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IMPLEMENTING FORTIS OPERATING SYSTEM (B)[[1]](#footnote-1)

Subramaniam Ramnarayan and Sunita Mehta wrote this case solely to provide material for class discussion. The authors do not intend to illustrate either effective or ineffective handling of a managerial situation. The authors may have disguised certain names and other identifying information to protect confidentiality.

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On April 20, 2017, Bhavdeep Singh, chief executive officer (CEO) of Fortis Healthcare Limited (Fortis), was pleased with the exceptionally good response to the “FOS week” celebrations held across all hospitals of the Fortis group. Since its relaunch in August 2015, Fortis Operating System (FOS) had come a long way from being considered an organizational ritual to its present state as a key driver of operational excellence across the organization. Bhavdeep was especially happy that the Fortis clinicians and administrative staff adopted FOS with a strong sense of ownership and commitment, and that FOS had regained its rightful place as an important management tool for enhancing patient satisfaction, the predictability of outcomes, and efficiency through attention to non-clinical processes.

Though FOS had been successfully rejuvenated, Bhavdeep knew that two so far un-met challenges required his attention. First, it would be necessary for FOS to continuously evolve and remain updated in the emerging world of digital disruptions and changing customer preferences; otherwise, the system would fail to remain relevant. How could the organization build innovative capacity in FOS? What could be done to ensure that the standard operating procedures (SOPs) underlying FOS kept evolving and adapting to changing times? There was yet another challenge that Bhavdeep foresaw. The nature of FOS meant it focused on “hard” measures contributing to patient satisfaction. However, in a pioneering move within India, FOS leadership had decided in a recent meeting to enhance their focus on compassion, warmth, and care, which could be classified as “softer” aspects of patient satisfaction; the organization had just created the new position of chief patient experience officer (CPEO) to pursue this agenda. Bhavdeep wondered what would be required to create close coordination and integration between the two verticals of FOS and Patient Experience, so that the Fortis group could become truly “patient-centric.”

FOS OVER THE YEARS

FOS began its successful journey in 2007 at Fortis Hospital Mohali, with consultancy firm McKinsey & Company playing a key role in facilitating change. In Wave 2 of implementation, FOS was implemented in Fortis Hospital Noida and Fortis Escorts Heart Institute (FEHI), Delhi. McKinsey & Company played only a limited role in Wave 2. Then, in Wave 3, FOS was taken to the rest of Fortis’ hospitals. The methodology adopted for implementation in Wave 2 and Wave 3 was essentially like that for implementation at Mohali; the challenges faced by the core team, however, were shaped by the unique context of each hospital.

In February 2009, Bhavdeep took over as CEO of Fortis, bringing with him about three decades of experience in the U.S. retail sector. After a long association with leading supermarket chain The Great Atlantic & Pacific Tea Company (A&P) in senior leadership positions, he had headed Spencer Retail and later Reliance Fresh in India. Bhavdeep said, “Given my prior experience, I was very big on processes, checks and balances, and compliance. I thought FOS worked very well and I supported it enthusiastically.”

Fortis grew rapidly. By 2013, it had a network of 62 health care facilities, including 31 operating hospitals, four daycare centres, and 20 satellite and heart command centres located in public and private hospitals. FOS ran successfully in all these facilities.

Leadership and Strategic Changes, and FOS Defocus

Bhavdeep resigned from Fortis in January 2011 for personal reasons. The new organizational leaders were focused on the strategic agenda of internationalization and taking Fortis to several overseas locations. With new organizational focus, there were large-scale changes in different Fortis facilities in terms of chief operating officers (COOs). The new senior leaders did not quite appreciate the role of FOS. While FOS reports continued to be generated, not much attention was paid to the reports and the reviews were relegated to lower levels. In another far-reaching leadership change, Shivinder Mohan Singh, executive vice-chairman and the architect of FOS, relinquished all executive responsibilities in January 2015 to pursue his inner calling of serving full-time in a spiritual organization.

Mangla Dembi, corporate FOS head and previously facility director (FD) at Fortis in Kalyan, Mumbai, said, “Earlier, the scorecard was called the COO’s dashboard—the COO would monitor it and use it to make strategic decisions. With all the leadership changes, the importance given to FOS declined dramatically. For many people, it wasn’t even clear as to why we were doing it. FOS became more of a data collection activity.”

Neeru Raina, asset lead at FEHI, stated, “After a few years of FOS implementation, though the reports were still getting generated, FOS was close to getting ‘fossilized.’ As it was still a part of our JD [job description] we continued to do it; but the old spark was missing.”

Another factor that contributed to the defocus of FOS was the high turnover of the hospital staff—an issue that plagued the Indian health care industry. There were many new people in front-line positions who were quite unaware of FOS and its significance in enhancing process efficiency, standardization, and patient satisfaction. Some of the SOPs had become irrelevant with the passage of time. In several places, manuals were missing, and people were figuring out their own solutions. There was little understanding of FOS beyond the compilation of certain routine reports. Not surprisingly, the clinicians considered FOS a waste of time and were wary of it. By 2015, FOS scores had fallen considerably in several hospitals.

**FOS REJUVENATION**

In July 2015, when Bhavdeep rejoined Fortis as CEO, he noticed that FOS had suffered due to benign neglect. He said,

When I came back in 2015, I was a bit disappointed to see that FOS had fallen behind. The organization and people had gone through multiple changes. I strongly believe that, even for the best of the programs, models, [and] processes, if you don’t have the right people leading, don’t have organization focus or alignment, and don’t have measurement or monitoring, then they become worthless. The same had happened to FOS, as it had lost the level of importance.

Bhavdeep strongly believed that to ensure the implementation and monitoring of protocols and processes, patient touch points, and patient care outcomes, it was imperative to rejuvenate FOS as a system, as the best practices were embedded in it. He initiated FOS rejuvenation as a pilot project at FEHI. Dr. Somesh Kumar Mittal, zonal head at Fortis, said,

When I joined FEHI, as the FD, the FOS score was just 44 per cent. That was the time Bhavdeep joined as the CEO. He was clear that there was a need to drive FOS. Bhavdeep came all the way to FEHI to champion FOS. He mentioned very clearly that the score had to go up and he would monitor it personally. Whenever Bhavdeep wants to drive a change, initially he picks up one or two units. For example, in his last stint, he had picked up Vasant Kunj for improving nursing care and Noida for improving cleanliness. In this stint, he gave the task to us to revive FOS and bring the score to [the] 90s. We changed the entire team. Previously, the person who was heading FOS here was looking after ER [emergency room] [and] medical administration, and FOS was one of the responsibilities. Given [her] strong performance track record and leadership potential, we identified Chandni [Gupta] as the FOS head. We asked her to focus exclusively on FOS revival at FEHI.

At FEHI, Somesh built the team and made the asset leads and process owners accountable for FOS. He initiated training on SOPs, as well as FOS manuals for asset leads, process owners, and front-line staff. The clinicians were kept updated. The relaunch of FOS at FEHI was communicated to all hospitals. Attention was paid to make FOS relevant to current times, the needs of patients, and newer technologies. For example, it was quite uncommon in 2007 for patients to take appointments to meet doctors; in 2015 it had become the norm.

As soon as the impact of FOS rejuvenation became evident at FEHI, Bhavdeep started pushing the other hospitals. He personally persuaded the people at the top and identified those in the hospitals who were passionate about FOS and could drive it. Bhavdeep said, “Right from the beginning, FOS has been used as a stepping stone for career development. We decided that high-potential individuals at senior levels should spend a certain amount of time in the FOS function before they take the next big jump. You cannot implement something like FOS by merely telling people about its importance. The person should be highly motivated and committed to FOS as a leadership tool.”

In November 2015, Mangla, who was FD at Mumbai and had a strong operational and process-oriented background, was identified to head FOS at the corporate level and be responsible for its rejuvenation. As Mangla reminisced,

Of course, I had my initial apprehensions about taking over a support role at the corporate level since I had been in operational roles all along. But I had complete trust in Bhavdeep’s vision. He strongly believed in the potential impact that FOS could have on organizational performance and as a huge differentiator in the competitive landscape in the health care space. He asked me to lead it [FOS rejuvenation] and help infuse it with renewed passion across our hospitals; to bring in greater focus, meaning, compliance, and patient-centricity. By asking an FD of a hospital to run FOS, he was clearly communicating to the organization that the focus was back on FOS. Daljit Singh [president of Strategy and Organizational Development] provided insights and guidance on the way forward; he helped me create a road map for the function.

The organization initiated certain important structural changes. One of the first steps was to establish functional reporting from the FOS heads at the hospitals to the corporate FOS head. This helped Mangla in building a working relationship with all FOS heads across the hospitals. Also, in an effort to empower the operations of the business closest to the patient, the number of regions was optimized from five to three, and the corporate office was re-christened the “Support Office,” to reflect its new orientation.

In November 2015, the pan-organization score was 67 per cent. The scores had been in the red for the previous two years in areas such as outpatients, discharges, and financial counselling. On taking over as corporate FOS head, Mangla initiated a number of interventions in collaboration with key people in the organization.

**Digitization**: The first aspect Mangla focused on was automating the FOS function. FOS digitization was planned in three phases with the help of the central information technology team. Phase 1 was implemented by February 2016 at the central level, wherein all reports were uploaded at a central portal that allowed the CEO, regional COOs, and other top managers to view the highlights of the report in the form of a dashboard. Otherwise, the report was being collated manually using Excel software. This provided the top leaders with the current state of affairs across the hospitals with respect to FOS. Phase 2 was planned for 2017–18 and would be an automation of the FOS data at the unit level, while the feasibility of Phase 3—automating the FOS data collection—was being determined.

**Capability Assessment**: Mangla, along with the human resources (HR) team at support office, commenced an exercise of capability assessment of all FOS heads across the hospitals. A tool was developed for doing so, and FDs and unit HR heads were made responsible for assessing the FOS heads on certain parameters, such as their team management skills, knowledge of processes, analytical skills, and execution skills. They were instructed to look for replacements for those who were not up to the mark. People who were positive about the idea of continuous improvement and had the right attitude and energy were selected as their replacements. Also, FOS heads were relieved of all other responsibilities other than FOS. Apart from functional reporting to the corporate FOS head, they reported directly to an FD.

**Metrics Definition**: Over time, some of the metrics in the scorecard had become irrelevant. Mangla initiated an exercise for revising the definitions of some of the scorecard metrics to make them relevant. The metrics that had become redundant were dropped.

**Sensitization through Boot Camps**: To have a one-on-one connect with the unit FOS heads and asset leads, every hospital conducted separate boot camps. The exercise was carried out over a day or two and brought the entire hospital staff into one room. To link FOS to patient experience, the tag line for the boot camp was “A Journey towards Patient Delight.” The first boot camp was done at Noida and was attended by Bhavdeep, Daljit, and other senior leaders. To provide the required emphasis for FOS, the top leaders went to all the boot camps conducted across the hospitals. The significance of FOS was discussed with all of the staff at the hospitals, and FOS was linked to two aspects: process efficiency and patient experience/delight. To generate excitement for FOS during the boot camp, a board was designed that displayed a pledge to join the journey to Patient Delight, and it was signed by the hospital staff (see Exhibit 1).

The objective of the boot camp was two-fold: sensitize people to FOS, and make them understand the processes and ways to improve them. The sensitization of people to FOS began by providing a global perspective of the Cleveland Clinic.[[2]](#footnote-2) The asset leads and process teams were trained on the DMAIC (define, measure, analyze, improve, and control) methodology through a one-hour tutorial; the rest of the day was devoted to activity-based learning. The units identified the metrics for improvement and redesigned the processes to achieve the desired targets. Quarterly targets were given to the asset leads on the chosen metrics, to improve scores. A presentation was given, and then circulated and shown at regular intervals in all the hospitals.

**Inclusion of FOS Module in Induction Training**: Role-based induction modules were formulated for all new joiners, clinicians, asset leads, and FOS heads. Asset leads and the unit FOS head undertook a detailed three-day and a six-day induction module, which were conducted by the FOS head of the hospital and of another hospital, respectively. A 30-minute session on FOS, conducted by unit FOS heads, was also provided during HR induction for all new employees, which was followed by evaluation. In addition, the list of asset leads across the hospitals was formalized, which resulted in their accountability. Earlier, based on availability, individuals were asked to carry out the tasks of asset leads, and the FOS head was made responsible for everything in FOS. A formal document was also created for handing over responsibility when a new person assumed the role. It was countersigned by the HR head, the FD, and the person taking over, resulting in the alignment of the new FOS heads to their roles and responsibilities.

**Standardization of Data**: The process of capturing data was standardized across the hospitals. This was done by making it mandatory to capture a certain number of parameters in a process; other parameters were optional for the units. This standardization was also essential for the automation of data capture.

**Revision of Process Manuals**: Reviews and revisions of process manuals dating from 2007 were taken up. By November 2016, process manuals were made exclusively for each hospital and were vetted by COOs and regional heads.

**FOS Audit**: A detailed audit tool was developed, and an extensive audit was carried out for all hospitals. The primary emphasis of the audit was on the authenticity of data. Each metric was analyzed based on certain parameters linked to the metric, current compliance status, and analysis of past data. For example, in the outpatient department (OPD), for data generation of patients delayed beyond 15 minutes for their appointment, the audit examined how entry and exit times were captured, how over-booked patients or walk-in patients were taken for calculation, whether the appointments list was available with the concerned staff at the front desk, and so on. Mangla said, “We deliberately planned to lay the road map first and set expectations to all before we started performing the audits. We knew that it would fail if it got reduced to an exercise of finding faults. We used it to generate useful feedback, and so people viewed it positively. In fact, FEHI was one of the first hospitals to make a call to learn the conclusions and audit findings. Trust started to develop slowly across hospitals.”

The detailed audit was planned to be done annually by the corporate FOS head. Other audits were conducted at the hospital, including (1) a cross-functional audit (an audit done at six-month intervals by one department for another); (2) a regional audit (an annual audit done by one region for the other); and (3) 10 commandments (a small audit with 10 key metrics, to be conducted by top management). An audit calendar was created, and FDs and senior clinicians were involved in the audit process. Mangla said,

I tell people that low scores are not a problem. If we know that a certain area is weak, we can put our heads together and resolve the issue. But the data has to be authentic. There are a lot of things done manually and we have a long way to go with regard to automation. Most of all, the definition document should be our bible; we should not interpret anything. The culture to drive FOS should be built on a strong foundation of being compliant.

**Metrics Revision**: Every Friday, for about two months, a two-hour meeting from 3:00 to 5:00 p.m. by conference call between FOS heads across hospitals and the corporate FOS head was conducted to revise the definition metrics and get everyone on the same platform for interpreting the metrics. Individual units picked up any two metrics in which they were proficient and did a thorough analysis of these metrics. The meetings examined what was to be done, and how calculations were done for the particular metrics until all 32 metrics in the scorecard were analyzed and revised. This exercise provided clarity on various metrics and positively engaged the unit FOS heads, as they were able to interact with the other FOS heads.

**Review and Sharing of Best Practices**: A two-hour FOS meeting was conducted every Wednesday at all Fortis hospitals. The meeting, which was made sacrosanct, was attended by all department heads, process owners, and clinicians, and coordinated by the unit FOS head. An FOS report card of other units and best practices were shared. Simmardeep Gill, zonal director at Fortis Memorial Research Institute (FMRI) Gurgaon, stated,

The meeting starts by showing the company scorecard, and then the particular hospital’s score card for the previous week and the current week are displayed so that we know where we stand in the company. The hospitals are divided into category A, B, [or] C depending on the size and scale, revenue, and location of the hospital. Report cards of all hospitals are tabulated on the basis of 32 parameters, and hospitals are ranked in [a] particular category. The best and the worst in [a] category are declared each month. If our scores are low on certain parameters, the team analyzes the situation and discusses alternatives. If we find another hospital doing consistently well on that parameter, we consult them, take their ideas, and even visit them, if necessary.

**Scorecard as Part of Key Result Areas**: To ensure accountability at the highest levels, the scorecard was made a part of the key result areas of the CEO, regional heads, and corporate and unit FOS heads.

**FOS B2B (Back to Basics)**: FOS B2B was initiated because the turnover of front-line staff was high. Colonel Harinder Singh Chehal, COO (National Capital Region), said, “FOS B2B is a must in this industry. We have huge attrition in nurses, medical staff, and doctors. With new people, we have to invest time to orient them to the basics of the job. Unless we do this, the kind of attrition we have, we will not be able to strengthen FOS or any other process.”

FOS heads spent one or two weeks in each asset to provide basic training to team members, generally targeting weaker assets. Training was conducted when the shift was changing. The FOS manual was discussed on the first two days with the asset team, and tests were conducted on the last day to assess learning. The scores were compiled and discussed at the Wednesday meeting.

**FOSCIF (FOS Continuous Improvement Forum)**:With changing customer needs and technology, it was important to ensure thatthe asset leads and process teams were involved in continuous improvement of processes. FOSCIF was initiated with emphasis on cross-functional and cross-departmental teams that held periodic meetings to improve processes. The teams conducted a microanalysis of processes to ensure that FOS remained relevant over the years. The FOS head also reviewed the FOSCIF for the particular department.

**FOS Corner**:To excite and energize the teams, a visual component—“FOS corner”—was created. Every department had an FOS corner, which was a whiteboard displaying the process flow chart, previous performance graphs of various metrics, and the performance scores aspired to every week.

**Weekly Meetings**: A patient welfare meeting was conducted every Tuesday at 4:00 p.m. The attendees included the FD, department heads, and staff one level below. Patient satisfaction scores from every department were analyzed, as were the top 10 compliments, the 10 worst criticisms, and all complaints. Once a month, a town hall meeting called HTML (*Hum Tum Milenge*[[3]](#footnote-3)) was held for all hospital staff. At HTML, every department presented what they were doing. The meeting ended with a few cultural events, fun games, and tea and snacks. The meeting improved bonding among hospital staff.

**Buy-in from Clinicians**: Mangla got buy-in of the FDs through sensitization exercises; boot camps; formal and informal interaction on a regular basis; and, last but not least, the active engagement and support from top management. However, getting buy-in from the clinicians at the hospitals was still a challenge. Here, the support of Dr. Bishnu Panigrahi, head of the Medical Support and Operations group, was sought to help achieve the induction of all junior doctors and the alignment of senior clinicians. FOS was now being talked about in the hospital medical councils by the unit heads and medical heads. Somesh said,

We cannot take for granted that we would obtain buy-in from the clinicians. So we initiated work on the discharge process—this was a big pain point not only for the clinicians but also for the hospitals. I was on the floor for three to four hours every day working on the discharge process. Out of the 30 parameters, we picked up only four to five key parameters to focus our attention [on] and gain quick results. I interacted with the clinicians during patient discharge just to send across the idea of planning the discharge process. It took me three to four months to get buy-in from [the] clinicians to plan discharge. Once the clinicians saw the impact of planning on the smooth discharge of patients, the trust started to build. Then we moved to other areas like Emergency, and finally we approached the challenge of controlling OPD waiting times. This required behavioural changes from the doctors. They needed to adhere to times. By this time, they had seen positive results in other areas, and reduced patient complaints. So it was easier to get buy-in.

Dr. Kousar Ali Shah, zonal director at Fortis Noida, used another way to get clinicians’ buy-in for FOS:

We have devised a forum for an entire day once a month in which clinical HODs [heads of departments] and administrative HODs meet in the boardroom. Each clinician is allotted 15–20 minutes to speak about any issue in the organization. It is an open platform and nothing is countered, and [an] issue is assigned to the concerned staff to be resolved, wherever possible. It is emphasized that even if the issue could not be tackled, we would get back with options/status. The concerned staff then work on every single issue that has come up. They meet the HODs personally and update them on the progress. Even if the issue continues to remain unresolved, HODs receive a briefing on the reasons and plans. In the follow up meeting at the end of the month, the minutes of the previous meeting and the progress on each of the points are reviewed and discussed. The suggestions and feedback of the HODs are sought, and they are encouraged to raise other issues. This gives a platform to clinicians to air their concerns. This has built the trust of the clinicians in the system. So even when they are questioned on deviances with regard to FOS processes, they take it positively.

**Mini Projects**: When there were processes that were consistently in the red, a few mini-projects were taken up in hospitals, with corporate support and regular guidance from Daljit. In Mangla’s words,

In FMRI, FOS scores were the lowest in the country at 65 per cent (September 2016) and the discharge process was one of the key challenges. So a mini-project was done called “Mad over Discharges” in September 2016. The project was carried out with the leadership of Col. [Harinder] Chehal, Simmardeep Singh Gill, [the] unit FOS head, [the] unit team, and my direct supervision, to improve scores. Col. Chehal led the team from the front and set clear expectations. Simmar gave a complete free hand to operate and unconditional support from his HODs. I more or less camped at FMRI for the duration of the project, acting as a guide, coach, and facilitator to help move forward. This set the ball rolling for us at FMRI.

There was a marked improvement in the discharge process at FMRI following the project (see Exhibit 2), and the hospital FOS scores increased from 65 per cent (September 2016) to 81 per cent (October 2016)—a huge revelation for the entire team.

**FOS Week**: FOS week was celebrated from April 10 to April 17, 2017, across all hospitals. It was a full-day event in every hospital. In the first half, the mini-audit called the 10 commandments was conducted by the members of the chief executive committee.[[4]](#footnote-4) In the second half, “FOS fare” awards in 10 categories were given to people who had contributed to FOS in their respective hospitals. The senior clinicians were involved in deciding who should be awarded, which resulted in a positive involvement of clinicians in the FOS function. Bhavdeep himself and other top leaders visited some of the hospitals to attend the award function and conduct the audit. The event was covered daily by the support office communications team. The team sent a daily update of the mega-event to the entire Fortis network, creating a positive and value-based impact for FOS. The event was also covered in “The Fortisian,” a monthly Fortis internal journal.

**Impact of FOS Rejuvenation**: The various interventions resulted in an improvement of the hospital operations. By April 2016, the pan-organization score had reached 86 per cent (see Exhibit 3). The improvement on various metrics of the scorecard was clear. For example, the percentage of patients with a final bill of more than 5 per cent of the estimate decreased from 14 per cent to 7 per cent (see Exhibit 4); the length of the discharge process decreased from 179 minutes to 138 minutes (see Exhibit 5); and the percentage of doctors arriving late for OPD patients decreased from 20 per cent to 15 per cent (see Exhibit 6).

FUTURE OF FOS AND ALIGNING it WITH ENHANCING PATIENT EXPERIENCE

The impact of FOS on hospital operations had reinforced Bhavdeep’s belief in the system’s potential. However, he believed that every system should evolve to remain relevant:

Five years from now, if FOS continued to work exactly the way it does today, I would say that we have a program that is losing relevance. SOPs underlying FOS should change; otherwise, we are in big trouble. FOS has to continuously evolve and get updated. In today’s world, technology is a significant enabler.

Phase 1 of digitization had been successfully executed at the corporate level, and other phases were planned. Phase 2 of digitization involved automating the data compilation activity at the unit level, making it available as the unit dashboard for review by the FD; otherwise, the FOS head of the particular unit compiled the data manually. This phase was in progress. Phase 3 of digitization involved data capturing at the unit level. This was both critical and difficult because of the varied information technology systems used in different hospitals, making data integration a challenge. There was a plan for a single software platform across the organization.

In November 2016, a new senior position, chief patient experience officer (CPEO), was created to drive patient experience and maintain alignment with the Fortis vision—“Entailing the finest medical skills combined with compassionate patient care.” Fortis was the only group of hospitals in India to have created such a position. The welfare officers in the various hospitals reported to the CPEO, and the CPEO reported to the CEO. It remained to be seen how the positions of corporate FOS head and CPEO would align themselves at the ground level to achieve the Fortis vision of moving toward patient satisfaction, in which the focus of the FOS head was on efficiency and standardization, and that of the CPEO was on the softer aspects of compassion, warmth, and care.

EXHIBIT 1: Fortis Operating system BOARD SIGNED BY ALL hospital staff DURING BOOT CAMP



Source: Company files.

EXHIBIT 2: “MAD OVER DISCHARGES” PROJECT AT FMRI, GURGAON

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|  |  |  |  |  |  | **Pilot Phase** | | | |  |  |  |
| **Metric** | **Unit** | **Target** | **July '16** | **Aug '16** | **Sept '16** | **Oct**  **03–09** | **Oct**  **10–16** | **Oct**  **17–23** | **Oct**  **24–30** | **Oct '16** | **Nov '16** | **Dec '16** |
| **Discharges planned** | % | 85 | 66 | 63 | 62 | 69 | 65 | 73 | 72 | 70 | 71 | 75 |
| **Length of discharge process (cash)** | Minutes | 90 | 185 | 169 | 160 | 110 | 105 | 102 | 96 | 103 | 99 | 90 |
| **Length of discharge process (others/PSU/**  **international)** | Minutes | 120 | 183 | 172 | 156 | 106 | 118 | 120 | 108 | 113 | 120 | 113 |
| **Length of discharge process (TPA)** | Minutes | 240 | 327 | 330 | 323 | 221 | 218 | 187 | 197 | 206 | 218 | 206 |

Note: FMRI = Fortis Memorial Research Institute; PSU = public sector units; TPA = third-party administrator.

Source: Company files.

**EXHIBIT 3: POST-REVIVAL FOS SCORES**

Note: FOS = Fortis Operating System.

Source: Company files.

EXHIBIT 4: POST-REVIVAL PATIENT FINAL BILL METRICS

Source: Company files.

EXHIBIT 5: POST-REVIVAL LENGTH OF DISCHARGE PROCESS

Source: Company files.

**EXHIBIT 6: POST-REVIVAL OUTPATIENT DEPARTMENT METRICS**

Note: OPD = outpatient department.

Source: Company files.

1. The authors gratefully acknowledge the support provided by the Max Institute of Healthcare Management at the Indian School of Business in the writing of this case. [↑](#footnote-ref-1)
2. Cleveland Clinic, a reputed multi-specialty academic hospital located in [Cleveland, Ohio](https://en.wikipedia.org/wiki/Cleveland,_Ohio), had initiated a transformational initiative in 2009 to enhance its patient experience scores. [↑](#footnote-ref-2)
3. A Hindi expression, roughly translated as “Let us meet together.” [↑](#footnote-ref-3)
4. Chief executive committee members included the senior managers who reported to the CEO directly; for example, head of Medical Support and Operations group, head of Nursing, head of operational excellence, head of HR, and head of Finance. [↑](#footnote-ref-4)