

From  TrendLeader
Connections

FYA - For Your Advantage, is a free twice-monthly electronic newsletter. With every issue, **FYA** provides insights into the topics that concern healthcare leaders today and the challenges they will face in the near future. The newsletter is provided free to healthcare CEOs. The editorial content is not copyrighted – except for those columns copyrighted by the author. CEOs may use the non-copyrighted material in any way they wish. The newsletter can be printed without prior permission.

FYA - For Your Advantage is produced by **TrendLeader Connections**. TLC offers a variety of healthcare products and services that help executives to differentiate between “fads” and “trends” and to make connections with “Trend Leaders” within the healthcare industry.

Table of Contents

Habits and the Culture of Workarounds	Page 1 - 2
OIG Alert	Page 3
A Scorecard for Healthcare Legislation	Page 4

FYA Staff

Publisher Jerry F. Pogue
Editor S. Harvey Price
Web Master Joel Schlarb
Circulation Manager Sheila Keizer

TrendLeader Connections

26 Shawnee Way, Suite C
Bozeman, MT 59715
(406) 586-6400

Habits and the Culture of Workarounds

By David L. Sundahl, Ph.D. (ABD), Founding Director, Rule 4 Consulting

Workarounds are – as I constantly hear from leaders in healthcare organizations – a huge impediment to higher quality, lower cost healthcare. In fact, most leaders I talk to bemoan what they call “the culture of workarounds.”

In my experience, the “culture of workarounds” is not conscious or goal-directed. That is, the tendency to work around problems rather than to fix them is not a conscious decision a doctor, a nurse, an aide or a technician makes. Rather, their response to problems is a matter of deeply ingrained habits.

The Power of Habits

Healthcare has seen the periodic resurgence of notions such as “mindfulness” whose intent is to awaken clinicians especially – but managers and others, as well – to a fuller awareness of what they are doing. The idea that emerges from these popular movements is that by becoming conscious of our actions we can better serve our patients, live fuller lives and make the world a better place.

Despite the many recommendations for becoming mindful, data show that nearly half of everyday behaviors are a matter of habit.

All of us have routines that we follow: we buy the same thing every day at Starbucks; we commute along the same route in the same way; we eat a cookie after lunch.

I'm a sucker for sweets. I can't resist them and I can't stop eating them once I've started. It drives my wife crazy. She can have candy around *forever*, because she can eat a piece and put it away. A bag of “fun size” candy bars can last her for weeks. Not me. I can't stop. If I eat one, I eat another and another and so on. Thus eliminating her long-held stash of treats in a matter of minutes.

Ice cream sandwiches are the worst. I tell myself that there's no harm in eating an ice cream sandwich after dinner, which is true. Four or five of them, on the other hand, is not good. In fact, it's not just unhealthy; I usually get a stomach ache from eating four or five ice cream sandwiches. In my attempt to regulate my ice cream sandwich intake, when we've got ice cream sandwiches in the freezer, I just take one. I eat it slowly, trying to enjoy it so that I will be satisfied and won't go for another – trying to follow Heather's example. Then, I immediately walk upstairs and brush my teeth, so that a second (or third or fourth) won't taste as good, and I'll have to brush my teeth again. Almost without fail, though, I wander back down to the kitchen at some point – sometimes without even thinking about what I'm doing – and grab two more. (Never just one more. Once I've given in, I figure, I might as well give in for real.)

(Continued...)

Habits and the Culture of Workarounds (Continued...)

The habit of eating ice cream sandwiches beyond the point where I feel sick is, for me, a deeply ingrained habit.

Habits are surprisingly powerful. In one respect they are powerful in the same way that ice cream sandwiches have a power over me: habits cause us to act, even when we don't necessarily want to.

I don't think that I want to make myself sick on ice cream sandwiches or drink another Diet Coke, but I do. Habits are also powerful in that they enable us to do much more than we could do otherwise. I could not, for instance, write this column without a whole host of habits – spelling, punctuation, typing, reading, etc. Without habits, I would be doomed to consciously choose each keystroke, every spelling, every punctuation mark. Instead, though, my fingers habitually – if not entirely reliably – find the right keys, I don't consciously process the sounds of letters and the meanings of words. These two aspects of habit – their ability to get us to do things and their automaticity – exert enormous influence over what we can and cannot do, what we can and cannot change.

Habits in Healthcare

In our work, we do a lot of observation and Socratic questioning. We often find ourselves in the uncomfortable position of exposing habits for what they are: suboptimal and behaviors that developed haphazardly.

Usually when we ask, say, a nurse, "Was it a problem that there were no test strips with the Accu-chek® machine?" She'll almost always say, "No, I can just get them from the other machine (or unit or whatever)." The nurse works around the problem without thinking much about it – in fact, without recognizing it as a problem.

The power of habits in delivering and managing healthcare to patients is often a source of stress and distress for leaders. Often, staff and physicians have habits that are not ideal for themselves or for patients. In fact, I frequently hear leaders decry the "culture of workarounds" in healthcare. The workarounds that people employ, as well as the tendency to work around problems, are both deeply habitual. As we spend time observing frontline workers, we consistently see smart nurses, technicians and doctors working around systems that

neither serve their needs nor the needs of their patients. When we ask them if a particular workaround was required because they encountered a problem, they almost always answer, "No, that's not a problem. I just do such-and-such."

Us: "Was it a problem that the physical therapist was taking your patient for a walk, when you went to pass her meds?"

Nurse: "No, I'll just take care of my other patients' meds and catch her when PT is done."

Us: "Was it a problem that the chart wasn't in the rack?"

Doctor: "No, that just means someone else is using it. If it's not in the chart rack, it's usually somewhere here in the nurses' station or in the room."

There are many examples of this, and, of course sometimes the very things that we ask about can escalate to the point where people will see them as problems – if the chart really is missing, if the patient is really delayed in getting her meds. The habits of thought and action that smart people acquire enable them to keep things moving, keep care from stopping. Unfortunately, these habits also have the powerful side effect that people are literally unaware that they are encountering and working around system problems.

Given the pervasiveness and the power of habits, any leader that wants to achieve true sustainability at the frontlines must confront the reality of human nature as it relates to habits.

David L. Sundahl was a Visiting Scholar at the Harvard Business School, where he studied, consulted and wrote on innovation and the creation of new growth business with leading organizations. He maintains a blog that you can access at www.managerialquality.org.



OIG Alert

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

Heads up! The Office of Inspector General ("OIG") of the Department of Health and Human Services ("HHS") has finalized its 2010 program to prevent fraud, waste and abuse, and may soon be visiting a hospital like yours. You and your management team should carefully review the OIG's Work Plan 2010 to ensure that you and your hospital are prepared in the event that the OIG comes visiting.

Consider the following OIG targets for planned reviews of Medicare Part A and Part B payments and services:

- **Hospital capital payments:** the OIG will determine whether the Medicare inpatient capital payments are appropriate
- **Provider-based status for inpatient and outpatient facilities:** the OIG will review the appropriateness of provider-based status for facilities that are separate from the hospital, both on and off campus
- **Inpatient prospective payment system wage indexes:** the OIG will review the accuracy of the hospital's wage data used to calculate wage indexes for the Inpatient Prospective Payment System ("IPPS")
- **Hospital payments for non-physician outpatient services under the IPPS:** the OIG will review the appropriateness of payments for non-physician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays at acute care hospitals
- **Payments to organ procurement organizations:** the OIG will review Medicare payments made to organ procurement organizations
- **Inpatient rehabilitation facility submission of patient assessment instruments:** the OIG will review Medicare payments for inpatient rehabilitation stays in which patient assessments were transmitted to the Centers for Medicare & Medicaid Services ("CMS") late to determine whether payments were correctly made
- **Critical access hospitals:** the OIG will review payments to critical access hospitals to determine whether such payments have met all designation criteria and were made in accordance with Medicare requirements
- **Medicare disproportionate share ("DSH") payments:** the OIG will review whether Medicare DSH payments were in accordance with Medicare's DSH payment methodology
- **Duplicate graduate medical education payments:** the OIG will review provider data from CMS' Intern and Resident Information System ("IRIS") to determine whether duplicate graduate medical education payments have been claimed
- **Interrupted stays at inpatient psychiatric facilities payments:** the OIG will review inpatient psychiatric facilities' ("IPFs") claims in cases of transfers from IPFs to the same or other IPFs
- **Provider bad debts:** the OIG will review Medicare bad debts claimed by acute care inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities and skilled nursing facilities to determine whether they were reimbursable
- **Medicare secondary payer:** the OIG will review the effectiveness of current procedures for preventing inappropriate Medicare payments for beneficiaries with other insurance coverage
- **Reliability of hospital-reported quality measure data:** the OIG will review a hospital's controls to ensure the accuracy of data related to quality of care that it submits for Medicare reimbursement
- **Hospital admissions with conditions coded present-on-admission:** the OIG will review Medicare claims to determine the number of inpatient hospital admissions for which certain diagnoses were coded as being present on admission
- **Hospital readmissions:** the OIG will review Medicare claims to determine trends in the number of hospital readmission cases.

Will you and your hospital be ready if and when the OIG comes visiting?

I would like to hear your comments.

Send them to:

Richard.Kneipper@phns.com



A Scorecard for Healthcare Legislation

Challenges are coming from all sides. The economy is having an adverse affect on hospitals at the same time that pressure is building in Washington to constrain hospital costs. There is a growing trend of requiring hospitals to take on greater risk in the form of pay for performance, restrictions on readmissions and never events. Frustrated physicians are asking hospitals to buy their practices. These are some of the challenges going on behind the headlines.

In the headlines are the machinations going on in Congress in the name of reform. The outcome of the maneuverings will certainly affect hospitals, but at the moment no one knows how. If you're following the play-by-play action in Congress to anticipate the outcome, here is a scorecard identifying the major players.

The Senate Finance Committee passed a healthcare bill last week. Now the attention shifts to the full Senate. Majority Leader Harry Reid and the White House have the challenge of introducing a bill that can win 60 votes to avoid a filibuster.

The challenge is daunting. How do they satisfy centrists who are suspicious of government-run public insurance – and liberals who insist on one?

As the challenge plays out, attention will be focused on six key senators, according to *The Wall Street Journal*.

The first is Maine Republican Sen. Olympia Snowe. She was the only Republican to vote for the Finance Committee bill. If she joins Democrats in the full Senate, she would give the bill a modicum of bipartisanship. If she doesn't, it will allow the Republicans to claim partisanship, which would put pressure on the Democrats to keep their caucus together.

The other Senator from Maine is Republican Susan Collins. She is further from the Democrats position than Sen. Snowe, especially on the question of including a variation of the public option. However, she has said she wants to vote for a health

overhaul, but she is dissatisfied with the current bill because it does not do enough to restrain costs.

Arkansas Democratic Senator Blanche Lincoln is up for re-election in a state carried by Republican Sen. John McCain in last year's presidential election. She voted for last week's committee bill, but added the caveat that "my support today does not ensure my support for a final product." Twice, she voted against a public option in the committee. Her biggest concern is keeping the legislation deficit-neutral. She may end up voting for the Senate bill because Wal-Mart, headquartered in her state, is supporting key elements of the overhaul.

Democrat Sen. Ben Nelson represents the conservative state of Nebraska. He has voiced misgivings about a public option. He has indicated willingness to compromise: a public option that would be triggered only under certain circumstances. The Senator will be looking for assurance that the government's role will be limited.

Sen. Mary Landrieu is a centrist Democrat from the conservative state of Louisiana. She faced town-hall meetings that exhibited considerable resistance to an overhaul. She says she is dubious about a public option. She is looking for a bill to protect small businesses and preserve Medicare funding.

Finally, there is Illinois Democratic Sen. Roland Burris. He has announced his intention to oppose any bill without a public option. Two other Senators have voiced a strong desire for a public option. They are Senators Bernie Sanders, an Independent from Vermont and John Rockefeller, a Democrat from West Virginia. Sen. Burris says Democrats are in peril if they shift to the right to court centrists and Republicans. The Senator has little to lose since he isn't up for re-election.

Follow these four women and two men in the weeks ahead.

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.