Strategic Cost Transformation: Putting Theory into Practice

A Governance Institute Webinar

Presented by

Marian C. Jennings, M.B.A.

M. Jennings Consulting

November 28, 2018

Today's Presenter

Marian C. Jennings is the president of M. Jennings Consulting, Inc. and a Governance Institute advisor. Ms. Jennings has over 30 years of healthcare consulting experience and is a nationally recognized expert in strategic planning, governance restructuring, and affiliation planning. She served as editor and co-author of *Health Care Strategy for Uncertain Times*.

Ms. Jennings is a frequent national speaker and author on the topics of strategy, health system integration, physician development strategies, contemporary governance, healthcare reform, and finance. Ms. Jennings holds a Master of Business Administration degree from Harvard University and a bachelor's degree in mathematics, *magna cum laude*, from Tufts University.

Learning Objectives & Continuing Education Information

After viewing this Webinar, participants will be able to:

- Define what is meant by strategic costs transformation.
- Review the kinds of initiatives that typically would be part of strategic cost transformation.
- Explain why re-examining the independent hospital's portfolio of services is essential for long-term viability.

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No advanced preparation required
Field of Study: Business Management and Organization
Delivery method: Live Internet
Maximum potential CPE credits: 1.0

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“Not business as usual”: understanding the cost transformation imperative

Culture reigns supreme

Transforming the underlying cost structure: practical advice

We Know What We Need to Do, But…

+ cost transformation strategy +

New Survey Finds Current Cost Transformation Initiatives Lack Required Urgency

By Todd Fitz

Need to proactively align cost structures with transition to value-based care	80%
Must close gaps between current performance and financial plans	70%
Have no cost reduction targets for next five years or have goal of 1-5% reduction	>50%

Source: © HMFA, Healthcare Cost Containment, October 2017.
https://www.kaufmanhall.com/sites/default/files/HFMA_Healthcare_Cost_Containment_Oct2017.pdf

"Fewer than one-in-five healthcare executives has seen cost reductions of more than 5 percent in any priority area in the last year"

Source: © Kaufman Hall, 2018 State of Cost Transformation … Time for Big Step.
https://www.kaufmanhall.com/resources/research/2018-state-cost-transformation-us-hospitals-and-health-systems-time-big-steps

Moving From “Knowing” to “Accepting”

(Modified Kubler-Ross Model)

Shock*	• Paralysis at hearing the bad news
Denial	• Trying to avoid the inevitable
Anger	• Frustrated outpouring of bottled-up emotion
Bargaining	• Seeking a “way out”
Depression	• Realization of the inevitable
Testing*	• Seeking innovative solutions that work
Acceptance	• Finding the way forward

*Model extended slightly from the original Kubler-Ross model.

Traditional Incremental Approaches Won't Suffice

Not for the Faint-Hearted

"A thorough or dramatic change in form or appearance"

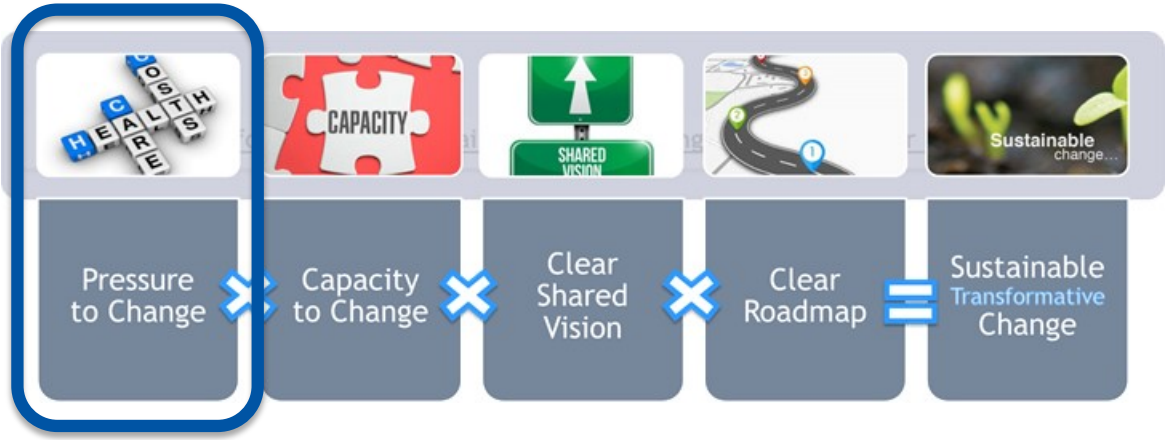
Synonyms:

change · alteration · mutation · conversion · metamorphosis · transfiguration · transmutation · sea change · revolution · overhaul

Success in Strategically & Sustainably Reducing Costs…

Leaders' Four Components of Strategic Cost Transformation

Pressure to Change × Capacity to Change × Clear Shared Vision × Clear Roadmap = Sustainable Transformative Change



Pressure to Change

Transforming our Costs of Delivering Care

What Is Value?

$$\frac{\text{Quality as Measured by the Consumer}}{\text{Payment (Cost to Consumer)}}$$

Questions for the Board

What is your current value positioning?

How much cost must come out?

Case Study: Payment Risks

Most organizations are dependent upon special payment programs to shore up the bottom line.

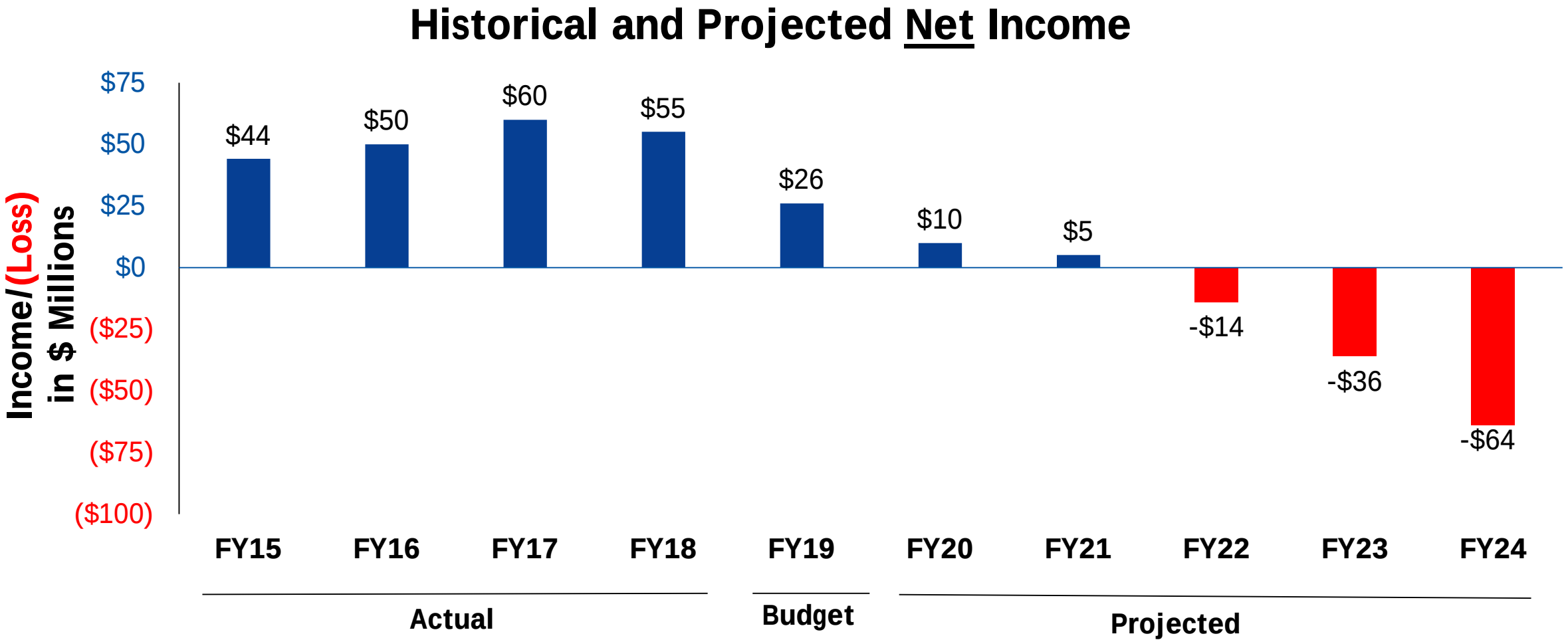
Impact on Our $1.0 B Case Study Health System if Special Payment Program(s) Shrink/Are Curtailed

	Financial Benefit to System	
	FY17	**FY18**
Medicare 340-b Drug Pricing Program	$34 Million	$32 Million
Disproportionate Share Designation	$10 Million	$ 9 Million
Critical Access Designation *(small outlying hospital)*	$12 Million	$11 Million
Provider-Based Billing	$12 Million	$20 Million
TOTAL RISK	**$68 Million**	**$72 Million**

Case Study Example: Financial Forecasts FY19–FY24

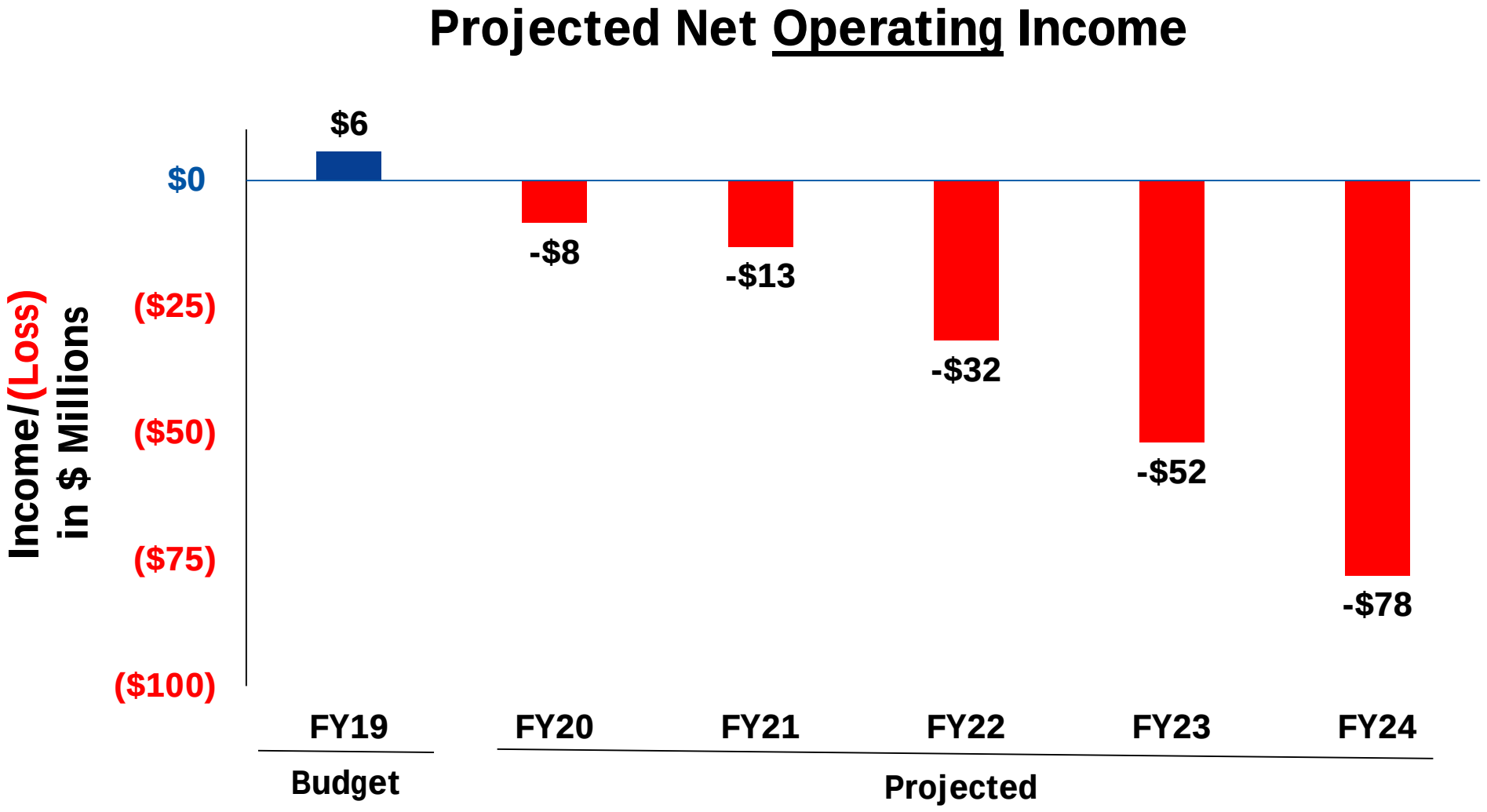
Projected losses starting in FY2022 (with small productivity improvements)

Expected Move to "Value" Yields Projected Major Deficits



Case Study Example: Financial Forecasts FY19–FY24

Looking at operating income only…with small productivity improvements



Case Study: Changes Within Our Control

Traditional Tools – Necessary but Not Sufficient

	Projection Years				
	FY20	FY21	FY22	FY23	FY24
Operating Income/(Loss)	($7,855)	($13,155)	($31,635)	($51,865)	($78,089)
Salary Improvements:					
1% Annual Productivity Improvement	$4,944	$9,833	$14,665	$19,444	$24,171
1% Annual Wage Increase Reduction	$5,528	$11,269	$17,900	$23,844	$30,566
Benefit Reduction	$3,584	$4,959	$5,207	$5,467	$5,740
Program Improvements:					
Occupational Health	$2,131	$2,220	$2,312	$2,406	$2,505
VNA	$915	$1,424	$1,862	$2,209	$2,639
Neurosurgery	$2,842	$2,842	$2,842	$2,842	$2,842
Physician Productivity Improvement	$1,183	$1,219	$1,255	$1,293	$1,332

Case Study: Changes Outside Our Control

"What If" Analyses (Two Examples of Many)

	Projection Years				
	FY20	**FY21**	**FY22**	**FY23**	**FY24**
Payment changes:					
OPPS to ASC impact	$0	$0	($ 5,166)	($ 5,166)	($ 5,166)
Cuts to 340b Drug Pricing (by 50% by FY24)	($8,000)	($10,000)	($12,000)	($14,000)	($16,000)

… and, if our newly started ACOs result in a decrease of associated hospital inpatient and outpatient utilization for those enrollees that are just 5% lower than expected:

- Our **FY2024 loss would increase by +$6.0 million**

Key Takeaway

Nearly all hospitals/systems need to reduce 15%+ of their underlying costs!

p.s., Kaufman Hall recommends that a hospital aspire to saving 25–30% over a five year period…[1]

Source: © HMFA, Healthcare Cost Containment, October 2017. https://www.kaufmanhall.com/sites/default/files/HFMA_Healthcare_Cost_Containment_Oct2017.pdf

Pressure to Change

Implications for the Hospital Board

- Charge finance committee with developing multi-year financial plan
  - Understand magnitude of your financial gap
  - Identify major types of initiatives to close the gap
- Understand your current value positioning*
- Understand current performance under value-based payment models
- Agree on your expectations of future payment changes/requirements
  - And their timing
- Require profitable performance this year!

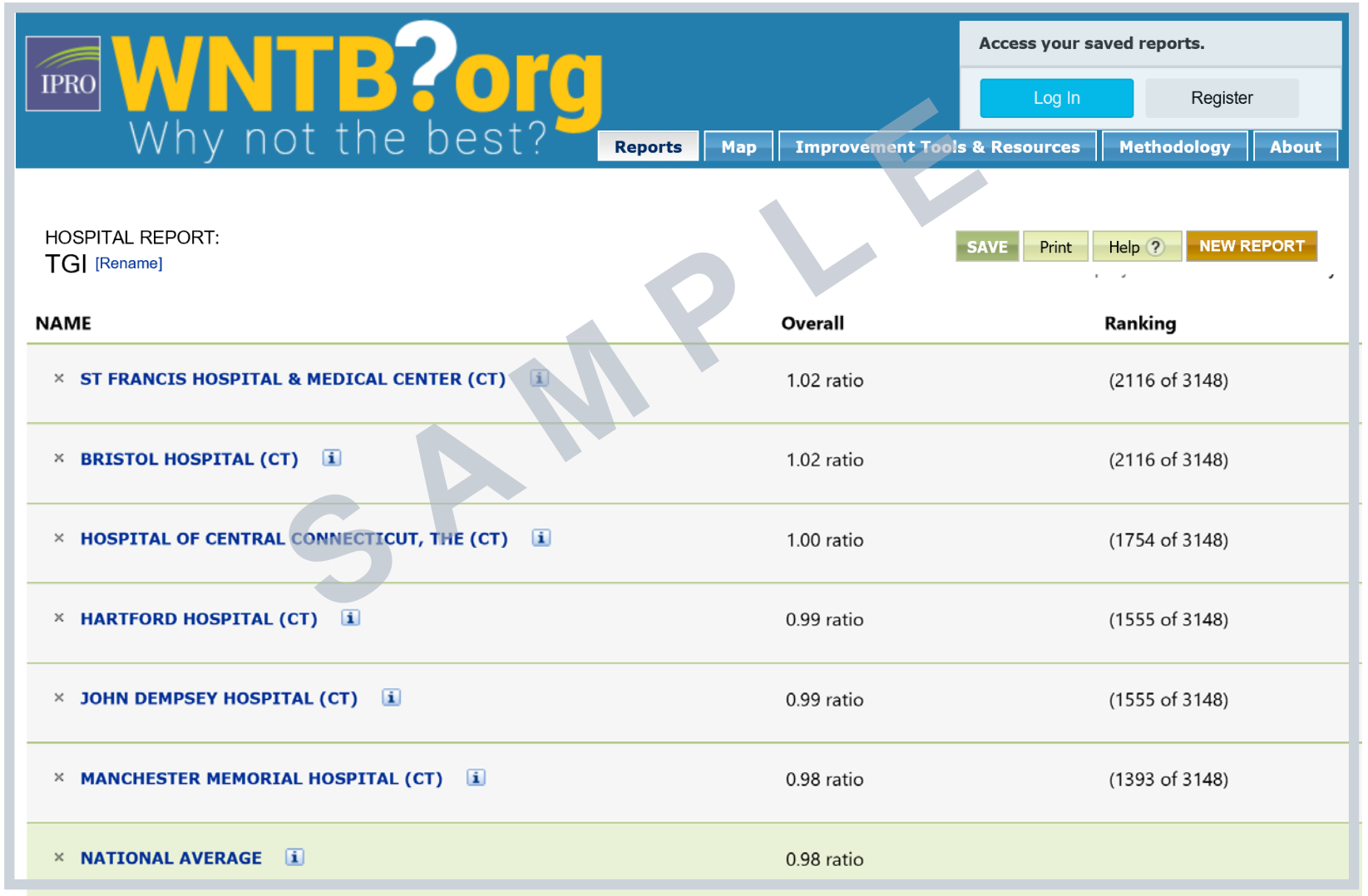
Link Work of the Finance and Quality Committees

Do You Know How Your Hospital Stacks Up on Cost?

Publicly available data: https://whynotthebest.org/

Spending per Hospital Patient with Medicare:
This measure shows whether Medicare spends more, less or about the same per Medicare patient treated in a specific hospital, compared to how much Medicare spends per patient nationally.

This measure includes any Medicare Part A and Part B payments made for services provided to ***a patient during the 3 days prior to the hospital stay, during the stay, and during the 30 days after discharge*** from the hospital.



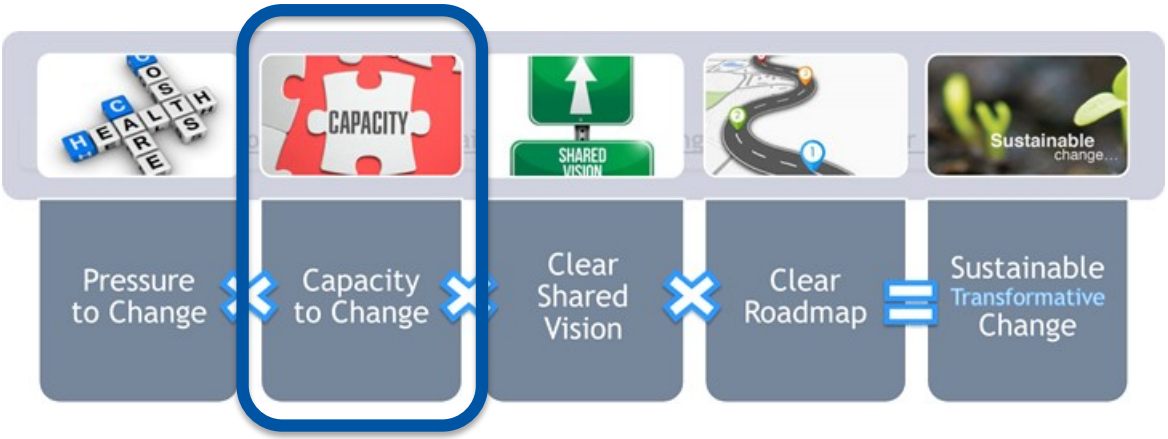
Pressure to Change

Implications for the Hospital Board

- Move quickly through your own shock, denial, anger, bargaining phases of the Kubler-Ross model!
- Charge management with educating physicians and staff about value-based delivery
- Create the vision and action plans for transition to value- and risk-based payment
  - "From treating sickness to optimizing health"

> *"If you live in Florida or Louisiana, you shouldn't spend a lot of time thinking about how likely it is that you'll be hit by a hurricane. Rather, you should think about what would happen to your organization if it was hit by one and how you would deal with the situation."*[1]

Source: [1]René M. Stulz, "Six Ways Companies Manage Risk," *Harvard Business Review*, March 2009.



Capacity to Change

Transforming our Costs of Delivering Care

Culture Reigns Supreme!

Key roles for the board and management are to create a high-performing **culture** that is ready and able to adapt, innovate, and take *prudent* risks …

- More collaborative
- More agile/nimble
- More team oriented
- More flexible
- More open-minded
- Less wedded to "not invented here" syndrome

Deliver results under today's business model while designing for the future and being ready for the unexpected

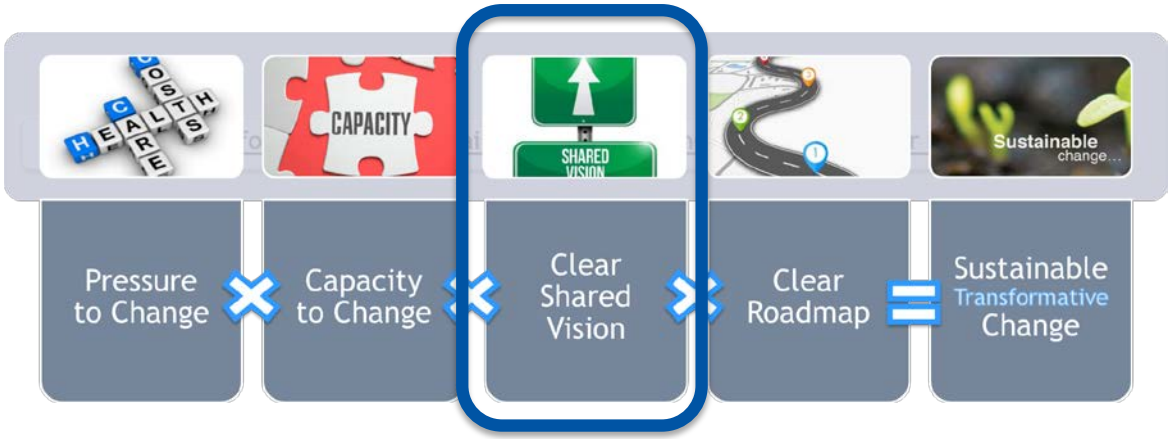
Questions for the Hospital Board

Generative Discussion Questions

- Does your board really believe that there is a "**compelling need to change now**" to reduce your underlying cost structure?
- Does your board's **culture support, inhibit, or have little impact** on your organization's ability to innovate/transform?
- How ready is your board to make **tough decisions proactively**?
- How good a **collaborative partner** is your organization?
- Does your board include individuals with the attributes, **competencies**, and experience to facilitate innovation/change?

Key Generative Discussion Question

- Has the board been satisfied with "traditional cost-cutting" approaches to value/addressing financial realities versus asking:
  - How can we produce quality care that costs 20-30% less?
  - Do we have the right portfolio and sites of services?
  - Do we encourage, allow, or discourage variability of care processes – and why?
  - What does it mean in our organization to "redesign care"?



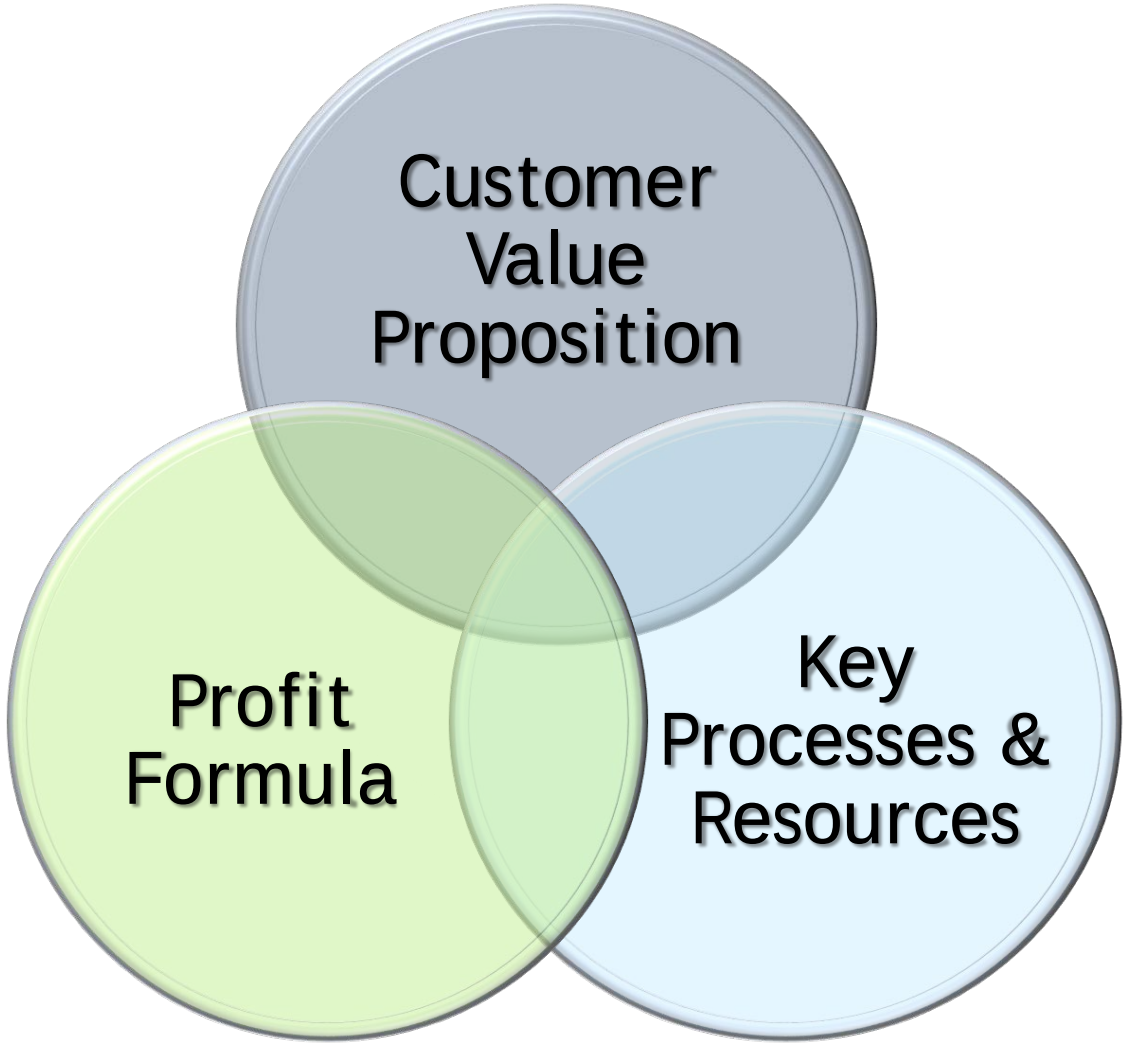
Clear Shared Vision

Transforming our Costs of Delivering Care

Our Future Business Model

What Innovations Are Needed to Deliver Value with Less?

Reinventing Your Business Model[1]



How Patients Define Value/Quality

- **Affordable** out-of-pocket costs
- Ability to schedule a **timely** appointment
- Confidence in the provider's **expertise**
- Office is **conveniently** located
- Consumer-oriented services like **mobile apps** and **extended** office **hours**

-Leavitt Partners, University of Utah[2]

Shared Vision of Success: Intentionally Include Strategies in Overall Strategic Plan FY2019-FY2023

Example: "Transformation Goal"

Strategies Include:

A.1 Physician Alignment for Managing Total Cost of Care – Further engage and align our primary care and specialty physicians to help our hospital deliver exceptionally high quality while effectively managing the total cost of care.

A.2 Clinical Redesign – Implement high-value clinical solutions across our continuum, including end-of-life/palliative care services, to improve access, quality, and the experience of patients and their families and to reduce cost.

Example: "Stewardship Goal"

Strategies Include:

F.1 New Payment Models – Build the competencies and infrastructure to manage care and the costs of care under new value-based and risk-based payment models.

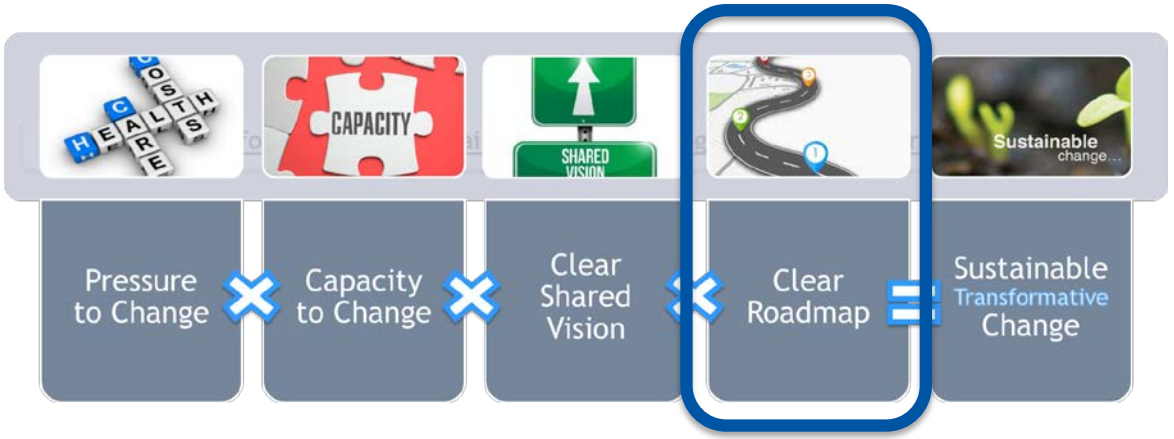
F.2 System Cost Imperative – To provide a cushion against environmental uncertainties and risk factors, successfully implement cost savings initiatives to improve our cash flow.

F.3 Leveraging Our IT Platform – Optimize and obtain the full benefits of Epic and business intelligence solutions to facilitate effective management of care across the entire continuum; support care team collaboration; and measure the activities, outcomes, and overall performances of providers across the system.

Shared Vision of Success: Intentionally Include Metrics in Overall Strategic Plan FY2019-FY2023

Metrics Examples:

- ✓ Primary Care Group has achieved at least 80% of maximum available incentives under value-based payment (VBP) and advanced alternative payment models.
- ✓ At least 50% of our specialists qualify for MACRA Track 2 (APMs) Medicare payments.
- ✓ Hospital achieves at least breakeven on CMS value-based payments in FY2019 and achieve at least 50% of available bonuses by FY2023.
- ✓ At least $50M in documented cost-saving related to clinical redesign by FY2023.
- ✓ Patient/client satisfaction remains in top decile for hospitals; at least top quartile for our physician group and home care.
- ✓ Our ACO has achieved all quality and financial performance objectives outlined in our board-approved business plan.



Clear Roadmap

Transforming our Costs of Delivering Care

Continuum of Responses to the Cost Transformation Imperative

- Increase Labor Productivity
- Improve Supply Chain/ Reduce Supply Cost
- Improve Revenue Cycle
- Use Cost Analytics
- Practice Multi-Year Financial Planning w/ Scenario Planning

- Tackle Overhead & Hierarchy/Structure
- Ensure a Sustainable Portfolio of Services
- Partner with Physicians on Enterprise Cost Control

- Fundamentally Transform the Delivery Model
- (Finally) Get ROI on EHR Investments

Enablers

Partnerships • Business Analytics/EHR • Outsourcing • Courage

Key Takeways from 2018 Kaufman Hall Study

Per KHA October 2018 Study …

72% cite traditional "labor cost/productivity" and "supply chain and other non-labor costs" as a key focus area

But . . . . . .

Among physician enterprise and service line initiatives:

71% do ***not*** cite **service rationalization** as a key focus

55% do ***not*** cite **physician enterprise management** as a key focus

52% do ***not*** cite **service line efficiency** as a key focus

Among clinical redesign and workforce initiatives:

62% do ***not*** cite reduction in **inappropriate clinical variation** as a key focus

60% do ***not*** cite **clinical workforce redesign** as a key focus

55% do ***not*** cite **clinical redesign (workflow and/or model)** as a key focus

Source: © Kaufman Hall, *2018 State of Cost Transformation … Time for Big Step.*
https://www.kaufmanhall.com/resources/research/2018-state-cost-transformation-us-hospitals-and-health-systems-time-big-steps

Improve Supply Chain/Reduce Supply Costs

More Traditional Approaches[1]

HealthcareDIVE

"Hospitals Are Taking Control of Their Supply Chain

Hospitals are turning to self-distribution models as they seek to cut supply costs

- Self-Distribution
- 'Just in Time' Distribution Models"

Innovative Approaches

DIY Generics[2]

High costs and low supplies drive hospitals to take on big pharma. But will it work? Page 6

Sources: [1]Healthcare DIVE, Supply Chain DIVE, December 11, 2017; [2]*Modern Healthcare*, January 22, 2018.

Cost Accounting/Cost Analytics

Questions for the Hospital Board

- ✓ Do we really understand the costs of our services/care *across the continuum*?
- ✓ What are the greatest cost opportunities and where do we start?
- ✓ Are our physicians aligned with our efforts?

- **Industry is seriously behind!**
- Essential to effectively:
  - Price services
  - Understand profit/loss of managed care contracts, ACOs, bundled payments
  - Make service line and location decisions
  - Identify best practices to share across sites
  - Provide physician-specific information/feedback

Tackle Overhead & Hierarchy

- Up to half of your costs may be considered "fixed"
- Future models will be less hierarchical
- Need more flexible structures that encourage collaboration and empower physicians and staff

Questions for the Board

- ✓ Have we asked management to identify potential **reductions in fixed costs and overhead costs** – including in clinical areas?
- ✓ How must our **organizational structure change** with the realities of our environment?

Ensure a Sustainable Portfolio of Services
Portfolio Analysis

- **Rational** resource **allocation**:
  - Centers of excellence/service lines
  - New primary care hubs
  - Physician practice acquisition
  - Health plan development
  - ACO development
  - Post-acute continuum
- Determination of **sites of care**
  - Access
  - Cost
  - Quality

Caution!

- Portfolio analysis is a tool; it never substitutes for judgement
- Must rest on a foundation of credible & timely data
- Essential that board, physicians, and management are involved

Ensure a Sustainable Portfolio of Services

Portfolio Analysis Conceptual Framework

Approach Explanation/ Description	**Close or Divest**	**Shrink/ Downsize/ Reposition**	**Stabilize/ Enhance**	**Grow**
	✓ Divest or stop operating ✓ No tangible benefits ✓ Consumes resources better devoted elsewhere	✓ Reduce resources allocated ✓ Free up resources better devoted elsewhere	✓ Improve program/ service ✓ Increase the tangible benefits ✓ Enhancement, not growth, is focus	✓ Devote strategic capital and time to growing the program/ service

Ensure a Sustainable Portfolio of Services

Generative Discussion Questions

Questions for the Board

- ✓ *If* we had reliable information, would we be ready to:
  - Make **tough choices** on closing, divesting, or outsourcing some of today's programs and services?
  - Consolidate selected specialty services regionally?
- ✓ Have we agreed on the criteria to be used? Who should be involved and how?

Partner with Physicians on Enterprise Cost Control

How aligned are our physicians with our overall "Value Proposition" & Cost Imperative?

Questions the Board Should Be Asking

- ✓ Does our physician **compensation philosophy/model** align with our cost imperative? Does it reward physicians for delivering high value care?
  - Or are physicians rewarded for individual "production" – the traditional FFS approach?
- ✓ Do we have in place an **effective managed care contracting vehicle** to include our system or hospital, our private, and our employed physicians?

Transform the Delivery Model: Standardization

"Mass Production"

"Job Shop"

Blind Standardization ≠ Always Beneficial

"Recognize that sometimes variability cannot be avoided and the costs of reducing variability outweigh the benefits"[1]

Questions the Board Should Be Asking

- ✓ Where do our really customers (really) value variation – clinically or administratively?
- ✓ Have our physicians/management identified what should and should not be an "art," from a clinical perspective?
- ✓ What new technologies could make a science of an art?

Sources: [1] Joseph Hall and Eric Johnson, *HBR*, "When Should a Process Be Art, Not Science?" March 2009.

Transforming the Delivery Model

Standardization & Best Practices: More than Cost Savings

Example

- ✓ 3-hospital system
- ✓ Hip replacement
- ✓ Best practices identified/ established
- ✓ Variability reduced
- ✓ Costs reduced by 10-20%

HOSPITAL SYSTEM SERVICE-LINE ANALYSIS: ORTHOPEDICS (HIP REPLACEMENT)

		Facility A			Facility B			Facility C		
		Provider			Provider			Provider		
		1	2	3	1	2	3	1	2	3
Net Patient Revenue		$150	$225	$185	$320	$240	$110	$440	$150	$80
Hospital Services	Diagnostic Interventional Surgical Nursing Other Clinical	Hospital Services: Metrics and Costs			Hospital Services: Metrics and Costs			Hospital Services: Metrics and Costs		
Total Expenses		$146	$224	$165	$290	$235	$111	$410	$165	$82
Operating Margin		3%	0%	11%	9%	2%	–1%	7%	–10%	–3%

Operating margin and physician variability were analyzed in three hospitals across a system for a comparable patient cluster of hip replacements. Through the costing process, the system's best practice for hip replacement was identified and finalized with a goal of obtaining better outcomes and utilization of resources and services. The process improvement project resulted in reduced variance among physicians, helping to reduce cost by 10 - 20 percent, increase operating margin, and reduce the overall number of outliers.

"Deliver same quality, safety, experience and cost across the enterprise"

Graphic source: "Managing the True Costs of Health Care: A Roadmap to Cost Analytics," *HFM Magazine*, February 2017. Dollars presented in $1,000s reflecting each provider's total NPR and expenses.

Transform the Delivery Model: Innovation: Partners Healthcare's iCMP

Program pairs nurse care managers with high-risk patients to coordinate care = better patient outcomes and ***cost savings of $2.65 for every dollar spent***

Integrated Care Management Program

The Integrated Care Management Program at Massachusetts General Hospital is a primary care practice-based service designed to support patients in achieving improved health and well-being.

Integrated Care Management Program

Chronically ill patients with multiple medical conditions often need the most help coordinating their care. The **Integrated Care Management Program (iCMP)** makes caring for these vulnerable patients its top priority. The goal of the program is to help patients stay healthier longer by providing the specialized care and services they need to prevent complications and avoid hospitalizations.

The iCMP program matches high-risk patients with a nurse care manager who works closely with them and their family to develop a customized health care plan to address their specific health care needs. The care managers closely monitor the patients during office appointments and after the visit when the patient is at home using phone calls and home visits. They serve as liaisons between the patient and other members of the care team. The care managers also help coordinate services such as diagnostic tests, transportation, social services, and specialist services. The program also ensures that iCMP patients who are in the emergency room continue to receive care that is tailored to their high-risk needs.

Over the past decade, more than 13,000 patients have enrolled in active care management. The program has 85 care managers, 18 social workers, 5 pharmacists, and 8 community resource specialists.In 2014, we also launched a Pediatric High Risk Program and are working closely with primary care offices to support this best practice.

In addition to improving health outcomes for patients, **iCMP is a best practice for controlling costs.** Since 10% of Medicare patients represent nearly 70% of Medicare spending, this is an important contribution to overall costs of care. By coordinating all of the care that some of our sickest patients require and monitoring their health we are able to avoid unnecessary, costly hospitalizations and keep patients at home, where they are happiest.

Source: Partners.org; "The Transformation Imperative: Costs, Consumerism Driving Innovation," *Modern Healthcare,* April 8, 2017.

Transformational Approaches

Get ROI/Leverage from your EHR Investments

"To realize an ROI [on EHR], organizations must prepare for the cultural revolution of merging clinical operations, revenue-cycle operations and information technology."[1]

- Jeff Goldsmith and Erick McKesson

Next-generation EHR should:

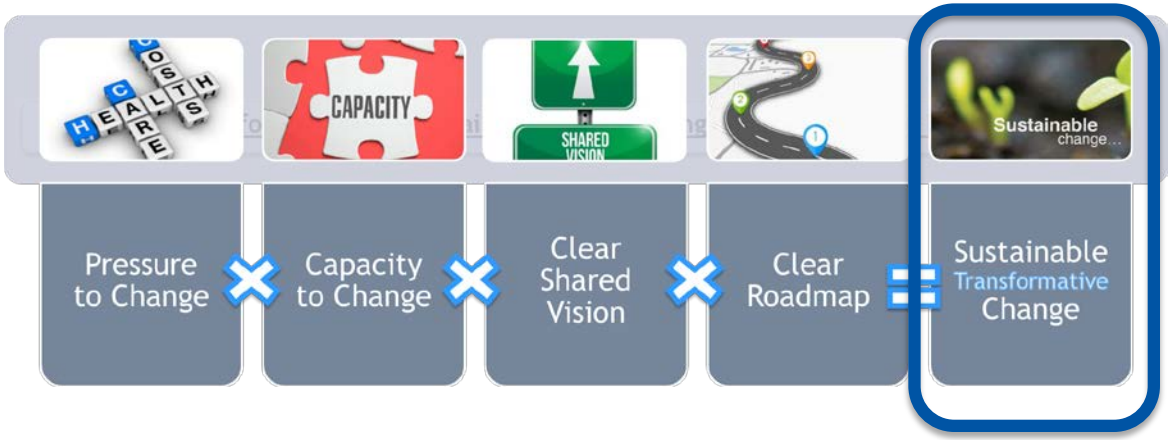
- Move toward "longitudinal" records: from **documenting** care to **planning** care
- Make the care process better for consumers/help us be consumer-centric

Which Population Health Companies Get Top Marks for Value?[3]

Healthcare providers struggling to choose a population health management vendor might wish to take some of these clues from their peers.

2018 KLAS: "Users are lukewarm about population health tools from Epic, Cerner and other EHR vendors"[4]

Sources: [1]"Commentary: Finding the hidden ROI in EHR implementation," *Modern Healthcare*, July 15, 2016; [2]Becker's Hospital Review, January 26, 2018;; [3]Health IT Analytics, January 30, 2017; [4]MedCity News, January 9, 2018



Closing Comments:

Strategic Cost Transformation

The Punch Line!

"Fasten your seatbelts. It is going to be a bumpy night."

Bette Davis

Sustainable Change/Innovation
to Move Toward Value with Fewer Resources

Lead from the top:

Board, Management, Clinicians

Many, many cost reductions possible without major disruptions

Link work of board(s) & committees to strategic cost transformation

Use full range of approaches: from traditional to more fundamental

Assume pace of change will be greater than you expect

A good "roadmap" alone is not sufficient

Align compensation incentives to <u>strategic</u> cost transformation
(not just cost-cutting)

"Tight-Loose-Tight"

Steel yourself!

This will be difficult and unrelenting

Questions & Discussion

Contact Us…

Marian C. Jennings, M.B.A.
President
M. Jennings Consulting
(610) 355-0610
mjennings@mjenningsconsulting.com

The Governance Institute
9685 Via Excelencia, Suite 100
San Diego, CA 92126
Toll Free (877) 712-8778
Info@GovernanceInstitute.com