Relationship capital

The path to profitable growth through patient loyalty and provider productivity

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A renewed focus on profitable organic growth

After decades spent developing their physical assets, implementing systems, and making acquisitions, leading health systems are asking how they can best get a return on these capital outlays.

Unprecedented consolidation has occurred in healthcare in the last decade. Large health systems have grown through acquisitions and partnerships with rival hospitals, ambulatory care facilities, physician practices, ancillary service providers, and even health plans.

These transactions have begun to reshape the industry and have created systems that have the potential to deliver care in new ways more aligned with health outcomes and value.

Yet the reality for many provider organizations is that this inorganic growth has been disappointing or short lived. Balance sheets have been burdened with debt; acquisitions and joint ventures have failed to realize synergies or capture share beyond what was embedded in the separate entities pretransaction; and integration challenges are a continuous drain on resources.

Faced with these challenges and the financial underperformance that often results, leading health systems are turning their attention to the question of how to drive more profitable organic growth. In other words, they are asking how best to use existing assets to attract and retain customers and win share with limited additional investments.

The good news for organizations that embrace this challenge is that significant opportunities exist to improve patient loyalty and provider productivity in most systems today. For example, multiple longitudinal studies we have conducted have found that 15–20% percent of the patients that schedule appointments with our clients fail to complete them. On top of this, large quantitative patient studies we have performed suggest that roughly the same number fail to make appointments at all when call or appointment wait times are unacceptably long.

This all adds up to a significant financial and clinical improvement opportunity. To put it in context, our claims data analytics reveals that it is not unusual for systems to lose hundreds of millions of dollars a year to competitors on patients who initially presented with their systems. Clearly, the reasons for such leakage are complex and some will be outside a system's control. Yet, increasingly forward-looking provider organizations are waking up to the opportunities they have to control their own fate and grow revenue by focusing on enhancing the consumer experience and improving "network integrity."

The challenge

Achieving sustainable and profitable growth in competitive and saturated markets in the face of:

- Rising consumer expectations
- New market entrants and disruptive technologies
- Continued rate pressure and risk shifting from payers
- Organizational complexity and inertia
- Limited access to capital

The opportunity

Shift from a strategy based on managing transactions, to one focused on investing in relationships by:

- Truly understanding the needs of both patients and physicians
- Prioritizing and meeting their most pressing needs today
- Predicting their future needs and putting foundational structures in place to meet them
- Assessing the adequacy of old governance and capital allocation structures
- Making collaboration and disciplined innovation core organizational competencies

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The struggle for hearts and minds

The climb ahead

Attracting and retaining patients is hard. Getting people to actively and consistently choose your physicians and system for multiple needs over many years is a perquisite for profitable organic growth but it is also a constant struggle. In most markets, people have multiple established systems and physician groups to choose from. To make matters worse, new entrants and business models are constantly presenting people with new places and ways to access information care and support.

To address these challenges, some systems have made moves towards "patient centricity," but these initiatives are too often unfocused or limited in scope and depth. The reality is that most providers know little about their patients' needs outside of direct medical care and are therefore ill equipped to systematically predict and influence the choices they make for themselves and their families.

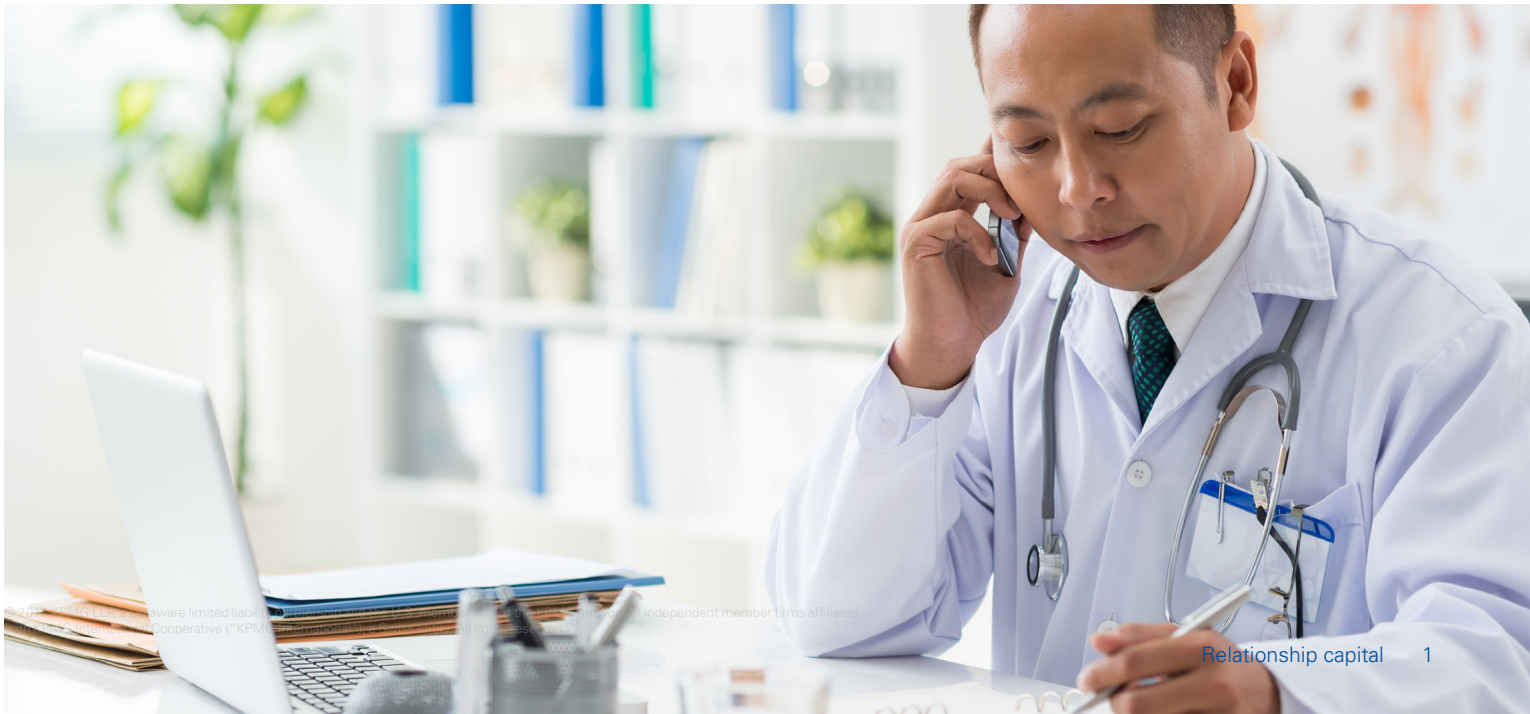
What is needed is a new approach. As a foundation, health systems looking to change this will need to create robust customer strategies that segment the needs and preferences of healthcare consumers and develop offers that specifically appeal to those segments, addressing their unique drivers and barriers. Even more, they will need to establish long-term relationships with people, understanding the ebb and flow of their lives and developing ongoing ways of meeting their changing healthcare needs.

Starting out

If this all sounds like a multiyear challenge, the bad news is that it probably is. In fact, you could argue that continuously meeting or exceeding consumers' expectations is a never-ending journey. Certainly, building a trusted, multiservice-line-based relationship with any given patient may take months or even years to achieve.

Yet, there are clear near-term opportunities for most systems. Slow or inconvenient access, for example, is the number one reason patients seek care elsewhere. Clear communication, compassionate care delivery, and the integration of digital and physical experience are other areas where many systems fall short of patients' basic expectations and lose their trust and loyalty as a result.

Meeting proximate needs in these areas is a way to drive profitable growth today. But it is also the first step towards building a sustainable competitive advantage based on the quality of a systems' relationships with its patients and physicians. Put differently, it is a starting point for a strategy that is focused as much or more on developing your system's "relationship capital" as its physical capital.



Building relationship capital

A strategy based on developing a health system's relationship capital can add tens of millions of dollars to the bottom line in many cases. At the same time, the organic growth it generates places less strain on the balance sheet than acquisitions or large-scale capital projects. While no two systems are ever quite alike, we suggest three basic strategic imperatives for systems looking to develop such a strategy:

1. Set goals based on profitable growth and value creation

2. Adapt your business model to better engage patients and earn their trust and loyalty

3. Adapt your operating model to support physicians and increase their satisfaction and productivity levels

Set goals based on profitable growth and value creation

All growth is not good. That is not to say it should not be a strategic priority for most systems, just that it must be focused to create value.

Savvy leaders recognize this. They look for growth opportunities beyond simply adding more physicians or building new facilities. They find ways to increase share and productivity in places where their system is well positioned to outperform local competitors.

This approach has two important economic benefits. First, it increases operating income by better leveraging old assets and capabilities to drive new revenue. Second, it is relatively "capital light" and places less burden on the system's balance sheet. Together, these factors increase return on invested capital (ROIC)—an important measure of value creation.

Of course, any economic benefit must be weighed against responsibilities to patients, physicians, staff, and local communities. But very often, the system's interests and those of its wider stakeholders will align around the need for sustainable growth.

Three steps can help set a clear strategic direction to achieve value creation and growth.

Step 1. Develop the baseline.

How profitable is the system? What drives profitability? How successful is the system at fulfilling its mission? Often, opinions differ. Data is unintegrated or unreliable. Relationships between the system, its physicians, and third parties distort financial results. Structural differences make comparisons to for-profit systems and private physician practices challenging.

Two things are needed to untangle the mess. First, an understanding of the system's true operating profitability by service line and care setting. Second, an organizational overview of where and how resources are deployed and an understanding of the impact this has on financial and mission-oriented results. Thankfully, systems can now integrate large operational and financial data sets to develop these analyses with increasing speed and accuracy.

Step 2. Set the ambition.

A solid financial and organizational baseline provides a basis for setting systemwide strategic and financial ambitions. With the right analytical tools, long-standing assumptions get overturned. Performance drivers are laid bare. And the real potential of the system starts coming into view. Leaders can then choose strategic and financial ambitions that will drive smart, profitable, and responsible growth. For example, when presented with a well-structured review of its "Strategy in Action" compared with its "Strategy on Paper" a health system may choose to create or revisit population goals, quality goals, patient retention rates, or other performance indicators.

Importantly, these ambitions should not be set in stone. Once an initial set has been determined, case studies and comparator data can be used to identify areas of system underperformance against key goals. At the same time, operational data and insights can be gathered to understand specific capability gaps across the organization and their impact on its performance. As this information is collected and analyzed, the strategic ambition should be refined based on the growing understanding of the system's circumstances.

Step 3. Determine focus areas.

The emphasis can now turn to specific initiatives. A useful practice is to rapidly develop a long list of possible strategic and operational options (or "hypotheses"). The feasibility and likely impact of implementing these can then be tested with targeted research and analysis. Leaders should use the outputs of these to clearly articulate the implementation requirements, milestones, risks, and potential benefits for each opportunity area. Wherever possible, scenario models should be used to estimate an initiative's potential impact on operating profits, cash flows, and invested capital—not just revenue growth.

For example, we helped a large academic medical center develop a detailed data-driven model to assess the possible operating income, costs, and unintended consequences associated with launching its own health plan to grow its local market share and expand into neighboring counties.[1]

1 A Calculated Risk, KPMG Institutes, February 9, 2016, http://www.kpmg-institutes.com/institutes/healthcare-life-sciences-institute/articles/2016/02/a-calculated-risk.html

Adapt your business model

to engage patients while earning their trust and loyalty

A system's business model is defined by the markets, patients, propositions, and channels it focuses on. The emphasis here is on the demand side. The question is: What can the organization do to better engage, attract, and retain patients while providing compassionate and high-quality care?

Patients:
Think like a loyalty business.

Airlines, hotels, online retailers, and others have invested to build relationship-based business models. They constantly mine consumer data to understand the needs and behaviors of their target customer segments so they can better serve them. By contrast, most health systems are still set up to measure and drive value from transactions like visits, procedures, and stays. Flipping this dynamic creates a competitive edge under both risk- and volume-based payment models.

The key idea is lifetime patient value. Is the system targeting the right types of patients? How do the needs of different patient segments vary and what drives their behaviors? What share of each segment's healthcare spend is the system capturing? How can it be increased? Analytical responses to these questions differ from conventional market share or patient satisfaction reports because they are longitudinal in nature. They look at journeys through the system over time—not the sum of transactions in a given period. This creates insights into ways to increase value by building patient trust and loyalty. For example, we recently worked with a large academic medical center to look at what proportion of patients' downstream spend they were able to capture following an emergency department or primary care "trigger visit" with the system. The results were startling. As much as 40 percent of the spend over the three months following the trigger visits was going to competitors. Put differently, hundreds of millions of dollars were "leaking" out of the system. Quantifying that kind of opportunity, breaking it down and understanding its drivers is far more useful than simply knowing a system's overall market share.

Effective analytical approaches look at patient journeys through the system over time—not the sum of transactions in a given period.

Propositions and channels:
If you do not do it, someone will.

Systems cannot build strong relationships without understanding and meeting the needs of their patients. Yet, poor access, customer service, and digital health options remain widespread challenges. This is unsustainable. Patients want choice and flexibility in how and where they schedule appointments and access information and care. Urgent care centers, retail clinics, 24-hour hotlines, virtual care companies, and app developers are scrambling to give it to them. These channels are not core to most systems' business models today, but they are not fads either. They are the first tremors of seismic shift in how care will be coordinated, accessed, and delivered this century. What to do?

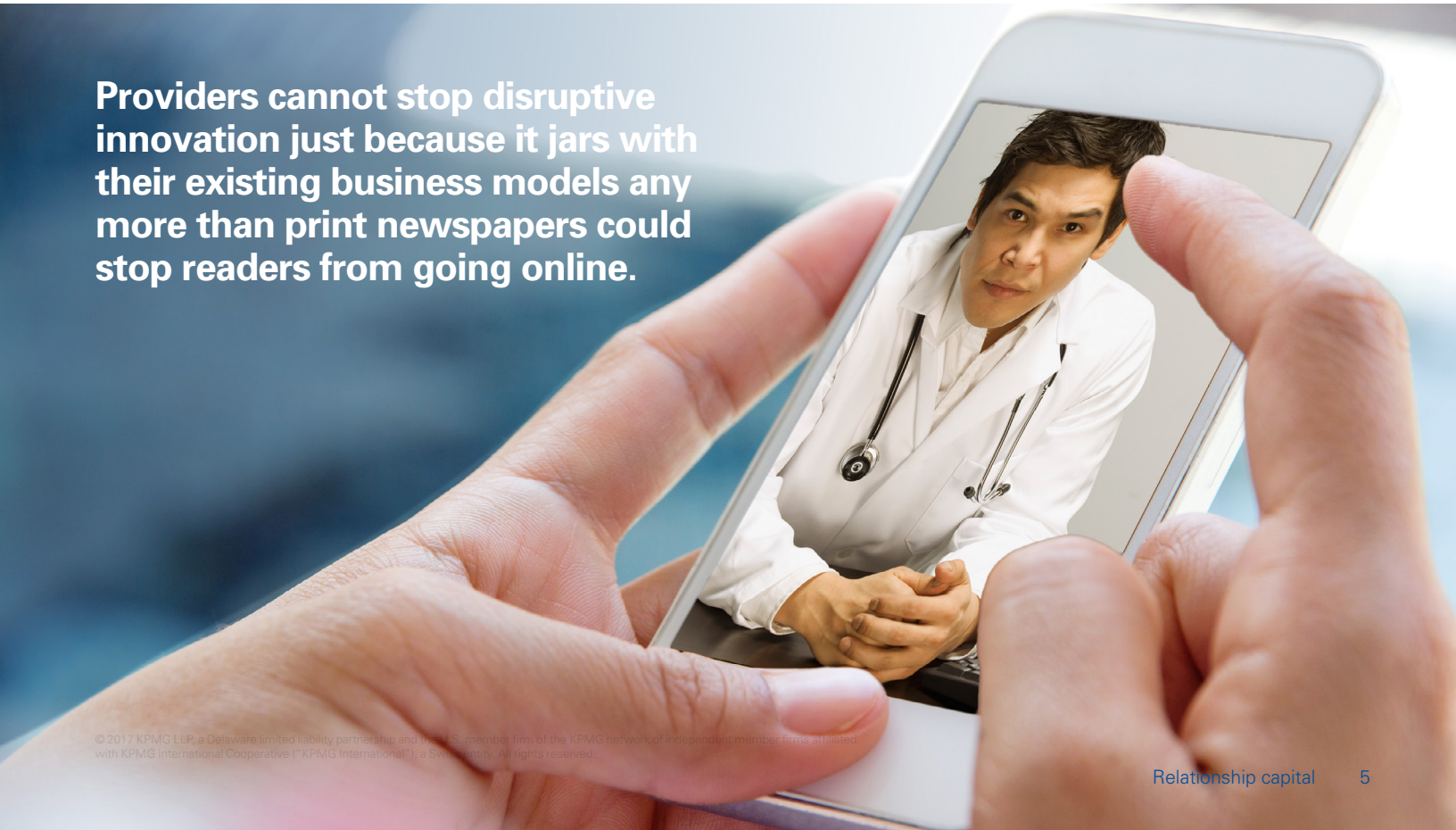
The key is to segment patients effectively and make meeting their unmet needs a systemwide priority. This will raise concerns about cannibalizing revenues. For example, by shifting office visits to lower-paid virtual ones. But there are two flaws with this thinking. First, it is transaction-based; it emphasizes the certain loss of $40 or $50 for a visit over the potential loss of a relationship worth tens of thousands over the patient's lifetime. Secondly, it implies providers can stop disruptive innovation because it jars their business model. They cannot—any more than print newspapers could stop readers going online. The question is not whether or when to change, it is how and who drives the change.

Markets:
Pick your battles wisely.

Physician networks have grown rapidly and opportunistically. Dysfunctional governance structures create tensions and bog down decision making. Reporting conceals variations in market share and profitability. Capital is inefficiently and inconsistently deployed across sites and service lines.

Rationalizing what services are offered and where can have a big impact through better matching of supply and demand. It can also help to improve quality and reduce patient leakage by placing complementary services in close proximity to each other. The starting point is understanding the value generated by sites and service lines. Simulation models can then be used to assess the potential impact of different options like site expansion, consolidation, or repurposing.

For example, a large regional health system client of ours asked us to study patient retention rates within the oncology service line. Using market claims data, we were able to show that leakage rates were lower for sites where the system offered imaging and a range of ancillary services in close proximity to physician offices. Other systems have found similar economic and clinical benefits from developing multispecialty clinics to colocate physicians and services they deem to be complementary. For many of these systems, the key question is how to improve access to and coordination of care across the system over time to better serve their local communities.



KPMG has many years of experience helping our clients to design and build business and operating model solutions to better attract, engage, and retain patients. The following case study reflects how we helped one client embark on such a journey.

Centralized "command center"

strengthens patient relationships by modernizing and enhancing a wide range of customer-facing functions

For one large regional teaching hospital, systemic inefficiencies, such as excessive wait times for outpatient appointments, extreme hold times (over 15 minutes) to schedule imaging appointments, and competitive pressures in their market were contributing to a reduction in inpatient and outpatient volumes.

The full cost of these challenges was striking. For example, KPMG identified that almost 20 percent of new patients that scheduled an appointment in primary and specialty care at the system never wound up coming to their appointment. These patient losses increased significantly as wait times increased. Equally alarming, existing patient behaviors followed similar pattern attrition suggesting that both acquisition and attrition rates were contributing to the share losses management were tracking.

In response to these challenges—which the system leadership rightly saw as opportunities, too—we worked closely with the client team to design a future-state "command center." Our team is now helping build out this physicial and virtual hub which will serve as the core focus for scheduling and coordinating the delivery of care and for implementing leading practices across the system.

In the near term, an important focus will be greater transparency, clarity, and coordination around the scheduling of ambulatory visits, imaging appointments, and acute procedures. The goal is to better balance demand to available supply—thus reducing appointment wait times and increasing patient throughput and productivity without adding significantly to labor or facility costs. Early indications are that the hub is succeeding in all these respects.

In the longer term, the plan is more ambitious. Multiple consumer-facing functions and services—ranging from virtual visits and nurse navigation to registration, billing, and financial assistance—will be colocated and, where possible, increasingly integrated. Key to that effort will be using a customer relationship management platform to provide a "single source of truth" on a given patient's profile and touchpoints with the system over time.

Beyond scheduling, a crucial component of the strategy involved working hand in hand with the clinical and administrative leadership team of the health system to begin the process of centralization of key services and developing the necessary contact center infrastructure to support these integrating functions. These other functions included preregistration activities, referral management, clinical care coordination, and 24-7 nurse triage lines. Ultimately, it is hoped that the center can house the delivery of virtual care appointments for certain patients and episode types.

As a result of centralizing these key functions, the system is able to determine—in real time—where capacity exists throughout the system, and where to shift demand to provide more timely access to care and ultimately improve interactions with patients and increase patient acquisition and retention. In other words, centralization in this case has little to do with cost reduction. Rather, it is more about developing a strategic capability to better manage capacity and meet the needs of consumers.

In short, this system is committed to a future based on better understanding and meeting the needs of its patients and physicians alike. It is well down the path towards being an organization that values its relationship capital as highly as its physical capital.

Adapt your operating model

to support physicians while increasing their satisfaction and productivity levels

An organization's operating model comprises its core processes, infrastructure, governance, culture, measures, and incentives. The focus here is on the supply side. The question is: How can the system best deploy its limited resources to support its strategic direction and business model?

Core processes and workflows: Unlock the hidden potential.

Successful efforts to standardize and centralize core processes and workflows have repeatedly been shown to drive productivity gains of 20 to 30 percent. Yet the role of the center is contested in many health systems. Centralization's supporters say it increases efficiency, improves load balancing, and accelerates leading practice adoption. Critics stress cultural challenges, varying physician needs, and the risks and costs involved. Both are right.

Rushed attempts to centralize scheduling, registration, billing, and other functions unravel fast, giving skeptics ammunition. But that is not a case against centralization—it is a case for getting it right. Two golden rules apply here. The first is to prioritize initiatives based on potential productivity gains. Stressing cost reduction sparks resistance and may be unrealistic in the near term. The second is to strike the right balance between physician autonomy and system control. The key is to find a fit with the group's culture, capabilities, and strategy. This can then evolve over time.

For example, we have helped numerous healthcare systems improve their patient access function in recent years. In doing so, we have learned to focus more on rationalizing appointment types across a system than on standardizing physician scheduling templates. While some choose to push through to the latter, others decide that culturally, it is unachievable. Either way, the key is to make progress within the constraints of a given system.

Technology and operational infrastructure: Step back to jump forward.

Competing priorities mean the building blocks of patient centricity are often shaky or missing. Technology teams are too swamped with large implementation or integration projects to focus on emerging needs like virtual visits. At the same time, pilot initiatives spring up like mushrooms across the system but never seem to scale.

Systems in this situation need to shift from putting out fires to getting serious about laying the foundations for consumer centricity. These include a scalable set of digital health offerings, multichannel self-service tools, and a robust customer relationship management platform. More recently, robotic process automation capabilities have also gained traction. Most systems have some or all of these technologies in place. Few are close to maximizing the returns on their investment. Focusing on lifetime patient value can help by getting foundational projects the funding and attention they deserve.

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Governance structure and risk: Give control to take control.

Every health system leader has seen initiatives fail because of physician disinterest or resistance. They also know that ensuring physicians have a leading role in designing and implementing changes is critical to their success.

Governance structures—like dyad models—that bring clinical and operational leaders together to solve complex problems can help. But system leaders must also send clear signals that, while the exact nature of changes might be in physicians' hands, the need for change itself is not up for debate. The attrition risks this may create can be mitigated with cultural and incentive changes. More importantly, they are normally outweighed by the benefits of affecting change.

People and culture: Make collaboration a habit.

Overly hierarchical, staid, or competitive cultures form a major impediment to value creation. Teaming between and within departments is often limited. Innovation slows. Relatively simple initiatives like standardizing staffing models and workflows to maximize the use of physician extenders fail to gain traction. Larger initiatives like standing up interdisciplinary care teams or multispecialty sites are not even discussed. Throughput, productivity, and revenue retention suffer.

In this situation, breaking ingrained habits is key. Without enough education, training, and practice, it is human nature to revert to old ways. It is important not to underestimate the time and financial investment required to change patterns of behavior. Systems facing this challenge should go slowly and celebrate small successes. They should also focus on simplifying processes and workflow tools to foster new habits.

Measures and incentives: What gets measured gets done.

The old saying is true. The tricky part is what to measure. By tracking and rewarding the wrong metrics, leaders cannot only fail to create value, they may even encourage behaviors that reduce it.

Physician compensation is the obvious example. Productivity-based plans have grown in popularity and their benefits are clear. But there can be unexpected consequences, too. For example, some physicians may pass over acute episodes or new patients in the pursuit of personal productivity. Others may see little benefit in supporting systemwide initiatives like hiring more nonphysician providers, reducing patient leakage or providing virtual visits.

There is no silver bullet for setting fixed and variable compensation. However, a growing number of approaches have been proven effective. Pooling some relative value units at the site or service line level can increase teaming and productivity per physician, for example. Interested systems should regularly review and model the options available to them to assess their potential impact on the system's financial and mission-oriented goals.

Summary: Levers of value for integrated delivery networks

Common issues and potential solutions for driving profitable growth

	LEVER	CHALLENGE	SOLUTION	TAKEAWAY
Goals	Strategic direction	Pursuing growth at the expense of value	Target scale and provider productivity gains	All growth is not good.
Business model	Markets	Inefficient use of capital across the network	Rationalize site and service configuration	Pick your battles wisely.
Business model	Patients	Transaction, not relationship-driven model	Focus on the concept of lifetime patient value	Think loyalty business.
Business model	Propositions and channels	Poor access, service, and digital health options	Make unmet patient needs a system priority	If you do not, others will.
Operating model	Core processes and workflows	Lack of standardization, scale, and flexibility	Balance central control and local autonomy	Unlock hidden potential.
Operating model	Technology and operational infrastructure	Shaky platform for being truly patient centric	Stop putting out fires; start laying foundations	Step back to go forward.
Operating model	Governance structure and risk	Physicians ignore or resist proposed changes	Let staff say how change happens not if it does	Give and take control.
Operating model	People and culture	Hierarchy and competition slow innovation	Go slowly, celebrate successes, and simplify	Make collaboration a habit.
Operating model	Measures and incentives	Failing to incentivize value-creating behaviors	Regularly review and model available options	What gets measured gets done.

The following case study outlines another example of how KPMG recently helped a system start to build stronger and more trusting relationships not just with their patients but also with their employed and affiliated physicians.

Centralized scheduling system

helps build better patient loyalty and provider productivity

Many healthcare systems which have grown recently through increased merger and acquisition activity have unearthed unforeseen challenges as they work to integrate medical groups, particularly when it comes to ambulatory scheduling. Organizing the chaos of disparate EMRs, physician calendars, rules, templates, and appointment types is no small task.

After making a series of acquisitions, one national system grew rapidly in size over the course of the last three to five years. As a result, they had operations in over 50 markets. Within even each market, scheduling systems, processes and physician preferences, and calendar management processes varied. As a result, for example, the system wound up having well over 1,000 appointment types.

These variations and physician-owned calendars simultaneously restricted patient access and provider productivity. Additionally, without a centralized contact center, patients were left with a sometimes confusing and frustrating experience trying to schedule appointments with first available providers that met the patients' preferred location and time.

Working closely with the client team, we helped consolidate scheduling for their clinics powered by a centralized patient access center serving each market. We were able to reduce the number of appointment types from 1,000 to just 15, resulting in:

– Increased physician productivity

– More efficient operations

– Improved patient access (reduced wait/lag times for appointments) and patient experience.

As a result of this work, the client has increased encounters per doctor by greater than 50 per month in target markets. Revenue has improved in target markets also.

Equipping the team with a playbook of tools and job aids, as well as providing training with visits to clinics, we are proud that our work will continue to help make lasting improvements and drive improved patient loyalty and increased value across the system.

Finally, this infrastructure has enabled the system to provide seamless online scheduling for patients and has provided the foundation for the client to support scheduling of virtual visits. In short, it has delivered lasting results that increased patient loyalty and drove value across the system.

Equipping the team with a playbook of tools and job aids, we are proud that our work will continue to help make lasting improvements and drive improved patient loyalty and increased value across the system.

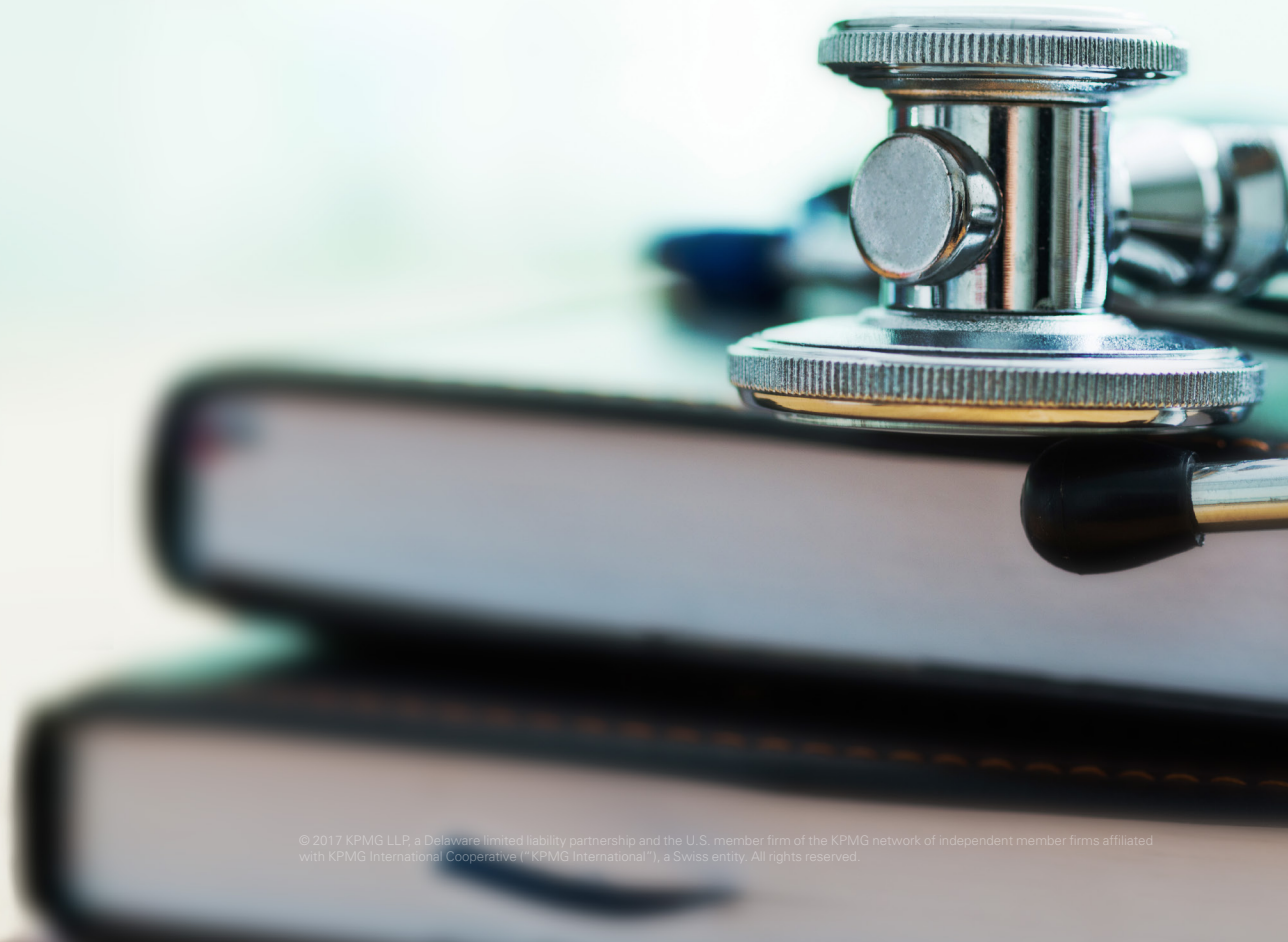
Closing thoughts

Making the kind of changes described in this white paper is difficult. Clinical and operational leaders must align on the opportunities their systems are facing and how they should be addressed. Capabilities must be developed that few provider organizations have today. Above all, systems must recognize the importance of building stronger relationships with patients and physicians—and make significant investments to do so.

After a decade or more of disruption, some leaders will balk at that list. Rightly or wrongly, they will argue that physicians and staff are simply too tired of change to make this work. Or that there is no clear business case to be made for establishing the processes, skills, and technology needed to drive patient loyalty and support provider productivity.

Others will see opportunities, not challenges. They will quantify the impact of long wait times on patient losses, or the scale and sources of leakage across their systems. In doing so, they will see that a more patient-centered and efficient system not only makes sound clinical sense, it also makes sound economic sense under both volume and risk-based reimbursement models. Then, they will get to work.

At KPMG, we understand both perspectives. But we also believe that the future of healthcare will be defined by systems that take a leaf out of other industries' books and develop business models built around relationships, not transactions. We are here to help our clients see the opportunities inherent in that vision and to build the strategies and operating models required to act on it.



About KPMG

KPMG LLP is a leader in convergence, helping organizations across the healthcare and life science ecosystem work together in new ways to transform and innovate the business of healthcare. KPMG's Healthcare and Life Sciences practice, with more than 2,800 partners and professionals supported by a global network in 152 countries, offers a market-leading portfolio of tools and services focused on helping our clients comply with regulatory change, improve outcomes through data analytics, adapt to the consumerism of healthcare, transition to value-based outcomes, and optimize investments in clinical technologies to guide them on the path to convergence.

To learn more about our Healthcare & Life Sciences practice and capabilities, visit us at www.kpmg.com/us/healthcarelifesciences.

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