Mark Masselli: This is conversations on healthcare. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well the campaign is finally over and the great news is President Obama has been reelected to his second four year term in a landslide on the Electoral College and over 50% of the popular vote really command in performance and the real referendum on the affordable care act, Margaret.

Margaret Flinter: I think so and you know many, this morning you're describing the campaign and retrospect is contentious and **nasty estiamba** you know I think that all kind of fades quickly into a distant memory, the reality is today is a new day just as it was four years ago, there's so much work to be done in the country. So congratulation to everybody who put themselves out there to campaign, congratulations to the winner, to the administration and I think it does both well for the future of health reform and the future of health and healthcare in this country and we're going to be focusing a lot on that.

Mark Masselli: We certainly are. You know we're celebrating about just a little past three years care for conversations and healthcare and certainly have been very focused it on the affordable care act and it's implementation across the country and the many states and we'll following those states as we move to the countdown clock will soon come up on our website you'll be seeing it, as we get very close to January 1st 2014. But I thought the President had hit a right core there about reaching over across the isle where the country has to come together not only in healthcare and many issues and this is a new day and hopefully everyone will take advantage of it.

Margaret Flinter: And while we are a little bit one note on the subject of healthcare on this show it is certainly true that there are many issues facing the country and we look forward to an active dialog on all of them. But you know, Mark, one of the things that he's amaze me for the last year or so is, how many states just sat on the sidelines of health reform waiting for the outcome of the election? But those states now if they've really got to make some decisions, they have to organize their health insurance exchanges or say Washington will let you do it for us and get the other initiatives organized to be prepared for those changes in 2014 when we look forward to seeing most Americans would some kind of insurance coverage and actually with pretty good health insurance coverage.

Mark Masselli: I think today you know all 50 states, there's a lot of communications going on from the governor's office to their Medicaid and Department of Health Offices. So a lot of changes will be underway and we'll be reporting them all here in conversation on healthcare. Our guest today though is a global expert on improving the way healthcare systems function.

Margaret Flinter: Marjorie Godfrey is the co-director of the Microsystems Academy at the Dartmouth Institute and an international leader in this area.

Mark Masselli: Her team has developed a system to improve workflow and medical settings by focusing on clinical Microsystems where the patients and clinicians meet, it's a system that realize heavily on team work and coaching to empower healthcare systems to function more seamlessly.

Margaret Flinter: And we're looking forward to this discussion but no matter what the topic you can hear all of our shows by googling CHCradio.

Mark Masselli: And as always if you have comments please email us at CHCradio.com or find us on Facebook or Twitter, we'd love to hear from you.

Margaret Flinter: And we'll get to our interview with Marjorie Godfrey in just a moment but first here's our producer Marianne O'Hare with this week's Headline News.

Marianne: I'm Marianne O'Hare with this Headline News. The reelection of President Barack Obama is seen as a victory for the affordable care act which stood a good chance of at least to partial repeal under a Romney presidency and exit polls around the country show a public largely divided over the healthcare law, polls in most state show better than 50% of those exiting their polling places felt the law or parts of it should be repealed which is not likely to happen now that President Obama has been given another four year term.

Meanwhile leadership in the GOP maybe rethinking their anti government strategy based on the outcome of this election, much of it centered around resistance to the healthcare law. Endless expect will be some discussion of striking a more conciliatory note as we move forward towards tough decisions looming on the horizon such as how to deal with the coming physical cliff. The election leaves the same, pre-election configuration on the hill, a Democrat in the White House, Republic controlled House and Democratic Senate, continued policy gridlock is also a very real possibility.

Colorado voters passed a measure allowing the sale of marijuana for medical and recreational use, the government will control the sale and distribution in that state. And if you want to know where you can find the cheapest MRI in Colorado, it has joined 12 States offering an online database showing price differentials of all medical procedures so patients can do comparative shopping, a trend that is expected to continue with the advancement of the affordable care act.

I'm Marianne O'Hare with this Headline News.

Mark Masselli: We're speaking today with Marjorie Godfrey, she's the director of the Dartmouth Institutes Microsystems Academy and as an instructor at the

Dartmouth Institute for Health Policy in Clinical Practice. Marjorie is a national leader in designing improvements strategies in healthcare delivery targeting the places where patients, families, and care teams meet. Ms. Godfrey has consulted in collaborating with numerous health systems around the country as well as in many countries around the world and is author of the textbook ”Quality by Design”. She is the chief author in “Architect of Clinical Microsystems Resource Group” a path to healthcare excellence. Marjorie, welcome to conversation on healthcare.

Marjorie Godfrey: Thank you very much. It’s a pleasure to be talking with you today Mark.

Mark Masselli: You know I think the term Clinical Microsystems is not part of the common language of healthcare. It’s really sort of a kind of surge term for great health systems and you’re a registered nurse but also someone who has consulted numerous healthcare organizations around the world and how do you improve their delivery system by focusing in on the Clinical Microsystems? So tell our listeners if you would where the term comes from and what's unique about Clinical Microsystems in the healthcare setting and why are they so essential in improving quality?

Marjorie Godfrey: Well thank you for this opportunity. Clinical Microsystems term actually emerge from research that had been done in the business world. So as researchers at Dartmouth when we were trying to study and understand what really makes the difference in improving healthcare something about this interface between patients, families, inter professional that a frontline of care we’ve stumbled across this book by James Bryan, “Queen Of The Tech School of Business” and the name of the book was “Intelligence Enterprise”. And what Bryan research group found was that high performing organizations and the service industry had several features that led to their success and helped describe the senior leaders of the organization had an obsession with the interface between employees and customers receiving services and goods.

And in that intersection, there was high value being exchanged, there was standardization of prophesies, there was an incredible used of technology that was available and what he found in this high-performing service industry units was that the loyalty to the company was extremely high customers were extremely satisfied and staff were happy. Well, when we read the book in our journey of trying to understand how to improve healthcare, Bryan coined a phrase called “The Smallest Replicable Unit (SRU) and when Paul Batalden and Gene Nelson looked at the book they thought “huh, I wonder what that is in Healthcare” and we actually ended up coining the smallest replicable unit to be a small system, hence Microsystems.

So what is the smallest unit of healthcare delivery in any healthcare system? It’s the interface between patients, families, doctors, nurses, secretaries, receptionist

and that would be called a Microsystem of the Healthcare System. So we had a Clinical Microsystems to that to indicate that we were talking about the clinical setting where care and services are provided, where we interact with patients and families and it involves all professionals and staff. And how do we study that small unit to understand how it can be the most effective, efficient, safe timely accessible and patient centered and core to the Clinical Microsystems Theory if you will, is in the center of all this is the patient and family that should be driving the care and services that we provide and continuously improve.

Margaret Flinter: So maybe go on from that to tell us how does the Clinical Microsystems model differ from what people are used to hearing about as performance improvement models or strategies like Six Sigma or like Lean, what's unique about the Clinical Microsystem model as it relates specifically to improving quality in healthcare delivery?

Marjorie Godfrey: The Clinical Microsystem is really about understanding the context, where are we providing care and services? What are the unique particularities about the people, the populations we care for? How do we do our work? And then what is our culture like? What is the leadership culture like? What's their performance data? That's really what the Clinical Microsystem is, everyday we have Microsystems that are being improved or not, but everyday these units are providing care and services. Once you understand that context is a whole collection of methodologies for improvement, often when I hear from those that I worked with the inter professionals at the frontline is they will tell me that they've been given a directive by their leaders to, for example, in ambulatory setting improved access to care and by being able to understand the particularities of our setting and how we currently do our work, maybe we do it differently for the working population. And that's what understanding our context helps them form and often what's missing is a deep understanding of the context which is what Clinical Microsystems brings to the whole scene of improving healthcare.

Mark Masselli: Marjorie, how do you take this principles to let say in emergency room setting or a critical care hospital and are there different approaches that work better for different types of healthcare organization and if so, what can we learn from this differences?

Marjorie Godfrey: Well that's a really good question too. And I think that's one of the desirable characteristics of focusing on systems within systems is that -- it can be easily adapted in any healthcare setting where care and services are being provided. So for example, you talk about the emergency room, how often are the conditions created for all of the professionals including the paramedics, the emergency response team, respiratory therapy to get together and talked about how do we do our work? And the tools that we've developed one particular is called the Five Piece. The Five Piece is really about understanding these particularities that I was talking about and letting those at the frontline, collect and

add to system data that's where we gather all the information from those doing the work, because even Toyota has taught us those closest to the work have the best knowledge of what's working well, what isn't working and by the way they usually have good ideas but it's the rare organization that tries to harness that information and leveraged it and invite those inter professionals to come together and have the reflection time to help contribute to making improvement.

And across all of those high performing units that we found these success characteristics in the categories of leadership at the frontline support by the larger organization, staff development, selecting the right team to come to work and helping them developing grow and then importantly it's having a stated way to do improvement that we have a common language in our organization, standard methodology that we all agree to we're trained in, we're supported in doing that and then tying this all together was the fact that there was information and information technology. How can information technology permeate the organization and the journey of the patient across multiple Microsystems to be able informed all the units and have a shared information environment.

Margaret Flinter: Marjorie, I know that you have been all around the world as you've been in the UK, Sweden, Japan and Canada, what have learn to there about what they do that should inform our health system quality improvement methods here in the United States?

Marjorie Godfrey: When you start engaging very busy healthcare professionals with patients and families at the frontline of care, you quickly learn that the issues that we have in the United States are the same in Sweden and England and Scotland and Ireland and Canada and in New Zealand. And what happens is the engagement of frontline staff is varied across different settings. So the beauty of the Microsystem work is it honors the local context and the systems within system so if we looked it say for example where I am completing my doctoral studies in Sweden, they have a sense of collectivism there in Sweden which is wonderful experience for me to have compare to how I've lived here in the United States. My colleagues in other countries, they don't understand why we don't want everyone to have health insurance because they've grown up in that culture and they understand the benefits of a healthy population.

So let's go back to Sweden a bit in that, with their governance and budget structure what's really cool and why they get such great outcome is for example, Ian Jönköping County in Southern Sweden that whole county have a governance body that works closely with the municipalities, that works closely with the healthcare system that also works closely with the professional education school to figure out how can we all get together and improve the care of the population because we know if we improve the population health, we'll have money and resources for other necessary things in the communities like bike path and I'd really think they have this collective vision for their population that makes a difference in the outcomes of their getting and Ian Jönköping actually have some

of the best outcomes in the world. We've been working with them, we being from Dartmouth have been working with the Ian Jönköping County since 1999, they have focused on intentionally in how the strategic plan and map. Since 1999 that they have moved through methodically to be sure leaders are developed at their levels that staff understand improvement that they've got patients and families actively involved and to the point that in the past few years they have actually developed a dialysis unit where the dialysis -- hemodialysis is completed by the patient and you kind of think about that razor eyebrows here in the United States, how could we have a patient to self administered hemodialysis? They have done it because they have taken the value that it brings the patients and families, patient express the interest to do this, they change their prophecies, they are getting better outcomes, people are feeling better, staff are delighted to be more in a support role, and it just to me is an illustration if you take these principals in improvement it really look for high value low cost options of the innovation that you can develop.

Mark Masselli: We are speaking today with Marjorie Godfrey. She is the director of the Dartmouth Institute Microsystems Academy. Marjorie is a national leader in designing improvements strategies in healthcare delivery and is consultant and collaborates with numerous health systems around the country. We're all quite interested in new approaches to train the next generation of medical professionals and training them to our model of care. What qualities make up a leader within the clinical Microsystems model?

Marjorie Godfrey: Well actually I think it's transformational of what's happening with leadership now. We had a responsibility when we're working with a frontline teams to inform the leaders that these teams are going to be different which means you probably are going to need to lead differently and it really takes some self reflection on the current leaders to decide if they want to be in that model or not and what are the key behaviors of these leaders is the ability to gain knowledge, gain knowledge about improvement, gain more knowledge about what patients and families think about the care, and based on that knowledge be able to take action.

So how would a leader act differently? And we have got lots of verbatims and experiences of leaders who you probably many of the listeners have heard the stories of the safety rounds where the leader is out of the executive suit out on the unit. And then there's this other behavior that's really hard for a leaders to engage and then it's review and reflection to step back and say based on what I have learned and what we put into action, how is it going? What's going well? What do I need to do differently? What we find that's really important is focusing at leader on the frontline, what does a leader do in the Microsystems with the staff and promote and develop and raise up all the staff to be involved? What does the leader do in the middle of the organization? Where you have multiple Microsystems where patients journeys have them crossed to multiple places and

we actually have a new program we're developing where it's all about understanding, feed forward and feedback between Microsystems.

It's all about coaching in the middle where you want to be able to coach awareness create conditions so multiple Microsystems will come together and meet and then of course the top of the organization like you and Margaret being the Macrosystem leader if you will it's really having the vision and interpreting all these incoming missiles we have in healthcare in an ever changing environment particularly around the affordable care act, so leadership and healthcare is not an easy task anymore. I really felt a new energy in a sense from leaders, I really need this help. I don't know how to do this, I have been trying to make it up along the way, I am welcoming this opportunity to learn how to lead quality and improvement so.

Margaret Flinter: Very fascinating and Marjorie if I can ask you to just speak a moment to what I think is one of the most intriguing aspects of the model you've developed, it's the role of coaches within this clinical Microsystems training people to be coaches within their own Clinical Microsystems. Maybe for our listeners just a moment or two, who these coaches are in the skills that you impart to them?

Marjorie Godfrey: There's been so much work done in building teams and team works and to not recognizing the fact that it's not one hero provider anymore that provides the care and services, it's actually a collection of different professions and disciplines coming together and my research is actually showing in this research in the literature all feel that in our attempts to try to provide care and improve care, we have often given frontline team the mission to improve the core measures and then the frontline have been left on their own. And what we have found in research is that those teams that maybe get the improvement knowledge and then get some help, they get someone reminding them, encouraging them, it's very exciting and the neat thing is most often and most organization we're not looking to hire a troop of coaches as much as using this who are the individuals? How can we have leverage their expertise and their interesting growing people to be able to do their job and also coach others to do it and it's very rewarding it can be seen as a an advancement for someone, the coaching is truly a developmental journey to support people to learn, to be able to know that they can provide care and improved care but having that human interaction and encouragement is what's made such a big difference in these groups to be able to move forward to transform themselves, to be able to provide care and improved care.

Margaret Flinter: We've been speaking today with Marjorie Godfrey, she is the Director of the Dartmouth Institute Microsystems Academy and an instructor at the Dartmouth Institute for Health Policy and Clinical Practice. Marjorie is a national leader in designing improvements strategies in healthcare delivery and

you can find much more about her work by going to clinicalmicrosystems.org. Marjorie, thank you so much for joining us today on conversations on healthcare.

Mark Masselli: Conversations on healthcare, we want our audience to be truly and to know when it comes to the facts about healthcare reforming policy, Lori Robertson is an award winning journalist and managing editor of Factcheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: Well, Mark and Margaret, we have reached the end of a long presidential campaign and we saw a quite a few whoppers been told by the candidates that includes they are exhausted about healthcare. The biggest whopper we heard again and again from the Romney campaign was that the affordable care act robbed medicare. Romney's camp told seniors that money you paid for medicare was being use for the federal health care law, but the law doesn't take money out of the existing medical trust fund and it can't take medicare's trust fund money in the future either. If medicare doesn't spend payroll tax money right away it gets a treasury bond and can cash in that bond anytime it wants.

From the Obama camp we heard the whopper that Romney back the law that outlaw's all abortions even in case of rape and incest, not true. There is no such law instead that references to a hypothetical questions from an audience number doing in a 2007 debate. The audience number ask if hypothetically Rosy weight with overturn and Congress passed a several band on all abortion and it came to your desk would you sign it? Romney said "I would be delighted to sign that bill but out of that it consensus for something like that didn't exist in the country, that's not where America is today," he said and that's my Factcheck for this week. I am Lori Robertson, managing editor of Factcheck.org.

Factcheck.org is committed to factual accuracy from the countries major political players and is a project of the Annenberg Public Policy Centre at the University of Pennsylvania. If you have a fact that you would like to check email us at chcradio.com will have Factcheck.org's Lori Robertson check it out for you hear on conversation on healthcare.

Margaret Flinter: Each week conversation highlights a bright idea about how to make warmness support of our communities and everyday lives. Smoking remains one of the worlds's leading causes of preventable death and yet quitting is still a challenge for so many smokers. Pregnant women who smoke pose a greater health risk to their growing babies increasing the likelihood for preterm birth and other lifelong health consequences and that's to say nothing of the health danger for infants exposed to second hand smoke. A recent study published in the journal of Women's Health highlights another promising intervention, municipal smoking bans. Municipal smoking bans are relatively recent phenomena, so this has been very little study of their impact on maternal

smoking cessation and infant help until now. In 2003 Pueblo Colorado initiated a city wide smoking ban that was strictly enforced. Researchers compare Pueblo to El Paso, Colorado which has some more population demographics but no municipal smoking ban. During a two year period they compared maternal smoke race in each city and the infant health statistics as well and what they found was pretty astonishing. 38% fewer pregnant women in probable smoke and there were 23% fewer preterm births compare to the maternal and infant population in El Paso.

They said the smoking ban had a direct improving impact on maternal and infant health in a short period of time. The report suggests that the evidence should be fathered for communities around the nation to consider following suits.

A strongly enforce municipal ban on smoking leading to significant improvements and maternal and infant outcomes, not to mention for the entire community now that's a bright idea.

This is conversations on healthcare. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace in health.

Conversations on health care broadcast from the campus of WESU at Wesleyan University streaming live at WESUfm.org and brought to you by the community centre.