Agenda

• Introduction
• Select Industry Trends and Healthcare Reform
• National Trends Impacting Hospital/Physician Relationships
• Clinical Integration
• Maximizing Our Investment in Physician Integration
• Preparing Your Organization: Where Do You Go from Here?
Select Industry Trends
Creative Destruction

“… a process of industrial mutation that incessantly revolutionizes the economic structure from within, incessantly destroying the old business model and incessantly creating a new business model.”

Joseph Schumpeter
1942

The current financial crisis coupled with the principles of healthcare reform (or emerging era of healthcare) are rapidly eroding the physician-hospital business model as we know it.
Strategic Challenges Facing Hospitals and Health Systems (Right Now)

- Declining inpatient and outpatient volumes (in many markets)
- Deteriorating payor mix
- The rise of “super insurers” with 50%+ market share
- Unsettled physician staff
  - Specialists “in play” in many markets
  - Exodus from freestanding ambulatory operations
- A rising competitive bar with the growth and development of “super regionals”
- Uncertainty regarding healthcare reform
- Financing challenges and increased cost of capital
Healthcare and Reimbursement Reform

**Potential Mechanisms to Drive Down Costs**

- Payment based on “best practice” levels of value (quality/cost)
- Bundled payments
- Quality incentive payments
- Reductions in readmission rates
- Reductions in home health, imaging and other “high margin” service payments
- Accountable care organizations – capitation revisited
Follow the Money – Industrial Organization Is a Function of the Underlying Economic Model: For Hospitals and Health Systems, the Equation Is Driven by the Prevailing Reimbursement Mechanism

<table>
<thead>
<tr>
<th>Prevailing reimbursement mechanism</th>
<th>Industry reaction</th>
<th>Government reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1960s/ 1970s: cost-based/ cost plus</td>
<td>• Building boom</td>
<td>• Control supply – Health systems agencies (HSAs) and certificate of need (CON) programs</td>
</tr>
<tr>
<td>• Mid 1980s – current: IP discharge/ activity-based OP units of service</td>
<td>• Drive more admissions and outpatient procedures, manage length of stay (LOS)</td>
<td>• Modify payment levels</td>
</tr>
<tr>
<td>• Future?: Outcomes-driven/ bundled payments/ accountable care organizations (ACOs)/ capitation-like structures</td>
<td>• Focus on care management capabilities, physician integration, information technology (IT)</td>
<td>• Tie payment to outcomes? • Promote full capitation?</td>
</tr>
</tbody>
</table>
Healthcare Reform: The Ultimate Market Dynamic

Typical community hospital

Low

Level of hospital/physician integration and care management capability

The Feds want you here

High

• Geisinger Health System
• Mayo Clinic
• Billings Clinic

What Does the Future Look Like?

• Continuous care and disease management as a core competency
  – Redesign – and execution – of the care delivery process
• Balanced regional service delivery systems, directing patients to the lowest cost setting practical with consideration to quality of care and patient safety
  – Significant real pressures will continue to drive “one-business unit” integration of physician, outpatient, inpatient services
• Integrated hospital and physician businesses – consolidated or virtually consolidated
• Sophisticated information technology (EMR/quality technology/data transfer)
• Efficient use of capital
Lessons from the Trenches
Why Are We Here?

• The current system doesn’t work for most health systems or for physicians

• The financial impact of physician integration represents a large and growing component of hospital budgets
  – Rating agencies are focused on physician-hospital alignment

• Employing and integrating physicians is scary
  – Many have tried, most have failed, and many are trying again

• Most organizations recognize that physician strategy is the most direct route to achieving one or all of the following:
  – More volume, higher quality, lower costs, better culture, and increased sustainability
Word From the Street

• “It’s raining cardiologists”

• “Our employed medical staff will grow from 250 to 450 in the next 18 months”

• “I will not subsidize primary care”

• “My physicians want to be bought out of their ASC or Imaging Center”

• “10 orthopedic surgeons just became employed by our competitor, but claim they aren’t going to shift volume”

• “Medical group development and integration is not an event – it is a journey”
Lesson #1: Physician Employment Is Here to Stay

A recent survey conducted by the Health Management Academy revealed that the majority of hospital executives expect the recent increase in physician employment to become the **new dominant standard** for physician-hospital alignment.

Lesson #2: Today’s Physicians Are Different

Consider Lifestyle Factors
(e.g., regular/ predictable hours and income, limited (if any) call coverage, work/ life balance)

Lower productivity
than in years past

More than 50% female

Super-Specialized
(for example Hand or Spine vs. Orthopedics)

Hitting the ROAD
(Radiology, Ophthalmology, Anesthesiology, and Dermatology)

Today’s physicians
+ Competitive pressures

Trend: development of multi-specialty groups
• Hospital owned/ formed
• Employed physicians
• Support lifestyle considerations
Lesson #3: Primary Care Is King…and a Fight between Specialists and Primary Care Is Looming…

Due to rapidly changing market forces, having a formal Primary Care strategy is again of critical importance:

- A focus on wellness and preventative care, especially in “baby-boomer” populations who value a Primary Care Physician relationship
- Tighter control of referrals and patient care driven by pay-for-performance
- The proliferation of the hospitalist model, which distances hospitals from communication with their Primary Care Physician referral base
- The growing number of large Primary Care groups with “clout” control the large number of specialist referrals and hospital admissions

Who will manage bundled payment?
Other Important Lessons

• #4: The physician shortage is real, particularly impacting primary care and rural healthcare.

• #5: Physicians employment doesn’t have to be a money loser.

• #6: Pay attention to recruiting. It’s an art, not a science. And it’s not just about money.

• #7: Focus on leadership. Invest in physician leaders, and invest in the person/people running your physician enterprise.

• #8: Transparency and engagement with physicians will make or break the success of your physician integration efforts – be sure that you have both!
Physician Integration
What Is Physician Integration?

- Physician integration is defined as having a collaborative relationship between the hospital and the medical staff supported along multiple dimensions:
  - Organizational structure and governance
  - Citizenship and leadership from broader medical staff
  - Medical staff support infrastructure
  - Financial incentives

- Physician *employment* does not beget physician *integration*; *integration* does not necessarily require *employment* (though it can be difficult to achieve without)

- Through proper integration, physicians and the hospital work together toward common goals and objectives
  - The biggest challenge will be integrating independent physicians under future reimbursement conditions
The Path to Physician Integration Will Require a Pluralistic Physician Model…at Least in the Interim

- Maintaining this hybrid strategy gives hospitals/health systems time to build capital and adequate practice management capabilities

<table>
<thead>
<tr>
<th>Independent Physicians</th>
<th>Clinically Integrated Physicians</th>
<th>Employed Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Independent physicians will likely continue to practice through a transition period</td>
<td>• Hospital systems will seek to partner with independent physicians to drive quality and effectiveness through a series of partnerships, particularly clinician-focused co-management and “Clinical Integration” strategies</td>
<td>• Multispecialty groups organized around driving highest quality healthcare</td>
</tr>
</tbody>
</table>
Pluralistic Physician Model Partnership Framework

Employment

PSA
Salary Guarantee
Productivity Based

Clinically Integration

Clinical Integration Platform
Clinical Co-Management

Independent

Volunteer Medical Staff
IT Connections
Affiliate Arrangements*

Multispecialty Group Formation

*Affiliate arrangements can include, but are not limited to: directorships, advisory committees, recruitment support etc.

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Developing a Sustainable Strategy
Two Questions to Address

What do physicians want?

&

What is our value proposition for physicians?
What Do Doctors Want?

- Meaningful work
  - Innovation, performance, flexibility, quality, ease of practice,
- Clear connection to those they work with
  - Return to medical training roots…true collaboration among providers driving organizational intelligence and performance
- Opportunity for input and governance
  - Physicians must feel like they have an effective voice
- Clear positive and negative feedback in a way they can understand
  - The development of a learning culture
Sustainable Strategy Case Examples
Case Study #1 – Clinical Integration and Advocate Health Care

Clinical Integration Definition:

A structured collaboration among hospitals, physicians and other providers designed to improve the quality and efficiency of health care. Joint contracting with fee-for-service managed care organizations is a necessary component of this program in order to accelerate these improvements in healthcare delivery.
Advocate’s Physician Platform

Total Physicians on Medical Staffs = 5,000

Total APP Physicians = 3,200

- Employed/ Affiliated: 800
- Independent APP: 2,400
- Independent Non-APP: 1,800

Advocate Medical Group: 650
Dreyer Group: 150
Advocate Physician Partners Incentive Fund Design

CI Incentive Funds Distribution

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Funds Distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$12.4 Million</td>
</tr>
<tr>
<td>2006</td>
<td>$16.7 Million</td>
</tr>
<tr>
<td>2007</td>
<td>$25.0 Million</td>
</tr>
<tr>
<td>2008</td>
<td>$28.2 Million</td>
</tr>
</tbody>
</table>

Source: Advocate Physician Partners

*Residual Funds are rolled over into general CI fund (not tied to individual physician or originating PHO) to be distributed in the following year
Case Study #2 – Clinic Model Development in the Northeast

• Transform the healthcare delivery to a fully integrated, sustainable system that provides optimal care to our community
  – “Hospital and the Medical Staff are not positioned for the future. We are not organized to respond to reform or new models of care.”

• Guiding principles
  – **SHARED**: vision, knowledge, governance, efficiency, financial benefit

• Key strategies for Clinical Transformation
  – Patient and our community at the center of all that we do
  – Primary care at the core of the health care delivery system
  – Physician leadership/ involvement at all levels of the organization
    ✓ Leadership partnerships with a physician and a nurse or administrator

• Culture of trust, shared values and vision driven through the development of a Compact
Case Study #3 – Carolinas HealthCare System

Carolinas HealthCare System

- 25-hospital regional system based in Charlotte, North Carolina
- Carolinas Physician Network consists of 630 physicians and 160 mid-level providers in 11 counties
  - Primary care physicians and specialists
- Carolinas Physician Network is growing rapidly and acquiring new practices every month
Leading Practice – Carolinas Physician Network (CPN)

As part of an integrated planning process, CPN has taken a more comprehensive approach to budgeting and financial projections:

- Office visits, at the provider level
- Automation of physician compensation calculations
- Integration with broader organization for consistency

### Carolinas Physician Network

<table>
<thead>
<tr>
<th>Budget Summary by Region – FY09 Budget</th>
<th>Region 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY07</td>
</tr>
<tr>
<td><strong>Physician productivity</strong></td>
<td></td>
</tr>
<tr>
<td>Physician FTEs</td>
<td>46.88</td>
</tr>
<tr>
<td>Mid-level provider FTEs</td>
<td>4.32</td>
</tr>
<tr>
<td>Total provider FTEs</td>
<td>51.20</td>
</tr>
<tr>
<td>Office visits (inpatient and outpatient)</td>
<td>204,214</td>
</tr>
<tr>
<td>% growth</td>
<td>8%</td>
</tr>
<tr>
<td>Office visits per provider</td>
<td>3,988</td>
</tr>
<tr>
<td><strong>Office visits per day per provider</strong></td>
<td>20</td>
</tr>
<tr>
<td><strong>Staff efficiency</strong></td>
<td></td>
</tr>
<tr>
<td>Staff FTEs (exclude MLPs)</td>
<td>182.70</td>
</tr>
<tr>
<td>Ratio of staff FTEs to provider FTEs</td>
<td>3.57</td>
</tr>
<tr>
<td>Office visits per staff FTE</td>
<td>1,117.75</td>
</tr>
<tr>
<td>Average hourly wage</td>
<td>14.36</td>
</tr>
<tr>
<td>AHW % increase</td>
<td>3.95%</td>
</tr>
<tr>
<td><strong>Revenue analysis</strong></td>
<td></td>
</tr>
<tr>
<td>Net patient revenue per visit</td>
<td>148.33</td>
</tr>
<tr>
<td>Per visit % increase</td>
<td>3%</td>
</tr>
<tr>
<td>Net revenue per provider</td>
<td>630,718</td>
</tr>
<tr>
<td><strong>Expense analysis</strong></td>
<td></td>
</tr>
<tr>
<td>CBITDAR per visit</td>
<td>77.15</td>
</tr>
<tr>
<td>Rent and depreciation per visit</td>
<td>17.24</td>
</tr>
<tr>
<td>Total salary (exc phys and MLP) per visit</td>
<td>30.92</td>
</tr>
<tr>
<td>Non-provider expense per provider</td>
<td>352,215</td>
</tr>
<tr>
<td>% increase</td>
<td>6%</td>
</tr>
<tr>
<td>Rent expense/ provider</td>
<td>62,916</td>
</tr>
<tr>
<td>Operating expense per visit</td>
<td>96.22</td>
</tr>
</tbody>
</table>
CPN – Real-Time Monitoring and Adjustment

• Given the expenses associated with “ramp-ups,” the impact must be accounted for in the current year budget cycle
  – CPN developed reports enabling leaders to identify potential problems and the key variances driving performance against budget at an early date

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Carolinias Physicians Network
MTD Report Card by Business Segment – April 2009

<table>
<thead>
<tr>
<th>Volume</th>
<th>Net revenue</th>
<th>Staff expense</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total visits</td>
<td>Total visit var</td>
<td>Visits per prov per day</td>
<td>NR var</td>
</tr>
<tr>
<td>var</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Segment A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice 1</td>
<td>40</td>
<td>3.70%</td>
<td>19</td>
</tr>
<tr>
<td>Practice 2</td>
<td>92</td>
<td>9.34%</td>
<td>36</td>
</tr>
<tr>
<td>Practice 3</td>
<td>(82)</td>
<td>-8.66%</td>
<td>20</td>
</tr>
<tr>
<td>Practice 4</td>
<td>(13)</td>
<td>-1.24%</td>
<td>17</td>
</tr>
<tr>
<td>Practice 5</td>
<td>242</td>
<td>34.90%</td>
<td>62</td>
</tr>
<tr>
<td>Total Business Segment A</td>
<td>(757)</td>
<td>-6.09%</td>
<td>23</td>
</tr>
</tbody>
</table>
Keys to Maximizing the Financial Investment in Hospital-Physician Integration

• Integration closely tied to organizational strategy
• Experienced practice management
  – Compensation and physician productivity
  – Effective contracting
  – Practice efficiency
• Robust data collection and management
  – At a physician, practice, and group level
  – Strong downstream tracking methodology
  – Cost avoidance impact
  – Real-time management
Preparing Your Organization: Where Do You Go from Here?
If We Take the Time, What Will We Get?

- Better quality
- Better customer satisfaction
- Better financial performance
- Better market position

What is the value proposition for physicians?
Key Traits of Successful Clinically Integrated Organizations

• Physician participation in leadership and governance
• Conversion from “hospital-ness” to “system-ness”
• Care coordinated across inpatient and outpatient functions
• Robust availability of information (enterprise intelligence)
• Strategic flexibility and streamlined governance
• Aligned incentives
• It’s all about CULTURE (which eats strategy, as we all know)
We’re in This Together

Questions / Discussion