

HFMA'S VALUE PROJECT

The Value Journey

Organizational Road Maps for Value-Driven Health Care

ACADEMIC
MEDICAL
CENTERS



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ORGANIZATIONS THAT INFORMED THE FINDINGS IN THIS REPORT

HFMA's Value Project research team acknowledges the extensive assistance provided by the following hospitals and health systems. Research for each cohort area—academic medical centers, aligned integrated systems, multihospital systems, rural hospitals, and stand-alone hospitals—was assisted and guided by 35 participating organizations. Researchers for HFMA's Value Project conducted in-depth site visits with two organizations within each cohort and discussed site-visit findings with the broader cohort participants to develop the road maps featured in this report. Participating organizations are featured below.

PARTICIPANTS IN DEVELOPING ROAD MAPS FOR HEALTH SYSTEM CHANGES

Academic Medical Centers	Aligned Integrated Systems	Multihospital Systems	Rural Hospitals	Stand-Alone Hospitals
New York-Presbyterian Hospital	Billings Clinic	Advocate Health Care	Andalusia Regional Hospital	Elmhurst Memorial
	Cleveland Clinic	Baptist Health South Florida	Copper Queen Community Hospital	Enloe Medical Center
Partners HealthCare	Dean Clinic	BJC HealthCare	Crete Area Medical Center	Holy Spirit Health System
Rush University Medical Center	Geisinger Health System	Bon Secours Health System	Franklin Memorial Hospital	Longmont United Hospital
University of Alabama at Birmingham (UAB) Hospital	Group Health Cooperative	Catholic Health East	New Ulm Medical Center	Platte Valley Medical Center
Vanderbilt University Medical Center	Scott & White	CHRISTUS Health	Whitman Hospital and Medical Center	Winona Health
	Spectrum Health	Dignity Health		
		Fairview Health Services		
		OSF HealthCare		
		Novant Health		
		Nebraska Methodist Health System		

ACADEMIC MEDICAL CENTERS

The emergence of value-based payment methodologies and the increased emphasis on transparency will have profound implications for academic medical centers. How do academic medical center leaders align and structure their organizations in a financially sustainable way? What types of strategic partnerships will be important on the road toward value-based business models? What key changes to care delivery should be considered if academic medical centers are to achieve greater value?

For purposes of this discussion, an academic medical center (AMC) is characterized as a teaching hospital, usually with a faculty practice plan and a medical school (which may or may not be part of the same legal organization). AMCs pursue a three-part mission: teaching, research, and clinical care.

As part of HFMA's Value Project research, five AMCs—New York-Presbyterian Hospital, Partners HealthCare, Rush University Medical Center, UAB Hospital, and Vanderbilt University Medical Center—were studied (see the exhibit on page 21). These centers are geographically dispersed, serve various types of markets, have different delivery models, and are of varying size in regard to the number of physicians in faculty practice plans and number of staffed beds maintained by each organization. Most are in markets dominated by a Blue Cross Blue Shield health plan. Medicaid revenue currently ranges from 8 to 28 percent in these organizations, and Medicaid budgets are tightening.

Two AMCs were selected for site visits: Partners HealthCare in Boston and UAB Hospital, part of UAB Health System in Birmingham, Alabama. There are some significant differences between the organizations. First, Partners HealthCare is substantially larger in terms of revenue and endowment. Also, the organizations' market environments are dramatically different. Boston is among the markets moving most quickly toward value-based payment and cost containment; in contrast, in Alabama, Blue Cross is the major commercial payer, and it is not yet actively pursuing value-based payment methodologies. However, UAB Hospital leaders anticipate mounting cost pressure as the state of Alabama considers conversion to managed care for Medicaid. Additionally, leaders are

KEY RECOMMENDATIONS

Academic medical centers should consider the following action steps as they position themselves for value-based business models:

- Align incentives across research, teaching, and care delivery functions of the academic medical center.
- Centralize governance.
- Develop primary care physician referral networks.
- Reduce the organization's overall cost structure and improve care processes.

concerned that carriers could make the AMC a "second tier" provider in their PPO plans, disadvantaging the organization in a way that could affect patient volume and revenue.

The organizational models of the two organizations also differ. Partners includes two teaching hospitals—Massachusetts General Hospital (MGH) and The Brigham and Women's Hospital (The Brigham)—six community hospitals, a rehabilitation hospital, and several other system components. The vast majority of the physicians practicing at MGH and The Brigham are employed. Most are also on the faculty of Harvard Medical School; however, Harvard Medical School is a separate legal structure. The UAB Hospital and UAB School of Medicine are part of UAB Medicine. However, the faculty practice plan is a separate organization.

Distinctions in delivery models also are evident. Partners HealthCare has a substantial primary care base that increasingly coordinates with specialists in the system. At UAB Health System, there are only 20 primary care physicians; these physicians are not positioned to serve as a "front door" to the organization.

CHALLENGES AND OPPORTUNITIES

Along the road toward greater value, AMCs have unique attributes that represent both opportunities to be leveraged in the emerging payment environment and challenges to be overcome as they move toward value-based business models.

Opportunities. Relative to most stand-alone and rural hospitals, AMCs are relatively well positioned financially. AMCs generally have enough cash flow and capital to enable them to invest, take risks, and overcome mistakes.

A superior brand reputation provides AMCs with leverage in several ways. First, it aids AMCs in discussions with payers, which are motivated to keep AMCs as preferred providers. Second, it can help promote strategic partnerships directly with self-insured employers and community leaders. Third, AMCs have the opportunity to build on their brands to secure referral streams from other providers. Often, academic medical centers are of sufficient size and reputation to have the opportunity to influence payers and the community. For example, even though UAB Health System is smaller than Partners HealthCare, both are the largest employers in their states. Size represents clout and the potential for partnerships and influence.

Challenges. A key challenge for AMCs lies in their complexity. Governance is often decentralized with separate mission statements and leadership in key functions (e.g., clinical care, research, education). Many AMCs also have a strong culture of consensus building that slows and diffuses decision making.

Physicians, who are often attracted to the academic medical center due to prestige and the opportunities it presents to teach and conduct research, may not be as involved in care delivery. This focus could complicate or slow care delivery transformation, which is key to success in the transitioning payment environment. Physician compensation models often vary widely across clinical

departments in an AMC and are often not designed in a way that encourages care delivery or improved care coordination.

Although the AMCs participating in HFMA’s Value Project research enjoy a strong brand reputation in their markets, all acknowledge being at risk for erosion of brand in a more transparent marketplace. AMCs question comparisons of their quality data with data from other providers because of concerns regarding insufficient risk adjustment for the higher-acuity patients that AMCs often treat. Additionally, the patient population served by the AMC, particularly the portion of this population who receive unique, subspecialty care, is distinctly different from other providers’ patient panels, which makes it difficult to compare AMC patient populations with those of other providers. And quality data may reveal deficiencies in performance that are difficult to accept within the AMC community, making it harder to drive the internal changes necessary to achieve and sustain superior performance. As a physician leader in an AMC noted, “Our brand is based on history. If the data do not say that we’re excellent, we struggle with that. We need to get over ourselves.”

DIFFERENCES IN APPROACHES AMONG AMCS

There are a number of key market-specific and organizational-specific differences among AMCs, including the following:

- Some AMCs are the major safety net resource for their region.

UNIQUE CHALLENGES AND OPPORTUNITIES FOR ACADEMIC MEDICAL CENTERS

Challenges

- High cost structure
- Cross-subsidization from clinical to education and research; subsidization across payers; vulnerability to research funding and state budget cuts
- Decentralized governance structure with separate mission statements (could be slower to change, less aligned)
- Some physicians spend more time on research or academics than on care delivery
- Loss of referrals to competitors (e.g., other networks seeking to reduce leakage, lack of primary care physicians)
- Other providers adding services and competencies to compete
- Brand threat from “partial transparency” (different patient populations and case intensity; inaccurate or incomplete data)
- Splitting a smaller pie of research dollars (winners and losers)
- Less flexible cost structure (e.g., integration of clinical and academic; faculty contracts)

Opportunities

- Enhance financial strength.
- Develop a culture of innovation.
- Create a strong brand.
- As large employers, identify opportunities to influence market direction.
- Leverage to form strategic partnerships.
- Leverage relationships with payers.
- Build on brand to secure referral streams from other providers.

- Some are the sole providers of NICUs, burn units, and transplant services in their communities, and these services are often underreimbursed.
- Some AMCs are independent, while others are part of larger, multihospital systems.
- Some AMCs have developed stronger centralized governance across major organizational components (e.g., teaching, research, and care delivery), while others have highly decentralized structures.
- Some AMCs have a well-developed primary care base, while many rely on a widely spread, less-closely-linked referral base.
- AMCs have differing revenue balances among clinical care, academic, and research functions, and differing endowment levels.
- Degrees of competition for physician employment differ among AMCs as well.

THE ROAD AHEAD: STRATEGIES AND INITIATIVES

AMCs recognize that the emerging payment environment will have a significant impact on their organizations. AMC leaders are striving to reshape their organizations by developing stronger centralized governance to enable more effective and timely decision making. They aim to retain all three major operational components—education, research, and care delivery—with an emphasis on shoring up care delivery, which they see as most critical for financial viability.

AMCs strive to:

- Create awareness of the emerging payment environment across key organizational components, including teaching, research, and care delivery
- Restructure to develop strong centralized governance, financial transparency, and improved alignment across the organization
- Revisit cross-subsidization across payers and organizational components
- Work to build a flexible and engaged organization
- Strengthen ties with physicians
- Develop and achieve a plan to improve care processes and reduce overall cost structure
- Develop primary care networks/referral strategies.
- Pursue strategic partnerships with payers

AMCs, like other types of providers, need to coordinate a number of initiatives to position for success under value-based payment, as described in the common road map. Some

initiatives that AMCs need to tackle are unique to this type of delivery system or are of particular emphasis for AMCs. These initiatives are highlighted in bold in the AMC road map.

Create organizational awareness. AMCs often have different boards, leadership structures, and mission statements governing each of their teaching, research, and care delivery functions. These distinct governance structures make it challenging for AMCs to make decisions nimbly and strategically as a larger organization. Further, many AMCs report the absence of dialogue among academic departments, specialists, the hospital, and other potential elements of a coordinated, detailed approach to care management. The CFO of one academic center noted, “We are using the possibility of a bundled payment project not because we think it will be a big winner for our system, but just to get an early dialogue going between the key elements of our system.”

AMCs that were studied for this report are educating leaders across the different components of the AMC and their boards about the emerging payment environment and other significant environmental dynamics. It is important that AMC leaders be transparent about financial transactions within the system, to provide a baseline for developing a workable financial plan aimed at the tripartite mission of the AMC.

Restructure to develop strong centralized governance, financial transparency, and improved alignment across the organization. This initiative involves capabilities spanning strategy and structure, and management.

To position for the emerging payment environment, AMCs may require a redesign of organizational structure and governance. The goal of this effort is to develop a centralized leadership structure that can make critical decisions on behalf of the AMC. UAB is taking a step in this direction: A centralized structure exists, but leaders need greater authority to make decisions on behalf of the system. Additionally, UAB’s system leaders require more agile decision-making capabilities. Like other academic medical centers, UAB is instituting a funds-flow model that combines all revenue from clinical practice and hospitals into one operation. Key benefits of this approach include:

- Streamlining of decision making
- Ending the practice of clinical departments directly contracting with outside entities
- Enabling the development of an integrated financial planning process

Partners HealthCare operates within an active state governmental and legal environment and is an example of how many elements of an AMC may need to change over time to form a more highly integrated organization. For example:

- Partners has a single board with responsibility for all key aspects of clinical care—including all hospitals, faculty and nonfaculty employed physician practices, and other elements of the continuum of care.
- The systemwide strategy envisions coordinating a broad group of evidence-based care activities across hospital, specialty, and primary care.

The Partners strategy also envisions:

- Cutting costs and containing the rate of cost increases to the rate of inflation
- Enhancements to care access
- Changes in reporting relationships
- Changes in physician and other incentives structures

- Revised reporting and dashboards (patient satisfaction and financial dashboards)
- Leveraging Partners' new EHR system
- Movements of selected patient populations out of the academic medical centers to other, less resource-intensive care settings

Additional mechanisms to bolster centralized leadership are to develop a common strategic plan and to determine management-level goals and incentives that help align the care delivery, research, and academic functions of the AMC. Both of the AMCs that were the focus of site visits are moving this direction. For example, UAB is being assisted by an outside consulting group to help align its goals, initiatives, and communications.

Revisit cross-subsidization. Because AMCs are likely to be cross-subsidizing not only across major organizational functions (e.g., care delivery, research, and education),

ACADEMIC MEDICAL CENTER ROAD MAP TO VALUE

LOWER ←

ORGANIZATIONAL CAPABILITIES

People/Culture		
Governance	Educate Leadership	Improve Transparency
Strategy and Structure	Review Strategy by Segment	
Management	Align Executive Leadership	Develop Common Plans, Goals
Physicians	Educate	Assess Performance
Staffing and Skills	Assess Needs	Plan Attritions
Communication and Culture	Articulate Value Message	Educate
Business Intelligence		
Clinical Information Systems	Implement EHR, All Settings	Establish Alerts
Financial Reporting & Costing	Directional, Limited	Precise, All Settings
Performance Reporting	Core, Process Measures	Strategic Measures
Analytics and Warehouses	Review Data Governance	Integrate Clinical, Financial Data
Performance Improvement		
Process Engineering	Identify Methodology(ies)	Establish Cross-Functional Forum
Evidence-based Medicine	Patient Safety	Readmissions and Hospital-Acquired Conditions
Care Team Linkages	Measure Primary Care Access	Expand Primary Care
Stakeholder Engagement	Create Transparency	Educate Patients
Contract & Risk Management		
Financial Planning	Rolling Calendar	Update Cash Flow Planning
Financial Modeling	Maintain Short Term View	
Risk Modeling	Analyze Profit/Loss	Estimate Financial Exposure
Contracting	Negotiate Prices	Partner with Quality

but also across payers, strategic planning by segment is of particular importance.

Some AMCs may choose to aim for a price position well above market. In that situation, it is important for the organization to have the business intelligence capabilities necessary to demonstrate to customers that the higher price is justified by superior performance on quality, lower total cost of care, or demonstrably higher complexity of cases treated. Such capabilities are likely to include the ability to define and measure various dimensions of quality, including outcomes, and slice quality and financial data on a payer, population, and patient basis, to a per-member, per-month level.

Work toward a flexible, engaged culture. Like the other cohorts in a value-based payment environment, AMCs often strive to create an agile culture willing to accept risk and occasional failure. Education of staff and physicians about emerging market dynamics and organizational

implications is key to creating a foundation for cultural change and engagement. Inviting—and even requiring—staff to participate in clinical improvement initiatives is a tactic many organizations are employing to facilitate engagement.

Some AMC managers believe they can capitalize on AMCs’ overall culture of innovation. The UAB Hospital established an innovation board, chaired by a physician. This board seeks to fund small, quick innovative proposals—up to \$5,000 per project, with results expected within 60 to 90 days.

Strengthen ties with physicians. Physician leadership of care delivery improvement efforts in AMCs, as in other cohorts, is paramount to success. However, it can be particularly difficult in an AMC setting to engage physicians in efforts to transform care delivery. Physicians may be drawn to the academic setting to teach and research more than to deliver clinical care. Also, compensation models often do not reward physicians optimally for care delivery or care improvement efforts.

Degree of Care Transformation & Financial Sustainability				HIGHER
STRATEGIES & INITIATIVES				
Develop Centralized Structure		Streamline Decisions		
Develop Strategic Plan		Bend Cost Curve		
Align Incentives		Manage to Measurement		
Align Compensation	Develop Leaders		Lead Strategies and Initiatives	
Add Staff Strategically	Educate	Align Incentives	Enhance Leadership	
Engage Stakeholders	Conduct Payment/Care Delivery Experiments		Foster Innovation	
Establish Disease Registries		Modify EHR	Develop Data Exchange	
Longitudinal		Complete Per-Member, Per-Month Costing		
Outcomes		Population Based		
Deploy Research-Related Analytics		Support Real-Time Decisions		
Initiate Efforts	Utilize Data	Expand Cross-Department	Expand Cross-Continuum	
Standards, Protocols	High Risk-Care	Chronic Conditions	Wellness	
Right-Size Specialty	Partner Strategically		Manage Care by Setting	
Share Decision Making		Establish Patient Accountability		
Update Capital Budgeting and Capital Access Planning		Quantify and Allocate Initiative Impacts		
		Conduct Multifactorial Scenario Planning		
Utilize Predictive Modeling		Develop Risk Mitigation Strategy		
Experiment with Value-Based Purchasing (VBP)	Partner with Payers	Prepare for Second-Generation VBP		

Improving physician engagement and leadership is of special importance to academic medical centers. The process often begins with educating physicians about market dynamics and internal revenue and funds flow, using multiple communication modalities.

Physician compensation structures should be retooled to reward productive care delivery and engagement in key organizational initiatives. UAB Health System is just beginning this process, and faces the challenge of a hodgepodge of compensation structures to reformulate. Partners HealthCare has already tackled this challenge. At Partners, physician compensation is based on a relative value unit system, with 2 percent of primary care physicians' compensation tied to risk-adjusted panel size. "We made this change two years ago, so that physicians who attended to more complex patients could see an increase in compensation," said Tim Ferris, vice president of population health management at Partners. "This small increase resulted in massive changes in attitudes and the culture. It sent a message."

Some form of individual physician performance assessment, such as scorecards that demonstrate a physician's practice patterns and patient satisfaction results relative to peers, is another tool to engage physicians. Tying performance measures directly to compensation would bolster the impact of individual performance reports. An additional step may be formal leadership education programs for future AMC leaders.

Develop plans to improve the overall cost structure. Many capabilities shown on the AMC road map relate to improving cost structure, among them strategy and structure, process engineering, and evidence-based medicine.

For AMCs in highly competitive or cost-sensitive markets, like Partners in Boston, controlling costs is a dominant issue and is a central component of strategic planning.

Partners agreed to lower its annual increase in costs for its three major health plan customers from 6 percent per year to 3 percent, a plan representing hundreds of millions in cost containment at the organization. Leaders across the organization are aligned around this effort. "We all have the same goal: to cut costs effectively, without fundamentally harming the viability and mission of the system. But what is critical is that we have the right glide path to get there," says Gary Gottlieb, MD, Partners president and CEO.

Some AMCs are pursuing opportunities to contain costs in inpatient settings, such as vendor contracts, supplies,

and staffing. Others are moving forward to both inpatient and outpatient care delivery-focused initiatives, which can offer an opportunity to focus on cost containment in ways that also favorably impact quality. An important early step is establishing a physician-led, multi-disciplinary forum with accountability to identify opportunities to reduce clinical variation and standardize care processes.

For example, Partners' cost-containment plan is predicated on improving how care is delivered. Foundational to its plan is a redesign of care delivery, with multi-disciplinary teams responsible for defining process standards for priority medical conditions. Leaders at Partners are finalizing approaches to instill protocols and standards at the point of care as well as processes to review care delivery for medical appropriateness. These steps can be challenging in an academic setting, in which physicians often are accustomed to having a high degree of discretion at the point of care.

AMCs also can use business intelligence to determine which efforts will be pursued. As more complete and integrated databases are implemented, organizations should be positioned to utilize clinical and cost data to identify opportunities for improvement, such as clinical services with high degrees of variation in outcomes or cost. Further, providers will advance their performance improvement capabilities when they move from department-specific efforts to cross-department and then cross-location projects.

Strengthen primary care. One reason to strengthen primary care is that AMCs with little or no primary care are increasingly concerned that they are at risk of losing referrals as competing organizations take steps to reduce "leakage" to specialists outside their own delivery networks.

Additionally, AMCs and other providers aiming for shared savings arrangements or population-based capitation are assessing the sufficiency of their primary care function by measuring access, determining and acting on needs to expand primary care, and then adding care coordinators and physician extenders to enable a team-based approach.

Partners HealthCare and UAB Health System are both bolstering primary care, although their starting points are different. At UAB, there are very few primary care physicians. The CEO of UAB Health System has established a joint goal with the leader of the medical school to better retain more of the primary care physicians that they train, and is pursuing other longer-term strategies as well.

In the near term, UAB is pursuing ways to tighten referral relationships with community primary care physicians. Partners, which has roughly a 50/50 split in physicians between primary and specialty care, is focusing on integrating care coordinators into primary care.

Pursue strategic partnerships with payers. An area of opportunity for AMCs, given their typically strong brand reputations and market leverage, is strategic partnerships with health plans and employers. Across cohorts, organizations that are farthest along in the journey toward value-based business models have established partnerships with payers in which insurance carriers help pay for value improvement initiatives, such as the infrastructure costs related to establishment of PCMHs. Others have arranged partnerships with commercial carriers to experiment with bundled payment. Such partnerships may prove key to finding the funding and organizational momentum to proceed with these important initiatives.

OTHER STRATEGIES AND INITIATIVES

As noted on the AMC capabilities road map, there are many other initiatives that should be pursued in parallel to those activities of particular emphasis to AMCs. Some of these additional initiatives, which are more thoroughly described in the commonalities section of this report, include the following.

Continue investment in clinical information systems. Like other types of provider, AMCs need EHRs in both inpatient and outpatient settings to help transform care delivery. A unique consideration for AMCs is how to modify the EHR to capture data required for all components of its organization, including unique requirements related to teaching and research. As Peter Markell, CFO of Partners, points out, “Our version of the EHR will need extensive customization. For example, we will develop our own genomics add-on module.” Additionally, Partners is examining the research and teaching-related needs that will drive business requirements for data warehousing and analytics. Ultimately, a more streamlined approach to data collection and systems integration should help improve Partners’ cost structure.

Conduct a strategic assessment of staffing needs. Staffing needs for AMCs should be adjusted to take critical needs into account. For most AMCs, this will mean adding care coordinators, other physician extenders, and analytics staff. As with physicians, formal training and leadership will be required. Training and orientation will vary with the type

of staff added, and could include cultural orientation, such as team-based training, or more technical training, such as that required for analysts. Incentive structures will also be needed to create greater alignment. AMCs should take advantage of opportunities to use positions that become open due to attrition as strategically as possible.

RECOMMENDATIONS

In some respects, academic medical centers have the longest, most complex road map to transformation and sustainability of any of the cohorts analyzed in HFMA’s Value Project. The number of change initiatives that are required, and the degree to which these changes need to be coordinated with each other, can seem daunting. The distance between the least and most transformed and sustainable AMCs, especially in the areas of people and culture, is significant.

However, most academic medical centers have several major advantages. By their very nature, AMCs are integrated health systems, whether they are in a single governance structure or a more decentralized governance structure. They have well-established cultures of innovation. They have an image of excellence and trust, and they often have substantial asset bases and a position of leadership in their communities and states.

Specific recommendations for academic medical centers as they transition from fee-for-service to value-based payment include the following.

Align incentives across research, teaching, and care delivery functions of the AMC. An important early step in preparing for the emerging payment environment is to create further alignment across major operational components. Key steps in this process include educating leadership—including boards of directors—about changing payment dynamics and their potential implications, improving transparency about financial flows within the organization, and developing strategic plans with shared goals and initiatives.

Centralize governance. This is a huge, and hugely important, initiative for academic medical centers. It is imperative that a strong centralized leadership structure exists to make timely strategic decisions affecting the financial sustainability of the organization. Some AMCs are implementing funds flow models that strengthen central leadership by streamlining decision making and allow for centralized financial planning.

Develop primary care physician referral networks. A more immediate concern of some academic medical centers is shoring up primary care linkages to ensure that their referral base remains strong. Additionally, some AMC's without a solid primary care foundation are taking initial steps to expand primary care, with an eye longer term on population health management.

Reduce the organization's overall cost structure and improve care processes. Depending on its specific market environment, it may be increasingly difficult for an AMC to defend its higher contracting prices. Given that government and private payers are all under escalating pressure to contain health insurance costs, an AMC that aims for a relatively high price position will need specific financial and clinical data to substantiate that it is bringing greater value to the market and to specific purchasers. This might be established by demonstrating that better outcomes

on a higher-priced procedure result in a lower total cost of care to purchasers, or by demonstrating that a higher price purchases care of significantly superior quality. Even with the right data, however, an AMC should ensure that its customer segments are willing to pay higher prices to obtain superior quality.

For most AMC's, the path forward is likely to focus on cost containment, and aim for a price position in greater alignment with other providers in the market. Leading AMC's are pursuing opportunities to streamline care delivery while improving quality, utilizing techniques such as process engineering and instilling standards and protocols.

Ultimately, the nation's healthcare system as a whole will assist in transforming AMC's and will benefit from their transformation. Because they are a vital part of the overall healthcare system, it is important that AMC's make the transition from volume to value effectively.

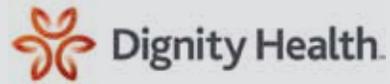
ACADEMIC MEDICAL CENTER RESEARCH PARTICIPANTS

Participating Organization	No. of Faculty	No. of Staffed Beds	Market Served	Payer Mix*	Geography	Delivery Models
New York-Presbyterian Hospital	6,144	2,262	Urban, Highly Competitive	33% Medicare 28% Medicaid 37% Managed Care/Commercial 2% Other	New York, N.Y.	Specialty care; very limited primary care
Partners HealthCare	4,852	2,294	Urban/Suburban, Highly Competitive	33% Medicare 8% Medicaid 48% Managed Care/Commercial 11% Other	Boston, Mass.	Integrated primary and specialty care
Rush University Medical Center	260	676	Urban/Suburban, Highly Competitive	38% Medicare 22% Medicaid 35% Managed Care 1% Commercial 4% Self-Pay	Chicago, Ill.	Specialty care; very limited primary care
UAB Hospital	900	1,052	Urban/Suburban, Less Competitive	28% Medicare 22% Medicaid 38% Managed Care/Commercial 9% Self-Pay 3% Other	Birmingham, Ala.	Specialty care; very limited primary care
Vanderbilt University Medical Center	1,823	985	Urban/Suburban, Moderately Competitive	26% Medicare 18% Medicaid 47% Managed Care/Commercial 9% Other	Nashville, Tenn.	Specialty care; very limited primary care

Payer mix is based on inpatient discharges, including normal newborns.

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HFMA'S VALUE PROJECT: PHASE 2 THE VALUE JOURNEY ORGANIZATIONAL ROAD MAPS FOR VALUE-DRIVEN HEALTH CARE

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