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About FYA

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Clinical Chokepoints and Optimizing Innovation: New Opportunities for Healthcare Providers and Industry

By John W. Kenagy, MD, MPA

Much has been written about the diffusion of innovation in healthcare and the multiple factors that influence the spread of a new technology. Studies have shown that the systems most likely to respond quickly to innovation have a culture of creativity and innovation, a responsive, problem solving organizational structure and strong leadership that is committed to effective change.

By contrast, the healthcare system is hierarchical in nature and driven by separate organizational structures that represent various, and often-conflicting, professional groups. The system is bureaucratic, with entrenched procedures and social norms that tend to hinder rapid change. It is filled with "chokepoints."

First, let's look at this issue from the point-of-view of the medical device, IT or pharmaceutical industries. The net result of the social context in which modern healthcare is practiced is that even the most promising innovations will encounter significant barriers to adoption. My associate, John Read, has defined these barriers as "clinical chokepoints."

Every product will run into dozens of these chokepoints during its lifecycle—some minor; some major, but their cumulative effect will be to flatten the growth curve of the product, reduce revenues to the manufacturer and slow the diffusion of the innovation in clinical practice. While it is more likely that the most significant chokepoints will arise early in the product's lifecycle, when practice patterns are apt to require the greatest modification for the innovation to be incorporated into the clinical routine, additional chokepoints may be encountered when new indications for the product are approved or the base of clinical applications is broadened.

Clinical chokepoints may also be specific to certain groups of practitioners or arise in specific institutional settings, where established protocols or clinician habits block the more rapid or widespread adoption of the treatment or device. The net result is that no matter how much the manufacturer invests in market research, focus groups, expert panels, pilot sites, clinical trials and Beta testing, unpredictable clinical chokepoints will delay the diffusion of the innovation at the point-of-care to the detriment of the innovator.

Now let's look at the problem from the point-of-view of the provider of healthcare – nurse, physician, manager, system executive. They, in

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Clinical Chokepoints and Optimizing Innovation (Continued...)

general, are interested in improving the workplace and their ability to effectively and profitably meet patient needs. Ideally, they are in complete alignment with the innovators in the IT, medical device and pharmaceutical industries. But, the problem is the practice of medicine is, by its very nature, unique, complex, non-reproducible work. It is performed by individuals with highly developed skill sets who have a significant stake socially, financially and emotionally in the outcome of their work. Often these new innovations come with unintended but significant complications to daily work and, consequently, the delivery system resists, stalls or ignores the innovation opportunity. The work place creates the "clinical chokepoint" that delays or stops the diffusion of the innovation.

Eliminating clinical chokepoints requires a deep understanding of at least three essential elements of clinical activity:

- The real-life context in which the work is performed
- The local processes and procedures that surround the work – and their relationship to the application of the new technology
- The possibility of – or tolerance within the system for – adaptability in the work

It is our contention that these elements can only be fully understood by the professionals working day-

to-day in the actual clinical setting. The key to hastening the adoption of any new medical technology, drug or device is to capture, document, codify, improve and disseminate these real-time insights that can only be gained by clinicians optimizing the innovation in the workplace. This creates a new opportunity for both manufacturers and health care providers to accelerate the diffusion of innovation of new products and services to mutual benefit.

The next three issues of *FYA* will develop the concept of optimizing a new product or service at the point of care to everyone's advantage – patient, nurse, doctor, manager, system executive and the IT, medical device and pharmaceutical industry. Joining, as co-authors, will be my associates John Read and David Sundahl who bring years of experience and expertise in solving this problem. What do you think? Can healthcare and industry optimize products and services together at the point-of-care? Can we speed the diffusion of innovation? What is your experience? Write me at jkenagy@kenagyassociates.com and we will include your thoughts in subsequent articles.

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About



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Not For vs. For Profit

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

Are you a not-for-profit hospital protagonist or antagonist? A recent June 20, 2006, *Health Affairs* paper ("How Nonprofits Matter In American Medicine, And What To Do About It") provides an excellent analysis of the pluses and minuses of not-for-profit hospitals and the impact of for-profit hospitals. Some of the paper's conclusions include:

- "Some policymakers doubt that nonprofits reliably contribute community benefits commensurate with the value of their tax exemptions as charitable organizations."
- After analyzing empirical studies, the paper stated: "All we can conclude is that nonprofits in some markets in some measures outperform for-profits, and that in other markets on other measures, for-profits outperform nonprofits."
- "Among hospitals cost and efficiency factors, while mixed, predominantly favor nonprofits."

The paper also concluded that there are significant variations in perception regarding the age-old issue of who provides better patient care – not-for-profits or for-profits:

- "For-profit firms deliberately build or purchase facilities in communities that have few uninsured or low-income residents."
- "The presence of nonprofit providers influences the behavior of for-profit organizations, and vice versa. The more for-profit hospitals in a locality, the more nonprofit hospitals (1) respond aggressively to revenue-increasing opportunities, (2) adopt profitable services, (3) discourage admissions of unprofitable patients, and (4) reduce resources devoted to treating the patients they do admit. Conversely, the presence of nonprofits in a community is associated with increased quality of care in for-profit nursing homes, reduced mortality rates in for-profit dialysis facilities, and increased trustworthiness of for-profit health plans."

The conclusions aren't surprising, although new. I think most would agree that not-for-profit hospitals play a critical role in the delivery of healthcare services throughout the U.S. And I also think that history has shown that not-for-profits are more mission oriented and less driven by profit motives than the for-profits, which often translates into a great depth and breadth of healthcare services for their communities.

On the other hand, history also has shown that the for-profit focus can often improve both operational efficiency and profitability. Perhaps the key message is that not-for-profits and for-profits have lots to learn from each other.

The study also analyzes the critiques of public policies that favor not-for-profits, including the following:

"(1) The aggregate benefits of nonprofit ownership are inadequate, (2) alternative policies-regulations, incentives, and consumer empowerment-could improve health care more effectively, and (3) the social costs of protectionist policies are too high."

The study's conclusion: "In our assessment, these critiques offer a persuasive rationale for reformulating, but not eliminating, policies that preserve a viable nonprofit health care sector." What's your conclusion?

I would like to hear your comments.

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About

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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."

END PIECE: Patients' Ratings vs. Quality of Their Care

Patients' ratings of their medical care do not substitute for evaluations of the technical quality of that care, according to a study by researchers from the RAND Corporation, UCLA and the U.S. Department of Veterans Affairs Healthcare System.

The study was the first to compare patients' own reports about the quality of their medical care with a comprehensive evaluation of their medical records.

Researchers studying vulnerable older patients found that while patients on average rated the quality of their medical care a 9 on a 10-point scale, comprehensive reviews of their medical records found they received recommended care just 55 percent of the time.

The findings provide additional insights into developing measurements of quality care at the health plan level. The study found that patients' views about the quality of their medical care was closely related to the quality of communications provided by their health providers.

Researchers from the Rand Corp. think tank, the University of California at Los Angeles and the federal Department of Veterans Affairs asked 236 elderly patients at two big managed-care plans, one in the Southwest and the other in the Northeast, to rate the medical care they were getting. The average score was high – about 8.9 on a scale from zero to 10.

Asked questions such as "How often did doctors and other health-care providers listen carefully to you? Did they explain things in a way you could understand?" patients rated their caregivers' communications skills even higher – at an average of 9.2 on a 10-point scale.

Americans as patients, in at least this respect, resemble Americans as voters. They often condemn the system, but they like their own connection to it. A recent *Wall Street Journal/NBC News poll* found 60 percent of the public disapproves of Congress, but a significantly smaller 48 percent wanted to replace their own congressman.

In the second part of their study, the medical researchers systematically examined 13 months of medical records to

gauge the quality of care the same elderly patients had received, using a comprehensive measure of quality developed by Rand's Assessing Care of Vulnerable Elders program. (An example: "If a vulnerable elder has an acute myocardial infarction or unstable angina, then he or she should be given aspirin therapy within one hour...")

The average score wasn't as impressive as those in the patient-satisfaction surveys: 5.5 on a 10-point scale. But here's an interesting finding: Those patients who graded the quality of their care as 10 weren't any more likely to be getting high-quality care than those who gave it a grade of 5. The most-satisfied patients didn't get better medical care than the least-satisfied.

"Patient ratings of health care are easy to obtain and report," says John T. Chang, a UCLA physician and lead author on an article summarizing the research in the journal *Annals of Internal Medicine*. That's one big reason they are so popular among managed-care plans and hospitals.

Another reason, Dr. Chang says, is that "people who respond to surveys in general tend to be those who are satisfied; those who aren't satisfied tend to leave the [health] plan."

"But," he adds, the surveys "do not accurately measure the technical quality of medical care."

Patients' ratings of the quality of their health care are being used to help both consumers and those who pay for health insurance decide which health providers to use.

Some health providers use patient assessments to report information about care because such surveys are relatively inexpensive to compile and patients generally report being satisfied with their personal health providers, according to researchers.

"This study shows that we cannot let patient ratings alone drive the debate over whether we need to improve the quality of care," said Dr. Neil Wenger, UCLA Professor of Medicine and a RAND researcher who is senior author of the study. "We need to measure the technical quality of care in order to have an informed discussion."