Value based health care:

Merging cardiology and cardiac surgery units – a management perspective.

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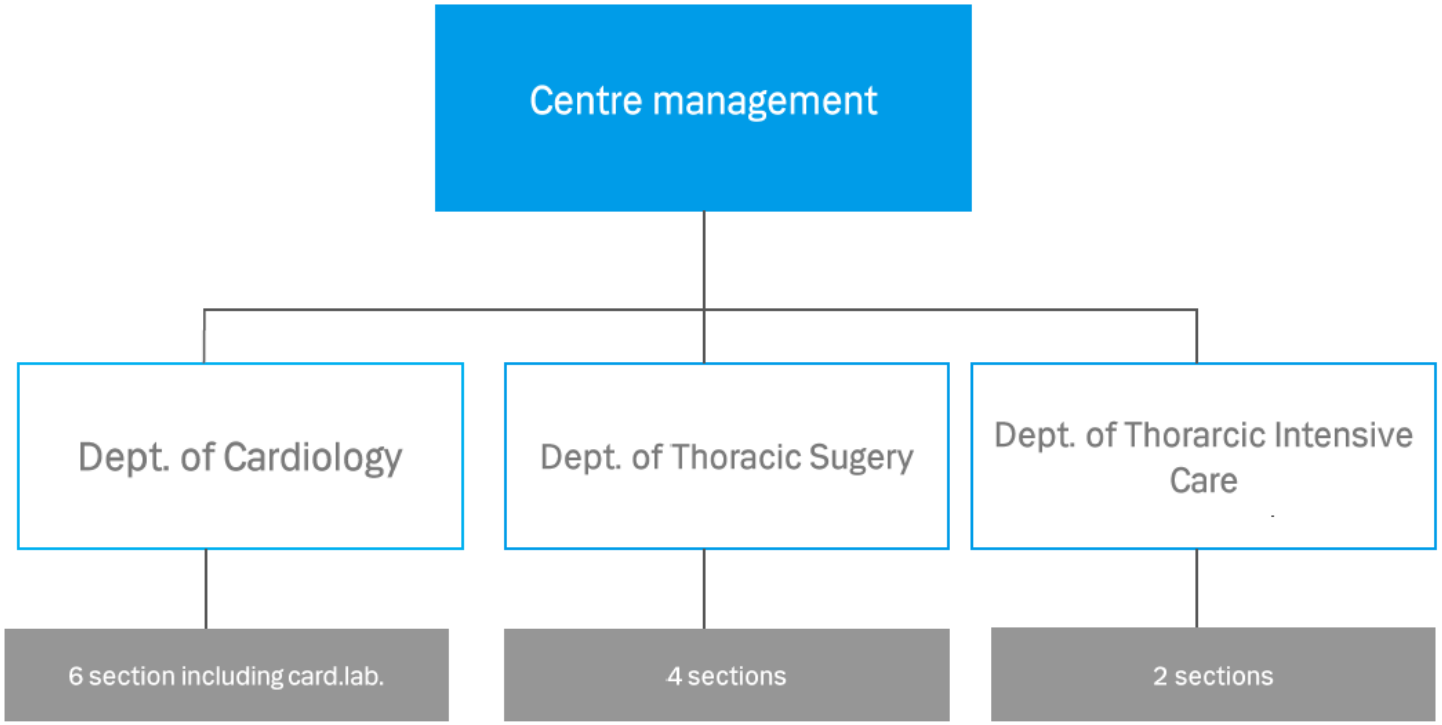
What is good hospital management?

The Heart Center – facts

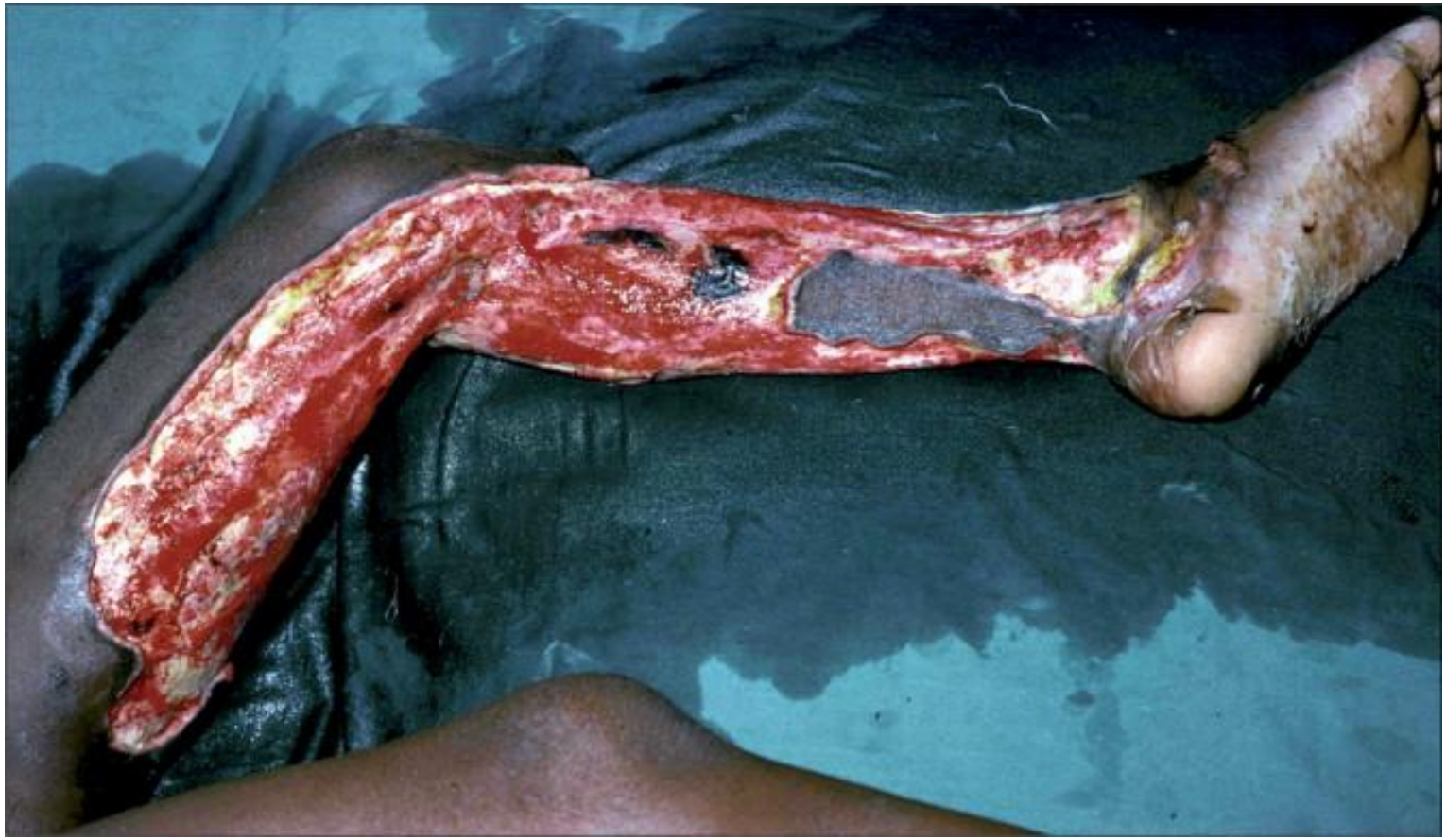


- 1 of 7 clinical centers at Rigshospitalet
- 3 departments
- 12 sections
- 166 surgical and medical beds
- 32 intensive beds
- 22.000 procedures p.a. (e.g. 1900 open heart surgeries)
- 1100 employees
- Operating budget: 110 mil. €

Why?

Why merge cardiology and cardiac surgery units?

If it ain’t broken – why fix it?

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”Every system i perfectly designed to get the results it gets”

Paul Batalden

My postulates:

- Departments (based on medical specialties) has traditionally been rewarded for optimizations in silos
  - Clinical results √
  - Waiting times √
  - Economy/Activity √

- This has in many case created a distrust between departments and to some extent made health care provision as a zero sum game…

- This culture affects our ability to professionally thrive and develop and it affects our current performance

Activity based financing being a contributing factor

Some of the drivers for re-thinking the structure:

- Patient pathways do not follow medical specialties and a patient centered focus will often be in conflict with a specialty focus
- Medical specialties have become more and more blurred and intertwined – also when it come to R&D

→ Medical specialties are loosing ground as the key organizing principle in hospital planning

→ Medical specialties are the key driver for professional development and sub-specialization will increase

Potential conflict

How do we challenge the specialties and silo-thinking without loosing all the good stuff?? Striking the right balance is difficult…and mistakes will be made.

What are the consequenses?

- A closer and far more obligating cooperation internally at The Heart Centre and with other hospitals…in the region and nationally
- An increased effort *before* treatment: Focus on shared decisions, and the patients' preferences and needs in choice of treatment – eg. TAVI vs. open heart surgery
  - Moving from "what's the matter" to "what matters to you"
- An increased focus on transitions *after* treatment: The patients' transition from Rigshospitalet's highly specialized function *to* the receiving hospital – sharing skills and an securing of the right care – our obligations have to expand to more than what goes on at Rigshospitalet
-

What are the consequenses II?

- Changes for the professions 1: Striking the right balance: The specialties can no longer be the only organizing principle in The Heart Centre, but must still be the heart and spine of what we do
- Changes for the professions 2: No specialty is ”an island” - The specialties needs to develop themselves in a much closer cooperation regarding the clinical work, research and quality improvement
    - Strategies and plans must be coordinated and agreed upon across The Heart Centre (focus on trust across departments and the common goal)
    - Prioritizing and re-allocating resources across the entire Centre becomes core task for leaders - as head of department you are not only an ambassador for your department….you is a part of the strategic management of The Heart Centre (a much more complicated management task)

Consequences for the organization and leadership?

- That we need to form an organization that supports a far more transverse flow and a far more individualized patient care
- That we recognize, that this development requires a shifting paradigme in the way we work as a leadership team, and requires a set of new leadership skills.
- Re-thinking the organizational framework. Leadership is crucial - working hand-in-hand as we move towards ”The New Heart Centre”.

→ we initiated a leadership program with focus on the common goal of the heart centre and a focus on “diffuse reciprocity”

Moving from specific reciprocity to diffuse reciprocity

Specific reciprocity:

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Uncertainty
Doubts
Perception of risks
Lack of information
Lack of trust

Eg: Buying a house

Diffus reciprocitet:

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Trust
Common handling of risks
High level of shared information
Relations and common obligations

Eg: Traveling with friends

Towards a New Heart Centre

- Large amount of patients with the same diseases but the pathways are very different (depending on the type of intervention)
- Need of organizational changes to facilitate more cooperation across specialties to increase quality of treatment, improve consistency and avoid many transitions in the patient pathways
  - Organizational change as a ”driver” for professional change

Two important organisational initiatives we are currently implementing

- *Focusing on ischeamic heart diseases and valve diseases*

1. Diagnostic work-up and visitation of patients:
    - Improved multidisciplinary and interdisciplinary cooperation
    - Better consideration of the patient's life situation and preferences in the choice of treatment (shared decision making)
2. Integration/merging of 2 cardiology and 2 surgical units treating patient with same heart diseases

The potential pitfalls

1. Lack of management focus on real integration of units – not just moving together…but integrating!

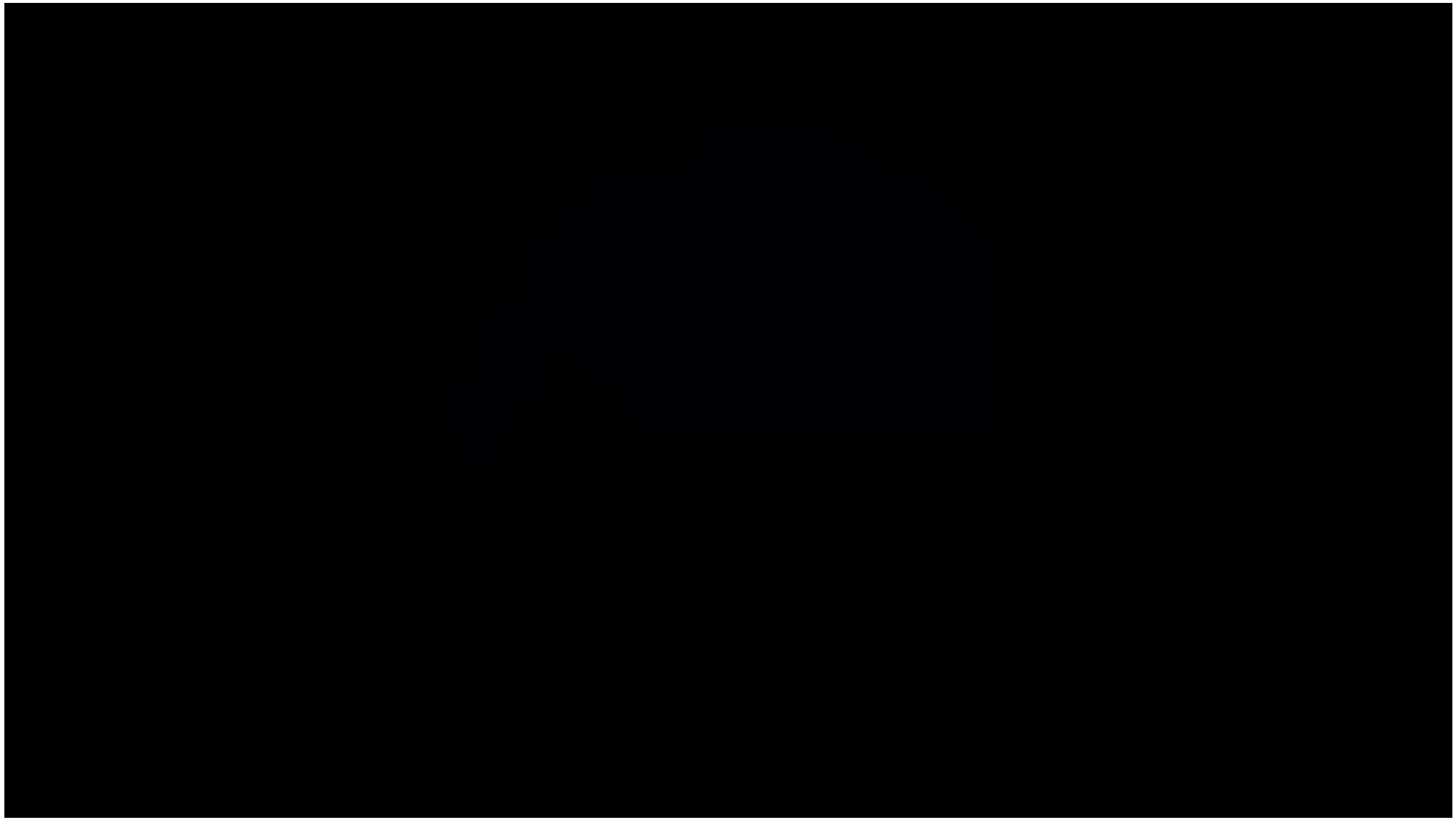
2. Will the surgeons do the rounds or just leave to the cardiologist? – it will have our attention..

3. Will we succeed in establishing a real interdisciplinary (learning) culture in treatment, development and research?

4. Attention to training of nurses in new tasks is a priority

5. Which patient has priority – “interdisciplinarity” does not mean “no discipline”

Rigshospitalet
The Heart Centre



Thank you!

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