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# Knocking Down Your Organization's Barriers to Efficiency and Effectiveness

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The money for digitization and comparative effectiveness research in the ARRA (“stimulus”) Act, plus this year’s reform effort and its sequelae together bring us a distinct and powerful challenge: How do we bring health care to people better, faster, cheaper?

And any good results of that push in the U.S. will show up in other national health care economies. Since the U.S. pays more and in many ways gets less than anyone else, the hunger for true cost-effectiveness is stronger here than anywhere else, and may well lead to startling new methods.

So that’s why I am looking at a walker. No, not for my own rapidly approaching enfeeblement. I am looking at a walker because what we need, at every level in health care, in every form imaginable, is disruptive innovation, the kind that does not show up from the big, established companies, but from garage inventors, tiny labs, and clever geniuses.

So I’m here at a tiny meeting of independent medical distributors, and one company is selling a special, hot, new walker. “If I were a hospital, why would I buy this?” I ask the vice president who is showing it. “It looks more expensive than the usual flimsy kind.”

The answer: It is more expensive, but it incorporates racks and attachments for infusion pumps, drips, telemetry, and whatever else the patient needs to drag along. A recovering patient taking those important but vulnerable steps down the hallway needs only one helper, not an entourage. Money spent on the walker is more than saved in labor costs.

Brilliant. And one after another, the participants show me devices with similar characteristics: they’re new, they cost the same or more than the competition, but could save a lot of money either by being more effective or safer, or by

allowing a patient to go home sooner, lowering length of stay.

- Here’s a non-invasive cerebral oximeter for use during CABGs, carotid endarterectomies, and similar operations. It costs \$200 per procedure and saves \$220,000 per 100 procedures (an average of \$2,200 per patient) by avoiding “pump-head” cognitive impairment.
- Here’s a simple oral swab that tests a patient’s response to warfarin. It could, by independent analysis, prevent some 18,000 strokes and \$1.1 billion in costs per year.
- Here’s an intraosseous infusion system. The infection rate on femoral central line placements commonly hovers around 10 percent, ED rates higher, at an average cost per infection of \$40,000. The IO system not only is easier and faster, it drops the infection rate below one percent.

So why aren’t we already using these breakthrough technologies? Because hospitals and clinics put up numerous barriers to their use—often, ironically, in the name of cost savings.

## Old habits

If you don’t think systemically, cost savings will not save you costs, quality improvements will not improve your quality, and more effective techniques will not improve your effectiveness.

For instance, who is the actual primary buyer for many of these devices? Most likely an institution’s materials manager or purchasing manager does the buying. And to these managers, a new device, or non-woven, or cleanser is almost never a solution; in fact, it’s the problem.

The materials manager is trying to make do with what the institution has, or reduce unit costs on any new purchase. Systemic savings (shorter length of stay, better respiratory outcome) do not show up on his spreadsheet, or his annual personnel review.

The clinician or therapist might be convinced that the device is more effective, but does not necessarily have the political oomph to pry the funding out of the budget. And

the pay of respiratory therapists, for instance, is rarely tied to better outcomes, but is often tied to giving more treatments.

Anything with real clinical implications often has to be approved by an institutional committee, made up, of course, of people who are used to doing things the old way.

Some of the largest firms in the medical distribution business actually lend staff to hospitals and group purchasing organizations. If you are a small manufacturer or distributor with a new idea, and you manage to get a meeting with the materials management team at a major hospital, those people sitting around the conference table with you and commenting on your PowerPoint may not even be on the hospital's payroll. Some of them may be on the payroll of your biggest rival.

Those within the organization, such as chief financial officers, who should be thinking systemically, often disdain to get into nuts-and-bolts operations questions. They will not even take a phone call from a manufacturer or distributor.

They often feel they have dealt with the cost problem by working with group purchasing organizations (GPOs) and vendor certification firms. Yet these very solutions can act as bulwarks against disruptive innovation.

By definition and inclination (as well as through the nature of their contracts with major suppliers), GPOs are not about breakthroughs from small companies. They are about getting the lowest unit cost from the big established manufacturers. Vendor certification firms act as gatekeepers for pay. It usually does not matter how many other hospitals or systems your firm may have been certified at, even other hospitals in the same chain, you have to re-certify (and pay a hefty fee) just to talk to the hospital.

If your organization is not examining its processes (all processes, from clinical to administrative to physical plant) regularly, formally, and systemi-

cally, through "lean manufacturing" or similar schemes, you will never see the thousand ways in which the organization itself actively blocks process innovation.

## Operating operations

For instance, let me ask you: Do your surgical teams set up the operating room differently for different surgeons doing the identical operation? Almost everyone does. Why?

On procedures like bypass grafts, mitral valve replacements, or cholecystectomies, in which the procedure is well-described and a proper evidence-based pathway is established?

Okay, maybe Dr. Draper has tiny hands, and maybe Dr. Marchand works better with be-bop on the stereo, and Dr. Johnson needs a foot stool. But on a well-described procedure, any

other variations are CDNRs: Clinical Differences for No Reason. "That's the way I learned it," or "I prefer it that way" is not a clinical reason.

The moment you start looking at the whole system, and asking the unasked questions, these are the things you will see popping up at you:

- Randomness without experimentation
- Experimentation without collecting data
- Standardization without "lean management"

You will see randomness without experimentation: People doing all kinds of things their own particular way without any attempt to figure out what is the better way.

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You will see experimentation without collecting data: “Let’s try it this way!”—followed up by nothing but “Let’s try it this other way,” management by the fad of the week and the whim of the moment.

If we call what we do “medical science,” then all variation is data. Science means rigorously collecting data, controlling variables, noticing differences, and discerning the difference that makes a difference—not just in the number of CCs of a drug, but in the location of hand-washing stations, the exposure to diurnal light, and who does the scheduling of nursing shifts.

At the other extreme, you will see a lot of standardization for no reason. We do it exactly this way because that’s exactly the way we do it. It’s like a secret handshake, and it is meaningless, without content.

In lean management, the people who actually do the work (birth the baby, secure the grounds, maintain the generators, insert the canulae) explore the best way to do it as teams, formally, iteratively, as a regular part of their jobs.

They measure the differences (waiting times, number of handoffs, number of infections) and share their findings, constantly working toward what is easiest, most effective, and cheapest. This is meaningful standardization.

Step back and look at the system at every scale, from the smallest working unit to the whole organization and the system it is part of. You will inevitably see conflicts of incentives and conflicts of business plans.

Take a look at your “mission, vision, and values,” and then look at various people in the organization and ask, “What are they actually paid to do? In detail? What can they do at work that will get them more of what they want—more salary, bigger budget, more prestige, more job satisfaction, more fun?

## Analyzing analysis

Health care is notoriously difficult to analyze systemically, but some of the best minds in business analysis have tackled it in recent years. All emphasize a need for new business models, new alignments, and new types of competition based on real value to the customer.

Michael Porter, the competition guru, teamed with Elizabeth Teisberg for the 2006 *Redefining Healthcare: Creating Value-Based Competition on Results*, finding and comparing the parts of health care that are actually working, and showing why and how.

Just this year, Clayton Christensen came out with *The Innovator’s Prescription: A Disruptive Solution For Healthcare*, with Jason Hwang and the late Jerome Grossman, both physicians.

They point out that there are many different types and modes of health care, from “intuitive” medicine for such things as depression, Alzheimer’s, and many types of cancer (for which diagnosis and therapeutic pathways are ill-defined, and subject to judgment, experiment and intuition) to “precision” medicine, such as strep throat, Gaucher’s Disease, and broken bones (for which both diagnosis and therapeutic pathways are very well-defined).

They argue that these call for entirely different organizational and payment models. Intuitive medicine must always be fee-for-service, because one cannot tell what kinds of services will be needed, or what the outcome will be.

Precision medicine, on the other hand, is amenable to standardization, and “fee for outcome.” It can be bundled, packaged into a “product,” given a definite price, and even a warranty. Clinicians engaged in these different types of medicine should sensibly be paid differently, in ways that get them more for doing smarter medicine, from fee-for-service to straight salary

to joint ventures and other models, including fees for managing facilitated networks of patients.

Business-model variations can be better designed to pull together the incentives for other types of medical delivery, such as urgent care, primary care, mothers and children, behavioral health, the management of aging, the management of specific chronic conditions such as COPD, CHF, addictions, and diabetes, and the management of frail end-of-life multi-system failure.

We act as if these are all functionally the same, and pay them all by a centuries-old physician-centered, fee-for-service model—and this confusion obscures any possibility of getting all practitioners pulling in the same direction.

For example: Carlos Olivares, executive director of the Yakima Valley Farm Workers Clinic in rural eastern Washington State told me recently, “The primary care physicians in my area were averaging about \$110,000 in income. They were complaining. When I asked them to staff the clinic for staying open in the evenings or weekends, they refused. Too hard, not enough compensation.

“So I did an analysis of all the visits to emergency rooms and specialists that could be handled by primary care physicians. I went back to them and proposed a joint venture: We’ll open an urgent care clinic, staffed late and on weekends as well, and I will give you 100,000 capitated lives.

“You figure out how to treat them inexpensively, do screenings, everything you can to keep them healthy. They jumped at the chance, we built it, and now they are averaging \$200,000 in income, and my members are far better served.”

Comparative effectiveness research, care registries, continuum-of-care ideals, condition-specific teams, the idea of “medical homes,” are all excellent things. But none of them will live up to their potential

until the business models are re-arranged to support them, until people are paid to work that way.

We need inventive, disruptive innovation in business models, service lines, compensation, all the way down to how you take out the trash and how many catheters you keep on hand. Business as usual will not help us, no matter how much harder we try.

As Rumi wrote: “Burn down this house. The treasure you seek is beneath the floor.”



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