LEADING IN TOUGH TIMES: A RESILIENCE PLAYBOOK

Summary of Proceedings | Resilience Roundtable 2022 and Virtual Conference 2023

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INTRODUCTION

We live in challenging times, often described as VUCA: Volatile, Uncertain, Complex, and Ambiguous. VUCA is the context in which we function in healthcare. Today's healthcare workforce is operating in an even more complex environment, heightened by COVID-19, as they continue to address labor shortages, economics and a fragile supply chain while working to create safety and optimal outcomes for those served. In this environment there are no simple or single solutions, yet the property of resilience continues to surface and deserves attention.

Resilience is the ability to respond productively and positively to immediate stressors and prolonged stressors, as we strive for excellence.

We are familiar with patient safety and quality improvement (PSQI) which uses established science/evidence and known and manageable variables. The aim is to stabilize processes and provide feedback in continuous learning-action cycles to reduce unintended variation and produce expected and better outcomes. In contrast, resilience is an emergent property and acknowledges the presence of unknown and unknowable variables. It is an adaptive science requiring plasticity, tolerance of uncertainty, discovery, innovation and feedback. Feedback may be distant in time and with disparate and conflicting signals and sources.

The New York Times on March 16, 2023 published a guest editorial by Atul Gawande entitled "The Aftermath of the Pandemic Requires as Much Focus as the Start." He reflects that because of the stressors of the pandemic, not only has life expectancy declined, improvements stalled or reversed, but the very infrastructure of healthcare has been decimated, beginning with the workforce. The pandemic resulted in higher death rates from the coronavirus, but also caused deaths by damaging healthcare more broadly. Gawande cautions that we are just beginning to see the effects. The challenge faced is not only a U.S. challenge, but a global call to action. The topic of leading in tough times has great relevance to what we are up against and how, in our spheres of influence, we might proceed.

What will it look like to build greater capacity and capabilities for individuals, teams, organizations and communities to predict and manage the unexpected? How can we both spring back from acute, immediate stressors and rebuild while confronting the chronic, prolonged stressors that compromise our fragile systems and expose gaps within these systems?

To explore this topic of resilience in healthcare, Cynosure Health hosted an experts' roundtable in October 2022, followed by a virtual conference in April 2023. This playbook captures the perspectives and insights of international experts in the fields of leadership and resilience who participated in these learnings. They are listed at the end of this document.

RESILIENCE BASICS

A working definition of resilience for this playbook is:

- Stretching without breaking
- Rapidly snapping back to usual or better performance
- Anticipating and building into the system the design to predict and mitigate the amount or impact of a stressor

There are two **types of resilience**, both required to successfully survive immediate and prolonged stressors (Edmondson, A).

1. **Psychological Resilience** is the ability of an individual or team to cope with a crisis mentally and emotionally, and to return to pre-crisis status quickly.
2. **Organizational Resilience** is the ability of an organization to anticipate, prepare for, respond and adapt to incremental change and sudden disruptions in order to survive and prosper.

Preconditions for resilience:

There are two preconditions for resilience: psychological safety and practices of high reliability.
Another precondition is the ability to think and respond creatively.

"Creativity is essential to resilience — it brings the new and unexpected ideas so necessary in times of disruption." –Tim Brown, Co-Chair, IDEO

Resilience to Immediate vs Prolonged Stressors

It is important to differentiate the two types of stressors, both of which can be present in healthcare at any given time.

Immediate Stressor – serious, unexpected, one-time, often dangerous emergency requiring immediate action (Edmondson, A.)

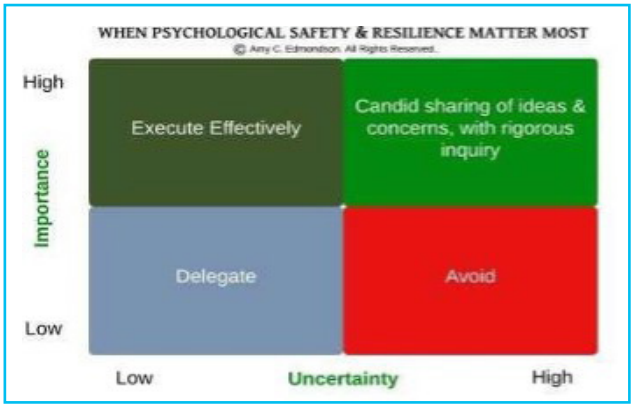
- Goal: limit immediate harm
- Stakes: obvious, clear and present danger(s)
- Timeframe: time-limited, short
- Psychological challenge: urgent fear, paralysis
- Risk tolerance: high
- Example: COVID-19 March 2020

Prolonged Stressor – ongoing period of intense difficulty, danger, or uncertainty (Edmondson, A.)

- Goal: enable sustained resilience
- Stakes: more subtle, unfold over time
- Timeframe: ongoing, long
- Psychological challenge: denial, disillusionment, burnout
- Risk Tolerance: medium
- Example: Today's post-COVID environment

Resilient organizations have 5 characteristics (Edmondson, A.)

- Aim high
- Team up
- Fail well
- Learn fast … then
- Repeat 1-4



LEADERSHIP MATTERS

Everyday leadership is defined as things one can do or say that positively influence people. Anyone can exercise leadership, but those in formal leadership positions have a greater responsibility to exercise leadership. Leadership is a noun and a verb. Yes, leadership can be learned. (It's a myth that leaders are "born" leaders.) The number one job of leaders is to build a culture. Organizational resilience depends on culture.

Leaders define, create, and sustain a culture of psychological safety, a landing strip for high reliability that is critical to resilience. They do this through:

- Teaming on the fly – with robust capacity to collaborate
- Joint problem-solving orientation – that is inclusive
- Capacity for frequent, rapid reflection – what are we learning?
- Transparency – broadly communicating alerts and learnings from failure and from what is working

Leaders demonstrate the following actions in tough times

- Facts: Emphasize what is the reality
- Hope: Emphasize a future in which we will prevail
- Other-orientation: Build resilience in individuals and team
  - Empathy – compassion with respect
  - Reinforce belief in the team
- Focus on the needs of the team — it's not about you, it's about them!
- Transparency: Keep the lines of communication open

What effective leaders do to create the conditions for organizational and individual resilience

- Go to Gemba to engage with frontline staff and understand technical work. Resilience is not created in conference rooms.
- Reduce the burden of work and remove barriers from workforce.
- Practice transparency (practical reality) about what we are up against.
- Be explicit about staffing/resource levels and the implications for care delivery with clinical staff and patients.
- Rethink the term "nonessential personnel" as it relates to bridging gaps in care and communications; and focus on "boundary-spanning" roles like social work, chaplaincy, child life and families.

Consider Use of the STICC tool

- *Situation* – What I think we face
- *Task* – What I think we need to accomplish or how we respond
- *Intent* – rationale for our response, the "why"
- *Concern* – what I'm looking out for, the risks, the unintended consequences
- *Calibration* – invite feedback; ask: Where are our gaps? What are we missing in the above?

Care for the Well-being of Workforce

- When considering leadership for individual and organizational resilience, the well-being and safety of the workforce cannot be underestimated as part of what it takes. This includes, but is not limited to, adequate supplies and PPE; security; frequent check-ins and communications that are carefully focused and curated to prevent overload; training and comprehensive wellness programs that are flexible and accessible; concrete assistance programs for childcare and dependent care; access to nutritional meals and snacks on site; recognition of recovery time in scheduling.
- Again, a culture of psychological safety creates a sense of meaning and belonging that is key to well-being, teaming and resilience.

CASE EXAMPLE

An example of leadership and resilience concepts in action:

You are at 70% of required staff to care for patients on your unit. What you can do/steps to take:

1. Be crystal clear in communication: tell the truth about what you're up against and develop a clear and agreed upon plan versus potential drift or random disintegration of care.
2. Resist the tendency to pretend everything is "okay." Pretending everything is okay adds burden to staff.
3. Establish shared goals. Explicitly determine what risks are worth taking, but periodically re-examine them to see if the situation/environment has changed and the risk is no longer acceptable.
4. Train, rehearse, simulate, and apply flexible leadership. In situations of escalating risk, the positional leaders defer to those on the ground with the most information and know-how. In clear and present danger, staff move into prescribed roles for which they have been trained and rehearsed; there is no time to negotiate roles. The person with the most expertise steps forward and assumes leadership.
5. Any team member can call for a standup huddle at any time during a shift if they feel they are becoming overwhelmed and drifting into unsafe practice. The clinical team, in real time, readjusts and redistributes workload/assignments to even out care. Leaders recognize the role of "nonessential" workers and their importance in indirect care and in supporting and buffering stress on clinical staff and patients.
6. Practice mindful rounding: risk assessments and situational awareness, real-time problem-solving and risk mitigation.
7. Engage in effective teaming with families and "boundary-spanning" disciplines to support and to buffer stress for patients and care staff.
8. Include patients as partners. Encourage them to speak up and speak out when they see subtle deteriorations in condition. They and their family members must understand the conditions in which staff are working and be part of the solutions.
9. Listen with empathy and kindness.

LANGUAGE MATTERS

Leading with inquiry

Examples of leadership responses to enhance resilience (e.g., during staffing shortage, computer interruption, sudden surge in volume, etc.):

- "We have never been here before and it is challenging. We need you. I have confidence and faith we can manage this together."
- "Speak up. What do you see? What do you think? Your ideas are important."
- Ask "What is going well? What is concerning you? What do you need?"
- Use "both/and" instead of "either/or" thinking to generate more options, identify gaps and develop strategies.
- "Who else needs to be included? Are all relevant perspectives present?" Relevance is defined by the circumstances.
- "What have we learned from this? What are we learning from this?"

PITFALLS TO AVOID

- "Abusive resilience": This describes workarounds and shortcuts that are rewarded in the service of productivity ("powering through" versus designing for safety in the circumstances we find ourselves in).
- Over-reliance on Incident Command Manuals. Mainly produced for accreditation or regulatory purposes, such manuals are often referred to as "Fantasy Documents." Most people who use them know that they will not do what you expect them to do in a crisis. There is no replacement for communication, teaming and judgment.
- Fantasy Documents, defined by Clarke, are formal plans which are not functional for coordinating actions to meet a crisis, but assert to others that the crisis can be controlled. The danger is they can provide false reassurance by outlining what people hope would happen if things go wrong.
- Lack of imagination in anticipating. Ask: What can go wrong? Could this happen here? Why or why not? What actions are required now to mitigate risks/threats?
- Failure to unleash the creativity of all persons to explore all the possible solutions.
- Failure to set a goal (e.g., giving the patient the best shot at an optimal outcome).
- Focusing on scarcity rather than abundance of/optimal use of resources and operations design. How do we capitalize on resources at hand or not yet recognized?
- Believing that resilience is the end in and of itself.
- Failure to recognize that the Fallacy of Composition and Fallacy of Division apply.
  - The Fallacy of Composition infers that something is true of the whole from the fact that it is true of one part of the whole. Example: Dr. Smith is a reliable surgeon at Excelsior Hospital. Therefore, all surgeons at Excelsior are reliable and there are reliable systems in the hospital's OR.
  - The Fallacy of Division occurs when one reasons that since something is true for the whole, it must also be true of all or some of its parts. Example: Excelsior Hospital has an excellent safety record. Therefore, every patient care unit, every department, every function, and every member of the workforce is uniformly safe.

- Assuming that all failure is negative. “Intelligent failure” is a positive tool and can lead to success. Intelligent failure:
  - Explores an opportunity
  - Is useful in novel territory
  - Is driven by a hypothesis
  - Keeps the cost and scope to test change and innovate as small as possible (just large enough to be informative and to recover from). (Edmondson, A.)
- Remaining isolated and rule-bound in approaching discontinuous circumstances. This results in brittle systems, which is the opposite of plasticity, a state that results from unleashing creative ideas, imagination and teaming.

RAPID-FIRE TAKEAWAYS

The following are some striking examples of wisdom shared by thought leaders at the Cynosure Health Resilience Roundtable and Virtual Conference to provoke further thinking, exploration and translation to practice.

- Develop the capacity to recognize hazards and risks early on when you spot them, identify early opportunities to mitigate and communicate broadly to frontline staff and management.
- You have to play the hand you are given. Don’t wait and wish for circumstances to change.
- Decision-making rests with those most knowledgeable and best able to manage, regardless of organizational hierarchy.
- If everyone in the organization does not understand the goals, there is no resilience to be had.
- Imagine, mentally rehearse and actually simulate conditions in which something can go wrong. What could go wrong as things change, and how will we address that?
- Use simulation for “system probing” to test how the system can actually respond to stimuli.
- Never use the word resilience as an endpoint; focus on the system, and what parts of the system allowed for this to happen.
- Culture binds (bounds) but it also blinds people.
- Goal of no mishaps forces the organization to explicitly determine what risks are worth taking and accepting. Focusing too much on error-avoidance makes people and systems brittle, when plasticity is needed.
- Resilience is the ability of an organization to follow a new route if unexpected things happen. What are the processes and sensors for early detection? 6
- Looking only at data means you are not getting the full story of what is happening.
- Every level has its own sharp-end outputs, but also its own blunt-end issues driving it: Everywhere, Everything, All At Once!
- Invest up front in training, support to staff, importing knowledge and tactics from other industries and healthcare settings, in order to improve performance; you will also improve resiliency. Investment in analytics improves prediction of probabilities of stressors that can arise.
- What do you do when it is clear that it is impossible to do what needs to be done? What is your process for determining the boundary of safe care (boundary of exceedency), rethinking workload and delivery of care?
- Resilient means “you never worry alone.”
- Always give the patient the best opportunity to have a good outcome, rather than focusing on harm.

CONCLUSION

Resiliency amidst stressors, in an environment of VUCA, has always been a need at both the individual and the organizational level. The COVID-19 crisis and ensuing societal upheaval further exacerbated the need for resiliency. It also raises the question of whether or not a single-minded pursuit of resilience is enough, or only one of the many transformational changes required by our healthcare system.

As human beings we have the power of imagination in the face of stressors. To unleash it, we need to overcome isolation and rigidity. Only then can we become resilient. Resilience is a choice, one that requires courage and creativity. This conference was designed to explore resilience as one of the changes we can make to improve patient care and our work environments. Equally important, it reminds us that we do have the power to choose.

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ADDENDUM

Resilience Strategy Questions

There are many thought-provoking questions that emerged for further reflection and study. Several of these are listed here to invite continuation of the topic of resilience.

1. Is there a difference between strategic plans and ongoing strategic thinking? How might that look?

2. Instead of the business mantra of "follow the money," could we design for the best possible healthcare outcomes and figure out how to fund it? Money could become the byproduct instead of the predominant driver.

3. Do we know what resilience is? Is it the same in all settings, cultures, people? What do you think of when the term is used? Is it an absolute state? Is the quest for resilience in itself a strategy?

4. What is the benefit of stating clear aims and understanding the associated risk?

5. What could be a silver lining in the pandemic? Do you think we learned some things?

6. Humility, curiosity, respect, kindness, optimism are recurring characteristics of leaders who can nurture and sustain cultures that are resilient. Can these be taught? How might we assign value to them in an industry that has rewarded "toughness" and "bottom line"?

7. Some argue that organizations need to address people's loneliness and basic well-being. People need to be working in teams where they feel supported and able to do the work. What is an organization's role in supporting basic well-being and sense of belonging? How do you see hospitals doing this effectively?

8. Especially in challenging and stressful circumstances, even the most committed and conscientious among us will at times fail to act in accordance with the cultural values and behaviors that we seek to promote. As leaders, what can we do when we fail? How can we help our staff when they fail?

9. Particularly in the current landscape, we observe a proliferation of new teams swiftly forming and disbanding. How can leaders tactically embark on establishing the desired culture within an environment characterized by constant change?

10. What strategies can organizations use to improve the flow of information, especially perspectives that are often not included, like those of patients and their family, caregivers and marginalized groups?

11. How do you balance the need to act quickly to respond to a threat with the time it takes to understand the true nature and implications of the threat?