LEUVEN CASE (B)

Managing Clinics, Care Processes and the Physics of Patient Flow

September 20, 2013

University Hospital Leuven, Belgium

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Questions for Leuven Case

• What are the problems?
• What are the root causes?
• What percent of the time is there a bottleneck?
• What tradeoffs exist?

Per capita expenditure on healthcare (€)

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University Medical Center Leuven, Belgium

- Annual budget: 450 million €
- 1,800 beds
- 7,000 employees
  - 550 FTE
  - 1,000 physicians
    - 500 consultants
    - 500 residents
- Activities / year
  - 63,000 admissions
  - 540,000 in-hospital days
  - 450,000 outpatients
  - 50,000 emergencies

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Financial results (1000 €)

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Flemish Hospital Network

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEUVEN UZ Leuven</td>
<td>1,880</td>
</tr>
<tr>
<td>BONHEIDEN Imelda</td>
<td>453</td>
</tr>
<tr>
<td>BRUGGE AZ St-Lucas</td>
<td>415</td>
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<tr>
<td>DENDERMONDE AZ St-Blasius</td>
<td>382</td>
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<td>GENK ZOL</td>
<td>822</td>
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<tr>
<td>HASSELT CAZ Midden Limburg</td>
<td>434</td>
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<tr>
<td>HASSELT Virga Jesse</td>
<td>567</td>
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<td>TURNHOUT St-Elisabeth</td>
<td>369</td>
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<tr>
<td>TURNHOUT AZ St-Jozef</td>
<td>296</td>
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<tr>
<td>AALST AZ OLV</td>
<td>800</td>
</tr>
<tr>
<td>KORTRIJK AZ Geninige</td>
<td>1,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,872</strong></td>
</tr>
</tbody>
</table>

Sample of Services

<table>
<thead>
<tr>
<th>Procedure</th>
<th>1997</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumcision</td>
<td>131</td>
<td>180</td>
</tr>
<tr>
<td>Tooth extraction (general ane)</td>
<td>44</td>
<td>558</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surg</td>
<td>465</td>
<td>560</td>
</tr>
<tr>
<td>Laparoscopic cholecystectomy</td>
<td>258</td>
<td>342</td>
</tr>
<tr>
<td>Inguinal Hernia</td>
<td>280</td>
<td>348</td>
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<tr>
<td>Appendectomy</td>
<td>202</td>
<td>235</td>
</tr>
<tr>
<td>Transtympanal draining using prothesis</td>
<td>246</td>
<td></td>
</tr>
<tr>
<td>Discus hernia</td>
<td>181</td>
<td>217</td>
</tr>
<tr>
<td>Adenoidectomy</td>
<td>281</td>
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Transplants

<table>
<thead>
<tr>
<th>Organ</th>
<th>1997</th>
</tr>
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<tbody>
<tr>
<td>Liver</td>
<td>25</td>
</tr>
<tr>
<td>Heart</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
</tr>
<tr>
<td>Kidney</td>
<td>125</td>
</tr>
<tr>
<td>Pancreas</td>
<td></td>
</tr>
<tr>
<td>Donor prelevation</td>
<td>65</td>
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</tbody>
</table>

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Chronology

- **1998 - 1999**
  - Operational: Change project (McKinsey)
  - Organisational: Change project

- **2000**
  - Implementation phase

- **2001 and on**
  - Annual Department plan
  - Annual Department plan
  - Strategic Implementation

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### Scope of Change

<table>
<thead>
<tr>
<th>Scope</th>
<th>Low</th>
<th>Transformational Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgency</td>
<td>Incremental change aimed at financial crisis</td>
<td>Create a Care Programs</td>
</tr>
<tr>
<td></td>
<td>Transformative Change</td>
<td>Set Corporate and Competitive Strategy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Low</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### STRATEGIC CHANGES - type

- **New Corporate Strategy: Networking/Alliances**
  - local level: general practitioners: e-health-LISA
  - national level (Flanders): network protocol with 10 hospitals
  - regional level: common government of regional hospitals
  - international level (NAMCE)
    - scientific exchange
    - university network
    - Leuven-Insead

- **New Competitive Strategy: Choice in Care Programs**
  - Decrease length of stay
  - Shift to outpatient activities

- **Developing A New Medical Strategy**
  - Selection of pathology: increase in “academic” pathology
  - Shift A – B – C-pathology
  - Networking with Community Hospitals
INTEGRATE OPERATING STRATEGY WITH SERVICE DELIVERY

- Develop a lean, non-bureaucratic organization
- Improve operating efficiency
- Decrease length of stay
- Shift to outpatient activities
- Selection of pathology severity: increase “academic” pathology
  - Shift A ➔ B ➔ C-pathology
  - Networking
- Choices in Care programs
  - Based on patient needs, clinical expertise, academic profile, interaction between care programs, and financing...

EXAMPLES OF OPERATIONAL CHANGES
(1351 ideas for all medical and non-medical departments)

1) Efficiency improvement
   - Example: Operation Room planning program
     - Theory of constraints (Goldrath)

2) Optimisation or integration of existing services (system quality)
   - Example: Stroke unit
     - Efficiency increased
     - Quality of care increased
     - Major hurdle: physician professional sensitivities / ownership

3) Starting new forms of services
   - Example: wound care team

4) Cost reduction
   - Example: purchasing
     - Sterile and non-sterile bandages: purchased separately
       (pharmacy vs. purchasing department)

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Flemish Hospital Network

<table>
<thead>
<tr>
<th>Location</th>
<th>Hospital Name</th>
<th>Number of beds</th>
</tr>
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<tbody>
<tr>
<td>LEUVEN</td>
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<td>1,800</td>
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<tr>
<td>Total</td>
<td></td>
<td>7,872</td>
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</tbody>
</table>

Ranking Faculty of medicine
K.U.Leuven

<table>
<thead>
<tr>
<th>University</th>
<th>Narrow P</th>
<th>P (articles)</th>
<th>CPP (cit. per pub)</th>
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</thead>
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<tr>
<td>Univ. Oxford</td>
<td>8018</td>
<td>7.37</td>
<td></td>
</tr>
<tr>
<td>Univ. Cambridge</td>
<td>6249</td>
<td>7.23</td>
<td></td>
</tr>
<tr>
<td>Univ. Geneva</td>
<td>3399</td>
<td>7.15</td>
<td></td>
</tr>
<tr>
<td>Univ. Leiden</td>
<td>5101</td>
<td>6.03</td>
<td></td>
</tr>
<tr>
<td>Univ. London</td>
<td>35517</td>
<td>5.82</td>
<td></td>
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<tr>
<td>Univ. Leuven</td>
<td>3853</td>
<td>5.80</td>
<td></td>
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<tr>
<td>Univ. Strasbourg</td>
<td>1658</td>
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<td></td>
</tr>
<tr>
<td>Univ. Edinburgh</td>
<td>5354</td>
<td>5.57</td>
<td></td>
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<tr>
<td>Univ. Heidelberg</td>
<td>4991</td>
<td>5.54</td>
<td></td>
</tr>
<tr>
<td>Univ. Zurich</td>
<td>5160</td>
<td>5.48</td>
<td></td>
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<tr>
<td>Karolinska</td>
<td>7795</td>
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<td></td>
</tr>
<tr>
<td>Univ. Paris</td>
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<td>5.38</td>
<td></td>
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<tr>
<td>Univ. Helsinki</td>
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<td>Univ. Copenhagen</td>
<td>5691</td>
<td>4.84</td>
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<tr>
<td>FU Berlin</td>
<td>3861</td>
<td>4.76</td>
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</table>
League of European Research-Intensive Universities

NAMCE (network of academic medical centers Europe)

• Collaboration with INSEAD
• getting new ideas on hospital management
• discussing, validating new evolutions
• scientific work on hospital management
• exchange of experiences with other European centers
What were the elements of organizational change?

- Strategic Re-direction
- New Board of Directors
- Delayering
- Care Programs
- New management Practices
  - Yearly department plans
  - New incentive scheme for MD’s
  - Steering committee for Medical Decision Making
  - Activity Based Budgets
  - Limited Appointment of Medical Chairs: 5-year with evaluation
  - Computer Aided Operating Room Scheduling

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**CULTURE CHANGE**

- **Basic idea**: create a customer-oriented rather than a provider-oriented organisation
  - 1) creation of medical-surgical divisions
  - 2) creation of mixed management teams
    - purpose: link the hospital domains in a structural way
    - Method
      - MD: clinical director
      - nurse: nursing manager
      - economic/administrative: administrative manager
    - **Implication**: Separation of professional and organisational responsibility

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HOW? CLUSTER MEDICAL-SURGICAL DIVISIONS

1. Mental health care
2. Mother and child
3. General surgery
4. Rehabilitation
5. Thorax
6. General internal medicine
7. Abdomen
8. Oncology
9. Critical care
10. Head / neck / neuro
11. Medical diagnostical services

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Organization chart UMC Leuven

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Care Program Concept

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Strategy?

• Medical specialities (e.g., emergency services, oncology, transplantation, hypertension, etc.) and clinical activities (admission, investigation, therapy, recovery, etc) are the sources of your advantage.

• Most hospitals can perform similar activities better than their rivals—
  – this is called the operating strategy

• Few hospitals offer different services and few perform different activities from rivals, or perform them in unique ways—
  – this is called strategic positioning
Clinical Activities

How can these be done differently? Can these become positioned as better services?

A care program consists of the coordinated delivery of all services provided to a group of patients with similar pathology and similar care pattern.
An activity center is a provider of clinical* or non-clinical** services to a care program. They constitute the operational units in which the means of the departments are concentrated.

* Medical, paramedical or nursing services
** Administrative or technical services
Concept of ‘Care Programs’

- Which care programs make us distinctive? Innovative, Effective, and Efficient
- Which care programs are most profitable?
- In which care programs are our patients extremely satisfied?
- In which care programs are our physicians, nurses, and other care providers extremely satisfied?
- Which activities in the care program add customer value?
- Which physicians are on the best practice frontier?

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REFLECTIONS ABOUT CARE PROGRAMS

For care program x, how can we:
- Increase financial attractiveness? (i.e. decrease length-of-stay; decrease RX / lab utilisation)
- Increase the profile?
- Attract more patients?

Source: McKinsey
CARE PROGRAM - Profile Score

Score regional origin

- score in function of the distance to the hospital
  - 0.1 f(staff member assigned to care program)
  - 0.1 f(written protocols)
  - 0.1 f(registration-database)
  - 0.1 f(yearbook)
  - 0.2 f(published outcome-indicator)
  - 0.2 f(multidisciplinary discussions)
  - 0.1 f(written patient information)
  - 0.1 f(staff member specifically authorised for quality control)

Score Patient care

Total score 100

Score relevance

+ 0.33 f(incidence pathology)
  0.33 f(exclusive technology and infrastructure)
  0.33 f(exclusive personal expertise)

Score research

0.66 f(peer review publications 1995-1997)
0.33 f(oral presentations 1995-1997)

Exhibit 21
Position of Clusters of Care Programs UMCL

- Transplantation
- Congenital
- Tumour
- Functional Digestive
- Degenerative / Functional Neural-Head-Neck
- Degenerative / Functional Cardiovascular
- Degenerative Skin-muscle & skeleton
- Psychiatry
- Obstetric
- Degenerative
- Infectious - Inflammatory - Immunology
- Missing
- Ambulatory
- Miscellaneous
- Profitable
- Non profitable
All care programs

Divisional Structure

Division Management

- Physician (Clinical director, head of the Division)
- Nursing manager
- Administrative manager

Departments:
- Gastroenterology
- Abdom. surgery
- Urology
- Hospitalisation
- Consultation

"Departments" Department-specific - AC
RESULTS

EVOLUTION DEGREE OF SUBSTITUTION DAY CARE

<table>
<thead>
<tr>
<th>Year</th>
<th>Substitution Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>31.7%</td>
</tr>
<tr>
<td>1997</td>
<td>36.0%</td>
</tr>
<tr>
<td>1998</td>
<td>47.5%</td>
</tr>
<tr>
<td>1999</td>
<td>52.9%</td>
</tr>
</tbody>
</table>

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STRATEGIC CHANGES – RESULTS: USED BEDS

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EVOLUTION LENGTH OF STAY 1997-2000: -15-20 %

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EVLATION OF PATHOLOGY SEVERITY
(A, B, C-pathology)

Discharges

Beds used

1997 1999

1997 1999

ILLUSTRATION: N transplant patients

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Financial results (1000 €)

Partial Organization Chart – Leuven Medical Center
Unintended Consequences

- Selective Investment and Growth of Care Programs—based on patient needs, core expertise, academic profile, interaction between care programs, and payment and financing
  - Capacity Problems: surgical cancellations
  - Political Problems: inside and outside
  - Increased Conflicts among physicians and caregivers
- Was this strategic shift financially sustainable in the Belgian Healthcare system?

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Surgical Patient Flow

<table>
<thead>
<tr>
<th>Flow of Elective Patients</th>
<th>Flow of ER Patients</th>
<th>Flow of Transplant Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td>OR</td>
<td>SICU</td>
</tr>
<tr>
<td>14.3%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>20%</td>
<td></td>
<td>General Beds</td>
</tr>
<tr>
<td>7%</td>
<td></td>
<td>Average daily discharge</td>
</tr>
</tbody>
</table>

Capacity
- 307 hrs/day
- 56 beds
- 1782 beds

Utilization
- 238 hrs
- 55 beds
- 1427 beds

Variability
- +/- 103 surgical hrs.
- +/- 4.1 days
- +/- 189 patient days
Cardiac Surgery activities as influenced by ICU capacity (2001)

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
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<tr>
<td>N beds</td>
<td>18.25</td>
<td>20.5</td>
<td>22.5</td>
</tr>
<tr>
<td>N cardiac surgeries postponed</td>
<td>29</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>N patients refused</td>
<td>69</td>
<td>59</td>
<td>27</td>
</tr>
</tbody>
</table>

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Conclusion: More Beds

In 2002, Bart, the Chair of the SICU requested 20 new SICU beds at a cost of €3 million. Though an analysis revealed a 40% chance of a bottleneck on any given day, the clinical leaders were reluctant to add capacity because of an anomaly in the information.

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More Beds?

When the Chair of Internal Medicine proposed the MICU (medical intensive care unit) as a buffer, the chair of the SICU had quipped, “You are messing up my strategy to obtain more beds. I do not need your MICU beds, let me handle this!”

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Questions for Leuven Case

• What are the underlying problems?
  – What are the root causes?
• Describe the best ways to schedule the OR?
• Explain these Tables:
  7-9; 11; 18; 19; & 20

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Solutions??

SHIFT OF PATHOLOGY SEVERITY
(A, B, C-pathology)

nursing days

A-care
B-care
C-care

* opsplitsing l-nl op basis van geëxtrapoleerd MVG-profiel 1997
Differential growth in cost and revenue with a shift from A to C pathology: Medical Imaging

N nursing days in ICU by transplant patients
Unintended consequence 1: Cost increase C-care requires more beds, especially ICU beds

**Length of stay (days)**

<table>
<thead>
<tr>
<th>1997, UZL</th>
<th>A-care</th>
<th>C-care</th>
<th>C vs A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care bed</td>
<td>0,1</td>
<td>7,9</td>
<td>79</td>
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<tr>
<td>Non-ITE bed</td>
<td>6,1</td>
<td>20,8</td>
<td>3,41</td>
</tr>
<tr>
<td>Total</td>
<td>6,2</td>
<td>28,7</td>
<td>4,63</td>
</tr>
</tbody>
</table>

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**Protracted Critical Illness (PCI) Patients in SICU (LOS > 21 days)**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. PCI patients (%)</th>
<th>Capacity utilization (%)</th>
<th>Mortality (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>7.0</td>
<td>34</td>
<td>20</td>
</tr>
<tr>
<td>1996</td>
<td>7.7</td>
<td>40</td>
<td>26</td>
</tr>
<tr>
<td>1997</td>
<td>9.0</td>
<td>46</td>
<td>16</td>
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<tr>
<td>1998</td>
<td>9.9</td>
<td>47</td>
<td>19</td>
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<td>10.5</td>
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<td>47</td>
<td>18</td>
</tr>
</tbody>
</table>

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Hospital SICU Data on Patient Mix

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>N patients admitted</td>
<td>2,296</td>
<td>2,221</td>
<td>2,196</td>
</tr>
<tr>
<td>N patients discharged</td>
<td>2,080</td>
<td>2,131</td>
<td>2,112</td>
</tr>
<tr>
<td>N nursing days</td>
<td>17,370</td>
<td>18,673</td>
<td>18,298</td>
</tr>
<tr>
<td>Bed occupancy rate (%)</td>
<td>91.1 %</td>
<td>98 %</td>
<td>95.6 %</td>
</tr>
<tr>
<td>Average length of stay (days)</td>
<td>8.2 d</td>
<td>8.6 d</td>
<td>8.5 d</td>
</tr>
<tr>
<td>Average care intensity (MVG*)</td>
<td>12.9</td>
<td>13.4</td>
<td>13.9</td>
</tr>
</tbody>
</table>

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What Happened?

- The Chair of the ICU retired in Fall 2002.
- A new Chair who believes in evidence-based medicine, believed that the transplant policy could be changed without patient harm. So patients after a liver transplant no longer get an isolation unit.
- By changing one person, the cultural system—(an old versus new philosophy of care)— and the political system (a new less powerful, new Chair of SICU) changed.
  - Old Chair maximized patient safety, at the expense of other patients waiting to get into SICU.
  - New Chair says if a patient dies in the ER, waiting to get into the SICU, that’s a quality issue, too.
- The ICU capacity problem has been ‘solved’ in the short term.

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Technical system (or current strategic design)

- What is the mission, strategy, goals, and constraints?
- Why are they doing this? values? Incentives
- Who is involved: people, roles, & responsibilities
- How is it being done? Key processes (decision making, communication, etc)
  - How are activities structured (differentiated, integrated and coordinated)?

Does this design work? Is there alignment or fit between strategy and the parts?

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Congruence Model
## Strategic Design

<table>
<thead>
<tr>
<th>Design Variables</th>
<th>Characteristics</th>
</tr>
</thead>
</table>
| • Critical Tasks | • Intrinsic satisfaction from meaningful work  
|                  |   – Direct Feedback/Autonomy—responsibility for outcomes  
|                  | • Routine, predictable tasks  
| • Formal Structure | • Cohesive work groups  
|                  |   – Explicit plans, goals, procedures  
|                  |   – Decentralized decision making/Balance of power  
| • Culture & Informal | • Meritocracy/fair process  
| • People | • Appetite for hard work & motivated  
|          | • Strong ability & willingness  
|          | • Capacity for self-management  

## Political Perspectives

Who are the *stakeholders*? What are the relationships among them?

What are their *interests*? Can the interests be *aligned for a coalition*?

What are their *sources of power*?

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Cultural Perspective

What shared values, mindsets, beliefs and assumptions do people have regarding what the organization is all about? Are they consistent across people and areas?

What implications do these values and assumptions have? Are they good or bad for performance?

Where are the bottlenecks?

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Explain capacity problems work in the three systems

• Technical System

• Social & Cultural System

• Political System

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**Figure 4. Growth and Underinvestment: A View of the Technical System**

- Medical Strategy: Incentives to Attract Complex Cases
- Growth in transplants and complexity
- Quality: cancellations, transplants denied, SICU readmits
- Gain per Surgeon’s Activity
- Perceived need to invest
- OR Time, SICU Bed and Staff Capacity Constraint
- Investment in Capacity
- Policy Environment

*Chilingerian and Vandekerckhove 2002*

**Figure 5. Tragedy of the Commons: A View of the Cultural System**

- Surgeon A's Activity
- Net Gains for A
- Hospital Case Mix Complexity
- OR Time, SICU Bed and Staff Capacity Constraint
- Surgeon B’s Activity
- Net Gains for B
- Degree of Trust & Cooperation
- Beliefs of the Chair of SICU

*Chilingerian and Vandekerckhove 2002*
Figure 6. Shifting the Burden: A View of the Political System

Demand for SICU

Surgical Cancellations and Queues

Perceived unfairness

Deterioration of Service Quality and Physician Morale

Develop More Service Capacity

Delay

SICU Availability

Political Power & Influence

Takeaways: Leuven turnaround

- Dangers of arrogant leadership, an inability to challenge physician autonomy, bureaucratic silos, & a culture of finger pointing

- Need for a strategic service vision based on real strengths of care programs—
  - identify a unique and valuable position, choose what not to do, choose a unique combination of activities

- Once strategy has been developed, the strategy must be aligned with the operations and embodied into everything the organization does

Chilingerian and Vandekerckhove 2002

Chilingerian 2013
**Takeaways: Leuven turnaround**

- Think in terms of long-term relationships with physicians and team members—align interests
  - Avoid reliance on authority—build commitment to shared clinical goals
- Institute fair process to deeply engage physicians & teach them develop their own strategic service vision
  - How? Focus on diagnosing the strategic problems: separating facts from assumptions
- Invest in clinical agendas to build partnerships not to make deals
  - Value different perspectives, set high standards
  - Prevent them from making strategic mistakes
  - Be honest in letting them know how things are going

"May I be excused? My brain is full."
Thank you

The Heller School for Social Policy & Management
Care Program Activity System

Target Patient Segments → Selection of Services (Offered/Not Offered) → RN Hiring

Technology choices → Standardized OR Slots

Test Turnaround time

Multi-specialty wards & Operational planners

REDUCED LOS & UNNECESSARY ANCILLARY SERVICES

INCREASED ADMISSIONS

Reward MD Efficient Practices

MD Incentive Plan

MD Hiring/Attitudes

Transfer Prices

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