As health systems organize for improvement work, there’s one factor they can’t afford to overlook—effective outcomes improvement governance and leadership culture. This is the most essential must-have in improvement work, as it ensures an organization will invest in outcomes improvement and allocate resources toward these goals in the best way possible.

Outcomes improvement functions on three systems to achieve organization-wide change:

1. Best Practice—what an organization should be doing.
2. Analytics—how the organization is doing (what percentage of the time it’s following best practices).
3. Adoption—how an organization can transform from what it is currently doing toward best practice (set goals to bridge the gap between the best practice ideal and what the analytics show is currently happening).

This report serves as an outcomes improvement governance handbook, centered on four core principles (plus the 11 steps to achieving them) that leverage these three systems:
1. Stakeholder engagement—how to engage the right people to govern outcomes improvement and analytics.

2. Shared understanding—how to establish a common understanding of improvement opportunities, and the associated resources and analytics required to achieve them.

3. Alignment—how to align incentives and balance organizational polarities.

4. Focus—how to optimally allocate scarce resources to the highest-yield improvement initiatives.

Well designed and executed governance optimally allocates scarce resources, which significantly accelerates the breadth and depth of outcomes improvement.

Principle #1: Stakeholder Engagement

The first principle of effective improvement governance is to engage all stakeholders around a common vision. This involves bringing the right people to the table. Members of a strong improvement governance include individuals who:

- Control key resources and funding.
- Have specific domain knowledge.
- Are the most qualified to make tradeoff decisions.
- Can influence others to adopt change.
These stakeholders fall into four levels of executive engagement, each comprising individuals who drive, support, resource, and facilitate change. The organization can facilitate cultural and adaptive change when this leadership structure achieves expertise and engagement at all levels:

- **Executive**—those who control resources and makes funding decisions.
- **Domain Leadership**—Those with domain or specific expertise in several areas, such as clinical, operational, and financial.
- **Adoption**—those with the ability or expertise to influence adoption and those who can support and encourage change.
- **Innovation**—those at the workgroup level who have the innovation skills to identify and address root causes and drive the process toward better outcomes.

### Step 1: Call to Action

The first step under principle #1 (stakeholder engagement) is the call to action. This is the true start to the improvement initiative—an opening ceremony of sorts, where the CEO makes a statement about where the organization will focus improvement efforts (e.g., safety). The call to action does several critical things:

- Creates early momentum.
- Starts engagement around the initiative
- Establishes authority and accountability.
- Communicates that outcomes improvement will be an organizational priority that’s backed with the necessary commitment and resources.

The organization’s highest leadership level makes the call to action (leaders who can drive and direct strategic action throughout the system). They begin by engaging stakeholders one on one and communicating the vision, using real patient stories to define their goals. Once leaders have earned a support base
for improvement, they present the strategy to the entire board or executive
team, set expectations, and designate authority and accountability for the
initiative. Finally, leaders use the call to action to solicit engagement and
participation across the organization.

Step 2: Form the Leadership Team

The next step under principle #1 is to form the leadership team that will head
the improvement initiative. These guidelines will echo those for stakeholder
engagement: members of the leadership team must be able to influence,
resource, support, and drive strategy, and understand the causes of poor
outcomes; they’re also involved in areas of the organize that the process
change will impact.

Leadership team members are the organization’s C-suite level executives—
most, if not all of them. These individuals have the experience to engage
stakeholders and ensure agile follow-through on improvement work. The
improvement leadership team must agree on the vision, authority structure,
and decision-making and prioritization processes.

Five guidelines can help organizational leaders establish improvement
leadership:

1. Keep the team small, but allow for adequate representation.
2. Don't automatically replicate the executive team.
3. Ensure team members are able and willing to implement processes that
   ensure the team’s effectiveness.
4. Seek out team members who are enthusiastic about the vision and
   conceive of outcomes improvement in a comprehensive way.
5. Stress the need for accountability and discipline.

What do organizations risk when they don’t meticulously form
an improvement leadership team? They may think they have all the parts in
place to carry out the initiative, but often find their leadership teams lack
critical members. For example, if they leave out the CFO (even if the CFO is
initially involved with the initiative), then they may get to the funding
stage and discover the CFO isn't deeply engaged in and
understanding of the strategy. The CFO is, therefore, less likely to
fund it in a timely manner. The lesson here is that for
improvement to succeed, the initiative must engage the C-suite
executives whose departments will be involved.
Principle #2: Shared Understanding

The principle of shared understanding denotes a common perception of the system's needs, capabilities, and readiness to take on the outcomes improvement strategy. The "how" of each organization's shared understanding can differ based on existing improvement needs (as dictated by government mandates, market pressure, or board-level directives), budgetary constraints, and if the organization already has a shared understanding of improvement work.

Step 3: Identify High-Level Opportunities

Designating priorities is central to outcomes improvement. This starts with identifying high-level opportunities, which the leadership team executes. They may start with a wide swath of high-level opportunities, but narrow it down to a few priorities—those areas linked to strategic objectives, where they're most likely to get meaningful results (the greatest ROI).

The leadership team can use a Key Process Analysis (KPA) tool (based on the Pareto Principle, or “80/20” rule) to find the best opportunities for improvement. Areas within the system with the highest variation and highest cost are top candidates for improvement because they stand to be impacted with only a small number of input factors. This helps the organization determine where to focus improvement work.

Step 4: Assess Organizational Capabilities and Readiness

Once the leadership team narrows high-level opportunities down to a few improvement priorities, all stakeholders in improvement work need to determine which priorities they’ll focus on. The most promising priorities are those for which the organization has three elements in place:

1. Capability—the appropriate technical and adaptive leadership skills are present.
2. Capacity—the required resources with skills are available for improvement work.
3. Willingness—the key stakeholders impacted are ready for change.

The diagram in Figure 1 shows a readiness assessment tool, which helps organizations determine how ready they are for an improvement initiative—as well how capable they are, what resources they need, where the gaps in readiness are, and how to fill the gaps. This online test asks five questions that
test asks five questions that fall into one of five categories:

1. Leadership, Culture, and Governance
2. Analytics
3. Best Practice
4. Adoption
5. Financial Alignment

There are several common gaps in organizational readiness—key resources that are often scarce:

- **Analytics and Data Infrastructure/Data Ecosystem**, including: 1) data capture (those who can make changes to the EMR or other source systems); 2) data provisioning and integration (data architects and BI developers); 3) data analysis/interpretation (e.g., outcomes analysts, statisticians, and data scientists).

- **Process Improvement/Quality Improvement** Infrastructure, including: 1) improvement facilitators (change agents); 2) process engineers skilled in improvement techniques (e.g. TPS, Lean, and Six Sigma); and 3) subject matter experts (those who can safely and knowledgeably innovate process).

- Communication Designers and Education/Content Designers.


**Principle #3: Alignment**

The principle of alignment is about breaking down silos within an organization by using a consistent improvement methodology, aligning incentives, and balancing priorities.

**Step 5: Adopt a Consistent Improvement Methodology**

With the fifth step, the leadership team agrees on how they will align—they adopt a consistent improvement methodology. The operative word here is consistent: consistency is more important than the actual makeup of methodology; a process that is standardized and repeatable will have more
impact than the methodology itself.

There are numerous improvement methodologies, such as Six Sigma, PDSA Cycle, Toyota Production System, and Lean. Regardless of the methodology in use, health systems need to communicate two aspects of their improvement initiative:

1. The root cause problems.
2. The challenges of improving outcomes for patients in the areas in question.

Members of the leadership team won’t necessarily have specific methodology skills in place. They may need to pursue offsite training on improvement principles or bring in experts for onsite training. Some systems develop an in-house training team or require their leadership team to pursue a self-study curriculum on improvement principles. In any case, specific training supports consistency in the methodology (regardless of the methodology used).

**Step 6: Align Incentives**

To ensure that all stakeholders in improvement are onboard with the work, leaders (C-suite) must align incentives—meaning, goals for clinical and operational improvement as well as financial bonuses and incentives. This is another way to break down silos. When incentives are aligned, all stakeholders have something to gain or lose, so they’re more likely to support and participate in the work.

Leadership can also facilitate engagement by identifying specific improvement goals in the context of incentives. They can set goals around clinical quality or financial, operational, or patient experience objectives—this helps team members understand the systemwide nature of improvement work and its dependence on many dimensions within the organization.

For example, rather than individual commissions, the Health Catalyst® bonus structure is based on three aligned incentives that reflect the organization’s success as a delivery system:

1. Success—one-third of everyone’s bonus is based on customer satisfaction scores and the number of client outcomes improvements.
2. Scale—one-third of everyone’s bonus is based on hitting timelines with customers and staying within the operating budget.
3. Sales—one-third of everyone’s bonus is based on hitting sales targets as a company.

The goal is to break down barriers and motivate all team members behind the improvement work.
Step 7: Keep Polarities in Balance

To keep polarities in balance, it’s important to first understand the difference between a polarity and a problem: a problem has an endpoint (a solution); a polarity is ongoing and must be managed over time—it tends to involve a balance—a center point—between two good things.

An example of a polarity in healthcare analytics is data protection and data sharing. If data protection is in the extreme, then IT controls the final sign-off on all data access. This means that a team member with a legitimate need to access an application might not be able to log in for months, which severely limits an organization’s ability to improve outcomes.

The other extreme—too much data sharing—is also undesirable. Without appropriate safeguards, the organization risks a data breach and privacy issues that could bring down the health system.

When polarities are balanced between data protection and data sharing, organizations have a process for granting appropriate access that’s secure enough to keep out the wrong users. Importantly, improvement teams have the
access to the data they need, when they need it, with clinicians and operational personnel granting that access.

The data protection and data sharing polarity is one example of the many polarities organizations manage in improvement work. Polarity management needs to be prioritized so that the health system is addressing one polarity at a time, in order of importance (versus ineffectively tackling them all at once). The leadership team can start by prioritizing five polarities and identifying the warning signs of either extreme for each one.

Leadership and appropriate experts can establish processes and policies to keep polarities in balance. Using the example of data protection versus data sharing, these policies and processes can include how long access is granted and who grants/removes access.

One way organizations can safeguard against extremes (unbalanced polarities) is to make the distinction between data governance and improvement governance. The key is to manage data governance in the overall context of improvement governance. Otherwise, health systems risk developing extreme policies that serve one principle but ignore the other. The solution is to keep policies focused on improving patient outcomes—hence, the importance of keeping data governance in the context of improvement governance.

There are many examples of governance polarities:

- Data protection AND data sharing
- Financial performance AND improved care delivery
- Information transparency AND information privacy
- Improve regulatory metrics AND Improve metrics most correlated to outcomes
- Data accuracy AND time to decision
- Data for learning AND data for research
- Spread and sustain improvements AND promote new improvements
- Clinician AND patient decision making
- Organizational goals AND payer incentives
And there are many examples of other polarities in healthcare:

- Quality AND cost
- Value AND volume
- Stability AND change
- Care (mission) AND cost (margin)
- Patient needs AND staff needs
- Standardization AND customization
- Patient experience AND medical outcome
- Clinical goals AND administrative strategy
- Process AND outcomes
- Primary care AND specialty care

**Principle #4: Focus**

The fourth core principle—focus—refers to disciplined decision making to prioritize, fund, organize, and sustain improvements. With focus, organizations work deeply in one or two areas at a time and avoid spreading their resources too thinly across several areas.

**Step 8: Analyze Opportunities and Determine Priorities**

In step eight, leadership analyzes opportunities for improvement to determine where they’ll get the most response to their efforts (the biggest ROI). Priority selection is best when it’s data driven so it’s objective and, therefore, more likely to earn broad support.

The biggest opportunity areas are, most likely, the largest processes with a lot of variation. Leaders can use KPA to determine opportunities based on several criteria:

- Opportunity level (process size and variation)
- Organizational readiness (combined from assessment)
- Current strategies and initiatives
- Potential synergies
Step 9: Allocate Resources

Allocating resources to the improvement initiative validates the work—it makes it real, as team members see improvement work replace or take priority over other responsibilities. Once the leadership team has identified areas with significant variation (step 8), they allocate resources to these areas. By building teams (including representatives from the analytics, clinical and operational, and financial teams) around the specific improvement, leadership focuses the organization around the initiative.

To allocate resources, the leadership team must do several things:

- Get realistic input from all key stakeholders.
- Account for the resource costs of team member participation.
- Include training resources in the budget.
- Be creative and think long term (e.g., repurpose/share roles).
- Ensure that the budget and plan align with other approved priorities.
- Once the budget and plan are drafted, solicit review and approval from key stakeholders again.

Step 10: Establish Prioritized Teams

With step 10, the leadership team establishes prioritized teams for improvement work; specifically, they oversee the formation of guidance teams and other levels of improvement teams for each prioritized area. Multiple interdisciplinary teams comprise the improvement workforce to account for the full scope of work—from leadership and guidance teams, to innovation (workgroup) and implementation teams. All team members receive training in improvement methodology.

To operationalize these teams, leadership organizes them around key work processes. They meet briefly—huddles or standups—every day to check in on work in progress.

Teams also follow a regular meeting schedule:

- Weekly iteration planning meetings to focus on care improvement goals for that week.
- Monthly adoption meeting to discuss the next intervention and its implementation.
- Quarterly guidance team meetings.
This process systematizes the improvement work, making support for ongoing improvement work part of the organizational structure.

**Step 11: Extend and Sustain Improvement**

The final step of the four-principle, 11-step effective governance roadmap is to extend and sustain improvement. This is the opposite of a project mentality, in which a health system targets an area for improvement (perhaps in response to a low quality score from the CMS) and forms a one-off team to address the issue. Once they achieve the targeted improvement, the team disbands. The organization has no system in place to sustain gains and continually measure and monitor the improved process.

To avoid this one-and-done approach to improvement, leadership forms a consistent team with long-term ownership of an improvement area. This team will devote a portion of their time to adopting and sustaining the improvements.

To extend and sustain improvement, leadership follows five guidelines:

1. Standardize reporting between levels of improvement teams.
2. Establish regular modes and times for communicating improvement work to the whole system and the community (share improvement goals, why they’re important, and how the improvement team is performing).
4. Adopt standard ways and times to review the value proposition—to determine if investments in various outcomes improvement areas are paying off.
5. Regularly review the appropriateness of the data and data use to ensure teams have the material they need and are using data to drive decisions.

**Effective Outcomes Improvement Governance Can be a Reality for All Health Systems**

At the core of governance for outcomes improvement is achieving more with less—making improvement success a reality for all health systems. Even the most dysfunctional organization can become great at outcomes improvement governance if they follow the four principles detailed in this report. If organizations use a principled approach to leadership to create engagement and focus around the work, maximize strengths, recognize and address weaknesses, then they can establish a methodology, define goals, and keep the process moving forward.

*Please contact us for a copy of the Health Catalyst® Governance Handbook.*
Tom Burton, Co-Founder and Senior Vice President

Mr. Burton is a co-founder and Executive Vice President of Health Catalyst®. His leadership and decades of experience in business intelligence, analytics, and process improvement have helped many care delivery systems significantly improve clinical, operational, and financial outcomes. Mr. Burton was a member of the team that led Intermountain Healthcare’s nationally recognized improvements in quality of care delivery and reductions in cost. He has taught courses on the Toyota Production System, Agile Software Development, value-based care, and data system design at various institutes including Intermountain Healthcare’s Institute for Health Care Delivery Research and Stanford’s Clinical Effectiveness Leadership Training. He has also given presentations at the Healthcare Analytics Summit™ and HIMSS. Mr. Burton holds an MBA and a BS in Computer Science from BYU.

David Grauer, Senior Vice President Professional Services

David Grauer joined Health Catalyst® as a Senior Vice President in September, 2016 after spending 23 years in various administrative positions at Intermountain Healthcare. Most recently, David served as the CEO/Administrator of Intermountain Medical Center in Salt Lake City.
ABOUT HEALTH CATALYST®

Health Catalyst® is a mission-driven data warehousing, analytics, and outcomes improvement company that helps healthcare organizations of all sizes perform the clinical, financial, and operational reporting and analysis needed for population health and accountable care. Our proven enterprise data warehouse (EDW) and analytics platform helps improve quality, add efficiency and lower costs in support of more than 50 million patients for organizations ranging from the largest US health system to forward-thinking physician practices.

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