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About FYA

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Innovation 2008 - Getting Physicians On-Board

By John W. Kenagy, MD, MPA, Director, Kenagy & Associates

This month's column continues to look at what will be "Hot" and what will "Not be Hot" Innovations in 2008.

Healthcare Innovation 2008

What's Hot	What's Not Hot
Growing Return on Investment (ROI) from operations	Capital expenditures for new technology and facilities
Developing people and relationships	Implementing IT systems
Purpose and commitment	Power and compliance
Local knowledge, ingenuity and real-time innovation	Consultants, external solutions and manufactured innovation
Transforming your culture	Fighting entrenched cultures
Multi-purpose hospitals	Specialty hospitals

It's the ability to adapt that makes the difference. Adapting means people learning to work differently; and the evidence is overwhelming that the keys to adaptive success in 21st century healthcare lie on the "What's Hot" list.

But, how do you get people to act differently? For example, how do you change the behavior of physicians over which hospitals traditionally have little control? Lessons learned in the last 10 years have shown the "What's Not" side of the table has failed to bring physicians on-board – and I don't think trying harder with what's not working is the answer.

The answer is engaging physicians with "What's Hot." Take the following steps and you will bring physicians on-board.

First, make no effort to involve all physicians at the start. Some will be ready, some will not; leverage that difference.

Second, work outside the traditional hospital/medical staff structure. Developed to maintain the status quo between two groups who did not trust each other – administration and physicians – it is a product of the 1960's and not appropriate to 21st century healthcare innovation. The *Lessons Learned* below are powerful tools for bringing physicians on-board with trust and optimism. Using them in typical medical staff/hospital Committee structures and politics is like tying a jet engine to an ox cart.

Third – use the *Lessons Learned* from successful adaptive innovations to make the difference.

Lesson #1 – Strategic Thinking – Engage physicians in strategic thinking around a common purpose that meets shared goals. In our experience, using the change in the basis of competition is a powerful tool to stimulate shared

(Continued...)

Innovation 2008 - Getting Physicians On-Board (Continued...)

strategic thinking. Instead of focusing strategy on *increasing functionality* of products and services, leverage the fact that the basis of competition in healthcare is changing to *increasing reliability, access, customization, emotional (spiritual) needs, convenience and low cost*. (If you have questions or want more data on the change in the basis of competition, e-mail me at jkenagy@kenagyassociates.com)

Lesson #2 – Execute – Lack of execution is the primary reason organizations fall short of their promise. Execution means closing the gap between intention, plans and reality – i.e., execution makes strategic thinking the reality at the point-of-care. In modern organizations, execution is never a simple algorithm that is "rolled out." Rather it means engaging physicians with a structured, disciplined approach that involves relentless questioning, problem solving and follow-through. Execution is not having more meetings; it is getting things done.

Lesson #3 – Problem Solve – Execution means problem solving at the point of care so that things get done. Our experience and the research of others show that more than 95 percent of system failures in health care are small *problems* (disruption in a worker's or team's ability to execute a prescribed task) rather than *errors* (execution of a task or process that was either unnecessary or incorrectly carried out). Therefore, focusing on problem solving rather than errors is powerful for both the hospital and physicians.

And it works. In one of many examples, combining

strategic thinking, execution and problem solving brought physicians on board and led to the following changes in six months in one hospital operating room:

1. Surgical volume increased 16 percent,
2. Overtime decreased 14 percent,
3. 95 percent JCAHO compliant.

What was different? – There were no taskforces, meetings or focus on increasing volume, decreasing overtime or increasing JCAHO compliance. Rather, strategic thinking aligned execution on problem solving. The results took care of themselves.

Executing for a small group of physicians immediately attracts others who want more of the same. I have been a physician for 35 years and I know docs hate to see another doc with a toy they do not have. It is the nature of the beast.

Physicians get on board when they have a chance to work with "What's Hot" innovation. The basic elements are *strategic thinking, execution and problem solving*. It's not rocket science; it's just different.

For questions or comments, e-mail me at jkenagy@kenagyassociates.com.



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About



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Bad Grades (Once Again) for U.S. Healthcare

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

As you may have seen on national news reports last week, our U.S. healthcare system just received yet another failing grade in a detailed performance and cost comparison to the health systems of Australia, Canada, Germany, New Zealand and the United Kingdom. According to the 2007 edition of The Commonwealth Fund's *"Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care"* (May 2007):

"Despite having the most costly health system in the world, the United States consistently underperforms on most dimensions of performance, relative to other countries...Compared with five other nations – Australia, Canada, Germany, New Zealand, the United Kingdom – the U.S. health care system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives."

This survey confirms many of the findings of two earlier editions of *"Mirror, Mirror"* – in all of the surveys the U.S. ranks last of the six nations in the overall performance of its healthcare system, and ranks last on indicators of patient safety, efficiency and equity. Yet the U.S. health expenditures per capita (based on 2004 data) are about two to three times those of the other five nations: U.S.-\$6,102; Canada-\$3,165; Germany-\$3,005; Australia-\$2,876; United Kingdom-\$2,546; and New Zealand-\$2,083.

Before you yawn and say that you've seen these bad grades before, this time the bad grades made the national media and it is, of course, election season and so this is probably going to get increased attention and scrutiny (see my commentary entitled *"Does Washington Finally Have the Will to Fix Healthcare?"*) in the [2/5/07 issue of FYA](#). Consider, for example, some of the additional findings of the Commonwealth survey:

- The lack of universal health insurance coverage in the U.S. is a principal reason why "the U.S. substantially underperforms other countries on measures of access to care and equity in health care between populations with above-average and below-average incomes;"
- The "U.S. is lagging in the adoption of information technology and national policies that promote quality

improvement." Based on the inclusion of physician survey data for the first time, the report states that "Information systems in countries like Germany, New Zealand and the U.K. enhance the ability of physicians to monitor chronic conditions and medication use."

- The area where the U.S. healthcare system performs the best is preventive care, an area that has been monitored closely for over a decade by managed care plans."

What the survey sees in the mirror on the wall about the U.S. healthcare system isn't very attractive. The survey's conclusions are based on a survey of nationally representative samples of adults and primary care physicians in the six countries – [please read it](#) and tell us what you think about the validity of its conclusions.



I would like to hear your comments.

Send them to:

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About

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FYA - For Your Advantage is brought to you by TrendLeader Connections. The function of TrendLeader Connections is producing educational materials and seminars that help healthcare executives differentiate between fads and trends; and making connections with "Trend Leaders" within the healthcare industry.

We are committed to delivering new perspectives and ideas, creative and innovative healthcare solutions, provocative concepts and quality educational materials to today's healthcare leaders. We want to concentrate on "what comes after what comes next."

CEO Rewards Linked to Quality of Care

Instead of rewarding hospital chief executives for their ability to attract patients and make money, many are finding a portion of their pay linked to a range of safety measures, from reducing medication errors to monitoring how often doctors wash their hands.

The Boston Globe reports that the change is a reaction to increasing pressure from Washington and state capitals over hospital safety. Trustees are turning to paychecks as a way of holding executives accountable for medical errors and hospital-acquired infections.

"Regulatory oversight, state attorneys general, and anxiety over billing practices has pushed it right into the boardroom," said James Rice, a compensation specialist in the healthcare division of Clark Consulting in Minneapolis. "The non-profit hospital sector is under intense scrutiny right now."

About half of the nation's non-profit hospital chiefs do not receive full bonuses unless they meet incentive goals, specialists said, including finding ways to double-check patient identifications, track tissue specimens, make sure test results are not lost and cross-check medications, according to the *Globe* report.

Hospital managers have looked to incentive systems in place at hotels, restaurants and other service industries, said Helen Drinan, senior vice president for human resources for Caritas Christi Health Care.

"We have to drive a higher level of performance, and part of that is getting your executives' attention," Drinan said. The six-hospital system, which is owned by the Archdiocese of Boston and includes St. Elizabeth's Medical Center in Brighton, began in 2006 to link up to 10 percent of executive bonuses on safety and quality improvement.

The *Globe* reports that at Beth Israel Deaconess Medical Center in Boston, chief executive Paul Levy, could lose as much as a third of his \$195,000 annual performance bonus if, among other things, he fails to increase the number of doctors and nurses who wash hands between patients, reduce certain types of infections and increase the number of employees who receive influenza vaccinations. This is the third year Levy has been subject to the requirements.

"Hospitals have been so focused on staying alive financially that maybe they forgot what their original mission was, which was to do no harm," said Lois

Silverman, who reviews Levy's compensation as chairwoman of the Beth Israel Deaconess board of directors. "Part of many individual bonuses were based on the financial status of the institution but that didn't seem to be enough for healthcare."

According to the *Globe*, Partners HealthCare, the largest healthcare network in New England, does not have written employment agreements linking safety goals to bonuses for executives, including Dr. Peter Slavin at Massachusetts General Hospital and Dr. Gary Gottlieb at Brigham and Women's Hospital. But Partners chief executive Dr. James Mongan does consider a host of safety performance measurements when deciding how much bonus money to pay, said Thomas Glynn, Partners chief operating officer. Among the measures Mongan reviews: what percentage of patients have bar-coded wrist bands, and what percentage of those with artery blockages get a balloon angioplasty within 90 minutes of arriving at the hospital.

"It is part of their performance appraisal, and it is very detailed and explicit," Glynn said.

Also, Mass. General this year began linking five percent of their compensation to an incentive payment for senior vice presidents and medical department chiefs who work under Slavin.

Mass. General received a negative safety review after a December 2006 inspection by the Joint Commission which found that not enough clinicians washed their hands and that some staff members did not adequately maintain patient records. The hospital said its incentives were established before the inspection report.

But monitoring something such as hand-washing is difficult. Mass. General sends infection-control squad members to discreetly mingle at medical units and observe how often clinicians wash between patients, said Gregg Meyer, who was hired as the hospital's first senior vice president for quality and safety last year. The hospital achieved an 87 percent hand-washing rate in the first quarter of 2007; its goal is to improve to 90 percent, Meyer said.

"It's not that quality and safety were never considered, but we're tying it much more explicitly to compensation," he said.