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Foreword

If the history of revolution around the globe has taught us one thing, it is this: leadership succeeds only when it learns to evolve. No matter how necessary and just the rebellion, when the dust clears, the leaders need to govern, to make systems work in order to keep a country or an organization running. And that requires an ongoing willingness to change and adapt.

For nearly a decade, the lean revolution in healthcare centered on improving quality and reducing costs in advance of the huge systemic changes we all knew were coming. With healthcare bills bankrupting families and threatening to do the same to the United States, major hospitals and health-system leaders began experimenting with various improvement methods. A healthy percentage of those organizations embraced lean thinking and adopted tools and methods from the Toyota Production System.

Many of us who saw the results of lean thinking in healthcare became true believers. We used the tools to halve the amount of time it took to deliver a life-saving balloon angioplasty to a heart attack victim.

We removed wasted time, movement, and resources from clinical processes and achieved better results with lower costs. Patients were happier; frontline staff were more engaged and energized. We wrote books and gave talks about our successes. The scientific method as interpreted by car manufacturers was going to save the American healthcare system.

And then it seemed like everyone hit a wall.

That statement may sound overly broad, but I have toured, investigated, and advised more than a hundred healthcare organizations in a dozen countries in recent years and have seen the impact. Cross-functional teams of nurses, physicians, pharmacists, and administrators made amazing, weekly breakthroughs in better patient care processes and then watched in dismay as the old ways crept back in and took over. Executives who eagerly supported lean thinking kept looking for the promised resource savings to hit the bottom line and wondered what went wrong. For many, it seemed like value-stream mapping and kaizen improvement projects were just tricks pulled from a shallow bag. Enthusiasm for the hard work of a lean transformation waned in some quarters.

It turns out that revolutionary change is necessary, but it is not sufficient.

The kinds of change that come from rapid process improvements are essential but are only the first steps of a lean journey. The core work of the transformation is changing the culture—changing how we respond to problems, how we think about patients, how we interact with each other. This is an issue not only in healthcare organizations; we have also seen manufacturing, service companies, retailers, and government agencies all struggle with the same issues. When lean thinking goes only skin deep and management does not change, improvements cannot be sustained, and savings never quite hit the bottom line.

Knowing this, I have watched with great interest as Kim Barnas and her team at ThedaCare hospitals in Wisconsin worked at transforming their culture by redesigning the system of daily management. After two years of experimentation, discussion, and study, they found a more deliberative approach to leading a lean healthcare system. By changing the expectations of what managers and frontline supervisors actually do each day, Kim and her team pushed the roots of lean deeper into the organization. This encouraged new ways of thinking, which led to new behaviors. Instead of adding continuous improvement to the list of manager's duties, improvement became the organizing principle of their work. Thus, a new management system emerged and it was clear that this was the secret sauce that so many had been seeking.

Kim discovered that changing a leader's work content changed the leader as well. From frontline supervisors to top executives, new management duties encouraged everyone to become more respectful, improvement focused, and process orientated. Instead of managing by exception—running after today's unique emergency—they fixed processes. They standardized processes. In doing so, more improvements to clinical processes remained in place. Projects initiated by frontline caregivers were aligned with the hospital's major initiatives *and* relevant to the unit or clinic. Continuous improvement became the working method instead of the extra task.

And finally, dozens of managers in ThedaCare's two major hospitals knew exactly what they were supposed to do and had the time to do it. In the first six years of ThedaCare's lean revolution, we lost many area managers. Some of that turnover would have occurred anyway, as always happens in periods of great change, but the enormity of that shift was a clear sign that managers were under too much pressure. Since 2010, when the business performance system began creating a supportive structure for leaders, just two area managers have left.

Next, Kim and her team started teaching their *business performance system* to other hospitals that were struggling to make improvements stick, from Canada to California. The system not only translates to other organizations, it usually thrives.

Let's be clear: ThedaCare's experiments and methods are not perfect. They will benefit from continuous improvement and every organization will need to customize the system to fit its needs. Still, we believe that this business performance system is a breakthrough in thinking about leadership.

We are finally moving beyond the age of heroes chasing exceptions and are looking forward to innovations in management that will move us even further ahead. The faster we can implement these ideas, the better it will be for all of us—patients, physicians, nurses, managers, and everyone who pays for healthcare.

—John Toussaint, MD
Founder and CEO, ThedaCare Center for Healthcare Value
January 2014

An Additional Word to Those Readers from Outside Healthcare

Why should managers and process improvers from other industries consult a book on lean healthcare management? Based on personal experience—as patients or as family members of a patient—many outsiders will surely think the term "healthcare management" is an oxymoron. And, until recently, that view was quite right. But times have changed, and in these pages readers from other industries will find a dramatic story of how the management team at ThedaCare conducted a series of experiments to pioneer a new way of managing that is relevant to any organization in any industry.

The ThedaCare team built on a solid foundation of rigorous process improvement with an equally rigorous process of policy deployment (*hoshin kanri*) to determine and communicate the organization's True North goals. Many readers from other industries will have done the same. But then the ThedaCare team pioneered a daily lean management system (which they call their business performance system) for every manager from the frontline supervisor to the president. And this breakthrough is what every organization in every industry needs now.

What are the principles of a lean management system?

Managing by process, using A3 and plan-do-study-adjust (PDSA) analysis, rather than the traditional method of managing by exception—the firefighting of things gone wrong that occupied most of the manager's time—and managing by metrics set up by senior managers (which occupied the rest of the manager's time).

Managing by using the "Five Whys" to identify the root cause of problems rather than assigning blame to one person.

Managing patient pathways end-to-end within product families of diagnosis and treatment rather than optimizing individual points along these journeys.

Finally, problem solving and improvement by line managers and their teams, with technical assistance from the staff "lean team," rather than the reverse, which is still the norm in most organizations.

And, what are the methods of a lean management system? ThedaCare uses the annual True North exercise to prioritize the key challenges and opportunities for the organization and to cascade these priorities down to every level for action. (This is separate from the familiar annual budget cycle, which is still needed but in the background rather than the foreground.) Many organizations have already done this but without obtaining the hoped-for results because of the weakness in line management and instability throughout their enterprise.

ThedaCare employs an A3-based PDSA process. This is not just for attacking problems at every level (e.g., excessive patient time between the emergency department and reaching a bed in a unit) but also for seizing opportunities (e.g., achieving an industry-leading reduction in drug reconciliation errors). Again, many organizations have embraced these methods but without the expected results due to weak deployment on the front lines.

They use standard work for all value-creating and incidental work in the enterprise—designed, documented, and continually audited, revised, and improved by line managers and work teams. This is the heart of the matter. Without creating stability in every work activity by means of standard work, sustainable improvement will continue to be elusive.

They also use daily standard work for every manager at every level, up to and including the president of the ThedaCare hospitals. This is the secret behind sustainable standard work: Daily observation of the

work at each level by line management, with periodic improvement of the work.

Is this management process easy? Definitely not. Can it be introduced without the direct, hands-on participation of senior management? Absolutely not. And is it perfect? Definitely, absolutely not. The author insists that what they have achieved so far only lays the groundwork for continuous improvement of their management system. For example, the challenge of managing the patient's journey end-to-end—across primary care, hospital care, and then continuing maintenance through the life cycle, often flowing through independent organizations—still lies ahead.

This said, I now find myself in an unexpected position. I am recommending this book to managers in other industries far removed from healthcare who have had some success with lean tools but who have struggled to create a management system that can fully utilize these tools on a continuing basis. I do this with the realization that ThedaCare is now far ahead of most organizations I visit in other industries in deploying lean management, even though these other companies started their lean journeys years earlier. This is an amazing turn of events, given the state of healthcare management only a few years ago, and one that gives me hope for lean management in every industry: If the managers at ThedaCare could progressively create a lean management system through several years of experiments—a system that eliminates the need for management heroics to put out ever-burning fires—and do this in an industry with perhaps the worst management practices, managers in other industries now have no excuse for failing to follow their example.

However, let me be clear that I am not advocating painting by the numbers. No reader from other industries can or should literally copy what ThedaCare has done. (And ThedaCare's best practices for lean management will continue to evolve in any case.) But readers from

every industry can and should learn from ThedaCare's story and then set off on a journey of exploration to create a lean management system suited to their circumstances. I hope you will be one of those readers.

—Jim Womack
Founder and Senior Advisor, Lean Enterprise Institute
January 2014

Success is not final, failure is not fatal:
it is the courage to continue that counts.

—Winston Churchill

Chapter 1

Drowning Our Leaders

For me it was the big time. Coming from a small health system in Battle Creek, Michigan, 1994, I had been recruited to create a philanthropic foundation for the large and well-regarded Appleton Medical Center. While being courted by the chairman of the board of trustees and the president of the hospitals, I was told that the future was mine to create.

Excited and proud, I moved my young family 350 miles across the great Lake Michigan to Appleton, Wisconsin and showed up for my first day of work. The hospital president took me to meet my secretary in her office. Then he showed me to my office, swinging open the door to reveal a large, empty space with a telephone sitting forlornly in the middle of the room. When I turned around, he was grinning.

"You're going to build this foundation from the bottom up," he said. "To do that you need to learn how to navigate our system. So here's the bottom: you find your own office furniture and supplies. Use your secretary and use the phone book to figure out how to get the things you need."

This was the old, time-tested leadership training program known as *throw her in the deep end*. Perhaps you have gone through this so-called training and know the feeling of seeing your peers step back and watch to see whether you can swim. It builds character, right?

Of course, the problem with sink-or-swim training is that some perfectly good puppies drown. If not aligned with the organization's vision, a new manager or executive can quickly fall off course, wasting valuable time and resources and damaging reputations as they flail. And yet, this is how leaders are generally welcomed into new positions: without training or a map to guide them, we leave them to their own devices. It is our first strike against new leaders.

Luckily, I did not flail in Appleton. As the two-hospital system grew to include five hospitals, 22 clinics, nursing homes, and rehabilitation centers unified under the name ThedaCare, my role grew steadily as well. I created another philanthropic foundation to benefit Theda Clark Hospital in Neenah, Wisconsin, and then took on a third for ThedaCare's hospice program. Meanwhile the parent, not-for-profit ThedaCare, became a complete cradle-to-grave health system and is now the largest employer in northeast Wisconsin, serving more than 350,000 patients annually. Since 2003, we have also been working hard to transform ThedaCare into a lean organization.

Lean was a serious initiative from the beginning. It was energetically championed by our CEO at that time, John Toussaint, MD, who began his own lean investigations in 2002. By this time, I was a vice president with operational responsibilities in the hospitals for obstetrics, cancer care, and surgery, in addition to the philanthropic foundations, so I was involved from the beginning of our ambitious lean initiative.

Like many organizations beginning a lean initiative, we started by putting together teams to map our value streams. First, though, we

had to define "value stream." In industry, value streams show how products and information flow through a company from raw material to fabrication and shipping. In healthcare, we decided, the patient was the product, and so the value stream would be the flow of a patient through a cycle of care. A cancer value stream, for instance, includes testing, diagnosis, treatment, and, some percentage of the time, hospice. For women having babies, our obstetrics value stream began with prenatal checkups, continued through delivery, and ended with baby's first visit with a pediatrician. In this way, we shifted our focus from organizing work around specialized departments (silos) such as pharmacy or surgery to organizing around the needs of the patient. We recognized that most patients flow through multiple value streams. Also, we learned that our first pass at any patient's care was disease specific— not necessarily taking multiple health issues into account.

Next, we set end-to-end improvement goals in those value streams—cutting through departments and old barriers—and pushed ahead with three or four *kaizen*[1] improvement teams operating every week across the organization. Our Friday report-out sessions were part information sharing, part tent revival. We trained more than two dozen people to become lean experts facilitating kaizen teams and then started rotating frontline leaders and executives through those facilitator positions for two-year terms. Organizing all the work was our ThedaCare Improvement System Office, overseen by a senior vice president reporting to the CEO.

We called our kaizen team weeks Rapid Improvement Events and made sure they were multidisciplinary, with nurses, patients, pharmacy technicians, family members, and doctors all joining together to solve problems. Wherever we applied lean thinking, quality was improving, costs were falling, and patient satisfaction was inching upward.

1. "Kaizen" is from the Japanese symbols meaning "change" and "good." It is translated as "change for the better" and usually refers to a lean improvement project in which a cross-functional team studies and then improves an area or process in one week.

Like most of my fellow leaders, I saw the benefits of lean as the economy stagnated in the mid-2000s and cost pressures on healthcare increased. We had all seen plenty of improvement programs, but lean was the first that was a complete operating system, balancing the needs of patients, caregivers, and the bottom line. Lean thinking was helping us improve quality for patients, reduce costs, and engage employees like no other approach.

About three years into this initiative, sometime in 2006, I was involved in improvement events in a cancer treatment value stream focusing on radiation oncology. We were getting breakthrough results: improving labor productivity[2] by 20%, improving same-day access to one's doctor by 30%, and slashing the time it took to move a patient from diagnosis to treatment from weeks to days. After a slow start, physicians had become more engaged in lean and were sometimes driving improvement work. Patients were on every kaizen team, helping to shape and guide our priorities. Sustaining our improved processes was a struggle, but I was sure we would solve that problem, too. It felt like we were sailing with a strong tailwind.

Then we hit a snag that could have sunk our lean initiative. And the snag was us. What hospital executives were asking of our line managers was slowly strangling our lean improvement efforts. We were heaping on more work, expecting managers to guide lean efforts while performing the same managerial duties as before, in the same way as before. And we expected them to figure out *how* on their own. This was nothing new. Like our throw-her-in-the-deep-end training, these competing priorities were another strike against our leaders.

2. At the highest level, productivity at ThedaCare is defined as gross revenue per full-time employee equivalent. At the unit level, managers track worked hours per unit of service to define productivity. A unit of service might be a lab report, a surgery, or 24 hours in a medical-unit bed.

One day, the very frustrated manager of a hospital intensive care unit yelled at me in my office (in a respectful Wisconsin way, of course), "You've changed the way our teams work, but you haven't changed how we lead. We don't have the tools for this."

Another manager wept in my office. Both of these were good and steady leaders, so I knew there was a real problem. I talked to other managers and to executives in ThedaCare's two main hospitals, and everyone recognized the truth of the ICU manager's statement and acknowledged the general frustration. Managers at ThedaCare are dead center—the bull's-eye—of our leadership structure. They are responsible for frontline supervisors and entire units; they answer to vice presidents and other executives. New and daunting responsibilities were pressing down from above and below. It was no wonder that cracks were starting to show at this level.

For nearly two years, we had been telling managers that the most important goal was improving patient experiences by improving the value streams they managed and then sustaining those improvements. But we at the executive levels were still acting as if hitting monthly financial targets in the budget—mostly unrelated to improvement work—was the real objective. Goals were being generated in boardrooms, but these were often inconsistent with what was happening at the front line. Worse yet, we were failing to offer meaningful communication, training, or guidance to the line managers now responsible for keeping all the critical improvement work on track.

We resolved to do something and reached forward to find a solution without quite grasping the extent of the project. It turned out to be enormous, even though our scope was limited to ThedaCare's two largest hospitals and not yet the whole organization. I thought we had a leadership process that just needed some tweaks. I had forgotten that empty office I was given on my first day. Fortunately, other people in

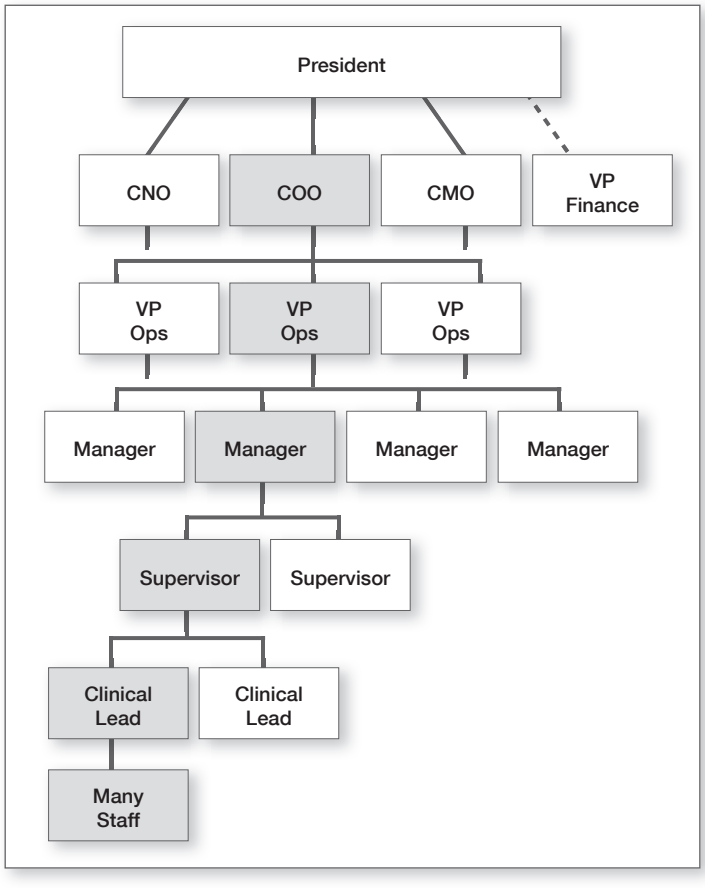
ThedaCare were also investigating ways to improve the way we manage processes and how we train our leaders—from supervisors to managers and executives. We were able to use the expertise of people in our support services, such as human resources and the lean improvement office, as we put together a team and began investigating ways to make—or remake, depending on your perspective—our system of leading and managing.

This book is the story of the experiments we ran, our successes and failures, and the new system we developed. We are offering our story because I know from visits to dozens of hospitals and healthcare organizations that our problem is everyone's problem. Healthcare organizations have embarked on lean programs at a very fast clip, but few see the need to update their leadership or management techniques. As a result, they end up undermining their efforts as quickly as they make operational improvements.

Before we go further, brief definitions of *leadership* and *management* are necessary. Leadership invokes heroism or charisma at the top. Management often sounds like the activities of a functionary in the middle ranks of an organization. Neither definition is useful. I like to say that we manage processes and lead people. The system I will describe in the chapters ahead offers a method for managing the work of leaders, as well as developing and mentoring those leaders. Because this system involves leading and managing, as well as learning to understand the business of a clinic or hospital unit and how it performs in order to drive performance, we called it our business performance system. With this name we remind ourselves every day that improving the performance of the business is the focus of our leaders, just as taking the best possible care of our patients is the work of everyone in our hospitals.

As we begin, it will also be helpful to understand our leadership structure. ThedaCare is a complex organization with six tiers of leadership in the

hospitals. (See illustration below.) At the front line are clinical leads who have limited managerial duties on their shift, in their unit. They take care of patients, make sure the shift is fully staffed, ensure their colleagues get adequate breaks, and lead some quality improvement activities. Next are supervisors, who oversee the work of a few clinical leads and are also in direct contact with patients. Supervisors manage the flow of a unit, interface with physicians, help create staffing models, and mentor their clinical leads.



ThedaCare Leadership Structure Chart

Direct patient contact is no longer in the equation once we reach the level of managers, who mentor and guide two to four supervisors each and are responsible for the business of a clinic or unit. (Clinics are doctors' offices grouped by specialty, seeing outpatients. Units are for patients admitted to the hospital.) We have 35 managers working in our two major hospitals.

Vice presidents have similar yet broader responsibilities in that they oversee managers and larger areas or value streams. ThedaCare's two main hospitals, Appleton Medical Center and Theda Clark Medical Center, have a total of three VPs who report to the chief operating officer. The COO is a member of the executive level of leadership that includes the chief nursing officer and chief medical officer, who oversee all nurses and physicians, respectively. The three executives report to the president (that's me) at the final leadership level.

The business performance system we have built at ThedaCare, which I think of as the common rudder for steering all of our efforts, involves some radical ideas. We have frontline leaders—from ICU nursing supervisors to clinical leads in radiation—talking to their managers every day about the state of the business. That's right. This not-for-profit healthcare system trains all leaders to think of their units as small businesses entwined in one larger business. We know that if we do not have a healthy business, we will not be around long to care for our patients. ThedaCare executives have always placed high value on our financial stewardship and the public trust. Developing business acumen in all leaders just takes the idea further. We want frontline supervisors, area managers, and executives talking about the health of their businesses. That means tracking unit costs as well as safety issues and patient needs.

We have also created standard work for clinical leads, supervisors, managers, and executives that guides our daily work. Instead of setting our leaders adrift with a long list of goals to be met, we created a

framework for gathering information, addressing problems, mentoring new leaders, and guiding improvement work.

For instance, standard work for every manager includes a no-meeting zone from 8 to 10 a.m. every morning. During that time, everyone knows managers will be at *gemba*[3] collecting information from supervisors and clinical leads. Standard work includes the specific questions that managers ask based on the current needs of the unit such as, "What issues affecting patient safety do you foresee today?" The manager can translate that information into new improvement work. Executives also have standard work. For example, a vice president and the chief operating officer meet each Tuesday morning with the manager of surgery, at gemba, to talk about performance and barriers. This is understood as a coaching opportunity as well as information gathering.[4]

Our chief operating officer follows and regularly audits her standard work. As president of the ThedaCare hospitals, I also have standard work. Since all standard work is informed by the organization's True North metrics—which are our few selected enterprise goals in five categories—every leader's standard work is linked to the efforts of every other leader, ensuring that we are all rowing in the same direction. It is just one aspect of our business performance system, but it has been revolutionary. We will explore our True North metrics and how we use them to link all standard work in chapter 3.

All of this has been undertaken in an attempt to replace firefighting with preemptive improvement work. In a hospital environment we are accustomed to firefighting, which is jumping to the quickest solution without really analyzing the problem. When something goes wrong or

3. A Japanese word popularized by the Toyota Production System, "gemba" means the place where real value is created. In a hospital, gemba is located wherever caregivers are directly helping patients.

4. Chapter 11 offers a more complete description of standard work at all levels.

real emergencies arise, the person who steps in to fix it with a quick solution is the hero. We like being heroes. But it is a problem to have 6,000 well-meaning heroes tackling problems in 6,000 different ways, often without regard to the needs of upstream, downstream, or parallel processes. Firefighting provides a short-term high but is a long-term drain on everyone's time and resources. What we want instead are carefully considered, deliberate, team-based countermeasures to attack problems. Even better, we want those problems attacked before they materialize as issues. We believe that without the need to be heroes, leaders can systematically address problems and leave no one in the organization adrift to sink or swim.

Four years into our experiment, I can report some remarkable results. In my role as head of the hospitals, I do 80% less firefighting. I complete my daily work faster than I dreamed possible. I work on larger issues such as improving community access to healthcare, improving the way in which we help patients navigate care, and managing to financial targets rather than getting sucked into a constant stream of emergencies. Supervisors and managers report greater confidence in their teams and increased job satisfaction since adopting standard work.

"Some people might think my job sounds repetitive, doing the same thing, asking the same questions of my team every day," says Vicki Van Epps, a supervisor in our radiation oncology unit. "But for me, the structure means there's no guessing. I know what I'm doing now and where I can find capacity to do anything extra."

The story of how we got here is important because, in creating a business performance system, the process is just as important as the product. A common Toyota saying is, "If the process is right, the product [the results] will be right." Keep that in mind. Healthcare is filled with highly educated people working in an often-emotional environment, and respect is essential when developing a new business performance system.

This means listening to your people, incorporating their ideas and concerns, running experiments, accepting that some of those experiments will fail, and trying again.

In developing our new system, I often sought the advice of my sensei,[5] Jose Bustillo, who helped me select a team, set an agenda, and rethink all of our assumptions. Following our A3 problem-solving template, the team developed a problem statement that began: "Every manager at ThedaCare manages his or her own way. There is no one system."

Then we created a cause-and-effect diagram, searched for the meaning of good leadership, used the scientific method to design experiments, and set up experimental development labs to keep the scale of our inevitable test failures small. Our process was not always pretty, but I know that if I had dreamed up a perfect plan in isolation and foisted it onto my subordinates, it never would have taken root. I will provide a complete description of our transformational process in the next chapter.

Our goal was a new leadership system in which frontline supervisors, area managers, and upper-level executives all know today's goals, yesterday's performance, and how to work through problems. Within three months, we pulled together a larger team and began writing standard work for supervisors and managers. Our new goal statement was "to develop people, to solve problems, and to improve performance."

Here, in a short story, is how our lives have changed four years later. Let's say that in the years before our business performance system, the hospital suffered a financial setback and the president—busy fighting fires—ordered a 3% cost reduction across the board. The team of nurses and technicians working in the intensive care unit threw up their hands and said, "There's nothing we can cut. We're already understaffed and spend all day on the run, caring for our patients."

5. *Sensei* usually refers to a teacher with advanced lean knowledge and experience.

Their supervisor, valiantly protecting her people, also protested understaffing, and the problem trickled up to the area manager. Aware that the ICU doctors were already grumpy about the nursing staff being thin, the manager made a decision. She cut the staff-training budget to near zero; reduced the hours of the senior, most highly paid, nurses; and created a very disgruntled ICU. One problem was solved, but a worse one was created. Sound familiar?

Here is how that 3% cost reduction issue plays out now. The manager asks the supervisor and her team to start coming up with ideas to reduce costs in the ICU. They are, after all, the frontline experts. In their daily huddles—brief, structured team meetings—the team throws around some ideas and then uses lean tools to see opportunities. They relocate medical supplies and reorganize their drug delivery system. This reduces time spent running around searching for materials. Now, team members can spend more time at the patient bedside and are able to eliminate both overtime and the additional nursing aides who were supplying temporary help during peak hours when it felt like everyone was running ragged. Cost reductions come with greater staff satisfaction and better patient care. I make this sound easy. It is not. It is hard work, but the outcomes are more satisfying and sustainable.

Another critical component of our work has been defining the role of doctors in improvement. Through trial and error over the past decade, we have come to the general rule that physicians are involved in Rapid Improvement Events when we are looking for breakthrough changes in the therapeutic process. If we need to slash the time it takes for a heart attack patient to get from the hospital's front door to a life-saving balloon angioplasty, for instance, we absolutely include doctors on the team because we are planning to improve their work. We also ask for physician input when the issue at hand concerns them, such as unit staffing. Most of the time, however, our daily continuous process improvements do not affect physician treatment paths, so we focus on

making changes around the doctor. It is important to note that we do not implement work that affects our physicians without their input and support. If we are going to change the flow of their work, they must be involved. Physicians have an important and ongoing voice in our business performance system. As we look ahead to the enormous changes facing healthcare organizations, we will be relying on the structure we have created to help us—administrators and physicians—adjust to new realities together. We explore this more fully in chapter 12.

Our world here in the upper middle reaches of the country may not be exactly like yours. Maybe our culture looks more like Toronto than Texas. We value a sense of belonging and are suspicious of lone-wolf characters or those who would push themselves forward into a spotlight. In fact, I would like to make it clear that every "I" in this book has a dozen authors, and I am merely the one telling the story on behalf of the hundreds who made it happen.

Every business performance system will be a little different because each must show the fingerprints of the people in that organization and the local culture. There are no shortcuts for creating one. There are, however, a few core concepts that cannot be skipped.

- Every leader begins each day assessing and understanding the status of the business, to see and anticipate issues.
- Problems get solved when teams work methodically through the scientific process.
- The leader is the team; the team is the leader. Although an individual may take the role of team leader, his or her function is to keep the team on track and document the work. On every unit, the true leader is the frontline problem-solving team. Supervisors and managers support those teams.

These core concepts thoughtfully implemented will be a catalyst. Once teams are engaged to solve problems—or to spot issues before they become problems—everyone will spend less time firefighting and more time doing the real work of the enterprise. Leaders will be invigorated to take on new, more global, issues. Change for the better accelerates while sustaining the improvements of a lean system becomes embedded into the DNA of the organization.

We need these changes in healthcare just as we need them in every organization seeking lasting change. So, let's dive into the process of change.