Variation in the way healthcare is delivered in the U.S. is a topic of critical focus for hospitals and other healthcare stakeholders. From the perspective of both cost and quality, a large amount of clinical practice variation exists—across regions, across hospitals in a region, across physicians in a hospital, and even across physicians in the same practice.

During the last two decades, the Dartmouth Atlas Project has been mapping geographic variations in the volume and cost of U.S. healthcare and documenting the lack of correlation between quality of care/outcomes and Medicare spending. More care at higher cost does not necessarily result in better outcomes; in fact, the opposite is often true. Furthermore, this variation in cost of care represents an enormous opportunity for reducing overall care cost.

Types of Variation
With insights gained from the early work of epidemiologist and Dartmouth professor Jack Wennberg, M.D., and UCLA health researcher and professor Milton I. Roemer, M.D., the Dartmouth Atlas of Health Care project defined three levels of care that are subject to variation:

- **Supply-sensitive care** is influenced by the availability of specific healthcare resources, such as hospital beds and certain medical or surgical specialists.
- **Preference-sensitive care** involves treatments that may be influenced by the patient’s values, preferences, or knowledge.
- **Effective care** involves services that are of proven value (with no significant tradeoffs) to those with specific medical problems; these services should be provided unless there are legitimate reasons not to do so.

As described in the sidebar on the following page, “unwarranted” or inappropriate variation occurs with each level of care.

**Appropriate Versus Inappropriate**
Due to unique patient and/or care-setting characteristics, there will always be a degree of appropriate variation in the practice of medicine, even for patients with the same diagnoses. It is clear, however, that through the use of evidence-based approaches to clinical decision making, hospitals and other providers nationwide can do much more to reduce inappropriate or unwarranted variation.

Inappropriate variation in clinical practice occurs when non-evidence-based care is provided, or when lacking widely accepted evidence-based care, the high level of variation cannot be supported on a quality or outcomes basis. Such care is often driven by non-clinical factors, such as legal, financial, operational (hospital processes), or other considerations that providers bring (consciously or unconsciously) to the process of making decisions about how patients are treated. Inappropriate variation can lead to reputational problems for healthcare providers, whether physicians, other staff, or affiliated organizations, and often leads to disparate outcomes for patients—either unanticipated or sub-optimal outcomes—and higher utilization and costs.

For example, patients in one hospital who are having a routine hip transplant might experience anywhere from 3 to 20 complete blood counts (CBCs), depending upon the provider, or an average length of stay from 3 to 19 days at a cost of $10,000 to more than $26,000 (Figure 1), even when adjusting for severity of illness or comorbidity. A significant number of “outlier” practices stemming from non-clinical factors could be driving significantly higher costs with little or no benefit (and at worst, potential harm) to patients.

continued on page 2
Building a Sustainable Program

To improve care quality, lower or optimize utilization, and reduce overall healthcare costs, hospitals and health systems seeking to move toward a value-based model of care should build a sustainable program for reducing inappropriate clinical practice variation. The program’s goal would be to enable more evidence-based, standardized practices that are clinically appropriate and within the organization’s current infrastructure and capabilities.

Appropriateness of clinical care requires deep knowledge of best practices, clinical practice guidelines, care protocols, and evidence-based medicine. The feasibility of increased standardization of practices using the organization’s current infrastructure and capabilities requires understanding of current clinical data collection and analytic systems and those required to ensure high-performing, clinically appropriate care delivery.

To build a sustainable program, organizations can identify areas of significant variation in clinical practice among physicians on the medical staff and clinicians employed by the organization and can determine the factors causing such variation. Organizations can also identify inappropriate variation with the greatest impact on care cost and quality, and purposefully implement programs to address such variation. A data-driven approach to change is highly recommended.

Data as the Enabler

The ability of any given organization to successfully and sustainably address inappropriate variation in care delivery among its physicians and other providers is highly dependent on access to credible data. Data have the power to change behavior. When physicians and other providers believe in the data showing wide and inappropriate variation in care quality, outcomes, and cost, the providers are often extremely responsive and will change their practices as needed. In many cases, no further inducement is required to bring their practices in line with those of their colleagues in the hospital, the health system, or the region.

For example, as documented by Dr. Wennberg many decades ago, hysterectomy rates in Maine and tonsillectomy rates in Maine and Vermont declined significantly when physicians were informed about comparative rates in their own and neighboring areas. During a 5-year period, based on feedback provided to physicians, tonsillectomy rates, which had exceeded the national rate, decreased 46 percent in 7 Vermont service areas.

More recently, Brent James, M.D., Chief Quality Officer of Intermountain Healthcare, documented the effects on physician practice of implementing an obstetrical labor induction protocol, measuring variation from that protocol and providing feedback to physicians. Labor inductions that did not meet clinical indications fell from 28 percent to 2 percent within a small number of years. A collateral benefit was a decline in the number of admissions to the newborn intensive care unit. Intermountain estimated that the induction protocol reduced Utah’s healthcare costs by $50 million per year.

Meeting the Data Challenge

Obtaining specific data on clinical practice variation can be challenging because organizations may not be collecting the data at this time. For
example, some organizations haven’t collected a significant amount of information on outcomes, either because outcomes-related events occur in settings beyond the hospital or because data collected in the hospital are limited to an “optimal” or “non-optimal outcome,” such as whether a patient gets an infection or not. To improve quality of care, providers will need to be able to define indicators of outcomes and collect and analyze data related to these indicators in detail.

There are a variety of approaches to building the required clinical information base. Most hospitals and health systems are investing in robust electronic health records (EHRs). Collecting data through these EHRs presents an opportunity for building their own clinical data analytics and warehousing capabilities. Other organizations that lack the human or capital resources to make this investment are working with vendors who can help them with data collection and provide the analytics required for monitoring and managing clinical performance.

**Identifying Areas of Variation**

As a starting point for most organizations, there is a specific data set that can be used to identify areas of variability and to target more specific data collection efforts. Looking at claims data for selected high-cost, diagnosis-related groups (DRGs) will allow for comparison of cost and volume data from all available sources. This can be followed by a deeper examination of the top areas of variation, looking at clinical, operational, and other administrative data in a targeted effort, and beginning to understand and identify outliers and the processes that may be driving up utilization and costs.

These “levers” of variation are at the core of practices and processes that may require change, often involving provider practices, hospital or other facility processes, or the decision-making methods that have the most direct impact on inappropriate variation. Review of operational processes and interviews with physicians and other staff can help to identify the underlying clinical and operational practices that drive inappropriate variation.

**Defining Opportunities and Developing Improvement Programs**

A close analysis of the preliminary data will likely indicate areas of greatest improvement opportunity. Prioritization of opportunities will be critical to achieving early success. At this point, the organization must commit to defining key quality, outcomes, access, and cost data that will need to be collected and analyzed at the appropriate level of detail. Benchmark data sources will also be required to identify deviations from standard practice now and going forward.

Prioritization of specific initiatives to improve standardization should be based on a financial analysis of the benefits of reduced variation and costs. Use of clinical practice guidelines will often be appropriate, selected based on the screening criteria identified by the Institute of Medicine.6 Criteria include validity, reliability/reproducibility, clinical applicability, clinical flexibility, clarity, multidisciplinary development, and documentation. Once organizations have the data and tools in hand, they can extend those programs to address clinical practice variation in other areas going forward.

In designing programs to improve standardization, early involvement of key physician leaders will be essential to validate objectives and enhance buy-in at the grass-roots level. For example, if management of patients with congestive heart failure is a key variation area, physician leaders can take the lead on developing or adapting a set of clinical practice guidelines for heart failure, implementing the order sets to support the guidelines, and defining the metrics needed to monitor activity and measure results.

Challenges with program implementation typically include overcoming cultural barriers to data sharing, defining collaborative models for best-practice dissemination, and aligning incentives for behavioral change. The culture of the physician network in a hospital largely determines whether data are shared in a transparent way. In some leading organizations, physician network members meet quarterly to discuss best practices. The physicians who are “positive outliers” (i.e., those achieving the most cost-effective care and those driving reductions in variation) share their data and practices with other physicians.

**Concluding Comments**

Under healthcare’s value-based business model, care efficiency, quality, outcomes, and access will be expected to improve while provider payments will be constrained. Indicators of quality and cost will be closely monitored and will be much more transparent to patients and purchasers. Physician and administrative leaders will need to think and act strategically about how to transform clinical processes to meet the new quality and cost imperatives. Inappropriate variation in clinical practice, a well-documented source of quality and cost problems, can no longer be afforded. A well-developed and implemented road map for reducing practice variation is a leadership imperative.

For information on Kaufman Hall’s clinical variation advisory services, please contact Scott J. Cullen, M.D., at scullen@kaufmanhall.com, or Matthew J. Lambert III, M.D., at mmlambert@kaufmanhall.com, or by phone at 847.441.8780.

**References**

1. For more information, visit www.dartmouthatlas.org.
6. Institute of Medicine, Committee on Clinical Practice Guidelines: *Guidelines for Clinical Practice from Development to Use*. Washington, D.C., National Academy Press.
Matthew J. Lambert III, M.D., joined Kaufman Hall in April as a Senior Vice President in the Strategy practice. With more than 40 years of healthcare experience as a physician, healthcare executive, and board member, Matt focuses on integrated strategic and financial planning, service line planning/distribution across systems, and medical staff planning/physician alignment strategy.

Prior to joining Kaufman Hall, Matt served as a senior hospital executive at hospitals in the Chicago area. He also provided consultation to hospitals and health systems in the areas of physician relations and the continuity of care. Matt is a member of the Leadership Development Council of the American Hospital Association and was a member of the Committee on Governance. He was a regent for the American College of Healthcare Executives (ACHE) and is a frequent speaker at that organization’s annual meeting.

Matt’s book, *Leading a Patient-Safe Organization*, was published in 2004 by Health Administration Press. He developed and leads the annual Physician Executive Boot Camp sponsored by ACHE for physicians new to management.

Matt received a B.S. from the University of Notre Dame and an M.D. from St. Louis University School of Medicine. He completed a residency in General Surgery at the University of Michigan Medical Center and served as a member of the faculty of the Department of Surgery at the University of Virginia School of Medicine in Charlottesville, Virginia. Matt received an M.B.A. from the College of William and Mary in Virginia.

Dep Ahuja joined Kaufman Hall in April as a Senior Associate in the Strategy practice. His responsibilities focus on developing market analyses, utilization projections, strategic planning, and program/service development for strategy- and physician services-related engagements.

Prior to joining Kaufman Hall, Dep served as a Consulting Manager at Apex Health Associates, where he performed service line analyses, developed business plans, and conducted market assessments.

Dep received an M.B.A from Case Western Reserve University, with concentrations in Health Systems Management and Finance, and a B.S. in Economics and Management, with focuses in Finance and Accounting, from Tulane University. He is a certified Project Management Professional (PMP) and a Certified Healthcare Financial Professional (CHFP).

Tanya Brasch joined Kaufman Hall in April as a Senior Associate in the Financial and Capital Planning practice. With 10 years of healthcare experience, Tanya focuses on cost management assessments, operational improvement plans, overhead cost analyses, and cost-reduction implementation support.

Prior to joining Kaufman Hall, Tanya was a consultant for a national consulting firm, developing labor solutions to improve hospital and health system financial and operational performance. Tanya previously analyzed and interpreted operational data at University HealthSystem Consortium and managed an operational benchmarking program at Newton Wellesley Hospital.

Tanya received an M.H.A. with Distinction from Simmons College and a B.S. from Northeastern University.

Celine Cely joined Kaufman Hall in April as a Senior Associate in the Financial Planning practice. Celine’s responsibilities focus on providing financial and capital planning for hospital and health system clients.

Celine has a strong analytical background. Prior to joining Kaufman Hall, Celine consulted in transaction advisory and valuation services at Sinaiko Healthcare Consulting, where her area of focus was physician operations, compensation planning, and joint ventures. She was previously an Equity Research Analyst in the managed healthcare sector at Piper Jaffrey.

Celine received an A.B. in Applied Math Economics and in Public Policy from Brown University.

Nathan Crosson joined Kaufman Hall in March as a Technical Support Analyst, providing technical support and installation assistance to software clients.

Prior to joining Kaufman Hall, Nathan worked as an IT Project Manager at American Engineering Corp. in Tokyo. He was formerly Japan Area Manager/Project Manager for J&J Worldwide Services and an International Business Consultant for GCS, also in Japan.

Nathan received a B.S. in Organizational Communications from Eastern Washington University and an M.B.A. from Portland State University.

Emily Heidkamp joined Kaufman Hall in April as Education Coordinator. In this newly created position, Emil manages software documentation, develops online support resources for ENUFF® Suite users, and enhances the software training curriculum.

Prior to joining Kaufman Hall, Emil freelanced as an Instructional Designer, Project Manager, and Multimedia Producer for such clients as Microsoft Xbox, Pearson Education, and *The Washington Post*.

Emil received a B.A. in History from the University of Illinois at Chicago.

Kelly Suga joined Kaufman Hall in May as a Client Service Representative in Software Support, where her primary responsibilities focus on assisting the software support team with client calls and issues.

Prior to joining Kaufman Hall, Kelly was a Human Resources Recruiter at Combined Insurance in Illinois and previously was a Personal Account Manager at PDS Tech in Tampa, Florida.

Kelly received a B.S. in Business/Project Management from the University of Phoenix.
Jim Collins

Jim Collins is one of the nation’s foremost authors and management educators. He has invested nearly a quarter of a century in researching and teaching on the topic of great companies—how they grow and how they attain superior performance—and on how good companies can become great companies.

Jim has authored or coauthored 6 books that have sold in total more than 10 million copies worldwide. They include: Built to Last, a fixture on the Business Week bestseller list for more than 6 years; the international bestseller Good to Great, translated into 35 languages; and How the Mighty Fall, a New York Times bestseller that examines how great companies can self-destruct.

Jim has worked with senior executives and CEOs at more than a hundred corporations. He has also worked with organizations in the social sector, from education and the arts to religious organizations, local and federal government, healthcare, and cause-driven non-profits. In 2005, he published a monograph, Good to Great and the Social Sectors.

His most recent book, published late last year, is Great by Choice: Uncertainty, Chaos, and Luck—Why Some Thrive Despite Them All, coauthored with Morten Hansen. Based on nine years of research, Great by Choice answers the question: Why do some companies thrive in uncertainty, even chaos, and others do not? The book focuses not just on performance, but also on the type of unstable environments that leaders face today.

Jim began his research and teaching career on the faculty at Stanford Graduate School of Business, where he received the Distinguished Teaching Award in 1992. In 1995, he founded a management laboratory in Boulder, Colorado, where he now conducts research and consults with executives from the corporate and social sectors.

Jim holds degrees in business administration and mathematical sciences from Stanford University, and honorary doctoral degrees from the University of Colorado and the Peter F. Drucker Graduate School of Management at Claremont Graduate University.

Paul Starr, Ph.D.

Paul Starr, Ph.D., one of America’s leading thinkers on public policy, is Professor of Sociology and Public Affairs at Princeton University, where he holds the Stuart Chair in Communications and Public Affairs at the Woodrow Wilson School.

Professor Starr began his career at the Center for Study of Responsive Law. In 1978, he started teaching at Harvard University, where he was Assistant and then Associate Professor of Sociology until 1985. Professor Starr started teaching at Princeton University in 1985.

Early in his career, Dr. Starr wrote a book titled The Social Transformation of American Medicine, which was published in 1983. A definitive history of the entire American healthcare system in the 19th and 20th centuries, this book won the 1984 Pulitzer Prize for Nonfiction and the Bancroft Prize in American History.

In the early 1990s, Dr. Starr was a health policy adviser to the Department of Health and Human Services and the White House. During 1993, he served as a senior advisor at the White House in the formulation of the Clinton health plan. Also in the 1990s, with Robert Kuttner and Robert Reich, Professor Starr co-founded The American Prospect, a monthly print and online magazine that covers politics and policy.


Professor Starr has also authored hundreds of professional papers, reviews, columns, and other pieces and has testified before Congressional committees at many points during the past decades.

Professor Starr received his Ph.D. in Sociology from Harvard University and his B.A. from Columbia University.

The 23rd annual Healthcare Leadership Conference will include more than a dozen sessions, roundtable discussions, and many excellent opportunities to network with other healthcare executives. Stay tuned for further information.
Budget Advisor® Supports Evolution of Budgeting Toward Rolling Forecasting

Keeping a Close Eye on the Organization's Financial Trajectory

One healthcare provider that is moving down the Rolling Forecasting path is Moffitt Cancer Center in Tampa, FL. Karen Wartenberg, Director of Financial Analysis and Budgeting, indicates that the organization’s decision to implement Rolling Forecasting was driven by recognition that in today’s fast-moving industry, the annual budget too quickly becomes outdated and insufficient as a management tool.

“During the last 12 months, our organization started to see the impact of healthcare reform, with significant changes in practice patterns and the utilization of services,” Wartenberg says. “Our managers needed a more up-to-date budget that could reflect changes in referral patterns, drug utilization or costs occurring after development of the original budget. This would free them from having to explain and reconcile budget variances that we know are going to continue going forward. Additionally, we realized that we needed a budgeting/financial planning model that would allow us to be more nimble and to proactively identify changes in the market and their impact on our projections.”

Moffitt is currently wrapping up the annual budgeting process for its next fiscal year beginning July 1. The Rolling Forecast, which will be produced on a quarterly basis moving forward, is expected to help bridge the gap between two levels of financial planning and analysis on which the organization has relied historically.

“Up to this point, we have used a very granular, detailed annual budget process and a very high-level monthly financial forecast,” Wartenberg explains. “Our goal is to reach the middle ground in which forecasts provide more detail on volume and the identification of commitments on various projects going forward and to track these changes more clearly into the future.”

With the forecasts that will be produced each quarter, Moffitt believes the annual budget process they conduct a year from now will be much less time and resource intensive, with fewer surprises. “The annual budget becomes more of an update and refresh of forecasting,” Wartenberg says. “We’re not really generating new news. We’re just continuing to evolve the financial planning and update it for the most recent considerations.”

Building on Continuous Performance Improvement Efforts

Winona Health in Winona, MN, intends to forego annual budgeting entirely and use the Rolling Forecast as its main financial management tool. Michael Allen, Chief Financial Officer, explains that the move is an outgrowth of the organization’s continuous performance improvement efforts.

FIGURE 1. IDENTIFYING THE GAP BETWEEN THE FINANCIAL PLAN AND ROLLING FORECAST
Source: Budget Advisor, Kaufman, Hall and Associates, Inc.

Net Income

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“We’ve been implementing a Lean Management System, which pointed us in the direction of having a more frequent planning process and one that is better linked to current operations,” Allen says. “We have a planning room, in which all of our organizational measures, actions, and improvement events are documented. Our senior management team meets there once a week and we go through a deep dive on each key metric once a month. There’s a direct connection between what happens in that room and our forecasting. It’s always in front of us, and we’re always talking about it.”

Like Moffitt, Winona sees the Rolling Forecast as bridging an important gap in its planning process. “Up to this point, we’ve used a one-year plan and a three-year plan. At the end of those timeframes, we assessed how we did,” Allen says. “Going forward, planning and assessment of progress are going to be more continuous, to better reflect the way events really happen.”

Delivering an Ongoing Financial Planning Model with Power and Flexibility

Both Moffitt and Winona are using Kaufman Hall’s Budget Advisor® software to proactively calculate the impact of current market changes on the organization’s financial projections and support their Rolling Forecasting process.

Budget Advisor for Rolling Forecasting, an add-on to existing software, provides an ongoing financial planning model that ensures:

- Changes in key business drivers (volumes, etc.) are input to produce updated financial projections
- Operational standards (staff/volume, etc.) are used to turn key business drivers into financial projections

“Up until this fiscal year, we set individual physician volume projections offline,” Wartenberg says. “By upgrading our software, we were able to add to Budget Advisor all of those important volumes and calculations related to physician revenue and set the stage for Rolling Forecasting with projections of what individual physicians are expected to achieve in the next 12 to 18 months.”

Budget Advisor provides flexibility such that forecasting can be done at the general ledger level or at a more aggregate level for those expense categories where a significant change is not expected over time. Organizations also have the option of defining a limited number of consolidated forecasting groups or managing the process through individual departments and cost centers. The Sidebar provides additional detail.

continued on page 8
Winona is looking to Budget Advisor’s versatile reporting capabilities as a key element in achieving its goals. “Budget Advisor is a vital component of what we’re doing—not only to run the numbers and refresh them on a regular basis, but also for reporting,” Allen says. “Our reports will no longer look at how we performed relative to budget, but rather how we performed this quarter versus last quarter versus the same quarter last year. The actual-to-actual comparisons will help drive continuous performance improvement” (Figure 2).

For more information, please contact Russ Anderson at 847.441.8780 or randerson@kaufmanhall.com.


domain:planning
topic:Software User Meetings Series

More User Group Meetings Are Upcoming

The first two meetings in our 2012 Software User Meeting Series have gone very well, and we are looking forward to the additional meetings that are scheduled later this summer. The dates and locations are:

7/19-7/20: Vancouver, WA (near Portland, OR)
7/25-7/26: Boston
8/23-8/24: Atlanta
8/28-8/29: Dallas

We have expanded our user group meetings this year to include a second day with sessions on Hospital Advisor and Capital Advisor and more opportunities for attendees to share and learn from their peers. Here is some of the feedback we’ve received from attendees of the Chicago and Philadelphia meetings:

“…very informative - especially to a new user! The networking with individuals from other hospitals was especially valuable.”

“I liked the format where users could ask questions during presentations and contribute to the discussion. Also, it was good to have representatives from Kaufman Hall on hand to contribute information based on their experiences from working with others.”

Please visit www.kaufmanhall.com/2012usermeetings to register for one of the upcoming meetings. Contact John Howlett at jhowlett@kaufmanhall.com or 847.441.8780 with any questions.
Calendar of Events

California Hospital Association
Modeling the Impact of Reform and Value-based Care and Payment
Daniel Majka
June 5, Sacramento, CA
Ellen Riley
June 20, Glendale, CA
Jody Hill-Mischel
June 21, Irvine, CA
AHA Solutions Webinar
Strategic Options in a Consolidating Market
Mark Grube and Kit Kamholz
June 21, 1-2 p.m. ET

HFMA ANI
Capital Access: What Investors Expect from Hospitals and Health Systems
Eric Jordahl (panel moderator)
To Partner or Not? A Panel Discussion of Strategic Options in a Consolidating Industry
Kit Kamholz (panel moderator)
June 25-26, Las Vegas, NV

Health Forum Leadership Summit
Clinical Integration: From Thought to Action at Henry Ford Health System
Scott Cullen, M.D., and Charles E. Kelly, D.O.
July 19, San Francisco, CA

HFMA Idaho Chapter
Physician-Hospital Integration: Sustainable Models and Strategies
Luke Sullivan
July 19, McCall, ID

HFMA Oregon Chapter
Global Budgeting in Capitation
Carlos Bohorquez
July 26, Eugene, OR

The Governance Institute
The Transformation of America’s Hospitals and Who Will Save Medicare?
Kenneth Kaufman
Strategic Options in a Consolidating Industry
Kit Kamholz (panel moderator)
September 11, Colorado Springs, CO

Colorado Hospital Association
The Transformation of America’s Hospitals
Kenneth Kaufman
September 13, Vail, CO

Society for Healthcare Management and Market Development
Affiliations and Acquisitions: Perspectives from Both Sides of the Deal
Stephen Sellers and Michael Finnerty
September 19, Philadelphia, PA

HFMA Maryland Chapter
Strategic Cost Management in the Value-based Era
Brian Channon
Transforming America’s Hospitals and Health Systems: What’s Next?
Jason Sussman
October 4-5, Cambridge, MD

HFMA New Jersey Chapter
Healthcare Finance and Treasury in the New Market Environment
Glenn Wagner
October 10, Atlantic City, NJ

The Governance Institute
Managing the Value Equation: Essential Leadership Strategies
Jason Sussman
October 15, White Sulphur Springs, WV

Maryland Healthcare Education Institute
Transformation Issues for Maryland’s Hospitals
Jason Sussman
October 22, Cambridge, MD

The Kaufman Hall Healthcare Leadership Conference
October 24-26, Chicago, IL

HFMA Nebraska Chapter
Strategic Cost Management and Managing Productivity
Tanya Brasch and Art Vasquez
January 31, 2013, Kearney, NE

Center for Healthcare Governance Symposium
Topic TBD
Mark Grube
September 10, Coronado, CA

ENUFF Software Suite® Training Sessions
(June–December 2012)
Budget Advisor®
General System and Reporting
July 31 and August 1
August 28 and 29
October 16 and 17
Budget Administration
June 19 and 20
September 11 and 12
December 18 and 19
Capital Advisor®
Capital Allocation – Usage
June 12
September 19
December 4
Capital Allocation – Administration and Report Modification
June 13
September 20
December 5
Capital Management – Usage
August 7
November 6
Capital Management – Administration and Report Modification
August 8
November 7
Hospital Advisor® Enterprise Edition
June 14 and 15
July 19 and 20
August 16 and 17
September 13 and 14
October 18 and 19
November 15 and 16
December 6 and 7
Hospital Advisor® 10.83 Version
August 3
September 10
November 19
Market Advisor™
Please contact Cathy Moore (see below).

Dates are tentative. For additional information and to schedule, please contact Cathy Moore at 847.441.8780 or cmoore@kaufmanhall.com.
Introducing Kaufman Hall Point of View Podcasts

Kaufman Hall is pleased to introduce Point of View Podcasts, a series of conversations with Kaufman Hall executives about the challenges and opportunities now facing hospitals and health systems. The podcasts offer brief, insightful perspective on key issues of concern. Approximately 10 minutes in length, the podcasts provide timely educational content for healthcare executives and trustees.

The first seven podcasts in the series can be accessed at https://www.kaufmanhall.com/SitePages/Podcasts.aspx. The initial podcasts include:

- **Who Will Fix Medicare? What Providers Can Do**
  Kenneth Kaufman, Chief Executive Officer

- **Three Often-Overlooked Opportunities to Reduce Costs**
  Brian S. Channon, Senior Vice President and head of Strategic Cost Management Advisory

- **Tips for Setting Cost-Reduction Targets**
  Brian S. Channon, Senior Vice President and head of Strategic Cost Management Advisory

- **Rethinking Management Structures and Incentives for Value-based Care**
  Mark E. Grube, Managing Director and head of the Strategy practice

- **Aligning with Physicians for Value-based Care**
  James J. Pizzo, Managing Director and leader of the Physician Advisory practice

- **Meeting the Challenges of Reducing Clinical Practice Variation**
  Scott J. Cullen, M.D., Senior Vice President in the Physician Advisory practice

- **What Role Will Your Organization Play in the Future Health-Delivery Model?**
  James J. Pizzo, Managing Director and leader of the Physician Advisory practice

Listen to the podcasts directly from the player on the Kaufman Hall website or download and listen to them at your convenience through the media player on your computer or mobile device.

We will be posting podcasts on other topics regularly, so be sure to check back for new content. Also, please let us know if there are specific topics you’d like us to address. As always, we welcome your feedback, comments, and questions, which should be directed to John Howlett at jhowlett@kaufmanhall.com.

We hope you find the Point of View Podcasts helpful. Please share this information with your management team and board.