



Rx for a Simpler Way

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Hospitals are very complex institutions, operating in an incredibly complex health care system. The conventional wisdom is that it takes equally complex structures to manage them, but that's not necessarily the case. My experience suggests that simpler structures may actually be more effective, and certainly more efficient. There are several opportunities for hospitals to simplify the way they do things.

Simpler planning

The first opportunity is to simplify the way they plan. The conventional approach to planning is for managers to set goals and objectives for the organization, or for their piece of it, map out detailed action plans for achieving them, and hold people accountable for carrying them out. But, in most cases, managers can't really predict or actually control how events will unfold in an organization beyond a window of a few months. That's because organizations don't really function like machines that chug along in a straight line once they are programmed properly. Their course is largely determined by the myriad interactions among all the individuals in the organization, and between the organization and its environment, all of which are inherently unpredictable.

However, that doesn't mean that leaders can't influence the general direction of their organizations. At a very fundamental level, all organizations, regardless of their size and complexity, are guided by a few simple rules. These rules are like the logic that guides the flight of a flock of birds. Researchers have been able to simulate the complex behavior of a flock of birds by specifying three simple rules in a computer program – keep toward the center of the flock, keep up with rest of the flock, and don't bump into the birds around you. Similar simple rules also guide large organizations, but they are usually implicit, so their influence is covert.

Here is an example of how these rules operate. Several years ago, I was working with an insurance company that was losing money, and the new executives were trying to get things turned around. The conventional wisdom in the organization, based on what had worked well in the past, was that market success comes from selecting low-risk customers at or above the market price, retaining them with good service, keeping volume up, and keeping expenses down.

They believed that price was dictated by the market; thus, profitability was a function of what was happening in the market, and out of the organization's control. This logic had held sway for some time, and most of the systems in place were designed to support it.

But, because of changes in the market, the company wasn't getting the same results, and many people were starting to question the conventional wisdom. They worried that continuing to increase the volume of business would make them less profitable, because it would require them to write riskier business, which would drive up losses. They also worried that high prices would leave them vulnerable to their competition and drive down volume. If volume fell, layoffs would follow. Finally, they worried that if they cut expenses, they would reduce service levels and make it hard to maintain strong customer relationships, which they saw as key to maintaining volume and price.

We found that a new story was emerging and beginning to take hold on the periphery of the organization. It maintained that if the company increased its claims and underwriting capacity (actually adding to expense), risks could be managed more carefully, prices could be determined more accurately and flexibly set at levels that were profitable, losses would fall, and volume could be maintained through stronger relationships with the independent agents who wrote the policies.

Both stories were living side by side in the organization. The mixed messages were causing people to feel stuck, even though the situation and the leadership demanded action. Because there wasn't a consistent set of rules to follow, people were reluctant to take initiative. They weren't sure how they could best contribute to overall success, because the fundamental logic for achieving success wasn't clear or consistent. Once the leadership became aware that these different stories existed, they were in a position to provide more consistent and coherent direction.

When the fundamental logic of an organization is made explicit in this way, it can exert a powerful influence on the behavior of individuals, and guide the entire organization in the same general direction, while still allowing for local flexibility. It can unleash the creative energy of individuals, without causing everyone to bump into each other or head off in all different directions. And when the fundamental logic is consciously changed and those changes are made explicit and become widely understood, the new logic can guide an entire organization in an entirely new direction.

This approach to planning is a radical departure from how most hospital managers have been trained and currently operate, but it is fundamental to the science of system dynamics, which has much in common with complexity theories that have emerged in the past two decades.

In most hospitals today, the fundamental logic isn't usually made explicit, but it goes something like this – if we follow government regulations, meet insurance requirements, stay within the budget, keep the doctors happy, and minimize the harm done to patients, we will be successful. But there is another logic that is starting to take hold – if we focus on the needs of patients and their families (not the needs of the institution, regulators, or payers), get it right the first time based on the best available scientific evidence and timely access to all relevant patient

information, allow patients to move through the system without any delays, and ensure that patients are better off as a result of the care they receive and are not harmed in the process, we can dramatically improve our quality and our costs.

Making their old and new stories explicit could help guide hospitals in a new direction. And planning and managing in this way would eliminate the need for much of the bureaucratic command and control infrastructure in place today that is designed to make sure that everyone is doing exactly what they are supposed to be doing at all times.

Simpler accounting

Another opportunity to simplify running a hospital is to take a different approach to accounting for costs. The typical hospital bins its costs into large budget categories like labor and supplies. Under constant pressure to reduce costs, it sets targets for cuts in each of the budget categories. Managers are then asked to come up with ways to do the same or more with less. Since labor costs make up 55-60 percent of the typical hospital's budget, staff is a particularly inviting target.

However, after repeated rounds of cuts, most hospitals are now operating at bare minimums of staff, leaving little room to continue cutting without seriously jeopardizing patient safety. And in many hospitals, much damage has already been done. Randomly plucking "nonessential" personnel out of care delivery systems that were already inefficient to begin with has begun to destabilize hospital operations, which then adds more costs as hospitals take heroic measures to deal with the resulting crises.

A growing number of hospitals are taking a different approach, embracing the idea that the best way to cut costs is to focus on improving quality. That means getting it right the first time -- and not wasting staff time or supplies on activities that don't directly improve the health of the patient. This approach is a radical departure from the conventional wisdom held by most hospital managers today about how to cut costs, but it has been a guiding principle of the quality movement for the past quarter century.

Experience shows that traditional cost accounting systems get in the way of improving quality, because they don't take into account the cost of poor quality, and they don't give credit for improvements in quality. This situation is exacerbated by a reimbursement system that is rife with examples of where poor quality care is actually rewarded.

A good example of this problem comes from a project I was involved in on a pulmonary unit at a large, general hospital. The staff nurses on the unit gathered data and documented a mismatch between the staffing pattern, patient flow, and patient acuity that was jeopardizing quality care. The nursing director responded by adding staff to the evening and night shifts, and the situation improved. The nurses reported that patient satisfaction increased, nurse satisfaction increased, the incidence of pulmonary embolism fell, there were fewer codes and transfers to the ICU, the length of stay for transplant patients fell, the readmit rate fell, and the number of staffed beds went from 32 to 35.

It doesn't take much to see that the patients on this unit were clearly better off. But because the hospital had no way to account for these improvements, the only thing that showed up on their radar was the additional staff. The staff and the manager on this unit have had to fight hard for the past year to maintain this new staffing configuration to protect their patients.

It wouldn't take much work for the hospital to calculate the savings from fewer complications, fewer days in the ICU, and fewer days in the hospital, but that doesn't happen routinely. In fact, in the Alice and Wonderland world of reimbursement, the hospital may have actually lost money as a result of the improvements on this unit. The complications, the more intensive care, the longer stays, and patients being readmitted to the hospital when things went wrong at home would likely have been covered by insurance.

If hospitals focused primarily on the needs of patients and actually accounted for the costs of poor quality, they would find that the biggest opportunities for cost savings lie in improving the quality of care. They could better target their cost reduction efforts in ways that improve the satisfaction of patients and staff. They could avoid the crises that are the inevitable result of cutting blindly, guided only by the budget. And they would also find that they could get rid of much of the complex infrastructure of endless meetings and reports that they use to manage their current, budget-driven cost reduction efforts.

Simpler operations

A third opportunity for hospitals to simplify is to streamline operations. In most hospitals today, operations typically follow the mass production model of creating separate departments for each function based on common equipment or processes, then moving patients around from one department to the next for different procedures. Each department has its own separate budget and objectives. Although breaking operations up this way may seem like it makes them easier to control, the fragmentation actually makes it more difficult to improve performance, and the handoffs are very unfriendly to patients.

The main problem with this approach is that, as systems become more complex and dynamic, overall performance is determined by how well the parts all work together, not by how well they work in isolation. This is a guiding principle of lean manufacturing, which maintains that focusing on one piece at a time and making that piece flow smoothly through the entire process without interruption leads to the highest quality and the lowest cost.

Some hospitals are starting to apply this principle to their operations. Their focus is on streamlining the flow of patients across departments and through the whole delivery system from intake to discharge, eliminating the handoffs that are the cause of so many errors and so much waste. By focusing on one patient at a time and organizing the delivery of care so that the right patient gets the right care from the right person at the right time, they are substantially improving quality and reducing costs. But, there are a few obstacles that stand in their way.

One is the cost accounting system – again. Studies I've conducted in manufacturing facilities show that 99 percent of the time a product spends moving through the production process is non-value added, and therefore a waste of time and resources. Yet, most improvement efforts focus

on squeezing more efficiency out of the 1 percent of the operations that do add value. As a result, improvement efforts continue to mine the same operations over and over again for marginal improvement opportunities, while ignoring the substantial opportunities that exist between and among the individual operations.

Similar studies of hospital operations paint the same picture. Patients spend hours queued up for the next step in the care delivery process or moving from one department to the next. Yet, most improvement efforts focus mainly on making each department more efficient, not on improving the flow among them. Nurses waste half their time nursing the system, rather than their patients.

What drives this seemingly irrational behavior is an underlying assumption that the whole is equal to the sum of the parts, and that the best way to optimize the whole is to optimize the performance of each of the parts. To simplify the task of managing operations, hospitals typically only measure the costs of individual departments, then roll them up into an aggregate figure for the whole hospital. But, this method doesn't account for all of the costs incurred in keeping patients in a holding pattern or transporting them from one place to another.

Another obstacle to improving flow is the way hospitals typically go about simplifying their operations. Most hospital reengineering efforts take the people out of the system first, then rearrange the work to fit the remaining people. Instead, the focus needs to be on taking the non-value added work out of the system first, then rearranging the people to fit the remaining work. The first approach tends to destabilize operations and demoralize staff. The second approach improves stability and allows staff to spend more time delivering care to patients, which is very satisfying, particularly if the staff are involved in making the changes.

A third obstacle is the misapplication of information technology. While new technologies can greatly simplify the handling of large amounts of information, eliminate redundant intake processes, and help avoid medical errors, their application doesn't always improve the flow of patients. In fact, simply introducing new technologies into the existing operating pattern can serve to enshrine the status quo, automating inefficiency and making it even more difficult to improve patient flow. It makes the most sense to simplify patient flow first, then figure out how to support the more streamlined operating pattern with the appropriate new technology. This approach can greatly reduce both the complexity of hospital operations and the investment in information technology required to manage them more effectively.

Simpler management of change

A final opportunity for hospitals to simplify things is to change the way they manage change. The typical way that hospitals manage change is that somebody comes up with an improvement idea at the top of the organization, a team puts together a plan to implement it, and then managers "roll it out" to the rest of the organization, using various techniques to get staff to "buy in." However, my experience is that this approach rarely produces the desired results.

One reason is because the people at the top of the organization are the furthest removed from the actual delivery of care, and are therefore in the worst position to know what the real problems

are, or what solutions might work best. The systems in organizations rarely work the way they are supposed to, or the way people think they do who don't work in them every day.

Another reason the conventional approach doesn't work very well is because most hospitals usually have several different initiatives going on at the same time. Many managers believe that the fastest way to improve performance is to improve as many things as possible, by as much as possible. Managers act as if leverage is a function of level of activity, and that the more levers they pull in the right direction, the more performance will improve. And the harder they pull on them, the faster performance will improve. Unfortunately, this mechanical thinking rarely produces a breakthrough, only more complexity, and often confusion.

The mechanical approach to managing improvements requires a lot of infrastructure to support it and ends up being very cumbersome to manage. It leads to lots of people sitting in lots of meetings working on lots of action plans that rarely get executed, because there's so little time left over and because resources get so diluted in the process. Managers end up spending more time in meetings managing the complex infrastructure they've created to make improvements than managing the actual work of delivering and improving care.

Over time, it gets increasingly difficult to get employees to buy into these initiatives. Most employees who have been around for a while have already been through a number of them and have become quite cynical about them, making it difficult to engage their attention and effort. Organizational development experts dub this syndrome "initiative fatigue." Front-line managers are particularly prone to burn out, since it falls to them to actually implement all of the initiatives that come cascading down the chain of command.

Fortunately, there are simpler, more effective ways to manage performance improvements. One way is to start on the floor with small changes at the point of care, led by the people who actually deliver that care. Front-line staff are in the best position to understand the needs of patients, and they are in the best position to understand how the systems they work in really work.

As the "experts" on the floor begin to address what's getting in the way of delivering the highest quality of care, they quickly expose where systems are breaking down or are nonexistent. Front-line managers can then see clearly where to focus their efforts to pave the way for further improvements. Where the solution is outside the scope of an individual department, managers at a higher level can mobilize the appropriate people across departments to resolve it.

To make this approach work, managers need to recognize that their level of activity isn't the key to improving performance. What's key is their ability to get focused on a few key points of leverage and stay focused on them until a breakthrough is achieved.

That takes a lot of discipline, which is missing in most hospitals, in part because people are trying to do too much at once or are spending most of their time fighting fires. To break this vicious cycle, managers need to focus on only 2-3 key leverage points at each level. That means that each unit or department should have 2-3 critical issues that they are working on, then 2-3 key issues across departments, and the same for the hospital as a whole. Ultimately, it's the

combination of focus, leverage, and disciplined execution that leads to breakthroughs in performance.

Once a breakthrough is achieved, the next challenge is to spread it to other areas of the organization. The natural tendency is to mandate that everyone else adopt the new best practices. However, that approach tends to provoke resistance, due to the “not invented here” syndrome. What works best is for those who made the breakthrough to share their story with others to demonstrate that a higher level of performance is possible and to educate others about what made it possible. The new higher level of performance then becomes the standard that everyone must meet. Others can either apply the lessons learned by the pioneering group or come up with a better approach of their own, creating the possibility of additional breakthroughs.

As a result, the change process becomes a series of experiments, all designed to achieve the same kind of results, and all operating within the same strategic framework, as outlined by the leadership in their basic story line for how to achieve success. This approach is at the heart of what it means to be a learning organization. Hospitals that operate this way pay close attention to what’s working and what’s getting in the way. They hold up the “positive deviants” as living examples of what’s possible for others to learn from and to emulate. And they systematically weed out old assumptions, policies, and structures that are getting in the way.

These simpler approaches to managing change eliminate the need for most of the command and control infrastructure that organizations use to drive change through the organization from the top down. They allow people to stay focused on what’s most important, and to spend their time on what makes the biggest difference.

Each of the approaches outlined above can greatly simplify the work of managing a hospital. Taken together, they suggest a radical new model for improving hospital performance.

To get everyone on the same page, the hospital leadership needs to articulate a consistent and coherent story that outlines their fundamental logic for achieving success. Unless that logic is explicit and available to everyone, there’s a high likelihood that people will get confused and work at cross purposes. Once the overall direction is clear, managers need to identify measures that are relevant to their own organization’s story (not everybody else’s desires, as is currently the case), develop simple, user-friendly measurement systems that directly support real-time improvement (not after-the-fact reporting), and set standards of performance that strive for excellence (not just getting better).

In this new model, change starts at the point of care and relies heavily on front-line staff to identify what’s getting in the way of achieving excellent results (not with a task force or committee assigned to “roll out” somebody else’s best practice and to engineer “buy in” from the staff along the way). The focus is on giving patients exactly what they need when they need it without harming them in the process, improving the performance of the system as a whole (not just its individual parts), and accounting for all of the costs incurred from intake to discharge, including the costs associated with poor quality care.

The structures required to support this approach are simple. At the unit level, front-line staff need access to timely and reliable information on patient outcomes and costs to determine whether the care they are delivering is getting the results they want, and to identify what they might do differently to improve quality and efficiency. At the hospital level, managers need to work together to support the improvement efforts in the units and departments, to address whatever is getting in the way, especially any issues that cut across units and departments, to review overall hospital performance and identify what's working and what's not working, to share breakthroughs in one area with other areas, and to regularly review their story line to maintain alignment and to make any necessary adjustments.

Many organizations have implemented one or more parts of this model, and their superior results demonstrate what's possible for organizations that choose to go down this path. Whoever can put them all together is destined to become the "Toyota" of the health care industry.