FYA For Your Advantage

An Essential Tool for Healthcare Leaders

Sponsored by PHNS Innovative Solutions to Complex Problems

Volume 8, Issue 15 - August 3, 2009

From

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Baseball and Healthcare: So, "Who's On First?"

By Sarah E. Hull, Vice President, Rule 4 Consulting

Who doesn't enjoy the famous, hilarious commentary by Abbott and Costello? Now that baseball season is in full swing, I find discussions in healthcare sales presentations often touch upon people's favorite baseball teams, and just how well they are stacking up against the competition.

As conversations then move on to the complex and often complicated issues surrounding patient care coordination – it has repeatedly struck me how healthcare personnel often experience a similar level of confusion with one another in communicating important, time-sensitive, private information on behalf of patients. The cost is misinformation shared that leads to compromised safety, and, at times, direct harm to the patient.

"We operated on the left leg and not the right? How did that happen?"

"We were slated to operate on the wrong patient who had the same name?"

Errors from operating room fires to wrong-site surgeries, medication dosing errors, or patient falls out of beds due to side rails not being put up do happen. Then, the finger pointing often begins:

"Well, who's in charge on the shift?"

"Who miswrote the order?"

"How could the surgeon not know?"

There are far more complex reasons for errors than just targeting a scapegoat within the system to blame. For sustainable change to take place, it's important to take collective responsibility as an organization while holding oneself personally accountable. That is at the heart of optimum healthcare.

In healthcare, it isn't a situation to "laugh off" lightly when things go wrong. The challenge for both management executives and clinicians is in knowing that unintended mistakes in care may lead to irreversible harm, and even worse, human lives lost. From a financial perspective, we are also aware from daily news reports that errors in care also significantly cost hospitals and patients.

Effective consulting groups work within healthcare systems and first focus on improving the level of teamwork and problem-solving capability in every system consulted with, down to the finest details – from management to front-line staff. The goal is to empower employees within the larger health system to commit to that level of accountability required to problem solve so that more can get done, more efficiently. Think of it like riding a bike, both wheels (the larger system objectives and the individual caregiver) working in tandem to

(Continued...)

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propel the rider (patient) forward more quickly over greater distances than when backpedaling, or mistakenly jamming gears. The entire bike stops when the chain falls off.

Reaching that goal counter intuitively requires everyone to slow up and first observe, down to the smallest details, what is actually taking place. Gathering that important data via an initial "Readiness Assessment" takes our group an average of four to six weeks. The result is that by focusing on what is happening on a daily basis, secondary root problems that underlie primary issues come to light and are resolved, and over time – with repeated practice under the guidance of a coach – more quickly. The cost savings to an organization, just in terms of time management, is significant. As a concrete example, late start times in one client hospital's OR have been reduced by 80 percent.

Consider what Keith Granger, President/CEO of Flowers Hospital in Dothan, AL, asks of his staff. He expects his executive team to report to him every afternoon by 3:00 any adverse events or near misses in the past 24 hours. That may explain why the 235-bed hospital got the highest quality scores in the nation as rated by the Centers for Medicare and Medicaid Services.

The goal is to provide tailored, hybrid solutions in problem solving that go beyond just the Toyota Production principles. It is also to enhance what is working and then coach learners on new methods of problem-solving when approaching issues using the scientific method for what isn't. As Clayton Christensen comments in his paper, *Will Disruptive Innovations Cure Health Care?* "when care is complex, expensive, and inconvenient, many afflictions simply go untreated." [1]

The work begins with that required level of detached observation, either within a management team or around the care provided to an individual patient. A person in a medically compromised position must rely on the expert care and knowledge of others to return to a place of health. Coaches work with caregivers to "hit home" that fact every time – no one is immune to a health crisis, and raising that level of sensitivity and awareness around the patient, especially at the end of an all night 12-hour shift where the care needs to be just as responsive, appropriate and accurate as at the start of the shift, is crucial to success.

There is little room for error.

If things don't go well, on this "playing field" a patient's quality of life may be irrevocably harmed even for fantastic heroics performed in a surgical suite to save the person's life. People are at a risk up to moments before they leave the hospital building.

So, as funny and engaging as the Abbott and Costello clip is – it's wise to remember that humor is often generated from unexpected situations given the perspective of time.

The goal in providing optimum patient care is that all patients leave hospitals thankful for their good fortune in becoming well again by receiving the best care possible for their specific condition, without a hemorrhage to their body, their psyche or their finances in the process. The intent is not to have family and care givers leaving grief stricken and shocked over a situation that went terribly wrong.

Too many stories like that will leave a health system that intends every day to exceed the expectations of each patient – "striking out." In my mind, the cost of compromising even one person's life due to an unintended error is too great of a price for any healthcare system, no matter its premier ranking on the healthcare playing field, to pay.

You can contact Sara Hull at eliza1112@comcast.net

[1] Clayton Christensen, Richard Bohmer, John Kenagy, "Will Disruptive Innovations Cure Health Care?", Harvard Business Review, Sept-Oct. 2000.

Reader Responses to "No Constituency for Quality?"

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

Please consider the following very thoughtful reader responses to my "No Constituency for Quality?" commentary in the last edition of *FYA*:

"I support quality in everything we do, however, I am not going to turn a blind eye to reality as those who think it should be a perfect world are prone to do. Most of them have little experience in living in a healthcare environment daily. I believe that 95% of quality is based on training and experience, the rest from the heart and judgment. In over 40 years of the daily stuff, I find most of the mistakes that are made are due to a momentary loss of focus by otherwise careful individuals. Yes, systems can sometimes be so screwed up that no one could function to a 95% level, but even then, knowledgeable, aware professionals can do quite well. We also need to have the argument that when you reach 95% in this business, you could spend billions to get another 1% of quality improvement. An ordinary person will make 10,000 judgment decisions in a day. A nurse or lab tech will likely make 50,000 judgment decisions a day, any of which might cause harm to a patient if made wrong. If you calculate that out to the number of bad outcomes nationwide, you may find a 99% 'quality' rate.

My thoughts on improving healthcare and reducing costs are: no tests should be allowed, no referrals should be allowed and no prescriptions should be allowed without the primary care doc seeing the patient first. All activity should be coordinated through the patient's primary care physician. Most of the bad stuff I see happen is in the handoffs and poor communication between the primary and the specialists. Once you get caught up in the vortex of several specialists, no one knows what the hell is going on and the patient feels ignorant and powerless to break up this self-feeding monster. I figure it's my body and my money and I will make the decisions! Nobody likes it, but it has saved me a lot of grief."

Gary Tiller

Chief Executive Officer

Ninnescah Valley Health Systems, Inc.

Kingman, Kansas

"I think your article this month is very thought provoking. There are a couple of reasons that we are not able to be true advocates for quality as healthcare leaders.

First, quality has become a marketing tool. Hospitals and hospital systems market their accomplishments and use them to differentiate themselves from others by cherry picking those areas that reflect positively. Too many quality conferences provide a parade of providers that claim to have made improvements and yet, no one asks why don't the national measures show improvement.

The second issue is the same one we have when we talk about our legislative leaders. While we have strong feelings of disapproval for the U.S. Congress as a whole, our representative is okay. While there is general distrust and dissatisfaction with the national healthcare system, people believe their local hospital is okay and hospital leaders give them information to support their belief.

I don't think we need health reform to achieve quality improvement and I don't think quality should need a constituency pleading to Congress for change. And I think on this one issue we need to make a commitment to make constructive change, if we do nothing else, and work together in an honest way to be a real industry instead of acting like Bedouin tribesman.

Keep up the good work."

Ed Gamache

Administrator/CEO

Deckerville Community Hospital

Deckerville, Michigan

I would like to hear your comments.
Send them to:
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What's at the Crux of Healthcare Reform?

David Leonhardt writes in *The New York Times* that every fight over healthcare reform is different and every fight over healthcare reform is the same.

The question, he offers, is who controls the doctor-patient relationship? That question has been at the core of every big battle over healthcare. Should doctors determine not only their patients' treatment, but also their own pay, through the fee-for-service system that has survived since the 1920s? Or should patients have more power in the relationship? And who should claim to act on a patients' behalf, monitoring treatments and bargaining with doctors?

A succession of presidents – from Harry S. Truman to Richard M. Nixon to Bill Clinton – volunteered the government for the role of patients' advocate, and their grand efforts all failed. Now it is President Obama's turn to try to remake America's medical system.

Leonhardt points out that last week's back and forth, when Congressional Democrats squabbled and Mr. Obama took his case to the public, highlighted how difficult his task will be. Reform of healthcare has the potential to threaten profits and incomes that make up one-sixth of the economy. More daunting, perhaps, Americans seem to have great trust in their doctors – more, certainly, than they trust the government on medical matters.

More than three in four Americans are "very satisfied" or "somewhat satisfied" with their own care, according to the latest *New York Times/CBS News* poll. But a substantial majority also say that the healthcare system needs fundamental change and that rising costs are a serious threat to the economy – a view that economists strongly share.

There's the dilemma, the political challenge facing any effort at an overhaul: Americans say they want change, but they also want to preserve their own status quo.

Leonhardt suggests the disconnect can be explained partly by the peculiar economics of healthcare. Because third parties – the government or a private insurer – typically pay the bill, many people miss the fact that the money originally comes from them. They see the benefits of medical care without seeing the costs.

But trust in doctors is a factor as well. Even when doctors order costly treatments with serious side effects and little evidence of their being effective, patients are reluctant to question the decision. Instead of blaming such treatments for the rising cost of medicine, many people are inclined to blame forces that health economists say are far less important, like greedy insurance companies or onerous malpractice laws.

One of the least discussed, but most important conflicts in the current healthcare debate isn't just a matter of Democrats vs. Republicans, Blue Dogs vs. liberals or patients vs. insurers. It is also doctors vs. doctors.

Medicare data shows that groups like the Mayo Clinic and the Cleveland Clinic generally provide less expensive care and appear to deliver better results. Armed with this data, the doctors who run the groups have been lobbying Congress to make their model a bigger part of health reform. Two weeks ago, 13 such groups released a letter saying that recent versions of proposed legislation did not control costs enough.

Their goal is to weaken the fee-for-service system. In its place, doctors might receive a lump-sum payment to treat a patient with a certain condition, based on average costs elsewhere and on what scientific evidence had found to be effective. Hospitals with especially good outcomes might earn bonuses.

Advocates say such a system could ultimately give doctors more control. Rather than having to organize their schedules around the tests and procedures that insurers agree to reimburse, doctors could opt for the treatments they deem most effective. "It's a lot more accountability, which is why it's scary for physicians," said Dr. Mark McClellan, a former head of Medicare under George W. Bush. "But in some ways it's also more autonomy."

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.