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FROM SUBSIDY TO INVESTMENT: DESIGNING CONTEMPORARY FUNDS FLOW MODELS FOR ACADEMIC HEALTH SYSTEMS

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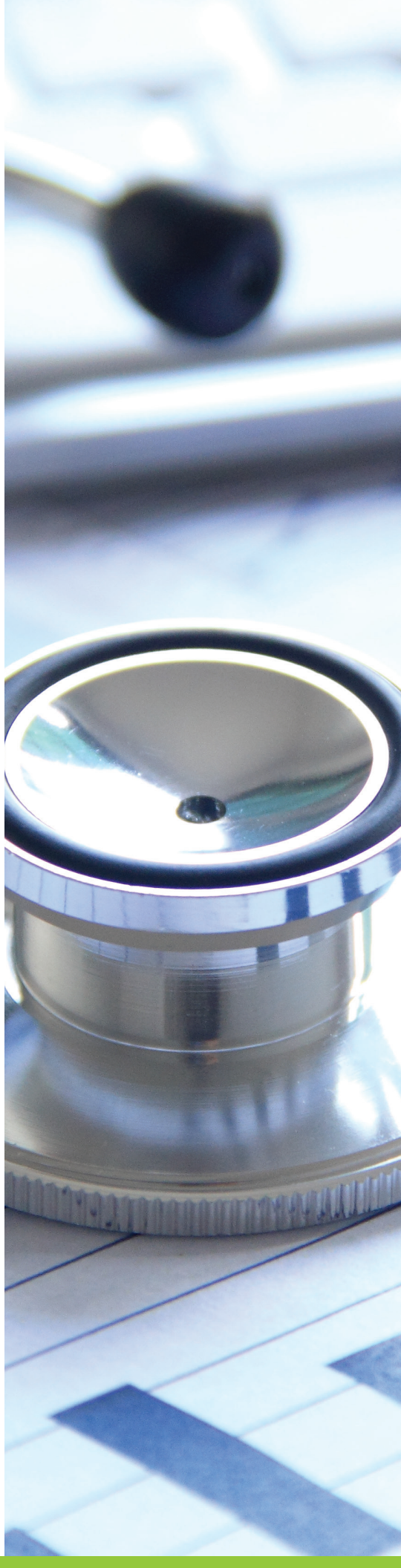


BACKGROUND

Academic health systems (AHS) are unique, complex, and highly matrixed organizations. They are responsible for multiple missions, including delivering extraordinary clinical care, innovation, and discovery while educating the next generation of providers. Fundamental to the AHS multi-mission promise is financial investment and support of all missions.

The major source of revenue for most AHS is the clinical care provided to patients. Funds flow from clinical revenues allows investment in the research engine to develop novel and cutting-edge solutions, recruit faculty, support clinical programs, and deliver superior educational material.

As a result, movement from subsidy to investment and development of the optimal model for funds flow support across missions is becoming an important leadership imperative for AHS CEOs, deans, and clinical leadership. But a fundamental question remains: What is the correct amount of investment of clinical funds to support academic missions?

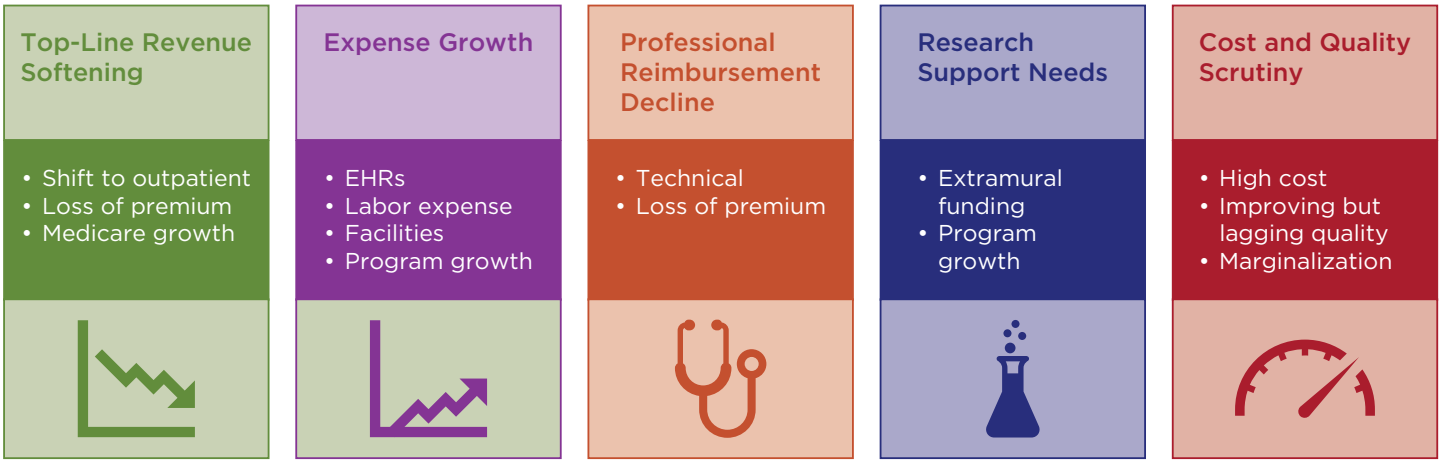
Funds flow has historically been viewed as a "subsidization" of academic missions. We do not hold this view, believing instead that investment of clinical funds into academic missions is similar to investment in research and development, with the expectation of a return on that investment.

Funds flow models often consisted of multiple negotiated agreements between the hospital/health system, college of medicine/university, and faculty practice plan. These agreements were often negotiated independent of one another, were not strategically aligned across missions, were complex to administer, and lacked transparency across business units.

As the healthcare landscape has evolved, AHS are facing significant economic headwinds. For example:

- Hospitals and health systems are experiencing top-line revenue erosion and growing labor expenses.
- Faculty practice plans are more dependent on support due to declining professional reimbursement and lack of technical revenue.
- The growth of research programs and decreasing extramural support make colleges of medicine more reliant on clinical dollars.
- Furthermore, AHS lag nonacademic counterparts in cost and quality metrics, threatening marginalization by payers and networks.

Factors Driving Academic Health Systems to Evaluate Funds Flow Models

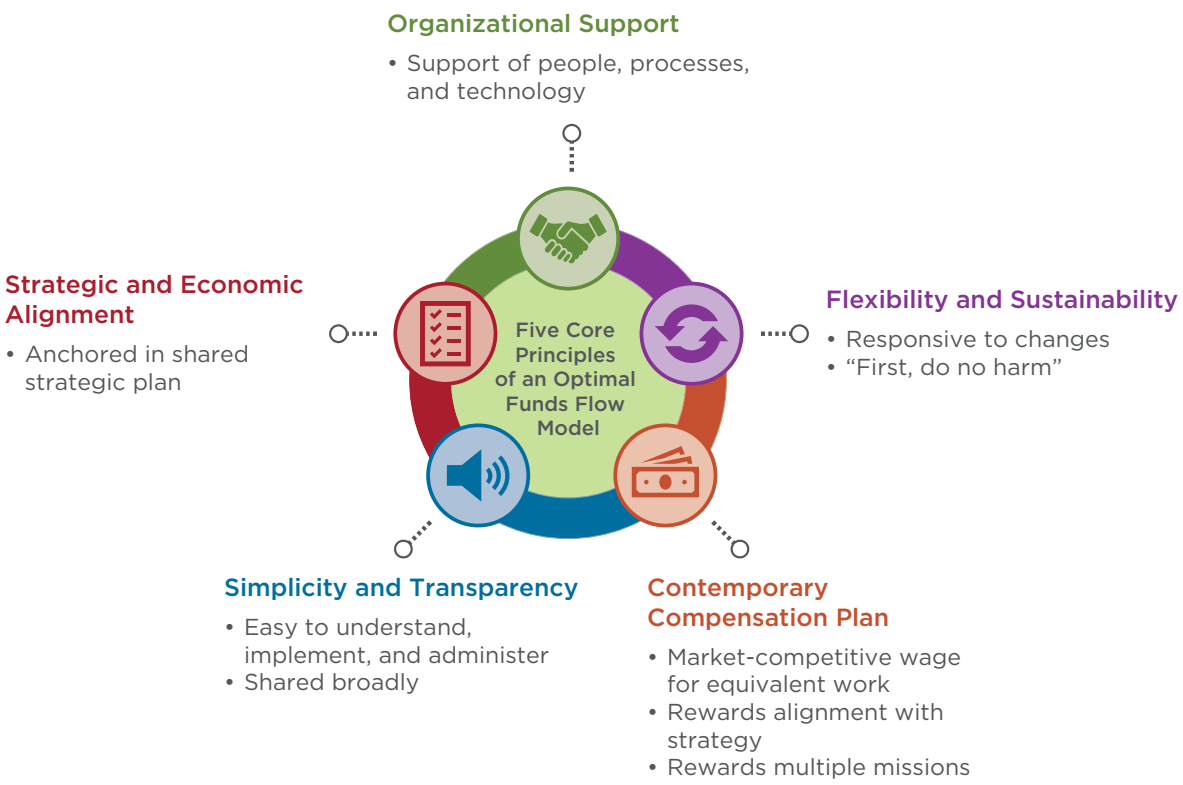


It is this perfect storm that has many AHS evaluating their current funds flow models and looking for trusted partners to assist them in developing an optimal model.

SUBSIDY TO INVESTMENT

In today's volatile healthcare environment, funds flow should be viewed as an investment in enterprise strategy and not a subsidy. Central to that belief are several core principles that help frame an optimal, next-generation funds flow model.

5 core principles of a successful funds flow model

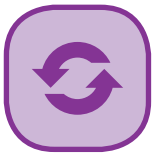


1. **Organizational support:** Any funds flow model must be founded on principles agreed upon by all stakeholders. A redesigned, contemporary funds flow model needs the support of people, processes, and technology to move through the necessary steps of evaluation, design, socialization, and implementation.

2. **Strategic and economic alignment:** The optimal model must be anchored around a shared economic and strategic plan that directs flow of support across missions based on agreed-upon enterprise goals. It is essential that the model is designed to withstand the stress of an ever-changing healthcare and academic landscape. Essential in any model implementation should be a "glide path" to full implementation to allow for acclimatization to the new model, and to mitigate unintended consequences as the model unfolds. This strategic and economic alignment should extend to AHS unit leadership with incentives that reward enterprise performance, in addition to individual unit performance.

3. **Simplicity and transparency:** Legacy academic mission support often results in multiple agreements that must be consolidated into a single model of support that is easily understood and administered, and transparent across all AHS units. This must be done with respect, recognition, and incorporation of historical key agreements that are critical to the function of academic units.

4. **Contemporary faculty compensation design:** Since faculty compensation accounts for a significant portion of academic funds flow, a faculty compensation plan is critical to an optimal funds flow model. The compensation plan must be contemporary and aligned with the strategic goals of the AHS. The plan should provide market-competitive compensation and reward not only clinical productivity but other important areas of performance, including value, patient and family experience, access, quality, safety, and contribution to academic missions. The components of these performance metrics and their weight in the compensation plan should be driven by each AHS' aligned strategic goals.



5. **Flexibility and sustainability:** The optimal model must allow future iterations to respond to changes in strategy and external factors, and always respect the fiscal sustainability of all stakeholders. Following the Latin phrase "primum non nocere," the optimal funds flow model should "first, do no harm."

KEY COMPONENTS TO A CONTEMPORARY FUNDS FLOW MODEL

Some might say that "once you have seen one funds flow model, you have seen one funds flow model." But the reality is there is no one-size-fits all model, with each model composed of several key components. How these components are adapted to each use case depends on many variables, including an understanding of structure and governance, degree of integration, overall enterprise strategy and goals, and the business readiness of the organization.

A general description of these components is outlined below. Not all components are applicable to every institution, and must be adaptable and modular to fit an institution's needs.

1. **Fixed or floor funding** — Directs support to several key areas:
   a. **Departmental expense support** — Considers academic department labor and non-labor expenses, including overhead/fixed expenses and faculty/nonfaculty salaries. It is built upon historical support knowledge, departmental expense buildup, and budgeted clinical faculty productivity/compensation plan.
   b. **Basic academic support** — Provides the dean's office and/or college of medicine with support that can be deployed at the discretion of the dean. There are many models on which this can be based depending upon the organization.

c. **Key supported services** — Supports such key services as medical directorships, education, and fixed coverage needs (e.g., trauma, hospitalists, intensivists).

The fixed or floor funding component can grow annually, indexed to some measure of inflation. Rules should be put in place to protect from financial exigencies and allow rewards during times of exceptional performance.

2. **Variable or performance-based funding** — Directs support to several key areas of the academic enterprise. The amount of funds that flow to these components should be driven by enterprise performance and distributed based upon defined metrics. Often, a gate can be inserted that opens when performance on key organizational metrics is met. For example:
   a. **Growth fund** — Based on a measure of top-line growth (e.g., revenue growth). A portion of this funding often flows directly to an agreed-upon workforce and faculty recruitment fund.
   b. **Strategic fund** — Based on a portion of bottom-line performance, such as operating margin, contribution margin, net income, and performance variance to budget, or EBITDA.

   Funds from both a growth fund and strategic fund can then flow to the dean's office, departments, service lines, or additional recruitment opportunities, based on agreed-upon gated performance criteria.

Academic health systems are multifaceted, nuanced organizations with multiple stakeholders. Redesigning a funds flow model must respect those nuances and the required change management during the process. In moving from subsidy to investment, strategic and economic alignment is essential. AHS that address this process in a deliberate and metered manner will find themselves in a position to improve and transform in alignment with their strategic objectives.

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Daniel DeBehnke, MD, MBA, is a managing director at Navigant, overseeing the firm's academic health system solutions. A board-certified emergency medicine physician, Dr. DeBehnke most recently served as CEO of the Nebraska Medicine health system and CEO of Medical College Physicians, a faculty practice plan affiliated with Froedtert Health and the Medical College of Wisconsin. He also was senior associate dean for clinical affairs and chief clinical integration officer at the Medical College of Wisconsin and has practiced on the front lines of Level I trauma centers, led a research laboratory, and participated on U.S. National Institutes of Health review panels.