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Moving the Needle:
Getting Things Done in Health Care

The RACI Tool for Health Care Executives

By Cassie Solomon

"Sometimes I lie awake at night and wonder what went wrong.
Then a little voice in my head says, 'One night is not going to be enough.'"
—Charles Schultz

SECTION ONE:
Understanding the Special Accountability Challenges that Health Care Organizations Face

- Do you feel like you are spending your time in endless meetings, not getting enough done, so that it crowds out the time you need to do your "real job?"
- Do you wonder if anyone knows how to make a simple decision in your complex health care organization, so that everyone can be free to execute?
- Do you wonder who should be held accountable for accomplishing the system's goals?
- Do you find that you have far too much data, and far too little information to help guide your actions?

If the answer is yes, then this white paper is for you. There is a kind of role confusion that afflicts groups and that creates barriers to progress; but before we solve the problems, we need to define them. The first section of this white paper deals with defining the accountability problems inside health care organizations, and the second section deals with the solutions—and the way the RACI tool can help. (For a complete description of the RACI tool, please CLICK HERE for the RACI White Paper.)

Health Care Today: Who's on First?

I spent the past two days sitting with the members of a senior leadership team of a major teaching hospital at their twice-yearly leadership retreat. As the pace of change accelerates for health care leaders, they spent time bemoaning the duplication of their efforts. Here are some examples:

1. Whenever the federal government announces a new grant opportunity, several different members of this system spring into action. Department chairs, the VP of strategic planning, and the head of a newly created "Quality Institute" all found themselves starting to respond to a grant opportunity last week. By the time four different senior executives had figured out that they were all doing the same work, tempers were frayed.

2. The system discovered that there are at least five entirely separate teams working on discharge planning initiatives, with no coordination among them. They had worked for two to three months before the duplication was even uncovered.

3. Even for a patient population with a specific disease like heart failure, there are multiple parties responsible. Cardiologists care for 50% the cardiac inpatients, hospitalists care for the other 50%—about half of those without the benefit of a consultation from a cardiologist. With value-based purchasing upon us, 100% of those patients need to be cared for according to a care pathway that has been carefully created based on evidence-based guidelines. But how can you get all of these clinicians—including many physicians in private practice—to actually use the thing? Who can you hold accountable for improving the overall quality of care?

We focused on these dilemmas with great passion and frustration over the course of a two-day offsite meeting. With so much work to do and pressure to perform, no system can afford the wasted energy of duplicating effort right now. This team of leaders is familiar with the RACI tool and so they were able to recognize the need for applying it. "We need to get the four of us together to sort out the RACI," the CMO declared. One negotiation and done.

Problem #1: We spend more and more time in horizontal organizational structures, where authority is unclear.

All organizations have two different structures, and health care organizations are no exception. The first of these is described in business schools as the "Vertical Organization". Think of it as the organization's formal hierarchy. You know you are dealing with the Vertical Organization when you can clearly identify your boss, the person or group to whom you are accountable.

How can you tell to whom you are accountable? Simple. Your boss is responsible for hiring you, evaluating your performance, and, if he or she is unhappy, for firing you, too. Your boss often controls access to resources, like budget or support or even organizational attention. As a result, very few people are confused about where the authority lies in their own Vertical Organization.

But over the past two to three decades, organizations have also started creating a great many teams and task forces and groups that are designed to cut ACROSS the vertical "silos" in their organizations in order to share knowledge and collaborate. These teams belong in the other organizational structure, the **"Horizontal Structure." To be effective, today's organizations need to have strong vertical AND horizontal structures.** Most managers and leaders in today's organizations—but especially in health care—are living in both structures simultaneously (Figure 1).

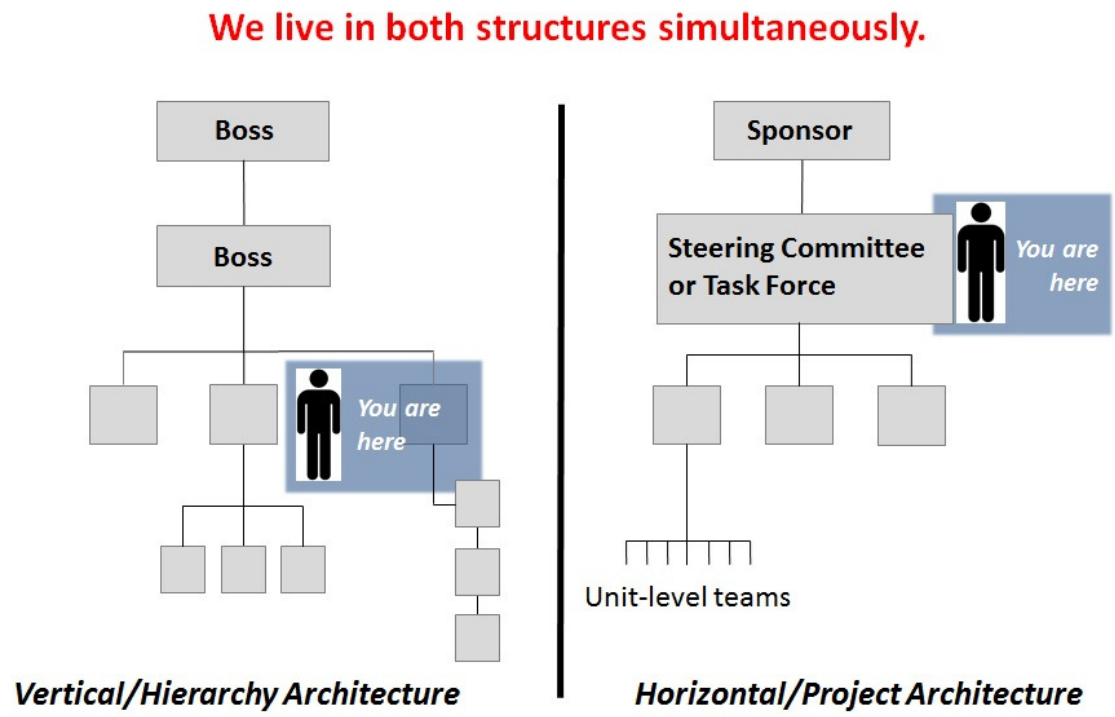

Figure 1

The problem is that in the Horizontal Organization, authority is much less clear. Who can make decisions? What exactly is the role of the team or task force? Who will evaluate whether we are doing a good job or a mediocre job? To think about what this looks like in action, consider what you would do if your boss gave you an assignment that was due tomorrow morning, and you also had to produce something for the task force you serve on tomorrow morning. Which one will you do?

Accountability is vague in the Horizontal Organization—and most of us spend more and more time there.

Problem #2: Clinical improvements are challenging to make because of *organizational* complexity, which often goes unrecognized.

Often, in our health care organizations, we don't stop to think about how "complex" a problem is to solve before we dive in. What makes problems complex is not necessarily clinical complexity—although we have that too—but organizational complexity.

Organizational Complexity Defined

When a project has "line of sight" accountability inside a single unit or department, the problem is simpler to solve. An example of this might be changing the behavior of people who regularly work together in a single unit or department and who have a clear authority relationship with a boss who is advocating for the change. (Note that "simple" in the complexity framework is not the same as "easy." Think about getting 100% compliance with hand hygiene on a floor unit.) But what if all the people involved in creating the change do not report to the same boss? More complexity. What if the change needs to be made across several units or departments? Even more complexity. What if the change crosses different service lines, or multiple facilities, or different organizations entirely (for example, a not-for-profit provider hospital and a private practice medical group)? *Still* more complexity.

Like complex patients, these complex organizational challenges are harder to diagnose and harder to prioritize, and the interdependencies are harder to manage. The more complex the problem, the more resources will be required to solve it. Resources may mean dollars, but more likely these problems will need more time, attention, staff support and **more structure**. Look at a complexity framework developed by one of my clients as they thought through these issues (Table 1).

Complexity Framework

Complexity Level	Definition	Approach	Resource Support
1	Local impact, focus within the clinical dept., line of sight, single role	"Just fix it" management focus	Front line staff-driven
2	Local impact, focus within the clinical dept., multiple roles	PDCA, LEAN tools	Some facilitation required
3	Impact beyond one clinical dept., focus primarily within a service line, multiple roles	Team charter A3, PDCA, LEAN tools, rapid cycle improvement	Assigned Office of Quality and Patient Safety Support
4	Impact horizontal & vertical, focus is system wide, multiple services crossing service lines and/or facilities	Team charter A3, PDCA, LEAN tools, rapid cycle improvement	Top-notch, experienced consulting resources

Table 1

Problem #3: Today, medicine is a team sport.

The more complex the issue, the harder it becomes to assign accountability for it to a single group (e.g., just unit 5C) or role (e.g. just nursing), and the more important it becomes to assign a multidisciplinary team to address it. Certain issues may still reside just within nursing (skin, falls), but almost every other clinical condition will involve multiple members of a team from different disciplines: hospitalists, specialist MDs, advanced practice nurses or physician assistants, RNs, respiratory therapists, other clinicians, or social and case workers, etc. The team may also include professionals outside as well as inside the hospital: visiting nurses, primary care practitioners, and even family members. *Voila!* This is why we are stuck with so much important activity in the horizontal structure of our health care organizations.

Let's take the example of improving Ventilator Acquired Pneumonia (VAP) performance at a large teaching hospital. Multiple units are involved in treating patients on ventilators, and the problem is system wide (Figure 2).

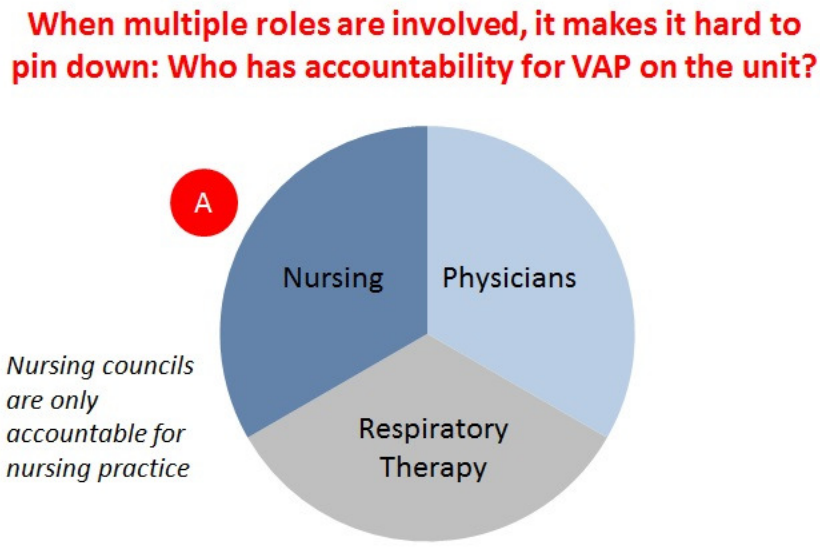

Figure 2

On any single unit, we are already at Level 2 complexity. What happens when you expand your view to include other units, and the whole health care system?

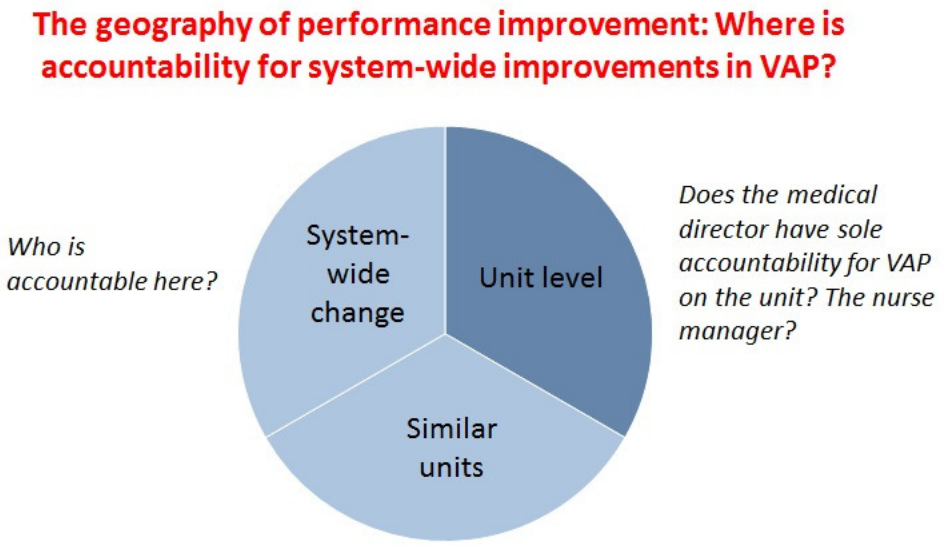

Figure 3

Problem #4: The data we provide is not aligned with the accountability we want to assign.

So we can see that without a multidisciplinary team that brings together physicians, nurses, and respiratory therapists, and probably includes representation from our most-involved units, it will be difficult to work on improving VAP system-wide. But there is one more challenge, which is that the performance data we provide is often not aligned. In many systems, data is provided on a unit basis, rather than on a patient basis. Unit-level data is geographic and mainly can be "attached" to a particular nurse manager and the nurses on that unit. Since physicians treat patients in many locations, the data doesn't align with their accountability very well. To speak effectively to physicians, we need to provide data on their performance or the performance of their partner group. This data can be more challenging to assemble and much more challenging to share, but without it, accountability is hard to assign (Figure 4).

	Data by Unit	Data by Physician Group
Nursing	**High Accountability** *Nurse managers are accountable for their units' performance*	Lower Accountability
Physicians	Lower Accountability *Physicians care for patients on many different units*	**High Accountability**

- If you want to change nursing behavior, provide unit-level data.
- If you want to change physician behavior, provide physician group or individual physician data.

Figure 4

SECTION TWO:
What Is RACI and Why Do We Need It Now?

RACI is a well-known project management tool, created in the mid-1950s, and is used widely in many industries and large companies such as Proctor and Gamble, eBay, Amazon, and the U.S. Department of Defense. It has been widely embraced by the software development industry and also by project managers worldwide. You can find downloadable articles at the Project Management Institute and across the web. I'm grateful to my mentors, Tom Gilmore and Larry Hirshhorn of CFAR, who have also taught it for many years with me at the Wharton School of Business. Because of the accountability dilemmas described above, it is an organizational lifesaver for health care organizations.

RACI gives us all a simple shorthand and a language to talk about roles in a neutral, nonjudgmental way.

When you clarify "Who has the R for that?" you are enhancing accountability. When you determine "Who has the A for this decision?" you are clarifying authority in the system. It's simple to teach and to use, and it's flexible.

Bringing project management tools into health care may seem esoteric at first, but take a look at the list of things that can go wrong when there is **role confusion** in a group—no fun, and all too common.

While it's funny to listen to Abbott and Costello's "Who's on First?" skit, it is quite different when two coworkers are talking "past" one another, both with good intentions.

When people are confused about their role, they don't work effectively. Sometimes they fight, but sometimes they just stop caring.

Problems with teamwork are often role problems.

When things go wrong with our teamwork, our training, language, and skills make us inclined to believe that the problem is with an individual. We might say, "If only they were more competent," or, "He's not a team player." But in our experience as consultants at The New Group and RACI Solutions, we find that, in fact, most of the problems that occur in organizations are actually located in the "seams" between people or between groups. This means that the problem is in the **relationship** between the two, rather than **inside** one person or one group or another.

How you define the location of the problem turns out to be important, because it will determine how you go about fixing it. If you think the problem is inside an individual, you may recommend an assessment or training or a coach to change that person's skill or behavior. If you think that a problem is inside a particular group, you may send the group away to do some team building. But if the problem is located **between** two individuals or **between** two groups, then these interventions won't work. Rather than an individual "fix," you may need a mediator to work with both sides of the equation. Rather than a team-building exercise with one group, you may need to hold a retreat with both groups in attendance, and help them work together differently.

These interventions into **relationship between** can be more difficult to pull off even if they are ultimately more successful. That's why the RACI tool is so welcome. It creates a **simple and neutral** language that people can use to discuss their different perspectives. It is a tool that often leads people into a negotiation. Once resolved, everyone can move forward again with clarity.

Using RACI gives you a chance to **negotiate** for what you want—how much responsibility, how much work, and how much decision-making authority. A project manager in one of my client organizations, working in the Heart and Vascular Institute, told me the following story last week.

> "I am a member of a team that was just getting so dysfunctional. There are two guys, and one of them has taken on responsibilities that used to belong to the other. These two fight. I didn't know who owned the process. It was clear to me that the meeting was being dominated by their conflict. We would all sit there and think, what is going on?

We got nothing accomplished; we were spinning our wheels. Those two have not defined yet who is doing what. I decided to try out the RACI template with the team. I put in decisions and activities that we were fighting over. I wrote down "incomplete" for everything. We went line by line and I would ask 'Who is accountable for this?' and we would fight it out until we resolved it, then I would write it down.

"It has run so smoothly since then! We had to have the fight, to clarify their roles, but now we pull this RACI up in the meeting at the beginning every time and say, 'OK, Bill, this is your area.' It helped us stop fighting and just focus on getting the work done. Apparently, they still go into other meetings and fight like cats and dogs, but in my meeting, it doesn't happen anymore. We are ahead of schedule."

SECTION THREE:
RACI: A Quick Review

Let's start by remembering the basic building blocks of RACI, the codes (Table 2).

RACI Codes

Responsibility "R"	The individual or group who actually completes the task, the action/implementation. Responsibility can be shared.
Authorize "A"	The individual or group who is ultimately responsible. Includes yes or no authority and veto power.
Consult "C"	The individual(s) or groups to be consulted prior to a final decision or action.
Inform "I"	The individual(s) or groups who are informed after the final decision has been made, or the individuals or groups who need to be informed that action has been taken after the decision has been made.

Table 2

RACI Definitions

Responsibility: The "R" code is the most important when you are trying to enhance accountability in the system. The person who holds the "R" is the one who will make sure that this piece of work gets done. It can mean that he or she will perform research and analysis and offer a recommendation to someone else. The accountability is very specific—if nothing gets done, he or she is the responsible party. Although he or she may get help from others, or delegate some or all of the work, the "buck stops here" with this person if nothing happens.

Authorize: The "A" role holds the authority in the system and must approve a decision or determine if a particular task has been done well. This person is accountable for something quite different; his or her job is to exercise judgment in making the decision. The risk is simple: he or she can be wrong.

Consult: The "C" role is perhaps the hardest to understand. A person is given a "C" role if he or she has a particular knowledge or expertise to contribute to the decision or the task. One requirement of a "C" role is that it must be included before the decision is made, and this is because if someone has a "C" it means that you believe his or her contribution is vitally important to reaching a quality decision. For this reason, try not to give a "C" to someone merely to get his or her "buy in" to a decision process. You are much better off giving a genuine "C" to a person or group that knows something you really want to understand before you proceed. The best analogy I have found for the "C" role is that of seeking a second opinion from a physician when faced with a significant medical decision. The second-opinion doctor is not obligated to do anything other than give high-quality advice; the decision whether or not to proceed with surgery or treatment remains with you. So the accountability for someone in the "C" role is to give you his or her best possible thinking—no more.

Inform: The "I" role is understood to be the weakest because the person doesn't participate in the decision before it is made. You inform them about the decision afterwards; the "I" role doesn't participate. Yet we have all been in situations where someone felt deeply offended because they learned about something in the wrong way—through the rumor mill or even by reading it in the newspaper! So thinking carefully about who "needs to know" about actions and decisions is good stakeholder management.

What about collaboration, when more than one person has the "R"?

With complex tasks, it's inevitable that more than one person will need to collaborate to get the job done. The danger with this is that it can be like doubles playing tennis: the ball can go straight down the middle between the two players because each one is thinking, "Oh, that's not my ball." To avoid this problem you can designate one person as the "R-prime" or "R_1" which means that in terms of accountability, this person is #1.

Can an activity or a decision have more than one "A"?

The Project Management Institute will tell you that you should assign only one "A" to a responsibility chart, but I generally find that in complex systems, like health care systems, that's not possible. The key point is that the more "A"s are attached to a decision, the longer it takes to move through the approval process. So reserve this situation for truly important matters—major change efforts or policy shifts—that warrant the time and energy involved. If relatively minor decisions have more than one "A" attached to them, ask yourself if you can streamline the decision or work to reduce their number.

Can a person have more than one role?

Yes, it is very common to have more than one role at a time. You can have the Authority (A) and the Responsibility (R) for a task if you do the work and also decide which course to take. You can also combine the Authority (A) and the Consultation (C) roles if you tell a subordinate, "Get my views of what is important (the C) and then bring your recommendation back to me for my approval." It is less common but also possible for someone to keep the Consultation (C) role and the Inform (I) role when delegating a task, but give both the Responsibility (R) and the Authority (A) to a subordinate. In this case you would say, "Get my views of what is important here, but then go out and do the work and make the decision yourself. In the end, just inform me about what you've chosen to do."

Creating a RACI Matrix

Step One: Choose a focal activity or decision for your chart.

The first step is determining the decision or activity you want to "chart." Since RACI is a simple tool, you can apply it to broad issues and very specific issues, so this step is a key thinking point. For example, do

you want to create a chart for the entire on-boarding process, or just the part of it that the front line manager is responsible for? Each of these will yield very different charts—and you can do both.

Let's start with a household example. Do you want to chart something very broad, like "housework," or do you want to chart a more narrow element, like "doing the laundry?"

Step Two: Determine the activities or steps involved.

This is where the RACI method crosses paths with project planning. To create a chart, you need to think through the steps involved in the activity, or the steps of the decision process. For example, if you are charting the task "doing the laundry," you might think of the following steps:

1. Bring clothes to the laundry room.
2. Sort lights and darks.
3. Pre-treat any clothes that are stained.
4. Decide which products to use (detergent, bleach, softener).
5. Wash a load of laundry.
6. Decide which clothes can go in the dryer and which clothes should drip dry.
7. Dry the laundry.
8. Decide which things need to be ironed, if any.
9. Iron clothes if necessary.
10. Fold the laundry.
11. Put the clothes away.

Can you mix up decisions and activities? Steps 4, 6, and 8 above involve decisions, after all. Yes! You can mix them into the project plan as long as they are fairly simple and don't require a whole separate kind of thinking through.

Step Three: Determine stakeholders who will be involved.

This is where the RACI method crosses paths with stakeholder analysis, and it is a valuable thing to do for any project. Who needs to be involved? Who **thinks** they should be involved? Who has been forgotten? For a complex or high-stakes project, it pays to do some brainstorming about this step with a small group of people.

In our laundry example, let's say the stakeholders are: Mom, Dad, Son, and Daughter. This is what the RACI chart we construct might look like (Table 3).

RACI Chart

		Roles of Participation			
		Mom	Dad	Son	Daughter
Decisions or Activities	1. Bring clothes to the laundry room.				
	2. Sort lights and darks.				
	3. Pre-treat clothes.				
	4. Decide which products to use.				
	5. Wash a load.				
	6. Decide dryer or air dry.				
	7. Dry clothes.				
	8. Decide ironing.				
	9. Iron if necessary.				
	10. Fold laundry.				
	11. Put away clean clothes.				

Table 3

In our simple example, you might not want to elaborate all these steps. You might decide instead that you want to chart a broader set of activities involving housework. If that's the case, you could collapse all the "laundry" steps above into a single line, called "Doing the laundry." Then it would be one among many other household tasks like "doing the grocery shopping" or "keeping kitchen floor clean."

Step 4: Decide if you want to chart the "as is" or the "will be."

Before you take the next step of filling in the RACI matrix with the codes (R,A,C,I) you need to make one more decision. Are you going to chart the "as is"—the way the world is working today? Or are you going to the chart the "will be"—designing the world the way you would like it to be? Sometimes the answer is obvious: if you are doing a project plan for the future, obviously you are charting **prospective** roles. But it is also possible to chart the "as is" world to learn more about how a system is working today, which is what we will do in our laundry example. The fascinating thing that can happen when you do this is that you discover that different stakeholders have different ideas about how the roles in the system work—then you need a dialogue.

Step 5: Fill in the RACI chart with roles of participation codes.

Take a moment and fill in the "laundry chart" above—hypothetically, of course. This step can either be done alone or in a group. When you fill in the RACI chart alone, you are revealing the way that you see the roles working in the system. Remember that someone else might see it differently.

RACI Chart

		Roles of Participation			
		Mom	Dad	Son	Daughter
Decisions or Activities	1. Bring clothes to the laundry room.	R		R	R
	2. Sort lights and darks.	R			
	3. Pre-treat clothes.	R			
	4. Decide which products to use.	A	R		
	5. Wash a load.	R	R		
	6. Decide dryer or air dry.	A			C
	7. Dry clothes.	R	R		
	8. Decide ironing.	A	C		
	9. Iron if necessary.	R			
	10. Fold laundry.			R	R
	11. Put away clean clothes.			R	R

Table 4

Step 6: Negotiate how you see the roles and how others see them.

Sometimes it makes sense to do RACI in a more formal way, where individuals each fill in a RACI matrix separately and then compare notes. The value of doing this is that you learn how people's perceptions differ.

Most of the time this step is collapsed into the step above—a group of people can sit around and talk about how to fill out the chart together. "Who has the R? Mary or Ben?" In the course of the discussion, they come to a common understanding.

Let's take a look at the RACI chart we started above, to see what it looks like when the roles have been assigned.

- Notice that it's not necessary to have every cell in the matrix filled out.
- Notice that it's not necessary to have an "A" on every line, except the ones where a decision is clearly involved: steps 4, 6, and 8.

So, in the chart above, Mom and Dad share the work of doing the laundry, but only Mom does the ironing. The daughter, whose clothes may be more complicated than the son's, wants to be consulted on which clothes go into the dryer; and Dad wants to be consulted on whether his shirts get ironed. The son and the daughter both have responsibility to bring their clothes to the laundry room and to fold and put away the clean clothes.

This raises an important question: Do things always happen the way you plan them in the RACI session? No. Of course not. **To be effective, a RACI chart needs to be a living document that represents a team's agreement.** To stick with our example, what happens if the son and daughter stop folding their laundry or putting it away? The RACI chart makes it much easier to hold them accountable in a much more neutral way by saying, "Hey, do you remember when we had that meeting about the laundry? Here's the RACI chart that we produced. You've got the 'R' here for doing some of the laundry—don't forget."

SECTION FOUR:
Becoming a RACI Champion

The RACI tool can be deceptively simple. But determining the steps of a major project can sometimes be just the first valuable step of applying it at work. Next, thinking through the various stakeholders who need to be involved—and how—can save a world of heartache down the line.

The more you use RACI and the more applications you find for it, the better and more proficient you become with the tool. Then it can become an even more powerful way to promote accountability and streamline decision making at work.

For more information about how and where to use RACI, visit www.RACISolutions.com and see the following blog posts:

When to apply RACI

- Surviving in the Matrix: RACI to the Rescue
- RACI for Mergers and Acquisitions
- RACI and Virtual Teams
- You Must Be New Around Here: Using RACI to Get New Hires Up to Speed

More on How to Use RACI

- Defining the RACI Codes: Understanding the Language
- Adding a RACI Chart to Your Microsoft Project Plan
- The Problem with RACI: Linking a Workflow Diagram with RACI Roles
- How Large Should a RACI Chart Be, Anyway?