Integration vs. Competition: The Future of Hospital-Physician Relations

Presented by:
Daniel Zismer, PhD
Dr. Zismer is an associate professor of health policy and management and chair of the MHA and Executive Studies Programs in healthcare administration, University of Minnesota. He also serves on the board of a national, privately held healthcare real estate development firm. His area of concentration for teaching, research and advising is the design, strategy and performance of integrated health systems.
American College of Healthcare Executives
Disclosure of Relevant Financial Relationships
By Faculty and Planners of Continuing Education Activities

It is the policy of the American College of Healthcare Executives (ACHE) to ensure balance, independence, objectivity and scientific rigor in all of its directly sponsored or jointly sponsored Continuing Education (CE) activities. The intention of this policy is to identify potential conflicts of interest, facilitate resolution according to protocols, and ensure that disclosure is provided to participants prior to the beginning of the activity so that learners may formulate their own judgments as to the objectivity of the activity. Failure to disclose is grounds for dismissal as a faculty member or planner.

All individuals in a position to influence and/or control the content of ACHE directly and jointly sponsored CE activities must disclose to ACHE and subsequently to learners that the individual has either no relevant financial relationships or the nature of the financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in the CE activities.

Conflict of Interest: Circumstances create a conflict of interest when an individual has received financial benefits in any amount from a commercial interest within the past 12 months and that individual is in a position to affect the content of CE regarding products or services of commercial interest.

Commercial Interest: A commercial interest is considered any entity producing, marketing, re-selling, or distributing goods or services.

Financial Relationships: A financial interest is established by payments for various activities to the individual, the individual’s spouse or partner by proprietary companies related to the content of a CE program. Examples of payments that constitute financial interests include grants or research support, employment, consultation, speaking or teaching activities, or royalties for companies. Financial interest also includes owning stock or options in any amount in these types of companies.

Name: Daniel K. Zismer, PhD
Program Title: Integration vs. Competition: The Future of Hospital-Physician Relations
Relationship:

Do you or any immediate family member have a financial relationship or interest (currently or within the past 12 months) with a proprietary entity?

If Yes, please indicate the individual, organization and the nature of the financial relationship below.

Do you intend to discuss an unapproved/investigative use of a commercial product/device? If yes, please disclosure such references to the learner in the educational activity.

I will adhere to the ACHE policy on Conflict of Interest Disclosure. I will uphold the ACHE standard to insure that balance, independence, objectivity and scientific rigor are maintained in the planning and presentation of this CE activity.

___________________________    _______________________
Signature                      Date

Daniel K. Zismer, Ph.D.,
Associate Professor and Director,
MHA and Executive Studies Program
Division of Health Policy and Management,
School of Public Health, University of Minnesota
Associate Adjunct Professor
Division of Medicine

Introduction

Beginning With a Definition: The Prelude to the Course

For purposes of this course, an Integrated health System (IHS) is one that employs most, if not all, providers required to meet mission, strategic, clinical models, operational and economic, and financial performance needs.

Note: Integrated models function well at varying sizes and are reasonably scalable at varying sizes
Practice operating expense inflation rates exceeding "per-unit" reimbursement rates
Practice revenues vulnerable to payer and policy changes
Practice re-capitalization costs; e.g., IT, EHR, facilities
Provider compensation inflation rates; esp. competition from health systems
Out-dated Practice buy-in/buy-out plans
Inability to contract for financial risk
Life-style demands of "new" physicians

Legal/regulatory pressures on arrangements with independent physicians
Inefficiencies of competition with the "medical staff"
Unaligned financial/economic incentives (unaligned with independent physicians)
Shifts in inpatient services delivery
Ability of the private practice model to recruit and retain
Growing need to contract for financial risk
Demand for common I.T. platforms

Independent Physicians
Integrated Health System
Community Hospital

Integration: A Markets-Driven Dynamic

Integrated Community Health System
Integrated Health System Design

Support Systems:
- Business Office
- Finance
- H.R.
- L.T.
- Facilities
- Marketing
- Legal
- Risk Management

Inpatient Services
Co-Managed Services
Ambulatory Sites (Including M.O.B.s)
Co-Managed Services
Medical Practice (or Divisions)

Board/Committees/Leadership
Senior Leadership Team
CEO
IHS: Board

49% Physicians and CEO
51% Qualified "community members" Reserved Rights

1. Accelerating demands for capital, coupled with advancing “capital consumption” rates; the rates at which health systems must invest to achieve strategic objectives in competitive and pressured markets.

What Should Health System Leaders Pay Attention To? Continued…

2. Mounting vulnerability and fragility of the independent medical practice business models (and the related “affiliated” medical staff models)

3. Waning interest of physicians emerging from practice in “private practice” medicine
What Should Health System Leaders Pay Attention To? Continued…

4. Capital markets and future requirements to “access capital” (what the credit markets will expect)
5. Larger, well-capitalized, integrated health systems pursuing third party payer risk as a principal market strategy (including governmental payer risk).

6. Demands for sophisticated electronic platforms underpinning care models and methods (e.g. regional, unified EMR and E-care platforms).
7. Need to rationalize clinical programming to size and scale operating efficiencies
8. Demands by markets for regional reach of coordinated and integrated clinical service line capabilities (see clinical service line section)
What types of Integration Should be Expected by Providers and What are the Implications of The Models Pursued

Learning Module #1: The Nature of the Integrated Model; Management and Leverage of a New Potential

- The nature of the model allows for control of all the factors (“moving parts”) that create the revenue and operating expense structures for the IHS.

- The principal differentiating characteristic is the provider employment model. The IHS is not dependent upon an independent “affiliated” medical staff model (It’s not a “virtual” model).
Learning Module #1 Continued…

• The IHS design and model affords leadership, an operational, financial and clinical model “potential” that is not inherent with or available to the more traditional not-for-profit, community healthcare delivery designs; the independent hospital/independent, affiliated medical staff model.

(The concept of “leverage” is central to the functionality of the model)
A principal advantage of the model for executives and managers is “what they aren’t concerned with”; competing independent physicians on the medical staff, competitors “buying” key physicians, multiple electronically “disconnected” providers treating patients, and uncoordinated payer contracting strategies.

The governance model, by design, connects board members with organizational strategy and operations to enhanced levels, by comparison with the more traditional community health system delivery models, due primarily to the composition of the board; i.e. up to 49% of the board (typically) composed from physicians employed by the IHS (physician leaders and members of the physician enterprise rank and file).
Learning Module #1 Continued…

• The physician enterprise is the key performance “flywheel” of the IHS design, the effective physician enterprise is organized as a multi-specialty group practice (or equivalent) with a physician-led leadership structure that manages the potential of this enterprise.

Learning Module #1 Continued…

• The nature of the revenue structure of the IHS is characteristically unique and important to the potential of the design:
  ▪ In excess of 50% of net operating revenues are generated in the outpatient settings, including provider professional services;
  ▪ Less than 30% of net operating revenues are generated from inpatient care;
  ▪ The more profitable areas of IHS revenue productivity are, typically, outpatient technical services.
Learning Module #1 Continued…

- Upwards of 60% of all net operating revenues and fixed asset allocations are in the outpatient service arenas.
- While primary care physicians are critical to the economic and financial performance success of all IHS’, primary care physicians are likely to comprise somewhat less than 40% of the total physician full time equivalent proportion of the larger, more clinically sophisticated IHS design.

Learning Module #1 Continued…

- Physicians within the IHS are employees paid for their efforts by the IHS. Physicians compensation (wages and benefits) are a significant component of the IHS operating expense structure, and may be the most “leverageable” component of the operating expense structure.
- Principles of Compensation are as important component of the IHS’ management strategy.
Learning Module #1 Continued…

• The provider component of the IHS operations structure includes physicians and other licensed clinical service providers (physician extenders). The most effective IHS provider service designs fully leverage the potential of the “clinical team” across specialties; i.e. teams of specialty physician and specialty-trained physician extenders, up to a 1:1 ratio.

Learning Module #1 Continued…

• High-functioning IHS’ fully leverage the potential of clinical teams. This leverage is realized across primary care and specialty services.
• High-functioning IHS’ fully open “front doors” to the system; primary care and specialty clinical services that lend-well to direct access by patients; e.g.

- Family Medicine
- Urgent Care
- Women’s Services
- Emergency Services
- Pediatric’s
- General Internal Medicine
- Orthopaedics
- Spine Care
- Behavioral Health

• Requiring all patients to access the IHS through primary care, creates demand management challenges; i.e. problem with patient services “velocity”.

• Primary Care Models are leveraged to levels where patient panel sizes may exceed the typical by 2-3 times (primary care physician-led teams, including 2-3 physician extenders).
Learning Module #1 Continued…

• Specialty Care Models are leveraged as well. Specialties with the greater potential for leverage are cardiology, orthopaedics, and OB/GYN (women’s services).

Learning Module #1 Continued…

• The medical enterprise within the IHS requires special consideration for sizing and balance; i.e. the right number of physicians (and other providers) overall with the right proportion of clinical specialties, including sub specialization within specialties. Proper sizing and balance manages access-to-care performance. Managing inter-specialty care access is a key success characteristic.
Learning Module #2: Key Characteristics of the IHS Model and Principles of Management

Key Characteristics:

1) The larger, more developmentally mature IHS’ are principally an outpatient services business.
2) Integrated physicians, by design, are not competitive with each other or the health system

Learning Module #2 Continued…

3) The IHS is composed of a portfolio of businesses (clinical service lines) that are variously exposed to: clinical innovations, competitive threats, payer reimbursement changes, and human resources supply dynamics.
4) Physicians are integrated at all levels of governance, leadership and management. Some reasonable proportion of physician capacity is allocated to leadership and management roles within the IHS and these physicians are compensated for allocated time.
5) “Physician productivity” is defined more broadly; beyond the production of patient services “units” and billable services to include their ability to expand the productivity of the clinical model to effectively manage clinical quality, services access, operating economics and financial performance for the IHS overall.

Principles of Management for the IHS

1. The IHS is “closed economy”. The more mature, well-developed and high-functioning control all the “moving parts” and employ most, if not all, physicians (and providers) required to meet mission requirements, strategic plans, operating economic models and financial performance expectations.
The “closed economy” (and related leverage potential) characteristic is the prominent differentiator and greatest source of operating economic and financial leverage. This characteristic allows for the ability to predictably and reliably size and balance the providers roster for the organization; i.e. the IHS is not dependent upon the vagaries of the independent practice, medical staff “affiliation” model for the delivery of physicians and other licensed providers.

2. The provider (physician’s especially) is the “economic flywheel” of the model. Providers regulate the operating flow and economics of the model (operating revenue and operating expense structures and ratios).

The common production metric of the provider is the work relative value unit (wrvu). The wrvu drives other clinical service units and operating revenues for the IHS. It is a uniform approach to the quantification and management of a physician “unit of effort”.

Principles of Management, Continued…
Provider productivity can slow-down or speed-up overall economics and financial performance for the IHS. There is a high-correlation between provider work effort and all other “production” within the model.

Management of referral access between clinical specialties is a key performance factor and tactic of the model.

Principles of Management, Continued…

3. Leverage of the Provider Model: The nature of the IHS design (including the ability to control the internal provider compensation model) allows for optimal leverage of the provider services model with the use of physician extenders. Provider leverage is optimized “by design” within the IHS.
Principles of Management, Continued…

- Primary care models leveraging up to 7500 patients per panel (with the application of team, EMR, evidence-based clinical best practices)
- Specialties leveraging physician extenders effectively; e.g. orthopaedics, cardiology, urology, women’s services, pediatrics (prime candidates for specialty leverage)

4. Managing the “Front Door”: Ensuring the IHS provides optimal ease of access at key points of access:

  - Primary care;
  - Urgent care (specialized urgent care services with identified facilities) – not, simply, after-hours services for established patients;
Direct access to key, strategic specialty services; orthopaedics, pediatrics.
Efficient emergency services including 23 hour observation
Hospitalists

Principles of Management, Continued...

5. Managing “Leakage” of Referrals: The nature of the design and the model requires appropriate retention of clinical referrals with the IHS.

The success of the economics of the IHS model is “levered” to optimal management of referral leakage (conversely, “keepage”)
Access Management Tactics:

- Proper sizing of the provider staff (with proportionality of specialties maintained);
- Appointment and access standards;
- Ongoing monitoring of referring physician satisfaction;
- Ongoing monitoring of patient satisfaction (with access, quality and value measured);
- Ongoing monitoring of out-referrals (reasons, referral sources and estimated value and cost to the IHS).
6. Provider Compensation Plan:

- Aligns incentives of providers with IHS and strategy;
- Defines “productivity broadly”
- More than one model may be applied:
  - Salary/bonus-based for primary care rewarding effectiveness of “the team”
  - Productivity-based (e.g. wrvu-based) for procedural specialties
  - Compensation design for providers is an ongoing process

Note: Inflation rate of provider compensation operating expense line managed with effective creation of “leverage”; applying provider potential to the “Top of the License”. High-functioning IHS’ manage the aggregate provider cost inflation rate aggressively
7. Capital Efficiency: IHS will consume capital at an accelerating rate:
   - I.T. (e.g. EMR and system “connectivity”)
   - Larger, more sophisticated and innovative ambulatory centers
   - Clinical technologies
   - Specialized “bed towers”

Principles of Management, Continued…

- Capital consumption rates will include “compressed depreciation curves” (compressed useful lives). The integrated model allows for more efficient approaches to capital development, capital scheduling, and capital turnover rate management (more efficient and effective revenue productivity generated from a depreciating fixed asset base)
Principles of Management, Continued…

- The IHS minimizes (or eliminates) physicians as competitors, which tends to increase the efficiencies available from the fixed asset base.

Principles of Management, Continued…

- IHS’ will tend to apply alternative capital financing methods to enhance access to affordable capital and to produce capital asset flexibilities that are not available from more traditional capital asset financing methods (e.g. tax-exempt debt) (see collateral materials)
Principles of Management, Continued…

8. Ambulatory Strategies are optimized (including geographically):
   - 55% + of total revenues earned in outpatient settings
   - Geographic dispersion at ambulatory services and programming
   - Larger more clinically-sophisticated facilities developed as “destination” strategies
   - A “retail” perspective on service offerings; including alternative health service offerings

Principles of Management, Continued…

- Spas, recreational and rehab services
- Facilities are “branded” with the IHS name
- Clinical service line programming extends through and across all facilities

(See collateral materials for examples)
9. The Clinical Service Line: More traditionally organized and managed community health systems will accord “clinical autonomy” to organizations owned and controlled by the IHS. Clinical programs differ by site.

- Multi-site IHS are converting clinical programming strategies; converting from “site autonomy” to unified clinical service lines extending uniformly across sites; inpatient → outpatient → home → E-Care offerings → video connections
IHS physician leaders develop and deliver evidence-based, best practices across sites leveraging the capabilities of the integrated medical enterprise.

Patients can enter clinical programs through many “front doors” within the IHS (across sites) and expect and receive a uniform clinical and patient experience.

Care efficacy and efficiency is enhanced by the availability of the EMR.

Patients connect through on-line, clinical service line support systems.

Clinical service lines track, monitor and evaluate care effectiveness and efficiency with the aid of a unique, clinical service line balanced scorecard.

Care standards and process variation is minimized through the interaction of providers and dyad-partner managers across sites. (see collateral information on the “dyadic” management model).

A unified “brand strategy” underpins clinical service line market positioning; a clear “brand promise”.

Principles of Management, Continued…
10. Pursuing Payer Risk: IHS' are best positioned to pursue market share expansion opportunities through innovative third party payer contracting models (including with governmental payers).
- Payer strategies include the transfer of risk from the payer to the IHS in multiple forms (capitation, bundled payments, episodes of care, etc.)

Principles of Management, Continued…

- Multiple payer contracts (and types) are treated as “revenue streams” (all contracts make up “The Whole”).
- Care methods and models are not modified or altered by payer; evidence-based best practices underpin all payer strategies.
- Payer contracts are, by design, time-limited. An advantage of the IHS model is contracting flexibility.
Summary

- Ten principles underpin all IHS strategic plans
- Principles convert to organizational behavior (actions), which convert to strategy, operations and outcomes, which convert to market advantages

Learning Module #3: The Anatomy of the Operating Economics, Finance and Financial Performance Analysis of the IHS

- Two principal components of the Economic/Financial Model, are the hospital(s) and clinics. Operating economic financial performance models and metrics differ markedly. IHS performance should be evaluated on a consolidated basis. These two principal components are managed separately, and together.
Learning Module #3 Continued…

• An important management decision in the model is the placement/positioning and accounting of key financial performance drivers (e.g. placement and positioning of outpatient ancillary diagnostics and therapeutics).


Learning Module #3 Continued…

• Critics of the model will argue that “employed physicians lose money” for IHS. This conclusion is typically driven by the “architecture of the accounting”; i.e. where and how revenues and expenses are accounted within the IHS accounting architecture.

(see examples)
Learning Module #3 Continued…

• Revenue sources (especially outpatient services) are frequently “located” under a hospital license for purposes of revenue enhancement made available by “Provider Based Billings”. Revenue potential is enhanced, but the “architecture of the accounting” must be manipulated (by design).

Common unproductive attitude: “If the service was provided in the hospital, the revenue does not belong to the physicians.”

Learning Module #3 Continued…

• Operating revenue breakdown of IHS favors outpatient services categories; e.g.
  ▪ 26% inpatient
  ▪ 25% outpatient ancillaries
  ▪ 12% professional fees (inpatient)
  ▪ 13% professional fees (outpatient)
  ▪ 12% pharmacy
  ▪ 12% other
Learning Module #3 Continued…

- What is notable about the “clinic” side of the economics and finances of the IHS (the assumption is the IHS employs most, if not all, licensed providers required).
  - The tracked, accounted, evaluated and managed unit of productivity is the work relative value unit (wrvu). Metrics related to performance evaluations are driven from the wrvu; as a “function” of the wrvu. Examples (from larger IHS’):

- Ave. annualized wrvu’s per phys Provider = 4750
- Net patient revenue per wrvu (clinic) = $136
- Salaries and Benefits per wrvu = $104
- Provider Salaries per wrvu = $51
- Staff salaries per wrvu = $30
- Ancillary revenue as % of Prod. Rev. = 30%
- Net operating revenue per wrvu overall = $500!

(when all IHS Revenue considered as a function of the wrvu)
Learning Module #3 Continued…

- Related Operating Metrics
  - Support staff FTE per Prov. FTE = 2.90
  - % of net operating revenues (clinics)
    - Salary and Benefits = 76% (all)
    - Prov. Salaries = 38%
    - Support Staff Salaries = 22%
    - Supplies and drugs = 7%

Learning Module #3 Continued…

- The “Clinics” (medical enterprise) may operate at a negative margin of 8-10% depending upon size, physician productivity and specialty mix and balance.

  But the wrvu drives the economics of the IHS outside the accounting architecture of the medical enterprise
Learning Module #3 Continued…

- When revenues and expenses of the hospital(s) and medical enterprise are consolidated, major operating expense categories as a percentage of net operating revenue yield predictable results:
  - Total people costs = 60-62%
  - Supplies = 14-16%
  - Cost of capital = 6-7%

It is a "People Business"!

Learning Module #3 Continued…

- The provider base of the IHS is the "economic flywheel",
  - With each wrvu produced by licensed providers, related clinical services are produced to generate total net operating revenues
  - The revenue leverage realized on the blended, average wrvu produced is affected by the physician/provider specialty mix, wrvu productivity of the physicians, in the aggregate, and the range of clinical services owned by the IHS.

A key economic metric to be tracked and evaluated is the aggregate value of the blended wrvu produced within the IHS.
Learning Module #4: Understanding the Quality of the “Earnings” and the Connections to Organizational Strategy, Operations and Resource Investment

Underlying Assumptions:

1) Earnings for the IHS (i.e. net operating margins –profits) can meet or exceed IHS targets, but the “quality” of the earnings achieved can differ markedly based upon a range of underlying circumstances.

Learning Module #4 Continued…

2) Earnings (and revenues) are vulnerable to a range of “lightning strikes”; externalities that are unexpected and swift to affect net earnings (operating margin) performance. Leaders/managers must learn to identify and assess these vulnerabilities.

The can be related to: health policy changes, changes in reimbursements by payers, clinical innovation shifts.
Learning Module #4 Continued…

Areas for Net Operating Margin Analysis (related in a question format)

1) Is the organization over-emphasizing certain revenue types or clinical services, causing economics that are contributing to an “unhealthy” proportion of the bottom-line? The problem is the bottom-line being overly-sensitive to one or a few clinical services or programs that are vulnerable to one or a few payers negatively affecting price (reimbursements).

2) Is the organization cost-cutting it’s way to profitability?
3) Might impending clinical innovations negatively affect profitability in one or several programming areas?
4) Is inflation in key operating expense areas being overly suppressed (e.g. salaries and wages) putting the organization at-risk?
5) Is the organization under-spending on capital assets (replacement capital and strategic capital spending)?
Learning Module #4 Continued…

6) Might pricing strategies (e.g. pricing power) cause key customers (payers) to seek alternatives and shift business to competitors?

7) Is the organization ignoring obvious market pressures to change clinical models and methods in order to “milk cash cows”?

Learning Module #5: The Design and Function of The Medical Enterprise within the IHS Creates the Aggregate Effect of the Physician as the Economic Flywheel within the IHS

What is a “Flywheel”?: A heavy wheel attached to machinery to keep the speed of the machinery even (regulated).
Underlying Assumptions:

1) If the physician/provider is the “economic flywheel” of the IHS, proper aggregation, organization and leadership of the medical enterprise within the IHS is a cornerstone of the strategic, operational and financial performance of the IHS overall.

2) Medical enterprise design and operation, and leadership is fundamental to its success.

3) The “leverage” achieved within the design is translated directly to IHS performance overall.

4) The definition of “provider productivity” is broadened, recognizing the value of providers working together with managers to enhance organizational performance.
• The nature of the medical enterprise design

1) The unified, multispecialty medical group practice: a single, integrated group practice “housing” all clinical specialties and required providers within specialties (see diagram)

2) The divisional model: The IHS houses multiple controlled medical practices (housed within controlled corporate subsidiaries or controlled divisions of hospitals controlled as corporate entities) (see diagram)
Learning Module #5 Continued…

- Both models share structural, leadership and operational characteristics:
  1) There is a single physician service leader (physician overseeing performance of the medical enterprise)
Learning Module #5 Continued…

2) Physicians serve within structured leadership roles; governance of the IHS, operational leadership of the medical enterprise (the multispecialty group or operating committees overseeing each diversion-controlled entity) as leaders of clinical divisions and/or department, or co-managers of clinical service lines that extend across sites within the HIS

(see diagram)

Learning Module #5 Continued…

3) Providers within the medical enterprise are responsible for
   a) The sizing and balance of the full provider contingent
   b) Productivity of the physicians as individuals and clinical service line “units”
   c) The development, implementation of evidence-based, clinical best practices
   d) Peer recruiting and hiring
   e) Peer review and performance evaluation
   f) peer disciplinary actions
Learning Module #5 Continued…

g) Ongoing review, evaluation and administration of the approved, provider compensation plan
h) Evaluation of clinical outcomes (effectiveness and efficiency)
i) Performance on access standards and processes
j) Maintenance of balance scorecards for clinical divisions and departments
k) Ongoing development of clinicians as leader
l) Innovation of care team and related care leverage models
m) Longer-term care model innovation and planning, including clinical technology planning

Learning Module #5 Continued…

The “Dyadic Model” as Medical Enterprise Design Characteristic and Management Tool (see diagram and collateral materials)

- A management model design that links particularly well within the HIS
- Pairs an administrative partner with a physician leader
The Dyadic Management Model for the Integrated, Community Health System

**Physician Co-Manager**
- Quality of the Clinical Professionals and work
- Provider Behaviors
- Provider Production
- Clinical Innovation
- Compliance
- Patient Care Standards
- Clinical Pathway/Model Management
- Referring Physician Relations
- Provider "Leverage"

**Administrative Co-Manager**
- Mission
- Vision
- Values
- Culture
- Overall Performance
- Internal Org. Relationships
- Strategy
- Operations
- Revenue Management
- Operating Expense Management
- Capital Planning and Application
- Staffing Models
- Performance Reporting
- Supply Chain
- Support Systems and Services

---

**Learning Module #5 Continued…**

- Dyad shares responsibility for performance of:
  - Quality
  - Patient satisfaction
  - Access
  - Referring physician satisfaction
  - Operating and budget performance
  - Capital asset efficiency
  - Provider recruiting and retention
  - Relationship with other clinical departments and support service
Learning Module #5 Continued…

- Important to note that with the Dyad Management Model, two people ARE NOT doing the same job.

Learning Module #6: Governance of the IHS

- IHS structural designs are typically more complex. They tend to resemble “holding companies”; i.e. multiple operating entities controlled by a unified (and sometimes incorporated) board.
Learning Module #6 Continued…

- IHS boards retain all fiduciary responsibilities and reserved corporate rights; e.g.
  - Hire/fire CEO
  - Bonding authority
  - Strategic, business and financial plan
  - Capital allocation methods
  - Buy, sell, merge, joint venture assets
  - Quality, safety, risk management plan
  - Selection and oversight of legal counsel and outside audit
  - Delegation of authorities to boards of controlled entities

Learning Module #6 Continued…

- IHS' with Regional (or multi-state) Regional reach are undergoing vision and strategic "conversions" reining-in control by local "hospital boards". If local boards exist, authorities are limited.
- Board composition of IHS’ differ from the “traditional” community hospital board (see collateral materials).
Learning Module #6 Continued…

- IHS boards (because of their nature and design) are more involved in policy AND operations than the conventional/traditional community health system boards.
- Board management is the responsibility of the CEO/Board Chair “partnership”. The high functioning boards exploit the discipline of the strategy map and balanced scorecard (see example).

Learning Module #6 Continued…

- A principal objective of the IHS board is to create a “learning organization” (see collateral materials).
- IHS Boards need to appreciate the full potential of the model.
- Structural options are important (see collateral materials) but a new perspective on principles of IHS governance are important.
Learning Module #7: The Psychology of The IHS Organizational Design

- Psychology Affects Culture and Culture Matters!

Learning Module #7  Continued…

Applications of the Fundamentals of Social Learning Theory (SLT)

- By definition the nature of the IHS model restricts and constrains personal and professional freedoms and prerogatives
- Physicians (as with other high-achievers) will resist external controls (they tend to be more internally controlled)
Learning Module #7  Continued...

- Behavior is a function of expectations (the ability to control or influence) for rewards that are valued
- Change expectations for control and/or reward value(s) and behavior changes

\[ Bf \quad Ex \quad + \quad Rv \]

(control)          (reward value)
Learning Module #7  Continued…

- Don’t underestimate the power of perceived control in IHS Design and Operations
- Physicians need to be engaged as Partners
- All must recognize that the model is not “virtual” – all are committed
- Physicians are deployed at four levels, governance, senior leadership, leadership of the medical enterprise, co-leadership of clinical service lines

Learning Module #7  Continued…

- No independent physicians in governance
- A single, unifying employment agreement
- A unifying compensation plan
- Independent Physicians not treated equally (treated equitably)
Learning Module #7  Continued…

- “Data” Transparency
- Physicians Manage Physicians
- IHS invests in physician leadership development
- IHS invests in Unified Brand
- Can’t “Lose Money” on Physicians

Learning Module #7  Continued…

- Productivity defined, evaluated and appreciated from a broader perspective
- Financial performance evaluated from a consolidated perspective
Learning Module #8: Applying Forensics to Financial, Strategic and Operating Economics Problem Identification and Resolution for the Integrated Model – Optimizing the Potential

(Making connections between organizational design, operations, operating economics and strategy, and strategic performance)

Purpose of the Next Section

Learning to Create Productive Forensic Discussions - Going Beyond the Obvious with a Problem Solving Approach. The Model:

Problem Identification
Problem Definition
Problem Investigation (the data)
Problem Explanation; Discussion and Debate
Problem Resolution Set Opportunities
Problem Resolution Action Decisions and Sequencing
Problem Resolution Evaluation Methods and Reporting

Case Vignette Format to Follow
IHS Learning Lesson’s:
Case Vignette #1: The Under-Sized Clinical Specialty – A Threat to the “Closed Economy”

- A sufficiently – sized primary care network (PCN) exists
- PCN referrals are dedicated to the IHS (i.e. primary care physicians prefer to refer “inside”)
- A 30 physician cardiology group is required

Case Vignette #1  Continued…

- The cardiology group is “down five FTE’s” (under-weighted in electrophysiology and interventional cardiology)
- At full capacity, each cardiologist is “worth” $5 million in net operating revenues (on average)
- The IHS may be foregoing $25 mill in net operating revenue and contribution margin of $6-7 million
Case Vignette #1 Continued…

- Aggregate wrvu productivity for active cardiologists is running at maximal levels (their compensation is also at the high-end of the expected budget and industry norms)
- The cardiologist department utilizes 4 nurse practitioners with a focus on the preventive cardiology clinic and the pacemaker follow-up clinic

IHS Learning Lesson’s: Case Vignette #2: Mis-alignment of Primary Care Compensation Plan

- Primary Care Network (PCN) is the principal “front door” of a developing IHS
- The PCN is under-sized by 20% (there are 50 physicians)
  - Six physician extenders are employed
Case Vignette #2  Continued…

- Characteristics of the PCN compensation plan are:
  - Physicians at-risk for payer contractual discounts, including governmental payers;
  - Physicians at-risk for collections on patient accounts;
  - Physicians at-risk for direct operating expenses of their practice;
  - Physicians at-risk for visit co-pays.

Case Vignette #2  Continued…

- PCP’s doing very well under the compensation plan (85ith%)
- Net operating revenue growth for the IHS decelerating
- Earnings are beginning to under-perform
- Specialists complaining of referral flow flattening
- Inpatient volumes flattening as well
IHS Learning Lesson’s:
Case Vignette #3: Compensation Design and Specialty Services (Cardiology)

- Physicians were hired individually
- Compensation plan is wrvu-based
- wrvu value is equal for all cardiologist ($50)
- Each physicians has his or her dedicated nurse
- Cash compensation plan for each physician is calculated as wrvu multiplied by wrvu value

Case Vignette #3  Continued…

- Physicians have “their own practice” and patient base
- Annual cash compensation (for cardiologist) ranges from $300,000 to $850,000
- Problems emerging
  - Aggregate wrvu’s exceeding budget
  - Direct operating expenses of the practice exceeding budget
  - Cardiac surgeries trending below plan
Case Vignette #3 Continued…

- PCP’s complaining of cardiologists “hanging on to patients too long
- Inpatient and procedural production is flat with excess capacity
- Supply costs exceeding budget by 18%
- Cardiologists complaining of internal compensation plan inequities

IHS Learning Lesson’s:
Case Vignette #4: Utilization of the Capital Asset Base – Capital Inefficiency and Orthopaedics

- 60% of all surgeries are ambulatory and by all indicators this service is operating at-budget and with efficiency
- Concern is with more complex in-patient surgical admissions
Case Vignette #4  Continued…

- While there is some sub-specialization, a number of the surgeons are “general orthopaedists” with varying preferences on procedure methods and implants (hips and knees, especially)
- Each surgeon has a preferred surgical team
- Patients are admitted and operated based upon the schedule of the surgeon (including days off and vacations)

Case Vignette #4  Continued…

- The IHS does not operate “joint camps”
- Operating room and bed turn-over rates expectations
- Hospital-focused specialty physicians concerned with maintaining efficiencies (staying close to the hospital)
IHS Learning Lesson’s:  
Case Vignette #5: Balancing Growth and Earning’s Performance

- Earnings (net operating margin) on plan in absolute terms
- Net operating margin slightly under plan (2.7% and not 3.1% at this point in fiscal year performance)
- Management expects volume pressures and decreasing operating revenues for next two quarters

Case Vignette #5 Continued…

- Twelve new physicians recruited (2 general surgeons, 3 hospitalists, 4 primary care, 1 infectious disease and 2 endocrinology)
- Concern is net operating revenue growth with eroding net operating margin
Case Vignette #5  Continued…

- Leaders recognize need to manage next phase of growth
- “Balance” of physicians may be of concern (not sure)
- “Profitability” of new recruits in question

IHS Learning Lesson’s:
Case Vignette #6: “Cost Cutting to Profitability”

- Board pressures management for improved earnings to prepare for next debt issuance (at advice of investment bankers)
- Hiring slows (especially new physicians)
- Wage increases limited to 2.2% across the board
- Capital spending frozen
Case Vignette #6 Continued…

- Supplies management is aggressive
- Nursing ratios at “The bed side” held to contract minimums (collective bargaining agreement minimums)
- Net operating margin for next quarter projected at 4.2% (20% above previous quarter)

117

IHS Learning Lesson’s:
Case Vignette #7: Exploiting Pricing Power

- IHS enjoys favorable market share position in metro suburb with favorable socio-economic characteristic's
- Well-distributed PCN
- Patient satisfaction is favorable
- Other high-quality IHS competitors in the market

118
Case Vignette #7  Continued…

- IHS viewed as being “high cost” based upon leaderships strategy of leveraging price
- Cardiology, orthopaedics, GI and Urology under-sized (with physicians) but all are highly productive (high wrvu activity)
- PCN concerned with access to specialty services

Case Vignette #7  Continued…

- Operating revenues on the increase, earnings on the decline
- EMR implementation scheduled for latter-half of the fiscal year
IHS Learning Lesson’s:
Case Vignette #8: Debt Suppressing Growth Potential

- Last fiscal year IHS borrowed 100 million to finance expansion of behavioral health inpatient beds and inpatient medical beds (all private rooms)

Case Vignette #8  Continued…

- 60,000 sq. ft. off-campus ambulatory center to house, 15 physician PCP group, 5 physician OB group, physical therapy satellite after-hours urgent care, and retail pharmacy (IHS decided to use tax-exempt debt and not alternative capital).
Case Vignette #8  Continued…

- Balance sheet ratios have shifted to the negative:
  - days cash on hand
  - debt to cash
  - debt to capitalization
- Volumes are expected to increase as is net operating revenue
- Earnings are at-risk

IHS Learning Lesson’s:
Case Vignette #9: Milking the Cash Cow

- Cardiovascular services are the leading service line; net operating revenues and contribution margin
- Cardiologists at higher wrvu productivity relative to historic benchmarks
- Cardiac surgeries are flat
- Cath lab volume flat; physicians at capacity is the assumption
Case Vignette #9 Continued…

- Access, as reported by PCP’s is acceptable
- Group of five cardiologist “on the market” (for sale) (do 25% of business at IHS)
  - Asking price is high
- Incremental costs of acquiring practice affordable (even if at high-end)

Case Vignette #9 Continued…

- Leadership believes physicians can be acquired (with clinic staff) without adding many new hospital staff
- Finance says cath labs and imaging diagnostics have several years of useful life remaining
- Incremental volumes in relationship to incremental capital investment requirements demonstrates higher earnings performance potential (increasing free cash flow production)
Questions for Leaders:

1. If not integration, what model and why?
2. If integration has been pursued and the model has under-performed, what are the reasons?
3. If we pursue integration (or more integration) what are the key requirements: infrastructure, organizational structure, leadership, internal incentives, capital?

Questions for Leaders:

4. Is governance right or is change required?
5. What strategy is required to optimize the effort?
6. How will physicians be accountable partners within the IHS?
7. How will “we” define and measure success?
8. Is the IHS strategy affordable?
Conclusion: Key Lessons

1. IHS’ are designed to function as a “Closed Economy”
2. The Model affords considerable positive and negative leverage potential
3. The Model is a “Formula Business”
4. There is an important psychology to The Design
5. Problem identification and resolution requires new “forensics”

Appendices and Supporting Materials
Principles of Physician Services Organization for A Fully Integrated Health System (IHS)

- **Principle #1:** The IHS will employ most, if not all, physicians required to meet mission, clinical service model, patient needs, strategies and financial requirements.

- **Principle #2:** Integrated physicians serve in positions of leadership at key levels within the IHS design: governance, senior leadership, the physician services organization and key clinical service lines. All physicians will have opportunities to serve in capacities that control or influence IHS mission, strategic direction and operations.

- **Principle #3:** Physician compensation will be at market rates (by clinical specialty) and related incentives will align physicians with IHS goals and objectives.

Principles Continued…

- **Principle #4:** Physicians will work in clinical teams with other physicians and clinicians for the benefit of patient care and service.

- **Principle #5:** Physicians will work collaboratively to develop and/or adopt accepted, best practices based upon evidence-based clinical and managerial practical and applied research results.

- **Principle #6:** To the greatest extent possible, physicians will endeavor to retain patient care within the IHS except when required clinical services are unavailable from the IHS or the best interests of patients cannot be served.
Principles Continued...

- **Principle #7**: Physicians are accountable to peers and the IHS for their professional behaviors and all agree to abide by organizational values and approved code of conduct.

- **Principle #8**: The IHS agrees to adopt a sufficiently encompassing definition of “provider productivity” recognizing the value provided by physicians beyond direct patient care. The IHS agrees to compensate physicians fairly for such efforts and contributions.

- **Principle #9**: The IHS agrees to ensure that fair due process will be applied in the evaluation of physician performance and potential disciplinary actions; fair and due process including appropriate internal and external peer review.

Principles Continued...

- **Principle #10**: Management of contracted obligations and covenants with physicians will provide for appropriate routine and necessary ad hoc review and fair hearing by IHS governance.

- **Principle #11**: The physician services organization within the IHS is governed by an IHS board which retains designated “reserved powers” over specified health system decisions.

- **Principle #12**: Physicians will operate from a common employment agreement; terms and conditions consistent across individuals and clinical specialties.
Principles Continued…

• **Principle #13**: Physicians are provided an employee benefits plan that is consistent with market conditions and legal and regulatory requirements as they relate to "qualities" plans.

• **Principle #14**: Physicians clinical practices are governed by credentialing and privileging criteria, policies and procedures, as developed by the IHS physician services organization with required approvals from IHS governance and related controlled hospital licensing and accreditation rules and regulations.

---

Integrated Health System
Financial and Operating Performance

Gross Revenues by Payor:
- Medicare: 41.1%
- Medicaid: 15.3%
- Work Comp: 1.2%
- Blue Cross Blue Shield: 15.4%
- Contract: 11.7%
- Non Contract: 5.4%
- Guarantor: 3.4%

Net Revenues by Payor:
- Medicare: 14.2%
- Medicaid: 12.6%
- Work Comp: 1.9%
- Blue Cross Blue Shield: 20.3%
- Contract: 7.9%
- Non Contract: 0.9%
- Guarantor: 0.8%
Integrated Health System
Financial and Operating Performance

Net Operating Revenues (Dollars)

- Inpatient services: $268,258,211
- Physician professional fees (outpatient): $107,179,067
- Physician professional fees (inpatient): $114,067,028
- Non-physician billing professionals: $41,461,709
- Pharmacy: $109,904,347
- All Other: $5,356,249

Net Operating Revenues (Percentage)

- Physician professional fees (inpatient): 12.45%
- Pharmacy: 12.00%
- All Other: 0.58%
- Inpatient services: 29.29%
- Physician professional fees (outpatient): 11.70%
- Non-physician billing professionals: 4.53%
- Hospital/clinic outpatient technical service: 29.45%

Handout 1
Fully Integrated Health System
Net Operating Expenses

- Depreciation, amortization and interest expense: 5.4%
- All Other Operating Expenses: 17.5%
- Physician Compensation and Benefits: 16.3%
- Allied Health Compensation and Benefits: 4.8%
- Professional Liability and General Insurance: 0.7%
- All Other Supplies: 1.1%
- Medical Supplies and Drugs: 14.0%
- All Other Staff Compensation and Benefits: 38.2%

© Essentia Health Consulting 2010
Integrated Health System
Financial and Operating Performance

Operating Expense (Dollars)
- Bad debt: $39,690,052
- Other facilities cost: $27,964,890
- Depreciation, Amortization, Interest: $49,772,414
- Drugs and Supplies: $140,479,662
- Staff Benefits: $76,791,611
- Physician Comp: $140,430,105
- Physician Benefits: $41,230,498
- Advanced Practice Clinicians (APC's) Salaries: $35,240,956
- Advanced Practice Clinicians (APC's) Benefits: $10,342,275
- Staff Salaries: $291,702,154
- Staff Benefits: $76,791,611
- Professional liability and Insurance: $6,140,528
- Other Expenses: $92,367,450

Operating Expense (Percentage)
- Staff Salaries: 29%
- Physician Comp: 16%
- Advanced Practice Clinicians (APC's) Salaries: 4%
- Other facilities cost: 3%
- Professional liability and Insurance: 1%
- Drugs and Supplies: 15%
- Staff Benefits: 8%
- Bad debt: 4%
- Depreciation, Amortization, Interest: 5%
- Physician Benefits: 4%
- Advanced Practice Clinicians (APC's) Benefits: 1%
- Other Expenses: 10%
- Physician Comp: 16%
- Other Expenses: 10%

Integrated Health System
Financial and Operating Performance

Professional work relative value units (WRVU)
- Non-physician billing providers (all): 341,190
- Physician surgical/procedures inpatient: 369,755
- Physician surgical/procedures outpatient: 184,028
- Physician medical inpatient: 555,711
- Physician medical outpatient: 865,052

Professional work relative value units (WRVU)
- All WRVUs produced "locally": 1,851,635
- All WRVUs produced "regionally": 494,100
Integrated Health System
Financial and Operating Performance
Billing Provider by FTE

Physician Resource Allocations

MHA Program
Physicians in Management

% Total Physicians (Number)

- 17.70%
- 82.30%

Physicians in Management

% Physician Time (FTE)

- 5.08%
- 94.92%
Physician Specialty Mix
% Total FTE Physicians
(FTE=382; n=452)

- Anes./Pain Management (22)
- Casual Phy Employees
- Cardiopulmonary (25)
- Emergency/Med (31)
- Gastroenterology/Oncology (21)
- Medical Specialties (44)
- Neurology (35)
- Pediatrics (23)
- Neuromusculoskeletal/Trauma (55)
- Surgical Specialties (46)

WORK RVU BY SPECIALTY
### Physician Specialties by %FTE (cont’d)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% FTE</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics/Gynecology</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>3.1%</td>
<td>Incl Ped/Onc, Rad/Onc</td>
</tr>
<tr>
<td>Radiology</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>2.6%</td>
<td>Incl Retinal, Optometry</td>
</tr>
<tr>
<td>Pathology</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Pulmonary</td>
<td>1.8%</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1.8%</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>CT/Vascular Surgery</td>
<td>1.6%</td>
<td>(78th percentile)</td>
</tr>
</tbody>
</table>

### Mid-Level Providers by %FTE (361 FTE)

<table>
<thead>
<tr>
<th>Credentialed Provider</th>
<th># FTE</th>
<th>% FTE</th>
<th>%ile Total FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP</td>
<td>91</td>
<td>25.2</td>
<td></td>
</tr>
<tr>
<td>PT</td>
<td>68</td>
<td>18.8</td>
<td></td>
</tr>
<tr>
<td>CRNA</td>
<td>58</td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>33</td>
<td>9.1</td>
<td></td>
</tr>
<tr>
<td>OT</td>
<td>24</td>
<td>6.6</td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td>22</td>
<td>6.1</td>
<td>(82nd %ile)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>16</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>Dietitian</td>
<td>13</td>
<td>3.6</td>
<td></td>
</tr>
<tr>
<td>CNS</td>
<td>12</td>
<td>3.3</td>
<td>(93rd %ile)</td>
</tr>
</tbody>
</table>
Mid-Level Providers by Sites of Care

<table>
<thead>
<tr>
<th>Site of Care</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>45%</td>
</tr>
<tr>
<td>Central Clinics (GIM, Ped, Specialties)</td>
<td>25%</td>
</tr>
<tr>
<td>Regional Clinics (FP, Other)</td>
<td>17%</td>
</tr>
<tr>
<td>Outpatient Physical Medicine</td>
<td>13%</td>
</tr>
</tbody>
</table>

Handout 3

HANDOUT 3: FULLY INTEGRATED HEALTH SYSTEM
WRVU PRODUCTION BY CLINICAL SPECIALTY (%)

<table>
<thead>
<tr>
<th>Clinical Specialty</th>
<th>WRVU %</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY PRACTICE</td>
<td>17.8%</td>
</tr>
<tr>
<td>ORTHOPEDIC SURG/MD ORTHO</td>
<td>8.3%</td>
</tr>
<tr>
<td>RADIOLOGY</td>
<td>6.9%</td>
</tr>
<tr>
<td>CARDIOLOGY</td>
<td>6.9%</td>
</tr>
<tr>
<td>GENERAL SURGERY</td>
<td>6.4%</td>
</tr>
<tr>
<td>GENERAL INTERNAL MEDICINE</td>
<td>5.1%</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>4.7%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>4.4%</td>
</tr>
<tr>
<td>HOSPITALIST</td>
<td>3.8%</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>3.0%</td>
</tr>
<tr>
<td>PATHOLOGY</td>
<td>2.9%</td>
</tr>
<tr>
<td>PEDIATRICS</td>
<td>2.8%</td>
</tr>
<tr>
<td>ONCOLOGY/RAD/IMPED/DNC</td>
<td>2.7%</td>
</tr>
<tr>
<td>NEUROSURGERY</td>
<td>2.7%</td>
</tr>
<tr>
<td>PULMONARY</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Note: Figures do not include Emerg Med, Anesth.
Performance Management

- Strategy Map
- Balanced Score Card

EXAMPLE: Strategy Map with Measures

Mission: Brings the soul and science of healing to the people we serve

Vision: Working together with our patients and communities, we are creating the next generation of integrated healthcare.

EXAMPLE: Strategy Map with Measures
# Balanced Scorecard

**EXAMPLE INTEGRATED HEALTH SYSTEM**

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Measure</th>
<th>Freq</th>
<th>Actual July</th>
<th>Actual YTD</th>
<th>Target YTD</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FINANCIAL</strong></td>
<td>Operating Margin</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Non-Operating Return</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Days in A/R - Hospital</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Days in A/R - Clinic</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Days Cash on Hand</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Margin on Growth Areas (Annual)</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td>Off Plan</td>
</tr>
<tr>
<td></td>
<td>Primary Care Clinic Patient Satisfaction (Annual)</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td>Off Plan</td>
</tr>
<tr>
<td></td>
<td>Growth Area Inpatient Market Share (Annual)</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td>Off Plan</td>
</tr>
<tr>
<td></td>
<td>Hospital Patient Satisfaction (Semi-annual)</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td>Off Plan</td>
</tr>
<tr>
<td></td>
<td>Appointment Access (Clinical Sections)</td>
<td>M</td>
<td>On Plan</td>
<td>NA</td>
<td>NA</td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Phone Access Non-Clinical</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Specialty Visit Access</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>% Sub Specialized Programs Developed (Annual)</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>% Studies in Targeted Growth Areas (Annual)</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>% IQC targets achieved (Quarterly)</td>
<td>Q</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Cost / Adj. Discharge*</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Cost/Encounter</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Hours on Diversion</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Length of Stay</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Gallup survey grand mean (Annual)</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>% Critical resource positions filled (Quarterly)</td>
<td>Q</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>Turnover rate (Quarterly)</td>
<td>Q</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
<tr>
<td></td>
<td>% of patient care activity converted to Epic (Quarterly)</td>
<td>Q</td>
<td></td>
<td></td>
<td></td>
<td>On Plan</td>
</tr>
</tbody>
</table>

* Case Mix Adjusted

**Terms Glossary**

**MHA Program**
Glossary Of Ratios

• **Return on Total Assets**: The Return on Total Assets ratio defines the amount of net income earned per dollar of investment. This ratio includes both operating and non-operating sources of income to provide a measure of the return on capital invested in operations. Adequate levels of return are essential to the continued viability of the health care facility and the replacement of its assets. Higher values for this ratio are viewed favorably by creditors.

  \[
  \frac{\text{excess of revenues over expenses}}{\text{total assets}}
  \]

• **Operating Margin**: The Operating Margin ratio defines the percentage of total revenue that has been realized in the form of operating income. Many analysts use it as a primary measure of a hospital or system’s operating profitability. Increasing values for this ratio are viewed favorably by creditors.

  \[
  \frac{\text{total operating revenue} - \text{total operating expenses}}{\text{total operating revenue}}
  \]

Glossary Of Ratios Cont’d.

• **Total Margin**: The Total Margin ratio defines the percentage of total revenue plus net non-operating gains that have been realized in the form of net income. This ratio, therefore, reflects both profits from operations and non-operations. Higher values for this ratio are viewed favorably by creditors.

  \[
  \frac{\text{excess of revenues over expenses}}{\text{total operating revenue}}
  \]

• **Operating Cash Flow Margin**: The operating cash flow margin, measures the ratio of earnings or losses before interest, depreciation, and amortization expenses to total operating revenues. A decline in the operating cash flow margin suggests that non-capital related expenses are growing at a faster pace than the revenues generated. Likewise, growth in the operating cash flow margin indicates that revenue growth is outpacing the rate of expense growth, leading to higher cash flow.

  \[
  \frac{\text{total operating revenues} - \text{total operating expenses} + \text{interest expense} + \text{depreciation and amortization expense}}{\text{total operating revenues}}
  \]
Glossary Of Ratios Cont’d.

• **Return on Equity**: The amount of net income earned per dollar of net assets or equity. Higher values for Return on Equity indicate a hospital’s ability to add new investment in plant, property and equipment without adding excessive levels of new debt.

  \[
  \frac{\text{excess of revenue over expenses}}{\text{net assets}}
  \]

• **Debt to Capitalization**: The Debt to Capitalization ratio measures the relative importance of long term debt in the system’s permanent capital structure. Systems or hospitals with higher values for the debt to capitalization ratio indicate that they have relied extensively on debt as opposed to equity to finance their assets and are said to be leveraged. This means risk in the minds of many creditors and may be viewed unfavorably.

  \[
  \frac{\text{total outstanding debt}}{\text{total outstanding debt + unrestricted fund balance}}
  \]

Glossary Of Ratios Cont’d.

• **Days Cash on Hand**: The Days Cash on Hand ratio measures the number of days of average cash expenses the hospital or system maintains in Cash, Marketable Securities and Board Designated Funds. High values for this ratio imply a greater ability to meet short term obligations and are viewed favorably by creditors.

  \[
  \frac{\text{cash + investments + board designated funds}}{\text{total operating expenses – depreciation expense/365}}
  \]

• **Free Cash Flow**: Free Cash Flow measures additional cash available after principal payments and routine capital additions. Free Cash Flow is a measure of profit and reflects available cash. Positive values for this calculation are favorable.

  \[
  \text{earnings (excess of revenue over expense)} - \text{principal payments} - \text{routine capital additions} = \text{Free Cash Flow}
  \]
Principles of Physicians Compensation as a Design and Management Tool

Daniel K. Zismer, Ph.D.,
Associate Professor and Director,
MHA and Executive Studies Program
Division of Health Policy and Management,
School of Public Health, University of Minnesota
Associate Adjunct Professor
Division of Medicine

Going-in Premise: It’s difficult to get a physician compensation plan right without a solid foundation of principles to guide plan design and management.
Principle #1: A single, unified physician compensation plan will cover all physicians within the IHS physician enterprise.

Meaning: Individualized agreements and plans are by exception (rare exception), all physicians are covered by a unified plan driven by: the principles that pertain, written description, IHS governance approval and IHS, physician enterprise administration.

Principle #2: The plan is market-based with recognition for local, regional and national markets.

Meaning: Physicians are recruited from local, regional, and national markets. The plan recognizes the opportunities inherent challenges.
**Principle #3:** Cash compensation is one component of a comprehensive plan that considers all cash and non-cash benefits and other essential components of a plan that seeks to attract and retain top talent.

**Meaning:** The value of the plan is considered and evaluated in its entirety. All components contribute to its value, overall.

**Principle #4:** The compensation plan (together with the underlying employment agreements) provides for sufficient security, stability and “protections” from market (payer) dynamics and health system payer contracting strategies.

**Meaning:** The compensation plan is sufficiently “disconnected” from the vagaries of local, regional, national, and governmental payment schemes, including methods generated by the health system to further market strategies.
**Principle #5:** The plan sufficiently aligns the incentives of: The individual, the clinical department (or division) the integrated medical enterprise and the health system overall.

**Meaning:** To the greatest extent possible, the clinical and professional activities of the individual will further the interests of the whole.

---

**Principle #6:** Methods of plan administration and decision making are transparent and available to the individual or interested groups for reasonable review and examination.

**Meaning:** Individuals and groups affected by the plan may have access to routine reporting on plan administration and have access to due process and “fair hearings” on disputable compensation-related decisions.
**Principle #7:** Definitions of “provider productivity” are clear and sufficiently broad to fairly consider and value professional activities that benefit the physician enterprise and the health system overall; i.e. professional activities beyond clinical services (“billable”) encounters.

**Meaning:** Physicians “productivity” in integrated systems should be observed, measured, valued, and compensated to recognized contributions beyond “seeing patients and generating billable units”. Related productivity must be managed to be affordable by the IHS.

167

---

**Principle #8:** The plan recognizes and compensates, the individual for productivity above and beyond required targets. Individuals may distinguish themselves from peers based upon compensation to exceptional productivity and service levels within accepted guidelines.

**Meaning:** Those who elect to produce (appropriately) above and beyond individual or peer group targets may be rewarded accordingly.

168
**Principle #9:** Individual physicians are not exposed to unreasonable compensation risk due to strategy and strategic growth plans executed by the physician enterprise or the health system.

**Meaning:** Physicians’ income is not at risk for such strategic initiatives as growth (specifically recruiting of physicians) or such strategic initiatives as geographic outreach or programmatic initiatives that benefit the whole at the potential expense of the individual or clinical group.

**Principle #10:** The plan will permit compensation at the higher end of reasonable market ranges so long as the health system derives reasonable value and the IHS is not put at unreasonable legal and/or regulatory risk.

**Meaning:** The IHS shall not restrict compensation with the imposition of unreasonable or unproductive compensation level caps.
**Principle #11:** Physicians are accountable to identified peers within the physician enterprise structure for clinical and professional behaviors that implicate productivity and compensation.

**Meaning:** Every physician reports to an identified and accountable physician leader for matters pertaining to compensation.

---

**Principle #12:** The physician enterprise within the IHS may create financial incentive plans that include non-revenue producing “behavioral” requirements (e.g. clinical quality, patient satisfaction, citizenship, etc.) that may affect an individual’s total annual cash compensation.

**Meaning:** In addition to “revenue producing” professional behavior requirements, physicians may be required to meet professional conduct and behavioral requirements driven by organizational values and codes of conduct.
**Principle #13:** Physicians singled-out for administration of penalties related to their compensation are provided “due process” and “fair hearing” as defined by written policies and guidelines.

**Meaning:** Individual physicians may not be penalized financially under the compensation plan without a prescribed course of action for fair and reasonable examination by accountable leaders within the physician enterprise and IHS leadership.

---

**Principle #14:** The compensation plan is open to routine and ad hoc review, evaluation and revision according to written organizational policy and procedure, and all physicians covered by the plan are subject to revision of the compensation plan with due process and action by designated authorities of the physician enterprise and the IHS.
Meaning: The physicians’ compensation plan for the IHS is under routine review and periodic change for the benefit of the individual and the organization and the compensation plan is guided by but not controlled by the individual’s employment agreement.

Summary

- Principles of compensation underpin all successful IHS compensation plans
- Compensation plans within the IHS change over time as a result of open and transparent process (e.g. three year cycles)
- The physician enterprise, within the IHS, is continuously engaged in compensation plan examination and change
Glossary of Terms – Integrated Healthcare

• **Accountable Care Organization (ACO):** An organization within the IHS developed to manage risk contracting with payers (including governmental payers) and the management of that risk (especially utilization patterns and related costs to the IHS). The ACO may contract with outside (independent) providers as well to ensure a comprehensive complement of clinical service providers are available to serve populations under contract.

Glossary of Terms Continued…

• **Accreditation(s):** Designations held by the IHS, provided by external bodies (organizations) conveying special status based upon the IHS ability to meet prescribed standards of policy, procedure, and performance; can by voluntary or a requirement to access certain markets and reimbursements from specific third party payers; healthcare organizations may access certain reimbursements based upon accreditations.
Glossary of Terms Continued…

- **Alternative Capital:** Capital accessed for specific organizational developments (including facility assets) by other than the more traditional means and methods (e.g. taxable or tax-exempt debt). Alternative capital may come in the form of facilities made available by lease from third parties, risk capital investments made by partners or a contribution of assets and programs by a partner(s) to a joint venture.

Glossary of Terms Continued…

- **Ambulatory Services:** Clinical care provided to patients on an "outpatient basis"; patients visit for brief episodes of care requiring 23 hours of contact or less with the IHS.
- **Bad Debt:** Charges for services to patients that were expected to be paid following delivery, that were not paid by the services beneficiary. Or the IHS’ inability to collect do to non-performance on procedures or time allowances specified by written agreement with the payer.
Glossary of Terms Continued…

- **Balanced Score Card**: A single-page report showing progress toward the important performance goals of the organization; clinical quality, patient access, key clinical indicators, organizational learning, and development and financial.

- **C.A.G.R.**: An abbreviated term of financial analysis referring to “compound annual growth rate”.

Glossary of Terms Continued…

- **Cath Lab**: A specialized clinical procedures room typically used by: cardiologists, interventional radiologists or interventional vascular specialists to visualize (through radioactive imaging techniques) diagnosis and treat intra-vascular disease and related anatomical anomalies.
• **Charity Care:** Services not-for-profit, tax-exempt IHS provided to patients who are pre-determined to be unable to pay for care at required levels. IHS agrees to provide services with no or a reduced expectation of payment. This is not the same as “bad debt” or contractual adjustments on services provided.

• **Compensation:** Payments made to IHS employees (including employed physicians) for services rendered to the IHS (and thereby to patients).

• **Contractual Adjustments:** Reductions in reimbursements (reductions from gross charges) an IHS agrees to accept from any payer by contract (verbal or written).

• **Clinical Co-Management:** A design where multiple professionals within a clinical discipline collaborate to direct, control, and manage a clinical service line within and/or across IHS facilities. Typically a time-limited written agreement between independent physicians and a health system.
Glossary of Terms Continued…

• **Clinical Department (Physician/Medical Enterprise):** A single-specialty clinical department within a clinical division (e.g. cardiology or general surgery or orthopedics, etc.).

• **Clinical Division (Physician/Medical Enterprise):** A collection of clinically related clinical departments housing IHS physicians and related clinical providers and staff: e.g. the “Division of Medicine” that contains multiple, related medical specialties organized under a division leadership structure team with an identifiable support services infrastructure.

Glossary of Terms Continued…

• **Clinical Services Portfolio:** The entirety of the clinical services and program made available by an IHS to patients served.

• **Competitor:** An entity in the same or similar business that aims to own, control or shift desired markets (customers) from the IHS to itself.
Glossary of Terms Continued…

• **Contribution Margin:** The financial margin (remainder) available after direct costs of clinical care and related clinical supplies are subtracted from accounted operating revenues; i.e. the remainder left to fund infrastructure (support services) operating expenses, costs of capital, and net operating margin.

• **EHR (or EMR):** Electronic Health Record – the computerized patient record.

Glossary of Terms Continued…

• **Embedded Medical Enterprise (or IHS physician enterprise):** The organizational structure within the IHS that houses (employs) IHS: physicians, related licensed providers, and typically, related support staff.

• **Employment Agreement:** A written contract between the IHS and an individual specifying terms, conditions, and responsibilities of the parties relative to an employment (e.g. a “contract employee” arrangement).
Glossary of Terms Continued…

• **Facilities:** Inpatient, outpatient, and support services structures (assets) that house (contain) clinical services and related support services.

• **Fiduciary Duties:** Categories of duties of the trustees: loyalty, obedience and care.

• **G.I. Lab:** A specialized clinical procedures room typically used by gastroenterology specialist or specially qualified surgeons to perform endoscopic procedures associated with the digestive tract.

Glossary of Terms Continued…

• **Governance (IHS):** The board or boards that contain seated trustees who operate as fiduciaries, acting on behalf of the best interests of the IHS; those responsible to control and exercise control through “reserved powers”.

• **Gross Charge:** A price placed on a service unit or product produced by the IHS that may or may not be paid by a consumer based upon contractual agreement or other intervening factors or circumstances.
Glossary of Terms Continued…

- **Hospital**: A licensed facility controlled by the IHS that provides: inpatient care, emergency services care, and to a limited degree, ambulatory care services.

- **Hospitalists**: Physicians specializing in the general care of hospitalized, inpatients. Members of the IHS employ hospitalists to focus on the quality and efficiency of inpatient hospital services working in concert with other members of the IHS medical team.

Glossary of Terms Continued…

- **IBNR**: An “incurred but not reported claim”; a clinical service unit delivered but not yet converted to a “billed event” (to a third party).

- **Infrastructure**: Assets, systems, and people employed and applied by the IHS to support the delivery of clinical care; sometimes referred to as the “indirect cost structure”.

- **Inpatient Services**: Clinical care provided to patients who are cared for within the walls of the organization for a period of 24 hours or longer.
Glossary of Terms Continued…

• **Integrated Health System (IHS):** A system that provides healthcare to patients; one where most, if not all, clinicians required to meet: mission, vision, clinical care model goals and strategic objectives are employed by the IHS (i.e. The "independent private practice model has no to minimal effects on the model).

• **Leverage:** Application of IHS people, assets, other resources, and potential to optimize clinical outcomes at the highest levels of efficiency, creating optimal value.

Glossary of Terms Continued…

• **Management:** Direct efforts by those with specified authorities to organize and apply people, resources and potential of an organization to achieve goals and objectives directed by governance of the organization and guided by the organizations: mission, vision, values, and strategic plan.
• **Medical Home:** A virtual home for patients within the oversight of a primary care provider responsible for patients’ health status, access to required services, coordination of care through the health system, health risk management, as well as the overall effectiveness of the patient/health system relationship.

• **Medical Staff:** Physicians (and select licensed medical professionals) employed by the IHS and independent providers affiliated with licensed hospitals owned and operated by the IHS.

• **Mission Statement:** A statement of an organization stating its principal purpose for being as well as its promise for those it services.

• **Net Operating Margin:** The profit margin earned by health systems on operations (not including earnings from investment income and gains).

• **Operating Entity:** A formal organizational structure functioning as an integrated component of the IHS (e.g. a controlled corporation or operating division-operating within the IHS super-structure).
Glossary of Terms Continued…

• **Operating Expenses**: A cost related to goods, services, bad debt, and issued debt consumed by the IHS to generate and deliver products and services to patients (and other customers).

• **Operating Revenue**: Revenue the IHS earns and realizes (collects) as a result of its contractual relationship with patients and third party payers.

Glossary of Terms Continued…

• **Organizational Design**: The group or groups of controlled corporate entities that link together under a health system governance structure to contain and control IHS assets, people and clinical services and programs.

• **Outreach**: The IHS activities designed to deliver services at geographic locations that are not considered main campus sites and those delivered from external sites: rented, leased, owned or those provided by program partners.
Glossary of Terms Continued…

• **Payer Mix**: The totality of all categories of reimbursement to the IHS (100%) arrayed by proportion of each payer category to the whole (i.e. 45% Medicare) typically described, by category, as “gross charges” (prices charged) and “operating revenues” (prices realized).

• **Physician Extender**: A licensed provider of clinical care who may bill directly for services working independently or under the supervision of a physician(s).

Glossary of Terms Continued…

• **Population Health (for the IHS)**: The health status of specifically defined populations (patients) cared for by the IHS. Priority measures of health status may differ based upon the subset of the entire population observed (e.g. diabetics, asthmatics, CHF patients, etc.).
Glossary of Terms Continued…

• **Primary Care Provider:** Typically categorized as: family medicine, general internal medicine, general pediatrics, and for some organizations, OB/GYN to the extent that these providers serve as primary care providers (and not consultative specialists) for female patients. Physician extenders may be categorized as primary care providers as well, unless they focus on patients with specialized medical needs.

• **Professional Services:** Clinical care (services) provided (typically by licensed health professionals) within the IHS.

Glossary of Terms Continued…

• **Provider:** Any clinician holding a license to provide clinical services directly to patients; more specifically, those with a license and ability to work independently in exercising clinical judgments on behalf of patients.

• **Reimbursement(s):** Revenues paid to (realized by) the IHS.
Glossary of Terms Continued…

- **Reserve Powers (rights):** Powers (rights) reserved to the trustees (governance) of the IHS. Typically: strategic plan, capital and operating budgets, assumption of debt, control of assets, hiring/termination of the CEO, reputational risk, and quality and customer services expectations.

Glossary of Terms Continued…

- **Revenue Cycle:** The entirety of the process of: registering a patient for a service to the full capture of all related chargeable inputs to care, to the creation of an accurate (fully vetted) services bill, to the successful submission of that bill for payment, to the successful collection of all service payments due.

- **Safe Harbor:** Safety (protection) from legal/regulatory exposure and risk resulting from the organizational design and an individual’s (e.g. provider’s) legal relationship with that organizational design (contractual or otherwise).
Glossary of Terms Continued…

• **Senior Leadership Team (SLT):** The senior officers employed by the IHS assigned to operate the organization under the control of the Chief Executive Officer (CEO) and the governing board.

• **Strategic Plan:** A plan designed and implemented by IHS management, with approval of governance that, when implemented, successfully creates optimal returns given the IHS resources and potential applied in the face of competitive forces and prevailing market dynamics.

Glossary of Terms Continued…

• **Strategy Map:** A single-page depiction of the organizations strategic direction with related goals, tactics, and pathways to strategic plan implementation.

• **Tax Status:** IRS code and chapters that govern the IHS' designation as a “for-profit” or “not-for-profit” (and tax exempt) organization.
Glossary of Terms Continued…

• **“Team Care”**: Multidisciplinary teams working collaboratively within the IHS with a focus on a specific specialty (or grouping of clinical specialties) with principal goals of: high quality and efficiency by allowing each member to optimize his or her clinical skills and potential; i.e. allowing each to work at “the top” of his/her license.

Glossary of Terms Continued…

• **Third Party Payer**: A third party that, by contract with a patient, agrees to pay for clinical services provided by the IHS to the patient under specific terms and conditions that affect direct payments (e.g. price paid and other terms affecting payment, including financial responsibilities of the patient under contract).

• **Third Party Risk**: The organization assumes financial risk transferred from third party payers (by contract) for specifically defined populations (e.g. specific clinical cohorts, demographic cohorts, and patients from identified employer groups).
Glossary of Terms Continued…

- **Urgent Care:** Clinical care provided by a licensed clinical professional that is without appointment and is non-life threatening, and thereby “non-emergent”.

- **Vision Statement:** A statement of aspiration for an organization relative to its regarded position in its industry, its markets, and/or its customers.

- **Work Relative Value Unit:** A specified unit of clinical service delivered by a licensed healthcare provider used for purposes of quantifying clinical effort, compensation to the provider, and often, billing to third parties.
NOTES