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About FYA

FYA – *For Your Advantage*, is a free twice-monthly newsletter published by TrendLeader Connections.

With every issue, FYA provides insights into the topics that concern healthcare leaders today and the challenges that will be faced in the near future.

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Innovation 2008

Making Innovation Safe with Learning Linessm

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

We are now eight months into a year-long look at the future of innovation in health care. Framed as "What's Hot" and "What's Not Hot," healthcare innovation in 2008 will be transitioning to a different set of parameters and a new framework for success. The future of innovation in healthcare looks like this:

Healthcare Innovation 2008

What's Not Hot	What's Hot
1. Capital expenditures for new technology and facilities	1. Growing Return on Investment (ROI) from operations
2. Implementing IT systems	2. Developing people and relationships
3. Power and compliance	3. Purpose and commitment
4. Consultants, external solutions and manufactured innovation	4. Local knowledge, ingenuity and real-time innovation
5. Fighting entrenched cultures	5. Transforming your culture
6. Specialty hospitals	6. Multi-purpose hospitals

For the last 10 years, the left side of this chart has dominated healthcare innovation; it is part of our culture. But times are changing. The evidence is overwhelming that the leading organizations of the 21st Century will increasingly be innovating on the "What's Hot" list on the right. The problem of working differently is very challenging for most organizations because, in particular, it means managers must stop doing work that is firmly embedded in their and the organization's culture.

Most organizations find it very difficult to change their cultures short of mass executions. But a few companies have avoided the Saddam Hussein method by eliminating the organizational barriers and defusing political landmines that we all have seen slow, stall or stop innovation. The key to success is to create *Learning Linessm* in small places within the organization designed to do "What's Hot."

The Learning Line concept developed from my research at Harvard Business School on adaptive innovation and the Toyota Production System.

- Every great adaptive innovator (e.g., Microsoft, Intel, Toyota, Hewlett-Packard, Southwest Airlines, etc.) avoided the barriers and landmines that stalled their competitors by organizationally separating fundamentally different innovations from established, traditional lines of business.
- Whenever Toyota taught a traditionally managed company to achieve the

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Toyota Production System (TPS), they did not implement "lean processes." They always created a "model line," an isolated place on the shop floor to problem solve, test, verify and improve TPS in a new environment.

This research led to the concept of a "Learning Line" – an isolated place, within a large, complex organization that can quickly problem solve, test, verify and improve new ideas in real time, with real work.

Learning lines are effective. We have developed more than 40 in a variety of hospitals (rural, urban, community, academic, 40-750 beds) and are now moving into outpatient, physician and home care environments with 100 percent success rate as long as the following criteria are met:

1. Unit management is stable, respected and has clear direction and support from leadership.
2. Successful, experienced teachers transfer the new skill sets to the unit's people and management
3. Complexity is controlled initially. Units with relatively fewer products or services make it easier (although we have successfully started on very complex units). It is important that leadership initially minimize or eliminate other competing new projects or initiatives, change in management or staffing, new technology, outside consultants, etc.

Finally, it must be professionally safe for staff and management on the Learning Line to test and improve. Productivity always increases on Learning Lines so management must agree to no layoffs as a consequence

of improved productivity. New capacity must be used elsewhere in the organization.

A Learning Line can quickly and very safely move resources away from "What's Not" to "Whats Hot" without taking big risks. This allows a hospital to quickly:

- Create a safe place to do something different,
- Diversify risk and increase the opportunity for success,
- Bypass organizational barriers and defuse the political landmines that slow, stall or stop successful adaptive innovation.

Another advantage of Learning Lines: they quickly generate results. Starting with just one Learning Line on a complex Medical/Surgical unit, a community hospital generated >\$1,700,000 of new value at the same time it decreased staff turnover by 51 percent and produced the greatest increase in patient satisfaction in a 17-hospital system. The hospital experienced increased quality and lowered cost while making care increasingly safer, more flexible and satisfying - improvement with no tradeoffs.

What do you think? Could you use a Learning Line? Send your comments and questions to me at jkenagy@kenagyassociates.com. We will have more on work place innovation next month.

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About



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Severity – The New DRG Rule

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

Severity Alert: On August 1, 2007, the Centers for Medicare & Medicaid Services (CMS) issued its final rule for Medicare Severity Diagnosis Related Groups (affectionately known as "MS-DRGs") to be effective October 1, 2007.

Is your hospital ready to play by the new MS-DRG rules? Have you calculated the financial impact of the new rules? If the answer is no to either of those questions, you may be about to have a serious problem and you need to focus on this immediately since you've got less than 40 days to get ready.

The CMS release was surprising to some since the U.S. House of Representatives passed an amendment in July 2007 that would require CMS to postpone the MS-DRG implementation for a year. But that amendment won't be effective unless passed by the Senate and signed by President Bush, so in the meanwhile the CMS rule is now final and about to be effective.

CMS says that the purpose of the new MS-DRGs is to prevent abuses under the current system – e.g., "Under the old DRG system (with payments based on broad averages) incentives could lead hospitals to 'cherry pick' – the practice of treating only the healthiest and most profitable patients," said CMS Acting Deputy Administrator Herb Kuhn. CMS is adopting MS-DRGs that replace 538 DRGs with 745 new ones that better recognize severity of illness. CMS says that the changes will not result in any savings to Medicare, but will increase payments to hospitals treating more severely ill and costlier patients, and will reduce payments to hospitals treating less severely ill patients.

What are the potential effects of the MS-DRG change by CMS? Here are some predictions:

- **Less \$\$\$:** CMS is implementing a 4.8 percent payment cut over three years: a 1.2 percent cut for FY08 and 1.8 percent cuts for each of FY09 and FY10. This cut could be offset by the improved documentation/coding/payments that CMS expects hospitals will adopt in response to the new MS-DRG;
- **Uneven impact:**
 - o *rural hospitals* are estimated to suffer a 1.1 percent loss of revenues;
 - o *urban teaching and disproportionate share hospitals* are estimated to get a 0.5 percent revenue increase; and
 - o *cardiac specialty hospitals* are projected to decline by nearly three percent since, according to CMS, they "generally treat the healthiest and least costly patients;" (these estimates are before expected improvements in revenue from improved documentation and coding).

- **More work for doctors:** The focus on severity DRGs will require doctors to provide coders with much more detailed documentation than they do now, which probably means a lag in revenues until doctors and coders are fully trained on the new MS-DRGs.
- **Not enough time:** The shortness of time until the October 1, 2007, effective date probably means that many hospitals will not be ready and thus will experience a reimbursement gap since they will not be prepared to comply with the detailed new MS-DRG requirements – and those hospitals experiencing revenue reductions from the new rule may not be prepared to offset those losses with expected revenue increases from improved documentation and coding.

Is your hospital ready to play under the new severity DRGs?

P.S.: A Quality Alert: Also on August 1, 2007, CMS issued a final rule regarding the Deficit Reduction Act of 2005 ("DRA") requirements for the Reporting Hospital Quality Data for Annual Payment Update ("RHQDAPU") program. The DRA requires, beginning with the payment update for FY 2007 and each subsequent fiscal year, a two percent reduction in the annual percentage increase amount for a hospital that does not submit certain quality data specified by CMS.



I would like to hear your comments.

Send them to:

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About

TrendLeader
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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."

New Incentive for Better Care

If hospital leaders needed another incentive to produce a safer environment for their patients, it came in the form of a new federal rule recently. Beginning next year, Medicare will stop paying for hospital mistakes.

Under rules issued two weeks ago, the government insurance program will no longer pay extra to treat certain infections that patients pick up in the hospital. Nor will Medicare pay for second surgeries to retrieve objects left behind in bodies or treatment for transfusion patients given the wrong blood type.

Hospitals themselves will pay to fix these and other medical complications that are considered largely preventable.

Government regulators and consumer groups say the changes give hospitals a powerful incentive to keep patients safe, especially from infections. Such infections kill nearly 100,000 Americans each year and cost hundreds of millions of dollars to treat.

Officials at the Centers for Medicare & Medicaid (CMS) say the new rules reflect a changing philosophy. "We are transforming Medicare from a passive payer simply processing claims to an active purchaser with a stake in quality and efficiency," said Tom Valuck, a physician and administrator at CMS.

Valuck said he did not know exactly how much the new rules could save Medicare, though others suggested it could easily reach into the tens of millions. Valuck predicted a cascade of savings if hospitals greatly reduce costly complications.

"You could have less home health care, less nursing home care and ambulatory services. Less physician follow-up," he said.

The new rules go into effect in October, 2008, and emanate from a 2005 law passed by Congress. Valuck and others said private insurers may follow the Medicare lead.

The changes focus largely on infections known to develop in hospitals: those associated with urinary

catheters, blood lines and coronary bypass surgery.

The U.S. Centers for Disease Control and Prevention has reported that there are more than 500,000 catheter-associated urinary tract infections alone each year, and that they cost \$451 million to treat. Valuck said hospitals will not be allowed to pass the cost of mistakes on to patients.

For Medicare to withhold payment, the complications must be considered preventable. For instance, stringent hand washing and other protocols – such as getting patients quickly off catheters and intravenous lines – can substantially reduce the spread of hospital infections. Many hospitals, aware the new rules were on the way, already have made changes and documented striking drops in infection rates.

In addition to hospital infections, the changes mean no extra payments to treat patients affected by:

- Injuries resulting from a fall in the hospital.
- Reactions when transfusion patients get the wrong blood type.
- Air embolism, when air invades the blood stream.
- Bed sores that patients develop while in the hospital.
- Objects, such as sponges or surgical tools, left in patients during surgery.

Medicare policy often influences the private insurance industry, and Valuck, of CMS, cited one insurer, HealthPartners of Minnesota, that will no longer pay for so-called "never events," or clear medical mistakes.

Mohit Ghose, a vice president of America's Health Insurance Plans, a trade organization based in Washington, D.C., said private insurers are looking carefully at the Medicare changes.

"This is one of the areas our members have to look at to advance the cause of improved patient safety and to create better value," he said. "But it won't happen overnight."