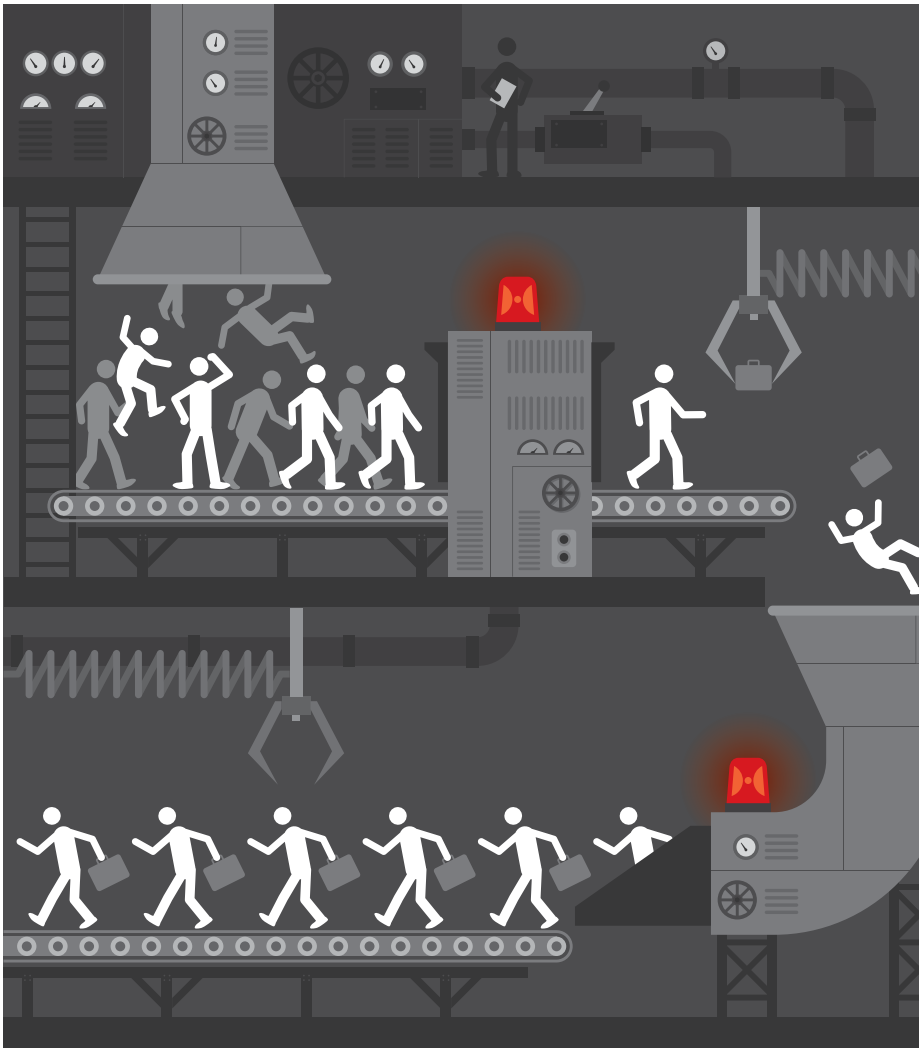
ROUNDTABLE

Strategic Operations

Hospital operations are hugely complex. Operational excellence and efficiency affects the patient experience, clinical quality and safety, and the organization's bottom line. Many executives, along with the federal government, look to information technology for improving operations. Regulatory incentives and requirements for employing IT offer more integrated operations but also create challenges in implementation. The cost of healthcare IT adds to the imperative of operational efficiency. HealthLeaders Media convened a panel of healthcare executives who share high-level perspectives on operations and deep familiarity with system IT to discuss how to achieve sustained excellence in operations while maintaining margins.



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PANELIST PROFILES

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Roundtable Highlights

HEALTHLEADERS: *There is a metaphor of a hospital as a factory. How far can that metaphor be taken?*

RICHARD VAUGHN: If you're going to look at this as a factory, you need to have the metrics [on] what you should improve, what your outputs are, and what your inputs are. One of the first things you need to do is to define what your product is. I think we're still struggling to determine who our customers are. We have this whole patient-centeredness approach, but the patient doesn't actually pay us. Then, where should you apply the limited resources you have in terms of redesigning your factory? ... What I'm trying to sell our organization on is being the best place to be a patient. And that, again, is patient-centered—all the way from the front end, greeting the patient, all the way to the back end of delivering services in a way that's most efficient for the patient. It's very consumer-centric. We're not used to that. We're used to making the patient stand in registration lines. We're used to making things easier for us, and not necessarily making it easy to be a patient. But the [hospitals] who are going to win are the folks who are putting the kiosks in, the folks that are providing three or four different ways to pay, the folks that are able to look across their resources in their entire organization and offer a patient an appointment with the CT scanner or an appointment with the oncologist next available, so that the registration clerk has all the information right in front of them and says, "What would you like? Would you like to be seen today? Tomorrow? Would you like to be seen within five miles of your home? Ten miles of your home?" That's where we need to go, I think, and that's where we're going to really have to move and change the organization and the culture—the way we think about how we spread our resources around.

MICHAEL GALLUP: Nobody working in a hospital wants to think of it as a factory. But I think there are a lot of manufacturing principles that can be used when it comes to driving quality. Anytime you're trying to get quality, then you have to drive variance out of the process. Let's say patient outcomes are your product. If you look at healthcare, there's a lot of variance. You don't do the same thing the same way twice or with the same patient. You have two patients sitting in side-by-side rooms and they have the same disease state, yet we handle them differently. Did we make sure we drove out all the variance that we could? Do you standardize so that when we see the variance, we know it has to do with that patient versus how the nurse handled it? Was it because we got this one out of bed three times when we took them to the radiology labs, but this one was out of bed one time? There's so much variance in how we operate that it has to help if you can just decrease the amount of variables that a doctor or a nurse has to think about and drive in standards in every way that we possibly can. Then let's look and see what's really the difference between these two patients.

HEALTHLEADERS: *Catholic Health Initiatives has 73 hospitals. Is the kind of standardization we're talking about feasible across a large hospital system?*

JAMES GREEN: Yes, it is. One lesson we're learning early on—and we are early on in this—is [the importance of] work flow process. Too often work flow is a sidebar. You may bring in a consultant or two, but the primary focus is all about the software implementation and how do we adapt to the software. That's where the focus is. But we learned in Nebraska, for example, with a practice management implementation, that if you think you are just swapping one piece of software for another without really, really examining and putting the right amount of emphasis on the work flow, you're going to have problems. So as we go forward, we're putting more of an emphasis on the work flow processes because they do vary so greatly among the facilities and the practices that your chances of success and your chances of adopting standard tools are greatly enhanced. But if it's [entirely] software-focused, you're in trouble out of the gate.

Tomas Gregorio, MBA
President and CEO
Meadowlands Hospital and Medical Center

HEALTHLEADERS: *Let's talk about the impact of healthcare IT, EMRs, and other*

systems on efficiency. A lot of people will hold that technology is how we're going to get to efficiency. But it's not happening yet.

GALLUP: There's no question that work flow improvements, such as the automation we do for hospitals, is where a large amount of efficiency can still be eked out of the healthcare delivery system. We are hearing from physicians that "It's high time we did this, I'm beginning to understand why this will really benefit us down the road." Some physicians tell us they see good benefits [from technology]—that certainly safety and quality are being improved, repeatable processes are being improved. They're not staying all night finishing their work. But we are hearing from both camps. Unfortunately many other physicians still are working late into the night to keep up with the new processes and getting all their notes and information into the system. So it's a painful process. It's a cultural change. They don't have the problem of lost charts or two days finding charts or all the paper-based problems. But there's a cost as well in changing the culture and changing the work processes and not seeing as many patients while this shift is under way.

James Green
Regional CIO
Catholic Health Initiatives

VAUGHN: I think what you're saying is that you can't make a blanket statement. You really do have to look at each individual implementation. What we find is that an internist who was [previously] seeing 30 patients and getting home by 5:00, he sits down, spends six hours, figures out and customizes the system. He already has an efficient office. He's got a whole spectrum of people to whom he gladly delegates ... Then you've got the other guy who says, "I never want anybody but me. I call every single patient myself. I never delegate." So for the guy who leaves at 5:00 who's seen 30 patients before EHR, it's going to be a short two weeks [to adopt technology]. He's going to be down 30% and then he'll be back up and probably even improve his efficiency. The guy who is leaving at 7:00 today is going to leave at midnight or go home and work for four hours at home, and bitterly complain, saying, "You've killed me. I don't see my kids. I can't go to any baseball games." I think what we see is [that in] the translation between paper and electronic, they don't get it. When it first comes up, they say, "Oh, this is electronic paper. Okay, electronic paper is better." Well, no. It's a new work flow engine. It's about using message pools, it's about taking advantage of your nurses and empowering them to do more than they've ever done before. It's about working more closely with your NPs, PAs, and really thinking about all of the office efficiency that you can create.

TOMAS GREGORIO: We are doing more tele-help stuff in [patients'] homes. We go so far as to make the appointment with the patient. We pick them up, we bring them in, we walk them through the entire process. I have people that actually walk that patient through, over to registration, walk them to the next place, have lunch with them. Guess what? When they go back to their doctor, they're going to say, "This is where we want go because they take care of us."

VAUGHN: It's the [theme of the] easiest place for me to be a patient. To emphasize your point, if you look at really good patient portals—where the patient can interact with the office, they can see their immunization record, they can request refills, they can leave an e-mail message for the nurse or the doctor—that is huge. Patients absolutely love that. It always comes up as one of the highest things that they mark. It's like 90% satisfaction. What else do you have that's got 90% satisfaction? Nothing. So there's clear demand [for patient portals]. Now, the problem is that you've got clinicians who don't want to deal with that, who are in the old model. "Patients shouldn't be able to see their record—it's my record." But Kaiser's been releasing millions of results immediately to the patient, with no physician intervention, for years. It's a huge satisfier. If you go to their clinic, there will be an e-mail message with the result in your inbox by the time you get home. They pushed past the resistance.

HEALTHLEADERS: *It took decades for productivity statistics to rise in technology. How long is it going to take in healthcare? And is it going to be quick enough?*

VAUGHN: I think we're in survival mode. You've got to have the data. Now we need to do process redesign, we need to see where our pain points are, we need to see what our costs are. For a long time in healthcare we

couldn't even tell you what it cost. We didn't even know internally what it cost us. We knew what the charges were, we knew what we were getting reimbursed, but we really didn't even know the number of nursing hours, the number of ORs. Now we have the opportunity to understand what our true unit cost is.

GREEN: Exactly. Without the metrics, we won't survive decreasing reimbursements. We wouldn't know where to readjust or right-size organizations in order to live within that model. And I think many organizations would fail.

GALLUP: But the problem is getting to the data that shows those metrics. Some systems won't talk to other systems. What would happen if we opened up [health] data? Nike has a pair of shoes with a device that can send data to the Internet as I'm running. In our world, in health IT, you would have to buy the shoes, the device, and something on the side to collect data, and then you would have to buy my BI tool, and then maybe you can get to the data. Look at the insanity of it. A device should talk to your open platform that sends all that data in. That's possible. We've got running shoes that do that. We can't get a medical device to send data to an open system?

HEALTHLEADERS: *Tom, you've installed open-source software at Meadowlands. Could you discuss that?*

GREGORIO: Right, we decided to go open source with our health information technology platform on the clinical side because we wanted the power to get to the data. We had to figure out how to get to it because it's a platform that was built in the '60s. But we were successful in being able to get whatever data we want, and what we don't know we're working on getting to it. I don't have to pay anybody; I don't have to ask permission. I do whatever I want with [the data]. And I can build anything on it that I want, as long as I give it back to the ecosystem, which is fine.

HEALTHLEADERS: *You purchased your hospital in a turnaround situation. What percentage of that was driven by finding new revenues, and what percentage was driving out inefficiency?*

GREGORIO: You walk into a place, you do all this planning for a year to find out what's under the covers. You're doing a forklift implementation of your technology because theirs is going away, and yours is coming in in a matter of nine months. That was leading up to the purchase agreement of the organization. On December 7 [2010], we take over. Now we have a new system, people being trained on the fly, a lot of moving parts. Along with this came a large OR practice, so all that volume came to the hospital, which significantly helped us revenue-wise. But there were ratios of people to patients that were totally out of whack. So we had to really do a lot of squeezing to take out a lot of the waste. In one instance, we migrated our unit secretaries; we eliminated those positions and we created technology folks at the units. They're clinical support analysts [who] are there just to make sure that everybody is using what needs to be used correctly. ... They show [doctors] how to place their orders with CPOE, they show them how to do all the different things that are being done on the computer now, which helps us with compliance. ... In the end, I'd say it was 60-40 [60% revenue and 40% efficiency]. We have been able to increase revenue.

HEALTHLEADERS: *How does a big healthcare system approach this equation? Are you going to pursue a 60-40 split between finding revenues and driving out inefficiencies?*

GREEN: In my role as regional CIO, I'm very accountable to the local hospitals, the local CEOs, and their staffs. I think one approach that CHI certainly understands is that there is the local brand. There is that hospital in the community, which is called "Mercy" or "St. Elizabeth's" and so on.

Michael Gallup
Senior Vice President,
COO of RTLS Division
TeleTracking Technologies

They don't see it as CHI; there's a little tagline on the sign that talks a little bit about CHI, but they think about that hospital and those people and the community events and everything that the hard-working executives do. So you as a leader take the system, view objectives, and then you set the pace. You may have a 60-40 kind of approach to it. But the local efficiencies, the local brand, can't be lost in all that. If you take a system too far [in pursuing efficiency], I think you're taking an essential ingredient out of the equation.

HEALTHLEADERS: *How does the ACO model and the patient-centered medical home affect operational efficiency?*

VAUGHN: It's an interesting challenge. I think everybody around the room here would still say ACOs are like unicorns—they're magical creatures and they have wonderful powers, but nobody has ever seen one. With an ACO, it's all predicated on how you get paid. Can I afford the investment required for wellness and population management? The CBO [Congressional Budget Office] came out with a report that said of the 34 disease management and care coordination demonstration projects out there, none of them returned a profit. After accounting for the fees that Medicare paid to the programs, spending didn't change or actually increased. I think that's what everybody wants to know—how can we make the model work? I agree with the premise—I agree that it should be patient-centered, I agree with tracking care gaps. But is it a stable financial model? A lot of people are very concerned about that. It seems that those that are winning have all the pieces. They've got a health plan, they've got physicians, they've got hospitals, and in some cases they also have the long-term facilities.

Richard Vaughn, MD
Corporate Vice President and CMIO
SSM Health Care

GREGORIO: What does an ACO do to drive efficiency, I think is the question. We still have this platform of 30% inefficiency that we're building it on. What is [the ACO model] doing to drive that out? Or are we just gluing a bunch of inefficiencies together?

HEALTHLEADERS: *I want to observe that our speakers have a lot in common. One is a CMIO of a good-size system, another is a regional CIO, and we have a CEO who used to be a CIO. But you guys haven't pinned the future on IT, by any means. In fact, you've pointed out the shortcomings of IT and the importance of using IT in the right way. ... What is the importance of the right IT systems for getting the strategic operational efficiency changes that are needed?*

GREGORIO: You hit the nail on the head: It's not a silver bullet. [The other speakers are] trained, I was trained that there needs to be a clinical or business need for any technology solution. We have to be driven operationally; it has to be or else it fails. Because the technology folks will go out and spend money, and then if they have no support, no executive leadership, it will fail. The CEO, the CMO, the CMIO must be driving. The CMIO is there as the hand-holder, the one who's relating what medical terminology needs to be dictated into the system, what the doctors need to be able to use. But as a technologist with that hat on, it's up to the others to drive it operationally. That's how we're trained.

VAUGHN: I think that's true, but would also say that there is a responsibility on the CIO's part to develop a strategic plan [for technology]. I'd like to see organizations come out and say, "Not only are we going to be the best place to be a patient or the easiest place to be a patient, here are the [IT] goals underneath that. We will always know who you are and we'll always have all the data we need to make a decision." Then start mapping back to that, so you can say to the registration clerk, "You're the first part of this whole process. If you register the person wrong, then the data doesn't match up." That's the kind of strategic influence that IT systems are now developing that hasn't made it quite into the strategic plan in a definable way. Strategic plans should really identify that. We've all said that the data is going to be king moving forward, so let me tell you what underlies that to make your strategic vision come true. The strategic IT vision isn't a separate vision.

GREEN: In a large system, the trick is the representation—bringing everyone to the table so that IT isn't seen as driving this down people's throats. "You picked this vendor, this is your solution, you're driving it down our throats. We didn't pick this; you picked it for us." That's never an IT executive's intent. So it's [a question of] how do you bring the governance, how do you bring the representation to bear at the selection process or at the requirement determination process so that everyone in the system feels this was a business decision.

GALLUP: Technology doesn't solve a process problem. Technology enables people to develop a better process. All the little widgets are not going to solve all our problems. I think that's huge. It's the process [that's crucial]. You can always find technology.

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