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Adaptive, High Performing Management Teams - Part 2

By John W. Kenagy, MD, MPA

Challenging times present great opportunities. Historically, in periods of rapid change, highly adaptive organizations have competitive advantage.

But, will your organization meet the challenge, adapt and make a difference? Find out by reading my new book, *Designed to Adapt: Leading Healthcare in Challenging Times*, to be published in June 2009. The book explores how your organization can:

- Adapt to rapid, unpredictable change,
- Eliminate behavioral and organizational road blocks,
- Make adapting part of everyone's job, every day.

I studied highly adaptive companies as a Visiting Scholar at Harvard Business School. To my surprise, I discovered they all shared common characteristics that I call Adaptive Design®; they were "designed to adapt."

Adaptive Design translated to healthcare focuses on just one thing: get patients exactly what they need at continually lower cost. It's the way to fix healthcare.

Rule #1 in Adaptive Design is, "One person can not do it alone." In my research, the mantra of the "great visionary leader driving revolutionary change" was exposed as a myth.

One person cannot do it all. It takes a high performing team to make a difference.

Therefore, Adaptive Design creates, improves and inspires high performing teams by getting people to think and act differently. It changes minds.

Changing minds is essential. Acclaimed advisor and author Marshall Goldsmith put it well in the title of his recent book: *What Got You Here Won't Get You There!* If you do not have an adaptive, flexible, visionary, high performing team now, don't expect that repeating the same behaviors will create one.

Each chapter of *Designed to Adapt: Leading Healthcare in Challenging Times* contains multiple real-life healthcare examples of how Adaptive Design can make a difference in your organization. The high performing team behaviors that you need are in Chapter 10, A New Way of Seeing; A New Way of Leading.

My last *FYA* column (Volume 8, Issue 5 - March 2, 2009) began a preview of Chapter 10 by looking at how six great adaptive leaders developed successful, high performing teams.

1. Bill Gates – Microsoft
2. Andrew Grove – Intel
3. William Hewlett and David Packard – Hewlett-Packard
4. Herb Kelleher – Southwest Airlines
5. Taichi Ohno – Toyota

Diverse leaders in diverse industries, but they all shared common leadership characteristics and all built *adaptive, high performing teams* with these characteristics.

The Five Characteristics of Successful Adaptive Leaders

1. **Set a clear, consistent, meaningful direction.**
2. **Develop people as the #1 resource.**
3. **Build trust and optimism.**
4. **Problem-solve what does not work.**
5. **Grow opportunistically and relentlessly by challenging the status quo.**

(Continued...)

Adaptive, High Performing Management Teams - Part 2 (Continued...)

My last column told the story of characteristics 1-3. Today I will review 1-3, and then add 4 and 5 with examples.

1. Set a clear, consistent, meaningful direction.

When I spoke with people who worked in the early stages of these organizations, I heard a consistent refrain, "We knew where we were going."

The direction Bill Gates set is legendary, "Get a workstation running our software onto every desk and into every home." Adaptive Design in healthcare focuses on just one thing: Get patients exactly what they need at continually lower cost. It's the way to fix healthcare.

2. Develop people as the #1 resource.

Since four of these leaders developed great technology companies, their focus must have been on technology. Right?

Wrong! All these leaders had one thing in common: They were fanatical about bringing out the best in their people.

3. Build trust and optimism

People make a difference when they work in an environment of trust and optimism. Jim Collins' classic book *Good to Great* also made the point: no one "builds to last" in an environment that lacks trust and optimism or breeds suspicion and fear.

Now characteristics 4 and 5:

4. Problem-solve what does not work.

Ideas are important, but these leaders' success never rested on rolling out a great idea. Their ability to take their ideas and relentlessly problem solve them made the difference.

Southwest Airlines, incorporated in 1967 as Air Southwest, originally served just three Texas cities: Dallas, Houston and San Antonio. According to a popular story, the business plan was first sketched out by Rollin Hand and Herb Kelleher over dinner on the back of a paper napkin – a great idea, but lots of problems to solve. A three-year legal battle with entrenched, incumbent airlines kept Southwest grounded until they prevailed in the Texas Supreme Court.

So, they did not even fly an airplane until 1971 and then faced more problems to solve. Continued losses for the next two years plagued the company and, in 1973, they were forced to sell one of their four Boeing 737-200s to Frontier Airlines just to make payroll.

This problem was not the end of the road, however. Rather than downsize, their problem solving continued until they discovered how to run a four-plane schedule with three planes! Harnessing the knowledge and creativity of everyone in the organization, they adapted with many small innovations that became the famous "ten-minute turn," their standard ground time for years. That's Adaptive Design,

In 1973, five years after the idea was birthed, problem solving

gave Southwest their first profit. They also learned to never stop opportunistically and relentlessly challenging their status quo. That has led to profitability every year since, a record unmatched by any other airline. And that's also Adaptive Design.

5. Grow opportunistically and relentlessly by challenging the status quo

Good managers marshal their forces when an organization stalls, reorganizes, hires and fires, buys new technology, brings in consultants, vigorously cuts costs and maybe even downsizes. Great managers *grow opportunistically and relentlessly by challenging the status quo*. As my book makes it clear, the ability to challenge the status quo lies at the heart of Adaptive Design.

Here is a dramatic example. Andy Grove led Intel to become a successful supplier of computer memory through the early '80s. But a seismic change was occurring in the computer industry that destroyed firms that could not adapt, including world-class companies like Digital Equipment.

Intel seemed in the same death spiral as profits of \$198 million in 1984 tumbled to \$2 million in 1985. That was when Grove and his team famously challenged the status quo to transform Intel from a memory company to a producer of semiconductors and microprocessors. The iconic Pentium chip was more than a great idea. It was grown by opportunistically and relentlessly challenging the status quo.

One of my mentors, Harvard Business School Professor Clay Christensen's disruptive innovation research shows it is almost impossible for an established company to innovate into a new business model. But "almost impossible" means it is possible. Andy Grove and his team opportunistically and relentlessly challenged the status quo to expand the possible for Intel – and never stopped.

Adaptive Design provides the direction, methods, skills, tools and inspiration that can make "expanding the possible" part of everyone's work, every day in your organization.

Is the answer to our healthcare problems trying harder what we are currently doing? Or is the status quo part of our problem? What do you think? Let me know.

If you would like more information about Adaptive Design or want to be on the publication announcement list for *Designed to Adapt: Leading Healthcare in Challenging Times*, contact me at jkenagy@kenagyassociates.com. In the meantime, let's adapt and make a difference.

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"Meaningful Use" Melee

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

"Meaningful use" of "certified EHR technology" is the gatekeeper to federal stimulus monies available for hospitals under the American Recovery and Reinvestment Act (ARRA) (see my 2/17/09 and 3/16/09 FYA commentaries, *Looking a \$19 Billion Gift-Horse in the Mouth and Re-examining the Stimulus Bill*). We don't know what that means until defined by the Secretary of Health and Human Services (HHS), but not surprisingly, industry players have already begun jockeying for position to try to convince the HHS how "meaningful use" ought to be defined.

On April 24, 2009, the Healthcare Information and Management Systems Society (HIMSS) adopted its proposed definitions of "meaningful use" and sent them to David Blumenthal, national coordinator of the Office of the National Coordinator for Health Information Technology (CCHIT). The HIMSS' definition includes at least the following:

- A functional EHR certified by CCHIT;
- Electronic exchange of standardized patient data with clinical and administrative stakeholders using the Healthcare Information Technology Standards Panel's (HITSP) interoperability specifications and Integrating the Healthcare Enterprise's (IHE) frameworks;
- Clinical decision support that provides "clinicians with clinical knowledge and intelligently-filtered patient information to enhance patient care"; and
- "Capabilities to support process and care measurement that drive improvements in patient safety, quality outcomes and cost reductions."

HIMSS also recommends that HHS adopt milestones that don't start phasing in until FY11 in order to "achieve the incremental maturation" (which sounds like code for "let's go slow"). HIMSS says that "interoperability of health information in the United States is currently very limited," which is demonstrably true since most healthcare vendor applications don't play well with others. So, HIMSS suggests that for FY11-FY13 the HHS require that a qualifying hospital only have:

- A major ancillary department information system (lab, pharmacy and radiology) and a clinical data repository;
- Discrete clinical observations electronically entered and available consistently throughout the organization;
- Adoption of compliance metrics and National Quality Forum endorsed quality measures that align with national quality and performance goals that are captured and reported upon without manual intervention or manipulation; and

- Electronic exchange of health information via scanned documents, text documents or XML transactions.

But the key to the HIMSS proposal is that the Computerized Physician Order Entry requirement be delayed: at least 51 percent of all medical orders be electronically entered by CPOE "for a minimum of two years commencing FY13" and 85 percent "for a minimum of two years commencing FY15."

A few comments on the HIMSS proposal:

1. Selling private sector oversight by CCHIT may be very tough in the wake of our ongoing financial crisis that many think got out of control. Many believe this was because of the lack of government oversight. Further, there may be political concerns because one-half of CCHIT's annual budget comes from private healthcare industry IT vendors. Mark Leavitt, chairman of CCHIT is a former tech vendor and CMO of HIMSS; and seven of the 19 voting members of CCHIT work for vendors or for-profit IT companies (see "The Dubious Promise of Digital Medicine" in *Business Week*, 4/23/09);
2. There are increasingly serious questions being raised about the benefits and the high cost of current healthcare EHRs/EMRs and whether our government should fund a continuation of the direction of current healthcare IT, e.g.:
 - a. The *Business Week* article refers to "the checkered history of computerized medical files...and legitimate questions about their effectiveness," but says that "red flags raised by doctors and researchers haven't gotten much attention in Washington, in part because the health-tech industry has forged strong ties to the President, his top medical advisers and Republican heavyweights such as Gingrich;" and
 - b. A National Research Council report (see my 2/2/09 FYA commentary *Current Focus of Healthcare IT Mis-Focused and Not Sufficient*) concludes that the current direction of healthcare IT should be changed. Changed because it improperly focuses on electronic documentation of transactions instead of providing clinicians with evidence-based decision support and feedback—i.e., physicians need IT that provides evidence – based decision support and feedback such as CPOE.



I would like to hear your comments.

Send them to:

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Government Sets EHR Incentives and Penalties

A new survey of hospital chief information officers finds that the federal government's \$36 billion "carrot" of financial reimbursements to install electronic health records won't be nearly as powerful an incentive as the "stick" of reduced Medicare reimbursements if they don't.

The survey of 100 hospital CIOs was conducted in March and released two weeks ago. The results were published in a PricewaterhouseCoopers LLP Health Research Institute report entitled, *Rock and a Hard Place: An Analysis of the \$36 Billion Impact From Health IT Stimulus Funding*.

By injecting \$36 billion in health IT through the stimulus fund, the federal government hopes to create a digital healthcare infrastructure that reduces costs and improves quality. Hospitals and physicians that want the stimulus money will find they have little choice but to comply with the new requirements or suffer future shortfalls in Medicare reimbursement.

Report highlights include:

- The stimulus funding for health IT is a small carrot compared to the amount of resources it will take to deploy this technology over the next five years. Also, providers will feel a big stick of financial penalties if they fail to use a government-certified electronic health record (EHR) in a government-certified manner beginning in 2015.
- Health IT is moving from a voluntary initiative over the past decade to a highly regulated one with new rule-making government committees, stricter privacy laws and more onerous fines.
- The stimulus funding for health IT won't begin flowing to hospitals and physicians until late 2010, but providers should immediately begin to determine whether their current systems will be in compliance and how they can capitalize on incentives. Payments will be higher for hospitals with higher Medicare inpatient and charity care volumes.
- With billions in new funding and government regulations, the health IT market will balloon far beyond the provider segment, providing new opportunities for health plans, pharma companies and other vendors.

- The Office of the National Coordinator will have broad new powers and \$2 billion in funding. Nearly all of the funds will flow to those that are already using systems in a strategic and government-certified way.

The survey also found that:

- 82 percent of hospital CIOs have already cut IT spending budgets in 2009 by an average of 10 percent, with one in 10 making more drastic cuts of greater than 30 percent.
- 66 percent of CIOs say they expect to be asked to make further cuts in IT spending before the end of 2009.
- 64 percent of CIOs agreed that it is impossible to balance demand with the need to cut costs.
- One-half of CIOs with more than 500 beds say that federal funding is "crucial" to their ability to implement EHRs.

A PwC analysis shows that a 500-bed hospital could receive an average of \$6.1 million in incentives to purchase, deploy and maintain a government-certified, interoperable EHR. By comparison, the average 500-bed hospital that fails to implement a system by 2015 could see a reduction in Medicare funding by \$3.2 million or more, depending on its Medicare volume.

PwC estimates that the average three-physician practice can expect to invest between \$173,750 and \$296,000 over two years to purchase and maintain an EHR system. Individual physicians, not practices, can receive up to a total of \$44,000 each for adopting certified EHRs. Like hospitals, the penalties may be severe enough to motivate compliance with government-certified systems.

The Congressional Budget Office says the \$36 billion in EHR incentives will be rebated between 2009-2015 for providers who adopt EHR. From 2016-2019, however, the federal government anticipates cost savings of \$15.5 billion in part because of the presumed money-saving efficiencies of healthcare IT, and also because the government in 2015 will begin to trim reimbursements for providers who aren't "meaningful users" of electronic medical records.

See Rick Kneipper's column on page three in this issue of FYA for a discussion of the term "meaningful user."

About



PHNS provides IT services for hospitals, other healthcare providers and businesses. PHNS' IT services include application hosting, co-location and managed services; electronic off-site data back-up and data vaulting; business continuity solutions; disaster recovery services; and systems integration services. PHNS also provides comprehensive business process

solutions for hospitals including admitting, HIM (including medical record management and storage, transcription, coding, release of information and electronic medical record services) and revenue cycle services. PHNS creates business-healthy hospitals by improving operations, enhancing technology and increasing cash on hand, which allows hospitals to focus on their core competency--patient care. PHNS has approximately 1,670 customers, including approximately 400 hospital IT and business process customers and approximately 1,270 IT customers. PHNS is headquartered in Dallas, Texas. See www.phns.com for additional information about PHNS.

Purchasing Points: Leveraging GPO Relationships

By Helene D. Gulczynski, MHA, MT (ASCP), and Barbara M. Maillet

In today's trying economic times, hospitals are searching for ways to reduce costs, improve value and maintain the quality of services provided. Considering what hospitals spend each year on medical equipment and supplies, this is a critical area of focus and an expense that can be dramatically reduced to preserve financial viability without compromising patient care.

Hospitals join group purchasing organizations (GPOs) in hopes of optimizing costs. And while some lab administrators feel this arrangement is less than ideal, particularly because it may limit their input into product selection, GPOs can help hospitals and their labs reduce expenses and optimize the bottom line if those relationships are effectively leveraged.

Creative Uses of GPO Services

Most hospital laboratories know that GPOs provide advantageous contracted pricing options, but GPOs have evolved their capabilities over the years to offer value-added services that can help labs develop creative and non-traditional contracts, evaluate new product offerings and negotiate favorable financing terms.

To that end, GPOs can help hospitals conduct a comprehensive review of their planned capital purchases, focusing on the return on investment in terms of both dollars and quality gains. For instance, an effective GPO partner can use benchmarked data from other hospital labs to pinpoint savings opportunities, avoided costs and potential quality gains.

Beyond contract pricing, an effective GPO can help laboratories save money by negotiating favorable payment terms. Many manufacturers and distributors are willing to defer payments until capital purchases begin to demonstrate value. This flexible payment option allows hospital labs to increase cash on hand and take advantage of tax and interest benefits while they wait for returns on their investments. An effective GPO partner can help keep labs informed of these options and help them achieve the most advantageous terms.

Examining Contracts for Cost Efficiency

On average, hospitals report that GPOs save them between 10 percent to 15 percent on medical products and supplies. But hospital labs can't take advantage of those savings unless they are familiar with the manufacturer contracts and able to lock in the best possible terms.

Given the fact that there are more than 800 hospital supply manufacturers, each with varying pricing options and purchasing tiers, managing this information can prove daunting to even the savviest purchasers. Aware of the volume and complexity of the contract management process, most national GPOs have evolved to offer automated solutions to help hospitals assess their supply chain in real-time, capture immediate savings and improve processes for sustained results.

Most of these solutions can automatically analyze laboratory purchases and help purchasers manage contracts and activate pricing online, examine spending trends and analyze on- and off-contract pricing to guide more effective product selection and financial performance.

Over time, it is highly likely that these types of automated supply chain solutions will develop and become more robust. However, as these systems grow, there is a risk that purchasers may be overwhelmed with the volume and detail of information coming from their automation tools. Going forward, it will be important to balance the granularity of information available with analytics capabilities to ensure that purchasers are provided with the best, most actionable data, not minutiae.

Exploring Standardization

One of the biggest group purchasing debates in any hospital concerns physician preference. Hospital leadership, the GPO and materials managers are all incentivized to control expenses by standardizing product purchases to capture volume discounts. Product users, however, are clinicians – and

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Purchasing Points: Leveraging GPO Relationships (Continued...)

laboratorians – who are relatively isolated from the cost implications of their choices. With each clinician making different requests based on hers or his individual needs, product standardization can become a significant challenge and impede the hospital's ability to conserve cash in one of the few areas they can control – the expense of supplies.

To make the most of the healthcare dollar, hospital leadership will need to confront this issue and work collaboratively with clinicians and department heads, including lab administration, to provide the appropriate breadth of choice, while making significant efforts to standardize as much as possible. While the GPO can help hospitals pinpoint off-contract spending and offer the most advantageous pricing for standardization, ultimately it is the hospital that must initiate discussions and win clinician support for a standardization effort to succeed.

Should the hospital succeed in a standardization effort, most GPOs are able to reward the effort by offering special "best price" product tiers and simplified contracting options to capture the maximum amount of savings. And, since supplies are contracted, the pricing is locked in, providing the hospitals with pricing certainty for a defined period of time, usually up to three years.

Improving Quality

Although the GPO's historic role and core competency remains the ability to negotiate and contract for reduced prices, some are expanding their offerings to provide benchmarked clinical data and opportunities for collaboration. This can help improve quality and avoid millions in added expenditures for liability and

malpractice insurance and reduced reimbursements for preventable healthcare-associated conditions.

In taking advantage of these and other GPO services, hospital departments can compare their performance in specific areas to peers and best performers; find opportunities for improvement; track the results of their efforts to improve financial, clinical and operational performance; and achieve even greater savings through improved outcomes.

A New Role

While traditionally serving as a valued partner to hospitals seeking to reduce supply expenses, GPOs have grown over the years to offer a wide variety of value-added services. In exploring creative new options and partnership opportunities with GPOs, hospital laboratories can significantly reduce their costs and improve the quality of patient care.

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