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Where Is the Bottom and What To Do About It?

By Jimmy Udall, director and founder of Rule 4 Consulting

I had the bottom pegged at 7,400. It seemed every time the Dow dipped below that point it would quickly spring back so, I figured, that must be the bottom. Nope, I was wrong; it's a good thing I didn't put any more money into the market. It's also a good thing that I'm not nearing retirement age like the family practice doctor I recently spoke with who had this to say about the economic crisis and the push for electronic medical records (EMRs), "I had planned to retire before they made us switch to an EMR, but with the hit I just took to my retirement account I won't be able to." Not a great place to be in for this particular doctor, but the implications of these two issues also weigh greatly on healthcare administrators as they make decisions about how to invest scarce resources in an increasingly difficult competitive environment.

Hospitals are handling the economic crisis in different ways. Ironically, a few of the smaller hospitals that I've worked with are better off than the larger health systems because of the latter's greater stake in income from investments. Even if they all lost the same percentage in the market, having a larger pie means you now have a much larger piece missing and you're scratching your head as to how to fill the gap. Again, hospitals are handling this problem in different ways. Some are acting quickly in the face of the crisis to freeze or drastically slow down investments in their people and infrastructure. Others are looking at the crisis as an opportunity to focus on reducing waste and becoming a leaner organization. There's a lot of evidence that supports the second approach, that and some discussion about how best to do it will be the focus of the rest of this column.

The first and most crucial difference between these two approaches, between a capital freeze and a focus on reducing waste, is that of an optimistic viewpoint and a pessimistic viewpoint. There is strong evidence, which you can find summarized in the box on the following page that shows the key difference in the success of projects is the optimism of the group undertaking them. The optimist doesn't always see the glass as half full, rather, she sees problems as temporary, caused by something outside of her, and specific to the issue. This allows the optimists to see issues more clearly than the pessimists and have a stronger beliefs in their own abilities to improve the situation. The pessimists, on the other hand, will view problems as permanent, their own fault, and indicative of larger problems. When viewing the economic crisis with this definition of optimism in mind, it suggests that organizations can leverage this crisis as an opportunity to improve their core business and the ones that do will be better positioned for the next one.

What can we do about it?

Organizations that drastically slash budgets and freeze capital realize that this is not a sustainable solution to our problems. There's nothing natural in this approach that fixes any of the underlying causes of waste and danger inherent in the current way we deliver our care. Healthcare executives know this and my

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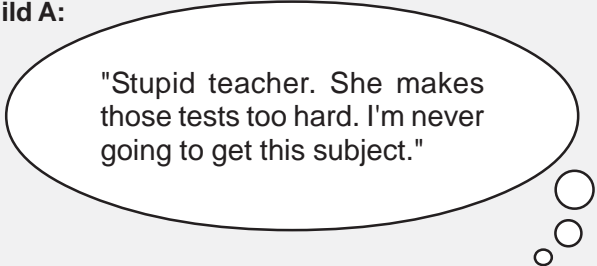
Where Is the Bottom and What To Do About It? (Continued...)

Defining Optimism

Optimism is not a matter of ignoring what's wrong in your life or the world. Rather, most importantly for our purposes, optimism is explaining the bad things we encounter as being temporary, local and impersonal.

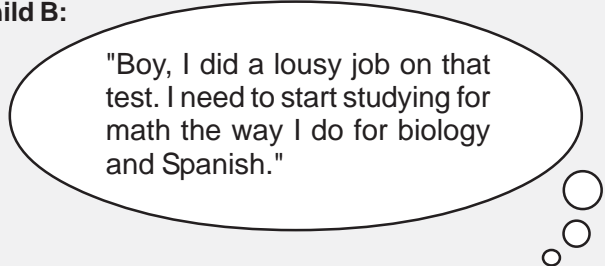
The classic example of what we mean by an optimistic explanatory style is: a child fails a math test.

Child A:



"Stupid teacher. She makes those tests too hard. I'm never going to get this subject."

Child B:



"Boy, I did a lousy job on that test. I need to start studying for math the way I do for biology and Spanish."

Child A makes the problem personal (teacher), pervasive (all tests) and permanent (never). Child B does not ignore his responsibility, nor does he ignore salient facts about his failure. Instead, he explains the causes of the failure as impersonal (a lousy job), non-pervasive (biology and Spanish are good) and temporary (if I study harder, I'll do better).

There are lots of interesting things about this simple difference in explanatory style. But for our purposes here, it's most important to note that **Child B is much more likely to do well on future math tests than Child A**. That is, the way the child explains the failure is the most influential cause of future learning and success.

Source: The blog at <http://www.managerialquality.org/2008/10/on-optimism-part-1.html>

guess is that many of them are wondering what to do next. Most will realize soon, if they haven't already, that flush times aren't around the corner and capital will eventually need to be thawed. For those, and all executives, here are some thoughts on what to do next.

The example alluded to in my quote from the doctor above is the one being considered by (or forced upon) many hospitals around the country: EMR. While nobody is arguing that the EMR is a solution to our economic crisis, it's one of the things on the table that organizations have to consider how to plan for and invest in during the crisis. Organizations that spend the extra effort on the front end improving their processes and working closely with vendors or mediators that will ensure staff are prepared to go from "go live" will see an ROI much sooner than organizations who skimp in these areas.

Many hospitals are also focused on using this crisis as an opportunity to engage their staff in improving processes and reducing energy waste, both of which

immediately improve their bottom line. The economic crisis is not exactly a secret and staff are now easily motivated to keep and improve their jobs. With the right approach and leadership, support organizations will see huge benefits to engaging in programs that leverage the knowledge and creativity of their staff to reduce waste. By acting to push waste reduction down to the staff level rather than implementing broad cost cutting measures, organizations will be better able to address the causes of waste. That approach will benefit them now and into the future.

Jimmy Udall is a director and founder of Rule 4 Consulting. Rule 4 specializes in prepping hospitals for EMR implementations and creating continuous improvement driven by front line staff. Jimmy can be reached at judall@rule4consulting.com.



Re-Examining the Stimulus Bill

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

Now that we've all had time to read the final published version of the "stimulus" bill, the size and variety of buckets of money being offered up to hospitals and physicians is virtually mindboggling.

My recent commentary ("*Looking a \$19 Billion Gift-Horse in the Mouth*") focused on the \$19 billion to incentivize "meaningful use" of "certified EHR technology." We don't really know what that means since we must await regulatory action due before December 31, 2009, to define such terms. However, the bill does give a clue – it says that a "certified EHR technology" must have the capacity to "support physician order entry," as well as, to provide clinical decision support, capture and query information relative to healthcare quality and exchange electronic health information with and integrate such information from other sources. Whoa – that's rather disconcerting since only 1.9 percent of hospitals in the U.S. have implemented physician order entry (aka CPOE) according to HIMSS Informatics and I suspect that few hospitals have EHRs that meet the other requirements. Perhaps more importantly, the amount of EHR money available for the typical hospital appears to be small enough (perhaps \$2-4 million) that the bill is truly only a stimulus and won't provide enough to justify an EHR decision that isn't otherwise justifiable.

Nevertheless, there's so much federal money being offered up that hospitals and physicians must carefully consider how to get their share of the extraordinarily rare federal largess offered by the stimulus bill. Interestingly, while many industry experts have already been urging hospitals and physicians to rush to get their share, that will be difficult to do until the final regulations and rules are published and since most of the monies don't start flowing until 2011. As a result, the Congressional Budget Office has estimated that a mere 2.3 percent of the stimulus bill funds for EHR implementations will be distributed in 2009 and 2010.

In the meanwhile, I strongly suggest that you should be parsing the rest of the stimulus bill since it contains

an unbelievable plethora of other buckets of monies that hospitals may be able to tap into, which for some reason very few industry experts are commenting about, including the following:

- \$1.1 billion for comparative effectiveness research, including comparison of the "clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders and other health conditions," and "the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data"
- \$650 million for "evidence-based clinical and community-based prevention and wellness strategies... that deliver specific, measurable health outcomes that address chronic disease rates"
- \$300 million to "support regional or sub-national efforts towards health information exchange"
- \$500 million for public health centers
- \$500 million for primary care provider training

These monies challenge hospitals to come up with creative, new proposals to change and improve our healthcare system in dramatic ways that could improve patient care quality, safety and service – and therein may lie the incredible potential of the stimulus bill to stimulate hospitals and physicians to start implementing the "game changing" ideas that will start the major reform of our healthcare system that is so sorely needed.

What's your stimulus bill game plan? Please let us know so we can share it with other hospital CEOs.

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



Reform Update

The *New York Times* reports that since last fall, many of the leading figures in the nation's long-running healthcare debate have been meeting secretly in a Senate hearing room. Now, with the blessing of the Senate's leading proponent of universal health insurance, Edward M. Kennedy, they appear to be inching toward a consensus that could reshape the debate.

Many of the parties, from big insurance companies to lobbyists for consumers, doctors, hospitals and pharmaceutical companies, are embracing the idea that comprehensive health care legislation should include a requirement that every American carry insurance.

While not all industry groups are in complete agreement, there is enough of a consensus, according to people who have attended the meetings, that they have begun to tackle the next steps: how to enforce the requirement for everyone to have health insurance; how to make insurance affordable to the uninsured; and whether to require employers to help buy coverage for their employees.

The talks, which are taking place behind closed doors, are unusual. Lobbyists for a wide range of interest groups – some of which were involved in defeating national health legislation in 1993-94 – are meeting with the staff of Mr. Kennedy, Democrat of Massachusetts, in a search for common ground.

Mr. Kennedy is fighting brain cancer, and participants in the talks said his illness had added urgency to the discussions.

While President Obama is not directly represented in the talks, the White House has been kept informed and is encouraging the Senate effort as a way to get the ball rolling on health legislation.

Kennedy aides summarized discussions of the stakeholders, known as the "workhorse group," in a recent memorandum obtained by *The New York Times*.

"While there was some diversity of views," it said, "the sense of the room is that an individual obligation to purchase

insurance should be part of reform if that obligation is coupled with effective mechanisms to make coverage meaningful and affordable."

The ideas discussed include a proposal to penalize people who fail to comply with the "individual obligation" to have insurance.

"There seems to be a sense of the room that some form of tax penalty is an effective means to enforce such an obligation, though only on those for whom affordable coverage is available," said the memorandum, prepared by David C. Bowen, a neurobiologist who is director of the health staff at the Senate Committee on Health, Education, Labor and Pensions.

The 20 people who regularly attend the meetings on Capitol Hill include lobbyists for AARP, Aetna, the A.F.L.-C.I.O., the American Cancer Society, the American Medical Association, America's Health Insurance Plans, the Business Roundtable, Easter Seals, the National Federation of Independent Business, the Pharmaceutical Research and Manufacturers of America and the United States Chamber of Commerce.

Their motives vary. Some say the moment to overhaul the health care system has arrived because of a confluence of events, including Mr. Obama's election, the growing number of uninsured and the relentless increase in health costs. Some want to protect the interests of their members and could ultimately oppose the legislation, depending on its details.

While a fragile consensus is slowly emerging, it is not unanimous. The Business Roundtable, representing big corporations, would place "an obligation on all Americans to have health insurance coverage" and says the government should offer financial aid to help low-income people buy it.

On the other hand, James P. Gelfand, senior manager of health policy at the United States Chamber of Commerce, said: "Forcing individuals to purchase insurance in the current market would be a disaster. Before we even have that discussion, we need to make healthcare more affordable and improve its quality."

About



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healthcare only. Unlike its competitors, PHNS strategically aligns itself with a hospital's clinical and financial goals and objectives. Through its unique business model, PHNS reduces costs by aggregating, consolidating and sharing resources among its participating hospital partners. PHNS helps hospitals manage information systems, computer technology, patient records, coding and patient billing to improve patient care, safety and efficiency and increase profitability and efficiency. For more information, visit www.phns.com.

Energy Conservation Efforts - Reduce Costs and Emissions

By Gina Pugliese and Nick DeDominicis

Hospitals' energy bills consume up to three percent of their total operating budgets and up to at least 15 percent of their annual profits. More than 90 percent of hospitals surveyed recently by *Healthcare Financial Management* magazine reported higher energy costs over the previous year, and more than half cited double-digit increases.

Those costs are not confined to higher utility, transportation and supply bills, but also the gradual destruction of the environment. It is estimated that global demand for energy resources will rise nearly 60 percent over the next 25 years; one can assume corresponding cost increases. In an effort to counteract that, healthcare organizations can implement energy conservation to reduce costs – allowing funds to be reallocated to patient care – and reduce emissions that contribute to global warming and, ultimately, public health.

an environmental and, subsequently, public health cost as Green House Gas (GHG) emissions (e.g., carbon dioxide, methane and nitrous oxide) are increasingly linked to health issues such as respiratory ailments. The GHG emissions result from the use of nonrenewable sources of energy (e.g., fossil fuels, coal, oil and natural gas). Many believe the healthcare industry contributes disproportionately to the detrimental public health consequences of climate change. In response to the scientific confirmation linking climate change and health, increasing importance has been placed on energy management initiatives and transforming core practices.

Growing numbers of hospitals have installed energy saving glass and reroofed with white roofing. Further, many healthcare companies have switched to energy efficient lighting and are considerably more likely to have installed lighting sensors than companies in other industries. The business case for sustainable design shows that green buildings have lower life cycle costs, use less energy and water, require less maintenance and last longer. The benefits increase with the use of energy efficient lighting, heating and ventilation. To keep true to its mandate – first, do no harm – hospitals need to continue turning their attention to change practices that can potentially jeopardize patient and worker safety.

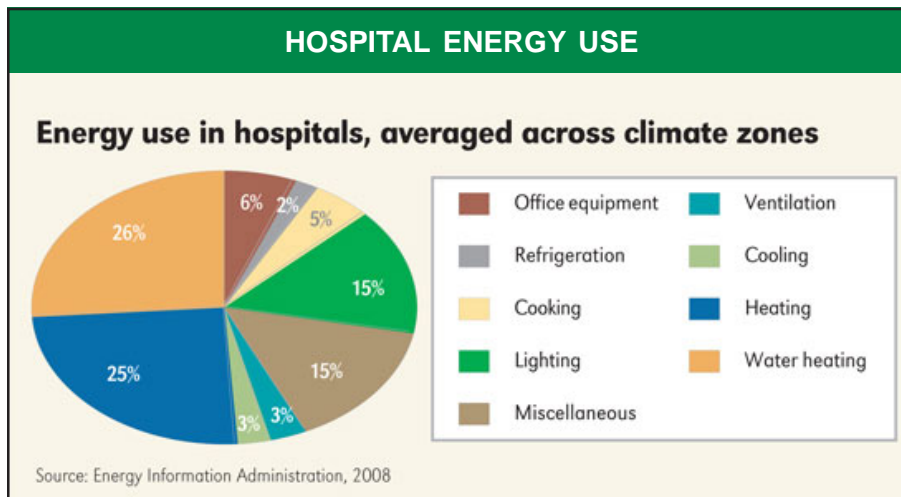
ACTION, RESULTS

According to the Environmental Protection Agency (EPA), every dollar a not-for-profit healthcare organization saves on energy is equivalent to generating \$20 in new

revenue for hospitals or \$10 for medical offices. Some hospitals are taking action and seeing results. Harold Richards, director of materials management for Ingalls Memorial Hospital, shared the following:

We participated in the Securing Proven Healthcare Energy Reduction reverse auction led by Premier and Practice Greenhealth and their Healthcare Clean Energy Exchange, and saved the hospital \$840,000 on the purchase of electricity and natural gas. We also began purchasing a portion of our energy from renewable sources, enabling

(Continued...)



The Energy Information Administration's data show the healthcare industry spends an estimated \$5.3 billion on energy for inpatient facilities and \$2.1 billion for outpatient facilities. According to the EPA, inpatient healthcare is the second most energy intensive industry in the U.S. (behind the food service industry), utilizing more than twice as much energy per square foot as non-healthcare office buildings. Further, hospitals alone use 836 trillion British thermal units (BTUs) of energy annually, have more than 2.5 times the energy intensity and CO2 emissions of commercial office buildings and are consistently in the top 10 water users in their communities.

There is a hard cost to energy consumption, as well as,

Energy Conservation Efforts - Reduce Costs and Emissions (Continued...)

us to buy five percent of our electricity as renewable for the same price as the traditional electricity generated from fossil fuels. We were able to combat rising utility prices, create a long-term energy budget and reduce our carbon footprint with a 3,433-ton reduction of carbon dioxide from our renewable energy.

Hospitals can aggressively manage energy use and costs by building a comprehensive energy management program. One way to do this is to organize an energy management steering committee with representatives from various departments including purchasing, finance, maintenance and facilities, quality assurance, government relations, clinical operations and medical personnel.

Materials managers are key contributors and should provide support for departments seeking cost savings in energy conservation efforts and work in teams involving key players such as facilities directors and CFOs. Their lifecycle cost analysis experience will be valuable in assessing energy efficiency attributes and ratings for items such as office equipment, computers, lighting, HVAC, appliances and water fixtures. Track success reducing energy consumption with the EPA's online portfolio manager. Top performers can achieve the Energy Star label representing facilities that achieve, on average, a 40 percent reduction in their energy consumption compared with peers.

The real contributors to sustained integration of best practices and appropriate use of technologies related to energy performance are: ongoing commissioning practices, measurement and verification protocols, diligent management practices and collaboration among all the key players in the hospital. Healthcare facilities

have a host of compelling reasons to pursue energy conservation and increase use of renewable energy. In spite of the challenges, the payback – to the bottom line, the environment and public health – is significant.

RESOURCES

ASHE/E2C: American Society for Healthcare Engineering (ASHE) and EPA jointly established ASHE's Energy Efficiency Commitment (E2C) program. www.ashe.org/ashe/facilities/e2c

EPA/Energy Star: Online tool helps track/assess energy and water consumption across a portfolio of buildings. Top-performing buildings receive Energy Star label. www.energystar.gov

Green Building Council: Not-for-profit organization committed to expanding sustainable and healthy building practices. www.usgbc.org

Practice Greenhealth: H2E-Healthcare Clean Energy Exchange: Created to improve environmental performance in healthcare. www.practicegreenhealth.org

SPHERE: Premier Inc. energy initiative, Securing Proven Healthcare Energy Reduction for the Ecosystem (SPHERE), helps hospitals reduce carbon footprint, greenhouse gases, impact on climate change and improve public health while reducing energy costs. www.premierinc.com/sphere

Gina Pugliese is vice president of the Premier Safety Institute, Charlotte, N.C. Nicholas DeDominicis is director of the Healthcare Clean Energy Exchange for Practice GreenHealth, Arlington, VA.



About **PREMIER**

About Premier Inc., 2006 Malcolm Baldrige National Quality Award Recipient

Serving more than 2,100 U.S. hospitals and 53,000-plus other healthcare sites, the Premier healthcare alliance and its members are transforming healthcare together. Owned by not-for-profit hospitals, Premier operates one of the leading healthcare purchasing networks and the most comprehensive repository of hospital clinical and financial information in the U.S. A subsidiary operates one of the nation's largest policy holder-owned, hospital professional liability risk-retention groups. Premier is also working with the United Kingdom's National Health Service North West and the Centers for Medicare & Medicaid Services to improve hospital performance. For more information, visit www.premierinc.com.