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Executive Summary

Incumbent health systems face a changing business model as care migrates out of the inpatient setting. They must also address increasing cost pressures as a tight labor market drives wage inflation. Improved performance within legacy operations and cost transformation to support needed investments in new strategic initiatives are critical as health systems position themselves for the future. And these initiatives must be modeled to ensure their chance for success, based on reliable data, enhanced by external perspectives and benchmarking, supported by engaged clinicians, and monitored through clear lines of accountability.

These are among the takeaways from Kaufman Hall/Axiom’s third annual survey of hospital and health system leaders on the state of performance improvement and cost transformation efforts within their organizations. For the first time this year, Kaufman Hall/Axiom has partnered with the Healthcare Financial Management Association (HFMA) in fielding the survey and developing this report’s findings.

“The volumes and revenue are declining. We need to make sure expenses fall faster.”
—CFO of a community hospital

The good news in this year’s survey is that respondents indicate their organizations are taking cost transformation more seriously. Last year, we asked respondents to identify what percentage cost reduction goal their organizations had established for the next five years: 32 percent said no cost reduction goal had been established. This year, we asked a similar question, requesting that respondents identify what percentage of current costs their organizations has targeted to remove over the next three years. Only 4 percent of respondents say their organizations have no
need to remove any current costs. Yet the good news of targeted cost reductions is offset by respondents’ honest assessment of their progress thus far. Fewer than 1 in 4 respondents say they have achieved “most” or “all” of their cost transformation goals. Targeted cost reductions remain modest, with 40 percent of respondents saying their organization’s targets are between 1 percent and 5 percent of current costs, far below what most health systems will need to break even on Medicare payments.

The survey indicates several clear performance improvement needs, including:

• Improving data and insights, including comparative insights into peer organization performance
• Providing physicians better information to improve engagement
• Creating a culture that supports achievement of performance improvement goals
• Establishing greater accountability for results

To address these needs, this report recommends that health system leaders pursue four key performance improvement strategies:

1. Refine and improve their understanding of costs

2. Deploy external perspectives and benchmarking to identify and drive sustainable cost restructuring efforts

3. Engage physicians with accurate and actionable data on quality and cost

4. Establish greater accountability for achieving performance improvement goals

Supported with successful practices that combine performance improvement tactics and technology, these strategies will position health system leaders to overcome obstacles to performance improvement, establish clear and sustainable performance improvement goals, and more fully tap major opportunities for cost transformation throughout their organization.
The Big Picture

Pressures on Revenue and Expenses

Falling inpatient volumes and rising wage inflation are putting pressure on health systems’ top and bottom lines.

The most commonly cited pressure on revenues was declining inpatient volumes, identified as the most significant force by 30 percent of respondents (Figure 1). Following in second and third place were downward pressure on commercial insurance rates, cited by 27 percent of respondents, and an increasing percentage of Medicare and Medicaid patients, identified by 19 percent.

**Figure 1: Revenue Pressures**

*Which of the following is putting the greatest pressure on your organization’s revenues?*

<table>
<thead>
<tr>
<th>Pressure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flat or declining inpatient volumes</td>
<td>30%</td>
</tr>
<tr>
<td>Downward pressure on commercial insurance rates</td>
<td>27%</td>
</tr>
<tr>
<td>Increasing percentage of Medicare/Medicaid patients</td>
<td>19%</td>
</tr>
<tr>
<td>Growth in high-deductible health plans/patient financial responsibility</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
<tr>
<td>Lower-priced competition in our service area</td>
<td>3%</td>
</tr>
</tbody>
</table>

Pressures on Revenue and Expenses (continued)

Reflecting tight labor markets in many areas of the country, rising salaries and wage inflation were by far the most common bottom-line pressure, identified as most significant by almost half the respondents (47 percent; Figure 2). With labor representing up to 60 percent of a health system’s costs, this poses a significant threat to cost transformation efforts.¹ At a distant second (23 percent of respondents) was capital required to fund strategic growth initiatives. The ability to access this capital will be vital as health systems work to adapt to emerging competitive threats in the marketplace and growing consumer demand for more convenient, lower cost healthcare services.²

Figure 2: Expense Pressures

Which of the following is putting the greatest pressure on your organization’s efforts to control expenses?

- Rising salary/wage inflation: 47%
- Capital required to fund strategic growth initiatives: 23%
- Supply chain (including pharmaceuticals): 12%
- Purchased services: 10%
- Other: 9%

Required Investments

Capital projects and new facilities are cited by 34 percent of respondents as the area requiring the greatest investment of organizational resources over the next three years (Figure 3). This is followed by expansion of primary and outpatient services networks (24 percent of respondents) and health information technology (17 percent).

Figure 3: Investment Needs

Which of the following do you predict will require the greatest investment of your organization’s resources over the next 3 years?

- Capital projects/new facilities: 34%
- Expansion of primary and outpatient services network: 24%
- Health information technology (EHRs, cybersecurity, interoperability): 17%
- Labor management/workforce development: 14%
- Digital technology/telehealth platform: 9%
- New care technologies/treatments: 1%
- Other: 1%


Almost 75 percent of respondents indicate that they will be investing in technology to help in their cost transformation efforts during the current calendar year (30 percent) or in the next one to two years (43 percent; Figure 4).
Required Investments (continued)

Figure 4: Planned Technology Investments to Support Cost Transformation Efforts

*Within what timeframe do you plan on investing in technology to help achieve your cost transformation goals?*

- **10%** We currently have no plans to invest in technology to support cost transformation goals
- **43%** In the next 1 to 2 years
- **30%** This calendar year
- **17%** In the next 3 to 5 years

Putting It Together

Falling inpatient volumes are an indicator of the ongoing shift in business models for incumbent health systems, as an increasing percentage of services and revenue migrate beyond the hospital’s walls. Although health systems are not yet seeing significant pressure on revenue from lower-cost competitors, they are seeing the need to invest in expansion of their primary and outpatient care networks. This is the tip of the iceberg. Health systems must invest in strategies that radically reform their cost structure and enable them to compete on access, convenience, and price in a rapidly changing healthcare market.

The pressure to invest in strategic initiatives is acknowledged, but rising labor costs are putting significantly more pressure on the bottom line. This underlines the need to push beyond traditional focuses on labor, productivity, and supply chain initiatives. True cost transformation and operational innovation opportunities, which have remained relatively untapped at many health systems, include unwarranted clinical variation, service line distribution, and portfolio rationalization. With three of four survey respondents planning to invest in technology within the next two years to help achieve their performance improvement and cost transformation goals, the need to dig deeper and deploy more sophisticated analytics to identify cost saving opportunities is recognized. But health systems also need guidance to develop a clearly articulated vision of the future and identify the steps required to make that vision a reality.

“At the moment, hospitals have total ownership of inpatient care, with robust, and generally profitable, outpatient services bolted on. Now, aggressive and well-funded companies are actively trying to loosen the bolts connecting hospitals with their outpatient services.

For hospitals, this is a first-order problem: While they compete with one another for their inpatient business, they will increasingly need to fend off well-funded and innovative new entrants angling for their outpatient business.”

—Kenneth Kaufman
Steps Taken Toward Cost Transformation

In comparison with last year’s report, there is both good news and bad news.

The good news

The good news is that far more respondents indicated that they have set cost-reduction goals for the next three years to help fund their investment needs and remain financially sustainable. In last year’s survey, when asked what percentage cost improvement goal their organization had established for the next five years, 32 percent of respondents said they had set no cost-reduction goal. This year, when asked what percentage of current costs their organization had targeted to remove over the next three years, only 4 percent of respondents said they had no need to remove any current costs (Figure 5).

The greatest number of respondents, 44 percent, say their organization has set reduction targets of between 6 percent and 10 percent of current costs over the next three years, while another 40 percent are targeting between 1 percent and 5 percent of current costs. Approximately 11 percent of respondents are targeting reductions in excess of 10 percent of current costs. No respondents have targeted cost reductions in excess of 20 percent of current costs.

Figure 5: Targeted Cost Reductions

What percentage of current costs has your organization targeted to remove over the next 3 years to fund planned investments and remain financially sustainable?

- 16-20%: 1%
- 11-15%: 10%
- 6-10%: 44%
- 1-5%: 4%
- We do not need to remove any current costs: 40%

How Much Is Enough?

While more respondents in this year’s survey report that their organizations have targeted cost reductions, more than 80 percent of respondents indicate that these targets do not exceed 10 percent of current costs.

As shown in Figure 1, downward pressure on commercial rates and an increasing percentage of Medicare and Medicaid patients were identified by respondents as the second and third most significant pressures on revenue. Kaufman Hall/Axiom and HFMA recommend that organizations establish a “break even at Medicare” target to address these pressures.

The magnitude of the effort required will vary from organization to organization, based on such factors as current margins on Medicare and prior success in removing costs, but will certainly exceed 10 percent of current costs for most health systems. For example, the CEO of a multi-state health system interviewed for this report said that even though they had continuously generated cost improvements of approximately $75 million per year for the past several years, they had calculated additional needed cost reductions of between $350 million and $400 million to break even at Medicare. With annual operating expenses of just under $2.5 billion, this computes to reductions of 14 percent to 16 percent of current annual operating expenses.

The importance of Medicare as a payment source will only grow as the population ages. Combined with new competitive threats from organizations unburdened by the costs of legacy inpatient services, this makes break even at Medicare a “no regrets” strategy for health systems. It also prepares organizations for the prospect of even more significant cost reductions as the healthcare business model shifts in a rapidly changing competitive environment.
Steps Taken Toward Cost Transformation (continued)

**The bad news**

Targeted cost reduction goals are complicated by respondents’ assessment of how successful they have been in achieving their goals. Fewer than 1 in 4 respondents (23 percent) say their organization has achieved “most” of their cost transformation goals; the greatest number, 66 percent, say they have achieved only “some” goals (Figure 6).

Organizations continue to rely heavily on traditional cost-saving opportunities, especially in labor cost and productivity, which was ranked as having the greatest potential opportunities for savings by almost 40 percent of respondents (Figure 7). This was also the area where respondents report the most success in achieving their goals (Figure 8). But almost as many respondents cite difficulties in achieving labor cost and productivity goals (31 percent) as those who claim success (Figure 9).

Another area of high potential and low success is unwarranted clinical variation (i.e., variations in clinical practice that add cost without improved outcomes). Sixteen percent of respondents selected unwarranted clinical variation as the most significant area of potential, second only to the percentage who ranked labor costs/productivity as the area of greatest potential. Yet only 4 percent of respondents have seen their greatest success in addressing unwarranted clinical variation, and it was named as the area of greatest difficulty by 25 percent of respondents.

![Figure 6: Success in Achieving Cost Transformation Goals](image_url)

*How successful has your organization been in achieving its cost transformation goals to date?*

- Did not achieve goals: 9%
- Achieved all goals: 1%
- Achieved some goals: 66%
- Achieved most goals: 23%
- Don’t know: 1%

*Source: Kaufman Hall/HFMA 2019 Performance Improvement Survey.*
Figure 7: Areas with Greatest Potential Cost Savings

Where do you see the greatest potential opportunities for savings in your organization’s cost transformation efforts?

- Labor cost/productivity: 39%
- Unwarranted clinical variations: 16%
- Overhead/shared service synergies: 11%
- Service line efficiency: 11%
- Supply chain and other non-labor cost: 10%
- Technology: 8%
- Service rationalization: 5%

Respondents were asked to rank options from 1 (greatest potential) to 7 (least potential). This graph shows the percentage of respondents that ranked each option as 1 (greatest potential).

Steps Taken Toward Cost Transformation (continued)

Figure 8: Areas of Greatest Cost Transformation Success

*In which of the following areas has your organization had the greatest success in achieving its cost transformation goals?*

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor cost/productivity</td>
<td>36%</td>
</tr>
<tr>
<td>Supply chain and other non-labor cost</td>
<td>32%</td>
</tr>
<tr>
<td>None</td>
<td>10%</td>
</tr>
<tr>
<td>Overhead/shared service synergies</td>
<td>9%</td>
</tr>
<tr>
<td>Service line efficiency</td>
<td>5%</td>
</tr>
<tr>
<td>Unwarranted clinical variation</td>
<td>4%</td>
</tr>
<tr>
<td>Service rationalization</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Figure 9: Areas of Greatest Cost Transformation Difficulty**

*In which of the following areas has your organization faced the most difficulties in achieving its cost transformation goals?*

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor cost/productivity</td>
<td>31%</td>
</tr>
<tr>
<td>Unwarranted clinical variation</td>
<td>25%</td>
</tr>
<tr>
<td>Service line efficiency</td>
<td>15%</td>
</tr>
<tr>
<td>Overhead/shared service synergies</td>
<td>11%</td>
</tr>
<tr>
<td>Supply chain and other non-labor cost</td>
<td>10%</td>
</tr>
<tr>
<td>Service rationalization</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
<tr>
<td>None</td>
<td>1%</td>
</tr>
</tbody>
</table>

Performance Improvement Needs

With two-thirds of respondents managing to achieve only “some” of their cost transformation goals, clear needs exist for more reliable processes and better tools in performance improvement. The survey findings indicate that these needs include:

- **Better data and insights, including comparative insights for peer organizations.** Lack of data and insights again emerged as the greatest impediment to achieving cost transformation goals (Figure 14). The biggest frustrations with financial benchmarking expressed by respondents include:
  - Difficulty integrating data from different sources
  - Too much manual work needed to normalize data
  - Limited ability to access comparative data for peer organizations

With respect to costing data, fewer than half the respondents agree that their organization has access to reliable, trusted costing data. Accordingly, fewer than half are using costing data consistently to guide decision making at their organizations.

- **Better information for improved physician engagement.** Physicians will respond to data, but only if they believe the data is trustworthy and they have access to data that is actionable. Survey results indicated that just over 20 percent of organizations have a trusted single source of data for the data and reports they share with physicians. And even fewer respondents agreed that clinicians at their organizations would say they have access to actionable information that helps them address unwarranted clinical variation and other cost-related quality concern (Figure 16).

- **Stronger culture of support for achievement of performance improvement goals.** While the good news in this year’s survey is that most organizations have targeted specific cost reductions, less than 25 percent of respondents report an ability to achieve “all” or “most” of their cost transformation goals. This suggests a culture lacking in the ability to unite around and achieve common goals.

- **Greater accountability for results.** The need to improve accountability was a major theme of last year’s report. In this year’s survey, the failure to hold leaders accountable was again one of the greatest impediments to achieving cost transformation goals (Figure 14).
Strategies and Successful Practices for Effective Performance Improvement

To address the needs identified in the survey, health system leaders should focus on four key strategies:

- Refine and improve their understanding of costs.
- Deploy external perspectives and benchmarking to identify and drive sustainable cost restructuring efforts.
- Engage clinicians with accurate and actionable data on quality and costs.
- Establish greater accountability for achieving performance improvement goals.
Strategy 1: Refine and improve understanding of costs.

The business case

As survey respondents indicated, inpatient volumes are declining, while expansion of primary and outpatient services networks are the second greatest area of investment identified over the next three years. Growth will likely occur outside the hospital’s wall, where incumbent health systems face the prospect of increased competition—in part on the basis of price—from new market entrants. These new competitors do not bear the burden of costs for providing acute inpatient care, nor are they burdened with legacy assets, delivery models, and culture. They often have significant reserves of capital at hand, either through private equity backing or the scale and resources of national competitors such as CVS Health or Walmart. Health plans are also positioning themselves to be the organizers of healthcare networks and will use unit price as a key factor in selecting preferred network providers. And as the federal government pushes for price transparency, pricing pressures likely will intensify.

Effective competition in emerging healthcare business models will depend on a more granular understanding of the actual costs required to offer a service or perform a procedure. Health systems will need to know which services are truly margin positive, and which are not, as they make decisions on where they have a competitive advantage. Health systems also will have to increase scale as they face new, national competitors. A clear understanding of cost structure and competitive advantage will help determine where health systems should pursue growth, or what assets they could bring to a partnership with another organization.

Survey findings

Fewer than half (47 percent) of survey respondents say they have access to reliable, trusted costing data (Figure 10). Accordingly, a similar percentage (48 percent) consistently use costing data to help guide decision making (Figure 11). Yet the survey results also indicate that more than 60 percent of respondents are using technology to gain a better understanding of costs (Figure 12), a sign that the need for better costing data is being pursued.
Strategy 1: Refine and improve understanding of costs. (continued)

Figure 10: Access to Reliable Costing Data
*My organization has access to reliable, trusted costing data.*

- Disagree: 47%
- Agree: 47%
- Don’t know: 6%


Figure 11: Use of Costing Data to Guide Decision Making
*To what extent does your organization use costing data to guide decision making?*

- Rarely: 9%
- Occasionally: 43%
- Consistently: 48%

Strategy 1: Refine and improve understanding of costs. (continued)

Figure 12: Role of Technology in Cost Transformation Efforts

What role does technology play in your cost transformation efforts?

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measuring results</td>
<td>76%</td>
</tr>
<tr>
<td>Understanding costs</td>
<td>63%</td>
</tr>
<tr>
<td>Benchmarking against prior time periods</td>
<td>61%</td>
</tr>
<tr>
<td>Identifying improvement opportunities</td>
<td>59%</td>
</tr>
<tr>
<td>Planning for the future</td>
<td>51%</td>
</tr>
<tr>
<td>Benchmarking against peers</td>
<td>50%</td>
</tr>
<tr>
<td>Technology does not play a role in our cost reduction efforts</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>

Respondents were asked to check all that apply.

Strategy 1: Refine and improve understanding of costs. (continued)

Successful practices

*Adopt a tiered approach to costing.* Improving costing data is a process of gradual improvement, and the benefits of more granular costing must be weighed against the intensity of effort required.

Organizations pursuing a more detailed understanding of costs should adopt a tiered approach that matches intensity of effort with items that have the highest impact on decision making. The most resource-intensive method—time-driven activity-based costing—is used at the highest tier for high-cost, time-driven activities such as operating room utilization. At the lowest tier, a traditional ratio of cost to charges approach can be used to allocate expenses in areas such as non-chargeable supplies or miscellaneous costs that have little impact on decision making (Figure 13).5

Adjust calculation frequency. As finance leaders adopt more detailed costing methods, they should also consider the calculation frequency and costing time period. A move from year-to-date to monthly or quarterly period costing will improve opportunities for trending. It also will ensure that early months are not reprocessed with each costing cycle, thus making the process more efficient.

*Improve the cost accounting system.* The need for a better understanding of costs may identify a need for an improved cost accounting system. The end goal is a cost accounting system that enables reporting across the care continuum and across multiple financial functions, and that produces information that health system leaders can stand by and act on.

Key elements of an effective cost accounting system include:

- **Flexibility.** As care moves from inpatient to outpatient settings, the system must have the flexibility to adapt to changing business models and sites of care, with the ability to draw costing data from across the care continuum.

- **Efficiency.** Easy-to-use costing models and built-in process management tools should enable an integrated end-to-end costing process that is easy to use and maintain.

- **Sophistication.** The system should be able to apply sophisticated costing methodologies based on the tiered approach to costing described above to improve cost accuracy.

- **Transparency.** Visibility into how costs are calculated and assigned down to the encounter level builds trust and confidence in costing data.

**Figure 13: A Tiered Approach to Costing**

<table>
<thead>
<tr>
<th>Costing Method</th>
<th>Costing Object</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time-driven activity-based costing</td>
<td>• High-cost, time-driven services such as operating room utilization</td>
</tr>
<tr>
<td>Activity-based costing</td>
<td>• High-impact implants, medical supplies, and pharmaceuticals</td>
</tr>
<tr>
<td>Relative value units (RVUs)</td>
<td>• Salary categories such as RN labor, tech labor, and physician labor</td>
</tr>
<tr>
<td>Ratio of cost to charges (RCC)</td>
<td>• Indirect costs with low impact on decision making</td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC.
Strategy 2: Deploy external perspectives and benchmarking to identify and drive sustainable cost restructuring efforts.

The business case

Competitive positioning requires not only beating competitors on price, but also on performance. Without an understanding of how processes can be done differently, or how peer organizations are performing, it is difficult to implement new initiatives or gauge whether they are setting the bar too low or too high. Comparative analytics also help prioritize efforts to seek a competitive advantage, identifying areas with the most potential gain. Data on the performance of peers, both external and internal, can be an effective tool in overcoming a top-cited impediment to not achieving goals because they are too politically sensitive (Figure 14). If a department or service line is demonstrably underperforming against its peers, attitudes about the need for performance improvement can change quickly.

Figure 14: Impediments to Achieving Cost Transformation Goals

What has been the most significant impediment for your organization in achieving its cost transformation goals?

- We lack good data and insight into our costs and where savings opportunities exist: 22%
- We find savings opportunities that are too politically sensitive to pursue: 21%
- We do not hold leaders accountable to performance for cost transformation goals: 21%
- We lack ability to maintain focus on the many cost initiatives underway across the organization: 10%
- We lack the ability to confidently predict our future financial performance to provide context for the cost transformation effort: 9%
- We have been unable to partner successfully with physicians: 6%
- Other: 6%
- We are unable to sustain improvements once savings are achieved: 5%

Strategy 2: Deploy external perspectives and benchmarking to identify and drive sustainable cost restructuring efforts. (continued)

Survey findings

Nearly all respondents (90 percent) are undertaking internally-led performance initiatives, and more than half have engaged consulting or data analytics firms (59 percent) or have implemented or optimized software technology (51 percent) as part of their cost transformation efforts (Figure 15). Half the respondents also are using technology to benchmark against peer organizations (Figure 12), With an “outside view” on performance, including the ability to compare performance against peer organizations, health systems have an easier time setting ambitious but attainable goals for the organization. They also have the data they need to overcome objections to performance improvement in politically sensitive areas of operations.

Figure 15: Tactics Used to Support Cost Transformation Efforts

Which of the following have been part of your cost transformation efforts?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internally-led performance improvement initiatives</td>
<td>90%</td>
</tr>
<tr>
<td>Engagement of consulting or data analytics firms</td>
<td>59%</td>
</tr>
<tr>
<td>Implementation/optimization of software technology</td>
<td>51%</td>
</tr>
<tr>
<td>Merger/acquisition/affiliation with other healthcare organizations</td>
<td>40%</td>
</tr>
<tr>
<td>Insourcing/outsourcing of major operational functions</td>
<td>36%</td>
</tr>
<tr>
<td>Non-traditional healthcare ventures</td>
<td>12%</td>
</tr>
<tr>
<td>None of the above</td>
<td>3%</td>
</tr>
</tbody>
</table>

Respondents were asked to check all that apply.
Strategy 2: Deploy external perspectives and benchmarking to identify and drive sustainable cost restructuring efforts. (continued)

Successful practices

*Bring in fresh eyes.* While it is important to groom leaders internally, it is also important to be open to perspectives from outside the health system. The CEO of a religiously affiliated multi-state system notes that a key factor in selecting a recently hired regional president to serve on the health system’s transformation team was the individual’s prior experience with a for-profit healthcare company. This experience added new talents and perspectives to the team.

Outside consulting firms or other external partners can also bring in new perspectives, or can provide an objective, consistent third-party view across a system. By defining and prioritizing opportunities and identifying organizational roadblocks, this third-party perspective can help accelerate change, overcoming organizational inertia and “analysis paralysis.” Interviewees preferred to be selective in their use of external partners, focusing on areas where, as one interviewee noted, “there is juice to squeeze.” Interviewees stressed the importance of outside firms that act as true partners. External partners can identify opportunities and help set up new processes, but the work ultimately must be done by internal teams that understand and take ownership of the need for transformation.

*Use external benchmarking to establish an outside view.* The outside view provided by external benchmarking supports health system leaders in setting targets that push their organization to perform at the highest level but reflect an informed assessment of how much opportunity is realistically within an organization’s reach. It also provides actionable data to identify and address challenges as they emerge to ensure progress on initiatives is being made.⁶
Strategy 2: Deploy external perspectives and benchmarking to identify and drive sustainable cost restructuring efforts. *(continued)*

External benchmarking tools should be able to:

- **Define an appropriate peer group.** What are the key factors that influence an organization’s outcomes (e.g., size of organization, market demographics, geography, etc.)? Peer organizations selected for comparative benchmarking should be defined by similar factors.

- **Ensure validity of comparisons.** Leaders must be confident that they are comparing “apples to apples” when assessing data from peer organizations. This is important not only in determining performance improvement targets, but also in building trust within the organization in the validity of the target. This will require an analytics solution that classifies and standardizes data across and within common categories.

- **Regularly refresh comparative data for peer organizations.** Once targets have been established, it is imperative that initiative leaders have access to timely information on a peer group’s ongoing performance, refreshed on a regular (e.g., monthly) basis. This will help determine, for example, whether challenges to progress are affecting the peer group as a whole or are unique to the organization and thus more likely attributable to internal factors.

Learn from experience. An organization’s own experiences can also provide an important reference point in benchmarking efforts. An effective analytics solution will extend a common set of key metrics and performance indicators internally and externally, both to track progress on internal initiatives and facilitate ongoing comparisons with external peer-group organizations. As an organization’s experience grows, so too will the value of data that demonstrates how often and how closely the organization was able to achieve its expected returns, and how consistently it tracked with the performance of its peer group as a whole. This knowledge may affect future target setting or indicate the need to identify internal factors that are creating obstacles to success.
Strategy 3: Engage clinicians with accurate and actionable data on quality and costs.

The business case

The success of a health system ultimately depends on the value of the clinical experience it offers. The ability to generate consistently high-quality, cost-effective outcomes is a crucial differentiator for consumers and payers alike. Transformative change within a health system is simply not possible without clinicians engaged in the effort to enhance quality and lower costs.

Engaging clinicians in this effort is difficult, however, in the absence of data they believe is trustworthy and accurately reflects their practice patterns. And if the data they receive is not actionable, it will have little impact on efforts to improve clinical performance.

Survey findings

Just 14 percent of respondents say that their clinicians would agree that they have access to actionable information that helps them address unwarranted clinical variations and other cost-related quality concerns. A slightly higher percentage (22 percent) say their organization has a single, trusted source of truth for the data and reports they share with clinicians (Figure 16).

Without access to trusted and actionable data, it is not surprising that addressing unwarranted clinical variation is the second most difficult area of improvement identified by respondents, nor that just 4 percent report success in addressing unwarranted clinical variation.

Figure 16: Indicators of Physician Engagement

**With which of the following statements do you agree?**

- **None of the above** (45%)
- **My organization has a trusted single source of truth for the data and reports we share with our clinicians.** (22%)
- **Our clinicians would say that they have access to actionable information that helps them address unwarranted clinical variations and other cost-related quality concerns.** (14%)
- **My organization makes effective use of clinical pathways, protocols, and guidelines to develop a common approach to patient care.** (38%)

Respondents were asked to check all that apply.

Strategy 3: Engage clinicians with accurate and actionable data on quality and costs. (continued)

Successful practices

“Don’t let perfect get in the way of better,” said the CFO of a community hospital we interviewed. While the survey responses indicate that perfect is far away for clinical analytics at most organizations, there are many opportunities to get better at engaging physicians with improved analytics.

*Involve physicians early.* As a health system builds a disciplined approach to the collection and display of clinical data in outcome reports, physicians should be involved in the selection of systems and tools that will be used. They should also review, select, and define relevant metrics for their specialties.

*Build trust in the data.* Be transparent about data sources and what these sources do and do not provide. Acknowledge any known limitations in data sets and be clear about how data will be used. Seek consensus on data sources most relevant for different practice areas and specialties.

*Anticipate and address common concerns.* Physicians will want to discuss the adequacy and applicability of severity or risk adjustments within their patient populations. They will also want to be sure that patients are being appropriately attributed to the physician that made the largest contribution to the clinical outcomes of a case. Be prepared to address how these issues are resolved within the clinical analytics system.

*Focus on developing a single source of truth for physician data.* Different data tell different stories. Focus on developing a clinical analytics solution that can aggregate data from disparate sources and systems into a single analytics source for clinical cost and quality data.

*Enable comparisons between internal and external peer groups.* As trust in the data grows, enable physicians to compare their performance with peers, beginning with internal peer groups. Gradually extend comparative analytics to peers at other organizations, addressing any concerns about comparability of data. Physicians whose performance is falling below their peers will typically be eager to close the gap in performance.

*Be consistent.* If a physician leader fails or refuses to address performance issues, the health system must take a consistent approach. System executive leaders—including the chief clinical officer—must work with leadership on the ground to establish expectations for appropriate behavior and to ensure that necessary actions are taken when those expectations are not met.
Strategy 4: Establish greater accountability for achieving performance improvement goals.

The business case

Forty percent of respondents are targeting cost reductions of just one to five percent of overall costs, and most respondents are achieving only “some” of their cost transformation goals (Figures 5 and 6). A mixture of moderate goals and moderate success in achieving them does not result in the transformative outcomes the current healthcare environment demands.

Survey findings

With fewer than one in four respondents saying that their organizations have achieved “most” of their cost transformation goals, most respondents likely are finding that the impediments to success that they have identified are significant barriers. A failure to hold leaders accountable was second only to a lack of good data and insights as the greatest impediment to success that respondents encounter (Figure 14).

Successful practices

Build a culture of accountability. Accountability is ultimately a question of culture, defined by an organization’s leadership through their ability to unite around common goals and by stakeholders organization-wide through their willingness to take ownership of and responsibility for performance results.

Building a culture of accountability begins with defining:

- Specific objectives to be met in each organizational dimension, based on an informed analysis of available opportunities.
- Initiatives that are in place or will be implemented to meet the objectives.
- Specific metrics that are appropriate to the performance of initiatives.
- Specific agreed-upon milestones of progress and accountable individuals.

Several interviewees noted that it is important that these definitions do not issue as a mandate from the executive team, but instead are developed collaboratively with leaders who will be accountable for the results. These leaders must feel ownership of the defined objectives, initiatives, metrics, and milestones. Accountability also must extend beyond achieving a specified objective. As one interviewee said, “Leaders must be accountable for financial performance or other defined objectives, but also for the happiness of their teams.”

Establish a results management office. One often-used tactic is appointment of a senior leader to serve as a performance improvement champion. This tactic can backfire, however, if others perceive that the champion is solely responsible for the success or failure of an initiative. A results management office (RMO) provides an alternative approach to accountability throughout the organization.

Specific responsibilities of an RMO can include project management or process redesign support; assistance with data integrity, analytics, and
Strategy 4: Establish greater accountability for achieving performance improvement goals. (continued)

.reporting; change management; and facilitation of consistent, proactive, and constituent-specific communications. Underperforming teams can seek out the RMO’s assistance voluntarily, but if a team is consistently underperforming, leadership has the option of requiring that the team accept help from the RMO. While the RMO and its staff help facilitate change, they are not directly accountable for results. Accountability remains with the team and its designated operational leaders (Figure 17).

Implement a strategy management solution. The work of performance improvement teams, RMO staff, and executive leadership will be made easier by implementation of a strategy management solution that enables stakeholders throughout the organization to easily track progress on initiatives and drill down to investigate possible causes when progress stalls or begins falling behind targeted milestones.

Key elements of an effective solution include:

- **Structured and clean data.** Performance improvement teams often will require data from multiple sources and systems. It is important that the strategy management solution is able to accurately classify and standardize data from multiple sources to provide a “single source of truth” for the organization.

- **Timeliness.** An effective solution should provide detailed and up-to-date information, regularly refreshed, to ensure initiatives stay on track.

- **Appropriateness.** The strategy management solution should offer multiple views of data as appropriate for end users—from broad views across the organization for senior executives to more focused and deeper views into specific initiatives for operational teams.

- **Accessibility.** All users should be able to easily drill down into reports to identify progress on goals, execution risks, and accountable leaders.

- **Visualization.** Data should be visualized in a way that enables users to quickly identify areas requiring attention. Simple examples are a dashboard solution that color-codes progress on initiatives as green (on target), yellow (at risk), and red (in trouble), or that uses arrows to indicate whether progress is trending up, neutral, or down.

Figure 17: Role of a Results Management Office in a Performance Improvement Structure

Source: Kaufman, Hall & Associates, LLC.
Facing the Future

One of our interviewees summed up the future for incumbent health systems as follows: “Commercial prices are going down, and I don't know how much longer we will have our current healthcare model.”

To prepare for this future, a commitment to continuous performance improvement is imperative. Opportunities will change and will vary from organization to organization, but the strategies presented in this report should be adopted across all organizations. They are designed to make health system leaders better informed, more accountable, and more able to drive change within their organizations. Supported by successful practices that combine performance improvement tactics and technology, these strategies will help leaders set appropriate goals and build a culture of accountability and engagement that optimizes the chance of achieving the desired results, regardless of the opportunity pursued.

“The basic mismatch between U.S. healthcare facilities and healthcare needs, and the unsustainability of healthcare spending to the U.S. economy, requires that legacy hospitals and health systems take on costs at a greater magnitude and with more permanence. That means taking a very hard look at the value being provided by each asset of the facility portfolio. Where assets are not contributing sufficiently to the healthcare needs of the community, and not meeting the strategic or financial needs of the organization, some very tough decisions are in order.”

—Kenneth Kaufman
This is the third year that Kaufman Hall/Axiom has surveyed hospitals and health systems on their performance improvement and cost transformation efforts, and the first year that Kaufman Hall/Axiom and the Healthcare Financial Management Association (HFMA) have worked together to field the survey and develop the report’s findings.

The report findings are based on 169 responses to a survey fielded by Kaufman Hall/Axiom and HFMA in August and early September 2019. Survey responses were supplemented by interviews with selected respondents, focusing on those who indicated their organization had achieved “most” of their cost transformation goals and were targeting significant cost reductions in the coming years.

Respondents represented a wide range of organizations, from single hospitals (28 percent) to health systems with 10 or more hospitals (20 percent). Most respondents were executive officers, vice presidents, or directors (Figure 18). More than 70 percent of respondents were in finance or executive leadership.

**Figure 18: Respondents’ Professional Roles**

*What is your role?*

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive / Officer</td>
<td>40%</td>
</tr>
<tr>
<td>Director</td>
<td>22%</td>
</tr>
<tr>
<td>Vice President</td>
<td>21%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9%</td>
</tr>
<tr>
<td>Manager</td>
<td>7%</td>
</tr>
<tr>
<td>Trustee</td>
<td>0%</td>
</tr>
</tbody>
</table>

About the Authors

From Kaufman Hall/Axiom

Kermit Randa is Chief Executive Officer of Kaufman Hall’s Software division, with responsibility for the firm's Axiom and Peak Software suites. Kaufman Hall/Axiom offers flexible, best-in-class performance management and decision support solutions to finance professionals across multiple industries including healthcare, higher education, and banking. Mr. Randa guides the division's growth and oversees product development and related services, including sales, implementation, training, and support.

Mr. Randa has more than 20 years of experience spanning healthcare and software. His areas of expertise include enterprise software insights and adoption, business transformation and innovation, strategic partnership cultivation and management, and risk identification, monitoring, and mitigation. Prior to joining Kaufman Hall/Axiom, Mr. Randa was Chief Growth Officer with Waystar (formerly Zirmed and Navicure), which provides integrated cloud-based healthcare revenue cycle management solutions. In that role, Mr. Randa led sales, marketing, channel, and business development functions, including introducing an integrated and comprehensive growth platform, and creating a cohesive operating team.

Mr. Randa previously served as Chief Executive Officer for PeopleAdmin, a Vista Equity Partners Company. He established the strategy, vision, and culture for the company, which provides talent management solutions for educational institutions. His previous positions include Executive Vice President for Vitera Healthcare/Greenway Health, Chief Operating Officer and Senior Vice President for Surgical Information Systems, and Director of U.S. Healthcare Sales and Business Development Manager for the EMC Corporation.

Mr. Randa holds an M.H.A. from Xavier University and a Bachelor of Urban Planning from the University of Cincinnati. He completed the Advanced Management Program at Harvard Business School, and is a Fellow of the American College of Healthcare Executives.

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Lance Robinson is a Managing Director of Kaufman Hall and Leader of the firm’s Performance Improvement practice, which includes individuals with deep expertise in labor, non-labor, productivity, supply chain, contracted services, overhead, clinical service mix, and revenue cycle management. Mr. Robinson works with hospitals and health systems nationwide to redefine the way healthcare leaders view performance improvement by providing data-driven insights and solutions for achieving widespread and sustainable results.

Mr. Robinson has more than 25 years of experience in healthcare, working on both the provider and consulting sides of the industry. Prior to joining Kaufman Hall, he was a Partner at Berkeley Research Group (BRG), where he led integrated performance improvement engagements and headed the non-labor service line for BRG’s Healthcare Performance Improvement practice. In those roles, Mr. Robinson managed multiple transformational performance improvement and clinical redesign engagements with large multi-hospital health systems, academic medical centers, community hospitals, and other healthcare organizations across the country.

Mr. Robinson previously was a Senior Vice President at MedAssets, where his responsibilities included serving as an advisor on supply chain to large integrated delivery networks. His prior experience also includes serving as Corporate Vice President of Supply Chain Services at Vanguard Health Systems, Director at PricewaterhouseCoopers, and Manager at Cap Gemini Ernst & Young.

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From HFMA

Rick Gundling is senior vice president for HFMA. Rick is responsible for the technical and content direction for HFMA, managing of its thought leadership efforts, and leadership of its Washington, D.C., activities. He also serves as staff liaison to HFMA’s Principles and Practices Board. Rick has written an extensive number of published articles on broad topics within healthcare finance and the healthcare industry. HFMA is a professional association with over 43,000 members engaged in the financial management of the healthcare sector.

HFMA’s thought leadership has covered payment reform, value creation, revenue cycle management, accounting and financial reporting, capital access, and many other areas that drive healthcare organizational high performance. Results of those initiatives have been used by hospitals, rating agencies, regulatory agencies, congressional committees, accounting standard setting bodies, state hospital organizations, and other government and industry leaders.

Rick serves as Treasurer for Neighborhood Health, a federally qualified health center, providing for the medically underserved in Northern Virginia. In addition, he acts as an external advisor to the George Washington University on its Master of Health Administration program.

Prior to his time with HFMA, Rick has served in fiscal services at the National Hospital for Orthopaedics and Rehabilitation, first as Director of Budget and Reimbursement, and then as Chief Financial Officer.

In addition to these positions, he was Budget and Reimbursement Analyst for Prince William Hospital Corporation and served as Controller at the Visiting Nurse Association of Northern Virginia. Rick is a Fellow of the Healthcare Financial Management Association, a Certified Management Accountant, and is a member of the Institute of Management Accountants.

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Chad has over 20 years of revenue cycle, reimbursement, and population health management experience, working as both an internal and external consultant to large healthcare systems. Prior to joining HFMA, he helped Fortune 500 companies reengineer their innovation and marketing processes as a consultant at the Corporate Executive Board.

Chad has an M.B.A. from the University of Maryland. He is active with the Virginia Chapter of HFMA where he has served as a past board member.

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References

1 This finding is consistent with Kaufman Hall proprietary data, which shows Full Time Equivalents per Adjusted Discharge remaining relatively flat in 2019 but Labor Expense per Adjusted Discharge rising year over year, which suggests upward pressure on compensation. *September 2019 National Hospital Flash Report.* Kaufman, Hall & Associates, LLC. Sept. 2019.


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