Delivery System Moves Front and Center

Healthcare’s faster, bigger, broader disruption demands of hospitals and health systems delivery strategies redesigned for the consumer-centric Internet economy. An old-economy mindset and old-economy strategies are serious threats to legacy organizations going forward.

Huge acquisitions across healthcare sectors are occurring rapidly and creating ever-larger players. The questions—what are the needs of the populations in our targeted regions, and where and how should we deliver services to meet those needs—are top of mind among these players (see sidebar on page 3).

Driving industry disruption and transformation is the reality that U.S. healthcare is too expensive. To reduce costs while improving quality, outcomes, and the consumer experience, health and healthcare services will need to be delivered at lower-cost sites and settings. Healthcare’s historically risk-averse, inpatient-focused, and slow-to-change culture will need to be reoriented for a fast-changing, highly competitive, high-tech environment, comments Kenneth Kaufman, Chair of Kaufman, Hall & Associates, LLC.

Health systems can best succeed if they alter their delivery systems to reflect the new realities.

Vision-Setting for Delivery System Redesign

Delivery system redesign involves re-visioning. Vision-setting by boards and executive teams should encourage creative thinking, asking the question, “If we started from scratch, what would we offer in our community, and where and how would we deliver that care?”

More than tweaks to the distribution of services are needed for health systems to retain relevance in their markets. Major delivery system redesign will be required to provide the access, pricing, and quality consumers want. Redesign initiatives must incorporate the right care, in the right place, and through the right caregiver/delivery model, asking the what, where, and how questions shown in Figure 1. Responses will and should vary based on the populations to be served, and general intrinsic and competitive characteristics of the marketplace.

For example, primary care, one of the care types listed under the dark blue box, can be delivered in a number of care sites itemized under the royal blue box, including retail clinics, physician offices, and emergency departments. Primary care also can be delivered through multiple care models, such as patient-centered medical homes, telehealth, and other approaches.

With the “what type of care” question, most health systems are likely to want to provide primary and outpatient care, emergency care, and inpatient care, but not necessarily all care models within these large buckets or at each care site. Each of these dimensions requires solid data, careful analysis and purposeful strategic decisions.

FIGURE 1. KEY QUESTIONS FOR SYSTEM REDESIGN FOR SPECIFIC POPULATIONS

<table>
<thead>
<tr>
<th>Care type: What type of care is delivered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care site: Where is the care delivered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virtual</td>
</tr>
<tr>
<td>Ambulatory Center</td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC.
Foundational insights about consumer needs and wants should inform decisions, and the business strategies the health system pursues. Solutions will vary based on organizational capabilities to serve different populations in different communities. Differing healthcare needs of various patient populations should be treated in different ways, as appropriate.

Articulation of a point of view about the need for organizational transformation is an important early step for leadership teams in re-visioning delivery design. Recognition that the organization will not be able to be all things to all people and that “one size does not fit all” is important for most organizations.

Also important is the goal of identifying delivery strategies that work in different payment environments, across risk and fee-for-service arrangements. Some of the organization’s markets may continue to be primarily fee for service, but as such, will be vulnerable to disruption. Low-intensity services provided by hospitals are particularly at risk. With Anthem Blue Cross Blue Shield leading the charge, hospitals can increasingly expect payers to deny payment for ambulatory, non-emergent services performed in hospital-owned settings. Steerage of patients by payers and employers to lower-cost, and often more convenient, freestanding locations is now common.

Essentiality and relevance of services offered therefore are must-have attributes for community providers, making them less vulnerable to traditional and new-market disruptors and payer leverage.

Redesign Framework

A framework can be helpful in identifying the types of strategies health systems should consider for delivery redesign (Figure 2). The X-axis represents sites of care by acuity level or the where dimension. Site infrastructure-related strategies can create a more accessible and efficient care delivery network for all populations served. The Y-axis represents the care model or how dimension, based on the resource intensity appropriate for a particular population segment. Both where and how dimensions are spectrums with many points along the axes within and between the quadrants.

The lower right quadrant—services distribution—includes high-acuity sites (e.g., hospitals, EDs) for patients with lower resource needs. For example, leaders can consider moving services for patients treated in inpatient facilities, such as those with dehydration or pneumonia, to lower-acuity hospital or ambulatory sites under a different model of care. Leaders also can consider shifting outpatient services from hospital to non-hospital sites, including imaging centers and ambulatory surgery centers.

In the lower left quadrant is an ambulatory network consisting of clinics, physician offices, and other facilities for patients with low-acuity and low resource-intensity needs, such as wellness services and primary care. To grow the ambulatory network, leaders can consider the composition and mix of services and alternate delivery models, such as virtual, urgent care, and retail care, that will further enhance access and decrease costs.

In the upper left quadrant are patients with high-resource intensity needs, but low acuity status. These patients might best be cared for under an advanced primary care model, such as a patient-centered medical home that provides continuity of care.

In the upper right quadrant are patients with multiple chronic conditions and/or comorbidities—and thus, high resource intensity and high acuity needs—who would be cared for under a complex care program. To achieve high-quality, efficient care, leaders may need to consider consolidation of programs for these patients across hospital sites, for example, complex cardiology, neonatal, cancer, etc.

Clinical variation lies at the center of the framework. Strategies to reduce unwarranted clinical variation, as well as inappropriate and/or avoidable care, should be considered across patient resource intensity segments and care delivery sites.

**FIGURE 2. FRAMEWORK FOR DELIVERY SYSTEM REDESIGN**

Source: Kaufman, Hall & Associates, LLC.
Leaders may need to be participating in all four quadrants. The questions are:

- How and where are we serving our patients now?
- How and where should we be serving them in the future?
- What information can we gain on consumer preferences and behavior to inform our answers to the second question?

Responding to these questions can be dauntingly complex. Offered here is an approach to system redesign that can be accomplished by organizations with a relatively broad footprint of hospitals and ambulatory sites within an approximately six-month time frame.

### Planning Process in Action

High-quality planning starts with a thorough analysis of data relevant to potential what, where, and how strategies for service delivery by service line or business and population segment. Obtaining the right data and using tools that enable the right analytics by the right team are key. Historical inpatient data by service line for hospital systems often are easier to obtain than outpatient performance data, but both will be needed to develop a clear understanding of past service line performance and future potential.

Internal data can be compared along cost and quality dimensions with benchmark data from regional or peer-group organizations. Market and patient population characteristics and projected growth trends in the targeted service areas also should be assessed. Data sets include volume/utilization, market share, cost, quality, patient characteristics (e.g., age, insurance coverage, clinical disposition/conditions, and other factors), clinician market characteristics (e.g., number of specialists, age, and location), competitive landscape, relevant consumer research, and stakeholder perspectives.

Using a structured approach, the efficiency and effectiveness of each business and service should be evaluated, as should the organization’s ability to sustain the business or service’s relevance in a changing market. The strategic values to payer networks of each business or service, and of the overall organization, are important considerations in this regard.

Analytics provide clear visibility into past and potential future volume, cost, and profitability across clinical service lines. Such visibility is increasingly important for both long-range and tactical planning activities. Access to and use of good data and analytics enable organizations to identify and test the right set of initiatives, and fully understand the opportunity and roadmap for execution.

During this assessment process, observations about which and how services might be better distributed across the delivery system begin to emerge for redesign teams. For maximum effectiveness, such teams should include nurses, physicians, executives, service-line leaders, managed care executives, and new personnel, such as innovation officers. Team members often can suggest strategic initiatives worth nominating for pilot testing. These initiatives or opportunities then can be prioritized, vetted by a leadership steering committee, and tested through one or more redesign interventions. The next sections provide a case example with details on how one regional health system executed this process.

### Building Scale for Healthcare’s Future

Recently announced partnerships are using different approaches to healthcare’s re-visioning:

- The CVS Health acquisition of Aetna is betting on a wellness/primary/chronic care model delivered through nurse practitioners and physician assistants in 10,000 CVS drug stores, which are being re-envisioned as community-based healthcare hubs.
- The acquisition of DaVita HealthCare Partners, one of the nation’s largest physician groups, by the Optum unit of UnitedHealth moves this insurance/data analytics firm further into the clinic space, where effective care management provided by physicians intends to reduce hospital-based care.
- The CHI and Dignity Health merger is expected to allow the combined health system to expand outpatient and virtual care offerings, broaden clinical programs for managing chronic illness, and advance digital technology for more personalized and efficient care.
- Amazon, Berkshire Hathaway, and JPMorgan Chase are aligning to form an independent healthcare company for their more than one million employees. It’s not yet clear how the alliance will operate, but the companies said that they would initially focus on technology to simplify care.

Tech companies are entering the healthcare market, with eyes on capturing big shares of its $3.2 trillion spending. Their digital tools are empowering consumers to diagnose, track, and improve their health and care anywhere they want. Apple released an app to test its watch’s ability to monitor and improve cardiac health. The company also recently added a feature on its iPhone Health app to allow users to download and see parts of their medical records.

### REFERENCES

Where Should We Provide Care?

Armed with the thorough data and analytics described in the previous section and choices regarding care type, the health system's redesign team considered the where dimension. The team evaluated care sites, including hospitals, emergency departments, freestanding ambulatory centers, physician offices, retail clinics, and virtual care, asking important questions related to each:

- What is the market opportunity for this specific site-of-care strategy?
- What are the competitive dynamics of the market (current and expected) for this care site?
- What payment models will impact this care site?
- What level of cost is associated with this care site?
- How willing are customers to seek care at this site?

The health system’s redesign team identified three core challenges that would benefit from initiatives related to care-site redesign:

1. With nontraditional competitors offering low-intensity surgical services in retail and ambulatory settings in the region, attrition of the system’s campus-based outpatient surgeries might accelerate, requiring a different site-of-care strategy to maintain presence in this space.
2. Market demand appeared to warrant fewer neonatal intensive care units (NICUs) in the region, which suggested that consolidation of NICU services may be appropriate.
3. Consumers may want more accessible ambulatory care, preferring to receive care somewhere other than at a hospital campus.

To assess the first challenge, for example, the team looked closely at data related to the volume of current hospital campus-based outpatient surgical cases associated with low (i.e. better) American Society of Anesthesiologist (ASA) classification scores for fitness for surgery. These patients could be eligible for off-campus surgeries in competitor- or system-owned ambulatory surgery centers (ASCs). Averaging across its three hospitals, the data showed that 76 percent of the system's total outpatient surgeries involved patients with ASA I “healthy person” or ASA II “mild systemic disease” scores (Figure 3).

To dive deeper with this challenge, the team assessed the financial impact to the health system if the bulk of these patients shifted to lower-cost sites with lower payment rates. The team forecasted rate reductions for Medicare, Medicaid, and commercial payers, based

FIGURE 3. DATA AND ANALYTICS FOR REDESIGN TESTING: OUTPATIENT SURGICAL VOLUME BY ASA SCORE

<table>
<thead>
<tr>
<th>% Outpatient Surgical Volume</th>
<th>Total</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA I</td>
<td>24%</td>
<td>21%</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>ASA II</td>
<td>31%</td>
<td>55%</td>
<td>13%</td>
<td>52%</td>
</tr>
<tr>
<td>ASA III</td>
<td>19%</td>
<td>57%</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>ASA IV</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC.
on current CMS payment rates and typical commercial ASC rates in the market. Estimates included consideration of the different mix of specialty services, procedures, and volumes by payer.

The assessment indicated that if patients moved from hospital outpatient departments to a freestanding ASC, the following would occur:

- Medicare rates would drop by 35-45 percent
- Medicaid rates would drop 65-85 percent
- Commercial rates would drop by 77 percent

While rate reductions would significantly reduce profitability for these low-intensity surgical services in a system-owned ASC, losing customers to new competition would be even more detrimental.

Using the redesign framework in Figure 2, Figure 4 summarizes the strategic responses developed by the team for all three challenges.

To address challenge No. 1 in the lower right quadrant, the health system’s redesign team recommended expanding its service distribution by developing a multifaceted ambulatory surgery center for low-intensity surgical services, with operating rooms, physician clinics, and ancillary services, and considering a broader, robust strategy for ASC development.

With challenge No. 2 in the upper right quadrant, analytics indicated that NICU beds across the system’s hospitals were indeed oversupplied, so the three NICUs would be consolidated into one NICU that could efficiently and effectively provide complex care for high-acuity and resource-intensive neonates.

With challenge No. 3 in the lower left quadrant, research in the region indicated that consumers do indeed want additional accessible ambulatory options for their non-emergent care. The redesign team recommended ambulatory network development through a micro-hospital/freestanding facility for patients who want their lower-acuity care needs fulfilled in more convenient settings. The facility would be equipped as a short-stay option, with an ED and observation unit. Physical therapy, retail pharmacy, and advanced imaging also would be offered.

Successful implementation of the three site-of-care strategies would require alignment with physicians who would drive value-based care, and development of sites with “the right” size and scale of operations. Also essential to the success of the care sites.

**FIGURE 4. PRIORITIZED STRATEGIC REDESIGN RESPONSES**

<table>
<thead>
<tr>
<th>Resource Intensity Across Segments (How)</th>
<th>Acuity Across Sites of Care (Where)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Complex Care Consolidation</td>
</tr>
<tr>
<td></td>
<td>Consolidation of neonatal intensive care unit services across regional hospitals</td>
</tr>
<tr>
<td>Low</td>
<td>Ambulatory Network Development</td>
</tr>
<tr>
<td></td>
<td>Micro-hospital/freestanding short-stay facility with:</td>
</tr>
<tr>
<td></td>
<td>• ED, observation unit, PT, retail pharmacy, advanced imaging</td>
</tr>
<tr>
<td>Low</td>
<td>Service Distribution</td>
</tr>
<tr>
<td></td>
<td>Multi-faceted ambulatory surgery center(s) with:</td>
</tr>
<tr>
<td></td>
<td>• Operating rooms, ancillary services, physician clinics, etc.</td>
</tr>
</tbody>
</table>

**FIGURE 5. SEGMENTATION STRATEGY RESEARCH**

**Differences in Healthcare Utilization**

<table>
<thead>
<tr>
<th>Consumer Segment</th>
<th>Avg. # of Annual Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Young and Healthy”</td>
<td>1.3</td>
</tr>
<tr>
<td>Medicare Eligible</td>
<td>5.3</td>
</tr>
<tr>
<td>3+ Chronic Conditions</td>
<td>7.0</td>
</tr>
</tbody>
</table>

**Differences in Healthcare Preferences**

Willingness to see an NP or PA instead of a physician

- 75%
- 70%
- 65%

Source: Kaufman, Hall & Associates, LLC.
would be provision of care-delivery models (the how question) appropriate to each site and patient segment, as described next.

**How Should We Provide Care?**

In considering the how dimension, the health system’s redesign team started with the premise that no one-size-fits-all model would meet the health needs and preferences of different patients or member groups. Instead, a patient segmentation approach would more appropriately address how care should be provided to patients with differing disease burdens, health risks, utilization behaviors, preferences, and insurance coverage.

The team looked first at the approach to primary and immediate (non-emergent) care, since all patient segments would require some of these services. The team’s goal was to consider a unique approach, which would allow for multiple primary and immediate care models.

In-depth consumer research and surveys were conducted to understand the different primary and immediate care needs and preferences of different patient segments, and how such segments likely would seek and use primary and immediate care across the organization’s delivery system.

Looking beyond solely payer categories (such as commercial, Medicare, Medicaid, uninsured) to disease burden and socioeconomics/demographics, the team defined three segments as follows:

1. Young and healthy/working well (ages 18-64)
2. Rising risk/at-risk based on 3+ chronic conditions (ages 18+)
3. Medicare eligible (ages 65+)

Data and analytics related to the system’s current patients and prospects in the region informed these definitions. Developing the right care model for the Medicare Advantage (MA) members in the third segment was of significant interest because the health system was operating under at-risk arrangements with this patient population. MA members might overlap slightly with the second and third segments.

To start assessing the how dimension, in-depth consumer research probed primary care utilization (i.e., the number of annual visits to a clinic or physician’s office), and patient preference regarding provider type, whether a physician or a non-physician, such as a nurse practitioner or physician assistant.

Figure 5 shows the results. The segment defined as “young and healthy” had primary care utilization averaging 1.3 visits per year. Seventy-five percent of this cohort would be willing to see a nurse practitioner or physician assistant instead of a physician. For the Medicare-eligible population, with an average of 5.3 visits per year, that percentage was 70 percent. For patients with three or more chronic conditions and an average of seven primary care visits per year, 65 percent would be willing to see a non-physician.

Access to primary care would be a key issue. Based on study of the comprehensive data collected earlier and further consumer research, the redesign team identified three access issues that might benefit from strategic redesign initiatives:

1. Many patients want primary care visits on a same-day or next-day basis.

**FIGURE 6. RESEARCH ON NECESSITY OF CARE IN URGENT CARE AND ED SETTINGS**

<table>
<thead>
<tr>
<th>Urgent Care</th>
<th>62%</th>
<th>38%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>88%</td>
<td>12%</td>
</tr>
</tbody>
</table>

**Necessary**

“The care I received was urgent and needed at the time I received it.”

**Not Necessary**

“I could have received this care at a later time and my health would not have been negatively impacted.”

**FIGURE 7. PRIORITIZED CARE MODEL RESPONSES**

<table>
<thead>
<tr>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Primary Care Development</td>
<td>Ambulatory Network Development</td>
</tr>
<tr>
<td>Clinic designed with a care team resourced to handle populations with higher needs (e.g., “Rising Risk”)</td>
<td>Strategies to increase convenience that appeal to the “Working Well,” such as user-enabled digital interface, expanded retail clinic footprint, etc.</td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC.
2. Nurse practitioners and physician assistants can provide much of the desired primary care in office, clinic, and other ambulatory settings.
3. A significant portion of immediate care (urgent care and emergency visits) can be delivered through alternative means.

Again, the team evaluated each issue. For example, to assess the third issue, consumer research was conducted to determine the percentage of consumers who considered the care they received in an urgent care or emergency department to be necessary or unnecessary. If the latter, alternative care models would be appropriate. Figure 6 shows the results: 38 percent said their care in an urgent care center was not necessary; for EDs, the percentage was 12 percent.

Further research indicated that these consumers were using ED and urgent care for non-urgent or non-emergent needs because they couldn’t get a primary care appointment in the next few days at a time that fit their schedule. Eliminating utilization of this higher-than-needed level of services through offering more convenient care options would take significant costs out of the system, while improving patient satisfaction.

The team prioritized numerous strategic responses for how-related delivery redesign (Figure 7). One strategy was development of delivery alternatives within the organization’s growing ambulatory network. As shown in the figure’s lower left quadrant, new retail clinics staffed by nurse practitioners and physician assistants would offer convenient primary care for the young and healthy/working well segment. Telehealth would be offered to ensure same-day access and care, and user-friendly digital interfaces would enable video visits, scheduling, prescription refills, and other services.

For patients ages 65+ with Medicare Advantage insurance, the organization developed an advanced primary care model (upper left quadrant of Figure 7), which would be a clinic with a care team resourced to handle older patient populations with higher needs. Clinic staff would focus on management of patients with advanced, progressive chronic illnesses to reduce avoidable ED visits, hospitalizations, and the total cost of care, while maintaining quality of life and extending independence.

The health system developed a unique approach to primary and urgent care, based on patient needs and preferences. No singular model could span care needs across healthy, sicker, and older populations. Instead, a variety of care models, using different types of providers working in different care sites, would be effective. As implementation of the recommendations of the redesign team progresses, the team will continue to assess performance of each element, and make adjustments as needed.

Building a Balanced Portfolio of Strategic Interventions

As disruptive forces threaten to erode the financial strength, consumer loyalty, and relevance of legacy healthcare organizations, such organizations must proactively reshape their delivery systems. Dramatic changes will be needed in care models, sites, and providers.

Getting serious about delivering the care consumers want at more convenient, lower-cost settings requires a holistic approach to the efficiency of the enterprise. The approach includes divesting or repurposing services or facilities that are duplicative or low performers, reducing unwarranted clinical variation, and dramatically redesigning processes for better quality and efficiency. A balanced portfolio of strategic interventions likely includes those new to the organization, new to the market, and new to the industry. “What if healthcare were designed so that in-person visits were the second, third, or even last option for meeting routine patient needs, rather than the first?” asked two authors in a recent article in The New England Journal of Medicine. Core requirements of all system redesigns include organizational readiness, board and executive sponsors, provider/caregiver engagement, incentive alignment, and effective change management. Vertical integration with insurers and technology providers, and access to provider risk models may play an important role in the success of future hospital redesign efforts.

Delivery system redesign is hard—really hard. Be prepared to work in all four “how and where” quadrants, and never underestimate the power of inertia. It’s far better to disrupt your own organizations than to have a competitor do so.

For more information, contact Anand Krishnaswamy (akrishnaswamy@kaufmanhall.com), John Poziemski (jpoziemski@kaufmanhall.com), or Walter Morrissey (wmorrissey@kaufmanhall.com) at 847.441.8780.

REFERENCES

Save the Dates for the Kaufman Hall Healthcare Leadership Conference

October 17-19, 2018 at the Four Seasons Chicago

Join healthcare leaders from across the country at the 2018 must-attend event for senior executives and trustees. This year’s speakers represent some of the nation’s top minds in business and healthcare.

Keynote speakers will be:

**Scott Galloway** is a Clinical Professor at the NYU Stern School of Business. He also is a serial entrepreneur, having founded nine firms, including L2, a think tank for digital innovation. His first book, *The Four: The Hidden DNA of Amazon, Apple, Facebook, and Google*, was published in 2017.

One of the world’s most celebrated business professors, he offers insights into the companies’ ascents, and associated lessons for competitors, business partners, and anyone living in the world they dominate.

**Siddhartha Mukherjee, M.D.,** an oncologist and cancer researcher, is the Pulitzer Prize-winning author of *The Emperor of All Maladies: A Biography of Cancer*. He has devoted his life to caring for victims of cancer, and his laboratory is on the forefront of discovering new cancer drugs using innovative biological methods.

An accomplished speaker, Dr. Mukherjee’s words both on the stage and on the page are powerful, illuminating, and inspiring. His newest book is *The Gene: An Intimate History*.

**Kenneth Kaufman**, Chair of Kaufman Hall, is known for his powerful insights on healthcare disruption. Through his presentations, articles, and blogs, he offers an unparalleled grasp of the economic, technological, and competitive forces undermining healthcare’s traditional business model, and guidance on how organizations should respond.

Mr. Kaufman has delivered more than 400 speeches and is the author of seven books, including *Fast and Furious: Observations on Healthcare’s Transformation*.

**Harry Kraemer** is Clinical Professor of Strategy at Northwestern University’s Kellogg School of Management, and former Chairman and CEO of Baxter International. Additionally, he is an executive partner with Madison Dearborn Partners (MDP), one of the largest private equity firms in the United States.

Mr. Kraemer is the author of two bestselling books, *From Values to Action: The Four Principles of Values-Based Leadership* and *Becoming the Best: Build a World-Class Organization Through Values-Based Leadership*. Back by popular demand, he will provide a new keynote for the 2018 conference.

Registration Opens in May!
The approach taken by organizational leadership teams to their rating agency review is vitally important in today’s rapidly evolving environment. An organization’s long-term competitive position is substantially dependent on its ability to raise affordable capital in the debt markets. This, in turn, is highly dependent on the organization’s credit rating and overall creditworthiness, so credit ratings matter.

Numerous expense and reimbursement pressures are affecting or could affect the credit ratings of healthcare borrowers and their access to capital. Additionally, Federal tax reform, direct competitive pressures between the corporate and nonprofit healthcare sectors, and other factors are fostering a greater degree of uncertainty and risk in the capital markets themselves. For all of these reasons, preparation for a rating review is really important. In-person rating agency meetings and subsequent communications are intended to enable rating agency analysts to assess the management team and an organization’s ability to repay debt—i.e., its risk of default. The end product from the rating agency is a specific rating and Outlook, which is reviewed regularly for the life of bonds or other instruments outstanding.

At the recent Kaufman Hall Healthcare Leadership Conference in Chicago, senior rating agency representatives offered insights about what they look for from management teams during in-person reviews. Selected comments on key aspects of rating agency reviews appear here from Martin Arrick, Managing Director of U.S. Public Finance Ratings Group at S&P Global, Lisa Goldstein, Associate Managing Director of Not-for-Profit Healthcare Ratings at Moody’s Investors Service, and Kevin Holloran, Senior Director and Sector Leader of the Public Finance Department at Fitch Ratings.

**Time Horizon**

**Martin Arrick**

Although an organization’s desired debt issuance may involve payments over a 30-year period, a credit rating is our current view of organizational ability to repay that debt. Our outlook generally covers a two-years-forward view for organizations with investment-grade ratings, and one-year forward for those with speculative-grade ratings.

Disruptive elements facing the sector or specific organizations may not have an immediate or near-term impact on their credit quality. For other organizations, major market disruptions may already be occurring and will need to be factored into the current rating and/or outlook.

We like to hear about what organizations are doing to address both current and potential issues. For example, a health system identified a royalty revenue stream that would be going away, so we factored that into our credit thinking because it was a definite outcome, albeit five years away. Or, as another example, the management team of a health system described its efforts to create a continuum of outpatient service offerings in an area where nontraditional competitors were starting to offer ultra-competitive low-intensity services. This discussion informed our thinking as well.
Rating Criteria and “The Story”
Kevin Holloran

In September 2017, Fitch Ratings released proposed revised criteria centering on key rating drivers—revenue defensibility, operating risk, financial profile, and asymmetric additive risk factors (e.g., debt structure, management and governance). After considerable market input, the criteria are now final, and were officially released Jan. 9, 2018.

Because the country’s healthcare system remains largely fee-for-service, rating criteria are still inpatient-focused. But we will adapt the criteria as the pendulum swings toward value. Metrics that potentially would penalize organizations that are doing the right things—i.e., keeping people out of the hospital by moving to a population health approach—will be de-emphasized.

Days cash on hand (DCOH) is one such metric. Organizations that are starting a health plan or a research program that might be monetized, employing physicians, or even functioning as a pharmacy benefits manager, have a growing expense base that squeezes DCOH. So emphasis on this metric penalizes such organizations for pursuing approaches that are promising to population health management.

Inpatient volume is still the cleanest metric across the country; outpatient data is not consistent, nor do all organizations have “covered lives.” There are no heavy, hard weights with our criteria. Rather, plenty of leeway and flexibility exist during rating reviews for leadership to tell the organization’s “story.” We want to hear this story.

Nontraditional Metrics and Organizational Direction
Lisa Goldstein

In 2013, Moody’s introduced 21 new indicators with some important nontraditional elements. These included new demand measures such as unique patients and new risk indicators such as risk-based revenues, employed physicians, and Medicare readmission rates. While inpatient admissions will continue to be important, unique patients will be a way to measure market share under population health strategies. This indicator is the number of individuals who receive care at the organization, whether inpatient or outpatient and irrespective of the number of visits, within a 12-month period.

Our conversation with a management team might include their efforts to improve health outcomes in their community (for example, by setting up mental health centers for the opioid crisis), new care coordination and consumer-centric approaches, and how much these initiatives will cost.

Rating reviews will continue to be financially oriented, but during the meeting with us, management teams should not be surprised if we don’t discuss the numbers at all. We want to use the face-to-face time to talk about strategy, governance, future direction, and levers the organization can pull if financial performance starts to decline. Getting into the nitty gritty of specific numbers, ratios, and computations can be accomplished via follow-up phone calls.

Consumerism, Payers, and Plan B
Kevin Holloran and Lisa Goldstein

Mr. Holloran: Consumerism is an issue that arises frequently during our rating review meetings. Like population health, it gets a disproportionate amount of discussion, although not quite as much action is taking place nationwide. But it’s the way healthcare is going. We want to know specifically how the organization is improving consumer access and approaches. One organization whose debt we rate is trying to completely reimagine the patient experience from the consumer perspective. They’re “living” consumerism, while others are just talking about it. Organizations that are not considering consumerism, whether through retail clinics, minute clinics, investments in technology-based delivery gadgets, or other approaches, are going to quickly fall behind the curve.

Ms. Goldstein: The biggest environmental issue we see right now involves payers and the pressure payers are putting on a provider’s top-line revenue. Many negotiations between payers and providers seem to be acrimonious, with many payers concluding “we’re done” with a specific provider. The challenge is that payers may have as much—if not more—brand equity in local markets, or regionally and nationally, as the healthcare organizations whose debt we’re rating. Payers also are steering patients to non-hospital based facilities for imaging and other outpatient services, raising the competitive landscape. Hospitals and health systems should have a Plan B for a scenario when they don’t get the rates and terms they are seeking in payer negotiations; and inform us if the contract vaporizes. Informing us early on about the substitute revenue strategy or a corresponding expense reduction strategy is recommended.
Forecasts and Assumptions

Martin Arrick

We definitely want to see organizational forecasts (which some organizations don’t share at this point in time). Forecasts should provide adequate level of detail, including assumptions, and extend three to five years, as appropriate.

For example, when we asked one management team about the possible impact of developments from Washington, an executive replied, “Let’s assume that with state Medicaid cuts to FMAP (Federal Medical Assistance Percentage), our percentage goes back to 55 percent; here’s the impact to our Medicaid book.” And the executive showed us specific forecasts for how the reduction would roll out and its impact on the organization’s revenue during the next years.

We want to understand the assumptions underlying the forecasts and learn what the organization sees as the risks. Conservative forecasts that management knows the organization can beat are less helpful; rather, we want to review a forecast that the management team believes they have a 50/50 chance of achieving or not.

Common Mistakes

Lisa Goldstein, Martin Arrick, and Kevin Holloran

A fair number of management teams come to the meeting ready to describe everything only as “going great.” The reality is this: Every organization in U.S. healthcare has a story to tell, and that story likely includes some degree of risk. So we want an open, honest, and brass-tacks dialogue, not a canned or rehearsed presentation.

When organizations are merging, and using the co-CEO and co-CFO model, we want to see one solid game plan, understand the interplay of the co-leaders, and why the combined organization has chosen the 2X2 model.

The more intimate the discussion via fewer people present, the better. It’s very valuable for us to see the depth of the next generation of leaders, and for organizations to give all meeting attendees a chance to speak—if they add value.

An organization’s credit rating is an asset to be managed as other assets. Protection and improvement of a credit rating requires careful attention and a high-quality financing plan.

Concluding Comments

Terri Wareham

By requesting a public rating, a healthcare organization is inherently committed to interacting with and providing ongoing information to the rating agency for the term of the issued debt that carries its rating. An organization’s credit rating is an asset to be managed as other assets. Protection and improvement of a credit rating requires careful attention and a high-quality financing plan. This plan reduces the average cost of debt and ensures access to debt to meet capital requirements.

To protect their credit ratings, the management teams of organizations with solid credit ratings bring to their rating reviews appropriately detailed information and highly engaged and informed c-suite leaders who speak succinctly about the organization’s strategy, financial plan, and demonstrated track record in achieving strategic and financial targets. The anatomy of a rating agency review is as fluid as the rapidly evolving healthcare environment. Readiness is imperative.

Kaufman Hall sincerely thanks the rating agency analysts for their participation in the conference session and this follow-up article.

For more information on best practices in financing and credit and capital management, contact a Kaufman Hall financial advisor at 847.441.8780 and stay tuned at www.kaufmanhall.com/consulting/healthcare/treasury-capital-markets.
Reflections from the 2018 Performance Management Summit

Tom Walsh, Software Division Chief Executive Officer at Kaufman Hall, sat down with Rob Kunzler, Chief Marketing Officer, at the conclusion of the 2018 Performance Management Summit (“Summit”), the firm’s annual software conference. Tom shared perspectives from the conference, including key client insights and the latest product innovations from Kaufman Hall.

Rob: You just wrapped up the 9th annual Summit—the third for you with Kaufman Hall. Tell me about this year’s conference.

Tom: I'm excited to share that the 2018 Summit was the largest in history. More than 350 CFOs and senior finance executives gathered in Las Vegas to hear from experts on leveraging modern technology to transform financial and operational data into organizational insights that enable performance optimization. In well-attended sessions, more than 20 clients shared their successes and learnings with their peers, a testament to the conference theme—Connecting for Success.

On the closing night of the conference, we had the pleasure of honoring five clients with our EPMmy awards: Dignity Health, MultiCare Health System, Quinnipiac University, The University of Vermont, and Westerra Credit Union. These organizations were recognized for accomplishments including innovation, performance, partnership, and individual contribution within their organization. This is one of my favorite parts of the conference because our clients celebrate their collective successes with their peer organizations.

Rob: During your keynote, you discussed the idea of Enterprise Performance ACTION. This sounded like more than a play on the EPM acronym. What did you mean?

Tom: We understand that our clients are using Enterprise Performance Management solutions as more than just tools for tracking and reporting. Our clients are leveraging these solutions to take and lead actions within their industry and for their customers. To our clients, it’s about activating deep insights into business strategies that fundamentally push an organization forward to success. It means taking action within their industry and driving the transformation of healthcare, higher education, and financial institutions, as opposed to reacting to it. It means raising the competitiveness and effectiveness of the organization, and that is what our clients are doing. As their partner, we play a strategic role in providing the business solutions that blend technology,
Kaufman Hall Again Recognized by Thomson Reuters as Industry Leader in Advising Debt Issuance

**Firm Surpasses 1,000 Long-Term Placements**

*Kaufman Hall* once again ranks as the No. 1 financial advisor in the U.S. in new healthcare debt issuance for both long-term municipal public and private offerings, according to Thomson Reuters’ 2017 *Municipal Market Analysis*.

Increasing market pressures and impending tax reform drove an unprecedented volume of financing in the fourth quarter of last year. Healthcare organizations had a significant need in 2017 to access capital in both the public and private markets, fund new money projects, reduce their cost of capital, and alter the credit structure of the enterprise. Kaufman Hall advised on the issuance of more new, long-term municipal healthcare debt than any other firm in 2017, supporting more than $10 billion in debt transactions on behalf of client hospitals and health systems.

Kaufman Hall advised on $6.81 billion in tax-exempt debt issues through 42 new healthcare long-term transactions (excluding private financings), representing a 23 percent share of activity with financial advisors in this debt market. The firm was also the industry leader advising on $3.48 billion in private long-term municipal issues, with 35 transactions to healthcare providers representing a 24 percent share of the U.S. municipal market.

Thomson Reuters has ranked Kaufman Hall as the No. 1 healthcare financial advisor for 12 of the past 13 years. Since 2006, the company has advised on more than 1,000 long-term municipal public offerings and private transactions totaling more than $111 billion in total par value, giving Kaufman Hall more transactions experience than any other firm in the not-for-profit healthcare market.

Kaufman Hall provides services exclusively to borrowers, and not issuing authorities. This allows Kaufman Hall's consultants to provide unbiased borrowing recommendations, and to vigorously advocate for clients' interests throughout the financing process.

To learn more about how Kaufman Hall is assisting hospitals and health systems with financing strategies, visit [www.kaufmanhall.com/fa](http://www.kaufmanhall.com/fa) or contact Terri Wareham at twareham@kaufmanhall.com or Eric Jordahl at ejordhal@kaufmanhall.com or 847.441.8780.

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Rob: You and other key members of the Kaufman Hall team shared a lot of exciting information around product innovation at the conference. Can you elaborate on that?

Tom: Our innovations stem from our technology culture and, importantly, also from our deep financial experience. The innovations are contemporary, purpose-built financial solutions that help our clients with Enterprise Performance ACTION. We’re investing significantly in products that respond not only to today’s opportunities and challenges, but also tools and technologies that will serve our clients in the many years ahead. We gave our clients a preview of some very exciting new software solutions for strategic initiative management, profitability insights, and comparative analytics that will be available later this year. It was energizing to see the client enthusiasm about these new solutions.

Rob: What are the dates and location for the 2019 Summit, so folks who are interested in attending can hold those dates?

Tom: By popular demand, we will be returning to the lovely Arizona Grand Resort in Phoenix March 10-13, 2019. I encourage everyone to mark your calendar and join us in the desert southwest for another energy-packed conference!

Rob: Thank you Tom.

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**Kaufman Hall Axiom Software Training**

For the current schedule of software training sessions and to register for a class, please visit [http://education.kaufmanhall.com](http://education.kaufmanhall.com)

Registration is limited. Class dates and availability are subject to change based on client demand.

For more information, please call 847.441.8780, or email training@kaufmanhall.com.
Industry Veteran Wes Champion Named Chief Executive Officer of Kaufman Hall

Kaufman Hall recently announced the appointment of R. Wesley Champion as Chief Executive Officer of the company as of April 2, 2018. Mr. Champion will succeed Therese Wareham, who has served as CEO since January 2012. Ms. Wareham, who founded Kaufman Hall with Kenneth Kaufman and Mark Hall in 1985, will continue as Managing Director, returning to full-time client work.

Champion joined Kaufman Hall in July 2017 as Managing Director and Chief Operating Officer. He previously held numerous executive positions in professional services and consulting. Prior to joining Kaufman Hall, he was Senior Vice President with Premier, Inc., leading Premier Performance Partners’ data-driven performance improvement practice. Mr. Champion also co-led Premier’s Performance Services operating segment, and was one of an 11-member executive team that successfully took Premier public in 2013.

“I am humbled, honored, and excited to have the opportunity to lead Kaufman Hall as CEO,” he said. “Kaufman Hall is unique in many ways, notably in the high caliber of people we have been fortunate to attract and retain, as well as our technology innovation culture. It is my goal to build on what Ken, Terri, the Managing Directors, software leadership, and others have created—a company that is committed to delivering unrivaled strategic financial performance solutions.”

Under Ms. Wareham’s leadership as CEO, Kaufman Hall has enjoyed strong growth, expanded its markets and client base, and acquired four companies to further its software and data capabilities. “I’m very proud of Kaufman Hall’s ability to help our clients compete in an extremely dynamic environment,” she said. “Helping our clients deal with complex strategic challenges has always been my passion, and I am pleased to continue applying that passion through my direct work with our clients.”

Ken Kaufman, Managing Director and Chair of Kaufman Hall, commented, “I am extraordinarily grateful for Terri’s dedication, leadership, and accomplishments in her role as CEO and throughout the history of Kaufman Hall. I am confident that Wes is the right person to build on Kaufman Hall’s tradition as an industry leader.”

“We are very grateful for Terri’s critical contribution and equally pleased to have Wes leading Kaufman Hall as CEO as the industries we serve continue to transform, and new opportunities for the company present themselves,” said Tim Sullivan, Managing Director of Madison Dearborn Partners. “We look forward to Wes continuing to accelerate Kaufman Hall’s strong growth trajectory.” Kaufman Hall is a portfolio company of Madison Dearborn Partners.

Mr. Champion and Ms. Wareham will work closely over the next several months to transition responsibilities, ensuring continuation of the key principles and values that have driven Kaufman Hall’s historic growth: to be a trusted advisor to its clients and to bring best practices in strategy, software, and data to achieve performance excellence.

STAFF NOTES

Please join us in congratulating...

Two executives have been promoted to Managing Director:

Ryan Freel joined Kaufman Hall in 2015. As a member of the firm’s Treasury and Capital Markets practice, he works with a wide range of healthcare organizations, including academic medical centers, multi-state health systems, children’s hospitals, and community hospitals. Prior to joining Kaufman Hall, Mr. Freel served as a Vice President in the Healthcare Investment Banking Group at Goldman Sachs, a Director in the Healthcare Finance Group at Citigroup, and a Vice President at UBS Investment Bank. His areas of expertise include taxable and tax-exempt financings in the public and private markets, derivative transactions, mergers and acquisitions, strategic planning engagements, and enterprise risk management.

Dawn Samaris is a member of Kaufman Hall’s Strategic and Financial Planning practice, and joined the firm in 2006. With more than 15 years of healthcare consulting and financial advisory experience, she is known for her thoughtful analytic approach to strategic issues. Ms. Samaris has extensive expertise spanning finance, strategy, capital markets, and partnership planning with a variety of organizations. Prior to joining Kaufman Hall, she was an auditor with Deloitte & Touche. Ms. Samaris is a regular speaker at healthcare industry conferences and organizational boards on the topics of strategic financial planning, healthcare’s evolution, and how industry trends inform the planning process.

Promoted to Senior Vice President were Gordy Sofyanos, who joined the Strategic and Financial Planning practice in 2011, and Gavin McDermott, who joined Kaufman Hall in 2010 and serves as a member of the firm’s Treasury and Capital Markets, and Strategic and Financial Planning practices.
Calendar of Events

MGMA Excellence in Practice Operations Conference
No Surprises: Better Budgeting and Forecasting for Your Practice's Future
Rod Nyberg
April 24, 2018, Phoenix, AZ

AHLA Health Care Transactions
Joint Ventures Used by Health Systems to Extend the Continuum of Care
Andre Maksimow with John Washlick of Buchanan Ingersoll & Rooney PC, and David DeSimone of CentraState Healthcare System
May 10-11, 2018, Nashville, TN

HFMA's Annual National Institute (ANI)
Strategies to Attract and Retain Consumers in the Age of Amazon
Dan Clarin and Jason O'Riordan
June 25, 2018, Las Vegas, NV

The Governance Institute September Leadership Conference
Anatomy of a Merger: Building New Governance & Culture
Mark Grube
Partnering for Healthcare's Transformation
Anu Singh
Sept. 25, 2018, Las Vegas, NV

IHA Fall Leadership Summit
Cost Transformation in Hospitals and Health Systems
Kristopher Goetz
September 26, 2018, Lombard, IL

Healthcare Leadership Conference
Save the date!
October 17-19, 2018, Chicago, IL

FIHFMA Fall Summit
M&A in 2017: A Year That Transformed Healthcare
Deborah Pike
Oct. 23-24, 2018, Oakbrook Terrace, IL

Kaufman Hall recently launched its third annual Healthcare Consumerism Survey and would appreciate your participation. The survey takes only 10 minutes to complete. Your responses will be confidential and shared only in aggregated form in the final report.

As a participant, you will receive a detailed report of our findings, including industry insights and practical strategies for long-term success. You also will qualify for a complimentary customized benchmark report comparing your organization's performance with the industry overall (delivered upon request in late summer).

Learn more: kaufmanhall.com/consumerism-survey