

MARCH 2009

HFMA's Healthcare Finance Outlook 2009



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Dear Colleagues:

To carry out the mission of health care, provider executives must face significant business challenges, including inadequate payment, rising costs, and intense competition. These challenges only intensify in the face of today's economic downturn.

In such an environment, it may seem unusual to discuss envisioning the future of health care a decade from now, as we've done in *HFMA's Healthcare Finance Outlook: 2009*. As one of those interviewed for this report aptly notes, "It is difficult to focus on what may happen in the next 10 years, when the focus is on what is happening in the next 10 months."

Yet maintaining this future-focused perspective is precisely what the industry needs to be doing in these challenging times. Strategic success comes not from continuous crisis reactions, but from careful planning and anticipating change. To be truly effective, leaders must have a vision for the future and a plan for moving from today's situation to fulfillment of that vision. That's where this report comes in.

To aid in the formulation of this vision, *HFMA's Healthcare Finance Outlook: 2009* combines forward-looking research and analysis with knowledge from some of the best and brightest in the industry. The result is:

- An examination of the industry's current state and leading indicators of industry change
- Forecasts of major industry movement in the next 10 years
- Critical actions for margin and mission success in this changing environment
- Examples of innovative projects taking place at large health systems to serve as a source of inspiration

We hope you will find *HFMA's Healthcare Finance Outlook: 2009* an important resource to help your organization stay ahead of industry change and make a difference in improving health care for the patients and communities you serve. Although it's daunting to anticipate the future, maintaining a future-focused perspective is vital to ensuring resources are available to fulfill the critical mission of health care for the long term.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Clarke". The signature is fluid and cursive, written in a professional style.

Richard L. Clarke, DHA, FHFMA
President and CEO
Healthcare Financial Management Association

HFMA's Healthcare Finance Outlook: 2009

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Introduction: Tomorrow's Influence on Today

Although it is easy to become lost in day-to-day operational challenges, truly successful health-care executives understand the importance of keeping an eye on the organization's long-term vision and developing strategy to prepare for the future.

Achieving tomorrow's organizational vision doesn't just happen. It begins with careful preparation and deliberate actions. By matching forecasts with financial and operational plans, hospital leaders best position their organizations to ensure they have the resources necessary to fulfill their missions of patient care. It is in this spirit that HFMA presents this year's *Healthcare Finance Outlook*.

Healthcare Finance Outlook: 2009 draws on the expertise of healthcare executives and industry thought leaders, through use of a survey and interviews, to forecast major industry movement over the next 10 years. Areas of focus include:

- Workforce
- Payment system

- Physician integration
- Technology
- Capital planning

For each of these areas of focus, HFMA will explore current state, examine key drivers of change related to future direction, and present a series of forecasts based on the survey and insights of experts interviewed. With various scenarios in mind, discussion will then focus on critical actions that today's healthcare financial leaders need to be taking, including examples of innovative projects already taking place at some large health systems that can serve as inspiration.

One of the greatest tests of leadership is the ability to develop strategic vision and align the organization and its teams around this vision—bringing to light tomorrow's influence on today. HFMA welcomes the opportunity to share this year's *Healthcare Finance Outlook* to support you in this important task.

About the Healthcare Finance Outlook Survey

HFMA gathered responses from more than 100 thought leaders in health care about their predictions for the future. Researchers presented a number of scenarios that took several leading drivers of change in mind and asked the leaders to assess likelihood of occurrence in the next 10 years. Additional probing focused on the most important actions to be taken in the near term in light of these predictions. Participants were also provided with opportunities to respond to open-ended questions relating to their reasons for prioritization and subsequent strategies.

Participants in the survey, which was conducted by e-mail in fall 2008, included CFOs of the nation's largest healthcare systems, selected HFMA members in leadership roles, and industry subject matter experts. More than half of responses received were from CFOs.

Based on the survey results, HFMA then selected top industry advisers with expertise specific to the leading change drivers identified to provide their perspectives on the survey results and the various outlook scenarios. These top experts also provided insight on critical actions and innovative strategies and projects.

The Healthcare Landscape Today

When assessing the likelihood of future events, it's best to begin with an understanding of the current healthcare landscape.

Perhaps no force weighs as heavily on the industry today as pressures to reign in cost and improve healthcare value. Simply put: Healthcare spending and the resulting cost burden to consumers has increased significantly and yet the nation lags behind the quality performance of others.

Healthcare spending is growing more rapidly than Gross Domestic Product, with public financing making up nearly half of all funding. Healthcare spend is estimated at 16.6 percent of GDP and is expected to climb to nearly 20 percent of GDP within the next decade.

Reasons for this growth are many, with some in a hospital's control while others are not. Just a few commonly cited cost drivers include accelerating regulatory requirements and high administrative costs, use of high-cost, high-tech medical equipment and procedures, influence of the current medical malpractice system, and growing costs associated with pharmaceuticals and associated research and development.

Although there are many opposing positions on how much of GDP should be related to health care, it is clear the cost of health care significantly adds to the cost structure of businesses as well as most individuals' personal budgets. One area that exemplifies this relationship is growth in health insurance premiums. Over the course of the past 10 years, average annual growth in healthcare premiums has reached nearly 9 percent. Employers generally have reacted to this rapid growth in premiums by looking for less expensive plan options and by shifting portions of the premium costs to employees.

Premium growth has far outpaced growth in employee wages and inflation. Thus, it should come as no surprise that at the same time consumers are being

saddled with greater levels of this cost burden, the nation is seeing growth in medical-related debt. The proportion of working-age Americans who struggled to pay medical bills and accumulated medical debt climbed from 34 percent to 41 percent—or 72 million people—between 2005 and 2007, according to a 2008 Commonwealth Fund report. Families with low or moderate incomes have been particularly hard hit, as have been adults who have gaps in health coverage or those underinsured. Because of medical bills or accumulated medical debt, an estimated 28 million adults reported using up all their savings, 21 million incurred large credit card debt, and another 21 million were unable to pay for basic necessities.¹

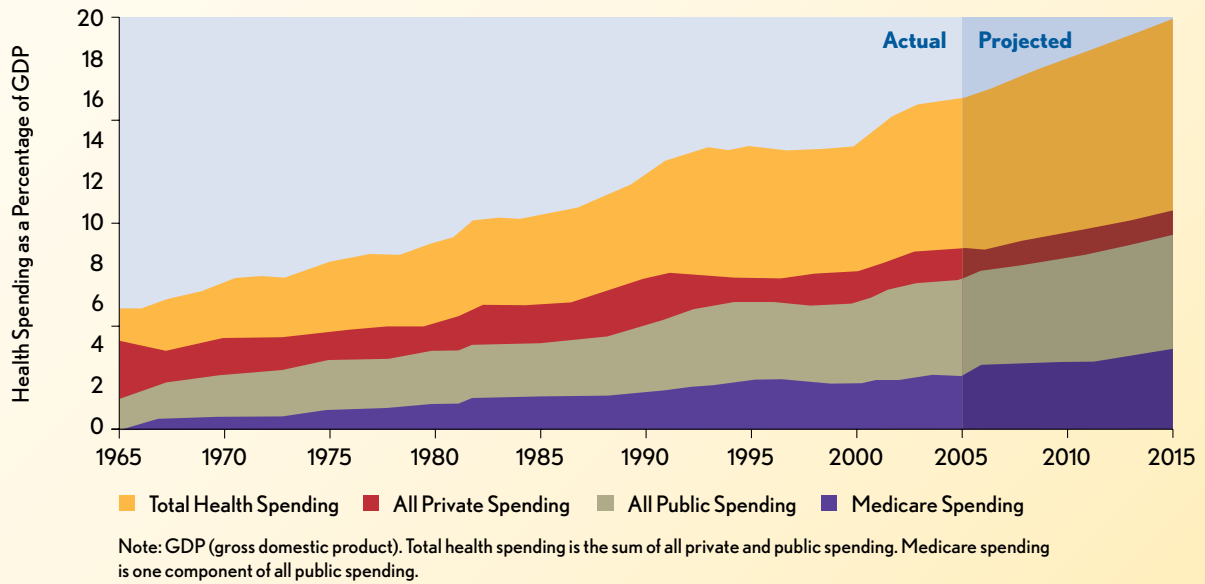
In addition to cost of care, the nation also is struggling with value of care. Despite growth in public and private healthcare spending, the United States has the worst mortality rate from treatable conditions when compared with 18 other industrialized countries (see page 4). It also ranks last in dimensions of access, patient safety, efficiency, and equity when compared with Australia, Canada, Germany, New Zealand, and the United Kingdom—despite spending twice as much as these countries on a per-capita basis.²

When examining drivers of these challenges to cost and quality, analysts typically focus on the following:

- Workforce
- Payment system
- Physician integration
- Technology
- Capital planning

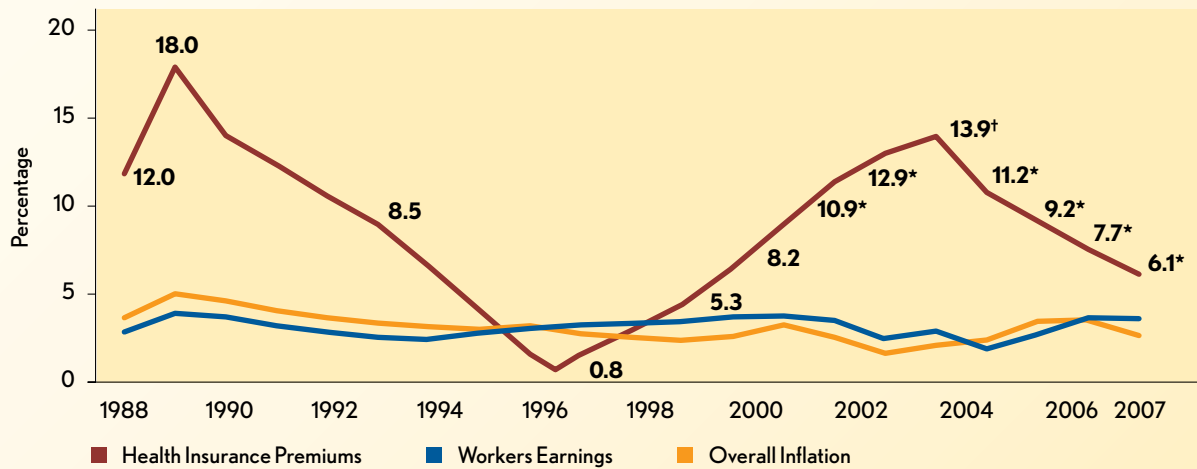
In many ways, addressing healthcare spending and the value equation in today's environment requires a comprehensive strategy based on a key understanding of these issues. Each plays a significant role in how today's healthcare organizations allocate capital and prioritize resources.

Health Care Spending Has Grown More Rapidly Than GDP



Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2006.

Increases in Health Insurance Premiums Compared with Other Indicators, 1988 -2007



* Estimate is statistically different from the previous year shown at $p < 0.05$.

† Estimate is statistically different from the previous year shown at $p < 0.1$.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).

Data: G. Claxton, J. Gabel, et al., "Health Benefits in 2007: Premium Increases Fall To An Eight-Year Low, While Offer Rates And Enrollment Remain Stable," *Health Affairs*, September/October 2007 26(5):1407-1416. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007, and Commonwealth Fund analysis of National Health Expenditures data.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008. Used with permission.

Overall Healthcare Ranking of Industrialized Countries

	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	3.5	5	2	3.5	1	6
Quality care	4	6	2.5	2.5	1	5
Right care	5	6	3	4	2	1
Safe care	4	5	1	3	2	6
Coordinated care	3	6	4	2	1	5
Patient-centered care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, healthy, and productive lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	\$2,876*	\$3,165	\$3,005*	\$2,083	\$2,546	\$6,102

Country Rankings: ■ 1.0–2.66 ■ 2.67–4.33 ■ 4.34–6.0

* 2003 data

Source: Calculated by The Commonwealth Fund based on *The Commonwealth Fund 2004 International Health Policy Survey*, *The Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults*, *The 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians*, and *The Commonwealth Fund Commission on a High Performance Health System National Scorecard*. Used with permission.

Workforce

Growth in labor cost is the single most important factor driving up cost of care. As noted in the report *The Costs of Caring: Sources of Growth in Spending for Hospital Care*, 62 percent of annual cost growth is related to rising costs of goods and services purchased by the hospital to deliver care and accomplish its mission goals. Two-thirds of that growth in the cost of goods and services is related to “wages and salaries” and “employee benefits.”³

What’s more, hospitals face continuing shortages of registered nurses, pharmacists, medical technicians and other clinical workers, adding to labor cost pressures on hospitals. High vacancy rates for registered and licensed nurses are largely a result of a declining number of students seeking careers in nursing, lack of adequate nursing school faculty, an aging workforce, and competition with nonhospital employers.

Although demand for services has softened somewhat in the current recessionary economy, providers are likely to continue to struggle with staffing issues—and their associated labor costs—as the aging U.S. population continues to increase demand for healthcare services.

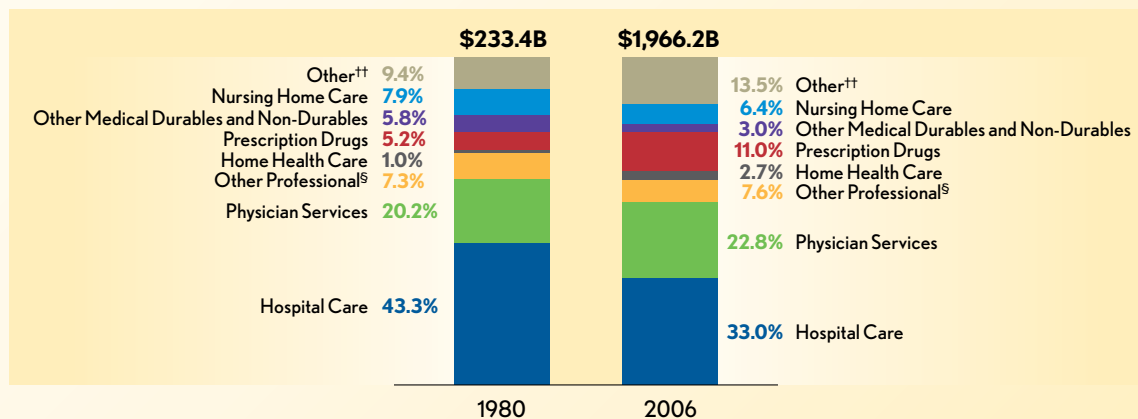
Payment System

Healthcare value also is shaped by incentives inherent in the current payment system. Reigning in healthcare spending and promoting clinical quality is directly dependent on how the nation will choose to address reform of the current payment system.

Today’s payment system often discourages primary care while rewarding expensive and no more beneficial specialty services. Although most conditions that generate the nation’s greatest healthcare expense are chronic in nature, today’s fee-for-service systems generally pay inadequately or not at all for the types of care coordination and ongoing management that have been shown to be effective when treating those with chronic illness and addressing the complex care issues often associated.

Also, under today’s volume-based payment system, hospitals, physicians, and others who provide high-quality, efficient care so as to reduce the volume of patient services needed face potential for decreased payment. In addition, the payment system encourages competition among healthcare providers for high-margin services, often leading to fragmented care, and in some cases, an oversupply—and overuse—of services.

National Expenditures for Health Services and Supplies* by Category, 1980 and 2006†



* Excludes medical research and medical facilities construction.

† CMS completed a benchmark revision in 2006, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/benchmark.pdf>.

†† "Other" includes net cost of insurance and administration, government public health activities, and other personal health care.

§ "Other professional" includes dental and other non-physician professional services.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released January 7, 2008.

Physician Integration

Improving quality and efficiency of care delivery also may require new relationships with physicians. Distribution of healthcare spending is shifting over time. Hospital spending now accounts for only about one-third of total healthcare expenditures, while spending on physician and other ambulatory services has been growing.

Also notable is that patient volume continues to shift from inpatient to outpatient settings, and the volume of nonhospital outpatient healthcare services has been increasingly rapidly (see page 6). Traditional hospitals find themselves fighting for market share with imaging centers, surgicenters, ambulatory care centers, and urgent care centers—many owned by physician investors.

As health care moves toward ambulatory settings, it is creating the opportunity and need for hospitals to develop new business models and physician relationship management strategies to remain competitive.

Technology

Opportunities for efficiencies and improved quality of care will likely be heavily dependent on technology as well. The electronic collection, aggregation, and

reporting of health-related information has been a central theme in the effort to improve the quality, safety, efficacy, and cost of health care. A hospital's potential to improve operational efficiency through automation exists in most every function from scheduling to capturing care documentation.

IT capabilities particularly needed in the current healthcare environment include improving, measuring, and reporting quality and safety of care; linking provider reimbursement to care performance; responding to increases in outpatient care; providing greater levels of patient service and engagement; and improving cost-effectiveness and coordination of care delivery.⁴

It should be noted that the nation's financial crisis has led to some delays in capital projects, cuts in capital and operating budgets, and reductions of workforce. However, a December 2008 national survey of more than 150 CIOs and senior financial executives shows health IT remains a strategic imperative. Electronic medical records, electronic health records, computerized provider order entry, and electronic medication management remained high-priority projects for about half or more of those responding to the survey, which was conducted by the College of Healthcare Information Management Executives, the National Alliance for Health Information Technology, and AHA Solutions.⁵

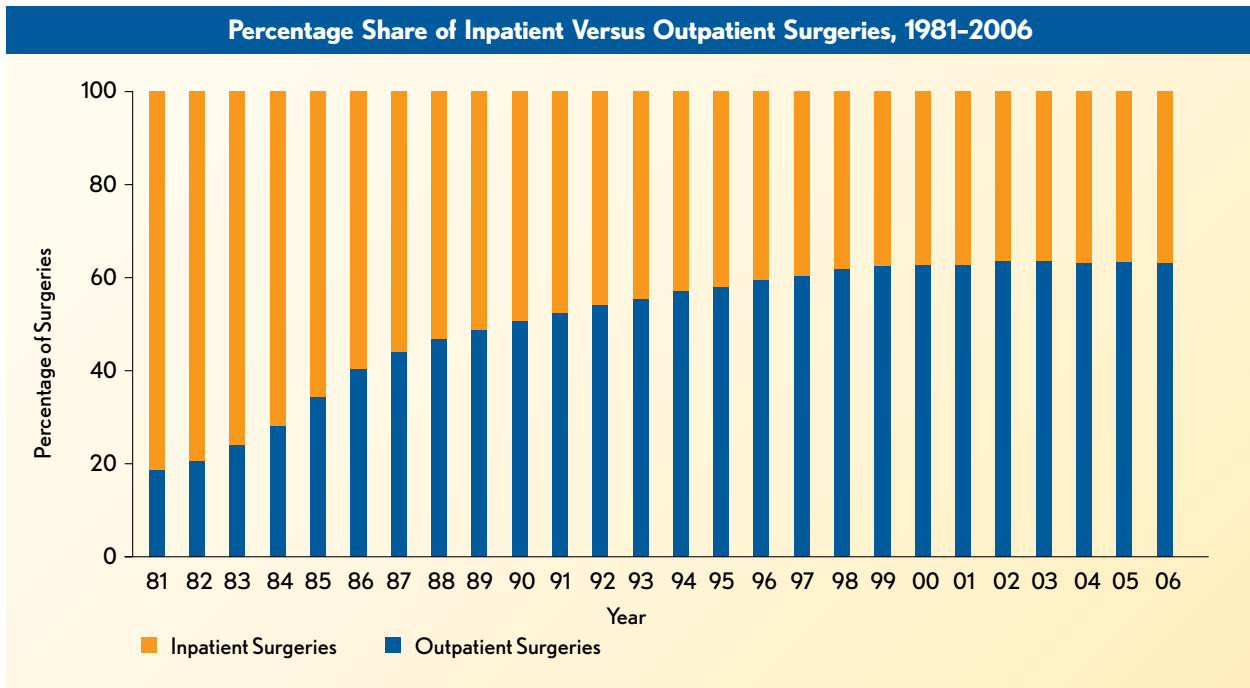
Capital Planning

Of course, the success of any significant initiative driving change in workforce, physician integration, or technology will depend on level of investment.

Effectively managing capital investments and portfolio risk takes on increased importance given today's economic challenges. It is becoming increasingly difficult and expensive for hospitals to finance facility and technology projects. As some industry advisers note: "It's now a buyer's market for healthcare debt and credit spreads have widened, which is deepening the gap between strong and not-so-strong hospital credits.

The 3 percent to 4 percent all-in-cost of capital (i.e., total cost of capital, including interest and ongoing fees involved with maintaining the financing) may not be seen again soon."⁶

Reduced debt capacity will have considerable strategic implications for most hospitals and health systems. In a November 2008 American Hospital Association survey of 736 hospital CEOs, the majority (56 percent) reported reconsidering or postponing new capacity/renovation projects. Forty-five percent indicated they were reconsidering or postponing clinical technology/equipment investments.⁷



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2006, for community hospitals. Used with permission.

Scenarios for the Future

By examining potential scenarios regarding these key drivers of today’s healthcare environment, hospital executives can best identify opportunities to leverage strategic action for competitive advantage in the near term as well as the future. With this in mind, HFMA’s survey participants and industry leaders identified the following trends and associated strategic needs.

Workforce

Fewer physicians and nurses are entering the healthcare workforce. The aging of the ranks of clinical as well as business and finance professionals further threatens to deplete key elements of the hospital and health system workforce. Given these trends, 37 percent of HFMA survey participants believe that the nurse shortage will exceed 20 percent in 10 years. Fifty-eight percent expect a high level of retirement and job transitions to create a knowledge gap in healthcare business and finance roles.

Because of these demographic and professional trends, 60 percent of survey respondents believe that in 10 years healthcare human resource management will be dramatically different than it is today. The most compelling difference will be employment. Most survey participants (91 percent) believe that hospitals will be

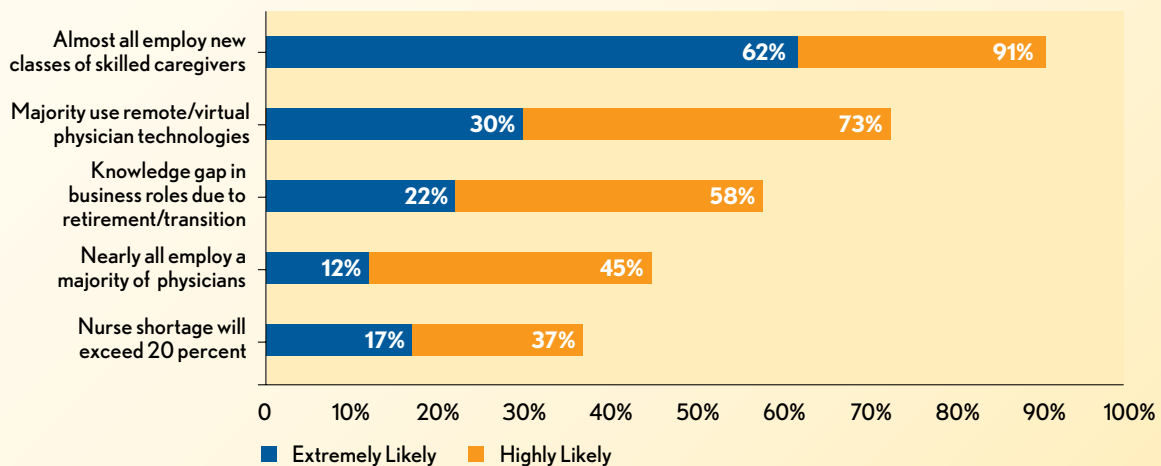
employing hospitalists, intensivists, laborists, and other new classes of skilled caregivers, and 45 percent predict nearly all hospitals will be employing most of their physicians.

While significant shortages of healthcare professionals are likely over the long term, they are not critical in the next six or seven years, according to industry estimates and expert opinion. The Association of American Medical Colleges projects a shortage of physicians ranging between 55,000 and 200,000, but the deficiency will not materialize until 2020.⁸ Recent research by Peter I. Buerhaus, RN, PhD, indicates that instead of seeing a shortfall of nurses on the order of 800,000, the deficit is expected to be around 340,000 in the next decade—still a formidable figure, but one that is more manageable than previous estimates.⁹

The impending economic downturn will temper some workforce shortages at least in the short run. The erosion of the U.S. economy actually is a golden opportunity for attracting new employees to the healthcare professions, particularly nursing.

“Nursing is perceived positively by parents who are thinking about their daughters and sons who are beginning a career. They like the economics and the security of the profession,” noted Buerhaus, who is the Valere Potter Distinguished Professor of Nursing and Director for the Center for Interdisciplinary Health

Workforce Scenarios in the Next Decade



Workforce Studies in the Institute of Medicine and Public Health, Vanderbilt University Medical Center, Nashville, Tennessee.

Downturns in the economy also will stimulate many nurses who are not working to re-enter the workforce. Buerhaus has traced the relationship between overall unemployment rates and nurse vacancy rates in hospitals in previous recessions, and he found that as the rolls of the unemployed climb so do the numbers of nurses working in hospitals. “The unemployment rate is currently around 6 percent, and is expected to increase—up to 7 percent or 8 percent. This will create strong economic incentives for increasing RN participation and hours worked in the nurse labor market,” Buerhaus said. “Seventy percent of nurses are married, so if their spouses lose their jobs or are worried they might, then many married RNs will be more than eager to re-enter the labor force.”

Therein lies the danger. “My worry is that we will repeat history,” he said. “As the nurse vacancy rates drop, nursing students will be asking, ‘Where are the jobs?’ Hospital executive leadership will be wondering, ‘Nursing shortage. What nursing shortage? Let’s move on to some other topic.’ But this will be a short-term and temporary change, and meanwhile the longer term trends shaping the future supply of RNs will continue.”

Projections from the U.S. Department of Health and Human Services show a demand shortfall of FTE nurses going from 27 percent in 2015 to 36 percent in 2020.¹⁰ New research from Buerhaus also predicts that nursing shortages in 2015 and 2020 will be significant, but that they do not appear to be of “the overwhelming 800-pound-gorilla type.” Employment data from 2006 show there has been a seismic reversal, as Buerhaus calls it, in the nursing sector. Although employment growth was -27,250 for U.S. and foreign born RNs in 2005, it exceeded +79,000 for both groups in 2006. From 2002-05, the cumulative growth of RNs between the ages of 21 and 34 was -10,371. In 2006, growth was +46,000.¹¹

Regardless, taking a longer term trajectory, the alarm bells clamor. The shortage of registered nurses could reach as high as half a million by 2025, according to a 2008 study that Buerhaus conducted with Douglas Staiger of Dartmouth University and David Auerbach of the Congressional Budget Office.¹²

The key driver is the aging of the workforce. The average age of nurses is increasing, and many nurses are nearing the end of their careers. In a 2006 national survey of nearly 1,000 nurses, 55 percent reported their intention to retire between 2011 and 2020.¹³ The majority of those surveyed were nurse managers, presenting a particular drain on leadership talent.

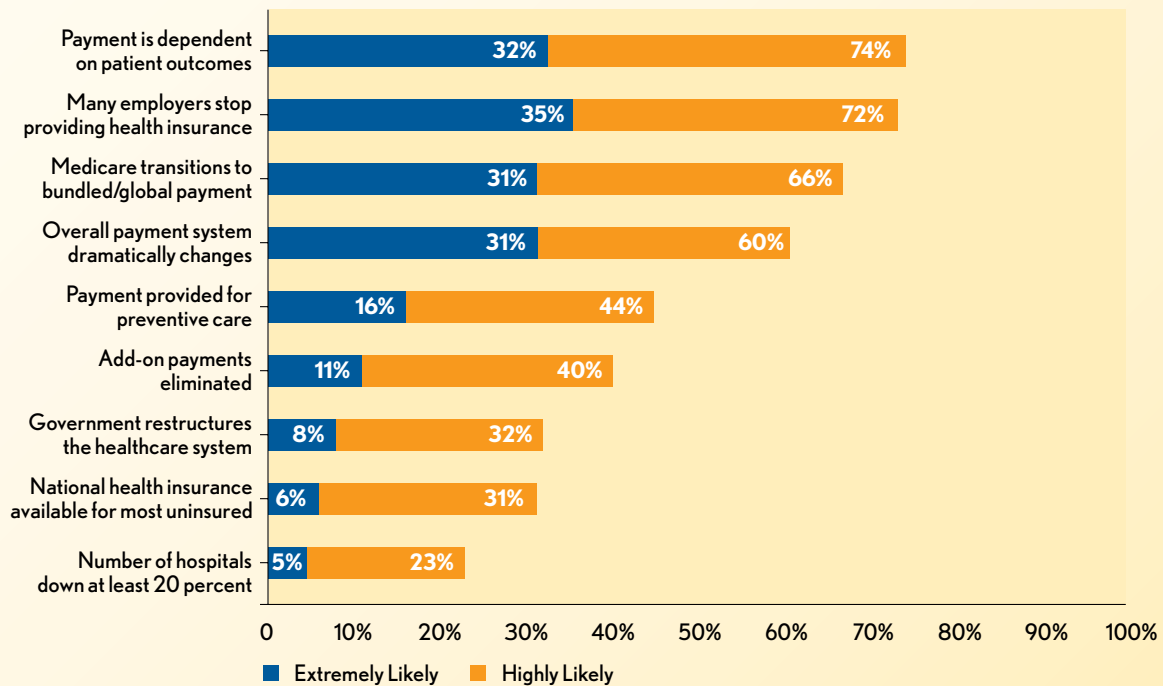
“Because we will have so many people retiring out of the workforce, if we don’t replace them and also expand the long-run supply to meet the projected increasing demand for nurses, then hospitals will be in trouble,” said Buerhaus. “We are going to have to get a lot of things right by eight to nine years from now to have a good chance of knocking the future shortage of 500,000 nurses down.”

It is exactly the wrong time to repeat history. “We need to continue the effort and momentum we have built over the past couple of years to improve the working environment and keep older nurses in the workforce. We also urgently need to address the capacity problem in schools of nursing, which blocks the ability to produce all the nurses that will be needed for the future,” he said.

According to the American Association of Critical Care Nurse’s report *2007-2008 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*, U.S. nursing schools turned away 40,285 qualified applicants from baccalaureate and graduate nursing programs in 2007 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Almost three quarters (71.4 percent) of the nursing schools responding to the survey pointed to faculty shortages as a reason for not accepting all qualified applicants into entry-level nursing programs.

Over the past five years, little has been accomplished to meaningfully expand the output of nursing schools and at the same time focus nursing education on the need to emphasize quality and patient safety. “We’re going to need more of a public policy response from the federal government. And if we are going to use public dollars to help schools of nursing expand their structural capacity, then we should link any subsidy to whether the program builds strong curricula in quality and safety, geriatrics, care of people with chronic conditions, and treatment in nonhospital settings,” Buerhaus concluded.

Payment System Scenarios in the Next Decade



Payment System

While 60 percent of HFMA survey participants state the current payment system will be dramatically different 10 years from now, several respondents were somewhat dubious. One commented that “significant change will occur, but it will take longer than 10 years to affect an overall payment system to improve financial health for providers.” Another noted the protracted regulatory process: “It will take longer than 10 years to get legislation through committees, legislation, and rule-making.”

Even if the overall payment system is not dramatically different, most participants (74 percent) contend that payment will be substantially influenced by patient outcomes, and 66 percent feel that Medicare will pay for most care with bundled or global payments by the end of the next decade.

Employers also will drive change in the healthcare payment system. Employers that continue to offer healthcare benefits will be looking for a payment system better able to demonstrate that they are getting their premium’s worth. “Employers will be demanding value-driven payment systems that are based on evidence-based practices instead of fragmented service reimbursement,” said a respondent.

An overarching prediction (cited by 72 percent of survey participants) is that employers will stop providing health insurance to their employees altogether. “I’m not sure the government will impact the payment system so much as employers no longer offering insurance, since the trend will force competition for the uninsured population who can afford healthcare coverage,” said one.

Lisa Goldstein, senior vice president and team leader for Moody’s Investors Service, New York, can foresee large employers scaling back or stopping healthcare benefits. “Auto companies will try to cut costs, and healthcare benefits will be a focus. So we can anticipate continuing rises in the numbers of uninsured and a continued pass-along of healthcare costs from employers to employees by way of high deductibles and copays,” she said.

As SSM Health System, St. Louis, continues to see growing numbers of patients bear increased responsibility for healthcare payments while it experiences mounting levels of bad debt because these individuals are not able to pay, CFO Kris Zimmer frets about a breaking point. For many providers, managed care payments have helped make up for inabilities of government or self-pay to cover costs of care. “If employers are not

going to provide meaningful coverage, then the health-care industry will not be able to stand by reverting to private pay," he said.

Rising costs and overall spending will make health-care payment transformation inevitable, noted Peter DeAngelis, executive vice president and CFO, Catholic Health East, Philadelphia. "Ultimately when you look at how the United States ranks against developed countries relative to healthcare costs per capita and increasing spending patterns through the government and other payers, you realize it's an unsustainable trend," he said. "Payment reform is needed to achieve equilibrium within the federal and state budgets, just at a minimum. More important than that, quality should be driving payment reform. So outcomes, which more and more will prove to be driven by coordinated models of care rather than episodes of care, will lead the payment system to change. The sooner this occurs the better for those we serve, even though accomplishing it will be challenging and require providers and payers, both public and private, to work together in ways beyond the current payment structures in the years ahead."

Change in fact is already under way. The Centers for Medicare & Medicaid Services (CMS) and some national and regional private insurers are tying payment to patient outcomes by refusing to pay hospitals for eight adverse or never events that were not present on admission: falls, mediastinitis after heart surgery, urinary tract infection or vascular infection following catheterization, pressure ulcers, objects left in the body after surgery, air embolism, and blood incompatibility. In the 2009 federal fiscal year, CMS's list of never events will expand to include surgical-site infections following elective orthopedic and bariatric operations, poor control of blood sugar levels, and deep vein thrombosis or pulmonary embolism after total knee or hip replacement surgeries.

In an effort to improve treatment outcomes, CMS, private insurers, Medicaid programs, and employers are piloting pay-for-performance programs that reward hospitals if they meet specific quality measures. After three years, CMS reported that as a result of the Hospital Quality Incentive Demonstration program, quality improved 16 percent for more than 1 million patients who had been treated for one of five conditions in 250 hospitals across 36 states. Hospitals that met quality measures for bypass surgery, heart failure

or heart attack, hip and knee replacement, and coronary artery bypass surgery shared in a total of \$24.5 million.¹⁴

The ProvenCare pay-for-performance program at foundation-model Geisinger Health System (GHS), Danville, Pa., cut complication rates after coronary artery bypass surgery by 40 percent and length of stay—which was already the lowest in the state—by a half-day.

"Patients were healthier, readmissions were reduced, ER visits after surgery were cut substantially, and the hospital made a little bit more money, which could be shared by the surgeons," said Bruce H. Hamory, MD, Geisinger's executive vice president and CMO.

ProvenCare, which covers the entire episode of care—including acute and chronic care management as well as secondary prevention, is now being applied to hip replacement, cataract surgery, coronary balloon angioplasty, elective heart valve surgery, and prenatal care, Hamory said.

Bundling payments, which was piloted by the Health Care Financing Administration in the early 1990s, is being revisited as a means of coordinating treatment in and outside the hospital. CMS is testing the bundling of payments to hospitals and physicians for post-hospital care as well as inpatient care of patients following cardiac or orthopedic care in four states in the first part of 2009.

"There has been a sea change concerning bundled payments in the past two years," said Paul B. Ginsburg, PhD, president of the Center for Studying Health System Change, Washington, D.C. "More and more people who weren't thinking about the concept before are now accepting or supporting the notion that our future will have more bundled payments. That's striking."

What is more uncertain is how it will come about. "Medicare may make changes on its own or in conjunction with other payers, and that makes it hard to predict the course of events," Ginsburg said.

Ginsburg is more of a contrarian when it comes to outcome-based payment. "I don't see that trend becoming very pronounced. You can go some distance with never events, but once you get past them, you have to have an effective risk-adjustment system to link outcomes and payment. That is going to be a barrier to payment systems that are based on outcomes," he said.

Pay for performance may not gain traction, Ginsburg added, because it is process-oriented and lacks physician buy-in. He points to a 2005 article in the *Journal of the*

American Medical Association that concluded standards of care and pay for performance based on clinical practice guidelines for common chronic diseases could adversely affect elderly patients. If clinical practice guidelines were applied, a hypothetical 79-year-old woman with chronic obstructive pulmonary disease, type 2 diabetes, osteoporosis, hypertension, and osteoarthritis would end up taking 12 prescribed medications and following a complicated regimen of care that could trigger adverse interactions, reported Cynthia Boyd, MD, from the Center on Aging and Health, Bloomberg School of Public Health, Baltimore.¹⁵

“It’s not that physicians don’t embrace consensus. It’s often that they don’t believe it will be beneficial for particular patients,” Ginsburg said. “I’m very influenced by the article by Boyd because it showed that cataloguing all the things a physician was supposed to do according to the guidelines was absurd. It wasn’t good care.”

Whether a pay-for-performance system will be financially beneficial to hospitals remains to be seen, according to SSM Health’s Zimmer.

“Some people have said that pay for performance is a proven success, but I don’t believe that has been the case so far,” he said, noting that incremental improvement and limited financial distinction for a small portion of patients isn’t likely to dramatically drive industry behavior. “What will matter in the future are focus and transparency associated with specific processes of care, along with a belief that pay for performance isn’t going to be an experiment forever.”

The underlying question is: How can a scattergun approach lead to meaningful payment reform? As Zimmer observed, the current environment is fragmented: “We have a Medicare payment system that is complex and changes frequently but by many measures is more efficient than the systems we have for other payers. We have Medicaid payment systems which vary by state and aren’t that effective. We have managed care and private pay systems, but no two are alike.”

Which of these payer groups could take the lead? “Government payment systems desire to provide coverage for a population in a fair and reasonable way, so in some ways you would think government-sponsored plans could be leaders in the way health care is delivered,” Zimmer said. “But I have never seen much evidence of government leading anything. Government is the glue that holds us together. It is a stabilizing factor and

provides infrastructure and the rules and boundaries we live within. That’s the good of government. But I don’t think we should expect government to lead care processes, improvement, and change.”

The private sector, by the nature of how it is built, is profit first, societal needs second, he added. “These are companies that are designed to drive profit to shareholders, so we shouldn’t expect them to put other priorities above that. If they can achieve a marketing or cost advantage, be creative leaders, and take industry in a new direction at the same time, then they’re happy to do it—but the first requirement is a business benefit,” he said.

Are providers the white knights in all of this? Not really, according to Zimmer. “The majority of hospitals and healthcare systems in America are truly driven to do good for their communities. It’s a very deeply rooted part of who they are, and it’s their primary objective. But when we do our work every day, we’re busy surviving.”

Because there is no forum or mechanism for directing or effecting major change, experiments in payment therefore keep nibbling around the edges. “Maybe that’s the only way to make major change in something as big and complex as the healthcare payment system,” Zimmer concluded. “We keep nibbling at it until we eventually see the light and can make rapid movement toward an end goal.”

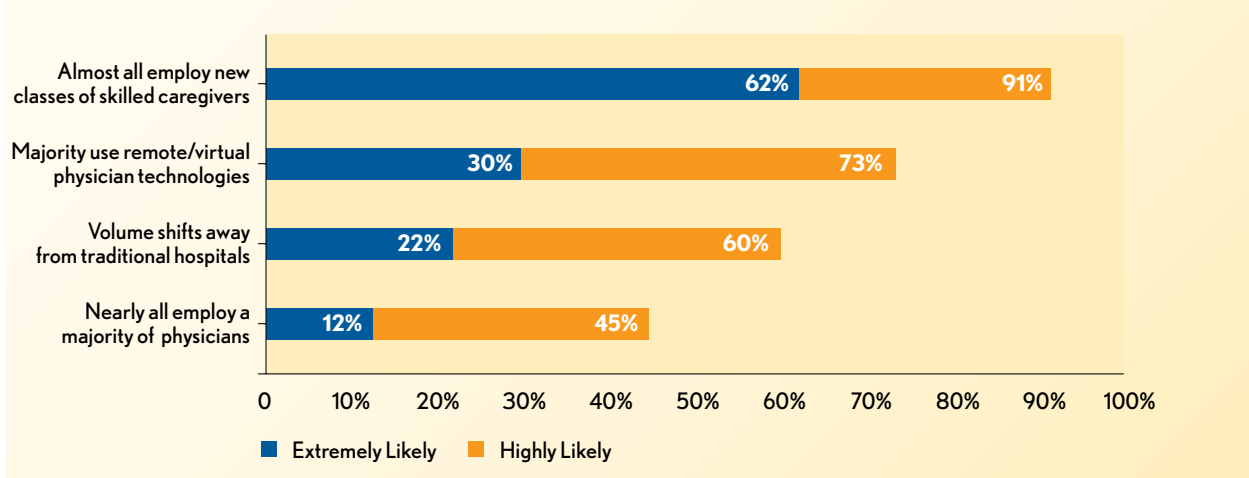
Physician Integration

What can hospitals and healthcare system leaders do to prepare for the workforce and payment challenges that will emerge a decade from now? The single most important near-term action identified by HFMA survey participants is to develop a business plan for integrating physicians, whether it is through employment, recruitment incentives, or alignment strategies. What’s more, 45 percent of survey respondents believe it is highly likely or extremely likely that “nearly all hospitals will employ a majority of their physicians” in the next 10 years. (See chart on page 12.)

Hospitals and healthcare systems are employing physicians far more frequently than they have in the past. A 2007 review of physician recruiting incentives shows that hospitals offered employment to physicians nearly twice as often in 2007 than in 2006 and 2005.¹⁶

Healthcare organizations are turning to employment to counter growing shortages of physicians in

Physician Interaction Scenarios in the Next Decade



cognitive fields, ensure call coverage by trauma and surgical specialists, and respond to outcome-based and bundled forms of payment. Hospitals will need to have strong working relationships with their medical staffs as well as physicians within their communities as interest continues to grow in tying payment to quality-based measures and cost-effective care.

“Hospitals are recognizing that they are highly dependent on physicians for not only their patients but also for directing, together with nurses and other professional groups, the processes by which those patients are cared for,” said Geisinger Health’s Hamory. “Both of those factors are leading toward physician employment.”

Although market situations vary, the move toward employment appears to have staying power. “Hospitals began actively employing physicians a year or so ago, and even with the economic challenges are continuing to do so. Hospitals are telling us that they cannot temporarily stop the employment. It’s critical to their long-term strategy,” said Moody’s Goldstein.

That said, hospitals need to learn from the mistakes of the past. In the 1990s, when hospitals were actively employing physicians as a hedge against managed care, they ended up losing more than \$90,000 per physician per year because guaranteed payment tended to reduce productivity. Hospitals also failed to develop a sense of community among primary care physicians and specialists because they employed physicians in single specialty practices and treated each group differently.¹⁷

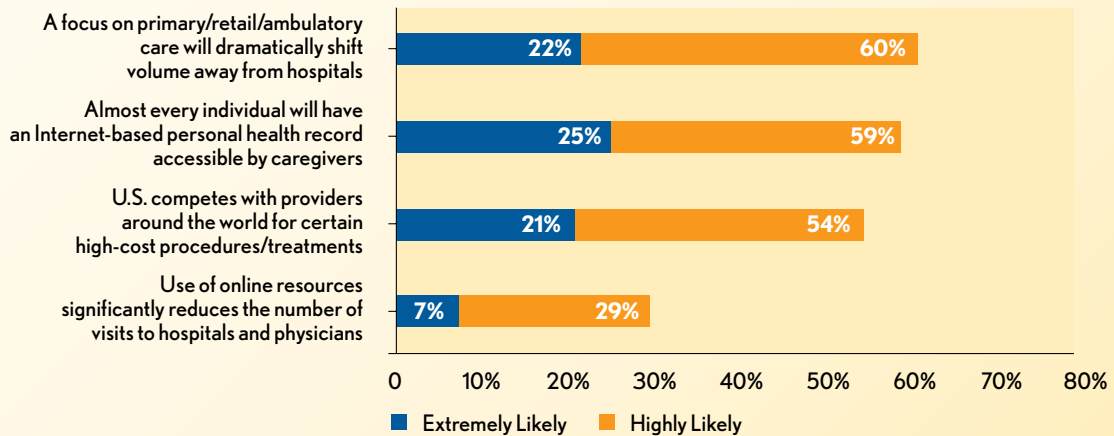
Paths to physician employment are far more flexible today, however, and include short-, part-, and long-term options. And physician compensation fluctuates on the basis of billings or net collections or in a relative value unit system that is linked to productivity or quality measures.

What’s also new in this area is that the desire to work out an economic arrangement is coming from both the hospital and the physician. “Ten years ago, when hospitals were employing and acquiring physicians, the decision was primarily driven by the hospital. These days, both sides recognize the value, and they are coming together in more collaborative ways,” she added.

Physician employment still may not be the best model for the future, however. “I’m not convinced that employment is the right endgame for hospitals,” Zimmer said, noting that hospitals must keep the big picture in mind.

According to a 2006 survey of 362 operational and clinical leaders in 300 hospitals, employment of certain classes of physicians was considered to be highly effective, but across-the-board physician employment was only moderately effective. The study, conducted by the Society for Healthcare Strategy and Market Development of the American Hospital Association, evaluated a wide range of physician-hospital alignment alternatives and ranked the most frequently used as well as the most effective strategies.

Patient Scenarios in the Next Decade



Of the 16 strategies highlighted in the study, the top three strategies ranked most effective involved the employment of hospital-based physicians:

- Employing intensivists (75 percent)
- Employing a vice president of medical affairs or some other high-level physician leader (74 percent)
- Employing hospitalists (74 percent)

Also notable, a majority of the sample felt the employment of primary care physicians was an effective option (65 percent) and were in favor of employing office-based specialists (64 percent). The options that ranked more effective than employing primary care or specialist physicians were:

- Providing financial support to independent practices to recruit new physicians
- Sponsoring retreats for physician leaders and senior managers or all physicians, board members, and senior executives
- Maintaining a formal physician relations program
- Actively involving physicians in planning and developing clinical service lines or centers of excellence¹⁸

The direction over the long term is not completely clear. Some groups of physicians are experiencing pay cuts and therefore are open to alignment with hospitals. However, some hospitals are so anxious to make physicians part of the team that they are willing to pay a compensation level that is overstated.

“Unless we can create sustainable value from employment integration, physician employment will be just a short-term strategy,” said Zimmer. “Then you get

into the debate: Is the long term a series of short-term tactics or does it involve movement toward some theoretical better destination?”

Beyond implementing effective employment models, which is a must-do activity, many other physician-hospital strategies can be viable both strategically and financially, said Jay Warden, senior vice president at Kaufman, Hall & Associates, who cites centers of excellence, management service organizations, co-management, participating bond transactions, and joint ventures as other options that can be considered.¹⁹

Technology

Many responding to HFMA’s survey anticipate virtual and remote physician technologies will be utilized by a majority of hospitals in the next 10 years. Also stressed was use of technology to change patients’ health care experiences and engagement in their care. When surveyed in regard to patient care scenarios, 59 percent of respondents believe it is extremely likely or highly likely that “almost every individual will have an Internet-based personal health record accessible by caregivers” in the next decade. Twenty-nine percent believe individuals’ use of online healthcare resources will significantly reduce the number of visits to hospitals, physicians, and other providers.

As hospitals face the future, respondents stressed the need to develop strategies to align IT with transformations in payment and care delivery structures. Such prioritization ranked fifth in importance of near-term actions to be taken by hospitals.

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Future-Focused Case Studies

The following providers are engaged in innovative projects that address many of the factors identified as most pressing to health care over the next 10 years. These large hospitals were selected specifically as inspiration for ways all hospital leaders can explore putting their vision into action to improve healthcare value and patient care.

Catholic Health East A Pioneer in Comprehensive Care Management

In 2006, Catholic Health East (CHE), Philadelphia, launched a strategic planning process to define the healthcare delivery model for 2017. The end result is a coordinated, integrated care management effort that empowers individuals and communities to achieve optimal health and quality of life. “We tried to frame out what healthcare delivery would look like, given the impaired payment system and lack of access to care, and the closest model that we could envision over a 10-year planning horizon was person-centered care that was coordinated throughout the life cycle and across the continuum of care,” said Peter DeAngelis, executive vice president and CFO.

CHE does not yet have a full-blown model for placing the person in the center of the healthcare delivery system or for organizing and managing care around that individual. But it is engaged in a four-phase process that takes existing care management functions within its existing acute care-based system and migrates them to community-based or person-centric comprehensive care management. After restructuring hospital-based case management, the initiative will move beyond the acute care setting to develop a patient portal, wellness tools, disease management protocols, and outcome measures. It will also integrate community approaches involving local providers and social or faith-based organizations and then develop regionalized strategies that will support and leverage systemwide approaches for care management.^a

CHE is beginning to test comprehensive care management concepts in a series of pilot programs. Pilot programs are working with managed care plans and geriatric care management programs to apply the concepts of comprehensive care management to targeted

patient populations, such as Medicaid patients, geriatric patients, and the Medicare risk population. “Hopefully, we will identify a win-win scenario between providers and payers that shows cost can be reduced and care improved, and that economic benefit might be shared among physicians, hospitals, and payers,” DeAngelis said.

The pilot programs are not far enough along to provide proof of the concept of person-centered care. But initial efforts are identifying the challenges that lie ahead. “The payment systems obviously must be reformed to align incentives of providers and insurers to this type of approach,” said DeAngelis. “Government and managed care players need to embrace a payment system that rewards care management rather than an episode-of-care or fee-for-service methodology. That is the biggest challenge.”

The foundation of any care management approach is a personal and comprehensive health record. “Inherent in the idea of a personal health record is the technological support and infrastructure that allows providers to population health information for individuals on a continuous and transportable basis,” he said.

DeAngelis is confident that both of these challenges will be overcome within the next 10 years. “Our research suggests that consumers, particularly the baby boomers, will want their own health information and demand it,” he said. “And the more it’s demanded, the more likely it will occur. Outcomes that are driven by better models of care, such as care management, will ultimately drive changes in the payment system. How we will get there, I’m not sure. But I do believe we will see both of these things in the next decade.”

Geisinger Health System Physician Integration

Geisinger Health System (GHS) efforts to design healthcare models for the future capitalize on physician integration. GHS is a regionally integrated three-hospital health system built around a 740-member employed physician group practice and an insurance company that covers a third of its business. It is jointly led by physicians and healthcare administrators at all levels, including its most recent experiments in collaborative healthcare ventures: a medical home model, chronic disease care optimization, and acute episode care.

GHS's patient-centered *medical home model* coordinates disparate elements of patient care by providing around-the-clock access to primary and specialty care; nurse coordinators at each practice site; a personal care navigator to answer patients' questions; all-around proactive evidence-based care to reduce hospitalization, promote health, and optimize the management of chronic disease; home-based monitoring; interactive voice-response surveillance; and end-of-life care support.^b

Physicians are encouraged to participate in the medical home through provision of monthly payments of \$1,800 per physician to cover the expanded scope of practice. To offset costs of adding staff and making other changes to coverage or infrastructure, physicians also receive \$5,000 per thousand Medicare members. In addition, an incentive pool is prorated on the basis of meeting designated quality metrics.

A primary goal of the project is to reduce the rate and extent of hospitalization. After one year at two pilot sites, the medical home model decreased hospital admissions by 20 percent and saved 7 percent in overall medical costs.

Chronic disease care optimization extends chronic care beyond the medical home to all Geisinger community practice sites. The system coordinates and provides evidence-based care for patients with congestive heart failure, chronic kidney disease, coronary artery disease,

diabetes, and hypertension. GHS's electronic health record helps standardize clinical practices by obtaining and summarizing patient data before each visit, identifying individual patients' needs and incorporating them into order sets, and tracking performance against a bundled set of performance metrics. "We are not looking at incenting physicians to achieve LDL [low-density lipoprotein cholesterol] control or some other specific metric. We're saying there is a high bar, a high expectation to get all evidence-based care elements done," said Bruce H. Hamory, MD, executive vice president and CMO at GHS.

The chronic care program offers financial incentives of as much as 20 percent of a physician's total compensation for meeting quality, value, and patient satisfaction objectives as well as improvements in bundled metric scores.

Initial experience with the program demonstrates improvements in quality as well as cost. "To take one example, we've taken influenza immunizations from 60 percent to 85 percent, and we've had the same success with pneumococcal vaccinations, which is up from 55 percent to 85 percent—an indication of real progress," Hamory said. In addition, the cost of treating anemia associated with chronic kidney disease dropped \$3,800 per patient per year.

Acute episode care, or Geisinger ProvenCare, reengineers the management of acute episodes by identifying and implementing best practices across the entire episode of care, instituting risk-based pricing, and engaging patients in their care. The first ProvenCare program for patients undergoing coronary artery bypass surgery includes 40 best practice steps in workflow routines, revamped patient education materials, and a "patient compact" that is signed by the patient and the physician. An overall price covers preoperative evaluations, hospital and professional fees, routine discharge care, and complications within 90 days of discharge.

^b Paulus, R., et. al, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs*, Sept./Oct. 2008, pp. 1235-1245.

Unlike current pay-for-performance programs, ProvenCare encompasses acute, chronic, and secondary preventive care, offers significant incentives, imposes financial consequences for noncompliance, and electronically tracks and reports care management.

“Keys to success are having physicians involved in the design and operation of the programs, along with administrators and nurses; providing data and immediate feedback; and using payment not as a motivator but as recognition for performance,” Hamory said.

Partners HealthCare Next-Stage Revenue Cycle Data Use

Increased complexity of payer rules, the growing influence of consumerism, and pressures on the bottom line are just a few of the factors that have triggered providers such as Partners HealthCare system to reexamine financial data use. Partners is engaged in an enterprisewide initiative to implement a single set of patient administrative systems and revenue cycle processes across its organization of academic medical centers, community hospitals, specialty hospitals, community health centers, and physician practices.

Technology will eventually support standardization of processes as well as information sharing from facility to facility in relation to patient scheduling, registration, bed management, and inpatient and outpatient billing. “To operate most effectively as a system, you have to ensure a patient’s information will be the same wherever the patient goes,” explained Peter Markell, the system’s vice president of finance.

Looking ahead, the organization hopes to interface its systems directly with those of insurance companies so as to improve eligibility verification processes. Such connectivity has the opportunity to improve financial performance as well as the patient experience, noted Markell. “As an industry, we leave too much money on the table,” he said. “There are too many denials and

losses of payment that are the result of missing or inaccurate patient data. And frankly, a common source of dissatisfaction for patients when dealing with the healthcare industry is the whole administrative flow of information.”

Partners HealthCare also is focusing on technology use to improve clinical operations. The system already is fairly advanced with use of electronic medical records in inpatient and outpatient settings. “Our main focus now is two-fold: one is to improve clinical decision support and the other is integration of the inpatient and outpatient medical records,” said Markell.

The overriding goal for the revenue cycle project and its eventual tie to clinical improvements is more effective and safe clinical practice and an improved patient experience.

Efforts to better engage patients in data sharing support the organization’s vision for the healthcare experience of tomorrow. Noted Markell: “People want different portals that will allow them to interact with us at their convenience—whether by phone, face-to-face communication, or computer. We’re really trying to make it easier to exchange information with us and to make healthcare administrative processes more service-focused and easier to navigate.”

Metro Health Healthcare Village

When Metro Health Hospital CEO Michael Faas realized that the organization could purchase 170 additional acres of property surrounding the site of a replacement facility, he wondered how he would optimize use of the land. Questionnaires and focus groups with community members suggested adding an upscale day care facility, fitness center, and medical services as well as restaurants, stores, and even a hotel or motel. On business trips to major cities around the country, Faas noted that many hospitals were surrounded by retail venues. The final lightbulb moment came as he was walking through a mall in an airport: Why not create an actual healthcare village? “I visualized this as the old town square but instead of having the courthouse in the center of it, we would have the hospital as the center of a destination people came to for lots of reasons,” he said.

Thus was born Metro Health Village, Wyoming, Mich., which includes a hospital, medical facilities, and retail outlets, including a grocery market that sells organic foods, a hotel, three restaurants in various stages of development, medical and dental offices, a hearing aid and audiology company, and a durable medical equipment provider. The hospital also is donating land to the city to develop a handicapped-enabled play park and designating an area in front of the hospital as a village green where people can gather for Friday night band concerts. “The idea is to come to the site for more than just sick care or a visit to the doctor’s office. It’s built around the concept of a leisure mall where you can park somewhere and walk the whole site and visit a park or some stores or restaurants,” he said.

Like any hospital, Metro Health Village is a major employer in its community. It is also an economic engine. In addition to enhancing the experience of

patients, physicians, and employees, Metro Health Hospital seeks to create the best community experience. “One of the ways we thought we could craft that is to act as a catalyst for economic development,” Faas said.

Metro Health Village’s goal after five years is to have 50 percent of its retail capacity filled. “We gave ourselves five years because we didn’t want to act like a developer and fill every building with any retail venue, like fast food operations or gas stations. We wanted to fill the buildings with the things that ought to be in a health village,” he said.

The retail operations that have already relocated to Metro Health Village are doubling and tripling their volume. “That’s the halo effect of the hospital being on the site, and having 12,000 cars drive through the site every day,” Faas said.

The village is taking its time because it doesn’t want to lose sight of its vision. “We are out to add value to the community and bring things into this area that are not otherwise locally available or things that are more advanced than currently available,” he said.

The vision for the future is one that has hospitals taking an active stance and providing concrete examples of the value they bring to the community. “We are going to continue to be a major player as employers, as contributors to the GDP and the service industry,” Faas said. “We are economic engines anyway. So how can we take advantage of that and build on it and leverage our already preferred status in the community to move it forward? In our case, we are taking a unique route to show our community that we are going to provide excellent quality of care at a reasonable price. But we are also going to be a leader in the community and take an active development perspective to the community.”

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“Health care is getting more complex,” noted Ian Worden, system vice president and CFO at St. Vincent Health System, a member of Ascension Health that includes 18 hospitals and close to three dozen joint ventures throughout central Indiana. “We need better tools for understanding our processes and being able to slice and dice the data.”

As part of a pilot program for Ascension, St. Vincent Health is in the process of converting its facilities to a unified revenue cycle system. One goal of the new technology is that once a patient is registered at a St. Vincent facility, the information will be accessible throughout the system. “Knowing patients’ information as they are referred for different services will help in terms of patient safety and clinical processes and being able to make sure billing is appropriate from the outset,” he said.

Integration of processes also is occurring. One key component of the project is development of a unified system for coding by entity, department, and service to improve the organization’s ability to mine clinical and financial data from the revenue cycle. So, for example, where traditionally a code for an EKG might vary from department to department and facility to facility, the organization now can map all EKGs to the same service code. Having a consistent database where the organization can compare data by entity, department, and service code will allow the organization to do such things as more accurately track changes in service use, use zip code analysis to determine optimal resource use for service needs, and better understand consumer response to pricing changes.

“It’s really all about, ‘How can I get my data to tell me information I need to know?’” says Worden. As business intelligence improves, he says the organization’s next goal will be improving decision support.

Business intelligence that provides the IT platform and associated tools to help gather, provide access to, and analyze data about the organization’s operations is just one of the major classes of technologies that should form the core of hospital executives’ long-range technology strategies, according to a recent article by John Glaser, PhD, vice president and CIO for Partners HealthCare, and Tom Foley, partner, Deloitte Consulting, LLP. Other technology classes include:

- EHRs, supported by the adoption of computerized provider order entry, care documentation, medication administration, and results management

- Customer relationship management tools that help treat the unique needs of individual customers
- Information technologies that support connected care at locations other than the hospital or physician office
- Clinical decision support that provides clinicians, staff, patients, and other individuals with knowledge and person-specific information, intelligently filtered or presented at appropriate times, to enhance health and health care
- Interorganizational systems shared by the hospital and other organizations, such as payer-provider transaction exchanges, provider-supplier-purchasing exchanges, and exchanges of patient data between two providers²⁰

That said, technology strategy in the future isn’t likely to focus on particular investment so much as the ability of the organization to use these investments to respond to marketplace change.

As the authors note: “Organizational competency and skill in leveraging technology investments will endure and become more crucial over time. The future may not demand the IT investment per se, it will demand the organization’s skill in using the investment to improve performance.”

Capital Planning

Amending strategic and capital plans to account for potential shifts in revenue and cost of capital (listed third in importance as a near-term action by survey respondents) has leapfrogged into prominence with the collapse of the credit markets and the looming recession. Because of the economic situation, Moody’s U.S. Public Finance report for November revised the outlook for the not-for-profit healthcare sector from stable to negative.²¹

The report paints a dismal picture. The linchpins that supported not-for-profit hospitals’ access to capital have diminished, as bond insurance has become severely restricted, the auction rate market has collapsed, and inexpensive and widely available liquidity support by banks has eroded.

Investment losses have depressed balance sheets and reduced liquidity, and new risks are emerging: Liquidity within hedge funds, private equity funds, and other alternative asset classes has declined and limited distributions of cash to investors. Hedge funds and

some private funds have made capital calls on current commitments by hospitals, and some private funds have frozen redemptions even after the lock-out period has passed.²²

The downturn in the U.S. economy is causing:

- An increase in charity care with rising unemployment levels and loss of health insurance benefits
- Rising bad debt expenses as hospitals struggle to collect payment from patients with high-deductible and high-copay health insurance plans
- A decrease in demand for health services by patients, particularly for elective or urgent procedures (which typically have higher profit margins for providers)
- Lower Medicaid reimbursements as a result of weakening state economies
- More difficult negotiations with commercial payers²³

Goldstein predicts another freeze in Medicare rates, similar to the one that occurred in 1998 with the passage of the Balanced Budget Act of 1997. “This was a severe blow to the financial performance of many hospitals because on average Medicare accounts for close to half of their revenues. With the ballooning Federal deficit, which could reach \$1 trillion, Medicare will again be in the cross-hairs of Congress,” she said.

In the near term, hospitals are struggling with two principal issues: When will they regain access to the debt market so they can fund strategic projects, such as major construction? When the market does reopen, how much will hospitals have to pay for capital? “These factors need to be built into financial results going forward,” Goldstein said.

On the asset side of the balance sheet, hospitals that have been invested in the stock market have to account for material contractions in their cash balances as the value of their stocks has gone down and funds that could be used as collateral against debt have evaporated.

Hospitals that are best prepared for the future, not surprisingly, are those with higher ratings that reflect their financial strength. “A year and a half ago, the market was buying just about every bond offering it could, and it didn’t really matter what your credit rating was. But we are at the point where credit ratings really do matter at the margin. When the markets open up fully again and hospitals are looking for bank letters and lines of credit or interim bridge financing, those

with an AA rating will get access to capital more quickly and more cost-effectively,” said Andrew J. Majka, partner and chief operating officer, Kaufman, Hall & Associates, Inc., Skokie, Ill.

Also in a good position are hospitals that have strong cash reserves or that have completed their major capital projects because they can absorb spikes in interest rates.²⁴

But no hospital can afford to sit on the sidelines and wait for capital markets to fully thaw. The demands on cash and cash flow are too persistent, and the need to remain technologically current and competitive is too great. Hospitals therefore are not jettisoning capital plans but revisiting them. “We haven’t been informed of anyone canceling a capital project,” Goldstein said. “Hospitals are delaying projects or going back to the drawing board. They are letting their capital ‘wish lists’ grow and the ‘must do’ capital list shrink, and they are taking a sharper pencil to return on investment (ROI). Whatever that ROI was a year ago, it needs to be reviewed because the ROI is likely going to be lower given the economy.”

Hospitals are considering alternative sources of capital to carry them through the near term, and many are using internal cash flow to spend on the project or earmarking cash on hand. Fundraising is another potential source, although donations are difficult to come by when the economy is worsening and corporate and consumer wealth is declining. Some hospitals may obtain a short-term loan or line of credit from a local or national bank to start a project, but with the risk that the debt market will improve by the time it has to refinance the line, said Goldstein. Hospitals are exploring off-balance sheet vehicles, such as operating leases, but these are rarely viewed as off-credit.

Hospitals also are taking a joint approach to contract expenses and revenue growth by reexamining service lines that do not contribute to cash flow and by focusing on top-line revenue opportunities, and many are seriously considering consolidation.

In the face of the collapse of the credit markets and the global recession, future scenarios have been reexamined, said Goldstein. “It is difficult to focus on what may happen in the next 10 years,” she said, “when the focus is on what is happening in the next 10 months.”

Strategies

Based on the likelihood of the various scenarios discussed, the next issue naturally becomes what hospitals should be doing to prepare. To this end, HFMA had survey respondents rank in importance a series of near-term actions, spanning the drivers of change discussed.

Looking farther out, however, how actionable will true change be? Industry experts interviewed in large part identified opportunities for providers to mitigate the effects of some of the industry's key challenges and provided advice for helping providers to secure the resources needed to service their communities in the future. For each change driver listed, the following discussion focuses on some of these desired actions.

Workforce

The average age of RNs in the workforce is 44, according to research by Buerhaus. "The largest component of our workforce therefore will soon be over the age of 50, and they will continue to be a large component of the workforce for the foreseeable future," he said. "So we

ought to be thinking hard about how we retain older nurses in the workforce because they hold a large amount of accumulated wisdom. Many older nurses also have insight and experience that can be tapped to help hospitals optimize care under an outcome-based payment system."

Hospitals can and are trying to retain older nurses by improving the ergonomic environment, minimizing the need for lifting, stooping, and unnecessary physical or mental stress. "Hospitals are trying to identify problems from the nurse's point of view and redesign work and the physical environment, including the location of supplies and equipment," Buerhaus said. "The healthcare industry is moving in a positive direction. Hospitals need to keep it up and realize that this is going to be a part of their organization's life for years to come."

Examination of staffing processes and optimizing resources also is important. Said one respondent: "Because the nursing shortage involves both supply and demand, hospitals need to rethink staffing patterns in response to availability or absence thereof."

Ranking of Importance of Near-Term Actions*

1. Develop a long-term business plan for physician integration.
2. Implement substantial and sustainable cost-containment strategies.
3. Amend strategic and capital plans to account for potential shifts in revenue.
4. Develop a strategic plan for human resource recruitment, retention, and training.
5. Develop strategies to align IT with transformations in payment and care delivery structures.
6. Redesign care processes and delivery systems to better integrate professional and facility components of care.
7. Forge innovative alliances with other service providers, exploring such things as regional health initiatives, micro financing approaches, and employer relationships.
8. Ensure online customer service capabilities keep pace with consumer expectations.
9. Significantly increase resources/planning for services delivered outside the traditional hospital setting.
10. Seek merger partner(s) to gain efficiencies of increased size and access to capital.

* Ranked from highest to lowest by percentage indicating "extremely important"

Staffing regulations may not be the answer, however. “Mandated staffing affects hospitals inequitably and will likely lead to inefficiency and higher costs,” Buerhaus said. “Some hospitals may be penalized financially through no fault of their own, while others are less impacted. Plus there is no empirical evidence that staffing ratios improve quality of care or the quality of the nursing clinical environment.”

Buerhaus also noted that freezing nurse staffing through regulated staffing levels restricts the hospital’s ability to adapt its capital and other labor resources to improve quality in the least costly manner. “There is great danger that imposition of staffing ratios will damage relationships and tear down the trust in the system for both the hospitals and nurses,” he said.

Future trends for all types of healthcare professionals will stress flexible career paths, or as one participant called it, “career customization.” As noted by the respondent: “There will clearly be a shift to thinking of employees (including doctors and other clinicians) as ‘system’ employees who will have mobility through the system in response to their preferences, priorities, and desires at particular points in their careers. When employees feel they have flexibility and control, they will find the healthcare workplace more attractive.”

These efforts will be part of an overall strategic plan for human resource recruitment, retention, and training, which was ranked fourth in importance as a near-term action by HFMA survey respondents, with 58 percent indicating it is “extremely important.”

Payment System

Given the strong belief that “healthcare payments will be substantially impacted by patient outcomes,” hospitals will need to aggressively pursue agendas of quality. As one survey respondent noted, “It is not going to be sufficient to merely have high quality. We must be able to measure, compare, and communicate it.”

Investment in resources that will aid the definition, measurement, and reporting of patient outcomes and supporting processes will be key. Hospitals will be best served through improving IT and focusing efforts to align with evidence-based medicine and industry best practices. In fact, the development of strategies to align IT with transformations in payment and care delivery structures was one of the top five actions ranked by survey participants.

Another significant payment trend to keep an eye on is bundled payment to cover specific episodes of care. Those organizations participating in Medicare’s acute care episode (ACE) demonstration project may present ideas for the most effective ways to build a supportive infrastructure.

But how to deal with the current day’s challenges? Implementing substantial and sustainable cost-containment strategies may be a way to mitigate some of the near-term effects associated with the current payment system. Executives are attempting to run leaner operations from top to bottom, with efforts such as using productivity measurement to drive labor use, streamlining discharge processes to improve patient throughput, or working with supply chain wholesalers on opportunities to obtain better volume discounts. That said, those hospitals best prepared for future shifts in revenue and a growing burden of uncompensated care will be organizations that have solid processes in place for amending strategic and capital plans accordingly.

Also, it should be noted that meaningful transformation of the healthcare payment system is a vastly complex endeavor, requiring collaboration among providers, payers, employers, and consumers. To ensure appropriate representation in discussions of payment, hospital leadership is advised to connect with peers and stay involved in efforts taking place through professional associations as well as government at all levels. Of course, climbing the policy agenda often begins by winning support through grass roots efforts.

As one survey respondent advised: “Be an ambassador for healthcare education in your communities. Don’t be afraid to tell them about how hospitals are really paid, how reductions occur with private payers, and the reimbursement constraints that we are forced to deal with.”

Physician Integration

While some may wonder exactly how physicians will be integrated with hospitals, few would disagree that alignment is needed. As one respondent said, “More and more hospitals will have to align with their medical staffs not only because they will have no other way to survive, but also because more and more physicians will want to opt out of the business risk of the practice of medicine.”

If employment is the option, it should “vest physicians in the viability of the hospital, including the

handoffs between caregivers. This is not a common practice, as there are still huge communication and commitment gaps with employed physicians,” said another survey respondent.

Development of a long-term business plan for physician integration—considered to be the most important near-term action by respondents—will involve across-the-board and organizational changes. As increasing numbers of physicians assume administrative positions in the hospital setting, governance and operations will be impacted. Therefore, said one participant, “Boards of directors should be brought up to speed on physician integration and related regulatory issues.”

Cost-containment efforts also will be affected. Noted one survey participant: “Cost containment will look different. It will focus on the elimination of variation of practice patterns to focus on efficient and national best practice quality measures and the reduction of complication rates.”

Financial planning must be particularly rigorous to protect against potential losses. “Hospitals need to be methodical and measured when they are aligning with physicians and examining the subsidies that will come from clinical operations,” said Goldstein.

Compensation also should be carefully planned. As one respondent noted, whether compensation structure is based on relative value units or units of time spent performing cognitive functions, “it should include incentives for meeting quality or pay-for-performance measures, reflect fair market value, and include regular updates.”

Technology

Many of those surveyed stressed the need to improve IT and continually review the long-term IT strategic plan to ensure it is in step with changes in payment and care delivery. As services and cost become more transparent and patients bear more out-of-pocket expenses, patients will seek providers that can demonstrate cost, quality, and outcomes. As one respondent noted, “An increase in consumerism, driven by rising costs and the structure of health plans, will require increased availability of information for patients.”

The Joint Commission suggests that technology adoption can play a major role in improving patient care, safety, and quality. In its 2008 report, *Guiding Principles for the Development of the Hospital of the Future*, the agency recommends the following actions to aid in this task:

- Establish the business case and sustainable funding sources to support widespread adoption of health IT.
- Redesign business and care processes in tandem with health IT to ensure benefit accrual.
- Use digital technology to support patient-centered hospital care and extend that care beyond the hospital walls.
- Establish reliable authorities to provide technology assessment and investment guidance for hospitals.
- Adopt technologies that are labor-saving and integrative across the hospital.

The age of transformation in technology use is upon us. “We are finally getting to the point where we are not only improving communication through automation, but also providing tools to help people think better,” noted SSM Health’s Zimmer. “We already have taken three or four inches of paper and put it into an electronic format. What’s different about the future is the sophistication of how we will share information, highlight needs, and standardize care and processes. We as an industry are about to do great things in terms of better and more efficient care through true and meaningful use of automation.”

Capital Planning

Amending strategic and capital plans to account for potential shifts in revenue and cost of capital (ranked third as a key near-term action) has become even more immediate with weakening economics. Given the current credit crunch, capital planning will be front and center. To navigate along a coherent path during these difficult economic times, at a minimum hospitals will need a rational capital plan and a willingness to share it. “It is crucial to have a logical, methodical, and well-articulated plan for anticipating and addressing a strategic move, a crisis, or a challenge as opposed to a poorly articulated or crisis reaction to whatever the

current challenge,” Goldstein said. “Also key will be transparent and full disclosure of strategic plans, how they are proceeding, and what decisions and tactics are being implemented.”

The best strategy an organization can use to appeal to tightening capital markets is consistent and predictable financial performance, noted Majka. “Capital markets want to know, If I am an investor in your organization, can I depend on you? Have you been consistently delivering financial results that measure up to budget?” he said.

Accountability is another major consideration for capital markets: How well do the CFO and the rest of the management team follow through? How accountable are they for financial results? If a hospital has a plan to reduce days in receivables from 78 to 60 and achieves it within a year, it will gain credibility, Majka said, noting that “If it falls short, it will raise questions and uncertainty: If the hospital missed on this target, what else might it miss going forward?”

Through balance sheet management, the hospital’s financial leaders should examine the organization’s investment policy and how risky it is, added Majka: To what degree are assets tied up in hedge funds that might not have immediate liquidity? How much is invested in equities, and where are they located? How long or short are the maturities of the fixed income portfolio? What may be the risk of a major catastrophic event on the asset side of the equation?

Other considerations involve the amount of variable rate risk an organization is taking on, how much exposure is related to bank letters of credit, and what happens if the bank is not able to honor its commitment or cannot renew the commitment going forward.

Only 23 percent of HFMA survey respondents believe that the number of hospitals will decline by 20 percent or more in the next 10 years as a result of financial constraints and capital challenges. Merger and acquisition activity nevertheless will accelerate in the near term, several respondents contend. Seeking a merger partner (to gain efficiencies of increased size and access to capital) was the tenth most important near-term action.

“Many strategies require resources that may be in short supply, and they will require fair-minded, equal and willing partners,” said one respondent. Another was convinced that “merger partners are absolutely necessary, especially among the largest not-for-profits, not only to gain efficiencies but perhaps more important to gain the leverage needed to neutralize the power of the behemoth managed care companies.”

“There is increased talk on the merger and acquisition front, especially by independent single-site hospitals,” Goldstein said. “There may be opportunities for larger, more financially secure not-for-profit or for-profit systems to be in the driver’s seat when it comes to future growth and to be in the position to pick and choose who they want to join their system.”

There also may be opportunities outside of the standard merger and acquisition routes. “Alignment with a global partner in technology, pharmaceuticals, or reciprocal medical groups may allow service lines that are high cost and have low margin coupled with low risk to be transferred to markets where labor and overhead are less expensive,” a survey participant said. Another suggested aligning with colleges and universities or health plans to coordinate disease management.

“The question about the reduction in the number of hospitals is complex,” one respondent said, “because the issue is how we define ‘hospital.’ There will be a major shift in services provided by hospitals, which may include closure of inpatient services, but the entity may stay in existence. Is that a ‘hospital’?”

Competition will drive a retail focus. “The basic shift of cost sharing will continue and health care will become more like retail than ever before. There will be more educated purchasers of health care ... and as patients realize they are now real purchasers of healthcare services, their demands will be higher,” a participant said. “As the industry shifts to a more retail environment, providers need to learn lessons from other industries as to how they compete for the purchaser’s dollar,” another added.

Conclusion: Vision into Action

Those hospitals best prepared for the future focus on change drivers, consider the likelihood of various scenarios, and develop value-based initiatives accordingly. Although this concept may sound easy enough, the actual process of taking vision into action often is one of the most challenging for leaders.

Just a few of the barriers healthcare executives typically find themselves against when making a case for change include lack of clinical, staff, or community support; insufficient resources to drive desired initiatives; and gaps perceived between long-range initiatives and day-to-day operations.

With this in mind, HFMA recommends the following:

Gain buy-in to your organization's vision. Energizing the organization around strategic initiatives is key.

- Provide a sense of urgency around identifying strategic options and pursuing key initiatives.
- Communicate to the board, executive leaders, and staff the dimension of the challenges driving the need for change.
- Create leadership consensus about the needed initiatives.
- Communicate proactively and continually with the organization's communities about shared healthcare challenges and goals.

Position the organization as a value-based innovator with long-term staying power. Focus initiatives around reducing the cost of care coupled with improving quality-driving value.

- Develop a vision of improving efficiency and quality.
- Communicate key initiatives to the capital markets as a means of positioning the organization as an innovator in addressing long-term challenges.
- Develop a strategic approach to cost management that permeates the organization's vision and key initiatives.
- Invest in staff's ability to work smarter.

Use forward-looking data and market intelligence to inform actions of today. The best decisions are based in research and reflect changing trends.

- Embrace and champion an evolution in traditional staff and professional roles that reflects realities of the changing labor market and advances in technology and care processes.
- Reexamine the importance of service lines, using a broad range of future environmental assumptions to assess importance to mission and viability.
- Examine key capital initiatives for potential effects on patient care and ROI.

Faced with economic difficulties, tightening payment, and increased demands on care delivery, today's hospitals find themselves at a time particularly crucial for preparing for the future, providing value in health-care delivery, and staying ahead of industry change. It is HFMA's hope that *Healthcare Finance Outlook: 2009* will be a useful resource for your organization in facing these challenges and shaping an agenda for change. As seen through the forecasts, survey results, and strategies presented, those hospital leaders with an eye to the future will be best positioned for realizing opportunities to improve health care for today—and tomorrow.

References

- 1 *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families*, The Commonwealth Fund, August 2008.
- 2 *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, The Commonwealth Fund, May 2007.
- 3 *The Costs of Caring: Sources of Growth in Spending for Hospital Care*, The Lewin Group, conducted on behalf of the American Hospital Association, July 2005.
- 4 Glaser, J., and Foley, T., "The Future of Healthcare IT: What can We Expect to See?" *hfm*, Nov. 2008, p.85.
- 5 *Health Care IT Spending and Economic Realities*, Thought Leadership Series, College of Healthcare Information Management Executives, the National Alliance for Health Information Technology, and AHA Solutions, December 2008.
- 6 Kaufman, K. and Grube, M., "The Capital Markets Crisis: What Strategic Adjustments Are You Making," *Strategic Financial Planning*, HFMA, Winter 2009.
- 7 *Report on the Economic Crisis: Initial Impact on Hospitals*, American Hospital Association, November 2008.
- 8 Chen, C., "Nationwide Physician Shortages Likely to Occur Beyond 2015," 2008 Physician Workforce Research Conference, April 30-May 2, 2008, sponsored by AAMC and Harvard University.
- 9 Smith, A., "An Interview with Peter I. Buerhaus, PhD, RN, FAAN: On Hopes and Threats for Nursing's Future," *Nursing Economics*, August 27, 2007, pp. 183-185.
- 10 *What Is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?* U.S. Department of Health and Human Services, Health Resources and Services Administration, April 2006.
- 11 Smith, A., "An Interview with Peter I. Buerhaus, PhD, RN, FAAN: On Hopes and Threats for Nursing's Future," *Nursing Economics*, August 27, 2007, pp. 183-185.
- 12 Buerhaus, P.I., Staiger, D.O., Auerbach, D.I., *The Future of the Nursing Workforce in the United States: Data, Trends and Implications*, Boston: Jones and Bartlett, March 2008.
- 13 *Nursing Management Aging Workforce Survey*, Bernard Hodes Group, July 2006.
- 14 Taylor, M., "Experiments in Payment," *H&HN*, September 2008.
- 15 Boyd, C., et al., "Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases," *JAMA*, August 10, 2005, pp. 716-724.
- 16 *2007 Review of Physician Recruiting Incentives*, Merritt, Hawkins & Associates, 2007.
- 17 Rowland, R., "MSOs: Getting It Right the Second Time Around?" *MGM Update*, Dec. 15, 1998.
- 18 McGowan, R., MacNulty, A., *Strategies for Strengthening Physician-Hospital Alignment: A National Study*, Society for Healthcare Strategy and Market Development, 2006.
- 19 Warden, J., *Creating Sustainable Physician-Hospital Strategies*, Chicago: Health Administration Press, 2009.
- 20 Glaser, J., and Foley, T., "The Future of Healthcare IT: What can We Expect to See?" *hfm*, Nov. 2008, pp. 85-87.
- 21 *Not-for-Profit Healthcare Sector Outlook Revised to Negative from Stable*, Moody's U.S. Public Finance, November 2008.
- 22 Ibid.
- 23 Ibid.
- 24 Ibid.

Appendix

A variety of resources explore central themes expressed in *HFMA's Healthcare Finance Outlook 2009* in greater detail. Those of particular interest from HFMA include the following.

HFMA Resources

HFMA's Healthcare Financial Pulse

www.hfma.org/fhs.htm

This web compendium includes news, analysis, reports, and case studies focused on the economic environment. The cornerstone is a longitudinal study tracking challenges, opportunities, and emerging trends that are affecting the financial status and future shape of the healthcare industry.

Patient Friendly Billing®

www.hfma.org/library/revenue/PatientFriendlyBilling

Resources provide clear recommendations to advance healthcare revenue cycle performance. Readers will find reports exploring aspects of billing and collections as well as insights on payment system reform. Particularly useful is the inclusion of samples of revenue cycle documents and other tools actually in use at some of the nation's hospitals.

HFMA Education

www.hfma.org/events

Conferences, seminars, and audiowebconference events provide pragmatic guidance on key challenges facing the healthcare industry.

HFMA Publications

www.hfma.org/publications

Magazines and newsletters provide practical information to meet pressing challenges and take advantage of promising opportunities. In print or online, HFMA's publications address most-pressing management areas such as revenue cycle, cost containment, financial leadership in nursing, and strategic financial planning.

HFMA Forums and Communities

www.hfma.org/forums

These special interest groups provide specific content and networking opportunities in the following areas: CFO, revenue cycle, managed care, healthcare compliance, Medicare payment, and physician alignment.

HFMA Library

www.hfma.org/library

A topic-searchable site features education reports on hot topics, roundtables with innovative hospital leaders, regulatory highlights, and tools to improve financial management processes. Explore the latest offerings on accounting and financial reporting, capital finance, cost control, and financial performance. Many of these resources are freely available to HFMA members and nonmembers alike.

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