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Navigating the Stages of System Development

Newly expanded hospital systems must progress through three development stages before reaping the benefits of scale and clinical integration.

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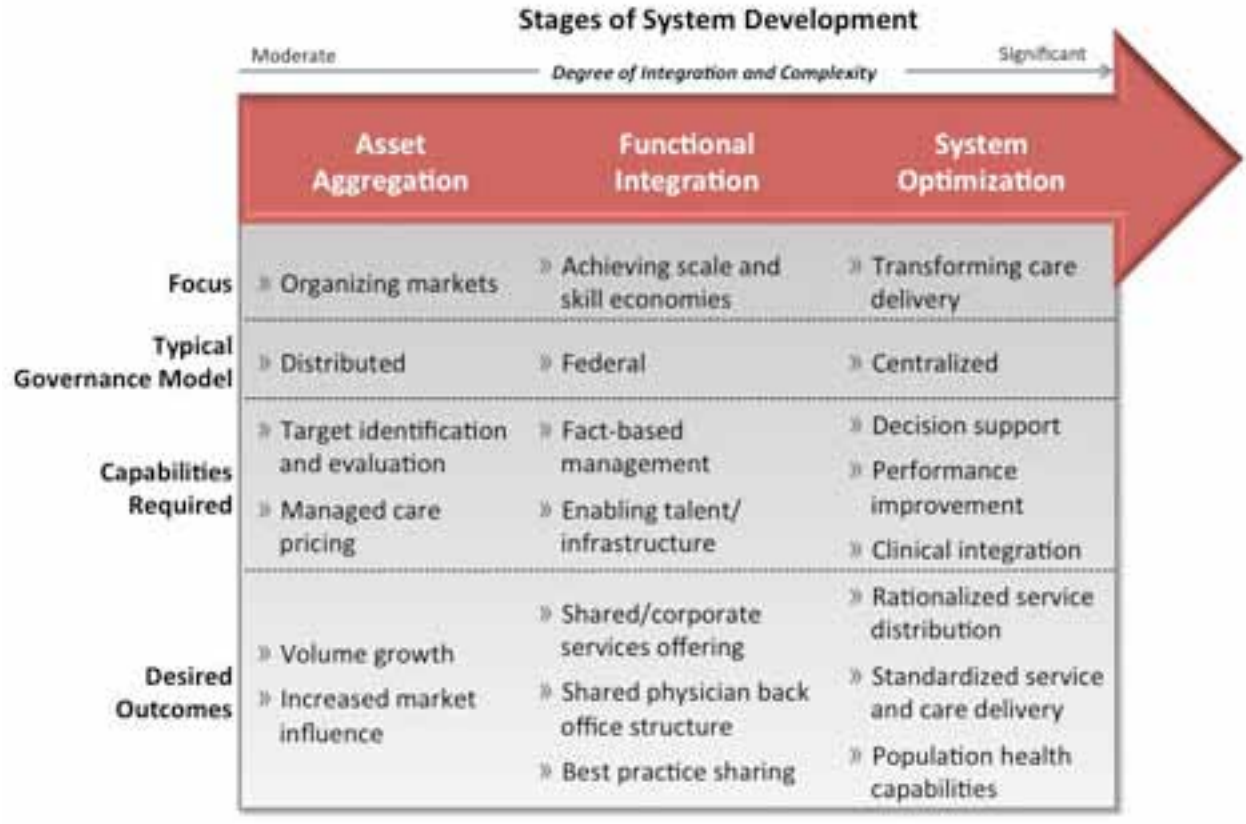
Converging factors have led boards and executive teams to view expanding, joining and forming systems as critical to future success: debt markets are increasingly valuing scale, scale economies are seen as a means to offset revenue erosion, and a large base of covered lives is considered imperative to succeeding in value-based competition.

Yet forming and expanding health systems never guarantee success. Instead, the opposite may be true, as research suggests that most mergers fail to create consumer value. For health system leaders, beating the odds requires successfully navigating three system development stages: asset aggregation, functional integration and system optimization. While some health systems progress linearly through the three stages, many systems navigate the stages multiple times, with regression driven by mergers or acquisitions. Descriptions of each stage, including likely governance models, illustrative case studies and required competencies, follow.

See Stages of System Development, below.



Source: Navigant, 2013

Stage 1: Asset Aggregation

Newly forming or expanding health systems' leaders find themselves in the asset aggregation phase. During this phase, parent systems link hospitals and their associated assets using new corporate structures. In the case of forming systems, the end result often unites formerly competing hospitals under a common corporate umbrella, but with little change in members' organizational structures and operations.

Governance: Asset-aggregating systems frequently use localized governance structures; subsidiary boards retain substantial autonomy, and system-level boards have representative structures, drawing membership from member hospitals' boards. This governance model reflects two realities: first, centralized coordination and decision-making are generally not required to achieve desired synergies, which usually relate to pricing. Second, in an attempt to preserve missions and allay cultural fears, a high degree of retained local control is invariably requested by joining hospitals' leadership and often granted by nascent or expanding systems to "get the deal done," sometimes with agreed-upon migratory paths to centralized governance.

Case study: Prime Healthcare Services, headquartered in Ontario, Calif., is an asset aggregating system. The privately held, for-profit system is a self-proclaimed turnaround expert. From December 2011 through mid-May 2013, Prime announced or executed 12 hospital acquisitions, all outside of California.

Five of Prime's pending acquisitions are New Jersey hospitals. It appears the system is attempting to achieve regional scale and market influence, in addition to capitalizing on a historically challenging operating environment that created an abundance of distressed hospitals. A recent article profiled Prime's turnaround playbook: it provides capital to improve facilities, recruit physicians, add services and, in some cases, enable ongoing operations. It focuses on quality improvement via staff training and medical director additions. Prime has received recognition for its quality improvement efforts and reviving struggling hospitals.

Capability requirements: Asset aggregation principally requires two capabilities: target identification and evaluation, and managed care contracting.

- **Target identification and evaluation:** As in any industry, health care merger and acquisition success regularly hinges upon finding the right partner at the right price. Numerous proposed mergers failed to materialize because of cultural incompatibility. Numerous consummated mergers failed to create value because of poor strategic fit. Still more mergers failed to realize their potential because the acquirer overpaid (either financially or via structural concessions), consuming resources needed to execute post-integration strategies or saddling new organizations with governance structures that inhibit success. As a result, leaders of asset aggregating systems need to attain classic corporate development expertise — the ability to craft merger and acquisition strategies (for example, Prime's focus on distressed assets), systematically evaluate partners, and price and structure transactions appropriately.
- **Managed care contracting:** Unique to health care, aggregating assets further requires managed care capabilities. In the traditional fee-for-service model, this manifests itself as joint-contracting to achieve leverage over payers in transactional, zero-sum game relationships. The fee-for-value model requires a more sophisticated suite of relationships to enable member organizations to reap the benefits of value creation. Examples include scalable bundling, narrow network, medical home and accountable care relationships, with structures that allow members to assume risk equitably and share performance improvement rewards.

Stage 2: Functional Integration

At the height of the fee-for-service era, health systems could succeed through asset aggregation alone. Amassing sufficient market shares over given geographies enabled many systems to achieve more favorable managed care rates and superior financial returns to those of competition.

However, hospital shortfalls in treating governmentally insured patients have expanded significantly over the past 15 years. At the same time, commercial insur-

ers, empowered by their own consolidation and national sensitivity to health care costs, are reining in rate increases, rendering hospitals' long-standing cross-subsidization strategies obsolete.

Recognizing this dynamic, many hospital systems have sought to offset anticipated revenue erosion through functional integration. In this stage, system members pursue cost-efficiencies by merging duplicative, back-office support services such as finance, human resources, information technology, supply chain, revenue cycle and those in physician practices.

While culturally challenging, functional integration usually allows all member organizations to benefit from cost-reduction, while retaining direct control over core patient-facing, revenue-generating functions.

Governance: At this point, the balance of power often begins to shift from member to parent boards, reflecting the need to grant systems purview over consolidated functions to achieve efficiencies. Many functionally integrating systems adopt "federal" governance structures, delineating local and system-level authorities.

Case study: Functional integration has been a major focus for many for-profit and Catholic hospital chains. For example, Tenet Healthcare Corp.'s functional integration journey dates to 2003, when it initiated investments to centralize its revenue cycle systems and personnel. After achieving successes internally, Tenet formed Conifer Health Solutions in 2008, offering its services to other provider organizations. Conifer provides Tenet opportunities to achieve growth, and leverage internally developed, scalable business process management resources and capabilities.

By 2012, Conifer provided services to about 380 provider organizations, and its services included not only revenue cycle management, but also capitation risk management and patient communications like scheduling, marketing support and post-visit outreach. Conifer says it can "typically achieve a 3 to 6 percent improvement in yield from enhanced revenue-cycle operational performance."

Capability requirements: The value-creating cost synergies resulting from functional integration are easily identified and quantified, but seldom easily accomplished. Benefiting from functional integration demands that system leadership makes fact-based decisions and invests in enabling talent and infrastructure.

- **Fact-based management:** Pursuing cost synergies inherently requires culturally tough decisions. Positions must be eliminated. Single, best-practice processes and systems must be adopted. In some instances, functions must be outsourced altogether. The analytical exercise of identifying the most financially prudent decision in these areas is easy. Implementing the optimal direction, however, is politically challenging, as communities exert political pressure to retain jobs, employees jockey for position and nonprofit cultures collide with decidedly business decisions. Plainly stated, health systems that succeed at functional integration are those led by teams that develop scalable, cost-effective shared services, despite myriad pressures to compromise.
- **Enabling talent and infrastructure:** Many nascent and growing health systems are ill-equipped to expand system-level responsibilities, which is necessary to move beyond asset aggregation. For example, skill sets and information technology used to provide a single hospital's finance function differ dramatically from those required to provide corporate finance support at multibillion-dollar organizations.

During functional integration, astute health system leaders do not blindly seed shared services with member institutions' pre-existing personnel and infrastructure. Rather, existing managerial talent and infrastructure are evaluated and, where necessary, new teams and infrastructure or outsourcing solutions are installed to overcome barriers to efficient consolidation.

Stage 3: System Optimization

Functional integration, though important, likely will be insufficient for health systems to remain viable. A transition to value-based competition is under way, the implications and underlying drivers of which have been well-documented.

As a consequence, system leaders must

optimize their systems to survive. Leaders of optimizing systems attempt to transform care delivery approaches, shifting emphasis from patient aggregation to patient appropriation (matching patient needs to delivery site cost and resource profiles) and improving population health.

System optimization requires asset and process plays. Asset portfolios must be rebalanced to reduce costs and improve quality and service by offering less resource-intensive, higher-utilized services across lower-cost settings, while concentrating resource-intensive, infrequently used services at fewer locations. From a process perspective, systems must eliminate care delivery variation, consistently adhering to best-practice care and service protocols.

Governance: At health systems that have not already centralized governance, the transition from functional integration to system optimization mandates consolidation of authorities. Absent members granting their systems jurisdiction over capital deployment and programmatic strategy, optimization synergies remain virtually unattainable. In many cases, local boards are relegated to advisory roles, retaining direct responsibility for clinical quality, medical staff credentialing, community needs assessments and fundraising.

Case study: Few health systems have achieved complete optimization, but Florida Hospital illustrates progress. The $8 billion system serves the Orlando market with seven hospitals, all sharing a single provider number.

It has established distinctive roles for individual inpatient campuses. Virtually all campuses offer primary and emergent services; whereas, referral and advanced programs are concentrated at one or a few locations. Florida Hospital has expanded ambulatory access through an owned urgent care network, creating distributed access to urgent services in low-cost settings.

Florida Hospital's asset strategy is supported by Florida Hospital Healthcare System, its integrated delivery network. Launched in 1995, FHHS is a partnership between Florida Hospital and its affiliated physicians and is governed by a board of directors comprising physician and hospital representatives.

FHHS offers full, third-party administrative services to self-insured employers through a comprehensive managed care network that includes owned and partnered care sites across a nine-county region. Recently, Florida Hospital announced its intention to further extend its proprietary network by launching a health plan in partnership with Health First. The long term objective is to offer Medicare and private products throughout central Florida. FHHS' stated goal is "to effectively coordinate high-quality, cost-effective patient care and help members remain healthy."

Capability requirements: Beyond value-based pricing strategies, as demonstrated by FHHS, system optimization necessitates decision support, performance improvement and clinical integration capabilities.

- **Decision support.** First, optimization compels system leaders to markedly improve decision-support capabilities. Today, opportunities to reduce costs, improve quality and improve service often cannot be achieved because they cannot be identified. Data are not collected or reside in disparate organizational settings (for example, physician offices, hospitals, payers), with limited connectivity across organizational boundaries. Electronic health records represent an important step, but provider data must be linked to payer or employer information. Additionally, sophisticated analytical tools and support personnel, which have long represented the hallmark of competition in other industries (for example, retail and hospitality) must emerge within provider organizations.
- **Performance improvement:** Abundant data and analytics provide little value without the ability to act on information. Consequently, optimizing systems must couple decision support with performance improvement discipline. Systems that win in the new paradigm will be those that convert diagnosed cost, quality and service opportunities into patient value by systematically designing, testing, implementing and improving responsive care and service protocols.
- **Clinical integration:** System optimization also requires moving hospital-physi-

cian relationships past finances to clinical integration. Advocate Physician Partners, Rolling Meadows, Ill., defines clinical integration as "a structured collaboration between [physicians] and [hospitals] on an active and ongoing program designed to improve the quality and efficiency of health care." Regardless of the financial model and structure used, five building blocks must underlie clinical integration efforts: shared leadership; coordinated provider networks; unified care and service delivery models; information technology and connectivity; and standardized clinical performance.

Strive for Optimization

Though the feverish pace of consolidation may continue, expanding or joining systems no longer will be sufficient to enable health systems and hospitals to succeed. Mounting reimbursement pressures and a competitive paradigm in transition require systems to extend roles beyond asset aggregation to survive. Successful systems will be those that rapidly develop requisite governance models and capabilities to functionally integrate and optimize care delivery. Health system boards and executive leaders should consider carefully the changes and investments required to enable their individual systems to win in present and future system development stages.

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