charting a path to efficiencies following a merger

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A business plan of operational efficiencies can help a health system achieve large-scale gains in cost performance and organizational alignment following a merger or an acquisition.

Healthcare reform is driving an increase in health system mergers and acquisitions. Almost without exception, these moves are billed as an opportunity to reduce costs and leverage scale to improve care delivery. Unfortunately, many merged organizations fail to fully realize the operational efficiencies envisioned before the transaction. Once select management positions are integrated and group-purchasing contracts have been consolidated, integration efforts often slow considerably or grind to a halt entirely. This pattern is seen both with true mergers, where two organizations are combined to create a new entity, and with transactions in which an organization acquires and absorbs another organization.

This failure to achieve the full potential of a merger or an acquisition carries two risks. First, incomplete integration can actually increase system costs, particularly when the combined organization creates a new layer of corporate oversight on top of the two merged entities. Second, poor integration can create trouble with regulators. The Federal Trade Commission, state attorneys general, and other agencies often approve health system mergers based in part on promised operational efficiencies. When these efficiencies fail to materialize, regulatory bodies can take action.

Why do merged health systems falter during the integration phase? A primary reason is that integration efforts lack a sufficiently comprehensive planning process. Specifically, many newly combined systems stop short of developing and executing comprehensive department-level integration and efficiency plans, causing the...
newly formed or expanded system to overlook efficiency opportunities—often critical ones.

In some cases, a merged system may develop a detailed integration plan at a high level and then issue the plan as an edict to departmental leaders and staff. All too often, these high-level plans are unrealistic and lack clarity and specificity with regard to resource requirements and accountabilities. As a result, such plans typically fail to engender organizational support, and execution falters.

An effective alternative is to develop a comprehensive operations improvement plan—most aptly called a **business plan of operational efficiencies** (BPOE)—using a broad-based departmental-level, or “bottom-up,” planning process. A BPOE is a comprehensive, detailed, and action-oriented plan for achieving full health system integration across administrative, support and infrastructure, and clinical functional areas. Created with the input of department and clinical leaders, a BPOE zeroes in on an organization’s true opportunities for achieving efficiencies while building support for comprehensive change.

**An Integration Road Map**

A BPOE is a road map for realizing the full benefits and desired efficiencies of a system merger or acquisition. Cost savings are a major focus, but an effective plan also identifies ways to deliver increased value by aligning resources and building on existing capabilities.

A key characteristic of a BPOE is that it is developed at the departmental level with input and insight from leaders who have firsthand experience in dealing with operational challenges at this basic level. This approach ensures that the plan is both realistic and sustainable. It also gives leaders at all levels of the organization an opportunity to become familiar with the plan and offer their insight and ideas before the plan is finalized. An effective BPOE does not simply dictate efficiency opportunities to organizational stakeholders. Rather, it provides a structure for engaging leaders at all levels of the organization and a framework to enable them to collaboratively identify efficiency opportunities and develop action plans for achieving them.

Departmental and clinical leaders should be involved early in the BPOE process so they can guide and validate the analyses and be prepared to execute the plan. We recommend the following five-step process.

**Secure executive sponsorship and involvement.** The BPOE process requires operational leaders to put everything “on the table,” so a strong mandate from executive leadership is critical. Success depends on strong support for the BPOE program from the system CEO and on active involvement of the COO, CFO, and chief medical officer.

**Establish an integration steering committee (ISC).**

The ISC’s charge is to organize and guide the BPOE process. Individual committee members should lead planning activities for specific departments and functional areas and step in when necessary to help overcome barriers or organizational resistance. A strong ISC will include a blend of administrative and clinical leaders to identify a balanced mix of cost-saving and quality-enhancement opportunities.

The ISC will work closely with the functional area leaders as they develop their plans to shape and advance their efforts in accordance with both the system’s strategic plan and other functional area integration plans. The ISC typically meets on a monthly basis to review plans, address identified barriers, and assign an individual ISC representative to work with each functional area leader.
and the leader’s teams to provide support and guidance, as necessary.

Develop guiding principles. The ISC’s first action should be to create a “value proposition” that formalizes the system’s goal of optimizing quality and outcomes while controlling costs. The guiding principles should be high-level goal statements that are specific enough to the system leadership team to drive decision making. Examples could include “We will provide the right care, at the right time, at the right place” and “Our patients will receive a consistent and fully coordinated care experience throughout the continuum.”

Identify and validate potential efficiencies. This is a two-part process. The first step is to use benchmarking data to take an objective look at every functional area within the system. The purpose is not to draw conclusions but to develop directional indicators of potential efficiency opportunities. The second step is to further investigate these potential efficiencies through an interactive, qualitative evaluation. Where benchmarking reveals a potential opportunity, discussions with unit leadership serve to validate and specify the action plans required to achieve the savings. Focus should also be on identifying barriers to implementation and quantifying the financial impact of any potential change.

The human resources (HR) department is one area in which efficiency opportunities are commonly identified. Organizations typically bring independent, self-sustaining departments into the consolidation process. Benchmarking the departments as a consolidated unit can illustrate the scope of operational-efficiency and cost-saving opportunities available by creating a centralized system function. A more in-depth, interactive analysis of the HR functions will identify duplicate departmental functions that should be consolidated and processes that should be standardized, resulting in opportunities for both salary and nonsalary cost reductions.

Develop an action plan for each department and function. Once true efficiency opportunities have been validated, the next step is to engage organizational leaders in developing a detailed integration plan. The guiding question for all efforts should be, “How can you redesign your functional area to add value to the system?” The product should be not just a set of strategies but a comprehensive list of detailed action items for realizing and sustaining the targeted efficiencies. These action plans are developed by the functional area integration teams and then reviewed by the ISC to assess their organizational impact and interdependence with other functional area integration plans. Once the action plans have been thoroughly vetted, the ISC will approve them and start the process to mobilize resources as needed to begin integration.

Systems that do not use this approach usually come up with only a handful of possible savings measures. In contrast, organizations that conduct a robust BPOE process typically identify hundreds
of potential efficiencies in administration, support services, infrastructure, and clinical services.

**Administrative Efficiencies**
Opportunities to integrate health system administrative services usually represent about 20 percent of the savings that can be achieved through a merger. Typical strategies include streamlining senior leadership, consolidating administrative functions, aligning contract services, and standardizing the health system’s quality infrastructure.

Centralization is a common theme for administrative functions. Newly merged systems sometimes focus on consolidating HR and finance departments. However, there often are significant opportunities in many other functional areas as well. Many large health systems maintain separate legacy units for compliance and marketing. Consolidating these functions can lead to both cost savings and performance improvements.

Historical performance is an important dimension of a BPOE analysis. For example, following a merger, the newly expanded health system may maintain two billing departments. A benchmarking initiative may disclose that one department has achieved strong revenue cycle metrics while the other department lags on key measures. This finding should inform decisions about departmental leadership and structure. Staff and productivity benchmarks also should be used to determine the optimal size of the combined department.

A particularly challenging issue is redesigning the leadership structure. It is critical that the merged system have a sensible matrix organizational chart. As a guiding principle, leadership positions should be built around functions, not individuals. On the other hand, a merger may create a need for new leadership roles in functional areas that previously were undermanaged. A population health leadership position is one example of a role often created for a newly formed health system.

**Support and Infrastructure Efficiencies**
Support departments and IT system infrastructure typically represent about 25 percent of potential efficiencies in merged health systems. In most situations, materials management offers many opportunities to gain efficiencies. For example, a newly merged health system can leverage its scale to negotiate better pricing on supplies. Such opportunities are not limited to pricing, however. Well-organized health systems can reduce spending related to preference items by establishing systemwide value-analysis teams and comparative effectiveness committees. These groups can be effective at wringing unnecessary and excessive cost out of the supply chain through product standardization.

Health systems also should take a fresh look at utilization patterns following a merger. Planning teams should look deeply into operations. For instance, we recently visited a hospital where every inpatient room was stocked with four or five cover blankets. Most went unused, while the system still incurred the expense of laundering them. This waste added more than $60,000 in costs annually.

Another major integration opportunity is facility and asset rationalization. As competitors, hospital systems in the same geographical area often mirror each other in terms of their physical asset base (e.g., clinic locations, physician offices, imaging facilities). Unfortunately, this asset footprint often remains largely the same following a merger. Merged health systems typically can realize major savings and
efficiencies by applying fresh strategic thinking to a system-oriented facility plan.

**Clinical Efficiencies**

Efficiencies in clinical operations usually are the hardest to achieve, but they often represent the bulk of potential gains. For most merged health systems, improved clinical efficiencies represent about 55 percent of potential savings. A major problem with most hospital mergers is the failure to consolidate legacy services into unified clinical programs. This challenge applies to all clinical programmatic offerings, both within the walls of the hospital and beyond. A comprehensive BPOE should incorporate all aspects of the care continuum, including ambulatory services, inpatient programs, home health, postacute services, and especially physician practice resources.

For example, the cardiology service line within a merged system often amounts to little more than a loosely organized collection of medical specialists, imaging resources, and interventional services. Many newly merged health systems have a significant opportunity to reduce costs and increase value by creating a single, unified cardiac program. Key characteristics include:

- Standard, evidence-based protocols
- Well-defined care pathways
- Coordination of services across the care continuum
- A single medical record supporting a unified patient experience

A seamless, systemwide cardiac program that incorporates these elements can reduce utilization and labor costs while improving access and patient satisfaction. This type of systematic approach should be applied to all specialty programs and clinical services, with the ISC and program leaders using these key characteristics as a basis for identifying improvement opportunities.

Clinical departments also have an opportunity to leverage scale. For instance, some merged health systems miss the opportunity to consolidate contracts for malpractice insurance. Joint contracting often can save a system more than $1 million annually. Product standardization and the adoption of system-oriented inventory management are two mechanisms by which both small and large healthcare systems can achieve savings. The size of the system will have an impact on the scale of total savings opportunities, with large systems typically wielding more buying power leverage than smaller systems.

The design of integrated clinical programs should be driven by the expected future demand for services, incorporating local, regional, and national trends, with population health being an increasingly important factor. Resources across the care continuum should be allocated to satisfy these demand projections, as opposed to being based on current capacity and existing infrastructure. The result is a portfolio of integrated clinical programs optimally structured to meet the rapidly evolving needs and expectations of community constituents.

**Turning Opportunities into a Plan**

The opportunities noted above are just a handful of examples. A well-organized BPOE process typically identifies hundreds of validated efficiency opportunities in every corner of the organization. The challenge for the ISC is to effectively coordinate and prioritize these items, and to position the organization for success when it comes time to execute the various action plans.

Key factors include:

- Time frame—Knowing how quickly an efficiency opportunity can be implemented and realized
- Difficulty—Recognizing which action items face the greatest obstacles in terms of culture or complexity
Prioritizing action items over a three-year implementation period is ideal because shorter time frames often are unrealistic and unachievable and longer implementations risk losing momentum. As with any change initiative, it makes sense to give priority to action items that will provide early, high-dollar gains. In our experience, roughly two-thirds of identified action items can be implemented during year one.

Administrative and support/infrastructure items generally can be fully realized between the middle and the end of year two. Action items that depend on IT integration can fall later in the implementation period, depending on the individual entities’ legacy electronic health records. Clinical efficiencies often take the longest to be achieved, as is evident in the exhibit below.

Source: The Camden Group, 2015

Efficiencies in administrative and support/infrastructure functions are typically in place after two years. The bulk of clinical efficiencies are usually not realized until the end of year three. In this example, total system savings amount to $31.2 million.
Understanding the Opportunity

Most health system leaders do not understand the scale of the efficiency opportunity that organizations typically enjoy following a merger. Even for mergers that took place several years in the past, a robust BPOE process can achieve surprising results. For example, consider the case of a three-hospital system in the Midwest that was formed by a merger in 2012. Leaders went after the “low-hanging fruit” early on, mainly in the area of corporate structure. In the years since, the health system continued to grow through the acquisition of medical practices and outpatient facilities. The health system was well-managed overall, with strong margins, giving leaders reason to believe the organization was running efficiently.

In 2013, system executives and operational leaders embarked on a BPOE process. Planning teams scrutinized operations within 48 departments and functional areas. They used benchmarking to identify potential efficiencies and a discussion process to validate opportunities to reduce costs, enhance revenue, and improve service delivery.

Altogether, the organization identified more than 500 action items that subsequently were incorporated into a comprehensive BPOE. To date, the integration process has helped the system realize more than $15 million in financial improvements, with the potential for an additional $35 million in efficiency opportunities that are being actively pursued. These savings typically equate to between 3.9 and 5.5 percent of the health system’s operating budget.

Objectivity and Transparency

The main challenge to an effective BPOE process is organizational inertia. Yet this challenge can be overcome with a strong and committed ISC that reaches out proactively to engage department leaders systemwide and helps facilitate an objective approach to analyzing efficiency opportunities and making decisions.

The key is transparency. System leaders must strive to create a highly structured and “above-board” process to help participants overcome mistrust and bias and work together to pursue the full range of integration opportunities. A transparent, collaborative process can spark broad-based organizational momentum, which can be critical to mitigating the destructive impact of stakeholders who resist change and prefer the status quo.

Ultimately, the BPOE process can be instrumental to transitioning an organization’s mindset from “us and them” to “we.” Moreover, creating a shared culture around efficiency and value is critical to achieving new operational efficiencies even in healthcare organizations that have not merged. Although a merger, by its very nature, is likely to present a much greater abundance of such opportunities, any hospital or health system can benefit from undertaking a BPOE-type analysis to optimize its cost structure in a healthcare environment that is relentlessly demanding increased efficiency.

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