

KSA White Paper

01.01.2010

Regional Referral Center: Implications

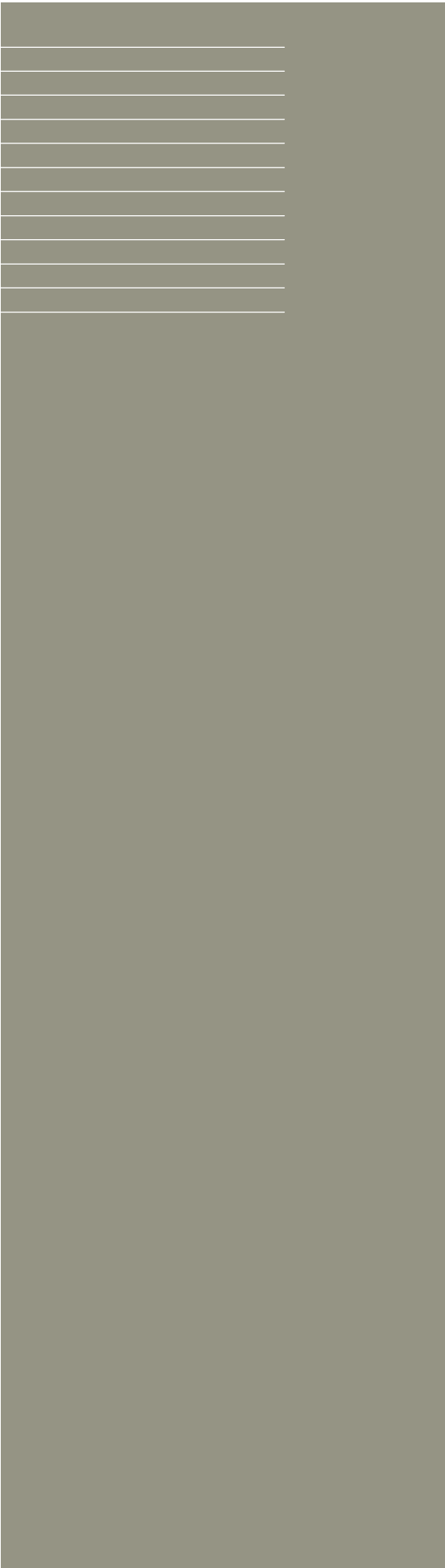


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Across the country, hospitals are described as regional referral centers when in fact they are fundamentally community hospitals. Additionally, many community hospitals have strategic plans that seek to move the organization to a regional referral center. Often these plans do not address many of the core implications of becoming a regional referral center and rather describe “regional referral center” in terms of volumes or desired outcome. We would like to have a better understanding.

To be fair, throughout this document we are speaking generally about the challenges of the private practice hospitals in the 175 to 350 bed range. Those outside this range (e.g., 600 beds), the academic medical centers, and the small 75 bed hospitals are much more obviously either referral centers or community centers. Nevertheless, we believe the principles and concepts discussed in this document can be scaled up (or down) to provide insight into any setting.

This research came about as a result of the increasing discussions in strategic planning about “becoming a regional referral center” by the typical 250-bed community hospital. Interestingly our experience showed that the requirements for success as a community hospital are significantly different from that of a regional referral center. The result, there are few hospitals that fall between the regional referral center and the community hospital. Those that try to straddle both the role of the community hospital and the role of the regional referral center generally fail to succeed. Those that successfully move from one role to the next also often do so quickly (in terms of organizational time i.e., 5 years).

To address this topic, we have researched community hospitals, regional referral centers, and those making the transition between to search for the characteristics that must change for a community hospital to become a regional center.

Through this research we believe we have outlined a model that better describes:

- The required changes a community hospital must make to transition to a regional referral center
- The characteristics the regional referral center must have to create long-term success

We hope that this will generate discussion and advance the ability for organizations to better define and focus their direction to the advancement of health care delivery. As you have thoughts or questions, we welcome the chance to add your experience and insights to this discussion and look forward to refining the concept.

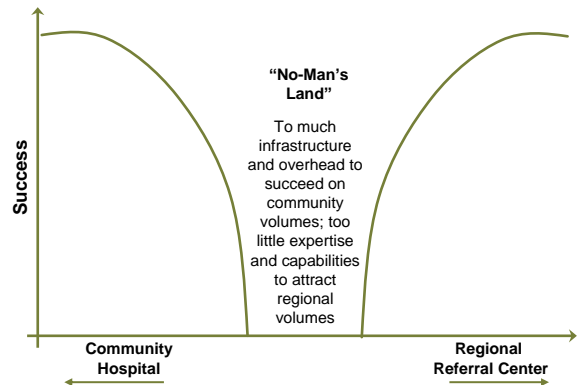
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There is no single agreed upon definition of what is a “Regional Referral Center”. At the extremes it is clear which hospitals fulfill primarily a regional referral center role versus those that have primarily a local community role. In between there are hospitals that exhibit both characteristics. However, there appears to be a “no-man’s land” between.

To survive, hospitals that move from community hospital to regional referral center must rapidly cross this no-man’s land. To cross this unfertile ground, it is important to understand the capabilities and different requirements for organizations as they move from local community-based hospitals to regional referral centers. To that end, we outline below the characteristics of a regional referral center and thereby suggest a working definition for “regional referral center”.



Regional referral centers are different from community hospitals on a many fronts. Based on our study of hospitals across the country, these differentiating factors fall into two categories: incremental factors and non-incremental factors

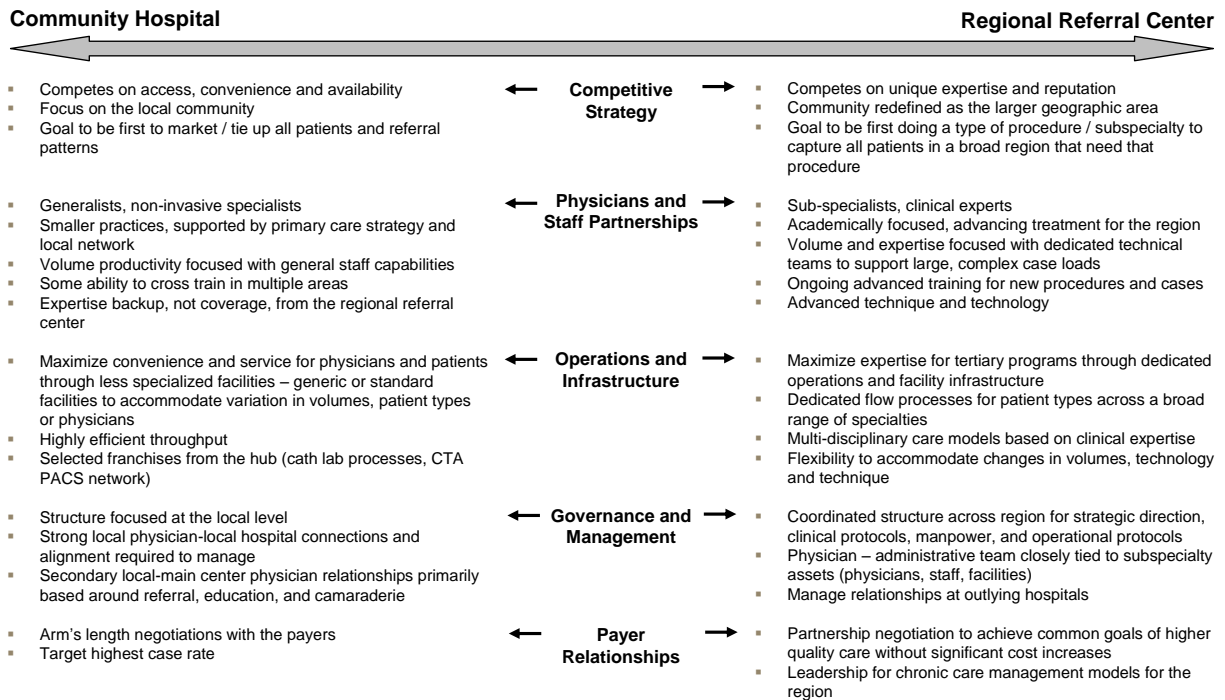
Incremental factors include characteristics such as volumes, scale, and resources. As a result of their incremental nature they are much more difficult to use to define when a hospital moves into the “regional referral center” category. Moreover, these incremental elements are very much outside the control of the administrative team, at least in the short term. As such we suggest that these incremental factors be thought of as requirements rather than goals.

- **Scale:** Without scale, all of these elements discussed below are exceedingly difficult to address, however we did not place a limit on scale as our research has shown us several examples of small hospitals with strong regional programs and large hospitals with limited regional reach. Nevertheless, without the critical mass to support the investments and specialized services (clinical, managerial, support) and infrastructure it is indeed difficult to fund the regional presence. Likewise, once the infrastructure is in place as it is at large centers, it is financially untenable to not have the margins from regional programs to support the organization.
- **Service area:** in rural parts of the country large areas are often consolidated to a single organization (e.g., Kearney, NE), while these patients are often referred long distances, the variability of other options by market makes distance a poor predictor of whether a hospital is a regional referral center or not.
- **Growth:** growth is typically positive, but not directly associated with a regional nature. Instead it may be a result of better serving the local markets and the spin-off reputation.
- **Scope:** a full range of services being offered is a hallmark of the regional referral center. Developing the expertise in a specialty to offer a full range of services often requires such development of supporting services that the infrastructure to support the next

subspecialty service is mostly in place. As a result, we often see that those organizations that have the one strong subspecialty often have many strong subspecialties. In fact, an analysis of the *US News and World Report* “Top Hospitals” reveals that the likelihood of being ranked in each succeeding specialty grows exponentially as a hospital is ranked¹.

The non-incremental factors are strategically more interesting. These factors are predominantly elements of the organizational culture or decisions about how to deploy hard and soft resources. As such, the non-incremental factors tend to be highly influenced by the actions of the leadership team and should serve as the focus for the organizations that want to become regional referral centers.

Our research has identified five non-incremental facets that separate regional referral centers from community hospitals: competitive strategy, physician and staff partnerships, operations and infrastructure, governance and management, and payer relationships.



Competitive strategy:

The means of competition for regional referral centers differs dramatically from community hospitals. To be effective, regional referral centers must develop distinctive expertise over that of the community hospitals to justify patients bypassing local care options. As such, the regional referral centers fundamentally compete on an *expertise strategy platform*. Community

¹ See KSA 2008 White Paper: *Scale Economies in Subspecializing Care: An Analysis of US News and World Report “Top Hospital’s”*

hospitals on the other hand have the advantage of location, ease of use, smaller scale, and the like that allows them to compete effectively on an access strategy platform.²

Physician and staff partnerships:

The relationship with the physicians in a regional referral center are successful when they prioritize rather than equalize. With the competitive strategy of expertise, the roles of physicians associated with the regional referral center are different depending on whether they are in leading or supporting roles for advancing the expertise strategies. Alternatively community hospitals thrive on local growth and access strategies. An egalitarian culture with the medical staff tends to be most successful for these community settings. Prioritization of the relationships, including how physicians are engaged by hospital leadership appears to be one of the defining factors for the success of regional referral centers. To create the expertise needed, the core physicians must be more stable, subspecialized, and directly aligned than to implement an access strategy in a community hospital setting. To effect this alignment, regional referral centers must have a multi-faceted physician alignment approach that includes leadership elements (strategic intent, operational culture, quality, market presence) and economic elements (joint ventures, employment, directorships, co-management).³

The staff culture is similarly different with greater use of dedicated staffing models to create technical expertise in a regional referral center. The resulting implication is reduced ability to cross-cover, less staffing flexibility, and greater staffing costs.

Operations and Infrastructure

The complexity of the operations increases dramatically in a regional referral center over a community hospital. As a result, deployment of resources (operational and infrastructure) become much more difficult and important. The need for prioritization of resources to advance the expertise competitive platform is high. Operational models and resources required by the leading subspecialty components of the regional referral center is much greater than the supporting components and thereby resources cannot be spread equally.

Infrastructure needs are similar. Dramatically more intensive infrastructure is required to support the subspecialty nature of the regional referral centers. The supersizing of healthcare⁴ is an issue of facilities being developed for the wrong purpose rather than the size of specific rooms. Specifically, building a community hospital to regional referral center standards is a poor use of money as the spaces will be oversized and inefficient for the needs of the community setting. However, the infrastructure needs of the regional referral center are quite different. ICU beds are a good example. Today, ICU beds make up 14% of the beds at a typical community hospital, but nearly 22% of the beds at a regional referral center.

Governance and management:

As influence grows to a regional nature, decisions become less consensus driven and more strategically deliberate. As such, it requires a different style and structure, one that promotes leadership over management at the regional referral center.

² See KSA White Paper: *Expertise – Access Strategy Continuum (2009)* for further discussion on the approaches to successful expertise and access strategies that can be employed by hospitals in a variety of situations

³ For further discussion about physician alignment see KSA White Paper: *Physician Alignment (2008)*.

⁴ See *Are We Super Sizing Healthcare?* AIA Seattle National Convention (February 2009)

Under a leadership structure, the senior management is often leading teams of individuals that manage the specifics. Service line structures, physician advisory councils, co-management agreements, and other similar structures are more often found in the regional centers where leadership is leading rather than managing.

In the same way the Board's role will continue to evolve to become more focused on governance and less on management advisory roles. There are five major ways in which the Board's role is different in a regional referral center. First, the Board's role remains one of ensuring the future of the organization is sound. This continues to include approving strategic direction, ensuring the direction is carried out. In addition, however, the Board's role in ensuring the future includes developing philanthropic support and advocating for the institution with the community takes on a greater role within the regional referral center.

Second, the complexity of running an organization as it moves towards a regional referral center increases exponentially. As such, the Boards of regional center focus much further on governance issues only, empowering management to conduct the operations. This is typically evidenced by the decreasing frequency of full Board meetings. A referral center will generally have Board meetings quarterly while community hospitals often are comprised of all local members and meet monthly. Committees of the Board typically take on larger roles and meet every other month.

Third, as strategy and strategic deployment of resources becomes much more important to success, and difficult, the Board and management need to be in direct agreement on the strategic priorities of the organization. With the establishment of priorities, there are "high" and "low" priorities. As such, it is important that the Board ensures the organization focuses on the high priorities. This is never more the case than with physician relationships. In a community hospital setting, physicians generally all will have a similar relationship with the hospital. In a referral center, all physicians are important to the success of the institution and physicians have different roles. Some roles are larger, leading roles, other roles are more supporting in nature. The Board and management need to be in complete agreement on these elements.

Fourth, the focus on quality becomes much broader. Quality at a subspecialty level requires strong leadership. Because of the complexity of the patients and treatments, regional centers can not tolerate lower levels of quality from the infrastructure, processes, staff, or physicians and must move quickly to rectify any areas that have sub-standard quality.

Finally, with the regional nature, the term "community" takes on a different meaning. No longer is it just the local market but the broader region. As a result the advocacy for and to the community becomes a different process for the Board.

Payer Relationships

Finally the last major factor is the relationships with the payers. As a community hospital with limited influence, the payer relationship tends to be "arm's length" and very transactional. To have a regional impact and define the healthcare for the future of the market, hospitals must have a much closer relationship with the payers. This does not mean an integrated delivery network of the 1990's. Instead, regional referral centers will be more apt to work with the payers to change the health status of the communities through innovative and novel approaches to delivering care. The increased focus on chronic care management, medical homes, other non-

fixed asset mediums of care are all examples of the regional referral centers working with payers and other healthcare participants to change the way healthcare is delivered. Without incorporating the payers into the equation, hospitals cannot have a regional influence on the health of a population.

Combined we now have a definition for what it takes to be a regional referral center. There are both requirements (volumes, scale, scope, etc.) and factors that administrations have influence over (competitive strategy, physician relationships, operations, etc.).

For those organizations with strategic plans that call for the hospital to become a regional referral center, leadership teams should have plans along each of these factors. To put into place these plans, it is more likely to succeed if the organizational culture has four competencies:

1. *Prioritization*: Willingness to define and act on organizational priorities at the expense of others and the ability to manage the fall out from the prioritization process and maintain relationships
2. *Leadership*: Proactively guiding the organization, associated physicians, specialty staff, etc. rather than managing processes.
3. *Customization versus Standardization*: Standardizing routine processes, but customizing to the specific needs for the service line and patient type (inpatient, outpatient, complex, simple).
4. *Alignment Competency*: Creating the connections between non-owned resources especially around subspecialty physician “partners”, but also including staff, competitors, and payers.

There are many organizations that claim to be regional referral centers, and more that have stated plans to become a regional referral center. The reality is that an organization cannot move from community hospital to regional referral center overnight. While certain elements such as size and resources constrain many organizations, there are five factors of regional referral centers that leadership teams can and must influence to successfully migrate an organization to regional status.