FYA For Your Advantage

An Essential Tool for Healthcare Leaders

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Toyota's Woes: Are There Lessons for Healthcare?

By John W. Kenagy, MD, MPA

The bloom is off the Toyota rose. Instead, its woes are documented in daily media reports of quality problems, recalls and threats of governmental intervention and regulation.

Those are headlines we might associate with the old GM, or maybe even healthcare, but not Toyota. Toyota was supposed to be the best. How could its processes fail in such a massive way?

I have an interest in the answer because, besides being both a physician and healthcare executive, I studied innovation management as a Visiting Scholar at Harvard Business School from 1997-2001 and worked with Toyota experts in healthcare for two of those years.

Harvard and Toyota taught me a great deal, but I learned more in the 10 years since. Full disclosure: I recently authored a book summarizing my 12 years of experience in developing highly adaptive healthcare.

In my research, there are three keys to long-term success in any rapidly changing business:

1. Success is not dependent on what you have done in the past or do now, but on how you *adapt what you do* to a constantly changing environment.
2. Current organizational structures, methods and the mindsets of the people embedded within them always slow, stall and usually stop adaptive change.
3. Those few organizations strategically and operationally "designed to adapt" have competitive advantages in a rapidly changing world. This is the *opportunity!*

Now the hard part: *How* to do it. The difficulty is *always how* to consistently execute in the face of organizational barriers and the inertia of people (e.g., staff, physicians, management, regulators, government, even patients) who don't want change.

My Harvard research discovered that successful start-up companies and only a very few large organizations (for example, Toyota, Intel and Southwest Airlines) had "designed to adapt" capabilities built into their management systems. Identifying those capabilities led to *Adaptive Design*: methods, skills and tools for creating adaptive healthcare. My experience with Toyota in 1998-2000 was part of my learning.

Toyota's current woes suggest it is not very adaptive now, so what's the difference and what are the lessons for us in healthcare?

Consultants and academics say Toyota's success came from its Lean process improvement tools. But I spent two years working directly with Toyota management experts and *was never taught a Lean process tool*.

Instead, I found Toyota's *unique management methods* focused on developing the knowledge, creativity and problem solving ability of everyone to improve.

When Toyota managed successfully, Quality was not a Department and Improvement was not a Project, or the work of a consultant, they were everyone's work every day and Toyota's performance showed it. But that is not happening now. I think it's a management problem and I propose that diagnosing why Toyota's management has failed to perform recently provides lessons for us in healthcare.

(Continued...)

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Toyota's Woes: Are There Lessons for Healthcare? (Continued)

Let's start with the basics. I was taught that four principles underlay Toyota's management success:

- Customer first
- People are the #1 asset
- Shop floor focus
- Continuous improvement

In my 1998-2000 Toyota experience, those principles guided management. My Toyota teachers said, "They set our direction, like the North Star." Those principles had a big influence on me and on Adaptive Design. Toyota's current woes suggest that, in the quest to become the world's largest automaker, management lost that direction.

For example, in my Toyota experience, "customer first" was more than a slogan. It was a principle that *informed everyone's daily work*. Toyota wasn't first; the plant wasn't first; sales or being #1 weren't first. Each customer's individual order came first and was to be filled ideally and exactly. When it wasn't, that was a problem to be solved immediately.

That impressed me so much that I adapted the concept to healthcare as Ideal Patient Care – a focus on first getting each patient exactly what he or she needed, customized, immediate, safe and without waste.

Setting that clear direction resonates with *everyone* and, when patients don't get Ideal Patient Care, it is a signal for immediate improvement. For example, using Adaptive Design, an East Coast hospital's department of surgery increased volume by 16 percent at the same time it decreased overtime by 14 percent and became 95 percent Joint Commission compliant. Those results did not come from projects or consultants focused on volume, overtime or JCAHO. Instead management and staff focused first on what was ideal for patients and problem solved when its care wasn't. That's putting the patient first.

As recently as February 6, 2010, *The New York Times* documented "a pattern of slow response to safety problems" at Toyota. That's not "Customer first." If Toyota management had stayed true to its principles, those brake problems would not have mushroomed into a nightmare.

Here's another Toyota management principle that seems to be missing now. I was very impressed with how "shop floor focus," meant *every manager,* from the frontline to the CEO, focused on and supported the shop floor. But reports suggest that Toyota's quality problems began as *management began to spend more time in meetings and offices* and less time focused on the shop floor.

For example, a 2004 *Wall Street Journal* article entitled "As Toyota Closes in on GM, Quality Concerns Grow," found "many shop floor leaders … spend too much time in their offices, instead of prowling the factory floor."

Last year, when Akio Toyoda, the grandson of Toyota's founder, became its new president, *The New York Times* quoted him, "We must get back to *genchi genbutsu* [our shop floor focus]." I believe Toyota management gradually lost that shop floor focus to a bureaucratic meeting and office mindset driven by its desire to be #1.

In healthcare, our "shop floor" is the point-of-care. In Adaptive Design that's the focus. For example, a Midwestern hospital medical-surgical unit used Adaptive Design to help management and staff combine a point-of-care focus with Ideal Patient Care and immediate problem solving. The results at 13 months showed the greatest increase in patient satisfaction in a 17-hospital system at the same time it decreased length of stay eight percent, increased staff productivity 14 percent and generated $1,700,000 in new revenue and savings.

"Shop floor focus" works in healthcare and has worked for Toyota. The record suggests Toyota management lost its shop floor focus to top-down decision-making in offices and too many meetings.

This diagnosis sounds negative, but don't sell your Toyota stock yet. The company will recover if it rediscovers and acts on its principles. For example, I believe that getting back to the basics and restoring the principles "People are the #1 asset" and "Continuous improvement" will make a difference.

It works in healthcare. I have found that "designed to adapt" means *everyone must be empowered and everyone must be accountable* to adapt his or her own corner of the organization to any and all new realities. That's powerful medicine.

In healthcare, leading in challenging times means empowering people and revitalizing trust, optimism, high performance and innovation that make a difference for patients. Get patients exactly what they need at continually lower cost. That's the way to fix healthcare.

By returning to its principles and enabling its people to get customers exactly what they need at continually lower cost, I believe Toyota will fix Toyota.

Dr. John Kenagy speaks to and advises healthcare management, staff and physicians. His book Designed to Adapt: Leading Healthcare in Challenging Times is available on Amazon, at www.johnkenagy.com and at www.SecondRiverHealthcare.com. Adaptive Design is a registered trademark of Dr. Kenagy.

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Will Comparative Effectiveness Work?

By Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

The American Recovery and Reinvestment Act (ARRA), the federal stimulus bill, provides $1.1 billion of funding for comparative effectiveness research. The purpose is to fund research that "compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders and other health conditions."

Funds are also to be provided to encourage development and use of "electronic health data that can be used to generate or obtain outcomes data." That sounds exciting to many who have long believed that healthcare quality can be improved, if caregivers had access to detailed comparative effectiveness studies, so that they could deliver the best, most efficient and cost-effective medical treatments to their patients.

The recently HHS/CMS proposed "meaningful use" rules also are focused on helping to achieve comparative effectiveness objectives as follows:

- **Stage 1** "focuses on electronically capturing health information in a coded format" and "reporting clinical quality measures and public health information;"
- **Stage 2** encourages the "use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible;" and
- **Stage 3** focuses on "promoting improvements in quality, safety and efficiency, focusing on decision support for national priority conditions, patient access to self management tools, access to comprehensive patient data and improving population health."

Yet what sounds like a great idea in concept might not be such a great idea in practice, as well chronicled in a fascinating article by Keith Winstein entitled, "A Simple Health-Care Fix Fizzles Out" in the 2/11/10 edition of *The Wall Street Journal*. The article states that "an examination of one of the best-known examples of a comparative-effectiveness analysis shows how complicated such a seemingly straightforward idea can get."

It summarizes the results of a cardiology study published in 2007 in the *New England Journal of Medicine* (the so-called "Courage" study) that "shook the world of cardiology" by finding that "the most common heart surgery – a $15,000 procedure that unclogs arteries using a small scaffold or stent – usually yields no additional benefit when used with a cocktail of generic drugs in patients suffering from chronic chest pain."

As a result of this "blockbuster" study, stent usage fell off dramatically (13 percent in the month after the study's release), but amazingly only for a while. The article's author found that "as the headlines about Courage faded, stentings soon began to rise again, and are now back at peak levels of about one million a year." The article cites an estimate that "the U.S. could save $5 billion of the $15 billion it spends on stent procedures each year if all doctors followed Courage's guidance."

As the author of Courage stated, "Most [cardiologists] haven't voluntarily incorporated the Courage criteria into their practice. What's going to continue to drive practice is reimbursement."

But if reimbursement is the key, the ARRA stimulus bill's provisions only provide for the sharing of comparative effectiveness and other healthcare information, and do not use the reimbursement club to force healthcare providers to follow studies like the Courage study. And according to the article, "Under federal law, Courage's findings about efficacy can't alter the amount Medicare pays doctors for stenting. The government insurance program is legally barred from considering a treatment's benefits when deciding how much to pay doctors for doing a certain procedure." As for private payers, they typically base their rate schedules on Medicare's.

There are numerous legitimate concerns about comparative effectiveness turning into "Big Brother" telling caregivers how to care for patients, which is a scary thought. However, shouldn't our healthcare system have a mechanism to ensure that a comparative effectiveness study like Courage is followed so that patients aren't subjected to treatments that provide no meaningful benefit to patients and waste billions of dollars? A decidedly complex issue – but isn't this one that needs to be resolved?

I would like to hear your comments.
Send them to:
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The Doctor Is In at P&G

Retail healthcare took another giant step. Procter & Gamble, best known as the company selling detergent, shampoo and diapers ventured outside the consumer products marketplace and into ownership of a nationwide medical group.

P&G has purchased MDVIP, a network of 350 doctors in 28 states that offers a boutique approach to medicine, promising more personal attention to patients in exchange for an annual fee.

For P&G, the venture will bring valuable insight into consumer healthcare. Worldwide, over-the-counter healthcare products are a $240 billion market, growing five percent a year, propelled by an aging population, longer life spans and an increasing interest in wellness.

P&G invested in MDVIP in 2006, but now owns all of it, and plans to install its own chief executive officer.

Based in Boca Raton, FL., MDVIP is the largest of what are known as concierge healthcare practices. Typically, patients pay an annual fee in exchange for more time and better access with their doctors, who have more time because they limit the number of patients they see.

For $1,500 each year, MDVIP patients receive an in-depth physical examination, a health assessment that includes family and social history and a plan to improve their health. Doctors continue to bill health insurance firms and collect co-payments. The number of patients per doctor is capped at 600 – compared to the typical 2,000 to 3,000 – and they are promised unhurried visits and 24-hour, seven-day-a-week access.

P&G plans to expand the business, which already has grown from 45,000 patients to 115,000 since it became a minority investor four years ago.

P&G says it does not plan to market its products through the physician offices, but rather use the company as "an incubator for primary care medicine," allowing it to gather information about patients and physicians, service and prevention. In 2008, for example, MDVIP worked with California-based Navigenics Inc., which P&G owns a stake in, to test that company's genetic marker that can gauge patients' predisposition to cancer, diabetes, heart attacks and other conditions.

It's also talking with General Electric to test some of GE's diagnostic machines.

MDVIP patients sign a contract that includes an option to permit information-gathering, which P&G says is collected only in the aggregate, not individually.

The MDVIP deal was engineered by P&G's FutureWorks unit, which seeks new avenues for sales outside of P&G's mainstream businesses. It's the P&G unit behind the expansion of Mr. Clean car washes, which are being franchised nationwide.

MDVIP doctors will not become P&G employees, but will continue to own their practices. MDVIP keeps $500 of the $1,500 annual fee and helps with administrative support, marketing, management and legal services.

Critics say MDVIP and other concierge healthcare practices can be elitist, skimming off healthy, well-to-do patients and leaving sicker, poorer patients to be cared for by traditional physicians.

"This may add to the growing disparity of healthcare in this country," said Dr. Lori Heim, president of the American Academy of Family Physicians. But she said she understands why both doctors and patients would opt for a change. "It reflects the frustration we have with a dysfunctional healthcare system," she said.

MDVIP says its pricing is affordable, and the concept attracts not just the well-off but a variety of ages and demographic groups.

P&G has named Daniel Hecht, who was a general manager in its now-sold pharmaceuticals business, to be CEO. MDVIP co-founder Dr. Edward Goldman will remain on the board, as will Bret Jorgensen, the current CEO. Co-founder and current chairman Steve Geller will retire.

About

PHNS provides IT services for hospitals, other healthcare providers and businesses. PHNS' IT services include application hosting, co-location and managed services; electronic off-site data back-up and data vaulting; business continuity solutions; disaster recovery services; and systems integration services. PHNS also provides comprehensive business process solutions for hospitals including admitting, HIM (including medical record management and storage, transcription, coding, release of information and electronic medical record services) and revenue cycle services. PHNS creates business-healthy hospitals by improving operations, enhancing technology and increasing cash on hand, which allows hospitals to focus on their core competency – patient care. PHNS has approximately 1,670 customers, including approximately 400 hospital IT and business process customers and approximately 1,270 IT customers. PHNS is headquartered in Dallas, Texas. See www.phns.com for additional information about PHNS.