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Healthcare Strategy: Is “Good Enough” Execution Really Good Enough?*

*This document addresses the not-for-profit (voluntary) segment of the healthcare industry as opposed to the investor owned segment.

From the perspective of organizational and managerial excellence, the best and brightest experts of management theory would undoubtedly believe that healthcare provider organizations lag far behind their counterparts in retail, manufacturing and other enterprises.

Anyone who closely examines the reason for this deficiency can begin to appreciate the dilemma healthcare provider organizations (HPOs), Boards, and Executive Teams face every day. It’s all about the money!

When you delve deeply into the complexity of a HPO, it becomes apparent that, at its core, the organization is a mini-conglomerate; comprised of a hotel, a fast food restaurant (cafeteria and snack bar), retail store (gift shop, outpatient pharmacy), laundry, doctor’s office (clinic), full service restaurant (patient and guest meals), collections agency, accounting firm, laboratory, product distribution center (warehouse / storeroom), cleaning service company (housekeeping), refuse / trash collection firm, etcetera. However, the sole purpose of these operating entities is to provide support for the treatment and care of people who are too ill or incapacitated to remain in their own environment. Therefore, the knowledge base of the people overseeing these various “companies” must be on a par with their non-healthcare for-profit counterparts while also being attuned to and empathetic for the patient care mission. Therein lays the root cause of healthcare’s management dilemma.

At a time when provider organizations are struggling to improve quality outcomes by enhancing the caliber of their personnel, they are constrained by the need to stabilize or reduce expenses, a major portion of which (approximately 50%) is the cost of the labor that supports this mission for which they must compete against other industries.

Another complicating factor for the qualitative aspects of management in healthcare is the need to establish cohesion and collaboration between the many operating entities within the mini-conglomerates and clinical entities (all of which are separate silos). Not only must HPOs develop processes to interface appropriately phased and positioned communications between so many different operating entities, HPOs must also enhance the appropriate interpersonal and managerial skills of the managers which vary from silo to silo; i.e. moving away from a dysfunctional amalgamation of technologies, languages and management scenarios when it comes to vision, values and objectives and into a mode of cross-functional dialogue.

Fortunately, HPOs are now taking a lesson from their counterparts in other industries which are gradually evolving – by focusing on the development of their management infrastructures below the level of the executive team. To address these needs, some larger HPOs have even hired Organizational Development (OD) or Organizational Effectiveness (OE) practitioners. While these efforts are beginning to show some results, the process is slow; predominately

because, unlike the industrial and business counterparts, health care middle managers must divide their focus between quality patient care outcomes and traditional business and management practices. The quandary is quite simple – if clinical and patient care related middle managers opted to work in healthcare for business applications, they entered the wrong field. In nearly every case, parallel business careers outside of healthcare offer higher incomes and a greater chance for advancement.

Simply, while the business side of managing an entity within a HPO is a serious endeavor, the nature of the industry and the primary metrics for efficiency are related to patient quality, followed by patient satisfaction and not just traditional business metrics of margins over costs and ROI for shareholders.

Because of the unique nature of revenue and profit restrictions in the voluntary (not-for-profit) segment of the healthcare industry, all but a few of the largest HPOs cannot afford the luxury of managing business practices separately from direct hands-on patient care related activities.

Logically, HPOs cannot afford to hire and retain individuals skilled in business management and leadership. Unless such skilled individuals are part of a HPOs executive team, the industry's salary ranges are no match for their profit-centered business and industry counterparts. Even if a HPO is able to employ such a “golden nugget”, suppliers and consulting firms frequently entice these individuals to leave the provider side of the industry.

Moving in the “Right” Direction

Many HPOs are preparing strategies to address the numerous deficiencies which have evolved in healthcare over the past thirty years (an era we consider as being the one where complexity has grown to the point of causing operational implosion). With varying degrees of emphasis and success, HPOs have started to address all of the following issues:

1. **Proper Staff Selection:** Knowledge, Skills and Characteristics are all important factors for selecting the “right” personnel. Providers are starting to screen applicants more carefully to ensure they fit the culture of the organization as well as having the desired level of technical or clinical knowledge and credentials.
2. **Team Dynamics:** Creation of true teams (in addition to the Executive Team) is an excellent tool that is just beginning to emerge within HPOs. Many Executive Teams recognize the inefficiency of their cross-functional processes at the middle management level. Already, many HPOs are striving to transition their committee structures to ones using true team concepts and principles touted by leading business authors and academicians.
3. **Objective Evaluation Processes:** Value analysis processes continue to be the primary focus to reduce non-payroll expenditures. Providers are committed to training their managers how to utilize value analysis as a mechanism to control the non-payroll outlays that comprise 40%+ of all expenditures.
4. **Comparative Measurement:** Benchmarking has grown in popularity and most HPOs now strive to achieve parity with “best-of-the-breed” performers. Some organizations actively pursue adopting highly effective practices used in other industries for use in their healthcare provider organizations.

5. **Lean / Process Improvement:** Operational efficiency can no longer be stagnant. While many HPOs' cultures are still recovering from some reengineering fiascos, others are embracing "lean" concepts or other operational theories similar to the RPV Framework (resources, values and processes) espoused by Clayton M. Christensen in *The Innovator's Dilemma*.¹
6. **Change Recognition:** Change management, albeit one of the most difficult and challenging tasks for highly complex organizations such as HPOs, is being recognized as one of the critical needs. Nearly every HPO now considers it necessary for change to be "sold"/ accepted at every level of the organization.

The need for change in healthcare has been brought to light in recent years by the industry-wide initiative which recognized the need for quality to be improved continuously while working with constrained resources at all levels. Clearly, many HPOs believe yesterday's TQM and CQI approaches have not been adequate. One of the most well known current approaches, Six-Sigma[®], emphasizes the equation $Q \times A = E$ (quality of the solution times acceptance of the idea equals effective results). The Six Sigma[®] concept incorporates many elements critical for organizational excellence; including but not limited to goal setting, leadership development, value definition, metrics for results, accountability, process ownership and change acceleration processes.

¹ Clayton Christensen, *The Innovator's Dilemma*, Harper Business Essentials, New York, NY, 2003

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NOTE: This document is not intended to judge the value of Six Sigma[®] or similar quantitative programs utilized in healthcare or to compare their strengths or weaknesses to alternative methodologies to establish team-driven outcomes. Using Six Sigma[®] as an example though, data driven approaches to analyzing the root cause of business problems and creating solutions do have certain limitations. In our opinion, it must be understood that, to date, the Six Sigma[®] concept has contributed more to the understanding of team processes and group dynamics than any methodology in the history of healthcare. In addition, the concept has made substantial strides in stimulating organizational collaboration, especially at the level below middle managers as it pertains to project specific initiatives. Despite limitations due to its focus on factual data, orthodox applications of Six Sigma[®] provide good training to "black belts" in project management, communication skills, change interventions, team building (albeit somewhat limited to time-bound, task-focused projects) as well as facilitation and teaching skills. From the aspect of team structures, Six Sigma[®] utilizes functional or cross-function teams² but its data-driven approach makes it fall far short of delivering optimal solutions for addressing product and service selection and utilization, innovation as well as building collaboration and cohesion related to organization-wide processes. Unfortunately, in healthcare, most organization-wide process initiatives intended to execute the key strategies of the organization are emotionally driven and, therefore, require a separate team configuration and distinctly different leadership approaches than project specific quantitative efforts. An excellent white paper, *The Journey to Excellence (J2E)* by Karl Albrecht which explains the need for a balanced approach to organizational development, not merely quantitative processes, can be found at: www.mindexprofile.com/downloads/J2E.pdf

In reality, Six Sigma[®] methodologies can offer benefits to HPOs choosing to utilize the concept to address project-specific change. However, these facilities will still fail to maximize the opportunity to excel at continuous, ongoing change processes. As a result, these organizations may be unable to meet tomorrow's needs for organization-wide operational efficiency and effectiveness unless they institute appropriate concepts to address leadership and the creation of revolutionary innovation at the middle management level, especially those that address subjective issues.

7. **Leadership and Management Selection:** The “Who” of an organization became popular following Jim Collin’s excellent book, *Good to Great* (Harper Collins, 2001). While every healthcare executive may not have read the book, nearly all managers and executives now understand the meaningfulness of the analogy of getting the “right” people on the bus.
8. **Leadership Development / Skills Enhancement:** Leadership creation is now recognized as being a critical objective in order to achieve operational excellence in today’s environment and to ensure adequate succession planning for tomorrow.

Are the industry’s actions all the “right” - right ones?

Aside from the decision to introduce the concepts of organizational development professionals into the mainstream of the healthcare industry, the eight solutions previously outlined may not necessarily be the real “right” - right ones to resolve the many problems facing the healthcare industry, at least not in the configuration of the actions currently being taken.

To fully understand the effectiveness of the many activities the industry is initiating to meet tomorrow’s challenges and explain how they could and should be modified or enhanced, the following examines each initiative separately.

1. Knowledge, Skills and Characteristics - In his book, *Good to Great*, Jim Collins addressed the need to focus on characteristics when he wrote, “People can learn skills and acquire knowledge, but they cannot learn the essential character traits that make them right for your organization.” While this logic is critical in traditional businesses, because the healthcare industry is centered on the knowledge required to provide quality outcomes for the treatment of sick patients, providers have focused on knowledge as the primary factor for hiring decisions.

Such considerations have, over the decades, been embedded in the thought processes during recruitment, regardless of whether or not the positions are directly related to hands-on patient care. Only recently have some providers expanded their criteria to incorporate a wider view of candidates by placing more weight on characteristics. (We refer to characteristics as the C Set).

In an article which appeared in H&HN Magazine Online, October 5, 2004³, Jim Nathan, President and CEO of Lee Memorial Health System in Fort Myers, FL, gave a good example of C Set matching when he was quoted as saying, “Behavioral competencies have helped us clarify the role for which we are recruiting, as a basis for effectively interviewing candidates and to assist with designing individually tailored executive development programs.” Another good example of applying C Set matching with an organization’s needs appeared in the March 2005 issue of Shared Services News. The author, Joseph A. DiPaolo, Director of Materials Management and Chief Sourcing Officer of Atlantic Health System (AHS), Florham Park, NJ, explains how the candidates for his 230 member shared services team were screened and selected based first and foremost on criteria of characteristics (C Set). With

³ Don Hutton and Steve Moulton, Behavioral vs. Technical Competencies, HHN Magazine Online, October 5, 2004

regard to obtaining the remaining ingredients, DiPaolo commented “AHS has committed itself to staff training as part of our cultural transformation. We offer a maximum of 32 hours of training per year, per employee-equivalent to four working days.”⁴

Clearly, these and many other HPOs are now placing a greater emphasis on having personnel with the “right” characteristics as an essential factor in creating a harmonious work environment as well as recognizing their importance as being critical to the formation of cohesion and collaboration – two “missing links” in many HPOs. While knowledge and skills (business, interpersonal communication, management, leadership, etc.) are learned in an educational environment or on the job, behavioral competencies are learned from life experiences and are the foundation upon which an individual interrelates with others, stimulates their career and differentiates their persona in the workplace. Without the “right” C Set, in a complex work environment like an HPO, even the highest levels of skills (S Set) and clinical/technical knowledge (K Set) competencies will not necessarily make a candidate desirable or successful. An important, less obvious factor in seeking to match characteristics with those identified for a specific job is an individual’s “circumstance based” behavioral competence; i.e. decisiveness, ability to handle stress, independence, leadership style, etc. For example, regardless of an individual’s interpersonal skills and technical knowledge, they may perform poorly in a HPO turnaround environment in comparison to another individual who has acquired that “curriculum” as part of their life experience, albeit work related. Morgan McCall, Professor of Management and Organization at Marshall School of Business, USC, asserts that people’s intuition is often guided by their experiences throughout their careers.⁵ Accordingly, an interviewer should drill down into an individual’s work experience to identify the level and depth of experience in adverse and complex environments. The need for a comprehensive and appropriate CSK Set®⁶ matching is apparent when you consider the need to bring a group of individuals together to solve particular problems (a.k.a. a team).

Finally, and most importantly, individuals must be analyzed from the aspect of their decision making thought processes; i.e., How People Think®⁷. Unlike traditional testing methodologies which attempt to identify behavioral characteristics and personality traits (HOW people act), the How People Think®⁸ concept proposes a process of candidate comparison to criteria predetermined by the employer designed to match thought processes to the needs of the company (WHY they make certain decisions under certain circumstances, WHAT techniques they will utilize to lead and manage personnel, HOW they will interface with other individuals with diverse education/technical backgrounds, and a host of other variables associated with leadership and decision making.

⁴ Joseph DiPaolo, Hiring and Motivating for Optimal Performance, Shared Services News, International Quality and Productivity Center, New York, NY, Volume 7, Issue 1, March 2005

⁵ Morgan McCall, High Flyers: Developing the Next Generation of Leaders, Harvard Business School Press, Boston, MA, 1998

⁶ Patent Pending

⁷ Patent Pending

⁸ Ibid

The Role of the Over-focused

While most, if not all, of the world's most brilliant and intellectually gifted individuals have core cognitive capabilities which enable them to competently focus on their respective areas of expertise, these attributes come with a price. Depending upon the depth of their focus, these individuals leave little time to practice and utilize interpersonal skills. In addition, with devotion to their chosen field of expertise, such individuals are rarely multi-skilled; i.e., have achieved "expert" or even exemplary status in separate specialties. As a result of their strong focus, these individuals are typically limited in their ability to create products or concepts outside of their sphere of expertise. In his 1969 book, *The Mechanism of Mind*⁹, Edward de Bono, widely recognized as one of the world's leading authorities on thought processes, uses a river and topography analogy to explain mental processes. In essence, he refers to memory as forming mental ruts or rivers which, over time, forge deeper and deeper troughs in our mental landscape. As de Bono explains the process, these troughs cause valleys to form in our minds. In our opinion, it is our focus which burrows the troughs into our minds. Accordingly, these aforementioned "experts" rarely have the predilection to concern themselves with other areas of expertise or focus because their troughs are so deeply engrained in their minds.

While one might view this observation as a negative comment, its meaning is quite the opposite. If it were not for the ability of people to maximize their focus on any given field of endeavor, the world would not progress. Unfortunately, from the perspective of cross-functional (inter-disciplinary) team dynamics, unless the "team topic" is within the specialty or sub-specialty of these individuals, their thought processes do not allow them to see over the valleys in their mind. To use a variation of the popular cliché, they cannot "think out side of their box." As a result of this dilemma, when individuals are placed into an interdisciplinary team process, the following reactions can dramatically hinder the dynamics of the process:

- Detailed research and data is required to evaluate alternatives.
- Compartmentalized knowledge does not lend itself to team based innovation. Instead, such experts typically excel in invention in isolation or with teams comprised of individuals with carefully matched expertise – a process which can produce incremental innovations but limits radical or breakthrough innovations.¹⁰
- Collectively, inter-disciplinary teams tend to be risk adverse. Accordingly, reaching consensus for a course of action is, at best, difficult. As a result, when multiple options are considered, the least risky is usually selected; not necessarily the one that offers the highest degree of probability for meeting the objective. This same "dynamic" prevents such teams from selecting multiple initiatives, even if they are addressing separate problems. Selection bias is the term for this phenomenon – team members frequently stress, "Let's focus on ABC" or "We should wait until XYZ is finished."

⁹ Edward de Bono, *The Mechanism of Mind*, Simon and Schuster, New York, NY, 1969

¹⁰ Lee Fleming, *Perfecting Cross-Pollination*, Harvard Business Review, Boston, MA, September 2004, Reprint F0409C

- Hypothetical concepts can be rejected unless results of “fact based” trials are already available
- The ability to perceive the value of concepts outside of their specialty is severely limited

Much in the same way that team composition and potential for optimal outcomes can be negatively impacted by over focused individuals; the same effects can be experienced by participation of individuals whose core cognitive capabilities include a diminished level of focus. The impact on group dynamics of individuals who are under focused or lack focus is obvious. The concept of How People Think®¹¹ clearly indicates that these individuals place an emphasis on action. However, while individuals who are action oriented are frequently valued as a team contributor because they function as a catalyst, this perceived attribute can be extremely damaging to the ability to achieve optimal results.

Simply, because their focus is on activity and, in many cases on the enjoyment they derive from variety, these individuals tend to function in the mental state of “good enough” decisions. As a result, their participation in cross-functional team processes typical generates the following pitfalls:

- Failure to invest the time to participate in or conduct adequate analyses.
- Conflict with “focused” individuals over what they perceive as unnecessary caution and indecision.
- Lack of true team spirit, unless they can lead the process (often bored with the pace and direction controlled by others).
- A focus on haste over quality assurance.
- The inability to perceive the long term value or corollaries associated with complex concepts.

Role for the Under-focused

While participation of individuals with the aforementioned core cognitive capabilities can make a valuable contribution to time bound, task specific team processes, the benefits of their participation will be dependent upon their area of expertise and the degree of their willingness to distract from their focus. At the same time, their participation in team processes involving broad based planning for strategy execution, breakthrough innovation (as opposed to line item invention/incremental enhancement) and the leadership necessary for culture creation, especially as it pertains to creating one of change acceptability, can be devastating.

2. Teams - The three best known types of teams in business are functional, self-directed and cross-functional.¹² With the exception of HPOs using Six Sigma® and/or similar methodologies, the “functional” variety of team configuration (excluding the Executive Team), is the most common format of teams in the healthcare industry; true self-directed and cross-functional teams are rarely used. By definition, according to Glenn M. Parker in his book, *Cross Functional Teams* (Jossey-Bass, 2003), the three primary types of teams would generally be described as follows:

¹¹ Patent Pending

¹² Glenn M. Parker, *Cross Functional Teams*, Jossey-Bass, San Francisco, CA, 2003

- a. Functional – the typical military mode departmental team with configuration based on hierarchal command-and-control processes comprised of a boss and their direct reports. Issues such as leadership, objectives, performance standards, etc. are usually well-defined and easily understood.
- b. Self-Directed – Parker explained the dilemma for offering a definitive description of self-directed teams when he wrote, “there are as many ways of describing a self-directed team as there are consulting firms specializing in the process.”¹³ While this team configuration is rarely used in healthcare, for the sake of differentiation between this process and a conventional cross-functional team, we describe it as a group of individuals who work together to address a particular issue or objective without a hierarchal infrastructure.

While such teams can be interdepartmental, they can also be intradepartmental. Such teams remain flexible with regard to tools and processes with their singular focus on delivering an optimal outcome for their assigned duties. These teams can be permanent or time-bound (i.e., often referred to as Task Forces). While, like all other team processes, they have a leader, that individual’s role is more like a gatekeeper than it would be in other team configurations. Issues such as team values, tools, procedures, priorities, metrics, etc. would be determined by the team itself. While such self-directed teams are overseen / directed by one individual, they are generally empowered based on defined authority to deliver a particular outcome.

- c. Cross-Functional – (a.k.a. multidisciplinary, interdisciplinary or interdepartmental). A fine line exists between our definition of self-directed teams and those espoused by many management consultants for this type of team. Typically, the composition of a cross-functional team would be interdepartmental and its mission, objectives, and metrics would be determined externally. The effectiveness of cross-functional teams is heavily dependant upon the skills of the leader. Also critical to the success of the team is the selection of the members to create the balance of the roles necessary to deliver desired outcomes.

HPOs are making some strides in moving toward an environment utilizing a variety of team-based activities. Unfortunately, the “silo” structure which exists industry-wide in HPOs is rendering these efforts nearly worthless from the aspect of optimal efficiency and effectiveness.

As part of the challenge to eliminate or neutralize silos in healthcare, the following facts about how and why these silos emerged needed to be discovered:

- which group dynamics hold them together,
- what, if any, are the benefits derived from silos and,

¹³ Ibid
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- if so, how can they be replaced,
- what aspects of the structures of silos are consistent throughout organizations,
- is their existence planned and, if so, by whom,
- how other industries deal with them

Based on our analysis, we realized, in essence, silos are really separate cultures within all organizations, not merely in healthcare.

Hospital departments such as a pharmacy, laboratory, radiology, surgery, etc. all compete for fiscal resources. At the same time, the managers of these silos have different regulatory criteria and standards set by their respective “professional” organizations, separate quality and production measures by which their performance is rated and separate operating budgets. In essence, these “silos” think and act as if they were independent businesses. The same mentality is compounded by the many separate silos functioning within many complex/segmented departments such as radiology, laboratory or the nursing department.

The medical staff has its own silos as well as other organizational and communications barriers. Within the medical staff, not only is each specialty a silo, having separate and competing groups of practitioners within each silo adds to the dilemma. Couple these problems with the attitude of each provider within a network or regional system and you get the full view of why healthcare has lost the ability to have the cohesion and collaboration necessary to embrace changes, including those associated with enhancing quality and controlling expenditures. At the same time, these deficiencies prevent the creation of organizational camaraderie and inter-departmental esprit des corps; essential ingredients to reduce stress, minimize errors, and decrease turnover.

Unfortunately, while the healthcare industry has many serious problems, they are not alone! Such silos exist within most industries. This fact is unnerving because, as corporate complexity and the number of sub-specialties grow at an astounding pace, essential organization-wide cohesion and collaboration deteriorates, further diminishing the chances for optimal outcomes through the use of cross functional collaborative initiatives.

3. Value Analysis – Unfortunately, the historic application of value analysis techniques in healthcare has been viewed as “a process” for managing non-payroll expenditures, which is rarely applied beyond the selection of rudimentary nursing care products. In reality, since value analysis is a tool which should be utilized as part of an organization-wide approach toward controlling all non-payroll expenditures, its use should not merely be relegated to a conventional product oriented “value analysis” team. The success of any HPOs non-payroll expense management efforts will depend upon the ability to establish collaboration between departments, while curing the problems of dysfunctionality with current “teams.” Integral to these efforts, processes must be created to address expense management by creating meaningful WIIFMs (what’s in it for me) solutions for employees, managers and the medical staff. In order to move beyond merely realizing incremental improvements to their efforts, HPOs

must shift their lopsided focus on training from the K Set (Knowledge) for the use of the tool of value analysis to the S Set (Skills) necessary to build effective, dynamic teams; ones which will prevent the problems associated with dysfunctional communications and competition which exists in inter-disciplinary approaches. The K Set training for the explanation and application of value analysis tools can and should be focused on a core group of individuals who can bridge the aforementioned problems by facilitating inter-disciplinary processes to build organization-wide acceptance; i.e., as internal consultants for the application of the tool of value analysis.

4. Benchmarking – Benchmarking, like value analysis, can be a valuable tool for HPOs. Unfortunately, the concept can be abused, especially if it is viewed as a solution rather than a seed or starting point. Because there are various types of benchmarking, it would be impractical to delineate their separate attributes and limitations in this document.

In our opinion, the tool of benchmarking must be used properly for the right applications (e.g., monitoring measures of performance) in order for its value to be maximized. However, misused to establish outcome targets, it can be performance limiting, contrary to initiatives to stimulate innovation, or operationally disastrous when used for best practice process modeling without taking into account the need for “adapting before adopting”. A detailed explanation of the perils and pitfall of improper use of benchmarking can be read in the April 2006 issue of Healthcare Purchasing News.¹⁴

5. Operational Efficiency - The books, *The Innovator’s Dilemma*¹⁵ and *The Innovator’s Solution*¹⁶ make reference to the use of an RPV Framework as a concept which encompasses the three factors which affect what an organization can and cannot do: resources, processes and values. For the sake of clarity, we define each factor as follows:
 - a. Resources – people, equipment, technology, etc.
 - b. Processes – the actions, procedures, practices, methods of communication, decision making, etc which allow transformation to take place.
 - c. Values – the standards by which employees and managers make prioritization decisions.

While the idea for the RPV Framework is relatively straightforward and simple to comprehend, HPOs should think carefully before adopting this concept. While the concept is good, the sequence is reversed as it would benefit healthcare. In healthcare, we feel RPV should be VPR. The focus should be on establishing the right values/objectives (V) and matching the process (P) to maximize those values. Only after a determination has been made to ascertain the “right” infrastructure (team

Note: One of the core concepts offered by CMOO includes a comprehensive reinvention of the healthcare application of value analysis pioneered by William McFaul in the late 1970s.

¹⁴ Benchmarking: Should the art or science be benched?, Thomas MacVaugh, Healthcare Purchasing News, KSR Publishing, Sarasota, FL, Vol.30, No.4, April 2006, p.13-16

¹⁵ Clayton Christensen, *The Innovator’s Dilemma*, Harper Business Essentials, New York, NY, 2003

¹⁶ Clayton Christensen and Michael E. Raynor, *The Innovator’s Solution*, Harvard Business School Publishing, Boston, MA, 2003, p.178-187

configuration), protocols, and procedures necessary to execute the desired strategy with optimal efficiency can a HPO decide on the role/duties necessary for the participants in the process to excel in the effort to produce an optimal outcome.

When a HPO has identified the appropriate process to execute its strategy with optimal efficiency and effectiveness, it can proceed to select the “right” resources to maximize the previous step. This phase of the VPR process involves several critical steps:

1. Select the “right” individuals who are capable of executing the strategy by optimizing the processes previously identified.
2. Ensure these individuals have the “right” training to perform optimally.
3. Provide the “right” tools to execute the strategy in keeping with the organization’s vision/objective.

In addition to the failure to establish the proper sequence in order to execute strategies optimally, HPOs often fail to identify the “right” tools. For example, if an HPO’s strategy was to become cost effective in all areas associated with non-payroll expenditures, a vast majority of the organizations would focus on selecting a group purchasing organization (GPO) which offered the lowest prices on their contracts, had the lowest percentage of operating expenses in relation to revenue, and/or returned the greatest percentage of money to its participants in relation to total revenue.

While these factors are the industry’s standard measures of GPO effectiveness, few HPOs focus on defining the “right” GPO as being one which provides mechanisms to allow department managers and physicians to have advance input into the selection of acceptable items and sources as well as the award process. As a result, a vast majority of HPOs are forced to struggle with processes associated with change dynamics (ex-post facto conversion to a product/service or source which may not be acceptable to the actual “user”).

Other pitfalls associated with the failure of address the “right” tools for cost effectiveness include the following:

- Dependence upon GPOs to select the “right” providers of data or support services; i.e., those that will meet the true needs of the individuals/teams participating in the process of executing the organization’s strategies.
- Focusing primarily on prices paid rather than also encompassing the issues of who, what, where, why, when, and how many of product and service consumption and utilization. Simply, having the lowest price available does not ensure the physicians or staff will use the product. At the same time, without the necessity of changing brands or sources, considerable money can be saved by reducing misuse, waste, or theft of products or services.
- Allowing “selection bias”; i.e. focusing only on quantitative processes such as Six Sigma® or lean instead of using multiple approaches which also encompass building cohesion and collaboration (critical factors for gaining change acceptability).

Fully deploying the VPR process is essential if a HPO expects to achieve operational improvement through the execution of a targeted strategy. Unfortunately for many initiatives, the sequence is often underappreciated and inadequately addressed.

Simply, most initiatives fail because of poor execution; as a result of improper “flow” by addressing “process” creation as the first step, failing to identify the “right” CSK Set®¹⁷ selection (the necessary blend of characteristics, skills, and knowledge needed to fill the “seats” necessary to perform the required tasks optimally), and failing to provide adequate resources to deliver the desired outcome.

While most HPOs would be wise to consider seeking expert external assistance to guide them through the initial process design and development phases due to limited internal resources, as a whole, the healthcare industry must refocus its efforts to place every ounce of mental energy on finding the “right” people to fill the “right” seats, in the “right” quantity, with the “right” customized circumstance based CSK Set®¹⁸ to deliver the desired outcome (including training and education) and empower them to identify the “right” tools to execute the strategy optimally.

It should be noted that recommendations and theories for process and change management associated with organizational improvement abound in management literature.¹⁹ Unfortunately, the same pitfall outlined in improper sequencing; e.g., RPV – VPR destroys the chance for optimal performance. As another example, in the book, *Leading the Revolution* by Gary Hamel, one of the world’s most renowned business strategists, he places the emphasis on people first when he delineates the 3 core processes as People, Strategies and Operations.²⁰ He also provides valuable advice by warning leaders that merely trying to rally the troops will not suffice.

Optimal outcomes cannot be achieved when individuals try to rush processes to get quick results so they can hurry to get back to their “normal” duties.²¹ Examples of such episodic program-driven, task-specific endeavors are found throughout management literature under the heading of rapid change acceleration concepts; including but not limited to the popular concept of Work Outs.²²

6. Change – The issue of change is one of the three most important factors which will determine the success of any HPO in the future; i.e. the ability to get the organization’s entire infrastructure to recognize the need for change and to actually embrace it. The two other factors are QUALITY and COST – both of which are driven by the ability to create an organizational culture for the acceptance of change²³. While the concept of creating a culture which will embrace change may seem to be a lofty ideal, it is attainable with focus, planning, perseverance and proper execution.

¹⁷ Patent Pending

¹⁸ Patent Pending

¹⁹ Dozens of change management theories and practices are widely used throughout the world. CMOO uses the IPE concept merely as an overly simplified illustration of the steps which must be considered as part of operational reconfiguration/redesign. The actual platform of methodologies designed by CMOO represent a compilation of more than 18 distinctly different approaches

²⁰ Gary Hamel, *Leading the Revolution*, Harvard Business School Press, Boston, MA, 2000

²¹ Ibid

²² The most common process for change acceleration used in conjunction with Six Sigma®

²³ Note: CMOO has designed processes in the form of patent applications designed to enable organizations to create a culture of change acceptability.

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This is a critical issue because, while the healthcare industry has been historically plagued by accepting “good enough” changes in order to execute strategies, “good enough” may simply not be good enough to meet the challenges ahead.

The cornerstones of the healthcare industry, hospitals, are highly complex “miniconglomerates” but with a complex dynamic of internal competition while still being subjected to the demand for change equal to or greater than any business. For example, each of their “independent companies” (departments/silos) are subjected to:

- ❖ Distinctly different reporting requirements to separate and sometimes multiple agencies.
- ❖ Quality standards and metrics established on a department-by-department basis.
- ❖ Mandated regulations (e.g., HIPAA), guidelines often subject to interpretation (e.g., CDC, JCAHO, OSHA, etc.).
- ❖ Varying procedures within a specific workstation due to the lack of standardization.
- ❖ In-service training problems because turnover exceeds the pace at which change can be stabilized, etc.

All of these factors are compounded by rapid technological advancements in operating practices as well as direct patient care.

While typical command-and-control leadership is absolutely critical in many aspects of day-to-day operations in healthcare, its use can limit the willingness of some individuals to accept necessary practices. Therein lays the difficult task for HPOs – getting employees to want to give the organization what it wants and needs; organization-wide collaboration and cohesion to respond to tomorrow’s QUALITY and COST challenges without viewing each new issue as “change overload”. The equation, $Q \times A = E$ (Quality times Acceptance equals Effective Results) is widely used in the Six Sigma® concept in healthcare to depict the critical nature of the need to gain *acceptance* to change (“A”). In our opinion, this formula should be reversed to “A” x “strategy/task/function/project” = E; unless the organization’s focus is only on quality.

While some devotees to Six Sigma® may argue this point as being too literal, we believe not enough emphasis has been placed on the psychology of change in healthcare to enable change to become an acceptable attitude, something which is necessary and expected, rather than being optional.

Today, many healthcare executives and managers view change as being something which can either be mandated or “sold” based on the specific need. This is another vivid example of how the healthcare industry has reversed the order of priorities for the critical processes associated with the execution of strategies. A vast majority of healthcare executives will readily admit that the ability to “sell” change is one of the greatest challenges in the industry.

Unfortunately, too few executives realize that change must be marketed before a conceptual “sale” is attempted. Attempting to get others to accept our concepts or

processes without adequate “marketing” is like trying to sell a product door-to-door to people prior to establishing the product’s reliability, the credibility of the manufacturer or the product’s usefulness.

After change is “sold”, the challenges continue. The “purchase” of a change by an individual does not guarantee they will retain (keep) the conviction, belief, or support for the idea or process. Change, when sold, must be serviced and maintained for the life of the idea or the process. To be truly effective, change must be sustainable.

The failure to understand this basic principle often results in “returned goods” (i.e., breakdown of processes with resultant failure such as poor quality of patient care or safety hazards). Furthermore, even if a change is “retained”, its purchase cannot be construed as implying an acceptable level of customer satisfaction (good employee morale); still another critical reason for ongoing preventive maintenance.

Due to the absolutely critical nature of enabling change, providers should consider placing a major emphasis on creating a culture of change acceptability rather than merely pursuing topic / issue-based initiatives one at a time; e.g. quality, patient satisfaction, safety (employee and/or patient), product conversion, etc. With a solid foundation for change management, the equation to derive “effective results” could be “A” (acceptance) x “anything” (your choice of strategic needs) = effective results. If the “A” exists, any initiatives introduced, will have a higher probability of acceptance and success.

In our opinion, because so many HPOs view their need for acceptance of change on a project-by-project basis rather than a “core” strategy, they waiver in their commitment to support the concept on a 100% consistent basis. On one hand, these organizations wave the banner of change acceleration while, on the other hand, they fail to “walk-the-talk” consistently at all levels of the organization. For example, during the processes for the evaluation of changing group purchasing organizations, some HPOs take more than one year to make the decision; despite the fact that millions of dollars of expense reductions can be at stake.

One health system which touts the use of Six Sigma® principles for their four divisions, designed a plan to implement the conversion of their organization-wide materials management information system (MMIS) over a span of three years. Another example would be the many instances where HPOs continually have topics which can generate large savings on their value analysis/product evaluation team agendas for six or more months. Until HPOs consistently walk-the-talk by stimulating urgency in their decision making processes, high complacency will prevail and valued / meaningful change will continue to be a struggle for most healthcare providers.

One of the most essential areas for improvement in order to stimulate urgency is the need for an organization-wide focus of executing strategies. In our opinion, HPOs do not lack the ambition, intelligence or planning to execute the strategies faster and more effectively. They lack leadership at the middle management level. (Due to the scope and complexity of this critical problem, it will be necessary for the details associated with rectifying this deficiency to be discussed with CMOO® in detail).

Much like the many dysfunctional processes which HPOs attempt to utilize to meet their needs (i.e. Q x A vs. A x Q, RPV vs. VPR, KSC vs. CSK®, using value analysis as a process vs. as a tool, using selection bias for options vs. multi-faceted or multiple processes simultaneously, etc.), efforts to initiate long term, meaningful change initiatives without creating the proper sequence are foolhardy.

7. The “Who” – For a variety of reasons, not the least of which has been the limited availability of fiscal resources, HPOs have been forced to adopt a “make do” attitude when making decisions regarding the selection of personnel to execute any given strategy or to fill a vacancy. Executives, almost instinctively, wonder first about WHO they can utilize for assignments which materialize. Complicating this problem has been the propensity for all business thought processes to flow from resources→process→values (objectives) as addressed previously and nearly every major business book and article reinforces that thought process. In addition, nearly every industry, including healthcare, searches continuously for the “hero model” of leadership; i.e., the “super”, one-size-fits-all, charismatic individual. Hundreds of millions of dollars are spent annually with “search and recruitment” firms in the healthcare industry alone searching for the “right” WHO – the perfect CEO.

In our opinion, a form of “benchmarking” as a process to search for leaders will continue as the most common model used in the marketplace. This concept utilizes the creation of criteria based on the attributes of “world class” leaders, per se; the “cream of the crop” based on their performance. It is highly likely that this model will be the one of choice for only a short period of time before boards and personnel responsible for the process of searching for leaders realize the pool of qualified candidates is shrinking – not from decreases in the quality of educational curriculum or the lack of experience – but from dramatic increases in the complexity of the jobs. In other words, the pool of candidates to fit the criteria specified for consideration is shrinking because the demands being placed on many positions are expanding beyond the capabilities of all but a handful of individuals. These “hero” modeling search and recruitment processes may have worked in the past but they will not be useful in the near future.

As HPO complexity increases at a blistering pace and boards as well as executive teams become more cognizant of the need to reconfigure both leadership/management strategies and operating mechanisms, there will be a greater awareness of the need to reconsider status quo decision-making processes; including ones associated with the leadership of the entire HPO. Already, in all but the smallest of HPOs, efficiency and operational effectiveness will necessitate the existence of executive teams comprised of individuals who are ideally suited to perform the tasks required.

Due to the fact that the waves of technology, knowledge, and pressure on healthcare providers to respond to demands for quality enhancement and cost reduction are coming much faster than ever before, the need to consider reevaluation of the job descriptions of key personnel to meet these challenges is becoming apparent. In the same manner as previously outlined when addressing VPR, HPOs will be forced to reconfigure the “seats” and then look closely at who is the “right” individual to fill them. Another critical consideration will be the alignment of the “right” people who

constitute the executive team to ensure they are “balanced” to offer an optimal (“right”) configuration.

8. Leadership Development – As mentioned previously, at the heart of the future of the healthcare industry are three critical factors: QUALITY, COST and CHANGE. Regardless of healthcare’s footprint moving forward, survival will depend upon a HPOs ability to execute the processes to address all three factors optimally, not only one or two of them but all three.

Unfortunately, leadership is probably the weakest link in the healthcare industry’s ability to move to a higher plateau of efficiency and effectiveness – not because of the lack of expertise at the executive level but the lack of the necessary leadership characteristics and skills at the middle management level.

While many HPOs are moving to address this serious deficiency, inertia is coming from the industry’s propensity to focus on form over function. The problem has been engrained in healthcare operations as the industry evolved. Prior to the mid 1980s decades of liberal reimbursement did not require true business-like management and leadership – patient care was the focus.

Today, the needs of the industry to place a major emphasis on the business side of day-to-day operations requires a reinvention of what management and leadership mean in healthcare. Now and in the future, designating someone as a leader does not signify they possess the attributes of leadership. Inappropriately, in some HPOs, every manager is referred to as a leader and, while by the dictionary definition they may direct or be in charge of the activities or duties of other people, designating these individuals as a leader has no correlation to their true managerial effectiveness.

Because the healthcare industry has not established detailed standards for gauging the effectiveness of a leader, it is impossible to list all of the leadership attributes an individual should display to be considered a “good” or, even more difficult, a “great” leader. On the other hand, it is substantially easier to identify an individual who lacks the qualities of a leader.

Even if an executive team can agree that an individual oversees a department that consistently performs under budget, meets established quality standards, completes assigned tasks on time, etc; can they also assume the individual is a “good” leader.

Shouldn’t factors such as staff satisfaction, employee retention rate, inter-departmental relationships, 360 evaluation results, etc. also be key indicators? Is there a price being paid (either directly quantifiable or indirectly through the negative impact on morale, organization-wide collaboration, etc) to attain the level of being a “good” leader merely in the eyes of some people who use historical measures of performance? If so, who pays that price?

Arguably one of the world’s leading management and systems thinkers, Peter Senge, weighs-in on the changing view of leadership in his bestselling book, *The Fifth Discipline*, when he wrote, “Our traditional views of leaders - as special people who set the direction, make the decisions, and energize the troops-are deeply rooted in an

individualistic and nonsystematic worldview. Especially in the West, leaders are heroes - great men (and occasionally women) who 'rise to the fore' in times of crisis. Our prevailing leadership myths are still captured by the image of the captain of the cavalry leading the charge to rescue the settlers from the attacking Indians. So long as such myths prevail, they reinforce a focus on short-term events and charismatic heroes than systemic forces and collective learning.

At its heart, the traditional view of leadership is based on assumptions of people's powerlessness, their lack of personal vision and inability to master the forces of change, deficits which can be remedied only by a few great leaders."²⁴

In our opinion, Senge has identified one of the root causes of the healthcare industry's a lack of leadership at the level of middle managers - the focus is often on creating individual leaders rather than on the creation of the leadership dynamics which will build collaboration and cohesion.

In *The Fifth Discipline*, Senge calls for organizations to address the five disciplines necessary to develop a "learning organization", a concept which includes but also far exceeds merely learning to use teams to lead processes. These disciplines are personal mastery, mental models, shared vision, team learning and system thinking (the latter being the 5th discipline).

Taking a peek into the future challenges for the healthcare industry necessitates only a bit of Likely Evolution Strategic Planning®. Logically, as cost pressures continue to mount, isn't it reasonably safe to assume that a flattening of organizational structures in the healthcare industry will have to occur? Isn't it also safe to assume that these changes will necessitate having the middle managers of HPOs trained to perform collaboratively through distributed (facilitative) leadership and team-based activities?

In *The Fifth Discipline*, Senge explained that, when interviewed by him regarding what role they would have as the leader if their organization was an ocean liner, managers often responded – captain, navigator (set direction), helmsman (steer), engineer (provide energy) or social director. But the one neglected role, according to Senge is the designer. Thinking ahead, won't the Executive Teams of HPOs need to find people who can design the teams and infrastructures necessary to execute the many strategies necessary to remain viable? Who has that job today? Can it be filled by any one individual?

Summary

Success in the consumer-driven healthcare environment where quality and cost data is transparent will require HPOs to realign and reconfigure their core strategies and decision-making processes. Two areas where which must be given the utmost priority are:

- Realignment of all planning and strategy execution processes such as KSC for recruitment and hiring, $Q \times A = E$ for a primary focus in an environment where the quality and pace of change acceptability will translate into success or failure,

²⁴ Peter Senge, *The Fifth Discipline: The Art and Practice of The Learning Organization*, Currency Doubleday, New York, NY, 1990

RVP for the execution of strategy, and the dependence upon traditional leadership configurations

- Refrain from using selection bias (limiting the selection of “tools” to accomplish a complex task or to address organization-wide needs) amidst the current environment where the pace of complexity and pressure is or will exceed the ability of the HPO to respond efficiently and effectively. For example, in a Guest Column for Harvard Management Update, Ronald D. Snee (a principal in Tunnell Consulting’s process and organizational excellence practice and an author of more than 150 articles and 3 books on management, performance enhancement, and statistics) wrote, “...Six Sigma® can gain momentum.

After two or three years, longer term benefits begin to emerge, and the culture of the organization begins to shift towards a scientific way of thinking about how to manage, including a greater focus on processes, data-guided decisions, and the effects of variation on the decision making process.”²⁵ In our opinion, while the enhancements to day-to-day operations for HPOs are valuable, cultural reconfiguration must also incorporate another scientific foundation – one of complexity science. Part of tomorrow’s culture of change acceptability must also provide balance between the elimination of statistical variation and the need for mental stimulation as well as the experimentation necessary to stimulate innovation and creativity.

Recently, “major industrial / commercial enterprises” have identified the deficiency of using selection bias when addressing corporate operating strategies (i.e., focusing on one approach such as lean or Six Sigma®). This issue was raised in an interview with Jeff Immelt in the August 1, 2005 issue of Business Week. While the article and the interview with Mr. Immelt addressed the issue of focusing on quantitative factors and the subsequent negative impact on innovation, the following question in particular caught our attention.

BW – “Is it a big leap from a Six Sigma® culture focused on productivity and quality to an innovation culture?”

Immelt – “I look at Six Sigma® as a foundation on which you can build more innovation. I don’t think every manager can do both [Six Sigma® and innovation], but I don’t need every manager to do both.”

In our opinion, regardless of why or how it occurred, major manufacturers reversed the order in which operation strategies should be addressed. Simply, they failed to act on the fact that, when the focus is on the ability to accept change as a part of daily work activities, any strategy, including quality improvement and innovation, can be executed more effectively. While GE and other major manufacturers appear to be readjusting to develop parallel processes to address innovation, the healthcare industry (due to its unique complexity) must address three critical parallel paths – subjective issues related to the psychology of change, quality and innovation. Today’s blistering pace for waves of changing

²⁵ Ronald D. Snee, *Can Six Sigma Boost Your Company’s Growth?*, Harvard Management Update – June 2004, Harvard Business School Publishing Corporation, Boston, MA

technologies, the introduction of new business models, and near instant access to information and knowledge are occurring too fast to allow any business to be a victim of selection bias.

While many HPOs place a priority on the elimination of variation, institutionalization of processes as well as the standardization and commoditization of products and purchased services, it is interesting to note that, at the same time, they recognize the need exists for middle managers to increase their skills in leadership as well as to stimulate creativity and innovation.

Accordingly, unless HPOs account for this contradiction of mental foci as part of their leadership development processes; efforts to increase productivity, decrease errors and stimulate innovation will continue to be futile. HPOs must create and maintain dual processes – a quantitative one as well as one to establish their organizational health (qualitative). The latter process is referred to by management experts such as Peter Senge as a learning organization²⁶ and by Karl Albrecht as organizational intelligence.²⁷

²⁶ Ibid

²⁷ Karl Albrecht, *The Power of Minds at Work*, AMACOM, New York, NY, 2003