

***SURVEY RESULTS:
DILEMMAS FOR THE LEADERS OF U.S. ACADEMIC MEDICAL SYSTEMS***

Recently, BDC Advisors, LLC has had the privilege of holding face-to-face meetings with leaders of 22 large metropolitan academic health systems. These individuals have the title President and CEO, or in a few cases Chief Operating Officer or Associate Dean for Clinical Affairs. The systems are well known, well respected, and are usually among the largest employers in their marketplaces.

THE MAJOR VEXED ISSUES IDENTIFIED

1. Insufficient revenue to meet *bona fide* needs of patients and other major constituents.
2. Insufficient capital to optimize access to newer technologies and to appropriately maintain and upgrade facilities.
3. Competitors diverting patients and staff from more lucrative product lines.
4. Strained physician relations.
5. Divergent needs of medical schools and teaching hospitals leading to increased tension between the two.
6. Dysfunctional mergers thwarting progress.
7. Provider-community relations worsening.

CONCLUSIONS AND SOME SUGGESTED RESPONSES

1. Grow net income using a menu of revenue-enhancing strategies. Success requires operating margins of 5 to 10% which cannot be achieved by cost cutting alone. Most of those interviewed oversee teaching hospitals that are at or near breakeven even though they are close to full capacity and continuously pare their expenses. Revenue growth requires more attention but it is often squeezed off the agenda by recruitment and retention of scarce nursing, technical and medical specialty staff, managing with capacity shortages, and dealing with incursions by competitors into traditional markets. BDC Advisors, LLC can help leaders to devote more attention to revenue growth by sharing its menu of revenue-enhancing strategies. Options range from dramatic improvements in contracting methodology to enhancing federal revenue to decreasing referral “leakage” to changing physician and management incentive plans, to name but a few. In addition, attention to some of the items below can produce significant revenue-side enhancements.

2. Spend capital selectively while tapping into innovative funding sources. While capital capacity is constrained by diminished cash flow, demands for capital arise on all sides. Interviewees cited emerging technologies, neglected facilities requiring upgrades, information technology, and ambulatory services as primary needs. Most organizations cannot afford all of the items on the wish list making careful analysis of capital expenditures increasingly important. Tools now exist to augment capital plans to account for the uncertainties of emerging technology and optimize spending plans. Fulfilling capital needs will also call for innovative approaches for raising funds, such as joint ventures with for-profit experts in property management, out-sourcing of information systems contracts, and advance planning for disruptive new technologies, with appropriate phase-out of *passee* programs and initiatives.

3. **Re-examine competitor strategy with new intensity.** A second look is now being taken by several academic medical center leaders at meeting the access and quality needs of their communities without duplicating efforts.
4. **Accept that single-specialty groups and other physician revenue-enhancing models are here to stay and figure out how to work with them.** Many leaders we visited have salaried physicians who are losing money, but they generate indispensable referrals and ancillary revenue. As many interviewees noted, physicians can often improve their economic performance in private practice, by reaping ancillary revenue which formerly accrued to the system. The shift of more therapy to ambulatory venues, the availability of newer non-invasive diagnostic techniques, and the success of focused factory models in many subspecialties suggest that the trend to competing private single-specialty groups will continue to increase. What to do? Aside from the obvious analysis of financial pros and cons, we recommend a look at what your own doctors really want, and possible innovative alternatives for achieving their goals. For example, our recent experience suggests that doctors want not only financial security, less hassles, and good information, but that a major unmet need is for more control. There are well-organized methods to achieve this for both salaried and private medical staffs, that will not put the system's strategy or financial performance at risk, yet can greatly enhance the relationships with the physicians.
5. **Stop the simmering tension between medical schools and teaching hospitals before it boils over.** Leaders cited many examples of tensions between medical schools and teaching hospitals and attributed them to multifactorial causes. Always the result is the same: poor outcomes for both parties. Despite the historical and cultural antecedents, redefining the role of the department chair is a major unmet need. Another solution is to hire and incentivize specific groups of physicians to fully understand and meet the needs of at least one of the two entities, as opposed to only partly meeting the needs of both, or meeting the needs of neither. Finally, the time-honored ideal of the "triple-threat" academic physician, expert in teaching, research, and clinical care, needs to be jettisoned in favor of faculty recruited specifically to be wonderful (and very productive) in one or two of these three areas.
6. **Fix mergers that do not deliver.** When academic medical centers carried out the consolidations and joint ventures of the last 15 years, they did so against the history of healthcare delivery as a cottage industry, with rugged independence, local control, and preservation of individual prerogatives maintained wherever possible. Many economies of scale, however, have been missed. Even more important has been the missed opportunity to differentiate the offerings of system members, truly emphasizing the core competencies of each member. Instead, every member provides, too often, a "complete" continuum of services, at unsustainable operating cost without maximizing attention to patient needs, quality outcomes, or revenue capture. System governance structures are overdue for change in many cases, and opportunities to draw from the strengths of healthy system governance are being lost.
7. **Tell your story to the community every day.** Healthcare providers as "big business" are easy targets of blame for the complex problems of the healthcare system. Rather than the heroes of the community, medical centers are often perceived as the villains. Interviewees saw image problems as a threat to philanthropic efforts and the community support needed for expansion. The need for medical centers to tell their story has never been greater and the audience must include the local business community, as well as government officials and the general public. Intensifying this effort can bear great fruit, especially if it is aligned with strategic and capital priorities. It is amazing how little the business community knows about successes in controlling costs, improving access, and improving outcomes. This constituency, the ultimate payor for

many patients, needs to be an advocate for academic medical centers in both the short term and the long term, in which they will influence the debate over meaningful healthcare reform.

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If you would like to learn more about the survey or to discuss any of BDC Advisors, LLC's approaches to revenue enhancement or to assisting our clients in designing and applying effective solutions to these dilemmas, please contact Peter H. Levine, M.D. at 508-756-7920 or Richard E. Wesslund at 415-247-1030.