

2016 AΩA Fellows in Leadership complete successful year and are prepared to serve



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Leadership in medicine, medical education, and health care is more complex in the 21st century than ever before. Escalating costs, unequal access, less than ideal outcomes, and political challenges have contributed to an unprecedented level of uncertainty in the delivery of health care and medical education.

The medical profession and the country are in need of leadership that is inspiring, insightful, engaging, and humble; leadership that understands and represents the needs of patients, physicians, medical educators, and trainees. Because of their unique knowledge of the practice of medicine, and understanding of medicine's core professional values, physicians are ideally prepared to serve as leaders.

Encouraging the development of leaders in academia and the community has been, and continues to be, a core AΩA value, and an important part of AΩA's mission.

The AΩA Fellow in Leadership Award recognizes and supports the further development of outstanding physician leaders through the tenets of leading from within; upholding AΩA's values and mission; and a commitment to servant leadership.

The five essential components of the AΩA Fellow in Leadership Award are:

1. Self-examination, the "inward journey," leading from within;
2. A structured curriculum focused on leadership, including an understanding of the relationship between leadership and management;
3. Mentors and mentoring;
4. Experiential learning to broaden the perspective and understanding of leadership as it relates to medicine and health care; and,
5. Team-based learning, and developing communities of practice.

Nominations for the AΩA Fellow in Leadership Award are made by the senior executive of a medical school, hospital, or health care organization, who agrees to serve as a mentor for the Fellow. The nominating organization and Fellow designate at least one additional mentor who, with the executive leadership mentor, support the completion of a leadership project serve as role models, offer advice as needed, and connect the Fellow with key individuals in leadership positions. At least one mentor is at the senior leadership level, i.e., a Dean, Chief Executive Officer, or the President of an association or organization that has a

regional or national presence.

These relationships, and leadership opportunities and experiences, are ongoing throughout, and after, the fellowship year.

The Fellows each receive a \$25,000 award for further leadership development and project funding.

Although AΩA purposefully developed its Leadership program for a small, group, it is based on the concept that when you train one leader, you train one individual—that is addition. However, when you train leadership trainers, you train future trainers of leadership—that is multiplication, and has an exponential effect.

The second cohort of AΩA Fellows in Leadership—Cynthia Arndell, MD (AΩA, University of New Mexico, 1994); Ronald R. Robinson, MD (AΩA, University of Texas McGovern Medical School, 1993); and Elizabeth Warner, MD (AΩA, Michigan State University College of Human Medicine, 1998)—were selected for their diverse backgrounds, career performance and success, leadership experience, mentor support, and proposed leadership project.

The Fellows have successfully completed their year of leadership development and join the growing AΩA Fellows in Leadership community of practice. They presented the findings, outcomes, and lessons learned from their projects to the AΩA Board of Directors during the October 1 annual meeting.

Cynthia Arndell, MD—Key Challenges in Interprofessional Education and Collaborative Practice Integration: Making the Case for Collaborative Leadership Development

Research supports the essential role of interprofessional collaborative practice in improving patient and population health outcomes, cost efficiency, and provider satisfaction.¹⁻³ However, the socio-historical, economic, and political forces inherent in academic and health care systems continue to thwart efforts toward successful integration of interprofessional education and team-based practice. Collaborative leadership requires extensive knowledge and skills to not only train educators and clinical providers in interprofessional teamwork, but to also develop strategies for effecting culture change. Without first, and foremost, laying a foundation, institutions will continue to struggle to successfully implement interprofessional education and collaborative practice models.⁴⁻⁶

The University of New Mexico Health Sciences Center (UNMHSC), recognizes the value of interprofessional education and prioritized curricular implementation across health professions and student disciplines. However, like

other academic health centers, UNMHSC struggles with the challenges and frustrations in actualizing curricular integration.

In 2012, UNMHSC leadership selected a faculty member representative from each major health profession to create the Interprofessional Education (IPE) leadership team. Because of my background as a nurse and physician, and my experience in interprofessional education and collaborative practice, I was selected as the University of New Mexico School of Medicine (UNMSOM) representative.

Initially, the IPE team functioned well. It had all the right ingredients for success—institutional leadership support to move forward on developing and implementing a required longitudinal curriculum for students across disciplines; an annual budget of \$6,000; and four hours to eight hours per week allotted to each team member for IPE work.

We believed IPE was the answer to every flaw in our health care system, and having attended multiple training sessions, we considered ourselves the experts who could recite the national IPE competencies as though they were an oath.

However, once the planning phase of curriculum development was fully under way, and the pressure was on, many things began to fall apart.

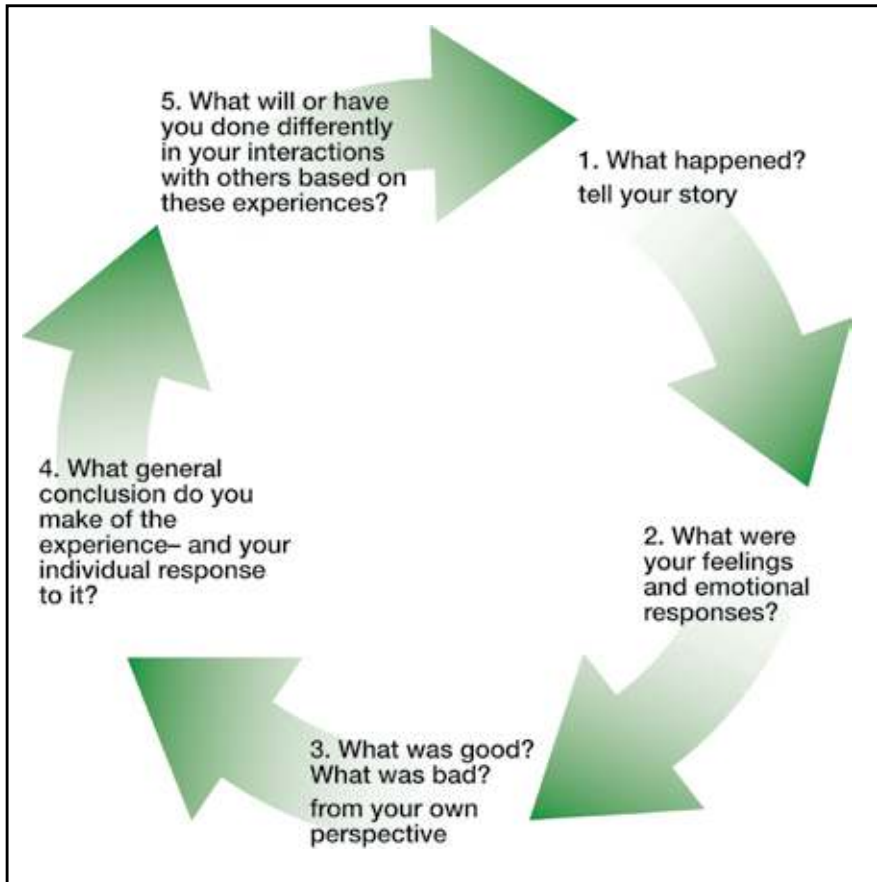
A rocky start

As educators, we know that reflection is a critical component of adult learning, and is core to professional and personal leadership growth. I use the Experiential Learning Cycle⁷ as a reflection tool for describing experiences in collaborative leadership development.

I was 10 minutes late when I entered the room to join the IPE meeting, and said, “Sorry, patient issues...” As usual, the representative from the College of Pharmacy, was taking the lead in facilitating discussion plans for the upcoming community-engaged interprofessional student curriculum. No one acknowledged my presence, and the group conversation addressing the format of the first session continued.

The faculty representative from physical therapy, said, “I really worry about the medical and physician assistant (PA) students presenting their findings from their community experience last summer at the first IPE student session. I think the other student and faculty cohorts will view this as an unfair advantage for the medical and PA students having already been in the assigned communities.” Other group members gave affirming nods.

The College of Nursing faculty member added, “I completely agree, and have heard other faculty in our college



Reflection, Eyler, et al, 1996

express similar concerns.”

I could feel my blood begin to boil, and emphatically stated, “Guys, we agreed that since the medical students and PAs have already been in the assigned communities, and completed community health assessments last summer, they should share their findings with the new student cohorts at the first session. This will inform other student cohorts that haven’t been in the communities so they can move ahead in addressing community-identified health priorities. Otherwise, it would completely minimize medical and PA student work, and create duplication of student group efforts.”

Dead silence. I watched team members exchange glances with each other. The College of Pharmacy representative said, “Cindy, we have to be sensitive to the fact that other student and faculty cohorts will view these community

presentations as, once again, the doctors being in full control!”

Like so many of our task force meetings, I left feeling angry, frustrated, hurt, and excluded from the team. I felt that the team had become dysfunctional—unfairly dismissing any of my input and suggestions. I was extremely anxious that curriculum implementation was only two months away, and involved more than 368 students and 54 faculty across disciplines. From my perspective, the team was still very early in the planning phase of the course.

I decided to share my concerns with our IPE team director who responded, “Can I be perfectly honest with you? Several team members have come to me complaining about the way you come into the meetings, often late, and wanting to change plans to accommodate the medical students.”

Feeling even more hurt and excluded, my initial thought was to just quit the team.

Although the individual colleges and schools had worked out schedules to ensure students would be free to participate

in each session together, there was great disparity among IPE team members as to the primary focus of course content and goals. It seemed to me that task force members were uncertain about their specific roles and assignments, planning efforts, and timelines. There was unequal participation among team members, and no truly identified leader—some members dominating the meetings, while others never had a voice. This resulted in incongruous and inefficient course development efforts, and imbalanced work assignments.

I felt as though I was doing more than my share of the work, and resented the lack of acknowledgment for my contributions.

Looking back, I realize how my perceptions, and resultant behaviors, negatively influenced task force planning efforts, and contributed to contention among team members.

Embarking on the inward journey

Fortuitously, during this time, I was selected for the AΩA Fellow in Leadership Award. My goals for the Fellowship were:

1. Identify the socio-cultural challenges that preempt effective integration of interprofessional student education and collaborative practice;
2. Explore leadership models to enhance our IPE initiatives; and
3. Strengthen my leadership skills in interprofessional collaboration.

A major component of the leadership training program focused on the importance of self-awareness as core to being an effective leader, i.e., the inward journey of deep self-reflection.

The process of taking a hard look at myself, and how my personality, communication style, and behavior could negatively impact team dynamics and reinforce the physician in control stereotype was the most difficult, yet the most crucial, first step in my personal and professional growth.

One of the earliest turning points in my journey of self-reflection, was a session I attended, by Dr. Neil Baker at a National Institute for Health Improvement conference. During “Personal Mastery for Transformational Leadership” session, Dr. Baker described his own failure in working with an interdisciplinary team by pushing his ideas onto team members and then not understanding why no one seemed to embrace them.⁸ He discussed how the autonomous way we are taught as physicians can impair our ability to effectively collaborate with other disciplines. Referencing the book *Primal Leadership*, he pointed out the real, and perceived, power differentials that exist among physicians and other health care professionals which can further reinforce siloed health care educational and delivery systems:

The slightest voice inflection, the most innocent remark can land hard on those you have authority over, causing them to make up stories that support increased caution and distort further interaction.

Goleman, et al, *Primal Leadership*, 2013⁹

I felt as though Dr. Baker was speaking directly to me.

I reflected on the times I had pushed my own ideas onto the IPE team, and how I had been met with resistance, and sometimes, open confrontation. I also reflected on the multiple situations in which I openly expressed my frustration to nurses, medical assistants, and receptionists about the way the clinic was running. Although my comments and behavior were not meant to be personal, other’s reactions seemed that of cowering and avoidance.

Growing as a leader

The AΩA Fellow in Leadership afforded me the opportunity to participate in multiple training sessions on collaborative communication and facilitating effective team dynamics.

Learning the theories foundational to collaborative leadership—authentic and servant leadership which delineate core intrapersonal leadership qualities; and followership, and shared and inclusive leadership, which describe interpersonal skills essential for collaborative leadership—helped me to understand how our education as physicians is, in many ways, antithetical to best practice models, including accepting uncertainty, showing vulnerability, admitting mistakes, and sharing decision-making.⁹⁻¹¹

A deep appreciation for my professional identity formation, along with the one-on-one coaching and mentoring from Dr. Dawn Foreman and Dr. Alan Robinson (AΩA, University of Pittsburgh, 1988, Faculty), has enabled me to recognize and undo unproductive behaviors, thereby mobilizing my strengths.

I went back to the IPE team to share my “ah ha” moment, and apologized for reinforcing the stereotypical physician in control. I asked how the team members felt I could best contribute to the upcoming course planning and implementation.

Success! The team members were incredibly supportive, acknowledging how hard it was for me to apologize, and how hard I had worked on the course development. As a result, we moved forward as a team to implement faculty orientation sessions, and the interprofessional student course.

Not surprisingly, the IPE student course sessions reflected the challenges the team had in curriculum development and planning, with many faculty and student participants across disciplines expressing confusion and discontent about expectations. However, instead of feeling as though we had failed, we stood together as a team, sharing accountability for what worked, and what didn’t work.

We reviewed student evaluations, and held multiple faculty participant sessions to receive feedback and take action on revising future IPE course sessions.

I came to understand that our team was an IPE microcosm. We experienced the same types of challenges learning to work together as interprofessional students and health care professionals experience working in teams.

I realized that our team was exceptional in many ways—we were courageous and willing to step out of our comfort zone to take on this immense task.

Moving forward

Since my AQA Fellowship, I accepted a new job as Medical Director for Case Management at the University of New Mexico Hospital. This position has afforded me the opportunity to apply the skills I acquired in interprofessional academia and the AQA Fellow in Leadership program to advance collaborative practice initiatives.

I entered this new role with a new perspective, skill set, and communication style. I took the time to build relationships with the nurses and social work case managers, and understand what they do and the value they bring to patient-centered care. This has allowed me to advocate for and facilitate face-to-face communication between the case managers and inpatient providers to ensure safe, appropriate patient discharge transitions.

Through my journey in leadership development over this past year, I now understand what it takes to acquire and maintain leadership skills—coaching, mentoring, practice, feedback, and continual self-reflection.

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Ronald Robinson, MD, MPH, MBA—Physician Leadership in the Community Hospital Setting

I'd like to give my thanks to the AQA Board of Directors, the Fellowship faculty, my mentor Dr. Page Morahan (AQA, Drexel University College of Medicine, 2010, Faculty), and the previous cohort of Fellows for their contributions to this vital program. AQA's investment in leadership education comes at a turning point in health care, and represents a commitment to remain relevant in the rapidly changing medical landscape.

My project had two major initiatives, both at my home organization Avista Adventist Hospital in Louisville, Colorado:

- To improve the organization's operational effectiveness in performing gynecologic surgery; and
- To light the leadership path for Avista's physicians.

Improving operational effectiveness in gynecologic surgery is both complicated and complex in the sense that there are many moving parts, all of which are delicately interrelated. For example, a simple decrease in the number of different laparoscopic tools in use during a case can significantly decrease the surgical time by minimizing the number of times an operator goes through the cycle of deciding to change tools, mentally selecting the next tool, physically removing the prior tool, and then bringing the new tool into action. Operators who choose to have fewer tools in use during their case can decrease their surgical time by up to 25 percent. This, in turn, decreases cost to the system, and time under anesthesia for the patient, thereby

increasing value to both the patient and the hospital.

The complexity of change in medicine is reflected in the fact that the same equipment change or process improvement can be implemented in two different institutions, or at two different times in the same institution, and have completely different results. This can be attributed to the butterfly effect, a chaos theory that posits widely varying outcomes based on a system's strong dependence on initial conditions. Tiny changes in the readiness of the group for change can ultimately alter the path of the group toward sustained success, or failure, and can accelerate, or even prevent, the occurrence of change in another location.

The second initiative in my Fellowship program involved the creation and dissemination of a leadership plan for Avista's medical staff. My intent was to maximally leverage existing resources, and to clearly define a way forward for my colleagues. Many physicians value the concept of leadership, and would like to pursue leadership, but lack the time and resources to create a path for themselves.

Avista's medical staff adopted a Medical Staff Leadership Education Initiative based on self-study and experiential practice, both under the supervision of knowledgeable mentors. The program is best visualized as a nested structure, and is matched to the different responsibility levels within the organization.

Evaluating outcomes

I used EvaluLEAD,¹ a leadership program evaluation

tool developed by the Population Leadership Program of the Public Health Institute, and funded by the United States Agency for International Development, to measure the outcomes of my project.

EvaluLEAD utilizes three domains (individual, organizational, and societal), each of which is divided into three categories of results (episodic, developmental, and transformative).

Episodic results are time-bound results stimulated by actions of the program or its participants and graduates; for example knowledge gained, or a written proposal.

Developmental results are changes that occur across time, represented as sequences of steps taken by an individual, team, organization, or community that reach toward, and may actually achieve, some challenging outcomes—a sustained change in individual behavior or a new organizational strategy that is used to guide operations.

Transformative results are changes that represent fundamental shifts in individual, organizational, or community values and perspectives, and that seed the emergence of fundamental shifts in behavior or performance, i.e., career shifts.

Intrinsic to the system is the knowledge that the activities it measures are the result of a large number of factors, and thus attributing the results solely to the leadership activity may represent an overly narrow perspective. The converse, due to the butterfly effect, is that seemingly insignificant efforts in one location may induce drastic change in other locations.

The results from my Fellowship are:

Individual domain

- Episodic result—Achieved servant leadership certification through the Greenleaf Center for Servant Leadership.
- Developmental result—Elected Chief of Staff at Avista.
- Transformative result—Appointed Chief Medical Officer of Avista.

Organizational domain

- Episodic result—Avista recognized as one of only three centers of excellence in minimally invasive gynecology in Colorado.



Nested view of Avista's Medical Staff Leadership Education Initiative Leadership education.

- Developmental results—Implementation of the Medical Staff Leadership Education Initiative, and Centura value optimization team now active at Avista, with nine promotions of physicians to leadership positions, including two to senior leadership.
- Transformative results—Senior leaders embracing physician leadership education, and Avista’s medical staff solving its own complex problems.

Societal domain

- Episodic—Physicians identified and categorized through multiple means, including self-reporting of readiness to lead, enabling optimal allocation of leadership resources.
- Developmental result—Other operating groups within Centura evaluating the medical staff leadership education initiative, among other tools, for use in developing physicians.
- Transformative result—Centura’s CEO committed to fostering leadership development throughout the system.

ROI

Measuring the return on investment (ROI) for leadership programs is challenging, and not all of the outcomes are immediate. Leaders grow where conditions are right, and I believe Gen. Stanley McChrystal said it best:

I started to think about leaders as gardeners. When you think about what a gardener does, a gardener doesn’t grow flowers or vegetables. A gardener creates the opportunity, shapes the ecosystem so plants have the opportunity to do what they do well. You’ve got to prepare the ground, you’ve got to do all the things that make it work, but you’re not growing anything.²

From a purely monetary perspective, I spent half of the AΩA funds (\$12,500) on each of the two major initiatives. Conservatively, my project was responsible for direct monetary returns of \$550,000 (personal \$180,000, group practice \$110,000, and hospital \$260,000). Based on the \$25,000 directly invested, and including an additional \$25,000 in indirect expenses, AΩA’s ROI is 1,000 percent.

Based on the EvaluLEAD analysis and the ROI calculation, I believe my fellowship was a success. I certainly did not anticipate these outcomes, and feel very fortunate to have returned these results to the program in its second year of operation.

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Elizabeth Warner, MD—Leaning into Leadership

As I reflect on my year as an AΩA Fellow in Leadership, I am humbled by what I have learned, how my thinking has changed, and I understand I am on a lifelong journey. In bestowing this award, the AΩA faculty professed their faith in our potential to grow as leaders and as human beings, and I will be forever grateful for this honor. Quantifying the value of this fellowship is impossible (or I can borrow Mastercard’s tag line, and say that it is “priceless”), for it has provided me a context and real content to hone my leadership skills. It has reinforced the need to continually develop my personal awareness and empathy, so I can better foster compassion for myself and others.

My project is to build and deploy a management system using Toyota Lean processing tools, thinking, and leadership behaviors to eliminate waste and add value to the patient experience. It is grounded in the principles of respect for people, continuous improvement, and relentless focus on delivering value to the patient or internal customer—three of the core principles of enduring operational excellence.¹

I serve as a physician champion and internal coach for my organization’s Lean transformation. Translating the Lean improvement methodology from manufacturing to health care is deliberate and delicate. It requires respecting all members of the care team, and acknowledging the massive complexity and chaos of the health care system, which sometimes obscures the needs and values of the patient and his/her family.

Sustaining Lean transformation is much more difficult than using a simple tool kit of applications that drive out waste and frustration in the workplace. It is a personal leadership transformation from an autocratic leadership style of telling and demanding to a focus on humble leadership, and supporting and developing others.² With a commitment to personal change and vulnerability, the Lean leader strengthens interpersonal relationships, teams, and entire organizations. The Lean leader supports and develops

teams to improve, innovate, and solve real problems.

The Lean management system is intended to:

1. Enhance strategic deployment of crucial business strategies to the bedside/exam table;
2. Connect information and problem solving among front-line teams and executives; and,
3. Provide a framework for leaders to support and develop the organization.

A strong management system is about shifting the leadership approach from the command and control style of “manage by objective,” or “get the results by any means” to “manage by process,” or “the process by which we achieve business results is as important as the results.”

Dr. John Toussaint, author, founder, and CEO of Catalysis (formerly known as ThedaCare Center for Healthcare Value) describes the contrast between white coat leadership in comparison to Lean leadership behaviors.³

Learning how to be Lean

As a leader of this system development, I regularly check and adjust my personal behaviors, and model my own learning to others, so we can progress and persevere on this improvement journey. These behavioral comparisons help me assess if my behaviors are in, or out, of alignment with the guiding principles for business excellence.

The 10 Shingo Principles of Lean transformation have been a touchstone for my work, and a source of clarity in the fear and fury of health care uncertainty.

Modeling personal behaviors to align with these principles; developing training and coaching sessions to teach them; and building systems to support health care workers with these principles provide a strong framework for

repairing and rebuilding the American health care delivery system.⁴

Our patients need safe, timely, reliable and cost effective health care. Humble leaders, strong Lean improvement methodology, and principled systems that support caregivers to practice ideal behaviors allow healers to care for the populations we have sworn to serve.

My clinical work with the inpatient Advanced Illness Management (AIM) team as a palliative care physician is a microcosm of the organizational work. The patient care team is strong and growing, and continuing to develop as strong patient/family advocates. The AIM team is actively participating in the Lean management system, and team members are learning how to stabilize work flows, and use the strength of the whole team in problem solving.

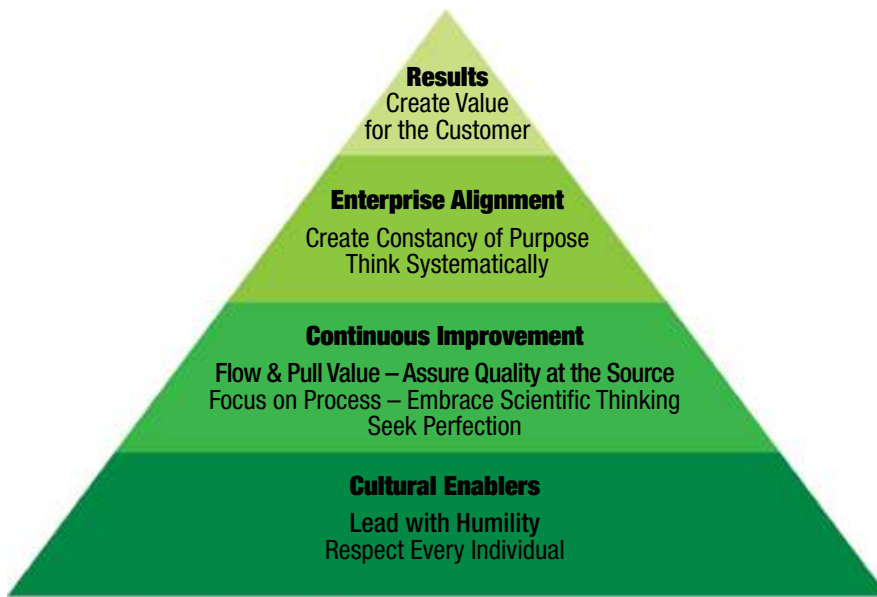
The list of mentors who supported me continues to grow—Katie Harrelson, COO at Bronson Healthcare Group; John Tooker, MD (AΩA, University of Colorado, 1970), my AΩA faculty mentor; Dr. John Toussaint; Pascal Dennis, author of several books, and founder of Lean Pathways; and Lani Watson of Lean Pathways.

The construct of the Fellowship encouraged me to gratefully receive the wisdom and guidance provided by these mentors, so that I can be more effective at serving others. Most often, their brilliance shone by a simple question, posed for me to ponder and learn. They modeled for me effective coaching, and humble inquiry skills, which are foundational for highly effective leaders. I will continue to practice and seek coaching from them.

My community has expanded greatly during the Fellowship year. In my Fellowship application, I was thinking of my organization, my city and the Southwest Michigan region. My community now includes all the learners—in and out of my organization—who are striving

| “White Coat” Leadership (Manage by Objectives) | Improvement Leadership (Manage by Process) |
|--|--|
| Exhibits an “all knowing” attitude | Demonstrates Humility |
| Adopts an “in charge” posture | Exhibits curiosity |
| Demonstrates autocratic tendencies | Facilitates improvement efforts |
| Adopts a “buck stops here” approach | Teaches others |
| Shows impatience | Learns from others |
| Blames others | Communicates effectively |
| Controls others | Perseveres |

A Comparison of Leadership Styles, Toussaint



10 Shingo Principles of Operational Excellence and Lean Transformation

for transformation of health care through ideal behaviors grounded in Lean principles.

I am communicating with members of the Healthcare Value Network (Catalysis) and supporting other hospital systems in their Lean transformations and the physicians' role in learning and practicing Lean. I am part of a learning cohort of executive leaders who gather twice annually to focus on self development and practice.

Conversations with, and coaching from, Danny Friedland, MD (AΩA, University of California, San Francisco, 1992), author of *Leading Well From Within*, and an integrative medicine leader, have reinforced the necessity of self-care and deep self-awareness to be most effective in leadership and change management.

The inward journey

I know now, more than ever, that leadership begins within oneself. With willingness, curiosity, humility, perseverance, and practicing personal standards I will continue to grow as a leader.⁵ I have evaluated my strengths, weaknesses, learned volumes—and unlearned as much—read voraciously, meditated intermittently, exercised sporadically, and have honestly and humbly studied all facets of my personal and professional life. The revelations of this practice have changed me, and many of my interpersonal relationships, team roles and organizational influence. Developing a deliberate practice of reflection (PSDA—plan, do, study, act) has helped me understand my sources of motivation and my potential contribution to health care.

I am defining myself as a Lean coach, physician and effective educator with the ability to translate Lean thinking to a variety of learners.

I will continue to write, reflect and coach learners throughout my expanding community of practice, and I hope to pursue a Master's degree in Applied Positive Psychology at the University of Pennsylvania to learn, and ultimately strengthen Lean transformational work with the power of positive psychology.

At the end of my Fellow in Leadership year, I am comfortable having more questions than answers, confident that

daring to be vulnerable is a sign of strength,⁶ and more clear about my life's purpose.

Author Simon Sinek suggests that we start with our "why,"⁷ but I will end with mine—I am here to joyously co-create a community promoting the health and well-being of all.

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