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Connections

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## Thinking Big

By Jon Roberts

It is difficult to look at a newspaper, or any news outlet, without seeing something about the sweeping changes that must happen in our healthcare system. I'd estimate that I encounter literally dozens of articles every day that outline where healthcare is headed and what ought to happen. If I read them all, I don't think I'd get anything else done. I must confess that I do get a certain kick from reading things about healthcare by people who only go to the hospital when they are sick. Anyway, I decided to take a look at [www.barackobama.com](http://www.barackobama.com) to see how healthcare reform is actually outlined by the current administration. Cut and pasted:

### CURRENT SITUATION

Making sure every American has access to high quality healthcare is one of the most important challenges of our time. The number of uninsured Americans is growing, premiums are skyrocketing and more people are being denied coverage every day. A moral imperative by any measure – a better system is also essential to rebuilding our economy – we want to make health insurance work for people and businesses, not just insurance and drug companies.

The Solution? Again, cut and pasted.

**Reform the healthcare system:** We will take steps to reform our system by expanding coverage, improving quality, lowering costs, honoring patient choice and holding insurance companies accountable.

**Promote scientific and technological advancements:** We are committed to putting responsible science and technological innovation ahead of ideology when it comes to medical research. We believe in the enormous capacity of American ingenuity to find cures for diseases that continue to extinguish too many lives and cause too much suffering every year.

**Improve preventative care:** In order to keep our people healthy and provide more efficient treatment, we need to promote smart preventative care, like cancer screenings and better nutrition; and make critical investments in electronic health records; and technology that can reduce errors while ensuring privacy and saving lives.

There you go, healthcare crisis solved!! Now go do it!! So, I am kidding. Wouldn't it be nice if just talking about the challenges of healthcare actually made things better for patients and staff? I think so. Anyway, if you are reading this, you are likely a healthcare leader. At some point, all the discussion and debate will need to be processed into something that people can actually act upon, and you, the reader, are probably going to play a big role in how that happens. So what do you make of healthcare reform? Are you excited about the changes that are coming? Are you nervous? (Are you thinking about retiring? I bet someone reading this is.) Listed above are three big, vague solutions to an even bigger, vaguer problem.

### What if "big" answers are not the answer?

In the paper titled, "The Impact of Operational Failures on Hospital Nurses

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## Thinking Big (Continued...)

and Their Patients," Anita L. Tucker, Lumry Family Assistant Professor of Business Administration, Harvard Business School, Boston, MA, estimates that up to one hour per shift, per nurse is lost to "small" operational failures at the bedside. The average cost of these "small" failures is estimated to be \$100 each. In case you're not reading between the lines here, these "small" failures are not insignificant and the costs are not small.

What kind of failures are we talking about? If you've been reading our columns for a while, you are probably familiar with "the wheelchair problem." A few years back, an experienced nurse at a client site said to me, "Hey consultant know-it-all, I just spent 10 minutes looking for a wheelchair to discharge my patient with. Also, I've been a nurse here for 20 years, and I don't think I'd be exaggerating to say that I've spent at least 10 minutes looking for a wheelchair every day since I graduated from nursing school. Fix that." Being a consultant, and new to the sight, I was armed with little more than a theoretical framework and zero credibility. During the next few weeks, we engaged the front line managers and staff in a systematic way of addressing this "small" problem and exploring solutions. After a few iterations of the problem solving process, not a single nurse reported looking for a wheelchair on this 44 bed med/surg unit for six weeks. (Note, we did not purchase more wheelchairs). Think about those numbers for a minute. A 44 bed high-ish acuity med/surg floor. Each nurse saving 10 minutes a day for six weeks. That is a big chunk of nursing time, and we are only talking about one failure!!!

At first glance, the CEO of the sight was not impressed. "Finding wheelchairs? We need to be solving big problems!" It wasn't until the CEO could see the aggregate impact of these small failures that she could fully support the process and actually move resources, beyond external consultants, towards building an infrastructure for continued problem solving.

During the next 15 months, front line leadership and staff addressed over 300 "failures" on the unit. Driven by staff and patients, the failures address nearly every imaginable aspect of hospital operations: missing and delayed meds from the pharmacy, problems relating to deliveries from sterile supply, the interface between patients and the cafeteria and safety issues with faulty equipment. The list goes on and on. As Tucker asserts,

the impact of addressing these failures was staggering. The finance department estimated that the hard and soft dollar saving from this one unit amounted to over \$1.7 million. Reduced waiting for patients and staff led to decreased lengths of stay and ultimately increased access. Addressing problems that related to missing supplies led to drastically reduced inventory costs. As the burden of the "small" system failures became greatly reduced, nurses found that they had more time to really meet the needs of their patients, rather than just going through the motions. One nurse commented, "When I used to notice in my patient's chart that they were a smoker, I would say, quit smoking, it's stupid. Now I actually have time to talk to my patients about their health and the decisions they make. And it makes a huge difference to the patient and to me. This is why I got into nursing." As you can imagine, patient satisfaction scores began to increase. Nurse turnover dropped dramatically. It was truly becoming less expensive to deliver better care. What I'm getting at here is that by addressing the small issues at the bedside, you can realize many of the global visions that we are constantly reading about in the news. What I never do come across in the news is how all this stuff is actually going to happen. I think that's something you are going to have to figure out.

### What does this mean for you, the hospital leader?

I think it is safe to say that big changes are about to happen and that can be scary. New technologies and unfunded mandates often leave us feeling like we're moving backwards in terms of meeting our patient's needs. Obviously, you can't decide to focus on either the "big" problems that you read about in the paper or the ones my colleagues and I write about in this column. The key to the success of the CEO described above was that she was able to focus on both, and some of her big problems began going away. You'll need to cultivate an organization that is resilient as you move forward into an increasingly uncertain future.

So there's my big answer. Good luck!

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## Hospitals Improving Quality and Efficiency

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

While our leaders in Washington, D.C., debate how to improve patient care, quality and efficiency, many innovative hospitals are designing and implementing their own quality and efficiency improvement initiatives without help or incentives from D.C.

An excellent example is development and implementation by a group of hospitals of a surgical safety checklist to reduce morbidity and mortality. That's a very appropriate focus since surgical care accounts for approximately 234 million operations annually throughout the world.

However, there is a significant risk of complications from operations that result in a perioperative rate of death from inpatient surgery of 0.4 percent to 0.8 percent and a rate of major complications of 3 percent to 17 percent – and unfortunately at least one-half of all surgical deaths and complications are avoidable.

The participating hospitals experienced significant reductions in complications from operations after they implemented use of a surgical safety checklist developed by the World Health Organization: postoperative complication rates and death rates each fell by an average of 36 percent.

Not only did the guidelines avoid unnecessary complications and deaths, but they also avoided the substantial unnecessary costs of such complications and deaths. The participating hospitals were from Seattle, Washington; Toronto, Canada; New Delhi, India; Amman, Jordan; Auckland, New Zealand; Manila, Philippines; Ifakara, Tanzania; and London, England. Check out the details in a January 2009 article in *The New England Journal of Medicine*.

Another great example was summarized in a commentary in *The New York Times* on August 13, 2009, by Atul Gawande, Donald Berwick, Elliott Fisher and Mark McClellan, all of whom are well-known physicians. The commentators gathered together physicians, hospital executives and local leaders from 10 U.S. Hospital Referral Regions, as defined by the Dartmouth Atlas of Health Care, that had per capita Medicare costs that are low or markedly declining in rank and where federal measures of quality are above average, and asked them to explain how they do what they do so efficiently.

The participating hospitals were located in Asheville, North Carolina; Cedar Rapids, Iowa; Everett, Washington; La Crosse, Wisconsin; Portland, Maine; Richmond, Virginia; Sacramento, California; Sayre, Pennsylvania; Temple, Texas; and Tallahassee, Florida. Consider some of the following wonderful results:

- "The physicians and hospital leaders from Cedar Rapids told us how they have adopted electronic systems to improve communication among physicians and quality of care. Last year, they decided to investigate the overuse of CAT scans. They examined the data and found that in just one year 52,000 scans were done in a community of 300,000 people. A large portion of them were almost certainly unnecessary, not to mention possibly harmful, as CAT scans have about 1,000 times as much radiation exposure as a chest X-ray."
- "The team from Portland told us of a collaboration of doctors, state officials, insurers and community leaders to improve care. For more than four years, physicians have been tracking some 60 measures of quality, like medication error rates for their patients, and meeting voluntary cost-reduction goals."
- "In Sacramento, a decade of fierce competition among four rival health systems brought about elimination of unneeded beds, adoption of new electronic systems for patient data and a race to raise quality. Sacramento also went from being one of America's high-cost areas for health care to being among the low-cost elite."

Best of all – check out the following conclusion from the commentators: "In their own ways, each of these successful communities tells the same simple story: better, safer, lower-cost care is within reach. Many high-cost regions are just a few hours drive from a lower-cost, higher-quality region. And in the more efficient areas, neither the physicians nor the citizens reported feeling that care is "rationed." Indeed, it's "rational."

D.C. should listen to innovative hospitals and physicians like those referred to above as it tries to figure out how to improve patient care, quality and efficiency in the U.S.

I would like to hear your comments.

Send them to:

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## We Want French System, They Want Ours

France claims it long ago achieved much of what today's U.S. healthcare overhaul is seeking: It covers everyone, and provides what supporters say is high-quality care. That's what David Gauthier writes in *The Wall Street Journal*.

But soaring costs are pushing the French system into crisis. The result: As Congress fights over whether America should be more like France, the French government is trying to borrow U.S. tactics.

In recent months, France imposed American-style "co-pays" on patients to try to control prescription-drug costs and forced state hospitals to crack down on expenses. "A hospital doesn't need to be money-losing to provide good-quality treatment," President Nicolas Sarkozy shouted in a recent speech to doctors.

And service cuts are prompting complaints from patients, doctors and nurses that care is being rationed. That concern echoes worries among some Americans that the U.S. changes could lead to rationing.

The French system's fragile solvency shows how tough it is to provide universal coverage while controlling costs, the apparent twin goals of President Barack Obama's proposed overhaul.

French taxpayers fund a state health insurer, Assurance Maladie, proportionally to their income, and patients get treatment even if they can't pay for it. The problem is that Assurance Maladie has been in the red since 1989.

Despite the structural differences between the U.S. and French systems, both face similar root problems: rising drug costs, aging populations and growing unemployment, albeit for slightly different reasons. In the U.S., being unemployed means you might lose your coverage; in France, it means less tax money flowing into Assurance Maladie's coffers.

France faces a major obstacle to its reforms: French people consider access to health care a societal right, and any effort to cut coverage can lead to a big fight.

France launched its first national healthcare system in 1945. World War II had left the country in ruins, and private insurers were weak. The idea: Create a single health insurer and make it compulsory for all companies and workers to pay premiums to it based on a percentage of salaries. Patients can choose their own doctors, and – unlike the U.S., where private health insurers can have a say – doctors can prescribe any therapy or drug without approval of the national health insurance.

Private insurers, both for-profit and not-for-profit, continued to exist, providing optional benefits such as prescription sunglasses, orthodontics care or individual hospital rooms.

At a time when the U.S. is considering ways of providing coverage for its entire population, France's blending of public and private medical structures offers important lessons, says Victor Rodwin, professor of health policy and management at New York University's Wagner School. The French managed to design a universal system incorporating physician choice and a mix of public and private service providers, without it being "a monolithic system of Soviet variety," he says.

It took decades before the pieces fell into place. Only in 1999 did legislation mandate that anyone with a regular residence permit is entitled to health benefits with no strings attached.

In France, "If you are in medical care for the money, you'd better change jobs," says Marc Lanfranchi, a general practitioner from Nancy, an eastern town. On the other hand, medical school is paid for by the government, and malpractice insurance is much cheaper.

### 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](http://www.phns.com) for additional information about PHNS.