Pediatric Insight
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Leadership Strategies in Challenging Financial Times

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Introduction

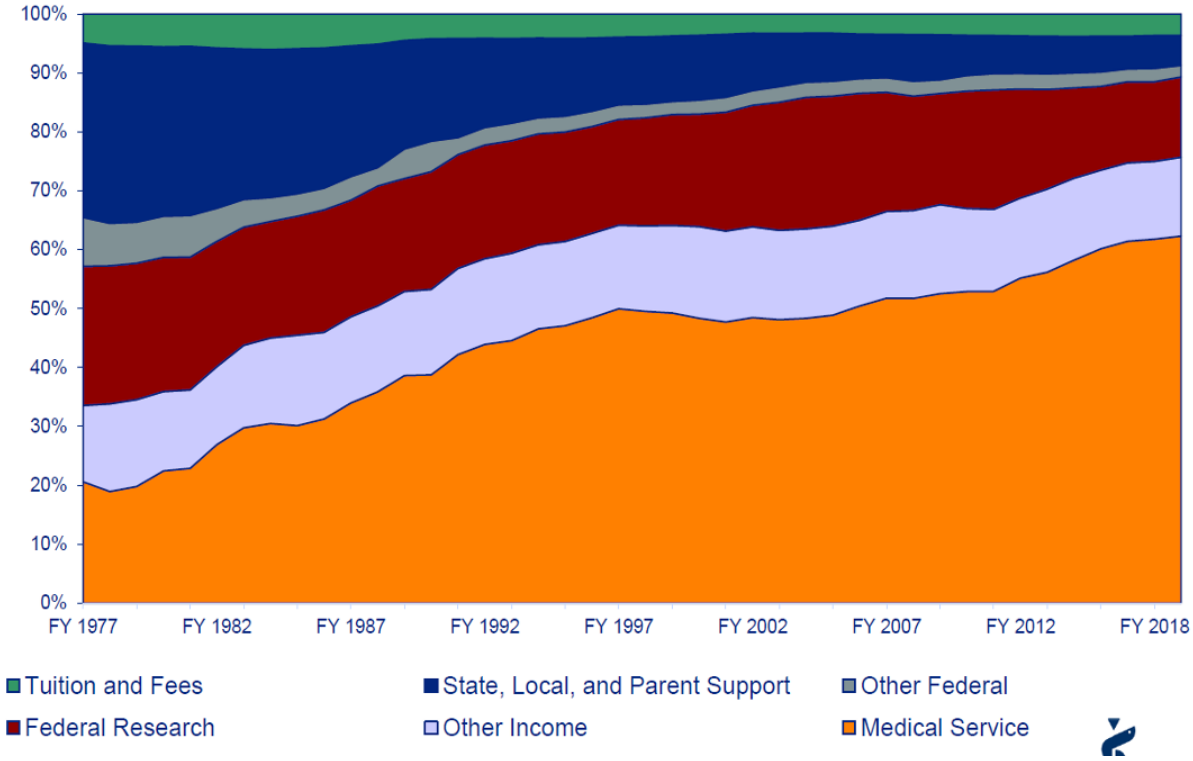
Financial challenges impacting departments of pediatrics in academic medical centers or independent children's hospitals are not new and are expected to occur in the future as funding models for health care evolve and as a consequence of external forces that impact care delivery occur. To put this in perspective, since 1980 we have experienced several significant periods of financial strain. And currently we are experiencing a significant financial challenge as a consequence of the Covid-19 Public Health Crisis (1,2). As examples of previous financial challenges, the introduction by Medicare of the Prospective Payment System in the 1980's created fixed payment amounts for particular clinical services that were meant to motivate providers to deliver effective and efficient care. While the concept developed in the early 1960's this change in reimbursement had a significant short-term strain in health care delivery financing. Following this, AMC focused their efforts to expand their clinical footprint to compete more aggressively for patients that would support the development of highly specialized clinical service lines (e.g. burn, transplant etc.) and medical education training programs creating a financial bubble that supported substantial growth in the size and complexity of AMCs. However, the Balanced Budget Act of 1997 brought tremendous financial pressure as a consequence of reduced Medicare payments, increased claim denials, caps to graduate medical education (GME) positions all at a time when AMC's were experiencing double digit rises in health care system costs (3). These periods of financial strain and early examples from the current economic crisis brought on by the Covid-19 pandemic provide opportunities to define a framework to guide strategies and decision-making in tough economic times.

Financial Streams that Support the missions of AMCs

It is important to understand why departments within AMCs are so vulnerable to changing financial funds flows in the clinical arena. Figure 1 from the AAMC (4) details sources of revenue as a percentage of total revenue over the last four decades. What becomes immediately evident is that clinical revenue as a percentage of total revenue has been the only source of funding to grow over this time period.

Figure 1. Revenue by Source as a Percentage of Total Revenue for Medical Schools with Full Accreditation. FY 1977 through FY 2018.

Figure 9: Revenue by Source as a Percentage of Total Revenue for Medical Schools with Full Accreditation, FY 1977 through FY 2018



It is this growth in revenue that AMCs depend on to support all three of their missions: care delivery, medical education and research & discovery. As such, any negative change in reimbursement, or significant loss or change in high margin clinical activity can have a profound impact on an institution's financial viability. Indeed, just prior to Covid-19 AMC were already facing declining incomes and rising labor costs that were negatively impacting clinical margins. As examples, a 2012 MedPac analysis determined that aggregate hospital margins had reached -5.4% (5) and a 2014 Agency for Healthcare Research and Quality reported elective admissions accounted for more than 30% of total inpatient hospital revenue ($700/case) and that outpatient revenue was equal to inpatient revenue. Many systems during this decade were already working on cost reductions through improved operational efficiencies, consolidating supply chain infrastructure, reducing workforce, changing funds flows to units, preferentially growing high margin service lines, reducing wRVU payments to departments, deferring capital investments and streamlining staffing models. Importantly, in 2018, just prior to Covid-19 the median hospital margin was only 2.0%, the median hospital days of cash on hand was only 53.4 days and those hospital systems in the 25%ile had operating margins of -4.4.% and only 7.6 days of cash on hand! With this financial reality, Covid-19 was soon to be realized as a different and likely the worst public health & financial collapse of our time.

Within the health care industry, Covid-19 has been particularly hard for AMCs given their overreliance on clinical income to support the academic missions of teaching and research. This recognition led the Moody's Investor Service in March 2020 to change the financial outlook for

not-for-profit and public hospitals from stable to negative. They predicted lowered cash flows as a consequence of closing clinics, deferring elective surgery, taking on complicated Covid caseloads (that required incremental resources e.g. PPE, vents etc.), expensive fixed administrative salary costs, the lack of Covid-specific DRGs and predictions of rising unemployment resulting in loss of employer based health benefits. A potential financial catastrophe beyond a perfect storm! However, Moody's also predicted that the majority of hospitals could weather this storm, particularly those with strong operating cash flows and sufficient days of cash on hand. Congress acted to pass the Coronavirus Aid, Relief and Economic Security (CARES) Act that provided substantial support to hospitals including AMC's early in the Covid-19 pandemic (6). Indeed, the Children's Hospital Association reported collectively their members received ~$1 Billion in Cares Act support. Additionally, CMS provided opportunities for systems to receive prospective payments for Medicare services through the Accelerated Advance Payment Program (7)

Developing Your Financial Recovery Plan

So, what can we learn from past responses of AMC's to historic financial downturns and early successful approaches being taken during the current Covid-19 financial crisis? The first step is recognizing and maximizing ongoing expense management strategies your organization has in place to maximize financial health. These approaches have generally fallen into three categories: 1. Strategies to Reduce Cost Base; 2. Strategies to Implement New Care Models; 3. Maximizing Collections &/or Improved Payment Models (Table 1).

Table 1. **Common Cost Saving Strategies in Pediatric Departments/Hospitals pre COVID19**

Strategies to Reduce Cost Base
• Standardize care to Reduce care variability by providers
• Eliminate nonvalue care and activities e.g. expensive diagnostics
• Ensure providers are operating within license
• Shift care to lower cost settings e.g. FQHC, telecare, ambulatory
Implement new Care Models
• eVisits Telehealth
• Reduce utilization for chronic care conditions e.g. asthma, diabetes, medically complex
• Reduce length of stay
• Services to manage mental and physical health conditions (e.g. Integrated Behavioral Health)
Maximizing Collections & Improved Payment Models
• Improved documentation & coding for services
• Population Health & Global Budget Payment Models

In other words, critically evaluate your ongoing efforts to grow revenue, manage expenses and maintain cash flows. Beyond this, in extremes of reduced cash flow there are 4 critical factors that should be further considered as you establish your financial stabilization and recovery program.

First, have an appreciation of the critical importance of maintaining the institutional *Cult*ure as strategies are developed and implemented. Teams follow leadership they believe in. Evaluate each strategy for potential negative impact to your institutional/department culture. Each strategy should enhance the communities shared belief that 'we are in this together' and the shared sacrifice is justifiable for the end means.

Establish your crisis *Command Team(s)* that will work with you to establish your plan and approach. Appreciate that you may need to expand the expertise beyond your core directors/immediate reports, your comfort level and in doing so, expose your vulnerabilities. What is most important is that you have advice that is honest, comprehensive, knowledgeable and timely.

Develop your *Communication Strategy*. Define the communication plan/approach to be implemented with the goal of honest, evidence-based, transparent, targeted and consistent communications that will quickly and effectively permeate all levels of the organization. There is never *too little* communication. Frequent targeted updates are best that all members of the institution can easily access and that your leadership team can easily and effectively disseminate through the organization.

Establish your plan by defining the *Principles and Strategies* you will initiate to manage finances, assets and staffing. Often these plans require a phased approach that can respond to known and unknown contingencies that have been identified by your command teams. This effort will define your roadmap, your '*flex up'* of strategies you may or may not need to initiate. These phased plans should be disseminated and understood through all levels of the organization. Ensure it is understood that success beyond what has been estimated at each phase means subsequent more difficult strategies will then not need to be initiated.

Importantly, resist pressure to reduce salaries, benefits and FTE. When and if it is necessary to implement reductions in personnel, make sure they are rational and focused with unit support and understanding. Across the board cuts in FTE can get short term spreadsheet results but they negatively impact teams and organizational culture. They can also result in loss of critical providers or services and offer the opportunity for others to 'recruit your talent'. Additionally, across board hiring freezes while financially good in the short term generally have dire consequences in the recovery phase/long term organizational health. If this strategy has to be employed help the organization to know it is temporary by defining how other strategies if successfully implemented can reverse this plan. Additionally, resist strategies that eliminate investment in faculty development, recruitment and succession planning. Recruitment strategies are a key to maintaining institutional growth, reputation and long-term financial stability. Generally, they are months to years in planning and are tied to opportunities for innovation in health care delivery and program reputation. Halting these investments, if necessary, should be time limited (<6 months), & coordinated with the units and candidates with the hope that plans can merely be delayed. Maintain a focus on your people versus capital investment. They reinforce you have established right priorities for the organization. Strategies that delay infrastructure investments to maintain personnel are just smart and they are effective. Reductions in FTE while new capital investments continue to be made is chilling to the organizational culture and may leave you with costly investments that never provide a return.

In summary, we currently are facing what is likely to be a multi-year financial challenge and recovery period. Financial strain in AMCs is not new and should be something every leader

plans for and learns from. This report outlines several key factors that can be critical to developing successful action plans and strategies during challenging financial times.

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