The 2017 Thought Leadership Compendium is a compilation of industry knowledge authored or presented by ECG consultants during the 2016 calendar year. Titles are organized by primary topic.
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These thought leadership pieces and more insights from ECG are available at [ecgmc.com/thought-leadership](http://ecgmc.com/thought-leadership).
Thank you for your interest in ECG’s thought leadership. Our consultants are dedicated to helping healthcare organizations solve today’s greatest challenges and prepare for changes on the horizon. ECG’s commitment to leading healthcare forward includes sharing informed opinions, astute insights, and innovative approaches through white papers, articles, blog posts, educational presentations, and expert commentary.

This most recent edition of our thought leadership compendium showcases many of our efforts over the past year to provide messages worth listening to. New this year, we’ve also sprinkled several case studies throughout to highlight the transformation and success our clients have achieved despite marketplace and industry challenges. We hope you’ll find content that resonates with you, and we welcome your questions regarding these important issues facing you and other healthcare leaders today.

Sincerely,
ECG’s Management Committee
The transformation of our healthcare delivery system continues to progress, and healthcare providers are constantly being asked to evaluate new delivery models for relevance, replicability, and fit. As a result, board members, senior executives, and physician leaders run the risk of investing significant financial, political, and emotional capital on well-intentioned initiatives whose results, whether positive or negative, may vary considerably from what was expected by the project’s various stakeholders. The first step in mitigating this risk is to develop a shared vocabulary with clear definitions for some of the most commonly referenced—and frequently misunderstood—models of delivery system transformation.

Authors: John Redding, MD, Senior Manager
         Terri Welter, Principal
         Erin Mastagni, Manager
         Emma Mandell Gray, Senior Manager

Publisher: ECG Management Consultants

Whether it’s to fix old cracks in the care continuum or prepare for value-based care, organizations are pursuing new models to better manage and improve the health of the population. As organizations begin to investigate the ROI potential for these models, the patient-centered medical home (PCMH) in particular is piquing interest. This article makes the case that organizations willing to invest the time and effort needed to transition to and maintain a PCMH model are likely to realize both clinical and financial benefits.

Authors: Emma Mandell Gray, Senior Manager
         Rachel Aronovich, Senior Consultant

Publisher: hfm Magazine
9 Ways Healthcare Will Change in 2016

Change is on the horizon. From the shift to value-based care to continuing merger and acquisition activity, is your organization ready for what’s to come? This article concisely outlines nine ways the landscape will be impacted in 2016, and offers insight on how to prepare.

Author: Andy Bachrodt, Principal
Publisher: Healthcare Financial Management Association (multiple chapters)

Seven Key Premises to Guide Healthcare Planning

The level of uncertainty around the future of the U.S. healthcare delivery system has made many consumers and providers skeptical of its near-term and future stability. As providers navigate the years-long journey from fee-for-service to fee-for-value, an assumption of seven premises will help them decide where to place their feet as they take their next steps in a boggy landscape where it’s become hard to discern quicksand from solid footing.

Author: Andy Bachrodt, Principal
Publisher: Becker’s Hospital Review

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CASE STUDY: Cone Health

Located in North Carolina, Cone Health is one of the region’s largest health networks. The nonprofit employs 1,300 physicians across more than 100 locations, including 6 hospitals, 3 medical centers, 4 urgent care centers, 95 physician practice sites, and several Centers of Excellence.

A Unique Approach to Introducing Consumer Telehealth Pays Real Dividends for Cone Health
CASE STUDY: Cone Health

Over the past few years, other competing health systems in the area have deployed and aggressively promoted direct-to-consumer (DTC) telehealth offerings, making remote care services available to all patients in the region, including Cone Health patients. DTC telehealth options are also proliferating in the region independent of health systems—via retail clinics, employers, and telehealth vendors.

With consumers expressing high interest in this low-cost, affordable form of care delivery, Cone Health leadership recognized the need to develop its own telehealth program, both to keep its patients from leaving the system and to attract new patients. In early 2015, Cone brought ECG Management Consultants on board to help plan and implement a telehealth strategy that was both competitive and provider-friendly.

THE PROCESS

ECG worked with Cone to develop a phased approach to establishing its telehealth program. Phase I—the focus of this case study—introduced telehealth to the organization through a small-scale pilot program offering asynchronous eVisits through Epic. In addition to launching telehealth, Cone wanted the Phase I program to engage with and respond to the needs of impacted stakeholders, particularly providers, and build a culture conducive to change management. The outcomes of Phase I built a foundation for a second phase in which Cone is deploying a larger-scale competitive program that adds a live video platform and expands use cases.

Key components of the Phase I strategy included:
1. Identifying a simple point of entry into telehealth
2. Creating work groups to represent impacted organizational stakeholders
3. Building clinical support for the new delivery model
4. Piloting with a small, yet representative, patient population of Cone Health employees
5. Designing an effective marketing and communications plan

Types of telehealth visits

There are two types of telehealth visits—synchronous and asynchronous. Synchronous visits are real-time interactions between providers and patients, similar to traditional in-office visits except that they occur over phone or video instead of in person. Asynchronous telehealth visits also offer an option for remote consultation, but instead of connecting with providers in real time, patients submit information for providers to review and respond to at a future time.

What is telehealth?

Telehealth is commonly defined as the use of remote healthcare technology to deliver clinical services. Put more simply, telehealth expands healthcare delivery beyond the traditional brick-and-mortar office setting by connecting providers and patients via the web, phone, or other technology when they are not in the same physical location.

- Some insurance companies cover telehealth visits, with a patient co-pay similar to an office visit.
- Some employers offer telehealth as a benefit, either free or at a low per-visit cost.
- Direct-to-consumer offerings allow patients to bypass insurance and pay a nominal per-visit fee directly to the telehealth provider—health system, vendor, or other.
CASE STUDY: Cone Health

1 Identifying a simple point of entry into telehealth

Cone wanted a provider-friendly solution that complemented its current competencies and patient offerings. Since Cone was already using Epic’s EHR for health records and documentation and MyChart for its patient portal, ECG suggested using Epic’s asynchronous eVisit module as an easy entry into telehealth. The familiar Epic platform ensured ease of use for providers and patients and alleviated integration concerns. Cone uploaded clinical questionnaires for a small number of conditions into the eVisit module. Patients with these conditions who were interested in remote care could fill out the appropriate questionnaire and receive a treatment plan from a provider post-submission, all within the MyChart portal.

Conditions Treated
- Cough
- Sinus pain
- Back pain
- Urinary symptoms
- Red eye
- Diarrhea
- Flu-like symptoms
- Vaginosis
- Contact dermatitis
- Sunburn
- Swimmer’s ear
- Tick bites

ECG worked with Cone to add a notification system that alerted participating providers to new eVisits coming into the system through a shared email mailbox, so providers weren’t tethered to their computers during eVisit shifts. As strong process and protocol users, advanced practice providers (APPs) were selected as the primary providers for the Phase I visits, with the expectation that they would train additional providers during Phase II.

2 Creating work groups to represent impacted organizational stakeholders

“One of the first things we noticed about telehealth was just how many areas of our organization it impacted,” said Dr. Jenkins, a provider champion who now holds the title of Vice President of telehealth. Cone established project work groups for each function impacted by telehealth, including operations/revenue cycle, IT, marketing and change management, and clinical standards. A number of the APPs who were actually treating patients via asynchronous telehealth visits were members of the clinical standards group, closing the loop on the development of telehealth-specific clinical protocols.

These work groups were established pre-implementation. They met often (at least twice a month) and maintained oversight of the functional scope even after the initial asynchronous visit telehealth program was implemented.

An executive-level steering committee was also formed to facilitate access to the various subject matter experts within each of the work groups and to identify and communicate gaps in resource needs as well as ensure quick resolution.

3 Building clinical support for the new delivery model

Having a clinically focused work group gave the organization an opportunity to develop the tools participating providers needed to easily deliver care through the telehealth program. The APPs in the clinical work group provided valuable commentary on the appropriateness and efficacy of telehealth-specific clinical protocols based on their experience treating patients. “When it came time to develop and test clinical protocols, our providers were immensely involved,” Dr. Jenkins said. “They had veto power and the ability to modify the clinical protocols we used—it really increased their buy-in and excitement.”

Cone also appointed provider champions like Dr. Jenkins to evangelize the initial telehealth program to other providers. They utilized existing provider communication channels to advocate...
for the program and cement support. The provider champions were able to share firsthand accounts of ease of use and integration with existing workflows. “By automating the care plans and clinical protocols as much as possible, we were able to solve for clinical variation and time spent documenting visits—also major provider satisfiers,” stated Dr. Jenkins.

In addition, Cone made sure that providers felt supported at the point of care. When APPs identified workflow issues, they were addressed promptly. Suggested modifications to clinical and operations protocols were communicated directly to the clinical and operations work groups, and they were typically approved and implemented within days.

4 Piloting with a small, yet representative, patient population of Cone Health employees

The reimbursement landscape for telehealth is complex. Specifically, North Carolina does not require commercial insurance plans to cover services delivered via telehealth modalities. Individual plans have discretion to make coverage decisions, and these vary widely. Medicare and Medicaid also have complex regulatory requirements and reimbursement practices for telehealth. Parity between in-person doctor visits and telehealth visits is not yet commonplace.

Cone Health didn’t want its providers to be discouraged by the limited reimbursement opportunities in the state, especially during this important introductory period, so Phase I asynchronous telehealth visits were only offered to Cone Health employees who belonged to a Cone Health insurance plan. This gave the health system complete control and created a cost savings opportunity—employees who may have otherwise presented at urgent care centers or even the ED with low-acuity medical issues could now receive high-quality, personal, and cost-effective treatment through the eVisit experience. Participants in the health system’s high-deductible plan were charged $30 per visit, while employees enrolled in the Choice plan had no cost associated with visits.

Another advantage of introducing telehealth to the employee population first was the opportunity it afforded to solicit honest feedback, which could then be incorporated into Phase II of the program. Regular communications developed by the marketing work group touted the benefits of the eVisit program and created a dialogue between the developers of the program and the Cone employees participating in it. The constructive feedback received from the employees, who were generally representative of the surrounding Greensboro community, helped Cone refine the eVisit program before it was rolled out to the larger patient community.

5 Designing an effective marketing and communications plan

Cone Health’s marketing and communications plan included internal and external activities to promote the new telehealth program. The marketing work group defined the overarching strategy and also monitored key results.

Internal communication included having the provider champions on the agenda for medical staff meetings and committee meetings across the organization. Early exposure to the new technology, as well as a thorough discussion of the clinical tools and related considerations, helped to prepare the provider community for a larger telehealth deployment in Phase II. In addition, information-sharing about the Phase I pilot ensured that providers would not be blindsided by any telehealth data or documented follow-up needs communicated by the eVisit providers.

Marketing efforts also targeted employees via benefits sessions and email blasts. As Cone began to conceptualize the second phase of its telehealth deployment—making eVisits available to a larger patient population and introducing video visits—marketing efforts expanded to include flyers at clinic sites, social media content, web marketing, and even radio spots.
PHASE I OUTCOMES

This first phase of Cone Health's telehealth program—asynchronous eVisits through Epic, offered to Cone Health employees—went live at the end of 2015. The asynchronous visit model succeeded in easing internal stakeholders' concerns about telehealth, and the simple setup helped achieve the goals of provider buy-in and engagement.

Patient engagement was high as well. Within 6 months, 700 eVisits were conducted. Even with limited hours of operation (4–9 p.m. on weekdays and 8 a.m.–8 p.m. on weekends), Cone was able to deliver care in a timely and convenient manner that satisfied patients and reduced acute care costs. Key metrics were collected through an automated survey sent to patients 1 business day after their eVisit.

Figure 1 — Results of the automated patient survey, sent 1 business day after an eVisit.

- **Received Care Within 1 Hour**: 96%
- **Number of Patient Survey Responses**: 262
- **Received Expected Level of Service**: 95%
- **Net Promoter Score**: 92%
- **Would Otherwise Visit Urgent Care/ER or Walk-In**: 61%
CASE STUDY: Cone Health

Figure 2 — Comparative wait times and visit costs for alternative care settings.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Wait Time</th>
<th>Visit Time</th>
<th>Cost</th>
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<tbody>
<tr>
<td>ER</td>
<td>Extensive testing costs</td>
<td>High wait times</td>
<td>5 hour visit</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Up to 1 hour wait time</td>
<td>3 hour visit</td>
<td>$150</td>
</tr>
<tr>
<td>Office</td>
<td>2 day wait</td>
<td>1–2 hour visit</td>
<td>$100</td>
</tr>
<tr>
<td>Retail</td>
<td>Walk-in</td>
<td>Video Minutes</td>
<td>$59</td>
</tr>
<tr>
<td>Video</td>
<td>Asynchronous</td>
<td>Asynchronous</td>
<td>$49</td>
</tr>
<tr>
<td>Asynchronous</td>
<td>Asynchronous</td>
<td>Asynchronous</td>
<td>$30</td>
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The ROI of Phase I is well demonstrated through a comparison of the cost of asynchronous telehealth visits to other care settings.

The success of Phase I allowed Phase II to begin as soon as the pilot program ended. In May 2016, Cone expanded the population served to include the general public and extended the hours of service and provider pool for asynchronous visits. Cone also added synchronous visits through a partnership with a well-known telehealth vendor. To properly oversee the telehealth program, Cone established centralized governance, with a new assistant director of telehealth supervising the expansion of the program to video and phone visits. This put Cone on track to meet the Phase II goal of building a competitive and robust telehealth offering. “Our gradual transition into telehealth offerings is something I would recommend to most organizations,” said Dr. Jenkins. “Being able to look at subsets of data and patient testimonial allowed us to solve for technical and operational issues that needed to be perfected before rolling out our offering to a larger population.”
LEGISLATIVE & REGULATORY ISSUES
Beginning in 2019, the Centers for Medicare & Medicaid Services (CMS) will implement a new payment system under which providers will be rewarded for delivering high-quality, cost-effective care and encouraged to shift toward alternative payment methodologies. Although the changes outlined in the Medicare Access and CHIP Reauthorization ACT (MACRA) will not take effect for several years, providers hoping to succeed under the new payment methodology need to begin making changes now. This article presents an overview of MACRA’s two-track payment system and the numerous (and significant) implications of MACRA for healthcare providers.

**Author:** Dave Wofford, Associate Principal

**Publisher:** hfm Magazine

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While the Centers for Medicare & Medicaid Services (CMS) and other payors look for new ways to reduce total cost of care, healthcare providers are simultaneously feeling the squeeze in reimbursement. However, the introduction of new programs and reimbursement structures suggests that CMS is open to loosening regulations under certain circumstances, opening the door for hospitals to financially reward physicians for participating in cutting costs through gainsharing. This column discusses how the financial opportunity for both health systems and physicians can be substantial under a gainsharing structure, especially for larger physician practices.

**Authors:** Jason Lee, Associate Principal

**Publisher:** CardioSource WorldNews

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On October 14, CMS released the much-anticipated final rule of MACRA, which goes into effect in 2017 and begins changing Part B reimbursement in 2019. This webinar, presented in partnership with Hooper, Lundy & Bookman, helps make sense of key elements regarding the MACRA final rule. It also reviews changes from the proposed rule that was released in the spring. Presenters discuss essential steps for success under MACRA performance metrics and ways to incorporate your organization’s MACRA plan into its overall payor strategy.

**Presenters:**

- Dave Wofford, Associate Principal
- Jason Lee, Associate Principal
- Monica Massaro, Manager of Biostatistics at PROMETRIKA, LLC
- Ben Durie, Senior Counsel at Hooper, Lundy & Bookman

**Host:** ECG Management Consultants

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Pursuing performance improvement across the ambulatory enterprise can be particularly daunting for cardiologists, who have a variety of competing patient demands to balance on a daily basis (e.g., inpatient rounding, clinic visits, testing reads, call coverage). We know this from our experiences in working with cardiology groups to help them overcome the obstacles they face. Instead of offering a consultant’s summary of the operational challenges confronted by cardiologists, this article tells the story of a recent ECG engagement with a midsize cardiology group in which our efforts were aimed at assessing and addressing the group’s operational issues.

**Author:** Michael Duffy, Senior Manager

**Publisher:** CardioSource WorldNews

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To effectively fulfill their role, trauma programs must strike the right balance of physician and nonphysician staff. Although the American College of Surgeons provides physician coverage requirements and direction for trauma centers, there is virtually no guidance on appropriate staffing for nonphysician team members. To help fill this gap, we recently conducted a study of how nonphysician team members are staffed at 14 Level II trauma centers across the country. This article shares the results of the study in order to offer guidance to existing and future Level II trauma programs on how to effectively staff nonphysician team members. In addition, it provides trauma program leaders with an objective peer comparison to help them create model trauma programs.

**Authors:** Jason Lee, Associate Principal
Dwight Asuncion, Senior Consultant

**Publisher:** H&HN Daily

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Healthcare news headlines continue to be peppered with stories related to quality measurement. Many highlight initiatives that incorporate quality metrics to drive improvements in the overall effectiveness and efficiency of healthcare delivery. For cardiologists and organizations with cardiac service lines, the prevalence of these programs means their income or revenue is increasingly tied to the achievement of performance standards. This column discusses the increasing use of quality measurement and why selecting the right quality metrics is crucial for organizational success.

**Authors:** Katy Reed, Associate Principal
Tessa Kerby, Manager

**Publisher:** CardioSource WorldNews

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Visit our blog for more posts on Performance Improvement.
CASE STUDY

Children’s Hospital Los Angeles Medical Group

Superior clinical performance needs to be supported by optimal financial performance. When new leadership at Children’s Hospital Los Angeles Medical Group realized the revenue cycle was compromising its clinical mission, a commitment was made to confront the problems head-on.
Children’s Hospital Los Angeles Medical Group (CHLAMG) consists of 564 physicians offering specialized pediatric care to children from around the world. Despite its size and long-standing reputation for clinical excellence, CHLAMG struggled with consistently poor revenue cycle performance. In turn, physician compensation, staff satisfaction, and retention, among other organizational aspects, were negatively affected.

“It was really daunting,” said Sara Small, who now serves as the Executive Director of Revenue Cycle for CHLAMG. “It was hard to even know where to start.”

Determined to prevent the under-performing revenue cycle from further undermining its ability to execute and expand its mission, CHLAMG committed to identifying and implementing the right solutions. “Our CEO’s number one goal when he took over was revenue cycle,” Small remarked, “and he backed it up in every way.”

CHLAMG asked ECG to conduct a rapid revenue cycle assessment geared toward surfacing areas of opportunity for both the near term and the longer term. The immediate priority was to isolate and address any A/R that was in danger of “timing out” and to reduce the large volume of outstanding A/R to more acceptable levels. Next, the focus transitioned to stabilizing the billing process by instituting the fundamentals of revenue cycle management. Finally, the organization established a methodology for ongoing process improvement.

“ECG’s focused analysis of the revenue cycle allowed us to understand very quickly where the functional blockages and pain points were that we needed to resolve,” Harrison said.

ECG then led the effort to improve revenue cycle performance, working with the medical group, its management services company, and the hospital administrators who had operational responsibility for the clinics.

“It’s pretty amazing that, at least in my experience, we have seen such significant improvements in such a short amount of time.”

SARA SMALL
EXECUTIVE DIRECTOR OF REVENUE CYCLE
CASE STUDY: Children’s Hospital Los Angeles

Four key activities helped CHLAMG realize transformative results:

1 **Improved Transparency and Communication**

   It was essential to provide stakeholders with timely, relevant, and accurate information regarding current performance, the changes being proposed, and the progress made toward those goals. To ensure that this was achieved, a Joint Operating Committee was created as the working group responsible for the turnaround project. This committee was overseen by members of the medical group’s board. Communication was improved through regular updates provided at the board, department, and division levels.

2 **Established Special-Purpose Task Forces (a.k.a. “Tiger Teams”)**

   To work down backlogs in areas such as authorizations, coding, and credentialing, special teams were created to focus exclusively on those areas for a designated amount of time. Additional resources were provided by an outside billing agency to create additional bandwidth so that these backlogs could be reduced without falling behind on incoming volumes. Backlog reduction goals and timelines were established, and progress toward the goals was reported at the aforementioned JOC, as well as in other venues on a very regular basis.

3 **Restructured Billing Team**

   Almost immediately upon her arrival as the new Director of Revenue Cycle, Sara Small began assessing her team and, with input from ECG, reorganizing to better meet the organization’s needs. Several managers were promoted, others transitioned out of the organization and replaced, and several new positions were created and filled. These actions have yielded greater staff accountability and productivity, improved communication and responsiveness to physicians, and significantly enhanced employee morale.

4 **Modified Work Flows**

   A variety of changes to work flows were made in order to better allocate work load, address IT interface issues, provide greater charge capture, and enhance compliance. Further improvements are in the works and/or envisioned for the future. Interestingly, though, changes to work flows have accounted for only a relatively small portion of the performance improvements. Most improvement has been the result of simply focusing attention and effort on the key activities that “move the needle” – which is made possible by effectively establishing transparency and accountability.

“ECG was organized, efficient, and kept us well informed on a weekly basis. They were great communicators, which made me feel confident about what was happening, where we were in the process, and that we were hitting our targets.”

LARRY HARRISON
CEO OF CHLAMG
After a 7-month engagement, substantial improvements to CHLAMG’s revenue cycle performance have been made and sustained, including:

- $7.6 million in additional collections, primarily through the reduction in A/R
- More than $1 million in monthly collections, leading to a total year-on-year increase of $16 million in collections with no fundamental change to the underlying business
- A reduction in A/R by 22 days
- A 67% decrease in the average time required to enter charges
- A stronger management and accountability infrastructure

The actions taken and improvements made exceeded the expectations of the leadership team. “All of the changes that occurred have been for the positive,” stated Harrison, “from procedure to productivity to the morale of the employees.”

As a result of this engagement, CHLAMG now successfully manages its revenue cycle in a completely different and more appropriate way. Ultimately, the improvements that have been realized and ongoing enhancements ensure that the financial performance more effectively supports CHLAMG’s ability to provide the very best care to the pediatric population.
PHYSICIAN STRATEGY
Why Hospitals and Provider Groups Should be Thinking About Physician Succession Planning

Physicians are aging out of the workforce in greater numbers than they are entering it. This not only feeds the already expected physician shortage, but it also triggers an urgent need for health systems and provider groups to continually assess physician transition and succession planning. This column argues that in today’s rapidly changing healthcare landscape of new care models, provider employment arrangements, and reimbursement rules, proactive succession planning is critical. Without it, hospitals and medical groups may find themselves unable to meet clinical demand.

Authors: Lili Hay, Senior Consultant  
Katy Reed, Associate Principal  
Publisher: CardioSource WorldNews

“With the increasing popularity of new patient care models, physician succession presents an opportunity to evaluate where and how physician services are provided in the community.”

Why Hospitals and Provider Groups Should be Thinking About Physician Succession Planning

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- Transforming Your Care Model? Don’t Forget the Physicians
- Aligning Children’s Hospitals and Physicians

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PROVIDER COMPENSATION
provider compensation

March 2016

Is Your Physician Compensation Plan Aligned With Cost?

The movement toward value-based reimbursement is pushing health systems, hospitals, and physician groups to improve quality while lowering costs. To meet this challenge, organizations need to more closely align cost management with physician incentives. While cost metrics have not traditionally been tied to physician pay, the standard is changing. This article presents a case for aligning costs with physician compensation, along with a method for doing so.

Authors: Jamaal Campbell, Associate Principal
          Miranda Mooneyham, Senior Manager
          Chris Franklin, Manager

Publisher: ECG Management Consultants

July 2016

Threats to Cardiologist Compensation in the Post-Alignment Years: How We Got Here and How to Proceed

Cardiology, perhaps more than any other specialty, has seen a rapid and nearly complete transition from private practices to health system partnerships. A consequence of health systems introducing compensation arrangements with aligned cardiologists has been the imposition of regulatory requirements that don't apply as broadly as they did to private practices. In light of the government’s recent and dramatic increase in investigations of fair market value (FMV) and commercial reasonableness (CR), this column discusses the impact on cardiologist compensation in the post-alignment environment.

Author: Adam Klein, Principal

Publisher: CardioSource WorldNews

“Successful systems find ways to engage physicians and empower them to influence cost management.”

Is Your Physician Compensation Plan Aligned With Cost?
Fostering Physician Collaboration Through Coverage-Based Compensation

As health systems seek to deliver coordinated care across the continuum, many are rethinking the way they incentivize physicians. Compensation plans must be redesigned to align with the changing healthcare landscape and to ensure physicians are able to collaborate to provide the best possible care for their patients. This column highlights how the Intermountain Heart Institute implemented a coverage-based compensation model for its 50 employed cardiovascular physicians.

Author: Will Crane, Manager
Publisher: CardioSource WorldNews

Pediatric Provider Performance in a Value-Based World

In this webinar, ECG’s team of experts reviews findings from our 10th annual Pediatric Subspecialty Physician Compensation Survey with data from 51 physician specialties and 6 advanced practice provider specialties, representing nearly 8,000 pediatric practitioners. The session will include our analysis of important physician and advanced practice provider performance trends from the 2016 survey. The webinar will focus particularly on market trends related to value-based provider compensation plans and how those plans integrate with overall organization strategies. As healthcare reimbursement transitions from volume- to value-based, it is essential that physician compensation plans also evolve to ensure organizational success under changing financial incentives.

Presenters: Angela Collins, Manager
Clark Bosslet, Senior Manager
Ken Roorda, Principal

Host: ECG Management Consultants

Provider Performance in a Value-Based World

In this webinar, ECG’s team of experts reviews findings from our 17th annual Physician Compensation Survey. The session includes our analysis of important physician and advanced practice clinician performance trends from the 2016 survey. A particular focus of this webinar is market trends related to value-based provider compensation planning and how those plans integrate with organizations’ overall strategies. As healthcare reimbursement transitions from volume- to value-based, it is essential that physician compensation plans also evolve to ensure organizational success under changing financial incentives.

Presenters: Maria Hayduk, Associate Principal
Josh Halverson, Principal
Matt Nolan, Senior Manager

Host: ECG Management Consultants
REIMBURSEMENT & CONTRACTING
April 2016

Are You Optimizing Your Provider-Sponsored Medicare Advantage Plan?

The Medicare-eligible population is increasingly choosing Medicare Advantage (MA) plans over traditional fee-for-service programs, despite the fact that many healthcare experts predicted a decline in MA enrollment once the ACA was passed. For provider organizations, the potential to strengthen bottom lines while forging a path to value-based care makes offering a provider-sponsored MA (PSMA) insurance product exceptionally attractive. However, provider organizations considering an MA plan, or those already sponsoring one, must be aware of and ready to manage the significant financial, operational, and regulatory risks. This article offers insight into how provider organizations can address these risks and optimize the performance of PSMA plans.

Authors: Tyronne Jolly, Manager
Rich Trembowicz, Associate Principal

Publisher: ECG Management Consultants

April 2016

Mastering Medicaid: Strategies for Successfully Managing Medicaid MCOs

Innovative Medicaid managed care models are driving healthcare transformation and, in conjunction with federal incentives, are leading to effective care delivery modalities that may very well extend beyond Medicaid. This article summarizes the increasingly prevalent Medicaid managed care model to help inform providers’ strategies for serving Medicaid patients. It also presents real solutions for addressing some of the key challenges organizations face in managing their Medicaid members.

Authors: Erin Mastagni, Manager
Rich Trembowicz, Associate Principal
Terri Welter, Principal
Emma Mandell Gray, Senior Manager
Jordan Kristopik, Senior Consultant

Publisher: ECG Management Consultants

April 2016

Making Sense of MACRA

The April 2015 signing of the Medicare Access and CHIP Reauthorization Act (MACRA) represented the most sweeping set of changes to Medicare’s physician payment methodology in more than two decades. Although MACRA reimbursement changes won’t be felt until 2019, providers and hospitals that understand the implications of the law will be better positioned to act now in order to achieve future success in a post-MACRA reimbursement environment. This column presents an overview of MACRA’s two-track payment system and the numerous (and significant) implications of MACRA for healthcare providers.

Authors: Dave Wofford, Associate Principal
Kevin Contorno, Senior Consultant

Publisher: CardioSource WorldNews

April 2016

There’s No Crying in Bundles: Making Your Worst Failure Your Greatest Success

This session brings together physicians from bundled payment programs at leading academic medical centers to share lessons learned—from the launch of their programs through the implementation process. Learn about the rationale for selecting certain bundles, the reasons why some were discontinued, and which bundle programs are being planned for the coming years.

Presenters: Deirdre Baggot, PhD, Principal
Tori Manis, Senior Manager
Hannah Alphs Jackson, M.D., Director for Value-Based Care at Northwestern Medicine
Joseph Bosco, M.D., Vice Chair for Clinical Affairs at NYU Langone Medical Center

Host: ECG Management Consultants
Since the introduction and rollout of the Affordable Care Act, CMS has sharpened its focus on bundled payments as a viable and sustainable alternative to the costly fee-for-service reimbursement model. Recent developments are giving us real insight into how heavily CMS is betting on bundles. Why? Bundles represent one of the few approaches in healthcare today where all stakeholders can benefit. This article provides guidance on how organizations can prepare for CV bundled payment programs as bundles become more prevalent.

**June 2016**

**CMS Is Upping Its Bet on Bundled Payments**

In July 2016, CMS announced three new mandatory bundles, called episode payment models, for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and hip/femur fractures. Additionally, a new program for increasing cardiac rehabilitation was also proposed. The AMI and CABG bundles present new challenges and opportunities for cardiologists and cardiac surgeons. In this column, we highlight the latest CMS mandatory bundled payment program and explain what organizations can do to prepare for cardiac bundles.

**Authors:** Deirdre Baggot, PhD, Principal
Tori Manis, Senior Manager

**Publisher:** CardioSource WorldNews

**October 2016**

**Forging the Path to Value**

The passage of the Medicare Access and CHIP Reauthorization Act (MACRA) signals Congress’ and CMS’ permanent shift from pure fee-for-service reimbursement to value-based payment. This has been echoed by CMS’ stated desire to move 50% of Medicare payments to alternative models by 2018. It would be shortsighted to expect MACRA to be the last major change; instead, providers should expect a continued migration toward ever-greater accountability for cost and quality. This article describes the process for healthcare organizations to establish a value-based reimbursement strategy.

**Authors:** Dave Wofford, Associate Principal
John Redding, MD, Senior Manager
Michele Le, Senior Consultant

**Publisher:** ECG Management Consultants
November 2016

**Understanding the Impact of the CMS 2017 ASC Payment Rule on Spine Procedures**

On November 1, 2016, the Centers for Medicare & Medicaid Services (CMS) released the 2017 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Payment System final rule. The policy changes clearly signal that the reimbursement environment for spine surgery continues to evolve, and this shift is not limited to Medicare. Commercial payors are expected to react to the CMS rule with updates of their own. This article shares highlights of CMS's final rule and discusses the implications for owners and operators of ambulatory surgery centers.

**Author:** Jeff Hignite, Manager  
**Publisher:** Becker's ASC Review

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December 2016

**Run to Risk: Making the Shift to Value-Based Payments on Your Terms**

In 2016, the Centers for Medicare and Medicaid Services made four major announcements related to bundled payment programs, demonstrating its commitment to moving more and more reimbursement to value-based payment models. And as goes Medicare, so goes healthcare. While the shift to value-based payments is often met with resistance, this trend will only continue. Instead of delaying the inevitable, health system leaders must recognize the competitive and financial benefits of entering into value-based arrangements early and on their own terms.

**Authors:** Rachel Bidgood, Senior Consultant  
Anna Henkel, Senior Consultant  
Deirdre Baggot, PhD, Principal  
**Publisher:** BoardRoom Press

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“Sitting on the sidelines of an environment that continues to shift toward value will make financial sustainability difficult.”

*Easing Into Population Health*

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**Featured Blog Posts**

- **CMS’s Mandatory A MI Bundle Is Cause for Chest Pain**
- **Payor Contract Negotiations: What Went Wrong?**
- **Easing Into Population Health**

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As patient care continues its transition to the outpatient setting, the ambulatory surgery center (ASC) has quickly grown in popularity as a high-quality, cost-effective alternative to hospital-based outpatient care. In turn, the number and types of services offered in the ASC setting have significantly expanded. A once narrow scope of procedures has given way to a diverse range of services by numerous specialties, including cardiology. This column discusses the advantages and disadvantages for cardiologists who are considering the adoption of an ASC strategy.

Author: Tessa Kerby, Manager
Publisher: CardioSource WorldNews

Rethinking Care for Emergency Department Super Utilizers in a Value-Based World

In response to the shift to value-based reimbursement, there is growing interest across the country in programs designed to curb nonurgent emergency department (ED) use by a population referred to as “super utilizers” (SUs). This article explores some of these programs, new funding opportunities to support the development of these programs, and the potential benefits to hospitals that implement them.

Authors: Anna Henkel, Senior Consultant
Nate McCarthy, Senior Manager
Publisher: ECG Management Consultants

Featured Blog Posts

Three Trends Shaping Outpatient Orthopedic Care

Five Keys to Success Under the Oncology Care Model

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August 2016

**Needing More From Your NICU: Improving Efficiency, Care, and Cost**

Like all healthcare organizations, children's hospitals face mounting pressure to reduce costs without compromising quality of care. This balancing act is especially delicate in the neonatal intensive care unit (NICU), where the sickest and most vulnerable pediatric patients are treated. Today’s NICU leaders must be proactive, with a critical eye on unit processes and a determined effort to build a culture that embraces change. This article identifies three areas that present the greatest opportunity for process improvement—staffing models, compensation methodology, and care coordination—and offers strategies for achieving stakeholder buy-in.

Authors: Shelby Jergens, Senior Consultant  
Clark Bosslet, Senior Manager  
Publisher: ECG Management Consultants

August 2016

**Offering Advanced Access to Cardiology Care**

Patients want more readily available care options, and provider groups are responding. Initiatives for expanding access range from extended hours of clinic operation to the development of telehealth programs to the increased use of advanced care practitioners. Still, receiving care starts with obtaining an appointment. Changing how clinic visits are scheduled goes a long way toward expanding access to care. This column highlights one particularly effective scheduling solution: the advanced access model.

Author: Miranda Mooneyham, Senior Manager  
Publisher: CardioSource WorldNews

December 2016

**Rationalizing Resources: A Framework and a Process**

Today’s complex health systems must adapt their existing organizations to the changes that are sweeping the nation’s healthcare industry. In doing so, they are compelled to find financially responsible ways to ensure that the services they deliver and the resources they provide are well aligned with the needs of their communities. Without the ability to rebuild from scratch, organizations must focus on rationalizing service and resource offerings. This article offers a five-step framework for health systems to strategically and successfully rationalize their healthcare services.

Authors: John Fink, Principal  
Katy Reed, Associate Principal  
Publisher: hfm Magazine

December 2016

**Should Your Organization Add a TAVR Program?**

Patients are starting to demand transcatheter aortic valve replacement (TAVR), and CMS is expanding the criteria to allow more patients to qualify for it. Many cardiac programs that didn’t immediately pursue the TAVR program are beginning to ask themselves if they should. The question we often hear is: How critical is a TAVR program to ensuring that the organization’s structural heart, valve, and cardiology service line is competitive and comprehensive? This column offers steps and considerations cardiac service line leaders can use to assess their current situations and determine if a TAVR program is right for their organization.

Authors: Tessa Kerby, Manager  
Katy Reed, Associate Principal  
Publisher: CardioSource WorldNews
TRANSACTIONS & AFFILIATIONS
A successful transition to a value-based payment environment is dependent on the pace at which an organization can identify, prioritize, and obtain the requisite programs, people, and processes to deliver high-quality, cost-effective care. The most effective organizations are proactively assessing their clinical capabilities and acquiring programs, services, and infrastructure to quickly fill existing holes. This webinar presents information to help executives understand how to properly examine their current continuum of services and ultimately develop a strategy to assemble the best infrastructure and institutional competencies to successfully drive regional integration.

**Presenters:** Matt Sturm, Associate Principal  
Sean Hartzell, Associate Principal  
Laura Hennum, Regional CEO, Dignity Health - St. Rose Dominican Neighborhood Hospitals with Emerus  
**Host:** ECG Management Consultants

The accelerating pace of physician practice acquisitions is driving increased competition for the critical human and financial resources necessary to complete these transactions—resources that must be carefully prioritized. This webinar presents a new framework that organizations can use to assess the strategic and financial implications of a potential practice acquisition and assign a priority ranking to the opportunity. Through case studies, this session illustrates a four-tier priority-ranking model and provides a prescriptive approach to pursuing affiliation opportunities in each tier.

**Presenters:** Matt Sturm, Associate Principal  
Sean Hartzell, Associate Principal  
Alex Ogburn, Vice President of Ambulatory Services at Saint Francis Medical Center  
**Host:** ECG Management Consultants

With the changing reimbursement landscape and the constant pressure to reduce costs, provider entities are forming strategic, value-based alliances as a means to remain independent while gaining the scale and efficiencies that typically arise from consolidation. This presentation examines the reasons for this trend and the factors that health systems should consider in determining whether to pursue a regional healthcare alliance. ECG consultants and Michael Hein, MD, President and CEO of ENHANCE Health Network, describe the development and successful implementation of ENHANCE, including the rationale for formation, key challenges and successes, and lessons learned.

**Presenters:** Reema Shah, Senior Manager  
Darin Libby, Principal  
Michael Hein, M.D., President & CEO at ENHANCE Health Network  
**Host:** ECG Management Consultants
In 2012, the merger of a large national health system and a regional health system in Nebraska pushed independent hospitals and provider networks in regions across the state into a very uncomfortable defensive position.
In 2012, the merger of a large national health system and a regional health system in Nebraska pushed independent hospitals and provider networks in regions across the state into a very uncomfortable defensive position. Once this acquisition was completed, the consolidated hospitals and provider networks covered roughly 70% of the population of Nebraska. Naturally, independent hospitals across the state were concerned about their ability to compete with a national healthcare system that possessed dominant market share and more robust financing mechanisms. The reality was that this merger threatened the viability of the independent systems throughout the region.

At the same time, many of these independent hospitals and provider networks treasured their autonomy, as do systems across the country. Despite this, acknowledging that there’s strength in numbers, the CEOs of nine independent systems came together to formulate a response. In June 2013, leadership from these systems engaged ECG to create a regional healthcare alliance, which now exists as ENHANCE Health Network. In January 2014, ECG was retained to assist with the implementation of ENHANCE, and today the alliance represents an effective alternative for systems throughout the country that want to preserve their independence while still being able to compete within a climate of consolidation.

What Is ENHANCE Health Network?
ENHANCE is a network of independent health systems that voluntarily came together to form an alliance, whereby each system can retain its independence while achieving the scale and scope required to be successful under value-based care and changing reimbursement structures.

“The rationale was ‘if we’re not standing together, we’re not going to be able to withstand this force across the state,’” stated Michael Hein, MD, CEO of ENHANCE. But he is quick to acknowledge and warn that while fear can be a great motivator of action, it’s not enough by itself to sustain a grand effort amid the inherent tensions and self-interests that come with alliances among otherwise competing organizations. So ENHANCE partnered with ECG in order to quickly move from a defensive posture to a strategic mission focused on facilitating high-quality, affordable care through education, innovation, and collaboration.

How Does the Alliance Work?
Participation in ENHANCE is voluntary and dues-based. Additionally, there are numerous ways organizations can engage in alliance initiatives. “One of the elegant aspects of ENHANCE, and something that I think is unique, is the more you are willing to participate and the more you are willing to give, the greater your benefits,” said Dr. Hein. “Systems have choices about the level of participation they want to have instead of it being imposed upon them.” Member organizations are involved on the governing board, as well as in strategic and operational planning. Additionally, owner and affiliate members are responsible for pursuing local clinical integration initiatives. This pursuit is aided by collective coordination across the network and access to shared resources, such as data infrastructure, education and knowledge transfer opportunities, and common contracting terms.

What Are the Goals of the Alliance?
ENHANCE seeks to be a high-performing network of Accountable Health Communities that deliver value-based care, resulting in lower total cost of care. Its mission is defined as:
“Enhancing health in our communities by facilitating high quality, affordable care through education, innovation, and collaboration.”

At its inception and in an effort to achieve the alliance’s mission, goals were created for two functional areas:

1. Improving care quality while lowering costs by creating a clinically integrated network that could eventually pursue joint contracting for value-based contracts

2. Reducing operating costs through shared services, such as creating joint supply chain initiatives, sharing staffing resources, and consolidating some non-patient-care functions

**Nine Owner Members of ENHANCE Health Network:**

- Bryan Health
- Columbus Community Hospital
- Faith Regional Health Services
- Fremont Health
- Great Plains Health
- Mary Lanning Healthcare
- Nebraska Methodist Health System
- Nebraska Medicine
- Regional West Health Services

*ENHANCE also includes more than 50 affiliate members.*

**ENHANCE Health Network Guiding Principles**

- Support local autonomy and independence.
- Focus on innovating to create value for purchasers and patients.
- Engage healthcare professionals.
- Embrace physician leadership.
- Provide options for degrees of involvement.
- Collaborate with independent providers who choose to work together.
- Provide access to care.
What Has ENHANCE Been Able to Accomplish?

In just its first year of operation, ENHANCE provided value to its membership in several ways.

**Members received savings** of more than $3 million through joint purchasing and shared service opportunities.

**The ENHANCE team secured grant funding** for the CMS Transforming Clinical Practices Initiative in order to help fund the transition of care delivery to a value-based system.

**A claims-based analytics tool was implemented** for members that identifies and tracks clinical and cost improvement opportunities for their self-insured employee health plan population, as well as other populations in the future.

**Quality improvement initiatives were launched** across all ENHANCE members’ employee health plan populations.

**The alliance executed PHO participation agreements** and provider opt-in forms to formally define ENHANCE’s provider network, which spans more than 3,000 providers across the state of Nebraska and into western Iowa.

Less tangible but equally important, Dr. Hein remarked, is the value members have derived from sharing intellectual capital, best practices, struggles, solutions, and lessons learned across organizations, which was unlikely before ENHANCE existed.
**What Challenges Has Enhance Encountered?**

Certainly, creating and managing a regional healthcare alliance is not without its trials. “There are numerous challenges that arise when leading and managing a regional alliance, yet these struggles present numerous learning opportunities that allow us to continually strengthen our organization,” said Dr. Hein. “Fortunately, we’ve been able to work with a strong and capable consulting firm in ECG that has masterfully led us through each step of the process.” Some specific challenges that the organization faces on a daily basis include:

**Ensuring all members are committed to the alliance’s success.** Voluntary participation in all initiatives is one of the most attractive aspects of the alliance, but it can also pull the alliance apart. This type of organization puts a premium on collaboration. The fact that not all organizations belong for the same reason makes it important to effectively show that the alliance’s success is critical to the success of member organizations.

**Demonstrating value and accomplishment.** This is difficult for any organization, but particularly so when there are many participating entities in different markets across a large geography. All systems want to know the value proposition and the ROI of being an ENHANCE member. Dr. Hein remarked on the importance of continually demonstrating a progression and meaningful impact to keep members engaged in the alliance.

**Achieving clinical integration.** Members represent distinct markets and a vast variability in size. Moving toward clinical integration is inherently very different among the individual organizations because of their unique payor/healthcare markets. ENHANCE provides a collaborative network, shared resources, and a consistent framework to help members advance clinical integration at a pace commensurate with their local market demands and dynamics.

**What are ENHANCE’S Future Plans?**

ENHANCE has a number of goals and targets to meet in 2016 and beyond related to CI efforts and value-based contracting. However, member organizations have ultimately banded together to make sure the communities they serve are measurably healthier and positioned at the top of county, state, and national health rankings.

To achieve this, ENHANCE aspires to create a network of Accountable Health Communities, which Dr. Hein said exist where healthcare delivery is efficiently and effectively fused with the public health sector, along with major employers and school systems.

“We want to tell a cohesive and compelling story about health that communities will embrace,” Dr. Hein declared. “We have placed this vision of Accountable Health Communities into our mission, and I believe that the pursuit of that goal will sustain us.”
### Presentations

**CARE MODEL TRANSFORMATION**

**Building a Statewide Clinically Integrated Delivery System**
- **Venues:** HFMA Lone Star Chapter, January 28, HFMA Texas Gulf Coast Chapter, May 23
- **Presenters:** Emma Mandell Gray, Senior Manager
  - Erin Mastagni, Manager

**It’s Complicated: Why Patient Complexity is Reshaping Care Delivery – And What It Means For Hospitals**
- **Venue:** Healthcare WebSummit, January 26
- **Presenter:** Shobhika Somani, Senior Manager

**Transforming Care Delivery: One Organization’s Journey Toward Patient-Centered Primary Care**
- **Venue:** MGMA New England, May 5
- **Presenter:** Emma Mandell Gray, Senior Manager

**Cone Health: Creating a Community Model for Population Health**
- **Venue:** University of North Carolina Chapel Hill, September 16
- **Presenter:** Emma Mandell Gray, Senior Manager

**Transforming Primary Care: Will the Investment Pay Off?**
- **Venue:** HFMA Washington-Alaska Chapter, September 21
- **Presenter:** Emma Mandell Gray, Senior Manager

**ENTERPRISE STRATEGY**

**Aligning With Physicians to Regionalize Services**
- **Venue:** HFMA Annual National Institute, June 28
- **Presenter:** John Fink, Principal

**Creating a Clinically Integrated, Academic-Community System Population Health Affiliation**
- **Venue:** HFMA Annual National Institute, June 28
- **Presenter:** Jeff Hoffman, Principal

**Changing Care Delivery Through Retail Partnerships**
- **Venues:** HFMA New Jersey Annual Institute, October 5
  - MGMA Annual Conference, November 1
- **Presenters:**
  - John Budd, Senior Manager
  - Asif Shah Mohammed, Associate Principal
  - Malita Scott, Senior Manager

**FACILITY PLANNING & CAPITAL ASSETS**

**Facility Planning and Construction in a New Health Care Environment**
- **Venue:** Moss Adams Healthcare Webcast, June 1
- **Presenter:** Don Briones, Senior Manager
INFORMATION TECHNOLOGY

EHR Vendor Landscape: Which Stars are Rising—and Which are Falling?
Venue: Estes Park Institute, multiple dates
Presenter: Robin Settle, Principal

Anatomy of an IT Strategic Plan: Building The Central Nervous System to Help Achieve Overall Organizational Success
Venue: Estes Park Institute, multiple dates
Presenter: Robin Settle, Principal

Health Information Technology—Why Is This Taking Up So Much of the Agenda at the Board Meeting?
Venue: Estes Park Institute, multiple dates
Presenter: Robin Settle, Principal

Dyad Leadership and EHR Success
Venue: MGMA/AMA Collaborate in Practice Conference, March 21
Presenter: Michelle Holmes, Principal

Emerging Technologies That Support Transitions of Care
Venue: HIMSS New Jersey Chapter, June 8
Presenters: Robin Settle, Principal  
Elaine Remmlinger, Principal

How Can Your Organization Adopt a Connected Telehealth Model?
Venue: North Carolina Healthcare Information & Communications Alliance Annual Conference, August 28
Presenter: Jake Fochetta, Manager

We Spent a Fortune on Our EHR, and Now You Want Us to Buy What?
Venue: CHIME 2016 CEO Forum, November 2
Presenters: Elaine Remmlinger, Principal  
Robin Settle, Principal  
Paul Murphy, Principal

Long-term & Post-acute Care: Interoperability & Health Information Technology
Venue: Health Dimensions Group National Summit, February 23
Presenter: Robin Settle, Principal

Health Information Technology—The Three Most Important Questions to Ask
Venue: Estes Park Institute, November 6
Presenter: Robin Settle, Principal

Getting the Maximum Return on Your Health Information Technology—I Thought This Was Supposed to Make My Life Easier
Venue: Estes Park Institute, November 6
Presenter: Robin Settle, Principal

PHYSICIAN STRATEGY

Succession Success: Real-Time Strategies for an Aging Physician Workforce
Venues: HFMA Lone Star Chapter, January 29  
Southwest Physician Recruiters Association, March 4  
ASPR Annual Conference, May 18
Presenter: Jennifer Moody, Associate Principal

Optimizing Strategy for the New Realities of Hospital Surgical Services
Venue: Becker’s Hospital Review Annual Meeting, April 28
Presenters: Kevin Kennedy, Principal  
I. Naya Kehayes, Principal

Emerging Technologies That Support Transitions of Care
Venue: HIMSS New Jersey Chapter, June 8
Presenters: Robin Settle, Principal  
Elaine Remmlinger, Principal

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Presenter: Robin Settle, Principal
Presentations

REIMBURSEMENT & CONTRACTING

Creating a Dashboard to Monitor and Optimize Results
Venue: Annual Bundled Payment Implementation Forum, January 25
Presenters: Kimberly Hartsfield, Senior Manager
Tori Manis, Senior Manager

The CJR Playbook in the Context of the Payment Reform Mash-Up
Venue: National Payment Innovation Summit, February 10
Spring IDN Summit, April 4
Presenters: Deirdre Baggot, PhD, Principal
Tori Manis, Senior Manager
Kimberly Hartsfield, Senior Manager

Hospital and Managed Care Contracting and Negotiation
Venue: Citi Research - Payor/Provider Day, April 6
Presenter: Terri Welter, Principal

Centralized Funds Flow and Its Impact on Departments of Surgery
Venue: Association of Academic Surgical Administrators Mid-year Retreat, May 20
Presenter: Matt Johnson, Senior Manager

Medicare ASC Payment Changes: Opportunities and Risks
Venue: Ambulatory Surgery Center Association Annual Conference, May 21
Presenter: I. Naya Kehayes, Principal

The CJR Playbook: Real Life Best Practices in Smart Implementation
Venue: National Bundled Payment Summit, June 7
Presenters: Deirdre Baggot, PhD, Principal
Tori Manis, Senior Manager
Kimberly Hartsfield, Senior Manager

The Changing Healthcare Environment: Understanding Medicare’s Payment Logic for Outpatient Procedures
Venue: Becker’s Annual Spine, Orthopedic and Pain Management-Driven ASC Conference, June 9
Presenters: I. Naya Kehayes, Principal
Matt Kilton, Associate Principal

Developing an Orthopedic Bundled Payment Program
Venue: American Alliance of Orthopaedic Executives Annual Conference, June 10
Presenters: Kimberly Hartsfield, Senior Manager
Jason Lee, Associate Principal
Michael Duffy, Senior Manager

The Critical Strategic and Operational Considerations of Bundled Payments
Venue: The Leader’s Board, July 22
Presenter: Deirdre Baggot, PhD, Principal

A Strategic Approach to Developing the Operational Capabilities for CJR Success
Venue: Healthcare Education Associates - CJR Boot Camp, September 26
Presenter: Sarah Wald, Senior Consultant

Build a 90 Day CJR Readiness Playbook for Your Organization to Execute Rapidly
Venue: Healthcare Education Associates - CJR Boot Camp, September 27
Presenters: Deirdre Baggot, PhD, Principal
Tori Manis, Senior Manager

Preparing for Bundled Payments
Venue: HFMA New Mexico Chapter Fall Meeting, October 14
Presenter: Tori Manis, Senior Manager

Key Thoughts on Great Managed Care Contracting
Venue: Becker’s ASC Annual Meeting, October 27
Presenters: I. Naya Kehayes, Principal
Deirdre Baggot, PhD, Principal

MACRA: Learn the Basics, Get Ready for a Post-SGR World
Venue: Spring Virginia Association of Hematologists and Oncologists Meeting, May 6
Presenter: Jessica Turgon, Principal

Implementing Effective Care Redesign: The Linchpin to Bundled Payment Success
Venue: Annual Healthcare Bundled Payments Congress, November 15
Presenter: Deirdre Baggot, PhD, Principal

Assessing the Financial Operating Performance of an ASC
Venue: Washington Ambulatory Surgery Center Association Annual Education Conference, November 18
Presenter: I. Naya Kehayes, Principal
## Presentations

### Revenue Cycle Optimization

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<td>Bundled Payments in the Total Hip and Knee Replacement Patient: Implications Across Disciplines</td>
<td>Baptist Orthopedics Nursing Symposium, October 22</td>
<td>Deirdre Baggot, PhD, Principal; Tori Manis, Senior Manager</td>
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