WHITE PAPER

Navigating Uncertainty: Current Thinking and Future Challenges for Regional Health Systems

Richard J. Priore, ScD, MHA, FACHE, FACMPE
January 2016

Bringing together insights from senior executives from large regional health systems and Excelsior's industry experience, this white paper highlights challenges facing regional health systems and how forward-facing executives are utilizing innovative approaches to better configure their organizations for the future.

Background

This white paper represents a summary of industry thought leaders' perspectives on navigating the increasing complexity and uncertainty in healthcare delivery coupled with recent experience gathered from clients, a leading healthcare performance consulting firm. Senior executives from large regional health systems were asked to share their insights relative to the current state and future challenges their organizations are facing and the mitigating strategies they are implementing to position their organizations in an increasingly dynamic, competitive, and payment constrained market. Excelsior participated in informal, one-on-one conversations focused on system integration and performance with executives representing six multi-hospital integrated health systems located throughout the US.

The systems profiled range from 4 to 9 acute care hospitals in tightly organized (100-mile radius) geographic clusters. Hospitals profiled range from 1,229 to 3,007 staffed beds, 69,999 to 159,054 annual discharges, 328,559 to 786,447 patient days, and $6.1 to $9.8 billion total net revenue. The broad categories of issues addressed by the empanelled executives included governance and management structures, population health management, utilization and expense management, and physician-system integration.

Governance and Management: Maximizing Regionalization Impact through Rationalization

LEADERSHIP IMPERATIVE #1
Leaders working to leverage their "systemness" to deliver more efficient and effective care must address the question of achieving full operating accountability with an appropriate degree of centralizing or decentralizing across the continuum of both horizontal and vertical service development, delivery, and management.

For the purposes of this work, we defined "regionalization" as the formal integration of geographically dispersed hospital operating units into one corporate leadership structure. As a foundational construct, we observed that best practice systems are moving towards full operating accountability through service rationalization—characterized by the appropriate location of health providers and facilities required to achieve optimal resource application given a specified population's needs.

Rather than a hospital subsidiary making most of the decisions about which programs and services to offer in its local geography, a "rationalized" delivery system approach will require a different governance structure: one that is able to make decisions that advance the strategic goals of the system while meeting the local needs of the individual hospital and physician community.

- For example, one system executive is confronting the cost, quality, and outcome challenges of operating multiple, geographically-close open heart surgery programs, all with suboptimal volume. The result is likely to be a reduction in some levels of local service to enhance regional care delivery effectiveness.

It was the consensus that, ultimately, every strong regional system will have to substantially alter both governance and management structures:

- As stated by one leader, subsidiary hospital governing boards within a regional system will be asked to more fully govern the entirety of the hospital operating units while the regional system board focuses more on risk taking and population heath management.
- Another leader stated that everything that mattered from a strategic positioning perspective would be accomplished at the system board level to allow for more nimble decision-making.

Views relative to management structure were similarly aggressive with open affirmation of substantial need to change from the present:

- A major underlying theme was that the traditional decentralized command and control structure inhibited the building and growing of effective programs that cut across the typical organizational "stove pipes" and had to be substantially modified if not totally revamped.
- The extension of this theme is that operational accountability to continually evolving and well-defined standards of performance—both clinical and financial—will be *the* major responsibility of regional system governance.

The decision to centralize or decentralize management will be dependent upon achieving economies of scale while allowing local decision-making flexibility for services that touch the patient at the point of care.

- Further, these leaders predicted that the holding company model, typically with little involvement in day-to-day operations of its subsidiaries, was not going to survive in the future healthcare environment. Rather, a more hands-on operating model approach will be needed.
- Many system executives discussed the critical importance of providing subordinate leaders authority commensurate with responsibility coupled with increasing levels of formal accountability to Board-established financial and clinical standards.

Rationalized regional operations will increasingly impact clinical care delivery and thus there must be increased levels of physician involvement in senior management and clinical direction.

- One example was designating responsibility for emergency services across all regional system hospitals, including managing physician schedules and call, to one clinical department chair.
- Another example was the utilization of a "horizontal vice president" structure where administrators serve as the co-lead for each acute care facility paired with a chief medical officer or chief of staff. Often referred to as the "dyad" or "shared leadership" model, the goal is to create functional and multidisciplinary teams responsible for total performance including clinical and financial outcomes.

With new levels of structured clinical input, rationalization was occurring regularly at three distinct levels:

- Most system leaders use a regionalized approach to rationalization of specific non-clinical functions such as finance, human resources, marketing, and design/construction.
- Some executives were also advocating rationalization of ancillary clinical services including lab, ambulatory surgery, and imaging. However, one CEO cautioned that such rationalization makes sense only if the regional executive responsible for the service can demonstrate improved labor utilization by moving staff from facility to facility.
- Finally, all system leaders acknowledged the critical importance of standardizing and leveraging information systems and technology across their organizations. They noted that it was only through such systems that true clinical and financial accountability could be established. In addition, such systems providing accurate, near-real time clinical and financial data will be required to effectively manage and improve the health of their respective patient populations into the future.

New Frontiers: Population Health Management and Evolving Payment Models

LEADERSHIP IMPERATIVE #2
Changes in reimbursement toward a risk-based model present the need and challenge to develop the knowledge and infrastructure to shift from a fee-for-service volume-based paradigm to value-based care delivery.

Each health system leader is, in one form or another, actively exploring the health reform-driven need to plan for increasing levels of clinical risk assumption. This includes a stepwise process of sharing risk within the provider community, moving to sharing risk with the payer community, to final assumption of full risk.

Responses to risk assumption varied from development of integrated continuums of care – either owned or in partnership with others – to entering into arrangements for "bundled" pricing and payment to actual assumption of risk for a specified population.

- One system executive actively plans to develop an insurance or financing vehicle; which could include starting an HMO, getting an insurance license, or joint venturing with a major commercial insurer.
- "We have to be in the insurance business," commented another leader in a different region of the country.

- Another executive is exploring population-based care as part of a statewide initiative.

Regardless, all system leaders acknowledged movement away from fee-for-service toward provider risk-based or risk-sharing population health management was inevitable and that rewards will be based on value not volume. Thus, it is paramount that the entire regional provider system becomes high performing.

Maintaining Margins by Reducing Unnecessary Utilization and Managing Cost

LEADERSHIP IMPERATIVE #3
Successful optimization of health delivery requires not only that we strive to improved the process and outcomes of our daily work but also that we build in strategies to sustain these improvements once achieved. *Brent C. James, MD*

System executives were unanimous relative to the absolute need to confront the challenge of significant and unnecessary utilization of services that are contributing cost with no commensurate patient benefit. Moreover, with the added negative financial impact of Sequestration and the Affordable Care Act on Medicare payment, system leaders are similarly convinced that there will be continuing declines in the utilization of hospital inpatient services.

They are therefore taking the necessary steps to eliminate as much inappropriate utilization and associated cost as possible:

- One system leader anticipates the need to re-tool operations to generate a positive margin or at least break-even on expected lower Medicare payment rates.
- Surveyed leaders expected the need to make near term reductions in operating costs on average between 15 and 20 percent.
- According to another view, an added challenge to achieving targeted financial performance is the planned expansion of Medicaid where the cost-to-reimbursement gap cannot be closed with anticipated higher volumes, requiring even tighter per case cost controls.

"Hang Together or Separately": The Physician Enterprise and System Integration

LEADERSHIP IMPERATIVE #4
Medicine and management must live with each other differently than they have in the past. The key lies in the willingness and ability of hospitals and physicians to give up old ways of thinking and behaving to build a new kind of social contract – a social contract based on paradox, ambiguity and change, risk and the pursuit of 'responsible excellence.' Stephen M. Shortell (1985) The Medical Staff of The Future: Replanting The Garden. *Frontiers of Health Services Management*, 1(3), 3-48)

Physicians will continue to be essential to the ultimate success of regional health systems. All executives stated that they are working hard to shore up critical gaps in physician alignment and clinical coverage. The range of integration models used by

health systems in physician engagement covers the spectrum from employment to multiple forms of professional service agreements. Leaders are challenged with aligning the often competing needs of both employed and independent medical staff members while creating a clinically integrated system.

- To meet this challenge, one executive sought new ways to enfranchise and partner with non-employed independent medical staff members by sharing full access to enterprise clinical data.
- Another had implemented several successful co-management efforts with selected members of his medical community.

The potential financial impact of partnering with physicians—both positive and negative—was evident in conversations with each of the system leaders.

- One executive strongly noted that physician behavior has to change from a fee-for-service mentality to the future of population health management if physicians are going to successfully participate in new care paradigms.
- Another expressed the absolute need to reduce the substantial losses of his physician enterprise to tolerable levels.
- Another projected the need for more and deeper economic alignment arrangements with physicians, noting the caveat that increased and significant physician involvement in reducing utilization and cost may have an unintended consequence. It could, he suggested, create a "new monster" once physicians grasp the entire underlying new economic picture.
- One executive mentioned another potential pitfall of the moving away from fee-for-service medicine was that more physicians would seek concierge-like practices at the expense of seeing far fewer patients, thus further exacerbating access to primary care while both the insured and elderly populations are increasing.

Two consistent themes echoed by the leaders were the need to recruit and retain quality physicians, especially in primary care, and develop strong physician leaders to champion the system's strategic goals. The latter was identified as essential to the shared governance approach in the system's clinical services and departments. Toward that end, an innovative approach used by one executive was creating a "Physician Leadership Cabinet" comprised of several clinical chiefs at each hospital and presidents of the medical groups. The system CEO uses this body as a sounding board and doesn't pursue any financial or strategic initiatives without its consensus.

Relentless Management Challenge: Aggressive and Constant focus on Cost

LEADERSHIP IMPERATIVE #5
All of the above imperatives have one common and underlying foundational element required for successful implementation – clinical care efficiency defined as clearly understood, articulated, and targeted balance between cost and quality of care rendered. In order to achieve this balance, it is an absolute imperative that senior health system leaders develop an organization culture dedicated to the principle of aggressive and constant cost reduction focus.

As Excelsior has conducted multiple performance improvement projects over the past three years (6 systems/17 hospitals/$260 million in improvement recommendations), it has become evident to us that the past approach of making major "adjustments" to a systemic cost base every two to three years is no longer a viable model of planned performance improvement. What will be required of the highly successful health organization is an unrelenting focus on every cost input to a patient interface with the system.

- This focus must extend from the initial scheduling of an outpatient appointment to the on-time start in the operating room to the appropriate timing of discharge from intensive care.
- It must also extend from the management of hourly nursing care inputs to the acquisition of medical surgical supplies to the utilization of consultant services.
- It must be based on widely known standards of practice and full organizational accountability for accomplishing those standards.

Of prime importance will be the attention devoted to operational effectiveness and efficiencies of physician practices. In the past, these entities have been fairly autonomous operating units. However, in a fully integrated system the practices, like hospitals, are simply an extension of that system and have to be managed to perform at the best possible level. Hospital-centric systems are not going to have the in-house skill set required to make this happen and are thus going to have to retain appropriately experienced physician practice executives to achieve high-level performance.

Thus, we believe an overarching challenge dictating success in implementing all of the above imperatives is two-fold.

- First is the establishment of expected standards of performance whether those be hours of care (both inpatient and ambulatory) to be provided per patient day or total resources to be utilized during a patient stay. These standards must be system-specific and developed with comprehensive input and agreement from all key stakeholders. They will, by definition, underpin the organizational value statement.
- Second, there must be full organizational accountability for achieving these expected standards of performance. In order for this to be achieved, senior leadership will have to provide both the affirmation that these organizational expectations be fulfilled and the tools required to achieve them. The active daily utilization of robust performance tracking tools in human resources, case management, and clinical resource management are essential in maintaining full institutional engagement in cost control. Retrospective evaluation of cost performance is no longer acceptable and must be replaced by concurrent measurement and management.

Summary

Effective regional leaders are continuously exploring and utilizing ways to leverage their "systemness" to provide a competitive market advantage and reduce operating costs. A key element to accomplishing this objective is devising the appropriate governance structure to promote an organization-wide strategy while preserving the unique needs and culture of individual markets. Best practice system leaders are examining horizontal integration and rationalization opportunities to "make or buy" population health

management functions, including insuring and financing the care for a specified patient community.

Recognizing continued pressure on financial performance from anticipated reduced reimbursement, system leaders are constantly combing their organizations to do more with less. They are seeking ways to partner with their providers to reduce unnecessary utilization of services while engaging them to grow their way forward in mutually beneficial relationships. While identifying the strategies around these key opportunities is important, the ability to act decisively to drive measurable performance and results will determine their ability to survive the increasingly challenging times ahead.

Conclusion

We at Excelsior, based on our immediate past experiences, resonate with many of the views these regional system leaders have shared with us. It is our belief that there are four core management initiatives required to chart a successful course over the next five years. These are: 1) Continuous organization reinvention; 2) Robust and continuous clinical resource management (CRM); 3) Aggressive physician enterprise management; and 4) Foundational development of population health management capabilities.

Continuous organization reinvention. We are certain that regional systems must be prepared to reinvent themselves through revisions to their governance and management structures, but in addition must be prepared to practice continuous downsizing and upsizing of services. While many are now faced with what might be viewed as "one time" adjustments to the new realities of payment reform, we hold a contrary belief. We are dedicated to the principle that high performance health systems of the future must adopt aggressive and continuous productivity management as a core value. Employee productivity cannot be effectively managed in a stepwise fashion, as is so often now the case. Bottom line: systems must be managing associate productivity to Medicare payment rates—both inpatient and outpatient.

Robust and continuous clinical resource management. Managing to Medicare cannot be achieved through associate productivity management alone. Each high performance health system must take on the challenging issues of partnering with their medical community, both employed and voluntary, to implement aggressive clinical resource management initiatives. To be successful, these CRM initiatives must be data driven, based on internal best practices benchmarked against both existing evidence based knowledge and other high performance hospitals, developed through physician-led multi-disciplinary teams, and implemented through well documented clinical process redesign processes. Based on our past experience, the objective of these efforts should be to reduce clinical resource utilization by at least 20%.

Aggressive physician enterprise management. Physician enterprise management is a new frontier for most hospitals and health systems. All regional systems have been actively involved in executing a large variety of contractual relationships with key members of their medical communities. The numbers of physicians employed by each has risen exponentially over the past four years. Yet, based on most recent Excelsior experiences, lack of practice management experience and expertise has created a unique opportunity for cost reduction and efficiency and productivity enhancement. Frequently we have worked with systems in which the physician enterprise is overstaffed, revenue streams coding efficiency are poorly managed, and practitioner

compensation is overly generous for levels of productivity. In addition, there is little or no expectation that these employed physicians will participate in other key system clinical activities such as CRM in an active fashion. Our recent experiences have uncovered from $10 to $25 million in cost reduction opportunity to be realized through increased practice efficiency in an organization's physician enterprise.

Foundational development of population health management capabilities. The concepts of Accountable Care Organizations (ACO) and Population Health Management (PHM) have come onto the radar of all regional health systems quite suddenly. However, we believe that the clarity of appropriate approach to both is going to be very idiosyncratic and driven by specific market characteristics – characteristics that many systems are only now beginning to understand as the attempt to more clearly define the population that they intend to serve into the future. Thus, it is our view that all of the above performance improvement activities are essential foundational steps required to successfully implement any ACO strategy while preparing a system for the next step into broader population health management. And, as all of the seasoned leaders that we have talked with have cautioned, each regional system must be fully prepared to assume financial risk. Only high performance systems will be able to do this with any reasonable level of confidence in their success.