Establishing A Successful Cost Improvement Program

January 22, 2015
Strata Decision Technology provides the leading cloud-based SaaS financial analytics and performance platform in healthcare.

**Mission**

Help healthcare providers drive margin to fuel their mission

**Translation**

Bend the cost curve

**Founded:** 1996

**Headquarters:** Chicago, IL

**Employees:** 120+

**Client Base:** ~175 Health Systems 1000+ Hospitals
An Overall Perspective...

National health spending reached nearly $2.6 trillion in 2010 and is projected to reach $4.5 trillion in 2020.

80% of $542B is within the scope of care providers

60% of $320B of waste is generated in hospitals

Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act.
Annual Cost of Waste in the US Healthcare System according to a 2012 CBO report (not including fraud & abuse)
Sources of Waste

- **Failure of Care Delivery**
  - $150.0
  - 21%

- **Failure of Care Coordination**
  - $36.8
  - 5%

- **Overtreatment**
  - $232.4
  - 33%

- **Administrative Complexity**
  - $157.4B
  - 23%

- **Pricing Failures**
  - $123.5B
  - 18%

60% of $420B in waste from over utilization
It’s No Surprise . . .

Payers Don’t Want to Pay for Services that Don’t Promote Health Outcomes

Low Value Volume Will Decline

Reimbursement will Follow

*Without Serious Cost Improvement*

Margin will Decline
As revenue shrinks and margins tighten, providers have identified cost reduction as their number one priority.

**ACHE 2014 CEO Survey**

*Most Challenging Issues Facing their Organization*

1. Financial challenges
2. Healthcare reform implementation
3. Governmental mandates
4. Patient safety and quality
5. Care for the uninsured/underinsured
6. Patient satisfaction
7. Physician-hospital relations
8. Population health management
9. Technology
10. Personnel shortages

**Top Financial Challenges**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Medicaid Reimbursement</td>
<td>69%</td>
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<tr>
<td>Bad Debt</td>
<td>67%</td>
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<tr>
<td>Decreasing Inpt Volume</td>
<td>63%</td>
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<tr>
<td>Medicare Reimbursement</td>
<td>57%</td>
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<tr>
<td>Competition</td>
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</table>
Survey Says...
100 Finance Leaders from Hospitals & Health Systems

88% of providers have cost savings initiatives underway
(Range: $50-$400M)

Only 17% are hitting the target!
Why Cost Savings Initiatives Under Deliver

- Difficult to Quantify & Track Savings: 55%
- Difficult to Keep Track of Projects: 44%
- Lack of Accountability: 44%
- Projects Don't Produce REAL savings: 27%
- No Staff to Lead Projects: 26%
How This Typically Plays Out

**Identify Savings Opportunities**
- Consultants
- PI Teams
- Operational Depts
- Clinical Depts
- Support Depts
- GPOs
- Focused Tools
- Benchmarking

**Validate Savings**
- “Soft Savings”
- Not Operationable
- Poor Cost Data
- Challenging Analytics

**Implement Savings Opportunities**
- Lack of accountability
- Lack of stakeholder engagement
- Lose focus... too many projects

**Track & Maintain Savings**
- Labor intensive to track
- On to the next thing

**Actual Savings are Low**

Cost Savings

Needed Savings Target

Time
All was OK when volume & revenue was here…

A Case Study
900 Bed Academic Medical Center

Net Expense Per CMI-Adjusted Equivalent Discharge

- Estimated CPI Inflation
- Fiscal Year
A Case Study

900 Bed Academic Medical Center

Net Expense Per CMI-Adjusted Equivalent Discharge

But not when it’s here...

Goal:
Reduce CMI Adjusted Cost per Case by 25% in 5 years
We Took Action...
Teams

Executive Committee
8 Teams
Targets of $10-$45

Leadership

Each Team:
1-2 Vice Presidents
1-2 Full Time Staffers
Cross Functional Directors

Process

Ideas
Validated Opportunities
Operating Model
Budget Savings

Tracking

Variances Reported
Root Cause Analysis
Corrective Action Plans
100 people
9 months
$5M
$500K (tracking)

Then, do it again next year

$11M over 2 years

The Cost of Taking Out Cost
But, It Worked!

- From Q3 2011 - Q2 FY13, reduced cost by $220M
- Moved from 67th percentile to near the 25th percentile among AMCs
SO WHAT’S DIFFERENT HERE?
LET’S LOOK AT SOMETHING THAT IS WORKING WELL...
1999
IOM Report on Medical Errors

1990
Individual Clinicians
No Data

1990
Quality Committees
No Resources

2000
Dedicated Quality Leaders
No Sponsorship

2010
CMO & VP Quality
Defined Metrics & Benchmarks
Dashboards, Analytics Staff
Quality Committees
Physician Leaders
Quality Leaders
Transparent
Full Participation
Accountability
“The safest thing to do is the easiest thing to do”

Dedicated Leadership
Dedicated Quality Leaders
Well Defined Committee Structure
Annual goals & Metric Driven

EHR, POE, ADE Alerts
Well Defined Metrics
National Benchmarking
EDW/Reporting
Finance Leads  
Operations Leads  
Value Committees  
Dedicated Cost Leaders

- Difficult Buy-In  
- Lack Focus  
- Lack Resources  
- Lack Sponsorship

60%  
<5%  
<1%
**MIND SET**

- “Cost” is a dirty word
- Not transparent
- Opt out mentality
- Diffuse ownership, little accountability

**SKILL SET**

- Cost improvement is one of many priorities
- Limited ‘consulting skills’ & analytical strength
- Few innovators and convention challengers
- Outsourced to consulting firms

**TOOL SET**

- Excel
- Re-purposed tools
- Benchmarking organizations
Today’s Focus
Building an Effective Cost Improvement Structure

Quality Improvement Structures

Cost Improvement Structures

NATIONAL COMPARISONS

DASHBOARDS, ANALYTICS STAFF & TOOLS

QUALITY COMMITTEES

PHYSICIAN LEADERS

QUALITY LEADERS

CMO & VP QUALITY

WELL DEFINED COST METRICS

DASHBOARDS & ANALYTICAL HORSEPOWER

COST COMMITTEES

CLINICAL & OPERATIONAL LEADERS

COST LEADERS

SR LEADER OF COST IMPROVEMENT
Building an Effective Cost Improvement Structure

Well Defined Metrics

An Effective Cost Improvement Program has Well Defined, Broadly Understood Cost Metrics and Goals

• Moving the metric will result in savings on the income statement
• Should account for changes in volume and acuity
• **MUST** align with organizational priority and payer mix
• Should be used to select projects

**Examples**
- Cost per CMI Adjusted Admission
- Cost per CMI Adjusted Equivalent Admission
- Cost per patient
Example Metric

Cost per CMI Adjusted Equivalent Admission

Total Cost

CMI Adjusted Equivalent Admission

\[ \text{Total CMI} \times \text{IP Admissions} \times \left( \frac{\text{Total Gross Revenue}}{\text{IP Gross Revenue}} \right) \]
Example Metric

GOAL: Break even on Medicare
**Soft Dollar Savings**

- Increase efficiency
- May decrease the cost for an individual patient, but not for the organization
- Savings are theoretical ... no direct impact on financial statements

**Hard Dollar Savings**

- Reduce the cost per unit of service for the organization
- May *not* reduce the cost incurred for an individual patient
- Savings show up on the income statement
- Have a positive impact on margin
Cost - It Comes in Two Flavors

Are you working on the one that is right for your organization?

**Cost** to Provide Care

*Definition*
Provide the same care in the same location, but at a lower cost

*Key Metric*
Cost per Unit of Service

*Examples*
Reduce hours worked per test or per day
Reduce the cost of implants & supplies

*Financial Impact*
Same Reimbursement = Higher Margin
Declining Reimbursement = Maintain Margin

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**Cost** of Care Provided

*Definition*
Provide the highest value care, which often costs less and has lower charges

*Key Metric*
Cost per Patient

*Examples*
Move care to a lower cost care setting
Reduce length of stay

*Lower Volume*
Fee for Service: Reduce Revenue
Capitated: Increase Margin
SELECT PROJECTS THAT ALIGN WITH ORGANIZATIONAL GOALS

SET TARGETS & EXPECTATIONS FOR COST SAVINGS
Building an Effective Cost Improvement Structure

Analytical Horsepower & Dashboards

Strong analytic skills combined with powerful tools are necessary for an Effective Cost Improvement Program

• Easy access to clinical, financial, and operational data
• Ability to make complex analyses understandable and compelling
• Automate dashboards and the distribution of drillable data to promote accountability
### Supply Details

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Building an Effective Cost Improvement Structure

Cost Committees

Having a defined committee structure that regularly engages clinical, operational, and financial leaders is necessary to promote accountability and ‘system thinking’

• Committees should review key metrics and require owners to explain variances
• Committees should prioritize improvements and ensure that they align with organizational goals
• Committees should coordinate improvements to ensure value streams are not sub-optimized
Cost Improvement Committee Structure

Cost Improvement Steering Committee

Cost Improvement Teams
- Length of Stay
- Service Utilization
- Insurance Expense
- Admin Staff & Cost
- Equipment & IT
- Facilities & Maintenance
- Front Line Staffing Cost
- Supplies/Drug Cost & Use
- Benefits & Compensation
- Other Operating Revenue

Project Teams
- Nursing Aid Model
- Unit Secretary Model
- Overtime & Agency Expense
- EVS & Transport Staffing

- Project focused teams
  - Design and plan improvements
  - Ensure improvements are operationalizable and implemented well
  - Team members: Director oversee, managers as SMEs, Cost Leader to staff

- Cross functional teams
  - Identify opportunities, validate savings
  - Oversee a portfolio of projects
  - Accountable for achieving goals
  - Team members: VPs as sponsor/innovator, directors as SMEs/source of ideas, Cost Leaders to staff & drive change

- Sr. Leaders from all areas
- Establish targets
- Select & prioritize initiatives
- Ensure alignment with organizational strategy
- Receive monthly reports on results and project status
Clinical and operational leaders are critical in driving meaningful cost reduction. Structuring projects to leverage their expertise rather than rely on them for analytics and project management is important to delivering results.

- Frame cost improvements as an opportunity to address big, inner-department issues
- Staff teams with dedicated analytical and project management resources to allow leaders to function as idea generators and subject matter experts
- Encourage deep dives into operational processes and roles definitions to find opportunities
- Tie performance reviews & bonuses to performance on cost initiatives for clinical and operational leaders
# Word on the Street

## What We Hear

- “There is nothing left”
- “Our ____ is a mess, we can’t cut anymore”
- “We look good on benchmarks, clearly there is no opportunity”

## What It Really Means

- Can’t see the forest for the trees
- Systemic problem that spans departments
- Opt out mentality

- “There is not enough time for me to focus on cost improvement”
- “Quality, patient sat, physician sat, employee sat always come first”

## What We Hear

- Cost improvement is hard work
- Lack analytical skill set, time and project management focus
- Cost improvement is framed as “cost cutting” not “delivering value”

## What It Really Means

- Cost reductions are not sustainable
- “Cost always creeps back in”

- So-called “improvements” aren’t operationalizable
- Lack of tracking, accountability and structures to keep cost out
Define the Desired Outcomes of the Cost Improvement Initiative

Guiding Principles

“What **CAN** we do with $XM?”, not “What do we have to **GIVE UP**?”

- Maintain or improve **quality** and **patient satisfaction**
- Minimize impact to **front line staff**
- **Improve the operations** of organization, especially patient throughput
- Increase the ability for managers to **impact outcomes**
- **Strengthen management** skills
- Strive for **highest and best use** of individual staff
- **Think big**... but be able to operationalize in 3-6 months
Building an Effective Cost Improvement Structure

Cost Leaders

Dedicating resources to identifying and quantifying cost savings opportunities, then collaborating with clinical and operational leaders to design & implement improvements is necessary to realize results quickly.

• Dedicated resources to drive cost improvement projects
  • Lead and facilitate cost improvement teams
  • Escalate improvement ideas to the steering committee for project selection
• Partner with operations, clinicians, and finance to design and implement improvements that are operationally sustainable and deliver financial results
• Challenge convention & push toward innovation
The Role of the Cost Leader

There is no silver bullet... everything has to be on the table

COST SAVINGS

STREAMLINE Systems & Structures
- Benefits
- PTO days
- Capital Budget/Depreciation
- Insurance/re-insurance
- Outsourced Services
- Consulting Services
- Duplicate IT systems
- Supply Chain

ELIMINATE VARIATION in Care
- Implants
- Physician preference items
- High cost drugs
- Duplicate Imaging studies
- High cost labs as inpt
- End of life care

PURPOSE-BUILT Org Structure
- Defining roles to fill distinct purpose
- Defining goals for roles
- Using data to drive accountability for results

LEVERAGE TECHNOLOGY for productivity
- Automate routine work
- Automate processes with rules based technology
- Identify and eliminate duplicative processes

LEAN OUT MGT Structure
- Create ‘flow’ within a directors span of functions
- Bring functions together than work together often

STAFF to Demand
- Match staffing levels to volume levels
- Match skill level to skill needs

FLEX to Volume
- Adjust staffing levels to fluctuations in volume

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Are we getting the results we need from this process/department/role?

Why do we do it this way?

What do we really need?

When do we need it?

Who is the most appropriate role to do this?

What do we need to do to make sure this is successful?
Create a **PURPOSE BUILT** Organization

**Case Management Model:**

- LOS higher than expected LOC Write Offs
- RN Care Facilitators responsible for discharge planning, UM, LOC assignment
- Re-Focused 12 RNs on LOC & UM; placed in ED & OR where LOC were made
- Replaced 30 RNs with LSW to focus on Discharge Planning

$450K in Cost Savings
Reduced LOC Write Offs by $5M
Create a PURPOSE BUILT Organization

Patient Care Technician Model:

Complaints of Painful Blood Draws
Difficult relationship between RNs and Aids
High Call Off Rates among Aids

Nursing Aids Staffed 24/7
Work directed by RNs
Aids responsible for most blood draws

Reduced Nursing Aid hours to 6a–11p
Defined roles and tasks

Funded a phlebotomy team to perform all non-stats draws

$2.25M in Savings
Create a **PURPOSE BUILT** Organization

Clinical Department Management Model:

- Clinical, Operational & Financial Targets are Not Consistently Achieved on Nursing Units
  - 1 manager per unit
  - Over 80% of time in meetings
  - 10% of doing timecards and schedules

- Each Service Line had 3 Managers
  - Operations: Throughput & Staffing
  - Clinical: Quality & Training
  - Performance: Finance & Patient Satisfaction

- Created a new administrative role to do routine functions

$5M+ in Savings
Charging a senior leader with responsibility for driving cost improvement elevates the importance in the organization and provides cost leaders with support to implement improvements.

- Reports dually to COO and CFO
- Champions cost improvement efforts among senior leadership team
- Garners support for improvements (IT, HR, etc)
- Should challenge convention and drive innovation
- Should promote positive messaging and coordination of initiatives
Leading Cost Improvement

Common Mistakes in Cost Improvement

• Finance leads
• Operations leads ... finance is involved only to count the money
• Everybody owns it = no leadership
• Small scale projects done by PI teams
• No analytical or change management horsepower
• Organization-wide collaboration

Leadership Model for Major Cost Improvement

• Co-ownership between CFO and COO
• Large organizations: VP of Cost Improvement
• Senior leaders accountable for results
• IT, HR, CMO poised to support projects
• Dedicated “Cost Leaders” to analyze data, lead change, coordinate across teams
• Cross functional teams
• Accountability for results
Getting Results
Don’t Leave it to Chance

Cost Improvement teams need clear goals, timelines, and deliverables.
Building an Effective Cost Improvement Structure

**Cost Improvement Structure**

- **SR Leader of Cost Improvement**
- **Cost Leaders**
- **Clinical & Operational Leaders**
- **Cost Committees**
- **Dashboards & Analytical Horsepower**
- **Well Defined Cost Metrics**

*Doing the same thing will only get more of the same... We need something different*
Reduce the Cost of Cost Reduction

Increase the Impact

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