Frontline lessons in transforming a large university hospital

An interview with Daniel Moinard and Julien Samson

The CEO and deputy CEO of the Hospices Civils de Lyon, France's second-largest university-hospital network, share their experience leading the institution's transformation.

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In 2009, Hospices Civils de Lyon (HCL), a group of 14 public hospitals (the second-largest university-hospital network in France), launched a major transformation program called "Cap 2013." The program was ambitious, not only because of the network's size but also because it included about 140 different initiatives covering all key hospital functions. The program aimed to achieve three goals: to improve the quality and safety of patient care, reinforce the institution's excellence in research and innovation, and improve its financial performance.

Results were dramatic. Within three years, HCL went from an annual deficit of €86 million in 2008 (about 6 percent of revenues) to a profit of €10 million in 2011 (and a €25 million profit budgeted for 2012). Along the way, the transformation enabled the institution to—among other things—modernize its purchasing department, reorganize its operating theaters to limit downtime between interventions, and establish new strategic projects for major specialties, such as cardiology and geriatrics.

In this interview, Daniel Moinard, HCL's CEO, and Julien Samson, its deputy CEO, share their experience overseeing the transformation program: how it was launched, how it was led, and what challenges stood in the way. They also outline what they believe are the key success factors for a transformation of this magnitude. Hortense de la Boutetière and Thomas London, partners in McKinsey's Paris office, conducted the interview.

Health International: *What was the situation at HCL before the launch of Cap 2013?*

Julien Samson: Between 2006 and 2008, budget deficits had accelerated rapidly (Exhibit 1). Three main factors were involved, two of which had resulted from the rapid implementation of DRG-based payments[1] to replace global budgets in financing French public hospitals. First, given HCL's case mix, the resulting tariff structure led to a "mechanical" decrease in revenues. Second, their introduction revealed that our institution had lower productivity than other hospitals, leading to additional deficits. The third factor had to do with the massive investments HCL had initiated in the mid-2000s—nearly €1 billion, mostly financed through additional debt. Today, the servicing of this debt significantly burdens our operations. The combination of these three factors created a critical situation, which by 2008 had become unsustainable.

Daniel Moinard: What was at stake with the launch of the transformation program was no less than the future of the entire institution.

Health International: *How did you gain alignment of the hospitals' personnel on the diagnostic and on the need to launch such a transformation?*

Julien Samson: This was one of the first challenges HCL faced and a crucial factor to get right. A series of audits was launched to assess productivity, investments, and the overall financial situation. The audits were designed to compare our performance and enable progress, and their results were widely disseminated, which established transparency about the situation in a fact-based manner. This transparency was decisive, because these comparative, objective assessments got the main leaders—medical, nursing, and administrative—across the institution to realize how critical the situation had become and how markedly the institution had to change.

[1] Diagnosis-related groups (DRGs, called *groupes homogène des malades* in France) have been used in France for more than 20 years to monitor hospital activity. DRG-based funding of public hospitals was gradually introduced from 2005 onward, and significantly accelerated in 2008.

The timing was also favorable, as it coincided with the preparation of HCL's new five-year strategic plan in early 2009. All departments were sending in their proposals to build the plan, and this input was gathered and used to design the transformation program. The Cap 2013 program was eventually positioned as the implementation part of the strategic plan, with a similar five-year horizon. This convergence created significant momentum.

Health International: *How did you define the program's aspirations? How did you structure it?*

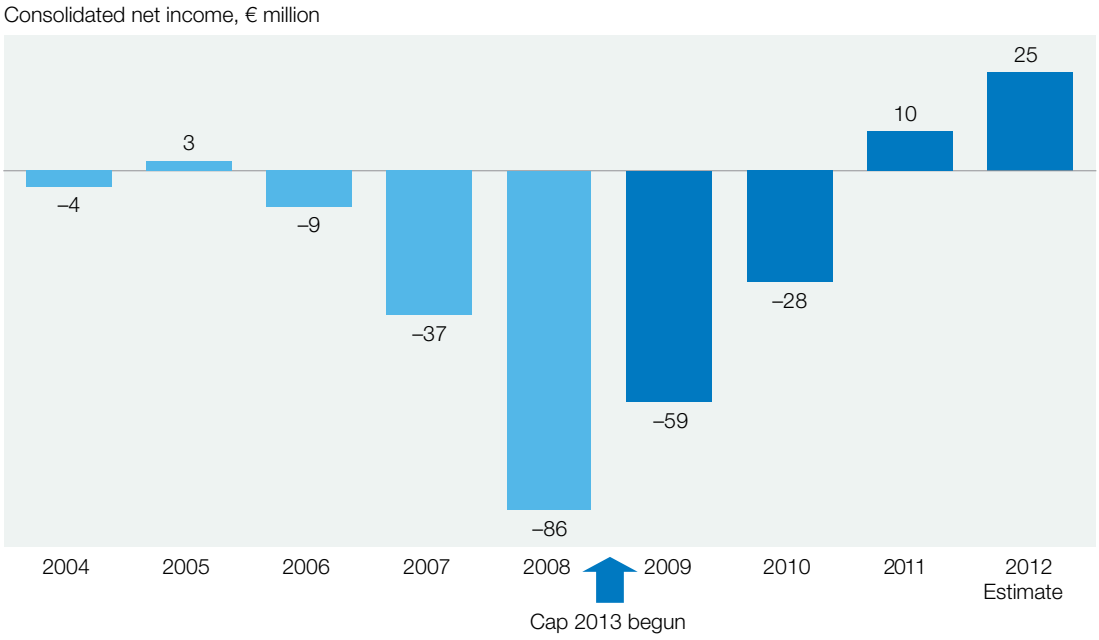
Daniel Moinard: The primary aspiration was relatively simple: wipe out deficits by 2013 in order to gain back means of action and prepare for the future. Once people had realized how dramatic the situation was and that the status quo was no longer possible, it was relatively natural for them to adhere to the change aspiration.

Julien Samson: Using input from the hospital's different departments, we developed the program's overall aspirations top down and in a short time frame, so that they were set in June 2009, three months after I arrived at HCL.

However, we did not design the overall program simply as a financial exercise to cut costs. Focusing only on financials is always an option, but it often falls short of getting people to truly embark on a transformation journey. Hence, the transformation plan also aimed at a second, strategic, objective: operational excellence in all of the hospital's key activities. It was about improving the way patients are treated, as well as the way medical and nonmedical personnel work together on a daily basis.

Exhibit 1

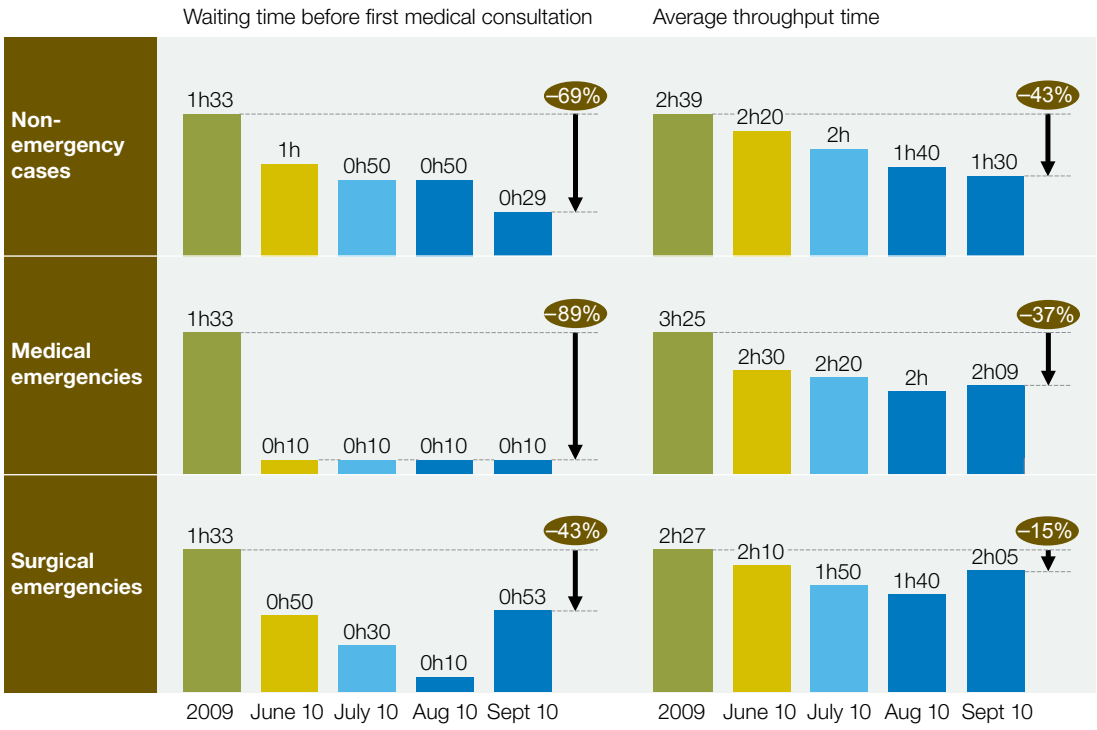
Operating deficits and surpluses at Hospices Civils de Lyon



Source: Hospices Civils de Lyon Web site; press clippings

Exhibit 2

Impact of Cap 2013 on HCL's pediatric emergency rooms



Source: Hospices Civils de Lyon

To succeed, the program had to do two things concurrently: it had to acknowledge the dedication and commitment of HCL's personnel and stress what was working well within the institution. But it also had to ensure that suboptimal processes were identified and fixed, that patient pathways were well organized, that bed-occupancy rates increased, that waiting times in the emergency room were reduced, etc. (Exhibit 2).

Practically, the program was structured along two major pillars. The first was a short-term, financially oriented restructuring plan. Among the issues addressed were purchasing efficiency (which achieved about a €50 million reduction in costs), nonstrategic real-estate divestments (€138 million in net asset divestment between 2009 and 2013), tight management of salary costs (about €45 million in expected impact), and increased clinical and nonclinical revenues. For instance, billing patients for private rooms brought in another €11 million rapidly. More accurate DRG coding enabled us to raise revenues by 5 percent, even though the number of hospital stays increased by only 1.3 percent.

We also aimed to optimize cash management and debt financing. For instance, we renegotiated some of our debt to reduce interest payments and changed the way we finance major equipment. We were able to reduce our capital expenditures by two-thirds.

Hospices Civils de Lyon: Key facts

Overall
- 14 hospitals
- 1.6 billion annual revenues

Patient care
- 5,500 beds and day spaces
- >120 operating rooms
- 22,000 health professionals

Research
- 6% of France's biomedical scientific publications (1,700 publications in 2010)
- 1,000 ongoing clinical trials

Education
- France's second-largest training institution for doctors and nurses

The restructuring led to the closure of five of our hospitals. It also enabled us to define new target staffing levels for each medical discipline, to merge some departments, and to outsource some services (e.g., nursery, transportation, cleaning, and maintenance). This led to significant reduction in workforce (about 1,000 people between 2009 and 2013), making us the only teaching hospital in France to reduce its overall personnel costs.

The second pillar was a transformation plan oriented more toward clinical operations. Its mix of short-term and middle- to long-term elements included operational-excellence projects for emergency rooms and operating theaters, as well as strategic and organizational projects for several specialties (cardiology, geriatrics, breast-cancer services, and digestive care, for example). It also included a complete restructuring of the biology labs and a reorganization across facilities to ensure consolidation of highly specialized services.

Tackling both of these pillars—financial and operational—simultaneously was undoubtedly crucial to our success. Both types of levers needed to be activated. People within the institution needed a concrete, positive aim to work toward so that they could become positively engaged. The program had to provide a clear meaning to people's daily activities and to light up the future.

Health International: *How did you manage communication on the program?*

Julien Samson: When embarking on such an endeavor, getting the communication right feels like a big challenge. We chose to be very transparent and straightforward in all communications. This also was a decisive element of managing change.

For the restructuring part of the plan, we regularly communicated our progress on all fronts. For the operational transformation,

"The goal of our communications approach was to unleash the energy, entrepreneurship, and willingness to move the institution forward that we knew existed throughout HCL."

Daniel Moinard

Education
Master's degree in public law from the Faculty of Law and Social Sciences, University of Poitiers

Graduate of the National School of Public Health

Career highlights
Hospices Civils de Lyon
Chief executive officer
(2011–present)

Scientific Council of National Agency for Performance Improvement Support
Chairperson
(2010–present)

National School of Public Health
Director
(1999–present)

University Hospital Centre of Montpellier
Acting CEO
(2010)

University Hospital Centre of Caen
Acting CEO
(2009)

University Hospital Centre of Nantes
Acting CEO
(2008)

Conference of the General Managers of University Hospital Centres in France
President
(2001–2004)

Other
Chevalier in the French Legion of Honor

the goal of our communications approach was to unleash the energy, entrepreneurship, and willingness to move the institution forward that we knew existed throughout HCL. We "let a thousand flowers bloom," accepting that there might be some failures; this approach helped us ensure that we were not depending on too few initiatives, which would have increased the risk of the overall program's failure. There was a strong logic for diversification, for testing new approaches. We wanted to put HCL back on a growth path—to get people into the mind-set of developing and building the institution instead of just managing or preserving what they had inherited.

Daniel Moinard: Today, the program is well under way, and we make sure that successes are sufficiently celebrated and rewarded. We regularly communicate the fact that we are well advanced in terms of our financial target and that this is allowing us to continue investing to improve the quality of patient care.

Health International: *What have been major obstacles in leading the program?*

Julien Samson: First of all, we realized that it is often quite difficult to replicate what was done in one part of the institution across other parts. Putting new standards and processes down on paper is not the primary enabler of operational-improvement programs in hospitals. Rather, what are more important are the mind-sets, behaviors, and motivation of the frontline staff. They are the ones who generate the momentum and make changes sustainable. To achieve real impact in hospitals, you need to spend time on site. You need to train change leaders who can go from site to site and spread the momentum, and this takes time. But it is an investment well worth making!

Second, although we have systematically encouraged trial and error and have tolerated failure for the benefit of risk taking, it is not easy to disseminate and anchor a culture of innovation in healthcare organizations.

Daniel Moinard: As the program unfolded, I did not feel we encountered strong resistance. However, a critical question often asked is: how do we make certain that the changes stick? How do we ensure the program's robustness and long-term sustainability? Top management's drive is not enough; you have to put in place the architecture necessary for maintaining impact. You have to imprint the new ways of working on the institution's DNA, not just through written processes, but also by rapidly training change leaders.

For this purpose, we have nominated project directors in all parts of the organization, and they ensure that the conditions for the program's sustainability are in place. Another critical aspect of sustainability is the involvement of medical leadership. In each department, each operating theater, and each emergency room, there needs to be at least one medical leader who will continue to push the project forward.

Health International: *What were your key success factors?*

Julien Samson: First, we were able to achieve clarity on our ambitions early on. Second, we acknowledged up front that in such a complex organization (HCL provides nearly 2,400 different "products" just for the DRG-based clinical services), we would have to launch many initiatives and let some fail. Risk taking has its advantages—we had several good surprises. For example, putting lean engineers with industrial backgrounds in operating theaters was a real bet! Yet it worked very well.

Also, transparency has been a major theme all along. A lot had to be done to get people to realize that transparency would help them in their daily work. You can only improve what you measure, and measuring requires transparency. The idea was to put in place simple key performance indicators (KPIs) for major processes—those in operating theaters or emergency rooms, for example—to measure and communicate the results being achieved. By the beginning of 2010, multiple KPIs were being used throughout the institution, notably in regular department meetings. The use of managerial KPIs was made easier by the fact that the use of scientific KPIs was deeply rooted within the culture of the clinical personnel.

Julien Samson

Education
Graduate of the Paris Political Studies Institute

National School of Public Administration (promotion Copernic) (2000–2002)

Career highlights
Hospices Civils de Lyon
Deputy CEO
(2009–present)

Scientific Council of National Agency for Performance Improvement Support
Vice President
(2009–present)

Office of Nicolas Sarkozy, President of the French Republic
Technical advisor in charge of social protection
(2007–2009)

Office of Jean-François Copé, Minister Responsible for the Budget and State Reform, and of Thierry Breton, Minister for the Economy and Finance
Technical advisor in charge of social and international affairs
(2005–2007)

French Council for Health Insurance
Rapporteur
(2004–2005)

Health and Social Security Finances Office, Directorate of Budget—Ministry for the Economy and Finance
Assistant office manager
(2002–2005)

Other
Author of *Managing a Hospital* (2012), *Political Economy of the French Constitutional Bylaw on Budget Acts* (2007), *Proposals for Reforming Fiscal Governance* (2005), and *Paris Police Department to Serve Parisians* (2000)

It also helped that both clinical and nonclinical personnel helped choose the KPIs we would monitor.

Daniel Moinard: Something that is less tangible but, it seems to me, is nonetheless very important is dialogue. In any hospital, many different types of people work together; effective dialogue is critical so that administrative managers can better understand the clinical staff and the clinical staff can better understand administrators. Within HCL, this type of dialogue has intensified over the past three years.

Health International: *In closing, what advice would you give to hospitals wanting to launch similar programs?*

Daniel Moinard: Start with a diagnosis and then make sure to reach alignment with all key stakeholders on two things: a factual assessment of the situation and shared aspirations. For sustainable impact, be sure to engage a critical mass of clinical and nonclinical leaders. Structure the program in a way that ensures rapid impact and engages all stakeholders positively. Finally, establish transparency on results—both successes and failures.

Hortense de la Boutetière and **Thomas London** are both partners in the Paris office. They work extensively across a diverse set of healthcare institutions, including academic medical centers, payors, and healthcare authorities.