Endeavor to Succeed

Building and Leading the Next Healthcare Generation

About the Author

Larry Stepnick is Vice President and Director of The Severyn Group, Inc., a Virginia-based firm that specializes in conducting qualitative and quantitative research, and writing and producing publications on a wide range of healthcare management issues. In addition to printed materials, The Severyn Group creates Web site content and electronic presentations for training and education purposes. Severyn's clients include a broad spectrum of organizations that represent virtually all aspects of healthcare, including financing, management, delivery, and performance measurement. The Severyn Group assists clients in resolving their most critical strategic concerns.

Prior to cofounding The Severyn Group in 1994, Mr. Stepnick served as Senior Vice President and an elected officer of The Advisory Board Company, a for-profit membership of more than 1,000 hospitals and health systems. Mr. Stepnick received his bachelor's degree from Duke University, where he graduated summa cum laude. He also holds an M.B.A. from the Wharton School of the University of Pennsylvania, where he graduated with honors.

Mr. Stepnick can be reached at (703) 723-0951 or via email at larry@severyngroup.com.

The Governance Institute

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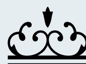
9685 Via Excelencia • Suite 100 • San Diego, CA 92126
Toll Free (877) 712-8778 • **Fax** (858) 909-0813
GovernanceInstitute.com



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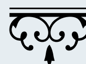

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President & CEO, Scripps Health,
San Diego, California

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Preface

Held November 8–10, 2015 at The Ritz-Carlton, Dove Mountain in Tucson, Arizona, The Governance Institute's 2015 Chairperson, CEO, and Physician Leader Conference brought together a distinguished group of faculty and attendees to discuss what healthcare CEOs, board chairs, and key physician leaders can do now to prepare their organizations for strength and relevance for both the near and long term. It reinforced the critical imperative of superb leadership in building the future of healthcare in the U.S., even in the face of uncertainty.

This conference provides an opportunity for The Governance Institute to help its members exchange practical ideas with experienced faculty and with each other. This year marks the 25th anniversary of the event. An excellent faculty joined with approximately 140 health sector leaders from 25 states. This paper summarizes the presentations and discussions that took place during the conference.

Please direct any questions or comments about this document to:

Kathryn C. Peisert
Managing Editor
(877) 712-8778
kpeisert@GovernanceInstitute.com

Faculty

The Governance Institute sincerely thanks the faculty of the 2015 *Chairperson, CEO, and Physician Leader Conference* (listed in alphabetical order) for being so generous with their time and expertise.

Darrell A. Campbell Jr., M.D., FACS
Chief Medical Officer & Henry King Ransom Professor of Surgery,
University of Michigan Health System;
Director, Michigan Surgical Quality Collaborative

Anne B. Docimo, M.D., M.B.A.
Chief Medical Officer, Jefferson Health System

Congresswoman Gabrielle Giffords
Founder, Americans for Responsible Solutions

Lisa Goldstein
Associate Managing Director of Not-for-Profit Healthcare Ratings, Moody's Investors Service

Zach Griffin, M.B.A., M.H.A.
General Manager, The Governance Institute

Steve Jackson
President, National Research Corporation

Captain Mark Kelly
Founder, Americans for Responsible Solutions

Stephen W. Kett
Program Director, The Governance Institute

Stephen K. Klasko, M.D., M.B.A.
President & CEO, Thomas Jefferson University & Jefferson Health

Peggy L. Naas, M.D., M.B.A.
Chief Medical Officer, Healthcare Performance Improvement, LLC

Rita E. Numerof, Ph.D.
President, Numerof & Associates, Inc.

Diana Oreck, CHT
Vice President, The Ritz-Carlton Leadership Center

Steve Pu, D.O., FACOS
Medical Director, Twins River Regional Medical Center

Steven J. Spear, D.B.A., M.S., M.S.
Senior Lecturer, MIT Sloan School of Management;
Senior Fellow, Institute for Healthcare Improvement; Principal, HVE LLC; Founder, See to Solve

Noel M. Tichy
Professor of Management & Organizations, Ross School of Business, University of Michigan

Chris D. Van Gorder, FACHE
President & CEO, Scripps Health; former Chairman, American College of Healthcare Executives

Executive Summary

Held November 8–10, 2015 at The Ritz-Carlton, Dove Mountain in Tucson, Arizona, The Governance Institute's 2015 Chairperson, CEO, and Physician Leader Conference brought together a distinguished group of faculty and attendees to discuss what healthcare CEOs, board chairs, and key physician leaders can do now to prepare their organizations for strength and relevance for both the near and long term. This paper summarizes the presentations and discussions that took place during the conference.

Endeavour to Succeed

Captain Mark Kelly and Congresswoman Gabrielle Giffords discussed the importance of setting goals and working diligently to achieve them through practice and persistence. Throughout their lives and careers, including the challenges associated with flying bombing missions during the Persian Gulf War and surviving and recovering from horrifying injuries from an assassin's bullet, Captain Kelly and Congresswoman Giffords have learned a variety of leadership and other lessons of relevance to healthcare leaders:

- Focus on what one can control.
- Communicate in a timely, accurate manner.
- Structure decision-making processes to avoid "group think."
- Put the right team together, avoiding "yes" people.
- Constantly look for ways to reduce risk.
- Remain patient.
- Never give up.

Succession: Mastering the Make or Break Process of Leadership

Noel M. Tichy, Professor of Management and Organizations at the Ross School of Business at the University of Michigan, discussed the importance of effective leadership development and succession planning within healthcare organizations. Key lessons include the following:

- **Incorporate "action learning":** The best leadership development programs incorporate opportunities for attendees to wrestle with real-world issues and problems faced by leaders.
- **Learn from successes and failures:** Every leader should think about his or her best and worst judgment calls, including what made them good or bad.
- **Have a teachable point of view™:** Transformational leaders have personalized, teachable views on leadership, growing the business, and creating change.
- **Spend the requisite time**: Leaders should commit one-half to one-third of their time to developing others.
- **Be a vulnerable role model and coach**: Transformational leaders are open to new ideas and feedback and can admit mistakes.
- **Blend the soft and the hard**: Transformational leaders effectively deal with people and business issues at the same time.
- **Energize others as they learn**: Transformational leaders create an emotionally engaging process that encourages participants to take risks and learn from their experiences.

"I Messed Up Healthcare in America (Put Your Name Here)" and "I'm Fixing Healthcare in My Community (Put Your Name Here)"

Stephen K. Klasko, M.D., M.B.A., President and CEO of Thomas Jefferson University & Jefferson Health, and Anne B. Docimo, M.D., M.B.A., Chief Medical Officer of Jefferson Health System, discussed the problems facing the healthcare system in America and how Jefferson Health is trying to fix them.

All key stakeholders have contributed to the creation of today's complex, inefficient, inequitable healthcare system. The issues that dominated the discussion 40 years ago—spiraling costs, the need to change payment systems, and how to measure outcomes—still dominate the conversation today. To truly address these issues, healthcare needs substantial disruption, led by the industry itself. Beginning in September 2013, Jefferson Health System started on this journey. Key steps include the following:

- **Revamping medical education**: The effort started with a fundamental revamping of medical education, beginning with the selection process used for applicants to Jefferson's medical school. Rather than choosing based solely on grade point averages in science classes and Medical College Admission Test (MCAT) scores, Jefferson began using these criteria only as a way to narrow down the applicant pool. Among those who meet minimum thresholds, Jefferson chooses based on the candidate's level of emotional intelligence.
- **Developing leaders from ranks of existing physicians**: Jefferson created the Physician Leadership Institute, a separate company that offers an 18-month program to physicians interested in becoming leaders of their organizations. The program features a formal nomination and acceptance process and requires a bilateral commitment between the physician and organization.
- **Transforming the delivery system**: Jefferson created a regional health system by merging with two other area systems. The goal is not to feed referrals to the inefficient, expensive downtown hospital, but rather to create a true community-based system that brings care to the patient. To make that work, Jefferson transitioned from a 57-member board dominated by academic medical center interests to a new board with near-equal representation from each of the three organizations. To enhance access to care, Jefferson created JEFF NOW®, which provides patients with instant access to a live representative and allows them to schedule care online, and JeffConnect, through which patients receive care via virtual visits.

- **Revamping data systems**: Jefferson has invested in new systems and uses the data to redesign care, manage population health, and accelerate the transition to personalized medicine.

From Volume to Value: Charting a Course for Surgery

Darrell A. Campbell Jr., M.D., FACS, serves as Henry King Ransom Professor of Surgery at the University of Michigan Health System, Director of the Michigan Surgical Quality Collaborative (MSQC), and previously served as Chief Medical Officer for the organization. Dr. Campbell spoke about a disruptive approach being taken by hospitals in Michigan to react to the major changes in payment for surgical care that will begin in 2019. For the past 15 years, hospitals in Michigan have been proactively working with Blue Cross Blue Shield of Michigan (BCBSM) on MSQC, a collaborative effort designed to define quality, cost, and value for surgical care and integrate surgery with other areas of medicine in ways that make sense to the patient. For the 73 participating hospitals, MSQC represents a strategy for leading change on the way care is measured, delivered, and financed. Rather than letting government make these changes for the industry, MSQC is taking the lead in an attempt to both be a good partner and to preserve the essential features of the surgical discipline. Participating hospitals have developed and forged consensus on standard definitions for comorbidities and complications, a common methodology for risk adjustment, and a standard 30-day endpoint. In addition to having experienced nurses collecting data at each hospital, MSQC staff members conduct periodic site visits to participating hospitals and regularly audit results and conduct tests to ensure inter-rater reliability. To date, over 400,000 general, vascular, and gynecological surgery cases have been evaluated, with approximately 124 variables being assessed for each case. MSQC is also working to integrate surgical care with anesthesia, emergency medicine, and primary care.

Competing at Speed in a Fast-Moving World

Steven J. Spear, D.B.A., M.S., M.S., serves as a Senior Lecturer at the MIT Sloan School of Management, a Senior Fellow at the Institute for Healthcare Improvement, and a Principal at HVE, LLC. Dr. Spear discussed the importance of competing on the basis of speed in today's fast-moving, competitive marketplace. In particular, he emphasized the need for fast learning, and shared two examples that illustrate this point:

- **Toyota Motor Corporation**: The most successful and profitable companies deliver value to the marketplace with incredible speed and ease. Toyota Motor Corporation sells more cars and makes almost three times more profit per vehicle than any other car manufacturer. Toyota's success does not stem from superior knowledge or proprietary technologies. Rather, it stems in large part from being better and faster at learning.
- **Navy nuclear power program**: Hyman G. Rickover was a U.S. Navy Admiral who oversaw the initial development of naval nuclear propulsion and subsequently controlled its operations for three decades. Known as the "Father of the Nuclear Navy," Admiral Rickover succeeded largely due to his ability to develop and lead a "learning engine" within his organization. The race with the Soviets to develop naval nuclear capabilities was fundamentally a learning race. The U.S. beat the Soviets largely because of Admiral Rickover's ability to create an organization able to quickly acknowledge and identify problems, develop solutions to those problems, and spread learning. Thanks to his leadership, the U.S. to this day still enjoys significant advantages over Russia in terms of nuclear capabilities, both for power and on warships.

Competitive Differentiation through Quality Innovation

This panel focused on how hospitals and health systems can differentiate themselves from the competition by focusing on quality-related innovations; panelists included: Rita E. Numerof, Ph.D., President of Numerof & Associates, Inc.; Stephen K. Klasko, M.D., M.B.A., President and CEO of Thomas Jefferson University and Jefferson Health System; and Peggy L. Naas, M.D., M.B.A., Chief Medical Officer of Healthcare Performance Improvement, LLC. Zach Griffin, M.B.A., M.H.A., General Manager of The Governance Institute, facilitated the discussion. Key lessons from the panel include the following:

- Expect a rapid pace of change.
- Prepare for new competitors.
- Define and monitor real-time quality.
- Craft a compelling story around specific product lines.
- Be competitive on costs.
- Learn to be a learning organization.
- Invest in training.
- Pay attention to quality ratings and social media feedback.
- Expect concierge health to grow.
- Be mindful of data privacy and security issues.

Applying The Ritz-Carlton Service Excellence Model to Healthcare

Diana Oreck, CHT, Vice President of The Ritz-Carlton Leadership Center, discussed The Ritz-Carlton service excellence model and how it applies to the healthcare industry. While hospitals and other healthcare facilities should never seek to be a hotel, they can differentiate themselves from the competition based on service. The goal should be to "do it all" by offering clinical quality, safety, and a great experience. To do so, organizations must invest in the following:

- **People**: All organizations have an existing culture. The goal is to leverage that culture to give customers a great experience. That experience begins with the employees and how they treat each other, which should be with dignity and respect. In fact, The Ritz-Carlton "guarantees" its employees a workplace characterized by trust, honesty, respect, integrity, and commitment. The goal is to create associates who are engaged, motivated, and proud, routinely acting like a "raving fan" of the brand. No employee should ever have a "just-a" mentality—for example, those who clean the room or empty the trash should never refer to themselves as "just a" housekeeper or "just a" janitor. Rather, they should try to create memorable moments during all interactions with customers.
- **Physical plant**: Customers pay attention to what they see when they walk into the facility. They notice whether the plants are alive and the bathrooms are clean. Patients and family members in the hospital have plenty of time to observe these things. Their senses become amplified and their imaginations run wild if they see, hear, or smell things that suggest anything but top-notch service. Because service is psychological, any feelings they have become facts in their minds.
- **Systems**: A culture of service can only take an organization so far without the systems in place to support employees. The first step is to choose the right talent. During the vetting process, The Ritz-Carlton seeks to understand whether an applicant has the spirit to serve, a positive attitude, and a strong desire to care for others. Typically, only one out of every 20 candidates is offered a job. Once hired, The Ritz-Carlton supports its employees through a variety of orientation and training programs throughout the first year. Disengaged employees quickly get put on a performance plan that lays out achievable milestones for improvement. Employees who do not make meaningful progress toward these milestones are quickly let go. The Ritz-Carlton also empowers employees to resolve customer complaints (rather than forcing them to go to a manager to address the issue).

Moody's Perspective on the Not-for-Profit Healthcare Sector: What Leaders Need to Know about Bond Ratings Now

Lisa Goldstein, Associate Managing Director of Not-for-Profit Healthcare Ratings at Moody's Investors Service, provided the rating-agency's perspective on the not-for-profit (NFP) healthcare sector. In August, 2015, Moody's changed its outlook on the sector, upgrading it to "stable" after eight years of having a "negative" outlook. The change reflects Moody's view that fundamental business, financial, and economic conditions for the NFP healthcare sector will neither erode significantly nor improve materially over the next 12 to 18 months. The upgrade stems primarily from three major factors that have led to improved financial stability over the past year: growth in operating cash flow, more insured individuals (which has led to less bad debt expense), and higher patient volume (after years of decline). Key ratios for fiscal year 2014 are all trending in favorable directions for hospitals, including measures of profitability, liquidity, and debt service coverage.

NFP hospitals are embarking on various consolidation strategies, and Moody's asks a number of key questions when evaluating them as part of a rating review. (The full report provides a list of these questions.) The quality of management and governance also plays a role in Moody's ratings. While no formal metric exists, Moody's sees the impact that boards and management have on an organization, and hence routinely evaluates the following:

- Composition of board and management
- External disclosure and internal controls
- Integration of short- and long-term planning
- Ongoing self-assessment and benchmarking
- Government and stakeholder relations

The Board, CEO, and Physician Leaders' Roles in Revolutionizing the Patient Experience

Steve Jackson, President at National Research Corporation, and Steve Pu, D.O., FACOS, Medical Director at Twins River Regional Medical Center in Kennett, Missouri, discussed the roles of the board, CEO, and physician leaders in transforming the patient experience. Approximately four years ago, Dr. Pu contacted Mr. Jackson to request help in "humanizing" the patient experience at Twins River Regional Medical Center. At the time, the hospital had a 33 percent "top-box" score on survey questions related to willingness to recommend the facility, placing it in the bottom 5 percent nationwide. Today, this figure has jumped to 78 percent, placing the hospital in the top 5 percent in the country. While the success of this initiative stems from many factors, the following lessons related to leadership and cultural change stand out as most important:

- Avoid "us-versus-them" discussions.
- Connect to the purpose, not the task.
- Inspire and engage physicians to lead the effort.
- Empower staff to oversee change.
- Map and address the emotional gaps in the care experience.
- Turn experience data into a "gold mine."
- Celebrate successes.

Effecting Change through Frontline Leadership

Chris D. Van Gorder, FACHE, President and CEO of Scripps Health and former chairman of the American College of Healthcare Executives, discussed the role of leadership in turning around Scripps, taking it from the brink of financial collapse in 2000 to the successful regional health system that it is today. While many factors are responsible for this turnaround, much of the success stems from use of various

leadership-driven strategies designed to engage physicians and front-line staff, giving them ownership and accountability over the various challenges facing the organization. These strategies include the following:

- **Fill the information gap**: When people have access to the same information, they often reach similar conclusions.
- **Build culture from the middle:** The goal is to create greater unity and a common culture focused on the patient.
- **Connect with people:** Distant bosses cannot be effective.
- **Be aware of every situation:** A former police officer, Mr. Van Gorder strives to make sure that his leadership team proactively understands every situation and empathizes with those involved.
- **Take care of employees first:** Scripps has a no-layoff philosophy. Whenever a job gets eliminated due to some necessary change, Scripps guarantees employees a new place within the organization.
- **Give responsibility and authority in combination with accountability:** Scripps clearly lays out its expectations with respect to performance goals and the consequences for not meeting them. Those who miss their targets more than once generally lose their jobs, with few exceptions.
- **Leave no one behind**: Scripps emphasizes the importance of achieving a healthy work-life balance and offers support in doing so. Scripps also has incentive compensation programs for both management and non-management.
- **Always ask "what if"**: Contingency planning is critical to success, particularly with respect to long-term, big-picture issues. Scripps always has a contingency plan in place, both for the good and the bad.
- **Lead courageously and decisively**: Leaders must challenge employees to move past what feels comfortable and to look at the organization differently.
- **Bring the mission to life**: Genuine, heartfelt actions speak louder than words. A variety of programs illustrate Scripps' commitment to its mission, including various community partnerships and a medical response team that regularly travels to help with natural and manmade disasters.

Endeavour to Succeed

Captain Mark Kelly and Congresswoman Gabrielle Giffords opened the conference with a discussion of the importance of setting goals and working diligently to achieve them through practice and persistence, including an unwillingness to give up.

Captain Kelly learned these lessons from his mother, who became the first female police officer in the state of New Jersey. After struggling to find his way in high school, Captain Kelly decided he wanted to go to flight school; become a naval aviator, test pilot, and astronaut; and then be the first man to walk on Mars. While he never quite made it to Mars, he did achieve the rest of his goals and flew into space on four separate occasions. Ironically, the secret to his success did not lie in any special talents. In fact, he struggled for a long time after entering flight school at the Naval Air Station in Pensacola, FL. After a year of training, the Navy requires pilots to land on an aircraft carrier. After a year of training, Captain Kelly could still barely land his plane on a runway, let alone a naval aircraft carrier. It took Captain Kelly four attempts to land without ending up in the water. Yet due to his countless hours of practice, persistence, and a never-give-up-attitude, he ultimately became a naval pilot and later an astronaut.

> "How good you are at something is not a good indicator of how good you can become with practice, persistence, and a drive to never give up."
>
> *—Captain Mark Kelly*

The classic overachiever, Congresswoman Giffords attended an Ivy League school, became a Fulbright Scholar, served as CEO of the family business, and was elected to public office, first as a State Senator and then as a member of the U.S. House of Representatives from Arizona's 8th district. She always wanted to serve her community, and being elected to Congress in many ways represented the fulfillment of that dream. Roughly a week into her third term, she very nearly lost her life after being shot in the head at point-blank range while meeting with constituents outside a Safeway grocery store. Six people died at the hands of the assassin, including a nine-year old girl, while over a dozen suffered injuries. Demonstrating the power of the human spirit to fight, Congresswoman Giffords survived, enduring countless surgeries and undergoing a grueling rehabilitation regimen that continues to this day. Six months after her injuries, she flew from a rehabilitation center in Houston, Texas to Washington, D.C., to vote on a controversial bill to raise the debt ceiling. After months of partisan rancor and pettiness, her presence brought Congress together to do the right thing and find a compromise on how to fund the government.

Throughout their lives and careers, including the challenges associated with flying bombing missions during the Persian Gulf War and surviving and recovering from horrifying injuries caused by an assassin's bullet, Captain Kelly and Congresswoman Giffords have learned a variety of leadership and other lessons of relevance to healthcare leaders, as detailed in the paragraphs below.

Focus on what one can control: At the age of 25, Captain Kelly flew his first combat mission, serving as the pilot of a two-person airplane carrying four 2,000-pound bombs targeted for a repair facility at an airfield near Basra, Iraq. Throughout the mission, Captain Kelly focused on what was in his control—navigating the aircraft through enemy fire—while his bombardier navigator focused only on what was in his control—finding and hitting the intended target.

Communicate in a timely, accurate manner: After dropping the bombs on the intended target, Captain Kelly decided to take a different route back to the base in order to avoid the heavy enemy fire he had encountered earlier. He turned east and traveled 50 to 100 miles into Iranian airspace. Because he did not alert anyone of his intentions, his plane was mistaken for an Iraqi plane and very nearly shot down by the U.S. military. His failure to communicate with his colleagues in a timely, accurate manner very nearly cost him and his navigator their lives.

> "When forming teams, I look for people who want to make things happen and would rather ask for forgiveness than permission. I don't want 'yes' people. I am perfectly capable of agreeing with myself."
>
> *—Captain Mark Kelly*

Structure decision-making processes to avoid "group think": NASA learned a lot about poor decision-making processes from its investigations into the two space shuttle accidents (*Challenger* in 1986 and *Columbia* in 2003). Perhaps the biggest problem stemmed from the potential for "group think" (i.e., when teams make decisions that no single member of the team would have made on his or her own). These poor decisions occur because individual team members do not feel comfortable speaking their minds and voicing their concerns. To address this problem, NASA built a new conference room for the mission management team that included physical features intended to encourage open discussion, including having everyone sit on the same level with easy access to a microphone. In addition, the room featured the following message written in large letters on its walls: "None of us is as dumb as all of us." Captain Kelly used a similar approach when physicians began presenting him with a myriad of treatment options right after his wife had been shot. He brought all her doctors and caregivers together in one room—roughly 20 individuals. He went around the room to get everyone's opinion, beginning with the youngest person and ending with the chief of neurosurgery. (If he had started with the chief, no one else would have dared to contradict his opinion and hence felt free to speak his/her mind.)

> "Fight to make the world a better place. Get involved in your community, be passionate, be courageous, and be your best."
>
> *—Congresswoman Gabrielle Giffords*

Put the right team together, avoiding "yes" people: Teams should be made up of individuals who work well together. As the commander of several space missions, Captain Kelly sought to find team members who "leaned forward" and made things happen. He also avoided "yes people" who always agreed with him. In fact, he required that team members tell him if they felt the team should be doing something differently to improve safety and/or the odds of the mission meeting its objectives.

Constantly look for ways to reduce risk: Flying the Space Shuttle comes with roughly a 2 percent chance of dying, about the same odds faced by those who stormed the beach in Normandy on D-Day. NASA works hard to reduce that risk by constantly paying attention to the details. The same approach should be applied in the healthcare industry, which faces similar levels of risk.

Remain patient: During Congresswoman Giffords' recovery, Captain Kelly learned that some things take a very long time and may in fact always be a work in progress. Exhibiting such patience is critical to reaching one's goals.

Fight, fight, fight: Congresswoman Giffords simply will not accept failure, as the word is not in her vocabulary. Her injuries have changed her life in many ways, but have not put a dent in her spirit or desire to continue serving the public and make the world a better place.

Succession: Mastering the Make or Break Process of Leadership

Noel M. Tichy, Professor of Management and Organizations at the Ross School of Business at the University of Michigan, discussed the importance of effective leadership development and succession planning within healthcare organizations.

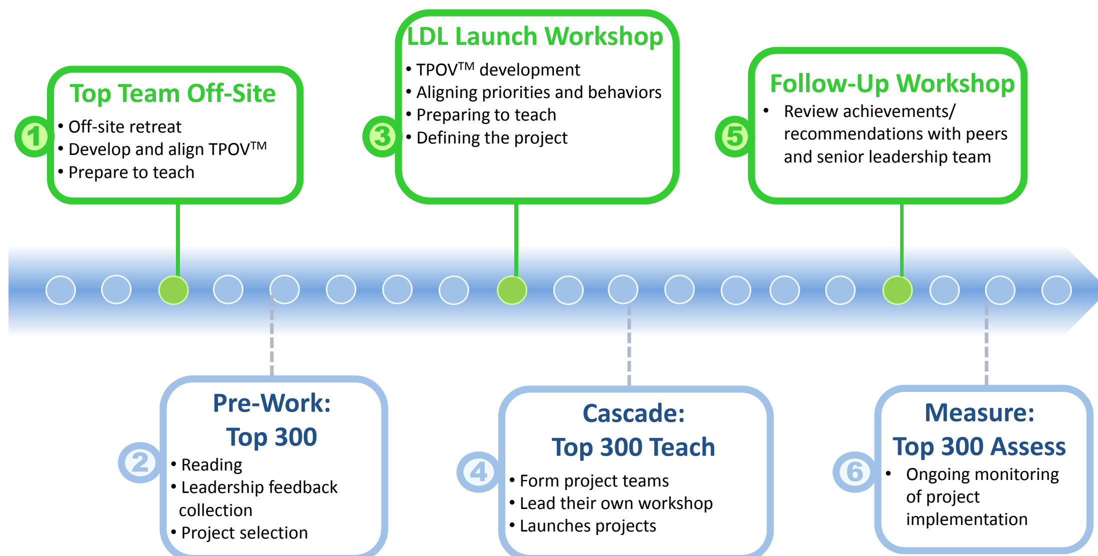
The Need for Action Learning

The best leadership development programs incorporate opportunities for "action learning" where attendees wrestle with real-world issues and problems faced by leaders. Dr. Tichy's most valuable leadership lessons came during his real-world experiences, first as head of the Dr. Martin Luther King, Jr. Health Center in the South Bronx (where he focused on improving population health in one of the poorest neighborhoods in the country), and later as head of the Hazard Family Health Center in Hazard, KY, in the 1970s (which nearly went bankrupt after the local coal mine cut health benefits). Dr. Tichy incorporates lessons from these experiences into leadership development programs that he runs and into his business school curriculum. Through the Global Leadership Consortium, corporate executives go to China, India, Brazil, and Russia to learn firsthand about the struggles facing developing nations. At the University of Michigan, nearly 10,000 business school students have gone through similar experiences in inner-city Detroit, where they get directly involved in addressing critical issues facing the community, such as poverty, crime, and inadequate schools. This real-world, action learning serves to ingrain a culture of community service and citizenship in leaders, which can then be instilled in companies.

> "Most human beings want to give back to the community; you just have to give them a platform to do so."
>
> —*Noel M. Tichy*

As depicted in **Exhibit 1**, action learning programs involve sending a team from each organization offsite to develop, align, and prepare a "teachable point of view" as part of a specific project.

Exhibit 1: Cascade Process



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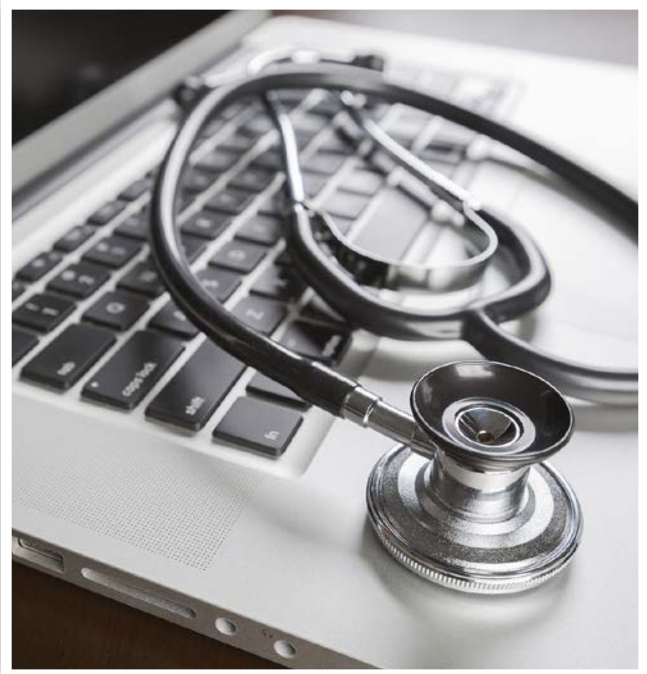
The goal of any action learning program is to come up with key takeaways that can be implemented. To avoid the potential for "group think" (as described by Captain Kelly), each team member should write down his or her own recommendations and then debate and defend them.

Learning from Successes and Failures

Every leader should think about his or her best and worst judgment calls, including what made them good or bad. For Dr. Tichy, his best judgment calls came when running the Hazard Family Health Center in the 1970s, a job that required the delicate balancing of payroll costs and effective collaboration with the Robert Wood Johnson Foundation and the Secretary of the Department of Health and Human Services at the time (Joseph Califano). This experience taught him more about leadership than any other in his life. His worst call came shortly after starting his own company offering various educational services to hospitals. A trusted colleague assured him that representatives from six hospitals were planning to attend an upcoming program. The day before the event, he found out that five of the six had never signed up. Unbeknownst to Dr. Tichy, his colleague was an alcoholic and a chronic liar, and Dr. Tichy's failure to recognize that nearly destroyed his organization.

Five Signs of Failure: A Self-Test for CEOs

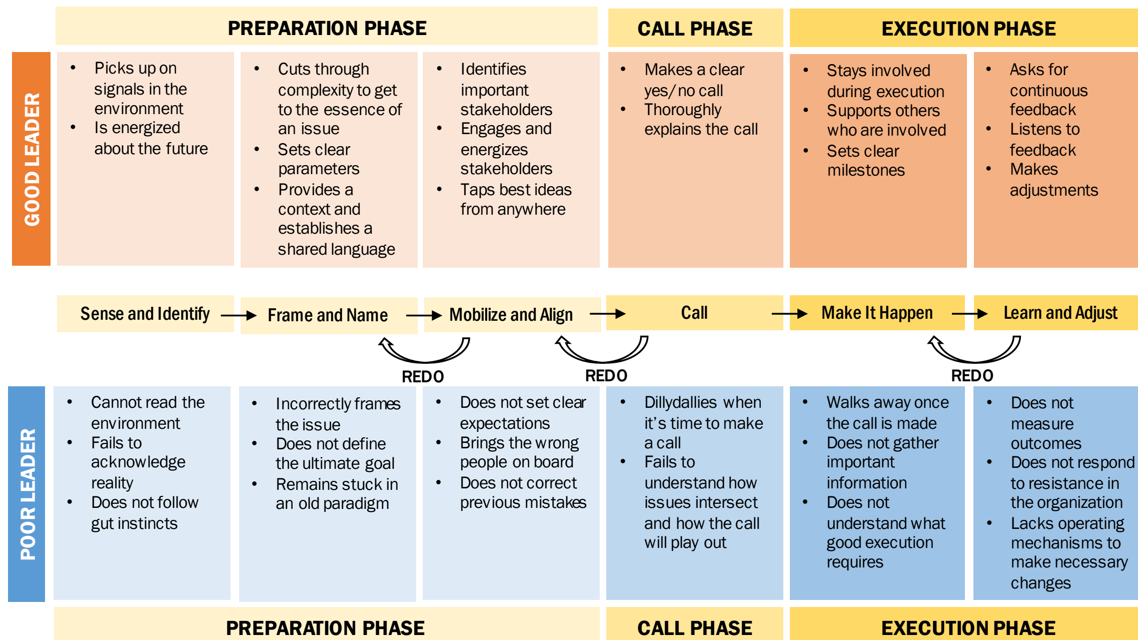
1. **How is your performance and your performance credibility?** Of course, you have to deliver results, but you are unlikely to do so if you have not developed performance forecasts for the next *eight* quarters, not just the usual four. You should have ideas now for changes you may have to make six to eight quarters out.
2. **Are you focused on the basics of execution?** You should feel connected to the flow of information about your company and its markets, including having regular, direct interaction with customers and frontline employees. In addition, you should follow through on all major commitments from your direct reports, and listen to the inner voice telling you whether these things are going well or badly.
3. **Is bad news coming to you regularly?** Every company, even the most successful, has bad news, usually lots of it. If you are not hearing any bad news, you may be letting trouble build. Any information you get should force you to take competitors seriously.
4. **Is your board doing what it should?** The board should be evaluating you and your direct reports, asking for information about your markets, and demanding a succession plan. (Roughly 80 percent of boards fail to get succession right.) But the board should not be executing strategy (which is your job) or trying to manage operations.
5. **Is your own team discontented?** Top subordinates often start bailing out before a CEO goes down.



CEO failures almost always stem from poor performance, yet too often CEOs are not held accountable for their performance. Even those that end up losing their jobs typically receive unbelievably generous financial packages, sometimes worth tens or even hundreds of millions of dollars. Studies of scores of CEOs, both successful and otherwise, have found eight qualities that characterize the best performers:

- **Integrity, maturity, and energy**: These are the foundation on which everything else is built. All stakeholders must believe in the strategies and the numbers.
- **Business acumen**: The best CEOs have a deep understanding of the business and a strong profit orientation, including an almost instinctive feel for how the company makes money.
- **People acumen**: Great CEOs are effective in judging, leading teams, growing and coaching people, and cutting losses when necessary.
- **Organization acumen**: Effective CEOs engender trust, share information, and listen expertly. They understand whether the organization is performing at full potential and delivering on its commitments. They are able to change—not just run—the business, and are both decisive and incisive.
- **Curiosity, intellectual capacity, and a global mindset**: The best CEOs are externally oriented, hungry for knowledge of the world, and adept at connecting developments and spotting patterns.
- **Superior judgment**: The top CEOs consistently demonstrate sound judgment.
- **Insatiable appetite**: The best CEOs are never satisfied, always striving for additional accomplishments and better results.
- **Powerful motivation**: Effective CEOs constantly strive to grow and convert learning into practice.

Exhibit 2: Leadership Judgment Process



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Leadership Judgment Process and Leadership Development

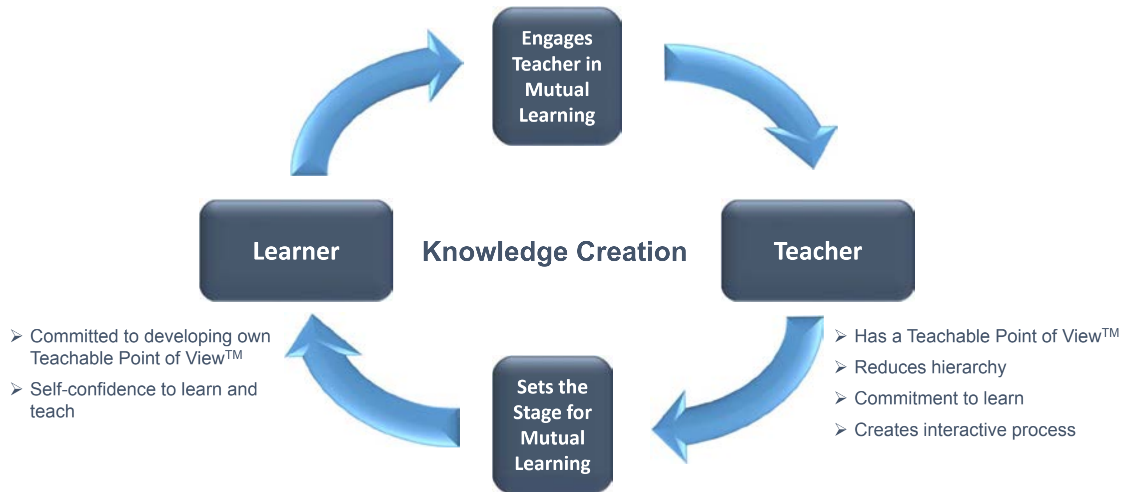
Transformational leaders constantly show good judgment, and doing so is no accident. Rather, it is the result of a deliberate process that begins with sensing and identifying the need for a judgment. **Exhibit 2** illustrates how this process works, both for good leaders and for poor leaders.

> "Leaders cannot develop unless they are taken out of their comfort zone."
>
> —*Noel M. Tichy*

Transformational leaders are able to operate effectively outside their natural comfort zone, control their own destiny, and willingly accept criticism and the fact that some people inevitably will "hate" them. Most importantly, transformational leaders are able to develop others into effective leaders, using a virtual teaching cycle (as depicted in **Exhibit 3** on the following page). To do so, they must do the following:

- **Have a teachable point of view**: Transformational leaders have personalized, teachable views on leadership, growing the business, and creating change.
- **Spend the requisite time**: These leaders commit one-half to one-third of their time to developing others.
- **Be a vulnerable role model and coach**: Transformational leaders are open to new ideas and feedback and can admit mistakes.
- **Create a learning program with real business projects**: Transformational leaders put people to work on real business projects that matter.
- **Blend the soft and the hard**: Transformational leaders effectively deal with people and business issues at the same time.
- **Energize others as they learn**: Transformational leaders create an emotionally engaging process that encourages participants to take risks and learn from their experiences.

Exhibit 3: The Cycle of Leadership



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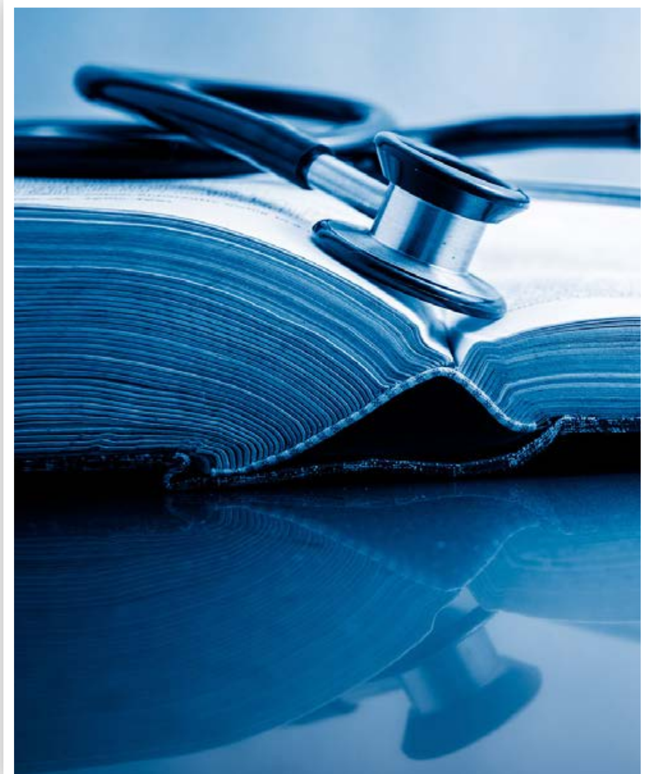
"I Messed Up Healthcare in America (Put Your Name Here)" and "I'm Fixing Healthcare in My Community (Put Your Name Here)"

Stephen K. Klasko, M.D., M.B.A., President and CEO of Thomas Jefferson University & Jefferson Health, and Anne B. Docimo, M.D., M.B.A., Chief Medical Officer of Jefferson Health System, discussed the problems facing the healthcare system in America and how Jefferson Health is trying to fix them.

All key stakeholders have contributed to the creation of today's complex, inefficient, inequitable healthcare system, including patients, drug companies, caregivers, payers, clinicians, policymakers, manufacturers, administrators, information technology (IT) vendors, and academic leaders. At a time of rapid scientific change, the pace of system change has been shockingly slow: the issues that dominated the discussion 40 years ago—spiraling costs, the need to change fee-for-service (FFS) payment systems, and how to measure outcomes—still dominate the conversation today.

To truly address these issues, healthcare needs substantial disruption, led by the industry itself. Over the next 10 years, healthcare stakeholders need to take accountability for controlling costs, ending FFS medicine, and measuring and improving quality. Bottom line: to do so, they need to start acting as leaders instead of followers in creating consumer-oriented organizations.

Beginning in September 2013, Jefferson Health started on this journey. Up until this time, Jefferson was a large, urban academic medical center (AMC) that, for the most part, pursued traditional AMC strategies. A $1.5-billion organization, Jefferson faced declining revenues and did not act while many other organizations in the area merged. In 2013, Jefferson's trustees and new leaders responded by launching an effort to build a new care delivery model that makes the existing one obsolete.



Revised Mission and Vision Statements

As part of its transformation process, Jefferson created revised mission and vision statements:

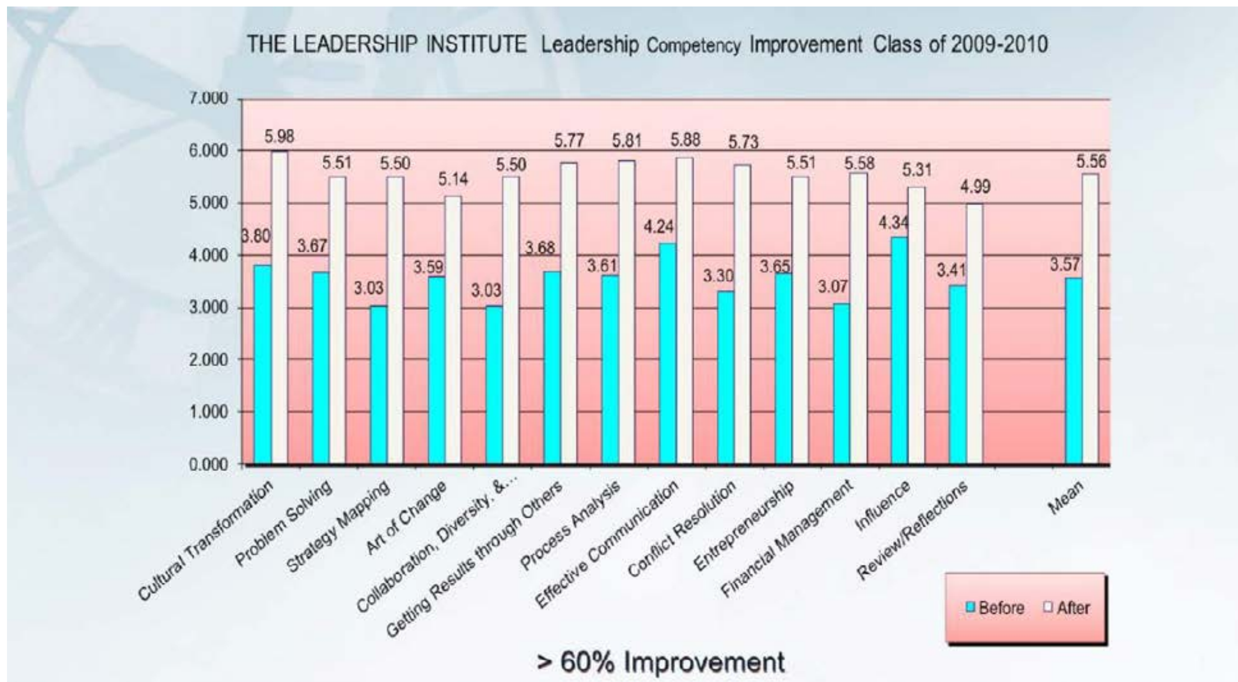
- ***Mission:*** "Health is all we do."
- ***Vision:*** "We will reimagine health, health education, and discovery to create unparalleled value and to be the most trusted healthcare partner."

Revamping Medical Education

The effort started with a fundamental revamping of medical education, beginning with the selection process used for applicants to Jefferson's medical school. Rather than choosing based solely on grade point averages (GPAs) in science classes and Medical College Admission Test (MCAT) scores, Jefferson began using these criteria only as a way to narrow down the applicant pool. Among those who meet minimum thresholds for GPA and MCAT scores, Jefferson chooses based on the candidate's level of emotional intelligence, which serves as a means of gauging how well would-be applicants will do in working as part of multidisciplinary care delivery teams, which will include members of "emerging" health professions. The thinking behind this approach is simple—since the future of healthcare will demand this type of care delivery, those with the emotional intelligence to work effectively as part of these teams will be most successful as doctors. Jefferson's approach is modeled after that of Southwest Airlines, which used to choose pilots based only on quantitative scores but now chooses based on how pilots respond to various emergency situations in a cockpit simulator.

The second step in revamping medical education focused on changing the curriculum. The goal was to stop saddling new physicians with the traditional biases taught in medical school, including a competitive bias that teaches a winner-take-all-mentality, an emphasis on autonomy that leads to a lack of trust in others, a hierarchy bias that teaches students about a natural pecking order where doctors are in charge, and a creativity bias that emphasizes the need to be risk averse and avoid out-of-the-box thinking. Because most physicians came from a system that preaches the virtues of autonomy, competition, and hierarchy, it is no wonder they resist the changes that need to take place. Surveys show that 70 percent of physicians who have been practicing medicine for three years or less feel

Exhibit 4: Major Competency Improvement Measures of Success



that medical school did not teach them what they most need to know to be successful, including how to do the following:

- Manage change
- Negotiate and communicate effectively
- Make patients happy
- Function effectively within a larger organization
- Run an effective meeting
- Be a leader
- Market their practices

To address this issue, Jefferson has completely revamped its medical school curriculum. The new curriculum focuses on four distinct areas: learning to work in a health system, cultural competence, leadership, and eliminating health disparities. In an effort to produce creative physicians, Jefferson has partnered with Princeton University to provide guaranteed admission to high-performing undergraduates in the fields of design and engineering.

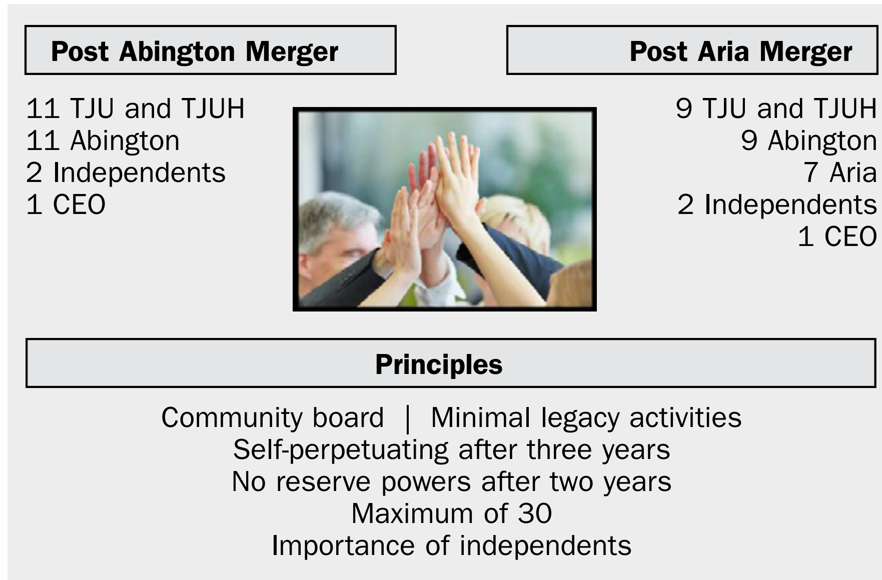
Jefferson's efforts to revamp education go beyond training new physicians. With support from a large grant, Jefferson created the Institute for Emerging Health Professions, which focuses on jobs that are just coming into the healthcare field, including positions related to telehealth, genomics, forensics, and other cutting-edge technologies.

Developing Leaders from Ranks of Existing Physicians

Revamping medical school education is a necessary, but not sufficient, step in transforming Jefferson, as it does nothing to change attitudes and behaviors among those already working in the system. In any healthcare organization, roughly 20 percent of doctors "get it"—that is, they understand and accept the need for transformation. About 15 percent will never get it, while 65 percent—the "silent majority"—will listen to and consider the calls for change but do not openly talk about these issues. Most health system leaders spend the vast majority of their time on those who get it and those who never will, while spending very little time trying to persuade the silent majority. Yet these are the doctors who can change the organization.

To address this problem, Jefferson created the Physician Leadership Institute, a separate company that offers an 18-month program to physicians interested in becoming leaders. The program features a formal nomination and acceptance process and requires a bilateral commitment between the physician and organization, complete with a written contract and payment to the physician for his/her time. The program features a formal graduation ceremony (complete with diploma) and also includes post-course mentoring and follow-up support. Would-be physician leaders learn about the delivery of comprehensive, quality care from the perspective of the patient, with an emphasis on the following topics: communication, continuity of service, customer service, healthcare management, empathy, leadership, mutual support, process efficiency, safety, situation monitoring, and teamwork. As depicted in **Exhibit 4**, those who completed this program in 2009–2010 have markedly increased their performance on a variety of objective parameters. After offering this course, moreover, the proportion of physicians who "get it" jumped from 20 to roughly 35 percent, while the silent majority fell by a comparable 45 percent

Exhibit 5: Board Members



Transforming the Delivery System

Like Blockbuster Video, AMCs have historically been too focused on brick and mortar rather than the actual service being delivered. This strategy has left them vulnerable to competition, much as competition from Netflix ultimately led to the demise of Blockbuster. Reed Hastings, CEO of Netflix, recognized that he was in the entertainment business, and that customers very much preferred having entertainment delivered to them in the mail and via online streaming to making trips to the store and paying late fees.

Similarly, most patients prefer local community settings and virtual care to traveling to an inconvenient, difficult-to-navigate, expensive AMC that generally does not offer better quality for most routine care. With payers and patients having a financial incentive to reduce costs, volume is shifting away from AMCs.

> "If you need a transplant, then come to an AMC. But if you need a hernia repair, you'd be nuts to go to one. You'll pay three times as much for care that can be done just as well if not better in a community hospital."
>
> *—Stephen K. Klasko, M.D., M.B.A.*

As an AMC, Jefferson has historically relied on four "pillars" to support the organization—academic medicine, clinical care, philanthropy, and innovation. The first two, however, represent the old model; a traditional strategy that threatens AMCs that are dependent on tuition, NIH grants, and FFS medicine. Nationally, NIH funding has flattened and inpatient revenues depend on new types of contracting. While many AMCs try to adapt to these trends by charging higher tuition and prices, and/or by reducing expenses through layoffs or pay cuts, Jefferson has chosen instead to invest in innovation and philanthropy as two new pillars. To that end, Jefferson created a regional health system by merging with two other area systems. The goal is not to feed referrals to the expensive downtown hospital, but rather to create a true community-based system that brings care to the patient. To make that work, Jefferson transitioned from a 57-member board dominated by AMC interests to a new board with near-equal representation from each of the three organizations that have come together. As shown in **Exhibit 5**, the new board has adopted several principles, including limiting board membership to 30 and focusing on the community rather than the parochial interests of various stakeholders.

As a result of these changes, Jefferson's financial future doesn't depend on new NIH money, FFS profits, or tuition increases. In fact, leaders have abandoned all plans for new inpatient beds. Rather, the focus is on creating an innovation-driven ecosystem for healthcare and an enhanced consumer experience. Most of the work has centered on redesigning services to make them better and more convenient for patients.

As depicted in **Exhibit 6** (on the following page), patients now expect healthcare to be part of the "consumer revolution," with liberal use of personalized technology to make scheduling and receiving care more convenient.

To meet these expectations, Jefferson created JEFF NOW®, which provides patients with instant access to a live representative and allows them to schedule care online. Jefferson also began virtual rounds, which allow family members to participate in daily rounding and discharge meetings from anywhere

Exhibit 6: Patients Expect Healthcare to Act as a Consumer Sport.

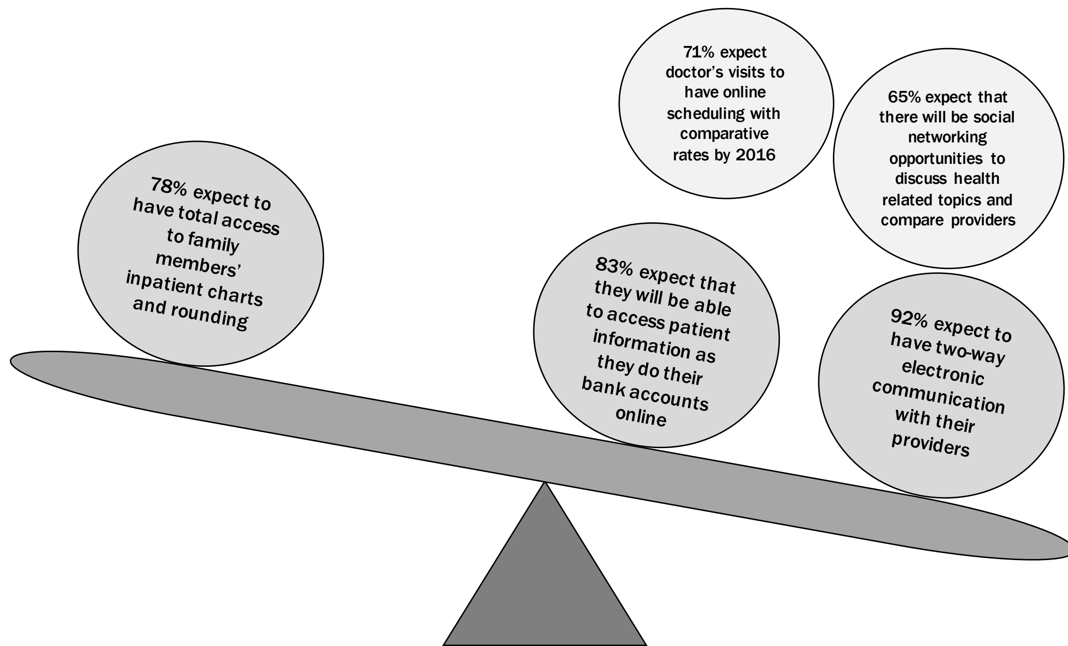


Exhibit 7: JeffConnect: Circle of Life

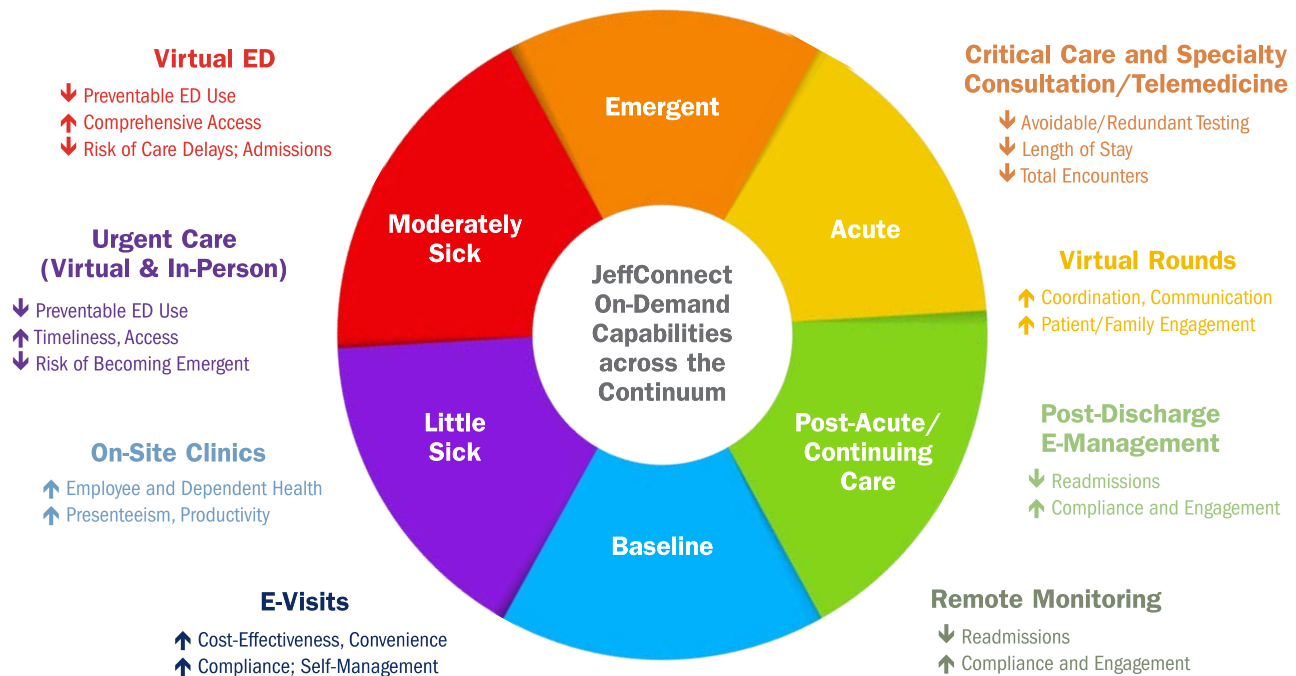
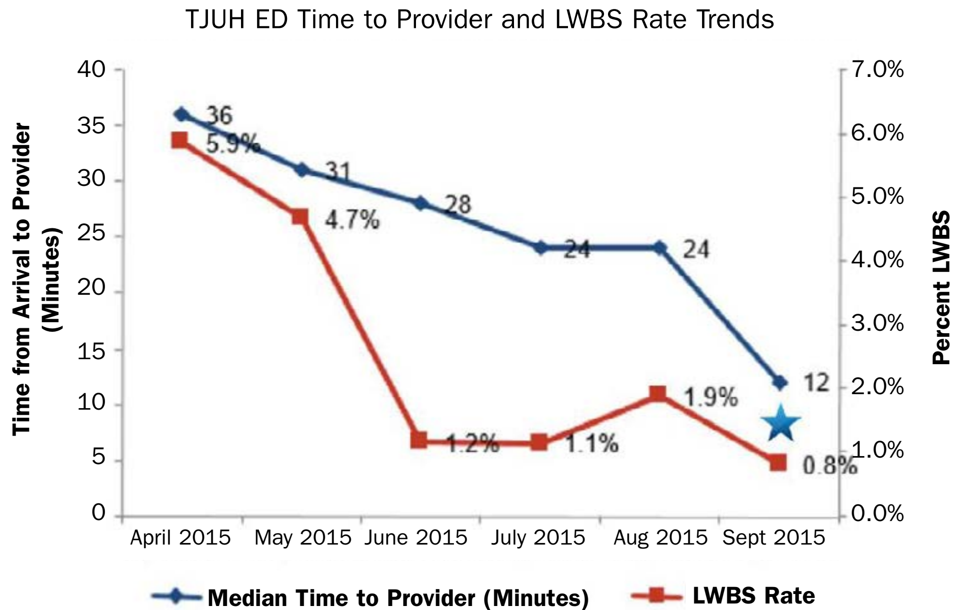


Exhibit 8: Improving Acccess and Care in an Urban, Academic Emergency Department



in the world. Finally, through the JeffConnect app, patients regularly receive care via virtual visits (see **Exhibit 7**).

These initiatives not only result in more satisfied patients and family members, but also help Jefferson with the transition to a fee-for-value model, as length of stay and readmissions are declining. Recognizing the importance of privacy issues related to delivery of this type of care, Jefferson has embarked on a partnership with the University of Delaware to evaluate encryption technologies that will be needed to allow for the continuation of clinical research without invading privacy.

Moving forward, the next frontier will include use of wearable devices that send data to providers for patients with chronic diseases and the use of drones to deliver medications to patients in remote areas. In addition, Jefferson recently launched a new initiative called CHESS (Center for Healthcare Entrepreneurship and Scientific Solutions), which uses predictive analytics and mathematical modeling to reduce uncertainty in medicine. The goal is to find out what really needs to change with respect to patient behavior and environment to reduce risks. For example, early work with congestive heart failure patients has shown the importance of adherence to appropriate diet after discharge. To address this problem, Jefferson is testing programs where the health system provides all food the patient should eat during the first three months after discharge and uses a hospitalist to be involved in post-discharge care. Early results are promising, including a 50 percent decline in readmissions during the first year.

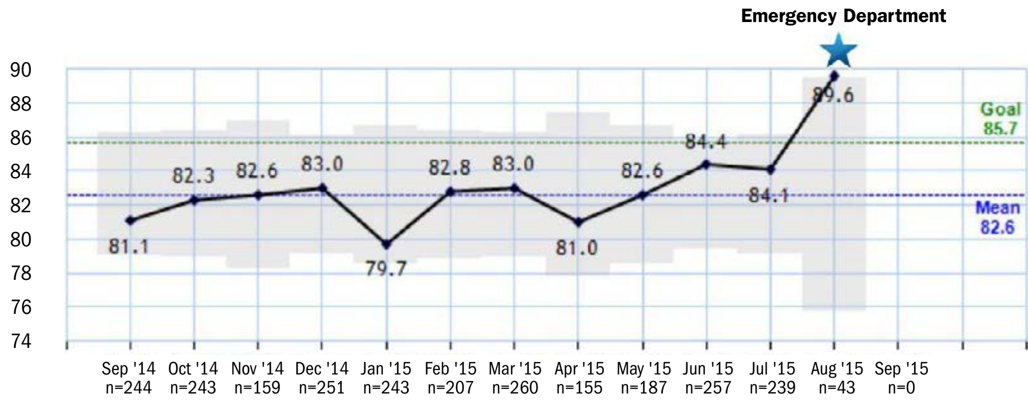
Revamping Data Systems

Like virtually all AMCs, Jefferson found that its data systems generally did not produce meaningful, actionable, and timely information. In response, Jefferson invested in new systems and uses the data to drive efforts to redesign care delivery, manage population health, and transition to personalized medicine.

Redesigning Care

Without such information, it becomes nearly impossible to redesign care delivery. After some initial skepticism that a new approach was even possible, teams have been able to use data to evaluate and improve processes. For example, one team assessed every process that occurs in the emergency department (ED), including who owns each process. Made up of nurses, housekeepers, physicians, and other key stakeholders, this group is redesigning the ED care flow process to make it more patient-centered. Part of this work involved creation of real-time ED "dashboards" for both administrators and frontline providers. Pulling together information from roughly half a dozen IT platforms, this dashboard provides actionable, contextual, layered information that drives real-time improvements in care. For example, the system will alert staff when wait times to see an intake physician exceed six minutes. This alert triggers another physician to come in to conduct ED intake, a process that continues until the wait time dips below four minutes. The dashboard also produces alerts whenever a patient leaves without being seen, an event that everyone considers unacceptable. As a result, the average wait time to see

Exhibit 9: Overall, Mean Trends



*August 2015—Preliminary Data; by date of service

Exhibit 10: Data Sources for Risk Analysis

an ED physician and the proportion of patients leaving without being seen have fallen significantly, while patient satisfaction scores have jumped meaningfully. (See **Exhibits 8** and **9** for more details.) The same approach is now being adopted throughout the system, including by inpatient units that are using it to boost throughput and reduce costs.

Managing Population Health

Jefferson is using data to move from a system that provides fragmented care (where patients routinely move from specialist to specialist) to truly managing population health. Investing in analytics and care coordination resources normally used by payers (see **Exhibit 10**), Jefferson is positioning itself to manage risk successfully by improving quality and reducing costs. As a co-owner of the Delaware Valley Accountable Care Organization, Jefferson will be part of a consortium managing approximately 100,000 Medicare lives by the end of 2016.

The key to success is to create actionable, patient-specific data for those with complex health needs so that care coordinators, physicians, and others can reach out in a timely manner to help them better manage their health. The focus is on the 5 percent of patients responsible for approximately 40 percent of costs. Reducing their costs by 15 percent could reduce overall costs by 6 percent, more than enough to pay for all the expenses associated with new infrastructure and network-building.

As an example of how this approach can work, Jefferson identified a 66-year old woman with a variety of medical and socioeconomic issues that had led to many ED visits and hospitalizations over the past year. Jefferson sent a pharmacist and care coordinator to her house to review medications, and partnered with a local pharmacy to create "punch sheets" to hold all her medications so that she could more easily take them each day. Jefferson also provided an electronic hospital bed for her home, had healthy food delivered to her house, provided regular transportation to dialysis appointments and diabetic management classes, paid for regular home visits by a pharmacist, and sent out appointment reminders. This approach will likely eliminate the need for multiple ED visits and hospitalizations each year, which will more than pay for all the support being provided and dramatically improve the woman's quality of life.

Transitioning to Personalized Medicine

Going forward, the transition to population health will evolve to personalized medicine, with population health data being used to create personalized care plans for individual patients. Through this approach, patients will receive the optimal treatment for their situation, such as the best hypertension drug for patients with a particular genetic make-up. This approach will require data scientists and informaticists to figure out the best approaches, but still rely on providers to help patients navigate the care and IT systems. Jefferson's work in the area of emerging health professions will play an important role in successfully transitioning to personalized medicine.

From Volume to Value: Charting a Course for Surgery

Darrell A. Campbell Jr., M.D., FACS, serves as Henry King Ransom Professor of Surgery at the University of Michigan Health System, Director of the Michigan Surgical Quality Collaborative (MSQC), and previously served as Chief Medical Officer for the organization. Dr. Campbell spoke about a disruptive approach being taken by hospitals in Michigan to react to the major changes in payment for surgical care that will begin in 2019.

For the past 15 years, hospitals in Michigan have been proactively working with Blue Cross Blue Shield of Michigan (BCBSM) on MSQC, a collaborative effort designed to define quality, cost, and value for surgical care and integrate surgery with other areas of medicine in ways that make sense to the patient. For the 73 participating hospitals, MSQC represents a strategy for leading change on the way care is measured, delivered, and financed. Rather than letting government make these changes for the industry, MSQC is taking the lead in an attempt to both be a good partner and to preserve the essential features of the surgical discipline.

Impending Payment Reform

For the past 12 years, Congress has intervened so that physicians do not absorb a significant cut in payments that stems from the "sustainable growth rate" or SGR provision of legislation that ties Medicare part B payments to growth in gross domestic product. As part of the *Medicare Provider Payment Modernization Act of 2014*, the tie between $214 billion in physician payments and SGR has been severed. However, this same legislation establishes a transition period for payments to physicians, from FFS to value-based reimbursement. The act calls for 30 percent of Medicare part B payments to be tied directly to quality or value through various alternative payment models by 2016, and for 50 percent of payments to be tied to these models by 2018.

Under this plan, fee-for-value payments tie reimbursement to various activities, such as meeting meaningful use requirements, participating in the Physician Quality Reporting System, and using patient registries. During this transition period, the proportion of Medicare payments tied to FFS reimbursement declines, but FFS unit payment levels continue to increase modestly, by roughly 1 to 2 percent per year until 2019. After 2019, however, there are no more FFS-based payments. At that point, Medicare will require that providers have a certain, yet-to-be-defined proportion of their patients in value-based alternative payment models, including accountable care organizations (ACOs), bundled payments, patient-centered medical homes, and/or full capitation for a population of patients.

Not surprisingly, private sector leaders have followed Medicare's lead. In fact, as part of the Health Care Transformation Task Force, a group of large healthcare employers (including provider systems and insurers) have committed to putting 75 percent of their payments into value-based arrangements by 2020. These arrangements are defined as payment models that "successfully incentivize and hold providers accountable for the quality of care, patient experience, and total cost for a population of patients, either across an entire population over the course of a year (an ACO) or a defined episode that spans multiple sites of care (an episode-based bundle)."

MSQC: Taking the Lead in Defining Quality

The $214 billion question, however, is how will government define "quality" when it comes to reimbursement. Sylvia Burwell, Secretary of the Department of Health and Human Services, has offered some guidance on the issue, noting that Medicare will be testing new payment models that reward value (quality divided by cost), changes in care delivery (e.g., more coordination, population health management), and increased use of health IT.

Rather than letting the government take the lead, clinicians need to consider being the ones who define and measure quality through the development and use of high-reliability measures that answer important questions and measure well-defined outcomes with high specificity and sensitivity. Launched in 2005, MSQC is a group of 73 hospitals that are doing just that. Through MSQC, BCBSM pays for an experienced nurse at each hospital to collect various data and send it to a third-party administrative center run by Arbor Metrix. BCBSM does not receive any of the information, and no hospital-specific data are available to any other stakeholder. Each hospital

Exhibit 11: Data-Sharing Process between MSQC & BCBSM

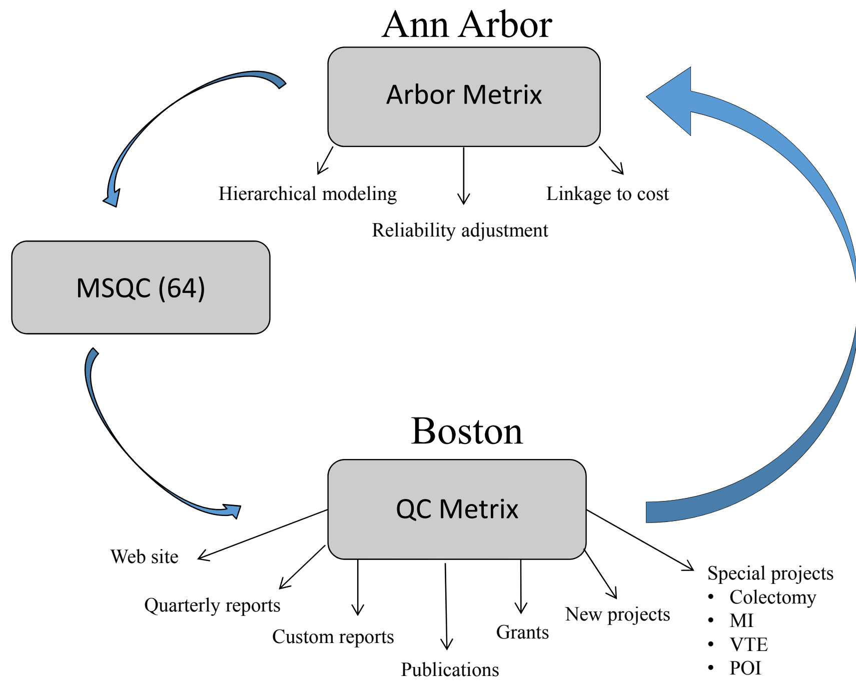


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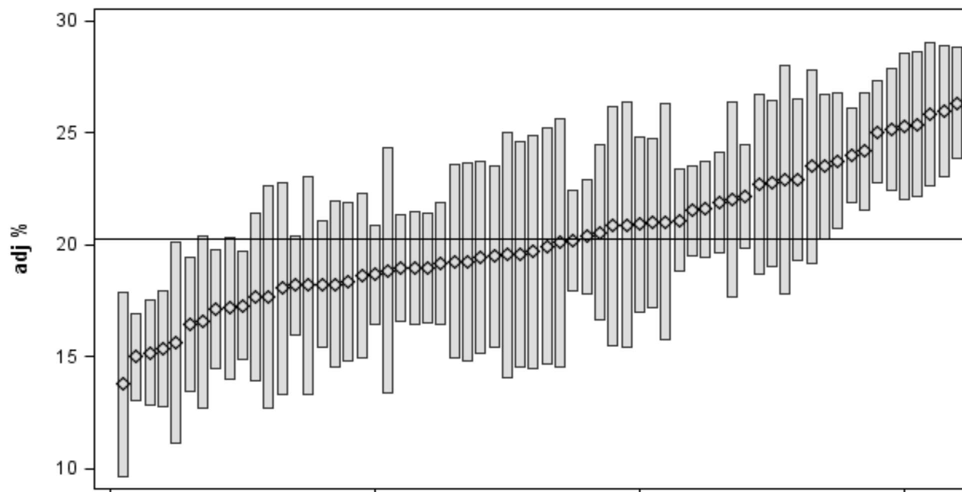
Exhibit 12: Elective Colectomy in Michigan

Any morbidity

Non-emergent colectomy*, MSQC 2008–2014



*CPT codes 44140, 44204, 44208, 44141, 44143, 44144, 44146, 44206, 44145, 44147, 44160, 44205, 44150, 44151, 44210, 44155, 44156, 44157, 44158, 44211, 44212.

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receives a report showing its performance versus a group of peers. (See **Exhibit 11** for more details on how this process works.)

Participating hospitals have developed and forged consensus on standard definitions for comorbidities and complications, a common methodology for risk adjustment, and a standard 30-day endpoint. In addition to having experienced nurses collecting data at each hospital, MSQC staff members conduct periodic site visits to participating hospitals and regularly audit results and conduct tests to ensure inter-rater reliability. To date, over 400,000 general, vascular, and gynecological surgery cases have been evaluated, with approximately 124 variables being assessed for each case.

Case Example: Developing a Colectomy Bundle

Colectomy is a common surgical procedure characterized by rapidly changing technique and a high incidence of complications. MSQC hospitals collaboratively developed a list of 22 common post-surgical complications and analyzed how frequently they occur within the first 30 days after the procedure. As shown in **Exhibit 12**, the percentage of patients who had at least one of these complications varies greatly across hospitals, even after risk adjustments designed to account for patient severity of illness.

This type of comparative data assists hospitals and clinicians in understanding where they stand versus peers, and helps them figure out what the good performers are doing. More detailed analysis of individual complications shows similar results; for example, incidence of surgical site infections (SSIs) ranges from 4 to 20 percent, while incidence of pneumonia ranges from below 1 percent to roughly 6 percent.

Defining and Measuring Quality

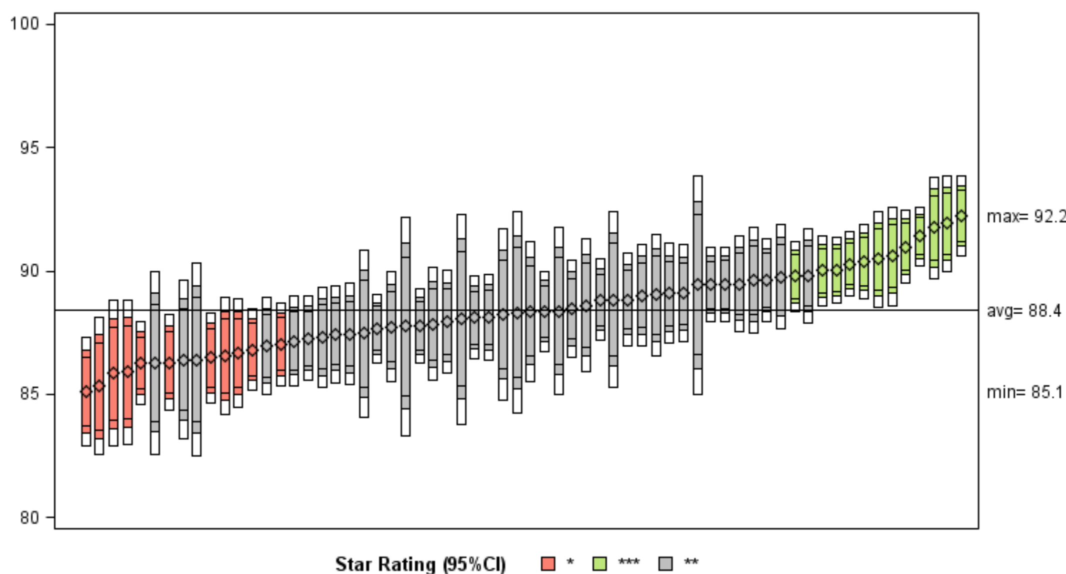
MSQC leaders asked surgeons in the field how they would measure the quality of care for patients undergoing an elective colectomy. They came up with a composite score based on five domains of quality: mortality avoidance (a binary measure), morbidity avoidance (with 21 components), anastomotic leak avoidance (a binary measure), a six-component bundle related to SSIs, and a four-component bundle related to utilization. As shown in **Exhibit 13**, wide variation exists across hospitals on this composite measure, with statistically significant outliers at both ends of the performance spectrum.

To reduce this variation, MSQC developed a surgical registry to examine variations in quality in more detail. This step led to the identification of the best-performing hospitals. Through site visits and other analysis, MSQC identified best practices used by these hospitals and distributed information on them through quarterly meetings that featured panel discussions focused on specific procedures. This approach led to a significant reduction in the infection rate, from 12 percent in 2008 to below 7 percent today. BCBSM is very satisfied with these results and hence has never asked MSQC for information on which hospitals are in fact the best performers.

Exhibit 13: Colectomy Composite Score*(Weighted Domains)

Average with 90%, 95%, and 99% CIs by Hospital and Star Rating**

Elective Colectomy*, MSQC 2012–2014 (64 hospitals, 4,180 cases)**



*This measure scores 1 point for each of six domains: A) MORTALITY AVOIDANCE, B) MORBIDITY AVOIDANCE, C) ANASTOMOTIC LEAK AVOIDANCE, D) SSI COLECTOMY BUNDLE and E) UTILIZATION.

**Star rating is based on statistical significance indicated by confidence intervals that do not overlap the overall average.

***CPT code in 44140, 44160, 44204, 44205

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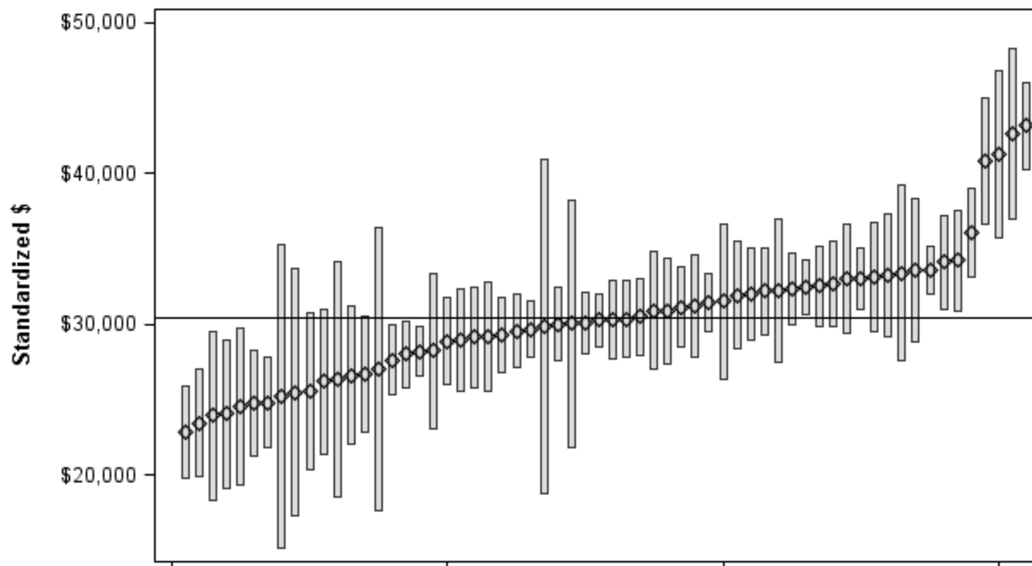
Exhibit 14: Total Episode Payment by Hospital

Colectomy, BCBSM, and Medicare Payer, MSQC 2009–2014



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Defining and Measuring Costs of Care

Medicare pays for a 90-day care episode for elective colectomy that includes the surgeon's fee, anesthesia, consults, hospital readmissions, return ED visits, and admissions to skilled nursing facilities. It excludes disproportionate share and graduate medical education payment and pharmacy costs. As shown in **Exhibit 14**, wide variations exist in total payments by BCBSM to MSQC hospitals, ranging from under $20,000 to well over $40,000. These data are risk-adjusted, which means that higher-cost hospitals cannot legitimately claim that their patients are sicker.

Measuring Value

High-cost hospitals often claim that they offer better quality than their lower-cost competition and hence are worth the extra money. To test this theory, MSQC developed a composite value score that links risk-adjusted quality composite scores to total episode payments. As shown in **Exhibit 15**, wide variation exists with respect to this measure of value, with some hospitals clearly standing out as outliers on both ends of the performance spectrum.

To test the hypothesis that it costs more to deliver high-quality care, MSQC graphed the total quality composite score versus the total episode payment. As shown in **Exhibit 16**, this analysis demonstrates an inverse relationship between quality and payment, with the best-performing hospitals receiving lower payments and the worst performers receiving higher ones.

MSQC has done the same type of analyses with hysterectomies, including a review of the appropriateness of the procedures. This work has found that some hospitals perform hysterectomies without pathological evidence to justify them and/or without providing counseling to patients on alternative treatments.

Integrating Surgical Care with Other Disciplines

MSQC is working to integrate surgical care with anesthesia, emergency medicine, and primary care, as detailed below.

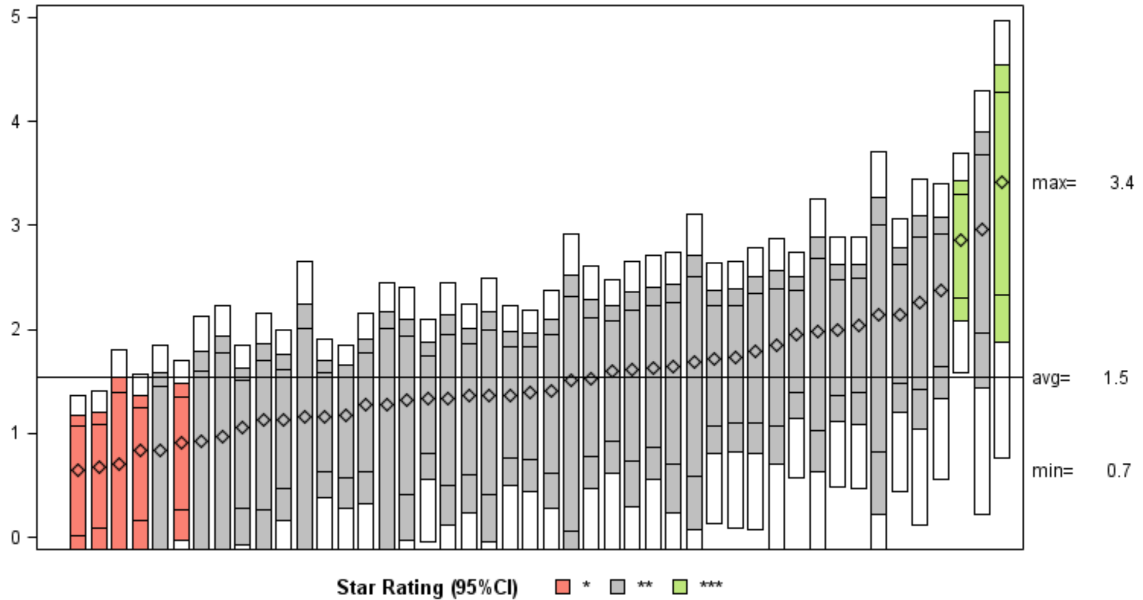
Anesthesia

While anesthesia management profoundly affects surgical outcomes and resource utilization, anesthesia processes remain parochial in nature, with little or no standardization across facilities. Due to limitations with standard chart reviews, MSQC developed a database to extract intra-operative information that can be linked to data on quality, costs, and value. As part of the national Multicenter Perioperative Outcomes Group, MSQC hopes to identify and standardize around best practices in anesthesia management during surgery.

Emergency Medicine

MSQC is also working as part of the Michigan Emergency Department Improvement Collaborative (more commonly

Exhibit 15: Colectomy Composite Score (Value*)



*Defined as composite score divided by total episode payment times 10K for BCBSM Payer.
** Star rating is determined by non-overlap of 95% CIs with the overall average.
***CPT code in 44140, 44160, 44204, 44205.
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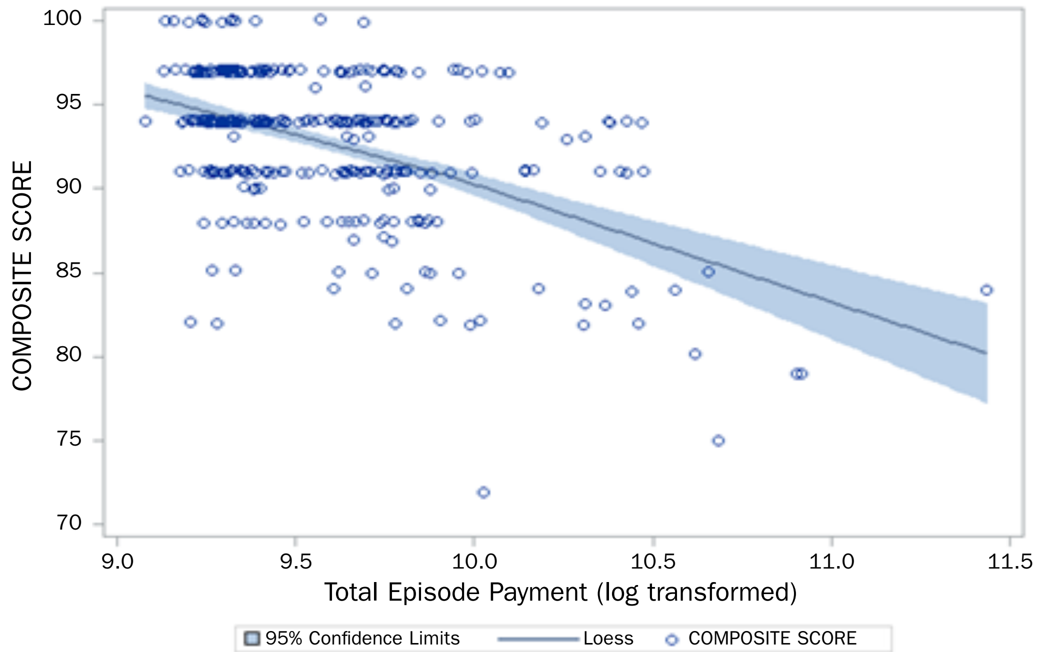
Exhibit 16: Composite Score vs. Total Episode Payment



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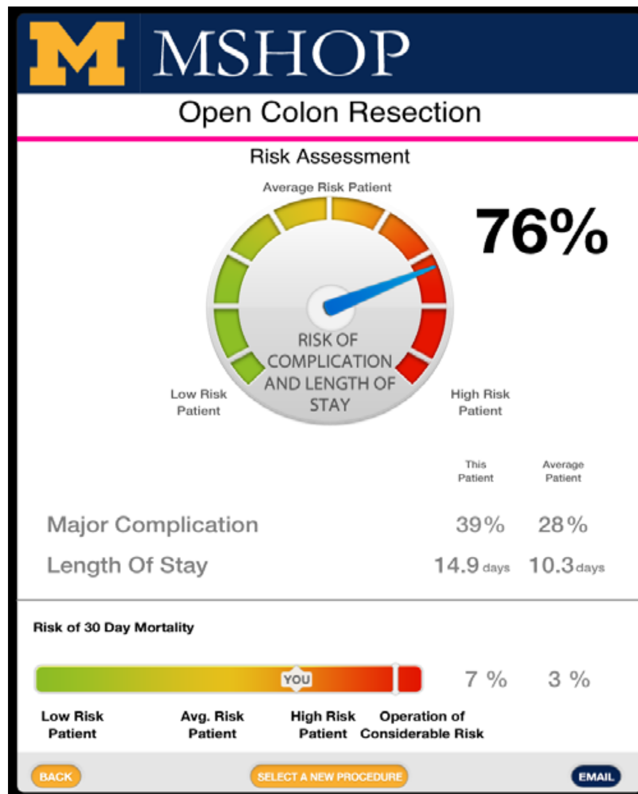
referred to as MEDIC) to identify where surgeons and ED physicians need to work more closely together, such as performing abdominal computed tomography scans on males with right lower quadrant pain, working up suspected pulmonary embolism in post-operative patients, and managing gastrointestinal hemorrhage, lower extremity cellulitis, and suspected surgery-related sepsis.

Primary Care

MSQC is involved in a primary care collaborative known as the Michigan Surgical Home and Optimization Program (MiSHOP). The Centers for Medicare & Medicaid Innovation provided a $6.4 million grant in 2014 to bring this program to 40 MSQC-participating hospitals. MiSHOP focuses on "pre-habilitation"—working with patients to prepare them for surgery during the weeks before an elective procedure. The goal is to have patients in the best possible shape before surgery. To that end, the program works to support and empower patients, including improving ambulation (e.g., by requiring patients to reach 7,000 steps per day before surgery), stopping drinking and smoking, getting chronic conditions such as diabetes and hypertension under control, improving nutrition, and optimizing cardiac function. Patients go through "boot camp" prior to undergoing elective surgery, and the grant will evaluate whether this intervention improves outcomes. To date, patients have reacted very positively to this initiative. As depicted in **Exhibit 17**, it includes online resources that show patients and family members their odds of survival and of major complications and their expected length of stay (versus the "average" patient). This information can be a major motivator for patients to "pre-habilitate" so as to improve their odds of success.

Exhibit 17: Open Colon Resection



Competing at Speed in a Fast-Moving World

Steven J. Spear, D.B.A., M.S., M.S., serves as a Senior Lecturer at the MIT Sloan School of Management, a Senior Fellow at the Institute for Healthcare Improvement, and a Principal at HVE, LLC. Dr. Spear discussed the importance of competing on the basis of speed in today's fast-moving, competitive marketplace. With the fluidity with which information, people, and materials can move, advantage cannot be held by position but instead requires constant maneuver to find and capitalize on opportunities. In particular, he emphasized the need for fast learning through a relentlessness of broad based seeing and solving problems, as organizations that do so reap huge rewards by delivering high-quality products and services to the marketplace faster than the competition. Finally, development and exploitation of a high-speed learning capability cannot be delegated or made episodic, but it has to be a primary responsibility of leadership.

Toyota Motor Corporation

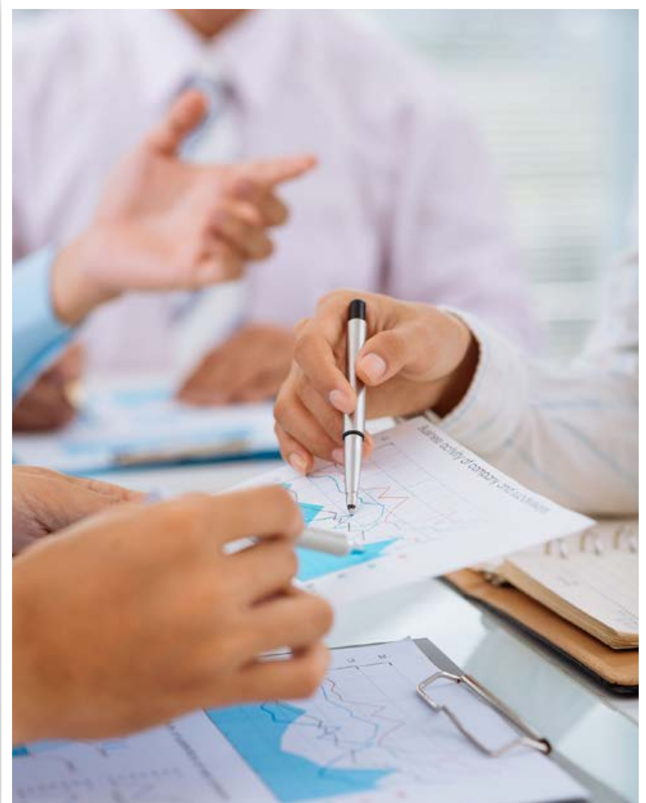
History shows that the most successful and profitable companies deliver value to the marketplace with incredible speed and ease. Perhaps the best example comes from Toyota Motor Corporation, which sells more cars and makes almost three times more profit per vehicle than any other car manufacturer. In its most recent fiscal year, Toyota earned $2,726 per vehicle, versus $994 for Ford, $850 for Fiat Chrysler, and $654 for General Motors (GM).

In the 1980s, Toyota essentially decimated the U.S. auto industry, which has yet to recover. By the mid-1990s, industrial companies throughout the world wanted to be like Toyota. The secret to Toyota's success was its ability to learn faster than other organizations. Few people realize that Toyota first entered the U.S. car market in 1958, with the introduction of the Toyopet, a terrible car that virtually no one bought. Toyota not only produced a lousy car in the 1950s, but did so with terrible inefficiency. In fact, Toyota's productivity at that time was one-eighth of the world standard. Yet just four years later, Toyota's productivity levels equaled the world standard, and by 1968 the company had doubled the world standard. No one in the U.S. knew about Toyota's rapid gains during this period, as they no longer sold cars in the U.S. market. But by the time the oil crisis hit in the 1970s, Toyota was producing incredibly reliable, fuel-efficient cars at much lower cost than any U.S. manufacturer. Toyota subsequently entered the U.S. market with products offering great value. The company also innovated with great speed, coming out with major model upgrades every two years, roughly twice as often as every other automobile manufacturer. As a result, U.S. automaker offerings often did not have much staying power; for example, the Ford Taurus at one point became the best-selling car in the country. But then the Toyota Camry showed up. Over time, new versions of the Camry rendered the Taurus obsolete, to the point that Ford discontinued the model. Between 1985 and 1995, Toyota expanded tremendously, opening plants in the U.S. at the same time that all U.S. automakers were scaling back significantly.

> "Between 1985 and 1995, Toyota thought the car industry was a great business in the U.S.; everyone else didn't."
>
> *—Steven J. Spear, D.B.A., M.S., M.S.*

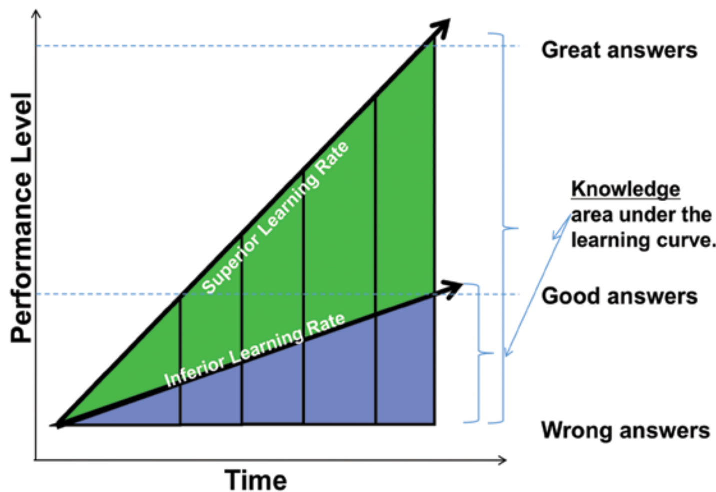
Toyota used the same fast-learning skills when concerns about emissions and fuel economy spawned the development of hybrid cars. During the same period when GM developed one version of the Volt, Toyota created various platforms for multiple hybrid models, selling 7 million units (compared to 70,000 for the Volt).

Toyota's ability to compete on speed does not stem from superior knowledge or proprietary technologies. Rather, it stems in large part from being better and faster at learning. Neither GM nor Toyota knew what the market wanted in terms of lower emissions and greater fuel efficiency. But Toyota quickly answered these questions because it had a superior rate of learning.



> “Everyone thought Toyota had ‘secret tools’ that no one else had. But Toyota used the same equipment and technologies as other companies; it simply learned more quickly than they did.”
>
> —*Steven J. Spear, D.B.A., M.S., M.S.*

Exhibit 18: Competing at Learning Speed



Source: © 2015 Steven J. Spear

The Naval Nuclear Power Program

Hyman G. Rickover was a U.S. Navy Admiral who oversaw the initial development of naval nuclear propulsion and subsequently controlled its operations for three decades. Known as the “Father of the Nuclear Navy,” Admiral Rickover succeeded largely due to his ability to develop and lead a “learning engine” within his organization. His relatively simple approach relied on a few critical capabilities, as detailed below:

- **Predict and test to discover problems**: Admiral Rickover always predicted what was going to happen and then compared those predictions to what actually happened. This process allowed him to identify any problems quickly, including what had gone wrong and why. For example, before leading any meeting, he would anticipate questions that might be asked and think about how to respond. During the meeting, substantive discussion ended up focusing not on these anticipated questions, but rather on “surprise” questions. As a result, meetings often led to new learning, in many cases providing the same new knowledge as several months of outside research and investigation.
- **Adjust to solve problems**: Once problems have been identified, the next step is to make adjustments to address the underlying cause(s).
- **Spread discovery by teaching**: Once solutions have been developed, the next step is to teach them to others so that they are adopted broadly.

The race with the Soviets to develop naval nuclear capabilities was fundamentally a learning race. The U.S. beat the Soviets largely because of Admiral Rickover’s ability to acknowledge and identify problems. To this day, the U.S. enjoys significant advantages over Russia in terms of nuclear capabilities, both for power and on warships.

> “If you don’t raise your hand and acknowledge that there is a problem, you cannot learn…you need to start with the premise that the goal is deliver more value faster than anyone else and that the biggest obstacle to doing so is ignorance. Then the only way to conquer ignorance is to see and solve problems, and then tell people about the solutions.”
>
> —*Steven J. Spear, D.B.A., M.S., M.S.*

Other Examples of Winning through Fast Learning

Many other organizations have succeeded by being faster learners and hence quicker to bring high-value products and services to the market. Examples include the following:

- **Intel**: Intel used leadership-led, nonstop problem identification and solving to save a U.S.-based plant that historically used trailing-edge technology on integrated circuits. With a throughput time of 64 days, the plant was scheduled to be closed. Within a year, throughput fell to 20 days, making the plant the fastest to market in the world. Unit costs fell by half, capacity increased by 25 percent, and yield loss fell significantly. These changes added over $10 million in profits to the company’s bottom line each month. While many other plants just like it closed, this plant remained open for over five additional years. (Competition from overseas manufacturers forced the closure of almost all U.S.-based plants during this period.)
- **Pratt and Whitney**: After losing a series of competitive bids, the company faced the very real prospect of going out of business. Through faster learning, cycle time fell from four to three years, leading to a 50 percent reduction in costly engineering change orders and the winning of several major contracts.
- **Alcoa**: Operating in a commodity business, CEO Paul O’Neill focused on improving worker safety, dropping the on-the-job injury rate from roughly 2 percent to 0.07 percent. This

reduction generated recurring savings of $100 million a year. Mr. O'Neill started by asking a simple question: "Why are we hurting so many of our workers?" The reason was ignorance, as no one really knew what was causing all the injuries. By identifying and addressing the underlying problems, Alcoa became one of the safest places in the world to work, much safer than most if not all hospitals.

- **U.S. Department of the Treasury**: After leaving Alcoa, Mr. O'Neill took the same approach at the Treasury Department, where he oversaw a dramatic reduction in the time it takes to close the government's books—from six months to three days.
- **UPMC (formerly University of Pittsburgh Medical Center)**: Mr. O'Neill also worked with a group of stakeholders in Pittsburgh to help UPMC and other providers improve patient safety by identifying and solving problems and then sharing the solutions. This approach led to a 70 percent reduction in central line infections across the region, with many hospitals reaching zero infections. Similar efforts have led to dramatic reductions in SSIs and in the time it takes for an ED physician to see patients. At UPMC Shadyside, this latter figure fell from two hours to 18 minutes.
- **Local women's shelter**: Historically, an abused woman who called this shelter was told that it would take four days to get her settled into a safe home, in large part because 42 different state and county agencies had to be involved in the process. Not surprisingly, few women could wait this long and hence many did not even bother to call. After identifying and addressing all the roadblocks and delays, the shelter can now get a caller to a safe place in four hours. They also will alert the police and get a restraining order against the abuser during that time. Shelter leaders also provide advice to local police on how to handle domestic abuse situations in order to help women and their children get to a safe place quickly.
- **New England Patriots**: Bill Belichick, coach of the New England Patriots football team, regularly employs Admiral Rickover's predict/test/adjust approach to identify and solve problems. He regularly quizzes his players on what plays other teams run in various situations. He brings in practice-squad players with the same physical abilities as the opponent and has them run these plays so that the team gets to practice against a "virtual" team quite similar to the upcoming opponent. As a result, the Patriots undoubtedly had seen and practiced against the exact play that the Seattle Seahawks ran at the end of the 2015 Super Bowl. Looking at replays of the game-ending interception (which sealed the victory for the Patriots), it becomes apparent that the New England defenders had a strong suspicion of what play the Seahawks were going to run, which was undoubtedly a product of Coach Belichick's approach to game preparation.

> "As leaders, be like Admiral Rickover. Predict what's going to happen. Test what really happened and then figure out what went wrong and why. Make adjustments to fix the problems, and then teach others what you have learned…Admiral Rickover fathered the U.S. nuclear Navy with a very small staff. He had no idea how to invent nuclear power, let alone put it on a warship. All he could do was teach people how to learn to do that…as leaders, we all have to be equally dynamic in teaching our organizations to learn."
>
> *—Steven J. Spear, D.B.A., M.S., M.S.*

Competitive Differentiation through Quality Innovation

This panel discussion focused on how hospitals and health systems can differentiate themselves from the competition by focusing on quality-related innovations. Panelists included: Rita E. Numerof, Ph.D., President of Numerof & Associates, Inc.; Stephen K. Klasko, M.D., M.B.A., President and CEO of Thomas Jefferson University and Jefferson Health System; and Peggy L. Naas, M.D., M.B.A., Chief Medical Officer of Healthcare Performance Improvement, LLC. Zach Griffin, M.B.A., M.H.A., General Manager of The Governance Institute, facilitated the discussion. Key lessons from the panel include the following:

- **Expect a rapid pace of change.** Healthcare is changing at the same rapid pace as the U.S. auto industry did in the 1970s and the in-home video business did over the past decade. To avoid the fate U.S. automakers and Blockbuster Video met, healthcare organizations must be prepared to differentiate themselves from the competition.
- **Prepare for new competitors.** The hospital or health system down the street is no longer the biggest threat. Rather, Walgreens, Wal-Mart, CVS, and other retailers are quickly entering the market, offering better and faster service. Leaders need to spend time talking to and understanding these organizations, including investigating ways to partner effectively with them.
- **Define and monitor real-time quality.** While healthcare is not yet a commodity (with quality of care being assumed), providers need to get better at defining and monitoring quality through use of real-time metrics that incorporate more than just clinical quality, but also safety, access, convenience, service quality, and the patient experience. Quality should be defined from the customer's perspective.
- **Craft a compelling story around specific product lines.** Provider organizations need to articulate a compelling narrative about why customers should come to them for a specific service, highlighting the clinical and economic value of doing so. Rather than making generic, big-picture claims about being the "best", providers should share data and details about how the organization fills a specific need better than the competition, such as managing certain chronic conditions, enhancing wellness, and/or handling specific acute procedures or episodes.
- **Be competitive on costs.** With consumers being asked to pay more out of their own pockets, provider organizations that offer low-cost/high-value care have an advantage. Competition includes freestanding outpatient facilities, retail stores, and even overseas competitors offering packaged prices for surgical procedures. For example, a consumer in Chicago can today fly with his or her spouse to the South Pacific for a knee replacement and pay only a quarter of what it costs at home.
- **Learn to be a learning organization.** As discussed earlier, organizations that can learn quickly will win by delivering high-value services to the market quickly and reliably. Engaging front-line staff in this learning process will be critical to success.
- **Invest in training.** No one likes to do things that are out of their comfort zones. Provider organizations need to invest in simulation centers and other forms of training to help physicians and other healthcare professionals learn to do things differently than in the past, including working in multidisciplinary teams with emerging health professionals. Simulation centers should also be used to help surgeons learn new technologies (e.g., robotics) and provide additional training to those who experience missteps. Airlines already employ this strategy by requiring pilots who experience bumpy landings to spend additional time in the flight simulator.
- **Pay attention to quality ratings and social media feedback.** Consumers now have access to a wide range of comparative information on the performance of provider organizations and individual physicians, including ratings and social media feedback. Negative anecdotes about an organization can be particularly troubling, as they can spread quickly and often are not accurate. Provider organizations need to invest in staff to monitor and in some cases proactively respond to unwarranted negative feedback.
- **Expect concierge health to grow.** In the U.S., some consumers will always be willing to pay more for extra services. While clinical quality will generally be assumed by consumers, providers will have opportunities to differentiate on the service front.
- **Pay attention to data privacy and security issues.** Provider organizations continue to collect more data to help in managing chronic conditions and population health. Consequently, the risk of threats to the privacy and security of patient-specific information has never been greater. To minimize this risk, providers should consider investing in encryption technologies and even hiring would-be "hackers" to regularly test the security of their IT systems.

Applying The Ritz-Carlton Service Excellence Model to Healthcare

Diana Oreck, CHT, Vice President of The Ritz-Carlton Leadership Center, discussed The Ritz-Carlton service excellence model and how it applies to the healthcare industry.

The Ritz-Carlton Leadership Center

Launched 15 years ago, The Ritz-Carlton Leadership Center came into existence after the company won its second Malcolm Baldrige National Quality Award. This award made The Ritz-Carlton Hotel Company, LLC one of only five two-time winners, and the only two-time winner in the service or hospitality industry. After winning, the company found itself on the receiving end of many inquiries about the "secret sauce" of its success, and hence company leaders decided to open the center. It now functions as a corporate university, assisting organizations in transforming their cultures, leadership, and service. Most of the center's work occurs onsite at client companies, although offsite presentations and workshops are also held. Roughly seven years ago, the leadership center began offering advisory services, largely in response to requests from healthcare clients wanting to understand how to improve HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey scores. Facing the need to focus intensely on the "four Cs" (consumerism, choice, competition, and costs), many healthcare systems came to The Ritz-Carlton looking for help in improving the consumer experience with their organizations.

> "It's not just the 'patient' experience. That's too narrow a definition. It's not about what occurs at the bedside. It's what occurs all the time, and not just with the patient, but with everyone."
>
> *—Diana Oreck, CHT*

Differentiation through a Leadership-Driven Culture of Great Service

Most consumers believe that healthcare providers are competent and trust that they do a good job. Even when they know macro statistics about medical errors and other quality problems, most consumers believe that their own providers provide safe, high-quality care. Moreover, they are often not in a position to judge the clinical quality of care. However, they can see and feel service, and, given a choice of providers, will make comparisons based on service. So while hospitals and other healthcare facilities should never seek to be a hotel, they can differentiate themselves from the competition based on service. The goal should be to "do it all" by offering clinical quality, safety, *and* a great experience.

Health systems and hospitals that come to The Ritz-Carlton Leadership Center go through a 15-month program that focuses on revamping the culture throughout the organization, with courses and design work focused on everyone, from frontline employees to senior leaders. The work must begin with top leaders. In fact, whenever the leadership center gets an inquiry from a healthcare organization, the first step is to meet with the president, CEO, and their direct reports to talk about culture and service strategy, and determine from this meeting whether the top leaders are fully committed to the program.

> "Senior leaders cannot abdicate responsibility for creating a culture of great service."
>
> *—Diana Oreck, CHT*

The People

All organizations have an existing culture. The goal is to leverage that culture to give customers a great experience. That experience begins with the employees and how they treat each other, which should be with dignity and respect. In fact, The Ritz-Carlton "guarantees" its employees a workplace characterized by trust, honesty, respect, integrity, and commitment. The goal is to create associates who are engaged, motivated, and proud, routinely acting like a "raving fan" of the brand. The company recognizes that every employee—from a janitor to the CEO—will at times interface with customers. To do so effectively, no employee should ever have a "just-a" mentality. For example, those who clean rooms or empty the trash should never refer to themselves as "just a" housekeeper or "just a" janitor. Rather, they should consider themselves to be ambassadors for their organization's brand and try to create memorable moments during their interactions with customers.

A culture of great service begins with the organizational mission. Too often, the mission is just a set of words on a piece of paper. To be effective, the mission must tie back to the culture each and every day. The Ritz-Carlton strives to always provide excellent service. The word "always" is critically important, as consistency leads to trust with customers, employees, and their friends and family, which in turn leads to referrals. The Ritz-Carlton Company has both a credo statement and a motto that together serve as the company's mission. The credo states that the hotel is a "place where the genuine care and comfort of

our guests is our highest mission." The accompanying motto is that employees are "Ladies and Gentlemen, serving Ladies and Gentlemen." To make sure that the credo and motto remain front and center, the company makes them a part of employees' daily lives. Three times a day (once for each shift), a staff meeting known as the "daily line-up" occurs during which the credo is read aloud. In addition, each employee has a pocket-sized card that displays the credo as part of his or her uniform.

> "No great company provides excellent service once in a while. You have to provide great service all the time… culture and service are our 'true north.'"
>
> *—Diana Oreck, CHT*

Research shows that three things stand out in people's minds when they think about their experience with an organization—their arrival, their departure, and anything that might have gone wrong in between. The Ritz-Carlton employees are taught to focus on these areas by ensuring that all guests receive a warm and sincere greeting (using the guest's name); that employees regularly seek to anticipate and fulfill each guest's needs; and that guests receive a warm goodbye when they leave, again using his or her name.

The Ritz-Carlton emphasizes 12 distinct service values with its employees. They fall into three different categories (functional, emotional engagement, and mystique), and cover issues such as safety, cleanliness, personal appearance, language, and behavior. For example, employee attire matters a great deal, as customers may think negatively of employees who wear outrageous or distracting attire. Even if that employee does a great job, the attire can ruin the experience for the customer. In healthcare, customers expect certain attire, such as physicians who wear white coats and nurses and other staff who wear solid-colored scrubs. With respect to language, employees typically need significant training on the appropriate words and phrases to use in various situations. They must learn to validate their customer's concerns and emotions, even when they may not believe they are valid or warranted. Phrases such as "it's not my job" or "I have never heard such a thing" should be avoided. Finally, employees must be taught to behave in certain ways while on the job, and to be positive ambassadors of the company's brand while off the job. With the ubiquity of social media in today's world, this behavior extends to anything that might show up in an online video or post that could reflect negatively on the company.

> "The goal is to have our employees live their lives by this culture, 365 days a year. It should not be thought of as what they are supposed to do. Rather, it becomes who they are."
>
> *—Diana Oreck, CHT*

The Service Values at The Ritz-Carlton stem from the company's strategic plan, which employees help to develop each year. While in many companies, employees do not even see the strategic plan, The Ritz-Carlton wants employees to be as aware of it as they are of the company's culture. The plan serves as a way to foster great passion among employees, primarily because it emphasizes the "purpose" of work rather than the "function." Every job has both a "how" and a "why" component. The key is to focus on the "why" so that employees feel motivated and realize that their work makes a difference. For example, a housekeeper's function may be to clean a room, but his or her purpose is to create a "home away from home" for guests. The purpose of a window washer at a children's hospital may be to clean the windows, but if that window washer wears a super hero outfit, then his purpose becomes something much more meaningful: to bring joy and happiness to sick children. Most companies spend too much time talking with employees about how to do their jobs and not about why they are doing it. Yet the "why" creates the emotional hook that engages employees in their work.

> "You have to perform the basics of your business flawlessly. If you don't, you can forget about delighting your customers, as they won't give you the opportunity to do so."
>
> —*Diana Oreck, CHT*

The Physical Plant

Great service is not only about interactions with people, but also about the physical plant and the five senses. Customers pay attention to what they see when they walk into the facility. They notice whether the plants are alive and the bathrooms are clean. Patients and family members in the hospital have plenty of time to observe these things. Their senses will become amplified and their imaginations will run wild if they see, hear, or smell things that suggest anything but top-notch service. Because service is psychological, moreover, any feelings they have become facts in their minds.

The Systems

A culture of service can only take an organization so far without the systems in place to support employees in delivering that service. The first step, of course, comes from choosing the right talent. During the vetting process for any would-be employee, The Ritz-Carlton seeks to understand whether that person has the spirit to serve, a positive attitude, and a strong desire to care for others. Typically, only one out of every 20 candidates is offered a job.

> "Companies should spend 90 percent of their effort on selecting talent and 10 percent on training."
>
> —*Diana Oreck, CHT*

Once hired, The Ritz-Carlton supports its employees through a variety of orientation and training programs, as detailed below:

- **Initial orientation**: The Ritz-Carlton reaches out to employees at least five times during the first year. New hires complete a three-day orientation focused on the culture before they ever interact with guests. These sessions are led by senior leaders at each hotel. The goal is to leave a psychological imprint on each new hire, making him or her literally weep with joy that they have joined the organization.
- **Daily line-up**: As noted, the line-up focuses every employee on the service culture every day.
- **Operational certification at day 21**: After three weeks on the job, employees spend another day in training. At this point, they are generally in a position to ask good questions and hence the training has more meaning than before they started interacting with customers.
- **Anniversary**: Additional support and training occur after one year on the job.

Research shows that in the typical organization, roughly 30 percent of employees are "superstars" who are engaged and committed to their work. Just over half (52 percent) are neutral, showing up for work and doing what is expected (but little more). The remaining 18 percent are disengaged and actively destroy relationships on a daily basis. At The Ritz-Carlton, disengaged employees very quickly get put on a performance plan that lays out achievable milestones for improvement. Employees who do not make meaningful progress toward these milestones are quickly let go, before they can undermine the performance of the superstars. That said, The Ritz-Carlton recognizes that it takes time for new employees to become superstars. During the first four months on the job, most employees are in the "hearing-it" phase with respect to the culture of service quality. After that, they typically migrate to the "believing-it" phase. Only after a year do they reach the "living-it" phase where they internalize the culture on an emotional and personal level and hence become passionate advocates for the organization.

As part of their orientation and training, employees are taught to have their "radar on and antenna up." The goal is to look for clues that customers give on the phone or in person about their personal needs and preferences. For example, if an employee notices that a guest likes to drink Diet Coke, he or

she can note that in the customer's preference card so that all employees can be sure to offer a Diet Coke to that guest when appropriate. Preferences get recorded discreetly in the company's IT systems and employees use this information as they see fit. The goal is not to invade anyone's privacy, but rather to delight guests by anticipating their needs, thus creating a positive memory for them.

> "Our employees seek to be masters and mistresses of anticipation, not to simply offer reactionary service when people ask for it."
>
> *—Diana Oreck, CHT*

Applying the Model to Healthcare

The Ritz-Carlton Leadership Center has successfully worked with many healthcare organizations to enhance employee engagement and customer satisfaction, which in turn has led to financial and other benefits. One example comes from Bon Secours Richmond Health System, which saw employee engagement scores rise from 3.98 to 4.52 over the course of a year. At the system's flagship hospital, employee turnover fell from 25 percent in 2006 to 15 percent in 2009; since that time, the hospital has continued to win employee engagement awards and enjoy low turnover rates. This hospital also improved its financial performance and reduced mortality rates after implementing the model. In fact, the "radar-on, antenna-up" classes made front-line staff more attuned to the needs of patients, to the point that they began recognizing when they were experiencing distress. In several cases, environmental services staff literally saved lives by alerting nurses in a timely manner to patients who appeared to be coding.

Finally, The Ritz-Carlton invests heavily in dealing with guests who experience a problem. Whenever something goes wrong, the affected customer will judge the organization by how the first person responds to the issue. In many organizations, disgruntled customers are shuttled from person to person and forced to repeat the complaint each time. As a result, the problem inevitably escalates and becomes more costly to resolve. To avoid this issue, The Ritz-Carlton empowers every employee to "make it right" with a dissatisfied customer. In fact, each employee has a $2,000 daily allotment to handle dissatisfied customers. The $2,000 figure is largely symbolic, as it almost never costs anywhere near that much to resolve an issue. But the figure has become symbolic to employees, sending a clear signal that the company trusts them to resolve issues without going to a manager.

Moody's Perspective on the Not-for-Profit Healthcare Sector: What Leaders Need to Know about Bond Ratings Now

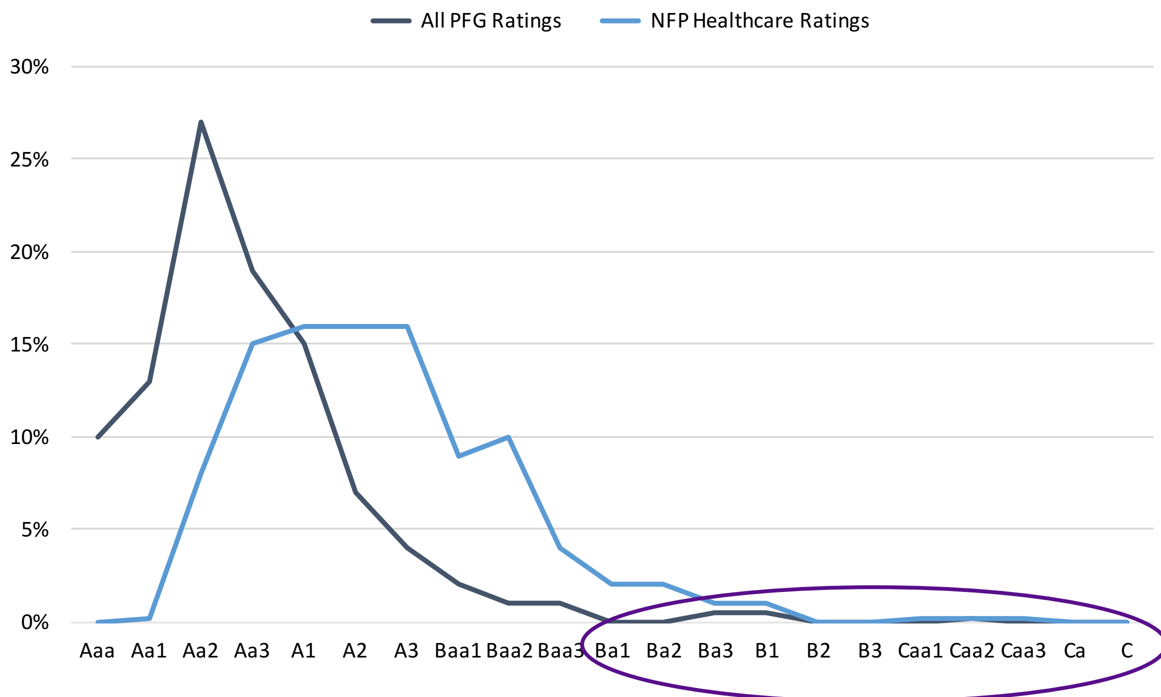
Lisa Goldstein, Associate Managing Director of Not-for-Profit Healthcare Ratings at Moody's Investors Service, provided the rating-agency's perspective on the not-for-profit (NFP) healthcare sector.

Overview

Moody's ratings reflect the capacity and willingness of an organization to meet its obligations. Moody's calculates an expected credit loss, which is the product of the probability of default and the projected loss given a default. Since 1970, 23 rated hospitals have defaulted, either because they could or would not pay their debt obligations.

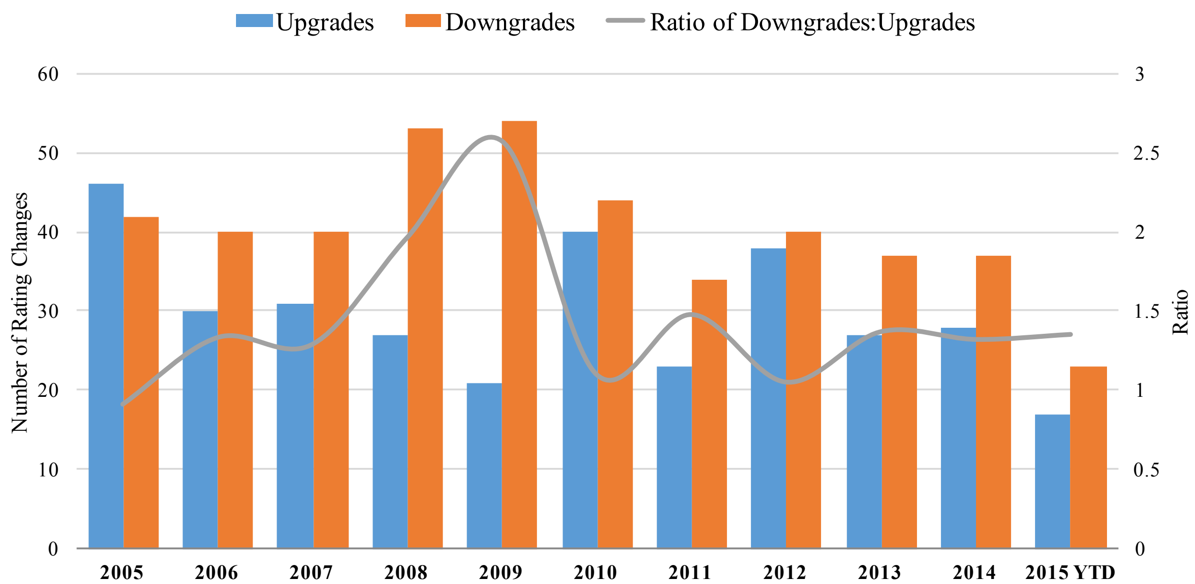
As shown in **Exhibit 19**, the NFP healthcare sector tends to have lower ratings than the public finance sector in general. While 10 percent of all public finance ratings are "Aaa" (meaning virtually no risk of default), there are no Aaa-rated hospitals or health systems (and likely never will be) with unenhanced debt. Because Medicare accounts for roughly half of hospital revenues, the sector will always be highly vulnerable to changes in Medicare reimbursement, which can and do occur with regularity. Consequently, NFP healthcare organizations will likely never be considered a risk-free or nearly risk-free investment. Only one system (Intermountain Health Care, Inc.) is currently rated Aa1, the next highest rating. Just under 10 percent of NFP healthcare organizations are considered to be high yield or below investment grade. Many of these tend to be small hospitals, although some large systems have made missteps and ended up with low ratings. By contrast, virtually all for-profit healthcare systems and hospitals are rated below investment grade. While these organizations tend to be very profitable (in part due to the lack of a charitable mission), they

Exhibit 19: Hospital Ratings Reflect Enterprise Risk, Volatile Business Model



Source: Moody's Investors Service

Exhibit 20: Downgrades Outpace Upgrades Almost Every Year



Source: Moody's Investors Service

remain highly leveraged with little cash on the balance sheet and a heavy reliance on lines of credit and other debt instruments to fund working and strategic capital.

As depicted in **Exhibit 20**, downgrades exceed upgrades in the NFP healthcare sector almost every year. In fact, in the past 20 years, there have been only four years when there were more upgrades than downgrades. This trend reflects the significant enterprise risk that characterizes the hospital sector.

In general, downgrades reflect any or all of the following:

- Declining financial performance and weakening debt service coverage
- Erosion of liquidity
- A material increase in debt
- Economic and/or competitive stress
- Debt structure elements or risks that impair liquidity

By contrast, upgrades tend to happen as a result of improved financial performance, debt service coverage, and/or liquidity; a change in legal structure and debt security; a material economic event; or a reduction in—or elimination of—debt structure risks. Liquidity (i.e., easily accessible cash) tends to be particularly important, especially when something goes wrong. Liquidity is measured by how many absolute dollars are available and how quickly these funds can be accessed when needed.

Outlook for the Not-for-Profit Healthcare Sector

In August 2015, Moody's changed its outlook on the NFP healthcare sector, upgrading it to "stable" after eight years of having a "negative" outlook. The stable outlook reflects Moody's view that fundamental business, financial, and economic conditions for the NFP healthcare sector will neither erode significantly nor improve materially over the next 12 to 18 months.

The upgrade stems primarily from three major factors that have led to improved financial stability over the past year:

- Operating cash flow growth is at a multi-year high following several years of minimal growth. In 2014, revenue growth outpaced expense growth for the first time in several years. That said, the days of 10 percent annual revenue growth are not forecasted, with 4 to 5 percent growth now being more typical.
- The number of insured individuals has increased, reducing bad debt expense. Between 2009 and 2015, the uninsured rate in the U.S. fell from over 16 percent to roughly 11 percent. Much of this decline stems from the expansion of Medicaid in 31 states. However, bad debt is also falling (to a lesser degree) in states that did not expand Medicaid, due primarily to the improving economy and greater awareness among low-income individuals that they are eligible for Medicaid under existing requirements.

Exhibit 21: FY 2014 Medians Show Margin Stability, Balance Sheet Growth

Key Ratios	2011	2012	2013	2014
Operating margin	2.6%	2.5%	2.0%	2.6%
Operating cash flow margin	9.5%	9.6%	9.0%	9.6%
Cash on hand (days)	174.4	191.3	201.4	205.8
Cash-to-direct debt	121.0%	127.1%	135.0%	151.2%
Cash-to-comprehensive debt	91.3%	90.1%	101.8%	108.3%
Maximum annual debt service coverage (x)	4.3	4.3	4.2	4.6
Debt-to-cash flow (x)	3.4	3.4	3.6	3.1

Source: Moody's Investors Service and hospital audits

- Patient volumes have started to grow again after years of decline, due largely to the better economy. Insured individuals are no longer putting off elective procedures because of financial concerns. In addition, hospitals are getting paid for treating newly insured individuals who previously avoided care. While the move to value-based reimbursement is underway, it seems to be progressing at a slow pace. Such reimbursement accounts for roughly 5 percent of total revenues in most markets, although that figure is higher in certain metropolitan areas (e.g., Boston, Minneapolis). The continued dominance of volume-based reimbursement has been a major driver of improved financial performance.

As shown in **Exhibit 21**, key ratios for fiscal year 2014 are all trending in favorable directions for hospitals, including measures of profitability, liquidity, and debt service coverage.

Looking ahead, multiple issues exist that need to be monitored. In 2016, the outcome of the presidential election could have a profound impact on the sector. In addition, questions loom about Medicare funding for risk corridors on exchange-based products and about the degree to which young, healthy individuals will continue to purchase exchange-based health plans. Some who have not used healthcare services may pay the penalty rather than re-enroll, particularly if prices go up as much as expected. In 2017, the mega-merger of insurance plans Humana and Aetna will, if approved, be a credit negative for NFP hospitals in their markets, as the merged entity will have more negotiating leverage. Also in 2017, Medicaid disproportionate share payments will be cut and the federal share of funding Medicaid expansion will fall to 95 percent. Finally, in 2018, the shift to value-based payments will accelerate, as Medicare reaches its goal of having half of payments tied to quality. In addition, the "Cadillac tax" begins in 2018, meaning that many companies with generous health benefit will have to pay this tax, which helps fund insurance subsidies for low-income individuals.

Key Strategies and Credit Implications

NFP hospitals are embarking on various types of consolidation strategies to guide them into the future, including the following:

- **Hospital-to-hospital**: Hospitals are merging with each other to expand into new or adjacent markets. Recent activity represents a second wave, with the first having occurred in the late 1990s to early 2000s.
- **Hospital-to-payer**: Hospitals are buying and/or partnering with existing insurers and in some cases embarking on the risky strategy of starting their own insurance company.
- **Hospital-to-physician**: Hospitals are employing physicians and embarking on various strategies to integrate clinically, including shared IT systems. Such activity will continue to varying degrees across the country. At present, hospitals employ over 25 percent of their active medical staff, a figure that has grown steadily in the last few years.
- **Hospital-to-other**: Hospitals are seeking to build a continuum of care to take on capitated risk and hence control the premium dollar. Strategies include various types of partnerships with retail pharmacy, specialty pharmacy, long-term care, home health, occupational health, and other non-hospital providers.

Several factors are driving physician integration and other consolidation strategies, including Affordable Care Act regulations and reimbursement reforms that are creating pressure to improve outcomes, enhance the patient experience, and reduce costs. In addition, the American Reinvestment and Recovery Act ties funding and penalties to electronic medical record connectivity, while many state regulations lead to the need for complex physician governance structures. Other factors driving consolidation include ongoing Medicare and Medicaid reductions in physician reimbursement, greater price sensitivity among consumers as deductibles and copayments increase, and the need for multidisciplinary, integrated care to better manage chronic, complex disease as the population ages.

Exhibit 22: Hospitals to Follow Banking and Airline Industries

Venue	Healthcare	Banking	Airlines
At Home	• Telemedicine • Virtual communication with M.D.s	• Online check deposit and account management	• Online ticket booking • At home ticket printing
Immediate	• Urgent centers • Walk-in clinics and access to clinical care	• Conveniently located ATMs and bank drive through windows	• Self check-in airport kiosk • Mobile device access
Person-to-Person	• In-person visit to the hospital with a specific M.D.	• Bank branch locations with bank teller interaction	• In-person check-in and assistance at airport

Source: Moody's Investors Service

Moody's asks a number of key questions when evaluating a hospital's consolidation and growth strategies:

- How will the hospital attain the expertise needed to execute the strategy?
- What are the capital requirements and funding sources? What if internal sources, such as cash flow, do not meet expectations?
- What is the short-term and longer-term impact on financial performance, competitive position, and debt coverage?
- How will the board monitor execution of the strategy? What if the strategy needs a mid-course adjustment?
- What is the physicians' role in the decision-making process?
- What is the anticipated pace of the strategy?
- What are the IT needs to navigate and execute the strategy?
- What are the regulatory requirements for the strategy? For example, is Federal Trade Commission approval needed? What reserve levels are necessary (for those going into the insurance business)?

The aging of America will also have profound implications for the NFP healthcare sector. As the population ages, government and commercial payers may choose to limit coverage of services that do not improve quality of life or longevity for elderly patients. For hospitals, aging means increased demand for existing resources, which will benefit earnings and cash flow. But aging also means increased competition in the outpatient sector. For insurers, the aging of the population leads to greater dependence on government as a source of revenues, as individuals shift from commercial plans to Medicare. That shift, in turn, will lead to increased revenue pressures for hospitals. Insurers will also face pressure to cover expensive new technologies and drug therapies, which will result in a higher premium (and hence increased financial risk) for seniors.

With the rise of consumerism, cost, convenience, and value will become integral to the strategy of NFP health systems and hospitals. Both physical and virtual convenience will be integral to capturing the consumer-oriented patient. As the demand for value and transparency continues to escalate, hospitals are investing in measuring and improving the customer experience. In addition, the continued shift of healthcare costs from employer to employee is creating a savvy, value-driven, cost-conscious patient, even as the economy has improved. At the same time, the rapid shift to outpatient care has led to increased competition for hospitals, including pharmacy-owned retail clinics and urgent care clinics, which have both grown rapidly. Like the airline and banking industries, hospitals must become user friendly, including offering at-home, immediate, and person-to-person care options, as illustrated in **Exhibit 22**.

Governance, Management, and Ratings

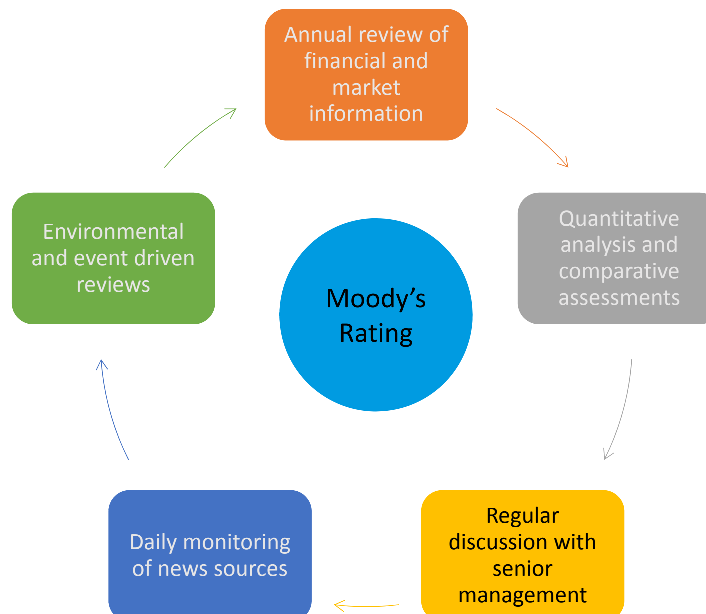
No formal metrics exist to measure governance and management within an organization. Yet Moody's routinely sees the impact that both can have. Getting ready for the future takes strong planning and execution, and may pressure margins in the near term. For any strategy undertaken, Moody's wants to understand anticipated capital needs and sources for that strategy; the projected impact on short- and long-term performance (at least one year out, ideally several years); debt service structure, covenants (to banks versus bondholders), and coverage; and the anticipated pace and execution of the strategy (i.e., will everything be done at once, or will one thing be executed at a time?).

Governance and management becomes intrinsic to the analysis, including the following:

- Composition of board and management: Moody's likes to see "new" kinds of expertise on the board, including individuals with expertise in engineering, manufacturing, real estate, alternative investments, mergers and acquisitions, and other regulated and/or unionized industries (such as utilities).
- External disclosure and internal controls.
- Integration of short- and long-term planning.
- Ongoing self-assessment and benchmarking.
- Government and stakeholder relations.

Moody's also seeks to develop a long-term relationship with the organizations it rates, as depicted in **Exhibit 23**.

Exhibit 23: Long-Term Rating Relationship with Regular Monitoring



Source: Moody's Investors Service

The Board, CEO, and Physician Leaders' Roles in Revolutionizing the Patient Experience

Steve Jackson, President at National Research Corporation (NRC), and Steve Pu, D.O., FACOS, Medical Director at Twins River Regional Medical Center in Kennett, Missouri, discussed the roles of the board, CEO, and physician leaders in transforming the patient experience.

Background: The Case for a Better Patient Experience

In an informal poll of CEOs and physician leaders a few years ago, over 95 percent of respondents indicated that they entered the field because of their desire and passion to help others and to improve the world. Asked what single strategy would best propel their organizations into the future, 100 percent picked focusing on the patient experience as a way to differentiate from the competition. By contrast, no respondent picked strategies commonly used by hospitals and health systems today, including acquisition of physician practices, building or acquiring new facilities, and reducing costs.

Transforming the patient experience is a never-ending journey that requires courageous leadership, a commitment to long-lasting culture change, common sense, and the ability to drive accountability throughout the organization. To succeed, leaders must rekindle the purpose and passion of why those within their organizations entered the profession in the first place. As shown in **Exhibit 24**, purpose exists at the intersection of passion, mission, vocation, and profession. It is a combination of what one loves and is great at doing, what the world needs, and what someone is willing to pay a person to do.

Research shows, moreover, that a better patient experience score is associated with higher quality. A study published in the *New England Journal of Medicine* found that Hospital Quality Alliance (HQA) program scores among hospitals in the highest quartile of HCAHPS ratings were, on average, roughly two to four percentage points higher than HQA scores among hospitals in the lowest quartile of HCAHPS ratings. In addition, hospitals with a patient-centered approach to care tend to have higher profit margins, fewer malpractice cases, and lower malpractice claims costs. They are also likely to enjoy higher levels of customer loyalty, as research shows that 41 percent of patients choose providers based on their non-clinical experience. Looking ahead, payment reform will mean that reimbursement will be increasingly tied to value, with patient experience being an important part of how value is measured.

Exhibit 24: Purpose at the Core

Transforming the Patient Experience at Twins River Regional Medical Center

Approximately four years ago, Dr. Pu contacted Mr. Jackson to request help in "humanizing" the patient experience at Twins River Regional Medical Center. At the time, the hospital had a 33 percent "top-box" score on HCAHPS questions related to willingness to recommend the facility, placing it in the bottom 5 percent nationwide. The CEO, board, physician leaders, frontline clinicians, and staff all knew that the hospital was doing poorly. For their part, physician leaders wanted to "take back their organization." Doing so, however, would not be easy. The hospital is located in a small town with 10,500 residents, 26 percent of whom live below the Federal poverty level and many of whom lack basic literacy skills.

As the 33 percent score suggests, the hospital had a terrible reputation in the community. Representative quotes include a patient who said, "I wouldn't take my dog there!" and a family member who described the hospital as "nothing more than a Band-Aid station." Physicians and nurses did not get along, with hospitalists describing the nurses as "incompetent" and nurses describing the typical doctor as "rude and arrogant." Frontline staff also felt disengaged and unhappy, with one laboratory technician summing up the problem quite well by noting that no one feels valued within the organization.

In December 2011 (after 18 months spent trying to win support from the medical center's for-profit owner), ExperiaHealth, a consulting group where Steve Jackson was Chief Operating Officer, came to the medical center for a week, spending time talking to patients, family members, employees, and physicians to learn what needed to be done to transform the patient experience. The overall goal was to re-instill the human-to-human connection of caring, including between doctor and patient, staff and patient, and doctors and nurses/other staff. With respect to the latter, a more collegial relationship was needed, with physicians appreciating what nurses and other staff do and recognizing the critical role they play. Underlying the effort were two key principles:

- **Recognize the art and science of medicine.** Medicine and healing are as much art as science. People believe in higher spiritual powers that go beyond physicians and healthcare providers, and these providers must explicitly recognize and tap into that spirituality to offer an optimal healing environment.
- **Make sure stakeholders "own" the transformation.** Everyone must "own" the effort and make changes not because they are told to do so, but because they want to and recognize that such changes are the right thing to do. Many vendors have their own task-based programs to improve the patient experience. But too often these initiatives fail because people lose interest in them.

To address the problem, the CEO, board, and physician leader sought to create a shared vision for excellence through the following steps:

- **Inspire and engage physicians to lead the effort.** After a lengthy process, this effort succeeded, with every physician standing up and voicing his or her belief in the effort.
- **Empower staff to lead change.** A small group of employees took charge of an initiative to improve working conditions by tackling issues that had long been left unaddressed. The team held each other accountable for change. After a series of small wins, momentum built and working conditions and morale improved.
- **Map and address gaps in the human experience.** This effort took a detailed look at the various processes, with an eye towards identifying and addressing problems related to the human experience.

The Sacred Moment

Among many changes that occurred as a result of the mapping process, the hospital introduced the "sacred moment," a dedicated time for patients to talk about what truly matters to them. As part of this effort, staff use prompts designed to humanize the experience and build a connection with the patient, including understanding their fears and concerns, identifying and engaging loved ones, addressing spiritual needs, and capturing comfort preferences (e.g., room temperature). Initially viewed as just another task performed by staff, this simple concept has become a powerful tool that staff readily embrace as the right thing to do. Patients love it, as suggested by the following representative quote: "thank you so much for caring about me; I didn't know you did that here." Nurses and other staff feel that the sacred moment gives them a sense of purpose, as indicated by the following employee comment: "I'm certain now that we benefit from the sacred moment as much as the patient. It really gives you perspective and reminds you that the people are why you loved healthcare. I entered the room focused on me and left focused on others. My smile didn't go back in my pocket that day."

The effort to revamp the patient experience has clearly worked at Twin Rivers Regional Medical Center. As of November 2015, the top-box score related to willingness to recommend the hospital has jumped to 78 percent, putting the hospital in the top 5 percent nationwide. Scores on the patient experience survey have increased significantly in every domain, something very few hospitals are able to achieve. In addition, the medical center has won two awards from The Joint Commission related to the quality of care in specific procedures.

Lessons Learned from the Twin Rivers' Experience

The Twin Rivers' initiative to transform the patient experience offers the following lessons related to leadership and cultural change:

- **Avoid "us-versus-them" discussions.** No one should ever say "they will not let us do that."
- **Reconnect to purpose, not task.** The focus should be on why things are done, not how.

- **Map the emotional drivers of experience.** The goal is to create human-to-human connections. While the sacred moment works at Twin Rivers, other approaches might be more effective elsewhere. In many cases, patients want to know the answers to a few simple questions: where are they being taken, how long will they be there, and what should they expect while there?
- **Celebrate successes.** Staff and leaders should regularly come together to celebrate successes, preferably over food and refreshments.

> "The fire burns in all your organizations. People are looking to be led, but not by the numbers. Numbers can guide you, but they should not define you. Rather, you should be defined by the empathy you show to patients and staff, and by your dedication to provide the resources and environment necessary to fulfill your purpose. That will create loyalty in your organization and your community, and that will sustain you through all the changes in healthcare."
>
> —*Steven Jackson and Steve Pu, D.O., FACOS*

Looking Ahead: Managing the Shift from Institutional to Peer Trust

Building consumer trust and loyalty matters a great deal, as the lifetime value of an individual patient to an organization totals roughly $1.4 million, while the value of a family averages $4.3 million. Up until recently, leaders of healthcare organizations tried to build consumer trust by investing in the brand and making and fulfilling promises to the community. Today, however, many consumers decide whether they trust an organization by connecting with peers through social media and external ratings organizations such as Yelp, Facebook, and HealthGrades. As illustrated in **Exhibit 25**, what drives consumer loyalty varies by age, with older individuals relying more on physician recommendations and younger ones being much more concerned with what they hear from others.

Healthcare consumers increasingly go online to look for information about providers. According to the 2015 Healthcare Consumer Trends Survey, 77 percent of consumers begin their healthcare search online; 45 percent look at online reviews before scheduling an appointment; and 29 percent view online ratings as the first step in a search to find a new physician. In addition, 40 percent are willing to go out of network to seek a higher-rated provider. As a result, healthcare organizations need to become much more transparent in publishing patient experience scores. In fact, many prominent systems, including the Cleveland Clinic, Inova Health System, Intermountain, and MedStar, use transparency as a way to acquire new patients.

Exhibit 25: Drivers of Loyalty and Selection Differ

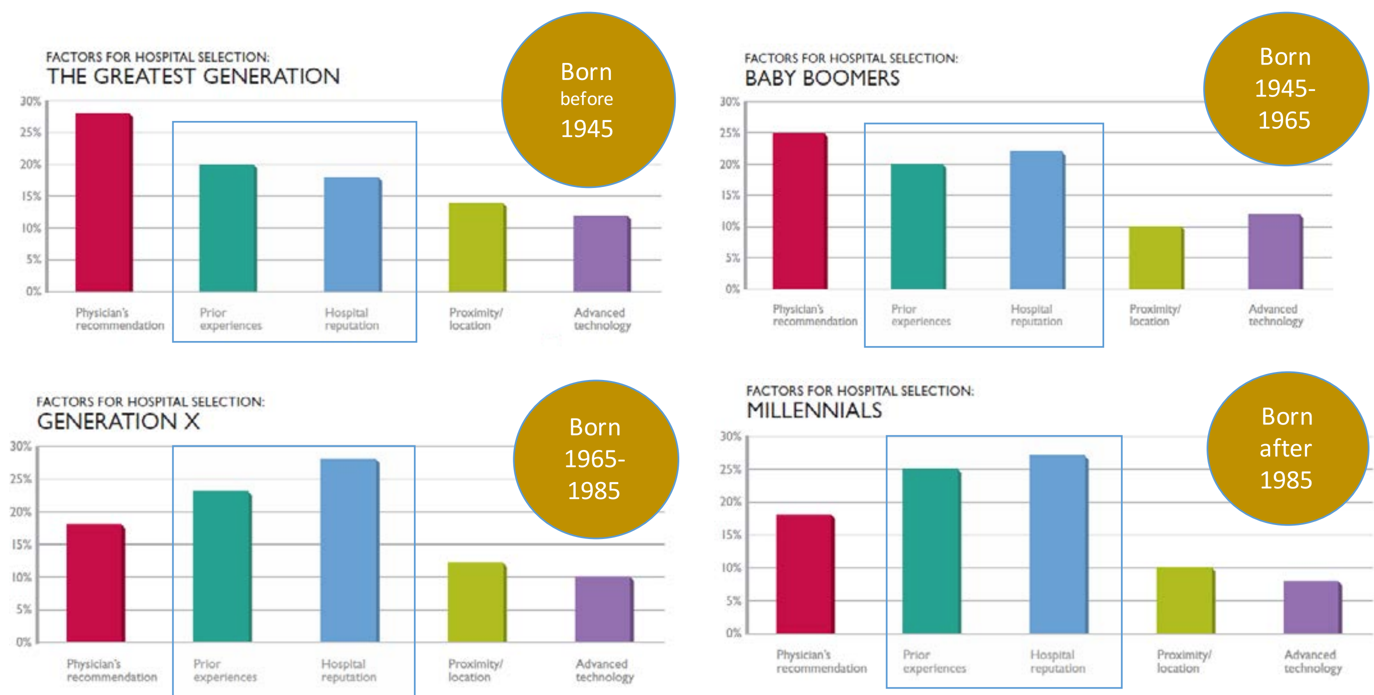


Exhibit 26: Ratings Comparison—Dr. Dana Rice

Inova Website	Healthgrades
- 4.8 out of 5 - 298 ratings	- 3.8 out of 5 - 10 ratings
Yelp	**Vitals**
- 2.0 out of 5 - 6 ratings	- 5 out of 5 - 1 ratings

These systems seek to control the online dialogue about their organizations and improve their online visibility (including taking steps to come up first in consumer searches). With external ratings organizations, scores are often not consistent across sites, and hence it becomes important to publish one's own ratings data. As shown in **Exhibit 26**, external rating organizations such as HealthGrades, Vitals, and RateMD often publish ratings based on a small number of reviews. By contrast, health systems and hospitals often have hundreds of ratings for their own providers.

Ideally, health systems should seek to make their own ratings of physicians come up first in any online search for that physician. Typically it is best to include unedited comments that represent both the good and the bad, although any profanity, slander, or potentially libel statements should be removed. The best systems have advisory groups to assess such reviews, and offer physicians an opportunity to appeal those they feel are unfair and/or factually incorrect. Many organizations wait until they have roughly 30 reviews before publishing any information, and then update the information on a weekly or monthly basis. (These updates help in remaining the first entry to come up in a consumer search.)

Takeaway Lessons

- Connect to the purpose, not the task.
- Empower physicians to lead the change.
- Map the emotional gaps in the care experience.
- Turn experience data into a "gold mine."

Effecting Change through Frontline Leadership

Chris D. Van Gorder, FACHE, President and CEO of Scripps Health and former chairman of the American College of Healthcare Executives, discussed the role of leadership in turning around Scripps.

Background

The origin of Scripps Health goes back to 1890 when Mother Mary Michael Cummings and the Sisters of Mercy founded St. Joseph's Hospital. In 1924, Miss Ellen Browning Scripps founded Scripps Memorial Hospital & Metabolic Clinic, and St. Joseph's was renamed Mercy Hospital. Since that time, Scripps Health has grown into a regional healthcare system with 30 ambulatory sites (up from five sites 16 years ago) that provide access points for patients. The system generates $2.7 billion in revenue each year and has roughly 15,000 employees and 2,600 physicians, 900 of whom are employed through a foundation model. (The rest of the physicians are independent practitioners.) An integrated, not-for-profit system, Scripps Health operates two of six trauma centers in San Diego County.

A System on the Brink of Failure

In 1999, Scripps' long-time CEO retired after 25 years on the job. The new CEO abruptly canceled all contracts with payers, with the goal of renegotiating them on better terms. In October of that year, Mr. Van Gorder was hired to be the system's chief operating officer. His first day on the job, bedlam erupted during a meeting when the physicians began inquiring about the status of the new payer contracts. Senior leaders incorrectly stated that they were all in place, when in reality they were not. The insurers had only discussed "term sheets" with Scripps but had not yet signed the final contracts. After the meeting, both employees and the medical staff questioned the credibility and trustworthiness of the new CEO.

Even before the new CEO took over, Scripps had been in the midst of a long-term decline as an organization. Employee morale and organizational culture had dropped to an all-time low, largely due to recently enacted budget cuts and development of an ill-conceived, unvetted plan to create alignment among all physicians. In addition, quality scores, financial performance, and philanthropic donations had been falling significantly, as had the system's reputation in the community. Local newspapers regularly wrote negative things about Scripps, including constant turmoil at the leadership level. Things got so bad at one point that physicians refused to answer surveyor questions during Joint Commission inspections, causing the system to almost lose its accreditation status. Annual staff turnover reached 25 percent and patient volumes fell dramatically, leaving the health system with only 55 days cash on hand. Physicians overwhelmingly passed a no-confidence vote in the current CEO, which eventually eroded board support and led to his resignation in May 2000. Shortly thereafter, Mr. Van Gorder took over as interim CEO.

The Turnaround under New Leadership

As his first step, Mr. Van Gorder met with each board member individually to ask a simple question—did the board member want him to really run the organization, or to "babysit" while they found a permanent CEO. Each board member asked him to act as the true CEO and not simply hold the spot for someone else. Some large donors preferred hiring a more experienced, well-known individual to run the organization, including a few who supported hiring the former Surgeon General, Dr. C. Everett Koop. But because Mr. Van Gorder had been on the job for only six months, no one could really blame him for any of the turmoil that had ensued. By the end of his first month, the board elected him as permanent CEO. Since that time, Scripps has embarked on a remarkable turnaround in both finances and quality, and is now regularly ranked as one of the 100 best companies to work for in the country.

While many factors are responsible for this turnaround, much of it stems from the use of various leadership-driven strategies designed to engage physicians and front-line staff, giving them ownership and accountability over the various issues facing Scripps. A review of each of these key strategies follows.

Strategy 1: Fill the Information Gap

When people have access to the same information, they often reach similar conclusions. However, no forum existed at Scripps to share information with key stakeholders, including the medical staff. To address this issue, Mr. Van Gorder established the Physician Leadership Council (PLC) in 2000. Made up of elected physician leaders from throughout the organization, this group serves as an advisory body to the CEO. The group does not have any formal authority, which initially became a point of contention with physician leaders who wanted spots on the board of directors. Mr. Van Gorder assured these leaders that the PLC did in fact have tremendous informal power, noting that the previous CEO lost his job largely because of objections from medical staff leadership. Rather than creating an "us-versus-them" culture by giving physicians designated slots on the board, Mr. Van Gorder proposed a different approach that emphasized mutual trust and collaboration. He pledged that the PLC would have the right to review and make recommendations on every major strategic decision facing the organization, a pledge he has kept to this day.

As an example of the power of information sharing, shortly after taking over as CEO Mr. Van Gorder faced a request from physician leaders for an additional $4 million for taking ED call. In response, Mr. Van Gorder agreed to the $4 million, but noted that he would be sending a memo to the nursing staff about this payment and the fact that it would mean that nurses could not get a raise. When the physicians expressed outrage at that idea, Mr. Van Gorder stated simply that it was the truth. Faced with a myriad of problems and only 55 days of cash on hand, Scripps simply did not have the money to pay an additional $4

million for ED call and give nurses a raise. He also shared the data backing up that claim. After considering the issues for several weeks, physician leaders agreed to cut their request in half so that the nurses could receive a raise. They essentially took ownership and accountability for the issue. Through the PLC, physicians now do that regularly at Scripps. The PLC is the second most powerful body at Scripps (after the board of directors) and it is still an informal body. Since the PLC's formation, 100 percent of its recommendations have been adopted. The board will not even consider approving a strategic plan unless the PLC has been involved in developing and approving it. Physicians specifically seek out elected positions so they can serve on the PLC.

Strategy 2: Build Culture from the Middle

When Mr. Van Gorder took over as CEO, leadership and staff at hospitals in the northern part of its service area often were at odds with those in the south, and vice versa. Much of the friction had to do with financial issues, since the northern hospitals tended to do better financially. Those in the north felt that the southern hospitals were inefficient, while those in the south felt that the northern hospitals only cared for rich (and hence well-insured) patients.

To create greater unity and a common culture focused on the patient, Mr. Van Gorder put in place a number of programs designed to build a culture from the "middle" of the organization.

- **Leadership Academy**: This year-long program consists of 12 monthly all-day classes. With 25 enrollees at a time, Leadership Academy provides a detailed orientation on how Scripps Health really works, including panels featuring chiefs of staff and nurses. Each session begins with a two-and-a-half hour question-and-answer session with Mr. Van Gorder (who stays for the whole day). While the program began with much distrust, slowly over time attendees began asking tough questions (which they were encouraged to do). Each year, 25 additional individuals graduate, with most becoming effective advocates for culture change throughout the organization. The Leadership Academy has also slowly brought staff and leaders from the various hospitals together as a system. Today the culture is one where these hospitals help each other out, with everyone recognizing the vital role of all the hospitals to the organization.
- **Emerging Leaders**: This course serves non-management staff with leadership potential, helping them break through to leadership ranks. It features various leadership development courses.
- **Center for Learning and Innovation**: This center serves all employees. Center staff interview every new employee about his or her career goals and help to develop a plan for achieving them.
- **Employee 100**: This program serves front-line staff and feeds into the Emerging Leaders program. It features six monthly half-day sessions structured as a miniature version of the Leadership Academy. It provides participants with their first direct exposure to the CEO and other executives.

Strategy 3: Connect with Your People

Distant bosses cannot be effective. Mr. Van Gorder regularly tries to connect with his staff by sharing a piece of himself with them. He seldom wears a suit and often spends time at the front lines of the organization. When the Ebola scare occurred, he went to the front lines and attempted to put on the contamination suit. When he could not do so following guidelines, he investigated the various recommendations and decided to adopt a different set of guidelines (those of the World Health Organization). To put people's minds at ease about Ebola, he publicly declared that—if Scripps received an Ebola patient—he planned to put on the suit and enter the patient's room alongside of staff. This gesture got everyone comfortable with the adopted guidelines and the idea of treating a patient should one arrive at the hospital.

Other tactics that Mr. Van Gorder regularly uses to connect with people include visiting the front lines without an entourage, hosting onsite coffee chats, regularly visiting departments and volunteering at events, participating in staff training, and periodically "walking in employees' shoes" by performing their jobs.

Strategy 4: Be Aware of Every Situation

A former police officer, Mr. Van Gorder strives to make sure that his leadership team proactively understands every situation and empathizes with those involved. To remain situationally aware, Mr. Van Gorder conducts employee surveys and focus groups throughout the year. Over 90 percent of Scripps employees participate in the Great Place to Work survey each year, which measures various indicators of satisfaction with and trust in leadership, including fairness, teamwork, pride, and credibility. Along with other surveys and focus groups, this survey creates accountability for management and provides the basis for ongoing investment in employees and the workforce. Between 2001 and 2014, scores have increased by roughly 30 percentage points.

Mr. Van Gorder also employs other strategies designed to keep him in touch with staff, including having an open-door and open-email policy. He proactively seeks to get a feel for the "mood" of the organization and the "body language" of employees, which may influence the timing of announcements on new

policies and strategic changes. Every day he reads and sends out a quick summary of the latest healthcare articles to physicians and alumni from all his programs. This time-consuming step saves work on the back end when he asks people to accept needed changes.

> "Situational awareness directs your attention away from yourself and all that you are. Your executive ego seems to evaporate as you put yourself right there with others, empathizing with their concerns."
>
> *—Chris D. Van Gorder, FACHE*

Strategy 5: Take Care of "Me" First

Scripps uses innovative recruitment programs to attract the best candidates to the organization and then supports those employees, which in turn gives them the freedom to put others first. Employees who feel that their livelihood or job is in jeopardy naturally focus on that first, and hence reject any changes that put them at risk. To address this issue, Scripps has developed a no-layoff philosophy. While not a formal policy, this philosophy puts the onus on management to fix problems before they require layoffs. Any failure to do so is a management failure. Whenever a job gets eliminated due to some necessary change, Scripps offers employees a new place within the organization. Affected individuals go to the career resource center where they receive 90 days of training related to their new job. To date, more than 1,000 individuals have switched jobs within Scripps, and 95 percent of them remain with the organization today.

Scripps invests in its employees even during tough economic times, with many changes being in response to the open feedback given by employees in surveys and focus groups. Scripps takes a lifecycle approach to its benefits, including a comprehensive wellness program. Salary reviews occur twice each year, and Scripps has a set of staged options for retirement. Thanks in large part to these initiatives, employee turnover has fallen from over 30 percent to just under 9 percent in the past 11 years.

Strategy 6: Give Responsibility and Authority in Combination with Accountability

Responsibility and authority must come with accountability. Scripps clearly lays out its expectations with respect to performance goals and the consequences for not meeting them. Those who miss their targets once are encouraged to seek support and resources to help them get back on track. If despite their planning and the assistance provided they miss their targets again, they generally lose their jobs, with few exceptions.

> "Responsibility, authority, and accountability are three legs of the same stool. They have to go together; it's an all-or-nothing deal."
>
> *—Chris D. Van Gorder, FACHE*

Strategy 7: Leave No One Behind

Scripps seeks to protect and serve its employees by being their greatest advocate. Scripps emphasizes the importance of achieving a healthy work-life balance and offers support in doing so, including employee assistance and crisis teams, corporate social events (e.g., outings to the movies, theater, and sporting events), and assistance with parenting, financial, and end-of-life issues.

Through the Success Shares program, Scripps offers financial incentives to employees who reach their performance

goals, including those on the front lines of care. Scripps offers incentive compensation for management and up to 8 days of additional pay for non-management positions for meeting site-specific patient satisfaction and productivity goals. In the past seven years, Scripps has distributed more than $6 million to non-management employees through Success Shares.

Strategy 8: Always Ask "What If"

Contingency planning is critical to success, particularly with respect to long-term, big-picture issues. Just like the U.S. military, Scripps seeks to always have a plan in place, both for the good and the bad. The key is to always be prepared to act when potential problems and opportunities arise.

> "If you don't take time to imagine the future, you have no hope of proactively addressing possible threats."
>
> —*Chris D. Van Gorder, FACHE*

Strategy 9: Lead Courageously and Decisively

Leaders must challenge employees to move past what feels comfortable and to look at the organization differently. Roughly six years ago, Scripps' leaders started *One Scripps*, which added a horizontal management framework to the organization. Faced with silo-based thinking and excessive variation across facilities, Scripps' leadership took all chief operating officers out of the hospitals and put them in new jobs where they had responsibility for horizontal oversight across sites. This change served to accelerate the shift from silo- to system-based thinking. It created constructive competition and tension to identify and reduce variation in both costs and quality across facilities, leading to $450 million in savings over six years. It has helped Scripps break-even on its Medicare business, enhanced alignment with physicians and between inpatient and outpatient units, and increased value for the community at large. It has also aligned the culture of employees and the workplace and helped to preserve Scripps' jobs and services.

As shown in **Exhibit 27**, the next step in this process is to move to producing "value by design" (rather than by accident, as typically occurs today). This process will take many years, well beyond Mr. Van Gorder's time as CEO.

Exhibit 27: An Evolution: Value By Design

Create consistent and predictable **outcomes** and **processes** across all settings, times and providers to provide value for our patients and other customers

Develop our people to solve problems and improve performance

Engage staff expertise

VALUE = Quality at the lowest cost and highest satisfaction

Strategy 10: Bring Your Mission to Life

Genuine, heartfelt actions speak louder than words. Scripps has a variety of programs that illustrate the organization's commitment to its mission, including various community partnerships and a medical response team that regularly travels to help with natural and manmade disasters, such as Hurricane Katrina, earthquakes in Haiti and Nepal, and California wildfires. In addition, Scripps regularly shares patient stories that demonstrate the organization's commitment to its mission. Every hospital has such stories, but too often they remain hidden. Yet sharing them can help build goodwill in the community and motivate the workforce by reminding employees of why they got into the healthcare field in the first place.