Montague (Monty)Brown, MBA,DrPH,JD

Retired Consultant (strategy, integrating systems, management)

Role: Consultant on Hospitals, Consortia, Management,Misc.

**Relevant Experience**:

**Positions held**: Director, Hospital Administration Program, Northwestern U; Prof. HA, Duke Univ.; Editor Health Care Management Review (25 yrs). Independent consultant (about 15 years); Americorps Volunteer (full time) tasked with building Medical Reserve Corps and Citizens Corp Council for Arizona. Chaired Arizona CCC one year.

**Focus of research and consulting** was on integrated health systems covering regional markets: helped design, build and operate regional and national consortia and other integrated networks; research on attitudes of health professionals, all employees, patients and physicians; multi hospital systems; shared services….all requiring networking.

**Considerations for linking organizations.**

These are my take away learnings from my most successful and least successful experiences ….which seem relevant for this project. Key decision makers include CEOs, Board Members, Payers, and Physicians and other related groups which are close collaborators with hospitals.

The will want answers to the concerns noted below.

1. **Are there pressures for major change sufficiently real to demand systemic response and change? In short can our approach to 20% of GNP for health care be the end of expansion or is it merely another step towards 30% of GDP?**
2. **Is the guiding research goal real, meaningful to the focal organization?**
3. **Will the research process and outcomes result in lowering cost; increasing revenue; achieving superior outcomes making the organizations services more attractive to buyers and patients?**
4. **Who will it hurt?**  Will it cause lost revenue, reduced roles for the hospital and its physician? Will it cause relocation or other disruption of services ? If hurt can be anticipated, have mitigating factors been included in the project along with their cost and possible attractive alternatives for those likely to lose.
5. **Are the others who must buy into the decision to collaborate on research and innovation to improve quality and outcomes? Some to consider include:**
* **At every level** of the organization there is someone who control the work and they often take an “ownership” stance towards that work. Respect that and gain their acceptance and trust. In the ranks there will be concern over losing as well as gaining from the innovation under consideration.
* **Physicians** as much as hospitals “own” the work of the hospital. Their interest cannot be ignored and thus their buy in to innovations research is often critical especially if the outcome may change their flow of patients and work.
* **Insurers** pay and incentivize. Research often consider impacts on how much insurers Pay for something.
* **Patients** “pay”, in charges shifted, time lost, on going treatments required, etc. This is a mistake and as consumers learn more about how things work resentment will grow and turn against those who ignored their needs.
* **Trade and professional associations** often follow projects and have opinions of which are good and not so good. Also most of them protect their perception of the interest of the profession or type of organization they represent. Briefing them and soliciting their opinions can be helpful since the decision makers noted above often consult them on such matters.
* **Public agencies, major trade associations, foundations, volunteers,** etc. have interest that may intersect with any given project. They will often find out about the project and seek information and sometimes inclusion. Listen carefully and consider their possible role(s). We may find that volunteers can do some of the needed work thus lowering cost and spreading a benefit to the volunteer who gains in health as a result of helping others.
1. **Bottom line**: we need better outcomes; less readmissions; better cures and rehabilitation; lower cost of care and at the same time create ways to assist patients, especially after acute care, to recover and not relapse. We need more attention to those not getting needed care and better ways of preventing problems where casual factors are well known, And while achieving those things cost must come down. If we proceed on our current course this may be an impossible task. The challenge here is to find ways to do it.