Exceptional Health Care Requires Leadership At All Levels

A Ministry Leader Describes How Her System Won the Baldrige Award

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People frequently ask me how our system, SSM Health Care, St. Louis, was selected to receive the 2002 Malcolm Baldrige National Quality Award in the health care category. To explain that, I'll have to go back a few years.

In 1986, when SSM came together as a formal health care system, those of us who were the system's executive leaders eagerly sought a way to engage our employees and physicians. Each year, at our annual leadership conference on Marco Island, FL, we introduced a promising new management philosophy with great hoopla and enthusiasm. Each one, we were certain, would be *the* one to transform our organization.

At the end of our 1989 conference—at which the focus had been "servant leadership"—I sat beside the hotel's swimming pool with William P. Thompson, SSM's senior vice president for strategic development. Both Bill and I expressed a vague feeling of unease. It seemed to us that no matter how much we communicated our system's mission and values, some things we hoped would happen were just not happening. Despite our enthusiasm for these management philosophies, something was missing.

What Bill and I realized was this: Despite our serious commitment to these management strategies, we did *not* see a constant striving for improvement. We did *not* see managers mobilizing employees to work on projects that were important. And we did *not* see processes in place that made the best use of people's talents. In short, we recognized that SSM was not nearly as good as it could or should be.

Although I hadn't realized it, we were doing two major things wrong. First—and this may already be obvious to readers who have come this far—we were prone to the management "flavor-of-the-month" syndrome. And, second, it was always *we*, the system's senior executives, who were sending the truth from the mountaintop to *them*, SSM's employees.

As these thoughts surfaced in our conversation, Bill

and I searched for an answer. We knew we had to find some way to tap the potential of all of our employees, something that would help us improve the complex processes that are inherent in health care. And we knew that whatever we did had to be for the long haul.

CQI

Today we at SSM constantly share information, about failures as well as successes.

Both of us had heard and read about an innovative new management approach that, although it had been used in this country primarily by manufacturing companies, was beginning to be tried in health care. The approach was known as "continuous quality improvement" (CQI) or "total quality management" (TQM). Because it sounded promising, we decided to explore it.

To make a long story short, we implemented CQI throughout the system in 1990. There isn't space here to describe what it was like to make CQI SSM's culture. Today it can be seen everywhere in the system—in our billing processes, in our surgical suites, on our nursing units, in our emergency departments, in our dietary departments, and in administration.

Today we at SSM constantly share information, about failures as well as successes. We share "best practices" and innovative initiatives through systemwide conferences, "benchmark" visits, our intranet site, phone calls, and structured face-to-face gatherings. And we constantly compare ourselves to the very best, both internally and externally.

But that's SSM today. Fortunately for me, I had no idea in 1990 what the extent of our commitment would be. I guess ignorance is bliss, because back then I was proud of the fact that I—an extremely impatient person—was willing to give the approach five years. By 1995, I assumed, we would have improved *everything*.

Help from IHI and Baldrige

I was certainly mistaken about that. In fact, when 1995 came around, we found that we hadn't progressed very far.

We didn't give up, however. Instead, we looked for tools that would help us focus our improvement efforts and achieve results more quickly. For the first, we turned to the Institute for Healthcare Improvement (IHI), a not-for-profit firm based in Cambridge, MA. The IHI offers a model, called *The Breakthrough Series,* with which health care organizations can make rapid improvements in quality while reducing costs.* And the IHI's model did help SSM achieve rapid improvement, which, in turn, brought an enormous increase in morale. *The Breakthrough Series* turned out to be the missing link between CQI and rapid results.

For help in focusing our efforts, we turned to the Baldrige National Quality Award Program.†

Since it was established in 1987, the Baldrige program has helped U.S. organizations, public and private, improve the quality and efficiency of their work.

Until 1999, health care organizations were not eligible to compete for the actual Baldrige award. Even so, beginning in 1996, SSM facilities began to apply for state quality awards modeled on the

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*For information about IHI and *The Breakthrough Series,* see www.ihi.org/ihi/ products/whitepapers/thebreakthroughseriesihiscollaborativemodelfor achieving+breakthroughimprovement.htm.

†For information about the Baldrige National Quality Program, see www. quality.nist.gov/.

SUMMARY

In 1990, SSM Health Care, St. Louis, implemented a management approach called "continuous quality improvement" (CQI) to help tap the potential of its employees. Five years later, SSM combined the approach with the "Breakthrough Series," a quality-improvement model developed by the Institute for Healthcare Improvement (IHI), and rapid results followed.

With quality improvements under way, SSM facilities began to apply for state quality awards modeled on the Baldrige National Quality Award program. The feedback from Baldrige helped SSM focus its ongoing quality efforts. Also, it provided the necessary framework for quality improvements and for establishing a culture in which leadership is encouraged at all levels. In 2002, SSM became the first health care system to receive the Malcolm Baldrige National Quality Award.

Baldrige. Although our facilities applied to these state awards to get feedback, they actually began winning awards, to our surprise and delight.

What has the Baldrige process done for SSM? It has given us a framework, a focus, and discipline. This framework, focus, and discipline were essential because our CQI approach to improvement was scattered and thus didn't have the overall impact that it could have had. Basically, the Baldrige program provided a new lens through which we could see our organization. It offered us a way to systematically evaluate our entire organization and understand the linkages among the hundreds of processes that make up the health care experience.

For instance, we realized, after just reading through the criteria for the Baldrige Award, that we had *21 pages* of mission statements for our individual facilities, rather than a single mission statement for the system. Now, if it's focus you need, 21 pages of mission statements is probably not the way to achieve it. That's human nature, I suppose: We often overlook the things that are excruciatingly obvious to others. The Baldrige program helped us at SSM see things we couldn't see for ourselves.

However, we did at least have the good sense to involve our nearly 3,000 employees, at all levels of our organization, in a yearlong process to articulate a single mission statement for SSM Health Care. They did an amazing job. The statement they came up with has only 13 words: "Through our exceptional health care services, we reveal the healing presence of God." It's a great mission statement. When, in 1999, health care organizations became eligible for the Baldrige Award and SSM entered the competition for it, we made the statement the focus of our first Baldrige site visit. We were so proud of it that we bragged to the examiners. "Isn't it great?" we asked them. And when we got our feedback report, we learned that the examiners did indeed think that those 13 words constituted a great mission statement.

And then the excruciatingly obvious reared its ugly head again. The feedback also told us: "You say you want to deliver *exceptional* health care services. Yet you haven't *defined* 'exceptional' services, and you certainly can't measure them until you define them." Besides that, the feedback pointed out that we had been comparing ourselves to *averages*, rather than to the *best* when setting our performance goals. So, for example, we were pleased to demonstrate that our infection rates were better than average, employee satisfaction was better than average, and patient loyalty was better than average. But when the examiners saw all those "averages," they reminded us that our mission statement doesn't say, "Through our better than average health care services, we reveal the healing presence of God!"

Talk about the excruciatingly obvious!

As a result of this feedback, we figured out how to translate our mission imperative—that is, "exceptional health care services"—into specific and measurable goals. We set those goals based on nationally recognized *best* practices for clinical outcomes, satisfaction, and financial performance.

What else did we learn from Baldrige? Among *many* other things, over four years and some 200 pages of feedback, we learned that our messages were not consistently deployed throughout our vast organization. We learned that although we had human resource goals, they were not integrated into a strategic and financial plan. We learned that we were better at tracking our finances and operations than we were at tracking the clinical results of our patients. And we learned that we did not have a consistent complaint management process.

As readers may have guessed, we've spent considerable time making improvements based on our Baldrige feedback over the years. We've figured out how to deploy a consistent message throughout our organization. We now have a strategic, financial, and human resources planning process. We've learned how to track the clinical results of our patients. And we've developed a complaint management process that is used systemwide.

At SSM, our commitment to improve is driven by our belief that what we do is more than a job, more than a career; it is a *sacred trust*. Baldrige has helped us move in the right direction, and that's the good news. The bad news is that while we are far better than we ever were before, we are still not where I want us to be.

People sometimes ask me if I'll ever be satisfied. The answer is: "Yes, I would be satisfied if, as a system, our patient loyalty was 100 percent, if every single one of our patients was completely safe 100 percent of the time, if there were *no* needless deaths, if our clinical outcomes were the best in the world, if physician and employee satis-

faction were 100 percent, if we were the employer of choice in every one of our communities, and if we were the hospital of choice in each of our communities. Then I would be satisfied. Maybe." But until that day comes, there's work to be done.

Leadership

The third element that helped us improve quality was seeing leaders at every level of the organization.

As the system's CEO, I realize full well that *our success as an organization rests not in my* hands. Rather, success rests upon the people who day in and day out—no matter how tired they are—form teams to keep our patients safe, develop processes to prevent infections, and work together in all sorts of ways to provide exceptional care. Our success rests upon the people who offer a gentle touch, a kind word, an open ear, a good idea. Let me tell you about one of the people in SSM who offered a good idea.

As CEO, I realize full well that our success as an organization rests not in *my* hands.

Armando arrived in Madison, WI, from Mexico a couple of years ago and got a job in housekeeping at our St. Marys Hospital Medical Center. In Mexico, he had owned his own catering business. Not only was he adept at cooking; he also had a keen mind for business. However, he did not speak any English. But Armando's potential quickly became obvious at St. Marys and his supervisor suggested that he enroll in the English as a Second Language course offered, free of charge to employees, at the hospital during work time.

As Armando's English improved, his confidence on the job increased. When an opening occurred in the hospital's cafeteria, Armando applied for it and got the job. He continued with his English classes. It wasn't long before Armando saw ways to make improvements in the cafeteria. And he took a huge risk. With the help of his English teacher, Armando presented a written proposal to his supervisor. He had noticed that when tomatoes were sliced for sandwiches, the end slice containing the stem was thrown away—thereby wasting part of the tomato. He suggested that the end slice be diced, and that the diced tomatoes be put in the salad bar. He calculated that his proposal would save St. Marys nearly $4,000 annually.

Now this story is about several things. It's about an exceptional manager who recognized the potential of an employee, and about a hospital that created the environment that called forth the leadership potential of an employee. But, above all, it's about the employee's willingness to step out of his comfort zone and demonstrate leadership.

Of course, the reader may be thinking: "We're talking about $4,000 out of an annual hospital budget of $500 million. That's nothing." However, I would argue that Armando's suggestion is indicative of the kind of contribution that is possible when you cultivate a culture in which every employee is a leader.

Such a culture is essential for SSM's success. We believe that we must make it not just possible but *imperative* for people to contribute, at all levels of the organization. If we fail to create that kind of culture, we jeopardize our ability to achieve our mission.

Let me mention some other leaders, leaders whose story has inspired us for more than a century.

In 1872, Mother Mary Odilia Berger, a German nun, wrote a letter to the only person she knew in the United States, a man she had nursed during the Franco-Prussian War two years earlier. This is what she wrote: "Dear Mr. Wegman, the present state of affairs [in Germany] is so discouraging that we feel inclined to cross the ocean."

With those words, she took a risk that is almost unimaginable in our time. Her lifework, she believed, was to start a religious congregation and be of service to people in need. She knew that couldn't happen in Germany; she had tried and failed to do so there three times. So, although she did not speak English, she was willing to risk everything by making the hazardous ocean journey to reach a country where there was a chance—just a chance—that she might realize her lifework.

In October 1872, five sisters sailed from Europe, reaching New York City in November. There they boarded a train and arrived in East St. Louis, IL, on November 16th, which happened to be a bitterly cold day. They crossed the Mississippi River by ferry. They arrived in St. Louis with only $5 among them.

The sisters subsisted by begging. They begged for money, for supplies, for food, and for medicine, such as it was. They begged so they could be of service to people in need. As it happened, the needs in St. Louis were great in November 1872, because that was the year of a smallpox epidemic. These sisters, these selfless women, willingly—and even lovingly—went into the homes of people with smallpox to provide

nursing care. Often there was little they could do other than ease a person's final hours, but they did that with love.

This is SSM's legacy. Those early sisters were willing to do whatever needed to be done to care for the sick. In fact, they were willing to sacrifice their own lives, if need be, to care for people with a deadly and contagious disease. They did this because there was something deep inside them that wanted to make a difference in people's lives—and that thing was leadership. I would venture to guess that most of the readers of this article are in health care because they also want to make a difference in people's lives.

If so, they are not alone. The vast majority of people in our organizations are there for the very same reason. However, the question is: Are we tapping their potential for leadership? Are we ensuring that they can make a difference for our patients?

Let me elaborate. Every day when our employees go home from their jobs, they become, in effect, CEOs, chief operating officers (COOs), and chief financial officers of small corporations called "families." In these families, our employees perform a whole host of functions, including dietary, transportation, finance, medical emergencies, public relations, community relations—you name it, they're in charge of it. They provide in-service education on topics ranging from new math to appropriate behavior in school, from how to get into college to how to change a tire, and including how to make Grandma's chocolate cake.

Not only do our employees manage the family's day-to-day operations; they also establish a vision for the future, they set appropriate goals, and they put in place strategies to achieve that future.

But then they return to work, where, in many instances, they are told what to do and exactly how to do it. The leadership abilities that are so evident in the home environment are never utilized in the work environment. I believe that is an unforgivable waste of talent and potential.

What does all of this have to do with exceptional clinical outcomes? With patient loyalty? With patient safety? Let's go back to Armando's story. Taken literally, Armando and tomatoes have absolutely nothing to do with clinical outcomes. But if you look at what that story represents, it has *everything* to do with them. Armando's story is about the kind of culture that facilitates exceptional outcomes; the kind of culture that nurtures that inner something within each of us that strives to be the very best.

It is, for example, the kind of a culture that facilitated a significant safety improvement at our SSM DePaul Health Center in St. Louis. Every year, DePaul has about 96,000 patient transports. Approximately 95 percent of patients (excluding those in the ICU) are transported to ancillary areas by unlicensed personnel. Patients can be away from their unit anywhere from 45 minutes to four hours.

During that time, how are transporters to know the severity of the patient's condition—whether, for instance, the patient has a high probability of falling or becoming confused? To ensure good communication among the various people involved in transporting, as well as with those performing the medical procedures involved, a CQI team developed what we call the "hall pass."

The hall pass is a form that monitors the patient's condition during visits to ancillary areas. It is filled in by the patient's nurse, as well as by all the various ancillary departments in which the patient undergoes testing. The hall pass includes contact information for the patient's nurse, information about the patient's medical condition, and updates concerning changes in the patient's condition that might occur as a result of the procedures performed. It also very clearly notes when the patient will require a nurse during transport. This ensures that no patient goes to a testing area without proper clinical coverage.

Why did we develop the hall pass? The long answer would be: To foster communication among the various "silos," if you will, because communication helps us keep our patients safe. And that's the truth. But you may find more significance in the short answer: The hall pass was the direct result of a sentinel event.*

Who came up with the hall pass idea? The hospital's president? The COO? The chief nurse executive? Me?

No. The hall pass was developed by Linda Thompson, DePaul's administrative director of

*A sentinel event is an unexpected incident, related to system or process deficiencies, that leads to a patient's death or disability. See Thomas and Nancy Hooyman, "The 'Sentinel Events' Study," *Health Progress*, November-December 2004, pp. 33-36, 62.

risk management, and Lisa Boyle, RN, director of patient safety. Linda and Lisa are people in our organization who saw an opportunity for improvement, put together a team, and developed a solution. That is real leadership.

You see, real leadership is not about authority, control, or giving orders. It's not about titles and executive benefits. The leadership I'm talking about does not necessarily concern corporate strategic planning or executive decision making. Clearly, strategic planning and executive decision making are vital to organizations, and I don't deny that there are people who must be accountable for the overall success of the enterprise.

But if I've learned anything from our effort to improve quality, it is to give up the illusion that because I am the CEO, I am the leader and everyone else is a follower. Or that a chosen few people with executive titles are the leaders, ready and able to imbue the entire organization with their infinite wisdom. Although some of us provide *executive* leadership for the system, and for facilities in the system, we have learned to say that there is no one in SSM who is *not* a leader.

Ultimately, it is an executive's ability to call forth leaders that will transform the organization.

Integrity Is the Key

After 15 years of effort—and with the help of CQI, the Baldrige program, and our decision to encourage leadership at all levels—our system has developed a culture of performance improvement. But some readers may be asking, "Just why is it so imperative to constantly push ourselves; to improve every day in every way? Don't we have enough to do already?"

I would suggest that the reason for the pursuit of excellence is because it's a matter of *integrity.* We don't make improvements solely because of regulations or to win awards, or even because of *To Err Is Human,* the Institute of Medicine's now notorious 2002 report on errors in U.S. medicine.[1] We make improvements because we are people of integrity.

Let me explore that thought. The word "integrity" comes from the same root as "integral," which means "essential to completeness." I see integrity as the quest that human beings instinctively embark on to make themselves whole. Innately, we know that we are not whole persons, and so we constantly strive to be better, to be whole. And this quest continues throughout our lives. Integrity pushes us to constantly improve.

Integrity is also something more. It has to do with how we live our values. If, for instance, I value kindness but have been unkind to someone, I'll feel like something isn't quite right in the pit of my stomach. If I value honesty but find myself telling a white lie, I feel uncomfortable. But when I live completely in sync with my values, I feel good about myself.

But there must also be integrity at the *organizational* level. If we are people of integrity, how can we rest if the organization for which we work is anything less than the very best? If the safety of our patients is ever at risk, how can we rest? If our patient outcomes are not as good as they should be, how can we rest?

When the first Baldrige examiners pointed out that SSM had been satisfied with no more than better-than-average results, they, in effect, called into question our integrity as an organization. The way I interpreted their comments was: "If you say you're about exceptional health care services, but you're content with better-than-average results, how can you call yourselves people of integrity?"

That is a question that keeps me up at night and causes me to push so hard during the day. I push because it is through our exceptional health care services that the healing presence of God will be revealed.

Not long ago, a surgeon at one of our facilities, Cardinal Glennon Children's Hospital in St. Louis, operated on a little boy with a cleft lip. Following the surgery, the mother went into the recovery room, and when she saw her son, she wept. When the surgeon asked her what was wrong, she said, "He's beautiful!" The surgeon smiled and said, "He was beautiful before." The mother replied, "I know, but now *everyone* can see it."

It is stories like this that make me push so hard. When exceptional clinical expertise is combined with that other element—some people call it mystery; some call it the healing presence of God—the health care experience is truly transformative. ■

NOTE

1. Institute of Medicine, *To Err Is Human: Building a Safer Health System,* National Academies Press, Washington, DC, 1999.