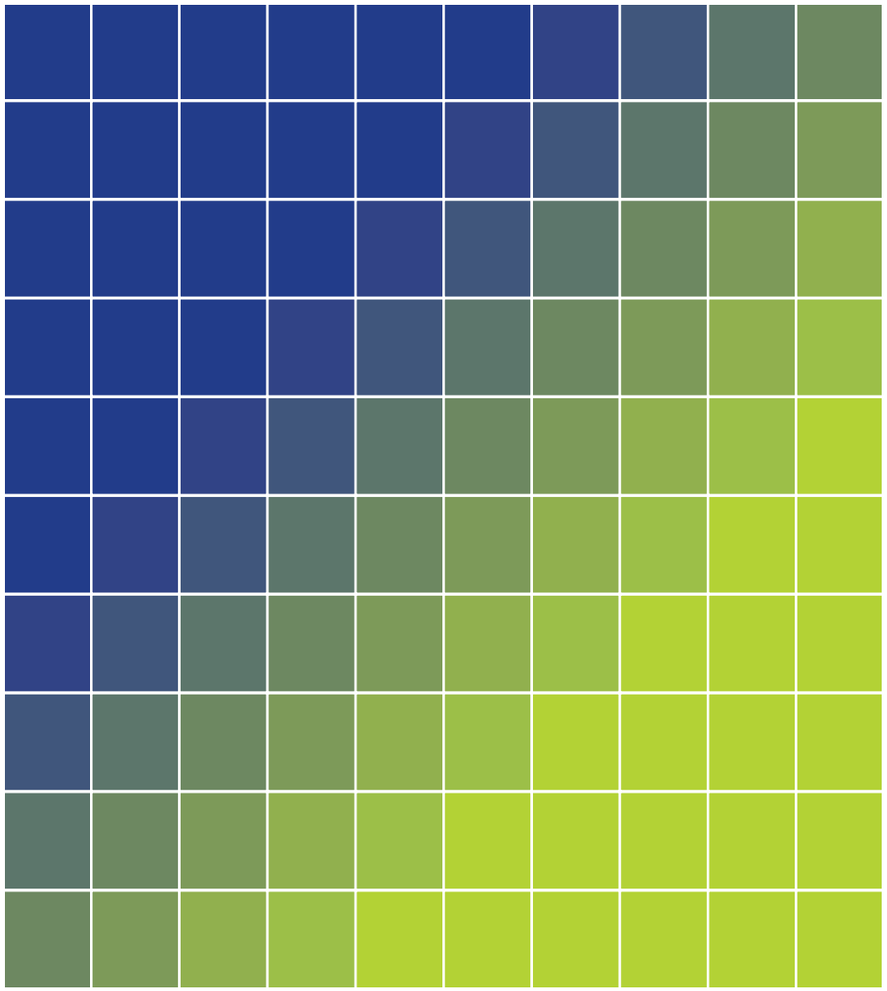


the STANDARD

1st Quarter 2014 April '13 - March '14

the delta companies™

INDUSTRY PERSPECTIVES

Exploring Clinical Integration: The collaborative agreement of health systems and physicians in alliance of improved patient care

Matt Robbins, *Recruiting Principal, Delta Physician Placement*

As the nation responds to growing quality-of-healthcare priorities brought in the wake of national healthcare reform, and as quality-based initiatives and continuity of care continue to be issues rolling off the tongues of health system professionals and physicians alike, the need to identify collaborative efforts between health systems and physicians for improved patient care has never been stronger.

■ Aligning hospital and physician interests give both groups a vested interest in quality and cost of care, resulting in strategic improvements and reduction to operational costs. ■

Birthed from this collaboration, the popularity of clinical integration (CI) organizations has skyrocketed. Many organizations have adopted CIs—a legal arrangement that allows hospitals and physicians to collaborate on improving quality and efficiency, while remaining independent entities. In fact, the nation has seen a huge surge in CI program development within the last few years. As of 2012, researchers identified the development of over 500 programs within the US, up from just a handful of CIs found in 2008. This progression is only predicted to rise as healthcare systems and providers seek collaborative efforts for improvement.

What has been the outcome of CI development, and what key issues affect health systems and physicians that adopt these programs? According to research conducted by The Advisory Board Company, CI programs have been met with enthusiasm across the board. Health systems receive the benefit of collaborative input from both employed and independent physician groups in the development of incentives, management, and infrastructure as it relates to quality and efficiency of patient care. Aligning hospital and physician interests give both groups a vested interest in quality and cost of care, resulting in strategic improvements and reduction to operational costs. Arguably, relationships between health system administrators and physicians have also strengthened as communication and planning are organized toward a common goal.

Physicians have strong motivation to join a CI organization for several reasons: having a direct influence on the quality of care provided to patients, establishing universal EMR systems throughout their network, and maintaining the ability to sustain independence (for independent physicians not ready to join hospital employment). Utilizing clinical integration also allows physicians to negotiate collectively with insurers for better payment rates for top-quality service, or for bonuses based on quality and cost improvements. Both physicians and health systems enjoy a legal "safe-harbor" from antitrust laws if the CI arrangements are properly executed and in adherence to Stark Law, the Anti-Kickback Statue, the Civil Monetary Penalties Statue, federal income tax requirements, etc.

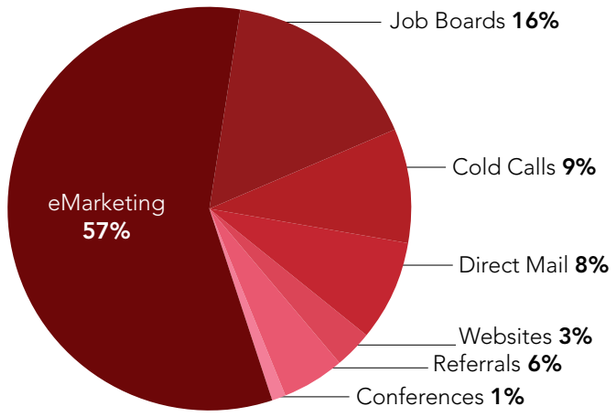
Physicians also are able to capture larger patient loads in a CI organization. As quality of care improves, word-of-mouth and in-network referrals help to eliminate patient migration and draw in other members of the community. In instances where a hospital partners with independent physicians toward the same vision of quality care, the hospital can be a powerful ally in program development. The hospital can collaborate with physicians to develop initiatives based on existing inpatient quality measures, lend financial support and personnel to inpatient and outpatient programs that provide true benefits to the community (vs. volume or value of referrals) and demonstrate a legitimate value of the CI program to payers and the community as a whole.

Physician buy-in is critical to the implementation and success of any CI system. Hospitals should select physician leaders who have demonstrated an interest in additional administrative responsibilities. Startup costs for a CI network can be substantial; however, these costs may be outweighed by benefits of the network, including long-term cost savings. Ultimately, care coordination and improved performance on clinical metrics will decrease the cost of care to the payer.

Clinical integration can improve the overall value of patient care. As physicians in a community come together with the goal of enhancing quality of care, patients are referred to a collaborative network and able to avoid unnecessary procedures or emergency room visits. Improving physician coordination across care sites also strengthens adherence to care protocols and enhances patient access to care services, which in turn, provides better quality of service to the community as a whole.

PLACEMENTS & INTERVIEWS

Candidate Sources



Data indicates sources of candidates for placements and interviews from April 2013 through March 2014.

The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. No one should act on such information without appropriate counseling and thorough examination of the particular situation. For more information regarding specific specialties, regions, or trends, contact Mary Glover, Vice President of Communications, The Delta Companies at (800) 521-5060 x4144 or mglover@TDCpeople.com

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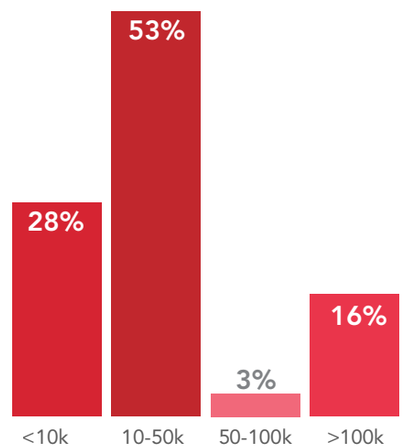
Placements by Population



Data indicates the percentage of placements made from April 2013 through March 2014 by the population of the search facility's metropolitan area.

PLACEMENTS & INTERVIEWS

delta physician placement

Placement Data by Specialty

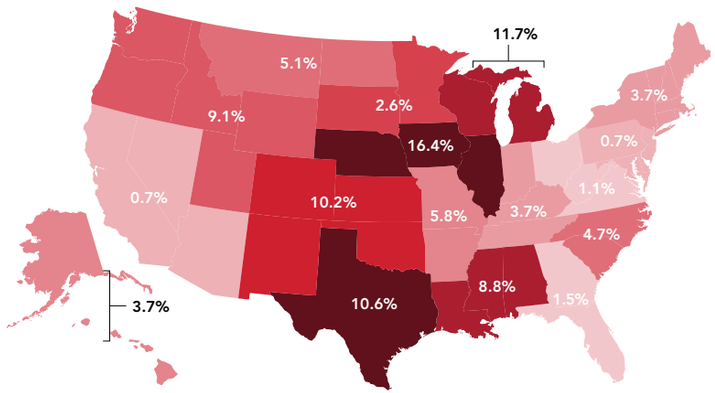
This data represents average statistics of placements and interviews by Delta Physician Placement over the twelve-month survey period. Since these averages only include placements and interviews, the compensation information presented indicates the rate at which candidates are choosing to interview or sign. Average days information can be used to forecast a probable timeline for a recruitment effort in a particular specialty.

		Average Compensation			Average Days		
		Starting Compensation	Sign-on Bonus	Potential Compensation	From Interview to Placement	Total Placement	Fastest Days-to-Fill
Primary Care	**Family Medicine**	$205,384	$25,250	$243,321	30	128	21
	Internal Medicine	$218,068	$27,000	$303,333	47	101	40
	Pediatrics	$194,833	$21,200	$231,500	45	220	125
	Psychiatry	$215,000	$19,375	$240,556	39	195	34
	Obstetrics/Gynecology	$286,250	$26,250	$393,750	22	131	78
Surgery	**General Surgery**	$381,875	$30,714	$450,000	44	97	37
	Orthopedic Surgery	$473,373	$56,667	$600,000	35	123	34
	Otolaryngology	$450,000	$37,500	$475,000	110	298	121
	Urology	$493,750	$36,667	$644,331	40	246	72
Sub-Specialties	**FM- Obstetrics**	$237,000	$25,000	$272,000	16	130	42
	Neurology	$283,333	$23,333	$408,333	41	35	33
	Pulmonary Critical Care	$300,000	$30,000	$400,000	24	44	16
Hospital Based	**Anesthesiology**	$550,000	-	$600,000	42	52	52
	Hospitalist	$235,889	$23,889	$262,000	24	116	62
	Emergency Medicine	$274,488	$27,778	$308,300	21	140	15

Data reflects averages from placements and interviews by Delta Physician Placement from April 2013 to March 2014. "Potential Compensation" data reflects average yearly compensation at full production excluding benefits. "Average Days" data does not include off-contract placements. "Average Days Total Placement" data is calculated from profile to placement.

MARKET DEMAND

Nationwide Search Distribution



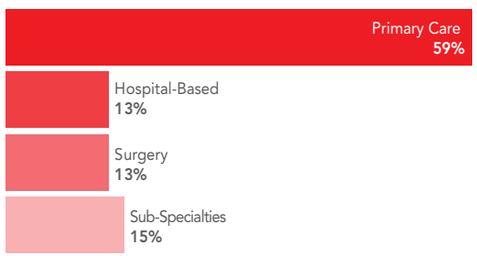
Map represents searches initiated by Delta Physician Placement on behalf of healthcare facilities from April 2013 through March 2014.

Specialty Demand Comparison

	1st Quarter 2014	1st Quarter 2013
1.	Family Medicine	Family Medicine
2.	Internal Medicine	Psychiatry
3.	Family Medicine - Obstetrics	Family Medicine - Obstetrics
4.	Orthopedic Surgery	Internal Medicine
5.	Hospitalist	Emergency Medicine
6.	Gastroenterology	Hospitalist
7.	Nephrology	Otolaryngology
8.	Obstetrics and Gynecology	Pediatrics
9.	Psychiatry	Psychiatry - Child & Adolescent
10.	Surgery - General	Surgery - General
11.	Dermatology	Gastroenterology
12.	Emergency Medicine	Medical Oncology
13.	Geriatric Medicine - FP	Neurology
14.	Hematology / Oncology	Obstetrics and Gynecology
15.	IM/Pediatrics	Orthopedic Surgery

Data compares the top 15 most requested searches initiated by Delta Physician Placement, comparing the 1st quarters of 2013 and 2014.

Search Specialty Distribution



Data indicates the percentage of searches initiated by specialty grouping between April 2013 and March 2014.

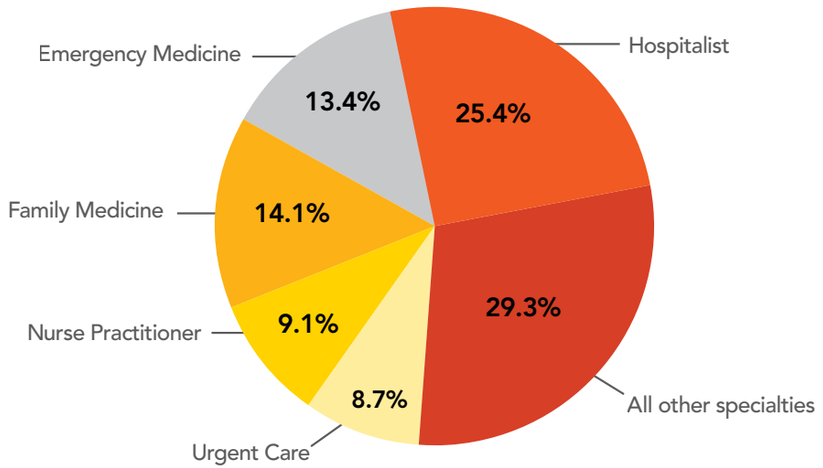
Candidate Placements

	Top 5 States Providers Have Taken New Opportunities
1.	Texas
2.	Iowa
3.	North Carolina
4.	New York
5.	Louisiana

Compares all states for the top 5 candidate placements as initiated by Delta Physician Placement from April 2013 through March 2014.

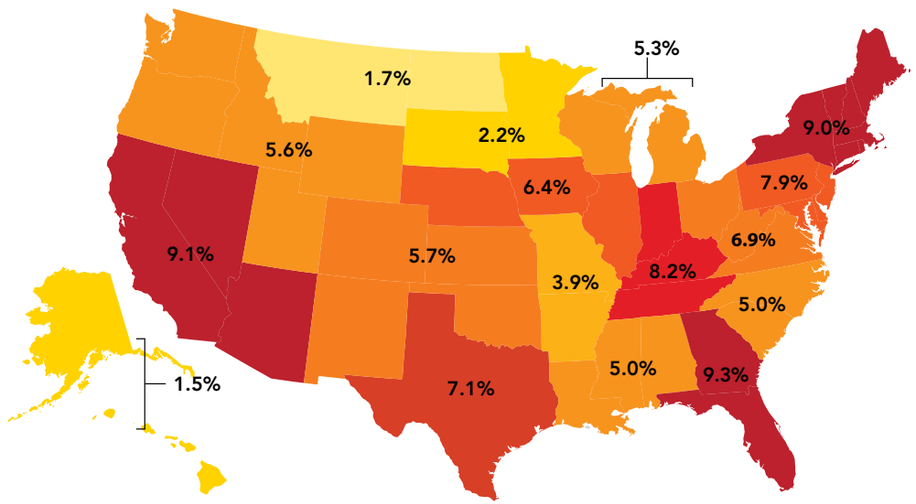
LOCUM TENENS

Days Requested - Top Specialties



Data indicates the top specialties by days requested from April 2013 through March 2014.

Nationwide Physician Distribution



Map represents the percentage of licensed physicians by region working with Delta Locum Tenens.

INDUSTRY PERSPECTIVES

Profit vs. community service: Should hospitals get involved in the home health service line?

By: Chuck Gilliland, *Senior Marketing Consultant, Delta Healthcare Providers*

Changes to inpatient rehabilitation dating back to 2006 have caused a shift in post acute care delivery settings. There has been a decrease in inpatient rehab services and increase within skilled nursing facilities (SNF) and home health services, according to Technology Insights research and analysis.

■ As the demand for these services continues to rise, a large opportunity has emerged for hospitals and health considering offering home health services; however, not all hospitals currently offer home health. ■

The Affordable Care Act has been a driving force behind the shift toward SNF and home health, increasing pressure to lower the cost of healthcare by utilizing the lower-cost services versus inpatient rehabilitation. While not all markets are actively shifting patients toward home health (such as Michigan, where mistrust of home health is prevalent), in general, ACOs, bundled payments, and other risk-based payment models are encouraging providers to use lower-cost post-acute care provider settings.

The Congressional Research Service released a report illustrating a dramatic increase in both the number of SNF rehab patients, and in the intensity of therapy provided to patients through these settings. In 1998, 71 percent of beneficiaries were primarily receiving therapy services, and by 2009 that number had increased to over 90 percent. The report also states that from 2001-2011, the share of days classified as ultra-high rehabilitation therapy increased from 7.4 percent to 49.7 percent. This rise could indicate that because more patients are being shifted to SNF settings, more intense rehab treatment is necessary for recovery. Or, it is possible that lower-intensity rehab patients are shifting from SNF to home health.

Additionally, pressure to shorten the average length of stay in SNF rehabilitation has increased, originating from both managed care payers and rehab patients. Long-term SNF patients who were once expected to stay in SNF settings for years no longer want to stick around, partly due to higher co-pays, and partly because young, healthy rehab patients feel uncomfortable or out of place in a nursing home setting. And, since cost of care per day has dramatically increased, payers are opting for shorter-term treatment. Essentially, pressures to move patients to lower-cost settings for shorter periods of time are pushing more rehab patients into the SNF setting or maybe even straight to home care, and some short-stay rehab patients will likely need home health, as well.

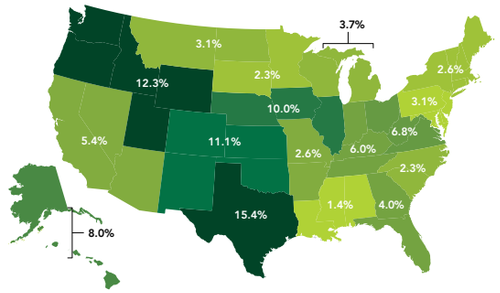
As the demand for these services continues to rise, a large opportunity has emerged for hospitals and health considering offering home health services; however, not all hospitals currently offer home health. In fact, only 44 percent of Delta Healthcare Providers travel therapists who are working in home health are currently working directly for a hospital that is running the home health service.

Hospitals may be reluctant to branch into home health service because, offering the service may not guarantee a profitable outcome for federally funded hospitals. Start-up costs to fund the service are high, and low reimbursement rates from Medicaid payers can offset profits earned from Medicare reimbursements. Privately owned home health agencies have more control over their payer mix. Due to this fact, profitability is a far more likely outcome for one of these agencies than for a hospital in the same market. But for many hospitals, profitability takes a backseat. Providing home health is a community service rather than a profit center. The decision hospital systems face is in determining what value offering home health service can add to their community, and if this need outweighs a potentially unprofitable service.

MARKET DEMAND

delta healthcare providers

Nationwide Search Distribution



Map represents searches initiated by Delta Healthcare Providers on behalf of healthcare facilities from April 2013 through March 2014.

Specialty Demand Comparison

	1st Quarter 2014	1st Quarter 2013
1.	Physical Therapist	Physical Therapist
2.	Registered Nurse	Nurse Practitioner
3.	Nurse Practitioner	Registered Nurse
4.	Occupational Therapist	Occupational Therapist
5.	Licensed Clinical Social Worker	Physician Assistant

Data compares the top 5 most requested searches initiated by Delta Healthcare Providers in the 1st quarters of 2013 and 2014.

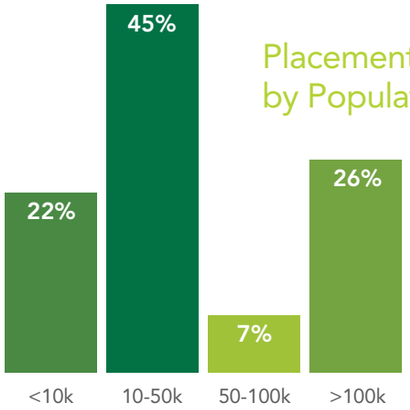
	Top 5 States Providers Have Taken New Opportunities		
1.	Texas	4.	Georgia
2.	Alaska	5.	Iowa
3.	New Mexico		

Candidate Placements

Compares all states for the top 5 candidate placements as initiated by Delta Healthcare Providers from April 2013 through March 2014.

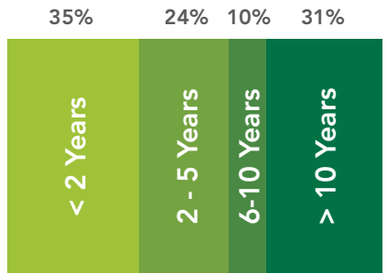
PLACEMENTS & INTERVIEWS

Placements by Population



Data indicates the percentage of placements made from April 2013 through March 2014 by the population of the search facility's metropolitan area.

Years of Experience



Data indicates the average years of experience of candidates for placements and interviews from April 2013 through March 2014.

PLACEMENTS & INTERVIEWS

Placement Data by Specialty

This data represents average statistics of placements and interviews by Delta Healthcare Providers over the twelve-month survey period. Since these averages only include placements and interviews, the compensation information presented is an indicator of the rate at which candidates are choosing to interview or sign. Average days information can be used to forecast a probable timeline for a recruitment effort in a particular specialty.

		Average Compensation				Average Days		
		Starting Compensation	Sign-on Bonus	Student Loan Repayment	Relocation Reimbursement	From Interview to Placement	Total Placement	Fastest Days-to-Fill
Rehabilitation	PT	$80,454	$8,846	$32,214	$3,885	9	73	1
	OT	$75,569	$10,435	$16,050	$4,021	11	69	1
	SLP	$77,030	$7,167	-	$5,500	3	28	7
Extenders	NP	$101,832	$6,984	$32,000	$6,985	14	76	8
	PA	$122,100	$5,750	$80,000	$4,556	13	62	19
Allied/Other	RN	$65,635	$4,643	$11,357	$5,300	8	78	4
	MT	$49,940	$2,000	-	$2,667	6	41	6

Data reflects averages from placements and interviews by Delta Healthcare Providers from April 2013 through March 2014. "Average Compensation" data reflects average yearly compensation for each position listed above. "Average Days" data does not include off-contract placements.

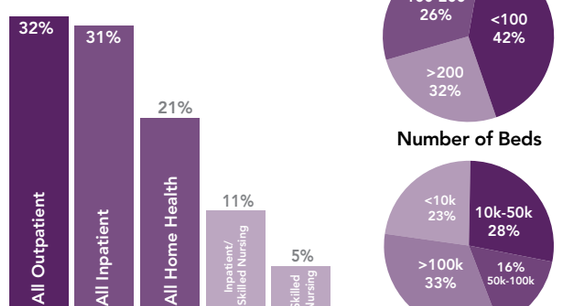
STAFFING

Assignments by Specialty

Specialty	Average Length Contract to Start Date	Average Length of Assignment
Occupational Therapist	4 Weeks	9 Weeks
Occupational Therapy Assistant	5 Weeks	8 Weeks
Physical Therapist	3 Weeks	10 Weeks
Physical Therapy Assistant	4 Weeks	12 Weeks
Speech Language Pathologist	4 Weeks	10 Weeks

Data is compiled from assignments placed by Delta Healthcare Providers from January 2014 through March 2014.

Facility Demographics

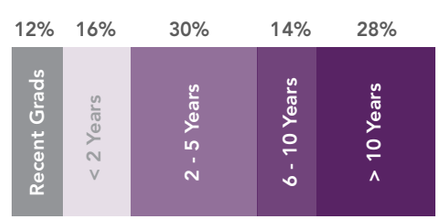


Practice Settings

Number of Beds

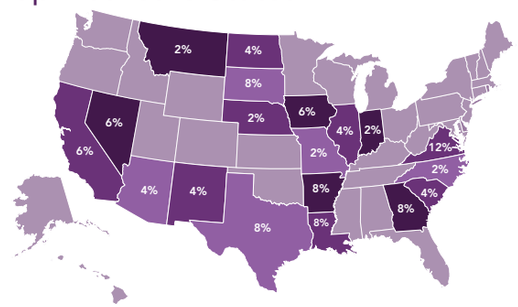
Community Population

Years of Experience



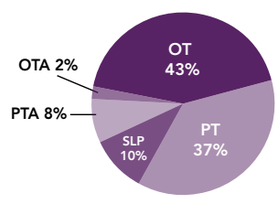
Data is compiled from assignments placed by Delta Healthcare Providers from January 2014 through March 2014.

Top Licensure States

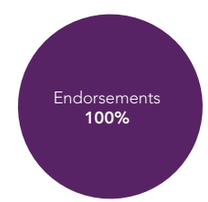


Map represents top licensure states by Delta Healthcare Providers on behalf of healthcare facilities from January 2014 through March 2014.

Licenses Per Quarter



percentage of licenses granted per specialty



Licensure Requests per New Graduate vs. Endorsement

Data is compiled from assignments placed by Delta Healthcare Providers from January 2014 through March 2014.

Licensure Cost

Specialty	Avg. Cost of Licensure
Physical Therapist	$249.46
Physical Therapy Assistant	$152.25
Occupational Therapist	$159.07
Occupational Therapist Assistant	$75.00
Speech Language Pathologist	$142.67

Data is compiled from assignments placed by Delta Healthcare Providers from January 2014 through March 2014.