

Systematic Leadership Tools to Meet the Adaptive Challenges of PCMH Transformation

Patient Centered Primary Care Collaborative (PCPCC)
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Who we are

A collaboration of: The University of Minnesota
Department of Family Medicine and Community Health
and The Leader's Toolbox, Inc.

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(Sponsor of the project being reported on)

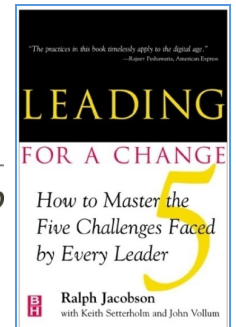


C.J. Peek, PhD

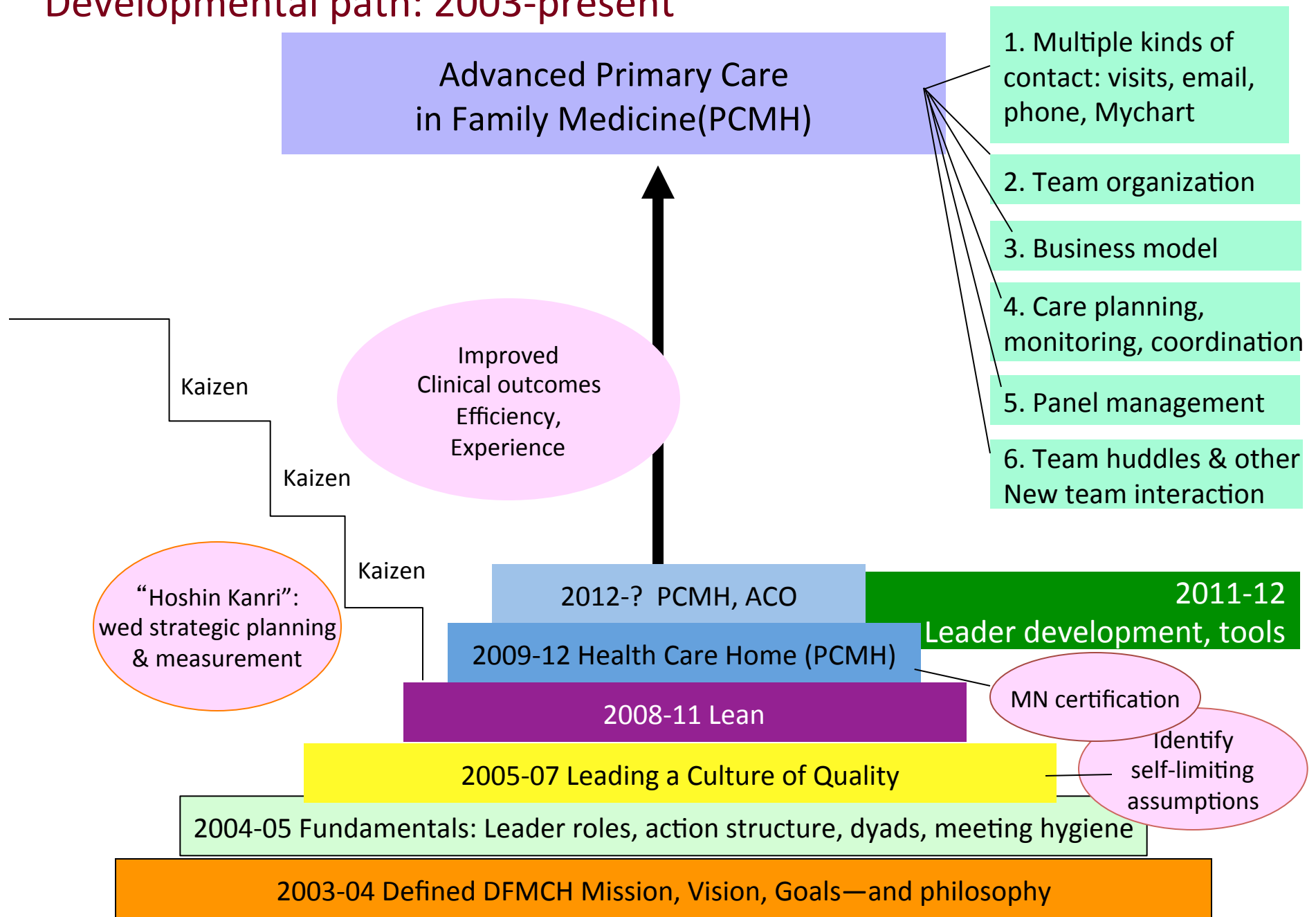
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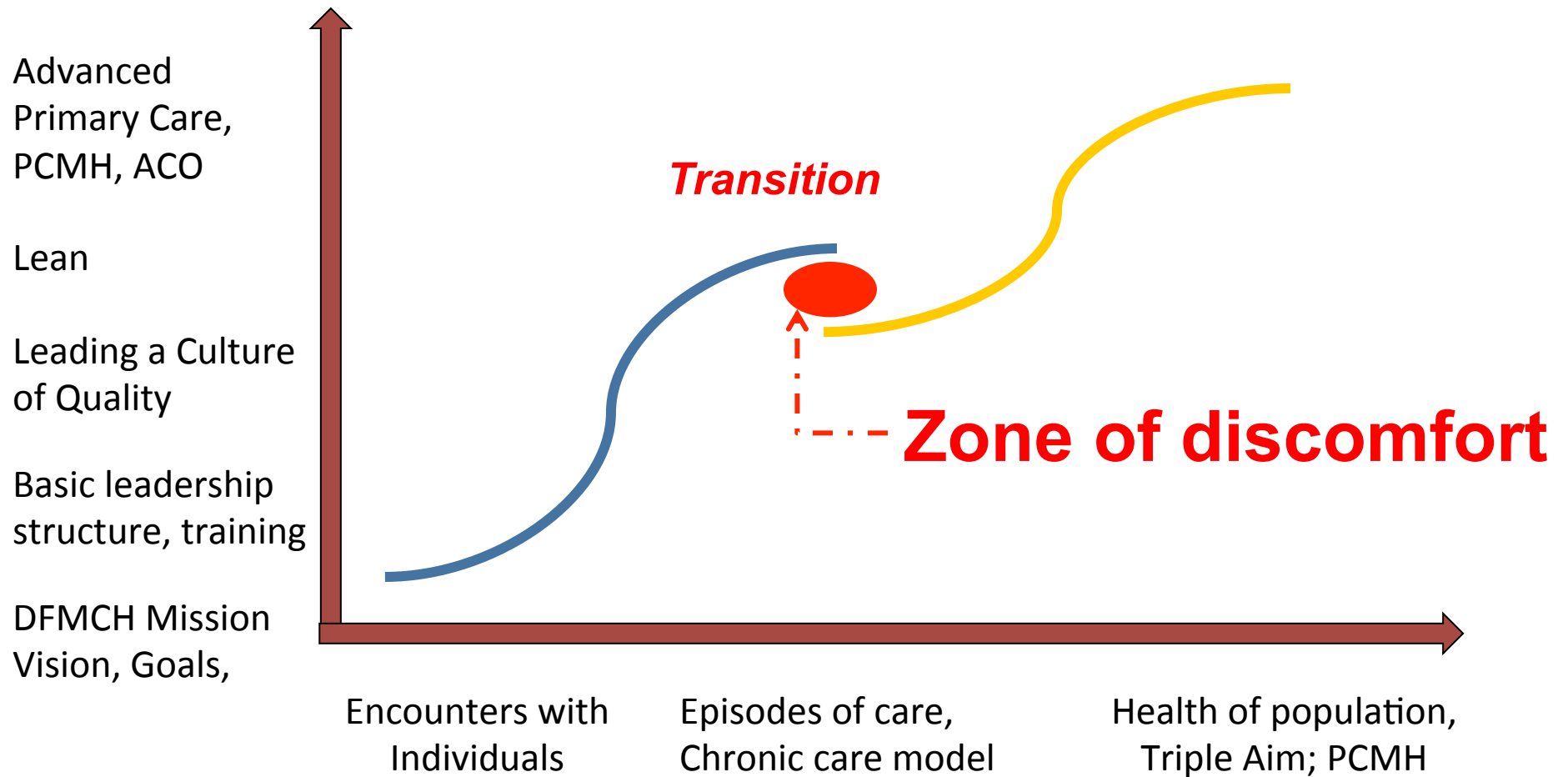
Founder, The Leader's Toolbox® Inc.
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Developmental path: 2003-present



Our "S Curve"

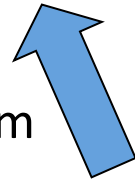


The Underlying challenge

Not yet prepared to meet the adaptive challenges of PCMH. . .
. . . Means we have to take our leadership to the next level

From...	To...
Different concepts of leadership	A common language
Cacophony of leader tools	Common leader toolbox
Different leadership goals	Common leader goals
Fuzzy notion of how to tackle adaptive change	Clearly defined “algorithm” for adaptive change
Political or “random” process	Rational, deliberate process

The project: A structured path from



to



Requirements: A Leadership development approach

1. *Distributed competence*: Local & central—care, education, & research (43 people)
2. *A cohort model*—not individuals/teams on separate tracks
3. *Clinician / administrator “dyads”* (partners)--not just doctors
4. *What to **do** as leaders—“**algorithms**”*...not just values / principles / aspirations / traits / personality
5. *Common “platform”* of leadership practices, language, tools
6. *Applicable to front-line staff*—not just executive ‘stars’.
7. *Staying power* for tackling adaptive change—**not “flavor of the month”**—with coaching

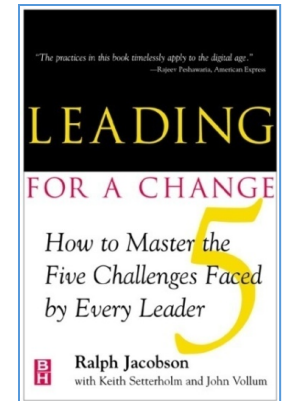
Leader's Toolbox® Principles

- Focus on leadership, not leaders
- Leadership produces deliverables
- Leadership is a process
- Tools/language are necessary for the *practice* of leadership
- Opportunities to practice *and* hold people accountable for results
 - Work on our most important issues of adaptive change
 - **Receive internal and external coaching support**
 - **Hold people accountable**
 - Implement as many results as practical
- Create a leadership network of people that know how to tackle the complex issues:



The **Leader's**
Toolbox™

Unlock the Power of Leadership



Use the same language and tools to address the organization's most important work

Tool: Three roles leaders play

1. Leader
2. Manager
3. Individual contributor

Where do you spend most of your time?



Lessons learned

1. People spend most of time on things--

- Know how to do; feel comfortable with
- Have the most visibility; the most immediate

Will never implement new models of care by using time the way we have!

2. Leadership work:

- Is critical—and not easy
- Requires tools *and making the time to use them*
- Asks you to track your time—allocate ratio of leader, manager, individual contributor

Proactively balance your time between leadership and other roles!

Impact requires making time as a community to do the most important work.

Everyone has leader work they must do.

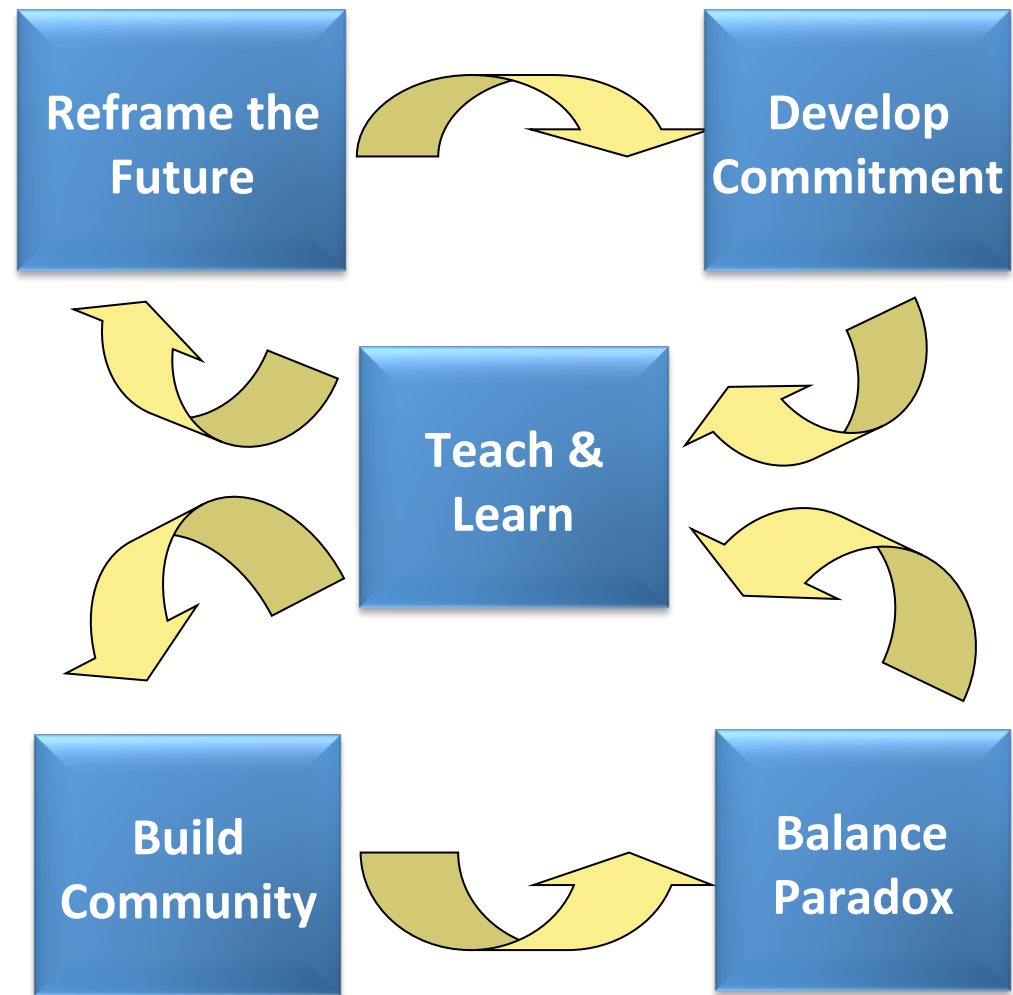
Tool: The Leader's Map™

Lessons learned

- Leadership is a process...not charisma
- Leadership is a shared responsibility
- There is *order* to change (“algorithm”, e.g., Leader’s Map)
- Lets you anticipate challenges *before* encountering them

Impact:

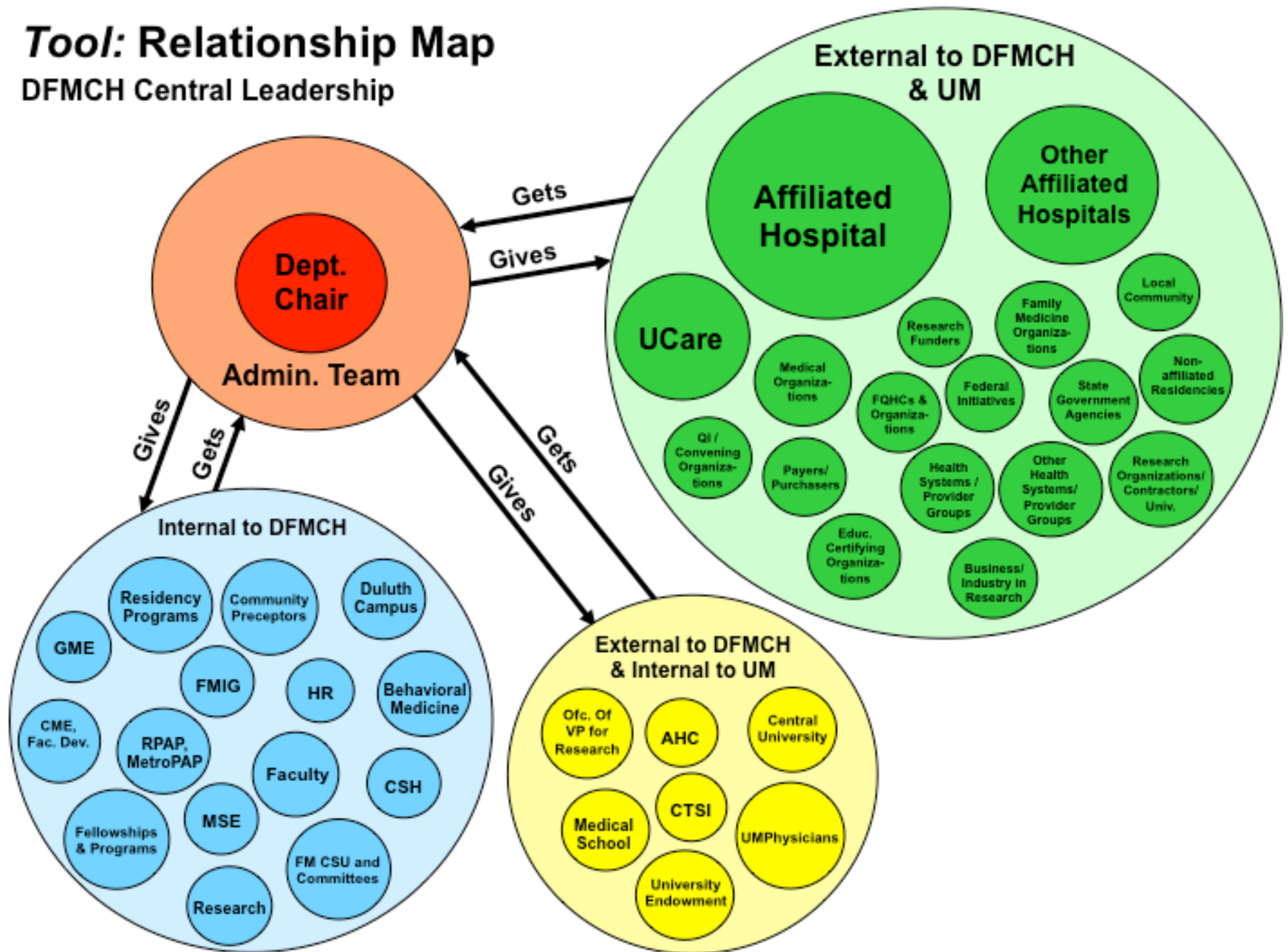
There’s a method finally
More design, less politics
Easier to get moving



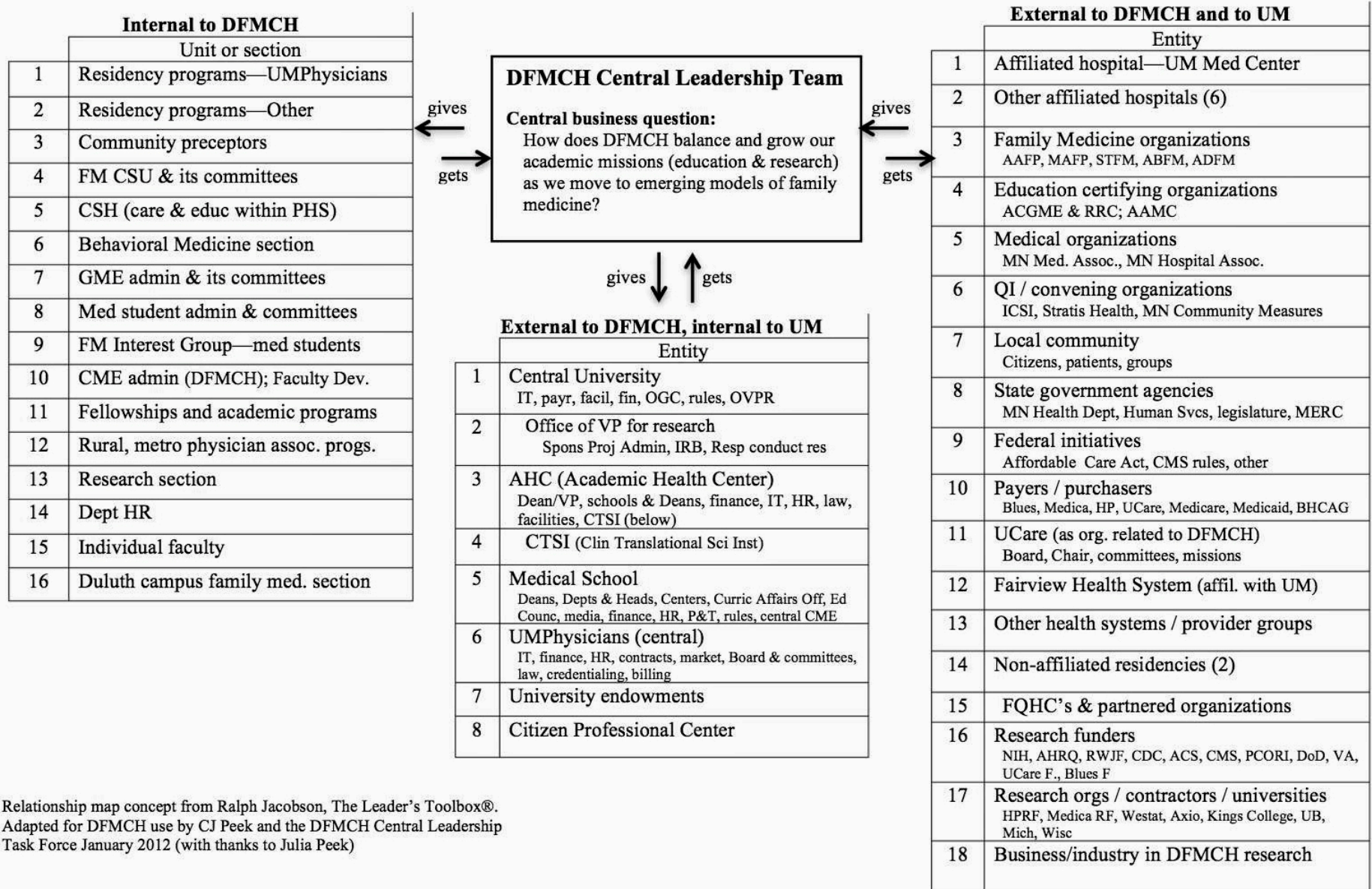
From Jacobson, R (2000). *Leading for a Change: How to master the five challenges faced by every leader*

Tool: Relationship Map

DFMCH Central Leadership



Central Leadership Relationship Map (simplified):
Department of Family Medicine and Community Health (DFMCH), University of Minnesota Medical School
 Simplified for presentation purposes 2/15/12



Tool: Central Business Question (CBQ)

A. What questions get at the most important issues for our practice?

B. What is the right (most pivotal) question we need to ask now?

C. *At what level (on the ladder) does this question need to be asked?*



Lessons learned:

- Focusing on the most apparent issue usually won't do
- Focusing on things perceived easy to control or do...won't do
- Focusing too globally on aspirations and principles won't do either

Impact:

Taking time to ask the right question—at the right level—**energizes the work**

Tool: Balance paradox (polarities)

(When “either-or” just won’t work—need the best of both)

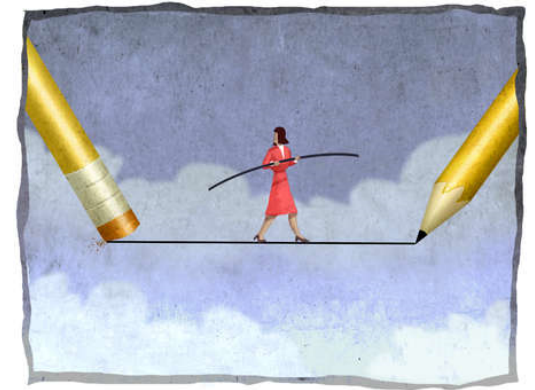


Lessons learned:

- Most of the issues that cause friction are not problems to be solved but paradoxes to be balanced
- Tension is good...now that we have an “algorithm” for balancing it
- It takes diversity of opinion to balance paradoxes / polarities
- Many PCMH and healthcare leadership issues are polarities to be balanced
- A job of leaders is to identify and balance paradoxes bumped into in making change

Our paradoxes (a sample)

1. Care and Education And Research
2. Patient-centered and evidence-based
3. Care of individuals and health of populations
4. “I and we” (acting locally—acting collectively)
5. Fidelity to a care model and local adaptation
6. Standardization and experimentation
7. Working under FFS and under emerging PCMH or ACO business models



1. Design team

Outcomes needed

Process to be used

Which participants

Which Tools

Targets

Engaging people



2. Train trainers (see one, do one, teach one)

12 trainers

Dyads focused on tools

Task for 3 teams: How to create strong local leadership teams?



3. Create leadership community

5 clinic teams: How to create advanced primary care (PCMH) at our clinic?

Central leadership team: How to support the clinics and manage external relationships?

Phase I Central Business Question (CBQ):

How to build stronger clinic leadership teams?

These “toolbox teams”

- Were given a challenge
- Asked to use the tools to address the challenge
- Provided coaching support
- Presented findings to senior leadership and each other

- Three teams (across 5 clinics) asked to address this question
- Resulted in 3 complementary paths to strong local leadership teams
- Realized that local teams need to
 - Take care of more local leadership issues; ask Dept Head and central for more coaching
 - Develop proactive ally relationships with external stakeholders (“we can help you”)
 - Provide greater local leadership...far more than operational issues. (More *leadership* in the mix with *management*)

Evident already: Are taking care of more issues themselves AND expecting more from central leadership team

Phase II CBQ's that emerged from clinics

1. How to define team-based care and build it here?
2. How to successfully join a local “gain-sharing” or “ACO-like” network?
3. How to engage with immigrant communities to best serve their health and wellness needs?
4. How to implement a team-based clinic structure—more robust—to fully realize health care home?
5. How to strengthen the educational programs at the Program in a financially viable way?

CBQ for Central Leadership:

“How do we balance and grow our academic missions (education & research) while we move to emerging models of family medicine and primary care?”

Central Leadership Task Force

- 14 leaders, closely facilitated in 5 pre-set mtgs
- Dyads across levels & missions; internal facilitator
- 3 mixed subgroups for 3 elements of charge

Charge: A new job description for central leadership team with--

- Updated mission, vision, goals
- Composition & process for a new central leadership team
- Plan to sustain leadership competency across levels and missions

Result:

- Deep and genuine conversations over difficult issues and paradoxes—adaptive change
- A consensus product at a very specific level—*charge completed on time*—in writing

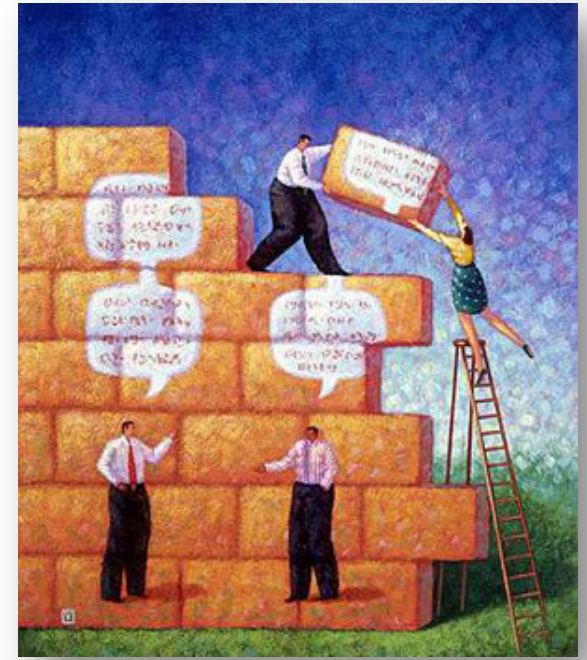
***Readiness to get in harness:* The Task Force was made to work just as a new central leadership would have to work.**

The Leader's Toolbox[®] worked for us because--

1. *Brought in at the right time* in our development (“S-curve”)
2. *Our requirements clear*—tailored to our own situation & needs
3. *Sponsor commitment*, resources, paired ext. / int. consultants
4. *Participants internalized language and tools*—adapting as needed
5. *Organization-wide cohort*—no “fixing” individuals or “making stars”; whole distribution of skills moved up.
6. *Initial application on work that matters*—their own CBQ's
7. *Leadership not mysterious or about traits*—it's what we do—**“we have an algorithm now”**

Journey and results so far.....

- *Tighter sense of community*—it's about us, not “them” —have to address issues together
- *Deeper relationships* across levels and across care, education, research
- *Leadership work has higher visibility and rigor*—“a real discipline—like my other work”



- See that operational management alone will not get us there
- Central leadership team “job”, structure, process vastly upgraded, along with mission and vision
- The common language of leadership has stuck
- Local teams playing at a higher level

Next steps—to reframe our future

1. Implement “toolbox team” plans to strengthen local leadership teams
2. Support clinic teams projects to answer their own CBQ’s
3. Create local leadership coaching support and better leader annual review process
4. Re-configure and launch central leadership team according to task force
5. Build stronger relationships with major internal and external stakeholders (with appropriate “gives and gets”)





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LEADING
FOR A CHANGE

How to Master the
Five Challenges Faced
by Every Leader

5

Ralph Jacobson
with Keith Serretichin and John Vollam