Seventh Edition

7

THE WELL-MANAGED HEALTHCARE ORGANIZATION

KENNETH R. WHITE

JOHN R. GRIFFITH

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

THE WELL-MANAGED HEALTHCARE ORGANIZATION

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

AUPHA / HAP Editorial Board for Graduate Studies

Christy H. Lemak, PhD, Chairman
University of Michigan

Mark Allan
Boston University

John Baker, PhD
University of Arkansas For Medical Sciences

M. Nicholas Coppola, PhD, FACHE
Texas Tech University

Connie J. Evashwick, ScD, FACHE
St. Louis University

Diane M. Howard, PhD, FACHE
Rush University

Ana Maria T. Lomperis, PhD
St. Louis University

John M. Lowe III, PhD
Simmons College

Michael R. Meacham
The Pennsylvania State University

Lydia Middleton
AUPHA

Mark Pauly, PhD
University of Pennsylvania

Bernardo Ramirez, MD
University of Central Florida

Andrew T. Sumner, ScD, FACHE
Georgia State University

Andrea W. White, PhD
Medical University of South Carolina

Lesly Wilson, PhD
University of South Carolina

LT Suzanne J. Wood, PhD, FACHE
Army-Baylor University

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

THE WELL-MANAGED HEALTHCARE ORGANIZATION

Seventh Edition

KENNETH R. WHITE

JOHN R. GRIFFITH

AUPHA

Chicago, Illinois

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Your board, staff, or clients may also benefit from this book's insight. For more information on quantity discounts, contact the Health Administration Press Marketing Manager at (312) 424-9470.

This publication is intended to provide accurate and authoritative information in regard to the subject matter covered. It is sold, or otherwise provided, with the understanding that the publisher is not engaged in rendering professional services. If professional advice or other expert assistance is required, the services of a competent professional should be sought.

The statements and opinions contained in this book are strictly those of the authors and do not represent the official positions of the American College of Healthcare Executives, of the Foundation of the American College of Healthcare Executives, or of the Association of University Programs in Health Administration.

Copyright © 2010 by Kenneth R. White and John R. Griffith. Printed in the United States of America. All rights reserved. This book or parts thereof may not be reproduced in any form without written permission of the publisher.

Reprinted April 2014

Library of Congress Cataloging-in-Publication Data

White, Kenneth R. (Kenneth Ray), 1956-
The well-managed healthcare organization / Kenneth R. White, John R. Griffith. -- 7th ed.
p. ; cm.
Griffith's name appears first on the earlier ed.
Includes bibliographical references and index.
ISBN 978-1-56793-357-4 (alk. paper)
1. Health services administration. I. Griffith, John R. II. Title.
[DNLM: 1. Health Services Administration--United States. W 84 AA1 W585w 2010]
RA971.G77 2010
362.1068--dc22

2010014186

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences—Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.♾™

Project manager and editor: Jane Calayag; Acquisitions editor: Janet Davis; Book design: Scott Miller; Cover design: Gloria Chantell; Layout: BookComp, Inc.

Health Administration Press
A division of the Foundation
of the American College of
Healthcare Executives
One North Franklin Street
Suite 1700
Chicago, IL 60606
(312) 424-2800

Association of University Programs
in Health Administration
2000 14th Street North
Suite 780
Arlington, VA 22201
(703) 894-0940

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

CONTENTS

List of Exhibits xvii

Preface xxiii

Chapter 1 Foundations of High-Performing Healthcare Organizations 1

Chapter 2 Cultural Leadership 39

Chapter 3 Operational Leadership 69

Chapter 4 Strategic Leadership: Governance 103

Chapter 5 Foundations of Clinical Performance 141

Chapter 6 The Physician Organization 182

Chapter 7 Nursing 219

Chapter 8 Clinical Support Services 250

Chapter 9 Beyond Acute Care to Community Health 281

Chapter 10 Knowledge Management 317

Chapter 11 Human Resources Management 346

Chapter 12 Environment-of-Care Management 383

Chapter 13 Financial Management 417

Chapter 14 Internal Consulting 459

Chapter 15 Marketing and Strategy 491

Glossary 527

Index 537

About the Authors 553

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

DETAILED CONTENTS

List of Exhibits xvii

Preface xxiii

Chapter 1 Foundations of High-Performing Healthcare Organizations 1

In a Few Words........ 1
Critical Issues 1
Questions for Discussion........ 2
Activities........ 3
Contribution 4
Stakeholders 5
  Customer Partners........ 6
  Provider Partners........ 9
  Sources of Stakeholder Influence........ 11
Ownership........ 13
  Not-for-Profit, For-Profit, and Government Owners 13
  Healthcare Systems........ 13
Designing Excellence in an HCO........ 14
  Cultural Foundation of Excellence: Transformational Management 16
  Operational Foundation of Excellence: Evidence-Based Management 23
  Strategic Foundation of Excellence: Positioning and Protection 30
Suggested Readings 36

Chapter 2 Cultural Leadership 39

In a Few Words........ 39
Critical Issues 39
Questions for Discussion........ 40
Purpose 41
Functions 41
  Promoting Shared Values........ 43
  Empowering Associates........ 44
  Communicating with Associates........ 45

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Supporting Service Excellence..47
Encouraging, Rewarding, and Celebrating Success..........51
Improving the Transformational Culture........................52
People..52
Sources of Leaders..52
Qualifications for Leaders...53
Leadership Development Programs...............................55
Paths for Beginners...56
Measures...57
The Culture and Leadership Functions..........................57
Assessing Leaders as Individuals...................................60
Ensuring Leadership Continuity....................................61
Managerial Issues..62
Starting the Path to Transformational Culture................63
Maintaining the Ethical Foundation..............................64
Resolving Fundamental Disagreements..........................66
Protecting Against Destructive Behavior........................67
Suggested Readings...67

Chapter 3 Operational Leadership 69

In a Few Words...69
Critical Issues...69
Questions for Discussion..70
Purpose...71
Functions...72
Boundary Spanning...72
Knowledge Management...79
Accountability and Corporate Design............................82
Continuous Improvement..88
Sustaining and Improving the Operational Structure.......90
People..93
Measures...93
Managerial Issues..94
Starting the Path to Evidence-Based Management..........94
Understanding the Risk Factors of the Model.................97
Suggested Readings...100

Chapter 4 Strategic Leadership: Governance 103

In a Few Words...103
Critical Issues...103
Questions for Discussion..104
Purpose...105
Functions...106

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Maintaining Management Capability............................108
Establishing the Mission, Vision, and Values 110
Approving the Corporate Strategy and Annual Implementation 110
Ensuring Quality of Clinical Care.................................115
Monitoring Performance Against Plans and Budgets 116
Improving Board Performance....................................119
People 122
Board Membership 122
Membership Qualifications 122
Board Selection 124
Board Organization 127
Education and Information Support for Board Members ...131
Measures 132
Managerial Issues..133
Operating Discipline 133
Legal and Ethical Issues of Board Membership.............135
Suggested Readings 137

Chapter 5 Foundations of Clinical Performance 141

In a Few Words...141
Critical Issues 141
Questions for Discussion..142
Purpose 143
Functions 144
Ensuring Accurate Diagnosis.......................................144
Ensuring Excellent Care..146
Implementing Protocols 148
Individualizing Patient Care Planning and Treatment....162
Improving Community Health 163
Improving Clinical Performance 165
People 167
Organization 167
Measures 168
Demand and Output 169
Quality Assessment 169
Patient and Associate Satisfaction 172
Managerial Issues..175
Sustaining a Culture of Teamwork and Respect 175
Credentialing and Ensuring Continued Competence.....175
Minimizing and Responding to Unexpected Clinical Events 176
Resolving Interprofessional Rivalries 176
Suggested Readings 177

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Chapter 6 The Physician Organization 182

In a Few Words....182
Critical Issues....182
Questions for Discussion....183
Purpose....184
Functions....184
- Achieving Excellent Care....185
- Credentialing and Delineating Privileges....187
- Planning and Implementing Physician Recruitment....194
- Providing Clinical Education....200
- Communicating and Resolving Unmet Needs....203
- Negotiating and Maintaining Compensation Arrangements....206

People....210
- Physician Leadership....210
- Organization of Physicians....211

Measures....211
Managerial Issues....211
- Managing Conflicting Values....212
- Maintaining Adequate Physician Supply....214
- Negotiating Compensation Arrangements....214

Suggested Readings....215

Chapter 7 Nursing 219

In a Few Words....219
Critical Issues....219
Questions for Discussion....220
Purpose....221
Functions....222
- Delivering Excellent Care....222
- Coordinating and Monitoring Interdisciplinary Care....228
- Educating Patients, Families, and Communities....230
- Maintaining the Nursing Organization....231
- Improving Nursing Performance....234

People....236
- Team Members....236
- Organization....241

Measures....241
Managerial Issues....242
- Recruitment and Retention....244
- Improve Nursing's Effectiveness....244

Suggested Readings....246

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Chapter 8 Clinical Support Services 250

In a Few Words....250
Critical Issues 250
Questions for Discussion....251
Purpose 252
Functions 253
  Providing Excellent Care 254
  Maintaining Patient Relationships 255
  Maintaining Consultative Relationships....257
  Planning and Managing Operations 259
  Promoting Continuous Improvement 262
People 269
  Team Members....269
  CSS Management 270
  The HCO Manager 270
  Organization 271
  HCO–CSS Relationships 271
Measures 272
Managerial Issues....274
  Should the HCO Offer the Service? 275
  How Big Should the CSS Be? 275
  What Are the Standards of Performance?....276
  What Form of Affiliation Best Meets the HCO's Needs?....276
  Does the CSS Have the Coordination It Needs?....277
  Are CSS Activities Correctly Assigned to Professional and Nonprofessional Associates? 277
  What Are the Continuous Improvement Goals? 278
  What Are the Long-Term Trends?....278
Suggested Readings 279

Chapter 9 Beyond Acute Care to Community Health 281

In a Few Words....281
Critical Issues 281
Questions for Discussion....282
Purpose 286
Functions 286
  Understanding and Promoting Community Health....286
  Establishing a Community Health Strategy 294
  Operationalizing a Community Health Strategy 302
  Improving Performance 304
People 304
Measures 305

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Operational 305
Strategic 307
Managerial Issues 307
Promoting and Teaching Community Health 309
Extending Management Concepts to Community Healthcare Teams 310
Expanding and Integrating Primary Care 310
Maintaining the Infrastructure for Community Health 311
Suggested Readings 312

Chapter 10 Knowledge Management 317

In a Few Words 317
Critical Issues 317
Questions for Discussion 318
Purpose 319
Functions 320
Ensuring the Reliability and Validity of Data 320
Maintaining Communications for Daily Operations 327
Supporting Information Retrieval for Continuous Improvement 329
Ensuring the Appropriate Use and Security of Data 332
Improving Knowledge Management Services Continuously 333
People 336
Chief Information Officer 336
KM Planning Committee 336
Organization 337
Measures 337
Managerial Issues 339
Exploiting the KM Planning Committee 339
Promoting the Use of Knowledge 340
Using Outside Contractors and Vendors 341
Suggested Readings 343

Chapter 11 Human Resources Management 346

In a Few Words 346
Critical Issues 346
Questions for Discussion 347
Purpose 349
Functions 349
Workforce Planning 349
Workforce Development 353
Workforce Maintenance 356

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Empowerment, Transformation, and Service Excellence 363
Compensation and Benefits Management 365
Collective Bargaining 371
Continuous Improvement 372
People 372
Human Resources Professionals 372
Organization of the Human Resources Department 372
Measures 374
Managerial Issues 375
Adequate Funding 375
Consistent Senior Leadership 377
Perceived Fairness 377
Strategic Achievement 378
Suggested Readings 378

Chapter 12 Environment-of-Care Management 383

In a Few Words 383
Critical Issues 383
Questions for Discussion 384
Purpose 385
Functions 385
Facilities Design, Planning, and Space Allocation 386
Facilities Maintenance 393
Guest Services 396
Materials Management Services 399
Enhanced Environmental Management 400
Performance Improvement and Budgeting 405
People 406
Managers and Professional Personnel 406
Outside Contractors 407
Training Needs 407
Incentives and Rewards 408
Organization 408
Measures 408
Output and Demand 409
Resource Consumption and Effectiveness 410
Quality 411
Managerial Issues 412
Facilities Planning and Space Allocation 413
Selection and Management of Outsourcing Contracts 413
Integration of Facilities Operations with Other Activities 414
Suggested Readings 414

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Chapter 13 Financial Management 417

In a Few Words....................417
Critical Issues 417
Questions for Discussion....................418
Purpose 419
Controllership Functions 419
  Transaction Accounting 419
  Financial Accounting 422
  Managerial Accounting 425
  Goal Setting and Budgeting 427
Financial Management Functions 434
  Financial Planning 434
  Pricing Clinical Services 437
  Securing and Managing Liquid Assets 440
  Managing Multicorporate Accounting 444
Auditing Functions 445
  Internal Audits 445
  External Audits 448
  Continuous Improvement of the Accounting and Finance Functions 449
People 449
  Chief Financial Officer 449
  Other Professional Personnel 450
  Organization of the Finance System 450
Measures 452
  Quantitative Performance Measures 452
  Subjective Quality Assessment....................452
Managerial Issues....................454
  Supporting Integrity in All Financial Areas 454
  Maintaining a Collegial, Blame-Free Culture....................454
  Managing Areas at Risk for Conflict 454
Suggested Readings 457

Chapter 14 Internal Consulting 459

In a Few Words....................459
Critical Issues 459
Questions for Discussion....................460
Purpose 461
Functions 461
  Supporting the Organization as a Whole 464
  Supporting Improvement Projects 472
  Supporting the Capital Investment Review....................475
  Implementing and Integrating 481
  Responding to Any Other Factual Concern....................481

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Improving Internal Consulting 482
People 482
Team Members...482
Organization 482
Measures 484
Managerial Issues...484
Ensuring Quality of Work 486
Sizing Internal Consulting 486
Protecting Associates' Empowerment....................................487
Suggested Readings 488

Chapter 15 Marketing and Strategy 491

In a Few Words...491
Critical Issues 491
Questions for Discussion...492
Purpose 493
Marketing Functions..494
Identifying and Segmenting Markets.....................................496
Listening to Stakeholder Needs...497
Developing Brand and Media Relations 501
Convincing Potential Customers...502
Attracting and Motivating Associates 505
Managing Other Stakeholder Relationships................................505
Improving the Marketing Activity 508
Strategic Functions 509
Maintaining the Mission, Vision, and Values 509
Defining the Strategic Position...509
Implementing the Strategic Position 515
People 515
Associates 515
Organization 516
Measures 516
Strategic Activity..517
Operational Measures 518
Managerial Issues...519
Skills for Successful Strategy..520
Strategic Leadership Requirements 520
Multihospital System Contribution 521
Suggested Readings 522

Glossary...527

Index..537

About the Authors..553

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

EXHIBITS

Chapter 1

1.1 Components of Healthcare Organizations 4
1.2 General Model of Stakeholder–Organization Interaction 5
1.3 Model of Stakeholder–HCO Interaction 7
1.4 Ownership and Size of U.S. Community and Federal Hospitals 14
1.5 System Affiliations of U.S. Hospitals 15
1.6 Foundations of Excellence in Healthcare Organizations 16
1.7 Mission, Vision, and Values Baldrige Award Recipients, 2002–2009 19
1.8 Bronson Methodist Hospital: Mechanisms for Communication, Skill Sharing, and Knowledge Transfer 21
1.9 Mercy Health System Award/Incentive Programs and Objectives 24
1.10 Template of Operational Performance Measures for Individual Teams and Activities 27
1.11 Template of Strategic Measures of HCO Performance 28
1.12 Process Analysis: Translating OFIs to Improved Performance 31
1.13 Competitive Tests for Investment Opportunities 32
1.14 Strategic Positioning and Monitoring Processes 33
1.15 Foundations Reinforcing the Agency/Accountability Relationships 35

Chapter 2

2.1 Functions of Cultural Leadership 42
2.2 The Service Excellence Chain in Healthcare 48

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

2.3 Frequently Negotiated Issues and Solution Paths for Excellent HCOs 50
2.4 Measures of Leadership Functions 59
2.5 Relating Leadership and Culture to Mission Achievement 60
2.6 A Comprehensive Leadership Management Program 62

Chapter 3

3.1 Functions That Sustain Operational Infrastructure 73
3.2 Boundary Spanning Activities of HCOs 75
3.3 Elements of the Epidemiologic Planning Model 76
3.4 Leadership Structure, Communications, and Accountability 83
3.5 Tests of Successful Leadership Accountability 85
3.6 Traditional Types of HCOs 86
3.7 Mercy Health System's Annual Planning Calendar 89
3.8 Qualitative Indicators of OFIs for Maintaining the Cultural and Operational Infrastructure 91
3.9 Performance Measures for Infrastructure Functions 92

Chapter 4

4.1 Functions of the Governing Board 107
4.2 Strategic Scenario Questions for Healthcare Organizations 112
4.3 Saint Luke's Hospital Strategic Scorecard 114
4.4 Ten Measures of Board Effectiveness 120
4.5 Typical Standing Committees of the Governing Board 128
4.6 Henry Ford Health System Governance Structure 131
4.7 Board Member Orientation Subjects 133

Chapter 5

5.1 Functions of the Clinical Organization 145
5.2 Simplified Diagnostic Process 147
5.3 Average Cost for Alternative Prostate Cancer Treatments 148
5.4 HCO Contribution to Excellent Care 149
5.5 Example of a Functional Protocol for Medication Order and Fulfillment 151
5.6 Example of a Patient Management Protocol for Acute Chest Pain 155
5.7 Core Values of High-Performing HCOs 166
5.8 Organization of Clinical Services 169
5.9 Profile of Service Line Operational Scorecard 170
5.10 HCAHPS® Hospital Patient Survey Questions 173

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Chapter 6

6.1 Functions of the Physician Organization 185
6.2 Flowchart of Physician Credentialing 189
6.3 Critical Volumes for Specialty Services 198
6.4 Cardiac Surgery as an Example of Combined Strategic, Service, and Physician Planning 199
6.5 Advantages of Physician Supply Planning 200
6.6 Physician Representation on Decision Processes 204
6.7 Compensation Relationships Between HCOs and Individual Physicians 208
6.8 Types of Physician Compensation for Patient Care 209
6.9 Institutional Clinical Organization Structure 212
6.10 Operational Measures of Physician Organization Performance 213

Chapter 7

7.1 Nursing Functions 223
7.2 Nursing and the Goals of Excellent Care 224
7.3 Nursing Process Example for Airway Management 225
7.4 Example of a Nurse Staffing Model for an Inpatient Unit 233
7.5 Assistance Available to Nursing Teams 235
7.6 Educational Levels of Nursing Associates 237
7.7 Nursing Practice Specialties in HCOs 240
7.8 Nursing Team Support Structure 242
7.9 Nursing Performance Measures 243

Chapter 8

8.1 Clinical Support Services in a Large HCO 253
8.2 Functions of the CSS, Showing Service and HCO Contributions 254
8.3 Conceptual Model of a Sophisticated Scheduling Process 257
8.4 Improvement Initiatives in Two CSSs 265
8.5 Core Organization of the CSS 272
8.6 Performance Measures for the CSS 273

Chapter 9

9.1 Conceptual Model of Personal Services for Community Health 284
9.2 Functions That Implement a Community Health Mission 287
9.3 Grouping of Disease and Prevention Forecasts, by Prevention

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Level, Population at Risk, and Service Program..............289
9.4 Goals of a Comprehensive Community Health Program 296
9.5 Examples of Operational Measures for Community Health Programs......300
9.6 Community Health Scorecard......308

Chapter 10

10.1 Functions of Knowledge Management Services......321
10.2 Common Patient Specification Taxonomies......324
10.3 Age-Specific, Crude, and Adjusted Rates: Utah Versus Florida......325
10.4 Examples of Internal Data Feeding the Data Warehouse 330
10.5 Common Uses of Information in High-Performing HCOs......331
10.6 Knowledge Management Planning Process......335
10.7 Accountability Structure for the Communications Function......337
10.8 Measures of Knowledge Management Performance......338

Chapter 11

11.1 Functions of Human Resources Management......350
11.2 Illustration of Workforce Plan Content......352
11.3 Core Files of HRM Knowledge Management......362
11.4 Typical Improvements for Human Resources Management......373
11.5 Organization of a Large Human Resources Department......374
11.6 Measures of the Human Resource......375
11.7 Measures of Human Resources Management......376
11.8 Human Resources and the Service Excellence Dynamic......377

Chapter 12

12.1 Environment-of-Care-Management Requirements......386
12.2 Functions of Environment-of-Care Services......387
12.3 Facilities Planning Process......389
12.4 Facilities Maintenance Services......394
12.5 Guest Services: Workforce, Patient, and Visitor Support 397
12.6 Functions of Materials Management......400
12.7 Enhanced Environmental Management Requirements......401
12.8 Environment-of-Care Organization for Large HCOs......409
12.9 Examples of Demand Measures for Environment-of-Care Functions......410
12.10 Implications of Cost Accounting on Environmental

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Services 411
12.11 Measures of Quality for Environment-of-Care Services....412

Chapter 13

13.1 Functions of the Finance System 420
13.2 Availability of External Price Information, by Type of Transaction and Level of Aggregate 423
13.3 Integrating Strategic and Operational Goal Setting 428
13.4 Major Budgets and Their Relation to Strategic Goals 429
13.5 Annual Goal-Setting Cycle 430
13.6 Major Steps in Developing Operations Budgets....431
13.7 Tests and Adjustments in Financial Planning 437
13.8 Pricing Structures for Healthcare Contracts 439
13.9 Implications of Alternative Funding Sources for an Ambulatory Care Project 441
13.10 Organization of the Finance System 451
13.11 Operational Measures of Finance and Accounting 453

Chapter 14

14.1 Functions of Internal Consulting 462
14.2 Internal Consulting as a Clearinghouse 464
14.3 Patient-Oriented Specification Taxonomies 468
14.4 Insurance Intermediary and Employer Specification Taxonomies 468
14.5 Healthcare Provider Specification Taxonomies 469
14.6 Run Charts and Control Charts 471
14.7 Checklist for Evaluating Improvement Proposals....477
14.8 Examples of Programmatic Proposals 478
14.9 Programmatic Capital Review Process 479
14.10 Operational Performance Measures for Internal Consulting....485

Chapter 15

15.1 Functions of Marketing and Strategy....495
15.2 Illustration of Marketing Functions....497
15.3 Major Listening Activities 499
15.4 Examples of Alternative Collaborative Structures for HCO Services 507
15.5 Spectrum of Potential Relationships with Organizations....508
15.6 Matrix of Market Attractiveness and Advantage....512
15.7 Miles and Snow Typology of Strategic Types....513
15.8 Formal Hierarchy for a Large Marketing Operation 517
15.9 Measures for Specific Campaigns....519

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

PREFACE

The Well-Managed Healthcare Organization, now in its 7th edition, is a text for students pursuing professional careers in managing healthcare organizations (HCOs). It describes actual practices that lead to high performance, based on our careful analysis of a small but reasonably representative set of HCOs that have been studied by competent peers and have produced auditable evidence of excellence. We believe the evidence of the superiority of these practices passes both academic and professional challenge. The footnotes in each chapter support our belief. There may be other ways to achieve excellence, but they have not been documented and quite possibly have not been discovered. Healthcare organizations that follow the methods we describe are well-prepared for health reform. We expect them to continue to thrive. Indirectly, health reform initiatives reinforce our message and are consistent with managing and leading excellent HCOs on the basis of evidence, best practices, benchmarks, and a culture of continuous improvement.

The common theme in these organizations is that a specific culture (transformational and evidence-based management) and certain management activities (listening, measurement, benchmarking, negotiated goal setting, and continuous improvement) are essential to high performance. Specialized teams must complete specified tasks correctly to measured standards. These teams include not only those involved in patient care but also clinical support (e.g., laboratory, pharmacy, imaging), logistics (e.g., information, personnel, training, supplies), or strategic (e.g., finance, internal consulting, enterprise level goals). Each chapter, after Chapter 1, has the following structure: Purpose, Functions, People, Measures, and Managerial Issues. The Functions section describes the unit's essential contribution to the whole, and the Measures section identifies opportunities to improve that contribution.

The challenge in managing HCOs is to sustain excellence over all the teams, and the solution to this challenge lies in two core thrusts:

1. Maintaining a culture that empowers each associate (transformational management)
2. Supporting continuous improvement with measurement, process analysis, negotiated goals, and rewards (evidence-based management)

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

In excellent HCOs, measurement is central, improvement is constant, leaders respond to associates and patients, professionals communicate as equals, everyone is treated with respect, and authority is derived from knowledge rather than rank. These are the foundations of high performance. The record of excellent HCOs shows quite clearly that the new management approach produces excellence in all the sites that now constitute the healthcare industry. High-performing HCOs successfully operate the full gamut of healthcare, including doctors' offices, general and special hospitals, continuing care, home care, and hospices.

Using *The Well-Managed Healthcare Organization*

Any organization is a collaboration to do what an individual alone cannot do. This collaboration succeeds by division of labor—assigning tasks for individuals and small teams to complete to achieve the goals of collaboration. The text begins (chapters 1 and 2) with a description of the collaborators, called *stakeholders.*

Performance excellence is built on a comprehensive and well-supported theory of management (Chapter 2). The elements of that theory are as follows:

1. An HCO is supported by many stakeholders who, in turn, benefit from its success. In general, stakeholders are either "customers" or "providers," and a key organizational issue is balancing and optimizing the rewards to each group.
2. The goals of the HCO are stated in its mission. Missions of HCOs are similar because all stakeholders share a common purpose of extending the length and quality of life and providing safe, effective, patient-centered, timely, efficient, and equitable care.
3. Goal achievement is evidence-based, using objective measures of performance, comparison to competitors and best practices, goal setting, and continuous improvement.
4. The rewards of improvement are shared among the stakeholders so that both customer and provider stakeholders view the organization as their preferred affiliation.

These elements constitute cross-cutting themes that recur throughout the text.

From chapter 3 to 15, the text describes the activities of an HCO in three divisions—corporate, clinical, and technical/logistic. Each chapter identifies an activity and the functions it must perform for the whole to succeed, its organization structures and personnel, its measures of performance, and some of the critical areas in which it needs managerial support. Each chapter addresses (1) "what this activity must do well for the whole to succeed" and (2) "how this activity measures and improves its performance."

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Each chapter begins with In a Few Words, a précis of the activity addressed in the chapter; Critical Issues, an outline that emphasizes the distinctions associated with excellence; and Questions for Discussion, five important and easily misunderstood application topics.

Chapter 2 describes leadership and the activities required of senior management to build and sustain the HCO's cultural foundations. Chapter 3 expands the discussion on the operational foundation, exploring the activities that identify opportunities for improvement (OFIs) and lead to improved work processes. Chapter 4 addresses governance, the strategic decision making that provides effective long-term response to stakeholder needs. Chapters 5 through 9 describe the operation of the various clinical and clinical support teams. Chapters 10 through 15 discuss the logistic and strategic support activities.

Each chapter addresses purpose, functions, people, measures, and managerial issues associated with the activity. The content of these chapters gives the student the ability to engage in meaningful dialogue with members of any activity or team, to understand how well a team or activity is currently performing and what its current OFIs are, and to assist in translating those OFIs to actual improvement. That pattern of listening, learning, and supporting improvement is what twenty-first century healthcare managers do for a living.

HCO managers build excellent organizations by ensuring that the functions are carried out as a whole. The theory demands comprehensiveness, as failure in one activity contributes to failure in another. The three divisions must all perform; an HCO cannot have clinical excellence without corporate excellence and logistic excellence. The learning manager, therefore, must grasp the totality and interdependence of the HCO as well as the contributions expected of each activity. He or she must also understand the application of the cross-cutting themes—the role of the mission, evidence-based decisions, measured performance, continuous improvement, and reward. The test of learning is the ability to explain these issues to others, such as customer stakeholders, beginning supervisors, and new employees.

We believe one effective path to mastery is to use the book partly as a text and partly as a reference. Some of the detail should be memorized, for immediate recall in conversations with others. The functions of the governing board (Chapter 4), the way budgets are developed (primarily chapters 3, 4, 7, and 12), and the use of the epidemiologic planning model (every chapter from 4 to 15) are prime examples. Other matters are not unimportant, but when they arise, they can be reviewed through the index and the table of contents.

A beginning student might best master the text, not by reading from page 1 to page 600 but rather by interacting with each chapter:

1. Read In a Few Words to focus on the contribution of the activity.
2. Study the Critical Issues, making an effort to relate them to her prior experience.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Online Learning System

The text offers a two-part online learning system designed to help students and instructors.

The **Companion Website** is designed for students and is available at ache.org/books/Well-Managed7. It contains the following:

- An overview of how to use the text to become an effective healthcare organization manager
- A glossary of all the technical terms identified in the text
- A folder for each chapter that contains (1) a one-page guide to mastering the chapter; (2) “Chapter Learning Goals and Milestones,” a list of the questions a professional should be able to answer and guides to where in the chapter the answers can be found; and (3) “Additional Questions for Discussion” to supplement the questions in the text. The questions are in addition to the five given in each chapter. They illustrate the issues managers must think about as they respond to associates’ questions and opportunities for improvement.

Instructor Resources are available only to qualified instructors. They contain all the Companion Website elements plus chapter-by-chapter teaching tips, guides for leading the Questions for Discussion, slides for classroom presentations, and gradable questions with answer rubrics. (For access, please apply at hap1@ache.org and include your course, university, and department names.)

3. Review the details of the functions to understand how each element contributes to the whole and how each is best implemented.
4. Study the exhibit that shows the performance measures, and review the Measures section to understand how the measures are defined and used.
5. Check the Managerial Issues section for important elements that relate the activity to management in the organization as a whole and to sustaining high performance.
6. Review the Questions for Discussion in relation to her or his prior experience, striving to understand both the importance of the question and the best way it can be answered in real HCOs.
7. Consider how the material in the chapter can be effectively conveyed to the right people in an HCO—that is, how can it be best summarized in formal policies and procedures, in training programs, and in day-to-day interactions.

The text can certainly be mastered in self-study. We believe a class or discussion group and a mentor or teacher can help substantially, particularly in the latter steps.

Acknowledgments

As the editions of *The Well-Managed Healthcare Organization* mount, keeping track of all who have contributed to this text by their examples becomes difficult. The applications of the HCO recipients of the Malcolm Baldrige National Quality Award are the most comprehensive documentation of the transformational and evidence-based approach. Our visits to Catholic Health Initiatives, Henry Ford Health System, Intermountain Healthcare, Legacy Health System, Medicorp Health System, MedStar Health, Moses Cone Health System, and Sentara Healthcare have helped us understand how leading practices are designed and implemented.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Over a period of time, both of us have worked with specific organizations, including Summa Health System in Akron, Ohio; Allegiance Corporation (a physician hospital organization) in Ann Arbor, Michigan; Mercy Health Center in Oklahoma City, Oklahoma; Mercy International Health Services in Farmington Hills, Michigan; and Bon Secours Health System in Marriottsville, Maryland. We are grateful to these HCOs. We are also grateful for the assistance of our colleagues at the University of Michigan and Virginia Commonwealth University.

Kenneth R. White, PhD, FACHE
Virginia Commonwealth University
Richmond, Virginia

John R. Griffith, MBA, FACHE
The University of Michigan
Ann Arbor, Michigan

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

CHAPTER

1 FOUNDATIONS OF HIGH-PERFORMING HEALTHCARE ORGANIZATIONS

In a Few Words

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.

Critical Issues in Excellence

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.
3. *Measuring performance, seeking benchmarks, and negotiating realistic goals.* Add quality, customer satisfaction, and associated satisfaction measures for every work unit.
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.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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?

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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.

Healthcare organization (HCO)
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.

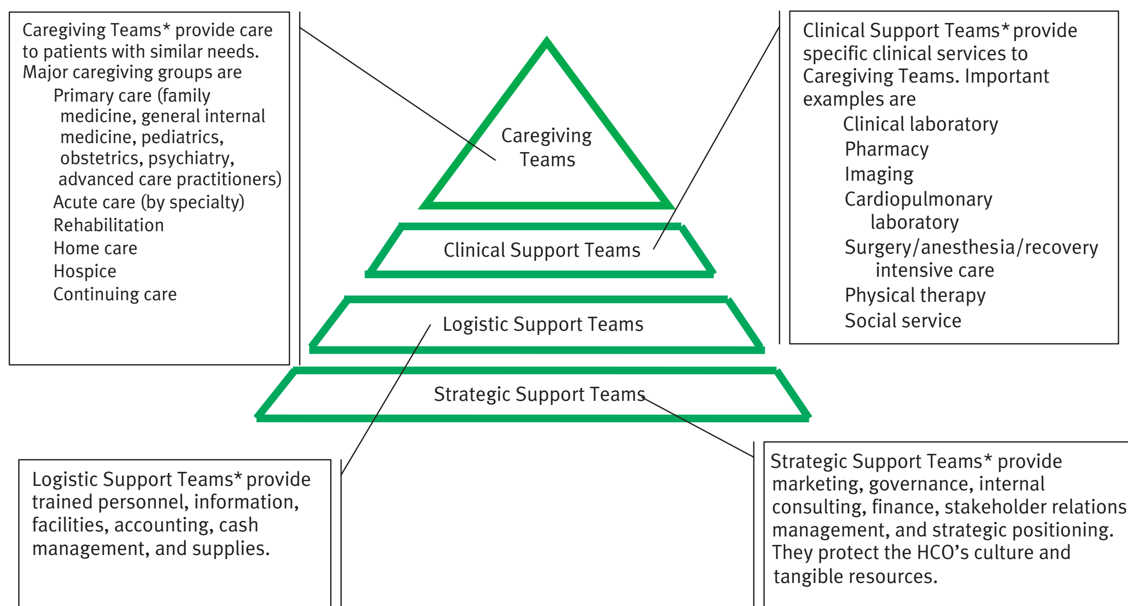
Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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."[1] 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.[2] 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.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

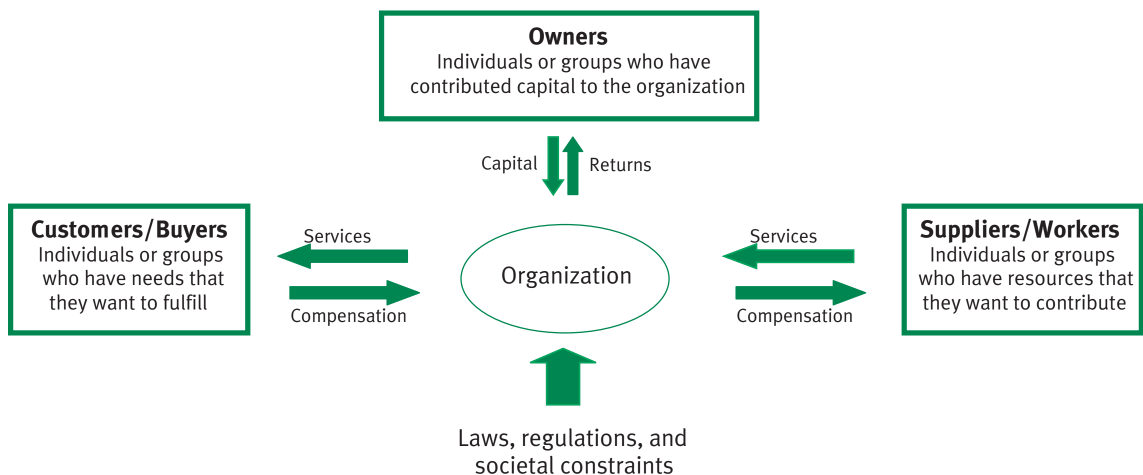
The nation's HCOs are the point of implementation for a healthcare system that has grown from its commitment to "promote the general welfare" (as stated in the Preamble to the Constitution) to be one of America's largest collective endeavors. The U.S. per capita cost of healthcare is the highest in the 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.[3] Much of the cost is returned to the community through employment,[4] 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,[5] and they thrive because they fulfill that need better than competing alternatives.[6] 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

Stakeholders
Individuals or groups (buyers, workers, suppliers, regulators, and owners) who have a direct interest in an organization's success

EXHIBIT 1.2 General Model of Stakeholder–Organization Interaction



Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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.

Customers
Patients and others who use the services of the organization and generally compensate the organization for those services; also, by extension, other units within the HCO that rely on a particular unit for service

Providers
Institutional and personal caregivers such as physicians, hospitals, and nurses

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 and Families

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.[7] 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.

Health Insurers and Payment Agencies

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

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

most HCOs. The federal Medicare program deals with HCOs through its **intermediaries**.[8] 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.

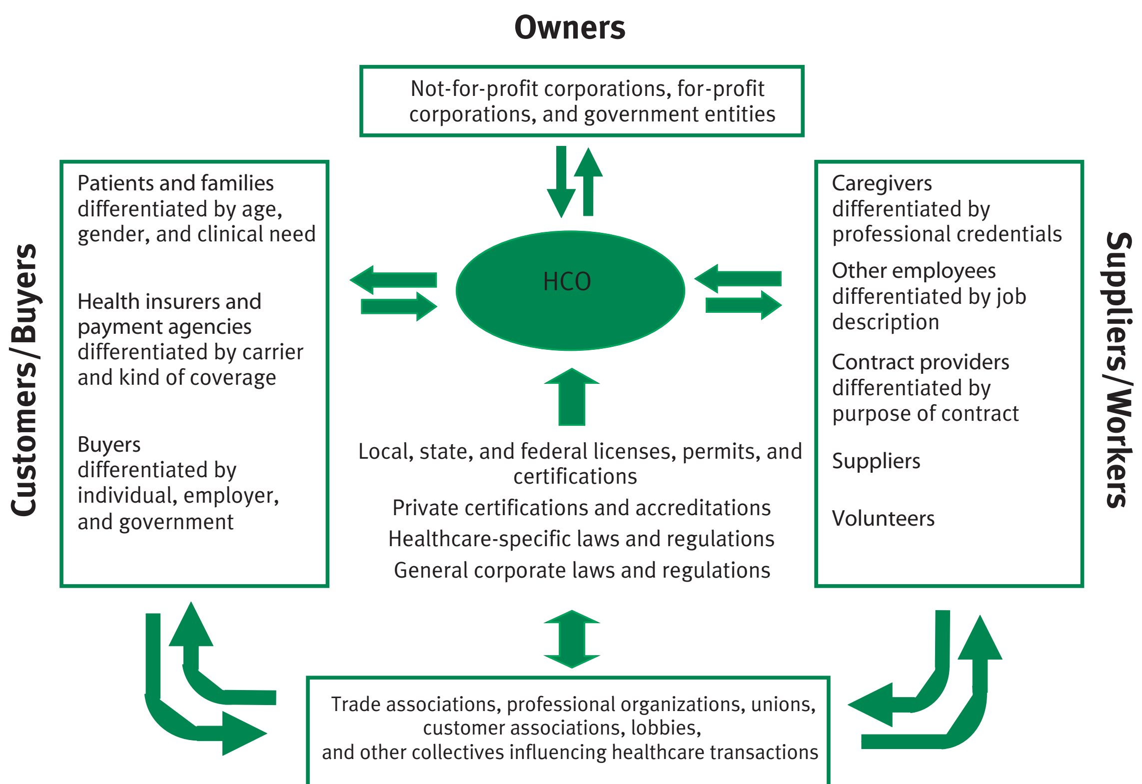
Intermediary
A payment or management agent for healthcare insurance (e.g., Medicare intermediaries that pay providers as agents for CMS)

Medicaid agency
The state agency handling claims and payments for Medicaid

Buyers

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



Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Regulatory Agencies

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
Agencies with established authority over healthcare activities; licensing agencies and rate-regulating commissions are examples

Certificate of need (CON)
Certificates or approvals for new services and construction or renovation of hospitals or related facilities; issued by many states

Quality improvement organizations (QIOs)
External agencies that review the quality of care and use of insurance benefits by individual physicians and patients for Medicare and other insurers

Health Insurance Portability and Accountability Act (HIPAA)
A 1996 federal act that establishes standards of privacy for patient information

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.

Community Groups

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.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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.[9] 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.[10]

Provider Partners

Associates

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

Associates
People (employees, trustees and other volunteers, and medical staff members) who give their time and energy to the HCO

Primary care practitioners
Initial contact providers, including physicians in family practice, general internal medicine, pediatrics, obstetrics, and psychiatry; nurse practitioners; and midwives

Referral specialist physicians
Doctors who care for patients referred by primary care practitioners on a limited or transient basis; likely to manage episodes of inpatient care

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Hospitalists
Physicians who manage broad categories of hospitalized patients

categories of patients and manage inpatient care only. Other professional caregivers (e.g., dentists, psychologists, podiatrists) may also be members of the medical staff.

Associate Organizations

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.

Licensure
Government approval to perform specified activities

Equal employment opportunity agencies
Government agencies that monitor the rights of associate groups; these are among those entitled access to the HCO and its records

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.

Suppliers and Financing Agencies

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.

Other Providers

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.

Strategic partnerships
Commitments with long-term obligations

Joint ventures
Formal, long-term collaborative contracts usually involving equity investment

Hospice
A model of caregiving that assists with physical, emotional, spiritual, psychological, social, financial, and legal needs of the dying patient and his family; the service may be provided in the patient's home or in an HCO

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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.

Participation and Market Pressure

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.

> ***Loyal/secure customers***
> Customers whose opinions of the organization are so positive that they will return for further interaction and will recommend or refer the organization to others

Negotiation

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.

Networking and Coalition Building

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.[11] 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.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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."[12] 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).[13]

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,[14] and The Joint Commission has added the measures to its criteria.[15]

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."[16] Pressures to build these capabilities and achieve

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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."[17] 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**.[18] 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.[19] 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.)

Community hospital
A short-stay general or specialty (e.g., women's, children's, eye, orthopedic) hospital, excluding those owned by the federal government

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

Healthcare system
Healthcare organizations that operate multiple service units under a single ownership

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

EXHIBIT 1.4 Ownership and Size of U.S. Community and Federal Hospitals

Ownership	*Number of Hospitals*	*Percent of All Hospitals*	*Total Expenditures (in millions)*	*Percent of Total Expenditures*	*Average Expenditures per Hospital (in millions)*	*Median Expenditures per Hospital (in millions)*
State and local government	1,110	22%	$ 77,914	14%	$ 70	$ 16
Religious not-for-profit	533	10	70,728	13	133	99
Other not-for-profit	2,425	47	315,265	57	130	62
For-profit	868	17	51,833	9	60	36
Federal	226	4	36,830	7	163	141
Total	5,161	100%	$ 552,570	100%	$ 107	$ 35

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

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

EXHIBIT 1.5 System Affiliations of U.S. Hospitals

System Affiliation*	Number of Hospitals				Total Expenditures (in millions)				
Ownership	Number of Systems	In Systems	Not in Systems	Percent in Systems	System Members	Not in Systems	Percent in Systems	Average Size of System	Median Size of System
State and local government	31	289	821	26%	$ 30,032	$ 47,882	39%	$ 869	$ 452
Religious not-for-profit	51	472	61	89	63,458	7,270	90	1,551	923
Other not-for-profit	211	1,190	1,235	49	179,009	136,256	57	785	518
For-profit	54	765	103	88	47,953	3,880	93	926	152
Federal	5	226	4	98	36,422	408	99	7,284	143
Total	352	2,942	2,224	57%	$356,874	$195,696	65%	$ 1,014	$ 483

*Many systems include hospitals of differing ownership. The systems are assigned to their largest ownership share.

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

on average or typical HCOs, but on the work of HCOs that have achieved excellence and documented it with objective measures.

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.**

Vertical integration
The affiliation of organizations that provide different kinds of service, such as hospital care, ambulatory care, long-term care, and social services

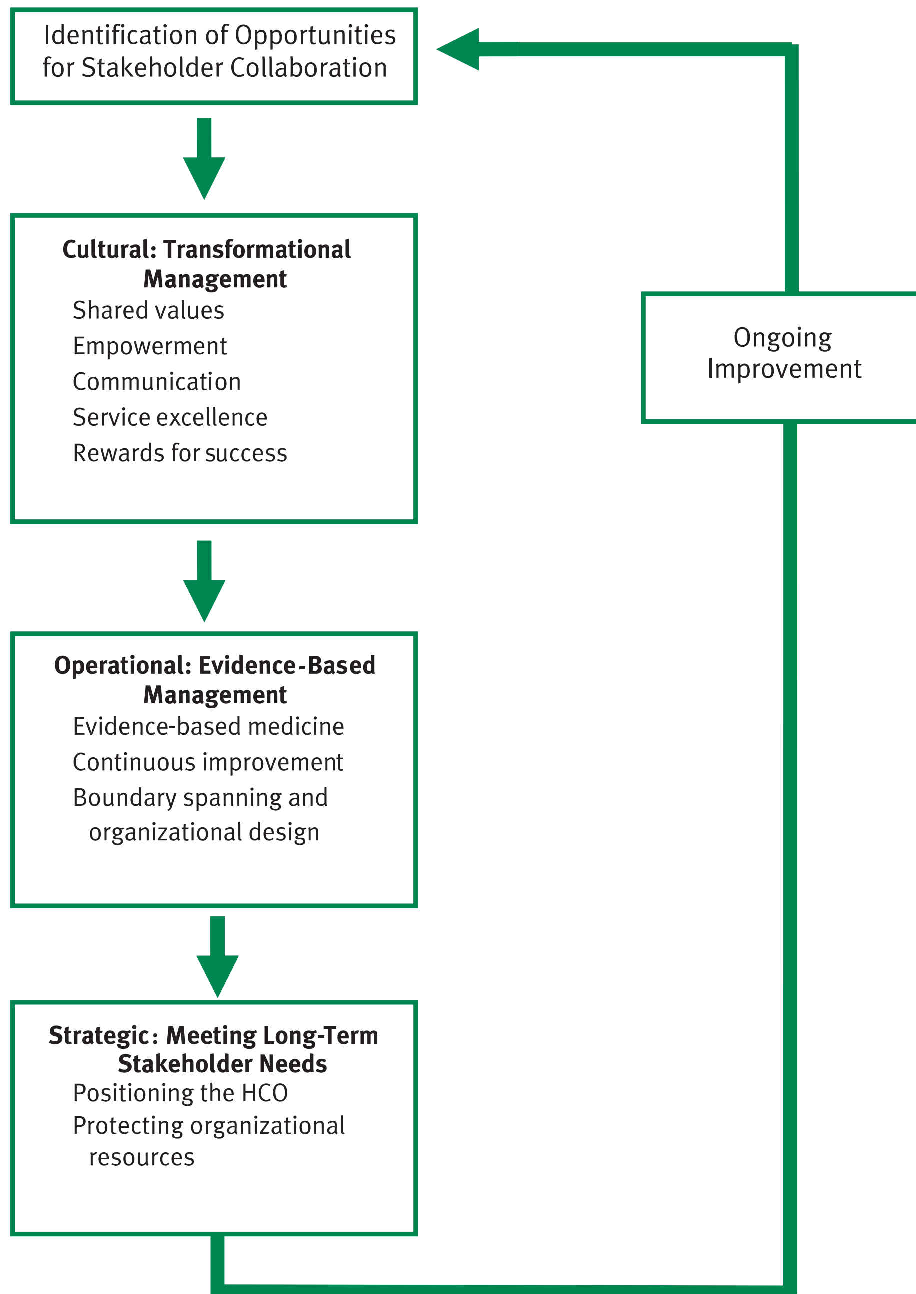
Horizontal integration
Integration of organizations that provide the same kind of service, such as two hospitals or two clinics

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.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

EXHIBIT 1.6
Foundations of Excellence in Healthcare Organizations



Cultural Foundation of Excellence: Transformational Management

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,

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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.[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.[24]

Shared Values

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.[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.[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),

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

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

non-maleficence (commitment to "do no harm"), and *justice* (commitment to equity and respect for all).[27] 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.[28] 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.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

EXHIBIT 1.7
Mission, Vision, and Values of Baldrige Award Recipients, 2002–2009

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

continued

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

EXHIBIT 1.7
continued

Organization	*Mission*	*Vision*	*Values*
Sharp HealthCare (CA)	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.	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.	Integrity Caring Innovation Excellence
Poudre Valley Health System (CO)	To be an independent, non-profit organization and to provide innovative, comprehensive care of the highest quality, always exceeding customer expectations.	To provide world-class health care	Quality Compassion Confidentiality Dignity/respect Equality Integrity
AtlantiCare (NJ)	. . . health and healing to all people through trusting relationships	Builds healthy communities	Integrity Respect Service Teamwork Safety
Heartland Health (MO)	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	The best and safest place in America to receive health care and live a healthy and productive life	Respect Honesty Compassion Trust Integrity Service

SOURCE: Information from Malcolm Baldrige National Quality Award website. [Online information; retrieved 12/8/09.] www.quality.nist.gov/Contacts_Profiles.htm.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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.

Negotiating

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

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

SOURCE: Information from Bronson Methodist Hospital application to the Malcolm Baldrige National Quality Award. 2006. "Bronson Methodist Hospital." [Online information; retrieved 9/2/08.] www.baldrige.nist.gov/Contacts_Profiles.htm.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

Teaching

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.

Protocols
Agreed-on procedures for each task in the care process

Procedures or processes
Actions or steps that transform inputs to outputs

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.[29]

Modeling

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.

Service Excellence

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.

Agency or accountability
The notion that the organization can rely on an individual or team to fulfill a specific, prearranged expectation

Service excellence
Associates anticipate and meet or exceed customer needs and expectations on the basis of the mission and values

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

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

met.[30] 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.[31] It is a universal practice among high-performing HCOs.[32] 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.

Rewards for Success

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.[33]

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[34] and continues today in more than half of the nation's hospitals.[35] 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

Evidence-based management
Relies heavily on formal process specification and performance measurement

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

EXHIBIT 1.9
Mercy Health System Award/Incentive Programs and Objectives

Reward	*Award/Incentive Programs*	*Objectives*
Celebrations	"Above and Beyond the Call of Duty" Partner* Recognition Dinner Quest for the Best Baskets for Champions Partner Idea Program "Someone to Admire and Respect"	Promote excellent services by rewarding/recognizing best practices, quality outcomes, innovation, teamwork, or partnering initiatives
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	Reward best-practice achievers of individual targets, tied to Four Pillars of Excellence** Reward superior customer service performance

*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

SOURCE: Adapted from Mercy Health System's application to the Malcolm Baldrige National Quality Award 2007, p. 22. [Online information; retrieved 9/20/08.] www.baldrige.nist.gov.

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.[36] 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.

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

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

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

guideline.gov.[37] Evidence-based medicine is deeply embedded in both graduate and continuing clinical education.[38] 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.[39] 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.[40] 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.

Boundary Spanning

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?

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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.

Knowledge Management

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.

Library of Work Processes, Protocols, and Measures

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

Operational measures or operational scorecards
Six dimensions of measurement that include three measures of inputs or resources and three measures of outputs or results

Strategic measures or strategic scorecard
Four dimensions of measurement (finance, operations, customer relations, and learning/human resources) appropriate for service lines or the HCO as a whole

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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

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

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**,[41] can be grouped as desired. One popular model, called the "Five Pillars," splits operations into quality and service and discusses demand as "Growth."[42] 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.

Training

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.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

EXHIBIT 1.11
Template of Strategic Measures of HCO Performance

Dimension	*Major Concepts*	*Healthcare Examples*
Financial performance	Ability to acquire, support, and effectively reinvest essential resources	Profit and cash flow Days' cash on hand Credit rating and financial structure
Internal operations, including quality and safety	Ability to provide competitive service Quality, efficiency, safety, and availability of service	Unit cost of care Measures of safety and quality of care Processes and outcomes of care Timeliness of service
Market performance and customer satisfaction	Reflects all aspects of relationship to customers	Market share Patient and family satisfaction Measures of access for disadvantaged groups
Associate satisfaction and ability to adapt and improve	Ability to attract and retain an effective associate group Learning and motivation of workforce Response to change in technology, customer attitudes, and economic environment	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

Communications Networks

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.

Accountability and Organizational Design

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

Accountability hierarchy
A reporting and communication system that links each operating unit to the governing board, usually by grouping similar centers together under middle management

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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

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.[43] It had widespread acceptance and is now a foundation for high-performing organizations in all industries. It is universal among excellent HCOs.[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.[47]

Benchmark
The best-known value for a specific measure, from any source

Opportunities for improvement (OFIs)
Result of comparing actual outcome against goal and goal against benchmark; also arise from qualitative assessments, including listening

Process improvement team (PIT)
A group that analyzes processes and translates OFIs to actual performance improvement

Root causes
The underlying factors that must be changed to yield consistently better outcomes

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

1. *Identify*: find improvable processes or OFIs.
2. *Analyze*: uncover root causes or possible corrections.
3. *Test*: develop alternative solutions and select the best for implementation.
4. *Evaluate*: implement the best solution, establish new goals, and monitor progress.

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.

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.

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

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.

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

Copying and distribution of this PDF is prohibited without written permission.
For permission, please contact Copyright Clearance Center at www.coyright.com.