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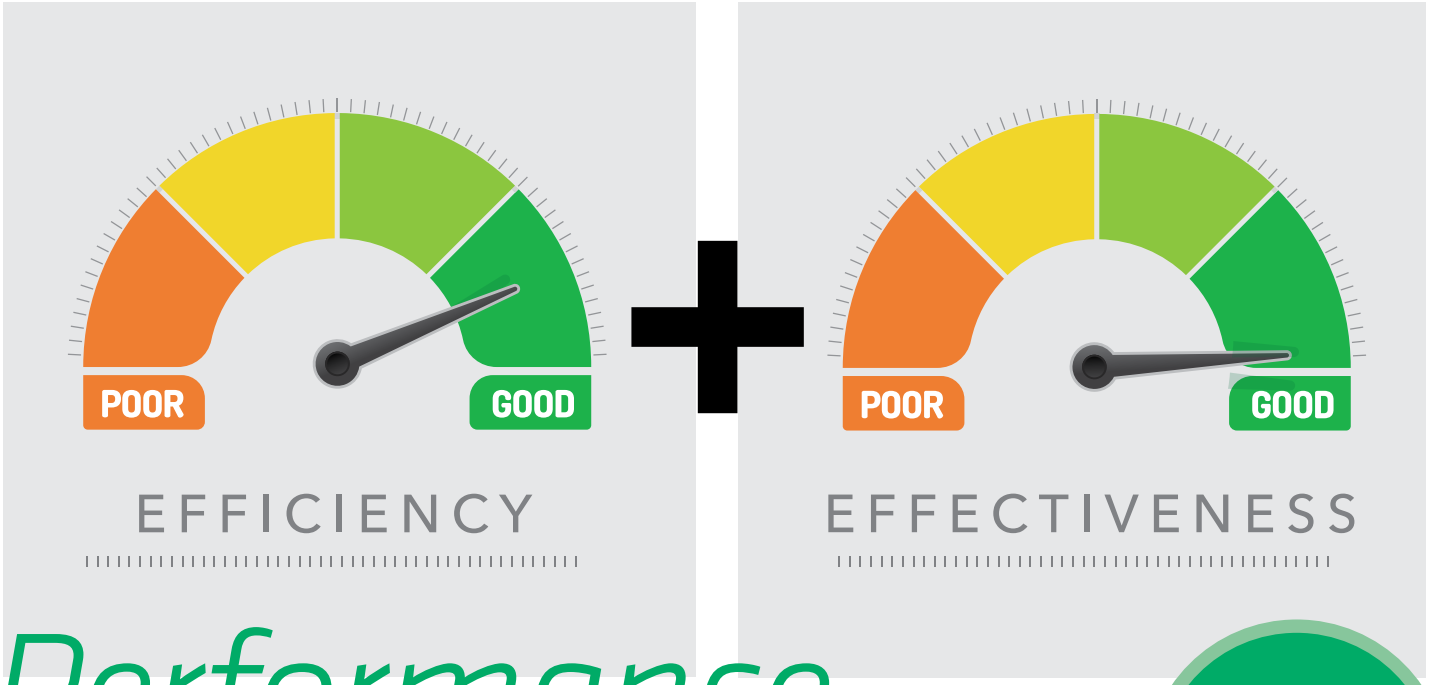

Performance Improvement-101

PART 1

by Jim Burnette, President/CEO, HospitalMD

Do you ever feel that trying to sort through the list of things you think you should do to improve your hospital's financial success and viability is like "pinning the tail on the donkey"? How many times have you felt like you were throwing ideas against a wall hoping something would stick? Or, did you make a change that you expected to achieve significant results only to find it made no impact?

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You are not alone. It's not always that your ideas are bad. It's just that some changes have no overall material impact, or may depend on changes in other parts of the process. The changes don't "stick" because they require adoption by staff. How do you deal with this complexity?

I believe the most important strategy for small community hospitals (SCHs) to use in a world of declining revenue and increasing costs is the appropriate application of **performance improvement methodology (PIM)**. I use the terminology of **PIM** here because methodology deals directly with the use of the operational tools and techniques of performance improvement **(PI)**.

DEFINITIONS AND CHARACTERISTICS

First, let's define several terms that have different meanings but are often used interchangeably and can lead to confusion: ***quality, value, and performance***. Quality and value generally relate to the actual clinical service (the medical decision-making) and not the delivery process.

Quality will be defined for our purposes as the degree to which the medical decisions meet a need and result in satisfaction (outcome). ***Value*** is the relative worth, benefit, and usefulness of medical decisions. Quality and value are subjective and are often judged based on the perception of the patient or other advocates.

On the other hand, ***performance*** is the measure of the processes that produce and deliver the service. There are two attributes of process performance: ***efficiency*** and ***effectiveness***. Efficiencv is the cost to deliver a clinical service for each patient visit. For example, the cost to treat a condition by Hospital "A" may be $200, whereas Hospital "B" incurs $300 for the same condition. Why? Because reduction can be accomplished through improvement in processes and does not mean working faster or harder. Improved efficiency alone says nothing about how well the service is delivered and is not performance improvement. We must also know the level of effectiveness.

Peformance Improvement (PI) and the application of Performance Improvement Methodology (PIM) are intrinsic to management and must be a continuous effort every day.

Effectiveness, on the other hand, is the measure of how "well" a service is provided, or how appealing the service is to the customer, and is associated with the level of customer service or satisfaction. One would say that Hospital "A" that treats a patient for a condition in 30 minutes (elapsed time, not labor time) regardless of the cost (whether higher or lower than Hospital "B") is more effective than Hospital "B" where it took 50 minutes for the same service.

MYTHS

Do you believe that improving efficiency implicitly comes with a decline in effectiveness? The truth is performance is increased when both efficiency and effectiveness are improved. In other words, any effort to improve performance that does not improve both is not an effective solution. There can be no compromise.

I have heard it said that PI is something that is required by regulatory statutes and is therefore something we have to do in addition to other aspects of managing patient care. The evidence of this myth is the view that PI involves periodic

(usually monthly) meetings to talk about problems and failures. Suggestions may be made about how to fix the problem that may or may not be implemented, and there is seldom any measureable improvement.

Actually, PI and the application of PIM are intrinsic to management and must be a continuous effort every day. Real improvement should be measured in financial statements, satisfaction scores, and be visible to staff and patients. In other words, everyone should benefit.

Let me give you an example: A client hospital's labor costs were excessive as measured as a percent of net revenue (60%). **HospitalMD** (HMD) was asked to assist the hospital to reduce labor costs to solve this problem. We agreed on an approach to redesigning the scheduling process for Nursing in 8 patient care departments. HMD insisted that all the parties agree that any solution that reduced cost (improved efficiency) must also improve effectiveness of staffing in order to say the project was successful. And we agreed that reduced costs must be reflected on monthly income statements and/or budget reports.

We defined effectiveness as a reduction in the sum of the daily differences in "actual" staffing levels to "standard" staffing levels based on staffing standards the hospital adopted. We further agreed that any solution must also result in a benefit to individual Nurses working in these departments in the form of days off with pay.

The scheduling method was redesigned and tested live over a period of 4 months. The results were (1) a reduction in annual labor costs for all 8 departments of $1.5 million (10%) and included addition of full time Nursing staff, (2) a reduction in daily variances by 70%, and (3) all Nurses within these 8 departments received an additional 17 days off per year with pay in addition to their usual personal time off (i.e., vacation or PTO) based on employment policy. In another example, we were able to reduce the overall average length of stay (ALOS) in a hospital by 35%.

I hope you come to believe (if you don't already) that PI and PIM are essential tools that will improve your service levels and achieve quantum leaps in financial viability. There is no reason any hospital cannot be profitable. I will be discussing more of this topic in the next **in•sight**. I welcome your comments and questions. I would like to hear about your experiences with PI. Call or email **insight@hospitalMD.com**. I will respond personally. Here's to your success!

For more in-depth resources on Performance Improvement Methodology (PIM), visit us at: **HospitalMD.com/resources**.

Jim Burnette is the Founder and CEO of **HospitalMD**. Jim has worked in healthcare for more than 20 years. His mission is to strengthen small community hospitals across the nation and help them thrive in today's rapidly changing healthcare climate. Jim is a graduate of Georgia Tech and resides in Peachtree City, a small community right outside Atlanta.

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