William Maples

Mike Seyfer: It's my pleasure to welcome Dr. William Maples, a client and friend. We've been working together for the last year, and I will say that I'm very inspired by the work that the Institute for Healthcare Excellence does.

A little bit about Dr. Maples; he leads the Institute for Healthcare Excellence, where he and the faculty work with organizations to nurture the relational skills necessary to create a culture which embraces trust, respect, compassion and teamwork. This in turn creates an environment where quality, safety, and efficiency efforts flourish. I will say, having sat through several parts of the training, what I witnessed and have also come to learn from some friends here who are physicians with Essentia Health, that went through this process, that it's real, it has results, and it does create joy in an environment that sometimes diminishes joy. So, I'd like to welcome Dr. Maples up to the stage.

Thank you very much.

Dr. Maples: Yeah, thanks, Mike. And thanks Hailey Sault for the invitation to spend the 30 to 45 minutes with you. Just maybe to share some provocative thinking around the topics that were already raised this morning and maybe even broader than that. You'll understand what I'm talking about in a few minutes.

As I listened to the first two presentations and I look around the room, I have a little bit of impatience in the sense that I've heard similar talks and themes over the last literally 10 years. And I really get a little impatient that we just continue to have the conversation and we're not moving the needle in the magnitude that any of us would hope.

So I'm hoping that each of you takes something back today, and make it actionable because I honestly stopped going to a couple of these conferences that were very thought provocative, got all the mind stirring, but it has to be put into action. So I'm going to hope to share some words in terms of how we can make that happen.

The title of my talk is Creating an Experience Culture to Deliver Care of Highest Value. So we're into this value based care theme and value based care is simply being reimbursed, when you actually improve the quality of life, the safety of care, the experience of care or the efficiency of care. And there are metrics that are actually tied to all of those and tied to a reimbursement scheme right now in Medicare, but coming hopefully into the private sector.

But the second part of the equation here is restoring joy, meaning and resiliency to the practice of medicine. There is no—I asked the question earlier to Nick, how do you think doctors and administrators and nurses are getting in the way? And I'm just going to share just one simple thought with you. There is no possible way that we can actually move into community care population health with half of our medical profession burnt out. It cannot happen. For those of you who are involved with patient experience, you will not be able to drive patient experience if we don't pay attention to this part of the equation.

As I launch into this, just a little bit about my journey in this. I practiced. I'm a medical oncologist, and I practiced for 25 years at Mayo Clinic. And I was asked in the last 10 years of my career there to really address the question, the motto of the Mayo clinic, are the needs of the patient come first.

And we changed vendors five times because the results of the surveys suggested we were not doing that. And so it had to be the survey. And so they finally actually stopped and said, stop. Let's really sit back and figure out what is the missing piece here. And so that's how the journey started.

And. Fast forward. When we launched this work, we not only found that we were creating an experience culture that was optimal for patients, but also optimal for staff. And by the way, we also saw that we were driving value. And so it was at that point that I stopped and said, you know, what am I going to do with my last chapter of service to medicine?

And it eventually led to the launching of the Institute where we're doing this work—that I'm going to share with you—across the country. It was that important to me that we really helped every possible nurse, physician, caregiver, CEO, administrator and help them in this journey.

So with that, let me just shape the situation. This is the challenge. I chose one metric here and it's patient experience because I know many of you are interested in patient experience and the audience, but you can put any metric that you want there. Infections, falls, pressure ulcers, you name it.

And the curve will look something like this. We have spent billions upon billions of dollars, and hours and hours upon time, doing evidence based medicine. And it's saying we should actually drive the patient experience if we just do this, this, and this, and we have seen incremental improvement in the results. Not where we would hope to be.

In the process, we're doing this to our caregivers. Do you ever feel, if you're in the health care delivery system, that you're in that beaker burning up wondering how you're going to actually get to the next thing and do the next thing. And in the good intent of actually doing those evidence-based measures and/or solutions to drive the experience that we want, we are burning out our staff because all they see is this: little incremental changes.

And they get exhausted. And actually I've seen systems give up because the progress has been so, so minimal. So this journey to excellence, we want something like this. I can't imagine any health system in America that doesn't want safety, quality, patient satisfaction, deficiency coordination and population health.

That is community health. That is your first two lectures this morning. That is care across the continuum. Everybody wants everything on this right side. And what we've done is we've thrown a bunch of things in the middle. Evidence-based, all good things, but we aren't driving to that end result that we want.

And we stopped and said, what is it? Why is this technology not working? And I heard a couple things this morning. You know, maybe the patients don't want it. Maybe we design it for the patients, but I think the problem is not really there. I think the problem is something else. There's something missing.

There's something that we're taking for granted that our staff is actually able to execute and they really do not have the right tools to execute all of those things in the middle. So what is it? And I'm going to spend the next few minutes discussing that with you. I asked the question earlier, why is it that the technology doesn't work?

I know I heard lots of things. It might be reimbursement and all dot dot, dot. I'm going to give you something provocative to think about on the fee for service side of things. The VA system is not fee for service. They have a program called whole health. And their whole health program actually—and they have a whole menu of things that can help patients walk through the social determinants of life as well as other solutions. Such as acupuncture, mindfulness, all sorts of things that they actually pay, give credit to their team when they enroll a patient into a program like that—zero fee for service, they took it out of the equation.

That's possible in the VA system and still they cannot get the engagement in the program that they want. This problem is not just a fee for service problem. There is something else inherently missing. The issue of reimbursed readmissions came up and we stopped doing the work because we were afraid we weren't going to get money for when patients came back.

I was in those conversations 10 years ago when I was leading quality at Mayo Clinic. And yes, that came up then. But the reality is with the baby boomers, we have so many patients to take care of. We thought we were going to be closing hospitals and now we're adding hospital beds.

It is not the reality. That is not the reason why we can't move this forward. And we keep going back to those things. It simply is not the reality of the problem. So what is missing? We're walking this fine line. This came up in some of the earlier conversations of going for fee for service to value based care.

Hand in hand we are walking to try to create the only way you can deliver value based care. The only way you can get community care is if you go to a team based care, a patient centered team based care. What matters to the patient? And right now we are still living in a physician centric model of care.

That's what needs to change. If we have any hope of getting community care or any hope of really driving value based care. And we skip over this. Time and time again, and I can say physician centric. I can say nurse centric. I can say health care provider centric. I don't mean to just single out the physicians in this situation.

We will get across the bridge. I think many of you feel like you're on that shaky bridge right now, but we have no choice but to get across the bridge if we're going to lower the costs of medicine that Nick nicely outlined this morning. The other piece of the equation that I think we need to address before we layer on more technology solutions and more of an evidence based practice is this simple formula George Eckes shared with us many years ago. That the ability to improve and you can put anything—improved patient experience, quality care, mortality—you know, any metric you want to put on the top.

And I'm not aware of any health care system that doesn't want to improve, but the ability to improve is equal to the technical capabilities multiplied by the cultural capabilities of the organization or the individual. Now, the last time I went to school, anything times zero was zero. And we put a whole bunch of money into technology and don't get me wrong, it's very valuable.

But without putting an equal amount of time in the other side of the equation, we're going to end up exactly where we have been the last 10 years with minimal incremental improvement. Because any improvement project will have some cultural component to it, but minimal, unless you truly focus on the cultural side of things.

Reflect on your own. How much time have you or your organization truly spent at evolving the culture of your organization? How much time have you spent on

technology, solutions, EMR, dot, dot, dot. That's why the first graph looks like it does and almost every other improvement graph that you look at.

Does culture matter? The literature—it's no longer a soft science—the literature is crystal clear that if you actually improve the culture, culture of teamwork, culture of respect dot, dot, dot, you will actually improve everything that is looked at on the left-hand side of the column, and more.

This is a study from Dr. Michael Leonard from Safe and Reliable Healthcare, and he looked at one hospital, same administration, same policies, same procedures, same technologies, everything the same. And he looked at units that had teamwork scores that were above 60 in his survey. And colored those green, and teamwork units that had teamwork scores less than 60 and look what happened to their HCAHPS scores.

That's, for those of you who are not familiar, that's a patient experience equivalent metric. Medication errors per month. Threefold decrease. Days between C diff infections. That's a serious infection that can happen when you're in hospitals and on antibiotics. Look at that three fold increase.

Those hospitals have the same cleaning policies, the same environmental services dot, dot, dot. Days between stage three pressure ulcers, big sores that happen, just on the basis of their teamwork culture, not on what policies they had, not on what technology they had. It had to do with teamwork.

When you look at teamwork climate for the employees, look at the employee satisfaction—doubled. Injuries, employee absenteeism, RN vacancy rates, nine-fold less based on culture. That's that side of the George Eckes equation that we need to begin to pay attention to, if you have any hope of delivering what your first two speakers really talked about today. And we keep skipping over it, we think we can get by that step and we can't.

At the same time I talked about this issue of burnout, we are also trying to find the solution to developing a culture of joy. Fortunately, the answer to both of these culture things is identical, so we don't have to have a wellness group working over here and a patient experience group working over here. They are identical. And let's talk [about] how they merge.

So let's talk a little bit about burnout first. No matter how you look at it, you can pick different surveys, different studies. About half of our health care team is experiencing some aspect of burnout. And it is not significantly changed despite, again, a focus—put it in the middle of that box of solutions that we've tried, really trying to improve the joy, the resiliency of our health care team. We know what happens when

our health care providers show up with some component of burnout—patient satisfaction drops, errors go up, infections go up, standardized mortality rates go up.

And I will suggest to you that there is no technology that will fix this because it isn't a technology problem. It is a culture problem. It is a teamwork problem. It is a trust problem. Just for a moment, in your own institutions, what is the level of trust that you have with your colleagues, with administration, with physicians, and even with patients?

I don't think this problem is with the patients. We typically make comments—they just don't get it, if they just were a little more motivated—it's not the patients.

Noncompliance. My CEO, I'll always remember this—don't even talk to me about noncompliant patients. They're compliant with what they have bought into, and it's our plan that we think they're not compliant with, but we haven't even paid much attention to what their plan is and what are they motivated to do.

Financial impact of burnout, Stanford Healthcare System. They looked at the percent of doctors who left their organization, if they had some burnout going on versus those that didn't, 21% to 10%, for that one area of Stanford. $16–56 million economic cost just to replace the physicians who are leaving because of burnout.

The national task force for health care and humanity. The Institute is part of that initiative, $9 billion it costs the health system. $9 billion from nursing turnover due to burnout. For those of you who think this is soft science, it's not soft, and if you truly believe these numbers, and they've been borne out by many, many different institutions and calculations, including the AMA dot dot dot. They're real, we cannot close our eyes to this.

And another way, 30% of primary care physicians—by the way, that's the same group that we were hoping to layer on some technology to really help with the preventive care things—they're leaving the profession by the age of 49. That's their peak performance, their peak of their career, and they're leaving the profession. 75% of physicians would not recommend that profession to their children. I can't think of a profession, having been in it for my entire life, that is more rewarding to help a human to human; and we can't recommend that profession.

Because of the environment that we're in, the culture that we're in. And by the way, about 40% of physicians are actually experiencing frank depression, and unfortunately we know too much and when we actually try to commit suicide, we're actually quite successful.

That's too late. That's way too late to begin the conversation about what we're going to do about this.

So what about this? How do we get to the joy? How do we get to the culture that's actually going to help us move into that population health? So Christina Maslach helped us really understand this and describe this burnout as emotional exhaustion, depersonalization—treating the gallbladder in 434 rather than Mrs. Jones, who has three children, and is wondering how they're going to make the next week happen with her gallbladder problem. And then personal accomplishment. Am I really valued? Am I connected to my mission? So she helped us understand that and measure that. And by the way, this is all negative sort of measurement and we're really good about that in medicine.

Don't we always measure? How bad are we? How many people have we killed? How many errors have we made? We're really, really good at focusing on that. That's that negative, that depth. So we measured how bad we are. Okay.

Then we came to Christine Sinsky and the AMA and they began to talk about this culture of wellness and this resilience, and then also brought into this whole thing, the efficiency of practice.

So how can we eliminate the hassles, the EMR hassles dot, dot, dot to truly create the wellness. And lastly, we evolved to the national task force in health care, Brian Sexton, Marcus Buckingham, to asking the real question: is zero burnout really where we want to have as our goal, or do we really want our staff to actually come to work thriving, and really being resilient and can emotionally recover?

Because then they're equipped to do the things that we're going to be asking them to do, including the things like social determinants of health and other aspects that are critical. And by the way, we need to have them come to the table with the city governments, with the largest employer, and be able to have these conversations. Right now, there is no possible way that that's going to happen. And we see that playing out over and over and over again. They simply don't have the joy, the thriving, the energy to really do one more thing.

At its core, being burnt out is the impaired ability to experience positive emotion. Think about it. When you're burnt out, you're focused on everything that's going wrong—again, that negative state. And the flip side of that is at its core, outstanding culture, that other side of the George Eckes equation, is the cultivation of positive emotion.

How do we actually have tiny episodes throughout the day where our health care providers can tap into positive emotion so that it's like a little engine that drives them and it undoes all the hassles that come about. That's the culture trick, to really make this tick.

Okay. What emotions are we talking about? You can see them there, joy, hope, gratitude, inspiration, awe, amusement, pride, serenity, and love. And when you tap into them, it actually produces that tiny engine effect and the undoing effect.

To be able to know if we're getting there. We created a new metric system to really look at, are we thriving? Are we able to emotionally recover? So not only can we talk about it, but we can measure it and more importantly, we can actually map solutions to help staff get to thriving, help staff get to recovery, intentionally design solutions to drive that. So for instance, if your team is having more problems recovering, bouncing back from all the challenges, solutions that can tap into small doses frequently of the sensation of pride or serenity, have the most impact.

If they're more troubled with thriving, based on the metrics, solutions that are more centered on awe, interest, amusement, love are more likely to really drive their thriving.

Things that we're really good at in medicine, embarrassing people, feeling ashamed, angry, guilty for what they're doing. They are absolutely detrimental to really creating the culture that we need to get the results that we want.

So how are we going to do that? It feels like the jungle and we need a machete. What's the path forward? And that is the essence of our work. And on this slide you can see there's four things that are really necessary to really drive this culture.

The first is systems work. Yes, we have awkward systems. We have to work on that. Those are the most time consuming and sort of very long pieces of work that we have to have patience with—they're not going to change overnight.

So I've heard organizations say, well, our systems are really broken. Our systems are broken in every hospital, all right? But are we going to wait for 10 years before we begin the work on the other pieces? We can't. We can't. All right. That argument is valid, but in and of itself should not be stopping us.

Secondly, is human centered leadership. So what can leaders do to cultivate a culture that taps into positive emotions in small doses, not big celebrations, like once every three months we're going to have a celebration of three people. But no, no, no. Every day. There are things that leaders can do to actually tap into those positive emotions. I

don't know about any of you who've been through leadership. That was not my leadership training.

My leadership training was how do you hire, how do you do profit and loss dot, dot, dot. It had absolutely nothing to do with how I was going to lead to tap into positive emotions.

Third is, our staff needs to have the tools to be able to connect with patients, with each other, across the whole team, and by the way, the patient is at the center of the team. They're a team member.

And last, there are things that can be done individually for individual well-being. Mindfulness. I'm sure many of you have heard that's been in the literature quite a bit. It does help. It does absolutely help, in and of itself, it's not sufficient but it can be part of the solution.

The national task force actually launched a pilot program within the last year tackling each of those elements to see if we could drive a culture that promoted joy, meaning in work, but also a culture that actually augmented improvement. Improvement in patient experience, employee experience, physician engagement, safety, outcomes, the whole gamut, the whole value based care gamut, and it really looked at five steps in the process.

First of all, we wanted to measure just what I shared, with the measurement of thriving and recovery, and map our solutions to what we actually saw happening in that organization.

Secondly, a focus on the leaders to help them develop the skills and tools necessary to lead to create a human centered environment. They're dealing with the profession that is human to human interaction in the most vulnerable time of their patients' lives. How can we not create a culture that is human centric? But yet we've not paid any attention to that, over all of my career.

Third, what are the skills that are necessary at the individual team level, nurse, physician, caregiver, to truly tap into relationships? When you ask people what is the thing that really drives your meaning and passion in life, and what is the thing that gives you fulfillment in the practice of medicine?—it is the human to human connection and the relationship. So what are those skills to drive that culture.

The next step is experience mapping where we do tackle the system work. But we do that in a special way, which I'll share with you in a second.

And then the last is this design, it came up in Nick's presentation this morning, but how do you take it all and weave it into the daily work so it's hardwired, so it isn't just something that they heard and thought it was good, but they actually are able to do it going forward and creating that culture change.

So a little bit about the human centered leadership and the skills necessary for the caregivers. This is the part that I think we jump over, the big question mark in the beginning. What are we missing, okay. So this program actually enables the caregivers to deliver on the promise that we have actually made to our patients. Promises of something like this: getting each patient to his or her desired outcome, without harm, with a great experience and without waste.

Most every health system has something like that in their mission statement. But we haven't really given the tools to our providers, our employees, to actually keep that promise. We're really good at plastering this up in boardrooms and saying, this is what we want. Go do it. We're really good at saying this is what an optimal experience is. Go do it.

But there are skills that are necessary to actually drive it. When we listen to our patients—and this goes into patient centered design—unfortunately, I'd like to tell you this has been a moving target over the last 20 years, and patients are going to be telling us, the millennials tell us something different than Gen X telling us different than baby boomers.

That's not the case. This is one steady fact for every single generation. When you ask them what they want, this is what they want. Being treated with dignity and respect, being listened to, easy to talk to, taking your concern seriously, willing to spend enough time with you and truly cares about you and your health.

Now, this is where the conversation stops from most patient experience leaders, CEOs. They get this message and say, this is what you need to do. And we take for granted that the team has the skills to be able to do it. The reality is, they don't, and it all goes down to communication.

Sentinel events almost always related. These are things that should never, ever, ever happen. Surgery on the wrong patient, on the wrong body part, things that you or I would not for a second, disagree on. And yet communication is behind all of it. Teamwork, trust, behind all of it. And by the way, the other fact is their leadership. It's all about communication. It's all about connecting. It's all about trust. It's all about relationships. If we think we have any chance of asking people to do something more, we have to start here and make certain people can execute what they need to do.

The program design is like this. We focus on six skills, six levers that actually connect to positive emotions. When you do this, positive emotions for the provider, positive emotions for the patient, positive emotions for physician talking to physician, physician talking to nurse, vice versa, nurse-nurse.

And they're mindfulness, presence, reflective listening, information gathering. This is interesting. That sounds trivial, but we are trained as physicians, nurses and medical team to ask a question: what's the matter? This is the flip, to ask the question, what matters to you? Because if we simply flip those words around and have the skills to ask the question. In that way, we will begin to uncover social determinants of health. We will begin to walk into the space, but until our team is ready and able and has the skills to do that, you can give advocates and whole lists of social determinants of health, AI, whatever you want, and the team is not ready to deliver that right now, from where they're coming.

How do you negotiate an agenda? Again, I talked about this. Is it our agenda? Whose agenda is it? I mean, it's the patient's agenda. I mean, we're there to give them our expertise and knowledge, but it is the patient's agenda and if they aren't bought into the agenda, there's no chance that it's going to happen.

That's why we have no-shows. That's why we have noncompliance with X, Y, and Z. There are other reasons. There's travel. I get that. All important stuff, from the morning topics. But a big part of it comes right here. When I watch clinicians, nurses, physicians try to do a joint agenda, it's 98% clinician, 2% patient. There is no way you're going to get to community health with that type of a joint agenda setting. And the team simply does not have the skills to do it with the way they've been trained up to this point. How do we connect with patients and team—we sometimes go right to the science, we're really good, that's where we're comfortable, but we skip over the emotion. So how do we recognize the emotion and then respond with the science. So people come into that conversation a bit different.

And lastly, we are really, really not too efficient, let me put it that way, in kind words, of showing appreciation for each other. We do appreciate—when you talk to people, they do appreciate their team, but do we show it? Do we actually express it in authentic ways that really help people move forward in those positive emotion space, to change the culture of one of team trust? And when that happens, we can actually begin to move the bar forward.

This is the type of stuff that happens with the skills, we get enhanced emotional intelligence, better teamwork. We've measured all of these things. Decreased depressive symptoms, reconnecting to purpose for the provider. We also get

connecting with patients and our entire team and we get more to a patient centered care model.

Just an aside, when we ask clinicians, do you deliver patient centered care? 90% of them say, yes, we do. When you ask patients, are you receiving patient centered care? Only 5% say they do. It is a huge, huge disconnect. These skills actually help the team take the blinders off to say, how are we going to get there?

Because if we're going to have any chance of community health, we're going to have to be patient-centered.

We've shown improved outcomes, improved efficiency, improved resiliency, and by the way, we can actually increase the empathy capacity of the caregivers when they are delivering care.

How many of you would like to go to receive health care and have a clinician not be able to be empathetic to your situation? It's not the way that we can actually get any positive emotion from that, on either side of the equation. When we tackle these, we actually close the gaps of what patients tell us what they want.

And by the way, when we ask our physicians, nurses, and support team members, what do they want? It's almost always teamwork, teamwork, teamwork. It's almost always communication. It's almost always leadership at the top. These skills actually close the gap, what is most important to humanize and care from both the patient's perspective as well as the health care team.

So a little bit about the results from this relationship piece work. And then I'll share a couple of other comments about the other steps of that five step process. This came from Duke University. It's a busy slide. I'll explain it to you. The black lines there, at Duke, they were asked, did your leader ask you about what was going well, on their leadership rounds?

If 38% of the people on the unit said, yes, you're in the black bar, that's pretty low. Okay. 38% had to say yes, they asked about that. You were in the top group. And all the way down to 23%, 13%, and then 0% on the last bar graph. But just simply asking that question, again, this is where the human centered leadership comes in. Simply changing the way we ask that question rather than, what went wrong, how are we going to prevent killing the next patient on this unit today? Simply asking what went well, look at what happened in terms of all of the factors in terms of the burnout climate, the leadership climate, the engagement climate, the job uncertainty.

Everything went in the right direction across Duke University when—simply—leaders were asked to focus on that as their main topic.

HCAHPS scores. I don't know how many of you are struggling with moving those HCAHPS scores? Anybody, want to raise your hand? Yeah, I see one hand. I think you're the only honest person.

So it's hard. It's really hard to move HCAHPS as a patient experience. This organization had done every evidence based care thing to the left of the graph for several years, and it was seesawing up and down, couldn't move it. They began this work of truly engaging all of their providers with the six skills that I shared with you in the center of that diagram.

And you can see what happened with communication with nurses, doctors, and the overall satisfaction of the organization. When you look at grievances and complaints, which to me is a surrogate for culture, why do people actually submit a grievance or a complaint—they're just really unhappy with the care and the environment that they received.

60% decrease in every institution that we've measured grievances after we've launched this work. That is a surrogate for a culture change. That is people are experiencing teamwork. They're experiencing trust. They don't feel they need to complain. By the way, this hospital is about a 300 bed hospital.

They calculated how much this actually saved them in terms of resolving—they calculated the typical cost for resolving one grievance. Needless to say, the negative press that happens when a grievance happens, $1.6 million on this alone.

Culture of safety. This is the HRQ culture of safety. There's only a few surveys out there that truly measure culture. Not many. You get hints of it with surrogate things. This organization began in the HRQ culture safety survey, almost in the lowest 10th percent in every single domain, 13 domains.

A year into the work they were into the 50th to 75th percentile. Their journey's not done, but they were well on their way to a different organization. A different culture, a culture of psychological safety, a culture where patients really mattered. And all of their outcome metrics were driven the same.

Engagement, keeping hearing this issue. How do we get the physicians engaged? How do we get the team engaged? How do we get them engaged in community work? Start with the skills. This is engagement from a Maryland hospital. They were making some improvements before we launched the work there. You can see what happened

to open communication at all levels of the organization. That's a surrogate for trust. A significant jump and sustained, by the way, after we launched the work.

Empathy. I mentioned that we can't actually drive empathy of our caregivers. This was at Beaumont Troy in Michigan. When we began the work, they were in the light green bar. They were about average. And I was glad to see that because they had done nothing to be anything different than average before we did this work. Three months into it they were at the 75th percentile and a year later, stable to perhaps even slight improvement in terms of their ability to show up with empathy, care, concern.

I'd rather get care at Beaumont Troy now than a few years ago.

And last, these questions about resiliency, emotional exhaustion. This is a VA hospital. And when we started, they were right about average as well. 50% of their team was emotionally exhausted or burnt out. Six to nine months after we launched the work their staff surveyed 71% now not feeling emotional exhaustion. Burnout dropped, in other words, from 50 to 29%.

Again, a staff that's ready to take on the next piece of work, be it community health, or be it the next initiative in a totally different place than when we began.

Emotional recovery, the ability to bounce back and some improvement here, they started in a pretty good space. It's really interesting when you look at institutions, some of them have a lot of challenges on recovery and less on thriving and some, the vice versa. So they are measuring two different things. All right?

And then thriving. I love coming to my job. I feel purpose in my job. I look forward to coming back to my work every day. It started at 50% and at nine months we were at 79% showing up in a totally different way. A totally different frame of mind than before we began this work. That's the cultural changes that can happen, which can actually drive everything else forward.

How does this affect outcome? Some of you may wonder, gee, that's nice. They may feel better about it, but I'll just share with you one story, from Mission Health, when I actually spent a few years there. When I came, they said we were 99.5% compliant with the ventilator associated pneumonia bundle. That was a few years back. It's changed now in recent years. But what that is, is a bundle that was meant to prevent any pneumonias when patients were requiring ventilatory support.

And the funny thing to me was, is that organizations that had really said they were compliant with that bundle, they had zero infections for five, six, seven years. And Mission was having about 12 infections a year. I said, something is not right. So we

looked at it and one of the steps in the bundle was, to give the patient, was a vacation from their sedative medicines so that they would have a chance to wake up and get off the ventilator.

So, found out that they really weren't doing that. They said they were doing it, but they really weren't doing that. And so when we launched the program to actually give patients their vacation from their sedation, you can see that they spent one less day, ventilator day, on average per patient after we launched the work than before.

How many in this room want to stay on a ventilator for one extra day? Yeah, one less day in the ICU. Tremendous things happen in the ICU. Complications, infections, and all sorts of things. And do you want to be in the ICU one day longer than you need to be? And when they looked at the number of propofol bottles used—that's Michael Jackson's drug—that's the drug that we use to actually sedate patients. We went from 500 bottles a month to less than a hundred in 6 units across Mission. Because they weren't needing to use the drug.

So what's the story behind this? How does it connect to these skills? The story is, two weeks after we launched this evidence based care, with technology, by the way, to help them actually execute the care, the nurses came to me and said, Dr. Maples, we don't want to do this. And I said, brutally honestly, tell me why? Tell me what's going on? And they were just about on the verge of getting the doctors to actually tip the whole thing. And we never would have seen these results.

And what they said is that the reason we don't want to do this is it's so much easier for us to take care of the patients when they're sleeping, and we don't have to talk to them. We don't want to do it. And if it was stopped there, we never would have seen the results I just shared with you. We invested in some skills to actually help them have the conversations and put the patient at the center of the care, not somebody that's resisting the care.

And the units are very different today. You go into any unit in that hospital and people are on ventilators awake, up, sitting, walking dot, dot, dot, and they are out of the unit much, much quicker. If we never would have invested in the time to really help the caregivers have the appropriate conversations, none of this would have ever happened.

That's how this tips over into central line infections, catheter associated urinary tract infections, you name it. It's all related to team. Remember those first slides I showed you about team culture and driving results? This is how it happens.

And risk adjusted mortality. The red line there is not 50%. It's set intentionally, if you cross the red line, you're in the top one-six—16—percent, in the nation. It's not so much that they actually had one of the best mortality rates in the nation, but it's what's on the bottom. In 2013, when I ran this data compared to 2009, apples to apples, more than 500 patients left the hospital, that would have never left the hospital three or four years earlier, all on the basis of culture associated with some other process improvement initiatives. But that's what's at risk.

Okay, let's look at experience mapping, another part of that five step process. This whole thing is to amplify the joys. By the way, amplifying joys connects to positive emotion and minimizing the hassles, which by the way, gets rid of those things on that right side of that graph, the embarrassment, the guilt dot, dot dot. The anger. Dot dot dot. So that's how this looks.

So many of you probably have done some lean work, where you really take the waste out of the system, because we want to make the system really the best, all right? The way we do that work is nice, but we're oftentimes, even though there's a step in the traditional lean process to get the customer's voice, we skip over it, we do it, it's interesting, and then all of a sudden we're into just, what dollars can we save? Every place you see a heart here is what we call an experience map. So we take the perspectives of the patients, of the physicians, of the nurses, of the support staff and say, walking through this process, what do you want to see every time, happen here, an always event?

By the way, if it's important to them that it's an always event, when an always event happens, what happens? It taps into positive emotions. It taps into the culture that you're trying to drive. So not only are you minimizing the hassle but you are intentionally putting in things that will actually connect the team to positive emotions, which will make it much easier to walk through this process and any other process that you choose. So we actually spend some time on the systems piece, again, to amplify joys and minimize hassles.

And lastly, we put in a design session where we look at some key processes within whatever area of the health system we're working with. And then we weave in everything from human centered leadership as well as the relations for health care transformation, the relational work, the connecting patients to caregivers, to caregivers to caregivers.

And we weave that into every possible step of that process. It doesn't take longer. It actually takes shorter, and what's happening is the team is connecting to positive

emotions multiple times throughout the day. Small doses, frequently, engines are revved up and they're ready to go and they're ready to take on the next piece of work.

You can do the same thing in 20 minutes and have a much, much better end result than we're spending in the 20 minutes now. And you're evolving the culture of the organization so that you can move forward.

This is what happened at University of Colorado. Look, just in the whole design session, I feel burned out at my work. 44% to 33% I've become more callous, dropped from 24% to 15%, our culture makes it easy to learn from mistakes all the way up to 59% and I love this: the people I work with care about me as a person. One of the key drivers of whole caregiver burnout. Went from 78% to 91%, a very, very different place to work now than before they began the work.

So this is a reflection from some health care caregivers in Indiana Health System after they actually went through the five step process, bringing humanity back into health care, making all of the team members see their value and tapping into that value to get the best performance.

Talking about value based care. This is it from all team members. Increase patient outcomes. That is value based care, increase caregiver joy. Decrease burnout, building mutual respect.

Okay, so I'm going to close with the journey to excellence. We all want to get here.

Again, the first two talks centered on population health this morning. There's more to it than just that. We cannot keep filling that middle bucket full of stuff unless we actually do the relational work at the beginning and make certain our caregivers have the right skills to execute all that good stuff in the middle.

There's lots of good stuff in the middle. A lot of it has been tossed to the wayside. Not because it's the wrong stuff, not because it's the wrong technology. It's simply our team was not ready to execute that work. And we have to start there before we launch into the next step. That's cultural transformation.

So I'll close with that. Thank you very much.

Mike Seyfer: Well, I've got one question to kick it off and having sat through—I shouldn't say that —having participated in, and I mean that, because it wasn't sitting through—having participated in an early stage of your training workshop. One of the things I was impressed about was sort of seeing how this work comes to life.

You had some good video examples. So maybe describe, if we walked into our physician's room today, what would be the difference that we would see as a patient between, in the before and after?

Dr. Maples: Yeah, it's a great question. And a lot of it can be subtle. I think you would see a—and it's palpable when, when actually people do, when they describe the culture, and it's hard for them to put in words just as, it's hard for me to put it into words for you—but I think you would see a conversation that was more rooted with respect.

You definitely see more listening rather than reacting. You would see fewer comments about what's wrong with the patients than really what can we do to actually help drive this forward? So a little bit of a different accountability. And you would see a pretty consistent expression of gratitude.

And, I think that would be, you know, my sort of summary of that. I don't know—Jennifer, do you have any other thoughts that you've walked into the organization?

Mike Seyfer: So just welcoming Jennifer Kripner, one of the Institute for Healthcare Excellence colleagues and leads a lot of the training for that organization.

Jennifer Kripner: Yeah. Thank you. Good to be here. And I think I would just add to that as well. A true connection of caring and an empathy with a bond of a relationship, that really would build that loyalty and connection to that patient. Really wanting to come back and continue that relationship.

Mike Seyfer: Thank you. Questions from the audience?

Audience member: So you're doing the good work of, retroactively, bringing this back into organizations. Are you in talks with any universities about bringing the curriculum into medical school or nursing school?

Dr. Maples: Yeah, it's a great question. And so, the answer is yes.

We've actually done that, but I have just one caveat for that. So any place that we work, we've worked with universities. We do absolutely include the medical students and the residents. I want to just rewind the clock a little bit. Johns Hopkins actually tried to begin this work thinking that, my goodness, if we just train the residents and the fellows, eventually all of us old people will be gone and we'll have the culture problem solved.

The problem with that is, it's not that easy. And what happens is that within one year after training—the empathy capacity for caregivers when they leave their training is probably at the highest level—it drops to rock bottom within one year, and it stays there unfortunately for 25 years. The majority of the clinician's career. Before it comes up, because we've, at that point, we've had some encounter with the health care system ourself and realized that it shouldn't be this way. So to your question. We can't just focus on residents and fellows. They enter into a culture that absolutely extinguishes everything that you're trying to do.

So that's one of the things that we came across in the beginning. It's easy to focus on them because they're a captive audience. You can say you need to do this dot, dot, dot. Organizations where they engage every single caregiver is where this work is the most successful because it is a culture change and you cannot change the culture when you have 80% of the people not engaged in the work, particularly those that are mentoring these other people.

So just a word of caution that you cannot just focus on that group, but that group does need to be included.

Audience member: I just had a thought that the culture of a health care organization just doesn't stay within those walls. It permeates out into the community because of stuff, negative culture. You hear about it. From all the people who work there, and then you get this perception in the community that that place, Oh, they're cold. They're not a place that's going to take care of you, but this place might, and that, you know, relates to dollars and cents. Who's going to shop there? So I just had that thought that it really doesn't stay right there.

Dr. Maples: It's a beautiful thought. And you're absolutely correct. So, you know, the patient experience metrics actually do flow out into the community, and it actually does create from the CFO's, you know, point of view, the sense of loyalty, the people coming back to the institution.

And by the way, this work should be tied into community health. This should actually permeate community health if we get this piece right. My premise is unless we get this right, we are not going to see the culture changes that were referred to in the first two lectures this morning.

Audience member: So, working with kids, it sort of seems to me that in general, I mean, being a kid these days is so different from when, even I was a kid, and I feel like the general resilience and joy, and there's so much more depression just in general

with our younger populations who will then eventually become adults and then may choose to be in this field.

Are you seeing that as far as, like, the baseline mental health resilience of anybody coming in, regardless of whether they're in health care, needs to be addressed and that being a difficult component.

Dr. Maples: A great question. And, you know, I think the best way that I can approach that is if you look at the burnout of health care providers and the health care profession, it's actually going up.

Slowly going up, maybe starting to level off a little bit now. If you look at the burnout for the population in general, it's actually going down. Slowly going down. It doesn't mean that we don't have an opportunity to focus on what you're talking about, but as a population, we are not seeing the whole country going up on the emotional exhaustion piece. It's actually going the opposite way. So I think we need to work on both of it. But I can't explain the whole problem with just the fact that everybody's getting worse. Because that's not the case.

Audience member: You talked about, you know, the limited potential of teaching things in medical school. It just kind of leads me to that human centered leadership as kind of being the core of all of this. It can't happen without that. And then I think about the high empathy level necessary for human centered leadership and are the right people in the seats for that to happen?

Dr. Maples: So your question is, are the right people in the seats for that to happen?

Audience member: I am, because I've seen changes in leadership qualities. For example, what's most valued?

Dr. Maples: I'll be brutally honest with you. Our health care leaders are not prepared to lead a profession that is human to human connected. I see very few, actually, health care leaders that really understand this, they understand that they have no idea what to do about it, and so they shy away from it.

So I would say very few C-suites are actually populated with leaders that understand this to the point where they're going to make a difference. Those that do get it and choose to embark in the work have significant, significant success in moving the culture of their organization.

While we're waiting for the next, Mike, which is, by the way, something that I started the talk off saying that I really wanted people to take action and not just listen to inspiring talks.

So this is the challenge I have for each of you. Bring your leaders here the next time you come to Believe in Better. Bring the people that are part of the conversation so that we truly have an another set of key stakeholders to move this work forward. Otherwise, it's just an inspiring conversation.

Audience member: This is a really fascinating topic and something that occurred to me pretty early on. We use Press Ganey as our, both patient satisfaction vendor and also our employee satisfaction vendor. And for the last two survey periods for employees, we have exceeded, Press Ganey's expectations, and we're getting accolades and national acknowledgment, but our patient satisfaction scores aren't growing at the same rate.

And it's a really interesting conversation that we have. And I think it hits exactly what you're speaking about. We talk a lot about our employees just really are happy in their little box with the way things are going, and so they're satisfied.

But that isn’t translating to the patient's point of view.

Dr. Maples: Yeah. I think there's a lot of dimensions behind that. I've seen that actually at multiple organizations where there's a disparity in terms of employee engagement and the patient satisfaction. And I think one thought I would really put out there is, you know, what are we really measuring in the employee satisfaction space? Are we really measuring the things that are connecting people to their purpose of their career. Are we really measuring things that measure thriving and resilience? Or are we measuring other things that are tangential to that, that maybe don't have the meaning?

So I think there are real pitfalls in that whole employee engagement piece of things. I just spent time with an organization in Washington, D.C. with that exact dichotomy. And so when you really look at it, there are gaps. When you look at the thriving and the resilience, there are gaps there, even with the employee engagement, the way that it measures.

So, I just share that thought with you. The other thing I would just like to say is be careful about, be careful about any metric system, any metrics that you use in that whole engagement and experience piece or really for that matter, any of the metrics.

It brings back a statement that Dr. Michael Leonard shared with me, he said, Bill, he said, you know it's true your organization is really performing at the top levels. But just remember, that's the cream of the crap.

Mike Seyfer: Another great quote. I've got time for one more question. I think, Nick, you had one and then we've got lunch coming up.

Nick Dawson: Bill, thanks a lot for this. This has been illuminating and has made me reflect on some conversations that I've been a part of as an executive in my role before. I'm tugging on a couple of the threads that others have brought up. And I'm thinking about that idea of how our organizations might reflect back in our community.

And if I thought for a minute that most of US Air or American Airlines pilots and safety people were in a state of burnout, I wouldn't fly. But if you go on nurse Twitter, that is a job that is chewing people up and eating them. I think it's true for physicians as well.

The question I'm leading to, is there a systemic cause? Is there something, is it in how we're training the industry? We've talked about C-suite leadership. Is there some big root cause of this that we really need to examine and say there's something way upstream that's fundamentally broken?

Dr. Maples: Yeah, it's a great question, Nick. And I think being part of the national task force, we had a chance to listen to lots of physicians, lots of nurses, lots of health care administrators in terms of really, you know, what is broken? And the single most—answering to a root cause—the single most important thing that is broken is the break of relationships between all members of the team. It comes back to that over and over and over again.

Now, what has caused that? I think a lot of the systems that we've designed has caused that. I think a lot of the technology that we've said, this is going to help you, actually has done the opposite.

I think the way that we reimburse physicians for time and nurses for time has been a cause of that. So we can talk about all of that and we should probably be working in the background at revising all of that. But you can see going from fee for service to value based care, it's a long journey.

There are tons of things that we can do in that middle piece to repair and rebuild the relationships. Or if we just keep throwing stuff in that middle box, we are going to absolutely burn our teams out more. So I would say the root causes, a break in the relationships, coming from a lot of different factors, but almost everything that we've

done in the last 20 years has actually moved the relationship between patient-caregiver team, and caregiver team to caregiver team, apart.

Mike Seyfer: Thank you very much, Dr. Maples.