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FYA Staff

Publisher Jerry F. Pogue
Editor S. Harvey Price
Web Master Joel Schlarb
Circulation Manager Sheila Keizer

TrendLeader Connections

26 Shawnee Way, Suite C
Bozeman, MT 59715
(406) 586-6400

Maximizing Authority Power in Healthcare

By John Kenagy, MD

Authority has taken a tough rap lately. Authority was a scourge and a curse for many of us who lived through the infamous '60s and '70s. But suspicion and fear of authority is not just a flower-child phenomenon.

Many people are uncomfortable with authority; it is something they want to avoid. That's a problem both for those in positions of authority ("how do I get them to do what I need") and those they manage ("what they want is not what I need to do").

Authority is an important topic in my book *Designed to Adapt: Leading Healthcare in Challenging Times*. This column is adapted from the book's Chapter 10 on leadership. Book references are provided for those who want more information.

"Authority power" is commonly confused with "position power." The President of the United States has lots of position power, but that does not equate automatically to authority power. For example, we gave President Bush great authority power during the troubled times of 9/11 and the Iraq War. But by the end of his last term, he was still President Bush, but had very little true authority power.

Position power and authority power are linked, but different. Position power is tied to a job description. Authority power is an essential human attribute that allows us to work together in coordinated ways for common benefit. Humans, as social animals, have built-in respect for authority. It is part of our DNA.

Think about it. When in trouble, we look to our leaders (organizational, political, religious, familial) for help. If they deliver on our expectations, we value it and will grant them more authority power. But if they fail to deliver, we withdraw that grant. Although they may retain position power, they lose something much more potent – the power of authority.

Authority power is embedded in the context of relationships, not a position. For example, a frontline worker may not have much position power, but she can gain a great deal of informal authority power from those she works with if she delivers on their expectations.

Humans are genetically hard-wired to expect authority to deliver on three essentials, particularly in times of stress. It's in our make-up. If you want to enhance your authority power, these are your three key deliverables.

First, we grant authority **the power to set direction**. When in trouble, we expect authority to show us the way. We need direction, a meaningful, common purpose to work together. We also expect authority to inspire us to reach beyond ourselves. In my research, I spoke with many people who worked in great adaptive organizations; they always told me, "We knew where we were going!"

Second, we give authority **the power to protect** – and we expect that protection. Great leaders make it safe to challenge the status quo to test and discover new methods. We expect them to vigilantly scan for and defuse potential threats. We also give them the power to mobilize and redirect resources in response to threats. Whether a successful manager, vigilant policeman, experienced teacher, great general or good parent, we expect protection and grant effective leaders the authority power to provide it.

Third, we grant authority **the power to create order**. "Help us work together effectively." We anticipate, in times of trouble, to be orientated to our places and roles. We expect authority to control internal conflict and remove barriers to success. Finally, authority helps us establish methods and norms of behavior for our common good. In his popular book, *Good to Great*, Jim Collins identified *structure* and *discipline* as two key characteristics of greatness. But to go from good to great, that order must generate consistent, valued results, not rigid standardization.

Deliver on those three attributes – Direction, Protection and Order (DPO) – and you will gain power no matter what your position. Fail to deliver DPO and your power is diminished, no matter what your title.

(Continued...)

Maximizing Authority Power in Healthcare (Continued)

When to Use Adaptive Design (AD)? It depends on the problem.

Types of Problems	Problem Definition	Problem Solution	Examples	Use AD?
I. Technical: predictable, mechanical, mechanistic solutions	Clear	Clear	Pick instruments for or schedule a surgery. Do an appendectomy. Send invoices. Get your kids to school.	No
II. Complex Technical: linked mechanistic solutions	Clear	Difficult to define, complex, interdependent	Decrease Ventilator Associated Pneumonia. Manage severe trauma or Accounts Payable. Build a new OR. Get your kids to graduate.	Optional
III. Complex Adaptive	Unclear; many potential causes; Chaotic, complex inputs and outputs; Rapidly changing variables.	Ill-defined, cause and effect unpredictable; complex, chaotic, interdependent, variable solutions	Get patients exactly what they need at continually lower cost. Change habits, values and behaviors of people. Raise a child.	Yes

That's a problem in the complex, dynamic, unpredictable world of healthcare. Management is so busy fighting fires, gathering data and going to meetings that we have little time to exercise authority. The temptation is to use our authority to buy or make a big, quick fix, but that often doesn't deliver and becomes another power reducing "flavor of the month."

A better, more power enhancing solution lies in using DPO to accelerate effective decision-making. There are many ways in which individuals and groups make decisions. For example:

- Autocratic (Do it!)
- Technical (Find the expert.)
- Democratic (Let's vote.)
- Consensual (We'd better all agree.)
- Adaptive (Real time information, linked to action, linked to results)

Each of these decision-making methods is important, but the method must match the problem. The table above compares three decision-making methods – technical, complex technical and complex adaptive.

If it's a technical problem, find the expert and solve it. But if it is an adaptive problem, technical solutions are designed to fail and inevitably decrease authority power.

Adaptive Design empowers authority by increasing problem solving capacity and linking information to action to results in real time close to the work. Management time and authority are precious resources. No problem should ever rise higher in the organization than it needs to. Anything else is a waste.

By increasingly moving problem solving into the work, Adaptive Design converts big, complex adaptive problems into small technical ones. This gets management off the fire-fighting/meeting treadmill and into leading with authority. That's DPO and it looks like this:

- Direction – "We are heading toward Ideal Patient Care (pp 76-77; 127-129)."

- Protection – "You are safe to challenge the status quo by signaling problems when care is not ideal (Chapter 7)."
- Order – "We work this way: disciplined, structured, replicable, testable, verifiable and improvable problem solving as close to the patient as possible (Chapter 8-9)."
- Decision-making – "There are times for autocratic, democratic and technical decisions. But when facing an adaptive problem, we use adaptive decision-making (Chapter 10)."

Twenty-first century healthcare is the world's most complex, dynamic and unpredictable business. That's a problem if you have only a twenty century management tool kit to work with: gather data, analyze in meetings, design projects, hire consultants, implement solutions, align incentives and hold people accountable.

Using Adaptive Design, leadership gains a new tool kit and a built-in way to generate greater authority power:

- Solve small problems quickly to eliminate the ambiguity, assumptions, workarounds and tradeoffs that add to the complexity of patient care.
- Develop people with the skills and accountability to problem-solve the system in real time as part of their everyday work.
- Build a solid foundation of trust, optimism, high performance and innovation focused on the patient.

Increase authority power throughout your organization to get patients exactly what they need a continually lower cost. It's the way to fix healthcare.

*Dr. John Kenagy is a vascular surgeon, former Visiting Scholar at Harvard Business School and patient. His book *Designed to Adapt: Leading Healthcare in Challenging Times* is available at <http://www.johnkenagy.com/>*



Hospital Governance Gone Awry

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

All hospital board members should be required to read an extraordinary report that was just released: the Final Report of the Miami-Dade County Grand Jury's report on what went wrong at Jackson Memorial Hospital, the public safety net hospital in Miami and third-largest public teaching hospital in the United States.

The purpose of the Grand Jury investigation and report was to analyze the "vast and widespread problems" that led to the financial crisis at Jackson and to propose "future plans for moving toward a significantly improved operation."

The tone of the report and the underlying problems at Jackson were set with the report's opening comment: "What a colossal mess!" And the report unequivocally placed the blame on those who managed and governed Jackson: **"those who had the responsibility of running this institution, as well as those who had the duty of oversight, have been irresponsible, complacent and reckless, and blindly relied on financial misstatements."** Ouch!!!

The following is a brief summary of the principal indictments of the report:

- **Dysfunctional governance system:** Jackson Memorial Hospital and Jackson Health System are run by the Public Health Trust (PHT), which operates subject to the oversight of the County Board of County Commissioners (BCC):

"The current governance system for Jackson has been described as an unwieldy two-headed monster. It has also been described as 'schizophrenic'...This 'schizophrenic' system has allowed each entity, the BCC and the PHT, to point fingers at each other. Each blames the other for this crisis...The Trustees failed in their duty of oversight over JHS management...[and] the PHT failed to recognize that a financial disaster was on the way even though the picture was being painted every month in JHS' monthly financial statements. Thus, the financial crisis is ultimately the fault of the PHT **and** the BCC **and** its county administrators."

- **Lack of board expertise:** The report found that "the business of running a hospital requires very specific expertise," especially because of "the hugely complicated and specialized nature of running a safety net hospital" such as Jackson. As a result, the report concluded that the governance structure of Jackson must

be changed so that a majority of the Trustees have "experience or a background in finance, accounting, business, management or labor" and that some of the board members have "backgrounds specifically in hospital finance, hospital management or experience with running a hospital."

- **Failure to recognize financial problems:** The report details a succession of financial problems that should have been spotted by management or the PHT Trustees or the BCC, including:
 - Jackson's auditors "challenged the reasonableness of the estimation techniques and the assumptions JHS management used in calculating its projected revenues...[and] found that during Fiscal Year 2009 the JHS's patient accounts receivables (projected revenues) were significantly overstated"; and
 - "We found that the lack of internal control outlined in the 2009 Management letter was a primary cause of the required adjustment and increase of the deficit/loss from the original \$46.8 million loss (arrived at by the JHS financial management team), to the \$244 million figure (arrived at with the independent auditor)."

The report concluded that everyone was at fault for failing to recognize these serious problems:

"JHS management should have recognized the problems. The PHT as well as county officials who regularly attend the PHT meetings, should have been able to read the proverbial handwriting on the monthly reports. The PHT...is the next layer of oversight after management. It has the duty and obligation of protecting our public hospital. The PHT's specific job is to make sure something like this does not happen. The PHT is comprised of exemplary citizens who donate their time to the very laudable cause of protecting this hospital. That is all well and good, but...there must be a requirement that some members of the PHT have the requisite and specific financial background to fulfill the PHT's duty of financial oversight. This is yet another example of how this governance system has failed."

I would like to hear your comments.
Send them to:
Richard.Kneipper@phns.com



Wave of Health Reform Provisions Coming Next Month

The Associated Press reminds us that healthcare reform hits another milestone next month, with new provisions that include a coverage expansion for young adults and restrictions on an insurer's ability to impose annual coverage limits or to reject children with pre-existing medical conditions.

Insurance coverage that starts on or after September 23 will have to comply with these changes and others that were put in place when President Barack Obama signed the health overhaul into law March 23. For most people, the changes won't affect their plans until coverage renews in the weeks or months that follow.

Here are the highlights:

- Adult children up to age 26 will be able to receive dependent coverage with all individual and group policies.
- Lifetime limits on the dollar value of insurance coverage will be prohibited. This refers to how much your insurance coverage pays out to cover claims.
- Restrictions will be placed on annual limits for coverage, a practice that will be prohibited in 2014.
- Insurers will be prohibited from rescinding or canceling coverage except in cases where the customer commits fraud.
- Insurers will not be able to exclude children from coverage because of a pre-existing condition, but they can require parents to sign up kids only during a fixed annual enrollment period to ensure they don't wait until a child gets sick to buy coverage.
- Insurers will be required to provide preventive care like immunizations or mammograms without charging co-pays or other forms of cost sharing. Some may not have to comply with this feature if their coverage existed March 23 and has not changed substantially.

Individual plans that have so-called "grandfathered status" like this also will not have to immediately follow the new restrictions on annual coverage limits or eliminate their lifetime caps. Over time, most plans will lose their grandfathered status as they make changes in benefit designs, said Jennifer Tolbert, a health policy analyst with the Kaiser Family Foundation.

Tolbert said these early provisions of the new law focus in part on consumer protections.

"It's basically improving the quality of coverage that people have," she said.

However, insurers and benefits analysts have cautioned that these restrictions and coverage expansions will raise the cost of insurance for some customers.

Several provisions of the complex law started unfolding in the weeks after President Obama signed it. For instance, people with Medicare prescription drug coverage are receiving \$250 rebates once they reach a gap in their coverage known as the "doughnut hole."

Enrollment has started in some states for temporary insurance that will cover people with pre-existing medical conditions who have been uninsured for at least six months. Some small businesses that offer employee health coverage can seek tax credits that will apply for this year.

The law will continue to develop over the next several years. In 2011, insurers will be required to offer rebates if they don't spend a minimum percentage of their premiums on medical costs. Details of that provision are still being worked out.

Some of the biggest reform provisions start in 2014.

By then, Medicaid will be expanded to reach more people. Most citizens and legal residents will be required to have healthcare coverage, and many will receive help from the government through income-based tax credits when they shop for coverage on health insurance exchanges.

About



PHNS provides IT services for hospitals, other healthcare providers and businesses. PHNS' IT services include application hosting, co-location and managed services; electronic off-site data back-up and data vaulting; business continuity solutions; disaster recovery services; and systems integration services. PHNS also provides comprehensive business process solutions for hospitals including admitting, HIM (including medical record management and storage, transcription, coding, release of information and electronic medical record services) and revenue cycle services. PHNS creates business-healthy hospitals by improving operations, enhancing technology and increasing cash on hand, which allows hospitals to focus on their core competency – patient care. PHNS has approximately 1,670 customers, including approximately 400 hospital IT and business process customers and approximately 1,270 IT customers. PHNS is headquartered in Dallas, Texas. See www.phns.com for additional information about PHNS.