THE PROBLEM
Why is change necessary? What will the benefits be? What’s in it for me? These three questions are at the core of leading successful change efforts. The irony is that when asked about change, most leaders think their job is to come up with answers—not communicate vision. In the new world of value, all teams will need a deeper understanding of context and direction in order to be nimble. Teams will need to understand the work that needs to be done today, understand the challenges of the future, and their role in moving towards that vision. Leaders will need to increase their competency with the leading skills of vision, direction, and alignment combined with the managing skills of measurement, prioritization and clear goals.

BIG IDEA: The following University of Utah case study examines a new core competency in delivering value at the systems level—leaders must possess the knowledge, skill and ability to effectively communicate a vision for change, by reconciling external pressures with organizational culture and values.

Background
In 2011, by all accounts University of Utah was winning the healthcare quality challenge. The organization had made the shift to deliver on CMS’s first round of public transparency (core measures). The organization had focused on patient satisfaction for several years, so HCAHPS was not foreign territory. And more importantly, Utah had been awarded a #1 national ranking among academic medical centers in the very competitive University Healthcare Consortium (UHC) Quality and Accountability Scorecard. But even with all this success, the hospital executive team was concerned. The quality landscape was shifting.

CMS was continuing to add increasingly complex measures of quality, often focused on patients with specific clinical conditions. Chief Nursing Officer Margaret Pearce could see that the organization could not continue to rely solely on the nursing led strategies of the past. Success would depend on physicians joining the effort to improve publically reported quality measures.

Learn more about the national transparency landscape on page 5.

The Leader
In 2011, Bob Pendleton was a busy physician. He was leading University of Utah’s hospitalist team, teaching trainees and developing research in a nationally recognized thrombosis management service. On a routine care day, he received a call from the hospital’s quality department asking for his help to improve performance on the CMS Pneumonia Core Measure. His response: “what is a core measure?”
As Pendleton learned about core measures, his reaction was a mixture of interest and shock. There was a national transformation happening around measurement in quality, safety, accountability and public transparency that he knew nothing about.

Pendleton spent several weeks researching quality metrics. He realized that this information was vast – and not on the radar of the health system’s physicians. Pendleton met with the Chief Medical Officer (CMO), Thomas Miller. He described the lack of physician engagement around quality measures and proposed a solution. The University of Utah needed a Chief Medical Quality Officer, a physician leader to understand quality metrics and then support fellow physicians in improving performance.

Learn more about motivation and change on page 5.

THE SOLUTION

Step 1: Invest in physician leadership

In 2012, Pendleton became the University of Utah’s first Chief Medical Quality Officer. Pendleton had led the hospitalists and thrombosis service, but this new position required him to better understand the needs of both administrative and academic worlds and to help translate external requirements to meaningful change for patients. His next step: learn quality.

Most books focused on narrow or theoretical definitions of quality—not the current fast paced changes of an integrated system moving towards value. And the sands were shifting much more than he anticipated.

Equally troubling were the cultural barriers Pendleton encountered. It was clear many of his physician colleagues were uncomfortable with the idea of having their performance measured in the first place. In order to move forward, he would need to directly address the perceived conflict between physician autonomy and external measurement of value.

Pendleton understood that above all else, the organization needed to believe that quality metrics mattered. He said “Early on, I really struggled with balancing all of these external pressures with the intent of transforming health care. It is so easy to lose sight of why we are doing this…You can easily criticize many of these measures as not being good enough.”

Instead of looking at the external pressure negatively, Pendleton found that quality metrics resonated with his personal vision of medicine. “For me, tying it back to the patient makes it easier…We are always saying transformation in health care is SO HARD. We should be saying that it is SO EASY. There is no better true north than making it possible for someone to live a better life with better health.”
Step 2: Spread the vision

Pendleton wanted to guide the organization and provide the tools and skills needed to improve. The work was complex and ever changing which necessitated that he help leaders, staff, and physicians piece together the context—the “why”—for change. He started sharing his vision with one on one meetings, but that soon mushroomed. He began to see what resonated and what didn’t. His message was essentially the same for every group: 1) We are moving from volume to value in healthcare, 2) value requires measurement to guide better care for our patients, and 3) here is what I need from you. Pendleton’s weekly talks became daily talks, often to groups he didn’t know existed. In the first two years, he estimates that he presented his vision nearly 800 times. Through these conversations, he refined and clarified his vision. He realized that the pressure brought by external performance measures felt like the “stick,” whereas the physician’s sense of altruism felt like the “carrot” for transformation.

Learn more about vision on page 5.

Step 3: Create a Coalition

Pendleton staunchly believed that this work required a team of physician leaders. Pendleton and Miller (CMO) proposed building a group of physicians who could wade through these ever expanding measures of quality together.

He looked for physicians who were interested and approached improvement with an open mind. Pendleton found that the most receptive were like him, faculty growing in their early to mid-career and deep in the trenches of clinical and academic work. Pendleton and Miller created a new position, similar to a physician quality officer, called a Chief Value Officer.

The Chief Value Officer would be embedded in their respective School of Medicine department or service. They would lead efforts in the department in all areas of the improvement – quality, cost, and service.

Pendleton would use the Chief Value Officers as an army to spread the vision of improvement. He found 22 physicians from both inpatient and ambulatory areas to serve as Chief Value Officers in 2014. Pendleton commented, “These are highly motivated and talented people…Now there are 22 people who understand the context, helping to shape the future.”

View the Chief Value Officer (CVO) Job Description on page 7.

THE REFLECTION

Pendleton has been on the job for three years, and now sees his role as a bridge between ideas. He enthusiastically pushed the first CVOs, the early adopters, into the spotlight. It became important to highlight and celebrate the early work so that others could see it was possible.
The coalition of new physician leaders has been key in engaging the organization. As John Kotter wrote in Leading Change: Why Transformation efforts Fail, building a “volunteer army” is critical to spreading change.

An effective vision that balances external pressure and internal culture was critical. Scholar and physician Thomas H. Lee wrote that “An effective vision helps people accept inevitable changes and put information and events into context.” Without context, no one would understand why the change was necessary.

Perhaps the most meaningful lessons of response to change come from the American military’s response to terror. Just like the volatile, uncertain, complex and ambiguous (VUCA) environments faced by the military, the future of healthcare can feel just as scary. VUCA settings force leaders to develop foresight to see where they are going, while also remaining flexible about how they get there.

Learn more about VUCA on page 6.
The National Transparency Landscape

In less than ten years, quality has shifted from the traditional CMS conditions of participation (accreditation) to voluntary public reporting (core measures), followed by mandatory reporting (2007). Publically reported measures started with process measures, moved to a focus on outcomes, continued to expand to include patients’ perceptions of quality (HCAHPS) and measures of quality at the clinical condition level. In 2012, Value Based Purchasing began the process of incentivizing improvements in quality, which has been followed by penalties for failure to improve. This revolution will continue to expand both in scope of measures, and financial impact on reimbursement, with a plan to shift both hospital and physician reimbursement from fee for service to fee for value.

More About Motivation and Change

“Many leaders of providers can pinpoint the moment when they realized that their world was changing; often it came when someone outside the organization started measuring its performance. Although few providers welcome this development, it provides context for a new breed of leaders. Traditional health care leaders try to buy time, fend off change, and maximize revenue under the existing payment system while they can. The new leaders focus on outcomes and use performance measurement as a motivating tool to organize their colleagues and drive improvements.”

More About Vision

“The vision expressed by leaders in health care must convey both understanding and resolve. It should acknowledge the importance of what clinicians currently do, but make explicit that they have to work differently in the future. It should be direct about the measures by which they must succeed. And it should be both optimistic and realistic, expressing the beliefs that care can get better and that delivering superior care is the best business strategy. An effective vision helps people accept inevitable changes and put information and events into context.”
More About VUCA

Lessons in volatile and uncertain change: In the 1990’s, the US Army War College introduces the concept of VUCA to describe the chaotic, turbulent and rapidly changing environment that became the “new normal” following the terrorist attacks of September 11, 2001. VUCA describes a more volatile, uncertain, complex and ambiguous environment.

The components of VUCA include:

- Volatility – The nature, speed, volume and magnitude, and dynamics of change.
- Uncertainty – The lack of predictability of issues and events.
- Complexity – The confounding of issues and the chaos that surrounds any organization.
- Ambiguity – The haziness of reality and the mixed meaning of conditions.

VUCA environments force leaders to develop foresight to see where they are going, while also remaining flexible about how they get there. Here are some of the strategies that can help leaders adapt to a VUCA world.

For Volatile situations, lead with vision:
- Communicate vision clearly
- Ensure your intent is understood

For Uncertain situations, seek to understand
- Broaden understanding by looking and listening beyond functional area
- Communicate with all levels of employees in the organization

For Complex situations, provide clarity
- Seek to make sense of chaos
- Stop seeking permanent solutions

For Ambiguous situations, embrace agility
- Communicate across the organization
- Move quickly to apply solutions
- Identify smaller successes

Source: In his series of blogs in HBR in late 2010- early 2011, the later former US Army Colonel Eric Kail outlined adaptive leadership tactics for a VUCA world.
CHIEF VALUE OFFICER

Role description

Objective and overall purpose

The Chief Value Officer (CVO) is the designated leader and liaison between his/her department and the Hospitals & Clinics whose role is to improve and sustain exceptional patient care that is safe, efficient, and cost effective.

Broad function and scope

The CVO serves as the representative and leader of the department for inpatient and/or ambulatory care to achieve institutional goals and to provide decision-making to improve the organization’s ability to provide exceptional care, manage growth, and develop and deliver on the strategic vision.

Key responsibilities

- Oversees and or executes work on improving key areas, including but not limited to:
  o Quality and related national quality standing priorities—example: applicable accreditation requirements, applicable metrics related to the UHC Inpatient & Ambulatory Scorecards, etc.
  o Safety—Department liaison for patient safety
  o Patient experience—HCAHPS, CG-CAHPS, and Press Ganey scores
  o Department clinical re-design initiatives that foster the consistent delivery of high-value care
  o Reimbursement (ability for the institution to thrive)—documentation of major comorbidities
  o Provider support—Epic optimization and operations
  o Strategic plans—providing input for space and facilities planning

- Practices key attributes
  o Fosters a safety culture within their Department
  o Supports University of Utah Health Care institutional mission
  o Demonstrates a high level of professionalism
  o Creates and maintains excellent working partnerships
  o Communicates frequently, clearly, and with a solutions-focus
  o Espouses transparency
  o Educates

- Identifies Medical Directors within his/her department to support initiatives, as applicable
- Attends and contributes to bi-monthly Chief Value Officer Council meetings, Inpatient/Ambulatory, as applicable
- Serves on (or identifies department representatives to serve on) other key system committees such as the Safety Committee as needed by the organization
- Formally presents and distributes key information with department leadership, faculty, advanced practice clinicians, and house staff, as applicable
- Collaborates with other CVOs
- Contributes to the development of UUHC’s Operational Strategy goals, is well versed in the tactics, and leads initiatives within department to contribute to the organization’s accomplishment of goals
- Provides feedback to CMO, executive medical directors, and other CVOs to improve care, operations, and processes
- Contributes to identifying solutions and decision making

Reporting structure

- Reports to the Chief Medical Officer Office and Department Chair
- Receives direction and support from executive medical officers, including the Chief Medical Information Officer, Chief Medical Quality Officer, Chief Medical Utilization Officer, etc.
- Designates Medical Directors within department to help achieve goals, as applicable