
Why Are We Still Underperforming?

BY JOHN TOUSSAINT

IN 1999, we learned from the Institute of Medicine that American health-care crashes the equivalent of a 747 each day, meaning about 300 people die unnecessarily from medical errors (Institute of Medicine 1999). Have we learned anything since this report came out ten years ago? I contend not much. While there is more public reporting of hospital performance, the results indicate even the best performers still incur 10,000 to 50,000 defects per million opportunities, or 2 to 4 sigma performance (Yang 2005), which means we may be only crashing a 737 a day now.

Why are we still underperforming on healthcare quality? The article by Kurt Stuenkel and Taunya Faulkner describes one healthcare organization's challenge to improve performance. David Mann's article documents specific leadership issues associated with underperformance and addresses how we need to change our leadership model to improve the situation. Our ultimate goal should be to change the way healthcare workers and managers practice and behave. In other words, change the culture of our organizations—which is still largely “command and control”—to that of continuous improvement.

Many experts have studied and written about the Lean management approach to continuous improvement (Womack and Jones 2003), and it has proven extremely effective in producing results (Spear 2008). So why aren't more companies adopting it? The root cause is unknown, but experience tells us that only 1 out of 20 companies that try to implement Lean is successful (Koenigsaecker 2009). My hypothesis is that there is a series of important components that must be implemented for a company to be successful at Lean. Most companies don't pay attention to all the components.

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7 STEPS TO CONTINUOUS IMPROVEMENT

Seven of these important components are listed below, and they are expanded in the following pages, especially those that relate to healthcare leadership and management.

1. Understand the mission of the organization.
2. Identify a clearly defined strategy that articulates the value the organization plans to deliver to the customer.
3. Set clear and simple goals and deploy them from the CEO to the frontline worker using "policy deployment" (Dennis 2007).
4. Visually report all performance data, including defects for staff and physicians.
5. Be transparent with results. In other words, publicly report physician and hospital performance measures, as is happening in Wisconsin through the Wisconsin Collaborative for Healthcare Quality (wchq.org).
6. Establish a methodology for improvement. At ThedaCare, this is the ThedaCare Improvement System, which is the Toyota Production System applied to healthcare.
7. Change the leadership philosophy to support continuous improvement.

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WHAT'S WRONG WITH HEALTHCARE MANAGEMENT?

Healthcare management needs an overhaul. The same problems that have plagued the American auto industry plague American healthcare. If healthcare continues on its current path, our future

looks more like GM's than Toyota's. The root cause of the problem is our outdated management system, which is based on a command and control paradigm, in contrast to a Toyota management system. The differences are well articulated in Mann's description of Lean leaders' roles and responsibilities. In our traditional healthcare management world, managers are rewarded for telling their superiors that dysfunctional systems are really fine. Therefore, they are indirectly taught to hide problems rather than address the issues, for fear it will show weakness in their management work.

In the Lean world, "no problem is a problem." Managers who *don't* identify problems in an open and honest way are considered weak. Problems and challenges are seen as valuable opportunities to mentor, learn, teach, or "go to gemba" (the place where value is created for the patient). Traditional and Lean management approaches are completely opposite from each other, which is why sustaining a transition to Lean is so hard to do, as Mann correctly points out.

As the healthcare debate rages on in America, it is essential that the effort to transition to Lean focuses on the *how*. How are we actually going to change care delivery? This is critical because the care delivery process contains most of the waste. Although some waste exists in insurance company administration, duplication of tests, etc., it accounts for a much less significant part of the overall healthcare bill. Delivery of care costs make up more than 70 percent of a patient's bill (Kaiser Family Foundation 2008), yet so little of the debate has been focused on this most important of all factors. By reducing waste, we can reduce the cost of American healthcare.

FIGURE 1. SAMPLE A3

TITLE: Toyota A3 - ThedaCare Center for Healthcare Value		Team: Review Taylor
Date Started:	Current Date:	
<p>1. Reasons for Addressing this Issue:</p> <p>The healthcare system must provide the best care at the lowest cost. This is the goal of the Toyota A3. The purpose of this A3 is to reduce the number of days inpatient patients are in the hospital. This is achieved by reducing the length of stay (LOS) and increasing the number of discharges per day.</p>	<p>4. Gap Analysis (Current State):</p> <p>Current State: The current state of the hospital is that the LOS is 7.5 days. This is due to a number of factors, including a high number of readmissions, a high number of patients who are not ready for discharge, and a high number of patients who are not being discharged on the same day as surgery.</p>	<p>3. Completion Date:</p> <p>Completion Date: The completion date for this A3 is 12/31/2011.</p>
<p>2. Initial State (Target State):</p> <p>Target State: The target state of the hospital is that the LOS is 6.5 days. This is achieved by reducing the number of readmissions, reducing the number of patients who are not ready for discharge, and increasing the number of patients who are discharged on the same day as surgery.</p>	<p>5. Risks/Approach (Current State):</p> <p>Risks/Approach: The risks of this A3 are that it may lead to a decrease in patient safety, a decrease in patient satisfaction, and a decrease in patient revenue. The approach to this A3 is to use the Toyota A3 methodology to identify the root causes of the problem and to implement solutions that address these root causes.</p>	<p>6. Additional Data:</p> <p>Additional Data: The additional data for this A3 is that the current state of the hospital is that the LOS is 7.5 days. This is due to a number of factors, including a high number of readmissions, a high number of patients who are not ready for discharge, and a high number of patients who are not being discharged on the same day as surgery.</p>
<p>3. Target State (Current State):</p> <p>Target State: The target state of the hospital is that the LOS is 6.5 days. This is achieved by reducing the number of readmissions, reducing the number of patients who are not ready for discharge, and increasing the number of patients who are discharged on the same day as surgery.</p>	<p>7. Risks/Approach (Target State):</p> <p>Risks/Approach: The risks of this A3 are that it may lead to a decrease in patient safety, a decrease in patient satisfaction, and a decrease in patient revenue. The approach to this A3 is to use the Toyota A3 methodology to identify the root causes of the problem and to implement solutions that address these root causes.</p>	<p>9. Impact/Change:</p> <p>Impact/Change: The impact of this A3 is that it will reduce the number of days inpatient patients are in the hospital, which will result in a decrease in patient revenue. The change is that the LOS will be reduced from 7.5 days to 6.5 days.</p>

WHAT C-SUITE EXECUTIVES NEED TO DO DIFFERENTLY

One of the most important components needed to support Lean is effective leadership. Problems arise when C-suite executives do not embrace and internalize Lean principles. They are then unable to lead the transformation to continuous improvement. I would agree with Mann that 80 percent of the effort in a Lean transformation should be expended on changing management's practices and behaviors. Without these changes, the effort will uniformly fail.

Speaking from my own past experience as CEO of ThedaCare, I felt my leadership style transform 180 degrees from one of command and control to one of mentor, teacher, and learner. That didn't happen until I had been on many kaizen teams and value stream teams, and had three years of policy deployment or hoshin kanri experience (Dennis 2007). The challenge in implementing Lean in healthcare is discovering how we convince C-suite leaders that this change is critical to the success of their organizations.

With the recent debates in Washington, the focus is certainly on creating better value in healthcare. Lean is the only methodology that I have seen in my 25

years of healthcare experience that has actually worked to create better value. Improved quality at a lower cost is the key motivator for C-suite executives to transform. It helps that their customers and the government are beginning to demand it.

Mann suggests that in addition to cultural change, the senior team's primary responsibility is "steering and oversight." Toyota calls this process "policy deployment," or taking strategy developed by the senior team and deploying it to the front line. Walking the talk is absolutely critical. The best way to deploy strategy is by "going to gemba" everywhere in the organization to learn, teach, and mentor at the site of care delivery. As Mann points out, this is managed through visual control systems, daily continuous improvement, and I would add, A3s.

An A3 lays out an entire problem-solving episode, large or small, on one sheet of paper (see Figure 1). It should be visual and extremely concise. It should tell a story, laid out from upper left-hand side to lower right, which anyone can understand. The A3 starts at the C-suite and is cascaded throughout the organization by the subordinate teams developing their own A3s to achieve senior management's goals. The closer the A3 document gets to the front line, the more detailed and specific the plan becomes.

As senior managers go to gemba and learn to see waste in the ICU, emergency room, and surgery suites, they are able to determine if their original A3 is actually connected to the daily work. If it isn't, they can consider why. In some cases, the senior management A3 plan is flawed; at other times, the frontline staff A3 is. Executives and managers at the place of work discuss the situation to determine what should change. This

COMMENTARY

doesn't happen unless executives get out of their chairs and go on a focused walk looking for waste, understanding problems, and reviewing results.

THE ROLE OF MIDDLE MANAGERS

Lower levels of management have different roles. A frontline manager's responsibility is to ensure that standard work is being applied and is improved through a scientific method. Verification that the standard work is followed occurs through a series of

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audits. If a defect is identified, there is a standard process in place for frontline staff to use to address the problem. Daily problem solving using the Plan/Do/Study/Act process is core to that manager's work. As Mann points out,

this management standard work needs to be codified and built into management expectations.

It is important to realize that when we start the Lean journey, we don't know what we don't know. We can't expect our managers to intuitively learn their standard work unless they are trained. As Stuenkel and Faulkner describe with their hospital experience at Floyd, training is an important part of understanding. The ThedaCare experience has been that manager training is absolutely critical for sustainability of results. Today, ThedaCare managers and supervisors complete a two-month Lean internship, which involves hands-on work in model cells. These cells or departments are usually led by managers who have two-year assignments as Lean facilitators. The facilitators are certified in Lean by the Association for Manufacturing Excellence (ame.org) and have as many as 100 kaizen and other Lean events in their portfolio. During this manager training, 50 percent

of the individual's time is spent working problems in the model cell unit; mentoring and teaching is done by a real expert.

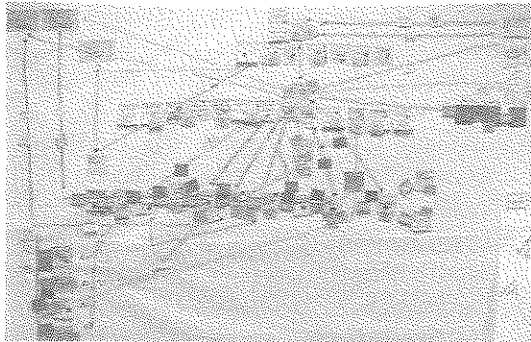
THE HOSPITAL'S CONTINUOUS IMPROVEMENT JOURNEY

The journey at Floyd Medical Center is interesting and one cannot argue with the savings the facility has achieved. Floyd has incorporated many tools on its continuous improvement journey, some of which are considered Lean tools and some of which aren't. One thing is clear, after studying Lean journeys in many organizations, there is no one way to implement Lean. The important point is that Floyd is building its continuous improvement method, which is what all hospitals need to be doing. Over time, Floyd will learn what works and what doesn't through experimentation.

Its journey to this point cannot be described as Lean, however. The process of 100-day workouts, for example, is not a Lean tool. Early in our improvement work at ThedaCare, we tried 60-day workouts and found most of the gains had been reversed at six months. We believe this was because it was manager "pushed," without enough staff involvement, understanding, and engagement. Teams reverted back to their previous ways when attention was turned to a different work process.

Lean is really about having the frontline workers design and improve the standard work. That should occur every day with real time measurement, not with control charts, but with simple hand-written performance measures done entirely by the frontline staff. For example, in the intensive care unit, the bedside nurse should be filling out the visual control board as to whether the head of the bed was at 30 degrees (which

FIGURE 2: VALUE STREAM FUTURE STATE MAP



reduces ventilator-caused pneumonias). If the frontline nurse fills out the data sheet for all to see, she becomes engaged, especially if she finds that the head of the bed is not at 30 degrees when she comes on for her shift!

We have found that four-day kaizen events with eight to ten staff effectively improve performance and lead to sustainability of that performance over time. Staff are able to implement new standard work in the unit by day four. In order for kaizen to be effective, though, the patient flow processes must be understood. This starts with a value stream map (see Figure 2). A value stream is the set of steps required to deliver value to the customer. These steps are categorized as either adding value from the customer's perspective or not. If not, the step is waste and must be removed from the process. To make the necessary changes, the people closest to the work must be allowed time outside of their regular duties to study the initial state and design a new future state that can be tested in rapid experiments. The key to the above is the word "rapid." In a week-long kaizen, there may be six to eight different experiments before new standard work is agreed upon by the team.

STARTING THE TRANSFORMATION

As Mann points out, leaders in the Toyota world are different. Our role is to mentor, facilitate, and teach—not to tell others what to do. This also is the hardest to learn of all the continuous improvement components. When these components are appropriately applied, cultural change is possible. The ultimate goal of any continuous improvement transformation is to change every employee to be focused on improving processes. Toyota employees implement between 50 and 70 ideas each year (an important measure of employee engagement). At ThedaCare, it might be one or two per year after having been on the Lean journey for six years!

Where is Floyd on this continuum? Unfortunately, we can't really tell from the information provided. We don't know the organization's mission, but my guess is that Floyd, like other healthcare providers on a continuous improvement journey, hopes to improve the care it delivers to patients. Floyd has established goals for each of its 100-day workouts, but the details aren't known. Visual management is being accomplished at Floyd through control charts, which would be more powerful if converted to staff managed charts but are still a good start. Floyd is clearly building its methodology through learning a tool set consisting of "5 whys," learning to see and remove waste, SIPOC analysis, and team development. From the description, Floyd seems to understand one of the most fundamental Lean principles, which is that focused experimentation with careful performance measurement leads to improvement.

I am encouraged that the leaders at Floyd are actively involved in their workout teams. But are the leaders struggling to solve problems with the frontline people who are living with these problems

every day? That's the critical part of the leadership change necessary to embed continuous improvement. It seems Floyd is on an improvement journey using mainly other methods than Lean.

CONCLUSION

The call to action for all of us in healthcare is to change the way we manage our business, because healthcare quality and cost

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performance in America are currently unacceptable.

Developing a culture of continuous improvement by changing the way we, as leaders, practice and behave is critically important. If we can all learn the Toyota leadership template Mann has

outlined and start a continuous improvement journey like Floyd is attempting, maybe we won't have to wait another ten years to stop crashing one plane a day.

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