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How to add hospitals while losing beds

By Lia Novotny | March 3, 2017

How does a healthcare system succeed in a highly competitive, saturated market? How does leadership manage M&A growth to actually realize the benefits?

Stephen Klasko, M.D., M.B.A., has been grappling with these questions as president and CEO of Thomas Jefferson University and Jefferson Health. Between 2014 and 2016, Klasko's Philadelphia-based health system underwent a massive restructuring, splitting operations from partner organization Main Line Health and merging with a series of community hospitals.

athenaHealth CEO Jonathan Bush recently sat down with Klasko to discuss leadership strategies, a "hub and hub" approach to mergers, and how healthcare organizations can survive today while positioning themselves for the future.

Jonathan Bush: Let's talk about the market a little bit. First, you bail out of Main Line Health. Second, you're in the shadow of Penn, Temple, Drexel. And you add Abington, Aria, and Kennedy. Why did you want to add hospitals in a world that is reducing beds? And how do you win in this market?

Stephen Klasko: We financially decoupled from Main Line Health because we had no strategic alignment. Then I merged Thomas Jefferson University with Thomas Jefferson University Hospital so they would be in alignment. Then we won reps from Abington, Aria and Kennedy Health — competing with entities like Penn and Trinity.

So, why did they choose us — and why did we choose them? It's not because I thought, "Boy, beds were a great thing to have."

JB: Exactly my question.

SK: The whole key for the future is going to be indispensability. If you talk to any academic medical center CEO and ask, '"What's your strategy for adding a community hospital," they'll say, "hub and spoke." Nobody wants to be a spoke. We presented a "hub and hub" model. What I want to do is get care out to where you are. I want to have fewer beds downtown because the university hospital is more expensive.

So, Abington gives us an amazing AA-type entity. Aria gives us all of northeast Philadelphia. Now we're the largest entity in Philadelphia and south Jersey with a very different model of getting care out

to where people are. We cancelled investment in new beds. I invested $30 million in telehealth.

"We could probably get 50 percent [of cases out of the ER], but at this point, that would bust us."

JB: You're talking about telehealth. Is there a timeframe when the Abingtons of the world aren't needed, at least not for their current use? And what happens to community hospitals in that world?

SK: They become different entities. Let me give you a real-life story. We have the largest orthopedic surgery group in the country: a private group called the Rothman Institute, 140 orthopedists. Back when we were the old Jefferson, they moved 722 cases out of my hospital even though they were my orthopedic department.

Why? Because they were doing the right thing. They were demand-matching. They said, "Look, if somebody isn't really sick, I'll treat them at a tier one hospital. Steve, you don't own any tier one hospitals."

I thought that was brilliant! So I now have five tier one hospitals for those 42-year old arthroscopic patients who need a 45-minute procedure. And we're strategically aligned.

JB: Now you can take the secondary care out of this expensive setting. You push it out.

SK: Exactly. My daughter has the health coverage that everybody will have [someday]: $250 a month, a $3,000 deductible and she makes about $60,000 a year. She calls me up one day and says, "Dad, what do you think about…." It was a community hospital outside of Tampa. I said, "Well, it's a good community hospital. But why? You're right on the university hospital campus."

She said, "I need a small procedure. It's $200 of my money at the community hospital, $800 at the university hospital. That's a weekend in Miami. Oh, and by the way, I went on PatientsLikeMe.com. The waiting rooms are cleaner and the staff is friendlier at the community hospital than the hospital you ran. Now, what were you gonna tell me, Dad?"

That's the future. That's the future we're getting ready for with these mergers.

"Right now, we're stuck in the twilight zone of healthcare between volume and value."

JB: It's still honeymoon time, but at athenahealth, we've been researching inorganic versus organic growth. Our inorganically growing enterprises are actually experiencing diseconomies of operational scale. Because the culture is not the same. Because they're working on the new marriage and not on the day-to-day. You don't want to be the guy facing the negative economies of mergers.

SK: Yeah, but we're not. It starts with the "hub and hub." We have no reserve powers when we do these mergers. They get an equal number of board seats. So, when somebody says, "How can we hand over this asset with no reserve powers? You could close one of my hospitals," I say, "We could, but the three of you could get together and close Jefferson if you wanted."

The second thing is — and this is very unusual — we have a 100 percent consolidated balance sheet. I fully expect that Thomas Jefferson University Hospital will become a loss leader as we move forward because we're going to be doing all of the complicated cases.

Third, what people in my position miss is: You need to over-communicate. I'm at Abington. I'm at Aria. I'm at Kennedy. So at the end of the day, [staff and physicians there] see this merger very differently.

Fourth, we look at a best-available-athlete strategy. Our chair of cardiovascular surgery is the chair at Abington Hospital. Can you imagine a Hopkins or a Penn taking over a community hospital and doing that? It's a very different model.

JB: How do you ensure that you don't bankrupt the business as you're shifting care to these lower-cost channels and starving your more expensive channels?

SK: We don't have huge margins. We have 9 percent, 10 percent EBITDAs and 3 to 4 percent margins.

We are able to maintain those margins by taking advantage of the fact that we're a great academic entity. People want to go to us. For example, we have some of the top pancreatic cancer surgeons. Those are still fee-for-service. We try to titrate.

There are a few things that I have slowed down so that we don't end up being ahead of the curve, like replacing ER volume with telehealth and urgent care. We could probably get 50 percent [of cases out of the ER], but at this point, that would bust us. But we're getting 30 percent out.

A lot of this is getting ready for the future, even though it's not how we make money now. I have to figure out: Can I survive doing what I'm going to need to do to be successful five years from now and still get a net operating income now? Right now, we're stuck in the twilight zone of healthcare between volume and value.

JB: What percentage of major medical centers get that, do you think?

SK: I was just with Aneesh Chopra, chief technology officer for President Obama. He would probably say five to ten percent.

Lia Novotny is a staff writer for athenaInsight.