

# Ask the Right Questions

The key is not to fix problems, but to prevent them.

BY JON A. HULTMAN, DPM, MBA

In the early '80s, "Total Quality Management" (TQM), Statistical Process Control (SPC), Just-in-Time inventory (JIT), Continuous Quality Improvement (CQI), and Theory of Constraints (TOC) were but a few of the many terms that came to be associated with the return of U.S. manufacturing to new competitive levels in the areas of cost and quality. Despite the potential for similar gains in the service sector, healthcare has been one industry slow to incorporate these same management tools. No matter what changes are made as the healthcare industry evolves, higher quality and lower costs will always be essential to success. When applied to a medical practice, strategies utilizing these long-proven techniques can lower costs while increasing quality just as they have done in the manufacturing sector.

One reason healthcare has been slow to adopt the diverse efficiency concepts used by manufacturing is that applying these concepts often results in radical change, which is difficult to undertake. Also, it is easier to

determine *quality* in a product than it is in a service. Applying these manufacturing techniques can result in the identification of problems that are leading to poor quality, and recognition of these causes makes it possible to implement solutions—ones

is that of the Florida Power & Light Company (FP&L). A June 1992 article in the management magazine, *Across the Board*, used FP&L to illustrate the problem of focusing on the "wrong problem." A study of this company revealed that its leaders felt they

---

**No matter what changes are made as the healthcare industry evolves, higher quality and lower costs will always be essential to success.**

---

that will both raise quality and lower costs. Because successful management decisions target identified problems, this process of identification needs to be emphasized. Working to fix the "wrong problem," or simply following conventional wisdom, will lead to poor outcomes just as the wrong surgery, even when performed well, results in a poor outcome.

Business schools teach efficiency techniques by using case studies of companies that have instituted efficient workflow. One classic example

had been successfully implementing TQM and other principles. They were preparing a celebratory visit to their mentor in Japan—Kansai Electric. Feeling they had developed a solution to a serious problem—a way to greatly reduce the time it took to repair their boiler tube leaks and, thus, minimize the significant amount of time the utility would be shut down each time a leak occurred—FPL's leaders were excited and confident. They were hoping to impress execu-

*Continued on page 138*

## Questions (from page 137)

tives at Kansai by demonstrating how quickly they could now repair their leaks.

Arriving in Japan, FP&L representatives started by asking the executives at Kansai how long it took them to repair their leaks. The company's executives seem baffled by this question. At first, thinking that their question had been lost in translation, the FP&L executives restated their achievement in different ways. Eventually, the interpreter translated a reply from the Kansai executives, asking, "Why do your tubes leak?" Kansai had found a method for preventing leaks in the first place and, therefore, had no need to shorten any repair time! Targeting the actual problem—preventing the leaks rather than "fixing" them later, Kansai had eliminated the root cause of boiler tube leaks. This was the superior solution. Because they focused on the real problem, quality was increased and costs lowered.

Similarly, medical practitioners spend a great deal of time

their practices, with little resultant increase in quality or lowering of costs. They are at a loss to explain why. The problem is that they seldom improved processes before programming them into their computers. They are simply the practice's same old paper processes, differing only in that they will now be performed equally inefficiently on electronic screens. By contrast, the focus should

Kansai executives might have asked, "Why do you need to enter this data twice?" After all, each doctor had already marked diagnoses and charges, and once should have been enough; re-entry should have been eliminated altogether. Today, codes and charges flow, as they should, directly from electronic charts, marked by the doctor (or a scribe), to billing. As we analyzed

---

## Preventing errors and problems, not fixing them, is the foundation of cost-reduction and quality improvement

---

be on, "How can these computers be used to *change, improve, or eliminate* processes?"

In my former practice—before the advent of electronic medical records—our search for "correct focus" began in 1992 when we asked the question, "Why do we file 'these' in our charts?" This question led to the discovery of an important bot-

other processes in our practice—from scheduling to people movement—we made similar discoveries by asking the right questions.

It is current practitioners, attempting to make a living in today's highly competitive environment, who have the most to gain by applying manufacturing principles and industrial engineering methods into their practices to create more efficient workflows. As soon as they begin to do so, they will be well on the road to finding the answer to questions akin to, "Why do your tubes leak?" *Preventing errors and problems*, not fixing them, is the foundation of cost-reduction and quality improvement, and while physicians understand such a principle when applied in clinical settings, they seem to have "mental blocks" when it comes to applying these same strategies to operational and financial issues. This needs to change. Practitioners need to initiate change now, and the place to begin is by asking questions—the right questions. **PM**

---

## Medical practitioners spend a great deal of time and money working to fix processes, some of which were not even necessary in the first place.

---

and money working to fix processes, some of which were not even necessary in the first place—their "leaks." Individual practices typically piece process tasks together over a period of years, patching—or "fixing"—various "problems" as they occur. Often, because the individuals re-engineering these processes are focused on fixing rather than preventing, the result is an accumulation of lengthy, cumbersome processes that are rife with waste, bottlenecks, and a wide variation of results.

The journey that many doctors have taken when "computerizing" their offices offers a common example in medicine. Many have spent a great deal of time and money integrating computer systems into

tleneck—the amount of time wasted to file EOBs and numerous other documents into paper charts when these documents were already in electronic form on our computer's server. Filing these unnecessary documents into charts also created very thick medical records which greatly diminished our chart filing capacity. Another one of our office bottlenecks was created by the fact that on the day of treatment, data was entered onto paper superbills rather than directly into computers. The superbill data was set aside and entered into the computer at a later time—sometimes, many days later. This delay reduced our collection percentage. We asked ourselves the question, "How can we eliminate our delay in data entry?"



**Dr. Hultman** is Executive Director, California Podiatric Medical Association, President, Medical Business Advisors, specializing in practice evaluations, valuations, and mergers. He is the author of *Reengineering the Medical Practice and Medical*

*Practitioner's Survival Handbook*.