

STRATEGIC FINANCIAL PLANNING

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A New Framework for Healthcare Performance Improvement

*Building a new, patient-centric
continuum of care requires a fundamental
restructuring of the healthcare system.*

By Gary Auton

The move to value-based payment is altering the structure and focus of healthcare organizations. Every sea change demands strong leadership and a winning game plan to achieve enduring success. That game plan is performance improvement.

However, health systems have performance improvement strategies that often are not in sync with emerging marketplace requirements. Performance improvement plans are frequently based on slow, incremental improvement centered on labor productivity, supply, and other non-labor costs. These traditional approaches, while useful, cannot alone offset payment and volume declines for most organizations.

Building a new, patient-centric continuum of care requires a restructuring of the healthcare system and a new taxonomy of performance improvement interventions that are faster, broader, and more strategic than those adopted in the past. Improvement initiatives must increasingly focus on long-term, high-impact areas that re-engineer clinical care, sharpen service portfolios, and exploit scale of operations.

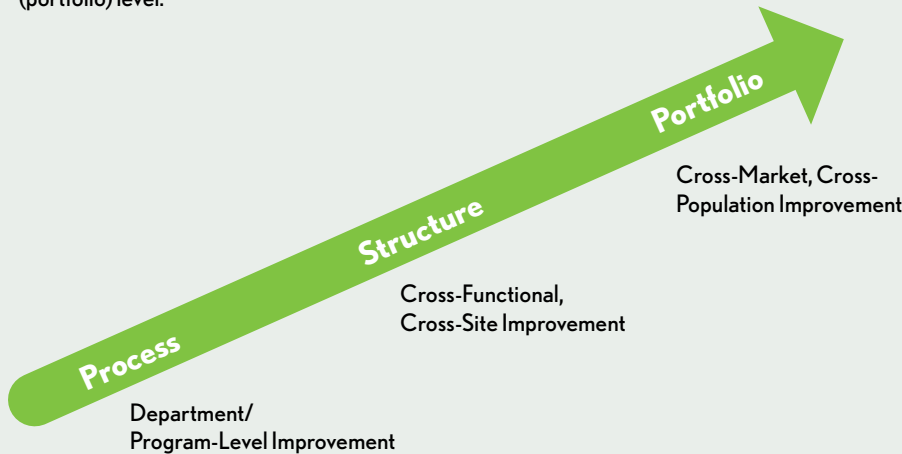
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Performance Improvement Levels in Health Systems

Performance improvement takes place at the department or program (process) level, the cross-functional or cross-site (structural) level, and the cross-market or cross-population (portfolio) level.



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Levels of Performance Improvement

Performance improvement opportunities accrue at different points and with varying scope in a health system. Specifically, performance improvement takes place at three levels: the department or program (process) level, the cross-functional or cross-site (structural) level, and the cross-market or cross-population (portfolio) level.

Process Level

Process changes represent the routine operational modifications leaders make daily in their areas of responsibilities. Process initiatives include routine department-level changes in work schedules, role design, and workflow improvements that improve staff utilization and service to patients. Specifically, program level changes include:

Process improvement. Strengthens the services and value provided to patients, families, physicians, and other stakeholder groups. Department-level initiatives usually focus on reducing waste, improving cycle time, and building reliability into key work processes.

Facilities optimization. Modifies the layout and workspace of a department to improve

patient flow and facilitate the effective use of resources.

Demand smoothing. Improves patient and work activity scheduling to balance workload across days and weeks.

Role and team design. Creates jobs and assigns responsibilities to improve flexibility and workload balance across work teams.

Dynamic staffing. Improves staff scheduling and deployment to meet variable workload demand.

The organizational impact resulting from process-level changes depends on department size and complexity. Organizations in the early stages of performance improvement should first focus on building department-level processes and systems.

Structural Level

At some point, health system leaders find that further improvement only can occur by addressing processes and systems that cross over into other areas of organizations. These improvement opportunities occur at the second, or structural, level. Structural improvements represent operational interventions that are executed among functions

both in single facilities and across multiple facilities in health systems. These interventions often challenge and alter the foundational assumptions of hospital and health system processes and organizations.

Structural improvement levers include:

Structural process improvement. Improves key business processes across functions and system entities to enhance service continuity.

Management restructuring. Redesigns leadership roles to better leverage management resources across departments, programs, and sites.

System rationalization. Leverages the advantages of system scale to rationalize staffing and resources across multiple entities.

5 Keys to Successful Performance Improvement

Think big. Leaders need to break with traditional, incremental improvement approaches and pursue broader, bolder interventions that have the promise of long-term strategic and operational payoff.

Leaders don't have to start from scratch. Most health system improvement opportunities can be anticipated. The key is to apply the appropriate "levers" to the most important areas and issues.

Don't wait too late. This work should begin while health systems are prosperous and are still evolving as integrated systems. It is difficult to make long-term changes when an organization is struggling with immediate margin challenges.

Engage key constituents. Leaders must align and motivate physicians, employees, and other stakeholders throughout the process or face a lack of support and opposition.

It's mostly about leadership. Large-scale performance improvement requires strong, visionary leadership from assessment through implementation. Organizational change and renewal is not possible without effective executives leading the way.

Example of a System-Level Gap Closure Plan

A hospital executive team developed a multiyear gap closure strategy featuring the deployment of 11 expansive performance improvement initiatives, including three initiatives focused exclusively on the physician practices division. The plan enabled the organization to achieve a positive operating margin by the second year.

	Performance Improvement Initiative	Improvement Levers	Economic Improvement Targets			
			Year 1	Year 2	Year 3	Year 4
Hospital- and System-Led Initiatives	Labor productivity*	#1-Process improvement, #2-Structural process improvement, #3-Facilities optimization, #4-Demand smoothing, #5-Demand grouping, #6-Role and team redesign, #7-Dynamic staffing, #10-Service redeployment	\$10,450,000	\$11,495,000	\$12,644,500	\$13,908,000
	Leadership restructuring and functional consolidation†	#8-Management restructuring, #9-System rationalization, #10-Service redeployment	\$2,000,000	\$5,340,000	\$9,450,000	\$10,395,000
	Supplies and purchased services‡	#11 Non-labor optimization	\$3,500,000	\$4,025,000	\$4,628,500	\$5,323,000
	Portfolio review§	#16-Service outsourcing, #17-Service divestment, #18-Continuum realignment	\$500,000	\$1,000,000	\$3,200,000	\$4,000,000
	Clinical utilization	#12-Utilization improvement	\$2,500,000	\$3,250,000	\$4,387,500	\$6,142,000
	Quality improvement#	#13-Off-quality improvement	\$0	\$1,950,000	\$2,340,000	\$2,808,000
	Revenue cycle**	#15-Revenue optimization	\$5,800,000	\$5,280,000	\$5,280,000	\$5,280,000
	Growth††	#14-Demand growth	\$2,580,000	\$2,760,600	\$2,953,842	\$3,614,000
Physician Enterprise Initiatives	Labor productivity‡‡	#1-Process improvement, #2-Structural process improvement, #3-Facilities optimization, #4-Demand smoothing, #5-Demand grouping, #6-Role and team redesign, #7-Dynamic staffing, #10-Service redeployment, #17-Service divestment	\$1,580,000	\$1,896,000	\$2,370,000	\$2,844,000
	Revenue cycle§§	#2-Structural process improvement, #15-Revenue optimization	\$1,500,000	\$3,000,000	\$3,000,000	\$3,000,000
	Growth##	#14-Demand growth	\$4,950,000	\$5,692,500	\$6,546,500	\$7,528,000
Forecasted gap			\$36,500,000	\$45,000,000	\$51,000,000	\$60,000,000
Gap closure total			\$35,360,000	\$45,689,000	\$56,800,000	\$64,842,000
Remaining gap			\$1,140,000	-\$689,000	-\$5,800,000	-\$4,842,000

Source: Galloway Consulting, an ADAMS company. Used with permission.

* Target 35th percentile benchmark staffing in all departments

† Start initially with regional management restructuring

‡ Physician preference, commodity, pharmaceuticals, and purchased services

§ Will take longer to implement

|| Focus on length of stay for Medicare patients and cost per case on cardiac, neurology, and orthopedic patients

Focus on reducing readmission, deep vein thrombosis, and ventilator-associated pneumonia

** Improve charge capture and coding; reduce denials

†† Reduce leakage; build service line referrals

‡‡ Improve staffing to 65th percentile Medical Group Management Association Benchmarks, divest low-performing practices, and consolidate support and administrative services

§§ Improve clinical documentation and coding

Open new practices and improve access to existing practices

Service redeployment. Relocates resources and services to different areas to improve service and lower operating costs.

Non-labor optimization. Builds processes and systems to manage enterprisewide supplies and other non-labor expenses.

Demand regrouping. Reaggregates work to achieve better resource alignment, build proficiencies, and improve workload balancing across time and functions.

Utilization improvement. Lowers case cost and contribution margins by reducing unnecessary utilization of clinical services.

Off-quality improvement. Improves clinical quality outcomes and minimizes the costs of unfavorable quality events.

Structural improvement projects are often complex, requiring a great deal of time and effort and the involvement of large, diverse groups of leaders and staff. When executed effectively, structural improvement initiatives can yield substantial gains in organizational performance.

Portfolio Level

Beyond process and structural changes, further performance improvement is achieved through alterations in health systems' portfolio of services and programs. Portfolio-level changes occur when health systems reconfigure and redesign programs and services to respond to changes in market demand. The aim of portfolio management is to maintain a service offering that meets market demand and maximizes revenues and margins. For health systems, portfolio improvement includes:

Service divestment. Identifies services to eliminate or markets to exit.

Service outsourcing. Determines which care continuum components should be produced internally versus by partnering entities.

Demand growth. Identifies strategic marketing opportunities and tactical growth initiatives to build top-line revenues.

Revenue optimization. Improves net revenues and margins through enhancements to organizations' revenue cycles.

Continuum realignment. Realigns programs, resources, and investments to build a stronger service continuum.

Portfolio improvement is a growing area of focus for large healthcare systems. As accountable care and population health initiatives transform healthcare delivery, health systems must institute changes to their service portfolio by reducing investments in existing programs and building new programs and capabilities. Similarly, growth and revenue cycle improvements are necessary for building and sustaining operating margins.

System-Level Gap Closure Plan

Performance improvement strategies must address an increasingly broad range of operational issues and extend for multiple years. For example, in a four-year financial gap closure strategy for a regional health-care system, a hospital CFO prepared a forecast of the organization's expected decline in operating margins under a scenario that net revenues per inpatient case for all payers would approach prevailing Medicare rates. Based on this scenario, the organization's operating margins would drop by \$36 million in the first year and grow to \$60 million by the fourth year.

The executive team then developed a multiyear gap closure strategy featuring the deployment of 11 performance improvement initiatives, including three focused exclusively on the physician practices division (see exhibit on page 3). The plan enabled the organization to achieve a positive operating margin by the second year.

Of note is that the strategy was built on assumptions of when benefits were expected to be achieved and that these savings would be sustained over time. For example,

the labor productivity team forecasted a savings of 175 FTE staff in the first year. The \$10.4 million savings would be sustained and accrue over subsequent years.

This example illustrates several dynamics of multiyear performance improvement:

- > Financial gap closure requires a multiyear portfolio of short-term and longer-term initiatives.
- > Short-term improvements are found primarily through a focus on labor productivity and non-labor expenses.
- > Revenue cycle improvements may generate substantial revenue gains in the short term as well, depending on organizations' current performance.
- > These short-term initiatives are necessary but insufficient for closing large financial gaps over extended periods.
- > Savings resulting from clinical utilization, quality, and portfolio improvements can be substantial, but they take longer to implement than other cost and revenue improvements, with benefits from the long-term initiatives generally accruing two to three years after launch.
- > Revenue growth normally includes short-term tactical improvement and long-term strategic opportunities.

The work required to transform health-care systems can be daunting. Large-scale performance improvement challenges leaders at all levels of the organization and usually surfaces unaddressed operational, strategic, and cultural gaps. Paradoxically, leaders who are tasked with driving performance improvement are often those individuals most threatened by the change. It is not surprising that many transformation initiatives fall short of expectations. However, by demonstrating organizational value and the impact on future viability, performance improvement champions can bring others on board. //

Gary Auton

is senior director, Galloway Consulting, an ADAMS Company (gauton@gallowayconsulting.net).