

# A Path to World-Class Service for Medical Organizations

By Donald D. Forrester, MD, CPE

## In this article...

Learn the steps to take to improve service and read about one California pilot project that saw remarkable success.

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The medical industry is ultimately a “service industry.” It exists to serve its patients, yet in some ways it has neglected this primary responsibility. Although there have been some examples of service-centered projects within the medical industry, they have been isolated or limited in scope.

Exciting work done in other industries since 1980<sup>1</sup> offers a hope that better—in fact, world-class service—can be defined and implemented in medicine as well. World-class service would most likely include:

- Eliminating waits and delays
- Making accurate diagnoses
- Providing the best treatment taking into account the patient’s values
- Developing systems to eliminate errors and waste in all their forms
- Focusing on primary and secondary prevention
- Substantially reducing costs
- Creating supportive environments for our workers

Understanding the reasons for our failure to address and improve service is the first requirement for initiating the transformation. The next step involves knowing where to focus and how to proceed within an organization. The final step is that we go beyond the organization to improve the health of our communities.

Over the last 30 years the challenges to the medical industry have been extraordinary. Medical knowledge has expanded greatly, so that now over 10,000 articles per week are added to the medical literature. Many more medications and procedures are available.

The medical industry has responded to the increasing complexity by creating ever-larger organizations. Simultaneously, there has been an increase in chronic diseases across all age groups coupled with an aging and growing population. This complexity, along with the application of the vast array of treatments and procedures, has led to more errors.

Although the medical industry did little in regard to service, the 1980s and 1990s saw the application of statistical process control methods to improve the quality of care. In 2000 and 2001, two reports, “To Err is Human”<sup>2</sup> and “Crossing the Quality Chasm,”<sup>3</sup> led the medical industry to further focus on the issue of preventable morbidity and mortality. Along with training offered by leaders in the field such as the Institute for Healthcare Improvement and Intermountain Health Care has led to many success stories.

An article by Brent James, MD, titled “Quality Improvement Opportunities in Health Care”<sup>4</sup> provides an excellent introduction to and historical perspective on preventing errors and improving quality. Given the importance of accurate diagnosis and proper treatment this emphasis is understandable. After all, patients expect accurate diagnosis and protection from preventable complications.

Organizations that are experienced in the application of statistical process control have some of the essential skills for improving service. However, they will need additional skills to meet the challenges of achieving world-class service.

Many of these additional skills are based on concepts that, like those involved in quality improvement, were developed outside of the medical industry (e.g., service improvement, sustainability, innovation and learning in organizations).

Health care professionals will need new skills beyond their clinical ones. The interim goal is to develop “sustainable high-performing clinical teams” working together to support their medical organization.



## Challenges

Our challenges fall into three areas:

1. Lack of knowledge regarding the concepts and skills necessary to provide world-class service
2. Lack of will exhibited by the existing culture and management approach of most medical organizations
3. Lack of skills within medical organizations for achieving successful sustainable innovation in complex systems

The easiest challenge to overcome is the lack of knowledge about the concepts and skills necessary to provide world-class service. This can be met with appropriately designed training sessions. Although well-designed training will result in some improvement, the results will be limited unless the other challenges are met.

A more difficult challenge is the “lodge cultures”<sup>5</sup> typical of most medical organizations and groups. These cultures value top-down decision making including project funding and solutions developed by management. These practices are at odds with the executive commitment and empowerment of front-line personnel

required to create world-class service organizations.

Management decisions concerning front-line innovation usually lack accurate information and don’t achieve buy-in or support from the personnel on the clinical teams. Buy-in by front-line personnel is particularly important to achieve dramatic service gains.

The Vroom decision model<sup>6</sup> states that buy-in requires that personnel be appropriately involved with decision making. In addition to obtaining buy-in, involvement of front-line personnel can ensure the identification of useful measures and processes for improving service.

Obtaining funding for projects is a challenge shared by both quality improvement and service improvement efforts. The challenge with service projects is greater because the value of improved service requires the use of assumptions and data not normally available in medical organizations and is more subjective in nature than typical quality improvement projects. For these reasons, service improvement funding is hard to obtain and often inadequate.

Adequate funding and buy-in are critical to transforming the work done on the front line. Although many ways to change organizational

culture have been touted, such as leadership change or management training, the best approach seems to be to transform the work itself and to begin on the front line.<sup>7, 8</sup>

The ability to successfully innovate in complex systems is the most difficult challenge in achieving world-class service. Although complex systems<sup>9</sup> react to interventions in unpredictable ways,<sup>10</sup> applying the proper approach can lead to dramatic success. The approach needs to be properly planned and sustainable.

One compelling model for sustainable innovation can be found in Hawken, Lovins and Lovins’ articulation of the four central strategies of natural capitalism.<sup>11</sup> These strategies are radical resource productivity, biomimicry, service and flow economy, and investment in natural capital. Translating these into more familiar terms within health care means using resources (buildings, technology, and personnel) more effectively, eliminating waste in all its forms, shifting from being patient-oriented to patient-driven, and restoring the health and well-being of patients and communities.

To appreciate the implication of these strategies for our current “disease care” system, it is useful to examine the differences between the premises of natural and conventional capitalism.<sup>11</sup>

The premises of conventional capitalism currently drive the medical profession. The result is an unsustainable path that everyone agrees needs to change. Our health care professionals suffer from burn-out (neglect of human capital). We continually increase our prices and support reimbursement structures that reward the use of more drugs and procedures (price not cost). We seek growth by creating new markets and changing diagnostic criteria and therapeutic targets (growth in output and dollars). We pay out rewards on an annual basis (short-term view).

**Table 1**

Natural Capitalism	Conventional Capitalism
Sustainable	Unsustainable
Values Human and Natural Capital	Neglects Human and Natural Capital
Resource Productivity	Human Productivity
Cost Not Price	Price Not Cost
Restores Capital	Growth in output and dollars
Long Term View	Short Term View

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Working to align our systems to the premises of natural capitalism would move us toward a sustainable path. We would design work environments that value our health care professionals (value human capital). We would efficiently use our personnel, equipment and buildings and eliminate errors in treatment (value natural capital and resource productivity). We would base our decisions on true costs to the entire system (cost not price). We would restore the health of our patients including contributing to their financial health (restores capital). Restoring health requires a focus on preventing, stabilizing and curing chronic diseases and not just controlling them. This fundamental change in our medical industry is plausibly our biggest challenge.

## Steps to take

Once the challenges are understood, how should a medical organization begin to proceed to create world-class service? The first step is the development of a pilot or alpha site within an organization that can serve as a testing ground for sustainable innovation.<sup>12</sup> The pilot site should be carefully selected, properly designed, thoroughly evaluated, adequately supported, and appropriately rewarded.

The alpha site ideally involves two providers and their direct support staff within the smallest functional service unit.<sup>13</sup> In outpatient medicine this would be either a primary care or specialty team with not more than seven providers. The providers and support personnel involved in the pilot should be early adapters.<sup>12, 14</sup> Once the pilot personnel are selected, then the whole clinical team needs to be involved in the design of the pilot program.

The design of the pilot should seek to optimize the whole system.<sup>11</sup> This design approach requires “thinking backward from down-

**Table 2**

Motivators	Hygiene Factors
Achievement	Pay
Accountability	Company Policy
Recognition	Supervisory Effect
Responsibility	Working Conditions
Work Itself	Job Security

stream to upstream in a system.” For instance the medical industry has focused on tertiary prevention with the use of procedures and medications to “control disease” (downstream) but not to “prevent or cure disease” (upstream).

Although there is a place for tertiary prevention, many patients would prefer primary or secondary prevention (upstream) with the avoidance of medications and procedures. Thinking “upstream” also involves the efficient use of personnel and the inclusion of fast, clean feedback loops.<sup>15</sup>

Most medical organizations track general satisfaction measures. Although useful as an organizational measure of performance, they are not helpful at the team level, as they don’t provide real-time patient-specific data. For this, clinical teams need to have a daily service recovery program to provide customized service to their patients.

The unpredictable response of complex systems to innovation requires measurement across all areas of performance (i.e., quality, service, finance, and staff satisfaction). This avoids the problem of achieving success in one measure—access, for instance — while not being aware of deterioration in other important areas such as quality or staff satisfaction. Thorough evaluation helps improve the pilot’s performance over time and

facilitates the diffusion of the innovation within the clinical team and to other clinical teams.

Finally, support and reward for a clinical service participating in a pilot needs to be agreed on before the project is begun. Support must include money, expertise, and the participation of management. Expertise and proper research are important to identify all the improvements to be initially built into the new pilot.

The alpha project requires the active participation of the authorizing sponsor (i.e., the person with budgetary and hire/fire authority). His or her participation includes managing the reinforcing sponsors represented by managers, both clinical and nonclinical, between the pilot and the authorizing sponsor.

This is a particular challenge in larger organizations with lodge cultures because they tend to have layered bureaucracies with many reinforcing sponsors and busy authorizing sponsors who lack the necessary skills and experience.

The clinical service should have a clear understanding of the benefits of participating in the pilot. Rewards for a successful pilot should focus on “motivators” that lead to professional satisfaction and not “hygiene factors” that are relative dissatisfiers.<sup>16</sup>

If properly planned and executed there will be significant savings and profits that allow for repaying the

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initial investment and for gain sharing with the clinical team for funding and rewarding future improvements in service and quality.

## New vision

A vision services pilot at Rancho Cordova with the Kaiser Permanente Program in Northern California redesigned their system and ran a pilot involving two ophthalmologists and their support staff.

The remarkable results included reducing the cost per visit by 33 percent while increasing patient satisfaction scores from mid to top in the region, increasing the number of patients seen by one provider from about 12 to 25 per half day, and raising staff satisfaction and pay.

The original investment of \$100,000 resulted in an annual profit to the area medical center of \$1.3 million. The improved efficiency resulted in a 200 percent increase in surgeries per surgeon and created the opportunity for the ophthalmologists to be involved in spreading the innovation to another clinic.

Unfortunately, the organization was unable to reap all the benefits of the success of this project because neither thorough evaluation nor gain sharing were implemented. Thorough evaluation would have facilitated the diffusion to other vision service departments. The lack of gain sharing missed the opportunity to further improve the pilot by perhaps adding a daily service recovery program or a program for eliminating errors in care.

Management could have used the profits to fund alpha sites in other clinical services. With multiple successful clinical services it becomes possible to dramatically improve performance at the interfaces between services (i.e., referrals, education, feedback loops).

As the number of successful “learning” teams increases, more and more individuals develop personal

mastery and systems-thinking and begin to influence the vision and the mental models of the organization itself. The organization becomes a learning organization (as outlined in the book, *The Fifth Discipline*, by Peter Senge<sup>17</sup>) that is delivering outstanding service to its members.

The final step for medical organizations to achieve world-class service requires them to improve the health of their communities. Being successful will require health care professionals to move away from self-interest and view the health of their communities as a natural commons.

The current “tragedy of our health commons”<sup>18,19</sup> reflected in our population’s arguably declining quality of life can be understood by analogy to what occurred in the cod fishing industry.<sup>20</sup> The fishing industry’s pursuit of growth, use of technology, assumptions about the market, and reliance on government led to the demise of both the cod and the industry.<sup>21</sup>

Similarly in health care we pursue growth without efficiency, apply technology without proper evaluation and diffusion, believe that the market will continue to pay increased rates and co-payments, and have faith that government and employers will continue to subsidize inefficient systems. As health care professionals we need to transform our mission based on aforementioned principles to take the final step to world-class service.

Of course, the definition of world-class service is context-dependent. It will vary depending on the individual customer and his/her community. While we wait for the first medical organization to deliver world-class service, some things are clear. The path to world-class service exists. Success is built on the principles for innovation in complex systems and “natural” as opposed to “conventional” capitalism.

Medical organizations will need to change their lodge cultures to cul-

tures based on a distributed leadership model that supports innovation at the level of the clinical team.

Health care professionals will need new skills beyond their clinical ones. The interim goal is to develop “sustainable high-performing clinical teams” working together to support their medical organization.

The ultimate goal would be sustainable organizations that improve the health of their communities. We need a new direction or the “tragedy of our health commons” will continue to worsen.



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