FYA For Your Advantage

An Essential Tool for Healthcare Leaders

Sponsored by PHNS Innovative Solutions to Complex Problems

Volume 9, Issue 5 – March 1, 2010

From TrendLeader Connections

FYA* - For Your Advantage**, is a free twice-monthly electronic newsletter. With every issue, ***FYA provides insights into the topics that concern healthcare leaders today and the challenges they will face in the near future. The newsletter is provided free to healthcare CEOs. The editorial content is not copyrighted – except for those columns copyrighted by the author. CEOs may use the non-copyrighted material in any way they wish. The newsletter can be printed without prior permission.

***FYA* - For Your Advantage** is produced by **TrendLeader Connections**. TLC offers a variety of healthcare products and services that help executives to differentiate between “fads” and “trends” and to make connections with “Trend Leaders” within the healthcare industry.

Table of Contents

***FYA* Staff**

Publisher Jerry F. Pogue
Editor S. Harvey Price
Web Master Joel Schlarb
Circulation Manager Sheila Keizer

TrendLeader Connections
26 Shawnee Way, Suite C
Bozeman, MT 59715
(406) 586-6400

My Winter PHD

By Dorothy E Bellhouse FACHE

Some people refer to PHD as "piled higher and deeper." Well, that's exactly the experience we've had this winter. It's been snowier than usual. As I write this, there is three feet of snow outside.

While I was tackling snow removal, I drew parallels to my improvement experiences in hospitals around the country. Please bear with me.

We were away for the second storm that left a foot of snow in our driveway already bordered by two-foot high snow banks. Upon our return, it was snowing again. We parked the car on the street, unloaded and bundled up to face the task ahead – clear the driveway so we could get the car off the street.

I coach organizations to build the capability of their people to improve their work as an integral part of their work every day. We focus on making small, specific improvements in the course of work using existing (often low-tech) resources.

It would have been nice to use a snow blower or have someone plow the driveway, but we had neither the "technology" nor the service. We had to rely on our existing resources.

We first determined that the outcome for that evening was to get the car off the street and a path to the door. That allowed us to concentrate on shoveling just that amount of snow to achieve that outcome.

At first we just dove into the task. However, we quickly organized ourselves to specific territories so we wouldn't duplicate effort or get in each other's way. This again made me think of my work where we design activities (from clinical procedures to meetings) specifically with commonly understood outcomes.

The snow had settled in and was heavy with a crust of ice on top. We started using our plastic shovels because they are light and easier to lift, but found they were no match for the icy snow. We then got a heavy metal shovel and trowel. In my work, we do small experiments and re-design when the experiment fails. Our hypothesis about using the plastic shovels was wrong!

We used our shovels to make a grid. First, chopping through the snow to create small, shovel-size blocks of snow to scoop up. Creating small batches, if you will, made each shovelful easier to lift and ultimately, faster. This mirrors a concept in our work that smaller batches and even batch sizes of one are better. We solve "big" problems one small problem at a time.

This reminded me of a materials manager whose initial response to the nursing unit not having a specimen cup when it needed it was to raise the stock level. In fact, his staff would bring extra supplies when it stocked, so the nursing staff wouldn't have to deal with a stock out. This made the shelves overflow, creating a challenge for the nursing staff to sort through and pick the specific item it needed. So the materials and nursing staff began experimenting with ways to make it easier to have just what they needed, when they needed it. Within a month, they achieved the results in the table below.

	Before	After
Time to assess for re-stocking	30 min	2 min
Time to collect needed supplies in the storeroom	25 min	10 min
Time to deliver and re-stock unit supply room	15 min	3 min
Days per week stocking	3	7
Total stocking time per week	210 min	105 min

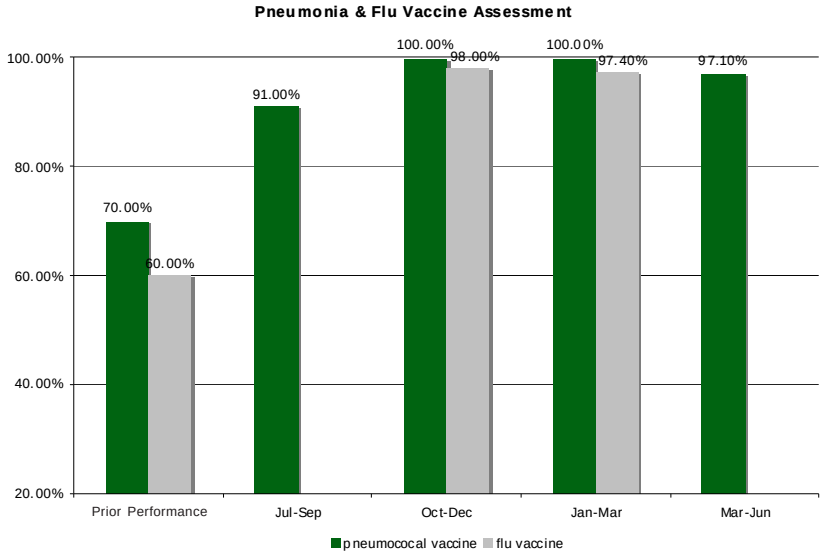
(Continued...)

My Winter PHD (Continued)

They reduced inventory by 21 percent and delivered small batches every day. The nursing staff called it the "never-out" system and the materials staff began planning to service other facilities within its system with no increase in staff. Small is big.

I also remembered another materials manager that achieved similar results. Together he and the nursing staff re-arranged supplies so they were easy for the materials staff to stock and easy for the nursing staff to find. In doing this, they found that nurses stopped pulling a more expensive butterfly clip that was close to the door. They often didn't need that sophisticated a clip, but it was the easiest one to find. This small change saved a couple of thousand dollars. Over a period of weeks, the materials staff and the nursing staff made small changes one by one – experimenting and improving as they went along. Within months, the materials staff realized that by understanding how nursing staff picked and used supplies for patients, they had saved close to a million dollars! The corporate office noticed this too. It invited the materials manager to a meeting so it could learn how he saved so much money. He told the story of the butterfly clip and the corporate staff listened politely, but kept asking what had saved the million dollars. The materials manager confessed it was no one thing, but rather a continuing series of small changes like the butterfly clip. Small is big.

I developed a rhythm shoveling. I got better and better at chopping just the right size snow block so it fit the shovel and I could toss it aside easily. The driveway was getting clearer. Our small steps were adding up; which led me to another parallel to my work with hospitals. A nurse manager and one staff nurse decided they could improve their mediocre core measure performance and started learning about how they got patients the pneumonia vaccine. In one day, they worked with staff to develop a prototype to test moving the process from discharge day to upon admission. They literally cut and pasted forms for staff to test. Overnight, the new process failed. A night nurse was confused about how to document when her patient refused the vaccine. Instead of telling her what to do, they listened and asked how the form could be clearer. So, on the second day, they revised the form and made just enough to get to the next day. Over the course of two weeks they made 10 revisions to the form (one by one, so they could learn about each improvement) based on questions from both nursing and pharmacy staff. They started in the last month of the third quarter and moved their core measure compliance from 60 to 70 percent (flu & pneumonia) to 91 percent. See bar chart.



The following quarter they were close to 100 percent and have maintained their performance at greater than 97 percent. Small changes made one by one in the course of work yielded sustainable improvement for patients. Small is big.

Healthcare leaders face a variety of "big" problems and in some cases, they feel like they're piling higher and deeper. Disaggregating these problems into specific pieces can allow you to "experiment" with solutions and make it more diagnostic when the solutions don't work as hypothesized. Building the capability of your staff to experiment in the course of work will lead to daily improvement and innovation. And small is big. It will build resiliency and the ability to adapt throughout your organization.

Healthcare is a complex dynamic environment. The ability to respond and adapt within existing resources will be key to continued success as we all strive to make care evermore ideal for patients.

Dorothy (Dolly) Bellhouse, FACHE
Director
Rule 4 Consulting
dbellhouse@rule4consulting.com

FYA For Your Advantage
An Essential Tool for Healthcare Leaders
Sponsored by PHNS Innovative Solutions to Complex Problems

2010 Hospital Financial Trends

By Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

The continuing general economic malaise continues to hit the hospital industry particularly hard. About 77 percent of hospital executives say that the recession has weakened their hospitals' financial positions according to the recently released *Healthleaders Media Industry Survey 2010* report. Only 25 percent of the hospital executives surveyed said that their organizations' prospects for growth are very strong, down from 28 percent the prior year.

The survey quotes Glenn Crotty Jr., MD, COO, at Charleston Area Medical Center in West Virginia as saying that most healthcare executives feel that "the financial picture will worsen. Most feel that this is BBA II" (referring to the "much-decried" Balanced Budget Act of 1997). Another interesting perspective came from Timothy Ranney, MD, VP of Medical Affairs for Good Samaritan Hospital in Kearney, NE: "Forward-thinking hospitals are concentrating all their efforts into being able to make money on Medicaid and Medicare…If you can do that, you can do well in almost any environment. And it's doable."

The CFOs surveyed by *Healthleaders* ranked their top three priorities for the next three years as:

- Physician recruitment and retention (37.50 percent)
- Cost reduction (35.53 percent)
- Patient experience/patient satisfaction (33.55 percent)

This is a major change from last year's survey that ranked quality/patient safety first with 68 percent, physician recruitment and retention next at 38 percent and reimbursement third at 31 percent. However, notwithstanding the immediate need to focus on cost cutting, there is recognition that it is also critical to focus on top line growth, and thus the increased focus on physician recruitment and retention since physicians produce revenues. This was well-stated in the survey by Michael Burke, CFO at New York University Langone Medical Center:

> "You can't cut yourself to prosperity. Sustainable growth comes from sustained growth on the top line and constant stringent management of the variable cost of that top line, and then making sure you get margin by growing."

These continuing and increasing financial woes for hospitals have also further bifurcated the hospital industry into the financial "haves" and "have nots" (see my 11/7/05 and 11/5/07 *FYA* commentaries) according to *Oppenheimer's Hospital Survey Analysis - 4Q/2010 Update on Capital Spending and IT Trends*:

- **Haves:** "Among those with good credit (BBB+ or better), profitability began to improve somewhat in 3Q and 4Q, balance sheets are strong, and liquidity returned sometime during the second half of 2009. And those hospitals with shortfalls are able to access capital markets and borrow at attractive rates."
- **Have nots:** "[T]he weaker credit hospital facilities not only are still suffering from an operating perspective, but they still have trouble accessing capital markets, particularly since credit spreads remain wide."

Some of the financial woes are self-inflicted. For example, a hospital CEO of a 400+ bed hospital recently told me that the hospital had been losing money for the past four years since it had not listened to its physicians, which caused a large and very profitable physician practice to leave and take up residence at a nearby hospital competitor, and that it's taken four years to put operating expenses in line with the resultant reduced revenues.

But some of the financial woes are hard to understand or predict. For example, the CFO of a large eight hospital system told me that despite budgeting the same or reduced revenues for 2010, both its inpatient and outpatient revenues for January and February 2010 are down significantly and they have not been able to identify the causes. Even more inexplicably, the system's inpatient and outpatient Medicare revenues are down significantly, which is counter-intuitive and wasn't predicted.

Regardless of whether or not Congress enacts healthcare reform, perhaps the hospital industry is undergoing the same kind of unprecedented and pervasive changes from our continuing recession that have forever changed other industries, and maybe these changes will be the new economic reality in which hospitals have to learn to operate for the foreseeable future. What is your experience and what is your opinion?

I would like to hear your comments. Send them to:
Richard.Kneipper@phns.com

Roundup of Telemedicine Activity

Last week, the Mayo Clinic announced that it will conduct a year-long study to determine if home monitoring of patients with chronic conditions can reduce hospitalizations and emergency department visits and lower health care costs.

For the study, Mayo will partner with GE Healthcare to implement the Intel Health Guide home monitoring technology in the homes of 200 high-risk patients older than age 60 who receive care at Mayo's Rochester, MN., facility.

Patients will use the Intel Health Guide device daily to measure vital signs and respond to several disease-specific questions. The data will be transmitted to a central database. Patients' primary care physicians and a clinical team at Mayo will have secure Web access to the data.

Gregory Hanson, a primary researcher on the project at Mayo, said the information will not be integrated into Mayo's electronic health record system, although he said it could be later.

Earlier this month, the Department of Veterans Affairs proposed a budget increase for its home telehealth program from $72 million in fiscal year 2009 to $163 million in FY 2011. VA's home telehealth program – the largest program of its kind in the world – currently delivers services to 35,000 patients.

Proponents say VA's telehealth expansion stands to offer critical care to patients in remote areas with limited access to care. However, other experts warn that the transition to telehealth services could cause some disruptions in patient care.

Last week, the Federal Communications Commission highlighted telemedicine as one of its top priorities when the agency released details about its forthcoming national broadband plan. It emphasized telemedicine as a major goal for the initiative.

Specifically it estimated that:

- Remote patient monitoring could save $197 billion in health care costs over 25 years; and
- Widespread adoption of electronic health records could save $513 billion over 15 years.

To achieve its telemedicine goals, FCC recommended that federal officials work to:

- Clarify regulatory, licensing and credentialing requirements;
- Conduct pilot programs;
- Ensure that patients have access to their health data;
- Increase reimbursements for telemedicine and other electronic health care services;
- Promote interoperability between administrative, clinical and research entities; and
- Send Congress a plan on how to expand telemedicine and health IT. The FCC also suggested that the Rural Health Care Program offer subsidies to help healthcare providers tap into the broadband networks.

More pharmaceutical companies are seeking to collaborate with technology firms to develop new health IT tools that could improve clinical outcomes and reduce costs, according to a new report released by Ernst & Young.

According to the report, drug industry officials believe real-time patient monitoring tools could help them demonstrate the clinical benefits and cost-effectiveness of various medications.

Some pharmaceutical health IT tools in development include:

- Mobile phone applications for chronic disease management and medical communication;
- Smartphone applications that upload readings from diabetic patients' blood glucose monitors; and
- "Smart pills" that transmit data about a patient's medication adherence and vital signs.

Although pharmaceutical firms traditionally generate revenue by relying on a few blockbuster drugs, the companies increasingly are branching out into consumer health and biotechnology arenas. Some observers have called the new model "Pharma 2.0."

However, the Ernst & Young report proposes that drug companies are entering a new era, dubbed "Pharma 3.0." Under this model, pharmaceutical companies will forge stronger partnerships with IT firms and other innovative technology companies.

The study is believed to be the first of its kind to test home monitoring among a wider patient population with a variety of illnesses.