physicians and mid-level providers were able to map the abstract properties of medical conditions that helped to determine appropriateness and adequacy of care. The effectiveness of the program can also be determined by the change in the patient

behaviors when they arrived at the physician offices and followed the directions mapped out by the Navigators for them. Patients moved from Point A to Point B.

While the enterprise team approach provided progress on Level 2 by making decisions to transform information such issues as RVU payments that were a disincentive for navigation, it was not clear what additional organizational understanding occurs at Level 2. Descriptions of the information as it travels through the system were not included in the design of this study; however it is likely warranted. While the team closely monitored the patient actions and impact during the initial launch of the program, how the choices made through the Patient Navigation program impacted the patient and the system at Level 3 Descriptions are also unknown. The idea that ship navigation contains implications to support learning in healthcare is compelling. Additional study is warranted to determine what constraints affected the performance, if any, of the patient or the organization as a result of the decisions made through the deployment of the EDPN. Further study is also needed to more fully understand if and how connections between ship navigation and navigation of patients could be applied.

Diffusion of Innovations. Everett Rogers (Diffusion of Innovations, 2003), extensive history of studying how ideas spread, discusses several concepts that explain the effectiveness of the program. Utilizing a framework for change that shares some commonality with Kotter's framework for leading change, Rogers identifies the process of innovative change in organizations as:

1) Agenda-Setting: general organizational problems that may create a perceived need for innovation.
2) Matching: fitting a problem from the organization with an innovation.

3) Redefining/Restructuring: the innovation is modified and re-invented to fit the organization, and organizational structures are altered.
4) Clarifying: the relationship between the organization and the innovation is defined more clearly.
5) Routinizing: the innovation becomes an ongoing element in the organization's activities, and loses its identity.

Rogers' conceptual model contains the idea of Matching and how making a decision to match the solution to the problem was significant. Numerous attempts to solve wait times in the Emergency Departments had been attempted with limited success. The ability to develop and implement the Patient Navigation solution fit, or matched, the problem and the organization. The ability of the team to take on the really difficult decision to send patients away, to create a different kind of safety net, to get to the root of the problem is likely an important component of what finally allowed the team to create a good fit for the solution. Once the team made the difficult decision and committed to support it, it created an atmosphere in which other difficult decisions more easily followed that supported matching solutions to the problem. The importance of this decision should not be undervalued because, as Linda states below, it was pivotal in the success of the team.

> *(Linda, VP ICS) When we visited Memorial Herman, they said, "We have the program but unless you stop treating the patients, if you just try to treat them and educate them they'll never change. If you stop treating them, they will change." They were never able to do it. They had a navigator but it was more around coordination of follow up and giving materials. They never got to the place where they stopped. So making that decision to say we will not provide care was probably the single biggest turning point in this. We'll assess them and if they don't need it, we're just not going to do it. Because there is a lot of fear about taking that step.*

Granovetter's (1973) Strength-of-Weak-Ties theory also describes weak ties as important to diffusion networks because they are bridge that links disconnected networks of information. By comparison, strong ties are shared by individuals within a network and much of the same information is already shared because most members of the network already know each other and have access to the same ideas. Weak tie relationships create a path to the networks of information that are not currently shared because access is granted by a bridging member of both networks. Weak tie relationships were an important component of the design of the enterprise team because the intention was to bridge existing silos. Zhou, Shin, Brass, Choi and Zhang (2009) argue that a moderate amount of weak ties is tied to creativity. The inclusion of Joe on the initial team could have been extended for any number of reasons, however, what emerged was significant because it allowed the role of the navigator to be designed from an enterprise perspective. Joe was able to bridge, in a weak-tie relationship the organizational networks of information. His ability to bridge between the Presbyterian Health Plan, the Emergency Department and billing systems played a critical role in the development of the Navigator role. What quickly emerged was the need to establish the strong tie framework that would support the ongoing role of Navigator. A department was formed, training was established, and a job description for the right people for the role were quickly established. Without taking those steps to solidify the role, success would have been less likely. Joe describes his approach below.

> *(Joe, Director PCSC) People say now they don't remember where this came from. I do know that having discussions with (the) President of the Health Plan, probably 18 months prior to this work beginning where he had started talking about the Triple Aim and how the Contact Center really served as the integrator for the Enterprise. When we say that an*

> *"integrator" is somebody who really looks at broad functions that are served from different business units and starts by understanding the connection points between those different areas. He and I discussed a program where we could utilize perhaps CSRs in a function that would integrate on the delivery system in some manner. We never really specifically discussed the ED, but I when this project kicked off and I was on the invite list for the project team I went in there and did not introduce this concept as, "Hey I've got this solution for what we can do." I was not a plant in the room by any means, meaning go in there and sit and listen and this is what we're going to do. But they had innovative leaders on the project team. I think that's one of the other innovative aspects: choosing the right people for the project team. Then allowing the group to actually throw out ideas and discuss. It was amazing how quickly everybody in the room came to the agreement that in order for this to work there had to be a process solution, technology solution, but most importantly, a people solution, to make this work. That's why the patient navigator was embraced.*

If the team did not establish a temporary review system to ensure that the patients were actually following through with navigation, the decision of the patient to follow the navigation directions was not strongly supported after they left the Emergency Department and dependent on the patient being able to transform the information received from the navigator into action they could reasonably take. While some support systems were put into place, like providing bus passes, the support to patients was still a weak tie solution. If patient compliance appears to lag, investigation should be conducted to determine if a strong tie solution - a more intentional transfer from the Emergency Department to a Primary Care setting - may be needed. This is an excellent example of how navigational discipline could inform healthcare improvements. A longitudinal study of the actual patient behavior from Emergency Department to the Primary Care setting would provide a Marr's Level 2 evaluation of the long term impact of navigation on patient care.

Social Networks. Rogers (2003: p. 323) identifies the opinion leader as a key role in change efforts. Change Agents are described by Rogers as individuals who introduce change from outside the system. They are usually bringing a message of change from an agency, or in this case, from a senior leadership position, and are usually professional and educated. They spark an innovative idea within a communication system that is transmitted to Opinion Leaders. Change Agents are important to introduce the idea into the system, but they are not the ones who make it happen. The CEO, Dr. Mike and Linda, as senior leadership, primarily played the role of Change Agent.

This program utilized physicians in as Opinion Leaders in ways that were unusual by Presbyterian standards and highly effective. Physician involvement, which is used interchangeably in the interviews to include physicians and mid-level providers, is described in Chapter 4 as a factor of success and is an example of effective involvement of physicians on three critical levels:

1. The senior co-sponsor, Dr. Mike, was an ED physician and engaged the physician leaders.
2. The physician leaders, Dr. Darrell and Dr. Isabella, then engaged the staff physician to create adoption.
3. Physician who adopted navigation played a role in the adoption of Emergency Department staff.

The direct involvement as a Change Agent as co-sponsor of the program, Dr. Mike, created credibility for the proposed intervention for the enterprise, and perhaps more importantly, for the physician leaders who became the Opinion Leaders for the physicians. His ability to identify legitimate concerns and cut through unfounded

resistance was critical to developing a clear understanding of what needed to be addressed. His direct engagement of the physician leaders in the Emergency Department, Dr. Darrell as the Medical Director, and Dr. Isabella was the Assistant Medical Director at the time of the implementation of the subject study, was time consuming and challenging, but later came to be a critical component of the adoption of the change. These two physician leaders were critical Opinion Leaders. At the introduction of the study, they were vocal about their lack of support for the program.

> *(Dr. Isabella, Asst. Medical Director ED) I went from I wasn't going to do it to buying in over weeks and months of negotiating to being the queen of the navigation program. I've had doctors who, without me prompting them when we recruited new doctors, they say, "We do this incredible thing in our Emergency Department. We navigate patients." These are the same people who were like I was. So it's interesting that now we use it as a recruiting tool. It's a pretty dramatic switch.*

As described in the quote above, the energy invested in the physician leaders helped to create strong advocates which supports the importance of the Opinion Leader role described by Rogers and to support his assertion that "the opinion leadership strategy generally has robust effects in health improvement" efforts (Rogers, 2001: 325). Valente and Davis (1999) support the use of Opinion Leaders and simulate the acceleration of diffusion among physicians using optimal opinion leader matching. They claim that it not only speeds up the process, it encourages completeness.

Dr. Darrell and Dr. Isabella followed the example provided by Dr. Mike. They engaged the front line providers, modeling the leadership demonstrated for them by Dr. Mike as the Change Agent. They navigated patients themselves so that they knew exactly what they were asking the physicians to do and could speak from experience. They rounded three times a day to support, listen and share learning. They held

physicians accountable so that what was expected was clear and compliance was transparent through reporting that showed navigation statistics by provider.

The staff physicians then acted as Opinion Leaders for the rest of the Emergency Department staff. Once navigation was initiated the staff looked to the opinion of the physicians to validate the navigation decisions. If physicians or providers were not in agreement, the entire program was at risk. As Marcia describes below, the entire system depends upon the decisions of physicians and providers when it comes to how care will be delivered.

> *(Marcia, Interim Director ED) I saw solutions immediately. I think for nursing staff, we were onboard. But when we saw resistance from providers we started questioning if we were doing the right thing. It was just difficult for staff because they felt they were being pulled two different directions.*

Research supports that use of Opinion Leaders as was demonstrated in this program. Opinion leaders should exemplify the system and express the system's structure. They conform to the system norms and have social accessibility. They do not necessarily hold a position of leadership, but they are a critical part of the informal communication system that diffuses innovations. They can make or break the ability of a new idea to catch on. The combined effect can be a tipping point when several Opinion Leaders adopt a new idea. Rogers cautions against overusing Opinion Leaders because of the need for Opinion Leaders to maintain the group respect. They need to be careful not to deviate too far from the norm of the group.

Effective Opinion Leaders must be connected in the communication channel. The communication channel is the process by which information is exchanged to reach mutual understanding. It has 4 requirements: something to share (the navigation or

learning that supports its full implementation), somebody with knowledge or experience, someone who doesn't know about it, and a channel connecting the two. The individuals involved should have similarities on most dimensions with the exception of the knowledge and experience about the innovative idea. These individuals should have both strong ties and weak ties. Effective Opinion Leaders in a social network are seen as technically competent. It is important that the others to which this individual is connected view them as having competence or expertise on the topic at hand. They have some level of education, experience or knowledge that causes others to believe that they know what they are talking about. This is in keeping with what was observed in the EDPN.

Effective Opinion Leaders are seen as socially accessible. This relates to being connected in the communication channel, but also includes the component that the others feel that they have the ability to communicate openly with them. They are not too high up in the hierarchy or they aren't perceived as distant. The relevance of social accessibility with respect to physicians played a critical role and allowed communication both to the patients and staff, but also critically, back to the team making the decisions.

> *(Dr. Darrell, Medical Director ED) It was a process of people hearing me and listening to me and coming back and saying, "does this fit your criteria?" or "What about this? What if we did this, would this be enough to make you comfortable or for your providers to feel comfortable." So it was my own education in terms of the process we were going to take and how this was going to be different and it was my education in terms of why it would be appropriate to do this and the education that yes, we do have the ability to care for those patients in another venue. So it took care of all of the concerns that I would have. And once you addressed those concerns, I certainly didn't think of everything, so I started putting it out to the physicians, and they'd say, "What about x, y, and z?" and I'd say, "Great question!" I'd go back to the leadership group that brought it to us, "What about this and how about this?" It was really coming together to formulate this model of what's the best win-win situation for everyone, how are we accomplishing decreasing inappropriate Emergency Department visits an also making sure that no one falls through the*

> *cracks. Even adding the benefit of the post-treatment navigation to it. I'm not really sure exactly what engagement means, it's a spectrum. People can be engaged if you pay them. Or they can be engaged if you incentivize them somehow. Or you can get their passion. You can find their passion and get them engaged.*
>
> *(Dr. Darrell, Medical Director ED) I think it's all that comes down to physicians are just people. Physicians want to be respected. They want to be heard. They want to have what they say matter and alter the outcomes of what's going on. Because it's something that they're passionate about. It's significant and that's something that I saw different with this program. That's something that I've tried to do in my leadership. I think that's kind of been my style from the beginning just because that's what I would respond to. But this program certainly has helped bring that to the forefront to what has to happen for any sort of successful implementation of programs small or large is really dealing with that.*

Informal communication structures exist alongside the formal communication structures. This is how members of the system track who interacts with whom and under what circumstances. The formal system is the hierarchy or organizational structure. Just as organizational charts depict how the formal system works, a social network is how the informal social system works. The social system allows all members to cooperate to solve a problem to reach a common goal. The sharing of a common objective is what binds the system together. Opinion Leaders are “the differentiated elements that can be recognized in the patterned communication flows in a system” (Rogers, 2003 p. 27). The importance of a shared focus on patient care cannot be separated from the importance of the physicians as Opinion Leaders because they were linked in the participants' beliefs and demonstrated in their discussions. With any other focus, the likelihood of engagement in the outcome would have been greatly diminished.

Relational structural mechanisms are useful to understand the flow or restriction of the flow of information, such as gossip. When describing how they got the information about how things were actually working, Dr. Isabella would ask the staff, "How's it

working? What's the gossip?" with a goal to understand the informal flow of information. Structural relationships provide a network for the care of others and are critical for sustaining cohesion and solidarity of the group. They provide the structure for mobilization for collective action. As the direct supervisors over the staff providers, the physician leaders were in the appropriate position to provide that structural relationship. Social networks are dynamic and change over time. Having accurate information about the existing networks can be an effective decision tool for strategic alliances or for determining which networks to leverage. Further study on the social network that was utilized in the Emergency Department is warranted to understand how to develop effective social networks with both weak tie and strong tie structures.

As healthcare organizations continue to take on increasingly complex strategic initiatives, managing the social networks to drive results takes on increasing importance (Cross and Thomas. 2009). Further development of the social network is warranted for developing an internal learning region as discussed by Hauser, Tappeinier and Walde (2007) that roots the collective learning in the local community at the center of the analysis. Their research provides empirical evidence that social capital triggers the output of the innovation process demonstrating the importance of weak ties in social interaction and innovation on a regional scale.

The strength of the physician social network that was demonstrated as important to the spread of the navigation program should be further studied to determine the effect of weak ties on those without the physical proximity determined to be critical to the utility of social capital in innovation. Capello and Faggian (2005) state that "social capital exists wherever society exists, while relational capital refers to the (rare)

capability of changing different skills, interacting among different actors, trusting with each other and cooperating even at a distance with other complementary organizations."

As Presbyterian continues to take on projects with increasing strategic complexity, the importance of developing social capital becomes important to understand. Social capital in external networks takes on critical importance in situations of increasing strategic complexity, as determined by Houghton, Smith and Hood (2009) because it strengthens the ability of the internal networks within an organization to take more complex initiatives when supported by external networks such national trade associations exist. An intentional plan to connect those who need the social capital of an external social network is important.

In a study designed to measure training versus social networks when disseminating educational innovations in a healthcare setting Jippes, et al, (Jippes, et al. 2010) confirmed the utility of both weak ties to introduce and strong ties to implement a process change. They confirmed Rogers (2003) assertion that the more communication that occurs between the members (the stronger the tie), the more homophilous (alike) the group becomes. This subject study also confirms this through the relationships of the physicians through which the diffusion occurred. The participants describe communication in 36% of their as the reason for their change to agreement. When describing the leader modeling considered as one of the success factors of the program, communication was a characteristic commonly referred to as what was modeled. This study also confirms the findings of Greenhalgh, et al. (2004) that more frequent communication decreases potential risk and results in high diffusion and adoption. The

rounding that was conducted three-times daily by physician leaders demonstrated a high degree of communication in close tie relationships.

Successful Focus. In Sternberg's "Successful Intelligence: How Practical and Creative Intelligence Determine Success in Life" (Sternberg, R., 1997) purports that successful people are not necessarily those with the highest IQ. Successful people build their success on Analytical, Creative and Practical Intelligences. Successfully intelligent people motivate themselves, know how to control their impulses, and know when to persevere. "Successfully intelligent people are flexible in adapting to the roles they need to fulfill. They recognize that they will have to change the way they work to fit the task and situation at hand, and then they analyze what these changes will have to be and make them." (Sternberg, 1997. P. 153) The team appeared to be effective in utilizing all three intelligences. Analytical intelligence was used to develop a solution that would solve the problem. Creative intelligence was demonstrated in the development of the Navigator role, and Practical intelligence was demonstrated as the physicians were allowed to adopt at their own rate. The combination of the team brought together people who could operate in all three successful intelligences.

In "*Successful Change Leaders: What makes them? What do they do that is different*", (Miller, 2002), Miller underscores the need for higher levels of adaptability in times of great change in order for leaders to demonstrate "grace under pressure" during the turbulent times. Utilizing Miller's top-line indicators of adaptability in the interviews, the study validates the conclusion that Miller's top indicators of adaptability (Optimistic, Self-Assured, Innovative, Collaborative, Purposeful, Structured, and Proactive) were characteristics that supported the adaptability of the participants in this study.

In "*Why Leaders Don't Learn From Success"*, (Gino and Pisano, 2011) make the case that triumphs should receive post-mortems with the same level of attention as failures. In the case of the participants in this study, they took the time to develop Lessons Learned (see Appendix) with respect to the learning they wanted to carry forward. What they had not done was a thorough reflection upon their own personal journey in the process. As they shared their stories, they solidified for themselves what they learned and by allowing it to be captured, enable sharing it with those will follow. This kind of openness was personally risky, but these leaders had learned how to successfully take that kind of risk.

Summary. The study of a successful change effort to identify what leaders learned as a result of their participation is an effective way to capture organizational learning. The team was effective in utilizing change methodology as demonstrated with several leading change writers. The ability of the team to transform the way in which care was delivered also resulted in the transformation of a third of the participants interviewed. This alone was a compelling reason for the study to uncover what supported their transformation and what can be applied to other efforts. The effective use of Distributed Cognition brought the team together to develop a solution for the enterprise. The physician social network followed best practice supported effective implementation of the effort. And finally, leadership was in charge, not just management. Successful efforts must be championed by those who understand the difference and are not afraid to lead.

Table 9: Summary of Key Findings and Implications

PERSONAL SHIFT TO AGREEMENT	
Findings	When describing the paradigm shift they experienced or observed, participants comments reflected the following four key factors as important to the shift. (Many comments contained relationships to each other, totals do not equal 100%) Trust **55%** Leadership **49%** Communication **36%** Patient Focus **13%**
Implications	Further studies should determine if a causal relationship exists between leadership, communication and patient focus and trust. Should such findings be validated, potential implications for practice include development of quantitative study methodologies.
SUCCESS FACTORS	
Findings	Participants identified five key characteristics as factors of the success of the program. The frequency of comments with respect to the other success factors are represented below: : Enterprise Solution **28%** Leader Modeling **24%** Difficult Decisions **23%** Navigator Role **13%** Physician Involvement **12%**
Implications	Further study should be conducted to understand how the science and practice of navigation could be further applied in healthcare settings. Research on the use of physician social networks is needed to understand how to utilize the physician social network effectively. The nurse social network was not uncovered in this study and would be useful for future study, as well. Further research is needed to understand how to support and/or build weak tie and strong tie relationships at appropriate levels. A five year study would be useful to understand if the change remained successful, if it got better, and/or if it changed.

LEADERSHIP CHARACTERISTICS	
Findings	Participants identified the leadership characteristics they demonstrated in the following frequency when compared to the other characteristics mentioned. Adaptable **31%** Innovative **17%** Collaborative **16%** Optimistic **10%** Purposeful **7%** Confident **6%** Self-Assured **6%** Proactive **6%**
Implications	Further study should be conducted to develop measurement systems for adaptability that create more predictive indicators for leaders involved in change efforts to inform selection of adaptable leaders to lead change efforts and/or development opportunities to build adaptability.

Further research. The findings of trust, leadership, communication, and patient focus should be more thoroughly developed to understand if a causal relationship to the development of trust exists in the model that was employed in the implementation of this program.

Hutchins (1990) study on Distributed Cognition with respect to navigation provides compelling indication that further study should be conducted to understand how the science and practice of navigation could be further applied in healthcare settings.

Additionally, the successful use of the physician social network was critical to the successful implementation of the program and research on the use of physician social networks is needed to understand how to utilize the physician social network effectively. The nurse social network was not uncovered in this study and would be useful for future study.

The importance of using weak tie and strong tie relationships in the development of Navigator role emerged as important in this study. Further research is needed to understand how to support and/or build relationships at the appropriate levels.

Further study should be conducted to develop measurement systems for adaptability that create more predictive indicators for leaders involved in change efforts. This could inform selection of leaders and should identify development opportunities to build adaptability.

Further study should be conducted to determine if validity and reliability of the findings are demonstrated when multiple researcher perspectives are included.

Implications for practice. The approaches employed provide implications for practitioners of change. These include:

1. Utilization of change leadership models such as Kotter and Rogers provide a framework for leaders that support successful implementation of change efforts.
2. When introducing transformational change of work paradigms, the people closest to the changed work functions experienced the most significant transformational change. Consideration for the level of support needed should be given to ensure successful transformation.
3. When utilizing an intervention that is new in the environment where it is implemented, but fully developed in another environment, further study of the learning from the field in which is developed is warranted. Taking advantage of lessons learned could save time and point to further applications.

4. Themes revealed in qualitative research may already have tools and qualitative methodologies that would be useful for further study. Social Network Analysis is an example would be appropriate application for further investigation as a result of the findings of this study.

References

Bailey, Julia (2008). *First steps in qualitative data analysis: transcribing.* Family Practice Advance Access. doi:10.1093/fampra/cmn003. Published on 27 February 2008. Downloaded from http://fampra.oxfordjournals.org/ on February 11, 2012

Bandura, A. (1977). Social Learning Theory. New York: General Learning Press.

Borgatti, S. and Cross, R. (2003) *A Relational View of Information Seeking and Learning in Social Networks.* Management Science 2003 INFORMS. Vol. 49, No. 4, April 2003, pp.432.445.

Boverie, P. and Kroth, M. (2001). Transforming Work. Perseus Publishing. Cambridge, MA.

Brokaw J. (2010). Keeping routine medical care out of hospital emergency rooms. Washington Post. May 18, 2010:A19. http://www.washingtonpost.com/wp-dyn/content/article/2010/05/17/AR2010051702807.html

Campbell, R.J. (2008). Change Management in Health Care. *The Health Care Manager.* Vol. 27, Number 1, pp. 23-39. Jan-March 2008.

Candy, P.C. (1991). Self-direction for lifelong learning. San Francisco: Jossey-Bass. 547 Pages. ISBN 1-55542-303-5.

Capello, R, and Faggian A (2005) Collective learning and relational capital in local innovation processes. *Regional Studies.* 39. 75-87.

Cole, M., & Engström, Y. (1993). A Cultural-Historical Approach to Distributed Cognition. In G. Salomon, *Distributed cognitions*, (pp. 88–110). NY: Cambridge University Press.

Cross, R. and Thomas, R. J. (2009) Driving Results Through Social Networks. John Wiley & Sons. San Francisco, CA.

Ford, J. D., Ford, L. W., and D'Amelio, A. (2008) Resistance to Change: the Rest of the Story. Academy of Management Review. Vo. 33. No. 2. 362-377.

Freire, P. (1970). *Pedagogy of the Oppressed.* New York, NY: Herter & Herter.

Gino, F. and Pisano, G. (2011). Why Leaders Don't Learn From Success. *Harvard Business Review.* April 2011.

Gladwell, Malcolm (2003). The Tipping Point: How Little Things Can Make A Big Difference. Back Bay Books. Time Warner Book Company. New York, NY.

Goleman, D. (2000). Leadership That Gets Results. *Harvard Business Review*. March-April 2000. R00204.

Greenhalgh, T. Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004) Diffusion of innovations in service organizations: systematic review and recommendations. *The Milbank Quarterly*, 82(4), 581-629.

Granovetter, M. (1973) The strength of weak ties. *American Journal of Sociology.* 78. 1360-1380.

Habermas, J. (1984). The Theory of Communicate Action Vol. 1*: Reason & the Rationalization of Society*. Boston, MA: Beacon Press.1971, 1984),

Hauser, C., Tappeiner, G. and Walde, J. (2007) The Learning Region: The Impact of Social Capital and Weak Ties on Innovation. *Regional Studies,* Vol 41.1 pp. 75-88. February 2007.

Heifetz, R. (2001). Leadership Without Easy Answers: Adaptive Work in an Era of Change. The Leadership Center. Atlanta, GA. www.learnleadership.com

Houghton, S., Smith, A. D., and Hood, J. (2003) The influence of social capital on strategic choice: An examination of the effects of external and internal network relationships on strategic complexity. *Journal of Business Research.* 62. 1255-1261.

http://www.emtala.com/faq.html. *What is EMTALA?* Created 22 April 2011. Retrieved 19 March 2012.

Hutchins, E. (1995). *Cognition in the Wild*. Cambridge, MA: MIT Press.

Jippes, E., Achterkamp, J. C., Brand, P.L.P., Kiewiet, D.J., Pols, J., and van Engelen, J.M.L (2010) Disseminating educational innovations in health care practice: Training versus social networks. *Social Science & Medicine (2010)* doi 10.1016/j.socscimed.2009.12.035.

Kelley, Tom (2005). The Ten Faces of Innovation. Doubleday by Random House. New York, NY.

Kennedy, C. and Harvey, D. (1997) Managing and Sustaining Radical Change. (1998). *Management Services*, *42*(12), 3.

Knoke, D. and Yang, S. (2008). Social Network Analysis. 2nd Edition. Series: Quantitative Applications in the Social Sciences. Sage Publications. Thousand Oaks, CA.

Knowles, M. et al (1984) *Andragogy in Action. Applying modern principles of adult education*, San Francisco: Jossey Bass. A collection of chapters examining different aspects of Knowles' formulation.

Knowles, M. S. (1990) *The Adult Learner. A neglected species* (4e), Houston: Gulf Publishing. First appeared in 1973. 292 + viii pages.

Kolb, David A. 1984. Experiential Learning: Experience as the Source of Learning & Development. Prentice-Hall, Inc., Englewood Cliffs, N.J.

Kotter, J. P. (1990) *What Leaders Really Do*. Harvard Business Review. May-June 1990.

Kotter, J. P. (1995) *Leading Change: Why Transformation Efforts Fail.* Harvard Business Review. March-April 1995.

Kotter, J. P. (1996) Leading Change. Harvard Business Review Press. Boston, MA

Kuhn, T. N. (1970) , *The Structure of Scientific Revolutions*. The University of Chicago Press. London, UK.

Kuhn, T. N. (1972). "Logic of Discovery or Psychology of Research". Cambridge: Cambridge University Press. p. 6.

Lacayo, V., Obregon, R., Singhal, A. (2008). Approaching Social Change as a Complex Problem in a World that Treats it as a Complicated One. *Investigacion Y Desarrollo* Vol, 16, No 2 (2008) – ISSN 0121-3261.

Lean Six Sigma Project 1089 Report Storyboard. December 2010. Presbyterian Healthcare Services project documentation.

Lewin, K., & Gold, M. (1999). *The complete social scientist: A Kurt Lewin reader*. Washington, DC: American Psychological Association.

Linsky, M. and Heifetz, R., (2002) Leadership on the Line: Staying Alive through the Dangers of Leading. Harvard Business School Publishing. Boston, MA.

Madsen, Susan R. and Hammond, Scott C. (2005). "Where Have All the Leaders Gone?" An Interview with Margaret J. Wheatley on Life-Affirming Leadership. Journal of Management Inquiry: Mar 2005.

Mato, D. (2004). Communication for social change in Latin America: contexts, theories, and experiences. *Development in Practice,* Vol 14, No. 5, August 2004.

Merriam, S. B. (1998). *Qualitative research and case study applications in education*. San Francisco, CA: Josey-Bass.

Mezirow, J. (1996) Contemporary paradigms of learning. *Adult Education Quarterly, 46, 158-173*.

Mezirow, J. (2000) Learning as Transformation. Jossey-Bass, San Francisco, CA.

Miller, David. (2002) *Successful change leaders: What makes them? What do they do that is different?* Journal of Change Management. Vol 2, 4, 359-368.

Neale, P., Thapa, S., Boyce, C. (2006) Preparing a Case Study: A Guide for Designing and Conducting a Case Study for Evaluation Input. Pathfinder International Tool Series Monitoring and Evaluation – 1. May 2006.

O'Keefe, D.J. (2002). Persuasion: Theory & Research. 2nd Ed. Sage Publications. Thousand Oaks, CA.

O'Sullivan, E. (2003) "Bringing a perspective of transformative learning to globalized consumption." *International Journal of Consumer Studies.* 27 (4), 326-330

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newberry Park, California: SAGE Publications, Inc.

Perry, M. & Macradie, R. (1999). *Distributed Cognition: Investigating Collaboration in Large & Highly Complex Organizational Systems*. Uxbridge: Brunel University Press.

ProSci. (2000) Benchmarking Study Issued on Change Management Practices. *Quality Progress,* October 2000. Vo. 33 Issue 10, P24, 1/3p.

Rogers, Everett (2003). Diffusion of Innovation. 5th Edition. Simon and Schuster. New York, NY. 417-430.

Schein, E. H. (1996) Kurt Lewin's change theory in the field and in the classroom: Notes toward a model of managed learning. *Systemic Practice and Action Research,* 9(1): 27-47.

Singhal, A. Papa, M., Sharma, D., Pant, S., Worrell, T., Muthusway, N., and White. K. (2006). Entertainment Education and Social Change. *Journal of Creative Communications* 1:1. Sage Publications New Delhi, Thousand Oaks, London.

Stake, R. (1995). *The art of case study research.* Thousand Oaks, CA: Sage.

Stern, M. (2010). Presbyterian Healthcare Services Alternative Venue of Care: Patient Navigation Program. Modern Healthcare Webinar. December 2010.

Sternberg, Robert J. (1997) Successful Intelligence: How Practical and Creative Intelligence Determine Success in Life. Penguin Group. New York, NY.

Stevenson, H. (2010). Paradox; A Gestalt Theory of Change for Organizations. *Gestalt Review*, 2010, vol. 14 Issue 2, p111-126, 16p

Townsend, M. *The Success Factors For Change Efforts.* Downloaded 4/5/11 from http://www.butrain.com/business-management-training-courses/ChangeSuccessFactors.asp. Copyright 2011 © Boston University Corporate Education Center

Valente, T.W., and Davis, R. L. (1999) Accelerating the Diffusion of Innovations Using Opinion Leaders. *The* ANNALS of the American Academy of Political and Social Science. 1999; 566; 55. Sage Publications.

Vygotsky, L. (1978) Mind in society: The development of higher psychological processes. (Edited by M. Cole, V. John-Steiner, S. Scribner, and E. Souberman). Cambridge, MA: Harvard University Press.

Wheatley, M. (1999). Leadership and the New Science: Discovering Order in a Chaotic World. Berrett-Koehler Publishers, Inc. San Francisco, DA.

Zimmerman, B. J. & Schunk, D. H. (2001) Self-regulated Learning & Academic Achievement: Theoretical Perspectives. (need publisher)

Zoll, A. and Healy, A. (2011). *When Failure Looks Like Success.* Harvard Business Review. April 2011.

APPENDIX
TABLE OF CONTENTS

PROGRAM DOCUMENTS

METHODOLOGY DOCUMENTS

Presbyterian Healthcare System
Executive Summary

Project Name: Alternative Venue of Care

Background:

A significant number of low-acuity patients seek medical care in Presbyterian emergency departments (ED) where costs are greater and continuity of care is lacking. This results in sub-optimal medical management of chronic disease, inappropriate use of ED services and higher costs in healthcare. As in integrated delivery system, Presbyterian Health Services must facilitate the delivery of healthcare at the most appropriate venue.

Mission Statement:

This project is a critical to achieve results related to two of the top six priorities identified for PHS in 2010, Medical Cost Optimization and Success in Medicaid. Key business impacts include the reduction in overall cost of healthcare through provision of services in a more appropriate venue of care; mitigation of financial risk related to healthcare reform and associated reduction in payment levels from government payors; improved ability for PHP to attract and retain customers based on competitive premiums; and reduction in bad debt for Medicare FFS and uninsured within PDS associated with ER use (through providing service in lower cost more appropriate venue of care).

Goal Statement:

Reduce by 50% the rate of low to moderate intensity emergency department services delivered in Central New Mexico by 12/31/2010.

Schedule: Began 4/1/2009 and finished 12/31/2010

Goal Achievement:

The rate of navigation from the ED is 12.4% for PH and 11.6% for Kaseman. Both PH and Kasemand have experienced a 50% relative reduction in low-moderate intensity ED treatment rate since initiating patient navigation: PH (58.1 to 29.3) & Kaseman (68.1 to 34.2).

Black Belt: [redacted]: _____ Date:_____
Signature & Typed Name

Champion: [redacted] _____ Date:_____
Signature & Typed Name

Reducing Non-Emergent Care Through ED Culture Change

Paul Faculjak PT, Lisa Farrell, Jaimie Martin, Mark Stern MD

Problem

Patients with non-emergent conditions frequent the Emergency Department (ED) where they receive episodic, fragmented and more costly care.

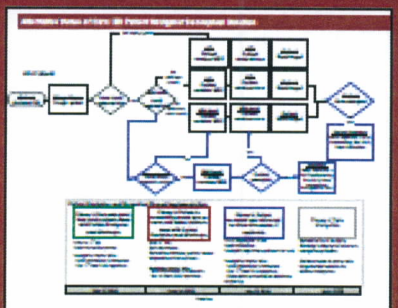
GOAL: Reduce inappropriate ED use by 31%.

Challenges

1. The ED is the community safety net, particularly for the uninsured and those without a medical home. (Of non-emergent patients: 92% seek care in the ED as their first choice; 74% have insurance; 53% have a Primary Care Provider.)
2. Mis-application of EMTALA law encourages treatment regardless of condition severity.
3. Physicians & nurses feel ethically obligated to treat all patients presenting to the ED.

Background

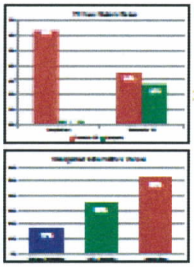
- Presbyterian Healthcare Services is a not for profit integrated health care financing and delivery system across New Mexico.
- Project scope was limited to central NM (3 hospitals with ED's, 5 Urgent Care centers & 10 Primary Care clinics).
- Design for Six Sigma project launched in April of 2010



Navigation Process

1. Medical Screening Exam by Physician/Mid-Level
2. Referral to Navigator or option to pay $350 for ED treatment
3. Primary care appointment w/i 12-24 hours or Urgent Care referral
4. Patient education & financial resource counseling

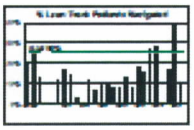
Safety



Criteria

1. Any patient > 90 days old who can safely be treated in Primary or Urgent Care in 12-24 hours.
2. Exclusions:
   - Intoxication
   - Lives out of town
   - Received blood tests, X-rays or EKG
   - Behavioral health

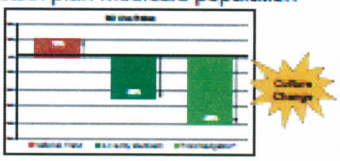
Provider Adoption



1. Comparative group reporting
2. Trend analysis to ID outliers
3. 1:1 provider coaching

Results

- Over 10,000 patients navigated in 17 months (10% ED volume)
- Low repeat navigation rate (6.1%)
- 40% reduction in post-navigation ED use
- 25% reduction in overall ED use by health plan Medicaid population



Critical Success Factors

- Joint clinical and administrative project leadership
- ED physician leaders core team members
- Primary Care and Urgent Care collaboration
- Leverage integrated system
  - Centralized contact center
  - Charity care for Urgent Care
  - ED provider RVU credit
  - Health plan reimbursement for medical screening exam
- Pro-active communication with community, regulatory, media, advocacy groups, & patients
- Risk analysis & mitigation planning
- Commitment to care at alternative venue w/i 12-24 hours.

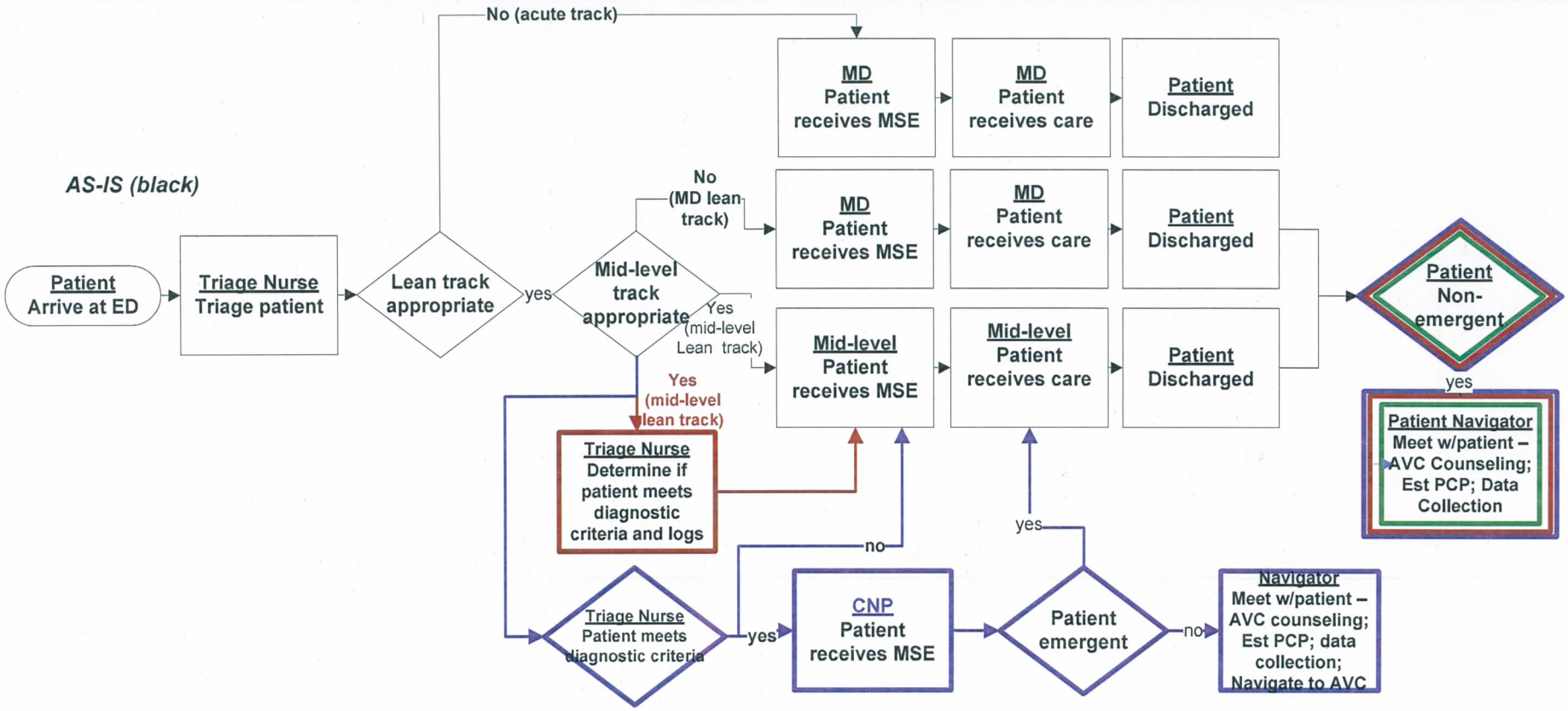
Project Team

[redacted]

Navigator Functional Requirements	Wt'd Score	Rank Order	Rate how well each Functional Requirement impacts each Critical to Quality Element: 1 - 10 (1 = Poor Alignment 10 = Excellent Alignment)							
			1. Access to tools & tests to do jobs	2. Access to timely care & information	3. Ensure appropriate patient at appropriate venue	4. Continuity of care	5. Affordable care	6. Compliance	7. Live up to Pres Mission	8. Prov, Staff, Pat Satisfaction
1. Directs and schedule patients	6	1	90	90	100	90	72	64	64	56
2. Ensures care is received	6	2	100	100	80	80	45	64	72	63
3. Is able to navigate complex system	6	3	80	80	90	90	63	40	64	56
4. Provides appropriate patient education	5	4	50	80	80	80	63	48	64	56
5. Optimizes health plan benefits and community resources	5	5	40	80	80	80	72	40	48	49
6. Ensures patients have PCP	5	6	70	80	90	90	63	16	40	35
7. Facilitates financial counseling	4	7	20	80	50	50	72	32	56	35
8. Facilitates transportation for patients	3	8	20	70	70	50	36	16	40	42

Management of Non-Emergent ED Patients Functional Requirements	Wt'd Score	Rank Order	Rate how well each Functional Requirement impacts each Critical to Quality Element: 1 - 10 (1 = Poor Alignment 10 = Excellent Alignment)							
			1. Access to tools & tests to do jobs	2. Access to timely care & information	3. Ensure appropriate patient at appropriate venue	4. Continuity of care	5. Affordable care	6. Compliance	7. Live up to Pres Mission	8. Prov, Staff, Pat Satisfaction
1. Facilitate selection of appropriate venue	7	1	80	100	100	90	81	64	80	70
2. Provide access to timely & affordable care	7	2	80	100	100	90	90	60	80	63
3. Reliably ID non-emergent conditions	6	3	80	80	100	80	72	80	80	70
4. Solutions addresses all patients - non-discriminatory	6	4	40	80	100	90	63	80	80	70
5. Ensure high comfort level that patient & provider are not at risk	6	5	80	90	100	80	54	72	72	63
6. Provide patient education of appropriate venue selection	6	6	50	100	100	90	81	48	64	63
7. Ensure risk mangement comfort level is high	5	7	50	60	100	70	54	80	64	63
8. Provide consistant messaging	5	8	40	80	90	80	63	64	64	56
9. Provide reassurance to patient	5	9	40	80	80	80	54	64	64	56

Alternative Venue of Care (ED): Patient Navigator/Screening Conceptual Solution



Patient Navigator and Screening Phased Implementation *(TO-BE)*:

Phase 1: Non-emergent/ lean track patients meet with Patient Navigator post discharge

Pilot downtown
Data collection phase

Navigator assist with:
- AVC education & materials
- Est 1st time PCP appoints.

Phase 2: Patient is screened by nurse prac or nurse and select patients meet with Patient Navigator post discharge

Pilot downtown
Data collection
Determine whether patient meets diagnostic criteria (track)

Navigator assist with:
- AVC education & materials
- Est 1st time PCP appoints.

Phase 3: Patient screened and redirected to alternative venue, if applicable

Pilot downtown
Data collection
Navigate applicable patients to AVC

Navigator assist with:
- AVC education & materials
- Est 1st time PCP appoints.
- Determine presumptive Medicaid eligibiilty

Phase 4: On-going assessment & expansion

May 17, 2010	June 14, 2010	July 12, 2010	2010 →

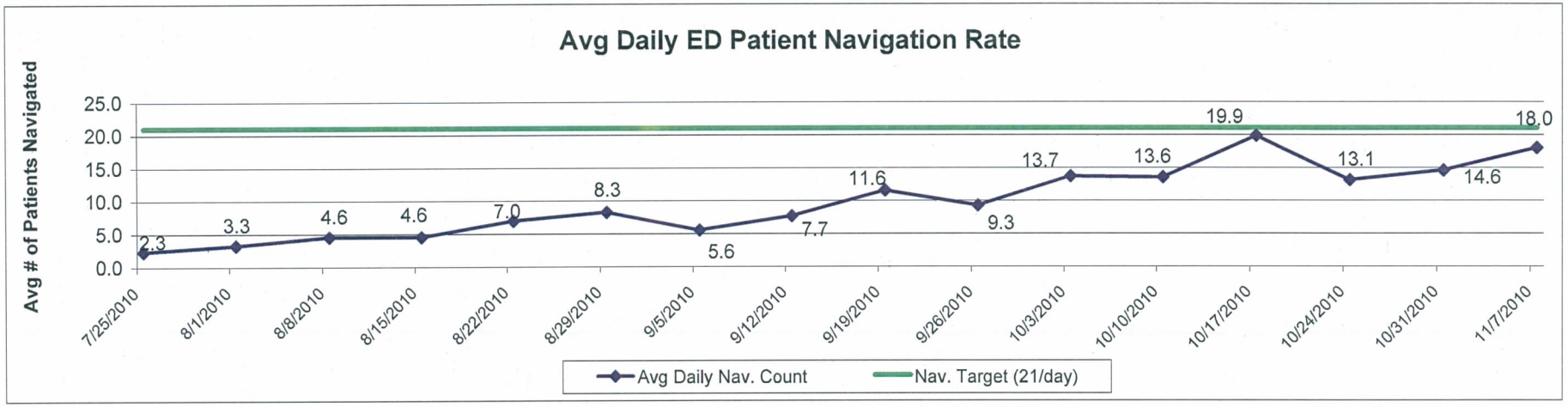
Timeline

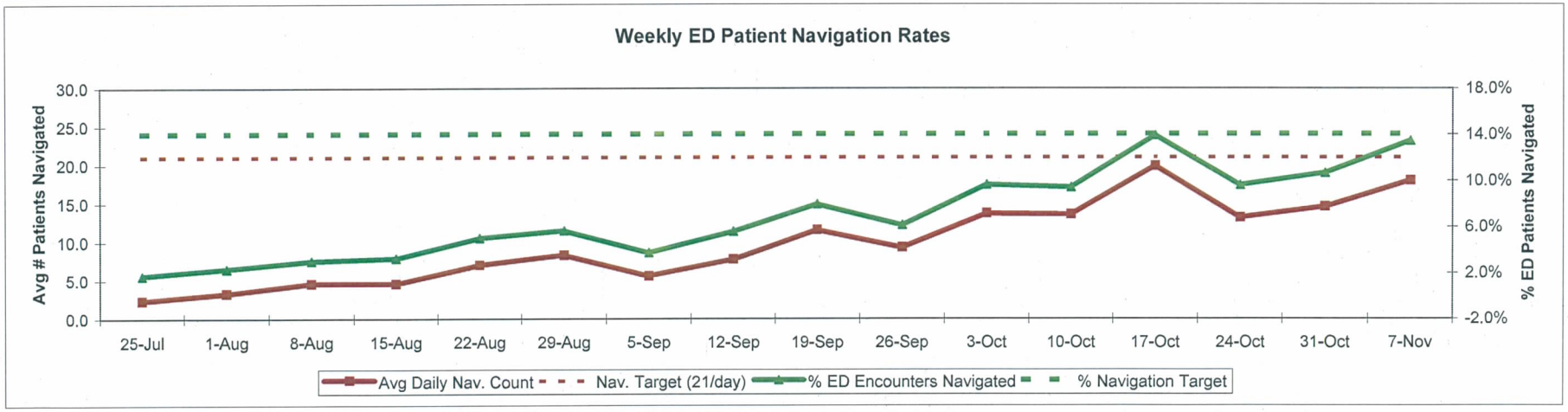
DRAFT As of 4.29.10

ED Patient Navigation Summary Report Week of November 7, 2010

Week of:	25-Jul	1-Aug	8-Aug	15-Aug	22-Aug	29-Aug	5-Sep	12-Sep	19-Sep	26-Sep	3-Oct	10-Oct	17-Oct	24-Oct	31-Oct	7-Nov
Navigation Count	14	23	32	32	49	58	39	54	81	65	96	95	139	92	102	126
Avg Daily Nav. Count	2.3	3.3	4.6	4.6	7.0	8.3	5.6	7.7	11.6	9.3	13.7	13.6	19.9	13.1	14.6	18.0
Daily Post Treatment F/U Rate	15.7	11.7	16.0	12.0	13.4	14.7	12.0	12.4	10.1	11.9	13.1	13.0	9.3	10.7	10.3	12.0
PMG PC Scheduled Count	3	4	4	7	3	15	7	9	12	10	34	11	0	0	0	0
PMG PC Attendance Rate	0%	75%	33%	100%	33%	75%	83%	50%	60%	70%	58%	67%	0%	0%	0%	0%
Total PH Lean Track Patients	554	569	581	577	562	586	568	549	541	606	578	569	590	540	642	
% PH Lean Track Navigated	2.5%	4.0%	5.5%	5.5%	8.7%	9.9%	6.9%	9.8%	15.0%	10.7%	16.6%	16.7%	23.6%	17.0%	15.9%	
% Navigation Target	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%
Nav. Target (21/day)	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21
PH ED Pt Count (MIDAS)	826	1005	1074	992	981	1031	1045	970	1021	1060	998	1012	1000	960	961	938
% ED Encounters Navigated	1.7%	2.3%	3.0%	3.2%	5.0%	5.6%	3.7%	5.6%	7.9%	6.1%	9.6%	9.4%	13.9%	9.6%	10.6%	13.4%
% Navigation Target	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%

Patients Navigated Grand Total: 1118 Post Treatment Patient Grand Total: 1391





Alternate Venue		11/7	11/8	11/9	11/10	11/11	11/12	11/13	Grand Total
Urgent Care	Urgent Care - Atrisco	3		4	1	1	2		11
	Urgent Care - Belen				1				1
	Urgent Care - Isleta	2	3	3		2	3	1	14
	Urgent Care - Non-PMG Urgent Care			2		1		1	4
	Urgent Care - Northside	2	6	9	4	4		5	30
	Urgent Care - Pediatric (PH)	1		1	2	1	2		7
	Urgent Care - Rio Rancho		1						1
Urgent Care Total		8	10	19	8	9	7	7	68 (54%)
Specialist	Specialist -				2				2
Primary Care	Primary Care - Atrisco			1					1
	Primary Care - Belen	1							1
	Primary Care - Isleta			3			1		4
	Primary Care - Non-PMG Primary Care	3	2	2	1	1			9
	Primary Care - Northside	3	1						4
	Primary Care - Rio Rancho			1					1
	Primary Care - San Mateo		2	1		1			4
	Primary Care - Los Lunas		2					1	3
Primary Care Total		**7**	**7**	**8**	**1**	**2**	**1**	**1**	**27**
Patient Refused Navigation	Patient Refused Navigation -	5	2	3	2	4	4	2	22
Other	Other -		1	2	1	1			5
Navigation Not Required	Navigation Not Required -	1		1					2
Grand Total		21	20	33	14	16	12	10	126

New PCP Assigned	PCP Location	11/7	11/8	11/9	11/10	11/11	11/12	11/13	Grand Total
	Atrisco			1					1
	Kaseman	1							1
	Los Lunas		1					1	2
	Non-PMG Primary Care					1			1
	San Mateo		1	1		1	1		4
	Montgomery	1							1
Grand Total		2	2	2		2	1	1	10

Conditions Navigated

Abdominal Pain (3)	Headache/Migraine (3)	Other-EYE PAIN (1)	Other-SHOULDER INJURY (1)
Abscess (2)	Hypertension (1)	Other-FLU SYMPTOMS (6)	Other-sinusitis (1)
Anxiety/Depression (3)	Medication Refill (4)	Other-FOOT PAIN (1)	Other-SPRAINED ANKLE (1)
Back/Neck - Pain/Sprain (4)	N & V (1)	Other-GOUT (1)	Other-STAPLE REMOVAL (1)
Chest Pain (1)	Other-AB NOSE PAIN (1)	Other-HEAD INJURY (1)	Other-STITCHES (1)
Chronic Pain (6)	Other-MVA (1)	Other-HEMOROIDS (1)	Other-SWOLLEN TONSILS (1)
Contusion (2)	Other-ALCOHOL ABUSE (1)	Other-KNEE PAIN LEFT (1)	Other-THROWING UP (1)
Dental Pain (4)	Other-ARTHRITIS (1)	Other-LUMP ON BREAST (1)	Other-TOE INJURY (1)
Diabetes (1)	Other-BROKEN NOSE (1)	Other-LUMP UNDER ARM (1)	Other-TROUBLE BREATHING (1)
Ear Ache (4)	Other-CHICKEN POX (1)	Other-MOUTH TINGLING (1)	Other-VAGINAL BLEEDING (1)
Fever (12)	Other-COUGH (1)	Other-NO SLEEP (1)	Rash (8)
Foot/Leg Pain (10)	Other-CROUP (1)	Other-NOSE BLEED (1)	Sore Throat (5)
Hand/Arm Pain (7)	Other-DIARRHEA, VOMITING (1)	Other-PARAESTHESIAS (1)	URI (8)

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Communication Plan

Appropriate Venue of Care Project ~ "The Right Place for the Right Level of Care"

Version: July 15, 2010

Background/Situation/Issue:

With healthcare reform, dwindling reimbursement from government medical plans, skyrocketing commercial health insurance premiums, and diminishing resources, it is now more important than ever for Presbyterian become a more efficient steward of medical resources and transform how we care for our patients and members.

Presbyterian wants to:

- Improve the quality of care.
- Improve access to care.
- Make care more affordable.

The Emergency Department (ED) is a good place to start. EDs across the nation and here in New Mexico are overburdened with patients seeking care for non-emergencies. The high volume of non-emergency patients creates barriers to care for patients with true emergencies. And when patients with non-emergencies are treated in a high cost acute-care setting, such as the emergency room, it drives up healthcare costs for all.

To address this issue, Presbyterian is embarking on a new model of helping patients who present at the Presbyterian Hospital ED with non-emergencies to access care in a setting that is better suited for minor illnesses and injuries.

The current proposed date for implementation of the new model is July 26. Prior to implementation, ED patients will be interviewed about their decisions to access the ED for their care. Beginning in mid-June patients will be counseled about alternative venues of care (when appropriate) after their ED visit. The information gathered in these first phases will better inform our assumptions and plans.

What are we trying to accomplish?

Business Objective:

- To help patients get the right care at the right place, thereby enabling better service for patients with true emergencies, improving the quality of care for all patients and helping reduce healthcare costs overall.

Communication Objectives:

- Educate employees and physicians about the issue and what we are doing at Presbyterian to address it.

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- Educate patients with non-emergent conditions who present at the ED about the best location for them to receive care for their condition (right place/right level of care) and provide specific options for getting established with a primary care practitioner.
- Educate patients, members and the public about how to determine the "right level of care at the right place" for their medical condition.
- To deliver our messages in a manner that helps the various audiences understand that Presbyterian is attempting to make a positive change that benefits patients and members in both the short-term and long-term.

Audiences:

- Patients
- Members
- Employees - progressive degrees of information and scripting based on role and proximity to areas affected.
- Physicians and providers – PMG, medical staff, PHP-contracted (four-county focus)
- Board members
- Regulators
- Local healthcare entities
- Elected officials
- Key Advocacy Groups (e.g. New Mexico Center on Law and Poverty)
- Employers, opinion leaders, insurance brokers – those who purchase health insurance and are watching changes in the healthcare market with great interest.
- Media

Opportunities:

- To engage employees and enable them to be advocates for this change within Presbyterian and in the communities we serve.
- To create understanding among all audiences that this change offers positive benefits and is necessary to improve healthcare.
- To change customer behavior in a way that helps them get better care.

Challenges:

- Dissatisfaction from re-directed patients and the impact to customer satisfaction
- Presbyterian could be perceived as the agent forcing unwanted change on patients, members and physicians – likely with the added perception that financial issues are the motive.
- Ensuring that regulators are supportive of the plans.
- Dissatisfaction from competing hospitals if they begin to realize a shift to their ED's

Core Messages/Supporting Evidence:

- To improve the quality, accessibility and affordability of health care, Presbyterian is embarking on a new model of helping patients who present at the Presbyterian Hospital ED with non-emergencies to access care in a more appropriate venue.
- Presbyterian is also working to expand the availability of care options so patients have more choice when it comes to obtaining "the right level of care at the right place."

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- Presbyterian is also working to educate patients and the greater community about how to determine the "right level of care at the right place" for their medical condition.
- Presbyterian wants more patients to become established with a primary care provider who can focus on the totality of the patient's health, including prevention and wellness.
- Through this effort, emergency department services will be better accessible for patients with true emergencies.
- By treating patients with non-emergencies in a more appropriate venue than a high cost acute-care setting, we help to reduce healthcare costs overall.
- By offering care in its integrated system, Presbyterian is better able to help patients access the right level of care in the right place.
- Presbyterian's goal is to widen the "safety net" of healthcare from the Emergency Department to across the continuum of care, starting with primary care.
- All State and Federal laws and regulations will continue to be followed to ensure patient safety and protect the health care system.
- Access to care will be timely and care will be equitable for all patients regardless of their ability to pay.

How will know that change is an improvement?

Program Measurement: TBD
Ideas:

- Number of patients re-directed from ED to appropriate care venue
- Number of patient encounters in ED, Urgent Care and Primary Care compared to benchmark
- Primary Care appointment availability, urgent care wait times
- Patient, Member, and Provider Satisfaction levels
- Amount of Charity Care provided
- Cost Savings of re-directed patients

What changes can we make that will result in an improvement?

Communication Tactics/Vehicles/Timing:

- Do we want to establish a dedicated phone number for questions? Web address?

Segment	Tactic, Vehicle	Timing	Accountable, Logistics	Approval	Post Implementation Follow-up
Employees					
Tier 1 – directly affected (ED, Urgent Care, Primary Care, PCSC, ABQ Ambulance, operators, Contracting dept.)	Staff meetings, talking points ED Physician meeting – completed 4/28	May/June/ July	Project team		Yes / No Timing: Method:

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Tier 2 – Leadership, Mgr, Sups	E-mail memo LDI presentation – completed 4/29	7/20			
Tier 3 – All EEs	E-mail memo, talking points PHP All –EE forums completed 7/8 and 7/9.	7/21			
Physicians					
Tier 1 – directly affected	Staff meetings	May/June/ July	Project team		
Tier 2 – PMG Lead MDs, PCP meetings, PMG Exec Council	Presentation, discussion E-mail to Primary Care and Urgent Care Providers	July 7/20			
Tier 3 – all PMG	Will receive All Employee e-mail memo	7/21			
Tier 4 – medical staff	E-mail memo	7/21			
Tier 5 –Four-county PHP contracted	Letter	7/21			
Board Members					
All boards	Front page of I.V.	6/18 Complete			
PHP board, PCNM board	Media alert, update after newspaper editorial briefing	7/15			
Patients					
Tier 1 – Presenting at ED	One-on-one communication with triage nurse, coordinator. talking points, written material	7/26			
Tier 2 – all PMG patients	Consider postcard, signage in PMG sites	HOLD on this TACTIC			
Tier 3 – specific outreach to patients who have accessed ED in last 18 mos for non-emergent conditions (de-dupe with similar PHP list)	Letter to Pts discharged from ED with certain Dx Data set based on encounter date, diagnosis, location _____ Select Patients: One-on-one communication with case manager	48,000 Letters go to post office on 7/21			
All – PHS.ORG	Post key external messages on phs.org – not on home page, on ED specific or hospital page	7/21			
Members					
Tier 1 – members who have accessed ED in last 18 mos for non-emergent conditions	WILL RECEIVE PATIENT LETTER	Letters go to post office on 7/21			
Tier 2 – all members	Information in member newsletters	Late July/August			
Other Commercial Payors					

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United Healthcare, others	Letter or phone call from Del. Sys. Contracting	7/9 – 7/23			
Local Healthcare Entities					
Lovelace, UNMH, Heart Hospital	CEO to CEO briefing	7/7 – 7/26			
NM Health Plan Association	Presentation	7/26-7/30			
Elected Officials					
Specifically identified group	Letter from Jim Hinton	Week of 7/19 * Recommending HOLD			
Regulators					
HSD – Secretary: Katie Falls	Letter, follow-up meeting if requested	7/13 Completed			
DOI – Johnny Montoya	Letter, follow up meeting if requested	7/15/10 Completed			
CMS – Branch Chief: Art Pagon	Letter	7/15/10 Completed			
DOH – Secretary: Dr. Alfredo Vigil	(DOH is the local agency that oversees complaints under the CMS conditions of participation)	7/9 – 7/16 pending			
NM Medical Review Association		7/15/10 Completed			
Agency on Aging and Long-term Services Secretary: Michael Spanier		7/15/10 Completed			
Key Advocacy Groups					
New Mexico Center on Law and Poverty	meeting	7/7 COMPLETE			
NM Voices for Children	Letter, follow up meeting if requested	7/9 – 7/23			
Healthcare for the Homeless	Meeting	7/9 – 7/23			
PHP Employer Groups					
All groups - Statewide	Letter or email from PHP – notification of change with delivery system service	Mail on 7/20			
Key groups ASO & 500+	Face-to-face meeting or phone call **Explore web video?	7/7 – 7/23			
PHP Brokers					
	e-mail	7/21			
Key Opinion Leaders					
	Letter or email Could send copy of editorial	Week of 7/19 * Recommending HOLD			

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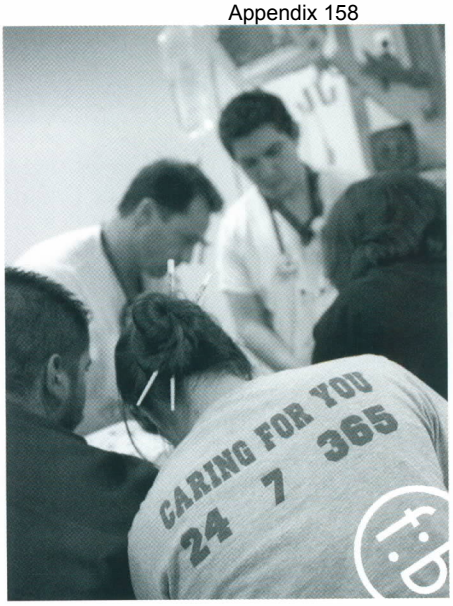
Media					
News release		Week of 7/19			
Editorial briefing, Media tour, presentation		7/14 Abq Journal, Ch 7 Completed Coverage expected 7/22			
Community Messaging					
Explore potential Public Service Announcements in cooperation with other local healthcare entities.		End of July			
Explore paid advertisements: TV, radio , outdoor Include Spanish-language media		End of July			

Budget: TBD

Approval: _____

Signature Date

Beginning July 26, 2010, the Presbyterian Hospital Emergency Department is starting a new process to help patients who come to the Presbyterian Hospital Emergency Department with *non-emergencies.*



What you can expect during your visit to the emergency department:

- You will receive a medical screening exam to determine your appropriate level of care.
- If your condition is an emergency, you will be treated in the emergency department.
- If your condition is not an emergency, you will be directed to an onsite patient navigator, who will make an appointment for you to be seen quickly in a primary care office or refer you to urgent care if primary care is not timely enough or inconvenient.

If you still wish to be treated in the emergency department after being informed your condition is not an emergency, you will be required to pay for services at the time of treatment. Under these circumstances, your health plan will likely not reimburse you if you have health insurance coverage.

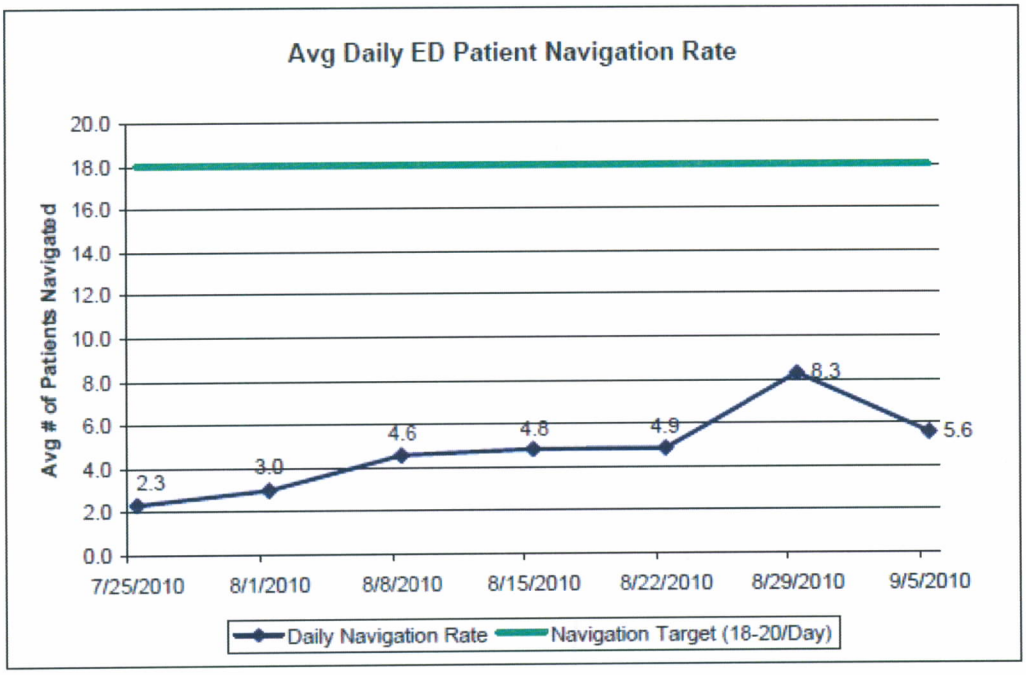
We thank you for entrusting Presbyterian with your healthcare needs. We realize you depend on us to keep you healthy and provide affordable, quality care. Making sure that you get the health care you need in a setting that is most appropriate for the level of care you need for your medical condition is one way Presbyterian is working to help lower the cost of health care.

We are very optimistic about this new and innovative approach as we work to make healthcare more affordable, accessible and of the highest quality.

phs.org **PRESBYTERIAN**

ED Patient Navigation Summary Report
Week of September 5, 2010

Week of:	25-Jul	1-Aug	8-Aug	15-Aug	22-Aug	29-Aug	5-Sep
Navigation Count	14	21	32	29	49	58	39
Daily Navigation Rate	2.3	3.0	4.6	4.8	4.9	8.3	5.6
Daily Post Treatment F/U Rate	15.7	12.0	16.0	12.4	13.4	14.7	11.9
PMG PC Scheduled Count	3	5	4	7	3	15	4
PMG PC Attendace Rate	33%	80%	25%	100%	33%	53%	75%
Navigation Target (18-20/Day)	18	18	18	18	18	18	18



ED Patient Navigation Report as of 12/31/2012

December 2012 CNM Acuity

CDM	KPH	PHS	RMC
00036701 - PRO-LEVEL 1 BRIEF	22	33	6
00036702 - PRO-LEVEL 2 LIMITED	190	253	101
00036703 - PRO-LEVEL 3 INTERMEDIATE	602	793	362
00036704 - PRO-LEVEL 4 EXTENDED	1510	2580	1265
00036705 - PRO-LEVEL 5 COMPREHENSIVE	286	1240	502
00036713 - PRO-LEVEL 6 CRITICAL CARE 1HR	9	91	16
00037993 - MEDICAL SCREENING EXAM	215	314	184

December 2012 MSE Data

	MSE versus Low Acuity (LVL 1, 2, 3, MSE)
Overall	23.2%
KPH	20.9%
PHS	22.5%
RMC	28.2%

From: Program Sponsor

Date

Emergency Department Patient Navigation
Leadership Team Members

Subject: ED Patient Navigation - Leadership Study

Dear Leaders:

As part of our learning process as an organization, I'd like to ask you to participate in a study to understand what you learned as a result of your efforts on the ED Patient Navigation project.

The purpose of this study is to learn more about your experience leading a successful change effort through the use of reflection upon your experience, habits of mind, and how, or if, you changed in order to capture learning from you who were directly involved in leading the Emergency Department Patient Navigation Program (EDPN).

I will be publishing the findings of this study in my PhD dissertation as the Principal Investigator of the study through the Organizational Learning and Instructional Technologies department at the University of New Mexico. I am also a Learning Consultant in the Presbyterian Learning Center. If at any time you wish to stop the interview, to stop video or audio recording, to change your response, or to restrict the information in any way, you are welcome to do so. No names will be used in the final report; your comments will be aggregated and reported together. You will have an opportunity to learn the findings of the study once it is completed.

You will be contacted soon to arrange a time for a one-on-one interview. I encourage you to participate and to speak freely and openly.

Please feel free to contact me if you have any questions or concerns.

Sincerely,

Leslie Rettinger
Principal Investigator
University of New Mexico

The University of New Mexico Health Sciences Center
Consent to Participate in Research

What leaders learn as they lead successful organizational change efforts

Purpose and General Information

You are being asked to participate in a research study that is being done by Leslie Rettinger, who is the Principal Investigator, and no others. This research is being done to evaluate through qualitative methods, what you as a leader experienced as you sought system-wide solutions to the complex problem overcrowding in Emergency Rooms. Your team accomplished the goals of the program which improved patient care and saved the money. You are being asked to participate because you have been identified as a leader who participated in this program. Approximately 12 people will take part in this study at Presbyterian Healthcare Services. There are no participants expected to participate from outside the State of New Mexico. Dr. Mark Stern, Medical Director, is the sponsor of this study.

This form will explain the study to you, including the possible risks as well as the possible benefits of participating. This is so you can make an informed choice about whether or not to participate in this study. Please read this Consent Form carefully. Ask the investigators or study staff to explain any words or information that you do not clearly understand.

What will happen if I participate?

If you agree to be in this study, you will be asked to read and sign this Consent Form. After you sign the Consent Form, the following things will happen:

1) You will be invited to participate.
2) A one-on-one interview will be arranged.
3) You will be asked to sign this consent form.
4) The interview will be conducted using the questions provided.
5) A video or audio recording will be made of the interview.

Participation in this study will take a total of 2 hours hours over a period of 2 months.

What are the possible risks or discomforts of being in this study?

Every effort will be made to protect the information you give us. However, there is a small risk of loss of confidentiality that may result from the comments made that identify you by your role. It is not anticipated that discussion of your leadership experience will create stress or emotional distress; however, if you have any concerns you may stop the interview or withdraw your comments at any time. No other risks other than inconvenience are known. Every effort will be made to minimize inconvenience to you. You may be asked to come back for additional questions after completion of the initial interview.

How will my information be kept confidential?

Your name and other identifying information will be maintained in locked files, available only to authorized members of the research team, for the duration of the study. For any information entered into a computer, the only identifier will be a unique identification (ID) number without your name. Any personal identifying information and any record linking that information to study ID numbers will be destroyed when the study is completed. Information resulting from this study will be used for research purposes and may be published; however, you will not be identified by name in any publications.

Information from your participation in this study may be reviewed by Dr. Mark Stern, federal and state regulatory agencies, and by the UNM Human Research Review Committee (HRRC) which provides regulatory and ethical oversight of human research.

What are the benefits to being in this study?
There may or may not be direct benefit to you from being in this study. However, your participation may help find out how you can identify, qualify, and apply learning from your participation in this project.

What other choices do I have if I don't participate?
Taking part in this study is voluntary so you can choose not to participate.

Will I be paid for taking part in this study?
No compensation is provided.

Can I stop being in the study once I begin?
Yes. You can withdraw from this study at any time without affecting your participation in the program.

The investigators have the right to end your participation in this study if they determine that you no longer qualify to take part, if you do not follow study procedures, or if it is in your best interest or the study's best interest to stop your participation. The Sponsor may stop the study at any time.

What if I have questions or complaints about this study?
If you have any questions, concerns or complaints at any time about the research study, Leslie Rettinger, PhD Candidate in Organizational Learning and Instructional Technology , or her associates will be glad to answer them at 923-8808. If you would like to speak with someone other than the research team, you may call the Human Research Review Committee (HRRC) at (505) 272-1129. The HRRC is a group of people from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human subjects.

What are my rights as a research subject?
If you have questions regarding your rights as a research subject, you may call the HRRC at (505) 272-1129 or visit the HRRC website at http://hsc.unm.edu/som/research/hrrc/.

Consent and Authorization
You are making a decision whether to participate in this study and whether you agree to video or audio recording. Your signature in both sections below indicates that you read the information provided (or the information was read to you). By signing this Consent Form, you are not waiving any of your legal rights as a research subject.

I have had an opportunity to ask questions about participation in this study and all questions have been answered to my satisfaction. By signing this Consent Form, I agree to participate in this study and give permission for my answers to be used or disclosed as described in this Consent Form. A copy of this Consent Form will be provided to me.

Name of Participant (print)	Signature of Participant	/ Date

OFFICIAL USE ONLY

APPROVED EXPIRES

The University of New Mexico Human Research Review Committee

I have had an opportunity to ask questions about video and audio taping and all questions have been answered to my satisfaction. By signing this Consent Form, I am indicating whether I agree or do not agree to participate in video or audio taping in this study. A copy of this Consent Form will be provided to me.

☐ I **give** permission for my answers to be recorded by video or audio as described in this Consent Form.

☐ I **do not give** permission for my answers to be recorded by video or audio as described in this Consent Form.

_____ _____/_____

Name of Participant (print) Signature of Participant Date

I have explained the research to the subject and answered all of his/her questions. I believe that he/she understands the information in this consent form and freely consents to participate.

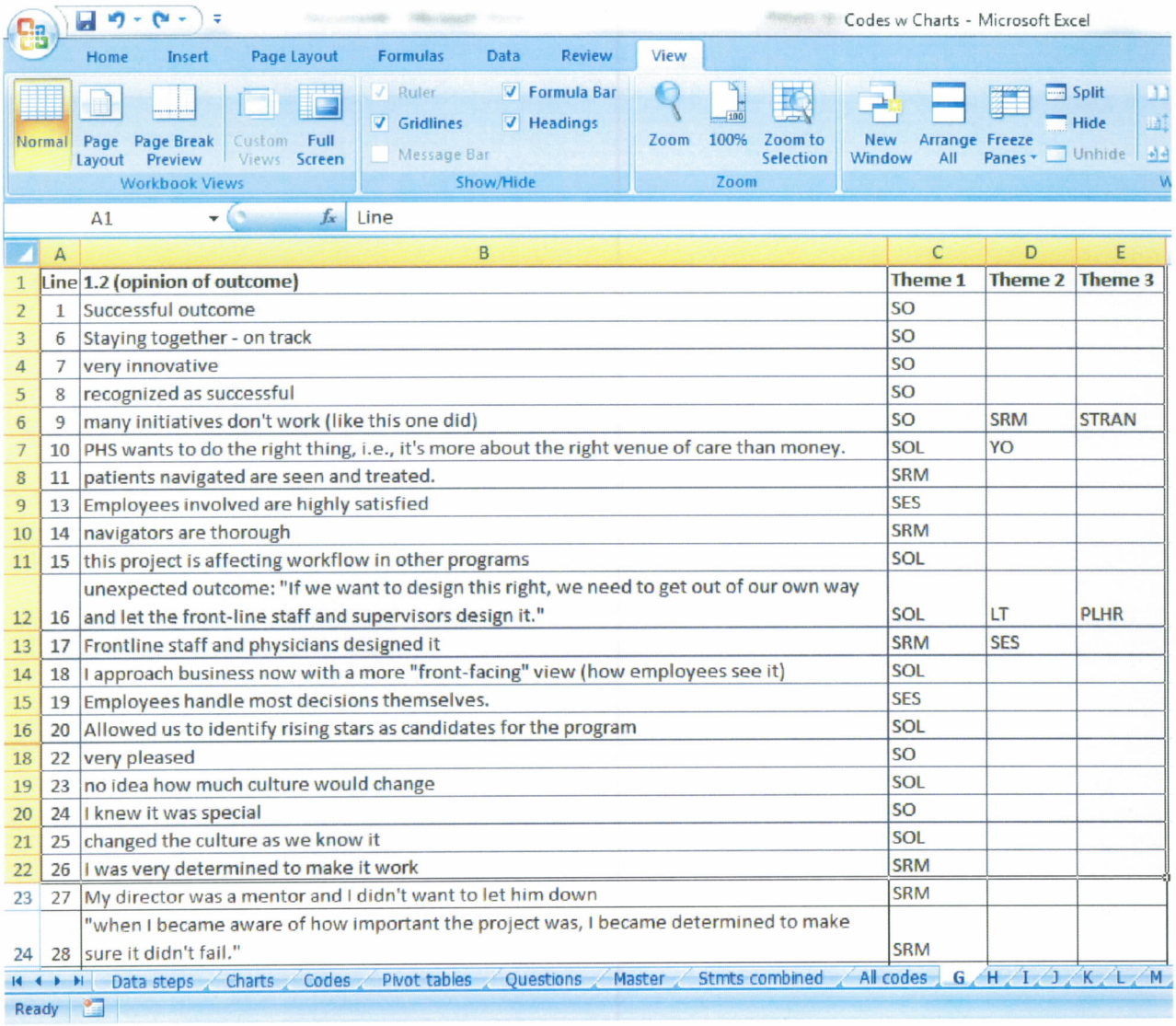
_____ _____/_____

Name of Research Team Member Signature of Research Team Member/Date

MASTER INTERVIEW NOTES EXAMPLE

PARTICIPANT ID	1.1 (role)	1.2 (outcome)	1.3 (changes)	1.4 (before v. after)	1.5 (surprise)	1.6 (crit decisions)	2.2 (did you shift)
RESPONSES							
11.1.27.12	Program manager, project manager	Successful outcome	Changes were impactful	B: Patients treated in ED	Not as much for me as clinical folks might have experienced	Pre-initiation decisions were important, such as selection of leader sponsors	No - stayed excited
	3/4 time along with a Black belt colleague	Long-term project	Large scale change	B: looking at ways to change how, but never considered not treating	I expected push back	Core-team buy in was important. They believed it and decided to support it	Some periods were more challenging than others
	1st PHS project	Not done in 6 months	Asking providers to do something they have never done	A: PCSC was a huge contributor to the success because of their involvement from Day 1		physician buy-in for non-emergent diagnosis was huge	Tough concerns challenged me to work through it
		Required lots of care and feeding	Physicians treated emergent patients	A: Best place to treat patients was to establish primary care relationship		Urgent Care was included later because there was a disconnect. Needed buy-in for ED vs. UC care decisions	

CODING OF STATEMENTS



	A	B	C	D	E
1	Line	1.2 (opinion of outcome)	Theme 1	Theme 2	Theme 3
2	1	Successful outcome	SO		
3	6	Staying together - on track	SO		
4	7	very innovative	SO		
5	8	recognized as successful	SO		
6	9	many initiatives don't work (like this one did)	SO	SRM	STRAN
7	10	PHS wants to do the right thing, i.e., it's more about the right venue of care than money.	SOL	YO	
8	11	patients navigated are seen and treated.	SRM		
9	13	Employees involved are highly satisfied	SES		
10	14	navigators are thorough	SRM		
11	15	this project is affecting workflow in other programs	SOL		
12	16	unexpected outcome: "If we want to design this right, we need to get out of our own way and let the front-line staff and supervisors design it."	SOL	LT	PLHR
13	17	Frontline staff and physicians designed it	SRM	SES	
14	18	I approach business now with a more "front-facing" view (how employees see it)	SOL		
15	19	Employees handle most decisions themselves.	SES		
16	20	Allowed us to identify rising stars as candidates for the program	SOL		
18	22	very pleased	SO		
19	23	no idea how much culture would change	SOL		
20	24	I knew it was special	SO		
21	25	changed the culture as we know it	SOL		
22	26	I was very determined to make it work	SRM		
23	27	My director was a mentor and I didn't want to let him down	SRM		
24	28	"when I became aware of how important the project was, I became determined to make sure it didn't fail."	SRM		

Interview Questions	Tab
Emergency Department Patient Navigation Leadership Case Study	
The purpose of this case study is to explore the personal experience of leaders in a healthcare environment as they participated in a successful change effort that transformed the delivery of care in an Emergency Room environment at Presbyterian Healthcare Services in Albuquerque, New Mexico.	
You have been identified as a leader with direct responsibility over the implementation of the Emergency Department Patient Navigation (EDPN) program. You are invited to reflect upon your experience in the EDPN program. Reflection is a powerful tool to capture learning that we might otherwise miss. The purpose of this study is to guide you through the process of reflection upon your own experience, habits of mind, and how, or if, it changed your personal leadership. The questions are meant to guide you through the process; however, if you find that there is something important about that is not captured as you answer the questions, please be sure to mention it.	
The findings of this study will be published as a dissertation by Leslie Rettinger. If at any time you wish to stop the interview, to change your response, or to restrict the information in any way, you are welcome to do so. No names will be used in the final report, however; your comments will be aggregated and reported together. You may be contacted at later date for follow up should additional questions arise.	
Please feel free to speak freely and openly.	
Please provide background information about your role in this effort and the context in which your participation took place.	
1. What was your role in this program?	
2. What is your opinion of the outcome?	G
3. What is your opinion about the changes that you implemented?	H
4. Please describe the state or context before the change and what is different now.	I
5. What aspects surprised you?	J
6. What do you consider to be critical decision points?	K
One definition of Transformative Learning involves experiencing a deep, structural shift in the basic premises of thought, feelings, and actions. As you reflect upon your participation in this project, please answer the following questions:	
1. What was your original state of mind when you started this program? Why?	L
2. Did you experience a shift in your thoughts, feelings and/or actions?	M

3. If so, was there something specific that happened or that you came to believe that influenced this change? What was it? Why did it influence you?	N
4. What did you learn?	O
5. How has that influenced your current thoughts, feelings and/or actions?	P
6. How did your participation on this project affect how you approach leading in other situations?	Q
O'Sullivan, E. (2003) "Bringing a perspective of transformative learning to globalized consumption." *International Journal of Consumer Studies*, 27 (4), 326–330	
Some studies have shown that leaders of successful change efforts tend to share common characteristics such as being highly adaptable. Leaders with low adaptability are more likely to block change because they themselves are unwilling to undertake the personal transition associated with major change. Highly adaptable people tend to be: optimistic, self-assured, innovative, collaborative, purposeful, structured, and proactive.	
1. Did you demonstrate any of these characteristics? If so, which ones? Please describe how you demonstrated these characteristics.	R
2. How will participation in this effort affect your adaptability in future leadership efforts?	S
3. Did your participation in this effort affect your adaptability in general? If so, how?	T
Successful change leaders tend to be actively involved and recognize the need to model the change themselves. They drive focus on the change effort more than their less successful counterparts. They tend to clarify the risks or costs of failure with respect to the customer, the organization, the individual employee, or to the leaders themselves in ways that help others to create meaning for their effort.	
1. How involved were you in this effort? What did your involvement look like?	U
2. Did you model the behavior yourself you wanted to see? What did you do?	V
3. Did you encounter opportunities when you needed to drive focus on the change effort? What did you do?	W
4. How did you create an environment for dialog and interaction for others to make sense of the change?	X
5. How and what did you monitor to ensure that the effort was successful? What was the result?	Y
Miller, D (2002). Successful change leaders: What makes them? What do they do that is different? *Journal of Change Management.Vol 2, 4 359-368.* Henry Steward Publications 1469-7017.	
Is there anything else you'd like to add?	Z
Additional follow up questions asked.	AA

THEMES	CODE
Team	
Composition	TCOMP
Provider involvement	TPI
Enterprise collaboration	TEC
Approach to barriers	TB
Communication	
Communication in general	COM
Honest: left it all in the room	CH
Extensive dialog	CD
Frequent	CF
Open	CO
Responsive	CR
Respectful/Listening	CRE
Did not delegate	CND
Transparent: Internal report available to all	CT
External commitment (community, other EDs, Govt & reg agencies)	CE
Data driven (anecdotes challenged by facts)	CDD
Data Support	
Reliable	DR
Fast	DF
Clinical language	DC
Risk Mitigation	
captured concerns	RC
Captured planned responses	RR
represented being heard	RH
written in language anyone could use	RL
dialog tool (captured concerns, then used when facing resistance)	RD
Leadership	
CEO Challenge	LC
Enterprise Leader support	LE
Mark & Lisa as co-champions	LML
Modeling of desired behaviors	LM
In the trenches	LT
Ambiguity tolerated	LA
Speed was key to momentum	LS
Patient care 1st	LP
Financial stewardship	LF
Committed to success	LCS
Different approach	LDA
Process Design	LPD
Willingness to make difficult decisions	LD

Innovative Approach	LIA
Optimistic Approach	LOA
Confident Approach	LCA
Proactive Approach	LPA
Trust	
Process built trust	TP
Communication built trust	TCOM
Shared risk built trust	TR
Shared accountability built trust	TA
Early wins increased trust	TW
Being heard built trust	TH
True Just Culture	TJC
Real solutions to a big problem built trust	TS
Enterprise demonstration of commitment built trust	TE
Ability to stop the line built trust	TSL
Yielding overall	
High stakes/high trust atmosphere increased willingness to change	YO
engagement of all in outcome	YE
Barrier removal	YB
Provider Yielding	
Changed practice in violation of training, industry, personal identity, preference and beliefs	YP
Not all providers yielded	YNP
Process Oversight Yielding	
Used tools to support, not control	YPO
Changed tools when no longer serving the bigger purpose	YPOC
"no fluff" lean approach - no process for process sake	YPOL
Other	
Surprises	AS
Adaptability	AA
Successful Outcomes	
Overall program achieved a successful outcome	SO
Requirements Met	SRM
Patient Satisfaction	SPS
Employee Satisfaction	SES
Organizational learning that increased willingness to take on others	SOL
Community benefit	SC
Better care	SBC
Successfully transformed care	STRAN
Commited to do the right thing	SRT
Successful financial benefit	SFB

MASTER LIST OF CODES

Successfully achieved access	SA
Success was mixed	SM
Success was negative or not achieved	SN
Personal Leadership	
Key Learning	KL
No transformation	
low personal risk = no transformation	PLNT
expected transformation, so it wasn't a surprise	PLE
Transformed	PLT
high personal risk = high transformation	PLHR
adaptabiity starts low but grows	PLAG
followed a successful example	PSE
expected failure and was surprised	PLSF
Personal shift to agreement	PSA
Adaptability	
Increased	AI
Started high and helped	ASH
Started low and didn't help	ASL
Beliefs before Intervention that Transformed	
Belief that successful outcome was possible	BSO
Belief that better care for patient would result	BBC
Belief that financial outcome outweighed best patient care	BFO
Belief that regulatory community would support approach	BRC
Belief that community of patients would respond	BPR
Belief that Navigators were the right role	BNR
Belief that leadership would support if challenged	BLS
Belief that employees will be heard	BEH
Navigators	
Navigator role in general	NR
Navigator front line decisions	NFL
Navigator skill	NS
Navigator support to staff	NSS
Navigator support to patient	NP
total # of codes	93

SAMPLE OF CODES ON INDIVIDUAL LINES

Line	Question (What is your opinion of the Outcome?)	Code	Theme
G10	many initiatives don't work (like this one did)	SO	1
G10	many initiatives don't work (like this one did)	SRM	2
G10	many initiatives don't work (like this one did)	STRAN	3
G11	PHS wants to do the right thing, i.e., it's more about the right venue of care than money.	SOL	1
G11	PHS wants to do the right thing, i.e., it's more about the right venue of care than money.	YO	2
G11	PHS wants to do the right thing, i.e., it's more about the right venue of care than money.	LP	3
G14	Employees involved are highly satisfied	SES	1
G15	navigators are thorough	SRM	1
G16	this project is affecting workflow in other programs	SOL	1
G17	unexpected outcome: "If we want to design this right, we need to get out of our own way and let the front-line staff and supervisors design it."	SOL	1
G17	unexpected outcome: "If we want to design this right, we need to get out of our own way and let the front-line staff and supervisors design it."	LT	2
G17	unexpected outcome: "If we want to design this right, we need to get out of our own way and let the front-line staff and supervisors design it."	PLHR	3
G18	Frontline staff and physicians designed it	SRM	1
G18	Frontline staff and physicians designed it	SES	2
G19	I approach business now with a more "front-facing" view (how employees see it)	SOL	1

PIVOT TABLES	
Row Labels	**Count of Line**
PSA	218
KL	170
LM	147
CD	143
LD	116
AS	109
LCS	108
LT	104
CDD	91
SOL	89
SO	87
TB	77
CRE	76
STRAN	64
TPI	64
CT	61
BNR	56
BSO	56
TEC	55
LE	53
YP	52
LML	50
AI	49
YPO	43
TCOMP	42
SBC	42
PLHR	42
BBC	41
PLE	41
YE	40
NR	40
PLAG	39
CND	37
SRM	34
LPD	33
TCOM	32
BPR	32
YO	30
LDA	29
TH	28
NS	28
CTIME	27
NFL	25
COM	25
LP	25

SPS	24
CF	23
ASL	23
BLS	23
TA	23
PLSF	21
CO	20
YNP	20
CH	18
LA	17
BFO	16
ASH	16
SES	16
NP	16
PSE	15
SC	15
RR	15
PLNT	15
TP	14
LIA	14
RD	13
TSL	12
RC	12
SM	12
CR	12
TS	11
DR	10
LOA	10
LC	10
TR	10
RH	10
NSS	9
CE	9
AA	8
TW	8
LS	8
DF	8
LCA	8
Code	8
SFB	7
SA	6
CR	6
RL	6
LPA	5
BRC	5
YB	5
DC	5
TJC	4
SN	2
(blank)	
Grand Total	**3453**