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Connections

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You Can Teach an Old Dog New Tricks

By Dorothy (Dolly) Bellhouse

I had the good fortune to attend a three-day ski clinic in Colorado last month. I learned to ski as an adult, although I have been skiing for more than 20 years. Skiing was taking its toll as I was getting older even though I always enjoyed being on the slopes. A colleague recommended this ski clinic touting that it would make it easier on my back and my joints. So, I signed up.

I arrived at the ski clinic with some trepidation. There were folks who had taken the clinic before and others who had skied in Europe. Most of them seemed younger. When asked the reason for attending the clinic, many said they wanted to be better in the bumps or they wanted to improve their style. My reason seemed to pale in comparison, I just wanted to ski better and more easily, so I could ski through my next decade.

So, why am I taking up this column space and your time to tell you about my ski clinic experience?

I have been thinking a lot about the challenges we all face in managing and leading healthcare organizations to make care ever more ideal for patients. My premise is that we have to learn to lead and manage differently to keep us from the old adage "insanity is doing the same things you've always done and expecting different results." We need to change the way we, as leaders, work. In the ski clinic, I not only learned to ski better, I discovered a lot about trying to learn how to do something differently when you've been doing it a certain way for a long time.

I've summed up my learning into the following four points:

- Simple isn't necessarily easy.
- A coach makes you better.
- Old habits die hard.
- One shot is not enough.

Simple isn't necessarily easy. At one point, a coach said, "look, I am only trying to get you to think about four words. That's not too much is it?" I agreed, yet trying to think and act on all four things while I was busy coming down the slope was hard and probably impossible for me. And during a break, the video clearly showed I wasn't performing!

In management, we are often too busy to incorporate much new into our repertoire. Learning something new in the course of a busy schedule is hard to imagine. Going to management courses also takes time. And often, when we return, we get immediately consumed leaving little time to practice what we've learned. I began to focus on one thing at a time – it's hard to multi-task when you're learning – and welcome regular feedback. My coaches could

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see things I couldn't. I recommend giving yourself time to learn under the guidance of a coach and then, practice. You may not be able to eliminate multi-tasking, but find short periods of time when you can focus on your new learning. For busy healthcare executives, 15 or 20 minutes of focusing on just one thing is a start. You can build from there.

A coach makes you better. I found that when I was following a coach, I not only felt better, I was braver. I trusted my coaches (they weren't going to do anything that would get me in trouble) and so, I would follow them into the moguls without thinking about it and found I did just fine. My coaches were able to see things in my performance that I hadn't yet learned to feel or see. They reinforced what was working and gave me drills to build my skill. That helped build my focus.

In management, so much of our work is instinctual and habitual. We do what we do because we know how to do it. We have learned from good bosses and not-so-good bosses. We have assimilated what seems to have worked and shed what doesn't. And yet, it is hard to see or describe the details of our work. And, it is even harder to know the unintended consequences of our work. We, too, need coaches we can trust to help us learn about our work, so we can improve it.

Old habits die hard. I had been skiing the way I skied for a long time. The way I thought about skiing and the way my muscles remembered skiing were deeply ingrained. As I practiced the new technique, I could see and feel the difference. However, whenever I felt uncertain, I would revert back. Knowing how to ski differently was necessary, but not sufficient. I needed as much to unlearn what I did before as I needed to learn the new technique. I needed practice to build a new way to ski – a new skiing habit if you will.

Learning new ways to lead and work will be like building a new habit. Research shows that it takes at least 90 days to build a new habit whether personal (a diet change, etc.) or work-related. And when you are stressed or pressured, the tendency will be to revert to your old way of working. That is normal. You just have to start again and apply the principles above – focus, practice and get feedback from a trusted coach.

One shot is not enough. I know it will take a while to truly adopt the new skiing technique I've learned. I need practice and probably a refresher to make this technique the way I ski. I know how the technique is different from how I used to ski and I know how good it feels when I do it. But, I also know those good results are not enough. In fact, on the two days I skied on my own after the clinic, I realized I was not using the new technique all the time. It was hard for me to hold the gain consistently, but at least I had learned to recognize when I was doing it and, importantly, when I was not.

The same holds true for managing differently in challenging times. We all will need practice and reinforcement. The concepts may be simple, but changing the way we work is work only we can do. We will learn and have success. We will also have failures – times when we revert back. We will need practice, coaches and refreshers to truly change how we lead our healthcare organizations to address complex problems into the future.

George Leonard in his book *Mastery*¹ says:

"To learn is to change. Education whether it involves books, body, or behavior, is a process that changes the learner. It doesn't have to end at college graduation or at age forty or sixty or eighty, and the best learning of all includes learning how to learn – that is, to change."

The good news is that an old dog can learn new tricks. Focus, practice and a coach can help.

(And, if you would like information on the ski clinic, just e-mail me.)

Dolly Bellhouse has 25 years experience in healthcare management developing and utilizing financial, negotiation and general management skills. She recently became a Director of Rule 4 Consulting. Her Web site is www.rule4consulting.com.



¹ Leonard, George. (1992) *Mastery - The Keys to Success and Long-Term Fulfillment*, New York: Plume (the Penguin Group), p.118

Reader Response Regarding Governance

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

My most recent FYA commentary entitled "Governing Through Economic Meltdown" contained the following suggestion that not-for-profits need to consider their governance and compensation policies during our current period of serious economic strife:

"Has your board considered whether the methods and amounts of compensation of the hospital's executives and employees are properly aligned with the hospital's financial results – i.e., the world now seems to believe that executives of failing banks, automobile manufacturers, etc. that receive government financial assistance ought not to be collecting large compensation packages when their companies are in financial trouble – should that apply to not-for-profit hospitals that are in financial trouble and are receiving massive government financial assistance through Medicare, Medicaid, tax exemption, etc.?"

That suggestion evoked the following thoughtful and incisive response from the CEO of a small, rural Midwest hospital:

"I administer a rural Critical Access Hospital in a community with 14.3% unemployment and rising. One of our mission dilemmas is offering needed health services that won't ever be self sustaining financially. It would be much easier to cut service lines and focus only on our more "profitable" services. Of course this wouldn't best serve our rural community. This is the tension that our board and leadership team struggle with on a daily basis. I personally think that the process is healthy, but never easy.

I enjoyed your article entitled, "Governing Through the Economic Meltdown," Your

question on executive compensation in not-for-profits is thought provoking. How should we compensate leaders in financially less than successful hospitals? My answer would be that it depends on the circumstances. In the final analysis most executives of large highly complex hospitals and systems are rewarded with six figure compensation packages that do not compare favorably wage wise to other private sector opportunities. In my experience the most difficult hospitals to manage are the large safety net hospitals that attempt to survive on large Medicaid and self pay payer mixes. If we were to reward leadership based on a profitability or operating margin model we would never find leaders willing to assume the helm of safety net hospitals. The same can be said for some small rural hospitals where care is needed, but a favorable payer mix is lacking. Hospital boards do have a fiduciary responsibility to remove leaders who fail to manage hospital resources in a responsible manner. Thanks for another good solid thought provoking article. I enjoy reading FYA and sharing it with my board."

Scott R. Graybill, FACHE
President/CEO
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I would like to hear your comments.
Send them to:
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Recession Affects Jobs in Healthcare

Healthcare is the only major industry outside the federal government still adding jobs, but it can't resist the affects of the recession. Across the country, hospitals are taking financial hits. They are seeing losses in the portfolios that they rely on for investment income. The number of uninsured patients is rising. Elective procedures are down at a third of hospitals nationwide.

With state governments continuing to cut budgets and talk of healthcare reform from Washington, industry executives are preparing for even leaner times, according to *The Wall Street Journal*. More than 16 million people – one in eight workers on U.S. payrolls – work in healthcare today, up from just one percent of the work force 50 years ago. Employment in healthcare and social assistance – which includes hospitals, doctors offices, nursing homes and social services such as day care – has grown by half a million jobs since the recession began in December 2007, while the rest of the economy has shed 5.1 million jobs.

But the pace of job growth in health services has slowed sharply this year. The sector added an average of 17,000 jobs per month in the first three months of the year, less than half last year's pace. Healthcare usually weathers downturns better than many other industries because consumers tend to cut spending on cars or clothes before they forgo trips to the emergency room or pharmacy. But this recession is the deepest in a generation.

Big hospitals such as the University of Pittsburgh Medical Center and Akron General Health System in Ohio have announced layoffs recently. In February, the number of mass layoffs for hospitals was double what it was a year ago, according to government data.

Since the Labor Department began tracking monthly unemployment figures in 1958, there have been nine recessions, but employment in health services has declined only a handful of times. The only significant losses to date occurred in mid-1984, as the industry shed 41,000 jobs, based

on slightly different historical data, following the double-dip recession of the early 1980s. Since then, no month has seen a drop of more than 4,000 jobs in healthcare, and there have been no back-to-back declines.

As manufacturing employment has declined, many cities have come to see healthcare as the employer of last resort. Rochester, MN, home to the Mayo Clinic, is one illustration of the industry's power to turn around regional fortunes and revitalize downtowns. Forty years ago, Mayo employed 4,000 workers; today, the international destination for top-tier healthcare employs some 35,000, more than a third of the city's total work force. But Mayo, like the rest of the industry, is now struggling to meet its capital and payroll obligations. Mayo is freezing salaries for doctors and senior administrators, reducing travel and overtime expenses and cutting capital spending this year by \$150 million. There have been no layoffs, though temporary staff are being pared back and only essential positions are being filled.

The Journal reports that growth in healthcare spending, and thus employment in the sector, is likely to rebound when the recession ends, a function of the enormous advances in medical technology and Americans' strong appetite for healthcare.

President Barack Obama has also named the sector one of his three pillars of the future U.S. economy, alongside energy and education. Health expenditures as a share of gross domestic product have more than tripled in the past 50 years to about 16 percent today, and the government's Centers for Medicare and Medicaid Services say that figure is likely to hit 20 percent within a decade.

"It's a long-term shift reflecting changes in technology and what consumers want," says Robert Fogel, a Nobel laureate and professor at the University of Chicago's Booth School of Business. "Healthcare is the growth industry of the 21st century."

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.

Keys to Engage Clinicians in Clinical IT

By Gregory R. Wise, MD and Richard Bankowitz, MD

Clinical IT systems put a wealth of information at clinicians' fingertips, and stories of successful implementation of computerized provider order entry (CPOE) and electronic medical record (EMR) systems abound. However, without understanding how new technologies will improve their day-to-day work or benefit patients, clinicians who need to embrace such changes could be slow to support new technologies. Since all staff are greatly impacted by these systems, it is important to gain their active participation in the design and implementation of the systems – to engage them in discussions about system efficiencies, positive impact on patient safety and bottom-line impact.

As with any change in technology, moving from paper reporting to EMRs has a number of benefits for hospital administrators, clinicians and patients, but also has its share of problems. Anything that disrupts the status quo tends to receive resistance. Thus, for EMRs to be successfully implemented throughout an entire hospital system, the mindset – and, more important, the workflows – of staff must be changed at every level of the organization.

Speak to System Efficiencies

To ensure the greatest efficiencies, systems must be open, compatible platforms to ensure scalability and reach beyond the hospital walls to other healthcare facilities. For physicians whose practices are split across two or three hospitals, efficiency is a must so it's key to focus on how EMR systems streamline process. For example, an orthopedic surgeon who might ordinarily have to sign his name a dozen times during a hospital visit will find his signature is needed just once – for an electronic signature. Simple time-saving

elements will help bring those clinicians who might be hesitant to change into the fold. They must believe the system can work for them.

Key in on Patient Safety

Patient safety can greatly increase with clinical IT systems. For example, with clinical IT pharmacy systems, it is possible to dispense drugs with multiple digital checks. Systems can double check for allergy histories, potentially deadly interactions or the potential for overdose due to kidney or liver compromise. Considering that the average Medicare patient takes 12-14 different medications during a hospital stay, having an automated checkpoint can be a much-welcomed layer of safety. A recent study also showed that the use of EMRs has an impact on malpractice settlements where facilities that used EMRs paid reduced malpractice settlements for physicians.¹

Digitized information has also allowed for a better understanding of the link between care and outcomes since hospitals and clinicians can analyze how care provided during and after a patient's visit relates to improved or worsened outcomes. Instead of just doing retrospective data analysis, some systems now utilize real-time data, such as automated infection surveillance, to provide feedback on a time-scale that allows active intervention by the clinician. Taking a close look at these data provides opportunities to develop new protocols and to examine all aspects of care to determine what can be done differently to improve safety.

Provide Bottom-Line Perspective

A recent study found that IT systems in one hospital led to a 58 percent reduction in duplicate

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lab tests through alerts at the time of order.² That equated to a savings of \$9,100 a month and a potential savings of \$109,200 annually. With today's health insurers paying less for expensive procedures, pinpointing areas of redundancy and eliminating costly medical errors is a win-win for patients, physicians, payers and the larger community. However, as difficult as it is for clinicians to see how installing IT systems can improve patient care, it can be even harder for them to see how technology improvements can positively impact their organization's bottom line.

With electronic records that are easy to archive and research, providers can get a quicker and broader view of the care process and outcomes, allowing clinicians to spend more time on what matters most – delivering care at the bedside. Further, clinical IT systems eliminate waste. When lab results are recorded in an electronic format, they are easier to find, making it less likely that patients will be subjected to repeated visits and redundant tests to document what is already known. The days of an expensive set of test results being overlooked, or even lost, in the paper record can be eliminated with EMRs. Every detail is documented, making care more efficient, thorough and convenient.

While work remains to be done with clinical

IT systems in terms of functionality, cost and the ability to communicate beyond hospital walls, the systems have done a lot to improve the way we practice medicine.

There is no doubt clinical IT has cut down on unnecessary or duplicate tests. It has prevented human errors, including dosage mistakes and saved patient lives. It is allowing clinicians to track progress and practice more effective preventive medicine through evidence-based care.

Imagine how much more medicine will improve as these systems are embraced, integrated and put to use for the good of everyone involved.

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1 Virapongse A, et al. "Electronic Health Records and Malpractice Claims in Office Practice." *Archives of Internal Medicine*. November 24, 2008.

2 Currin Jr.,JG, et al. "Sustaining a Quality Culture and Engaging Physicians Through Clinical IT." Premier, Inc. June 2008.

About **PREMIER**

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

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