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INSIDE:

The Development of Subacute Services: Struggling to Complete the Continuum (Part One) 3

Strategic Ad-visory: "Corporate" Ad Campaigns for Hospitals? You May See Many More in the Years Ahead 6

How Service Line Management Can Work in Integrated Systems 8

Cleveland Clinic and Kaiser Forge Innovative Relationship 9

The Outline of the Agreement between Kaiser Permanente and Cleveland Clinic 11

Ahead of Reform: Artists, Performers Provide Patients with Welcome Diversions 11

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Speed, Flexibility, and Competitiveness Make the New American Hospital

"It isn't size, it's wit and speed," says management consultant Clay Sherman in paraphrasing the battlefield secrets of a Desert Storm commander. "Wit and speed will beat size and mass any day."

As president of Management House, Inverness, IL and author of *The New American Hospital: A Time for Greatness* (Jossey-Bass, 1993), Sherman believes hospitals lack similar wit and speed. He views hospitals as plagued by bureaucracy, questionable quality, and "cookie-cutter, copycat innovation," as evidenced most recently in "merger mania."

Speaking in Chicago at the American College of Healthcare Executives' congress on administration, Sherman outlined how hospitals can drive change by managing the "soft side" of innovation. Among his ideas:

- **Avoid boneheaded cost cutting.** "Don't betray your management philosophy through thoughtless layoffs," counsels Sherman. "If you weaken and damage the culture, you'll be even less able to compete." As a favorable alternative to layoffs, he suggests mobilizing teams to generate creative cost-cutting ideas.

- **Focus on markets, quality, cost, and service.** "Find new markets, redesign services, drive up quality, cut prices relative to competitors, and deliver supreme service," advises Sherman. For example, he suggests that hospitals set extravagant or "outsize" targets such as increasing customer satisfaction by 10 percent over the next year.

Mark Clement, CEO of Holy Cross Hospital in Chicago, set an outsize target of increasing customer satisfaction to the 75th percentile compared to hospitals nationwide in the first year of his tenure. What made this achievement remarkable was the facility's starting point of the 13th percentile.

- **Accept the revolutionary and escalating nature of change.** "The knowledge explosion is the most powerful driver of change in health care," asserts Sherman. Even more critical is the pace of change. While general

knowledge doubles every eight years, medical knowledge doubles every four years. And breakthroughs in genetic engineering promise to rush patient demand for radical therapies.

• **Respond to change by building a "change machine."** As Sherman puts it, "Reflect on how you can process large amounts of change in shorter periods of time." The solution, he believes, is lower-level decision making, empowerment, freedom and autonomy, and training. Still, he acknowledges that some middle managers may be ill-equipped to produce decisions formerly made by vice presidents. "As more self-directed work teams emerge, a growing number of managers may get caught in the middle."

Hospitals will fail to secure competitive advantage unless they choose one of three paths: cut costs, develop high perceived quality, or become the unique sole provider in their markets.

• **Establish a "defensible position."** Among the most popular positions targeted in the work of Harvard Business School professor Michael Porter are: the lowest-priced provider, Wal-Mart; the highest quality (price/value ratio) provider, Nordstrom; and the unique provider, L.L. Bean.

To evaluate customers' perceptions, Sherman recommends these questions: "Are we the best hospital you've ever been to? If not, what was the best hospital, and what did it do for you that we weren't able to do?" He's convinced that hospitals will fail to secure competitive advantage unless they choose one of three paths: cut costs, develop high perceived quality, or become the unique sole provider in their markets.

To illustrate the concept of defensible position, Sherman cites Lincoln Electric, a Cleveland-based producer of arc welding equipment that ran General Electric and Westinghouse out of the market with three simple ideas: "Produce more and more of a progressively better and better product at a lower and lower price." Another key to Lincoln's success is a bonus system through which employees can earn up to 100 percent of base pay and where "employees' earnings and promotions are in direct proportion to their contributions to the company's success."

• **Develop a strategy to sustain competitive advantage.** "Play at being at prime," quips Sherman, defining "prime" as a state of "unprecedented and hard-to-top peak performance." His advice: "Make your hospital the best place to work. It's not mediocre people who leave, it's the ones with real talent." For this reason, he recommends that hospitals ask departing employees why they chose to leave and what it would have taken for them to make a decision to stay.
For Sherman, the key is culture. "Culture is a lot like custard because it holds everything in place. But you need the kind of custard that supports creative chaos, change, excitement, and innovation." He lauds 3M for its *11th Commandment:* "Never kill an idea."

• **Revamp work processes and set new goals.** Sherman recommends involving employees in setting goals such as improving the customer satisfaction rate by the end of the calendar year and monitoring progress with a large scoreboard in the cafeteria. He also suggests that organizations measure their innovation rate. Among the issues: How many innovations were introduced? What was the quality of the innovations? How fast were the innovations implemented?

Sherman does see a growing number of "New American hospitals" tracking innovations by department and division and setting standards for the number of ideas per full-time equivalent.

Also on his slate for enhancement is decision speed. He believes executives should make policy decisions within one month and operating decisions within seven days. "If executives fail to [act on] an idea, managers should have the authority to go ahead without them."

• **Develop toughness.** For Sherman, the questions hospitals must face are the questions posed by five-star coaches: "How bad do you want it? Are you willing to pay the price?" As he puts it: "Many great teams have been beaten by other, less talented teams who have the hunger to win. If employees aren't excited to be at work, leadership hasn't done its job."

Sherman advises organizations to review every process, policy, and procedure, and pose two questions: Why are we doing this at all? Why are we doing it this way when other organizations are doing it better, faster, and easier? "If you want excellence, you'll have to pay the price. No one will kiss you on both cheeks and give it to you."

• **Enhance speed, flexibility, and range of motion.** Citing such recent Olympic stars as Tommy Moe and Dan Jansen, Sherman believes hospitals must be able to race, flex, stretch, and change directions. The solution is "idea contrarianism" and "breakthrough benchmarking," by which hospitals not only match a standard set by another organization, but also try to top it by 10 percent.

Key to achieving speed and flexibility are "rapid deployment forces" that often take the form of problem-solving groups. For example, Hillcrest Medical Center in Tulsa, OK created more than 900 problem-solving teams to help the center meet its goal of four innovations per FTE per year. St. Mary's Medical Center in Evansville, IN pushed for innovation and implemented 3,300 ideas in its first year, using 1,935 teams to do so. Competitors that cannot match this volume and speed in innovation will be lost.

-- by Joyce Flory

The Development of Subacute Services: Struggling to Complete the Continuum

Part One

Subacute care is one of the hottest topics today. The past year saw the formation of, not one but, two trade associations. It is also the subject of a major conference and an area of keen interest in more general trade meetings. However, subacute care continues to be much misunderstood, or in the words of one Minnesota consulting group: "Providers are daunted by the complexities of market entry. However, it is revered as the missing piece to the integrated network puzzle."

This two-part article by Janis E. Tropp, an associate with the Reston, VA-based consulting firm Lammers+Gershon Associates, provides some straightforward answers to propel executives interested in pursuing subacute care services onto the next plane of investigation.

Defining the concept

Most observers consider subacute care the loophole in the prospective payment system. So it comes as no surprise that health care providers reimbursed on a per case basis eagerly initiate discussion about this non-traditional level of care. However, these discussions have become the source of months or even years of conflict as each provider group works to create its concept of subacute services. For example, while the Commission on Accreditation of Rehabilitation Facilities is working to develop standards of care for subacute services in the rehabilitation industry, these services still are not clearly defined due to the paucity of consistent regulations or reimbursement mechanisms.

Exceptions can be found to any definition of subacute care, which is also called transitional care, post-acute care, and skilled care, depending on the type of provider. One would assume subacute care is care provided to patients who are less acutely ill than those requiring the services of an acute care provider. Using this definition, the services provided to a paraplegic patient receiving intensive inpatient rehabilitation services would be considered subacute. This care is actually referred to as acute rehabilitation. Another possible definition for subacute services is care provided at a lower intensity in terms of professional hours of patient care per patient. But a comatose patient in a "subacute" unit of a rehabilitation hospital often requires more nursing hours per day than the person admitted for "acute" rehabilitation. A ventilator-dependent patient in a facility that defines itself as a subacute provider requires more intensive nursing services than many patients in a medical/surgical unit of a general hospital.

Only if a separate definition is developed for each provider type does a clear definition of subacute services begin to emerge. For a general inpatient provider of medical/surgical services, subacute care is for patients requiring less intensive medical attention, including nurses and physicians. For inpatient providers of "acute" rehabilitation services, subacute care is for patients requiring fewer daily hours of physical, occupational, and speech therapies. Nursing homes with subacute units and specialty subacute facilities may provide services to both of these patient groups.

With that in mind, management groups seeking to develop subacute services must agree on the working definition for *their* organization.

Historically, the concept of subacute services has evolved in response to the prospective payment system (PPS) for Medicare patients. If a hospital receives a fixed payment for a patient, it realizes increased profits