Four Strategies to Optimize Investment in Your Employed Physician Network

Many hospital and health system C-suite leaders and board members are asking about the size of their organizations’ investments in physician practices, and whether the physician enterprise is optimized to meet organizational goals, now and going forward.

Often, hospital physician networks develop in reactive response to competitive pressures and new opportunities in local markets, as physicians approach organizations seeking employment or partnership. Such development has strengthened and extended hospital networks. However, the growth of subsidies is a major issue for a significant number of organizations.

Every capital outlay and expense requires scrutiny as organizations look to improve quality, outcomes, and patient experience while reducing costs. But a recent survey indicates that physician enterprise management and network efficiency—areas that could yield transformative improvements with high levels of investment—are not being addressed at a pace that acknowledges required urgency. Most cost-reduction efforts currently focus on traditional areas, such as revenue cycle, supply chain, and labor productivity.

These circumstances and changing market realities for hospital-employed physicians (see Sidebar 1 on page 2) suggest the following:

1. Many hospitals and health systems would benefit from development and implementation of a clear rationale for the number of employed physicians in specific specialties, and a thorough approach to improving efficiency and collaboration within the physician network.
2. An enterprise-wide approach to cost transformation must include physician operations and related delivery networks.
3. Physician involvement—if not leadership—in these endeavors is critical to achieving targeted teamwork and efficiencies.

There are four strategies healthcare leaders can put in place to right-type, right-size, and right-place their employed physician networks and ensure that practices in the networks function effectively and efficiently.

Determine the Right Number and Location of Employed Physicians

The right number of employed physicians can be identified through a disciplined analysis of each service line, the unique position of services offered, the service line's value proposition, and the future expected value of each business. As services continue to move to ambulatory settings and virtual delivery, hospital volumes are expected to evolve in some areas, so rightsizing the physician network should follow suit. Relevant questions for leadership teams appear in Sidebar 2 on page 3.

The use of supply/demand modeling to obtain answers is recommended, but reliance on traditional physician-need studies should be avoided. These studies typically are based on the physician-only model of care, in which a primary care doctor or specialist is the sole clinician seeing the patient. They typically point to physician shortages as high as 50 percent in some areas for primary care doctors and more than 65 percent for specialists, and often are used to justify hiring additional physicians.

A better supply/demand model provides insight into the number of physicians actually needed by quantifying the impact of changing patient demographics on the demand side (such as increased consumer expectations related to timely access) and alternative care delivery methods on the supply side (such as use of non-physician professionals).
All delivery methods should be developed with physician input and in a culturally appropriate way that allows clinicians to practice at the top of their license. Thoughtful scenarios can be developed for different staffing models that use advanced practice providers (APPs), such as nurse practitioners and physician assistants, departmental support, and technology to extend the size of patient panels that can be served by the average primary care physician or specialist employed by the organization.

For example, one organization used supply-side modeling to estimate panel size served by an adult primary care medical group under three different pilot care models:
- Physician only
- Physician and APP
- APP (with departmental support)

Figure 1 clearly indicates that the care models using APPs enable larger panel sizes. Panel size with a physician plus an APP nearly doubles (3,000) that of a physician-only model (1,800). As shown in Figure 2 (page 3), per-patient cost is lower with the models using APPs ($178) than the physician-only model ($248); however, care should be taken to ensure that patients are appropriately assigned to models that align with their specific care needs. Additionally, the piloted care models using APPs demonstrated improved patient satisfaction and access. The full analysis across the organization’s primary care enterprise suggested that costs would decrease by $8.6 million to $9.9 million in salaries and fringe benefit savings alone, as physicians increase their panel count capacity due to improved operational and clinical efficiencies provided by non-physician providers.

Panel size also can be used to inform the mix of primary care physicians and specialists. Over time, most groups need to evolve to be heavily weighted toward primary care. Leadership teams should think differently about panel sizes and should not assume that historical experience should guide projected levels. Most physician groups are carrying a panel size well below optimized levels.

Supply-side studies that can be used to identify the right number of physicians include:
- Analysis of the productivity of the existing physician enterprise to determine where increased capacity is required based on overly full schedules or relative value units (RVUs) in excess of reasonable levels
- Assessment of the organization’s access metrics, such as “days to next-available appointment” and “third-available appointment,” along with evaluation of scheduling practices
- As described more fully in the next section, review of current physician performance to identify high and low performers (physician leadership in such review is critically important)

Finally, financial/affordability analyses should be conducted to identify how much an organization can spend to subsidize the physician enterprise, given system-wide operating results, capital needs, and other factors. Concurrent consideration of capital spending to acquire physician practices, build/retrofit facilities, upgrade information technology, and other major initiatives must be based on solid business plans with uniform criteria that ensure consistent evaluation across opportunities.

Optimize Practice Operations and Staffing
This is a book-length subject, but consideration of a few key issues provides a place to start: benchmark use for clinical improvement, non-physician staffing formulas, and “top-of-license” practice.

SIDEBAR 1
Current Realities with Hospital-Employed Physicians

- The shift to hospital employment continues, with more than half of physicians not having an ownership interest in a practice, according to the most recent data from the American Medical Association.
- Many health systems have seen flat-to-declining volumes, despite the growth in their employed physician base.
- The continuous pressure to increase productivity to drive compensation has reached a level of diminishing returns for many health systems.
- Investors and the agencies that rate healthcare debt are closely watching hospital losses from physician practices. They are citing such losses, among other reasons, for rating downgrades.
- “Downstream” revenue calculations for acquired practices are no longer reliable given factors such as increased outpatient competition, lower payment rates for diagnostic services, and erosion of inpatient services as healthcare moves to ambulatory and virtual delivery.
- Annual subsidies of the physician enterprise include net losses per employed physician as high as $560,000 for neurosurgery practices and $163,000 for primary care practices. These subsidies represent the new costs of doing business for health systems that are significantly different than historical business costs.

Note: Net investment per physician calculation based on 2016 data from the American Medical Group Association.

Benchmark use for clinical improvement. An organization-wide approach to performance improvement is supported by a commitment from the leadership team to aggregate, analyze, and disseminate credible data to clinicians related to quality, outcomes, and cost. Benchmark data and advanced analytics using such data enable leaders, quality assurance professionals, and physician/nursing teams to compare clinician performance against historical trends and peer groups. Patterns of performance emerge based on factors such as diagnosis, co-morbidities, treatment type, outcomes, costs, and patient satisfaction. High-performing clinicians can be identified and their practices studied for replication by their peers, as appropriate.

Non-physician staffing formulas. Getting to the right number of non-physician staff is both an art and a science. Traditional non-physician staffing formulas (science) have been based on a per-physician FTE, using median industry benchmarks to identify the number of required staff. A more comprehensive approach (art + science) considers physician productivity. It supports physicians who are working at near or peak capacity with additional staff to meet their unique needs. Also important to appropriate staffing is the issue of access to non-physician staff needed by specific populations, such as those with extra acute, chronic, or preventative care needs. Flexibility in staffing formulas is required.

Top-of-license practice. A proven means to avoid unnecessary costs, top-of-license practice involves professionals working to the full extent of their education and training, avoiding the waste involved in doing procedures or tasks that could be done by someone with less education and training. System benefits

SIDEBAR 2

Questions to Ask Related to the Right Number of Physicians

- Which services are expected to grow, and which likely will shrink?
- Where is geographic growth or attrition expected?
- In which markets and with which services does the organization have a distinct competitive advantage?
- As community needs are identified and benefits assessed, might service lines in two health system hospitals be combined? Might some services be reduced or contracted to third-party providers?
- In which services can non-physician clinicians increase the efficiency of delivered care, reducing the number of required physicians or extending physician panel size?
- What are the implications of call coverage and training requirements?
- What is the current mix of primary care physicians relative to specialists, and how will this mix change?

Source: Kaufman, Hall & Associates, LLC.
from having everyone practice at the top of their license include improved reimbursement and clear delineation of tasks, procedures, and duties. Patients also benefit from having clinicians whose skills are continually improving with use. To optimize operations, top-of-license practice entails the following:

- Physicians provide only high-acuity care
- Moderately acute care is provided by APPs
- Management of chronic illness is shared by physicians, APPs, and RNs
- Telemedicine is used as appropriate between providers and directly with patients
- Pre-visit preparations are performed by support staff to decompress the patient visit time

Dynamic use of facility space under different care models can set the stage for the patient experience while effectively using backstage space to co-locate key processes and create visual cues. Such cues ensure the communication that keeps providers on track with top-of-license duties.

**Align Compensation and Performance Goals**

Physician compensation that provides fair and stable income while aligning with hospital goals is the single most important factor driving the future performance of a hospital’s physician enterprise. The key principle is to develop uniform compensation standards and metrics that are applied consistently across physicians, locations, and specialties. Standards should cover work effort/productivity, quality, cost-effectiveness, and patient access, and should support the organization’s strategic objectives. Sidebar 3 (page 5) lists characteristics of better-performing compensation plans.

**FIGURE 3. EXAMPLE OF COMPARATIVE COMPENSATION ANALYSIS BY SPECIALTY IN A HYPOTHETICAL ORGANIZATION**

Of the numerous compensation models used nationwide, compensation per work relative value unit (wRVU) remains the preferred method for a number of reasons:

- The physician is held accountable only for his or her productivity and clean charge entry
- The compensation per wRVU can be adjusted to reflect changes in net collections
- The method allows for the integration of quality, service, access, and strategic metrics, and rewards physicians based on health system goals, such as achieving high levels of patient satisfaction or expense management (e.g., through creation of “shadow wRVUs” paid out in proportion to productivity)
Beginning arrangements for wRVU-based compensation—with incentives for quality, access, service, and other metrics layered on top—typically are 70 to 85 percent productivity based and 15 to 30 percent incentive based.

A comparison of physician compensation by specialty with an industry benchmark is recommended. Figure 3 (page 4) shows percentage variance in compensation by specialty from an industry median based on a conversion factor with compensation per wRVU. Compensation in this organization varies much more than it should, with many physicians receiving less than median compensation (marked by the blue line) and some very expensive outliers receiving 40 to 60 percent more than median compensation. The hospital or health system carries risk associated with those physicians who receive considerably less than median compensation, due to the higher possibility that they may depart for employment elsewhere.

**Improve Network Integrity**

High network integrity requires a high-functioning referral management process. In such a process, physicians and other clinicians in hospital-owned practices refer patients to the parent organization’s providers (hospitals, post-acute providers, and other physicians employed by the organization), as appropriate to patient-care needs. Without such a process supported by high-quality data, analytics, tools, and a thoughtfully designed system to provide appropriate access, patients may seek care directly from an out-of-network provider who is not incentivized or aligned to manage that care.

“Leakage” to non-network providers—whose costs are then attributed to the network—can significantly increase the total cost of care while potentially providing lower quality and less-coordinated care. Goals are to keep care local, where appropriate, and to retain as many of the diagnostic and treatment services as contracts allow. Reasons for leakage include lack of available “in-house” services, medical necessity, patient preference, and physician preference/referral relationships.

An analysis of patient referral flows (or lack thereof) between hospital-owned physician practices and to other owned facilities helps to identify opportunities to reduce internal leakage and enhance alignment with key affiliated provider groups. These findings can inform consumer-facing strategies and the supply-side need analysis mentioned earlier.

Figure 4 illustrates the level of leakage/improvement opportunities by specialty and market for one employed primary care medical group. This group experienced a medium level of leakage with local hematology/oncology referrals (20 to 50 percent of referrals), for example. The group felt that exploration of improvement opportunities might prove productive. Further analysis indicated that patient preference accounted for 40 percent of the leakage, lack of available in-house physicians accounted for 36 percent, while provider preference accounted for 17 percent. Redesigning the patient clinic experience could positively impact patient

continued on page 6

### Sidebar 3.

**Characteristics of Better-Performing Compensation Plans**

- Align organizational and physician goals
- Align physician work effort to compensation
- Use objective measures that enable benchmarking
- Employ relatively few performance measures
- Have clear definitions that are applied consistently
- Are relatively simple and easy to understand
- Are financially viable for the organization and physician(s) and sustainable over the long term
- Meet regulatory requirements

### Figure 4. Example of Summary of Internal Referral Leakage Opportunity in a Hypothetical Organization

<table>
<thead>
<tr>
<th>Specialty Referral</th>
<th>Local</th>
<th>State</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
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<tr>
<td>Cardiology</td>
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<tr>
<td>General Surgery</td>
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<tr>
<td>GI / Colorectal Surgery</td>
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<tr>
<td>Hematology/Oncology</td>
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<tr>
<td>Neurology</td>
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<tr>
<td>Neurosurgery</td>
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<td>Orthopedics</td>
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<td>Otolaryngology</td>
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<tr>
<td>Pediatric Specialties</td>
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<tr>
<td>Physical Medicine and Rehabilitation</td>
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<tr>
<td>Pulmonology and Sleep Medicine</td>
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<tr>
<td>Urology</td>
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</tbody>
</table>

**Level of Leakage/Priority**

- High (>50%)
- Low (<20%)
- Medium (20%–50%)
- Specialty not currently offered by Medical Group

Source: Kaufman, Hall & Associates, LLC.
preferences; extending physician panel size with use of APPs could reduce leakage due to lack of physicians.

**Potential Future Scenarios**

The current approach to physician employment used by many hospitals and health systems likely is unsustainable in the short or long term. Given this reality, three scenarios can be considered.

First is divestiture and exiting physician practice ownership through sale of the practice to physicians, similar to what occurred in the 1990s. This scenario is unlikely given the tough economics and operational and compliance challenges of private, independent practice.

Second is the sale of practices to for-profit or not-for-profit entities that employ physicians, private equity groups, and others. These entities typically aggregate physicians/groups in regions with the intent to manage as much care as possible locally and direct as much care as appropriate away from hospital settings.

The third scenario, which is recommended, is for hospitals to optimize their physician operations, ensuring the right investment by pursuing the four strategies offered here. Improved data, analytics, and tools to measure the performance of the employed physician operation will enable hospitals and health systems to rightsise and right-locate employed physicians and non-physician professionals, optimize practice operations and staffing, align compensation and performance goals, improve network integrity, and make the necessary adjustments for a more sustainable future.

For more information, contact Walter Morrissey (wmorrissey@kaufmanhall.com) and Dawn Samaris (dsamaris@kaufmanhall.com) at 847.441.8780.

**REFERENCES**

Innovation Drives Development of Two New Software Products for Healthcare

Jay Spence

Constant change in the healthcare industry, coupled with cost and quality pressures, leave provider organizations looking for more creative and strategic ways to improve operational, clinical, financial, and strategic performance. With 30+ years of serving the ever-changing needs of healthcare organizations, Kaufman Hall continues to develop innovative software solutions, investing in products that respond to today’s opportunities and challenges, and provide tools and technologies that will serve clients in the many years ahead.

Kaufman Hall clients received a preview of two new software solutions for strategic initiative management and comparative analytics at the firm’s Performance Management Summit in March. The company also showcased these solutions at the HFMA Annual Conference June 24-27.

Axiom Strategy Management enables healthcare leaders to centrally guide and manage strategic performance improvement initiatives across their organizations. The solution structures a comprehensive view of organizational performance, providing visibility into key performance measures in the context of defined strategic goals and organizational objectives (Figure 1). It also improves alignment across management levels with tools that enable new initiative planning through on-going tracking, and features that promote collaboration in managing ongoing project milestones, with clear visibility into progress related to specific project goals.

Designed for organizations seeking to manage strategic performance improvement initiatives from the planning phase through results realization, this solution helps to align the organization around performance improvement activities that are most impactful to improving financial, clinical, and operational improvement outcomes.

Axiom Comparative Analytics offers hospitals and health systems the industry’s most robust and up-to-date set of information, and a clearer path to understanding and improving financial performance. This solution generates financial, payroll, and utilization metrics for comparison across a healthcare organization, and with relevant, industry peers for a data-driven view of organizational performance.

The comparisons are enabled through a uniform classification process developed by Kaufman Hall that minimizes the burden for users and provides value across similar operation segments. These discoveries offer invaluable information for organizations, enabling them to identify root-cause issues and develop initiatives to address them. As a result, healthcare leaders can develop more meaningful key performance indicators and quickly take action on financial issues that may have a material impact on the organization’s bottom line.

To learn more about Axiom Strategy Management and Axiom Comparative Analytics, or to request a demonstration, visit our website at https://www.kaufmanhall.com/.

Jay Spence can be reached at jspence@kaufmanhall.com or 847.441.8780.

FIGURE 1. SAMPLE EXECUTIVE DASHBOARD

Source: Kaufman, Hall & Associates, LLC.
Siddhartha Mukherjee, M.D., D.Phil.

Oncologist, researcher, professor, and Pulitzer Prize-winning author

Three Visions of the Future of Healthcare
Thursday, October 18, 9:30 a.m.

One of the greatest minds in medicine and science, Dr. Mukherjee will share his thoughts about healthcare’s future. A professor at Columbia University Medical Center and the director of an innovative laboratory, he is the author of *The Emperor of All Maladies: A Biography of Cancer, The Gene: An Intimate History,* and dozens of articles in scientific journals. Dr. Mukherjee’s interests span the breadth of challenges facing healthcare, including what individual clinicians can do to fix spiraling costs, the struggle of navigating the treatment of patients with addictions, and whether better data and the ability to harness such data offer the medicine we’ve been looking for.

Scott Galloway

Professor, entrepreneur, and foremost thinker on the power of big-tech companies

The Hidden DNA of Amazon, Apple, Facebook, and Google
Thursday, October 18, 11:00 a.m.

Scott Galloway will explore how the four most influential companies on the planet have infiltrated our lives so completely, and whether anyone can challenge them. Clinical Professor of Marketing at New York University's Stern School of Business, and Founder of L2 and eight other firms, he is the author of *The Four: The Hidden DNA of Amazon, Apple, Facebook, and Google.* In 2012, Galloway was named one of the "World's 50 Best Business School Professors." His weekly YouTube series, "Winners and Losers," has had tens of millions of views.
Harry Kraemer  
Former Chairman and CEO of Baxter International

**Becoming the Best**  
Thursday, October 18, 1:30 p.m.

By popular demand, Harry Kraemer returns to share tools for becoming the best leader, the best organization, and the best person. The author of two bestselling books—*From Values to Action* and *Becoming the Best*—Kraemer is currently Clinical Professor of Strategy at Northwestern University’s Kellogg School of Management. He is an executive partner with Madison Dearborn Partners, one of the largest private equity firms in the U.S., and former Chairman and CEO of Baxter International.

Kenneth Kaufman  
Chair, Kaufman Hall

**The New Healthcare Ecosystem**  
Wednesday, October 17, 2:15 p.m.

Known for his powerful insights on healthcare disruption, Kenneth Kaufman will kick off the conference on Wednesday afternoon with his observations on how huge new competitors and partnerships are trying to fundamentally change healthcare—and how hospitals and health systems can play a leading role in the future delivery system. Kaufman has delivered more than 400 speeches and is the author of seven books, including *Fast and Furious: Observations on Healthcare’s Transformation*.

James H. Hinton and Maryjane Wurth  
A leading health system CEO and an executive of the American Hospital Association

**Meeting Disruption Head On**  
Wednesday, October 17, 3:45 p.m.

In a conversation with Kaufman Hall Chair Kenneth Kaufman, James Hinton, the CEO of one of the nation’s most innovative health systems, and Maryjane Wurth, a senior leader of the American Hospital Association (AHA), will share their ideas on how hospitals and health systems can stay relevant amid strong forces aiming to disrupt the hospital industry. Hinton is CEO of Baylor Scott & White Health, which is the largest not-for-profit healthcare system in Texas and one of the largest in the U.S. Wurth is AHA’s Executive Vice President and Chief Operating Officer, and President and CEO of Health Forum, which supports hospitals and leaders by providing education, data, tools, and other resources.

**ALL NEW FRIDAY PANELS**

**What’s Next for Private Equity and Healthcare?**  
Friday, October 19, 8:00 a.m.

Learn from our panel of experts about new partnership possibilities that will take healthcare in innovative directions.

- **Elizabeth Q. Betten**  
  Managing Director, Madison Dearborn Partners

- **Paul Moskowitz**  
  Vice President, Private Equity, Bain Capital Private Equity

- **Rich Roth**  
  Chief Strategic Innovation Officer, Dignity Health

- **R. Wesley Champion**  
  CEO, Kaufman Hall

**What Disruption Could Mean to Your Credit Rating**  
Friday, October 19, 9:15 a.m.

In this interactive session, hear how the top analysts are thinking about the credit-rating impact of megamergers, payer moves, AI, retail health, and more.

- **Martin Arrick**  
  Managing Director, S&P Global

- **Lisa Goldstein**  
  Associate Managing Director, Moody’s Investors Service

- **Kevin Holloran**  
  Senior Director, Fitch Ratings

- **Therese L. Wareham**  
  Managing Director, Kaufman Hall
The Healthcare Financial Management Association (HFMA) and Kaufman Hall recently announced the creation of the Financial Analytics Leadership Council. The goal of the new council is to drive change in the healthcare industry’s approach to financial decision support, reflecting the increasingly important role of analytics in managing financial performance.

Key findings from Kaufman Hall’s recent national survey of senior financial executives working in healthcare indicate a pressing need for guidance on how to develop stronger analytical systems and practices:

- 90 percent of respondents state that their organizations should do more to leverage financial and operational data to inform strategic decisions.
- 70 percent have either no cost measurement tools, or tools they describe as too simplistic or as sources of inaccurate data.
- 84 percent view peer financial benchmarking activity as important, yet just 56 percent are benchmarking their organizations’ performance against industry peers.

“Senior healthcare executives know all too well the challenges of harnessing data for decision making,” says HFMA President and CEO Joseph J. Fifer, FHFMA, CPA. “Guidance provided by this council will be invaluable in meeting and overcoming the challenges that organizations are facing.”

Executives from several leading health systems have signed on to be part of the Financial Analytics Leadership Council steering committee that will work with HFMA and Kaufman Hall representatives to organize educational programming. Steering committee members include:

- Brady Boudreaux, Vice President Financial Analytics for Memorial Hermann Health System
- Martin D’Cruz, Vice President Managed Care for St. Vincent Health-Indianapolis, part of the Ascension Health network
- Damara Harper, Director of Business Intelligence and Decision Support for North Kansas City Hospital
- Rebecca McArthur, Corporate Director of Financial Systems Deployment for OhioHealth
- Dawn Short, Director of Financial Reporting and Decision Support for Sparrow Health System

“Never have financial analytics been more critical to the mission of healthcare,” says McArthur. “Making it a priority, participating in the discussion, and working toward best practices as an industry have become imperatives.”

An initial steering committee meeting took place in conjunction with the HFMA Annual Conference in late June. Moving forward, the council will outline a series of programs that will take place over the second half of 2018 and early 2019. Those interested in learning more about the Financial Analytics Leadership Council should contact Chuck Alsdurf, HFMA Director of Finance Policy and Operational Initiatives, at calsdurf@hfma.org.

Kaufman Hall Names New Leader for Healthcare Performance Improvement Practice

Healthcare performance improvement expert Lance Robinson recently joined Kaufman Hall as Managing Director and leader of the firm’s Performance Improvement practice.

“Kaufman Hall has a long history of hiring the best of the best financial consulting talent to help build great practices that can solve the toughest business challenges our clients are facing,” said Wes Champion, CEO of Kaufman Hall. “Lance brings more than two decades of financial leadership experience along with a proven track record of success serving some of the largest and most complex clients in healthcare. We are excited to add an executive of his caliber to our roster.”

Robinson will help Kaufman Hall continue to redefine the way healthcare organizations view performance improvement. A recent Kaufman Hall survey shows that while 96 percent of healthcare leader respondents say cost transformation is a “significant” to “very significant” need for their organizations today, more than half have either no goal for the next five years, or a goal of only 1 percent to 5 percent improvement over that period. Kaufman Hall is looking to close this gap by expanding the definition of performance improvement to address changes needed to reduce the total cost of care, including margin improvement, business reconfiguration, and clinical redesign.

Prior to joining Kaufman Hall, Robinson was a Partner at the Berkeley Research Group (BRG), where he led integrated performance improvement engagements, which resulted in substantial growth in the firm’s revenue and market reputation. He also served as the non-labor service line leader for BRG’s Healthcare Performance Improvement practice. He previously held leadership positions on the consulting and provider sides, including Senior Vice President at MedAssets, Corporate Vice President of Supply Chain at Vanguard Health Systems, Director at PricewaterhouseCoopers, and Manager at Ernst & Young.

The addition of Robinson to the executive team is the latest in a series of significant investments Kaufman Hall has made to serve the long-term financial and business planning needs of its healthcare clients. Earlier this year, the company announced the appointment of Champion, formerly a Managing Director and the company’s Chief Operating Officer, to the position of CEO. It also introduced several new software products in June, including Strategy Management, Comparative Analytics, and Relationship Profitability and Pricing System, to help executives solve some of their most important business challenges in rapidly changing industries.

“Kaufman Hall has a tremendous reputation for innovation and client service excellence,” said Robinson. “The company offers a unique mix of consulting services, deep data analytics capabilities, and intelligent software solutions that answer many previously unmet needs. I am thrilled to have the opportunity to work with this team and its clients to reshape what performance improvement means in healthcare.”

Robinson is a graduate of the University of Alabama, where he earned both an M.B.A. in Accounting, and a B.S. in Health Care Management and Accounting.

Calendar of Events

The Governance Institute September Leadership Conference
Anatomy of a Merger: Building New Governance and Culture
Mark Grube
Partnering for Healthcare’s Transformation
Anu Singh
Sept. 25, 2018, Las Vegas, NV

Illinois Health and Hospital Association Fall Leadership Summit
When 5% is Not Enough: Radical Cost Transformation in Hospitals and Health Systems
Kristopher Goetz
Sept. 26, 2018, Lombard, IL

The Governance Institute October Leadership Conference
Anatomy of a Merger
Anu Singh
Oct. 9, 2018, Colorado Springs, CO

Iowa Hospital Association Annual Meeting
Strategic Pricing in an Era of Consumerism
Jason O’Riordan
Oct. 10, 2018, Des Moines, IA

FIHFMA Fall Summit
M&A in 2017: A Year that Transformed Healthcare
Deborah Pike
Oct. 23, 2018, Oakbrook Terrace, IL