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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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## Managerial Quality

By Jon Roberts

"We just need to hire better people." How many times have you heard someone say this? How many times have you thought this? This statement, in my opinion, captures one of the great misunderstandings of leadership; skill and expertise are innate, not learned. I believe that the *opposite* is true; skills and expertise are not innate, but learned. Additionally, since the costs of acting on this misunderstanding are not insignificant, it should become the fundamental role of leadership to develop the skills and expertise of the people they lead, rather than aiming to hire the "perfect" candidate.

Below I will elaborate on this misunderstanding, explore its consequences, and hopefully, open the door to a discussion about "managerial quality."

What makes someone an "expert," or even adept, at something? Is it based strictly on native ability? While some degree of native competence is essential, the road to "expertise" is generally long and fortunately, fairly well understood. Consider professional athletes for examples of people who have mastered their craft. Is there any "superstar" who acquired his or her skill without extensive instruction, frequent feedback (more often than yearly) and practice? There may be, but I believe those people are exceptions. And while there are leaders in healthcare who demonstrate exceptional leadership ability, most of them got there the old-fashioned way.

So why do we expect that people we hire to work for us ought to know how to do their job with expert precision? We could discuss this forever, but I think it has something to do with our pressure to economize our efforts and attention. It would be wonderful if skill and expertise did not need to be developed in people, but that is just not how the world works.

What are the costs of attempting to hire for expertise, rather than aptitude? They are extensive. First, the administrative costs of hiring and firing are pretty well understood. Though I don't have anything to quote, I recall reading that the cost of hiring and replacing a nurse can be 1.5 times

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that person's annual salary, if they leave before two years. As a person's income increases, so does the cost. Also, consider the amount of time that is spent with "problem" clinicians and managers. I'd bet that almost every person who reads this can think of at least one leader, who once showed promise, who now has everyone wondering, "What were we thinking?" The time spent wondering, "What will this person do next?" has an enormous cost. Lastly, consider the expert clinician who was promoted to the ranks of leadership and then quickly fell out of favor.

In these cases, you've not only incurred the costs of a problematic leader, but you've lost an experienced clinician. One last thing here about the implications of hiring for "expertise" rather than constantly developing the skills of the people we lead. Healthcare is constantly changing, and so are the institutions that deliver care. In a constantly changing workplace, the responsibilities of leaders often shift with the environment. A leader who can handle today's challenges may not be equipped to handle a new challenge tomorrow. When a new challenge does not fit a formerly successful leader's skill-set, what are you going to do?

So, if you agree that hiring "better" people is not the answer to leadership shortcomings, what is the answer? How does your organization go about developing the skills of new leaders? How do you go about developing the skills of leaders when their responsibilities change? Look closely at how a successful nurse is assimilated into the ranks of leadership. What does that involve? Does the process provide instruction, frequent feedback and

practice? Is it adequate? My guess is that it might provide those things and it is likely insufficient.

What are you going to do the next time you think to yourself, "We need to hire better people?" I have some ideas on this, but I'm interested in yours. Have you ever helped a failing leader recover? How did you do it? I believe that there is a great opportunity for the "Quality Movement" to move beyond clinical care and into the realm of leadership. What do you think?

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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."

## Docs Aren't Using Electronic Records

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

While our U.S. government continues its push for increased use of electronic medical and health records to improve healthcare, a recent government-sponsored survey found that less than 20 percent of U.S. doctors have started using electronic records. The study of over 2,600 doctors was financed by the Department of Health and Human Services and a grant from the Robert Wood Johnson Foundation and was published online by *The New England Journal of Medicine* on 6/18/08 and summarized in *The New York Times* on 6/19/08.

This low doctor use is particularly striking because the doctors interviewed by the study were very positive about the significant benefits of using electronic patient information – 82 percent said that electronic records improved the quality of clinical decisions, 86 percent said that electronic records helped to avoid medication errors and 85 percent said that electronic records improved the delivery of preventative care.

So, why don't docs use something that they think improves the quality, safety and effectiveness of patient care? No surprise – it's purely economics – another example of the "haves" versus "have nots" in the U.S. healthcare provider world. The initial cost for electronic records for a physician is estimated to be \$15,000-\$20,000 to upgrade computers and networks, buy and implement new software and add training and technical support. That's beyond the financial wherewithal of most small physician groups. Thus, according to the study, less than nine percent of small doctors' offices with 1-3 doctors, which represent about 50 percent of U.S. doctors, use them; whereas 51 percent of U.S. doctors who practice in larger practices with 50 or more doctors use them.

Of course we've heard the cost concern before, usually with the docs and hospitals saying that the insurers/payers will reap the most benefits of electronic records so they ought

to pay for them; and the insurers/payers saying that they're doing all they need to do and the government ought to help – which is why there are repeated calls for the U.S. government to step in and put up the funding.

However, the cost to do that could be tens of billions of dollars, and many in Congress aren't yet convinced that the government should step in to put up the money. See, for example, my recent FYA entitled "Congressional Budget Office Questions Healthcare IT Cost Savings" regarding a recent Congressional Budget Office study that found that while "health IT appears to make it easier to reduce health spending if other steps in the broader healthcare system are also taken to alter incentives to promote savings." "By itself, the adoption of more health IT is generally not sufficient to produce significant cost savings." It also concluded that the benefits of electronic records are not easy to capture for providers and hospitals that are not part of integrated systems.

Another issue is that 54 percent of doctors have said that they haven't yet implemented electronic records because they have not found an electronic record that meets their needs, according to Dr. David J. Brailer, former health information technology coordinator for the Bush administration in *The New York Times* article. Dr. Brailer referred to this as a "deficit in innovation." Perhaps the mega technology companies can provide the needed innovation since we now see companies like Microsoft and Google offering electronic health records that are consumer-controlled.

Any thoughts on either the barriers or the solutions?

I would like to hear your comments.  
Send them to:  
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### About



PHNS is an innovative healthcare services company providing strategic outsourcing services in information technology, health information management and receivables management to over 400 hospitals. PHNS is not a consultant, vendor or software company but a partner, a solution. PHNS understands healthcare because our partners are healthcare and healthcare only. Unlike its competitors, PHNS strategically aligns itself with a hospital's clinical and financial goals and objectives. Through its unique business model, PHNS reduces costs by aggregating, consolidating and sharing resources among its participating hospital partners. PHNS helps hospitals manage information systems, computer technology, patient records, coding and patient billing to improve patient care, safety and efficiency and increase profitability and efficiency. For more information, visit [www.phns.com](http://www.phns.com).

## Study Shows Most Doctors Support National Health Insurance

Reflecting a shift in thinking over the past five years among U.S. physicians, a majority of doctors – 59 percent – now supports national health insurance, according to a new study by Indiana University researchers.

Such plans typically involve a single, federally administered social insurance fund that guarantees healthcare coverage for everyone, much like Medicare currently does for seniors, the researchers said.

The plans typically eliminate or substantially reduce the role of private insurance companies in the healthcare financing system, but still allow patients to go to the doctors of their choice.

Published in *Annals of Internal Medicine*, the study reports that a survey conducted last year of 2,193 physicians across the United States showed 59 percent of them "support government legislation to establish national health insurance," while 32 percent oppose it and nine percent are neutral.

The findings reflect an increase of 10 percentage points in physician support for national health insurance (NHI) since 2002, when a similar survey was conducted. At that time, 49 percent of all physician respondents said they supported NHI and 40 percent opposed it.

Support among doctors for NHI has increased across almost all medical specialties, said Dr. Ronald T. Ackermann, associate director of the Center for Health Policy and Professionalism Research at Indiana University's School of Medicine and co-author of the study.

Support for NHI is particularly strong among psychiatrists (83 percent), pediatric sub-specialists (71 percent), emergency medicine physicians (69 percent), general pediatricians (65 percent), general internists (64 percent) and family physicians (60 percent). Fifty-five percent of general surgeons support NHI, roughly doubling their level of support since 2002.

Doctors have often expressed concern about lack of patient access to care due to rising costs and patients'

insufficient levels of insurance. An estimated 47 million Americans currently lack health insurance coverage and another 50 million are believed to be underinsured. At the same time, healthcare costs in the United States are rising at the rate of about seven percent a year, twice the rate of inflation.

The healthcare issue continues to rank high among voter concerns in the 2008 elections, placing third in a recent poll after the economy and Iraq.

In addition to measuring attitudes toward NHI, the survey also asked doctors about their views about "more incremental reform," often interpreted as state – or federal-based programs – requiring or "mandating" that consumers buy health insurance from private insurance companies, legislative measures providing tax incentives to businesses to provide coverage for their employees or similar steps.

Fewer physicians (55 percent) were in support of "incremental" reform. Moreover, virtually all those opposed to national health insurance also opposed incremental reform to improve access to care. In fact, only 14 percent of physicians overall oppose national health insurance, but support more incremental reforms. Ironically, many medical organizations and most politicians have endorsed only incremental changes.

Dr. Aaron E. Carroll, director of Indiana University's Center for Health Policy and Professionalism Research, and lead author of the study, commented: "Many claim to speak for physicians and reflect their views. We asked doctors directly and found that, contrary to conventional wisdom, most doctors support the government creating national health insurance."

Other signs indicate that attitudes among doctors are changing. The nation's largest medical specialty group, the 124,000-member American College of Physicians, endorsed a single-payer national health insurance program for the first time in December 2007.

You can learn more about this issue from the Chicago-based advocate group Physicians for a National Health Program. Its Web site is: [www.pnhp.org](http://www.pnhp.org).