

Closing Comments to the
Chronic Care Learning Communities Collaborative
Outcomes Congress, December 9, 2005

Tom Bodenheimer

It's remarkable what the teams in this collaborative were able to do. Usually, when people take on new work, they stop some work they were doing before. That doesn't happen in improvement collaboratives. You take on new goals and new work. And you continue your day to day responsibilities. Taking care of patients or managing a clinic. The patients don't stop coming. The clinic doesn't stop needing a director.

Doing today's work taking care of patients or running a clinic PLUS working to improve care for tomorrow's patients – that's what defines a champion. You are all champions.

That's the good part of what we have done in this collaborative. But think about it: that's also the bad part.

An improvement strategy that relies on champions – people who push beyond what most humans are willing to do – cannot work forever.

Let's think about an improvement team. We set our collaborative goal -- 60% of patients with diabetes in the population of focus should have HbA1c below 7. The population of focus is 150 to 200 patients, the patients of 3 clinicians.

Let's step back a minute. A collaborative team has improved 200 patients' HbA1c for one year. But to reduce the risk of diabetic complications, the improvement has to last for 20-30 years for each patient. So far our improvement is a bit shallow. It needs to get deeper.

Another thing. Let's say 4000 patients in your health system have diabetes. We improved the care for 200 of them. Our improvement is limited in breadth. It needs to get wider.

We feel good now about what's been accomplished with these pilot populations and we should. What would make us feel really **really** good? If all patients with diabetes in our health system had HbA1c levels below 7 for

the rest of their lives. We need changes like that – changes that are deep and wide.

OK. Now I've really messed up. We were feeling good and now I've made us feel bad.

Well, champions are never satisfied. That's what a champion is. The lack of deep and wide improvement is not because of us. The lack of deep and wide improvement is a limitation in the improvement strategy. An improvement strategy cannot solely rely on champions like yourselves working overtime. The collaborative improvement team is a necessary part of improvement work, but it is not enough.

For all of us who are chronic care champions, what would make us really happy? All patients in our health system become experienced self-managers of their chronic condition. All patients with diabetes, hypertension, high cholesterol, and coronary heart disease have all their lab values in perfect control and are taking all their medications every day. No one has emergency department visits, hospital admissions drop dramatically, and mortality goes down. That's happiness.

To reach those goals, we need a more powerful improvement strategy. We need an improvement strategy with 3 components.

First component: Our Chronic Care Learning Communities collaborative multiplied by hundreds. Hundreds of teams in each health system, working in every clinic, hospital ward, emergency department, physical therapy suite, and health education department. The people on the ground, not the people on top, know what is happening on the ground, what is wrong with it, and how to fix it. That's the bottom-up component of improvement work. Improvement will not happen without it.

Second component of an improvement strategy: The leadership of the health system gives improvement work the same priority as keeping the institution afloat financially. Which leadership are we talking about? We always pick on *senior* leadership. But it needs to be *all* leadership. Senior leaders, junior leaders, sophomore leaders and freshman leaders. The clinic nursing director who decides what medical assistants do each day. The Chief Information Officer who can get help get you a systemwide chronic disease registry next week -- or can make it take two years -- or never.

All leadership is needed for wide and deep improvement. We need to work with any leader with the power and responsibility to determine budgets – how the money is spent. And any leader with the power and responsibility to define the job description of front line personnel. Many of you here who are chronic care champions are also members of your health system leadership. You are leadership champions; you are models for what all health system leaders should be.

A wonderful physician is medical director of the Louisiana state health care system, including Charity Hospital in New Orleans – what's left of it. Mike Butler. Some of you know him. I can't imagine the challenges Mike is facing post-Katrina. Here's what Mike told me last year: if you take some of the nurses on the in-patient service and you transfer them to become care managers in ambulatory care, you will improve out-patient care, reduce admissions, and you won't need them as in-patient nurses. But someone has to take the leap of faith to make that initial change. That's real leadership.

Improvement teams rarely have the power to say to a medical assistant, you are now in charge of the diabetes registry. But someone has that power. It might be a manager, it might be a union rep. Whoever has that power needs to care about the Chronic Care Model. Whoever has that power needs to make sure that the medical assistant understands the Chronic Care Model, receives training and has the time to work the registry. Having the time is critical. Lisa Johnson said once, and I keep repeating: If you want to do something new, you have to stop doing something old.

I hate to be disrespectful, but our current mode of involving leadership is to beg. Mr. CEO or Ms. CEO, *please* budget 3 nurse care managers. Ms. nursing director, *please* let one medical assistant input data into the registry. It's OK to beg. But begging isn't going to do the job.

Another mode of involving leadership is to target the CEO and get the CEO on board, and have the CEO mandate the changes we need. Public hospitals are blessed to have some wonderful CEOs and some wonderful medical directors. Many of them *are* on board. But they can't order all their clinic medical directors, clinic nursing directors, information systems geniuses, and union leaders to do what is best for chronic care. It's like *ordering* a patient to stop eating fat, to exercise 30 minutes a day, and to take 6 medications. Or *begging* the patient to do those things. It doesn't work.

You need to provide information to the patient and make decisions collaboratively with the patient and *inspire* the patient. It's the same with leadership. Ordering doesn't work and begging doesn't work. Inspiration can work.

Health system leaders need to be champions at the same level that you, the collaborative teams, are already champions. How is that going to happen?

3) That brings us to the third component of a powerful improvement strategy: the Center for Learning and Innovation.

Each health system needs a center for learning and innovation. What is that about? Remember champions on collaborative teams work overtime to do today's patient care work and also improvement work to make tomorrow better. You have two jobs. That's hard to keep up year after year.

A few people in each health system need to be *100% dedicated to improvement work*. A few people need to have *no* day-to-day responsibilities for making budgets, managing personnel, or caring for patients. Their only responsibility is improvement work. Organizing collaboratives, providing information to all levels of leadership in the organization, being improvement advisers to many improvement teams, assembling patient focus groups to help evaluate the improvement work. Those few people constitute the center for learning and innovation. Those are the Wendy Jamesons. Each health system needs a few Wendys. The perfect situation is to have a Wendy, a Mike Hindmarsh, and a Karen Scott Collins? Maybe we'll add an Ed Wagner. That would be a powerful center for learning and innovation.

A key job of the center for learning and innovation is to inspire the organization's leaders and to transform the leaders into chronic care champions. Not just CEOs. Not just medical directors. All leaders. All leaders in an organization need to know and love the improvement model. All leaders need to live and breathe the chronic care model. We need front line champions and we need leader champions.

Even if you have leader champions, they are busy. They have to deal with budgets, with personnel problems, with 10 regulatory agencies, with putting out fires. Improvement work will always take a back seat. Remember the

tyranny of the urgent? Acute care will crowd out chronic care? A budget crisis or a personnel disaster will always crowd out improvement work. That's why every system needs a few people whose *only* responsibility is improvement work.

There are some centers for learning and innovation. IHI in Boston. Improving Chronic Illness Care in Seattle. California Health Care Foundation. They are great; without them, nothing would have happened. But they are outsiders. For a center for learning and innovation to have the legitimacy, it needs to be inside the health care organization. It needs to be created and budgeted by the leaders of the health system in which it is located. Otherwise, it will be stuck in a basement office, will have to scrounge for funds, and will fail. A health system with 1000 employees should be able to finance a center for learning and innovation with 3 full time people. 3 Wendys. It is an investment in the future of the organization. I know 2 organizations that have done this. One is the Jonkoping County health system in Sweden which has done outstanding improvement work. The other is Kaiser Permanente which puts money into its Care Management Institute. There are others. But 95% of health care organizations do not have a center for learning and innovation.

OK. What have we said? The improvement teams in this collaborative have done wonderful things. But we need a more powerful improvement strategy. Lots of improvement teams, leaders at all levels who are champions, and a few people within the health system whose only job is improvement.

I did a study of chronic care in California's safety net 3 years ago. Not much was happening in public hospitals. Now, a huge amount is happening, thanks to the people in this room. We've taken the first step. The next step is to set our goals deep and wide: that all patients with chronic conditions in our health systems become good self-managers and are in excellent control of their chronic conditions.

When we achieve all that, it will be so satisfying. Today is a great day. The day in the future when we reach those ultimate goals, that will be a perfect day.