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***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

A Tale of Two Rollouts

By Jon Roberts

Two weeks ago I wrote a column for *FYA* about the challenges that hospital administrators face in the course of large scale IT adoptions. See the column here if you missed it. I promised to revisit the subject in the next column. Here it is.

A few years ago, we got a call from a past client who was getting very anxious about the new electronic medical record that the hospital was about to adopt. The hospital was part of a larger health system and luckily, not the first hospital to "go-live." The first rollout was, by all accounts, not a success. Fortunately for our client, she had the sense to try something different rather than just trudge along a predictable (and dangerous) path.

First, let's look at **outcomes**, taken from a working paper written by staff at hospital "B".

Return to pre-implementation staff productivity:	
Hospital A: 12 months	Hospital B: 9 weeks
"Incidents" in first seven days as a ratio of daily census:	
Hospital A: 6.5	Hospital B: 3.5

To summarize, it took more than five times longer to return to previous productivity levels with almost twice as many verbalized safety concerns at the hospital that used the traditional approach to IT implementation.

What did hospital B do differently?

Context

Traditionally, we teach people how to use a new technology by walking them through an exploration of all the functionality of the new technology. Hospital A did this in a classroom setting, which is pretty standard procedure. At hospital B, a wise "super-user" took note of a nurse who stated, "This all sounds great, but I have absolutely no idea how to admit a patient, and I'm going to need to be able to do that." The super-user helped make a case for teaching people to use the new system in the context of how they take care of patients, rather than the context of the capability of the system. This was a profound discovery.

Immediately, super-users began observing staff in all departments in order to learn what tasks different people do so that they could practice those tasks with the new system. Staff became energized, rather than

(Continued...)

A Tale of Two Rollouts (Continued)

intimidated, when they learned how their work would change. Also, learning the system by practicing doing their work, staff actually had some sense of how things needed to be customized. Remember the nurse who wanted to know how to admit a patient? I was there when she learned how to do that. After her third pass through, she said, "This actually works better than the way we're doing it now!" I was excited to hear that.

Problem solving

To be fair, I should mention that hospital B had a platform for process improvement/problem solving that was fairly robust before we explored a new way to integrate the new EMR. Staff at hospital B had learned to see problems in their work as an opportunity, rather than a reason to throw up their hands in despair. That capability was critical to the success of the implementation. Also, this capability made it very clear who each staff member would turn to for help. The shared language and openness around system shortcomings allowed the staff and implementation team to swiftly address every problem they encountered and quickly move on to the next one.

Staff at hospital B had the skills they needed to speed up that process, as evidenced by the return to pre-implementation productivity demonstrates. At Hospital A, and almost every place I visit, when staff members discover a problem with a new technology, the most common reaction is (approximately) "Why would we even change to this system? It makes no sense." The difference in the perception of problems at the two hospitals had a huge impact on the rollout. When hospital B went "live" with the system, they had already identified and addressed 1,030 problems. Hospital A had addressed about 130.

Timing

Did you catch that I said *already* when I mentioned the problems addressed at each hospital? That's key here. Both sites are 400-plus bed hospitals. Large-scale IT implementations are incredibly complex. Hospital A had just as many problems with the implementation as hospital B, and they did eventually sort those problems out, but they did it after going-live, not before. Sorting these problems out is a lot more complicated when you have real patients who need things. It also lends itself to workarounds, which greatly reduces staff productivity. (Check out my August 16th column for the cost of workarounds.) Remember the number of post go-live incidents I mentioned earlier? Hospital B avoided real incidents by simulating them before it went live.

Summary

Implementing IT systems in hospitals is very complicated stuff. The cost of implementing these systems is much higher than we expect. The extent to which this is true often offsets the benefits of the new system. If you want different outcomes, you're going to have to take a different approach.

1) Redesign the teaching program so that the emphasis is on how staff members take care of patients, rather than how the technology works.
2) Have a systematic methodology for addressing problems and engage your staff in the process. They understand their own work much better than you or I do.
3) Allow staff to encounter as many problems as possible before the system goes live, not after.

Now you have my magic answer, good luck.

Jon Roberts is a principal at Rule 4 Consulting. You can reach Jon at jroberts@rule4consulting.com.

Comparative Effectiveness of Red-Tape

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

"To date, we have exclusively looked at the delivery side of the healthcare equation, while nobody is sounding a call for reform on the administrative and regulatory side of the equation." So starts an outstanding commentary by Patricia Gabow, the physician CEO of Denver Health, an integrated public safety net healthcare system, in the December 14, 2009, edition of *Modern Healthcare*.

Dr. Gabow urges that healthcare reform use evidence-based comparative effectiveness to measure not only clinical effectiveness, but to also measure the effectiveness of the administrative and cost burdens "that hospitals and other healthcare providers incur in complying with government and other regulatory bodies' administrative rules and regulations." This is an excellent suggestion since huge amounts of healthcare dollars are diverted from patient care in order to deal with administrative and regulatory red-tape, including the following identified by Dr. Gabow:

- **Administrative costs:** "administrative costs consume between 18% and 25% of the U.S. healthcare dollar."
- **Compliance costs:** administrative cost estimates do not include the escalating rising costs for hospitals to comply with the rapidly changing regulatory and other requirements adopted by Congress, CMS, state and local governments, accreditation organizations, insurance companies and other payers, etc., etc., etc. Poignant examples cited by Dr. Gabow include:
  - 12,000 pages of Medicare billing rules
  - 21 patient quality and safety organizations that have promulgated more than 3,000 quality measures
  - Joint Commission's 442 page manual
  - CMS' 1,677 performance standards and a 370-page hospital standards manual
  - 26 boards that dictate post-graduate physician training and medical student training (one of which recently is considering new resident work-hour rules that "are estimated to add $1.6 billion in costs with unclear outcomes")

And those examples of bureaucratic red-tape are before the 2,000+ pages in the healthcare reform bills that Congress is trying to adopt and the flood of additional federal and state regulations that will undoubtedly follow. Yet, as Dr. Gabow points out, "While the Congressional Budget Office creates detailed estimates of the cost to the federal government of changing the delivery and payment systems, it does not look at the cost of new federal regulations and guidelines to providers."

More significantly, Dr. Gabow points out "There is no systematic integration across organizations or central oversight to identify duplicative, overlapping or contradictory rules, nor is there any cost-benefit standard for this confusing array of regulations and rules."

Of course that is especially true because our healthcare system lacks a centralized and standardized set of regulations, policies and procedures, and instead requires hospitals and other healthcare providers to deal with bewildering and inconsistent bureaucratic administrative mazes at the federal level, at individual state levels and with other administrative organizations and payers.

If Congress is really serious about enacting meaningful reform of our ailing healthcare system-not merely focusing upon access issues – then it ought to embrace Dr. Gabow's proposal to use evidence-based comparative effectiveness to review and reform our healthcare administrative and regulatory morass in order to reduce the diversion of administrative time and costs from patient care.

What do you think?

I would like to hear your comments.
Send them to:
Richard.Kneipper@phns.com

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.

Comparing Healthcare and Agriculture

President Obama asked his staff to read an article written by a physician in the December 14 issue of *The New Yorker* magazine. It should be on your reading list also. The title of the article is "Testing, Testing: The health-care bill has no master plan for curbing costs. Is that a bad thing?" In it, Atul Gawande compares healthcare reform to the reform of the U.S. agriculture system at the start of the twentieth century.

Dr. Gawande is a surgeon at Brigham and Women's Hospital in Boston and at the Dana Farber Cancer Institute, as well as, an associate professor at Harvard Medical School and the Harvard School of Public Health. He writes regularly for *The New Yorker* and has authored best selling books on the subject of healthcare.

In his latest article, he writes "Cost is the spectre haunting health reform. For many decades, the great flaw in the American health-care system was its unconscionable gaps in coverage... The emerging health-reform package has a master plan for this problem... But the legislation has no master plan for dealing with the problem of soaring medical costs. And this is a source of deep unease."

"At the start of the twentieth century, another indispensable but unmanageably costly sector was strangling the country: agriculture... Only by improving the productivity of farming could we raise our standard of living and emerge as an industrial power... The Untied States did not seek a grand solution. Private farms remained, along with the considerable advantages of individual initiative. Still, government was enlisted to help millions of farmers change the way they worked. The approach succeeded almost shockingly well."

"America's agricultural crisis gave rise to deep national frustration. The inefficiency of farms meant low crop yields, high prices, limited choice, and uneven quality. The agricultural system was fragmented and disorganized, and ignored evidence showing how things could be done better... And lack of coordination led to local shortages of many crops and overproduction of others."

"You might think that the invisible hand of market competition would have solved these problems, that the prospect of higher income from improved practices would have encouraged change. But laissez-faire had not worked. Farmers relied so much on human muscle because it was cheap and didn't require the long-term investment that animal power and machinery did."

"Much like farming, medicine involves hundreds of thousands of local entities across the country – hospitals, clinics, pharmacies, home-health agencies, drug and device suppliers... The history of American agriculture suggests that you can have transformation without a master plan, without knowing all the answers up front."

"Government has a crucial role to play here – not running the system but guiding it, by looking for the best strategies and practices and finding ways to get them adopted, county by county... Pick up the Senate health-care bill – yes, all 2,074 pages – and leaf through it. Almost half of it is devoted to programs that would test various ways to curb costs and increase quality. The bill is a hodgepodge. And it should be... At this point, we can't afford any illusions: the system won't fix itself, and there's no piece of legislation that will have all the answers, either."

"The task will require dedicated and talented people in government agencies and in communities who recognize that the country's future depends on their sidestepping the ideological battles, encouraging local change, and following the results. But if we're willing to accept an arduous, messy, and continuous process we can come to grips with a problem even of this immensity."

"We've done it before."

Here is a link to the full article.

From all of us at ***FYA***...

Have a joyous holiday season!