HEALTHLEADERS MEDIA

Impact Analysis

Align Physicians and Hospitals in a Non-Aligned World

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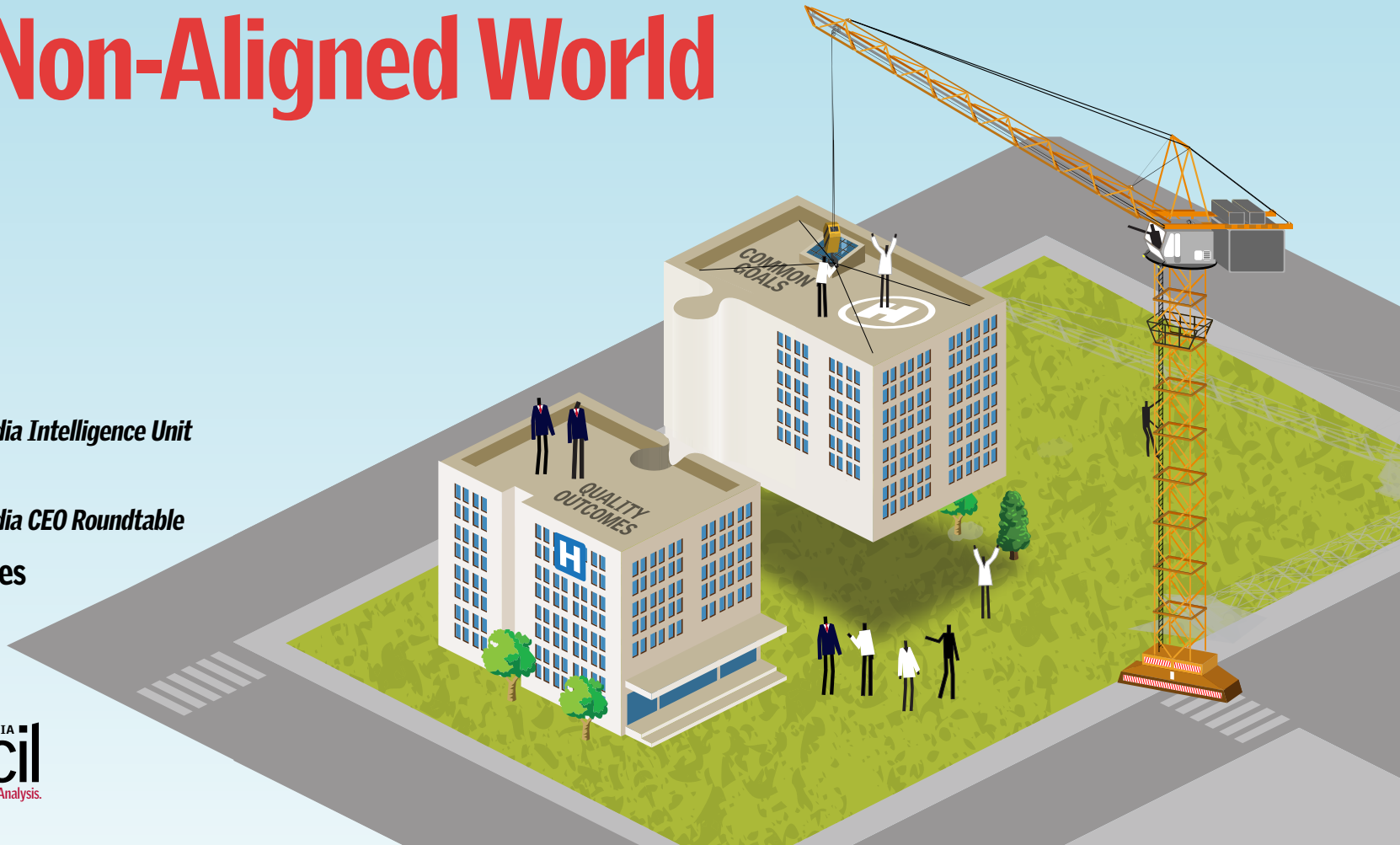

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Insight BY JIM MOLPUS

Only You and Your Physicians

Several healthcare leaders met at the Indian Wells Conference Center near Palm Springs, CA, in January for a HealthLeaders Media CEO Roundtable to share ideas on the best models and practices for today's community-hospital physician alignment.

Hospital CEOs and the leaders of their medical staffs must chuckle whenever they hear terms like "plan" or "organization" to describe the alignment between hospitals and physicians in the post-PPACA era. The only universal truth is that there are no universal solutions to drawing physicians and hospitals into a model that rewards physicians, hospitals, payers, and patients for better care.

Variables including physician culture and history, market demographics, payer mix, the number of uninsured, access to primary care, and a host of other influences can drastically change which physician alignment structures may work for a particular market or the health systems within it. Hospitals and their physicians must share common values, including transparency and accountability, and they must embrace a

shared direction with some common goals. But the tools are as varied as the markets.

HealthLeaders Media hosted a panel of five health systems' CEOs and CMOs recently to discuss the physician alignment challenges facing hospitals of all sizes. While each healthcare organization was working on its own path, there were some common lessons.

Don't Be Afraid of Big Moves

MemorialCare Health System was not among the first adopters of the medical foundation model used in California, but made the switch in 2010 to better align its physicians with new demands, says Diana Hendel, CEO of three MemorialCare hospitals in Long Beach.

Tim Rice, president and CEO of Lakewood Health System, a rural provider based in Staples, MN, integrated the hospital and clinic a few years ago after a history of independence. That has allowed Lakewood to now pursue medical home pilots. Integration has been a sound substrate, but even that has to flex, Rice says.

"So over time our integration just continues to evolve and it really has got to be fluid," Rice says. "Even if you come to terms on a specific relationship, you don't catch everything. So if something does come up during the year, you still do what's right and you make those modifications."

"We're definitely viewing ourselves as having one foot on the dock and one foot on the boat for likely a decade."

Diana Hendel, PharmD, CEO, Long Beach (CA) Memorial, Miller Children's Hospital Long Beach, and Community Hospital Long Beach

Experiment Relentlessly

Try joint ventures and medical homes. Mix RVUs with quality bonuses for physician compensation. Employ some specialists. Whatever works for your health system works for your health system. As long as the experiments or pilots are within your risk tolerance, there is physician support and infrastructure for it, and it fits the mission, then today's experimentation can bring tomorrow's successful service. David Brooks, CEO for Providence Health & Services' Northwest Washington region, says a cardiac joint venture has become a great tool.

"We've had a bundled-payment shared PHO with our medical staff for about 13 years specific to heart care," Brooks says. "It's

called the Northwest Cardiac Network, which is half owned by the hospital and half owned by a number of physicians. We have done bundled payments in open heart cases, percutaneous cardiac intervention, and cardiac cath. We take a bundled payment and it's from two commercial plans and we create a pool. We create performance incentives around the service and cost, and we share back the resources assuming we hit performance targets between the institution and the hospital. It's worked wonderfully well. It has integrated the cardiac medical providers and has been a great tool."

For better or worse, hospitals and physicians are at the forefront of an extended era of disruption as healthcare makes the belated but necessary transition from fee-for-service to value-based healthcare. As Hendel says, "We're definitely viewing ourselves as having one foot on the dock and one foot on the boat for likely a decade." Only hospitals and physicians that team to find the precise mix that works for them are likely to keep from falling in. IA

Jim Molpus is strategic relationships director for HealthLeaders Media. He can be contacted at jmolpus@healthleadersmedia.com.

Perspective BY RICHARD A. SHEFF, MD

Creating Local Solutions to Physician-Hospital Alignment

Hospital and physician leaders seek practical steps to take today to succeed in the healthcare of tomorrow. The old model of the democratically self-governed medical staff is not fully up to the tasks before us. Hospital and physician leaders must take bold initiatives or risk being overtaken by rapidly changing forces in healthcare. Here is what we find most practical in our work with physicians and hospitals to begin the journey of aligning physicians and hospitals in a non-aligned world.

- Conduct an ongoing dialogue with your physicians. As long as physicians and hospitals hold disparate views of the future, you and your physicians will never pull in the same direction. These dialogues should be structured as shared experiences and shared learning, culminating in crafting a vision for healthcare in your community that includes physician success, hospital success, and good patient care. This is not a single retreat, but an ongoing, collaborative process.
- Create a new physician-hospital compact, a renegotiation of the "give and get" between hospitals and physicians today, based on your new vision. Go beyond platitudes to build a framework for physicians and your hospital to do new things together in a purposeful way. Doing this well requires that hospital and physician leaders master the art of "crucial conversations," a critical core competency for moving forward together.
- Create economic integration by providing a range of financial options including, but not limited to, physician employment, joint ventures, and medical directorships. Transform the dialogue about ED call from "Pay me for my time or else" to "How does ED call fit into a fair, balanced strategy for physician success, hospital success, and good patient care in our community?"

- Create clinical and operational integration. Take your service lines to the next level by driving for the following goals of a service line done well: improved branding and marketing, good clinical outcomes, patient and family satisfaction, referral source satisfaction, cost-effectiveness, and greater market share and margin for both physicians and hospitals. These goals can only be accomplished by fundamentally changing how physicians practice medicine, a far more ambitious goal than most service lines target today. Consider a physician council where busy physicians and hospital leaders come together to focus on business development. Instead of starting a Medicare ACO, begin with an accountable care organization for hospital employees or with a commercial payer. Start building the infrastructure you'll need to manage the care of a population because eventually you'll need it.
- Revise your approach to meeting regulations. Don't over-interpret standards. Reduce documentation requirements and get nurses back to the bedside. We've found this to be a surprisingly effective strategy for physician-hospital alignment.
- Select one or more of the other current models—medical home, global pricing, service line comanagement, etc.—and implement it. Consider taking on a tough community challenge together, such as creating a medical home for indigent patients. The key is to start somewhere to break out of old molds and begin learning what works.
- Invest in physician leadership development and succession planning. None of the needed changes will be possible without skilled, committed physician leadership.

Most importantly, commit to experiment and learn together. All healthcare is local, and your solutions must be local. Recognize nobody really knows how to improve quality and reduce costs of the magnitude we face. Commit to getting through the learning curve together, to creating a shared delivery network capable of providing cost-effective, coordinated care to your community. This is the best road to achieving physician success, hospital success, and good patient care—together. IA

Richard A. Sheff, MD
Principal and Chief Medical Officer
The Greeley Company
Danvers, MA

ACO Survey Data

Powered by the HealthLeaders Media Council

OBJECTIVE STATEMENT

This data is drawn from several HealthLeaders Media surveys to determine healthcare leaders' insights regarding ACO strategy, physician alignment, and physician compensation.

METHODOLOGY

- **HealthLeaders Media Industry Survey 2012, CEO Report:** In October 2011, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience, representing hospitals, health systems, and physician organizations. A total of 117 completed surveys are included in the analysis. The margin of error for a sample size of 117 is +/-9.1% at the 95% confidence interval.
- **HealthLeaders Media Industry Survey 2012, Physician Leaders Report:** In October 2011, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience, representing hospitals, health systems, and

physician organizations. A total of 136 completed surveys are included in the analysis. The margin of error for a sample size of 136 is +/-8.4% at the 95% confidence interval.

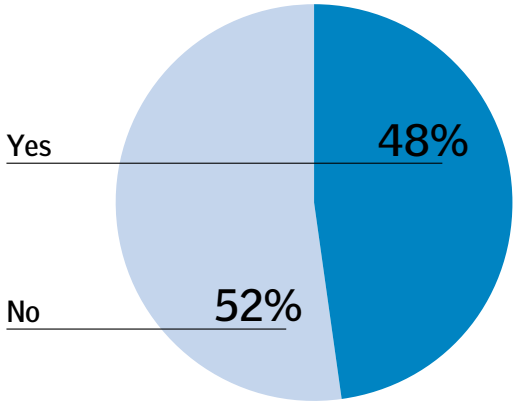
» **HealthLeaders Media Intelligence Report, Physician Alignment: The Collaborative Care Disconnect:** In June 2011, an online survey was sent to the HealthLeaders Media Council. Qualified respondents were screened to ensure they work in a hospital or health system setting. A total of 292 completed surveys are included in the analysis. The margin of error for a sample size of 292 is +/-5.7% at the 95% confidence interval.

» **HealthLeaders Media Intelligence Report, Physician Compensation: Shifting Incentives:** In July 2011, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. Respondents work in hospital, health system, and physician organization settings. A total of 316 completed surveys are included in the analysis. The margin of error for a sample size of 316 is +/-5.5% at the 95% confidence interval.

Survey Data Results

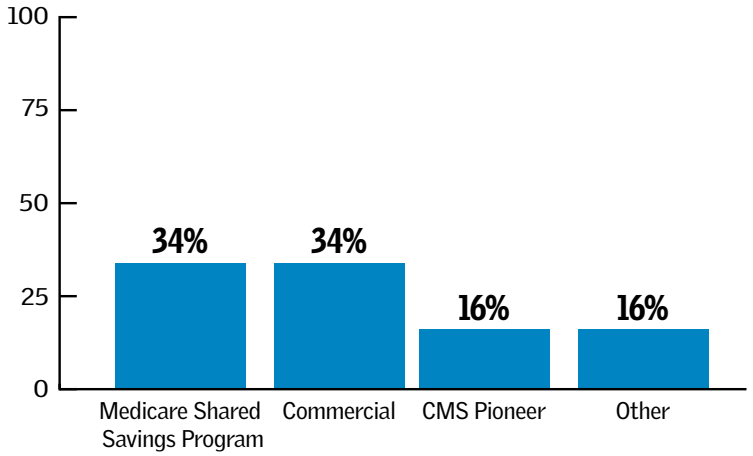
HEALTHCARE CEOS' INTEREST IN JOINING AN ACO

Will your organization be part of an accountable care organization within the next three to five years?



Base = 117

The 48% who answered Yes were asked, Which ACO model will you be a part of?



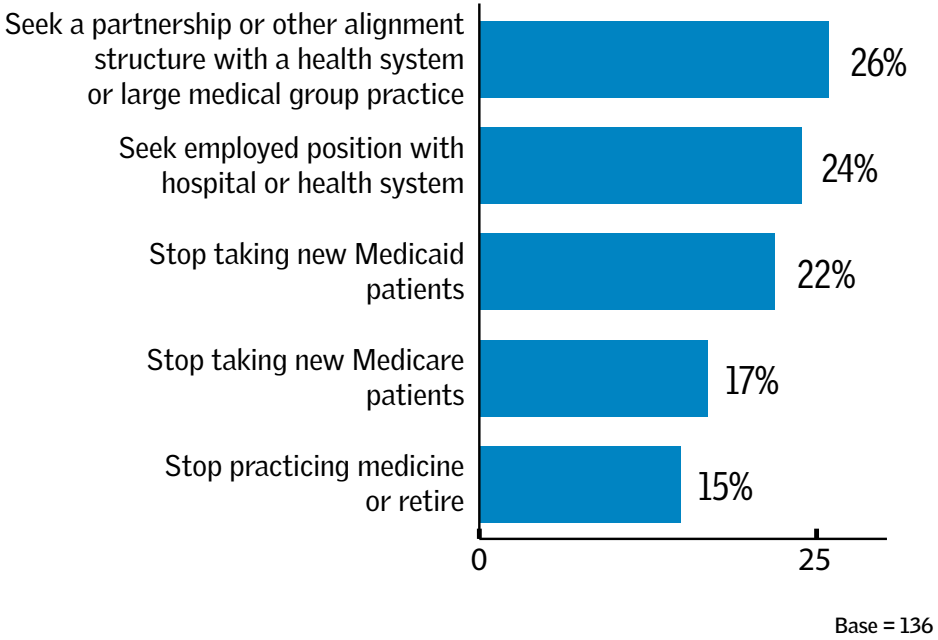
Base = 56

Source: HealthLeaders Media Industry Survey 2012, CEO Report, February 2012; www.healthleadersmedia.com/industry_survey.

Survey Data Results

PHYSICIAN LEADERS' INTEREST IN ALIGNMENT

How will you respond to low Medicare/Medicaid reimbursements?

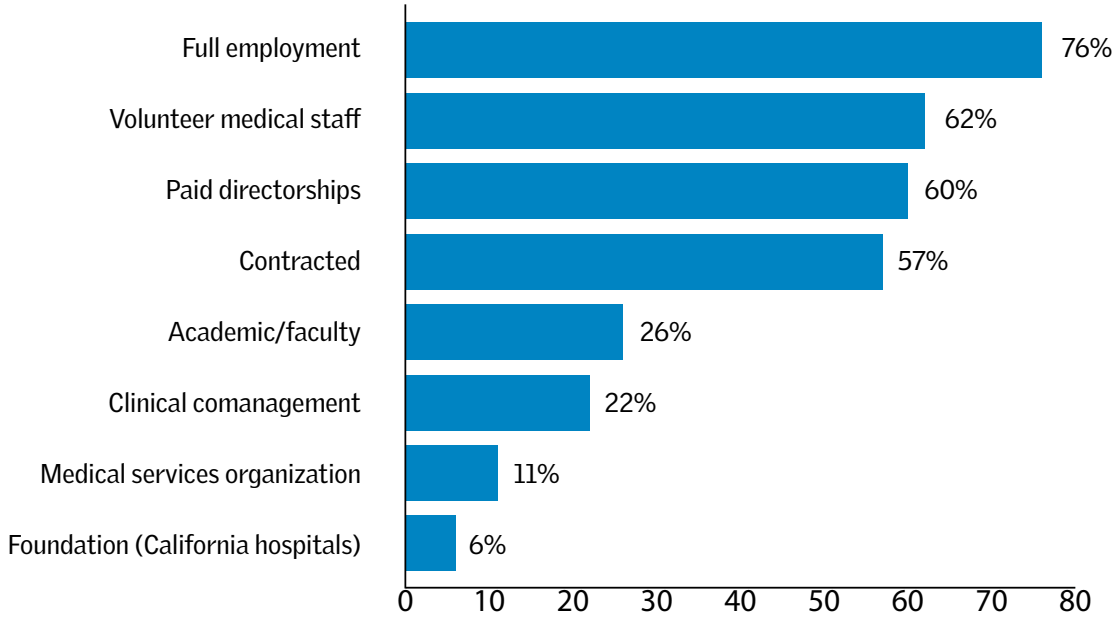


Source: HealthLeaders Media Industry Survey 2012, CEO Report, February 2012; www.healthleadersmedia.com/industry_survey.

Survey Data Results

HOSPITAL AND HEALTH SYSTEM LEADERS ON PHYSICIAN ALIGNMENT MODELS

What are your organization's current medical staff models?



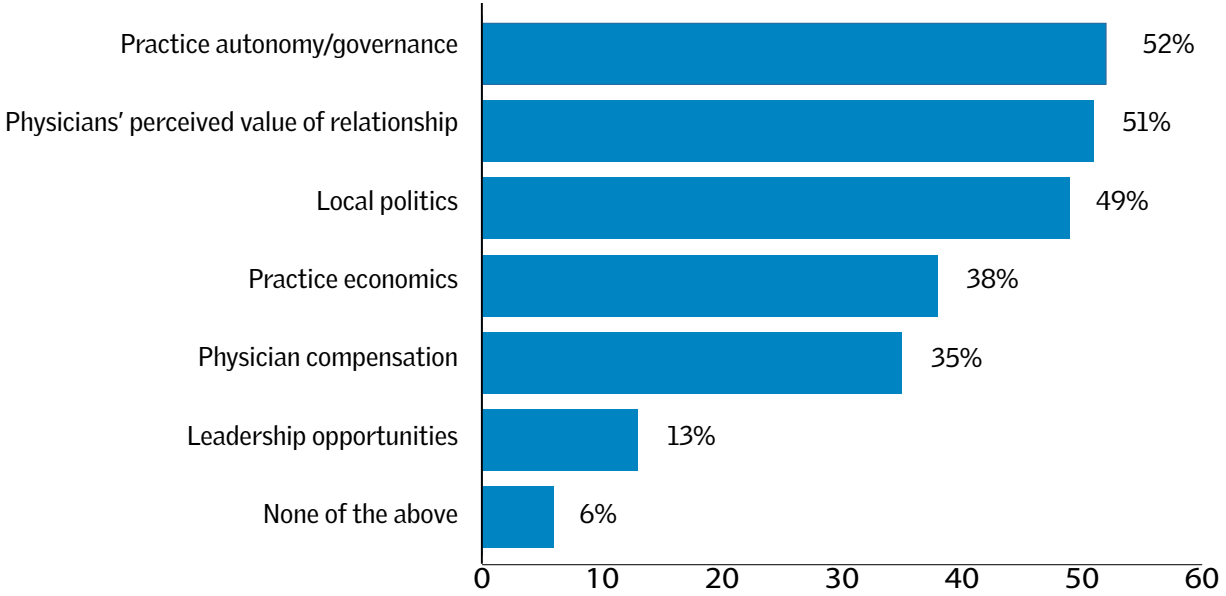
Base = 292
Multi-response

Source: HealthLeaders Media Intelligence Report, Physician Alignment: The Collaborative Care Disconnect, September 2011; http://content.hcpro.com/pdf/content/270973.pdf.

Survey Data Results

HOSPITAL AND HEALTH SYSTEM LEADERS ON INHIBITORS TO PHYSICIAN-HOSPITAL RELATIONS

Which of the following are considered inhibitors to physician-hospital relations at your organization?



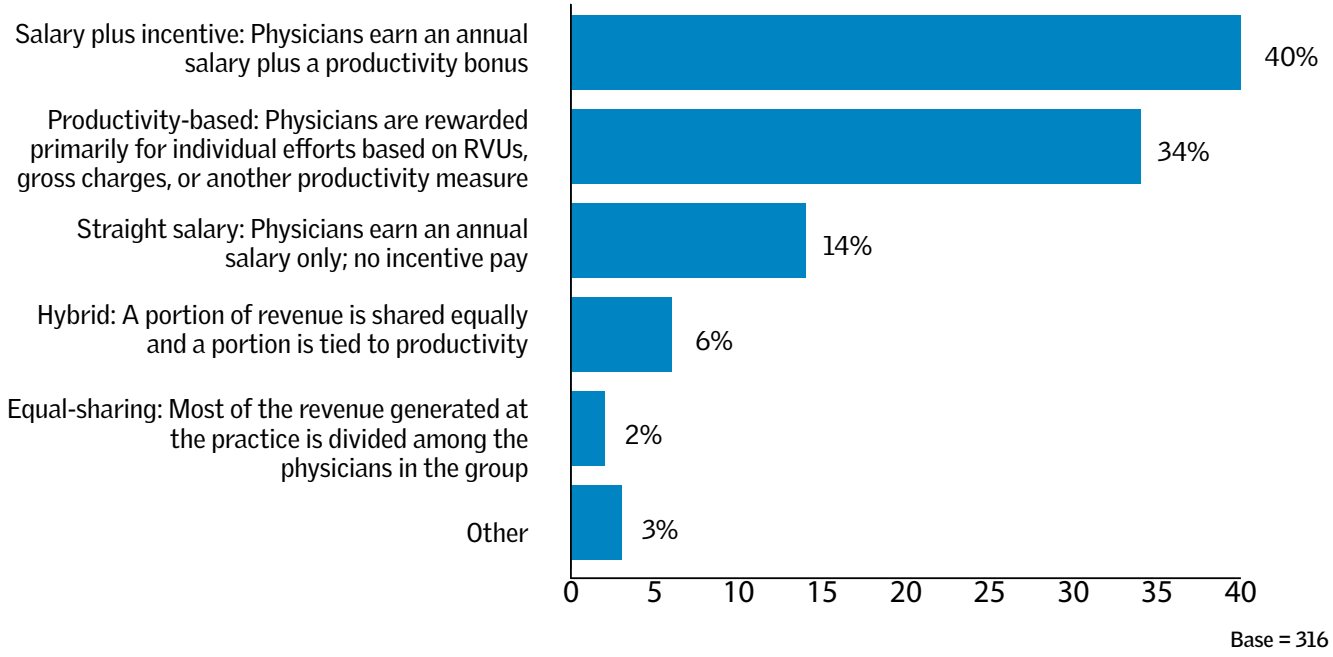
Base = 292
Multi-response

Source:: HealthLeaders Media Intelligence Report, Physician Alignment: The Collaborative Care Disconnect, September 2011; http://content.hcpro.com/pdf/content/270973.pdf.

Survey Data Results

HOSPITAL, HEALTH SYSTEM, AND PHYSICIAN ORGANIZATION LEADERS ON COMPENSATION MODELS

What best describes your organization's dominant physician compensation model?

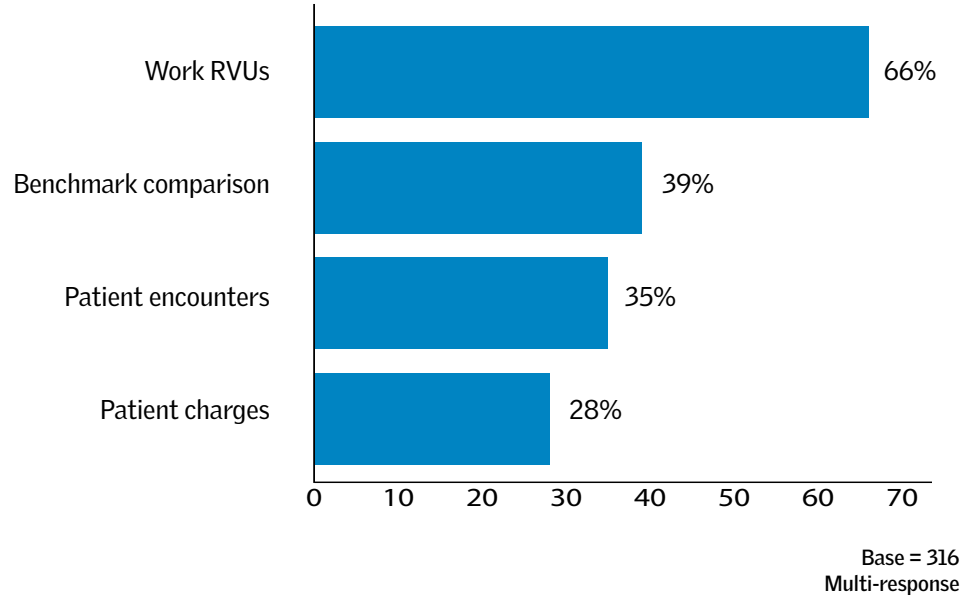


Source: HealthLeaders Media Intelligence Report, Physician Compensation: Shifting Incentives, October 2011; http://content.hcpro.com/pdf/content/272110.pdf.

Survey Data Results

HOSPITAL, HEALTH SYSTEM, AND PHYSICIAN ORGANIZATION LEADERS ON PHYSICIAN PRODUCTIVITY

Which of the following does your organization use to measure physician productivity?



Base = 316
Multi-response

Source: HealthLeaders Media Intelligence Report, Physician Compensation: Shifting Incentives, October 2011; http://content.hcpro.com/pdf/content/272110.pdf.

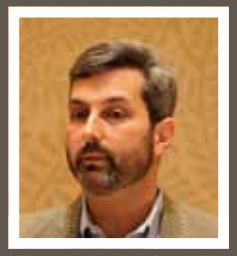
Impact Analysis Roundtable

Post-Reform Physician Alignment in the Community Hospital

BY JIM MOLPUS

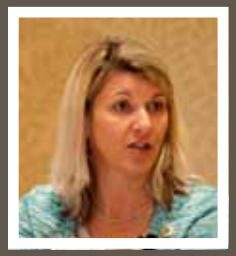
THE PANELISTS

Jim Molpus
(Moderator)
Strategic Relationships Director, HealthLeaders Media



David Brooks
CEO, Providence Health & Services, Northwest Washington region

John Halfen, MD
Medical Director, Lakewood Health System, Staples, MN



Diana Hendel, PharmD
CEO, Long Beach (CA) Memorial, Miller Children's Hospital Long Beach, and Community Hospital Long Beach

Ed Jeffries, MD
Chief Medical Officer, Baton Rouge (LA) General Medical Center

Tim Rice
President and CEO, Lakewood Health System, Staples, MN

Post-Reform Physician Alignment in the Community Hospital

HEALTHLEADERS MEDIA: Our annual industry survey asked clinical and executive leaders if their healthcare organization would be joining an ACO of any description in the next three years. It was a virtual tie with 51% saying yes. Does this response suggest some growing ambivalence about accountable care among leaders? How do you view that universe and what, if any, structures do you have in place to pursue it?

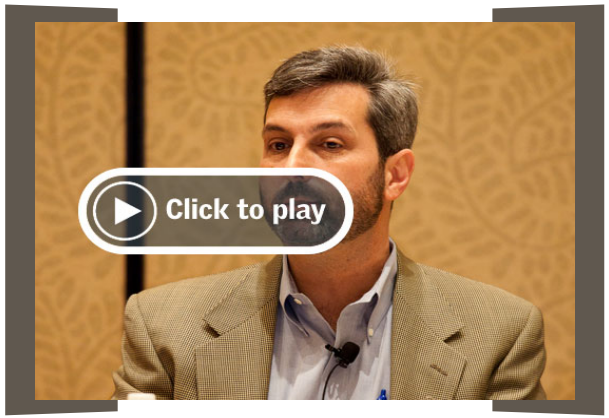
DAVID BROOKS: It depends on the day. The cliché here is that we want the AC part of ACO, not necessarily the O. So we certainly are pushing toward creating more accountable care, which means integrated care, responsible care, and organized care. The tools and the vehicles are going to evolve and change. Being part of the Providence system, which has 28 hospitals up and down the West Coast, we have some central system resources and we conducted a comprehensive ACO review for every market. We started it at Everett because we've probably got the more organized, integrated delivery systems within most of our communities. We used benchmarks like Milliman and Robertson, usage rates, and other things and found we were already a very high-performing market in the sense of utilization. The overall population cost of care is one of the lowest in the country. We have found the challenge with a lot of the ACO structures is that you start at the point of sharing some of the economics for improved performance, but that may not work well if you're already better than the national average. So our benchmark would start where we're already at—which is already very low-cost, high-performing, at least as measured by utilization. So we're struggling with figuring out what's the economic upside to invest a lot on the structural side if we're already achieving a lot of those outcomes.

DIANA HENDEL: At MemorialCare Health System we are keenly focused on comprehensive integration of all aspects of our delivery network. We already fully integrated an electronic medical records system at our six hospitals, and to a growing extent, in ambulatory and physician settings, as well as offering an electronic health record for our patients. We've made great progress in service line integration across the system, and our efforts in Lean have paid off, thanks to incredible participation of our employees and physicians. When it comes to physician integration, in California, like Texas, we aren't able to directly employ physicians. That's why we're seeing a surge in medical foundation–type arrangements to allow a formal integration model for physicians. When we unveiled our foundation

early last year, the timing was perfect since we had ample time to learn from other health systems' trials and errors over the last 15–20 years. The model we crafted took advantage of a long learning cycle and best practices, and the results have been a very smooth integration of hundreds of physicians and practice employees into the MemorialCare network. We were fortunate in that almost two decades ago we developed a Physician Society of more than 1,500 independent physicians who work with our clinicians and employees systemwide to create best practice guidelines in dozens of clinical categories. As CEO of three facilities—a large teaching hospital, one of the nation's biggest children's hospitals, and a community hospital—I work directly with scores of individual practitioners, medical groups, and large independent physician associations. In, working with thousands of different practitioners, we have multiple models. With the Pioneer ACO, we went through the first pass and made the first cut. But similar to Providence Everett, we found we were already performing at a high level and that the Pioneer ACO did not create the yield needed to justify moving forward.

»**VIDEO**REWIND

David Brooks, CEO, Providence Health & Services, Northwest Washington region, on his hospital's ACO analysis.



ED JEFFRIES: The short answer is that we do not plan to pursue an ACO in the near future for many reasons that have already been expressed in terms of the potential benefit to be gained versus experiencing the cost. I realize, and I think our administration realizes, that unless we change physician behavior we are going to have difficulty no matter what type of reimbursement system we use. We're pursuing a medical home right now with one of the local insurance companies. So we're going to use that experience to refocus and retrain our physicians in terms of how they currently deal with patients on an individual basis to a population-based approach ... We will learn, move forward, watch what happens around us, and try to learn from other people's successes and mistakes. We will probably participate as providers in some of the ACOs but we are not going to have financial involvement with any of them. We will probably pursue some of the pilot programs that Medicare is rolling out. We'll see how they work and how they are received. But basically we're going to hold back and watch what happens in the market and try to get our physicians refocused.

JOHN HALFEN: There's a viewpoint that 22% of the healthcare expenses are on complications of care that could be reduced, and that's $400 billion that could be reduced yearly. And we're looking at our own selves and what we've done to reduce those expenses. What we really are looking at is not accountable care organizations, but accountable care contracts with payers that will reimburse us for what we are saving them at this point in reimbursements for our expenses.

HLM: Diana and Dave, you talked about the cost-benefit analysis not being there to justify your participation in the Pioneer ACO. Are there other pilots and programs that do fit?

HENDEL: We found that rather than going down the path of the Pioneer ACO, MemorialCare Health System would best be served in the long run by developing integration in a network of providers working closely with payers and employers. We've had a long history of partnering with these stakeholders in a number of different activities and continue to expand our options and collaboration. One current area of focus is the California Children Services. Reimbursement for 75% of our patients at Miller Children's Hospital is through CCS. Traditionally, that's been fee-for-service, a reimbursement model that, as you can imagine, has meant longer lengths of stay, more utilization, and less integration. The state and its eight designated children's hospitals came together and made a decision to move toward a very different model, which is a much more capitated network. The pilot will be on a relatively small scale and involve children with chronic diseases that may last their entire lifespan. The data will allow us to evaluate the clinical and financial impact on that child as they move into adulthood. We're looking at that as both a study and a model that we can create to better integrate care while improving costs and outcomes.

VIDEOREWIND

Diana Hendel, PharmD, CEO, Long Beach (CA) Memorial, Miller Children's Hospital Long Beach, and Community Hospital Long Beach, on her hospital's ACO analysis.

BROOKS: Remember, the structure of the formal ACO or the components of accountable care are all toward a macro basis. How do we innovate and how do we improve performance for our communities? How do we improve the safety of care? How do we improve the patient experience and how do we lower overall cost for the community? That's what we're all supposedly and hopefully trying to shoot for. The vehicles and tools are going to ebb and flow. For Medicare, we're using our own health plan. For the commercial side, we're working with the various health plans in the state. We've got medical home pilots. We have shared-risk approaches. For Medicaid, we're working with a couple of other health plans specific to that population base. We've had a bundled payment shared PHO with our medical staff for about 13 years specific to heart care.

HLM: Medical home is certainly one of those tools that Dave refers to. What are the structures of the medical home that you've put in, particularly the physician components?

HALFEN: I think that it all begins with getting the adequate tools in place and adequate times. So there's certain philosophies that make a medical home work, one of which is having people work at the top of their license. We had busy physicians before this started—nobody had special time for patients. We developed an urgent care department and started using more physician extenders for urgent care where those people are seeing patients whose needs aren't as critical, and then the more complicated patients are being seen by the physicians. And then going down further another step from that is putting in a care coordinator who is able to field a lot of questions. The third part is we make the patient

part of their care, educating them, letting them know that they can call up 24 hours a day and let us know what's happening with them.

TIM RICE: If you're looking just from the financial side, it starts with the philosophy of pursuing programs that would do what's right for our patients. What we have found even though there's been definitely a dollar investment in medical home, just the word of mouth and patient satisfaction is worth a lot. We've actually seen growth of volume and patients wanting to be part of the system because of that word of mouth about having that access and that type of focus on care. We felt that was an appropriate investment and we have actually seen the growth from the model.

JEFFRIES: We have somewhere between 10,000 and 14,000 participants in the patient-centered medical home pilot we have with Blue Cross. Ours is going to be based on a financial model of the savings against the market trend for total medical cost for the area. Typically in our area it's about 8% a year. And so any savings of that will then be shared equally with Blue Cross and with the physician group. And then the physician group, in order to qualify for receiving that bonus, has to meet its 10 quality parameters. It's very easy to pick 10; the hard part is setting the baseline on these parameters and what the goals for improvement are. We're working on that piece now. And then 80% of their bonus will be based on the quality parameters, 15% on their use of generics, and 5% on patient satisfaction.

HLM: So if you're getting paid on reducing overall growth costs, where do you put the effort? Is it in chronic care? Is it in diabetes?

JEFFRIES: We're going to go for the low-hanging fruit, okay? They're going to produce a list that's going to show us—however you want to view it, the top 200, bottom 200—in terms of cost expended to an individual patient. We're going to begin to look at those and try to make obvious savings where we can on ER visits, etc. We found one patient who had 42 ER visits in one year to eight different ERs and spent $81,000. I mean that's pretty low-hanging fruit when you get right down to it. Now not all of them will be that straightforward, but then we're going to look at the chronic conditions of diabetes and hypertension. We will try to look at the ones that are not getting their blood pressure or hemoglobin A1c controlled. Those are all things that are very doable and we could easily see a 4% savings against the trend just doing those things.

HLM: Tim, you made the move to integrate the hospital and clinic years ago. How has that evolved as you face the new challenges like medical home?

RICE: One of the first things we realized as we got into it was how little we knew about the clinic business. When we integrated we had specific staff and compensation models that we felt would be the ones that we should utilize. And as we got into it even with

»VIDEOREWIND

Ed Jeffries, MD, Chief Medical Officer, Baton Rouge (LA) General Medical Center, on the financial model being used in its medical home pilot.

the initial medical director, we realized that a lot of them wouldn't work. So over time it just continues to evolve and it really has got to be fluid. You develop a model that you feel that works both operationally, fits the practice in the organization and what's changing in the market. We do use RVUs. We have some on salary. We have developed a set of bonuses over time. We're now working on a shared [bonus] regarding a medical home, but even if you come to terms on a specific relationship, you don't catch everything. So if something does come up during the year, you still do what's right and you make those modifications.

HLM: How are you transitioning your physicians away from the fee-for-service mentality?

BROOKS: Well, that's the dual imperative and that's part of the challenge. The good news is we've integrated all these health systems. The bad news is we've integrated the health system. So as these primary care physicians help manage healthcare utilization and healthcare costs, guess where a lot of those excess ED visits are coming out of? Now if we switch the financial mechanisms so that the health delivery system gets rewarded for that, not just the payer, we share part of the spoils, so to speak, in that regard, then we can take those resources and help retool the health system, right? But if we don't do that and we're still paid incrementally and we reduce the amount of increments that we're producing, the numbers aren't going to pan out and we're going to have a big problem on our hands.

HALFEN: I think we as physicians need to realize that the best way to reduce expenses is by increasing the health of that patient so that they do not need to come into the emergency room or go into the hospital. That's the major reduction. Whether the doctor orders more laboratory tests—some of my partners order more tests than others—is the big determinant. You're not going to reduce costs very much by changing that. You're going to reduce the costs more by improving their health.

JEFFRIES: From the hospital perspective on volumes, those are negative things. I think the opportunity for health systems involved is to partner with insurers who are showing better quality results long term so their overall volume will increase. You're not going to make as much per stay, but you're going to have higher volumes. Your bed days per 1,000 will decrease but the total number of patients available for services will increase.

HENDEL: We're definitely viewing ourselves as having one foot on the dock and one foot on the boat for likely a decade. That changes the emphasis from a volume perspective of procedures or admissions or units, to concentrating much more on the overall greater health of our communities and the patients and families we serve. It is both a challenge and a tremendous opportunity. The emphasis on population health is the one single activity that excites me most about healthcare in the coming 10–15 years. IA

»VIDEOREWIND

John Halfen, MD, Medical Director, Lakewood Health System, on the imperative to make physician alignment programs work now.

Additional Resources

For more information about our **Impact Analysis** participants, go to:

Lakewood Health System
www.lakewoodhealthsystem.com

Providence Health and Services
www.providence.org

Long Beach (CA) Memorial
www.memorialcare.com/long_beach

Baton Rouge (LA) General Medical Center
www.brgeneral.org

About Us
HealthLeaders Media is a leading multi-platform media company dedicated to meeting the business information needs of healthcare executives and professionals. To keep up with the latest on trends in physician alignment and other critical issues facing healthcare senior leaders, go to *www.healthleadersmedia.com*.

About The Greeley Company
The Greeley Company provides advisory and educational services for healthcare executives and professionals. We help clients to achieve, maintain, and defend compliance with accrediting bodies and governmental agencies, evaluate and improve systemwide clinical quality, and work collaboratively with physicians toward mutually beneficial strategic goals. For more information, visit *www.greeley.com*.

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Paul Mattioli,
Senior Director of Sales
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Additional Materials

The Challenge to Collaborate
Until you identify the source of a problem, you are not likely to develop a solution. A common theme that runs through the results of the HealthLeaders Media Industry Survey 2012 is collaboration—the need for it and, too often, the lack of it. This fourth annual offering—through survey data and analysis of that data by healthcare leaders themselves—reveals the targeted priorities and concerns from within the industry's C-suite. The comprehensive project, conducted by the HealthLeaders Media Intelligence Unit, breaks down the results into multiple reports that explore issues of special interest to finance, physician, nurse, and senior leaders. We drill down further in reports that focus exclusively on CEOs, community and rural leaders, and service line revenue growth.

www.healthleadersmedia.com/content/MAG-276414/Our-Annual-Industry-Survey-The-Challenge-to-Collaborate

How Can Physicians and Hospitals Both Succeed When They Compete and Collaborate at the Same Time?
In this white paper, Richard A. Sheff, MD, CMSL, chair and executive director of The Greeley Company, discusses Polarity Management, a powerful approach to identifying and managing unsolvable problems. Many of the most important challenges faced by physicians and hospitals today, such as physician success vs. hospital success, quality vs. cost, patient safety vs. provider autonomy, and standardization vs. customization of patient care, are polarities to manage, not problems to solve.

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Rethinking ED Call: How to Balance Physician, Hospital, and Community Needs
In this white paper, Richard A. Sheff, MD, CMSL, chair and executive director of The Greeley Company, describes the idea of dealing with ED call by sharing the pain. Ultimately, the question every physician wants answered is: How much will I be paid for ED call? When this question is asked and answered through a process that helps physicians and the hospital agree on how to share the pain, a fair and sustainable outcome is possible.

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Publisher
MATTHEW CANN
mcann@healthleadersmedia.com

Strategic Relationships Director
JIM MOLPUS
jmolpus@healthleadersmedia.com

Editorial Director
EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bwertz@healthleadersmedia.com

Senior Director of Sales
Northeast/Western Regional Sales Manager
PAUL MATTIOLI
pmattioli@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

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