Estimate of the Situation

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The Affordable Care Act: Real World Impacts and Options

"Whenever you find yourself on the side of the majority, it is time to pause and reflect."

— Mark Twain

Best Practices?

Google the words "best practices", and you will find about 419 million internet pages addressing the topic. Google "hospital best practices" and the list shrinks to a mere 81 million web pages. That this two-word phrase so quickly became a universally-recognized part of the hospital management vocabulary is hard evidence that consultants have been at work.

It's all about timing (and a few other things). Add the buzz word-like popularity of "best practices" to the staying power of a much abused saying ("There's no point in re-inventing the wheel"), stir in the culture's insatiable hunger for instant results, and shake well. You now have the potential makings of real trouble.

"Best practices" have been defined as "documented strategies, activities and approaches shown through research and evaluation to be effective in achieving the highest levels of excellence in productivity, profitability and competitiveness." Part of the concept's appeal is its elegant simplicity. Find the best way to do something and copy it. Problem solved. Ah, if only it were that simple.

Famed management guru Peter Drucker described the modern hospital as "the most complex social organization ever designed by man." That complexity is a fact. For that matter, so are the department heads' frequent claims of "uniqueness." Every hospital differs from all others in literally thousands of ways. These differences exist even among peers that share the same basic mission and challenges.

Is it not interesting that the same managers who are quick to employ the "uniqueness argument" as a defense against adverse performance comparisons are usually among the first to insist that the best way to resolve the variance is to import a solution from "high performers" in their peer group? Aren't these the very departments that were previously claimed to be so dissimilar as to make performance comparisons invalid? (Note: These differences do not negate the value of benchmarking so long as peer groups are selected correctly. (See "How are peer groups selected?" in our FAQ section.)

Here is a short list of hospital-to-hospital differences that can be found in countless combinations and permutations of combinations, each with tremendous implications for productivity, profitability and competitiveness:

- Systems and Work Process Factors
  - Patient access.
  - Nursing care delivery.
  - Medication administration.
  - Order entry.
  - Results reporting.
  - Care documentation.
  - Patient discharge.
  - Supply inventory and control.

- Organizational Factors
  - Organizational structure.
  - Feedback loop reliability.
  - Planning.
  - Information dissemination.
  - Employee work schedules.
  - Patient appointment schedules.

- Resource Factors
  - Clinical equipment.
  - Information systems.
  - Supplies.
  - Human resource numbers, skills and training.
  - Physical space adjacencies, size, and layout.
  - Management skill set.

- Institutional Culture Factors
  - Management focus.
  - Adaptability.
  - Accountability.
  - Timely responsiveness.
  - Work ethic.
  - Employee commitment and buy-in.
  - Medical staff expectations.

The greatest shortcoming of the "best practices" concept in the long term is that it serves to stifle management creativity. Imitation by definition cannot produce progress. It would be more accurate (and instructive) to re-label the "best practices" concept to something like "best practices that we know about--so far!"

More practically, the sheer number of performance-defining variables makes it impossible to identify with certainty those "strategies, activities and approaches" that can or should be universally emulated. The likelihood that visits to "best practices" hospitals will identify an exportable "cause" of high performance that will work in your hospital is vanishingly small.

Although imitation has been described as the most sincere form of flattery, as a technique to advance performance improvement in the modern hospital it may not produce the best results. After all, it does not matter in the least that Mercedes Benz has the best transmission in the world if that transmission cannot operate in your Buick.

We suggest the following approach to applying the "best practices" concept in any hospital: Look inside your organization first! Identify performance-limiting factors. Consider both the cost of "fixing" those factors as well as the cost of not fixing them. Remember that these may involve:

- Systems and Work Process Factors.
- Resource Factors.
- Organizational Factors.
- Hospital culture Factors.

Specify target outcomes. In other words, describe the conditions the hospital wants to exist as a result of resolving performance-limiting factors. Quantify them when possible. An example might be, “Redesign the staffing grid on 3 North to meet labor budget requirements.”

Select, develop and implement the solution that will work best in your hospital. Consider the institution-wide effect on all departments, the medical staff, and other stake holders. For example, “Establish a standard discharge time to improve productivity in Admitting, Housekeeping, Nursing Units, and Dietary”.

It is during this last step that you might consider emulating "best practices" from other hospitals or industries *but only after the potential solution has been thoroughly evaluated to insure that it fits the unique operating and cultural characteristics of your hospital*.

Hospitals have expended much treasure, time, and energy attempting to import "best practice" solutions that had great initial surface appeal but ultimately proved to be unworkable because of internal factors. The best practices for your hospital will be those that most closely match your unique characteristics and needs. We can help you identify them.

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