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### About FYA

FYA - *For Your Advantage*, is a free twice - monthly newsletter published by TrendLeader Connections.

With every issue, FYA provides insights into the topics that concern healthcare leaders today and the challenges that will be faced in the near future.

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## Exploit, Explore or Both? State of the Art Innovation

By John W. Kenagy, MD, MPA

How do "state of the art" innovators do it? This 100th issue of FYA develops the answer. First, the best companies excel at developing and innovating their current methods, products and services. They extend from their core and it is very difficult to beat the best in any industry (technology, manufacturing, sales, services or healthcare) at what they do.

Secondly, it is equally clear that the best companies have difficulty innovating outside their current business models, organizational structures, habits, behaviors and values. In other words, it is hard to innovate outside of your core and culture - and that creates opportunity for competitors. "State of the art" innovators create from both inside and outside their core, but they are rare (historically, less than 10 percent of companies). So how can your institution become a "state of the art innovator?"

You have to think and act differently. Leading companies are great at exploiting their current capabilities, but uniformly poor at developing new opportunities because it takes a different alignment and culture to explore.<sup>1</sup> In last month's FYA, I introduced a chart that compared the differences.

Alignment of:	Exploitative business	Exploratory business
Strategic intent	Cost, profit, hit targets and goals, ROI	Innovation, growth, risk and reward, new value
Critical tasks	Operations, efficiency, improvement, implement new technology	Develop new products and services, breakthrough innovation
Competencies	Operational solutions, on-time on-budget, profitability	Entrepreneurial solutions, funding and growth
Structure	Formal, mechanistic	Adaptive, flexible
Controls, Rewards	Margins, measures, compensation	Milestones, growth, incentives
Culture	Efficiency, stability, low risk, quality, customers	Risk taking, speed, flexibility, experimentation
Leadership role	Authoritative, top down	Visionary, involved

(Continued...)

<sup>1</sup> Adapted from O'Reilly C, Tushman M. "The Ambidextrous Organization." Harvard Business Review, April 2004.

### Exploit, Explore or Both? State of the Art Innovation (Continued...)

Where does your organization align? In my experience, almost all established firms and large health care organizations have an exploitative business alignment. And all is fine until the opportunities start to dry up or new business models begin to compete. I introduced the 10 warning signs for trouble in last month's FYA:

#### The Ten Warning Signs for Exploitive Organizations

1. Profitability is increasingly challenging.
2. There is an increasing need to focus on "the numbers."
3. It is necessary to exit established, traditional lines of business because they are no longer profitable.
4. Increasingly aggressive competitors are taking advantage by competing "on a different playing field." Somebody is changing the rules of the game.
5. Consolidation and merger/acquisition strategies are necessary to maintain profitability by taking capacity out of the system and/or gaining market power.
6. Cost cutting and downsizing become key business tactics.
7. Regulation increases at the same time as organizations seek governmental support to maintain viability.
8. Consultants emerge with more and more "fixes."
9. New, expensive technology seems increasingly the only answer.
10. People start to talk about "transforming the industry."

Exploitative businesses faced with these signals need to develop an exploratory alignment to continue to grow and prosper. And therein lies the rub; historically less than 10 percent of exploitative businesses can make the transition.

Ninety per cent of organizations fail to develop new, exploratory opportunities because they work inside their current

business structures and with their current capabilities, methods, habits, behaviors and values. The mantra is, "We have been successful in the past, let's leverage our strengths." Ideally, it would work, but the problem is exploratory innovation needs a different alignment, a different set of capabilities and a different culture. Therefore, current business capabilities and structures often become disabilities when developing something new.

The 10 percent that make up the state of the art companies (e.g., Toyota, Intel, Alcoa) does something different. Instead of leveraging their capabilities inside, they create separation between the current and the new; organizationally distinct units, but tightly integrated at the senior executive level. "Separation allows the exploratory business to create an appropriate alignment and new, unique processes, structures and cultures. Top-level integration ensures that the fledging units have access to established resources - cash, talent and customers - and simultaneously insulates them from the innovation-chilling effects of "business-as-usual."<sup>2</sup>

Kenagy & Associates, LLC, uses Learning Lines<sup>sm</sup> to create organizational separation inside hospitals (e.g., see FYA's 3/20/06 and 4/20/06). What is your experience? Have you created separation between the established and the new? How have you overcome the "innovation-chilling effects of business-as-usual?" What are your ideas? Send me your comments, ideas and experience so I can share them with your fellow-readers in next month's FYA. Email me at [jkenagy@kenagyassociates.com](mailto:jkenagy@kenagyassociates.com) then next month we will continue the story.

<sup>2</sup> *Ibid*, p.2.

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#### About



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## Indigent Care-Time for a Regional, Not Individual Hospital Approach

By: Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

The status quo can be a wonderful thing-if it happens to be working for your advantage. But the status quo for indigent care isn't working well for many of the indigent and those hospitals providing most of the indigent care. Some of the providers are starting to challenge the antiquated indigent care status quo.

Consider Parkland Health & Hospital System in Dallas, the Dallas County public hospital. Most would agree that Parkland does an outstanding job of providing high quality indigent patient care-but Parkland has a problem with the way in which indigent care is being financed. Although Parkland's mission is to provide healthcare "to the indigent and medically needy of Dallas County," Parkland also provides care to indigents who are residents of other counties throughout the North Texas Region, as well as, Mexico and South America.

In 2005 Parkland had \$76.5 million in total medical care costs for non-Dallas County residents, of which over \$26.8 million was not reimbursed. That means that Dallas County taxpayers paid \$26.8 million to provide care for indigents from neighboring counties and countries who aren't contributing anything to Parkland for the costs of that care.

Each Texas county has the legal responsibility under Texas law to be the last payer of last resort for indigent healthcare. However, Texas law has a huge loophole that allows each county to set its own standard for indigence and eligibility for financial assistance subject only to a minimum standard that includes individuals with income of less than 21 percent of the federal poverty level (which is only \$4,100 per year for a family of four). Parkland believes that minimum would unreasonably deny healthcare to huge numbers of indigents, and so Parkland sets its definition of indigence at 200 percent of the federal poverty level (\$38,700 for a family of four). Accordingly, if a county chooses to use the extremely low level allowed by Texas law to define indigent care, the county can then legally avoid financial responsibility for most indigent care and shift the cost of that care to neighboring counties like Dallas County. This is exacerbated by the fact that Dallas County and nearby Tarrant County (Ft. Worth) are the only counties in the region that have publicly funded hospitals. Thus the status quo works fine for most neighboring counties and countries because Dallas County residents are paying for much of the care for residents of those counties.

Dallas County's innovative response to this unacceptable status quo: the Dallas County Commissioners are sending bills to neighboring counties and countries for their share of the costs of indigent care for their residents. The Commissioners hope that quantifying the indigent care costs by county and country will help to demonstrate the inequity of the current status quo and will cause the neighboring counties and countries to agree to shoulder their share of the costs of providing indigent care to their residents.

Hopefully, this highly publicized novel approach will lead to a fair and equitable regional approach for providing and financing indigent care costs in North Texas, rather than the unacceptable status quo.

What do you think (I confess that I'm biased since I am a member of the Board of Managers of Parkland)? Do you have similar problems in your region? Do you have other approaches to suggest?



**I would like to hear your comments.**

**Send them to:**

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### About

**TrendLeader**  
Connections

FYA - For Your Advantage is brought to you by TrendLeader Connections. The function of TrendLeader Connections is producing educational materials and seminars that help healthcare executives differentiate between fads and trends; and making connections with "Trend Leaders" within the healthcare industry.

We are committed to delivering new perspectives and ideas, creative and innovative healthcare solutions, provocative concepts and quality educational materials to today's healthcare leaders. We want to concentrate on "what comes after what comes next."

## END PIECE: The Hospital That Could

**W**ould you like to read about success where failure is common? Here's the story of an inner-city hospital that was expected to fail and did-until it implemented a two-year turnaround plan that is working. Last year, the hospital had a surplus of \$2.6 million dollars. Two years ago it had a loss of almost \$20 million.

This is the story of 200-bed North General Hospital in Harlem, New York. It's located in a low income black and Latino neighborhood. The hospital struggled with minimal government reimbursement rates. Its basic service was providing low-margin routine checkups and physical exams.

Samuel Daniel, MD, the CEO of North General, and his management team were determined to turn the hospital's prospects around. The first thing they did was focus more on treating ailments that existed in Harlem in high rates. This included cardiovascular problems, hypertension, obesity, diabetes and infant mortality. It expanded the surgical procedures that brought in additional revenue. It promoted its services at neighborhood fairs and community centers. And it established an alliance with one of New York's most prominent teaching hospitals located one mile away-Mount Sinai Medical Center. This gave North General access to higher skilled specialists than it could afford to hire.

North General pays Mount Sinai \$2.7 million annually to gain access to 16 Mount Sinai doctors who perform vascular surgery, lung biopsies and other highly specialized services at North General. Among the special services are urology, rheumatology, radiology and pediatric psychiatry. North General receives the revenue from these services.

The contract with Mount Sinai gives North General staffing flexibility because it can ask Mount Sinai to send specialists for extra hours as more patients come in for these specialty services. This helps North General control labor costs by linking a doctor's work hours to patient volumes.

Mount Sinai benefits with higher revenue from higher volume. Last year, North General transferred 375 patients to Mount Sinai for cardiology, neurosurgery and obstetrics services. As a teaching

hospital managing complex cases, Mount Sinai needs a referral source from community hospitals.

North General's plan is working. From 2002 to 2005, the number of patient discharges jumped 40 percent to nearly 9,000, and is expected to rise to 9,225 this year. Outpatient volume in that same three year period rose 32 percent to 95,746 visits. The hospital expects 103,520 visits this year.

During the three year period leading up to 2005, North General's revenue rose 45 percent, largely from higher patient visits-including surgical procedure volumes that jumped nearly 20 percent. This year, the hospital estimates revenue will rise 2.7 percent to \$152 million from \$148 million last year.

Two years ago, North General began offering bariatric surgery. Last year, the hospital performed 109 such surgeries and expects to perform 125 this year. Medicare and Medicaid typically pay the hospital \$10,000 to \$12,000 for each bariatric surgery-with complicated procedures bringing in as much as \$20,000. Last year, the bariatric surgery program generated \$725,000 in revenue and \$25,000 in profit.

North General added ambulance service in 2002 and expanded it in 2004. This boosted its emergency room visits by 16 percent to 34,450 in 2005 compared to 2002. The hospital estimates that eight of 10 patients who are admitted to the hospital come through emergency room visits.

A two-year-old Women's Health Center designed to combat infant mortality-a large problem in Harlem-handled nearly 4,000 visits last year. In 2005, the hospital expanded its AIDS center and opened a new cardiac-catheterization laboratory. AIDS testing, which is profitable, amounted to 6,400 visits last year and expects 7,250 visits this year. Since opening in December, the catheterization laboratory has handled 152 visits and projects 300 cases by the end of this year.

North General faces all the obstacles that doom inner-city hospitals, yet it is showing signs of health through innovative actions.

*(The Wall Street Journal was the primary resource for this information.)*