NAVIGANT

THE PATH TO A SUSTAINABLE OPERATING MARGIN, MISSION, AND MARKET ESSENTIALITY

Preparing for the "New Normal"

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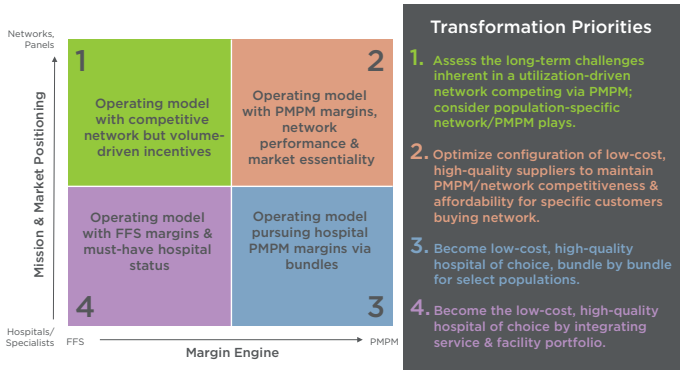
Part two of a four-part series. Click here for part one.

Health systems nationwide are striving to calibrate their margin, mission, market position, and operating model aspirations while facing the new normal of mounting margin pressure.

We observe that most health systems aspire to fall into one of four categories, based on their margin engine, mission, and market position (Figure 1).

Figure 1: Calibrating Future Margin, Mission, and Market Position



As discussed in the previous article in the series, executive leadership needs to recognize that committing to any one quadrant takes considerable attention and time from all levels of the organization — because the operating model (the people, the processes, the tools) needs to match the system's margin, mission, and market positioning aspirations:

- Systems in quadrant 4 will need to double down on being the low-cost, high-quality hospitals of choice. Traditional for-profit hospitals tend to fall into this quadrant.
- Systems in quadrant 3 will need to organize their delivery model, structure, and economics to sustain margins through more per member per month (PMPM) reimbursement. This requires a deeper focus on cross-continuum and bundled products, services, and reimbursement models targeting specific populations. Specialty hospitals often fall into this quadrant.
- Systems in quadrant 1 arguably face the most challenges as they've likely invested millions of dollars in becoming a network yet make the majority of their margins on volume rather than reducing total cost of care. These systems need to reassess their market, mission, and resources, and decide

whether quadrant 1 is sustainable, or whether to move to quadrant 2 or 4 with a scalable, unified platform that improves the overall end-to-end experience. Many of the nation's largest health systems fall into quadrant 1.

- Systems in quadrant 2 need the leadership, operations, and measurement systems to continually optimize the configuration of low-cost, high-quality suppliers to maintain a competitive offering in the eyes of their target customers. Relatively few systems fall into this more enviable quadrant.

In this article, we explore specific steps related to how leading systems "pick their quadrant" and champion change around a clear, compelling, and believable action plan, with a focus on the first of four leading practices — **softening the ground** to help staff change what they do to deliver the intended mission, margin, and market positioning under the new normal.

Leading systems soften the ground by carefully assessing, debating, and committing to their sweet spot between "the boat and the dock" (i.e., their current vs. future quadrant, and the associated timing and magnitude of change). And the more change is necessary, the more time leaders must spend with constituents to ensure the "why" is clear, the "what" is compelling, the "how" is believable, and the "who" is sufficient.

Following is a set of steps we observe systems taking to prepare their organizations for change and the new normal.

Step 1: Diagnose your organization's willingness, readiness, and ability to change

The more change, the greater the need to set the stage and "soften the ground." Thus, leadership teams need to assess their staff's willingness, readiness, and ability to change existing work and organizational structures and decision rights while assessing the market's need for change.

Leadership teams that jump into action before diagnosing their staff's readiness, ability, and willingness to change can get ahead of their team, send mixed messages, and lose staff if not burn them out. Leadership teams that exhibit the greatest success tend to work together to discuss and process the following questions.

- What are our system's top **future** goals and objectives, from the perspectives of our board, staff, patients/customers, and network partners? What's truly non-negotiable?

Figure 2: Framing Objectives, Goals, and Tradeoffs

Network Partners/Providers	Patients/Customers	Board/Staff
		
• Two times the patient care and half as much paperwork /administrative hassle • Top decile national quality and safety rankings • 85% retention rate and employer of choice • $25K-50K potential primary care physician bonus payout and/or referral program • Self-service administrative services, e.g., scheduling, staffing • Clinical alerts with voice activation, mobile capabilities	• Up to $1K annual savings per family of 4 with 75% steerage • 24/7 easy-to-use provider access, e.g., mobile • Integrated, customer-centric mobile reminders for members, patients, and family • Concierge-like services and rewards for health, cost-effective behaviors	• 1-2% added operating margin driven by streamlined ops, reduced overhead, and differentiated services and product portfolio • Real-time data integration, analytics, and activation infrastructure supporting seamless end-to-end experience via hospital command center, network management center, and consumer contact center • Deep, national benchmark data and science focusing work on what matters most to customers • Bottom up (not top down) patient-and provider-centric design

- Which of the following represent the greatest gaps between the organization's **current** reality and its future goals and aspirations?
  - The talent and balance of power between affordability advocates vs. margin advocates
  - Willingness to cede control of clinical operations to a more centralized, standardized approach
  - Infrastructure to support timely decision-making, report outcomes, and process adherence
  - New reporting relationships
  - Lack of clarity or alignment around essential operating margin and days' cash on hand targets vs. total medical cost trend targets
  - Employee incentives
  - Willingness vs. ability to make difficult program and facility consolidation decisions
  - A critical mass of senior leaders who want to leave the system in better shape than when they started
  - A lack of mid-level leadership with experience facing challenges of this magnitude
- Retrospectively, what has your system done to standardize and centralize key functions such as call centers, patient contact centers, and hospital command centers? Prospectively, what **specifically** must change — from a people, process and toolkit-level by function — to centralize staffing, scheduling, patient placement, ambulance and helicopter operations, care management, and transfers?

- Retrospectively, what has your system done (vs. needs to do) with value-based contracting opportunities to improve and diversify margins and reduce total medical costs? For most systems, value-based payments have been insufficient to fund a new operating model, or to justify a different organization to focus on preventive care and wellness or a more deliberate approach to avoid unwarranted variation from evidence-based practice.
- How much margin will be derived under capitation agreements in 3-5 years, mindful of the plethora of hospital-based efficiencies that need to be addressed first?
- How does your organization stack up against payer, physician, and hospital networks capable of making money on capitation?
  - If your organization is 10% to 30% more expensive than competitors, are your physical locations and quality offerings considered to be "must have," and by whom? If not, what makes your organization believe it can sell a compelling PMPM-based product or service?
  - What is your plan to improve the return on your employed medical group? If your medical group net investment or operating loss is greater than $100,000 per primary care physician and $150,000 per specialist, then what revenue, cost, and placement priorities will be made to create a sustainable medical group?

Step 2: Set the stage for change

After taking stock of goals and gaps, boards and leadership should meet to level set on a few key items.

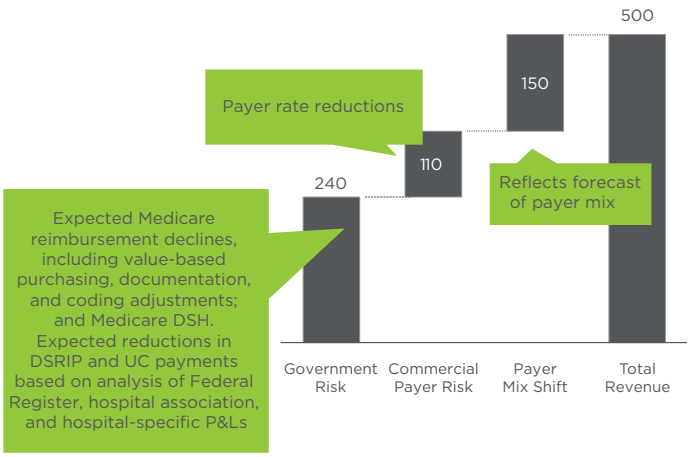
First, they should publicly recognize that the issues listed previously raise generational questions fundamental to their systems' mission, scale, scope, size, and structure. The annual board retreat meeting won't be sufficient to frame, let alone address, these challenges. The system may lose some talent, depending on where it sets its margin, mission, and market positioning goals and sights, and the board needs to recognize changes won't happen overnight.

Next, hospital executives that commit to simultaneously improve operating margins (e.g., to 3-6%) and manage to a lower-than-market total medical PMPM cost trend need to validate the reasonableness of their expectations and timing before they go public with staff and the community. At that time, the board should set the expectation that management's plan clarifies "why" there's a need for immediate change; ensure that "what" must change is compelling to key stakeholders; ensure "how" change will occur is believable; and sufficiently resource the "who."

THE WHY

From a "why" perspective, leaders need to educate line staff — not just management — on why this time is different, and why the status quo is less attractive. A classic approach to establish why is to size the revenue gap, although other approaches such as affordability gaps do exist (Figure 3).

Figure 3: Sizing the Revenue Gap



For academic medical centers (AMCs) and flagship facilities, the "why" of change may be a difficult sell because many of these tertiary/quaternary facilities remain full and can even make margins on Medicare, thanks to supplemental payments. However, the old status of "beds full, pockets empty" is re-emerging, as Medicare cuts loom and patients postpone care that could likely have been delivered years earlier.

Yet, flipping from "high-volume AMC" to "bundle master" to "high-performing, low-cost network" requires specific internal preparation and market acceptance.

For community hospital-based systems, the case for "why" change is necessary appears to be much easier. Although hospitals in more affluent areas have been buoyed by high commercial reimbursement, others have seen a significant increase in bad debt, lower volumes, and deteriorating payer mix.[1]

1. Jeff Goldsmith, Rulon Stacey, and Alex Hunter, "Stiffening Headwinds Challenge Health Systems to Grow Smarter," September 2018: https://www.navigant.com/insights/healthcare/2018/health-systems-financial-analysis.

THE WHAT

From a "what" perspective, leaders need to work with line staff to get employees to buy into the plan so employees are compelled to work smarter — not just harder — and in different ways with others.

The plan must make it easier for employees to deliver — and patients receive — the right care, in the right place, and at the right time and right cost, every time. And this should occur regardless of whether the system returns to its hospital roots or expands to become a true network of care.

Furthermore, the plan should:

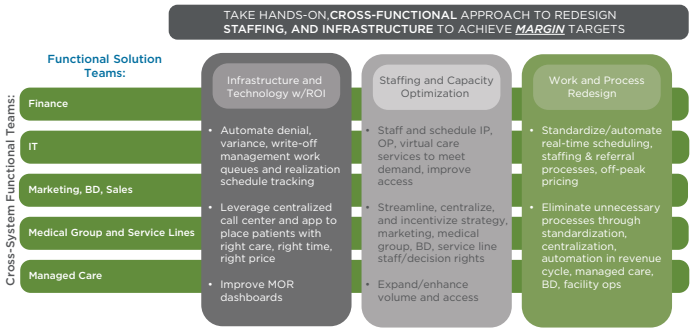
- Reimagine the provider and patient experience on a more streamlined, automated, and personalized platform (e.g., eliminate multiple call centers).
- Reduce such logistical headaches as coding, documentation, data integration, patient identification, scheduling, staffing, and outreach for line staff and their customers and patients.
- Build internal capabilities to better anticipate and avoid errors, unnecessary expense, and wait times, using predictive analytics to start and selective artificial intelligence over time as proof points emerge.
- Avoid "shiny objects" and "flavor of the month" offerings that may change as soon as traction is achieved.
- Offer staff an opportunity to grow their skills for the greater good, potentially under a new organizational structure that emerges as milestones are met.
- Ensure staff and customers have a say in how solutions are designed, deployed, and maintained, using a more standardized method around how opportunities and operations are assessed, designed, deployed, and monitored.
- Potentially include "symbolic moves" (e.g., cutting a program) to send the signal to staff that the status quo is not acceptable.
- Align the strategy, long-range financial requirements including capital and performance improvement priorities, with a monitoring process to ensure progress is made.

The "what" may also benefit from a "common enemy," whether that be a competitor, an intellectual quandary, or the "path of least resistance."

THE HOW

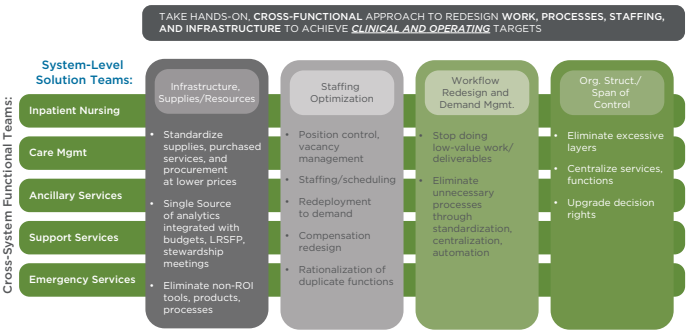
To be successful with the "how," the board, leadership, and staff must all believe it's realistic. This requires "right-sizing" of the work, the processes, the people (e.g., roles, staffing, reporting relationships, committees), and infrastructure/technologies to optimize revenue, clinical operations, and corporate shared services. This cross-functional approach (noted in the exhibits below) is a major investment in time that will challenge the entire organization, but is required if the organization is going to get the improvements required to achieve its goals.

Figure 4: Margin Optimization Redesign — A Functional View



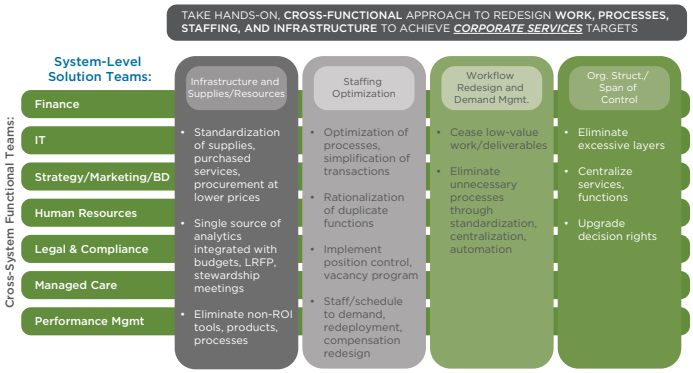
Systematically assess waste reduction, standardization, centralization, automation, and business process optimization (BPO) opportunities

Figure 5: Clinical Operating Model Redesign — A Functional View



Systematically assess waste reduction, standardization, centralization, automation, and BPO opportunities

Figure 6: Corporate Services Redesign — A Functional View



Systematically assess waste reduction, standardization, centralization, automation, and BPO opportunities

Organizational structures also need to be refreshed with clear profit and loss accountabilities, industry span of control benchmarks, and support services to deliver the level of specialty and wellness/preventive services customers will be willing to pay more and travel farther for.

Line staff should have a series of prioritized projects, pilots, proof points, dashboards, and training to establish confidence that their efforts are yielding personal and system gains. This results in line staff reporting their willingness to take on new work, roles, goals, and collaborations with other team members they may not have worked with previously.

Furthermore, internal performance improvement, the project management office, and analytic resources need configuration/alignment to support cost reduction, revenue growth, and diversification projects using a common methodology, set of operating budgets, and overall long-range financial plan.

Finally, system leaders must take a fresh look at affordable access to improve consumer loyalty, starting with such fundamentals as clinician contact hour standards, visit types, hours of operation, use of advanced practice providers and nurse practitioners, and online visits.

THE WHO

It's up to leadership to make sure the "who" is sufficient by ensuring key people aren't asked to take on the impossible (in addition to their regular jobs); succession planning is actively encouraged; next-level talents are engaged in redesigning work, processes, roles, dashboards, and governance; and, internal training and coaching become valued services to staff.

Preparing for change is one of the most overlooked parts of a health system's transformation, yet it is the core of success. It takes special people to prepare the path for a new way of working, particularly if performance has already declined and switching quadrants is necessary. There's no time like the present to assess your organization's readiness to change its work, structures, and systems, and frame the challenges and accelerators with the core group of change agents within your organization who can catalyze the journey.

SUMMARY/CONCLUSIONS

In order to thrive under the "new normal," health system leaders must "soften the ground" to prepare their organizations for change. Doing so requires a clear articulation of the current vs. the future, and clear commitment to their quadrant of choice and timing to get there. But that is not enough. Leaders also must take the time to craft a clear **why**, a compelling **what**, a believable **how**, and a sufficient **who**. Doing so "with" your fellow leaders (rather than "to" your fellow leaders) is critical to success.

Case Study: Texas Health Resources

Texas Health Resources (THR), one of the largest nonprofit health systems in the United States, with 29 hospital locations, employed a deliberate process to convey the why, what, and how when it launched its "Fresh Air" initiative in 2015

STEPS

1. Burning platform (What)
2. Vision for the future (What)
3. Why now? (Why)
4. Focus on fundamentals (What)
5. System transformation office (How, Who, When)
6. Hardwiring behavior change into goals, rewards, behaviors, and the new "THR Way"

From town hall meetings to screen savers, THR canvassed the organization to inspire an initiative that has sustained margins while expanding the system footprint. This includes a major alliance with a health system and a joint venture with a large health plan.

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