Dr. Andrew Agwunobi is a leader of Berkeley Research Group’s Hospital Performance Improvement practice. Before joining BRG, Dr. Agwunobi served as Chief Executive of Providence Healthcare, a five-hospital region of Providence Health & Services in Spokane, Washington.
Hospitals Are Making Financial Progress…But

Aggregate Total Hospital Margins,\(^{(1)}\) Operating Margins\(^{(2)}\) and Patient Margins,\(^{(3)}\) 1992 – 2012

\[
\begin{array}{ccc}
\text{Year} & \text{Total Margin} & \text{Operating Margin} & \text{Patient Margin} \\
92 & -6\% & 0\% & -6\% \\
93 & -4\% & 2\% & -4\% \\
94 & -2\% & 4\% & -2\% \\
95 & 0\% & 6\% & 0\% \\
96 & 2\% & 8\% & 2\% \\
97 & 4\% & 10\% & 4\% \\
98 & 6\% & 12\% & 6\% \\
99 & 8\% & 14\% & 8\% \\
00 & 10\% & 16\% & 10\% \\
01 & 12\% & 18\% & 12\% \\
02 & 14\% & 20\% & 14\% \\
03 & 16\% & 22\% & 16\% \\
04 & 18\% & 24\% & 18\% \\
05 & 20\% & 26\% & 20\% \\
06 & 22\% & 28\% & 22\% \\
07 & 24\% & 30\% & 24\% \\
08 & 26\% & 32\% & 26\% \\
09 & 28\% & 34\% & 28\% \\
10 & 30\% & 36\% & 30\% \\
11 & 32\% & 38\% & 32\% \\
12 & 34\% & 40\% & 34\% \\
\end{array}
\]


“…the average operating margin in 2013 was 3.1%, down from 3.6% in 2012 based on data available for 179 health systems, …A total of 61.3% of organizations in Modern Healthcare's analysis saw their operating margins deteriorate over the previous year.

2013

Source quote: "Fewer hospitals have positive margins as they face financial squeeze By Beth Kutscher Modern Healthcare http://www.modernhealthcare.com/article/20140621/MAGAZINE/306219968
Posted: June 21, 2014
Many Are Still Struggling

Chart 4.1: Percentage of Hospitals with Negative Total and Operating Margins, 1995 – 2012

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2012, for community hospitals, and *DefinitiveHC database.
...and The Next Few Years Won't Be Easier

“Even the strongest hospitals and health systems are, at best, only likely to hold existing margin and reserve levels, (assuming investment market growth) while weaker providers will likely see ongoing operating margin and cash flow erosion and eventually balance sheet pressure leading to rating deterioration which has already materialized and will continue in 2015.”

Martin Arrick Managing Director Standard & Poors
Financial Pressures will Continue

- Weaker revenue environment
  - Still related to the economy with high levels of unemployment and underemployment, reduced health insurance benefits (high – deductible plans)
  - Medicare: sequestration, HAC penalties, re-admit penalties
  - Commercial plans offering smaller rate increases, seeking value based contracts

- Heightened competition for (in)patients; utilization trends remain generally weak

- Increased spending on information technology and physician employment
  - Cost of employing physicians without commensurate rise in volumes

- Many of the ‘easier’ cost cutting tactics already deployed

- Capital pressures building; must shift to an ambulatory strategy

- Pace of ‘reform’ highly variable

Source: Martin Arrick Managing Director Standard & Poor’s
U.S. Not-For-Profit Acute Health Care Rating Actions 2014

Data as of December 31, 2014

Source: Standard & Poor’s
Sample Hospital: “Reaching Beyond the Low Hanging Fruit- Finding the Next 20%”

Historical margins

- Elective volume declines
- Payer mix worsens
- Continued IP shift to OP
- Heightened Competition
- Operations, IT, MD hiring

Historical margins

36M

New margins

Traditional

- Labor 27%
- Revenue Cycle 20%
- HR 13%
- Non Labor 11%

Clinical Redesign

- Clinical Variation
- Models of Care
- Physician Practices
- LOS/Throughput

Source: BRG analyses and experience
What is Clinical Redesign?

Clinical Redesign comprises innovative efforts to reduce inpatient and outpatient clinical costs using a physician co-designed and co-implemented model that:

- Sustainably improves health system margins
- Protects or enhances quality outcomes
- Harnesses and aligns physician participation
- Promotes physician integration within the organization
- Reduces the clinical cost structure and cost per case thus enhancing ability to bear risk
Examples of Clinical Redesign:

1) Clinical Variation Reduction

APR-DRG 174 & 175 – Percutaneous Cardiovascular Interventions with & without AMI

Analyzed inpatient stent procedures with an MS-DRG of 246 – 249 (PCI procedure with DES or non-DES stent)

Variation identified in the following areas:

- Number of stents used per case
- DES v. BMS usage ratio
- IVUS catheter utilization
- Antiplatelet therapies
- Length of stay

Outcome: Interventionalists held monthly meetings to discuss evidence based guidelines for the identified drivers of variation as well as all discuss all cases where 2+ stents were placed.

Resulted in $1.02M reduction in costs over 9 months.
## Examples of Clinical Redesign:

### 2) Models of Care

<table>
<thead>
<tr>
<th>650 Bed tertiary hospital</th>
<th>470 Bed community hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action:</strong> extends hospitalist service to health system-owned Skilled Nursing Facility (SNF)</td>
<td><strong>Action:</strong> redesign intensive care unit model including MD staffing, acuity of patients managed without intensivist consult, palliative care screenings, multi-disciplinary clinical delivery, and virtual stepdown</td>
</tr>
<tr>
<td><strong>Outcome:</strong> reduces SNF related ED visits by 30%</td>
<td><strong>Outcome:</strong> Despite volumes increasing and CMI remaining stable, the unit specific ALOS dropped from 3.7 to 2.5</td>
</tr>
</tbody>
</table>

**Effort co-leadership by hospitalists**

**Effort co-leadership by intensivists, surgeons, hospitalists**
3) Clinical Variation Reduction

APR-DRG 221 – Major Small & Large Bowel Procedures
5 procedures analyzed for opportunity:
1. Lap Hemicolecctomy
2. Open Hemicolecctomy
3. Lap Sigmoidectomy
4. Open Sigmoidectomy
5. Partial Small Bowel Resection

Identified:
• Variation in potentially preventable complications
• Overutilization of ICU, routine CXRs, and TPN
• Opportunity to reduce ALOS.

Outcome: Surgeons decided to adopt evidence based practice pathways for these 5 Procedures-Total $ opportunity identified $631,000.

Effort co-leadership by 7 surgeons
Without Physician Engagement Clinical Redesign Just Doesn’t Work

"I care deeply about the patients. About the administration, not so much."
“More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery systems” - NEJM 2011

1) Source: “Hospitals' Race to Employ Physicians — The Logic behind a Money-Losing Proposition” (NEJM)
Employed or Independent – The Trend

In 2010, MGMA found that the share of hospital-owned practices reached 68% vs. 30% in 2004.

Key Misalignment Themes

**Physicians**
- Data-based decision making/want all relevant information
- Lack of business training/decision making authority
- Skepticism about hospital’s agenda/blame hospital for problems
- Culture of independence and autonomy
- Patient care pre-eminent regardless of margin
- Lack of shared financial incentives

**Executives**
- Data less timely, or detailed
- Reticent to share all information/decision making
- Lack of clinical training
- Skepticism about Doc’s agenda
- Want docs to play with the hospital team
- Blame docs for problems
- No Margin no mission
- Financial rewards for performance

Source: BRG’s observations and experience
Six Steps for Engaging Physicians in Cost Improvement
Step 1: Define the Need

Why should the Physicians Care? And Why Should They Participate?
Creating and Articulating a Compelling Vision

Key Elements

- Clarity
- Patient-centric
- Simple
- Actionable

If you stumble at this step you will lose physicians therefore:

- Be transparent about the challenges
- Seek Physician leadership input into the vision
- Seek physician leadership input into the communication plan
Step 2: Share Clinical Cost Data and Let the MDs Help You Interpret It.

- LOS by APR-DRG
- LOS by MD
- Benchmarking data (comparable/internal)
- Cost per case by physician
- Breakdown of costs into categories
- Margin analysis
- Linkage to overall financial improvement

![Stent Usage per Case by Physician](image)

![LOS by Physician](image)

APR DRG 174 & 175 – PCI w & w/o AMI
## Avoiding Pitfalls – Gaining Alignment

<table>
<thead>
<tr>
<th>Pitfalls</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospitals’ financial, clinical-cost, and operational data will never</td>
<td>• Set realistic expectations - “the data is directional”</td>
</tr>
<tr>
<td>be fully satisfactory to physicians</td>
<td>• Acknowledge data shortfalls upfront</td>
</tr>
<tr>
<td>• MDs legitimately see every patient as different</td>
<td>• Create ownership of the data by making it transparent and easily</td>
</tr>
<tr>
<td>• Many physicians may not understand the clinical-cost/financial data</td>
<td>modifiable</td>
</tr>
<tr>
<td>• Many may be embarrassed to ask basic questions</td>
<td>• Be open and non-defensive in correcting errors</td>
</tr>
<tr>
<td>• More complex data isn’t necessarily better – For MDs it’s not so</td>
<td>• Proactively explain all business jargon and financial terms in</td>
</tr>
<tr>
<td>much about statistical analyses as it is about precise, timely</td>
<td>layman’s language</td>
</tr>
<tr>
<td>information for decision-making</td>
<td>• Translate the data into message before presentation</td>
</tr>
<tr>
<td></td>
<td>• At a minimum use severity adjusted data</td>
</tr>
</tbody>
</table>
## Avoiding Pitfalls – Gaining Alignment

- **Pitfalls**
  - They will ask “what about quality metrics”
  - They will question the objectivity and quality-protection goal if you start with a must-hit financial target
  - They need much more than just clinical cost information if they are to make decisions

- **Actions**
  - Incorporate **quality metrics** and address quality concerns
  - Start with a **process** to identify a $ target not simply a $ target
  - Be **transparent** with cost, revenue and any other data necessary for them to make informed decisions
Step 3: Shared Authority & Responsibility

Geisenger
- MD and administrator paired at every level. Both must agree on a budget and be able to speak for each other at meetings
- Incentive compensation and goals are the same
- The capital allocation committee is chaired by a physician and most of the membership are physicians

-Mayo Clinic
- “…What differentiates Mayo Clinic is the structure that makes the physician accountable for what happens throughout the institution. If the institution fails, the physicians have only themselves to blame. This fact affects physician behavior at Mayo Clinic in a positive way. They must keep the institution’s interests in mind because those interests are aligned with their own.”

-Interview with Dr Hamory Executive Vice President and Chief Medical Officer, Geisinger Health System 8/9/13

“Crucial to clinical integration is giving physicians a real involvement in decision-making at the hospital. Physicians must be able to work with hospital administration to identify a shared set of goals for the enterprise – what do they want to accomplish together – and then they can together develop tactics to achieve those goals.”

Nick Wolter, M.D., CEO, Billings Clinic
Step 4: Provide the MDs with Structure and Guidance

Senior Exec Team

Steering Committee

Cardiology Workgroup
Orthopedics Workgroup
Hospitalists
General Surgery
## Avoiding Pitfalls – Gaining Alignment

<table>
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</thead>
<tbody>
<tr>
<td>• The physicians may not perceive it’s real decision-making authority</td>
<td>• Use combination of early wins, and permission to modify data, to show</td>
</tr>
<tr>
<td>• The physicians will stall, become frustrated or go in the wrong</td>
<td>the MDs they have true co-leadership authority.</td>
</tr>
<tr>
<td>direction without guidance</td>
<td>• Support the work of the committees</td>
</tr>
<tr>
<td>• The physicians don’t have as much time as administrators do to focus</td>
<td>• Provide specialty-specific clinical-cost improvement expertise at</td>
</tr>
<tr>
<td>on financial improvement.</td>
<td>least in initial stages</td>
</tr>
<tr>
<td></td>
<td>• Build on existing committees and hold evening/early morning sessions</td>
</tr>
</tbody>
</table>
Step 5: Focus On Initiatives That Simultaneously Reduce Costs and Improve Patient Care

Higher Quality

Protection or Enhancement of Quality

Future State

Status Quo

Lower Cost

Reduction in Unnecessary Costs

Examples
- ICU Length of Stay
- Unnecessary Consults
- Unnecessary Imaging and labs
- Potentially Avoidable Conditions
- Blood Utilization
- Palliative Care

Examples
- ICU Length of Stay
- Unnecessary Consults
- Unnecessary Imaging and labs
- Potentially Avoidable Conditions
- Blood Utilization
- Palliative Care
Caveats / Consideration

If you don’t keep dollar savings targets (or at least cost-saving Initiatives for implementation) in front of MDs to ensure accountability for progress, efforts will become only about quality.

Therefore:

- Set up a tracking mechanism for documenting implementation
- Set up reporting mechanism from work groups to steering committee

<table>
<thead>
<tr>
<th>E.G Workplan Outline first 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization and Set-up – First 30 days</strong></td>
</tr>
<tr>
<td>Convene first ICU committee to outline work plan and meeting schedule</td>
</tr>
<tr>
<td>Deploy Subject matter expert(s) to gather protocols, competency assessments and other implementation materials</td>
</tr>
<tr>
<td><strong>Quick-Hit Actions – First 90 days</strong></td>
</tr>
<tr>
<td>Modify admission and discharge protocols</td>
</tr>
<tr>
<td>Implement staff-initiated palliative care “assessment” protocols</td>
</tr>
<tr>
<td>Approve protocols for Hybrid ICU</td>
</tr>
<tr>
<td>Implement hybrid CCU</td>
</tr>
<tr>
<td>Enhance competency of routine care staff</td>
</tr>
<tr>
<td>Evaluate benefit of/ plan possible step-down unit</td>
</tr>
<tr>
<td>Compare hospital practice with Evidence-Based Practice (EBP) for Pneumonia, Septicemia, and Heart Failure to identify quick wins</td>
</tr>
</tbody>
</table>

**Critical Planning Activities - Decisions**

- Planning for enhanced care of intermediate patients
- Planning for communication of changed ICU/CCU protocols
- Separation of data/metrics for CCU and ICU to facilitate measurement of success
Step 6: Incentivize Physicians to participate in financial improvement

• Some of the incentives inherent in an physician co-led financial improvement effort are intangible/ non-monetary and apply to both employed and independent physicians:

• Leadership and career development
• Ability to participate in decision-making
• Ability to help patients
• Ability to fix broken operational processes
• Good hospital-citizen duties
• Part of existing medical-leadership role

“To end the current fragmentation, waste and complexity, physicians and other care providers should be rewarded, through financial and nonfinancial incentives, to band together into traditional or virtual organizations that can provide the support they need to practice 21st century health care.”

The Commonwealth Fund, “A High Performance Health System for the United States” (November 2007)
### Overcoming Pitfalls – Gaining Alignment

<table>
<thead>
<tr>
<th>Pitfalls</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Some MDs may ask for compensation for spending time in meetings and contributing their expertise | • Set *expectations* upfront  
• Explore *incentive mechanisms* e.g. co-management agreements  
• Proactively develop a *philosophy and plan* regarding incentives |
Questions?