Perspectives on sustainable cost performance
A roadmap for complex performance priorities

Three key strategies for sustainability

- **Transformational**: Drive non-hospital value
- **Transitional**: Eliminate clinical care inefficiencies
- **Traditional**: Implement radical operating discipline
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Health systems are facing unprecedented margin challenges and threats to long-term financial sustainability.

Structural changes in the industry are causing compressed revenue growth for years to come. That puts cost management at center stage again. In fact, many organizations are making headway in limiting cost growth. But it simply isn’t enough to compensate for ongoing slower revenue growth.

Seasoned health system leaders have certainly engaged in short-term cost-cutting campaigns in the past, but future financial sustainability is a longer-term journey. It will require a more expansive — and sustained — approach to cost avoidance and reduction. By this we mean aggressively focusing on three critical performance levers:

- **Traditional**: Instill rigorous, new operating disciplines in “tried and true” areas like corporate services, labor and supply chain.
- **Transitional**: Bring together clinicians and administrators to eliminate clinical care inefficiencies and prepare for new reimbursement models.
- **Transformational**: Expand health system value beyond the hospital as the engine for future growth, and optimize assets and investments for the future.

Each organization will have to map its own path to sustainability and choose the most relevant and effective strategies. We have assembled a collection of blog posts that span these performance levers. We hope you find the insights and strategies discussed in these blogs to be thought-provoking and helpful wherever you may be on your journey to financial sustainability.

Please do not hesitate to reach out to me with any comments or questions. I’d love to hear from you.

John Johnston
Featured **writers**

**John Johnston**  
**CPA, MHA**

John brings more than 25 years of health care finance and executive experience to his role as practice lead for the Optum Advisory Services Hospital Performance Improvement team. He focuses on large-scale margin improvement and cost reduction, and has assisted standalone hospitals and multihospital systems in developing and implementing complex strategies for financial sustainability.

**Rick Conlin**  
**MBA, MSM**

Rick is a founding partner of the Optum Advisory Services Hospital Performance Improvement Practice. Rick has two decades of executive ops experience across multiple industries, with special focus on mission critical industries (health care, DoD, aerospace, nuclear). He is a former officer in the Naval Nuclear Propulsion Program, a novelist and a regular contributor to industry thought leadership.

**Vince Joseph**  
**MHA, FACHE**

Vince is a health care executive with over 30 years of system leadership experience. He has participated in several merger and acquisitions and also has a strong track record in turnaround management in areas of quality and finance. He works closely with leaders to develop effective performance improvement strategies and system organizational design.
A new world order for hospital margins

BY JOHN JOHNSTON

Experienced health system executives have become quite adept at flexing their “margin muscles” when necessary. In recent years, revenue typically has grown at a higher rate than expenses, with only occasional periods of slower revenue growth.

During those times, system leaders have actively turned their attention to cutting costs proportionally to stabilize margins. However, for two consecutive years now, expenses have risen faster than revenues, and all signs are pointing to a future of persistently slower revenue growth.

Converging pressures squeeze margins

Medicare rate increases are marginal and more dollars are moving into risk-based payment. Commercial rates have slowed dramatically, shrinking what has been an important subsidy to offset Medicare and Medicaid losses. Moreover, the shift away from hospital-based care and the corresponding move from inpatient to ambulatory fee schedules are likely to have an even greater effect than that of smaller rate increases. The ongoing impact of all these changes means that system executives must be able to exercise their margin muscles in a new way that they can sustain over the long term.
A recent Advisory Board survey of 146 health system C-level executives found that cost control has replaced growth as the most urgent strategic priority.

“Preparing the enterprise for sustainable cost control” was far and away the top-ranked topic. The second highest topic was “Innovative approaches to expense reduction.”

The responses suggest a recognition of a structural margin challenge — and the need for different-in-kind, sustainable solutions.

Just how different is the margin challenge confronting health systems today? And how can health systems adapt their cost-cutting approach to this new world order?

Hospitals, which remain the financial epicenter of the health system, face an especially critical challenge. Despite the movement toward value-based care since the passage of the Affordable Care Act in 2010, health systems today still rely heavily on hospital margins to drive overall bottom-line performance. A recent Moody’s report noted that median operating cash flow for not-for-profit health systems declined 15% in 2017, a reflection of the impact lower hospital margins have on overall system cash flow.

A new world order for hospital margins

Three capabilities for sustainable cost reduction

Financial sustainability for hospitals — and the health systems they help support — requires a discipline of aggressive cost cutting and ongoing cost avoidance. Three emerging foundations are enabling health systems to tackle this challenge in an organized fashion, laying the groundwork for success.

1 | A comprehensive financial forecast

In order to guide strategic decision making, a reliable financial forecast should combine the change in payer terms with changing usage and volume patterns, competitive activity and market disruptors to predict annual net revenue on a rolling three- to five-year basis. Operating expenses and strategic and routine capital requirements will predict margin and — more importantly — cash flow. This information must become the new starting point of health system planning and operational priorities.

2 | A strategic margin plan

A comprehensive approach is needed to identify both short- and long-term initiatives that will reduce cash outlay and lower the overall cost of care. Traditional margin drivers such as productivity, supply chain and revenue cycle still apply. But new margin terrains including care delivery efficiency and service line rationalization should be a significant focus because of the impact on strategic and financial results.

3 | A robust oversight system

Financial goals will be met only by deploying multiple initiatives across the organization. Each initiative team will need a tactical action plan, an empowered leader and project management resources. Ensuring the teams meet their objectives and the required financial results are actually realized requires discipline and focus. An effective oversight system ensures all activities are coordinated and also empowers, equips and holds teams accountable for results.

Many health systems already have begun to experience the financial downturn caused by the changes taking place in the industry, while others are still meeting their financial targets.

Regardless of where an organization is today, it is time to start laying the foundation for long-term financial sustainability.
Have hospitals done enough to reduce costs?

BY JOHN JOHNSTON

Recent news about hospital margins has been increasingly worrisome. At the end of 2017, Moody’s Investors Service predicted declining cash flow for hospitals while declaring a negative outlook for the industry. And in April 2018, they announced that the median hospital operating cash flow margin fell from 9.5% in 2016 to 8.1% in 2017, its lowest level in ten years.¹ The Medicare Payment Advisory Commission’s latest report to Congress reported aggregate hospital Medicare margins fell to negative 9.6% in 2016 and suggested the 2017 run rate could hit negative 11%.² After several years of steady margins for not-for-profit hospitals and health systems, margins appear to be taking a downturn, and the issues are unlikely to be short-lived.

Moody’s cited several factors underlying its negative outlook. Low Medicare rates, declining commercial rates and shifting of care from inpatient to outpatient locations are having a major impact on top-line revenue. And few — if any — industry experts expect them to reverse course. Similarly, the forces driving higher costs — investment in physician practices, escalating pharmaceutical prices and shortages in nursing labor — also appear to be settling in for the long haul.

In this new normal of margin pressure, hospital leaders cannot afford to be complacent about costs. We must adopt a posture of constant — and more aggressive — cost containment if we are to protect future margins. One finance executive of a large West Coast system described their financial situation this way: “In order to keep up, we need to cut at least $20 million out of our cost structure every year going forward.” It’s essential to move beyond short-lived cost-cutting initiatives and campaigns and develop instead a strategy and an infrastructure that prioritizes high-impact changes that will continue to yield savings year over year.

The next issue to address is where to find cost savings after years of tackling cost reduction. Although the specific answer to this question will depend on many variables, there is still a fairly consistent level of meaningful cost savings that can be achieved within five major areas of hospital operations: labor productivity, supply chain, purchased services, administrative overhead and clinical care delivery. Although it’s certainly true that most organizations have already made cuts in these areas, there is still much room to improve.

All these developments mean we have to take a hard look at costs today, but with an eye to success in the long game. For many of us, it feels like we have been here before, and we must ask ourselves some difficult questions: How far can we push costs down before we get to rock bottom? What can we do differently to reduce costs in a way that’s truly sustainable?
Labor productivity is a prime example of the opportunity to be more rigorous. In the past two years, median productivity benchmarks have been getting more aggressive, so a department currently meeting a benchmark productivity target that was set more than two or three years ago may well have room to improve.

It also is all too common for hospitals to allow all sorts of exceptions when comparing performance with benchmarks under the guise of being unique. A health system in the Northeast recently revisited its productivity targets and found substantial savings by being more rigorous — first, by updating its productivity targets using current benchmarks, which disclosed more than 80 full-time equivalents of opportunity. Another consideration was that more than 10% of its total FTEs belonged to cost centers that did not have to meet productivity targets because they had previously been deemed exceptions. By taking a new look at these cost centers, the health system was able to identify another 50 FTEs of opportunity.

In purchased services, many leaders believe they have already captured the lion’s share of savings by outsourcing some services and functions. But in many cases, they have been missing out on significant savings because they have not pushed these contracts as far as possible.
Several years ago, for example, a mid-size health system in the Southeast negotiated with a major vendor for a performance-based management contract for food and environmental services that yielded savings of $1 million through staff reductions and lower supply costs, as well as an additional $1.5 million investment in upgraded retail and patient dining. Leadership was very satisfied with the arrangement, so when it was suggested a few years later that they review the contract, they were skeptical that additional savings could be achieved.

But through a very careful review, the system was able to win even more favorable terms on a five-year extension. With the new contract, the arrangement moved to a full-service model, with 400 of its hourly staff transitioning to the vendor’s payroll. This move generated an additional $900,000 in annual savings. The system was careful to make sure the affected employees were kept whole; not only did these employees keep their positions, they also retained their current hourly rates and original hire date and tenure and received an employment guarantee for 12 months. Finally, the system also secured another $1.4 million in investment for dining spaces and established performance incentives to ensure the vendor met continuous performance improvement goals.

Health systems have taken millions of dollars out of their cost structures in the past. Astute leaders will look for savings everywhere, including places where they achieved savings in the past. And they will need to re-instill a rigorous cost discipline that will push their teams to drive meaningful savings that will bring year-over-year benefit to their organizations.
The past few years have seen a frenzy of health system mergers, as providers look to consolidation as a means to get on solid strategic and financial ground. But for many, although consolidation has often succeeded in bringing greater price leverage and buying power, the larger, hoped-for financial benefits have been elusive. According to a study of recent mergers and acquisitions, 59% of acquired hospitals failed to outperform their market peers two years after acquisition. Moreover, one in five acquired hospitals actually went from having positive margins before being acquired to negative margins two years after the acquisition.
Although delivering on the true promise of consolidation is a journey that is unique to each organization, successfully integrating corporate services is a common practice and can be an important step toward improved financial viability. But this must mean more than an initial focus on the post-merger “wins” of department consolidation and savings. More progressive systems are now reevaluating their system-level corporate services and looking to optimize their performance while also identifying new sources of cost savings. Doing so requires an understanding of the unique challenges that “systemness” brings and the exercise of a thoughtful balance of power between system and local needs.

Revisiting the consolidation of corporate services

When hospitals merge, corporate services are among the first areas to be consolidated. Departments such as human resources, finance and accounting, planning and marketing, purchasing and supply chain, information technology, and revenue cycle offer opportunities for significant savings through elimination of duplicative staff functions and improved contract negotiating for outside services. But over time, some problems have emerged.

First, achieving better cost performance has been much more difficult than expected. A host of operational challenges of full integration of services persist, sometimes even leading to actual cost increases rather than decreases. According to a recent revenue cycle benchmarking survey, cost-to-collect performance has been flat since 2013 and is actually a bit higher compared to 2011, suggesting that for many systems, economies of scale have not had as much impact as expected. The inability of systems to meaningfully reduce such administrative expenses is especially frustrating to local leaders across the system, who typically have little visibility into how these costs are allocated to their budgets.

Second, these consolidated departments often don’t adequately meet the service needs of the individual institutions. As an example, a large, multistate hospital system consolidated IT across the system and established one standard electronic health record (EHR) platform, a fairly common practice in large health systems. However, policies put in place at the system level limit the ability for local hospitals in the health system to adapt certain elements of the EHR setup to align with some unique workflow practices.
If clinicians at one hospital want to make a specific change to key workflow setups, they must submit a request to corporate IT leadership. System IT governance policies sometimes block useful local modifications in order to preserve a desired level of systemwide continuity. This friction between corporate objectives and local challenges plays out frequently in hospital systems across the country.

In some cases, it is not unusual for a local hospital in a system to hire additional staff on the local payroll to fill perceived corporate service gaps. While these costs are not reflected in the total corporate services costs, they are effectively adding an extra layer of hidden costs. At one regional health system, a member hospital was experiencing high nurse turnover and struggled to fill multiple open positions. Frustrated by the inability to secure enough time and support from the system’s human resource function, hospital leadership opted to hire a dedicated recruiter.
Reassessing performance and cost together

With the margin impact of rising operating expenses being compounded by slowing revenue growth, health systems face new urgency in driving more value from integrated corporate services. Health systems need to reassess both cost and performance within the context of system finances to identify where corporate services are not cost-effectively meeting the needs of system-level and local constituencies.

1. The first part of this assessment is to consider whether the overall level of corporate services cost is sustainable. Is the total cost of corporate services as a percentage of total operating revenue too high? And equally important, how is this percentage trending? Similarly, is the corporate services allocation to local hospitals a higher proportion of their total costs compared to independent hospitals of similar size and complexity? The answers form the basis for determining the necessary and appropriate cost ceiling for overall corporate services.

2. The second part of the equation is then to uncover which departments may be underperforming and understand the root-cause drivers. Looking for those hidden costs being incurred at the local hospital level to offset deficiencies in the corporate function is a “bottoms-up” endeavor, undertaken at each facility. Conducting a routine survey of end users within the health system to identify specific gaps in performance that need to be addressed is also a useful tool for surfacing performance gaps. Together with the top-down financial picture, these insights into the overall cost and effectiveness of corporate services give health system leaders the information needed to set cost ceilings and performance goals.
Putting workforce productivity in perspective: Are you taking what matters into account?

BY JOHN JOHNSTON

It seems barely a week goes by in the news lately without a story of a health system announcing that they need to cut labor costs significantly. Even in the absence of dire financial straits, executives are anticipating the need to shore up margins as a hedge against an uncertain future.
At roughly half or more of the typical hospital’s total operating budget, workforce constitutes by far the largest expense category. But with staffing levels already leaner than in previous eras of cost reduction, finding ways to cut costs without slashing productivity is a significant challenge. Maximizing the efficiency of clinical and non-clinical staff is at center stage, and with it the imperative to set — and meet — productivity targets that optimize workforce output.

Progressive organizations are working to develop productivity targets that are ambitious yet sustainable by taking a multidimensional approach that answers three questions:

**Begin with revenue**

Many hospitals begin a labor cost-reduction initiative by going straight to a cost-center benchmark analysis. Although such analysis is important, the first step should be for finance leaders to forecast how much of net patient and operating revenue can be allocated to workforce costs. That threshold determines the overall cost target, which the individual cost-centers targets must work together to meet. In fact, finance leaders often ask, “should we be targeting top quartile or top decile?” The response should always be the same: “Which decile aligns with your overall cost target?”

Typically, a sustainable level of investment in labor is below 54%, but for some hospitals, market conditions will require even lower levels. Labor inflation rates may make cost reductions necessary to ensure financial viability. A CEO of a large system on the West Coast summed up the challenge at his health system this way:

“Today we’re at 55% of net patient revenue, and we can make that work for now. But next year, I’ll probably only get a 1% increase in overall rates, while my labor inflation rate will increase by 3%. So if I do nothing about labor costs, we will fall behind.”

Most hospitals face this same dilemma.
The last step is to calibrate overall targets to account for outliers. One health system, for example, faced a large workforce reduction in order to avoid tripping bond covenants. Following the benchmarking process above, it turned out that several larger cost centers would need to reduce overall staffing by a significant percent to fall within the target benchmarks.

When situations like this occur, an incremental approach is needed to get to target to avoid compromising quality. This health system responded by capping the improvement target at 15% of the current productivity, with a plan to get to the final target over a longer period of time. Doing so enabled those cost centers to make changes without negatively impacting patient care, but it also forced other cost centers to set a more aggressive productivity target in order to hit the overall labor cost goal.

Benchmarking as art, not science

Once the parameters for overall labor costs are in place, it’s time to look for opportunities to use staff resources more effectively. Benchmarks give executives insight into each cost center’s performance against organizations of similar size, service mix and acuity. But benchmarks have to be used wisely. On the one hand, no two hospitals are alike, so there is no perfect comparison. On the other hand, leaders too often zero in on a comparison that defends the status quo instead of seeking insights into improvement. A better approach is to identify a benchmark range for each cost center (e.g., between top quartile and top decile), then set an exact target that reflects the specific circumstances of the cost center at the organization.
A multidimensional definition of productivity

Meeting a benchmark target number of worked hours is essential but certainly not sufficient to optimize productivity. All the inputs need to be taken into account in order to optimize the output: utilizing staff of all levels effectively to provide the best care. Health care organizations must understand the cost of work hours, what role is performing specific tasks, the timing of the work and, ultimately, what kind of work is being performed.

One area that consistently holds opportunity is premium pay. Clinical leaders should evaluate all premium models and ask whether they address current circumstances. There’s a good chance outdated shift premiums still exist that have outlived their usefulness. And there are numerous other considerations that need to be taken into account in developing a multidimensional understanding of productivity. It’s a challenging and often complex undertaking, but given the preeminence of productivity in preserving quality of care and financial sustainability in today’s reality, it’s well worth our attention.
Penn Medicine’s secret to better value management:

Deliberate collaboration

BY RICK CONLIN

With all the news of a grim financial outlook ahead for health systems and especially the acceleration of cost growth, value management leaders are confronting the need to rein in spending in a meaningful way. This need is annual — and repetitive.
Many organizations already have taken a first pass at locally renegotiating supply contracts at the system level, outsourcing and centralizing some purchased services, and at times pushing on the financial aspects of their group purchasing organization relationships. These efforts can be effective but exhausting, especially to physician and clinical leadership. Today, despite all the success of prior work, cost pressures are higher than ever.

Continuous cost accountability requires weekly effort and discipline. And in times of rapid change, this process can become even more challenging, as was the case with Penn Medicine, an academic medical center based in Philadelphia.

**Building on sophisticated value management**

In early 2017, Penn Medicine was getting bigger, having grown from a network of Philadelphia inner-city hospitals to a multistate, regionally integrated delivery system. The organization had successfully executed several cost-management initiatives, achieving supply pricing that was among the best in the nation and negotiating a few key purchased services contracts for better terms.

As the organization continued to grow — expanding outside of the city with the acquisition of Chester County and Lancaster General Hospitals and more recently hopping across state lines to acquire Princeton Health in New Jersey — Penn Medicine leaders saw new opportunities and challenges.

The larger organization’s new buying power and efficiency potential that came with growth also became more complicated. With the acquisitions came a much broader and more diverse geography, as well as a wide array of existing organizational cultures and personalities to manage.

**Start with collaboration**

Penn Medicine leaders recognized the need to do things differently within this new context. Thus, in early 2017, Penn Medicine approved a new blueprint for enterprise value management after months of collaboration with physicians and members of multiple hospital C-suites. This collaboration came from across the newly expanded Penn Medicine Enterprise, inclusive of existing system leadership, individual system leadership both new and old, and plenty of physician input. Its value came not only in gathering valuable input but also managed change. With all of that well-managed participation, critical stakeholders began to feel ownership of the process.
Their blueprint mapped out a redesigned and reinvigorated organizational governance structure built around existing enterprise-wide disease teams, full representation of CFOs across the system, multiple representatives from physician leadership and plenty of preserved individualism. Physicians and newly integrated system leaders felt listened to. When building plans for future system integration, there was also a focus on finding individual pockets of warranted variation. This helped preserve specific local best practices while also building trust among those involved.

This new structure was charged with overseeing a dual-pronged strategy on an ongoing basis.

One part of that strategy was a focus on identifying and achieving savings in the most promising supply and purchased services opportunity areas (e.g., physician preference items and cross-system commercial service cost centers) all across their newly expanded system — whether locally or across the enterprise.

The other was about driving an iterative approach to key spend category strategies, moving well beyond simple price point reductions to broader and more holistic and longer-term cost strategies.
Execution and communication
Penn leaders managed every painstaking detail of their collaboration on a weekly basis. They established centralized accountability and direction for value management strategy through a Network Supply Chain council (NETSC). They maintained monthly top-level transparency and support for all managed cost-savings initiatives. This group, comprising health system CFOs and supply chain leadership, established top-down savings goals and held themselves accountable for those goals, with heavy clinical-level strategy and physician involvement.

Set up successful second year
Penn Medicine set out to save $8–$10 million across 2017 and achieved approximately $9 million. Those results helped bolster confidence as the health system began its second year of cost-savings strategy implementation. In the very beginning, executives and physicians of the NETSC sat at the table with perhaps less than fully enthusiastic receptivity to value management. Following a year of hard work and deliberate collaboration, those were the voices leading the charge to do the more progressive work.

The fact is that getting physicians and hospital executives to think about cost reduction, no matter how progressive, is tough. The system’s efforts to build a shared sense of trust and willingness to work hand in hand in a deliberate way, are not only effective now but will be for years to come.
Are you really reducing care variation costs?

By John Johnston

With hospitals facing slow revenue growth, health system leaders face mounting pressure to rein in spending. As leaders look to achieve significant and lasting savings, many are placing more emphasis on reducing unwarranted care variation. In fact, a recent survey found that CFOs consider such variation the single largest source — roughly 40% — of cost-savings opportunities.
But ask an executive to articulate his or her organization’s care variation strategy and what often comes back is a wide-ranging list of discrete initiatives: length of stay reduction, order sets for sepsis, antibiotic protocols, blood utilization reduction, etc. Although all are worthy endeavors, when we take a closer look, we often find that they were identified somewhat randomly, are consuming quite a lot of staff and physician time, and that there is no formal roll-up of the initiatives into an organized structure. Most alarming, we often find that while there is a strong belief that these initiatives will result in cost savings, there is often very little financial rigor applied to the work underway.

Recently the chief medical officer of a 350-bed community hospital convened several physician leaders in response to a mandate from the CEO to reduce care variation costs by $20 million. Although there was some anecdotal evidence of success of the various initiatives, no one was able to point to specific financial results that had been realized. Decision support leadership reluctantly pointed out that cost accounting data was only being reviewed randomly by the initiative team, no work plans had been created to focus the work, and no financial measures were being tracked. Finally one of the physicians stated, “We think we are saving money, but we don’t really know, and I have a feeling we will be disappointed with what we find out.” Now the hospital is stepping back and evaluating the financial performance of service lines, DRGs and clinical departments against benchmarks to identify the full scope of their cost-reduction opportunity and make a data-driven decision as to where they should allocate resources.

Are you really reducing care variation costs?
An organized strategy

To make the leap from mediocre financial results to large-scale impact, most health system leaders need to get much more organized and much more rigorous in developing an overarching strategy for care variation, and take a strong hand in guiding and measuring specific initiatives. Moving the needle on financial impact is best achieved through a systemic, centralized approach to care variation in which system-level leadership focuses efforts on the biggest drivers of cost and quality opportunity, and tightly manages the initiatives with targeted work plans and timelines. At the highest level, it starts with leadership answering these fundamental questions:

- Where are our greatest financial opportunities?
- What are the most important drivers of clinical and financial improvement tied to care variation?
- How do we ensure our teams get the greatest results?
- How will we measure and track financial benefit to our bottom line?
Identifying priorities

Perhaps the greatest challenge with the unorganized approach to care variation is that initiative teams are launched but not given a work plan to guide their focus. When the improvement “agenda” is left to the initiative teams to figure out, they often devote the majority of their attention to important issues, but not necessarily the ones that impact costs. A health system in the Midwest recently identified over $4 million in cost savings tied to care variation in their sepsis population. A team of physicians and clinicians was convened with the charge to reduce costs. The team launched several initiatives. However, in 12 months, only $30,000 was saved via standardization of the antibiotic selection. A subsequent review of the team’s initiatives revealed they had not focused on any of the top drivers accounting for the majority of the $4 million opportunity. Their experience offers good lessons for all of us as we pursue more ambitious clinical variation cost savings:

- **Focus teams on the big cost-opportunity drivers.** When unguided, clinical leaders often focus only on “line item” resources. In this case, the team locked in on antibiotic use, which carries a relatively low unit cost, but ignored their overutilization of the ICU, which accounted for more than 20% of the cost opportunity. Cost accounting data should be used to isolate the areas with greatest cost variation and that information should be communicated to the team tasked with making improvements.

- **Quantify the gap to evidence-based best practice.** Another big cost and quality opportunity ignored by the sepsis team was their poor success rate of early identification. A comparison of their processes against best practice revealed the clinical protocols that needed to be changed and that this gap resulted in adding two to three avoidable days per stay.

- **Include all stakeholders to ensure full visibility.** The sepsis team included hospitalists, nursing, pharmacy and emergency department physicians. But care management and discharge planning were not involved, limiting the overall view of the entire stay. The team was relaunched and expanded to include all of the main departments involved in the care of sepsis patients. In addition, representatives from two local nursing homes were invited to participate, which helped the team address readmissions and more efficient discharges.

The financial pressures facing hospitals continue to increase and care variation opportunities must be addressed in order to maintain viability. Now is the time to develop a centralized, system-level approach to care variation that will bring the right discipline and financial rigor to focus improvement teams on the right initiatives and track the resulting savings to the bottom line.
What do finance leaders have to do with high-reliability patient care?

By John Johnston

The challenges hospitals and health systems face in providing patient care with consistently high levels of safety and quality have never been more complicated, or more important. Inpatient admission data from hospital and health systems consistently show patient severity levels increasing over the past three years — indicating that hospital inpatients are sicker and that managing their outcomes is more difficult. At the same time, public awareness of safety failures — together with increased attention to quality metrics by consumers and payers — means that performance shortfalls are under greater scrutiny. Furthermore, publicly reported metrics such as rates of hospital-acquired conditions (HACs) and readmissions carry the potential for payment penalties imposed by health plans and government payers alike.
The science of high reliability has been embraced by other high-risk industries, such as aviation, to great success. A similar approach for health systems offers a compelling opportunity to move beyond a reactive posture toward safety and quality to proactively and systematically seeking out and preventing failures. The Agency for Healthcare Research and Quality (AHRQ) recently updated its Patient Safety Primer to provide an overview of the characteristics of high reliability and their applicability to health care. AHRQ emphasizes that high reliability is “an ongoing process or an organizational frame of mind, not a specific structure.” It goes on to describe high reliability as a condition of “persistent mindfulness” toward quality and safety.¹

Developing a high-reliability culture requires:

- A strong leadership commitment
- A mandate for quality and safety improvement
- Rigorous, ongoing and data-driven process improvement

Finance leaders have an important role to play in each of these areas, because gaining insight into the relationships among cost, quality and safety can provide an important basis for funding these efforts and expanding their impact. The cost of poor safety, clinical variation and unreliable quality remains high. Finance leaders in many organizations are now contributing analytics expertise and leadership to support strategic improvements and drive a culture of high reliability.

Reconciling high reliability with financial improvement

A critical ingredient for improving quality and eliminating patient safety failures is the development of — and consistent adherence to — optimized care standards and processes. Such an effort offers a largely untapped opportunity for cost savings for the organization. In a recent survey of CFOs, 40% of respondents said they consider reducing care variation to be the greatest source of potential savings, putting it ahead of improving labor productivity, supply chain processes and revenue cycle performance. Thus, although it is undoubtedly complicated, reducing unwarranted variation in care delivery can have a material impact on margin.

Consider this example: Two patients of the same age, with the same comorbidities, present at the same hospital emergency department (ED) and receive the same diagnosis of heart failure. In one case, the ED team follows a care pathway developed by a multidisciplinary team of physicians, so the patient receives a standardized treatment regimen. The patient’s care plan progresses methodically over the course of a three-day stay. No complications occur and the patient is discharged to home after three days. In the other case, the clinical staff fail to follow the care pathway. The patient receives more medications along with a blood transfusion, is admitted to the intensive care unit for four days and stays in the hospital for 12 days, only to be readmitted two weeks later.

This deviation from best practice costs the hospital more than $13,000 for this patient.

A culture of high reliability constantly seeks out opportunities to establish better care processes that embrace evidence-based care pathways, target early identification to overcome misdiagnoses, and make variance identification and reporting easy for the hospital team. When scaled across numerous disease states and patient groups, reductions in care variation can have a significant impact on outcomes — and on margin. Finance should play a role in sharing insights into the ROI from efforts to improve care processes.

**The importance of documentation**

Finance also has a special role to play in helping clinicians understand the impact of accurate coding and documentation in ensuring that the organization captures all necessary clinical diagnosis and intervention data. Accurate, complete documentation and coding produces revenue benefits from improvements in multiple areas, including case-mix-index calculations, clean billing claims and accurate quality metrics. However, many clinicians struggle to reconcile the differences between information captured in a patient chart and information summarized on a patient bill, making it critical to provide clinicians with ongoing support and education. Finance leaders are in the best position to identify potential coding and documentation gaps, dedicate the appropriate education and training resources to support improvement, and track accuracy metrics to ensure sustainability.

**Partnering across the aisle**

Historically, finance executives and clinical executives have not always collaborated well. The tension between clinical investment and limited financial resources often results in opposing viewpoints regarding priorities and how to address ongoing challenges. Ultimately, finance leaders have to believe that improving quality and patient safety is a worthy investment of limited resources. Finance leaders have an opportunity to be true champions of high reliability, to reach across the aisle to their clinical counterparts and work together. High reliability is first and foremost about quality. However, there are clear financial benefits that accrue to the bottom line when quality is improved.

Just as it is important for finance leaders to understand and communicate the benefits of high reliability, it also is essential that they recognize the ways in which they can support and accelerate the impact. Practically speaking, laying the foundation for a culture of high reliability requires dedicating specific resources for enhancing and sustaining process improvement in key areas of care delivery and the core operations related to it. This effort can include implementing tools to monitor and manage the process improvement, establishing selective physician incentives, and establishing analytic and engineering resources.
Taking stock of surgery

Is it time to revisit your assumptions?

BY JOHN JOHNSTON

Health system leaders have long known the financial importance of strong surgery volume. Through the years, most hospitals have streamlined operations within the operating room (OR) to maximize throughput, grow capacity and attract new business. They’ve also done so to expand their reach in the market. The question facing hospitals today is: Has our approach to surgery kept up with the new reality?

With only modest growth forecast in inpatient and outpatient surgery in the next few years and the likelihood of greater downward pressure on payment, competition for surgery market share is heating up. Recent surgical technology advances add new complexities to a business that is already complex. Now is the time for health systems to take a step back and assess the cost efficiency of their surgical business — from the mix of services across care sites to performance in the hospital OR and across the perioperative continuum — to stay competitive and profitable.
Rationalizing service delivery across the system

For many systems, surgical business line expansion to multiple locations has been an incremental process and management has not always kept pace with the reach — and complexity — of the footprint. It’s no longer about running a single hospital inpatient OR efficiently. It’s about managing numerous facilities and locations that often have different governance structures and that provide a broad range of increasingly specialized services. It is not uncommon today for a large community health system to have built a separate cardiac surgery suite, bought a free-standing ambulatory surgery center, or entered into a joint venture for an orthopedic surgery center. And if the organization has taken any one of these steps it likely has taken all of them. The combination of multiple locations and greater specialization creates challenges to managing efficiency, patient satisfaction and coordination with surgeons and their offices. Health system leaders are faced with creating new management and governance structures to ensure the overall surgical business line meets clinical, operational and financial goals.

With payment levels declining and patient price sensitivity increasing, leaders also need to assess the full surgical portfolio across the entire system and identify opportunities to deliver care more cost effectively. Are outpatient procedures performed at the best location to align quality and cost? Is there duplication of services that could be eliminated? Would consolidating specific services into fewer locations enable operational efficiencies and leverage management talent better? How can that be done without inconveniencing physicians and patients?

A medical center in the Midwest that had expanded over 10 years to include seven different ambulatory locations recently decided to bring ophthalmology procedures and many gastrointestinal labs into the hospital’s outpatient wing and reduce the number of freestanding locations to five, while still preserving geographic convenience for physicians and patients alike. This consolidation is expected to reduce annual operating costs by $4 million.
Renewing discipline in the OR

As to performance within the hospital OR itself, leaders generally believe they addressed this problem years ago: improving on-time starts, instituting block scheduling and refining surgeon preference cards. Although those initiatives were successful at the time, an important concern is whether the ORs have continued to operate at the same level of rigor. With the expansion into new services and the addition of new physicians, we’ve seen again and again how discipline erodes and the OR drifts into inefficiency.

It’s not enough to re-instill the same performance metrics. As competition intensifies, we also must revisit our assumptions about what constitutes high OR performance. This effort should address a number of key questions:

- Does our executive team have a meaningful dashboard containing OR business characteristics that you can use to drive strategy?
- Does our operational dashboard include nationally benchmarked process measures stratified by service line?
- How are we currently evaluating service line performance, efficiency and resource stewardship?

Managing the perioperative continuum

As demographic shifts bring hospitals ever-more complex patient populations, it is essential to have the full picture of performance across the entire surgical encounter to optimize clinical outcomes for the patient and financial performance for the organization. Consider, for example, the case of a 64-year-old female patient coming in for a knee replacement. If pre-admission screening does not adequately uncover comorbidities and other considerations (e.g., obesity and diabetes) and the fact that the patient lives in a home with stairs, the patient may have a difficult recovery within the hospital or have complications after being discharged, even if the procedure itself was successful. Tracking performance metrics only in the OR wouldn’t indicate a problem. But a broader examination of length of stay, comorbidities and 30-day readmissions would reveal that the episode did not result in a successful clinical outcome and in fact ended up generating excess costs.

Redefining surgical performance to incorporate quality and cost measures across the entire surgical episode provides a more meaningful way assess the outcome for the patient — and the efficiency of a health care organization’s model. Such measures are necessary to successfully compete for surgical volumes and deliver high-quality services profitably — under both fee-for-service and value-based care. Future sustainability will come not simply by reinforcing the cost discipline of the tried and true, but by revisiting assumptions about what a cost-efficient surgical model really looks like.
Your health system is ready for the future — but is your leadership structure?

By John Johnston and Vincent Joseph

Over the past several years, health systems have become much larger, more complex organizations. This evolution is the result of myriad changes across the industry, including the ongoing movement toward risk-based payment, dramatic shifts in sites of care from inpatient to outpatient, and massive consolidation in the provider marketplace.

The diverse entities that now make up the typical health system — including physician practices, outpatient surgery centers and post-acute facilities — are no longer minor satellites in the orbit of inpatient hospitals. Rather, they play an increasingly important role, not only in serving the care needs of the community, but also in ensuring the long-term viability of the health system.

Looking ahead, health system leaders face what promises to be a difficult and sustained challenge to margins, as revenue and volume continue to move out of the hospital and into these non-hospital entities. Health systems will need to align leaders from all parts of the organization around a shared vision for clinical practice, operations and financial sustainability, and then equip their leadership teams to actualize that vision — year over year over year. They also will need to know how to hold these aligned leaders accountable and develop the right infrastructure to enable these leaders to collaborate in driving high performance across all parts of the system.
Accountability and alignment for business units

Many health systems now structure their leadership around key business units: hospitals, long-term care, ambulatory facilities and physician networks. Larger systems may have a regional structure in which the various entities in a region are led by a regional leadership team. In either case, leaders must be held accountable not only for the performance of their own individual business unit or region but also for systemwide results.

It is critical that all goals be clearly communicated and specific, measurable and time-sensitive. One such goal, for example, might be “to achieve the top decile in a federally reported metric by year end.” Leaders must be responsible for their individual entity’s margin, growth, quality and outcomes performance. It is equally important to align leaders to overall performance through risks and rewards at the system level. For example, all business unit leaders might have a performance goal of 5% operating margin at the system level — which can be achieved only through their collective efforts.

Effective oversight and support

A leadership structure with clear accountability for performance is important, but it is only part of the equation for successful performance. Leaders need to understand not only what they must achieve but also how they can work together to do so. A highly focused performance oversight process can address both considerations.
These business review meetings bring together front-line business unit leaders with critical system leadership, typically the CEO, CFO, COO, CMO (and sometimes the CNO and vice president of HR). Having all these leaders in the room allows problems to be brought to the surface, understood and addressed in the moment, before they escalate. These meetings also serve to break down silos across the system and enable business unit leaders to share information and work together on effective solutions.

As an example, at a Southern health system, the director of a successful wound-care center recently had received seed money to open a second location. After two quarterly reviews, the site was 20% below its targets for volume and revenue. In response to questions from the CMO, the site director noted that vascular surgeons from the system’s multi-specialty group simply were not referring there. The CMO took ownership of diagnosing the situation and soon visited with the surgeons in question. Following several conversations, the CMO offered one of the surgeons a position as a co-director of the center. The surgeon then felt she had some stake in the site and input, and she and her colleagues began referring patients there. The site soon met its goals.

A leadership model centered around high-performing business units aligned to system financial imperatives creates a results-oriented environment. And an infrastructure for top leadership to communicate regularly, evaluate quarterly and reward outstanding performance provides support and an incentive for motivated leaders to execute on their goals. Together, these mechanisms enable organizations to achieve and sustain high performance for the future.
Is 2019 the beginning of the post-hospital era?

BY JOHN JOHNSTON

Across the past 25 years — almost my lifetime in the health care industry — many things have changed about hospitals economics. Community hospitals have merged to become large health systems, and these systems now employ a high percentage of their medical staffs. Payer rates have fallen and often are accompanied by quality incentives and penalties.

Patients play a greater role in choosing — and paying for — their health care.

Through all these changes, hospitals have remained at the heart of the health system enterprise and its strategy. Fueled by reliable annual volume and revenue growth, hospitals could consistently be counted on to generate a predictable margin. Until they couldn’t.

For two consecutive years, the rate of hospital revenue growth has declined. The most recent Moody’s report predicts 2019 will continue the trend. Hospitals are making headway on reining in expense growth. Yet it won’t be enough to make up for the revenue slowdown.
The reality is that patient care is leaving the hospital at an unprecedented pace, never to return.

Starting in 2019, we have entered the “post-hospital era” of health care. And health systems are struggling to respond to this new reality. If you are looking for a sign that your organization may be behind the curve, look no further than your monthly board report.

Most health systems continue to primarily emphasize volume and other traditional hospital metrics in monthly performance scorecards:

• Admissions
• Emergency visits
• Deliveries
• Patient days
• Occupancy rates

These are the success metrics of yesterday.

The metrics that increasingly point to success today are:

• Non-hospital business growth
• Efficiency of clinical care
• Avoidable care
• Denial rates
• Profitability by line of business or by payer

Yet these metrics receive very little, if any, attention at the executive or board level.

If there is any truth to the old adage “we manage what we measure,” these key performance indicators suggest many health system leaders are not guiding their organizations toward future success.

Health systems can take a strategy lesson from hockey legend Wayne Gretzky. While everyone else was focused on chasing the puck, he transformed the game of hockey with his strategy to “skate to where the puck is going.”

Health system leaders need to adopt a similar, forward-looking mindset. It’s time to shift focus away from traditional volume and entity-based performance goals. It’s time to create new performance goals that will guide your system into the post-hospital era.

**Key metrics to watch**

We are still in the early stages of transition. The full suite of necessary performance metrics is still a work in progress. Here are some guidelines for key measures that financial leaders should begin to track and emphasize in monthly performance reports.

**Non-hospital business metrics.** This area will be the engine for future growth. So it’s critical to develop measures of the organization’s effectiveness in capturing and capitalizing on this business. Key questions include:

• What percentage of total system revenue is generated outside the hospital walls? Is this percentage growing at the appropriate rate?
• What are your utilization trends for key strategic investments like telehealth and physician offices?
• What are your referral capture trends from your medical staff investments?
Is 2019 the beginning of the post-hospital era?

Financial metrics. With margins and cash flow under duress, systems must be much more rigorous in prioritizing strategic investments.

Measuring performance return on investments in key clinical service lines is necessary to be able to align system assets with opportunities for profitable growth. Key questions include:

- What are your profit margins by key line of business and by key payer contract?
- What is your total cost per case by line of business and what is its trend line?
- What is your return on hospital and non-hospital capital?

Clinical efficiency metrics. As organizations transition to value-based care models, leadership must be able to measure the efficiency of clinical care delivery. Key questions include:

- What are your avoidable admission and readmission rates?
- How many patient days exceed Medicare geometric mean?
- What percentage of admissions and observation claims is being denied?
- What percentage of ancillary capacity is being used?
- What is your contribution margin for each of your core service lines?

Population health and risk metrics. As organizations take on greater risk, they must understand their success within current risk arrangements and predict future margin strength or vulnerability. Key questions include:

- What is your performance under any risk-based payment models you are in today? And what would be the impact on the organization if performance was extrapolated to all patients?
- What is your Medicare Advantage performance?

The adoption of new system performance metrics is an important step toward guiding a health system into the post-hospital era. It’s time to leave behind yesterday’s measures and the outdated strategies they feed. Replace them with new measures that line up with “where the puck is going.”
Explainer video

How to achieve financial sustainability
In this short video, Optum Advisory Services experts John Johnston and Eileen Russo lay out the three strategies health systems must address to preserve margins and become financially sustainable.

Infographic

Health systems and financial sustainability
This infographic offers a roadmap for health systems to balance complex performance improvement priorities and move toward sustainability.

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1-800-765-6807 | empower@optum.com | optum.com/advisoryservices

To discuss your financial sustainability strategy and how Optum can help, please reach out to our lead author:

John Johnston
johnstoj@advisory.com