FYA For Your Advantage
An Essential Tool for Healthcare Leaders
INNOVATIONS
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Innovation 2008 – Try Harder or New Opportunity? It's Your Choice

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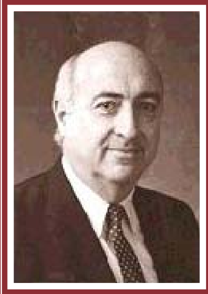

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About FYA

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.

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.

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How do you know if your hospital/health system should "try harder" or develop new opportunities? Which side of the Healthcare Innovation 2008 table are you on?

Healthcare Innovation 2008

What's Not Hot (Try Harder)	What's Hot (New Opportunity)
1. Capital expenditures for new technology and facilities	1. Increasing Return on Investment (ROI) from current operations
2. Implementing IT systems	2. Developing people and relationships
3. Power and compliance	3. Purpose and commitment
4. Consultants, external solutions and manufactured innovation	4. Local knowledge, ingenuity and real-time innovation
5. Fighting entrenched cultures	5. Revitalizing your culture
6. Specialty hospitals	6. Flexible, multi-purpose hospitals

For the last 10 years, the left side of this chart has dominated healthcare innovation. Therefore, "what's not hot" is deeply imbedded into current hospital/health system strategies and methods. But times are changing. The evidence is overwhelming that trying harder is not the answer and the leading organizations of the 21st Century will transition to the "What's Hot" list to the right. But, how do you know if it is time for your organization to begin the move? Does your hospital or health system need to "get hot?"

One way to know is to take the test. My October *FYA* column featured an "Innovation Self-Assessment Test" to help you better understand your new opportunities. If you haven't taken the test yet, go to my October *FYA* column *Does your Hospital/Health System Need to "Get Hot?" – The Self Assessment Test* and take the test. It won't take longer than five minutes.

Last month's *FYA "Innovation 2008 – The Answers"* gave you the key; all the scores reported to me were above 50, many were above 75. The problem is a high score indicates being on the What's Not Hot side and trying harder. I won't trivialize the difficulty in doing something different. Moving to the right side of the list is simple, but it's not easy. Here is a case study that illustrates the problem.

When Great Capabilities Become Disabilities.

The CEO of a small health system wants to transform his organization but, to some extent, is the victim of the organization's success. His management team has been uncommonly successful at maximizing its current position. The system has:

(Continued...)

Innovation 2008 - Try Harder or New Opportunity? It's Your Choice (Continued...)

- Used mergers and acquisitions to create market power to drive higher pricing
- Focused on what pays – procedures, orthopedics, cardiac-pulmonary and other profitable services; and bought MD practices to create a stable source of referral for these key profitable services
- Built a new hospital in a well-healed, suburban market with fewer "low and no pays"
- Aggressively cut costs, exited unprofitable markets and downsized to decrease its biggest variable cost – people, particularly in unproductive services
- Made sure everyone is focused on his or her numbers, constantly searched for new metrics while investing in consultants, benchmarking, regulatory compliance, policy initiatives, best practices and a multitude of quality initiatives (PDCA, Six Sigma, Lean, Transforming Care at the Bedside, *etc*.).
- Accessed capital and invested heavily in facilities, IT, new technology and information systems.

It seems all of this managerial work has been successful because the organization now has a positive bottom line – so the management team wants to do more of the same. But, there is an unending list of more things to do and they have not been able to sustain without continually "trying harder." The CEO realizes they are not unlike the major American auto markers or airlines that were vulnerable to smaller, upstart competitors. He is concerned his health system is like General Motors or United in the 1990's – fat, happy, but at grave risk.

What can he do about it? The organizational structures of this health system are aligned, processes are in place, resource allocation methodologies established, and all the habits, behaviors and values of all the people imbedded in this system are deeply entrenched. And they're "successful." The time, effort and energy required to buck the existing system would be great and how does he know if transformation will be successful? But, the CEO is really correct – they are running so hard to stay in place, that they do not have time to consider getting off the treadmill and working differently.

What's the CEO's option – try harder or develop a new opportunity? And if it's a new opportunity, how would he do it? Send me your thoughts. We will develop the answer in next month's *FYA*. Contact me for questions or comments at jkenagy@kenagyassociates.com.

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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.

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U.S. Scorecard on Chronic Diseases

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

The daughter of a very close family friend was telling me last week how excited she was about her first medical school interview scheduled for the next day. Little wonder she was excited to be invited to an interview since she said that she had applied to 15 top medical schools, but the odds were very tough because many med schools had over 12,000 applicants. They only interviewed around 750 and only accepted about 125.

With the wonderful exuberance of youth, she also told me that she had become convinced that the U.S. healthcare system needed to be improved after she had spent a summer working in healthcare in Nicaragua. She said everyone there, regardless of ability to pay, received excellent, friendly and prompt (i.e., no long lines or waits) healthcare. She said that experience convinced her that our U.S. healthcare system must be changed in order to provide equal care for all, particularly the approximately 45 million uninsured – but she did praise the high quality of the U.S. healthcare system compared to other countries' healthcare systems. I'll skip the political discussion that ensued.

At the risk of dampening her exuberance, I felt compelled to point out that the quality of our U.S. healthcare system doesn't always rank as high as she thought compared to other countries. A disturbing example is a recent study by Rollins School of Public Health at Emory University that found that U.S. adults over the age of 50 are more likely than their European counterparts to be diagnosed with chronic disease (see the summary in a recent edition of *HITS, Modern Healthcare's* daily IT e-newsletter). The Emory research team compared the prevalence of chronic diseases in the U.S. against those in the European countries of Austria, Denmark, France, Germany, Greece, Italy, the Netherlands, Spain, Sweden and Switzerland, and found that U.S. healthcare didn't measure up very well in the following categories:

- Heart Disease: twice as likely to occur in older U.S. adults than in older European adults;
- Arthritis: twice as likely in older U.S. adults than in older European adults;
- Cancer: 12 percent of older U.S. adults have cancer compared to 5.4 percent of older European adults;
- Diabetes: 11 percent of older U.S. adults have diabetes compared to 11 percent of older European adults;
- Obesity: 33 percent of older U.S. adults are obese compared to 17 percent of older European adults; and
- Smoking: 53 percent of older U.S. adults were active or former smokers compared to 43 percent of older European adults.

As an older U.S. adult, I find that extremely disturbing, and I'd like to know why older Europeans have so much less chronic disease than older Americans, but unfortunately I haven't seen any explanation for that.

From the point of view of my young doctor-to-be friend, the cost to our U.S. healthcare tab of this excess of chronic diseases in the U.S. is staggering – an estimated $100 billion to $150 billion per year according to the Emory study. A separate study by the Milken Institute found that the total cost to the U.S. economy of treatment and lost productivity from chronic diseases in the U.S. is more than $1.3 trillion per year!

Time is running out for we older Americans to fix this U.S. chronic disease problem – but if we don't soon, I'm confident that my young friend and her exuberant generation will find a solution.

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."

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A Trend: Conflict of Interest Policies

The University of Pittsburgh Medical Center is one of the latest healthcare providers adding a conflicts-of-interest policy that will establish new guidelines for distributing sample medications provided by drug companies.

The wide-ranging policy also will impose restrictions on consulting relationships, ban gifts from industry representatives and call for other restrictions.

According to the *Pittsburgh Post-Gazette*, the policy will apply to about 50,000 people – faculty, staff and students of the university's Schools of the Health Sciences, and other professionals and staff employed or contracted by UPMC's U.S. operations.

An earlier draft policy had proposed curtailing use of drug samples, but concerns were raised that that could deny some uninsured or underinsured patients access to needed medication.

Others noted, however, that current methods of distributing samples help industry representatives gain access to doctors to influence their behavior.

A working group of pharmacists, physicians and administrators has been assembled to consider other ways of distributing drug or device samples.

While policy details are being finalized, a central facility within UPMC will accept sample medications from companies, and then provide them to doctors' offices.

The new arrangement will "remove the relationship between company representatives and prescribers," said Dr. Barbara Barnes, associate dean for continuing medical education at the Pitt School of Medicine.

The overall conflicts-of-interest policy is scheduled to take effect February 15.

For UPMC or Health Sciences personnel, penalties for noncompliance would range from counseling to written reprimands, revoking hospital privileges, fines or termination.

Companies repeatedly violating the policy could have their sales and marketing personnel suspended from UPMC and the Health Sciences schools for a year or more.

Among the provisions:

- UPMC and Health Sciences personnel would be unable to accept tickets to sporting events or other gifts from drug industry representatives, including pens and note pads. Food provided by the industry generally would be banned, though some exceptions could be made for continuing education events and industry-sponsored off-campus meetings.
- Sales and marketing representatives may only have access to clinical facilities if their companies have registered with UPMC supply chain management or the Pitt purchasing department. Company representatives also would have to be invited to meet with healthcare providers for a specific purpose.
- UPMC and Health Sciences personnel could attend off-campus, industry-sponsored meetings, but with certain restrictions. Speakers could receive travel reimbursement and "a modest honorarium not to exceed $2,500," but would have to determine their own lecture content and present a balanced assessment of treatment options.
- Industry support for scholarships and fellowships would require a written agreement, with selection of awardees controlled by Pitt or UPMC personnel.
- Consulting services provided to industry must involve a contract stipulating specific tasks and products to be delivered, "with payment commensurate with the tasks assigned."

For Health Sciences personnel, consulting arrangements must be approved in advance by a faculty member's dean, department chairman or administrator.

Written approval by the dean will be required if annual payment from one company would exceed $10,000. UPMC personnel who are not faculty would need prior written approval from supervisors.

It is common for academic medical centers to work with industry to advance research or medical treatment, said Dr. David Korn, a senior vice president for the Association of American Medical Colleges.

If physicians help to develop a device, they and their academic centers may be entitled to royalties, though the centers would have to use the funds for research, Dr. Korn said.

But other scenarios are more troubling, he said. If device companies, for example, make payments to physicians based on the number of devices implanted in patients, "those really smell like kickbacks," Dr. Korn said.

That kind of relationship also could distort a medical center's ability to make objective decisions about device purchases, he said.

The association will probably consider the complex issue of consulting relationships with industry next year, he said.