Advancing Community Health through a Strategic Partnership

As a hub of healthy activities, a nonprofit organization works to engage residents in a culture of wellness

By Karen Sibenaller

You never know when or where an idea or valuable connection will develop. A casual sidewalk conversation in 2010 between Winona, Minn., residents Will and Shirley Oberton and Michael Allen, Winona Health CFO, led to an ongoing partnership that supports the system's goal of improving community health.

“The Obertons expressed an interest in making a difference in the community by helping people live better, healthier lives,” Allen recalls. “That is also at the core of our mission as the community's primary healthcare provider.”

That by-chance conversation led to broader discussions that triggered the development of Live Well Winona, an organization dedicated to serving as a hub of healthy activities in the town of almost 28,000.

“It began with the desire to help community members live the healthiest life they could and the understanding that that looks different to each individual,” says Oberton, currently the organization’s board chair. “Live Well Winona takes a holistic approach to individual health, fostering a wide range of healthy activities and lifestyles.”

In the beginning, according to Allen, “Winona Health’s role was to assist Will and Shirley in nurturing the idea and facilitating a series of community meetings to develop a workable model. Our involvement today is mainly in the form of administrative support and participation on the board.”

Thanks to a generous grant from the Obertons, coupled with their leadership and the health system's support, Live Well Winona began to apply for 501(c) nonprofit status in 2011.

Putting Together a Team

Janneke Quick, Live Well Winona’s community wellness director, notes that early on, getting the right players to the table was itself a challenge. “We wanted to ensure that we reached all areas, targets, and demographics of the community in order to begin changing the culture.” She credits much of the organization's progress to collaboration with individual community members who shared an enthusiasm for a healthy lifestyle and a vision of a healthier community. They were able to identify such individuals by giving presentations to organizations such as Rotary, United Way, Chamber of Commerce, area schools, and community groups that promote wellness. In addition, public relations efforts led to coverage in local media.

“We had a number of organizations coming to us wanting to collaborate on health initiatives that they’d been dreaming about for years but weren’t sure how to implement,” says Quick. Partnerships grew rapidly as both organizations and individuals realized that Live Well Winona could offer the non-financial support needed to execute their events, develop their resources, and market their programming.

For example, Live Well Winona partnered with Winona State University to organize a local wellness conference to showcase health resources and topics. Another project, the virtual volunteer center, which connects volunteers with opportunities, is the result of conversations with Winona Volunteer Services, the local United Way, and Winona County staff.

Today the board represents seven organizations and includes three private citizens.

Assessing Community Needs and Resources

Although Winona has its share of the health conscious, including fitness (Continued on next page)
Strategic Partnership (continued from page 2)

fanatics, at least 35 percent of the population has room for improvement. According to 2010 figures:

- 35.9% of the population is overweight (BMI 25-30)
- 23.8% are obese (BMI 30+)
- 16.2% don’t exercise
- 17.6% smoke
- 20.8% have high blood pressure

Because unhealthy habits contribute to a large number of preventable medical conditions, Live Well Winona took a proactive approach to supporting activities and promoting resources to help individuals take control of their health.

“We spent time researching what’s available in the community and connecting with other individuals and organizations with an interest in health promotion,” says Quick. “We’ve identified needs, targeted specific gap areas in the community, and determined which health disparities we would focus on.”

The Live Well team often had to remind themselves that change does not happen overnight.

“Raising awareness and convincing people of the need to improve their health can be hard,” says Quick. “People often don’t know how to take the first step. We’re here to share opportunities and provide encouragement and inspiration.”

Gaining Visibility

Live Well Winona moved into a storefront in December 2011, providing a home base for staff and space for small classes and meetings.

During its first year, Live Well Winona and Winona Health collaborated on several initiatives and events. For example, Live Well Winona participated in Winona Health’s Healthy Kids Club events, providing additional activities for children and their families while also gaining visibility and increasing awareness of the new nonprofit.

This year, Live Well Winona partnered with eight local 5k races to launch the Mississippi Medley 5k Series, reaping increased participation over previous years in the early races. Says Quick, “We’ve heard many people say that they are starting out the series walking but plan to be running by the end.”

Practical Advice to Help Pave Your Path

For others considering a community wellness initiative like Live Well Winona, Quick offers these tips:

- Take the time to understand what the community wants and needs.
- Find partners who share your vision or have a common goal.
- Focus on targeted initiatives that can be sustained around the main health disparities that you identified as problems in your community.
- Build relationships across the community to ensure you have good support and community buy-in, and to avoid duplicating efforts or wasting resources.
- Understand that culture change takes time, so value small accomplishments and build on them.
- Make sure you continue to have a vision for the future.
We’ve all seen the statistics: the United States spends far more per capita on healthcare than any other country, and yet ranks 25th out of 30 OECD* countries in life expectancy and 26th in infant mortality.

In this environment, it comes as no surprise that there is tremendous pressure to reform our system. As part of the reform process, new care models will evolve to meet supply and cost constraints, and care delivery will continue to transition toward broader multidisciplinary teams and networks in place of current physician-centric models. Public payer reimbursement rates will erode due to budget pressure, with commercial and self-funded insurers to follow. As a result, competition for the best insured sectors—and the most complex patients—will intensify.

As these trends accelerate the industry’s movement from volume to value, providers that embrace high-quality, low-cost care can improve their bottom lines now and enhance their competitive position in the future.

Clinical integration—assessing and coordinating clinical activities—helps deliver that value and is an essential precursor to accountable care (see Figure 1).

Three Models
Organizations that can successfully move from a focus on employment-based alignment to one on integration will be in a better position to truly create and capture value. That’s because employment is expensive and can take years to produce results, whereas non-employed alignment can facilitate clinical integration, population health management, and innovative payer partnerships quickly and at lower cost.

In particular, there are three non-employment alignment models that can help achieve clinical integration.

Professional Services Agreement (PSA) Model. The PSA model is similar to employment, but different in that physicians are able to preserve some autonomy by maintaining their own compensation, benefit, and governance structures as part of a separate LLC (see Figure 2). Typically, the hospital purchases the physician practice and staff and assumes management responsibilities.

This is an ideal model when physicians want to be more tightly aligned with the hospital for contracting and care integration purposes—but not so tightly that they have to give up their professional culture and decision-making authority. The PSA model also gives physicians the option to sell equity stakes in their ancillaries or real estate.

Benefits to the hospital or health system include the following:

- It is able to contract as a single integrated entity.
- Partnerships with payers are more direct.
- There is no need to purchase physician goodwill.
- Assuming risk for a defined population moves it closer to population management.
- It gets new ancillaries.
- Physicians are incented to support its strategy.
Clinical Integration (continued from page 3)

Population Health Management Model.
In this model, health systems and physicians both independently contract with a payer to coordinate managing the care of a set population, as shown in Figure 3. This can include creating a health plan or carving out a branded product to offer.

The population health management model makes most sense for organizations interested in developing a payer strategy with one or more physician groups that do not want to be employed.

Benefits to the hospital or health system include the following:

- There is an incremental increase in patient volume.
- The partners develop a shared value contract or a “product.”
- Healthcare premium costs for employees (healthcare expenditures if self-insured) are reduced.
- Employee hospitalization costs are reduced.
- There is a competitive advantage in gaining experience in managing population risk.

Co-Management Model. There are two ways to form a co-management model: either the hospital contracts directly with physicians, or the physicians form a new management company that contracts with the hospital (see Figure 4). Either way, the physicians and hospital jointly manage a given program or service.

The direct contract model is simpler and faster to implement and can deliver immediate financial benefits, but the management company approach creates more opportunity for multiple service line arrangements, partnerships with payers, and gain-sharing strategies.

Co-management works well for organizations that want to improve the quality of care in a particular specialty or service line. Where the PSA model unites physicians from multiple specialties, co-management brings together physicians from multiple groups who practice a single specialty.

Case Study: An Orthopedics Co-Management Company
A free-standing, physician-owned,
orthopedic hospital and two community hospitals with co-management agreements with physicians decided to join forces to improve the quality and efficiency of orthopedic care in their community using a co-management company model.

The three hospitals entered into a bundled payment model with a narrow network strategy driving increased volume at higher profitability. This strategy was centered on three key areas: increasing efficiency, implementing quality benchmarks, and improving the patient experience.

As part of the strategy, they bundled care for an acute joint replacement episode into a package, including surgery, anesthesia, the implant, hospital care, and post-acute therapy. They also pursued a series of cost-cutting efforts, including limiting unnecessary care, standardizing order sets across hospitals, integrating IT among the hospitals and clinics, and standardizing implants, which can be up to 40% of the base cost of an acute event. They implemented new quality benchmarks aimed at getting patients up and moving earlier, better controlling pain, and eliminating infections. Finally, improved communication across the continuum enabled earlier consultations, thus delivering the care patients needed while reducing their wait in intensive care.

All three organizations saw significant benefits as a result of the integration. Inpatient care expenses for hip and knee replacements fell an average of 12 percent, contributing to a five percent increase in margin. Plus, average length of stay dropped 63 percent for knee replacements and 53 percent for hip replacements (see Figure 5). Significantly, readmissions also fell.

A series of streamlined processes improved OR productivity, which meant that the system was able to substantially increase its joint volume. Finally, Press Ganey patient satisfaction scores shot up from the 15th percentile to the 92nd and orthopedics, which traditionally lagged the system as a whole in satisfaction, now outperforms it (see Figure 6).

Jeff Hoffman
Senior Partner
Kurt Salmon
San Francisco, CA
415-296-9200
Jeff.hoffman@kurtsalmon.com

*Organisation for Economic Co-operation and Development
In a growing suburb north of Tulsa, Okla., 73-bed Bailey Medical Center produces loyal patients at an extraordinary rate. Throughout 2012, Bailey’s Net Promoter Score (NPS) – the emerging metric to measure customer loyalty – spent much of the year above 90 percent, staying above 95 percent for four months and rising to 97 percent of discharged patients in July; astonishing for an organization in any service industry.

For example, in 2012, Virgin America captured the top spot in the travel and hospitality industry with an NPS of 66 percent; in financial services, it was USAA’s direct banking operation at 83 percent, and in online services it was Google at 56 percent.

When asked how Bailey could improve even further, one patient offered this suggestion: “Move it closer to where I live.”

Promoters are enthusiastically loyal to your brand, your organization, your product, and your service. They tell all their friends how great you are. They buy more and are receptive to your other products and services.

Passives believe you are just OK, and they would be just as likely to use your competitor.

Detractors actively hurt your organization. Their negative word of mouth creates additional detractors. They’re costly, time-consuming, and drive people away from your products and services.

The Net Promoter Score is calculated by subtracting the percent of detractors from the percent of promoters. The highest score one can obtain is 100 percent, while low scores delve deep into the negative range. At that time, Bailey consistently scored in the 50s.

“If you go back four years ago in this facility, we were struggling,” says Keith Mason, CEO of Bailey Medical Center. “In 2009, we were losing money, our patient and employee satisfaction scores were off, and clinical quality needed some improvement. I went to the staff and said, ‘Forget about the money, let’s put our focus on improving our quality and service and see what happens.’”

Key to performance improvement were listening carefully and responding quickly to the customer, taking a page from the retail world. The voice of the patient is a compelling and motivating agent of real change—much more powerful than hospital administration or an outside consultant. As a follow-up to the NPS question, Ardent hospitals ask inpatients two more: “Why did you give us that score?” and “What else can we do to improve?” The verbatim answers and the opportunity to contact the patient again and dig deeper provided guidance for reshaping hospital operations and processes, as well as clinician and staff behavior.

For example, at another Ardent hospital, an older woman, a fall risk, said she would have given it a 10 instead of an 8, but “I am nearly 80, and when I needed assistance to the bathroom, it was a male who came to assist me and I was very uncomfortable with that.” Having learned this valuable lesson, male staff are now quick to say, “I’m here to help you, ma’am.”

Bailey’s rise in patient loyalty began more than four years ago. In 2009, Ardent Health Services, a Nashville, Tenn.-based hospital and healthcare company, introduced NPS to the hospitals owned by its subsidiaries, including Bailey. At that time, NPS was just catching on (although not in healthcare), spurred by the 2006 book, The Ultimate Question: Driving Good Profits and True Growth, by Fred Reichheld, business strategist and fellow at Bain & Company.

The concept, developed by Reichheld, links growth in customer retention, customer acquisition, and profitability to customer loyalty rather than satisfaction. (See Figure 1.) NPS uses a single question, “How likely would you be to recommend [a company, product, or service] to your friends, your colleagues, or your family members?” Based on the answer, one can sort customers into three categories—promoters, passives, and detractors—and begin to predict future behaviors. (See Figure 2.)

Loyalty, Not Satisfaction

At Bailey Medical Center, the difference was felt in quality, financial, and service performance.

By Kevin R. Gwin

Net Promoter Score: Driving Beyond Patient Satisfaction to Loyalty
to help you to the bathroom, but if you’d prefer, I can easily ask Sally from down the hall to help you instead."

**Refocusing Bailey**

Working with a quality improvement task-force consisting of himself, the CNO, the CFO, and the directors of all hospital departments, Mason immediately began to implement changes that would facilitate this kind of focus. He educated his management team and the hospital’s entire staff, including the medical staff, on NPS and the survey’s results. He garnered a commitment from each leader that quality and service would be a priority and true teamwork would be used to make improvements.

He launched a 9 a.m. daily huddle, which all directors and administrators attended, to talk about issues and set expectations. In less than 30 minutes, leadership was aligned for the day ahead. Today, the meeting still occurs two days a week. Also, the house supervisor’s shift report is distributed to every director at the end of each and every shift, so that the entire leadership of the hospital knows what happened during that time and can begin to address any problem areas immediately.

“We had to quickly improve our communication and work better together,” says Mason. “This gave us the opportunity to ensure we were all on the same page and patient care was at the forefront of all our efforts.”

Mason also implemented a rounding regimen. Each director and manager started rounding on the hospital on certain days, three times a week, interacting with employees, patients, and family members. The rounding included lobbies, waiting areas, and the emergency department to learn about and begin to address delays. (For a time, Mason created a “no sit zone” for patients waiting in the ED to ensure that there was, in fact, no waiting.) The regimen continues today: nurses round hourly on their patients and the CNO and CFO round three times a week, while Mason and the director of quality and risk both round daily.

“We began to see our hospital and its operations from the patient’s and family member’s perspective,” explains Mason. “It was eye-opening. This might have been the best change we implemented. We listened, we problem-solved, we learned.”

Lonna Klahr, manager of medical/surgical and the ICU, adds, “Staff at a community hospital are inevitably going to see patients and their families out in public; we’re going to interact with them when we go out to eat or go to the store. So we want them to have a positive experience.”

Every week, Mason distributed the NPS scores to staff by floor, by service line, by nursing unit, and even by room number. He shared them with each leader and in town hall meetings and staff meetings with employees. He included all of the patient comments, so his staff could get a feel for the voice of the patient. He required his leaders to call patients who were detractors, learning more about what happened and how it made them feel. And he talked about the scores and the comments constantly.

“I lived it, breathed it, ate it, walked it, and talked it. It became a very real part of me,” added Mason.

**Real Results**

In 2010, things began to change. Despite some layoffs, employee engagement and satisfaction jumped. The mean score rose from 3.32 to 3.45 (out of 4.0) in six months; today, it stands at 3.52.

NPS also began to move. In 2010, the monthly scores traveled through the 70s and into the 80s. The next year, they continued to rise into the upper 80s and low 90s, and HCAHPS performance followed suit (although it trailed behind because HCAHPS carries 12 months of data).

Clinical quality improvement gained traction as well. In the last nine months, Bailey has scored 100 percent on core measure performance. Even the hospital’s bottom line moved up. In 2010, Bailey Medical Center broke into the black for the first time, earning a small profit. In 2011, Bailey’s earnings before interest, taxes, depreciation and amortization (EBITDA) grew more than 800 percent, and in 2012, it grew another 46 percent.

Accolades have followed. In 2012, Bailey Medical Center was named one of the Best Places to Work in Healthcare and one of the 100 Great Places to Work in Healthcare by Modern Healthcare’s and Becker’s Hospital Review, respectively.

Culture transformation and customer and employee loyalty are difficult and, at times, tedious accomplishments. They require solid leadership, commitment, teamwork, trustworthy data, and good coaching, as well as the courage to terminate employees unable to perform to standard. The key understanding Bailey gained is that patients do not differentiate between clinical quality and customer service; they perceive them as exactly the same thing. The only way to achieve the best possible healthcare outcome for the patient is to perform both exceptionally well. Doing so will produce growth, in part because of loyal behavior from patients—which is what the Net Promoter Score is all about.

**Kevin R. Gwin**

VP, Communications
Ardent Health Services
Nashville, Tenn.
615-804-0884
Kevin.gwin@ardenthealth.com

**Figure 1. Top Ranking Correlates to Customer Behavior**

Source: Satmetrix. Used with permission.

**Figure 2. 3 Categories of Customers**

Bailey Hospital goes back to patients who fall in the detractor and passive ranges to glean insights into what went wrong and how they can change to ensure the problem doesn’t recur. Often it’s a single issue: room temperature, a particular staff person, trash not taken out.

Source: Satmetrix. Used with permission.
Healthcare marketing has never been simple, but the marketing channels we use today are much wider, deeper, and have many more tributaries than ever before. There are literally thousands of advertising placement choices we can make in today’s fragmented media markets. And message resistance is growing across all of our audiences.

Fortunately, I don’t think we ever need to fear complete marketing immunity: people clearly need and want to know about the healthcare products and services available to them. But given the multitude of media choices and the increasing difficulty of getting our messages heard or seen and understood, it has become critical to know what is working and what is not. This is especially true given the relatively small budgets many of us have to work with.

**Capturing and Counting**

Brand advertising and direct response both play an important role in marketing, and the effective use of each involves some blend of art and science. Brand advertising builds awareness and influences preference but the effects are seldom immediate and therefore difficult to quantify, making ROI uncertain, especially in the short term. Direct marketing is much closer to the scientific end of the spectrum, in that the immediate effects can easily be measured.

In fact, direct marketing is a form of the scientific method: we develop a hypothesis (about media choices) based on a blend of past experience, secondary research, observation, and intuition; we test the hypothesis through controlled experimentation (a marketing campaign) and empirical measurement of results; we learn by analyzing the results (what worked well, not so well, and not at all), and we apply that knowledge to the next campaign. This iterative process, applied consistently to our direct marketing efforts, should allow us to generate as many responses and conversions as possible from our budget—and thus maximize our return.

If you are like most of us, you have a fixed budget for a particular marketing campaign. For example, let’s assume you have a media budget of $200,000 for a fall campaign to market a health insurance plan for individuals and families. Your goal is to generate as many qualified responses and conversions (in this case, sales) as possible. Based on what you know and hope to learn, you decide on the following allocation of dollars across media types, some of which you have used before, some you would like to test. (See Figure 1.)

Now that you have your media buy “hypothesis,” the next steps are to carry out the campaign, collect data, and analyze your results.

The most important part of any direct marketing campaign is tracking. Without an accurate method of attributing response and sales to specific tactics, you cannot learn and will not be able to optimize your spending over time. There are various methods of results tracking, ranging from precise techniques such as discreet phone numbers and URLs for each individual ad, to more anecdotal methods such as asking respondents how they heard about the offer when they contact you. The more automated your tracking methods, the more accurate your data and the more informed...
your allocation decisions.

Tracking methods such as asking respondents where they saw or heard an ad are fraught with errors, by both respondents and those capturing the data. In contrast, using separate phone numbers and URLs for each advertisement or media type is among the best methods, since it allows you to measure not only by type of media, but also by individual ad placements within each media type, if you’d like.

Know Your Numbers

The number of responses generated by your campaign is obviously of great importance. But far more important is the number of conversions. Generating phone calls and website visits is clearly a vital part of the equation. But unless the inquiries are qualified and people actually purchase your offering, much of your budget and efforts are wasted. Remember, the highest number of sales at the lowest possible cost is your ultimate goal.

Figure 2 shows the results for our hypothetical campaign:

Looking at cost-per-inquiry (CPI) only, you might conclude that search engine marketing and online banner advertising were the two most effective media types. You would be correct in terms of lead generation: online banner ads generated 3,500 responses at a very low CPI of $10. But the number of conversions was relatively low at 59, and the cost-per-sale (CPS) was $593, compared with just $221 for search engine marketing.

The most telling measurements in terms of marketing efficiency are ROI and A-to-S ratio. A/S is simply the inverse of ROI: you divide the advertising cost (A) by the sales revenue (S). The ROI on banner ads was $6.49, meaning that for every dollar spent, you generated $6.49 in revenue. The A/S was over 15%, meaning the advertising cost represented more than 15% of sales revenue. By either measurement, you can see that online banner ads were far less efficient than the four other media types.

By contrast, search engine marketing and ads on social media sites were very cost effective, with ROIs of $26.95 and $17.50 respectively. And despite higher CPIs, old fashioned targeted direct mail and newspaper inserts actually turned out to be much more cost-effective than online banner ads.

Optimize Your Mix

When you are able to accurately and consistently track your marketing results, you can make more informed decisions that will help you maximize your budget. The key is finding the most effective and cost-efficient media mix through continuous experimentation, analysis, and learning.

But it’s not all science; even with precise tracking tools and the most rigorous analysis, you will still need to apply both creativity and judgment to maximize results. After all, using only one or two of the most cost-effective media types could mean missing portions of your target audience that prefer to use other types. And overusing a channel will eventually decrease response and drive up cost. (See sidebar.)

In short, finding the perfect blend of art and science—including aesthetic sensibility and intuition—is the secret to getting the most from your marketing budget.

Keith Langrehr
Director, Institutional Marketing
Johns Hopkins Medicine
Baltimore, MD
410-502-2654
Klangre1@jhmi.edu

Why Ads Stop Working

The reason advertisements eventually stop generating response is “decreasing marginal value,” a concept you might remember from economics. A simple analogy will illustrate the point: assume you are very hungry and order a pizza. The first piece you eat has tremendous value to you. The second piece also has substantial value, although not quite as much as the first. As you eat more pizza, the value of each piece goes down in sync with your waning appetite. At some point, there is no longer any value at all. (Sooner or later there will likely be negative value!)

The same is true for advertisements. Eventually, an ad that worked very well will begin to wear out its welcome and you and will see the CPI and CPS numbers climb. How long this takes depends on many factors, but the end result is inevitable. You might keep this in mind when you order your next pizza—and definitely when you place your next media buy.
**Strategic Partnership**
*(continued from page 2)*

**Building a Healthy Website**
A perusal of the Live Well Winona website (www.livewellwinona.org) illustrates how the organization has flourished in the last year and a half. Visitors find not only a well-organized clearinghouse of activities, but other kind of resources, including information about service clubs, alternative healthcare, sporting equipment rental, nutrition, support groups, physical activity leagues, and health assessment tools and calculators.

“Building a robust website—and keeping it fresh—is a priority for us,” says Quick. “It incorporates information and inspiration encompassing all aspects of health: physical, social, occupational, spiritual, and intellectual.” Staff have enlisted area experts to contribute articles on a variety of health-related topics, from exercise and nutrition to mental health to work-life balance.

Indeed, the Live Well Winona website has become the virtual “health hub” of the community. It includes a community calendar, race calendar, resources directory, interactive accountability tools, and the newest addition, the virtual volunteer center. The website had 312 visits per month when it launched in February 2012; a year later, that number had increased to 1,479. Live Well Winona has 234 “likes” on Facebook and 275 people have signed up to receive its monthly e-newsletter.

**Looking to the Future**
In the coming year, Winona Health will contribute half of Live Well Winona’s annual budget. “Our partnership provides a definite benefit to community members,” says Allen. “Our clinical providers and staff work hard to help patients maintain or improve their health, and are able to direct those looking for additional information, inspiration, and support to Live Well Winona.”

A Winona Health employee recently referred to Live Well Winona as an arm of the health system. “That’s a good way to describe our relationship,” says Quick. “We’re planning an increasingly active role working with Winona Health’s staff to help facilitate outreach.”

Karen Sibenaller
Senior Editor/Media Relations Coordinator
Winona Health
Winona, MN
507-457-4157
ksibenaller@winonahealth.org

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**SHSMD Datebook**

**Through July 19:** Accepting applications for the SHSMD Annual Conference Scholarship (sponsored by Prairie Dog/TCG)

**July 8-19:** SHSMD U online course: “Healthcare Market Research,” with Rob Klein

**July 28:** Deadline for receipt of suggested updates to SHSMD Bylaws for approval at the Annual Conference

**July 31:** Deadline for early-bird Connections 2013 registration

**August 5:** Ballot for the 2014 SHSMD President-elect and Board of Directors e-mailed to members

**August 31:** Deadline to vote for the 2014 SHSMD President-elect and Board of Directors

**September 9:** Cutoff date for Connections 2013 discounted room block reservations at the Sheraton Chicago Hotel & Towers (800-325-3535); for registered attendees only, subject to availability

**September 29–October 2:** Connections 2013, SHSMD Annual Educational Conference and Exhibits, Sheraton Chicago Hotel & Towers, Chicago

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**SHSMD CareerLink E-newsletter**

SHSMD doesn’t just connect members to education, resources, and colleagues in the profession, it also links members to opportunities for career advancement in the weekly CareerLink e-newsletter. Sent to all members via e-mail each Tuesday, CareerLink lists dozens of open positions in healthcare marketing, communications, public relations, strategic planning, physician relations, business development, and more in healthcare organizations and firms throughout the country. In addition, SHSMD members who are ready for the next steps in their careers may post position-wanted listings free of charge. If you are not receiving your weekly CareerLink e-newsletter, please contact SHSMD at 312-422-3888 or shsmd@aha.org for assistance. Archived copies are available online at SHSMD.org > Resources > Newsletters > CareerLink.

And don’t forget! The next time you are seeking top-notch, qualified candidates for open positions in your department, consider listing in CareerLink. For pricing details and to submit a position-available listing, visit www.shsmd.org/careerlink.
Every issue Rick Wade presents a real-life scenario much like one you might encounter in your own organization and asks how you would handle it. Readers are invited to respond on “The Tightrope Walker” click poll on www.shsmd.org/tightrope. Rick, formerly senior vice president for strategic communications at the American Hospital Association, works with hospital and health system leaders who are coping with change, innovation, or crisis.

It’s that time of year. The hospital will file its IRS Form 990 next Tuesday and the local media – one daily newspaper, one weekly, one TV station, and one radio station – will be calling. You can feel a tension headache coming on.

You head for the Friday briefing session with CEO Bob Inweever and CFO Bill Sharp – an experience comparable to a root canal.

“Let’s get this over with,” Inweever growls. “Get the press release out, same as last year. Just change the numbers. Sharp will be your sidekick for media interviews, but don’t do any unless you have to. Use complicated accounting jargon. Questions on executive salaries, refer them to me.”

“Last year, you were unavailable for comment,” you point out. You’ve tried in vain for years to have the board chair field those calls, but no dice.

You plod through the list: net profit nine percent, up from last year; exec pay, up 12 percent on average, mostly due to accounting rules on deferred comp. Even so, the numbers are toxic compared to the employee raises of 1.2 percent. Charity care is down 27 percent.

“How can that be? The state cut Medicaid. The economy is awful, unemployment still double-digit.”

Bob and Bill share a sideways glance, followed by a long silence. “It’s the IRS’ fault,” Sharp says at last. “They changed the rules. We have to calculate charity care using actual costs. It’s a step toward greater transparency.”

“What were we using before?”

“The charge master of course,” Inweever sniffs, “our basic price list.”

“But no one pays charges! Insurers squeeze discounts. Medicare and Medicaid pay whatever they want.”

“It was all perfectly legal,” Inweever interrupts. “I like to think of those charges as what we deserve to be paid.”

“But Bob, reporters will zero in on that number. It looks like we’ve been lying. Why weren’t we using cost numbers all along?” you ask.

Inweever pats your shoulder. “You’ll find a way to finesse this. You’re as good as you ever were.”

“To be perfectly honest,” Sharp says, “Many hospitals have figured their charity care that way for years. At one time, it was a reasonable measure—and figuring out costs was almost impossible. But with all the contracting, negotiating, and competition, our charges today are just a tool in the battle with insurance companies. I think we need to sit down with the reporters and explain this. There are only four of them.”

“Too risky,” Inweever snorts. “Send out the press release. Let them call you if they want the 990. Any questions on charity care, refer them to our legal counsel. Let him do the explaining.”

Sharp tries again. “But it’s not that we’re doing less charity care. In fact, we’re doing more. Transparency is good, sir.”

“It’s all government regulation,” Inweever shoots back. “Trying to control us. I can see right through it.” He turns to you. “You do agree with me, don’t you?” You pause and pick up on Sharp’s phrase:

“To be perfectly honest, sir, I think …

1. “You’re right. Trying to explain this is risky. Let the lawyers handle it.”

2. “We’ll look like we’re hiding something if we bring in the lawyers.”

Comment on The Tightrope Walker #18

The scenario: You’re sitting with your oldest friend, who is also HR director at one of your system’s hospitals, at her family 4th of July picnic and she asks if there’s anything she should be telling her staff about changes ahead. As a system executive, you know that centralization will shortly wipe out her position and her department. You waver between (a) putting her off, (b) telling her the truth, and (c) using weasel words.

Rick Wade says: The poll produced a first: a dead even split between the first two choices. No one went for weasel words: 14 percent said “other.” A tough call, but I’d opt for telling an old friend the truth and trusting her. The line between the professional and personal is often blurry. If you chose “other,” what did you have in mind? (You can reach Rick at inheritthewind@verizon.net.)
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