

## **Enhancing Strategy Execution at York Central Hospital**

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The Health Transformation Learning Partnership (HTLP) involved the transformation of three healthcare organizations (partners) in Ontario: North York General Hospital (NYGH), York Central Hospital (YCH) and the South East Community Care Access Centre (SE CCAC) using a combination of organizational transformation techniques.

There were two main objectives of the project. The first objective was to apply organizational transformation techniques to provide the three partner organizations with the tools and techniques that they need to help them to improve quality of care, improve efficiencies and successfully adapt to the changes underway in Ontario. The techniques used are intended to build the capacity of these organizations.

The techniques include the development of balanced organizational scorecards, balanced governance scorecards, strategy maps, accountability agreements and process improvements, to improve quality and safety within the organizations, and to enhance the organizations' ability to respond to changes in their environment. The project also involved the innovative use of storytelling to enhance results. This approach to transformation has not been used in Ontario, and is innovative in that for the first time in Ontario, it applies a unique combination of organizational transformation techniques to build human capital within an organization.

An early premise of the HTLP was that "in Ontario we are great at Strategy Development but poor at Strategy Execution." The backing for this was provided by Kaplan And Norton's *The Execution Premium* and by HTLP team member Ted Ball.

The theory to be tested was that by implementing Ted Ball's Quantum Journey model (see <http://quantumtransformationtechnologies.com/>), organizations would show performance improvement (by executing strategies successfully), would build their capability to execute strategy, and would thus be able to maintain and sustain results over time. The Quantum Journey included the Balanced Governance Scorecard, Strategy Mapping, and the Office of Strategy Management. Taken together, these elements were referred to as the Strategy Management System (SMS). The SMS was combined with Personalysis, Mutual Accountability Agreements, and the Learning Journey for the management group. They contributed to a common language and common framework for decision-making and problem-solving, led to spin-off innovations (such as Physician Leader Accountability Agreements), and created better alignment between the Executive Leadership Team (ELT), Directors, and Managers. However, the methodology was not actionable for the entire organization because it did not penetrate the front lines. Thus, as of 2010, after 5-6 years of this work and multiple "Strategy Refresh" cycles, York Central Hospital still ran a structural deficit. In short, the hospital lacked the culture of shared accountability (as

well as the necessary knowledge, skills, and methods to support it) that would enable it to balance the budget each year while achieving other important strategic objectives.

In early 2009, the CEO of York Central Hospital left and was replaced by Jo-Anne Marr, Vice President Patient Services and Chief Nursing Executive. Jo-Anne was interim CEO while the Hospital Board underwent a restructuring process prior to the search for a permanent CEO.

Members of the ELT began meeting before the CEO's departure to discuss their concerns about the hospital's budget challenges. They were worried that if the hospital did not balance the budget on a regular basis, it would prevent their ability to innovate and would also raise the likelihood of the Ministry appointing an investigator and perhaps a supervisor. When the LHIN requested an Operational Review, they welcomed it. They felt it would provide the needed external push to legitimize a move to balance the budget and create the significant change in culture needed to sustain the gains.

In the meantime, David Stolte had joined YCH as Chief Strategy Officer. After going through an early learning curve, he began to sense the discrepancy between Strategy Development and Strategy Execution at YCH. Stolte recalls spending extensive time on developing a new Destination Statement in late 2009 and early 2010, to the point where it became more and more difficult to agree on goals, objectives, and accountabilities for 2010 by the April 1 start of the fiscal year.

The ELT charted a new course for Strategy Execution for 2010. Their fresh look at the Discipline of Strategy Execution would build on the framework already in place while extending and enhancing it to address the issues with which the hospital was grappling.

Starting in early 2010, the ELT adapted the concept of WIGs (Wildly Important Goals) to York Central Hospital. Adapted from Stephen Covey, the idea of WIGs was to focus the entire organization on a few things and thus to mobilize energy around key priorities. Stolte and others on the senior team felt that the hospital was too diffuse in its priorities and also that its chronic structural deficit could no longer be sustained, especially in times of fiscal austerity. The notion of WIGs included:

- Having three goals (no more, no less) for each year;
- Revisiting and updating them annually; and
- Maintaining, in parallel, the Scorecard and Strategy Map developed over the previous several years.

The Strategy Management System would still include broad goals and strategies (such as clinical priorities, program objectives, and linkages with key Ministry and LHIN mandates) in the Strategy Map and Scorecard. The SMS would be used as a navigator and reference tool by the Board, Senior Management, and clinical leaders. But, at the unit level (managers, directors, and staff), something more focused was needed to point the organization toward key goals and raise

the odds of achieving them. Thus, the discipline of Strategy Execution was extended to include WIGs.

For 2010, the Executive Leadership Team chose three WIGs: Balance the Budget; Develop a two-site model; and Create a Culture of Safety. The highest priority was placed on reducing the structural deficit. Closely linked to that was the re-design of patient care, which was thought to have potential both for cost reduction and improving quality and access to care. Finally, the Culture of Safety was chosen to provide a goal that was less financial and more oriented toward direct patient care.

At the same time, and as part of its involvement in the Health Transformation Learning Partnership, YCH was embarking on a six to nine month Lean journey. The timing turned out to be good (though it was not planned in advance), since the Lean methods (including 5S, Kaizen events, Value Stream Mapping, and Daily Management) dovetailed well with Budget Recovery.

In order to focus the attention of the organization on the first WIG, the hospital launched a 100-Day Action Plan to reduce the annual budget deficit by \$8.5 million. This campaign was both prompted, and reinforced, by an Operational Review conducted by an outside firm in the spring of 2010. Fifty-two recommendations were made, most of which were folded into the 100-day campaign. The campaign was led by Jo-Anne Marr and fully supported by the Executive Leadership Team. It included a number of key strategies, including:

- “Communicate, motivate, communicate”: although the senior team was well aware of the problem and the urgent need to address it, many in the organization did not have a sense of the magnitude and importance of the problem. Nor did they have an idea of specific ways in which they could contribute to solving it. Most managers had never been held accountable for daily management or trained and coached in how to manage their budgets. Thus, there was a need to communicate not only why the campaign was needed, but also what it would entail and how staff could help.
- Weekly meetings of a cross-unit, cross-disciplinary Change Team;
- Visual Management;
- Project Management;
- “Keep score”;
- Full engagement and backing by the executive team; and
- Monthly Program Review meetings.

Overall, the campaign was successful. YCH realized half of the required savings (\$4.2 million) in 100 days. Many commented that the program represented a breakthrough for the hospital. For instance, after the new CEO, Altaf Stationwala, had come on board two months after the 100-Day Action Plan and conducted a number of entry interviews and focus groups, he commented: “We have made a change in culture; now our task is to sustain it.”

The campaign ran from July through October. In December, the authors conducted an after-action review of the program, using Storytelling and Dynamic Evaluation methods. Specifically, we gathered and analyzed the leadership experience of the campaign via interviews, focus groups, and discussion with the ELT.

Reflecting on the campaign, members of the change team and executive leadership team commented:

- *“We got great results; I feel really empowered.*
- *We went from silos to silos opening up.*
- *The Change Team was nimble.*
- *Physicians were getting it and buying in, for instance, with respect to expected date of discharge.*
- *We met all of our goals, with no arguments or micromanagement. I never saw such good working together.*
- *People responded really well: they know their jobs better, they are making calls to Finance, budgets are realigning.”*

The 100-Day campaign produced many discoveries and “nice surprises.” One was the use of visual management as a tool for translating overall objectives to daily management at the unit level. This practice, introduced by the Lean consultants in the surgery value stream, spread rapidly to other units because managers were looking for ways of translating overall unit goals to visible, daily metrics staff could understand. Other nice surprises included the observation that “we did better than we thought we could.” In addition, three other discoveries stood out:

- The introduction and successful trialing of a patient care coordinator model on a pilot unit (an idea which had been under consideration for several years but had not been implemented before);
- The featuring of a more understandable metric (“Unit-Producing Professionals”) which enabled unit managers and front-line staff to manage budget targets on a daily basis (as opposed to the metric, “Hours per Patient Day,” which managers either did not understand or could not translate into daily actions); and
- A breakthrough in patient care redesign (specifically, bed management) despite a VRE outbreak during the pilot phase. Under the leadership of the Interim Chief Executive Officer, and despite considerable trepidation, the team “went for it” anyway (that is, they aimed for their stretch goal). The results were so good that the next time a similar situation came up, the team decided to “go for it” with no external prompting.

Another basic discovery was regarding the underlying assumption at the organization which was that “everyone was clear about their budget target. This was NOT true. They didn’t believe it; so the question was, ‘what do we do now?’ We changed the focus from ‘budget target’ to ‘run rate.’” In other words, the ELT designed ways to help staff change the thinking that led to the

structural deficit in the first place, and coached them (and each other) on how to build shared accountability around balancing the budget through how they behaved every day on the job.

There were also some unintended consequences, or areas for improvement in subsequent rounds of strategy execution. For instance, a challenging but necessary part of the campaign was a reduction in force. About 20 employees left due to early retirement, layoff, or job changes. There was a larger ripple effect, though, both because a reduction in force had not happened at the hospital in recent memory and because of rolling notices (required by the unions) which went out to about 60 people regarding possible job changes. This was a result of the Change Team operating as eight related task forces during the 100 Days. The Change Team was comprised of a number of leaders who were assigned concurrent projects to run. Each was designed to reduce the budget in some area. Each operated as a problem-solving task force and sometimes came up with proposed reductions in force. These were not coordinated, so the notices of possible layoffs trickled out at different times. In short, personnel impacts were not coordinated across the eight projects. Sometimes notices were not coordinated effectively; sometimes the task forces discovered needed changes and new opportunities mid-stream and decided to move ahead anyway given the sense of urgency and pace required to accomplish the budget reduction goal.

Another unintended consequence was that if people were not on the action teams, they could feel left “out of it.” The “single focus” of the 100 Days led to a lack of multi-tasking, so some agendas were delayed or put off. Finally, the magnitude, speed, and perceived suddenness of some changes created disorientation and lag of implementation in some areas of change.

The leadership team was careful to note that so far they had focused on their story of the change, but that it might look different from the perspectives of managers and staff, especially in units which were most impacted by the changes.

As YCH transitioned from a sole focus on the Strategy Map and Scorecard, and Office of Strategy Management, to enhancing the discipline of strategy execution, David Stolte and Cheryl Avrich drafted a position paper on strategy execution. Based on the emerging experience of fiscal year 2010, it included four elements:

- a. The Kaplan and Norton methodology for Balanced Scorecarding;
- b. The Covey methodology for WIGs;
- c. Lean improvement methodology; and
- d. Storytelling and Dynamic Evaluation, referred to as the “qualitative dimension” of strategy execution.

These elements were to be deployed by means of a four-step strategy execution cycle:

- Plan;
- Execute;
- Review/Evaluate;

- Adjust/Act.

The position paper recognizes that none of these methods fulfill all of the requirements of a robust strategy execution methodology. By combining them, it suggests, the hospital will have a better chance of meeting its goals and sustaining the gains than if they use any of the subset combinations, or if they use a more typical approach (i.e. annual strategic planning without enhanced methods like those identified here).

Thus far, the experience of York Central Hospital suggests that a culture of shared accountability and fiscal results cannot be achieved entirely by the use of a Strategy Management System (including the use of a Balanced Scorecard, Strategy Map, Mutual Accountability Agreements, and Office of Strategy Management), as well as a capacity-building learning journey for managers and directors. While these elements do appear to have contributed to an organizing framework for accountability, learning, and results, the kind of change leadership and organization-wide action learning represented by the 100-Day Campaign is also required.

The use of Lean methods was a further contributor to the results of the 100-Day Campaign, but not in the ways one might have expected. The Lean journey was too new at YCH to produce tangible evidence of streamlined processes and cost efficiencies. However, the Lean philosophy and methods (as represented by visual daily management) provided an important ingredient of the “success formula” used by YCH to make significant gains in budget reduction.

For 2011, YCH has chosen the following WIGs: Achieve Budget Target (Part II), Improve Patient Satisfaction, and Reduce Patient Waiting. Stolte and the senior team are working to integrate the various elements of their formula for Strategy Execution and deploy them as a seamless toolset. Among the enhancements will be new strategies for improving patient satisfaction (i.e. from an average of 60% to 70% of respondents who say they would definitely recommend the hospital to their friends and family). For instance, YCH has borrowed a three-part formula from the Studer Group (Hardwiring Excellence), including Leadership Rounds, Post-Discharge phone calls, and Key Messages at Key Times. Another enhancement under consideration would be the use of qualitative information, such as stories and observations, in addition to surveys and other quantitative data. Taken together, the emerging discipline of strategy execution at York Central has the potential to achieve next-stage results and to maintain and sustain them over time.

The story-based after action review of the 100-Day action plan revealed that many of the actions taken during the campaign were highly effective and should be repeated in future such campaigns. These included:

- 100% ELT commitment. The ELT took action as a whole and each member contributed;
- Physician engagement and leadership;
- The cross-area, cross-discipline Change Team;

- Monthly Program Review: “an opportunity to tell our story, and be open and practical about the challenges;”
- Project management, including goal-setting, visual management, “keeping score”, and accountability;
- The overall structure and mission of the 100-Day Campaign; and
- Consistently following the mantra, “communicate, motivate, communicate.”

Discoveries and areas for improvement identified in the after-action review included the importance of early wins and momentum. For instance:

- The supply chain manager came back to the Change Team and said “I captured \$1 million;”
- Bed management had a VRE outbreak and hit their stretch goal anyway;
- The Medicine unit had been thinking about having a Patient Care Coordinator for years and said, “let’s do it.”

These all happened within a couple of weeks and were really significant wins. They led others to feel excited and hopeful, and to ask “why not us?” In addition, keys to success identified in the after-action review were:

- The development of a culture of shared accountability by how the Program Review was handled (that is, through a culture of reporting and collaborative problem-solving rather than one of blame and shame), and
- The development of a translational, transitional metric (“Unit-Producing Professionals”) that had meaning for staff and could be used to get traction with daily work.

These would appear to be key elements of creating and building momentum for change and should be maintained and sustained in future efforts.

In addition, the review identified some areas for improvement in the future, such as:

- Concurrent management of personnel changes;
- Using qualitative analysis consistently to augment quantitative measurement and analysis; and
- Adopting new methods of project scoping, monitoring, and review under conditions of dynamic change and uncertainty.

Overall, this was a highly effective change campaign for York Central Hospital, one in which the four elements of the hospital’s new Discipline of Strategy Execution are interacting and reinforcing each other. York Central looks forward to continuing to build organizational learning capacity and to the continuous discovery of ways to spread and sustain positive change over time.

## Enhancing Strategy Execution Toolkit

Typically, the Strategy Execution cycle for any strategic/improvement initiative involves:

1. **Planning**
  - Set the goal; identify measures and data collection; select changes/improvements that are most likely to influence/predict the target – who, what, when, where)
2. **Executing**
  - Implement the plan, collect data (start in one area)
3. **Reviewing/Evaluating**
  - Analyze results in relation to objectives/goals
4. **Adjusting/Act**
  - Determine what, if anything, needs to change; standardize results

*.... If the plan worked, expand to other areas; if not, start cycle again adding learning from previous cycle. Often, this is called a PDSA/PDCA cycle.*

**To increase our chances of success** of reaching our goals at YCH in the execution phase of our goals, we are:

- A. Using the **Kaplan and Norton Methodology** for Strategy Maps and Balanced Scorecards
  - This helps us focus on what our key customer groups want, what we need to get there and how we will know we are there (measurement in BSC)
  - It also helps us align our actions throughout the organization so that we are all working toward the same goals
- B. Using a **LEAN approach** for process improvements
  - This provides a front-line team approach and discipline throughout the PDSA cycle using key tools such as Value Stream Mapping, A3/A4's, Kaizen events, Visual Management of data
- C. Using a **Covey approach** with 4 disciplines to:
  - Narrow our focus - maximum of 3 Wildly Important Goals (breakthrough, transformational goals where 20% of our time is spent)
  - Develop Actions and Lead measures that will “influence” and “predict” the achievement of the goals
  - Using a visual scorecard – so that everyone can see where we are winning
  - Regular updates/huddles/meeting – to review results and assign next steps
- D. Add a **Qualitative dimension** to the cycle to:
  - Improve problem diagnosis, ability to problem solve and monitoring; and
  - Ultimately, to increase team commitment and get better results.
    - i. The project, starting at the Reviewing/Evaluating phase in the cycle would focus on the execution of the 100 Day Action Plan – what worked, what didn't, what we could improve – to apply to other WIGs.