Preparation for the Inevitable Perilous Journey from Entitlement to Accountability

-A Practical Guide-

1. There is no new money!
2. Avoid becoming a ‘false positive’
3. Key: Successful resolution of conflict

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N8’s Qualifications

- 35 years in healthcare
- Strategic advisor to health systems and medical groups
- 72 publications
- Faculty for ACHE, The Governance Institute, AHA, MGMA, AAFP and many hospital and physician associations
- Focus: strategy, physician-hospital transactions, managed care, financial turnarounds, payer negotiations, education
- 2005 Presentation Theme: Shelter from the Storm

As Managing Director of Kaufman Strategic Advisors (since 2007)
- On-site 305 health systems in 45 states
- 230 physician transactions and valuations
- Hit rate of .800!

www.kaufmansa.com

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2011-2012 Publications

- Clinical Integration: Déjà vu All Over Again? Futurescan 2012, Health Administration Press
- Weathering Changes to Provider-Based Reimbursement, Hospitals and Health Networks Daily, May 30, 2012
- A Coming Physician Shortage for Medicare and Medicaid Patients, Hospitals and Health Networks Daily, July 25, 2012
- Medicare ACOs: Not the Best Way to Start, Hospitals and Health Networks Daily, Aug 29, 2012
- The Co-Management Conundrum, Hospitals and Health Networks Daily, Sept 28, 2011
Organizations fail when they refuse to confront their ‘brutal facts’

Routinely use data, metrics and other tangible evidence to identify and confront external threats and internal weaknesses.

The data is out there, it is open, it is freely available, but openness alone has not driven change!

Challenge traditional beliefs, create conflict -- “do your very best thinking”

Critical Core Competency: Embrace Constructive Conflict

The ability for multiple provider entities, with divergent economic interests and different backgrounds, to work together and AGREE to care redesign to better meet the needs of defined populations of patients using a process such as LEAN.

- Invite Leaders Representing Divergent Views
- Radical Transparency of Information and Opinions
- Engage In Constructive Conflict and Reach Resolution
- Global Support For The Result
Who believes that they are overpaid for the work they do today in healthcare?

The Law of Reciprocal Economics:

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

Immutable Law of Business Performance

Good strategy clearly defines a specific pathway through complexity, uncertainty, and resistance to achieve a desired level of performance

Bad Strategy

- Lofty goals, high hopes and unrealistic ambitions
- Long on gibberish short on specifics
- A budget
- A long list of things to do

Good Strategy

- The essential competencies for future success (national)
- Honest identification of challenges (local)
- Specific actions to overcome challenges (local)

Ultimately makes an organization sustainably differently better as measured by market share and profitability

1 Overestimating the Importance of Culture By Dan Beckham HH&N 8/16/2012
2 Good Strategy, Bad Strategy Richard P. Rumelt
Ask ‘WHO’ not ‘What’

Recruit self-motivated leaders who share your core values and will focus on ‘the cause,’ (not themselves,) inspiring others through their ACTIONS

- Strive to be one of the dumbest people in the room
- While no leader can single-handedly make an organization great, the wrong leader can single-handedly bring a company down

Success = Strategy + Competency + Luck

Failure is always an option… the cost of failure can be greater than the rewards of success

- Wrong leader
- Wrong strategy
- Lack of competency to execute
- Unlucky
Industry disruptions usually originate from outsiders using new technology to deliver products/services of proximal quality which are more affordable, accessible, and customer friendly.

Retail clinic visits grew from 1.48 million in 2006 to 5.97 in 2009.

Which Company Best Reflects Your Current Strategic Culture?

- Always looking to invent the “next big digital thing”
- Easy-to-use, reliable disruptive products people love
- Apple CEO Tim Cook says “Incredible products coming”

- Resisted digital (strong confirmation bias)
- Eventually concluded that digital was inevitable
- Waited for the ‘perfect time to change’
Who the Gods Want to Destroy They First Give 40 Years of Success

Announces partnership with MDLIVE to provide 24/7 virtual visits for patients.

Michigan Governor Rick Snyder has signed a bill in the state that requires health insurance providers to recognize claims for health services delivered by telemedicine methods.

For $44.95

1. Create your free MeMD account.
2. Consult with a medical provider using a webcam.
3. Get the right treatment plan for you!
The Brutal Fact

Government eventually responds to a perceived threat to the well-being of its citizens with solutions that are:

- well meaning but confusing,
- over-reaching and clunky,
- usually influenced by special interests and,
- fraught with unintended consequences

The Brutal Facts: No One is Immune to Arithmetic

- Healthcare is one of the top expenses for most US households
- Based on the current trend, the cost to insure a family of four in 2020 will be $40,000
- The rate of potentially preventable deaths differs in 306 ‘hospital referral regions’ by a 300%
- 20% of Americans have an unmet medical need and 16% have had to change their life to afford care
- Medicare + Medicaid = Deficit
- The empirical evidence is that, in aggregate, the quality of service and outcomes provided by the US healthcare system is not worth the high cost
- Embedded economic incentives lead to overuse
"The pending economic crisis will be the most predictable crisis in our nation’s history!"

~Senator Tom Coburn MD

Bundled payments, ACOs, medical homes can reduce cost levels but not the overall growth rate... Medicare spending will grow faster than projected... The Trust Fund will be insolvent by 2024... and Congress won’t be able to avoid changing course.

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

Total state spending on Medicaid now surpasses spending on K-12 education~ Report of State Budget Crisis Task Force

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

IOM Estimate: $765B in Waste

Implications:
1. There is no new money
2. Success will come from doing less for more!

Source: Adapted with permission from IOM, 2010; from The National Academy of Sciences; “Best Care at Lower Cost: The path to Continuously Learning Health Care in America”
How is Care Managed for the Frail Elderly?

### 78 y/o WF

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

### 18 Medications
- Calcium
- Temazepam
- Simvastatin
- Vitamin B12
- Lasix
- Lantus insulin
- Metformin
- Timoptic eye gtt
- Lumigan eye gtt
- Omeprazole
- Diltiazem, Requip
- ASA, KCL
- Glipizide
- Metamucil
- Zyrtec

### 12 Current Physicians
- PCP
- Ophthalmologist
- Neurologist
- Gastroenterologist
- Podiatrist
- Oncologist
- General Surgeon
- Cardiologist
- Endocrinologist
- Hospitalist
- ENT
- Dermatologist
How is Care Managed for Cancer Patients: Provider vs. Patient Centered Care?

- Competing Entrepreneurs
- Multiple Medical Records
- No Central Navigator
- No Standardized Protocols
- No Outcome Data
- No NCI Designation
- Cost>MD Anderson

2004 US Olympic Basketball Dream Team
Dear Doctor:

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

Excessive Pricing

<table>
<thead>
<tr>
<th>Providers within 10 miles</th>
<th>Back – MRI Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Low</td>
</tr>
<tr>
<td>Freestanding Imaging Center</td>
<td>$ 531</td>
</tr>
<tr>
<td>Northern Medial Center</td>
<td>$1,591</td>
</tr>
<tr>
<td>Saint Steven’s Regional Med Center</td>
<td>$1,803</td>
</tr>
<tr>
<td>Memorial Medical Center</td>
<td>$2,015</td>
</tr>
</tbody>
</table>

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

Sincerely,

Director
Provider Engagement and Contracting

Friday, September 21, 2012

LOS ANGELES TIMES

Cedars, UCLA Doctors Cut from L.A. Health Plan

“...Costs are up to 50% higher than competitors and the quality of care isn’t measurably better”...taking out those groups produces a substantial difference in cost.”

Predictions: 2012-2018

ACA is fundamentally flawed law --Worry about: ACA-2

● No empirical evidence to support sustainable control of costs
● The goal is to provide:
  – World Class Quality
  – Affordable Care
  – Coverage for Everyone
  – Immediate Availability When Needed
● We are ‘stuck’ with fee-for-service w/ value-based penalties as the dominant form of payment for at least the next five years: (HHS has missed 20 of 42 ACA deadlines)
● No malpractice reform
● Lack of attention to heroic end of life care
● Health insurance companies remain exempt from antitrust
● State participation in Medicaid expansion is still optional
● No focus on the exorbitant cost of medical education
● Nothing addresses personal responsibility
Core Competency:

- The board, management and medical staff differentiate between valid ROI-based strategies and the latest fads and are consistently focused on executing their critical strategies. In addition, they possess the ability to respond to unforeseen challenges quickly and effectively
  - Several R&D projects, searching for innovations developed by others

Predictions: 2012-2018
Payment Will Be Modified and Provider Quality and Cost Evaluated by “Actual vs. Expected”

<table>
<thead>
<tr>
<th>Complication</th>
<th>Documentation</th>
<th>Reimbursement</th>
<th>LOS</th>
<th>Relative Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urosepsis:</td>
<td>MS-DRG 690</td>
<td>$4,170</td>
<td>3.5</td>
<td>Low</td>
</tr>
<tr>
<td>Sepsis due to UTI:</td>
<td>MS-DRG 872</td>
<td>$6,164</td>
<td>4.7</td>
<td>Low</td>
</tr>
<tr>
<td>Sepsis due to UTI w/CC:</td>
<td>MS-DRG 871</td>
<td>$10,022</td>
<td>5.5</td>
<td>High</td>
</tr>
</tbody>
</table>

1. Principal diagnosis: Urosepsis (ICD-9-CM 599.0, 995.92)
   Secondary diagnosis: Acute renal insufficiency (ICD-9-CM 593.9)
2. Principal diagnosis: Sepsis with SIRS due to urinary tract infection (E. coli in urine) (ICD-9-CM 038.9, 995.91, 995.92, 599.0, 041.4, 593.9, 584.9)
   Secondary diagnosis: Acute renal insufficiency (ICD-9-CM 593.9)
3. Principal diagnosis: Severe sepsis with SIRS due to urinary tract infection (E. coli) (ICD-9-CM 038.9, 995.92, 595.92, 593.9, 584.9)
   Secondary Diagnosis: Acute renal failure or acute kidney injury (nontraumatic) due to sepsis (ICD-9-CM 584.9)

“CMS, DOJ and the FBI are initiating more extensive medical reviews to ensure that providers are coding accurately and will take action where warranted.”

HHS Secretary Kathleen Sebelius and AG Eric Holder 9/25/2012
Transparency Will Be Used to Force Accountability

Patient Safety Measures

<table>
<thead>
<tr>
<th></th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Complications</td>
<td>No Different than U.S. National Rate. Get results for this Hospital</td>
<td>No Different than U.S. National Rate. Get results for this Hospital</td>
<td>Worse than U.S. National Rate. Get results for this Hospital</td>
</tr>
<tr>
<td>Deaths for Certain Conditions</td>
<td>No Different than U.S. National Rate. Get results for this Hospital</td>
<td>Better than U.S. National Rate. Get results for this Hospital</td>
<td>No Different than U.S. National Rate. Get results for this Hospital</td>
</tr>
</tbody>
</table>

Medicare Spend Per Beneficiary

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Spend Per Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1.06</td>
</tr>
<tr>
<td>B</td>
<td>0.95</td>
</tr>
<tr>
<td>C</td>
<td>0.94</td>
</tr>
</tbody>
</table>

~ www.HospitalCompare.HHS.gov

Predictions: 2012-2018
Hospitals Will Become More Accountable, a.k.a., Exposed to Increased Penalties, For Care (Physicians are Next)

"From the patient perspective, death is a key outcome."

Value Based Purchasing/Patient Safety Initiative

8-10% Medicare Rev:
- Process adherence
- HCAHPS: Patient Satisfaction
- Mortality
- Readmissions
- HAIs

2014 Proposed ‘Values’
- Clinical Outcomes
- Medicare Efficiency
Beware Physician Compare: Medicare Site Inaccurate

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

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

### Washington Post 4/14
Starting 2015 Medicare will implement the Physician Value-Based Payment Modifier

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**CONFIDENTIAL**

**2010 QUALITY AND RESOURCE USE REPORT**

**MEDICARE FEE-FOR-SERVICE**

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<table>
<thead>
<tr>
<th>Dr. [Physician Name]</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI) [4]</td>
</tr>
<tr>
<td>Specialty: [ ]</td>
</tr>
</tbody>
</table>

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**ABOUT THIS REPORT FROM MEDICARE**

**WHAT**
- This report presents information from the quality of care provided to Medicare beneficiaries by DHI physicians in 2005 to call the account that Medicare paid you and other Medicare providers for diabetes.
- This report is for informational purposes only. It will notify your Medicare selected quality of your participation in the Medicare Program.

**WHY**
- To enable you to compare the quality and cost of care Medicare beneficiaries and all Medicare beneficiaries.
- To highlight the quality and cost of care Medicare beneficiaries.
- To identify possible components of a payment modifier to the Affordable Care Act of 2009. The payment modifier will provide the differential payments to physicians in the Medicare fee-for-service program for the quality of care a patient received compared with care. This report begins to provide you with quality and cost that can be used in a future payment.

**WHO**
- Medicare is required by federal legislation to show the payment modifier in the Medicare Physician Fee-For-Service Program.
- Medicare is required to apply the payment modifier to all physicians and groups of physicians.

**WHAT YOU CAN DO**
- Consider the information in this report to help you identify clinical issues in which you are doing well and those areas that might need improvement.
- Share your thoughts about how to make these reports more meaningful and accurate. You can email CMS at CMS.MedicarePhysicianFeedback [xxxx] @xxxx [yyyy]. You can participate in one of the conferences that CMS has scheduled with report recipients.
- More information is available at [www.cms.hhs.gov/MedicareQualityofCare].
Medicare Is Evaluating Per Capita Costs of Patients “Whose Care YOU Directed” By Physician

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

“Quality is a Law Enforcement Issue.”
~Lewis Morris, Chief Counsel to the Inspector General HHS Ret.

Medicare Taking Lessons From Commercial Payers
Recovery Audit
Prepayment Review
Prepayment audit on 15 DRGs in 11 states (cardiology and orthopedics) – no payment for hospitals and ‘take back’ from physicians for unnecessary admissions!
- Starts August 27, 2012
FL, CA, MI, TX, NY, LA, IL PA, OH, NC, MO

June 21, 2012
A New Jersey System has agreed to pay $9 million to settle claims that they admitted Medicare patients into the hospital who should have been treated in less-expensive settings.

August 30, 2012
Feds Use Data-Mining Techniques: Notify Hospitals of Liability for Wrongly Implanted Heart Devices
Core Competency:

- Educate providers and implement a system to consistently produce exceptionally accurate clinical documentation
- Develop systems to standardize care and achieve top decile performance on current and future Value Based Purchasing Metrics

Predictions: 2012-2018
The Game Changer - The Ability to Cost-Shift Will Be Diminished

Note: Medicaid includes DSH

- Deductibles/co-pays
- Medicaid Expansion
- Exchanges
- Aging
- Premium Caps

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

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Health Plans Will Bring You to Tiers!

**Cost Per Episode**

<table>
<thead>
<tr>
<th>Episode or Procedure</th>
<th>10th %ile</th>
<th>Median</th>
<th>90th %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraine</td>
<td>$94</td>
<td>$397</td>
<td>$2,006</td>
</tr>
<tr>
<td>Stent</td>
<td>$16,092</td>
<td>$23,744</td>
<td>$36,487</td>
</tr>
<tr>
<td>Normal Delivery</td>
<td>$6,149</td>
<td>$8,549</td>
<td>$12,090</td>
</tr>
<tr>
<td>Cervical Fusion</td>
<td>$17,092</td>
<td>$26,227</td>
<td>$41,431</td>
</tr>
</tbody>
</table>

**BC Mass. Hospital Choice Cost Share Plan Benefit**

<table>
<thead>
<tr>
<th></th>
<th>Co-Payments as of 9/25/2010</th>
<th>With Hospital Choice Cost-Sharing Feature as of 1/1/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>$500</td>
<td>$1500</td>
</tr>
<tr>
<td>High Tech Radiology</td>
<td>$50</td>
<td>$500</td>
</tr>
</tbody>
</table>

Dear n8,

A hospital wanted a 20% increase. We said ‘no’ that our customers could not afford the resulting premium increase. They started a smear campaign. It backfired, we eventually settled after allowing them to experience being out of network for a month.

I contrast this with our recent deal with another major provider who is going all out with agreement to be our partner in the exchange, bundled payments, risk for quality outcomes, etc. This group will prosper…Those that can’t get over the old models will not.

President X-BCBS FOn8

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

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

Beginning of Time 2011

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Clearly Providers Must Reduce the Cost of Care

“The biggest problem in health care isn’t with insurance or politics…There is almost a complete lack of understanding of how much it costs to deliver patient care, much less how these costs compare with outcomes achieved…making matters worse, participants in the health system do not even agree on what they mean by costs.”


Core Competency:

- The ability to negotiate market rates and terms necessary to fund transformation and eventually share in savings:
  - Physicians: >130% of Medicare
  - Hospitals: > 150% of Medicare
- Implementation of a cost-accounting system that accurately measures, reports and benchmarks cost by episode, department, and provider
- Critical functions and systems are standardized, coordinated and controlled centrally. People are held accountable for achieving performance targets. Action plans are in developed to rapidly bring performance in line with established targets. Assets are rationalized
- Hospital-based physicians are held accountable for optimizing cost and value-based performance through routine measurement and oversight
The AAMC predicts a shortage of about 45,000 primary care physicians and 46,000 surgeons and medical specialists during the next decade.

Physicians Will Intensify Efforts to Stabilize Their Incomes

Illustration by James Lee
Predictions: 2012-2018
Current Physician Employment/Engagement Economics are Not Sustainable

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

1. Most health systems lack the competency to develop and operate an embedded, integrated medical group.

2. Most physicians lack the competency to behave as high value employees focusing on the overall success of the system.
March 28, 2012

Dear Acting Administrator Tavenner:

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

Core Competency:

- The ability to coalesce a collection of employed physicians into high functioning *truly integrated* medical group (vs. a collection virtual private practices.) This requires:
  - A physician leadership hierarchy
  - Sophisticated common infrastructure
  - Alignment with system goals and values
  - Operating at benchmark productivity and efficiency
  - Evolving physicians from "seeing patients" to leading patient care teams
  - Incentivizing providers with a blended compensation system rewarding individual and group performance—productivity, quality, service, citizenship
  - Single signature contracting
Managing Population Health

Independent Providers Commit to Participate in a Delivery System Designed to Consistently Improve Coordination, Quality and Cost of Care

**STEP 1: CLINICAL INTEGRATION**

- Provider-governed organization aligned with hospitals (requires rules of engagement)
- Demonstrate the ability to deliver **PREDICTABLE, MEASURABLY BETTER** clinical quality, safety, coordination, and efficiency **CONSISTANT WITH THE BEST SCIENCE IN MEDICINE**
- Significant investment in infrastructure including IT focused on clinical improvement, ($1-4 Million initial investment)
- Contracts with payers designed to compensate network participants for value created and achieved
- Able to function across a wide range of reimbursement modes, from fee-for-service to capitation
Clinically Integrated Network

Infrastrucure and Policies to Improve Clinical Performance

Single Signature Contracting

Full Continuum of Care

Hospital #1

Employed Medical Group

Specialists

PCP’s

Hospital #2

Specialists

PCP’s

Clinically Integrated Network Governance

SNF & Home Health

CI Physicians - Metrics

Average Length of Stay
APR-DRG, Severity, Hospital-Type Adjusted

CI Physicians – 3.71 Days
full standard deviation below predicted

Other Physicians – 5.26 Days
consistent with National Average

Patients discharged by CI physicians have a 29% lower length of stay than those treated by other physicians within the health system.

72,093 Patients Discharged
**CI Physicians - Metrics**

**Average Charges**  
APR-DRG, Severity, Hospital-Type Adjusted

CI Physicians - $23,430  
Other Physicians - $34,885

Patients discharged by CI physicians have total charges 33% lower than those treated by other physicians within the health system.

72,093 Patients Discharged

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**CI Physicians - Metrics**

**Complications of Condition**  
APR-DRG, Severity, Hospital-Type Adjusted

CI Physicians - 4.67%  
Other Physicians - 5.73%

Patients discharged by CI physicians have a rate of complications of condition that is 18% lower than those treated by other physicians within the health system.

72,093 Patients
You Cannot Innovate, if You Cannot Do the Basics

Market Share and Profitability

Urgency

NOW

Breakeven on Medicare
Optimize Current and Future VBP Performance e.g., Readmits Pat. Sat.
Transition Employed Physicians into an Integrated Medical Group
Design a Clinically Integrated Network
Profit from a Contract or JV with a Medicare Advantage or Private Plan

2012-2018

2018+

Medicare ACO (Population-based Payment)

Bundling (Acute Care Episode Demo)

Everett Clinic opts out of ACO Program

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R&D

Design a Clinically Integrated Network

NOW

Culture of Entitlement (Based on Tradition)

Accountability (Based on Results “Value”)

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

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

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Hospital-Physician Culture: “Fellow Citizens” or UN

“A more perfect union.”

“Protect individual rights and self-determination.”

© Kaufman Strategic Advisors, LLC

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JERKS

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Core Competency:

- Engage physicians in all aspects of patient care and hospital operations – practice radical transparency:
  - Create a physician cabinet
  - Appoint a majority of physicians to the Board’s Quality Committee
  - Consider dyads for key ‘care-lines’
  - Select physicians to lead clinical redesign initiatives

Some Physicians and Hospitals Just Don’t Get IT

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

(Dr. Marc Siegel, 12/20 Fox News)
Some Physicians and Hospitals Are Un-Engageable

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

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

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

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

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The person who says something is impossible shouldn’t interrupt the people who are doing it!

MUST Reads

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Six Practical Steps to a Soft Landing

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

Good Luck and Thank you!

“no Fear, no Envy, no Meanness.” — Bob Dylan

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

We can no longer tolerate a healthcare industry that markets non-existent excellence, fraught with kickbacks… that allows clinicians to use outdated treatments and/or perform surgery even when they lack adequate training.

Dr. Marty Makary, Johns Hopkins Pancreatic Cancer Surgeon, Author of Unaccountable
### Rate Your System's Readiness (1-poor, 2-fair, 3-average, 4-good, 5-excellent)  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>1.</strong></td>
<td>The strategic plan defines the essential competencies for future success and is based on an objective assessment of both the market and existing local competencies. Challenges are clearly defined. Strategies focus on adding value for patients, are ROI-based, and are expected to measurably improve quality, market share and profitability.</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Governance structure provides role clarity and avoids historical provincial allegiances. The trustees and system leadership support the system's strategic plan which delineates a clearly defined unified direction, regardless of institutional inertia or resistance.</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Critical functions and systems are standardized, coordinated and controlled centrally. People are held accountable for achieving targets. Critical performance metrics are routinely measured and reported. When necessary, action plans are developed to rapidly bring performance in line with established targets. Assets are rationalized.</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>The board, management and medical staff differentiate between valid strategic issues and 'noise' or the latest fad and they possess the competency to respond to unforeseen challenges quickly and effectively.</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>There is an organized approach to engage physician leaders in planning, execution and conflict resolution.</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>Multi-year projections are based on conservative assumptions of reimbursement, volumes and expense growth.</td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td>An expense reduction plan is in place, focusing on standardization and elimination of waste using a proven redesign method. There is a process to eliminate unnecessary duplication of services in multiple sites.</td>
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<tr>
<td><strong>8.</strong></td>
<td>Clear accountability is assigned for MANAGING and optimizing the performance of hospital-based physicians and medical directors.</td>
</tr>
<tr>
<td><strong>9.</strong></td>
<td>A third party, objective performance assessment has been completed and implementation plans are in place for optimizing critical functions: e.g., revenue cycle, clinical documentation, IT, cost accounting, reporting on quality/outcomes, clinical integration, capital allocation, employed physician practices and performance of key services, e.g., ED, ICU, hospitalist, surgery, radiology, etc.</td>
</tr>
<tr>
<td><strong>10.</strong></td>
<td>A process is underway to develop a digitally connected network of physicians committed to delivering efficient-predictable-evidence-based-coordinated care and share in payer savings –starting with system employees.</td>
</tr>
<tr>
<td><strong>11.</strong></td>
<td>The hospital is able to negotiate commercial reimbursement rates in excess of 145% of Medicare for institutional services and 130% of Medicare for its employed/clinically integrated physicians.</td>
</tr>
<tr>
<td><strong>12.</strong></td>
<td>The system places a heavy emphasis on &quot;who&quot; vs. &quot;what&quot; decisions. That is, recruitment self-motivated leaders who share the system's core values and will focus on 'the cause,' (not themselves,) inspiring others through their actions.</td>
</tr>
<tr>
<td><strong>13.</strong></td>
<td>The employed physicians are coalescing into a medical group vs. a virtual collection of private practices. Practice performance is benchmarked and reported. Compensation is based on individual and group and/or system performance. There is significant focus on maximizing the use of Mid-level providers.</td>
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</tbody>
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