# Clinical Renovations: A Scientific Structure for Success

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**The significant problems we face cannot be resolved at the same level of thinking we were at when we created them.**
—attributed to Albert Einstein[1]

**"… the purpose of bureaucracy is to compensate for incompetence and lack of discipline—a problem that largely goes away if you have the right people in the first place."**
—James C Collins, *Good to Great*[2]

## Introduction

American medicine has produced dramatic and miraculous advances in care over the past several decades, and Kaiser Permanente (KP) has often been at the forefront of innovations in delivering this care. Nonetheless—and although advances in technology and quality have produced major benefits to the American populace—the medical industry nationwide has never been noted for excellence in customer service. While many industries became accustomed to the pressures of competition, this concept remained foreign to medicine. Now, however, times have changed.

**Although compromise may be politically expedient, systems that result from compromise are usually compromised systems.**

## The Past—A Problem to be Solved

In the past, the Pediatrics Department at KP Honolulu consistently adhered to standards of efficiency, effectiveness, and customer service that had become common nationally in medicine: Phones often went unanswered; access was often difficult to obtain; systematic approaches to operations either didn't exist or were obtuse and dysfunctional; and customer service was congruent with these supporting structures. An evident fact was that delivering this level of service to our members was no longer viable—and that neither would we be if we continued in the same way.

We approached this challenge by focusing on three essential needs: well-functioning operations, empowered employees to run these systems, and supportive leaders to help build the systems and facilitate the employees' performance. This article discusses our approach to changing the systems to work for the end result: serving our patients.

## The Diagnostic Approach

Many of our operations did work quite well—just not for our patients. Dysfunction often existed because the system was designed to be effective for someone along the process path; for example, sometimes systems were designed for the ease of employees working at the beginning of the process. Some systems were designed to protect a "weak link"—real or perceived—or to appease a certain interest group or hardened silo. Honest introspection into many of our paradigms revealed uncomfortable patterns that nonetheless needed to be addressed.

Closer inspection showed that most operations were failing because they were designed "backwards": Focus was placed not on what was needed but on what we thought we could provide. Operations often reflected the bureaucratic hierarchy, not the abilities of employees or the needs of Health Plan members. Systems often evolved from a series of compromises. Although compromise may be politically expedient, systems that result from compromise are usually compromised systems.

In this way, the end result was often a set of dysfunctional systems, disempowered employees, and poor customer service. This structural and cultural paradigm had to change so that a more functional operation could flourish.

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## The Reconstruction

The first step in any improvement program is to realize that you can't do it alone. Nonetheless, our clinical systems were designed and managed predominantly by doctors and nurses—none of whom traditionally are trained in operational processes. We therefore needed to add to the management team a business consultant, an industrial engineer, or sometimes, a referee. We needed professionals to assist us with duties that were outside of our profession.

During our clinical redesign, we developed a structure that can be applied to a variety of settings. In this structure, the hierarchical pyramid is inverted so that the leadership supports the staff with principles, tools, and empowerment, thus allowing them to function at their highest capacity.

We call this approach "gyroscopic operations." A gyroscope provides stability and maintains direction by using momentum created by rapid rotation of a wheel. Despite outside forces placed upon it, a smoothly operating gyroscope resists movement from its core direction. We wanted our systems to operate in the same manner.

We believe that this approach is one key to our success and can be useful for other clinics. A schematic of this approach is shown in Figure 1.

In this approach, employees are given principles, guidelines, and tools to do their job well. They then perform independently with these principles for guidance and with leadership for support. The support structure is completed by systems (created to allow consistent realization of each goal) and measures (delivered for redirection or fine tuning directly to the employees whose performance is being measured).

Construction of this structure must be accomplished in stages. First, principles and goals are determined. For example, the primary care leadership determined that all patients should have a primary care physician and should see their personal care provider (PCP). Patients should also be seen on the day that they call about an illness. Each of these principles is a universal, intuitive truth that few would challenge.

Once these principles were set forth, a system was designed to achieve each goal. To be effective, the system was set up so that the path of least resistance was to provide the desired service; if employees must "swim upstream" against the system or if they have no tools enabling them to easily perform duties consistent with the guiding principle, then that goal will not be realized fully or consistently. If receptionists are assigned to give patients same-day access, then appointments must be available on that day. If receptionists are assigned to match patients with their PCP, then a functional mechanism must exist by which this assignment can be consistently achieved. Employees need tools that serve them and make it easy to do the work the right way.

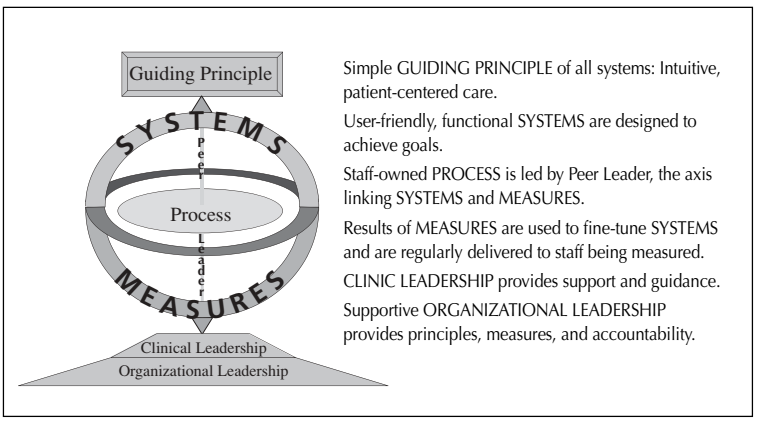


Figure 1. Schematic illustration likens operational structure of KP Honolulu Pediatrics Department to a gyroscope in which functional processes of the clinic are directed toward a guiding principle and are kept in balance by clinical peers. These functional processes operate within a structure of systems and measures and are based on clinic and organizational leadership.

The other internal support implemented was measurement that reflects movement toward the guiding principle. These measures are delivered to and reviewed with the employees whose performance is being measured.

These supports are linked to the staff by a local leader chosen from among the employees themselves. This leadership position—an essential piece of our approach—is not recognized officially in the organizational hierarchy but is held by a person to whom the staff look for competence, information, and direction. Moreover, by assuming this leadership role, a staff member implies that all members have the potential to be leaders. This message begins to diffuse sharp de-

**Table 1. Objectives of KP Hawaii pediatrics department clinical staff and extent to which these objectives were met in July 2003**

| Process | Honolulu pediatrics data | KP Hawaii data |
|---|---|---|
| Same day access | Available daily | Intermittently a struggle |
| Same PCP access[a] | 93% | 79% |
| Exit linking[a] | 77% | 56% |
| Health care team satisfaction index[b] | 87% | 72% |

[a] Data from Regional Data Center, July 2003
[b] Health Care Team Survey, Spring 2003

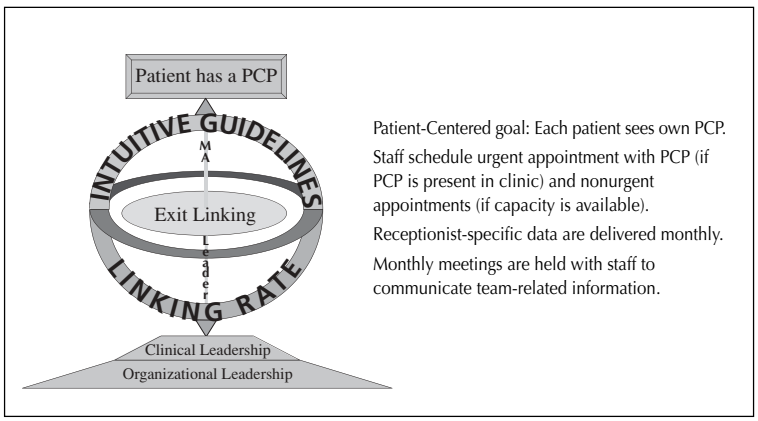


Figure 2. Schematic illustration uses gyroscope analogy to depict operationalization of three principles for high-quality service and care: creation and maintenance of user-friendly processes, use of exit linking, and assignment of all KP members to their own personal care providers (PCPs). MA = medical assistant.

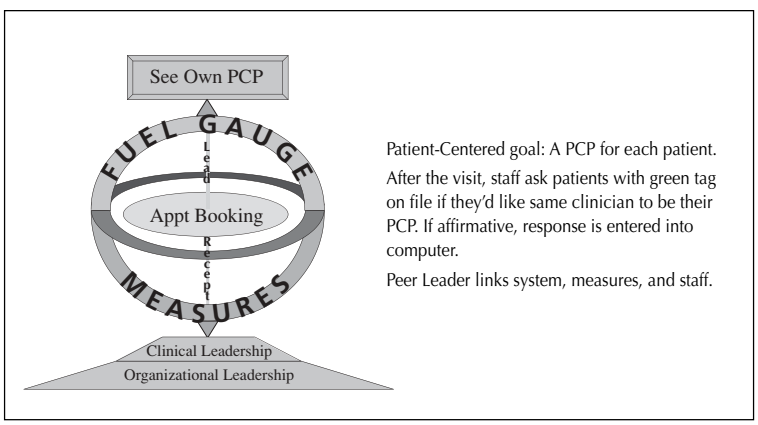


Figure 3. Schematic illustration uses gyroscope analogy to depict process of ensuring that patients obtain appointments with their own PCPs.

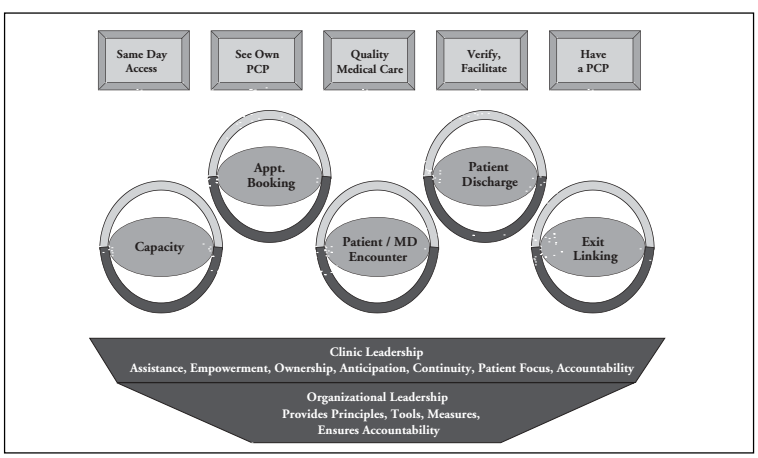


Figure 4. Just as the three-dimensional orientation of an airplane's flight path is maintained by a series of gyroscopes that monitor and correct changes in altitude, pitch, and direction, so are the dimensions of a medical encounter monitored and corrected within a clinical setting.

marcations in the workplace hierarchy and empowers the staff to think of themselves not only as empowered but as responsible.

Employees using these systems may be considered the flywheel of the gyroscope. Allowed to perform in a low-friction environment, they provide the momentum and stability that keep the system oriented in the direction of its core principles.

We based the new approach on the premise that all people come to work to do a good job. Giving them principled goals, functional systems, and feedback are generally sufficient incentive to create both improvement and satisfaction.

A gyroscope thus provides a metaphor for this structure. The most important part of this structure is the staff, who perform their duties in a functional environment, provide momentum and stability, and maintain direction. The leaders act as a supporting structure and provide a platform on which the employees perform their jobs.

## Application and Extrapolation

KP's Health Care Team Leadership provided the principles for quality service and care. A "gyroscopic" structure and new systems were applied to each of these goals, and—when possible—systems were automated to accomplish the goals. Examples of such principles and their operationalization are shown in Figures 2 and 3.

The KP Hawaii Region determined that linking members to their PCP would be best attained after the first visit to a KP clinic. Medical assistants were chosen as the best suited for performing this function, and systems were designed and automated to accomplish it. Measures were delivered and reviewed with a medical assistant who took an active interest and led in the endeavor. The team and clinic leadership enabled the processes, and the organizational leadership supplied measures and evidence-based principles upon which to focus.

Figure 3 is an abbreviated schematic of operations involved in passage of a patient through a routine clinic visit. As the patient moves through the clinic, a variety of operations occur simultaneously. To be accomplished consistently, goals must be intuitive as well as important to the staff and to patients. Systems must work to achieve these goals easily; the staff must be empowered to maintain and improve each operation; and relevant, actionable measures must be delivered regularly. All these tasks and objectives must be supported

by the leadership, not imposed by it. Figure 4 shows how this approach for monitoring and correcting aspects of a medical encounter is analogous to the gyroscopic activity of an airplane's navigational system.

In its clinical redesign, KP's Honolulu Pediatric Department has focused on several principles set forth by the Health Care Team leadership. By applying the "gyroscopic operations" structure to these goals, processes were automated for consistently achieving the objectives (Table 1) of the clinic's staff (Table 2).

## Conclusion

Creating a structure in which employees can perform professionally to the best of their ability makes patients and employees—clinical as well as nonclinical—universally happier. We have learned that if we empower people to do a job well, they will do so. Give them the tools to do it, and they will use them. Build systems that work for the end customer, and these systems will work for everyone. Focus on doing the right things for patients, and the resources already available will usually be sufficient.

We have found that good service is beneficial to patients, physicians, and all other employees. When patients have access to their primary care physician, when receptionists are able to give appointments when patients need them, when physicians are not backlogged or rushed, when flow through the clinic is smooth and expedient, and when staff can perform interdependently to their highest potential, all involved will find themselves much more effective—and possibly, therefore, more contented. ❖

Kaiser Permanente Honolulu Pediatric Health Care Team

**Table 2. Members of KP Hawaii Pediatric Health Care Team**

| |
|---|
| William F Pfeiffer, MD, Pediatrician, Team Co-Leader |
| Summer Muragin, RN, Team Registered Nurse and Team Co-Leader |
| Rebecca Noble, RN, Adolescent Program Registered Nurse, Former Team Co-Leader |
| Wilma Kam, MD, Pediatrician |
| Matthew S Lau, MD, Allergist |
| Phil Meyers, MD, Pediatrician |
| David Paperny, MD, Pediatrician, Adolescent Medicine Specialist |
| Dwight Yim, MD, Pediatrician, Geneticist |
| Sherry Sakaida, RN, BSN, Nursing Supervisor |
| Cynthia Copp, RN, APRN, Nurse Practitioner |
| Mary Kawasaki, RN, APRN, ILBC, Nurse Practitioner |
| Christy Furukawa, PNP, Call-in Nurse Practitioner |
| Mitzi Kaneko, RN, Team Registered Nurse |
| Gayle Smith, RN, Team Registered Nurse |
| Myra Cleary, RN, Call-in Registered Nurse |
| Holly Eborn, RN, Call-in Registered Nurse |
| Linda Freeman, RN, Allergy Nurse |
| Billie Mullally, LPN, Team Licensed Practical Nurse, Injection Nurse |
| Christine Agpaoa, MA, Medical Assistant |
| Mary Domingo, MA, Medical Assistant |
| Judi Kruszewski, MA, Medical Assistant |
| Wealth Miarecki, MA, Medical Assistant |
| Annabelle Pajela, MA, Medical Assistant |
| Narcisa Ricamona, MA, Medical Assistant |
| Dolores Yacapin, MA, Medical Assistant |
| Joyce Colobong, MA, Call-in Medical Assistant |
| Shieleen Gregorio, MA, Call-in Medical Assistant |
| Sandra Carvalho, Scheduler, Receptionist |
| Annette Lee, Lead Receptionist |
| Janice Lee, Receptionist |
| Melanie Lo, Receptionist |
| Casina Waterman, Receptionist |
| Imogene Franquez, Receptionist |
| Jennie Kawamoto, Receptionist |
| Rana Llanto, Receptionist |

**Acknowledgments**

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