

# TRANSFORMATION OF HEALTHCARE VIA STAGE I AND STAGE II MEANINGFUL USE ACHIEVEMENT



Life in Healthcare is no longer just being in the fast lane. It is Wile E. Coyote with the latest ACME rocket strapped to his back and roller blades on his paws. So, when you think of the transformation of care through the achievement of Stage I and Stage II objectives of Meaningful Use, it is not uncommon to have your mind zipping from process to issues to technology and back again.

These initiatives are not small endeavors. Transformation of Care and achieving Meaningful Use are highly complex undertakings with numerous projects (both IT and clinical), multiple departments, governance committees/work groups and staff in the range of 100-200 resources. Communication is paramount; yet with all of these disciplines, baseline knowledge and a common lexicon are usually lacking. So, the issues are numerous and typically hard to manage. How does an organization approach these initiatives so that all of these moving parts stay in synchronization and head in the same direction? One approach is to break down the initiative into the critical components that are necessary to be successful. For Transformation of Care, the critical components would include: Governance, Process/Workflow Re-Design, Clinician Proactive Involvement, Evidence-Based Content Development and Management, Technology, Education, Quality Improvement, Behavioral Change Management, and Continuous Assessment. In many organizations that are undertaking these projects, the project driver comes from the acquisition of new technology. There may be business/clinical sponsorship, but the organization, as a whole, will look to the IT Department to initiate or drive the project. Unfortunately, this is backwards from where the project should be. So, let's discuss each of these components and dissect the timing and how they need to work together:

**Governance:** Implementation projects of this magnitude require strong investigative and decision making groups in order to set strategy, make decisions and generate/receive value. Detail work groups must also be working in conjunction with the governance structure and the IT project, but, most importantly, all three of these groups must be constantly in synchronization with regard to communication, decisions, strategy and policy. Two areas to guard against are: 1) committees having only a partial picture of the issue or decision to be made; and 2) effective communication flowing back and forth between all of the committees to keep everyone in the loop.

**Process/Workflow Re-Design:** The Re-Design phase is often driven from the IT project plan and by the software vendor. This phase typically occurs early in the implementation cycle so that adequate time is allotted for the Build phase and testing. However, because it is done early in the cycle, clinicians tend to face two dilemmas: 1) their knowledge of the software and its capabilities are not understood at a deep enough level to make meaningful decisions; and 2) because these types of implementation projects are in the 18-24 month implementation range, clinicians do not engage mentally this early. Hence, a conscious effort must be made to educate, at a detail level, the clinicians and engage them proactively. In addition, Re-Design requires a patient-centric approach and the movement of the patient and his/her interactions with caregivers must be considered. Design processes should follow the patient flow while simultaneously evaluating staff roles, processes, information creation/movement, patient needs/clinical guidelines/policies, and metrics for measuring success.

**Clinician Proactive Involvement:** As mentioned before, clinician involvement must be constant and proactive and shouldn't be offset with minimal involvement in the beginning and heavy involvement at go-live. Many organizations compensate their clinicians to be actively involved, and this has proven to be successful. Equally, there are organizations that did not compensate their clinicians and were also successful. The keys to clinician involvement are strong communication, expectation setting (value and benefits to the clinicians), improved/efficient workflows, the reality of clinical content evidence and a documented path to improved patient outcomes.

**Evidence-Based Content Development and Maintenance:** With many implementations, evidence-based clinical content development is often thought of as order set builds and are scheduled close to go-live. This is a major mistake, especially if the organization's clinical strategy is not well developed or if an organization is going through a clinical content standardization process. Clinical content should always be thought of as a "program vs. project"; it needs to start early in the implementation cycle, should include decision support/alerts, should address quality metrics/reporting/improving outcomes and is tied directly to clinician adoption.

**Technology:** Technology often gets a bad rap for the failings of the implementation project. "The software doesn't work; it wasn't testing appropriately; it doesn't do what I want it to do" are all common complaints. Oftentimes, it is not the software itself, but rather the decisions that went into building the software that are to blame. Just as one doesn't reprogram MS Excel when creating a spreadsheet, the project team must guard against replicating what the old application did into the replacing application.

**Education:** Education should be subdivided into four tiers. There is general education that should be conducted early and often with a broad audience of directors, sponsors, executives, and clinicians. There is technical education for the IT resources who will build the software. Functional education is required for key users and clinicians, and this should be done very early in the implementation cycle. Repetitive education on this level is critical to help ensure that good decisions are being made especially with workflow. Functional education should be very detailed and center on actual cases, workflow issues, and/or special processing; and, the more the clinicians are exposed to this, the better they will accept and adopt it. Detailed "how to" education should be conducted right before go-live.

**Quality Improvement:** Quality improvement has become a proactive science and requires active participation during the implementation cycle. As mentioned before, the Quality Department must play an active role during clinical content development, quality metrics and improvement strategies. Reporting is also an important task to define necessary informatics. Through the testing cycle, Quality should validate its strategies by utilizing the application and reports.

**Behavioral Change Management:** Just as they say "nothing happens until you sell something," the transformation of care is all about changing behavior of all of the involved constituents. In today's world, projects transcend departments and job responsibilities, so it is vitally important that resources understand not only the bigger picture, but also embrace change. Needless to say, it is also time to remove any resource who does not want to embrace change.

**Continuous Assessment:** One area that does not get much attention, but should, is the continuous assessment of where a project is and how it is progressing. In the past, most projects were monitored by a project status report or a weekly/monthly verbal communication. Although these are somewhat effective, they tend to reflect what the author feels is important, and what they lack is an objective assessment of where the truth really lies. The objective assessment will also allow for immediate and corrective action of any facet of the project and should be reviewed by the executive sponsor and leadership team. The combination of objective measures and the subjective “gut feel” of the project manager/director will allow for a more definitive and truthful view.

In summary, each organization faces unique challenges as they strive to transform their care for their patients. The dynamics and organizational heterogeneity creates new and different perspectives that must be addressed. Only by tackling these critical components simultaneously during the life cycle of an implementation can an organization effectively achieve successful results and transform care.

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