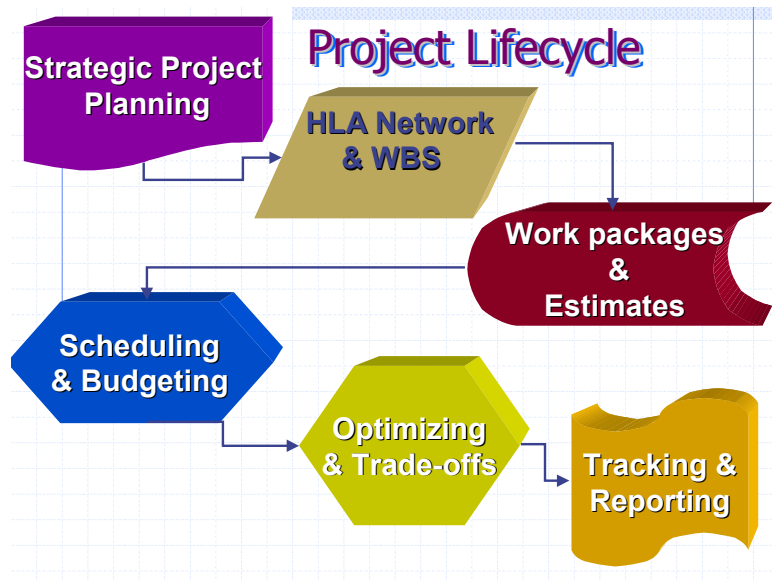


Managing Healthcare Projects



By Dick Billows

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1 – Lessons Learned

We will begin by sitting in on a "lessons learned" meeting for a failed project in a medical center. Though a gloomy way to introduce the topics we're going to cover in this book, it gives us an inventory of many of the PM problems that are all too typical in today's project management environment. After all, the point of this book is to help you avoid each one of them.

Our project manager doodled with a green fountain pen in the margin of the blank "Lessons Learned" document, sketching figures of project managers hanging from a noose. The PM had notified all the project's players of the meeting but everyone was late, just like during the project. A few of the project team members straggled in. The PM received crisp nods from some team members but many just went to their seats, eyes downcast. They'd all worked pretty hard. Oh, there were a couple that goofed off and played some games with duration estimates. However, the team members' hard work had produced nothing for them except association with a failed project. The resentment on most of their faces clearly signaled that they blamed the PM for the failure.

Some Administrative Staff members tromped in as a group led by the VP of Operations who'd had almost no involvement at the beginning of the project and whose time investment grew exponentially as deadline after deadline was missed. They were followed by supervisors from the Laboratory and X-ray departments. Last to enter were the team members from the Information System department who looked like they were marching to the guillotine for beheading.

"My gosh, yet another meeting," the VPO sneered. "We're still trying to fix the mess upstairs! If anything, the number of patient complaints and billing errors are even worse than before we started this disaster. And the Medical Staff is upset as the errors are affecting them too!"

At those words, a silver haired physician in surgical blues strode into the room, fixed the VP of Finance with a cold stare and literally sneered at the project manager. Dr. Jacobs, Chief of the Medical Staff had always been too busy to attend even a high-level planning meeting, as had the other Chiefs of services. Nevertheless, they were never too busy, or so it seemed, to complain about the results.

Dr. Jacobs said, without sitting down, "This latest disaster is affecting the quality of patient care and neither I nor the Medical Staff will tolerate that. It must be fixed immediately."

Then Jacobs glanced around the room and a thin smile came to his face, "I'm not a business manager. All I want to do is practice medicine and treat my patients. So you people will have to work very hard to fix this and please do it quickly, people's lives depend on this."

With that, Dr. Jacobs turned and left the room.

In the silence that followed Jacobs' departure, the PM capped the fountain pen, thinking that this was a wonderful way to begin the meeting and said, "Well, the idea of the "lessons learned" meeting is to try to identify what went wrong so we can improve the way we do projects."

"You people," the VPO snapped, looking around at everybody in the room, "have to do a lot better! We cannot keep having these project disasters."

"We delivered every requirement you specified even though the software you and Dr. Jacobs picked was crap," barked a member of the Information Systems staff, already red in the face.

The VPO snapped back "Go tell that to the patients who are still complaining about our billing system and how long it takes us to straighten out problems."

The PM knew it was time to regain control of the meeting. "One of the problems with our planning was that we didn't focus on reducing the number of complaints. In the beginning, we only talked about the new fancy reports that everyone wanted. Then the list of requirements kept growing every week."

From the expressions on the faces of the first-line supervisors from Lab and X-Ray, the PM knew the last comment was a mistake.

"It kept growing because you never gave us what we wanted," one of the supervisors said.

The VPO pushed back from the table and stood up, "This is getting us nowhere!" Then the VPO pointed a finger at the PM's face and said, "You were seven months late and \$300,000 over budget and we still have the same problems."

The VPO turned and took two steps toward the door before whirling back and saying, "And what I like the least about the way you people do projects is that all the bad news always comes at the end, when we can't do anything about it!"

BAD SURPRISES WHEN IT'S TOO LATE

As the project team and some Administrative Staff members continued the debate, the PM thought about the VPO's last words. There had been a lot of bad news late in the project. Sure, some of it could be attributed to overly optimistic estimates and some to scope creep. However, as the completion date kept getting pushed out, people got very nervous about reporting any more slippage. Whenever they did, the sky fell on them from all quarters. Including, the PM had to admit, from the project manager. Although they should have been honest enough to

We "frame" the project within business requirements that link departmental achievements to measured business results

report problems, the PM could have done a better job accepting bad news and protecting them from executive tongue-lashings. The PM knew that getting bad news was better than not hearing about it because then no corrective action was possible. Another real problem was not having the tools to spot small problems early. With the project plan they had built, both the team members' status reporting and the PM's reporting were subjective. No one really knew how the project was going until they got near the end.

A supervisor's angry voice broke the PM's reverie, "We never understood that technical mumbo jumbo you made us sign off on! And none of you have any business telling us to change the way we operate in our department. You need to adapt to our way of doing things. "

"The idea of these projects is to make improvement, not preserve the status quo from 1960!" A Business Office manager sneered.

CHANGES, CHANGES AND MORE CHANGES

Sure, they'd tried to "freeze" the project requirements and they'd gone through a very thorough approval and sign off process on all the process and technical specifications. Then every week the list of features and functionalities grew. People saw a report, screen layout or workflow change and said, "This won't work for us the way you've got it." Then the project team member said, "Well, I'll have to fill out a change request because that's a change and it'll take more time and cost more money." The two would go around and around debating whether this was or was not a change and it would be escalated. Then the same debate would occur at a higher level with everyone becoming more and more angry. Most times the change was added to the plan but usually with no corresponding increase in budget or duration. If the PM insisted on budget and duration increases to reflect the cost of a change in the project, the team was blamed for doing a poor job of laying out the project requirements.

The fact was the operating department supervisors did not understand the technical language of the requirements and the vendors and technical staff never understood the needs of the operating areas. It was also true that neither the PM nor anyone else had a clear understanding of the business and performance results that the stakeholders in Administrations, the Medical Staff and ancillary departments were seeking from the project. Of course, all those stakeholders delegated their planning role to lower level subordinates and never gave them any direction. So the initial plan provided no strategic framework and left the door wide open for an endless series of changes.

PROJECT TEAM WANDERING IN THE WILDERNESS

The PM scanned the angry frustrated faces of the project team members. The original completion date had been "plucked from the sky" before the PM had even been selected as project manager, much less done any analysis. The PM argued about

the date but got nowhere trying to convince the executives of the impossibility of reaching it. As a result, the duration and work estimates were jokes and everyone on the project team knew they would fail to hit the due date before they even started work. As a result, they had no commitment to their individual due dates. The situation got worse when the stakeholders kept adding new requirements with few increases in budget or duration.

What really dragged the project team into their deep depression was the hours they had to work. Most of them were on several projects but no one was managing their overall workloads or setting priorities in terms of which project's work should come first. All those functional managers' promises of "full support" proved to be worth very little because they pulled their people off the project whenever something came up.

Just then, a Laboratory supervisor raised the 60-page project plan over his head and threw it at the garbage can, missing by four feet and scattering Gantt charts all over the floor. The PM looked at all those Gantt charts fluttering to the conference room floor and wondered if the project plan had been a little too detailed. They started the planning with a lot of talk about the business outcomes and clear direction. But all the pressure to get started with the work led to the project plan being little more than a very detailed list of micro-activities. Was that micro-management, the PM wondered? Moreover, the plan had not really specified the things required from administrative areas, like process changes and staffing. Either way the project plan had been useless. They were only two weeks into the effort when people started saying, "We've already done that" or "We can't do that yet because..." so all those details in the project plan really didn't provide the project team with guidance. In addition, some of the more experienced people seemed to make a point of doing things in sequences other than what was laid out in the project plan. They explained that they'd found a better way to do it but the PM often felt that their point was just doing it differently than the plan.

In the still rapidly deteriorating "lessons learned" meeting, a project team member screamed, "Why didn't you tell us in the beginning about the big problem with patient complaints?"

"We did!" chorused the three remaining people from the Medical Staff.

"Oh, you mentioned it but two thirds of what we did had nothing to do with reducing patient complaints."

PLANNING, MISSION STATEMENT MUSH

That last exchange captured the essence of the project. As dumb as it sounded, they had done a great deal of irrelevant work and it wasn't until toward the middle of the project that they understood how the Executive Staff would measure the business success of the project. The PM sighed in exasperation. That lack of understanding of the business purpose had also made change control impossible. Instead of being able to evaluate the

Team members who have to guess the end result that is expected from them don't give us their "best work" nor do those we micromanage

change requests based on whether or not they contributed to the desired business results, they were left with only the ability to argue about the vague “value” of changes.

The PM wondered what they could have done differently. During the planning, the VPO and Medical Director hardly gave them a moment of time; delegating planning to lower-level decision-makers who were equally unaware of the criteria that would be used to judge the project success. Why wouldn't the VPO give them any time? Probably because every meeting they ever had with the VPO was devoted to detailed technical discussions that simply were not of interest to that level of decision-maker. Instead of setting up a network of business achievements that were objectively measurable, the PM settled for mission statement mush, which was approved because there was nothing in it but vague generalities.

The PM tiredly rose and left the room, thinking two thoughts. First, this happens to us over and over again but we never learn any lessons from it. Second, wouldn't it be nice if I could do it all over again.

ACHIEVEMENT-DRIVEN PROJECT MANAGEMENT

We'll develop techniques to address these problems in the remaining chapters of this book. We'll also work through the unique aspects of project management in the healthcare environment and the unique stakeholder issues with which PMs in healthcare must cope. The foundation for these techniques will be our Achievement-driven Project Management Methodology (AdPM™). We build this foundation with unambiguous business achievements that define success for the project as a whole and each of its components before we start. Measured achievements require that we think about end results, rather than just activities, before we start work. However, the payoff for the PM who makes this intellectual investment comes each week in the form of:

- ❑ Team members who know what is expected of them before they start work
- ❑ Executives who understand what they are “buying” from the project and, as importantly, what they will not get
- ❑ Scope and change control processes that are based on hard-edged objective data, not opinion
- ❑ Smaller project plans that are easily maintained and updated so the PM knows exactly where the problems are.

It is normal for all of us to think in activity terms; what we want people to do. To conceive measured achievements we need to go a step further. We think about what we want people to do and then how we will assess their performance when they are finished. It is this latter measurement that is our measured achievement. Let's consider a few examples of activities and their conversion to measured achievements:

Activity	Measured Achievement We Can Verify	Type of Measured Achievement
Complete the design	CIO approves system design	Approval achievement – We measure success by an executive or a technical reviewer signing off
Develop new billing statement	98% statements mailed within 2 day of discharge	Metric that we can objectively verify
Design billing system prototype	Billing system approved by Quality Assurance as complying with Standard Operating Procedure #6	Approval achievement that meets a published standard
Tally number of bills on hold	Bills on hold total less than \$100,000	Metric that we can calculate
Correct billing errors	98% of errors corrected within 1 business day	Metric that we can objectively measure

While the measured achievements in the middle column are in a number of forms, each gives us, or the person doing the work, a clear and unambiguous performance expectation. It tells them when they are done and makes clear what level of performance is required. For project executives, measured achievements detail what they are getting and what they are not getting. By laying out our plan, we quantify expectations before we start work, not halfway through the project. This is a real asset in scope control. Consider the activity of correcting billing errors shown above. Laying out this clear end result tells the team member the standard they must meet. It also tells an executive the error correction expectation. If that level is not good enough, we can change the plan now rather than redo it later.

Let’s look at how we’ll use this measured achievement thinking in our project management process.

MEASURE OF SUCCESS (MOS™) & ACHIEVEMENT NETWORK (HLA™)

The most significant measured achievement in our plan is the measure of success (MOS™). It quantifies business success for the project as a whole and “frames” the entire effort. Once we have stakeholder agreement and approval of the MOS™, we’ll construct a network of high-level achievements that are the principal ingredients required to deliver the MOS™.

Executives are accustomed to controlling & evaluating projects with only one measurable dimension, duration, or at most two, budget & duration. We’ll give them four and much better decision-making about trade-offs.

Not all of these HLAs™ will be related to patient service, if that is the target of our MOS™. Some will capture the Business Office achievements and others may require IS efforts. As an example, say we have a project to build a patient history system for our Patient Services department. When we understand their MOS™ of decreasing the time it takes to respond to a patient's inquiry by 25%, we'll build a high-level achievement network that includes not only system achievements but also achievements for training the staff and altering their internal departmental processes. These high-level achievements usually span functional and departmental boundaries and including them in the plan gives us the information about how our entire effort has to support the MOS™. As well, within a given organizational sub-unit we may need achievements by the Medical Staff, other caregivers, ancillary services and department administration. The important point is that we want to manage an integrated cross-functional effort because that improves the odds of success for the entire project.

Before we work through the planning process, there is a core technique that we'll use in Broadbrush planning and throughout the project; it's called quantified trade-offs.

TRADE-OFFS AND SCOPE CONTROL

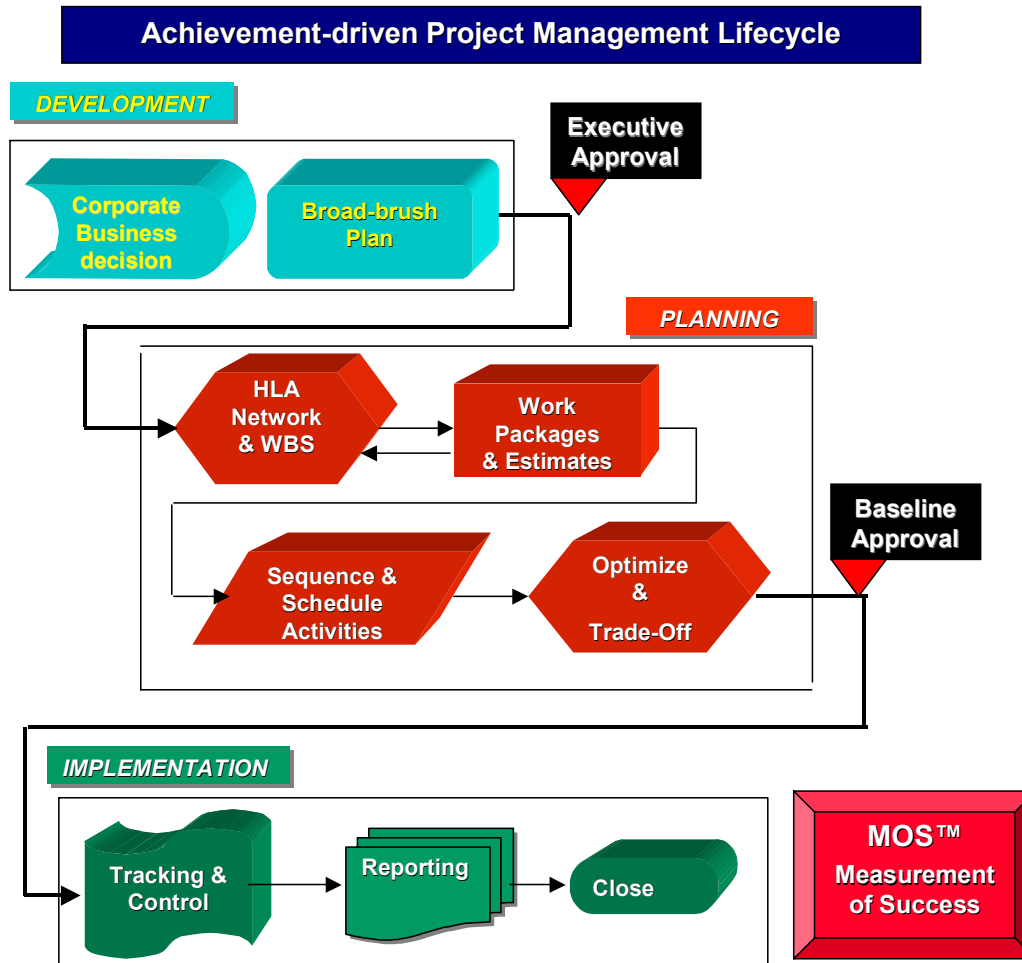
Our measured achievement focus lays the groundwork for managing with quantified trade-offs. The trade-offs we will work with come from the "four corners" of the project we will develop. Instead of describing the project with a budget, due date and a long narrative, we describe it with four quantified dimensions. These 4-Corners are:

- ❑ Measure of Success (MOS™)
- ❑ Budget
- ❑ Duration
- ❑ Risk (probability of success).

Our intent is to build a project plan where each of these four corners is quantified and we can discuss quantified trade-offs between them. We establish the idea of trade-offs between these four corners early in the project and then we will use it for scope control during:

- ❑ Detailed planning
- ❑ The final project approval presentation and
- ❑ Every week as we track actual results and deal with changes and problems.

Rather than try to "fight" with stakeholders about changes to the plan or changes to the requirements, we will present data on these trades-off before they ask. If the executives wish to shorten the duration of the project, we will calculate the impact on one or more of the other corners of the project. We can certainly shorten the duration but the trade-off may increase the cost, reduce what we achieve or lower the probability of success. This trade-off mentality is the key to maintaining a high probability of a successful project by giving us an effective and data-based approach to change and scope control. It also allows stakeholders to exercise strategic control over what they are "buying" from the project and that can earn us many benefits in our relationships with the different audiences with which we have to deal.



Our project management lifecycle diagram summarizes the Achievement-driven Project Management (AdPM™) process we’ll be following throughout the remainder of the book.

The project plan flows from the stakeholders’ decisions about business objectives in measured achievement form. It gives us a strategic framework that we will verify with our Broadbrush planning process. Then we’ll detail the plan to build a foundation for executive decision-making and for tracking project progress.

2 - Strategic Project Planning

In this chapter, we'll work through the process of strategic project planning, seeking to "frame" our project within boundaries of measured business outcomes in the stakeholders' operations. We'll also work with the stakeholders to establish and gain their approval of the strategic framework of the project and the processes we'll use to deliver the end result. The strategic plan includes:

- ❑ An objective measure of project success (MOS™)
- ❑ A high-level achievement network (HLA™) which lays out in measurable terms our path to the MOS™. It quantifies the boundaries of the project's scope including achievements from all involved departments
- ❑ Assessment of risks, mitigation strategy and strategic assumptions
- ❑ The project charter including authority structures and accountability relationships
- ❑ Change control processes and decision-making rules.

Having this framework in place before we start work substantially increases the probability of the project being a success in the stakeholders' eyes as well as providing solid scope control. However, strategic planning is a difficult process, which is why it is skipped in so many projects.

WHY WE SKIP STRATEGIC PROJECT PLANNING

Most HC projects start with the assembly of a grocery list of requirements that grows each week during the project because there is no strategic plan to restrain the expansion of the project or target its success. We have little ability to define what's in and what's out of the project. Oh, we see long narratives supposedly defining scope and objectives but they rarely contain objectively measurable definitions of success and the measured steps we'll take to reach that end business result. So why do people skip strategic planning? Because it requires that we:

- ❑ Gain access and the participation of stakeholders and executive level decision-makers
- ❑ Learn about the performance requirements of each functional unit

When projects are defined solely as the implementation of a new system, we are unlikely to have satisfied stakeholders at the end or produce value for the healthcare organization.

- ❑ Speak the stakeholders' language
- ❑ Secure performance commitments up front
- ❑ Cope with the conflict that occurs whenever we make tough decisions
- ❑ Conceive a cross-functional effort that spans functional “silos” and nudges the hierarchy just a bit.

No wonder people skip this strategic planning; it's so much easier just to start work and hope for the best. Let's explore several of these challenges in more detail.

First, the language of strategic planning is not about activities, it's about end results. While it's easier and more comfortable to talk about the means, we need to talk about the ends first. We talk the stakeholders' language and our discussions are not limited to what they want but focus on what they will achieve with the new capability the project will provide. Our focus is not on medical equipment, data collection systems or patient/insurance billing procedures. It is on the measured impact the project will have on “patient care” and the “patient data collection.” When we dive into the details of a physician's or clinic's professional practice, we encounter resistance...sometime fierce resistance. It is always easier to assemble a list of their wants than it is to secure their commitment to what they will achieve and what they will deliver with those systems or equipment. Many who will be in these discussions will want to get into the delicious technical details or talk about what the screen on the new equipment should look like, not what we have to achieve for the business. The PM and HC project team members can be their own worst enemy in this regard. We are more comfortable talking about areas of our expertise than the stakeholders' business, particularly the caregivers. However, we need to engage executive decision-makers in this process. We quickly lose them if we let the planning sink into the “activity trap” of technical equipment or processes and their functions.

Second, few PMs enjoy conflict and strategic planning triggers it. Moreover, this conflict is usually with people with higher rank or status than we have. Rather than burying disagreements, a strategic planning process that focuses on hard-edged and measurable business results brings them to the surface. We're not creating conflict. Rather, we want to resolve as much of the existing conflict over business results and “what's in the project” as early as possible. No HC project can meet all of the different stakeholders' expectations. The question is when in the process we face these conflicts and start to control the scope. We can defer the existing conflicts or schmooze them over in the interest of “getting off to a good start,” and then face them toward the end, when changes are many times more expensive. Alternatively, we can begin scope control early, which is much better than waiting until the duration and budget start to slip.

Those are some of the challenges we face in strategic project planning. As a rule of thumb, every hour spent on this process saves 10 hours during the life of the project. The two-step strategic planning process we'll use to frame our tactical

planning substantially increases the probability of delivering the business results the stakeholders want within the time frame and budget to which we will commit. With an approved strategic plan, we begin the project with:

- ❑ The ability to focus our efforts on objectively measurable business results
- ❑ Executive agreement on the measured path we will take to reach those end results
- ❑ Commitment from the stakeholders to the achievements they must deliver as part of the effort
- ❑ Executive understanding of the risks inherent in the project and the cost of mitigating those risks
- ❑ Clear authority and accountability relationships across functional lines
- ❑ Executive agreement on the processes and procedures for making the inevitable changes.

Figure 1 Project Lifecycle

