Critical Issues in Excellence

Healthcare organizations (HCOs) include all organizations that provide healthcare. The Well-Managed Healthcare Organization focuses on excellent HCOs—those that delight their patients, families, caregivers, and other associates and that provide care that is safe, effective, patient-centered, timely, efficient, and equitable. To achieve excellence, HCOs build a culture around their mission, vision, and values. They empower their associates, encourage them to meet patient and customer needs, measure their performance, and reward them for improvement. They use evidence-based medicine and systematic analysis of work processes. Extensive boundary-spanning and strong internal relationships allow them to meet strategic challenges. They carefully protect their organizational resources from any kind of loss or diversion.

1. Emphasizing mission, vision, and values. Make the contribution and importance of care itself a shared value.

2. Building a culture that listens, empowers, trains, and rewards. Begin a program that identifies what people see as barriers to their work and remove them.


4. Maintaining close relations with all stakeholders. Extend the listening activities so that every major affiliate has a point of contact and is assured of fairness and responsiveness.
QUESTIONS FOR DISCUSSION

Consider these questions as you read the chapter.

1. This chapter outlines a transformational style of management, emphasizing values, empowerment, communication, trust/accountability, and rewards. Why do high-performing HCOs strive for transformational styles? Some people say that transformational is completely unrealistic; you must enforce order, they say, to have accountability. How is accountability achieved in high-performing, transformational HCOs? How comfortable would you be working in a high-performing, transformational organization?

2. The history and current activities of HCOs are strongly oriented to healing the sick. The first word of this chapter—“patients”—is consistent with that tradition. Some say that the real role of HCOs is community health, including but going well beyond healing the sick. (Contrast the missions of SSM, Bronson, and Saint Luke’s with those of Baptist, Robert Wood Johnson, and North Mississippi in Exhibit 1.7.) Should the text have started with, “Building healthy communities is the focus of HCOs, including patient care but going well beyond”?

3. Systematic change (page 29) is a four-step process: identify, analyze, test, evaluate. What is new about that? Could you achieve systematic change without measurement and benchmarking? Think of your last encounter with a service organization (e.g., HCO, university, restaurant). What would be different if the organization practiced continuous improvement and systematic change?

4. What happens to an organization that fails in its strategic positioning (see Exhibit 1.14)? Can you name an example or two, and then identify with hindsight where they failed?

5. Ben Franklin founded The Pennsylvania Hospital in 1760, before the American Revolution. His fund-raising arguments were as follows:49
   - We need a refuge for the unfortunate, and Christianity will reward you for your generosity to this cause. (Although Franklin did not say so, Islam, Buddhism, and Judaism also praise charitable behavior.)
   - You might need it yourself this very night.
   - Among other things, we can keep contagious people off the streets.
   - We can certainly handle this better as a community than as individuals.
   - Grants from the Crown and the Commonwealth will lower the out-of-pocket costs. (He might have added that the grants were “new money” that would eventually end up in Philadelphians’ purses.)

Are these still valid appeals to gain support for a community HCO? What would you change or add to Franklin’s arguments?
Patients are the focus of healthcare, and in the twenty-first century patients are commonly treated by teams. A single caregiver working alone soon must seek support for clinical needs like laboratory, imaging, and pharmacy, or for logistic ones, like information, facilities, and supplies. For a serious problem, such as heart surgery or recovery from stroke, several different caregiving teams will be required. Cure will result from the coordinated efforts of close to 100 people bringing highly specialized skills and using an array of diverse equipment and an extensive set of drugs and supplies. Continuing management of the underlying cardiovascular disease will require a different team that will support the patient for months or years. The healthcare organization (HCO) creates, supports, and coordinates those teams. It is a formal legal entity that reaches across the panorama of medicine, other clinical disciplines, and business to identify and deliver care to its community.

Activities

An HCO supports individualized patient care with an array of teams, as shown in Exhibit 1.1. The caregiving teams differ according to patients’ needs. They are backed by three levels of support—clinical, logistic, and strategic—that are themselves composed of specialized teams. Each patient care team performs an activity that is essential to a specific group of patients, and each support team performs an activity that is essential to the work of some or all patient care teams. A small HCO has few patient care activities and contracts with other organizations for support; a large one has a broad array of patient care and support. A healthcare system has many patient care activities in several geographic locations.

Teams are usually housed in purpose-built spaces (e.g., clinics, operating rooms, business offices) so that HCO facilities reflect the activities depicted in Exhibit 1.1. With the growth of electronic communication, however, many teams can be geographically remote. A primary care team needs a process that yields timely laboratory results, but that might be a centralized laboratory. All care teams require strategic capability, but it might be provided from the system headquarters in another state.

Exhibit 1.1 is static. Any real HCO is highly dynamic in three senses:

1. The HCO constantly responds to the changing array of patients and their changing needs. This makes most HCOs a 24/7/365 operation.
2. The HCO evolves as medicine and management change, reflecting both the latest scientifically proven treatments and new developments in management practices and information technology.
3. The HCO adjusts to the changes in its community’s needs.
As the population grows, shrinks, and changes in age and ethnic diversity, the epidemiology of disease changes and the HCO must respond. One function of the strategic activities is to manage these changes. While the focus of the clinical and support activities is “this patient, now,” the strategic focus is “all patients, into the future.”

**Contribution**

The mission HCOs fulfill is one of humanity’s highest callings: to assist others in the “beginning of life, the end of life, and the shadows of life.” HCOs are essential treatment resources for heart disease, cancer, stroke, obstetrics, major trauma, and several hundred other conditions, providing preventive and episodic care, emergency care, surgery, intensive care, rehabilitation, chronic disease maintenance, and end-of-life care. At least one large HCO exists in virtually every county in the United States and is usually surrounded by several smaller ones such as doctors’ offices. About 60 percent of Americans use HCOs in a given year. Although most contacts are relatively simple office visits, one in ten Americans is hospitalized and about three in ten require major outpatient care. It is a rare family who has not had recent contact with an HCO. That contact is often lifesaving, but it is also often intimate, expensive, life threatening, and frightening.

**EXHIBIT 1.1 Components of Healthcare Organizations**

*HCOs have varying sets of clinical or clinical support activities. The logistic support and many strategic support activities are required for any clinical activities.*
The nation’s HCOs are the point of implementation for a healthcare system that has grown from its commitment to “promote the general welfare” (as stated in the Preamble to the Constitution) to be one of America’s largest collective endeavors. The U.S. per capita cost of healthcare is the highest in the world, consuming about one-fifth of the gross domestic product. HCOs and their physician affiliates consume about half of the cost. They justify their cost by meeting powerful individual drives for health and longevity, by making a substantial direct contribution to their local economies, and by implementing a widespread commitment to Samaritanism and social justice. The American healthcare system can be viewed as an investment, contributing to national productivity by adding years of healthy life. Despite its cost, the investment is highly profitable. Much of the cost is returned to the community through employment, as an HCO is often the community’s largest employer.

**Stakeholders**

Formal organizations exist because they fulfill a need that individuals working alone cannot meet, and they thrive because they fulfill that need better than competing alternatives. By definition, any organization serves many masters or stakeholders—individuals or groups who have a direct interest in its success. Organizations are economic entities shaped by stakeholder needs. Stakeholders are buyers, workers, suppliers, regulators, and owners who cooperate through economic exchanges as shown in Exhibit 1.2. In a free society, stakeholders can choose to participate in the organization or not, and a shortage caused by some stakeholders...
selecting alternative sources is disabling for the organization. Organizational excellence begins with and is measured by stakeholder satisfaction.

Exhibit 1.2 reflects most of the world’s economic activity, but reality is not as simple as it suggests. Stakeholders’ desires are inherently conflicting. The buyer wants to buy inexpensively; the supplier to sell dear. Each of us is a stakeholder in many organizations. Most of us are alternately buyer (i.e., customer) stakeholders and seller (i.e., provider) stakeholders, and we and our organizations exist in networks of negotiated solutions to those conflicting desires. The most fundamental element is neither our organization nor our stakeholder desires; it is our ability to negotiate. An important way to understand organizations is as devices to negotiate solutions.

Because of the cost, financing structure, importance, and the intimate and life-changing nature of healthcare services, American HCOs represent one of the most complex applications of Exhibit 1.2. Several levels of complexity are added. The stakeholder environment for HCOs is shown in Exhibit 1.3; the complexity of HCOs arises from the multiplicity of HCO stakeholders and from the nature of healthcare services.

**Customer Partners**

Patients are the most important stakeholders. They expect, and deserve, care that meets the goals summarized in the Institute of Medicine’s report *Crossing the Quality Chasm*: safe, effective, patient-centered, timely, efficient, and equitable. They also expect reasonably comfortable amenities and confidentiality. Friends and family accompany most patients, and many family members serve as informal caregivers, so HCOs must establish close and direct relations with them.

Patients’ expectations include a major element of trust. *Information asymmetry*—the organization and its caregivers possess substantially more knowledge about the patient’s needs than the patient does—makes it impossible for many patients and families to articulate their needs. Instead, they expect the HCO to do that for them, thoroughly and fairly. Much of the failure in patient relations comes from difficulties with managing that trust.

Patients rely on a variety of mechanisms to pay for care, which can easily cost a large fraction of a family’s annual income. Health insurers and fiscal intermediaries provide most of the revenue to HCOs, making them essential exchange partners. Private health insurers are agents for buyers, which include governments, employers, and citizens at large. Two large governmental insurance programs—Medicare and Medicaid—are exchange partners with
most HCOs. The federal Medicare program deals with HCOs through its intermediaries. Medicaid, a combination state and federal program that finances care for the poor, is run by the state Medicaid agency or an intermediary. Representing the buyers, payment organizations use contractual requirements, regulatory support, and incentive payments to improve the quality, safety, and cost of care.

Much health insurance is provided through employment, making employers important exchange partners. Historically, unions played a major role in establishing health insurance as an employee benefit. Federal, state, and local governments purchase care for special groups of citizens and also buy insurance as employers do. Buyers, who must meet the demands of their own exchange networks, have taken action to restrict the growth of costs, acting principally through payment organizations. Their pressure is likely to continue.

EXHIBIT 1.3 Model of Stakeholder–HCO Interaction

**Owners**
- Not-for-profit corporations, for-profit corporations, and government entities

**Customers/Buyers**
- Patients and families differentiated by age, gender, and clinical need
- Health insurers and payment agencies differentiated by carrier and kind of coverage
- Buyers differentiated by individual, employer, and government

**HCO**
- Local, state, and federal licenses, permits, and certifications
- Private certifications and accreditations
- Healthcare-specific laws and regulations
- General corporate laws and regulations

**Suppliers/Workers**
- Caregivers differentiated by professional credentials
- Other employees differentiated by job description
- Contract providers differentiated by purpose of contract
- Suppliers
- Volunteers

**Trade associations, professional organizations, unions, customer associations, lobbies, and other collectives influencing healthcare transactions**

**Intermediary**
A payment or management agent for healthcare insurance (e.g., Medicare intermediaries that pay providers as agents for CMS)

**Medicaid agency**
The state agency handling claims and payments for Medicaid
Most payment organizations mandate two outside audits of HCO performance—accreditation by The Joint Commission or its osteopathic counterpart the American Osteopathic Association and audit by a public accounting firm of the HCO’s choice. Some insurance plans are accredited by the National Commission on Quality Assurance (NCQA), which also accredits ambulatory care and disease management. Medicare and Medicaid—contracts that are essential to most HCOs—are monitored through deemed status, a determination of conformance usually established through the accreditation agencies.

Government regulatory agencies are exchange partners that at least nominally act on behalf of the patient and buyer. State licensing agencies are common, not only for hospitals and healthcare professionals but sometimes also for other facilities such as ambulatory care centers. Many states have certificate-of-need laws, requiring HCOs to seek permission for construction or expansion. Quality improvement organizations (QIOs) are external agencies that review the quality of care and use of insurance benefits by individual physicians and patients for Medicare and other insurers. HCOs are subject to many consumer-protection laws, including the Health Insurance Portability and Accountability Act (HIPAA), which addresses major issues of patient-record confidentiality.

HCOs require land-use and zoning permits; they use water, sewer, traffic, electronic communications, fire protection, and police services and thus are subject to environmental regulations. HCOs often present unique needs in these areas that must be negotiated with their local government.

The courts can also be viewed as regulatory agencies. HCOs may be sued for malpractice or negligence—harmful conduct that is unintentional but avoidable with reasonable care. Suits are brought by individuals in specific cases, but the court findings establish the rules of conduct for future actions. Thus the courts can also be viewed as regulatory organizations.

HCOs make numerous, varied, and far-reaching exchanges with community agencies and groups. They facilitate infant adoption; receive the victims of accidents, violence, rape, and family abuse; and attract the homeless, the mentally incompetent, and the chronically alcoholic. These activities draw them into exchange relationships with law enforcement and social service agencies.
In addition, HCOs work with United Way charities. They facilitate baptisms, ritual circumcisions, group religious observances, individual spiritual activity, and rites for the dying. They provide educational facilities for caregivers and services to the community such as health education and disease prevention programs, assistance to support groups, and mobile clinics. These activities often make HCOs partners of cultural, religious, educational, and charitable organizations. Prevention and outreach activities draw HCOs into alliances with governmental organizations, such as public health departments and school boards, and with local employers, churches, and civic organizations.

Not-for-profit HCOs often occupy facilities that, if taxed, would add noticeably to local tax revenues. The community may hold the organization to certain conditions, such as a certain level of charity care, in return for nonprofit status. As a result, the electorate and the local government are stakeholders collectively, and the electorate contains many of the HCO’s stakeholders individually. Communication with stakeholders often involves the media—print, radio, television, and Internet coverage—and purchased advertising. Web-based public sources such as HealthGrades and Why Not the Best are increasingly influential in forming customer opinion, although they do not give consistent results.

**Provider Partners**

The second most fundamental exchange, next to patients, is between the HCO and its **associates**—people who give their time and energy to the organization. HCO associates are employees, trustees and other volunteers, and medical staff members.

Employees are compensated by salary and wages. Trustees and a great many others volunteer their time to the organization; their only compensation is the satisfaction they achieve from the work. Medical staff members receive monetary compensation from either patients and insurance intermediaries or the HCO. **Primary care practitioners**—physicians in family practice, general internal medicine, pediatrics, obstetrics, and psychiatry; nurse practitioners; and midwives—are the most common initial contacts for healthcare. **Referral specialist physicians** tend to see patients referred by primary care practitioners and to care for these patients on a more limited and transient basis. They are more likely to manage episodes of inpatient hospital care. **Hospitalists**, a recently established referral specialty, accept relatively broad
categories of patients and manage inpatient care only. Other professional caregivers (e.g., dentists, psychologists, podiatrists) may also be members of the medical staff.

Associates are often organized into groups that manage their exchanges to varying extent. Unions, or collective bargaining units, sometimes represent employed associates. Physicians often form professional associations and practice groups. Neurologists, for example, can become a group to represent their interests to the organization as a whole. Group membership is itself an organization; individuals choose it because a group can meet some needs that would otherwise go unmet. The success of the group depends on the exchanges that commit the individuals to the group.

Government agencies of various kinds monitor the rights of associate groups. Occupational safety, professional licensure, and equal employment opportunity agencies are among those entitled access to the HCO and its records. The National Labor Relations Board and various state agencies define which organizations are unions and establish rules for their relations with employers. The HCO is obligated to collect Social Security and income tax withholding.

HCOs use goods and services—from artificial implants to food to banking to utilities—purchased from outside suppliers. Financing partners help HCOs acquire capital through a variety of equity, loan, and lease arrangements. HCOs often enter into strategic partnerships with suppliers and other provider partners.

In the course of meeting patient needs, HCOs have considerable contact with other providers, including organizations and agencies whose service lines may be either competing or complementary, such as primary care clinics, mental health and substance abuse services, home care agencies, hospices, and long-term-care facilities. Many large HCOs have formal relationships with these organizations, such as referral agreements, strategic partnerships, joint ventures, and acquisition and ownership. It is not uncommon for two HCOs to collaborate on some activities, such as medical education or care of the poor, and to compete on others. Even competitors with almost exactly the same services negotiate contracts with each other. Federal and state antitrust laws regulate the negotiation between competitors, but these prohibitions are specific and other communication is permitted.
Sources of Stakeholder Influence

The ultimate source of stakeholders’ power is the marketplace—their ability to participate in the exchange. In reality, influence is exercised through ongoing negotiation rather than discontinued participation. Stakeholders form coalitions and networks to enhance their influence and facilitate negotiation. The results of negotiation are embedded in marketplace contracts and reinforced through government regulation. Ultimately, but rarely, the courts resolve disputes in relationships.

Successful HCOs work steadily and systematically to increase the loyalty of their stakeholders. Their efforts are proactive and extensive. Their goal is to identify stakeholder needs and design effective responses before unmet needs become points of contention.

Stakeholder participation is carefully measured. Customer participation is measured by market share, and provider participation is measured by retention and shortages. Satisfaction of participants is also monitored. The goal here is to acquire and retain loyal or secure customers and associates.

Rather than discontinue their participation, stakeholders usually present their concerns for negotiation. The stakeholders’ desires frequently conflict and can easily become adversarial, as in the traditional relationship between unions and management. Successful HCOs strive to minimize adversarial relationships by building a record of responsiveness and truth telling, making a diligent effort to find and understand relevant facts, maintaining respect and decorum in the debate, and searching diligently for solutions. The goal is to have the stakeholders leave the discussion feeling that their concerns were heard, that the decision was fair, and that no realistic opportunity to improve the decision exists. “My (or our) concerns have been heard and met as well as possible” is the feeling that results from successful negotiation.

Each exchange partner of the HCO has relationships with exchange partners of their own. Individuals and families affiliate with employers, businesses, schools, churches, and community groups. Stakeholder coalitions form among these relationships based on shared values or common needs. Many are more or less permanent, while others are temporary alliances to forward a specific goal.

Similar networks exist for other social issues. They are the essence of “community” because they facilitate our living together harmoniously. Nurturing these networks is fundamental to the social fabric. HCOs that deal effectively with these networks contribute to their communities in two ways: (1) they provide and improve healthcare, and (2) they strengthen the social fabric.
A small group of essential caregivers, such as the obstetricians in the community, can challenge how the HCO meets specific needs, such as the care of low-income mothers. Unions or associations that represent doctors, nurses, or patients are more permanent stakeholder coalitions. Buyer- and consumer-oriented networks, such as the National Business Group on Health, CalPERS, and AARP, are coalitions that allow stakeholders to address complicated social problems, such as healthcare’s uninsured and health promotion.

Many coalitions become permanent to forward their stakeholder agendas. An important example is The Joint Commission. A successful example is the National Quality Forum (NQF), which was created in 1999 “to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach.”

NQF has a board of 25 members, including 7 organizations that directly represent healthcare providers and 18 that represent buyer coalitions. NQF has established a mechanism to evaluate and standardize measures of quality. These measures are recorded for public use and posted on the website by the Agency for Healthcare Research and Quality (see www.qualitymeasures.ahrq.gov).

Stakeholders can imbed their viewpoint into law, regulation, and contract. They can also sue in courts. These actions are social controls on HCOs. They create the various regulatory mechanisms. For example, The Joint Commission has been given extraordinary power by Medicare and Medicaid, which withhold payment unless its standards are met. As a result, it can effectively shut down any HCO by denying accreditation. Medicare and private insurance programs now use the NQF measures in pay-for-performance programs to improve quality, and The Joint Commission has added the measures to its criteria.

Social controls almost always reflect good intentions—safety, quality, individual rights, equity, and efficiency. Accomplishment is another matter. It is fair to conclude that both the regulatory agencies dealing with healthcare delivery and the contracts of the health insurers and intermediaries have generally fallen short of expectations. Safety, quality, healthcare disparities, and cost remain problems despite decades of activity in these areas. In part, this reflects the complexity of the goal and the difficulty of measurement. In part, it reflects the limitations of the market and governmental systems.

The use of objective measures of performance may provide an improvement. Many observers agree that “The U.S. health care delivery system is in need of overhaul. Care is fragmented, unsafe, and inefficient. . . . [S]tronger organizational capabilities and supports are urgently needed to achieve high levels of performance.” Pressures to build these capabilities and achieve

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**The Joint Commission**

A voluntary consortium of HCOs and professional provider organizations that ensures a minimum level of safety and quality in HCOs

**Social Controls**

Stakeholders can imbed their viewpoint into law, regulation, and contract. They can also sue in courts. These actions are social controls on HCOs. They create the various regulatory mechanisms. For example, The Joint Commission has been given extraordinary power by Medicare and Medicaid, which withhold payment unless its standards are met. As a result, it can effectively shut down any HCO by denying accreditation. Medicare and private insurance programs now use the NQF measures in pay-for-performance programs to improve quality, and The Joint Commission has added the measures to its criteria.
performance are likely to mount. By the start of the Obama administration, many experts argued that broad changes in the overall system of healthcare are essential. One group of experts from 13 different stakeholder organizations advocated “to create a national center for effectiveness research, develop models of accountable healthcare entities capable of providing integrated and coordinated care, develop payment models to reward high-value care, develop a national strategy for performance measurement, and pursue a multi-stakeholder approach to improving population health.” The model described in this text is consistent with such a program. It is based on actual HCOs that have documented their success in meeting multiple stakeholder needs.

Ownership

Not-for-Profit, For-Profit, and Government Owners

Acute care hospitals are the largest single group of HCOs. They are also the largest and oldest components of most large HCOs. They are licensed corporate entities and easily identified for statistics and therefore provide a convenient, though incomplete, description of twenty-first century HCOs.

Most hospitals are community hospitals. Historically, they were controlled by either the local government or not-for-profit organizations owned by the community and expected to fulfill community needs. The not-for-profit corporations were given substantial tax advantages, recognizing that their services would otherwise be required of government. In the 1970s, a movement to for-profit ownership quickly reached about 10 percent of all community hospitals, and increased sporadically thereafter. As of 2007, the formal organization of hospitals, shown in Exhibit 1.4, was dominated by not-for-profit corporations. The local government and for-profit sectors were smaller in total, and concentrated among smaller hospitals. In addition, a small number of federal hospitals serve military, veterans, Native American, and federal prison needs. (Federal hospitals are excluded from counts of community hospitals.)

Healthcare Systems

As Exhibit 1.4 shows, most hospitals are relatively small HCOs. A hospital has about eight full-time employees per million dollars in expenses. The median hospital has only about 300 full-time employees. In the 1980s, HCOs began to organize multiple hospitals and other healthcare activities into a healthcare system. By 2007, more than half of all hospitals and almost two-thirds of healthcare expenditures were in systems. Although many systems are large interstate operations that often include a broad spectrum of
EXHIBIT 1.4 Ownership and Size of U.S. Community and Federal Hospitals

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Number of Hospitals</th>
<th>Percent of All Hospitals</th>
<th>Total Expenditures (in millions)</th>
<th>Percent of Total Expenditures</th>
<th>Average Expenditures per Hospital (in millions)</th>
<th>Median Expenditures per Hospital (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State and local government</td>
<td>1,110</td>
<td>22%</td>
<td>$77,914</td>
<td>14%</td>
<td>$70</td>
<td>$16</td>
</tr>
<tr>
<td>Religious not-for-profit</td>
<td>533</td>
<td>10</td>
<td>70,728</td>
<td>13</td>
<td>133</td>
<td>99</td>
</tr>
<tr>
<td>Other not-for-profit</td>
<td>2,425</td>
<td>47</td>
<td>315,265</td>
<td>57</td>
<td>130</td>
<td>62</td>
</tr>
<tr>
<td>For-profit</td>
<td>868</td>
<td>17</td>
<td>54,833</td>
<td>9</td>
<td>60</td>
<td>36</td>
</tr>
<tr>
<td>Federal</td>
<td>226</td>
<td>4</td>
<td>36,830</td>
<td>7</td>
<td>163</td>
<td>141</td>
</tr>
<tr>
<td>Total</td>
<td>5,161</td>
<td>100%</td>
<td>$552,570</td>
<td>100%</td>
<td>$107</td>
<td>$35</td>
</tr>
</tbody>
</table>

*SOURCE: Data from American Hospital Association Annual Survey Database, Fiscal Year 2005.*

care, the most common system structure is simply a few hospitals and related patient care activities such as primary care operating with one management structure within a single community. The median size of systems was about $500 million expenses per year, or 4,000 employees.

Like the hospitals from which they arose, not-for-profit and governmental systems dominate the market. There are five federal systems, four large for-profit systems, and a number of small for-profit systems. Although many hospitals owned by local governments remain independent, many others have joined not-for-profit or for-profit systems. Exhibit 1.5 shows the system affiliation of community hospitals.

### Designing Excellence in an HCO

The better an HCO is managed, the greater the total advantages it produces. Excellence is achieved when these needs of both customer and provider stakeholders are optimally met:

- Patient care is safe, effective, patient-centered, timely, efficient, and equitable.\(^{20}\)
- The community’s health and healthcare needs are met.
- Caregivers and other associates are attracted to the HCO, and they are given support to do their best.
- Expenditures are controlled so that the total cost is within the community’s economic reach.

*The Well-Managed Healthcare Organization* describes how excellence is achieved by large HCOs. It identifies the essential functions, their organization, and the measures that document their performance. It is based not
The teams shown in Exhibit 1.1 can work as independent units, a marketplace where each team is a vendor, selling either to the patient or to another vendor. Much of American healthcare is essentially that. Small HCOs—doctors’ offices, pharmacies, hospitals, equipment vendors, nursing homes, etc.—operate without any permanent relationship to each other. They buy logistic services from other vendors. There is no overarching strategy; the patients and the care teams will select each vendor as they need them. Large HCOs and healthcare systems have a very different vision, called **vertical integration**. They will integrate and support a large group of the care teams, most commonly in acute care and rehabilitation, but increasingly also primary care and long-term care. Many also pursue the same kinds of care teams in multiple sites, or **horizontal integration**.

As shown in Exhibit 1.6, excellence has three major foundations:

1. **Cultural**, a commitment to values that attract the respect and support of stakeholders as individuals;
2. **Operational**, a system that seeks out, evaluates, and implements opportunities to improve stakeholder returns; and
3. **Strategic**, a system that deliberately monitors the long-term relationship between stakeholders and responds to changing needs.
The history of organizations in all industries suggests that stakeholders must build a cultural foundation that consists of five major elements: shared values, empowerment, communication, service excellence, and rewards for success. Excellent HCOs make major investments in clarifying,
publicizing, and implementing their commitments to these elements. Their investments create a culture sometimes called *transformational management* that is highly satisfactory to both customer and associate stakeholders.

The transformational culture provides team members with important but intangible rewards—a sense of contribution to critical values, empowerment to shape the work, and partnership with like-minded individuals. The power of transformational management has been extensively documented.\textsuperscript{21,22,23} It produces substantially better performance for two reasons:

1. Associates’ insights about the job frequently improve the processes used, eliminating waste and inefficiency.
2. Associates are psychologically committed to the goal, rather than simply sellers of their services. Also, when they are well trained, they can adjust to changes that arise, enabling them to avoid many causes of failure.\textsuperscript{24}

HCOs state that their **mission** is the central purpose of stakeholder collaboration. The fact that that mission is one of humanity’s highest callings makes work in an HCO inherently attractive to many people. The mission to serve the sick provides a common bond that crosses many of the usual separations in society, and it is strongly endorsed by most of the world’s religions. It is consistent with the ethical foundation of the caregiving professions. It is frequently mentioned as a personal commitment and source of satisfaction by HCO associates at all levels. Excellent HCOs build deliberately on a strong, visible commitment to this mission.

The mission is supplemented with a shared **vision**, an idealistic goal such as universal healthcare. Evidence from other industrial sectors suggests that *BHAGs*—big, hairy, aggressive goals—challenge associates and lead to better overall performance.\textsuperscript{25} The mission and vision are, in turn, supplemented by commitment to **values** shared rules of conduct. Values reflect the humanistic consensus of American thought: respect for all, compassion, honesty, trust, stewardship, and improvement.

The mission, vision, and values of an HCO are usually written by multiple teams with broad stakeholder representation so that many associates and customers can take part in the discussion and commit to the concepts. As a result, the wording of mission, vision, and values differs from HCO to HCO, but common threads are obvious between them.\textsuperscript{26} The moral concepts behind the mission, vision, and values are often stated as *autonomy* (commitment to the patient’s right to decide his or her own course), *beneficence* (commitment to serve the patient’s needs),

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### Shared Values

| **Mission** | A statement of purpose—the good or benefit the HCO intends to contribute—couched in terms of an identified community, a set of services, and a specific level of cost or finance |
| **Vision** | An expansion of the mission that expresses intentions, philosophy, and organizational self-image |
| **Values** | An expansion of the mission that expresses basic rules of acceptable conduct, such as respect for human dignity or acceptance of equality |
non-maleficence (commitment to “do no harm”), and justice (commitment to equity and respect for all). Exhibit 1.7 shows the mission, vision, and value statements of HCOs that have documented their excellence for the Malcolm Baldrige National Quality Award.

Excellent HCOs publicize and display their mission, vision, and values widely, often on every associate’s badge and always on every major entrance path, including the website. The mission, vision, and values are extensively advertised to the community at large and are an attractive statement to customers, communicating that “This HCO is here to meet your health needs.” They also serve to guide potential associates at all levels.

Empowerment

One purpose of transformational management is to create an environment where every associate can feel comfortable to think: “I will treat patients with compassion and be confident that members of my team and those in other teams will do the same. I will do my job, and I can trust others to do theirs. I can rely on what I’m told. My needs will be met. I won’t be ignored, let alone harassed. And we will get better over time.” This comfort level reflects empowerment.

Empowerment

The ability of an associate to control his or her work situation in ways consistent with the mission

Empowerment is particularly important in healthcare, where caregiving professionals must make rapid and correct responses to patient needs. It improves overall performance because associates (1) are not distracted or frustrated by their work situation and (2) feel empowered to meet patient needs. Empowered workers are known to be more effective. Empowerment has long been a concern of the caregiving profession. Excellent HCOs ensure that their doctors, nurses, and other caregivers are empowered, but they also extend the same support to all associates.

Communication

Failures of communication are an obvious source of difficulty. “I didn’t know you needed that” is a clear and frequent example. Transformational management addresses communication in several ways, some of which are discussed in this section. Excellent HCOs pursue all such methods, making frequent, candid, and useful communication a hallmark of their organizations and a strength in improving performance.

Listening

Much of modern healthcare (more than most people think) can be quantified, but much remains subjective. Excellent HCOs formally and informally listen to all stakeholders to complement and strengthen their measured performance. Listening means deliberately soliciting stakeholder input through various communication methods, such as surveys, positive and negative event reports, group and individual interviews, direct conversations, e-mails, and blogs. The results of listening are systematically described, tallied, and analyzed to identify trends and opportunities for improvement.
## EXHIBIT 1.7

Mission, Vision, and Values of Baldrige Award Recipients, 2002–2009

<table>
<thead>
<tr>
<th>Organization</th>
<th>Mission</th>
<th>Vision</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSM Health Care (OK, IL, MO, WI)</td>
<td>Through our exceptional health care services, we reveal the healing presence of God.</td>
<td>Communities, especially those that are . . . marginalized, will experience improved health in mind, body, spirit and environment</td>
<td>Compassion, Respect, Excellence, Stewardship, Community</td>
</tr>
<tr>
<td>Baptist Hospital (FL)</td>
<td>To provide superior service based on Christian values to improve the quality of life for people and communities served.</td>
<td>To become the best health system in America</td>
<td>Integrity, Vision, Innovation, Superior service, Stewardship, Teamwork</td>
</tr>
<tr>
<td>Saint Luke's Hospital (MO)</td>
<td>Highest levels of excellence in . . . health services to all patients in a caring environment</td>
<td>Best place to get care, best place to give care</td>
<td>Quality, excellence, Customer focus, Resource management, Teamwork</td>
</tr>
<tr>
<td>Robert Wood Johnson University Hospital (NJ)</td>
<td>Excellence through service. We exist to promote, preserve and restore the health of our community</td>
<td>To passionately pursue the health and well-being of our patients, employees and the community</td>
<td>Quality, Understanding, Excellence, Service, Teamwork</td>
</tr>
<tr>
<td>Bronson Methodist Hospital (MI)</td>
<td>Provide excellent healthcare services</td>
<td>A national leader in healthcare quality</td>
<td>Care and respect, Teamwork, Stewardship, Commitment to community, Pursuit of excellence</td>
</tr>
<tr>
<td>North Mississippi Medical Center (MS)</td>
<td>To continuously improve the health of the people of our region</td>
<td>To be the provider of the best patient-centered care and health services in America</td>
<td>Compassion, Accountability, Respect, Excellence, Smile</td>
</tr>
<tr>
<td>Mercy Health System (WI)</td>
<td>The mission of Mercy Health System is to provide exceptional healthcare services resulting in healing in the broadest sense.</td>
<td>Quality—Excellence in patient care Service—Exceptional patient and customer service Partnering—Best place to work Cost—Long-term financial success</td>
<td>Healing in its broadest sense, Patients come first, Treat each other like family, Strive for excellence</td>
</tr>
</tbody>
</table>

*continued*
### Exhibit 1.7

<table>
<thead>
<tr>
<th>Organization</th>
<th>Mission</th>
<th>Vision</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharp HealthCare (CA)</td>
<td>To improve the health of those we serve with a commitment to excellence in all that we do. Sharp’s goal is to offer quality care and services that set community standards, exceed patients’ expectations, and are provided in a caring, convenient, cost-effective, and accessible manner.</td>
<td>Sharp will redefine the health care experience through a culture of caring, quality, service, innovation, and excellence. Sharp will be recognized by employees, physicians, patients, volunteers, and the community as: the best place to work, the best place to practice medicine, and the best place to receive care.</td>
<td>Integrity Caring Innovation Excellence</td>
</tr>
<tr>
<td>Poudre Valley Health System (CO)</td>
<td>To be an independent, non-profit organization and to provide innovative, comprehensive care of the highest quality, always exceeding customer expectations.</td>
<td>To provide world-class health care</td>
<td>Quality Compassion Confidentiality Dignity/respect Equality Integrity</td>
</tr>
<tr>
<td>AtlantiCare (NJ)</td>
<td>. . . health and healing to all people through trusting relationships</td>
<td>Builds healthy communities</td>
<td>Integrity Respect Service Teamwork Safety</td>
</tr>
<tr>
<td>Heartland Health (MO)</td>
<td>To improve the health of individuals and communities . . . and provide the right care, at the right time, in the right place, at the right cost with outcomes second to none</td>
<td>The best and safest place in America to receive health care and live a healthy and productive life</td>
<td>Respect Honesty Compassion Trust Integrity Service</td>
</tr>
</tbody>
</table>

For example, Exhibit 1.8 shows the planned communication and training approaches at Bronson Methodist Hospital in Kalamazoo, Michigan. Bronson, a Malcolm Baldrige National Quality Award recipient in 2005, explains in its Baldrige application that managers are expected to dedicate much effort to ensuring that these processes are completed frequently and well. Each senior manager is expected to spend five hours per week listening to caregiving, logistic, and clinical teams.

Empowerment requires that organization goals and plans be discussed in advance to gain widespread understanding and commitment. Understanding and commitment are not automatic. Their achievement requires exploring implications, identifying concerns and barriers, and finding ways to remove those barriers. From the manager’s perspective, conflicting stakeholder needs must be negotiated and a mutually acceptable settlement reached.

Negotiation is a major shift in organizational thought. The bureaucratic organization, going back to Machiavelli’s time and before that, operated under the command from superior to subordinate. In excellent HCOs, however, commands are used only in extreme emergency situations, where a team leader must coordinate the team quickly through uncharted territory. All other interactions are established by implicit or explicit negotiation.

**EXHIBIT 1.8**
Bronson Methodist Hospital: Mechanisms for Communication, Skill Sharing, and Knowledge Transfer

| Pre-hire and selection process (C, SK, TT) | Competency assessments (C, SK, TT) |
| New hire orientation (C, SK, TT) | Workshops and educational courses (C, SK, TT) |
| Nursing core orientation (C, SK, TT) | Employee forums and focus groups (C, TT) |
| Leadership communication process (C) | Employee neighborhood meetings (C, TT) |
| Leadership communication forums (C) | Computer-based learning modules (C, SK) |
| Knowledge-sharing documents (C, SK) | Leader rounds (C, SK, TT) |
| Department meetings (C, SK, TT) | Self-study modules (C, SK) |
| Bulletin boards (C) | Skills fairs and learning labs (C, SK, TT) |
| Communication books (C) | Safety champions (C, SK, TT) |
| E-mail for all employees (C, TT) | Preceptors (C, SK, TT) |
| Instant messaging (C, TT) | Externships/internships (C, SK, TT) |
| *InsideBronson* intranet (C, SK, TT) | Management mentor program (C, SK, TT) |
| Department-specific newsletters (C) | Shared governance (C, SK, TT) |
| Shared directories (C) | Teams, work groups, councils, and committees (C, SK, TT) |
| Daily huddles (C, SK, TT) | Staff performance management system (C, SK, TT) |
| *Healthlines* newsletter (C) |  |
| CEO/CNE open office hours (C, TT) |  |
| Leadership (C, SK, TT) |  |

*C*: communication; *SK*: skill sharing and knowledge; *TT*: two-way transfer

The activities of Exhibit 1.1 are learned. They follow prescribed scripts that are replicable for every process but can be adapted to individual patient needs and unanticipated events. Patient care follows **protocols**—from greeting a patient (“Good morning, may I check your armband?”) to administering an intravenous drip to performing a surgical “timeout” whereby the circulating nurse verifies the patient, procedure, location, and any unusual risks. Specific **procedures** or **processes** are also followed for nonclinical activities, such as cleaning washrooms, posting payments to patient accounts, and conducting meetings of the governing board.

All processes are learned, and most are taught by the organization. High-performing organizations invest heavily in teaching (using a variety of approaches), measuring learning, and rewarding correct application. Bronson Methodist, for example, documents an average of more than 100 hours of teaching for each full-time employee.

Actions inevitably speak louder than words. Everyone in leadership positions must model the behaviors that support the organizational values. High-performing HCOs expect their managers’ professional actions to personify and implement the mission, vision, and values. Training programs help managers understand how to respond to common problems in ways that encourage associates. These programs often include coaching and mentoring to improve skills and counseling when specific problems arise. Managers at all levels are expected to point out to each other anything that falls short of model behavior. Managers undergo a multi-rater review, a system that allows subordinates, coworkers, customers, and supervisors to evaluate the managers anonymously.

Every team and organization functions under a contract or agreement; that is, team members are agents who agree to carry out individual acts and to share accountability for the results. Caregiving teams are agents for patients who are unable to act for themselves. The concept of **agency** or **accountability** (also called **stewardship**) is essential to build trust within the organization. HCOs reinforce trust and stewardship by building team spirit and by modeling and rewarding correct behaviors.

Trust and accountability, agency, and stewardship are difficult to sustain. They are subject to moral hazard; any member can do less than her share, free-riding on the efforts of others. High-performing HCOs build trust and stewardship with a program of **service excellence**, recognizing that associates will work to meet customer needs if their own needs are...
That is, if management shares the values of its workers, listens to them, responds to the issues they raise (empowering them), trains them, and supports them logistically, the workers perform to the extent that customers’ needs are satisfied.

Service excellence has gained wide support, particularly in service industries. It is a universal practice among high-performing HCOs. In addition, team evaluations and team pressure help make free-riding unattractive or difficult. An important motivator among workers is the belief that their colleagues will not let them down, so they will not let their colleagues down in return.

The most important reward for most associates is the satisfaction of having done a good job. Excellent HCOs not only provide that reward but also strengthen and complement it. Success at continuous improvement provides measurable gains in achieving stakeholder goals. HCO operations become safer, more pleasant, more responsive, and more efficient. The new processes developed are better than the ones they replaced. The negotiated goals are almost always achieved. Patients and families express their gratitude.

High-performing HCOs distribute a substantial portion of the gains back to the associates who helped produce those gains. HCOs do this in two ways—celebrations and incentive pay. Celebrations include parties, meals, various tokens of recognition, and prizes such as gift certificates or small amounts of cash. They are frequent, usually informal, and can be put together quickly. Often, first-line supervisors are given a budget explicitly for celebrations. Incentive compensation links employee performance to the HCO goals. Substantial financial rewards are provided to associates in return for achieving continuous improvement goals.

The reward system of Mercy Health System in Janesville, Wisconsin, is shown in Exhibit 1.9. The six celebrations offer prizes for various individual achievements that embody the organization’s vision and values, such as offering extra help to a patient or family, serving on a demanding committee, contributing a useful solution or a new idea, or reaching out to a coworker. The incentive compensation is open to all but is tailored to specific professions and economic situations. Mercy’s retirement program is designed to retain its best associates.

**Operational Foundation of Excellence:**

**Evidence-Based Management**

The operational foundation reflects a major shift in thinking that began in the 1990s and continues today in more than half of the nation’s hospitals. This model, often called evidence-based management, relies more heavily on performance measurement and formal process specification than on traditional approaches. Evidence-based management deliberately
parallels evidence-based medicine, a similar shift in medical thinking toward the systematic use of science to identify clinical best practices.

The core concept of evidence-based medicine is that scientific knowledge should drive as many clinical decisions as possible. Much of medicine is judgmental, but as the diagnosis is clarified, evidence can be drawn from existing similar cases. Patient care protocols or guidelines define the scientifically proven steps appropriate for treating most patients with a specific disease or condition. Functional protocols detail the specific steps for performing individual clinical procedures, such as admission interviews and subcutaneous injections. These protocols specify what must be done, by whom, and when, making explicit the agency and stewardship obligations behind service excellence. These are not rules; the empowered caregiver has the obligation to depart from the protocol when the patient’s condition requires it.

Although evidence-based medicine encountered substantial resistance when it was introduced around 1990, it has become the standard of practice. Many professional organizations and academic medical centers prepare patient care protocols, and more than 2,000 such protocols are listed on...

**EXHIBIT 1.9**
Mercy Health System Award/Incentive Programs and Objectives

<table>
<thead>
<tr>
<th>Reward</th>
<th>Award/Incentive Programs</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celebrations</td>
<td>“Above and Beyond the Call of Duty” Partner Recognition Dinner</td>
<td>Promote excellent services by rewarding/recognizing best practices, quality outcomes, innovation, teamwork, or partnering initiatives</td>
</tr>
<tr>
<td>Quest for the Best Baskets for Champions Partner Idea Program “Someone to Admire and Respect”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incentive Compensation Report cards/performance appraisals; bonuses dependent on organizational and individual achievement of targets Physician incentive program Individual merit increases Matched savings retirement plan</td>
<td>Reward best-practice achievers of individual targets, tied to Four Pillars of Excellence** Reward superior customer service performance</td>
<td></td>
</tr>
</tbody>
</table>

*Partners are all employees, including managers and senior management
**Four Pillars of Excellence is Mercy Health System’s dimensions of strategic measurement: Quality—excellence in patient care and service; Exceptional Patient and Customer Service; Partnering—best place to work; and Cost—long-term financial success


Patient care protocols or guidelines
Formally established expectations that define the normal steps or processes in the care of a clinically related group of patients at a specific institution

Functional protocols
These determine how functional elements of care are carried out
Evidence-based medicine is deeply embedded in both graduate and continuing clinical education. In fact, the Accreditation Council for Graduate Medical Education has made practice-based learning and improvement, interpersonal and communication skills, and systems-based practice three of the six general competencies required for all physicians entering medicine after 2001. The other three general competencies—medical knowledge, clinical skills, and professionalism—trace back to Hippocrates. Practice-based learning and improvement, interpersonal and communication skills, and systems-based practice implement evidence-based medicine and are highly compatible with the values of excellent HCOs.

Evidence-based management applies the scientific method to managing organizations. It is widely recognized in other industrial sectors, and it requires a thoughtful, thorough, and professionally disciplined approach. In HCOs, it is built around the following elements:

1. **Boundary spanning**: establishing and maintaining effective relationships with all stakeholders, and adapting the HCO to the needs of its community
2. **Knowledge management**: maintaining a detailed fact base about the organization, including performance measures, benchmarks, and work processes, and making that fact base accessible to associates through training and communication
3. **Accountability and organizational design**: identifying and integrating the contribution and goals of each HCO component
4. **Continuous improvement**: continually analyzing and improving all work processes, following a systematic cycle of measurement, opportunity identification, analysis, trial, goal setting, and training for implementation

Evidence-based management is a major philosophic change. Like the advances in web communication, it is one of the latest steps in the centuries-long growth of empiricism and science in human enterprise. Used with transformational management and evidence-based medicine, evidence-based management creates HCOs that can achieve performance previously thought to be beyond reach.

An excellent HCO must be able to provide reliable and timely answers to several recurring questions:

1. What are the opportunities for improvement as seen by customer stakeholders?
2. What are the demands and restrictions imposed by regulatory agencies?
3. What services should be available to our customers?
4. Which services should our HCO own and operate, and which should it acquire by contract?
5. How big should each service be?
6. What are the formal links between services and with the enterprise as a whole?
7. How do we acquire capital?
8. How do we acquire new technology and replace outdated facilities?
9. How do we ensure an adequate group of associates?

These questions identify the components of the HCO, relate them to each other, and relate the HCO to external suppliers and stakeholder networks. They are strategic questions, but the operational foundation must include substantial information gathering and analytic activity to ensure that the best alternatives are fully prepared and understood. Listening to customer stakeholders is an important part of this activity. Understanding and influencing the thinking of insurers, buyers, and regulators allow proactive instead of reactive relations. Quantitative analyses and forecasts of external data, such as population trends, economic trends, and epidemiology, support proposals that are economically realistic and that identify and reduce risks.

Facts drive evidence-based decisions. Knowledge management is sometimes called the data warehouse or the source of truth for the organization. Excellent HCOs build and maintain a large library of work processes, protocols, and performance measures; a training system to convey knowledge and skills that associates will retain; and a communication system to relay information relevant to immediate applications.

There is a “way we do things” for most activities in HCOs—from how the governing board is selected, to how a new patient is greeted, to how a spontaneous obstetric delivery is managed. Many different associates will be involved in most of these processes, and consistency is important. The processes will change, and the changes must be recorded. In evidence-based management, change is deliberately sought, using performance measures.

As shown in Exhibit 1.10, six dimensions of measurement are necessary to guide the individual teams listed in Exhibit 1.1. This set is called operational measures or operational scorecards. Three of these measures address the inputs or resources: demand for service, physical resources or costs, and the satisfaction and commitment of the unit’s human resources or associates. The other three measures address outputs or results: output and productivity (ratio of resource to output), quality of service or product, and customer satisfaction.

Success for the whole is more than the sum of success of individual teams. The measures must be carefully aggregated to progressively higher levels of accountability. Certain measures—chiefly income and financial position—cannot be calculated at the individual team level but are critical for the HCO as a whole. Strategic measures are those that assess the enterprise as a whole. As shown in Exhibit 1.11, they...
are carefully aggregated from operational measures to reflect the needs of major stakeholder groups. About 30 measures are used, covering four major dimensions—customers, suppliers and associates, operations, and finance.

Strategic measures, sometimes called the balanced scorecard, can be grouped as desired. One popular model, called the “Five Pillars,” splits operations into quality and service and discusses demand as “Growth.” In the next chapters, the templates in exhibits 1.10 and 1.11 are expanded to show the kinds of measures used by excellent HCOs in each activity and in the aggregate. The system of measures described in exhibits 1.10 and 1.11 tracks the stakeholder relations for each unit of the HCO, making clear what the unit’s critical contributions are and allowing for negotiated goals with measured achievement. Quantified goals and measures substantially reduce ambiguity and clarify each team’s and associate’s obligation. Frequently posted results discourage procrastination. When customers frequently post ratings of your work and attitude, the ratings are difficult for you to ignore.

Work processes and protocols must be learned by all users. In healthcare, many such protocols require users to master specific manual, verbal, and observational skills by practicing these processes regularly. Exhibit 1.8 includes a number of training activities or “knowledge transfer” in Bronson’s terminology. Bronson and other high-performing hospitals invest about twice as much time—2 to 2½ weeks per associate per year—in training. Much of this training is made available through organized sessions, but much is provided “just in time,” supplied on site by coaches, consultants, or leaders.

<table>
<thead>
<tr>
<th>Input Oriented</th>
<th>Output Oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demand</strong></td>
<td><strong>Output and productivity</strong></td>
</tr>
<tr>
<td>Requests for service</td>
<td>Counts of services rendered</td>
</tr>
<tr>
<td>Market share</td>
<td>Productivity (resources/treatment or service)</td>
</tr>
<tr>
<td>Appropriateness of demand</td>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td>Unmet need</td>
<td>Clinical outcomes</td>
</tr>
<tr>
<td>Demand logistics</td>
<td>Procedural quality</td>
</tr>
<tr>
<td>Demand errors</td>
<td>Structural quality</td>
</tr>
<tr>
<td><strong>Cost and resources</strong></td>
<td><strong>Customer satisfaction</strong></td>
</tr>
<tr>
<td>Physical counts</td>
<td>Patients</td>
</tr>
<tr>
<td>Costs</td>
<td>Referring physicians</td>
</tr>
<tr>
<td>Resource conditions</td>
<td>Other customers</td>
</tr>
<tr>
<td><strong>Human resources</strong></td>
<td></td>
</tr>
<tr>
<td>Supply</td>
<td></td>
</tr>
<tr>
<td>Development</td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
</tr>
<tr>
<td>Loyalty</td>
<td></td>
</tr>
</tbody>
</table>

EXHIBIT 1.10
Template of Operational Performance Measures for Individual Teams and Activities

Training
The culture of high-performing HCOs emphasizes listening, which requires facts and information such as patient orders, patient conditions, supplies used, and hours worked. Part of knowledge management is supplying this information promptly and accurately. Electronic medical records, e-mail, web access, telephone systems, newsletters, posters, and memos create a network through which time-dependent information can be exchanged.

Integrating an HCO requires careful planning to combine the caregiving and support teams into an effective whole. This means creating effective networks of accountability. Each team must know its contribution, and within the team, each member. In a transformational culture, these contributions are negotiated, but they must still be integrated into the whole.

A framework must exist for the negotiation and integration. The framework, called an **accountability hierarchy**, is a communications network that promotes factual exchange among related work teams and links each work team to the governing board. In

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Major Concepts</th>
<th>Healthcare Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial performance</td>
<td>Ability to acquire, support, and effectively reinvest essential resources</td>
<td>Profit and cash flow Days’ cash on hand Credit rating and financial structure</td>
</tr>
<tr>
<td>Internal operations, including quality and safety</td>
<td>Ability to provide competitive service Quality, efficiency, safety, and availability of service</td>
<td>Unit cost of care Measures of safety and quality of care Processes and outcomes of care Timeliness of service</td>
</tr>
<tr>
<td>Market performance and customer satisfaction</td>
<td>Reflects all aspects of relationship to customers</td>
<td>Market share Patient and family satisfaction Measures of access for disadvantaged groups</td>
</tr>
<tr>
<td>Associate satisfaction and ability to adapt and improve</td>
<td>Ability to attract and retain an effective associate group Learning and motivation of workforce Response to change in technology, customer attitudes, and economic environment</td>
<td>Physician and employee satisfaction Associate safety and retention Training program participation and skill development Availability of emerging methods of care Trends in service and market performance Ability to implement changes in timely fashion</td>
</tr>
</tbody>
</table>
addition to negotiating performance goals, the accountability hierarchy facilitates review of investment opportunities.

Not all patient needs are filled by associates; many are met by contractual partners, and some services are provided by remote organizations. Various legal structures are available to manage these relationships. Most large HCOs now have subsidiary corporations, joint ventures, and long-term contracts, which are sometimes called strategic partnerships. The accountability hierarchy of associates is supplemented with a designed array of other relationships.

Continuous improvement depends on performance measurement and commits the HCO to systematic change; what was done last year is no longer the automatic standard for the future. Continuous improvement was recognized in the 1980s, largely as a result of the work of W. Edwards Deming.\textsuperscript{43} It had widespread acceptance and is now a foundation for high-performing organizations in all industries. It is universal among excellent HCOs.\textsuperscript{44,45,46}

Systematic change is built on establishing goals, reporting actual results, and comparing actual outcome against goal and goal against benchmark. This comparison identifies opportunities for improvement (OFIs or “oafies”) and involves all teams, ideally all associates. OFIs also arise from qualitative assessments, including listening. Systematic change entails determining OFIs to design and implement changes in the work processes to achieve better performance. Exhibit 1.12 shows how processes are analyzed to translate OFIs to actual performance improvement.

The analysis is carried out by a process improvement team (PIT). Successfully translating OFIs to improvement requires finding the root causes, the underlying factors that must be changed to yield consistently better outcomes. These root causes almost always lie in the methods, tools, equipment, supplies, information, training, and rewards provided the team, and almost never in issues of individual effort or attitude. The proposition that opportunities to improve performance lie with process rather than with people has been proven countless times in all kinds of organizations.\textsuperscript{47}

Systematic change is a four-step process that applies to any OFI:

1. \textit{Identify}: find improvable processes or OFIs.
2. \textit{Analyze}: uncover root causes or possible corrections.
3. \textit{Test}: develop alternative solutions and select the best for implementation.
4. \textit{Evaluate}: implement the best solution, establish new goals, and monitor progress.
An older version of this concept is the Shewhart cycle, which labels these four steps as Plan, Do, Check, and Act.

The process, shown as the circle in Exhibit 1.12, can be quite elaborate, involving hundreds of associates and steps. A number of formal approaches to analysis are popular, including Lean Management, Six Sigma, and GE Work-Out; these are rigorous, objective, and thorough work processes for continuous improvement.

OFIs that apply to only one team can often be addressed by that team, but most OFIs are complicated and need a formal coordinating structure called the performance improvement council (PIC). The PIC is composed of representatives from all major activities or activity groups and is usually closely linked to senior management. The PIC’s first job is to prioritize the OFIs, and top priority are the OFIs that have the highest potential impact on mission achievement and strategic performance measures (Exhibit 1.11). The PIC pursues as many OFIs as possible, limited only by the ability of the organization to staff the improvement projects. An important part of PIC activity is coordinating multiple projects and keeping them aligned with the annual goal-setting activity.

**Strategic Foundation of Excellence: Positioning and Protection**

An HCO must support its cultural and operational foundations with a strategy or process for matching the activities and resources to stakeholder needs. **Strategic positioning** is an integrative activity that seeks maximum return from the resources available. Its success is measured by improvement in the strategic measures (Exhibit 1.11). Decision making provides definitive answers to boundary-spanning questions. **Strategic protection** safeguards the assets of the organization, including ensuring the reliability and validity of the data and information used for patient care and continuous improvement.

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**Performance improvement council (PIC)**
A formal coordinating structure composed of representatives from all major activities or activity groups; the PIC’s first job is to prioritize the OFIs

**Strategy**
A systematic response to a specific stakeholder need

**Strategic positioning**
The set of decisions about mission, ownership, scope of activity, location, and partners that defines the organization and relates it to stakeholder needs

**Strategic protection**
Safeguards the assets of the organization

---

**Strategic Positioning**
Strategic positioning has two major components. The first component is data intensive and analytical. The boundary-spanning and organization-designed activities generate proposals for responding to the most important questions. The second component is the decision to implement specific proposals. Decision making requires experience, imagination, diligence and risk taking.

Excellent HCOs use their governing boards, managers, and internal and external consultants for strategic positioning. Planning committees are established to pursue specific opportunities. They operate much like PITs in that they usually follow an iterative review process, such as the competitive tests for investment opportunities (see Exhibit 1.13). But planning committees have a broader
EXHIBIT 1.12
Process Analysis: Translating OFIs to Improved Performance

Can the OFI be addressed within the Unit or Activity?

**NO**
Performance improvement council prioritizes OFIs and pursues most promising ones.

**YES**
Unit or activity prioritizes OFIs and pursues most promising ones, using internal PIT.

PIT is established with:
- Charge
- Membership
- Timetable

PIT pursues systematic change and reports recommendation to sponsoring unit or PIC.

Improved process is implemented through involved units, revising:
- Multidimensional performance goals
- Training
- Supplies and equipment
- Information needs

- Expected improvements are achieved.
- Rewards are shared by associates.

---

**Performance improvement can be carried out at any level of the organization.**

**Every PIT has a charge, membership, and timetable at the outset.**

**Membership includes any unit affected by process, including operators, suppliers, and users.**

**Larger PITs can also get budgets and resources.**

**Systematic analysis can be expanded to formal programs such as Six Sigma or Lean.**

**Implementation is a separate step. New training and measures are often required.**

**The PIT proposes new performance goals on all dimensions affected by the new process.**

**Steps toward success are celebrated with recognition, parties, and prizes.**

**The financial gains resulting from improved performance are shared by all associates.**

OFI: opportunity for improvement; PIC: performance improvement council; PIT: process improvement team
agenda and greater license to consider innovation. They evaluate the impact of alternative actions on the strategic performance measures.

Exhibit 1.14 shows how excellent HCOs coordinate their strategic activity using an annual cycle of review that integrates analysis, proposals, and ongoing operations data to establish specific plans. These plans forecast expectations for the strategic performance measures several years into the future on the basis of the planning committee’s analyses. The forecast is refined as time passes, and for the immediate next year it becomes the initial proposal for strategic goals. The governing board and its committees review the forecast and establish the annual goals, which guide internal goal negotiations. Senior management is responsible for forecasting. It participates actively in the discussions and facilitates communications between governance and those in charge of activities.
EXHIBIT 1.14
Strategic Positioning and Monitoring Processes

Data and analyses are compiled by strategic activities and discussed in PITs, planning committees, and other teams. Results are summarized in reports shared with activities or teams affected.

Detailed proposals for revisions are prepared by PITs and planning committees.

Operating teams review and prioritize proposals that affect their units.

The governing board makes the final decisions.

With the help of strategic staff and senior management, the governing board adopts specific quantitative goals for the coming year.

Senior management leads the negotiations with each activity and unit, establishing goals for the operational measures.

All units, activities, and the governing board monitor performance, focused on the 90-day horizon.

Annual Review of:
- Stakeholder needs
- Performance trends
- OFIs
- Competitor activity
- Technology changes
- Financing trends
- Regulatory requirements

Evaluation and Adoption of Proposals for:
- Mission, vision, values
- Scope of services
- Facilities
- Long-term associate needs
- Mergers and affiliations
- Long-term financing

Adoption of Annual Goals for Strategic Performance
- Customer satisfaction and market
- Associate satisfaction and retention
- Earnings and capital investment
- Long-term associate needs
- Mergers and affiliations
- Long-term financing

Negotiation of Individual Team Goals and 90-Day Performance Plans

Monitoring Performance Against Goals

OFI: Opportunity for improvement; PIT: process improvement team
Strategic Protection

All the assets of an HCO are subject to known hazards. Money gets stolen; facilities get damaged; people get hurt; information gets distorted. Any kind of asset can be lost. The first line of defense is work processes designed to protect against these risks. Cash is handled in centuries-old processes that make theft and embezzlement rare. Security programs protect facilities and their people. Information handling includes careful attention to accurate inputs, safeguards for appropriate access, and backups for mechanical failure. Excellence must go beyond simply putting these processes in place. It must systematically monitor the security processes and the risks to ensure compliance. Thus, cash and cash processes are examined by external auditors; facilities and security personnel are monitored through video surveillance; data and programs are audited to verify their validity and reliability.

A less-obvious risk inherent in all organizations is the failure of an individual or team to completely carry out their responsibilities. Individuals and teams in HCOs act as agents for patients or internal customers and must be accountable to complete their duties. Other individuals and teams must be able to trust the agents. A high level of trust is essential to sustaining the culture of excellence. As noted, agency, accountability, and trust are inherently subject to moral hazard. Any excellent organization must protect against agency failure, which can occur at all levels—from the temporary employee to the chief executive officer to the governing board. Excellent HCOs have learned to strengthen and protect their agency relationships through six important steps shown in Exhibit 1.15. The first four steps are built into the culture and procedural foundations. The last two—audit and correction—require special attention.

Audits

At least three different kinds of audits go on simultaneously in an evidence-based management system and serve to strengthen accountability:

1. **Transparent performance review.** Each level of the organization has current goals and receives performance data frequently. Excellent HCOs encourage open review of these reports, both within the units and with other units. They use 90-day plans for goal achievement, including corrective plans where necessary. The openness creates an atmosphere that makes it difficult to carry out activities that are contrary to the mission.

2. **Internal audits and reviews.** The fact that audits can be conducted at any time, by auditors deliberately isolated from the activity, on either a random or selective basis serves as a strong deterrent to misfeasance. The processes that ensure reliability of quantitative reports also discourage misrepresentation. The extensive network of listening helps ensure conformance. Reports of difficulty are carefully handled in ways that protect people who report potential problems.

3. **External reviews, audits, and oversight.** The governing board, representing the owners and stakeholders as a whole rather than the organization and its associates, is an ongoing external monitor for the organization. Customer
stakeholders are regularly evaluated by The Joint Commission, external financial auditors, and routine financial and clinical reports. They may pursue criminal or civil redress if they have evidence of difficulty.

High-performing organizations have made the audit structure more robust. They have built reviews into the governance process so that board members evaluate each other and their performance as a team. They have voluntarily implemented the standards of the Sarbanes-Oxley Act, calling for greater protection against fraudulent diversion of assets, fuller disclosure of actual performance, attestation to the accuracy of published results by board members and senior management, increased auditing, and avoidance of conflict of interest in all board decisions.48

When failures of accountability, agency, or trust occur, excellent organizations deal with them using a structured program in which managers at all levels have been trained. The program begins with a warning and discussion of causes and corrections. Subsequent failures lead to retraining and a candid discussion about the consequences of failure for the individual as well as the organization. A written record is often created. Continued failure leads to termination or reassignment. When the behavior in question is dangerous, threatening, or deliberate, discharge is often immediate. Deliberate lying, falsification of records, harassment of others, criminal behavior, and violation of community norms usually lead to immediate discharge, regardless of the rank involved.

The cultural, procedural, and strategic foundations are designed to promote excellence, and they are largely successful. When these foundations

<table>
<thead>
<tr>
<th>Values</th>
<th>Mission, vision, and values are collectively developed, prominently displayed, and frequently cited.</th>
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<tbody>
<tr>
<td>Clarity</td>
<td>Specific desired behaviors are advertised to potential associates and explicitly taught in orientation programs.</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>The responses given by management to associate queries and requests apply the mission, vision, and values.</td>
</tr>
<tr>
<td>Modeling</td>
<td>The behavior of management is consistent with mission, vision, and values.</td>
</tr>
<tr>
<td>Audit</td>
<td>A system of checks and balances assists management and other associates by detecting departures from mission, vision, and values.</td>
</tr>
<tr>
<td>Correction</td>
<td>When necessary, management implements a graduated corrective response that usually includes warning, retraining, second warning, and discharge.</td>
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</tbody>
</table>

**EXHIBIT 1.15 Foundations Reinforcing Agency/Accountability Relationships**
are maintained, failures of accountability and agency are rare. If they are not maintained, the entire organization is threatened, and drastic reconstruction is in order. Monitoring and maintaining the foundations is a strategic activity primarily of the governing board and senior management.

**Suggested Readings**

*On the history of healthcare organizations:*

*On critical issues facing healthcare organizations:*

*On organization theory as applied to healthcare organizations:*

*Additional questions for discussion and other teaching aids available from Health Administration Press’s Companion Website: ache.org/books/Well-Managed7.*

**Notes**

1. Attributed to Hubert Humphrey, U.S. senator and vice president.
2. Comprehensive data on the use of healthcare is available from the National Center for Health Statistics. [Online information; retrieved 11/20/08.] www.cdc.gov/nchs/about/major/health/nhsa.htm.


