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Relationships That Drive Results

Key Issues Facing Hospitals 2013

Presented by:

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Key Issues Facing Hospitals - 2013

I. Overview and Key Strategy Issues
II. Physician Hospital Alignment
III. Sustainability
IV. ACOs
V. Other Issues

Key Issues Facing Hospitals - 2013

I. Overview - Key Strategy; Discussion and Issues

A. Hospital Centric Issues

a) The go to hospital in the area, What is the key strategy – market dominant, lean, niche dominant?
b) A place payors and networks cannot go around; How can the hospital make itself indispensable?
c) A deeper physician network - Where does the hospital stand in terms of physician alignment? Is it a leader in employment? What is its physician alignment strategy? How much risk does it have regarding top admitters?
d) Possible aspirations – E.g., the best management team locally, the best physician network, the best quality system in the area, the best orthopedic or oncology program
e) Know your big money areas – protect these; what are the key strengths and risks?
f) Exclusion from payor products and networks – ACO's, etc. – how bad is competition? Where does the hospital stand in terms of payors and payor strategy? How concerned as to network hospitals and their payors strategies?
g) Need for scale to normalize costs – retain leadership, build depth; recruit doctors
h) Normalize costs over scale; better purchasing power; ability to amortize talent
i) Great in revenue cycle, billing and collections
j) What kind of investments are needed? Does the hospital have a solid balance sheet and margins? Can it take reasonable risks?

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I. Overview – Key Strategy Issues

B. General

a) Tremendous disruption in health care
b) More employment of physicians nationally

c) Less doctors available per hospital
d) The slow erosion of pure fee for service medicine
e) The need to be critical to a market; build on strength – the "go to" hospital in the area
f) High quality and critical mass
g) The need to have enough capital and income to make reasonable investments and take calculated risks
h) Tepid growth, pressure on inpatient cases, sequester, layoffs, big chains reporting decreased profits, increased taxes, unemployment

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II. Physician Hospital Alignment – 9 Core Thoughts

What is the alignment strategy? Where does it stand in terms of physician alignment? Is it the leader in the area? How vulnerable is it?

1. Consolidation. We are seeing increased consolidation at the hospital, physician and payor level. Hospitals are consolidating with other hospitals and acquiring practices. Payors have already greatly consolidated with other health plans and are now increasingly seeking to own and operate providers. Here payors do so as a hedge against a dominant provider or as an expansion of their business line.
2. Employment Preference. Employment of physicians seems to be the preferred method of engagement for health systems if they can afford it. It tends to work in a fee for service environment and provides the control/alignment they are seeking if and when the world shifts to more of a shared risk/shared losses environment.
3. Other Models. Systems which are not highly focused on employment are examining other models of engagement such as joint ventures, gain sharing, professional services agreements, co-management, call coverage, medical directorships and other approaches.

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II. Physician Hospital Alignment – 9 Core Thoughts

4. Are Financial Relationships an Imperative? Increasingly systems cannot afford to not have financial relationships with their doctors. Close to 80 percent of physicians have a financial relationship with a hospital and hospitals are at significant risk if a material number of their admitters in a fee for service world are "free agents" and don't have a financial relationship with them. The larger the system the more it can remain stable despite the loss of a few key admitters.
5. Loss of Dollars Per Physician. Hospitals reportedly still seem to lose substantial dollars per doctor on the employment/professional side. This seems to have gotten worse as more doctors have become employed and productivity has regressed to the norm.
6. Culture, Cash and Competence. Successful hospital owned group practices have a culture that is physician positive and tolerates a good deal of autonomy and independence but not outrageous behavior, are highly competent in handling all of the non-doctor aspects of operating a practice. They also pay fairly. Doctors must feel not disrespected on compensation and must enjoy working in the group.

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II. Physician Hospital Alignment – 9 Core Thoughts

7. Sustainability. A key question is whether hospitals will be able to maintain the huge investment in employing physicians as the reimbursement world substantially changes.
8. Looming Physician Shortages. "We have a shortage of every king of doctor, except for plastic surgeons and dermatologists, " said Dr. G. Richard Olds, the dean of the new medical school at the University of California, Riverside, founded in part to address the regions' doctor shortage. "We'll have a 5,000 physician shortage in 10 years, no matter what anybody does." (Doctor Shortage Likely to Worsen in Health Law – NY Times July 28, 2012) - 150,000 shortage in fifteen years; - (Wall Street Journal, April 12, 2012) – try recruiting to small communities
9. Leakage. Hospitals increasingly concerned about "leakage" from aligned physicians

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III. Sustainability

Can it be the go to hospital in the area?

Can it position itself such that payors need the hospital?

Can it afford to position itself in such a way?

1. 6 Key Factors to Assess - *The New Community Hospital Imperative – Kurt Salmon Associates
   a. Geography – Barriers or not – remote or competitive area?
   b. Payor Mix -
   c. Physician Alignment – Depth, how tight are relationships, top 25 admitter analysis? Will you need to recruit/employ doctors? Do you need to examine acquiring practices?
   d. Asset Base – How healthy? Are there key areas you need to invest in? Do you need substantial renovation or relocation or make other substantial expenditures?

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III. Sustainability

1. 6 Key Factors to Assess - *The New Community Hospital Imperative – Kurt Salmon Associates
   e. Cost Structure – high cost structure, low cost structure, adjustable or not? How big are your monthly costs? How many days cash on hand do you have? How big are your margins? How strong is your base business? How do costs relate to its cash on hand and its margins? Does the hospital have borrowing capacity?
   f. Quality of Care? Is it a leader or a dog? Would board members take their families to the hospital?

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III. Sustainability

2. 4 examples of hospital bankruptcy - Hospital that have filed for bankruptcy in the last few years have struggled due to many of the circumstances described above. A few recent situations include:

A. Top 25 Admitters. Two key physicians on a hospital's medical staff are employed and go to work for a competing hospital. These two physicians made the difference between success and failure for the hospital to break even. Here, the hospital's failure to better integrate those key physicians contributed to its eventual financial failure.

B. No Clear Focus. The hospital had too much debt and was built too large. This hospital has approximately $80 million dollars in debt and no specific focus for business. In this situation, the hospital took on two much debt and was unable to overcome the debt with its revenue.

C. Billing and IT Problems. Another bankruptcy developed from the implementation of "a custom software concept" and another one developed from the shifting of all billing and collections overseas. In each situation, the hospital lost several months worth of revenues. Here, the hospitals had a cost-structure that could not be sustained with cash on hand or other funds.

D. Quality Problems Kill Loyalty. A hospital early on had several deaths. This led it not to being able to recover between the mix of malpractice cases and costs, the inability to obtain insurance and the reputational harm to the facility.

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IV. ACOs

Does the hospital have sufficient depth and expertise to be out in front in developing payor initiatives?

Can other systems and plans contract around the hospital?

A. ACOs - Thoughts -- Tom Scully, Partner, Welsh, Carson, Anderson & Stowe stated: "The biggest flaw with ACOs is that they are driving more power to hospitals—not to doctors. Very scary, and I am a hospital guy. The goal of ACOs was to organize doctors to focus more on patients and keep the patients out of hospitals. Instead, doctors are selling practices to hospitals in droves. The start-up cost of a real ACO is probably $30 million and up in a midsize market—and doctors don't have that capital. So hospitals are pitching that they will be ACOs, and buying up practices. Ever meet a hospital administrator who wants to work to empty his beds? This means more power in expensive institutions, more consolidation of those giants—and more bricks and mortar and more costs. And with zero antitrust enforcement in the last 30 years in the hospital world, we are cruising for regional hospital-based oligopolies—not good for doctors, patients or our hopes for a more efficient system. And the well-intentioned concept of ACOs is feeding that fire. "— (Wall Street Journal Article Jan. 23, 2012, "Can Accountable Care Organizations Improve Health Care While Reducing Costs?" by Anna Wilde Mathews)

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IV. ACOs

B. ACOs—Jeff Goldsmith, President, Health Futures, Inc. stated: "Managed care is not merely a matter of large populations (5,000 to 20,000 patients probably isn't large enough), but of subpopulations with unique health problems that require different protocols and approaches to improving their care. In the general population, the healthiest half account for a grand total of 3% of health costs. If those are the folks you end up worrying about in an ACO, you're wasting your time. It is the incredibly heterogeneous 5% of the population that generates 47% of all costs that you need to focus on, and if you don't have enough of them in your "attributed" population, you cannot concentrate the resources to change their care and lives." (Wall Street Journal Article Jan. 23, 2012, "Can Accountable Care Organizations Improve Health Care While Reducing Costs?" by Anna Wilde Mathews)

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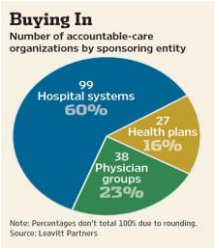
IV. ACOs

C. ACOs—



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V. Other Issues

1. Physician Burn Out and Leadership - Doctor Burnout: Nearly Half of Physicians Report Symptoms, August 21, 2012 (reported by Janice Lloyd, USA Today) "While the medical profession prepares for treating millions of patients who will be newly insured under the health care law, the Mayo Clinic (Rochester, Minn.) reports nearly 1 in 2 (45.8%) of the nation's doctors already suffer a symptom of burnout. "The rates are higher than expected," says lead author and physician Tait Shanafelt. "We expected maybe 1 out of 3. Before health care reform takes hold, it's a concern that those docs are already operating at the margins."

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2. Physician Burn Out and Leadership - The Many Dangers Posed by Burned-Out Doctors (By Chase Scheinbaum in Businessweek, on August 22, 2012) "Doctors' enthusiasm for medicine has been waning since the 1970s; half do not recommend the profession to their children. Male doctors are 1.4 times as likely to commit suicide than non-doctors. In recent years, their malaise has led to the creation of physician wellness programs at Vanderbilt University and the University of California, San Diego, to name two. Short-fused physicians have even spawned a booming niche in the anger-management industry. Burnout worries Shanafelt, an oncologist and professor of medicine, because "burned-out physicians are more likely to make mistakes"—such as the failures of communication or the intimidation that experts say beget medical errors. William Norcross, executive director of a physician wellness program at U.C.S.D. (who had no involvement in the study) concurs. By way of explanation, he adds, "I look at [burnout] as being kind of like a zombie: You lose your feeling, you lose your empathy. You don't care as much."

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3. Physician Burn Out and Leadership - The Many Dangers Posed by Burned-Out Doctors (By Chase Scheinbaum in Businessweek, on August 22, 2012) "Shanafelt predicts that unhappy doctors will cut back their hours or retire early. In turn, that could further stress the overstretched medical system. For example, he says, it may exacerbate the country's existing doctor shortage, predicted to grow to more than 60,000 within three years, according to the Association of American Medical Colleges. With baby boomers seeking medical services and Obamacare insuring many more Americans, now would be a bad time for disillusioned doctors to back out. The study ranked medical specialties by the percentage of doctors who are burned out—or conversely, satisfied with their jobs. Emergency doctors ranked lowest, with a burnout rate of 70 percent, while practitioners in such fields as dermatology and pediatrics were among the most content. Already, Norcross says, prospective doctors have taken notice of older physicians in badly afflicted specialties like general surgery—which the study places last in career satisfaction—and are choosing not to enter them. "Our medical students are seeing general surgeons and primary care physicians burned out, and they don't want any part," he says.

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V. Other Issues

4. Knees – 600,000 knees per year, $9 billion, 250,000 to 300,000 Medicare (see Wall Street Journal article dated Sept. 25, 2012)
5. Population Health – will it work for larger communities? Does the hospital have a population health plan?
6. Health Information Technology – Where is the hospital at in EMR and other IT systems?
   a) Labor Force – can labor force handle it?
   b) Physician productivity decreases.
   c) Costs are very extensive
   d) Is IT strategy a competitive advantage/disadvantage with patients/physicians?
7. Quality alliances (Mayo, Cleveland Clinic, etc.)

Questions or Comments?

For follow-up issues, please feel free to contact:

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