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Health System Fitness
*A Proven Approach
to Transformational
Cost Reduction*



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EXECUTIVE SUMMARY

In an environment of reimbursement reductions and declining revenue yields, stepwise cost reductions of 10 percent or more will be a top priority for hospitals and health systems. To achieve this level of savings and continue to fulfill their missions, hospitals and health systems will need a proven, yet nontraditional, approach capable of producing transformational cost reduction. Such an approach must enable health systems to simultaneously cut costs and grow stronger, unite everyone in the organization in a systematic and long-term cost reduction effort, and drive out the fear that inevitably accompanies, and often blocks, sustainable cost savings.

THE COST REDUCTION IMPERATIVE

Cost reduction is the top priority for hospitals and health systems in the near term. A survey conducted by the American College of Healthcare Executives in fall 2011 revealed that “financial challenges” and “healthcare reform” were the top two categories of concern among 514 community hospital CEOs, and within the latter category, the topic of most concern was “reducing operating costs.”

These concerns are well grounded. Reimbursement reductions are inevitable as federal and state governments grapple with out-of-control healthcare budgets. In January 2012, the Congressional Budget Office reduced its projected estimate of Medicare spending over the next decade by US\$69 billion. The American Hospital Association estimated that Medicare reimbursement cuts will

result in the loss of 278,000 hospital worker jobs. And Booz & Company models calculated that hospital revenue yields will decline by 15 to 25 percent in the coming years.

The looming shortfall in revenue yields will be exacerbated by two conditions. First, the inability or unwillingness of commercial payors to shoulder the rising burden of healthcare costs will create more pressure on the revenue line—cost shifting will be increasingly difficult for health systems. Second, there will be a steadily increasing need for funding as health systems are called on to invest in infrastructure, such as the physical plant, information technology, and medical technology, and in growth initiatives, such as acquisitions, new service lines, and organic market expansion.

Coping with these conditions will be particularly difficult for health systems that are already under financial pressure. They must right their ships as soon as possible to weather the storm ahead. But even advantaged health systems that currently enjoy strong market positions should act

now. Otherwise, they may not have the funds needed to pursue strategic priorities and adapt as the basis for competition shifts in the sector. Or worse, if declines in volume and reimbursement occur faster and deeper than forecasted, unprepared administrators may be forced to freeze hiring, cut jobs, and take other unplanned and unwelcome austerity measures. This is already occurring in some markets, and health systems that were not prepared are coping with deteriorating financials as well as the organizational trauma of reductions in force. In short, health systems can either address cost reduction proactively or risk having it forced on them.

To succeed in this more austere environment and find ways to redeploy funds for strategic investment, hospitals and health systems must realign their cost structures—and do so while delivering top-quality care, improving outcomes, and increasing patient satisfaction. We believe health systems need to reduce their overall cost structures by at least 10 percent, a highly ambitious goal that represents an unprecedented level of cost reduction.

TRANSFORMA- TIONAL, NOT TRADITIONAL

The standard cost-cutting approaches that were traditionally applied to hospitals and health systems will not produce the transformational levels of cost reduction needed now.

To date, much of this cost cutting has been tactical in nature and consequently doesn't reach the core of the cost structure. Tactical cost cutting tends to be confined to individual departments or facilities. Typically, it is more focused on clipping budgets than making operational changes that drive out significant cost. The tactical levers that health systems usually pull, such as improved supply chain management, capital spending freezes, and cutting head count, do produce cost savings, but the savings tend to be limited and unsustainable in the long run. According to a survey conducted by the Healthcare Financial Management Association, less than 23 percent of health system executives believe that these actions deliver substantial positive results.

One reason that tactical cost reduction fails to produce substantial change is its reliance on an experiential approach through which industry "experts" apply lessons learned from other hospitals and health systems. This seems credible on the surface, but it contains an inherent flaw: The healthcare sector has failed to contain costs in the past and now faces the challenge of attaining an unprecedented level of savings, so how can relying on conventional wisdom and past experience be expected to save the day?

Similarly, benchmarking is often advocated as a cost reduction approach, but although it can be a viable means of hypothesizing whether and where there is room for improvement, it should not be used as a way to drive out costs (see "*Beware Benchmarking*," page 4). More fundamentally, relying on hospital sector benchmarks when the sector is underperforming simply doesn't make sense.

What health systems need is a cost reduction approach that can produce stepwise savings of 10 percent or more versus the single-digit improvements typically produced by other cost-cutting approaches. Such an approach to cost reduction must be systematic and forward-looking: It must improve results not only in the coming year, but in the years ahead. And it must allow for the transition time and retraining needed to minimize the organizational pain that comes with change. To achieve and sustain this level of savings, a transformative cost reduction methodology must be properly sequenced:

1. It must enable health systems to better understand their cost structures, recutting the financials to better gauge the true cost of activities across the organization.
2. It must drive out costs by redesigning care delivery and administrative processes and functions, while simultaneously unlocking the capacity, service, and clinical quality gains that are necessary to compete in the post-reform marketplace.

3. It must support a more effective cost management system: using standardization to lock in improvements and prevent cost creep, as well as changing the organizational culture to foster an atmosphere of continuous improvement to capture future gains in cost, quality, and service.

Such an approach is entirely consistent with creating the levels of fundamental change at the enterprise level that have been essential in other industries that have dramatically restructured their costs, but it has not been widely undertaken in healthcare. The typical hospital operating model has remained relatively unchanged over many years, and the result is an accrual of operational inefficiencies across the administrative and clinical areas that are keeping costs high, inhibiting quality, and detracting from the patient experience.

Another consequence of the lack of fundamental change is skill gaps that make it difficult for health systems to successfully undertake transformative cost reduction. Because the healthcare sector generally has not been subject to multiple waves of cost reduction, the skills for such programs are underdeveloped in administrators and clinician leaders.

Beware Benchmarking

Many health systems use benchmarking to guide their cost-cutting efforts, but its application should be limited for the following reasons:

First, it's difficult to find "apples-to-apples" benchmarks, which inevitably leads to irresolvable debates on the validity of the comparison—hardly what one wants when trying to persuade an organization or individual manager to take bold action.

Second, benchmarking can tell you if your organization is underperforming, but it doesn't tell you why. When benchmarks are used to create targets for line managers but are not accompanied by an inventory of actionable operational changes, line managers keenly (and rightly) resist.

Third, benchmarking can tell you how well your peers are performing, but it is not necessarily an accurate indicator of optimum performance. For example, one large hospital system found no opportunity for improvement when it used benchmarking to compare its revenue cycle function to those of its peers. It then undertook a cost driver analysis, which identified cost reduction opportunities amounting to more than 25 percent of its current cost base, in addition to new revenue opportunities.

DIFFICULT, NOT IMPOSSIBLE

If transformative cost reduction is essential for health systems, why haven't more systems undertaken the challenge? Typically, they shy away for two reasons: complexity and fear. Both are serious concerns.

There is no doubt that the healthcare industry is complex. Health systems must comply with a multitude of state and federal regulations. They must manage varied relationships with providers, which themselves use many different business models and incentive plans. They must navigate the reimbursement requirements of various payors. Their workforces are highly diverse and often represented by various unions. They must treat patients whose needs often cut across medical specialties, and cope with variations in volume. Care is fragmented across hospital departments, supported by myriad medical technologies, and enabled by information systems that often are not interoperable or integrated.

Cost reduction efforts have also been constrained by the lack of creativity, open-mindedness, and will to change within health systems. Often, administrators, physician leaders, and boards have been loath to take bold, proactive action to reset hospital cost structures. Healthcare systems tend to be people-friendly and community-oriented organizations that are genuinely concerned with the human toll associated with ambitious cost reduction targets. Furthermore, cost reduction efforts are frightening to employees, especially middle managers, who are essential to initiative success because of their deep understanding of how their organizations function.

Complexity and fear are real obstacles, but they can be overcome. To do so, what is needed is a cost reduction methodology that is capable of shedding light on the inefficiencies that plague complex operations. When that happens, opportunities are revealed that galvanize managers. The fear of

the unknown is stripped away as management teams begin to see the realities of the cost structure and how it is operationalized. Soon, fear is replaced with the energy needed to achieve sizable breakthroughs: People become owners of change rather than victims, and transformational cost reduction becomes possible.

This may sound like hyperbole, but it has happened in other industries that have successfully achieved stepwise cost reduction in the past. Consider the dramatic restructuring that has occurred in the U.S. automotive and airline industries, the investments in technology that have cut costs in financial services, and the revolution

in commercial aircraft manufacturing wrought by advanced production and lean techniques.

In fact, there is ample evidence that working smarter and optimizing cost structures are not impossible challenges in healthcare: There are innovative health systems that have found ways to deliver care more economically and efficiently with better outcomes. Some of our recent work for clients illustrates the point:

- A multi-hospital health system identified \$91 million to \$121 million in cost savings from corporate functions, representing 10 to 24 percent of the in-scope cost base.

- A hospital lab with substantial community outreach identified savings equivalent to 15 to 18 percent of its operating expenses.
- A network of primary-care clinics cut its visit costs by 21 percent and unlocked capacity to handle 20 percent more patients.

In the current environment, well-executed operational improvement programs that produce sustained cost savings like these can do more to bolster the bottom line than most growth strategies.

A BETTER APPROACH

To cut through complexity and fear, health systems need a cost reduction approach with two major components. First, it requires a technical component—a strategic framework and a tool kit that gives managers the ability to make sound triage decisions as to where to invest their efforts and then helps them to determine how to redesign operations to improve performance and extract costs. Second, it requires a cultural component that addresses and overcomes the inevitable emotional resistance to cost reduction, enabling managers to energize the organization and get results.

Cut Costs, Grow Stronger

Unlike budget-based cost reduction, transformational cost reduction starts at the strategic level, with explicit trade-offs about where to place, minimize, or eliminate investment bets, and then cascades down to the

operational level. This ensures that management gets to the root of an organization's cost structure (namely, the business decisions that predetermine a majority of costs before the first patient is treated), focuses on margin maximization, and creates a stronger organization that is better positioned for future growth.

Toward this end, health systems must identify the organizational capabilities that differentiate them in the marketplace. It is these capabilities—and the interconnected people, knowledge, systems, tools, and processes that enable them—that allow an organization to consistently deliver in its mission and out-execute its competitors. Booz & Company research has revealed that winning companies across industries build and hone their capabilities systems (typically composed of three to six interwoven capabilities) to succeed in their marketplaces.¹

Health systems must identify the organizational capabilities that differentiate them in the marketplace.

Capabilities are an essential filter for transformational cost reduction decisions. Health systems should focus their discretionary costs on essential capabilities, and cut expenses that do not directly support them. In short, they should not ask what they should cut, but what they should keep. The answers to this question will tell them how they can carve strategic opportunities out of their cost structures (see Exhibit 1).

Once management knows where it should focus its cost reduction efforts at the strategic level, it can begin to

systematically determine the cost baselines in those areas that hold the most potential for savings. Baselineing is a common exercise in cost reduction, and though it may seem mundane, it can easily become a source of contention and fodder for resistance if it isn't conducted properly.

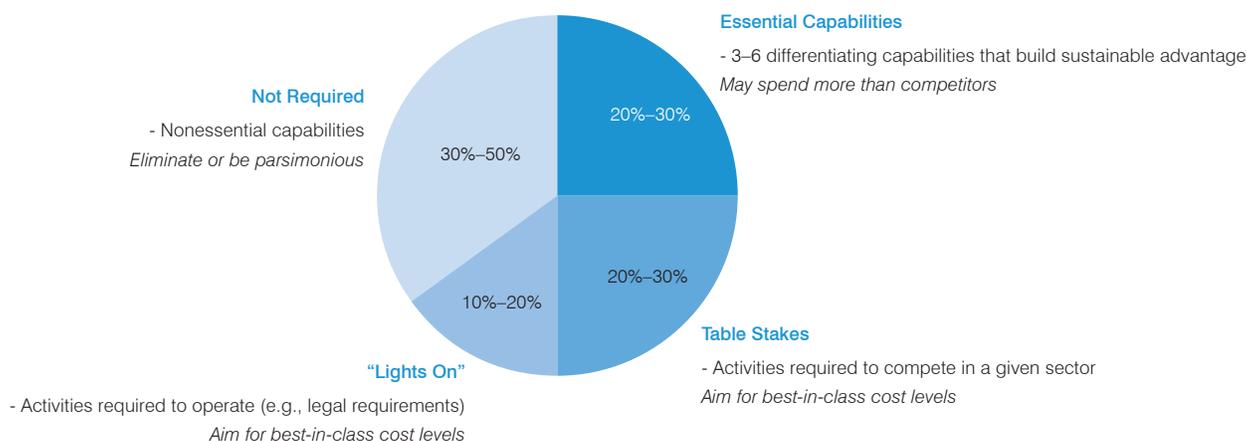
To be credible and serve as a sound foundation for change, baselineing must produce a "single source of truth" about how and why resources are consumed by the organization. This illuminates the current reality and surfaces cost reduction oppor-

tunities; it ensures that there is an accurate basis for analysis; it prevents disagreements that can derail cost reduction opportunities; and it creates the confidence needed to make and stand by cost reduction recommendations.

One of the tools that Booz & Company developed for this purpose is a hierarchical approach to analyzing the root causes of a cost structure called the ISSR framework. The framework is organized into four categories of cost (based on similar root causes) that are prioritized by the magnitude of their

Exhibit 1
The Capabilities Filter

STARTING COST BASE BREAKDOWN



Source: Booz & Company

impact and the difficulty in addressing them (see Exhibit 2):

- Inherent costs: “What do we do?”
- Structural costs: “How do we do it?”
- Systemic costs: “How well do we do it?”
- Realized costs: “How well do we apply ourselves?”

ISSR supports an analysis of cost and quality that is grounded in the operational realities of a health system. Such an analysis helps organizations understand the alternative operational and strategic choices that can be made in order to positively impact cost.

For example, baseline analyses in hospitals typically reveal many small departments with narrow spans of control, dedicated management teams,

and staff members with highly specialized jobs. Among the consequences of these silos: suboptimal patient experiences because care is fragmented and no one has responsibility for the entire patient experience; workload spikes, bottlenecks, and delays because no one is considering overall patient flow; and many redundancies in work, testing, and documentation between departments. Once these problems are identified, improvements can be

Exhibit 2
Targeting Cost Drivers with ISSR

Cost Drivers	Typical Types	Examples
Inherent	<ul style="list-style-type: none"> - “Product” lines - Mission - Target Market 	<ul style="list-style-type: none"> - Clinical expertise and service lines - Basis for competition - Teaching mission (e.g., academic medical center) - Patient segments targeted and served
Structural	<ul style="list-style-type: none"> - Physical Configuration - In-House vs. Contracted Services - Technological Capabilities - Health Information Technology 	<ul style="list-style-type: none"> - Size, focus, and location of facilities - Facility layout and breakdown into units/wards - Organization and deployment of ancillary capacity - Investments in and use of medical diagnostics - Use of contracted clinical services - Deployment of EMR, CPOE, HIS, etc.
Systemic	<ul style="list-style-type: none"> - Process Efficiency - Quality Assurance - Organizational Design - Use of Automation 	<ul style="list-style-type: none"> - Evidence-based medicine - Standard administrative and care processes - Quality assurance vs. quality control - Patient-flow efficiency and bed management - Internal metrics and best practices - Spans and layers of organization - Staffing algorithms
Realized	<ul style="list-style-type: none"> - Skill Levels and Professional Growth - Wage Rates and Incentives - Localized Efficiency 	<ul style="list-style-type: none"> - Experience and skills of employees - Job aids and efficiency tools - Clear understanding of roles and responsibilities - Speed and effectiveness of process execution - Incentives and link to performance

Source: Booz & Company

targeted. For instance, a single point of accountability can be assigned for each patient’s care; job roles can be combined; self-directed teams can be created to eliminate excess management; and so on.

As health systems move from diagnosis to treatment in their cost reduction efforts, they should resist the temptation to immediately cut budgets and capture savings. It is simply too early in the process. Risk-averse managers, who are energized by the prospect of innovative changes to the operations but not yet convinced of the exact savings, need more detailed designs in order to be comfortable with accountability for the savings—if they are not comfortable, they won’t be bold. Thus, health systems that under-

take transformative cost reduction should focus first on the planning and approval processes needed to ensure that proposed changes can be properly implemented. This requires assembling opportunities into a portfolio, prioritizing them, and defining the human capital, investments, and staff resources needed for their successful implementation. Further, planning should include a final check to ensure that the proposed actions will not negatively affect the mission of the organization, including the patient experience and clinical quality.

With these plans in hand, the management team can make sound “go/no go” decisions. But approaching the cost reduction effort systematically does not mean going slowly. Maintaining

momentum is important: It typically requires two years to reset a cost structure, although some changes can be implemented almost immediately. So, once plans are in place and the “go” decision is made, the plans should be implemented as quickly as is feasible.

Drive Out Fear

An effective approach to transformational cost reduction must also include viable tactics for overcoming emotional resistance to cost-cutting initiatives at every level of the organization.

Neutralizing an organization’s fears requires understanding them, cataloging them, and mitigating them with a full array of tactics (*see Exhibit 3*). These fears occur at all levels. Leaders fear that a commitment to reduce

Exhibit 3
Tactical Responses to Fear

Who	Key Concerns	Mitigation Tactics
Leaders - Functional leaders - Business unit leaders - Senior management team	- Savings expected immediately without a phased-in transition plan - Savings opportunities will be high-level concepts that are unsubstantiated and not actionable - Budget will be cut before operational changes are made - Savings analysis will not be transparent - Worries about career and power base	- Break program down into gated stages to move cost savings from ideas to implementation - Give executive team the collective responsibility for reviewing each savings opportunity and making the “go/no-go” decision - Commit to changing budgets only after the detailed design work is complete - Frequent, candid reports on program progress at senior leadership meetings
Team Members - Project management office - Working teams - Subject matter experts	- Recommendations will cause job losses - Censure by superiors and peers for participating in cost reduction	- Phase in savings over time and use them to fuel growth initiatives - Implement head count reductions via redeployment and natural attrition - Select team members who are high potentials and underscore their role as change leaders - Guarantee team members’ jobs for successful performance - Assign an executive sponsor to ensure there are no reprisals
Middle Management - Facility leaders - Department heads - Operations directors	- Lack of senior leadership support for long-term effort - Belief that cost reduction will devolve into budget cuts rather than real changes in how work is done - Belief that there is no more fat to cut—any reductions will hit muscle - Helping to identify operational improvements is akin to admitting to managerial incompetence	- Demonstrate commitment by following through with the program - Ensure that the analysis of savings opportunities and the detailed designs are rigorous and of highest quality - Frequent communication with program sponsors and senior leadership team - Guarantee amnesty and ban the blame game

Source: Booz & Company

costs will simply result in immediate budget cuts that force them to do what they've always done with fewer resources. Line managers fear a lack of commitment among senior management and the possibility that muscle will be cut along with fat. Team members fear that the cost savings they recommend could hurt their colleagues, and they worry about censure by their immediate superiors for participating in the effort.

To take the fear out of cost cutting and open the way for transformational improvement, cost reduction should not be done behind closed doors or pushed down to middle management. It requires a robust and transparent change manage-

ment process that should be led or actively sponsored by the CEO or by an influential member of the senior leadership team reporting directly to the CEO. The initiative should be added to the senior management team's regular meeting agenda, and all concerns should be openly discussed and addressed. All the senior executives should be promoting the initiative with their direct reports, many of whom will be involved in some part of it. And there should be regular check-ins (every week or two) with team members and line managers who constitute the front line of change—the goal is to create as inclusive an effort as possible in which people throughout the organization surface and implement cost reduction ideas.

Cost reduction should be done by employees, not done to them.

There also must be open and frank communication across the organization throughout the process. This helps to minimize counterproductive rumors. The “difficult” questions should be addressed early on, especially those about how surplus employees will be treated. Management should commit to treating the workforce with respect and decency and then follow up with actions—for instance, the use of retraining programs, natural attrition, and hiring freezes to avoid layoffs.

The goal is to create as inclusive an effort as possible. Cost reduction should be done by employees, not done to them.

CONCLUSION

Transformational cost reduction is an imperative for health systems, no matter what level of success they have achieved to date. It is the only way to ensure a healthy and prosperous organization that can deliver on its mission tomorrow.

Transformational cost reduction takes time, but when the right team follows the right process, we have seen health-care organizations reach the moment when the proverbial lightbulb goes on and illuminates the myriad of potential changes needed to improve efficiency. When this happens, cost cutting becomes an inclusive and highly participatory effort. Everyone gains a deeper and broader understanding of the problematic nature of

the status quo, and joins in the quest for better, more cost-effective ways to deliver higher levels of patient care and service quality consistent with the organizational mission.

When a collective understanding and openness to reasonable and viable alternatives to long-standing practices is established, sizable breakthroughs can be achieved. Better yet, a health system's operational improvement capabilities are enhanced along with this success. The health system learns an approach to transformational cost reduction and gains tools that can be leveraged across all its facilities and departments on an ongoing basis. Continuous cost reduction becomes a reality.

Endnote

¹ To learn more about capabilities, see *The Essential Advantage: How to Win with a Capabilities-Driven Strategy* (Harvard Business Review Press, 2011), by Paul Leinwand and Cesare Mainardi.

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