Cost Reduction in Health Systems: Lessons from Analysis of $200 Millions Saved by Top Performing Organizations

By Chip Caldwell, Greg Butler, and Nancy Poston

The biggest difference between rats and people
is that rats learn from experience.
-- B.F. Skinner

Summary. The number of healthcare organizations requiring targeted cost reduction due to state and federal budget shortfalls is demanding more intense senior leader accountability than at any time in memory despite years of efforts to curb expenses. Leaders are discovering that traditional methods have largely exhausted themselves and are seeking fresh approaches to meet their strategic imperatives. This study of over 200 U.S. healthcare organizations, including detailed site visits and interviews at forty-two organizations with $188 million validated cost recovery, uncovers specific non-delegable senior leader roles found among top performers, including techniques for goal-setting, use of data, characteristics of their organization-wide accountable change models, and culture characteristics.

Chip Caldwell, FACHE, is a faculty member of ACHE and Chairman, Caldwell Butler and Associates, LLC, a consulting firm based in St. Augustine, FL. Greg Butler is a faculty member of ACHE and President, Caldwell Butler and Associates, LLC. Nancy Poston, FACHE, is Managing Principal, Growth Strategies, at Caldwell Butler.

In the recent blockbuster movie, *Toy Story 3*, Andy, as he is packing for college, is asked by his mother, "What are you going to do with all these old toys?" Realizing he can only take *one* toy with him, Andy selected Woody, choosing to donate the remainder to a child day care center. Why Woody? In Andy's words, the faithful cowboy toy is the one toy who is always there for you, always consistent, never waivering, always dependable to stand by his convictions, regardless of circumstance, hardship, or peril.

As will be revealed in this article, this same vital behavioral characteristic emerged from the 2010 findings of detailed analysis of forty-two organizations through senior leadership interviews and site visits and our 2008 study of over two hundred U. S. hospitals' cost performance analysis (Butler 2009). Senior leaders of top performing organizations exhibit an unwaivering, consistent, and disciplined approach to strategy achievement, goal-setting, speed of implementation, and ownership of the effectiveness of the organizational change model utilized to extract costs. (Mr. Butler's 2-day ACHE course focused on this topic can be found at www.ache.org, click on "Education" and his book can be purchased from Health Administration Press at www.ache.org.)

During the course of this article we will describe the following:

- The description of the thirty-seven healthcare organizations in the database producing almost $200 millions in validated costs, including specifics of the senior leader interviews and selected site visits at forty-two organizations;

- The “what” – Affinitized groupings of the 16,952 manager-implemented changes that achieved these $200 millions savings by type of savings, magnitude of savings, etc.
- Reveal the “how” – More important than the “what”, *how* did the top performing organizations achieve results and what factors led to the non-starter organizations’ lack of results.
- “Take Home” Value – What assessments and interventions might readers apply in their own organizations to model and replicate results of top performers while avoiding the failure factors of Non-Starters.

The urgency of cost reduction is compelling. Senior leaders failing to read the tea leaves, as it were, hoping for better times, as opposed to proactive action today, do so ill-advisedly. In a survey of 525 CEOs, the American College of Healthcare Executives reported that the three concerns topping the list were financial challenges, healthcare reform implications, and care for the uninsured, all three pointing to the urgency of improving their organizations’ cost position (ACHE 2010). While senior leaders have faced the need to reduce costs for many years, the “perfect storm” of compelling factors has never been more urgent nor more pressing. El Camino Hospital CEO Ken Graham (2010) observed, “As insurers bundle, we expect a 10 percent to 15 percent decrease in reimbursement rates.” Thirty-one states are projecting budget shortfalls greater than 10 percent at the same time that Medicaid enrollment is expected to climb 5.4 percent (Von Drehle 2010). A recent Pew Center analysis found that state

budget shortages averages 12 percent with California topping the list with a whopping 49 percent imbalance, as shown in Table 1 (Pew 2009). The reasons for concern and, hence immediate attention, are indeed compelling to say the least.

State	Budget Shortfall
California	49%
Arizonia	47%
Illinois	41%
Nebraska	38%
National Avg	12%

Table 1. State Budget Shortages

Source: Pew Center. "Beyond California: States in Fiscal Peril." CNN, November 11, 2009

Approach to the analysis

The authors conducted a four-phase approach to create the content for the analysis, as follows:

1. We first downloaded 16,952 specific changes representing $188,486,604 of validated savings implemented by managers from thirty-seven organizations within our online improvement database (Figure 1) (Caldwell 2010a). The data were then exhaustively analyzed for trends by department/ cost center, type of cost (salaries, supplies, etc.), type of department, magnitude/impact, etc. The demographic characteristics of the database were as follows:

- 55 percent were part of a multi-institutional health system.
- 29 percent were academic/teaching classified.
- 5 percent were Critical Access Hospitals.

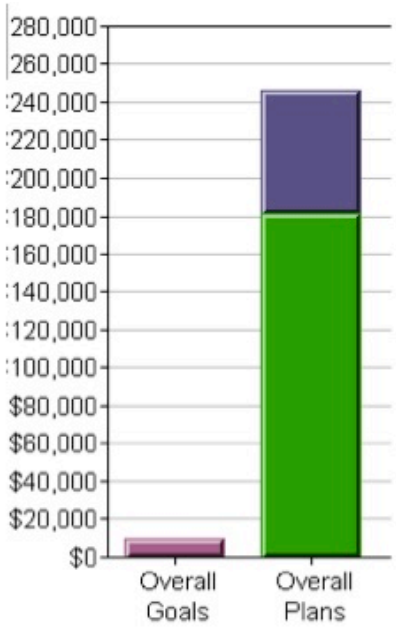

Figure 1. Analysis Database

Source: www.caldwelltools.com, accessed November 8, 2009 covering the period July 13, 2007 through October 28, 2009. With permission.

2. Reaffirmed the findings from our previous analysis of over 200 healthcare organizations as found in our Health Administration Press book *What Top Performing Healthcare Organizations Know: 7 Proven Steps for Accelerating and Achieving Change* (Butler 2009) and *Lean-Six Sigma for Healthcare: A Senior Leader Guide to Improving Cost and Throughput* (Caldwell 2009).

3. Interviews and selected site visits (in some cases more than one site visit), with forty-two healthcare organizations derived from the database above, past relationships, and literature review of successful cost initiatives. In order to discern differences between top performing organizations and non-starter organizations, the database was divided into high performers and low performers. Seventeen organizations were represented in the top performing group as follows (in order of interview/visit) (* denotes site visit; ** denotes multiple visits):

- Kurt Stuenkel, Chief Executive Officer, Floyd Medical Center, Rome, GA **
- Mark Jones, Chief Executive Officer, University Hospital at Princeton **
- David Jimenez, EVP, Catholic Healthcare Partners **
- Kevin Cook, Chief Executive Officer, Mercy Health System Scranton **
- Rob Thames, Chief Operating Officer, St. Anthony's Hospital, St. Louis **
- Sarah Sinclair, Chief Nursing Officer, Cleveland Clinic ** (multiple site visits while CNO Memorial Hermann)
- Margaret Lewis, President, HCA Capital Division, Richmond (18 hospitals)
- Brian Bauer, Chief Executive Officer, HCA Terra Haute Regional Medical Center *
- Mark Tolosky, Chief Executive Officer, Baystate Health System, Springfield, MA
- Chris Denton, Chief Financial Officer, HCA Henrico Doctors, Richmond
- Brett McClung, President, Texas Health Southwest **
- Peter Goslin, Chief Executive Officer, Monadnock Community Hospital, Peterborough, NH **
- Jim Dague, Chief Executive Officer, and Randy Christophel, Chief Operating Officer, Goshin Health System, Goshin, IN
- Brad Chambers, Chief Executive Officer, and Neil McDonald, Chief Operating Officer, Union Hospital, Baltimore **
- Dennis Pullin, Chief Executive Officer, and Dave Pitman, Chief Financial Officer, Harbor Hospital, Baltimore **
- John Rockwood, Chief Executive Officer, National Rehabilitation Hospital, Washington, DC **
- Todd Sorenson, MD, CEO, Regional West Medical Center, Scottsbluff, NE *

The "What": Specific Areas of Cost Reduction

An analysis of the $188 millions saved within the forty-five departments tracked by various categories is shown in the tables below. As would be expected, the impact by department follows the size of the department in relation to the organization except human resources (HR) and education. As for impact areas, the fact that revenue cycle/ coding and staffing heads the list is no surprise.

Dept	# Changes	% Total Dollars
Nursing	2337	19%
HR or Education	362	6%
Imaging	444	6%
Surgery	500	6%
ED	255	5%
Pharmacy	418	5%
Administration	300	4%
Bus Office	248	4%
Medical Records	250	3%
Cath/GI/Endo Labs	164	3%
Case Mgmt -UR-Social S.	170	3%
Maintenance	246	2%
Purchasing/Stores	245	2%
Phys Offices	475	2%
Total		**71%**

Table 2. Changes by Dept

Dept	# Changes	% Total Dollars
Nursing-General/Unspec	1048	51%
Nursing - Med - Surg	347	14%
Nursing - Critical Care	239	12%
Nursing - Telemetry	137	10%
Nursing - L&D	160	4%
Psych Unit	216	5%
Oncology	116	2%
Nursing - Orthopedics	35	1%
Nursing - Pediatric	39	1%
Total	**2,337**	**100%**

Table 3. Changes by Nursing Dept

Budget Impact Area	# Changes	Total Dollars	% Total Dollars
Rev Cycle/Coding/Other	3226	$64,282,349	34%
Salaries/FTEs	2575	$50,765,178	27%
Supplies	3548	$35,936,910	19%
Other Fees/Outsource	832	$16,542,442	9%
Benefits	154	$10,300,903	5%
Prof Fees/Agency	191	$5,994,839	3%
Maint	297	$4,663,983	2%
Grand Total	10823	$188,486,604	100%

Table 4. Changes by Budget Impact Area

Lean Waste Type	# Changes	Total Dollars	% Total Dollars
Material & Information movement (incl Rev Cycle)	3441	$55,165,105	29%
Out of Quality Staffing	2172	$53,414,961	28%
Over-Processing/Redundancy	1612	$25,985,888	14%
Waiting	770	$18,411,773	10%
Over-Inventory/Supplies	1634	$17,559,415	9%
Motion	744	$10,165,513	5%
Over-Correction/ Inspection	450	$7,783,948	4%
Grand Total	**10823**	**$188,486,604**	**100%**

Table 5. Changes by Lean Waste Type

	#	%
>$500K	50	0%
>250K	87	1%
>100K	235	1%
>50K	393	2%
>25K	647	4%
>10K	1109	7%
<10K	14431	85%
Total	**16952**	**100%**

Table 6. Changes by Magnitude

However, not to be lost in this analysis is that, due to the fact that the changes follow department size and budget composition, the differentiators between top performers and Non-Starters cannot be found in what changes were made. Non-Starters know what to change, they simple do not possess the factors that drive successful change. This observation sets us up for the next section on *how* top performers achieve results.

The "How": Success Techniques of Top Performers

An interesting observation about the skills and competencies of senior leaders in top performing organizations and senior leaders in non-starter organizations is that rarely did we observe that *all* the senior leaders in top performing organizations would themselves be considered top performing senior leaders nor did we find that *all* senior leaders in non-starter organizations were themselves Non-Starters. That is, just as in life itself, we discovered variation in the leadership competencies among the senior leadership teams in both groupings. Certainly, the weighting of the competencies of the entire teams leaned in the direction of the performance of the organization, but leadership was not the defining characteristic. Rather, many other factors like structure, prioritization, goal-setting, use of data, and the culture provided for a much richer differentiation than leadership alone.

Beliefs of Non-Starters. Before we embark upon a detailed journey through these four differentiators, it is instructive to process the beliefs of Non-Starters. Non-Starters seem to offer a well-rehearsed litany of reasons why their lack of performance exists. Common observations are these:

- Too much focus on analysis and not enough focus on implementation. They seem to get bogged down in arriving at the perfect analysis, unwittingly causing delay after delay after delay. An unintended consequence of this analysis paralysis approach is that the very audience of most importance – top performing managers – become frustrated and tune out, while low performing managers fuel the analysis paralysis fire.
- Fear of …. (fill in the blank). Non-Starters seem to have an overabundance of fear of change. It's not that top performers are not faced with obstacles, but rather that they do not seem to be willing to allow obstacles to stand in the way of speed of change. Frequently expressed reasons to delay by Non-Starters are fear of physician reaction, fear of nursing resistance, fear of board or community criticism, and fear of their lack of knowledge regarding any proposed course of action. Similarly, Non-Starters act as if no change is a safer course of action than change.
- "The timing isn't right." Similar in form to fear, Non-Starters seem to be immobilized by other priorities. For example, it is not uncommon for Non-Starters to state something like, "Well, you know, Joint Commission is expected in the next month or two." When senior leaders are asked exactly how many managers must invest more than an hour or two per week to Joint

Commission readiness, it is not lost on these senior leaders that only a handful of managers are fully invested in Joint Commission work and that a wiser course of action would be to exempt this handful of managers while moving ahead with all other managers; total inaction still prevailes in the end. So it goes with IT system implementation or Magnet or any number of other priorities. Top performers, on the other hand, seem able to balance a myriad of complex priorities, exempting certain managers from one activity or another as the need presents, but moving forward with speed nonetheless.

- A culture of "No". Non-Starters exhibit the interesting observation that everyone has the right to say "no", but no one has the ability to say "yes". This seemed particularly true in academic organizations.
- Belief that six months doesn't make a trend.
- Belief of salvation from outside (i.e. higher reimbursement).
- Hope.
- Indecision / slow to act.
- Looking for perfect data &/or perfect benchmark.

So, what seems to separate top performers from Non-Starters? The answer is that, like Woody, senior leaders stay focused on the required strategic objective and the game plan they have created to get them there. Upon distillation of the mass of verbatims and notes from observed improvement meetings, the differences between top performers and Non-Starters can be neatly attributed to four differentiators, *all non-delegable roles of senior leaders*. This bears

repeating. Senior leaders in top performing organizations seemed to excel in four specific, non-delegable areas. Senior leaders at top performing organizations differentiated their organizations by mastery of four factors as follows:

- *Speed.* They dramatically transformed the organization's processes and culture toward speed of execution, involving goal-setting, effective use of data, manager action plan creation, and action plan implementation.
- *Culture of accountability*.
- *Organization-wide accountable change model*.
- *Accelerating impact of lean* (vs the traditional manufacturing-oriented training approach.)

These four non-delegable senior leader influencers are examined below.

Speed.

In listening to and observing the impact of senior leader activities, processes, and communications, it is clear that they value speed of implementation as their ultimate competitive advantage. The main competencies exhibiting speed involved goal-setting, depth of goals, and use of data.

Speed of goal-setting. While their non-starter counterparts continue to dwell on the available data, question its validity, seek addition analysis, hold numerous meetings, and generally experience delay after delay, top performers are quick to establish the metrics for success. In many cases, we observed a somewhat

"loosey-goosey" approach to progressing very quickly through the goal-setting process, seeming to accept "good is close enough" and "perfect might be elusive" in pursuit of speed to action planning and implementation. In two organizations, rather than argue whether the financial comparative benchmark was 100 percent accurate, senior leaders acknowledged that the comparisons were flawed, but asked, "How far off are these benchmarks? Are they 50 percent off? Are they 25 percent off?" When a concensus concluded that no data are 50 percent off, then 50 percent gap closure became the goal *and it was non-negotiable*, with action plans due that day. This 50 percent gap closure observation was one of our many surprises. We expected to find that top performers set stretch goals and held managers accountable to them. Instead, we found that top performers set speed to action plan implementation higher than the aggressiveness of the goal and centered their interventions around implementation-oriented tasks, not analysis-oriented tasks.

Use of benchmarking limited. Very few set goals at the department level, opting to set manager expectations around the number of required changes per month vs an arguable benchmark or goal. Most did set and communicate a CEO-level goal, but did not break these goals into VP-level or department-level goals. Kurt Stuenkel, Chief Executive Officer, Floyd Medical Center, Rome, Georgia, observed that their financial benchmarking process, as a key driver of sustainable cost improvement, had largely exhausted itself. "Floyd succeeded with benchmarking in the late 1990s and early 2000s, but after doing these

comparisons each year for several (years) in a row, the methodology became a bit stale" (Stuenkel 2010, 6). At Mercy Health System Scranton, CEO Kevin Cook observed that "benchmarking was the keeper of the status quo" (Cook 2010). It turns out that this bias towards action among top performers is well supported. In their landmark "In Search of Excellence" research, Peters and Waterman found that top performers favor a bias towards action (Peters 2004). Our analysis of the 16,952 change database producing $188 millions saved support this contention statistically. As Figure 2 points out, as the number of manager changes increases the total dollar impact rises proportionately. Therefore, setting action goals, that is, number of manager changes per month at, say, two changes per month, is highly predictive of success while failing to focus on implementation adequately risks non-starter status.

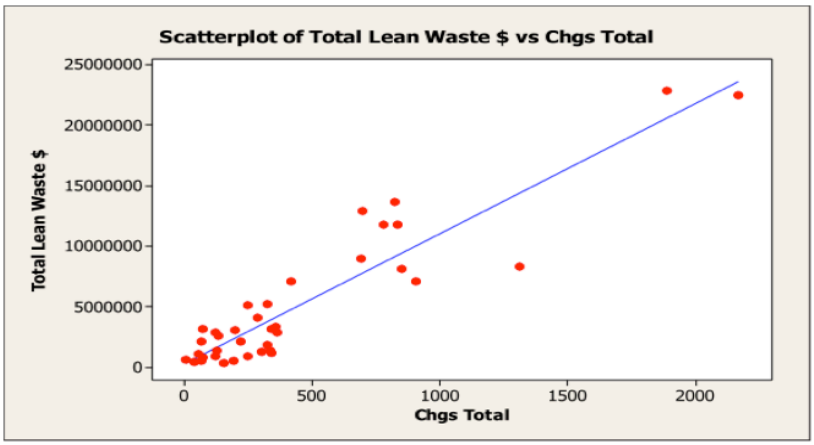

Figure 2. Number of manager changes trumps goal aggressiveness.

(Source: Caldwell Butler & Assoc, LLC, files. Reproduced with permission.)

Speed in use of data. Senior leaders exhibit an uncanny ability to discern when enough data is adequate to launch improvement plans as opposed to their non-

starter counterparts. Non-Starters seek, almost like the search for the holy grail, the perfect data in order to begin implementation. Senior leaders seek to answer a different question. They ask, “Do we have adequate data to begin?” and do not allow data imperfections to stall getting to manager action plans. This is not to state that we observed haphazardness, laziness, nor mediocre data, but rather that, once a critical mass of useable data becomes available, top performing senior leaders expect that action will immediately be taken on that data, while data analysts correct unusable or inaccurate data in parallel.

***Building a culture of accountability*.**

Not unexpectedly, another set of key differentiators observed between top performers and Non-Starters was culture, but again with a surprise or two. Several distinct observances regarding the actions and behaviors of senior leaders, such as building confidence and self-esteem, fostering a collaborative vs. siloed approach to improvement, among others, are remarkable.

Senior leaders in top performers seek to build manager confidence and self-esteem over constant correction and criticism of manager creative work. This was another one of our surprises in that it took us several months of observing and discussion until its importance became apparent. But let us say this: In the short list of critical differentiators separating top performers from Non-Starters was senior leader and manager confidence. Senior leaders undoubtedly

recognize this important cultural variable and seek, through actions and behaviors, to do everything within their power to continually raise manager confidence. Here's the surprise: Non-Starter senior leaders, when presented an action plan, a budget proposal, a creative idea, a task force recommendation, almost any piece of work, go into critique mode. And manager confidence and self-esteem clearly takes a hit as a result of senior leader criticism, however well-intentioned. The following short list highlights just some of the techniques and behaviors we observed:

- Even when reviewing initial or draft action plans at are weak, senior leaders of top performing organizations seemed to comment on the positive aspects of the action plan or ideas, as opposed to, the weak components of the action plan. This behavior was observed for one-on-one meetings, as well as, group meetings and gatherings. Senior leaders in non-starter organizations, on the other hand, when presented with an initial or draft action plan, idea, or task force recommendation, immediately go into critique mode. They pick through the action plan ideas, providing instruction and guidance about the idea; this practice on the surface would seem instructive, which is why the factor was one of our biggest surprises. However, the impact of critique on manager confidence, over many, many occurrences over many, many managers is demonstratably devastating to manager confidence. By stating the practice of critique in this way, its negative consequences become apparent; however, critique is a widely accepted practice nonetheless. Lest you conclude from

this observation that senior leaders in top performers do not provide constructive critique, that was not the case. Top performers do critique and counsel, but it is the timing of the critique that seems to make all the difference. The first pass on an action plan or idea review produces praise, which builds confidence and self-esteem, but a few hours or a few days later, a senior leader will re-raise the action plan or idea and offer suggestions then. The whole concept is subtle, but its practice cannot be understated in impact in building manager confidence.

Expectation of cross-department collaboration. We found evidence of collaboration in both top performers and Non-Starters, but there was a profound difference in its application. Top performing organizations' leaders recognize that the most profound changes occur in the handoffs in care processes and support processes and, therefore, establish both formal and informal mechanisms to foster collaboration between department managers. And they communicate an expectation of collaboration and participation. But, they hold a singular manager or vice president accountable for implementation. That is where non-starter organizations often slip up. Non-starter organization leaders permit collaboration to serve as an excuse for failure to implement an action plan; there is the finger-pointing that goes on that is not accepted behavior in top performing organizations. The collaborative excuse-making practice was among the most prevalent reasons why multi-institutional systems fail at implementation as will be discussed the section on multi-institutional systems later in this article.

Critical role of nursing. One would think that the central role of nursing would emerge as a clear differentiator between top performing organizations and Non-Starters and indeed it did. There were no organizations in the study in which nursing was not an active, willing, collaborative participant. In fact, an early predictor of failure is the lack of engagement by nursing leaders. Sarah Sinclair (2009), Chief Nursing Officer of the Cleveland Clinic, believes that the centrality of nursing in the more complex next generation of cost-cutting will be even more vital and we believe she is right. From a nursing prioritization perspective, all organizations we observed were pressing with multiple objectives – JCAHO, IT implementation, Magnet, clinical improvement activities, etc. However, a huge difference between top performers and Non-Starters is that nursing leadership in top performing organizations seem to rally around the cost imperative as opposed to seeking exemption from it.

Status quo not an option. Another distinct differentiator between top performers and Non-Starters is the expectation of change. Non-Starters cling to the status quo, offering up many creative barriers to change, but in their defense, many legitimate reasons exist why a particular change idea is unworkable. However, that is where the difference begins. In top performing organizations, the mindset appears to be, sometimes overtly stated and sometimes only a cultural characteristic, that status quo is not an option and, therefore, they seek to tweak or modify a change idea until it is workable. A case in point: Henrico Doctors

CFO Chris Denton (2009) explained that within his organization's cost recovery task force consisting of managers and other key influencers, "For every rejected idea, directors must replace it with another idea." A non-starter case in point. During a site visit, a Chief Operating Officer sitting around a table with an emergency department improvement team consisting of the physician director, nursing director, and other key influencers remarked, *in public*, "If they do not want to make any changes, what can I do?"

Managers as skilled change agents. Margaret Lewis, President of HCA's Capital Division of eighteen hospitals (2009) stated, "(In my experience, top performing organizations) must have managers capable of change." During interviews, senior leaders of top performing organizations raised the important role of managers as change agents and in many cases described specific practices within their organizations, like training, mentoring, and presentation formats, whose intent was to build the skills of managers.

Relationships built on trust and integrity. Top performing organizations exude trust. You can almost feel it -- among managers, among physicians, among board members, among all key stakeholder groups. In non-starter organizations there is a lot of non-support talk – about the doctors, about senior management, about just about everyone. This talk creates division, lack of cohesion around key strategic action plans, and appears to be a major cause of delay and lack of speed. Senior leaders of top performing organizations take no prisoners on this

front. They insist on supportive behaviors and do not permit destructive behaviors. And they also practice trust-building behaviors. David Jimenez, Executive Vice President of Catholic Healthcare Partners (2009), an accomplished financial turnaround specialist, told us a story about a physician meeting that he knew would be contentious. The physicians, it appears, had been promised many things that were simply beyond the financial capabilities of the organization and these misperceptions had been allowed to perpetuate for many months and presented as a major barrier to collaboration. Jimenez' expectations, based on years of practice, were as follows: He knew that he would have to open the meeting with the physicians by first telling them that the organization could not meet its promises and he fully expected a second phase of the meeting to be a lot of anger. He then knew to communicate, honestly and openly, what could be done; he laid out an alternative plan that was aggressive, impressive, and believable. And he knew that the conclusion of the meeting would be consensus building around the new plan. Senior leaders of non-starter organizations do not seem to possess the courage to suffer the pain of the first two phases of Jimenez' approach nor they do not have confidence in the later two phases. Regardless of the reasons, non-starter organizations are hampered at all turns by a lack of trust, whereas, top performers enjoy trust as a significant competitive advantage.

***Organization-wide accountable change model*.**

Senior leaders of top performing organizations exhibited distinct differences when compared to their non-starter brethren in two vital arenas – the structure of accountability and the effectiveness of four distinct roles. An important note: The change literature and traditional education encourages us to believe that cultural transformation must precede any implementation transformation. We found this presumption to be invalid. Rather, it was our observation in more than one case that a self-declared non-starter organization can progress from non-starter status to top performance *in 100 days*, *if* the structural components outlined below are executed with commitment, diligence, and discipline. This bears repeating. Organizations whose speed of change and accomplishment of results are lagging strategic needs can, within a 100-day period, progress from non-starter to top performing upon implementation of just a few interventions.

Components of the accountability structure. In constructing an accountable change model, senior leaders seemed to seek speed in goal-setting as mentioned above, speed in action plan creation, and speed of implementation. Any delay, *even when the delay was beyond their control*, is seen as an accountable change model failure. While not all organizations followed the exact same constructs, it is our belief that the following components, if replicated, will almost guarantee top performance:

- Shorter goal achievement implementation cycles with a trimester timeframe recommended. Rather than a yearlong deployment, top performers set

shorter implementation and course-correction cycles, which is why we adopted the 100-Day Workout as our approach. Figure 4 illustrates the trimester implementation cycle that we termed the 100-Day Workout.

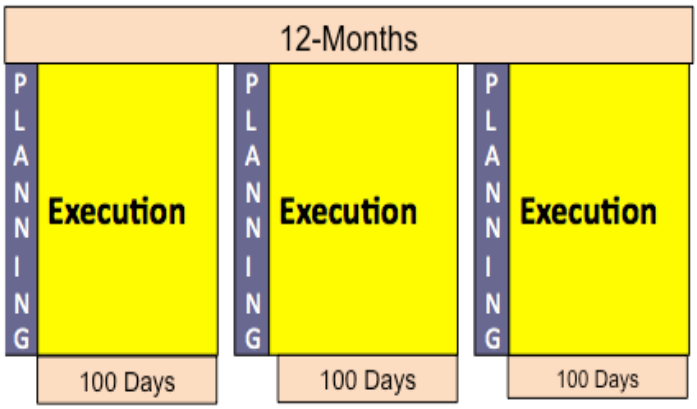

Figure 4. Implementation-oriented organization-wide change model.

- Clarity of goal. Top performers clearly communicate the objective, complete with metric(s) and milestone dates.
- Kick-off, usually a ½-day to ¾-day event at which managers receive the goal statement, required data, education, and specific time to complete draft action plans. A hallmark of this meeting is that managers are expected to turn in draft action plans before the meeting adjourns, whereas, Non-Starters have a tendency to allow managers to leave the meeting without draft action plans. This may be one reason that top performers speed to action greatly outdistances non-starter organizations.
- Formal standardized action plan that includes the change, the due date, assumptions, and expected cost recovery on an annualized and fiscal year impact basis.

- Monthly accountability check-ins. Another hallmark: Top performers are disciplined almost to a fault about formalized monthly check-ins. A couple of organizations in the study hosted bi-weekly check-ins aligned with payroll reporting. An example of an effective accountability check-in was found at Harbor Hospital in Baltimore. At the June 10, 2010 manager results check-in meeting, Dave Pitman, CFO, and Dennis Pullin, CEO, assured that each manager was aware of her/his accountability to achieve eight changes by July 13 by presenting the slide shown in Figure 5, asking managers if they were experiencing any factors that would prevent them from achieving the goal (Pitman 2010). Immediately after discussing this slide, managers participated in a breakout, grouped by vice president, to discuss action required to completely implement their action plans.

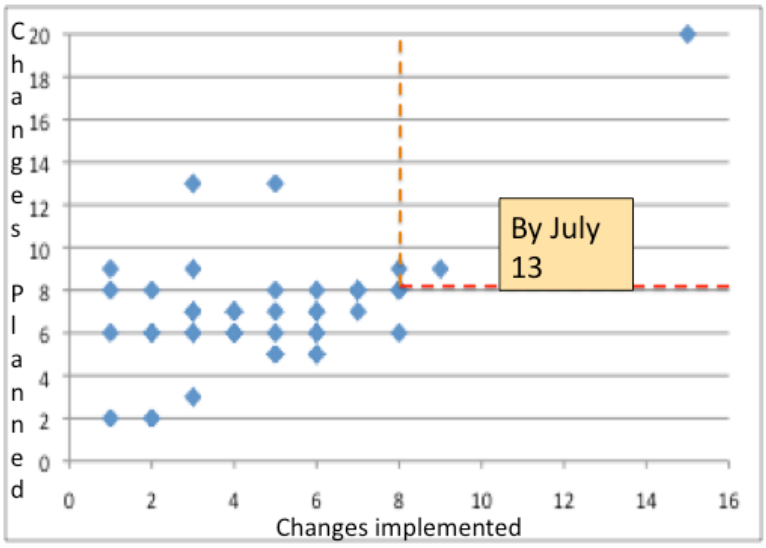

Figure 5. Manager accountability at Harbor Hospital.

- Real-time implementation tracking. Top performers sponsor a disciplined real-time implementation tracking process. In some cases these tracking systems are Internet-based, but in other cases, the tracking tool was far from sophisticated, leading us to the conclusion that the sophistication of the tracking tool is less relevant than the discipline and attention to manager completion of their committed action plans.
- Informal, in addition to the, formal, check-ins. In addition to the many formal monthly check-in process, many top performing organizations revealed more informal techniques between check-ins. For example, David Jimenez, Executive Vice President, Catholic Healthcare Partners, discussed the importance of asking managers about the status of their action plans during walk-arounds (Jimenez 2009). In a few cases we discovered quasi-informal techniques to predict a lack of goal achievement between formal monthly check-in meetings. For example, HCA Terra Haute Medical Center CEO Brian Bauer described a process for assuring that managers achieve their labor productivity budgets every single month. To assure budget achievement, the CFO conducts three to four predictions during the month based on month-to-month payroll information. For those managers for which the estimated end-of-month budget prediction suggested non-conformance, they receive an email by 1pm of the date of analysis, giving them until the end of the day to submit a gap-closure action plan (Bauer 2010).

- IF-THEN-THEN mindset to assure cost reduction: While none of the senior leaders of top performing organizations used the term “If-Then”, the concept of expecting managers to link a specific change idea to a specific cost center reduction is clearly present. That is, in order to assure the reduction of cost center budgets, senior leaders insist that managers continue to work on a specific change idea until the cost reduction task is evident. We heard terms such as “clear line-of-sight” or “connect-the-dots” frequently to showcase this “If-Then” framework. Non-starter organization action plans, on the other hand, contain enough loosely defined or “hope to achieve” cost reduction linkages to make any reviewer anxious. In one non-starter observation, the organization had invested almost a full year implementing a new care model to extract over $2 millions in cost, only to find that no costs were reduced; the prime attributable reason for this lack of success could be traced all the way to the beginning of the idea where it lacked an adequate “If-Then” construct. Many discharge or emergency department throughput initiatives contain an “If-Then” weakness.
- Proof of concept tool. Top performers show an affinity for data to document that a change resulted in a cost center reduction, whereas, Non-Starters are less inclined to insist upon such discipline, relying instead upon subjective attestations. A tool we use in our work is called Rapid Cycle Test (RCT), an Excel-based template in which managers are asked to show a pre and post graph linking the “If-Then” premise to a successful reduction in cost.

- Applicable lean tools: Some, but not all, top performers use effective lean methods and tools like lean waste, In-Quality Staffing, SIPOC structures, etc., to accelerate or formalize their idea generation activities. However, we did not find that use of lean or Six Sigma was a differentiator in terms of top performance or non-starter status. Just as many Non-Starters used lean as did top performers; top performers simply are better implementers than Non-Starters, while Non-Starters used lean for analysis-analysis-analysis vs. a bias for action.

For an exceptional case study with more detailed treatment of the above processes, Kurt Stuenkel, CEO, and Tauyna Faulkner, Master Black Belt, Floyd Medical Center, Rome, Georgia, published an excellent article in *Frontiers* magazine Fall 2009 edition (Stuenkel 2009). (For reprints, go to www.ache.org.)

The purpose of the accountability structure is to assure that the need for gap-closing interventions by managers occurs as early in the process and as often in the process as needed to assure top performance.

Special observances regarding multi-hospital system performance

A special note regarding multi-hospital system performance, including several site visits: An analysis of eight multi-institutional systems, some of them top performers and some of them Non-Starters, uncovered one reason why systems sometimes unwittingly set themselves up for failure. The secret to multi-

institutional excellence lies in understanding the two components of any effective change model – that is, the idea generation process, what we refer to as the playbook, and the implementation/ change process. Non-starter leaders and their lean experts fail to recognize these two distinct and separate elements of change and, thereby, with good intentions, take both upon themselves. This approach is not an effective route to system-wide improvement. The best role for the corporate function, whether lean or other functional area whose job is to stimulate improvement, is to foster creativity and construct an agreed-upon playbook for implementation. Where non-starter system senior leaders and their lean staff fail is in assuming that the corporate office can drive implementation. A case in point. In one interview, an 8-hospital system had organized a surgery improvement collaborative with a crafty sounding title. At the end of one year, the group had agreed upon changes anticipated to save less than $500K across the system, just over $50,000 per organization!! However, one hospital within the system was engaged in another process to drive out costs, this one spearheaded by the CEO and CFO. The surgical services supervisor at this hospital, who was also part of the system collaborative, had logged almost $250,000 in CFO-validated savings all by herself; compare this to the yet unrealized $500,000 savings promised by the entire group of eight (Caldwell 2010b). An interesting side note of this case is that two members of the system surgery task force in separate interviews expressed great appreciation of the system collaborative, seemingly unaware that investing a year for such paltry promised savings was not a grand accomplishment.

Compare the above-described Non-Starter system approach to top performing system thinking. Margaret Lewis, President, HCA Capital Division, an eighteen hospital division of Hospital Corporation of America based in Richmond, confirmed and supported by two hospital-based senior leaders within her group, described an effective performance acceleration structure for all strategic imperatives, not just cost reduction (Lewis 2009; Bauer 2010; Denton 2009). Two vital components of this structure is the availability of credible, timely data supported by a corporate-type effort, with accountability placed squarely on the shoulders of senior leaders within the individual hospital entity. That is, top performing system senior leaders recognize that an effective change model encompasses both an idea generation process resulting in a playbook, best assigned to corporate lean staff, and an accountable implementation process, best placed squarely on the shoulders of entity CEOs.

Figure 6 highlights the differentiation between the role of system offices and the role of entity CEOs.

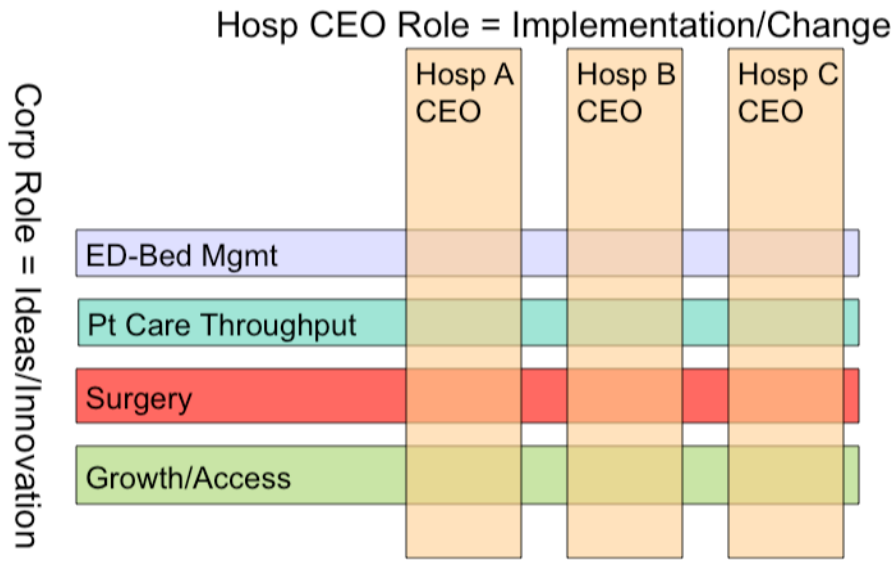

Figure 6. Multi-institutional System Change Model

One non-starter system presumably believed it had solved the problem of entity implementation by assigning entity CEOs to head the various system-sponsored task forces. During the interview, the system executive vice president expressed frustration that the task forces had achieved little. This was not due to a lack of competence of the CEOs, but rather that system task forces are not an adequate replacement for local CEO accountability.

A summary of the structure, characteristics, culture, and behaviors of top performers and Non-Starters are shown in Table 7 below.

Top Performers	Non-Starters
• A "we can make this work" mindset that involves a willingness to experiment, try new ideas, tweak	• More energy and dialogue devoted to why an idea will not work. "Oh, we could never do that here"

ideas, always toward the aim of changing processes.	mindset.
• Senior leaders seek to build the confidence and self-esteem of managers through encouraging behaviors and review processes.	• Senior leaders suppress managers' enthusiasm for creativity and change by being critical of new ideas (even sometimes good intentioned).
• Make known personnel decisions quickly.	• Rarely make the tough personnel decisions, allowing ineffective senior leaders and managers to perpetuate non-starter behaviors, frustrating top performing senior leaders and managers.
• Data used to drive a bias toward action with a "do we have enough data to get started" thinking. Action begins in days.	• Always looking for data to be perfect or the change design to be perfect before beginning implementation. Action, if any, takes months to begin.
• Speed to action is the prevailing mindset among senior leaders and managers	• Delay and inaction is an accepted way of life.
• The structure for implementation supports and encourages	• Little accountability can be observed at any level in the organization.

accountability, with the following components: ➢ Formal action plans clearly accountable by a singular manager. ➢ Monthly check-ins to assure action plans on track. ➢ For plans that become delayed, an effective contingency planning process is in place to catch up.	

Table 7. Summary of Top Performer and Non-Starter Differentiators

Accelerating impact of lean vs. the traditional manufacturing-oriented training.

There is a naïveté among senior leaders about the use of accelerating quality systems, particularly lean. Senior leaders at top performing organizations use lean as their tool of choice and, thereby, insert an active role for themselves far beyond the role taught in a manufacturing lean approach called “executive champion.” Senior leaders in non-starter organizations perceive lean as a set of projects; senior leaders in top performers see lean as a means to achieve strategic outcomes. Non-Starters have a tendency to utilize significantly more

analytic tools and very few implementation-oriented tools. At Non-Starters, lean and Six Sigma experts continue to press for tools that fall into the analytic set, like spaghetti maps, value stream maps, root cause analysis and regression analysis. Once a first run of analysis is completed, the expert presents the results to the managers, asking, “What additional analysis do you need?” And, the analysis loop repeats itself again, and again, and again. Lean experts at top performers, on the other hand, work diligently to complete the analysis, asking managers, “Do we have enough analysis to begin testing changes while I continue to gather more data?” as opposed to “Do you want more analysis?” This subtle difference in mindset makes all the difference. Top performers implement two times to five times more changes than their non-starter counterparts. Figures 7 and 8 highlight the point.

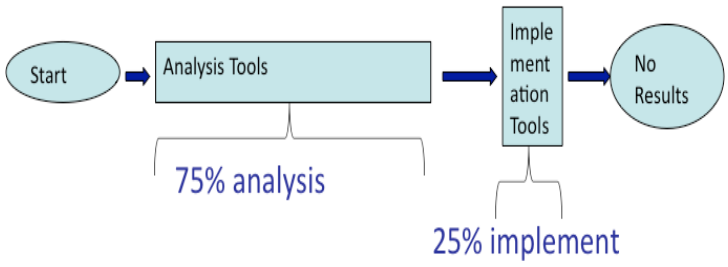

Figure 7. Non-Starters emphasize analysis most.

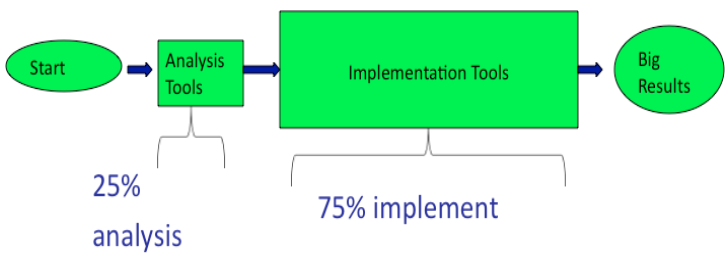

Figure 8. Top performers emphasize implementation most.

"What You Can Do" Self-Assessment and Interventions Exercises.

The self-assessment exercises below are intended to stimulate senior leader action plans. They may also be used by interested board members in their own organizations since the top performer/non-starter characteristics are applicable to non-healthcare organizations, as well. In larger organizations, vice presidents can use these exercises within their own divisions to build action plans. Reprints of this article can be found at www.ache.org.

Senior Leader Self-Assessment for 1-hour senior leader meetings (or completed during a senior leader planning retreat).

1. *Closing the Gap to Top Performance* exercise. Ask senior leaders to bring their copy of this article and/or make a copy of the summary of differentiators in Table 2. Ask the senior leader group to take ten minutes and rank the top three variables impacting your organization on the left side (Top Performers) and the right side (Non-Starters), recording their reasons beside each one. On a flipchart, seek consensus on the group's top three impactors on both the left and right sides, discussing their reasons. Conclude the exercise by seeking a commitment from the senior leadership team to implement specific

interventions to capitalize on the discussion, with a senior leader champion committing to spearhead the action plan. Make a note in the calendar to repeat this exercise in 100 days. (Note: Top performers will have completed the action plan within 100 days.)

2. *Building Manager Confidence* exercise. Senior leaders in top performers take conscious actions and exhibit distinct behaviors to build manager confidence and self-esteem while avoiding behaviors critical in nature that suppress confidence. For this exercise, on a piece of paper, ask each senior leader to draw a line down the middle of the page, labeling the left side, “Builds manager confidence” and on the right side, “Suppresses manager confidence”. Give the group ten minutes to record their own and the group’s structures, techniques, processes, approaches, and behaviors that fall into each grouping, seeking to list at least three in each column. Upon conclusion, on a flipchart, again with the two columns, solicit the top influencers on each side of the flipchart. Discuss the list, seeking to achieve consensus on specific interventions to strengthen confidence-building behaviors and processes and to eliminate or mitigate the negative impact of confidence-killing processes and behaviors. Reevaluate and discuss the effectiveness of the action plan in 100 days.
3. *Creating a Bias Toward Action vs. Analysis Paralysis* exercise. The goal of the exercise is to evolve to 75 percent implementation and 25 percent analysis. Examine the last ten projects completed or in-progress, whether lean or traditional, including cost reduction initiatives, clinical improvement

initiatives, and throughput initiatives. Roughly calculate the duration in days of the amount of time spent in the analysis phase and the amount of time spent in the implementation phase. Share this analysis during a senior leader meeting, recording “What went well?” and “What can be improved?” ideas on a flipchart. Assign accountability to make needed changes and report back to the senior team in thirty days and again in 100 days.

In summary, distinct differences can be found between top performing and non-starter organizations. These differences are both structural and cultural. Yet, an over-riding observation is clear. Senior leaders in top performers exercise clear, non-delegable roles that are not found in non-starter organizations and the effectiveness of these roles seems to make all the difference.

References

American College of Healthcare Executives (ACHE). 2010. “Top Issues Confronting Hospitals”. *Healthcare Executive* 25(2):98.

Bauer, Brian, CEO, HCA Terra Haute Medical Center. Interview by Chip Caldwell November 17, 2009 and site visit April 2010.

Butler, Greg, Chip Caldwell, Nancy Poston. 2009. *What Top-Performing Healthcare Organizations Know: 7 Proven Steps for Accelerating and Achieving Change*. Chicago: Health Admin Press.

Caldwell, Chip. 2010. Analysis of Caldwell Butler & Associates, LLC, Internet tracking system www.caldwelltools.com, accessed November 8, 2009 covering the period July 13, 2007 through October 28, 2009.

Caldwell, Chip. 2010. Internet tracking system www.caldwelltools.com, accessed July 1, 2010.

Caldwell, Chip, Greg Butler, and Nancy Poston. 2009. *Lean-Six Sigma for Healthcare*, 2d ed. Milwaukee, WI: Quality Press.

Cook, Kevin, CEO Mercy Health System Scranton. Interviews by Chip Caldwell December 10-11, 2009, January 21, 2010, & June 18-19, 2010.

Denton, Chris, CFO, HCA Henrico Doctors. Interview November 16, 2009.

Graham, Ken, CEO, El Camino Medical Center, El Camino, CA. Interview by Chip Caldwell January 21, 2010.

Jimenez, David, Executive Vice President, Catholic Healthcare Partners. Interviews by Chip Caldwell November 4 and November 11, 2009.

Lewis, Margaret, President, HCA Capital Division (18 hospitals). Interview by Chip Caldwell November 16, 2009.

Peters, T. and R. Waterman. 2004. *In Search of Excellence.* NY, NY: HarperBusiness Essentials, 119-155.

Pew Center. "Beyond California: States in Fiscal Peril." CNN, November 11, 2009

Pitman, Dave, CFO, Harbor Hospital, Baltimore. Site visit by Chip Caldwell June 10, 2010.

Sinclair, Sarah, Chief Nursing Officer, Cleveland Clinic. Interviews by Chip Caldwell Dec 3, 2009.

Stuenkel, Kurt and Taunya Faulkner. 2009. "A Community Hospital's Journey into Lean-Six Sigma." *Frontiers* 26(1):5-13.

Stuenkel, Kurt, CEO, Floyd Medical Center. Site visit June 23, 2009 and interviews November 4, 2009, December 10-11, 2009 and May 13-14, 2010.

Von Drehle, D. 2010. "The Other Financial Crisis". *Time.* New York, NY. June 28, 2010, 22-29.

---- END OF ARTICLE ---