AHN

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Dr. Mark Rubino — Inside the Mind of a Hospital President

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Key Highlights

The Big Topics Facing Health Systems Today

As the market continues to experiment with value-based care across health systems, **different models are emerging around the level of health system / payer alignment and integration.**

- Health systems are increasingly aligning with payers – informally, as well as through ownership – in an effort to gain control over care delivery and associated costs.
- Pittsburgh is a market where this type of health system / payer integration has matured. In the Pittsburgh market, the primary players are UPMC and Allegheny Health Network. There are no strong independent MSOs in the Pittsburgh urban environment – Western Pennsylvania going all the way up to Erie.
- As this type of integration advances – whether through health system / payer integration or through retailer / payer / provider network relationships – will the Pittsburgh market dynamics that were historically viewed as more of an outlier look more normal?

Hospital network footprint management is an increasingly complex equation to manage as hospitals face a competing set of priorities, including:

- A need to provide a broad range of clinical services, as well as a need to care for both urban and rural markets.
- Increased care delivery specialization – i.e., progression away from "the generalist doctor."
- Growing pressure to provide services at cost effective price points in the context of broader market shifts to value-based care and increased competition from scaled MSOs.
- Tight provider supply dynamics within certain specialties leading to coverage shortages.

As a result, hospitals are grappling with key questions around:

- **Sustainable resource allocation across larger health systems.**
  - Which specialized care teams are only able to be maintained at central hub locations vs. also residing within local market spoke access sites?
  - What is the optimal balance between MD-led care vs. APP-led care?
  - How can telemedicine and other technology solutions be effectively leveraged to improve efficiency?
  - **The sustainable role and feasible clinical service scope of smaller, independent community hospitals.**

Value-based care adoption varies greatly across different health system models and remains relatively nascent across many health systems. **Complex hospital service scopes, entrenched fee-for-service cultures and complexities around provider compensation models make the transition to value-based care slow.**

Key To Success Across Value-Focused & Payer-Integrated Health Systems

- Intelligently and closely managed resource allocation across the network.
- Provider inclusion in health plan decision-making. At Highmark Health, if there is a senior team meeting, physicians are included in the room.
- Holistic and transparent provider compensation models that aim to keep providers whole and yet reward performance across more than just volume.
- Clean, user-friendly, and readily available performance information, analytics and benchmarking.
- Efficient care delivery optimizing the utilization of both APPs and technology.

Health System Market Expectations

- More consolidation as the hospital market increasingly requires a broader site-of-service network to serve the community both comprehensively and profitability.
- More integration between health systems and payers as the market continues to experiment with value-based care.
- More partnership & collaboration between health systems and other provider groups and sites-of-service. As health systems and payers become more integrated, the focus will increasingly be on managing total cost of care vs. more narrow focus on health system site-of-service profits, which will necessitate broader collaboration and partnership.
- Provider compensation models will continue to be a much-deliberated topic and challenge. Health systems will ultimately need to invest in holistic compensation programs, including more sophisticated analytics, reporting transparency, and provider engagement & communications strategies.

Background

My background is originally in obstetrics and gynecology. I finished my residency back in 1987. For about 25 years, I was involved with growing a large practice of obstetricians and gynecologists. As I started to realize I wanted to branch out and do something else with my career, I obtained a master's in medical management at Carnegie Mellon, after which I had the opportunity to be a Chief Medical Officer at Allegheny Health Network. I did that for eight years and then Cindy Hundorfean, our new CEO who came over from the Cleveland Clinic, asked me to serve as President at Forbes Hospital. Today I serve as the president of two hospitals, and I have still maintained a small practice treating patients I have seen over the years in my gynecology practice. Today at AHN we have ten hospitals - acute care hospitals - and we have another four, what we call neighborhood hospitals, that are really access points with an ED of ten beds and 10 inpatient beds that we've located in strategic areas.

The AHP system was born in response to UPMC having too much power and influence over Highmark as a payer in its local marketplace. Is that a fair historical assessment?

I think it is. At that point in time, Highmark was in contract negotiations with UPMC who was threatening to not participate with the insurer. So, the insurer affiliated with, and subsequently purchased, the Allegheny Health Network.

For those who don't know, Highmark is a regional payer that is part of the Blue Cross and Blue Shield Association, operating across several states with Pennsylvania being one of the core markets. Highmark and its AHN system are integrated the way that Kaiser is integrated, United is integrated. How does the Highmark payer/provider integrated system, in your mind, contrast and compare with Kaiser's, United's, and other versions?

Highmark as an insurer, is one of the five largest Blues plans. Highmark generates approximately $25B in revenues. However, when you compare that to the revenues of United, Aetna or CVS/Walgreens, you can see what we're up against. I think the key difference is we are a "not for profit," so whatever profitability you can achieve by the efficiencies of care and the transformation of the healthcare model, the profits can be reinvested back into the model as well as back into the communities we serve, as opposed to the shareholders. I think that's a key difference as we try to figure out how to drive the transformation and what we're going to have to do to have a sustainable model of healthcare in this country.

I'm focusing for a second on Kaiser, which is also a nonprofit, but closed network system - the largest in this country. How do you think of the Highmark model versus Kaiser, which I know historically was more West Coast based, but with every day that passes, now recently acquiring Geisinger, becomes more and more national?

I never used to have to think about Kaiser before, but that is changing with the recent acquisition of Geisinger in the state of Pennsylvania. What's interesting about that is Geisinger is right in the middle of the state with probably not the same degree of marketplace competition we have in the urban centers like Pittsburgh and Philadelphia. I don't know enough about the Kaiser model to give you a complete commentary, but on a macro level, we as a hospital system, although we're owned by Highmark, our clinical relationship goes beyond Highmark with participation with multiple insurers. We are also on a fee-for-service model, and don't have many at-risk contracts just yet. The Kaiser model is known to be an at-risk kind of contract with exclusivity. I think we could probably learn from this model as we transition to our own at-risk models.

This is especially important as we think about creating the alignment of incentives around the caregivers and the providers. I think this will be an interesting thing to watch and learn from as we move forward.

We also have to see if Kaiser adapts their model in consideration of the current marketplace.

It's this contrast between control versus patient choice, provider choice, and the end-result. More control equals more cost containment, but not necessarily more choice. It is an interesting contrast, and I guess now that Kaiser is a neighbor, it will be interesting to observe how they go?

What we're trying to do is create clinical care models and have Allegheny Health Network be the pacesetter of this transformational change. If this is successful, you can share this with your affiliates as well as other Blues plans. We need to change the perspective from "control" to decreasing the variation of care through the adoption of evidence based clinical protocols.

Within the Blues ecosystem where optionality does exist, how do you continue to see progress towards managed care, risk-based reimbursement, coordinated care, all the ACA initiatives that are actually in some respects being accelerated? How do you transition from fee-for-service into more cost containment, if that's the plan?

I think we're going to learn along the way. Right now, we're analyzing the employed physician contracts and trying to align the incentives as we plan to adopt more risk models. It can't just be the number the number of procedures, or the number of encounters. We have to achieve more of a balance with the alignment of incentives, and this has to be tied to compensation. So, yes, we're looking at the compensation that clinicians are receiving. We're planning to keep the providers whole as we enter these new relationships, show them their compensation under the new value-based model as opposed to an RVU based contract, and really start to try to drive those incentives.

It's interesting what's happening. I've been in practice for over 35 years starting in private practice with a total cash compensation model. When we were first acquired, we continued with a compensation model based on cash and if we were going to have a bonus at the end of the year, we had to achieve a positive cash margin. It wasn't based on RVUs, this arbitrary metric of how you value the care provided. However once things expanded, and we had to deal with many of the clinicians doing work that was either reimbursed poorly or not paid at all. The RVU model provided the necessary supplement to support their compensation as well as allowing us to compete in our marketplace to recruit physicians.

This approach is not sustainable at this point, and it doesn't really align with the incentives. I do think it's going to be a gradual process. We also must adjust to the fact the recently trained physicians want to be employed. Their desired lifestyle considerations, having a reasonable call responsibility, is creating new challenges. As a result, we don't have as many physicians willing to go into the rural communities, because they don't have the necessary call coverage they demand. We see far less clinicians going into a number of the medical specialties, for example, Rheumatology, Endocrinology, Nephrology, Neurology.

A lot of these specialties are underserved right now. Most of our hospitals are in an urban center and we're finding it increasingly difficult to find some specialty trained physicians. Once we have recruited our target physicians and we have the specialty service, we are challenged by figuring out how many hospitals will offer each service line, and balancing service supply and demand with wait times people are experiencing.

Are there less physicians or are there more physicians concentrated in a smaller number of specialties? If so, which specialties, and why?

I think any data you evaluate right now is going to need to be looked at through the lens of the last few years, and there's been a significant number of retirements and resignations post-pandemic. As far as I'm concerned, the data is difficult to interpret because it's very geographically driven, and it's changing very quickly. I'm concerned a little bit about Pennsylvania. Some of this ties into what happens in the political and legislative areas. In the recent past, you couldn't venue shop malpractice cases in Pennsylvania, and it really reversed our malpractice litigation costs. Now you can venue shop again, and we're very much concerned about the litigation costs as cases are driven to the urban areas where the awards are often highly excessive. A lot of young physicians avoided Pennsylvania when that happened in the past.

Going back to this question of transitioning from cash-based to RVU-based to value-based, are you a believer that this transition from RVUs to value-based compensation will happen, happen efficiently within an open network type ecosystem like what exists at Highmark/AHN?

If we're comparing our current compensation model with Kaiser's, I think it must be a hybrid. I think you do have to have incentives to work. We're therefore landing with a percentage of the compensation being based on some degree of volumes, but with a review of indications for testing and procedures, outcomes and especially quality of care. The transparency

around the way we provide care now is higher than it has ever been before. Department chairs have a direct vision as to what's going on with their physicians. I think that we can create a balance between incentives to do the clinal work and allowing the focus to be on quality of care and appropriate utilization of testing and procedures. Most physicians, if they can remain to a degree whole, will be comfortable with this approach.

What they're concerned about is that the bottom's going to fall out regarding their compensation, and I do think the new physicians have a different view of the world related to work-life balance.

(interviewer: I've never met a compensation system that is perfect, and I've never met a compensation system that isn't dynamic, borderline stochastic, meaning constantly in flux. Compensation really is the end product of many different inputs, any one of which is subject to change, and so even when you look at value-based care compensation models, and they are constantly attacked by some of the largest leaders in this country, including leaders within United/Optum, for relying on highly challenging reporting that is often late, very late, often inaccurate, highly challenging networks that suffer from patient leakage. How do you get paid on savings when your patient leaves halfway through your annual experiment and joins another network? That suffer from provider leakage, tremendous information gaps. How do you demonstrate savings if half the providers you're relying on are outside of your network and not interested in reporting outcomes? That's just sort of the tip of the iceberg. You then run into a changing regulatory environment, changing economic conditions. What was a bonus one year is no longer a bonus the next year. Changing definition, changing goalposts, changing metrics, which a lot of providers complain about. "My expectations were set at X. Now they're revised to Y." Sort of the rules of the game change as we go along, and so it is a tricky process. Where it's worked very well has been where it's been concentrated in one specialty, namely primary care, as opposed to multi-specialty, and where it's been implemented within a very closed network system. Other than that, it's been hard, whereas the RVU system has come a long way. I take your point that the transition needs to be slow and steady as opposed to aggressively rushed.)

If you're a primary care doctor and in solo practice maybe 25 miles from a metropolitan area, busy practicing in your usual approach to care, it's helpful to look at your data in real time and see how you compare with others. Our Clinically Integrated Network allows this to occur. I often hear physicians state "Wow, why am I so much different than this doctor I'm sitting next to that I like, and know, and I trust?" By exchanging a few conversations about, "Hey, this is the way we do it, this is our standard approach. You want to avoid that particular medication because, yes, it is generic, but it's very expensive." They would just change their practice pattern and the discussions were not adversarial, actually they are very constructive. I think the attitude is, "Okay, this is keeping me current and will improve my quality scores. Yes, it'll probably help me from a revenue standpoint, but I'm not measuring it purely in dollars and cents as I participate in these meetings."

You look at your career as a hospital president, and you are able to contrast it with a long time spent building a practice and then a multi-site practice, almost MSO. How do you compare those two jobs, the day-to-day management, the complexities, the issues you normally face with leading hospitals versus leading practices? What do you see as the biggest, say, two or three differences?

It's scale. I think in any management situation, you're going to have to deal with conflict at some point in time, as well as change management. I think that the variables at the hospital level just have a lot more opportunities for conflict, and the requirement to manage change in a much more engaged fashion with a much larger and diverse staff. The one thing that I've benefited from is that my leadership began in a facility that I served for many years. I did not seek out or apply for the role as president instead I was asked to serve. I did grow in my responsibilities from being an active clinician in a large OB/GYN practice and then serving as a medical staff leader, eventually being asked to be a chief medical officer. At that point I had a 25-year relationship with our hospital staff, so I had the trust and goodwill to do what we did at our hospital.

And we did a lot of things over the last 10 or 15 years at our hospital, such as starting a trauma program which was very difficult to do. When we started the cardiac program, the implementation was relatively straightforward. Trauma, however, required a huge amount of engagement. Many clinicians elect to work in a community hospital that doesn't have a trauma program. However, with the growth of our community, we had so many traumas arriving to the emergency room that it became important to do so. I think it's learning a skillset. I think my master's program helped me from a management standpoint, and being able to understand what you need to do to implement change. Critical is engaging all the interested parties, all the people that you really need to communicate to and getting them to buy into the vision, and really understand how this vision is going to affect them on an individual case.

When I look at AHN, it's not the 10 outpatient surgery centers, the urgent care centers, not even the two and a half thousand physicians that strikes me as clearly differentiated from MSOs, because large MSOs are rapidly getting to that scale of outpatient ambulatory footprint. Rather, it's the two and a half thousand beds, the 14 hospitals, the inpatient, the super high acuity procedures, and possibly - I don't know this but I'm asking - research, and certainly if not in your case, then in other systems, clinical trials, and academics. That's sort of the list of things that I don't see MSOs focusing on, making much headway on, in the years to come. Are those the building blocks, sustainable building blocks of differentiation that health systems will rely on? Is it the integration with payers that will make all the difference? How does AHN successfully compete with well capitalized outpatient MSOs over the next five to 10 years?

As we go down this path of an aging population, I think Pennsylvania is relatively unique in that it's a highly populated state that doesn't have a whole lot of out-migration or a lot of immigration. In a lot of areas, it's just aging. As a result, the payer mixes are shifting very quickly. The independent hospitals are going to have to negotiate with the payers to try to cover the gap between what is reimbursed versus the cost of providing the care. I think for us, globally as a society, the reimbursement pie is only so big. There's only so many dollars in the system, and the hospitals are going to have to be supported, and the insurers, along with the government, are going to have an obligation to make sure the access to that care is supported as well. There's going to have to be some kind of balance.

I think the likely model soon is going to be a combination of the "not for profit" and the "for profits" and the players in those markets are going to have to have a relationship with the insurers. Will it be totally integrated? Will they be owned? I think in a lot of areas, they probably will be. It is in Pittsburgh. It's primarily UPMC or AHN right now, and the independents out there are struggling. We do not have strong independent MSOs in our urban environment, Western Pennsylvania going all the way up to Erie. It doesn't exist.

Who's surviving better right now are the entities that are integrated, because whatever is happening on the utilization side has been balanced by the payor side of the equation.? When utilization was down the insurers made money, the hospitals lost money, and those that were integrated were able to cover that because of the profitability of the enterprise. Those that are not integrated had, for a period, federal dollars come in, but those federal dollars are not there anymore, and that's what's creating challenging dynamics at a time when the workforce is becoming increasingly expensive to maintain. They're also having less specialists coming into their areas, and inflation is just driving up costs in supplies.

We're at a tipping point, and we're probably going to see more acquisition activity taking place, by the companies that have the dollars to be able to acquire the facilities and the practices that are struggling.

That's an interesting point. You're an integrated payer-provider system. You are perfectly hedged against utilization. If it goes up, you're happy. If it goes down, you're happy.

There must be a balance, because ultimately, they're going to have to sell insurance and the independents that they have a contract with are asking for more money because they're struggling. Everybody has their hand out right now, and understandably so, but the reimbursement pie is fixed, so somebody's going to get squeezed, and who is it going to be? Are we going to have a period of disruption where people will just come in, like the Kaiser, like the United, like the Aetna, those that have huge cash positions. I think that's the concern.

When you think about outreach, your affiliated providers and other strategic partnerships, what gets you excited? What third-party relationships do you see working very well for you, your two hospitals, and the healthcare system at large? Is it employer-based? Is it academic-based? Where do you see really high value strategic partnerships fueling your goals?

Number one, continuum of care. We need to have partnership and affiliation to be able to deal with the throughput of our patients as they go through the system, from admission to our skilled facilities, our LTACs and other forms of home care. Currently, because of the pandemic, throughput has been very difficult to manage, and it's created a lot of situations where the hospitals have longer length of stays, creating more expense, as well as borders in the EDs. The whole care path has been disrupted, so rebuilding is required around these partnerships.

The other thing is going to be around decreasing variations of care, data management, partnering with the entities that allow you to identify where we could drive efficiencies. There are limited resources being utilized to really take care of the increasing population of complex patients, and we're going to have to create new models.

Physicians also need some help with their workload and responsible tasks. There's a JAMA article about Artificial Intelligence assisted responses of patient questions. We get so many more queries now from our patients on our electronic records. Many more patients have digital portals, and they are reaching out to us, with more questions. When do you do those? You're doing those often at the end of the day. The study compared the physician responses to the AI generated responses, which the physician could review before it was sent out to the patient.

The AI generated responses were rated to be much clearer, much more empathetic, which is interesting. The adoption of this technology has the potential to reduce physician burden which can help with clinical burnout.

I think it really is going to come down to utilizing resources in a more efficient manner. That's going to drive your partnerships with those that allow you to achieve those efficiencies. We must also eliminate those partners that create inefficiencies or expense in a much quicker fashion.

We've talked a lot about physician burnout, the change in really this potential generation of physicians wanting to have that work-life balance. I wanted to talk a bit about competition. Knowing the geography where your hospitals are located, there's a competitor right down the street, literally. How does your system or your hospital differentiate itself, that, cost and quality aside, if you wanted that independent orthopedic surgeon to do his knees or that neurosurgeon to do his spines at your hospital, what's your differentiator, with everything else on par? Cost and quality?

I think our differentiator is we have physician engagement across the leadership structure in total partnership with our insurer. What has been motivating for our physician leadership is if there is a senior team - senior vice-president and above meetings - held by Highmark Health, then the physicians are in the room. That has historically not been the case. If anything, there's been more of an adversarial relationship. We want our physicians to know that they'll be engaged in the process of what we're trying to build, our vision is about providing the right care at the right time and at the right place.

For example, I have multiple orthopedic surgeons on my staff. We have a surgery center down the street that's part of the network that is not on my P&L, and that is where many of the hips and knees are now being done. It decreases the cost for the patient. It's a patient satisfier, it's a physician satisfier. I think that knowing that the physicians can be engaged in the processes to really determine what is best for them and their specialty, and it's not always around the dollars. A lot of it is about actually having a say in their operations and making sure that they can do what they need to do, start their case when they want to start their case, go home when they are scheduled to go home. If you can get that for them, then they usually want to be part of your system.

The next part is around urban versus rural, and how your system is leveraging technology. You drive 45 minutes east from your hospital and you are in a rural market. How is AHN handling those strokes, or how can you leverage technology to manage that rural setting and then feed that into the system?

It must be done at two levels. Number one, there are just not enough bodies to go around. Our network has been blessed in that we're able to recruit and were able to get the talent, but we're having to use telemedicine to satisfy the rural market demand. In the past, we would help a lot of the rural hospitals with some of their coverage issues and have a doctor rotate there two, three times a week. Well, now you can cover seven days a week, but it's through a tele-consult, utilizing the technology that we have through telemedicine. Also, the expansion of the EMR to have remote access or some kind of electronic record integration.

Number two is with the care extenders, and being able to utilize them at the top of their licensure. , We are utilizing the physician assistants, the nurse practitioners that we're training, placing them in areas that will allow our physicians to oversee them do the exam, maybe do the minor procedure, and really to be able to take that level of expertise to the community. I have responsibility for a smaller hospital that is in a smaller metropolitan area, and then a larger hospital in a larger suburb. Well, with primary service areas that overlap, I'm going to have to coordinate care between these two institutions. We're not going to be able to do everything at one place that we do at another. You just can't do it anymore, but if we went back 25 years, that's what was being done. You had a general surgeon doing a gallbladder, a hysterectomy, a mastectomy. Now, that's not the case. You have a breast surgeon, you have a vascular surgeon, you have a colorectal surgeon, you have a plastic surgeon, and you have so much specialization to reach a higher standard of care. It just can't be delivered in every facility.

I think the whole AI question is going to be interesting. The problem is, with physicians, you want them doing what they have been trained to do to do as opposed to doing multiple tasks which can often be done by others.

How we coordinate that care and how we better use our physicians will be critical, we want them in what I call enhanced practice.

For example, for a primary care doctor, there's a pharmacist there, there may be a psychologist, and there will be a case manager. It really is going to take a team approach to be able to get ahead of the disease process in a way that we could really impact how a patient engages in their health care.

So far, we've seen an information revolution. There's an enormous amount of data that didn't exist before. We've seen an analytics revolution, but have we seen a physician productivity revolution, where an individual doctor can do a lot more in the same amount of time?

Most of our primary care practices have an enhanced model now. When that doctor walks in, the patient's prescriptions have already been reviewed, done. Any of the case management issues have been addressed, so they could spend more time in direct conversation and not doing a lot of those tasks that historically they would have to try to do in a 15–30-minute visit.

Every physician is really an executive, a CEO of his or her domain, and so every minute counts, and so, can we build an infrastructure to support that?

I've done a lot of work in platforms around the country where provider retention, provider attrition is a huge issue and something that's moving the needle in a lot of these organizations from a profit to unprofitable situation. I have a question about anesthesia. Anesthesia is an interesting breed in that you need them to do these operations, they kind of tend to move as a herd. How are you managing that inside of your health system, and are you seeing attrition in anesthesia or leverage in anesthesia being a meaningful issue that you have to manage on a day-to-day basis?

Over the years we had a lack of anesthesiologists, then we had almost a glut of anesthesiologists for a period. Some of that was driven by the CRNA ratios and the ability to cover a fixed number of ORs managed by well-trained CRNAs. It's gone back and forth, but at this point we have some stability regarding anesthesia. The competition for CRNAs has been tighter for us, and the signing bonuses can often be $50,000 or higher for a CRNA. It hasn't been on my radar, because we've had stability lately and we have an employed model. In Western PA, we have two training programs that produce a fair number of anesthesiologists, and the competition's been more around the CRNAs.

How do you feel about specialty mix in your two hospitals specifically? When you think about investing in either employing or acquiring, training more primary care versus nephrology versus ortho versus diagnostics, radiology, imaging, which specialties do you stay away from because you don't think they're a good fit inside a health system? Is it gastro, doing colorectal procedures? Is there something that you stay away from because it doesn't really belong in a health system? Conversely, are there specialties that you're heavily focused on because they're a strategic synergistic fit? Does that change from year to year or decade to decade?

It does change. Right now, we established a urology program because there's not enough Urologists. Urologists basically capped their urology residency program 15, 20 years ago, and right now there's more Urologists retiring than there are being trained, so there's a severe shortage of urology across the country. Quite frankly, a urologist can make a very good living just by doing office-based Urology, with a little hospital exposure, not doing the big cases such as robotic prostatectomies or robotic nephrectomies. That puts a lot of pressure on just those patients being transferred into the urban centers for those bigger procedures. Most academic centers or large hospital systems have most of the specialties with residency programs. Since there's a cap, the ones we are funding above the cap are the specialties where we have a strategic need. That has really been centered on Family Medicine, Urology, Neurology, and Endocrinology.

It's a supply demand calculation. If there's excess demand and a shortage of supply in the marketplace, then something that you might have historically thought of as outpatient affiliated network base becomes a residency play, in-house.

Gastroenterology is also one where there's a lot of trainees that would rather just go to the MSO model and limit their practice to the outpatient world. You're exactly right, and because they can be compensated well there, and they don't have to deal with call coverage. Don't take this as a bias or anything, but there is a gender issue playing out here as well. The medical schools currently are graduating more females than males. I have a daughter that's a Urologist. She and her two partners are the only Urologists in the entire neighboring county. She is raising three children and family time demands are high which create work-life challenges. What's happening is, most women are going to want to raise a family, and that's going to limit their ability for some of their clinical hours, especially from a coverage standpoint and a call standpoint. They're going to want to be in a practice where there is help to cover pregnancies as well as achieve some work-life balance. I think that that's creating another level of stress on the system related to the available workforce and the selection of a specialty from a lifestyle standpoint.

When you don't have all the hours in the week necessary to throw in everything, the outreach, developing referral relationships, maintaining them, patients don't just show up when you're on your own, and then treating those patients and then staying compliant, all the reporting being available to those patients at every minute of every day, you need a team. Often, the larger the team the better, because there's a lot of shared responsibilities when you have those constraints.

Getting back to the anesthesia question, what's interesting is, we did personality traits assessments, and the leader of our anesthesia, our department chair, his personality trait was around harmony and empathy. Totally different than a lot of the other proceduralists in the room, which was around execution and competition. I think that anesthesia, like obstetrics, is based on a team approach. However, these teams are made up of highly competitive individuals. They're achievers, they're hard-driven, they're type As, but we get into these care teams that really need a more collaborative type of individual. I think as we recruit physician leaders, we need to be trained to understand and manage this. I think there's this expectation now that physicians are going to assume more of the leadership positions, but we don't come into it with necessarily management skills, dealing with conflict, change management, and working with as a team.

I think some of that is going to have to be incorporated into the educational process, because truly, if we're going to achieve efficiencies of care and be able to drive evidence-based models and get everybody on the same page, you're going to need collaborators. You're going to need people that are comfortable in that world.

It's a very reductive point, but very fundamental. Coordinated care amongst physicians that like coordination. Many islands, now becoming an archipelago. How you are thinking about, as acuity is going up in hospitals because of so much movement to outpatient, how you are thinking about reorganizing or re-staffing a hospital to really meet the need of the patient acuity.

Your question's right on. I have two hospitals. I'm not going to be able to take care of the acuity at one of the hospitals that I have that I could take care of at the other, so I must consolidate some resources, and we are looking at that. We may be doing one type of acuity at one hospital and doing another type of acuity at another. Let's say hospital X is maybe going to do more of the cardiovascular care, and we put those teams together there because you've got to cover the Cath Lab, Open Heart, Thoracic and Vascular procedures. Maybe hospital Y is going to do more of the cancer surgeries, and yet still maintain many of the basic services at each hospital. There may be a need for some movement of the physicians, based on need, but it is going to have to be staffed and consolidated to take care of the increasing acuity, in a different way than we're used to doing it historically. I don't think we're going to have all the resources to do the complicated complex procedures we are doing in multiple sites. We're just not going to be able to do it everywhere, so I think we're going to have to have units that are more specialized, and those units of specialization may be in different places throughout a network of hospitals. It doesn't even have to be just a large integrated network of 10 hospitals. It may be two or three that are going to figure out what they're going to do, and what the other person's going to do, and where they're going to put their resources and expertise and then share them across a geographic area.