



# Finding the Right Method: An Overview of the Virginia Mason Production System

March 24, 2011  
Diane Miller  
Executive Director  
Virginia Mason Institute

**Standard Work Sheet**  
OUTPATIENT SURG. CENTER  
Process Name: SURGERY Process: SETUP Date Prepared or Revised: 04/04/08  
Fac Name: ENT Room/Location: ENT Tx: CLOSE

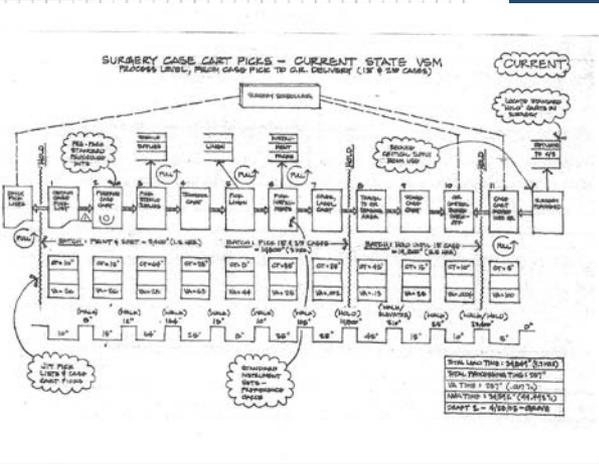
OR 1  
OR F  
DESK

(circle the appropriate one) Lead or Cycle Time Observation Form

Process	Set-up	Run	Change-over	Wait	Hold	Queue	Transport	Storage	Delivery	Return	Total
1	2	3	4	5	6	7	8	9	10	11	12

**Standard Work Combination Sheet**  
Area: Interventional Radiology Operator: RN Prepared by: Rudolph/Baylor  
Process: IR - day of service Date Prepared: 2/25/07  
Item Name: All set-up

Virginia Mason Medical Center 2008 Idea Template  
Idea Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Problem or Opportunity: \_\_\_\_\_  
How you tested the idea and results you got: \_\_\_\_\_  
TOTAL: \_\_\_\_\_  
Task for using idea: \_\_\_\_\_  
Your Name: \_\_\_\_\_  
Title/Position: \_\_\_\_\_  
Title/Position: \_\_\_\_\_  
Reviewing Supervisor: \_\_\_\_\_  
Have your friends: \_\_\_\_\_  
Supervisor's Name: \_\_\_\_\_  
Remend



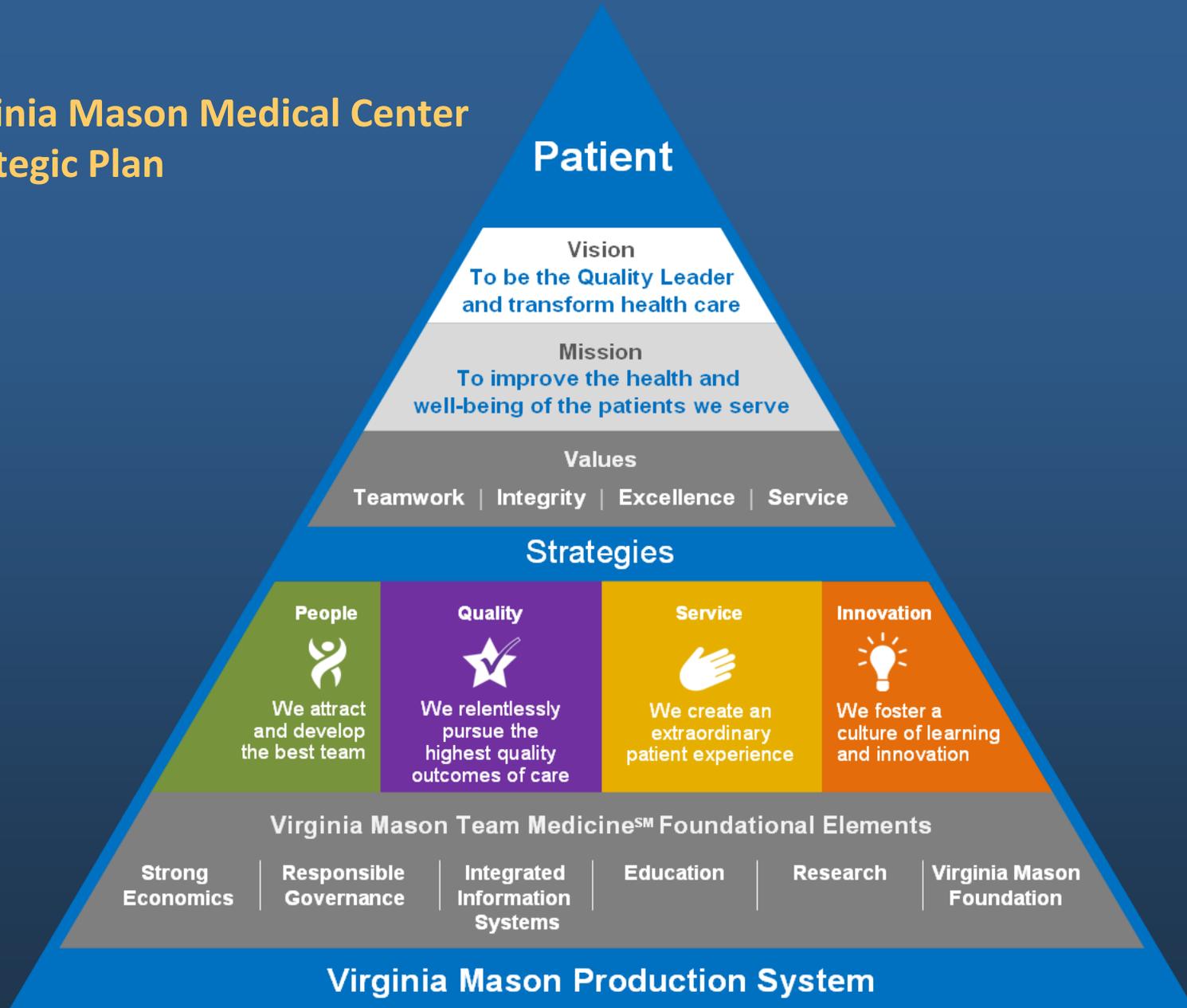
# First, Some Background...

## Virginia Mason Medical Center

- An integrated healthcare system
- 501(c)3 Not for Profit
- 336 bed hospital
- 8 locations (main campus and regional centers)
- 450 physicians
- 5000 employees
- Graduate Medical Education Program
- Research center
- Foundation



# Virginia Mason Medical Center Strategic Plan



# The VMMC Quality Equation

$$Q = A \times \frac{(O + S)}{W}$$

**Q: Quality**

**A: Appropriateness**

**O: Outcomes**

**S: Service**

**W: Waste**



# The Virginia Mason Production System

We adopted the Toyota Production System key philosophies and applied them to healthcare



- The patient is always first
- There is an engagement of all employee to provide the highest quality
- There is an obsession with safety
- We strive for the highest staff satisfaction
- Creating a successful economic enterprise

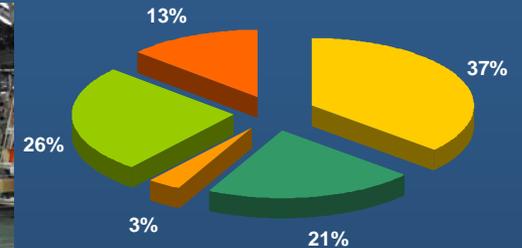


# Commitment to the Highest Quality and Obsession with Safety

All employees are empowered to be inspectors for safety and improvement opportunities

✓ Patient Safety Alert System (PSA)

✓ Everyday Lean Idea System (ELI)



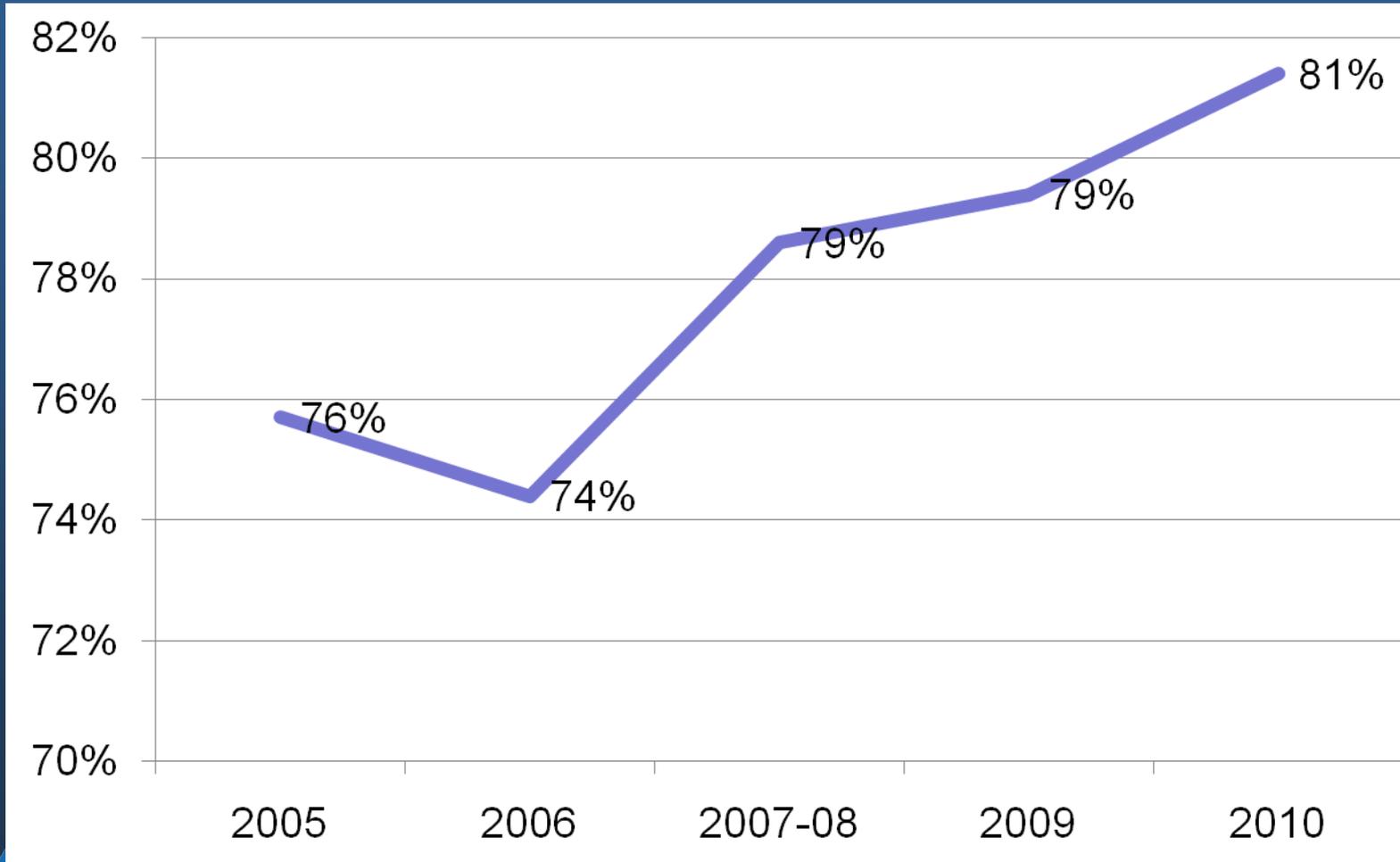
Virginia Mason Medical Center 2008 Idea Template

<b>Idea Title:</b>	<b>Problem or Opportunity:</b>	<b>Date:</b>	<b>Issue:</b>
How you tested the idea and results you got:		Circle types of waste reduced for patients and/or your team:	
Tips for using idea:			
<b>Contact Information</b>			
Your Name:	Email:	Department:	Employee #:
Time Available:	Email:	Department:	Employee #:
Reviewing Supervisor:	Email:	Department:	Employee #:
Have you finished testing and implementing idea? <input type="checkbox"/> No <input type="checkbox"/> Yes		To share your idea with others and earn like points, submit through the Idea Supermarket online form or send in this template form!	
Supervisor finished reviewing & recognizing idea? <input type="checkbox"/> No <input type="checkbox"/> Yes		Send any questions or requests that I can't answer to your idea@vmmcc.com or your idea@vmmcc.com to the email box.	
Remember to report the idea as a Patient Safety Alert if applicable.			





# Staff Speak Up Freely\*

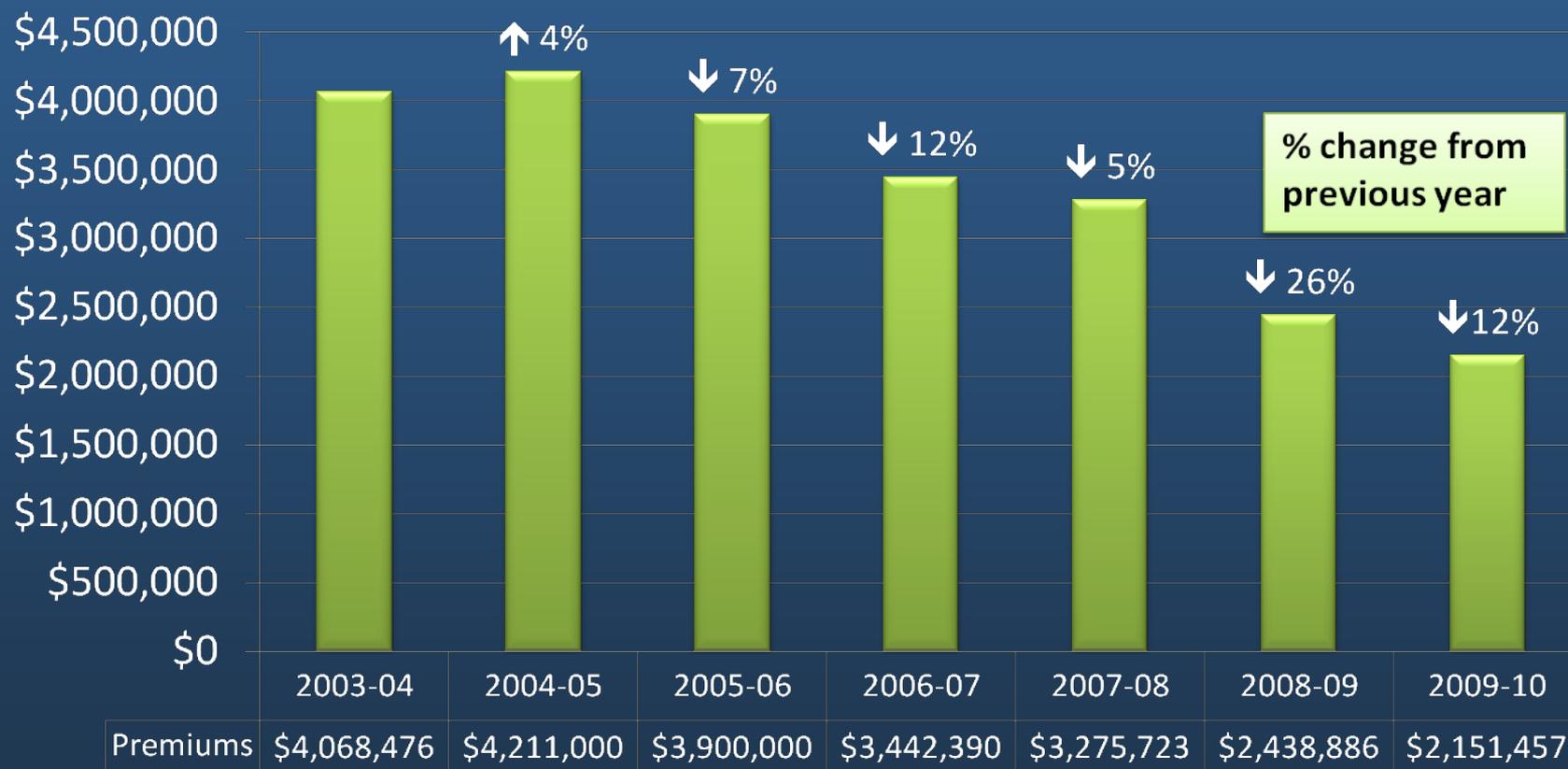


\*Question: Staff will speak up freely if they see something that may negatively affect patient safety



# Reduced Cost of Poor Quality

## Hospital Professional Liability Premiums



# Everyday Lean Idea

## Employee Idea Implemented

**My Everyday Lean Idea**

My Name: Nancy Boone - Hill Date: 8, 2, 2006

Where I Work: Hematology/Oncology

**When should I write down my ideas?**

1. When I see a mistake being made in my work area
2. When the problem happens.
3. When something you do every day makes you think there is a better way to get the job done.
4. When you see ways to make Virginia Mason safer for patients in your work area.
5. When you see ways to make Virginia Mason better for you and your work team.

**How can I use this tool?**

1. Complete an Everyday Lean Idea and get feedback from your team members if the idea will impact other processes. Who knows? Their input might make your idea better!
2. Try your Everyday Lean Idea. Implement it if logical and then pick an idea coach to review how it went (see back). This could be a teammate or your supervisor.
3. Don't be discouraged if one idea doesn't work. Many times, several ideas are needed to find the right solution.

**1. Here's the situation and problem it is causing**

Remember, a picture is worth 1,000 words!  
 - Circle the types of waste involved  
 What happens if you ask "why" 5 times?

**2. Here's a description of my idea**

Make flow chart (laminated) & place flows hide for reception, rooms - keep in file room (see enclosed). This provides a quick flow to follow which most staff learn by trial error over many months of searching.

**3. Here's how I tested my idea**

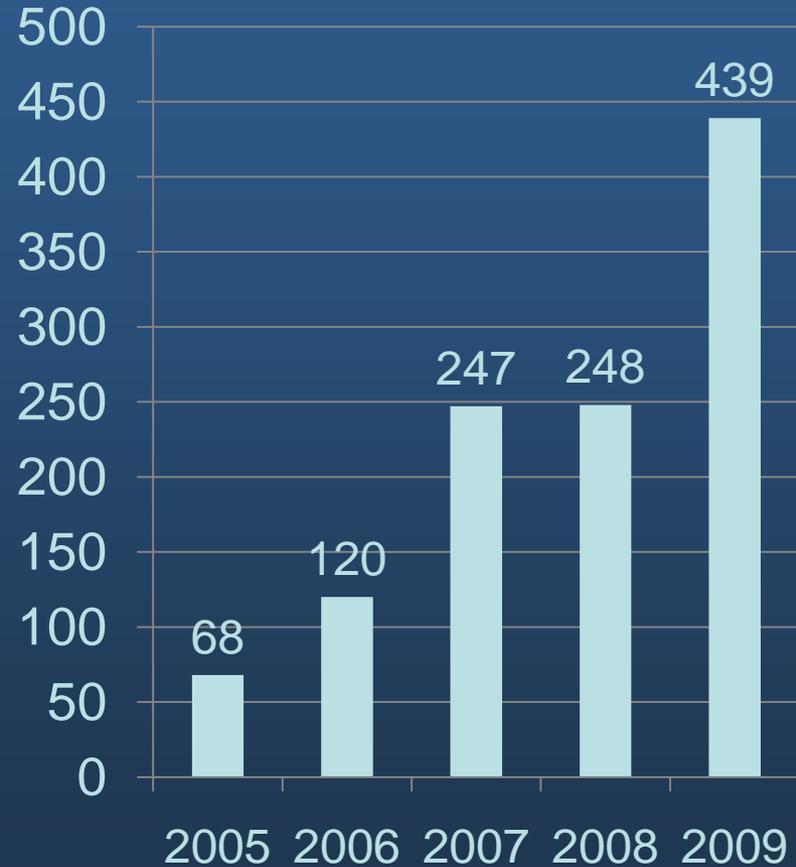
Make flow chart/flow diagrams for support staff to use. Diagram placed in flow file room & discussed at support staff meetings.

**4. Here's the effect from trying the idea**

New staff members now have a fast depicting where flow could be so more flows found. Also used as a reference for substituted staff when flow missing.

**Handwritten Notes:**

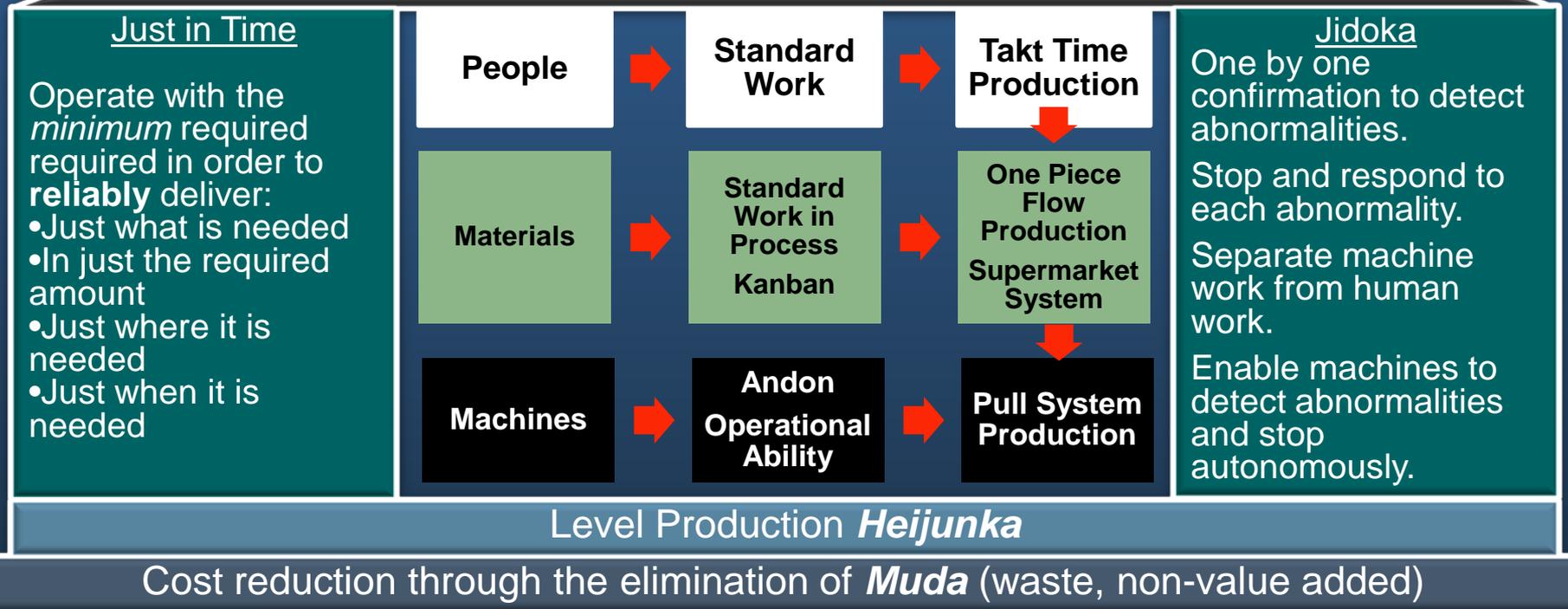
- Processing:** I need this pls! (circled)
- Motion:** Do you happen to have any flows? (circled)
- Defects:** - lost flows = lost chemo orders
- Defects:** - can't find flows
- Defects:** - different people looking for same flow throughout day
- Defects:** - flows filed in wrong MD's file section
- Defects:** - frustration by all
- Defects:** - problems if changes: NO flow for MD appl, nurse, needs to initiate new chemo orders; many people & many mistakes spent hours for flows.



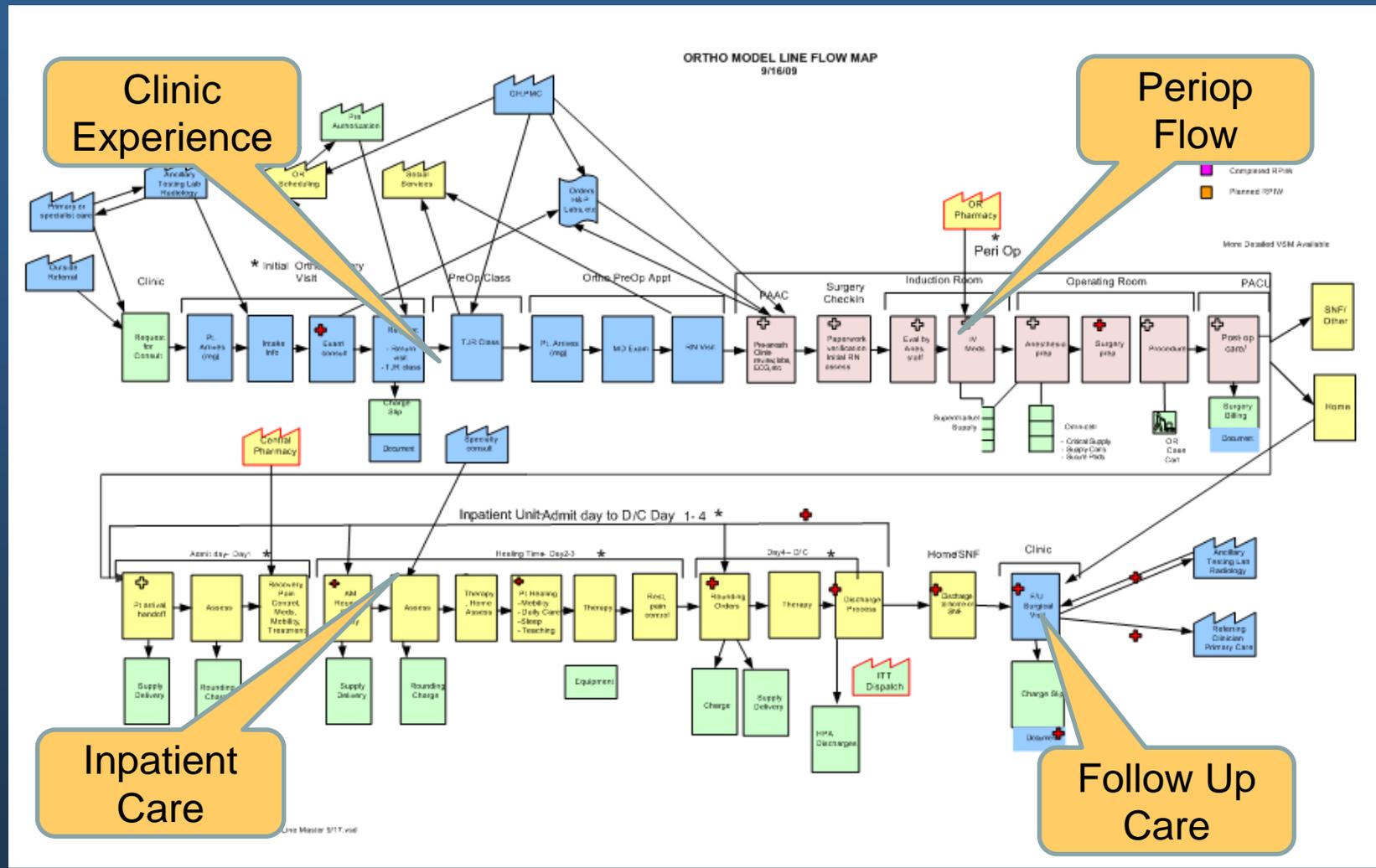
# VMPS Strategies

The method by which we manage and deliver on our mission and vision

## The Virginia Mason Production System To Make Things the Right Way



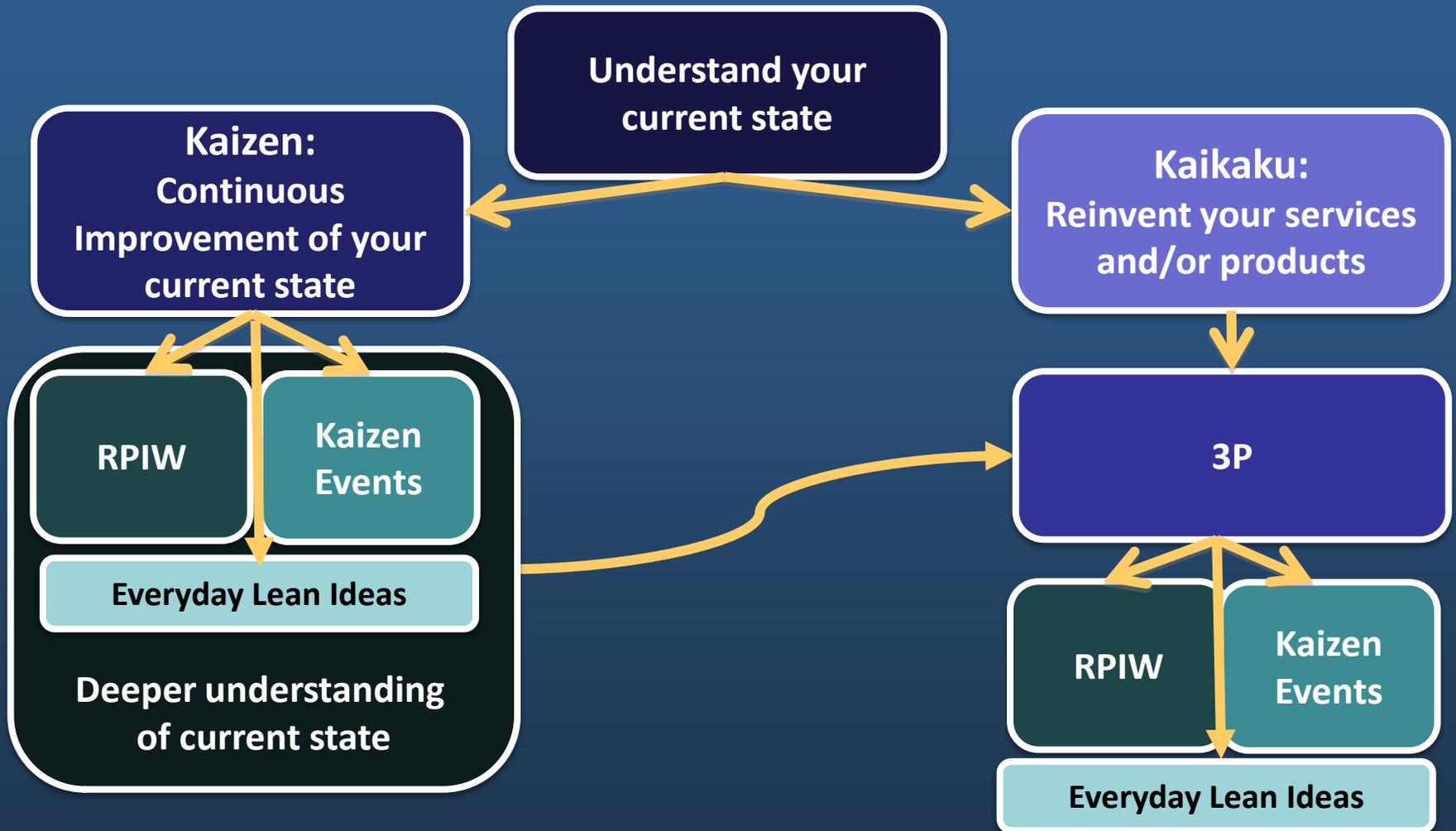
# Value Stream Map: Key Tool to Understand the Patient Experience



Key Tool to Identify Improvement Opportunities



# VMPS Improvement Pathways



# Ambulatory Surgery Center Throughput Analysis

	<u>Before</u>	<u>Today</u>	<u>% Change</u>
● Time Available (10 hr day)	600 min	600 min	0%
● Total Case Time (cut to close plus set-up)	107 min	65.5 min	39%
● Case Turnover Time (pt out to pt in)	30 min	15 min (ability to be <10 min)	50%
● Cases/day	5 cases/OR	8 cases/OR	60%
● Cases/4 ORs	20 cases	32 cases	60%



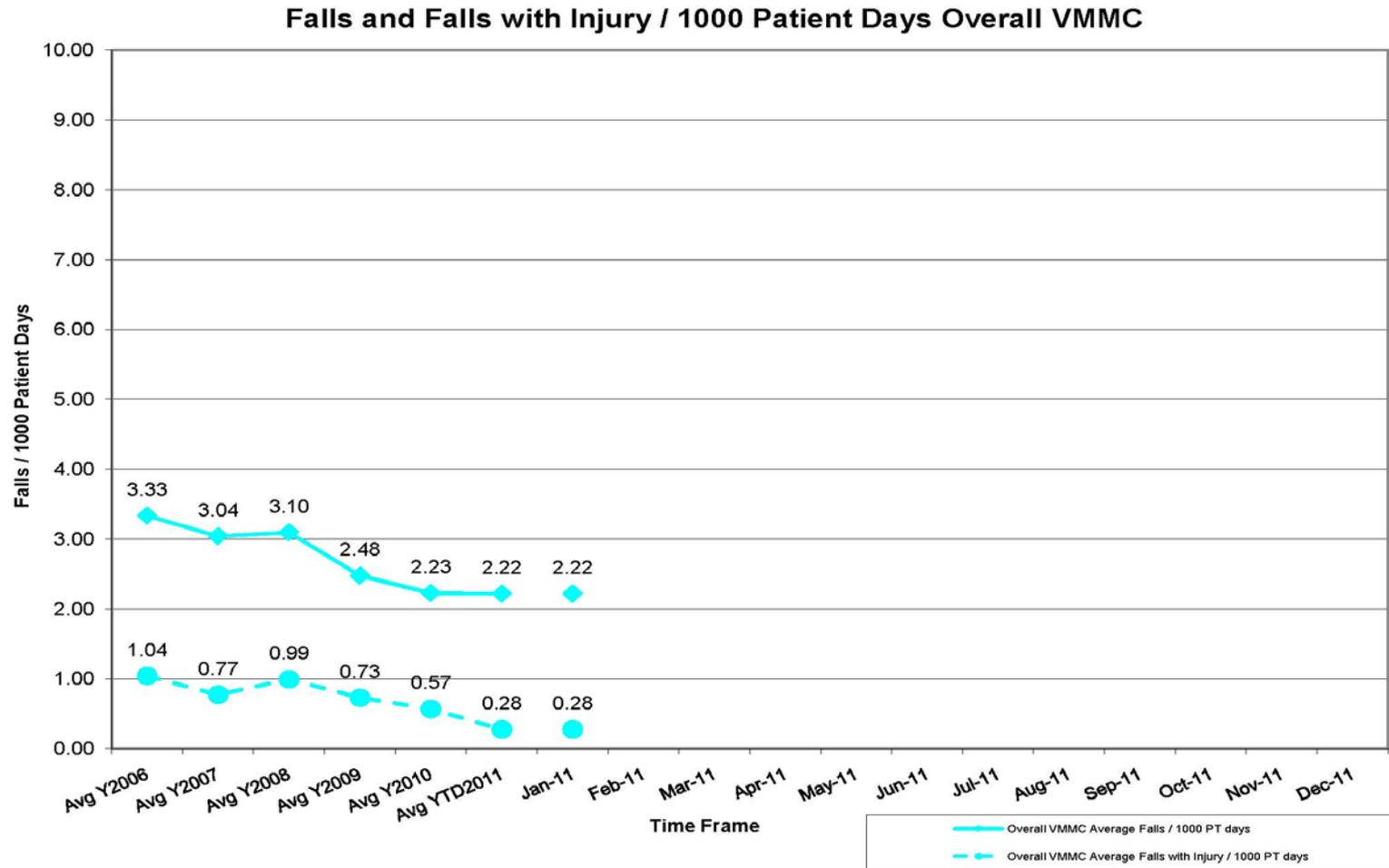
# “Nursing Cells” – Results > 90 days

RN time available for patient care = 90%!

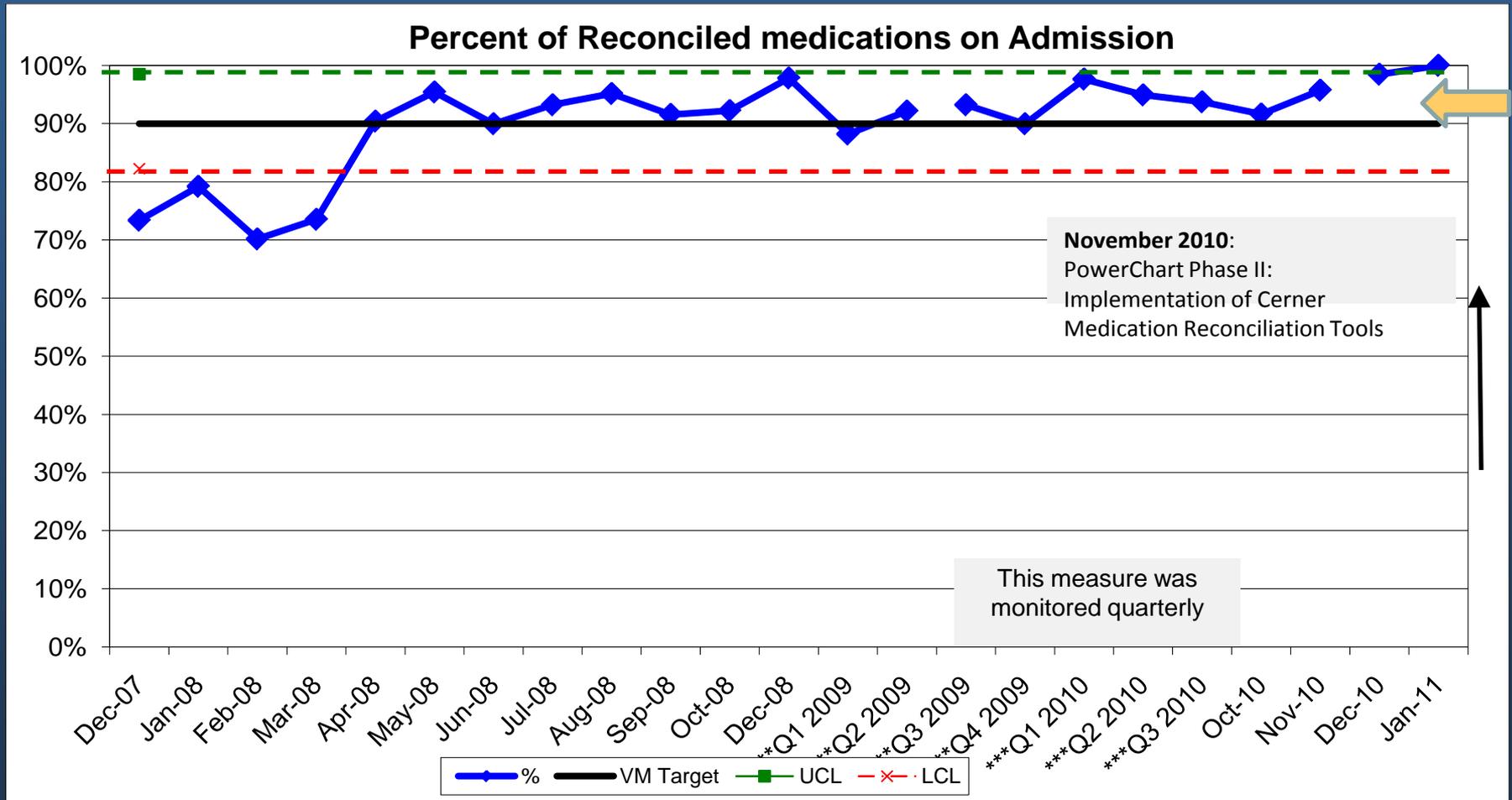
Before	After
• RN # of steps = 5,818	846
• PCT # of steps = 2,664	1256
• Time to the complete am cycle of work = 240'	126'
• Patients dissatisfaction = 21%	0%
• RN time spent in indirect care = 68%	10%
• PCT time spent in indirect care = 30%	16%
• Call light on from 7a-11a = 5.5%	0%
• Time spent gathering supplies = 20'	11'



# Measuring & Reporting

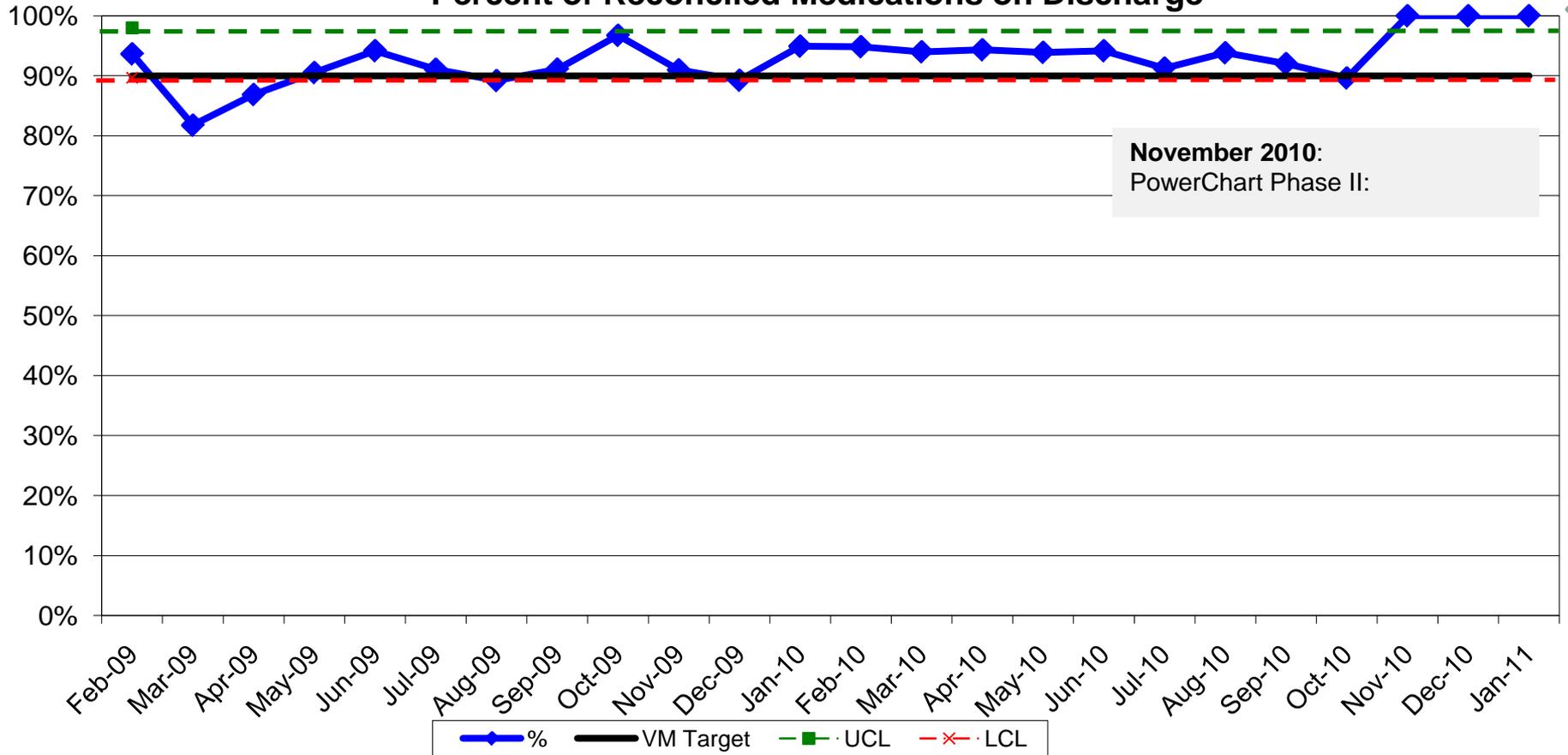


# Reconciliation: Admission



# Reconciliation: Discharge

Percent of Reconciled Medications on Discharge



During 2007 – 2009 VM and Boeing collaborated to implement an “ambulatory ICU” program.

Aim: reduce Boeing’s healthcare cost for employees with the most expensive health conditions by 15% while improving their health status



The Boeing Company: Connect and protect people globally

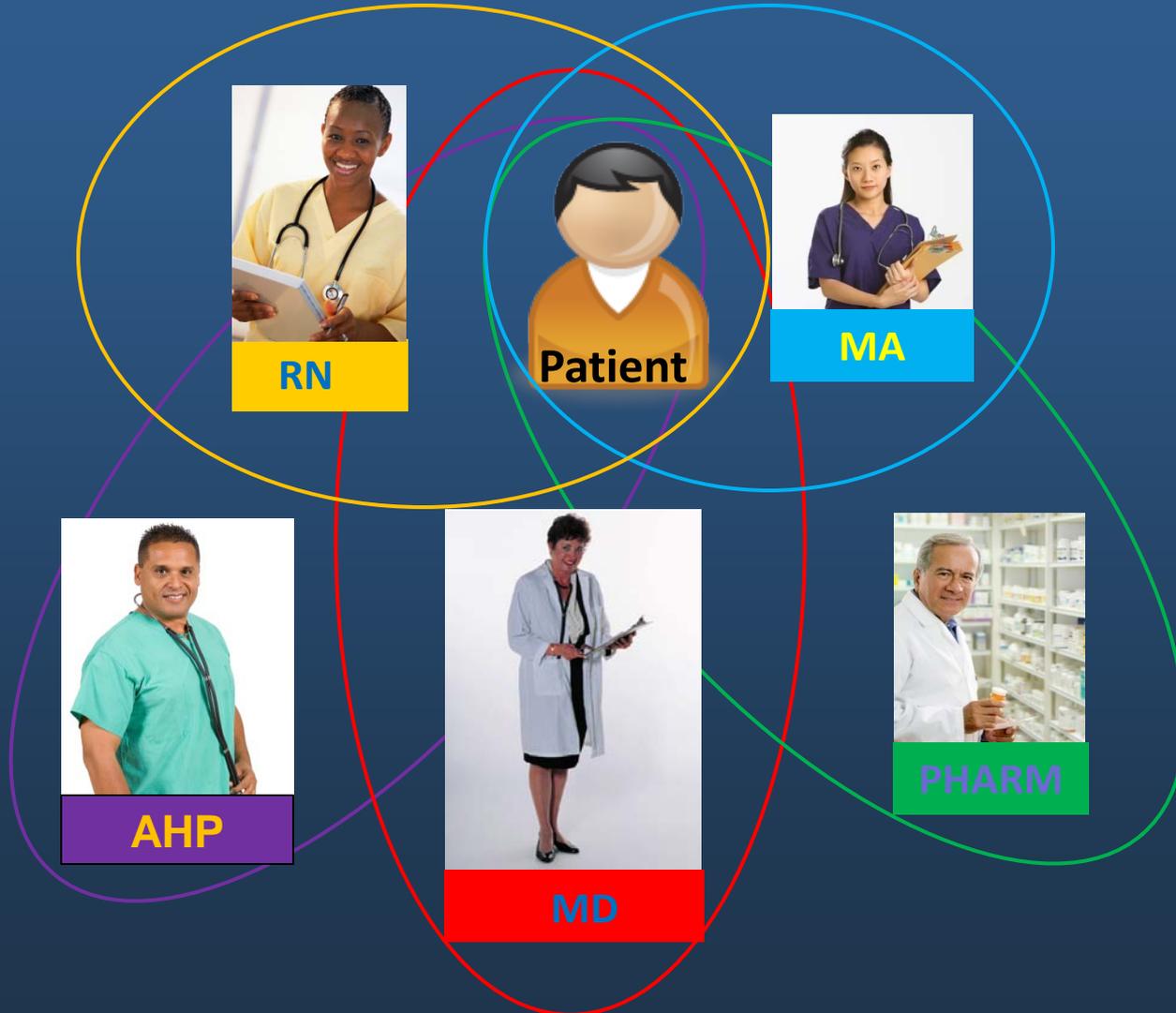


# We leveraged VMPS work to transform primary care to guide pilot project.

- Patient-centered
- Mistake-proofed, defect-free (safe)
- Waste-free processes (smooth flow)
- Reliable
- All team members contributing to their highest level of skill and licensure



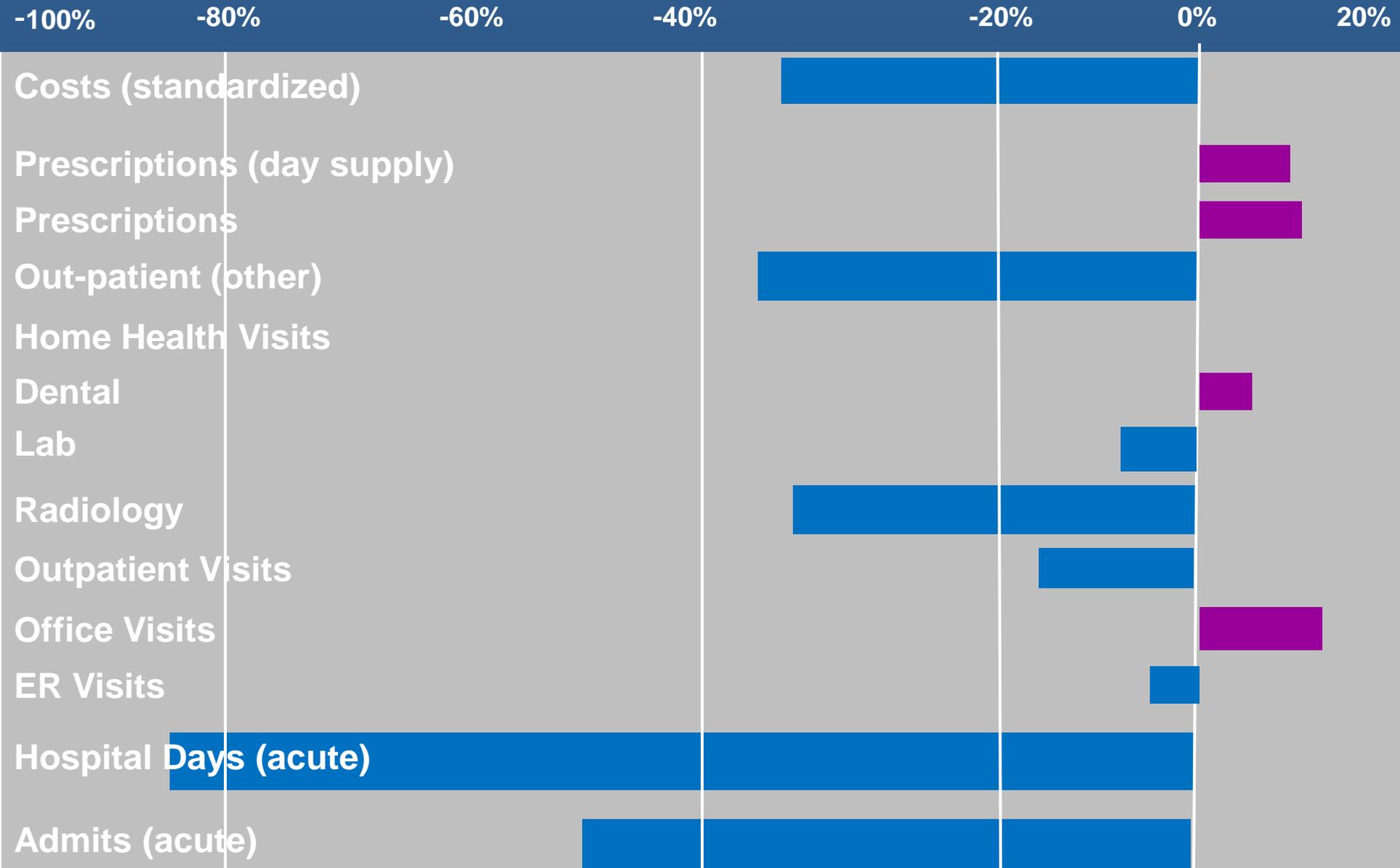
# Primary Care at Virginia Mason leverages a team delivery system.



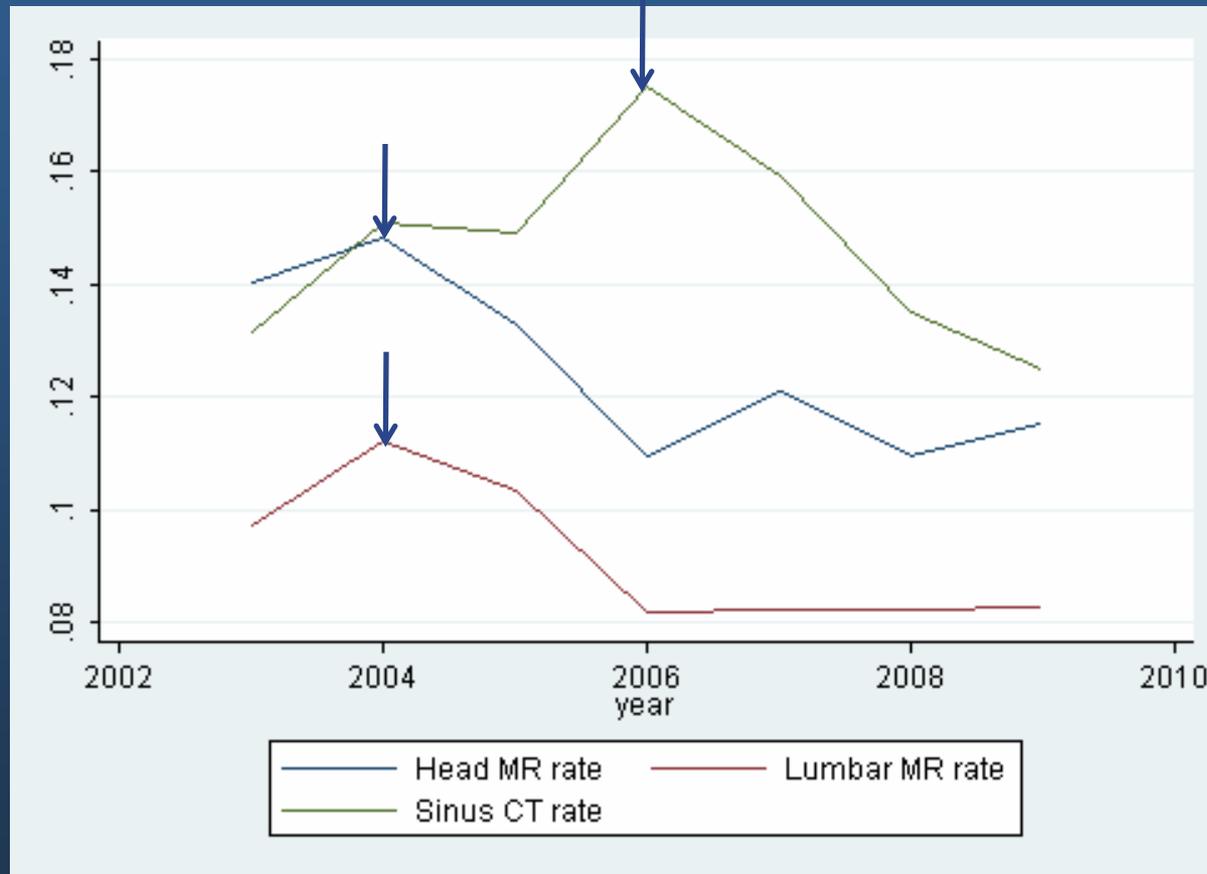
# The IOCP experience was valuable to both the participating patients and Boeing, the employer sponsor.

	<b>% Change</b>
% change in physical functioning score for IOCP patients compared to baseline	+ 14.8%
% change in mental functioning score for IOCP patients compared to baseline	+ 16.1%
% change in patient-rated care “received as soon as needed” compared to baseline	+ 17.6%
% change in average of patient-reported work days missed in last 6 months compared to baseline	<b>- 56.5%</b>

# VM's cost/utilization metrics were outstanding



# Ensuring Imaging is Value-Added



Mistake-proofing implemented ↓

Reduction in imaging

Headache: -23%

Low back pain: -25%

Sinusitis: -25%



# VIRGINIA MASON NAMED AMERICA'S TOP HOSPITAL OF THE DECADE.



## National rating based on patient safety, high quality.

Virginia Mason Medical Center is one of only two hospitals in the United States – the other is the University of Maryland Medical Center in Baltimore – to earn the title of Top Hospital of the Decade by The Leapfrog Group rating organization.

The Leapfrog Group is a coalition of public and private purchasers of employee health benefits founded a decade ago to work for improvements in health care safety, quality and affordability.

Both Virginia Mason and UMMC were cited for their strong public com-

mitments and major achievements in reducing medical errors and for innovations in patient safety and quality.

In announcing the honor, The Leapfrog Group Board Chair David Knowlton described the efforts of the two hospitals as "extraordinary in every sense of the word."

He said they chose to commit themselves to change, accountability and transparency. Virginia Mason has proved that providing high quality health care at a lower cost is not only achievable, but should be an expectation. "They've done the work that others must now undertake."

## A commitment to continuous improvement.

Virginia Mason's climb to the top began about ten years ago and has been a steady, deliberate effort.

At the turn of this young century, leadership at Virginia Mason became convinced the future depended not only on national policy changes and sweeping reforms, but also on factors closer to home – such as eliminating waste, cutting costs, and improving the quality of services.

And, most important, always putting the patient first, above all.

After looking in vain for outstanding examples of progress to learn from within the U.S. health care industry, Virginia Mason leadership ventured very far outside the box.



Gary S. Kaplan, MD, FACP, FACPE, FASPC  
Chairman and CEO of the Virginia Mason Health System

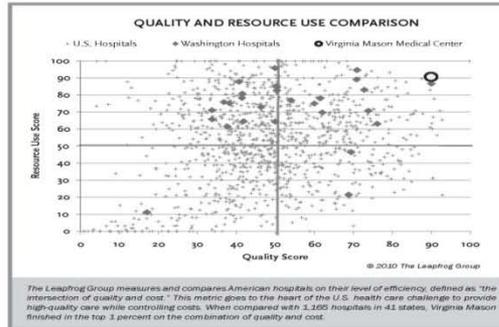
Their search took them across the world, to Japan, and across industries, to Toyota, where they studied concepts and processes at automobile plants. Medicine and health care are obviously quite different than manufacturing cars (or anything else), but management concepts such as continuous improvement and zero-defect processes can be applied to a wide range of human activities.

Virginia Mason began to apply some of those principles to health care management and organizational structure. Over the years, Virginia Mason leaders crafted what now is known as the Virginia Mason Production System – VMPS.

## Real changes. Real results.

Results of VMPS over the last decade tend to startle many health care professionals: nurses at Virginia Mason Medical Center now can spend on average 99% of their time with patients, compared with an average of 35% elsewhere; physicians see more patients during the day, with more time to focus on the patient during the visit; the time to report lab test results to the patient has been reduced by 85%; the hospital has saved \$1 million in supply expense in a single year; with increased patient safety and quality professional liability insurance cost decreased 48.9% from 2004 to 2009; the pharmacy has improved medication distribution from the moment of physician-order to availability for administration from 2.5 hours to ten minutes.

Success at Virginia Mason has attracted national attention. For each of the last five years, it has been ranked high among Leapfrog's Top Hospitals. Hospital administrators from around the world have expressed interest in VMPS, and hundreds have traveled to Seattle to learn more. To accommodate them, Virginia Mason established an Institute with a mission to help other health care professionals understand and apply the same or similar principles in their own organizations. The idea is better health care for more patients at a lower cost. Now,



## Learn more.

You are invited to find out more about Virginia Mason Medical Center's continuing efforts to improve health care for all at [VirginiaMasonInstitute.org](http://VirginiaMasonInstitute.org) or [VirginiaMason.org](http://VirginiaMason.org).

To find more information about The Leapfrog Group, visit [leapfroggroup.org](http://leapfroggroup.org).



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December 2010

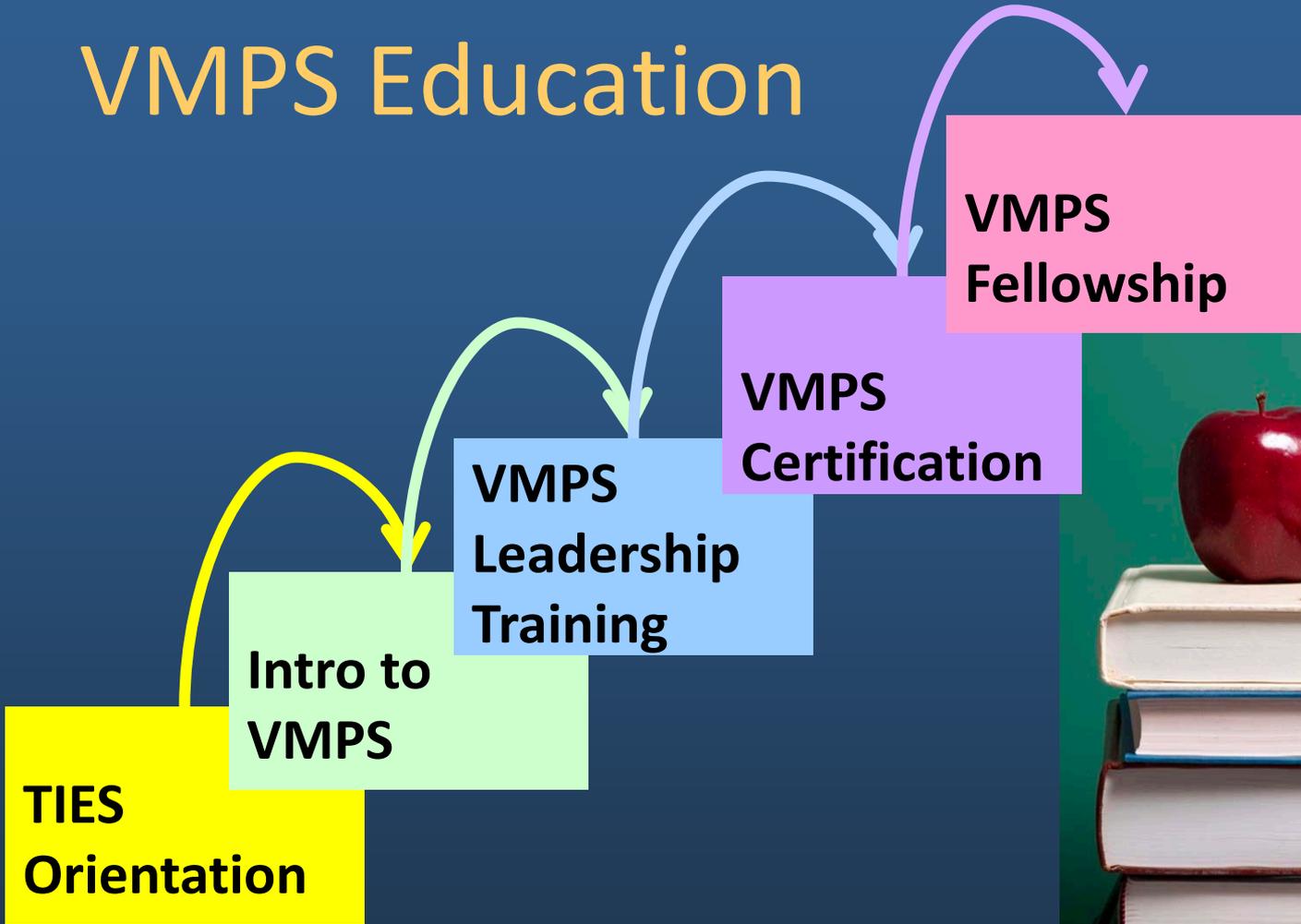


# Structural Requirements for VMPS

- 1-5% of all VMHC staff as KPO
- KPO aligned with operational executive leadership
- Executive sponsorship with accountability for sustained results
- Education



# VMPS Education

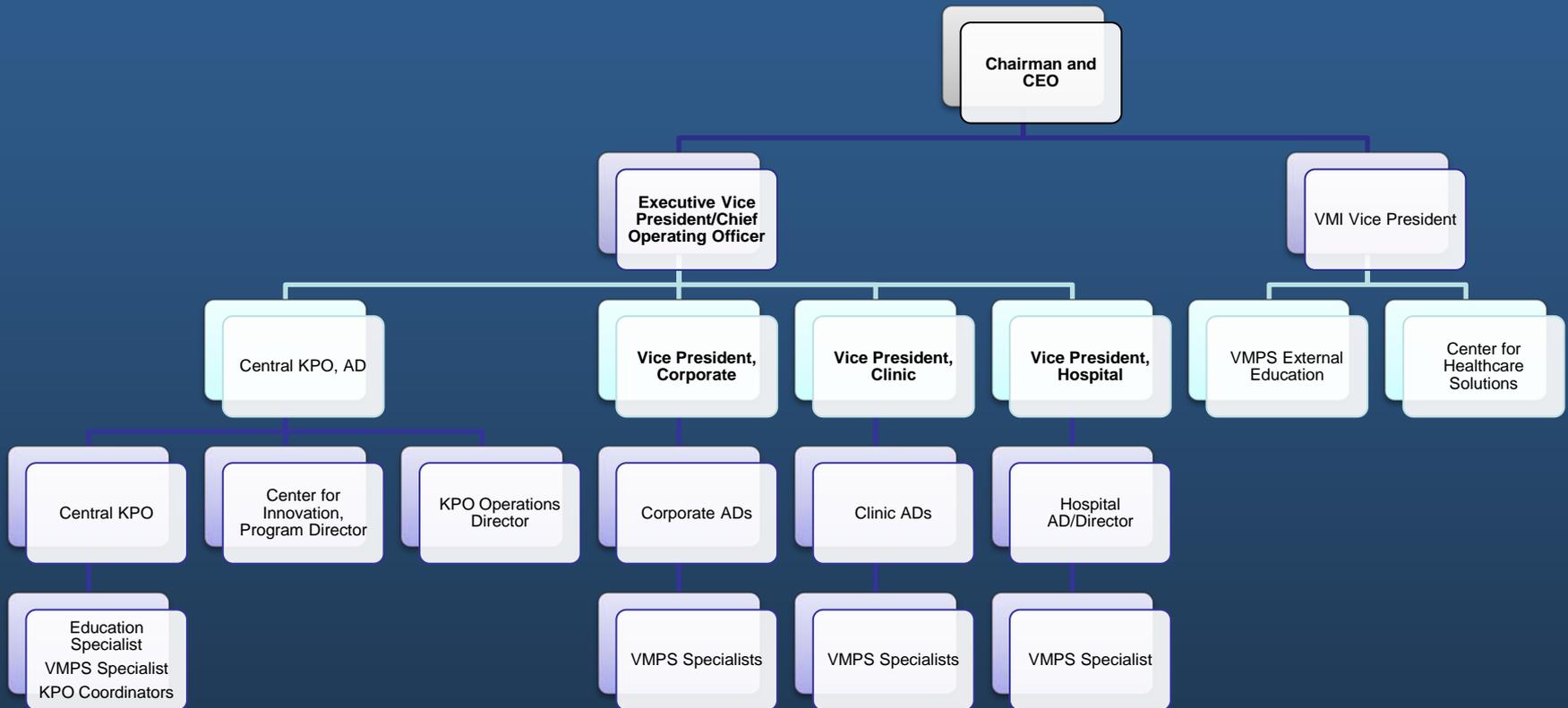


# VMPS Educational Strategies

- Everyday Lean Idea Campaign – All Staff
- Intro to VMPS (course) & Mistake Proofing – All Staff requirement
- Management Courses in VSM, Std. Ops, Mistake-Proofing & 5S
- VMPS for Leaders – 100+ Leaders per year
- VMPS Certification – Senior management requirement
- Kaizen Fellowship – Select senior management
- Japan Genba Kaizen – Management & staff
- Japan Flow Tour – Fellows and advanced senior leaders
- 3P Certification – select certified leaders



# VMPS Management Structure



# VMPS Tiered Reporting

**PeopleLink Tier 3 Reporting:**  
**Managers report to department staff and Administrative Directors**



***“Stand Up”* Tier 2 Reporting:**  
**Vice Presidents, KPO and Administrative Directors report updates on key metrics to the Chief Executive Officer**



**Tier 1 Reporting:**  
**Senior Executive Leadership reports updates on key metrics to the Board of Directors**



# Tier 3 Reporting: PeopleLink Wall



What our Customers are Saying

**Focus for the Year:**  
Decrease our Lead Time: the time from when our patients call for an appointment to the time when their episode of care is complete.

**Why is this Important?**  
Decreasing our lead time will get patients who need our services in the door more quickly. Recently, a patient ended up in the Emergency Department on two separate occasions while waiting for her visit in...

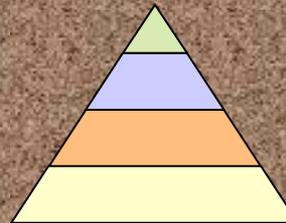
Our Focus and Purpose

Target Progress Report											
DATE	DATE OF LAST UPDATE	Performance Metrics									
FOR THE WEEK ENDING		MEASUREMENT	TARGET	ACTUAL	VAR	TREND	STATUS	REMARKS	OWNER	START DATE	END DATE
		Lead Time (min)	30	35	5	↑	Red				
		Quality Indicators (QIP/MS/CS)	95%	92%	-3%	↓	Red				
		Volume Reduction (10-17)	100%	98%	-2%	↓	Red				
		Cost (per patient)	\$100	\$105	\$5	↑	Red				
		Operational Health & Safety (OHS) Score	100%	100%	0%	↔	Green				

Goals Listed on a Target Sheet



Supporting Data



Supporting Data



Supporting Data

Process Step	Value Stream Map	Process Step	Value Stream Map
1	△	1	△
2	△	2	△
3	△	3	△
4	△	4	△
5	△	5	△
6	△	6	△
7	△	7	△
8	△	8	△
9	△	9	△
10	△	10	△

Value Stream Maps

NAME	POSITION	APPROXIMATE TO COMPLETE	RESPONSIBILITY	STATUS
				○
				○
				○
				○
				○
				○
				○
				○
				○
				○

Newspaper

We Need Your Ideas On:

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We Need Your Ideas On...

Virginia Mason Medical Center - 2008 Idea Template

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

PROBLEM STATEMENT: \_\_\_\_\_

PROPOSED SOLUTION: \_\_\_\_\_

IMPACT: \_\_\_\_\_

STATUS: \_\_\_\_\_

DATE: \_\_\_\_\_

Staff Everyday Lean Ideas

Virginia Mason Medical Center - 2008 Idea Template

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

PROBLEM STATEMENT: \_\_\_\_\_

PROPOSED SOLUTION: \_\_\_\_\_

IMPACT: \_\_\_\_\_

STATUS: \_\_\_\_\_

DATE: \_\_\_\_\_

Blank Everyday Lean Ideas

# Tuesday “Stand Up”



# Central KPO Focus: Accountability

## Focus

### Increased emphasis on maintaining gains – learning from our implementation efforts

- Baseline measures of workshop completion including 30, 60, 90 day re-measures ensuring we implement our improvements
- KPO Divisional “Christmas Tree” visual depicting event follow up status – green is good.

PDSAs in process to increase implementation efforts: weekly checking, Tier 3 attendance, revised preparing the people (front-line staff) education, asking staff who are not on the RPIW teams to submit ideas and participate in simulations throughout the workshop week.

## Results

### Kaizen event to increase the urgency – metrics improved:

- 1) 90 day re-measurements are not submitted to KPO reduced from a pre-Kaizen defect rate of **50%**, now **24%**
- 2) In the 90 day reports, there are less than 2 improvements achieved pre-Kaizen defect rate of **15%**, now at **10%**
- 3) Re-measurement not reported and/or less than two improvements after 90 days, pre-Kaizen defect rate of **58%**, now at **30%**

KPO	AD	EVENT NAME	START DATE	WSL	KPO Specialist	Received Paper Final Report	Received Electronic Final Report	Uploaded to Web Site	Received 30-day Re-measures	Received 60-day Re-measures	Received 90-day Re-measures
CL	Eusek	KE - Phys dan Documentation	3/12/08	X	Fulter						
CL	Eusek	KE - Safe Logout Administration	6/5/08	Respect-Burman							
CL	Eusek	RPIW- Fed. Way - Clinic Flow	8/18/08	Inoues	Truick						
CL	Eusek	RPIW- Fed. Way- Pa Refill/ PA Central	8/18/08	Tufano	Truick						
CL	Eusek	KE - Lab Supply Room Reorganization	11/13/08	Denson							
CL	Tufano	KE - Cancer Documentation of Clinical Information	11/20/08	Williams	London						
CL	Tufano	RPIW - Red 5 IFCC Day of service	11/21/08	Lalonde	Kernan						
CL	Tufano	RPIW - All Direct and Indirect Care	12/1/08	Cone	London						
CL	Eusek	KE - Onboarding of New Satellite Leader	12/10/08	Brown							
CL	Eusek	KE - Injectable Medical Documentation	12/11/08	McCoy	Straizer						
CL	Tufano	KE - SS Standard Work for Floor - Day of Visit	1/22/09	Baghacian	London						
CL	Tufano	KE - Establishing and Injection Room	1/26/09	N/A	Brewer						
CL	Eusek	RPIW - Cardiology MA Training and Setup	2/2/09	Boswell	Fageland						
CL	Tufano	KE - Team Management Interdisciplinary Education (Mentor)	2/24/09	N/A	Noel						

KPO	AD	EVENT NAME	START DATE	WSL	KPO Specialist	Received Paper Final Report	Received Electronic Final Report	Uploaded to Web Site	Received 30-day Re-measures	Received 60-day Re-measures	Received 90-day Re-measures
Hosp	GRound	KE - Flow Stations in the ER	4/15/08								
Hosp	Peris	RPIW - Flow IT Hub Activity Long Patients	4/24/08	Chapman	Meyer						
Hosp	GRound	RPIW - set up of SEPT Placement in Clinic	4/28/08	Paul	Meyer						
Hosp	Peris	KE - Emergency Progression (Private) Value WCT	4/30/08	Patton & Castaldi							
Hosp	GRound	RPIW - CHF All. Prepared Patients and Families	5/29/08	Charter	Whipple						
Hosp	GRound	KE - Emergency Transition from Hospital to Medical Home	5/29/08	Graves							
Hosp	GRound	KE - Surgery Prep RA/PCI Work Flow	7/21/08	Brishop & Hoyle							
Hosp	GRound	KE - RN to MD Contin. Pressure Flow on Admit	11/25/08	Ching	Sansauer						
Hosp	GRound	RPIW - RN Employment Planning	11/24/08	Richards	Sansauer						
Hosp	GRound	KE - Procedural Site Making	12/05/08	King, R.	Cutcher						
Hosp	GRound	RPIW - PT Mobility TR	12/05/08	Cutcher	Cutcher						
Hosp	GRound	KE - Nursing Students	12/05/08	Wainwright	Sansauer						
Hosp	GRound	KE - Hospitalist Boarding	1/24/09	McDonnell	Whipple						
Hosp	Peris	RPIW - Flow of Patients for Discharge Transport	1/29/09	Cutcher	Cutcher						
Hosp	GRound	KE - Team Sort	1/30/09	McDonnell	Whipple						

KPO	AD	EVENT NAME	START DATE	WSL	KPO Specialist	Received Paper Final Report	Received Electronic Final Report	Uploaded to Web Site	Received 30-day Re-measures	Received 60-day Re-measures	Received 90-day Re-measures
CO	Grice	RPIW - Redesign Assembly Line Space	3/3/08	Johnson	Grice						
CO	Foley	KE - DRG Assurance Work Flow	3/21/08	Krohler	Foley						
CO	Foley	KE - Lab Late Charges	4/24/08	Lewis	Foley						
CO	Foley	RPIW - VMMSY Finance Contractual Clauses	4/28/08	Lewis	Foley						
CO	Foley	KE - HES Front Desk Work Flow	5/13/08	Fulter	Foley						
CO	Grice	KE - Lead Role in Sterile Processing	5/29/08	Grice	Grice						
CO	Foley	RPIW - Business Process in the Hospital	6/2/08	Sundt	Sundt						
CO	Grice	RPIW - Pharmacy Sterile Processing Contract	7/7/08	Grice	Grice						
CO	Foley	KE - RPA Denials	8/20/08	Stewart	Foley						
CO	Foley	RPIW - Business Flow of Patient Admission	8/25/08	Fulter	Foley						
CO	Foley	KE - WBS Review & Standards Publishing Process	9/25/08	Phillis	Foley						
CO	Foley	RPIW - Provider Maint. - Emergency	11/0/08	Poppy	McDonnell						
CO	Foley	KE - Medicine Support	12/2/08	CHS-Stewart	Sundt						
CO	Foley	KE - Mortgage Benefits Collections Process	12/2/08	Lewis	Sundt						
CO	Foley	KE - SS Criteria for Policies / Processes	12/2/08	Noel	Sundt						

KPO	AD	EVENT NAME	START DATE	WSL	KPO Specialist	Received Paper Final Report	Received Electronic Final Report	Uploaded to Web Site	Received 30-day Re-measures	Received 60-day Re-measures	Received 90-day Re-measures
CO	Grice	RPIW - Patient Satisfaction Data Review	12/8/08	Vander-Hoof	McDonnell						
CO	Foley	KE - Patient Reduction on DM Daily Order Proc	12/9/08	Donnelly	McDonnell						
CO	Foley	RPIW - Policies Deployment	12/05/08	Phillis	Sundt						
CO	Foley	KE - Product Review / Supplies	12/05/08	Sylvester	Sundt						
CO	Foley	KE - Sterile Process Decentralization	12/05/08	Fulter	Stewart & Kernan						
CO	Foley	KE - Patient Safety Alerts Setup	02-09-09	Liao	Sundt						
CO	Foley	KE - Pharmacy 3rd Party Billing	12/08/08	Woolf	McDonnell						
CO	Foley	RPIW - DRG Account Documentation / Reimbursement	12/02/08	Williams	N/A						
CO	Foley	RPIW - Accounts Receivable Follow-up	1/29/09	Lewis	Sundt						
CO	Foley	RPIW - Quality Performance Indicators	1/26/09	Sylvester	N/A						
CO	Foley	KE - Spreading Engagements and Travel	1/28/09	Creeper	N/A						
CO	Foley	KE - Financial Management of Adverse Events	1/28/09	Suko	Schaller						
CO	Foley	WBS Review Review Process	2/2/09	Sundt	Wynn, M						
CO	Foley	KE - Benefits Compliance / S.S. Waiver Review / Assessment for Product Review	2/28/09	Mahan	N/A						
CO	Foley	KE - Mortgage Call Types and Process Flow	3/26/09	Schwartz	Stewart						
CO	Foley	KE - RPS/PC Call Types and Process Flow	3/25/09	Truman, C. Foyell							

# Ongoing Challenges

- Patient First
- Belief in Zero Defects
- Professional Autonomy
- “Buy In”
- “People are Not Cars”
- Pace of Change
- Victimization
- Leadership Constancy
- Rigor, Alignment, Execution
- Drive for Results



# Leaders' Role in Signal Generation

“Leaders are signal generators who reduce uncertainty and ambiguity about what is important and how to act”.

— Charles O'Reilly III



OR



# VMMC Leadership Compact

## Organization's Responsibilities

### Foster Excellence

- Recruit and retain the best people
- Acknowledge and reward contributions to patient care and the organization
- Provide opportunities for growth of leaders
- Continuously strive to be the quality leader in health care
- Create an environment of innovation and learning

### Lead and Align

- Create alignment with clear and focused goals and strategies
- Continuously measure and improve our patient care, service and efficiency
- Manage and lead organization with integrity and accountability
- Resolve conflict with openness and empathy
- Ensure safe and healthy environment and systems for patients and staff

### Listen and Communicate

- Share information regarding strategic intent, organizational priorities, business decisions and business outcomes
- Clarify expectations to each individual
- Offer opportunities for constructive open dialogue
- Ensure regular feedback and written evaluations are provided
- Encourage balance between work life and life outside of work

### Educate

- Support and facilitate leadership training
- Provide information and tools necessary to improve individual and staff performance

### Recognize and Reward

- Provide clear and equitable compensation aligned with organizational goals and performance
- Create an environment that recognizes teams and individuals

## Leader's Responsibilities

### Focus on Patients

- Promote a culture where the patient comes first in everything we do
- Continuously improve quality, safety and compliance

### Promote Team Medicine

- Develop exceptional working-together relationships that achieve results
- Demonstrate the highest levels of ethical and professional conduct.
- Promote trust and accountability within the team

### Listen and Communicate

- Communicate VM values
- Courageously give and receive feedback
- Actively request information and resources to support strategic intent, organizational priorities, business decisions and business outcomes

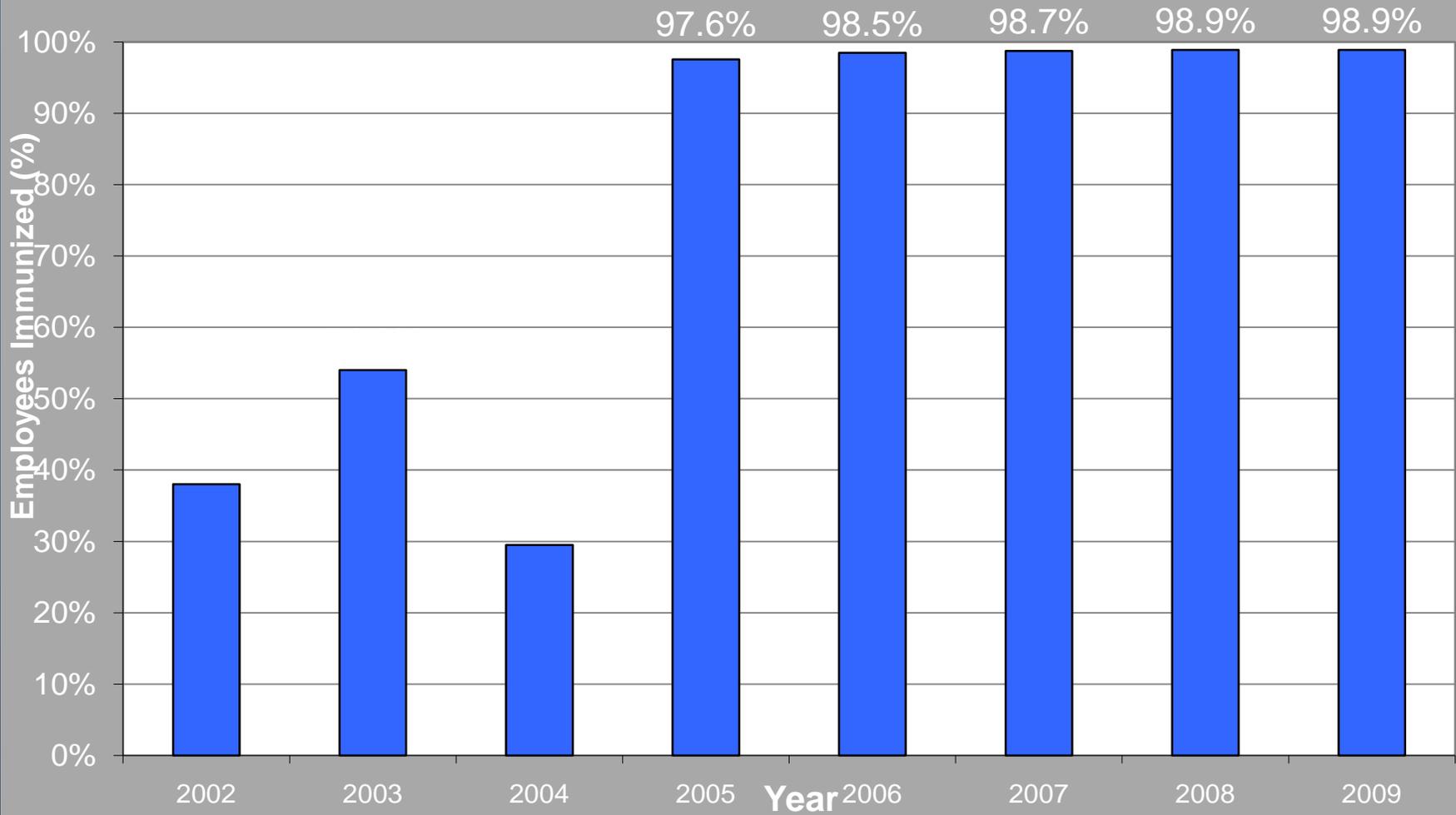
### Take ownership

- Implement and monitor VM approved standard work
- Foster understanding of individual/team impact on VM economics
- Continuously develop one's ability to lead and implement the VM Production System
- Participate in and actively support organization/group decisions
- Maintain an organizational perspective when making decisions
- Continually develop oneself as a VM leader

### Foster Change and Develop Others

- Promote innovation and continuous improvement
- Coach individuals and teams to effectively manage transitions
- Demonstrate flexibility in accepting assignments and opportunities
- Evaluate, develop and reward performance daily
- Accept mistakes as part of learning
- Be enthusiastic and energize others

# Figure: Influenza Immunization Rates

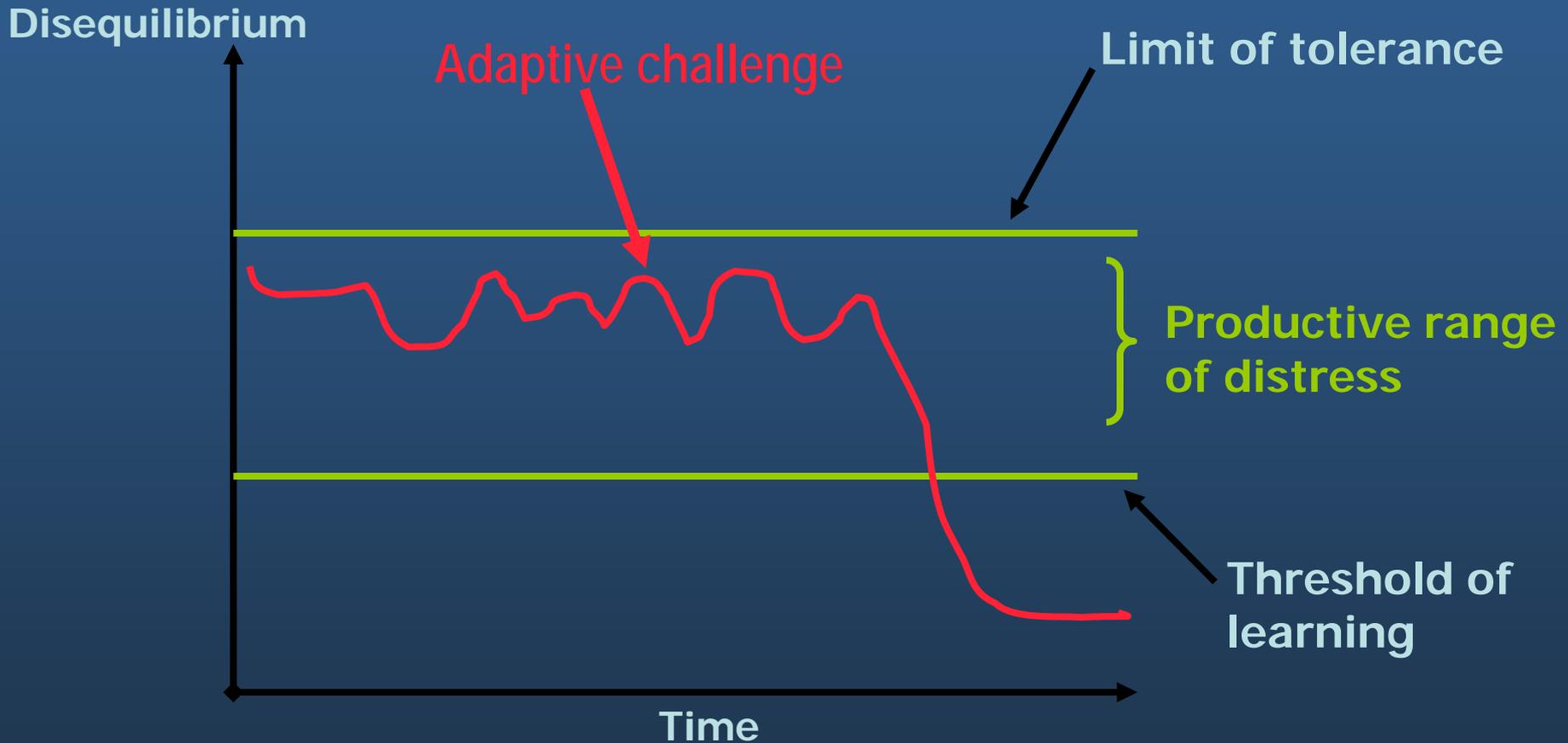


# Wisdom from Ronald Heifetz

The most common cause of leadership failure is treating an adaptive problem with a technical fix



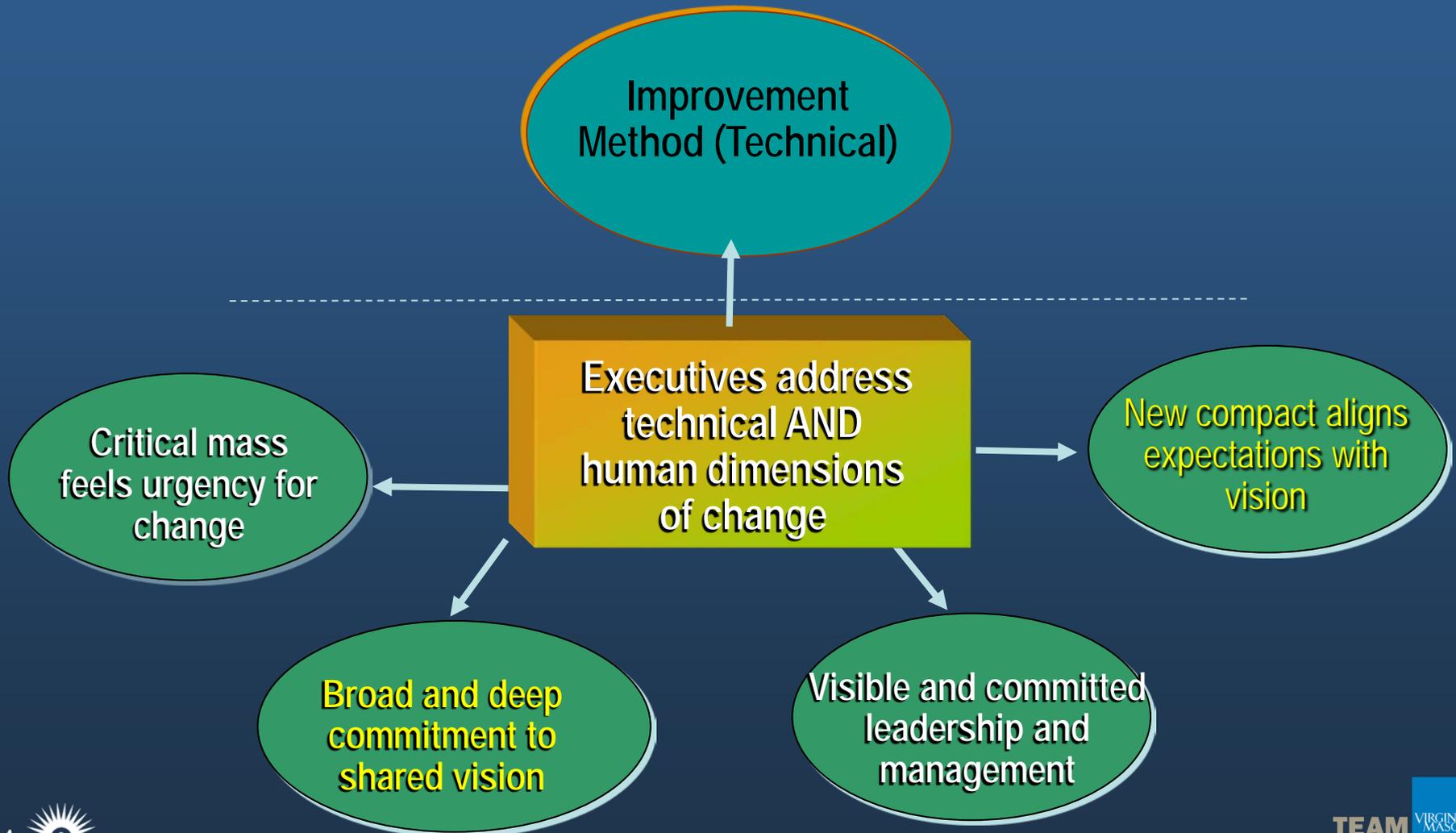
# "Distress" and Adaptive Work



Heifetz, Ronald A. and Marty Linsky. *Leadership on the Line*, Harvard Business School Press, 2002, p 108



# Requirements for Transformation





*“In times of change,  
learners inherit the earth,  
while the learned find  
themselves beautifully  
equipped to deal with a  
world that no longer  
exists.”*

Eric Hoffer

