

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



Pick Your Poison, Or Find a Better Way to Fix Healthcare Page 1 - 2

More re: "Meaningful Use" Page 3

Hospital Executives Becoming Millionaires Page 4



Hospitals Benefit from Implementing a Balanced Scorecard Approach Page 5 - 6

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

Pick Your Poison, Or Find a Better Way to Fix Healthcare

By John W. Kenagy, MD, MPA

Get patients exactly what they need at continually lower cost. It's the way to fix healthcare. How do I know? Let me tell you.

In the 40 years since my graduation from medical school, we all have tried hard and failed to stem the soaring cost of healthcare by focusing on big solutions to control costs. Where has this landed us? Billions of dollars further in debt in the middle of a financial crisis.

President Obama says, "The biggest threat to our nation's balance sheet is the skyrocketing cost of healthcare." Peter Orszag, director of the White House Office of Management and Budget is more specific, "Healthcare reform [must be] self-financing and also [bring] down costs ... both for families and for the federal government." I believe they are right. So, now we can't fail.

That's a big problem and puts the pressure on to find a big solution. But all these so-called big solutions are offering more of the same.

As a physician, healthcare executive, management scholar, author, advisor and, most importantly, a patient deeply immersed in the healthcare system, I have watched us repeat – and fail at – the same scenario, over and over again. Yogi Berra said it best, "It's déjà vu all over again."

First, we discover we have BIG problems, and then we collect and analyze the data, consult the experts, have lots of meetings, plan, analyze and predict, then design and implement big solutions. Here are some of the "solutions" I have been part of in my career. Do any of these sound familiar to you?

- More regulations, new regulatory entities, tighter compliance demands
- New ways to pay and insure (HMO's, capitation, increase co-pays and deductibles, Medical Savings Accounts, single payer, etc.)
- Better metrics, aligned incentives, scorecards and tighter management
- Information Technology, new medical technologies and new facilities
- Managed care, "population-based medicine," reengineering, care redesign, clinical pathways, guidelines, evidence-based medicine, etc.
- Some form of care rationing
- Many consultants and management experts with many hot new solutions
- Lots of projects and improvement initiatives

The record shows these solutions failed to control healthcare costs yet, we are still relying on them.

My fear is, as Einstein asserted, "Insanity is repeating the same behaviors and expecting different results."

And now the stakes are higher. Failure is not an option.

The only method I've seen to significantly decrease cost was the care rationing that occurred during the "Managed Care Revolution" of the 1980's. Yet, that came at the price of care.

The evidence shows that current health care reform is going to boil down to "pick your poison," as in who do you want to ration your care? – Elected officials, government bureaucrats, academic experts, insurance companies, doctors, nurses, managers, computers, your pocketbook? Pick your poison.

Personally, I have no interest in picking my poison. I want a different way to fix this mess.

(Continued...)

Pick Your Poison, Or Find a Better Way to Fix Healthcare (Continued...)

As Einstein laid out the problem, he also pointed us toward the solution when he said, "You cannot solve the problems of the present with the solutions that produced them."

Big solutions for big problems have repeatedly failed to control healthcare costs. Those data-driven big solutions are now part of the problem.

There is no question we need a "transformation" to control healthcare costs. But how? My work and research as a Visiting Scholar at Harvard Business School and the research of many others show that you don't design and implement transformations with big solutions. You make them with many small solutions.

Transformations follow a predictable course: a small number of leaders steadily adapt their organizations to deliver what the rest cannot. Harvard Professor Clayton Christensen's model of disruptive innovation tells that story over and over again. Toyota did not design and implement the Toyota Production System or the downfall of GM; they made it. Southwest Airlines did not design and implement the world's largest airline in passenger miles flown; they made it. And those are just two of hundreds of examples.

Healthcare transformation begins with those few organizations strategically and operationally "designed to adapt." These organizations have incredible competitive advantage in a rapidly changing world.

How do we build adaptive organizations?

We follow the methods that create great, transformational innovations. In healthcare this formula works time and time again. Here's how:

- It's always about people. Start with something people need for which current methods don't deliver. Look closely at the patient; it all starts there.
- Remember current solutions are part of the problem. Eliminate barriers and distractions by starting fast, small, simple and, as much as possible, separate. You can stay physically inside your current organization by just, as some of my colleagues say, "putting a bubble around it." I call that your health system, hospital or clinic's "learning line."
- Don't design and implement with projects. Rapidly problem solve as part of everyone's everyday work. The healthcare frontline loves to problem solve; adaptive management adds the direction, discipline and structure needed to make a sustainable difference.
- Develop people, trust and optimism. Clarity, consistency and authenticity build trust, local knowledge and ingenuity that turbo charges your success. Rekindle the common desire of almost everyone in healthcare to make a difference. That flame always grows.
- Repeat success opportunistically and relentlessly. This is

simple but not easy because of our top-down, big solution habits and expectations. It is now ready to blossom for those few leaders who want to make a difference.

This cycle has been successfully repeated with many people and organizations in healthcare. The secret is a simple, disciplined methodology called adaptive design, reflected within my book *Designed to Adapt: Leading Healthcare in Challenging Times*, to be published in September.

Consider these results:

A 45-bed medical surgical unit in a Midwest hospital focused on adaptive, real-time problem solving for 13 months. The results: this unit had the greatest increase in patient satisfaction in a 17-hospital system. At the same time it increased staff productivity 14 percent, decreased length-of-stay eight percent, decreased staff turnover by 51 percent and saved \$1.7 million.

An East coast operating room increased surgical volume by 16 percent, at the same time that it decreased overtime by 14 percent and became 95 percent JCAHO¹ compliant. It achieved this – not by focusing on volume, overtime or JCAHO – but by real-time problem solving in the course of work.

A mountain state hospital pharmacy achieved the assumed "impossible" by decreasing drug costs 2.4 percent over two years and thereby saving \$2 million. Focusing on drug costs wasn't part of the equation; it was solving hundreds of small problems that had prevented patients from getting the medications they needed.

This is a solution primed and ready for what healthcare needs now.

The challenge is that solving small problems rapidly is not seen as a big solution; therefore, it's not on the radar screen.

Recent health system and hospital management work, including the Mayo Health System, has solved that problem. Empowering people and holding them accountable to solve small problems rapidly has become a big solution because it is now a methodology a CEO and management team can implement.

The next step is to find a few leaders who want to make a difference. It is easy to know if that's you. Do you think that care should start and end with the patient? If that fits, the next steps are simple and quickly make a difference. Contact me at jkenny@kenagyassociates.com and I'll tell you how you can start to get patients exactly what they need at continually lower cost. It is the way to fix healthcare.



©2009 John W. Kenagy, MD, MPA,
Director, Kenagy & Associates, LLC
(K&A)

1. Joint Commission of Accreditation of Healthcare Organizations

More re: "Meaningful Use"

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

Hopefully you're paying close attention to the increasingly intense debate over how tough the "meaningful use" requirements should be for hospitals and physicians to get a piece of the \$30 billion of federal stimulus dollars for improved healthcare IT.

While Congress clearly mandated that the stimulus dollars should only be spent to improve patient care and quality, healthcare vendors (led by HIMSS) are aggressively urging HHS to impose "meaningful use" requirements over five or more years, with the principal phase-in of important clinical tools like computerized physician order entry (CPOE) delayed until 2013-2015.

Others are strongly urging HHS to demand that new healthcare IT funded with the stimulus dollars be focused on technology that fosters prompt improvements in patient care and quality. One such very thoughtful report is called "Achieving the Health IT Objectives of the American Recovery and Reinvestment Act-A Framework for 'Meaningful Use' and 'Certified or Qualified' EHR." (Markle Foundation Connecting for Health, 2009) (April 2009). The report includes the following recommendations:

- "The overarching nationwide goals of health IT investments are to improve health care quality, reduce growth in costs, stimulate innovation, and protect privacy." To achieve this, the report urges that the "meaningful use" goals and metrics be specified before technology is commissioned and the incentives are offered or else "the government will risk wasting valuable resources and losing support from both health care providers and the public for further health IT investments."
- "The definition of 'meaningful use' should hinge on whether information is being **used** to deliver care and support processes that improve patient health status and outcomes. The definition should focus on the needs of patients and consumers, not on the mere presence or functions of technology." This is sage advice since the healthcare world is littered with the future promises of new technologies that were never realized.
- "Meaningful use should be demonstrable in the first years of implementation (2011-2012) without creating undue burden on clinicians and practices." First, this trumpets a welcome push for prompt benefits, as opposed to the HIMSS approach that

recommends that CPOE, one of the beneficial technologies singled out by the stimulus bill, doesn't hit 85 percent use until a two-year period starting in FY2015. Second, the undue burden recommendation is critically important since improvements in patient care and quality will only happen if physicians, nurses and other clinicians use the new technology. It's been a tough sell to get them to use them on current EHR technologies that are difficult to use and take more time than paper-based processes.

- "The meaningful use definition must optimize **achievability** for providers and **benefits** to patients and consumers. Improving **medication management** and **coordination of care** provides early opportunities for such an optimization." Right on the money – numerous studies have shown that improving medication management and coordination of care are essential to improving patient care quality.
- "However, assuming that only comprehensive EHR systems can achieve the goals of meaningful use might delay progress or lock out other lightweight, network-enabled solutions that may achieve the same goals in the near-term and can provide bigger functionality over time." This is an outstanding recommendation since many of the EHRs in the market today provide way more functionality and cost way more than many (most?) healthcare providers (hospitals and physicians) can afford, and thus our stimulus monies should focus on technologies that will have the broadest possible appeal and impact.

On June 16, 2009, a workgroup of the HIT Policy Committee (which was created by the ARRA stimulus bill) will unveil its recommendations on the definition of "meaningful use" of EHRs. Hopefully they will incorporate some of these excellent recommendations from the Markle Foundation report.



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

Hospital Executives Becoming Millionaires

Looking for a benchmark? *The Pittsburgh Post Gazette* reported that University of Pittsburgh Medical Center Chief Executive Officer Jeffrey Romoff was given almost \$3.95 million in compensation in fiscal 2007, up 19.7 percent from the year before.

Romoff also received pension plan contributions of \$41,968 and an additional \$20,380 for taxable expenses, such as a car allowance, spousal travel, legal and financial counseling.

His total pay is significantly higher than the \$1.2 million average for CEOs at hospital systems with more than \$1 billion in revenue (as surveyed early last year by Chicago consulting firm Sullivan, Cotter & Associates Inc). At the same time, his compensation, the year before, of \$3.3 million, trailed counterparts at the Cleveland Clinic (\$7.5 million) and several other non-profit systems around the country such as San Francisco's Catholic Healthcare West (\$5.3 million).

The nonprofit UPMC disclosed Romoff's compensation in its annual filing with the Internal Revenue Service. UPMC, the region's largest employer with 48,000 workers, also revealed more this year about income its employees received from "related organizations."

For example, the deputy director of clinical services for UPMC Cancer Centers earned \$355,000 and \$499,408 from UPMC Presbyterian/Shadyside (where he is chief of hematology/oncology division at UPMC Shadyside). But he also collected \$749,540 from Oncology-Hematology Association Inc., a for-profit subsidiary of UPMC. That's a total of \$1.6 million – second only to Romoff in total compensation as reported to the IRS.

The treasurer of the UPMC Cancer Centers and deputy director of business affairs for the University of Pittsburgh Cancer Institute earned a total of \$1.48 million in fiscal 2007 – \$355,000 as an officer of UPMC, \$393,621 from UPMC Presbyterian/Shadyside and \$737,840 from Oncology-Hematology Association Inc., the for-profit subsidiary.

In all, UPMC lists 11 people who collected more than \$1

million in fiscal 2007. They include the UPMC Executive Vice President, \$1.2 million; general counsel, \$1.05 million; and neurological surgery chief, \$1.3 million (\$142,493 of that from the University of Pittsburgh).

The five highest-paid employees who are not officers include doctors who earned \$1.02 million, \$1.05 million, \$1.18, \$1.2 million and \$1.3 million, respectively..

This can't feel great to board members who are facing significant 2008 losses (though the losses, driven by investments shaken by the subprime debacle, can't be said to be Romoff's fault)

The non-profit University of Pittsburgh Medical Center – a profit machine in recent years – did something rare during the first nine months of fiscal 2008.

It lost money.

Net income was a negative \$7 million, compared with a gain of \$459 million in the year-ago period, the drop largely due to turmoil in financial markets and the resulting pressure on UPMC's \$3 billion equity and fixed-income investment portfolio.

Despite the overall decline, UPMC Chief Financial Officer Robert DeMichie argued that it was a "very solid performance" for the region's largest employer and dominant medical provider, pointing to its sizable cash flow, six percent growth in admissions to its 20 hospitals, a 12 percent increase in enrollment to its insurance arm and a 12 percent increase in operating revenue.

"UPMC's financial position remains very, very strong."

The fact that UPMC's investment portfolio -- the primary source of UPMC's large profits in recent years – gave up a negative \$151 million in the first nine months compared with a \$279 million gain in the year-ago period "is not a surprise to us," said UPMC treasurer Talbot Heppenstall, citing the credit crunch that roiled markets worldwide this year. And the losses were on paper only – due to an accounting change last year; UPMC treats quarter-to-quarter portfolio drops as actual losses.

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.

Hospitals Benefit from Implementing a Balanced Scorecard Approach

By Fred J. Pane, R. Ph., BS, FASHP

For years, many hospitals and health systems were solely focused on the financial aspect of hospital operations, especially at the C-suite and Board of Directors level. There were discussions on improving the operating margin, cash on hand and bond ratings; decreasing days in A/R, length of stay and cost/outlier DRGs; right-sizing the organization; and establishing productivity measures. Quality assurance and performance improvement programs were also being implemented throughout the hospital and health system, but there was no connection being made to productivity measures or financial performance. Quality information was being reported to a quality or performance improvement committee and financial information to the hospital's finance committee and Board of Directors. A cultural change needed to occur all the way down to the department level of operations.

Some hospitals were early adopters and implemented the "Balanced Scorecard" model, a performance management tool used to monitor financial and quality performance down to a hospital department level. For example, a Balanced Scorecard can be used to determine whether an adjustment in productivity or staffing in a nursing unit has a positive or negative impact on quality metrics (patient falls, medication errors, etc.) and/or patient satisfaction. A pharmacy department's Balanced Scorecard may assess a productivity measure, such as hours worked or pharmaceutical care units, track drug expense metrics or 30-day readmission rates based on drug recommendations and also track medication error rates or order turnaround time. The pharmacy will not receive a patient satisfaction score, but the hospital will conduct periodic employee surveys of nursing or other medical staff to obtain input on customer satisfaction to balance the scorecard.

Over the last year or more, the American College of Healthcare Executives (ACHE), as well as other

professional organizations, have covered the topic of the Balanced Scorecard and how it needs to be aligned with hospital and health system organizational strategies and performance management. The *Journal of the American Medical Association* (JAMA) has published scorecard information urging hospitals to grade quality measures on how often patients experience harm and how often they receive evidence-based interventions, while addressing whether new measures help change care delivery to improve safety. Peter Pronovost, M.D., assistant professor in the department of anesthesiology, Johns Hopkins University School of Medicine, says many new quality measures are of questionable validity and practical use to hospitals. He believes the scorecard can help hospitals make more informed decisions (Pronovost, P et al. JAMA Mar 09).

It has been suggested that an organization needs a strategic set of priorities that go beyond financial performance. Even bond rating companies, such as Moody's, are looking for quality initiatives in hospital mission statements. With the advent of Pay for Performance, Value Based Purchasing, Hospital Acquired Conditions and Never Events, government (Centers for Medicare & Medicaid Services) and private payers are increasing their focus on quality and tying reimbursement back to quality performance and patient outcomes. There is a new payer model: "No Quality = No Payment" (or lower payment), a Balanced Scorecard approach to patient care.

Today, hospitals are implementing the Balanced Scorecard model and determining what metrics various departments should be monitoring, in addition to patient satisfaction and 30-day readmissions, in most cases. CEOs are asking hospital departments to develop and focus on quality metrics. Hospital departments need to agree on what are the best financial and clinical metrics

(Continued...)

Hospitals Benefit from Implementing a Balanced Scorecard Approach (Continued...)

to be measured and if they are pertinent to the operations of the individual department and the hospital's strategic plan.

As was discussed in the January/February 2008 issue of *Healthcare Executive*, management's role is ensuring success of the performance improvement system, including making sure expectations are clearly defined across the system by: 1) enabling staff to understand and align their individual goals with system-wide strategies and objectives; 2) improving communication through ongoing performance dialogue; 3) promoting the development and growth of employees through the use of goal setting, coaching and feedback; and 4) helping create a culture aligned with strategic objectives (Bloomquist, P et al *Healthcare Executive* Jan/Feb 08).

How might you employ a Balanced Scorecard approach in your facility? Implementing a Balanced Scorecard typically includes:

1. Translating the vision of the healthcare organization into measurable, operational metrics, both financial and clinical;
2. Communicating the organizational vision to departmental operations;
3. Establishing agreement on departmental metrics, which are linked to the individual department's performance for accountability;
4. Continuous review of learnings, benchmarking and feedback related to the established metrics;

and

5. Documentation of improvements, both clinical and financial.

Charles R. Denham, in the *Journal of Patient Safety*, provided a compelling argument that the philosophy of "No Margin, No Mission," is quickly being replaced by "No Outcome, No Income" (Denham C, *Journal of Patient Safety* 2008). The Balanced Scorecard can contribute to improvements in the healthcare system's financial situation, as well as, clinical outcomes and result in a safer environment for patients and staff.



Fred J. Pane, R. Ph., BS, FASHP, is senior director of Pharmacy Affairs at Premier Inc. and an ACHE member. He can be reached at fred_pane@premierinc.com.

References:

1. Pronovost PJ, Colantuoni E., "Measuring preventable harm: helping science keep pace with policy," *JAMA*, 2009 Mar 25;301(12):1273-75.
2. Bloomquist P, Yeager J., "Using Balanced Scorecards to Align Organization Strategies," *Healthcare Executive*, Jan/Feb 2008, 24-28.)
3. Denham C, "CEOs: Meet Your New Revenue Preservation Officer.....Your PSO," *Journal of Patient Safety*, 2008, 4 (3): 201



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.