AUGUST 2004

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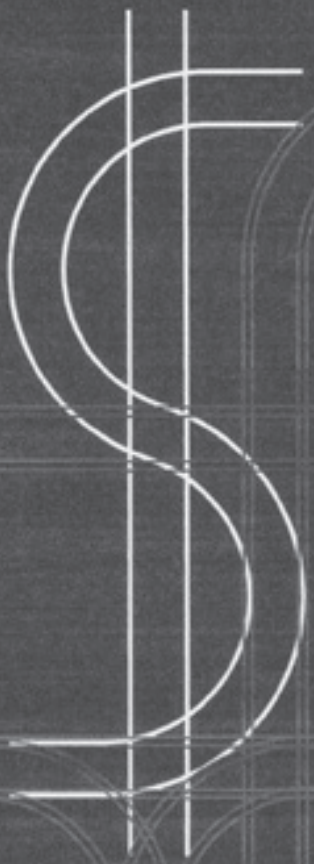

light at the end of the tunnel for denials management

investing in clinical IT
commentary by Jeff Goldsmith

good actors in a bad movie
Richard Clarke on charging and collections

Jeff Goldsmith

investing in clinical IT

Hospital CFOs can play a key role in health care's long-overdue productivity revolution.

AT A GLANCE

To ensure that clinical IT implementation is accomplished properly, healthcare organization executives should involve care givers and gain medical staff support. CFOs need to stretch beyond their own comfort zones and become technically literate and involved in clinical IT issues.

The Future of Capital Spending, HFMA's third *Financing the Future* report (March 2004), presents the surprising results of a survey. The surprise was the emerging primacy of information technology (IT) investment in the hospital capital spending mix: the three highest priority capital spending items were all technology investments—digital radiology, computerized physician order entry (CPOE), and major IT system investment. By contrast, increasing bed capacity was a distant eighth on the list.

Traditional Clinical IT Processes

These results are heartening, and strongly suggest a long overdue recognition that the primitive state of IT in hospitals constrains their ability to improve both operating performance and patient safety. They also recognize that traditional hospital strategy, which has focused on revenue enhancement and service-line development, may have reached a point of diminishing economic returns and now requires fundamental retooling and rethinking of core clinical processes.

The current generation of hospital CEOs has spent a good portion of their careers fighting a multifront rear-guard action against external threats to their franchises. These threats included the revenue-eroding influence of health plans, the entrepreneurial development by medical staff members of competing ambulatory services, and incursions by investor-owned rivals into their markets. CEOs felt compelled by rising market chaos to focus most of their energies outside their institutions in merger-and-acquisition-oriented strategies.

For most of the past 20 years, inpatient services either declined in volume or grew modestly. Ambulatory volumes (particularly surgery and imaging) grew reliably, but much less rapidly than overall market demand for comparable services. While CEOs focused on external threats, hospital operations and the political complexities associated with them were delegated to a frustrated cadre of clinical managers who felt that what they were doing was not appreciated by those in charge.

Signs of erosion of the clinical services enterprise were abundant, but frequently ignored. The most important of these signs were flagging morale among clinical staff (physician and nonphysician) and the increasing

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scarcity of personnel in skill positions of all descriptions in hospitals. Simply put, hospitals burned out an entire generation of care givers and their supervisors, who spent a good portion of their days either documenting care or fighting the hospital's primitive scheduling and resource management systems, which relied upon the use of paper and telephone-based support.

The costs of burnout and turnover—that is, replacing experienced clinical specialists (nurses, pharmacists, radiology technicians, and others) with inexperienced people—rarely penetrated CFO consciousness. This is partly because hospital accounting has not traditionally incorporated human capital costs into the equation. These issues began attracting CFO attention as rising rates of overtime use and the extortionate cost of temporary staffing agencies began clobbering operating earnings in the late 1990s. Hospitals saw almost a 30-year trend of steadily increasing FTEs per adjusted occupied beds finally end in the late 1990s, when it could be argued that hospitals simply ran out of replacement troops.

Meanwhile, outside the hospital in the general economy, firms were reaping sustained gains from the use of IT to redefine and improve their business processes. These productivity gains were the key to the extraordinary boom seen in the United States and other modern economies during the same period. These gains—most pronounced in retail and wholesale distribution, computer manufacture, financial services, and telecommunications—were the direct result of strategic investments in IT, and the creation of new and agile enterprises.

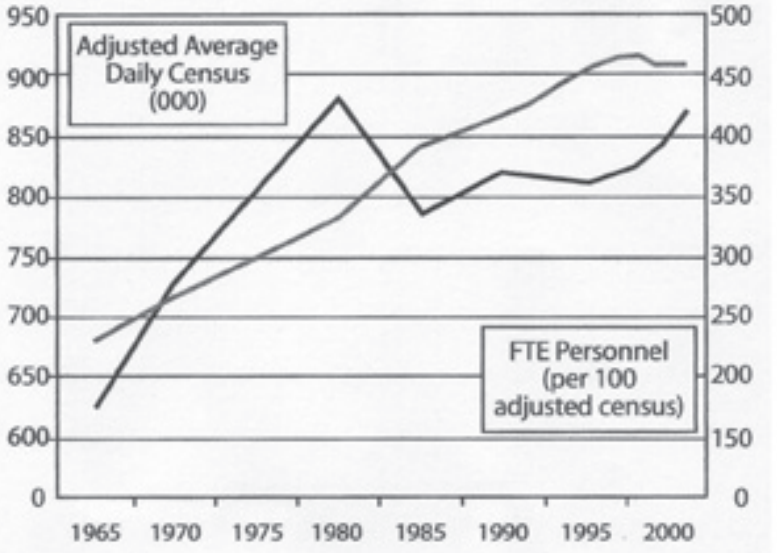
Hospital executives recognize that their ability to generate new revenues to cover the increased cost and complexity of healthcare delivery will be compromised in future years, not only by state and federal budget deficits, but also by the rising share of healthcare costs being borne directly by consumers through increased cost sharing. Productivity gains represent the sole salvation of hospitals in a resource-constrained world, and they cannot be achieved without tilting the capital spending mix toward IT.

HOW ARE HOSPITALS FINANCING THE FUTURE?

Financing the Future **is a yearlong project to help hospitals take advantage of growth opportunities. HFMA members can access the reports at www.financingthefuture.org.**

Labor costs rose steadily for three decades, even as inpatient days plunged.

U. S. COMMUNITY HOSPITAL EMPLOYMENT TREND 1965-2001



Source: American Hospital Association *Hospital Statistics, 2001.*

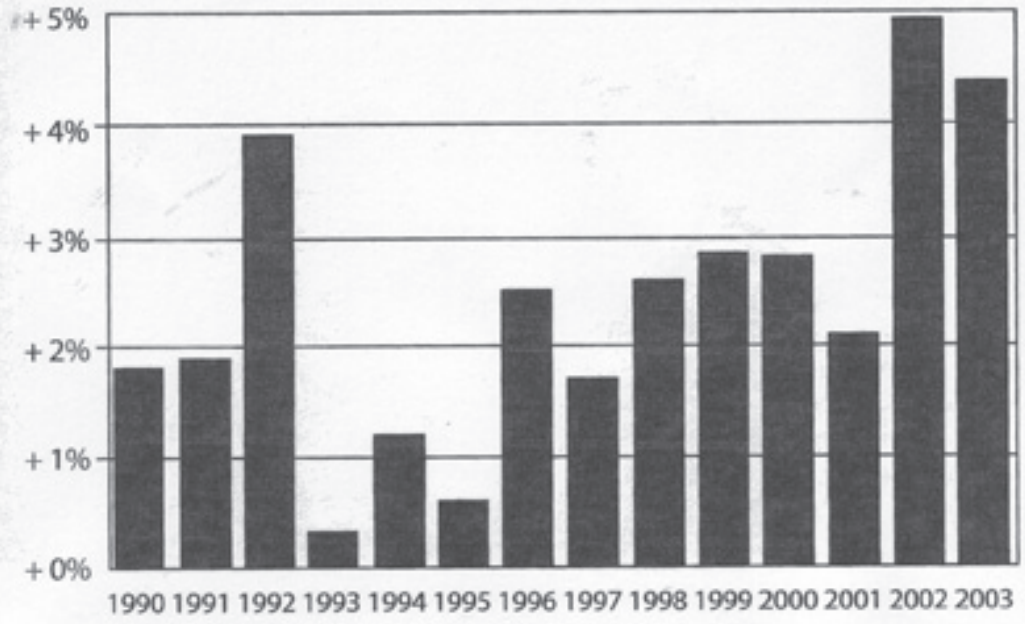
This situation is going to push many hospital CEOs and boards outside their comfort zones. Expanding physical plants and purchasing radiology equipment are familiar and gratifying exercises of executive authority. Moreover, there are powerful constituencies on hospital boards and in the medical staff that can be counted on to applaud these investments. It is also relatively easy to quantify the potential return on invested capital in many of these familiar uses.

IT investment, on the other hand, is risky and unsettling to CEOs. Most CEOs had limited preparation in their training for understanding IT, and their career experiences have been littered with disastrous "partnerships" with IT vendors and a checkered history of IT implementations. IT vendors have often misrepresented the state of maturity of the applications they sell, recruiting unwitting "alpha" site hospital partners.

CFOs have complained, particularly about clinical IT applications, that they cannot document adequately the return on capital for these investments. This is because it is politically difficult and managerially challenging to change the operating culture of hospitals sufficiently to realize these gains. To implement clinical IT properly, clinical process and workflows must be redesigned to eliminate wasted motion and unnecessary clerical tasks performed by scarce clinical personnel. Huge portions of nursing and other direct patient care time devoted to documentation and scheduling can be redeployed to direct care activities if clinical process is appropriately "reframed."

This reframing, however, is enormously disruptive of established clinical routines. If clinical IT implementation is done properly, "everyone's cheese gets moved." Without the appropriate involvement of care givers, and broad and deep medical staff support, internal "immune systems" will rise up and kill the IT implementation process. This is why hospital CEOs and senior management must be prepared to get their hands dirty, and to commit sufficient attention and political capital to see the implementation

U. S. PRODUCTIVITY: ANNUAL CHANGE IN THE OUTPUT PER HOUR OF ALL WORKERS IN NONFARM BUSINESSES



Source: Bureau of Labor Statistics.

Strategic investments in IT by nonagricultural industries have increased productivity significantly.

through. IT implementation and clinical transformation go hand in hand; merely to purchase the technology and delegate the culture and process change required to the technology partner is to invite a costly and embarrassing failure.

What Can CFOs Do?

CFOs can help with this process. They can ensure that productivity gains claimed in clinical IT implementations are realized in practice. They can monitor the redesign to ensure that clerical employment is reduced, and nursing hours actually spent in direct patient care increase as the implementation process matures. They should insist on reduced turnover, agency use, and overtime in direct patient care positions, with appropriate lead times for implementation built in. They should set process-improvement targets, particularly for reduced adverse drug events, improved results reporting (leading to shorter lengths of stay), and reduced requests for duplicative testing (which have adverse Medicare payment consequences for inpatient care).

CFOs must also stretch beyond their own comfort zones in revenue cycle and enterprise resource management applications. CFOs must become technically literate and involved in clinical IT issues. CFOs have a valuable contribution to make in midwifing a new era of clinical productivity, accountability, and quality, and in helping their CEOs and boards make intelligent purchasing and implementation decisions. Implementing change of any kind is the soft underbelly of many healthcare enterprises. However, with patience and enlightened leadership, CFOs can help their institutions make more effective use of scarce clinical personpower and safeguard the health and well-being of their patients. ■

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