AAMC APPD

ACADEMIC PRACTICE PLAN DIRECTORS MEETING

Navigating the Waterfront of Funds Flow

May 15, 2015

THE CHARTIS GROUP
Management Consultants

About The Chartis Group

THE CHARTIS GROUP
Management Consultants

Select clients we are privileged to serve:

Our mission is to materially improve the delivery of healthcare in the world.

- **250 professionals across four practice areas:** strategy, clinical transformation, accountable care solutions, and information and technology
- Tailored, practical solutions through **data-driven critical thinking**, rigorous analytics and creativity coupled with extensive industry experience
- **We have been privileged to work with the following:**
  - Over 2/3 of the AMCs on the U.S. News "Honor Roll of Best Hospitals"
  - 7 of the 10 largest healthcare systems
  - 4 of the 5 largest not-for-profit health systems
  - 9 of the top 10 children's hospitals
- **AMC Segment Focus**
  - Enterprise Strategic Positioning
  - Economic Planning and Alignment
  - Faculty/SOM Alignment
  - Integrated Mission Planning
  - Clinical Program Development
  - Care Model Development

About The Chartis Group

Tom Kiesau, Director

- Over 15 years of consulting to the healthcare industry, including VP roles with Apollo Health Street, Alta Resources, and a national revenue cycle consulting firm
- Assists clients in the areas of enterprise strategic planning, mergers and acquisitions, service line growth strategy, patient access, economic alignment, and strategic outsourcing
- Has served more than 50 provider organizations including health systems, children's hospitals and AMCs
- Graduate of the University of Wisconsin and University of Chicago Booth School of Business

Michael Tsia, Engagement Manager

- 7 years at The Chartis Group
- Assists clients in the areas of economic alignment and funds flow, enterprise strategic planning, physician alignment, and service line growth strategy
- Serves as a leader in the firm's funds flow and economic alignment sub-practice
- Recent clients include: Emory University, University of Washington, UC San Diego, University of Arizona, Lucile Packard Children's Hospital, Dallas Children's
- Graduate of UC Berkeley and Harvard University Kennedy School of Government

Discussion

What have been your experiences with funds flow redesign? What challenges have you faced?

What changes need to happen in the future to optimally position your practice(s)?

What are the impediments to implementing the change that is needed?

Discussion Topics

I. Our view of academic economic alignment & funds flow

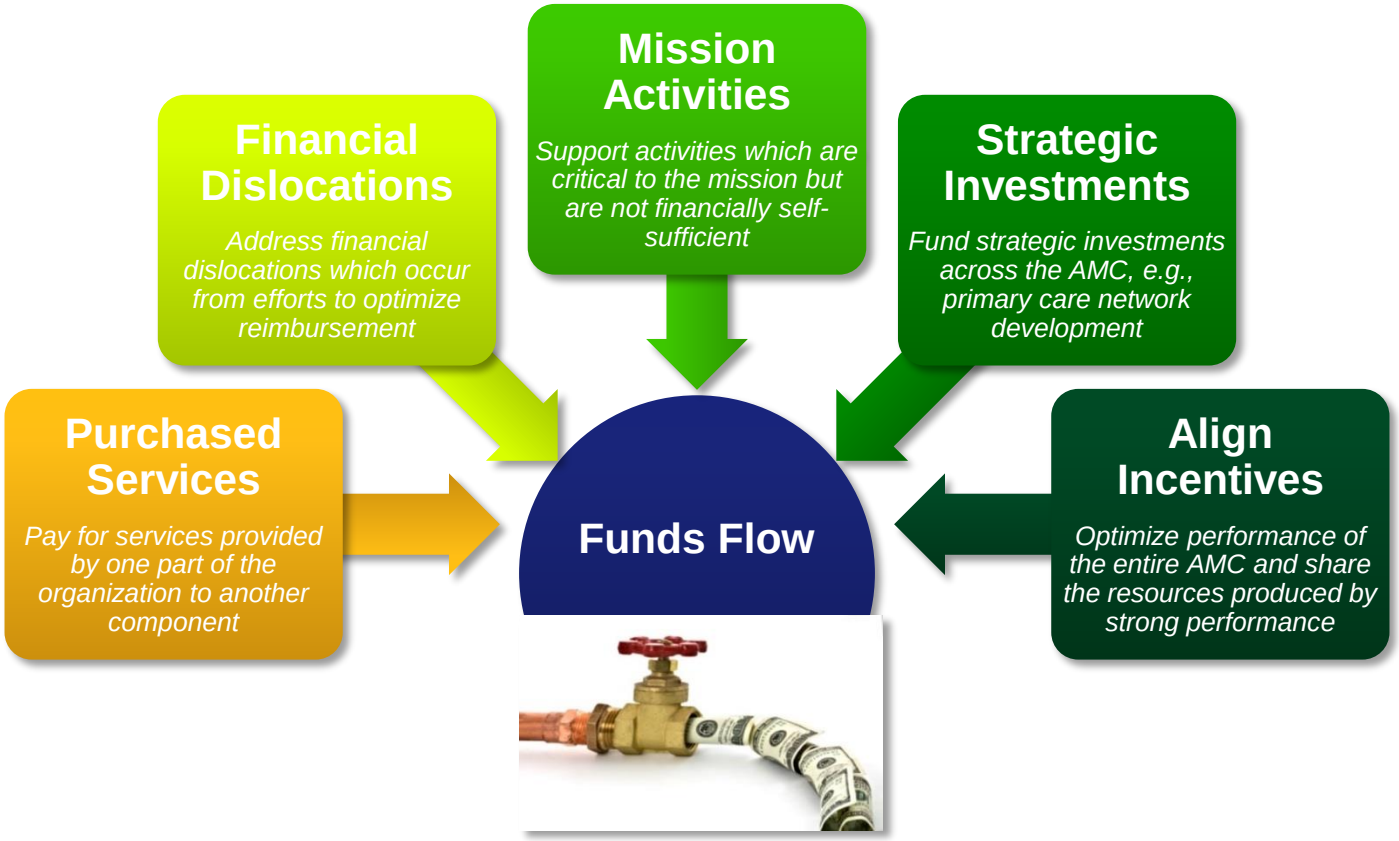
II. Major recent trends in alignment

III. Organization examples

THE CHARTIS GROUP
Management Consultants

What is Funds Flow?

'Funds Flow' represents the numerous mechanisms used between the organizational units comprising Academic Health Centers to:



Funds Flow is more than simply the exchange of money for services rendered

It is one of the major vehicles by which AMCs, SOMs, and FPPs align their strategies, define expectations and support one another.

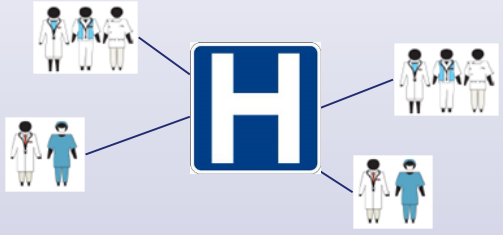
The Case for Economic Alignment

For many AMCs the traditional value proposition, current market position and economics will be challenged:

Growing Challenges to AMC Economics

Declining reimbursement will put increasing pressure on the clinical mission and its historical cross-subsidization of the research and teaching enterprise

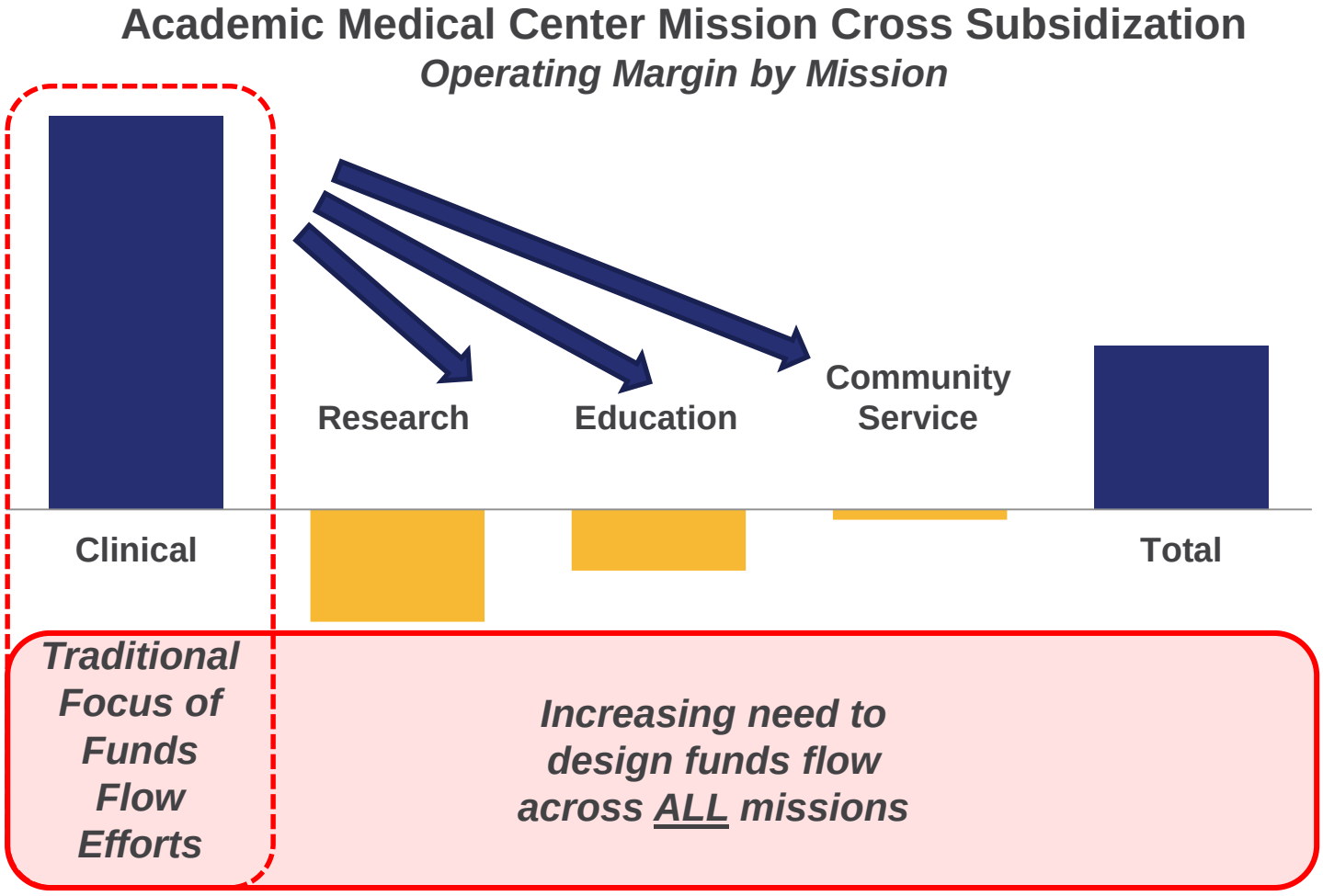
Ability to participate in accountable care models and/or networks will be increasingly essential to maintaining commercial lives



Community-based networks will drive migration of complex care to lower-cost, non-academic settings

The Case for Economic Alignment

The historical economic model of AMCs has been based on “mission cross-subsidization.” As they face growing margin pressure across all missions, those patterns will be challenged.

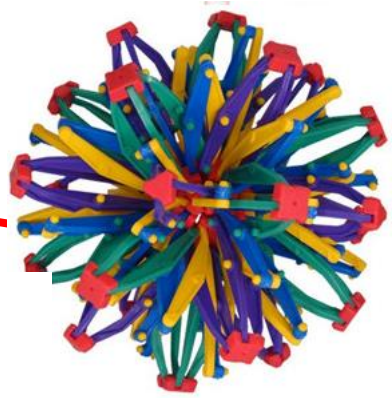


The Case for Economic Alignment

In additional to challenging economics at the organization level, funds flow initiatives are difficult to pursue because of several unique characteristics.

Organizational politics

- Unit-focused, siloed thinking
- Issues of organizational influence and money
- Implicit prioritization of programs through funding design



Complexity

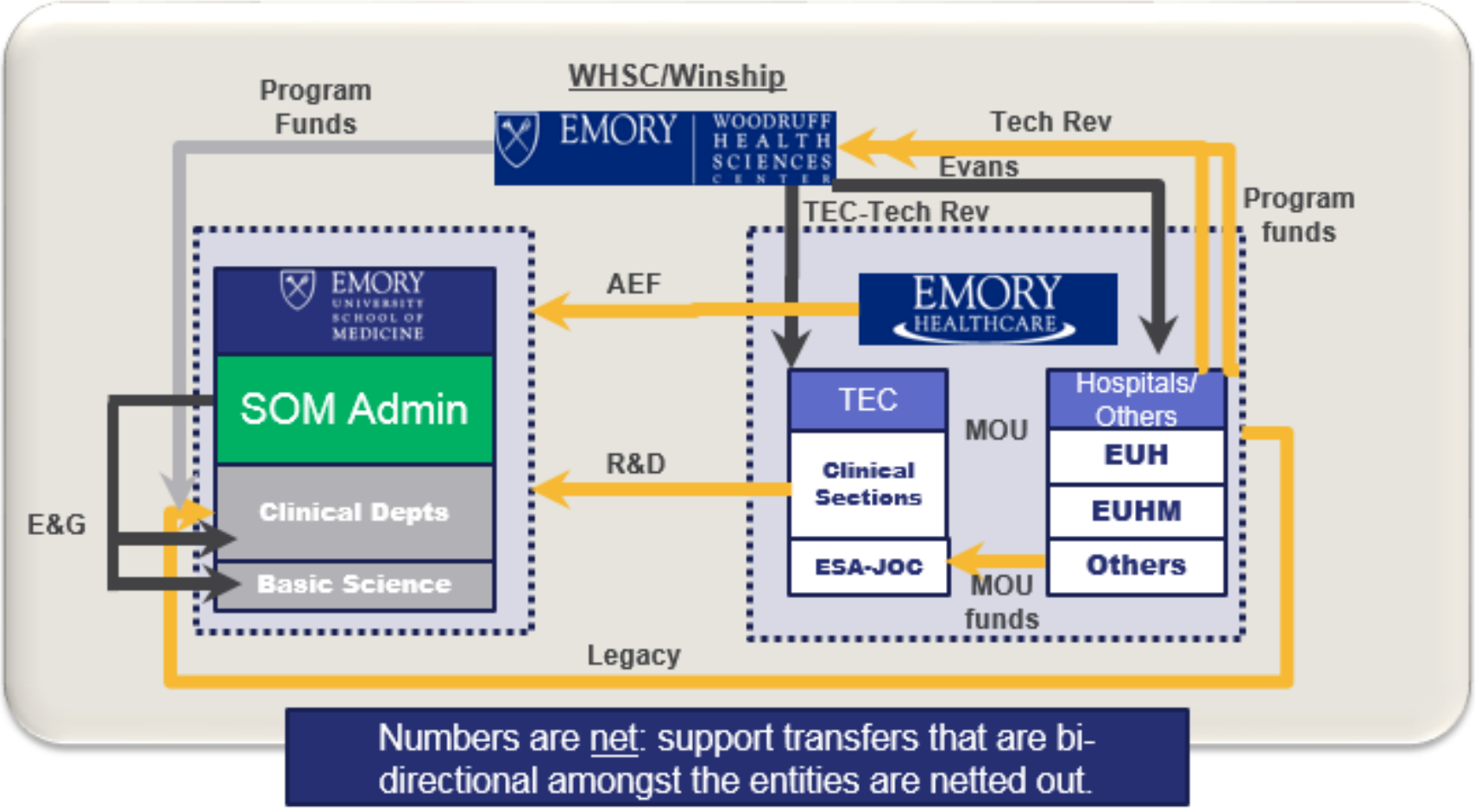
- Data lives in multiple systems across SOM, hospital, and FPP
- Hard to track true physician time and effort across missions
- Funding agreements often purposely complicated

Research and Teaching Mission Structures

- Flat research funding: need bridge funding
- Transition from department structures to service lines
- Issues of tenure, transforming “buggy whip makers”
- Traditional “black box” now facing more business discipline

The Case for Economic Alignment

Funds flow projects are particularly difficult to “get off the ground” because of the complex web of existing funds flow agreements.

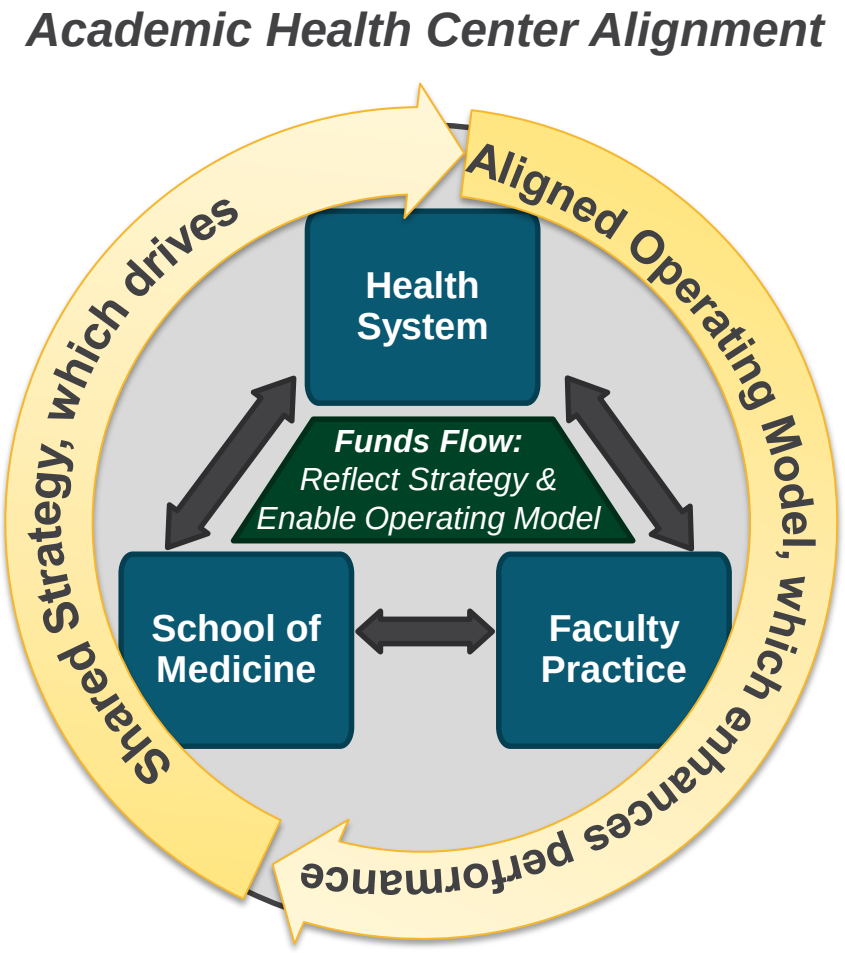


Chartis Alignment Framework

Funds Flow is one of several mechanisms which need to be in place to achieve overall alignment of hospitals, faculty, schools of medicine and other associated entities:

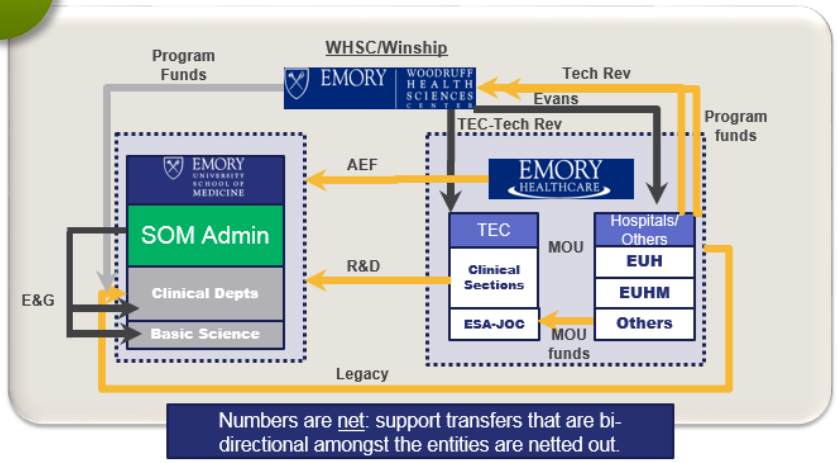
Funds Flow Framework

Restated, the optimal funds flow methodologies and amounts should reflect an AHC's strategic intent and enable the desired operating model to drive high levels of performance

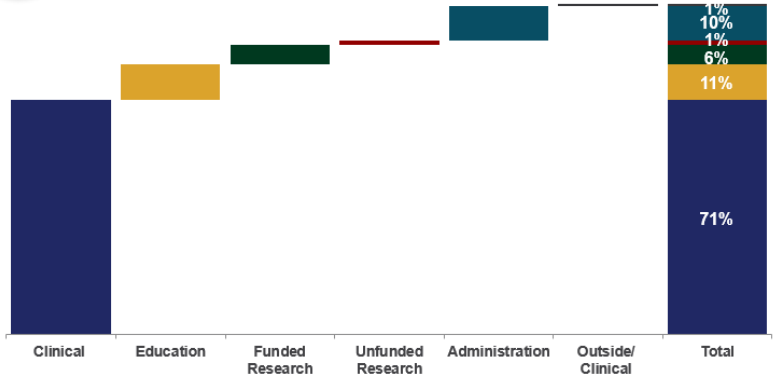


Funds Flow Key Analyses

1 Inventory Existing Funds Flow Agreements



2 Understand Individual Faculty Effort Across Missions



3 Analyze P/L Performance Across Missions

NEUROLOGICAL SCIENCES	Clinical	Admin - Dept	Admin - Hosp	Research	Teaching	GME	External	Total
Total Operating Revenue	$8,105,448	$0	$0	$7,361,350	$0	$0	$280,724	$15,747,523
Total Direct Expenses	$16,642,141	$0	$436,613	$8,478,597	$1,998,461	$1,062,766	$280,724	$28,899,302
Faculty Salaries	*6,943,464*	*0*	*328,846*	*2,522,554*	*1,428,699*	*714,850*	*182,144*	*12,120,558*
Faculty Bonuses	*558,436*	*0*	*12,926*	*147,314*	*112,396*	*67,949*	*0*	*899,021*
Faculty Fringe	*1,422,947*	*0*	*0*	*0*	*0*	*0*	*0*	*1,422,947*
Staff Salaries	*3,114,434*	*0*	*0*	*1,533,376*	*49,816*	*49,112*	*0*	*4,746,737*
Staff Benefits	*2,618,544*	*0*	*94,842*	*1,145,384*	*393,750*	*230,855*	*39,616*	*4,522,991*
Malpractice	*1,291,457*	*0*	*0*	*0*	*0*	*0*	*0*	*1,291,457*
All Other Direct Costs	*692,859*	*0*	*0*	*3,129,969*	*13,800*	*0*	*58,963*	*3,895,591*
Total Indirect Expenses	$450,336	$0	$0	$901,944	$74,640	$0	$0	$1,426,920
Dean's Tax	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Space	*450,336*	*0*	*0*	*901,944*	*74,640*	*0*	*0*	*1,426,920*
Overhead	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Admin Recharge	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Fund Overhead	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
SP Fund OH	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Change in Net Assets (Pre Funds Flow)	($8,987,029)	$0	($436,613)	($2,019,190)	($2,073,101)	($1,062,766)	$0	($14,578,699)

4 Measure opportunities for faculty productivity – clinical and academic

Spectrum of Financial Integration

No single funds flow model addresses all funds flow objectives equally well.

Low ***SPECTRUM OF FINANCIAL INTEGRATION*** ***High***

	Independent Entities	***A la Carte Managed Cross Funding***	***Up-Side Gain Sharing***	***Down-Side Risk Assumption***	***Full-Risk Partners***
Features	• Most AMCs before 2000 • One-off negotiations	• Acknowledged interdependence • May rely on mission-based management • Allow median practice cost & compensation • Payer Mix support • Call/coverage • Faculty academic time	• Agreement to share gains on specific proportions based on performance • "Bottom-line split" or other gain sharing agreement • No cost base assumption	• Medical Center assumes either revenue or expense risk for the physicians • Guaranteed revenue/wRVU • Cost base assumption	• Merge expenses and revenue base • Integrated profit and loss measurement • Proportional sharing of prosperity according to risk • All expenses subject to cost management review
Benefits		• Clear algorithms determine what is being paid for & how • Promotes transparency • Can introduce institutional incentives	• Incentivizes both organizations to improve bottom line • Could overlay on today's approach	• Encourages growth • Promotes clinical productivity	• Promotes integration of activities and shared decision-making • Eliminates most 'funds flows'
Challenges	• Reactive • Deficits accumulate • Receivership • Recapitalization	• May be difficult agreeing upon required sustaining funds • May be more cumbersome to manage than today	• SoM has no downside • May still include variety of issues	• Calibration of wRVU payment can be cumbersome • Large departure from today's model	• Can be difficult to execute culturally and organizationally • SoM departments may perceive this as reduced independence

Discussion Topics

I. Our view of academic economic alignment & funds flow

II. Major recent trends in alignment

III. Organization examples

The Chartis Group
Management Consultants

Shifting Trends in Funds Flow Design

1. *Tighter margins that limit cross-subsidization*
2. *Value based methodology focus*
3. *More challenging financials in academic research*
4. *Extending model to community settings*
5. *Increased integration across SOM, hospital, FPP (though clinical integration needs more definition)*
6. *Renewed focus on enterprise strategy*

Traditional Funds Flow Models

Academic Health Center

Shifting Trends in Funds Flow Design

	Trend	Implication	What is means for AMCs
1	***Tighter margins that limit cross-subsidization***	• Downward pressure on margins in all missions, including clinical, will make the pool of funds available to support teaching, research, and advocacy smaller	• Focus your methodology across missions on delivering revenue **growth and realizing operational efficiencies**
2	***Value based methodology focus***	• As reimbursement begins to shift towards value, all constituents within the organization need to be aligned and incentivized around the achievement of value	• Incorporate incentives around delivering **value: cost, quality, service** • Shift methodology weighting to **emphasize what's most valuable**
3	***More challenging financials in academic research***	• Basic science is under financial pressure: flat NIH funding, reduced private grant acceptance, aging tenure base, changing focus toward translational research	• Need a methodology that allocates a **sustainable amount of internal funding to Basic Research** • Create methodology that holds **researchers accountable for securing funding and expense management**

Shifting Trends in Funds Flow Design

	Trend	What it means	What it means for you
4	***Extending model to community settings***	• Drive to value is also driving consolidation: AMCs partnering more and more with community hospitals. • Need to extend funds flow model to these settings. • Community partners are worried about what they are getting back for supporting research.	• Create **consistent & aligned expectations** for faculty and aligned community physicians • **Define expected roles and interactions** between community and academic stakeholders
5	***Increased integration across SOM, hospital, FPP***	• The academic enterprise presents a uniquely differentiated attribute that cannot be (easily) replicated by community competitors, if it's potential can be harnessed. • Need to figure out what true clinical integration means.	• Develop **collaborative relationships** among leaders within the academic entity • **Involve all stakeholders** in the design of the new funds flow methodology • **Align (individual) organizational leadership incentives** with shared enterprise-wide objectives
6	***Renewed focus on enterprise strategy***	• Realizing the value from the academic enterprise must be consciously and thoughtfully pursued, it doesn't just happen serendipitously	• Academic organizations need an **enterprise-wide strategic plan** • Funds flow **principles and funding mechanisms must be aligned** with enterprise objectives • **Personal economic incentives** must extend through the organization

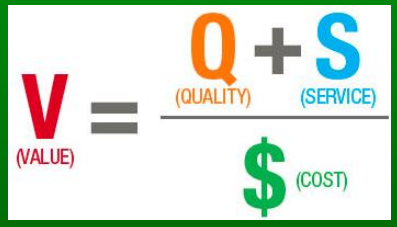
Future Characteristics of the AMC

For most AMCs to thrive in the future, they will need to evolve into **academically-based integrated delivery systems**, leveraging their unique capabilities to differentiate from advancing community-based integrated delivery systems.

Build your network

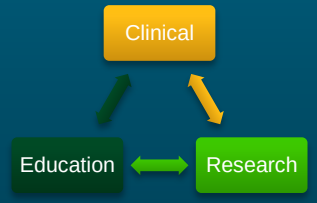
- **Build a distributed network of pre-eminent primary care, ambulatory and specialty care** assets in locations that are accessible to patients in a broad region
- **Embrace community specialists through new models** ranging from clinical integration to employment and by redefining faculty practice models into integrated group practices

Deliver Value



- **Deliver and demonstrate the region's most effective care** for disease episodes and for populations requiring complex care
- **Deliver lower complexity care in more convenient, lower cost settings**
- **Build the capabilities to effectively manage care** across the continuum over long periods
- **Design and test new care models** which optimize outcomes, access and value by enabling all team members to function at the top of their license and skills

Leverage Your Competitive Advantage



- **Leverage the 'science of health care delivery'** to maintain and enhance a culture of innovation and continuous learning which differentiates the AMC from non-academic health systems and advances knowledge
- **Embrace a mixed reimbursement model** including assumption of risk on behalf of selected patient populations, while continuing to effectively operate under fee-for service

Discussion

Are there any other AMC-specific trends you have been experiencing lately?

How have these trends affected your organization, and how have they changed the funds flow methodology?

What was the result?
What were the lessons learned?

Discussion Topics

I. Our view of academic economic alignment & funds flow

II. Major recent trends in alignment

III. Organization examples

THE CHARTIS GROUP
Management Consultants

Spectrum of Financial Integration

No single funds flow model addresses all funds flow objectives equally well.

Low ***SPECTRUM OF FINANCIAL INTEGRATION*** ***High***

	Independent Entities	***A la Carte Managed Cross Funding***	***Up-Side Gain Sharing***	***Down-Side Risk Assumption***	***Full-Risk Partners***
Features	• Most AMCs before 2000 • One-off negotiations	• Acknowledged interdependence • May rely on mission-based management • Allow median practice cost & compensation • Payer Mix support • Call/coverage • Faculty academic time	• Agreement to share gains on specific proportions based on performance • "Bottom-line split" or other gain sharing agreement • No cost base assumption	• Medical Center assumes either revenue or expense risk for the physicians • Guaranteed revenue/wRVU • Cost base assumption	• Merge expenses and revenue base • Integrated profit and loss measurement • Proportional sharing of prosperity according to risk • All expenses subject to cost management review
Benefits		• Clear algorithms determine what is being paid for & how • Promotes transparency • Can introduce institutional incentives	• Incentivizes both organizations to improve bottom line • Could overlay on today's approach	• Encourages growth • Promotes clinical productivity	• Promotes integration of activities and shared decision-making • Eliminates most 'funds flows'
Challenges	• Reactive • Deficits accumulate • Receivership • Recapitalization	• May be difficult agreeing upon required sustaining funds • May be more cumbersome to manage than today	• SoM has no downside • May still include variety of issues	• Calibration of wRVU payment can be cumbersome • Large departure from today's model	• Can be difficult to execute culturally and organizationally • SoM departments may perceive this as reduced independence

Case Study #1: Up-Side Gain Sharing

1 Context

- Major academic medical center with significant research portfolio and outstanding U.S. News top 10 clinical hospital
- Seeking new methodical funds flow system not based on just complex web of historical funding agreements
- Looking for teamwork in reducing costs and contributing towards improving bottom line

2 Methodology

- Clinical practices are paid for purchased services (medical directorships, hospital-based staffing) and clinical coverage "above the line" first
- Hospitals provide clinical practices an agreed upon percentage of the remaining bottom line at the end of each fiscal year
- Distributed bottom line is split between two categories of funding ("restricted" and "unrestricted")

Year End Bottom Line Distribution

Set % of net operating income

Restricted Funds

Set % allocated to this fund

Funding Allocation

Used for:

- *Dean's account*
- *Chair recruitment packages*
- *Program development*
- *Rainy day fund*

Unrestricted Funds

Set % allocated to this fund

Distribution to Units

Used for:

- *Dean's tax payment*
- *Centralized overhead*
- *wRVU payments*
- *GME resident FTEs*

3 Lessons Learned

- **Understand how you want to prioritize programs and deal with the political consequences:** some historically profitable programs may feel like they are not getting their fair share of the bottom line split
- **Show stakeholders how they can effectively improve the bottom line:** some are not as quick to engage (or still act in their unit's interest) if they feel like they can't make much of an impact
- **Find ways to direct the bottom line dollars to your strategic priorities:** harder to pay for specific items when it is a general split

Case Study #2: Down Side Risk Assumption (pg. 1 of 2)

1 Context

- Major academic medical center with large research portfolio (top 10 in NIH funding)
- Looking for new funds flow model with **more structure** and with **incentives to support enterprise strategy**
- **12-month process** of designing new system and testing model with each clinical department

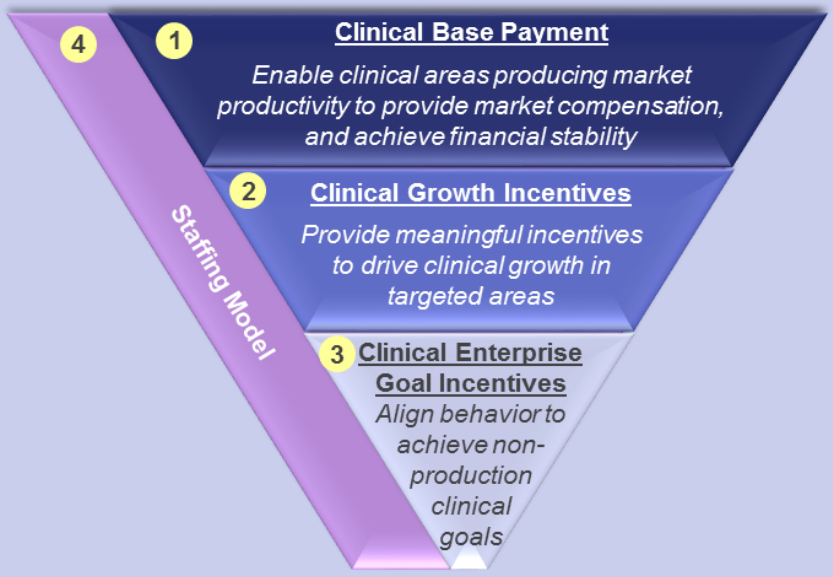
Guiding Principles

1. Promotes high service, patient-centered care and profitable clinical growth
2. Drives accountability, including shared risk
3. Is transparent
4. Reinforces excellence in academic missions
5. Engages faculty and garners support
6. Is financially sustainable
7. Preserves flexibility to fund urgent needs
8. Is predictable and simple

2 Methodology

- **wRVU clinical base payment:** paid per wRVU, pegged on FPSC salary and productivity benchmarks
- **Staffing model:** clinical base payment for hospital-based, non-wRVU production departments
- **Clinical growth incentives:** offers incentives to departments to grow in select areas
- **Clinical enterprise goal incentives:** align behavior to achieve goals not related to just production
- **All overhead expenses** assumed by clinical enterprise

Funds Flow Tiers



3 Lessons Learned

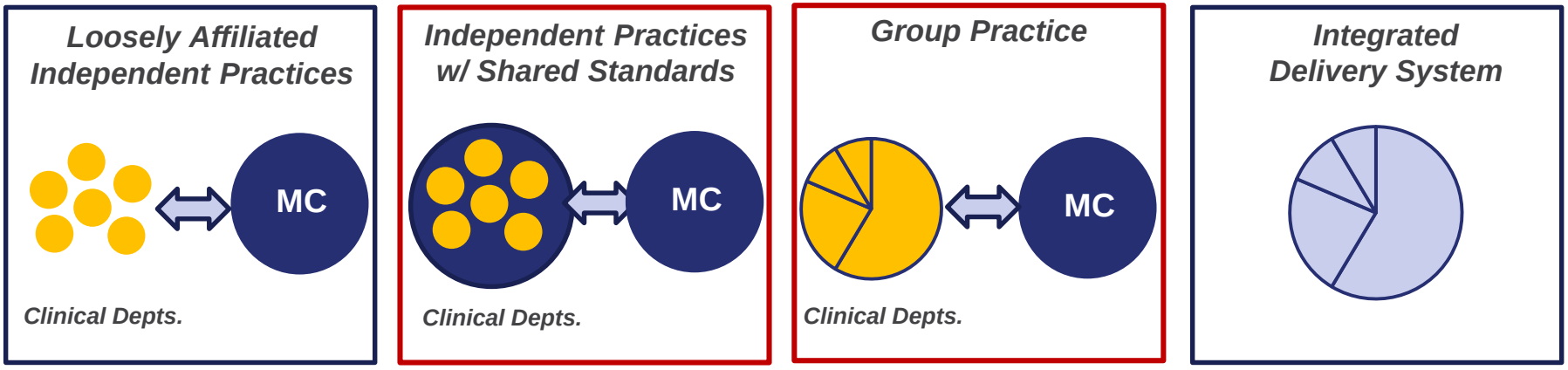
- Important to **engage leaders of each department** with extensive modeling
- **Temper productivity payments** with goal incentives, as system moves towards pop. health
- Difficult to **manage overhead expenses** and **protect payer mix** when departments are not incented to manage those elements
- **Patient access and throughput critical** for success
- **Clinical enterprise assumes much financial risk** but gains significant rewards in alignment

Case Study #2: Down Side Risk Assumption (pg. 2 of 2)

This proposed funds flow model builds a foundation to enable this AMC and the clinical departments to truly function as an integrated delivery system

Spectrum of Clinical Practice Models

Degree of integration →



★ *Client Today* →

The proposed wRVU model removes barriers to managing to a common set of 'group practice' standards by creating a shared management oversight structure

Financials			
Independent Department Financials	Independent Department Financials	Consolidated under group practice structure	Consolidated
Operational Standards			
Independent Department Standards	Consolidated management, Shared standards	Consolidated management, Shared standards	Consolidated

Case Study #3: The Case for Change at Emory

Current Challenges

1. Insufficient resources dedicated to enhancing the strategic position of Emory Medicine overall
2. Inconsistent academic department funding methodology
3. Legacy structure and agreements have led to high variation in resource distribution and access
4. Although executive management team is "one body" and aligned, it is not optimized: system is bogged down by "one-off" internal negotiations
5. Incentives are inconsistently structured to reward faculty and units for advancing the enterprise across all missions

Redesign Objectives

1. Creation of an Emory Medicine Strategic Fund
2. Clear, consistent and transparently applied operating budget methodology for clinical and academic components
3. Program financial support from clinical enterprise aligned with strategic priorities and overarching performance for the system as a whole
4. Reduce internal negotiations and articulate clear rationale for funding decisions
5. Faculty and program incentives will be aligned with advancing the enterprise across all three missions of the academic health system

Phased Approach

Phase I

Academic Operating Budgets

- Faculty contributions in research and education (GME, UME)
- Over NIH Cap salary support and transitional salary support
- Research SaLaD (incentive) Fund

Phase II

Clinical Program Support

- Faculty contributions in quality, service / access, clinical productivity
- Medical Directorships / Purchased Services
- Clinical SOUP (incentive) Fund

Phase III

Strategic Investment Fund (Academic & Clinical)

- Strategic Investment Fund
- Innovation distribution model
- Funds flow between Emory Healthcare and School of Medicine
- Program support principles between The Emory Clinic and Emory Hospitals
- Determining timing of launch and transition model

FSA Phase I

Academic Operating Budgets

Faculty Research Non-Grant Salary Support	A	Research Faculty Salary Support
	B	Support of Research Salary Over NIH Cap
	C	Transitional Research Faculty Salary Support
	D	Research SaLaD Fund
Faculty Education Leadership Salary	E1	GME Faculty Leadership
	E2	UME & Allied Health Faculty Leadership
Core Dept Admin Budget	F	Core Department Administrative Budget
	G	Department Programmatic Investment

EMORY MEDICINE

FSA Phase I: Key Components

Academic Operating Budgets

A Research Faculty Salary Support

- Sets consistent expectations around research faculty productivity and extramural support
- Intended for all research-intensive faculty (>20% effort research)
- Faculty expected to cover 65% of research salary (up to NIH salary cap) through extramural funding
- SOM will cover remaining 35% of salary
- Glide path in transition period (55%, 60%, 65%)

B Support of Research Salary Over NIH Cap

- Sets expectations around prioritization of funds for supporting salary over NIH cap

C Transitional Research Faculty Salary Support

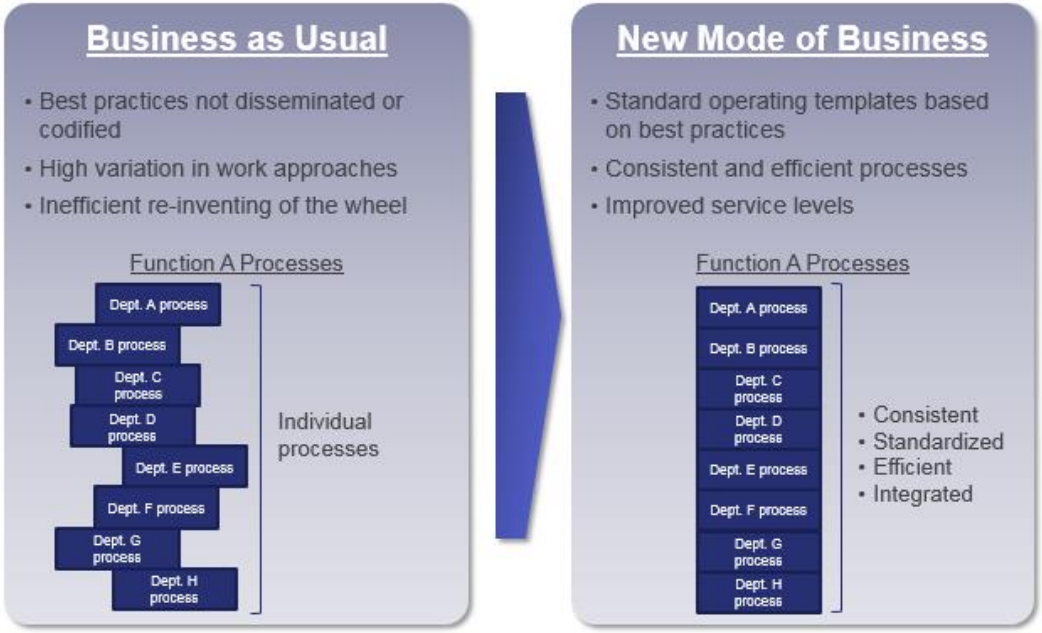
- Bridge funding available for historically productivity faculty who need it

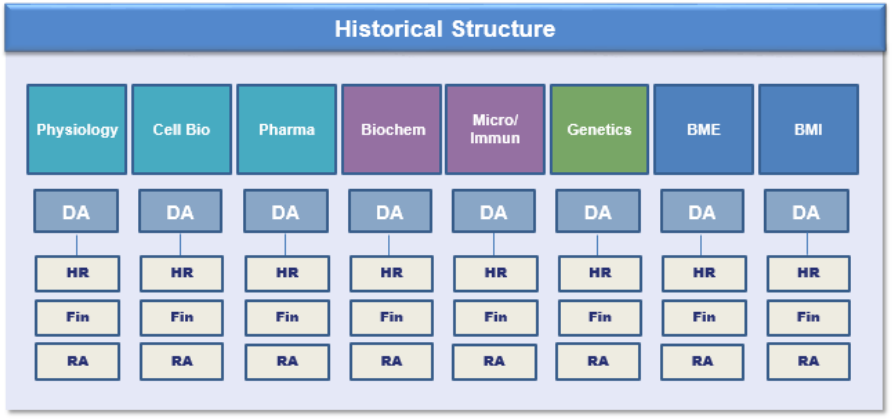
D Research SaLaD Fund

- Incentivize faculty to maximize external salary support
- Build and maintain financial stability for investigator and department
- Annual deposits for grants above 65% salary coverage – split between dept. and individual

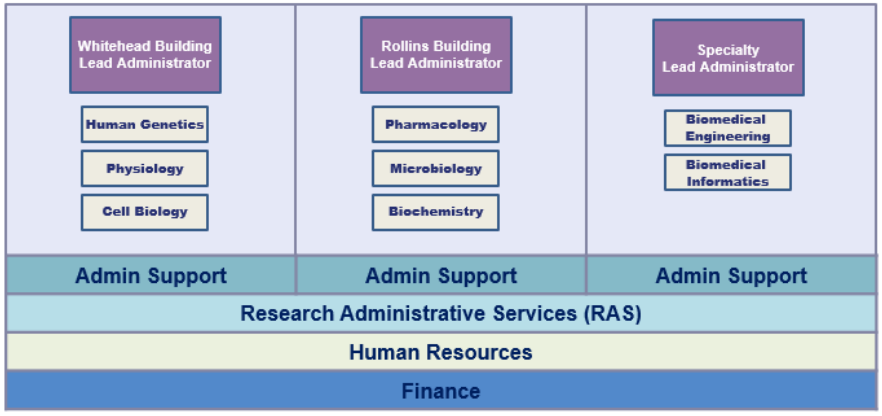
EMORY MEDICINE

Basic Science Re-Organization

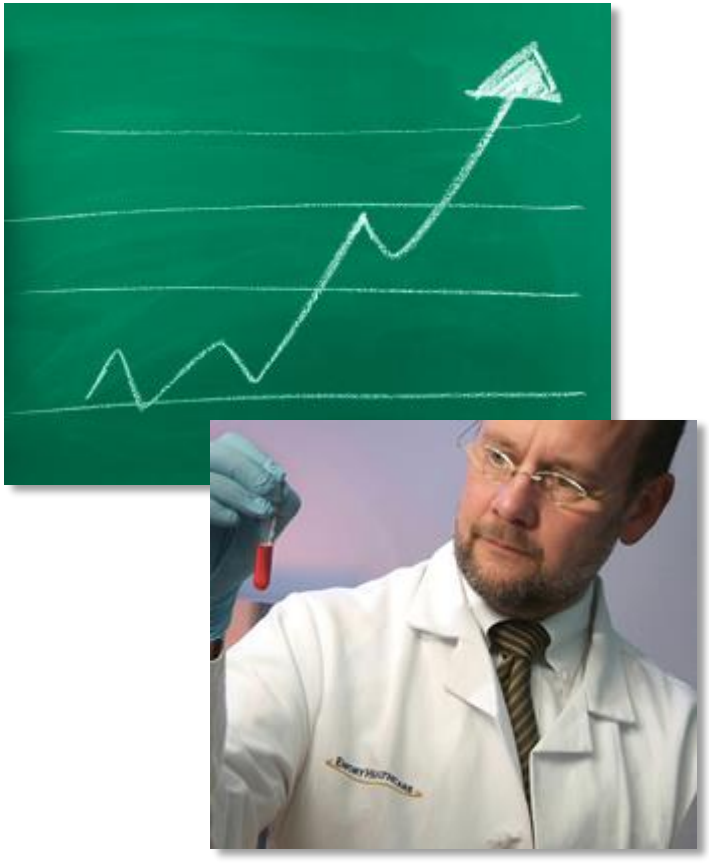




Note: DA = Division/Department Administrator; RA = Research Administration.



FSA Phase I Results



1. FSA Phase I sent a clear message: we are holding faculty and units responsible for performance
2. Research grant submissions have risen significantly
3. Research grant awards have increased sharply: 9 months year over year performance suggests 17% increase over FY14
4. New basic science organizational structure is much more streamlined and should yield cost savings in new fiscal year

FSA Phase II

II Practice Operating Budgets

Faculty/ Unit Clinical Contribution	A	Quality and Value Contribution & Population Management
	B	Service, Access & The Emory Pledge
	C	Clinical Faculty & Team Productivity Contribution
Faculty Purchased Services	D	Medical Directorships
	E	Medical Purchased Services (Call and Consult Coverage, ED Response)
	F	Clinical Program Support
	G	Other Institutional Directorships/Leadership Role (Emory Medicine)
Section Admin Budget	H	Core Clinic Operational Budget
	I	Core Section Administrative Budget

EMORY

FSA Phase II: Key Components

A Quality and Value Contribution & Population Management

B Service, Access & The Emory Pledge

- **Each unit's performance measured against defined scorecard metrics**
- **Metrics must be reasonably "impactable" by faculty members and unit leaders**
- **Metrics are a balance of organization-wide goals (risk-adjusted mortality rate) and unit-specific goals (division's appointment utilization %)**

C Clinical Faculty & Team Productivity Contribution

- **Funding does not equal comp. plan**
- **Each unit's performance based on benchmark productivity, not NOI or cash**
- **Individual faculty member cFTEs tracked carefully to measure productivity**
- **Each unit (team of individuals) must meet 65th percentile UHC benchmark productivity**

D/E Medical Directorships & Purchased Services

- **The funding hospital/entity will ultimately determine medical director/direction needs.**
- **Amount is contracted physician's actual base salary rate excluding incentives, multiplied by % of FTE agreed upon for service (e.g. 0.20 FTE)**
- **Medical directors personally sign the MOUs in addition to department chair, to ensure accountability**

F Clinical Program Support

- **Program support no longer individually negotiated with hospital**
- **Practice plan gets one support payment to fund all program development**

Example of Unit Scorecard

Illustrative

Unit A

	Category	Metric (FY14 Goal) and Points	Current Performance
Faculty/ Unit Clinical Contribution	A Quality and Value Contribution & Population Management	Capture of Vital Signs Measurement During Patient Rooming (85%) 2 Points	79.6% 1 of 2 points
	B Service, Access & The Emory Pledge	1. Appointment Lag – Time (Days) for New Patient Visits (14 Days) 2. Overall Patient Satisfaction – Likelihood to recommend (73rd) 4 Points	7.3 Days 75th %ile 4 of 4 Points
	C Clinical Faculty & Team Productivity Contribution	Section Productivity (65th %ile) 2 Points	66th %ile 2 of 2 points
Section Admin Budget	H I Managing Total Salary Dollars per wRVU	Total Salary Dollars per wRVU ($50.95) 2 points	$58.31 0 of 2 points

EMORY MEDICINE

Unit A: 7 out of 10 Points

25 FTE's * $13k per FTE * 7 out of 10 = $227.5k

FSA Phase III

III **Strategic Investment Fund**

EMORY UNIVERSITY SCHOOL OF MEDICINE

EMORY HEALTHCARE

Strategic Investment Fund (SIF)

All unit cash is seen as institutional resource

Chair Commitments | **General Investments** | **Innovation Fund**

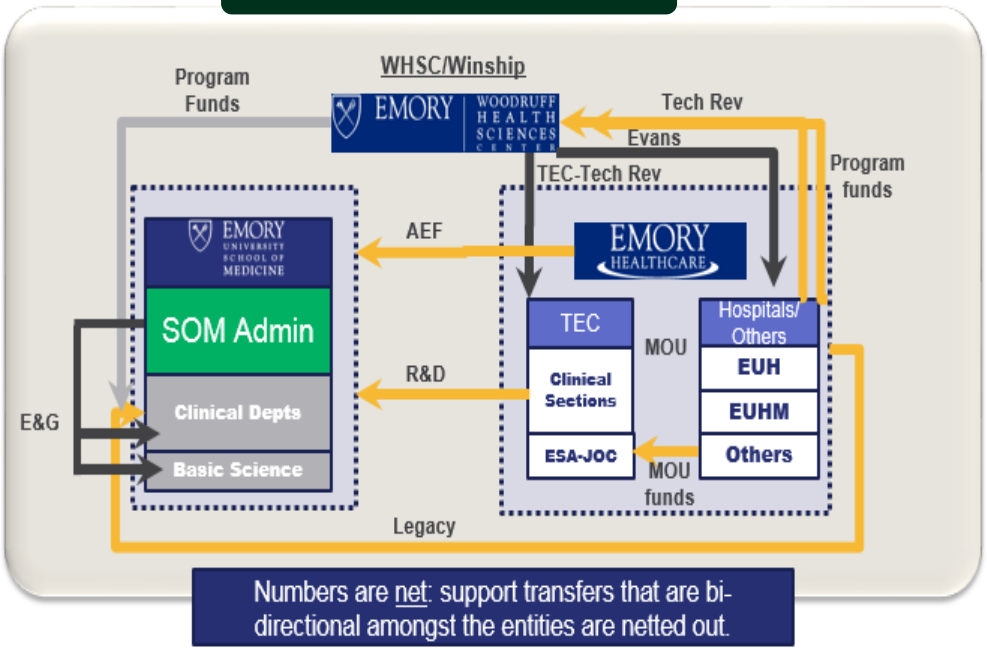
- Focus is on “disruptive innovation” that will create new value for the enterprise
- Program favors applications that translate science to improve health
- Strong business plans with key milestones are required and evaluated by a subcommittee

EMORY

Emory Case Study: Overall Results

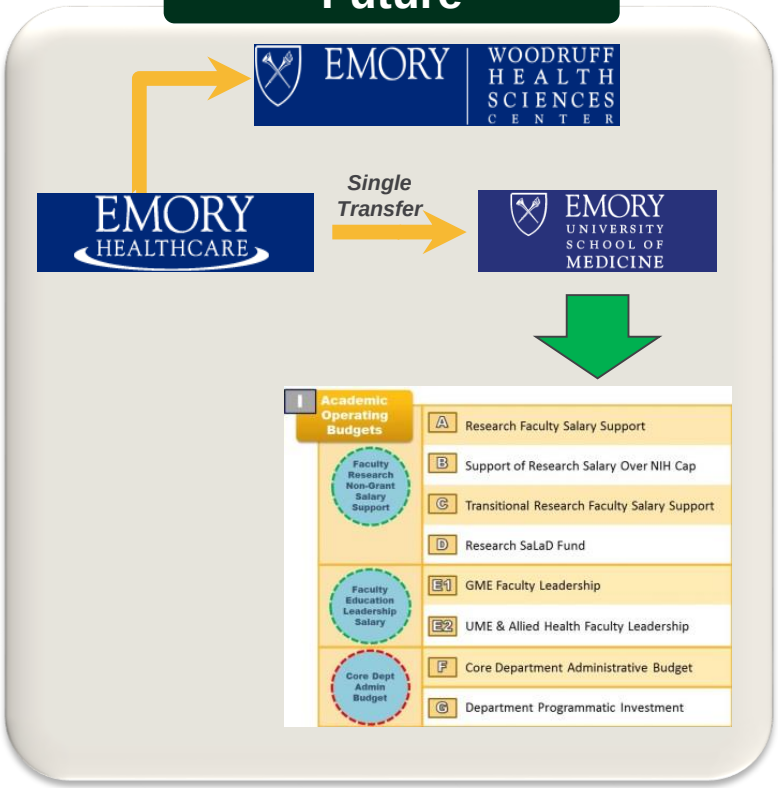
1. Funds flow across enterprise is streamlined, methodical, and transparent
2. Education and research are key differentiators for Emory – and are now supported in a more direct manner
3. Funds are used strategically and go to the areas where leaders believe will have the greatest impact
4. Negotiations between entities significantly reduced

Past



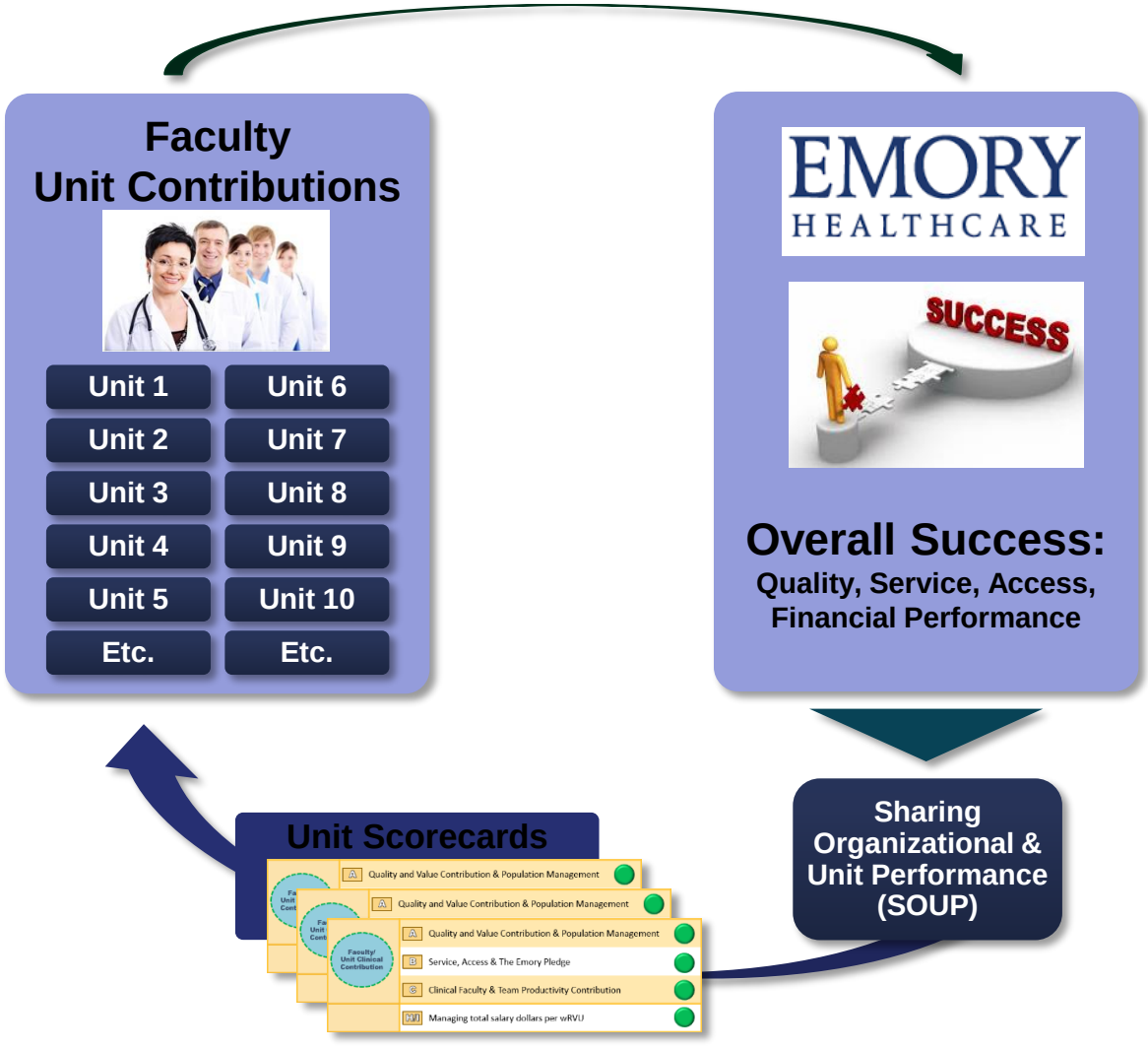
Numbers are net: support transfers that are bi-directional amongst the entities are netted out.

Future



Emory Case Study: Overall Results

1. Clinical section performance not based on unit profit / loss statement (variables faculty cannot control)
2. Instead, clinical sections act as one faculty practice plan: overall success is shared based off of metric-driven scorecards
3. FSA Initiative in implementation mode. Highly successful Phase I implementation and gradual Phase II implementation currently.



Major Project Challenges

1

Funding vs. compensation: Funds flow does not equal compensation. It determines the pool of funding available for expenses like compensation, but it's not a one-for-one correlation. A department might not get as much funds flow but may still be able to pay out salaries like normal. We worked hard to help individuals understand the distinction, which made them much more open to change.

2

Haves vs. Have-Nots: Why change the funding structure if you come out a major winner today? We had to help the "haves" understand why the status quo is not sustainable – meanwhile, we had to buffer the battle between the haves and have-nots to make everyone understand that we are part of one team.

3

The rumor mill: Funds flow changes hit where it hurts most – the wallet. So naturally, change makes individuals nervous, and they will seek information. Once rumors start to circulate, it's hard to change perception. We had to make sure materials stayed confidential and that we communicated with stakeholders regularly.

4

Leadership changes: The single most important success factor for funds flow is the strength of executive leaders. They must have the fortitude to push through this high level of change. At Emory we have undergone quite a bit of leadership change, and we have had to rely on select leaders within the clinic and school of medicine to push through change.

Lessons Learned

Sometimes it's better to titrate the change: By using a phased approach, we were able to implement the new model without radically "rocking the boat" all at once. We have a long runway for change to give administrators time to adapt.

Involve the right stakeholders:
We brought together a group of key department chairs to offer design recommendations every week. We reported out to the Council of Chairs in a special all-day session every few months.

Trust is central to change:
Change on this grand of a scale requires a heaping load of trust. We achieved it by offering unprecedented transparency and building a collaborative culture.

Focus on the big picture:
It's easy for leaders at an AMC to get territorial and think only about the interests of their own organizational unit. We spend the beginning of each meeting reminding leaders to think about the institution's overall objectives and to not "sweat the small stuff." That comes with trust that we'll iron out the wrinkles in the end.

You have to provide a large enough carrot: It's not enough to tell individuals they have to accept change to survive. They have to see tangible benefits. Our system offers high performers high rewards, and those high performers are the leaders who carry the institution already.

Questions?

Contact Information:

Don Brunn
donald.brunn@
emoryhealthcare.org

Tom Kiesau
tkiesau@chartis.com
312.725.6554

Michael Tsia
mtsia@chartis.com
626.456.2325