



UNLOCKING THE SECRET TO STRATEGIC SUCCESS

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“There are four major antagonists to strategic Continuous Improvement that must be addressed immediately.”

The first step is learning how to shift the organization’s drivers from tactical to strategic and that means creating a **new** strategy to achieve *today’s* goals. Yesterday’s tactics at best lead to yesterday’s goals and those just aren’t good enough. The world of healthcare is tougher than it’s ever been, and successfully implementing the right strategy is the only answer.

Many smart people advise that, when trying to win over people in an intellectual or commercial way, it is not wise to be critical. However, “no pain, no gain” is not just about going to the gym. Until people or organizations can see, understand, and address their pains – including the self-inflicted ones – it is impossible to achieve improvement, growth, and success. Some of you may need to brace yourselves.

As is frequently the case with large comprehensive initiatives, the most important element in shifting the planning and operations of a healthcare provider is to take the right first step with commitment and conviction. When it comes to becoming dramatically more strategic, upper management and particularly the person who is the driver/firestarter must fully understand what that first step is and how to take it.

Most healthcare leaders, when asked to list their objectives, problems, and stress points, will shake their heads, roll their eyes, and say there are too many to name. That is both a diagnostic of the problem and a signal of the *effects* of an overt tactical and even reactionary environment. On a day-to-day view of the operation, there is certainly a difference between time priority and importance priority on the things that must be done, but managing those, probably in multiple layers, still requires the right perspective on a starting point. White papers often work toward a big reveal of a most impactful point farther into the document but here is one of the most impactful points right now.

“In order to plan and operate strategically, the purpose of the operation must be simply, clearly, and unequivocally stated as a cornerstone and fulcrum point for all major decisions.”

In order to plan and operate strategically, the *purpose* of the operation must be simply, clearly, and unequivocally stated as a cornerstone and fulcrum point for all major decisions. Hopefully, all readers will agree that the purpose of a healthcare provider organization is to deliver care that makes patients better. That’s it. The purpose of the organization is not to hire people, to submit data to CMS, or even to pay its bills. Those ancillary functions and many like them are important enablers of progress toward the primary purpose and must be accomplished, but not without optimal service to the real purpose of providing care that makes patients better.

Next, we look at the function of management. That is always to optimally achieve the purpose of the organization, which for the people we are talking about is still to deliver care that makes patients better. We all

live in an entropic universe, meaning that every operation and system is constantly experiencing degradation, problems, and breakdowns, so we must improve just to keep up and we have to be really good at improving, all the time, to actually do better over time. So, yes, we just described the continuous improvement notion, which everyone has been talking about forever. But why are most not accomplishing that in a meaningful way? It is not that people don't believe in it or that it cannot be achieved, but rather that there are four major antagonists to Continuous Improvement that directly affect almost all healthcare provider organizations:

- Start-up Challenges for Continuous Improvement
- The Seduction of Tacticalism
- Head Stuff versus Hand Stuff
- The Anti-Strategic History of Information in Healthcare

Start-up Challenges for Continuous Improvement

There are hardly any healthcare provider organizations that are currently starting from scratch. Consequently, almost all Continuous Improvement initiatives begin with an active operating environment full of existing people, processes, history, systems, artifacts, culture, and problems. Often, a CI effort comes with the turnover of one or more senior managers and



executives. But those situations come with their own dynamics that compete with the CI effort for organizational oxygen and brain cells. The old guard among middle managers is posturing for survival and comfort while breaking in the new guy to “the way things are done around here”. The new guy or guys – which in my language is gender neutral – are trying to create warm, productive relationships and at the same time put their “fingerprints” on something new and wonderful – or possibly to lead

a major turnaround which is usually ALL about financial survival. All these dynamics surrounding a turnover are about very close, personally held motives that make real commitment and open-mindedness to a new CI effort among the key players and leaders quite difficult.

Another setting in which a Continuous Improvement initiative is undertaken is when an executive decides that several problem areas, or one very big one, absolutely must be handled with a strategic reset, and getting on board with CI is frequently a component of that. The biggest issue in that situation is the CI is seen as a new *project*. Projects have designated leaders, boundaries, scopes, timelines, and endpoints. CI is then a thing inside the organization and participants develop a mental map of what is, and is not, a part of, or impacted by, a new CI initiative. Largely, they fail to consider or refuse consciously or subconsciously to consider, changing the fundamental approaches to their work and operations. They hold on to all those existing elements that they want to protect from change for reasons of self-interest. While it is natural to desire the comfort of familiar things, that desire becomes malignant when it turns into a refusal to seriously consider alternatives over a period of many years.

The Seduction of Tacticalism

It is too easy to let continuous improvement get derailed. The first and most fatal way to do that is to erode the pursuit of strategic operations by falling prey to the seduction of **tacticalism**. Understanding what that is and how to resist it is where we go next.

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The vast majority of staff in a healthcare provider organization are quite likely to identify with, and feel committed to, the aforementioned purpose to deliver care that makes patients better. But far fewer genuinely feel responsible for the strategic means by which senior management has set out to accomplish that. Read that last sentence again. People have been educated and trained, in both academic and on-the-job settings, to break down major objectives and goals into “doable” pieces and tasks which are then distributed across the organization. Time goes on and everyone gets very focused on, and we will postulate very good at, completing their tasks. This becomes the very essence of comfort among front-line staff and *especially* middle management. Checking proverbial “boxes”, generating data on performance metrics or key performance indicators (KPIs) – supposedly the most important part of management – and producing process artifacts such as reports collectively takes on a cultural if not religious level of absorption and no one questions their meaning or value. Staff, supervisors, middle managers, and eventually senior management

take pride in success in those small elements and eventually attach their own status and self-worth to those indicators of tactical accomplishment. The organization has, for real and natural reasons, committed itself to tactical operation.

A major contributor to the distraction from the strong orientation to purpose is the highly regulated healthcare industry itself. Requirements and mandates very clearly influence many of the decisions made. Of course, no one is suggesting they be ignored, but they *can* be considered within the context of what the organization is doing for its own strategy for success. Here is a case in point, and a very important one in this realm. Before there were widespread sophisticated efforts for tracking Quality, Safety Events (FKA “adverse incident reports”), and Performance Improvement, operational imperatives existed to submit data to industry/government agencies and “data vendors” as intermediaries. Fundamentals of information management and subsequent requirements and specifications for data management tools were derived from the exact manner in which agencies wanted data submitted – for *their* purposes, not those of the hospital.

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Most healthcare leaders today understand fully that the 12-to-24-month cycle of receiving constructive insights from those agencies’ work on submitted data is not conducive to a timely improvement cycle in their organizations. Years ago, the focus and expended effort on local, immediate PI increased, yet the fundamental design of “reporting systems” persisted, despite being non-optimal for efficient use by the PI team. As such, PI work has historically been a brute force effort, involving a lot of time and effort, making it one of the first things to be sacrificed during time and money-crunch situations. More about that in the next section.

We all hope that the up-front operational design of methods, processes, policies, and workflows originally did a great job of serving that top purpose of the organization, even though some examples, like the regulatory picture above, did not. However, time brings a landslide of new people with different ideas (some better than the original); changes in the size and structure of the organization; new operational requirements imposed; more or fewer resources by which to do the job; and new tools that are more advanced and comprehensive that enable and require modifications of existing process chains and workflows.

Unfortunately, the calcified organization as described above instinctively resists and sometimes even outwardly rejects, these changes – a condition for which many will argue healthcare is famous, or infamous. Sometimes this opposition to change or the distorted adoption of it, does cause overt failure in some functions and the organization or parts of it subtly reverts closer to the previous tactics. Unfortunately, this protection of the older means, methods, processes, tools, and functions almost always results in the cancellation of gains in efficiency that could be accomplished by sincere and open-minded embrace of the changes. Additionally, it is very difficult for workers to recognize the relative inefficiencies in their preferred, ingrained processes, tools, etc. because of that comfort in continuing to “do what they have always done” which did deliver relative contextual success in the past.

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It is not because all layers of management want tactical failures or gross inefficiencies. As we said, almost all healthcare workers are truly committed to the simple, stated purpose to deliver care that makes patients better and to the notion of Continuous Improvement as the overall means to accomplish that. But few truly understand the arc of senior management’s strategic plan for accomplishing that purpose and the means of achieving it, even when that plan is sound and effective. As those changes mentioned above appear for possible adoption in the organization, it is typically the case that senior management doesn’t do a great job of selling the relevance of the proposed changes and presenting the way forward in an operationally meaningful and convincing way.

Head Stuff versus Hand Stuff

Healthcare organizations have spent an enormous amount of money over the past 50 years on education, consultants, conferences, speeches, and communication programs – repetitively – in pursuit of the **correct** purpose to deliver care that makes patients better and the notion of Continuous Improvement. Most healthcare leaders seem to have a seriously exaggerated belief that presenting cognitive inputs (head stuff) will have a positive, strong, and *persistent* effect on behavior patterns (hand stuff). After those episodes of *fresh* (whether novel or just repeated old ideas with new words) cognitive input, everyone is excited about wanting to do their jobs better and having new ideas, methods, and even work steps in their heads. But as they go back into their work environment with the same

barriers, demands, tools, pressures, and signals, that cognitive input fades into the background and the status quo is re-invested. Why they hold on to those beliefs that cognitive input alone will effectively change behavior and their expectations of demonstrable improvement, I do not know, but I think many just don't know what else to do.

One of the most prevalent, dramatic, and impactful examples of the head stuff versus hand stuff dilemma is the mechanical operation of the Performance Improvement function which, obviously, is at the core of the Continuous Improvement strategy. Almost every healthcare delivery organization embraces and invests in a "conceptual methodology" for implementing performance improvement – Lean Management, Total Quality System, Six Sigma, Malcolm Baldrige, Toyota Quality System, or others. These methodologies have been around for ages, are promoted by hundreds of experts, and have supported the accomplishment of significant improvements in many areas of healthcare. This sounds like a great contribution, right? Well, yes and no.

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Each of these methodologies are comprehensive and straightforward blueprints for how humans should do human/manual work to accomplish the tactical steps and functions of performance improvement. And they are very good for that. While it could be said that implementation of, and adherence to, those methodologies are BOTH head stuff and hand stuff, there is still a big issue. As described above, fixation on specific tactics, steps, inputs/outputs, artifacts (reports, forms, diagrams, documents), and tasks is the very foundation for resistance to potential changes that arise over time and that can deliver real advances in both effectiveness and, more importantly, efficiency.

Because the use of these methodologies is so highly regarded and ensconced in the operation of highly regarded organizations, organizations take on additional expenditures of time and money, on top of the actual improvement function, to demonstrate adherence to details of the methodology. They use, jargon specific to their methodology, spend extra time generating specifically formatted diagrams and documents, hold numerous meetings with specific agendas, and send many employees to a series of courses to get various training certifications. Any application of information technology in this area is, by necessity, extremely tactical in

nature to accommodate all this required structure. Any advanced software design approach that more efficiently serves the *goals* of performance improvement but not specific tactics, tasks, and overt methods, is simply not acceptable to those who are truly committed to following a specific methodology.

Why is this and how did good organizations get here?

The Anti-Strategic History of Information in Healthcare

Involvement in the design, development, and delivery of Information Technology in several industries over several decades has given me some depth and breadth in trendspotting, causes and effects, and human and organizational behaviors regarding both information technology and information usage. Of course, segments of the industry and specific instances vary significantly, but some patterns remain meaningful.

Forty years ago, most industry verticals began to truly recognize that optimal use and management of information using the best technology available, was no longer a 'nice to have' or a necessary evil to grudgingly attended to but was THE gateway to strategic success. In healthcare, it's been a bit different. Why?

"early on, computer usage was considered a distraction from the true purpose of delivering the best possible patient care"

Most understand this first historical piece. As information technology became more and more critical to the operation of all businesses over the last 60 years, it remained more acceptable for the key players in healthcare (doctors, nurses, and other clinicians) to avoid developing hands-on computer usage skills. Especially early on, computer usage was considered a distraction from the true purpose of delivering the best possible patient care. Well-designed systems to leverage what was going into the computer simply didn't exist yet, so it wasn't viewed as worthwhile.

What evolved from that historical situation may not be as clear. As those people advanced in the organization and gained broader responsibilities over the span of years and decades, they did not have much of a *progressive* understanding of what IT was about and how to solve the problems in

their jobs and organizations with IT. Even as they did gain some hands-on skills for writing documents, crunching some numbers, and eventually communicating electronically, a significant number of advancing managers and executives remained fixed on a personal and tactical view of the application and benefits of IT and the planning of it.

Organizational IT planning is quite different and *strategic* organization IT planning is *very* different from an individual's personal perspective. As these managers advanced further into the executive ranks and were faced with directing a new initiative that required Information Technology, the preferred means was largely to delegate to people lower in the organization, who frequently had a greater understanding of IT, the definition of a project to build or buy IT solutions, and the setting of requirements for that project. This went on for long enough that it became very well cemented in IT acquisition in healthcare that department heads and staff specialists made those important organizational IT decisions. Thus, far more so in healthcare than in other industries, "point solutions", or task-level software used by specific individuals or small numbers of workers in separate units of the organization, were most frequently sought and purchased without adequate consideration of long process chains or holistic operations of the organization. Very tactical, not very strategic.

This is further complicated by another remnant of early information work in healthcare. Organizational boundaries sometimes evolved around tasks and even specific persons' skill sets and so became antithetical and



counterproductive to optimal process chains and workflows across the organization. The desires among these group or department managers for autonomy and control – even when some of their direction and decisions were very good – led to interdepartmental conflict and competition more than to optimal collaboration in process chains and the achievement of enterprise goals. Even as more "enterprise solutions" addressing corporate goals and long process chains

(like EHRs), have been considered and bought using interdepartmental product review teams, it remains today an awkward, contentious, and very long process to reach consensus regarding selections of products around strategic goals of the organization.

There are also persistent issues with individuals' efforts in planning, selecting, and implementing information solutions in healthcare. They seem to roll up into group efforts, probably for these same historical factors.

Many healthcare managers and executives have a rather rudimentary view of the capabilities of IT. A lot of the IT products available at the time healthcare was struggling to implement it initially were largely of a "database" model – used for entering, and retrieving data as it was entered, with little if any processing, workflow, or non-linear functioning. Somehow, many have remained fixated on that model. So, the requirements posed in selecting IT solutions even today, are largely, 'what information is entered/ stored?', 'how does the entry process look?', and 'what do the outputs/ reports look like?'. Secondary or tertiary consideration is given to things like, 'how easy is it to use?', 'is the total output of the software coherent and easy to understand?', 'is the functioning of the software compatible and optimally oriented to my work *outside* the computer?', 'how much manual manipulation of data will I still need to do?' etc.

"massive systems with massive price tags were bought without understanding the need to ensure **alignment of the purpose** of their organization's use"

It may seem unnecessarily abrasive to suggest that many healthcare leaders are bad at shopping for IT solutions. But the stark reality is obvious. Many healthcare organizations have spent from millions of dollars to hundreds of millions of dollars on first generation Electronic Health Record (EHR) systems only to have most of their doctors, nurses and other staff hate using them or even refuse to do so. The massive systems with massive price tags were bought without understanding the need to ensure **alignment of the purpose** of their organization's use of the EHR system and the purpose for which the EHR system was originally designed. Of course, the buyers' purpose was to support and facilitate the delivery of patient care by doctors, nurses, and other clinical staff. Unfortunately, as technical and design analysts understand, early EHR systems were actually designed to support and facilitate the diagnostic-code-based billing process that has become tremendously complicated and ungainly. Without doubt, progress has been made in revising and refining those systems and newer systems in the market are better at the providers' purpose. But there are still a lot of complaints stemming from that original design issue. And yet, that same lack of aligned purpose continues to be a problem in products intended to serve Quality Management, Safety Event Reporting and Performance Improvement.

As was described earlier in this white paper, the new and very critical purpose among provider organizations is no longer to simply send reports to governmental agencies and other external organizations but to drive improvement in Quality and Safety of their patient care internally, quickly and efficiently. Even those older systems that do a good job on the external submission tasks that still exist have clearly not advanced or expanded to address this new, improvement focused purpose.

Many leaders shopping for software to replace paper forms insist that the entry form in the software look just like the corresponding paper forms. This negates many of the advantages in design and functionality that are inherent in processing data in digital form. The appeal of having what is familiar is natural but should become secondary when the medium and modality are fundamentally different. Understanding how information is captured and presented on paper simply is not the same as designing the structure, processing, and movement of data inside an application. But users continue to ask very quickly in a product review setting, frequently even before seeing a complete demonstration, “Is it customizable?,” They don’t realize how much that retrograde desire for the familiar past is antithetical to the streamlining, labor-saving, and goal-oriented advances that they should be seeking, and that are made possible by modern software design. Plus, customization is a huge hidden expense that is seldom adequately considered.

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With a limited understanding of what true enterprise solutions, embodying critical process chains throughout the organization, really do to *shape the work* going on, it is hard to appreciate the streamlining and accountability that can be achieved by the software, with a corresponding reduction in both training and managerial oversight effort on protocols, methods, or policy adherence. When an organization implements the right well-designed software, the effort of both managerial oversight and executive leadership is reduced, while the effectiveness of both is enhanced. This is a fundamental benefit of what the IT industry has been calling “digital transformation” which, sadly, most of the healthcare industry has not yet embraced well, or at all, for several of the reasons stated above.

One Very Clear and Immediately Doable Step Forward

Let's recount a few points made in this white paper.

- The goals and strategy of the organization must be extremely aligned to the purpose of the organization and the means to accomplish the goals and execute the strategy must continually support that purpose.
- Continuous Improvement IS the most important element of strategy in any organization that pursues its purpose.
- The execution of the strategy, and the decisions that precipitate from that, must have defensive characteristics to deal with several known antagonists to strategic operations.
- When and how organizational leaders kick off efforts to become more operationally strategic can make or break the initiative before it even starts, and deep thinking is needed.
- History, with its then-current ideas, norms, beliefs, and patterns, *must not* be blindly honored and perpetuated with a "that's the way we've always done it" mentality if real progress is to be made.
- Organizational boundaries and the probability of divergent approaches, methods, tools, and decisions can have very detrimental impacts on process chains, strategic organizational operations, and the selection of and commitment to, important enterprise IT solutions.
- Enabling steps, artifacts, tasks, and "check boxes" that were important in *old* processes cannot become sacred cows or absolute givens in strategic process redesign and IT solution selection.
- Workers cannot be expected to work better or do more of the right work simply by being educated, trained, and preached into the right mentality. They must be equipped to work in the optimal way to support the strategic goals.
- Implementing well and purposefully designed software, completely aligned with the purpose and strategy of the whole organization, is the most impactful change an organization can make to accomplish its strategic goals.

While we cannot offer a perfect solution or resolution of all the historical and continuing issues covered in this paper, we *can* offer a major step forward with respect to all these summary points, in immediate, focused, and practical terms.

The purpose of our company, Prista Corporation, the provider of ActionCue Clinical Intelligence, has been from the beginning to deliver the best platform in the healthcare industry/market for facilitating the management and improvement of clinical care. We knew from the beginning that Performance Improvement must be the foundation and core around which everything else was to be redesigned. Are ActionCue’s functionalities for Quality Metrics reporting and presentation, Safety Event reporting, investigation, analysis and follow-up, Scheduled Task management, Checklists, and much more, better designed than corresponding, competitive “point solutions”? We think so. But the true power of our solution comes from the well-designed, optimal integration of those things into a Performance Improvement workbench that is an order of magnitude advance over a collection of many moving parts held together by massive, often frustrating human effort.

ActionCue Clinical Intelligence is a comprehensive working platform with the facilitation of clinical and financial performance for any healthcare

delivery organization at its core. It is the first, and for over a decade has remained, the foremost example of applying fundamental innovation and advanced human-centered design to a healthcare IT solution that directly supports the Performance Improvement function. ActionCue CI optimally integrates the precursor functions of Quality Management (Performance Measure tracking) and Safety Event reporting, investigation, and follow-up. This drastically reduces both the workload on staff and managers but also the incidence of information

or events “falling through the cracks” or going “stale”. The expert-tailored workflows with embedded educational content and tips ensure that users do the right things in a timely manner.



It is a true Enterprise solution, from three very important perspectives. First, it embodies strong and efficient collaboration between three principal parts of the healthcare delivery organization – Quality, Safety/Risk, and Performance Improvement – as well as all other departments and functions in the organization that contribute to patient care delivery and successful outcomes. Second, unlike most other rudimentary reporting programs or databases involved in these work areas, ActionCue CI’s user interface and user experience (UI/UX in “tech-speak”) are ideally designed for easy use by busy executives with broad spans of control. ActionCue CI allows this group to obtain “big picture” summary views of performance from various angles of interest, with the ability to dig into those insights and details in which they are interested – without asking an assistant to prepare a report. Third, the architecture and workflows cover the entire span from data and information capture to delivery of clear, focused actionable insights. Everything is built-in, available on day one, and no one in the client organization has to build anything.

Contact Prista today to see how ActionCue Clinical Intelligence can transform your healthcare delivery operation.

Schedule a quick demo:

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<https://pristacorp.com/actioncue-ci-solution/#demo>



About the Author:

Don Jarrell is a recognized expert on the topic of software and application design for several industries. In addition to founding Prista and designing ActionCue, Don has served as the Software Business Manager, a Product Management function, for Alcatel USA, Director of High-Level Design and Business Architect at The Equitable, and the Director of Product Line Planning/Product Line Management with Northern Telecom, Inc (later known as Nortel Networks).

About Prista:

Prista's flagship product, ActionCue Clinical Intelligence, has transformed the way hospitals manage risk, quality and performance improvement by making information immediate and easy-to-use and understand. While a number of software solutions address some of these functions separately, none deliver information in a single, collaborative environment that provides the actionable insights and reporting found in ActionCue CI.

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