

VIEWPOINT

Breaking the Rules for Better Care

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A few years ago, the Dean of the School of Business at the University of Leicester, Dr Zoe Radnor, tried to understand the reasons for the “bicycle book” that she discovered at an English hospital she was studying. All staff who arrived at work by bicycle routinely signed a register book at the front door. Hundreds of these registers, once full, had been collected and stored for decades in clearly marked boxes. “Why?” Professor Radnor asked. No one knew.

The answer took some sleuthing. The first books dated from World War II—when rationing of fuel was the rule of the day, and when any staff who commuted by bicycle thereby earned extra food ration credits for saving on gas. Now, three-quarters of a century later, the bicycle book process remained alive and well, embedded in the organization’s brainstem, not its cortex. It was pure waste.¹

Administrative burdens and complexity are alleged to be among the most costly forms of waste in US health care, at levels far exceeding those in other nations.^{2,3} Further, such requirements are said to detract from the care experience of patients and to drain time and morale from physicians and other staff, for whom they disturb value-added interactions.⁴ This Viewpoint describes an effort undertaken in a network of North American hospitals and clinics to explore the types and magnitudes of such waste at the front lines of care.

The Leadership Alliance (Alliance), convened by the Institute for Healthcare Improvement, comprises approximately 40 North American hospitals, associations, and other care systems committed to delivering

Alliance organizations varied in their approaches to identifying unhelpful rules; some formally surveyed their staffs, some hosted organization-wide meetings, and others used volunteers to interview patients and families. Of the 42 organizational members of the Alliance, 24 participated in the “Breaking the Rules for Better Care” effort, and, in 1 week, with the assistance of patients, families, and clinical and nonclinical staff, identified 342 rules perceived to provide little or no value to patients and staff.

Institute for Healthcare Improvement staff reviewed all the rules nominated by participants for duplicates, allowing identification of the total unique submissions as well as the most popular submissions. They then classified the rules into 3 types:

1. Habits embedded in organizational behaviors, based on misinterpretations and with little to no actual foundation in legal, regulatory, or administrative requirements (eg, forbidding drinking water to be available for staff at nursing stations)
2. Organization-specific requirements that local leaders could change without running afoul of any formal statute or regulation (eg, making patients and families pay for parking or restricting visiting hours)
3. Actual statutory and regulatory requirements (eg, the “3-day rule” for patients’ access to skilled nursing facilities—which was by far the most frequently mentioned obstructive regulation).

Of the 342 rules collected, 57 (16%) were type 1; 211 (62%) were type 2; and 74 (22%) were type 3. The Table shows the 10 most common rules suggested for change and the number of times each rule was suggested.

Many Alliance members took action on rules identified by their patients and staff. Four types of action were most common: (1) debunking myths about nonexistent or misinterpreted regulatory and administrative rules through staff education, (2) seeking clarity from

appropriate regulatory agencies about the true scope and intent of rules, (3) changing local administrative policies for which no sufficient rationale could be found, and (4) speaking with “collective voice” to policy makers about regulations harmful to care or wasteful of limited resources. (The last category included meeting with Centers for Medicare & Medicaid Services leaders to discuss the adverse effects of the 3-day rule and the excessive number of federally required measures.)

Contrary to initial expectations, although wasteful statutory and regulatory barriers existed, the majority (265/342 [78%]) of obstructive and wasteful rules identified by patients and staff were fully within the administrative control of health care executives and managers to change.

The majority of suggestions from staff for changing rules were aimed not at their own conditions of work

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on the promise of the “Triple Aim”⁵: better care for individuals, better health for populations, and lower per capita health care costs. Alliance participants have defined, and are continually refining, a set of “radical redesign” principles⁶ to guide transformational changes in health care delivery. One of the redesign principles is “Make It Easy.” This principle calls for the continual removal of administrative barriers that contribute little or no value to care, impede the work of clinicians, frustrate patients and families, and waste time and other resources.

In January 2016, the Alliance declared a “Breaking the Rules for Better Care Week,” in which the leaders of each participating organization were encouraged to ask their patients and staff a simple question: “If you could break or change any rule in service of a better care experience for patients or staff, what would it be?”

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Table. Breaking the Rules for Better Care: Most Frequent Suggestions

Rule	Frequency of Suggestions
Visiting hours: Eliminate visiting hours and other restrictive policies that reduce the ability of families and loved ones to be with patients.	15
Three-day rule: Eliminate the CMS rule that requires a patient to spend 3 consecutive days as an inpatient in a hospital to qualify for Medicare coverage of a skilled nursing facility, to provide patients with the right care, in the right place, at the right time.	13
Licensure: Ensure that each member of the care team is operating at the top of his or her license to improve patient flow (eg, allow front-desk staff to make appointments rather than triage nurses or allow transport staff to move patients from the bed to the wheelchair).	13
Patient access: Improve patient access to appointments and to their physicians between appointments (eg, make more same-day appointments available or provide a daily "call-in hour" so patients can talk to physicians directly).	10
Waiting time: Reduce the time patients and families wait for appointments, to go into surgery, or to be discharged, to respect their time and reduce their anxiety. Participant suggestions included better application of queuing theory, demand and capacity planning, avoiding double booking, and giving patients a discharge schedule to know what to expect.	10
HIPAA: Revamp current HIPAA regulations or clarify myths about HIPAA that lead to delays and difficulty in communicating with patients, families, or other care providers.	8
Engage families: Identify better ways to engage loved ones near and far to support patient healing.	6
Sleep interruption: Reduce unnecessary interruptions to hospitalized patients during the night to help patients sleep and heal.	5
Paperwork: Simplify paperwork and reduce rework to ensure patients do not need to provide duplicate information and to reduce administrative burden.	5
Patient mobility: Ambulate patients more during their hospital stay to improve healing and reduce harm.	5

Abbreviations: CMS, Centers for Medicare & Medicaid Services; HIPAA, Health Insurance Portability and Accountability Act.

but rather at better attending to the comfort of patients and families, alleviating their physical, emotional, and financing concerns.

Many of the rules suggested by staff related to issues many organizations have been working to address for years: visiting hours, wait times, and access. Yet these issues persist in many hospitals and clinics, including the most pioneering of institutions. In most cases, staff had very specific recommendations for how to address long-standing issues such as access or wait times. For example, one staff member suggested a "doctor call-in number" to improve access—an option already in place at their child's pediatric practice. While the rules most frequently suggested for change were often complex, many were as simple as the 1-blanket-per-patient limit or not offering food to the partners of maternity patients.

This exploration among Alliance members had several limitations. Most notably, it was not always possible to determine whether a suggested rule was a habit, myth, or in fact a rule for which alteration required modifying a regulation or law. Generalizing from this effort to a clear profile of wasteful habits, myths, regulations, and

laws is not appropriate. A more complete study would standardize data definitions and processes for eliciting candidate rules for change. In addition, a more methodical inquiry into the historical and current rationales for obstructive rules would be wiser than simply encouraging anarchy.

Nonetheless, these suggestions from the Leadership Alliance indicate that health care organizations can take direct action to reduce a substantial portion of the onerous administrative waste often reported in US health care, without requiring politically difficult battles to alter regulations, laws, or payment rules. As is often the case in complex production systems, much wisdom lies within the workforce and among those they serve. If asked, in a safe environment, to identify senseless obstacles to productive work, they can and will do so in service of providing better care for patients and families. Health care leaders may be well advised to ask their clinicians, staffs, and patients which habits and rules appear to be harming care without commensurate benefits and, with prudence and circumspection, to change them.

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