HEALTHLEADERS MEDIA

CFO EXCHANGE

Insights Report

October 2013 | Report 1 of 3

DIANA THOMAS

From Volume to Value

FINANCE LEADERS ON THE IMPACT OF THE BIG CLINICAL SHIFT

Analysis and in-depth discussions from healthcare finance leaders taken from the HealthLeaders Media CFO Exchange in August 2013

An independent HealthLeaders Media report supported by TransforMED

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Analysis

ON THE EDGE OF OPTIMISM

JIM MOLPUS
Leadership Programs Director
HealthLeaders Media

Chief financial officers are often the most reliable oracles to predict the future direction of health systems because they usually are the realists in the executive suite. The CEO may be the Type A visionary who makes the big plans, but the CFO takes those plans and puts them into the real world of a business.

The participants of our annual invitation-only HealthLeaders Media CFO Exchange, which took place this August at The Broadmoor in Colorado Springs, echoed some similar themes. The CFOs generally expect their local healthcare markets to get more consolidated and be a much tougher competitive environment. Downward pressure on reimbursement will only mean more pressure to eliminate waste and make what may be painful choices about which services they can continue to offer.

Ultimately the one question that may be the most difficult to predict is also the most important: How will their healthcare organizations make the switch from a business model based on volume to one based on value, quality, and managing the health of a population? If you read the highlights of our discussion of what we call "The Clinical Shift," you may sense a CFO's natural caution with optimism that, indeed, his or her health system will work through the hurdles. There are hills to climb—physician alignment models to revise, new skills to be acquired, and new payer and employer partners willing to truly share the risk in a meaningful way.

The report that follows highlights the directions many of our CFOs are taking their health systems in the next year. We will check back with the members of our 2014 HealthLeaders Media CFO Exchange to see if that optimism has been rewarded. EIR

Sponsor Perspective

LEADING THROUGH THE BIG CLINICAL SHIFT

BRUCE BAGLEY, MD, FAAFP

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Leadership, as applied to the critical need to manage change and promote organizational development, is at the heart of health system redesign in the transformational environment since the Patient Protection and Affordable Care Act of 2010. We have learned a lot about what it takes to achieve transformational change in the primary care practice since the American Academy of Family Physicians funded TransforMED as a nonprofit subsidiary after the release of the landmark 2004 report, *The Future of Family Medicine*.

It is abundantly clear that success in the reformed healthcare environment will require not only primary care practices but also hospitals and healthcare systems to function at a higher organizational level. Every healthcare organization will do well to develop some real agility in response to changing clinical and business needs, because no one knows exactly what the payment environment or the care delivery model will look like five years from now. There will be increasing pressure for actual or virtual integration of clinical care, financial arrangements, and information technology. Winning players in the new world of healthcare will have found a way to be comfortable with increasing levels of interdependence and integration.

To develop and fortify primary care services through patient-centered medical homes, leaders must consider four essential elements for practice transformation and organizational development: Teamwork, Leadership, Communication, and Metrics.

Past surveys of the primary care landscape found that practices generally lacked a professional approach to the management of their finances, personnel, and clinical quality. Without applying these key "TLCM" elements, practices will continue to founder in a rapidly changing sea because of shifting or problematic structures for leadership and decision-making.

In addition, two current TransforMED projects through the Centers for Medicare & Medicaid Services' Innovation Center related to primary care redesign and to patient-centered medical

Ultimately, our role as healthcare leaders is to help everyone appreciate that there is a better, more effective and efficient way to help patients than the traditional format that was designed a century ago.

neighborhoods reveal a need for these "TLCM" organizational development skills at all levels of integrated delivery systems.

The best teams result from the quality of the interactions of all the players, and we must not be afraid to redefine roles and responsibilities to make a great team out of the people we have. Active, two-way communication is the central nervous system of any high-functioning organization, but we should keep in mind the many ways besides verbal to stay connected, transfer information, or monitor team progress. Amid uncertainty, we must use metrics in three categories—financial performance, clinical performance related to the most common chronic illnesses, and quality (improvement efforts that determine if a change actually leads to better performance)—as the foundation for data-driven decision-making.

Ultimately, our role as healthcare leaders is to help everyone appreciate that there is a better, more effective and efficient way to help patients than the traditional format that was designed a century ago to bring the patient face-to-face with the physician for the purpose of diagnosis and treatment of disease, infirmity, or injury. In this quest to operate healthcare organizations that achieve optimal outcomes for patients and a better bottom line for the enterprise, our challenge is to boldly apply positive leadership to help others see that this work of transformation is not an additional burden but rather a path to a better place: the new world of healthcare. EIR

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DRIVING THE ALIGNMENT, LEADERSHIP, AND SKILLS FOR MANAGING HEALTH

JIM MOLPUS

Every hospital and health system is facing the same basic challenge: how to transform a provider organization essentially built for a high volume of acute care services into one that can manage the health of a population of people cost-effectively.

Collectively, the 38 hospitals and health systems represented at the annual HealthLeaders Media CFO Exchange are focusing on a relatively small circle of strategies to manage this major shift in the business fundamentals of healthcare, including experimenting with physician alignment models, boosting physician leadership, and piloting population health with their own employee base or other defined groups.

Without a clear regulatory outlook or proven business model, the CFOs say their organizations are taking a measured, but purposeful, approach. In the CFO Exchange member survey, 89% of respondents said that direct employment of physicians was in use at their health systems as a physician alignment model or pilot, followed by joint ventures at 64%. While employment may dominate the overall strategy, each system is working to create its own fingerprint for how it can bind its physicians across multiple disciplines to achieve higher levels of clinical and financial efficiency.

Sharon Joy, vice president of financial operations and chief financial officer for physician and ambulatory network services at the North Shore-LIJ Health System, says the 16-hospital system has been aggressively employing physicians in key areas for the past four years.

"We've gone from one thousand employed docs to 2,500 employed docs," Joy says. "Approximately one-third of those are hospitalists and intensivists. We have worked to secure physicians who were already loyal to us." Joy says when the most recent recruitment push began, 80% of the effort was "defensive" and aimed toward physicians who were affiliated with the health system. Now that 80% has flipped and is more "offensive" in seeking out new physicians and growing market share. While employment is still a working tool for the health system, Joy says the organization is starting to see its limits.

"That strategy of employment now is slowing down because although it is beneficial on the physician side, on the health system side, we now have all the risk," Joy

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says. "Significant capital dollars for practice site improvement were necessary, and the physicians needed to change the way they practiced when they became part of the health system. So we've begun to adopt other models of aligning physicians that is not pure employment and allows us to share the financial risk—for example, creating joint ventures with groups of physicians."

Health systems are looking to come up with the right physician blend that keeps physicians loyal and allows for a clinical integration platform that drives higher quality.

Charlie Hall, CFO of Atlanta-based Piedmont Healthcare, says his five-hospital system has been taking a deliberate approach to the clinical shift for years. "We've got to make incremental changes each day," Hall says. "We're all driving these big battleships that you can't turn 180 degrees in a matter of a year. Some of the popular press thinks we can, but we know we can't. We've got to be sure that we're driving the ship. And that's what we're doing in terms of the clinical shift.

"Nine hundred of our physicians are in one clinic," Hall says. "Some of them we employ. Most of them we do not. Over a period of 10 years, we have got them clinically integrated so that we can sign our managed care contracts with one signature. We're in the process of putting together a health plan, which we've never done before. But that's just a natural step. Again, we're continuing to try to build, not trying to make a 180-degree turn, but making sure directionally we're going where we need to go."

John Grigson, CFO of Lubbock, Texas–based Covenant Health, says the organization started reorganizing its physician alignment six years ago.

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"We created a new organization specifically to clinically integrate with our physicians," Grigson says. "It's a PHO [physician hospital organization], but it is a separately incorporated 501c3 organization. Covenant Health is the sole member of that organization and it created participation agreements to align physicians with its purpose. So physicians join the organization by signing the participation agreement, and when they sign the agreement they're committing to several things. They're agreeing to participate in the clinical integration program, which has both hospital and individual physician quality initiatives which they have to meet, and they have to agree to have an electronic medical record. This clinically integrated organization has the ability to negotiate contracts. And so we use the organization to sign population health management contracts, not only with ourselves, but with carriers in town, and we're even beginning to go to self-funded employers using the organization."

Greg Pagliuzza, CFO of Trinity Regional Health, which is a member of Iowa-based UnityPoint Health, says his local system employs some 550 providers mostly in primary care, but has added flexible models to allow for more broad-based clinical integration. "Our employment focus is primary care, but we do, on an ad hoc basis, use specialists or employed specialists as necessary. We also use clinical comanagement agreements to get alignment more with the independents. I want to say we're open to groups who are interested in joining us on an employment basis, but for the independents who definitely want to stay independent,

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our focus is allowing them to become members in the ACO. It just depends on the numbers and their specialty, but we do want as many involved as possible."

The local healthcare market is a primary driver in developing a physician strategy. In the hyper-competitive Dallas market, Baylor Health Care System, now Baylor Scott & White Health, has a variety of models to align with its 4,000 physicians, says CFO Fred Savelsbergh.

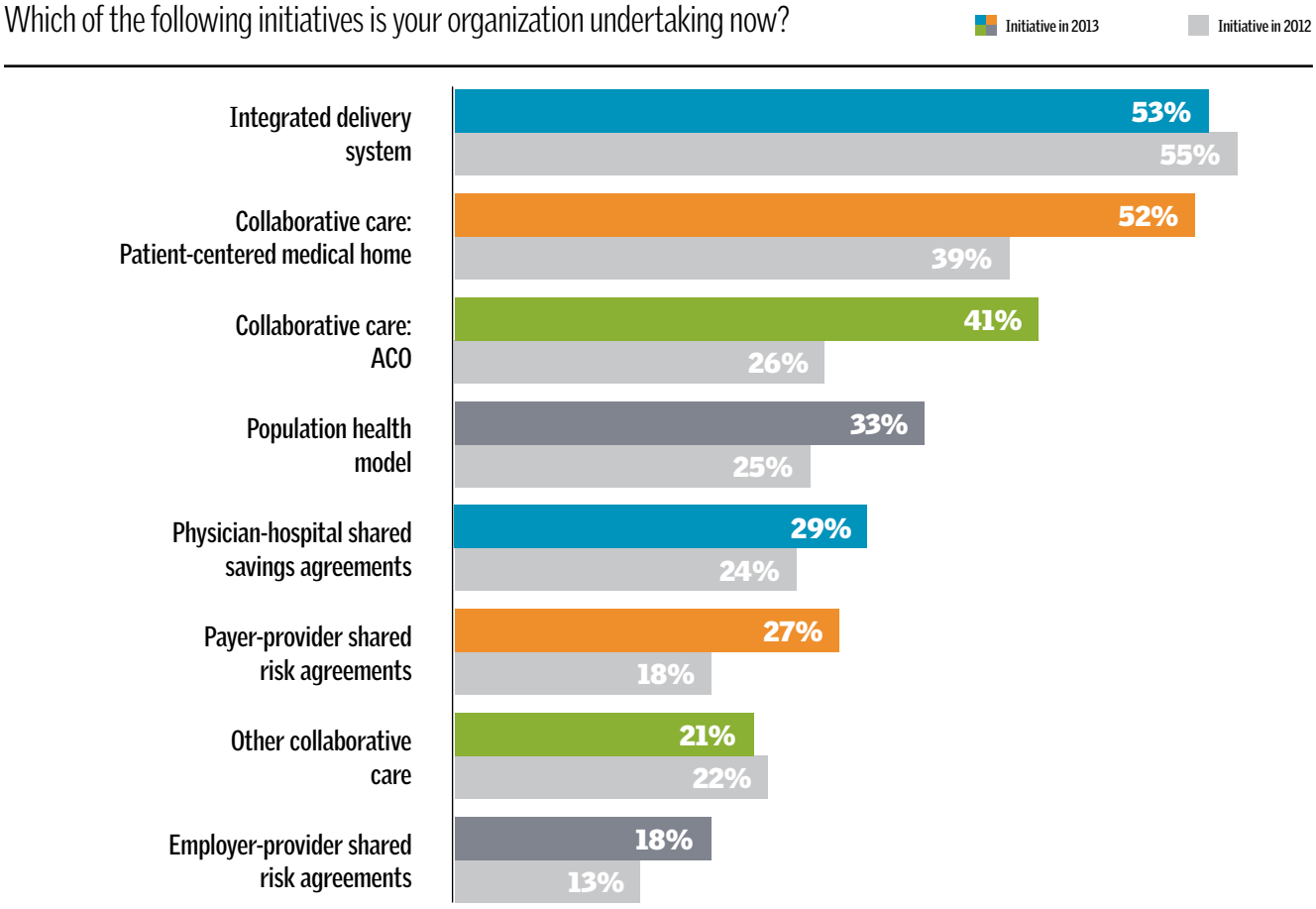
"There's no certificate of need in Texas, so it's wide-open competition," Savelsbergh says. "The market is flush with cash so there are emerging business models that occur day in, day out." The health system's employed medical group, Health Texas Provider Network, has 600 employed physicians, with 400 in primary care and 200 in specialty and subspecialty care, he says. "An emerging model within Baylor is the Baylor Quality Alliance, which is an ACO-type model, but without the participation agreements. Independent physicians can align in there. A new emerging model as well is Baylor Physician Services, which is more for the independent physicians and includes more management and organization-type services. We also have joint ventures with physicians in short-stay hospitals and ambulatory surgery centers. So we run a diverse group of models to meet the market's needs."

Academic medical centers with closed physician staffs face a particular challenge. John Yeager, CFO of West Virginia United Health System, operating six hospitals, says their flagship hospital experienced growth with a joint operating agreement it formed with physicians three years ago.

"The hospital, prior to the joint operating agreement, was fortunate to operate at a 2.5% operating margin," Yeager says. "After we began operating under the agreement, both economic as well as clinical activities were integrated, resulting in the operating margin more than doubling. We found that the benefit started with integrating management. For example, there were two revenue cycles that we're able to combine into one operation. The CFO of the hospital was also responsible for the financial operation of the clinical practices resulting in economies of scale."

TRENDING INITIATIVES

Which of the following initiatives is your organization undertaking now?



Multi-response

SOURCES: HealthLeaders Media Intelligence Reports, *Physician Alignment in the New Shared Risk Environment,* September 2013; and *Physician Alignment: Integration Over Independence,* September 2012.

A new dynamic for physician leadership

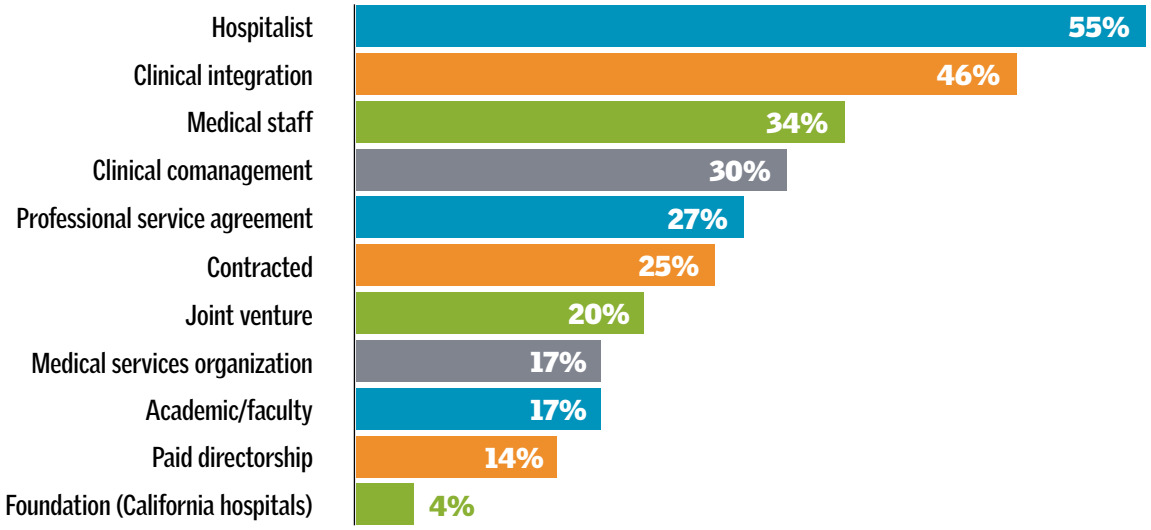
While the CFOs discussed the need for a flexible, hybrid physician alignment strategy, many of the health systems represented are also adopting a new organizational structure that puts a premium on physician leadership.

Charles Ayscue, CFO of Mission Health in Asheville, N.C., has seen medical leadership grow under the tenure of CEO Ron Paulus, MD. "Our CEO is a physician, and it makes quite a difference once you have a physician to help drive." Ayscue says the senior leadership team includes several senior vice presidents who are MDs, overseeing overall quality and innovation, as well as specific MD/VPs in charge of outpatient and inpatient medical affairs. "So, I think if you've got a physician in leadership, they bond better with all of the caregivers and quality outcomes become the primary strategy, with financial outcomes becoming the secondary strategy."

Rick Hinds, CFO at UC Health in Cincinnati, says his health system put physicians in charge of its hospitals two years ago. "That's worked to varying degrees of success. And then whenever we do committee work, we always pair up a doctor with an administrator. So that's how we're driving the service lines."

PHYSICIAN ORGANIZATIONAL MODELS

Please select the top three physician organizational models as you expect them to be in three years.

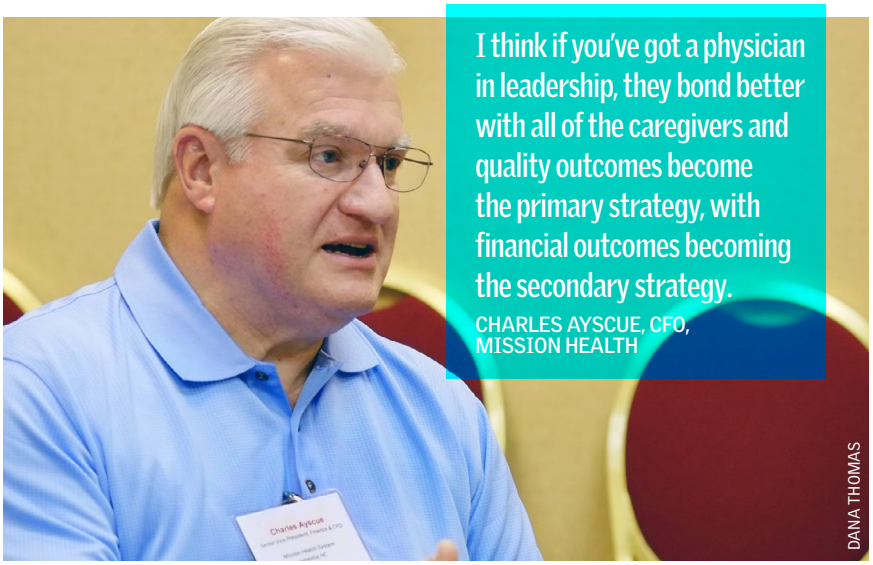


Multi-response

SOURCES: HealthLeaders Media Intelligence Report, *Physician Alignment in the New Shared Risk Environment,* September 2013.

Kendall Johnson, CFO of Baton Rouge (La.) General Medical Center, says his system has focused on "physician-driven quality and performance initiatives through interdisciplinary committees of physicians, nurses, and ancillary departments at every level of the organization to enhance both patient and physician satisfaction. We've also engaged our medical executive committee in leadership development initiatives, and they in turn are encouraging their colleagues to be involved in decision-making through participation in interdisciplinary committees that work closely with hospital leadership in the strategic development and implementation of hospital services and programs to help engage and align physicians."

Driving the type of change that is required means improving not just the vertical leadership within one hospital or unit, but also driving overall service line improvement across the organization. San Diego–



based Scripps Health undertook a leadership redesign more than two years ago that has a matrix of vertical and horizontal leadership, explains CFO Rich Rothberger.

"We've taken out of the hospitals the COOs and have made them leaders within certain areas," Rothberger says. "We now have experts who are responsible for vertical integration of different functions, including supply chain, pharmacy, the OR, cath lab, and respiratory. We are also working on imaging, radiation oncology, and hospice services and home health across the continuum.

"It's been very successful in terms of trying to cut cost and take out non-value-added variation," Rothberger says. "And now we're migrating to the next phase on the clinical side. We now have leaders who are working in care lines around cardiovascular, OB, and musculoskeletal services with the whole idea there that those are the high-cost areas and are there opportunities to engage the physicians around reducing the variation in selections of implants, drugs, preformatted orders, protocols, and so forth."

> While healthcare reform will focus more on prevention and wellness, in the short term, the challenge remains in that serious and catastrophic conditions represent a considerable percentage of the overall costs and are not necessarily impacted by wellness activities or a focus on specific diseases or chronic conditions.
>
> KAREN TESTMAN, CFO, MEMORIALCARE HEALTH SYSTEM

Pilots and models

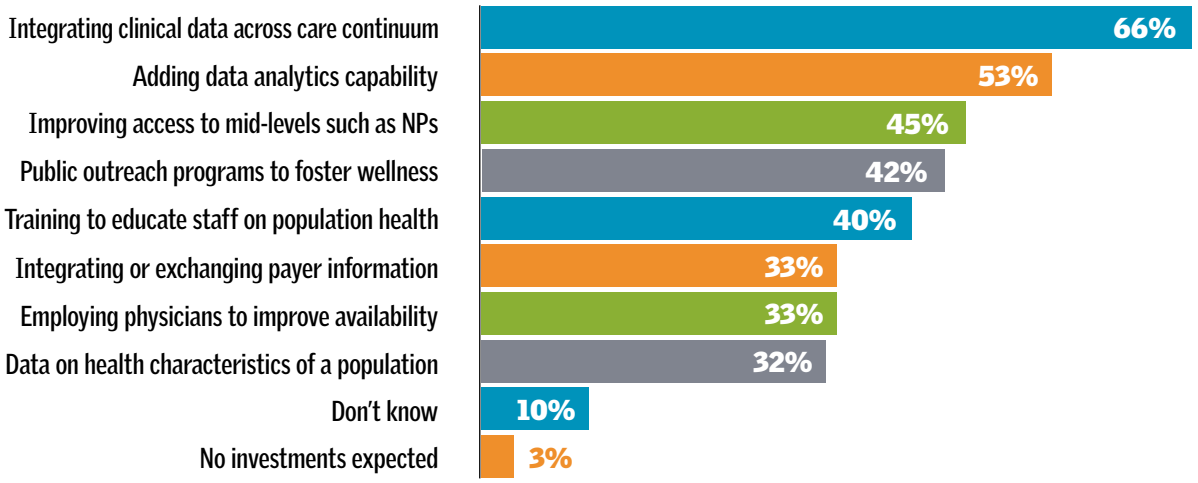
Beyond the physician alignment and leadership structures that must be developed, the health systems represented at the CFO Exchange are pushing forward with pilots in everything from patient-centered medical homes to ACOs to build the skills and develop the experience necessary for the future state of healthcare.

Craig Richmond, associate CFO for MetroHealth in Cleveland, says that as a public health system with 20% of its payer mix uninsured, finding ways to better manage care at reduced cost drove it toward some new models. "Several years ago we adopted a patient-centered medical home model in our primary care practices. This program serves the uninsured patients (many with chronic conditions) in a more clinically effective and cost-efficient way by partnering patients with primary care teams. Each patient is partnered with a team that consists of a primary care provider, nurses, and a care coordinator, among others. An area of focus has been in the reduction of unnecessary emergency department visits and hospitalizations for the medical home patients. We have been able to reduce the average cost of care for patients enrolled in the program since its inception."

Eddie Soler, CFO of Florida Hospital in Orlando, says his organization is taking a careful approach. "We are going to take it very slow but we've done a number of things for target populations," Soler says. "We know that 20% of patients [in] our emergency rooms don't need that level of care. And so we've targeted various populations and we've created these clinics that they can go to at no cost to them because we figured it was cheaper for us to run that clinic than for them to come in our emergency room and [be] tying up beds and using up resources. There's been a lot to talk about patient-centered medical homes

POPULATION HEALTH INVESTMENTS

In which of the following areas do you expect to make investments in the next three years in order to pursue population health management?



Multi-response

SOURCES: HealthLeaders Media Intelligence Report, *Population Health Management: Steps to Risk Sharing and Data Analytics,* October 2013.

and our primary care practices and, quite honestly, we are still trying to understand what that means in terms of driving down our own costs."

Karen Testman, CFO for MemorialCare Health System in Long Beach, Calif., says her health system has been looking to its own self-insured employee health plan to model programs that improve health and reduce cost for its almost 12,000 employees.

"We have been focusing on specific disease states," Testman says. "Therefore, employees who have hypertension, diabetes, and other chronic conditions are part of a comprehensive program that includes counseling for diet, exercise, and other health prevention and health enhancing services as well as follow-up monitoring. We're doing things like covering the cost of their hypertensive drugs 100%. With this incentive to participate and the most important incentive of maintaining and improving their health, we're seeing some pretty amazing results as far as weight loss, lifestyle changes, medication and treatment compliance, and employees saying they have never felt better. While healthcare reform will focus more on prevention and wellness, in the short term, the challenge remains in that serious and catastrophic conditions such as NICU babies, trauma cases, and complicated cancers represent a considerable percentage of the overall costs and are not necessarily impacted by wellness activities or a focus on specific diseases or chronic conditions." EIR

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TransforMED is a wholly owned subsidiary of the American Academy of Family Physicians. TransforMED is the trusted leader in patient-centered medical home and patient-centered medical neighborhood transformation. TransforMED consultants leverage best practices from their experience guiding transformation projects across the country to provide clinical integration services, collaborative environments, and learning opportunities to medical practices and stakeholders such as payers, hospital systems, IPAs, and state and federal government bodies. *www.transformed.com*

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