Success Belongs to Those Who Can Manage Money and Quality as Two Sides of the Same Coin

From Common Sense To Health Cents

Tackling A Growing Financial Risk with SQSS

This decade is shaping up to be a time of palpable financial hardship for a lot of healthcare organizations as discretionary dollars for building the future shrink more rapidly, performance demands keep multiplying and too many providers cannot make money and quality work together in support of a stronger bottom line. It is a time where finding the money and manpower to grow the future will be increasingly difficult to do and leadership tenures will become tougher to preserve if those at the top of organizations do not figure out how to manage quality so it is right the first time in business smart ways.

The reality of what this means can be found in the recent story of a hospital that decided to improve its bottom line during financially tough times by engaging in a workforce reduction on the frontlines without thinking about how the work of those removed would still get done. As it was the work of the people removed that created the patient/provider interfaces that fostered patient perceptions of being well cared for and personally cared about, leadership’s decisions made in the context of the “little quality” that continues to dominate industry practices worked against it.

All of the hospital’s major indicators of business health declined. Volumes dropped off. Error rates went up and stories of patient harm grew. Patient satisfaction scores went down. Accusations of poor quality and service dominated social media sites. Revenues shrunk and costs associated with fixing the damage done consumed what little could have been invested in growing the future. When asked how much better off the hospital was because of a plan that did not manage money and quality as two sides of the same coin, the chief executives did not have a lot to say as they updated their references and contemplated their next career moves. Rather than looking for ways to save money while protecting the experiences of their patients so to safeguard the patient loyalty that strongly influences patient volumes and revenues these days, the CEO and CFO dismissed quality as an incidental to achieving their goals and made the hospital’s situation devastatingly worse.

While there was a time that healthcare leaders could dismiss the real role of effective quality programs in business health and get by, evolving market dynamics are making the old-school assumptions that have fostered that disconnect poor business tenets. More intense outside efforts to reduce costs, fewer discretionary resources, more consumer-oriented patients, diminishing public interest in saving providers who cannot save themselves and poor models for managing quality in cost-effective ways are coming together to create the perfect storm that will force a growing number of providers to face financial demise in spite of how hard they work.

Some of the greatest financial risks that now exist for the survival of the average hospital, in the presence of dwindling pots of money that would have historically kept weak organizations alive, are created by a growing reality that hospital leaders can be spending as much as thirty to forty-five cents of every dollar earned on quality activities that deliver too little. They force too many resources to be invested in fixing issues from the past and surviving the present at the expense of being able to grow the future. The approaches make it too easy for leaders to make poor choices that sacrifice money while having no idea the size of the damage they have done until it is too late to undo. The reactive and retrospective nature of practices focused on a list of risks that is too small for what really hurts financial, operational and reputational health just keep growing the financial stressors related to not getting an abundance of things right the first time and not hanging on to desired performance in business smart ways.

These costs, which are commonly referred to as the costs associated with poor quality in the world of business, now hover close to being twice what they should be for health care’s current market dynamics. Because of them, the risk of ceasing to exist grows more rapidly for providers entrenched in past practices because they cannot move their quality-related costs in the direction of twenty cents on the dollar so they can survive and ten cents on the dollar if their business goal is to maintain successful growth patterns.

Leaders will ask the tough questions about what it really means and challenge every old-school assumption that promotes investing too much money and manpower in cleaning up messes and managing quality from behind. They will seek out business smart ways that raise the bar on quality while reducing the cost of doing it without sacrificing what is important to the buying public. They will use Strategic Quality Support System (SQSS) to jump start the moves they need to make and expedite catching up.

Where Do You Spend Your Money?

Fixing the Past
Surviving the Present
Growing the Future
Dollar Spent

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For future opportunities associated with a technologically-advancing industry.

The ability of the average provider to survive, and potentially thrive, in today’s market dynamics is no longer as easy as having a mission to serve, a message of caring and a history of being there. It is also unlikely to be found in asking the American people to pay more, accept a lower standard of care or finally consent to preventable harm being a tolerable consequence of patient care. As a new generation of patients teaches the industry what true consumerism looks like, the environment is quickly becoming one where those most likely to survive will manage money and quality as though they are two sides of the same coin while those that thrive get really good at it.
The Risk Is In the Irony

So much of what now hurts the average health care provider lives in the irony of a series of false assumptions and narratives that hospital leaders accepted nearly forty years ago because of where the industry was at the point in time its technological revolution took off. The perpetuation of these beliefs and practices has produced a thirty-year-old gap between where quality is and where it needs to be for current market dynamics as a focus on cost containment and a new generation of patients willing to travel to get the quality of care they want drastically change the equation for success and how one achieves it. Rose-colored glasses that have not read the fine print for where these narratives and assumptions would take health care if they played out for too long fostered the industry’s stall in the mid-1990s in a quality model that will never be strong enough to protect financial, operational and reputational health because of how little it can achieve and how much it adds to the cost of care.

While quality programs in most industries exist to protect businesses from those losses that can damage them because of problems in the end product they sell, health care’s stalled in a bureaucratic culture that evolved to satisfy a regulatory relationship that is generally counterproductive to finding the more business smart ways that long term survival requires. The effect lives in the story of a hospital that needed to create three more positions to retrospectively review medical records as part of a national project in order to figure out when it was not getting patient care right long after it would be too late to make it right for the patients affected. Because he could only afford to hire one new person, the CEO took two nurses off a patient care unit that worked short-staffed eighty percent of the time. The CEO was asked how it would benefit the hospital to reduce the number of people caring for patients in support of an activity that would always be a day late and safety measure short in getting work right the first time and protecting the hospital from financial and reputational harm. His answer was at the heart of the self-inflicted wounds that now compound the financial stresses that so many healthcare organizations experience as he replied that it was the way it has always been done and is what makes the regulators happy. When he was asked about the piece of the plan for protecting patient loyalty if his approach did not make the patients happy, he had no response.

The business role of an effective quality program is to control for the risks that can threaten financial, operational and reputational health by minimizing the potential for physical, financial and reputational harm while fostering growth in the five critical business outcomes of patient loyalty, new patient acquisition, patient retention, market domination and profitability. This purpose got lost during the early days of health care’s technological revolution in a debate with its regulators and surveyors over what “quality assurance” meant in an environment where the same type of standardization that built a great car could be its own risk for great patient care. Unable to push through the often heated discussions that were fueled by the evolution of a hostile evaluator relationship between surveyors and hospitals who were the primary providers of the time, a dangerous answer emerged. Rather than answering the questions about what QA meant in securing the future of health care as it transformed into a safety-critical industry, everyone opted for a less challenging answer that made quality improvement the reported focus of the provider/surveyor/regulator relationship.

The shift in terminology was symbolized by the JCAHO announcement in the 1980s that it would no longer survey for “quality assurance” but would be looking for “quality improvement”. It continues to be reflected in Quality Assessment and Performance Improvement (QAPI) language and approaches used by CMS. While the change in focus, or at least language, relieved immediate tensions between hospitals, physicians, regulators and surveyors, the fact that the industry carried it over into how it actually managed what creates its business risks and how it spends its money sent most providers down a very dangerous path. A lot of today’s hospitals, nursing homes, physicians and leaders now struggle to create the capacity to keep growing the future the way they need to because they lack an effective and efficient way of securing the integrity of what they deliver every day.

As the demands of the environment keep growing and traditional approaches to managing quality remain so resource-consumptive, the fact that more and more gets spent on just surviving the present leaves too many providers losing the race to success as market expectations evolve and grow the gap between what is and what needs to be. The acceptance of an easy answer that minimized the importance of building stronger systems and approaches focused on getting it right the first time and holding that performance in business smart ways now keeps the average provider spending too much on fixing the past and managing the present. It has kept approaches to quality management too manual and led to an environment where sustainability for any length of time is increasingly difficult to achieve as it is based on workforce memory under stress and staff retention so there is someone to remember what needs to be done.

Leaders can have no idea their organizations are headed for trouble until the costs and potential losses associated with a fix are significant. The industry’s relationship with the American people is continuously at risk as providers are too frequently a day late and safety measure short for their efforts to count in creating the message of quality people are looking for. The continual diversion of resources to managing paper leaves patients to wonder who will take care of them and just how important health care perceives their satisfaction to be. The choice to practice QI in the absence of strong QA because that is what satisfies the provider/regulator/surveyor relationship forces huge sums of money and manpower to be dedicated to constantly fixing what is a problem as every retrospective chart review searches for what was not done right and most incident reports identify new but old risks that need fixing again and again. Efforts to grow the future consistently take too many steps backwards every time leaders try to push forward because there is nothing to hold the ground they have already gained.

The effect of this business environment can be found in a story of a hospital CEO that had a mock survey done in preparation for the real thing and ended up with a list of 237 quality assurance-related activities that were weak enough to create the risk of a problematic survey that could negatively impact the hospital’s ability to bill Medicare. Typical of the position so many leaders can find themselves in these days, he
The Risk Is In the Irony (con’t)

had to plead ignorance to his board about how it happened, be uncertain as to how he would free up the money and manpower to fix it all without damaging the forward movement of the strategic plan, live with the uncertainty about whether he would have to explain the same list of problematic non-compliances for the next survey and find it increasingly difficult to explain why repeat problematic performance is not an indication of his ability to lead.

Because the CEO, and thus his hospital, bought into the belief that quality assurance was unimportant to business success, he had no business smart way to hold performance gained for the last survey and every survey that came before it. The combination of all the new stresses added by an increasingly hypercomplex and demanding technological environment, growing outside pressures and his efforts to grow the future in the absence of some mechanism for helping the workforce handle all their demands that have been piling up for almost four decades meant that something would more than likely fail. Because operationally he only valued quality-related performance when it became important to a pending survey or cleaning up after a bad one, it was easy for quality responsibilities to be where the workforce would find its relief. While the CEO focused on his strategic goals in the absence of an ongoing message and engagement that made quality equally as important, he created the space for what would become his Achilles heel.

As this CEO’s discretionary healthcare dollars continue to shrink, demands keep growing and a whole host of weaknesses related to a resource intensive memory-based quality model become increasingly problematic, his perpetuation of old school assumptions, practices and attitudes about quality in spite of evidence that they work against success will destine him to dedicate larger and larger sums of money and manpower to every future survey in order to clean up problems that emerge out of the hospital’s past so that it can survive the present. Every strategic goal he implements will come with a greater risk of failure as there is no piece in the plan for how he will balance the added demands it creates for an overwhelmed workforce he can no longer afford to grow.

The significance of this operational weakness that can be found in too many of today’s hospitals and nursing homes has become a real financial threat as the average one-hundred bed hospital can now have between 10,000 and 20,000 non-clinical quality assurance activities that have to be continuously in play to control for the risks that health care’s technologically-advanced environment creates while the explosion of clinical standards has easily doubled the number of activities that have to be right the first time to avoid the financial and reputational risks of not doing so. The stress created by the absence of business smart approaches that can foster getting all these activities right the first time and maintaining their long term sustainability without pulling any more caregivers off the frontlines has become all too real. A new generation of more consumer-savvy patients with much higher expectations and no strong sense of loyalty to one provider is feeding the strength of the perfect storm that will decide who survives and who does not.

The risks associated with a healthcare environment missing strong and business smart quality practices have become detrimentally significant for the country’s smaller hospitals as the ratio of activities that have to happen to working FTE exponentially increases as the size of the organization shrinks. The challenges these smaller hospitals now face in the absence of better ways to manage their quality obligations without overwhelming their workforces and stealing from the time they spend on direct patient care are growing at an alarming rate as old school rationales that have used their size as an acceptable reason for weaker performance become the very concerns that a new generation of patients uses to pass them by. They are a great example of the dynamics that so many providers now face as the list of small hospitals at risk of financial failure grows with each passing month because being labeled a “safety net hospital” in the absence of the patient volumes that secure the bottom line is not enough. While many outsiders encourage their leaders to believe that practicing little quality will be enough to save them, their negative profit margins, shrinking patient volumes and inability to invest in future growth are telling a very different story as they struggle to keep health care local.

Life is not much easier for the largest of the hospital’s past so that it can survive the present. Every strategic goal he implements will come with a greater risk of failure as there is no piece in the plan for how he will balance the added demands it creates for an overwhelmed workforce he can no longer afford to grow. The risks associated with a healthcare environment missing strong and business smart quality practices have become detrimentally significant for the country’s smaller hospitals as the ratio of activities that have to happen to working FTE exponentially increases as the size of the organization shrinks. The challenges these smaller hospitals now face in the absence of better ways to manage their quality obligations without overwhelming their workforces and stealing from the time they spend on direct patient care are growing at an alarming rate as old school rationales that have used their size as an acceptable reason for weaker performance become the very concerns that a new generation of patients uses to pass them by. They are a great example of the dynamics that so many providers now face as the list of small hospitals at risk of financial failure grows with each passing month because being labeled a “safety net hospital” in the absence of the patient volumes that secure the bottom line is not enough. While many outsiders encourage their leaders to believe that practicing little quality will be enough to save them, their negative profit margins, shrinking patient volumes and inability to invest in future growth are telling a very different story as they struggle to keep health care local.

Life is not much easier for the largest of the country’s hospitals where having the greatest degree of hypercomplexity and technological risk means that their lists can easily contain 100,000 to 300,000 activities or more while newly emerging healthcare systems can have combined lists across all their member organizations that can exceed 500,000 and even 1,000,000 depending on network size. Their new threat lives in an emerging business model where the performance of one member determines the opportunities and net gains (or net losses) of the whole group. The real test for survival will come as this decade plays out and the industry sees whether banding together to create something bigger will be enough if the contributions of too many members are negative ones in the absence of a mechanism to manage network-wide losses.

The thirty-year-old gap between where health care quality is and where it needs to be for financial survival and business health is creating a pretty scary time for any leader responsible for leading an organization of any size and configuration to success. Traditional approaches to quality are forcing too many to operate with a hope and prayer type of leadership. They hope that everything is happening the way it is supposed to in order to minimize the potential for financial, operational and reputational loss. At the same time, they pray that today will not be the day that destroys what they are working to create because some failure that they have no way of knowing about is lurking in the shadows waiting for the right alignment of variables to force huge sums of money and manpower in the direction of cleaning up a new mess.

The Risk Is In the Irony (cont.)
The Risk Is In the Irony (con’t)

In its simplest form, the 1:10:100 Rule says that every hour or dollar spent getting something right the first time becomes 10 hours or $10 when errors have to be corrected mid-course and 100 hours or $100 if the errors have to be fixed after the fact. It is the practice of managing to the “100” (fixing things after the fact) associated with health care’s stall in a bureaucratic quality culture that is now a serious financial risk for the average provider and keeps too many patients in harm’s way. The cost is an important consideration for technologically-advancing and safety-critical industries like health care where what is associated with after-the-fact fixes can easily increase by factors of 10, 100, 1,000 or more depending on how big the consequences of the errors are and remedies need to be.

The negative impact of health care’s choices that keep it managing too much quality to the “100” in pursuit of short term gains without consideration for long term losses has become increasingly problematic over the past decade. The damage done is felt more frequently and deeply as the healthcare dollar shrinks at a faster rate. It lives in what is left over for things like raises, stronger benefit packages that can compete, keeping pace with the technological revolution and strategic growth. It is the impact that became very real for the CEO who had to try and bring 237 activities back into compliance in the six months right before survey. The fact that eighty percent of the identified activities had been previously surveyed requirements and deficiencies meant that most of the fixes he had to implement were some factor of “100” that diverted spending from the future to clean up the hospital’s past.

The greatest salvageable costs associated with managing to the “100” are found in about a dozen primary practices currently embedded in how health care manages quality in the absence of strong quality assurance activities. One such cost is associated with the industry’s ongoing dependence on incident reporting as its dominate form of risk management and how often the resulting answer is not the creation of a quality practice strong enough to reduce the risk of a repeat error. Because leaders have typically treated these costs as necessary evils to their regulatory relationships rather than threats to business health, hospitals and nursing homes just keep racking up the following costs that keep eating away at future growth.

1. To understand the recoverable costs associated with incident reporting, it is best to begin with the cost of just one in the current environment. A leader can start with one hour of time for the person who has to complete an incident report.
2. Add ten hours of time for the individual who has to initially investigate and manage the event. This is commonly the risk manager who has to receive it, log it, initially investigate it, orchestrate all future reviews and manage its closure.
3. Add three hours of leadership costs for the discussions and involvement of every operational leader that is impacted by the investigation.
4. Add three hours of time for the individual who has to complete an incident report.
5. Add one hour of staff time if the incident has to be reported to a regulatory agency.
6. Triple the risk manager costs if the incident involves patient harm or an investigation by an outside agency.
7. Quadruple leadership and physician costs if the error results in long term or permanent harm.
8. If the event requires the creation of a formal corrective action plan for an outside agency that requires long term tracking, add a cost factor of three hours for every quality professional involved.
9. If the event resulted in additional care being provided to the patient, add in those costs as lost revenues under DRGs and “Never Events”.
10. If the incident required the notification of the patient and some form of mass testing or treatment, add in those costs.
11. If the incident is a potentially compensable event (an event that could result in a lawsuit), add in the possible costs associated with managing the claim for a period of three to seven years (depending on venue) and its potential direct losses.
12. Add in the costs associated with disciplinary or privilege-related actions that are part of the corrective action plan for a professional staff member.

The 1:10:100 Rule

### Current Costs for Healthcare Quality

| $0.30 - $0.45 of every dollar earned |
| Fixing the Past | Surviving the Present | Growing the Future |
| Dollar Spent |

### Needed Costs for Healthcare Quality

| $0.10 - $0.20 of every dollar |
| Fixing the Past | Surviving the Present | Growing the Future |
| Dollar Spent |

While the costs associated with just one incident are significant, it is the cumulative costs of how many risks health care still manages this way that can be devastating as the number keeps growing at a rate of about ten percent every year in the absence of effective quality activities that hold performance as technology introduces more risks, hypercomplexity and tight-coupling grow the chance of human error and outside forces demand a higher level of accountability. While managing quality in the form of incidents might be the norm, it is a status quo that creates a host of serious self-inflicted wounds that are becoming increasingly life-threatening for the provider who has to make the bottom line work and grow the future. It is a practice that easily competes for first place with nearly a dozen other practices common to a bureaucratic quality culture that prompts people to work hard in the name of quality and still end up at the top of the “at risk of extinction” list because of how it is done.
Working with SQSS to Free Up Manpower and Build Quality

SQSS was built to help leaders expedite closing the thirty-year-old gap between where quality is and where it needs to be for current market dynamics by supporting four important business activities. The first three focus on being able to manage larger numbers of safety-related and operational activities to the “1” in sustainable and efficient ways that protect workforce capacity and productivity. The fourth involves creating the “big data” that is becoming increasingly important to marketing one’s commitment to quality for a new generation willing to travel to get what it wants and a frustrated public now acting on its own to identify the preferred providers who can give people the best odds.

Potential patients, family members and businesses are now coming into hospitals, nursing homes, clinics and physician offices frequently asking for the “big data” about how well a provider does what it does. The challenge the request creates for most providers is that they do not have what these people are looking for because they never built the systems to create and maintain the information in usable formats. Part of the problem is that too many providers do not generate and collect the kind of “quality assurance” data that people are asking for because they have never treated it as important beyond the “little quality” they practice to satisfy the provider/regulator/surveyor relationship. When they now present what little data they have and the argument that the government only requires “little quality”, they are not prepared for the push back they get and the potential loss of patients it could represent.

One young man explained it when it was suggested he use one of the many sites that produces little data to answer his questions about who is best. He pointed out that he was not looking for the provider who can play well to an open book test that asks about a handful of measures that have nothing to do with what is important to him. He was looking for the provider who offers the best chance of getting everything important to his sister’s cancer care right the first time and has the numbers to back it up. In the absence of the process and outcome data that demonstrates how well a provider does what it does for those things important to his sister’s care, he was not comfortable making the leap in faith that comes with the argument that a hospital that can get a few things right must get everything right. After all, “what is to say that the hospital that measures success in terms of a little open book test will not sacrifice what is important to his sister’s care so it can pass.”

In addition to providing an infrastructure for getting large numbers of things right the first time and hanging on to that performance for long periods of time in support of an answer to the above challenge, SQSS is built to strengthen the performance potential of the workforce so more manpower can be dedicated to the front lines where patient care occurs. The goal is for more people to have more time to invest in making patients feel well cared for and personally cared about because they spend less time on problems from the past and managing the present.

Performance potential is the product of demands placed on a workforce and the ability of that workforce to satisfy those demands. It is an important factor in determining a healthcare provider’s margin for quality as it influences how much capacity a caregiver has to create patient-focused experiences where care is right the first time. It is a consideration that has become especially important in the current healthcare market as leaders start to more intensely feel the impact when they chose poorly between taking care of the patient and satisfying demands associated with a bureaucratic quality culture. The creation of a new form, the addition of three seemingly innocent steps to a procedure and the creation of a new committee to clean up some problem from the past is no longer the easy answer it once was to creating the perception of action as leaders now have to consciously think about how they will come up with the FTEs to make these types of soft quality activities happen without damaging other aspects of performance and patient care.

Every piece of SQSS is designed to improve performance potential by either reducing demands on manpower as the computer system takes over what was once manually managed or increasing the capacity of what each person can manage and get right the first time by giving every employee a second memory using a tool built for greater efficiency and effectiveness. Because the System can perform a multitude of the administrative activities associated...
Working with SQSS to Free Up Manpower (con’t)

with scheduling, tracking, reminding, data collection, and report generation that are done by people in a manual model, it is demonstrating the potential to increase discretionary workforce capacity by as much as one to two FTEs for every one-thousand tasks it manages when used to its full potential in getting work done. Once a provider gets really good at using it to get work right the first time, that savings can easily double as things like managing incident reports and attending committee meetings to discuss how to fix the past become less frequent.

These are the types of cumulative savings that are becoming increasingly significant for the average leader operating in an environment with little to no discretionary resources and dwindling pots of money to draw from in order to preserve status quo. The impact on safety and how time is used has started to take on greater significance as a new generation of consumers is not so accepting of the explanations that healthcare has historically used to downplay harm, long waits and costs that are perceived to be avoidable. While the grandparents and great grandparents of this generation may see sitting in the waiting room as a social outing, this new consumer group treats repeated delays as a reason to look for something better. As their grandparents and parents are frequently tolerant of the way the environment operates in the past, there is now too much riding on the choices healthcare leaders make about quality in an increasingly chaotic environment with much more fragile financial margins and dwindling pots of money for saving providers who misstep. It makes the operational quality-related risks that health care has been willing to accept or ignore over the past thirty years serious financial risks that must be addressed in plans for survival. While there are a number of external variables that currently work against the financial health of the average provider, it is how well a leader limits those self-inflicted wounds that compound the externally-driven damage done that will determine who survives long enough to see the fix to what places a perception that they have no power to change it, these young people are making choices with their feet and much more accepting of the idea that weak performers who cannot meet consumer expectations may not survive. In support of an emerging business need to do a better job managing the expectations of this generation and finding the time to do it, SQSS is built to help leaders push workforce performance potential back up and get “making the patient feel personally cared about” back into the definition of quality for the patient/provider relationship.

Leaders wanting to ponder the power of such a tool can contemplate how many dollars and manhours they might save if SQSS managed all their compliance-oriented survey requirements, professional staff credentialing and credential renewal requirements, employee health requirements, contracts, new employee orientation requirements, handwashing surveillance activities, environment of care rounds, clinical competencies and physical plant safety requirements such as generator checks, fire extinguisher checks, and equipment safety checks. They can then consider the savings that could come with doing all that in one system rather than multiple tools that each have their own costs. They could add up the savings associated with getting rid of the duplication of efforts that live in traditional silos. Because so much data would live in one place, they could think about how easy it would be to stay on top of what is happening in their buildings by glancing at reports that are continuously auto-generating and the comfort of being able to know when quality drift is starting to occur so to keep corrections simple, small and timely. Leaders could consider the kind of “big quality” reports they could generate and how nice it would be to finally stop having the “Small-N” conversation because SQSS does “Large-N” sampling. They should contemplate how nice it would be to not be that CEO who implements a strategic plan with no idea how the added stress will impact quality until the fallout is real and how beneficial it would be to use their leadership capital to sell a new future rather than survive some mess from the past.

Catching Up and Managing to the “1” With SQSS

There is now too much riding on the choices healthcare leaders make about quality in an increasingly chaotic environment with much more fragile financial margins and dwindling pots of money for saving providers who misstep. It makes the operational quality-related risks that health care has been willing to accept or ignore over the past thirty years serious financial risks that must be addressed in plans for survival. While there are a number of external variables that currently work against the financial health of the average provider, it is how well a leader limits those self-inflicted wounds that compound the externally-driven damage done that will determine who survives long enough to see the fix to what places health care and its public in harm’s way. Because most leaders and organizations now lack the time and resources to manually bridge the gap that will determine survival, they need to thoughtfully consider how Strategic Quality Support System can help them as they lead for the changes that allow them to manage to the “1”. The moves they need to make do not negate the importance of what current regulatory and survey efforts strive to achieve but they make them possible in ways that support a long term need for financial, operational and reputational health.

What this means lives in the story of a hospital CFO who was good about putting all his obligations in the System. When payer contracts were due for renewal, dates for special reports that were due to Medicare, verification schedules of key billing obligations, making sure that grant reports important to cashflow were done and a whole host of activities that would impact organizational health and perceptions of how well he did what he did were all in SQSS. He unexpectedly died but his choice to make sure that all those things important to keeping the organization on track for a stronger future did not suffer because SQSS knew what they were and when they had to happen. A few simple keystrokes moved them all to the CEO’s to-do list until a new CFO could be hired. With the business goal of protecting the hospital from the two or
Catching Up and Managing to the “1” With SQSS (con’t)

more steps backwards that generally occur when people in key positions are lost, the willing-ness of this key leader to use SQSS insulated the hospital from a self-inflicted wound that could have been huge. Whether it was the Medicaid contract that might not get renewed or an important pension document that could create an IRS problem if it did not get filed on time, his important activities would not get missed in the stress that his loss created because SQSS kept them on the hospital’s active list of things to do.

Why it is important to ensure this type of control to avoid the losses that come with having to fix the past can also be found in the story of a physician credentialing coor-dinator. Her CEO felt he did not have the time to designate the person who would act as her back-up should she ever have to miss work for an extended period of time. SQSS could not be set to know who to move all her work to with a few simple keystrokes as over three hundred physician credentialing activities were loaded. The decision not to be proactive and let SQSS take care of reassigning her responsibilities in a detailed enough way to minimize the potential for error resulted in the first act of managing to the “100” that wasted time and money when she had to unexpectedly and immediately leave. Waiting for the next survey to find out that the new coordinator could not pass it because over half of the credentialing files had errors was the second when no one was set up in the System to monitor the work of an inexperienced person.

SQSS can play a big role in increasing the capacity to manage and control the thousands of activities that are now important to protecting health care as it protects its patients. It gives leaders the power to manage quality real time so to model their outcomes to be what they need them to be rather than waiting for the data that tells them if their hopes and prayers have been answered. It supports collecting and organizing the kind of big data that needs to be part of a provider’s message of competence and caring as questions about why one provider is a better choice than another become more frequent.

The ability to manage and create that message can be found in the above report that could be reflective of the ten to twenty thousand activities important for a one-hundred bed hospital to get right the first time. The report auto-generates for whatever number of activities is reflective of an organization’s size and quality assurance obligations as people take care of their contributions that SQSS reminds them to do. It updates as fast as every activity gets done to support managing quality real time. Leaders in the C-suite can easily know who is taking care of business and who is not so they can act to create the data-driven accountability that leads to the outcomes that protect their organizations and sell their services. The System creates an organized pool of data where a few simple keystrokes can easily convert thousands of data points into timely information across a range of reports for better decision-making while supporting the message that “this one hundred-bed hospital manages thousands of activities to keep our patients safe and this is how we do.” While the hospital may not be able to guarantee perfection in an environment that changes as fast as health care, it is the volume and breadth of tangible data that trends well that strengthens it message of quality.

The capacity to create this kind of message lives in leaders requiring SQSS to know what has to happen, who has to do it, when they have to do it and who the back-up is. Whether it is a temperature check that has to happen every day or a CMS report that has to be filed once every ten years, SQSS will remember and pop it to the right person’s to-do list. While people are taking care of their “My QCs” (My Quality Contributions) that the System generates for lists every day to help them get work right the first time, managers and quality professionals are proactively keeping the lists current using its simple task generation tools and periodically validating work that the System cues them to check. As long as everyone works with SQSS to get a comprehensive number of tasks done, managers are managing drift real time and senior leaders are creating accountability as they support the changes that will make the work environment stronger, the reports that SQSS is continuously generating in the background become a sea of dark green boxes that communicate the control that patients are looking for and health care needs. The process is one of hardwiring the control of current work activities through SQSS as people just take care of their tasks day-to-day, week-to-week, month-to-month, year-to-year and decade-to-decade while freeing up leaders to stay focused on future growth.
Getting The Most Out of SQSS!

Getting the most out of Strategic Quality Support System starts with four leadership goals which include:

1. Gaining control of the thousands of quality assurance type activities that need to be right the first time in resource-wise and sustainable ways so to reduce the risk of having to invest so much in cleaning up problems from the past.

2. Managing improvement and growth initiatives so to maximize the potential for value-adding outcomes in the shortest time possible without damaging the performance potential of the workforce.

3. Proactively managing a broader number and scope of risks that have the potential to damage financial, operational or reputational health.

4. Moving to a "big quality" model that reaches well beyond achieving regulatory compliance to protecting and growing business health.

These are goals that grow in importance every day as the business environment for health care is now one where there are no big cuts or windfalls that will save a provider. The pots of money that once created grants and funding sources that allowed providers to grow without having to challenge status quo are hard to find. Financial sources scrutinize operational capacity to manage the added stress of debt more closely and are much quicker about intervening when they fear for their own losses.

The environment has become one where those with the greatest potential to survive, and potentially thrive, in the evolving conditions are those that continuously grow the efficiency and effectiveness of their current practices. They free up a few FTEs here and spend dollars more wisely there to create the pool of funds and resources that will come from nowhere else as all the complaining about the shrinking healthcare dollar gets lost in the hurm of a country with its own economic problems.

SQSS can be an important tool for the CEOs looking to get ahead because of its ability to help create the resource capacity that they need as it helps to free up one to four FTEs associated with every one-thousand tasks that it can manage. The predictable savings become more secure when 1.7 FTEs or more of managerial time can be permanently reallocated to growth-oriented activities because everyone just works with the System to manage their day-to-day responsibilities and get everything right the first time without prompting. The savings keep accumulating when performance is sustained from survey to survey, the number of risks managed as incidents goes down and there is a reduction in the number of committee type groups involved in fixing some problem from the past. The possibilities keep growing for organizations that evolve out of a bureaucratic approach to quality that has an insatiable appetite for resources and people start thinking outside-the-box to understand the "big quality" scope of things that SQSS can help them with.

The implications of what could be saved and how easy it is to sacrifice are found in the story of a human resource director in a small hospital who did not want to use SQSS because she liked her Excel spreadsheets and was comfortable in spending most of her day monitoring them while sending out letters and reminders and chasing down managers to tell them to remind their employees to get things taken care of. Because these practices were her habits and where she felt most comfortable, she preferred them to learning the unknowns of a computer system even if it could save a lot of steps and manhours. Rather than requiring her to systematize her human resource activities that SQSS could do more efficiently so she could have the time for helping to grow the future, the CEO agreed to honor the HR director's request to perpetuate her old habits "because it was easier than listening to her complain." Typical of what happens too often in the current environment, the CEO still expected her to help with future growth and operated with the blind assumption that the director would just get it all done because that was her job.

The first time this leader knew that it was not all happening was when the hospital had a bad survey because the HR director had stopped monitoring her spreadsheets and issuing reminders. She had shifted her focus to the strategic planning activities that her boss asked her about all the time. Typical of what can happen to people when faced with an imbalance between capacity and demands, she focused on what satisfied her short term stressors with the plan of catching up. Without some way of increasing her capacity, there was no catching up and she simply fell farther and farther behind. Even when she realized she was headed for failure, she did not say anything because she did not know how to address it without looking bad as she would also have to admit to how long she had not been taking care of her primary responsibility. As the CEO had no way of knowing what was happening outside of her assumptions that everything was happening the way it was supposed to, she simply had to wait for a bad survey that would deliver the news as the HR director hoped and prayed for the miracle that would save her.

The fact that the answer to the bad survey was that the hospital would hire a new employee for the human resource department at a total cost of about $43,000 so the director could continue to operate in her habits added significantly to the cost of the survey failures that had to be managed to the "100%, $43,000 and more that was planned for future growth was suddenly committed to surviving the present. The implications for what would not be spent on the future reached well beyond the simple act of allowing one person to operate in the past. It set a precedent for others in the organization who did not want to embrace change. With time, the ripple effect of one business choice to let one person perpetuate past inefficiencies because it created a short term benefit was felt all the way to the CEO's relationship with the board when she could not explain why she was not creating the future she was hired to build because she could not free up the resources to make it happen.

The best place to start with SQSS implementation involves turning the thousands of quality assurance tasks that it can manage over to the
Getting The Most Out of SQSS (con’t)!

System. It is where the greatest saving can be found as it becomes easier to get work right the first time, free up manpower, hold performance for long periods of time, always be survey ready and auto-generate the reports that keep leaders in the loop and that outsiders want. It makes the next survey easier to achieve without a lot of special investment, reduces the risk that forgetting a key safety practice will be the root cause of having to clean up a new problem and begins to build the message of control that health care desperately needs. It can free up that critical managerial time that is always tied up babysitting quality as managers currently spend so much of their day saying “did ya” and “don’t forget” that they cannot focus on making patients feel well cared for and personally cared about or helping to roll out new initiatives. The impact is in the math. If on average, every task that SQSS manages conservatively frees up thirty minutes of managerial time from scheduling, babysitting, report generation and fixing every month, the savings per 1000 tasks is roughly 360,000 minutes, 6,000 hours or the equivalent of about three fulltime managerial people. The failure to make people take care of their tasks without managerial intervention can reduce that number to about 1.3 for the hospital that averages thirty problematic tasks a day (doubled on weekends when no one is babysitting). What the final figure looks like is ultimately a business choice that leadership makes about how active and independently people are expected to use SQSS.

While all the savings mentioned throughout this newsletter might seem small, it is important to not underestimate their cumulative effective. For the one hundred-bed hospital with 15,000 tasks that can conservatively save one FTE for every one-thousand tasks, the saving is about fifteen fulltime people who are generally in some of its more costly positions. If that same hospital makes really good at managing to the “1”, and can take that number to two, three or even four FTEs per thousand tasks, the CEO could be looking at a capacity of between thirty and sixty fulltime people who currently spend too much time chasing compliance, shuffling paper, sitting in meetings and managing corrective action plans to the “100”.

The savings represent the discretionary capacity leaders need in order to grow the future and please the public without growing their most expensive cost center in the general ledger. Even the smallest of the country’s hospitals with no more than four thousand tasks can do a lot with the performance potential of the four or more FTEs that their leaders can create as, in many situations, they many SQSS up to a handful of people drowning in titles and responsibilities to create the capacity they cannot afford to hire.

Leadership and messaging from the C-suite is key to success. Experience has demonstrated that about sixteen percent of the workforce immediately embraces the use of the System because they can see how it will help them and make their lives easier. About twenty percent actively resist and the other sixty-four percent or so wait to see what the senior leaders do and just how strong their ex- use the reports to determine how hard everyone is working and whether it seems to matter. Those who work hard wait to see if leaders recognize who they are while holding the weak performers, who have historically hidden in the shadows, accountable as SQSS creates the hard data for who is who. As easy as SQSS makes it for Mary’s manager and senior leader to know how committed she is to doing her best because the data is building in all these reports as she works, a big piece of just how hard she keeps working and using SQSS to help them will be dependent on the feedback she get. As she takes care of all her responsibilities to hold the line, outperforms her teammates on team-based activities, rarely makes an error, has no patient complaints or work-related injuries and rarely takes a day off that is not prior approved, it is leadership’s response and how the data gets used that decides the strength of her loyalty. She, like most of her coworkers, will wait to see if...
Getting The Most Out of SQSS (con’t!)

The purpose of the quality piece of SQSS is to tell a highly robust computer system what has to happen, when it has to happen, who has to do it, who will do it if the primary responsible party is absent and how to do it right. The System can then simply generate to-do lists for every person in the organization every day to manage them without the resource-intensive manual resource-intensive approaches that have dominated the industry and limit what it can do. It does not matter whether it is an activity that has to happen twice a day or once every ten years, the System will remember and make sure that people her leaders really want what SQSS can do for them or if they let the twenty percent or so who want it to fail win because it is really nothing more than one more flavor-of-the-month that is the C-suite’s newest way of creating one more thing for them to do.

SQSS is built to foster an integrated approach to quality management across all levels of the organization. As part of supporting a stronger type of quality management, it gets rid of many of the wasteful costs that come with today’s siloed approach that manages too much quality from behind. It is designed to promote stronger teamwork in multiple ways both vertically and horizontally. While many of its operational features support stronger communication and sharing on the front lines, the System is generating the reports to support the quality responsibilities for all three levels of leadership that are critical to creating success. The purpose is to make sure that each level of leadership gets the information it needs in a format that works for its leaders real time. The goal is to overcome the damage created by two long standing practices that have always set healthcare leaders up to fail. The first is managing too much to the “100". The second involves having to wait too long to find out what one’s outcomes are and too frequently finding them out at the same time the public does.

Every report in SQSS is designed to operate as an “at-a-glance” report. That means that each report updates as fast as any work gets done no matter how many tasks the day may bring. When quality assurance activities go undone, the System makes a notation in the respective reports as fast as the due date and time are not satisfied while it also notifies the responsible manager so the performance can be corrected before it can cause trouble. While the quality assurance piece of SQSS helps everyone get work done right the first time in resources-wise ways, it also creates the effective storage of information that might not be needed until a year or so from when it is collected. Because all reports update as fast as work gets done, every time a leader looks at one, he or she is seeing what quality looks like at that moment in time. The approach is designed for greater control real time with a clear understanding that while the reason activities do not get done or done right might not be intentional, the impact does not change. Every financial loss associated with managing to the “100” goes straight to the bottom line and every reputational loss can be one more patient/provider relationship sacrificed. Recognizing that success in the evolving market will not be a product of explanations and intentions, SQSS is designed to help leaders more efficiently and effectively stop failures before they can result in harm to a patient or the provider.

One of the important business tenets that SQSS was built to support dates back to an old Roman engineering principle that whatever you build makes its greatest contribution if it is something you create once but use in multiple ways. It is how leaders maximize the dollar they have to spend to create a bigger gain in the world of business and how smart leaders thrive with a weak dollar. The way SQSS links getting work done to automatically generating reports that can be tailored to be more specific through a few simple clicks is one of those savings as it cuts out the multitude of hours that managers, leaders and quality professionals have typically dedicated to creating the documents to report quality. Every hour freed up is an hour that could be reallocated to frontline work that creates revenues and helps to make patients more satisfied. While people on the frontlines might perceive their traditional paper logs to be easier, what they need to appre-
Getting The Most Out of SQSS (con’t)!

The purpose of the quality piece of SQSS is to tell a highly robust computer what has to happen, when it has to happen, who has to do it, who will do it, and the activity description. The System does not care if the primary responsible party is Lou, Lisa and Jamie who do not know what is going on and is not staying out in front of that next big loss has become the leader who needs to keep his or her resume updated at all time. While SQSS is helping managers to make sure that day-to-day activities are getting done, manage for improved performance and watch for signs of quality drift, it is also creating the capacity for senior leaders to more easily monitor the performance of all the departments they are accountable for. It is an important level of awareness to have as it is easier today than it has ever been for leaders at the top of an organization to lose leadership capital and be fired because too many quality-related issues are being managed to the “100”. As plausible deniability and finger-pointing are not as effective as they once were in isolating those in positions of power, the leader who does not know what is going on and is not staying out in front of that next big loss has become the leader who needs to keep his or her resume updated at all time.

The operational reports that SQSS auto-generates for this level of leadership make it easier for senior leaders to be in the loop as they balance their responsibilities to make sure that today is what it needs to be while ensuring that tomorrow
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arrives on time in ways that will yield a net gain. In this example, the hospital has a new manager in the Emergency Room. While the downward trending in departmental performance might simply be reflective of a new manager settling in, it does not change the potential risk the decline might represent for the safety of patients and organizational health. That means it cannot be ignored. While the answer might be as simple as helping the manager settle in faster, knowing and doing something about it is what is important so leaders do not end up addressing issues to the “100” and defending what might be interpreted as poor leadership.

The third level of reports that SQSS is continuously updating provides that 30,000 foot view that the board and CEO need to tell them how the whole organization is looking. It takes all the quality activities that every department manages in SQSS and rolls them up into monthly performance scores that reflect each department’s overall success in making its contributions to protecting human life and the health of the organization. Whether the cumulative number is one hundred activities, a thousand, ten-thousand or one-hundred-thousand, these reports reflect the “big data” success of the whole based on the sum of its parts.

At the same time the System is auto-generating departmental and service-oriented reports at a 30,000 foot level, it is also generating a similar report across the major areas of risk that healthcare organizations are trying to control for. The purpose of these quality function reports is to make it easier to identify trends and patterns that may not be limited to the performance of one department. They support the fact that while department managers have a responsibility for what happens in their departments, quality professionals are responsible for performance across an entire organization in their assigned areas of risk. To help them do their jobs, every task in SQSS is labeled for the quality function it supports when it is built so aggregate reports based on category of risk can be generated. All the activities that support infection control comes together to create a functional performance score just as every safety, corporate compliance, HIPAA compliance and credentialing activity rolls up into a respective score. In addition to supporting the different quality professionals in being more efficient and effective in their roles, this report helps leaders with the legal and regulatory responsibility for “big performance” to know where their greatest risks reside.

In the example below, there were a number of months where New Team Member Orientation and Public Reporting needed to be areas of concern as the red and orange boxes indicated less than desirable performance. The fact that the fix to orientation had to be about fixing the larger system for how it got done rather than attributing it to poor departmental performance became obvious when one simple click took leaders into a more detailed report that showed what was not working and how widespread it was. Rather than guessing what to fix or aerial bombing a workforce that did not have time for wasteful activities, leaders had instantaneous access to the details important to thoughtful data-driven decisions that could raise the bar on quality at the same time they kept costs down and protected the performance potential that shapes the patient experience.
SQSS is designed to bring the critical high level functions of quality and risk management together in a way that works better to effectively and efficiently hold the line. While its quality pieces work to hold current performance and constantly strengthen that performance to minimize the risk of ever having to problem-solve to the “100”, the risk management pieces support timely risk identification and management for an environment that is constantly changing and where the variables that create risk are frequently realigning. The quality assurance features discussed in the previous pages work to continuously manage that robust list of activities important to holding current performance so to reduce risk. The quality improvement tools support a type of rapid-cycle improvement that works well for an environment where time counts in reducing how much gets managed to the “100” and how long active risks exist. The performance improvement design helps to manage the multidisciplinary improvements that can now be critical to making one desired outcome happen in a hypercomplex environment where as many as two dozen contributions can have to come together in the right way to create one success.

The goal of the collaborative design is to strengthen the relationship between identifying risks and picking the right improvements that will negate the potential for repeat errors and losses. It works to correct a long standing imbalance between protecting negative information and taking the necessary steps to reduce the risk of repeat financial, operational or reputational harm. This disconnect that remains common in health care today is another byproduct of the stall in a bureaucratic quality culture that continues to promote an unhealthy type of secrecy and division of effort protected by operational silos. It is a piece of the movement from “little quality” to “big quality” that never happened for the healthcare industry.

Having both major functions of quality and risk management managed in SQSS allows for a healthier integration of risk identification, timely quality improvement, effective quality assurance to hold new levels of performance and continuous quality improvement as the patient care environment continues to evolve. Leaders can more easily watch for the rate of error to go down while the performance of the quality assurance activity designed to control for it goes up which tells them that the rapid cycle quality improvement activity selected was the right choice. It becomes easier to recognize if a plan for improvement was poorly conceived, as can easily happen in a hypercomplex environment, and make the changes important in reducing the potential for greater short term and long term losses.

The risk management side of SQSS brings a range of risk management activities such as root cause analysis, great catches and near misses together in one place so it is easier to efficiently and effectively expedite being proactive and targeting what is broken. The System supports the identification of risks as great catches (managing to the “1”) and near misses (managing to the “10”) as part of the effort to stop managing so much to the “100” (as incidents). Instead of having employee health, fiscal management, infection control and other different categories of risk hidden in silos all over an organization, SQSS is designed to bring all risks together in one place in support of stronger enterprise risk management. While the people who need to know the big picture can easily do that, those with the responsibility to manage specific areas of risk can see just what they need to see.

Trajectory of Error Analysis for Stuck my finger with a used suture needle

<table>
<thead>
<tr>
<th>Stage</th>
<th>Label</th>
<th>Result</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Injury/Harm</td>
<td>Standards of care not met, with injury occurring or reasonably probable</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Failed defense</td>
<td>Standards of care not met, with injury occurring or reasonably probable</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Failed defense</td>
<td>Standards of care not met, with injury occurring or reasonably probable</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Failed defense</td>
<td>Standards of care not met, with injury occurring or reasonably probable</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Root cause</td>
<td>Standards of care not met, with injury occurring or reasonably probable</td>
<td></td>
</tr>
</tbody>
</table>

Outcome: Minor Injury/ Minor Treatment with Need for Follow-up Care

From Common Sense To Health Cents

Getting The Most Out of SQSS (con’t)
Getting The Most Out of SQSS (con’t!)

An important risk management characteristic of SQSS is how leaders using it have control of the list of reportable occurrences their staff are asked to report. Rather than working with a formal risk management program to identify some risks that a vendor identifies as important and a second manually managed list that addresses what the first does not allow for, leaders can set the list of reportable events in SQSS to align with the risks that come with the complement of services and operational activities their organizations perform. As part of the need to keep pace with a dynamic environment, they have the power to instantly update that list as fast as new risks evolve. A great example is the hospital that does hyperbaric therapy and has always had to have that department report its incidents using a paper tool because the risks specific to the technology it uses and the type of care it delivers has not fit well in the standardized lists that were hard-wired into the electronic tool the rest of the hospital used. Working in two systems created a lot of extra work and disconnect for the people responsible for managing risks across all level of leadership until they could all work together in SQSS.

In support of a stronger type of enterprise risk management, SQSS makes it easier to bring all non-clinical risk categories such as HIPAA and Corporate Compliance that have operated in their own silos into its integrated approach so it is easier for leaders to see the whole picture and use its tools to manage for success in a consistent way that supports stronger communication and teamwork. In their effort to manage the risk category for Fiscal Integrity, CFOs can use SQSS to identify and trend billing and financial-related errors that impact the financial health of their organizations at the same time they can use it to coordinate and track the plans for achieving greater control of activities that can reduce receivables and lead to big fines. In one example, rather than having his billers call departments to collect missing information so they can drop bills and fix system failures one failure at a time, the CFO has his billers send JDIs (Just Do Its) in SQSS so he can trend and pattern for common failures. Having to contact the lab sixty-seven times in a month for the same piece of information to drop the same type of bill quickly became an easily identifiable trend. Being able to continuously collect and trend hard data real time in a user-friendly way turned a weak practice that had been a long-standing norm that wasted manpower every time it occurred into an opportunity. Rather than utilizing manpower to clean up the past one error at a time, the CFO was able to allocate more to the activities of timely billing and working claims that keep the life blood (money) of any hospital flowing.

SQSS is designed to promote stronger teamwork across multiple disciplines and groups. One way it does that is by being set to know who needs to know of an incident as fast as it is reported. Rather than the risk manager spending a lot of time distributing information, SQSS can notify the risk manager, infection control professional and manager of the unit where a new infection exists as fast as an employee clicks “send” to report it. As fast as an employee injury is reported, the risk manager, employee health professional and manager of the employee injured are in the know so everyone can be doing their part to protect the employee and minimize the risk that the same injury could happen to other team members. Quality teams can grow with a few simple clicks to be reflective of whoever needs to be involved in closing the quality loop for risk identification, quality improvement and resetting current practices to be what is needed to negate future losses.

SQSS also generates a set of risk management reports to make it quick and easy to monitor errors and their breakdown by important variables that tell the trends. Three simple clicks can produce the following report that isolates patient falls and shows when they are occurring. In a glance, the nursing leader can know that the greatest frequency involves “falls from bed” with eighty percent occurring between the hours of “midnight.
Getting The Most Out of SQSS (con’t)

For period: June 2013 - May 2014

<table>
<thead>
<tr>
<th>Medical/Surgical Nursing - Floor 2</th>
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</thead>
<tbody>
<tr>
<td>Performance/Cost/QI Initiative</td>
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<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>To have 95% of all patients report adequate food temperatures when meals are served (flow chart, show history)</td>
</tr>
</tbody>
</table>

and 3:00 a.m.” and that more falls happen on Sunday than any other day. One more click can isolate whether the risk of falling on one unit is more prevalent than on another. Another click can tell the leader the distribution of falls on Sunday. Every click takes a leader deeper into the data to make it easier to target a plan that fixes what is not working without damaging what is. The goal is to overcome a long standing problem in health care where changes leaders pick are too big. While fixing one problem, leaders too frequently create new problems because they disrupt things that are working just fine. It is a type of aerial bombing that has helped to keep the cost of managing to the “100” high because the list of what needs to be fixed too frequently trades one type of incident for a new one that is a product of an effort to improve.

The QI tools in SQSS are designed to support a rapid cycle improvement technique that plays well for industries like health care where the need for continuous quality improvement is driven by an environment that is always evolving. The technique is designed to support achieving desired outcomes faster while protecting the performance potential of the workforce by keeping the time they spend in the Valley of Despair small. The Valley is a business term used to described a decline in productivity that people experience in how they work when they are engaged in implementing change. Because change generally disrupts the habits that people have built for the repetitive pieces of a work activity and it is these habits that help to create productivity, the longer people remain embodied in the uncertainty of change, the longer and more significantly their productivity is affected.

The loss of productivity becomes a self-inflicted wound when quality improvement initiatives are poorly managed, last too long, involve change that is bigger than what is really necessary or promote soft quality activities that permanently damage performance potential. It is a type of harm that has negatively impacted health care more than most leaders can imagine if their focus has been on managing quality improvement to satisfy the provider/surveyor/regulator relationship without paying attention the effect on important business variables that determine long term health. They are practices that have become increasingly dangerous as the healthcare dollars shrinks and the number of demands that require a system-oriented improvement have grown, especially for leaders with an accumulation of activities that repeatedly require fixing in the absence of strong enough practices to hold the line.

The situation is one where a QI initiative that lasts for three years might perform well in passing a survey or participating in a national project but it is not too helpful for the CEO that is expected to keep a hospital growing. While a new form that lasts for three years might perform well in passing a survey or participating in a national project but it is the repetitive piecemeal of activities that repeatedly require fixing in the absence of strong enough practices to hold the line.

Making the initiative at the bottom of this page happen in order to secure greater patient satisfaction with food temperatures so to generate better stories about food quality is important. It is equally as important to do it in a way that does not damage some other aspect of the patient experience. A trip into the Valley that lasts too long or a plan that is too resource intensive can yield enough collateral damage to turn an opportunity into a loss. While the effect created by spending too much time in the Valley on an initiative like this was something that leaders from the past could tolerate in an environment where practicing “little quality” was enough and resources were easier to add, today is a time where success is much more dependent on how leaders create greater capacity and improvement with what resources they have. It is a time when the average hospital department needs to be managing somewhere between three and five quality improve-
The purpose of the quality piece of SQSS is to tell a highly robust computer system what has to happen, when it has to happen, who has to do it, who will do it if the primary responsible party is absent and how to do it right. The System can then simply generate to-do lists for every person in the organization every day to manage them without the resource-intensive manual approaches that have dominated the industry and limit what it can do. It does not matter whether it is an activity that has to happen twice a day or once every ten years, the System will remember and make sure that people grow in importance with each passing day.

The PI piece of SQSS is designed to support managing those multi-disciplinary initiatives associated with the constantly evolving hyper-complexity of the healthcare environment. Its purpose is to overcome a pretty high failure rate associated with these types of initiatives because of their tendency to resemble herding cats in a manual quality model. One example of what that transition looks like can be found in the PI report to the right for a hospital that had been working on a performance improvement initiative for two years trying to get its number of late charges down because of the impact they were having on timely billing. Leadership moved the initiative into SQSS to take advantage of a format that made it easy to see the efforts of every department that generated charges so that leaders could more easily identify what was working along with what was not. While every department that generated charges was managing their contributions in their QI tools, SQSS was automatically pulling the applicable information together in this PI report for the CFO and aggregating the data for his timely review. Once a month he would take a glance at the report and have brief conversations and strategy sessions about steps to strengthen performance where it was needed. Being able to see each contribution allowed him to recognize success where it existed and keep corrective action plans targeted, simple and small for the departments that needed something different.

The CFO could easily recognize Physical Therapy, Radiology and Respiratory Therapy initiatives at any one time and each initiative needs to conclude with success in less than nine months if organizations are to keep pace with how fast the environment is changing. As multiple initiatives tied to safety, the practice of evidence-based medicine, securing patient loyalty and growing the future all compete for importance, the old-school practice of having one initiative in play at all times to pass survey can easily become an organization’s swan song if it is also its business model. It is what makes current multi-year initiatives like CPOE potential problems for leaders who do not recognize what dragging them out can mean as they keep their people in the Valley long enough to create true despair and limit the capacity of their organizations to move on to the next great opportunity that may be important to growing the future. While national initiatives might target important things, it is how they are managed that determines their contributions to success.

A simple click allows for the graphics of a QI initiative to be displayed. Another click lets one see the story that tells the who, what, where, when and why of an effort to create something better. While senior leaders may only need the quick and simple data that comes with the basic at-a-glance reports to know that everything is exactly what it needs to be or is moving in the right direction in a business healthy way, the board and public may benefit from graphics that make it easy to visualize progress while surveyors may want the written stories to better understand the effort to improve. Rather than tying up a lot of manpower in creating the range of reports that support satisfying a number of needs, SQSS has different levels of information sitting in the ready waiting for the moment they are needed. A CEO or any leader could be engaged in an impromptu conversation and with a few simple keystrokes come up with the information that creates that message of control that grows in importance with each passing day.

The PI piece of SQSS is designed to support managing those multi-disciplinary initiatives associated with the constantly evolving hyper-complexity of the healthcare environment. Its purpose is to overcome a pretty high failure rate associated with these types of initiatives because of their tendency to resemble herding cats in a manual quality model. One example of what that transition looks like can be found in the PI report to the right for a hospital that had been working on a performance improvement initiative for two years trying to get its number of late charges down because of the impact they were having on timely billing. Leadership

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<td>Meaningful Use: CPOE</td>
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Getting The Most Out of SQSS (con’

ty for how well they were doing in getting their
charges in on time while they kept working to
make their performance stronger as is reflected
in the shift from light green to dark in his report.
At the same time, he focused more time and
energy on brainstorming the system changes
important to helping the Lab and Pharmacy. As
these two departments generated the highest
percentage of diverse charges, they naturally had
the greatest potential for failure as they also
experienced some of the most frequent changes
driven by outside forces. Being able to focus on
their more complex needs without damaging the
simplicity of what worked for everyone else was
the difference between aerial bombing and
tailoring systems through effective targeting.

The report generation features in the QI and PI
features of SQSS afford leaders the ability to
generate the kind of reports they have always
needed but never been able
to create because they could
not free up enough man-
power to make them hap-
pen. The features are de-
signed to allow for smaller
and more targeted reports
that can more easily support
better analysis and decision-
making. The key to doing
that lives in the ability to build
a variety of smaller and more
focused reports that can all
include common numbers
while the manpower neces-
sary to keep them all current
is limited to putting the nec-
esary data in SQSS once. In
the example to the right,
physician profiles for the
purpose of credentialing
and privileging are building
automatically as all those
people who collect and man-
age the supporting infor-
mation put their numbers in
their respective SQSS work-
sheets. While the System
is building the profile needed internally for
activities important to quality management, it
is also duplicating applicable data to a second
profile built for the external purpose of mar-
keting.

The feature means that a hospital could
have ten different specialized reports de-
signed to support various leadership needs
that all require its infection rate. SQSS would do
all the heavy lifting in maintaining those reports
because as fast as the infection control profes-
sional puts the infection rate in her quality im-
provement worksheet, the System would auto-
matically populate the number to every report
department to have its
own reports that reflect
how well it does chas-
ing one-hundred (or
perfection) in compli-
ance with its evidence-
based standards for
clinical care and chas-
ing zero in its error rates for
things that can cause
patient harm. Those
reports could all aggre-
gate up into specialized organization-wide reports
to let operational and strategic leaders know how
critical activities and outcomes are looking without
the allocation of extra manpower. Reports no
longer have to resemble small books that over-
whelm people. Leaders do not have to work from
one report that tries to communicate so much
information that what they
share resembles a hodge-
podge of numbers that is
too voluminous and unre-

d
ty that has to happen twice a day or
ed the industry and limit what it can do.

Because SQSS is designed to manage large
volumes of data and automatically pull it all to-
gether in meaningful ways as new data is added, it
can help leaders to more effectively manage
and monitor complex processes where multiple differ-
ent activities all have to come together to create
one desired outcome. It supports a critical leader-
ship activity associated with monitoring all the
pieces of an activity and managing them to yield
the collaborative effort that creates success in a
hypercomplex environment. One of the best
examples that may exist today involves the chief
financial officer’s need to monitor the revenue
cycle that has taken a once simple act of getting
paid and turned it into something that rivals the
complexity of a NASA space mission. To do a good
job, a CFO must be able to monitor about sixty
data points that represent activities that can be
performed by a dozen or so groups that can be
spread across different buildings and even differ-
ent states. All these data points reflect a lot of little
processes that must all come together so a hospi-
tal can get paid.

Bringing volumes of data points together in
SQSS is as simple as making each entity do their
quality work in the System. Converting it all into
easily trendable patterns and reports that create
the kind of information that leaders need for bet-
ter decision-making is as easy as building the elec-
tronic reports and telling the System where each

Getting The Most Out of SQSS (con’t!)

Managing complex processes like the revenue cycle in SQSS is focused on maximizing the time and manpower invested in the actual activities important to revenue collection. While managers and people key to some piece of the larger process are managing their own work in their electronic worksheets, SQSS is pulling the applicable information into the right place in a leader’s report. The System deletes hours of resource-intensive and duplicative activities associated with passing data from one person to another so that someone can manually organize it and put it into reports. SQSS can free up hours of administrative time that can be reallocated back to the frontline work that drives revenues, grows the future and keeps patients happy. Whether the need is the creation of physician profiles that support effective credentialing and privileging activities, managing a process as complex as the revenue cycle, creating competency profiles for clinical staff, managing new hire and orientation activities where hiring just one ICU nurse can involve over one hundred individual tasks or tracking the thousands of activities that now define quality for the average hospital, leaders who capitalize on the type of systematization that SQSS offers can do more in ways that cost less at the same time they set themselves up to have fewer potential areas of surprise that are managed through hope and prayer.

As leaders grow the use of SQSS in support of stronger business practices focused on more efficiently and effectively securing current performance, they also should consider how it can help them coordinate a range of other activities. Leaders of healthcare networks can generate system-wide reports that let them easily monitor the contributions of each member organization. While monitoring one report that brings the 30,000 foot view of performance for all members together in one place, one simple click can take a leader into a provider-specific summary for one member organization to better understand why it excels or why it struggles. In addition to supporting a stronger type of awareness and leadership, this feature is designed to foster that greater sense of being one that is difficult to achieve when bringing a number of diverse organizations together. Because SQSS can support everyone in sharing common goals that make the larger network measurably stronger while making each entity’s contributions easy to see, leaders can more effectively define what success looks like, manage it and know when the collective efforts of the group are making it happen.

SQSS was also built to support managing strategic growth initiatives, especially those where it can take a long period of time to achieve the desired results. The goal is to manage as many improvement type activities as is possible in one place using one approach so to reduce the number of demands on performance potential. The fewer
Getting The Most Out of SQSS (con’t!)

systems and approaches that people have to know and move in and out of, the more efficiently and effectively they can work. The type of operational coordination that can occur in SQSS is an important leadership practice for strategic initiatives in fast-paced and constantly changing environments. As Kaplan and Norton pointed out in their work, new gains associated with the addition of new services and strategic initiatives are rarely instantaneous. Success can frequently take up to three years to be fully realized after leaders invest considerable time, energy, and money building and feeding an initiative so it tips the scales in the direction of profitability and a stronger future. It is the delayed nature of these gains that promotes so many to fail and become expenses that work against future success. The financial risk lives in all that is invested in the beginning for an end-product that never materializes as the initiative gets lost in crisis management and meeting more immediate needs. It is why some data suggests that the failure rate of powerful tools like the balanced scorecard can be as high as seventy to eighty percent for fast-paced and high stress environments like health care. Leaders build beautiful strategic maps but what they are supposed to achieve gets lost in the absence of an effective way to keep an initiative alive as it competes with day-to-day demands.

Recognizing that strategic goals are simply performance improvement initiatives with much longer target dates, leaders can use the PI features of SQSS to support their different types of initiatives in one place to save time, money and manpower while increasing the chance they will happen. Short term PI initiatives, such as the one for reducing late charges, focus on making the immediate future more resilient in order to create a stronger set of day-to-day operations that can support business health. Long term strategic initiatives like those managed inside an operational balanced scorecard for the addition of a new service focus on making sure that long term goals happen so an organization can keep pace with market needs and opportunities. In the example to the right, a hospital sets a strategic goal of increasing its overall patient volume by 5% over three years. One key activity in support of achieving that goal is to supplement its HCAHPS surveys with a set of patient-focused surveys. The goal is to do a better job securing patient loyalty, new patient acquisition, patient retention and market domination in an increasingly competitive environment by focusing on the details that define a great experience in the eyes of the patient. While the hospital’s CAHPS surveys remain important to national benchmarking activities and evolving payer models, the business side of the organization needs something that digs deeper into the details that determine loyalty for a new generation willing to travel to get what it wants.

The first twelve to eighteen months of the project are focused on getting the right patient-focused surveys built for the different types of patient care rendered, implementing them and teaching people how to maximize the use of a system that can painlessly administer and aggregate an unlimited number and variety of surveys. It is a time for teaching managers on the frontlines how to use the data their surveys yield to manage patient loyalty real time. Consistent with what Kaplan and Norton wrote about in their work, the second twelve to eighteen months focus on monitoring for impact and refining the process so that it really works for the hospital. Data collection for improved patient volumes and revenue gains is set to start around month twelve as leaders start watching for those first signs of positive impact that take time to come while they also begin to use patient feedback to drive the quality improvement initiatives that refine their master plan and strengthen the odds that their strategic goal will happen.

Using their strategic map as a guide, three years of activities are mapped out and loaded into SQSS so each one strategically shows up on people’s to-do lists at that point in time when they need to happen to keep the initiative on track. While people can begin new steps sooner if time and resources allow for it, SQSS protects the initiative from just disappearing and no one having any idea what happened to it until someone asks how it is going. Leaders can keep one eye on an initiative’s progress and quickly identify the need for their involvement so the effort stays on course while the other eye is already focused on what comes next.
Most executives are hired with the expectation that they will grow a stronger future. How the average healthcare leader does that with a shrinking dollar and a workforce that struggles just to manage current day-to-day demands in an environment where staying relevant is the product of keeping pace with rapidly changing market expectations using costly technologies that have short shelf-lives has become a career shaping conundrum. The past three or more decades have produced an abundance of stories about how poorly it has worked for leaders who try to grow the future and produce greater profitability without asking whether the quality of what they create will yield the financial outcomes they seek. Every passing decade has made the pain of choosing poorly more costly and leadership tenures more tentative.

We built Strategic Quality Support System with the specific goal of helping leaders to jumpstart the evolution of their quality programs that stalled in the 1990s and close a thirty-year-old gap in an environment where time is not a leader’s friend. Maximizing what the System can do to save money and manpower while helping people to work in more efficient and effective ways that create what the public wants is largely dependent on what leadership wants out of it and a leader’s commitment to making it happen. In making SQSS successful, it is important for leaders to remember that all their people know is what the past three decades have taught them and encouraged them to believe about quality. How far they now grow and what they use SQSS to achieve is largely dependent on where leadership’s encouragement and expectations take them.

The System has been built for the frontline employees who have to balance day-to-day demands and capacity while still finding the time and energy to make patients feel well cared for and personally cared about. It is designed to support the manager that has to make sure that every day is exactly what it is supposed to be, the senior leader who has to bring today and tomorrow together in ways that keep pace with an ever changing environment, the CEO who is hired to grow the future, the board who is ultimately accountable for the strength of what the patient experiences and the patient stakeholders whose lives and quality of life depends on health care’s ability to hold the line and keep pace in an environment where what is state-of-the-art today can be old-school tomorrow. It is designed to help health care overcome the weaknesses found in a bureaucratic quality culture where an insatiable appetite for resources robs too much time, money and energy from the patient/provider relationship. SQSS operates to support a big quality model that reaches far beyond what little quality and passing open-booked tests can ever achieve.

As you contemplate how you will use our System and set the bar for what you want to achieve, I ask that you start out considering the following seven questions:

1. If the largest employer in your community asks for similar data to decide whether to encourage its workforce to use a preferred provider and rejects “little quality” measures associated with activities like HCAHPS and Hospital Compare as not being enough, what will you give that patient to keep his or her business local?

2. If a patient walks in your office tomorrow looking for the quality data that would sell your organization as his or her preferred provider and rejects “little quality” measures associated with activities like HCAHPS and Hospital Compare as not being enough, what will you give that patient to keep his or her business local?

3. If a patient walks in your office tomorrow looking for the quality data that would sell your organization as his or her preferred provider and rejects “little quality” measures associated with activities like HCAHPS and Hospital Compare as not being enough, what will you give that patient to keep his or her business local?

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5. If the largest employer in your community asks for similar data to decide whether to encourage its workforce to use a preferred provider and rejects “little quality” measures associated with activities like HCAHPS and Hospital Compare as not being enough, what will you give that patient to keep his or her business local?

6. If you are asked to band together with other providers for the purpose of protecting financial health inside the philosophy that there is strength in numbers, is the answer to improved performance as simple as every one sharing in the losses and risks of one another based on a hope and a prayer that nothing bad will happen? Is it enough to physically tie up a region without knowing that one is tying up the group’s reputation for quality for a generation of patients with loyalties as fleeting as the wind and willing to travel to get what it wants?

7. Can the “little quality” that health care has practiced for the last thirty years somehow become enough to support the financial, operational and reputational needs of your organization as the healthcare dollar continues to shrink and demands grow or is it time to make the “big quality” moves that reach well beyond the assumption that getting a handful of things right will somehow magically protect a provider from all the potential losses that “little quality” ignores?

For almost forty years, health care has been an industry full of opportunities to grow it financial and reputational health by feeding the five critical business outcomes of patient loyalty, new patient acquisition, patient retention, market domination and profitability because of what its technological revolution has done for it. At every turn, quality has been standing there to either help or hurt what is ultimately achieved because of how it is managed. This decade is shaping up to be a critical time for industry leaders and physicians to decide whether they continue to treat quality as an incidental to business success or critical to achieving the success that they seek. SQSS is a tool designed to help close the gap between what quality management in health care is today and where it needs to be as the industry runs out of the resources and goodwill for relying on status quo.