Strategy as Simple Rules: Understanding Success in a Rural Clinic

Christy Harris Lemak and Elizabeth Goodrick

Drawing on chaos and complexity theories, we apply the concept of "strategy as simple rules" to analyze the success of one rural health clinic. We document how such rules may emerge as success is viewed retrospectively. We describe four simple rules that emerged in this setting and explicate how our case analysis may assist other rural providers.

Strategic management was embraced by health care organizations in the 1980s as hospitals began to cope with a changing and less munificent environment. Originally developed in the context of business organizations, the basic idea behind strategic management is that organizations can make choices so as to improve their ability to prosper in their environment. The assumption underlying this paradigm is that the future is controllable and thus organizations should anticipate, plan, and act in a rational manner so as to benefit. And, indeed, there are a number of studies that suggest that health care organizations, including rural hospitals, that engage in strategic planning have better performance.1-4

Still, there are several different schools of thought that call into question some of the fundamental tenets of a strategic planning approach. Weick, for example, coined the term retrospective sensemaking to refer to the tendency of organizations to construct rational accounts of actions after they occurred.5 Mintzberg6 first discussed the notion of emergent strategy in 1972 to explain how organizations that do not plan before they act still succeed. Counter to decades of strategic management teaching, such organizations do not control and plan but rather make sense of what they have done and retrospectively adapt.7 Thus strategy emerges from a stream of action instead of being deliberately determined a priori. While these ideas have been developed in other industries, their application to health care organizations is extremely limited.8

An even more serious challenge to the traditional foundation of strategic management has come from the current application of chaos and complexity theories.9,10 Reacting to the intense, high-velocity change characterizing many industries, some have argued that the assumption of linearity underpinning traditional

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approaches to strategic management is outdated. Instead of predictability, turbulent environments have resulted in complex adaptive systems operating at the edge of chaos. To guide them through the chaos, successful organizations have recognized the need for “a few key strategic processes and a few simple rules.” While illustrated mainly by arguments from the computing industry, the concept of strategy as simple rules makes sense for “all kinds of companies in fast-moving markets.” Ashmos, Duchon, and McDaniel used the notion of simple rules to explain why hospitals that included physicians in strategic planning and decision making had higher performance than those that did not. In the recent Institute of Medicine Report, Crossing the Quality Chasm, Plesk and others call for the development of a few simple rules to guide the development of the twenty-first century health care system. This article applies the concept of strategy as simple rules to a successful rural health care clinic and then suggests how lessons learned at the clinic may inform other rural clinic managers. While there is a body of health care management research on specific rural hospital strategies as related to closure, conversion, and similar decisions, we could find no previous studies of strategic management activities in rural health clinics. Topping and Calloway found that small, rural mental health providers had “few opportunities for proactive or strategic planning.” Conventional wisdom and anecdotal evidence suggest that small, rural health clinics tend not to engage in elaborate strategic planning processes, making these organizations an ideal setting to explore the idea that strategy can be embedded in simple rules.

LITERATURE REVIEW

While having roots earlier, the changing health care environment in the 1980s turned the United States health care sector decisively toward a business model for organizing. Searching for ways to cope with shifts in the amount of and methods for reimbursements between Medicare and other payers, hospitals embraced the strategic management tools of the business sector. In the ensuing years, the concept of strategic management has become central to management of health care organizations. Fundamental to the concept of strategic management is the idea that organizations can cope with environmental changes by proper selection and implementation of strategy. Strategic management provides organizations with systematic ways to manage both their internal and external environments by helping organizations determine which strategy they should pursue. By understanding and anticipating environmental conditions and trends, health care organizations are thought to increase their likelihood of success and survival. Indeed, there is some evidence that strategic planning by health care organizations improves performance. Others suggest that the links between strategic planning activities and organizational performance are tenuous.

In any case, underlying traditional approaches to strategy are a number of assumptions. The most important one is that the future is orderly, knowable, and predictable. A major role for health care managers under this paradigm is to predict possible outcomes of different courses of action. Managers seek to predict which industries, strategic positions, and competencies will be viable and for how long. Based on these predictions, managers make strategy decisions. Errors are thought to be the result of prediction and planning skills that can be improved by more sophisticated information systems and techniques for manipulation of this information. The assumption is that managers want to lead the organization to a stable equilibrium that aligns the organization’s strengths and weaknesses with the opportunities and threats present in the external environment.

A fundamental challenge to this traditional emphasis on predictability and control has come recently from applications of complexity and chaos theories to strategy formulation. Originating in physics, complexity and chaos theories focus on nonlinear dynamics in complex adaptive systems. A basic concern in chaos and complexity theories is how nonlinear systems change over time and the ways in which they are different from linear systems. Linear systems are fundamentally tidy and predictable systems in which the whole is equal to the sum of its parts. This means that each component is free to act independently without regard to what is happening elsewhere in the system. Nonlinear systems, in contrast, are far less predictable because everything is connected. The independence of nonlinear systems means that the whole can be greater than the sum of the parts. The system as a whole can have properties that transcend the contributions of individual parts. Unlike linear systems, nonlinear systems are dynamic with a sensitive dependence on initial conditions, making the future not totally knowable. In such systems, small chance events can become magnified by positive feedback.
Still, nonlinear systems are not random but rather represent a different form of order. Complexity and chaos theories teach us that many seemingly random movements are patterns contained within specific bounds. Each system creates order and emerging forms as part of their natural development. Such complex adaptive systems are composed of many “agents” that are constantly organizing and reorganizing themselves into larger structures through mutual accommodation and rivalry. As a result, control of such systems tends to be highly dispersed, arising from competition and cooperation among the components rather than from mutual coordination. Through their actions and reactions, each component creates or closes opportunities for others.

Complexity and chaos theories offer a different foundation for a model of strategic management in fast-changing industries where the central challenge is change. These newer theories of order draw attention to limits of control and to the evolutionary and self-organizing nature of systems. In the new economy, traditional concepts of strategic management are problematic because the pace and nature of change make predictability fallacious. Complexity theory emphasizes the partial connectiveness between systems and the importance of learning to operate effectively at the edge of chaos. Such systems unfold nonlinearly over time, suggesting a different focus for managerial analysis.

Even though initial support for the validity of complexity and chaos theories for strategic management came from the computing industry, health care researchers have become intrigued with the concept because of the changes besetting the health care sector. As Begun and Luke summarize, the common perception among both health care executives and researchers is that there is rampant change in the health care delivery system that makes it difficult to predict outcomes. In response, we find Peirce arguing that complexity theory is better suited to health care organizations than traditional models because traditional models fail to explain essential features of health, including change, paradox, and uncertainty. Similarly, Plesk maintains that the U.S. health care system is a complex adaptive system, requiring a different design than a mechanical system.

While chaos and complexity theories provide a fundamentally different prescription for strategy that potentially could alter our understanding of health care organizations, the concepts can be difficult to define and apply. It is sometimes difficult to translate exactly what are the managerial implications of interesting ideas like “strange attractor,” “competing at the edge of chaos,” or “phase transitions.” There is a danger of these concepts becoming fads that are imported into health care management and repackaged into a new language.

In our view, one of the most useful ideas for managers to glean from this intellectual tradition is the concept of simple rules. Arguing that complexity science provides a new paradigm to guide system behavior, Plesk describes how the research on complex adaptive systems reveals that “simple rules can lead to complex, emergent, innovative system behavior.” He argues that simple rules create the conditions for self-organization of a system under which experimentation can occur. His interest is in finding the few simple rules that might guide the development of the twenty-first century health care system.

In contrast, Brown and Eisenhardt focus on strategy in single organizations and argue that “simple rules” allow organizations to establish a “semi-coherent direction” that is collectively understood. Compared to a strategic plan that is precise andunchanging, a semi-coherent direction enables organizations to manage continuous change. By providing for “disciplined flexibility,” managers are able to sort through opportunities within rapidly changing environments. Growing out of experience, especially mistakes rather than great foresight, simple rules help managers seize opportunities that allow organizations to build up long-term advantages.

Eisenhardt and Sull further posit that organizations develop and use one or more of five types of “simple rules” to guide decision making. The first category of rules describes how-to rules that describe how key organizational processes are executed. One simple how-to rule for hospitals that has been linked to higher performance is to “let the doctors decide.” Boundary rules are the second category of rules. These rules help managers decide which opportunities to pursue and which to exclude. For example, in the

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1980s hospitals were expanding into areas unrelated to health care—dude ranches, janitorial services, bottling companies—which, in hindsight, did not justify the diversion of executive time. Out of these experiences many hospitals developed boundary rules about diversification that excluded owning an asset simply to increase revenues. Priority rules are the third type of rules. Priority rules give managers a way to rank possible strategic opportunities. A health care example could include the rules established by religiously sponsored providers regarding the importance of meeting "mission" objectives as they make resource allocation and other decisions. The fourth category includes timing rules that guide organizational action by setting the pace for implementation and execution of newly accepted strategic initiatives. Finally, exit rules give managers ways to determine when to end activity in outdated opportunities. Optimally, organizations have two to seven targeted, specific, and simple rules from these five categories in place at any given time.

In this article, we adopt the simple rule typology proposed by Eisenhardt and colleagues since our interest is in understanding the success of a single organization. In the next section we describe the background and setting of the subject of our investigation, a rural health clinic located in northern Florida.

**BACKGROUND/STUDY SETTING**

We explore the concept of strategy as simple rules in the Alachua County Organization for Rural Needs, Inc. (ACORN) clinic, a rural health clinic providing medical care, dental care, and social services primarily for low-income residents in four counties in Florida. While continuity and accessibility of primary health care has been shown to be a key determinant in improving health status and reducing mortality, the rural poor often do not have access to the physician practices that function as the usual source of care for those with sufficient financial and other resources. Instead, a network of hospital emergency rooms, outpatient departments, and community health centers comprise the "safety net" of primary care for those who are poor, uninsured, or otherwise underserved. In rural communities, local health centers, such as ACORN, are often the only available resource for medical and social services.

Many, though not all, health centers participate in the Department of Health and Human Services' Health Resources and Services Administration Bureau of Primary Health Care funding programs. For federally qualified health centers, federal support contributes about 26 percent of annual revenues to clinics. Due to the various federal designation policies, some rural providers are not eligible for (or, when eligible, opt not to become part of) the federal health clinic programs. ACORN is a not-for-profit clinic that is not federally funded. Without any regular source of federal support, ACORN and other similar rural health care providers operate in turbulent and unpredictable environments. Their financial viability is highly dependent upon fluctuations in the local economy, the priorities of local funding agencies and community organizations such as churches, the continuing involvement of volunteer practitioners, and other local activities and market fluctuations.

ACORN was founded in 1974 when two VISTA volunteers were funded by two local churches to provide health care to migrant farm workers in outlying, rural parts of Alachua County, Florida. A medical clinic was opened in 1976 in the small, rural community of Brooker. While a large academic medical center and several other community hospitals are located in Alachua County, ACORN is the only provider of care in the northern, rural section of Alachua County. This northern part of the county and the surrounding counties of Bradford, Union, and Columbia may be described as a "pocket of persistent poverty" rather than a sparsely populated "frontier" rural area. Like other similar rural communities, there are few or no transportation services available, making it difficult for patients to obtain primary care and nearly impossible for clinicians to make referrals and coordinate specialty care services provided in the larger communities.

In 2001 ACORN provided more than 12,000 medical and dental visits to people living in 18 counties. Almost all (95%) of ACORN patients are at or below 180 percent of federal poverty guidelines. The clinic sees a mix of white (67%), African American (26%), and Hispanic (7%) patients. About 18 percent of ACORN patients are children, and 85 percent of adult patients suffer from multiple chronic health conditions. A major emphasis of the clinic is primary care, prevention, and assistance with access to and coordination of care within the region's complex system of providers.

A key feature of the ACORN Clinic is its use of volunteer physicians, dentists, nurse practitioners, and other health care professionals. While rural health clinics typically are staffed by a combination of public health service physicians, nurse practitioners, and some volunteers, ACORN relies entirely on volunteers to provide health care. These volunteers accounted
for 12,139 hours of service in 2001. ACORN has established unique and lasting relationships with the nearby University of Florida Health Science Center and Santa Fe Community College health professional education and training programs. In addition, ACORN receives support for health professional training programs from the local Area Health Education Centers program. As important, ACORN has also developed and maintained important partnerships with private dentists and physicians, the United Way, local public health units, and other agencies.

ACORN’s unique structure of partnerships and volunteer relationships has been recognized by several national organizations. Specifically, ACORN’s executive director received a Robert Wood Johnson Community Health Leader Award in 1997. The same year, the clinic was honored with a Mutual of America Community Health Partnership Award. The following year, ACORN was presented with the National Rural Health Association’s Outstanding Rural Health Program of the Year. The ongoing success of the clinic and its recognition by national organizations and awards make ACORN a model worthy of further examination.

RESEARCH METHODS

Our analysis of ACORN began as a study of how and why the clinic has remained successful for so many years. We were particularly interested in developing a set of ideas that could be shared with rural health care policy makers and managers of other rural clinics. As we examined the history and current operations and approaches of ACORN, the framework of strategy as simple rules informed and organized our understanding of this successful organization.

The following case study methods were used in our research. We gathered information on ACORN through semi-structured interviews, participant observation of key strategic planning processes, and review of clinic documents. More specifically, the first author conducted one-on-one, semi-structured interviews with ACORN’s executive director (four interviews), the board chairperson, a former and long-serving board member (two interviews), and a long-time clinic volunteer practitioner. Each interview began with a focus on the informant’s understanding of clinic history and possible determinants of its ongoing success. In addition, the first author was asked to become a member of the ACORN board of directors early in the research process, and thus she observed and participated in the following strategic planning meetings that were conducted over a nine-month period: (1) approximately 10 informal information gathering and planning sessions with the executive director, the board chairperson, and the board member who lead the clinic’s 2001 strategic planning process; (2) three information-gathering sessions held with current and past clinic board members, volunteer physicians, nurse practitioners, and dentists (a total of approximately 10 individual practitioners), and community representatives (e.g., the head of the United Way); and (3) one strategic planning retreat that included clinic leaders and staff, board members, community representatives, and other stakeholders (approximately 25 individuals). Overall, the focus of these sessions was to gather information on what works well at ACORN, what does not work well, and what are the most important issues facing the clinic in the future. The second author independently reviewed notes from the interviews and strategic planning sessions.

The third prong of our research included reviewing documents associated with ACORN, including (1) all financial records and statistics maintained by the executive director; (2) historical documents, including board meeting minutes and a comprehensive scrapbook of newspaper and magazine articles about the clinic; (3) two videos created about the clinic when recent awards were won (these included vignettes with reports by patients and volunteer clinicians); and (4) results of recent staff and volunteer satisfaction surveys, including written data summaries and written comments to open-ended items. Both authors reviewed clinic documents and developed a list of emerging ideas and concepts.

In summary, we used an iterative process of going back and forth between our data and the theory to gain a thorough understanding of why ACORN survived and succeeded against considerable odds. In the next section, we provide a synthesis of attributions made by key ACORN stakeholders and supported by clinic documents vis-à-vis the simple rules concept proposed by Eisenhardt and Sull.

THE SIMPLE RULES FOR THE ACORN CLINIC

Rule #1: Reduce Hassles for Volunteer Practitioners

Each clinician volunteer who participated in our study described his or her favorite part of ACORN as getting to “just practice medicine” or “serve the
patient” without pressures to keep visits short and complete massive paperwork requirements and other administrative hassles. The clinic staff works hard to take care of everything so that volunteer time is spent with patients, not on paper, forms, and requirements. For many of the volunteers, this is a welcome change from the complex academic medical center environment where they spend most of their time. Some say ACORN provides an important social and “community” role for otherwise busy and time-pressed physicians, dentists, and other providers. This “how-to” rule means volunteers get a meaningful and “hassle-free” experience and want to keep coming back.

Keeping things hassle-free for volunteer practitioners is an example of an emergent strategy at ACORN. Making the clinic a meaningful volunteer opportunity developed as a “side effect” or “unintended consequence.” ACORN’s executive director described how she began to hear comments from practitioners about their growing dissatisfaction with complex academic medical center rules, the growing administrative burden associated with managed care and other insurers, and new requirements stemming from legal threats in their practices. Volunteers often asked for more ACORN shifts where they could “just practice medicine” and “solve patient problems, not insurance company ones.” The director shared these comments with the board and began a more explicit program of keeping the volunteer program as “hassle free” as possible. While the clinic has always valued the time of practitioner volunteers, more attention was paid to making ACORN the “volunteer opportunity of choice” for local physicians, dentists, nurses, and other providers. This notion now appears in several documents that describe the clinic to potential volunteers and funders. As a result, the clinic has seen growth in the number of volunteers, the total volunteer hours, and the hours per volunteer in recent years. For example, the total volunteer hours at the clinic doubled from approximately 5,000 hours in 1995 to more than 12,000 hours in 2001. Thus this “how-to rule” has been important to the ongoing partnerships that have kept ACORN viable when other funding sources have run out, and it has allowed ACORN to explore new opportunities, such as specialty dental clinics, outreach programs, and other services that are staffed by volunteer practitioners.

Rule #2: Keep it Simple for Patients

A second “how-to” rule of keeping things hassle-free plays a key role in ACORN’s success. What began as simple, face-to-face care provided by a few volunteers in the 1970s has been preserved because ACORN staff found that patients were more likely to come back when they felt comfortable. Even though legal and regulatory requirements mandate paperwork and process constraints, and volume growth has required more scheduling and coordination efforts, the “keep it simple for patients” rule has made keeping care hassle free for patients a priority.

The “keep it simple for patients” rule emerged from the clinic’s meager beginnings when ACORN’s physical location moved from church to church and to other available community space. At this time, volunteer practitioners frequently conducted home visits. As the clinic grew and established its current physical location, staff continued to focus on making the ACORN experience a simple, personal process. Hiring staff from the local area is a priority and most staff know patients by name. Functions are designed so patients are not burdened with paperwork, forms, and “process.” For example, forms and paperwork are completed on behalf of patients or together with them. Further, whenever possible and despite the complex volunteer schedules, an ACORN patient is assigned to specific practitioners who coordinate specialty consultations, mental health services, and other health and social services. Patients frequently refer to ACORN staff and volunteers as “family” and clinic scrapbooks are filled with newspaper accounts of the community “heroes” working with the poor at ACORN. The sense of comfort has been maintained, in part, because the clinic has focused on keeping things simple despite pressures to complicate or add administrative “red tape” to the patient care process.

Today, while the clinic is larger and has state-of-the-art equipment and facilities, many ACORN patients are similar to those seen in the 1970s: many are not educated, do not speak English, and have little experience navigating today’s more complex health care system. While other local free clinics have grown in size and complexity, ACORN has retained the “personal” feeling and culture. The “keep it simple for patients” rule is often raised when ACORN leadership evaluates federal funding programs that would add more bureaucracy and, potentially, more complex rules and regulations about patient care. The question that must be addressed by leaders and directors before new initiatives are sought or developed is, can we do this and still keep things simple for our patients?
Rule #3: Let local Community Needs Dictate Service Offerings

The third simple rule guiding ACORN is a boundary rule that specifies that the clinic should offer "what the community needs, no matter what." Over the years, ACORN has developed a variety of programs to meet specific local community needs, some of which are unusual for a rural health clinic. ACORN does not restrict notions of what should be offered to those of traditional medical or dental approaches. The clinic has offered acupuncture and other alternative or integrated medicine programs for years. Furthermore, the clinic has included needed social programs that many may consider tangential to traditional medicine and dentistry. For example, the clinic provides services specific to migrant populations during the months of the year when those populations are at their peak. Finally, the clinic has not confined itself to providing all services, if other organizational arrangements would better serve the community. For example, a new obstetrics and infants program is being developed through new partnerships with a community hospital and county public health units.

This "boundary" rule about letting the local community needs dictate service offerings emerged partly because of ACORN's origin as a VISTA project. As well as fostering a sense of creativity and innovation among clinic staff and supporters, this boundary rule has also resulted in donations for these programs from local families, companies, and foundations. Because ACORN strives to provide what the community needs rather than what must be done to satisfy funders or regulators, there is a sense of community ownership of ACORN. As a result, ACORN is viewed as an institutionalized part of the local community both by the community and other funders. Over the years, this rule has also guided board decisions about exploring federal and other funding programs. The board has chosen not to be subjected to mandates from federal or state agencies because of concerns over losing the local control over programs and services important to the implementation of this rule.

Rule #4: Leverage Partnerships Into More Resources

Most stakeholders and community members agree that a key aspect of ACORN's success has been its sustained partnerships with a variety of organizations. ACORN has spent considerable energy making the partnerships mutually beneficial. Over the years, this notion of "leveraging partner relationships" has become a way of thinking that has allowed the clinic to ride out periods of uncertain funding and given ACORN the ability to do much more than would be possible if they relied only on the resources available on-site.

For example, the clinic has maintained educational partnerships with the nearby University of Florida and Santa Fe Community College for many years. For the health education partners, the relationships offer staff for ACORN patients while providing important and meaningful training locations for dentists, hygienists, and nurse practitioners. Evaluation of these educational programs reveal that students typically describe the ACORN "rotation" as a favorite training experience. Over time, these great training experiences result in future volunteerism for those clinicians who stay in the area. More important, however, ACORN partners have gone to outside funders to develop creative programs that include ACORN. For example, the College of Dentistry has used its ACORN experience to lobby for new state funds to offer dental outreach services. This has given ACORN the ability to add a special children's dental clinic and expanded dental and oral surgery services that are desperately needed by local residents. Similarly, grant funding undertaken by education partners and the Area Health Education Centers bring more clinical resources to ACORN.

The "leverage partnerships" rule developed or emerged from the early days of the clinic when it had few physical and human resources and yet managed to deliver care to hundreds of migrant workers in rural Alachua County. The idea is similar to the biblical story of Jesus turning a few loaves and fish into a meal for thousands. The early and ongoing support of local churches gives the clinic a "missionary" culture that supports creative thinking of how to "turn one dollar into three." There is a true story of a few dedicated dentist volunteers who drove to Omaha, Nebraska, to pick up free dental equipment that was available at one's alma mater dental school. The volunteers rented a truck and drove for three days straight to bring the equipment to ACORN. Similarly, the current executive director heard that two houses were being torn down in Gainesville. She managed to have them donated to ACORN and physically moved to the current location in Brooker to be used as clinic space.

These stories of taking something small or free and turning it into a core part of clinic operations have been extended in recent years to grant funding,
organizational partnerships, and other less tangible clinic resources. When new funding becomes available, ACORN leaders quickly assess ways of leveraging the dollars, the people, and the relationships into more services for patients. This “how-to” rule, both in its original and extended form, has played an important role in ACORN’s continued growth and success over time.

IMPLICATIONS FOR RURAL CLINIC MANAGERS

In this case study, we have discussed some simple rules that have been developed and led to success at the ACORN Clinic. We found that, over time, ACORN has not detoured from its rules, even when other choices may have been easier or, at least, more popular for some stakeholders. We believe that this application may assist managers of other rural clinics in several ways.

While the stories and examples are inspiring, it is important to remember that no one set of “simple rules” is sufficient across different organizations. Thus what is most important for rural clinic managers may be the basic concept of “simple rules” guiding decisions, rather than the specific content of ACORN’s rules. Our study implies that other rural providers should take a look at what has worked for them over time and try to determine whether they operate using a few “simple rules” for action. As important, clinics should examine reasons why seemingly good ideas have not been successful over time. In addition, articulating the rules for directors, employees, volunteers, and community members may create a stronger understanding of clinic values and, ultimately, garner more support and resources for the long run.

Furthermore, strategy as simple rules may offer clinic managers advantages over traditional strategic planning approaches. Most important, operating under the guidance of a few simple rules may be more empowering for managers as they navigate changing environmental conditions. For example, when simple rules are understood and shared, clinic managers will feel comfortable making decisions quickly without obtaining formal, direct approval from the board. In addition, managers have the flexibility to make choices that may not fit a formalized strategic plan or rigid goals that may not be appropriate as aspects of the environment change.

Still, other rural clinics may be able to learn from the simple rules that have guided ACORN decisions. For example, the concept of leveraging modest resources has been shown to be an “energizing” organizational strategy that is linked to strong performance in a variety of settings. This suggests that rural managers must look outside the immediate community to assess what resources may be available. These resources may include volunteer clinicians, but may also include partnerships with colleges and universities and other creative programs that create “win-win” situations for all involved. In essence, clinics can learn from ACORN about leveraging the relationships and partnerships they have into something more.

Finally, ACORN’s simple rule of making the experience special for volunteer physicians, dentists, and nurses may be applicable in a variety of other settings. ACORN has only volunteer clinicians, which sends the message that needy patients will not get care if local health professionals stop donating their time and energy. Still, clinics with a mixture of paid and volunteer staff may be able to find ways to engender and maintain the ongoing commitment of needed health professional volunteers.

IMPLICATIONS FOR HEALTH CARE MANAGEMENT RESEARCH

This article applies the concept of strategy as simple rules, originally developed in the computer industry, to a successful rural health clinic. While others have argued that simple rules usually grow out of experience, especially mistakes, we found simple rules at ACORN emerged as success was viewed retrospectively. In other words, our findings suggest that simple rules can result from a stream of action as organizations make sense of how they have succeeded, as well as failed. In this view, success is not the result of controlling and planning but rather due to organizations applying what they have learned. While the idea of emergent strategy has been developed in other industries, its application to health care organizations is extremely limited. By linking the concept of simple rules with the notion of emergent strategy, we advance our understanding of the variety of ways health care organizations cope with turbulent and complex environments. In doing so, we contribute to the embryonic literature applying insights derived from chaos and complexity theories to the strategic management of health care organizations.
By linking the concept of simple rules with the notion of emergent strategy, we advance our understanding of the variety of ways health care organizations cope with turbulent and complex environments.

While we found convincing support for the notion of simple rules in one setting, future health care management research ought to more broadly study this concept in a variety of health care organizations. A first step would be to extend this case study to a representative sample of rural health care clinics to determine if the strategic dynamics uncovered here are unique to ACORN. Since the small size and extremely resource-poor environments of rural health clinics are not representative of all health care organizations, a second direction would be to systematically investigate the applicability of the notion of simple rules in a variety of health care organizations. While ultimately the extent to which our findings generalize is an empirical question, we think that strategy dynamics we observed are not unique, especially since the notion of simple rules was developed in settings far different than ours.

Our case study raises some interesting questions about the role of volunteerism in the lives of physicians, dentists, and other health care professionals. ACORN is not unique in its reliance on volunteers. For example, the Volunteers in Medicine Program was funded by the Robert Wood Johnson Foundation to develop free clinics for the uninsured staffed by retired physicians. Similar programs arrange for retired physicians to serve the elderly in communities in Florida and elsewhere. In addition, there are a number of international physician volunteer organizations, including Doctors Without Borders, Doctors to the World, and others.

At ACORN, leaders have found growing interest among local professionals for the chance to donate their time to needy individuals in a hassle-free environment. This suggests that the changing nature of professional work, including growing administrative oversight and demands, may be associated with increased volunteer activity among physicians. Future research, grounded in sociology and social psychology, could identify whether and how volunteer activity among working and retired health professionals is related to burnout and job and career satisfaction.

Drawing on chaos and complexity theories, we have applied the concept of strategy as simple rules to analyze the success of one rural health clinic. In doing so, we found that simple rules can emerge as organizations make sense of how they have succeeded. We suggest that operating under the guidance of a few simple rules may be useful for other rural clinic managers who must navigate changing environmental conditions. In our view, the concept of strategy as simple rules is worthy of future study in other health care organizations and settings.

REFERENCES


