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Connections

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In Praise of Adaptive Design

By Jimmy Udall, Director and Founder of Rule 4 Consulting

With the publication of Dr. John Kenagy's new book, healthcare leaders will be hearing a lot about Adaptive Design. As the first employee of John's company Kenagy & Associates, I played a role in developing what would later become Adaptive Design. I'm pleased to see these ideas in print and excited that they're reaching a larger audience.

The publication of [*Designed to Adapt: Leading Healthcare in Challenging Times*](#) provides me with an opportunity to reflect on the evolution of Adaptive Design and my own experience working with John Kenagy, as well as, implementing Lean with another consulting group. I hope these reflections will provide the reader context for the ideas in John's book and some background into Lean and other process improvement methodologies your organization might be considering alongside Adaptive Design.

Adaptive Design

The ideas laid out in John's book are the result of his long career as a surgeon, healthcare executive, scholar, consultant and author. Most of the ideas, though, start with his experience working with and researching Toyota. Toyota's success is renowned and the application to healthcare is, by now, proven. John and I got our first opportunity to implement what would later be called Adaptive Design, in the winter of 2001. For John the consultant, it was an opportunity to implement the ideas he had been researching for years to improve the problems he had seen for decades as a physician and executive. We focused intensely on the things that John believed made Toyota successful: tapping the creativity and problem solving ability of front-line staff. Our focus was intense and, in retrospect, perhaps a bit myopic. We set to work in an ICU doing as John had learned at Toyota; we encouraged the staff to identify as problems workarounds that cost them time and energy. We then used their ideas for improvement, along the way teaching them to think about their work and their jobs differently. While the staff could see the benefits of such an approach pretty quickly, the same could not be said about some members of the leadership team. In particular, the chief nursing officer at the time saw her job (as many leaders still do) as a problem solver of first and last resort. What was the value of solving small problems, she would ask, when there were so many large ones that she could see daily? And why couldn't she tell the staff how to solve problems if she knew the best solution?

When these questions came up, John and I tried our best to ask thoughtful questions like John had seen modeled at Toyota:

1. How can you and your managers possibly solve all the problems in this organization if there are so many problems and so few of you?
2. Are you really solving problems at their root or simply putting out a fire that will flare up again?

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In Praise of Adaptive Design (Continued...)

3. How much time do you spend developing the problem solving abilities of those below you in the organization, so that you've got more problem solvers?

Although the hospital still uses a modified version of Adaptive Design today, both John and I felt that things could have gone better. We realized that the above may be good questions, but only if the management team is prepared to hear them. We also felt that we let the staff's learning get ahead of that of the management team. Our focus was on changing the culture of the organization to be centered on getting the staff and the patient what they needed. Any time a patient or staff didn't have what they needed, that was a problem which would trigger an immediate response from the organization. This is uncontroversial for the staff because it could see the impact of solving these sorts of problems quickly change its working environment. The management team, however, was further removed from the work and was used to seeing "big" changes.

Since our work on this initial project, we've learned a lot and modified our approach based on our experience, and that experience is what makes John's book valuable. Perhaps most importantly, we learned to spend more time with the management team, recognizing what now seems painfully obvious: you need the support and understanding of the management team and the staff's enthusiasm to make a project successful.

Lean and Adaptive Design

Sandwiched between working with John at Kenagy & Associates and starting Rule 4 Consulting, I worked with a company teaching Lean in healthcare. Because they both stem from experience with Toyota, Lean and Adaptive Design are often considered together by hospitals if they're looking to change the way they do business or simply trying new ideas. Explaining the differences in a side-by-side comparison is difficult, and though I'm often asked for just that, I think it's important for the reader to understand that nearly all process

improvement and organizational change ideas over the last 30 years have come from someone going to Toyota, seeing something they liked, and saying, "Gee, we should try that." John Kenagy – to be overly simplistic – did just that, added 10 years of consulting experience, and called it Adaptive Design. Others did the same and called it Lean. Each added their own flavor and experience.

I found Lean to be more results focused and tools based, whereas Adaptive Design is more process focused and culture based. This is corroborated by the fact that early Lean adopters tended to be engineers who worked in manufacturing and saw an opportunity to improve healthcare, whereas John Kenagy was a physician who developed his Adaptive Design while consulting and testing ideas. While I benefited from Lean and still use some of the tools today, I found that I missed guiding the organization through the learning process and helping it change its culture, as well as, its problem solving tools. I found I was better suited for implementing Adaptive Design which led me to found Rule 4 Consulting and partner again with John Kenagy.

Choosing One?

Regardless of the differences between Adaptive Design and Lean, hospitals have seen tremendous benefit implementing both. Choosing between the two should be a matter of fit for your organization, rather than a judgment of which method is better in the abstract.

Allow me to close as I started: on a personal note. I want to thank John Kenagy for the opportunity and experience to learn and implement Adaptive Design. I hope many more get the opportunity to learn from his wisdom and experience.

Jimmy Udall is a director and founder of Rule 4 Consulting. Rule 4 specializes in prepping hospitals for EMR implementations and creating continuous improvement driven by front line staff. Jimmy can be reached at judall@rule4consulting.com.



Quantity vs. Quality – Reader Response

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

My "Quantity vs. Quality" commentary in the September 8, 2009, edition of FYA prompted the following excellent reader response:

This is one of the many very troubling issues we face in healthcare, and I appreciate your efforts to both shine a light on it, and to sound an alarm bell regarding the need to proceed with caution.

To share some observations:

- 1. Observation:** "Quality" definition and measurement in healthcare is unlike most other industries. **Rationale:** If I make engine bearings, for example, I can very objectively and consistently measure quality elements such as engineering tolerances, size, failure rates over time, etc., and the quality measurements in my factory are largely isolated from outside influences as long as I get inputs (i.e. raw materials) of adequate quality/condition. If I deliver healthcare, I'm trying to (a) keep people alive, and/or (b) help people have an acceptable quality of life. Although we struggle at the edges of life (both beginning and end), we have pretty well defined and measured when people are alive or dead. But the "acceptable quality of life" is very subjective and case-specific, and we may never be able to conclusively define and measure it due to the infinite variability each person brings with them, both physically and philosophically. Further, this measurement is greatly impacted by outside influences (e.g. a long list of lifestyle choices) and I have minimal control over the quality/condition of the people who come to me for care (e.g. the person who is severely mangled in a car crash, or one who is in stage 4 cancer, or one who has a pain in her belly, or one who is a bodybuilder with knee pain, or one who is a life-long smoker and alcoholic with lung, liver and kidney failure). What is expected of me in each and every case so that we all agree on the definition and measurement of the quality of the healthcare services that I have produced? Perhaps delivering healthcare is more like delivering education in terms of defining and measuring "quality," and we are still struggling mightily with quality scores in the education field. To the best of my knowledge, we don't base payments to education providers upon their quality scores, but why not? However, many times I have seen healthcare providers improve quality (without having any payment tied to it) when they are presented with the opportunity and information to do so.
- 2. Observation:** Over-emphasizing "Quality" measurements pushes the healthcare provider towards managing the numbers instead of managing the patient. **Rationale:** Given the infinite variability each patient brings with them, when considered both physically and philosophically, what can the healthcare

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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.

Quantity vs. Quality – Reader Response (Continued...)

provider do to have better quality scores? After the common sense steps of making sure they are following best practices and are up to date on training, equipment, supplies and procedures, then what? The healthcare provider can try to control the condition of their "inputs" by placing restrictions on who they will allow to receive the benefits of their expertise. Of course, this raises the ethical dilemma of who is going to take care of those people who are screened out by the providers who now have the high quality scores? And why do those providers who are arguably doing the most good (i.e. accepting the most difficult people) take the risk of ending up with the lower quality scores? True, we can do "risk and severity adjustments" for the scores, but there remains much subjectivity. And when we tie the payments to such subjective, easily manipulated, and inconsistent systems, we greatly increase the incentives for there to be fudging by both those who design the payment structure and those who are paid under that structure (a case in point is the running debate over the Medicare payment adjustment for "coding creep," which drives a wedge of rancor between the payer and the provider, with the patient caught in the middle). In fact, I have personal knowledge of a situation where an expectant mother with a high risk pregnancy was denied access to the specialty care she and her baby potentially needed because the providers didn't want to take a risky situation into their outcomes statistics, and we're not even to where the payment is tied to those numbers. In summary, we need to be very careful that we don't put the healthcare provider in the position of having to choose between doing what is best in managing the patient or doing what is best in managing their quality scores (to get their largest payment).

To attempt a conclusion:

Although it looks good on the surface, and sounds good in speeches, basing payments to healthcare providers on "quality" scores is not adequately supported by the existing quality definitions and measurements. Further, there will certainly be unintended consequences that are both negative and damaging if we move heavily into basing our payments upon the existing quality measurement systems.

To suggest an alternative:

Use the incentives that are inherent in a payment system to make the delivery of healthcare services both more efficacious (i.e. Quality) and efficient (i.e. Value) by bundling payments to providers in a way that aligns incentives to fully integrate and coordinate care across the complete spectrum of providers and modalities. This approach has the potential to truly reform the delivery of healthcare services with the emphasis on managing to what is best for the patient.

Bill Luke
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Bill Luke

Bill makes some very strong points
– what do you think?

I would like to hear your comments.

Send them to:

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Rick Kneipper