GOOD GOVERNANCE CASE STUDY

An Online Series by The Governance Institute®

One Jefferson:
Accelerating Reinvention of Academic Medicine through Growth, Integration, and Innovation

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The Governance Institute®

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One Jefferson: Accelerating Reinvention of Academic Medicine through Growth, Integration, and Innovation

Statement of Interest

By 2012, Thomas Jefferson University Hospital faced questions about its future both as an academic medical center and as a stand-alone large hospital in Philadelphia. Both the university, with its historic medical school, and the health system, with its historic main hospital, had separate boards and presidents. Trustees came to conclude that the entities were not prepared for significant economic change, marketplace competition, and changes in payment models. In response, the trustees merged the university and hospital boards and hired a single president and CEO to lead a strategy of survival and success.

The result of this transformation strategy is clear in the numbers.

Jefferson (both Thomas Jefferson University and Jefferson Health):

	2013	2018
Revenue:	$1.6 billion	$5.1 billion (annualized)
Hospitals:	3	13
Colleges:	6	12
Faculty:	1,242	3,867
Students:	3,169	7,945
Employees:	14,000	30,000

Jefferson's experience provides two points of exploration.

First, by 2013, national organizations were questioning the survival of traditional academic health centers, at a time when universities and their hospitals were uncoupling, breaking the traditional model. In the *New England Journal of Medicine*, prominent authors asked if the traditional academic health institution was facing "extinction."[1] That perspective article called on traditional big city academic medical centers to become high-efficiency regional networks, with research targeted for ROI, while redesigning medical education.

In answer, Jefferson became an example of a counter-trend; instead of separating the hospital and university, Jefferson merged them. It pursued a joint transformation of both.[2]

Second, Jefferson is an example of leadership dedicated to rapid transformation. Jefferson CEO Dr. Stephen Klasko has pursued hospital and university mergers through a hub-and-hub model of board governance, and a hub-and-hub model of patient and student services. He has become a national advocate for healthcare without a physical address, the "Blockbuster to Netflix" mentality applied to health. In merging with Philadelphia University, he has argued that higher education must provide a different level of value for each student, for society, and for their potential employers.

1 Victor J. Dzau, M.D., et al., "Transforming Academic Health Centers for an Uncertain Future," *The New England Journal of Medicine,* Vol. 369, No. 11 (September 12, 2013), pp. 991–993.

2 Paul Voosen, "Is it Time for Universities to Get Out of the Hospital Business?" *Chronicle of Higher Education,* May 2016.

This case study examines the pluses and pitfalls of rapid transformation of a university-hospital complex at a time when many face potential "extinction."

Key Strategic Actions

(discussed in more detail throughout this case study):

- Ending the old "Jefferson Health System," uncoupling from the main clinical partner.
- Merging the university (TJU) and hospital boards under one Thomas Jefferson University governing board.
- Launching full-practice telehealth and urgent care strategies.
- Assuming leadership within the Delaware Valley Accountable Care Organization (DVACO) and improved relationship with Main Line Health System.
- Merging with other area health systems to grow and prepare for population health and value-based payment: Abington Health, Aria Health, Kennedy Health.
- Merging with Philadelphia University to create a comprehensive university.
- Beginning the largest healthcare consulting contract in the country in terms of duration and risk sharing, with GE Healthcare under the following goals:
  - » The hospital of the future will be an agile, efficient system of hub-and-hub networks working to promote health in neighborhoods and homes.
  - » The healthcare system of the future will lose its "brick and mortar mentality" and become a consumer-facing organization focused on care and caring when and where it is convenient for the consumer.
  - » The hospital system of the future will practice population health and reduce the unacceptable disparities in outcomes that plague cities like Philadelphia.

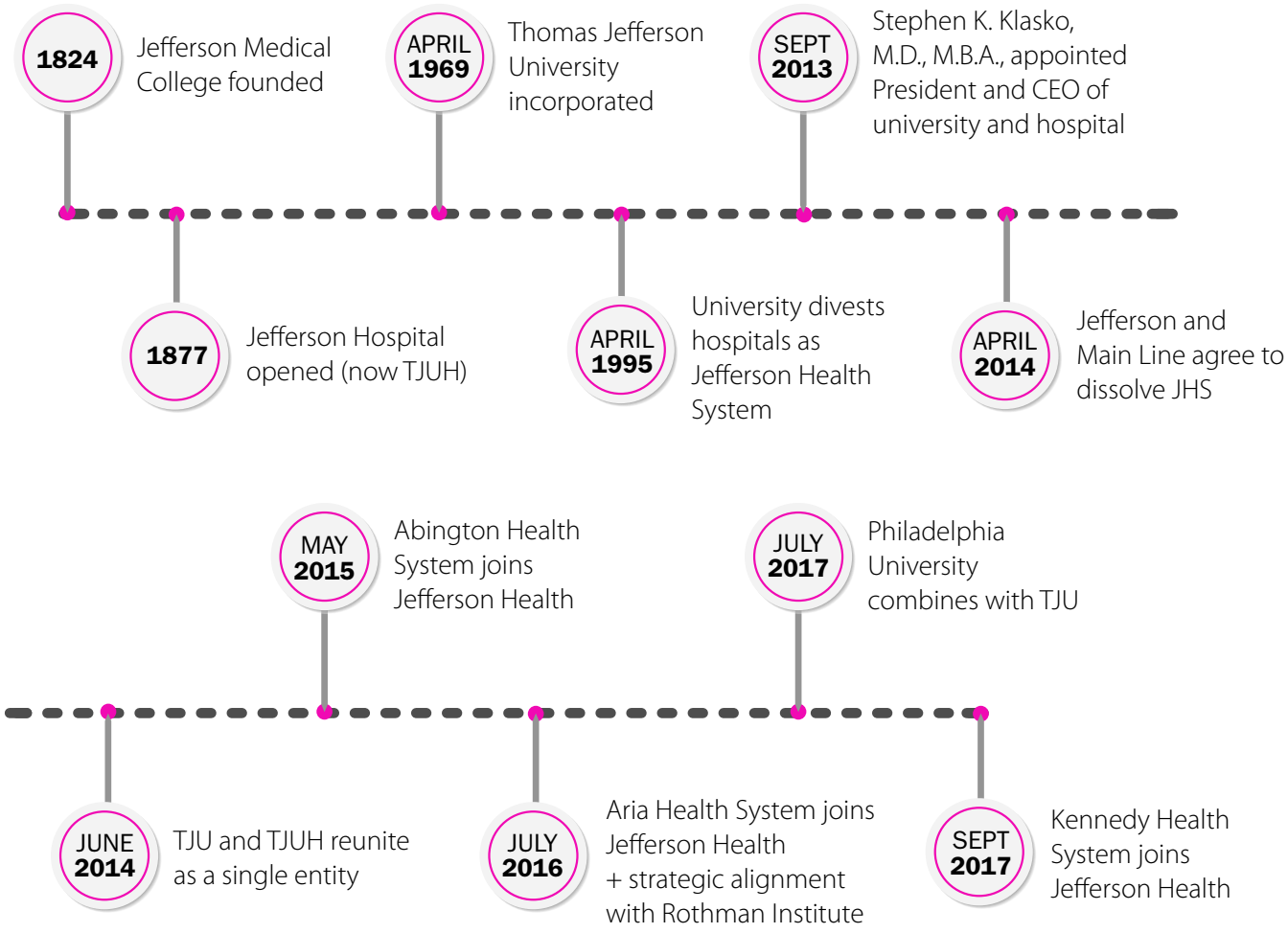
In the "Beginning": A Divided Organization Lacking Identity

A Jefferson board member for 15 years, William Landman of MainLine Investment Partners came to believe that Jefferson was a divided institution lacking strategic freedom. He became one of several board members who, around 2012, decided it was time for a bold move. "It became clear to me that we had to reunite the medical school and the hospital," he said.

The TJU hospital was originally separated from the university to ensure that the university wasn't "dragged down" by the economic balances of the hospital. "The academic side of the business was capped," said Landman. "It employed all of the physicians. The clinical side became much better run and was making significant profits. But there was a constant conflict with academics and physicians needing more money. It was very hard to have accountability." But when TJU Hospital was separated from the university, it became part of an entity known as Jefferson Health System (JHS), which involved a few other regional health systems, including Main Line Health as the majority owner.

Thomas Jefferson University's board chair at the time, David Binswanger, saw things in the same light, and worked with Landman over a two-year period to create a reunification plan for the university and hospital. But there were significant barriers. "We put together a small group of board members and realized that we have to get to the next step. We knew we couldn't get there with our current leaders," explained Landman. "So, we asked ourselves, how do we get out?"

A Timeline of Thomas Jefferson University Hospital (TJUH)/Thomas Jefferson University (TJU)/Jefferson Health



The reunification process revealed the need to:

- Redefine the relationship with Main Line Health, which provided three fundamental benefits: access to capital via a strong bond rating, negotiating leverage with payers, and a focus on quality.
- Hire one new CEO to oversee both the university and the health system.

A search committee was created, consisting of university representatives, physicians, employees, medical students, nursing students, and members of the hospital board. The over 50 candidates being considered fell into three buckets: those with very impressive résumés but without much experience in transformation (more of a focus on running things more efficiently); candidates with ideas of how to change organizational direction—ideas that weren't dramatic but more incremental; and in the last bucket fell Dr. Stephen Klasko.

"He was different from any of the candidates we interviewed by a mile," Landman said Dr. Klasko "had a sense of energy that's different than most physician business people. He had an exuberance. He didn't try to hedge his bets." Dr. Klasko presented to the board his opinion on where the healthcare industry is going and posited that, for Jefferson to remain a dominant player in the market (and globally), the organization would have to integrate and improve upon its technology, grow dramatically and quickly, and change the physician culture. He was completely transparent with the board rather than being "guarded" to try to get the job. "He was really about changing healthcare and making Jefferson an early adopter of the changes he saw coming," said Landman.

Richard Hevner, board member at the time who succeeded Landman as TJU Hospital board chair, recalled his first meeting with Dr. Klasko and the head of the hospital. "We looked at each other after and said, great candidate, but the university will never accept him, because he's too much about change. And a lot of times in these things they select someone that they like, they respect, but who is not going to interfere with the way they do things. Both institutions had to make a very decisive majority decision that we were going to be disruptive and innovative and it's no longer an old Philadelphia institution like it used to be."

Dr. Klasko reflected back about taking the position. "At the end of the day, I got brought in, probably in an unlikely way because Jefferson's a pretty conservative place and I'm not. I figured they had lots of people applying for this job—maybe I was the last of the 15 people they'd brought in originally. Or they could've gotten a dean from a top 10 medical school or somebody that's from a top 10 hospital system. I recognized I can take a safe approach, in which case I would probably die slowly. They clearly got me, knowing that I'd done some great things in Tampa [at the University of South Florida]. And they chose me. So I said to myself, 'I'm going to take a no-limits approach. And I'm either going to be incredibly successful or have the shortest presidency ever.'"

By hiring Dr. Klasko, the Jefferson board picked a CEO known as determined, impatient, and focused on the future. Starting his career as a private practice obstetrician, he became frustrated with physicians who refused to change practice patterns because of a fear of the "dark side"—the business of medicine. As a result, Dr. Klasko pursued an executive M.B.A. at the Wharton School, and became involved in research on the biases that physicians bring to practice—biases that can slow change and make physicians skeptical of transformation. His belief in change led him to the deanship at Drexel, then to the University of South Florida. By 2017, he was considered among America's most influential healthcare leaders in *Becker's Hospital Review* and *Modern Healthcare.*

Michael Hoad, a journalist by trade who worked with Dr. Klasko since 2004, and is now Vice President of Enterprise Marketing, described the challenges Jefferson was facing at the time Dr. Klasko came on board. "In 2013, people were asking if academic health systems were going to survive. At what point do you say that the old model of depending on hospital margins and expanding NIH funding and tuition increases is unsustainable? All three of those funding sources were being challenged. Without a clear strategy for a very different future, even the entity's 193-year old reputation was being challenged."

When Dr. Klasko became the new leader of Jefferson in 2013, he brought along Phillip Green, a consultant who has worked with Dr. Klasko for more than 20 years. "My role has always been to facilitate M&A and business development strategy," Green explained. "When we got here, it was clear we had to do something different. So, we decided that we needed to find a way to financially decouple from [JHS]."

Main Line Health: Financial Decoupling

Why was this important? Uncoupling freed Jefferson to create its own integrated health system, but it involved significant financial risk.

In the "status quo" arrangement with Main Line Health, any entity within JHS needed to get approval from each member including Main Line to borrow capital. The Main Line board was concerned that if something happened to TJUH they would have to fund the hospital's bonds. This essentially prevented the university hospital from strategic growth of any significance. Dr.

Klasko began discussions with the JHS board about separating from Main Line in early 2014. "Jefferson University Hospital had never been rated because the rating had always been through JHS. We were not strategically aligned. We didn't have the same GPO—we didn't even necessarily order supplies together. I had to show the board what the future looked like, that our relationship with Main Line Health was crucial, but that the old governance structure would not allow us to strategically differentiate." In Dr. Klasko's estimate, if things remained the same, TJU would have 18 percent less revenue in 2020 vs. 2013 due to the industry moving towards value-based payments, declining NIH funding, and the unsustainability of rising tuition. Some members of the Main Line and JHS management who did not approve of the change threatened that Jefferson could lose up to $1 billion in new payer contracts and bond market reactions. Dr. Klasko countered to his board, "We may not get a AA rating, but we're not going to lose $1 billion either. But we can make the future ours." The change was made that June for the cost of $40 million in "swaps" with Main Line. (Dr. Klasko and Jack Lynch, the CEO of Main Line Health, worked hard to ensure that despite the uncoupling, the relationship with Main Line became more positive and even more strategically aligned, so that down the road they would be able to partner to create the Delaware Valley ACO together, which he and Lynch currently co-chair.)

Dr. Klasko was able to secure an 11-month, $365 million direct loan from Bank of America to repay debts, sustain Jefferson's plans for growth, and provide time to secure a bond rating and payer contracts.

The subsequent meetings with bond rating agencies went better than expected. Dr. Klasko recalled one of these conversations. "They said they really liked what we were doing here but that they assess risk for a living. So I said, 'It's interesting you say that, because four of your last five downgrades [at other organizations] have been because you didn't feel the place recognized what was happening in the future and wasn't ready for it.' So we got an A1 from Moody's and an A from Standard and Poor's. That was a huge morale boost. The rating agencies recognized that we had a strong reputation, a great care delivery system, and a strategy that recognized that the external environment was changing. That set the stage for us to merge the governance and management of the university and the hospital under a single board and a single President-CEO. So that's the first merger we did."

In the summer of 2014, Thomas Jefferson University (TJU) and Thomas Jefferson University Hospital (TJUH) were reintegrated into Jefferson Health, and began the process of reinventing the academic health system. Before the reintegration of the hospital and the university, Dr. Klasko reported to three different boards totaling 140 people: the JHS board, the TJUH board, and the TJU board. Now there was a single board for this new combined entity. "Someone commented that I was leading a place unaccustomed to any bold strategic moves. We were viewed as the most conservative place. That's a tough place to start for someone who was hired for his transformational strategic mindset," said Dr. Klasko.

"The JHS board was almost like a holding company at that point. So we got out of JHS and merged it all into one board [of 25 people]," explained Caro Rock, TJU board member and current chair of the governance committee. Dr. Klasko also encouraged the board at that time to begin looking for two independent board members from outside the area, to provide diversity of both background and perspective.

Differentiation in the Region: Creating a New Mission and Vision

Leaders at Jefferson had, throughout most of the organization's history, held University of Pennsylvania over their heads as their main competitor. But Penn was larger, enjoys a huge endowment, has a long history of greater research funding, and had a prestigious ivy-league reputation.

Dr. Klasko knew that Jefferson would have to get out from under Penn's shadow by being different, rather than trying to compete on NIH funding and *U.S. News & World Report* rankings. "Our new mission and vision were not going to be about trying to beat Penn. We want to reimagine how healthcare and medical education are delivered, but at a better value," Dr. Klasko said. He held a town hall meeting with Jefferson physicians and employees and started with the question, "I'm an investor. Tell me something about Jefferson that's going to get me excited. What is our future?" The answers he received focused on Jefferson's rankings against Penn, Temple, and Drexel universities. His response: "Every single vision in this city is to be the premier academic learning center in Philadelphia. A) it's physically impossible, and B) it's boring. We want a totally different vision. Let's be the entrepreneurial academic alternative to Penn. Let's approach this the way Amazon approached beating the retail giants."

To develop this mindset, he set up focus groups with the staff and physicians to generate the best collective ideas for the new mission and vision. The identity of the health science university brought them to "Health is all we do" for the mission, and eventually they worked out the vision to reimagine healthcare to create unparalleled value. This new mission and vision would play an important role in Jefferson's next steps—to bring on new partners.

Organization Profile Today

Jefferson Health offers an extensive care network with offices throughout Pennsylvania, New Jersey, and Delaware.

Clinical care delivery:

- 13 hospitals
- 30,000 employees
- 5,938 physicians/practitioners
- 7,254 registered nurses
- 2,824 inpatient beds
- 126,972 admissions
- 522,770 ED visits
- 2,241,926 outpatient visits
- 52 outpatient centers and urgent care centers
- Five freestanding ambulatory surgery centers
- Five freestanding imaging centers
- $230 million in charitable care and community benefit
- JeffCare Alliance, which covers 136,414 attributed lives and includes 1,545 physicians
- DVACO, jointly co-chaired by Jefferson and Main Line Health

Academic:

- 3,400+ full/part-time faculty
- 7,500+ students (including East Falls campus students—former Philadelphia University students)
- $108.5 million in public/private research funding
- Thomas Jefferson University: Sidney Kimmel Medical College, Sidney Kimmel Cancer Center (NCI-designated), Jefferson College of Biomedical Sciences, Jefferson College of Health Professions, Jefferson College of Nursing, Jefferson College of Pharmacy, Jefferson College of Population Health, College of Architecture and the Built Environment, Kanbar College of Design, Engineering and Commerce, College of Science, Health and the Liberal Arts
- Abington Dixon School of Nursing
- Abington Graduate Medical Education
- Aria Health School of Nursing

Awards & Recognitions:

- In August 2017, President and CEO Dr. Stephen Klasko was named the 85th "Most Influential" individual in healthcare by *Modern Healthcare*. Earlier in the year, he ranked 24 among Most Influential Physician Executives, also by *Modern Healthcare*. And *Becker's Hospital Review* named him among the "100 Great Leaders to Watch in Healthcare."
- TJUH in 2017 was named an elite Honor Roll Hospital at number 16 in the nation by *U.S. News and World Report,* ahead of hospitals like Duke, NYU Langone, and Mt. Sinai. Ranked number two in ophthalmology, number four in orthopedic surgery, number eight in head and neck surgery, number 14 in neuroscience, and number 20 in cancer (improved from 29).
- The Jefferson College of Nursing's M.S.N. program is ranked among the nation's best by *U.S. News & World Report* (2016–2017).
- The Occupational Therapy Program within the Jefferson College of Health Professions is ranked among the top 10 graduate school programs in the nation by *U.S. News & World Report* (2016–2017).

New Mission: "Health is all we do" became a rallying cry for clinical mergers in 2014. The mission was revised in 2017 to reflect the new comprehensive university: "We Improve Lives."

Vision: To reimagine health, health education, and discovery to create unparalleled value.

Building the New Jefferson through Rapid Growth

The growth imperative: The new, fledgling organization helmed by Dr. Klasko (TJU and TJUH) "was vulnerable as an academic medical center with a limited geographic bandwidth," Green said. "We decided that we needed to find a way to grow, and do it pretty quickly." Dr. Klasko felt strongly that immediate growth would enable Jefferson to prepare (better and faster) and succeed with value-based payment models. To him, Jefferson needed to make these immediate changes to get to a desired future state, even though the traditional fee-for-service structure would not reward these changes.

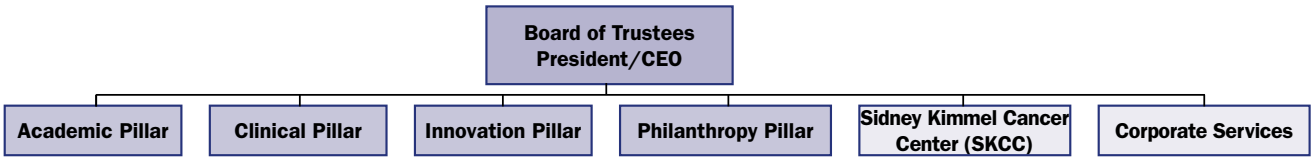
Dr. Klasko provided an example: "So if a competing CEO is building 500 new hospital beds at a time when we really don't need more hospital beds, that CEO will say: 'I'm glad Klasko is investing in telehealth so he can get 25,000 cases moved out of the expensive inefficient ER. And I'm glad that he's getting $49 for the urgent care visits that are worth $3,000 in my ER.'"

Jefferson has to understand that risk, Dr. Klasko said. "So we're now probably better than any academic medical center about getting ready for the future. But I'm not sure that, if we do it as fast as I'd like to do it, that it will make financial sense. It is fine strategically to grow where the puck is going, as long as the money is following the puck."

"Steve wanted to make sure we were making the right decisions for the organization, and [the board] pushed back on Steve to provide that background," Rock said. "He saw the vision but we wanted to know what was behind it. I think his management team has been very good at providing that information. I'm sure some of the board felt they needed to do extra work to catch up in terms of the industry—to be certain whether this makes sense. I think we saw the writing on the wall, that we needed to scale. We needed to be able to negotiate with the payers. I think we understood that [as a board]."

> "I equated Jefferson at the time to an aging dowager living in a mansion on a hill outside of town. And the grass was now four feet high. And she was living in the living room with a Bunsen burner because she couldn't afford to maintain the mansion anymore. Taking a 193-year-old institution and giving it a startup mentality with a speed-to-market approach was really what [Dr. Klasko] brought to the table."
>
> *—John Ekarius, Executive Vice President & Chief of Staff*

Dr. Klasko created a blueprint for strategic action with a four-pillar model to support the vision to grow:



The pillars each have equal importance and shape the management structure such that the head of each pillar reports directly to Dr. Klasko, and those are the only four people who vertically report to him. That allows Dr. Klasko to remain focused on the bigger-picture strategic goals.

"Steve is an unusual CEO in that he is 100 percent transparent. There's no hidden agenda. I think strategically he's as good as anybody I've ever witnessed—and articulate. So, when you put a great strategic mind together with somebody who's just totally transparent and can passionately explain what he wants to do and why he wants to do it, it created a lot of confidence from day one."

—William Landman, Trustee

How Jefferson Grew: The Hub-and-Hub Model

In July 2014, "we were negotiating with two other academic medical centers in the area about potentially bringing them into the new Jefferson model," Dr. Klasko said. "But my board chair asked, 'Why don't we look at merging with the prettiest boy or girl at the prom? The worst that can happen is they say no.' Well, who's the prettiest boy or girl at the prom? Abington [Memorial Hospital]." But Abington, a $1 billion entity with a five percent margin and positive payer mix, was in the midst of talks with another academic medical center. Despite this, Dr. Klasko met with Abington CEO Laurence Merlis, who summed things up: "McKinsey says there are three places we could go with. But in each case, we're going to get a minority of the board. It's going to be a hub and spoke, and if we want to go with somebody, and the governance situation and strategy are no different, then we would just choose based on traditional parameters of best balance sheet, etc. And if you're going to be a hub and spoke, you might as well be a spoke of a top-five hub." Dr. Klasko responded, "What if you weren't a spoke? What if we were a hub-and-hub? What if we gave you half of the board seats?" Neither Merlis nor Dr. Klasko felt at that time that the Jefferson board would agree to that. Dr. Klasko asked for 15 days to get back to Merlis. "I went back to my board chair and said, 'Remember you told me to go to the prettiest boy or girl at the prom? Well, I found that entity and they are willing to date us, but there's a catch.'"

The two organizations agreed to this partnership with a definitive agreement in January 2015, and by May 2015 the merger was closed. Jefferson split governance literally in half with Abington—11 board seats each to start, which would go down to 10 each after the first year. Hevner had been on the Jefferson board for 20 years and would stay on as chair of the new joint board. Stephen Crane, Abington board chair, was selected to become the vice chair (and he is now the chair of the Jefferson board as of July 1, 2017). They then proceeded to select board members for all of the committees and subcommittees in the same manner, half from each organization, "and from day one people were in the enterprise mindset. We shared charters. We rewrote some of the charters so they would mirror each other," Rock explained. "We had several meetings out at their campus, had several meetings [at Jefferson], and we really aligned our missions and it worked very well." John Ekarius, Executive Vice President and Chief of Staff, added, "After the first year, you would not be able to tell an Abington board member from a Jefferson board member because they had spent so much time really working together and perfecting the model."

"We looked at the marketplace. I think we went through a very thoughtful process before we jumped into shared governance with Abington. They shared a lot of similar values with Jefferson and a similar culture. It was a partnership in the shared governance. So we did our homework."

—Caro Rock, Trustee

According to Merlis, Abington was looking for a partner because it lacked the scale and sophistication in the areas they needed to invest in, without being part of something larger with an organization that shared its values. "For us to be successful in the future environment that truly would be based on a foundation of population health, [we needed to partner] with an organization that had the sophistication and the vision that would resonate with us, where we'd get the economies of scale, scope, and skill. We were looking, in particular, to be part of an academic organization. Abington is very successful—financially, clinically, and market position. But our board and senior management recognized that we needed to assure that our strategic position in years to come would allow us to serve the community."

Crane added, "The [Abington] board was frustrated because we could never improve our margins more than one or two percent, and we saw the headwinds getting worse. We could survive as an independent community hospital, but we'd wake up in five years and be weaker. We would find that the inevitable consolidation in the Philadelphia area had left us behind. But we also realized that the cultural fit might be the hardest for our physicians. We're pretty independent—we have a pluralistic medical staff model. It was important to our physicians to keep that."

There was some concern that Abington would give up some flexibility as part of another system. But they knew they did not want to partner with an organization where the assets or value would leave the community. "The benefit [of joining Jefferson] is the ability to have a vision that resonates," said Merlis, "so that people are truly getting behind the sense that we could become the world-class, entrepreneurial, academic organization that truly believes in the guiding principles that brought us together."

"We decided to take our 193-year history of care and caring, and reimagine the way care is delivered. That's how we won the Abington sweepstakes. That's why we were able to attract partners, for example Aria, where we won the RFP over two national entities. That's how we were able to attract Kennedy, a premium-quality community academic health system in South Jersey. We knew those other organizations could offer more capital, and in one case, higher ratings in *U.S. News & World Report.* But I said, 'Here's our vision. We're no longer a hospital company. We are a consumer health entity. We're going to get care out to where people are. We're going to invest in telehealth. We're going from Blockbuster to Netflix. Why join Blockbuster when you can join Netflix?"

—Dr. Stephen Klasko

This hub-and-hub/shared governance evolution with Abington became the model for approaching the next partners. "The message became, 'We are going to become one of the largest academic medical centers in Pennsylvania, but we're going to do it the right way,'" Dr. Klasko said. "We're not going to take over anybody. Everything we're going to do will be with a shared governance model. Anybody we merge with will have the same number of board seats as Jefferson and Abington."

After the Abington merger, there remained several board members who thought it would be better to slow the growth process down and wait until there were signs that things were working prior to seeking the next partner. However, Dr. Klasko knew that there would be only so many opportunities with the right candidates, and if one was passed up it might not still be there a year later. So he pushed with the board to move forward, working on integration "informally" as they went, until the system reached a leveling-off regarding the need to bring in more partners.

Aria Health

Two weeks after the Abington deal was closed, Jefferson sent in its response to an RFP put out by Aria, a 170-year old organization that had been part of the old JHS. Kathleen Kinslow, CRNA, Ed.D., M.B.A., currently the Executive Vice President and Chief Integration Officer at Jefferson, had been CEO at Aria for six years when they issued the RFP.

"Most of the board members had been on the [Aria] board for 40 years. Their father was on the board or their grandfather was on the board. So, the idea of merging was not something they took lightly," said Kinslow. "When I saw the financial situation and what we needed to do—I'm very involved in the legislative side so I knew what was coming down the road—I needed to convince them that we had to seek a partner."

Kinslow and the board went through a strategic and scenario planning process over six months, and the collective conclusion was that Aria needed a partner. "Someone on the board said, 'Well, we could wait 10 years to do this,' and then someone else said, 'No, I don't think you understand. If we don't find a partner, we're not going to exist.' And it changed their thinking," said Kinslow. With the help of an investment banker through the RFP process, they received 25 responses and narrowed it down to three. Each came to do a presentation for the Aria board and physicians, and then they went on site visits to the three organizations.

The two finalists were Jefferson and a large, successful New York based integrated health system. "[The New York system] was very organized and our board liked that," Kinslow said. "But they didn't have a defined strategy of what they really wanted to do in Pennsylvania. The opportunity came up and they were going to seize it, but they couldn't say what was going to happen after that. It was the only reason, really, why we went with Jefferson."

Kinslow knew the shared governance concept was attractive to her board, but she doesn't consider that the major catalyst for their decision. "I think that if you truly have a good board, it goes back to how you live your mission. For a non-profit organization, if you're not giving back to your community, then what are you doing? And it's hard because you think, 'Of course we're going to like each other! We're hub-and-hubs!' And then they get there and it's a little different than expected. People need to learn to like each other and build trust and communication. Anyone can change structure. It's how you change the dynamic in the organization—that, to me, is how you get people on board."

Kennedy Health

Before the Aria agreement was final, Jefferson continued to look at the entire marketplace and determined they needed a New Jersey strategy. "25 percent of our patients come from New Jersey," said Rock. "Possibly 30 percent of our employees come from New Jersey. A number of our doctors, probably 20 percent live in New Jersey, so it made perfect sense from a strategic standpoint to add Kennedy."

"By September or October of 2015, only four months out from Abington, I began a discussion with Kennedy," said Merlis. "And that was an expedited process. By the end of 2015 we knew Kennedy would be joining us as well."

Kennedy President and CEO Joseph Devine said his board was always cautious about partnering because their organization was doing well. "Our growth pattern and our trajectory over the last five years has been exceptional. We're financially strong. We're clinically outstanding. We were recognized last year for our sepsis mortality rates—the only hospital in the nation to be honored. You get that because your outcomes are outstanding. But I always thought that Kennedy had the potential to be something even better than it was."

Similar to Abington and Aria, the Kennedy board was asking itself about the industry's future. Kennedy lacked the ability to have larger networks to provide seamless care across the continuum. Kennedy had some existing relationships with Jefferson in neurosciences and orthopedics with the Rothman Institute. They evaluated a lot of potential partners in New Jersey. "We were not looking for consolidation," said Devine. "We were looking for growth." Kennedy was also looking to increase their brand recognition, as well as build the ability to have higher-level services in South Jersey.

"I never had any opposition from the medical staff. The medical staff was 100 percent on board from the beginning. From our standpoint, and most importantly to our board, it's the ability to have a strategic impact on a much bigger vision and then making sure that New Jersey is part of that vision. [Jefferson will] protect that interest, and we can now realize the regional opportunity that is even bigger," Devine said.

"To me, the first thing you need to have in any merger is trust about the people in your organization. When I came to the table with my board's permission, I basically said, 'This does not have to include me. I'm doing this on behalf of Kennedy because I need to look at what the future of healthcare is going to be in South Jersey.'"

—Joseph Devine, FACHE, President & CEO, Kennedy Health

Philadelphia University

Why was this important? In addition to building an educational pipeline, the addition of non-health disciplines provides new collaborations to meet Jefferson's goal of reimagining health and higher education.

The most recent to partner with Jefferson, and perhaps the most unique, is Philadelphia University, a primarily undergraduate design, architecture, and business school. This partnership became effective July 1, 2017.

"Dr. Klasko set up tours for everyone to go out there and spend time with [Philadelphia University President] Stephen Spinelli," Rock said. "I had not really seen what they were doing on campus. 30 percent is related to health sciences. 95 percent of their graduates get jobs. They have 100 acres for expansion. The design and innovation they are working on is going to be huge in terms of our ability to expand and grow on the innovation side, and their partnerships with corporations are unbelievable. I think it was very smart of Dr. Klasko to make sure the board had that background. If we had to make that decision without it, I think most of the board members would have said no way. If you go out there and speak to the deans and students, and listen to Steve Spinelli, and see the campus and what they've accomplished, you realize what the possibilities are."

Hevner added, "We only wanted to do it if there was a vision as to how the two schools would come together. Normally we would do a letter of intent and then have an *ad hoc* committee do the due diligence, overseeing and listening to management, and doing more in-depth reporting to the board. On this one I thought it was different, so we had the concept right."

"Dr. Klasko has strategically aligned a lot of different organizations in a brilliant vision of the ecosystem that could spell greatness for Jefferson's future," said Spinelli, who is new to healthcare. "If I didn't buy in, I wouldn't be part of it."

"For the most part, we [TJU] were a graduate institution. They [Philadelphia University] were an undergraduate institution," said Ekarius. "We're mostly health sciences, and they are business, architecture, design, and engineering. So, the premise was that what's going to save us in the future is design thinking and innovation—combining design and medicine or design and healthcare in ways that are not quite clear just yet but are emerging." Part of the vision with this new partnership involves coming up with a new, more affordable model for delivering higher education.

"How do we marry a basketball team [Philadelphia University is a Division II NCAA participant] with a medical school? There are some unique opportunities to work with design, medical education, and device development that Philadelphia University can focus on. There will be some unique synergies in the way we train and educate our students so they can get through a graduate degree at a quicker pace."

—Stephen Crane, Board Chair-Elect

"It's so new, the pace is frenetic," Spinelli said. "There are still so many parts to put together, and I don't think we yet have a clear path. We want to clearly establish strategic priorities and then manage against those priorities." When Spinelli became president of Philadelphia University several years ago, the university didn't have a strong endowment but more of an "emergency fund," as Spinelli put it. "Two bad years and we would be done. We had to be very targeted. I thought I was going to get fired with a vote of no confidence." He was able to bring up the reputation by increasing the graduate job placement rate. One motivation behind partnering with Jefferson is to be able to maintain it. "The jobs are changing. The market will change quickly. Can we be nimble and move faster?"

With each new partner, the leaders have been brought on board as part of the new, "One Jefferson" management team. "My sense of Larry, Kate, Steve Spinelli, and Joe Devine is that they're absolutely committed," said Hoad. "They understand Dr. Klasko. They're absolutely committed to making sure that the organization as a whole works because what was true of Jefferson is also true of them."

What Each Organization Brought to the Table

Abington Memorial Hospital

- Two hospitals
- $1 billion in revenue
- 100 years old
- Five percent margins
- Competed with Penn and Main Line Health
- Shared governance, no reserve powers, no capital commitment

Aria Health

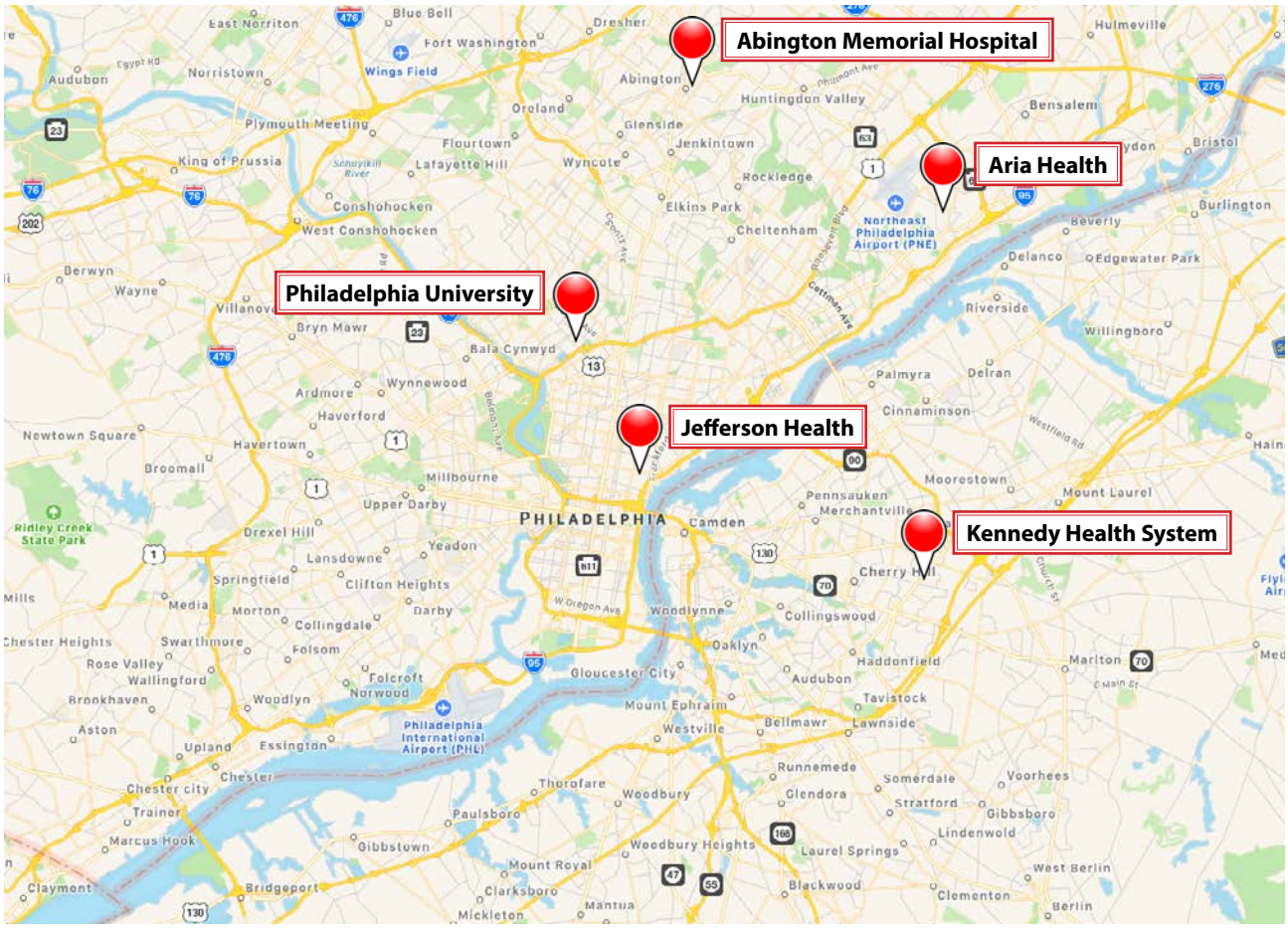
- Three-hospital system
- $500 million in revenue
- Turn around to break even
- Competed with Northwell, Tenet, Trinity
- Shared governance, no reserve powers, no capital commitment

Kennedy Health System

- Three-hospital system
- $600 million in revenue
- Shared governance, hub-and-hub model
- Commitment for what gets earned in New Jersey stays in New Jersey

Philadelphia University

- 105-acre campus with capacity for growth
- 72,000 square foot student center
- New athletic and fitness center
- Fields DEC Center (design, engineering, and commerce)
- Significant conference space
- College programs: design, engineering, and commerce; architecture and the built environment; science, health, and the liberal arts; school of continuing and professional studies



Shared Governance and the Hub-and-Hub Model

Green had previously constructed a model of shared governance for Lahey Medical Center in Boston. He suggested to Dr. Klasko a similar model to essentially guarantee board seats for each new system joining Jefferson ("governance as currency," as several Jefferson leaders put it), with a longer-term plan to phase out representational governance and renew board member terms based on performance in a true "community board" model.

"We convinced the community and the boards [of the systems that partnered with Jefferson] that the legacy governance structure, the old archaic structure, had to give way to the new model. And the new model was to form a board where the focus was on what was best for the community. It was not what was best for the legacy health system," Green said. "I think the lynchpin—the common governance and the community board [we created]—is the differentiator from everybody else who's amalgamating assets and giving you one board seat. When that happens, you're just a subsidiary to another health system. You're not an equal partner with the other health systems.

"For example, Aria, which is a small community hospital system, was offered the same number of board members as the $1.2 billion Thomas Jefferson University with the name brand. So, if you're on equal footing, then you have to walk the talk. The shared governance model is real, it's not perceived. So we now have a [system] board that is not dominated by any legacy interest."

> "Aria and Abington could have gone with Penn or any other academic medical center. But they chose us because they believed in Steve's vision. And they loved the idea of protecting their community and protecting their charitable mission with shared governance. So it was a brilliant way to grow without spending much money. And it really resonated with boards."
>
> *—William Landman, Trustee*

Naturally, the shared governance process resulted in a very large board, which had 57 members at its peak in 2014. It went down to 25 with the addition of Abington (the Jefferson board volunteered to reduce itself to 11 members when Abington joined, so they would have equal seats), then up to 33 with Aria, and 45 now with Kennedy and Philadelphia University. The total stands at 45.

"After Abington we brought on two fully independent outside board members," said Rock. The new additions were Vivian W. Pinn, M.D., Former Director (Retired), Office of Research on Women's Health, National Institutes of Health, and Michael Sneed, Worldwide Vice President, Global Corporate Affairs at Johnson & Johnson. "They filled another series of core competencies and have really added to the business," Rock explained.

Current System Board Makeup:

10 Jefferson representatives	2 Philadelphia University
10 Abington	2 independent
10 Aria	TJU President & CEO *(ex officio)*
10 Kennedy	

An essential part of the shared governance model was creating the hub-and-hub system rather than a traditional hub and spoke. From an operational standpoint, the hub-and-hub concept, which is still a work in progress, allows for each location within Jefferson to determine its own patient and community needs, and work with the system as a whole to keep clinical service lines that are necessary rather than moving service lines to certain locations or creating narrowly-focused centers of excellence. It plays on two very important concepts in Dr. Klasko's vision:

- Think globally, act locally.
- The future will reward those that can get great quality and access to healthcare out as close to where the patient is as possible.

Jefferson's ultimate goal is to provide access to a care delivery system that allows patients to receive care close to home, in the most cost-effective setting. Part of this evolution will involve reducing duplication among services that are in close proximity to each other, maintaining focus on where patients want to receive care.

Evolving Governance for System Integration

As the shared governance board and hub-and-hub model are evolving, there remain some cultural challenges. "When we're sharing governance, you have equal governance and everybody is a hub, so it's hard to effectuate change. You go to Abington and say this is the way we want to do things for these reasons, they say, well, we're a hub and we don't want to do that," explained Landman. "But there's got to be best practices and culture spread across every campus and every physician and every employee. And we're still trying to create one culture and one way of doing things."

The emphasis on doing what is right for patients has helped board members coming in from the new partners to shift their perspective away from their own organization to thinking more as "one" Jefferson. While there is progress to be made, especially with the newest partners, the board members participating in this case study overwhelmingly spoke about "we" as in "Jefferson" when sharing their story (it was difficult to tell which organization they had come from), indicating that the unified culture is well on its way to being stitched in to the fabric of the system board. The next step is translating that culture throughout the organization.

> "If you can get a shared governance model where everybody checks their egos at the door and recognizes that you can trust the board to do the right thing by all the constituent members, it's the purest model. No one today sees themselves as a TJU trustee, an Abington trustee, an Aria trustee, or a Kennedy trustee. Everybody sees themselves as a Jefferson trustee. So, it just doesn't get any better than that."
>
> *—Phillip Green, Consultant*

Due to the large board size, the board makes use of the executive committee for certain decisions until it becomes a more manageable size. With the help of consultant and Governance Institute advisor Dr. Eric Lister, the board has put a process in place to address its size, shift away from legacy representation, and set performance expectations. Today, each entity within Jefferson has the power to choose board member replacements if one of their 10 seats is vacated. However, as of 2019, the system board will no longer be a legacy board but a "community board." At that time, if a board member leaves or his or her term is up, the whole board will choose the right candidate based on the needs of the whole system. When board members from the legacy organizations come up for term renewals, they are not guaranteed renewal but will be assessed based on their performance, so that in time, the board culture will shift from legacy representation to "One Jefferson."

In addition, there remain "division" boards at each entity. Right now, those boards are primarily responsible for local quality/safety (including community health needs assessments, medical accreditations, and other regulatory responsibilities) and philanthropy. The roles of those boards continue to be assessed and will evolve as the parent board and the whole system evolves. "The division boards have had some expectation-related challenges," explained Ekarius. "In fact, at a recent governance committee meeting we discussed the notion that as we finalize a number of standardized policies and procedures and committee charters for the parent board committees, we'll turn our attention in this coming fiscal year towards much greater work with the division boards."

The division boards have a council of board presidents so they can dialogue together. Dr. Klasko attends division board meetings and medical staff events across the system also to help maintain the dialogue and system connection. The division board members have the potential to eventually sit on the parent board.

Overcoming Cultural Barriers with Management

Culture inevitably comes into play when organizations merge. In the case of Jefferson, not only were there cultural issues with the new partners, but there were some barriers between the hospital and the university that needed to be addressed right away. "The CFO of the university spent all of his time trying to get more money from the hospital. The three boards listened to three CEOs who didn't necessarily get along with each other, and really spent most of their time arguing about sending money back and forth," Dr. Klasko said. In addition, the hospital IT staff didn't want to share any data with the medical school. Three management teams were culled down to one almost immediately after the financial decoupling from Main Line, but it became clear to Dr. Klasko and the board that some of the team members were not going to fit into the new vision and culture they were looking to achieve. "We had a lot of supervisors in management who spent 20 years here sharing good ideas and being told, 'We don't do that at Jefferson,'" Dr. Klasko said. So, hand in hand with gaining new partners came new members of the management team over time. "The new people I was able to bring in were really people who needed to be there, but then there became a lot of tension between the new people and the people who had been loyal to me through this process," said Dr. Klasko.

In order to bridge these cultural gaps, Dr. Klasko and Green created a "Turning Insight into Action" (TIA) council, which pulled the most entrepreneurial people from the management team (both new and old), including the former CEOs of the partner organizations who now have new roles within Jefferson Health, to become the creative team to help fulfill the mission and vision of the new Jefferson. Dr. Klasko is chair of the council. "Basically, it's a great sounding board for crazy ideas and figuring out if we can implement them. They are the ones building the business and operation plans. They are the ones asking how these ideas will affect our hospitals. It really started to improve morale among the team and a recognition that we will do this and we will do it quickly, but we will be engaging more people to own the process and get things done," said Dr. Klasko.

Innovation at Jefferson

For the innovation pillar, Jefferson is working towards fostering ideas and converting them into products and services—testing new business models and nurturing entrepreneurialism among employees, students, and the community. The intent is to find alternative revenue sources, new ways to create value, and continue the ability to differentiate from competitors.

"What differentiates us is that we're actually doing it," Green said. "It's not a question of throwing around a lot of money. It's finding out things that are transformational from an innovation perspective and trying to prove that it works and commercialize it."

Many of the projects are just in their infancy, but the aim is to focus on innovations that are in smaller niches, that don't require FDA approval, and have value beyond Jefferson. "Would we buy it if somebody else brought it to us? That's the acid test," Green explained. "If we could develop an innovative product that improved ROI, would we pay $50,000 or $100,000 a year? Because if we wouldn't buy it from someone else, then we're focused on the wrong thing."

Innovation Goals

The Jefferson Innovation Center, led by Dr. Rose Ritts (who was recruited from Duke University after a national search), was created to develop goals and implement innovations, with dedicated staff who will:

- Develop a strategy for developing entrepreneurship inside and outside of Jefferson: "Spin out, spin in."
- Develop a spirit of innovation through a series of innovation tournaments, hackathons, and seminars to foster creative thought.
- Create training programs that will help faculty and staff envision new ways to commercialize their discoveries.
- Sponsor Innovation Challenge Grants that will bring ideas to fruition.
- Offer budding entrepreneurs access to expert evaluation of their ideas, orientation to business plan development, and step-by-step assistance.
- Provide legal and business advice as well as access to shared services.

- Offer accelerator programs to assist startups.
- Connect entrepreneurs and innovators with venture capital funds and grant programs.

Innovation projects (and partnerships) currently underway include:

- The next generation of telehealth with several vendors, developing mobile and Web technology that allows patients and providers to have immediate visits via video, secure chat, and phone.
- JeffConnect: Virtual ED, virtual and in person urgent care, on-site clinics, e-visits, critical care, and specialty consultation via telemedicine, virtual rounds, post-discharge e-management, and remote monitoring.
- Working with Exos for physical fitness optimization with Jefferson employees to deliver a personalized approach to proactive health. This project will extend to patients via the Myrna Bird Center of Integrative Medicine at Jefferson, which combines traditional, complementary, and alternative medicine therapies.
- The SKCC-Lifeguard program which creates clinical connectedness and enables the patient and the patient's caregiver access to relevant patient care information and has a knowledgeable partner available 24/7/365.
- The Marcus Center for Integrative Health which is bringing new worldwide technologies not normally employed in traditional American medical centers.
- Redesigning medical education through new selection criteria of candidates (enrolling students who are leaders as well as critical and creative thinkers, focusing on emotional intelligence), increased use of simulation tools, and cultivating skills so new physicians can work effectively in inter-professional teams. Essentially, Dr. Klasko's vision with medical education is to determine what healthcare jobs will exist 10 years from now, and then design the programs now to prepare students for those jobs.
- Development of the Center for Cannabis Medical Education and Research, as part of the new Institute for Emerging Health Professions, includes the Lambert Centre named for a gift, and the development of an ecofibre.
- Smart hospital rooms powered by IBM Watson and unique rooms that can listen using Harmon Kardon.
- An entrepreneurial academic approach to population health analytics.
- A partner program with other entities in the region to improve health cybersecurity.
- Bridging clinical and research areas in parallel to drive the highest impact for discovery and development.

Results to Date

The board and leadership feel strongly that Jefferson's strategic growth over the past three years has better positioned the system for future success with population health and accelerating both innovation and value. Physicians are looking at their customer and service lines with a new lens and developing more cross-disciplinary delivery of services.

Key statistics include:

- $28 million in cost reductions (see more detail in the section on integration below).
- Operating income has gone from $31.3 million in FY 2014 to $94.3 million in FY 2016.
- Operating margin has increased from 1.5 percent in FY 2014 to three percent in FY 2016.
- Increased market share for all inpatient services (highest market share among regional competitors).
- Bond ratings up from A to A+ (S&P) and A1 to A stable (Moody's).
- Innovation and philanthropy pillars creating alternative sources of revenue.

"This four-pillar model is something that allows us to think differently," said Merlis. "The integration process has begun to identify best practices. The sense that we do believe in a true community governance model where organizations feel they have input and influence during this transition period is both substantively and optically very positive. We recognize that the success of the organization's future is based on embracing the private practice of medicine in a variety of different ways, and investing in population health and clinical transformation. The people and resources that we have been able to pull together would not have been possible at any of our independent organizations."

Next Steps: Integration

Full integration of operations and care delivery across the system remains the biggest priority for Jefferson today, noted Green, who is known as a national leader in mergers and acquisitions. "We're going from $1.5 billion to $5 billion," Green said, "You can't just throw these things together. And although it would take most organizations 10 years to fully integrate, we've got to figure out a way to do it in two or three years to maximize efficiency."

Dr. Philip Sasso, Jefferson board member and Chair of the Department of Anesthesiology at Abington explained, "Unfortunately the focus [during the growth period] was on the next meal as opposed to how to make the individual parts work together. I don't think there was a [common] understanding of where the system was going. There wasn't an integration person for a long period of time, so that resulted in a lack of information, and people get nervous and anxious. I think the communication at the board level was very good, but I think it wasn't an institutional standpoint, it was more of an enterprise focus."

> "Changing culture is a very difficult thing to do, and we put together five organizations that each have their own structure. So it's not going to be easy. I think integration is key and culture develops from the board and the management on down. Steve was first a very caring physician himself, so he really understands it."
>
> *—Caro Rock, Trustee*

To address this enormous challenge, Dr. Klasko put in place an integration task force of board members and employees from across the system, led by Kinslow as Chief Integration Officer. "We put teams in place and started moving forward with what we were calling 'use cases,'" said Kinslow. Their first integration task was to find ways to reduce costs. "Each case team included an executive sponsor, a key administrator, and a physician. Each case was approved by the finance team. The implementation would begin and we would track key milestones. Eventually we would turn the case over to the stakeholders in that area so they would own it for the long-term, and we would continue to monitor its progress." To date, this effort has involved $28 million in cost reductions, exceeding their $25 million goal.

Cost reduction and integration efforts have focused on:

- Labor and supplies
- Unifying staff use of benchmarks and performance indicators
- Standardizing quality and evidence-based protocols for acute-care surgery, trauma, transplant, and cardiovascular service lines
- Reducing unnecessary readmissions
- Getting the system on the same EHR

Integrating Physician Culture

Kinslow and her team have been working more to integrate physicians and change the physician culture also. They had a retreat attended by 250 physicians, along with several social engagements, to provide the physicians an opportunity to feel that they can work together as a part of something bigger. "I think every organization here has brought some best practices as well as some things they needed to change. With the surgeons, their conversation has changed over the past eight to nine months. It's no longer about who is doing what best, but they are bringing forward new ways to work together and make overall improvements." In addition, there is a physician advisory council (put in place about a year ago) with representation from each Jefferson entity. The council began with a discussion of what the hub-and-hub concept meant for the medical staffs, which focused on growth for key service lines in each area coupled with the best quality of care. They developed guidelines for communication between staffs and medical executive committees, to create a continuous feedback loop. Ideas and suggestions coming out of the council go to the system board for consideration. Dr. Klasko and the board chair attend some of the council meetings. Those on the council are highly engaged—they have the option of attending meetings via phone or video conference, but Kinslow said most of the physicians choose to come in person because of its importance to them. This idea is currently being expanded to the development of management and nurse advisory councils.

Accelerating Integration with Help from GE

According to Kinslow, now that they have to move beyond the "low-hanging fruit," they need improved analytics to establish new areas of opportunity. To take things further, most recently Jefferson developed a unique partnership with GE Healthcare to aid in the integration process, resulting in an eight-year, shared-risk relationship with a goal of saving $500 million to $1 billion. Beginning in summer 2017, GE inserted 30 of their team members at Jefferson to collaborate and implement integration processes, including improving analytics and simulation modeling to help remove redundancies and maximize efficiencies to direct services that best meet patient needs. GE has some risk in the deal too—it's not all one-sided. GE's CEO at the time, Jeff Immelt, agreed to the deal because Jefferson "is the fastest growing academic health system in the country," and GE is looking towards becoming more of a solutions company. Dr. Klasko recalled his conversation with Immelt. "I think there's a 0.0 percent chance you'll be able to achieve the integration you need to achieve by yourself," Immelt told Dr. Klasko. "For GE, we have confidence that if we can do it here, if we can do integration powered by GE Health solutions, we'll have no trouble getting the attention of many other clients." After meeting with Dr. Klasko, the GE team met with the Jefferson board. According to Dr. Klasko, they said to the board, "You're getting this deal because we have never done this before. We'll do this in a hundred places three years from now." One of the board members expressed concern about GE not having as much at stake as Jefferson. The reply was simple and straightforward: "This is our [joint] future. You might have 30,000 employees; we have millions of investors. They will be watching this to see if we can succeed in defining this new future of healthcare."

For incoming GE CEO John Flannery, the key was Jefferson's and Dr. Klasko's "commitment to change."

"[GE is] putting its reputation on the line for this ongoing live laboratory," Kinslow said. "How do I get into healthcare in a big way, and how can I go out after this is successful and say to the Penns and the Yales, 'This is what we did at Jefferson. Look at this turnaround, and these are the outcomes we've been able to produce.'"

Integration goals include:

- Unifying the medical staff culture and protocols, including credentialing and performance expectations (currently a blend of academic, employed, and independent physicians).
- Further meshing management into one cohesive team, including recruiting new talent.
- Increasing employee engagement and team building.
- Unifying compensation and benefit plans for all employees in the system, to allow them to move more freely across the system into different roles.
- Reducing duplication and standardizing variations in care, along with a greater emphasis on performance improvement.
- Integrating the academic and clinical pillars to maximize efficiency and sharing of best practices.
- Building out the data warehouse to maximize analytics, reporting, and EHR functionality.

The Role of the Academic Medical Center and University as the System Integrates

Academics and research are costly, but according to Jefferson leaders they put the organization at an advantage from a differentiation standpoint and delivering a different level of care. "There's no doubt in my mind that Abington and Aria [and the other organizations in the system] will be better healthcare providers because of their affiliation with the academic research that Jefferson brings," Landman said. Academic medicine, combined with the hub-and-hub model of care delivery, allows for patients to be treated in their own community, near their home and their family, while receiving the benefits of evidence-based best practices—essentially taking

the academics into the communities, to differentiate the system from its competitors and make a true difference in the quality of care provided.

Crane added, "There will be a little bit of conflict between academic and clinical. What makes this unique is having the academic research side of the business, from the revenue perspective—it is a small financial step child, but it's still our core vision of what we want to be and the heart and soul of the enterprise. So, communication is going to be the number one most important thing in making sure this makes sense to the physicians. If we centralize something or frankly, decide that we can't keep a service line in one of the hospitals, the physicians need to understand that the decision is unique and there's input in the process around it—that it doesn't actually mean that everything else is at risk just because of what happened in one place."

Critical Success Factors and Lessons Learned

The Jefferson team overwhelmingly agrees that having the strong, visionary leadership of Dr. Klasko was key to the system's accomplishments to date. Dr. Klasko has earned the reputation of being a risk taker, but Green doesn't see it that way. "I don't think it's a question of taking risk. We have been very careful about what we're doing and where we are going. It is really more about a willingness to embrace the community in ways that the community responds well to."

Key success factors the team pointed to include:

- Vision and strategy are critical, along with a sense of urgency.
- There must be an understanding of why risks must be taken and how to determine which risks to take.
- Look for dynamic change agents ("…that doesn't mean reckless, but it means people with vision," said Landman).
- Timing and execution are critical.

What to do differently? First, Landman felt that they should have brought in a new management team sooner, rather than trying to accommodate people in existing positions who were not a good fit for the new strategic direction. But Hoad countered, "[Dr. Klasko] elected not to do a series of firings, which a lot of CEOs at that level do, and the reason he did that, I think, is he understands that controversy can derail the process. Nobody stands up and says, 'Typewriters are better. I'm not using a computer!' But it happens within the culture. So then how do you change a legacy culture?"

There needed to be earlier clarity of roles, authority, and responsibility as the organizational structure took shape. Merlis felt that one mistake was not communicating as frequently or clearly with the physicians, resulting in some skepticism. "Some of the original premises of the initial definitive agreement were not felt to have been understood. Nor was there understanding of where we needed to change these premises, based on the market or the accelerated growth of our system. I think we've worked with the medical staff and identified where we could be doing some things better. I think the balance between operations and execution on one end of the spectrum versus innovation and creative partnerships—we have to be successful at both." He pointed to the physician advisory council as the primary solution to this issue.

For Dr. Sasso, "assumptions were made on the part of administrations about what they had to do upfront, and what their foundational goals were, and they didn't have physician input for what that meant before they rolled them out, and I think that caused a lot of anxiety at that second round of integration. Steve is now going out to hospitals and systems and relaying that clinical message and his understanding of that."

"When an organization has gone through as many changes as we have had in a short period of time it requires clarity. I think we have to do a better job creating that clarity around our strategy. Second, to do that you need great focus. So, I think as a leadership team, we need to put in place those components of the organization that allow focus to be understood based on input as well as agreed-upon priorities. Not every idea is a good idea."

—Laurence M. Merlis, Executive Vice President & Chief Operating Officer

Looking to the Future

Going forward, TJUH (the keystone academic hospital) may become smaller (from a total-beds point of view) as more care is moved out into the communities. "I think that if we just looked out six or seven years we would find that we probably have a very different physical footprint in center city, a smaller, more efficient one," Ekarius said. "I anticipate we would have a new building by then, and repurposing some of the older spaces that we have as things are transformed to outpatient sites or to regional sites around the region." Devine added, "If the efficiencies and the things that are working are in place for the system, it's going to benefit everyone. So, we need to make sure that clinically we're delivering the right services in the right place for the right value. Then everything else will follow."

"If we were just doing what we were doing and we hadn't merged, Blue Cross will cut our rates five percent a year, 25 percent over time," Hevner concluded. "I really believe that if we hadn't done what we did, first bring Steve in, then merging the university and everything else, somewhere in the early to mid-20s we'd be having an auction and turning over keys. The risk was staying on the burning platform. But you have to understand, the platform is burning."

What's Next for Jefferson?

- Payer Challenges:
  - » Market dominating single payer
  - » New entrants to market
  - » Preparing for value-based contracting
- Diversity and inclusion in Philadelphia
  - » Zip code disparities in longevity
- Creating employee engagement
- Integration, integration, integration
  - » Merger of two universities
  - » Physician culture issues and leadership development
- Governmental risks
  - » Repeal and replace
  - » Per capita caps approach toward Medicaid
  - » Focus on deficit reduction

Jefferson's Strategic Roadmap: 12 Priorities to 2020

Clinical Leadership	1	Establish common understanding of "hub-and-hub" model and implications for each acute care facility with respect to optimizing around current capabilities and financial opportunities, along with articulating the path toward market leadership across major service lines.
Academic Mission	2	Integrate and align the physician network to enable a seamless patient experience across the care continuum (e.g., two-way access to Jefferson clinician, more efficient ED wait times, etc.).
	3	Develop the internal infrastructure to recruit and onboard productive physicians that meaningfully increase volume through employed or aligned arrangements.
Quality & Innovation	4	Grow Jefferson's ambulatory/pre-acute footprint to meet consumers' care needs within their communities, contribute referral volume to our physicians and acute care assets, and solidify Jefferson as the leading provider of these services.
Financial Strength	5	Optimize Jefferson Health's approach to payers, maximizing performance in the FFS business model using the system's scale, improving capture on existing value-based contracts, and making selective investments in preparation for population health.
	6	Assess opportunities in existing geographies within the Philadelphia market to add further scale and skill economies through partnership or M&A, pursing those with a sound mid-term business case.
Clinical Leaderhip	7	Strategically move towards being a comprehensive university with a self-sustaining education program that features learning that is transdisciplinary, personalized, experiential, and lifelong.
Academic Mission	8	Invest in distinctive research programs, encouraging collaborative endeavors across health services and applied research, and ensuring they maintain at least a partial focus on areas that translate into near-term patient care impact (e.g., late stage clinical trials, new care protocols and delivery models, etc.).
Quality & Innovation	9	Establish and enforce clinical standards across the care continuum, with performance tracking and investments to ensure delivery of consistent, high-quality care.
	10	Build a nimble, business-friendly innovation arm that facilitates corporate investment and partership on patient and physician engagement technologies and other priority areas for care transformation.
Financial Strength	11	Achieve a sustainable EBIDA margin from clinical operations, helping to facilitate increasing reinvestment in our mission.
	12	Focus philanthropic efforts on the top strategic goals, accelerating and increasing Jefferson's impact.

Underpinning the strategic priorities is a fundamental operating model decision for Jefferson around the corporate center that will help maximize the value from integration within 18 months.

The Five Questions:

1. When does pace outrun our ability to execute and integrate?
2. How quickly do we integrate recognizing the tension between employee/physician engagement vs. financial imperatives?
3. How do we translate culture across the merged enterprise?
4. On our trek to "indispensability," how do we negotiate with a dominant insurer who is trying to hold onto their position as new entrants flood the market?
5. What are the "bullets I can't see" that might kill us?

Needless to say, Jefferson has come a long way since 2013. "They found the right guy. There is no question," Hoad said. "Had they found a traditional president, we would have faced a future with a restricted and restrained strategic position in the evolving East Coast partnerships for delivery. The board knew what they were doing. You have a classic case study in a guy who uses a non-traditional management style to create change. But in the first couple of years there was resistance. Integration is hard. Telemedicine is hard. Reducing cost is hard. What drives Steve is a vision of a different future, as well as his personal charisma. I've seen him give talks where people wait afterwards for half an hour to talk to him and shake his hand, and people tell him that they would love to work at Jefferson. They were people getting ready to leave healthcare, and now they want to come to Jefferson. I've seen that over and over and over again."

For the board of trustees, which launched the change and, as a result, brought much change to the board itself since 2013, the stakes were high. "I think had we not come together the way we did and have someone like Steve get involved with the leadership, we'd be part of a larger delivery system by now," said Rock. "I don't know if Jefferson would still exist. We really had to do what we did. You know what the structure was, the doctors on the academic side, and the department heads, and everybody had their own silo, there were no performance metrics. I think Steve has been instrumental in bringing us into the next century."

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