Observations of US Health System Governance, Strategy, Operations, Financings and Financial Management: Results of Three Years of Applied Research and Health system Leader Interactions

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1) Consolidation and Integration; Health systems and Physicians:
   - has accelerated and will continue;
   - waning interest by physicians in independent private practice;
   - capital structures of private practices vulnerable
   - majority of physicians to be employees of integrated health systems

2) Integrated Health System Present Very Different Strategy Profiles (as compared with historic, traditional community hospital):

- 60% ambulatory business
- coordinated clinical service lines across geographic sites
- pursuit of financial risk as a principal of strategy
- population health strategy feasibility
- rapid investments in large, ambulatory facility geographic “beach heads”

Frauenshuh Healthcare Real Estate Solutions, developed a new 120,000 square feet ambulatory care center in partnership with the Franciscan Health System in Tacoma, Washington. The new ambulatory care center fundamentally changes how care is provided by organizing physician practices into whole floor centers of excellence that support collaborative care and population health management. Segregated patient-only hallways, self-rooming, and expedited registration and check-out procedures enhance and streamline the patient experience. Frauenshuh fully financed the project and provided the hospital with a 50 percent ownership interest in the facility though the contribution of land and equity grant with limited impact on the hospital's balance sheet.

3) Industry Under-developed in the Area of Interprofessional Team Care and Care Coordination:

- professionals working in-parallel (not interprofessional)
- territorialism across professions
- physicians generally not interested in “working to the top of their license”
- lack of clinical care scalability at point of clinical service manufacturing and delivery

4) Physician Compensation Plans Do Not Effectively Align Incentives Between Providers and the Health Systems:

- still largely productivity-driven (wrvu's produced)
- incentives to produce wrvu's to highest levels
- reimbursements based upon wrvu's (e.g. Medicare scheme) allocates more wrvu's for complex encounters, but incentives may favor physicians doing less complex encounters

- in primary care settings, work done by physicians and APNs can look the same and APNs can be doing the more complex work
- definitions of “provider productivity” are not sufficiently broad within many compensation plans
- emerging evidence calls into question the assumption of physician shortages

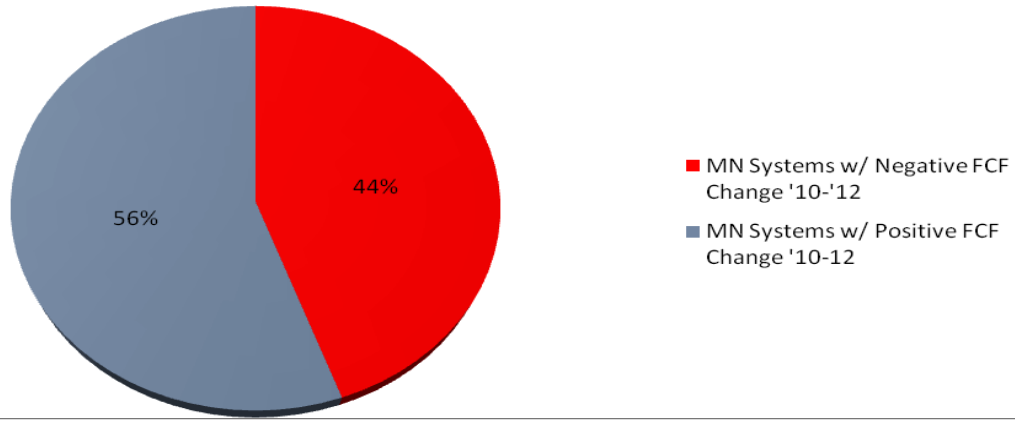
5) Balance Sheet Liquidity is at-Risk

- negative effects from “dilutive transactions”; mergers and physician practice acquisitions
- down-ward pressures on FFS reimbursements and utilization rates exacerbating problem

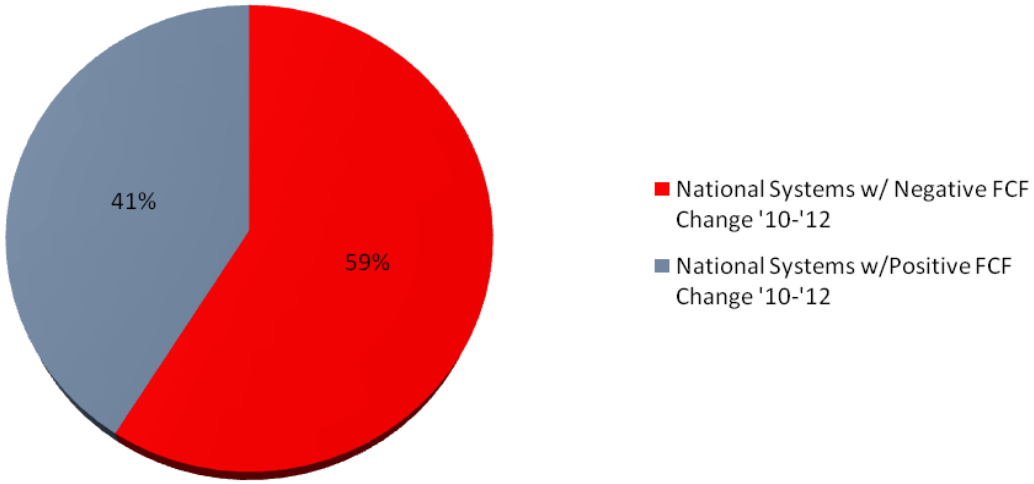
6) Free cash flow productivity of Health System Models and Strategies Differs Markedly

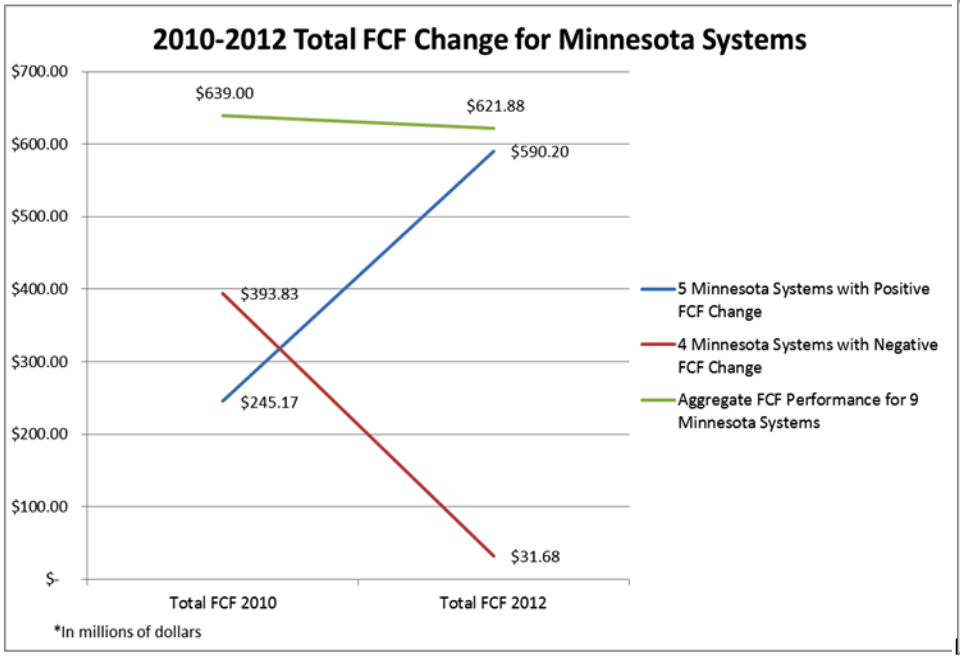
- three year decline in average FCF production for the industry
- closer look shows some are doing very well while others are doing very poorly
- for-profit sector stressing FCF generation at levels higher than NFP sectors

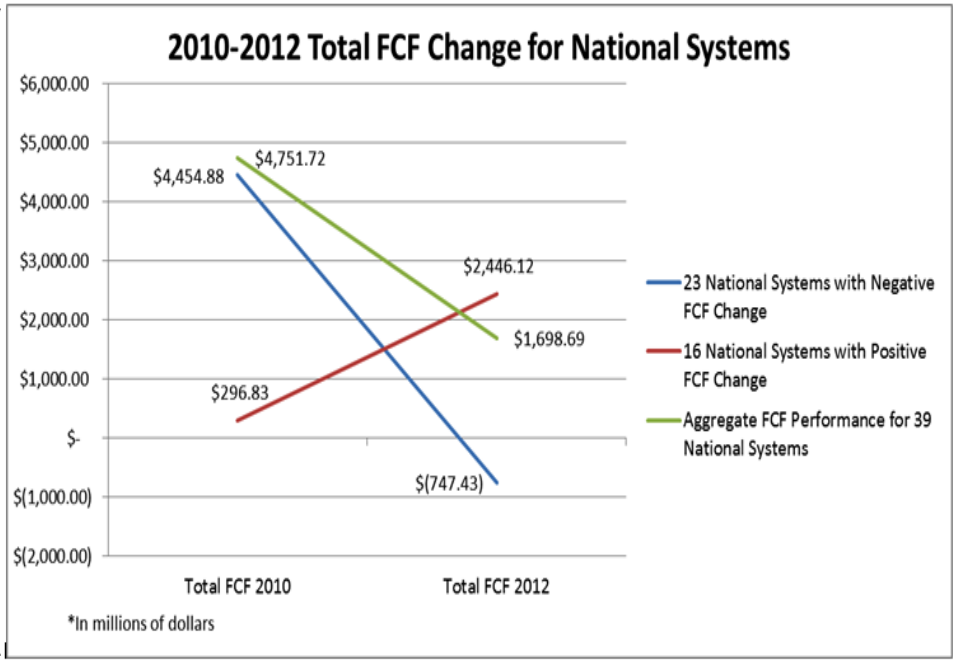
% Minnesota Systems w/ Positive vs. Negative FCF Change



% National Systems w/ Positive vs. Negative FCF Change







7) Alternative Financing Methods for Strategic Initiatives are Under-appreciated by NFP's

- much of the required strategic investments will not be financeable with tax-exempt debt
- real cost of capital financed by tax-exempt debt is misunderstood; related covenants "locks up" and constrains balance sheet liquidity, which has under-appreciated costs attached
- expected changes in US accounting rules will significantly alter income statement and balance sheet treatment of leases which will make alternative facility asset financing more attractive;
- the value of exiting a leased strategic facility is under-appreciated

8) Financing Broad Mission Responsibilities Will Become Increasingly Challenging Requiring More Active Governance Oversight

- cost shifting to a shrinking number of commercial payers has been exploited to staggering and unaffordable levels (what is the evidence);
- the reforming US healthcare economics will not tolerate unmanaged losses on governmental payers, uncompensated care and expansive community services campaigns

9) Acquisition of Public Health-Based Competencies Will Become Essential and Challenging for Health Systems

- total cost of care evaluations;
- the epidemiology of populations;
- health status surveillance and evaluations;
- large-scale behavioral interventions
- acquisition and accommodation to evidence-based best practices
- ability to adjust total costs of care to evidence-based best practices

10) Boards must become “Learning Organizations” and Rapid Cycle Adapters

- integrated design bring employed physicians to governance
- the span of traditional board activities may not be sufficient; e.g. policy, community service and mission oversight, capital structure, etc. Boards may need to become more operational and faster to adjust to environmental pressures and opportunities
- informatics for boards should be expanded

11) Innovation and Rapid Cycle Adoption of Evidence Based Best Practices Requires Investments, New Competencies and Active Management

- innovation is under-managed and under-invested institutional resource
- few good models
- competency goes to rapid cycle adoption and innovation of clinical, total cost of care and managerial best practices
- health system need to be taught the skill of innovation (should be intentional, directed, disciplined and evaluated for total returns)

12) Physician Leadership and Management Competency Development is a Required Strategic Investment

- the chasm of knowledge and language between physicians and health system administrators is revealed and enhanced by integration
- physician leaders will feel at a disadvantage and ill-prepared
- territories are threatened
- boards become confused and wonder who to believe; “doctors or administrators” organization needs a reliable, objective compass

13) Managing the “31%” Factor

- much (perhaps too much) attention is paid to the direct cost structure of clinical care
- G & A receives less attention
- disproportionate investments will go to infrastructure
- management teams will lack competencies in effective, scalable management of related areas

14) The Emergence of Brand Loyalty and Related Strategies

- consolidation will elevate the importance of brand
- brand clarity will be easier in a less-fragmented market place
- brand loyalty strategies will become more powerful
- brand will become synonymous with health and health status
- best physicians will be attracted to the strongest brands

Conclusion

- the speed of consolidation is under-appreciated;
- understanding of required governance, leadership and operating competencies are not sufficiently clear;
- the liquidity risks are real and the pressing question is what model(s) meet the challenges of change while they build balance sheet liquidity;
- change requirements at the point of care "manufacturing and delivery" are immense;
- demand for IHS strategic investments (especially "ambulatory" are "spring-loaded").