

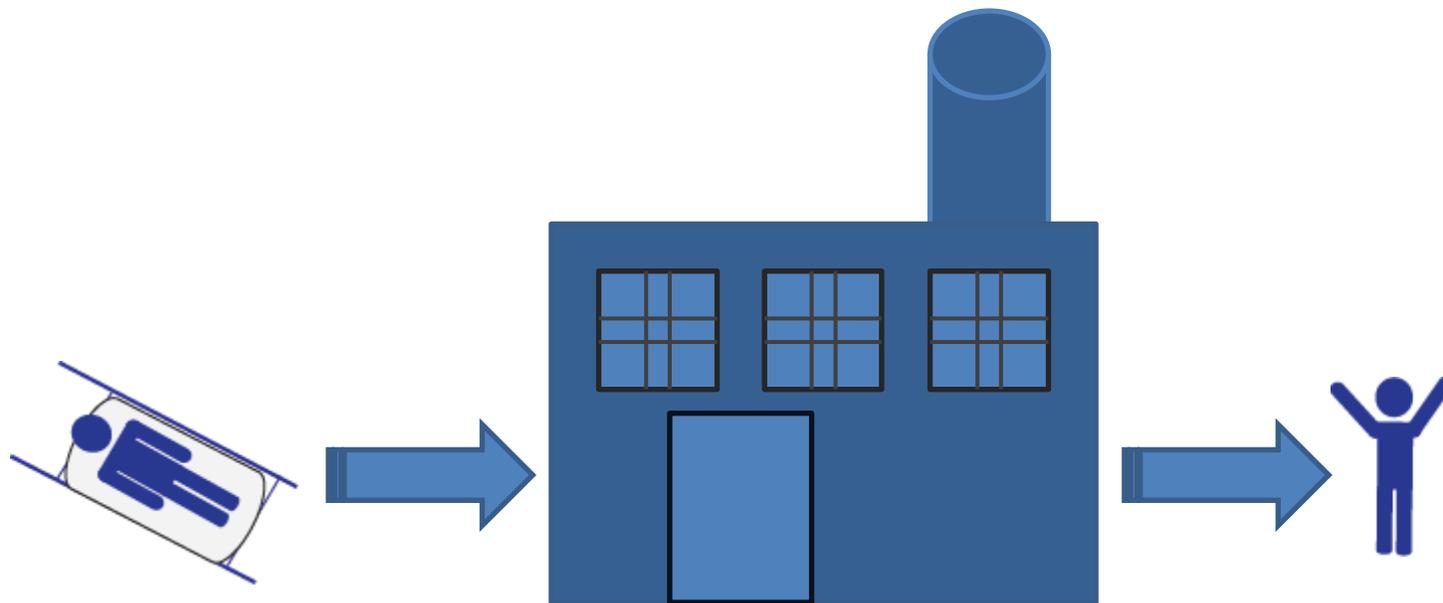
## Health Care as Social Practice: Utilizing the Social Sciences to Improve Hospital Performance

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A few years ago, I stayed three nights in a hospital after a scheduled surgical procedure. When the surgeon visited me, once, in the Intensive Care Unit, he told me that things had gone as expected and I should refrain from drinking from a straw. He did not sit down, he did not touch me, and as he completed his statement, he was visibly backing out of the room.

While among the most technologically advanced industries regarding diagnostic and treatment methodologies, the world of health care has been slow to change care delivery practices. A prevailing “factory” model for care delivery assumes a linear process.



This model is not optimal in today's complex environment, particularly when the latest health care legislation has changed the landscape so drastically. Hospitals can no longer expect patients to enter the building, be treated using a standard care model, and leave healthy<sup>1</sup>.

Patients are not products and staff are not machinery. In response, a central tenant of VHA's

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<sup>1</sup> In addition to the expectation of leaving healthy, patients now expect to leave happy. The Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) survey measures hospitals' success in achieving patient satisfaction, and there will soon be a financial impact for underperforming organizations. See: <http://www.hcahponline.org/home.aspx>

model is that providing health care constitutes a social practice. Therefore, applied social sciences are especially appropriate to its study and its improvement. We understand that quantitative studies are essential, there are many measures that hospitals must track and publicly report, but in order to understand how care is delivered and how it can be improved, one should consider the social factors that are at work.

Approaching health care from a social science perspective presents a strategy that does not exist in the mindset of the majority of traditional caregivers. In a colleague's recent conversation with a physician, he noted that, in the past, medical schools taught students to get in the patient's room and get out as soon as possible. This physician's medical school training centered on the patient's immediate physical needs, because the factory model centers on efficiency. This efficient and highly focused approach logically sounds like a good idea. A patient comes in, caregivers perform repairs according to strict standards and protocols, and the patient leaves. Everyone has tasks that they have been trained to do and they carry these out the same way every time. Or at least that is the idea, and until recently, it was considered an ideal way to provide care. Hospitals now talk about how they resist the idea of "making widgets." Instead "patient centered care" is the new standard. But how do you make the rapid switch from the assembly line to providing personalized care to individuals?

VHA is a cooperative founded in 1977 by a group of 30 Hospital CEOs who wanted to work together to tackle the problems of community-based, nonprofit healthcare facilities – at that time primarily by creating leverage to buy hospital supplies at a reduced cost. VHA exists to ensure the success of not-for-profit, community-based health care. Our mission today is to improve our member's clinical as well as economic performance. VHA currently serves more than 1,300 not-for-profit hospitals nationwide, and more than 24,000 non-acute health care organizations such as imaging centers, home health care agencies, and pharmacies. There are 14 regional offices covering 47 states, as well as an office in Washington, D.C. VHA brings its members tremendous purchasing power and non-staff related cost-cutting methods, delivering more than \$1 billion in value and savings in 2010. VHA also advocates for responsible

healthcare reform and works toward exerting positive political influence<sup>2</sup>. Additionally, the networking that VHA makes possible creates an alliance of hospitals who share information about quality, safety, and patient satisfaction.

Returning to our discussion on the factory model, hospitals increasingly espouse the idea that “making widgets” is out and “patient centered care” is in. As an outsider, it initially sounds troubling that there even needs to be a discussion about who is at the center of care – if not the bleeding trauma victim, then who? However, hospital staff, nurses, and doctors are required to complete a tremendous number of tasks that do not directly relate to patients, and they have to document almost all of these. A common mantra in hospital Quality Improvement departments is, “if you didn’t document it, it didn’t happen.” This applies to everything from attending a computer moderated training session, to administering medication, to washing your hands. This not only puts tasks in the way of patient care, but leads to a significant level of job dissatisfaction among people who want to work with - people. A reawakening in the early 2000s began to move caregivers back to the bedside. Initiatives such as Creative Health Management’s “Relationship-Based Care” program<sup>3</sup> and VHA’s own “RetuRN to Care<sup>4</sup>” are popular.

Despite these gains in framing, in times of stress people tend to go back to what they know. Groups of people, or organizations, are no different. What hospitals currently “know” is that health care delivery is a process, which brings us right back to the factory model. When someone in the industry discovers a successful process, the logical next step in this framework is to outline this process and have all the other hospitals follow it, sometimes by mandate. VHA has created a unique tool for hospitals that are underperforming on key indicators, as outlined

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<sup>2</sup> See: Becker, Cinda. 29 April 2002. “VHA touts value for money; Cooperative faces questioning from Senate panel.” *Modern Healthcare*.

<sup>3</sup> See: Koloroutis, Mary; Marie Manthey; Jayne Felgen; Colleen Person; Leah Kinnaird; Donna Wright and Sharon Dingman. 30 June 2004. *Relationship-Based Care: A Model for Transforming Practice*. Creative Health Care Management; 1 edition.

<sup>4</sup> The capitalized RN in RetuRN refers to registered nurses.

by various governmental agencies<sup>5</sup>, to use as a blueprint for their own performance improvement initiatives. These are icon-based diagrams, accompanied by descriptive text, that outline a leading performer's successful practice. Presented on our web-based VHA IMPERATIV™ portal, these Leading Practice Blueprints® contain mixed-media, using pictographs to form a type of enhanced flowchart that shows who does what, where, and in what order combined with a dynamic (being brought up when clicking on various parts of the visual) written text that refers the reader to relevant supplementary materials. The use of pictographs, or icons, makes the story more concrete by implementing a visual language. Spatial arrangement communicates information about time, place, and relationship. Arrows contribute to sequence and the direction of flow. The "picture" we draw is a visual record, which the written text supports. Richness is conveyed through the accompanying materials, which include quotes from practitioners, video and audio clips, photographs, and copies of the tools used (such as the checklist used in a medication reconciliation process). In a way, after reading the text and perusing the supplementary materials, the visual becomes a quick reference for the story. These Blueprints are not process maps: they seek to tell a tale. Let us discuss briefly why VHA documents practices and not processes.

Our work in this area draws largely from John Seely Brown and Paul Duguid, who co-authored *The Social Life of Information*. I find it is anthropological in perspective. A process, according to Brown and Duguid, represents linear steps, such as A leading to B, resulting in C. It tends to look at things from the outside and presents a longitudinal view, meaning not the view held by people doing the job together but a distance-based view of one person who hands it down to the next and so on down a single line. There is no internal representation and there are no side-to-side links represented. Practice, on the other hand, is "the activity involved in getting work done." It looks from within, with a lateral perspective. This entails the peer group, or the fellow

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<sup>5</sup> For example, the Centers for Medicare & Medicaid Services (CMS) upholds the standards set forth by the Surgical Care Improvement Project (SCIP) and requires hospitals to track how frequently they use anti-clotting precautions for surgery patients. See: <https://www.cms.gov/QualityInitiativesGenInfo/> and [http://www.cfmc.org/hospital/hospital\\_scip.htm](http://www.cfmc.org/hospital/hospital_scip.htm)

practitioners. This of course connects to the popular concept of “communities of practice,” as described by Jean Lave and Etienne Wenger in their work on *Situated Learning*, 1993.

Figure 1:  
Process – Linear/Longitudinal

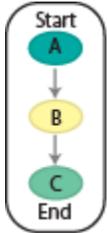
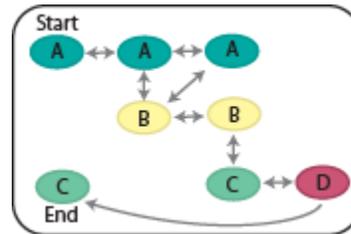


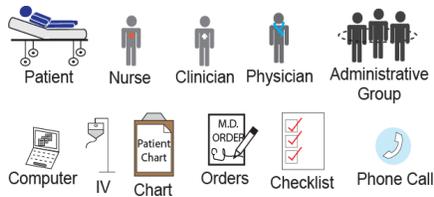
Figure 2:  
Practice - Lateral



I have a simple, work-in-progress, graphic interpretation of Brown and Duguid’s concept, shown above. In the linear process, we have a clear indication of our steps progressing in order: A, B, and C. With the lateral practice we have multiple characters at each stage, communication moving in all directions, the introduction of the peripheral D, and then eventually reaching the same C from the first figure. We strayed quite a bit outside our single line, even though we are still looking at something that starts with A and ends with C.

To get the perspective of a leading performer’s practice, we begin with an hour-long group interview with both leaders and bedside caregivers combined, where we talk about what it is like to work in the hospital and how they got started on improving their performance in general. We then engage the practitioners in a two-hour long co-creation session. The co-creation session facilitator asks questions while trying to let the story evolve. The practitioners help place graphic icons on poster board so that the visual representation of their practice gradually forms. Re-usable stickers allow the group to move icons around in successive iterations. If applicable, we take a tour after co-creation, to get a better feel for what happens, observe demonstrations, and collect photographs and tools. We take all of the information with us for processing and final modeling, and then we send it back to the hospital for internal validation.

Figure 3:  
Icon Stickers



Aside from documenting the clinical practice of a leading performer, we also appreciate that cultural factors play a huge role in success. As Loizos Heracleous explains, “an organization’s cultural assumptions develop historically, underpin values and beliefs, and have subtle but nevertheless pervasive effects on organizational actors’ interpretations and actions, as well as on organizational arrangements” (2001). The team teases these cultural assumptions out during our first hour, and continues to collect “nuggets” as they we reveal them throughout the day. Our blueprinting process has grown since 2007, and we now complete two distinct Blueprints for each leading practice; one focuses on the clinical practice, while the other highlights the cultural distinctions of the hospital. When we introduce these two different Blueprints to hospitals, we commonly say that the practice is *what* they do, while the culture is *how* they do it. The cultural distinctions might include key relationships, sustainability measures, and the hierarchical structure of management, although the components that go into a culture Blueprint are different for every leading practice and for every hospital.

I noted that the old model of health care involved finding out who did it best and then telling everyone to do it that way. Blueprints seek to avoid this first by presenting a practice rather than a process; flow moves in several directions, which allows for the introduction of variables. Beyond that however, the Blueprints reject the idea of the commonly touted “Best Practices,” which implies that there is one preferred way of doing something. Instead, for each indicator we offer Blueprints from several different hospitals that have demonstrated “Leading Practices.” There is never one right way to do something. Underperforming hospitals are given the opportunity to choose among the leading practice Blueprints in full or among their parts. They can mix and match components as they see fit, in order to find a practice that works in their context.

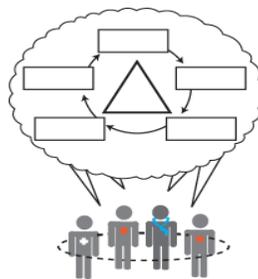
This work has been evolving for almost four years, and we have begun to look at the question of what does Blueprinting really do? We identify leading performers, document and visually model their clinical practice and their culture, and then distribute that to our members. Our goal is to support VHA's mission, which I noted as improving the clinical and economic success of not-for-profit health care. We have come to realize that our medium for accomplishing this is knowledge transfer.

Information is easily packaged, and can be helpful in viewing a straightforward process. If you want to make an origami swan, you can find that in an origami book and teach yourself. If you want to be an origami master, that is something different. It requires an understanding of paper types and textures, of how shapes combine, of the complex geometry created by folding, and of myriad other topics that I am not aware of. It takes knowledge. Just as a practice requires a practitioner, knowledge, as Brown and Duguid point out, requires a knower. Information on the other hand is self-sufficient. With knowledge and knowledge transfer the challenge becomes, how do we insert a knower into our Blueprints and the other services we are currently growing? We are answering that with stories.

Figure 4:  
Packaged Information



Figure 5:  
Knowledge Resides in Knowers



Daniel Pink, author of *A Whole New Mind*, talks about stories as being “context enriched by emotion” (p.103). Pink, a business and economic consultant and former White House speechwriter, points out that story is more memorable than fact, and was for millennia the human way of communicating important information. Of course, story still fills this role, but professional situations downplay its value. Let us look at an example. I will first give you a fact, and then tell you a story. Fact: A 2007 report in *Emerging Infectious Diseases*, a publication of

the Centers for Disease Control and Prevention (CDC), estimated that the number of *Methicillin-resistant Staphylococcus aureus* (MRSA) infections treated in hospitals doubled nationwide between 1999 and 2005, from approximately 127,000 to 278,000, while during the same time period deaths increased from 11,000 to more than 17,000. Now the story: In 2005, a hospital admitted an infant suffering with respiratory problems as a transfer from another facility. The admitting hospital did not screen the new patient for MRSA. The child ultimately died of a MRSA infection. Not only was that tragic, but he infected eighteen other infants in the nursery, and two of those died as well. Which of these communications more strongly indicates the need for routine MRSA screening? Incidentally, that hospital is now a national leading performer in reducing rates of hospital-acquired MRSA infection.

Qualitative methods have proven essential to the creation of our Leading Practice Blueprints. Our blueprinting team uses ethnographic methods and an anthropological perspective to view a number of cultural factors, in effect viewing the hospital as a tribe. We tease out its hierarchy, customs, rituals, myths, language, initiation rites, artifacts, etc. At times, the tribe's region and neighboring tribes make an impact. By necessity we complete the research stage of our work quickly. There is, however, supporting evidence that ethnographic methods, while traditionally used in lengthy and thorough projects, can be successfully used when time is a commodity which cannot be extended. In his paper on "Commando Research," Stephen Schensul demonstrates that even very rapid assessment can be insightful (1978). Schensul successfully used observations and interviews conducted over about 45 minutes on a single day simultaneously by teams in several locations to understand why English as a Second Language programs were faltering. The length of time spent in the field greatly depends on what the research community will tolerate. Early on in my work with VHA, I brought up the fact that I was uncomfortable with our department's claims of undertaking "extensive observations." A colleague pointed out to me that, for this community, allowing outsiders to come into the hospital and watch people for an entire day was in fact extensive. I had been a bad anthropologist, and fallen into the trap of ignoring the emic perspective. Right now, our

research community will not tolerate what it perceives as outsiders wandering around watching and asking questions for weeks at a time.

I contrast this with a Rapid Assessment study presented at the SfAA meetings in 2009 by Lynn Deitrick of Lehigh Valley Hospital & Health Network. She and her colleagues spent four weeks undertaking ethnographic observations, staff discussions, technical noise meter readings, photographing, and spatial mapping in order to understand the source and reason for unacceptable noise levels in the hospital. However, this was at the specific request of the hospital, with which she had an established working relationship. She and her team were not comprised of outsiders and the hospital administration, not the project team, had initiated the research endeavor. This made their continued presence more acceptable. On a note of similarity with our own practices, Deitrick notes that for Rapid Assessment to be effective the composition of the team is important. Our own mix of specialists in anthropology, design, engineering, and clinical practice allows for a careful balance of formal knowledge and trade know-how.

Our method of approaching health care as a social practice comes into the field in a time of struggle and uncertainty. The economic downturn pressures hospitals and other acute care centers to work both efficiently and effectively. However, the old factory model of standardization and process compliance falls far short in solving the problems facing healthcare today. Bringing in ethnographic methods allows our network of organizations to help each other make meaningful and productive changes.

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