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It's About Time: What CEOs and Boards Can Do For Doctors, Nurses and Other Healthcare Professionals

By James L. Reinertsen, MD

Hospital CEOs and board members have important things on their minds, such as strategic plans, capital and operating budgets, and community partnerships. But few issues cause more sleepless nights for hospital leaders than relationship problems with physicians and nurses. After all, physicians and nurses deliver the care that is at the heart of any hospital's mission. If hospitals lose key physicians or are chronically short-staffed in nursing, quality and safety will be at risk, leaders will fail to execute strategies, plans and budgets, and the hospital's mission will be in serious jeopardy.

So what is to be done? Hospital leaders often say: "We tried buying the physicians' practices. We thought we were helping them out by managing their business affairs, allowing them to focus on practicing medicine, but it turned out to be a disaster. We lost enormous amounts of money, and the doctors were even unhappier under our ownership than they were on their own! And now that they're back on their own, they're thinking of starting up their own facilities. What can we do?" And with respect to nursing, the lament is: "We tried any number of things to engage the nurses—Patient Focused Care, Shared Governance...you name it—but we still can't attract enough nurses to staff all our units properly. And the future looks even worse, what with baby boomers needing more hospital services, and fewer nurses entering the field. What can we do?"

It would be foolish to give simple answers to such complicated questions. But the theory of complex adaptive systems might allow us to posit a "Simple Rule" that could have a profoundly positive impact on hospitals' relationships with doctors and nurses. That simple rule is: *Hospital leaders should systematically remove everything that steals 'Touch Time' from doctors and nurses.*

The rule may sound simple, but applying it is not. To use this rule well, hospital leaders must have a deep understand-

ing of the basic reasons why patients have sought out healthcare practitioners over the centuries. Is there any common reason why patients have come to star-reading astrologers in ancient Mesopotamia, enema-wielding priests in ancient Egypt, entrails-readers in the Roman Empire, bone-throwing shamans in Africa, and now white-coated scientific doctors and nurses? What do patients want doctors and nurses to do? And what do these professionals need to serve their patients well?

Down through the millennia, three fundamental needs have driven people to seek out practitioners of the healing arts: the need for an explanation of the present situation, the need for a prediction of the future, and the need for a future that is changed for the better.

Explain the Present

Patients seek not only a diagnosis, a "what." They also want to know why their suffering has occurred. They need an explanation that fits the context of their lives: family structures, knowledge bases, work, superstitions, and beliefs. When patients have lumps, or pains, or fears, doctors and nurses cannot explain the situation fully without knowing the patient well enough to be able to set a scientific explanation into this deeply personal context.

Predict the Future

This need is not just about a prognosis. The questions asked by patients—"Will I ever have a baby?" "Will I live long enough to see my grandchild graduate?" "Will I ever play hockey again?"—do not have easy answers in textbooks. In order to answer them well, physicians and nurses must not only have a scientific understanding of the course of disease. They must also understand the hopes, fears, and dreams of the person behind the question.





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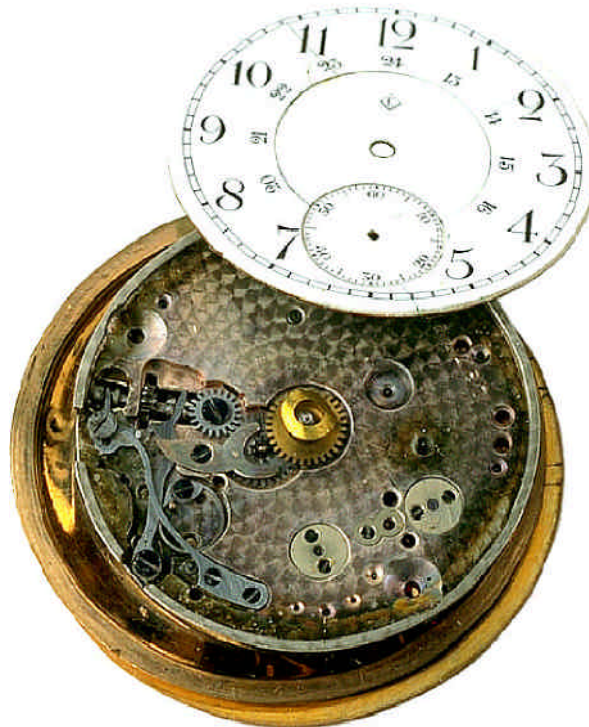
Change the Future

Virtually all of the miracles of modern era of medicine have come about as a direct result of the new-found ability of science-based health professions to meet this third need. Because of the application of the scientific method to the healing arts, physicians and nurses can now change the future from what it would otherwise be for patients with major trauma, infections, abdominal emergencies, childhood leukemias, and many other acute and chronic diseases. This work is not simply a matter of choosing the right antibiotic, or chemotherapy agent or surgical approach. Patients' futures are more reliably changed when the physician and patient trust, respect, and care for each other—i.e., when they have established a relationship capable of enhancing healing. And such a relationship is even more important when cure is not possible, but healing is.

Time, and Time Again

If healthcare professionals are to meet any of these three needs, they must capably perform the core process in health care: *developing healing relationships*. And although this core process is complex and dependent on many factors, one process element is absolutely essential: *time*. Without time to listen, probe, touch and think, doctors and nurses cannot adequately explain the present, predict the future and change the future for the better. Their deepest frustrations about their work are about time: fear that rushed patient visits will cause them to make serious mistakes, anger about the time they waste in cumbersome regulatory and organizational workflow processes, and a profound sense of loss of control over how they

spend their time. *And so, out of a core process of health care—developing healing relationships—and a fundamental requirement of that process—*



sufficient time in close enough proximity to the patient in order to develop a healing relationship ("touch time")—comes a simple rule for health care leaders: Remove everything that steals touch time from doctors and nurses.

Where Does The Time Go?

Surveys of nurses on hospital shifts and of doctors in office practices show that approximately half of their time is spent actually providing patient care—in the patient's room or exam room assessing, listening, explaining, administering treatments and comforting. The rest of their time is spent in documenting their work, searching for information about patients or diseases, waiting on hold trying to schedule procedures, trying to con-

nect with colleagues, filling out forms required by payers and regulators, and in general, navigating a complex maze of organizational and external environmental "touch time toxins." The doctors and nurses don't necessarily think that each of these activities is wrong—they know that it is important to document care, schedule diagnostic procedures, communicate with colleagues and bill correctly for services. What bothers them is how much time is wasted while doing these and other things, and how loss of time impairs their ability to give safe and effective care to patients. And when health care administrators respond to budget pressures by reducing staffing ratios, without also dealing with these time toxins, our doctors and nurses grow understandably angry, trust breaks down, and organizational performance starts to slip.

Many touch time toxins are within the control of hospitals and healthcare systems. Other toxins are a product of a confusing mix of regulatory and payment environmental signals sent to doctors and nurses: "Don't do too much care or you'll be punished, don't do too little care or you'll be punished, don't cooperate too much in the care of patients, don't make any mistakes while you're at it, and by the way, fill out another form at every turn." This article will deal only with those time toxins that are within an organization's direct control—things the board, CEO and administration of a hospital could do something about.

Your Frontline Staff Knows

Where to begin removing toxins to time? One of the best approaches I have seen is being developed in several Pittsburgh hospitals with the support and leadership of the Pittsburgh Regional



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Health Initiative. These organizations are implementing a comprehensive performance improvement process based on the Toyota Production System (TPS). (See www.prhi.org.) In this highly structured approach, exceptionally capable improvement advisers observe and describe the work of the front line staff, ask the staff what they want to improve, and then the adviser and staff make improvements immediately, using the scientific method, while the staff's work is ongoing. The key rule is: "The only people who have the right to improve the work are the people doing the work." The improvement agenda is not driven from above—it arises from the concerns of those delivering the care.

In one hospital, the nurses stated that their biggest problem was batteries—specifically, the batteries in the computers used in the medication administration system. The medication carts were driven by laptop computers, and batteries in the laptops frequently went dead while administering medications, requiring a great deal of rework and frustration for the nurses. Within hours, under the guidance of the TPS improvement adviser, the nurses had built a reliable "kan-ban" system with visual controls for managing the batteries so that a well-charged battery was always in the laptop. *And that simple change freed up three hours of nursing time per shift—about 25 minutes per nurse.*

By using similar approaches to the other problems the nurses identified—streamlining communication processes at shift change, creating a reliable system for supply of gloves and gowns for infection precaution rooms, etc.—significant additional amounts of time were freed up. And what did the nurses do with the time? Among other things, they took the time to wash their hands prop-

erly between patients, and serious infections with multiple-drug-resistant *Staphylococcus aureus* (a major problem in that hospital) plummeted. They also used the time to explain procedures, and assess patients, and communicate with

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family members. Clinical results, and patient and staff satisfaction all improved dramatically. One comment from a smiling nurse speaks volumes: "This is the first time since I've worked here that administration has actually been helpful to my primary work—taking care of patients." By solving "time-stealing" and annoying problems in daily work, the TPS gave back touch time, and the nurses were able to explain, predict and heal.

Does your hospital have its equivalent of the dying laptop batteries? Your frontline staff knows where their time is being wasted. If you want to know, just observe them at work, and ask them what is stealing time from the work they think is important. Before you do, however, you should be aware of two caveats:

- Don't ask staff where their time is being wasted if you don't have a capable method for dealing with what they tell you. Implementing the TPS involves a major investment in learning—for everyone including the CEO.

- Don't ask staff where their time is being wasted if your primary objective is to remove the wasted time so that you can cut staff. You need to show them that your primary objective is improvement

in their joy and pride in work—because that is the primary determinant of your hospital's performance.

A Sense of Control of Time

If a core strategy for healthcare leaders is to increase the amount of touch time for doctors and nurses, it would be a mistake for us to think about time in purely quantitative terms—the "number of minutes per shift of touch time." It is just as important that the frontline staff perceive a sense of control over their time. The best illustration of this comes from the experience of Luther Midelfort Mayo, (LMM) a fully integrated health system in Western Wisconsin. (See *Rozich, J, Resar, R. Using a unit as-*

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assessment tool to optimize flow and staffing in a community hospital. *Jt Comm J Qual Improv* 2002; 28: 31-41.)

The hospital leaders of LMM were struggling with a problem shared by many hospitals—backups and bottlenecks in the flow of patients among various units. They heard about a “Traffic Light” system for managing flow, in which each unit was designated Green (ready to accept patients), Yellow (caution, add patients only if really neces-

sary) and Red (stop, the unit is not accepting patients—commonly termed “capped.”) In trying out the system, they realized that the key issue was not flow, but rather, control of work and time. Yes, it was useful for flow management for everyone in the hospital to know each unit’s status—Green, Yellow, or Red—but the real issue was *who decides the status of each unit? The hospital administration? The nurse manager? Or the frontline staff?*

After careful consideration, LMM decided to implement the traffic light system in the following way. The screen saver for every computer in the hospital became a display of each unit’s status, Green, Yellow, or Red. It is updatable minute to minute, and the updates are “public” to everyone in the hospital. The decision to change from one color to another is made by each unit’s frontline staff and unit supervisor, based on their assessment of unit staffing, patient severity, anticipated turnover of beds, and other factors. In other words, those doing the work make a judgment about quality and safety, and their unit status changes accordingly. Interestingly, LMM didn’t call this system “The Traffic Light System for Managing Patient Flow.” They called it “The Nurse Capping Trust Policy.”

The effect of the policy was profound. Nursing morale improved almost overnight. Turnover rates for nurse dropped to unheard-of levels. Flow and throughput improved. And interestingly enough, the actual rate of “capping”—i.e. units going to Red status—actually declined from its historical levels prior to implementing this policy.

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There is often a lot of distrust between hospital leaders and front line staff. It was not easy for the administrators of LMM to give control of capping to the nurses. But if we are to start dealing with major problems such as staffing shortages, nursing morale, and bottlenecks in patient flow, we must begin to rebuild trust. In essence, we must not only help our staff to build healing relationships with their patients—we must also build healing relationships with our own staff. A great place to start is to give them a sense of control over the quality and safety of their work—in particular, the time pressures under which the work must be done.

Make the Right Thing the Easy Thing to Do

But what about the doctors? There is no question that the principles of the TPS—especially, “the only people who have the right to change the work are those who do the work,” apply to physicians just as much as to nurses. It is also apparent that physicians, who bear an enormous professional and legal responsibility, often in life-or-death situa-

tions, have an even greater need for control of their time, and of the safety of their work, as do nurses and other care professionals. Hospital leaders must look for opportunities to work with physicians to remove wasted time from their workflow, and to apply the lessons of the “Nurse Capping Trust Policy” to their staff physicians.

The overarching principle for working with physicians to improve touch time, however, is very simple: *make the right thing the easy thing to do.* This phrase was first articulated by David Abelson, MD, at Park Nicollet in Minneapolis,

and has been an extremely important technique to create more touch time for busy physicians, and simultaneously, to improve the quality of care.

The best example is the work of Jackson Thatcher MD, a cardiologist at Park Nicollet and Methodist Hospital who has led a team of colleagues on a multiyear effort to improve the care of patients with coronary artery disease. At the beginning in the 1990s, the team focused on acute myocardial infarction (AMI), and struggled to get the staff physicians to use the evidence-based care models they were developing. Then they hit on a good idea: Why not make evidence-based care the easiest option for busy physicians? The team arranged to place ready-made “standing orders” for the admission of a patient with AMI on the front of each chart at the time of admission. The attending physician would have two options: to simply sign the standing orders (including all the proper treatments for the patient, according to the most current scientific evidence) or to open the chart and begin a 10- to 15-minute process of writing one to one-and-a-half pages of orders, (a process which, data showed, used the current best evidence with high degree of variation).



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What do you think happened? Naturally, the vast majority of physicians chose to sign the standing orders. It saved time! Within a short time, AMI patients at Methodist Hospital were receiving the best known treatment at an astonishingly high level, and outcomes started to improve accordingly. The process has continued for seven years, with new evidence being incorporated as needed into these “standing order guidelines” by the medical staff, *with the result that 94% of patients admitted to Methodist with AMI now survive.* The team has extended this method to post-AMI care, and to upstream prevention of coronary disease in primary care offices, with similarly excellent results. Based on this experience, Park Nicollet is in the process of implementing a wide array of common standing orders, designed by their physicians, and clearly focused on making better care easier to do by saving time—five minutes

here, 15 minutes there—it adds up significantly by the end of the day. (See Thatcher JL, Gilseth TA. *Experience with Process Improvement and Outcomes Analysis in Acute Myocardial Infarction in a Community Hospital, 1990 - 1999.* *J Invas Cardiology* 2000;12:574.)

In a hospital or health system environment, it might be interesting to inventory all the policies and initiatives of the past few years to see which ones have given physicians more touch time, and which have stolen touch time from them. What about your new billing and coding requirements? Your JCAHO-driven policies and procedures? The computerized order entry system you put into place last year? Anything that slows down work (makes the right thing harder to do, if you will) it is almost certain to generate enormous amounts of ill will

among physicians. This isn't because physicians are lazy prima donnas who don't want to make important changes. As described above, the Methodist physicians made extensive changes to their care processes, in part because they were changing their own work (as in the TPS), and in part because, with the help of nurses and administrators, they made the change “the path of least wasted time.”

The lesson from Park Nicollet, and many other similar stories, is clear—phy-

outcome of the patient's care, they are acutely aware of wasted time, and will eagerly take any opportunities to convert wasted time into touch time.

High Stakes

When I ask hospital CEOs what's at stake in maintaining good relationships with physicians and nurses, they usually mention business risks—e.g. loss of key admitting physicians to competitors,

or decreased volumes because of inability to staff licensed beds with capable nurses. These are extremely important issues for any hospital—enough to warrant plenty of sleepless nights for the hospital's leaders. The strategy outlined above—removing everything that steals touch time from nurses and doc-

tors—would be an excellent overall approach to reducing these serious business risks, and is worth considering on that basis alone.

But there are even bigger stakes. Your relationships with physicians and nurses drive more than your business performance. These relationships are the principal drivers of your clinical performance—up to and including the ultimate measure of an acute hospital's quality—its mortality rate.

In Britain, each acute hospital's performance, including case-mix adjusted mortality rates and other clinical indicators, is reported to the public annually. (See www.drfooster.co.uk/home.) Many feel that it is only a matter of time (and not much more than a year or two) before similar reports, extensively adjusted for comparability across hospitals,



sicians are extraordinarily sensitive to time issues. Why? Because they want to rush even faster through their patients so that they can generate more billings? That cynical view might apply to a few physicians, just as a similar view might apply to a few nurses and “capping.” But the vast majority of physicians value time—specifically, touch time, because they need time in order to build relationships with patients and families. Without good relationships, they cannot take good clinical histories, explain diagnoses and procedures in sufficient detail, and answer all the questions patients have. If they are always rushed, they will never feel they are doing a good job of these things—and, since they are held accountable for virtually anything that might be missed, or any mistakes in execution of a treatment plan, and for the ultimate



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will be widely available to the public in the United States. Preliminary analysis of U.S. hospitals already indicates a lot of variation in mortality rates: for high mortality hospitals, the risk that an admitted patient will die may be as much as three times higher than in the lowest mortality hospitals. And this variation cannot be explained by any of the known “risk adjusters,” such as age, sex, diagnosis, etc.

Given the high likelihood that mortality and other clinical performance data are going to be publicly reported, do you know your hospital’s mortality rate? How does it compare to other hospitals in your area? If you knew your mortality rate, didn’t like it, and wanted to improve it, what would you have to do? Questions like these are uncomfortable for most board members and CEOs, because they haven’t often faced such questions before. But mortality rate is a very important indicator of your hospital’s performance on its core mission: to cure when cure is possible, and to heal when you cannot cure. Mortality rate—the likelihood that a patient coming into your hospital for a hip operation, a stroke, or a myocardial infarction—is the ultimate in “stakes” for your patients, your community, and your institution. *And no matter what specific actions you might need to take to improve mortality rates and other clinical performance indicators, you cannot hope to be successful without a close working relationship with your physicians and nurses.*

When risk of dying in a hospital setting is analyzed, one controllable factor stands out: the status of the work force. If your doctors and nurses are happy and working together as a team, you are likely to have excellent performance, in your ICUs, operating rooms, and throughout the entire hospital. If there is serious discord between your staff and the administration, or among various pro-

fessional disciplines, performance starts to slip. Other factors, such as consistent application of all the known scientific evidence to your care process, and ability to promptly place your patients in the right setting for their care (flow management) will undoubtedly also prove to



be important in improving your mortality rate performance. But implementing these and other changes requires teamwork—not only across clinical professional disciplines, but between administrators and clinicians. There is no question that if hospital leaders want to improve performance on mortality and other clinical indicators, the best overall strategy would be to improve the state of the frontline caregivers: doctors, nurses, and other health professionals.

A good example, one that combines all the various lessons above, comes from a prestigious hospital in Boston, in which clinical teamwork had suffered in the wake of a contentious merger. The cardiovascular surgical performance on mortality and morbidity, formerly excellent, deteriorated to the point where it

was the worst in Boston, and continued to worsen. Both the hospital administration and the cardiovascular surgeons knew that they would be embarrassed by these results, if made public, and they set to work to improve performance.

After a difficult process of rebuilding individual relationships one-by-one, and of remaking a team that included the advanced practice and operating room nurses, technicians, and others, they were able to honestly confront their data and design improvements. Some 16 clinical processes were redesigned and standardized according to the best current scientific evidence. By standardizing and simplifying common processes such as prepping and draping, and post-operative insulin management, the team made it easier to do it right, and reduced the potential for serious errors. The coordination and staffing of the post-operative care was improved—including a modest increase in staffing for certain critical care units, approved by administration at the request of the clinical team. Surgeons and nurses worked together, teaching each

other nuances of technique that dramatically reduced pump time. And the results were extraordinary: death rates for coronary artery bypass grafting plummeted to levels better than any known benchmarks!

In this example, the clinical team redesigned their own work and removed many time-wasting activities. With the support and encouragement of the hospital administration, the team standardized around best practice and saved time by making the right thing the easiest thing to do. And they were given control of their own time, in that they recognized an unsafe staffing situation, recommended a solution and then implemented it. Overall, the staff’s pride in their work increased dramatically, along with performance. Turnover of key staff de-



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creased sharply, and recruiting of staff to this team became much easier. Volumes of cardiovascular surgery increased, and financial performance improved accordingly. This team didn't solve all the other problems the hospital faced, but they set an example for how these problems could be addressed. In order to develop healing relationships with their patients, and to reliably cure when cure is possible, they first need to develop healing relationships with one another—administrators, surgeons, and nurses. And they couldn't develop these relationships without time.

It's About Time: Summary

The most powerful determinant of the performance of your health care organization is the state of its work force. If your doctors, nurses, pharmacists and other professionals are locked in combat with your administration, or with one another, there is no question that your clinical and financial performance will suffer accordingly. Although each institution's set of workforce issues varies, there is one overarching principle that can function as a Simple Rule in the com-

plex adaptive system formed by your institution:

Remove everything from your environment that steals touch time from your physicians and nurses.

By doing so, you will start to put a spring in the step of your staff. Improved morale and teamwork will drive improved performance on important clinical indicators such as mortality and morbidity. The mission of your hospital will be more secure. And you will sleep better.

James L. Reinertsen, MD, heads The Reinertsen Group, an independent consulting and teaching practice helping health care leaders create organizational environments in which the work of nurses and doctors can thrive. He brings to this work an unusual combination of skills and experience. He practiced rheumatology for 20 years, earning a reputation as a superb, patient-centered consultant. He has been a respected CEO of complex health care systems in challenging markets for 15 years. Dr. Reinertsen has served as an innovative thought leader in health care leadership development, clinical quality improvement, patient safety, health system integration, and health care market design.

He has also lent his skills and experience to the Institute for Health Care Improvement (IHI), where he is a Senior Fellow, heading IHI's leadership development sector, and to clients such as Sutter Health, Intermountain Health Care, and The Henry Ford Health System, among others. He has continued to lead health care thinking as a subcommittee member of the Institute of Medicine's work that produced the landmark publications "To Err Is Human" and "Crossing the Quality Chasm," and as an author of papers in major medical journals.

From July 1998 to August, 2001, Dr. Reinertsen was Chief Executive Officer of both CareGroup, a six hospital, 1400 physician system, and of Beth Israel Deaconess Medical Center, a teaching hospital of the Harvard Medical School. He is a Professor of Medicine at Harvard Medical School.

Before his engagement at CareGroup, he served as the first Chief Executive Officer of Park Nicollet Health Services (formerly HealthSystem Minnesota) in Minneapolis, an integrated care system that includes Methodist Hospital and Park Nicollet Clinic. He was President and CEO of Park Nicollet Medical Center from 1986 to 1992, and President of Park Nicollet Medical Foundation from 1983 to 1985.

From 1992 to 1997, Dr. Reinertsen was Chairman of the Institute for Clinical Systems Improvement (ICSI), a collaborative effort to develop and implement best practices in health care, sponsored by the Buyers Health Care Action Group, Park Nicollet, Mayo Clinic, and HealthPartners - a Twin Cities health plan. ICSI is a nationally recognized example of what physician groups that otherwise compete with each other can accomplish when they collaborate around common professional and business goals.

A frequently invited speaker on these issues for physician, hospital, and integrated delivery system organizations, he also has authored more than 40 articles in journals such as *Annals of Internal Medicine*, *British Medical Journal*, *New England Journal of Medicine*, and the *Joint Commission Journal on Quality Improvement*. Dr. Reinertsen is Past President of the American Medical Group Association, and is a former member of the Board of Directors of the American Board of Internal Medicine.

He joined Park Nicollet Medical Center as a consultant in rheumatology in 1978, following two years as a Clinical Associate at the National Institutes of Health in Bethesda, Maryland. A member of Alpha Omega Alpha, he received his medical degree from Harvard Medical School in 1973, and completed an internship at San Francisco General Hospital in 1974, and a residency at the University of California Hospital in 1976. Doctor Reinertsen is a 1969 summa cum laude, Phi Beta Kappa graduate of St. Olaf College in Minnesota.

