



# Centura Health®

## CEO Report FY12

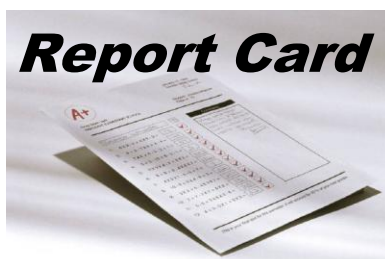
With added focus on






























































and



# Year in Review



Top Performer: 	On Plan: 	Uncertain/in Transition: 	Off Plan: 			What Plan?: 
Outcome Expectation	System <i>(Campbell)</i>	CHAH <i>(Denholm)</i>	SSG <i>(Sabin)</i>	SDG <i>(Haffner)</i>	MNDOG <i>(Brickman)</i>	MRMC <i>(Dignum)</i>
<b>Collaboration and Leadership Development</b> <i>(Ambory)</i>						
<b>Community Health Improvement</b> <i>(Hebert, King)</i>						
<b>Disciplined Entrepreneurship</b> <i>(Campbell)</i>						
<b>Growth</b> <i>(Nicholson)</i>						
<b>People</b> <i>(Ambory)</i>						
<b>Outcome Effectiveness</b> <i>(Brown, Pappas)</i>						
<b>Service and Partnerships</b> <i>(Brickman, Denholm, Haffner, Sabin)</i>						
<b>Stewardship</b> <i>(Enderson)</i>						
<b>Transformation</b> <i>(Campbell)</i>						

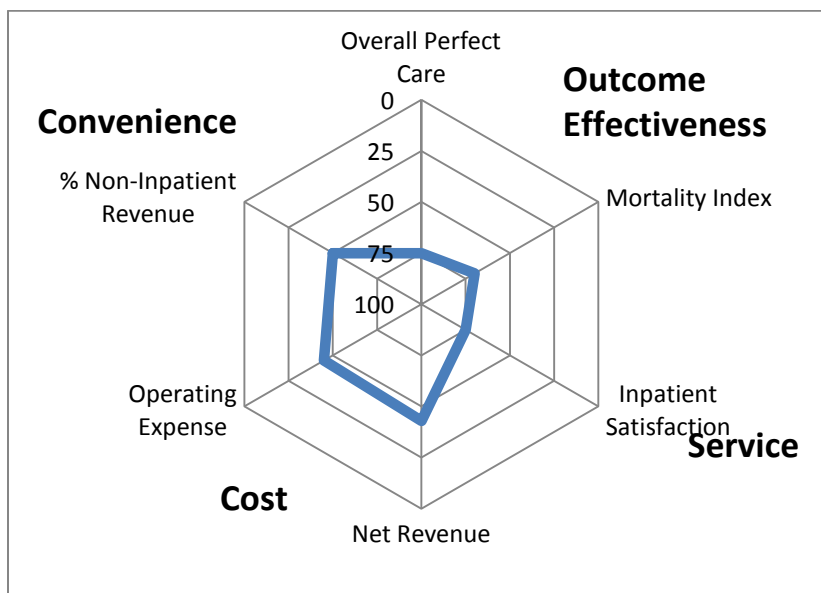
On balance, FY12 was a very challenging but reasonably good year where we made progress on a number of levels and fell short of our expectations in some areas. Although hospital inpatient volumes continued the decline here and across the nation, significant growth in physician practice and clinics visits, hospital outpatient visits, and emergency department visits fueled our case mix adjusted

admissions growth of nearly 5 percent. Despite the challenges from unexpected shifts in payer mix and thanks to some non-recurring gains, our operating EBITDA was at a record level of \$311 million or 13 percent of net revenue. Although our net revenue increased by an impressive 9 percent, our operating expenses increased by an anxiety inducing 9.6 percent. We did a reasonably good job with managing labor productivity, consuming 43.7 percent of net revenue on total compensation expense versus 44.6 percent last year.

Three very significant highlights for the year were the progress we made on “meaningful use” of information technologies (spotlighted below), our progress with talent management, and reaching the point where our average hospital is now in the top quartile for overall inpatient satisfaction. We had some wins and some shortcomings with respect to outcome effectiveness, and had some areas of improvement but we were generally disappointed with our associate satisfaction rankings.

Our organizational transformation efforts clearly escalated in FY12, yet we are experiencing profound market changes in Denver and Colorado Springs which challenge us to even further escalate our efforts. We have made considerable progress in developing Colorado Health Neighborhoods and conceptualizing the Second Curve Development Network, which together represent the main body of our transformation work.

Our overall Value Profile shows that our strengths are outcome effectiveness and service, while our greatest opportunity is with regard to cost.



## Focus on Information Technologies

Based upon the strong foundation we built over the past several years including excellent work on evidence-based practices, order set development, IT infrastructure (including data security) and more IT software enhancements and installations than I can count, FY12 saw significant dividends beginning to

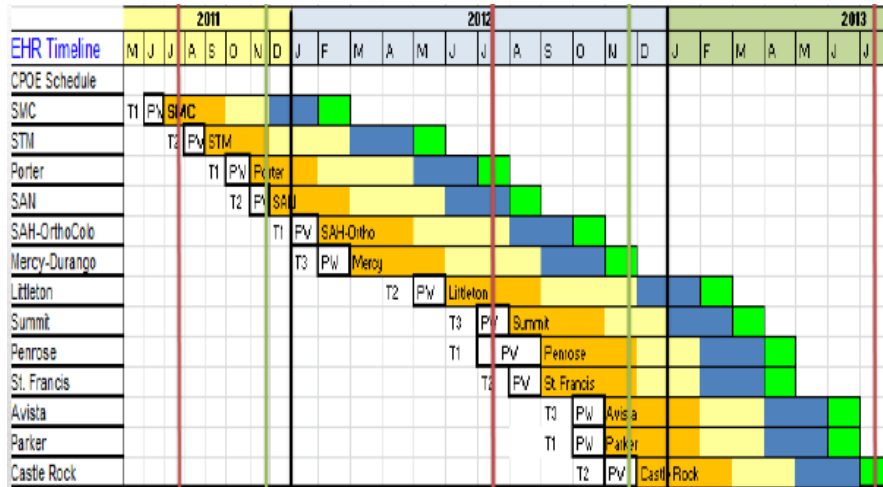
be realized from our efforts to achieve optimal “meaningful use” of information technologies for the benefits of our patients across the system. Late in the year, we received the first \$6 million installment on the ultimate \$42 million payoff (and avoidance of \$35 million in penalties) as detailed in the table that follows.

*Anticipated Meaningful Use Payments to Centura Health (by calendar year)*

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Medicare	\$0	\$13,558,881	\$10,169,160	\$6,779,440	\$3,389,720	\$0	\$0	\$0	\$0	\$0	\$0	\$33,897,201
Medicaid	\$0	\$4,034,888	\$3,227,911	\$806,978	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$8,069,777
Penalty	\$0	\$0	\$0	\$0	\$1,999,062	\$3,998,125	\$5,997,187	\$5,997,187	\$5,997,187	\$5,997,187	\$5,997,187	\$35,983,122
Totals	\$0	\$17,593,769	\$13,397,071	\$7,586,418	\$5,388,782	\$3,998,125	\$5,997,187	\$5,997,187	\$5,997,187	\$5,997,187	\$5,997,187	\$77,950,101

In addition to the financial payoff and penalty avoidance from meaningful use efforts, hospitals and providers across the nation are seeking to achieve the highly coveted recognition by the Health Information Management Systems Society (HIMSS) as being at Stage 7 in electronic medical record (EMR) adoption. Today, three of our hospitals (St. Mary-Corwin Medical Center, St. Thomas More Hospital, and Porter Adventist Hospital) have achieved Stage 6, along with less than 10 percent of the hospitals in the nation. After our remaining hospitals complete their CPOE “go-live” within the next several months, we expect all Centura Health hospitals to reach the rare air of Stage 6.

*CPOE “Go-Live” Schedule*



*HIMSS EMR Adoption Model*

Stage 7	Medical record fully electronic; CDO able to contribute to EHR as byproduct of EMR
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS
Stage 5	Closed loop medication administration
Stage 4	CPOE, CDSS (clinical protocols)
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology
Stage 2	CDR, CMV, CDSS inference engine, may have Document Imaging
Stage 1	Ancillaries – Lab, Rad, Pharmacy – All Installed
Stage 0	All Three Ancillaries Not Installed

Although we are making considerable progress toward meaningful use in both our hospitals and physician practices, there have been and will continue to be considerable challenges, particularly related to our ambulatory electronic health records (EHR) system. Known as LSS, the EHRs we are installing in all CHPG practices offer one distinct advantage and a very glaring disadvantage. Because LSS is integrated into our hospital information system (MEDITECH), we are able to seamlessly exchange information and inter-operability between our physician practices and hospitals. Unfortunately, whereas MEDITECH/LSS offers the best overall suite of products for our specific situation, LSS by itself is by no means a “best in breed” product. The decision to go with the LSS electronic health record system was fully vetted through a 90-day long Values in Action (VIA) process that concluded in February, 2010 and included twenty-four stakeholders (with eight physicians directly participating). Despite the results of the VIA, today most CHPG physicians are highly dissatisfied with LSS, reporting it to be “clunky” and “inferior.” Our CHPG and IT leaders have been working with MEDITECH for several months to significantly improve the LSS product, and while discernible progress is being made, it is not nearly good enough or fast enough. Very recently, in an attempt to turbo-charge these efforts, MEDITECH has tripled the number of software developers assigned to our specific needs.

## Focus on Variation

### **Variation is essential for survival of the species.**

-Loose interpretation of the works of Charles Darwin.

### **Variation is horrible for quality of the product.**

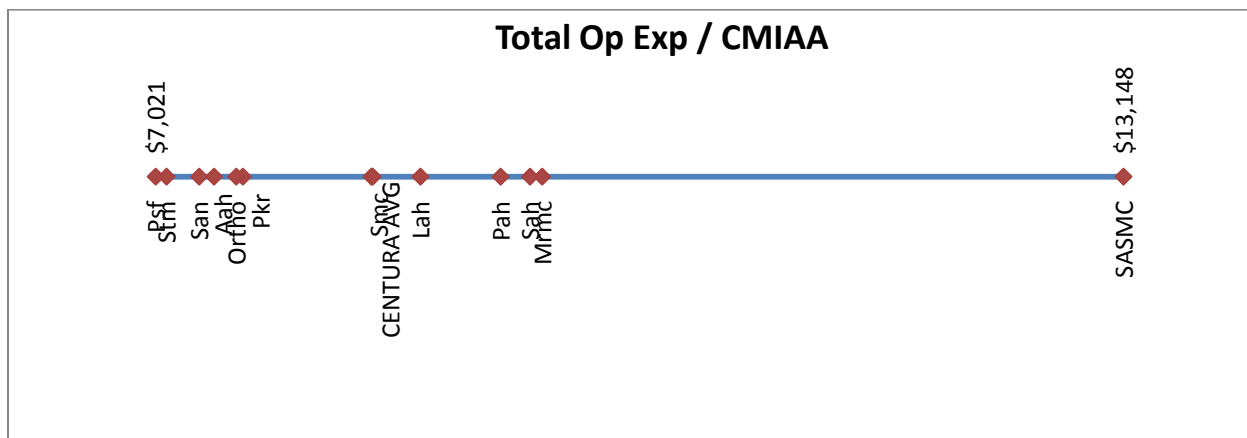
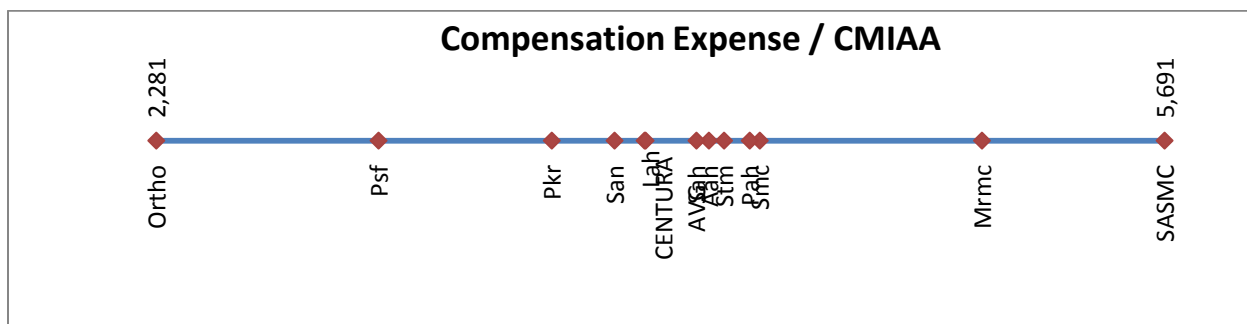
-Loose interpretation of the works of W. Edwards Deming

Depending on one’s perspective, variation results in either survival or failure, and the lack of variation either results in extinction or long-lasting success. Those seem like pretty stark and contradictory options! In reality, variation is both good and problematic. Variation from proven successful practices is wasteful and unproductive. Yet when the best course is uncertain, variation should be embraced because it increases the probability that one will ultimately arrive at the desired destination. Either way, variation is costly and should be carefully monitored. Even in circumstances of uncertainty where variation increases one’s probability of finding the best course, one can hardly afford to pursue an endless variety of options. Just as problematic, it does an organization little good for one small scout team to find the location of the promised land if they are the only ones to know of that location. There must be a high degree of rigor and coordination applied to variation in organizations. Unnecessary variation in proven processes should be minimized or eliminated. Even necessary and essential variation in times of uncertainty must be carefully planned, monitored and communicated to ensure minimal waste and maximal opportunity for everyone to learn together.

Given the reality that many of our entities existed for 100 years before Centura Health was formed in 1996, there is considerable variation in process, structure and outcome throughout the organization. Whether that variation is necessary or unnecessary is in the eyes of the beholder. Many of us are inclined to judge our own variation necessary and everyone else’s unnecessary. If indeed our approach is generating demonstrably better and fully transferable results, we are probably right. Yet there are many situations where our results are not demonstrably better and/or they are due to our unique

situation and not applicable to other situations. There are also many situations where we engage in endless debate over whose results are the best, how “results” should be defined and measured, and the degree to which our own situation is unique and incomparable to others. In my dictionary, the definition of benchmarking is “the endless pursuit of validation that you are very good.” For many of us faced with benchmark data seemingly implying that we are not destined for the gold medal, our tendency is to attempt to invalidate the metrics or otherwise show they are inappropriate benchmarks for us.

Since 2008, all Centura Health senior executives have held ourselves to “joint and several” accountability for achieving a position where we balance discipline and entrepreneurship. This disciplined entrepreneurship is exactly the balance we must achieve relative to variation. We want to eliminate unnecessary variation and stimulate thoughtful, coordinated, necessary variation. The Disciplined Entrepreneurship section of prior month versions of this report have recounted our progress in that regard, and the remainder of this section will focus on areas where we may have unnecessary variation. With no intended prejudice for or against the underlying rationale, the tables below show differences in the total costs of treating various inpatients in our hospitals. After adjusting for volume and case mix, among our hospitals we have a 149 percent variation in staff compensation expense and an 87 percent variation in total operating expense. Certainly, the comparatively high cost structure for SASMC is a reflection of what it takes to operate a top-notch hospital with relatively low patient volumes. The relatively low total cost structure at PSF reflects the economies of scale associated with our largest hospital. Even if we exclude the four greatest outliers at both ends of the spectrum, our cost variation exceeds 30 percent. It is highly questionable whether all of this variation is necessary.



The following tables show the variation between our hospitals for inpatient care for just two relatively high volume diagnoses. The variance between our hospitals in the average cost per case for one of the most routine diagnoses (normal vaginal delivery) is 65 percent while the variation for a more complex case (joint replacement) is 118 percent. Economies of scale due to high volumes do not appear to be a reliable determinant of low cost.

*Cost Variation for Selected High Volume Diagnoses*

<i>DRG 775 Normal Vaginal Delivery</i>		
<b>Entity</b>	<b>Cases</b>	<b>Avg Dir Cost/Case</b>
<b>AAH</b>	1,129	\$2,097
<b>PKR</b>	894	\$2,333
<b>STM</b>	151	\$2,673
<b>SFMC</b>	1,653	\$2,865
<b>SASMC</b>	212	\$3,368
<b>LAH</b>	1,057	\$3,430
<b>SAN</b>	595	\$3,458
<b>SMC</b>	345	\$3,465

<i>DRG 470 Major Joint Replacement</i>		
<b>Entity</b>	<b>Cases</b>	<b>Avg Dir Cost/Case</b>
PH	849	\$8,263
ORTHO	1,151	\$10,148
STM	115	\$10,884
AAH	235	\$10,971
SAH	221	\$11,003
SAN	106	\$11,156
PAH	1,251	\$11,521
SFMC	328	\$12,247
PKR	227	\$12,957
SMC	311	\$13,777
LAH	184	\$16,613
SASMC	64	\$18,053

Of course a major determinant of clinical cost variation among hospitals is different clinical practice patterns by physicians. Just within our highest volume hospital for DRG 470 Major Joint Replacements (PAH) and only among those seven surgeons who performed more than 40 of these particular cases in FY12, the average cost per case varied by 25 percent.

Variation is not exclusive to clinical practices, and there is certainly variation among our hospitals in a wide range of areas including the effectiveness of our care coordination activities, the amount of overhead expense, our ability to deliver “Perfect Care,” case-mix adjusted average length of hospital stay, and even the amount of money spent on advertising. In fact, among our hospitals in FY12, advertising expenditures adjusted for the size of the hospital carried a 143 percent variance. Variation is a reality for us, and while we have historically been able to afford unnecessary variation, that is no longer the case. The Value Optimization Council under the direction of Jeff Brickman and Clinical Integration and Standards Council under the direction of Steve Brown and Sharon Pappas are both focused on minimizing unnecessary and ineffective variation throughout the system. The Growth and Innovation Council is focused on promoting coordinated entrepreneurship. The combined efforts of these Councils over the coming months are essential for Centura Health to truly achieve disciplined entrepreneurship.

# Outcome Effectiveness

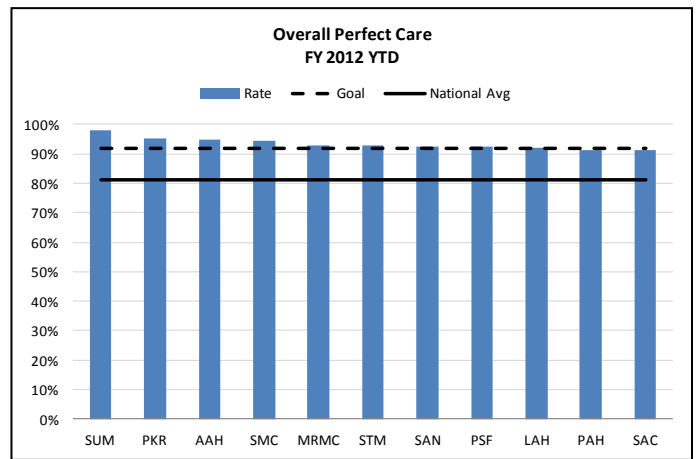
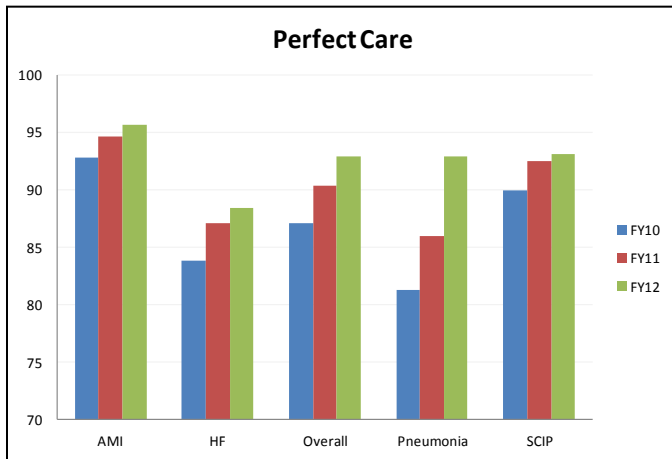
The environments of care in our organizations are carefully planned and operated in a manner that leads toward optimally effective and long-lasting clinical outcomes. (Executive Champions: Steve Brown and Sharon Pappas)



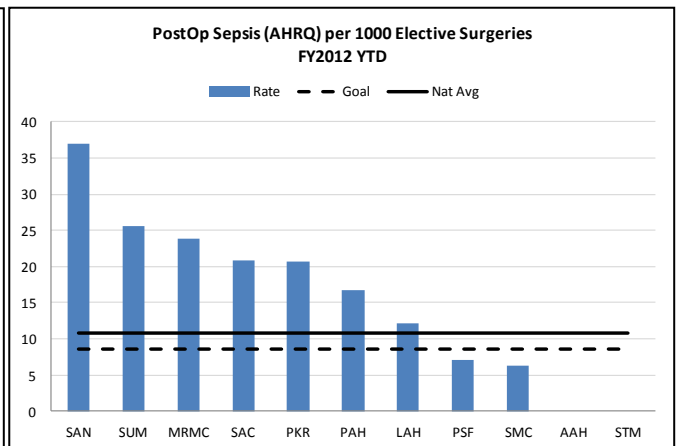
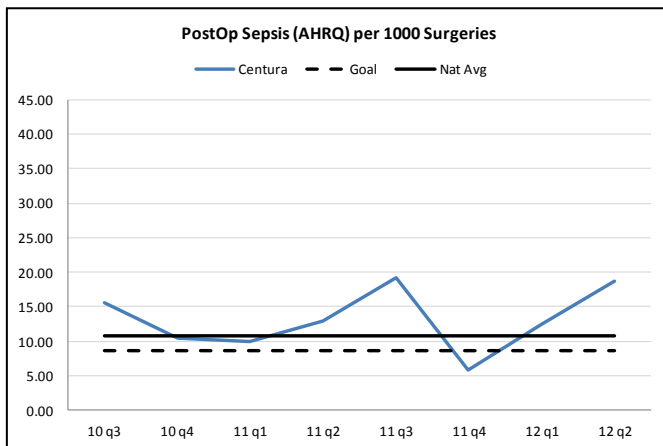
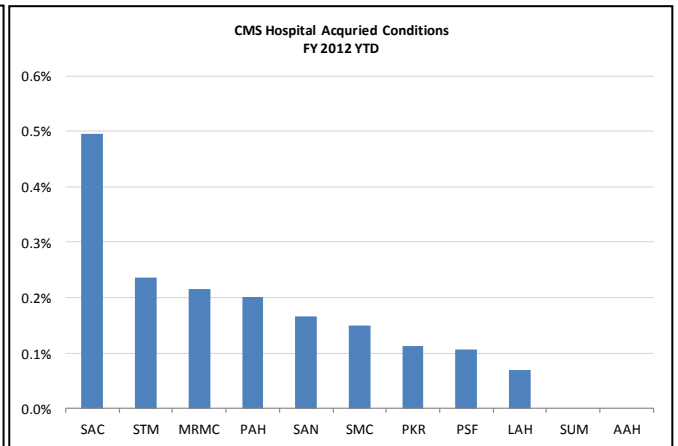
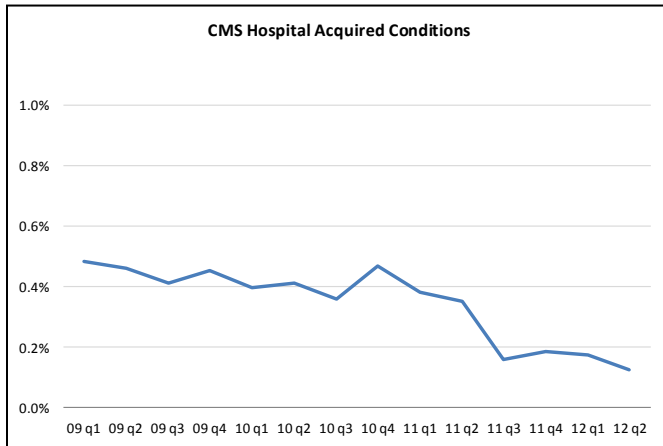
	Goal	Benchmark	Trend	MNDOG	SDG	SSG
<b>Acute Care</b>						
<b>Evidenced Based Process Measures</b>						
Overall Perfect Care	92%	81%	→	92.58%	92.74%	93.12%
AMI Perfect Care	99%	90%	→	94.24%	96.32%	96.46%
Heart Failure Perfect Care	98%	81%	→	89.24%	93.49%	84.53%
Pneumonia Perfect Care	95%	81%	→	91.51%	91.33%	96.32%
SCIP Perfect Care	91%	77%	→	93.38%	92.40%	93.41%
Overall Composite Score			→	93.15%	95.91%	94.40%
<b>Patient Safety</b>						
Inpatient Occurrences With Injury	0.20	0.27	→	0.29	0.33	0.32
CMS Hospital Acquired Conditions	0.19%	0.27%	→	0.25%	0.13%	0.12%
Accidental Puncture or Laceration (AHRQ)	2.30	2.88	→	2.26	2.72	2.58
Pressure Ulcer (AHRQ)	4.14	5.18	→	0.75	0.70	0.16
PostOp Sepsis (AHRQ)	8.59	10.74	→	21.74	16.50	6.51
PostOp PE or DVT (AHRQ)	5.82	7.28	→	13.36	5.83	4.47
<b>Hospital Acquired Infections</b>						
Ventilator Associated Pneumonia	1.30	2.3	→	3.7	0.2	1.6
Central Line Infections	0.75	1.5	→	0.9	0.8	0.2
Hip/Knee Infections	0%	0%	Down	0.0%	1.1%	0.4%
Catheter Associated Urinary Tract Infection	0.26	0.32	→	1.32	0.26	0.20
<b>Acute Care Outcome Measures</b>						
Mortality Rate Index (O/E)	0.60	1.00	→	0.63	0.58	0.79
30 Day readmit rate	9.3%	10.3%	→	10.0%	12.0%	11.4%
HCAHPS Value Based Purchasing Score	54	Meets Target	→	73	55	54

We are pleased to report that we met our system-level goal for the year to achieve at least 92 percent “Perfect Care;” the result of continuing focus over the past several years. However, despite our improvement and goal attainment, our scores lag several other Colorado health systems. The chart on the top right of the following page shows our performance by hospital.





As illustrated in the charts below, we have seen a steady decrease in the number of iatrogenetic conditions over the past three years, with St. Anthony Hospital providing our current greatest opportunity for further improvement. We have also seen a recent increase in post-operative sepsis, with several hospitals exceeding our goal and the national average for this metric.



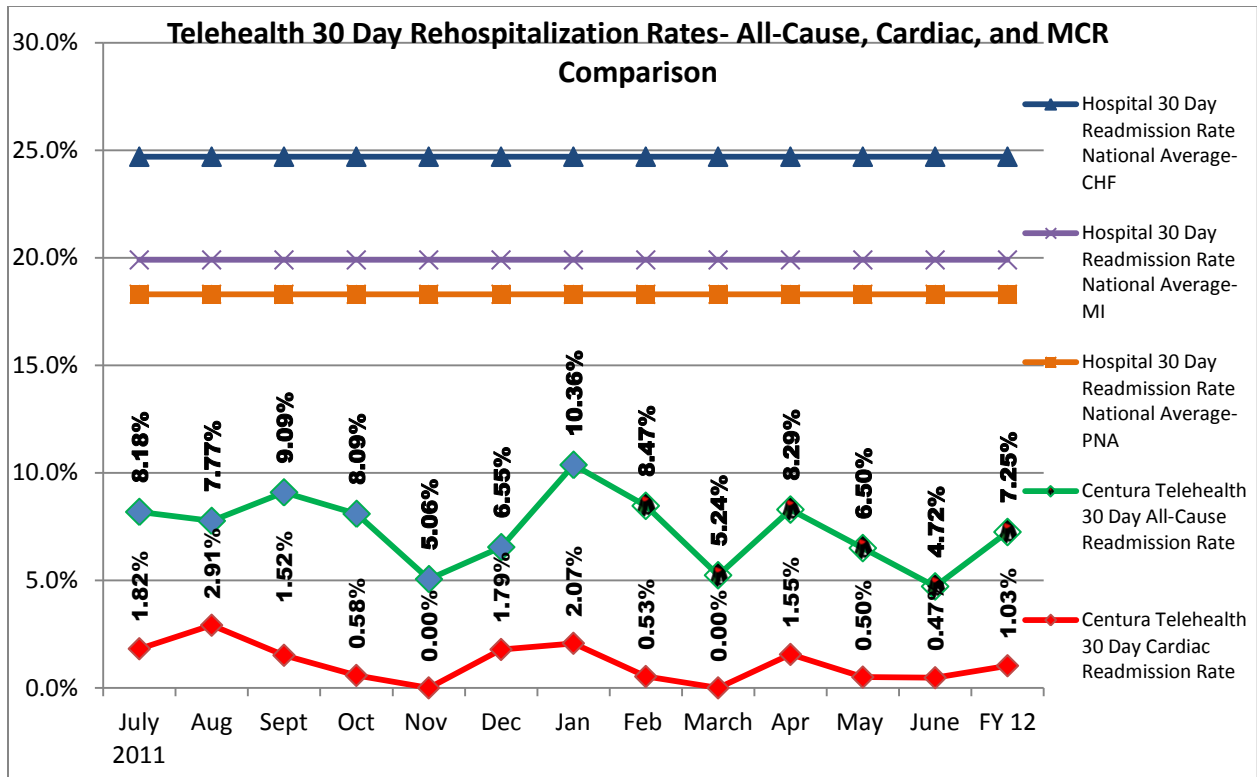
As reflected in the following table, our ambulatory care metrics are modest in number, showing mixed performance results. In the near future, we will be in a position to show significantly increased sophistication in monitoring outcome effectiveness in Centura Health Physician Group.

	Goal	Benchmark	Centura
<b>Ambulatory Care (CHPG)</b>			
CMS Meaningful Use Measures			
Adult Weight Screening	68%	24%	45.33%
Hypertension: BP Measurement	100%	66%	98.33%
Preventative Care: Tobacco Use	88%	80%	72.5%
Medication Reconciliation			
Med Rec Completed	80%	80%	84%
Satisfaction			
Likelihood of you recommending this provider	93%	90%	92.9%

	Goal	Benchmark	Trend	Centura
<b>Centura Health at Home</b>				
Home Care				CHAH
Acute Care Hospitalizations	18%	25%	→	14.2%
Improvement in Ambulation	68%	60%	→	78.7%
Improvement in Bed Transferring	67%	57%	→	67.5%
Improvement in Bathing	75%	67%	→	77.5%
Improvement in Mgmt of Oral Meds	59%	49%	→	64.3%
Improvement in Status of Surg Wounds	90%	89%	→	89.7%

<b>Senior Living Communities 5 Star Ranking - June 2010</b>					
	Overall Quality Stars Ranking	Health Inspection	Quality Measures Ranking	Staffing Ranking	RN Staffing
Medalion Retirement Center	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Namaste Alzheimer Center	★★★★★	★★★★★	★★★	★★★★★	★★★★★
Progressive Care Center	★★★★★	★★★★★	★★★	★★★★★	★★★★★
Villas at Sunny Acres	★★★★	★★★	★★★★	★★★★★	★★★★★
Villa Pueblo	★★★★	★★★	★★★★	★★★★★	★★★★★

In our home care operations, we continue our strong performance in terms of outcome effectiveness, with a significant opportunity for further improvement in how we coach patients on bed transferring. A very noteworthy success story is in the incredibly low hospital readmission rate for Medicare home care patients monitored through our telehealth technology as reflected in the chart on the following page. CHAH senior living communities also have achieved hospital readmission rates dramatically lower than both the state and national averages. In addition, all senior living community overall ratings have significantly improved as a result of ongoing attention to staff education, resident involvement, facility upgrades and repairs, improvement in infection control, and leadership development.



**Successes**

Incredibly low hospital readmissions of home care patients monitored via telehealth technology.

Central line infection rate improved from 1.08 in FY 11 to 0.72 in FY12.

The actual number of hospital acquired conditions overall decreased from 218 in FY 11 to 140 as of June 12.

Improved senior living community ratings.



**Opportunities**

Catheter associated urinary tract infections remains an area of focus along with falls with fractures.

Reduce inpatient readmissions.

Reduce post-operative sepsis and ventilator associated pneumonia.

Continue our excellent progress with identifying and adopting evidence-based practices.

# Growth

Ensure there is a systematic approach to growing and developing the System, as evidenced by strategies, tactics and objectives that are successfully implemented to generate optimal year-to-year growth in service delivery, volume and revenue, with particular attention to the establishment of new services, programs, modalities, and facilities. (Executive Champion: Pam Nicholson)



	Actual	Budget	Variance	Last Year	Variance
<b>Admissions</b>	88,082	91,059	-3.30%	89,082	-1.10%
<b>Adjusted Admissions</b>	169,170	169,291	-0.10%	163,163	3.70%
<b>Total Surgeries</b>	66,569	68,389	-2.70%	65,794	1.20%
<b>Outpatient Visits</b>	1,040,717	992,112	4.90%	979,434	6.30%
<b>Total ER Visits</b>	373,848	366,110	2.10%	359,296	4.10%
<b>Deliveries</b>	10,913	11,080	-1.50%	11,164	-2.20%
<b>Total CMI</b>	1.5502	1.4845	4.40%	1.5028	3.20%
<b>Average Length of Stay</b>	4.14	4.19	-1.20%	4.16	-0.40%
<b>LTC Resident Days</b>	415,267	464,599	-10.60%	440,258	-5.70%
<b>Home Health Patients</b>	21,603	23,637	-8.60%	42,130	-48.70%
<b>Physician/Clinic Visits</b>	594,049	575,490	3.20%	451,859	31.50%
<b>CMI Adj Admissions</b>	217,630	213,410	1.98%	207,950	4.66%

The Colorado inpatient market continues to be flat or slightly decreasing. As reflected in the table above, our admissions for the year were 3 percent below budget and 1 percent below prior year. However, we have seen strong year-over-year increases in outpatient visits, emergency department visits, and physician office/clinic visits. We have seen significantly decreased volumes in Centura Health at Home, although the home health numbers reflected above are distorted due to a change in definition from last year to this year.

FY12 bore too many growth initiatives to recount, but among the most noteworthy were the Castle Rock Adventist Health Campus, the work on Colorado Health Neighborhoods, and major physician transactions including cardiology groups in South Denver and South State.

The tables that follow identify year-over-year changes in CMI adjusted admissions (CMIAA) by hospital and changes in total net revenue by operating entity. Our most significant growth was at OrthoColorado Hospital, Littleton Adventist Hospital, and Parker Adventist Hospital. On a service line basis, we generated more than \$300 million in emergency department services, a 17 percent increase over the

prior year. We also saw relatively gaudy growth in a number of outpatient services including cardiac catheterization/electrophysiology, radiation oncology, and miscellaneous ancillary services. On an inpatient basis, we had double digit growth in oncology net revenue.

<i>Change in CMIAA by Hospital</i>			
	<b>FY12</b>	<b>FY11</b>	<b>Change</b>
<b>ORTHO</b>	4,923	3,258	51.1%
<b>LAH</b>	24,735	21,807	13.4%
<b>PKR</b>	17,923	16,170	10.8%
<b>STM</b>	5,793	5,356	8.2%
<b>MPMC</b>	11,923	11,155	6.9%
<b>AAH</b>	10,300	9,719	6.0%
<b>PAH</b>	25,950	24,498	5.9%
<b>PSF</b>	53,826	51,766	4.0%
<b>SAH</b>	33,214	32,637	1.8%
<b>SMC</b>	18,339	18,084	1.4%
<b>SAN</b>	15,481	15,291	1.2%
<b>SASMC</b>	3,555	3,607	-1.4%

<i>Change in Net Revenue - 12 Largest Entities</i>			
	<b>FY12</b>	<b>FY11</b>	<b>Change</b>
<b>ORTHO</b>	\$48,797	\$40,880	19.4%
<b>LAH</b>	\$257,422	\$217,509	18.4%
<b>PKR</b>	\$189,432	\$169,720	11.6%
<b>PAH</b>	\$265,091	\$245,768	7.9%
<b>SAN</b>	\$116,323	\$108,236	7.5%
<b>PSF</b>	\$438,268	\$408,169	7.4%
<b>SMC</b>	\$148,939	\$138,889	7.2%
<b>AAH</b>	\$89,586	\$84,026	6.6%
<b>SAH</b>	\$361,126	\$341,086	5.9%
<b>STM</b>	\$43,030	\$41,888	2.7%
<b>SASMC</b>	\$72,239	\$69,400	4.1%
<b>MPMC</b>	\$131,500	\$126,338	4.1%

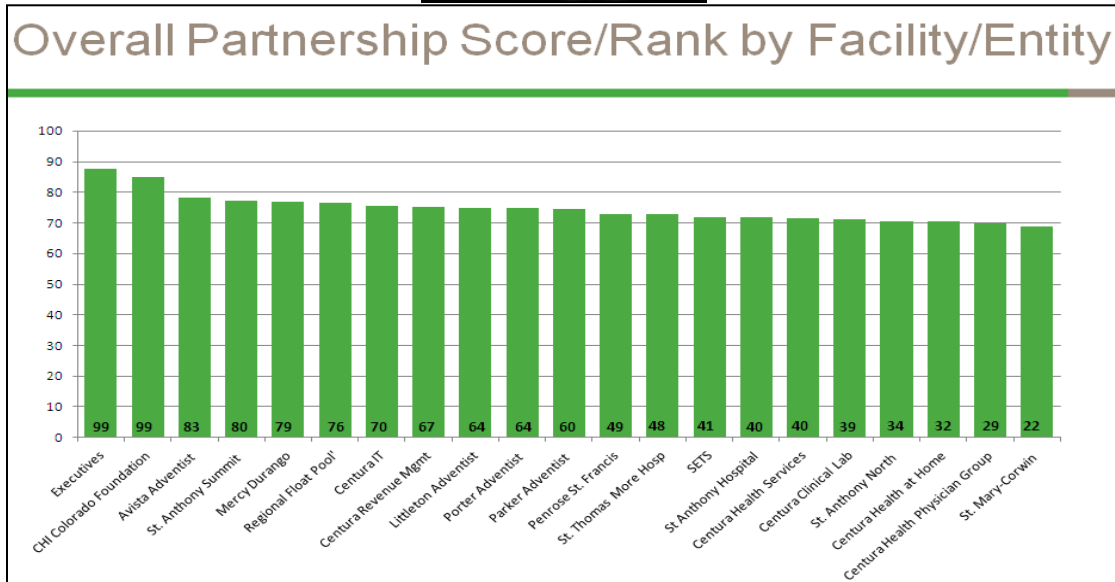
<b>Net Revenue Change by Major Service</b>			
<i>(IP = Inpatient, OP= Outpatient)</i>			
	<b>FY12</b>	<b>FY11</b>	<b>Change</b>
EMERGENCY OP	\$317,122,265	\$271,334,358	16.90%
GENMED IP	\$181,725,446	\$173,810,215	4.60%
ORTHO IP	\$181,397,456	\$174,263,768	4.10%
SURGERY OP	\$147,780,839	\$131,791,720	12.10%
GENSURG IP	\$144,271,233	\$134,387,626	7.40%
SPINE IP	\$119,955,901	\$124,033,000	-3.30%
CARDIAC IP	\$104,127,445	\$103,501,904	0.60%
IMAGING OP	\$88,493,807	\$81,229,543	8.90%
ANCILLARY SERVICES OP	\$69,334,138	\$59,285,970	16.90%
ONCOLOGY IP	\$62,017,757	\$56,121,747	10.50%
OBSTETRICS IP	\$56,668,668	\$55,307,128	2.50%
CATH & EP LAB OP	\$45,604,808	\$35,275,041	29.30%
RADIATION ONCOLOGY OP	\$32,406,910	\$25,594,268	26.60%
NEUROLOGY IP	\$28,303,896	\$26,406,261	7.20%
NEONATOLOGY IP	\$27,108,267	\$27,109,029	0.00%

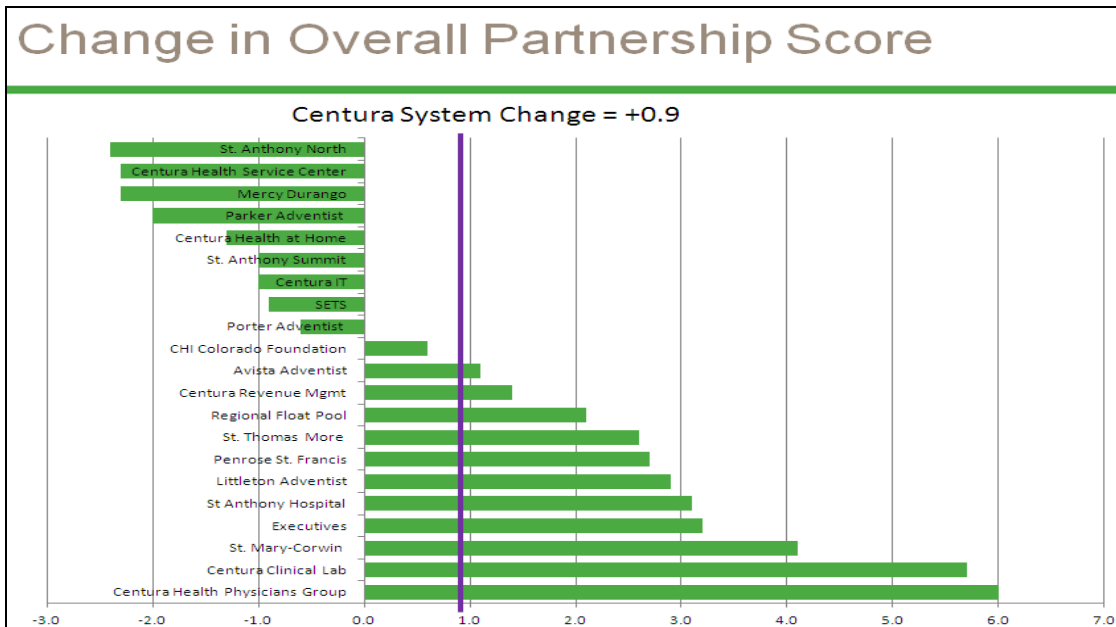
Clearly reflecting the shift in the locus of care, our outpatient net revenue increased by 12.1 percent on a year-over-year basis whereas inpatient net revenue grew just 1.3 percent. Outpatient revenue is now 52.4 percent of total revenue (up from 48.4 percent last year). Over the next two years, we expect outpatient care to generate 60 percent of our total net revenue. At some point, health systems will relinquish our preoccupation with inpatient care and begin to shift from growth metrics like inpatient admissions and market share of hospital admissions to metrics like the number of “enrolled lives” and define market share as the percentage of total health care expenditures captured.

We continue to explore numerous strategic alliances both inside and outside of Colorado, and in FY12 we completed several such arrangements including several hospital affiliations. Perhaps the most surprising was that we signed a letter of intent with HCA to partner with them on our pediatric system of care. Our first announcement was regarding St. Francis Medical Center and our next will be Littleton.

## People

*The people and cultures of our organizations reflect our values, are directly linked to the strategic intent of Centura Health, and are continually developed and strengthened to ensure the organizations and our ministries will endure long into the future. (Executive Champion: Julie Ambory)*





In the 4<sup>th</sup> quarter all Centura Health associates were asked to participate in the associate partnership survey. We were pleased that 79 percent of Centura associates responded to the survey (compared to a national average of 65 percent) and we achieved a mean score of 73.1, which is a 0.9 point increase from the previous survey. In total, 42 out of 52 questions had an improvement in mean score from our prior survey; 25 of these increases were statistically significant gains. However, we were not pleased to learn that our national standing decreased from the 56<sup>th</sup> percentile to the 50<sup>th</sup> percentile. Despite our efforts, our associate satisfaction is just average. As the two charts above reflect, our strongest pockets of satisfaction are among our executives, the CHI Foundation staff, and the staff at Avista Adventist Hospital, whereas our biggest opportunities are at St. Mary-Corwin Medical Center, Centura Health Physician Group, and Centura Health at Home. We saw very significant improvements for Centura Health Physician Group, Centura Clinical Lab, and St. Mary-Corwin Medical Center. Conversely, satisfaction dropped most significantly at St. Anthony North Hospital, Service Center (shared and centralized services under the governance of our operating entities), and Mercy Regional Medical Center. Our greatest opportunities for system-wide improvement are as reflected in the table below:

Rank	Last Rank	Section	Opportunity
1	2	Systems and Leadership	Excellent performance is recognized here.
2	1	Systems and Leadership	Leaders really listen to employees.
3	3	Systems and Leadership	I have opportunities to influence policies and decisions that affect my work.
4		Custom Section	Results from the previous employee surveys have been used to make positive changes.
5	10	Custom Section	I am confident that decisions within my workgroup are made consistent with the core values of this organization.
6	6	Direct Management	My direct manager communicates effectively.
7	5	Direct Management	My direct manager provides coaching to help me achieve my goals.
8	4	Systems and Leadership	My work group is asked for opinions before decisions are made.
9		Teamwork	There is good coordination of effort in my work group.
10	9	Custom Section	Promotions are handled fairly here.

# Stewardship

The financial assets and performance of our organizations are protected and continually strengthened with year-to-year improvement to ensure the organizations and our ministry will endure long into the future. (Executive Champion: Dan Enderson)



	Actual	Budget	Variance	Last Year	Variance
<b>Net Operating Revenue</b>	2,388,517	2,349,488	1.7%	2,190,298	9.0%
<b>Total Compensation</b>	1,043,571	1,034,282	-0.9%	977,373	-6.8%
<b>Physician Remuneration</b>	78,150	74,648	-4.7%	66,954	-16.7%
<b>Supplies</b>	380,523	383,462	0.8%	354,078	-7.5%
<b>Purchased Services</b>	240,174	255,858	6.1%	211,723	-13.4%
<b>Other Expenses</b>	304,040	275,277	-10.4%	253,841	-19.8%
<b>Total Op Expense bf Int/Dep</b>	2,077,197	2,050,799	-1.3%	1,894,666	-9.6%
<b>Depreciation and Amortization</b>	145,808	146,375	0.4%	138,013	-5.6%
<b>Interest</b>	32,466	34,055	4.7%	25,767	-26.0%
<b>Total Op Expense af Int/Dep</b>	2,255,471	2,231,229	-1.1%	2,058,447	-9.6%
<b>Operating Income</b>	133,046	118,260	12.5%	131,852	0.9%
<b>Operating EBITDA</b>	311,319	298,689	4.2%	295,632	5.3%
<b>Operating Margin Pct</b>	5.60%	5.00%	10.7%	6.00%	-7.5%
<b>Operating EBITDA Margin Pct</b>	13.00%	12.70%	2.5%	13.50%	-3.4%

We closed the year beating budget by \$12.6 million and exceeding prior year results by \$15.7 million. Operating EBITDA for the year was \$311 million and operating EBITDA margin reached 13 percent. Given the changes in the market, on the surface those numbers seem very good and indeed they are. However, there is a storm brewing beneath the surface that has me very concerned. The most obvious cause of that concern is the 9.6 percent year-over-year increase in operating expense relative to the 9.0 percent increase in net revenue. That 0.6 percent difference equated to \$11 million.

As reflected in the table that follows, there are clearly some bright spots in our ability to better manage expenses in accordance with changes in revenue. At the top of the chart are CHPG and Ortho Colorado; with both entities controlling expense growth in a year when we saw huge increases in associated net revenue. Not to take anything away from the great work of those two entities, even more impressive was St. Anthony Hospital where we held expense growth to less than 1 percent despite a nearly 6 percent increase in net revenue. The new hospital clearly helped, yet despite that benefit, cost controls



were quite effective. Other entities with very positive cost management were St. Anthony Summit Medical Center and Penrose-St. Francis Health Services.

<i>Change in Net Revenue &amp; Expense</i>		
	<b>Revenue</b>	<b>Expense</b>
<b>CHPG</b>	64.0%	53.8%
<b>ORTHO</b>	19.4%	12.7%
<b>SAH</b>	5.9%	0.7%
<b>SASMC</b>	4.1%	1.1%
<b>PSF</b>	7.4%	5.4%
<b>PAH</b>	7.9%	7.6%
<b>SAN</b>	7.5%	7.4%
<b>PKR</b>	11.6%	12.9%
<b>STM</b>	2.7%	4.1%
<b>SMC</b>	7.2%	9.5%
<b>AAH</b>	6.6%	8.9%
<b>MRMC</b>	4.1%	7.5%
<b>CHAH</b>	-7.5%	1.6%
<b>LAH</b>	18.4%	27.5%

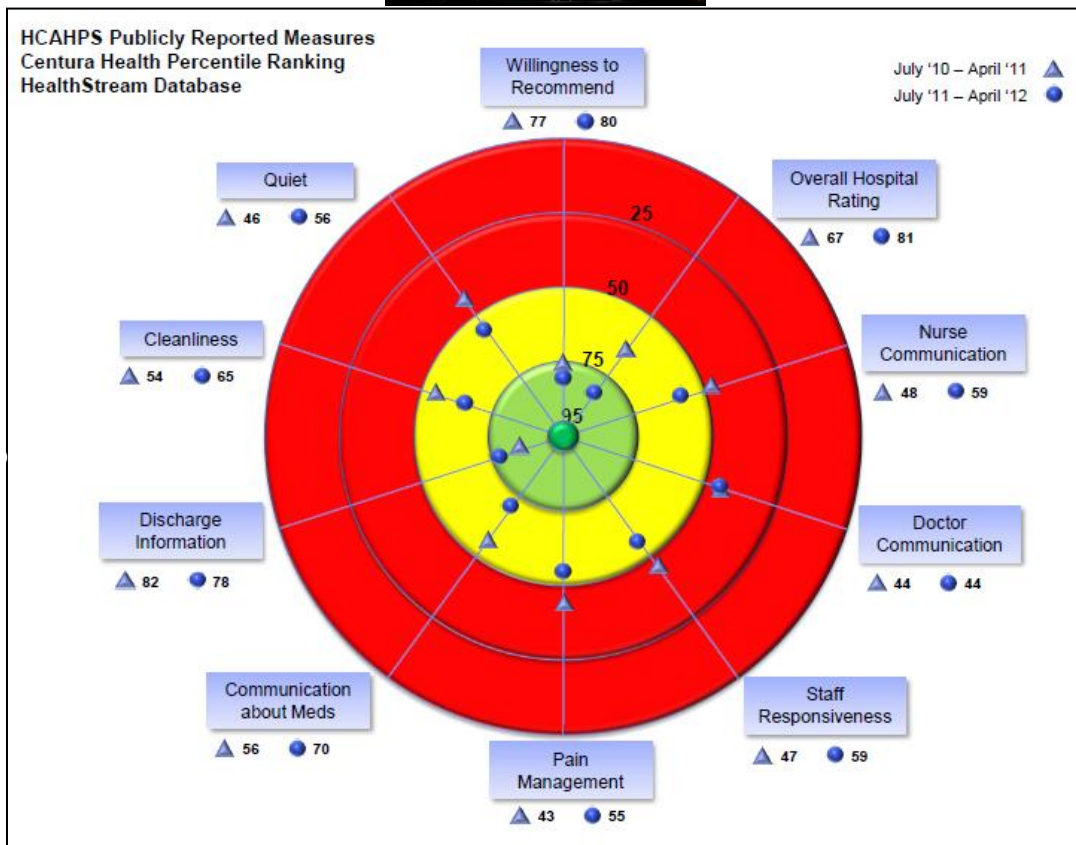
At the other end of the table, we clearly face some challenges at Littleton Adventist Hospital, Centura Health at Home, Mercy Regional Medical Center, Avista Adventist Hospital, St Mary-Corwin Medical Center, St. Thomas More Hospital, and Parker Adventist Hospital.

It is very important to note that our strong financial performance for the year was clearly aided by two transactions that were out of the ordinary. First, we received \$9.8 million (net of fees) from the rural floor group settlement with Medicare, and second we received \$6 million from the State of Colorado as our first payment for hospital meaningful use. The table below provides a “roll-forward” perspective on our net revenue growth for the year:

<i>Net Revenue Roll-Forward (\$ millions)</i>		
<b>Net Revenue in FY11</b>		<b>2,190.0</b>
New Acute Volume	67.2	
Increase Acute Rate	27.8	
New Physician Practice Revenue	62.4	
Shift in Payer Mix	(7.7)	
Increased Provider Fee	30.0	
Rural Floor Settlement	12.5	
Medicaid Meaningful Use	6.0	
Change In Post Acute Revenue	(5.3)	
Increase in Other Op Rev	2.0	
Offshore Cost Appeal Settlement	3.6	198.5
<b>FY12 Net Revenue</b>		<b>2,388.5</b>

# Service and Partnerships

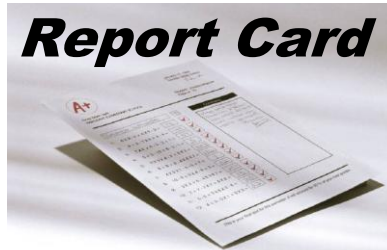
There are creative, pervasive, and systematic approaches to build close, trusting relationships reflecting our commitments to service and partnerships. (Executive Champions: Jeff Brickman, Erin Denholm, Randy Haffner, and Margaret Sabin)



The picture above tells the story. For FY12 on the strength of significant improvements at St. Thomas More Hospital and St. Anthony Hospital, our *average* inpatient satisfaction score is now in the top quartile nationally. We saw year-over-year improvement in eight of the ten metrics and reached the top 20 percent of all hospitals in patients' willingness to recommend them, and the top 19 percent of hospitals in overall inpatient satisfaction. AAH, SASMC, MRMC, and PKR continue to post superstar numbers for patient satisfaction.

# Collaboration/Leader Development

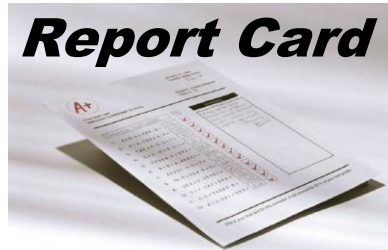
*There are robust systems and processes to foster leadership formation, knowledge transfer, and teambuilding to create synergy from our efforts. (Executive Champion: Julie Ambory)*



Examples of Disciplined Entrepreneurship	How We are Doing
<p><i>All organizations have effective governing board development plans and leader/manager professional development plans, and there are measurable results from those plans.</i></p>	<p><b>B</b> We continue to make great progress toward robust leader/manager professional development plans. While many hospitals have focused efforts on governing board development, few have formalized those efforts under a development plan.</p>
<p><i>Knowledge, information, and best practices are regularly shared between operating entities and executives throughout the System. There is abundant evidence of teamwork and transparent communication among and between key stakeholders, and systems exist to foster continuous improvement in our collaboration.</i></p>	<p><b>B+</b> We continue to make progress in knowledge management and sharing. There are fewer occasions where we miss opportunities to work as a team, and it is much less an issue that we intentionally withhold information and work in silos. However, we are also experiencing some of the side effects of collaboration, including compromised organizational agility.</p>
<p><i>Internal promotions exceed external hires for all leadership and management vacancies.</i></p>	<p><b>B-</b> While we are not yet where we want to be in this regard, there has recently been a demonstrable increase in internal promotions.</p>
<p><i>There are concerted efforts to proactively employ effective change management processes and techniques in all organizations.</i></p>	<p><b>C</b> Change management processes are becoming more sophisticated and prevalent, although we are by no means industry leaders in this regard.</p>

# Transformation

*Our organizations have demonstrated the ability to apply innovation and risk-taking to reinvent and transform health care delivery across Centura Health. (Executive Champion: Gary Campbell)*



Examples of Disciplined Entrepreneurship	How We are Doing
<p>An effective and systematic process exists to foster creativity and prudent risk taking in establishing new approaches to health care delivery.</p>	<p><b>B</b> Our Growth and Innovation Council is making good progress.</p>
<p>There is evidence of significant growth in revenues derived from new services, programs, and entities established over the preceding five years.</p>	<p><b>B+</b> SFMC, MRMC, OrthoColorado, Castle Rock, and new physician practices generated combined revenue representing more than 16 percent of total Centura Health revenue.</p>
<p>There is a systematic approach by all operating entities and the corporate office/service center to nurture and maintain distinctive organizational competencies that establish an economic driver for the organization. Public perception research indicates that the distinctive competencies of operating entities and the System as a whole are widely recognized.</p>	<p><b>C</b> The concept of distinctive competencies has certainly been added to our lexicon, and there are numerous efforts underway in this regard. Quite naturally, those efforts often “feel” foreign and challenging.</p>

Over the past few months, we have seen clear signs that the second curve of health care is coming and it is moving at an increasing pace. We have seen direct evidence of the health care transformation occurring around us:

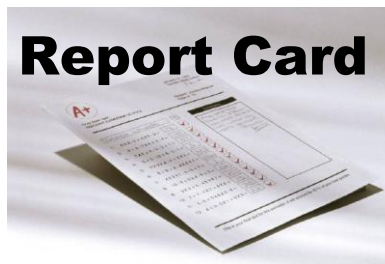
- Three large physician groups/IPAs now have global risk for Secure Horizons (43,000 lives).
- Two large IPAs have joined forces and have secured a Pioneer ACO (28,000 lives).
- On large IPA signed a shared savings contract for Anthem commercial PPO lives.
- An IPA approached us offering sub-capitation for chemotherapy drugs.
- A large physician group is discussing shared savings with multiple payers.

- The state passed legislation to begin delegating global capitation for Medicaid in 2013.
- Payers and physicians are focused on reducing avoidable admissions.
- The Prometheus Bundling Project is being rolled out in southern Colorado.

All of this market change is a clear indication that we must continue our work to prepare for the transformation and even to escalate our efforts, while continuing to build upon our foundation and to drive increased health care value in the communities we serve. Our most significant transformation effort is Colorado Health Neighborhoods, where we are still on track to open our first ten neighborhoods by the end of the calendar year.

## Community Health Improvement

*In concert with specific Centura Health strategies and objectives, Centura Health executives are expected to demonstrate continual progress in improving the health of the communities we serve. (Executive Champion: Susan Hebert and Stephen King)*



Examples of Disciplined Entrepreneurship	How We are Doing
<p>There is a systematic approach to identify and address priority health needs within the communities served by Centura Health organizations.</p>	<p><b>B+</b> We have completed data collection for community health needs assessments and are currently analyzing the data. Under the leadership of Susan Hebert and Stephen King, the Community Health Improvement Council is making very good progress and all hospitals are on track.</p>
<p>Community benefit services plans exist in all operating entities to proactively manage community health improvement and overall community benefit. As a direct result of planned initiatives fostered by operating entities and in partnership with the community, there is evidence of improved health status in the health of communities we serve.</p>	<p><b>C-</b> For the most part, our efforts are exemplary although not the result of formalized community benefit services plans. Frequently, our efforts are “one-off” and opportunistic rather than the result of comprehensive, measurable plans. Reliable metrics are largely non-existent, although we are laying a good foundation for improvement in our analytics.</p>

Examples of Disciplined Entrepreneurship	How We are Doing
Effective advocacy is regularly applied in support of the health needs of the communities served.	<b>A</b> We have a good track record of effective advocacy locally and at the State level.

Total community benefit rose from \$290 million in FY11 to \$342 million in FY12, an increase of \$51 million or 18 percent. In FY12 we had a \$6.8 million increase in Community Service-Broader Community and Community Service Low Income. This increase reflects both better capture of these contributions through a more standardized approach to eligible costs and best practice system capture. These categories will become crucial as the Community Health Needs Assessment and new 501R and 990 reporting requirements will put much more emphasis on these aspects of community benefit in maintaining our not for profit status in FY13.

The Community Health Needs Assessment (CHNA), as outlined in the Patient Protection and Affordable Care Act, was successfully accomplished during FY12. The following steps were implemented and completed:

- The Center for Health Administration at CU provided a summary of data to each hospital facility which was collected and analyzed from sources available to the general public, primarily from the Colorado Department of Public Health and Environment.
- Each facility established a CHNA Steering Committee which reviewed the data from CU and gathered additional data from community leaders and focus groups, and coordinated these efforts with their County’s Department(s) of Public Health.
- The CHNA Steering Committee established a list of health needs within the community and ranked them by priority.
- A CHNA & Action Plan for each facility was submitted to the Department of Mission & Ministry by June 30, 2012.
- The Senior Team at each facility has reviewed and approved the list of health needs. Final approval is anticipated at the next meeting of the Community Board at AAH, MRMCM, PRK, PSF, SASMC, SMC and STM. The remaining hospitals have already received approval from their Community Board.

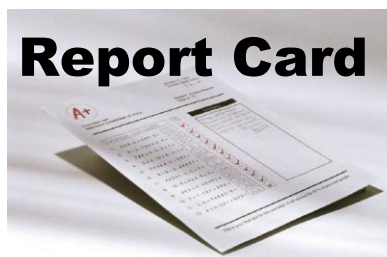
In addition to the CHNA, each hospital’s CHNA Steering Committee established an **Action Plan** to address the specific health needs selected from those identified in the CHNA.

The 2012 state legislative session brought opportunities and challenges to Centura Health. Working in concert with the Colorado Hospital Association Legislative Council, we worked in opposition to some proposed legislation and worked to amend and/or support several other issues. While leadership in both houses reduced the number of bills introduced, we worked actively to oppose, support or monitor 99 pieces of legislation.

FY12 was a significant year of growth and redirection for Global Health Initiatives (GHI). Notable progress has been achieved to strengthen and expand partnerships and to develop sustainable healthcare projects that enable long-term benefits to both the recipients and providers. In addition advances have been made to create a more system-wide approach to GHI in Centura Health.

# Disciplined Entrepreneurship

*The activities of the corporate office/service center and operating entities are aligned and coordinated to advance the common good of Centura Health and the continued evolution of the organization. (Executive Champion: Gary Campbell)*



Examples of Disciplined Entrepreneurship	How We are Doing
Strategic plans, CEO incentive goals, etc., include a clear linkage and alignment between System strategies/objectives and operating entity strategies/objectives.	<b>A</b> These linkages exist and are widely communicated and understood.
Operating entities work cooperatively together to build synergy for Centura Health activities within the state.	<b>B+</b> We have opportunities for further improvement, but there is ample evidence of collaboration across the organization.
There is effective and efficient migration of operating entities to Centura Health standards, including ongoing communication with key stakeholders in support of the Centura Health standards.	<b>B</b> We are making progress here, although there remains substantial room for improvement.
Operating entity CEOs and governing boards articulate and advocate key Centura initiatives and the role of their organizations in achieving those initiatives.	<b>B</b> Operating entity CEOs regularly express “ownership” of Centura Health initiatives. Our hospital boards clearly recognize the existence of the system, although sometimes resent the system or long for the days when their hospital was independent. Too often, “Centura Health” is regarded as a foreign body different from the hospital. However, there is increasing evidence of “system” thinking.