

Excerpts from:

Getting All Systemic On It: Knocking Down Your Organization's Barriers to Efficiency and Effectiveness

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(original in *PEJ*, the journal of the American College of Physician Executives, Sept./ Oct. 2009)

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

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 healthcare, 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 the annual meeting of the Independent Medical Distributors Association, and one company is selling a special, hot, new walker. “If I were a hospital, why would I buy this?” I ask the VP 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 either 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 \$2200 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%, 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 1%.

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

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? An institution’s materials manager or purchasing manager. 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 systemically, through "lean manufacturing" or similar schemes, you will never see the thousand ways in which the organization itself actively blocks process innovation....

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."

Healthcare futurist Joe Flower has emerged as the premier thought leader on change and the future in health care. A 30-year veteran writer, speaker, and health care analyst, he is a faculty member of the American Hospital Association and the American College of Physician Executives. His clients have included the World Health Organization, the U.S. Defense Department, the UK National Health Service, most state and provincial hospital associations in North America, and a wide array of hospitals, professional associations and companies across health care in the United States, Canada, and Europe.

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