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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.

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Learning Compassion from a Flower

By Fred Lee

My wife, who was once the director of nurses for a rehabilitation hospital in California, asked one of her nurses one day to give a meditation at a staff meeting. The nurse brought a Shasta daisy and stood up in front of the room. She asked the members of the group to imagine that this flower represented their life and that each petal was something they were grateful for, something that made their lives rewarding, meaningful and fun. They were asked to write their thoughts on a piece of paper and share it with the person beside them. Then the nurse made a master list of "petals" on a flip chart. After doing the exercise, the entire mood of the room was elevated. Counting one's blessings is energizing and fun.

Then the nurse asked the question, "What will happen to these beautiful petals, one by one, as you get old?" She went over to the flip chart and pointed to the first item on the list. "What will happen to our friends and loved ones?" she asked. "They will die." And she pulled out some petals from the flower in her hand and let them flutter to the table in front of her. "What will happen to our health? It will fail." More petals fell.

She went through the list: job, home, car, recreation, shopping, eating, reading, traveling, crafts, helping others, independence, etc. The petals kept falling. Soon there was a profusion of disconnected petals on the table. In the nurse's hand was a forlorn stem with a few lonely petals remaining. The nurse then brought everybody's imagination to the point. Holding up the pitiful remains of that beautiful flower she said, "This is what is happening to our patients. Their lives were once just like our lives: flowers in full bloom. They had all these lovely things in their lives too. Think of the losses they have suffered. Think of all the grief they have had to bear in giving up their petals one by one, some all at once such as when they have a stroke. When my life looks like this sad flower, I wonder what kind of person I will be. I hope I am cheerful and cooperative and friendly to everyone around me. But I have a feeling there will be days when I don't care about doing what my nurses want me to do.

(Continued...)

Learning Compassion from a Flower (Continued...)

There will probably be times when I will be grumpy and depressed and angry. I may not respond the way others wish I would. I might think they don't understand because, look at them; they're all in the prime of life. Their flowers are full. They have no idea."

Then the nurse looked over the group and said, "When I think of this flower and my life, I do have an idea. Although I haven't walked in their shoes, I can imagine what they are going through, and I feel so fortunate to be an important part of their lives even when they're difficult."

My wife shared this experience over dinner nearly 30 years ago, and it is still vivid in my mind. Our little family did the exercise together at the table. As we did, I thought about an old aunt I had stopped visiting in the nursing home because she was so crabby. That weekend, and many more, we went to see her, and I have never looked at an elderly person in the same way since.

That is the power of imagination to motivate. We can be threatened or bribed into treating people with respect: the motivation of compliance. We can have value statements on the wall that encourage us to be kind and loving even when

we don't feel like it: the motivation of values and willpower. These motivations have their place and are useful, but this nurse demonstrated that neither is as powerful in motivating as imagination. Imagination influences feelings and feelings are the wellspring of desire. When we desire to do something from the depths of this well, it makes our actions easy and natural and real.

Compassion, caring, comforting and kindness – which make up the bulk of adjectives linked to patient loyalty – are rooted in one's capacity for empathy. According to Webster's New World Dictionary, "empathy" is "the ability to share in another's emotions or feelings." It is composed of two Greek words that mean "affection" and "feeling." When people receive empathy, they feel loved and cared about. In other words they sense our compassion.

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



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Governing Quality

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

Consider the following strong statements on the importance of patient care quality:

"[I]mproving the quality of healthcare services" is one of the hallmarks of a successful compliance program and effective compliance programs "begin with a formal commitment to compliance by the hospital's governing body and senior management."

These statements are particularly significant because they come from the Corporate Integrity Agreement recently entered into between the Office of the Inspector General ("OIG") in the Department of Health and Human Services and Tenet Healthcare.

According to a recent article in the *BNA Health Law Reporter* (10/19/06), "all attorneys interviewed by BNA agreed: Hospital boards will have to do more to oversee quality in the future." The article quotes one lawyer as stating:

"It is not that boards have been insensitive to quality of care issues in the past – quite the contrary – but rather they have not seen quality of care as a corporate compliance issue as opposed to a risk management or reputational issue."

But the OIG's Tenet corporate integrity agreement clearly suggests that quality is a major fiduciary responsibility of hospital boards. The BNA article states that this fiduciary duty requires "ensuring the six guiding aims cited in the Institute of Medicine report *Crossing the Quality Chasm* – that healthcare should be safe, effective, patient-centered, timely, efficient, and equitable – as specific elements of this fiduciary duty."

And there is a growing consensus that hospital boards must take a more active and aggressive role in ensuring the quality and safety of their hospitals.

"Groups ranging from the Institute of Medicine to the National Quality Forum have called for trustees to have a louder voice in the quality and safety strategies of the organizations they oversee," according to a recent *HealthLeaders EXTRA!* "Governance Reinvented" article. The article states that whereas historically quality and safety issues were delegated to medical staff members, many boards now "spend twice as much time discussing quality issues as financials."

This is a new role for many hospital boards – how involved is your hospital's board in quality and safety matters?



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

TrendLeader Connections

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."

Learning from Other Industries

More hospital leaders are turning to other industries to solve daunting challenges in delivering quality healthcare. In an unlikely collaboration, Britain's largest children's hospital has revamped its patient handoff techniques by copying the choreographed pit stops of Italy's Formula One Ferrari racing team. The hospital project has been in place for two years and has already helped reduce the number of mishaps.

A 2005 study found that nearly 70 percent of preventable hospital mishaps occurred because of communication problems, and other studies have shown that at least half of such breakdowns occur during handoffs.

Hospitals are starting to improve the way they transfer patients. They are borrowing ideas from fields more skilled in the art of high-risk handoffs, including aviation, spaceflight and the military. Earlier this month, an international conference had as a speaker a submarine commander who spoke about lessons from the Kursk, the Russian submarine that sank in 2000.

The Wall Street Journal reports that Kaiser Permanente of California has a handoff method based on a change-of-command system developed for nuclear submarines. At Trinity Medical Center in Rock Island, IL, nurses and doctors actually "pass the baton." They place documents with key patient information inside a plastic baton and pass it on during a patient handoff. A facility in St. Joseph's Health System in Orange, CA, uses a method it calls "Ticket to Ride" – a series of questions about the patient's medications, infections and other medical issues that have to be asked of a person transferring the patient between departments. Blount Memorial Hospital in Maryville, TN, encourages its staff to "Just Go NUTS," an acronym for a four-step handoff routine it recommends (Name, Unique issues, Tubes, Safety).

Recent trends have increased the risk during handoffs. A nurse shortage means more hospitals are hiring temporary staff. Because of new rules, medical interns are also working fewer hours, which makes shift changes – and therefore handoffs – more frequent

Earlier this year, the Joint Commission on Accreditation of Healthcare Organizations began requiring U.S. hospitals to standardize their approach for handoff communications or risk losing their accreditation.

The Great Ormond Street Hospital, located in London, England, was one of the first children's hospitals in the English-speaking world. It was established in 1852. The facility treats 100,000 children each year and is known for its expertise in infant heart surgery, a field where a lot can go wrong. Two decades ago, a lot did go wrong.

Between 1987 and 1993, surgeon Marc de Leval performed 104 "arterial switches" at Great Ormond Street Hospital. The operation corrects a congenital heart defect and is often done within the first two weeks of a newborn's life. At one stage, seven of Dr. de Leval's

patients died in quick succession. Soon after, in 1994, Dr. de Leval published an unusually frank paper about what had gone wrong. His key insight was that the infant deaths couldn't entirely be explained by the risk of the procedure or obvious failures such as a machine breaking down. Instead, he pointed to general "suboptimal performance" by himself and his team.

One Sunday in 2003, the British hospital's pediatric ICU chief and a surgeon turned on a TV set to watch a Formula One race as a way to wind down after a particularly difficult case. Both were racing fans, and they noticed striking similarities between patient handovers at their hospital and the interchange of tasks at a racing pit stop. But while a 20-member crew could switch a car's tires, adjust its front wing, clean the air vents and send the car roaring off in seven seconds, hospital handovers seemed downright clunky by comparison.

The two physicians invited members of a British team that fields race cars in Formula One contests, to provide insights into pit-stop maneuvers. Armed with videos and slides, the racing team described how they used a human-factors expert to study the way their pit crews performed. They also explained how their system for recording errors stressed the small ones that might go unnoticed, not the big ones that everyone knew about.

That point struck a chord with Dr. de Leval. He immediately saw that pit-stop handovers were successful precisely because of an obsession with tiny mistakes, a conclusion similar to the one he had reached in his 2000 paper about arterial-switch operations.

Two doctors from the hospital went to Ferrari's headquarters in Maranello, Italy, to meet with the company's racing team technical director. When the doctors returned to London they began to incorporate Ferrari's lessons, along with advice from two jumbo-jet pilots, into the hospital handover process. They wrote a protocol describing every step in the handover procedure. Between December 2003 and December 2005, they also did a careful study to see if those changes made any real difference to patient safety.

The doctors recently submitted a paper to a peer-reviewed journal that describes 50 patient handovers at Great Ormond Street Hospital over that two-year period. The study looked at 23 handovers before the Ferrari-inspired changes were put in place, and 27 after. After the changes, the average number of technical errors per handover fell 42 percent and "information handover omissions" fell 49 percent. It also took slightly less time to execute each handover, though, unlike the Ferrari team, the doctors weren't trying to speed up their process

The application of the Toyota system to healthcare has attracted the most attention lately. But, as this example shows, there are many other industrial companies to emulate.

(Information for this article comes from the Wall Street Journal)