



S. Harvey Price is editor of *For Your Advantage*. A health care industry strategist based in Boca Raton, Fla., Mr. Price has worked as an independent consultant since 1971. His clients are community hospitals, hospital systems and major corporations.

### 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.

The newsletter is provided free to healthcare CEOs only. CEOs may use the material in any way they wish—except for the editorial content that is copyrighted by the author. You are welcome to print copies of FYA.

TrendLeader Connections  
406-586-8775  
[www.ForYourAdvantage.com](http://www.ForYourAdvantage.com)

## How (not) To Diffuse An Innovation: Part One

By John Read and David Sundahl

Several years ago David bought a simple, very reliable heart-rate monitor (HRM). He used the HRM and his cyclo-computer (essentially a small digital speedometer) to track his progress. After this trusty HRM died, he decided on a replacement device with more features: a new, high-tech cyclo-computer advertised as the ultimate training tool for serious cyclists. It provided data and reports not only on speed, but also cadence, power, heart-rate, caloric consumption and more.

After using the new gizmo on a few rides, he was disappointed to discover it was a poor replacement for the HRM and speedometer.

Previously, he had been able to ride along and check his speed and heart-rate with a quick glance at his wrist (HRM) and the bike (computer). Although both functions were now in a single device, he couldn't check them at the same time. Rather, he had to push a button twice to switch between speed and heart rate. A small thing, but this and the complexity of the advanced features caused him to reinstall his old computer and buy the latest model of his old HRM. Someone else, he thought, can take the early-adopter's job of figuring out how to make good use of great features he felt he didn't really need.

Most people have had similar experiences. We buy things that promise to make us better at what we do, only to find they are needlessly complicated or don't offer a true advance over the status quo.

This column and two more to follow will address *diffusion* of innovation – that is, how innovations become more than cool ideas or the toys of gadget freaks. This column will outline the basic principles of successful innovation and diffusion; the second will present a case study in diffusion; the third will provide practical advice about how to start innovating and diffusing those innovations.

### Successful Innovation

The first issue to consider is what makes for successful innovation. Clearly, there is no magic formula – otherwise, all products and services would be better than they are. Nevertheless, there are some things that can help guide innovators in the right direction.

1. *Trial and error.* Experience is always a good teacher. True innovators should not fear failure because the keys to success are often hidden within our missteps.
2. *Feedback.* Success has many parents, and few things are as powerful as the insights and observations from users of innovations.
3. *Continuous Improvement.* Most great innovations are not a one-time phenomenon. They evolve over time. Successful innovators constantly seek to improve or re-invent their product or services. Continuous improvement is the secret to long-term success.

(Continued...)

### How (not) To Diffuse An Innovation: Part One (Continued...)

#### Why (successful) diffusion matters

Good innovations that aren't used are at best useless and at worst dangerous. Consider, for example, process innovations, often referred to as "best practices." On the one hand, if best practices regarding, say, scheduling don't spread throughout an organization, there may be no immediate (or even long-term) consequence. Maybe no one in the marketplace adopts the best practices, keeping the playing field level. Or maybe the market changes so radically that scheduling is of no consequence (think: dot-com bust). The failure for innovations to diffuse may simply have no real-world effects.

On the other hand, the failure of certain process innovations to be adopted is dangerous. Although best practices for prevention of peri-operative infections are well known, peri-operative infections harm, even kill many people each year.

Diffusion matters because successful diffusion of good innovations can improve our lives.

#### Rogers' criteria for successful diffusion

In his book, *Diffusion of Innovations*, Everett M. Rogers outlines the five most salient features of innovations that are successfully diffused.

1. *Relative Advantage*: Do (potential) users see the innovation as conferring some advantage over existing solutions?
2. *Compatibility*: Do (potential) users see the innovation as being compatible with existing practices and values?
3. *Complexity*: Do users see the innovation as being relatively easy to understand and use?
4. *Trialability*: Can users try the innovation out before committing to more?

5. *Observability*: Can users see the innovation's benefit to others?

The cyclo-computer, for example, got good marks for relative advantage and compatibility, but on the last three criteria it scored poorly. It wasn't particularly useable; David couldn't increase its use incrementally; most of all, he had no way of observing the connection between the cyclo-computer's use and its benefits. Peri-operative infection control measures score well on everything but trialability and observability. In general, the prevention practices do not incrementally increase people's commitment and use of them—either you do them or you don't. What's more, the connection between cause and effect is distant, making it difficult for would-be users to muster the will to implement them.

We'd like to enlist your help in this discussion. Use Rogers' framework to evaluate your own experiences diffusing innovations. Then e-mail us your examples of innovations that worked (or didn't) and why. We'll pick one or two from among them to add to our second and third columns.

---

*John Read and David Sundahl are associates at Kenagy Associates and can be reached at [jread@kenagyassociates.com](mailto:jread@kenagyassociates.com) and at [dsundahl@kenagyassociates.com](mailto:dsundahl@kenagyassociates.com).*



#### 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).

## Retirement \$\$\$

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

How well are you caring for your employees' retirement funds? For many healthcare providers the answer is – not very well. The total return for defined-benefit pension funds for hospitals and other healthcare providers was 7.7 percent in 2005, down from 10 percent in 2004 and 18.1 percent in 2003 according to the recently issued *Commonfund Benchmarks Study Healthcare Report 2006*. The report studied the investment practices of 202 not-for-profit healthcare organizations with a total of \$105.8 billion in operating funds and \$45.4 billion of defined-benefit pension funds in 2005.

Why the major downturn in returns? One of the reported reasons is that many healthcare organizations still have very high percentages of their retirement funds invested in low-yielding, low-risk fixed-income investments and cash equivalents. Most investment professionals will opine that it will be difficult for defined-benefit pension funds to meet their payment obligations to employees without a prudent, but significant, allocation to equity securities. According to the report more healthcare organizations are starting to revamp their investment practices – 82 percent of those responding said that they had rebalanced their investment portfolios in 2005 (87 percent for those with portfolios of \$500 million to \$1 billion) compared to 77 percent in 2004. This rebalancing included shifts into higher percentages of domestic equities, shifts into international equities and alternative investments such as hedge funds, private capital, venture capital, leveraged buyouts and distressed debt – although, interestingly, while most reported that they increased their alternative investment allocations from 10 percent to 15 percent, smaller providers with assets between \$51 million and \$100 million reduced their alternative investment allocations from nine percent to six percent.

There also is a trend away from defined-benefit pension plans throughout the county and particularly in healthcare. In 1985 there were 112,000 single-employer defined-benefit pension plans, but by 2004 that number had dropped by almost 75 percent to less than 30,000, according to the ERISA Industry Committee. In 2005, 21 percent of the 202 organizations that responded to the Commonfund Report said that they had already closed or expect to freeze their defined-benefit plans.

When was the last time that your hospital's board did a global review of your employee retirement plan strategy, structure and performance? Does your retirement plan oversight committee include a majority of investment experts (this requires sophisticated investment experience, which most board members do not have)? How long have the expert advisors and managers for the retirement plans been in place (long tenures in tumultuous investment markets may mean lack of proper oversight)? How many investment fund managers do

you have in each asset allocation category and how have they performed over one year, three year, five year and 10 year horizons compared to peers? Has there been a review of the return expectations and return requirements of your retirement plan? And when was the last thorough review of your retirement fund, including review of the following?

- Actuary performance and reports
- Master trustee or custodian performance and reports
- Independent investment consultant performance and reports
- Investment policies and asset allocations
- Investment fund managers and performance

These issues can be subject to substantial fiduciary duties under state law and federal ERISA law and need to be considered prudently and thoroughly – more importantly, you owe it to your employees to be good stewards of their retirement funds.



I would like to hear your comments.

Send them to:

[Richard.Kneipper@phns.com](mailto:Richard.Kneipper@phns.com)

### 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: Is This the First Step To the Last Step?

**W**e wrote about Wal-Mart in the last issue of FYA. We pointed out that the company had made headlines when it announced that it planned to cut the cost of generic drugs drastically – to \$4. Now the largest retailer is back in the news with headlines about its new employee health insurance plan.

The company announced that as of Jan. 1 its primary health insurance offering for new hires will be a high-deductible plan with premiums as low as \$11 per pay period in some areas. After employees are enrolled in Wal-Mart's coverage for a year, they can combine the high-deductible plan with a health-savings account, which provides them a tax-free method of setting aside their own money – plus a contribution of up to \$2,400 from Wal-Mart – for medical expenses.

According to the *Wall Street Journal*, Wal-Mart critics see the new plan as a means of deterring unhealthy job seekers. They point out that the plan's \$1,000 primary deductible is pricey, even with Wal-Mart's inclusion of three free doctor visits and three free generic prescriptions per year. The plan includes additional deductibles such as \$1,000 for inpatient hospital stays and \$300 for prescriptions. And its out-of-pocket maximum--the amount an insured employee must spend in a given year before the company pays 100 percent of further costs – of \$5,000 for individuals and \$10,000 for families is high.

Eighty-four percent of retailers offer a preferred-provider organization as their primary option for employees, according to the Hay Group. The average deductible on those plans ranges from \$250 to \$350. Costco Wholesale Corp., considered by many to provide among the best employee benefits in the retail sector, offers a primary plan with premiums of \$15 to \$25 and deductibles of \$200 for full-time employees and \$500 for part-timers. Costco strives to pay 90 percent of the cost of its premiums for its employees. Wal-Mart traditionally has paid two-thirds of the premiums in its plans.

Wal-Mart claims that the low-premium, high-deductible plan makes its coverage affordable for more of its employees.

Wal-Mart this year shortened the eligibility wait time for part-time workers to one year from two and allowed their children to get coverage. Approximately 46 percent of Wal-Mart's U.S. workers are enrolled in its plans, compared to the retail-industry average of 43 percent.

Wal-Mart claims the new plan, called the Value Plan, will save money for most of its employees. More than half of its covered associates didn't spend enough last year to exhaust their deductibles, yet they had to pay premiums higher than those in the Value Plan.

Like other U.S. companies, Wal-Mart long has sought methods to rein in rising health-care costs. According to the *Wall Street Journal*, Wal-Mart's costs for healthcare benefits grew by 19 percent to \$1.5 billion from 2002 to 2005.

Wal-Mart employs more than 1.3 million people in its U.S. operations.

The Bush administration has pushed plans with high deductibles and health-savings accounts to make insured workers spend more carefully. And Wal-Mart executives have described a need for employees to become "better consumers of healthcare." For example, an internal Wal-Mart memorandum that was leaked last year noted that the retailer's work force overuses high-cost services such as emergency-room visits instead of lower-cost, preventive services such as doctor visits and prescriptions.

Yet, so far, few employers have embraced the plans. According to a survey released last month by the Henry J. Kaiser Family Foundation, only seven percent of U.S. employers offer high-deductible plans in tandem with health-savings accounts, and only four percent of covered employees enroll in the savings accounts. Among retailers, Target Corp. earlier this year added to its offerings two varieties of health-savings accounts with low premiums and high deductibles.

In the final analysis, many observers see these changes as the beginning of the end of employer responsibility for healthcare insurance.