

This is a sample of the instructor materials for *The Well-Managed Healthcare Organization*, ninth edition, by Kenneth R. White and John R. Griffith.

The complete instructor materials include the following:

- Instructor Notes for each chapter, including discussion points for the book's Practice Applications
- A test bank with application-oriented multiple-choice questions
- Presentation PowerPoint slides for each chapter
- PowerPoint slides of the book's exhibits

This sample includes the Instructor Notes, presentation PowerPoint slides, and exhibit PowerPoint slides for chapter 1, "Foundations of Well-Managed Healthcare Organizations."

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Instructor Notes for *The Well-Managed Healthcare Organization, 9th ed.* Chapter 1: Foundations of Well-Managed Healthcare Organizations

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Student Takeaways

1. HCO leadership is a professional commitment to excellence in healthcare, like the commitment of doctors and nurses.
2. Excellence is defined, measured, and benchmarked in six dimensions: safe, effective, patient-centered, timely, efficient, and equitable care.
3. Modern care is delivered by many specialized teams. Think of leadership as:
 - a. Helping each individual fulfill their team role
 - b. Helping each team work effectively
 - c. Helping integrate many teams' activity to meet total patient needs
4. Stakeholders create HCOs to fulfill patient needs. Continued support from all stakeholders is essential; loss of any stakeholder support weakens and can eventually destroy the HCO.

This book is for people who want to be professional HCO leaders. Each chapter concludes with examples of what leaders do to ensure HCO success and Practice Applications to reinforce learning of how leaders act to support their teams. Instructor Notes for the Practice Applications can be found below.

Instructor's Introductory Comment

For chapter 1, the key words are:

- *“Safe, Effective, Patient-Centered, Timely, Efficient, and Equitable” (SEPTTEE)*
- *mission*
- *teams*
- *stakeholders*
- *best practice*
- *transformational management*
- *continuous improvement*

Are there questions about chapter 1?

Now, let's turn to the first set of Practice Applications (PAs).

You might want to advise the class on how to prepare the PAs. We suggest either encouraging informal team discussion before class or assigning in-class groups to make initial cuts at the right things to do and say, followed by a general class discussion and instructor guidance to the best answer. The PAs from the book are reproduced here, with advice, in the form of Instructor Notes, on the appropriate discussion.

Practice Applications and Notes

Practice Application #1

HCOs are strongly oriented to healing the sick, one person at a time. The first word of this chapter—“patients”—is consistent with that tradition. Consider the following reasons for seeking care:

- Your grandmother, well into her 80s, 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, which 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?

Instructor Notes

Look for:

- *Health as the overall goal. The best result is the highest possible level of performance for each individual.*
- *Use of the SEPTTEE goals.*
- *The path to excellence is completely different for each case. Many teams will be involved.*
- *Strategic teams are there to make the other three kinds of teams effective.*
 - *Giving orders is not promising, especially since most of these teams know more about their business and the patients’ needs than anyone in strategic leadership.*
 - *Asking questions—and listening carefully to answers—might be a great way to start.*

The “other factors” question is there to promote understanding of population health. Grandma will need increasing support for daily living. Dad should quit smoking, keep his weight under control, and take his cardiac meds. Mom needs to avoid alcohol, keep her weight, and breast feed. These goals are much easier for middle-class and higher-income people.

Practice Application #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 a dinner for two. Bronson Healthcare (Michigan) has a lottery for recipients with a substantial cash prize. 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?

Instructor Notes

Look for:

Yes, these awards. . .

- *Are popular with associates.*
- *Help build enthusiasm.*
- *Make clear how our associates should treat our customers.*
- *Promote both better associate satisfaction and better patient satisfaction.*
- *Increase associate motivation.*
- *Reinforce a universal commitment to meeting patients' needs.*
- *Have tangible (monetary value) and intangible (no monetary value) forms.*
 - *Ask: Which do you suppose is more powerful? (There is no definitive test, but a lot of evidence suggests that intangible rewards—praise, recognition, celebration—are powerful.)*

Ask: Can you think of reasons why reward programs should not be universal? Who should skip them?

Look for:

- *It's a lot of work.*
- *If it's done badly—if associates think the winner should not have received a prize or a better nominee was overlooked—it can be destructive.*
- *Some religious groups have strong opposition to lotteries.*
- *If the overall HCO performance is poor, or if it's bottom decile in quality or worker satisfaction, it might be smart to take some other steps first.*

Comment: These tools are nearly universal among high-performing HCOs. It would be professionally wrong not to consider them in an HCO where performance is median and improving.

Practice Application #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?)

Instructor Notes

Are these the right measures? Look for:

- *The right measures need to be:*
 - *Reliable: Random noise has been removed; when a change appears in the numbers, it reflects a real change in performance.*
 - *Valid: The benchmarks are achievable; when the process is improved, it will be reflected in the value reported.*
- *We should check for improvements, and change when they are documented.*

Why are they important? Look for:

They help us improve. They identify OFIs. They keep us from accidentally backsliding. They discourage arguments, postponement, and evasion

How were the measures selected? Look for:

- *The measure is vetted by NQF or a similar organization.*
- *The measures were carefully reviewed by all users at our HCO.*

Can we really get better? (If we set a goal, how do we know we can reach it?) Look for:

- *Unit__ has done it. They will share how they did it.*
- *We've checked carefully to eliminate factors outside your control*

Will we be punished us for not reaching our goals? (Why should I make an extra effort to reach the goals?) Look for:

- *Our HCO never punishes people for an honest effort.*
- *Patient satisfaction will be higher. That makes your job safer.*
- *(If correct) There are prizes and bonuses for achieving goals.*

All of these topics will be addressed in later chapters. These answers are designed to establish the core ideas—rewards-oriented measured performance and continuous improvement.

Practice Application #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?

Instructor Notes

Look for:

- *Exhorting the underachievers to try harder is unlikely to work. You have not found or corrected the root cause, or changed any of their processes or habits.*
- *A prize, or at least recognition, for the best puts the issue on the table. Leadership cares about medication errors.*
- *Asking second best to copy is not likely to work.*
- *Try a team approach to solving the problem. Ask each unit, including the best, to identify what it thinks the problems are. Review the findings collectively. Develop plans to implement improvement, measure gains, and reward.*

The question is foundational for continuous improvement, in chapter 3.

Practice Application #5

Select an HCO where you might serve a summer internship or graduate fellowship and look it up in WhyNotTheBest.org or 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?

Instructor Notes

The lessons that are likely to appear are the following:

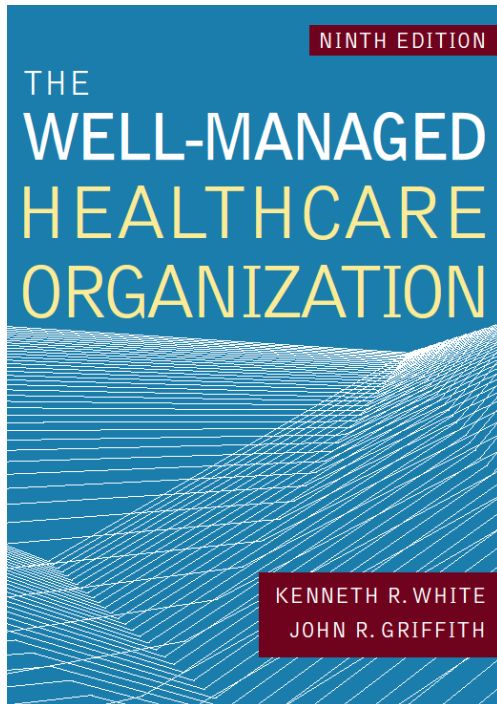
- *OFIs are commonplace.*
- *Treat them as opportunities.*
- *Seek, reward, and copy excellence.*
- *Give priority to easy fixes. Create some victories.*
- *Celebrate the victories.*
- *Focus relentlessly on the possible.*
- *Don't criticize. Show the path to improvement.*

The question to ask about your summer experience is “What are they doing about their OFIs?”

One possible set of values, for North Mississippi Medical Center is shown on the next page. It suggests:

- *Seeking excellence: Tishomingo is local best practice.*
- *Plenty of OFIs, compared either to the national top 1% or 25%. The flagship, NMMC, is challenged.*
- *Why are Calhoun & Pontotoc missing? (Probably because they are too small to generate reliable results.)*
- *What's a good way to proceed?*
 - *Get everybody's attention. Give Tishomingo recognition.*
 - *Get a PIT at every site with data.*
 - *Pay special attention to NMMC. It's probably larger than the others combined. Conversation with senior leadership: Where does patient satisfaction fit on their improvement agenda?*
 - *Ask the PIT for OFI priorities.*
 - *Use a systemwide PIT (with delegates from each site) to look at collective OFIs.*
- *“Highly satisfied” and “Would recommend” are too global to be good OFIs.*
 - *The specifics—the rest of the list—relate to specific practices that can be changed.*

	North Mississippi Medical Center (MS)	Calhoun Health Services (MS)	Clay County Medical Center (MS)	Marion Regional Medical Center (AL)	Pontotoc Health Service (MS)	Tishomingo Health Services Inc (MS)	Webster General Hospital/ Swing Bed (MS)	National Top 1%	National Top 25%
Percent of Patients Highly Satisfied	75 %	N/A	72 %	77 %	N/A	81 %	73 %	92 %	78 %
Doctors Always Communicated Well	84 %	N/A	86 %	88 %	N/A	93 %	91 %	95 %	85 %
Nurses Always Communicated Well	82 %	N/A	86 %	85 %	N/A	91 %	83 %	93 %	83 %
Patients Always Received Help As Soon As They Wanted	66 %	N/A	74 %	80 %	N/A	81 %	70 %	90 %	73 %
Staff Always Explained About Medicines	66 %	N/A	75 %	67 %	N/A	74 %	64 %	85 %	69 %
Pain Was Always Well Controlled	70 %	N/A	77 %	75 %	N/A	83 %	71 %	86 %	73 %
Patient's Room Always Kept Quiet At Night	72 %	N/A	78 %	76 %	N/A	83 %	59 %	88 %	68 %
Patient's Room and Bathroom Always Kept Clean	71 %	N/A	88 %	81 %	N/A	86 %	77 %	93 %	80 %
Patients Given Information About Recovery At Home	86 %	N/A	85 %	79 %	N/A	93 %	75 %	96 %	90 %
Patients Would Definitely Recommend	76 %	N/A	74 %	74 %	N/A	78 %	71 %	93 %	78 %
Patients Understood Care*	54 %	N/A	60 %	58 %	N/A	61 %	60 %	71 %	56 %
* "Patients who 'strongly agree' they understood their care when they left the hospital."									



Chapter 1 – Foundations of Well- Managed Healthcare Organizations

What Is a Healthcare Organization?

- A corporation providing the services of multiple patient care teams supporting care providers with providing clinical, logistic, and strategic services
- Healthcare organizations (HCOs) have a purpose that is contained in **mission statements**
- A **mission** is the organization's purpose, its reason for existence

Population Health

- Growing focus of HCO missions
- To manage chronic disease
- Focus on needs that go beyond healthcare, like housing, social support, transportation
- Meet the needs of people who are not patients to help them stay well
- Reduce healthcare disparities
- *Healthy People 2030*

What Is Excellence?

- Every patient gets the right thing, at the right time, without error of defect, for the best possible outcome
- A multidimensional concept
- Continuously improving performance
- Based on benchmarks, or best known performance
- IOM aims: safe, effective, patient-centered, timely, efficient, equitable

Team Structure

- Clinical teams
 - Care providers (healthcare professionals)
 - Interprofessional (or interdisciplinary)
 - Patient-centered (may include family caregivers)
- Clinical support teams
- Logistic and strategic teams
- Population health teams

Stakeholders

- Patients and families
- Associates (employees, volunteers)
- Licensed independent practitioners (LIPs)
- Insurers and government payment agencies
- Buyers
- Regulatory and accrediting agencies
- Owners and community groups
- Suppliers

How Do Stakeholders Influence?

- Networking
- Coalition building
- Legal controls
- Financial controls based on outcomes (incentives or fines)
 - Example is value-based purchasing
 - Managed care models

Some stakeholder groups are more important than others. The less important ones can be ignored.

- A. True
- B. False

Healthcare Regulations

- What is the purpose?
- What are the government agencies that regulate and why?
- A few examples:
 - Certificate-of-need
 - Health Insurance Portability and Accountability Act (HIPAA)
 - EMTALA

Licensure and Accreditation

- Compulsory
 - CMS
 - Conditions of Participation
 - State departments of health
 - Licensure and inspection
 - Other government – OSHA, EPA, Life Safety Code, NRC, HIPAA, EMTALA, CDC, FDA, CLIA, HAZMAT, OIG, IRS
- Voluntary
 - The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) (osteopathic hospitals), DNV Healthcare, others
 - Relationship to federal reimbursement and deemed status
 - Institute for Healthcare Improvement (IHI)
 - National Quality Forum (NQF)
 - College of American Pathologists (CAP) – lab only
 - American Association of Blood Banks – lab only

Deemed Status

- CMS certification **OR**
- The Joint Commission (TJC) accreditation **OR**
- Hospital Facilities Accreditation Program (HFAP) **OR**
- DNV Healthcare **OR**
- Others approved by CMS

The Healthcare Marketplace

- Evolution of health systems
- Healthcare economy (exhibit 1.4)
- Hospital sector (exhibit 1.5)
- Physician and other health services
- Post-acute and specialty care
- Accountable care organization

Ownership

- Not-for-profit
 - Secular
 - Religious
 - Catholic
 - Other
- Government
 - Federal
 - State
 - Local (county/city; authority)
- For-profit (or investor-owned)

Tax-Exempt Status

- IRS Code 501(c)(3) – federal tax exemption
 - Requirements (IRS, 1969)
 - ER without regard to pay
 - Open medical staff
 - Community benefit (definition vague)
 - Board has members of the community
 - Community benefit defined and specified (2008)
 - Form 990, Schedule H
 - www.guidestar.org
 - State and local taxes are separate decisions
 - Trend in property tax assessments

Special Designations

- Safety net hospitals
 - May be statutory (county hospitals) or other nonprofit
- Disproportionate Share (DSH) Hospitals
 - Medicare and Medicaid – Social Security Act of 1986
 - Amended by the ACA (2010)
 - Mechanism to pay hospitals for uncompensated care based on a complex statutory formula
- US Indian Health Service
 - Hospitals, health centers, behavioral health services operated by Department of Health and Human Services

Critical Access Hospitals

- Established by BBA of 1997
- Requirements
 - Meet the conditions of participation
 - Rural location
 - 24-hour emergency department
 - ≤ 25 inpatient beds
 - Additional \leq rehab/psych beds
 - Average length of stay < 96 hours
 - Located > 35 miles to nearest hospital or > 15 miles in mountains or be state-certified as a “necessary provider”
 - Medicare pays 101% of reasonable and allowable costs

Federally Qualified Health Centers

- Target medically underserved in rural and urban areas
- Ambulatory primary care centers (migrant health, community health)
- Rural health clinics
- Assists in enrolling for Medicaid and CHIP
- Funded with federal cash grant and cost-based reimbursement for Medicaid
- Payment for virtual communication services (effective 1/19)
- Malpractice covered by Federal Tort Claims Act

Hospice and palliative care are designed to reduce the burden of symptoms caused by life-limiting diagnoses and death.

- A. True
- B. False

Achieving Excellence in HCOs

- Transformational culture
 - Mission, vision, values
- Continuous improvement
- Commitment to evidence

Managing and Leading Excellent HCOs

- Reducing variation in HCO performance
- Meeting the needs of clinical care teams
 - Close, quantitative monitoring
 - Leadership rounding
 - Carefully negotiated goals
- Supporting continuous improvement
- Baldrige winners as examples

Evidence-Based Management

- Know about problems and opportunities for improvement (OFIs)
- Know what works – “best practices”
- Know why to implement
- Know how to put into practice
- Know when to do it
- Know who to involve

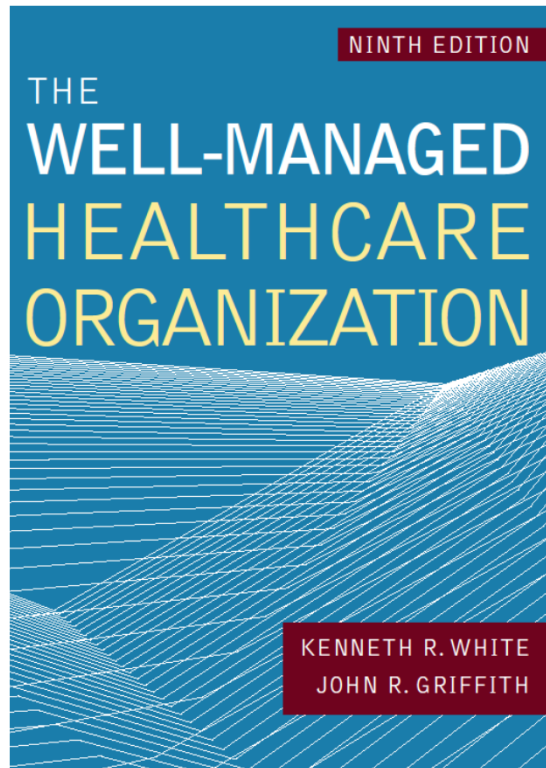
Hospital Conversions: Who Cares?

Mayberry is a city of 150,000 citizens in the heart of New England. This quaint community is served by two hospitals. One is Mayberry General Hospital (MGH), a community hospital of 150 beds, founded in 1920 by a group of physicians. It has a loyal medical staff of 50 (average age = 58) and an average occupancy rate of 90%.

St. Agnes is a 250-bed Catholic hospital sponsored by the Sisters of Perpetual Help. It was founded in 1947 at the invitation of the Archbishop of Boston. It has an occupancy of 60%, falling financial margins, and a medical staff of 200 (average age = 45).

St. Agnes is proposing to buy MGH, resulting in an ownership conversion.

Who cares?



Chapter 1 Exhibits

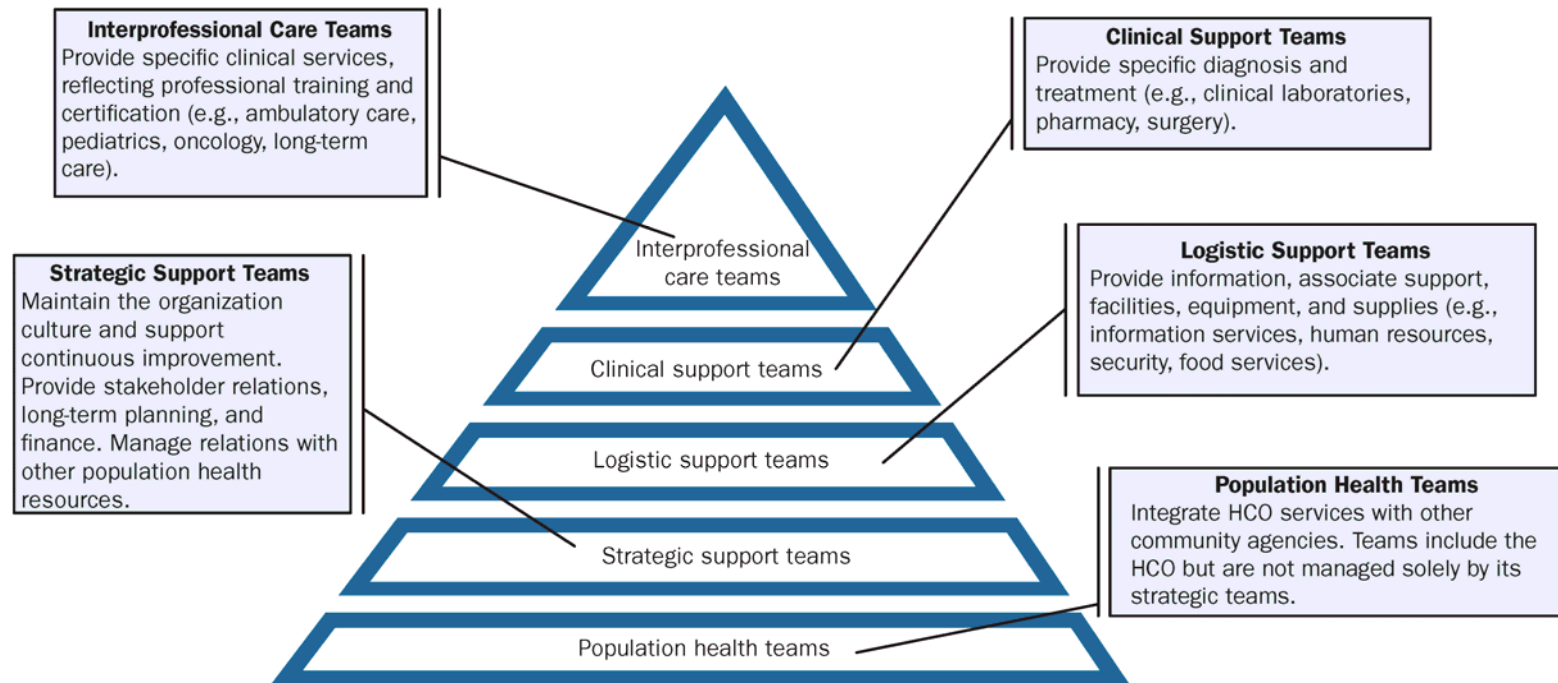
EXHIBIT 1.1

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.

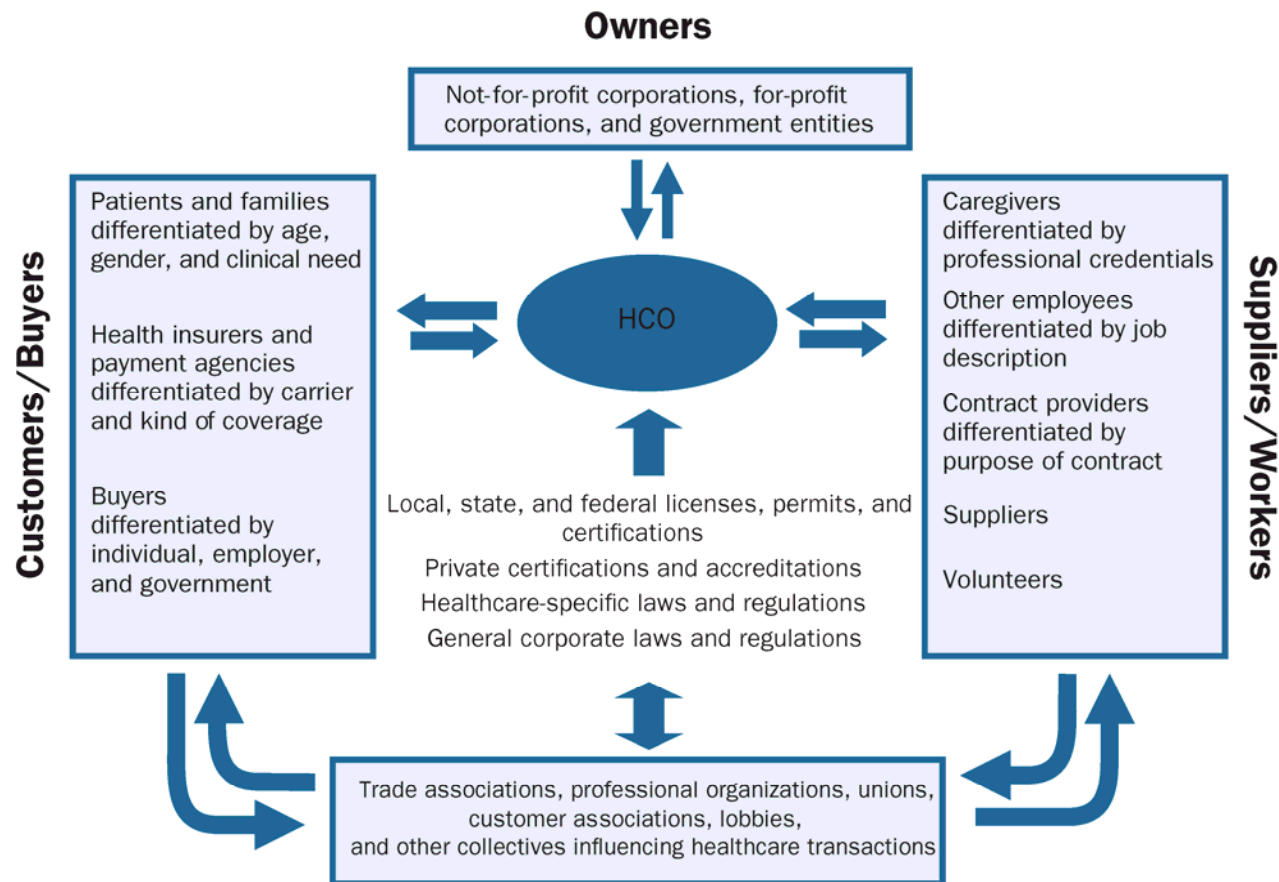
Source: Adapted from Academy of Medicine (2000).⁷

EXHIBIT 1.2 Components of Healthcare Organizations



Note: HCO = healthcare organization.

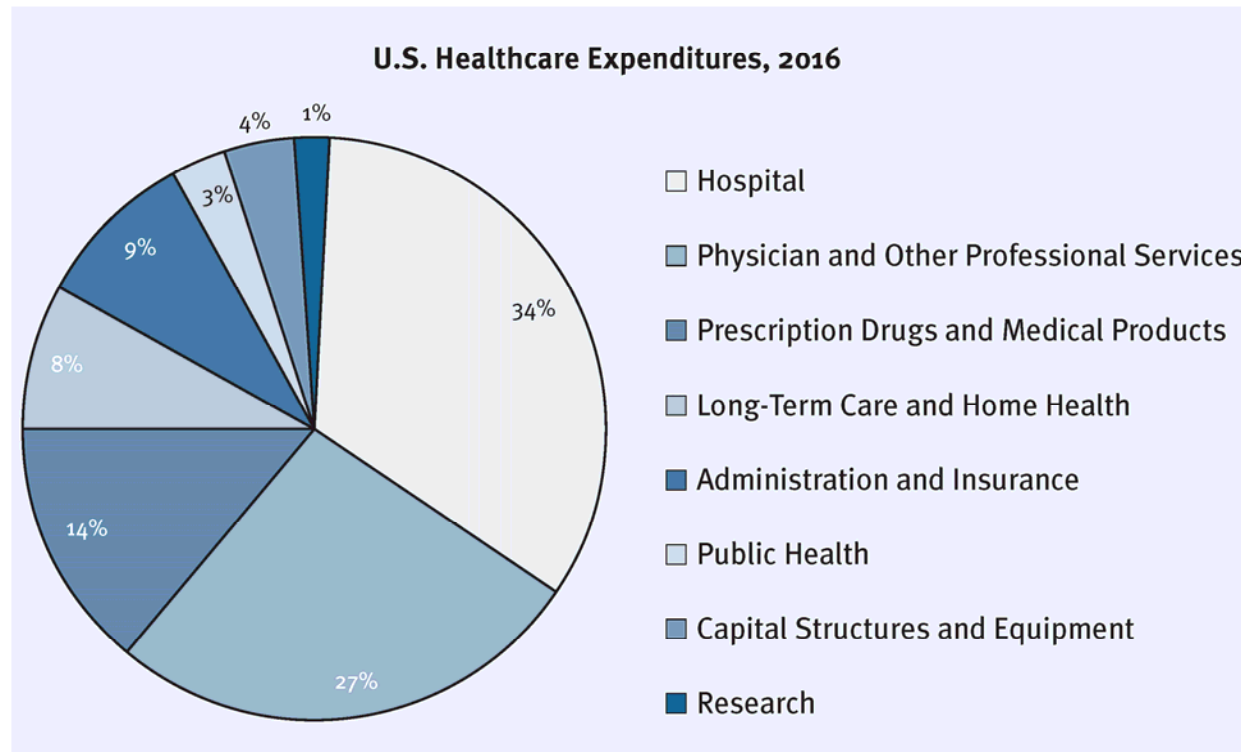
EXHIBIT 1.3 Model of Stakeholder–Healthcare Organization Interaction



Note: HCO = healthcare organization

EXHIBIT 1.4

How Healthcare Money Is Spent



Source: CMS (2018).²⁷

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).²⁹

EXHIBIT 1.5
Ownership and
Specialization
of US Hospitals,
2016

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).³⁸

* 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.