

# 1

## FOUNDATIONS OF WELL-MANAGED HEALTHCARE ORGANIZATIONS

### CRITICAL ACTIONS<sup>1</sup>

1. *Emphasize mission, vision, and values:*
  - Be prepared to state your healthcare organization's mission, vision, and values (MVV).
  - Know how to explain how MVV were developed by a stakeholder consensus.
  - Be prepared to answer questions such as "Why are MVV important?", "Do people really believe that?", "What if I see things that do not reflect the MVV?", and "How do we use the MVV in decision-making?"
2. *Recruit and support a diverse and inclusive workforce:*
  - Establish recruitment programs that encourage underrepresented groups to attain technical and professional skills.
  - Ensure that evaluations and promotions are free of bias.
  - Uphold respect as an organizational value, so that every associate is comfortable in the workplace.
3. *Guide coordinated action of interprofessional care teams and support teams.*

Describe excellence and identify worker actions that deserve encouragement.
4. *Relate to stakeholders.* Know which dimensions of excellence each stakeholder group focuses on and how HCO leadership should listen to its concerns.
5. *Build a transformational culture:*
  - Seek best practices rather than fixing problems.
  - Define what constitutes a "constructive response" to associates' and stakeholders' concerns.
  - Practice rounding by managers and senior leaders can improve the performance of associates.
6. *Use measured performance, seeking benchmarks and continuously improving.*

Know the following terms and be able to explain clearly to any stakeholder how they contribute to excellence: scorecard, goal, current performance, benchmark, 90-day plan, opportunity for improvement (OFI), process improvement team (PIT).

## Purpose: Mission of Healthcare Organizations

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### Healthcare organization (HCO)

A corporation providing the services of multiple patient care teams, such as a hospital or clinic, supporting care providers with clinical, logistic, and strategic services.

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### Mission

The central purpose of an organization; its reason for existence.

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### Population health

The health of a defined group of individuals, such as a state or civil division, or insured group, measured by the incidence and prevalence of disease or infirmity.<sup>3</sup>

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Patient care is a central purpose of any **healthcare organization (HCO)**. Excellent care to each and every patient is often stated as the HCO's **mission**. HCOs provide care in a variety of inpatient and outpatient settings, using their organizational strength to meet patient needs. Many started as acute care hospitals and then grew as care sites broadened and specialized.

Many HCOs now expand their mission to “sustaining **population health**,” a substantially broader mission seeking the World Health Organization (WHO) goal: “a state of complete physical and social well-being and not merely the absence of disease or infirmity.”<sup>2</sup> For HCOs, “not merely” is the operative phrase. Population health includes

- excellence in care to individual patients, including preventive care;
- fulfillment of needs that go beyond healthcare—the housing, food, and social support that are essential to sustaining health and managing chronic disease; and
- meeting the needs of people who are not patients to help them stay well and avoid becoming patients.<sup>4</sup>

The US Department of Health and Human Services specifies national goals and objectives for population health in the Healthy People program. The goals for 2030 are the following:

- Attain healthy, purposeful lives and well-being.
- Attain health literacy, achieve health equity, eliminate disparities, and improve the health and well-being of all populations.
- Create social and physical environments that promote attaining full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage with stakeholders and key constituents across multiple sectors to take action and design policies that improve the health and well-being of all populations.<sup>5</sup>

“Healthy, purposeful lives” is deliberately ambitious. HCOs that adopt a population health–focused mission create collaborative systems that encompass public health, safety, education, housing, and urban planning organizations to move their communities toward the WHO goals. The HCO is only one participant. Its patient care contribution is central, but healthcare disparities may be created by variations in income, race, ethnicity, and geographical dwelling place. Persons with lower incomes have greater challenges to their health and fewer resources to respond to those challenges. Housing, safety, and food supplies are often inadequate. People of color are often victims of less desirable health outcomes than white counterparts.

HCOs must address disparities and develop goals that are consistent with Healthy People 2030. Fortunately, leadership concepts that create excellence in care are also successful in the population health mission.<sup>6</sup> The transformational culture and continuous improvement themes that create the best possible patient care also support the interagency collaboration that drives population health. Chapter 9 describes HCO actions that can form the foundation for this expanded mission.

## Defining Excellence

### Excellence in Patient Care

Excellence occurs when every patient care act is the right thing, only the right thing, and delivered as soon as the patient needs it, creating the best possible outcome for every patient. The challenge is formidable. Most serious patient health events—a birth, a heart attack, or ongoing diabetes care, for example—require hundreds of specific acts. An error in diagnosis can cascade into a series of problems that sometimes leads to fatality. An error by an early team can create problems for downstream teams. A strategic failure or a logistic failure—a staff or supply shortage, for example—can force a care team to improvise or delay care.

Excellence is a multidimensional concept. It is achieved by measuring, analyzing, and improving performance on each dimension of exhibit 1.1 and by striving for **benchmark**, the best-known performance. “Benchmark” is a realistic comparison—a value that a similar organization has achieved. It is often a moving target, as better processes are designed and implemented, but it marks the achievable frontier.

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#### Benchmark

The best performance on a specific measure of which the organization is aware.

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**EXHIBIT 1.1**

Criteria for  
Excellence in  
Patient Care

Care Is . . .	Elements	Measures
Safe	Care is free of accident or error.	Medication errors, infections, wrong-site surgery, falls, and other accidents, with an ultimate goal of zero.
Effective	Patients' diseases and conditions are fully and accurately diagnosed and improved to the limit of current knowledge.	Freedom from disease, freedom from pain, recurrence of need, and residual disability.
Patient centered	The patient's needs and goals are established with the patient and the family.	Surveys of patient and family satisfaction with care.
Timely	Care is given without avoidable delay.	Delays for care, waiting times, length of stay, and reports of unexpected interruptions.
Efficient	The previous four criteria are achieved at minimum cost.	Cost per episode and annual cost of care for a population.
Equitable	The first five criteria are achieved regardless of the patient's national or ethnic background, geographic location, age, gender, or income.	Discrepancies and disparities between population groups.

Source: Adapted from Academy of Medicine (2000).<sup>7</sup>

### Excellence in Population Health

Excellence in population health is also measured and benchmarked, but the measures are of population, not patients. Population health is measured by the **incidence** and **prevalence** of disease, disability, or premature loss of life.

#### Incidence

"Incidence is the number of newly diagnosed cases of a disease. An incidence rate is the number of new cases of a disease divided by the number of persons at risk for the disease. If, over the course of one year, five women are diagnosed with breast cancer out of a total female study population of 200 who do not have breast cancer at the beginning of the study period, then we would say the incidence of breast cancer in this population was 0.025 (or 2,500 per 100,000 women-years of study)."<sup>8</sup>

The definitions of *incidence* and *prevalence* illustrate the need for collaboration to achieve the population health mission. Although any HCO can calculate its exhibit 1.1 measures, the population-based incidence and prevalence measures must be approached as a community-wide project.

### Sources for The Well-Managed Healthcare Organization

*The Well-Managed Healthcare Organization* describes excellence in proven processes used by HCOs with top-tier outcomes. It focuses on the patient care

mission (recognizing that excellence in patient care is an essential foundation) and on the HCO's unique contribution to the broader mission of

population health. It describes tested processes that have achieved superior results with real patients. Much of the text is based on reports of HCOs that have received the Malcolm Baldrige National Quality Award.<sup>9</sup> Award recipients have carefully documented their culture, processes, and results. Their documentation has been independently audited. Their results are typically in the highest quartile and often in the highest decile. Collectively, they provide a full range of care, from preventive to palliative, to a broad spectrum of US communities. The processes they use constitute the Baldrige model, an integrated set of **best practices** and work processes that produce benchmark results.<sup>11</sup> While there are many excellent HCOs that do not explicitly follow the Baldrige model, there are no comparable documented, audited descriptions of HCO excellence.

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#### Prevalence

Prevalence is “the total number of cases of disease existing in a population. A prevalence rate is the total number of cases of a disease existing in a population divided by the total population. So, if a measurement of cancer is taken in a population of 40,000 people and the result is that 1,200 were recently diagnosed with cancer and 3,500 are living with cancer, then the prevalence of cancer” is

$$(1,200 + 3,500) \div 40,000 = 0.118$$

(or 11,750 per 100,000 persons).<sup>10</sup>

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#### Best practices

Work processes that have been proven to achieve benchmark.

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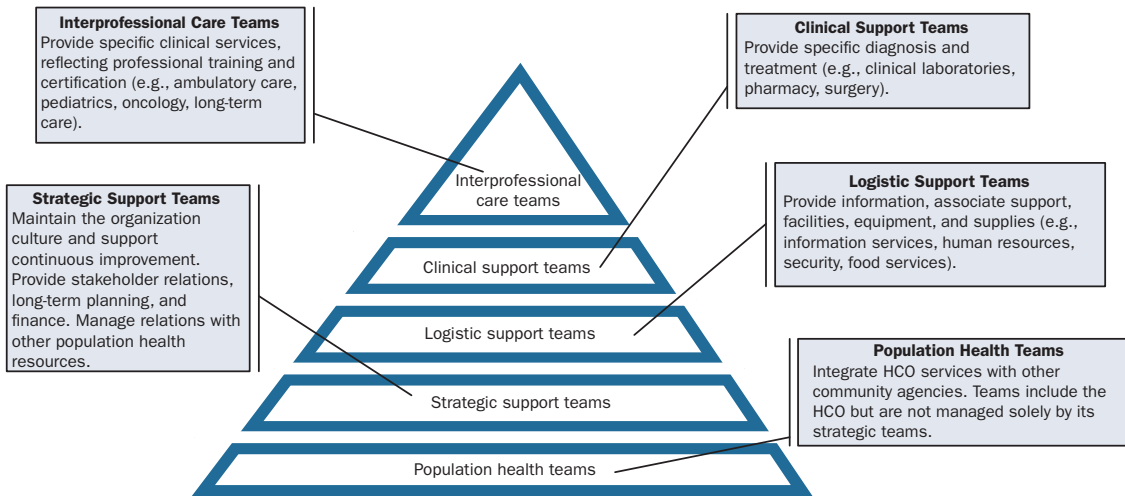
## Team Structure of Twenty-First-Century Care

Modern healthcare is complex, expensive, and enormously successful. It has added decades to countless lives, as well as the health to use those decades productively. Its success, complexity, and cost arise from the diversity of scientific advances in treatment and the need to tailor treatment to individuals with varying needs. Healthcare delivery is almost always a team activity. Cases in which individual care providers change the course of disease are real but rare. Excellent HCOs have committed to diversity, equity, and inclusiveness in their workforce. They select individuals based exclusively on the skills they bring, independent of ethnicity, gender identity, sexual orientation, religious affiliation, or other identifying features with the goal of associates that represent the communities being served.

### **Clinical Teams—Interprofessional Care and Clinical Support**

Interprofessional (also called interdisciplinary) care teams, shown in the top triangle of exhibit 1.2, deliver virtually all twenty-first-century healthcare. As shown in the upper left box, they provide highly specialized technical responses to diverse patient needs. They include physicians, nurses, other allied health professionals, and nonprofessional caregivers. A sequence of several interprofessional teams is often necessary as a patient’s needs evolve. It is not unusual for a lifesaving event—cardiopulmonary resuscitation, cancer cure, or treatment of an endangered pregnancy, for example—to require several teams with different skill sets and several dozen different care providers.

## EXHIBIT 1.2 Components of Healthcare Organizations



Note: HCO = healthcare organization.

The care teams in the top triangle have three major duties:

1. They assess and diagnose, a crucial first step and an ongoing process. Diagnosis labels symptoms and complaints as illness, indicating possible disease and its prognosis. Effective and efficient therapy—including reassurance, watchful waiting, and supporting patient self-efficacy—depends to a large extent on an accurate interpretation of (early) symptoms and the outcome of the diagnostic process.<sup>12</sup>
2. They provide and coordinate treatment, integrating drugs, surgery, rehabilitation, and other activities into a plan of care that involves the patient in key decisions and maximizes the patient’s safety, recovery, and comfort.
3. They monitor the patient’s response and adjust treatment interventions as indicated.

Excellence of care teams is measured by their performance on the factors shown in exhibit 1.1.

Care teams are almost always small and interdisciplinary, including a

#### Licensed independent practitioner (LIP)

“Any practitioner permitted by law and by the [HCO] to provide care and services, without direction or supervision.”<sup>13</sup>

licensed independent practitioner (LIP), a nurse, and other professional and supportive care providers as needed. Teams are organized to treat similar patient needs. Primary care—the patient’s first contact—includes teams for general internal medicine,

family medicine, obstetrics and gynecology, mental health, and emergency care. Clinical specialty teams provide surgery, intensive care, and other specific therapeutic interventions. Other teams address rehabilitation, management of continuing disability, and palliative care.

HCOs approve privileges for LIPs based on their **credentials**, specifying their role within the scope of their license and assigned clinical responsibilities.

### Clinical Support Teams

Frontline care-providing teams are supported by other clinical teams providing specialized professional services, such as laboratories, pharmacies, anesthesia, imaging, surgery, rehabilitation therapies, and home health. Treatment plans developed by the primary care team call for specific requests and services for specific patients. The team's excellence is also measured by the six exhibit 1.1 dimensions, and the support services they provide often use powerful and potentially dangerous technology. The terms *safe* and *effective* are not trivial where small errors can be fatal. Rigorous protocols and extensive training, often professional certification, are the key drivers of clinical support excellence.

### Logistic and Strategic Teams

Both interprofessional care and clinical support teams are supported by logistics teams providing information, training, supplies, facilities, food, and financing. These teams contribute to excellence by furnishing patients, guests, and clinical teams with critical resources. The dimensions discussed in exhibit 1.1 measure excellence for logistics teams, broadening "patient centered" to "customer centered." Safety remains important; HCOs are open to numerous threats, from dangerous substances to catastrophic events. Timely, efficient, and equitable care depends on these systems.

Strategic teams are responsible for achieving long-term excellence, for maintaining the teamwork structure, and for sustaining the HCO's relations to its **stakeholders** (individuals or groups who have a direct interest in the organization's success and whose needs shape its mission and strategies), customers, payers, and the community at large. These activities are the central functions of leadership. They are measured by the exhibit 1.1 measures and by additional dimensions, such as the extent of HCO services, unmet needs in the HCO's marketplace, and the long-term sustainability of performance.

A population health mission requires a fifth level that goes beyond the HCO itself. As noted earlier, population health is measured by incidence and prevalence of disease, disability, and premature death.

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#### Credentials

"Documented evidence of licensure, education, training, experience, or other qualifications; used to assign specific care privileges to an LIP consistent with the scope of their license and assigned clinical responsibilities."<sup>14</sup>

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#### Stakeholders

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

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Real HCOs have used a wide variety of relationships to assemble the exhibit 1.2 teams. Historically, not-for-profit community HCOs served most of the nation, contracting with LIPs as credentialed affiliates who operated their own small corporations rather than being employed. Volunteers, usually including governing board members, have served without compensation and continue to be an important resource.

### **Current Trends**

The current trend, however, has been toward centralization and employment. Most care is now provided by large HCOs with a full array of exhibit 1.2 services. LIPs are now mostly employed, rather than independent contractors. For example, Kaiser Permanente, the largest nongovernmental HCO in the United States, uses a formal employment structure for almost all of its needs.

Clinical support teams are now employed or organized as corporations contracting with the HCO. Many logistic and some strategic needs are met by contracts with corporations providing specialized services to many HCO customers. It is still true that many thousands of small care teams operate as independent corporations, focused on specific patient needs such as psychological counseling, dialysis, and long-term care. They refer patients to larger HCOs to meet any needs outside their expertise.

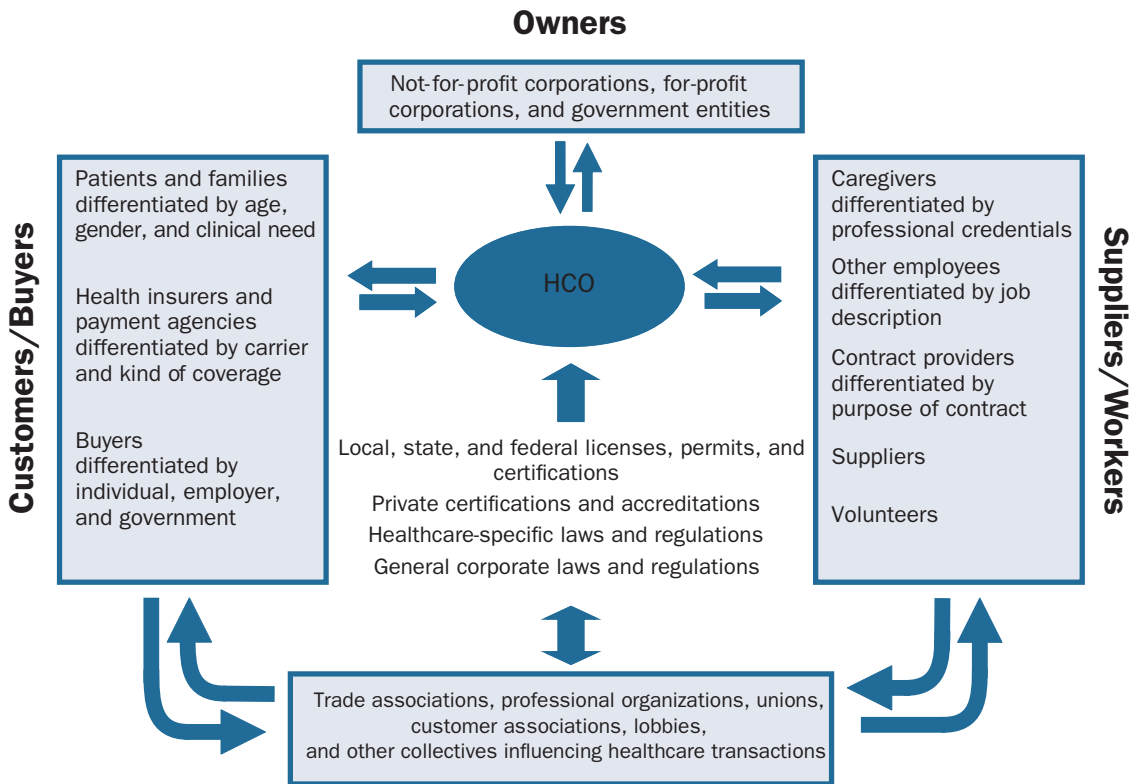
### **Stakeholders**

All organizations, including HCOs, exist because they fulfill a need that individuals working alone cannot meet, and they thrive because they fulfill that need better than competing alternatives. Organizations serve stakeholders. HCO stakeholders are patients, patient families, insurers, workers, suppliers, regulators, and owners, as shown in exhibit 1.3. Most stakeholders can choose to participate with a specific HCO or not. Any HCO's survival depends on attracting sufficient numbers of each kind of stakeholder; otherwise it fails and disappears.

Stakeholders' desires are inherently conflicting. Patients want immediate service; insurers want low costs; workers and suppliers want high compensation. HCOs and other organizations exist by negotiating solutions to those conflicting desires. Business can be understood as a set of relationships among groups that have a stake in the activities that make up the business. Business is about how customers, suppliers, employees, and managers interact and create value. To understand business is to know how these relationships work.<sup>15</sup>

HCOs represent one of the most complex applications of the stakeholder model. Stakeholders in each of the four categories actively express their needs and can "vote with their feet"—that is, change their affiliation to a different HCO. Leadership's basic obligation is to identify and meet the



**EXHIBIT 1.3** Model of Stakeholder–Healthcare Organization Interaction

Note: HCO = healthcare organization

stakeholders' important concerns and to negotiate unmet needs as **opportunities for improvement (OFIs)**. The following sections identify the principal concerns of the major groups in each stakeholder category: patients and families, associates, other customer partners, and owners and community groups.

The exhibit 1.1 criteria fulfill most stakeholder needs. HCOs that excel on exhibit 1.1 measures thrive in the stakeholder marketplace. They become “great places to get care” and “great places to give care,” easily passing governmental and accreditation requirements. Their finances are strong, and their owners have no cause for concern.

### **Patients and Families**

Patients seek accurate diagnosis and effective treatment but also confidentiality and as much comfort as possible for themselves and their families.

### **Opportunities for improvement (OFIs) (usually pronounced “oh-fees”)**

Any situation where current performance is inferior to benchmark. Excellent HCOs seek and resolve OFIs, creating an environment where improvement is a central part of the culture.

### **Patient-centered care**

Care that is respectful and responsive to individual patient preferences, needs, and values.<sup>16</sup>

**Patient-centered care** increasingly involves patients and families in providing “care that is respectful and responsive to individual patient preferences, needs, and values.”<sup>17</sup>

Web-based public sources such as HealthGrades ([www.healthgrades.com](http://www.healthgrades.com)) and WhyNotTheBest ([www.whynotthebest.org](http://www.whynotthebest.org)) are increasingly influential in forming customer opinions, although their validity is often questionable.<sup>18</sup> They rely heavily on published values for exhibit 1.1 measures.

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### Associates

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

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### Associates

**Associates** seek comfortable working conditions and fair compensation. Trustees and a great many others volunteer their time to not-for-profit HCOs; their compensation is the satisfaction they achieve from the work. However, most associates are salaried or earn hourly wages. Their compensation is often an

important issue, but it is largely driven by national or regional markets; individual HCOs have little choice but to follow the market. Collective bargaining and unionization is limited in HCOs. The use of *rewards* (compensation for specific goal achievement) allows excellent HCOs to share the financial gains with associates. Rewards are usually in addition to a competitive wage or salary.

Working conditions may be the more important consideration in attracting and retaining workers. *Respect*, a value universal in excellent HCOs, has two clear and important meanings: (1) that associates feel their voices are heard and their employers make reasonable efforts to accommodate them, and (2) that associates know they will not be harassed (that is, no other worker, at any level, will make inappropriate sexual or personal comments). As chapter 2 discusses, excellent HCOs systematically solicit associate input, identifying and meeting realistic needs.

Government agencies of various kinds monitor the rights of associate groups. Occupational safety agencies, professional licensure groups, and equal employment opportunity agencies are among those entitled to access to the HCO and its records. The National Labor Relations Board and various state agencies establish rules for relations with unions. HCOs must comply with all those requirements.

### Other Customer Partners

#### Health Insurers and Government Payment Agencies

Health insurers and government payment agencies provide most of the revenue to HCOs, making them essential stakeholders. Two large governmental insurance programs—Medicare and Medicaid—are essential partners for most HCOs. The federal Medicare program deals with HCOs through

payment agencies called *fiscal intermediaries*. Medicaid, a state and federal program that finances care for the poor, is run by the state Medicaid agency or an intermediary.

Payment organizations seek the lowest possible price. Recent changes establishing incentive payments have allowed them to press for improvements in quality and safety as well. The Affordable Care Act (ACA) encouraged new approaches to addressing chronic disease care and HCO accountability for the cost and quality of care. Payers increasingly use **value-based insurance design**, which rewards HCOs for performance.<sup>19</sup>

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#### Value-based insurance design

Linking financial incentives to the quality and efficiency of care provided.

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### Buyers

Much health insurance is provided through employment, making employers important stakeholders. Employers pay a large share of health insurance premiums. They must meet the demands of their own stakeholders, so they have encouraged value-based insurance design. They often also serve on HCO governing boards, where they must balance the HCO needs of the community with the needs of their companies' stakeholders.

### Regulatory and Accrediting Agencies

Regulation of HCOs and their associates is provided by a wide variety of groups and agencies, both public and private. For example, all states license HCOs that provide any inpatient care. LIPs and many support specialists are licensed through state-administered examinations and programs that establish national qualifications. Many states have **certificate-of-need** laws requiring HCOs to seek permission for construction or expansion. Quality improvement organizations are external agencies that review the quality of care and use of insurance benefits for Medicare and other insurers.

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#### Certificate of need

Approval for new services and construction, expansion, or renovation of hospitals or related facilities; issued in many states.

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#### Health Insurance Portability and Accountability Act

Federal law that addresses issues of health insurance but also requires HCOs and their workers to protect patient information and confidentiality diligently.

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#### Emergency Treatment and Labor Act

Federal act requiring all HCOs that provide emergency care to accept all patients, regardless of ability to pay, until the patients are stabilized and can be safely moved.

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HCOs are subject to many consumer protection laws, including the **Health Insurance Portability and Accountability Act**, which addresses major issues of privacy and security of protected health information. The **Emergency Treatment and Labor Act** requires all HCOs providing emergency care to accept all patients, regardless of ability to pay, until they are stabilized and can be safely moved. HCOs are subject to antitrust law; large mergers or consolidations are reviewed by the Department of Justice and the Department of Commerce. Not-for-profit HCOs often occupy facilities that, if taxed, would add noticeably to local revenues. The community may hold the

organization to certain conditions, such as a certain level of charity care, in return for nonprofit status. Provisions of the ACA require not-for-profit hospitals to review community needs and report the **community benefit** value of the HCO contribution.

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### Community benefit

Services provided gratis by HCOs to their surrounding communities. Current law requires hospitals to satisfy a *community benefit standard* to qualify as tax-exempt charities under section 501(c)(3) of the Internal Revenue Service code. The standard addresses charitable care, educational services, and other benefits.

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### The Joint Commission (TJC)

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

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### External auditor

A firm certified to review corporate financial statements and attest to their accuracy.

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The Centers for Medicare & Medicaid Services (CMS), as well as most payment organizations, mandate external reviews of HCO performance through accreditation and financial audits.<sup>20</sup> Essentially, all HCOs must comply. Many small hospitals are approved directly by CMS,<sup>21</sup> but CMS also allows several other organizations to grant accreditation (these organizations have what is referred to as *deemed status*). Most large HCOs choose accreditation by **The Joint Commission (TJC)**. The National Commission on Quality Assurance accredits ambulatory care and disease management programs (as well as insurance programs). Financial audits are provided by **external auditors**, firms certified to attest to the accuracy of major financial reports for CMS and the Securities and Exchange Commission.

HCOs interact extensively with local governments. They require land-use and zoning permits and are subject to environmental regulations. Their demands on water, sewer, traffic, electronic communications, fire protection, and police services are often unique in the community.

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 standards of practice for future actions. Thus, the courts can also be viewed as regulatory organizations.

### Owners and Community Groups

Owners and community groups are vital customer partners. HCOs are responsible to their owners through governing boards (see chapter 4). Not-for-profit HCOs are legally owned by the groups they serve and are obligated to use their capital for their mission fulfillment. The obligation is usually interpreted as sustaining the long-term existence of the HCO. Not only must current expenditures be mission-oriented and compliant with tax and licensing law, but funds must be found to continue operation, replacing worn facilities and meeting new technological needs. For-profit HCOs, owned by their stockholders, are expected to earn a competitive return on their capital.

HCOs must make numerous and varied exchanges with community agencies and groups. For example, patient and associate needs draw HCOs into exchanges with law enforcement and social service agencies. In addition,

HCOs work with United Way and other charities. HCOs facilitate religious observances of associates and patients. They provide educational facilities to improve community health and well-being. Such activities often make HCOs partners of cultural, religious, educational, and charitable organizations. Population health activities, including prevention and outreach, draw HCOs into formal alliances with governmental organizations, such as public health departments and school boards, and with local employers, churches, and civic organizations.

### **Other Provider Partners**

#### **Suppliers and Financing Agencies**

HCOs must work with a variety of organizations to obtain goods and services. Goods ranging from drugs to artificial implants are purchased from outside suppliers. They also purchase banking, utilities, and many similar services from outside entities as well; in order to strengthen their bargaining with suppliers, HCOs join purchasing collaboratives. They often also purchase services from specialized vendors, such as food service, legal counsel, or strategic planning consultants. In addition, HCOs need the assistance of financing partners to acquire capital through a variety of equity, loan, and lease arrangements. The relationships between HCOs and their suppliers of goods and services are commercial contracts.

#### **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 HCOs incorporate and own these services. Others may have formal relationships, such as referral agreements, affiliations, strategic partnerships, and joint ventures. 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 other activities.

### **Stakeholder Influence: Networking, Coalition Building, and Legal Controls**

The ultimate source of stakeholders' power is the marketplace—their ability to participate in a specific exchange. Exchange partners attempt to identify and meet their needs by negotiation, rather than shifting their allegiance. 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 work toward a specific goal.

Buyer- and consumer-oriented networks are stakeholder coalitions that address broad issues. The National Business Group on Health and AARP, for example, have worked to change problems such as the cost of insurance, lack of insurance, and inequalities in well-being. Stakeholders and their organizations can lobby politicians, but they can also effect change by suing in courts.

HCOs also form coalitions. The American Hospital Association is one of the largest. It lobbies for HCOs at the federal level, and its state-level association partners lobby state governments. TJC is a coalition of the American Hospital Association and four organizations representing physician and dentist caregivers. The National Quality Forum is a coalition of buyer and provider organizations that evaluates and standardizes measures of quality.<sup>22</sup> Its work has been essential to the development of HCO performance measures.

The government is another stakeholder that has a profound influence on healthcare. Governmental regulation almost always reflects good intentions—safety, quality, individual rights, equity, or efficiency. Accomplishment of these standards 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.<sup>23</sup> In part, this situation reflects the complexity of the goal and the difficulty of measurement. In part, it reflects the limitations of the market and governmental systems. In part, it reflects the failure of HCO management.

## The Healthcare Marketplace

### *The Origin and Development of HCOs*

Until the late nineteenth century, much patient care was delivered by individual professionals. Hospitals were refuges for the impoverished and dying. The technological advances that began with anesthesia and control of bacteria in the mid-nineteenth century started rapid growth in the field that continues to the present; that growth is matched by ongoing shifts in how care is organized.

Throughout the twentieth century, hospitals provided inpatient care that was more complex than could be delivered in physicians' offices or patients' homes. Physicians typically practiced in small private corporations with a few colleagues in the same specialty.<sup>24</sup> Licensure of hospitals arose as their technical capability increased, then became mandatory for Medicare payment. **Critical access hospitals**, HCOs with 25 beds or fewer and without nearby competition, were established in 1997 by the Balanced Budget Act (Public Law 105-33) to

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#### **Critical access hospitals**

HCOs with 25 beds or fewer, and without nearby competition, established to provide support for rural communities.

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provide support for rural communities. **Safety net hospitals** were distinguished under Medicare and Medicaid to compensate hospitals with a disproportionate share of low income, uninsured patients. Chronic care facilities, often called *nursing homes*, emerged and were separately licensed. Home care became a valuable service. Patient and family comfort, the consumer rights movement, and the cost of dying stimulated the rise of a palliative care specialty and a pursuit of patient self-determination and “a good death.”<sup>25</sup> Many other healthcare services were provided by specialists in pharmacy, dentistry, mental health, and other fields.

Though HCOs typically began with one or more twentieth-century hospitals, near the end of the twentieth century these independent organizations began merging. They aggregate services as well as individual care sites, aiming to serve comprehensive health needs rather than a single specialty. They provide emergency services, ongoing ambulatory care, extended outpatient surgery, and rehabilitation. Many now operate nursing home services, home care, and palliative and hospice care. Local HCOs are organized in interstate and intrastate **health systems**, often around religious affiliations.

The trend has been for independent healthcare providers to join HCOs. By 2017, more than half of practicing physicians had become employees of HCOs.<sup>26</sup> HCOs now provide the majority of care, and many have moved to address population health as well.

HCOs organize **service lines** around the specialties of interprofessional care teams. They serve a geographic population, limited by the need for hands-on care and travel times. The growth of electronic communication has allowed primary and continuing care teams to work at locations convenient to patients, including home care. Specialty, inpatient care, clinical support, and logistic support teams can be located centrally and serve many care sites. Strategic support might be provided from the system headquarters in another state.

### **The Current American Marketplace**

Almost every community has one or more HCOs and several continuing care and specialty healthcare services. This fact means that healthcare is one of the largest sectors in the US economy, consuming \$3.1 trillion in 2016, almost one-fifth of the total gross domestic product. A breakdown of how healthcare dollars are spent is provided in exhibit 1.4. The growth of expenditures is a matter of constant political concern because of its impact on other sectors. However, the rise of healthcare has been a two-edged sword—the sector

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#### **Safety net hospitals**

Hospitals with a disproportionate share of low income, uninsured patients (as defined by Medicare and Medicaid).

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#### **Health system**

A set of HCOs in several geographic sites, under central strategic leadership.

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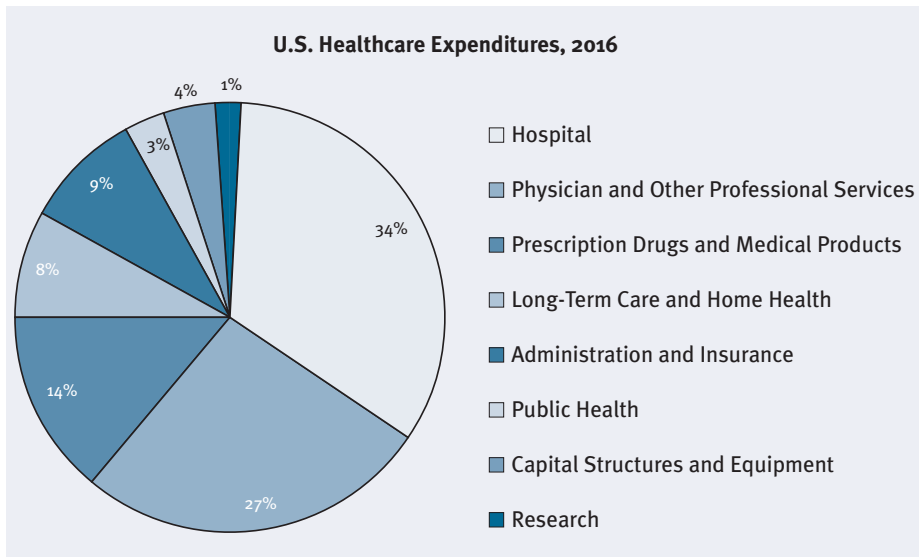
#### **Service line**

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

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**EXHIBIT 1.4**

How Healthcare  
Money Is Spent



Source: CMS (2018).<sup>27</sup>

is also one of the nation's largest employers, including many unskilled jobs. It is notable that HCOs (or, as the federal government would still term HCOs providing acute inpatient care, *hospitals*) are the largest single expenditure and that public health is among the smallest. It is also important that the number of nonhospital providers is shrinking as physicians and other caregivers move to hospital employment.

### **The Hospital Sector**

Despite upheaval and uncertainty in the American healthcare market, hospitals are still major players. They are structured and administered in a variety of ways (organization and ownership of hospitals are shown in exhibit 1.5). *Community hospitals* (nonfederal HCOs with licenses for inpatient care that are open to the public) constitute about 90 percent of the total expenditures. Three-quarters of that care is provided by nongovernment, not-for-profit hospitals. Investor-owned, for-profit hospitals provide 10 percent. In the 1970s, a movement to investor-owned hospitals quickly reached about 10 percent of all community hospital expenditures. It increased to 15 percent by 2010 but has declined since. For-profit hospitals have a presence in 45 states, with the highest concentration in Florida, Texas, Tennessee, and Virginia.<sup>28</sup>

Hospitals owned by state and local governments provide 13 percent of care. They are operated and financed similarly to nonprofit hospitals. They are also exempt from most taxes. Virtually all federal hospitals are in four systems (Department of Defense, Department of Veterans Affairs,



**EXHIBIT 1.5**

Ownership and Specialization of US Hospitals, 2016

Hospital Type	Count	Revenue (billions)
Nongovernment not-for-profit	2,849	\$ 677
Investor-owned (for-profit)	1,035	\$ 95
State and local government	956	\$ 132
Psychiatric, long-term, and other special-purpose hospitals	485	\$ 20
Federal government hospitals	209	\$ 68
Nonfederal psychiatric hospitals	397	\$ 19
All US registered hospitals	5,931	\$ 1,011

Source: American Hospital Association (2018).<sup>29</sup>

Indian Health Services, and federal prison hospitals). Although the number of federal hospitals has been stable, federal expenditures on healthcare have climbed less rapidly than the national average.

Little evidence exists that ownership type changes the quality of care. All hospitals are organized around interprofessional care teams, as shown in exhibit 1.2, and almost all are accredited or certified under rules controlled by CMS. Thus, they tend to operate similarly.

Most hospitals are small; more than 2,000 have fewer than 100 beds. These small organizations consume only 10 percent of expenditures. Conversely, only 7 percent of hospitals have more than 500 beds, but they constitute one-third of expenditures. Large hospitals have a broader array of services, including many expensive specialties. Teaching hospitals, which fall under many of the categories listed in exhibit 1.5, are an important element of the mixture as well. They are almost exclusively large and not-for-profit, with government, religious, and nonreligious owners.

Healthcare reform has increased pressure for both vertical integration (across services) and “horizontal” integration (linking similar services). Advantages of scale—such as the ability to gain debt financing or access to advanced knowledge management systems—drive both horizontal and vertical integration.

Most for-profit hospitals are in large national systems. More than two-thirds of community hospitals are members of multihospital integrated delivery systems. The average medium-sized healthcare system generated around \$2 billion of annual revenue in 2010; an independent hospital of medium size generated \$30 million. The median independent hospital had about 150 associates, and the median HCO system about 10,000.<sup>30</sup>

Many HCO systems operate in multiple markets and states; most provide services beyond acute hospital care. Their size provides numerous operating advantages, and they are growing. The trend is likely to continue—additional small, independent HCOs will join HCO systems. HCO systems will expand outpatient services and become the dominant source of personal healthcare. Specialty hospitals (e.g., cancer hospitals) and specialized services (e.g., urgent care centers, retail clinics, nursing homes, hospices) will still exist, but many of these will join systems as well.

### **Physician and Other Health Services**

The values shown in exhibit 1.4 are payments for caregiver services, independent of the caregiver's organization or the physical site of care. In addition to independent practitioners and HCOs, community health centers—often **federally qualified health centers**—are not-for-profit clinics addressing the

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#### **Federally qualified health center**

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

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#### **Accountable care organization (ACO)**

Group of healthcare providers that works collaboratively and accepts collective accountability for cost and quality of care for a specific population. The patient-centered medical home is an accepted model for becoming an ACO.

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#### **Patient-centered medical home**

“Mechanisms for organizing primary care to provide high-quality care across the full range of individuals' health care needs.”<sup>33</sup>

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needs of the poor and uninsured, and they have grown in recent decades. They have independent local governing boards but often affiliate with local HCOs. **Accountable care organizations (ACOs)**, created by the ACA, are operated by large HCOs, affiliating with group practices and community health centers to provide comprehensive care.<sup>31</sup> The **patient-centered medical home** is a mechanism for providing primary care that can be applied in any of these organizations.<sup>32</sup> It emphasizes careful listening, close adherence to patient wishes, and flexible delivery models.

### **Post-Acute and Specialty Care**

The current US healthcare marketplace also includes post-acute and specialty care. Many patients require support that is more intensive than primary care but less intensive than acute inpatient care. The providers 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 (e.g., HCR Manor Care) that also operate nursing homes. HCOs in this sector expanded rapidly in the late twentieth century, but growth has slowed. DaVita, a national chain of kidney dialysis centers, and several corporations offering bariatric or plastic surgery facilities are specialized for-profit systems. Some for-profit HCOs limit their practice to specific kinds of patient needs, such as urgent care or physical therapy. It is not clear whether these or similar systems will grow.

Specialty end-of-life healthcare—chronic care, home care, palliative care, and hospice care—present a patchwork of owners and structures in the

marketplace. 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. Home care is provided by HCO systems and by specialty not-for-profit and for-profit corporations. Historically, palliative care and hospice services have been provided both by HCOs and by small, independent not-for-profit corporations. In the future, it is likely that HCOs will acquire these organizations or form joint ventures with them, improving patient access to palliative care.

### **Other Sectors of the Healthcare Economy**

Exhibit 1.4 shows that HCOs receive about one-third of the consumer spending for healthcare. HCOs influence expenditures on physician compensation, prescription drugs, and medical products. More than half of drug and product expenditures require prescription by an LIP. The insurance sector accounts for only 9 percent, which may seem minimal. This percentage results from the fact that insurance payments are recorded in the sector receiving them—much of the capital expenditure goes to HCOs. That 9 percent is the cost of operating health insurance companies. Research, representing only 1 percent of the expenditures, is principally money spent by the National Institutes of Health. Many large HCOs also participate, usually through a university affiliation. Though small, this portion is vital; it supports healthcare's continuous advancement.

## **Achieving Excellence in HCOs**

Excellence with the team structure of exhibit 1.2 requires the following:

- Individual team members who are trained, supported, and motivated
- Teams that work well together, integrating each individual's contribution
- Coordination of multiple teams to meet each patient's unique needs

The Baldrige Performance Excellence Model achieves excellence by creating a **transformational culture**—one that systematically encourages individuals and teams to use **continuous improvement**, the ongoing, evidence-based study and improvement of work processes.<sup>34</sup> Transformational culture and continuous improvement are each important departures from tradition. Baldrige recipients have universally concluded that both are essential to excellence.

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#### **Transformational culture**

An environment of relationships between associates and between associates and leadership that emphasizes every associate's right to question or criticize a work-related process or decision and that requires every leader to respond constructively to concerns or questions raised by any associate.

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#### **Continuous improvement**

An ongoing organizational system that identifies improvement opportunities, rank-orders them, and systematically analyzes and improves work processes to move team performance closer to benchmark.

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### ***Transformational Culture***

The culture of an HCO is major determinant of its overall excellence. Culture is “how we act here” in terms of relationships between associates and with their leaders. Culture is built by repetition, particularly the repeated actions of leaders, who have daily opportunities to reinforce or revise habits. Truly outstanding organizations tend to have a Baldrige-style transformational culture (described in detail in chapter 2). Such a culture is dedicated to meeting associates’ needs and to creating a stable, committed workforce that continues to learn and improve.

Focus on transformational culture introduces many innovations to the workplace. It replaces rigid professional hierarchies and domains of authority with collaboration and open discussion. It commits leaders at all levels to providing constructive answers to any associate’s concern. A constructive answer can be judged in two dimensions, and transformational culture uses both to improve excellence: the objective (“Was the process changed or the problem removed?”) and the subjective (“How did the asker feel about the response?”). The open environment makes associates capable of identifying many valuable improvements. In addition, and possibly more important, associates are confident that they are supported by their teams and the HCO.

Transformational management, an essential component of transformational culture, is sustained by three elements:

1. *Training.* Managers at all levels are trained in the reasons for sustaining the transformational culture. They know why constructive answers are important and how to answer common questions. Their training is supplemented by coaches who can assist and reinforce the principles. Managers and leaders at all levels are obligated to seek a constructive answer.
2. *Rounding.* Baldrige healthcare managers and leaders are expected to spend at least five hours a week with associates in the teams outlined in exhibit 1.2. The result is that members of frontline teams will often see not only their team leader but also senior leaders. They can ask senior leaders directly about their concerns.
3. *Rewards and recognition.* All Baldrige recipients make heavy use of nonmonetary rewards: verbal and written thanks, recognition, prizes. All provide cash incentives for their leaders. Most also reward each associate for achieving the negotiated goals.

The transformational culture is also reinforced in the annual planning process, described in detail in chapter 3. The goals are negotiated over several months, searching for goals and processes that associates believe are realistic. “Best practices” show that the proposed goals are realistic. Once negotiated, if a goal appears to be endangered, an action team is assembled to work out

a solution. The result is that objectively, almost every goal is achieved, and subjectively, every associate accepts the goals as realistic.

### Continuous Improvement

Continuous improvement is one of the practices that can help HCOs attain excellence. It is supported by measurement and sophisticated process analysis tools, such as Lean and Six Sigma, that became available in the 1980s and have substantially increased in quality since. Improvement requires routine, accurate reporting of measures for each exhibit 1.1 criterion to each care team and each support team. The measures are compared to similar operations inside and outside the HCO, identifying benchmarks and best practices. Any actual performance that is lower than the benchmark is an OFI. Even the best HCOs have several thousand OFIs. They achieve excellence because each team continuously reviews its measures, ranks its OFIs, and pursues continuous improvement to address them.

### Commitment to Evidence

The discussions that support change are not simply expressions of feelings and desires—they must be undergirded with proof. Excellent HCOs insist on **evidence-based medicine**, requiring caregivers to provide the latest scientifically proven treatments and preventive activities. Similarly, leadership must adhere to **evidence-based management**, implementing proven developments in management practices and information technology. “It comprises four fundamental activities that can be applied in the everyday exercise of management judgment and decision making: (i) use of the best available scientific findings; (ii) gathering of and attending to organizational facts, indicators, and metrics in a systematic fashion to increase their reliability and usefulness; (iii) ongoing practice of mindful, reflective judgment and use of decision aids to reduce bias and improve decision quality; and (iv) consideration of ethical issues, including the short-term and long-term impact of decisions on stakeholders.”<sup>36</sup>

Evidence-based medicine and evidence-based management are interrelated ethical commitments. Although rarely stated in the HCO’s values, they are the foundation of continuous improvement. In excellent HCOs, they also influence the transformational culture. They are made clear to all professional associates and all leaders and become the ground rules for every meeting and conversation.

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#### Evidence-based medicine

“The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.”<sup>35</sup> The central concept of *judicious use* is that what is justifiable or reasonable to believe depends on the trustworthiness of the evidence.

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#### Evidence-based management

Management that incorporates well-established scientific findings regarding critical thinking, human judgment, decision-making, and learning to aid managers in acquiring quality information and putting it to use. The set of practices that make up evidence-based management achieve better-quality results in organizations by improving the practitioner’s knowledge, judgment, and competencies.

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## Leaders

**Leaders** have an instrumental role in organizational excellence and they are needed at all levels of the organization. They are HCO associates who accept responsibility for implementing the mission and goals of the organization—they carry out its commitment to discussion, evidence, and improvement. Each team has a leader, usually expert in the team’s specific function. Leaders make sure that the right teams are present, that all team needs are met, and that the teams are achieving improvement goals. Leaders must also be managers, and in the context of this book, the terms are often used interchangeably.

### Leaders

Associates who accept responsibility for achieving and maintaining excellence by supporting team efforts and team coordination. Many leaders were historically called “managers.”

Organizations usually have senior leaders who form coordinating groups focusing on strategic support. A governance body oversees the integration of decisions with the desires of stakeholders. Leaders were called “managers” in the twentieth century. The change in terminology reflects a broadened concept of professional responsibility. That concept, expanded in chapter 2, emphasizes understanding and responding effectively to team and individual associate needs.

Many care providers have leadership roles in HCOs. Regardless of whether they have been medical providers, however, all HCO leaders should be professionals dedicated to the core commitments of the Hippocratic Oath, which have guided health caregivers for almost 2,500 years. Two commitments of the original oath remain central: First, do no harm; second, help the sick.

The Academy of Medicine’s goals, discussed in exhibit 1.1, expand these commitments. The American College of Healthcare Executives Code of Ethics extends them to leadership. Among other duties, its members strive to do the following:

1. Conduct professional activities with honesty, integrity, respect, fairness, and good faith in a manner that will reflect well on the profession.
2. Work to ensure the existence of procedures that will safeguard the confidentiality and privacy of patients or others served.
3. Promote a culture of inclusivity that seeks to prevent discrimination on the basis of race, ethnicity, religion, gender, sexual orientation, age, or disability.
4. Work to identify and meet the healthcare needs of the community.
5. Work to support access to healthcare services for all people.<sup>37</sup>

Leadership for excellence begins with a personal commitment to this Code of Ethics. In terms of the national healthcare system, these goals are important OFIs, and they form a checklist for every HCO.

### **The Role of Strategic Teams**

Leaders and governance at excellent HCOs often serve on strategic teams. These teams, which form the base level of exhibit 1.1, ensure the following:

1. The necessary resources are at hand:
  - Each team member has the training, tools, and facilities that her role requires, including training in effective teamwork.
  - The team's performance measures and benchmarks are correctly calculated and promptly available.
  - The correct teams are available for each patient.
  - Every clinical team has up-to-date knowledge of patient needs.
2. The transformational culture is maintained:
  - Each team member is encouraged to do his best.
  - Team leaders are trained in maintaining collaborative team behavior.
  - Individual team members work effectively together.
  - The teams work well with other teams.
  - The culture meets individual workers' needs, engenders collaboration, and celebrates improvement effort.
3. Continuous improvement is implemented:
  - Performance is measured in multiple dimensions, always including quality, user satisfaction, provider satisfaction, and cost.
  - Benchmarks are sought for each measure.
  - OFIs are identified, ranked, and systematically pursued.
  - New processes are designed after thorough analysis and with careful attention to associates' needs.
  - Realistic goals are carefully negotiated, supported, and achieved.

## **Managing and Leading Excellent Healthcare Organizations**

This book focuses on requirements for managing and leading excellent HCOs. Thus, every chapter concludes with a discussion of important management and leadership opportunities—commonly occurring situations where individuals make a difference through professional responses that promote excellence. Three opportunities are universal and overarching, in the sense that they create a foundation for all success: reducing variation, meeting the needs of teams, and continuous improvement.

### Reducing Variation in Healthcare Organization Performance

Regional variation in health and healthcare is a major leadership opportunity. Health outcomes, costs, and patient satisfaction differ from community to community; where you live in the United States has an important impact on your health insurance premium, your out-of-pocket costs, your safety, and even your survival. Using 2016 information from WhyNotTheBest.org, a website for comparative data, exhibit 1.6 compares three communities with substantial differences. The communities are hospital referral regions, each including several HCOs and at least one multispecialty referral center. Several points are notable:

- None of these communities reaches benchmark, the national top 10 percent, in any measure.
- Chances of dying in the hospital are all almost 20 percent higher than benchmark.
- Chances of being readmitted within 30 days are 10–13 percent higher.
- Although for technical reasons there is no national cost benchmark, cost of care per capita is 28 percent higher in Tampa, Florida, than Portland, Oregon, and 17 percent higher in New Brunswick, New Jersey, than in Portland. Local insurance premiums and patients' out-of-pocket payments reflect these differences.
- Increased expenditures do not necessarily lead to better outcomes.

#### EXHIBIT 1.6

Examples of Variability in Healthcare Organization Performance, 2016

	Mortality Composite (%) *	Readmissions (%) **	Risk-Adjusted Per Capita Costs ***
Tampa, FL	13.1	19.9	\$9,967
New Brunswick, NJ	12.6	20.3	\$9,127
Portland, OR	13.0	19.0	\$7,815
US Top 10%	11.0	17.6	N/A

Source: Data from WhyNotTheBest.org (2017).<sup>38</sup>

\* Deaths within 30 days from all causes after an initial hospitalization with a principal diagnosis of heart attack, heart failure, or pneumonia.

\*\* Patients readmitted to a hospital within 30 days of discharge from a previous hospital stay for heart attack, heart failure, or pneumonia.

\*\*\* Total annual Medicare payments per beneficiary, standardized to remove geographic differences in payment rates for individual services and adjusted for differences in beneficiaries' health using CMS's risk-adjusted model.



HCOs are far from the sole cause of these variations. Population education and income account for about half of the difference. However, more detailed analyses, conducted for the whole population rather than just Medicare, reveal that these results understate the problem. Using data available from about half the nation, and adjusting rigorously for conditions outside the HCOs' control, a recent study found that hospital mortality risks differed by a ratio of two to one and patient safety differed by a ratio of ten to one.<sup>39</sup>

HCO leadership is obligated to work on these OFIs. How might leaders proceed?

- Post performance data, with the national benchmarks, for all to see and discuss.
- Seek and copy best practices. Look for benchmark communities that resemble yours, and invite their leaders to discuss how they achieve and sustain their results.
- Analyze the detail available on the HCO's intranet or other data sources to identify OFIs for specific interprofessional care teams using data for the diseases they treat. Leaders begin the conversation by asking the teams for their opinions and suggestions.
- Support associates' efforts, providing resources for implementing best practices and rewards for tangible progress. Rigorously keep the focus on improvement, not correction.

At Baldrige-winning institutions, leadership will create process improvement teams (PITs) in each service line to pursue OFIs. It will provide expert advice and support for the PITs to identify root causes and design new, more effective processes. Leaders will retrain all workers in the new processes and put descriptions of them on the HCO's intranet. Finally, it will identify and celebrate every gain and every best practice. Notably, it will focus on copying the best. The weakest performers will be encouraged rather than criticized.

### **Meeting the Needs of Clinical Care Teams**

Clinical care teams deal with “the beginnings of life, the end of life, and the shadows of life.” (The phrase is on the Health and Human Services Administration Building in Washington.) They plunge daily into intimate, highly personal details and family relationships. Their jobs are emotionally and intellectually demanding. Excellence requires not simply their skill, but their emotional commitment. Strong evidence exists that across the United States, many team members are fatigued, frustrated, and struggling to fulfill their obligations to patients—a condition described in the literature as “burnout.” Studies have reported physician burnout as high as 50 percent. Nurse burnout is also serious, leading to high turnover as well as ongoing struggles for individuals and HCOs.<sup>40</sup>

Caregivers at Baldrige Award–recipient HCOs are substantially happier. Most caregivers say they are satisfied with their work; turnover is below 10 percent per year. Best practice—what leaders in other HCOs should emulate—calls for the following:

- *Close, quantitative monitoring.* The HCO tracks caregiver satisfaction, turnover, absenteeism, and on-the-job injuries. Managers and leaders institute measures in every work unit to monitor indicators of associate engagement and measures of a safe, healthy, and stable work environment.
- *Leadership rounding.* Senior leaders working for Baldrige winners spend a minimum of five hours per week at clinics, nursing stations, physicians' offices, kitchens, billing offices, laboratories, loading docks—all the places where basic work is done. In the sort of transformational culture discussed in chapter 2, leaders are encouraged to join in the work where they are qualified. This activity gives the leaders visibility among workers and an understanding of their experiences. It also gives lower-level associates direct access and helps middle- and lower-level managers sustain servant leadership.
- *Carefully negotiated goals.* The processes of goal setting and continuous improvement described in chapter 3 are intertwined. Every goal is known to be achievable. The path to achieving it is often new work processes. These are carefully developed, reviewed by associate teams, and put in place with full training for all involved associates.

The result creates a great place to give care. Current associates remain, learn, and increase in skill. The reputation makes recruitment easier.

### **Supporting Continuous Improvement**

Excellence is learned. HCOs do not leap from mediocrity to excellence. Using continuous improvement, they get better every year by careful, deliberate effort. At award-winning HCOs, leadership pursues a specific path, developed in detail in chapter 3 and applied in subsequent chapters. Leaders ensure the following:

- Local, regional, and national benchmarks and best practices are identified.
- PITs give every associate an avenue to understand the best practices and help adapt them to the local situation.
- Every associate understands that the goals are realistic and achievable. (“Stretch goals,” an effort to go beyond benchmarks, are more challenging.)
- Success is celebrated and rewarded.

Excellence is achieved when these needs of both customer and provider stakeholders are optimally met, in ways such as the following:

- Care is safe, effective, patient centered, timely, efficient, and equitable (exhibit 1.1).
- 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 in the community's economic reach.

*The Well-Managed Healthcare Organization* describes how excellence is achieved by large HCOs. The following chapters identify the essential functions, their integration, measures, and personnel qualifications for essential components, describing the work of HCOs that have achieved and documented excellence.

## Practice Applications

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

1. HCOs are strongly oriented toward healing the sick, one person at a time. The first word of the body of this chapter—"patient"—is consistent with that tradition. Consider the following reasons for seeking care:

- Your grandmother, well into her eighties, wants a checkup. She has many of the limitations of age—her hearing, eyesight, and mobility are not what they were, and she has diabetes.
- Your father, 55, has acute chest pain that started a half hour ago and seems to be getting worse.
- You (or your partner) might be pregnant.

What constitutes an excellent result for each of these events? What care teams and clinical support teams are likely to be involved? How do the strategic teams help the clinical teams achieve excellence? If the HCO delivers that excellence, what other factors would be important to continued good health?

2. Mercyhealth (Janesville, Wisconsin) has two rewards recognizing associates' exceptional effort, Above and Beyond the Call of Duty and Someone to Admire and Respect. Nominations come from patients, colleagues, or guests. A committee reviews them and selects winners. Personal letters are sent to

home addresses, and recipients are recognized in departmental meetings. Similar programs at other HCOs often involve small prizes, such as a gift certificate for dinner for two. Bronson Healthcare (Michigan) has a lottery for recipients with a substantial cash prize. Should every well-managed health-care organization have a similar program? Can you describe to a customer stakeholder why the program is (or is not) a good idea?

3. Evidence-based management relies heavily on numbers. Benchmarks, goals, and unit performance are established in order to measure performance and outcomes. The quantitative approach raises many questions, and a competent professional leader must 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 frontline service associates do, but the transformational culture 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.

- Are these the right measures? (Why are these goals important? How were the measures selected?)
- How do I know my team can achieve these goals? (Do they include a lot of things outside our control?)
- Can we really get better? (If we set a goal, how do we know we can reach it?)
- Will we be punished for not reaching our goals? (Why should I make an extra effort to reach the goals?)

4. Five similar nursing stations have very different results on medication errors. How will you approach the OFI? Go to the worst, and tell them they must improve? Go to the best, and give them a prize? Go to the second best, and ask them to copy the best? Do all of these? Something else? What's the right approach, and why is it best?

5. Select an HCO where you might serve a summer internship or graduate fellowship and look it up in [WhyNotTheBest.org](http://WhyNotTheBest.org) or [healthcostinstitute.org](http://healthcostinstitute.org). Identify three to five OFIs that you think the HCO should be addressing. What questions should you ask when you interview, and what answers would you look for?

## Notes

1. The "Critical Actions" section for each chapter summarizes the actions a healthcare organization's (HCO's) leadership must complete to sustain its operations. Leaders' actions usually involve building and working with teams to support or improve

the HCO's culture, worker capability, and work processes. Leaders supply insight and guidance drawing on their broad understanding of the HCO's role, structure, governance, and strategy. Reviewing Critical Actions will help students identify what leaders do and how they do it—the approaches and methods they use that contribute to long-run excellence.

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