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Working Hard & Working WELL

CHAPTER 2

Why I Take Performance Management Personally

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Why I Take Performance Management Personally

A period of my professional life that had an enormous impact on me came in my forties, when I helped turn around Cedarcrest Regional Hospital, an acute-care state psychiatric hospital in Newington, CT.

It was a time of struggle and more than occasional agony. From my current vantage point I can see clearly the embarrassing number of mistakes I made. I indulged a hair-trigger temper. I escalated to drastic solutions far too quickly. I failed to "walk in the shoes of others." I rarely turned to potential mentors for advice. In my defense, I can only plead youth—and an almost crushing sense of personal accountability for the lives of the patients who had been entrusted to my care.

The example I'm about to share is misleading in at least one way: It presents in a linear manner a transformation that in reality was a meandering process, consisting in fits (literally) and starts. The story suggests an upfront clarity that I didn't have, and efficiency in implementation that I couldn't even imagine.

When I took over leadership of the hospital in 1991, the concept of performance management had not yet emerged into widespread use, as far as I know. Certainly I didn't know anything about it. But perhaps because of my background as a social scientist, I did have a ferocious conviction that in order to make wise decisions we need to have robust, timely, and accurate information. That became

the foundation of my efforts to lead the hospital's turnaround. And in the course of that work I learned about each of the pillars and elements of performance management that I will describe in detail in Chapter 3.

Here's my story.

At about 8:00 a.m. on November 1, 1991, I walked into the front hall of the acute-care state psychiatric hospital for which I had just been appointed superintendent (chief executive officer). Rather than head directly to my office, inspired by the then-voguish philosophy of "management by walking around," I detoured onto one of the five locked wards. Each held twenty patients who had been deemed a "danger to self or others" by a psychiatrist at a community hospital in the area.

Nobody challenged or even approached me as I entered. That was somewhat surprising, given that I was unknown to the hospital staff and that I was entering a ward full of patients officially labeled dangerous. As I stood near the door scanning the ward, my gaze was almost immediately captured by the sight of an elderly man sitting on the floor about twenty feet from me in what seemed to be a puddle of urine. He was rocking back and forth, occasionally hitting his head against the wall. And for five minutes, by my watch, nobody did anything.

Finally I approached the nursing station and asked the nurse behind the desk for the person in charge. She looked at me quizzically.

"What do you mean?" she said.

I was speechless for a moment, thinking that the question was pretty basic and absolutely essential to managing a ward for dangerous patients. So I pressed my question until she decided that the right person for me to talk to was most likely the "charge nurse." At no point did she ask me who I was or what my issue might be.

Eventually I was able to speak to the "charge nurse," and I asked her why the patient on the floor was not receiving any help. Her first response was to ask me who I was. (Finally!) When I told her I was the new director of the hospital, she took my question seriously. The

nurses couldn't help the man, she explained, because the psychiatrist of record had not yet examined the patient, who had been brought to the unit within the past hour, and thus had not yet written any treatment orders.[2]

When I summoned the psychiatrist and asked why this was the case, he pointed to the fact that the social worker had not yet completed her admission paperwork, so he could not examine the patient. The social worker defended her performance by saying she had been having a series of unproductive telephone conversations with the referring hospital because the transfer information was incomplete.

I was already very disturbed by (even angry at) the lack of personal and professional responsibility. Yet a series of questions revealed an even more appalling fact. On the level of the ward, nobody was actually in charge! The psychiatrist reported to the chief of psychiatry, the social worker reported to the director of social work, the nurse reported to the director of nursing, and so on. All those chiefs of the various professional disciplines worked in offices away from this (or any) ward, and had no means to monitor whether or how the work was getting done on the ward, except in retrospect when they checked in.

This single experience—it can be thought of as a "sentinel event"—was enough to convince me that the hospital had a dysfunctional system and a culture in which performance expectations were set abysmally low.

An hour later I led my first executive-team meeting. It included all the aforementioned chiefs plus the director of rehabilitation services, the human resources director, and the director of finance and administration. After a brief get-acquainted chat, I told them what I had just experienced. Then I said, "We've absolutely got to have unit chiefs so that people can be held accountable at the point of service—the ward—for what they do and how they work."

2. This in itself failed to conform to a well-established practice in acute-care hospitals—namely, keeping two staff members within arm's reach of newly admitted patients until they have been assessed for their risk of dangerousness. It does not require a physician's orders if written into the hospital's "Policies and Procedures" manual.

The response around the table was not encouraging. In effect, the entire executive team agreed that (a) the hospital was unionized, (b) union contracts governed all operations, (c) there were no ward chief or unit chief jobs recognized by any of the contracts, and therefore (d) it was not possible to institute such positions to manage work at the ward level.

I looked around the table in disbelief and decided that this moment would either make or break my tenure as superintendent.

"So . . . we have turned over management of the hospital to the unions," I said.

I paused. Nobody said anything. So I continued.

"Here's what is going to happen. We are ending this meeting now. Tomorrow we will meet again at this time. There will be only one agenda item, namely how to implement a system of ward chiefs. Any one of you who doesn't have something to contribute to that conversation should not attend. And anybody who doesn't attend will not have a job, effective immediately."

Some people call what I did "creating a burning platform"—in this case for the executive managers.

Not me behaving well. Not a pleasant experience. But it worked.

The next day's meeting revealed that the hospital's management team could indeed manage the hospital. Further, the team could make decisions that were not anticipated by the union contracts—and even decisions that contravened specific contract provisions. Union members would have to comply with these decisions, but of course they could (and would be expected to) file grievances immediately. The grievance process, however, was far from efficient; as a rule, it played out over many months.

The team decided that although it would be incredibly challenging to deal with the multiple grievance processes they anticipated, it was worthwhile to work with me on a plan to appoint the five clinically strongest staff members who showed some interest in management to the new unit chief positions. The idea was to implement a simple management matrix: each unit chief, regardless of discipline,

would be held accountable for managing the work flow of his or her ward, and hence could assign and monitor the completion of tasks by all staff. The chiefs of the professional disciplines (psychiatry, social work, and so on) would be held responsible for monitoring work quality and holding the staff in their respective disciplines accountable for meeting professional practice standards.

A good start, but not enough of a lever to motivate serious organizational change. So I proceeded, shortly thereafter, to create a burning platform for the staff, whose complacent approach to the quality and pace of their work was striking.

Until that time, whenever a community hospital emergency service wanted to transfer a patient to our hospital, they called the "Admissions Office"—which I enclose in quotes because really that office functioned as a Barrier-to-Admissions Office. Its standard line was "Our beds are full; call back in a couple of days."

The beds *were* always full, in fact. No one seemed concerned about that, though surely it is not beside the point to note that it takes less effort to hold on to old patients one knows than to admit new patients one doesn't yet know. But the critical issue, as I saw it, was that patients who were desperately in need of care were being kept in restraints or in close to comatose conditions in community hospital emergency departments for two to three days at a time because our hospital was a bottleneck. Here was such abysmal care that I simply could not tolerate business as usual.

So I called a meeting of the "admissions" nurses and told them that, for the foreseeable future, I was taking over their role and could be called upon day or night to approve admissions for any referrals to our hospital. "And by the way," I told them, "I plan to say the same thing every time: 'Please bring the patient over here immediately!'"

This led to a lot of head-shaking. "You can't do that," they said. "We're always full. We rarely have room to admit patients."

To which I responded, "Well, let's remember our mission. We are an acute-care hospital. If we don't have room to admit patients who need acute care, then we'll assemble beds from pieces in the

basement and put them in the hallways, and if necessary in the doctors' and social workers' and psychologists' offices. But we will take patients immediately upon referral!"

Of course such a stance will be tested, and for a few days that is exactly what happened. I admitted referrals immediately, even though our beds and rooms were full. Staff members—and, for that matter, managers too—became uneasy, then concerned, and finally panicked. They said we were creating a dangerous situation in the hospital, and if an inspector were to appear, we might be decertified and closed down.[3]

"Yes," I agreed. "We probably would. And should. How about we work together to run the hospital differently, so that we always have room?"

This was asking a lot of them, so to sweeten the deal I asked them to meet with their union representatives and come up with the most difficult, most problematic aspect of working in the hospital, and I would make a commitment to alleviating that problem. It didn't take long for them to identify as their biggest work issue the fact that there was a very high rate of violence among the patients. A large number of nursing staff were being injured, some seriously, and having to stay home to recover.

So I made the following offer: I would guarantee that we would drive down the rate of violence by 75 percent over the coming twelve months if they would do two things: (a) drop their grievances regarding the installation of unit chiefs, and (b) change the loose way in which we were using the American Psychiatric Association's scale for rating psychiatric dysfunction—the Global Assessment of Functioning (GAF) scale—and implement it rigorously, assessing every patient every day. Finally, I made an absolute commitment to resign

3. The hospital had received very poor ratings from both the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Health Care Financing Administration (HCFA), which approves federal revenues to reimburse the states for the costs of hospitalizing disabled patients. Closure of the hospital was an active item on the state government agenda before I arrived—a fact that the hospital leaders, managers, and staff had avoided acknowledging.

my position after twelve months if they went along with these requests and the rate of violence did not drop by the full 75 percent.[4]

This combination of "setting operational fires" plus a commitment to deliver a change that the staff wanted bought us twelve months of staff buy-in to the approach to performance management I was introducing piecemeal. During this period I was fortunate to be able to hire Roger Coleman, MD, MPH, as the new medical director. Dr. Coleman brought a very strong background in performance measurement and analysis. I also discovered that the director of nursing, Helene Vartelas, APRN, had long been dismayed by how low the performance bar had been set and had been yearning for the hospital CEO to support her ideas about how to improve patient care. Coleman and Vartelas effectively became co-chief operating officers of the hospital—a relentless "dynamic duo" if ever there was one. We soon became a very strong and determined leadership team, and things began to change.

1. We started the process of having every patient rated according to the GAF daily, and we made sure patients got to a rating of 65 before we discharged them. **This single measurement was the key metric for driving subsequent hospital improvements.** The GAF provided a simple measurement, easy to understand and easy to use, of what we adopted as our mission-determined intermediate outcome (a rating of 65 upon discharge for every patient). It also became the tool for monitoring our patients' progress daily. And under Dr. Coleman we began convening "crisis meetings" for all patients who did not move up in their GAF scores for three straight days. In these meetings we changed the practice of asking "What's wrong with the patient?" to "What aren't we doing that we should be doing, or what do we need to do better, for this patient?"
2. These crisis meetings identified key treatment gaps. In fact, we were providing about five hours of active treatment per

4. It would seem that I thereby created a burning platform for myself. But I already had such a burning platform as a condition of my appointment: I had been charged to eliminate the deficit and bring the hospital into the black.

week to each patient, a level way below national standards. We adopted the government's standard of twenty-five hours of active treatment per patient each week,[5] discovered that there were key competencies that many clinical staff members lacked (such as the ability to conduct psycho-educational groups on the wards, as opposed to one-on-one individual treatment sessions conducted in the professionals' offices). The director of medicine and the director of nursing set about training staff to work in these and other new ways. For example, when we discovered that we had a large subgroup of often violent or otherwise disruptive patients who were not psychotic but functioned as if they were (with diagnoses such as borderline personality disorder), we reviewed the literature and found a rigorously tested approach to working with such patients, called Dialectical Behavior Therapy.[6] Even though the hospital's budget was always in danger of slipping into the red, we made an up-front investment in capacity building and sent a dozen staff to be trained by the person who had developed DBT, Marsha M. Linehan, PhD, a psychology researcher at the University of Washington. Further, we tapped into the interests of a staff psychologist who was delighted to take over the delivery of DBT in the hospital (without expecting extra pay), and we arranged for the newly appointed DBT director and staff to receive ongoing case consultation and clinical supervision through Dr. Linehan.

3. By redesigning the hospital's clinical work to include more group-based, reality-focused treatment that emphasized evidence-based methods to manage symptoms and dysfunctional behavior, we were able to reach our target of providing twenty-five hours of active treatment to each patient every week—and the treatment we provided was better designed to help patients cope. Not surprisingly, patients began to get better more quickly, and the average length of stay at the hospital dropped from over 45 days to about 17.5 days per

5. The HCFA has this standard.
6. This form of treatment combines cognitive-behavioral techniques with methods for stress reduction and stress management.

stay. Further, contrary to the predictions by those staff who resisted the changes we were making, the average time that discharged patients spent in the community before returning did not drop; rather, it increased by some 50 percent—and that became the long-term outcome for which we held the hospital accountable. This was a **highly relevant long-term outcome for our target population**—chronically ill individuals with serious psychiatric disorders that periodically flared up in acute episodes, during which they became dangerous to themselves or other people.

4. Using the newly instituted daily patient GAF scores, we found that fully 20 percent of our patients were well enough that they did not need to be locked up twenty-four hours a day in order for us to manage their risk. Under the leadership of the director of social work and with the full support of the medical director and the director of nursing, we unlocked one ward and replaced it with a day hospital program (with associated residential beds). This program focused on community reentry through skill-building groups that prepared patients for leaving (which the social work staff loved). For example, eligible patients took trial trips out of the hospital into normal community environments (such as the mall or relatives' homes), including overnight community stays when appropriate. This led to a new system of managing patient flow in the hospital, with both patients and staff seeing a patient's transition to the new program as important evidence of his or her progress. Not only did this help reduce the time patients spent in the hospital (driving outcome achievement), it also saved a considerable amount of money, because the new program required fewer licensed clinical staff members to conform to regulatory standards (driving budget requirements).
5. Finally, under the leadership of Dr. Coleman and with full engagement on the part of the director of nursing, Helene Vartelas, and Margaret Higgins, RN, the quality assurance director, we initiated a **pilot project to drive down the level**

of violence among patients. We involved union representatives in the selection of staff to participate in planning the project and thereby secured buy-in from the start. The project entailed the following steps:[7]

a. **Data collection.** We tracked all incidents of violence over a three-month period.

b. **Data analysis.** We identified the contexts and conditions in which episodes of violence took place, and we searched for patterns.

c. **Accountability.** Through our data analysis we came to see that we needed to put in place a system of accountability for making decisions to increase patient freedoms (such as going to the bathroom unaccompanied). We agreed that on every shift one nurse would be the designated person to make such decisions on each ward, and that the treating psychiatrist would then review those decisions.

d. **Research.** We asked union members to immerse themselves in the literature about predicting violence among psychiatric patients and develop a list of the indicators that had been used in evidence-based studies of patient violence.

e. **Measurement.** The research team led discussions with other participants to distill the list of indicators down to a manageable dozen, and designed a rating tool using these indicators. We then began a series of training sessions in which nurses and psychiatrists used the tool to rate patients being considered for advancement to greater freedoms. Over time we worked to achieve "inter-rater reliability"—that is, ratings that were highly consistent from one staff member to the next.

f. **Organizational learning and performance management.** We required, after a pre-established date, the use of the rating tool before a patient could be advanced to a higher level of freedom. But we did not make the staff use the rating tool mechanically, because we did not want it to be used to override or subvert their clinical judgment. Of course we wanted to avoid making overly permissive decisions that granted freedoms too quickly. Just as important, though, was to avoid making overly conservative decisions that held back patient progress. We used the data we collected to learn from our experiences, and

7. The pilot project is described in Coleman and Hunter 1995; Coleman, Hunter, Vartelas, and Higgins 1996.

> rather quickly our staff got quite adept not only at using the tool but also—and more crucially—at making solid clinical decisions. Within a year of the introduction of the pilot project, our measurements showed a decrease in violence by about 80 percent—well above the 75 percent I had promised the staff. This was an all-around win: for patients, who avoided the trauma of becoming violent; for staff, who were getting hurt much less frequently; and for me, because by delivering on my promise I could keep my job.

In summary, over a five-year period we turned around a rather dysfunctional hospital that had been threatened with loss of accreditation by the JCAHO[8] and with decertification by the HCFA,[9] and developed it into a high-performing hospital where patients got well quicker, violence was reduced, and treatment met national standards. In 1996 the hospital was accredited "with commendation" by the JCAHO, which put it into the top 5 percent of all hospitals in the United States. The hospital culture had come to fully embrace high performance expectations.

I have shared this extended example in the hope that both its details and the conceptual framework that I subsequently developed out of these experiences will inspire and guide leaders to drive, and staff to embrace, needed organizational changes more intentionally, directly, and efficiently than we did. Table 1 summarizes the major elements of this case.

8. The Joint Commission on Accreditation of Health Care Organizations is a nonprofit agency to which the government cedes much of its regulatory assessment of healthcare organizations' performance.
9. The Health Care Financing Administration approves the reimbursement to states for the costs of treating people with disabilities.

Table 1. The Tangible Impact of Performance Management at the Psychiatric Hospital

ORGANIZATIONAL ELEMENTS	BEFORE NOVEMBER 1, 1991	AFTER OCTOBER 31, 1996
Operational metrics		
a. Average (mean) emergency room waiting time	2–3 days	1–2 hours
b. Average patient length of stay	45+ days	17.5 days
c. Level of patient violence	High (400 hours per month of patients in seclusion and/or restraint, which was our proxy for level of violence)	80% lower (80 hours per month of patients in seclusion and/or restraint)
d. Dosage of active treatment	Low: 5 hours per patient per week	400% increase: 25 hours of active treatment per patient per week
Patient outcomes at discharge (intermediate outcome)	Unclear or idiosyncratic to the treating psychiatrist	Patients achieve a rating of 65 or better on the American Psychiatric Association's Global Assessment of Functioning (GAF) scale
Hospital design	Five locked wards for all patients for the duration of their stays featuring patient security management	Four locked wards plus a new open ward/day hospital featuring treatment focused on community reentry—with planned patient flow moving from the locked wards through the open ward/day hospital
Staff competencies	All psychiatric treatment staff (psychiatrists, nurses, social workers, psychologists) have general mental-health training appropriate to their specialties	20% of psychiatric treatment staff (psychiatrists, nurses, social workers, psychologists) are trained in Dialectical Behavior Therapy (DBT) designed to treat a particularly challenging subgroup of patients
Certification by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	At risk	Certification "with commendation," a rating that places the hospital in the top 5% of all U.S. hospitals
Accreditation by the Health Care Financing Administration (HCFA)	At risk	All risk elements fully addressed