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# The Revolution in Hospital Management

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## EXECUTIVE SUMMARY

Five healthcare systems that have either won the Malcolm Baldrige National Quality Award in Health Care or been documented in extensive case studies share a common model of management: they all emphasize a broadly accepted mission; measured performance; continuous quality improvement; and responsiveness to the needs of patients, physicians, employees, and community stakeholders. This approach produces results that are substantially and uniformly better than average, across a wide variety of acute care settings. As customers, courts, and accrediting and payment agencies recognize this management approach, we argue that it will become the standard for all hospitals to achieve.

This article examines documented cases of excellent hospitals, using the reports of three winners of the Baldrige National Quality Award in Health Care and published studies of other institutions with exceptional records.

<p>For more information on the content of this article, please contact Professor Griffith at <a href="mailto:jrg@umich.edu">jrg@umich.edu</a>. To purchase an electronic reprint of this article, go to <a href="http://www.ache.org/pubs/jhmsub.cfm">www.ache.org/pubs/jhmsub.cfm</a>, scroll down to the bottom of the page, and click on the purchase link.</p>
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**E**xcellent organizations demonstrate long-term results that satisfy most or all of their stakeholders. This article examines documented cases of excellent hospitals, using the reports of the three winners of the Malcolm Baldrige National Quality Award in Health Care and published studies of other institutions with exceptional records (see Table 1). These reports show that the organizations share many management practices.

While these are certainly not the only excellent institutions, their achievements have been successfully applied in a wide variety of settings, generating results that are substantially superior to those of typical hospitals. Their approach has now been tested in over 100 diverse American communities, suggesting that it is an appropriate model for most U.S. hospitals and healthcare systems.

The Malcolm Baldrige Health Care Criteria for Performance Excellence (2004) provide a template that shows how this management approach has been built into day-to-day actions that produce excellence in quality, cost, financial stability, and physician and worker satisfaction. The Baldrige criteria in general are deliberately designed to cover a broad range of businesses and strategies and organized in seven sections that emphasize leadership, strategy, patient relations, worker relations, information management, operations, and results.

## **LEADERSHIP**

Leadership is "how senior leaders address values, directions, and

performance expectations, . . . focus on patients and other customers and stakeholders, empowerment, innovation, and learning . . . also . . . governance and . . . public and community responsibilities" (Baldrige Health Care Criteria 2004).

The Baldrige expects leaders to establish universal two-way communication practices and to use them to deploy organizational values and performance expectations. Leading hospitals now do the following:

1. Use mission, vision, and values statements as central referents to describe the organization to its publics, attract compassionate workers, focus ongoing dialog, and test propositions for change. SSM Health Care (SSMHC 2002) has a "Passport" for every employee that states its mission, vision, and values. St. Luke's Hospital's (SLH 2003) "Very Important Principles" card lists its strategic goals. Catholic Health Initiatives (CHI) keeps its values—"Reverence, Integrity, Compassion, and Excellence"—constantly in the mind of its associates by including them on badges, posters, and other printed media (Griffith and White 2003).
2. Use several hundred measures and benchmarks to provide each responsibility center with multidimensional measures of performance (Griffith and White 2002; Simmons 2000). Baptist Hospital, Inc. (BHI 2003) aggregates more than 75 measures to 14 for governance reporting. SLH

**TABLE 1**  
**Characteristics of Systems and Hospitals Studied**

<b>Hospital or Healthcare System</b>	<b>Documentation</b>	<b>Size</b>	<b>Scope of Service</b>	<b>Locations</b>
Baptist Hospital, Inc.	Baldrige National Quality Award Application, 2003	\$158 million revenue; 492-bed urban hospital	Tertiary and referral care	Pensacola, Florida
Catholic Health Initiatives	Case study; <i>Thinking Forward</i> book	\$6 billion revenue; 47 "market-based organizations" of one or more hospitals	Ranges from "critical access" hospitals to tertiary centers; includes long-term and palliative care	64 communities in 19 states
Intermountain Health Care	IHC annual reports; Harvard Business School Case 9-603-066	\$3 billion revenue; 20 hospitals and clinic facilities	Ranges from rural clinics to Intermountain Medical Center, a tertiary medical teaching center	27 communities in Utah and Idaho
SSM Health Care	Baldrige National Quality Award Application, 2002	\$2 billion revenue; 21 general and specialty hospitals with clinic facilities	Acute, long-term, rehabilitative, and palliative care	7 markets in Missouri, Illinois, Wisconsin, and Oklahoma
St. Luke's Hospital	Baldrige National Quality Award Application, 2003	\$308 million revenue; 482-bed suburban hospital	Tertiary and referral care	Kansas City, Missouri

- (2003) aggregates 86 broadly used measures to a color-coded scorecard of 27 for senior leadership.
3. Report promptly and often publicly. Important performance measures are reported daily, biweekly, and monthly so that all managers and most employees know exactly where they stand. Both BHI (2003) and SLH (2003) stress 90-day action plans. BHI claims, "The agility inherent in 90-day review . . . gives BHI an advantage in its highly competitive environment." SSMHC (2002) reports 49 measures monthly and 14 more quarterly. At SSMHC " . . . specific goals and objectives . . . are posted in [each] department. Posters provide a visual line of sight connection from SSMHC's mission to department goals."
  4. Use the measurement system to shape two-way communication. Performance improvement teams (PITs) identify, test, and implement process changes that drive next year's goals. A hospital may have a dozen or more teams redesigning processes. PITs are facilitated and supervised by a senior management group (BHI 2003; SLH 2003; SSMHC 2002; Griffith and White 2003). SLH (2003) claims its performance management process "produces a set of specific, measurable behaviors that exemplify the core values for each and every SLH employee." The values, the scorecard, and continuous quality improvement (CQI) converge to empower workers and lower-level managers. A culture is created that requires senior management to listen to and respond to frontline concerns (BHI 2003; SLH 2003; SSMHC 2002; Griffith and White 2003).
  5. Attract and retain effective team members. Leading organizations monitor satisfaction, turnover, and safety routinely for physicians and employees. All have formal and informal listening activities such as forums and walking rounds. SLH has an "administrator on call" 24 hours a day/7 days a week and an "open door policy." The "service value chain" concept—satisfied workers produce satisfied customers and improved overall performance—has been widely accepted (Heskett, Sasser, and Schlesinger 1997). BHI pioneered the service value application to hospitals, and along with SSMHC, has won national awards for employment practices. CHI is implementing the concept at several sites, pursuing a "Spirit" model that focuses employee education on a new topic each month (Griffith and White 2003). SSMHC (2002) is implementing an accountability-based professional practice model "to give nurses and other employees greater decision-making authority." As of 2004, all hospitals have implemented the model in nursing, and many have implemented it in all clinical services (Friedman 2004).
  6. Use financial incentives to reward goal achievement, supplementing

the recognition and celebration included in CQI and the service value chain. BHI and SLH use a merit increase program with individual objectives and a detailed review. CHI offers substantial cash incentives for managers. At least one CHI site provides performance-based awards for all workers. Intermountain Health Care (IHC) allows its managers to earn bonuses that meet national pay standards (Griffith and White 2003).

The Baldrige asks how senior leaders create "an environment . . . that fosters legal and ethical behavior" (Baldrige Health Care Criteria 2004). BHI (2003) leaders are required to attest that they "have no knowledge of violations of Baptist's high standards." CHI and SSMHC use an audit system that makes the internal auditor accountable to an outside agency. CHI supplements the audit with quarterly certification of reports by its local CEOs and CFOs. It has a similarly sophisticated compliance process, designed as much to create effective relationships as to prevent violations of the law (Griffith and White 2003). SSMHC uses the model compliance plan proposed by the Office of the Inspector General as a foundation but "goes beyond compliance . . . to ensure that SSMHC values are reflected in all work processes . . . .KPMG has identified SSMHC's corporate review process as a best practice nationwide" (SSMHC 2002).

The Baldrige application asks how the organization "addresses its responsibilities to the public

[and] practices good citizenship." Leading hospitals and systems have identified and measured their community contribution (Catholic Health Association 2001) and made their information public (see each organization's web sites). SLH has established a joint venture in cancer care with its largest competitor, HCA. In Portland, Oregon, four healthcare organizations have linked with state and county health departments to establish a collaborative network (Griffith 1998). BHI (2003) collaborates with a competitor to run clinics.

The Baldrige is also concerned about how the hospital "contributes to the health of its community." The best hospitals have established effective processes for contributing to promote healthy behavior and to prevent illness. They have promoted alternatives to acute care, such as chronic disease management and palliative care (Griffith and White 2003). The American Hospital Association's "Healthy Communities" movement has taken hold as a priority in winning hospitals. SSMHC (2002) launched a systemwide "Healthy Communities" initiative in 1995, and it also has a committee to foster environmental awareness at each local site. In Kearney, Nebraska, CHI established an award-winning collaboration with local industry, government, and religious organizations. The model has increased in popularity and gained commitment while sharing the cost of the program with other organizations (Griffith and White 2003). BHI (2003) sponsors a Partnership for Healthy

Communities and “Get Healthy Pensacola” program . . . [E]nrollees can earn prizes or discounts arranged with local businesses . . .”

### STRATEGIC PLANNING

According to the 2004 Baldrige Health Care Criteria, strategic planning is “how your organization develops strategic objectives and action plans. . . . how your chosen strategic objectives and action plans are deployed and how progress is measured.”

The Baldrige application expects the components of continuous improvement—goals, empowerment, analysis, and revision—to be imbedded in the culture. Change is the rule. The strategic process is about how alternatives are selected and implemented through a plan with explicit goals and timetables.

Leading institutions do the following:

1. Begin an annual cycle with a review of mission, vision, and values, both to keep these current and to reinforce them as core criteria to guide their strategy.
2. Undertake a rigorous, multifaceted environment review of threats or opportunities presented by the market, technology, critical caregivers, competitors, and regulation. They explicitly integrate financial needs and resources. Support from system corporate offices has helped many hospitals.
3. Use retreats to build consensus around the implications of the

facts and the appropriate strategic responses.

4. Set goals based on systematic analysis of benchmark and market data as well as local history.
5. Use task forces or PITs to change performance. PITs have broad participation, clear charges and deadlines. The plans they develop have explicit timetables and performance expectations.
6. Empower member units by delegating authority.
7. Build plan achievement targets into managers’ goals and incentives.

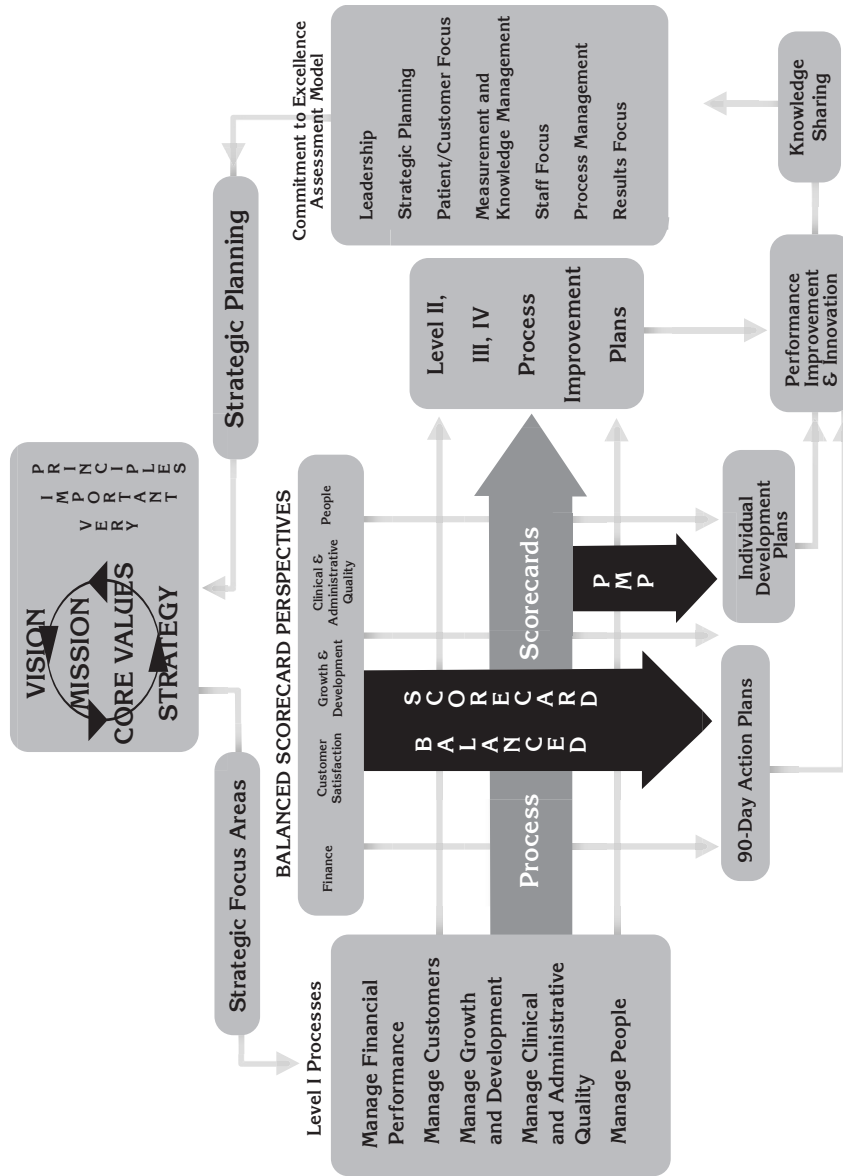
SLH has evolved a particularly comprehensive strategic process. As shown in Figure 1, it is based on three dimensions of “roll out” (SLH 2003):

- From strategic (Level 1) concerns through several levels of accountability (Levels II through IV)
- From long-term to short-term (90 day) action plans.
- From strategic goals to process improvement to individual development plans.

Measures, goals, and process improvement plans are articulated at each step of each dimension. The strategy role out itself is improved by feedback from each of the three dimensions.

Figure 2 shows the 90-day tracking mechanism at the senior management level. At SLH, it is in color: blue, green, yellow, and red for four levels of goal achievement. Managers can “drill down” for run charts, goals, and

**FIGURE 1**  
**SLH Leadership for Performance Excellence Model**



Source: St. Luke's Hospital, Kansas City, Missouri.

**FIGURE 2**  
**SLH Hospital Scorecard Sample Template**

Key Measure	Qtr Year	SCORING CRITERIA										Raw Score	
		Target		Stretch		Goal	Moderate			Risk			
		10	9	8	7	6	5	4	3	2	1		
FINANCIAL	Total Margin												6
	Operating Margin												4
	Operating Cash Flow												5
	Days Cash on Hand												7
	Cost per CMI Adjusted Discharge												6
CUSTOMER SATISFACTION	Would Recommend (IP;OP;ED)												7
	Overall Satisfaction (IP;OP;ED)												8
	Longer Than Expected Wait Time (IP;OP;ED)												7
	Responsiveness to Complaints												4
	Outcome of Care												9
	IP Active Admitting Physician Ratio												9
	OP Admitting Physician Counts												5
GROWTH & DEVELOPMENT	**Community IP Market Share												6
	Eligible IP Market Share - Draw Zips												5
	Eligible IP Profitable Market Share - Draw Zips												3
	IP PCP Referral - Ratio - Draw Zips												6
	OP Referral Counts Draw Zips												10
CLINICAL & ADMINISTRATIVE QUALITY	***IP Clinical Care Index												8
	***OP Clinical Care Index												7
	***Patient Safety Index												6
	***Operational Index												7
	***Maryland Quality Indicator Index												8
	***Infection Control Index												5
	***Medical Staff Clinical Indicator Index												8
	Net Days in Accounts Receivable (IP/OP)												6
PEOPLE	Human Capital Value Added												4
	Retention												10
	Diversity												7
	Job Coverage Ratio												8
	**Competency												10
	**Employee Satisfaction												7
<b>**</b> Indicates annual measure. <b>***</b> Detail in Appendix B											<b>Overall Score</b>	7	
											<b>Overall Score</b>	7	
<b>Overall Score</b>											<b>Goal</b>	7	
<b>Overall Score</b>											<b>Stretch</b>	10	
For performance to be scored greater than Level 1, the performance value must meet or exceed the scoring criteria within a Level.													

Source: St. Luke's Hospital, Kansas City, Missouri.

benchmarks. Similar reports go to the “Level” managers of Figure 1.

The processes for strategy are not substantially different from those used at IHC and Henry Ford Health System a decade ago (Griffith, Sahney, and Mohr 1995). The difference, as IHC executives noted at the time, is implementation. Focused on the results, leaders implement the process with both vigilance and rigor. Vigilance allows them to spot opportunities and threats faster. A network of informed and committed agents uncovers new ideas. A rich background to evaluate them develops quickly. Rigor protects them from the usual causes of bureaucratic delay. Denial, special interests, and paralysis by analysis simply are not acceptable in leading institutions. The loop is closed by the short-term plans.

### **FOCUS ON PATIENTS, OTHER CUSTOMERS, AND MARKETS**

This criterion is about “how your organization determines requirements, expectations, and preferences of patients . . . and markets. . . . builds relationships . . . and determines the key factors that lead to . . . satisfaction, loyalty, . . . retention, and . . . service expansion” (Baldrige Health Care Criteria 2004).

The Baldrige application expects solid and expanding relationships with patients, families, physicians, other healthcare providers, students, insurers, employers, patient advocacy groups, the community, and government agencies. The leaders systematically do the following:

1. Refine a comprehensive system of “listening and learning tools” using focus groups, community need surveys, patient and other customer satisfaction surveys, reports from PITs, meetings with physicians, and industry market research. BHI is “obsessed” with patient care and customer satisfaction, surveying every inpatient and one of eight outpatients. Scores are near the 99th percentile in the nationwide data (BHI 2003).

SLH creates a “patient path,” a patient-friendly format of the care plan that explains timing and purpose. All employees are empowered and expected to resolve complaints. Each patient is assigned to a patient advocate (PA) who visits patients on their first, fifth, and tenth day, and more frequently if needed. Many of the PAs are bilingual and serve as translators (SLH 2003).

2. Assess opportunities for improving service and clinical quality. Through environmental scanning, one of SSMHC hospitals discovered an opportunity to satisfy an increased demand for heart services as a result of the dissolution of a physician group. The hospital then opened the first heart hospital in its community, for which the hospital received an “Innovator of the Year” Award (SSMHC 2002).
3. Analyze performance to identify what contributes to patient loyalty. The SSMHC planning staff provides monthly reports to each entity that identify trends and opportunities

- in patient loyalty. For example, classes about particular diseases or conditions, support groups, and e-health information empower patients to proactively manage their disease/condition and therefore build loyalty (SSMHC 2002).
4. Meet requirements of physician partners and build physician loyalty. SSMHC (2002) hospitals have physician liaisons and other staff members who focus on physician relations, recruitment, and retention. BHI and SLH (2003) survey physicians annually and hold periodic interviews and focus groups. BHI (2003) implemented a "Physician Action Line," which allows members of the medical staff to give BHI leaders feedback. When BHI leaders found out that a common physician irritant was not being able to locate nurses quickly, they issued wireless phones to nurses. BHI also trains physician office staffs and assists with office patient satisfaction surveys.
  5. Treat employers as important customers. BHI surveys community employer groups to assess satisfaction, attitude, and needs. In focus groups with employers, BHI (2003) discovered a desire to encourage healthy lifestyle and responded with an incentive-based healthy lifestyle program for workers.
  6. React immediately to customer complaints with a standardized process of response, tracking, follow-up resolution, and pattern analysis. BHI (2003) maintains a customer loyalty team that focuses on making things right when responding to complaints. Complaints are addressed within 24 hours at SLH (2003), and SSMHC (2002) uses a software management program for tracking complaints developed by one of its hospitals.
  7. Celebrate extra effort for the customer, and "recover" from service errors. All of the Baldrige winners describe service recovery processes that focus on listening to the customer and recommending problem solutions. Employees at BHI (2003) are empowered with spending guidelines for resolution of problems that involve lost items, delays, or complaints concerning physicians. Extra effort by employees is explicitly rewarded with written acknowledgment, celebration, and gifts. CHI's "Complaints as a Gift" program emphasizes that complaints are an opportunity to make things better (Griffith and White 2003). Dominican Hospital (DH 2003) tracks compliments for communication to employees, physicians, and key stakeholders and celebrates results with individual employees.
  8. Search outside the healthcare industry to learn about maintaining customer loyalty and building customer relationships. BHI's (2003) Standards Team, a subcommittee of the Culture Team, actively pursues best practices in leading nonhealth-care organizations.

## MEASUREMENT, ANALYSIS, AND KNOWLEDGE MANAGEMENT

This criterion is defined as "how your organization selects, gathers, analyzes, manages, and improves its data, information, and knowledge assets" (Baldrige Health Care Criteria 2004).

The Baldrige scores knowledge as a resource that is slightly more important than the human resource. The points are equally divided between "measurement and analysis of organizational performance" and "information and knowledge management."

"Measurement and analysis" require definitions, input, verification, standardization, archiving, and analysis of large volumes of data from multiple sources. The management challenge is to develop, maintain, and use these data to improve performance. The leading institutions follow these steps:

1. Build medical-records coding and data, billing, materials management, cost accounting, satisfaction surveys, and human resources data so effectively and reliably that they are taken as a given. CHI and SSMHC use their internal audit function to ensure the accuracy of critical nonfinancial measures (Griffith and White 2003; SSMHC 2002).
2. Benchmark and compare to best practice. No goal is set without benchmarking. SLH (2003), for example, uses six outside commercial sources for comparisons, including survey companies, financial analysts, and market analysts plus VHA, Maryland Quality Indicators, and the Missouri PRO. SLH and BHI are signed up for the Centers for Medicaid and Medicare Services' "7th Scope of Work" initiative that goes beyond the Joint Commission's "Key Measures" (SLH 2003; BHI 2003). SSMHC (2002), which believes "external visits are key to the benchmarking process," has a guide book on its intranet that describes sources and uses of benchmarks.
3. Provide internal consultants to help PITs analyze the relationships between measures, identify trends, and prepare forecasts. Improvement proposals are expected to provide quantitative forecasts of all relevant measures, and accepted proposals are expected to achieve the forecasts. IHC's Institute for Healthcare Delivery Research has been central to several significant process changes (Bohmer, Edmondson, and Feldman 2003).
4. Use a formal structure to improve the data processing resource and the selection and definition of measures. SSMHC (2002) and BHI (2003) use an information council, including senior management and representation from users and information specialists. Ad hoc information management teams develop and evaluate specific measurement and knowledge programs. They bring in technical expertise, listen for implementation issues, and create specific short-term and long-term

plans. SSMHC (2002) and CHI (Griffith and White 2003) use a farm system—required, standard, and nonstandard—that allows individual units to experiment with new measures.

5. Involve line management in knowledge management. The leaders have invested heavily in managerial effort, worker training, and data warehouses over a period of years. They believe these investments have paid off, and they plan to continue a high level of investment.

The 2004 Baldrige Health Care Criteria state, "Information and knowledge management . . . examines how your organization ensures the availability of high quality, timely data . . . for all your key users." The criteria address needs, not methods. They do not demand an electronic medical record or even computerized patient order entry. The leaders do the following:

1. Build the process management and general business capability ahead of their clinical information systems. They have emphasized using standard commercial software and the information it produces rather than developing modifications.
2. Use web technology to put management information at the caregivers' and the managers' fingertips. BHI (2003) claims that it "provides a 'no secrets' environment with organizationally educated, knowledgeable

employees." All employees and physicians are encouraged to access the BHI intranet for information.

3. Expand electronic medical record capability. Access to clinical information is now a high priority. IHC has the most comprehensive electronic medical record, which was developed over several years (Griffith and White 2003). BHI's information system covers order entry and some results reporting. SLH has only recently moved to an electronic order entry, results, and communication system.
4. Emphasize reporting to physicians. SLH has built a system to supply discharge summaries, key findings, EKG results, and cardiac imaging to referring physicians. It is also developing an electronic intensive care unit monitoring and reporting system, allowing intensivists in the flagship hospital to care for patients in smaller institutions. SLH and CHI are working actively on telecommunications with rural hospitals and patients (SLH 2003; Griffith and White 2003).
5. Keep data secure and confidential to meet HIPAA (Health Insurance Portability and Accountability Act) requirements. Permanent committees supervise confidentiality policies and access. SLH has an extensive firewall system, hourly tape backups of critical data, and a disaster recovery process.

This strategy emphasizes measures and users, as opposed to hardware and technical capability. The leaders show

that when the strategy is pursued for a few years, it results in a situation where people “understand where the numbers are coming from and move on to improving . . . operations” (Griffith and White 2003, 35). From that emerges a culture that is evidence based, quantitative, and committed to continuous improvement. CHI has shown substantial results in only three years, with a modest investment in hardware (Griffith and White 2003). IHC’s managers believe its cost accounting system and deliberate collaboration with physicians are as important to success as its medical record technology (Bohmer, Edmondson, and Feldman 2003).

### FOCUS ON STAFF

This focus is defined as “how your organization’s work systems and staff learning and motivation enable all staff to develop and utilize their full potential . . . and maintain a work environment . . . conducive to performance excellence and to personal and organizational growth” (Baldrige Health Care Criteria 2004).

The Baldrige expects human resource practices that attract and retain competent and satisfied employees and that continuously improve their skills. The work environment must develop staff, volunteers, students, and independent practitioners by aligning their expertise and efforts with the organization’s overall strategy. The leading institutions do the following:

1. Strive to identify and keep good employees as the core of the human resources strategy. BHI’s (2003) employee turnover rate has declined from 31 percent in 1997 to 13.9 percent in 2003. The percentage of staff reporting positive morale has risen from 47 percent in 1996 to 84 percent in 2001. In 2002 and 2003, BHI was ranked in the top 15 in *Fortune’s* 100 Best Companies to Work For in America. SSMHC’s (2002) all-employee turnover rate fell from 21 percent in 1999 to 15 percent in 2002. SLH’s (2003) employee retention approaches 90 percent. All three exceed the Saratoga Institute’s median, which is about 70 percent in 2002.
2. Create human resources systems that foster high performance. Job descriptions, career progression, motivation, communication, recognition, and compensation are well-designed, integrated processes. Selection, training, and on-the-job reinforcement of knowledge and skills are tied to individual and organizational objectives and action plans. Explicit policies provide ways to recognize employees, physicians, and volunteers. An executive career development program identifies and develops future leaders (SSMHC 2002). SLH (2003) uses matrix accountability to manage work and jobs, emphasizing multidisciplinary teams and committees to enhance a patient-focused delivery model.
3. Emphasize organizational learning and adaptation to change. These organizations provide more than 40 hours training to each employee

per year, with managers receiving almost twice as much as hourly workers. SLH (2003) appointed a chief learning officer in 2003 to identify learning needs for all staff, volunteers, and physicians. BHI's (2003) commitment to tracking the learning investment in business results led to its recognition as a "Top 50" learning organization by *Training* magazine in 2003.

4. Continually improve staff well-being, motivation, benefits, and workplace safety. To attract and retain the women who comprise 82 percent of its workforce, SSMHC (2002) offers flexible work hours, work-at-home options, long-term care insurance, insurance coverage for legally domiciled adults, retreats and wellness programs. Its workers regard its tuition assistance and student loan repayment programs as differentiating SSMHC from its competitors. At SLH (2003), factors that determine employee well-being, satisfaction, and motivation are uncovered through formal surveys, open forums with senior leaders, targeted focus groups, senior leader "walk rounds," "stay" and "exit" interviews, and a peer-review grievance process.
5. Promote a diverse workforce. SLH (2003) has focused intensely on ensuring that its workforce reflects the diversity of the community, including diversity training for all employees and "lunch and learn" sessions about diversity-related topics. Minority managers and professional staff have increased

from 3 percent in 1998 to almost 10 percent in 2002. SSMHC (2002) has used a diversity mentoring program to increase minorities in professional and managerial positions from below 8 percent in 1997 to 9.2 percent in 2001, part of a larger diversity program that was recognized as a national best practice in 2002 by the AHA. Both SLH and SSMHC substantially surpass the healthcare industry average of 2 percent.

### PROCESS MANAGEMENT

Process management deals with "your organization's process management, including key health care, business, and other support processes for creating value" (Griffith and White 2003).

The Baldrige approaches organizations as a large set of work processes. Each process is described and monitored by performance measures that usually cover availability, cost, quality, customer satisfaction, and worker satisfaction. The benchmarks, goals, and stakeholder opinions from the strategic planning criterion are used to identify opportunities for improvement. A performance improvement council commissions PITs to pursue the most promising opportunities. Table 2 shows the scope of process improvements among Baldrige winners. Because of page limitations of this journal, the processes listed are the applicants' best examples. They include both outpatient and inpatient activities, although they focus on the expensive episodes. Prevention and chronic disease care remain frontiers, but many activities

**TABLE 2**  
**Examples of Successful Process Improvement from Baldrige Winners**

Direct Care Processes	Site	Results
Implementation of hospitalists	BHI	Substantial reduction in length of stay, and 34 percent decrease in cost of inpatient care
Clinical pathways	SLH	~60 percent of patients assigned treatment protocols
Medication errors and patient falls	All	Decreased substantially
Heart-risk screenings	BHI	More than doubled in three years
<b>Patient and Customer Focus</b>		
Patient satisfaction	BHI	Increased to, at, or near the 99th percentile (inpatients, outpatients, LifeFlight)
Referrals from primary care physicians	SLH	Improved by one-third
Admitting-physician satisfaction	SLH	Improved by one-quarter
Patient volumes	BHI	Six-year growth in admissions, outpatient, emergency department use
Cardiology and orthopedic market shares	BHI	Increased by one-third
<b>Clinical Support Processes</b>		
Precision of blood chemistry results	SLH	"outperforms national stretch targets"
Electronic diagnostic reporting to attending physicians	SSMHC	Increased fivefold
Mammogram turnaround	SSMHC	Four days to one day
Lab tests/adjusted discharge	SLH	"among the lowest in the nation"
<b>Other Support Processes</b>		
<i>Financial</i>		
Bond rating	SSMHC	Rating achieved by only 1 percent of U.S. hospitals
Current ratio	BHI	Steady increase, exceeds Moody's median
Days in accounts receivable	SLH	Reduced by more than half, now below COTH top quartile
	BHI	Reduced by two-thirds and dropped below Moody's median
	SSMHC	Increasing
Operating margin	SLH	Increasing trend, exceeds COTH top quartile
	SSMHC	Increasing trend, matched top quartile of Catholic systems

Return on assets, equity	SLH	Increasing trend, exceeds COTH top quartile
Cash collections	SLH	Increased by one-third (SSMHC and BHI reported similar progress)
Days cash	SLH	Improved by one-half
Net income per FTE (adjusted)	SSMHC	Improved to exceed top quartile of Catholic systems
<i>Productivity</i>	SLH	Improved by half, exceeds consultant's benchmark
Operating expense per adjusted patient day	SSMHC	Declined from 1999 through 2002
FTEs per adjusted discharge	BHI	Substantial reduction
Supply cost per discharge	SSMHC	Reduced, below Catholic systems top quartile
Costs per hire	SLH	Moved below COTH benchmark
<i>Human Resources</i>	SLH	Reduced by two-thirds, below consultant's benchmark
Employees trained on compliance and ethics	SLH	100 percent
OSHA incidents	SSMHC	Reduced by 40 percent
Employee satisfaction	BHI	"Best in class" in 1999, improved subsequently
	SLH	Steady improvement
	SSMHC	Approached consultant's "best in class"
Employee turnover/retention	BHI	Improved to "best in class"
	SLH	Improving, exceeds national benchmark
	SSMHC	Improving, top quartile of consultant's data
Employees terminating because of dissatisfaction	SLH	Declining
RN vacancy rate	BHI	Reduced to one-fifth of regional average
Special-effort recognition	BHI	Increased by one-third
Workers' compensation rating	BHI	Improved to "best in class"
Lost-time injuries and claims	SSMHC	Declining, well below OSHA averages
Needle sticks	BHI	Reduced by one-third, less-than-half national average
	SLH	Exceeds national benchmark
Back incidents	SSMHC	Declining

Training hours per employee	SSMHC	Increasing by two-and-one-half times the reported industry average
Advanced CQI training	SSMHC	Increasing
Training effectiveness—demonstrated skill	SSMHC	Improving
Return on training investment	BHI	Exceeds national "Top 100"
Employees performance on personal improvement goals	SLH	Steadily increasing
Employee health survey results	SLH	High-risk employees improved
Diversity in managerial/professional positions	SLH	Improving, exceeds local population and national average
	SSMHC	Improving, exceeds national average
<i>Service Quality</i>		
Patient room work orders—ten-minute response	BHI	"Best in class"
Employee suggestions	BHI	Increased both submitted and implemented
Registration information accuracy	BHI	Decreased errors by one-third
Medical record completions	BHI	Decreased noncompliance by half
DRG coding errors	SLH	Reduced by two-thirds
Baldrige assessment scores	SLH	400 to 600, before winning award
Admission wait time	SLH	Improving
"Single call" elective admission	SLH	Tenfold growth
Information system availability	SLH	99.9 percent (SSMHC reported 99.5 percent; BHI reported "best in class")
Information system customer satisfaction	SSMHC	Improving
Supply-order accuracy	SLH	Over 99 percent
Charity care provided	SSMHC	Increasing

that generate general waste and quality problems are addressed.

The leaders' process management programs do the following:

1. Change the culture of their organizations from professional judgment to measured performance. Nursing, medicine, human resources, and accounting are not evaluated on the opinion of their professional leaders; rather, they are evaluated by performance measures.
2. Support a service line structure that organizes accountability around groups of patients with similar needs, rather than the traditional functional silos. The service lines integrate inpatient and outpatient activity.
3. Pursue all important opportunities. The leaders have the capability to support many teams simultaneously. They have no sacred cows, where history or authority protects a process from review.
4. Decision of whether performance is "good" or "not good enough" is based on comparison to goal. Any measure, from the post infarction mortality rate to days of accounts receivable, is "good" if it achieves a previously negotiated goal. The goal is often moved forward each year, based on benchmark or, in some cases such as incorrect surgical sites or medication errors, on zero defects.
5. Listen extensively to supplement the measures. Qualitative information from customers, workers, and other stakeholders is broadly sought and sensitively analyzed.
6. Revise processes based on careful analysis of qualitative and quantitative information, "outside the box" search for alternatives, and study of the work of others. Like the measures, the processes are compared to similar situations elsewhere. Learning from others is a way to speed improvement and reduce its risks. SSMHC (2002) has "collaboratives," and CHI has "affinity groups" of managers that perform similar jobs across their systems (Griffith and White 2003). SSMHC, CHI, and IHC participate in Institute for Healthcare Improvement programs to share best practices (IHC 2004).
7. Train improvement team leaders. Team leaders get "meeting in a box" tools, analytic skills, money to travel to comparison sites, and funds for experimentation.
8. Monitor improvement teams closely. Timetables and interim goals are set. Rigorous analysis is expected. Constructive advice on complex situations and conflict resolution assistance is available from senior management.

## **ORGANIZATIONAL PERFORMANCE RESULTS**

According to the 2004 Health Care Criteria, this criterion refers to "performance and improvement. . . . relative to those of competitors and other organizations providing similar health care services."

The measurement focus of leading hospitals allows them to document their achievements, which, in turn, has led to a number of awards. The Baldrige winners exceed national medians in more than 75 percent of their reported measures.

## DISCUSSION AND CONCLUSION

These institutions' achievements set a new standard for performance accountability and excellence that we believe is a revolution in hospital management. Simply put, they have shown how to run healthcare organizations substantially better than is typical. Similarly, they have documented the processes that produce excellence. The new norm will not be overlooked in boardrooms, reimbursement negotiations, bond rating agencies, accrediting reviews, and courts. Just as medicine now follows guidelines for care; successful managers will use evidence and carefully developed processes to guide their decisionmaking. Healthcare systems and hospitals that copy these processes can expect to do well. Their stakeholders—patients, trustees, physicians, nurses, payers—will be pleased. As word spreads, other stakeholders will demand no less.

Professional excellence for hospital management will become the ability to use these processes and match or exceed these numbers. Hospital managers, across the nation and at all levels, face a substantial challenge.

The evidence suggests that the challenge can be met in only a few years. Although IHC and SSMHC began

their quality journeys before 1990, BHI began intensive employee training in 1997 and CHI achieved success in just three years. As Sister Mary Jean Ryan (2004), president and CEO of SSMHC, says, "the Baldrige criteria also establish a path to meet that challenge." The first four leadership steps—mission, measures, prompt reporting, and two-way communication—are the right beginning.

Revolutionary change includes profound shifts in organizational culture. Governance becomes proactive rather than reactive. It turns to ongoing cooperation instead of negotiated settlements. The concepts of professional domains—the board's, the physicians', the nurses'—gives way to dialog about the cost and quality per case; it is a fundamental shift in perspective from inputs to outputs, from tradition to results, from static to dynamic. Management is now dually accountable—upwards for results, downwards for supporting and training associates and teams. The approach is firmly grounded in learning and rewards; it is not punitive or coercive. Collaboration has become the key word at all levels. Teams collaborate to improve care, support units collaborate to meet caregiver needs, and the organization as a whole collaborates with stakeholders to further mutual aims.

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## PRACTITIONER APPLICATION

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**W**ith one-third of the nation's hospitals running in the red and another third breaking even, the need for a model of healthcare management cannot be more imminent. This article provides an insightful glimpse into the practices of some of the nation's best health systems and begins to answer the need for a standard management approach through which organizations can achieve excellence. By operationalizing the Baldrige Criteria and using process-based decisionmaking, the systems described in this article have achieved superior quality in operations and excellence in relationship management.

An emphasis on the Baldrige criteria, however, will not forge excellence in and of itself. The Baldrige winners described here and other organizations that strive to emulate them must undertake a simultaneous culture shift—one that embraces quality as a differentiator and a key to long-term success. The acceptance of these principles will prove useful for the practitioner in several ways.

The Baldrige approach to management does not create a cumbersome new bureaucracy as a means for achieving results. This initiative is successful because

quality roots itself within and throughout an organization. The *choice* of adoption and *belief* that quality will make a difference in care delivery are large components of achieving excellence.

The Baldrige model provides intangible principles through which management can lead and derive operational goals. More important, however, are the tangible experiences of the systems that have implemented the Baldrige model and have incorporated quality into their *raison d'être*. Organizations that strive for similar recognition and results can learn from the mistakes of past Baldrige winners.

The establishment of a common ground for comparison is another advantage for organizations that implement the Baldrige approach to quality and management. The accomplishments of organizations that live by these principles provide a standard against which the industry can measure performance. The implications of standardization reach beyond internal system boundaries and extend out into the community, providing a language for collaboration across systems and improved health information for consumers.

Most importantly, this article is a guide, demonstrating *how* some of the most successful systems have achieved results. Healthcare institutions do not have to reinvent the wheel; instead, they can look to these exemplary organizations to learn how to focus resources into a formula that will result in operational excellence. Change is both realistic and realizable, and it does not take a lifetime or enormous capital investment to create a culture of quality.

The authors assert that "The institutions' achievements set a new standard for performance accountability and excellence that we believe is a revolution in hospital management." I challenge that proclamation, arguing that while a revolutionary groundwork has been laid, the true revolution will occur when many more hospital executives guide their organizations using a commitment to quality and the Baldrige criteria as a foundation. In turn, these hospitals and health systems will exceed the standards of today and become the models for operational excellence of the future. In the words of Dr. Joseph Juran, "We are headed into the next century which will focus on quality . . . we are leaving one that has focused on productivity."