ROUNDTABLE

An Enterprise Management Approach to Healthcare

Healthcare delivery and financing models are evolving rapidly as healthcare reform means hospitals and systems need a sharpened focus on the healthcare trifecta—the patient experience, operational efficiencies, and financial health. Unfortunately, many are faced with gaps in operational knowledge as they reinvent themselves. Never has the call for strategic collaboration been stronger, but as hospitals redirect their time and resources to unfamiliar areas, success hinges not only on their ability to start or change initiatives, but also on targeted operational and clinical support that can be turned on and scaled up quickly. Collaboration has become more than a leadership philosophy. In the value era it is a key business strategy that can trim costs while providing direction and solutions in areas vital to a healthy bottom line, including technology, workforce, revenue cycle, and supply chain. An enterprise management approach to healthcare can provide proven teams that are focused on their respective areas of expertise, allowing executives to effectively focus on their core mission: enhancing clinical processes to improve healthcare quality and patient outcomes.

PANELIST PROFILES

GUY MEDAGLIA
President and CEO
Saint Anthony Hospital
Chicago

ERIC DEATON
CEO
Danville (Va.) Regional
Medical Center

PATRICK J. CAWLEY, MD, MHM, FACHE
Executive Director/CEO
MUSC Medical Center
Charleston, S.C.

MICHAEL O'BOYLE
President and CEO
Parallon
Franklin, Tenn.

PHILIP BETBEZE (MODERATOR)
Senior Leadership Editor
HealthLeaders Media
Brentwood, Tenn.

Roundtable Highlights

HEALTHLEADERS: *How is the task of leading your organizations becoming more complex as you take more responsibility for quality and outcomes?*

ERIC DEATON: We don't have much control over outcomes pre- and post-admission. So we have to collaborate more with postacute entities to make sure patients are compliant, that they're getting the correct treatment, and that we're able to reduce costs while enhancing quality. We still have not gotten to the point where patients are taking responsibility for their own healthcare. That is a big part of our challenge going forward. We have partnered with many entities to work on the postacute side with patients to make sure they're educated and that they are getting the correct treatment inside and outside the hospital.

GUY MEDAGLIA: Getting out into the community was a strategic challenge for us. But we've been able to overcome that through a community program that focuses from the time you're discharged to your follow-up appointment. We're not throwing money at it; we're being strategic by pulling in resources through other not-for-profit community services. It is complex. It's always going to be a work in progress.

PATRICK CAWLEY, MD: Getting providers educated about the new paradigm is work in and of itself. You can't just focus on the admission. You've got to think long term, and that is a constant education process because until providers buy in to that, we're not going to span those transitions of care. You've got to start thinking from the patient perspective. I'm not talking patient satisfaction, but really what bothers the patient.

MICHAEL O'BOYLE: There's no easy answer. The issues being addressed get more complicated every day. Managing a service business requires better information and more coordination than ever before. And the financial realities are more compressed and more challenging than ever. The employer community and the governing bodies want to make the answers simple, but they're not. They want answers that are easier said than they are practiced.

HEALTHLEADERS: *Given that complexity, have you empowered your subordinates to utilize outside expertise to solve some of these problems?*

DEATON: We have utilized Lean and Six Sigma practices throughout our organization. We're breaking down and scrapping processes that have been in place for years but obviously cannot work in the future. We have a full-time Lean professional. My job is to help him approach people in a way that's not frightening so they know there's going to be a positive outcome.

O'BOYLE: From a service perspective, delivery systems have to get their leaders to use a more standardized methodology to approach problems. Lean and Six Sigma only get you so far. Getting your people involved in national societies or best practice organizations can provide ideas, but not necessarily the best solutions. When I was working in a provider setting, we were focused on labor utilization, and a problem we were having was adjusting staff to meet the census level. Our experts got us about 80% of the way, but we just couldn't get the last pieces done. There were necessary components to improve analytics, with the biggest part being a daily management tool. But knowing where to go and receiving a collaborative approach to get there were two different things. Sometimes you needed an outside perspective for help practically and politically.

MEDAGLIA: In 2007 our hospital had over $60 million in debt and was losing $12 million a year. My first goal was to make sure that we created an environment where a talented senior team could play off one another and challenge each other. That helped us in areas that traditionally were a struggle, like nursing. We had to become more efficient to reduce our expenses while still improving our quality. A lot of that involved reaching outside the industry and was done out of the need to exist. We're pushing everybody to go beyond what they feel comfortable with. That's difficult to do. It doesn't always make you popular.

Guy Medaglia
President and CEO
Saint Anthony Hospital

HEALTHLEADERS: *As leaders of your organizations, how do you decide what to focus on first?*

CAWLEY: You have to be looking at strategic collaborations that will take the organization to the next level. At the same time, you've got to empower the team. They have to move into a mode of continuous improvement. That requires education, good leadership, and great communication. But even that's going to be insufficient. Businesses are tired of double-digit increases in insurance and premiums. They're

looking for drastic changes in the level of cost, and if we don't deliver on it, the solutions will be given to us.

DEATON: One of the issues that concern people relative to healthcare delivery is the speed at which decisions get made. In our industry, some things take forever. And it frustrates the heck out of those who pay the bill and are involved in other industries where decision-making doesn't take so long. But you think about the collaborations that are necessary and you can understand why healthcare happens at the pace that it does. The right balance is hard to find. We have to make better decisions faster, because time is not on our side.

Eric Deaton
CEO
Danville Regional Medical Center

HEALTHLEADERS: *These connections that you're trying to make with outside providers and trying to get people to access care in the right place at the right time make sense, but the ROI isn't necessarily there yet.*

MEDAGLIA: When I first entered the industry as a consultant, the first place I was at there were some clinics and when I did an analysis of all of them, they were losing money. The CEO says they're supposed to. That drove me a little crazy. At Saint Anthony, we determined that in order to make our clinics profitable we needed a new clinic model. I have two clinics under this new model, and both make money. One is 18,000 square feet, of which 8,000 of it is rented to a federally qualified health center. So now I have my primary care there and I'm collecting rent. The community needed a dentist. So a dentist rented 1,000 square feet. Also, within that building, Saint Anthony is offering specialty services like occupational medicine, rehabilitation, immediate care, and a 15-chair dialysis center. The rental partnership concept seems to work.

CAWLEY: Every component has to work on efficiency. You've almost got to go back to traditional business concepts—the parts make the whole. And this business of cross-subsidization has to get out of our heads. If a part isn't working, then you have to figure out whether you can get rid of it or not. There are times to make a strategic decision to have a loss leader, but let's make the decision rather than say, "Oh, that always loses."

O'BOYLE: Part of the solution is having the data to understand what a loss leader is and is not. Frankly, healthcare has that figured out much better than other industries give us credit for, but solving the problem is often dependent on how you get paid for providing a service. When you walk into a retail store and you buy an item, the store knows exactly how much and when they're going to get paid. They can forecast it adequately and appropriately, and it doesn't matter who buys the item. In healthcare, how much you receive depends on who pays the bill, how much each party to the transaction is responsible for, and how the bill gets adjudicated when a third-party is involved. That uncertainty is complicated to predict with great accuracy.

HEALTHLEADERS: *Clinical decision-making and finances go hand-in-hand like never before. How do you deal with the intersection of the financial and the clinical?*

CAWLEY: We've developed a specific process. It starts with physicians, then pulls the clinical team in, and together they develop a care plan. We call it MUSC Care, and it could be around a procedure or diagnosis or symptom. And there's an expectation to develop a standardized way to approach that problem. We have a medical librarian who specializes in reviewing evidence-based medicine, and that's been helpful. But the team has to come together and decide the approach. Once they decide, we marry them with our analytics team and start measuring. We can't measure everything. We're at the point that we're still developing our analytics and getting the right tools. And we're knocking on the door on how to give them the data in real time. At best, it's still a few weeks old.

O'BOYLE: One question that needs to be answered is why certain tests need to be done multiple times. For example, I have a relative who had a heart problem and had all kinds of tests performed by a very reputable hospital. However, the hospital had trouble diagnosing the issue, and so he and his tests were referred elsewhere. The second facility did the tests again, even though they were done only days earlier. I'm not a clinician, so I don't pass judgment, but if you're an outsider looking in, the process makes little sense. There needs to be an increased focus on enabling technologies and effective processes to better integrate the financial and clinical.

CAWLEY: One issue is the incentives, which are usually wrong. It does hurt to redo all those tests. But there's a clinical issue, too. There are a core group of tests that, depending on the institution, may need to be repeated. You're never going to get away from that completely, but you've got to change the incentive. You've got to actually incentivize us to not repeat, to actually look at it from the patient's perspective and the total cost of care. Some of the financial incentives force medical centers to do the best for their system rather than the patient.

MEDAGLIA: I have a split of employed and private practitioners. And no matter who I go to, what always comes up when I look at repetition on tests is, 'Look, I'm the one that's going to get sued.' I don't know whether or not that's a legitimate reason. But that's contributing a lot of excess costs, an awful lot. And it's a waste of productivity.

CAWLEY: There is some data to back up that the worry of lawsuits is legitimate, but it's more complex than that. In Charleston, we have a health information exchange, which is in all the hospitals, and every emergency room in the area has access to exactly what tests were done at the other hospital. And we've started to link it up to primary care offices. But some of the offices and emergency rooms are not checking it. But, once again, there's not an incentive. They're getting paid at the end of the day whether they do that chest x-ray or not.

DEATON: It's difficult right now because we're going two different directions. We're going down one based on quality outcomes, another one based on being paid for what we do and the number of tests we perform. I've been in healthcare for 28 years, and it's as hard as it's ever been trying to balance those issues right now. We have to educate our staff to understand that we have to reduce costs in the system for the viability of our hospitals today and in the future. And we have to make them understand that this does not mean undermining quality—both can be achieved.

HEALTHLEADERS: *What do you consider to be your core, mission-specific responsibilities that you would not be willing to delegate?*

MEDAGLIA: For us it would be our community program, staffed with 22 people. We have a variety of programs that the community can access. We offer GED programs. We have Spanish-speaking programs. We have counseling programs. The counseling programs are tied to mental health, but it's outside of the realm, because there really is no adolescent mental health program in our area. And we have programs that cover understanding insurance.

DEATON: A few years ago, I would have said there are a lot of things we would not farm out. But today, I can't really think of anything where I would not consider partnering. Our business office and materials management is a good example. The business office is something, given collections, that's very close to your community. So how that's handled is really important, because if someone has a bad experience and that's the last thing they did involving you, that's what they remember.

CAWLEY: I can't think of anything that I wouldn't potentially delegate out or subcontract. It gives you flexibility. The other thing it gives you is a natural re-look, because we want the best; the other company wants the best. So both sides are constantly evaluating as opposed to if you had it yourself, you may only reevaluate it if it's a problem. The only thing that stops us from doing more right now is that there are not enough services that you can contract to on a reliable basis. Or maybe there's only one company that provides that type and there's not competition in the market.

HEALTHLEADERS: *So you're building time for you to focus on political or cultural issues?*

CAWLEY: What I like about outsourcing is I can sit down across the table from the other company and we can talk about the vision about what I expect, what they expect, and we keep it at a high level and then drive down on metrics. And value is clearly on the table. I don't always get that in my own leadership team because I may have a middle manager running that process who doesn't fully appreciate or understand the bigger strategic issues.

O'BOYLE: Leaders are more willing to outsource certain operational functions, for example, than they are a business office because they perceive a greater accountability for control over cash. That said, we're seeing more and more providers seeking solutions in all operational areas. Every provider's comfort level is different, so picking a partner is critical. Outsourcing companies are an extension of the hospital and/or physician, so expertise and approach really matter.

Patrick J. Cawley, MD, MHM, FACHE
Executive Director/CEO
MUSC Medical Center

MEDAGLIA: There was a time where everybody thought that our CEO had lost his mind, meaning me, because I wanted a divorce from Ascension. Part of the reason was so I could get my own partners. We started to look at partnerships ahead of that. I knew I couldn't afford an IT system. But I was able to outsource it and come up with a better partner. Ascension is well run and very efficient, but I saved an awful lot of money after the separation. I don't think enough organizations look at the benefits of outsourcing. They see the security of a big system. Once we started to get healthy financially and people in Chicago started to take notice, we were able to go to tertiary facilities and ask them to work together. Developing those types of relationships is, in a way, outsourcing.

DEATON: We're part of LifePoint Hospitals, a system of almost 60 hospitals

in communities similar to ours. One of the things that I really like about that is the ability to pick up the phone and call a fellow CEO and ask, "How are you doing this?" and not have to go outside our organization. There is also ease of benchmarking. We get a lot of statistics from other hospitals within LifePoint that we compare with our own.

CAWLEY: We have found that with some collaborations, we know we're the right partners and you can't force it because there's trust that has to be earned first. You might have to take a year or two of establishing that trust before you can actually get to a better discussion around how you can collaborate to achieve economies of scale. You try to force it, it might take you longer. In some of our more recent collaborations, we've learned to just relax, let's try something small, maybe get a win around that and then expand.

Michael O'Boyle
President and CEO
Parallon

DEATON: If we can't provide a service, Duke University Health System, our partner in Durham, usually can. It's about an hour away, so it's easy for us to get patients there. The key is making sure those patients come back to us. One of community doctors' biggest fears is that when their patients get into a big system, it's hard to track them, and they never see that patient again. That's a real dissatisfier, so we have to work to ensure patients return to our local community for care available here.

HEALTHLEADERS: *Guy, you've developed another way to get the partnerships you need with your Focal Point project.*

MEDAGLIA: Focal Point is allowing us to develop some partnerships with organizations that wouldn't even look at us before. We came up with this private-public partnership concept. We understood what the community wanted in the way of education, recreation, even hospitality. So the idea was, if we create this private-public partnership, we would be able to take the funds from the private component and have it generate financial resources for the rest. The city contributed 11 acres, and the anchor is a replacement hospital. But the development is a little over a million square feet. We have our 150-bed hospital that could actually scale down to much less. Then we have a charter school. We have a vocational school that's going to pay rent to the corporation. We'll also have retail, a recreation center, day care, and adult day care. The majority of them pay rent so the hospital anchors a community within a community.

> **"Good partners** recognize that they are agents of the health system or company that employs them and must be sensitive to the needs of all parties touched by that system."

HEALTHLEADERS: *We're not there from a financial incentive situation, but what advice would you give to your peers regarding partnerships?*

MEDAGLIA: First, you have to take some risk. The best advice I can give is take your organization and run it like a business. In the end, I don't care if it's a for-profit or not-for-profit model, you're accountable for the performance of the organization. Don't blame somebody else. Don't blame the commercial insurer, the doctor, the state, or the feds. It's changing and you have to get out in front of it and find out how to make it work for you.

DEATON: You have to leave your ego at the door and know that you don't have all the answers. It's good to listen to people who are closest to providing care for the patient because they really know where the rubber meets the road because they do it every day. At the same time, you can't be afraid to be a leader. You can't sit back and let other people make decisions for you.

CAWLEY: Believe that value as defined by the patient is where we're going. Not as defined by the employer—even though the employer pays for most of it right now—or the insurance company or the provider, but if we provide a product that is superior in the eyes of the patient, it'll all be fine in the end. We have to retrain our thinking to do that. But we have to believe in it first.

O'BOYLE: There's always more than one entity that has to be considered where financial incentives are concerned. While it starts with the provision of care to the patient, it doesn't end there. The process often includes the employer, the payer, and the regulator, along with others. They're all customers of the system, and problems are created if a partner doesn't satisfy each of them across the value chain. Good partners recognize that they are agents of the health system or company that employs them and must be sensitive to the needs of all parties touched by that system.

Reprint HLR1113-4

EXPERIENCE AND PARTNERSHIP CAN CHANGE EVERYTHING.

THAT'S THE VALUE OF COLLABORATION

At Parallon, we know from experience that working together leads to the most significant results. Our customized business and operational solutions have streamlined day-to-day operations, driven long-term financial success and improved patient outcomes for hundreds of hospitals, including those within one of America's largest healthcare systems. Let us put our 12 years of end-to-end operational and executional excellence to work for you.

Learn how a collaboration business strategy can drive your success. Download *The Value of Collaboration* at parallon.com/collaboration

PARALLON®

Revenue Cycle Purchasing Supply Chain Consulting Services
Information Technology Workforce Solutions