LEADING THE CHANGE

A CRUCIAL ROLE FOR ACADEMIC MEDICAL CENTERS IN SHAPING THE FUTURE OF HEALTHCARE

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"All AMCs must now operate successfully in the old system while building the capabilities and structures that will allow them to succeed in the new model. Planning, timing, and paying for this shift are some of the most difficult challenges AMCs face."

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The contributions of academic medical centers (AMCs) have long been recognized as crucial to the health and well-being of the nation and, indeed, of people worldwide. Even so, AMCs today face pressures on every front. The clinical enterprise is challenged as the payment model moves toward shared risk and accountability. Reduced National Institutes of Health (NIH) funding and decreased philanthropy pose threats to research activities, while the education mission faces reduced government support and the inability of tuition to keep pace with inflation.

This triple threat, however, also presents new opportunities for innovation—an area where AMCs historically excel. Further, as AMCs respond to these pressures with innovative ways of achieving their missions, they will also be creating a model all health systems can use as a guide to improve quality and decrease the cost of care. In this respect, as with other breakthroughs at AMCs, the benefits of their innovation will extend far beyond the scope of their campuses.

In some cases, meeting the current challenges requires a broad discussion among many stakeholders. Restoring the education mission to a solid foundation, for example, demands a contribution of ideas and commitment cutting across the public and private sectors. The question of who should pay for medical education must be preceded by a true understanding of costs, how they are currently allocated, and how they can or should be assigned in the future. AMCs can and should lead this discussion, but any determinations and decisions are not theirs alone. Similarly, the role of AMCs in providing safety net care raises broader societal issues, most specifically who provides indigent care if AMCs do not, or, conversely, how AMCs expect to thrive in the market under the burden of unreimbursed care. Here too, AMCs can lead the discussion, but the ultimate resolution is not completely within their control; it requires a broader societal consensus.

The clinical enterprise, however, is an area where AMCs are much more in command of their own destinies. The evolving healthcare landscape includes external forces that AMCs must accommodate—competition, collaboration, and partnerships, for example—but, in general, clinical operations represent an opportunity where each AMC can and must set and implement its own strategy.

Getting the clinical mission right—that is, aligning clinical strategies and performance with the new market realities—is especially important given the role clinical operations play in supporting the other missions. A transformative approach to clinical operations is crucial to achieve Triple Aim goals and to bolster the education and research missions as well.

FORCES OF CHANGE

Much of the pressure on the clinical mission stems from the transition to fee-for-value from a traditional fee-for-service payment model. The scope and speed of this shift differs from market to market. Yet, to one degree or another, all AMCs must now operate successfully in the old system while building the capabilities and structures that will allow them to succeed in the new model. Planning, timing, and paying for this shift are some of the most difficult challenges AMCs face.

As the payment model changes, AMCs must also respond to operational pressures—to increase access, affordability, and quality simultaneously—while operating on significantly reduced reimbursement from all payers. This is occurring at a time when competitive forces and regulatory mandates necessitate new and often substantial investments in IT and data analytics—investments that have, as yet, not always correlated to improvements in quality or value.

Taken together, these challenges require operating the clinical enterprise within a significantly lower cost structure. Many healthcare leaders now believe that organizations will need to make performance improvements in the range of 20 percent to 40 percent in order to thrive on lower reimbursement, while continuing to provide high value to their communities and stakeholders.

The imperative of lowering cost while providing high value is driving change across the healthcare landscape. An example can be seen in the recent announcement by Cleveland Clinic that it would prepare for the future by reducing its budget by 20 percent over the next several years.

For many institutions, past successes make this new challenge more daunting. A decade ago, reimbursement reductions led many or most AMCs to improve overall cost/revenue by an increment of roughly five percent. Typically, these initiatives focused on the most readily available cost-saving initiatives, such as revenue cycle improvements. As competitive and cost pressures continued to increase, many of these same organizations undertook a second round of belt-tightening, improving the cost/revenue structure by an additional 10 percent to 12 percent. These earlier successes harvested, and then went significantly beyond, the low-hanging fruit, expanding the focus of initiatives to patient through-put, the supply chain, labor costs, and other areas, often taking a more comprehensive approach. Contemporary efforts must now identity and capture further opportunities in organizations that are already performing at very high levels.

> **"The challenges AMCs face required a response that is not incremental, but transformational. Strategies must address all aspects of the clinical enterprise — from operational excellence to how changing revenue streams will drive changes in the care delivery model and in scale."**
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> **JEFF JONES,** MANAGING DIRECTOR HURON

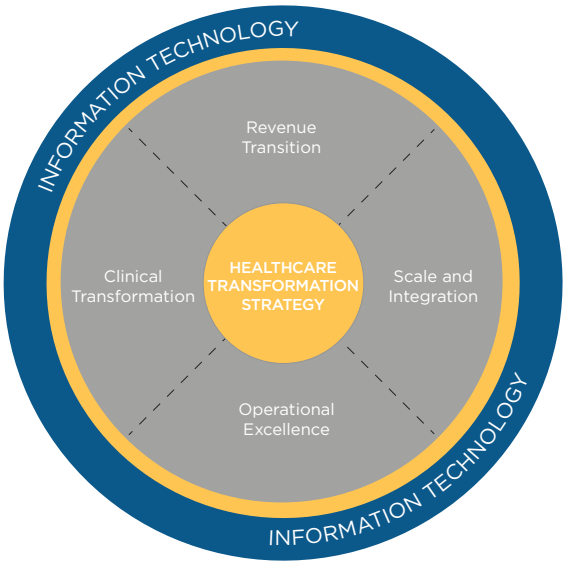
The strategies and actions now needed to achieve an additional 20 percent to 40 percent of cost/revenue improvement are fundamentally different from these past efforts. Efficiency and operational excellence remain critically important, of course, but doing what has been done in the past with greater or even optimum efficiency will not be sufficient to thrive in the post-reform environment. Instead, changes in the revenue model will dictate changes in how and where care is delivered. In turn, new models of care delivery will lead each organization to reexamine issues of scale and

integration. Taken together, these changes amount to a transformation in clinical care—a top-to-bottom rethinking of the clinical enterprise.

A TRANSFORMATION STRATEGY

Achieving and sustaining this magnitude of change requires each AMC to function as a unified organization with a clear vision and strategy and alignment of goals and values across the enterprise. Because of their unique structure and mission, AMCs could be a step ahead of community hospitals in creating this alignment.

In addition, new or refined governance structures should be in place to guide the transformation. The overall transformation strategy must be able to leverage existing organizational strengths and take into account the dynamics of the local market. As the transition progresses, leadership must continually evaluate those factors to calibrate priorities and make decisions.



In our experience, organizations that develop a strong transformational strategy and use it to inform and integrate change throughout the institution typically are able to achieve a 6 percent to 10 percent annual improvement. This type of strategic, comprehensive focus has delivered measurable results at a range of AMCs.

The University of Kansas Hospital Authority, for example, undertook an enterprise-wide approach to lowering costs while continuing to deliver superior care, achieving $60 million in annually recurring improvement. Texas Children's Hospital, a 503-bed hospital and academic medical center in Houston, identified $60 million in cost/revenue improvements as part of its 'Delivering on the Vision" initiative. At Yale-New Haven Hospital, a comprehensive cost and value initiative focused on reducing the cost per unit of service and enhancing the quality of care. The initiative gives clinicians detailed information on the extent and cost of care variation, fundamentally changing the way care is provided. Leadership expects the initiative to generate benefits of up to $125 million each year for the next several years.

At other AMCs, the transformational journey has begun with a focus in specific areas—revenue cycle or clinical operations—and then expanded. UCLA Health System, for example, achieved a $68 million annually recurring improvement by addressing the revenue cycle before building on that success to redesign clinical operations processes.

Whether undertaken through a comprehensive approach, or a series of initiatives, a strategy that is truly transformational will typically focus in four key areas:

1) REVENUE TRANSITION

To manage the transition to a value-based payment model, AMCs need a detailed understanding of top-line revenue and how it may shift. This transition impacts the bottom line in complex ways, making it crucial to predict, plan for, and manage this change.

AMCs need to develop the ability to forecast, track, and manage revenue flow with a level of granularity not needed in the past, when growing revenue was primarily a function of increasing volume through patient acquisition. While the transition is underway, organizations will operate under the fee-for-service and fee-for-value model simultaneously. This underscores why the ability

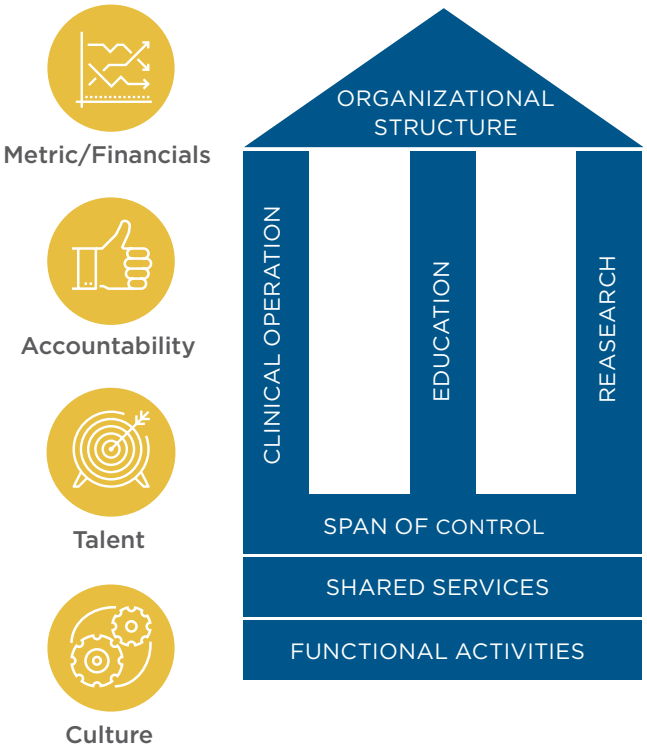
to project and track revenue flow with increased clarity is one of the new competencies the transition demands.

For example, as Accountable Care Organizations (ACOs) and Clinically Integrated Organizations (CIOs) emerge and become more dominant, they present new potential revenue streams. How to capture those streams, through shared savings, bundled payments, capitation, or a combination of methods, will depend on the institution, the market, and competitive forces. As a first step in responding to these opportunities, AMCs need the ability to map existing and forecasted revenue flows with significantly increased precision, as one component of a strategic plan.

Developing this ability will require a high level of transparency among entities that are accustomed to operating independently. Stakeholder groups—such as hospitals, group practices, individual physicians, and others—must work together, breaking down silos and sharing financial information appropriately in order to compile an accurate picture of current and forecasted revenue. Some changes in the revenue stream may be swift; other areas may change more slowly. There will be areas of ambiguity and clarity, which may shift over time. AMCs that are able to operate as a single, focused entity— as opposed to a collection of independent units—will have a tremendous advantage in responding to this change.

As this transition continues, a solid understanding of changing revenue streams will drive business decisions about how to deploy resources—where to pull back and where to invest and expand in order to grow market share. Many AMCs across the country—such as Yale New Haven Health System, Partners Healthcare, UCLA Health System, New York-Presbyterian, Northwestern Memorial HealthCare, and many others—are pursuing initiatives to expand their networks of care, based in part on forecasts of future revenue streams.

AMC ORGANIZATIONAL ELEMENTS



Certainly, AMCs will remain the leading providers of complex care. But by optimizing revenue management capabilities and using the information and insights gained to expand market reach, AMCs can improve performance across all levels of care—primary to quaternary—as the healthcare landscape continues to evolve. Our experience in the market indicates that this improvement is typically in the range of 5 percent to 8 percent over three to five years.

2) CLINICAL TRANSFORMATION

As payment reform alters revenue streams, it drives changes in the care delivery model, presenting unique challenges and opportunities. Historically, the care delivery model for AMCs has served two broad purposes: safety-net care for vulnerable populations and tertiary and quaternary care on referral from other providers. As competitive forces tightened over the past decades, many AMCs expanded that focus to include all levels of care, often including some type of primary care network or affiliation. This model,

though broader, was still built around episodes of care delivered within the hospital or clinic.

Payment reform now drives system-wide changes affecting where care is provided and who provides it. New care delivery models have to address all levels of care and all facilities and delivery points, starting before patients enter the hospital and continuing after they leave.

This requirement creates a challenge for AMCs, which typically do not have large primary care networks, compared to community hospitals. Strategies to address this vary by institution, ranging from practice acquisition to affiliation models. Regardless of the approach, building some type of effective primary care network is critical to achieving the goal of managing population health. The overall approach must also support revenue streams and provide the volume of patients needed to continue medical innovation.

In addition to redefining the breadth of care delivery—from traditional hospital to full continuum of care settings—new payment models also change the manner in which that care is delivered. Value-based reimbursement systems rewarding quality outcomes and penalizing readmissions create incentives to minimize care fragmentation and reduce medically unnecessary care variation. Achieving this requires successful clinical integration with highly engaged physicians and physician leadership, significant alignment between physicians and the hospital, evidence-based quality metrics, sophisticated IT capabilities, and some model of physician-led governance so that care is seamlessly coordinated for all patients, across all providers and clinical settings.

Making this transition can be challenging in an environment where physicians traditionally exercised great independence and where departments are accustomed to high levels of autonomy. But AMCs also have some unique advantages, compared to community hospitals, since by their nature they have a broader range of clinicians with a greater spectrum of skills and capabilities. In certain important areas—telemedicine, for example—their resources may be greater or more advanced. Because of this, AMCs may already possess many of the clinical tools needed to manage population health.

> **"AMCs typically have a broader range of clinicians, more resources in their various schools and programs, and more experience with innovative delivery methods such as telemedicine. All of these are advantages in meeting today's challenges.**
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The various schools and programs operated by most AMCs—nursing, pharmacy, social work, etc.—offer another advantage. These resources are well positioned to contribute expertise, resources, and leadership toward the goal of redesigning and expanding the care delivery model.

Finally, AMCs have an advantage in their large employee base, which provides the opportunity to test and refine innovative programs and develop best practices regarding population health and risk sharing. After developing successful programs with employees, AMCs can apply the same or similar models to much larger populations.

The new model shifts care delivery in two crucial ways: from discrete episodes of care to the broad continuum of health, and from centralized delivery points, such as hospitals and stand-alone centers, to delivery points aligned with demand, geography, and the competitive landscape. These shifts lead to new kinds of partnerships, as AMCs work with both non-profit and for-profit organizations, locally and regionally, to expand their reach. As these new partnerships grow, governance becomes increasingly critical. The ability for AMCs to be both strategic and nimble, functioning with the

focus of a single entity even as they create new partnerships, will be an important determinant of success.

Our observation is that responding to these opportunities and imperatives in a strategic way, and embracing transformative rather than incremental change, creates the opportunity to improve performance significantly—in the range of 8 percent to 13 percent over three to five years.

3) SCALE AND INTEGRATION

Changes in care delivery will lead many AMCs to reconsider issues of scale and integration. Traditionally, this is an area that has not been subject to a sustained strategic focus. Rather, as AMCs have executed on their traditional care delivery model, their operational and physical infrastructure has grown up around them, with many or most decisions guided by discrete circumstances, rather than an overarching strategy. Leadership must now undertake a new examination, focusing on how well old organizational and physical structures serve the new model, and where they must change.

> **"Academic medical centers are responding to unprecedented pressures on their tripartite missions. By implementing innovative strategies and solutions to improve quality and decrease cost, AMCs can create the opportunity to thrive in the evolving healthcare environment while leading the way for other healthcare organizations."**
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> **JEFF JONES,**. MANAGING DIRECTOR, HURON

Depending on their existing organizational infrastructure and the speed and degree of change in their market, AMCs may need to assess the scale needed to deliver care under the new model and develop plans to achieve that scale. Although specifics vary, the care model almost certainly requires new partnerships and a higher level of coordination throughout the enterprise, irrespective of the formal organizational structure.

Planning must also include an examination of existing program and facility assets, and an evaluation of how well they are matched to the market, raising questions that are uncomfortable. Internal politics and entrenched loyalties at all levels of an organization, up to and including the board of directors, will make this type of dispassionate analysis difficult. The danger is that existing biases can lead to a process of rationalizing existing assets and preserving the status quo, when what is needed is a strategic, proactive reassessment that optimizes assets by matching them to the organizational mission and to the new market realities. In any organization, achieving this requires discipline, communication, patience, and transparency.

The benefits, however, can be significant. Clearly defining delivery and growth assumptions and matching them against hard and soft assets is essential to the goal of improving quality while lowering costs. Such an effort, based on market experience, can return cost/revenue improvements of 5 percent to 8 percent over three to five years.

4) OPERATIONAL EXCELLENCE

Over the past 10 to 15 years, most or all of the nation's AMCs have undertaken performance improvement initiatives of various degree and scope. In response to increasing cost pressures during this timeframe, many AMCs achieved significant operational improvement across the clinical enterprise, reducing costs and improving revenue while maintaining or improving quality and patient satisfaction.

This focus on performance, while no longer sufficient to deliver the full measure of gains that the new market will demand, remains a crucial contributor to success in the post-reform environment. As organizations develop new

delivery models and forge new partnerships, they will also need to consider how to continue, expand, and increase the focus on excellence in both existing and new areas of the enterprise.

Specific strategies and areas of focus will differ; the organization and vision of each AMC, including the relative weight given to their three missions, will guide their responses. Yet no matter how the market changes, or at what speed, organizations that increase efficiency and quality while reducing costs will be well positioned to thrive and to continue the tradition of innovation that is the hallmark of academic medical centers.

Our experience suggests that there is another 7 percent to 10 percent of performance improvement available to AMCs over a three- to five-year horizon. In recent years, this is an area where many non-AMC health systems and community hospitals have excelled, achieving significant annually recurring cost and revenue improvements. For example, the three-hospital Trinity Mother Frances Hospitals and Clinics system realized more than $60 million of annually recurring improvement through recent efforts, while the 14-hospital Baptist Memorial Healthcare System achieved $183 million in performance improvement. These results, and those at many other hospitals and health systems, stem from focusing on performance at every level of the organization. The opportunities for AMCs in this area are equally large, or even greater. With their emphasis on innovation and a history of challenging and reshaping the status quo, AMCs may ultimately set the pace for healthcare in the area of operational efficiency as well.

CHALLENGES AND OPPORTUNITIES

The shift from fee-for-service to payment models in which significant portions of revenue are linked to quality and outcomes in risk-sharing agreements requires AMCs to develop new strategies and expand their traditional competencies. Incremental performance improvement is no longer sufficient; operational excellence must be supported by fundamental changes to revenue strategies, care delivery, and organizational infrastructure. Further, the need to operate successfully under the fee-for-service model during the transition makes the challenge of transformation more complicated.

These challenges are significant, but what AMCs do best is innovate and forge new paths, providing leadership in a field that has never been static. While today's challenges may be new, the history of academic medicine indicates that AMCs will seize the opportunity to help lead the change. By doing so, they will continue to play a vital role for the well-being of their communities, the vnation, and beyond.

ABOUT HURON

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