FYA For Your Advantage™
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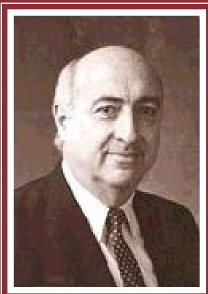
An Essential Tool for Healthcare Leaders
From TrendLeader Connections
Sponsored by PHNS The HealthCaring Solution



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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.

The newsletter is provided free to healthcare CEOs only. CEOs may use the material in any way they wish—except for the editorial content that is copyrighted by the author. You are welcome to print copies of FYA.

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P4P: The Ramifications

By Fred Lee

Pay for performance has a certain ring of truth and seemingly unassailable logic to it. Why should people be paid the same if they do not perform the same? Doesn't it demoralize the hard workers and encourage laziness when you give everyone the same increase in pay?

If all individual jobs were identical, and had a direct link between individual performance and profit, this practice would not be the problem it creates where teamwork is essential. A person milling six machine parts an hour ought to get more than one who mills only four parts an hour. Hence we have piecework compensation. There are certainly many jobs that lend themselves to direct comparisons of output or income creation. Pay for performance started with them and appears to be more effective with them. As Ed Lawler writes in his book, *From the Ground Up:*

> An individual pay-for-performance system does not fit an organization that is designed around processes and teams and that emphasizes the importance of lateral relationships and cooperation. Individuals who need to cooperate and help each other should not be put in a position of competing for the same rewards.

What about nurses in a hospital? Are they not part of processes and teams with lateral relationships dependent on cooperation? And think of the variation in performance that is beyond their control. Every patient is different. No two situations are alike and individual care cannot be standardized as on an assembly line. Even patient flow cannot be controlled. Physicians can have radically different ways of doing things and make differing demands on individual staff members. A dozen departments must work closely with the patient-care team to deliver maximum results for each individual patient. About the only thing that comes close to a standardized system is charting. Should a nurse manager base the pay for performance on how well the paperwork is done – because that is a fairly objective and individual activity? If we believe patient perceptions are vitally important, we have a problem with wide variations in perceptions, measurements and comparisons. Then there is the effect of the nurse

(Continued...)

P4P: The Ramifications (Continued...)

on the morale of the nursing team. It is vital too. Would we want a system that ignores what is subjective and rewards only what is objective? If the system lends itself to favoritism and accusations of unfairness, how effective is it?

Let's say my hospital insists that I give some less in order to give others more, but I believe that they are all of superior value and work ethic. After all, I didn't hire them on the curve. I didn't think I needed some weak ones in order to reward the better ones. In fact I hired each one from the top end of the bell shaped curve in the first place. In a pay-for-individual-performance system I could give only a median raise if I rated them all equally excellent. On the surface this seems fair, except that if three percent is the mid-range number, it says "You are barely average" to an employee. These talented people are all high achievers. Any one of them would be at the top of his or her class in a group of people doing the same thing. Their walls, which are lined with plaques and awards, are proof that they have the talent. How demeaning it would be to rate them all as average when they have worked with dedication and achieved a stature and recognition far above average. Nothing I can think of could sap their energy and sabotage their team spirit quite like being told that if I give one an "A," it has to come from somebody else who gets dropped to a "D" – or give everyone a "C." Worse still is that with the grade comes a difference in pay! Where is the logic or fairness in that?

How long could I keep such talented individuals if they felt unappreciated by their organization with no sensible justification based on their actual work? What would this do to their energy and motivation? To their self-confidence? To their morale? To their self-esteem? To their relationship with each other? To their relationship with me? The negative consequences of this arbitrary system can be disastrous. It's a system that creates one winner and five losers. To the one winner it will feel like a reward. But to the five losers, it will end up feeling like a punishment.

Does that make it a system of rewards or punishments?

Fred Lee is a highly popular speaker; and the author of "If Disney Ran Your Hospital." His book was named the 2005 book of the year by the ACHE.

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About

PHNS is an innovative healthcare services company providing strategic outsourcing services in information technology, health information management and receivables management to over 400 hospitals. PHNS is not a consultant, vendor or software company but a partner, a solution. PHNS understands healthcare because our partners are healthcare and healthcare only. Unlike its competitors, PHNS strategically aligns itself with a hospital's clinical and financial goals and objectives. Through its unique business model, PHNS reduces costs by aggregating, consolidating and sharing resources among its participating hospital partners. PHNS helps hospitals manage information systems, computer technology, patient records, coding and patient billing to improve patient care, safety and efficiency and increase profitability and efficiency. For more information, visit www.phns.com.

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Wiring Your Docs

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

Are you aware of the great new opportunity that you have to help wire (literally and figuratively) your doctors into your hospital? Last month CMS and OIG adopted a new rule that allows hospitals to "donate" to physicians items and services related to electronic medical records. This permits arrangements involving software packages that include functionality related to the care and treatment of patients (for example, patient administration, scheduling, billing and clinical support). The new rule is called the "Stark EHR Exception and the Anti-Kickback Safe Harbor" and permits arrangements that were otherwise prohibited by Stark and the Anti-Kickback laws and rules.

This could give you a huge opportunity to provide your physicians with electronic links to your hospital's electronic patient information, which could both improve patient care and improve your relationship with your physicians. Many hospitals have wanted to provide such electronic links to physicians in the past, but were concerned about possible Stark/Anti-Kickback violations. Now, subject to careful compliance with the new safe harbor rule, these arrangements can be put in place.

Of course, to quote a past Presidential candidate, "the devil is in the details." For example, the rule requires the recipient docs to pay 15 percent of the donor's cost of the items and services provided, and such payment must be made before the receipt of the items and services. And additional payments are required for any updates, upgrades or modifications. In addition, there cannot be any donor limitations that limit or restrict the use, compatibility or interoperability of donated items or services with other e-prescribing or electronic health records systems; and the donor cannot seek to induce a recipient to change loyalties from other providers or plans to the donor. The donor also may not restrict or limit the recipient's right or ability to use the items or services for any patient. But be sure to check with your legal counsel for all of the fine print "details."

The new rule is another step by the Administration to encourage and expand the use of electronic health records in patient care throughout the U.S. That is a worthy goal. However, from the hospitals point of view, this new safe harbor offers hospitals an unprecedented opportunity to electronically link their docs with the hospitals, and hopefully to build a closer, more efficient working relationship with their docs. And unless you're one of the few that completely control your physicians, such a linking could provide your hospital with a significant competitive advantage. So – are you already taking advantage of this new opportunity? If not, why not?

I would like to hear your comments.
Send them to:
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About

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."

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END PIECE: Relief or Public Relations?

Wal-Mart made headlines recently when it announced that it plans to cut the cost of generic drugs drastically – to $4. News analysts immediately hailed the move because it could make many treatments affordable to the uninsured, reduce the burden on Medicaid and bring competitive pricing to the pharmacy industry.

Even company critics were quick to praise the plan, conceding that it represents a case of the giant retailer using its size and ability to lower costs to improve the lives of regular Americans.

In the days after the announcement, the *New York Times* looked at the program more closely, with details confirmed by Wal-Mart, and concluded that the impact could be "blunted by several factors."

The newspaper noted that the plan, which is said to cover 300 drugs, includes only about 124 separate medicines in various dosages, like 12 versions of the popular antibiotic amoxicillin. It leaves out some popular drugs altogether, like the generic version of the cholesterol-lowering treatment Zocor.

And while uninsured people should benefit from the program, those with insurance may save only a dollar or so, making a trip to Wal-Mart not worth it. In Florida, where the program will have its debut, most people on Medicaid pay nothing and may have little incentive to shop around for cheaper prescription drugs.

As it has for dozens of consumer products, Wal-Mart reduced prices of generic prescription drugs by attacking the few remaining pockets of inefficiency in its operations. For example, it cut out third-party distributors that stood between the chain and drug manufacturers. Wal-Mart appears to be taking some of those profits from the traditional middlemen to lower the prices it is charging for these generic drugs.

The company also introduced rapid, automated machines into its pharmacy distribution centers that had long relied on workers to fill orders. In doing so, Wal-Mart reduced the amount of time that costly drugs sat in warehouses, rather than on store shelves where they could create revenue. "It is not glamorous," Bill Simon, an executive vice president at Wal-Mart told the *Times*. "It's pennies at a time."

Under the plan, which will begin in the Tampa, Florida, area – and the company says will eventually expand to the rest of its 3,000 in-store U. S. pharmacies beginning next year – the $4 fee charged by Wal-Mart will be paid by a combination of consumers, insurance companies and the federal government, depending on a person's health coverage. On average, generic drugs are now sold at retail for $10 to $30 for a 30-day supply.

An insured customer will not pay more than $4, no matter what the co-payment is, the company said. Wal-Mart would bill the insurer for the difference if the co-payment was below $4. Customers whose co-payment is above $4 are unlikely to use insurance, but pay for the drug out of pocket. Where required, Medicaid users would still pay a small co-payment for a prescription drug, with the government billed the balance. In the past, Wal-Mart might have billed the government significantly more than $4 for a generic drug. "

Wal-Mart said it would not lose money on the low-cost generic drugs - and, in fact, several industry analysts predicted the company's pharmacy business would benefit from the new plan. Unlike CVS or Walgreen, which rely on prescription sales for most of their revenues, Wal-Mart's pharmacy business represents less than 10 percent of its total revenue and the company has identified it as an area that needs improvement.

By drawing in customers of all incomes into the store at least once a month to fill generic drug prescriptions, Wal-Mart could increase overall pharmacy and store sales.