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THE LANGUAGE OF VALUE ANALYSIS

Greetings from Carol Stone

This issue of our newsletter focuses on the language of value analysis. As Value Analysis Professionals, you understand and speak a language unique to the profession when you talk CPT codes, DRGs, rebates, NPVs, and all of the other abbreviations and terms that roll easily off your tongue. However, these terms are not necessarily readily understood by your clinical customers, by your various stakeholders, and perhaps even by some of the newer members of the profession who haven't yet gotten all of the terminology under their belt. Therefore, in this issue, we'll define the most commonly used terms, review why they are important, and determine how to best communicate the importance of the concepts they represent to others.

We'll also take a broader look beyond the language itself, to the impact 'speaking a different language' has on individuals and our working relationships. We'll look at how to recognize some of the signs that communication has gone astray, and focus on how to communicate, even while using a 'different language,' in a way that helps all parties understand one another and work together most productively.

As always, I hope you enjoy this issue. At Bard, we appreciate receiving your feedback on the newsletter, so if you have any suggestions for future topics, or just want to tell us what you like about the newsletter or how it could be improved, send me an email. If you know of others who would like to receive the newsletter, we would be happy to add them to our distribution list. Just forward their names and mailing address to me at carol.stone@crbard.com.

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THE LANGUAGE OF VALUE ANALYSIS:

THEORETICAL PERSPECTIVE

When you think about it, we all speak differently. What we say, and how we say it, are influenced by our gender, educational level, life experience, and preferred way of communicating. Most of the time, this diversity does not create a problem – we talk about the weather, share our thoughts, order our lunch, and as such, get through our days.

However, when the interactions are more sensitive – when arguing with a teenager, communicating your needs to your spouse, or engineering change in the workplace – the language we use becomes much more significant. Recognizing and accommodating differences in communication styles between individuals increases understanding, and inspires trust, personal accountability, and increased cooperation. Better communication avoids resentment and mistrust. Conversely, misunderstandings breed tension and conflict.

Our Model

Our own 'model' of the world, the one each of us formed through our experiences, influences how well we listen and communicate. Not only do we use different words, but the words we use may have different meanings to us than to someone else. In their book – *Messages: The Communication Skills Book* – McKay, Davis, and Fanning note that some of the words we use every day can mean very different things to different people.*

Different Meanings

Words we use to defend a proposal, change, or teammate, can be interpreted in a variety of ways by others, depending on their job, their goals, their own personal values, and even their mood that particular day. That observation tells us that in addition to being clear with acronyms or phrases that become the shorthand of a particular profession, be it value analysis, medicine, law, or short-order cook, we need to consider so much more.

For example, think about the words in the table below. In a team meeting, one member could state "I think we should go with Dr. Smith's analysis. He is the most ***qualified*** in this situation." Around the table, heads nod, yes, Dr. Smith is the most qualified. However, Anne is thinking he is most qualified because he has the most years of experience on the team. Jim is thinking, yes, he is the most qualified because he is the head of surgery. Pete is thinking, OK, I'll go along, but I'm not sure he is the most qualified. Sure, clinically he knows the most, but I have the most information on the competitor's products, I've done all the financial analyses on this project, and I don't agree with everything Dr. Smith concluded. But, since others think he is most qualified, I guess he is, since he is our only clinical representative, so I'll go along. And on and on, around the table, with everyone defining 'most qualified' in their own way.

Understanding

McKay, et al suggest that most people talk in ways that make it hard for others to understand their experiences. They discuss four language patterns that prevent people from understanding one another: ***1) deletion, 2)vague pronouns, 3) vague verbs, and 4) nominalization.***

Deletion

Deletion refers to material or information left completely out of a sentence. To make communication clearer, listeners can ask qualifying questions to fill in what was missing. Examples of the deletion pattern include statements like "I'm ready," "I want help", "Ann is the worst," "This won't work," and "I don't see it." We all speak in these clipped, short comments, that don't really help others understand our thoughts or the reasons behind the conclusions we are stating.

Vague Pronouns

Use of **vague pronouns** often results in confusion or misinterpretation. Vague pronouns include: They say the proposal isn't correct. (*Who are they?*) It's going wrong. (*What is?*) That's not true. (*What isn't?*)

Vague Verbs

We also use **vague verbs**. I *love* the idea. (*Specifically, what do you like?*) The vendor *pushed* too hard. (*What did he do or say?*) You *missed* the point. (*What is incorrect or misunderstood?*)

Nominalizations

Finally, McKay and colleagues define **nominalizations** as abstract nouns that give the false impression of being concrete things or events. Examples include 'the problem,' 'this discussion,' and 'your opinion.' Nominalizations don't clearly denote something people can agree on. If someone mentions 'the problem' everyone around the table may all nod that they agree about the problem, but everyone may be defining 'the problem' in a different way.

***Just as a start,** think about how we use the words below in our interactions at work:*

Fair	Obligation	Best	Logical	Confusion	Cheated
Critical	Qualified	Accurate	Believable	Good	Easy
Support	Help	Cooperation	Energy Level	Commitment	Nice
Trustworthy	Necessary	Right	Intelligent	Dedication	Practical

THE LANGUAGE OF VALUE ANALYSIS:

PRACTICAL PERSPECTIVE

Value Analysis, like other professions, uses terms, phrases, and words that become second nature to those in the discipline. However, when others in clinical departments listen, they may think the Value Analysis Professional is speaking 'Greek.' Certainly, there is no intention to speak in ways that others won't understand. However, we become so comfortable that thoughts come out in our own 'language.' Sometimes, a listener will stop and ask for a definition. But, usually, the conversation just rolls along, with the parties departing thinking that all is clear and resolved, while that is far from the truth.

In this issue, we've compiled some of the terms that are used routinely by Value Analysis Professionals. Are you comfortable with these terms? Is there an opportunity to educate your key stakeholders about what these terms mean, so when they roll off your tongue, the stakeholder understands?

Commonly Used Terms

Capital Expenditure/Capital Equipment – a fixed asset – land, buildings, equipment.

Cash Discount – reduction in price offered to a purchaser if payment is made within a shorter period of time than the maximum time specified.

Caveat Emptor – "Let the buyer beware." A seller is more familiar with the product, the buyer must watch out for his own interests.

Caveat Venditor – "Let the seller beware." The seller must deliver what has been promised to the buyer.

Charge – a debt or debit.

Condition Precedent – an event, defined in a contract, which must occur before parties to the contract have any obligations.

Conflict of Interest – person involved with two organizations or groups such that one can benefit at the expense of the other, or involvement with one group makes it difficult to act objectively with regard to the other.

Credit Limit – the value a seller places on a customer's credit; seller's judgement of the amount of debt a customer can incur and still pay the firm.

Depreciation – reduction in value of a fixed asset because of wear and tear from use.

Finance Charge – difference between the price of a cash purchase and the total paid by a customer who finances the purchase.

Fiscal Year – any period of 12 consecutive months used as a basis for reporting financial activity or budgeting.

Fixed Asset – any permanent asset that cannot be disposed of without interfering with the operation of a business or organization.

Fixed Cost – expenses that do not vary with business volume, like rent or taxes.

Markup – difference between the selling price of an item and the cost price.

Maturity – the date upon which the borrower of a loan, note, or bond is obligated to pay the full amount of the debt.

Obsolescence – a reduction in the value of a fixed asset resulting from revolutionary inventions, unusual growth, or development or other factors that make it not useful before the end of its normal life.

Operating Expenses – expenses incurred in conducting the normal operations of the institution.

Overhead – costs incurred that are not applicable directly to the services offered by the institution.

Present Value – because money has earning power, value of a sum of money at a given date, which is less than a future date.

Rebate – a deduction from a fixed payment, not taken at the time of payment, but like a refund is returned to the buyer after the full amount due has been remitted.

Key Financial Indicators

Direct Cost – the fixed and variable costs of all resources (goods, services, etc.) consumed in the department. Includes direct medical costs and direct non-medical costs (for example, transportation or child care).

Indirect Cost – a cost that cannot be directly attributed to a particular department, but that is borne as part of an overall operation. For example, payroll expenses of senior management, utilities, and general legal expenses are indirect costs.

Indicators – quantitative measures used to measure the performance of outcomes of one or more departments. Indicators are calculated using data elements. For example, the direct cost data element is used to calculate the direct cost per adjusted discharge indicator.

Tier Pricing – pricing based on volume and/or dollars or units.

Total Supplies – represents the net expense (cost including freight and distribution fees less rebates) for all patient chargeable and department consumable supplies for all cost centers. Supply items have an expected life of less than one year unless they are used for the repair and maintenance of equipment.

Key Clinical/ Reimbursement Indicators

APC – Ambulatory Payment Classifications organize CPT codes into groups that are assigned a fixed reimbursement amount. This affects

Medicare payment in the hospital outpatient setting. The cost of devices and supplies are included in this bundled payment.

Category III Codes – Temporary codes for emerging technology, services, or procedures that require further analysis before being given Category 1 Code or not. As these codes are assigned to emerging technologies, some payers may deny or delay payment.

CPT – Current Procedural Terminology – a coding system used to describe services and procedures provided by physicians. Produced, maintained, and revised by the American Medical Association, it is updated annually. CPT codes are five-digit codes and represent the 1st level of HCPCS codes or approximately 90% of HCPCS.

DRG – Diagnosis Related Groups are a classification system used to identify distinct types of hospital inpatient cases and are the foundation for Medicare's inpatient payment system. There are currently 508 DRGs that classify patients into clinically cohesive groups that demonstrate similar resource consumption by hospitals.

Fee-for-Service – A billing and reimbursement method in which a physician charges for each medical service or unit provided to a patient.

Global Period – A defined period of time (0 to 90 days) during which all medical services related to a similar condition or diagnosis are included in the payment for the initial surgery.

HCPCS – Healthcare Finance Administration's Common Procedural Coding System – the federal government's three-level coding system that standardizes coding for the Medicare and Medicaid programs and has been adopted by the majority of third-party payers. Level 1 is CPT codes. Level ll codes are National codes for services and supplies not found in CPT i.e., durable medical equipment, injectable medications, and ambulance services. Level ll codes are five-digit and begin with letters A-V. Level lll codes are local codes approved by CMS for use only in a state or region and begin with the letters S,W,Y, and Z.

HOPPS – Hospital Outpatient Prospective Payment System is Medicare's system for paying hospitals for services rendered to beneficiaries in the outpatient setting. These payments are based on Ambulatory Payment Classifications (APC) that group similar procedures based on resource utilization.

ICD-9 – International Classification of Diseases-Ninth Revision – developed by the World Health Organization in Switzerland, it is used by virtually all third-party payers in the US to describe patient condition. ICD-9 is separated into diagnosis and procedure codes.

IPPS – Inpatient Prospective Payment System is Medicare's system for paying hospitals for services rendered to beneficiaries in the inpatient setting. These payments are made based on a patient's assignment into one or more Diagnosis Related Group (DRG).

Pass-through Codes – Codes assigned to new or innovative drugs, biologics, or devices whose cost are not insignificant. Developed in order to gather information on costs so that a technology could be appropriately placed into outpatient payment group. These products were given C-codes for a period of not less than two but not more than three years. (C codes are also used to identify device categories when CMS sets their yearly payment rates.)

Payer – the person or organization that pays a healthcare provider for healthcare services prior to or after the services have been provided.

Profiling – an analytic tool that uses epidemiological methods to compare practice patterns of providers on the dimensions of cost, service use, or quality of care. The provider's pattern of practice is expressed as a rate aggregated over time for a defined population of patients.

Revenue Codes – Internal accounting codes developed by the American Hospital Association (with input from private payers and CMS) that are used to group categories of service such as lab services, nuclear medicine, med/surg supplies. ❖

FOOD *FOR* THOUGHT

In our very busy world we have become task oriented. We have something to accomplish in a short period of time, and it is just one of the many items on our 'to do' list. Thus, we forge ahead in our conversations with others, get our business done, and move on to the next task. Rarely do we 'check in' to see if the other person heard our intended message. Only if there is obvious confusion do we notice non-verbal cues from the other person that they may not be following our train of thought.

So, how can you slow yourself down to make sure that your language is clear, that you haven't used terminology foreign to your listener, and that you walk away from every interaction ensuring that your message was heard and understood as you intended?

Try the following:

- Really listen to yourself talk – how many buzz words or terms particular to Value Analysis are you using when in conversation with others or when you are in a team or committee meeting?
- Really observe your listener. Can you see their eyes glaze over? Do you sense any hesitation as they are listening to you? Are they trying to get a question in – as you continue speaking – and then they never ask?
- Take the time to check in at the end of a conversation – see if the person really understood your message.

You may find that just by forcing yourself to SLOW DOWN, listen to yourself, and observe others, you will readily sense times when your listener doesn't understand your message.

SHARE *Your* VIEW

Melanie Davis is a Value Analysis Manager. She has been in her position for eight years. She was the first VA Professional hired in her hospital, and she has been critical in building the department, and the discipline, over that time. She loves her job, does it well, and is active in several of the VA Professional Societies. She has made VA her career.

The downside, she is so involved, and so happy, with what she does, that she forgets that the world of her customers and stakeholders doesn't revolve around value analysis. She often speaks in terms that aren't familiar to people. She easily does calculations in her head, rattles off numbers, and is not always patient with those who don't see how she got her answers, and drew her conclusions about the best plan of action. While people like her and respect her, she is not as effective as she could be if she just "fixed" this aspect of her performance.

If you were her supervisor, what would you advise Melanie to do?

SCENARIO 1

Melanie should go to a management development program, where she can receive 360-degree feedback from her colleagues. If she understood her impact on others, it may help her to change her behavior.

SCENARIO 2

Melanie should continue as is, and not change anything. She loves her job and is happy. People like her and respect her. Over time, others will catch on to the terminology she uses.

SCENARIO 3

Melanie should identify one person from her teams who can act as her mentor in this area. When Melanie starts to use terms and phrases that are unfamiliar to others, and turn them off, her mentor can give her a prearranged sign. Melanie can then correct her behavior 'in the moment.' ❖

Email your thoughts on this case to gardner@gmced.com. A sample of responses will be published in the next issue.

Potentially Useful Web Sites

- American Hospital Association **www.aha.org**
- American Medical Association **www.ama-assn.org**
- Association for Healthcare Resource and Material Management **www.ashcsp.org**
- Association of Healthcare Value Analysis Professionals **www.ahvap.org**
- Centers for Medicare & Medicaid Services **www.cms.hhs.gov**
- National Association Healthcare Quality **www.nahq.org**
- Healthcare Financial Management Association **www.hfma.org**
- Association for Benchmarking Health Care **www.abhc.org**

What's Your Reality?

Suggestions for dealing with daily issues...

Do you ever feel like your team meetings mimic the old Abbott and Costello routine – *Who's on First?* However, in that setting, where you are responsible for getting things done, you may not find misunderstandings and miscommunication to be very funny.

As you are well aware, teams are made up of people with different backgrounds, experiences, education, perceptions, and personal baggage. Have you seen what should be a routine team meeting go quickly downhill because of poor communication that generates misunderstandings, resentment, and lost time?

Routinely, teams are presented with incomplete or disorganized information, too much data, not enough data, or a message delivered in a way that is inappropriate for the group at hand. There are many barriers to effective communication, including, but not limited to, the jargon or use of unfamiliar terms discussed in this issue.

The next time you see a team meeting going astray because of poor communication, it may help you to get the group back on track if you can identify what is occurring, and then find a solution to that particular problem.

Potential barriers to communication you may observe:

- *Expectations/Preconceived notions about other team members*
- *Personal agendas getting in the way of team goals*
- *Emotions taking over*
- *Harried/busy schedule preventing members from listening or considering other opinions – just want to get it over with*
- *Jargon and terminology*

SHARE YOUR VIEW...

In the last issue, we met Donna Samuels. Donna has been a Value Analysis Manager for five years. Donna is having trouble managing her various teams – they have trouble making decisions, and team members are beginning to drift away. Donna took to heart her supervisor's criticisms regarding her approach to teams, and she wants to learn all she can about creating high performance teams. We offered three scenarios for where she should begin.

SCENARIO 1

She should immediately take a course.

"While a course is sometimes useful, it is not always the panacea. Assuming it fits into her schedule, Donna can take a course, but she should concentrate during the training on finding practical ways to apply what she learns when she is back on the job."

SCENARIO 2

She should hire a consultant to work with each of her teams..

"If Donna has the money for a consultant, this may be a good way to 'shake things up' and get the team back on track. A consultant can often raise issues or identify personality conflicts that an internal person can't. The consultant might initially sit in on team meetings, diagnose the team problems, and then work with Donna to develop an action plan. Once the plan is developed, Donna may be able to proceed on her own."

SCENARIO 3

She should determine the role of each of her groups and prioritize developing only some of them into high performing teams.

"This is an excellent idea, because not all groups are meant to be high performing teams. If Donna sets realistic expectations for herself, her groups, and her supervisor, she may be able to concentrate her efforts on those one or two groups that really do need to operate as a team, and then spend the time to develop them into high performing teams." ❖

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Our thoughts and messages are lost if our listeners don't understand a word we say.

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