Successful Implementation of Quality and Performance Improvement Plans

Critical Areas to Address in Strategic Planning

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Overview

It has been over a decade since the publication of the Institute of Medicine’s (IOM) landmark reports *To Err is Human* (1999) and *Crossing the Quality Chasm* (2001): these two reports led to a significant change in how we view our medical system in general, and how we define quality health care in particular. Their impact is difficult to overstate – the reports seem to be cited in the vast majority of quality and patient safety literature that has followed their publication, and the shift in our priorities in health care reform to adopting reimbursement models based on outcomes, rather than volume, can easily be attributed to the attention these reports brought on how inadequately, if not dangerously, our current system performs.

This increase in awareness has aided in our collective understanding of the need for improvement. Unfortunately, there is a difference between being “understanding” that a problem exists and “solving” it, and much of the recent research suggests that we have not made considerable progress since the IOM reports’ release. Consider the following:

- The Agency for Healthcare Research and Quality states in its 2010 National Healthcare Disparities Report that, while quality is increasing slowly but steadily (at an improvement rate of only about 2.3% per year), healthcare access and disparities are not improving at all (pp. H2-H5).
- A study conducted in 10 North Carolina hospitals from 2002 to 2007 (chosen for their active involvement in patient safety improvement programs) found no discernable improvement: the study found that 18% of patients were harmed by the care that they received, and that two-thirds of the injuries or deaths were preventable (Grady, 2010, para. 2-6).
- A 2010 report from the Inspector General, using October 2008 Medicare data, determined that 13.5% of Medicare beneficiaries experienced an adverse event resulting in serious
patient harm post-discharge, while another 13.5% experienced temporary harm that was corrected prior to discharge. Of these events, physician reviewers determined that nearly half were “clearly or likely preventable.” The financial cost for the patient harm in this month alone was nearly $325 million – extrapolated to annual figures, the Inspector General estimates that the total FY 2009 cost of such events is $4.4 billion (pp. i-iii).

• The Joint Commission states that, despite the increased attention to patient safety, they believe the number of wrong-site surgeries is actually getting worse, not better (Davis, “Wrong Site Surgeries on the Rise”, para. 2).

When the IOM crafted their reports over ten years ago, it is reasonable to assume that they had hoped for much better results than these. There are innumerable factors that account for why this progress has been so elusive, but the logical factor for us to examine is the link between strategic planning and implementation – this is where the link between “understanding” the problem and “solving” it lies.

**Select External Factors Necessitating Quality and Performance Improvement Gains**

In this era of reform, the poor performance previously noted won’t be tolerated much longer: as we are increasingly seeing, external stakeholders are applying tremendous pressure to solve the problem of quality and performance improvement. Again, there are countless external factors that come into play, but from a hospital perspective, there are two factors that are immediately of concern and stem from the reform movement—reimbursement changes and the onset of new delivery models.

**Reimbursement for Care Provided**

In the PricewaterhouseCoopers report, “Top 10 health industry issues in 2010: Squeezing the Juice out of Healthcare,” the authors note that the Centers for Medicare and Medicaid Services’ (CMS)
shift from volume-based reimbursement to value-based reimbursement “signals a shift in CMS’
attitude from a ‘passive payer’ to an ‘active buyer’ of healthcare services” (p. 6). Some of this value-
based reimbursement simply represents what “value” hospitals provide in their fee structures – for
instance, Medicare Advantage plans will reimburse a greater percentage of the Fee-For-Service (FFS)
when the FFS rate is low than when it is high (Kaiser Family Foundation, “Summary of…”, 2010, p.6).
But much of the reimbursement reform is to take place in the realm of Pay-For-Performance (P4P)
plans where reimbursement is lowered for excessive preventable rehospitalizations, hospital-acquired
infections, lack of adherence to established quality measures, etc. (p.8-10). This carrot-and-stick
approach has been shown in the past as being effective to stimulate providers to adopt practices that
are deemed better for patient care: for instance, in a University of California study, it was found that
financial incentives were one of the main predictors in whether physicians would advocate care
management practices to the chronic-illness patients (Shortell, et al., 2009, abstract). Finally, insurers
have also been keen to use a bundled payment method similar to the capitation models of the 1990’s,
but with performance measures included in order to incentivize more effective (and therefore,
cheaper) care, and not just prioritizing efficient, cost-cutting models.

Delivery of Care

Another concern is that, under the current reform legislation, CMS has the authority to
implement a successful pilot program which, as in the case of Accountable Care Organizations (ACO’s)
or other bundled-payment models, could essentially force hospitals to adopt new business models.
These models go beyond straight reimbursement, however, and into the realm of redesigning delivery
systems.

There are three characteristics of the Accountable Care Organization as illustrated by the
Robert Wood Johnson Foundation and Urban Institute (Devers & Berenson, 2009): the ability to
provide, and manage with patients, the continuum of care across different institutional settings,
including at least ambulatory and inpatient hospital care and possibly post-acute care; the capability of prospectively planning budgets and resource needs; and sufficient size to support comprehensive, valid, and reliable performance measurement. The key takeaways from these characteristics are the coordination between multiple organizations, and the pooling of resources among them, in a manner that we are not accustomed to. The hospital alone is a vastly complex organism – how will an ACO be manageable?

Even if CMS doesn’t create an environment necessitating a change to the delivery system, the federal government is not the only force to consider: federal reform only provides the minimum-necessary requirements that hospitals will have to meet to receive adequate Medicare reimbursement. State Medicaid programs, or state initiatives in general, may have measures that exceed or enhance these requirements. For example, in Massachusetts, a pilot program to test the efficacy of “Patient-Centered Medical Homes” is underway, which involves several primary care practices that are either directly a part of, or affiliated to, hospitals and community health centers. These medical home models may have their own minimum requirements for quality and performance measures, using bundled payments and performance bonuses to encourage better care delivery (EOHHS, 2010).

Regardless of what the stimulus ends up being, it is highly probable that we are moving in the direction of adopting ACO-type models in the future. According to ACO expert Harold Miller, successfully implementing an ACO requires eight major characteristics (2009):

1. Completed and timely information about patients and the services they are receiving.
2. Technology and skills for population management and coordination of care.
3. Adequate resources for patient education and self-management support.
4. A culture of teamwork among staff.
5. Coordinated relationships with specialists and other providers.
6. Ability to measure and report on quality of care.
7. Infrastructure and skills for managing financial risks.

8. Commitment by leadership to improving valued.

As we will see, these characteristics could very easily apply to implementing a comprehensive quality or performance improvement strategy: this comparison should clue us in on how our current efforts may be insufficient. This also shows that developing sound management practices regarding QI/PI in hospitals will not only be beneficial for its own sake, but may also provide a template for tackling the system redesign that is sure to come.

**Defining Strategic Planning**

Of the management practices that will play the most crucial role in such efforts, it could be argued that strategic planning should be placed at the top. In *Strategic Management for Public and Nonprofit Organizations*, John Bryson (2004) defines strategic planning as “a disciplined effort to produce fundamental decisions and actions that shape and guide what an organization (or other entity) is, what it does, and why it does it” (p.6). Bryson then lays out the “ABC’s of Strategic Planning” as summarized below (pp. 6-7):

**Fig. 1 – The “ABC’s” of Strategic Planning**

- **A** Where you are
- **B** Where you want to be
- **C** How to get there
It is noteworthy that strategy implementation is considered by Bryson to be part of the strategic planning process – we’ll revisit this concept in the next section. For now, in reviewing this model, we learn that “A” and “B” represent the current and desired future state, respectively, of the mission and mandates, systems and structures and resources available to the organization; “C” represents the strategic planning and resource allocating that will be required to implement the strategy (p.7).

An example of such planning as relates to quality improvement is found in *Quality Management* (Goetsch & Davis, 2006, pp. 93-94), where the authors state that the mission, vision, and values (or, as they refer to the latter, “guiding principles”) help organizations determine their *broad strategic objectives*, or “[w]hat must the organization do to achieve their vision” (p.93). Attending to this “what” by creating objective targets then allows for developing specific plans as to “how” to achieve them. The authors offer the following as “characteristics of well-written broad strategic objectives” (pp.93-94):

**Fig. 2 – “Well-Written Broad Strategic Objectives”**

![Diagram of strategic objectives](image_url)
As we can see from both illustrations, the idea is to use the mission, vision and values (or, “guiding principles”) to serve as the point of origin from which all planning and implementation should stem. However, as will be demonstrated in the next few sections, the commonly-held beliefs about what “strategic planning” entails need to change to allow for greater implementation success.

The Disconnect between Strategic Planning and Local Initiatives

Where strategic planning can become problematic is when a hospital makes the strategic decision to incorporate quality- or performance-improvement programs, but does not ensure that the initiatives that are undertaken at the local or operational level tie in to its strategic objectives. Often, divisions or even units are given the direction from leadership to adopt QI/PI practices or initiatives, but not given sufficient direction as to how those initiatives relate to the organization’s specific strategic needs. The Institute for Healthcare Improvement (IHI) notes that numerous internal and external forces help create “a long list of worthwhile projects and measures, each of which makes sense on its own. However, the collection of projects is less likely to make sense as a coordinated whole aligned with the strategic direction of the organization” (Nolan, 2007, para. 1). When this proliferation of loosely related, local initiatives succeeds at its respective local levels, it provides little stimulus for the divisions or departments which incorporate them to ensure they also fit within the organization’s strategic planning – from their perspective, the initiative was a success; it also may make planners hesitant to question that lack of fit, due to an “if it isn’t broke, don’t fix it” mentality.

Another problem with allowing for such decentralization of authority in choosing QI/PI programs is the problem of “spread”: when local initiatives are successful, managers find it difficult to translate that local success to other areas within the organization. As another IHI white paper states, “[a] key factor in closing the gap between best practice and common practice is the ability of health care providers and their organizations to rapidly spread innovations and new ideas. Pockets of excellence exist in our health care systems, but knowledge of these better ideas and practices often
remains isolated and unknown to others” (Massoud, Nielsen, Nolan, Schall, & Sevin, 2006, p.1). A key balancing point in hospitals is realizing the benefit of innovation through decentralized initiatives versus the need to align the initiatives to a central strategic direction. Achieving this balance allows for improvement at both local and organizational levels, and allows for greater spread of local innovation because the innovation is tied in to a shared, common perspective. If the slow rate of improvement in our healthcare system is a reliable indication, then this balance is not adequately maintained.

The Disconnect between Strategic Planning and Implementation

In their book Execution (2002), longtime AlliedSignal CEO Larry Bossidy and noted business scholar Ram Charan note that, “[i]n its most fundamental sense, execution is the way of exposing reality and acting upon it” (pg. 22). Of course, exposing this reality is easier said than done: the sheer complexity of modern healthcare organizations makes it difficult for leaders to be cognizant of all of the separate “realities” of the organization and how these realities combine to provide a useful perspective for planning efforts going forward. A useful analogy for this complexity is provided in Steven Spear’s Chasing the Rabbit, where he tells us that, for a group of teenagers to refurbish a car from the 1960’s to working order, all that would be necessary was that they had the right tools and that they were “competent at metalwork”: meanwhile, to attempt to refurbish a modern car, with its advanced computers, polymers, electronics, etc., it would require “not only advanced degrees in materials science, pyrotechnics, combustion engineering, dynamic controls, electrical engineering, and computer science, but [also understanding] how these fields work together…” (2009, pp.36-38)

Spear’s point is that, in today’s complex systems, “bringing the pieces together is a discipline in its own right. The better you are at it, the closer your organization’s performance is to [its] potential... The worse you are at it, the farther off the curve you are” (p.39). In order to “bring the pieces together,” it is imperative to adopt a systems approach – that is, to determine how the whole of the organization is made up of the sum of its parts. Swayne, Duncan, and Ginter (2008) note that using a
A systems approach allows planners to take in the “big picture” by seeing how the major components of the system come together, and not get bogged down in the lesser aspects of the organization (p.23).

This helps define the system, which can facilitate decision-making on its own; however, seeing how well all the pieces come together also helps determine how an organization compares to its competition: as noted strategic management scholar Michael Porter writes, “[S]trategic fit among many activities is fundamental not only to competitive advantage but also to the sustainability of that advantage. It is harder for a rival to match an array of interlocked activities than it is merely to imitate a particular sales-force approach, match a process technology, or replicate a set of product features” (“What is Strategy?”, 1996, p.61).

If leaders of complex organizations don’t put forth the effort to gain a systems perspective, they risk missing the key areas in which the implementation of their plans will falter. Bossidy and Charan (2002) argue that implementation (or, in their parlance, “execution”) is often shunned by strategic planners, mistakenly viewed as residing within tactical or operational realms; in reality (p.21-22):

Execution is fundamental to strategy and has to shape it. No worthwhile strategy can be planned without taking into account the organization’s ability to execute it... Execution is a systematic process of rigorously discussing hows and whats [sic], questioning, tenaciously following through, and ensuring accountability. It includes making assumptions about the business environment, assessing the organization’s capabilities, linking strategy to operations and the people who are going to implement the strategy, synchronizing those people and their various disciplines, and linking rewards to outcomes.

To meet those criteria when implementing strategic plans, it would seem that the need for leaders and managers to employ a thorough systems approach would be self-evident. Unfortunately, this does not appear to be the case: Bossidy and Charan (2002) claim that “[t]ypically the CEO and his senior leadership team allot less than half a day each day to review
the [strategic] plans... Typically too the reviews are not particularly interactive. People sit passively watching PowerPoint presentations. They don’t ask questions” (p. 22). This seems to indicate that strategic planning is more of a function that leaders feel the need to perform by rote than an actual effort at gaining a systems perspective: this lack of effort can be one reason why there is a disconnect between planning and implementation. Another, according to healthcare speaker Joe Flower, is that strategic planning in healthcare reflects the “needs and desires of individual decision-makers” who are not incentivized to incorporate other views or demands into their planning (“Health Care as…, 2009, para. 17).

Viewed through this lens – a lack of systems perspective – it is fairly easy to assume that quality- and performance-improvement initiatives don’t pan out, or live up to their potential, because the effort isn’t made on a senior leadership level to tie these initiatives to the needs and goals of the organization as a whole. The question is, how does management adopt such a perspective?

**Using Alignment to Guide Implementation**

**The “7S Model” for Strategic Implementation**

One answer to how leadership can develop a systems perspective can be found in implementation models such as the well-known “7S” model advocated by McKinsey & Company, in which each “S” denotes a particular element of the organizational environment which can affect the implementation of the plan. Three elements are considered “Hard” elements – easily definable, and therefore easily manipulated by the organization: these elements are the *Strategy, Structure, and Systems* of the organization. The other four elements are considered “Soft” elements – those which are abstract, more resistant to definition, as they are intangible and dependent upon the culture of the
organization: these elements are *Shared Values, Style, Staff and Skills* (Mindtools, “The McKinsey 7S Framework”, para. 1-7).

As Gopinath and Siciliano (2004) state, and as the following figure illustrates, “[t]he basic message of the model is that (1) many factors exist that determine an organization’s success; (2) all of them must be in alignment with each other; and (3) they are all equally important. Since all factors are equally important, there is no start or finish to the model” (p. 114).

**Fig. 3 – The 7S Framework**

One could convincingly argue that, even if all of these elements are equally important, the “soft”, cultural aspects of health care require a different sort of attention than in most other industries: the culture of a hospital simply has different traditions, moral and ethical underpinnings, societal expectations, and professional status considerations than that of a manufacturer, or a cellular service company, or an investment bank. These cultural aspects of health care organizations are unique enough to suggest that, regarding any strategic program implementation in general, and certainly an
improvement effort, in particular, these “soft” elements require a higher level of consideration than in other models.

It also could be argued that there is considerable overlap between these elements, which is reasonable due to their intangible qualities. For instance, per Gopinath and Siciliano (p. 113), “Staff” refers to the human resources of the organization while “Skills” regards the organizational capabilities. Are these really two separate entities, or are “Skills” just one of many human resources? As for “Style,” the authors claim this is defined by the “values and beliefs” of the organization, whereas “Shared Values” are the “abstract guiding concepts...shared by most employees.” Isn’t one just a natural continuation of the other – are they really separate, distinct elements?

The purpose of the line of questioning is to introduce a new idea: that the element “Shared Values” should really be called “Shared Vision.” A shared vision is more distinct, and goes beyond a guiding concept, a value, or a belief: it could be defined as a comprehensive understanding, acceptance, and endorsement of the strategic direction by the organization’s culture. None of the existing elements address these ideas specifically: it is assumed that these elements will grow organically from the other soft elements should they be properly attended to. This is incorrect – it assumes that a shared vision can be manufactured or fabricated by following a process, or by plugging the correct variables into an equation. It is a classic example of the wrong-headedness of most management techniques: it describes a shared vision as something that is created when we incorporate our organization’s culture into our strategic plans. Does incorporating sound like sharing to you?

This isn’t merely a question of semantics. As will be seen throughout the rest of this paper, the organizations that have made the greatest strides in quality and performance improvement are those which have not made or created a shared vision, but have allowed one to develop by achieving that centralized/decentralized balance discussed earlier.
The Role of Culture in Healthcare Quality and Performance Improvement

Health care quality improvement pioneer Avedis Donabedian developed a conceptual framework in 1966 for evaluating the quality of health care: that the *structure*, or organization, of health care, combines with the *process*, or method of delivery of that care, to define in the *outcomes*, or results that that care achieves (pp. 166-172). This model has been cited countless times in health care quality measurement and improvement literature and education over the years.

Provonost, et al. (2006), argue that a fourth dimension to Donabedian’s model could be *culture*, or “the context in which care is delivered” (p. 1601). By this, the authors argue that culture plays a part in the many variables that effect patient safety outcomes, such as teamwork, staff’s level of comfort in raising concerns, and so forth (p. 1602). The authors urge that organizations should measure their knowledge, awareness, and ability to self-analyze by utilizing performance criteria that reflect these cultural attributes (p. 1602-1603).

The importance of addressing the culture of the organization cannot be overstated. Obtaining alignment between the wants and needs of the internal stakeholders and the strategic goals of management is crucial to the successful implementation of QI/PI initiatives; unfortunately, organizations may feel pressured to “give in” to the demands of these stakeholders. This relates to the earlier statement that it is imperative to maintain a balance between central strategic planning and local innovation: Shortell, Bennett & Byck (1998) note that a cultural obstacle to quality improvement arises “when organizations look inward to the needs of their professionals, rather than outward to the needs of their customers, or when physicians do not become involved because of inexperience or resistance to working as members of teams, or because they perceive that CQI [continuous quality improvement] is primarily a cost-control mechanism” (p.608). Yet, the authors also note that, “[s]trategically, the main obstacles are an inability to select goals that would clearly fit into the
organization's strategic priorities and failure to make quality improvement work a central part of organizational planning.” (p.608)

This delicate balance is further confused by the fact that, although a strong aligning principle is necessary to maintain the strategic fit of QI/PI initiatives, a strong, centralized operational approach to applying QI/PI is actually detrimental to the program’s potential: Shortell, et al., (1995) found that a positive correlation existed between organizations with “group” (teamwork-related) or “developmental” (innovative) cultural types and effectiveness in QI programs, but not in “hierarchical” (bureaucratic) or “rational” (efficient) organizations (p. 395).

Fig. 4 – The Four Cultural Types

These findings provide two key insights that organizations must take note of. First, the authors note that “larger size health care organizations, which tend to be more hierarchically and bureaucratically organized, face particular challenges” (p.395). This is, they argue, because QI favors decentralized, flexible approaches to centralized, top-down approaches (p. 397). They further state that “specific plans to improve quality (i.e., strategic quality planning) by those who can do something about it and providing people with the tools and authority (i.e. empowerment and training) to carry out
quality improvement work appear to be most consistently associated with superior clinical efficiency” (p.397). One critical area that this finding should be applied to is when planning the structures and coordination of an ACO-type model, especially in regard to QI/PI.

Second, the authors advise that culture has more of an effect on quality improvement than the completeness and comprehensiveness of the improvement tools and methodologies the organizations choose to use (p. 397) – the obvious implication being that it is far more important to ensure a complete understanding of organizational culture than a complete understanding of total quality management, Six Sigma, or Toyota Lean. This finding was reinforced by a study in 2006 that determined that employee commitment and employee control initiatives were a more accurate predictor of quality improvement than the adoption of quality practices (Gowen, Mcfadden, Hoobler & Tallon p. 772).

Recent research, however, claims that our assessment of culture’s impact may be overstated. In 2007, a British study published in Family Practice found a predictive relationship between culture, climate and quality in 1998 study of small primary care practices, but did not see a predictive relationship in an expanded study in 2003 (Hann, Bower, Campbell, Marshall & Reeves, pp. 326-328). There are some caveats that must be considered with the study design – the studies used a limited set of criteria, and the data was gathered from snapshot points in time, but the finding is still curious. One explanation that the authors offer is that the larger practices included in the second study did not fare as well – as previously noted, larger organizations tend to struggle more with quality improvement due to their bureaucratic nature. Another explanation, one not provided by the authors, is the problem of sustainability – once an organization has successfully implemented a quality improvement program, how does it ensure that the program continues to meet its strategic and operational goals in the years that follow?
Sustainability and implementation are separate, but related, functions that speak to the “spread” problem mentioned earlier. One way to address this problem is to address the need for both vertical and horizontal alignment. Kathuria, Joshi, and Porth (2007) state that horizontal alignment refers to the “coordination of efforts across the organization and is primarily relevant to the lower levels in the strategy hierarchy” (p. 505). The authors then state that horizontal alignment occurs in two ways: cross-functional integration, referring to the “consistency of decisions across functions ... so that activities and decisions across marketing, operations, HR, and other functions complement and support one another”; and intra-functional coordination, or “internal fit”, where there exists “coherence across decision areas ... within each function” (p.505). The authors argue that at the both horizontal and vertical alignment must occur at this intra-functional level in order to for successful implementation (p.505), but it is logical to assume that this extends to sustainability as well. Regarding shared vision, the evidence we are presented of its importance and impact is often anecdotal. Horizontal alignment research could ultimately provide a deeper understanding of the effect of a shared vision on organizational performance; unfortunately, the authors state that most research has been limited to only focusing on two distinct functional areas within an organization (p. 508-509).

The Missing Element – A Shared Vision

Reading through the evidence of culture’s effect of Quality and Performance Improvement, what conclusion can be drawn that explains the important role culture plays? While any of the “soft” elements – “Style”, “Skills”, “Staff”, and “Shared Values” – can (and do) figure into the picture, the key aspect appears to be a “Shared Vision.” This element threads its way through each example or finding provided because, while they all impact alignment, it is the latter that most directly and concretely speaks to alignment. In fact, based on what has been covered up to now, it seems that a logical
progression forms where we can assume that alignment is the key to successful implementation, and a shared vision is the key to successful alignment.

**Fig. 5 – The Root to a Successful Implementation**

But what, exactly, is a shared vision? The definition provided earlier, and any other definition that we immediately come up with upon being posed the question, is likely to be insufficient: the application of such an expansive idea covers too broad a spectrum. In fact, Peter Senge, author of *The Fifth Discipline*, argues that even calling it an “idea” is insufficient: “A shared vision ... is a force in people’s hearts, a force of impressive power. It may be inspired by an idea, but once it goes further ... then it is no longer an abstraction. It is palpable. People begin to see it as if it exists. Few, if any, forces in human affairs are as powerful” (2010, Chapter 10, para. 4) [electronic format: see bibliography entry for details]. It must be said: if we agree with the statistic that healthcare quality only improves at about 2.3% per year, then Senge’s use of words like “impressive,” “powerful,” and “palpable” do not seem applicable to the current state of quality and performance at most hospitals.
How do we change this? How do we take this element – a shared vision – and apply it to healthcare improvement strategies? As previously discussed, as an intangible element, it can’t be “applied,” but it can be fostered by creating an environment that allows for it to come about. While the requisite attributes for a shared vision may be open to opinion or interpretation, leaders and managers can take cues from successful organizations that appear to be properly aligned to an improvement strategy, apply the lessons learned to own organizations. A review of the recent literature and case studies suggest three prominent themes arise repeatedly in such high-performing organizations:

- **Shared Accountability** – ensuring accountability from all stakeholders, including the highest levels of leadership
- **Shared Goals** – deploying strategic goals in a manner that employs a systems perspective, providing a central aligning principle while allowing, if not encouraging, local innovation;
- **Shared Language** – a common understanding of data: its importance, uses, definitions, and the need for standardization

*Fig. 6 – Three Proposed Integral Factors for Developing a Shared Vision*
The Three Integral Factors in Developing a Shared Vision

To address these three factors adequately, strategic planners must step outside their traditional role and act not only as planners but as facilitators – creating an environment in which the overall strategic direction is planned by stakeholders across all levels of the organization. However, the first place to start should be the level at the top – the board.

Shared Accountability: Getting the Board Involved in Improvement

From 2006 to 2008, IHI ran its “5 Million Lives Campaign,” a follow-up to the previous “100,000 Lives” campaign, with the stated goal of preventing five million instances of patient harm over the two-year period. According to senior vice-president James Conway, “… the campaign has recommended 12 interventions. The only nonclinical intervention is to fully engage the governance leadership in quality and safety, more commonly known as ‘Getting Boards on Board’” (p.211 – emphasis added). It is noteworthy that IHI placed such importance on governance; when we review the five functions that Conway recommends boards undertake (pp. 216-218), we notice that they address many of the deficiencies previously noted in this paper:

- Set strategic aims
- Gather data (including patient stories)
- Setting and monitoring measures
- Organizational learning
- Establish executive accountability

Hospital boards have largely gotten the message: researchers at AHRQ note that roughly 80% of hospital boards provide quality oversight, and about two-thirds utilize an actual QI committee (Jiang, Lockee, Bass & Fraser, 2008). They also note that this level of involvement and oversight is beneficial: their research concludes that mortality and process of care better in hospitals with boards that exhibit the following behavior or structures (Jiang, Lockee, Bass, Fraser & Norwood, 2009):
• Board-level quality committee
• Board-established quality improvement strategies
• Setting quality agenda
• Quality topics at board meetings
• Dashboards with benchmarks/KPI’s
• Linking senior leadership performance evaluations to quality criteria

Obviously, these criteria are strikingly similar to Conway’s advice. Still, with all of the mounting evidence indicating that this is the right path for boards to take, that advice is still not universally accepted. Current research (Ford-Eickhoff, Plowman & McDaniel, 2011) shows that many boards are reluctant to engage beyond the “mentoring and advisory” roles traditionally held. This means that boards have little input on the early stages of strategic planning process (identifying and clarifying areas of opportunity, challenges, etc.), instead only impacting the result-oriented aspects of the process (generating alternatives, making a choice) (p.146). By taking such a passive role, boards obviously lose out on the opportunity to frame the strategic direction of the hospital, especially in terms of quality and performance; however, they also miss the opportunity to frame how they are kept informed of how the improvement initiatives develop. Not surprisingly, framing how quality-improvement information is passed to the board has an actual effect on how well those improvement efforts go: research from the Journal of Patient Safety determined that there was a positive correlation between having frequently-reviewed, board-level dashboards of shorter content, and higher quality of care (Kroch, et al., 2006). The authors pose that this tighter focus allows for more actionable findings (p.18). This indicates the need for the board to be in on the development of dashboards, as this would be integrated with the strategic planning of the organization.

Another benefit of boards seeking greater involvement in quality improvement is that the action may help other internal stakeholders seek greater involvement as well. Researchers (Weiner,
Alexander, & Shortell, 1996) have previously shown that physicians are often resistant to organizational quality improvement efforts due to concerns about hospital motives, time constraints, and the effects of reducing variation on patient care: however, active physician participation in governance led to increased likelihood of advocating quality improvement practices. The researchers attributed this to the development of a “shared vision” over the course of time as physicians, board members, and management interact (pp. 410-411).

That finding is integral to IHI’s idea of “Getting Boards on Board.” By showing QI/PI to be a priority, the board simultaneously encourages participation and accountability across the system as a whole. But, again, it doesn’t “create” a shared vision: rather, it creates an environment from which the growth of participation and accountability allow for a shared vision to develop.

**Shared Goals: Balanced Scorecards**

Balanced Scorecards are tools traditionally used in industrial settings to provide managers with information regarding assets and performance. In the 1990’s, Harvard Business School scholar Robert S. Kaplan and David P. Norton, president of the Balanced Scorecard Collaborative, Inc., became convinced that balanced scorecards could serve as a strategic implementation tool in service industries such as healthcare (Swayne, Duncan & Ginter, 2008, p.378). The “balance” found in the scorecard is the inclusion of performance metrics from a set of “perspectives” – financial, customer, internal process and innovation, and employee learning and growth. Every measure of every perspective is linked to the strategic plan of the organization – this is what makes a balanced scorecard not just a simple reporting tool, but a tool with the ability to link the strategic plan to implementation (McLaughlin & Hays, 2008, p.76).

One of the benefits of using the balanced scorecard approach is that its flexibility allows it to be used effectively at any organizational level. An example to illustrate this can be found in the United Kingdom’s National Health Service (or “NHS,” their counterpart to our Department of Health and
Human Services). The NHS was among the first to embrace balanced scorecards as a way to monitor performance across the entire healthcare delivery system. With high costs as the primary driver, NHS developed a strong national framework in the late 1990’s for performance improvement, and utilized scorecards as part of their Performance Assessment Framework (PAF). Similar to standard use, the PAF scorecards sought to measure four perspectives: service user, internal management, continuous improvement, and financial (taxpayer’s) perspectives. With these perspectives in mind, NHS chose to monitor six performance areas that were linked to their strategic aim of improving care while reducing cost (Arah, Klazinga, Delnoij, Ten Asborek & Custers, 2003, pp. 377 - 398):

- health improvement
- fair access
- effective delivery of appropriate health care
- efficiency
- patient care experience
- health outcomes of NHS care

[As an aside, compare the NHS areas of measurement with the six aims of IOM’s Crossing the Quality Chasm: Safe, Effective, Patient-centered, Timely, Efficient and Equitable (2001, pp. 2-3).]

In an example more relevant to this discussion, administrators and physicians at the Mayo Clinic (Curtright, Stolp-Smith & Edell, 2000) chose to adopt a balanced scorecard because the “threat of organizational myopia arises if management overemphasizes one set of indicators. Thus, organizations need to link strategic goals to a limited set of indicators that measure performance across a broad spectrum of categories.” (p.60) The Mayo clinic found that it had more than enough data about financial outcomes, but not enough about the operational performance of the organization (pg. 62). To rectify this, Mayo chose the balanced scorecard approach, in part due to the idea that this approach allows it to revisit the organization’s vision and key strategic principles, develop performance
categories based on those principles, and then develop measures that best inform on how well the clinic performs in each of those categories (pg. 62-65).

Duke University Hospital (Meliones, et al., 2008, pp. 1-15) provides an excellent example of how to use a balanced scorecard as bridge between strategic planning and performance improvement. Senior management modified the balanced scorecard slightly, choosing to use the perspective “Quality and Patient Safety” rather than “Internal Business Process”, and replaced “Learning” with “Work Culture”. Then, management chose specific operational metrics that met the strategic aims of these perspectives. To align staff and faculty to these measures, they used the scorecards all the way down to the unit level. Finally, Six Sigma and Team Training (a communication tool similar aviation’s Crew Resource Management) were instituted and utilized to reduce variation and waste, and improve communication and education.

**Fig. 7 – Using Balanced Scorecards to Link Strategy to Implementation**

Using the Balance Scorecard as a roadmap, Duke University Hospital was able to effectively target its PI initiatives based on organizational need: the Hospital has seen its net margin more than double since inception, while improving safety (i.e., 44% decrease in adverse drug effects), efficiency (i.e., 38% increase in discharge efficiency), and reducing risk for adverse moderate sedation 3 times over through the use of Six Sigma, and increasing the staff’s perception of the quality of communication dramatically (pp. 6-8).
As the Duke University Hospital case illustrates, balanced scorecards do not have to be rigid in their application – in fact, if the whole point is to use them to monitor the unique strategic goals that an organization develops, it only stands to reason that hospitals can change the perspectives of the scorecards to meet their strategic planning needs (although care should be taken to ensure that the change does not omit critical strategic areas).

Shared Language: Managing Data Quality

If Senge’s assertion is true, that a shared vision may be inspired by an idea but transforms into something beyond an abstraction, then his assertion implies that a vehicle must be present to allow such a transformation. That vehicle is almost certainly communication: in the realm of industry, with large, complex organizations and diverse cultures, the most common and most effective form of communication is data. For healthcare QI/PI, this holds even truer. None of the stories or evidence presented thus far can be told without data: it is the shared language that we all rely upon.

The obviousness and totality of this reliance, therefore, makes it striking that we also use data so poorly. An Australian/New Zealand study found that the cost of poor data quality could be as high as 10% of organizational revenue (Malcolm, 1998). A reason for this may be that executives understand the business, but do not understand the data: to mitigate this, they rely on analysts, who understand the data, but do not understand the business (Nichols, 2010).

A perfect example of the implications of not comprehending data, or ensuring sound data quality, can be seen in the example of Tufts Medical Center. By the end of 2003, the hospital (then called “Tufts-New England Medical Center,” or Tufts-NEMC) was faltering financially and had resolved to change leadership and bring in Ellen Zane as their new CEO. Zane accepted the position and walked in under the impression that, although the hospital was losing roughly $3 million a month, it still had about two years of cash on hand; she was dismayed to learn that Tufts-NEMC was in fact losing about
twice that figure, and that she had only about 10 months cash on hand. This new reality forced Zane to immediately change her priorities: “… strategy was the last thing I could worry about – I had to worry about payroll… It was incredibly important to begin to think about how to stabilize” (Ingalls & Brem, 2006, via Swayne, Duncan & Ginter, 2008, pp. 555-556).

It is a fair question to ask how an organization can be so far off in its understanding of its financial health. A more relevant question might be, if such a lacking of comprehension and self-awareness can occur in an established, renowned academic medical center, in the heart of one of the most competitive health care markets in the country, then what confidence should we have in the level of self-awareness in hospitals in general?

Data quality obviously doesn’t only apply to the financial aspects of healthcare: quality and performance improvement require sound data to determine both the need to establish a program, and the efficacy of the program once it is implemented. It is the backbone of Shewart Cycles, Six Sigma, Lean, CQI, and every other improvement methodology; it is also the backbone of the Balanced Scorecards we all should use to ensure that are efforts are properly aligned, measured, and reported; it is also the backbone of engaging the board in improvement strategies, by communicating the need in terms of its effect on patient care and satisfaction, reimbursement opportunity, and general overall health of the organization as a whole.

Data quality also plays heavily into healthcare reform. Hospitals will be increasingly accountable for reporting their data – this reporting will be used to assess the value they provide, which not only effects reimbursement (as if that weren’t enough), but also perceived value and quality in the public, where more and more patients are becoming consumers, a trend encouraged by private insurers, employers, and government alike. Hospital data is no longer an internal form of communication between leaders, managers, doctors, nurses, and staff; it is also no longer a form of communication to a select few interested external stakeholders like regulators, researchers, and
Hospital data is now becoming a statement of value to the market, and the leading indicators of value are quality, safety, and efficiency.

With so much at stake, it is surprising – and concerning – that there exists such a paucity of relevant research regarding the quality of data in healthcare. There is considerable argument over how to interpret it, but very little attention to researching best practices on how to collect it, analyze it, manage it, standardize it, teach it to staff and providers... This situation is almost certainly attributable to the nature of data: it isn’t “sexy”; it is, at times, dense and difficult to understand; it is also often difficult to communicate its importance to others. The final problem is that, much like implementation in general, it is often relegated by leaders to operations planning and management. This is a mistake. As Bossidy and Charan have stated, strategic leaders and planners need to know both the “hows” and the “whats”: data is both “how” we know “what” is wrong, and “how” we know if “what” we implemented to fix it has worked. It is the core of any type of planning, and the comprehension of its meaning, importance, and use must be shared before any shared vision can develop.

An example of an organizational understanding of the importance of data can be found in Geisinger Health Systems in Pennsylvania. In 2009, leading up to his push for health care reform, President Obama cited Geisinger as one of the high-quality, low-cost models that our health care system should aspire to (White House Press Secretary, 2009). Geisinger itself states that “[c]entral to nearly all Geisinger innovation is the use of the EHR and data infrastructure to automate care, remove geographic barriers, empower consumers, and improve reliability” (Paulus, Davis & Steele, 2008, p. 1244). Geisinger cites as examples: EHR access for all stakeholders, including consumers; performance monitoring and tracking, and; building the business case for quality improvement. By establishing data as the core of its innovation, Geisinger provides an aligning principle that everyone, from top to bottom, must recognize in order to improve.
To achieve this, Geisinger’s leadership almost certainly must have developed what can be termed a “data strategy” to allow for such an infrastructure to evolve. Kerr, Norris, and Stockdale (2008) state that businesses need a “data strategy” to develop “an organization-wide policy on data management that regards data as a crucial business resource and requires that accountability for data quality and utility reaches to the highest levels of the organization” (p.260). The reason for a data strategy is to avoid a disconnect between the strategy the organization develops and the data it gathers to support it – it can be ill-fitting, inaccurate, incomplete in that it does not include data from all available resources.

Fortunately, strategic planners and leaders have a framework at their disposal to determine what constitutes good data – the American Health Information Management Association (AHIMA) provides in the following “Data Quality Model” the characteristics for managers to review (paraphrased) (via Wager, Lee & Glaser, 2009, pp.47-53):

- Accuracy – correct, valid values
- Accessible – readily available to decision-makers
- Comprehensive – completeness of data collected for a specific use
- Consistent – use of formats, abbreviations, terms, etc.
- Current – up-to-date
- Well-defined – the data is defined in a manner in which everyone understands its meaning or relevance
- Granular – atomic, cannot be further sub-divided
- Precise – numerical values not calculated incorrectly or rounded inappropriately
- Relevant – data must have a relevant connection to the purpose for which it is collected
- Timely – the ability to get the right data at the right time
It is necessary for strategic planners to engage internal stakeholders in an open discussion as to how well the data that is used to support planning and decision-making (and later, monitoring) fits with the AHIMA criteria. The decisions that these leaders make are highly-committal, in terms of both duration and resource allocation; to make such commitments without having such a discussion is in and of itself risky. However, in terms of quality and performance improvement initiatives, taking the time for this discussion provides allows all parties to weigh-in and provide input and feedback on not only the data strategy itself, but how that data strategy relates to the other factors of a shared vision. This will provide some additional benefits that strategic planners otherwise miss out on. For instance, having the discussion allows for all parties to present how the unique characteristics of their respective areas of expertise will impact the data strategy – this can help leaders develop a systems perspective for determining how all of the pieces will fit together under the strategy. The discussion also provides an opportunity for unit and division leaders to possibly improve on the strategy by discussing their own current initiatives, what data approaches they are utilizing: this discussion can encourage the spread of innovation. Discussing how specific measures are to be utilized in performance reviews helps reinforce accountability. Finally, it gives the units and divisions a clear understanding of the overall strategic direction the organization is seeking.

**Conclusion – The Patient Perspective**

No true systems perspective can be achieved without taking in the perspective of the patient. When discussing and debating why the progress in healthcare improvement remains so slow and incremental, it could be argued that a lack of urgency exists among the stakeholders. Viewing the problem from the patient’s perspectives can help to essentially “rephrase the question” whenever stakeholders get caught up in the minutiae of the strategy. It also helps disparate groups find a
common ground: regardless of our roles and professions and ideals, the one thing we share in common is that, at the end of the day, we are all patients.

The next time leaders begin to plan a strategy for a quality improvement initiative, they should follow the guidelines previously mentioned in this paper; however, at the end of that first meeting to lay this groundwork, the discussion should end with a focus of the patient experience. For instance, if the meeting runs for an hour, then the meeting should end not with a summary of what has been accomplished, but a reminder that, during that hour-long meeting, an average of 10 people in this country will have died from a hospital-acquired infection (Klevens, et al., 2007).

This urgency may be the necessary catalyst to spur the needed change in our healthcare delivery system. With all of the time, energy, and resources we have brought to bear on increasing quality and performance in hospitals, it is time to rightfully conclude that effort and planning are, each taken alone, insufficient. Strategic planning of quality and performance initiatives in healthcare must incorporate a greater emphasis on how those plans may be realized, and the only way to accomplish this is for planners to accept that traditional ideas and practices regarding strategic planning must be put aside, and that a concerted effort must be made to widen their perspective to a system level. The best way to accomplish this is to adopt practices that allow a shared vision to develop, and the first step in creating such an environment is to allow stakeholders from all levels of the hierarchy, from the board to the unit, to become strategic planners as well.
Bibliography


