Accelerating Healthcare Transformation through Adaptive Work Systems Design: The Fairview Medical Group Case

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On May 10, 2011, Fairview Health System released the following press announcement:

> MINNEAPOLIS --Fairview Clinics have been certified by the Minnesota Department of Health as a health care home (also known as a "medical home"). To achieve this designation, 35 Fairview primary care clinics met a rigorous set of standards demonstrating that they consistently deliver care through a team approach and seek to improve the quality of care while also effectively managing the cost of care.

This announcement was noteworthy because all the other integrated health care systems in Minnesota seeking certification were able to get five clinics approved… combined.

This case describes an innovative organization design and change process used by the Fairview Medical Group to accelerate innovation and establish an adaptive learning network for the primary care clinics at Fairview Health Services.

Laying the Foundation

Fairview Health Services is a 106 year-old, non-profit healthcare system in Minneapolis, Minnesota. It operates 6 community hospitals and in partnership with the University of Minnesota, Fairview operates an academic medical center with two campuses.The hospital systems are supported by the Fairview Medical Group's (FMG) 450 employed physicians, 40 primary care clinics, a wide range of specialty services, and home care and senior services.

In August, 2007, Mark Eustis was appointed CEO and wanted to build on Fairview's reputation for excellence by facilitating fundamental change in anticipation of the health care reforms that were occurring at the federal and state levels. As part of that agenda, Fairview acquired the Columbia Park Medical Groupin late 2007. Traditionally, physicians were fairly autonomous and reported up through the hospital structure. With the new acquisition, the organization began thinking about how to integrate the physicians into a more market facing and branded set of services.Led by Terry Carroll, Senior Vice President of Transformation, that integration was being pursued along two parallel, but related, paths.

[1] The order of authorship is alphabetical. The authors are grateful to Val Overton, Julia Harrington, and Sally Wahman for their contributions and insights into the change and design process. This case drew on information provided in interviews, the Fairview website, and published articles on the change process.

First Path: Contract Changes and the Development of Care Packages

During the 2008 contract negotiations with the Medica health plan, top executives at both companies wanted to establish an alternative to the traditional "fee for service" reimbursement model. In 2009, a two-year contract was completed that paid Fairview based on the achievement of defined outcomes for quality and total risk-adjusted cost of care for all Medica members served by Fairview-employed primary care physicians.In essence, Fairview put some of their eligible reimbursement pool at risk based on quality and total cost of care. They were very early adopters in applying this thinking and the contract with Medica existed for well over a year before other health systems engaged with payers in similar contracts.

From Fairview's perspective, success in the relationship required a new financial model based on a different set of skills, processes, and relationships with payers for reimbursement. It required an understanding of the patient population, including their current level of health and illness and being able to measure the cost of care and clinical outcomes. The Medica relationship allowed Fairview to access information that was vital to improving the health status of Medica-insured patients. The analytics they developed helped to answer questions like: Who is about to get sicker and benefit from some kind of outreach? Which members with chronic diseases do we predict could be healthier and, therefore, have a lesser need for services?

The work initiated under the Medica contract eventually resulted in the development of "care packages."Care packages are an evidence-based, regularly updated, best practice approach to delivering appropriate services to defined populations to ensure a consistent level of quality and service across multiple clinics. Care packages for asthma, diabetes, migraines, lower back pain, attention deficit disorder, and other conditions were expected to increase quality and reduce costs to take advantage of contract provisions, and the organization began thinking about how best to standardize these common procedures. For example, the clinics discovered that more than 80 different care sets existed for managing diabetes across the system. Care packages allowed the Fairview Clinics to present a standard care plan and clinical approach for chronic conditions.

Second Path: Care Model Innovation

Mark Eustis, Terry Carrol, and Dave Moen, an emergency room physician, were thinking about how to build an "innovation capability" at Fairview Health Services. As part of that process, Mark and Terry asked Dave if he wanted to move from being a physician to Medical Director of Care Model Innovation and help direct this transformation. The group worked with an external consultant, Stu Winby, who described how innovation processes could be designed and organized. The primary output of that discussion was a decision to develop a prototype primary care clinic that reflected the emerging health care reform regulations.

At the time, the clinics operated according to a process where, in the best case, the patient would make an appointment through a scheduler, check-in at the time of the appointment, be shown to an examination room, interact with a provider (e.g., doctor, nurse practitioner, or physician's assistant), have the appropriate orders or prescriptions written, check out, and engage in any follow up activity. But the process often didn't go that way. Too often, when you called the clinic to ask about your sore throat, you'd talk first to a scheduler. If no appointment was available, you would be referred to a triage nurse, who would send a note to the physician. Depending on how busy he or she was, the note might sit for hours before the physician would see it and send a note back to the triage nurse, perhaps telling the nurse to add you to the schedule. The nurse would call you back, and when you came in, the doctor would have to see you before ordering a strep test. Then you'd wait for results, and if they were positive, the doctor would finally write you a prescription.

Such processes – good and bad – were common in primary care clinics. Nurses were there to triage, schedulers scheduled, and a physician was someone who saw patients during the day and when they could, entered their observations and treatments into an electronic medical record. There was no coordinated plan of care for patient populations across the system, no standard processes to follow, and lots of wasted time and effort. As described by one participant, "our clinic processes looked like everyone else's; we sat in our office and waited for patients to come to us. We treated them, sent them home, and sent them or their insurance company a bill."

The structure of the clinic reflected the process. A physician and administrator team led the clinic but had different reporting relationships. The physician leadership reported to the Executive Medical Director of the Fairview Medical Group whereas the administrative managers reported tothe vice president of operations. Reward systems followed traditional processes. Clinic staff and physicians were given annual performance reviews with differing levels of informal feedback throughout the year. For clinical staff, those reviews triggered merit pay increases while physicians were paid a salary on the basis of individual productivity and clinical outcomes.

Beginning with Fairview's Eagan Clinic in January, 2009, Moen worked with the staffunder the assumption that the best people to change a system were the ones doing the work. He said, "I don't know how to fix the clinic, but I know that you know how to do it better than anybody, so let's get started."That year, four clinics – Egan, Hiawatha, Rosemount, and Northeast –became involved in the care model innovation project, and adopted the following goals:

- Reduce the total cost-of-care growth rate
- Improve patient satisfaction
- Increase the number of patients cared for by clinic physicians
- Improve quality of care measures

While the goals were clear, the means to achieve them were not. The clinics had to develop a more patient-centered model, use resources more efficiently, learn how to coordinate care better, understand the role of virtual care, and so on. Based on research by Thomas Bodenheimer and others, the clinics began to think about the formation of "care teams" that might view health in a more systematic and systemic way. Eventually, each of the four prototype sites reorganized its workforce into clinical care teams, which includedabout three providers (physicians, nurse practitioners, and physician assistants), nurses, medical assistants, and schedulers. Patients maintained their relationship with the primary care provider but were able to access the entire care team and each team was responsible for a panel of patients assigned to the provider on the team. The number of teams in a clinic was a function of the size of the clinic; small clinics might have only 1 or 2 teams while large clinics could have as many as 5 teams.

The effort to convert the four clinics took about 14 months, and considerable effort went into measuring if costs could be pushed down or clinical measures improved. Overall, the early data was mixed. On the positive side:

(1) The Eagan Clinic reported that the percentage of patients obtaining needed immunizations and screenings increased significantly within five months of launching the new team-based approach,

(2) Reassigning duties within the teams improved patient access to care and overall efficiency (e.g., primary care physicians saw their end-of-day duties—patient messages, lab result review, and charting—decrease from an average of 90 minutes to zero because other team members were now handling that work and another clinic reported the percentage of

patient messages that required a physician's response fell from 30 percent to 3 percent, as other team members were empowered to address patient needs themselves), and

(3) The prototype sites developed new ways to serve patients, including nurse-only visits, group appointments, team appointments, and virtual care visits via e-mail and phone conversations. In the traditional model, a patient being monitored for high blood pressure was routinely scheduled to see a physician; now hypertension patients could be seen by a registered nurse if clinically appropriate.

On the other hand, there were some initial costs involved in the primary care transformation. The cost of hiring additional staff members for the physician-led teams in the clinics and the short-term drop in productivity increased the cost-per-patient in these clinics by more than 15 percent during the transition to the new care delivery model. Patient satisfaction changes were also mixed.

Val Overton, Vice President of Quality and Innovation, noted that, "Some quality and other measures did take a hit but we also began to see the possibilities because there were signs of quality improvement and cost declines. Although it was hard work, the engagement was very high. Our staff surveys clearly indicated that nobody wanted to go back to the old model. There was lots of anecdotal evidence of how much better this model was." The physician reaction was quite varied. Conceptually, the idea of managing the health of a population and taking care of them in between visits before they got sick appealed to primary care physician, but changing habits and processes was a challenge.

As the two paths of change – care package and care model innovation – matured, Minnesota's Department of Health announced the criteria, process, and accelerated deadline for certifying primary clinics as healthcare homes. Fairview Clinics leadership estimated that there was an 80% overlap between the care package and care model innovation work and the requirements of the certification process. The challenge facing Terry Martinson and Fairview Clinics was "how do we scale this?" and "how do we set up a way to continue to learn, improve, and address the health of a population of people?"

Establishing the Innovation and Learning Network

Similar to the care model innovation work, the goal was clear but the means to achieve it was not. How was Fairview Clinics to diffuse the knowledge, skills sets, and capabilities developed in the pilot clinics to 30 other clinics in less than 10 months? Fairview Clinics had more than 400 providers across more than 40 clinics over a 300 square mile area. If it took 14 months to convert one clinic, even with improved efficiencies, changing the system would take way too long.

Winby had introduced Fairview Health Services to innovation design and "decision accelerators" (DA), a large-group conference model that was useful in quickly generating and refining innovative ideas, visions, strategies, and action plans. His work in early 2009 as part of the care model innovation project focused on DAs to develop criteria selection processes around the electronic medical record. Carroll, Martinson, and Moen again enlisted Winby's thinking about the design of an innovation network.

Winby's Adaptive Work System model, shown in Exhibit 1, was the core platform for a Work Innovation Network (WIN) that could design, develop, optimize, and diffuse a variety of innovations. The model is scalable in that it can be applied by small groups thinking through an issue to extremely large groups diffusing innovations. For example, a physician leader (1) can become aware of an emerging problem with a key account and want to develop a strategy (2) to address it. She puts a few ideas on paper and begins to mobilize (3) and engage different stakeholders to refine the strategy. As she shows the strategy to different people (5 and 6), they propose changes to the plan (6 and 7) until the plan is ready for action.

At a broader scale, a leadership team (1) can recognize the need for change and propose the development of anaccountable care organization (ACO) (2) to improve the health care system's readiness for health care reform. The idea of an ACO is shared with a large number of stakeholders in a decision accelerator conference setting (3) and a plan for organizing the group (4) is developed. The teams work on their part of the plan (5), share it with others (6), receive feedback on the quality of their part and how it aligns with other parts (7 and 8) until such time that the large group is ready to meet again to determine the next steps. Such a process held the promise of routinizing the development, formalization, and diffusion of innovations as well as provides the basis for large-systems learning.

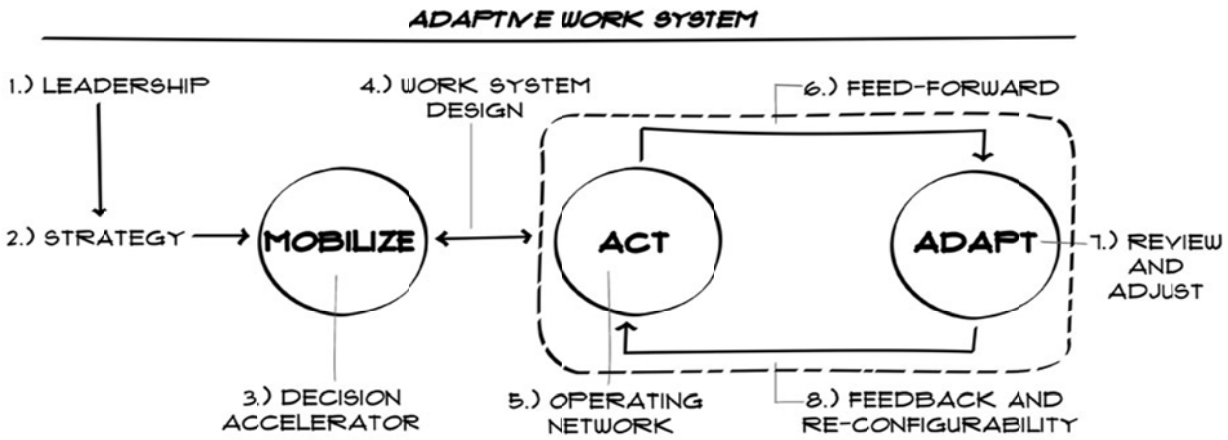

Exhibit 1 - Winby's Work Innovation Network (WIN) Model

Leading and Strategizing

In March, 2010, Carroll, Moen, Martinson, Winby and others began to discuss whether Winby's idea of a work innovation network (WIN) might apply to the rapid diffusion of the new team-based care model and care packages. Winby encouraged them to think of the clinics as a network and about establishing a "learning collaborative" where good ideas were tested, formalized, and spread. The result of these meetings was a decision to accelerate the change and attempt to certify all of the Fairview Clinics.

Over the next couple of weeks, Winby's team joined forces with Julia Harrington's team (in fact, Harrington had only moved into her position as Director of Performance Excellence four days earlier under a completely different mandate) to plan the first "mobilize" event which eventually became known as the "Big Bang."

Mobilizing the Clinic Network

According to Winby's model, the next step was to mobilize the clinic community with a DA. On May 27, 2010, approximately 150 physicians, clinic staff, and other stakeholders from the 40 clinics met at the Minneapolis Convention Center. The purpose of the event was to educate the clinics on the care package and care model innovation design by the prototype clinics and help them develop work plans to

implement the requirements with speed and quality.The agenda for the Big Bang event is shown in Exhibit 2.

Activity	Description	Deliverable
Introduction	Objective setting, overview of the conference	Understanding of the activity flow, clear expectations
Trade Shows	Small group presentations of specific functionalities required to meet the health care home requirements; each clinic visits all 6 topics	Understanding of the functionalities
Iteration Planning (I)	Develop a 30-day "iteration" plan to implement selected functionalities	30-day action plan
Iteration Planning (II)	Develop a 60-day "iteration" plan to implement selected functionalities	60-day action plan
Trade Shows	Small group presentations of specific functionalities required to meet the health care home requirements; each clinic visits all 6 topics	Understanding of the functionalities
Iteration Planning (III)	Develop a 90-day activity plan to implement selected functionalities	90-day action plan
Balancing the Operating Model	Planning for implementation while respecting operating conditions…balancing the load	Implementation plan

Exhibit 2 - "Big Bang" Agenda

Following opening comments, members from each of the clinics spread out to participate in one of six "trade show" events. At each trade show station, representatives from one of the pilot clinics would describe one aspect of operating "functionality" according to the new model.

"Functionality" was defined as "shippable product," something that a customer would see as valuable and wants it. For example, a functionality could include a process that made making an appointment easier as well as processes to support internal capabilities, such as being able to complete paperwork for reimbursement. The functionalities were grouped into four increasingly sophisticated phases that were expected to meet the requirements for certification under both the Minnesota model of Healthcare Home and the federal model of Accountable Care Organizations (see Exhibit 3).

Phases	Functionalities
Phase 1	• The clinical care team model • The adult preventative care package • A set of minimum standard processes, including huddles, ops meetings, message handling, telephone routing, in-basket management, etc.
Phase 2	• 10 additional care packages • Achievement of the clinical health home requirements as stipulated by Minnesota regulations • Establishment of dedicated population panel management resources.
Phase 3	• Implementation of appropriate and well managed care transitions • A referral management process • Processes to minimize and manage hospital admissions.
Phase 4	• Programs for measuring diabetes, COPD, asthma, CAD and CHF treatment quality • Standardization of chronic patient care management processes.

Exhibit 3 - Key Functionalities

Following the first round of trade shows that were focused more around Phase 1 functionalities, each clinic team met to develop a 30-day "iteration" plan. An iteration plan described the functionalities the clinic hoped to accomplish over a particulartime frame according to the accountable care or health care home model. It was called an "iteration" plan because the expectation was that the clinic could only go so far, on its own, before it need the opportunity to share its progress with other teams, learn from their experiences, ensure that the capabilities they were building were complimentary with the other functionalities in the network, and then move onto the next iteration of capability building. This 30-day effort was followed by the development of a 60-day iteration plan. The teams then engaged in another round of trade shows, focused more around Phase 3 and 4 functionalities, as well as final rounds of iteration planning were performed. Each clinic left the meeting with a 30-60-90 day plan for achieving certification. The goal was to establish these functionalities in all 40 clinics by September 28, 2010 when the large group of 150+ people from across Fairview Clinics would reconvene to discuss and learn from each other the challenges and benefits of large scale implementation and innovations.

Acting and Adapting: Leveraging the Network for Learning

The work system design that supported the Act and Adapt cycle was based on a community metaphor. As shown in Exhibit 4, each clinic was conceived of as a "block" in a town that was composed of several houses (clinical care teams). Multiple clinics became neighborhoods, and multiple neighborhoods became a town. The logic of the act and adapt cycle was that more frequent meetings should occur at the block level than the town level to increase information sharing and learning at the local level. Shared learnings at the local level were raised to the neighborhood and the town.

According to the care team model, care teams came together for daily "huddles" todiscuss issues about individual patients as well as ways to improve patient flow and care processes. On a weekly basis, the "block" (e.g., clinic) would meet. At each point in the 30-60-90 day iteration plan, the neighborhoods would come together to see what functionality was approved, reflect on how and why changes were implemented, and help each other plan for the next iteration. Finally, town meetings were convened every 90 days.

HOUSE = 1 Clinical Care Team
▪ Huddles daily-twice a day-iteration opportunities ▪ How is work changing? How are we working together? ▪ What are we learning together? Fail fast ▪ Team Building/Panel Management (Phase 1&2)
BLOCK = 1 Clinic
▪ Weekly Meetings-how do we learn from other teams? ▪ How is overall clinic changing/adapting? ▪ Team Building/Panel Management (Phase 1&2)
NEIGHBORHOOD = 4 to 6 Clinics
▪ Meet every 30 days –it's an opportunity to "Catch your breath" ▪ What can we learn from other clinics? ▪ How is our learning progressing? ▪ Local innovations/optimizations to tie in additional clinic sites
TOWN (FMG) = Multiple Neighborhoods
▪ Meets every 90 days – Town hall meeting ▪ What has been learned in neighborhoods? ▪ What best practices can be adopted by the entire town?

Exhibit 4 - Work Innovation Network Nodes and Learning Activities

Even with the 30-60-90 day iteration plans in place, a considerable amount of support was necessary. Harrington noted that, "Coming out of the 'big bang' event, one of the things we did to get the WIN up and running was assign a performance excellence person to each clinic to help deploy the new care model. This helped to meet people's expectations that resources would being made available to support the changes." Each performance excellence person was assigned a "neighborhood" (about 5 clinics). The neighborhoods then became the 30-60-90 day context for diffusion.

The execution of all the changes in a short period of time was an overwhelming amount of work. Through the 30-60-90 day iteration plans and neighborhood meetings, a lot of effort went into keeping track of where the "heat" was. The neighborhoods were on the 30-day cycle and the first meetings varied widely in their effectiveness. By the time of the 60-day neighborhood meeting, a common agenda and a "tell us what you are learning, how do we rely on each other" methodology had formed that was extended to the 90-day meeting. The local clinics were very proud of their accomplishments and it was difficult to establish a balance between "this is the best practice, adopt it" and "that won't work here, our way is better."Harrington's team created the "True North" dashboard that scored each clinic on how well they were meeting their 30-60-90 day objectives and rolling that up to track overall progress.

As the system approached the end of the 90-day cycle, everything and everyone became overwhelmed; there was a need to slow down and consolidate progress. The clinics were encouraged to agree on what had been done and to prepare for the health care home certification visits. By the time the state of Minnesota surveyors came out, the clinics were able to show how the new work processes actuallyoperated. The certifiers went to 10 random clinics, asked the same questions, and kept getting the same answers. They were so surprised by the consistency that, despite invitations to visit the other clinics, they did not. They were amazed that the work had been accomplished in all 40 clinics.

From Accelerated Innovation to an Optimized Learning Network

Following the certification announcements, the clinics entered into what Martinson, Overton, Harrington, and Winby call the "optimization" phase. They noted that with any innovation, there is a lot of variation in the way a process or activity is carried out and there needs to be time and effort dedicated to optimizing a process. Once a process is optimized and formalized, it is more programmable and can be diffused as best practice more easily. Moreover, while the WIN project accelerated change in 40 individual and geographically distributed clinics, the clinic network needed to start acting like a system if it was going to learn and address population health issues. The optimization process includes the following activities:

- Setting up and formalizing coordination and communication
- Establishing a WIN bank for best practice sharing and diffusion
- Establishing supportive systems and processes to round out the design

First, since the certification process, Fairview Clinics has been developing the data management and communications process to enable the measurement of population health metrics and the sharing of best practices. Measuring the health of served populations is a critical ingredient to laying claim to health savings reimbursements. With the establishment of the database, Fairview Clinics can start to drive medical care from the center by identifying high risk patients, where the system was performing (and where it was not), building appropriate care plans, establishing responsibility for executing certain protocols, and generally supporting clinics in the delivery of care.

A second important activity is the establishment of the "bank" (see Exhibit 5). The bank is an electronic depository of care packages, clinic procedures, functionalities, and other learnings for development and diffusion. The neighborhoods and towns continue to serve as a communication and learning infrastructure, but the bank is intended to serve as a central location where changes and best practices can be documented and formalized. Fairview Clinics is currently working to encourage people to both push information into the bank and pull information from it.

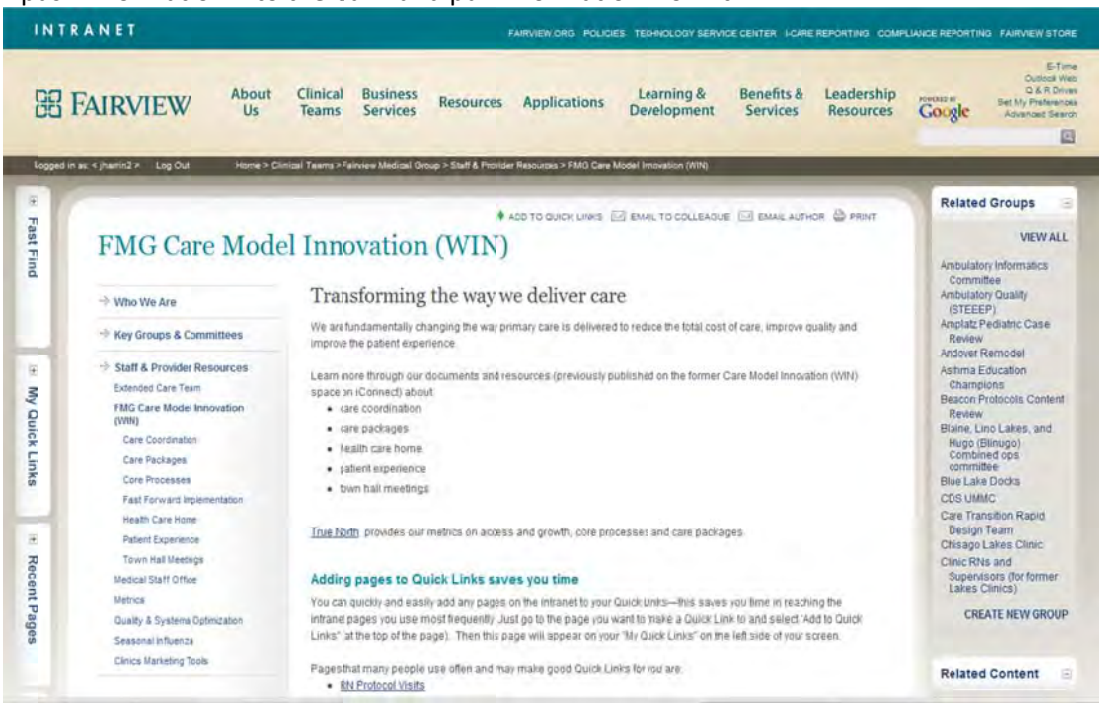

Exhibit 5 - The WIN Bank Website at Fairview Medical Group

Finally, the certification work was primarily oriented toward implementing new care delivery processes. The Fairview Clinics are focusing now on other aspects of organization design that are required to sustain these changes. For example, training physician leaders through the Fairview Leadership Academy on principles of adaptive leadership and the skills needed to inspire culture change is now a part of leadership responsibility and accountability. Additionally, more than 1,200 physicians, nurses, and other staff members have participated in simulations designed to foster teamwork and behavior changes.

In addition, FMG is redesigning physician and staff compensation and recognition. The new primary care compensation model rewards performance that drives success toward what is being called the "Triple Aim" or the extent to which costs, quality, and satisfaction improve. Productivity is now measured upon the acuity adjusted panel managed and significant portions of provider salary are based upon clinical quality, patient experience, and total cost of care. This creates line of site between provider behaviors and the Triple Aim. There are also rewards based upon how the team performs in addition to individual performance. By receiving a base salary with incentives for their performance on quality and cost measures, the physicians are better aligned to the new contracts and way of working.

Performance management changes for the staff have focused on recognition more than compensation, although some bonuses have been arranged for front line employees if the patient satisfaction scores improved. For example, the organization has focused on recognition at the local level for achieving different quality targets, implementing challenging work processes, and so on. Neighborhood and Town Hall meetings celebrate and recognize Fairview Clinics accomplishments.

Reflections and Learnings

The Big Bang, 30-60-90 day iteration plans, and optimization processes have supported culture change within the Fairview Clinics. Beginning with the Big Bang, FMG's physicians and staff have been working together in completely new ways, and their story is one of accelerated change and dynamic learning, but it is not a fully complete story. While the successes are indeed remarkable, the organization recognizes that change is never over. It continues to monitor progress and has noted several places where improvement is necessary as it proceeds through the optimization phase.

First, the organization is wrestling with the tension of needing to operate as a system and empowering its clinics and people. Care model and care package innovation began, in line with Moen's belief, under the assumption that local participation in the change process was critical to success. As that success was achieved at the local level, the need to leverage the system and address population health issues emerged and cannot be approached in a manner that violates the assumption. It must consistently align to a value of participation. The Fairview Clinics is working hard to recognize and learn how to balance this tension.

Innovation, optimization, and diffusion must all be managed and implemented with the same values of participation and involvement, but must also be managed to result in coordinated outcomes. Such an "ambidextrous" organization must find a way to balance innovation, change, and creativity with reliability, efficiency, and predictability. The Fairview Clinics are working to build the capability to drive innovation and optimization in local clinics, but to also to build the mindset that what is innovated and optimized in one clinic, on behalf of the network, is worthy of acceptance and adoption by the whole. Extreme ownership of work processes at the local level can sub-optimize system performance at the network level. Building that mindset and cultural change is a primary area of focus.

Second, technology or care delivery process changes are only one piece of a puzzle to achieve cultural change. The technological and work-related changes must be integrated with other organizational design changes to create a system of activities. The Fairview Clinics has learned that there

is a lot of adaptive culture change that needs to happen concurrently and they are doing that through Heifitz's Adaptive Leadership model. Physicians in particular are giving up pieces of work they had traditionally identified as their own but really could be done by someone else. The work innovation network process was critical, but so too is the need to help people adapt from change to change. The structural changes, planning and goal setting, communication, and performance management changes are complimentary to the work changes and will ensure that the system drives the required cultural changes.

Third, rapid change is sensational but it can be wasteful. There has to be a period where the system rationalizes all the change. Early on, the changes were disruptive and there was a need to protect the work and not let others interfere but also to support it with resources. A lot of the success resulted from executives who were willing to provide time and resources and the slack to let the organization muddle through it. If "experts" or "consultants" had told the clinics what to do, it probably would not have worked as well as it did.

As Val Overton noted during healthcare home certification, "There was so much coming at people that a lot of things probably fell through the cracks. As the organization thinks about optimizing, a round of reflection about 'what worked, what's in place, and what didn't work' is necessary." There was concern about whether the problems being faced were a function of bad "product" or the result of a leadership issue.

As the organization works through this reflection, it is noticing new opportunities. The clinics, for example, have recognized that the work flow changes have actually increased their capacity to take on new work at the individual clinic level but also at the FMG level.

Summary

The adaptive work system model and the work innovation model have now been formalized as the innovation engine of an organization that can both create and deliver. Both in FMG and elsewhere at Fairview Health Systems, work is organized through DA mobilizing sessions followed by a series of activities that reflect the Act and Adapt iterative implementation cycle. This approach to work organization has increased the system's speed to value, agility, continuous innovation, social capital, and integrated innovation, and it has significantly increased FMG's ability to learn.