

JacksonHealthcareReview



VOLUME 1.1
September 2009



The Bottom Line on Thought Leadership

By: Rick Jackson, CEO Jackson Healthcare

► **Jackson Healthcare Review collects executive summaries of thought leadership for busy healthcare executives.**

Our goal is to find relevant ideas, data and best practices and summarize them in ways that get to the bottom line of what busy healthcare executives need to know. Think *Harvard Business Review* meets *The Kiplinger Letter*. In addition, we will share timeless “big ideas” in thought leadership from respected authors and practitioners.

As a healthcare executive, I have an obligation to stay current on what’s happening in the industry, at the Capitol and in the world as a whole. But the reality is I can’t keep up with the onslaught of news and information and effectively serve my employees, partners and customers.

I’m betting you can’t either and I hope, with *Jackson Healthcare Review*, we can help you stay current on the latest industry-specific thinking without wasting your valuable time.

Feel free to reach out and share your feedback by emailing us at jhr@jacksonhealthcare.com.

How Are Hospitals Responding to Current Economic Challenges?

► In June 2009, HFMA’s Healthcare Financial Pulse continued to look at this question.

On a quarterly basis, the Healthcare Financial Management Association is surveying healthcare financial executives to assess the effects of the economic downturn on hospitals and health systems.

Here are highlights from the report:

1. 54% of hospitals reported negative total margins.
2. 73% of hospitals reported a decrease in days cash on hand.
3. Nearly 80% of hospitals with over 500 beds had greater than 20% non-operating revenue declines; however, 48% of hospitals under 500 beds reported significant declines.
4. Rural hospitals suffered the most significant patient revenue declines, yet urban hospitals also reported declines.
5. Access to capital and spending are down.
6. Nearly 40% of hospitals reported increases in the cost of debt.

The full survey can be accessed at <http://www.hfma.org/pulse>.

Can You Justify Your Quality & Costs?

Source: *The New Yorker*, June 1, 2009

► In a June 2009 *New Yorker* article titled, “The Cost Conundrum,” author and surgeon Atul Gawande targeted McAllen, Texas. According to Gawande, McAllen is one of the most expensive healthcare markets in the country and he wanted to know why.

What did the author determine was the cause of McAllen’s cost inflation?

It wasn’t an unhealthy population, as many speculated. It was due to over-utilization (i.e. doctors performing more diagnostic testing, hospital treatment, surgery and home care than necessary).

The article disputes the belief that “more is better,” citing that “the more money Medicare spent per person in a given state the lower that state’s quality ranking tended to be.”

One of the more concerning quotes in the article was attributed to the executives of Doctors Hospital at Renaissance: “The other doctors and hospitals in McAllen may be overspending, but, to the extent that his hospital provides costlier treatment than other places in the country, it is making people better in ways that data on quality and outcomes do not measure.”

Gawande goes on to say, “Health-care costs ultimately arise from the accumulation of individual decisions doctors make about which services and

treatments to write an order for. The most expensive piece of medical equipment, as the saying goes, is a doctor’s pen. And, as a rule, hospital executives don’t own the pen caps. Doctors do.” As an aside, it is important to note that the doctor’s pen contributes to efficiency and patient quality, as well.

The article boils down to this: doctors who work together to root out waste and eliminate financial incentives can work together to increase patient quality while lowering costs.

Mayo Clinic was offered as an exemplary model.

Is your hospital and medical staff incentivized to effectively and efficiently meet the needs of your patients? Or is the focus on maximizing revenue?

If you were forced to not only answer this, but prove your value to someone who knew at least as much about your quality and cost data as you do, how would you honestly respond?

Read the original article at <http://bit.ly/12Qnw9>

“Two economists working at Dartmouth, Katherine Baicker and Amitabh Chandra, found that the more money Medicare spent per person in a given state the lower that state’s quality ranking tended to be.”

- Atul Gawande, MD

Copyright © 2009 Jackson Healthcare, LLC. All rights reserved.

Jackson Healthcare Review is published by Jackson Healthcare, 2655 Northwinds Parkway, Alpharetta, GA 30009. The content of *Jackson Healthcare Review* represents our interpretation and analysis of information that is generally available to the public or obtained from industry sources believed to be reliable, but is not guaranteed as to accuracy or completeness.

Jackson Healthcare provides clinician staffing, anesthesia management, hospital management and healthcare information technology to hospitals and medical groups. Editorial information: jhr@jacksonhealthcare.com. Website: www.jacksonhealthcare.com.

Developing a Regional Health System Strategy

Source: *The McKinsey Quarterly*, July 2009

► In the July 2009 issue of *The McKinsey Quarterly*, Penny Dash, MD, Chris Liewellyn, MD and Ben Richardson address how health systems improve the health of the population they serve through quality, access and financially sustainable healthcare.

This article draws from the authors' work in the United Kingdom and through colleague experiences in other countries. It takes a global perspective in its premise that "a regional approach to strategy development can enable health systems around the world to make significant improvements in health care delivery."

What's interesting about this approach is it integrates financial and clinical perspectives in an effort to avoid 1) clinically-based strategies that may be too expensive to implement and 2) financially attractive strategies that do not improve health and services.

3 Ways to Define "Regional"

1. Geopolitical: zip codes, cities, counties, etc.
2. Ecosystem: end-to-end patient referral patterns, including primary and secondary hospitals
3. Population: optimal population base over which to design services

5 Steps to a Regional Strategy

1. Determine why change is necessary.
2. Determine how the needs of the population will evolve.
3. Determine what clinical pathways will best meet patients' future needs.
4. Determine which delivery models are needed to support optimal care.
5. Determine whether the proposed changes are affordable and feasible.

Read the original article at <http://bit.ly/ApqPG>

When it Comes to Healthcare Reform, Americans Trust MDs Over Politicians

Source: *Gallup.com*

► A Gallup Poll conducted June 13-14, 2009, reported some noteworthy public perceptions.

According to the study, **73% of Americans say they are "confident in doctors to recommend the right thing for reforming the U.S. healthcare system."** Overall, doctors, hospitals and academic researchers were determined to "have a potentially

important advantage over government leaders," and "are well-positioned to have bipartisan clout with the public."

Compare these poll results with the fact that 58% voiced confidence in President Obama, 42% in Democratic leaders in Congress and only 34% in Republican leaders in Congress.

This opens up an important question: How are you dialoguing with your employees and the communities you serve on healthcare reform? Are you taking advantage of this confidence?

Read the original article at <http://bit.ly/iN4w5>

JacksonHealthcareReview

Classic Thought Leadership: Ram Charan on ‘Why CEOs Fail’

In the June 21, 1999 issue of *Fortune* magazine, author and advisor Ram Charan penned a classic piece that remains as relevant today as it did when it was written. It answers the question, “Why do CEOs fail?”

According to Charan, it’s not because they lack intelligence or strategic vision. **Most CEOs stumble due to a simple, fatal shortcoming: EXECUTION.** In other words, their biggest problems occur when they’re indecisive, don’t deliver on commitments and don’t get things done.

Often “flawed strategy” is blamed for a CEO’s failure, when in fact it’s their ability to execute.

What is the most common way CEOs blow it?

People problems. They fail to put the right people in the right jobs and they fail to fix people problems in time.

Charan says, “...failed CEOs are often unable to deal with a few key subordinates whose sustained poor performance deeply harms the company.”

Charan goes on to identify the six most common excuses and rationalizations that CEOs use.

1. *“He has to succeed.”* Occurs when a talented subordinate is seen as a successor.
2. *“He’s my guy.”* Emanates from a history of working together.
3. *“I can coach him.”* Sometimes you can’t.
4. *“Wall Street and the press like him - I’d better keep him around.”* Creates a debate of company viability vs. image.
5. *“I’ve fired a lot of people lately.”* CEO worries board won’t think internal leaders are being effectively developed.
6. *“I’ll take the devil I know over the devil I don’t.”* Occurs when an insular culture is perceived not to accept an outsider.

Email your ideas and feedback to
jhr@jacksonhealthcare.com