

## From Chaos to Quality Care: Selections from an Interview with Dr. Jack Kitts

Brian Golden in conversation with Dr. Jack Kitts

To read the article by Linda Hunter et al. (see page 32), it is easy to think that The Ottawa Hospital is doing everything by the rules. Developing a multi-year quality plan calls for that. But behind every plan there is a more colourful history not always told. We wanted to offer some of that colour and asked Brian Golden to talk about it with Dr. Jack Kitts, president and CEO of the hospital. Early in the planning cycle Dr. Kitts declared that the hospital's goal is to be in the top 10% in North America measured by quality and patient safety. A bold objective. For that reason we are featuring Dr. Kitts and his hospital in this issue of *Healthcare Quarterly* and inviting their team to provide quarterly updates so we can learn along with them.

**BG:** Declaring that you're going to focus on quality is a bit odd in a way, unless we believe The Ottawa Hospital in the past didn't care about quality. Why now, and what's different about this focus on quality?

**JK:** I have to start with when I came on the scene. If I take you back to April 1, 1998, the Health Services Restructuring Commission in Ontario had forced a number of mergers and closures of Ontario hospitals. And so April 1, 1998, was the official day that The Ottawa Hospital came into existence. It was a forced merger, as I think most were at the time, between the General, the Civic, the Riverside and the Grace Hospitals and programs like the Cancer Centre.

The Ottawa Hospital was born with a lot of controversy, a lot of hostility, a lot of community rebellion, negative press and more. The whole thing became a media circus as a number of hospitals – both academic and community – were forced together, didn't want to be together and did so with little preparation.

Over the course of the next three years, the hospital rolled up the largest debt of any hospital in the country. There were serious concerns about staff morale and increasing concerns about the quality of patient care.



During the long weekend of July 2001, the provincial government of the day fired the hospital board and appointed a supervisor who in turn fired the chief executive officer (CEO). By October 2001, we had serious concerns about finances, the quality of care and morale and the fact that there was no board or CEO. Now you have to remember that back then this was kind of unheard of. Since then, we've become acclimatized to coaches and supervisors and things like that; but at that time it was really the first of its kind. Hamilton followed shortly after. It was a very uncertain, chaotic time in the history of The Ottawa Hospital.

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To make a long story short, the supervisor asked me, vice-president of medical affairs at the time, to be an acting CEO while they did a national search. My job as acting CEO was really to try and gain the confidence of the staff, including the medical staff. I think that's why he picked a physician in terms of hanging in there while we tried to right the ship with a new board and a new CEO.

Over the course of the four months that I was acting CEO, we began to put together a recovery plan to try to reduce or minimize the deficit and not add to the debt. By February 2002, things started to go a little better; we seemed to improve and to have a plan or some direction. By November, they had appointed me as the permanent CEO and installed a new board of governors.

Now you have to understand that back on that Saturday of a long weekend in July, these new board members had seen a lot of their friends and colleagues pictured on the front page of the *Ottawa Citizen* with a big "Fired" sign above them. As a result, they came in highly motivated not to end up in that same predicament. So they really studied governance, and they studied governance very well. They came in with the notion that the hospital needed strong financial stewardship but also quality of care stewardship and a strategic direction. I was a brand new CEO and they were a brand new board. Board members had no question in their mind that quality was a major concern for them, along with finances and strategy.

At my first evaluation, I was the CEO and the chief of staff was Chris Carruthers – a great chief of staff. The board, as part of their good governance, decided that the CEO and the chief of staff would have to submit performance plans to improve quality and finances and human resources and morale and so forth. Then they would do an annual evaluation and determine a certain amount of our pay to be performance pay or pay at risk.

So I felt pretty good about the hospital going in for my first evaluation with the executive committee of the board. The

board chair said to me, "Does this hospital provide high-quality patient care?" I said, without hesitation, "Absolutely, absolutely we do now." He asked, "How do you know?" I couldn't answer. I said the usual – because we've got good doctors, we've got good nurses, everybody means well, everybody's focused on the patient, etc., etc., and he said, "No, how do you know?" And I finally had to say, "I don't." It was then that I felt very sheepish and was thinking that we didn't even know. This was 2002. The board said to me that as part of my performance the next year, they wanted me to develop a Quality Plan and submit it by April 1. "We have to approve it, and then we'll monitor it and give you performance pay based on your Quality Plan and how well you've achieved it." I said, "Okay, no problem."

Wendy Nicklin, who is now the CEO of Accreditation Canada, was responsible for quality, and Tena McClellan was the director of quality. They were on top of their game – as recognized by invitations to present at the Ontario Hospital Association. They knew quality. So I said to them, "Let's have a Quality Plan."

The first thing we did was we spend three months with the board's Quality Committee trying to define what we meant by *quality* and coming up with the usual variations of a definition of "the right treatment, at the right time, for the right patient." Wendy and Tena went off to write the Quality Plan that I would present proudly to the board, and we'd all live happily ever after.

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In January, the team gave me close to a final draft of the Quality Plan. It was excellent. It was about 35 pages, and it was tremendous. It had all of the right processes and buzzwords. It was really a very good read at the time, and I felt very proud. I gave it to the board. About a week later, the board sent it back saying that it was not a plan but – at best – a primer on what quality is. I don't know how many quality plans you've seen or would have seen back then, but everybody had the "Quality Primer." It was sort of a statement of what quality ought to be. And that wasn't acceptable. This was now early 2003 and I was saying, "Guys, a Quality Plan has a strategic goal, it has tactics, it has investments, it has timelines, it has targets and it has outcomes. The board wants an action-oriented outcome-based plan." I said to Wendy – actually it's ironic, she's the CEO of Accreditation Canada now and at the time was the board chair of Accreditation Canada – and I said, "Wendy, Accreditation Canada has accredited thousands of hospitals across the country. Can you find somebody with a Quality Plan? We'll tweak it, fix it up, make it work for The Ottawa Hospital and we'll be done with it."

No one had one.

So I was in a bit of a state. We had to create a Quality Plan. Remember our definition of quality; you can't measure that definition in any way, shape or form. It's not tangible.

Now at the time, Chris Carruthers was at a meeting in Arizona. He phoned me and said, "Jack, I think I know what quality is." I'm not sure if he was at an Institute for Healthcare Improvement meeting or not, but he said, "Quality has four parameters: access, appropriateness, safety and satisfaction. If you take those as your quality framework, you can create tactics, targets and outcomes, make investments to improve access and improve appropriateness. Now *appropriateness* is defined as effective and efficient. If you can measure access and wait times, you can measure effectiveness, you can measure efficiency, you can measure safety and you can measure satisfaction. With this, The Ottawa Hospital can improve the quality of care and actually be able to measure the outcomes."

**BG:** In order to talk about improving, you have to know where you are at present. I imagine The Ottawa Hospital, like most organizations, didn't have a very good sense of where it was at that time.

**JK:** Exactly. The first thing we looked at was access. Our first action item was to create a wait time information system. This was before Alan Hudson's time on this file. We couldn't tell you what our baseline was and we couldn't tell you what our current level was, so we couldn't tell you what our target was until we were able to measure wait times. That was our first action item under our first Quality Plan in 2002 – to actually find a way to measure wait times.

We were going to implement the Saskatchewan wait time system that they were putting out, and then Ontario came along and had a different one already worked out – predating the wait time information systems.

Under effectiveness, the only thing we could think of was the readmission rates that Canadian Institute for Health Information (CIHI) usually published about 18 months or two years after the fact. Under efficiency, we looked at cost per waited case – actual versus expected. We looked at saveable days, the usual things, but again the CIHI data were 18 months old if not two years old. Under safety, things had started coming out about nosocomial infections – you can see where we're going. Then satisfaction. We started doing patient satisfaction surveys before it became a provincial mandate.

So that's how it came about. A very informed and motivated board of governors, a CEO who had no past history or baggage to say this is the way we do it here, and a very committed team to help us come up with that and succeed.

**BG:** That's helpful because one thing I want to talk about is the role of the CEO in all of this, because the article, in fact, doesn't

mention the CEO, with the exception of two sentences. What I want to talk about now is how you've engaged the clinical staff and in particular your non-employed physicians who believe, in many cases rightly, that they're providing high-quality care. Any time you engage in a quality initiative, you're implying, "We're not doing as well as we could." How have you engaged the staff in a way that hasn't made them defensive?

**JK:** The first thing I did was add eight department heads to my senior management team. I don't know why it wasn't 12, because that would have been the Medical Advisory Committee (MAC), but I added eight department heads. It was based on, obviously, the four: I added medicine, surgery, obstetrics/gynecology and mental health right off the bat. We have a huge mental health problem, so I added those four.

Anaesthesia was a big concern on the wait time strategy and shortages. Diagnostic imaging was a big concern for me in a merged organization with no information systems. Family practice was ready to walk out and revolt, so I added Shaun McGuire [medical director, medical affairs, at the Ottawa Hospital]. Then I added emergency and critical care.

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Probably the best thing I ever did was to get physicians around the table. You can imagine back then there was a great divide between administrators and physicians. Administrators were concerned that physician self-interest would ruin the whole team dynamics. They would be representing themselves and not the hospital, and what if we came to a vote? What would happen then? None of that came to fruition. What it did was to really engage the physicians in the overall corporate challenges and opportunities. Honestly, I don't see people feathering their nest or protecting their turf. Their comments are very corporate – good for the whole. None of the worst fears have ever come to pass. The first thing was get them engaged – bring them into the tent.

The second thing. At that time, you may recall, there had been a few publications in the United States about people being killed in hospitals with a frequency equivalent to a 747 plane crashing once a week. I kind of looked at that and thought that was crazy. I didn't want to go to the States; I was glad I was in Canada. Then the *CMAJ* published an article, I think it was an editorial and maybe based on a study, in 2004. This was around the time we were restructuring, and basically what I garnered from the article was that one in 13 patients in our hospitals has an adverse event.

**To read the full interview please go to [www.longwoods.com/content/22342](http://www.longwoods.com/content/22342).**

**BG: Yes. We're no better or worse than the United States and many other developed countries.**

**JK:** And 30–40% of them are preventable adverse events; 10,000–24,000 die each year in Canadian hospitals from a preventable adverse event. If you repeat that and you believe that – and there have been lots of publications since then to substantiate it, not the least of which is Ross Baker's publication – you have to wonder why we are so complacent about it. Why is nobody losing sleep about patients dying in their hospital from preventable adverse events? That's when it sort of struck me that it's all about the culture. We can have the best Quality Plan, we can have the best strategies, the best tactics, we can do the whole thing, but if we don't change the culture, we're not going to move the yardsticks. I think the whole hand hygiene crusade since then has proven that. You can't improve your hand hygiene rates unless you go back and try to understand the culture.

**BG: What are the levers that an executive team and a CEO have to change culture?**

**JK:** I think the number one thing is to go back to the basics and make everybody understand your mission, vision and values. That's the cornerstone of the entire culture. It has to be a culture committed to your mission. We are an academic health sciences centre, but I want to keep it really simple. I say our mission is to care for patients. Period. Full stop. The patient is everything in this hospital – that's our mission. And no matter where you work, when you walk through the doors of the hospital, your mission is to make sure the patient is the centre of your universe.

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**BG: Okay, but 150 other hospital CEOs in Ontario will say exactly the same thing. How do you make it believable and show that it's not just a slogan from the CEO?**

**JK:** Well, I think you carve your vision. Our vision is to ensure that every patient is treated exactly like you would treat a loved one. You can see that there's not much about academic innovation, research and education. We are an academic health sciences centre, don't forget. Look at the mission and vision statements of academic health sciences centres; they are all the same. It's tripartite – it's patient care, education and research. The vision is always about academic excellence. I've noticed that we are very provider-centric. It's not about the patient. It's very much about the providers. I'm being a little bit controversial here, but you watch the discussions and see how processes are set up – it's very much provider-centred. I know you can't discount the provider, but it isn't based on the patient's needs to

the greatest extent. It is a culture that basically is different. We've talked about the patient-centred approach since we graduated from medical school and even before, but it really isn't when you actually peel back the onion. It's a lot about providers but not just providers at the bedside; it's also about administrators running the hospital.

If we don't work generally after 4 o'clock and we don't work on weekends and we take all our holidays and we just kind of ...

**BG: You start to look like a bank of yesteryear.**

**JK:** I think we've got a long way to go to be more patient-centred than provider-centred. I don't mind saying that. I think we've got a long way to go to actually "walk the talk" on patient-centredness as opposed to saying, yes, of course it's patient-centred. Let's show it. I don't believe anymore that health professionals are too busy to actually take the time to communicate and treat patients with compassion and respect.

**BG: Let me talk a little bit less about the carrot and a little bit about the stick. All of your colleagues would say patients are critical. They would say patients are central to what they do and are the reason why they do it. What are the consequences – for providers and staff – of not putting the patients first or in the centre?**

**JK:** You saw in the accompanying article a paper referred to by Mark Keroack at University HealthSystem Consortium and some of his colleagues. Do you know anything about that group?

**BG: Yes, but say more.**

**JK:** Mark Keroack is a doctor who is the chief medical officer of this consortium. The consortium was, at the time, 79 academic health science centres. Now it's 110. In the early and mid-1990s, they came together as a few big academic centres in the United States for purchasing power – to get better prices on purchasing equipment and supplies. Over the next few years, they developed a database much like our CIHI database and decided that they were going to actually compare each other and benchmark each other on quality and safety of care and operational efficiency. They've been at this for about 15 years, and they've got quite a database of quality, safety and efficiency measures not unlike those at CIHI – all the ones that you would know here. The difference between them and CIHI is their data. They come out every quarter – every three months. You can argue about whether the performance measures in aggregate are truly reflective at the individual patient level, but they're the best thing I know of in terms of actually measuring and benchmarking data and performance measures. It's not all highly reflective and accurate and stuff. In the hospital standardized mortality rate you can argue that, but at least it's something and it's timely.

About a year and a half ago, I got interested in this and asked 10 of my colleagues from across the country to join

me – CEOs from the big academic centres. I got Vancouver Coastal, Alberta Health, Saskatoon Regional Health Authority, Winnipeg, McGill and University Hospital Network and St. Michael's in Ontario.

**BG: Yes, I'm part of the group of researchers working with these organizations. We are all very excited about the possibilities of forming this kind of partnership among like-minded leaders.**

**JK:** Oh, that's exactly it. Basically, this could be a Canadian part of the consortium. Anyway, I've been down to Chicago since then and looked at how they work and what they're doing, and I think it's impressive and may actually allow us to measure and benchmark and improve quality.

In the absence of performance measures, Brian, I don't think there are a carrot and a stick; because the practice of medicine today, contrary to popular belief, is still very much an art. If you take five physicians in the same field and you go to them with a problem, there will probably be five different approaches, particularly if it's not a common problem, and five different ways of treating it; and everybody is basing their work on experience or, at best, expert consensus. There's not a lot of evidence-based science to guide our practice, and that's why I say it's still more art than science.

I can't go up to eight orthopedic surgeons and tell them which technique and which prosthesis and which antibiotics give them the best outcomes at the least cost. I can't do that. Until we can do that, medicine will still be very much an art. Once we can do that, however, with performance measures that actually reflect outcomes and costs at the individual patient level, we won't need any carrot or stick because physicians by nature are very competitive. If you can show them that their results are not as good as their colleagues' results, they will improve upon them. You won't need a carrot or a stick; just show them the results. But it can't be 18 months to two years old, and it can't be an aggregate that is really not reflective of what their practice is today. We have to chase that Holy Grail; that is, be able to measure performance on both quality outcomes and costs at the individual patient and provider levels.

**BG: And then feed it back to those who can affect it.**

**JK:** Exactly.

**BG: Just a couple more questions for you. You're into the second year of the hospital plan at this point?**

**JK:** Yes. Actually what we've talked about – and that's why the CEO wasn't mentioned and the early phase wasn't mentioned in the article – is that the first 2003, 2004, 2005 and 2006 plans were all annual plans. They weren't multi-year strategic quality plans. They were annual quality work plans. We kept asking ourselves at the end of the year, "Well, if it's not done, don't we

just carry it over?" You know quality is difficult to complete. This article, however, talks about what we decided to do in 2008. I think this is a multi-year corporate quality plan. The first four or five were annual work plans. That's the difference. Jim Worthington [Dr. James Worthington, the vice-president of medical affairs, quality and patient safety at The Ottawa Hospital] and his team decided in 2007 to create a multi-year plan because annual work plans were becoming a little onerous and probably not as effective as a more strategic multi-year plan.

**BG: Two questions. What's been most challenging? And what's been most surprising?**

**JK:** I think the most surprising involved the notion that everybody comes to work every day to do exactly the best they can for the patient. Nobody comes to do any harm. What was surprising was the lack of awareness and acceptance of harm being done. It's sort of like we have a culture where we have to give informed consent. If you're told that you have a 1% chance of having a significant complication and it happens, everybody shrugs and says, "See? We told you." What's surprising is the notion that when a patient has an adverse event and is harmed, all the alarms and whistles don't go off. Am I making any sense?

**BG: You are, but say more about the cultural change that's needed.**

**JK:** It's basically the acceptance, I guess, the acceptance of an imperfect world and system. The biggest challenge is to change the culture from one where everybody believes that health professionals are being worked off their feet, are highly stressed and are not supported; therefore, patients should be happy to have the treatment, shouldn't worry about whether there is information and compassion to go with it, just be happy to be treated. I don't accept that anymore. And I say nobody in this hospital is too busy to be nice to the patients.

I think that was another challenge. How do we get over the fact that we are very busy, in a stressful environment and there are always too many priorities and other things? How do we get over the fact that we still have to find the time to make the patients feel like they're valued and their providers really, really care? Do you know what I mean?

**BG: Yes.**

**JK:** Patients and health professionals have accepted the fact that we don't need to be caring, nice and compassionate because we're so busy. I think that's a challenge – to say, we are very busy and there's no question we've chosen a profession where there will always be too many things to do, too many priorities, not enough time in the day and an inability to say no. That's the environment we work in; that's the environment we've chosen. *But we still have to be able to adapt to make sure that the patients feel that they are everything.*

**BG:** Well, what's amazing to me, as a bit of an outsider in this, is that there is virtually no patient or family who interacts with the system and thinks we're even close to being where we ought to be. There's an incredible asymmetry between those inside who think we're doing a pretty good job and so many who experience it and think, "My gosh, they just don't seem to care enough about us at all." I'm not talking about individual care givers, but the system they work in and the quality of the experience it produces.

**JK:** That's what I said. The most surprising thing is we seem to be unaware of what it's really like.

**BG:** And what is possible.

**JK:** And what is possible. We're a big place, as you know, and I think if you look at our vision to provide each patient with world-class care ... I tell the academics that world class is leading-edge research, leading education and exceptional service. Exceptional service, I tell them, is for all who don't actually touch a patient. Still treat patients like loved ones even if you're just transporting them from one place to another. Give them that extra warm blanket, and don't let them sit while you chat to one of your buddies. Provide exceptional service and compassion that we would want for a loved one. Pretty unorthodox for an academic centre to place the patients in the centre of the universe without the blatant academia, but I think it's time to get back to that. Put the patients at the centre of the universe – it isn't always so – and make sure that they feel like they are at the centre. Good research and good education will be on top of that.

**BG:** When we think about it, these academic centres are often the largest centres and have the most patients coming through. If you don't do it, it's not going to happen for a lot of people.

**JK:** Yes. There are the most patients there, and they're the most vulnerable. And, yes, it's good to get them in a clinical trial. Yes, it's good to give them leading-edge therapy and technology. But there's still a human part of it that has to continue to pay attention to put them at the centre of everything we do. **HQ**

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## Reference

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