

BUILDING THE HIGH PERFORMANCE HEALTH SYSTEM **A FOUR PART SERIES**

PART I: THE COST RESTRUCTURING IMPERATIVE AND THE NEED FOR AN OPERATIONAL STRATEGY

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THE IMPERATIVE

As our colleagues have argued in earlier white papers,^{*} health reform is underway – all government action or inaction aside. There are two inescapable facts of the market:

- **Costs will be contained** – either through new payment structures or a continuation of our existing fee for service system, but with draconian rate cuts.[†]
- **Quality will continue to be measured and reported**, and there will be more and more metrics and financial incentives.

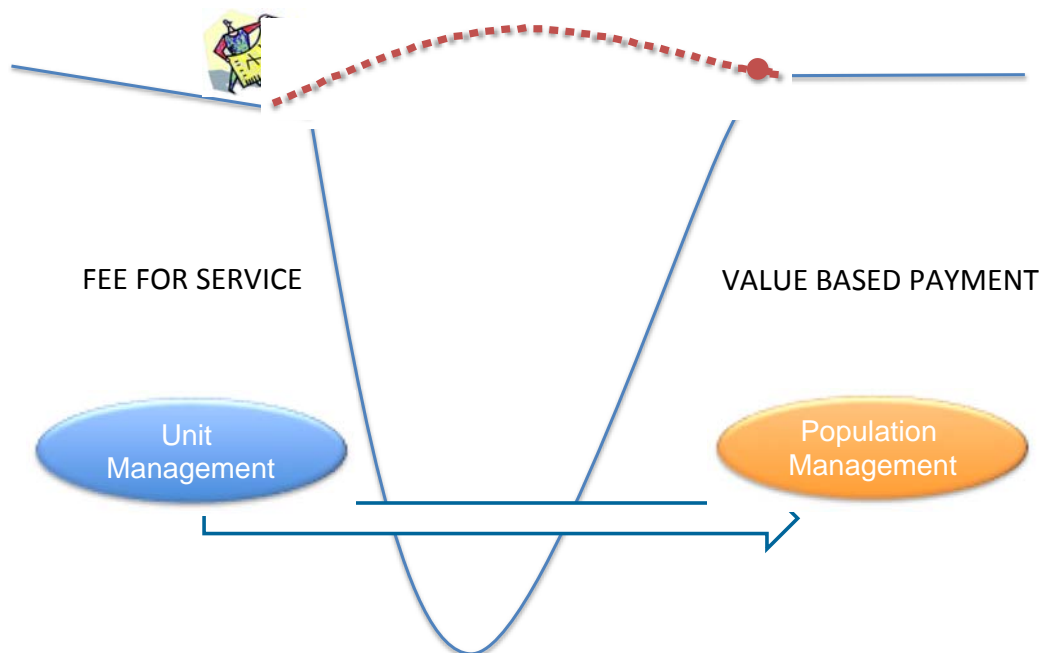
These market forces will increasingly require systems to compete on their ability to be both high quality *and* low cost. Delivery systems that demonstrate this value proposition to the market will have a competitive advantage. Payers will create incentives that will drive their members to get care at more efficient delivery systems, and thus the **high performance health system** will win in the market.

Many systems have been diligently working on meeting the targets for the quality metrics. While challenging, this focus on quality metrics has barely altered system operations. Cost containment – really a coming tsunami of societal cost reduction – will be far more disruptive to hospital systems. Driving this change will be a collapse of price, coupled with a shift to value based payments tied to population health.

^{*}For a recent example, see *Reform is a Market Issue*, by Rick Wesslund, available at www.bdcadvisors.com.

[†]This is a national issue, as evidenced by the response from the national investor owned hospital companies. For example, on August 25th, 2011, Charles Martin, chairman and CEO of Vanguard Health Systems, cautioned investors that *the company faces continued pressure from all payers to cut costs while improving quality and outcomes*.

Crossing the Crevasse



We believe that fee-for-service prices will stagnate, and increasingly, payers will shift to value based payments such as pay for performance, bundled payments, shared savings, total cost of care, and global capitation. This means that hospital systems must become more efficient now – under fee for service – and also must begin building the operational capability to deliver care efficiently under a value based payment model.

The tactics required for reducing costs under fee-for-service are almost the polar opposite of tactics required for reducing costs in a value based system like “total cost of care” or “population health.” Hospital systems will thus need to “reverse polarity” and develop deep collaboration with community physicians, drive down utilization and lower facility costs. This shift to value based payments will also require new investments, thus making the requirement to radically lower costs even more pressing. These new investments will include building the necessary physician infrastructure, and developing an IT capability that will allow for the management of a population.

While many systems have begun the work of developing a physician strategy (though many really have not), very few are developing a “low cost of care” approach. In addition, there is very little focus on this problem in the health care literature. Indeed – it is remarkable that almost no one is asking: “How can my system provide care at the lowest possible cost?” Or, “How do I plan on shrinking my revenues in order to provide my community with more money to spend on schools, and infrastructure, and job growth?”

In this series, we seek to begin the conversation on how systems will:

- Assess their cost position in the new market, and develop an appropriate strategic and operational plan.
- Fundamentally change their operations in order to dramatically downsize the delivery cost infrastructure.
- Build the new performance systems and information tools necessary to effectively manage the organization in the new business model.
- Determine the means – beyond “education” or “leadership development” – for essentially *rebooting* system managers and executives so that they will have the skills necessary in a transformed business environment. Executives, physicians, and line managers will need to achieve this redesign.

WHAT USED TO WORK WILL NOT WORK GOING FORWARD

Health systems will need to go beyond the usual suspects targeted in “performance improvement” efforts, in order to achieve the level of cost restructuring that will make them competitive in the new health paradigm.

Historically health systems have made only incremental changes to their cost structures.

In times of *fallow*, systems often resort to cost cutting “campaigns.” These include all the old favorites: decreasing employee benefits, cutting nursing and/or ancillary staff levels, reducing supply costs, cutting travel, conferences, food at meetings, and bottled water etc. While these have a place – many organizations have little left to cut along these lines, and need to move beyond this campaign mentality.

In times of *crisis*, systems resort to “across the board” cuts, but asking managers to come up with a plan to take out 3, 5 or even 10% of their budgets does not work for long term cost reduction because:

- The system often lacks the structure to manage the multitude of projects, and lacks the resources to keep track of progress and results.
- Siloed organization components do not trust the broader structure so they protect resources even if they do not really need them.
- The process for cuts starts and staff knows that leadership will change faster than they will and they will wait out another leadership upheaval.
- Cut costs are often added back in as soon as there is a letting up of the budget cutting mentality and the organization moves to another focus.

Often these initiatives result in leaders losing the trust of the staff. This is not to say that this work is not valuable. If done with integrity, aligned with a strategic plan and with realistic goals, real money can be taken out of the overall cost structure.

We are beyond fallow and crisis – we are now entering a time of *radical transformation of our business model*, and it will require a new level of cost restructuring that we call “operational strategy.”

STRATEGIC COST CUTTING

Strategic cost cutting is an organic process that starts with a “real” **organizational strategy** creation process that results in the entire senior leadership *committing in blood* to an organizational strategy that focuses on what the organization will have to look like in a new environment (who we want to become), and the path to getting there.

Health system leadership teams need to have a clear view of the world that they are going to be operating in, and a clear vision for how they need to transform their organization to be competitively successful in that world – e.g. What will the market value? At what price? What changes in our business model will be required to compete under those circumstances? This comes from a dynamic and multi-year strategic plan.

Key questions to ask during this process:

- ***How much will utilization decrease?*** When the organization factors in demographic shifts, the required reduction in readmissions, and the expected accelerated shift to outpatient, how many discharges will be lost? If the organization further considers the impact of a shift to value based payments – how will that impact discharges? Finally, if the organization considers the impact of a radical shift, such as the utilization of the “Hospital at Home” technology that would take 21 medical conditions including pneumonia and CHF out of the hospital, how does that change discharges?
- ***Given those kind of utilization reductions, what will happen to the competition in our market?*** If inpatient utilization decreases by 25, 35, even 50% - how many hospitals in our market will fail? Who has the capital reserves to build for the value based payment world? Can we weather this storm?
- ***How big would our market need to be for us to remain viable in the future?*** If we are managing a population, but want to keep our hospitals at 80-90% occupancy, what does that mean for the size of our service area? Can we successfully expand it by 25-50%?
- ***What is the right physician strategy for managing this transition?*** Is there any possibility that we are going to “control” this number of physicians? Do we need to have a means to really partner with physicians moving forward? What does that look like?

Once the *organizational strategy* is in place the systems must have a formal sister component that we simply call an **operational strategy**.

Without the development of an **operational strategy** to partner with an **organizational strategy**, major reductions in cost structures will be difficult to implement and thus systems may not be able to have the resources to improve quality, build their networks or thrive in a more competitive marketplace.

An operational strategy:

1. Determines how the organization will eliminate costs in the current environment, in a way that both builds capital for future investments, and in a way that builds the capability to transition across the crevasse to value based payments.

2. Has a timeline for fundamentally reorganizing the cost structure of the organization so that it can deliver care to a population at a much lower cost, and it can compete with all forms of outpatient and ambulatory care on price.
3. Develops a plan for build/buy/or closely partner with the assets needed to reduce admissions to the hospital, and length of stay, including tools to better partner with physicians on managing patients to stay out of the hospital, manage patients as they leave the hospital, hospice care, home health, and the transition to treating many of the medical conditions currently treated inpatient (e.g. COPD, HF, pneumonia, asthma, DVT) in the home.

An organization cannot reinvent itself in its organizational strategic plan without a concomitant operational strategic plan. Going from an organizational *strategic plan* to operational *execution* leaves out a vital step. Without spending the time, resources and effort to lay out the operational infrastructure, setting cost goals is like searching for an address without a map (or a GPS device).

We first suggest a gap analysis of the effectiveness of the present structure, processes and ability to execute. The following are a few examples of the issues an operational strategic plan should include:

- ***Does the organization have a positive culture of accountability?***
 - Has senior management clarified the primary goals of the organization and communicated them to all staff? Are those goals few, clear and quantifiable?
 - Is there a goal and incentive structure that includes quarterly review of quantitative performance down to the supervisor level linked to key organizational priorities?
 - Does management staff feel the system is fairly created and evaluated?
 - Does this system include medical leadership (i.e. are Medical Directorships incentive and outcome based)?
- ***Does the organization have the correct IT systems in place to monitor, capture and report operational information in a real time way?***
 - Do these systems allow the organization to capture the total cost of care and key quality metrics?
 - Is there a centralized data repository with clinical, quality and financial data?
 - Are Operations structured so that input of data is a logical part of work flow and there are formal venues for information review?
 - Is there a means of communicating strategic goal results in real time back to staff to demonstrate how they are doing on the key metrics today (not a month ago)?
- ***Is the organizational structure supportive of both the organizational and operational strategies?***
 - Does the organization work in silos and if so, how can these silos be integrated?
 - Is Nursing a key player in all decisions around quality, service, cost and efficiency?
 - Are the major processes such as throughput, supply chain and revenue cycle managed as a key part of the operational infrastructure? Are there senior leaders dedicated to these efforts?
 - Is the Committee structure effective, are the Committees efficient in carrying out their charges and are the Committees supportive of major operational goals?

- Is Quality a function of the Quality Department or does all management see quality as one of their core functions?
- ***Is there a culture of focusing on value based care?***
 - Is there a formal Clinical Resource Management infrastructure, does it focus on variation in practice, ancillary utilization, evidence based care and 30 day readmissions?
 - Are Lean/6 Sigma etc. techniques incorporated into the management DNA and are the major core processes, such as admission and discharge, being redesigned? If not, these skill sets are key to efficient operating and there needs to be a prioritized plan to do that?
 - Especially in more complex delivery systems, overhead can be over 40% of total cost. Thus, is there a ruthless focus on managing overhead costs?
- **Is Human Resources primarily a developmental or transactional service?**
 - Does the management staff have the skill sets and experience to execute the operational goals?
 - Is there constant and never-ending staff and leadership training whose focus is tied to the results the organization is seeking from the strategy?
 - Does HR take the lead in evaluating employee satisfaction and are there formal processes to move from survey results to gap closure?

Once this gap analysis is completed, an operational strategic plan can be created, prioritized and implemented. When that occurs, we believe it will be significantly easier and natural for the organization to execute on value. Thus, the high performance organization is one which has a dynamic organizational strategic plan, a real operational strategic plan and has demonstrated the ability to execute on these plans

Upcoming Articles in this Series:

- PART I: The Cost Restructuring Imperative, and the Need for an Operational Strategic Plan
- PART II: Critical Tactics for High Performance Health System
- PART III: Tools for Managing the High Performance Health System
- PART IV: Building the Culture of the High Performance Health System:

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