

From  TrendLeader Connections

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To Pledge to Do

By Dorothy (Dolly) Bellhouse, FACHE - Director, Rule 4 Consulting

We need commitment from the top. Management commitment is essential. We need the CEO to sponsor this. These requests come to you from senior management colleagues, directors, managers and consultants. And then, there's the converse that you may or may not hear. Like, management doesn't understand. The executives are on the sidelines. We never see the CEO or worse, the CEO isn't interested or doesn't care.

What is commitment? What does it mean to you? What does it mean to your management team? What does it mean to your staff? What does it mean to consultants you engage to help with key initiatives? My 1982 American Heritage Dictionary offers that commitment is a "pledge to do."

When someone asks for your commitment or the commitment of your team, do you always know specifically what they need you to do? And if for some reason, they think they don't have your commitment, how do you know?



In this simple figure, managers, directors and/or initiative teams are making a request for your and your team's commitment. You've had requests like this before and know what to do. You allocate resources, set budgets and release staff to participate in the learning and work depending on the circumstance. Further, you may attend report-out meetings, visit the units and departments involved and recognize staff's and teams' efforts formally or informally. Yet, how do you know if your "commitment" activities are exactly what was expected and more importantly how do you know if something isn't the type of "commitment" they had in mind or needed? What you plan to do may be necessary, but insufficient.

In my work, we use the principles of the Toyota Production System as we coach and teach organizations adaptive management. The second "unwritten rule" of the Toyota Production System states that connections should be direct and there should be an unambiguous way to send requests and receive responses¹. Both customers (managers, directors, teams) and suppliers (you and your management team) have responsibilities in this type of connection. The customer needs to make a defect-free request and the supplier needs to provide a defect-free product or service.

In this case, the service is your commitment. Easily said, but the connection doesn't stop there. Both the customer and the supplier have further responsibilities. As

(Continued...)

They Didn't Mention \$



CEO & Management Colleagues

To Pledge to Do (Continued...)

I / we need your commitment which includes:

- Removing barriers and help us solve problems as we encounter them in the work place
- Coming to visit during the initiative work

Do you need financial or other resources?
What specifically do you need me / us to do?

We need to make a "defect-free" request



Managers, Directors & Initiative Teams

the request is being made, the supplier should know if it is not defect-free and help the customer be specific. A commonplace example is when you place a phone order for a pepperoni pizza, your pizza supplier may ask a number of questions (Thick or thin crust? Whole wheat? Extra cheese? Small, medium, large? Pick up or take out?) to make sure you get exactly what you want. Similarly, the customer is responsible for letting the supplier know if the product or service supplied is not defect-free. In the pizza analogy, if the pizza is not exactly what you ordered, you should let the pizza supplier know. Otherwise, how can he improve if he doesn't know he produced a defective product? So, your customers need to let you know if the "commitment" service you have provided is not defect-free or what they had in mind.

Making it safe for customers to let you know when you "deliver" a defect is a key leadership skill. In order to improve connections in your work, you need encourage others to let you know when they don't get what they needed or expected.

Since I experience requests for management commitment often, I have been thinking about how this connection rule applies. It is easy to assume that everybody thinks about management commitment in the same way. However, in this time of ever-increasing challenges and priorities, assuming we know how management will demonstrate their commitment to any one initiative can cause problems. At best, the customer is frustrated. At worst, they lose confidence in you and enthusiasm for the work. For the management "suppliers," assuming they know what their customers need or expect is equally problematic. They may not understand people's frustrations and miss opportunities to reinforce the work or be puzzled about why the initiative fizzled out and think the customers unreliable. However, poorly specified connections are often routed in assumptions.

In this second figure, starting on the right, the customers are specifying their request. Yet, the management suppliers sense their request is incomplete and ask questions to make sure they can supply what the customers need. In this case, the managers/directors may have assumed the work had already been budgeted. The questions the CEO and team ask give the customers the chance to detail specific ways to demonstrate commitment. When should leaders visit and what should they do, etc.?

Unambiguous to Toyota means no assumptions. This simple example takes a common request and makes it explicit and clear.

My hypothesis is that if you asked your management team what "management commitment" is, you would get at least as many definitions as you have executive colleagues. My old dictionary's definition of commitment as "a pledge to do" resonates with how I think about adaptive management commitment.

The next time you are pledging to do something, test specifying your connection. Wouldn't it be ideal if you knew your customers and you thought about your pledge in the same way?

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1 The DNA of the Toyota Production System, S. Spear & K. Bowen, Harvard Business Review September-October 1999

Are You Getting Ready for ICD-10?

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

Have you and your hospital started planning for the transition from ICD-9 to ICD-10? We covered the challenge of the transition in the September 8, 2009, issue of *FYA* ([Vol. 8, issue 17](#)). Here is an update, especially for the many hospital executives who have told me that they haven't started yet since the ICD-10 transition deadline is almost four years away – October 1, 2013 – and many are hoping that the deadline will be postponed once again.

That may be a risky gamble for three reasons.

First, there are much earlier and equally important related deadlines in 2010 and 2011 that have to be met under new HIPAA transaction standard requirements for Medicare Fee-for-Service. The Secretary of the Department of Health and Human Services ("HHS") has adopted Accredited Standards Committee ("ASC") X12 version 5010 and National Council for Prescription Drug Programs ("NCPDP") version D.0 as the new HIPAA electronic transaction standards for healthcare providers, clearinghouses and billing services that submit transactions from Medicare Fee-for-Service contractors. The new 5010 and D.0 versions will permit reporting using the new ICD-10 procedure and diagnosis codes. So, if you care about Medicare Fee-for-Service, then you need to meet the following HHS deadlines for HIPAA covered entities:

- **By December 31, 2010:** must achieve "Level I" compliance, which means that your covered entity "can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing"
- **By December 31, 2011:** must achieve "Level II" compliance, which means that your covered entity "has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards"
- **By January 1, 2012:** must be fully compliant

Second, the ICD-9 transition to ICD-10 is going to be a huge undertaking-many think it will take much more

time and cost more than the Y2K transition. It will impact every system, process and transaction that contains or uses a diagnosis code, and thus will have a monumental effect on hospitals, physicians, nurses, clinicians and payers. The ICD-10 code set allows for more than 155,000 different diagnosis and procedure codes, which is a huge expansion of the 17,000 codes available in ICD-9. In addition, ICD-10 has 3-7 characters compared to the 3-5 in ICD-9, and includes both alpha and numeric characters, compared to only numeric characters in ICD-9, which will require most systems and applications to be rewritten. Also, consider the following excellent advice from the American Hospital Association in its recently published "HIPAA Code Set Rule: ICD-10 Implementation:"

"Planning for ICD-10 must engage executive leadership, particularly since the coordination challenges span a wide-range of functional areas, including finance, information services, decision support, compliance and the medical staff...Taking short cuts or providing a minimal effort to achieve compliance without examining the steps or opportunities to maximize the benefits associated with ICD-10 could result in significant redesign costs later on."

Third, if you and your hospital are going to seek stimulus monies under the American Recovery and Reinvestment Act ("ARRA"), then you need to integrate your ICD-10 planning into your strategy to achieve "meaningful use" of electronic health records under the ARRA so that you have a carefully integrated plan for improving patient care and quality while ensuring appropriate levels of reimbursement for services.

So, it's time for you to decide whether you and your hospital are way behind or still have lots of time to deal with these forthcoming major ICD-10 related changes.

I would like to hear your comments.

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Swine Flu: Heavy at Some Hospitals, Mild at Others

While just about every hospital in the United States has made some provisions for a possible swine flu crisis, not all seem to be experiencing the surge of patients for which their emergency departments and intensive care units have prepared.

Last week, the ABC News Medical Unit contacted more than 60 hospitals from every region of the country to determine where the H1N1 activity appeared to be the heaviest, as well as, which hospitals had swine flu patients in their intensive care units – a sign that at least some cases were severe enough to warrant extraordinary treatment measures.

What the reports out of these hospitals suggested was that not only does the extent and severity of the illness vary from region to region, but in some cases it varies even among hospitals in the same state.

California is one such state. Dr. Larry Satkowiak, medical director of the emergency department at Children's Hospital Central California near Fresno, said that at his hospital, the virus has certainly added to the normal emergency department caseload.

"Compared to last year, we're up about 25 percent from last October," he said. "Most of that is due to flu-related illnesses."

Roughly 300 miles south, Dr. Jake Jacoby, hospital director for emergency preparedness and response at the University of California at San Diego, said all the plans are in place for dealing with a swine flu surge that has not yet occurred.

But where the virus has hit hard, the burden on already-strained emergency departments is unmistakable. In Ohio, a number of medical centers reported that the virus had taken hold in their coverage areas.

Ohio State University Hospital was one medical center that reported a heavy flu burden.

"We are not in a crisis at this point, but we are trying to determine what level we can handle," said Richard Davis, associate executive director of Ohio State University Hospital and the Ross Heart Hospital in Columbus, Ohio. "The intensive care unit capacity at Ohio State, and nationally, is running at a very high capacity normally. If you insert a new incremental demand, you have to make some adjustments to deal with that."

Dr. Mark Moseley, medical director of the emergency department at the Ohio State University Medical Center, said the strain is not limited to equipment and resources; staff, too, are feeling the effects of the crush.

Two of the cases at Ohio State University Hospital were severe enough to have required a technique known as extracorporeal membrane oxygenation, or ECMO – a step up from the usual intensive care which is reserved for patients whose lungs are so severely damaged that they can no longer function properly.

But even as medical centers in Ohio appeared to be dealing with elevated activity from the virus, there were hints that the flu activity could be tailing off, at least slightly. According to Nationwide Children's Hospital, the combined number of patients who sought care at the hospital's emergency department and four urgent care centers peaked on Oct. 12 at 958 before it began to trend downward. On Oct. 22, the combined patient volume was only 661 – still higher than the typical October average of 476, but a marked improvement over past weeks.

But with flu season around the corner, doctors agree that it is no time to relax.

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.