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Table of Contents



When One Door Closes, Another Opens: Finding Opportunity in Healthcare's Failure Page 1 - 2

Quantity vs. Quality Page 3

The New ICD Is Coming, The New ICD Is Coming Page 4

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When One Door Closes, Another Opens: Finding Opportunity in Healthcare's Failure

By John W. Kenagy, MD, MPA

The *Wall Street Journal* recently published a poignant healthcare story entitled, "Hospitals Own Up to Errors." The piece told the tale of Kaelyn Sousa who suffered a bump in a fall at home when she was 18-months-old. To ensure the injury wasn't serious, Kaelyn's mother took her to the emergency room of Baptist Children's Hospital (Baptist) in Miami. While the girl was under sedation in an MRI machine, her breathing tube dislodged, cutting off her oxygen and causing a crippling brain injury.

Some hospitals would have covered this story up in an attempt to avoid all of the expense and exposure associated with the serious medical error. But Baptist took a different approach. The facility disclosed to Kaelyn's family all of the details that led to the incident. In doing so, it identified gaps in current methods of care, which they are now working on to correct.

Baptist is one of a growing number of hospitals throughout the country that are "taking steps to admit grievous mistakes and learn from them to overhaul flawed procedures." This is in stark contrast to healthcare's typical 3-step, 3-D approach to failure, which includes:

Step One: Deny, Deny, Deny

Step Two: Delay, Delay, Delay

Step Three: Defend, Defend, Defend

Failure becomes opportunity only when you admit it. Baptist admitted the error up-front and is on the right path to bettering care.

The most sophisticated way to institutionalize a process for turning failure into opportunity is the work of Lee Taft, J.D, M.Div. He has clearly shown that a structured, disciplined approach to coping with failure through immediate understanding, acknowledgement and apology is better for everyone – the patient, family and hospital staff – and everything – future risk management and the hospital's bottom line.

Fanning the Flame of Quality

You can't gain opportunity from failure until you acknowledge it. With that in mind, I'll offer some heretical advice – you should seek to profit from the failure of the quality movement in healthcare.

I have been a physician for almost 40 years. I have also been a healthcare executive, academic scholar, author, advisor and most importantly, a patient once embedded (literally) inside our healthcare system with a severe injury.

From those viewpoints, I have watched quality improvement initiatives grow from a tiny flicker in the late 1970s to a roaring flame in the first decade of the 21st Century.

Today, every hospital has a quality department, tens of thousands of people do hundreds of thousands of quality improvement projects every year, and billions of dollars are spent on quality consulting and technology.

Now Medicare wants to "pay for quality." As a result, healthcare scorecards are proliferating. How else will we know we are paying for quality if we don't have a scorecard?

Insurance companies are getting on board to hire more people to create more scorecards.

Hospitals are hiring more people to monitor, gather data, do more analysis, implement more projects, buy bigger technology and more.

Quality is a multibillion-dollar industry and a major cause of healthcare inflation.

(Continued...)

When One Door Closes, Another Opens (Continued...)

So, how are we doing? The Federal Agency for Healthcare Research and Quality reported in May that the rate of adverse events – a key measure of patient safety – rose by about one percent in each of the past six years and is continuing on this upward trend.

Despite diligent effort and billions of dollars, *we are not better; we are worse*. That seems like a failure to me, but how is that possible?

My research as a Visiting Scholar at Harvard Business School helps shine some light on this puzzle. During this time, I focused on innovation, particularly why a few companies excelled while most others failed.

The companies that failed shared a common characteristic. They all lapsed into a state of denial when confronted with the fact that long standing, highly valued strategies and methods were no longer the solution, but had become part of the problem. They were failing, but nobody could say it.

Let's say it: The healthcare quality movement, as we know it, has failed. Just like at Baptist, just saying those words creates the opportunity.

Resuscitating Healthcare's Quality Movement

Methods yield outcomes. Therefore, all our past improvements have culminated to create our current failure. My research shows that the root cause of our dilemma is *the way we are approaching the problem*. When viewed through this light, we can begin to see our methods, though well intentioned, are antiquated and ill-suited to the unpredictable complexities of 21st Century healthcare quality.

Currently, we manage healthcare quality with methods that worked successfully for mid-20th Century factories. We identify the biggest problems, gather data about them, then bring experts together in meetings to identify best practices and technology to implement as standardized solutions. It's data up/implement down, but in the fast-moving, complex world of 21st Century healthcare, these methods can't keep up with the problems.

The faster the rate of change, the more flexible and responsive we must become. As I describe in my forthcoming book, *Designed to Adapt: Leading Healthcare in Challenging Times* (Second River Healthcare Press, September 2009), adaptive innovators like Intel, Southwest Airlines and Toyota, and a small but growing number of healthcare organizations, work differently. Instead of data up/implement down, they are identifying better ways to rapidly adapt by making small fixes exactly when and where they are needed.

I call this process "adaptive design." Here's how it works:

1. **Set a clear, simple, meaningful direction.** When I talk to people who have worked in transformational start-ups, I

always hear a persistent refrain: "We knew where we were going." Adaptive leadership makes the direction clear, consistent and authentic. In healthcare, above all else, this focus should be on the patient.

2. **Get the right people involved, and then develop them.** In complex, dynamic, unpredictable work, the people who can impact change are not in meeting rooms. They are on the frontline, close to value-adding work, because that's the only place to get a handle on what's happening now. Gathering data for reports and studying spreadsheets in conference rooms can't deliver quality care.
3. **Don't design and implement anything without experimentation.** Develop everyone to problem-solve the system when it fails by creating safe, testable, viable and improvable experiments as part of every day work. In adaptive design, quality is **NOT** a department and improvement is **NOT** a project, it's the everyday work of every person.
4. **Problem solve with ingenuity rather than technology.** Link with technology only after the work has been simplified. Use simple technology as an accelerator, not a solution.
5. **Replicate what works, relentlessly, but not as a best practice.** There are no best practices in healthcare, only the opportunity to continually make new best practices.

Don't just take my word for it. Consider this case of a hospital on the East Coast. Using the adaptive design method, the East Coast hospital's OR became 95 percent Joint Commission compliant. What's even more astounding is that it achieved this success without doing any projects focused on The Joint Commission compliance. Rather it captured the knowledge and creativity of everyone in the unit to problem solve its work adaptively. Simultaneously, the OR volume *increased 16 percent while overtime fell 14 percent, all with no projects*.

It's clear: The quality movement in healthcare has failed. But, that's only a problem if we refuse to admit it. The good news is that there is an alternative. Develop and capture the knowledge, creativity and problem solving ability at the frontline of healthcare. Patients will increasingly get what they need at continually lower cost. That's the way we'll fix healthcare.

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Quantity vs. Quality

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

The healthcare reform debate is once again taking center stage in our nation's capital as members of Congress return from their August break where they got lots of input from vocal constituents. Let's shift the attention away from the highly emotional "public option" issue to an extremely important issue that directly affects patient care and yet isn't getting much air time – should we reform our healthcare system to pay for the quality of care that providers deliver instead of the quantities of care that they deliver?

This isn't, of course, a new issue. A 2006 Institute of Medicine ("IOM") report entitled *"Rewarding Provider Performance: Aligning Incentives in Medicare"* stated:

"The existing systems do not reflect the relative value of health care services in important aspects of quality, such as clinical quality, patient-centeredness, and efficiency...nor recognize or reward care coordination...[in] prevention and the treatment of chronic conditions."

The IOM recommended that pay for performance (P4P) programs be adopted to incentivize providers to focus on quality not quantity.

This misalignment of incentives was recently highlighted in a Center for American Progress report entitled *"A Historic Opportunity – Wedding Health Information Technology to Care Delivery Innovation and Provider Payment Reform"* by Todd Park (who just became the Chief Technology Officer of HHS) and Peter Basch:

"[T]he current U.S. health care payment system pays predominantly for the volume of services rendered, such as office visits and procedures, and not for the quality of health care outcomes. And it's a payment system that effectively punishes providers for achieving efficiencies such as the elimination of avoidable hospital readmissions and unnecessary in-person office visits."

Quality is becoming an increasingly important issue for Congress to address since (1) Congress has finally realized that it will have to find ways to cut costs out of our healthcare system in order to cover the costs to insure all or most of the uninsured and

(2) improving quality and results could eliminate a huge amount of money spent on healthcare that has little or no impact on patient quality and care. "It's widely estimated that 30% of U.S. healthcare spending – some \$700 billion a year – is spent on tests, treatments and procedures that provide no value," according to an article in the July 28, 2009, edition of *The Wall Street Journal*. No surprise there – all of us can cite multiple examples of how we asked for or got care that we really didn't need, but didn't object because we weren't paying for it.

Medicare has adopted various P4P initiatives to improve quality and avoid unnecessary healthcare costs, and it has reported some initial cost improvement results on some of these initiatives. However, as The Joint Commission said in a Public Policy on P4P on April 28, 2009, "Notwithstanding their recent proliferation, pay-for-performance programs are largely untested" and it cautioned that P4P programs must be very carefully designed since they are operating in "a complex reimbursement environment...that often creates barriers to reaching the goal of consistent, high quality care for all patients."

Congress mandated improvement in healthcare quality in order to qualify for the American Recovery and Reinvestment Act of 2009's \$34 billion of EHR funds, and hopefully it will also mandate healthcare quality improvements in its healthcare reform legislation. If so, one way to achieve both healthcare quality improvements and cost reductions is change our reimbursement incentives to reward quality, not quantity.

But, as The Joint Commission cautioned, any decisions to pursue a P4P approach should be done very, very carefully "to ensure that metrics upon which incentive payments are based are credible, valid and reliable" and to "align reimbursement with the practice of high quality, safe health care for all consumers."

I would like to hear your comments.

Send them to:

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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.

The New ICD Is Coming, The New ICD Is Coming

The Centers for Medicare and Medicaid Services (CMS) have issued a new fact sheet on the ICD-10 coding system healthcare organizations will be required to use by Oct. 1, 2013.

According to CMS, the new classification system, used by hospitals and physicians both for classifying disease and for billing, will result in significant improvements over the ICD-9 system by providing greater detail and the ability to capture additional advancements in clinical medicine. The transition may not be smooth. Some are comparing the transition to Y2K: much ado about nothing. Others are reminding us that Y2K involved one code change, IOCD-10 involves thousands of code changes.

ICD-10-CM/PCS consists of two parts: the ICD-10-CM, the diagnosis classification developed by the Centers for Disease Control and Prevention for use in all U.S. healthcare treatment settings; and the ICD-10-PCS, the procedure classification system developed by CMS for use in the U.S. for inpatient hospital settings only.

According to the fact sheet, diagnosis coding under the ICD-10-CM system will use three to seven alpha and numeric digits and full code titles, but the format is similar to ICD-9-CM. The new procedure coding system will use seven alpha or numeric digits

while the ICD-9-CM coding system uses three or four numeric digits.

The current system, ICD-9-CM is 30 years old. According to CMS, it is outdated, obsolete and "cannot accurately describe the diagnoses and inpatient procedures of care delivered in the 21st century."

The CMS fact sheet says ICD-10-CM/PCS will improve the ability to measure healthcare services; increase sensitivity when refining grouping and reimbursement methodologies; enhance the ability to conduct public health surveillance; and decrease the need to include supporting documentation with claims.

It will also provide codes to allow comparison of mortality and morbidity data and will provide better data for identifying fraud and abuse and conducting research.

CMS says organizations and facilities can prepare for ICD-10-CM/PCS implementation by developing a plan that includes identifying stakeholders, assessing impact, formulating strategies and providing training on all levels.

ICD-10-CM/PCS will not affect physicians, outpatient facilities, and hospital outpatient departments' use of Current Procedural Terminology (CPT) codes on Medicare fee-for-service claims as CPT will continue to be used.

Structural Differences Between the Two Coding Systems

<p>ICD-9-CM Diagnoses Codes:</p> <ul style="list-style-type: none"> • 3 - 5 digits; • First digit is alpha (E or V) or numeric; and • Digits 2 - 5 are numeric. <p>Examples:</p> <ul style="list-style-type: none"> • 496 - Chronic airway obstruction, not elsewhere classified (NEC); • 511.9 - Unspecified pleural effusion; and • V02.61 - Hepatitis B carrier. 	<p>ICD-10-CM Diagnoses Codes:</p> <ul style="list-style-type: none"> • 3 - 7 digits; • Digit 1 is alpha; • Digit 2 is numeric; and • Digits 3 - 7 are alpha or numeric (alpha digits are not case sensitive). <p>Examples:</p> <ul style="list-style-type: none"> • A78 - Q fever; • A69.21 - Meningitis due to Lyme disease; and • S52.131a - Displaced fracture of neck of right radius, initial encounter for closed fracture.
<p>ICD-9-CM Procedure Codes:</p> <ul style="list-style-type: none"> • 3 - 4 digits; and • All digits numeric. <p>Examples:</p> <ul style="list-style-type: none"> • 43.5 - Partial gastrectomy with anastomosis to esophagus • 44.42 - Suture of duodenal ulcer site. 	<p>ICD-10-PCS Procedure Codes:</p> <ul style="list-style-type: none"> • 7 digits; and each digit is either alpha or numeric (alpha digits are not case sensitive and letters O and I are not used to avoid confusion with numbers 0 and 1). <p>Examples:</p> <ul style="list-style-type: none"> • 0FB03ZX - Excision of liver, percutaneous approach, diagnostic; and • 0DQ10ZZ - Repair upper esophagus, open approach.