

**By S. Harvey Price**



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)

## What is Disruptive Innovation III "The Flaw in the Professor's Theory"

by John W. Kenagy, MD, MPA

This column is part of a series that began in August. Each column is linked to use as you wish with your board and senior management team.”

So now may be a good time to review last month's column: *What is Disruptive Innovation II - When Trying Harder is Not the Answer* [Volume 4, Issue 20 - October 17, 2005](#) and answer the question at the end. And for all the rest of us who barely have the time to read this column, the scenario is:

Intel Senior Management Team 1997. Harvard Business School Professor Clayton Christensen has just presented his "Disruptive Technology" theory to explain the fall of Digital Equipment (DEC). DEC made the world's best minicomputers but was "disrupted" by the personal computer (PC's). DEC, like almost every company Christensen has studied, failed to adapt and successfully change direction when challenged by a "disruptive technology."

Andrew Grove, Intel's powerful CEO, was seated in the front row and was obviously interested and engaged. Heaven for a Harvard Business School Professor - the CEO gets it! It just doesn't get any better than this! Or does it? At the end of the presentation Grove's comment was, "Professor, I see the flaw in your theory."

In last month's FYA, I asked, "What was the flaw?" Thanks to Robert Montion and Duane Iwamura - both from Tulare District Hospital in Tulare, CA who sent the best responses. Robert said DEC had so much capital invested in current products, that it couldn't economically move into innovation - "disruptive innovation was blasphemy until sufficient ROI had been achieved." Duane suggested DEC "had their 'financial blinders' on by focusing their improvements on the needs of high end users." They should have focused on the mid-level users, the largest percentage of the market. Both answers make business sense. So what did Andy Grove say?

"Professor, I see the flaw in your theory. You say personal computers were a 'disruptive technology' to DEC. But, PC's are trivial technology. Digital had engineers who could design a great PC on the back of a napkin. It wasn't a technology or product problem. Digital did not have an organization that could make PC's. They did not work that way."

So why didn't Digital just innovate? If PC's were "trivial technology," their management team must not have been smart enough or tried hard enough. But Digital made the decisions that sank their company in the 1970's, when they were the "best managed company in the world."

What would you have done? The table on page 2 describes the two paths in the 1970's computer market.

You are the senior leadership at DEC in the 1970's. You have to keep DEC on  
*(continued)*

**"The Flaw in the Professor's Theory" (...Continued)**

	DEC - Minicomputers	Personal Computers (PC's)
<b>Design</b>	"The world's best" integral design - complex, capital-intensive; needs expert driven, highly structured coordination and control capability.	Modular design - simple components made in many different places; needs flexible, low-cost design/assembly capability.
<b>Price</b>	\$100,000 and going up	\$3,500 and going down
<b>Profit Margins</b>	Must be high to fund big projects, expensive technology, facilities and more R&D.	Low and going lower
<b>Sales</b>	"The world's best" field sales force; close, valued relationships with loyal, long-term, Fortune 500 customers.	Retail sales to kids, gamers, techies and ??
<b>Service</b>	"The world's best." Highly developed and coordinated on-site service, part of the total package.	Unknown
<b>Customer Needs</b>	High end business computing functionality	Toys and typing

the path for success. Which path makes best business sense? Is DEC at a crossroads? How would you know?

DEC failed. What should they have done differently and why? Send me your diagnosis at [jkenagy@kenagyassociates.com](mailto:jkenagy@kenagyassociates.com). I will acknowledge the best ideas in next month's column when we present what Grove and Christensen learned from this exchange. And start to apply the answers to health care.

If you have questions or suggestions about using these columns with your Board or management team or need more information, contact me at

[jkenagy@kenagyassociates.com](mailto:jkenagy@kenagyassociates.com).

These columns may seem far a field from health care. Don't worry; we are almost home. I am a physician and health care is what I do. If you want a sneak peak at the subject matter for future columns and the "New Success Factor," see the Kenagy & Associates, LLC website:

<http://www.kenagyassociates.com>.



**About**



PHNS is an innovative healthcare services company providing strategic outsourcing services in information technology, health information management and receivables management to approximately 160 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).

## Who's the Patient Care QB?

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

I used to think that the quarterback in charge of my patient care was my primary care physician, supported by a strong team of nurses, specialists and hospitals as needed. However, I'm increasingly getting signals that I need to be the QB, even though it doesn't make sense to have an untrained, unqualified rookie in charge of such an important game involving my health when I'd rather have a Peyton Manning in control of the game for me.

One of the strongest signals was a *Health Affairs* paper dated November 3, 2005, that reported on a 2005 survey of patient care experiences of "sicker" adults in six countries including the United States. "Sicker" adults included those who met one of the following criteria: rated their health as fair or poor; had a serious illness, injury or disability that required intensive medical care in the past two years; or had major surgery or had been hospitalized for something other than a normal pregnancy. The survey results, which were relatively consistent in the six countries, were very sobering and strongly suggest that I can no longer be a Monday morning quarterback when it comes to my own healthcare. Consider these survey results and see if you reach the same conclusion:

- o **Care coordination:** "For patients in the midst of complex care, coordination and information flow across sites of care are instrumental for provision of efficient and safe care." Coordination failures were reported most often when patients saw multiple doctors, and one-fifth of patients in all countries experienced "breakdowns in coordination." And "patients seeing four or more physicians were three times as likely to report at least one type of error as those seeing one physician." Even worse, the study found that coordination gaps occur most frequently in the U.S. "where one-third of patients reported...coordination failures."
- o **Transitional care:** In all six countries at least one-third of patients who had been recently hospitalized "reported failures to coordinate care well during hospital discharge." Poor transitional care is a major cost and quality concern since it can result in

complications and can increase the likelihood of hospital readmission--- as shown by the fact that 10 percent of patients in all countries said that "they were readmitted to the hospital or revisited the emergency room as a result of complications after hospital care."

- o **Errors and delays:** One-third of U.S. patients reported "medical, medication, or lab errors and... duplicate tests or medical record delays", all of which can put patient care at risk. One of the most disturbing findings was that "the United States often ranks last or tied for last for safety, efficiency, and access."

Like it or not, it sounds like I need to start training for game time, or that I need to get one of my family members or friends to start training for game time, since those study findings make it clear that I can't depend on the QBs of yesteryear to carry the ball for me. Do you agree or disagree?



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: IRS to Investigate Compliance and Compensation

Here is something new to monitor. The Exempt Organization Compliance Unit (EOCU) of the Internal Revenue Service announced a new initiative aimed at tax-exempt hospitals. According to the 2006 Implementing Guidelines released on October 25, the EOCU will solicit information from hospitals about how they meet the community benefit standards of the IRS code 501(c)(3); and how they determine pay compensation for executives.

The Health Care & Life Sciences Practice of the national law firm of EPSTEIN BECKER & GREEN\* offers the following information.

The new EOCU initiative aims to investigate hospitals' current compliance with the fundamental standard of tax-exemption for hospitals-the community benefit standard. The IRS recognizes that the promotion of health qualifies as an appropriate tax-exempt purpose as long as the community as a whole benefits. The IRS reviews a number of factors to determine whether the hospital is providing a community benefit. These factors include:

- Whether the hospital operates a full-time emergency room open to all people, regardless of their ability to pay.
- Whether the hospital provides non-emergency services for all people who are able to pay for these services themselves or through insurance or public programs.
- Whether the hospital participates in Medicare and Medicaid.
- Whether the hospital has a board of directors that is representative of the community.
- Whether the hospital has an open medical staff.
- Whether the hospital applies any surplus funds toward improving facilities, equipment, patient care, medical training, research and education.

Recent litigation and statements from public figures, including lawmakers, have focused on charity care as the primary basis for tax-exemption. While there is no indication that the IRS has changed its application of the community benefit standard, hospitals should be prepared to address questions aimed at identifying the extent of the hospitals' charity care policies and programs.

Consequently, the new EOCU initiative represents both a challenge and an opportunity for tax-exempt hospitals: the challenge is to appropriately prepare for and respond to further IRS scrutiny while the opportunity is to use this new scrutiny as a vehicle for better understanding the community benefit the hospital provides. Some tax-exempt hospitals already prepare "Community Benefit Reports," which describe and quantify the

community benefit provided by a hospital (for example, comparing costs for services to receipts). In addition, a Community Benefit Report may describe the services provided by the hospital, such as community health education and screening programs, free or discounted transportation services, health hotlines (e.g., "ASK-A-NURSE"), child care programs and subsidized services (e.g., emergency rooms, neurology, intensive care).

Once completed, these Community Benefit Reports can be used by hospitals to better align their community benefit services with their operational and clinical objectives. In addition, by making its Community Benefit Report readily available to the public, elected officials and community leaders, a hospital may proactively demonstrate the good it does for its community and create a larger community of supporters. As a by-product, Community Benefit Reports may be useful if a hospital is required to respond to an IRS inquiry. Therefore, tax-exempt hospitals not yet preparing Community Benefit Reports should consider doing so.

The new EOCU initiative with respect to hospital compensation practices follows last year's initiative to review tax-exempt organization compensation practices.

Specifically, last year, the IRS initiated a letter-writing campaign in which 1,250 compliance questionnaires were sent to a wide range of tax-exempt organizations. The purpose of this campaign was to study: how tax-exempt organizations determine and report compensation, how often the organizations loan money to their employees, the incidence of business relationships between these organizations and their employees, the proportion of compensation as compared to the organization's assets and whether the organizations reported any "excess benefits" on their annual tax returns.

If the IRS's activities with respect to its Fiscal Year 2005 compensation initiative is an indication of this new EOCU initiative, then a hospital should expect requests for information regarding the manner the hospital determines compensation, the nature of compensation and benefits paid or made available to hospital employees and other aspects of the hospital's compensation structure.

If this new EOCU initiative is administered in the same manner as last year's initiative, then the IRS may target organizations whose reporting has been determined deficient in some respect. Accordingly, hospitals should be prepared to respond to any such request with detailed information regarding its compensation practices.

*\*FYA appreciates this information provided by EB&G. The information is not intended as legal advice. E-mail your comments to [hprice@foryouradvantage.com](mailto:hprice@foryouradvantage.com).*