Preparing for the *Inevitable* Perilous Journey From Entitlement to Accountability

-A *Practical* Guide-

"… we must choose between reality and madness."

~Billy Joel , Summer- Highland Falls

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N8's Qualifications

www.kaufmansa.com

- 35 years in healthcare
  - Strategic Advisor to health systems and medical groups
  - 68 publications
  - Faculty for ACHE, The Governance Institute, AHA, MGMA, AAFP and many hospital and physician associations
  - Focus: physician-hospital transactions, managed care, financial turnarounds, payer negotiations, education
  - 2005 Presentation Theme: *Shelter from the Storm*
- As Managing Director of Kaufman Strategic Advisors (since 2007)
  - On-site 210 health systems in 45 states
  - 200 physician transactions and valuations
- Hit rate of .800!

The Classic Approach to Strategy Will NOT Work During Turbulent Times

The Classic Approach To Strategy

There is a predictable path to the future from that of the past.

Just In Time Strategy for a Turbulent World ~McKinsey

Turbulence

A Portfolio of:

- Big Bets - ROI
- Small Bets
  -R&D initiatives

Just In Time Strategy for a Turbulent World ~McKinsey

Which Company Best Reflects Your Current Strategic Culture?

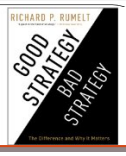
- Always looking to invent the "next big digital thing"
- Easy-to-use, reliable disruptive products people love
- Expands beyond traditional boundaries
- Brand confidence
- Rewarded with record profits and market share in a bad economy

1983%

1399%

1975: “Normality Bias” - Digital What?

Strategy Defines HOW You Will Move Forward and Tackle the Fundamental Challenges



Bad Strategy

- Lofty goals, high hopes and unrealistic ambitions
- Long on gibberish short on specifics
- Strategic objectives that fail to address critical issues or are impractical
- A budget
- A long list of things to do

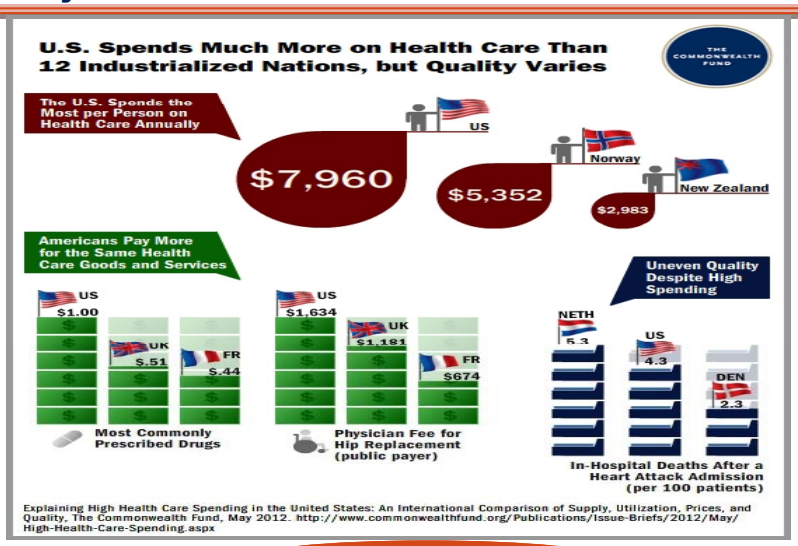
Good Strategy

- **Careful definition of :**
  - **the essential competencies for future success (national)**
  - **honest identification of challenges (local)**
  - **Specific actions to overcome challenges (local)**
- **Ultimately makes an organization sustainably differently better as measured by market share and profitability**

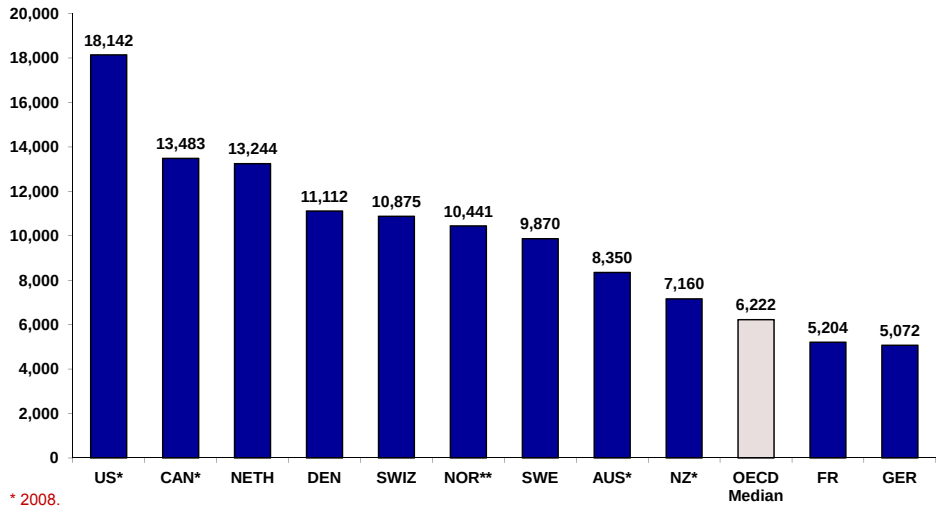
Are YOU Getting an Appropriate Return for Your Family's Investment in Healthcare?

Family Income	$80,000	$250,000
Contribution To Premium + Copayments + Deductibles	$8,000	$8,000
Federal and State Taxes Divided by 4 (40% rate)	$8,000	$25,000
Medicare Tax	$2,000	$1,000
Total	$18,000	$34,000

This just in:

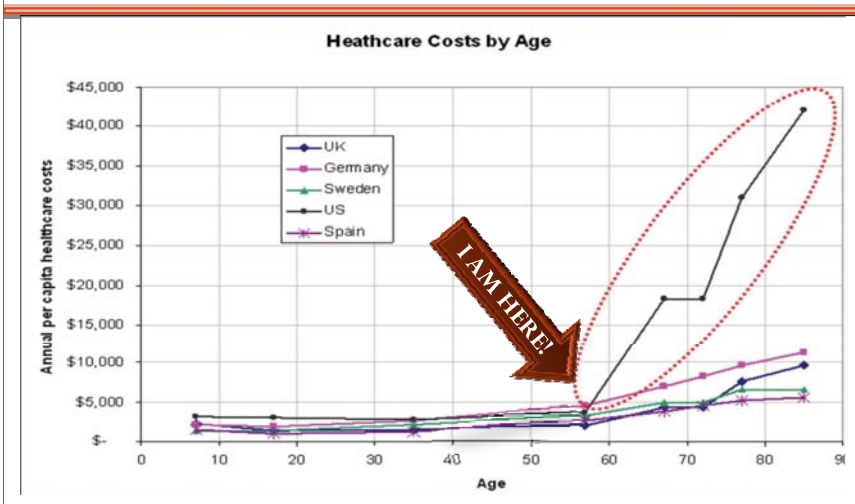


This just in:
Spending per Discharge, 2009
Adjusted for Differences in Cost of Living



* 2008.
** 2007.
Source: OECD Health Data 2011 (Nov. 2011).

U.S. Healthcare is Only Expensive When You Use It!



Source: "Fischbeck, Paul. "US-Europe Comparisons of Health Risk for Specific Gender-Age Groups." Carnegie Mellon University; September, 2009.

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Companies That Experience the World From the Customer's Perspective Develop Better Strategy

78 y/o WF

Problem List:

1. Type II diabetes with neuropathy
2. Iron deficiency anemia
3. Breast cancer
4. Pernicious anemia
5. Coronary artery disease
6. Peptic ulcer disease
7. Osteoarthritis
8. Hypertension
9. Allergic rhinitis
10. Eczema
11. Glaucoma

McKinsey, *Have You Tested Your Strategy Lately?*

18 Medications

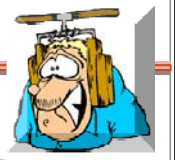
Calcium	Metformin	Enalapril
Temazepam	Timoptic eye gtts	ASA, KCL
Simvastatin	Lumigan eye gtts	Glipizide
Vitamin B12	Omeprazole	Metamucil
Lasix	Diltiazem, Requip	
Lantus insulin	Zyrtec	

12 Current Physicians

PCP	Ophthalmologist
Neurologist	Gastroenterologist
Podiatrist	Oncologist
General Surgeon	Cardiologist
Endocrinologist	Hospitalist
ENT	Dermatologist

2004 US Olympic Basketball Dream Team

Does the Data Support Maintaining the Status Quo?



Physician Visits During Last 2 Years of Life:
Long Island: 91
Boston: 59
Salem: 38

Variation in Mastectomy vs. Lumpectomy
7x

Average Insurance Payment for Normal Delivery
US: $8,435
Australia: $4,592
Germany: $2,147

Non-Radiologist Self-Referrers are
2.48 Times as Likely to Order Imaging

Spending per UAW Beneficiary – 19 Cities:
$4,500 - $9,000

Does the Data Support Maintaining the Status Quo?

Dear Doctor:

Anthem

RE: Patients Incur Lower Out-of-Pocket Expenses When Using a Free Standing Imaging Center

Providers within 10 miles Back – MRI Spine		
Name	Low	High
Freestanding Imaging Center	$ 531	$ 742
Northern Medial Center	$1,591	$1,802
Saint Steven's Regional Med Center	$1,803	$2,014
Memorial Medical Center	$2,015	$2,226

We appreciate your partnership in considering the financial impact to your patients, especially during these challenging economic times.

Sincerely,

Director
Provider Engagement and Contracting

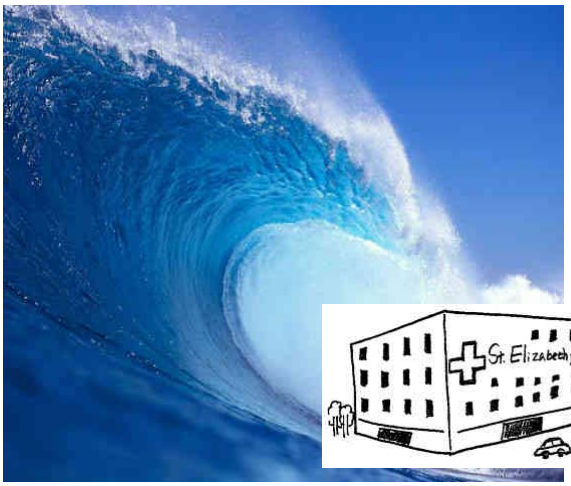
Price Variation in Autoworker Plan Across Communities by Service Type, 2009
100% = Medicare

	Low Price	High Price
Emergency Room	135%	310%
Hospital Inpatient	125%	250%
Physician Services	85%	120%

Highest: Indianapolis
Lowest: Akron

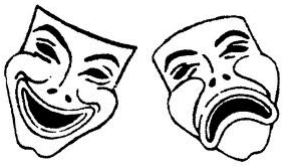
Source: Research Brief, No. 7, Feb. 2012; Health Status and Hospital Prices Key to Regional Variation in Private Health Care Spending by Chapin White

Healthcare Reform
The Tsunami of "Innovation"



Everyone Should Plan for a 10% Reduction in Revenue per Unit Over the Next 30 Months

The Law of Reciprocal Economics:



One person's cost is another person's revenue.

Who believes that they are overpaid for the work they do today in healthcare?

Acknowledgement:

Politicians are Unwilling to Address the "Third Rails" of Healthcare

Malpractice Reform

- **93% practice defensive medicine to avoid lawsuit**
  - 59% often ordered diagnostic tests
  - 52% referred to other specialists
  - 33% prescribed medications

~David Studdert, et al.

June 2005, survey of 824 physicians

Heroic End of Life Care

- **28% of Medicare spending/recipient occurs in the final year of life**
  - 12% occurs during the final two months

Health Insurance Anti-Trust Exemption & Interstate Sales

Personal Responsibility

- **38 states have obesity rates over 25%**
- **42 states have diabetes rates over 7% (-4 in '95)**
- **1 in 5 adults smoke adding $100B of cost**

Cost of Medical Education

Major Themes

- **The current economic glide path for the healthcare delivery system is not sustainable *(no one is immune from arithmetic)***
- **Government eventually responds to a perceived threat to the wellbeing of its citizens with solutions that are well meaning but confusing , over-reaching, and clunky which are influenced by special interests and fraught with unintended consequences –** Transportation Security Administration
- **ACA is a fundamentally flawed law --Worry about: ACA-2 *The Crisis (2016!)***
- **We are 'stuck' with value-based fee for service for at least five years**
- **Many health systems and physician practices will experience distress Performance= (1/3 S + 1/3 E + 1/3 L) and Failure=(S-C)**
- **Culture may beat strategy but those that adopt new software and technology are usually the ultimate winners -** NowClinic℠
- **Following *theoretical strategic wisdom* can get you in trouble (unless you are a consultant – or a bureaucrat)**

"Current incentives are contributing to unexplained and/or unintended variation health care quality and cost." ~ IOM 10/12/2011

A highly rational response to the set of economic incentives. ~ McKinsey 2009 US Healthcare

- ***FFS rewards episodic intervention, throughput, ancillary utilization, radical autonomy, and leveraging for rates***
- ***Fraught with potential conflicts of interest***
- ***Creates 'coopetition' and is eroding the public trust***
- ***No "accountability" for patient management:***
  - Best measurable outcomes at lowest cost
  - Referring to the appropriate level of care
  - Coordination of care/team care
  - Standardizing around best science
  - Patient responsibility

Theoretical Wisdom

- Shared Savings/Pioneer ACOs
- Bundled Payments *(Health Affairs 30, no. 11– Slow Start Shows Problems In Implementing New [Bundled] Payment Models)*
- Managing Population Health and Prevention (Hospital workers: 8.6% poorer health status)
- PCMH (AHRQ-"Benefits Unknown" 12/30/11)
- Pay-for-Performance Study Results 'Sobering' April 2, 2012

"Market rewards [from Medicare ACOs] may not materialize for a long time, IF EVER!

Center for Studying Health System Change January 11, 2011

F as in Fat: How Obesity Threatens America's Future 2011, 69% of Baby Boomers are overweight!

JULY 2011

Congressional Budget Office

January 2012

Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment

Demonstration	Participating Organizations	Incentive Offered	Effects on Medicare Spending
		Pay for Performance	
ACO	10 Physician group practices	Keep some of estimated reductions in total Medicare spending, partly on the basis of quality of care	Little or None
Premier Hospital Quality Incentive	278 Hospitals	Receive bonus for meeting quality-of-care targets	None
Home Health Pay-for-Performance	273 Home health agencies	Keep estimated reductions in total Medicare spending, if quality-of-care targets are met	Little or none in the first year[a]
		Bundled Payments	
Competitive Bidding for Bundled Payment	7 Hospitals and relevant physicians[b]	Bundled payments negotiated for coronary bypass surgeries	10% decline in spending CABG

Source: Congressional Budget Office.

a. Results are available only for the first year of the two-year demonstration

b. Physicians who treated heart bypass patients while they were hospitalized.

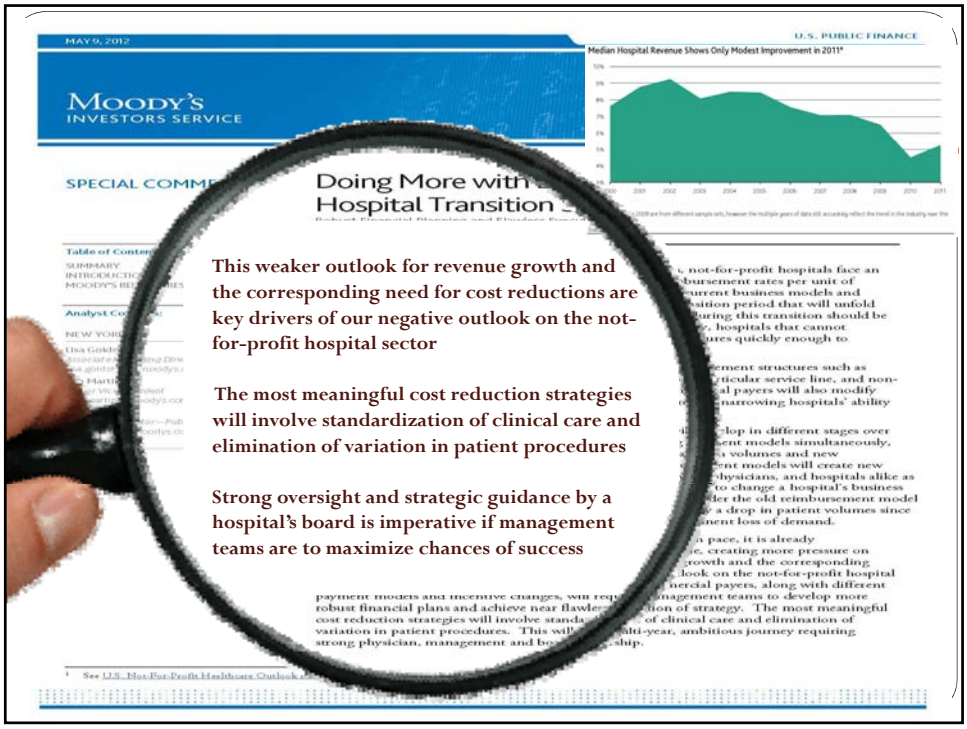
"What we learn from experience is that we never learn anything from experience!"

"The housing boom is soon to go bust. And it will affect everyone…"

~Gary Shilling, Forbes
October 14, 2002

"All the doom and gloom forecasts are not only irresponsible but are downright wrong."

~David Lereah
Chief Economist of NAR (2005)



citi

North America | United States
Health Care Facilities (Citi)

Equities

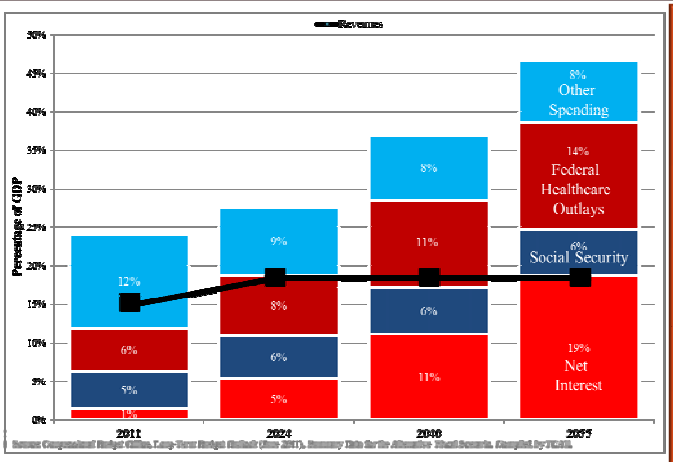
3 January 2012 | 111 pages

Health Care Facilities 2012 Outlook

Bracing for a Long Bear Market in U.S. Entitlement Spending

- **It's Just Too Hard to Be Bullish on Government Revenue**
- **Medicare Fears Will Likely Return in 2H12**
- **July Medicaid Rates Could Surprise to the Downside**
- **What Would Concern Us Most** - Republican control of the Senate.

"The pending economic crisis will be the most predictable crisis in our nations history!" Senator Tom Coburn MD



Notes: Data are from GAO's Spring 2012 [a] This also includes spending for insurance exchange subsidies and the Children's Health Insurance Program.

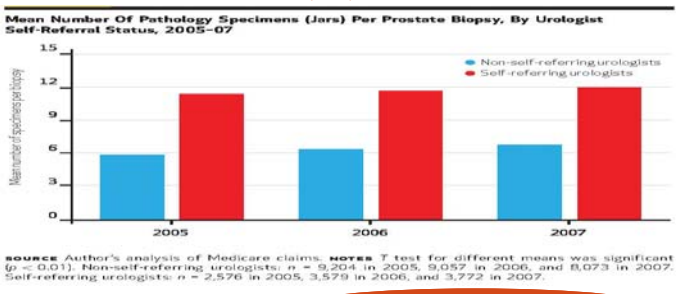
Bundled payments, ACOs, medical homes can reduce cost levels but not the overall growth rate… Medicare spending will grow faster than projected .. and Congress won't be able to avoid changing course.

~Richard S. Foster, Chief Actuary for CMS *February 28, 2012*

"Unchecked provider latitude can create a culture of money." ~Atul Gawande, MD, Luisa Franzini, et al.

Per Capita Spending	El Paso	McAllen	Percent Difference	US Average
Medicare	$7,947	$14,817	86%	$8,451
Blue Cross	$2,428	$2,266	-7%	

Source: McAllen and El Paso Revisited, By Luisa Franzini, Osama, Mikhail and Jonathan Skinner; Health Affairs 29, No 12,(2010) 2302-2309



SOURCE Author's analysis of Medicare claims. NOTES *T* test for different means was significant ($p < 0.01$). Non-self-referring urologists: $n = 9,204$ in 2005, 9,057 in 2006, and 8,073 in 2007. Self-referring urologists: $n = 2,576$ in 2005, 3,579 in 2006, and 3,772 in 2007.

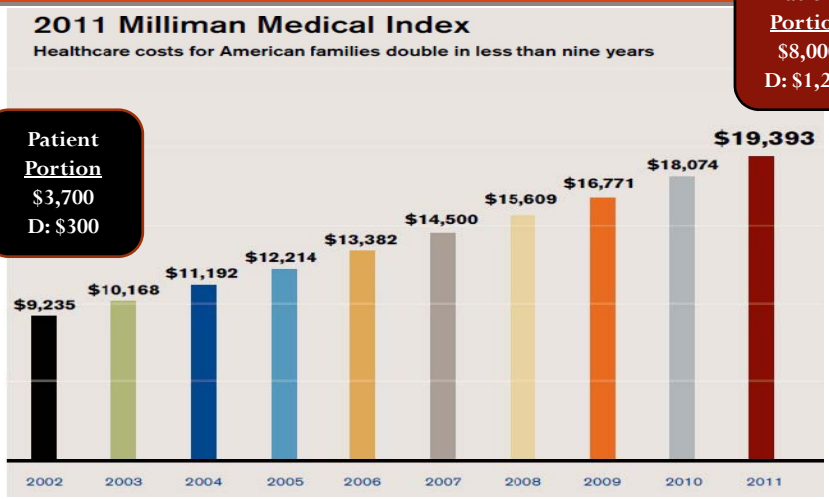
Recovery Audit Prepayment Review

Prepayment audit on 15 DRGs in 10 states (cardiology and orthopedics) – no payment for hospitals and 'take back' from physicians for unnecessary admissions! –

Effective June 2012

A Decade Of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family[1]

Patient Portion
$8,000
D: $1,200



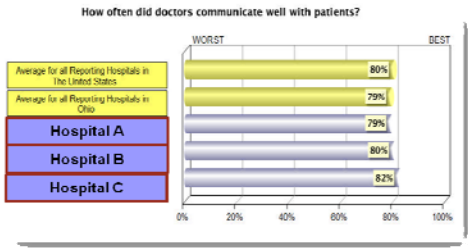
Source: "2011 Milliman Medical Index," Issued May 2011
[1]HEALTH AFFAIRS 30,NO. 9 (2011): 1630–1636.

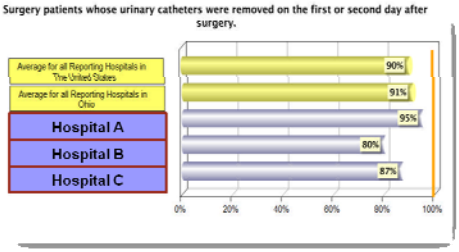
Megatrend:

Transparency

Transparency Will Be Used to Force Accountability

~ www.Hospital Compare.HHS.gov





Patient Safety Measures			
	Hospital A	Hospital B	Hospital C
Serious Complications This is a 'composite' or summary measure.	No Different than U.S. National Rate. Get results for this Hospital	No Different than U.S. National Rate. Get results for this Hospital	Worse than U. S. National Rate. Get results for this Hospital
Deaths for Certain Conditions This is a 'composite' or summary measure.	No Different than U.S. National Rate. Get results for this Hospital	Better than U.S. National Rate. Get results for this Hospital	No Different than U.S. National Rate. Get results for this Hospital

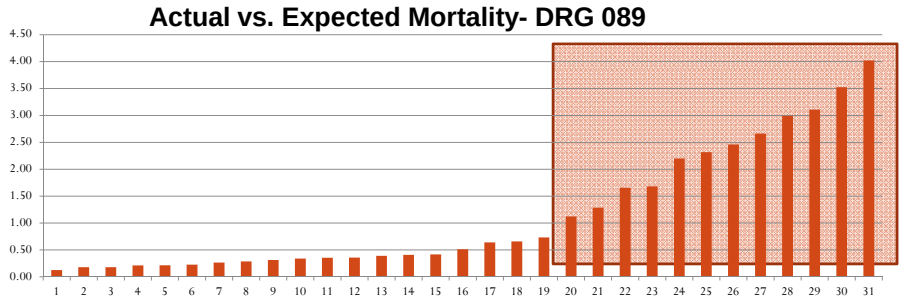
Medicare Spending Per Beneficiary	
Hospital A	1.06%
Hospital B	0.95%
Hospital C	0.94%

Beware Physician Compare:
Medicare Site Inaccurate

Doctors say if CMS can't get simple biographical information right, expanding the website to include quality scores by 2013 might not produce a trustworthy resource.

~Charles Fiegel, amednews staff; posted May 9, 2011

Transparency Creates New Challenges for Boards, Management and Medical Staffs!



HealthGrade's100 Best Hospitals for 2012
30% lower risk-adjusted mortality across 17 procedures and diagnoses

PhD
Clinical Documentation
ICD-10

CONFIDENTIAL
2010 QUALITY AND RESOURCE USE REPORT
MEDICARE FEE-FOR-SERVICE

Dr. [Physician Name]
National Provider Identifier (NPI) [#]

Specialty: [ ]

ABOUT THIS REPORT FROM MEDICARE	
WHAT	This report presents information about the quality of care provided to Medicare fee-for-service (FFS) patients you treated in 2010 and the amount that Medicare paid you and other Medicare providers to deliver this care. This report is *for informational purposes only*. It *will not affect* your Medicare payment or your participation in the Medicare Program.
WHY	• To enable you to compare the quality and cost of your Medicare patients' care with that of Medicare patients treated by physicians in your specialty and by all physicians in Iowa, Kansas, Missouri, and Nebraska. • To highlight your degree of involvement with all patients you treated, based on claims you submitted to Medicare. • **To identify possible components of a payment modifier required by the Affordable Care Act of 2010. The payment modifier will provide for differential payment to physicians or to groups of physicians under the physician fee schedule based upon the quality of care furnished compared with cost. This report begins to provide you with quality-of-care and cost information that can be used in a future payment modifier.**
WHEN	Medicare is required by federal legislation to phase in the payment modifier beginning in 2015. By 2017, Medicare is required to apply the payment modifier to all physicians and groups of physicians.
WHO	Medicare is providing this confidential feedback report to you and other physicians who practice in Iowa, Kansas, Missouri, and Nebraska. We chose physicians in these states because they share a common Medicare Administrative Contractor that could help disseminate the reports.
WHAT YOU CAN DO	• Consider the information in this report to help you identify clinical areas in which you are doing well and those areas that might need improvement. • Share your thoughts about how to make these reports more meaningful and actionable. You can email CMS at CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com with your comments, or you can participate in one of the conference calls that CMS has scheduled with report recipients. • More information is available at http://www.cms.gov/physicianfeedbackprogram.

1

Washington Post 4/14

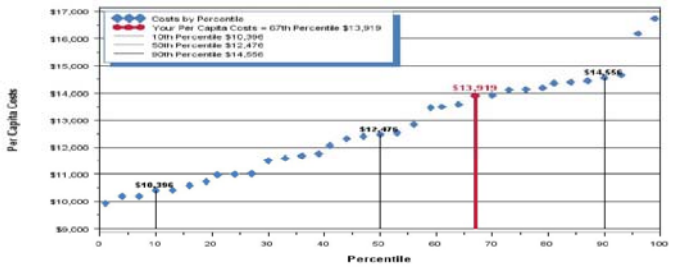
Medicare officials are trying to refine the way they judge doctors as they follow the health-care law's directive to phase in the new payment system, called a Physician Value-Based Payment Modifier, starting in 2015. It will initially apply only to physician groups and some specialists selected by the government, but by 2017 the payment change is supposed to apply to most if not all doctors.

Per Capita Costs of Patients Whose Care YOU Directed

Per Capita Costs of Patients Whose Care You Directed

Exhibit 6 shows the distribution of total risk-adjusted and price-standardized per capita costs, by percentile, among physicians in your specialty practicing in Iowa, Kansas, Missouri, and Nebraska, for patients whose care was **directed.**

Exhibit 6. Distribution of the 2010 Total Per Capita Costs of Patients Whose Care Was Directed by Physicians in Your Specialty in Iowa, Kansas, Missouri, and Nebraska

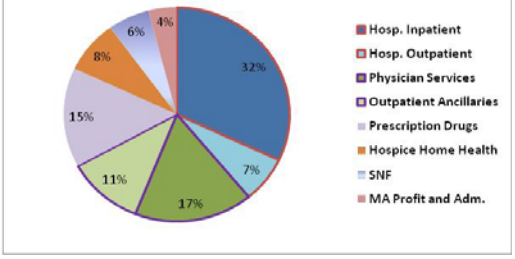


Megatrend:

Medicare/Medicaid
Cut, Cap, and Consequences

Medicare Will Continue to Put "Relentless Pressure [On Medicare Rates] to Force Efficiency"

2009 Medicare Expenditures



Medicare Rate	Increase 2012
Hospital	+1%
Physicians	-27% to +1%

Health Industry Likely To Back Automatic 2 %Cuts Over Any New Budget Plan

Reuters reports
(Reid/Yukhananov, *Reuters*, 9/6)

"America's hospitals are very disappointed with MedPAC's recommendations today regarding changes in Medicare payment to hospitals," AHA President and CEO Rich Umbdenstock (1/12/2012)

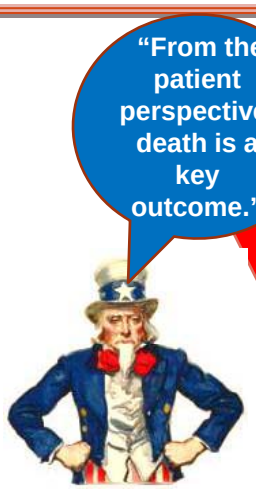
Look What's Happening Out In The Street

March 28, 2012

Dear Acting Administrator Tavenner:

The undersigned [50+ physician] organizations are writing to express our profound concern about the imminent storm that is about to occur due to simultaneous implementation of multiple programs that will create extraordinary financial and administrative burden as well as mass confusion for physicians.

Hospitals Will Be Held Accountable For Care In 2013 (Physicians are Next)



Value Based Purchasing/Patient Safety Initiative

8-10% Medicare Rev:

- Process adherence
- HCAHPS: Patient Satisfaction
- Mortality
- Readmissions
- HAIs

2014 Proposed 'Values'

- Clinical Outcomes
- Medicare Efficiency

MSPB Statistics (To be published in 2013)

Medicare Spending per Beneficiary

HEARTCARE REGIONAL MEDICAL CENTER

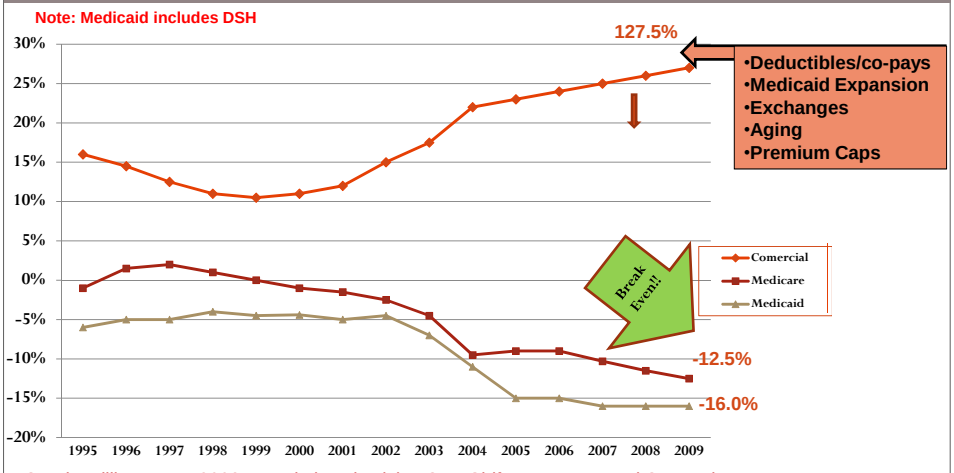
	Your Hospital	State	Nation
Average MSPB Measure	1.08	1.05	0.98

MSPB measures actual to expected cost - 3 days prior to admission through 30 days post discharge

Megatrend:

Limited Rate Increases/Limited Networks

The Game Changer - The Ability to Cost-Shift Will Be Diminished



Graph: Milliman-Dec 2008; Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid and Commercial Payers; KSA Estimates 2008 & 2009.

[1]Center for Studying Health System Change, November 2010

The Main Event!

37 States and HHS to Review/Approve Premium Increases

	Requested Rate Increase	State Authorized Rate Increase
New Mexico, Presbyterian Healthcare Health Plan	9.7 %	4.7 %
Connecticut, Anthem Blue Cross Blue Shield	12.9%	3.9%
Oregon, Regence	22.1%	12.8%
New York, Emblem, Oxford, and Aetna	averaged 12.7%	8.2%
Rhode Island, United Healthcare of New England	18 -20.1 %	9.6-10.6%
Pennsylvania, Highmark	9.9%	4.9-8.3%
Average Increase in Mass.	16.3% -'10	2.3% - '12

SOURCE: http://www.hhs.gov/news/press/2012pres/01/20120112a.html

Health Plans Will Bring You to Tiers!

Insurance premiums are reduced by nearly 25% using "narrow networks."

~ LA Times April 3, 2011

WellPoint Offers Members Cash For Using Less Expensive Facilities

BC Mass. Hospital Choice Cost Share Plan Benefit	Co-Payments as of 9/25/2010	With Hospital Choice Cost-Sharing Feature as of 1/1/2011
Inpatient Hospital	$500	$1500
Hospital Day Surgery	$250	$1250
High Tech Radiology	$ 50	$ 500

"Our census is down by 70 vs. 2 years ago...we are seeing a decrease based on narrow networks, we're getting left out! We have a $22M gap for next year." ***~ email to n8 8/17/11***

BOSTON GLOBE

Coakley Moves to Regulate Health Cost

Seeks to limit provider prices

By Liz Kowalczyk Globe Staff / April 6, 2012

Children's, Blue Cross Deal Curbs Payments

Boston Globe, January 24, 2012

Children's Hospital Boston has agreed to a three-year contract with Blue Cross that will not pay Children's any more money this year... And less than a 3% increase in years two and three.

Steward Community Choice, a JV with Tufts Health Plan

This plan, which uses a narrow network of physician offices and community hospitals, will be priced up to 30 percent below current market rates.

Aetna CEO: Health Insurers Face Extinction

" We need to move from underwriting risk to managing populations…"

Press Release:

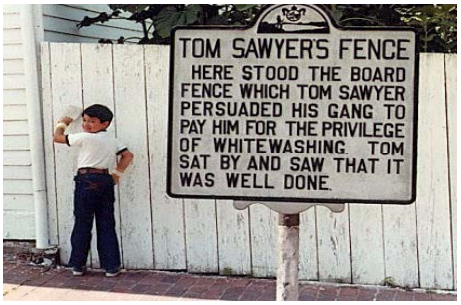
March 27, 2012

Telehealth Service Offered by Highmark Gives New Meaning to the Term House Call

Physicians available 24 hours a day, seven days a week .

Megatrend:

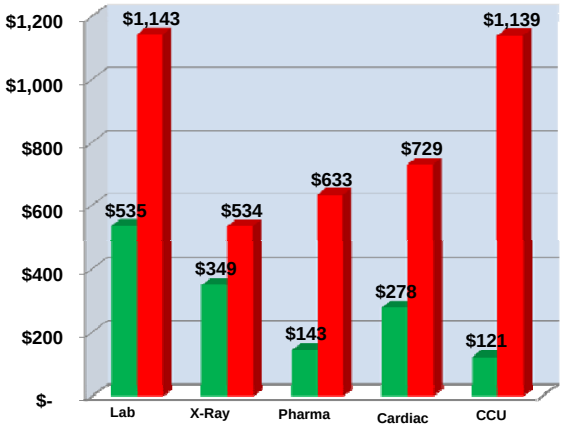
Multiple Opportunities to Participate in Experiments with Innovative Payment Models



Concept attributed to Jeff Goldsmith

A Micro-view From the Payers Perspective

DRG 089: 192% Cost Differential ($2,702) with No Measurable Difference in Severity/Outcome/Quality



High Variability

- **Cost**
- **Outcomes**
- **Mortality**
- **Readmissions**
- **Complication Rates**

"Eminence Based Medicine"

Providing sub-optimal medical care with increasing confidence over an impressive number of years. *~British Medical Journal, Vol. 1 Sept. 2001*

Excessive testing costs $200-$250B per year

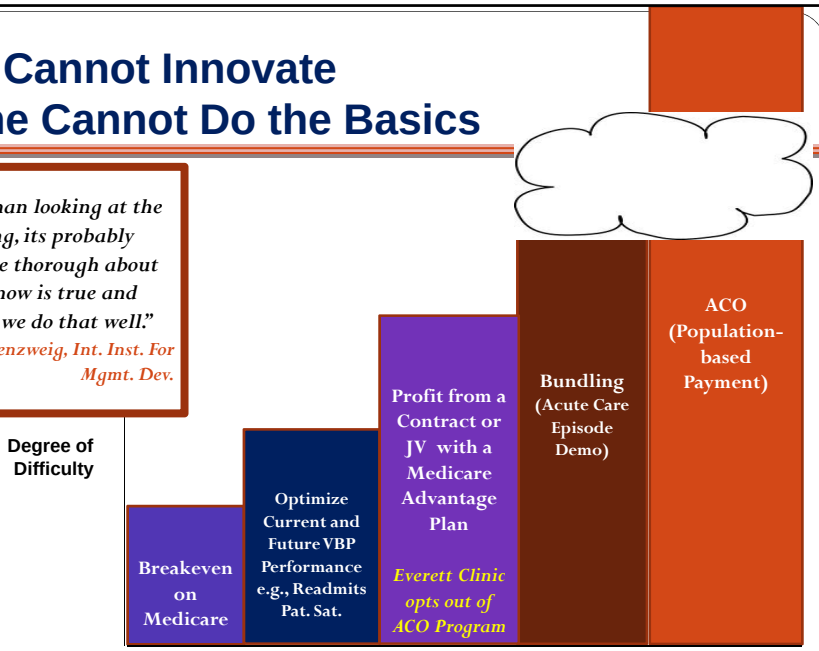
~Dr. Steven Weinberger, MD CEO ACP

"More than 45 percent of men with low-risk prostate cancer underwent guideline-inappropriate imaging."

~Health Affairs, 31, no.4 (2012):730-740

One Cannot Innovate if One Cannot Do the Basics

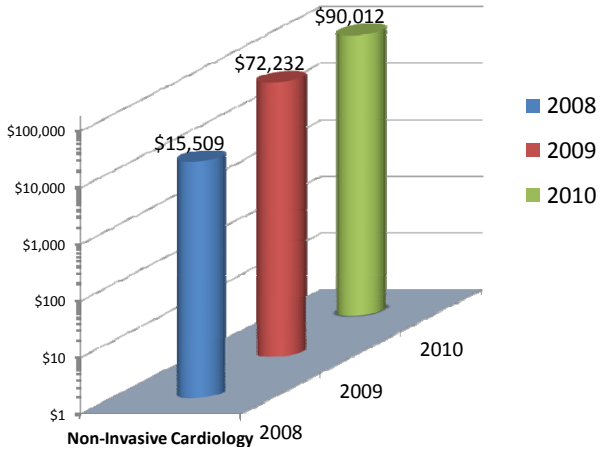
"Rather than looking at the next musing, its probably better to be thorough about what we know is true and make sure we do that well."
~Phil Rosenzweig, Int. Inst. For Mgmt. Dev.



Megatrend:

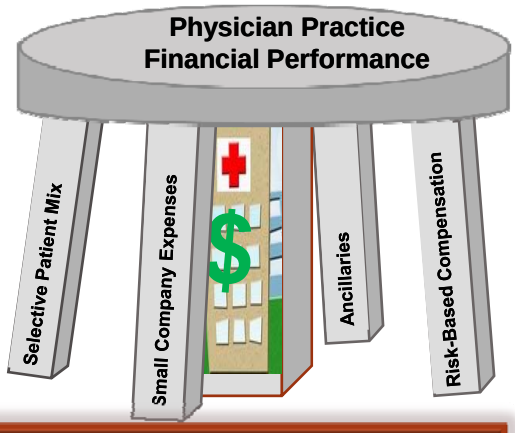
Physician Recruitment/Income Stabilization Will Create Severe Financial Strain for Many Health Systems

Difference in Median Compensation Hospital Owned vs. Private Practice



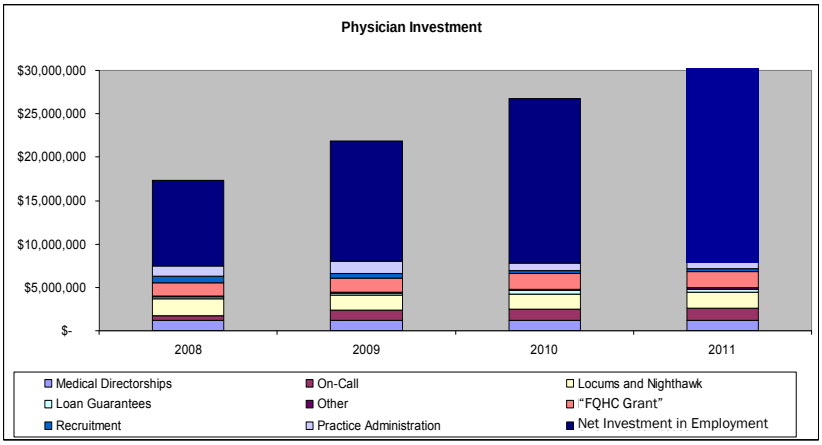
Employed Physicians--Your Highest Paid Workforce Perfectly Designed to Produce the Results You Get

1. Collection of Entrepreneurs
2. Poorly structured deals
3. Underfunded, inexperienced management/infrastructure
4. Weak physician hierarchy
5. No code of conduct/vision
6. Tolerance for breaking the rules
7. Compensation based on individual productivity
8. Minimal communication and benchmarking (feedback)
9. Physician data reported as a separate company



Are we engaged, partners or just stuck in a lousy relationship ????

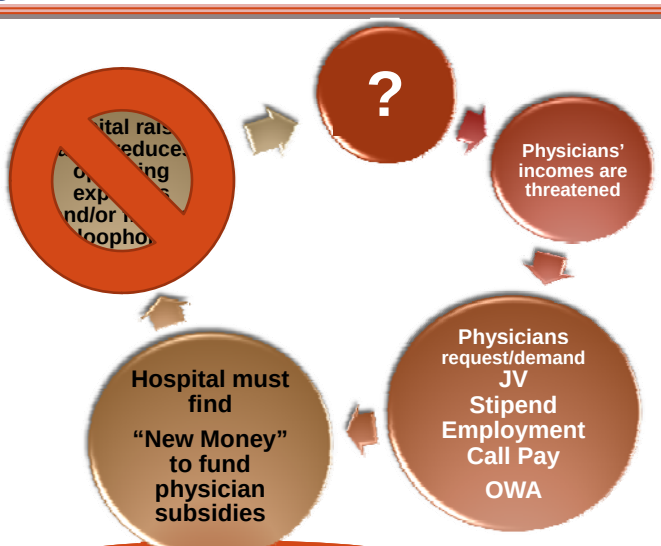
How Much are You Investing in Physician Employment?



The Economics of Traditional Physician-Hospital Engagement are Not Sustainable

"Medicare needs to move, over time, to paying the same amount for the same service, regardless of the provider type…"

~ Glenn Hackbarth, MedPAC Chairman (1/18/2012)



Megatrend:

Intensified Scrutiny on
Fraud, WASTE and Abuse

"OIG Weighs Hospital Data, History When Picking Targets for Compliance Reviews."

~January 9, 2012 Medicare Compliance

"Doctors should be aware that we are scrutinizing records and detecting fraud and kickbacks," "We hope that our aggressive enforcement will deter doctors from cheating the taxpayers and endangering patients."

~U.S. Attorney Barbara L. McQuade (January 11, 2012)

"They always say that big changes are coming -nothing has changed so far."

Just Because the Monkey is Not on Your Back, Doesn't Mean the Circus Has Left Town!

Culture of Entitlement
(Based on Tradition)

Accountability
(Based on Results "Value")

"Our Implicit Compact was about entitlement, protection and autonomy. By virtue of joining the medical group, each physician felt, 'I'm entitled to patients, I'm protected from the environment by administration and I can do whatever I want, whenever I want to."

~Dr. Gary Kaplan, MD, Virginia Mason Medical Center, 2000

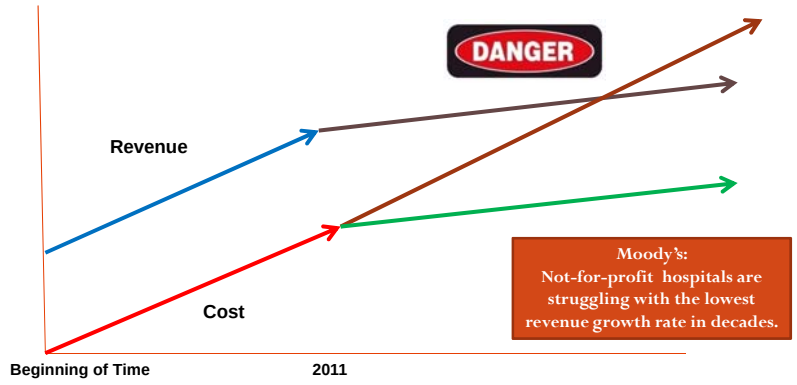
Define True North - Articulate Your Plan and the Process for Measuring Success

True North defines your beliefs, values, and principles and your source of competitive advantage – Your compass during turbulent times.

To operate a financially strong HOSPITAL by maximizing revenues through pricing and volume growth, the provision of a broad range of services and meeting the individual clinical and financial needs of each physician.

To operate a financially strong, high functioning HEALTH SYSTEM that consistently achieves measurable optimal value, for every patient, i.e., outcomes / cost.

The Rate of Growth In Net Revenue Per Unit of Service Has to Decline for Someone (or Everyone)



Moody's:
Not-for-profit hospitals are struggling with the lowest revenue growth rate in decades.

Guiding Strategic Policies - Transforming From Entitlement to Accountability

- **Collaboration between a Hospital System and a Large Group of Employed, Contracted and Affiliated Physicians To Improve Outcomes and Lower Cost:** Create a culture of trust, transparency, and shared values– opportunity to be the preferred 'narrow network' **(prepare for conflict!)**
  - **Clinical Transformation:** The ability to deliver digitized- efficient-predictable-evidence-based-coordinated care throughout the health system (inpatient and outpatient).
  - **Value-based Infrastructure:** Achieve industry best benchmarks in outcomes and efficiency using established work redesign technologies in collaboration with the hospital-based physicains.
  - **Patient Centered Culture:** Rigorous disciplined measurement and transparency.
- **Mutual Benefit Model for Employing Physicians:** Aligned incentives, patient centered focus, win-win deal structure and a positive **FRBL**
- **Payer Strategy:** Increase revenues through volume/steerage, rates, quality bonuses and **savings**
- **Non-organic Growth:** Selectively add new facilities and physicians

"I was really becoming frustrated that we were doing things pretty much the same way as when I was an intern 40 years earlier."

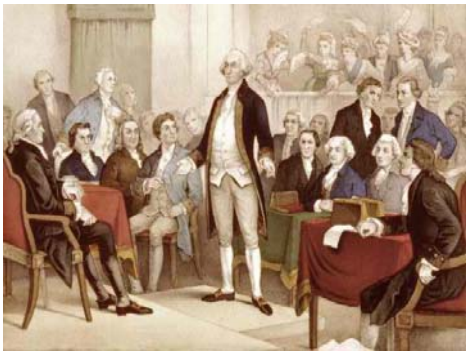
~Dr. Patricia Gabow, MD

Denver Health

- 42 — percent of their patient population is uninsured
- $275 million — cost of uncompensated care in 2007
- $450 million — cost of uncompensated care in 2011:
- 400+ rapid-improvement projects since 2005
- #1 — ranking in patient survival among academic medical centers
- Lean produced $135 million — financial benefit w/o a reduction in workforce
- Positive bottom line every year
- $46 million in financial benefits from Lean projects in 2011

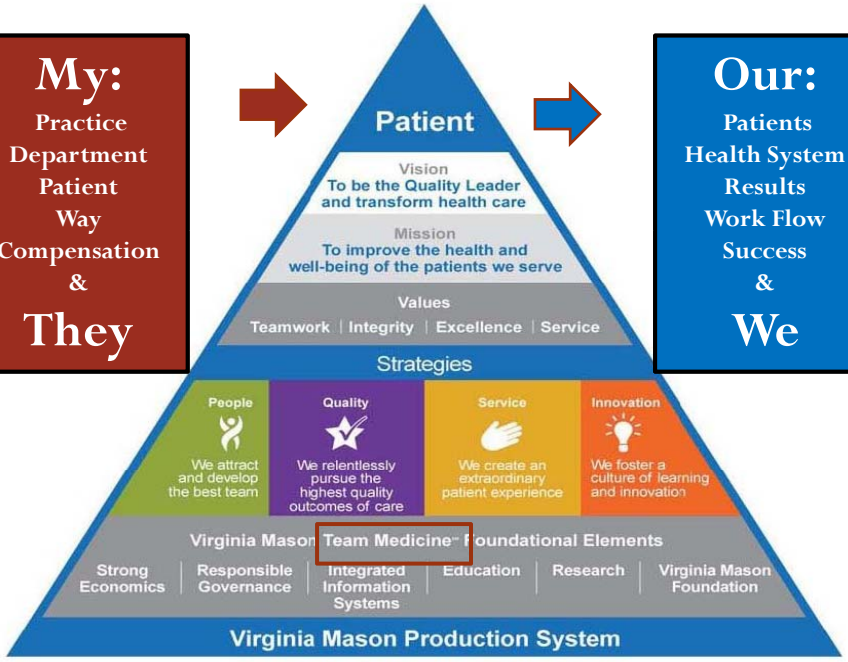
Hospital-Physician Culture: "Fellow Citizens" or UN

"A more perfect union."



"Protect individual rights and self-determination."

My:
Practice
Department
Patient
Way
Compensation
&
They



Our:
Patients
Health System
Results
Work Flow
Success
&
We

2003 *Survey*: 91% of nurses experienced verbal abuse and mistreatment–7% said intimidation played role in a medication error!

~ Institute for Safe Medication Practices

It is as important to be effective as it is to be right!

Guidance for Physician Leaders

- Lead from the front
- Be a role model: clinically, administratively, personally
- Know your team & challenge them to be their best
- Support fellow chiefs with an eye on the overall mission success for the system

Slide borrowed from
Dr. Wayne Gluf, MD USN Ret.
Chief of Neurosurgery, TMF Medical Center

Some Physicians and Hospitals Just Don't Get IT

"Medicare is cumbersome, an unnecessary interface between us and our patients, and most importantly, it doesn't pay us sufficiently to justify the work we do."

(Dr. Marc Siegel, 12/20 Fox News)

Kodak FILM

Everyone has a plan until they get punched in the mouth.

Some Physicians and Hospitals Are Un-Engagable

"I have always been successful doing it this way, why should I change?"

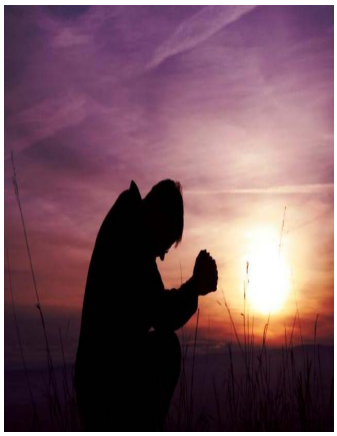
*If you don't like change, you are really going to hate being **rated and reported** as "low-value" and tiered out of networks.*

If you publish data on my performance, I am going to take my patients to your competitor.

I used to be afraid that you would leave – now I'm afraid you will stay. Let me get my keys and drive you.

The person who says something is impossible shouldn't interrupt the people who is doing It!

MUST Reads



"The truth is that our finest moments are most likely to occur when we are feeling uncomfortable, unhappy or unfulfilled. For it is only in such moments that we are likely to step out of our ruts and start searching for different ways or truer answers"… ***~M. Scott Peck***

1975 Kodak

Six Practical Steps to a Soft Landing

- Select a cost target and a systematic approach to cost reduction through redesign and stick to it! (expect resistance)
- Establish a “physician cabinet” of medical directors, MEC and “care-line” leaders to be ‘partners’ in guiding the system (radical transparency)
- Assign accountability for MANAGING and optimizing the performance of hospital-based physician services and medical directors
- Establish a performance culture: routinely measure and report critical performance metrics (focusing on costs and outcomes) and demand action plans when targets are missed
- Have a third party conduct an *objective* performance assessment and develop implementation plans to optimize all critical functions: e.g., revenue cycle, documentation, IT, cost accounting, reporting on quality/outcomes, patient flow, capital allocation, employed physician practices etc.
- Develop a digitally connected network of physicians committed to delivering efficient-predictable-evidence-based-coordinated care – start with system employees

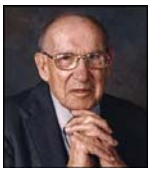
Rate Your System

(1-poor, 2-fair. 3-average, 4-good , 5-excellent)

	1-5
1. The strategic plan is clear and is based on an objective assessment of both the market and existing competencies, clearly defines challenges, is ROI-based and focuses on adding value for patients.	
2. Governance structure provides role clarity avoiding historical provincial allegiances and promotes a unified direction overcoming institutional inertia and resistance.	
3. Critical functions and systems are standardized, coordinated and controlled centrally. People are held accountable for achieving targets. Critical performance metrics are routinely measured and reported, and when necessary, action plans are in developed to rapidly bring performance in line with established targets.	
4. The board, management and medical staff differentiate between valid strategic issues and 'noise' or the latest fad and are able to execute strategies and respond to unforeseen challenges quickly and effectively .	
5. There is an organized approach to engage physician leaders in planning, execution and conflict resolution.	
6. Multi-year projections are based on conservative assumptions of reimbursement, volumes and expense growth.	
7. An expense reduction plan is in place focusing on standardization and elimination of waste using a proven redesign method. There is a process to eliminate unnecessary duplication of services in multiple sites.	
8. Clear accountability is assigned for MANAGING and optimizing the performance of hospital-based physician services and medical directors.	
9. An third party, objective performance assessment has been completed and implementation plan is in place to optimize critical functions: e.g., revenue cycle, clinical documentation, IT, cost accounting, reporting on quality/outcomes, clinical integration, capital allocation and employed physician practices etc.	
10. A process is underway to develop a digitally connected network of physicians committed to delivering efficient-predictable-evidence-based-coordinated care and share in payer savings --starting with system employees.	

In times of crisis, some run TOWARDS the fight – Good Luck!

"no Fear, no Envy , no Meanness." ~Bob Dylan



"The greatest danger in times of turbulence is not the turbulence, it is to meet the turbulence with yesterday's logic."

"You cannot connect the dots looking forward ; you can only connect them looking backwards. So you have to trust that the dots will somehow connect in your future. You have to trust in something –your gut, destiny, life, karma, whatever – love what you do, stay hungry, stay foolish."

~ Steve Jobs, 2005

Mission

Improving healthcare delivery by enhancing the strategic/financial performance of providers.

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