

1

FOUNDATIONS OF HIGH-PERFORMING
HEALTHCARE ORGANIZATIONS

Critical Issues for Excellence

1. *Emphasizing mission and vision.* Make the contribution and importance of care itself a shared value among all the organization's associates.
2. *Understanding and meeting the needs of all stakeholders.* Extend the listening activities so that every major customer, associate, competitor, or other affiliate has a point of contact and is assured of fairness and responsiveness.
3. *Building a culture that listens, empowers, trains, and rewards.* Begin a program that identifies what associates see as barriers to their work and remove them.
4. *Measuring performance, seeking benchmarks, and continuously improving.* Negotiate realistic goals for every work unit that adds quality, customer satisfaction, and associated satisfaction measures.
5. *Protecting the corporate capability.* Assure that the organization's physical assets and information are protected and that the rights of its stakeholders are fulfilled.

Questions for Discussion

These questions are about applying the chapter content. It is often helpful to discuss them with classmates or mentors, gaining different perspectives on the issues.

1. This chapter outlines a transformational style of management, emphasizing values, empowerment, communication, trust/accountability, and rewards. Some people say that transformation is completely unrealistic; you must enforce order, they say, to have accountability. How is accountability achieved in high-performing, transformational HCOs?
2. HCOs are strongly oriented to healing the sick, one person at a time. The first word of this chapter—*patient*—is consistent with that tradition. Some say that the real role of HCOs is population health, including but going well beyond healing the sick. (Contrast the missions of SSM Health Care, Bronson Healthcare, and Saint Luke's Hospital with those of

Baptist Healthcare, RWJ University Hospital, and North Mississippi Health System in Exhibit 1.7.) Should this chapter have started with, “Building healthy communities is the focus of HCOs, including patient care but going well beyond”?

3. What happens to an HCO (or any 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?
4. Mercy Health System has two staff awards: “Above and Beyond the Call of Duty” (ABCD) and “Someone to Admire and Respect” (STAR). Both are intended to recognize individuals for exceptional effort. Nominations come from patients, colleagues, or guests. A committee reviews and ranks them. Personal letters are sent to the awardees’ home address, and recipients are identified in departmental meetings. Similar programs (they have various names) often involve small prizes, like a dinner-for-two gift certificate. Bronson has a gift drawing for recipients.
5. Should every well-managed healthcare organization have a similar program? Can you describe to a customer stakeholder why the program is (or is not) a good idea?
6. Evidence-based management relies heavily on numbers. The benchmarks, strategic and unit scorecards, and goals are all quantitative. A number of questions arise about such a quantitative approach. A competent professional manager has to be able to answer them at several levels of sophistication. (The chief of surgery and the chair of the board will expect more specifics than the kitchen workers, but servant leadership obligates leaders to answer both to the questioners’ satisfaction.) For Chapter 1, let’s answer them at the simplest level, say for a smart high school graduate.
 - a. Are these the right measures?
 - b. How do I know my team can influence the measures? (Don’t they include a lot of things outside our control?)
 - c. Can we really get better? (If we set a goal, how do we know we can reach it?)
 - d. Will the leadership punish us for not reaching our goals?

Purpose

Patient care—meeting the diagnostic and therapeutic needs of individuals—is the primary focus of healthcare organizations (HCOs). The purpose of any HCO is

to provide care to individual patients.

It is usually stated as the HCO’s “mission.” The purpose can be expanded to “population health,” but the larger purpose depends upon excellence in care to individual patients.

Patient care is also an important contributor to a broader purpose—the health of individuals and populations. An extensive social structure influences health, including schools, environmental sanitation, public safety, public health, and other activities. HCOs are an important part of this structure. The healthy population that the structure achieves is central to “life, liberty, and the pursuit of happiness,” the shared goals of American society.

Any HCO delivers care through one or more caregiving teams, as shown in the top triangle of Exhibit 1.1. Caregiving teams are backed by three levels of support—clinical, logistic, and strategic—that are themselves composed of teams. A small HCO has one or a few caregiving teams and often contracts with other organizations for support; a large HCO has a broad array of patient care and support teams. A healthcare system is an organization of HCOs, often meeting a wide range of needs and operating in several geographic locations.

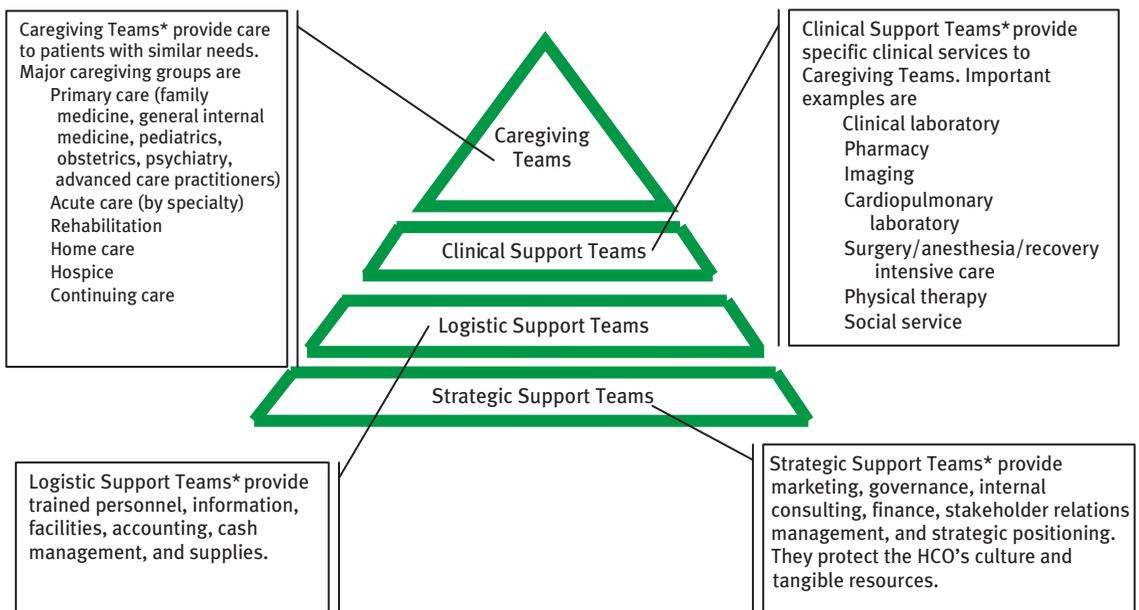
HCO teams are usually housed in purpose-built spaces (e.g., clinics, operating rooms, business offices) so that facilities reflect the activities depicted in Exhibit 1.1. With the growth of electronic communication, many facilities and their teams can be geographically dispersed. A primary care team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

Many HCOs work to improve the health of patients and communities.^{1,2} A population health mission requires excellence in patient care, so the population health mission is an addition to the overall mission. There are four steps in improving **population health**: defining the

Population health

The health outcomes of a defined group of individuals.

EXHIBIT 1.1 Components of Healthcare Organizations



*HCOs can contract for clinical and logistic support activities, retaining control of their strategic activities. Large HCOs, integrating many different care teams, dominate the healthcare marketplace and have been growing.

population (by geography, sociodemographic factors, disease state, risk, insurance coverage, or in some other way), measuring the current state of health in the population, setting goals for improvement, and directing resources toward making improvements.³ The U.S. Department of Health and Human Services specifies national goals and objectives for population health in the Healthy People 2020 program.⁴

Improving population health requires identifying and overcoming determinants of health, typically through collaborative relationships among HCOs and across a variety of other organizations in a given community, including public health, community development, education, and social service sectors. Evidence suggests that medical care represents a relatively small influence on population health, but personal care provided by HCOs is a critical part of improving population health.⁵

As shown in Exhibit 1.2, an HCO directly influences population health by investing in a full range of personal health services. Many HCOs that formerly focused on acute inpatient care (“hospitals”) have moved to broaden their scope, adding primary and rehabilitation services. Population health expands beyond Exhibit 1.2, to community-wide activities to promote healthy behavior and deliberate efforts to promote safety and reduce environmental hazards. More indirect influence can result from an HCO creating partnerships with local community health centers in order to improve access to immunizations and healthy behaviors for pregnant women.

The Collaborative, Dynamic Nature of HCOs

The HCO creates, supports, and coordinates the caregiving and support teams. HCOs involve extensive collaboration within and across teams. Within a single hospital, for example, one team of caregivers works together to perform a surgical procedure and several teams manage the patient’s care before and after surgery. Exhibit 1.2 extends that model to comprehensive indi-

vidual patient care, beginning with the prevention of illness and extending to end-of-life care. The various teams are grouped in **service lines**, patient care teams coordinated around a set of similar diseases or patient needs.

Service lines

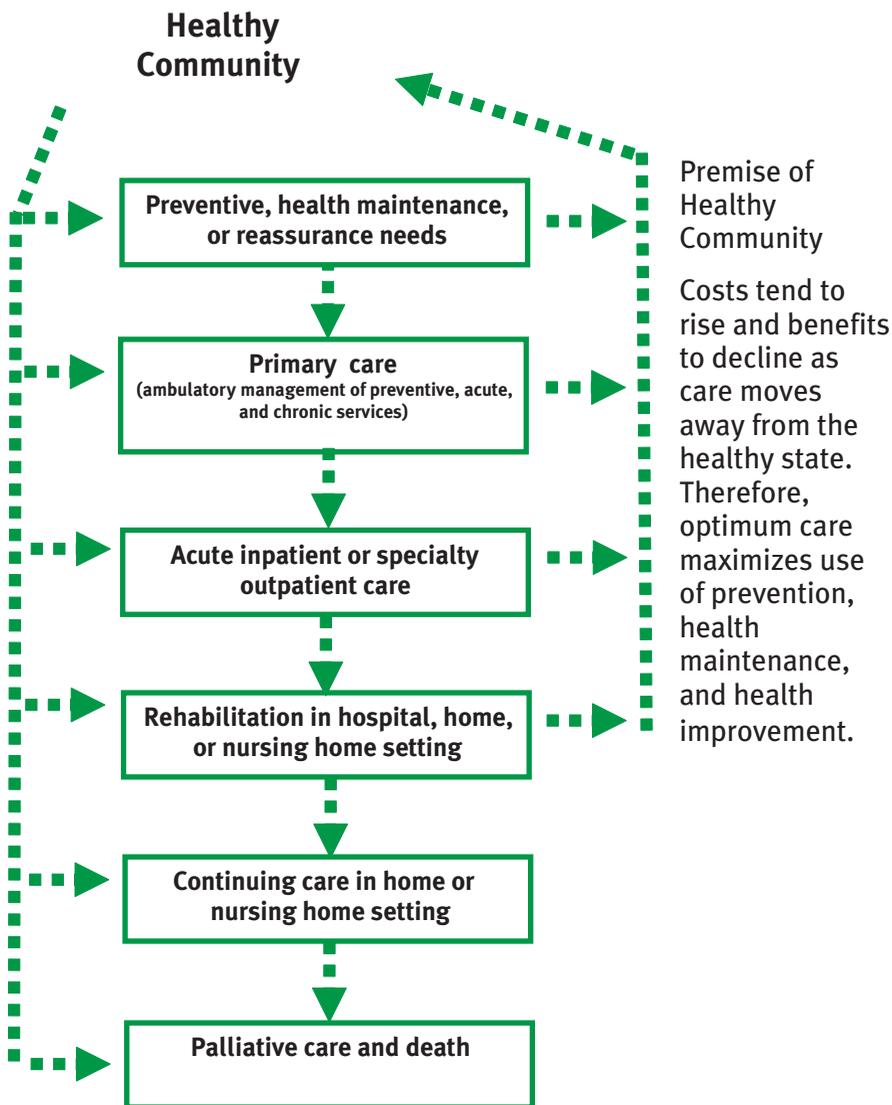
Patient care teams organized and coordinated around a set of similar diseases or patient needs.

Large not-for-profit HCOs now provide a comprehensive array of service lines, coordinating primary care, inpatient and outpatient acute care, rehabilitation, and follow-up care to support the treatment and recovery.

Exhibit 1.2 is static. Any real HCO is highly dynamic in three ways:

1. The HCO constantly responds to the changing array of patients and their changing needs. This makes most HCOs a 24/7/365 operation, prepared for more than will happen in any given day.

EXHIBIT 1.2
Personal
Services for
Community
Health



2. The HCO evolves as medicine, health, and management change, reflecting both the latest scientifically proven treatments, activities to prevent illness, and new developments in management practices and information technology.
3. The HCO adjusts to the changes in its community's needs. As the population grows, shrinks, and changes in age and ethnic diversity, the epidemiology of disease changes and the HCO must respond.

One function of the strategic activities of the HCO is to manage these changes. While the focus of the clinical and support activities is “this patient,

now,” the strategic focus of many leading HCOs is “all patients and our community, into the future.”

Stakeholders: The HCO’s Owners and Market Partners

HCOs exist in a changing, complex environment and are influenced by a variety of external and internal factors. All organizations exist because they fulfill a need that individuals working alone cannot meet,⁶ and they thrive because they fulfill that need better than competing alternatives.⁷ Organizations serve

many **stakeholders**—individuals or groups who have a direct interest in the organization’s success and shape its mission and strategies. Stakeholders are buyers, workers, suppliers, regulators, and owners. They can choose to participate in the organization or not.

Organizations must meet stakeholder needs; otherwise they fail and disappear.

Stakeholders’ desires are inherently conflicting. The buyer wants to buy inexpensively, the supplier to maximize profit. Each of us is a stakeholder in many organizations. Our organizations exist in networks of negotiated solutions to those conflicting desires.

A summary of the stakeholder environment for HCOs is shown in Exhibit 1.3. Because of the intimate and life-changing nature of healthcare services, their cost, and the complex structure to finance the costs, HCOs represent one of the most complex applications of the stakeholder model. HCOs become “excellent” or “high performing” because they are able to negotiate effective solutions among their stakeholders.

Customer Partners

Patients and Families

Patients are the most important HCO 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.⁸ They also expect reasonably comfortable amenities and confidentiality. Friends and family accompany most patients, and many family members serve as important caregivers, so HCOs must establish close and direct relations with them. HCOs are increasingly focusing on **patient-**

centered care and involving patients and families in care planning and decision making so that they can provide “care that is respectful [of] and responsive to individual patient preferences, needs, and values.”⁹

Stakeholders

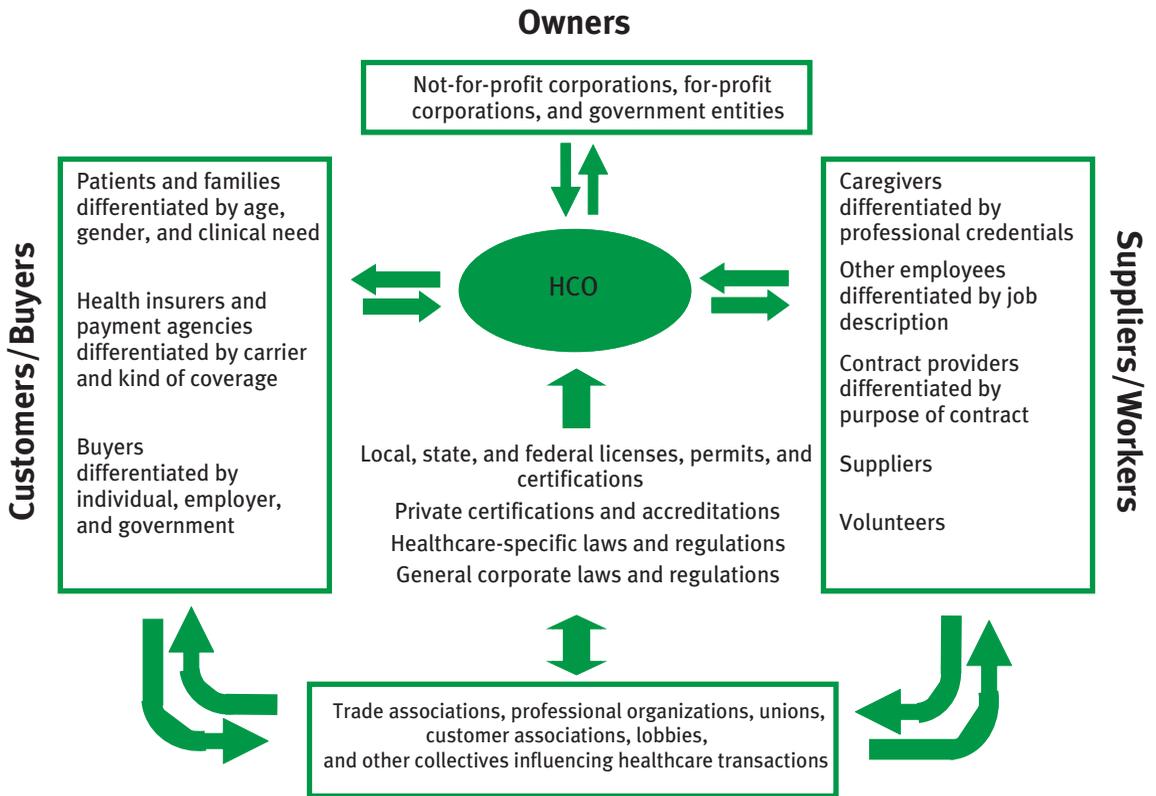
Individuals or groups who have a direct interest in the organization’s success.

Patient-centered care

Care that is respectful of and responsive to individual patient preferences, needs, and values.

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

EXHIBIT 1.3 Model of Stakeholder–HCO Interaction

fiscal intermediaries provide most of the revenue to HCOs, making them essential stakeholders. Private health insurers are agents for buyers, which include governments, employers, and citizens at large. Two large governmental insurance programs—Medicare and Medicaid—are exchange partners with most HCOs. The federal Medicare program deals with HCOs through fiscal intermediaries.¹⁰ 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.

The insurance industry and HCOs' relations to it were dramatically changed by the passage and implementation of the **Patient Protection and Affordable Care Act (ACA)**. This historic legislation has significant implications for healthcare organizations,

Fiscal intermediary

An outside contractor that processes claims for U.S. government programs such as Medicare and Medicaid.

Patient Protection and Affordable Care Act (ACA)

A federal law (P.L. 111-148) providing for a fundamental reform of the U.S. healthcare and health insurance system, signed by President Barack Obama in 2010.

including increased insurance coverage for many patients, new approaches to support those with chronic disease, and greater accountability for the cost and quality of care.^{11,12} The ACA was developed in part to support the the “Triple Aim”—three goals for transforming the health system, including improving the individual patient experience with healthcare, improving the health of the population, and reducing the per capita cost of care.¹³

Value-based purchasing

Linking financial incentives to the quality of care provided.

The ACA has increased the number of insured individuals and created new payer arrangements for HCOs. These changes use **value-based purchasing** approaches that reward HCOs for quality and sustained patient health.¹⁴

Buyers

Much health insurance is provided through employment, making employers important stakeholders. 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. Insurance buyers, who must meet the demands of their own exchange networks, have taken action to restrict the growth of costs, acting principally through value-based purchasing, which is expected to become a major force in shaping most HCOs.

Regulatory Agencies

Government regulatory agencies are stakeholders 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. The QIOs have been instrumental in the national Surgical Care Improvement Project, a national quality partnership of organizations interested in improving surgical care by significantly reducing surgical complications.¹⁵ The project has almost universal endorsement among regulatory and healthcare trade associations, and an important record in reducing the hazards of surgical care.¹⁶ HCOs are subject to many consumer-protection laws, including the Health Insurance Portability and

Certificate of need

Certificate or approval for new services and construction or renovation of hospitals or related facilities; issued in many states.

Accountability Act (HIPAA), which addresses major issues of privacy and security of protected health information. The **Emergency Medical Treatment and Active Labor Act (EMTALA)** requires all HCOs providing emergency care to accept all patients, regardless of ability to pay, until they are stabilized and can be safely moved.

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and can be safely moved. Provisions of the ACA require not-for-profit hospitals to review community needs and report the **community benefit** value of the HCO contribution.¹⁷

Most payment organizations mandate external reviews of HCO performance through accreditation and financial audits. Accreditation is voluntary, but HCOs must have accreditation by a Centers for Medicare & Medicaid Services (CMS) deemed-status organization, such as **The Joint Commission**, in order to receive funds from Medicare. Most payment organizations also require annual audits by the accounting firm of the HCO's choice. Some insurance plans are accredited by the National Committee for Quality Assurance (NCQA), which also accredits ambulatory care and disease management programs.

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 and violence; and attract the homeless, the mentally ill, and those with chronic substance abuse concerns. These activities draw HCOs into exchanges with law enforcement and social service agencies.

In addition, HCOs work with United Way and other charities. HCOs facilitate baptisms, ritual circumcisions, group religious observances, individual spiritual activity, and rites for the dying. They provide educational facilities for caregivers and services to improve community health and well-being, such as health education and disease prevention programs, assistance to support groups, and mobile clinics. Such 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

Community benefit

Current law requires hospitals to satisfy the community benefit standard in order to qualify as tax-exempt charities under section 501(c)(3) of the Internal Revenue Code.¹⁸ The standard addresses charitable care, educational services, and other benefits HCOs provide to their communities.¹⁹

The Joint Commission

A voluntary consortium of professional provider organizations that evaluates and accredits a wide range of different HCOs.

for nonprofit status.²⁰ Communication with stakeholders often involves the media—print, radio, television, and Internet coverage—and purchased advertising. Web-based public sources such as HealthGrades and WhyNotTheBest are increasingly influential in forming customer opinion, although they may not give consistent results.²¹

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. The term *associates* is intentional and reflects the concept of servant leadership, which will be discussed in Chapter 2.

Employees are compensated by salaries and wages. Trustees and a great many others volunteer their time to not-for-profit HCOs; 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. **Licensed independent practitioners (LIPs)** are caregivers granted legal status to provide specific kinds of healthcare, categorized as primary care or specialist providers who are usually physicians or advanced practice nurses (nurse practitioners, nurse midwives). **Primary care practitioners** include physicians and advanced practice nurses specializing in family medicine, general internal medicine, pediatrics, obstetrics, and psychiatry and are the most common initial contacts for patients. **Specialist practitioners** 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**

accept relatively broad categories of patients and manage inpatient care only. Other LIPs (e.g., dentists, psychologists, podiatrists) may also be members or associates of the HCO's medical staff.

Associate Organizations

Associates are often organized into groups that manage their exchanges to varying extents. Unions, or collective bargaining units, sometimes represent employed associates. Physicians and advanced practice nurses often form professional associations and practice groups. Neurologists, for example, can become a group to represent their interests to the organization as a whole.

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Associates

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

Licensed independent practitioners (LIPs)

Caregivers granted legal status to provide specific kinds of healthcare.

Primary care practitioners

Initial contact providers, including physicians, nurse practitioners, midwives in family medicine, general internal medicine, pediatrics, obstetrics, and psychiatry; often a longitudinal relationship.

Specialist practitioners

Licensed independent practitioners who care for patients referred by primary care practitioners on a limited or transient basis; likely to manage episodes of inpatient care.

Hospitalists

Physicians who manage broad categories of hospitalized patients.

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.

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 Provider Organizations

In the course of meeting patient needs, HCOs have considerable contact with other HCOs, such as primary care clinics, mental health and substance abuse services, home care agencies, hospices, and rehabilitation and long-term care facilities. Many large HCOs incorporate and own these services. Others may have formal relationships with organizations, such as referral agreements, affiliations, strategic partnerships, and joint ventures. It is not uncommon for two HCOs to collaborate in some activities, such as medical education or care of the poor, and to compete actively on other activities.

Sources of Stakeholder Influence

The ultimate source of stakeholders' power is the marketplace—their ability to participate or choose not to participate in the exchange. In reality, influence is exercised in four ways that achieve ongoing negotiation rather than discontinued participation.

Participation and Market Pressure

Successful HCOs work steadily and systematically to increase the loyalty of their stakeholders. 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. Surveys monitor satisfaction of both. Loyal customers and associates are vital assets of any HCO.

Negotiation

Stakeholders often present their concerns for negotiation, usually through organized representation. Desires frequently conflict and can easily become adversarial, as in the traditional relationship between unions and management.

High-performing 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 win-win 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.

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.

Buyer- and consumer-oriented networks, such as the National Business Group on Health and the AARP, are coalitions that allow stakeholders to address complicated social problems, such as healthcare's uninsured and health promotion. The Joint Commission is a provider coalition that has been accepted as a central quality monitor for HCOs. The National Quality Forum (NQF) is a coalition of buyer and provider organizations that evaluates and standardizes measures of quality.²² The measures become a central component for measuring HCO performance and for contracting with insurers.

Social Controls

Stakeholders can imbed their viewpoints 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 CMS through 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,²³ and The Joint Commission has added the measures to its criteria.²⁴

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, access, 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 American Healthcare Marketplace

HCOs constitute one of the largest sectors in the U.S. economy. They are geographically universal but organizationally diverse. Every community has HCOs—typically one or more hospitals, several physicians’ offices, and various continuing care and specialty services—but how those HCOs are organized differs from community to community.

Ownership and Centralization

This section describes HCOs—hospitals, primary care, post-acute care—by the services provided, ownership type, and extent of centralization.

Hospitals

Acute care hospitals are the largest single group of HCOs in terms of dollars. They are licensed corporate entities and also the largest and oldest components of most large health systems. Hospitals consume 30 percent of all healthcare expenditures; an additional 20 percent is spent on their affiliated physicians. Other expenditure is dispersed among a variety of vendors, utility providers, and others.²⁵ In combination, hospitals and physicians are the focus of most stakeholder efforts to control cost and quality. The organization of hospitals is shown in Exhibit 1.4. The 4,800 “general” or “community” hospitals account for 90 percent of hospital expenditures. These hospitals typically provide acute, inpatient medical, surgical, and obstetrical care. Fifteen hundred specialty hospitals consume only 10 percent of expenditures.

Hospital ownership is dominated by nonreligious and religious not-for-profit corporations. The not-for-profit structure has afforded substantial

EXHIBIT 1.4 Ownership and Specialization of U.S. Hospitals, 2010

Ownership	General Medical/ Surgical Hospitals	Other Hospitals	Total			
	Expenditures (billion \$)	Count	Expenditures (billion \$)	Count	Expenditures (billion \$)	Count
Federal	\$ 49	197	\$ 4	18	\$ 53	215
For-profit	\$ 63	794	\$17	793	\$ 80	1,587
Nonreligious not-for profit	\$395	2,250	\$38	341	\$433	2,591
Religious not- for-profit	\$ 85	501	\$ 2	45	\$ 87	546
State/local government	\$ 97	1,082	\$17	290	\$114	1,372
Grand total	\$689	4,824	\$77	1,487	\$766	6,311

Source: Data from American Hospital Association Annual Survey Database, fiscal year 2010.

tax advantages to not-for-profit organizations, recognizing that their services would otherwise be required of government to fulfill.²⁶ Community hospitals operated by local government are organizationally similar.

Exhibit 1.5 shows the relative expenditures of hospitals by ownership. Religious, other not-for-profit, and local government hospitals, often called *community hospitals*, provide about 80 percent of the total care. Federal and for-profit hospitals provide about 10 percent each. Virtually all federal hospitals were under the purview of four systems: Department of Defense, Veterans Affairs, Indian Health Service for Native American healthcare, and federal prison hospitals. In the 1970s, a movement to for-profit ownership quickly reached about 10 percent of all community hospitals, and expenditures plateaued at that level. For-profit, or investor-owned, hospitals are heavily concentrated in specialty hospitals rather than community hospitals, and they tend to be small.

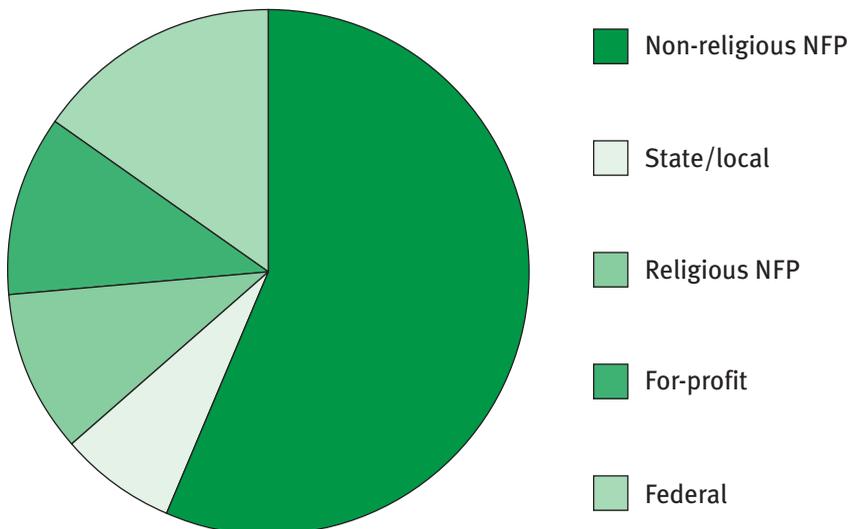
The trend has been toward larger HCOs, integrating both hospitals and other HCOs into **healthcare systems**. Most for-profit hospitals are in large systems. More than two thirds of community hospitals are in systems, by either count or expenditures. The median size of healthcare systems was \$2 billion per year in 2010; the median size of independent hospitals was \$30 million.

Many healthcare systems operate in multiple states; most provide a range of services beyond acute hospital care. Their size difference provides a

Healthcare system

A corporate or governmental structure including one or more hospitals and often other hco services.

EXHIBIT 1.5 Hospital Expenditures by Ownership



NFP: not-for-profit

Note: Total does not add up to 100 percent due to rounding.

Source: Data from American Hospital Association Annual Survey Database, fiscal year 2010.

number of operating advantages over independent hospitals. The typical HCO system is now almost 10 times the size of the typical independent hospital. Small organizations must purchase many clinical and logistic support services from independent vendors and obtain strategic advice from consultants. Larger systems can own and coordinate these activities more effectively. It is likely that they will grow, becoming the dominant source of personal health-care. Specialty hospitals (such as cancer hospitals) and specialized services (such as urgent care centers, retail clinics, nursing homes, and hospices) will still exist as “niche” businesses targeting special patient needs and populations.

Primary Care

Primary care HCOs were traditionally organized around one or a few practitioners—doctors’ offices, or urgent care centers, for example—generally tax-paying limited liability corporations, only slightly different from an owner-operated business. Larger groups of caregivers have steadily increased in popularity and expanded rapidly after passage of the ACA. Many individual practitioners affiliate with hospitals through a contract called “privileges.” Privileges define quality and service obligations but allow a wide variety of financial arrangements. The traditional independent fee-for-service medical practice has largely yielded to larger corporate structures, including jointly owned physician hospital corporations and employment contracts. The joint corporations are generally for-profit. They employ physicians but permit practitioner owners to take an equity (ownership) position and participate directly in strategic decisions. Many physicians and other caregivers are now directly employed by large HCOs. Community health centers, often **federally qualified health centers**, which are not-for-profit clinics addressing the needs of the poor and uninsured, have grown in recent decades. They have independent local governing boards but often affiliate with local hospitals. **Accountable care organizations (ACOs)**, created by the ACA, expand the concept of a **patient-centered medical home**. ACOs will largely be run by large HCOs, affiliating with group practices and community health centers, although other models are developing.^{27,28}

Federally qualified health center

Services for underserved areas or populations that offer a sliding fee scale, provide comprehensive services, have an ongoing quality program, and seat a board of directors; funded with grants under section 330 of the Public Health Service Act.

Accountable care organization (ACO)

A set of healthcare providers—including primary care physicians, specialists, and hospitals—that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients.²⁹ The patient-centered medical home is an accepted model for achieving the ACO goals.

Patient-centered medical home

A mechanism for organizing primary care to provide high-quality care across the full range of individuals’ healthcare needs.³⁰

Post-acute and Specialty Care

Many patients require extended support at less intense levels than acute inpatient care. The HCOs filling these needs can have any of a variety of corporate structures. Post-acute rehabilitation facilities are operated both by

hospitals and by national for-profit chains that also operate nursing homes. They expanded rapidly in the late twentieth century, but growth has slowed. DaVita, a national chain of kidney dialysis centers, and several corporations operating bariatric surgery facilities are specialized, publicly owned, for-profit systems. It is not clear that they or similar systems will grow.

Chronic care facilities, or nursing homes, are operated both by not-for-profit hospitals and by a few large national for-profit chains. Independent local corporations are declining in number.

Palliative care and hospice services have been provided by hospitals and small independent not-for-profit corporations. It is likely that large HCOs will own or joint venture with many of these organizations.

Designing Excellence in an HCO

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

- Patient care is safe, effective, patient centered, timely, efficient, and equitable.³¹
- The HCO participates actively with other community organizations to meet population health needs.
- 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 integration, and the measures that document their performance. It is based not 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 in a marketplace where each team is a vendor, selling either to the patient or to another vendor. Much of American healthcare was essentially that. Small HCOs—doctors' offices, pharmacies, hospitals, equipment vendors, nursing homes, etc.—traditionally operated without any permanent relationship to each other. They bought logistic services from other vendors. There was no overarching strategy; the patients and their care teams selected each vendor

as they needed them. Leading HCOs and healthcare systems have a very different vision, called **vertical integration**. They will integrate and support a large group of care teams, most commonly in acute care and rehabilitation but increasingly also primary care

Vertical integration

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

and long-term care. Many also pursue the same kinds of care teams in multiple sites, known as **horizontal integration**.

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

1. *Cultural*, a commitment to values that attract the respect and support of stakeholders as individuals
2. *Operational*, a system that seeks out, evaluates, and implements opportunities to improve stakeholder returns
3. *Strategic*, a system that deliberately monitors the long-term relationship between stakeholders and responds to changing needs

Horizontal integration

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

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, 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.^{32,33,34} 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 acting as 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.³⁵

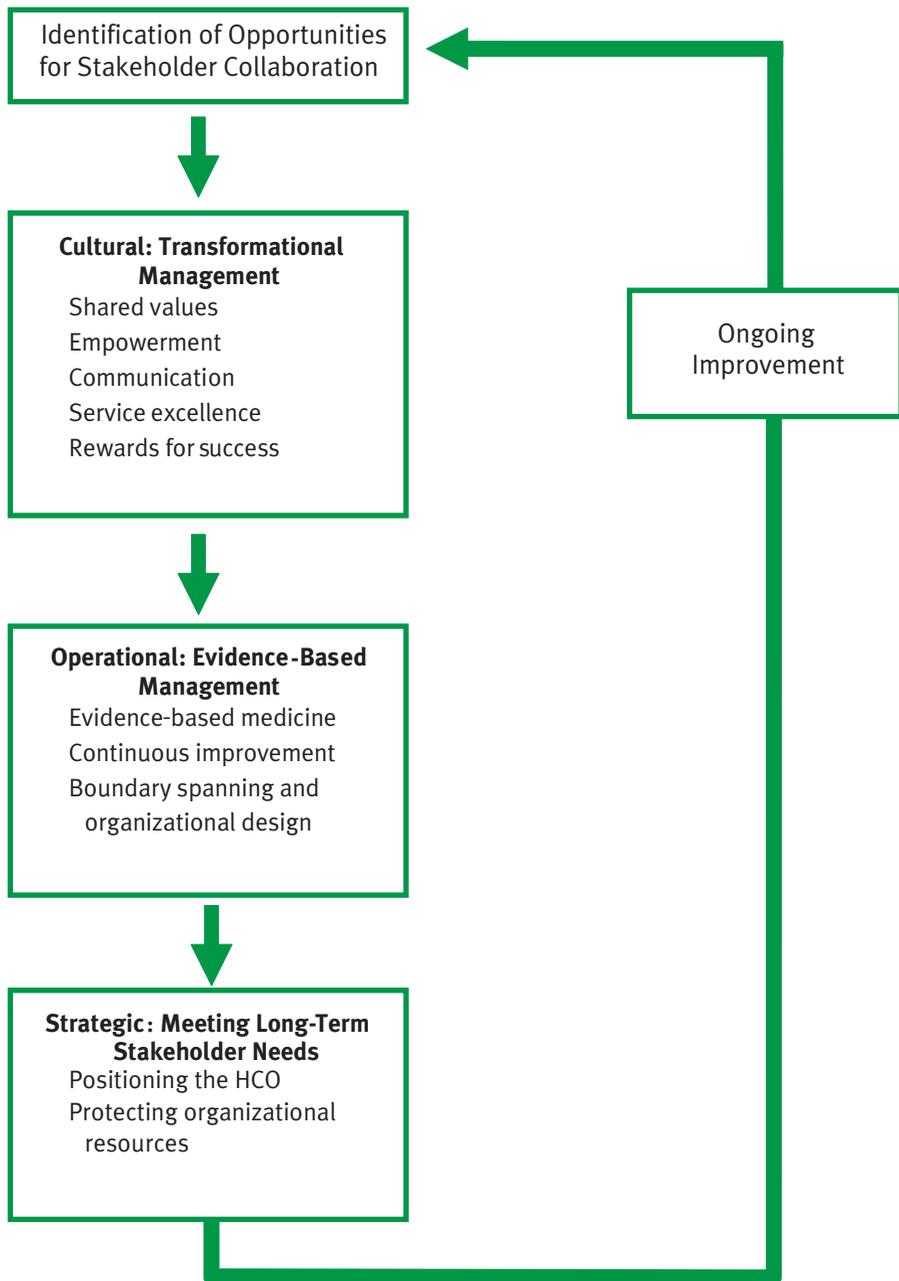
Shared Values

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

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. Missions were frequently vague, such as “Excellence in care.” Now many leading HCOs are moving to population health missions, explicitly accepting responsibility for the broader goal.

EXHIBIT 1.6
Foundations
of Excellence
in Healthcare
Organizations



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.

Vision

An expansion of the mission that expresses intentions, philosophy, and organizational self-image.

The mission is supplemented with a shared **vision**, an idealistic goal such as universal healthcare. The mission and vision are, in turn, supplemented by

a 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 statements differs from HCO to HCO, but common threads are obvious among them.³⁶ 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), *nonmaleficence* (commitment to “do no harm”), and *justice* (commitment to equity and respect for all).³⁷ They can easily be expanded into the twenty-first-century goals for care delivery: safe, effective, patient centered, timely, efficient, and equitable. Exhibit 1.7 shows the mission and vision statements of HCOs that have documented their excellence for the Malcolm Baldrige National Quality Award.

Values

An expansion of the mission that expresses basic rules of acceptable conduct, such as respect for human dignity or acceptance of equality.

EXHIBIT 1.7

Mission and Vision Statements of HCO Baldrige National Quality Award Recipients

Year	Organization (State)	Mission	Vision
2002	SSM Health Care (MO) www.ssmhealth.com/ system	Through our exceptional health care services, we reveal the healing presence of God.	Through our participation in the healing ministry of Jesus Christ, communities, especially those that are economically, physically and socially marginalized, will experience improved health in mind, body, spirit, and environment within the financial limits of the system
2003	Baptist Healthcare (FL) www.ebaptisthealthcare.org/	To provide superior service based on Christian values to improve the quality of life for people and communities served.	To be the best health system in America.
2003	Saint Luke’s Health System (MO) www.saintlukeshealthsystem.org/	[A] faith-based, not-for-profit, aligned health system committed to the highest levels of excellence in providing health care and health-related services in a caring environment. We are dedicated to enhancing the physical, mental, and spiritual health of the diverse communities we serve.	The best place to get care. The best place to give care.

(continued)

EXHIBIT 1.7**Mission and Vision Statements of HCO Baldrige National Quality Award Recipients (*continued*)**

<i>Year</i>	<i>Organization (State)</i>	<i>Mission</i>	<i>Vision</i>
2004	RWJ Universtiy Hospital Hamilton (NJ) http://rwjhamilton.org/	[C]ommitted to excellence through service. We exist to promote, preserve and restore the health of our community.	[B]e a Quality Driven Center for Health that is nationally recognized for passionately exceeding the needs of our patients, employees, physicians and community.
2005	Bronson Healthcare (MI) www.bronsonhealth.com	Provide excellent healthcare services	To be a national leader in healthcare quality.
2007	Mercy Health System (WI) www.mercyhealthsystem.org	[P]rovide exceptional health care services resulting in healing in the broadest sense	Mercy's many service lines have individual visions. See, for example, the Trauma Center: "We are committed to provide: Regional trauma leadership Community injury prevention education Education to those who care for the injured The highest quality of care through continuous quality improvement" (http://www.mercyhealthsystem.org/body.cfm?id=487)
2007	Sharp HealthCare (CA) www.sharp.com	[I]mprove the health of those we serve with a commitment to excellence in all that we do.	[B]e the best health system in the universe. Sharp will attain this position by transforming 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. Sharp is known as an excellent community citizen embodying an organization of people working together to do the right thing every day to improve the health and well-being of those we serve.
2008	Poudre Valley (CO) (now part of UC Health) www.uchealth.org/	Putting patients first. Leading the way in academic medicine, Building healthier communities.	We improve lives. In big ways through learning, healing and discovery. In small, personal ways through human connection. But in all ways, we improve lives

EXHIBIT 1.7**Mission and Vision Statements of HCO Baldrige National Quality Award Recipients (*continued*)**

<i>Year</i>	<i>Organization (State)</i>	<i>Mission</i>	<i>Vision</i>
2009	AtlantiCare (NJ) www.atlanticare.org/	We deliver health and healing to all people through trusting relationships.	AtlantiCare builds healthy communities.
2009	Heartland Health (MO) (now Mosaic Lifecare) www.mymosaiclifecare.org	To improve the health of individuals and communities located in the Heartland Health region and provide the right care, at the right time, in the right place, at the right cost with outcomes second to none	To make Heartland Health and our service area the best and safest place in America to receive health care and live a healthy and productive life
2010	Advocate Good Samaritan (IL) www.advocatehealth.com/gsam/	To serve the health needs of individuals, families and communities through a wholistic philosophy rooted in our fundamental understanding of human beings as created in the image of God.	
2011	Henry Ford Health System www.henryford.com/	To improve people's lives through excellence in the science and art of health care and healing	Transforming lives and communities through health and wellness—one person at a time.
2011	Schneck Medical Center (IN) www.schneckmed.org/	To provide quality health care to all we serve	To be a healthcare organization of excellence: every person, every time
2011	Southcentral Foundation (AK) www.southcentralfoundation.com	Working together with the Native Community to achieve wellness through health and related services.	A Native Community that enjoys physical, mental, emotional, and spiritual wellness.
2013	Sutter Davis Hospital (CA) www.sutterdavis.org/	To enhance the health and well-being of people in the communities we serve, through a not-for-profit commitment to compassion and excellence in health care services	Sutter Health leads the transformation of health care to achieve the highest levels of quality, access and affordability.
2012 and 2006	North Mississippi Health System (MS) www.nmhs.net/	To continuously improve the health of the people of our region.	What We Want to Be: The provider of the best patient-centered care and health services in America

Source: Information from Malcolm Baldrige National Quality Award website. [Online information; retrieved 8/11/14.] www.baldrige.nist.gov/Contacts_Profiles.htm.

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."

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 organization's mission.

Empowerment is particularly important in healthcare, where caregiving professionals must respond rapidly and correctly 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.³⁸ 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.

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.

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

Pre-hire and selection process (C, SK, TT)	Competency assessments (C, SK, TT)
New hire orientation (C, SK, TT)	Workshops and educational courses (C, SK, TT)
Nursing core orientation (C, SK, TT)	Employee forums and focus groups (C, TT)
Leadership communication process (C)	Employee neighborhood meetings (C, TT)
Leadership communication forums (C)	Computer-based learning modules (C, SK)
Knowledge-sharing documents (C, SK)	Leader rounds (C, SK, TT)
Department meetings (C, SK, TT)	Self-study modules (C, SK)
Bulletin boards (C)	Skills fairs and learning labs (C, SK, TT)
Communication books (C)	Safety champions (C, SK, TT)
E-mail for all employees (C, TT)	Preceptors (C, SK, TT)
Instant messaging (C, TT)	Externships/internships (C, SK, TT)
<i>InsideBronson</i> intranet (C, SK, TT)	Management mentor program (C, SK, TT)
Department-specific newsletters (C)	Shared governance (C, SK, TT)
Shared directories (C)	Teams, work groups, councils, and committees (C, SK, TT)
Daily huddles (C, SK, TT)	Staff performance management system (C, SK, TT)
<i>Healthlines</i> newsletter (C)	
CEO/CNE open office hours (C, TT)	
Leadership (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 8/11/14.] www.baldrige.nist.gov/Contacts_Profiles.htm.

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.

Empowerment requires that organization goals and plans be discussed in advance of implementation 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.

The activities shown in 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 "time-out" whereby the circulating

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EXHIBIT 1.8

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

Negotiating

Teaching

Protocols

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

Procedures or processes

Actions or steps that transform inputs to outputs.

nurse verifies the patient, procedure, location, and any unusual risks. Specific **procedures** or **processes** are also followed for nonclinical activities, such as cleaning washrooms, posting payments to patient accounts, and conducting meetings of the governing board.

All processes are learned, and most are taught by the organization. High-performing organizations invest heavily in teaching (using a variety of approaches), measuring learning, and rewarding correct application. Bronson Methodist, for example, documents an average of more than 100 hours of teaching for each full-time employee.³⁹

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 an 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 building trust within the organization. HCOs reinforce trust and stewardship by building team spirit and by modeling and rewarding correct behaviors.

Trust and accountability, agency, and stewardship are difficult to sustain. They are subject to moral hazard; any member can do less than her share, free-riding on the efforts of others. High-performing HCOs build trust and stewardship with a program of **service excellence**, recognizing that associates will work to meet customer needs if their own needs are met.⁴⁰ 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.

Agency or accountability

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

Service excellence

Concept whereby associates anticipate and meet or exceed customer needs and expectations on the basis of the mission and values.

Service excellence has gained wide support, particularly in service industries.⁴¹ It is a universal practice among high-performing HCOs.⁴² 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.⁴³

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 1990s⁴⁴ and continues today in more than half of the nation's hospitals.⁴⁵ This model, often called **evidence-based management**, relies heavily on performance measurement, identification of best practices, and formal process specification. Evidence-based management deliberately parallels *evidence-based medicine*, a similar shift in medical thinking toward the systematic use of science to identify clinical best practices.

Evidence-based management

Relies heavily on performance measurement, identification of best practices, and formal process specification

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

<i>Reward</i>	<i>Award/Incentive Programs</i>	<i>Objectives</i>
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

**The *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 8/11/14.] www.baldrige.nist.gov.

The core concept of evidence-based medicine is that scientific knowledge should drive as many clinical decisions as possible.⁴⁶ Much of medicine is judgmental, but as the diagnosis is clarified, evidence can be drawn from existing similar cases. **Patient care guidelines** define the scientifically proven steps appropriate for treating most patients with a specific disease or condition. They are translated to **patient care protocols** that can be implemented in specific HCOs. **Functional protocols** detail the specific steps for performing individual clinical procedures, such as admission interviews and subcutaneous injections. These protocols make explicit the agency and stewardship obligations behind service excellence. Protocols are not rules; the empowered caregiver has the obligation to depart from the protocol when the patient’s condition requires it.

Evidence-based medicine has become the standard of practice. Many professional organizations and academic medical centers prepare patient care guidelines, and more than 2,000 are listed on Guideline.gov, the federal website recording them.⁴⁷ Evidence-based medicine is deeply embedded in both graduate and continuing clinical education.^{48,49}

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Patient care guidelines

Formally established, scientifically based expectations that specify what must be done, by whom, how, and when, subject to the caregiver’s judgment regarding the individual patient.

Patient care protocols

Guidelines that have been tested and accepted for use by a specific HCO.

Functional protocols

Formally established, scientifically based expectations that specify how and by whom specific care activities are carried out.

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.⁵⁰ 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?
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

Data Warehouse

Facts, usually numbers, drive evidence-based decisions. Excellent HCOs build and maintain a **data warehouse**, a large library of work processes, protocols, and performance measures; a reporting system that keeps all associates current on measured performance and goal achievement; and a communication system to relay information relevant to immediate applications. The warehouse

Data warehouse

Library of work processes, protocols, and performance measures available to all associates.

is web-accessed. It typically contains several hundred protocols and procedures and several thousand individual data sets. (An acute care HCO needs several hundred measures to implement its operational scorecards, described below.)

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.

Strategic and Operational Scorecards

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 an **operational scorecard**. It is usually generated monthly and reports three dimensions of inputs or resources—demand for service; physical resources or

Operational scorecard

Performance report for a single work unit or an aggregate of several related units, reporting three dimensions of inputs or resources—demand for service; physical resources or costs; and status of resources, such as the satisfaction and commitment of the unit’s associates—and three dimensions of results—output and productivity (ratio of resource to output), quality of service or product, and customer satisfaction. The actual measures can differ by unit, but enough common measures must be used to allow similar units to be aggregated into service lines.

costs; and status of resources, such as the satisfaction and commitment of the unit’s associates—and three dimensions of results—output and productivity (ratio of resource to output), quality of service or product, and customer satisfaction. The actual measures can differ by unit, but enough common measures must be used to allow similar units to be aggregated into service lines.

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. The **strategic scorecard**, sometimes called *balanced scorecard*, measures the enterprise as a whole or in large components,

*Input Oriented**Demand*

Requests for service
Market share
Appropriateness of demand
Unmet need
Demand logistics
Demand errors

Cost and resources

Physical counts
Costs
Resource conditions

Human resources

Supply
Development
Satisfaction
Loyalty

*Output Oriented**Output and productivity*

Counts of services rendered
Productivity (resources/treatment or service)

Quality

Clinical outcomes
Procedural quality
Structural quality

Customer satisfaction

Patients
Referring physicians
Other customers

EXHIBIT 1.10

Operational
Scorecard:
Performance
Measures for
Individual
Teams and
Work Units

particularly those with independent financial structure, such as joint venture corporations. As shown in Exhibit 1.11, they are carefully aggregated from operational measures to reflect the needs of major stakeholder groups. About 30 measures are used, grouped in major dimensions—customers, associates and suppliers, operations (quality and cost), and finance.

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 these exhibits tracks the stakeholder relations and mission achievement 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 to ignore.

Work processes and protocols must be learned by all users. Web-based outlines are helpful, but many healthcare 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 systems and hospitals invest about twice as much time—two to two-and-a-half weeks

Strategic scorecard

Measures of overall enterprise performance grouped in major dimensions—customers, associates and suppliers, operations (quality and cost), and finance. The strategic scorecard is reported to the governing board and is appropriate for service lines, the HCO as a whole, or its major components.

Training

EXHIBIT 1.11

Template of
Strategic
Measures
of HCO
Performance

<i>Dimension</i>	<i>Major Concepts</i>	<i>Healthcare Examples</i>
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

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.

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 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.⁵¹ It had widespread acceptance and is now a foundation for high-performing organizations in all industries. It is universal among excellent HCOs.^{52,53,54}

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)** (pronounced “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. 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.⁵⁵

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.

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.

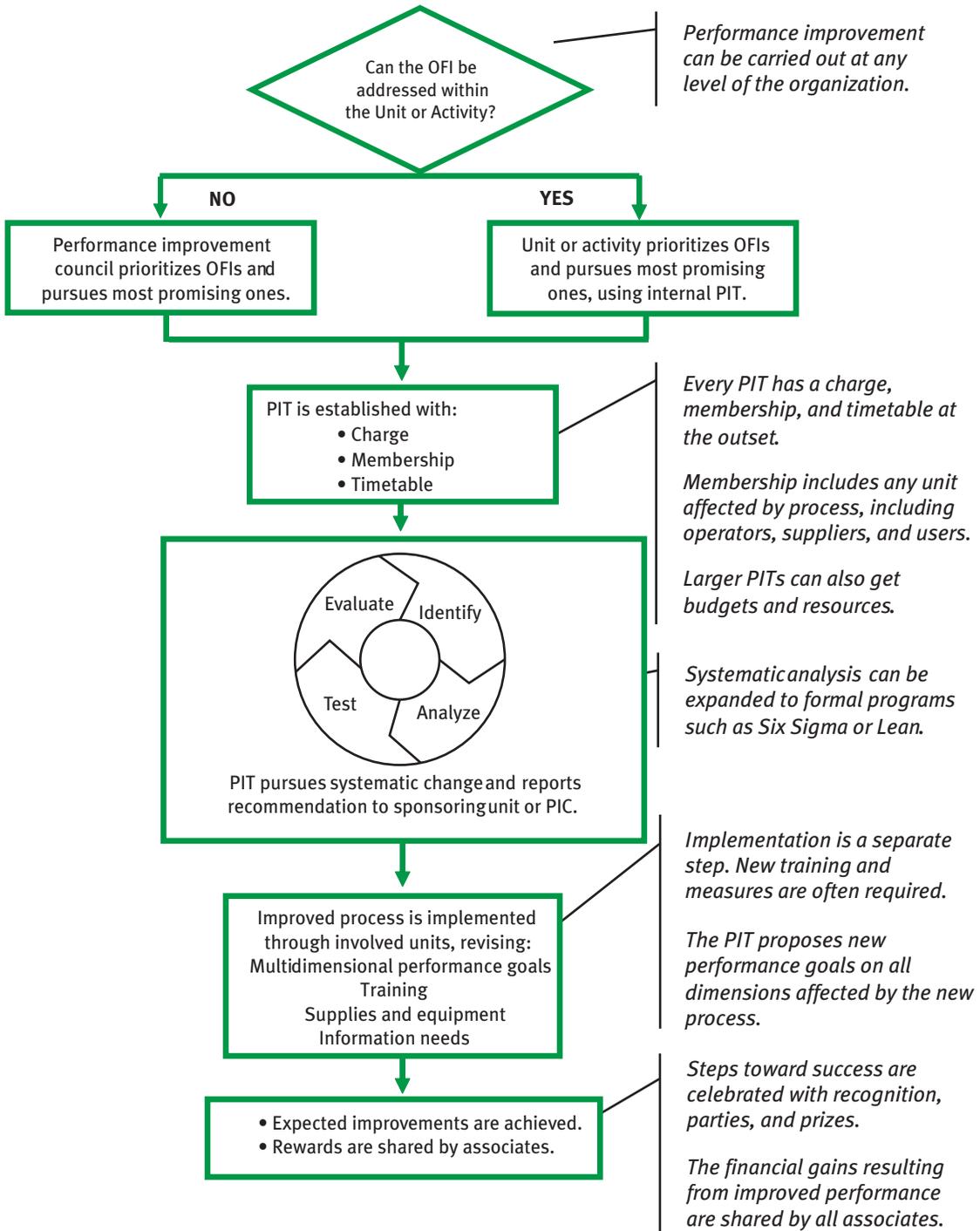
Process improvement team (PIT)

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.

EXHIBIT 1.12 Process Analysis: Translating OFIs to Improved Performance



OFI: opportunity for improvement; PIC: performance improvement council; PIT: process improvement team

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.

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 the strategic scorecard (Exhibit 1.11). The PIC pursues as many OFIs as possible, limited only by the ability of the organization to staff the PITs. An important part of PIC activity is coordinating multiple PITs 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

Activities to safeguard the assets of the organization.

Strategic Positioning

Strategic positioning has two major components. The first component is data intensive and analytical. Boundary spanning (externally oriented) and organization OFIs (internally oriented) 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 agenda and greater license to consider innovation. They evaluate the impact of alternative actions on the strategic performance measures.

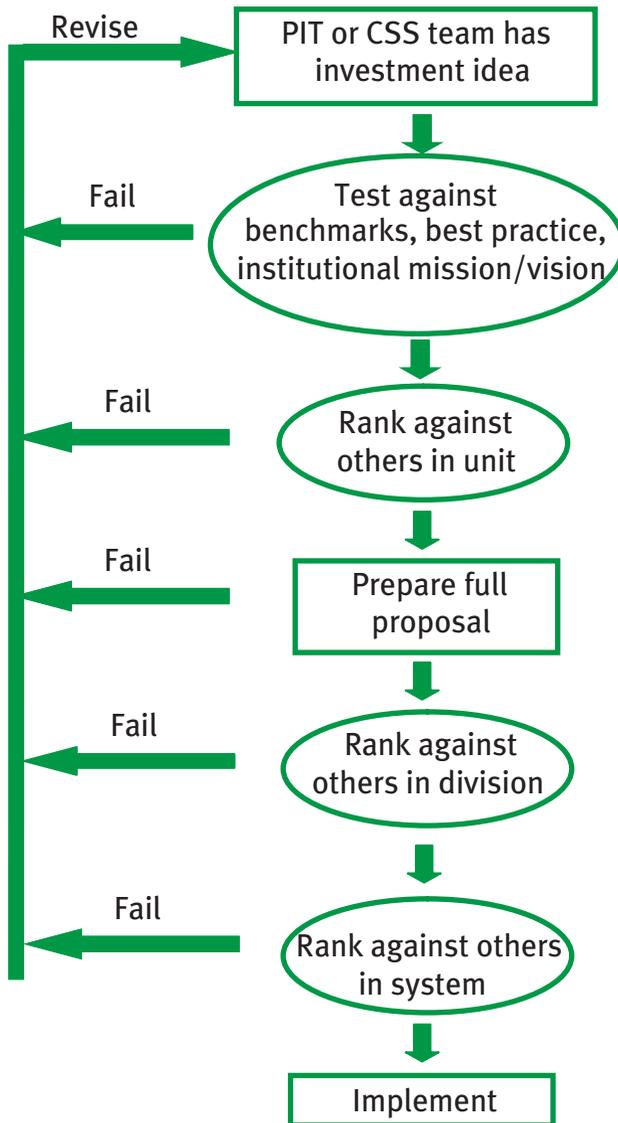
Exhibit 1.14 shows how excellent HCOs coordinate their strategic activity using an annual cycle of review that integrates analysis, proposals, and ongoing operations data to establish specific plans. These plans forecast expectations for the strategic performance measures several years into the future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

Strategic Protection

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

A less obvious risk inherent in all organizations is the failure of an individual or a team to completely carry out its responsibilities. Individuals

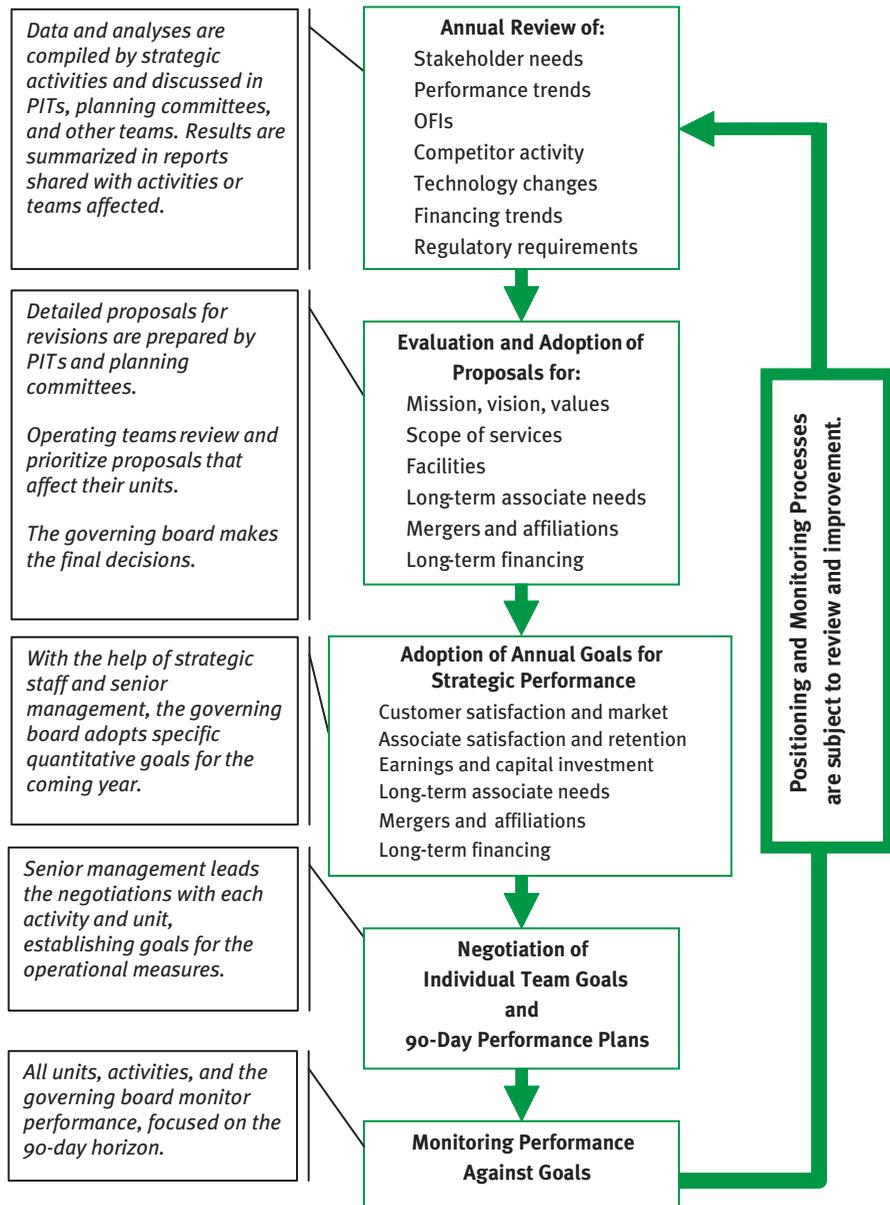
EXHIBIT 1.13
Competitive
Tests for
Investment
Opportunities



CSS: clinical support service; PIT: process improvement team

and teams in HCOs act as agents for patients or internal customers and must be accountable to complete their duties. Other individuals and teams must be able to trust the agents. A high level of trust is essential to sustaining the culture of excellence. As noted, agency, accountability, and trust are inherently subject to moral hazard. Any excellent organization must protect against agency failure, which can occur at all levels—from the temporary employee to the chief executive officer to the governing board chair. Excellent HCOs have learned to strengthen and protect their agency relationships through six

EXHIBIT 1.14
Strategic
Positioning
and Monitoring
Processes



OFI: Opportunity for improvement; PIT: process improvement team

important steps, shown in Exhibit 1.15. The first four steps are built into the culture and procedural foundations. The last two—audit and correction—require special attention.

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

EXHIBIT 1.15
Foundations
That
Reinforce
Agency/
Accountability
Relationships

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

1. *Transparent performance review.* Each level of the organization has current goals and receives performance data frequently. Excellent HCOs encourage open review of these reports, both within the units and with other units. They use 90-day plans for goal achievement, including corrective plans where necessary. The openness creates an atmosphere that makes it difficult to carry out activities that are contrary to the mission.
2. *Internal audits and reviews.* The fact that audits can be conducted at any time, by auditors deliberately isolated from the activity, on either a random or selective basis serves as a strong deterrent to misfeasance. The processes that ensure reliability of quantitative reports also discourage misrepresentation. The extensive network of listening helps ensure conformance. Reports of difficulty are carefully handled in ways that protect people who report potential problems.
3. *External reviews, audits, and oversight.* The governing board, representing the owners and stakeholders as a whole rather than the organization and its associates, is an ongoing external monitor for the organization. The services to customer stakeholders and owner stakeholders are regularly evaluated by The Joint Commission, external financial auditors, and routine financial and clinical reports. The stakeholders may pursue criminal or civil redress if they have evidence of difficulty.

High-performing organizations have made the audit structure more robust. They have built reviews into the governance process so that board members evaluate each other and their performance as a team. They have voluntarily implemented the standards of the Sarbanes-Oxley Act (legislation directed at for-profit entities), calling for greater protection against fraudulent

diversion of assets, fuller disclosure of actual performance, attestation to the accuracy of published results by board members and senior management, increased auditing, and avoidance of conflict of interest in all board decisions.⁵⁶

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

The cultural, procedural, and strategic foundations are designed to promote excellence, and they are largely successful. When these foundations are maintained, failures of accountability and agency are rare. If they are not maintained, the entire organization is threatened and drastic reconstruction is in order. Monitoring and maintaining the foundations are strategic activities primarily of the governing board and senior management.

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