



A New and Better Approach to Achieving Clinical Transformation

By Marsha Parker, R.N., Director, Executive Services, CTGHS

Ward Keever, Executive Director, Executive Services, CTGHS

Remember a few years back, when the term “paradigm shift” emerged as the buzz word of the day? We all attended presentations, read Joel Barker’s book, and dropped the term casually into our conversations to let our constituents know we were up-to-date in our thinking. Now that we’ve moved on to other terms—such as ‘clinical transformation’—we may need to consider both of those terms together. Yes: you guessed it. We want to share with you a paradigm shift in our approach to clinical transformation.

Paradigm shifts, as you may remember, are basic changes in the ‘rules of the game’: new approaches and solutions with an impact that alters the playing field. The transition from large computers to small computers was a paradigm shift. So is the ongoing contemporary switch to wireless communications like cell phones and wi-fi LANS and WANs. In thinking about paradigm shifts, it’s important to keep in mind that corporations heavily invested in the older paradigms are not normally the ones that provide the new paradigm: consider IBM vs. Microsoft, for instance.

So now let’s look at clinical transformation. Everyone is talking about it. Some organizations have actually undertaken it. Unfortunately, the current paradigm for clinical transformation is expensive and time-consuming. Even providers willing to commit significant clinical resources to the project too often find their initial high expectations dashed by disappointing results.

The current paradigm or model for clinical transformation follows these steps:

1. Start with today’s clinical workflows for most of the clinical processes throughout an organization and develop process charts that depict current practices and all variations. Such workflows include ordering a lab test, administering medication, and the like. The goal is to focus on workflow processes that will improve overall efficiencies and reduce medical errors. External consulting costs include providing expensive facilitation resources for the development of these charts and potentially, charges for the use of external software tools to support this goal.
2. By comparing these charts among nurse stations, we identify practice differences, look for problem areas, and seek opportunities to standardize the practices of care. We also look for incremental opportunities for FTE reductions.
3. Once the differences and identified areas for improvement have been hashed out, we seek agreement among all the stake holders on how best to standardize care for each process across the entire organization, which may include multiple hospitals.
4. And finally, we develop training modules to deliver to all care givers to help achieve the approved standard processes.

The current clinical transformation model concentrates on standardizing the delivery of care throughout an organization. Is this the right focus to effect real change?



The new paradigm for clinical transformation aims to provide care that meets or exceeds approved standards. This very different model delivers incremental benefits through a more focused approach.

The focus of this current clinical transformation paradigm is to standardize the delivery of care within an organization. Not only does it take a long time and significant internal energy to achieve this standardization, but we also suggest that it represents the wrong focus.

The new paradigm focuses on the delivery of care to approved standards, e.g., the Joint Commission Core Measures and the National Committee for Quality Assurance (NCQA) ambulatory indicators. This approach concentrates on actually improving clinical care. The steps required to achieve this paradigm are very different:

1. Start with the future state and define exactly what success will look like. For one thing, it will be measured against a goal of having everyone practicing to an institutionally agreed-upon standard of care rather than the standardization of care itself. Define those standards of care and develop a conceptual model that includes the following:
 - a. Identify best practices based upon evidenced-based medicine and not incremental cost considerations, e.g., FTE reductions
 - b. Understand what a computerized system, regardless of vendor, can do to support this model
 - c. Develop the formal care standards required to achieve these goals
2. Develop process charts for only those processes that need to be addressed to facilitate practicing to the approved standard of care. Process variations among nurse stations are acceptable as long as the agreed-upon standard of care is achieved and demonstrated by the individual practitioners.
3. Develop training modules using scenarios as the basis for these modules.
4. Emphasize the need to practice to a standard and develop 'learning loops' that provide individual education and accountability for results.

The new paradigm offers at least three major benefits:

1. Implementing clinical transformation is less expensive because the paradigm:
 - Requires fewer process workflows than are now recommended by many consultants
 - Consumes fewer internal resources
 - Does not require universal agreement on how to standardize care, saving both time and money
 - Avoids inclusion of unnecessary training modules that often, over time, fall by the wayside
2. The new paradigm also enables the project to achieve incremental results as the organization makes progress toward the agreed-upon common goal. The scope of the culture change management efforts are focused, reducing the operational impact on your organization, while delivering the maximum clinical improvement. These results cause excitement and buy-in to self-perpetuate throughout the project, achieving the ultimate goal: healthier patients sooner, through evidenced-based medicine.



3. Perhaps most important is that success, which is defined early in the process, is the actual enactment of improved standards of care, which also achieves real operational cost savings in the form of fewer re-admissions, reduced occupancy stays, fewer infections incurred during a hospitalization, and increased cooperation among physicians and nurses toward a common goal.

If we want to promote improved US healthcare, our clinical transformation goal must be focused beyond incremental cost reductions and avoidance of errors. It must be grounded in documented, improved clinical practice which positions all care providers at the head of the class in a 'pay for performance' world. Tying clinical improvement goals to standards of care rather than standardized practice is something that all caregivers can rally around.

Marsha Parker is a Director for Executive Services with CTG HealthCare Solutions™, responsible for providing executive-level consulting as well as development and oversight of CTGHS' Clinical Solutions consulting services and methodologies. An R.N. and a former COO and CNO, Parker has over thirty-five years of experience in implementing large-scale change projects in a variety of healthcare settings and specific clinical transformation solutions with an emphasis on process and practice change leading to outcomes achievement. Her specialty is crafting organizational change at the systems and clinical practice interface. Most recently she has been a primary designer of the architecture of method, tools, and techniques being used in the healthcare modernization efforts for southern England.

Ward Keever serves as Executive Director for CTG HealthCare Solutions' Executive Services. As a former CIO, he has over thirty-five years of experience in the healthcare IT industry, with a strong background in strategy development and implementing strategic and tactical IT systems in large health system settings and specific solutions for applications within the healthcare industry.

For more information, contact:
ward.keever@ctghs.com