HEALTHLEADERS MEDIA

Impact Analysis

DECEMBER 2012

Delving Into Cost Drivers

HEALTHLEADERS MEDIA C-SUITE EXCHANGE

CASE STUDY 1 OF 5

A FIVE-PART SERIES drawn from the 2012 HealthLeaders Media Exchanges. Nine CFOs gathered for a roundtable-style discussion on establishing true costs and driving them down.

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Synopsis BY KAREN MINICH-POURSHADI

CFOs Wrestle With 'True Cost' to Arrive at a Sustainable Cost Structure

IN SEPTEMBER 2012, HealthLeaders Media held its second annual CFO Exchange, bringing together 30 finance leaders from hospitals and health systems nationwide. The gathering at The Sanctuary in Kiawah Island, S.C., served as a rare opportunity for financial leaders to discuss with peers how their organizations are tackling some of the most demanding healthcare mandates in history while maintaining a grip on the purse strings.

Topping the agenda were discussions of how:

- To identify true costs and lower them as much as possible
- The financial shift from fee-for-service to population health management influences strategy
- To capture financial data and use it to impact business analytics and processes
- To optimize the revenue cycle
- Accountable care organizations are effecting clinical and business integration

In this first Impact Analysis from the 2012 CFO Exchange, nine CFOs take a deeper look at how they are assigning costs and driving them out at their respective organizations. The need to reduce costs—not just once, but permanently and sustainably—was top of mind for these leaders, and many felt the weight of a deck seemingly stacked against them. Our CFOs are grappling with declining Medicare reimbursements, value-based purchasing penalties, and a shift in inpatient volumes, while continuing to fund huge technology initiatives and expansion through physician acquisition or employment.

Healthcare reform is influencing everything from the hospital cost accounting systems to decision support and how physicians are compensated. CFOs are mindful that, while uncovering their true costs may be the only path to the deep budgetary cuts needed for their organizations' long-term survival, it is a complex and elusive undertaking.

Though consumer-directed healthcare is driving patients to become more participatory and decisive healthcare consumers, healthcare organizations are not much closer to knowing their actual cost of care. Healthcare boards of directors and executive leaders need a more accurate picture of how much everything costs, and they're calling on financial leaders to explain how costs are assigned for everything from pens to procedures. Despite expert backgrounds and years of wrangling with costs, our CFO panelists felt they hadn't completely mastered this renewed pursuit of cost assignment and reduction. They wonder how it will be influenced by bundled payments and population health—multifaceted initiatives that will not be under their control.

Until these new models of healthcare begin to bear financial fruit, many CFOs are taking a fresh look at expenses across the organization and are adapting old approaches to reducing costs. They are scrutinizing administrative centralization, repurposing real estate to optimize beds, growing market share through physician employment or acquisitions, developing alliances to bring about greater economies of scale, and paying close attention to physician preference and utilization as well as labor opportunities.

Will these efforts be enough? Many healthcare organizations have far to go in reducing their cost structures, according to the October 2012 HealthLeaders Media Intelligence Report on cost containment. While 20% of healthcare leaders responding to the survey said their organizations needed to reduce operating costs by only 1%–3% (beyond previous reduction efforts), 29% said that 4%–5% more costs had to come out, 26% said 6%–10%, 14% said 11%–20%, and 9% said they needed to cut more than 20% of operating costs! Read on for insights from leading CFOs on how to make it happen. IA

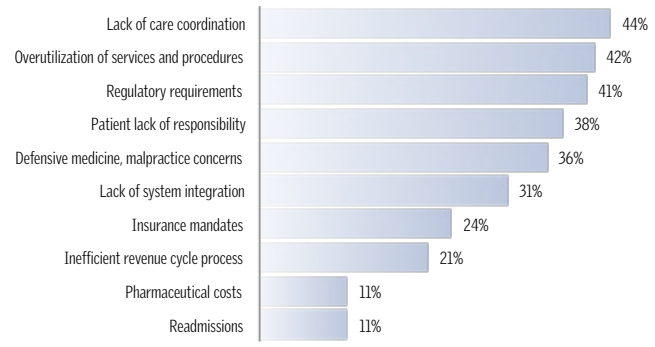
> *"Honestly, you can't get to any [true cost]—there is no end zone. You just keep sorting the data and going through your biggest problems. And the interesting part is, as you're fixing one, there's a problem going on that you may not realize yet."*
>
> Robert S. Shapiro
> Senior vice president and CFO
> North Shore–LIJ Health System
> Great Neck, N.Y.

Intelligence Unit Data

From the HealthLeaders Media Intelligence Reports

FIGURE 1 | Most Significant Drivers of Waste

Q | What are the top three most significant drivers of waste for your healthcare organization?

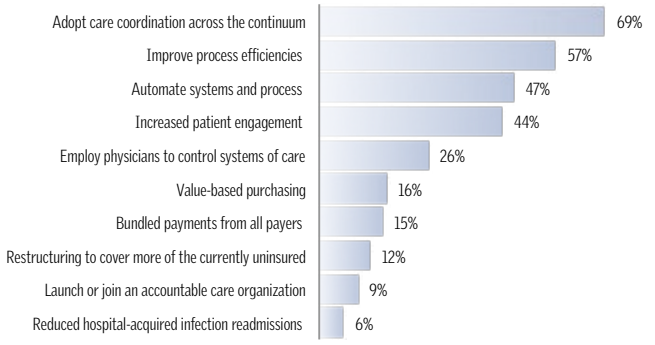


Base = 309, Multi-Response

Source: Collaborating to Improve Care and Cut Costs, HealthLeaders Media Intelligence Report, June 2012

FIGURE 2 | Interventions Most Likely to Reduce Cost of Healthcare

Q | What are the top three interventions most likely to significantly reduce the cost structure of healthcare for your organization?



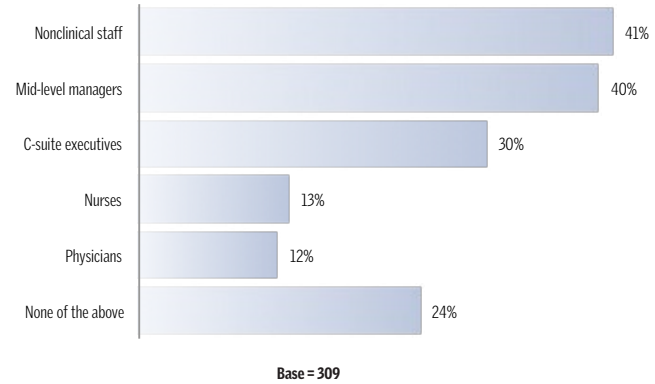
Base = 309, Multi-Response

Source: Collaborating to Improve Care and Cut Costs, HealthLeaders Media Intelligence Report, June 2012

Intelligence Unit Data

FIGURE 3 | Cuts in Salaries or Staffing

Q | Labor costs are among the top cost drivers in running a healthcare organization. Where can you find cuts that will yield worthwhile savings in terms of salaries or staffing?

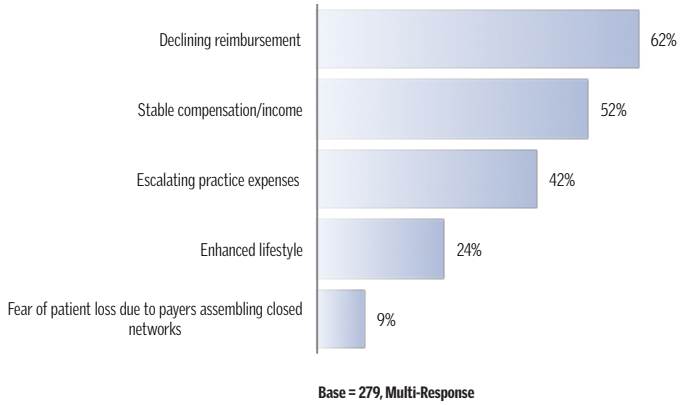


Source: Collaborating to Improve Care and Cut Costs, HealthLeaders Media Intelligence Report, June 2012

Intelligence Unit Data

FIGURE 4 | Clinical Area Expected to Have Highest Dollar-Value Cost Reduction This Fiscal Year

Q | Please identify the clinical area in which you expect the highest dollar-value cost reduction in this fiscal year.



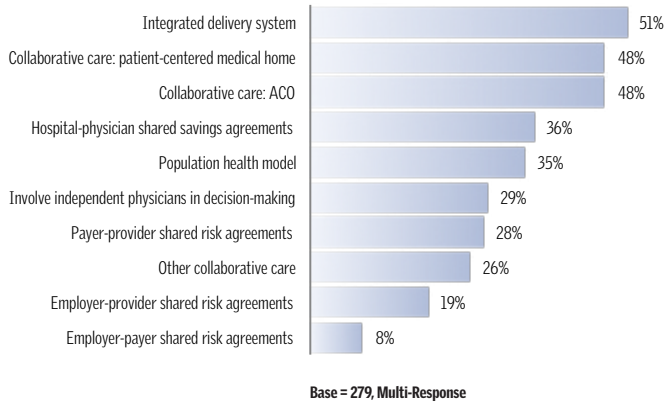
Source: Cost Containment: Targeting Cuts, Enhancing Efficiency, and Using IT, HealthLeaders Media Intelligence Report, October 2012

Intelligence Unit Data

FIGURE 5 | IT Investments That Deliver Most Cost Reduction

Q | Which of the following re delivering or will deliver the most cost reduction (or financial benefit) for you?

Among those investing in IT systems by integrating clinical and financial data



Base = 279, Multi-Response

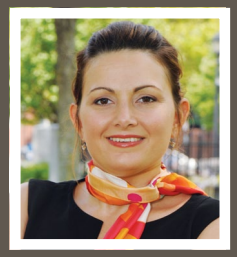
Source: Cost Containment: Targeting Cuts, Enhancing Efficiency, and Using IT, HealthLeaders Media Intelligence Report, October 2012

HEALTHLEADERS MEDIA

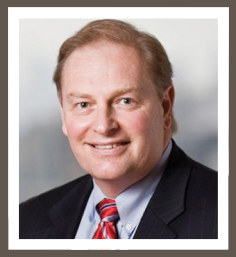
Impact Analysis ROUNDTABLE

THE PANELISTS

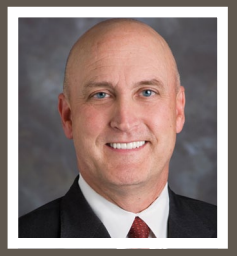
HEALTHLEADERS MEDIA
CFO EXCHANGE



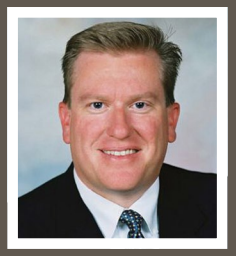
Karen Minich-Pourshadi (moderator)
Senior Finance Editor
HealthLeaders Media



Michael Burke
Senior Vice President, Vice Dean, and CFO, NYU Langone Medical Center, New York, N.Y.

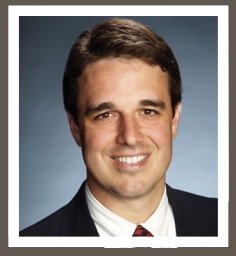


Benjamin R. Carter, CPA, FHFMA
Senior Vice President and CFO
Trinity Health, Novi, Mich.

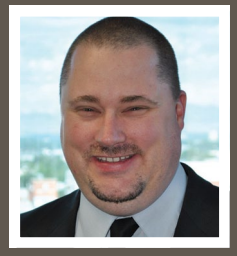


Aaron Coley
Vice President of Decision Support
MemorialCare Health System
Long Beach, Calif.

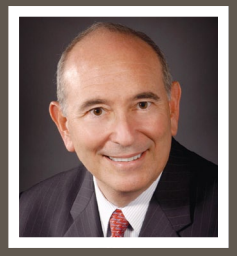
Rick Hinds
Executive Vice President and CFO
UC Health
Cincinnati, Ohio



Jeffrey Limbocker, FHFMA, MBA
CFO
Our Lady of the Lake Hospital
Baton Rouge, La.



Michael O'Malley
Associate CFO
Denver Health and Hospital Authority
Denver, Co.



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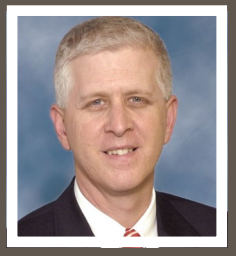
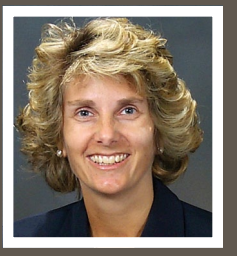
Great Neck, N.Y.



Roland Thacker
Senior Vice President, Treasurer, and CFO
Columbus Regional Healthcare System , Columbus, Ga.



Elizabeth Ward
CFO
University Hospitals-UT Southwestern
Dallas, Texas

ROUNDTABLE: Delving Into 'True Costs' and Driving Them Down

THE NEED TO REDUCE COSTS—not just once, but permanently and sustainably—is top of mind for healthcare CFOs, and many feel the weight of a deck seemingly stacked against them. Financial leaders are grappling with declining Medicare reimbursements, value-based purchasing penalties, and a shift in inpatient volumes, while continuing to fund huge technology initiatives and expansion through physician acquisition or employment. Healthcare reform is influencing everything from the hospital cost accounting systems to decision support and how physicians are compensated. CFOs are mindful that, while uncovering their true costs may be the only path to the deep budgetary cuts needed for their organizations' long-term survival, it is a complex and elusive undertaking. At HealthLeaders Media's second annual CFO Exchange, held last fall in Kiawah Island, S.C., attendees talked about how they are assigning costs and driving them out at their organizations.

» VIDEOREWIND

Robert Shapiro, senior vice president and CFO at North Shore–LIJ Health System in Great Neck, N.Y., comments on how an organization can reach "true cost."

BY KAREN MINICH-POURSHADI

HEALTHLEADERS MEDIA: *How does your organization assign cost, and how close are you to a "true" cost?*

ROBERT SHAPIRO: Like many of you, we have decision support systems which we treat as the beginning for this process. Decision support just allows us to drill down to a level of detail so we can figure out [cost] by patient or many other functional areas. But the best part of the conversation doesn't necessarily come from analyzing the data; it comes from going down to the departments where they're experiencing the daily activities so we can get a better handle on what's driving the costs. That's something you can't see just based on analysis.

[When it comes to true cost,] honestly, you can't get to any—there is no end zone. You just keep sorting the data and going through your biggest problems. And the interesting part is, as you're fixing one, there's a problem going on that you may not realize yet.

»VIDEOREWIND

Elizabeth Ward, CFO at University Hospitals–UT Southwestern in Dallas, discusses the role of databases in improving understanding of costs across an organization.

ELIZABETH WARD: What I've found at [my] organization is, we've spent about two years in the decision support build to help identify costs. We've got a one-to-one relationship between supply items and chargeables so that they can flow that through [the system] and quickly get a cost. What isn't done as well is getting a good handle on labor costs. That's something that we've got to drill down on in terms of what labor is really variable. How can you identify cost when you have one less patient a day? It's too fluid sometimes to get that direct cost. However, one area that this organization has done really well is bundled pricing; we're doing a lot of specialty pricing. We have specialized teams, for example, in our heart transplant area. They're using that peer pressure: The physicians are looking at each other and comparing their costs to each other to see who uses the most blood, who uses the most OR time. And they are working with each other to improve.

MICHAEL BURKE: Our cost accounting system was provided through Eclipse, which allows us to use metrics to define our true direct costs, as well as to allocate overhead for episodic care. For this reason, last year we focused on the true costs incurred by physicians when they ordered a physician preference item, such as an implantable device. We then focused on physician preference items for treatment, such as a knee replacement, a hip replacement, or stenting, and then compared the costs incurred by the physicians ordering the physician preference items to those that were not. With that information in hand, we then worked with the chairman of the department to discuss alternative solutions to bring down the prices of each physician preference item.

> *"There's another twist to this, too: Where do we need a doctor versus where do we need a mid-level? And what's the expectation of the public in terms of seeing a physician versus seeing a mid-level provider? How do they practice to the level of competency and ability, but manage the expectations of the public that always wants to see the highest level versus the level that is actually needed? That's a question we've got to grapple with if we're really going to address the labor issues."*
>
> Elizabeth Ward

Doing so has allowed us to effectively drive out costs and to reward the physicians because the savings are shared with the department, which can be used to fund initiatives that otherwise

may have not been possible. In fact, in 2011, the hospital saved nearly $2 million on hip and knee implants after presenting physicians with market data that showed there was an opportunity to reduce costs by up to 10%. It also reduced the costs of spine products by $3.6 million this year.

We also looked at overhead costs for certain things like beds or commodity products, and we've started to use what we call "reverse auctions." To begin a reverse auction, you invite vendors to offer opening bids on an item for a one-time period. Afterwards, you give them more information and then you decide to bid or not, which leads them to keep bidding down. We started an auction, for example, on 42 types of beds we wanted to purchase and received initial bids of about $1.7 million, but by the end of the auction the price was about $1 million. We saved $700,000 as a result.

» VIDEO REWIND

Rick Hinds, executive vice president and CFO at UC Health in Cincinnati, explains his organization's process of cost allocation.

AARON COLEY: We've used that process with commodities. We've not touched clinical devices, but we've done bulk paper, computers, and clinical equipment, but not implantable devices. We use VHA, technically a GPO, but I would say 70% of our supply chain is self-distributed, self-inventoried, and we've worked with other health systems that aren't competitors but similarly minded not-for-profits to do bulk purchases and reverse auctions. We use VHA's infrastructure and their license because we're not a licensed GPO, so they're the infrastructure to keep us legally compliant with all of the regulations. Our next journey is to purchase services. We haven't done environmental services or those types of things, but we're hopeful to extend it out of the commodities.

Also, MemorialCare has taken the cost accounting data, and we're sharing with the physicians the data on a severity-adjusted basis

> *"Our biggest success has been on the labor side, driving out variability and managing it daily versus biweekly or monthly. We've taken benchmark data and pushed it down [to the clinical staff] over the past three or four years, and now we're seeing some significant savings. It's tough—we have mandated nurse ratios and it limits some of the creativity. Fifty percent of our cost is labor, and benchmarking is key to reducing it."*
>
> Aaron Coley

so they can see how they're performing with their costs compared to their peers. So rather than just show utilization at a charge level, we've taken it to the next level and floated physicians [information on] our direct variable cost and what it takes to provide that service on a severity-adjusted basis. So the physician's argument that "my patients are sicker" or "my outcomes are better" is all linked together.

RICK HINDS: We use EPSi to do our cost allocations, and as all of us in the industry know it's a pretty laborious process. There is a process of allocating cost based on whatever we feel the drivers are for those costs. We update those drivers two to four times a year, depending on the type of cost that we're talking about and the revenues. We also do product line reporting based on that, and we calculate contribution margins and fully allocated costs. I think we're at about 80% of our true cost.

» VIDEO REWIND

Jeffrey Limbocker, CFO at Our Lady of the Lake Hospital in Baton Rouge, La., explains the challenge organizations face when deciding which software to invest in to help with cost allocation.

BENJAMIN CARTER: We have our own homegrown cost accounting system. In my opinion, direct costing is improving. In this industry, historically, it was very common to use cost and charge ratios to estimate cost. We found this to be inadequate, so we have worked at directly linking the costs of supplies, implants, and other direct variable costs to the services we provide. When you start moving into indirect costs and allocations, it is a little bit more art than science—for us, anyway. We have 49 hospitals and we're trying to get them all to assign cost the same way. It's very challenging because each hospital has its own nuances, so trying to get common standards and approaches on the indirect side can be tough. But I think we do pretty good on the direct-cost side.

ROLAND THACKER: The term "directional" is a very good term which we use all the time to describe this [effort]. When we pushed our data out to our physicians about five or six years ago, we had to be very careful because they'd pick it apart and find all the errors, especially when you're driving down to the doctor level within a service line. We are careful to say, "This cost data is directional, and our goals here are to have incremental improvements over the current numbers." We use ratios for doctors against their peers, and then we say, "We want you to just get better." This doesn't mean that's the exact number they have to hit, but we want it to move in the right direction.

JEFFREY LIMBOCKER: We're a long-standing TSI cost accounting shop, and so we're on Eclipsys. Some of the hospitals in our health system use Trendstar and the others don't do cost accounting. So we're really struggling with the investment to upgrade EPSi because of it being directional versus not perfect and actual or "true." I've always been a supporter of [cost accounting], but the investment required to get from a 70%–80% directional

[cost estimate] to 90%–95% actual cost is a tough decision, especially in light of all the competing priorities currently for investment dollars.

CARTER: And costs change over time, so the cost accounting system is only as good as the assumptions that go into it. Cost accounting systems have to be maintained constantly, and there is still an art to it, although some executives think these costs are absolute numbers.

LIMBOCKER: I'm having that conversation with my CEO now. I'm not sure we make hard decisions based on cost accounting data often enough to justify the investment. It is directional, though, and it helps us decide where we spend our time. But I can only tell you what the average price of an item is. We're trying to track our supply costs [exactly] by item and not averages, but that often requires a dramatic expansion of our chargemaster.

HINDS: Yes, that's where you realize it's going to cost you millions of dollars to improve your cost accounting, and possibly only get incremental improvement in accuracy.

MICHAEL O'MALLEY: It's similar at Denver Health. We just implemented a cap pricing model for implants in the operating room, particularly in orthopedics, and that's generated some significant savings. We were curious to see how the vendors would react, but ultimately it was extremely successful and in the end generated substantial savings, and all the physicians are on board.

SHAPIRO: The operating margins in New York state have always been a challenge. Some of you are familiar with 1%–2% margins. We've had to go through the consolidation process years ago. We found it would be our best opportunity to pull all of the administrative staff into one back office. And we experienced anywhere between 10% to 20% [labor] reductions. It's redundant management, an overlap in middle management and many times

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>
> Benjamin Carter

»VIDEOREWIND

Roland Thacker, senior vice president, treasurer, and CFO at Columbus Regional Healthcare System in Columbus, Ga., discusses decision-making when considering back office consolidation.

senior management, and that's where most of the savings come from. Now, though, we're now going through the second phase of that project, what I call the ultimate fixed cost reduction. In New York, as we see a tremendous movement to ambulatory, certainly the RACs and MACs are pushing us down that path because it's an unforgiving process as to how they want to pay us. So for us it's time to take a look at the big structures and figure out, "Is that the right model?" We're a regional health system, not a national health system, so do we need all of the bricks and mortar in place now?

HEALTHLEADERS MEDIA: *Where are you focusing your efforts for cost reductions; where do you see opportunities?*

CARTER: Practice standardization is a main area for Trinity Health. We are a large enough system for centralized shared service organizations that leverage skills and scale as much as possible. Continued growth of these organizations will help us make sure all the high-touch work with our patients stays on the front line, while all the high-transaction items are examined by a single team focused on bringing transactional costs down.

HINDS: We continue to squeeze everything you can out of today's cost structure, but then we've got to really step back and redesign the way we deliver healthcare to take out large amounts of costs.

THACKER: We do utilize decision support for service line analysis that has standard costing methodology, and at this point we're focused on direct costs and contribution margins by service line.

WARD: In a former system I worked at, we took out all the back-end cost and we got between 10% and 20% [cost reduction]. It was a merger situation and we exceeded the [cost reduction] expectations by about $10 or $15 million. And we condensed where services were provided, so all the cardiac went to one hospital and all the babies went to one hospital—this was within a three- to five-mile radius, so it was easier to do. But the other thing that we did that I want to ask others if you've thought about doing is, we looked at consolidating lab services. We did that among three health systems. Now, that lab has been sold to a venture capital firm and has actually become a regional lab operation. That change cut our cost on labs from an average of $12 a test to between $7 and $8 a test.

In my present organization, our goal is to build a data warehouse that is "one source of truth," where our chairs and executive team can actually drill down and understand the cost and address those costs. And we still want significant growth, so we're looking at this as the clinical enterprise that has to make money to support the academic and research organization within our medical center. So we know we've got to right the costs because we've got to produce

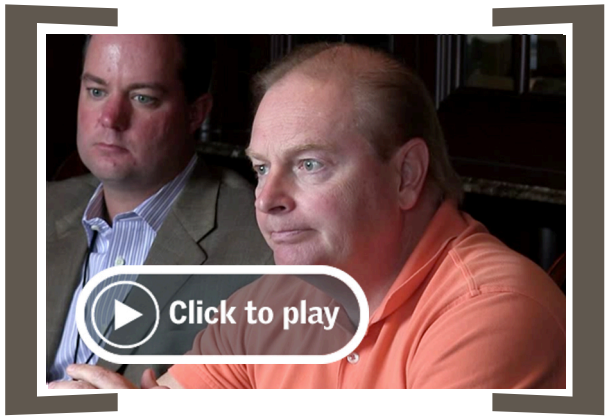
» **VIDEO**REWIND

Benjamin Carter, senior vice president and CFO at Trinity Health in Novi, Mich., discusses where the waste is in healthcare and what financial leaders can do to drive it out.

enough bottom line to support education and research that's getting reduced support from the federal and state governments.

SHAPIRO: I believe that site of service is our single largest opportunity with fixed costs. Put aside closing the building, it reduces cost but it doesn't help us with our margin, our P&L for a sustainable future, unless the payment model changes. I think the biggest waste of money is spent through insurance companies. They add no value to the "product" that we make, figuratively speaking. We make people well—not insurance companies. With insurance companies becoming more administrative services only–based and not necessarily taking risk, things have changed. I used to give them credit for balance sheets but I'm taking that away from them because I heard that 80% of insurance companies' business is now self-insured ASO business. Hospitals can certainly become more efficient and we're getting there, but insurance companies are the biggest waste of time and money. Those are the dollars that need to enter into healthcare delivery processes and not the administrative process that insurance companies represent.

O'MALLEY: We're in the middle of an extensive workforce management initiative to look at all aspects of labor costs. We brought in a consultant to help us understand more about our



»VIDEOREWIND

Michael Burke, senior vice president, vice dean, and corporate CFO at NYU Langone Medical Center in New York City, explains his organization's innovative approach to decreasing physician preference.

> *"Also for us historically, flexing down to volume is our biggest challenge. Another challenge is sitter utilization, ensuring we have a good protocol to determine the need and following that protocol."*
>
> Michael O'Malley

hours per patient day, but even further than that, just simply are we following our own internal policies in terms of PTO [paid time off], no lunch breaks, clocking in at an assigned location? If we knock those costs out, it's amazing the amount of money it translates to. Also for us historically, flexing down to volume is our biggest challenge. Another challenge is sitter utilization, ensuring we have a good protocol to determine the need and following that protocol.

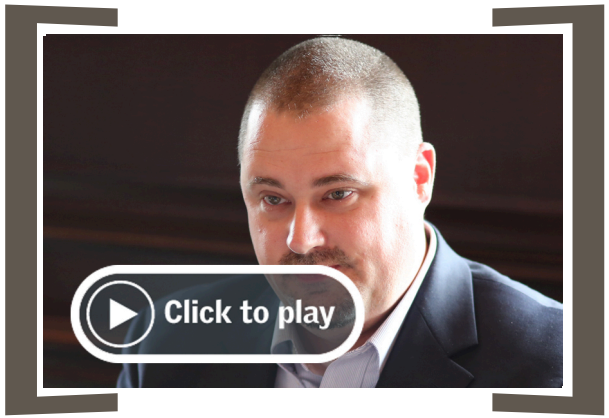
COLEY: About the sitter issue, in my experience the one thing that really works on a sitter was developing a nurse-driven sitter protocol, and taking the decision-making away from the physicians. I've seen physicians ordering sitters on units where they didn't like the nurses or they didn't think the ratio was appropriate or they didn't really understand the clinical criteria for having the sitter. When we got the medical staff to agree to taking it away from the physician and

putting that into the nurses' hands, and having the nurses put in place very strict protocols around when they could order sitters, we ended up with about an 80%–90% reduction in our sitter utilization.

LIMBOCKER: I'll call it a sort of cost of doing business in this era of healthcare right now. We just installed Epic on the outpatient ambulatory side, and I can see it's going to take a few years, but I can see some real benefits. It may hurt some areas a bit in the meantime in terms of productivity, but the benefits to the patient, the revenue cycle, and care management should drive out costs. It will require patients, however, to deliver the ROI over the next several years. The connections between the different systems in the continuum of care for the patient are going to be critical. In the future, when there's bigger risk sharing or capitation, more ACO development, this sort of foundational technology has to be there.

HEALTHLEADERS MEDIA: *How are you approaching keeping your labor costs lower, while at the same time trying to keep pace with the need to grow and add physicians?*

THACKER: Our labor costs are at 48% at this point, but recently we hired Premier to implement a labor management operations advisor to get that number lower than 48% because we've got to do that.



»VIDEOREWIND

Michael O'Malley, associate CFO at Denver (Colo.) Health and Hospital Authority, shares his organization's approach toward finding ways to reduce labor costs.

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>
> Jeffrey Limbocker

SHAPIRO: We employ 2,600 physicians in a teaching environment, but one-third of that 2,600 has come over the last 18 months as we prepare for the future. Unfortunately, in the short term you have to grab the opportunities when they occur—I'm referring to employing physicians, and it tends to be specialists, but more so in the primary care specialties such as pediatrics, internal medicine, and cardiology. So if you truly believe that things are changing quickly, then your marketplace will dictate how quickly you act and how much you spend. Of course, after that we have to go through a process of rationalizing what people are doing and making sure that redundancies are dealt with. I know it sounds like a buy-now-figure-it-out-later approach, but in competitive markets like we have in the downstate New York City area ... if you wait, you lose.

COLEY: Our biggest success has been on the labor side, driving out variability and managing it daily versus biweekly or monthly. We've taken benchmark data and pushed it down [to the clinical staff] over the past three or four years, and now we're seeing some

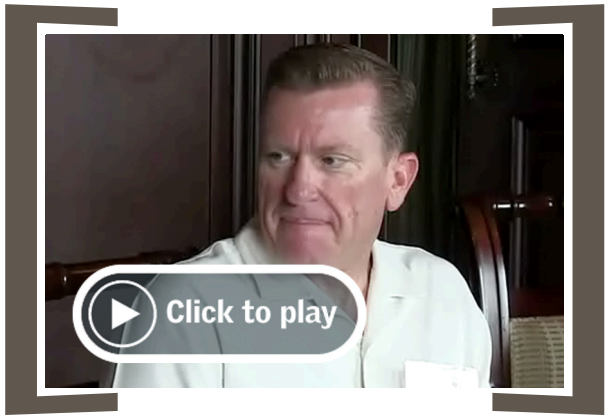
significant savings. It's tough—we have mandated nurse ratios and it limits some of the creativity. Fifty percent of our cost is labor, and benchmarking is key to reducing it.

BURKE: Right—what we've found on the labor side is we need to match the appropriate level of care we're providing within that setting to the right benchmark.

WARD: There's another twist to this, too: Where do we need a doctor versus where do we need a mid-level? And what's the expectation of the public in terms of seeing a physician versus seeing a mid-level provider? How do they practice to the level of competency and ability, but manage the expectations of the public that always wants to see the highest level versus the level that is actually needed? That's a question we've got to grapple with if we're really going to address the labor issues.

» **VIDEO**REWIND

Aaron Coley, vice president of decision support at MemorialCare Health System in Long Beach, Calif., discusses challenges with vendor selection and physician preference



HEALTHLEADERS MEDIA: *Many of you may be experiencing declines in inpatient volume and a shift toward outpatient utilization. How does this affect your operation overall and in terms of capacity utilization?*

WARD: Our overall business is growing. We're fortunate because we've actually had a 5% growth at my organization year over year. In the Dallas area the population growth is significant, but other hospitals in the area are not seeing that kind of growth. So we're expecting at least a 3%–4% growth, and in some of our outpatient areas, cancer particularly, we're seeing anywhere from 20% to 25% growth year after year, and that's been sustained.

> *"Our volumes have shifted, so we're definitely looking at space costs and allocation. We're in a growth mode as we're providing more care in ambulatory settings."*
>
> Michael Burke

BURKE: Our volumes have shifted, so we're definitely looking at space costs and allocation. We're in a growth mode as we're providing more care in ambulatory settings. Previously you might have inpatient facilities running at 65% or 70% occupancy, but now we're providing more care in ambulatory facilities. On the inpatient side, we are renovating and reconfiguring our space to provide private room–focused care as opposed to semi-private rooms.

CARTER: I should qualify our volume decline. Trinity Health saw a 1.5% decline in inpatient admissions. On the other hand, we also saw an almost one-for-one increase in observation cases, so the

issue that we are struggling with is that the beds are still full, but it's with observation patients rather than inpatients. So we have to tackle coding and documentation so that we get reimbursed the right amount. Assuming that the observation classification is the appropriate one, we are looking at how to provide more cost-effective treatment plans for patients in outpatient beds, rather than for inpatients. What we found in many of our hospitals is that the observation patients end up being admitted. We are having to make some real modifications in the way we're treating patients like those, by creating units that can best manage 24-hour or under stays. Our outpatient business is growing, though, so some facilities have excess capacity. We are looking at other programs that can help us repurpose the space.

HINDS: Although we're growing, our concern is that we're not going to grow forever, but we had to expand now. There was another healthcare facility in town that had large volume declines, so we took over a portion of their facility and moved one or two of our programs over and then renovated our units for med-surg. The cost ended up at about $150,000 a bed, and we added about 130 beds in our system to meet the current need. We avoided spending the million dollars a bed for new space. We've expanded inexpensively to meet the current need, but recognizing that we might need to downsize at some point in the longer term.

THACKER: With our acquisitions—we purchased hospitals from HCA—we found most of the back office already supervised. So for those two acquisitions the back office is centralized with Parallon (formerly HCA). Because HCA many years ago made that move to [centralize it], we left it there. It's been a test to see how we operate with all the back office revenue cycle, because they have proven their cost to collect is lower, because the technologies and synergies came from the economies of scale, that kind of thing. So we are contemplating doing the same thing with our tertiary care facility because [Parallon is] now going out under a different name—a different umbrella—and actually putting that out to nonaffiliated facilities, to be able to work on multi-platforms. Even within the VHA group in Georgia, they've had discussions about, "Would you all benefit from a centralized revenue cycle approach?" So this topic is being discussed more and more in the industry, and some have already done that. We're contemplating doing it with our tertiary facility, outsourcing to try to reduce the cost to collect.

> *"We continue to squeeze everything you can out of today's cost structure, but then we've got to really step back and redesign the way we deliver healthcare to take out large amounts of costs."*
>
> Rick Hinds

CARTER: Are you considering, in your flagship, outsourcing it to HCA?

THACKER: Yes, we're considering it but we've got a lot of different issues going on right now. Because we're on multiple platforms, we're trying to decide how to take the whole health system, our physicians, and clinicians down to one. So with all the change we are looking at, we've asked our IT vendors, "How can we leverage [your platforms] in order to get the best product and get all three facilities on the same platform so we can be more efficient?" We're trying to take two disparate systems and put it into one. We're new to that but we recognize the need to do it for our EHR and other reasons. We're still working on a solution.

HEALTHLEADERS MEDIA: *Are you looking at risk-based models with your payers? What are some of the structural challenges you're finding?*

WARD: We're finding there is usually upside but not downside risk [for these contracts], but we're in the infancy. The insurers are putting a little bit of their skin in the game, but the insurance companies have an expertise to bring to the table that we, as hospitals, don't have. That's the actuarial analysis and the data analysis. We're trying to see how we can use that to our advantage, particularly in these risk-based contracts, to become partners. But you also have work with the payers on what is a fair margin. We need to get them to understand what margin it takes to support the organizations and provide care to the patient. Our negotiation payments aren't cost plus a fair margin, like most other businesses.

"The term 'directional' is a very good term which we use all the time to describe this [effort to arrive at true cost]. When we pushed our data out to our physicians about five or six years ago, we had to be very careful because they'd pick it apart and find all the errors, especially when you're driving down to the doctor level within a service line. We are careful to say, 'This cost data is directional, and our goals here are to have incremental improvements over the current numbers.' We use ratios for doctors against their peers, and then we say, 'We want you to just get better.' This doesn't mean that's the exact number they have to hit, but we want it to move in the right direction."

Roland Thacker

Everybody understands capitalizing your business, but what I don't think healthcare has done a good job at is projecting what our true costs are and what it takes to actually take care of a patient. Quite frankly, as an industry we've done that to ourselves, and now we have to figure out how to fix it.

COLEY: We have risk-based contracts in California—capitation never really went away. So we've been in that space for a long time and it's profitable. The problem when you're partly in capitation and partly not is getting the full efficiencies out of it. So until all the payer systems are online, it becomes a difficult type of tool to work.

BURKE: It's a valuable tool for populations that may have trouble managing costs. In many cases we will work with an HMO or other payer to come up with an episode of care–type of pricing, which is sometimes more effective. We have worked hard to manage our employees' healthcare costs in a more efficient way. But we don't have a lot of payers right now that will give full capitation for management of lives because Manhattan is a very fragmented market, and we just don't have the ability to manage those patients.

HINDS: Patients and payers are going to have to drive this, but if you step back and look at healthcare reform, where is the patient involved, and where are the economic incentives for them to do the right things in terms of wellness? The payers are going to have to drive that behavioral change, and if we or other hospitals become a payer through risk sharing, then we'll have to do it.

CARTER: We are applying for one of the bundled payment demonstration projects in one of our markets, but we don't yet know if we will be chosen and how that will pan out. We are developing accountable care networks and working hard at clinical integration, but we really don't have much in the way of risk-based contracts yet. We just don't know that we're ready yet to manage effectively in that space; we don't want to see the industry achieve the same outcomes it did in the late 1990s. We just don't want to repeat the same mistakes, so we are being cautious ... This work has really been a greater benefit to the insurance companies rather than to our system because we have a number of patients in our patient-centered medical homes, and they've been effective at reducing hospital utilization. At the same time, we do not have the benefit of a gainsharing contract.

SHAPIRO: Ultimately, gainsharing will bring together parties that aren't necessarily under the health system's direct control. Over time I think we'll see a slow end to where you don't [need] gainsharing. Hospitals will either consolidate or employ everyone and everything will just be under more [centralized] control, or everyone in healthcare will recognize you can't operate like we did in the past if you're going to reduce costs and survive in the future. IA

Additional Resources

For more information about our **Impact Analysis** participants, go to:

Columbus Regional Healthcare System
www.columbusregional.com

Denver Health & Hospital Authority
www.denverhealth.org

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www.memorialcare.org

North Shore–LIJ Health System
www.northshorelij.com

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Additional Materials

How Hospitals Can Shape Sustainable Cost Control

HealthLeaders magazine, June 2012

It is among a healthcare leader's greatest challenges: how to make truly sustainable, long-term cost reductions instead of annual, tactical cuts. The need to control costs is vital to the long-term success of organizations in an era of healthcare reform. In a survey of the HealthLeaders Media Council, 55% of respondents said that even with annual cost savings from initiatives over the past three years, they need to pull an additional 4%–10% out of their operating budgets, and 23% said they need to pull an additional 11% or more. To achieve this magnitude of savings—and maintain it—requires organizations to shed reactive, tactical approaches in favor of deliberate, well-planned approaches. Several healthcare systems have achieved financial and clinical rewards through different approaches—using a value management methodology, sharing costs with partners, redesigning inpatient care, and leaning on Lean process techniques.

http://www.healthleadersmedia.com/content/COM-281205/How-Hospitals-Can-Shape-Sustainable-Cost-Control.html

Uncovering True Costs

HealthLeaders magazine, February 2012

Healthcare reform will, if it hasn't already, have a huge impact on hospital cost systems. With shouts from Congress and consumers for healthcare to reduce costs and payers turning to bundled payments, now more than ever healthcare organizations need to know the true cost of treatment and procedures. Arriving at true cost, however, requires finance leaders to consider a new set of cost modeling tools: process-based cost modeling. PBC, sometimes referred to as activity-based costing or micro-costing, is a form of full-cost accounting that offers CFOs a tool to better understand the resources consumed in providing the organization's products and services. PBC has proven its worth in other industries over the years, but until healthcare reform put the spotlight on cost, micro-costing for healthcare wasn't necessary. However, it also hasn't been embraced by the industry because the initial implementation can be time-consuming. PBC requires every resource in a service to be manually tallied and updated annually, including the quantity of labor, frequency, supplies used, and unit cost.

http://www.healthleadersmedia.com/content/MAG-276465/Uncovering-True-Costs

Collaborating to Improve Care and Cut Costs

HealthLeaders Media Intelligence Report, June 2012

Initiating collaborative relationships is the key to improved quality, most healthcare leaders say. Many also agree that major increases in HIT spending are necessary, but others are more cautious about spending for technology improvements. And more than two-thirds see transparency as improving quality of care, while a sizeable minority has reservations about it, according to the 2012 HealthLeaders Media Economics of Better Care Survey. Teamwork is an emerging focus, with nearly three-quarters (72%) entering collaborative care relationships, while 28% say they are not. At the same time, healthcare leaders are reluctant to engage in shared savings programs as a risk-sharing cost reduction tactic: 63% say they have no plans for such programs, which are a foundation of the evolving accountable care organization models.

http://www.healthleadersmedia.com/intelligence/detail.cfm?content_id=280838&year=2012

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A Division of HCPro

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