

A paradigm-free period? The deceptive pause in strategy

Jeff Goldsmith

For centuries, American Plains Indian tribes enjoyed a close relationship with the buffalo. (It probably wasn't all that enjoyable for the buffalo.) Every part of the buffalo-meat, bones, hide-found its way into some aspect of Indian life. But killing one was a challenge. Before Native Americans obtained weapons of mass destruction from the white man, they had to hunt the buffalo on foot and from horseback. Indian braves found the most efficient way to kill them was to dress in buffalo robes, and run toward the edge of a cliff. The buffalo would stampede right off the cliff, vastly simplifying the hunting process. These braves were probably the first management consultants.

For most of my career in strategy, hospitals and health systems behaved a lot like a herd of buffalo- it wasn't a pretty sight. Because they lacked confidence in their own personal experience and judgment, CEOs often took their strategic cues from what their competitors or peers in other states were doing. The herd would start moving, and eventually thunder off a cliff. Many of these stampedes-diversification, health plan start-ups, competing against primary care physicians, merging with bitter competitors-ended in predictable pileups at the bottom of the cliff.

Beware "the Twaddle Echo Factor"

What passed for strategy was actually guided imitation facilitated by expensive external advisors including attorneys, investment bankers, and consultants, who validated the need for and direction of the stampede- and often profited from cleaning up the wreckage at the bottom of the cliff. Health information technology expert J.D. Kleinke's marvelous phrase, "the Twaddle Echo Factor" (theoretical industry trends that morph into hardened "facts" by mindless repetition), neatly captures the mixture of unreality and self-deception in this process. No wonder strategy has gotten a bad name.

What is eerie, and wonderful, about the present moment in healthcare is the near-total absence of the sound of hoofbeats. It is a "paradigm-free" period-a deceptive calm pervades the healthcare landscape. Many of the threats that motivated herdlike behavior-health reform, Columbia/HCA, the physician practice management firms, managed care plans-either collapsed under their own weight or were defeated by the dogged, rear-guard actions of hospitals and systems.

Moreover, after a lot of hard work, industry fundamentals seem to be improving. Cash flow seems to be strengthening. Improved Medicare payment and a tougher bargaining stance with managed care plans has paid off in improving unit revenues. A more aggressive focus on expense control has enabled many health systems (investor-owned chains first, then non-profits) to restore or improve their operating margins. One is tempted to ask the question: Is a strategy required at all, or is it merely enough to restore cash flow and morale and "get the trains to run on time?"

However much executives may talk about it, hospitals and systems are a long way from operational excellence-the systems and skills needed to realize it are still not in place in many organizations. The embarrassing and politically inconvenient spread between investor-owned and not-for-profit financial performance is not solely attributable to more fortunate locations and aggressive pricing by investor-owned companies, but to a more demanding operating philosophy, and the systems to support it.

But, even if the trains can be made to run on time, they are still headed in the wrong direction. Hospitals have two critical weaknesses, and addressing them meaning fully will not be possible without achieving strategic consensus among the hospital's diverse constituencies.

Fundamental changes are essential

Many hospitals are almost laughably customer unfriendly. But more importantly, they are also unacceptably dangerous places. Addressing these two challenges-becoming truly customer responsive and markedly reducing the risk of clinical errors-requires more than incremental improvements in execution of

basic business processes (which, do not mistake me, are essential). The reality is that addressing these two critical weaknesses in hospitals requires a fundamental transformation of systems, work processes, and culture.

Doing this will require a redirection both of capital and of management resources-something that may be possible without strategic planning, but, realistically, will be extremely difficult. Further, because there is no accepted industry template, and no set of prepackaged consulting products that can achieve either goal, creative effort and leadership will be required to accomplish them. Unless they are top priorities of boards and senior managements, they simply will not happen.

Despite the rhetoric about becoming more consumer-focused, at best, most healthcare organizations pay mere lip-service to consumerism. There is still a powerful hangover from a decade of largely unsuccessful "business to business" strategies that treated consumers as "lives" to be acquired whole sale in blocks of ten thousand, like sides of beef. Meanwhile, health professionals and their administrative counterparts in many institutions continue treating patients like children, and family members like interlopers in the care process.

More importantly, however, many hospitals are unacceptably dangerous places. In 1999, the Institute of Medicine's report in its landmark study, *To Err is Human*, that hospitals kill between 50,000 and 100,000 patients a year was greeted with a chorus of denial: "The studies are flawed" (probably true), "It's really only 30,000," "Not in our place!" or "This isn't New York, it's Connecticut" (or Oregon, or North Dakota, or...).

Unacceptable variations in the technical quality of care between practitioners, between nursing units, between shifts, are things one hesitates even to measure-because the reports are "discoverable" in malpractice litigation- let alone do something about. Powerful tools like medications are sometimes wielded like blunt instruments, rather than complex, precision-guided munitions. In many institutions, infection control is something that receives rapt attention around the time of Joint Com mission surveys, and a mere nod the rest of the time. Credentialing is often social, and not skill-based.

There are lots of bureaucratic excuses for not treating patients with the same standard of safety that we'd want for our own family members, yet none of them hold any water. And, when the insiders or their family members get cancer or need coronary bypass surgery, how do they behave? In all too many cases, they will not hesitate to slink quietly out of town, to M. D. Anderson, or the Mayo Clinic, to receive their care, leaving systemic problems and weaknesses unaddressed.

Addressing quality of care

What needs to be done about these things? The customer friendliness problem is easier to address. Effective financial and clinical information systems will go a long way toward remedying some of the problems here. Something can be done about the repetitive requests for information, multiple registrations for the same visits, billing systems riddled with errors, medical records not showing up in time for clinic visits or admissions, or other systems problems.

However, to say that customer unfriendliness is a systems problem that can be remedied by aggressive digitization of financial systems and installation of customer relationship management software ignores the cultural underpinnings of this problem. "Patients" too often means "people who wait." Famed health services researcher Odin Andersen's image of the patient as a "breathing brick" is deeply ingrained in the culture of healthcare provision. How many baby boomers fit this description? How many of us will tolerate being treated this way ourselves?

We can train clinical staff and patient-facing administrators to treat patients like customers. We can aggressively measure the results in exit interviews with patients and family members. And we can tie bonus compensation and other, nonfinancial awards, such as recognition, to improvements in the customer's experience. The most important overlooked feature of General Electric's- originally Motorola's-famous "Six Sigma" process is the need to establish the critical aspects of the service experience from the customers' point of view, and set performance improvement targets based on what they tell us.

Improving safety is more complex for hospitals than it is for airlines, banks, or semiconductor manufacturing plants. But the fact that anesthesiologists achieved a 90% reduction in anesthesia death rates, to near Six Sigma defect rates, in the 1980s and early 90s should suggest that the "healthcare is different" excuse one hears so often is nothing more than arch-twaddle-the defense of an indefensible status quo.

We can learn from Don Berwick's work at the Institute for Health Improvement that making hospitals safer may be a function of changing seemingly mundane processes like scheduling and clinical information flow, rather than of an institutionwide "jihad" against incompetent practitioners. Lucian Leape's work tells us that culture change, and a diligent search for the systemic problems of communication and coordination that place patients at risk, is the key to improving quality.

Information technology will help here too, as "intelligent" electronic medical records, computerized physician order entry, and sophisticated clinical decision support, including customized practice guidelines that practitioners develop themselves, can bring about a safer and more coherent response to patient needs.

However, systems investments are insufficient by themselves. Better systems will not make people collaborate or share information, nor will they improve morale and work skills, or break down departmental tensions and rivalries. Many of the intangible ingredients of a safer healthcare experience require changing the culture and work of care providers, and sometimes the care providers themselves.

Balancing systems and facilities

Hospitals continue to lag in IT investment. Healthcare capital spending plans remain biased toward concrete over information technology. Hospital executives are under tremendous pressure right now to add physical capacity. They should resist. It is easier to respond to capacity constraints by building more buildings than it is to examine how much of the increased use of ICUs, operating suites, and procedure rooms is really driven by unacceptable variation, poor productivity such as slow room or bed turnover, or clinicians motivated by economics, rather than by documentable clinical need.

Construction projects make everyone feel good, except perhaps the neighbors. The reason may be an as-yet-undiscovered endorphin-stimulating pathway radiating outward from hospital construction cranes. Systems installations and the culture and workflow changes they bring-these are painful to everyone. The experience is more like a root canal or rewiring an automobile engine while it is running. Capital resources are limited, and finding the right balance between physical facilities and systems investments will be a continuing challenge for hospital managements and trustees. Setting this balance is an important outcome of an effective strategy process.

Absent a strategic planning process, it will always be easier for those who defend a mediocre status quo to nestle comfortably among their excuses for not doing a better job. Strategy ought to reconfirm the importance of the clinical mission of healthcare organizations, a welcome correction of the unconscious bias toward financial positioning found in many of the strategies of the 1980s and 1990s. And it ought to set the bar of quality-of the customer's experience and of the objective reality of safe, effective, and appropriate care-higher.

Improving the quality and safety of the patient's clinical experience isn't glamorous-it is hard, messy work. It lacks the "sense of adventure" that a colleague says makes "system building" so much fun. But it may leave us and our society a more lasting legacy. What kind of healthcare experience will we demand for our parents or our children? What kind of experience will be acceptable to us as we age? We ought to be asking, about the myriad of potential strategic alternatives, "Which of these will make a difference that patients and their families will actually notice?"

If we are not delivering care to this standard, ultimately we will pay a political and social price for our inaction, in clumsy and inflexible regulation, a hostile press, and a spate of angry motion pictures. It's a blessing that there are no hoofbeats, no apparent stampede, right now. Instead of blindly following the herd, healthcare managers, trustees, and clinicians are being invited to examine their own products and relationships, and to rededicate themselves to clinical excellence and a dignified, safe patient care experience.

Jeff Goldsmith is president of Health Futures, Inc. (<http://www.healthfutures.net>) of Charlottesville, VA, and a board member of COR Healthcare Market Strategist. He can be reached at 434/979-9524 or at hffutures@healthfutures.net. Christine Malcolm of Computer Sciences Corporation provided helpful guidance and advice on this article.

Reprints of this article are available from <http://www.corhealth.com/asp?RN=MN0204002>