SCALE community

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# The Reality of Scaling Health System Networks

## A Story Close to Home with Physician MSOs

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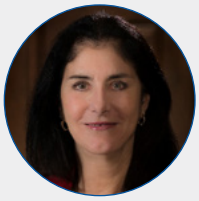

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## Key Takeaways

While the hospital and MSO markets are often looked at as largely distinct, health systems are, in many ways, structured a lot like physician MSOs and are subject to many of the same market forces. Both have formed in response to offensive and defensive pressures to scale. Both health systems and physician MSOs represent multi-site physician-based networks grappling with questions, opportunities and challenges around:

- Creating a unified culture across the network
- Integrating culture and operations across disparate legacy sites
- Optimizing performance and affecting change across the network
- Weighing growth for the sake of growth versus realizing tangible revenue & cost synergies through scale
- Balancing the potential upside of value-based care and emerging digital / virtual / mobile solutions with the investment and execution lift required to effectively and holistically roll out these programs
- Managing a business that is ultimately a people-driven business
  - Provider partnership & engagement
  - Overcoming organizational inertia and legacy biases
  - Managing for a desire to retain local market autonomy
  - Stakeholder incentive alignment

Organizations in both markets that have successfully integrated have benefited from favorable market positioning and compelling value creation and returns on growth. Organizations that have failed to navigate through effective post-close integration have often faced adverse outcomes as they scale, ultimately resulting in value destruction. And, organizations that have stood still have languished and become add-on acquisition targets.

Similarly, in both markets, setting the guiding principles for organizational culture & strategy begins at the Board level. The quality of Board discourse can vary widely across individual assets and is a key leading indicator of the quality and durability of the organization being built.

Hospitals and physician MSOs often view each other as either playing in different silos or competing with each other. Given these structure, strategic and operational similarities there may be value in these two pockets of the market spending more time (i) engaging with each other (ii) learning from each other and (iii) consider ways to partner to help solve for the other party's opportunities and weaknesses.

## Background

I started my career back in 2005 in the Pennsylvania Health System and moved up in administration, eventually becoming CEO of a Pennsylvania hospital and the COO at a larger hospital at the University of Pennsylvania. I became the CEO of the broader Pennsylvania health system, which was a three-hospital system in Philadelphia plus an enormous outpatient footprint. Six years after that, we merged into Thomas Jefferson University, where I was the Chief Integration Officer. My role was to bring 17 hospitals into some semblance of an integrated healthcare system. And to give you an idea, we were building everything from scratch because there was no common, as you could imagine, HR. So, all of the back office corporate departments had to be formed, including finance, putting together a CBO, doing revenue cycle, and then moving that forward. But, the biggest challenge, which is always a challenge in any organization, in any integration, was developing a common culture. And still, to this day, they're struggling with that. Cultural integration is the thing that I think is most apparent in any of these deals that go forward and why they often fail. After that, I left and worked for Prospect Health System and did extensive work with them on the venture capital side, as well as managing the East Coast market for them. I had 17 hospitals across New Jersey, Connecticut, Rhode Island, and Pennsylvania and was responsible for everything there. I left to do consulting work. Most recently, I was at Atlanta Care for the last eight months. So, I have a pretty varied background. I was also on the education side. I have a doctorate in education, an MBA, a master's in nursing, and a master's in education.

## Interview

### What was it like every day managing 17 hospitals? What does that job look and feel like on a typical day?

That's a great question. I mean, people were always kind and cordial, but what it felt like you needed to focus more on influence than on leadership. And often, in our careers, because there exists a hierarchy in many organizations, we get things done because we are the boss over a particular issue or department. But, when you had 17 hospitals, and you can imagine the various groups that you were trying to satisfy - from the physicians to the CEO of those hospitals to their boards - that what you had to do is really learn how to influence. It's a different skill set than management or even leadership. So, influence took time, and it was something that I didn't discover right away. You can imagine that you could see some failures because I was used to being the CEO. When you're the CEO, normally if you tell people this is where we're going or this is what we should do - and I believe in a collaborative leadership style, but even with that - when you're the CEO, people generally follow you.

When I was the chief integration officer, they could choose not to if they didn't want to. And even though I reported directly to the CEO of the hospital, there were those who shook their head and said yes and then went off and did what they wanted. So, the biggest thing and my day-to-day challenge was really how to learn to influence people in the appropriate way to get them moving in your direction, while having them think it was all their own idea.

### These 17 hospitals, did they fall within a larger family of hospitals across the Jefferson Health System, or was this the entire universe at the time?

The entire universe at the time. Academic medical centers are really different from community hospitals. In academic medical centers, you have is little fiefdoms because every chair is a leader of their department. We had had a lot of community hospitals. The hospital, for those of you who are in the Philadelphia area, was Abington - Einstein just recently joined with them. And, many of those hospitals came with multiple hospitals. When I had Aria, I had three, Abington had two, and Einstein had four. Then, there were several hospitals in New Jersey, which had been the Kennedy Healthcare System. All very different cultures, very different ways of looking at things, different product lines that they all thought they were the best at performing. I was just at a conference down in Key West, and I spoke with an Abington former colleague. In her comment to me, she was disappointed at the outcome of their merger because she thought that they were going to get all these things and everybody was going to be looking to Abington to say, "oh, how do you do this?" Because in their mind, Abington did it the best. When you go into a large system like that, what you're going to fall under is the umbrella of the parent, and the parent was Jefferson, and the parent wasn't as interested in preserving local level autonomy. So, when you go back to influence, you've got all these people who come into this with different beliefs of what it's going to look like, and you've got to bring it to a singular belief. So, to your question, people came in as somewhat large entities in different geographies serving different populations - some very high socioeconomic, some low - and the chairs, as I was saying, and the parent at Jefferson had a lot of power in how things were going to go.

**What was the primary benefit that you were able to, or at least tried to, sell to all these different constituents attached to the concept of integration? What did you think was the most realistic and most impactful in terms of benefits to them?**

It was early on that I realized, and I mentioned it when we first started talking, that culture was the key because everything else is tactical. Creating a CBO is a tactical thing, to put HR policies in place - again, it's tactical. It's trying to get people to understand that they're in a new entity. What we did, and it's funny, they're still using it today, we created this term, and it was "One Jefferson." We put it on everything. We really started from branding and marketing - really internal marketing - to our people to get them to feel the pride of being part of Jefferson. We tried to preserve their individual culture, but also to understand that they're part of a larger culture. It wasn't until you saw some movement in the One Jefferson cultural adoption that you got real cooperation. People had to grow to understand that they were no longer a standalone organization and that they were now part of a bigger whole and that they needed to behave differently because of that.

That sounds simplistic, but that was the biggest thing that we were really bringing together. With everything else, we had a lot of help. At one point, we did a very large contract with GE Healthcare, and there were probably 150 consultants working with me. Jefferson was a big organization with consultants; they had lots of consultants in and out, but we were doing a lot of the work, the tactical work, and then also working on the cultural aspect. One of the things that the hospital system brought, and this is probably seven or eight years ago, was really focusing on AI and staffing in healthcare. As you all know, in particular areas such as the operating room - if you're a trauma center, labor and delivery, in the ER - it's subject to unpredictable volume, which makes it difficult to staff. We were using AI and machine learning way back then to try to do some smoothing and ensure that we had the appropriate staffing. So that was a big help. But going back to your specific question, it's really about changing the culture. They say when you're doing mergers, culture eats innovation every time, or culture can eat the whole process of the merger. And it is absolutely true.

**We see hospitals becoming health systems, hospitals joining preexisting health systems, health systems expanding across state lines, and health systems expanding across the entire country. We see the demise of individual hospitals of all kinds – academic, community for-profit and nonprofit - due to their lack of size. We also witnessed, especially most recently, the FTC and state-level regulators becoming increasingly concerned about large health systems becoming monopolistic in certain markets. How do you balance those two concepts because they seem to be in contradiction with each other? On the one hand, there's an enormous momentum to scale and aggregate as a health system in order to survive. Most hospitals are struggling in terms of profit margins. Budgets are struggling in terms of their manpower and labor costs. And, yet, they're not really supposed to get too large. What are your thoughts on the subject? Do you see clear and obvious benefits to aggregating hospitals? Is it a net positive? What's been your experience of it?**

So most mergers don't work correctly because, just as I was describing to you, they don't become one entity. I think if you look at, and I know they're all on strike out there now, Kaiser Permanente, they've done fairly well at integrating the hospitals that they have brought together. Scalability only helps you if, in fact, you get to a place where you're not having duplication of services. And, it is really hard for organizations to do that. And, what do I mean? If you go back to the Jefferson example, when they brought all the hospitals together, you had several of the hospitals doing open heart surgery. Geographically, they were maybe 10 miles from each other. What needed to happen, and still hasn't happened because of political reasons, is you should get down to one program – the open heart surgery program should be housed at one of the organizations, and that is where all the resources should be put. But, nobody wanted that to happen because part of the issue is how the finances are set up. So, the first thing in your question is that when you do mergers, they need to be set up correctly so that you're not disincentivizing people not to make the right decisions. In reality, when you look at scalability, and you look at the research that is done now, it's not truly longitudinal because this has only been going on in healthcare for maybe the past ten years, and it hasn't really decreased the total cost of care. As an example outside of healthcare, I was at this board meeting the other day and all of the discussion in the banking industry now is about scalability and that you have to get to a billion dollars. When we merged Aria, that was the conversation - if you could be a billion dollars, you're going to be okay. Well, that's not true because now you've got these organizations that, and Jefferson again is an example, are not making margin post merging. What I'm telling you is not inside secrets - you could go out and look and find this information out yourself - I just want everybody to be aware that I'm not breaching confidentiality here. Jefferson is a $5 billion company and they haven't made margin since they did these mergers, and many of those hospitals were making margin beforehand.

So, in my estimation, scalability is really not the answer. If you go forward with scalability, what you need to do is then become efficient and effective.

And if you don't do those two things and you just bring whatever the industry is together, you just have a lot of pieces and no coordination.

**It feels like it's not a panacea. We see this in the outpatient world as well, the overly simplified business philosophy of "as long as I'm growing, I'm fine." And, "it doesn't really matter how many assets I'm acquiring; there's no such thing as acquiring too many." "It doesn't matter what the diversity is amongst the assets, there's no such thing as too much diversity." Our experience of that is that's far too simplistic and that the reality of scaling any business is far more difficult than that. Is that fair?**

I think you're absolutely correct. And I think the FTC has reason to be concerned not only in healthcare, but education is doing this now and, as I said a moment ago, banking too. It's no longer a singular community hospital that's serving a geography of maybe 25 miles. It could be a geography over multiple states, and if it fails, you've left a tremendous void. People are not going to stop merging because they do think it's a panacea in this era that we're living in now, but I think that what we need to understand and learn from the lessons of why many of these mergers don't achieve the outcomes that we've been looking for.

**I'm thinking of value-based care, virtual care, technology automation. You mentioned AI, and I'm also thinking about the movement, the migration of care to outpatient care and ambulatory care over the past 20 years. Which of these trends has been the greatest source of opportunity for health systems? Which of those big changes are they really heavily invested in and generating great results?**

I think if you start with value-based care, a lot of it was developed from CMS, it became something that quite many organizations and CEOs adopted. And I will tell you, as a clinician, I think value-based care is really where we should be going. However, it goes back to the same thing when I was saying why some mergers fail: it was disincentivized because payment models never caught up with the concept of how you were going to be delivering care. We saw this many years ago when it was the rise of HMOs, and they were not adopted by many of the American population just because they didn't want to have to get a referral source. So, I think value-based care is important. I think a lot of CEOs still think it is, but they're holding onto the fee-for-service model as much as they can, and they're not going to let it go. In actuality, the organizations who didn't do anything in value-based care did far better and have better margins today than those who tried to do it. So, from a strictly financial perspective, I think that value-based care is sort of teetering, but from a clinical perspective, it is the right way. When you talk about outpatient remote patient monitoring, interestingly, there is some data that is coming out, and it is saying that value-based care and all of this effort to try to improve the care of the patient in the home has not been decreasing the total cost of care. That was really the impetus behind it, as we had thought it was going to. I found that interesting because I think if you run these programs properly, they absolutely should reduce the cost of care. What is the big problem? It's compliance. And part of it is when the health systems set these programs up, they are not investing enough money into some of the boots-on-the-ground people to be able to have this effectively operationalized. Many hospitals say, "okay, what is my biggest cost?" It's labor. It's usually 60 to 70% of our expense portfolio, so let me eliminate some positions because that's an easy way to try to get that cost down. And who do they eliminate? People like your care coordinators and your social workers. You see lots of that happening. I think remote patient monitoring is the way to go, but again, it's this misalignment of how people get paid for things. Medicare does pay for it now, but a lot of the other insurers do not. So now we're having a two-tiered system where you get Medicare patients on it, but everybody else, they're not going to have that available to them. So, to your question, I think the big global things that are on the horizon, or have been here for a while, all have utility, but we've got to look at how it's set up. It all comes down to what somebody told me early on in my career, and this is true: follow the dollar, and if we don't do it correctly and someone can't make money from it whether it's a good thing for the patient population or not, it's not going to take hold. One of the things that you did mention is around AI. I had a lot of opportunity to investigate this in a previous role that I was just in.

And I think that, and this is true for the entire labor market, when the cost of labor becomes so high, and you have double-digit increases every year, they're going to figure out how to do a lot of functions through technology, and you're already seeing it.

I was speaking to somebody in the military yesterday and he was telling me, which ties into your question, that there is a new aircraft carrier that was just developed by the United States Navy. If you were to stand the aircraft carrier upright, it would be the size of the Empire State Building. It's very, very big. And aircraft carriers used to require 24,000 people, naval people, to operate it. This new one requires only 1,400 people. And, so it's the point that I'm making - and you're seeing this in healthcare, you're seeing this in every industry - is that labor costs are driving technology to figure out how to do a lot the work without people. That doesn't mean that we're going to not have people in any

role, obviously, but the jobs are going to be very different. And I think that we're on the precipice here that many of the traditional roles that people have played in healthcare are going to be upended because of technology. So, to your specific question, I think that is going to be the one that is going to be the biggest disruptor. And, that is what we need to watch because I do believe that it's going to have a significant effect on the labor market.

**Automation tends to work well in a very narrow scope as soon as it's introduced into a very complicated environment. I would say a hospital on its own offers so many different services, and healthcare has a lot of inherent complexities to it. This concept of unintended consequences and complexity. Complexity raises its head time and time again. I'll use an analogy to match your analogy. The NASA space program and the construction of satellites have gotten far more complicated over the last 50 to 70 years. There are many more parts today in a rocket than there were 50 years ago, and that complexity creates error. They still blow up, they still fail, and it creates a lot of need for a lot of technical expertise. There are hundreds and hundreds of companies involved in the construction of any one rocket through outsourcing. So, it's interesting when we talk about these large changes, virtual care, value-based care outpatient, some of them are more experiments than others, and some of them create more unintended consequences than others and things that are experimental. Some hospitals can participate, others can't, some succeed, others don't. They're not necessarily as one-dimensional as pure automation would like to think. So, it's just interesting to observe other big trends out there. And, I am wondering how the average health system executive, if there is such a thing, feels about these trends. This might include vertical integration, absolute integration between payers, health systems, and providers, and then horizontal integration. Now introducing large big box retailers, both digital and brick and mortar, into the health system equation. How do health system executives react to those big changes? Just because a change is big doesn't mean that it's sustainable, right? We've seen waves of new entrants into certain marketplaces that come and go over time. How do they view payer ownership of large provider groups? The best example is UHC. Do they view retail groups owning health system assets as sustainable and the path of the future, or do they view it as a temporary wave?**

There's a great deal of concern around some of the new entrants, Amazon and United being in the provider market. So many of the hospitals had all their data in Optum, and now you have United owning it, even though they say there's a huge firewall and that they're not going to transgress that. So there definitely is concern. When I speak to my colleagues, some are more concerned than others. Others believe because they have a large scale that, they can compete. But, in reality, I think it would be hard to compete against somebody like Amazon or United if they really wanted to go all in. I think that what people are forgetting is this, and this is where I believe scale has a lot of potential: the physician. No one comes to a hospital to see an administrator or to see your insurance company. The relationship is with the physicians. And the only industry where the source of revenue is often totally independent from the source of what is providing that service is in healthcare. Physicians are often independent. Now, you're seeing some movement towards physicians becoming employed, but that often, depending on how it's set up, is not working that well because you're seeing a decrease in productivity. So, you see a physician that was producing X amount of RVU and, after moving to employment, now it's cut in half, they're taking longer breaks - which you would say, of course, people deserve, but that has been the unintended consequence, to use your words, around that. The other thing I think that we're seeing is that many physicians are joining into these mega groups. You've got urology, ortho, and then some of the physicians, notably primary care, are joining with other organizations like the United's of the world. It's going to be wherever the physician lands where all this movement in the market ends up.

This is what I think is the most important thing a hospital can do, is to really value their physicians, have them be at the table, make sure they're part of decision-making, and be seen as true partners.

Because if they don't start doing that – and I think oftentimes hospital administrators, I don't think I know they see the physician as a valued partner - that is what has created this disassociation. I really believe that that is the piece that we have to watch, and that is the piece that is most pivotal here. And then just one other aside with that, my other large concern, and I've noted this over the last several years, and you talked about the complexity in healthcare, which is absolutely true, are boards. So many hospital organizations have boards that have, they might be the local grocer or the person who was on their foundation. They have no concept of how to run these multiple billion-dollar companies that have much complexity to them. So it's very concerning to me that the governance piece, which is extremely important, is not up to par in most organizations. And then, at the same time, you've got a hospital failure to understand the importance of the physician.

**I'm reminded listening to this answer of other examples that have come and gone. Standard Oil/John D. Rockefeller's oil company used to have a 90% market share of the oil industry. And I know at the time, the one person in this country who thought that made perfect sense was John D. Rockefeller. So the nature of companies, whether it's United or Standard Oil, is to grow, but these things are rarely sustainable as the decades pass. So. it's just interesting to see how things will evolve.**

**Where do you see the hospital world going as opposed to the independent practice world? How do they relate to the same sort of hospital systems that we have?**

Here on the East Coast, I think you're going to continue to see the hospital practice world grow. There is this thought that if we own the physician, whether it's through a big practice, or in some other way, that we will be able to be successful. In California, as you are probably aware, you're not allowed to employ physicians there. And so, I think you're going to continue to see large growth in physician practice plans, and then the relationship with them is going to be very important in those states where you have that. You're going to see it evolve a bit differently based on different geographies, but I think that the most important thing when you think about the physicians is they have been socialized through their entire career, and rightfully so because they have to make these kinds of decisions to be independent thinkers and to be very decisive in what they do. And yet, they're not treated like that within the ecosystem. And I think why you're seeing the physician burnout phenomenon is that they're dissatisfied with their role and they're looking to go into other venues. There is a statistic that says that if their children or someone asked them, they would say, don't ever go into healthcare.

**Building on that question, should we expect an increase in outreach from health systems to form strategic partnerships with other health groups in the name of coordinated care and optimal outcomes for health systems and the challenges that they face today? Part of this is sort of opportunity seeking. Part of it is risk mitigation.**

I think it depends on how innovative the CEO is and how much they can convince their board of the importance of that. You see, Cedar Sinai has large innovation centers. Penn has Penn Innovation, and they're working very closely with startups as well as with current companies to have more vertical integration. So, not just horizontally, but vertically as well. I don't think you see that everywhere. Part of going back to scalability, if you're large enough, you can afford to do that. If you are a community hospital, it's going to be unlikely that you could have that as part of your agenda because of the cost. And at the same time, you don't have the bandwidth; you don't have the capability of hiring individuals who can make that their full-time role. So I think it's extremely important. There are so many interesting tech companies that are out there that are going to change the face of healthcare when you look at what's happening in the behavioral health space, which is extremely important. Andy Savage, who was the previous head of CMs, he started a company that is somewhat like the one about that you come and present to the group of people, Shark Tank. He's done something like that with startups, and he has brought organizations together. When I was at Jefferson, I was part of that group, and you would go and look at various people and demonstrate what they had, and you could choose to become a beta site for them or not. But that kind of thing is not going to be available to all hospitals, as I said because you have to have enough scale to be able to do it. But I think it's going to be really important as we move faster and faster in the development of ways to look at healthcare differently and look at the world differently.

I think AI is going to have a significant change in the way we do things over the next five years that we probably can't even contemplate today.

And it will definitely be seen in healthcare as well. A while back, I had mentioned that I thought it was going to displace some people, and I don't want to leave anybody with the thought that I'm saying that I don't think we're going to have doctors and nurses. It will be things like your registrar. You're not going to need a person to do that. I actually had blood drawn the other day at one of the local hospitals, and when I went in there, everything was totally automated. There used to be 20 people that were registering people, and there was one person there now, and all that person did was ask you if you were able to get through the sequence of things. So it's those types of changes. And you take that registrar person, how do we reeducate you? That's another big thing that I think that we need to think about in healthcare. I'm not suggesting we don't have you anymore - it's how do we teach you to survive and thrive in this new world?

**Maybe on that topic of surviving and thriving in the new world, I'd like to get your thoughts on the question of incentive structures within the hospital system. You've talked a lot about the need for change, confronting new types of competition, and new ways to compete. You also mentioned the challenges at the board level and the quality of the board in certain cases. Given all of that, what is the catalyst for innovation at the hospital, oftentimes that are nonprofit? You've worked across many different types of hospitals, some public, some for-profit, some nonprofit, some large, some smaller. Can you just talk us through that dynamic as a CEO? That dynamic as a board? And that dynamic at different types of hospitals with different ownership structures?**

I would say the for-profits, one of the things they do really well in is the data. And they manage and drive change through data, which I believe is really important. And I think the not-for-profits could certainly learn from them. One of the biggest advantages that healthcare has, in general, is the amount of data that we have. And if you look for an example, American Airlines, when COVID hit, monetized their data - they were able to hedge through what was going on during the pandemic and people not flying. Healthcare has far more data than that, and yet we have not learned how to monetize it. I think that when you think about innovation, it goes back to who are the people running it.

Not everybody believes in it. There are some people it's like, let's go back and just keep doing things the way we've always done them. I mean, when you look at the staffing model in the hospital, it's a nurse, it's a tech, it's a doctor. Well, what is the biggest rise that we've had over the past ten years? It's mental health problems. And they don't know how to deal with that on a med surg unit. Why don't we have social workers up there? Why do we just staff the way we've always staffed it? It's because we're not innovative. We tend as an industry in healthcare to be very conservative, to be able to not look outside of the box to say, well, we'll just keep doing this this way because we've had success ten years ago. So, I think that the leader of today needs to be really different, and you need to be open to ways of doing things. And that's why I believe that the board is so important here because you can't just have them agree with everything. The CEO, says there has to be pushback, and there has to be differentiation at the table. You've got to have a lot of diversity of thought, and you don't see that there. So, in order to get to what you're talking about, I think there needs to be change. And what will happen as people keep merging. You will see, hopefully, people who become innovative and continue to go down that road, but those who don't might be in existence any longer, or they might be merged into something else. So I think it's going to be really important. That's got to be part of the toolbox of the leader. And in a lot of places, I will tell you, it is not. I think that I will tell you that when I was at Jefferson, they were hugely innovative, but the CFO didn't want to see it happen. So that's the other thing. How do you bring your executive team together to have everybody on board? That's not an easy thing to do.