Strategic Cost Transformation for Post-Reform Success

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Executive Summary

The tremendous change underway in the U.S. healthcare industry is driving the need for hospitals and health systems to move beyond traditional cost-reduction initiatives. By taking a proactive approach now, healthcare leaders can control the cost-reduction agenda—making it strategic and transformative in nature. This will allow them to create and implement a plan that is aligned with organizational strategy and goals.

HOSPITAL AND HEALTH SYSTEM BOARDS WILL PLAY A CRITical role by providing oversight through this transition. This white paper is intended to help hospital and health system boards meet their increasingly important responsibilities related to strategic cost management. It offers recommendations and more than 45 specific action items to guide board members and senior leaders in these efforts.

Laying the Groundwork

Hospitals and health systems face an array of challenges as they adapt to the new business model. To develop effective cost-management strategies, healthcare leaders must understand the complex nature of the types of changes that will be needed. They also must determine the organization's role in the new environment, and develop strategies to address the pressures from the changing business model. The following action items pertain to adapting to the new business environment (please see the full white paper for more details on each of the action items listed in this summary):

1. Grasp the nature and magnitude of required change.
2. Consider and determine the organization's likely role in the new environment.
3. Understand key pressures creating the requirement for strategic cost transformation.

Financial Principles and Oversight

A strategic approach to transforming a hospital or health system's cost structure requires significant understanding of the principles of organizational financial oversight. Five action items will be helpful to boards in this regard:

4. Understand the importance of achieving strategic-financial equilibrium.
5. Ensure a "back-to-basics" financial planning approach.
6. Oversee development and implementation of a master plan for strategic cost transformation.
7. Ensure a strong business platform, with the right systems and technology functioning at all levels.
8. Foster cultural change.

Cost Management and Margin Improvement

With the required groundwork completed, hospitals and health systems should evaluate traditional opportunities to improve the efficiency of existing operations or services. Effective cost management requires an integrated approach involving system-wide assessment, planning, and implementation. Addressing inefficiencies related to labor costs, non-labor costs, and revenue cycle management long have been foundational to cost-reduction strategies. The action items in this section will assist in managing costs and improving operating margins.

Planning and Execution

9. Understand common barriers.
10. Ensure top-down target setting, with staff involved in implementation.
11. Encourage enhanced cost intelligence.
12. Ensure that accountability has been established.

Labor Costs

13. Ensure evaluation of compensation ratios.
14. Advocate for assessment of staffing metrics.
15. Ensure redefinition of productivity drivers.
16. Support the implementation of mechanisms for ongoing data collection and analysis.

Non-Labor Costs

17. Encourage evaluation of key areas for non-labor cost-reduction opportunities.
18. Ensure evaluation of purchase order and accounts payable processes.
19. Ensure that clinicians are engaged in identifying and planning initiatives.
20. Request use of solid outcomes research to help guide decisions.

Overhead Costs

21. Encourage reduction of overhead functions and costs.

Revenue Cycle

22. Ensure identification and implementation of revenue cycle improvements.
23. Support management in staying abreast of changes in revenue cycle management.
24. Support acquisition of resources for reliable payment information.
25. Encourage centralized registration, billing, and payment.

26. Support the provision of good financial counseling.
27. Encourage other key efforts to improve revenue cycle management.

Business Restructuring

Initiatives that focus on business restructuring offer the biggest opportunities for major savings due to the large capital investments and expenditures involved. Business restructuring efforts can be broken into four major buckets: evaluating the businesses and services offered, evaluating service distribution, facilities planning, and enhanced capital allocation.

Businesses/Services Offered

28. Ensure use of an evaluation framework, asking key questions.
29. Ensure quantification of the impact of business/services restructuring.

Service Distribution

30. Ensure evaluation of where and how services might be better distributed.
31. Encourage development and implementation of a service distribution plan.

Facility Planning

32. Ensure development of a solid facilities plan.
33. Require development of projections for future inpatient and outpatient demand and corresponding capacity needs.
34. Request examination of the age and functionality of facilities.
35. Ensure that facility needs are based on the service distribution plan.

Enhanced Capital Allocation

36. Require a structured corporate finance approach to capital allocation.

Clinical Transformation

Clinical transformation initiatives involve fundamentally reshaping care processes with the aim of improving quality, outcomes, and efficiency of care. This requires that boards and management work closely with clinical staff to assess the components of the current care system and processes, and identify and implement improvements based on evidence-based best practices.

In a value-based care delivery and payment system in which organizations manage a population's health, the types of clinical transformations addressed here will improve quality, reduce costs, and allow organizations to sustain desired clinical and financial performance.

Care Processes and Effective Care Transitions

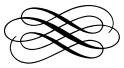
37. Ensure identification and elimination of inappropriate clinical variation.
38. Ensure data-driven identification of problems and opportunities.
39. Encourage efforts to improve care transitions.
40. Encourage design of "care platforms" for specific patient populations.
41. Encourage clear designation of primary clinical decision-making responsibilities.

Physician Enterprise

42. Support a long-term perspective regarding the physician enterprise.
43. Know the current and future costs of the physician enterprise.
44. Ensure effective and sustainable compensation programs.
45. Ensure that the organization is managing employed physicians to achieve goals.

Relationships with Other Providers

46. Ensure a thorough process for identifying and evaluating potential partners.



The nation's healthcare system is changing rapidly. Traditional cost-management initiatives that have worked in the past will not be sufficient in a future with decreasing volumes and constrained revenues. Navigating the current challenges requires a comprehensive approach to strategic cost transformation.

A proactive approach is recommended. The steps outlined in this white paper, including the following, can help to guide those efforts:

- Assess the organization's role in the new healthcare era.
- Ensure that the organization has in place a comprehensive and integrated strategic financial planning process.
- Continuously evaluate cost-reduction and cost-management opportunities in traditional areas of labor costs, non-labor costs, and revenue cycle management.
- Evaluate even more significant opportunities through business restructuring, including development and implementation of service distribution and facilities plans to ensure efficient and effective use of resources.
- Seek clinical transformation opportunities aimed at enhancing the provision of high-quality care at the lowest-possible cost.

Introduction

The tremendous change underway in the U.S. healthcare industry is driving the need for hospitals and health systems to move beyond traditional cost-reduction initiatives.

THE INDUSTRY IS TRANSITIONING FROM A "WHOLESALE" *SICK* care model that focuses on volume of services provided through a fee-for-service payment system, to a "retail" *health*care model focused on improving the quality and efficiency of care through value-based care delivery and payment structures.

Reflecting this business-model change, employers, payers, and consumers increasingly are seeking lower costs and better, more consistent care quality, outcomes, and access to services. Hospital leaders are balancing these demands along with the twin pressures of declining inpatient utilization and decreasing reimbursement from commercial and government payers.

Hospital and health system leaders can either wait until these challenges escalate to the point that the organization faces a financial crisis and is forced to respond, or take a more proactive approach. If they opt to wait, the crisis will control the cost-reduction agenda. Executives will then have little choice but to make immediate, deep cuts that will disrupt or even damage the organization.

By taking a more proactive approach, healthcare leaders can control the cost-reduction agenda—making it strategic and transformative in nature. This will allow them to create and implement a plan that is aligned with organizational strategy and goals. With such alignment, collateral damage is minimized or even eliminated, and the risk that costs will creep back into operations over time is reduced. The organization will be healthier than before the plan is implemented and better positioned to compete in the new environment.

Building new competencies to adapt to the new business model will be essential. Hospitals and health systems will need to restructure their care models from a provider-centric inpatient focus to a patient-centric outpatient focus. This will require balancing implementation of significant cost reductions and ongoing cost-management processes with establishment and implementation of measures to ensure the provision of high-value patient care.

Hospital and health system boards will play a critical role by providing oversight through this transition. Providing such support and oversight for cost management are integral to boards' fiduciary responsibilities. The goal is to protect and enhance an organization's financial resources and to ensure that limited resources are used responsibly. As such, the board will be responsible for holding healthcare executives accountable and providing the financial oversight and strategic direction that are among its six core duties[1] cited by The Governance Institute. (See sidebar, Core Board Duties and Recent Performance Results.)

1 Kathryn C. Peisert, *Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition*, 2013 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

Core Board Duties and Recent Performance Results

Strategic direction: Boards are responsible for envisioning and formulating organizational direction by confirming that the mission of the hospital or health system is being fulfilled, articulating a vision, and specifying goals that result in progress toward the organization's vision.

Financial oversight: Boards must protect and enhance their organization's financial resources, and ensure that those resources are used for legitimate purposes and in legitimate ways.

Boards' performance on financial oversight: Findings of The Governance Institute's 2013 biennial survey of hospitals and healthcare systems showed that financial oversight is a critical role of hospital and health system boards preparing for the new healthcare era. The survey found:

- 60.7 percent of respondents said their boards provided excellent performance in financial oversight.
- CEOs gave their boards' performance in financial oversight the highest performance score of 4.5 out of 5.0, down slightly from 4.52 in 2011.
- Financial oversight rated second in the adoption of recommended practices, after being ranked first in adoption since 2009.
- 3.7 percent of respondents added board members with expertise in cost-reduction strategies to prepare for value-based payments, although that number is expected to grow substantially in future years.

The survey also found that almost 90 percent of respondents are making changes to prepare for population health and 93 percent are making changes to prepare for value-based payments. "This indicates some movement on the part of the nation's hospitals and health systems to address problems with quality and cost in the care delivery system," according to the report.

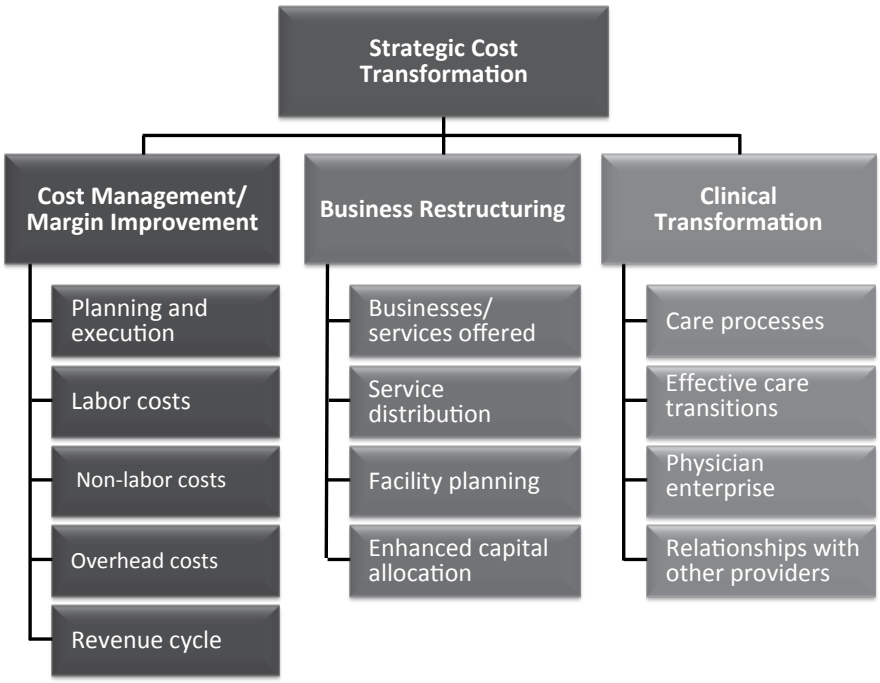
Source: Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition, *2013 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.*

While The Governance Institute's 2013 biennial survey of hospitals and healthcare systems found that overall performance scores are reasonably strong for these key duties among the nation's hospital boards, there remains room for improvement. Boards should strive to achieve perfect performance in financial oversight. As stated by John Wooden, former head basketball coach

at the University of California, Los Angeles: "Perform at your best when your best is required. Your best is required each day."

This white paper is intended to help hospital boards meet their increasingly important responsibilities related to strategic cost management. It offers recommendations and more than 45 specific action items to guide board members and senior leaders in these efforts. The action items are organized by the categories outlined in **Exhibit 1**, which provides the framework for the work that needs to be done in organizations in order to achieve strategic cost transformation. The extent of work required for individual hospitals and health systems within each category will vary by region and organization, and depending upon how far along the organization is on the cost-reduction path. Healthcare leaders should consider this framework within the context of their market conditions and organizational capabilities, and prioritize accordingly.

Exhibit 1. Three Pathways for Strategic Cost Transformation



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Laying the Groundwork

Preparation for an effective organization-wide effort to restructure costs requires understanding the new business environment and the key financial principals that ensure effective oversight, strategic-financial planning, and implementation by the board and executive team.

The New Business Environment

Hospitals and health systems face an array of challenges as they adapt to the new business model. To develop effective cost-management strategies, healthcare leaders must understand the complex nature of the types of changes that will be needed. They also must determine the organization's role in the new environment, and develop strategies to address the pressures from the changing business model.

1. Grasp the Nature and Magnitude of Required Change

Protecting and enhancing the organization's competitive and financial position in the new business environment will require boards and management teams to:

- Determine whether the organization's current focus and strategies continue to be relevant in the new healthcare era (Action Item 2).
- Balance their organization's need to remain competitive with numerous operating pressures (Action Item 3).
- Simultaneously address cost management and cost structure.
- Right-size the organization's cost structure with appropriate levels of staffing, capital spending, overhead support, and supply chain strategies.
- Take an integrated approach to cost transformation, which is critical because a siloed approach will not be effective.
- Restructure costs by evaluating the key areas outlined in Exhibit 1, and by identifying opportunities to implement effective cost reduction in each area.

The magnitude of challenges now facing hospitals and health systems may be unprecedented, but hospitals have equally significant strengths: deep respect in their communities, committed boards and executives, well-developed skills and processes for acute care, and—for many—significant financial resources.

2. Consider and Determine the Organization's Likely Role in the New Environment

Hospital and health system boards and management teams need to be thinking about, planning for, and moving toward the organization's future role. This includes developing strategies related to:

- Managing the health and healthcare of a defined patient population
- Participating in healthcare exchanges
- Taking on risk through contracting arrangements

- Building necessary competencies—both human and financial (as described in other publications)[2]

Different categories of providers are likely to emerge based on organizations' abilities to incur risk in managing a population's health. For example, some large regional health systems will function as population health managers. Such organizations will need to be financially strong and equipped to offer a wide variety of primary and specialty care by either providing or contracting for a full continuum of services. At the other end of the spectrum, some small hospitals and post-acute care facilities will provide specified services—often through contractual arrangements—to target populations working within the network of a population

2 J. Pizzo, C. Bohorquez, A. Cohen, E. Riley, and D. Ryan, *Value-Based Contracting*, Kaufman Hall and Health Research & Educational Trust, July 2013; M.E. Grube and K. Kaufman, *Inflection 2.0—The Real Change Begins*, Kaufman Hall Point of View, August 2013.

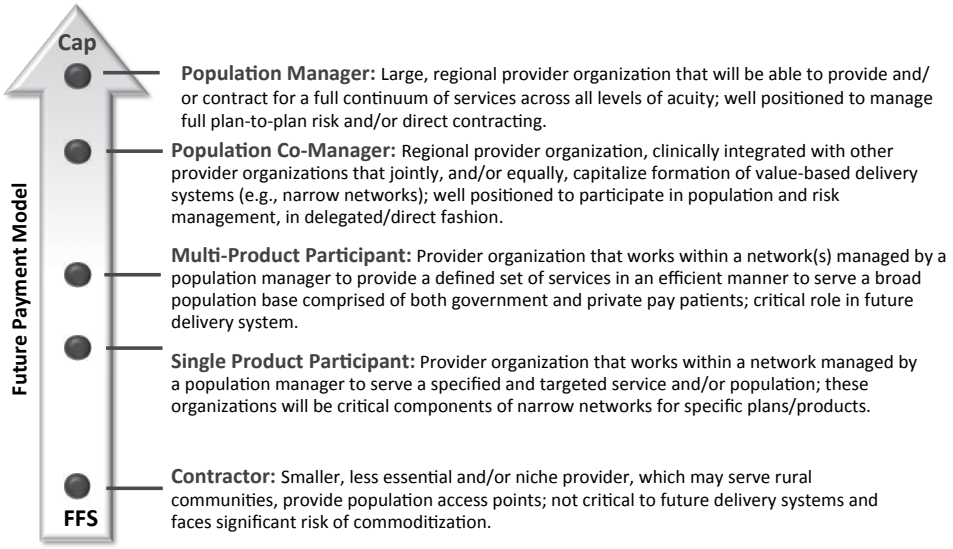
health manager. **Exhibit 2** outlines the different categories of providers needed under the new business model.

Decisions about the desired and most appropriate role for an organization in this context should be firmly grounded in its strategic financial condition and its organizational and leadership competencies. Where additional capabilities are needed to achieve the desired position, healthcare leaders must assess how best to accomplish those goals. Organizations of all types are currently working to reposition themselves to meet similar strategic goals through affiliations or more formalized, integrated partnerships.

As part of making these decisions, boards and management teams will have to reevaluate the organization's entire portfolio of businesses, services, and facilities. Where major deficiencies or inefficiencies are found, they must be willing to redefine their core businesses and service lines, and reshape how services are distributed. More on such strategies will be discussed in this publication.

Regardless of the approach, boards must be ready, willing, and able to make tough decisions to help lead their organizations to long-term financial sustainability.

Exhibit 2. Categories of Hospitals and Health Systems under a Value-Based Model



Source: Kaufman, Hall & Associates, Inc. Used with permission.

3. Understand Key Pressures Creating the Requirement for Strategic Cost Transformation

Numerous factors are contributing to the need for organizations to implement effective and sustainable strategic cost-transformation programs, including those described below.

Increasing Price Sensitivity by Consumers and Healthcare Purchasers

For healthcare consumers, increasing price sensitivity is driven primarily by the fact that patients and families are bearing a larger portion of the responsibility for paying their own healthcare bills. This is occurring as more employers opt for high-deductible health insurance plans as a means of reducing their company's healthcare costs. For healthcare providers, this trend can mean increased challenges with accounts receivables and bad debt as more individuals are unable to pay their medical bills.

Rising Costs

Hospitals and health systems face increasing capital expenditures and accelerating operating costs associated with building new competencies. Such competencies may include tight physician integration, an infrastructure for better managing patient care, enhanced information technology platforms, and establishing partnerships across the continuum of care.

Declining Utilization

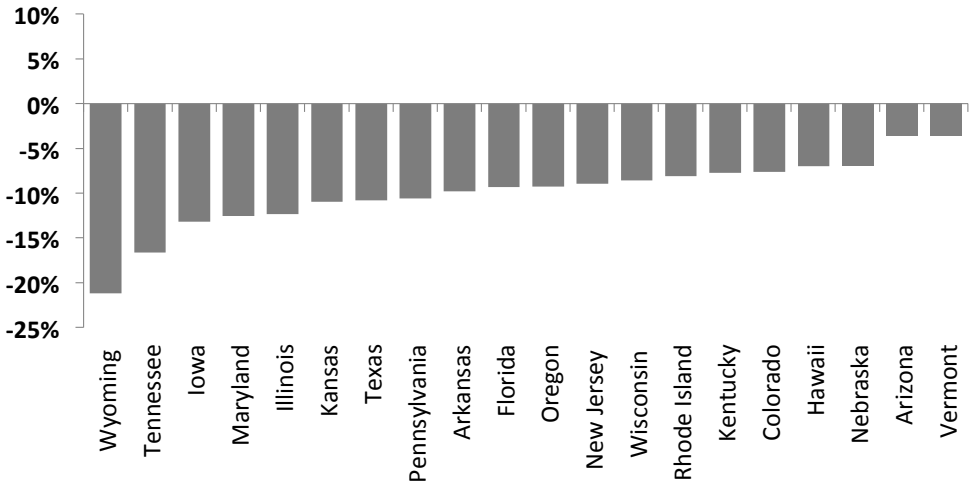
Declining demand for inpatient and certain outpatient services is occurring across the country, making it increasingly difficult

to accurately predict future use rates. While research[3] shows utilization has been falling during much of the last decade, the trajectory and magnitude of declines have increased in recent years.

A multistate study by Kaufman Hall[4] showed that inpatient use rates per 1,000 fell significantly from 2007 to 2012. Ninety percent of sample states saw inpatient utilization drop more than 5 percent. Declines in individual states ranged from 21 percent in Wyoming to 3.5 percent in Vermont (see **Exhibit 3**).

Another study by Kaufman Hall of 71 hospitals in seven counties in the greater Chicago area[5] examined the potential drivers behind utilization declines. It showed an average 5 percent decline in utilization per 1,000 patient population across all age groups. Researchers found a high degree of correlation between utilization declines and the level and pace of the market's shift toward value-based care, demonstrating that providers are doing a better job of keeping patients out of the hospital through improvements in preventive and primary care.

Exhibit 3. Inpatient Use Rate Trends from 2007 to 2012



*Weighting based on state population as percentage of total sample size population. Discharges exclude normal newborns as defined by DRG 391 and MS-DRG 795.

Sources: Data from the U.S. Census Bureau, Agency for Healthcare Research and Quality's HCUP State Inpatient Databases, Pennsylvania Health Care Cost Containment Council, and the Illinois Department of Health and Human Services. Kaufman, Hall & Associates, Inc. Used with permission.

The growth of outpatient utilization also is expected to slow. Projections by the Centers for Medicare and Medicaid Services (CMS) indicate that the upward trajectory of outpatient visits and surgeries has slowed in some age groups and will lag in the coming years. Annual medical services utilization among patients ages 18 to 64 fell from 4.8 provider visits per 1,000 patient population in 2001 to 3.9 per 1,000 in 2010.[6]

Revenue Pressures from Insurance Exchanges, New Contracting Models, and Public Payers

Many hospitals and health systems also are feeling downward payment pressures from rates offered through public as well as private health insurance exchanges. Such exchanges are expected to alter payer mix and payment streams for many providers. This is due to the fact that uninsured patients will be gaining coverage while currently insured individuals may be shifting from employer-sponsored commercial plans (with traditionally higher reimbursement rates to providers) to exchange plans (which may offer providers lower payment rates).

Some organizations are feeling the impact of employers that are contracting directly with select providers with the aim of reducing healthcare costs. For example, Walmart, Lowe's, and other large employers joined the Pacific Business Group on Health Negotiating Alliance to launch a "centers of excellence network." The network has contracted with four leading healthcare systems for knee- and hip-replacement surgeries for more than 1.5 million employees and their dependents. Walmart also has longstanding bundled-fee arrangements with six leading hospitals and health systems to provide heart, spine, and transplant surgeries to its employees, and Lowe's has similar arrangements with the Cleveland Clinic for employees' cardiac and spine-related surgeries.[7] The effect of such direct contracting on non-participating hospitals and health systems in certain regions can be significant.

On the public payer front, increases in Medicare and Medicaid payment rates are not keeping up with cost inflation. Changes in payment structures, such as readmissions penalties and limited success with pilot shared savings programs, also may be contributing to a negative net revenue impact for some organizations.

These factors and others reflect increasing pressure on hospital and health system revenues. Moody's Investors Service forecasts that total revenue increases will not be greater than 3–5 percent over the next few years.[8]

The combination of decreasing inpatient volumes, limited outpatient volume growth, and insufficient revenue increases leads to increased pressure on hospitals and health systems to enact

3 R. York, K. Kaufman, and M. Grube, "Decline in Utilization Rates Signals a Change in the Inpatient Business Model," *Health Affairs* blog, March 8, 2013.

4 *Ibid.*

5 R. York, K. Kaufman, and M. Grube, "Where Have All the Inpatients Gone? A Regional Study with National Implications," *Health Affairs* blog, January 6, 2014.

6 B. O'Hara and K. Caswell, *Health Status, Health Insurance, and Medical Services Utilization: 2010,* U.S. Census Bureau, July 2013.

7 Walmart, "Walmart, Lowe's, and Pacific Business Group on Health Announce a First of Its Kind National Employers Centers of Excellence Network" (press release), October 8, 2013 (see www.news.walmart.com).

8 Moody's Investors Service, *2014 Outlook—U.S. Not-for-Profit Hospitals,* November 25, 2013.

sustainable strategic cost-management efforts as expeditiously as possible.

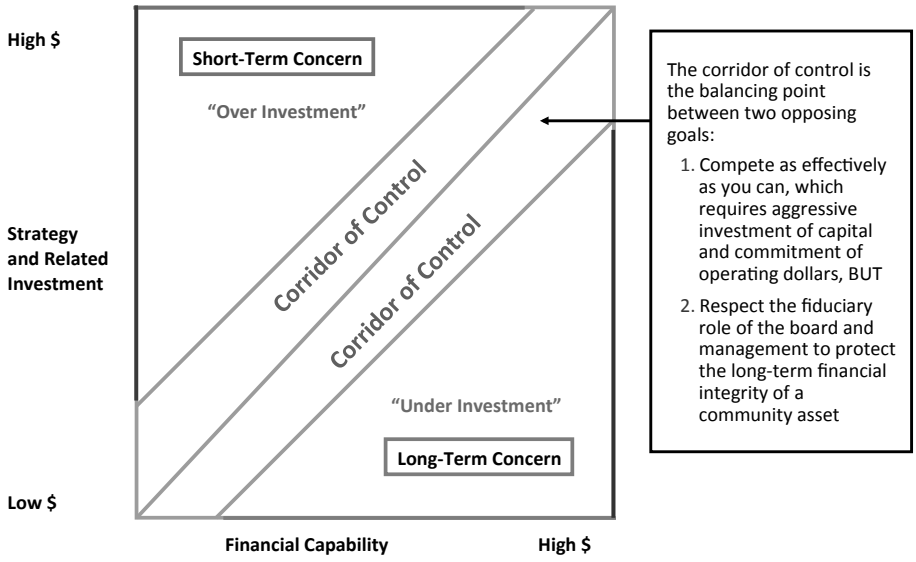
Financial Principles and Oversight

A strategic approach to transforming a hospital or health system's cost structure requires significant understanding of the principles of organizational financial oversight. Five action items will be helpful to boards in this regard.

4. Understand the Importance of Achieving Strategic-Financial Equilibrium

The ultimate goal for hospitals and health systems is to operate with stability or balance within the "Corridor of Control." A concept conceived by Kaufman Hall more than two decades ago, the Corridor of Control represents the equilibrium point between strategic investment of capital and commitment of operating dollars, *and* protection of the organization's long-term financial integrity as measured by continued, effective access to capital. This concept is illustrated in **Exhibit 4**.

Exhibit 4. Corridor of Control



Source: Kaufman, Hall & Associates, Inc. Used with permission.

If an organization is operating below the Corridor of Control in the area of "long-term concern," it may be at risk of undermining its market position because it is not investing sufficient capital to build the new competencies required to succeed in a value-based business environment. However, if an organization is operating above the Corridor of Control in the area labeled "short-term concern," its financial needs, or strategic capital appetite, exceed its current financial capabilities. In the extreme, this can cause a liquidity crisis and trigger a default on debt. More commonly, this capital position reflects an organization that—given levels of performance—is limited in its ability to respond to market opportunities and threats. An organization operating in the "short-term concern" area likely has more limited short-term access to capital and must allocate that available capital capacity with great care, often to the detriment of identified strategic initiatives.

Available capital capacity (both short- and long-term) can be more effectively increased by achieving sustainable cost transformation within a strategic context as opposed to waiting for a "crisis" to drive the need. The financial equilibrium approach provides such a foundation.

5. Ensure a "Back-to-Basics" Financial Planning Approach

To develop an effective and sustainable cost-management program, board members should work with the organization's management to ensure it is using an approach founded in traditional corporate financial planning principles. This approach bridges finance, strategy, clinical operations, and management. Its use allows healthcare leaders to gain a thorough understanding of the current financial and capital position of the organization and its likely trajectory over the next five to 10 years. It is vital that hospitals and health systems understand their baseline financial trajectory and quantify the potential impact of various operating pressures, reexamine existing strategies, and project the financial impact of current and future initiatives.

By using a disciplined process, organizations can rigorously test alternative "portfolios" of initiatives, using sensitivity analyses to identify the initiatives that will meet the organization's strategic goals while optimizing its competitive financial position. The gap between resources required to fund the desired portfolio of initiatives and the organization's current capital position quantifies the organization-wide strategic cost-management requirement.

Hospital leaders should use the resulting strategic-financial plan to set expectations, assign responsibilities, and establish accountability for achievement of revenue goals and expense targets. Navigating the financial gaps during the transition to a value-based model will be complex and challenging for organizations. Additional rigor, discipline, and resources can be helpful.[9]

6. Oversee Development and Implementation of a Master Plan for Strategic Cost Transformation

When the organization's current and projected future positions have been quantified, its needs identified, and different initiatives and scenarios tested through the financial plan, healthcare leaders can begin to develop a strategic cost-transformation

9 J. Sussman and B. Kelly, *Navigating the Gap between Volume and Value: Assessing the Financial Impact of Proposed Health Care Initiatives and Reform-Related Changes*, Health Research & Educational Trust and Kaufman, Hall & Associates, Inc., June 2014.

master plan. Such a plan articulates the order and timing of specific cost-transformation strategies to best meet both short- and long-term goals.

Most organizations will need to address all of the key cost-transformation categories identified in Exhibit 1—cost management, business restructuring, and clinical transformation—but concurrent pursuit of all three pathways may excessively strain the current resources available to the management team. The order of priority for cost transformation for any organization will vary based on its market, clinical resources and environment, and financial position. In addition, the political will of the organization, the strength of its management and clinical teams, its culture of measurement and accountability, and other factors will play a significant role in how strategic cost transformation proceeds. An objective evaluation of these characteristics is strongly recommended.

7. Ensure a Strong Business Platform, with the Right Systems and Technology Functioning at All Levels

To ensure sustainable cost management, organizations must have the systems and technology in place to accurately monitor, analyze, and manage progress. These should be corporate finance-based business systems and tools that enable strategic planning, financial planning, cost allocation, capital allocation and management, budgeting and cost control, and capital structure and risk management.

Systems and tools for quantifying and monitoring information related to clinical care also will be essential in the transition to a value-based care model. Such systems and tools will need to be flexible and adaptable to support the monitoring and management of organizational performance under changing care delivery and payment arrangements.

Organizations must ensure they have qualified personnel in place who are capable of using these resources to the maximum benefit. Where such individuals are lacking, management should hire or train staff to gain the necessary skills and expertise.

8. Foster Cultural Change

Implementing strategic cost transformation almost always requires cultural change. Supported by the board of directors, executive leaders must create a culture of transparent results and accountability across the organization.

Communicating the goals, objectives, and reasons for implementing the plan to all stakeholders is critical. In order to ensure that the required changes are sustained over the long term, hospital and system leaders should recognize, encourage, and enable active participation organization-wide. All parties will need to be engaged and support the process to enact permanent change.

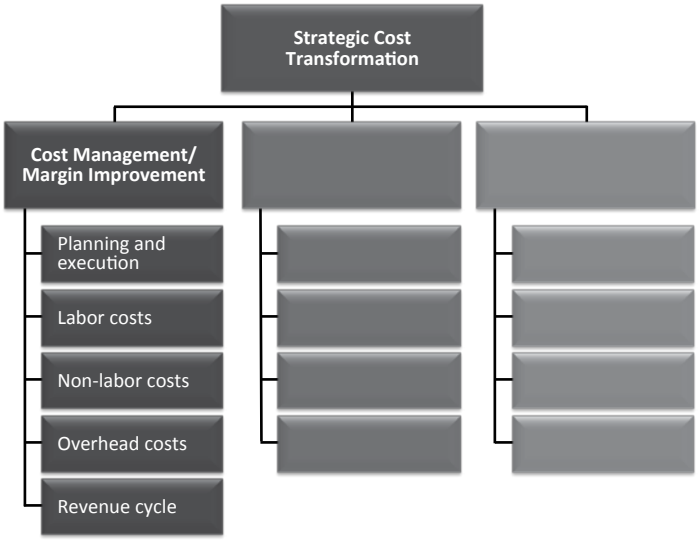
While cost management is an operations function for which the management team is responsible, cost transformation requires the support and oversight of the board to ensure that resulting strategies and operations are consistent with the organization's overall mission and vision. New mindsets, enabled through strong leadership, will create meaningful change.

Cost Management and Margin Improvement

With the required groundwork completed, or well into the process of being put in place, hospitals and health systems first should evaluate traditional opportunities to improve the efficiency of existing operations or services.

EFFECTIVE COST MANAGEMENT REQUIRES AN INTEGRATED approach involving system-wide assessment, planning, and implementation. Addressing inefficiencies related to labor costs, non-labor costs, and revenue cycle management long have been foundational to cost-reduction strategies. Provider organizations have done a particularly good job during the last several years of increasing operational efficiencies, but cost management is an ongoing process, not a one-time initiative.

Management should make regular evaluation and management of operating costs an integral part of the organization's financial planning structure. New opportunities may exist in areas previously deemed "untouchable," those that have flown under the radar (such as duplicated overhead costs), or those for which no benchmarks historically have been available. The following provides examples of areas in which organizations can look for potential savings, and action items for identifying these types of opportunities.



Planning and Execution

Effective planning allows organizations to be proactive and make changes in a timely manner in order to avoid accumulated and increasing costs over time. Sustainable cost initiatives must be built directly into the long-term financial plan and annual budget in a way that ensures transparency and accountability.

9. Understand Common Barriers

Leadership teams routinely make decisions that produce unintended consequences. Such consequences can limit the effectiveness of cost-management initiatives. To realize sustainable results, hospitals and health systems must identify and overcome the obstacles that have prevented them from achieving or maintaining past cost-reduction goals. Eliminated costs often creep back into operations as a result of failing to face these common barriers.

Three common attitudes typically are root-cause barriers to sustainable cost reduction. They can be expressed as follows:

1. "We've already picked the low-hanging fruit. You're mistaken if you think we have extra FTEs (full-time equivalents)."
2. "If there are any unachieved savings, they definitely are not in my area."
3. "Benchmarks just don't apply to us because they don't exist, or we know that we are running a tight ship and don't need them."

Directors should encourage management to analyze past successes and failures, have honest dialogue about these attitudinal barriers, and address historically problematic decision points. Doing this allows organizations to strengthen their capacity to overcome future execution barriers and achieve lasting results, while also improving transparency. Some problematic decision points may include:

- Focus on activity-centered cost *avoidance* rather than true cost *reduction*
- Adoption of benchmarks that are not aligned with financial goals

The difference between activity-centered cost avoidance and true cost reduction is apparent in the following example. A large academic medical center can absorb a 15 percent increase in respiratory therapy volume without adding staff. Productivity will increase as the same number of staff takes on a larger patient load and the organization avoids adding staffing costs. Even so, this does not result in a decrease in existing hospital costs.

Setting realistic benchmarks also is essential. There may be strong motivation to adopt benchmarks that cast the organization or a particular department in a favorable light, but doing so can be counterproductive. For example, a small community hospital that was experiencing increasing financial losses chose to use heart surgery indicators to benchmark itself against larger and more complex hospitals with more service lines. By comparison, the smaller hospital appeared more efficient and cost

effective, even though its heart surgery costs had increased dramatically in recent years. The adoption of non-comparable organizations as benchmark comparisons made it difficult for leadership to identify cost-reduction opportunities that would have been uncovered through benchmarking against more comparable hospitals, and against the organization's own previously achieved performance levels.

10. Ensure Top-Down Target Setting, with Staff Involved in Implementation

Senior management must be willing and able to identify targets based on required performance levels. Once targets are established, department managers then play the vital role of developing the strategies to achieve those targets. Absent top-down target setting, trying to gain consensus from staff can be time consuming and result in a lengthy negotiation process that diverts energy and time that needs to be dedicated to implementing cost-reduction strategies and realizing savings.

Board members should support executive management in setting targets that enable authoritative decision making. Decisions need to be followed by broad communication of those goals and the engagement of department managers in determining how targets will be implemented and assessed. Middle managers are the most qualified to determine how best to achieve targets. Enabling them to execute change encourages their active participation in achieving the organization's goals, and fosters transparency and accountability.

Educating staff across the organization about the reasons behind the targets creates system-wide understanding of the strategic necessity for the organization to implement specific initiatives.

11. Encourage Enhanced Cost Intelligence

Establishing a successful and sustainable cost-reduction program requires improving an organization's "cost intelligence" by identifying its true drivers of cost. Directors should ensure that their executive teams evaluate, analyze, and understand the organization's costs, and identify those areas that are contributing to unnecessarily high costs.

This requires analyzing how costs and productivity are measured within specific departments and for the organization as a whole. Cost and productivity measurement should be aligned with the organization's cost-management goals. For example, a hospital's lab may require certain patient groups to have daily blood tests. This may result in high productivity measures for the lab, but it also increases costs through the continued administering of tests that may be unnecessary. Refer to Action Item 15 in the following section, Labor Costs, for more information on how productivity measures should be adjusted during the transition to value-based healthcare.

12. Ensure That Accountability Has Been Established

Strategic cost management requires having processes in place to continuously monitor and manage cost-reduction efforts. Board members should work with senior leadership to ensure that managers implement processes to track plans, report results, and execute initiatives on an ongoing, visible, and real-time basis.

Through regular communication of goals and the tracking of progress toward cost-reduction goals, leaders can increase the visibility of results to help foster a culture of accountability and enhance organization-wide knowledge. Goal communication and tracking also help to guide future improvement strategies. In some cases, routine monitoring may reveal initiatives that are ineffective or out of date—such initiatives should be discontinued or adapted accordingly.

Labor Costs

Labor costs typically constitute more than half of a hospital or health system's operating expenses, and therefore offer significant opportunities for removing cost from the organization. Board members should encourage and support efforts to reduce labor expenses as a means of increasing efficiency while also ensuring the continued provision of high-quality care for patients.

Healthcare leaders can identify opportunities to reduce labor expenses by comparing their costs to national and regional benchmarks, as well as internal historical data. The following areas should be evaluated: compensation ratios, staffing metrics, and productivity drivers. The following action items discuss each of these areas individually.

13. Ensure Evaluation of Compensation Ratios

Key performance indicators in assessing compensation ratios include paid time off at the business unit level, paid time off at the department level, total compensation per FTE, total salary per FTE, overtime costs, and salaries and benefits.

By reviewing compensation ratios, an organization may identify opportunities to reduce costs by better managing staffing and productivity to reach financial performance targets. These potential savings then can be quantified by comparing them with historical compensation ratio levels. This can help to demonstrate the savings opportunities to broader management and other stakeholders, and build support for strategic initiatives.

14. Advocate for Assessment of Staffing Metrics

Evaluating staffing metrics may reveal opportunities to reduce labor costs in multiple areas. For example, many hospitals and health systems can realize significant savings by ensuring maximum staffing efficiencies at various patient volumes. Measuring the difference between operating staff efficiency at peak patient volumes versus average volumes often leads to identification of excess staff capacity at a particular volume level or time period.

Other cost-saving opportunity areas include: reducing functional redundancies and overhead (see Overhead Costs section) across facilities, and minimizing use of overtime and premium labor by cross training.

15. Ensure Redefinition of Productivity Drivers

The transition to a value-based healthcare system will require many hospitals and health systems to redefine traditional measures of productivity. Under the old model, productivity has been measured based primarily on individual, department-specific

activities. This system often incentivizes physicians, nurses, and other medical staff to provide more services, even when those services may not be required to achieve high-quality patient outcomes. For example, measuring productivity in radiology by the number of images billed may incentivize unnecessary imaging that increases organization-wide costs—thereby reducing revenue under a value-based model—while providing little or no benefit to patients.

Redefining productivity measures requires organizations to move away from a focus on department-specific activities that incentivize *more* care, to measures that incentivize the *right* care. New models for measuring productivity require breaking down silos and eliminating traditional divisions that exist in hospitals.

Board members should encourage focus on broader service line- and hospital-level measures. Having common measures that are used across the organization helps to ensure consistency and make it easier to monitor productivity going forward. For example, the emergency department, intensive care units, and inpatient medicine units should use common measures that allow them to better collaborate to reduce errors in patient placement, ensure the most appropriate levels of care, and reduce lengths of stay.

Transitioning to cost-per-case productivity measures refocuses emphasis on the cost and necessity of the service rather than on the quantity of departmental volume produced. It allows for a more patient-centered approach that enables organizations to focus on important initiatives such as improving throughput, reducing patient wait times, and decreasing lengths of stay. By promoting efficiency and high-value care, measuring productivity on a cost-per-case basis also aligns with new value-based payment models and population health management.

Involving physicians and other clinician leaders early on in this process is essential. These individuals most directly influence the course of patient care, such as the number and nature of lab tests, respiratory therapy consults, or medications ordered. This places them in a unique position to offer feedback and recommendations on how to lower per-unit patient costs by providing more efficient and effective care. Once new productivity measures are identified, frontline staff must be engaged in implementing those new productivity measures and any related initiatives.

To make such changes, hospital and health system leaders must be willing to move away from decades-old definitions of productivity, and be prepared to inform and engage physicians and medical staff in making the transition. Everyone throughout the organization needs to have a clear understanding of why the new approach creates better alignment with strategic and financial goals, so that they can see how their work impacts the broader organizational mission.

Frontline staff should be engaged to implement both the new productivity measures and resulting cost-reduction initiatives. Routine and transparent communication will facilitate dialogue to address complex topics and any challenges that arise, and ensure that the organization's overall goals remain a key focus for all involved.

16. Support the Implementation of Mechanisms for Ongoing Data Collection and Analysis

Instead of measuring productivity on a monthly or quarterly basis, organizations need to have real-time productivity data. This enables managers to provide effective feedback to clinicians and medical staff to drive daily operating decisions. Organizations must implement technology and mechanisms for constant, ongoing data collection and analysis, such as technologies that link payroll time and attendance with a hospital's patient tracking system.

Board members should support management in taking the necessary steps to develop these capabilities, and ensure they are being used effectively by requesting updates and reports to ongoing initiatives that incorporate the data.

Non-Labor Costs

As with labor costs, non-labor cost-reduction opportunities can be identified by comparing an organization's non-labor costs to industry standards using internal and external benchmarks as a percentage of revenues.

17. Encourage Evaluation of Key Areas for Non-Labor Cost-Reduction Opportunities

Opportunities to reduce non-labor costs may be found in a variety of areas. Board members should encourage thorough evaluation of all avenues for potential savings. For example, hospitals often can realize savings by standardizing purchases of goods and supplies organization-wide.

Standardizing physician preference items is another area that can offer significant savings. One Chicago-area community hospital saved $665,000 annually after cardiologists practicing there agreed to use the same device for electrophysiology tracking, rather than requiring the hospital to supply different brands and models of such devices to suit individual physicians. Other areas that should be evaluated for non-labor cost-reduction opportunities include logistics and purchased services, such as food or cleaning service contracts.

18. Ensure Evaluation of Purchase Order and Accounts Payable Processes

To measure non-labor costs internally, directors should encourage the continuous analysis of purchase order and accounts payable processes. This allows the organization to assess where and how money is being spent for items such as supplies, equipment, and contracted services across all departments and service lines. Management then can use this information to pinpoint high-cost areas and identify potential savings opportunities.

19. Ensure That Clinicians Are Engaged in Identifying and Planning Initiatives

As with developing new productivity measures and other initiatives, the involvement of physicians, nurses, and other clinicians to identify potential non-labor savings and design initiatives to address those opportunities is invaluable.

Because they are the ones using the goods, supplies, and services every day in the provision of patient care, clinicians are best equipped to provide insights into what works and what doesn't. They will know from experience where limited resources are being misspent or could be spent more efficiently and effectively. For example, nurses often can help shape non-labor cost-reduction initiatives by providing insights into the subtle differences related to use of one medical device versus another.

20. Request Use of Solid Outcomes Research to Help Guide Decisions

Under a value-based business model, efforts to reduce non-labor costs involve more than trimming expenses. Initiatives must aim to reduce costs while also maximizing the value of care provided. Decisions regarding efforts to reduce non-labor costs should be based on solid financial *and* clinical outcomes data. This allows for objectivity in building support for new non-labor initiatives.

Evidence-based research that illustrates the benefits of proposed changes is critical in communicating initiatives across the organization and gaining buy-in from both clinical and non-clinical staff and other stakeholders. For example, leaders may demonstrate the potential benefits of switching to a particular wound care product using studies that show measurable patient benefits—such as reducing scarring or accelerating recovery time—which would improve patient outcomes while also reducing total wound care costs.

Analytics also can be helpful in altering how products are used, such as encouraging the reduction of waste by eliminating the unnecessary opening of excess sterile surgical packs before procedures in the operating room.

Overhead Costs

Identifying and addressing overhead costs can pose particular challenges for hospital and health system leaders because these costs often have become ingrained in the fabric of organizations. As a result, they may have gone largely unnoticed in prior cost-reduction efforts and may now be difficult to eliminate.

21. Encourage Reduction of Overhead Functions and Costs

Board members should support a thorough review of organizational operations with the aim of identifying, quantifying, and reducing overhead costs. Overhead costs typically refer to business expenses beyond direct care-related labor, goods, supplies, and services that must be paid on an ongoing basis, regardless of demand, payments, or other factors. A nursing department, for example, may have high overhead costs if it has a large number of non-clinical managers in proportion to its clinical staff.

Other sources of overhead costs include functions such as human resources, accounting and finance, revenue cycle, information technology, marketing, legal/risk management, and materials management. Streamlining such functions to reduce redundancy and/or repetition within and across facilities can yield significant savings. These functions could and often should be standardized, and costs significantly reduced, by centralizing or regionalizing administrative and/or overhead functions.

Revenue Cycle

A seamless, comprehensive revenue cycle function encompasses the full spectrum of the patient experience, beginning at pre-registration through to final disposition and payment of the patient account. Oftentimes, these functions are widely dispersed and function in silos across an organization. A 500-bed hospital, for instance, may have as many as 150 people directly involved in the revenue cycle process.

22. Ensure Identification and Implementation of Revenue Cycle Improvements

Board members should develop a general understanding of the various functions of the revenue cycle, and support management in assessing revenue cycle functions with the goal of identifying opportunities for both customer service and revenue yield improvements. Effective revenue cycle management initiatives typically can garner an organization's yield improvement from 2–4 percent of net patient revenue. That can be significant, particularly since many hospitals and health systems routinely have operating margins ranging from 3–5 percent.

Revenue cycle management initiatives should begin with an assessment of the organization's overall revenue cycle performance, including efforts to identify baseline quantitative metrics, assess processes, and compare them to industry best practices and benchmarks.

By identifying revenue cycle improvements, healthcare leaders also can reduce "leakage" (i.e., lost revenue) resulting from issues such as payer denials or unpaid patient residuals.

23. Support Management in Staying Abreast of Changes in Revenue Cycle Management

The numerous components of revenue cycle management—such as billing processes and coding requirements—are constantly changing. Because of this, and because so many individuals are involved throughout the revenue cycle, organizations must be proactive, keep informed of the current status of cycle components, and effectively manage all of those components. Individuals involved in coding and billing should work directly with clinical staff on a routine basis to ensure coding is accurate. Such

initiatives are increasingly important, as billing has become more complex in recent years.

24. Support Acquisition of Resources for Reliable Payment Information

A fundamental goal of revenue cycle management is to have clean and accurate payment information, preferably at the process onset. This involves verifying every patient's demographic and insurance information at the time of service or before. This verification also allows for the discussion and collection of patient residuals at the time of service, provides patients with critical information, and ensures accuracy for billing of claims.

Hospitals and health systems should develop and implement systems to ensure that all services are coded correctly and any required pre-authorizations are signed, processed, and approved. Without the proper systems in place to ensure billing accuracy and compliance, organizations risk having to write off unresolved claims as bad debt. Having centralized functions where possible and practical is critical in ensuring consistency, as discussed in the next action item.

25. Encourage Centralized Registration, Billing, and Payment

As mentioned earlier, revenue cycle functions often are widely dispersed across organizations. Having centralized billing, preregistration, and follow-up teams is beneficial in that it standardizes these functions and helps to streamline processes. It also makes it easier to implement systems that ensure collection of accurate payment and billing information at the time of or before the patient visit, and reduces re-work on the back end of the process.

Centralized patient registration increases the likelihood that all patient information will be collected and verified in a consistent and reliable manner. Such processes also are beneficial for patients, because they provide patients with accurate information on the potential costs of treatment upfront.

26. Support the Provision of Good Financial Counseling

In the changing reimbursement landscape, hospitals need to invest in strong financial counseling for patients and follow-up programs. Identifying patients prior to service who are uninsured or under-insured is essential to assisting them in finding potential coverage solutions, appropriate payment options, or qualifying for charity care. In addition, financial counselors and navigators will be critical to assisting patients in understanding new options available to them as a result of the Affordable Care Act (ACA), such as the public healthcare exchanges, and expanded Medicaid coverage in some states.

27. Encourage Other Key Efforts to Improve Revenue Cycle Management

Boards also can encourage pursuit of other initiatives to improve revenue cycle management. For example, organizations need to focus on charge capture and accuracy for all services provided. Having staff and technology that validates appropriate charge capture and documentation provides seamless coordination between coding, billing, and clinical departments.

Another important component of a strong revenue cycle is the operation of systems to review payer denials. For example, a hospital may have open accounts related to services provided six months ago that remain unpaid in spite of efforts to resolve payer denials. An interdisciplinary team (with clinical, managed care, and financial/revenue cycle experts) should focus on determining why the accounts were initially denied, and correcting and resubmitting the claim. By defining the root cause and correcting operational inefficiencies, organizations can prevent future payer denials and underpayments on similar claims.

Lastly, having automated billing systems that can be updated as needed is essential. (See sidebar, Case Example of Revenue Cycle Management.)

Case Example of Revenue Cycle Management

A three-hospital health system assessed its revenue cycle performance and identified numerous deficiencies. The organization had an outdated computer system and high accounts receivable days and uncompensated care that were well above industry benchmarks.

The review indicated that revenue cycle management had not received sufficient information technology support and that current systems had limited abilities to track and report on key metrics. Software designed to help manage revenue cycle functions had been purchased years ago, but was never implemented. As a result, staff had limited access to necessary information at the time of patient registration, and billing staff had developed manual methods to cope with inefficiencies in the system.

To overcome these challenges, leaders at the health system are implementing a year-long strategy to transform revenue cycle operations to meet industry best practices. The initiative is projected to result in an estimated $24 million in combined annual cost savings and revenue yield.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

After evaluating these more traditional areas for cost-management opportunities, many hospitals and health systems will find that the projected savings are insufficient to get the organization to its full strategic performance goals. The next step is looking for opportunities in more structural areas, as discussed in the following sections.

Business Restructuring

In most cases, an incremental and traditional approach to cost management is insufficient to address the root cost issues of any health system. Initiatives that focus on business restructuring offer the biggest opportunities for major savings due to the large capital investments and expenditures involved.

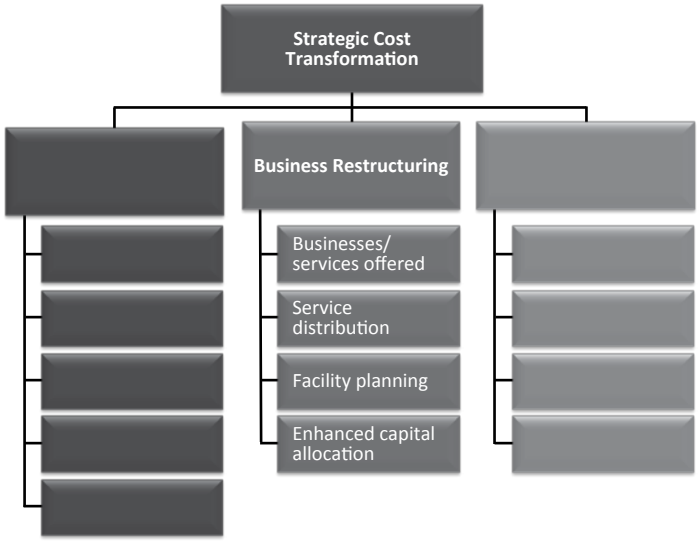
BUSINESS RESTRUCTURING EFFORTS CAN BE BROKEN INTO four major buckets: evaluating the businesses and services offered; evaluating service distribution; facilities planning; and enhanced capital allocation.

Businesses/Services Offered

The first step in business restructuring is to conduct a comprehensive evaluation of all of the businesses and services offered by a hospital or health system. This requires a critical review by leadership to determine which are most aligned with current and future goals. Numerous factors should be taken into consideration, including the organization's:

- Mission
- Nature of operations
- Market environment and competitive position
- Financial performance
- New-era compatibility (e.g., extends the care continuum, enhances alignment with physicians, or provides a critical lower-cost setting)

Determining the essentiality of a business can be a difficult task. As with most social goods, there is nearly an insatiable appetite for the services hospitals and health systems provide, and some services may have a strong historical or sentimental link for the organization. Board members should encourage a thorough and objective examination of *all* businesses and services provided. Leaders must determine if the organization is structured in a way that most appropriately addresses the current and future opportunities and issues in its community. For example, whether a health system's skilled nursing facilities, laboratories, or other businesses may be outside of its core mission.



This type of assessment is increasingly important as healthcare providers are pressured to decrease costs and improve value. Hospital and health system leadership must drive "portfolio scrubbing" initiatives, which may redefine an organization's core businesses and services, service distribution, and market services.

28. Ensure Use of an Evaluation Framework, Asking Key Questions

In order to evaluate each of the organization's businesses and services, leaders should ask and answer two fundamental questions:

- What businesses and services are core to our mission and vision going forward?
- Where can we most effectively invest our limited capital and resources to meet the current and future healthcare needs in our communities?

This assessment must have a solid framework within the financial planning process. Analyses should take into account current operations, the costs of those operations, and projected future investments required to grow specific businesses and/or service lines, such as the costs associated with hiring more physicians or expanding facilities. (See sidebar, Key Questions for Business Evaluation.)

Key Questions for Business Evaluation

- Is this an essential business that is required to deliver upon our mission?
- Will this business become more or less relevant as the post-reform success requirements evolve?
- Is this business fully integrated into the fabric of the institution and its care delivery model?
- Is the hospital/health system best positioned to own and operate this business or could another organization provide these services more effectively through contractual or other relationships?
- Could the hospital's/health system's resources be more effectively deployed to further advance the organization's mission?

Source: Kaufman, Hall & Associates, Inc. Used with permission.

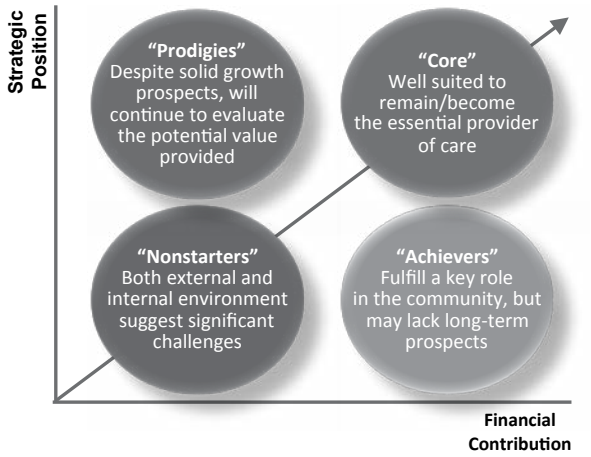
Through this analysis, each business/service can be stratified at a basic level into one of four categories reflecting its strategic position and contribution to the larger organization: core, achievers, nonstarters, and prodigies. Each of these is described in **Exhibit 5**.

Strategies related to the assessment of businesses and services often are highly complex and require significant time. The evaluation itself typically takes four to six months. Leaders must be prepared to make difficult decisions that involve the potential for significant gains as well as substantial associated risk.

29. Ensure Quantification of the Impact of Business/Services Restructuring

In doing this evaluation, healthcare leaders must consider the total value of the business or service line, and whether it represents the best use of the hospital's or health system's limited resources. This requires quantifying the impact of strategies related to maintaining or divesting non-core business initiatives as part of the financial planning framework. Strategies to be quantified may include consolidating services and/or establishing centers of excellence to generate increased efficiency and improved access to care. These analyses should incorporate the direct and indirect savings or costs associated with a particular business or service line, and the anticipated overall revenue and expense impact on operations. (See sidebar, Example of Business/Service Evaluation and Restructuring.)

Exhibit 5. Business/Service Evaluation Matrix



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Example of Business/Service Evaluation and Restructuring

An academic medical center developed a financial plan for each of its businesses, including fact-based assumptions as to volume, revenue, expense, and associated capital costs. Sensitivity and scenario analyses generated a range of possible future trajectories.

After evaluation of all of the plans, management decided to divest the organization's home health business and a reference laboratory business. The organization lacked home health expertise, the business was not profitable, and losses were expected to increase over time. The reference laboratory business, on the other hand, was very profitable, but did not meet leadership's criteria as a core service as defined by its overall mission, vision, and goals.

By selling all or a portion of both businesses to other major providers in the market, the organization was able to ensure that the community retained quality services. At the same time, the academic medical center was able to redirect capital capacity to other vital initiatives.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Service Distribution

Evaluation of service distribution involves examining how an organization's services are spread across its service area within the context of the broader geographic market. This assessment is particularly important with the transition to population health management and healthcare reform, as hospitals and health systems begin to think about their most appropriate role in managing the health of people living in the communities or regions they serve.

30. Ensure Evaluation of Where and How Services Might Be Better Distributed

The goal of this evaluation is to determine which services to offer where, and at what level, to best meet community needs in the most efficient and effective way possible. Board members and management must ask whether the organization can continue to provide high-quality, appropriate care, and the right level of patient access, while also reducing duplication of services and associated costs.

To improve the efficiency and effectiveness of care and enhance the value offered to patients, hospitals and health systems must right-size and right-site their delivery network. This requires them to determine how best to distribute various service lines, ambulatory facilities, and other business units across the delivery system.

Hospital and health system leaders need to ask key questions, including:

- What will it take to achieve a well-distributed and rationalized delivery network that extends across the continuum of care?
- What role will our organization play in this delivery network?
- What do we need to do to ensure that we are delivering services in the lowest-cost setting possible?
- What do we need to do to ensure that we are concentrating delivery of highly complex care in fewer sites to drive quality and cost efficiencies?
- What do we need to do to ensure that we are making efficient and effective use of scarce operating and capital resources?
- What concrete, quantifiable benefits can be achieved through the following: clinical outcomes improvement, operational savings, capacity management, and capital avoidance?

By answering these questions, hospital and health system boards and management teams can develop a strong foundation upon which to build a plan for most effectively distributing the organization's services. (See sidebar, Examples of Service Distribution Initiatives.)

Examples of Service Distribution Initiatives

Example 1: Eliminating Duplication of Services in a Large Regional Health System

Leadership at a $3 billion regional health system with five hospitals had a goal of reducing the organization's annual costs 20 percent by optimizing the distribution of inpatient and ambulatory services across its metropolitan market. To evaluate the possibilities, the system engaged in a structured planning process aimed at eliminating capital and operating expenses.

A plan was developed to eliminate duplication of services within the system by consolidating three neonatal intensive care units and three obstetrics and gynecology programs into one central location. Two cancer center programs located within five miles of one another also were consolidated. Lastly, the system plans to limit the expansion of its neurosciences and cardiovascular programs in the years to come.

By implementing these initiatives, the health system has realized capital spending savings of $150 million to date by reducing unneeded service duplication. The potential for saving another $30–$50 million in operating expenses also has been identified.

Example 2: An Accountable Care Organization Shifts Services to Maximize Efficiencies and Improve Care

The leadership of an integrated delivery system with four independent affiliated hospitals recently agreed to refine the system's service distribution platform. The goal was to develop a service line strategy across a large regional area that would optimize the system's chances of succeeding as an accountable care organization under a value-based care delivery model.

The system used a robust planning process to design a regional plan focused on its cardiac services. To drive quality improvements and cost reductions, interventional procedures such as percutaneous coronary interventions, stents, and cardiac electrophysiology will be provided at two sites across the region. As a result, the provision of these routine procedures will be moved out of the system's large academic medical center to smaller community hospitals that can provide those services at lower cost. Cardiac surgeries, meanwhile, will be centralized at the academic medical center.

By centralizing the various functions in the most appropriate facilities, the system will be able to increase the volumes of such cases performed at each facility. Since higher volumes often translate into higher-quality care due to the enhanced expertise of those performing the procedures, the organization will be able to ensure continued high-quality results related to relevant performance indicators.

These initiatives are projected to result in an annual operating savings of $4–$5 million for the system.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

31. Encourage Development and Implementation of a Service Distribution Plan

A service distribution plan is a multi-year organizational blueprint for transformational cost restructuring through the improved allocation of services offered.

A solid fact base provides the foundation for such a plan by better contextualizing barriers or challenging issues. The fact base should include data related to the organization's markets, strategic and financial positions, and the impact of current and possible future trends on those markets and positions. Within this planning framework, key realities and assumptions must be defined related to payment mechanisms, the competitive environment, physician market characteristics, and core competencies required for provider success.

A comprehensive financial fact base must also be developed, quantifying the organization's current and future capital position and debt capacity. In the current uncertain environment, scenario modeling and sensitivity analyses are imperative in order to understand how changes in utilization, payment, capital, and other assumptions will impact future strategic and financial performance.

The final plan developed for the service delivery system, based on the above-described process, should fully define:

- How the organization will serve the market
- How each of the organization's operations and service lines will relate to other operations and service lines
- How clinical resources will be organized and deployed
- The financial impact of the service distribution plan on the overall organization

Most organizations will not be able to be all things to all people. They will need to define and re-scope core community service offerings consistent with overall capital, management, and clinical resources.

Facility Planning

Hospitals and health systems invest substantial capital in their facilities. As much as 40 percent of a non-profit hospital's balance sheet is associated with the real estate it owns. But the dynamics of the nation's healthcare system are changing. The new era of healthcare demands that organizations provide high-quality care in the lowest-cost setting possible. With increasing frequency, that setting will not be an inpatient facility.

Many hospitals and health systems have an outsized delivery system, which has been overbuilt during the decades of fee-for-service payment and a robust economy. Many organizations are over-invested in inpatient capacity and under-invested in primary and ambulatory care capacity as a result. Correcting this imbalance requires that organizations shift to a focus on providing services in outpatient facilities and home settings. This demands a comprehensive approach to facilities planning, as outlined in the following strategies.

32. Ensure Development of a Solid Facilities Plan

Developing a viable facilities plan requires a thorough evaluation of the organization's facilities within the context of the larger system and its broader service area. Organizational leaders will need to assess the current and projected future demand for services within that market, and the practical long-term functionality of individual facilities.

A solid facilities plan incorporates one or more of four strategies:

- Facility-related capital avoidance and reduction (such as previously planned renovations or new construction)
- Retrofitting of current capacity to suit needed future capacity
- Divestiture/closure of unneeded capacity
- Reduction of ongoing facility-related operating costs

The next three action items describe plan components.

33. Require Development of Projections for Future Inpatient and Outpatient Demand and Corresponding Capacity Needs

A critical step in effective facilities planning requires projecting future inpatient and outpatient demand and corresponding capacity requirements for the market or markets served. Board members should support management in considering multiple factors, including current and projected market conditions, the degree of projected inpatient migration from surrounding areas, anticipated shifts in market share, the impact of Medicaid expansion and other healthcare reform-related changes, and market-level use rates by service line, payer, and age group. Anticipated changes in underlying inpatient and outpatient service utilization rates driven by insurance, technology, demography, and cultural changes also must be included in projections.

34. Request Examination of the Age and Functionality of Facilities

As part of developing the facilities plan, healthcare leaders need to assess the age and functionality of facilities system-wide to determine if they can serve the organization's needs long term. Where deficits are identified, the strategic focus should be on quantifying costs associated with improving the existing space, converting unneeded capacity to new functions, or creating new space.

In one case, a health system evaluated its facilities and found it had an oversupply of inpatient facilities and a shortage of facilities for its expanding outpatient services. With the support of its board, the management team decided to convert an underused inpatient facility into an outpatient ambulatory surgery center with an emergency department and some observation beds. The initiative is projected to save the organization $6 million in fixed costs annually.

35. Ensure That Facility Needs Are Based on the Service Distribution Plan

Identification of the facility needs related to a service distribution plan requires knowledge of the anticipated clinical capacity requirements. These are based on targeted utilization levels.

The service distribution plan defines which services across the continuum of care should be delivered at which locations and to what scale based on quality, access, operating cost, capital cost, and competitive considerations. This information provides the foundation for the organization's facilities plan.

In developing the facilities plan, healthcare leaders can determine how much space will be needed by examining capacity requirements outlined in the service distribution plan. They also must consider the medical staff that will be required to serve those patients. Space allocation regulations and guidelines for the different types of facilities and services should be followed based on projected patient demand and staffing. The costs associated with constructing new facilities or expanding or renovating existing facilities also should be considered, based on local industry construction costs.

Enhanced Capital Allocation

Many cost-reduction strategies described up to this point may require initial investments to shift or expand services and maximize the use of resources over the long term. To enable these efforts and other strategic initiatives, hospital and health system boards and management must evaluate the organization's existing capital resources and use a financial, strategic, and operating approach to determine how to most effectively allocate those resources.

36. Require a Structured Corporate Finance Approach to Capital Allocation

A structured corporate finance approach to allocating capital provides a standardized and strategic platform for analyzing, reviewing, allocating, and monitoring capital expenditures. Using such an approach, initiatives that require significant capital investment would each have a supporting business plan to help management assess and monitor where and how resources are being spent.

The most important financial decisions made each year by an organization's senior management and ratified by its board relate to how much capital to spend and on which projects and initiatives the dollars will be spent. The long-term success of a healthcare organization is highly dependent on the capital investment decisions it makes today. Every decision either adds to or reduces organizational value. Decisions to invest capital must increase the organization's value—its ability to generate capital for future projects, maintain or improve its creditworthiness, and accomplish its mission. For every investment that does *not* generate value, the organization must seek other ways to create the cash flow and return that should have been generated. The cumulative effect of incremental decisions determines the organization's overall success.[10]

Organizations cannot shrink their way to success. Organizational leadership must act on the knowledge that growth and investment to create growth are the foundation for the organization's future. Strategic investments that protect or improve the organization's net cash flow stream must be part of the long-term strategic financial plan along with its identified cost-transformation strategies.

High-performing organizations give the formal allocation of capital a high priority. They understand that existing capital capacity, defined as the amount of debt and cash flow-based capital an organization is capable of generating and supporting, is a function of past performance. The creation and regeneration of capital capacity depend on the organization's continuing ability to make value-adding investment decisions, while maintaining strict control of ongoing costs.

New sources of cash flow are harder and harder to find. In an environment of constrained payment, scarce resources, and increased competition, the cost of making bad capital investment decisions can be severe. A sound capital allocation process must be fully integrated with an organization's strategic cost-transformation plan and process.

10 J. Sussman, *The Healthcare Executive's Guide to Allocating Capital,* Health Administration Press, 2007.

Clinical Transformation

Clinical transformation initiatives involve fundamentally reshaping care processes in an organization with the aim of improving quality, outcomes, and efficiency of care for patients. This requires that boards and management work closely with clinical staff to assess the components of the current care system and processes, and identify and implement improvements based on evidence-based best practices.

THE INVOLVEMENT OF PHYSICIANS, NURSES, AND OTHER clinical leaders from the beginning of this process is absolutely essential. They have the experience, expertise, and knowledge needed to determine where improvements can be made to achieve the best results for patients, staff, and the organization as a whole. The involvement of clinical leaders also is vital to generate buy-in from the broader clinical professional staff.

In a value-based care delivery and payment system in which organizations manage a population's health, the types of clinical transformations addressed here will improve quality, reduce costs, and allow organizations to sustain desired clinical and financial performance.

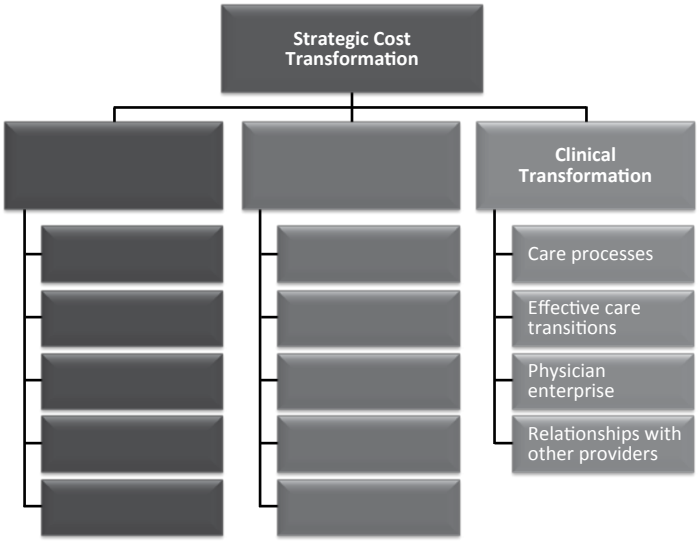
Care Processes and Effective Care Transitions

Redesigning care models and implementing care transition processes can help not only reduce unnecessary expenses, but also enhance communication and working conditions for physicians and other clinical staff, and improve the overall quality of care for patients. The New England Healthcare Institute estimates that nearly one-third of healthcare spending could be eliminated without reducing quality of care.[11]

The transformation of care processes also helps organizations better prepare for population health management and functioning under a value-based business model. Such initiatives, however, require major effort and effective coordination between management, finance, and clinical staff.

37. Ensure Identification and Elimination of Inappropriate Clinical Variation

Variation in the way healthcare is delivered should be a topic of critical focus for hospital and health system boards.[12] A large amount of clinical practice variation exists nationally—across regions, across hospitals in a region, across physicians in a hospital, and even across physicians in the same practice. In some areas and hospitals, patients receive more care at higher cost than patients in other areas and hospitals.



More care does not necessarily result in better outcomes. In fact, the opposite often is true, as has been well documented by the Dartmouth Atlas Project over the past two decades.[13] Furthermore, variation in the cost of care represents an enormous opportunity to reduce overall care cost. Whether occurring within an organization or among organizations in a region, variation generally has little basis in evidence-based medicine and can have significant negative implications for care quality.

Inappropriate variation in clinical practice occurs when non-evidence-based care is provided or, when lacking widely accepted evidence-based care, the high level of variation cannot be supported on a quality or outcomes basis. Such care is often driven by non-clinical factors, such as legal, financial, operational (e.g., hospital processes), or other considerations that providers bring, consciously or not, to the process of making decisions about how patients are treated. Inappropriate variation can lead to reputational problems for healthcare providers, including physicians, other staff, or affiliated organizations, and leads to higher utilization and costs, and disparate outcomes for patients in the form of unanticipated or suboptimal outcomes.

11 New England Healthcare Institute, *How Many More Studies Will It Take? A Collection of Evidence That Our Health Care System Can Do Better,* 2008.

12 M. Lambert, "The Board's Role in Care Quality and Safety," *Kaufman Hall Point of View,* Kaufman, Hall & Associates, Inc., October 2012.

13 Dartmouth Atlas Project (www.dartmouthatlas.org).

Organizations should focus on identifying physician leaders on the medical staff who can help review clinical processes and provide guidance in increasing the rate of clinician use of clinical practice guidelines for the diagnosis and treatment of diseases, as appropriate. Intended to minimize inappropriate variations in practice and improve equity, efficiency, and quality of care, clinical practice guidelines have been developed and disseminated by professional organizations, research organizations, and healthcare providers for more than a half century. Defined simply as tools to assist clinicians with clinical decision making, such guidelines are based on the best research evidence available and offer recommendations that, on the basis of that evidence, will be effective within defined patient populations or settings.[14] Engaging the expertise of physicians and other clinical leaders in selecting and implementing such guidelines is essential because they are best equipped to determine where and how improvements can be made, and to help gain buy-in from other members of the medical staff.

The application of evidence-based clinical practice guidelines allows hospitals and health systems to improve the quality of care for patients, while reducing costs and thereby demonstrating value for employers, payers, and other stakeholders. Further, use of evidence-based clinical practice guidelines positions organizations to meet the increasing transparency requirements around quality and cost metrics, and rising demand from patients and others for high-quality care at the lowest-possible cost.

38. Ensure Data-Driven Identification of Problems and Opportunities

A data-driven approach will be critical to physician participation in reducing care variation.[15] Credible data have the power to change behavior. Physicians who receive trustworthy data that demonstrate wide, unwarranted variation in their own care typically need no further inducement to bring their practices in line with their colleagues.

An organization-wide approach to reducing clinical variation must be supported by a commitment to defining, collecting, analyzing, and monitoring key data related to quality, outcomes, access, and cost. These data provide benchmarks for clinical guidelines and protocols, and pertinent information to guide future revisions based on new analytical findings.

Building a sustainable program of practice standardization can be taken one piece at a time. The focus may be on an individual diagnosis-related group (DRG), use of a certain drug or device, an office visit, specific test, condition, work process, clinical program, or some other element of patient care. The choice of which piece to tackle first can be based on its likelihood of early success, which, in turn, will build the trust and commitment needed for further improvement efforts.

Detailed data will be needed. Defined and provided by department directors, these solid data are essential to pinpointing improvement opportunities. Such data should be collected on a routine basis to allow for continuous monitoring of progress, and to help hospital and health system staff and leadership identify additional problem areas that may arise as care processes evolve over time. (See sidebar, Example of Measurement of the Delivery of Care Value, for an example of an initiative implemented at one health system to track patient outcomes.)

Example of Measurement of the Delivery of Care Value

A university health system sought to improve its clinical processes in order to prepare for a value-based payment model and better position the organization as a population health manager within its geographic market.

A value management committee was established and charged with defining value metrics and designing clinical initiatives aimed at driving value for the organization. More than 400 metrics were evaluated and analyzed. The committee then worked with physicians and sought input from employers and payers to identify a smaller number of key metrics that would be monitored on a routine basis. Having input from medical staff and other key stakeholders ensured that the selected metrics were meaningful, and helped leadership in building support for the initiative.

The committee continues to monitor and review the selected metrics on an annual basis to help guide ongoing improvement efforts. The initiative is focused on three major clinical initiatives—managing chronic disease, improving generic prescribing, and reducing overall hospital days. It will extend to other areas as progress is made and additional needs identified.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

39. Encourage Efforts to Improve Care Transitions

Another common problem area in the provision of patient care is the lack of continuity of healthcare services as patients transition from one provider to another, or from one facility to another. Poorly managed care transitions give rise to poor outcomes that frequently result in hospital readmissions that could otherwise have been avoided.[16] The federal government estimates Medicare readmissions cost $26 billion annually, of which more than $17 billion could be avoided with better care management. Under the ACA, hospitals and health systems face penalties of up to a

14 The Joint Commission, *Using Clinical Practice Guidelines in Ambulatory Care,* Joint Commission Resources, 2004.

15 K. Kaufman, J. Blake, and M. Grube, "Five Hard Things Hospital Leaders Must Do to Transform U.S. Healthcare," *Kaufman Hall Point of View,* Kaufman, Hall & Associates, Inc., July 2013.

16 G. Gerhardt, A. Yemane, and P. Hickman, et al., "Data Shows Reduction in Medicare Hospital Readmission Rates During 2012," *Medicare & Medicaid Research Review,* Vol. 3, No. 2, Centers for Medicare & Medicaid Services, 2013.

3 percent reduction in base Medicare payments for preventable readmissions in 2014.[17]

These types of improvements—such as reducing readmissions—contribute to more efficient and effective use of hospital resources. A Georgia health system, for example, decreased 30-day readmissions by approximately 40 percent through an initiative in which pharmacists deliver prescribed medications directly to patients at the bedside before discharge, and offer education and follow up once they leave the hospital.

Efforts aimed at improving care transitions should encompass a broad spectrum of activities, including services that patients receive before discharge, post-discharge activities, and activities aimed at bridging inpatient care with the care patients receive outside of the hospital walls. Specific strategies have a track record of success, such as the use of care coordinators and multidisciplinary teams to facilitate handoff communication. (See sidebar, Example of Care Transition Improvements.)

Example of Care Transition Improvements

In evaluating its care processes, a regional health system in California found that a large portion of its readmissions were occurring among patients that had been treated previously for heart disease. System leaders evaluated the options and decided to partner with the Institute for Healthcare Improvement to implement a program to better manage heart disease patients.

Several functions were set up to ensure these patients received the care and information they needed both before and after they left the hospital. Initiatives included:

- Use of teach-back techniques to educate patients about how to better manage their chronic disease
- Follow-up calls to patients to check on their status, encourage them to abide by self-care protocols, and ensure that they scheduled and attended follow-up physician appointments
- Referral of patients to specific services as needed to benefit their care and quality of life
- Collection and analyzing of readmission data to track trends among this patient population
- Communication and collaboration with clinicians across the continuum of care

As a result of these efforts, the health system saw 30-day readmission rates for heart failure patients age 65 and older drop from 24 percent to 13 percent between 2009 and 2011. Ninety-day readmissions dropped from 40 percent to 26 percent over the same period.

Source: D. McCarthy, A. Cohen, and M. Johnson, "Gaining Ground: Care Management Programs to Reduce Hospital Admissions and Readmissions Among Chronically Ill and Vulnerable Patients," Innovations in Care Transitions, *The Commonwealth Fund, January 23, 2013.*

17 Robert Wood Johnson Foundation, *The Revolving Door: A Report on U.S. Hospital Readmissions*, February 2013.

40. Encourage Design of "Care Platforms" for Specific Patient Populations

High-performing healthcare organizations often design "microsystems of care" or "care platforms" to match the needs of specific patient subpopulations and proven care pathways for improved care quality and value.[18] The care platforms include the staff, information and clinical technology, physical space, business processes, and policies and procedures that support best practices and evidence-based care.

Care platforms incorporate and, as possible, standardize the custom requirements for the patient population. They also identify where exceptions are likely to occur, create mechanisms for dealing with them, and establish accountability for individual and "system" performance and improvement.[19]

Board members may consider asking management to evaluate the use of these types of care platforms to determine whether their organization might benefit from a similar approach.

41. Encourage Clear Designation of Primary Clinical Decision-Making Responsibilities

Lastly, hospital and health system leadership seeking to improve care processes and care transitions will need to ensure that there is clarity around which clinician has primary decision-making responsibilities for a particular patient's care. Written contracts that define the level of care and responsibilities of each provider are needed to avoid siloed care within individual departments. A "who's the governing physician program" can be helpful.[20]

Clearly designated responsibilities are particularly important for patients with multiple chronic conditions who will receive care from multiple providers across various facilities and units within a system and beyond. Lack of clarity about responsibilities can put patients at risk for suboptimal outcomes, and organizations at risk for increased costs.

Physician Enterprise

As the nation's healthcare model transitions from a volume to a value-based model, many hospitals and health systems are opting to employ more physicians as a means to secure physician loyalty and expand care continuum capabilities. Initiatives aimed at improving the physician enterprise are designed to foster clinical integration, improve consistency of quality, and enhance oversight and accountability.

42. Support a Long-Term Perspective Regarding the Physician Enterprise

Organizations making progress with their physician enterprise typically offer physicians multiple points of entry. Employment, joint venture, and other affiliation models may be appropriate.

18 R. Bohmer, "The Four Habits of High-Value Health Care Organizations," *New England Journal of Medicine,* Vol. 365, No. 22, December 1, 2011.

19 R. Bohmer and D. Lawrence, "Care Platforms: A Basic Building Block for Care Delivery," *Health Affairs,* Vol. 27, No. 5, September/October 2008, pp. 1336–1340.

20 E. Carrier, M. Dowling, and H. Pham, "Care Coordination Agreements: Barriers, Facilitators, and Lessons Learned," *The American Journal of Managed Care,* Vol. 18, No. 11, November 2012, pp. e398–e404.

While employing physicians brings benefits to an organization, it also comes with significant investment requirements. Management has to take all factors into consideration in making physician hiring decisions, and be ready to say "no" to physicians seeking employment if it is not in the best interest of the organization or its overall mission and goals.

Similarly, acquisitions of physician practices should be based on the hospital or health system's long-term goals. In making such decisions, organizational leaders must consider specific specialty and geographic coverage goals, current and future projected volumes, quality metrics, financial performance requirements, and strategic and cultural fit.

43. Know the Current and Future Costs of the Physician Enterprise

Organizations implementing physician enterprise efforts may be working within a range of physician employment models, including:

- Direct employment by the hospital
- Employment by a wholly owned, tax-exempt subsidiary
- Employment by a wholly owned, taxable entity
- Employment by an independent or joint-ventured entity
- Employment by an independent, financially aligned foundation

Each of these models has different cost implications. The Medical Group Management Association estimates that organizations lose an average of $176,000 per year for every physician they employ.[21] Healthcare leaders must be prepared to make this kind of investment if doing so will benefit the organization's overall mission. But they must accurately capture the current costs of the physician enterprise, develop financial projections for future costs, and define thresholds for the organization's physician investments.

Acquiring a physician practice typically creates an operating loss. This may be due to any number of factors, such as the need for more comprehensive non-physician employee wage and benefit programs, significant investment in technology, strategic investments in facility upgrades, and higher medical malpractice coverage requirements.

44. Ensure Effective and Sustainable Compensation Programs

Board members should be aware that many physician compensation structures used today are ill-suited to address rapid changes in healthcare delivery and payment. For example, salary-based compensation models underperform as revenues, utilization, and payments decline.

Organizational leaders should study different compensation models to identify the ones that best meet goals related to the physician enterprise, hospital quality, service, access, and financial objectives. Compensation models based on net income typically are better able to negotiate shifts in payment and utilization.

Physician compensation should be tied to quality, service, cost effectiveness, access, and other strategic goals. Productivity should be *the* key factor driving compensation and the primary metric for incentive-based compensation models.

45. Ensure That the Organization Is Managing Employed Physicians to Achieve Goals

Board members should support efforts to actively track and monitor the performance of physicians. Performance levels then should be compared to physicians practicing elsewhere in the hospital or health system, as well as those practicing at other organizations. This requires using internal historical data and published external benchmarks.

Two revenue-related areas require particularly close performance monitoring, review, and proactive intervention when needed. These areas are physician revenue cycle performance and treatment of technical revenues post-acquisition.

Effective management of physician revenue cycle performance maximizes collections and minimizes collection costs. Those unequipped to handle this function should consider outsourcing it to a proven firm. Technical revenues refer to those revenues generated as a result of physicians, but not directly billable by the physician for regulatory reasons. These may include revenues from lab tests, therapies, or other services ordered in the course of a patient's care. In many cases, technical revenues are billed by the hospital at hospital rates, but they should be factored into the equation as physician-generated revenues and physicians should be held accountable according to benchmark performance levels.

Relationships with Other Providers

Many hospitals and health systems will need to partner with other organizations in order to expand services across the continuum of care to manage a specific population's health. Partnerships can enable coverage of discrete services thereby reducing or eliminating the significant costs that would be involved in building or duplicating such services.

Many types of partnerships are occurring in today's changing healthcare environment, ranging from those that require little or no integration of organizational governance, to full mergers and acquisitions. A variety of less-integrated partnership models are emerging. These allow organizations to take advantage of synergies such as enhanced clinical alignment, lower operating costs, or the ability to grow and expand services.

21 Medical Group Management Association, *MGMA 2013 Cost Survey.*

46. Ensure a Thorough Process for Identifying and Evaluating Potential Partners

Healthcare leaders who are considering possible partnerships must take a comprehensive approach to evaluating the options. Such decisions require time and resources, and therefore should not be entered into without careful consideration, review, and planning.

By using a traditional, comprehensive financial planning approach to evaluate the organization's current and projected capital position, healthcare leaders can identify needs and build the business case for a partnership. A preferred model or type of partnership can be selected based on those needs and other factors, such as culture and organizational structure.

To identify a partner, board members should support the management team in initially casting a broad net. The list of potential partners then can be narrowed down through an iterative process that involves these three key phases:

- Evaluation of strategic options—this involves a high-level assessment of the benefits that may be offered by each prospective partner
- Development of a business case for a specific potential partner—including a thorough assessment of each organization's current position based on market and industry realities
- Establishment of a business plan—which will formally outline how the organizations will be integrated once an agreement is signed

(See sidebar, Examination of Non-Control Transactions, for a look at one partnership model that falls on the low end of the spectrum in terms of the level of organizational integration required between partners.)

Examination of Non-Control Transactions

Non-control transactions are hospital affiliations that don't involve the sale of a majority interest or transfer of majority governance control from either party. This model may be particularly appealing to community health systems that want to maintain their independence or to larger health systems that want to expand their reach without the costs and obligations of a more integrated partnership.

The benefits that non-control transactions provide for smaller health systems may include:

- The opportunity to partner with a larger organization to support capital or programmatic needs without relinquishing governance control
- The opportunity to use the partnership to "test drive" the possibility of pursuing a more integrated partnership in the future

For larger health systems, non-control transactions offer benefits such as:

- Allowing for the expansion of the continuum of care without the need to complete a full merger or acquisition
- The opportunity that the new partner or partners will serve as a source for patient referrals

Examples of non-control transaction agreements include special member models, branding arrangements, and management and joint operating arrangements.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Conclusion

The nation's healthcare system is changing rapidly. Traditional cost-management initiatives that have worked in the past will not be sufficient in a future with decreasing volumes and constrained revenues. Navigating the current challenges requires a comprehensive approach to strategic cost transformation.

IN FULFILLING THEIR FIDUCIARY RESPONSIBILITIES, BOARD members must be well informed of the new pressures, and support the identification and implementation of sustainable solutions. The process should be guided by integrated strategic, financial, capital, cost reduction, facility, and physician enterprise plans that are based on realistic assumptions about utilization, revenue, and costs.

A proactive approach is recommended. The steps outlined in this report, including the following, can help to guide those efforts:

- Assess the organization's role in the new healthcare era.
- Ensure that the organization has in place a comprehensive and integrated strategic financial planning process.
- Continuously evaluate cost-reduction and cost-management opportunities in traditional areas of labor costs, non-labor costs, and revenue cycle management.
- Evaluate even more significant opportunities through business restructuring, including development and implementation of service distribution and facilities plans to ensure efficient and effective use of resources.
- Seek clinical transformation opportunities aimed at enhancing the provision of high-quality care at the lowest-possible cost.

Healthcare leaders must be prepared to make tough decisions, and implement aggressive and ongoing strategic initiatives designed to maximize cost-transformation opportunities. Board support of strategic cost-transformation initiatives that help ensure the provision of high-quality, low-cost care—such as those described in this white paper—will lower healthcare spending organization-wide and nationwide.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