HARNESS THE POWER OF INTEGRATED TEAMS

Dr. Mulvihill’s Case Study | By Mari Ransco, MA, Chrissy Daniels, MS, Steven Johnson, MBA, Benjamin Tanner, MHA, Sean Mulvihill, MD

THE PROBLEM

Ask anyone in healthcare if they are part of a team and they will likely say yes. But those are usually discipline-specific teams of nurses, pharmacists, and physicians. Each team delivers care to the patient in a hub and spoke model, where each group touches the patient independently. But do we design our care through integrated teams and deliver it through coordinated process? Barriers to integration include our historical hierarchies, our time-starved environment, our measurement and goals, and even our language. Changing culture requires deliberate planning executed by persistent leadership.

BIG IDEA: The following case study examines a new core competency in delivering value at a system level. At the University of Utah, leaders created integrated oncology teams organized around the patient. Collapsing historical silos and empowering front-line leaders grew adaptive teams that offered better value to cancer patients.

Background

In 2001, the University of Utah Board of Trustees finalized their decision: the university would build a hospital dedicated to the treatment and healing of cancer patients. The pieces seemed in place: Jon Huntsman Sr. had already given $100 million for the completion of the Huntsman Cancer Institute, dedicated to research, and now he was promising another $125 million.

Some hospital leaders were ready to experiment with a new way to deliver patient care: multidisciplinary teams. But team-based care and a dedicated cancer hospital challenged several institutional norms. Cancer care was not organized around the patient; both in clinical delivery and in the way the data had been organized.

Barrier #1: Physician-centric delivery system

The care delivery system had long been organized around the physician. Patients experienced physician-centric systems most directly as long waits to see a renowned doctor after their diagnosis. It was a traditional department structure—patients would move from department to department on progressive days. One day they may see an oncologist, and then return the following week to see a surgeon.

Learn about catalysts for progress on page 5.
Becoming more patient-centered also meant changing the nature of faculty research. Administrators and physicians believed that patients wanted to participate in clinical trials and translational research. Those types of physician-researchers would need to be grown internally or recruited externally.

**Barrier #2: Incomplete data**

Another barrier to developing a new cancer program was decentralized medical records. A dearth of data around cancer patients was both a problem at the University of Utah and at a national level, which hindered strategic planning around oncology patients.

**The Dyad**

Dr. Sean Mulvihill joined the faculty in 2002 as the chair of surgery. In his surgical practice, Mulvihill specialized in cancers of the liver, pancreas and bile ducts. He would play a critical role in organizing physicians into effective teams.

Ben Tanner felt a personal drive to make cancer care easier to navigate and supportive of patients and their families. Tanner had personally experienced the complicated and stressful nature of cancer care at the University of Utah, and had eventually sought care at MD Anderson Cancer Center in Texas. He came back to Utah, determined to bring this model back.

**THE SOLUTION**

**Step 1: Alignment**

Hospital leaders decided to reorganize cancer care into multidisciplinary teams in 1999. Initially, leaders believed that once everyone understood the vision, the doctors would implement. Ben Tanner knew everyone involved had deep personal compassion for patients, so organizing around the patient should be easy.

Managing how vision translated into action was hard. Twelve clinical oncology teams were established: melanoma, breast, thoracic, neuro-brain, urological, gastrointestinal, sarcoma, gynecological, head/neck, hematologic, palliative, neuro-spine. (It has since grown to 13 areas.) Physicians joined the teams with promises of dedicated clinic and office space. Each team consisted of a medical oncologist, surgeon, radiation oncologist, pathologist, radiologist, pharmacist, and social worker.
Yet, the teams existed only in name. Organizing a system around the patient proved exceedingly difficult. While the teams of physicians existed, the support structure did not, and patients continued to enter the system in a variety of uncoordinated ways.

**Step 2: Team Structure**

A new physician leader, Sean Mulvihill, would help build the physician engagement sorely needed. He created the structure necessary for the multidisciplinary teams to deliver on their promise.

First, Mulvihill looked for new physicians to lead the multidisciplinary cancer teams. He recruited faculty who had the respect of their peers and believed the multidisciplinary approach, but were not embedded in the current state. Mulvihill reduced complexity for the teams by empowering them to act. Each team leader developed goals with Mulvihill and Ben Tanner centered on the areas needed for success: patient volume, research engagement, and financial return.

Mulvihill, Tanner and the physician team leaders established autonomy, accountability, and peer-to-peer transparency as their guiding principles.

Mulvihill invested in context so that team leaders could understand the drivers of organizational success. The structure established by Mulvihill empowered leaders for action and experimentation at the local level.

Learn about “Strategy Networks” on page 7.

**Step 3: Expanding the Team**

The rest of the team needed to grow to support the physician team. Tanner invested in new positions, such as patient coordinators, to help patients navigate the system and organize appointments.

Small wins fueled support and engagement. The new Huntsman Cancer Hospital shattered expectations by earning money in its first year, instead of losing millions of dollars as everyone expected.

As the team structure gained influence, more people became part of important local decision making. All members of the care team, including nurses and coordinators, were welcome. The message was that more context in the hands of all the people that touched the patient provided better value for the patient.

**THE REFLECTION**

Huntsman Cancer Hospital is now a world-renowned center of cancer care and research. Outpatient and inpatient volume continues to grow, with some of the best patient satisfaction in the county. Researchers at Huntsman have received international attention for their work. Over $35 million is spent each year on direct cancer research.
Key to success has been focus on three guiding principles:

1. Patients come first
2. Unified effort. We’re all in this for the same reason: to serve
3. Excellence in all we do

Teams are constantly auditing their work based on performance metrics (patient satisfaction, clinic volume, and financial returns) and designing team-based solutions. The core of success has been agility in the multidisciplinary teams to respond nimbly to change.

Mulvihill and Tanner fostered a culture that valued context and transparency. They helped each team understand the big picture of organizational success, and then supported them as they designed local solutions. Importantly, they also nurtured processes that facilitated teams learning and collaborating with each other. General Stanley McChrystal illustrates this concept in his book, Team of Teams. McChrystal defines context as a pattern of consistent transparency that empowers a team to continuously and accurately correct actions and decisions. Context increases the effectiveness and agility of teams.

Learn more about using context to empower teams on page 7.
On Catalysts for Progress

1. Setting clear goals: People have better work lives when they know where work is heading and why it matters.
2. Allowing autonomy: To be truly intrinsically motivated and to gain a sense of self-efficacy when they do make progress, people need to have some say in their own work.
3. Providing resources: Providing resources allows employees to envision success on a project, but it also signifies that the organization values what they are doing.
4. Giving enough time—but not too much: People need realistic timelines.
5. Help with the work: Help can take many forms, from providing needed information, to brainstorming with a colleague, to collaborating with someone who is struggling.
6. Learning from problems and successes: When problems are faced squarely, analyzed, and met with plans to overcome or learn, people fare better. People also fare better when successes, even small ones, were celebrated and then analyzed for knowledge gained.
7. Allowing ideas to flow: Encouraging ideas to flow freely within the team and across the organization.


More About Huntsman Cancer Institute’s (HCI) Transformation

Imagine you are diagnosed with cancer. You begin to experience a range of emotions; grief, worry, pain. You begin to pin hopes on an appointment with a specialist that is several weeks out. What will the doctor tell me? What are my chances? Anticipation is dominated by fear of the unknown. On the day of the appointment, you awake early after a sleepless night. You drive, perhaps 45 minutes, struggle to find parking, and arrive at your appointment only to wait several hours for a world-renowned professor of medicine. But she’s worth the wait, right? After 2 hours, you finally see the doctor and discover that your medical records didn’t make it to her office. While waiting for your records, the doctor says, let’s have you re-scanned. The next available radiology appointment is a week out. You face another week of waiting. Home again, watching the television, you see an ad for MD Anderson Cancer Center in Texas and wonder, would it be different, or better?

This might have been your experience if you had received cancer care at the University of Utah in 1998. The University of Utah treated cancer patients, but were they getting the best care?

Each leader was given a team and a budget with discretionary spending with clear expectations for the growth of the clinical program. Each team leader completed a pro forma, market needs assessments, and showed
trending data. Mulvihill’s team of leaders met as a group monthly for open roundtable discussions about their programs with the expectation that they would transparently share team performance. At an annual report-out, team leaders reviewed their budget performance, clinical volumes, and the progress of the clinical trials.

Mulvihill remembered, “That peer review concept had a lot of influence on the way we did our day-to-day work and management. We’re going to be accountable to each other and critique each other’s performance. Everybody wants to excel because you don’t want to be embarrassed in front of your peers. When you put it in a public forum, what we accomplished with clinical trials, about clinical volumes, then everybody feels a good pressure.”

The team was focused on the success of the system as a whole, not just on the success of an individual. Mulvihill recalls, “We felt accountability to make this work, to show that we could do this effectively. I felt our success was going to be predicated on everybody being held accountable for their clinical program. It’s not that the breast cancer program is successful, and then by the way, we’re losing all this money over in oncology in orthopedics and neurosurgery. We had to be accountable to each other.”

Mulvihill invested in context so that team leaders could understand the drivers of organizational success. They worked as a team to define local success in context of organizational success. Mulvihill built a volunteer army who were individually responsible for their part of delivering value to cancer patients. Physicians moved to being leaders of teams, and worked as partners with clinical administration. The structure established by Mulvihill empowered leaders for action and experimentation at the local level.

**On Integrated Practice Units (IPUs)**

“At the core of the value transformation is changing the way clinicians are organized to deliver care. The first principle in structuring any organization or business is to organize around the customer and the need. In health care, that requires a shift from today’s siloed organization by specialty department and discrete service to organizing around the patient’s medical condition. We call such a structure an integrated practice unit. In an IPU, a dedicated team made up of both clinical and nonclinical personnel provides the full care cycle for the patient’s condition.”

**What is an Integrated Practice Unit?**

1) An IPU is organized around a medical condition or a set of closely related conditions (or around defined patient segments for primary care).
2) Care is delivered by a dedicated, multidisciplinary team of clinicians who devote a significant portion of their time to the medical condition.
3) Providers see themselves as part of a common organizational unit.
4) The team takes responsibility for the full cycle of care for the condition, encompassing outpatient, inpatient, and rehabilitative care, and supporting services (such as nutrition, social work, and behavioral health).
5) Patient education, engagement, and follow-up are integrated into care.
6) The unit has a single administrative and scheduling structure.
7) To a large extent, care is co-located in dedicated facilities.
8) A physician team captain or a clinical care manager (or both) oversees each patient’s care process.
9) The team measures outcomes, costs, and processes for each patient using a common measurement platform.
10) The providers on the team meet formally and informally on a regular basis to discuss patients, processes, and results.
11) Joint accountability is accepted for outcomes and costs.


On Strategy Networks

Kotter writes, “The core of a strategy network is the guiding coalition (GC), which is made up of volunteers from throughout the organization…A strategy network…needs lots of leadership, which means it operates with different processes and language and expectations. The game is all about vision, opportunity, agility, inspired action, and celebration—not project management, budget reviews, reporting relationships, compensation, and accountability to a plan…It is vital that this army be made up of individuals who bring energy, commitment, and genuine enthusiasm. They are not a bunch of grunts carrying out orders from the brass. Rather, they are change leaders. Whereas hierarchies require management to maintain the efficient status quo, networks demand leadership from every individual within them.” Excerpt from Kotter JP, “Accelerate!” Harvard Business Review, November 2012. https://hbr.org/2012/11/accelerate.

Using Context To Empower Teams

It is more than simply “decentralizing decision making. If you push authority (and responsibility) for decisions down to lower levels but don’t accompany that with all the contextual understanding (based on information flow), you’ve set your teams and junior leaders unfairly up for failure. You can’t expect people to make the right decisions unless given the tools. But when you pass both the contextual understanding down, and accompany that with the freedom to decide and act, you find the decisions made closer to the action (or closer to the patient) can be faster, more precise, and nuanced where necessary. In combat I found that given the tools, junior leaders made extraordinary judgments under great pressure—but only when I created an environment that sets them up for success.” (FastCo interview of authors of Team of Teams) http://www.fastcompany.com/3045477/work-smart/goodbye-org-chart