

## INSIDE

### Top Hospital CEOs Share Goals for 2011:

Hear from Cleveland Clinic's Dr. Toby Cosgrove, UCLA's Dr. David Feinberg, Massachusetts General's Dr. Peter Slavin and more. p. 16

### Is Your Hospital Ready for Meaningful Use?

11 best practices for maximizing your hospital's ARRA payments. p. 44

### From the Red to the Black:

10 Remarkable Hospital Turnarounds. p. 25

### Healthcare Reform Making You Anxious?

Learn 10 ways for coping with uncertainties of reform from Chuck Lauer, former publisher of *Modern Healthcare*. p. 8

## INDEX

**Hospital-Physician Relationships & ACOs** p. 21

**Hospital Finance & Business News** p. 24

**Stark, Fraud & Abuse** p. 36

**Transactions & Valuation** p. 39

**Compensation** p. 41

**Healthcare Information Technology** p. 44

**Executive Briefing: RTLS** p. 48

**Facts & Figures** p. 53

## BECKER'S

# Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

January/February 2011 • Vol. 2011 No. 1

## The Year Ahead: 10 Key Trends for Hospitals in 2011

By Leigh Page

Two hospital CEOs, three association executives and two consultants discuss 10 trends for hospitals in 2011.

**1. Lower reimbursements.** In addition to lower Medicare reimbursements in the fiscal year starting Oct. 1, hospitals may face yet more cuts as the federal government redoubles efforts to reduce spending. "The problem is this country has a huge deficit," says Steven I. Goldstein, an AHA board member and president and CEO of

continued on page 9

## 9 Strategies for Maintaining Profitability in 2011 and Beyond

By Jaimie Oh

A multitude of forces — some already in effect and others set to take effect in 2011 and beyond — pose possible threats to hospital profitability. Hospitals have long been faced with the challenge of compensating for reduced Medicare and Medicaid reimbursements and, more recently, for the effects of a slow economic turnaround. Now other forces — such as an increased number of patients covered by government payors, bundled payments, accountable care organizations and healthcare IT pressures — may also compromise hospital profitability in the future.

continued on page 11

## 10 Ways to Improve Your Hospital's Heart Program

By Rachel Fields

A great cardiac program can boost patient volume, improve your hospital's reputation and significantly increase revenue. Here, five cardiology program experts — three from the hospitals ranked as having top five heart programs by *U.S. News & World Report* — offer advice on how to build a great heart care program.

**1. Appoint great leaders.** Bobbi Daniels, MD, CEO of University of Minnesota Physicians, says the most important thing in a great cardiology program is outstanding hospital and physician leadership. "Our cardiology leader has a large breadth of experience, and he's the executive medical director of the entire clinical service. He has business experience and he's a no-nonsense manager who really demands perfection and focuses on both clinical and financial outcomes," she says. She adds the cardiology leader is teamed up with a hospital leader who directs the cardiology service line. By having those two forces — clinical and administrative — present in your cardiology program leadership, you can

continued on page 13

## SAVE THE DATE

### Hospitals and Health Systems Conference - Improving Profits, ACOs, Physician Integration & Key Specialties

Featuring Keynote Speakers Chip Kahn, President of the Federation of American Hospitals, and Chuck Lauer, Former Publisher of *Modern Healthcare*

May 19-20, 2011 • Chicago, IL  
For more information visit,  
[www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)

Veolia Energy delivers sustainable energy solutions to 5,550 healthcare institutions around the world.



#### HOSPITAL CLIENTS RECEIVE

- Uninterrupted supply of critical power, steam, cooling, and medical vacuum
- Mitigated operating risks and performance guarantees
- Operating and capital cost savings
- Budget transparency
- Extended useful life of equipment
- Reduced energy consumption and equipment downtime
- Improved carbon footprint
- Improved health and safety
- Improved service quality

#### OUR SUSTAINABLE SOLUTION CAPABILITIES

##### Design, build, acquire, own, operate and maintain:

- Thermal energy assets (heating and cooling)
- Power generation assets
- Combined heat and power assets

##### Operate and maintain:

- Medical vacuum and gas
- Compressed air
- Cleanrooms
- Air conditioning
- Refrigeration
- Steam
- Hot Water



Contact us today to find out how we can partner with you to help you address your challenges.

P: 617.849.6656  
[www.veoliaenergyna.com](http://www.veoliaenergyna.com)



# Catch patient payments before they get away.

Patient Access Intelligence can more than double your point-of-service cash collections and decrease bad debt by as much as 10%.

- Improve charity care screening
- Automate eligibility verification
- Eliminate redundancy and manual processes
- Reduce denials and billing delays
- Increase patient satisfaction

Patient Access Intelligence is a single, integrated front-end solution that streamlines and expedites the patient financial clearance process.

To learn more, visit [www.medeanalytics.com/pai](http://www.medeanalytics.com/pai) or call MedeAnalytics at 510-379-3300.



© 2010 MedeAnalytics, Inc. All rights reserved

MedeAnalytics delivers healthcare performance management solutions to improve financial, operational and clinical outcomes, with compelling return on investment and rapid time-to-value.

\* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guaranty the use of this product.

**MEDEANALYTICS**<sup>®</sup>  
MEASURE. MANAGE. LEAD.

# It is a matter for Principle.

## Healthcare and Seniors Housing Valuations

Principle Valuation's experienced professionals have a long history of providing valuations in all economic climates. That's why more and more owners and lenders are getting "Principled", turning to us with confidence for advisory and valuation services for business enterprises, intangible assets, real estate and equipment.

- Purchase price allocation
- Financing - conventional
- Financing - HUD 232 Lean and 242
- Insurance
- Equipment inventory/valuations
- Impairment
- Real estate tax analysis
- Building life studies
- Market studies
- Stark compliance
- Cost segregation studies
- Expert witness testimony

- 
- Hospitals
  - Skilled Nursing • Assisted Living
  - Independent Living • CCRCs • ASCs
  - Medical Office Buildings • Physician Practices

It is a matter *for* Principle  
312.422.1010 • [info@principlevaluation.com](mailto:info@principlevaluation.com)



**Principle Valuation, LLC**

PEOPLE AND VALUES YOU CAN TRUST

230 West Monroe • Suite 2540 • Chicago, IL 60606  
312.422.1010 • [www.principlevaluation.com](http://www.principlevaluation.com)

# Confirm Your Excellence.

The right accreditation process brings out the best in a healthcare facility.



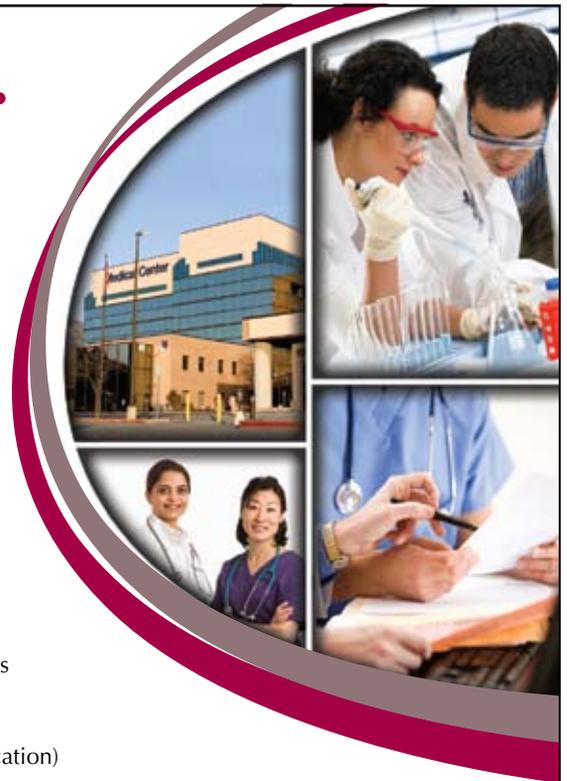
**Our Customer-first approach is**

**Nationally recognized**  
**Comprehensive**  
**Educationally focused**  
**User friendly**  
**Cost-effective**

**Serving:**

- Hospitals
- Ambulatory care/surgical facilities
- Office based surgery
- Mental health facilities
- Substance abuse facilities
- Physical rehabilitation facilities
- Clinical laboratories
- Critical access hospitals
- Primary stroke centers (certification)

Visit our Web site [www.hfap.org](http://www.hfap.org) for more information  
or email [info@hfap.org](mailto:info@hfap.org)



## Becker's Hospital Review Annual Meeting ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

Great topics and speakers focused on key business,  
clinical and legal issues facing hospitals and health systems —  
53 sessions, 79 speakers

Featuring Keynote Speakers Chip Kahn, President, Federation of American Hospitals; Peter Kongstvedt, Principal, P.R. Kongstvedt Company, and Senior Health Policy Faculty Member, George Mason University; and Richard Pollack, EVP, Advocacy and Public Policy, AHA

May 19-20, 2011 • Chicago, IL

To register, call (800) 417-2035

or e-mail [registration@beckershospital.com](mailto:registration@beckershospital.com)

Register online: [https://www.regonline.com/  
beckershospitalreviewannualmeeting](https://www.regonline.com/beckershospitalreviewannualmeeting)

For more information, visit: [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)

**BECKER'S**

# Hospital Review

**BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP**

January/February 2011 Vol. 2011 No. 1

## EDITORIAL

Lindsey Dunn

*Editor in Chief*

800-417-2035 / [lindsey@beckershealthcare.com](mailto:lindsey@beckershealthcare.com)

Rob Kurtz

*Editor in Chief, Becker's ASC Review*

800-417-2035 / [rob@beckershealthcare.com](mailto:rob@beckershealthcare.com)

Rachel Fields

*Associate Editor*

800-417-2035 / [rachel@beckersasc.com](mailto:rachel@beckersasc.com)

Laura Miller

*Assistant Editor*

800-417-2035 / [laura@beckersasc.com](mailto:laura@beckersasc.com)

Molly Gamble

*Writer/Editor*

800-417-2035 / [molly@beckersasc.com](mailto:molly@beckersasc.com)

Jaimie Oh

*Writer/Reporter*

800-417-2035 / [jaimie@beckersasc.com](mailto:jaimie@beckersasc.com)

Leigh Page

*Writer/Reporter*

800-417-2035 / [leigh@beckersasc.com](mailto:leigh@beckersasc.com)

## SALES & PUBLISHING

Jessica Cole

*President & CEO*

800-417-2035 / [jessica@beckersasc.com](mailto:jessica@beckersasc.com)

Annie Stokes

*Account Manager*

800-417-2035 / [annie@beckersasc.com](mailto:annie@beckersasc.com)

Gina Botti

*Asst. Account Manager*

800-417-2035 / [gina@beckersasc.com](mailto:gina@beckersasc.com)

Ally Jung

*Asst. Account Manager*

800-417-2035 / [ally@beckersasc.com](mailto:ally@beckersasc.com)

Austin Strajack

*Asst. Account Manager*

800-417-2035 / [austin@beckersasc.com](mailto:austin@beckersasc.com)

Cathy Brett

*Conference Coordinator*

800-417-2035 / [cathy@beckersasc.com](mailto:cathy@beckersasc.com)

Katie Cameron

*Client Relations/Circulation Manager*

800-417-2035 / [katie@beckersasc.com](mailto:katie@beckersasc.com)

Scott Becker

*Publisher*

800-417-2035 / [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com)

Becker's Hospital Review is published by ASC Communications. All rights reserved. Reproduction in whole or in part of the contents without the express written permission is prohibited. For reprint or subscription requests, please contact (800) 417-2035 or e-mail [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com).

For information regarding **Becker's ASC Review**, **Becker's Hospital Review** or **Becker's Orthopedic & Spine Review**, please call (800) 417-2035.

## FEATURES

### 7 Publisher's Letter

### 8 10 Ways to Cope in This Anxious Time of Healthcare Reform

### 16 12 Top CEOs of Hospitals and Health Systems Share Goals for 2011

### 18 52 Women Hospital & Healthcare Leaders

### 19 40 Hospital Benchmarks

#### Hospital-Physician Relationships & ACOs

### 21 7 Steps Hospitals Must Take to Embrace ACOs: From Kevin Brennan at Geisinger Health System

### 21 ACOs: One System's Approach Toward Accountability and Success

### 22 Should Your Hospital Develop or Join an ACO? 5 Questions to Ask

### 23 Accrediting Body Issues Proposed Standards for ACOs, Asks for Comment

#### Hospital Finance & Business News

### 24 7 Factors to Assess the Sustainability of a Hospital: Assessing a Hospital's Viability, Its Financial Situation and the Severity of the Threats it Faces

### 25 10 Successful Hospital Turnarounds

### 27 8 Things to Know About Medicare's Bundled Payment Pilot

### 28 Bundled Pricing Opportunities & Challenges: Q&A With Baptist Health System's Michael Zucker

### 27 Brochure for Improving Profitability and Business and Legal Issues Conference

### 35 The Case for Shifting More Services to Midlevel Providers

#### Stark, Fraud & Abuse

### 36 9 Key Considerations for Healthcare Internal Investigations

### 37 Maryland's St. Joseph Medical Center to Pay \$22M to Settle False Claims, Kickback Allegations

### 38 CHRISTUS Health in Houston to Pay \$1M Settlement in Medicare Fraud Lawsuit

### 38 Ohio's Marion General Pays \$1.2M to Settle Stark Violations

### 38 Simi Valley Hospital Settles Medicare Fraud Lawsuit, Agrees to Pay \$5.15M

#### Transactions & Valuation

### 39 6 Things Health Systems Look For When Acquiring a Hospital

### 40 University of Louisville to Merge With CHI, Jewish Hospital & St. Mary's

### 40 Michigan Attorney General Approves Detroit Medical Center Sale

### 40 Caritas Christi Sale Finalized; New For-Profit System Plans ACO

#### Compensation

### 41 4 Factors That Determine Hospital Executive Compensation

### 42 5 Factors Affecting Physician Compensation

### 43 5 Top-Paid Medical Specialties

### 43 Physician Compensation and Revenue Differs Based on Hospital Ownership

#### Healthcare Information Technology

### 44 11 Best Practices for Maximizing Healthcare IT Incentive Payments

### 46 CCHIT to Launch EHR Certification for Hospitals

### 46 CMS in Final Stages of Testing Incentive Management Systems

### 47 Changes to HIPAA in the Interim Rule and Best Practices for Maintaining Compliance

#### Executive Briefing: RTLS

### 48 7 Best Practices for Installing Real-Time Location Systems in Your Hospital

### 52 Case Study: Implementing RTLS at Texoma Medical Center

#### Facts & Figures

### 53 For-Profit Hospital Operators 3Q 2010 Financial Results

### 54 Hospital & Health System Executives Moves

### 54 Hospital and Health System Transactions

### 55 Advertising Index

## Publisher's Letter

2010 was an interesting year for hospitals. Hospital leadership, with the overhang of healthcare reform, aggressively examined and often moved forward with plans for accountable care organizations. Every system also seemed to be refining and adopting a new physician alignment strategy. Hospitals also had to pay new levels of attention to recovery audit contractor issues, fraud and abuse issues and other types of legal concerns.

Finally, a large percentage of the 1,600 to 1,700 independent hospitals in the country continue to examine whether or not they can stay independent and thrive for the long run.

2011 promises to be a really interesting year on several fronts as well.

Throughout the year, *Becker's Hospital Review* will cover the most important issues facing hospitals. For a free subscription to the magazine mailed nine times a year, please email [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com) or visit our website at [www.beckershospitalreview.com](http://www.beckershospitalreview.com). Please also review the channels and the website at [www.beckershospitalreview.com](http://www.beckershospitalreview.com).

We are excited to host *the Becker's Hospital Review Annual Meeting* May 19<sup>th</sup> and 20<sup>th</sup> in Chicago. The meeting is focused on ACOs, improving profitability, key specialties and physician-hospital integration. We have outstanding keynote speakers and 53 different focused business sessions.

If you register early for the meeting, by February 1, 2011, please deduct \$275 from the registration price and register for the total price of \$500.

We look forward to seeing you in May.

Should you have any questions, please contact me at (312) 750-6016 or at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com).

Very truly yours,



Scott Becker

P.S. For advertising and business related inquiries please contact Jessica Cole, President and CEO of ASC Communications at (312) 505-9387 or at [jessica@beckersasc.com](mailto:jessica@beckersasc.com).

Both are experts with sharp instruments...  
One is focused exclusively on healthcare.



Many consulting firms offer FMV analysis...  
We are focused exclusively on healthcare.

HealthCare Appraisers  
INCORPORATED

Experts in *Healthcare* FMV

[www.HealthCareAppraisers.com](http://www.HealthCareAppraisers.com) | [info@hcfmv.com](mailto:info@hcfmv.com) | (561) 330-3488

Delray Beach | Denver | Dallas | Chicago | Philadelphia

### HealthCare Appraisers

provides a full spectrum of valuation services and Fair Market Value ("FMV") solutions **exclusively** for the healthcare industry:

### Compensation & Service Arrangements

- Employment Arrangements
- On-Call Arrangements
- Medical Directorships
- Co-Management Arrangements
- Collections Guarantees for Hospital-based Physicians
- Joint Venture Relationships
- Affiliations

### Business Valuation

### Consulting & Advisory Services

### Litigation Support

# 10 Ways to Cope in This Anxious Time of Healthcare Reform

By **Chuck Lauer**, Former Publisher of Modern Healthcare and an Author, Public Speaker and Career Coach

**1. Hold meetings with staff.** Hold a series of meetings with all your personnel — nurses, physicians, housekeeping and others — to talk about the implications of the healthcare reform act. There's a lot of confusion in all quarters about reform. Discuss how it could affect them both personally and professionally. Most hospital personnel I've talked to don't have a clue about what issues and problems their C-suite executives are dealing with. Enlighten them on what's at the top of your mind so they won't be surprised when changes come.

**2. Walk around your institution.** Now is the time for all C-suite executives to pay a visit to various departments and talk with all levels of personnel. Ask board members to walk around, too. Then they'll be able to understand exactly what you have been talking about in your discussions with them. Some board members will probably not have the least bit of interest in doing this because of their schedules but others will respond enthusiastically. It may be a risky move but in the end it will be helpful when you have to go to the board and ask for support and funding of various projects.

**3. Become a new person.** CEOs tend to have so many administrative problems confronting them that they forget the real business of a hospital. Sometimes, in both large and small institutions I have visited, the personnel don't have a clue who the CEO is. That should never be the case, no matter what size your institution is. Start turning to your C-suite team to handle pressing problems while you become more visible — not only to your people but the patients who have chosen your institution for care. In short, get out of your office and spend more time on the firing line.

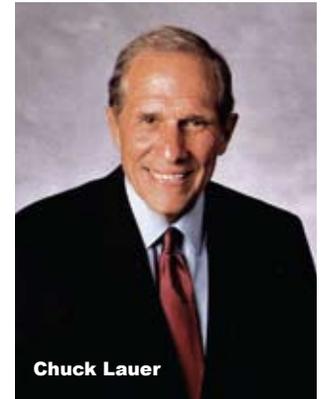
**4. Reach out to physicians.** Some physicians are frustrated and angry. They may have returned to the hospital as employees after trying to run a surgery center or participating in a group practice. They think they know what's going on, but from my experience they really don't know what the hospital is all about and they don't know what is in store for them as employees. They think the hospital is a fat cat, making money hand over fist and not sharing it with them. The more you enlighten them about what is going on, the better it will be for you and your board.

**5. Speak to the community.** Now is the time for you to get more involved in the community. Offer to be a speaker at various meetings and conferences. Talk about your institution and what is happening inside it. Most laymen don't have a clue about what is going on there, so it's important for you to enlighten them. Talk about the things that affect you: healthcare reform, the difficulty of attracting new physicians and about anything else you feel is appropriate. Give them a dose of reality and they will respect you for it. They are as confused as everyone else is and they need your leadership.

**6. Groom your own leaders.** There is a critical shortage of real leaders in all industries. Leaders who are willing to take risks, leaders who enjoy their roles, leaders who can make sound and well balanced decisions. Mentoring is a sorely needed resource. A major vacuum will develop in your institution without it. It's hard to take the time to mentor others these days but someone took the time to mentor you, didn't they? Develop your own leaders in your own organization so that when the time comes for you to retire, you can leave it in the hands of people you developed into true and responsible leaders.

**7. Showcase heroes who can inspire.** Every day in a hospital, there are people who do extraordinary things that need to be recognized for

their performance. Every week, make sure one or two individuals — maybe even three or four — are recognized for their contributions to the excellence of the institution. Their deeds and actions will serve as inspiration to others, which will have a sizeable impact on morale. It also shows that those in management positions really do care and can recognize exceptional work.



Chuck Lauer

**8. Rework your mission statement.** Your mission statement should be up-to-date to reflect the current state of the healthcare industry. View it as an evolving document. Hanging it on the wall in the lobby doesn't really inspire anyone. Take it down every so often and rethink it, with the help of your staff. They are the ones who live the mission every day.

**9. Greet arriving patients.** Have you ever gone to the ED to observe how patients are treated when they first enter? I bet not, but that's only a guess. How about sitting at the information desk when people arrive and need directions to whatever department they need to go to. Do you give them eye contact and maybe even lead them where they need to go? People entering a hospital are confused and intimidated. How do personnel at the information desk handle people who are our customers?

**10. Say thank you!** When people are discharged from your hospital, do you ever take the time to thank them for coming? The next contact they get after discharge is usually a paper questionnaire asking them about their stay. Why not talk to them before discharge? Then they can give you their true feelings about their stay and you can get a better fix on the way they were treated as customers in your hospital. Stop asking patients to fill out forms and start talking to them — either on the phone or, better yet, in person. ■

*Chuck Lauer ( [chuckspeaking@aol.com](mailto:chuckspeaking@aol.com) ) was publisher of Modern Healthcare for more than 25 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide.*

## Becker's Hospital Review Annual Meeting ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

Great topics and speakers focused on key business, clinical and legal issues facing hospitals and health systems —  
53 sessions, 79 speakers

Featuring Keynote Speakers Chip Kahn, President, Federation of American Hospitals; Peter Kongstvedt, Principal, P.R. Kongstvedt Company, and Senior Health Policy Faculty Member, George Mason University; and Richard Pollack, EVP, Advocacy and Public Policy, AHA

May 19-20, 2011 • Chicago, IL

To register, call (800) 417-2035

or e-mail [registration@beckershospital.com](mailto:registration@beckershospital.com)

Register online: <https://www.regonline.com/beckershospitalreviewannualmeeting>

For more information, visit: [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)

**The Year Ahead: 10 Key Trends for Hospitals in 2011**  
(continued from page 1)

University of Rochester (N.Y.) Strong Memorial Hospital & Highland Hospital. For the fiscal year that started in October, CMS implemented a 2.9 percent reduction in the market basket update for hospitals, says Carolyn Scanlon, president & CEO of the Hospital & Healthsystem Association of Pennsylvania. CMS said hospitals were overpaid in 2008 and 2009 due to changes in hospital coding practices that do not reflect increases in patients' severity of illness, but Ms. Scanlon says CMS did not account for the historical trend in case mix growth.

Meanwhile, Congress may consider more cuts for hospitals, recommended by the president's bipartisan deficit commission, the National Commission on Fiscal Responsibility and Reform. Recent recommendations by the co-chairmen of the commission included many proposals affecting hospitals, such as accelerating cuts in disproportionate share payments, immediately putting hospitals under the purview of the Independent Payment Advisory Board, reducing teaching payments for hospitals and cutting bad debt payments to hospitals.

Craig A. Becker, president of the Tennessee Hospital Association and an AHA board member, says the proposed cuts would be unfair. "We already gave at the office," he says, referring to \$155 billion in cuts over 10 years that hospitals agreed to in the healthcare reform law. But the chairmen's proposals would still have to be approved by at least 14 of the commission's 18 members, says Charles "Chip" Kahn III, president of the Federation of American Hospitals. He doubts that will happen. However, even if the commission dumps the proposed cuts, Ms. Scanlon says the commission has legitimized them, and they will be fodder for numerous other cost-cutting bodies in the future. "The commission has created a laundry list of areas to look for savings that other people can cherry-pick later," she says.

**2. RACs gather momentum.** Hospitals can expect lower revenues and increased administrative costs in 2011, as Medicare recovery audit contractors gather momentum and Medicaid RACs start. In the first half of 2010, all four Medicare RACs denied \$19.2 million in Medicare claims and about half of reporting hospitals reported increased administrative costs due to the RAC program, according to the AHA's RACTrac survey. Medicare RACs are just gearing up in some states, such as Pennsylvania, Ms. Scanlon reports. Medicaid RACs, which start in each state by the middle of 2011, aim to recover \$9 billion a year by 2012 — a bonanza for states low on funding. Each state is supposed to have contracted with a RAC by Dec. 31 with a start date of April 1, but some predict implementation may be postponed until July.

**3. More uncompensated care.** "Hospitals are still required to take care of any patient who comes through their doors," Mr. Goldstein observes. Even as the economy recovers, already high numbers of uninsured are expected to climb further next year, because unemployment is a lagging indicator in the recovery. Mr. Kahn says numbers of uninsured, a lagging indicator in a recovery, are not about to fall and may even increase in 2011. "This is not going to get any better until 2014," he says. The CDC estimated 59.1 million Americans were uninsured at some point in the 12 months that ended April 1, 2010 — 9 million more than were estimated in a previous Census Bureau study.

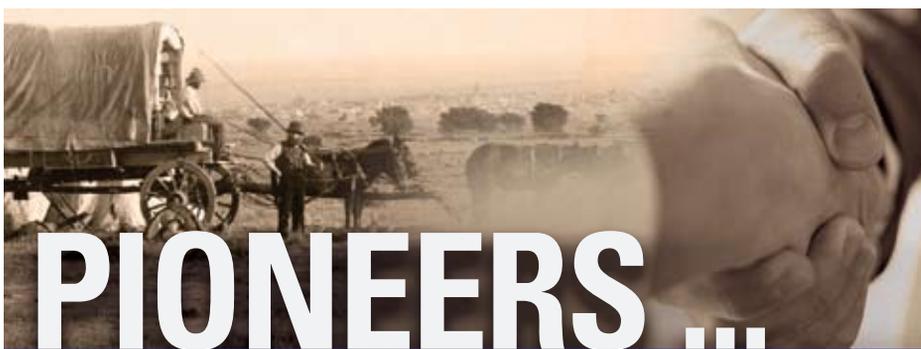
Because the reform law waits until 2014 to expand coverage to 32 million more Americans, "the next few years will be difficult for hospitals, with a downward pressure on utilization," says Allan Baumgarten, a Minneapolis-based research consultant who reports on healthcare markets. "To be competitive, hospitals will have to balance the challenges before them." For example, they will need to build relationships with physicians and make investments in healthcare IT.

**4. Political gridlock.** Republicans took over the U.S. House while the Democrats hung on to the Senate in the November elections, making it difficult for Congress to pass much of anything, Mr. Becker says. "We will have two years of gridlock in Washington," he predicts. Historically, a divided Congress means lower federal spending. This could dampen efforts to ensure adequate Medicare reimbursements, such as passing a permanent Medicare physician fee fix at a cost of more than \$300 billion. Rather than answering

healthcare groups' plea to pass a 13-month fee fix, Congress may pass a series of short-term fee fixes into next year, as demonstrated by its plans to pass a one-month fee fix to end Dec. 31.

Perhaps even more striking than its victory on the U.S. House, the GOP picked up at least 11 governorships and many state legislatures in the November elections. Though this change probably won't create gridlock, it could slow the wheels of government as the new regimes get started. It also presents new opportunities for hospitals, Ms. Scanlon says. As Pennsylvania shifts from Democratic to Republican leadership, she thinks there will be a chance to pass tort reform, traditionally a GOP issue. Pennsylvania voters have replaced their Democratic governor and House with Republicans, who also retained the state's Senate.

**5. Uncertain fate of healthcare reform.** Senate Minority Leader Mitch McConnell (R-Ky.) has called the healthcare reform law "the single worst piece of legislation that's passed since I've been in the Senate" and he and Rep. John Boehner (R-Ohio), the presumptive Speaker of the House next year, have vowed to repeal it. President Obama's veto pen will probably make sure they don't, but hospitals face the possibility that some parts of the reform law may be discarded, says Ron J. Anderson, MD, president and CEO of Parkland Health and Hospital System in Dallas and an AHA board member. "There are so many ways to hold it up through hearings and not fund parts of it," he says. Healthcare organizations may even help start the dismantling process. The AHA recently backed the repeal of the Independent Payment Advisory Board, which the AMA has long opposed. Under the law, the board



in Physician-Hospital Joint Venture Surgery Centers.  
**Our Focus Since 1995!**

**FREE on-site consultation!**

Call us at 877.304.8940

[info@healthinventures.com](mailto:info@healthinventures.com)



health inventures.

[www.healthinventures.com](http://www.healthinventures.com)

will direct HHS to carry out specific physician payment cuts starting in 2015, and hospitals would come under its purview in 2020.

Dr. Anderson thinks partial repeal would be a big problem for hospitals. "Different pieces of the law are all tightly woven together," he says. "If you pull out one thread, you don't know how much it's going to weaken the whole thing." For example, hospitals have put up with some unpleasant aspects of the reforms, such as lower Medicare reimbursements, with the understanding that there would be more patients to make up for those losses, but the chief target of reform opponents is to repeal the individual mandate. Should that be repealed, "Hospitals are going to say, 'If you're not covering these people you're not living up to the deal,'" Dr. Anderson says.

**6. Anticipated ACO rules may open the floodgates.** Right now, most hospitals are holding off on starting accountable care organizations, but the floodgates could open if hospitals like the proposed rules for ACOs, which CMS is expected to release before the end of the year. Hospitals "haven't been sure just what an ACO is," Mr. Kahn says. "When the regulations are out, they will be able to determine whether they want to participate."

Without regulations defining these organizations, "the ACO is a unicorn, in the sense that no one has ever seen one," Dr. Anderson says. Mr. Becker reports very few hospitals in Tennessee have started ACOs, and Ms. Scanlon cannot think of any hospitals in Pennsylvania that have done so, though she notes that a few integrated systems like Geisinger Health System could easily form one. The proposed rules would have to address a number of anxieties hospitals have. For example, Mr. Becker doubts whether there will be enough money in "shared savings" payments to make it worthwhile to operate an ACO. Dr. Anderson says he is concerned that Medicare beneficiaries would have a chance each month to decide to leave ACOs, because that would make it difficult to maintain stability.

If the floodgates open and everyone decides to build an ACO, hospitals and group practices would have to decide who would run them, says Robert Betka, a hospital consultant at Catalyst Management Advisors in Grand Rapids, Mich. "Who will be leading the show, the hospital or the physician?" he says. "The physicians are the ones who generate the hospital revenues, but hospitals will want to have a say. I don't think it's going to be pretty."

**7. Greater focus on experimentation.** Ms. Scanlon says in order for hospitals to prosper next year and beyond, they will have to be creative. "It's about creating new forms of healthcare delivery," she says. "Payment for bundled package of services is going to be the future. Hospitals will take risk for finances and for outcomes. They will need to form new organizational alliances or new payment vehicles." In addition, they will need to align not just with physicians but with other providers such as rehabilitation and long-term care services.

Leading this new focus on experimentation will be CMS' new Center for Medicare and Medicaid Innovation. With \$10 billion in funds to dole out in the next 10 years, the center will be testing aspects of ACOs and a variety of other models to reduce healthcare costs and improve quality. "These new models may or may not be scalable, but it does begin the process," Mr. Kahn says. Medicare Administrator Don Berwick, MD, is orchestrating all this experimentation, but his recess appointment expires at the end of 2011. To stay on, Dr. Berwick would have to be approved by the Senate, but "I don't think he can be approved," Mr. Kahn says. Opponents of reform have targeted him as the poster child of all they see wrong with the reform law, citing his comments about rationing of care and the advantages of Great Britain's system of socialized medicine.

**8. States will further cut Medicaid spending.** Cash-strapped states included big cuts in Medicaid in their 2011 budgets. "The next few years will be enormously challenging," says Mr. Goldstein at Strong Memorial. "There will be declining federal and state funding. Medicaid cuts in particular. Hospitals are still required to take care of any patient who comes to their door."

Medicaid funding could get worse next June, when extra federal funding for Medicaid ends. But Mr. Kahn says the degree of the problem varies by state and, in any case, the healthcare reform law requires states to maintain a minimum level of eligibility. Also, many states have been using the enhanced funding for non-healthcare activities, Mr. Becker says. He says his own state of Tennessee, for example, has been using part of the funds for schools.

**9. Healthcare IT payments start.** "Many hospitals do not have IT systems," Mr. Goldstein says. "The challenge for hospitals is to find the resources to build IT and work with the medical community to implement IT for physicians." Dr. Anderson says Parkland has a \$100 million electronic health record system, but that level of investment may be overwhelming for some hospitals. "If I were a small rural hospital, I'd probably think differently about EHRs," he says.

Federal funding for "meaningful use" of EHRs, which starts next May, may be a strong incentive for hospitals to take the plunge. Some \$30-\$40 billion will be distributed to hospitals, physicians and other providers, with each hospital receiving as much as \$11 million and physicians' offices getting as much as \$44,000 to \$64,000 per physician.

**10. More hospital consolidation likely.** Hospitals are shifting to more integrated systems in expectation of ACOs and other bundled payment arrangements. For-profit companies are completing blockbuster takeovers of systems in Detroit and Boston, and there could be many more consolidations to come, carried out by for non-profits as well as for-profits. "This trend could continue," Mr. Kahn says. "There are more available options for hospitals, such as investments to grow IT, if they are part of growing systems."

Consolidations are also fueled by declining reimbursements, with small hospitals and physicians running into the arms of hospital systems. "A lot of people want to be part of a larger system," Mr. Baumgarten says. "And yet the well managed independent hospital has very good potential for the future." ■

Improve Your  
Infection Control

with the nation's #1 provider  
of linen and laundry rental  
services to the medical industry.

ImageFIRST™

HEALTHCARE LAUNDRY SPECIALISTS



*We Deliver confidence, convenience and patient comfort.*

1-800-932-7472 • [www.imagefirst.com](http://www.imagefirst.com)

BECKER'S

Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

---

SIGN UP FOR A FREE ONE-YEAR  
SUBSCRIPTION! CALL (800) 417-2035!

## 9 Strategies for Maintaining Profitability in 2011 and Beyond (continued from page 1)

### Looking outside of your organization

**1. Focus on physician integration.** More hospitals are turning to employment and physician integration as a means of preparing for future reimbursement models. Bob Meyer, president and CEO of Phoenix (Ariz.) Children's Hospital says his organization has aimed to increase physician integration for some time with a focus on the hospital's employed medical group and recruiting specialists without hurting its strong referral base of independent pediatricians. Mr. Meyer says hospitals should market themselves to those physicians who are leaning towards hospital employment and integration as an alternative to private practice.

To increase physician integration, Mr. Meyer hopes to attract a physician leader to Phoenix Children's. "We're in the process of recruiting a national figure to be the physician CEO or leader of our practice management group because what is very important is having a strong physician leader at that high of a level," Mr. Meyer says. "In my opinion, the most successful practice management models are all physician-led."

Mr. Meyer says hospitals need to start including clinicians — physicians and nurses alike — in the strategic development of their organizations. "We have a shared governance model where physicians have a fair amount of input into our overall, long-term strategy, and the ability to recruit and have those physicians aligned with us is the first step in our strategy toward success."

David Pate, MD, JD, president of Boise, Idaho-based St. Luke's Health System, agrees with Mr. Meyer and says hospitals should work toward a goal of increased physician alignment. "How can hospitals work with physicians to get aligned to better manage throughput, length of stay, help minimize hospital-acquired illnesses and prevent avoidable readmissions? Those things are going to help us prepare to be more successful in the direction where healthcare is going under healthcare reform," he says.

**2. Affiliate and align with other institutions or healthcare organizations.** Mr. Meyer says Phoenix Children's has entered into affiliation agreements with the University of Arizona to expand its relationship with the university's medical school. The incentive of receiving graduate medical education funding from the state in order to provide care to Medicaid beneficiaries also drove the move toward an affiliation. In addition to its educational affiliation, Phoenix Children's has also built a strategic alliance with St. Joseph's Hospital in Phoenix to combine the two organizations' pediatric expertise and offerings, which will allow the two groups to establish a stronger foothold in an intensely competitive healthcare climate.

"There is a tremendous strategic benefit to combining service lines across our two organizations," Mr. Meyer says. "St. Joseph's already has a well-developed pediatric program, and so on a combined basis our volumes put us at No. 1 in the country for pediatric neurosciences, No. 6 for pediatric orthopedics and so on. Those service lines, which are our centers of excellence and strategic focus, will later allow us to recruit leaders in those programs and build upon our reputations."

Gary Weiss, CFO of NorthShore University HealthSystem based in Evanston, Ill., adds that hospitals should consider the benefits of alignment with stronger and more viable health systems. In order to maintain profitability, hospitals and health systems will have to find ways to become more efficient and flexible in an increasingly dynamic healthcare landscape, especially as more Americans become insured as part of healthcare reform. While smaller hospitals could possibly look to merge with larger and more financially stable hospitals, larger hospitals are likely very interested in opportunities to absorb additional revenue streams by acquiring and integrating smaller organizations or group practices. "It will be an increasingly difficult environment for smaller hospitals to make investments in technologies, equipment and uncompensated care in an industry where the competition has certainly heated up.

Practice groups might also assess the tradeoffs in finding strength in finances and talent to face this difficult environment," he says.

**3. Collaborate closely with private payors.** With decreased reimbursements from Medicare and Medicaid, hospitals will have to turn to private payors and explore non-traditional contracts that revolve around quality of care, as opposed to fee-for-service. Dr. Pate says hospitals should consider working with private payors to compensate for the lack of reimbursement from federal healthcare programs. Because private payors often-times mirror federal healthcare programs' changes in reimbursement and coverage, hospitals should exert more effort into working collaboratively with private insurers to negotiate reimbursements that are fair and quality-based. Quality-based reimbursement gives insurers an incentive to continue working with a facility that demonstrates a commitment toward excellent clinical outcomes.

"The current reimbursement mechanism encourages utilization of services, so the more you do the more you get paid," says Dr. Pate. "The answer for healthcare organizations is to effectively work and talk with payors on how to change the reimbursement system so that the system rewards behaviors for improving outcomes and quality of care at lower costs."

In order to achieve this goal, hospitals will have to turn away from the long-adopted tradition of fee-for-service payment models and consider alternative payment methodologies, such as a shared savings program where insurers would be able to pocket some of the savings achieved from improved patient care and outcomes. Because many private insurers are skeptical and not ready to take on significant risk, the key is working and collaborating closely and fostering relationships with private insurers, which will help your healthcare organization successfully adopt an alternative payment method, Dr. Pate adds.

### Looking Within Your Organization

**4. Adopt business and operational models better suited for future changes.** Because the healthcare industry is becoming inundated with a number of factors that could — and most likely will — drastically change the way healthcare has traditionally been delivered, hospitals have little choice but to alter their approaches to business and operational models to acclimate to the changes that are likely to occur.

"I view the hospital as an enterprise having three lines of business that are distinctly different, and each need a unique infrastructure in order to continue achieving business success," Mr. Meyer says. "Those three are physician practice management, hospital business and fundraising. Each of these will require unique IT requirements and will be led by individuals with different skill sets."



ASC Development, Management, & Billing

Physician Practice Billing

Payor Contracting Consulting

Facility Operations Audits

*Partner for Prosperity*

(970) 685 - 1713

Reaching out to philanthropic sources as an added source of funding is a nontraditional option more hospitals may need to consider going forward, Mr. Weiss says. Additionally, hospitals will have to consider the slow turnaround of the economy and develop more flexible options for patients who are struggling financially — possibly by offering financial counseling and flexible payment plans for medical services. “Hospitals and health systems need to find ways to obtain payment for services provided to remain viable providers of health care in their communities at a time when the rate of unemployment is lingering at approximately 10 percent,” Mr. Weiss says. “The key is thinking of new ways to operate in a difficult economic environment to remain profitable.”

**5. Denial management should be a focal point.** Although many hospitals already have established billing departments, coders and other hospital staff members to assist in maintaining an efficient revenue cycle, it is incumbent upon hospitals now, more than ever, to ensure revenue cycles are efficiently and effectively capturing appropriate payments. Particularly with the upcoming transition from ICD-9 to ICD-10 codes, hospitals will need to take extra precautions to ensure their respective organizations are in-tune with correct coding guidelines. Mr. Meyer says Phoenix Children's, which has historically faced challenges with denials, has a renewed focus on open communication in order to reduce the organization's rate of claims denials.

“Part of our problem with claims denials was the integration of our physician group and hospital because a lot of referrals come from that group. This pushed us to break down the silos between physicians, the hospital and billing department and put more focus on the connect points between all these groups,” Mr. Meyer says.

**6. Revisit staffing costs at your healthcare organization.** Staffing costs are one of the largest expenses for healthcare organizations, so hospitals should revisit them to ensure productivity and efficiency are balanced. If the balance is off-kilter, hospitals will need to find ways to streamline staffing costs or reorganize the hospital's structure. Dr. Pate says hospitals should not immediately jump to layoffs but instead reassess every position and ensure the organization is not under- or overstaffed.

“From my perspective, hospitals often go after layoffs because it's the easiest area to start cutting down costs,” Dr. Pate says. “But what can sometimes happen is, if you reduce your work force, you have a lot of unanticipated costs associated with those layoffs, and sometimes organizations that

lay off their employees end up hiring those same positions back anyway.”

Dr. Pate suggests hospitals look at ways to streamline staffing and reduce overtime pay as an alternative to layoffs. Many healthcare organizations have implemented lean processes that cut out waste and establish more efficient processes and procedures.

### 7. Set targets to reduce cost per patient day in the hospital.

Dr. Pate says hospitals can increase profitability by focusing on areas that cost the organization the most money. Length of patient stay is one of these areas. Hospitals should look very closely at the processes and procedures that may be contributing to increased lengths of stay and make the appropriate changes in policies to reduce that time.

“For example, hospitals may want to assess their emergency departments to make sure their patients are not staying in that department for an inordinate amount of time, which can become more costly and result in poorer clinical outcomes,” he says. “If you have that long of a delay in the throughput, the hospital has to start asking itself how to get treatments and patient care delivered in a more timely manner.”

In conjunction with looking retrospectively at ways to reduce patient readmissions and prolonged lengths of stay, hospitals should also be proactive in preventing patient admissions in the first place. “There is an additional opportunity for hospitals that focus on improving quality and safety, which leads to avoidance of complications. Better quality is less expensive care if you can deliver it right the first time,” Dr. Pate says.

### 8. Adopt healthcare IT solutions that can help increase profitability.

Implementing health IT solutions in your healthcare organization is a two-pronged strategy for increasing profitability going forward into 2011. As the federal government continues to roll out criteria and measurements for meaningful use of electronic medical records in 2011 and beyond, healthcare providers can cash in on incentives to be doled out upon demonstration of meaningful use. Further, it is already widely accepted that cornerstones of health IT solutions, such as computerized physician order entry and EMRs, are proven tools to cut down costs, streamline efficiency and improve clinical outcomes.

In one such example of using health IT to reduce costs, NorthShore, which has been using an EMR since 2003, implemented a web portal for patients called NorthShoreConnect. The portal allows patients to log in and sched-

## West Coast Medical Resources, Inc.

*Proudly serving the surgical community since 1997*

[www.westcmr.com](http://www.westcmr.com)

**Managing your unwanted disposable surgical inventory wasn't part of your job description...  
So put our fourteen years of experience to work and let us do what we do best.**

Every year your facility experiences product conversions from new contracts, surgeon preference changes, and many other factors. OEMs and distributors simply don't take most inventory back. So how do you maximize your return and minimize wasting your time dealing with it?

**CALL THE SURPLUS  
SPECIALISTS  
... WCMR !!!**

**Randy Ware, President / Founder**

**Toll Free: 800-565-6385**

**Phone: 727-392-2800**

**Fax: 407-386-9555**

**[westcstmed@westcmr.com](mailto:westcstmed@westcmr.com)**

What am I going to do  
with all this STUFF?!



ule visits to their physicians and view results of tests they underwent along with notes from their physicians. "That's a game changer in the delivery of care. It's giving new tools to patients allowing them to have more control of their healthcare, and on the hospital side, we don't need a staff member to schedule that test or visit or make that follow-up phone call anymore," Mr. Weiss says.

As an early adopter of technology, NorthShore has also invested in sophisticated software that enables the organization to capture data on patient diagnosis, treatments and outcomes and analyze what treatment methods yield the best clinical results, thereby reducing the potential for readmission.

"We have a large research institute that is pursuing informatics on healthcare experiences to understand the quality of the healthcare provided. Our goal is to develop more standardized treatment protocols that will lead to better outcomes. Our industry will be pursuing this more, and those that are able to do this effectively will be in a better position to build the greatest patient loyalty, quality and profit margins," Mr. Weiss says.

**9. Prepare for the future.** Despite a rather cloudy future — with rules and regulations over ACOs and meaningful use looming on the horizon and a precarious economy still on its way to recovery — healthcare organizations can still do more to prepare for the future. Mr. Weiss says his health system's leaders are working tirelessly to assess every avenue and possible option in the realm of ACOs and creating a work plan ensures success in each of the varying models of care delivery and payment.

"Our management team is dedicating time and resources to take a step back and think about episodes of patient care, shared services models, bundled payments and ACOs. We've included administrators and physicians in the discussion of each of those models for the delivery of care and financing mechanisms, whether it be value-based purchasing, episodic payments, capitation, partial capitation and so on. We've been considering each of those payment methodologies and what it will take to be successful in each of those scenarios," Mr. Weiss says. ■

### Becker's Hospital Review Annual Meeting ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

Great topics and speakers focused on key business, clinical and legal issues facing hospitals and health systems —  
53 sessions, 79 speakers

Featuring Keynote Speakers Chip Kahn, President, Federation of American Hospitals; Peter Kongstvedt, Principal, P.R. Kongstvedt Company, and Senior Health Policy Faculty Member, George Mason University; and Richard Pollack, EVP, Advocacy and Public Policy, AHA

May 19-20, 2011 • Chicago, IL

To register, call (800) 417-2035

or e-mail [registration@beckershospital.com](mailto:registration@beckershospital.com)

Register online: <https://www.regonline.com/beckershospitalreviewannualmeeting>

[beckershospitalreviewannualmeeting](http://www.BeckersHospitalReview.com)

For more information, visit: [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)

### 10 Ways to Improve Your Hospital's Heart Program (continued from page 1)

involve clinical staff and administrative staff in providing quality care and cutting costs down to the front line. "A lot of outcomes that have to occur are very dependent on who's providing that service," she says. "That can be anyone from the front desk to the billing person, so the leaders have to be able to get the complete buy-in of everyone who contributes to patient care."

She says great leadership means setting clear expectations that can be tracked through measurable outcomes. When physicians, nurses and staff members submit reports on their progress, the cardiology leaders should look at the results and make a tangible plan to improve. "When people don't meet expectations, they need to know your leaders will be invested in solving those problems," Dr. Daniels says. "Just saying, 'Why didn't you meet these outcomes?' is not enough. You need to be willing to redesign processes, develop new care models and use those to overcome shortcomings."

**2. Combine government-recommended quality measures with measures that serve your specific community.** Dr. Daniels says when hospitals track quality, they should focus both on the publicly displayed CMS guidelines and the measures that make sense for their local market. Once the hospital has tracked data on quality outcomes over time, administrators can look at the

results to determine which issues are most pressing for cardiology program patients. Maybe the hospital is suffering from high readmission rates because patients are not instructed in proper post-discharge care. "Leaders need to look at the quality measures physicians feel are critical for patient care in that particular program," she says.

**3. Choose a payment model that incentivizes physicians to perform better.** There are various models of compensation that can incentivize good behavior by physicians, including distributing compensation by the physician group, employing physicians and basing a portion of compensation on meeting quality outcomes. These three options are not mutually exclusive — for example, Massachusetts General Hospital uses pay-for-performance and employs its physicians — but rather are all good ideas for encouraging quality patient care.

*Compensation distributed by the cardiology group:* The University of Minnesota Physicians' cardiology service line lets its two cardiology groups distribute the money received through a particular fee schedule as the group sees fit. This way, the people in charge of monetary distribution are those on the front lines of heart care. "The leaders are still held accountable to make sure call is covered, productivity standards are met and patient needs are met," Dr. Daniels says. "But in cardiology, you may have some people who are predominantly doing clinic visits, and the [lower] revenue they generate may not reflect their value to the overall program." She says the cardiologists

are in the best position to know how their colleagues should be compensated. Conflicts over compensation can also be handled within the group. "Cardiologists want to control their environment and their destiny, and the more they're allowed to participate in how compensation is distributed, the more they will be a valued and engaged partner," she says.

*Employed physicians:* Since its inception, Cleveland Clinic has refused to pay its physicians on a fee-for-service basis. Instead, every physician is compensated 100 percent with a pre-determined salary rather than a combination of salary plus incentives. Steve Nissen, MD, chairman of cardiovascular medicine at Cleveland Clinic's Heart and Vascular Institute, says the policy prevents "turf wars" between physicians and ensures that quality patient care — not financial benefit — is the top priority for every provider. "It's a very liberating environment because it means if you have to take more time with a patient, you take more time," he says. "It's about quality rather than quantity. Rushing patients through and doing more procedures does not enhance the remuneration received by our physicians." Employing physicians also means physicians don't hesitate to refer a patient to a colleague. "If you go into [other institutions], often the interventional cardiologists and the cardiac surgeons are at odds," he says. "That's not the case here. You can't do what's best for the patient if you're protecting your turf. You have to be willing to say, 'Somebody else is better equipped to get a better outcome.'"

*Compensation based on quality outcomes:* At Massachusetts General Hospital, physicians have been compensated based partly on pay-for-performance for the last five years. G. William Dec, chief of cardiology and director of the MGH Heart Center, says the hospital has achieved great outcomes by implementing several aggressive campaigns every year to improve a certain facet of clinical care. A few years ago, the hospital incented physician groups to improve hand-washing by giving a collective incentive to each group if its incidence of hand-washing rose to 85 percent. "Based on feedback from physicians and nurses, that's been very successful," Dr. Dec says. "I've been a visiting professor and made rounds at some very famous places, and I can't count the number of times I've walked into a patient room and the entire team walks in and doesn't wash their hands. At MGH, it's just been hammered into our heads. We all know it's the right thing to do, but providing an incentive is important to getting the process started."

He says instituting pay-for-performance can help improve the reputation of a big academic medical center. "There's this idea that academic medical centers are big black boxes where patients get sent in, and the doctors in the community never hear what happens," Dr. Dec says. "I think that by tracking these kinds of things and making them performance standards, you can change your practices and that perception."

**4. Organize your teams by specialty.** One way to facilitate state-of-the-art care and reduce mortality rates is to organize your physicians according to heart care specialty, Dr. Dec says. MGH's heart care program is organized into 11 disease-specific specialty areas, including arrhythmia management, heart failure, hypertrophic cardiomyopathy, coronary artery disease and other illnesses. Those 11 groups are guided by physician champions, nursing leaders, cardiac imaging leaders and cardiologist and surgeon leaders, and they meet regularly to discuss clinical issues and strategic planning. The 11 groups, while somewhat separate in function, are all housed underneath the heart center steering committee that decides strategic direction for the overall heart program. "When you have these collaborative teams where people really specialize in a particular area, and some surgeons do a lot of bypass surgery and some surgeons work on thoracic aortic disease, you have a group of people with a very high level of experience who know what to do when things go wrong."

**5. Build a structured process for deciding which technologies to invest in.** Dr. Dec says up until recently, physicians at MGH worked with different companies and brought in new technology that sometimes competed with existing technology. Now the hospital is trying to take a more critical approach to adding new procedures and new technologies by appointing a committee that reviews the cost, potential benefits and implications of each suggested addition. "These are often very

large investments, like getting a surgical robot for the OR or getting a new valve program," says Dr. Dec. "If we're considering a new procedure, we think about how many we could afford to do, how much time it will take, whether it will displace other services and what tests would not be paid for based on insurance percentages."

James T. Willerson, MD, president of Texas Heart Institute in Houston, says the heart institute works with companies to develop devices with potential for use in heart and vascular disease. "If a company has developed something that we want to use, we tell them we want to be a partner with them for the development and help make the product constantly better," he says. He says the institute also promotes physician-led research because physicians are so in tune with the needs of their patients. "Physician-led research translates to things that are the most important to the patient," he says. "Those are the things that have a direct effect at the patient's bedside."

**6. Review every single patient death.** According to *U.S. News & World Report*, mortality rate is used to rank the best heart centers in the nation. Though the top-ranked heart centers are also judged on their willingness to accept difficult cases — and lots of them — they are also expected to keep mortality rates low. With one of the highest patient severity levels in the country at 7.2 in 2009, Cleveland Clinic impressively manages to keep mortality rates for cardiac surgery patients low at 2.7 percent. Dr. Nissen attributes this accomplishment to the Clinic's heart institute's strict policy about reviewing patient deaths. "The purpose of each [quality review] is to understand if there was anything we could have done better or differently. What can we learn from the loss of the patient?" he says.

The institute could game the system, he says, by accepting easy cases to improve mortality rates. But it doesn't. The patients operated on at the institute are "among the sickest of the sick." The trick to accepting difficult cases and maintaining low mortality rates is having consistent policies in place to educate physicians on the routine for every procedure. Every procedure has an accepted set of policies associated with it, and every action is documented and measured to determine where problems lie. "Does that mean every single patient has a great outcome? No," Dr. Nissen says. "But we always try to learn something from our successes and our failures, and we review [both types of] cases."

**7. Eliminate unnecessary transitions between providers.** When ranking the best heart hospitals in America, *U.S. News & World Report* prioritizes a high volume of cases as well as high levels of patient satisfaction. Those two factors might seem at odds with each other, since more patients presumably means less time spent with each. However, Dr. Dec says MGH deals with its high volume of patients by doing a careful evaluation of each patient before sending him or her to a provider. "For new patients, we have an outpatient access office, where a few nurses talk to the patient and the physician about what type of cardiologist or surgeon the patient needs to see," he says. "We avoid redundant work-ups, so while the patient may have to wait for an appointment, the physician will be the right person [for their condition]." He says when the patient sees the right specialist in his or her first appointment, the hospital eliminates time spent transitioning the patient from a general cardiologist to another provider.

**8. Track your percentage of new patients and try to increase it.** Dr. Dec says MGH keeps track of the percentage of new patients rather than follow-ups for each physician group and each individual physician. "We are challenged to keep open slots for new patients, and we'd like to start doing 30 to 40 percent new patients," he says. He says the difficulty in keeping new patient volume high is that people who come to the hospital for a cardiac service and have a good experience may not want to return to their original community physician. "There's a tremendous amount of loyalty and they want to come back for their lifetime," he says. "You have to help move that transition because a lot of that care can be done by physicians in the community quite well. The challenge is trying to migrate people after the procedure."

## Becker's Hospital Review Annual Meeting ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

Great topics and speakers focused on key business, clinical and legal issues facing hospitals and health systems —  
53 sessions, 79 speakers

Featuring Keynote Speakers Chip Kahn, President, Federation of American Hospitals; Peter Kongstvedt, Principal, P.R. Kongstvedt Company, and Senior Health Policy Faculty Member, George Mason University; and Richard Pollack, EVP, Advocacy and Public Policy, AHA

May 19-20, 2011 • Chicago, IL

To register, call (800) 417-2035

or e-mail [registration@beckershospital.com](mailto:registration@beckershospital.com)

Register online: <https://www.regonline.com/beckershospitalreviewannualmeeting>

For more information, visit: [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)

### 9. Promote good relationships with community providers and other hospitals.

If your cardiac program has good relationships with referring physicians in the local community, you can guarantee a steady stream of patient volume. Especially if you serve as a regional referral center for several hospitals without robust cardiac programs, your hospital can provide a great resource to remote communities and receive generous referrals as a result.

Julie Thompson, the STEMI coordinator at Theda Care health system, says the health system has improved relationships with community hospitals by reducing the time it takes to identify patients as having a STEMI heart attack and route them to the appropriate provider. "If a rural hospital sends a patient to us, we can identify through our EMS service that they're having a STEMI heart attack in their living room, and by the time their family drives to our hospital to be with them, they're already tucked in bed and recovering," she says. Improving early identification of heart conditions can increase the patient volume you receive from remote hospitals because the hospitals know their patients will be handled well.

Your hospital can build good relationships with community providers by asking physicians to reach out to local physicians and offer your services. "Many physicians in the greater New England community have established personal relationships with our staff, and there are a lot of really tight relationships between our long-term cardiologists and referring doctors in the community," Dr. Dec says. "Those kinds of relationships are just nurtured by keeping in touch with the community."

**10. Promote collaboration between nurses, physicians and administration.** The *U.S. News & World Report* rankings for heart care are partly based on a hospital's nursing standards. Nearly three-fourths of

the ranked facilities — including the Cleveland Clinic and Massachusetts General Hospital — are recognized by the American Nurses Credentialing Center as "Nurse Magnet" hospitals for high-quality nursing care, an honor awarded to only one in 15 U.S. hospitals.

Dr. Dec says MGH encourages nurse leadership by appointing the heart care nursing director as one of the senior vice presidents of the hospital. "She has a tremendous amount of influence about decision-making and where resources are put and how staffing is done," he says. "She is at most senior leadership meetings emphasizing the importance of nursing." He says appointing strong nurse leaders — and encouraging lower-level nurses to work toward leadership positions — will emphasize the importance of nurses to your heart care program. He adds MGH has an active program through the Knight Foundation that encourages nursing leadership and nursing research. "If there's a particular look at changing the way discharge is done on one of our cardiac floors, the nurse leader for the care team brings a whole cadre of nurses to talk about the nitty gritty and explain where delays exist," he says.

Dr. Nissen says Cleveland Clinic also encourages nurses to get involved with important issues and take on leadership roles. Instead of adhering to a traditional hierarchy where the physician knows best, the Heart & Vascular Institute encourages nurses to speak up when they see a problem. "If you have a mutual respectful relationship with the nursing staff, it makes an enormous difference," he says. "Occasionally a nurse will complain that a physician is [treating a nurse poorly], and I call them in and say, 'That's not how it works here.' We give our nurses a seat at the table." He says this policy attracts the best nurses in the country, and those that work at the Clinic are happy with their jobs. ■

## Are Your OR Expenses Putting Your Hospital Under Water?

Staying afloat for many hospitals today depends upon how well administrators balance financial and administrative performance and clinical outcomes with quality. For these hospitals, taking a critical look at the OR—anesthesia services in particular—may reveal quality and performance issues that typically lead to the erosion of profits.

Learn more. Download "Five Warning Signs of Suboptimal Anesthesia Management", our free white paper, at [info.somniaanesthesiaservices.com/suboptimal2/](http://info.somniaanesthesiaservices.com/suboptimal2/)



Supporting Healthcare Facilities  
and Anesthesiology Groups Nationwide

877.795.5788

# 12 Top CEOs of Hospitals and Health Systems Share Goals for 2011

By Rachel Fields

The next few years bring significant changes to the healthcare industry, from incentives distributed for “meaningful use” of electronic medical records to significant fee cuts to the implementation of a new coding system. Looking to the future, 12 top hospital and health system CEOs identify the top goals for their facilities for 2011.



Banko

**Peter Banko, CEO of St. Vincent Health System in Little Rock, Ark.:**

“Our most pressing goal for 2011 is market relevance, [meaning the creation of] meaningful partnerships with payors, physicians and other hospitals to ensure St. Vincent is relevant in the Arkansas market in 2014,” Mr. Banko says. He adds St. Vincent Health System has set several additional goals for 2011, including: making quality, service and patient safety measurably better than its competitors; achieving consistent and predictable financial performance and managing its organization and staff through the changes to come.

He says the system needs to expand its relationships with payors by entering into pilot programs on risk-sharing, bundled payments, medical homes and other future skill sets. The system will also expand its primary care base through employment, management and affiliation, and work to be the health system of choice for alignment of specialists in core service lines. As far as strengthening relationships with other hospitals, “we will partner with existing providers and/or develop a meaningful presence to create a regional distributed network in central Arkansas,” he says.



Campbell

**Gary Campbell, president and CEO of Centura Health in Denver, Colo.:**

According to the system’s website, Centura Health’s 2020 Strategic Plan involves the creation of a “complete system of care,”

moving from individual hospitals to entities connected through standardized best practices and system-wide communication. Centura Health also hopes to grow outreach to rural communities through state-of-the-art technology, an important mission considering 47 of the state’s 64 counties are rural. According to Mr. Campbell, the most pressing issue for 2011 is the formation of new models of care. “Centura Health will continue to transform healthcare in Colorado by responding to the needs of its patients and communities [and] developing new models of care delivery through creative approaches to physician integration,” he says.



Cosgrove

**Delos M. “Toby” Cosgrove, MD, president and CEO of Cleveland Clinic:**

“My hope is that we establish a more efficient, effective healthcare system that moves away from paying for services and instead, paying for quality. By rewarding providers for de-

livering a higher level of quality, we become more focused on patient-centered care. This approach drives satisfaction, improves patients’ clinical outcomes, and reduces overall healthcare costs. It will allow us to actively manage patients’ health, lowering the burden of chronic diseases and reducing complications and unnecessary admissions. With this focus, we have a higher standard of care and can move from delivering ‘sick’ care to delivering ‘health’ care.”



Feinberg

**David Feinberg, MD, CEO of UCLA Hospital System:**

“Our focus today, tonight, next year and in 100 years is on the patient in front of us. If we take great care of our patients — and that means they get the absolute highest quality and incredible compassion and are treated with dignity and respect and in a culturally sensitive way. If you were to ask patients to rate us on a scale of 1-10 or refer us to a friend, 99 percent of patients will give us [the highest score]. I tell people here, ‘Don’t worry about healthcare reform. Don’t worry about the awards that used to concern us. Just worry about the patient.’ When you think about the patient — and that patient is a politician, is an employee, is a voter, is a mom — they will make sure the UCLA health system survives ... the ‘perfect storm’ [of upcoming healthcare issues].”

**Bill Leaver, president and CEO of Iowa Health System in Des Moines, Iowa:**

“In 2011, just like we have this past year, Iowa Health System will continue to lead efforts to improve the quality of care through innovation in delivery and cost efficiencies,” Mr. Leaver says. He adds the system will focus on three key areas: reimbursing healthcare providers for adding value to the healthcare delivery system, supporting high quality care to the system’s communities and remaining fiscally viable as a driving economic force. “All of this will be built on an infrastructure that allows us to coordinate care to our patients in a way that creates better outcomes at a better value,” he says.



Leaver

**Thomas J. Strauss, president and CEO of Summa Health System in Akron, Ohio:**

“Summa Health System is playing a leading role in the development of accountable care organizations, and I look forward to launching our ACO, both nationally through Premier and locally with our insurance company, SummaCare. In partnership with area physicians and other healthcare providers, the ACO will further allow us to contain costs, provide greater value and enhance the quality of care provided to our patients and families. My goal is to have a successful ACO launch that will continue to align the work of our hospitals, physicians, patients and SummaCare and will contribute to a healthier community.”



Strauss



Houmann

**Lars Houmann, FACHE, president and CEO of Florida Hospital in Orlando:** Mr. Houmann identified the top goal for Florida Hospital as “tightening alignment with our physicians.” He adds, “We are focusing on several critical service lines and the overall hospitalist model to improve the patient experience, strengthen the core product, and produce better clinical and financial results.”

**Sherrie Sitarik, executive vice president/incoming president and CEO of Orlando Health:** “The top goal for Orlando Health in 2011 is to continue efforts at integrating a patient-first model of care throughout the organization. For us, patient-first means adapting and adjusting everything from our policies and procedures to our scheduling and thinking so that patients’ needs take priority in each and every interaction.”



Sitarik

**Peter Slavin, MD, president and CEO of Massachusetts General Hospital in Boston:** “I think what society is asking us to do now — and what I think is crucial for us to do now — is to not only make quality better, but also to make care more affordable, so families, businesses and the government can continue to receive care at a reasonable cost,” says Dr. Slavin. He says because the current trend of healthcare spending is not sustainable, innovation is absolutely necessary to lower costs “I think that innovation falls into two broad categories,” he says. “One is unit cost. We provide certain units of care in the hospital — a hospital day or a radiology test, for example — and we need to figure out how to deliver those specific units in a less costly manner.”

The other [category] would be to use fewer units in the care of each individual. One of the problems we face is that there’s overuse, underuse and misuse of healthcare, and my sense is that there’s probably more underuse than the other two categories. We need to deliver the care our patients need and no more and no less than that.”



Slavin

**Glenn D. Steele Jr., MD, PhD, CEO of Geisinger Health System in Danville, Pa.:** “Geisinger will be working with a number of health systems from across the country to try to infuse our innovation methodology into their totally different sociology and market to see whether together we can build healthcare value.”

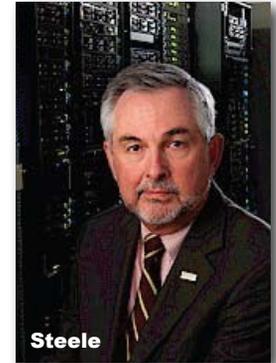
**Nancy Schlichting, president and CEO of Henry Ford Health System in Detroit, Mich.:** “Our top goal is a relentless focus on our seven pillars of performance — people, quality and patient safety, service, growth, academics, community and financial.”

**Chris Van Gorder, FACHE, president and CEO of Scripps Health in San Diego:** “At Scripps Health, our top goal for 2011 is to successfully implement our new horizontal co-management structure, which we put in place in the fourth quarter of 2010. Health systems are already feeling the financial affects of healthcare reform, through reductions in reimbursements from Medicare and private insurers. It’s critical that we adapt to these challenges in a way that not only cuts unnecessary costs, but also improves patient care and preserves jobs for our employees.”

Our approach is to reorganize every department in our health system within a horizontal co-management structure, which aims to standardize clinical and operational functions across our five hospital campuses and 22 outpatient centers. This is a unique approach, as very few health U.S. systems have a complete system-side horizontal leadership structure to go along with the traditional vertical management structure.”

Mr. Van Gorder says the health system will work to extend this new structure to its 2,500 affiliated physicians. The new model will help cut costs by identifying possible annual cost reduction and standardizing hospital function. “As we make these changes, we’ll continue to take care of our employees, just as they take care of our patients,” he says. ■

■



Steele



Schlichting



Van Gorder

## Apply Now for Becker's 2011 “100 Best Places to Work in Healthcare”

**Becker's Hospital Review and Becker's ASC Review are now accepting nominations for the “100 Best Places to Work in Healthcare.”**

Applications available on [www.beckershospitalreview.com](http://www.beckershospitalreview.com) or by contacting Rachel Fields ([rachel@beckersasc.com](mailto:rachel@beckersasc.com)). There is no fee to apply.

**The deadline for nominations is January 31, 2011.**

If you are interested in sponsoring the list, contact Jessica Cole ([jessica@beckersasc.com](mailto:jessica@beckersasc.com)).

# 52 Women Hospital & Healthcare Leaders

## 52 Women Hospital & Healthcare Leaders

Here is a list of 52 women who demonstrate outstanding leadership within the hospital and healthcare industry. To read the full list containing profiles of each woman leader, visit [www.beckershospitalreview.com](http://www.beckershospitalreview.com).

**Marna P. Borgstrom**, president and CEO of Yale-New Haven Hospital in New Haven, Conn.

**Angela F. Braly**, president and CEO for WellPoint in Indianapolis.

**Ruth W. Brinkley**, president and CEO of Carondelet Health Network in Tucson, Ariz.

**Katherine Bunting**, CEO of Fairfield (Ill.) Memorial Hospital.

**K. Bobbi Carbone, MD, MBA**, COO of William Beaumont Hospital in Royal Oak, Mich.

**Janet Corrigan, PhD**, president and CEO of National Quality Forum in Washington, D.C.

**Diane Corrigan**, CFO of the Hospital of the University of Pennsylvania, part of the University of Pennsylvania Health System, in Philadelphia.

**Susan Croushore**, president and CEO of The Christ Hospital in Cincinnati.

**Karen Davis**, president of the Commonwealth Fund, based in New York City.

**Faye Deich, RN**, COO of Sacred Heart Hospital in Eau Claire, Wis.

**Nancy-Ann DeParle, JD**, director of the White House Office of Health Reform under President Obama in Washington, D.C.

**Laurie Eberst, RN**, president and CEO of Catholic Healthcare West Ventura County Market Service Area and St. John's Regional Medical Center in Oxnard, Calif.

**Linda Efferen, MD**, senior vice president and chief medical officer of South Nassau Communities Hospital in Oceanside, N.Y.

**Patricia Gabow, MD**, CEO of Denver (Colo.) Health.

**Deborah L. Gorbach**, vice president of accounting (equivalent to CFO) at Akron (Ohio) General Medical Center.

**Pauline Grant**, CEO of Pompano Beach, Fla.-based North Broward Medical Center.

**Mary Grealy**, president of the Healthcare Leadership Council Association in Washington, D.C.

**Barbara Greene**, president of Franciscan Physicians Hospital in Munster, Ind.

**Misty Darling Hansen, CFO** of Tucson, Ariz.-based University Medical Center.

**Debbie Hay, RN, BSN**, president of the Texas Institute for Surgery in Dallas.

**Crystal Haynes**, CEO of Saint Louis (Mo.) University Hospital.

**Patricia Hemingway Hall**, president and CEO of Health Care Service Operation in Chicago.

**Mary Kay Henry**, international president of Service Employees International Union in Chicago.

**Cathryn Hibbs**, CEO of Deaconess Hospital in Oklahoma City.

**Constance A. Howes**, president and CEO of Women & Infants Hospital of Rhode Island in Providence, R.I.

**Susan Humphrey-Barnett**, area operations administrator for the Providence Health & Services Alaska.

**Karen Ignani**, president of America's Health Insurance Plans in Washington, D.C.

**Catherine A. Jacobson**, CFO and treasurer at Rush University Medical Center in Chicago.

**Deborah Carey Johnson, RN**, president and CEO of Eastern Maine Medical Center in Bangor, Maine.

**Donna Katen-Bahensky**, president and CEO of the University of Wisconsin Hospital and Clinics in Madison.

**Jane Keller**, CEO and chief nursing officer for the Indiana Orthopedic Hospital in Indianapolis.

**Valinda Rutledge**, CEO of Gaston Memorial Hospital, part of CaroMont Health, in Gastonia, N.C.

**Sister Carol Keehan**, president and CEO of the Catholic Health Association in Washington, D.C.

**Mary Jo Lewis**, CEO at Sumner Regional Health Systems in Gallatin, Tenn.

**Roberta Luskin-Hawk, MD**, CEO of 321-bed Saint Joseph Hospital of Chicago, part of nine-hospital Resurrection Health Care.

**Sally A. Mason Boemer**, senior vice president for finance at Massachusetts General Hospital in Boston.

**Elizabeth G. Nabel, MD**, president of Brigham and Women's and Faulkner Hospitals in Boston.

**Sister Mary Norberta**, president and CEO of St. Joseph Healthcare and St. Joseph Hospital in Bangor, Maine.

**Ora Hirsch Pescovitz, M.D.**, CEO of the University of Michigan Health System.

**Bonnie Phipps**, president and CEO of St. Agnes Healthcare in Baltimore.

**Karen Poole**, vice president and COO of the Boca Raton (Fla.) Community Hospital.

**Andrea Price**, CEO of seven-hospital Mercy Health Partners in Cincinnati.

**Mimi Robertson**, president and CEO of Presbyterian/St. Luke's Medical Center and Rocky Mountain Hospital for Children in Denver, Colo.

**Kathryn Ruscitto**, president and CEO of St. Joseph's Hospital Health Center in Syracuse, N.Y.

**Linda B. Russell**, CEO of The Woman's Hospital of Texas in Houston.

**Christina M. Ryan**, CEO of The Women's Hospital in Evansville, Ind.

**Sister Mary Jean Ryan**, chair and CEO of SSM Health Care in St. Louis.

**Rachel A. Seifert**, executive vice president, secretary and general counsel for Community Health Systems in Brentwood, Tenn.

**Peggy Troy**, CEO of Children's Hospital and Health System in Milwaukee, Wis.

**Mary Wakefield, PhD, RN**, administrator of the Health Resources and Services Administration in Rockville, Md.

**Beverly B. Wallace**, president of the Shared Services Group for Nashville, Tenn.-based Hospital Corporation of America.

**Ellen Zane**, president and CEO of Tufts Medical Center in Medford, Mass. ■

**TO SUBSCRIBE TO the FREE Becker's Hospital Review E-weekly,**  
 go to [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)  
 or e-mail [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com)

## 40 Hospital Benchmarks

**H**ere are 40 hospital benchmarks to help evaluate how your hospital performs on various measures of quality, patient experience, finance and operations.

### Quality

The following information is from CMS' Outcome of Care Measures report, unless otherwise marked. Percentages reflect the national average and are calculated from Medicare data on patients discharged between July 1, 2006 and June 30, 2009.

1. Readmission rate for heart failure patients — 24.7 percent.
2. Readmission rate for heart attack patients — 19.9 percent.
3. Readmission rate for pneumonia patients — 18.3 percent.
4. National mortality rate for heart failure patients — 11.2 percent.
5. National mortality rate for heart attack patients — 16.2 percent.
6. National mortality rate for pneumonia patients — 11.6 percent.
7. Patients dying in ED — 0.1 percent. (Source: National Hospital Ambulatory Medical Care Survey: 2007 ED Summary from National Health Statistics Reports, 2007.)
8. ED visits in which patients left without being seen — 2.0 percent. (Source: 2008 National Healthcare Quality Report from the Agency for Healthcare Research and Quality, based on 2006 data.)

9. Outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy — 32.7 percent. (Source: U.S. Department of Health and Human Services' "Use of Medical Imaging" data, as based on Medicare claims.)

10. Average time between patient entering ED and seeing a physician — 56 minutes. (Source: Centers for Disease Control and Prevention, 2010.)

11. Average length of stay in ED — 4 hours, 7 minutes. (Source: Press Ganey, Emergency Department Pulse Report, 2010.)

### Patient Experience

The following data is from the Hospital Consumer Assessment of Healthcare Providers and Systems' "Survey of Patients' Hospital Experiences" data, which was collected in 2009. Percentages reflect the national average.

12. Patients who reported they would "definitely" recommend a hospital — 69 percent.
13. Patients who reported staff "always" explained medicines before delivering it to them — 60 percent.
14. Patients who reported their physicians "always" communicated well — 80 percent.
15. Patients who reported their nurses "always" communicated well — 75 percent.
16. Patients who reported that the area around their room was "always" quiet at night — 57 percent.

17. Patients who reported they "always" received help as soon as they wanted — 63 percent.

18. Patients who reported that staff "always" explained medicines before administering it to them — 60 percent.

19. Patients who reported that their pain was "always" well controlled — 69 percent.

20. Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) — 66 percent.

### Finance

The following data is from Healthcare Management Partners' HMP Metrics Quarterly Report, 2010. Quartile rankings were assigned based on the mean values calculated for the hospitals within peer groups. The first quartile contains the top 25 percent of the best performing hospitals in an applicable peer group. The fourth represents those falling below 76 percent. The following reflects the mean average.

21. Total profit margin, all hospitals
  - 1<sup>st</sup> Quartile — 13.40 percent.
  - 2<sup>nd</sup> Quartile — 4.85 percent.
  - 3<sup>rd</sup> Quartile — 0.57 percent.
  - 4<sup>th</sup> Quartile — -6.80 percent.
22. Total profit margin, non-profit hospitals
  - 1<sup>st</sup> Quartile — 11.42 percent.
  - 2<sup>nd</sup> Quartile — 4.04 percent.
  - 3<sup>rd</sup> Quartile — 0.15 percent.
  - 4<sup>th</sup> Quartile — -7.04 percent.

23. Total profit margin, investor-owned hospitals  
 1<sup>st</sup> Quartile — 19.16 percent.  
 2<sup>nd</sup> Quartile — 10.43 percent.  
 3<sup>rd</sup> Quartile — 4.30 percent.  
 4<sup>th</sup> Quartile — -4.48 percent.
24. Total operating profit margin, all hospitals  
 1<sup>st</sup> Quartile — 12.32 percent.  
 2<sup>nd</sup> Quartile — 2.24 percent.  
 3<sup>rd</sup> Quartile — -2.91 percent.  
 4<sup>th</sup> Quartile — -11.94 percent.
25. Total operating profit margin, investor-owned hospitals  
 1<sup>st</sup> Quartile — 20.03 percent.  
 2<sup>nd</sup> Quartile — 10.48 percent.  
 3<sup>rd</sup> Quartile — 2.85 percent.  
 4<sup>th</sup> Quartile — -7.79 percent.
26. Total operating profit margin, non-profit hospitals  
 1<sup>st</sup> Quartile — 9.60 percent.  
 2<sup>nd</sup> Quartile — 1.71 percent.  
 3<sup>rd</sup> Quartile — -2.54 percent.  
 4<sup>th</sup> Quartile — -10.89 percent.
27. Days net patient revenue in accounts receivable, all hospitals  
 1<sup>st</sup> Quartile — 33.71 days.  
 2<sup>nd</sup> Quartile — 44.91 days.  
 3<sup>rd</sup> Quartile — 53.16 days.  
 4<sup>th</sup> Quartile — 70.26 days.
28. Days net patient revenue in accounts receivable, investor-owned hospitals  
 1<sup>st</sup> Quartile — 35.31 days.  
 2<sup>nd</sup> Quartile — 45.42 days.  
 3<sup>rd</sup> Quartile — 53.21 days.  
 4<sup>th</sup> Quartile — 70.09 days.
29. Days net patient revenue in accounts receivable, non-profit hospitals  
 1<sup>st</sup> Quartile — 32.36 days.  
 2<sup>nd</sup> Quartile — 43.26 days.  
 3<sup>rd</sup> Quartile — 50.64 days.  
 4<sup>th</sup> Quartile — 65.65 days.
30. Total labor costs as percentage of net operating revenues, all hospitals  
 1<sup>st</sup> Quartile — 37.97 percent.  
 2<sup>nd</sup> Quartile — 45.71 percent.  
 3<sup>rd</sup> Quartile — 51.58 percent.  
 4<sup>th</sup> Quartile — 59.40 percent.
31. Total labor costs as percentage of net operating revenues, investor-owned hospitals  
 1<sup>st</sup> Quartile — 34.05 percent.  
 2<sup>nd</sup> Quartile — 39.04 percent.  
 3<sup>rd</sup> Quartile — 44.26 percent.  
 4<sup>th</sup> Quartile — 53.87 percent.
32. Total labor costs as percentage of net operating revenues, non-profit hospitals  
 1<sup>st</sup> Quartile — 41.26 percent.  
 2<sup>nd</sup> Quartile — 46.22 percent.  
 3<sup>rd</sup> Quartile — 50.29 percent.  
 4<sup>th</sup> Quartile — 56.77 percent.
33. Full-time equivalent staff per adjusted occupied bed, all hospitals  
 1<sup>st</sup> Quartile — 3.45 FTE.  
 2<sup>nd</sup> Quartile — 4.37 FTE.  
 3<sup>rd</sup> Quartile — 5.12 FTE.  
 4<sup>th</sup> Quartile — 6.48 FTE.
34. Full-time equivalent staff per adjusted occupied bed, investor-owned hospitals  
 1<sup>st</sup> Quartile — 3.21 FTE.  
 2<sup>nd</sup> Quartile — 3.93 FTE.  
 3<sup>rd</sup> Quartile — 4.51 FTE.  
 4<sup>th</sup> Quartile — 5.76 FTE.
35. Full-time equivalent staff per adjusted occupied bed, non-profit hospitals  
 1<sup>st</sup> Quartile — 3.61 FTE.  
 2<sup>nd</sup> Quartile — 4.55 FTE.  
 3<sup>rd</sup> Quartile — 5.27 FTE.  
 4<sup>th</sup> Quartile — 6.55 FTE.
36. Average age of plant, all hospitals\*  
 1<sup>st</sup> Quartile — 3.63.  
 2<sup>nd</sup> Quartile — 7.70.  
 3<sup>rd</sup> Quartile — 10.59.  
 4<sup>th</sup> Quartile — 15.39.
37. Average age of plant, investor-owned hospitals\*  
 1<sup>st</sup> Quartile — 2.12.  
 2<sup>nd</sup> Quartile — 4.83.  
 3<sup>rd</sup> Quartile — 8.23.  
 4<sup>th</sup> Quartile — 12.96.
38. Average age of plant, non-profit hospitals\*  
 1<sup>st</sup> Quartile — 4.90.  
 2<sup>nd</sup> Quartile — 8.65.  
 3<sup>rd</sup> Quartile — 11.28.  
 4<sup>th</sup> Quartile — 15.75.
39. Hospital's median days-cash-on-hand — 110 days. (Source: 2010 American Hospital Association Environmental Scan, based on 2008 data.)
40. Average fiscal year return on investable assets for non-profit healthcare organizations — 18.8 percent. (Source: 2010 Commonfund Benchmarks Study, based on 2009 data.) ■

\* Average age of plant measures the average age of the hospital including capital improvements and major equipment purchases. A higher age compared to its peers indicates that the hospital has deferred the replacement of its capital when compared to its peers, which can lead to further distress.

## Apply Now for Becker's 2011 "100 Best Places to Work in Healthcare"

**Becker's Hospital Review and Becker's ASC Review are now accepting nominations for the "100 Best Places to Work in Healthcare."**

Applications available on [www.beckershospitalreview.com](http://www.beckershospitalreview.com) or by contacting Rachel Fields ([rachel@beckersasc.com](mailto:rachel@beckersasc.com)). There is no fee to apply.

**The deadline for nominations is January 31, 2011.**

If you are interested in sponsoring the list, contact Jessica Cole ([jessica@beckersasc.com](mailto:jessica@beckersasc.com)).

# 7 Steps Hospitals Must Take to Embrace ACOs: From Kevin Brennan at Geisinger Health System

By Leigh Page

**G**eisinger Health System, an integrated network in Danville, Pa., served as one of the models for the new accountable care organization. The system participated in CMS' seminal Medicare Group Practice Demonstration, a precursor of the ACO, and recently CMS tapped Richard Gilfillan, the head of the Geisinger Health Plan, to run its Innovation Center, which is overseeing ACOs. Here Kevin Brennan, Geisinger's CFO, discusses seven steps hospitals can take to embrace the new era of accountable care.

**1. Establish an integration strategy.** The hospital has to decide on an overall coordinated strategy. For example, what will the hospital's relationship with its physicians be? Will it buy practices or collaborate with them? Whatever it chooses to do, "a hospital's role will no longer be just to service a voluntary medical staff," Mr. Brennan says. And what will be the hospital's relationship with private payors? Integrated care will require a more collaboration and a totally revamped payor contract.

**2. Understand your culture.** Each organization has its own culture that will impact how changes can be implemented. Who is going to resist the changes? How does the hospital plan to overcome the naysayers?

**3. Alter incentive payments.** Hospitals will be rewarded in the future for outcomes rather than for sheer quantity. Physician payment plans that were built on work RVUs will have to include metrics to assess their

ability to work with other caregivers, follow quality guidelines and improve efficiency.

**4. Transform billing system.** Very few billing systems in hospitals today are capable of handling bundled services, in which one payment is made to the hospital and physicians. "The marketplace is relatively immature here," Mr. Brennan says. "Hospital have just a limited experience with things like bundling."

**5. Rethink scheduling.** Upcoming payment policies penalizing hospitals for readmissions will require hospitals to have scheduling systems that identify newly discharged patients and make sure someone reaches out to the patient within 48 hours. "Can the hospital connect with community referral sources?" Mr. Brennan says.

**6. Measure clinical outcomes.** Hospitals not only need to have IT systems in place to measure clinical outcomes and then also be able to use the information. "The government is publishing outcomes on quality and cost," Mr. Brennan says. "Do you have the infrastructure to follow these metrics?"

**7. Build cost-accounting infrastructure.** Hospitals will need to know exactly where they are losing money so that they can make the necessary changes. They need to be able to analyze detailed information on costs and revenues by patient, by different types of patients and other measures. ■

## ACOs: One System's Approach Toward Accountability and Success

By Joseph A. Scopelliti, MD, Guthrie Health System

**O**ne of the prominent aspects of the recent healthcare reform discussion is the effort to change the reimbursement methodology for both hospitals and physicians. A number of models, including the patient centered medical home, partial or full capitation or bundled payment structures have been proposed. Some of these have been around for more than a decade and others are now being piloted for the first time across the country.

One newer model, the Accountable Care Organization, is closely aligned with our vision at Guthrie for providing high quality integrated care. The purpose shared by all these models is to provide incentives (through reimbursement methods) to healthcare providers who are able to effectively and efficiently manage patient healthcare needs across the continuum of care.

One of the key differences in the ACO model is the design that requires providers — primary care physicians, specialists and hospitals — to be

accountable for the health of a population of patients which they serve. Use of tools like electronic health records which give providers direct access to important patient health information, and foster an environment where best practices are shared and patient care is well coordinated, are all components of ACOs. Built into the ACO model is an incentive for the value of care, as opposed to the volume of care. This aspect of the ACO model is meant to further support the true coordination of care.

Not surprisingly, many experts predict that integrated health care organizations, like our own, will be most successful at implementing the ACO model. Organizations like Guthrie are very well positioned to meet the basic criteria of this model of care. One challenge that exists in all integrated delivery systems is developing an infrastructure for measuring and managing the progress of the greater organization against its' strategies and goals. Our practice of using the five-pillar framework (quality, service, people,

finance and growth) to set goals at every level of the organization provides us with a consistent focus and a way to measure improvement year over year. The ability to align goals across the primary/specialty care and acute care settings provides us with a tool that encourages better collaboration when addressing areas like quality of care and patient safety. Multi-specialty group practices, like the Guthrie Clinic, are best situated to achieve this true collaboration.

Though primarily a management tool, this framework can be used in the process of developing a structure for strategic planning. Using this goal-setting model helps guide us as we make decisions about determining our focus for the future. Our recent strategic planning process allowed us to integrate this measurement system into a "dashboard" that focuses us on the steps necessary to achieve the goals of the overall plan.

For healthcare organizations like ours, their successful future depends on several factors. At the

very core of every successful business is the quality of the people that make up that organization. Nowhere is this more important than in a service industry like healthcare. To be the provider of choice in the region we need to both hire and develop the best staff at every level. That needs to be coupled with facilities and technologies that enhance the diagnosis and treatment of disease. These will be critical to deliver superior clinical care. Another area of focus will be to enhance

access to care and to organize that to be convenient for patients. The healthcare environment needs to be comfortable and convey a sense of confidence to our patients such that they feel they are in a healing environment. And, most importantly, we need to do all of the aforementioned in ways that demonstrate service excellence and embody our core values of excellence, teamwork and patient-centeredness. ■

*Joseph A. Scopelliti, MD, is co-CEO, medical affairs for Guthrie Health and president and CEO of Guthrie Clinic in Sayre, Pa. Dr. Scopelliti has served as a practicing gastroenterologist at the Guthrie Clinic and as a clinical instructor with the State University of New York Upstate Medical University at Syracuse since 1984. Since 2005, he has also been associated with the University of Rochester (N.Y.) as an associate clinical professor of medicine.*

## Should Your Hospital Develop or Join an ACO? 5 Questions to Ask

By Lindsey Dunn

**T**he Medicare Shared Savings Program, also referred to as the accountable care organization program, was created by the Patient Protection and Affordable Care Act and will be effective by Jan. 1, 2012. The program will allow physicians, hospitals and other healthcare providers to join together to better coordinate care and share in cost savings created by lowering population health costs while maintaining quality. The program is significant, because it marks the first time the government has asked physicians and hospitals to manage population health costs.

Since the legislation was passed, hospitals and other providers across the country have been working to decide if they should develop ACOs in an effort to participate in the program. These entities, however, require considerable infrastructure, resources and cost, and have no guarantees of success. As such, many providers are unsure if the risk associated with developing an ACO is worth the potential payoff. While the final regulations governing these entities have yet to be released, hospitals that are considering whether they should become involved in an ACO should ask themselves the following five questions.

**1. What is the hospital's relationship with its physicians?** Before determining its participation in an ACO, a hospital must assess its relationship with its physicians. Success within the ACO model will require working closely with physicians to reduce costs and better coordinate care. If a hospital lacks aligned physicians, it will face more challenges in finding success within an ACO, says John Harris, a partner with DGA Partners, a healthcare consulting firm. Hospitals with integrated physicians are better positioned to be successful under this type of model.

While specialty physicians are not expected to be left out of ACOs, hospitals should focus first on their relationships with primary care providers, as these providers determine a group's ability to create a viable ACO under the current legislation.

**2. Does the hospital have a large enough primary care provider base?** In order to apply to join the Medicare shared savings program, ACOs must be able to care for a minimum of 5,000 Medicare beneficiaries, which means it must have enough primary care physicians involved to meet that threshold. Mr. Harris estimates this translates to about 15 to 20 primary care physicians. The recent increased use of hospitalists has left many hospitals with more distanced relationships with primary care providers, which makes meeting this minimum difficult for some facilities, he says.

Hospitals that employ or closely align with a significant base of primary care physicians are well positioned to lead an ACO, while those that lack these relationships may need to think about whether joining an ACO estab-

lished by another entity is a better option. To improve alignment, hospitals should educate primary care providers about the benefits of joining the ACO and the financial and quality impacts from doing so, says Mr. Harris.

**3. What other providers could be involved?** In addition to hospitals and physicians, ACOs may want to align with other types of providers in their communities, such as skilled nursing facilities and home health providers. While an ACO probably does not need the involvement of these post-acute providers to become an ACO, their participation is likely to enhance an ACO's ability to coordinate care and reduce costs. As such, hospitals may want to take stock of their relationships with these providers and consider integrating them into their systems, if possible, or determine other ways to align with them, such as through contracts that ensure ACO goals will be pursued.

**4. Should the hospital develop its own ACO or work with another hospital or system?** A hospital may consider partnering with a larger health system or other smaller, independent hospitals to create the ACO. These arrangements allow a hospital to spread its overhead costs associated with the ACO more broadly. Additionally, Mr. Harris predicts CMS will set a higher savings threshold for smaller ACOs, making it less challenging for large ACOs to achieve the level of savings needed to receive shared savings payments.

**5. How will the hospital counter the impact of reduced admissions?** One of the key goals of the ACO program is to better coordinate care in order to reduce healthcare costs, which means reducing the utilization rate of the most costly services, such as inpatient admissions and complex outpatient procedures. These procedures drive up overall healthcare costs, but are also key revenue generators for hospitals. If a hospital joins an ACO, it must accept and prepare for the chance of decreased volume.

Hospitals will need to increase their market share in order to maintain volume levels in an environment that rewards low utilization. "Assume admissions from the population the hospital traditionally cares for are going to go down, which means the hospital has to reach out to a broader population base to make up for that lost volume," says Mr. Harris. Market share can be gained by aligning with a broader base of primary care physicians or by avoiding the leakage of cases to other hospitals.

"If the Medicare Shared Savings Program leads to similar opportunities with commercial health plans, it could both provide value to those health plans and their members, and it could also help shift the hospital and its physicians to a more integrated model of care," says Mr. Harris. ■

# Accrediting Body Issues Proposed Standards for ACOs, Asks for Comment

By Leigh Page

The National Committee for Quality Assurance, which accredits managed care organizations, has released a set of draft standards for accountable care organizations and is asking for public comment through Nov. 19, according to a release by NCQA.

NCQA currently develops quality measures for health plans, including Medicare Advantage plans, and recognizes organizations as patient-centered medical homes. The draft criteria were developed by an NCQA task force to assess “core capabilities” for ACO success.

“Criteria should provide a blueprint for ACO development and assess core capabilities that improve the likelihood of success,” the task force stated. “While performance measurement is critical to evaluate ACO success, it will take some time before organizations can be judged on the outcomes they achieve.”

Here are 13 key parts of the proposed standards.

**1. ACO structure.** The organization has the infrastructure to coordinate providers and works to increase quality, improve patient experience and effectively manage its financial resources.

**2. Resource stewardship.** The organization has the capability to manage its resources effectively. This involves use of a clinical utilization management plan that includes a process for verifying patient eligibility and benefits, information systems to track utilization, risk adjustment methodology used to determine required reimbursement-levels and shows how it works with payors to determine reimbursement requirements.

**3. Health services contracting.** The organization arranges for pertinent healthcare services and determines payment arrangements and contracting. At least a portion of practitioners’ compensation is based on the performance of the ACO as a whole, using clinical quality, cost and satisfaction indicators, and there is a process to monitor utilization patterns for inappropriate restrictions on care that may arise unintentionally from existing payment arrangements.

**4. Availability of practitioners.** The practice provides patients and families with access to appropriate routine and urgent care. It establishes quantifiable and measurable standards for the number of practitioners providing primary care.

**5. Practice capabilities.** The practice provides patients and families access to appropriate routine and urgent care. It must develop an individualized care plan in collaboration with patient/family that includes treatment goals that are reviewed and updated at each relevant visit for at least 75 percent of patients. Identifies patients/families who might benefit from additional care management support for at least 50 percent of patients.

**6. Data collection and integration.** The organization collects and integrates data from various sources, including, but not limited to electronic sources for clinical and administrative purposes.

**7. Initial health assessment.** Assessment of patient health is relevant to the management of clinical needs. The organization has a process to assess a new patient’s health status within 90 days of the patient’s assignment to the organization. The process includes how the organization follows up with patients that it could not reach or assess in its initial attempts.

**8. Population health management.** Accurate identification of care needs and the provision of population health management programs enables organizations to provide quality patient-centric care. There is a documented process to identify patients who are eligible for wellness or preventive care services, chronic disease management services and complex case management.

**9. Practice support.** The organization encourages practice sites to engage in registry data collection, electronic prescribing and patient self-management.

**10. Information exchange for care coordination and transitions.** The organization has a coordinated system of care between multiple providers to offer integrated, timely and effective care.

**11. Patient rights and responsibilities.** The organization has a coordinated system of care between multiple providers to offer integrated, timely and effective care.

**12. Performance reporting.** The organization measures and reports clinical quality of care, patient experience and resource stewardship. At least once a year, the ACO monitors at least three preventive care measures, at least five chronic care clinical measures, at least one acute-care clinical measure and at least two measures of expenditures, resource use or appropriateness.

**13. Quality improvement.** At least annually, the organization measures and analyzes the results of performance measurement activities and takes action to improve effectiveness in key areas.

In addition, the NCQA asked stakeholders for input on the following issues:

1. Should the types of specialists that should be included in the ACO be specified in the criteria? If so, must they be part of the organization’s legal structure, that is, subject to the direct authority of the ACOs governance?
2. The task force is proposing four levels of scoring for ACOs. What capabilities would you expect to see for each ACO level?
3. Does the eligibility criteria capture the organization types that have the capability to act as ACOs?
4. How might currently available measures such as HEDIS, Meaningful Use, and California IHA be used? Do the criteria align with stakeholder expectations for ACOs? Are there areas not addressed that should be?
5. For organizations seeking to become ACOs: Does your organization have materials/documents, etc. to demonstrate compliance with the criteria? If not, which areas are challenging?
6. Are there critical functions not included in the current draft standards? ■

# 7 Factors to Assess the Sustainability of a Hospital: Assessing a Hospital's Viability, Its Financial Situation and the Severity of the Threats it Faces

By Scott Becker, JD, CPA, and Lindsey Dunn

There are approximately 4,500 medical-surgical hospitals in the country. Of these, nearly 2,500 are affiliated with or a part of system, nearly 2,000 are independent, and approximately 200-250 are physician-owned hospitals.

Over the last ten years, there have been approximately 70 hospital bankruptcies. This includes approximately 46 from 2000 to 2006 and approximately another 25 to 30 over the last four years.

For a great overview of issues impacting hospital viability, see an article titled "Factors Associated with Hospital Bankruptcies: A Political and Economic Framework" by Amy Yarbrough Landry & Robert J. Landry published in the *Journal of Healthcare Management* in July/August 2009. The article stated, for example:

"Bankrupt hospitals are smaller than their competitors. They are also less likely to belong to a system and more likely to be investor owned. Factors associated with filing organizations are placed into a political and economic framework derived from Park's work on municipal bankruptcy filings. Common nonfinancial factors associated with hospital bankruptcies include mismanagement, increased competition, and reimbursement changes."

The hospitals that tend to go bankrupt are generally independent, smaller and generally not rural. However, there are several hospital systems that have filed for bankruptcy and there are a significant number of rural hospitals that have filed for bankruptcy as well. For example, three-hospital Forum Health, based in Youngstown, Ohio, filed for bankruptcy in March 2009. Community Health Systems has since moved to acquire the system, beating out competitor Ardent Health with a \$120 million bid.

A few of the key factors that drive bankruptcy include poor management, some large change in information and/or billing systems, a legal investigation, a large quality problem early on in the hospitals' inception and certain other issues. Smaller hospitals with less cash on hand and smaller operating margins have less flexibility to pursue diversification and can have a much harder time withstanding these kinds of challenges than larger affiliated hospitals.

## 7 factors

The following provides a brief analysis of seven factors that can drive a hospital towards bankruptcy.

**1. Geography.** The greater moat and protective barrier a hospital has from other competition, the better chance it has of surviving. The more that a hospital is one of several choices for patients and physicians, the more susceptible it can be to bankruptcy. Hospitals in areas with low levels of competition for both patients and medical staff are less susceptible to bankruptcy than hospitals in more competitive markets.

**2. Physical plant.** To remain competitive, hospitals with aging physical plants must weigh the costs of a renovation with the increased business a renovation may bring. Because of the large amount of debt typically taken on by hospital for such renovations, a hospital that does not have to make significant changes in its physical plant or undergo significant physical renovation has a better chance of being able to sustain significant challenges and changes.

**3. Physician alignment.** Physicians are directly responsible for patient referrals to hospitals, and as such, hospitals with strong physician alignment — through employment, co-management or other relationships — are most likely to maintain or increase patient volume. If a hospital is poorly aligned with its physicians, and the market lacks a great deal of independent physicians to align with, the hospital is much more susceptible to bankruptcy.

**4. Payor reimbursement.** There is almost no substitute for being in at least a reasonable reimbursement market. In a very challenging reimbursement market, no matter how strong management is, it can be very hard to thrive. Markets with a single dominant commercial payor can be particularly difficult. With increasing pressures on government-run health program reimbursements, the value of strong private-payor contracts to maintain margins will only increase.

**5. Cost structure.** Hospitals with a high cost structure either due to high debt, high employee costs or the inability to amortize costs over larger revenues are more susceptible to bankruptcy. High employee costs may include wages and benefits, including pension plans, which have been particularly hard-hit by investment losses brought on by the recent economic decline. Further, hospitals that are unable to make labor and cost changes or undertake changes in the total number of employees are also much more susceptible to bankruptcy.

**6. Management.** There is very little that is as important as finding a great CEO and leadership of a hospital. If there is one place to over invest in, it is leadership. A leader must be able to block and tackle plus be a business and marketing guru and generate cases and business for the hospital. It is a multi-faceted job that requires great talent.

**7. Quality.** Quality can cause bankruptcies if either a hospital develops an ongoing reputation for being a low quality provider or if a hospital has substantial quality debacles early on in its history. Early deaths in a facility can be a problem that a hospital can never recover from. Also, a hospital's ongoing reputation as a low quality institution can make it very hard to attract patients or physicians. These seven issues taken together can explain nearly any hospital bankruptcy. Conversely, small independent hospitals that maintain financial success typically experience challenges in only a few or none of these seven areas. For a great paper on this topic, see "The New Community Hospital Imperative" by Kurt Salmon Associates. The Kurt Salmon report states:

"Based on Kurt Salmon's consulting experience, the following six competitive factors are strongly correlated with the ability of small, independent hospitals to achieve long-term financial success:

1. Effective geographic barriers
2. Favorable payor mix
3. Strong physician alignment
4. Significant high-quality asset based
5. Low-cost structure
6. High-quality care

The most successful hospitals achieve competitive advantage by exploiting at least one, if not more, of these six factors. The most desirable positioning is to compete on factors that are both within the organization's ability to control and that create effective barriers to entry against competitors."

## 5 financial questions

A separate set of questions that can help assess a hospital's viability relate to its expected investment costs and margins. As mentioned early, hospitals with a reduced need for costly capital projects and other investments are less at risk for bankruptcy. For example, a hospital should assess the following five questions:

1. Does it have a need for substantial renovation or relocation?

2. Does it have a need to invest substantially in information technology?
3. Does it have to examine acquiring practices or make other substantial expenditures?
4. How do its costs relate to its cash on hand and its margins?
5. Does the hospital have borrowing capacity?

### Severity of threats

In assessing the severity of threats, four situations that a hospital will look at are:

1. Is it being excluded from payor contracts or is it likely to see significant payor reimbursement declines?
2. Are the physicians that the hospital relies on (or are the independent physicians in the community) being bought out by competitors?
3. What is the cost structure as a percentage of revenues? How does this compare to other facilities?
4. Does it have a great CEO, CFO in place

or not? Can the hospital afford to recruit premier talent?

### 4 examples of hospital bankruptcy

Hospitals that have filed for bankruptcy in the last few years have struggled due to many of the circumstances described above. A few recent situations include:

1. Two key physicians on a hospital's medical staff are employed and go to work for a competing hospital. These two physicians made the difference between success and failure for the hospital to break even. Here, the hospital's failure to better integrate those key physicians contributed to its eventual financial failure.
2. The hospital had too much debt and was built too large. This hospital has approximately \$40 to \$50 million dollars in debt and about 50 different owners with no specific force for business. In this situation, the hospital took on too much debt and was unable to overcome the debt with its revenue.

3. Another bankruptcy developed from the implementation of "a custom software concept" and another one developed from the shifting of all billing and collections overseas. In each situation, the hospital lost several months worth of revenues. Here, the hospitals had a cost-structure that could not be sustained with cash on hand or other funds.

4. A hospital early on had several deaths. This led it not to being able to recover between the mix of malpractice cases and costs, the inability to obtain insurance and the reputational harm to the facility.

The factor and examples listed above provide a brief overview of several issues that can help assess whether a hospital is headed toward severe financial challenges. Hospitals that find themselves at risk should consider what steps can be done to reduce costs and/or increase revenue in order to stave off a bankruptcy. Hospitals that are challenged by a number of these factors may need to consider an affiliation, merger or sale with or to another entity with greater market share, clout and resources if they wish to remain viable. ■

## 10 Successful Hospital Turnarounds

By Rachel Fields

**S**trong leadership and smart changes can make the difference between closing your doors and leading the market. Here are 10 hospitals that accomplished successful turnarounds.

**1. Anaheim (Calif.) General Hospital.** In late Oct. 2010, Anaheim General Hospital regained approval to bill Medicare and Medi-Cal following two unannounced inspections in April and July. The hospital did not collect any payment for treating patients for a year after a series of failed safety inspections cut off government funding. In an interview with *MSNBC*, CEO Tom Salerno called the recertification "a rare achievement." He credited the accomplishment to the medical staff that worked hard to address safety problems.

Funding from Medicare and Medi-Cal is rarely pulled, but when it is, hospitals often fail financially. Martin Luther King Jr./Drew Medical Center in Los Angeles closed in 2007 after similar failed inspections that lost the hospital its \$200 million annual funding. In Feb. 2008, inspectors found five immediate jeopardies, including a lack of necessary medication in the operating room and unsafe medical equipment.

In order to regain Medicare and Medi-Cal funding, the hospital required its staff of 320 to go through extensive training on infection control, patient falls and medication safety. The hospital recently purchased new lab equipment and started a \$1.2 million expansion of the emergency room. Though patient volume has dropped considerably since funding was pulled, Mr. Salerno is confident that volume will pick up due to increased hiring.

**2. Auburn (N.Y.) Memorial Hospital.** Over the course of a decade, Auburn Memorial Hospital experienced a prolonged period of financial contraction due to the departure of physicians, patients and service lines. Cash reserves were reduced, and the hospital found itself unable to invest. The hospital declared bankruptcy in April 2007.

President and CEO Scott Berlucchi arrived at the hospital following the declaration of bankruptcy. The hospital had been forced to close its ob/

gyn unit and reduce available beds from 180 to 99 following a Berger Commission Report in late 2006. Mr. Berlucchi asked the state to revisit the recommendation to close the ob/gyn unit and explained that the need to provide ob/gyn services to the Auburn community was directly in line with the hospital's core values. The recommendation was reversed after six months of discussions.

The hospital was able to acquire a state grant secured by Sen. Michael Nozolio for a new CT scanner, as well as additional upgrades, and Mr. Berlucchi approached multiple foundations for grants in the Auburn community. In addition, a hospital turnaround consultant spent six months reviewing and streamlining operations through personnel management, corporate restructuring and improving efficiency of core operations. The hospital board, along with Mr. Berlucchi, also targeted ORs, private rooms, heating and ventilation and other areas for upgrades. The hospital has seen dramatic financial and clinical turnarounds since the turnaround strategy was implemented upon Mr. Berlucchi's arrival.

**3. Children's Hospital of Orange County (Calif.).** Just over a decade ago, Children's Hospital of Orange County was in genuine danger of financial failure, losing \$48 million between 1997 and 1999. Hospital officials feared the hospital might be forced to close. In a 2007 interview with *Smart Business*, Kim Cripe, president and CEO of CHOC, said the hospital is now thriving. In 2007, the hospital took a plan to its board to build a new patient tower — one with a \$510 million price tag.

In 1996, the hospital was hit by a change to the reimbursement scheme for hospitals mandated by California's Medicaid insurance program to serve the indigent population. The change steered patients to other hospitals and damaged CHOC's market share, according to the *Smart Business* report. To counter these problems, Ms. Cripe combined cost-cutting efforts with a plan to provide high-value, high-tech services to set the hospital apart from others in the region.

This plan required putting a new management team together, replacing all 13 members of the hospital's senior management over the course of 18 months. Ms. Cripe appointed new members with strong financial skills, business development, marketing and human resources experience. With that team, the hospital went into the black by 2000 and had taken revenue to \$377 million by 2006.

**4. Erie County Medical Center in Buffalo, N.Y.** During his time as CEO of Erie County Medical Center, CEO Michael Young took the hospital from a \$30 million loss in 2005 to a \$17 million profit in 2007. According to Mr. Young, when he arrived at Erie, everyone referred to the hospital as "the county," a term he didn't like because it immediately focused on the negative financial performance of the hospital. In order to turn the hospital around, he started by changing its image. "We tore down the old building in front of the hospital, put in a brand new lobby with a coffee shop and replaced some old elevators," he said. "Several relatively inexpensive cosmetic changes in public areas made the hospital look clean and inviting. For example, we spent \$52,000 on new ceiling tiles and tights in the front lobby."

Mr. Young also led the hospital in publicizing its great clinical outcomes and trauma center. "Though we had no money for advertising in our first 18 months, there was plenty of free publicity on radio and TV talk shows, and we used it," he said. He said hospitals looking to turn around have to focus on their strengths and make sure people know about them.

During Erie County Medical Center's turnaround, the hospital also increased its average daily census and ER visits by upgrading technology and improving patient throughput, upgrading facility computers and making sure cash was collected every day. "When more money started coming in, we were able to buy new clinical equipment, which then brought in more doctors, who then bring in more patients," Mr. Young said.

**5. Floyd Memorial in New Albany, Ind.** After losing \$12 million in 2008, Floyd Memorial Hospital & Health Services accomplished a financial turnaround that resulted in a net income of \$18.2 million in 2009. The hospital strengthened finances by recruiting physicians to grow inpatient volume. Nearly 33 physicians joined the medical staff in 2008, bringing the total number of active and courtesy physicians on staff to 439, and hospital employment grew from 1,732 to 1,809 in the same year.

CFO Ted Miller said the hospital improved its revenue cycle and critically evaluated expenditures to strengthen its financial position. For the 11-month period ended Nov. 30, 2009, acute-care inpatient discharges grew by 6.4 percent from a year earlier, inpatient surgeries grew by 6.8 percent and days worth of cash on hand grew by 8 percent.

Jerrold Z. Miles, chairman of Floyd's board, credited the improvement to the involvement of physicians, employees, board members and specialized committees focused on finance, as well as the efforts of hospital administration.

**6. Medical Center of Plano in Dallas.** From 1975 until the late 1990s, Medical Center of Plano was in good financial health and had developed a solid medical reputation that drew patients from across the country, according to a *Gallup Management Journal* report. But when the hospital decided to transition from a rural community hospital to a 427-bed state-of-the-art tertiary care hospital, it began to see problems with staffing, turnover and morale. Retention became a serious problem, and the hospital started spending a lot of money on staff turnover. During the first year of the transition, the hospital lost 300 staff members — 25 percent of the staff as a whole and 70 percent of first-year employees.

The administration realized that purchasing new medical equipment, airing more commercials and recruiting more staff wouldn't fix the hospital's problems. Instead, MCP needed to increase employee engagement or risk losing patients to one of its 29 competitors. The medical center turned to outside help to increase employee engagement by hiring a company to measure employee expectations — which turned out to be near the bottom for all HCA hospitals, with 27 percent of employees actively disengaged.

To bring up engagement levels, MCP concentrated on every item measured in the employee survey and also examined pay and benefits programs to ensure the hospital's competitiveness. In spring 2004, turnover among first-year employees plunged from 70 to 30 percent, according to the report, and in 2005, the percentage of actively disengaged employees had dropped from 27 percent to 9 percent. As engagement levels have risen, so has revenue — a few years after the turnaround began, the Medical Center made almost a billion dollars.

**7. Natividad Medical Center in Monterey County, Calif.** In late 2006, Natividad Medical Center, the smallest public safety net hospital in California, was hemorrhaging around \$25 million a year, according to a *Health Care Finance News* report. It had lost \$15 million the year before, and the hospital expected the losses to continue. In 2006, the hospital hired CEO Harry Weis to turn the hospital around, and in 2008, the hospital made \$10.5 million dollars. In 2009, that number decreased slightly to \$7.6 million and jumped back up to \$10.5 million in fiscal year 2010.

The hospital accomplished the turnaround with the help of two other non-profit facilities — Community Hospital of the Monterey Peninsula and Salinas Valley Memorial Healthcare System. CHOMP donated \$4 million to Natividad over two years, while Salinas donated \$6 million over three years, knowing that if Natividad were to close its doors, the hospitals would take the annual hit for uncompensated care for the uninsured.

In return for the donation, each donor was allowed two seats on Natividad's board while the money was being disbursed. Natividad also used a consulting firm to work on revenue cycle and renegotiate care contracts. The hospital currently supports its county by running a medical indigent program and giving hundreds of thousands a year to the county health department.

**8. Scripps Health in San Diego, Calif.** CEO Chris Van Gorder was named leader of San Diego-based Scripps Health in 2000. When he joined the health system, the organization was losing \$21 million a year, and the previous CEO had just left office after receiving votes of no confidence from Scripps' physicians. By 2008, eight years after the introduction of Mr. Van Gorder, Scripps Health had an operating margin of \$109 million.

Mr. Van Gorder said his predecessor had a good strategic plan for managing the hospital's turnaround, but he hadn't worked with system physicians in order to implement the plan. The difference between the two approaches was crucial: Mr. Van Gorder called the approximately 3,000 physicians on staff at Scripps "the key to our financial turnaround."

He said one of the keys to turning around the health system was brining physician voices into the executive suite. "The Physician Leadership Cabinet is a monthly forum between elected physician leaders and hospital administrators," he said. "The goal is to share information and address controversial issues as a team, before they can become problems. It is an advisory group, but for the past 10 years, we have accepted 100 percent of its recommendations."

**9. South Hampton Community Hospital in Dallas.** Ed Downs started the position as CEO of South Hampton Community Hospital in the summer of 2009, when the hospital was coming out of its second bankruptcy. Financial problems had forced a closure of the facility, dropping its census from around 50 patients to zero without any warning to the hospital's staff. Though the doors were quickly reopened, the closing was highly publicized, making the recovery process more difficult.

As the hospital's new CEO, Mr. Downs' goal was to get the facility back to living off its revenue — a feat he accomplished in one year with the help of management, physicians and staff. He said his first 120 days at the hospital were filled with meetings with medical directors, physicians, employees, vendors and community members to determine the hospital's most pressing issues. The second step was to fix inefficient process, such as the method for admitting new inpatients. Once processes had been thoroughly examined, the hospital focused on customer service and providing great patient care, using a full-time marketing employee to regularly visit EMT shifts and collect complaints or compliments about the hospital.

The final goal for the hospital was to attract new physicians, a feat it accomplished by meeting with physicians who had stopped sending patients to the hospital to find out their issues with the facility. Mr. Downs used the hospitals' biggest physician champion to provide a physician's point of view at the meetings. By offering block time and new product lines, as well as using medical staff to reach out to colleagues, the hospital added a number of physicians, including nephrologists, vascular surgeons and a pediatric cardiologist. South Hampton emerged from bankruptcy within the year, and the hospital's census and outpatient visits are up.

**10. UCSF Medical Center in San Francisco.** Mark Laret, CEO of UCSF Medical Center, was brought in to lead the hospital 10 years ago following a financially disastrous and brief merger with Stanford Hospital & Clinics in the late-1990s. He took a hospital that was losing \$1.5 million per week and helped turn it into one of the top 10 hospitals in the country,

according to *U.S. News & World Report*. "In my first year here, we were projected to lose \$60 million and, currently, we have been making between \$60 million-\$100 million over the last several years," he said.

He said the hospital started its turnaround by developing a management team with common values and getting "the entire organization, not just the staff, but the medical staff and academic leadership" on the same page concerning the organization's goals. He put together a non-fiduciary advisory board that included senior leaders in the community to focus the hospital's priorities.

Mr. Laret said one of the main lessons he learned about executing a successful turnaround is that academic medical centers are high-dollar volume, low margin business. "If you're losing money, a few changes can give you a big turnaround," he said. ■

## 8 Things to Know About Medicare's Bundled Payment Pilot

By Lindsey Dunn

**T**he Patient Protection and Affordable Care Act includes a provision to begin a national pilot on payment bundling, which is essentially an expansion of CMS's ongoing Acute Care Episodes Demonstration project. The pilot is scheduled to launch by Jan. 2013. Although specific regulations surrounding the pilot have yet to be released, here are eight considerations for hospitals and physicians should consider as they determine their involvement in bundled payment initiatives.

**1. The pilot will expand the ACE demonstration in a number of ways.** The pilot project is expected to expand both the types of conditions as well as the length of time covered by bundled payments. While the current ACE demonstration project covers only acute-care services, the bundled pilot will include pre- and post- acute services — spanning three days before and 30 days after — an acute-care episode. The legislation calls for the HHS Secretary to select eight "conditions" to be included in the pilot. The conditions will likely include conditions beyond what is covered by the ACE demonstration, which covers certain acute-care episodes related to cardiac and orthopedic surgical services only.

Hospitals that plan to submit a bid for the pilot should begin to explore how to offer competitive but appropriate pricing that cover costs for care 30 days after discharge. Michael Zucker, FACHE, senior vice president and chief development officer for Vanguard Health Systems' Baptist Health System in San Antonio, which is one of only two sites in the ACE Demonstration that offers bundled pricing for both cardiac and orthopedic procedures, says positing a system to accept bundles for this type of care is challenging even for Baptist, which has a good deal of experience in bundled pricing. "There is a lot of variability when you start to look at care beyond an inpatient stay," he says. "At 30 days post-dis-

charge, you are looking at working with a whole other group of providers. It's an entirely new layer of complexity."

**2. Expect the pilot to include chronic conditions.** Although the regulations governing the pilot have not yet been released, expect chronic conditions to be included as covered conditions, says Jonathan W. Pearce, a director with DGA Partners, a hospital consulting firm. The PPACA instructs the Secretary to take into consideration that the conditions selected include a mix of chronic and acute conditions as well as medical and surgical conditions.

**3. Because it's a "pilot" rather than a "demonstration," expect the project to be ongoing.** The bundled payment project being referred to as a "pilot" in the PPACA rather than a "demonstration" suggests that the project will be ongoing, according to Mr. Pearce. While no one can be certain whether the language was deliberate, Mr. Pearce cites a 2008 MedPAC report stating that a pilot doesn't need enabling legislation to continue. This distinction was made in order to avoid healthcare providers investing in infrastructure to participate in projects that would later be shut down, says Mr. Pearce.

**4. No single type of provider designated to lead bundled projects.** The legislation does not indicate whether hospitals, physicians or other providers should lead individual bundled payment projects, but instead outlines which type of providers must be included. The legislation specifically requires the following providers are involved to submit application for the pilot: a hospital, a physician group, a skilled nursing facility and a home health agency. However, the expected financial structure of the pilot makes it likely that hospitals will take the lead role.

For Baptist Health System, leading the charge to participate in the ACE project was attractive

because it served as a mechanism for the health system to more closely align with its physicians. Because the pilot permitted shared savings, the physicians could be financially incentivized for providing more efficient, higher quality care.

**5. It's unclear whether participation will require accepting bundled payment for all covered conditions.** It is unclear at this time whether participating provider groups would be required to accept bundled payment from CMS for all covered conditions to participate in the pilot, says Mr. Pearce. He says that an "all or nothing" participation requirement could be challenging for hospitals because it would require gathering consensus from physicians in a number of specialties, "What if your cardiologists are onboard [to accept bundled payments], but your rheumatologists are not?" he asks. "Are you out of luck?" An all-or-nothing requirement would likely reduce the number of providers able to develop structures to participate in the pilot. "It's not so much an issue of 'consensus' as it is 'active participation' in the patient management and cost reduction efforts that are critical to success under bundled payments," says Mr. Pearce.

**6. Financial incentives have yet to be determined.** The legislation gives the HHS Secretary the power to determine the bundled payment methodology, and these have yet not been released. Mr. Pearce predicts that as with the ACE demonstration project providers will bid to participate, offering a discount of expected fee-for-service costs for a care episode or care episodes. He also believes that the providers participating in the project will be able to share in a certain percent of cost savings created. Under the ACE, demonstration project, that additional payment was capped at 25 percent on top of fee-for-service Part B payments for physicians. There's no precedent for other (i.e., post-acute) providers. While the legislation does not specify any shared savings,

it is unlikely the project would be viable if it didn't offer this opportunity, says Mr. Pearce.

Mr. Zucker reports the 25 percent incentive is a strong driver for the physicians to assist the hospital in lowering the cost and improving the quality of care at the health system. "Even though we faced some resistance from physicians at first, once the first few physician champions started receiving gain share distribution checks, word spread quickly," he says. "We had a tremendous amount of interest after that." Through the

program, Baptist Health System has saved an estimated \$2.2 million dollars while maintaining quality scores in the 96th to 98th percentile.

**7. Relations with physicians, post-acute services will be key to success.** Even though specific regulations have not been released, it is clear from the current legislation that a key to success under this bundled payment pilot will require close relationships with physicians, as physicians drive costs and their active engagement in efficiency is key to success under bundled payments.

Additionally, hospitals will need to create similar relationships with skilled nursing and home health entities. Hospitals may consider working to better integrate with them as they wait for the regulations to be released, says Mr. Pearce.

**8. Involvement won't likely exclude involvement in Medicare's ACO program.** Mr. Pearce doesn't believe any language in the legislation would bar hospitals from participating in both the bundled payment pilot and the Medicare Shared Savings, or ACO, program. ■

## Bundled Pricing Opportunities & Challenges: Q&A With Baptist Health System's Michael Zucker

By Lindsey Dunn

Vanguard Health Systems' Baptist Health System in San Antonio is one five hospitals in the country participating in Medicare's Acute Care Episode Demonstration project and one of only two to offer bundled pricing for both cardiac and orthopedic procedures. Here Michael Zucker, FACHE, senior vice president and chief development officer at the health system, discusses its bundled pricing initiative and shares opportunities and challenges for other hospitals looking to enter into this space.

**Q: Tell me briefly about Baptist Health System's participation in the Medicare ACE Demonstration project. What are some of your key successes to date?**

**Michael Zucker:** Our interest was piqued in the summer of 2008 when CMS announced it was going to launch a demonstration project around bundled pricing. The opportunity presented itself to us — the project was made available to providers in four states (Okla., Texas, N.M., and Colo.). We were interested in being a part of it, and from that point we began to look at it from a strategic standpoint. At that time, we weren't aware that this type of program would position us so well for the future of healthcare reform. Everyone has been very pleased with the results of the program. So far, we've saved over \$2.2 million through the program, and we have distributed \$500,000 in shared saving distributions to physicians. Our quality improvements in the DRGs under the ACE program have also been noteworthy. Many of our measures have shown incredible improvements since beginning the ACE program and measures such as infections rates have been in the top percentile among our peer groups, and our compliance to evidence based medicine protocols have been above 97 percent.

**Q: One challenge many hospitals face when launching bundled pricing programs is physician buy-in. How did you**

**gain support from physicians for your program?**

**MZ:** We viewed the ACE project as an opportunity to create alignment with our physicians. It is very difficult to do outside of the program. None of the physicians participating in our program are employed. The program allowed us the opportunity for gainsharing, which we believe is a strong driver in us being able to align our interests.

As you can imagine not all of the physicians were excited about the prospect of having the hospital be "in control" of the dollars, or specifically, the bundled payment. But, we had several physician champions who could see beyond the challenges and the potential benefits of the program. We did, however, see a few physicians take their cases elsewhere. In our efforts to reduce costs, the physicians and hospitals through our newly created PHO, Physicians Aligned for A.C.E. (a.k.a. PAACE), eliminated some orthopedic vendors from our preferred list of vendors. As a result, a few physicians decided their allegiance to their vendor was stronger than that to this evolving program.

**Q: Some hospitals enter into bundled payment contracts with the rationale that it will increase volume. Have you seen that at Baptist?**

**MZ:** So far, we haven't seen any material increases in volume. Our volume has actually been flat, but given the economic downturn around the country, flat might be pretty good. There has been some shifting of volume if we examine it on a physician by physician basis. For example, a doctor that used to do 50 percent of his or her cases here may now be doing 60 percent, likely because of the gain sharing program and improvements in quality outcomes. However, it's difficult to directly relate any changes back to the program.

**Q: What do you think has been most**

**critical to Baptist's success in efforts around bundling payments?**

**MZ:** I think openness and transparency with our physicians has been key. We formed a separate PHO with a 50/50 governing board that ultimately defines most of the measures for quality and cost benchmarks and administers the gainshare program. There has to be openness and trust by both parties for this type of program to work.

**Q: What was the biggest challenge your health system faced in getting this program off the ground?**

**MZ:** Getting the physicians participation in the very beginning was a bit of a challenge. We had a handful of physician champions who did the majority of the work [developing protocols and metrics] even though the rest of the medical staff was skeptical. In the first month, only six physicians received gain sharing checks. This may have been the turning point, as other physicians began to take notice and physicians began to realize the program was working. The second month there were 13 physicians receiving gainshare checks, and word spread quickly after that. The program has been successful, but we definitely had to get over some uncertainty and skepticism in its early days.

**Q: Does Baptist have any plans to expand bundled pricing arrangements with other payors or for other conditions?**

**MZ:** We're really focused on high cost, high volume procedures, which probably is why CMS picked orthopedic and cardiac procedures to test this with first. Right now, we are examining how we might extend this to post-acute care [Editor's note: the Patient Protection and Affordable Care Act creates a pilot that will bundle payment for care up to 30 days post-discharge]. It will require working with an entire new set of providers and an entire new set of challenges and opportunities. ■

# Becker's Hospital Review Annual Meeting ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

- Great topics and speakers focused on ACOs, Physician-Hospital Integration, Improving Profits and Key Specialties
- The smartest people in the healthcare arena
- 53 Sessions, 79 Speakers
- Focused talks and panels on the most important subjects facing health systems today
- Keynote presentations from Charles N. Kahn III ("Chip"), President, Federation of American Hospitals and Peter Kongstvedt, Principal, P. R. Kongstvedt Company, LLC, Author, and Senior Health Policy Faculty Member in the Dept. of Health Administration and Policy at George Mason University
- Keynote panel moderated by Charles S. Lauer, Former Publisher of Modern Healthcare Magazine, Consultant, Speaker, and featuring Thomas J. Sadvary, President & Chief Executive Officer, Scottsdale Healthcare, Michael D. Israel, President & Chief Executive Officer, Westchester Medical Center, Joseph A. Scopelitti, MD, Co-CEO, Medical Affairs, Guthrie Health, President & CEO, Guthrie Clinic
- Keynote presentation by Richard J. ("Rick") Pollack, Executive Vice President, Advocacy and Public Policy, American Hospital Association

**May 19-20, 2011**

Palomar Hotel

505 North State Street, Chicago, Illinois

**For more information, call Becker's Hospital Review (800) 417-2035**

**If you would like to sponsor or exhibit at this event, please call (800) 417-2035**

**To register, contact Becker's Hospital Review at 800-417-2035  
or fax 866-678-5755 or Email: [registration@beckershospital.com](mailto:registration@beckershospital.com)  
Register online: <https://www.regonline.com/beckershospitalreviewannualmeeting>**

## Becker's Hospital Review Annual Meeting –

# ACOs, Physician- Hospital Integra- tion, Improving Profitability and Key Specialties

This exclusive conference brings together hospital business and strategy leaders to discuss how to improve your Hospital and its bottom line in these challenging but opportunity-filled times.

The best minds in the Hospital field will discuss opportunities for Hospitals plus provide practical and immediately useful guidance on ACOs, physician-hospital integration, improving profitability and key specialties.

- 1) Benefit from the efforts of Becker's Hospital Review to attract attendees and speakers that are among the smartest people in the Hospital industry today.
- 2) Take discussion and thinking to the highest levels.
- 3) Access expert views from all sides of the Hospital world.

**For a free subscription to  
Becker's Hospital Review,  
call 800-417-2035.**

## PROGRAM SCHEDULE

### Conference – Thursday, May 19, 2011

7:00am – 9:00am Registration  
9:00am – 5:15pm Conference  
5:15pm – 7:00pm Reception, Cash Raffles, Exhibits

### Conference – Friday, May 20, 2011

7:00am – 8:00am Registration and Continental Breakfast  
8:00am – 5:00pm Conference, Including Lunch and Exhibit Hall Breaks  
5:00pm – 6:30pm Reception, Cash Raffles, Exhibits

### Thursday, May 19, 2011

7:00 – 9:00 am  
Registration

9:00 – 12:00 pm  
Exhibitor Set-Up

9:00 am - 9:30 am  
**A - ACO Partnerships - A Case Study**  
Bob Edmondson, Vice President,  
Planning, West Penn Allegheny  
Health System

**B - Achieving Success as an  
Independent Hospital, A Case Study  
Approach**  
Darin Morgan, Manager, Healthcare  
Strategy Practice, Kurt Salmon As-  
sociates

**C - Orthopedics, An Overview of the  
Next Five Years**  
John Cherf, MD, MPH, MBA, Presi-  
dent, OrthoIndex, Clinical Advisor,  
Sg2, Orthopedic Surgeon, Chicago  
Institute of Orthopedics

9:35 am – 10:20 am  
**A - Commercial Payors and Health  
Reform - Manage Payor Efforts  
to Slow Costs and Drive Favorable  
Outcomes**  
Lawrence Nall, Vice President,  
Managed Care, Quorum Health  
Resources, LLC

**B - Physician Compensation - A  
Review of Compensation Metrics for 5  
Key Areas, Primary Care, Cardiology,  
Oncology, Orthopedics and  
Neurosurgery**  
Steve Rice, Executive Vice President,  
Integrated Healthcare Strategies

### **C - Replacing Revenue for a Hospital When Developing Ambulatory Businesses**

Robert Zasa, MSHHA, FACMPE,  
Founder, ASD Management

### 10:25 am – 10:55 am **A - An Overview of the Leading Investor Owned Hospital Chains, HCA, CHS, Vanguard and More**

Anu Singh, Vice President, Kaufman,  
Hall & Associates

### **B - Healthcare Reform and Its Impact on Providers and the Credit Market**

Shane Passarelli, Senior Vice President,  
Healthcare Finance Group, Gary D.  
Samson, Partner, McGuireWoods LLP  
and Carsten Beith, Managing Director,  
Cain Brothers

### **C - What's New, Next and Best in Healthcare Strategy, Marketing and Communications - How to Build Market Share**

Rhoda Weiss, Ph.D., National Healthcare  
Consultant, Speaker, Author & Editor,  
Marketing Health Services Magazine

11:00 am – 11:45 am  
**A - The Best Ideas for Hospitals Now**  
Tom Hearn, Senior Vice President  
Ambulatory Care, Novant Health,  
Thomas J. Sadvary, President & CEO,  
Scottsdale Healthcare, and Barbara  
Gray, Vice President, Accountable  
Care Collaboratives, Premier, Inc.  
Moderated by Scott Becker, JD, CPA,  
Partner, McGuireWoods LLP

### **B - The Evolution of Service Line Co- Management Relationships, What Services, What is Fair Value, How to Pay for It**

Scott Safriet, MBA, AVA, Principal,  
Healthcare Appraisers, and Krist Wer-  
ling, JD, McGuireWoods LLP

### **C - ASCs as a Physician Alignment Tool**

Christian D. Ellison, Vice President,  
Health Inventures

11:45 am – 12:30 pm

Networking Lunch & Exhibits

12:30 pm – 1:15 pm

### **A - Developing an Outstanding Group Practice, Financial Sustainability, Culture and Other Issues**

Joe Golbus, MD, President, NorthShore University HealthSystem, Paul R. Summerside, FAAEM, FACEP, MMM, MD, Chief Medical Officer, BayCare Clinic, Chairman of the Board, Aurora Bay-Care Medical Center, Moderated and led by Walter W. Morrissey, MD, Vice President, Kaufman Hall

### **B - Key Strategies to Maintaining A Great Independent Hospital**

Sean M. Fadale MBA, FACHE, Vice President, Business Development, Nicholas H. Noyes Memorial Hospital, Virginia Tyler, M.Div, FACHE, President, Tyler Consulting, Katie Carow, MBA, Principal, Carow Consulting

### **C - Valuing Practices for Acquisitions - Assessing Acquisition Price and Compensation**

Jon O'Sullivan, Senior Partner, VMG Health, Greg Koonsman, Senior Partner, VMG Health

1:20 pm – 1:50 pm

### **A - Developing a Sustainable Physician Strategy**

Kenneth H. Cohn MD, MBA, FACS, CEO, Healthcare Collaboration

### **B - Whole Hospital Joint Ventures Between For Profit Hospital Companies and Not For Profit Hospitals**

Pete Lawson, Executive Vice President Development, Health Management Associates

### **C - The Re-emergence of Orthopedic Surgery Employment**

Leslie R. Jebson, Executive Director, University of Florida Orthopaedics and Sports Medicine Institute, Program Director, University of Florida Graduate Program in Physician Practice Integration, Mark S. Thomas, Senior Attorney, Dell Graham

1:55 pm – 2:35 pm

### **A - Using a PHO as the Foundation of an ACO**

Eric P. Norwood, FACHE, President & CEO, DeKalb Regional Health System, Inc., Albey Wildstein, MD, Chairman, DPHO, Inc., Susan L. Helton, Executive Director, DeKalb PHO

### **B - Maximize OR Performance: How to Align Perioperative, Anesthesia, and Surgical Staff to Drive Efficiency in Your Largest Revenue Center**

Timothy Dowd, MD, Managing Partner, North American Partners in Anesthesia

### **C - Physician Employment and Compensation: Develop and Implement Physician Compensation Models That Work**

BJ Millar, Director Physician Services, Quorum Health Resources, LLC

2:35 pm – 2:50 pm

Networking Break & Exhibits

2:50 pm – 3:30 pm

### **A - The 5 Best Ideas for ACOs**

Joseph A. Scopelliti, MD, Co-CEO, Medical Affairs for Guthrie Health, President & CEO, Guthrie Clinic

### **B - Contracting with Hospital-Based Physicians - Direct Contracting vs. Outsourcing**

Alan Channing, President and CEO Sinai Health System, Chairman Elect, Illinois Hospital Association, Lynn Massingale, MD, FACEP, Executive Chairman, TeamHealth Moderated by Scott Becker, Partner, McGuireWoods LLP

### **C - Operational Ideas to Improve Surgical Department Efficiency**

Larry Teuber, MD, President, Medical Facilities Corporation

3:35 pm – 4:25 pm

### **KEYNOTE PANEL - The Best Thoughts on Physician Alignment**

Charles S. Lauer, Former Publisher of Modern Healthcare Magazine, Consultant, Speaker, Moderator, Thomas J. Sadvary, President & Chief Executive Officer, Scottsdale Healthcare, Michael D. Israel, President & Chief Executive Officer, Westchester Medical Center, Joseph A. Scopelliti, MD, Co-CEO, Medical Affairs, Guthrie Health, President & CEO, Guthrie Clinic

4:30 pm – 5:15 pm

### **KEYNOTE - Perspectives on Healthcare Reform**

Charles N. Kahn III ("Chip"), President, Federation of American Hospitals

5:15 pm – 7:00 pm

Networking Reception, Cash Raffles and Exhibits

**Friday, May 20, 2011**

7:00 am – 8:00 am

Registration

8:00 am – 8:55 am

### **KEYNOTE - The Impact of Healthcare Reform on Payors and The Consequences for Health Systems**

Peter R. Kongstvedt, MD, FACP, Principal, P.R. Kongstvedt Company, LLC, Author, and Senior Health Policy Faculty Member in the Dept. of Health Administration and Policy at George Mason University

9:00 am – 9:35 am

### **KEYNOTE - An Overview of Washington DC and AHA Priorities**

Richard J. ("Rick") Pollack, Executive Vice President, Advocacy and Public Policy, American Hospital Association

9:40 am – 10:20 am

### **A - ACOs - A Panel Discussion**

Martin Manning, President, Advocate Physician Partners, Brian J. Silverstein, MD, Senior Vice President, The Camden Group, and Eric T. Nielsen, MD, Vice President, The Camden Group Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

### **B - 10 Key Financial Questions for Healthcare Executives**

Gary E. Weiss, Chief Financial Officer and Treasurer, NorthShore University HealthSystem

### **C - Anesthesia Relationships - Current Trends and Issues**

Marc E. Koch, MD, President & CEO, Somnia Anesthesia

10:20 am – 10:35 am

Networking Break & Exhibits

10:35 am – 11:15 am

**A - Assessing Healthcare Outcomes; A Roundtable on Industry Trends**

Peter R. Kongstvedt, MD, FACP, Andrew Hayek, President and Chief Executive Officer, Surgical Care Affiliates, Moderated by Gordon A. Soderlund, Senior Vice President, Strategic Relationships, The DASCO Companies LLC

**B - Roundtable Discussion on Physician-Hospital Joint Ventures**

Allan Fine, Senior Vice President, Chief Strategy & Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President of Development & Acquisitions, Ambulatory Surgical Centers of America

**C - Key Concepts to Combine the Efforts of Great Orthopedic Groups with Hospitals to Achieve Greatness and Profits in Orthopedics**

John Phillips, Regional Chief Operating Officer, CHRISTUS St. Michael Health System, and Bob Kahn, Chief Executive Officer, Orthopedic Specialists of Texarkana, PLLC

11:20 am – 12:00 pm

**A - A Key Concepts to Police, Improve and Measure Quality**

Paul R. Summerside, FAAEM, FACEP, MMM, MD, Chief Medical Officer, BayCare Clinic, Chairman of the Board, Aurora BayCare Medical Center

**B - The Best Ideas to Improve Financial Performance**

John A. Orsini, CPA, Executive Vice President of Finance, Chief Financial Officer, Resurrection Health Care, Barbara Martin, President & Chief Executive Officer, Vista Health System, John R. Zell, Vice President of Finance and Chief Financial Officer, OSF St. Joseph, Moderated by Adam Lynch, Vice President, Principle Valuation

**C - 4 Key Ideas and Concepts to Improve Cardiovascular Program Profitability**

James M. Palazzo, MBA, President, Paragon Health and Chris Thomson, Executive Director, Heart and Vascular Center, The Christ Hospital

12:05 pm – 12:40 pm

**A - ACOs: The Position of ASCs, Hospitals and Physicians**

Andrew Hayek, President & Chief Executive Officer, Surgical Care Affiliates

**B - The Path to Becoming an Elite Health System - Best Practices from Great Hospitals**

Bill Woodson, Senior Vice President, Sg2

**C - Building a World Class Oncology Program,**

Nancy Bookbinder, MPH, Founding Director and President, Oncology Resource Consultants, Inc.

12:40 pm – 1:30 pm

Networking Lunch and Exhibits

1:30 pm – 2:10 pm

**A - Making Employed-Physician Models Profitable**

Gary E. Weiss, Chief Financial Officer and Treasurer, NorthShore University HealthSystem, Andrew D. McDonald, FACHE, Senior Manager, Healthcare Consulting, LBMC Healthcare Team, Moderated by Amber Walsh, JD, Associate, McGuireWoods LLP

**B - Using Lean Principles to Reduce Cost and Surplus from the Hospital**

Gary Hagens, DMD, Chief Operating Officer and Vice President of Medical Management, Advocate BroMenn Medical Center, Advocate Eureka Hospital

**C - An Analysis of What Works What Doesn't - Key Thoughts for Physician-Hospital ASC JVs**

Jeff Simmons Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

2:15 pm – 2:50 pm

**A - The Future of Physician-Owned Hospitals Under Health Care Reform**

Mike Russell, MD, Texas Joint and Specialty Hospital

**B - How to Have Margin Discussions with Your Physicians**

Nick Sears, MD, Senior Vice President, Chief Medical Officer, MedAssets

**C - Squeezing Water Out of a Stone - How Hospitals Can Survive the Coming Reform**

Anthony Sanzo, Chief Executive Officer, TeleTracking Technologies, and Lisa Romano, Chief Nursing Officer, Vice President, Teletracking Technologies

2:50 – 3:05 pm

Networking Break and Exhibits

3:05 – 3:40 pm

**A - Integration Vs. Competition - The Future of Hospital-Physician Relationships**

George Conomikes, President & CEO, Conomikes Associates, Inc.

**B - Examining Strategic Alternatives - Should Your Hospital Sell, Affiliate or Stay The Course**

Rex J. Burgdorfer, Juniper Advisory, Kristian Werling, JD, McGuireWoods LLP

**C - Acquiring Cardiology Practices - Key Concepts on Price and Compensation**

James M. Palazzo, MBA, President, Paragon Health

3:45 pm – 4:20 pm

**A - Physician-Hospital Relationships - 5 Keys Concepts For an Effective Internal Investigation and Defending False Claims Cases**

Scott Becker, JD, CPA, Partner, David J. Pivnick, JD, BBA, Associate, and Lainey Gilmer, JD, MBA, McGuireWoods, LLP

**B - 10 Key Statistics to Analyze a Hospital's Financial Performance**

Zachary Hafner, Vice President, Strategic, Financial and Capital Planning, Kaufman, Hall & Associates

**C - The Impact of Healthcare Reform on Oncology and Strategies to Succeed**

Brett M. Hickman, Partner, Healthcare Industries Advisory Practice, PricewaterhouseCoopers LLP

4:25 – 5:00 pm

**Ten Key Legal Steps for JVs and Physician-Hospital Financial Relationships**

Scott Becker, JD, CPA, Partner, McGuireWoods LLP

5:00 pm – 6:30 pm

Networking Reception

Register by April 1, 2011 and SAVE!

# Becker's Hospital Review Annual Meeting – ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

Great topics and speakers focused on key business, clinical and legal issues facing hospitals and health systems –

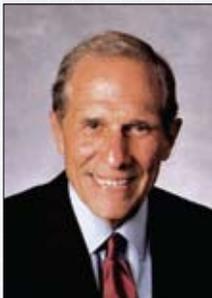
- 53 Sessions
- 79 Speakers

Thank you to our corporate sponsors!



Charles N. Kahn III  
("Chip")

- Charles N. Kahn III ("Chip"), President of the Federation of American Hospitals
- Richard J. ("Rick") Pollack, Executive Vice President, Advocacy and Public Policy, American Hospital Association
- Joseph A. Scopelliti, MD, Co-Chief Executive Officer, Medical Affairs for Guthrie Health, President & Chief Executive Officer, Guthrie Clinic
- Thomas J. Sadvary, President & CEO, Scottsdale Health
- John Cherf, MD, MPH, President OrthoIndex, Clinical Advisor, Sg2, Orthopedic Surgeon
- Charles S. Lauer, Former Publisher, Modern Healthcare Magazine, Consultant, Speaker
- Joe Golbus, MD, President, NorthShore University HealthSystem
- Lynn Massingale, MD, FACEP, Executive Chairman, TeamHealth



Chuck Lauer

- Gary E. Weiss, Chief Financial Officer & Treasurer, NorthShore University HealthSystem
- Bob Kahn, Chief Executive Officer, Orthopedic Specialists of Texarkana, PLLC



Peter Kongstvedt

- Peter R. Kongstvedt, MD, FACP, Principal, P.R. Kongstvedt Company, LLC, Author, and Senior Health Policy Faculty Member in the Dept. of Health Administration and Policy at George Mason University
- Gary A. Hagens, DMD, MSD, MMM, Chief Operating Officer, Advocate BroMenn Medical Center/ Advocate Eureka Hospital
- Barbara Martin, President & CEO, Vista Health System
- Michael D. Israel, President & Chief Executive Officer, Westchester Medical Center
- Allan Fine, Senior Vice President, Chief Strategy & Operations Officer, The New York Eye & Ear Infirmary
- Leslie R. Jebson, Executive Director, University of Florida Orthopaedics and Sports Medicine Institute, Program Director, University of Florida Graduate Program in Physician Practice Integration
- Paul R. Summerside, MD FAAEM, FACEP, MMM, Chief Medical Officer, BayCare Clinic, Chairman of the Board, Aurora BayCare Medical Center
- Andrew Hayek, President & CEO, Surgical Care Affiliates
- Alan Channing, President & Chief Executive Officer, Sinai Health System, Chairman Elect, Illinois Hospital Association

For more information, call (800) 417-2035 or email  
[sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com)

If you would like to sponsor or exhibit at the program, please call (800) 417-2035.

TO REGISTER, CALL 800-417-2035 • FAX 866-678-5755 • EMAIL [registration@beckershospital.com](mailto:registration@beckershospital.com)  
<https://www.regonline.com/beckershospitalreviewannualmeeting>

# conference speakers

Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Carsten Beith, Managing Director, Cain Brothers

Nancy Bookbinder, MPH, Founding Director & President, Oncology Resource Consultants, Inc.

Rex J. Burgdorfer, Juniper Advisory

Katie Carow, MBA, Carow Consulting

Alan Channing, President & Chief Executive Officer, Sinai Health System

John Cherf, MD, MPH, President, OrthoIndex, Clinical Advisor, Sg2, Orthopedic Surgeon

Kenneth H. Cohn, MD, MBA, FACS, Chief Executive Officer, Healthcare Collaboration

George Conomikes, President & Chief Executive Officer, Conomikes Associates, Inc.

Timothy Dowd, MD, Managing Partner North American Partners in Anesthesia

Bob Edmundson, Vice President Planning, West Penn Allegheny Health System

Christian D. Ellison, Vice President, Health Inventures

Sean M. Fadale, MBA, FACHE, Vice President, Business Development, Nicholas H. Noyes Memorial Hospital

Allan Fine, Senior Vice President, Chief Strategy & Operations Officer, The New York Eye & Ear Infirmary

Brandon Frazier, Vice President of Development, Ambulatory Surgical Centers of America

Nap Gary, Chief Operating Officer, Regent Surgical Health

Lainey Gilmer, JD, MBA, McGuireWoods LLP

Joe Golbus, MD, President, NorthShore University HealthSystem

Barbara Gray, Vice President, Accountable Care Collaboratives, Premier, Inc.

Zachary Hafner, Vice President Strategy and Financial Planning, Kaufman, Hall & Associates

Gary A. Hagens, DMD, MSD, MBA, Chief Operating Officer, Advocate BroMenn Medical Center/Advocate Eureka Hospital

Andrew P. Hayek, President & Chief Executive Officer, Surgical Care Affiliates

Tom Hearn, Senior Vice President Ambulatory Care, Novant Health

Susan L. Helton, Executive Director, DeKalb PHO

Brett M. Hickman, Partner, Health Industries Advisory Practice, PricewaterhouseCoopers

Michael D. Isreal, President & Chief Executive Officer, Westchester Medical Center

Les Jepson, FACMPE, FACHE, LHRM, MHA, Executive Director, University of Florida, Orthopaedics and Sports Medicine Institute

Bob Kahn, Chief Executive Officer, Orthopedic, Specialists of Texarkana, PLLC

Charles N. Kahn III ("Chip"), President, Federation of American Hospitals

Marc E. Koch, MD, President & Chief Executive Officer, Somnia, Inc.

Peter R. Kongstvedt, MD, FACP, Principal, P.R. Kongstvedt Company, LLC, Author, and Senior Health Policy Faculty Member in the Dept. of Health Administration and Policy at George Mason University

Greg Koonsman, CFA, Principal, VMG Health

Charles S. Lauer, Former Publisher, Modern Healthcare Magazine, Consultant, Speaker

Peter Lawson, Executive Vice President, Development Health Management Associates

Adam Lynch, Vice President, Principle Valuation, LLC

Martin Manning, President, Advocate Physician Partners

Barbara Martin, President & CEO, Vista Health System

Lynn Massingdale, MD, FACEP, Executive Chairman, TeamHealth

Andrew D. McDonald, MD, FACHE, Senior Manager, Healthcare Consulting, LBM Healthcare Team

BJ Millar, Director Physician Services, QHR-Quorum Health Resources, LLC

Darin Morgan, Strategy Manager, Kurt Salmon Associates

Walter D. Morrissey, MD, Vice President, Kaufman, Hall & Associates

Lawrence Nall, Vice President, Managed Care QHR - Quorum Health Resources LLC

Eric T. Nielsen, MD, Vice President, The Camden Group

Eric P. Norwood, FACHE, President & Chief Executive Officer, DeKalb Regional Health System, Inc.

John A. Orsini, CPA, Executive Vice President of Finance and Chief Financial Officer, Resurrection Health Care

Jon O'Sullivan, Principal, VMG Health

James M. Palazzo, MBA, President, Paragon Health

Shane Passarelli, Senior Vice President, Healthcare Finance Group

John Phillips, MD, Northland Orthopedic Group

David J. Pivnick, JD, BBA, Associate, McGuireWoods LLP

Richard J. ("Rick") Pollack, Executive Vice President, Advocacy and Public Policy, American Hospital Association

Steve Rice, Executive Vice President, Integrated Healthcare Strategies

Lisa Romano, Chief Nursing Officer, Vice President, TeleTracking Technologies

Mike Russell, MD, Texas Joint and Specialty Hospital

Thomas J. Sadvary, President & CEO, Scottsdale Healthcare

Scott Safriet, MBA, AVA, Principal, Healthcare Appraisers

Gary D. Samson, Partner, McGuireWoods LLP

Anthony Sanzo, Chief Executive Officer, TeleTracking Technologies

Joseph A. Scopelliti, MD, Co-Chief Executive Officer Medical Affairs, Guthrie Health, and President & Chief Executive Officer, Guthrie Clinic

Nick Sears, Senior Vice President, Chief Medical Officer, MedAssets

Brian Silverstein, MD, Senior Vice President, The Camden Group

Jeff Simmons, Chief Development Officer, Regent Surgical Health

Anu Singh, Vice President, Kaufman, Hall & Associates

Gordon Soderlund, Senior Vice President Strategic Relationships, DASCO Companies

Paul R. Summerside, MD, FAAEM, FACEP, MMM Chief Medical Officer, BayCare Clinic, Chairman of the Board, Aurora BayCare Medical Center

Larry Teuber, MD, President, Medical Facilities Corporation

Mark S. Thomas, Senior Attorney, Dell Graham

Chris Thompson, Executive Director, Heart and Vascular Center, The Christ Hospital

Rowena Timms, Vice President Public Affairs, CaroMont Health

Virginia Tyler, M. Div, FACHE, President, Tyler Consulting

Amber Walsh, JD, Associate, McGuireWoods LLP

Gary E. Weiss, Treasurer & Chief Financial Officer, NorthShore University HealthSystem

Rhoda Weiss, PhD, National Healthcare Consultant, Marketing Health Services Magazine

Kristian Werling, JD, Associate, McGuireWoods LLP

Albey Wildstein, MD, Chairman, DPHO, Inc.

Bill Woodson, Senior Vice President, Sg2

Robert Zasa, MSHHA FACMPE Founder, ASD Management

John R. Zell, Vice President of Finance and Chief Financial Officer, OSF St. Joseph Medical Center

# The Case for Shifting More Services to Midlevel Providers

Written by Steve Ronstrom, CEO of Sacred Heart Hospital, Eau Claire, Wis.

**W**ith reimbursements shrinking and patient volume expected to rise under the reform law, our healthcare system comes up against a stark reality. There are not enough physicians to go around, and the federal government certainly is in no mood to expand physician supply by funding more GME training slots.

As we move to new methods of reimbursement, such as bundled payments and accountable care organizations, we have an opportunity to rethink what physicians do and honestly assess what tasks could be handled by other professionals who have sufficient training to do it. I'm thinking of nurse practitioners, physician assistants and nurse anesthetists.

People disagree on what exactly to call these professionals. This is due to longstanding debates about their scope of practice and the amount of physician supervision they need. I still hear them called "physician extenders," suggesting they're nothing more than an appendage of physicians. The American Academy of Nurse Practitioners, on the other hand, wants to call them "independently licensed providers," which I find a bit murky. Aren't physicians also "independently licensed providers"?

I prefer the term "midlevel providers." Since each state has a different definition of what these professionals are allowed to do, "midlevel providers" is about as specific as you can get, denoting a level of expertise somewhere between physicians and registered nurses.

## How midlevels could help

It has been estimated that midlevels, who have about 2-3 years of postgraduate training, could perform as much as 80 percent of what physicians do. Several scientific studies show quality outcomes for midlevels and physicians are the same across many tasks. Usually working under physician supervision, midlevels can perform a history and physical and preliminary diagnosis, turning the patient over to a physician when needed. In Wisconsin, midlevels are even allowed to prescribe some drugs, though this is still not allowed in many states.

Midlevels work across all specialties. Giving them many of the tasks physicians traditionally do could greatly improve productivity, and that is what the American economy is all about. Productivity is the engine of our prosperity, and no sector of our economy needs improved productivity more than healthcare. Our services are approaching 17 percent of GNP, an unsustainable level. We need to get it down to 15 percent, an enormous feat given evolving demographics. It would involve a basic reassessment of how we use our healthcare workforce.

The healthcare system sorely needs this extra pool of providers. The Association of American Medical Colleges forecasts the nation will be short 62,900 physicians in five years due to aging of baby-boomer patients, retirements of many baby-boomer physicians and expansion of coverage under the Patient Protection and Affordable Care Act. The healthcare reform law has authorized \$167.3 million to build the supply of primary care physicians, but the AAMC said this won't be enough. While medical schools have been increasing class sizes, graduates will still vie for federally funded residency positions that have been capped at 100,000 slots since 1997.

There are about 240,000 midlevels in the United States, compared with 700,000 physicians, but numbers of midlevels are expected to rise relatively rapidly. Physician assistants, for example, are projected to be the second-fastest growing health profession, after home health aides, in the coming decade, and 8,000 new nurse practitioners are being added to the workforce every year.

## Meeting physician pushback

Midlevels still encounter resistance from organized medicine, which plays out in states' scope-of-practice laws and insurers' reimbursement decisions. Patients, however, seem to have accepted this class of providers. Despite some initial mistrust, studies show patients warm up to them. That makes sense. The midlevel can spend more time with patients and thus develop a firmer relationship than a physician can. In the end, patients don't care whether the person treating them has gone to medical school or not. Basically they want someone who will listen to them and has sufficient training to deal with their condition.

Even physician resistance seems milder. The AMA recently denounced a new Institute of Medicine report recommending the same reimbursements for midlevels and physicians for the same work and calling for uniform scope of practice standards across the country. "Increasing the responsibility of nurses is not the answer to the physician shortage," said AMA Trustee Rebecca Patchin, MD, noting physicians have much longer training than midlevels. But Dr. Patchin, a former nurse, did endorse a "physician-led team approach" using these caregivers, and that's a good start.

In fact, the horse has already left the barn. Physicians' practices are now routinely using midlevels for many higher-level tasks than what nurses do. Even some leaders in academic medicine, once a holdout against the trend, strongly endorse shifting more tasks over to midlevels. In a recent interview, Edward Miller, MD, dean of the Johns Hopkins School of Medicine, said U.S. healthcare does not

need more physicians and should rely more on midlevels and ancillary staff.

Dr. Miller predicted the floodgates will open for non-physician providers as soon as we shift from fee-for-service reimbursements to new systems of bundled payments, including ACOs and capitated rates. "The payment system, I feel, is the culprit of much of this," Dr. Miller told the *Johns Hopkins University Gazette*. "I only get paid if I touch as you as a physician. But if I get a premium per month to take care of you, maybe I don't need to see you every time. Maybe my nurse practitioner sees you."

## What needs to be done

For midlevels to flourish, we need uniform scope of practice standards across all states and guaranteed reimbursements by all payors. While Medicare generally reimburses midlevels at 85 percent of the rate for physicians, some insurers still won't pay independent midlevels. These payors either don't recognize the CPT code modifiers for midlevel services or don't include midlevels in their provider panels. The answer is to work directly with employers who are interested in using midlevels to keep their costs down. Self-insured employers can create protocols specifying which tasks should be performed by midlevels instead of physicians.

As supervisors, physicians have a key role in deciding what midlevels can do. When determining tasks for midlevels, physicians should ask themselves, "Could you teach someone else to do this particular task?" If so, it may not need to be done by a physician.

In shifting more work to midlevels, we need to guard against burnout. Establishing eight-minute office visits, for example, would make providers feel rushed and patients dissatisfied, and it would eliminate a key advantage of midlevels — to spend more time with the patient and establish a rapport.

The bottom line is that we are not using our healthcare workforce to its full capacity. Scope of practice restrictions, payor policies and physicians' attitudes are reducing the productivity of midlevels at a time when we need it more than ever. ■

*Stephen F. Ronstrom has more than 25 years of hospital leadership experience, having served for the past 12 years as an executive in the Hospital Sisters Health System. He is currently president and CEO of the Hospital Sisters' Western Wisconsin division, which includes 344-bed Sacred Heart Hospital in Eau Claire, Wis. Learn more about Hospital Sisters Health System.*



# 9 Key Considerations for Healthcare Internal Investigations

By Scott Becker, JD, CPA, David Pivnick, JD, and Elaine Gilmer, JD, MBA, McGuireWoods

**H**ealthcare providers face a climate of increased investigation coupled with a quickly changing business environment. The Department of Justice has requested increases in its budget, including substantial increases in the DOJ's 2011 budget for investigating and litigating healthcare fraud cases. There has also been a very substantial increase in False Claims and other whistleblower litigation aimed at hospitals and health systems. These developments create a recipe for serious legal challenges. Moreover, a quickly changing business environment has led to a variety of new and creative ways for hospitals, surgery centers and physicians to interact. The existence of these new and aggressive relationships combined with an ever-increasing investigative climate creates substantial risk of regulatory and legal exposure.

When a hospital or health system becomes aware of potential improper conduct either through an employee, an independent contractor or otherwise, the standard response is to commence an internal investigation. In conducting such investigations, there are several different issues and factors that come into play. This article briefly describes nine such considerations.

**1. Plan and subject matter expertise.** The internal investigation should start with a core work plan. This may include the scope of the investigation, what documents are going to be reviewed, who is going to be interviewed, and what is expected in terms of a final product. Generally, it is helpful to identify a list of questions that the company wants answered and often some of these questions will be open ended. Additionally, it is helpful to include in the plan the timing and sequencing of the activities that will be conducted. For example, before starting with interviews, it is helpful to review a substantial number of relevant documents to provide information that can be used in conducting the interviews. The interviews may start with an outline of 10-15 basic questions and then include additional questions as the interview evolves. Furthermore, it is helpful to interview the party on the opposite end of the relationship and not just the hospital official or other party who supervised or engineered the relationship for the hospital. For example, in certain situations a hospital supervisor may have an understanding of their risk and be very cautious in answering questions, such as "how did you decide on that person for providing funds to?" but the recipient of the funds may provide a clearer or more frank answer as to how they believe they were selected.

The investigative team should include lawyers or consultants with specific and deep knowledge of the areas under investigation, each by industry niche (e.g., hospital business practices, physician referral relationships, surgery centers, pharmaceutical or device marketing practices, etc.) and by legal statute (Anti Kickback, Stark, exempt organizations, FDA, etc). This is critical both from assuring the right questions are asked and the right focus is taken to the effort. It is also critical to help bring a level of efficiency to the investigation.

**2. Who to report to?** An internal investigation is typically conducted for the chief legal officer or general counsel if the company has such an officer. In companies without such an officer, internal investigations are often conducted for the president, chief executive officer or board. The persons responsible for conducting the internal investigation will generally provide his or her findings to the person that has requested and is responsible for the internal investigation. However, an exception arises where the person who has requested the investigation has a conflict or does not appear responsive to the findings of the internal investigation. In such situations, the general advice is that those persons responsible for the investigation should take their findings further up the corporate ladder until the investigation is properly responded to. This scenario presents a very interesting judgment call and will often require an analysis of the severity of the conduct under review and of the significance of any conflict that exists. It is critical to understand the chain of authority for internal investigations.

**3. Constituents.** In most internal investigations, there will be a mix of different perspectives on what the individual parties involved in the investigation are attempting to accomplish. The chief compliance officer or general counsel may have a perspective that the business people have acted too aggressively, improperly or simply not heeded their advice. In contrast, an executive may be looking for a report that provides them with a confirmation that they have performed properly. The persons responsible for conducting the internal investigation must have an understanding of each of these different constituents with a comprehensive view of what each expects, while at the same time being prepared and willing to record their true findings and to conduct an unbiased investigation. In essence, one party might want a report that essentially approves the conduct in question, whereas another party might be seeking a report identifying wrongdoers and suggesting appropriate redress. These

divergent views can also affect the manner in which these constituents respond to and participate in the investigation. From an investigator's standpoint, the goal is to provide the company with the most accurate and useful report possible without being persuaded by other persons' objectives and agenda. Rather, the internal investigator must be willing to diligently investigate, to provide prophylactic guidance and advice on how to improve things on a going forward basis, and must consider whether affirmative next steps are required with respect to past conduct. For example, the investigator may need to evaluate whether there should be a self disclosure of the conduct to the government, whether current relationships should be terminated and whether other steps are necessary.

**4. Independence.** The internal investigation should almost always be handled by outside counsel that is independent of the company and the conduct in question. For example, to the extent that high-ranking officers were heavily involved in the conduct to begin with, such persons should not handle the investigation and it is imperative that the findings of the investigation go beyond the general counsel or such officers. Further, where outside counsel has been involved in or in any way provided advice relating to the conduct in question, serious consideration should be given as to that counsel not conducting or otherwise being involved in the investigation. Separating persons who are subjects of the investigation from the conduct of the investigation is imperative in ensuring a careful, reasoned investigation without interference by persons with a personal stake in the outcome. Moreover, independent investigators are more likely to consider each of the issues and to be unaffected by preconceived opinions regarding the subjects of the investigation.

**5. Hold notices.** At the start of an internal investigation, it is often helpful and important to send out a memorandum warning all persons who may have relevant information not to destroy any documents, e-mails or other correspondence relating to the facts at issue. A hold notice is particularly important if there has been any sort of government or litigation inquiry. A hold notice helps to ensure that the investigators are able to obtain and review all relevant documents and helps to avoid potential liability associated with the destruction of documents. Additionally, prior to the inception of an internal investigation it is also helpful for companies to have established document retention policies, which should be implemented and enforced.

**6. E-mail records and discovery.** Depending on the scope of the internal investigation, it can be very helpful to review e-mail records and other documents related to the parties involved. In a government investigation, all e-mails will almost certainly be subpoenaed and they often contain the types of information that can be particularly challenging in defending a company. It should be noted, however, that conducting such a comprehensive investigation of e-mails can become extremely expensive. For example, in one internal investigation there were approximately one million e-mails that were reviewed over the course of three weeks by lawyers working 24/7. This is an expensive undertaking. It will however ensure a thorough investigation and a complete understanding of the documentary evidence that exists and the challenges presented by such evidence.

**7. Conducting interviews.** When conducting interviews, it is helpful and advisable to have two persons present in addition to the interviewee. One of the individuals is then able to conduct the interview, while the other individual takes notes. This allows the person conducting the interview to really focus on the interview and on the responses being given, in order to ensure that appropriate and necessary follow-up questions are asked. The interviewer can also then focus on the body language and conduct of the interviewee.

Additionally, the person who is actually taking notes is better able to focus on accurately recording the questions and responses without having to formulate follow-up questions or determine the course of the interview. It is often helpful to have the person responsible for note-taking provide a short, written memorandum after the interview articulating the issues that have been discovered and discussed through the interview. Having multiple persons present during an interview provides an additional and significant benefit by encouraging the interviewee to be accurate and by deterring interviewees from altering or amending their answers after the interview has concluded.

**8. The Upjohn Warning.** When conducting an internal investigation, a witness will often state that he or she does not want the investigator to repeat the witness's statements. However, as the internal investigation is often intended to identify and remedy wrongdoing, it is often critical that the witness's statements are included in the final investigative report. Moreover, the company may consider it beneficial to disclose those statements. Therefore, it is often not possible to fully protect the confidentiality of each witness and his or her statements. In this regard, each person should be warned that the attorney represents the company rather than the individual employee and, therefore, the attorney-client

privilege on the communications belongs to the company and not the employee. This is called an Upjohn Warning after the seminal case of *Upjohn Company v. United States*. In Upjohn, the United States Supreme Court held that the attorney-client privilege is between the attorney and the company even where the attorney is communicating with employees of the company. Accordingly, the Upjohn opinion is very relevant in the context of internal investigations because it sets forth the ownership of the privilege and ensures that the employee cannot invoke the attorney-client privilege to prevent a disclosure that benefits the company or that the company intends to make. Accordingly, the investigator should be careful to provide an Upjohn Warning.

**9. A written policy.** Companies ideally should implement a written policy setting forth with specificity the guidelines and parameters of their internal investigative process. The existence of a written policy governing internal investigations helps to ensure that any such investigations are conducted in an orderly fashion and also serves to deter any employees from engaging in improper conduct during an investigation, as the policy will set forth what is expected and required. This written policy should be communicated to employees to ensure that they are aware of the existence of the policy and of its provisions. ■

## Maryland's St. Joseph Medical Center to Pay \$22M to Settle False Claims, Kickback Allegations

By Lindsey Dunn

**S**t. Joseph Medical Center in Towson, Md., has agreed to pay the United States \$22 million to settle allegations under the False Claims Act that it paid kickbacks and violated the Stark Law when it entered into a professional services contract with MidAtlantic Cardiovascular Associates, according to a news release by the U.S. Department of Justice.

The settlement resolves allegations of the payment of kickbacks to Pikesville, Md.-based MidAtlantic under the guise of professional services agreements in return for the group's referrals to the medical center. The settlement specifically resolves issues related to 11 professional services agreements, covering the period of Jan. 1, 1996 to Jan. 1, 2006, which were being investigated for being above fair market value, not commercially reasonable or for services not rendered.

As part of the settlement, the hospital also agreed to settle allegations that it received reimbursement from federal health benefit programs between Jan. 1, 2008 and May 12, 2010, for medically unnecessary stents performed by Mark Midei, MD, a one-time partner in MACVA who was later employed by SJMC.

St. Joseph's also signed a corporate integrity agreement with HHS' Office of Inspector General, requiring SJMC to engage in activities that will help ensure accurate billing and appropriate relationships with referral sources.

The settlement stems from a whistleblower suit brought forth by a group of competing cardiologists. ■

**TO SUBSCRIBE TO the FREE Becker's Hospital Review E-weekly,**

**go to [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)  
or e-mail [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com)**

## CHRISTUS Health in Houston to Pay \$1M Settlement in Medicare Fraud Lawsuit

By Jaimie Oh

**C**HRISTUS Health, a hospital system based in Houston, has agreed to pay almost \$1 million to settle allegations that it committed Medicare fraud by falsely billing the federal healthcare program for unapproved medical costs and failing to disclose overpayments, according to a news release by Phillips & Cohen.

The allegations were brought to light by whistleblower Mark Razin, a Healthcare Financial Advisors employee who worked with CHRISTUS on cost reports to maximize Medicare reimbursement. The allegations against the hospital system accuse the health system of committing fraud as far back as 1988, with allegations including wrongful billing to Medicare for advertising, marketing and administrative costs. CHRISTUS also allegedly failed to disclose errors made by a fiscal intermediary that reviewed Medicare cost reports which caused the overpayments. Hospitals are required to report overpayments caused by reimbursement errors to Medicare.

Mr. Razin will receive a portion of the settlement under the qui tam, or whistleblower, provisions of the False Claims Act. Although he filed the lawsuit against CHRISTUS in 1998, the details of the case has been remained sealed until Tuesday when a federal district court judge in Los Angeles decided to unseal the case. Details of whether the health system has admitted to wrongdoing are not disclosed in the news release.

CHRISTUS Health operates more than 40 hospitals and facilities in Texas, New Mexico, Arkansas, Louisiana, Oklahoma, Utah, Missouri and Georgia. ■

### Becker's Hospital Review Annual Meeting ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

Great topics and speakers focused on key business, clinical and legal issues facing hospitals and health systems —  
53 sessions, 79 speakers

Featuring Keynote Speakers Chip Kahn, President, Federation of American Hospitals; Peter Kongstvedt, Principal, P.R. Kongstvedt Company, and Senior Health Policy Faculty Member, George Mason University; and Richard Pollack, EVP, Advocacy and Public Policy, AHA

May 19-20, 2011 • Chicago, IL  
To register, call (800) 417-2035  
or e-mail [registration@beckershospital.com](mailto:registration@beckershospital.com)  
Register online: <https://www.regonline.com/beckershospitalreviewannualmeeting>

For more information, visit: [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)

## Ohio's Marion General Pays \$1.2M to Settle Stark Violations

By Lindsey Dunn

**M**arion (Ohio) General Hospital has agreed to pay \$1.2 million to resolve self-reported allegations of the Stark Act and Anti-Kickback Statute, according to a *Marion Star* report.

The violations, which took place between 2003 and 2009, were self reported by the hospital to the U.S. Attorney General's office earlier this year.

The violations included a number of financial relationships with physicians that did not involve a written contract. Specifically, the hospital provided an after-hours answering service and medical waste disposal services to independent physicians at below-market rates and provided payment without a written contract to independent physicians who treated uninsured patients, among other violations.

The hospital claimed that none of the violations were intentional, according to the report. ■

## Simi Valley Hospital Settles Medicare Fraud Lawsuit, Agrees to Pay \$5.15M

By Jaimie Oh

**S**imi Valley (Calif.) Hospital has agreed to pay the U.S. government \$5.15 million in order to settle allegations that the hospital filed fraudulent claims to Medicare, according to a *Pacific Coast Business Times* news report.

The whistleblower lawsuit, filed by a former hospital employee, accused the hospital of fraudulently billing Medicare and Medi-Cal between 1991-1997 for psychiatric services rendered to ineligible patients. Simi Valley also allegedly paid a medical director \$12,000 each month to work on a nonexistent program, according to the report. Details on what the program was or aimed to achieve were not included in the report.

In settling the lawsuit, Simi Valley has not admitted to any wrongdoing. ■

# 6 Things Health Systems Look For When Acquiring a Hospital

By Rachel Fields

**H**ospital acquisitions by health systems are increasing as hospitals find it easier to survive as part of a larger organization. Here Mark Bogen, CPA, vice president of finance at South Nassau Communities Hospital in Oceanside, N.Y., discusses six things health systems should look for when considering an acquisition.

## 1. No skeletons in the hospital's closet.

A health system looking to acquire a community hospital should look closely at the hospital's legal and financial records to "make sure there aren't any skeletons in the closet," Mr. Bogen says. "In my career, through working on a number of potential mergers, acquisitions and takeovers, I've seen situations where [a hospital] appears to be fairly healthy, but if you don't get your fingernails dirty, you might miss some large issues." He says even though hospitals undergo regular audits, there are many areas where auditors may not get involved.

He says "skeletons" might include a history of fraud and abuse cases that might have been missed by hospital audits. He says health systems should also look closely at hospitals that are self-insured for malpractice insurance to make sure no coverage gaps exist. "One of two major malpractice cases could really put a financial hit on the organization," he says.

## 2. Good physical condition and sound technological investment.

Part of the future financial success of a hospital resides in the physical condition of the building and the presence of technology, Mr. Bogen says. A building in poor physical condition may not be able to adapt to the future needs of the organization or require a significant investment to reflect the image the health system wants to project.

"The health system needs to look at whether it would have to invest a significant amount — whether in bricks and mortar or in technology — to raise the hospital's value," he says. Although a community hospital that lacks up-to-date technology may not be attractive to a health system, the presence of "the latest and greatest toys" doesn't necessarily bode well either. "It should also concern you if the hospital buys every toy available and then doesn't use the technology in the way it should be used, both from a financial and clinical standpoint," he says. Again, the hospital should strike a good balance in technology investment between purchasing necessary, up-to-date equipment and not catering to every physician desire.

## 3. A diverse medical staff.

When a health system is evaluating a community hospital for a potential acquisition, Mr. Bogen says the medical staff is an important factor in deciding the hospital's appropriateness. He says the medical staff is evaluated on a number of factors, including:

- **Shared responsibility for medical specialties.** He says an attractive hospital will have several major physicians who take responsibility for a particular medical specialty. "If you have one doctor who does 35 percent of surgeries in a major area and he or she leaves, that takes away a lot of revenue," he says. "You want to have more than one doctor driving the physician train or the surgical train."

- **Academic credentials.** If the health system is involved with a medical school or an academic medical center, Mr. Bogen says the system might want to extend faculty positions to physicians in the community hospital. "In that case, you want them to have credentials and be able to make that transition," he says.

- **Healthy succession rates.** If the medical staff of the community hospital is aging, a health system will look at succession rates to determine if younger physicians are ready to take the place of those who will soon retire. "You always worry about that," he says, especially with the impending provider shortage. "If you've got a fairly aged staff that's not being replaced, that's a problem."

- **History of legal issues.** If a community hospital has a history of malpractice issues, that should raise a red flag for a health system looking to acquire, Mr. Bogen says.

## 4. Potential financial success for internal reasons.

In a down economy, it can be difficult to know whether a community hospital is failing financially because of unavoidable economic factors or because the hospital is poorly managed. Mr. Bogen says one of the most important steps in evaluating a hospital for an acquisition is to understand why the hospital has or has not been successful. "There are a lot of metrics you can examine," he says. "You look at length of stay, case mix, adjusted FTEs per occupied bed. You look at revenue cycle issues and days in A/R." He says a health system should examine the hospital's coding team for quality. "Coders these days are like gold — you can't get them and you can't keep them, especially the good ones," he says. "Even though they may come with the appropriate letters after

their name from a credentialing standpoint, you don't know what you're getting from a quality standpoint."

He says health systems should look at both internal factors — revenue cycle issues, staffing, quality metrics — and external factors — local economy, patient volumes, reimbursement rates — to determine why the hospital is succeeding or failing. He says the "why" is important because only looking at the hospital's success or failure doesn't tell you much. For example, a stand-alone community hospital may be able to perform much better when associated with a large health system. "If the hospital hasn't had a lot of leverage and success in negotiating managed care contracts, your system could bring a 15 to 20 percent increase to the managed care side of the business with no investment required," he says.

## 5. A good balance of inpatients and outpatients.

According to Mr. Bogen, the days when a hospital could market itself effectively with an inpatient/outpatient split of 90/10 are over. "In the world today, I think a hospital needs to have a 60/40 split inpatient/outpatient," he says. "I know some organizations that are close to 50/50. Nowadays with [reimbursement] cuts on free-standing ASCs, many physician groups are coming to the hospitals and offering full or partial ownership to bolster revenue as a result of the cuts in Medicare rates."

## 6. Strong hospital management.

When a health system acquires a hospital, the financial situation of the hospital often determines whether the hospital administration stays. But even if the hospital is struggling financially, administrators can be kept on board if they communicate well with hospital staff, have strong connections to the community and present a clean history of legal issues. "The health system should talk to the doctors and find out what kind of relationship the doctors have with the senior administrative team," he says. "The system should also look at a history of legal issues and compliance issues and whether the hospital has been successful in litigation attempts."

He says a strong management team should be active in the community "beyond the four walls of the hospital." Looking at empirical data will give some idea of whether hospital administrator should be replaced, but talking to hospital staff and community members can reveal those hidden factors that might sway a health system's decision. ■

## University of Louisville to Merge With CHI, Jewish Hospital & St. Mary's

By Molly Gamble

Officials from the University of Louisville (Ky.) have signed a letter of intent to move ahead with a merger between the school's healthcare system and two other healthcare organizations to form a statewide organization, according to a *Courier Journal* report.

The three-way merger will join Jewish Hospital & St. Mary's HealthCare/Jewish Hospital HealthCare Services in Louisville, Ky.; Catholic Health Initiatives and its Berea, Ky.-based operation, St. Joseph Health System; and University of Louisville Hospital/James Graham Brown Center and the University of Louisville.

Combined, the organization will have more than 3,000 physicians, 91 locations and combined revenue of more than \$2 million. The expected completion of the merger has not been released. ■

## Michigan Attorney General Approves Detroit Medical Center Sale

By Lindsey Dunn

Michigan Attorney General Mike Cox has approved the sale of eight-hospital Detroit Medical Center to Vanguard Health Systems in a deal valued at \$1.5 billion, according to a *Detroit Free Press* report.

In his report, Attorney General Cox determined that without the sale, DMC would be forced to close its facilities or discontinue services. As part of the approval, DMC must provide written reports for 10 years to a 20-person oversight board on the system's performance. The system must also provide a way for the public to provide feedback, according to the report.

The Attorney General's approval was required because the deal includes the transfer of assets from a non-profit entity to a for-profit one.

The Federal Trade Commission has already approved the deal, which is tentatively scheduled to be completed on Dec. 31. The deal now awaits approval from CMS, which must okay the transfer of billing from a non-profit to a for-profit firm, according to the report. ■

### ATTENTION HEALTHCARE ADMINISTRATORS:

*Why Spend Your Money...  
When You Can Spend Ours?*



- New Facilities & Services
- Predictable cost structure
- Significant earnings upside
- No upfront capital required

The C/N Group, Inc. works with healthcare systems to improve and expand their outpatient services. Under a Purchased Services model, we can develop any outpatient facility and through a simple turnkey asset lease, provide you with new services to offer the community.

The lease can include the real estate and/or the ancillary business itself.



One Cambridge Square • 114 East 90th Drive • Merrillville, IN 46410  
Tel:219-736-2700 ext. 225 • Fax:219-756-3100 • www.thecng.com

## Caritas Christi Sale Finalized; New For-Profit System Plans ACO

By Leigh Page

The \$895 million sale of formerly not-for-profit Caritas Christi Health Care to for-profit Cerberus Capital Management has been finalized and the new system is planning an accountable care organization, according to a report by the *Boston Globe*.

The six-hospital system in the Boston area will operate under a Cerberus affiliate, Steward Health Care System. Ralph de la Torre, the current Caritas CEO, who will continue in his post under the new ownership, has said the system plans to build an ACO and may expand beyond Massachusetts.

Cerberus will spend about \$116 million on projects, including new and renovated ORs, as part of a pledge to invest \$400 million in capital improvements over the next four years. Cerberus also agreed not to close any Caritas hospital for three years and to extend that pledge for two more years unless one of the hospitals loses money for two consecutive years.

Buyouts of a not-for-profit hospitals by for-profits often require a great deal of regulatory scrutiny. The Caritas Christi transaction was previously approved by the Massachusetts Attorney General, the Massachusetts Public Health Council and the state Supreme Court. The system was run by the Boston archdiocese until 2008. ■

# 4 Factors That Determine Hospital Executive Compensation

By Rachel Fields

**H**ospital executive compensation runs the gamut, with the top health system CEOs making millions of dollars a year. Here three experts discuss four factors affecting hospital executive compensation.

**1. Medical background.** According to the 2009 AMGA Medical Group Compensation and Financial Survey, the median compensation of non-physician CEOs in healthcare organizations was \$259,302 in 2009, compared to \$417,934 for physician CEOs in healthcare organizations in the same year. According to Lois Dister, executive vice president and managing principal of Cejka Executive Search, physician executives are currently in high demand. “Reform and the development of accountable care organizations require leadership skills that encompass clinical background, finance, operations and medical information,” she says.

Ms. Dister says the best healthcare organizations will provide physicians with opportunities to gain experience in a multitude of areas, such as service line growth, financial management, technology advancement and clinical integration. “Earning an MBA affords physicians an opportunity to not only learn business-relevant subject matter, but to have the shared experience of a very different learning process which prepares them to work alongside their non-physician colleagues,” she says. For those physicians considering executive positions, the pursuit of an MBA may be worth it — according to Cejka Executive Search’s research, physician CEOs and presidents with an MBA earned a 22 percent greater median salary than those without.

**2. Community type.** According to the Internal Revenue Service’s Exempt Organizations Hospital Compliance Project Final Report, top management officials at non-profit hospitals saw wide differences in compensation based on the community surrounding their hospitals. According to the report, top management officials earned the following average salaries based on community type:

- High population — \$650,200
- Critical access hospitals — \$152,699
- Rural — non-critical access hospitals - \$289,500
- Other — \$427,500

*Editor’s note: Data on for-profit or community hospital executive compensation is not currently available.*

**3. Hospital revenue.** Hospital revenue also plays a factor in compensation of hospital CEOs. According to Ms. Dister, the struggling

economy may mean hospital executives sacrifice bonuses or incentive pay. “Because we have seen a trend toward basing a larger percentage of total compensation on performance, the component based on financial performance [of the hospital] would stagnate or drop with the decline of hospital revenue and margins,” she says.

Nolan A. Newman of accounting firm Newman Dierst Hales agrees that the fluctuating economy means CEO contracts often include a plan for how compensation will be affected if the hospital is financially unstable. “If the hospital is not prospering financially or is having real financial problems, the plan document could be very clear about the solution,” he says. He adds that CEOs often forego part of all of their bonuses in order to help the hospital. The increasing transparency concerning executive salaries means the public will often criticize hospital CEOs for accepting bonuses when their hospitals are struggling financially, he says.

According to the Internal Revenue Service’s Exempt Organizations Hospital Compliance Project Final Report, top management officials at non-profit hospitals made the following average compensation based on hospital revenue:

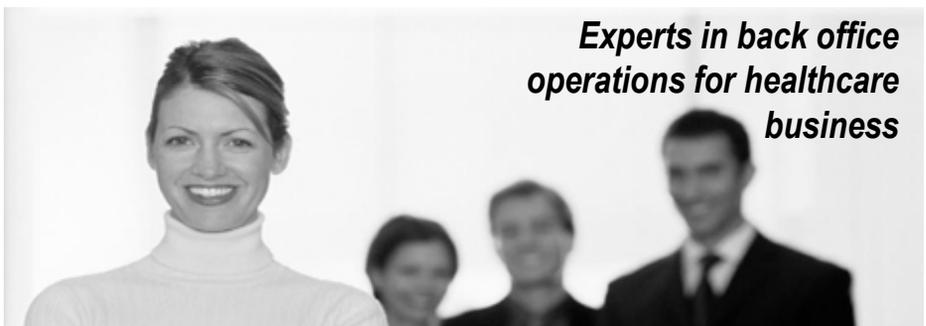
- Revenue under \$25 million — \$149,700
- Revenue between \$25 and \$100 million — \$289,600

- Revenue between \$100 and \$250 million — \$465,300
- Revenue between \$250 and 500 million — \$642,100
- Revenue over \$500 million — \$877,200

**4. Completion of pre-determined goals.**

According to Bill Quirk, national director of healthcare consulting for Hay Group, the use of executive incentive plans in U.S. hospitals is becoming ubiquitous. He says around 90 percent of hospitals in America today use incentive plans, compared to almost zero in the early 1980s, meaning executives who expect to receive top compensation will have to meet standards set forth by the hospital.

If a CEO is making \$100,000 per year, Mr. Quirk says he or she might be incented on a short-term basis at 30 percent of that base salary to meet annual goals. So if goals are completed in a given year, the CEO would earn \$130,000. That same CEO might also be held to a long-term incentive program, which multiplies that percentage over a number of years for goals that take longer to implement — the construction of a new cancer center or the development of a service line, for example. So for a three-year long-term incentive plan, the CEO would be compensated an extra 90 percent of his or her salary during the third year. ■



**Experts in back office operations for healthcare business**

ACCOUNTING CREDENTIALING PAYROLL & IT SOLUTIONS  
HUMAN RESOURCES EMPLOYEE BENEFITS

*make outsourcing your strategy in 2010...*

Reduce Risk. Reduce Cost. Maximize Performance

4 Westbrook Corporate Center, Suite 440  
Westchester, Illinois 60154  
708.492.0519 | www.medhq.net



# 5 Factors Affecting Physician Compensation

By Rachel Fields

**P**hysician compensation can vary widely by specialty, hospital ownership, geographic location and many other factors. Here are five factors currently affecting physician compensation, according to various reports.

**1. Specialty.** According to a study by researchers from the University of California Davis School of Medicine, specialists can earn up to twice as much as primary care physicians. The study found that primary care physicians made the lowest wages out of all physician specialties, at an average hourly wage of \$60.48. In broad categories of practice, surgeons made the most at \$92 per hour.

An examination of more specific subspecialties showed the biggest discrepancy between primary care physician and specialist compensation. The highest wages for subspecialties went to neurologic surgeons and radiation oncologists, who earned an average of \$132 per hour and \$126 per hour, respectively.

**2. Hospital ownership.** Primary care physicians in multispecialty hospital/IDS-owned practices reported median compensation of \$192,116, over \$12,000 more than PCPs in multispecialty not-hospital/IDS-owned practices, according to an MGMA report titled "Cost Survey for Integrated Delivery Systems 2010 Based on 2009 Data."

PCPs in multispecialty not-hospital/IDS-owned practices earned \$179,688 in median total annual compensation.

**3. Region.** Physician compensation differed based on geographic region, according to the Medical Group Management Association *Physician Compensation and Production Survey: 2010 Report Based on 2009 Data*. Family practice physicians based in the eastern United States earned a median salary of \$197,860, while family practice physicians in the midwest earned \$207,263. Family practice physicians in the southern U.S. earned \$238,307, and the same physicians in the western U.S. earned \$175,924.

The region with the highest salaries for anesthesiology, invasive and noninvasive cardiology, emergency medicine, gastroenterology and ophthalmology was the southern United States. Neurology, OB/GYN and general orthopedic surgery salaries were all highest in the Midwest United States, according to the study.

**4. Group type.** Physician compensation also varied based on group type, meaning whether physicians belonged to a single specialty or multispecialty group, according to the MGMA survey.

Anesthesiologists, invasive, invasive-interventional and noninvasive cardiologists, emergency medicine physicians, gastroenterologists, OB/GYN, neurologists and ophthalmologists all made higher median salaries when working with single specialty groups than with multi-specialty groups. General orthopedic surgeons, general surgeons, trauma surgeons and internal medicine physicians, on the other hand, made more working with multispecialty groups.

**5. Rate of income growth.** While some specialties are traditionally compensated at higher levels than others, physician compensation is also affected by the rate of income growth over several years. Here are the five medical specialties with the highest average gains in income offers between 2008/9 and 2009/10, according to data from Merritt Hawkins' *2010 Review of Physician Recruiting Incentives*:

1. Hematology and oncology income offers increased 14.9 percent on average between 2008/9 and 2009/10, moving from \$335,000 to \$385,000.
2. Neurology income offers increased 8.9 percent, from \$258,000 to \$281,000.
3. Orthopedics income offers increased 7.9 percent, from \$481,000 to \$519,000.
4. Radiology income offers increased 6.6 percent, from \$391,000 to \$417,000.
5. Dermatology income offers increased 5.7 percent, from \$297,000 to \$314,000. ■



**Managing the Art of the Deal**

Having completed over 250 joint ventures raising over \$100,000,000 from physician investors, The Securities Group specializes in the formation and funding of healthcare partnerships.



THE SECURITIES GROUP, LLC

*The Securities Group. Solid Strategies, Proven Results.*

6465 North Quail Hollow Road #400 • Memphis, Tennessee 38120  
901.328.4814 • www.thesecuritiesgroup.com

BECKER'S

## Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

**SIGN UP FOR A FREE ONE-YEAR  
SUBSCRIPTION! CALL (800) 417-2035!**

# 5 Top-Paid Medical Specialties

By Rachel Fields

Here are 13 statistics about compensation of the five highest-paid medical specialties, according to MGMA's *Physician Compensation and Production Survey: 2010 Report Based on 2009 Data*.

## 1. Orthopedic surgery — spine

- Orthopedic surgeons specializing in spine made an average of \$710,055 in compensation in 2009.
- Orthopedic surgeons (spine) working in a multi-specialty group practice made more than those working in a single-specialty group practice, at \$622,568 compared to \$605,139.
- Orthopedic surgeons (spine) working in metropolitan areas of 50,000-250,000 residents made more than any other demographic classification, at \$717,710.

## 2. Surgery — neurological

- Neurological surgeons made an average of \$675,825 in compensation in 2009.
- Neurological surgeons working in a single-specialty group practice made more than those working in a multi-specialty group practice, at \$601,117 compared to \$599,933.
- Neurological surgeons working in metropolitan areas of 50,000-250,000 residents made more than any other demographic classification, at \$782,332.

## 3. Dermatology — mohs surgery

- Dermatologists specializing in mohs surgery made an average of \$674,454 in compensation in 2009.
- Dermatologists (mohs surgery) employed by a hospital made more than those not employed by a hospital, at \$644,642 compared to \$570,955.

## 4. Orthopedic surgery — sports medicine

- Orthopedic surgeons specializing in sports medicine made an average of \$653,642 in compensation in 2009.
- Orthopedic surgeons (sports medicine) working in a single-specialty group practice made more than those working in a multi-specialty group practice, at \$599,948 compared to \$580,378.
- Orthopedic surgeons (sports medicine) working in metropolitan areas of more than 1,000,000 residents made more than any other demographic classification, at \$617,913.

## 5. Ophthalmology — retina

- Ophthalmologists specializing in retina made an average of \$619,114 in compensation in 2009.
- Ophthalmologists (retina) working in a multi-specialty group practice made more than those working in a single-specialty group practice, at \$594,696 compared to \$570,319. ■

# Physician Compensation and Revenue Differs Based on Hospital Ownership

By Rachel Fields

Physician compensation and revenue differed based on whether physicians worked for hospital/integrated delivery system-owned practices or not-hospital-owned groups, according to a recent MGMA report.

According to the report, the median total medical revenue for a multispecialty hospital-owned practice was \$448,597 per FTE physician, compared to \$798,608 for not-hospital-owned groups. Specialty care physicians work-

ing in multispecialty hospital/IDS-owned practices earned 19.85 percent less in total compensation than those in multispecialty not-hospital/IDS-owned practices, at \$294,984 compared to \$353,549.

Primary care physicians in multispecialty hospital/IDS-owned practices reported median total compensation of \$192,116, over \$12,000 more than PCPs in multispecialty not-hospital/IDS-owned practices, who earned \$179,688 in median total compensation. ■

## Apply Now for Becker's 2011 "100 Best Places to Work in Healthcare"

**Becker's Hospital Review and Becker's ASC Review are now accepting nominations for the "100 Best Places to Work in Healthcare."**

Applications available on [www.beckershospitalreview.com](http://www.beckershospitalreview.com) or by contacting Rachel Fields ([rachel@beckersasc.com](mailto:rachel@beckersasc.com)). There is no fee to apply.

**The deadline for nominations is January 31, 2011.**

If you are interested in sponsoring the list, contact Jessica Cole ([jessica@beckersasc.com](mailto:jessica@beckersasc.com)).

# 11 Best Practices for Maximizing Healthcare IT Incentive Payments

By Jaimie Oh

Under the American Recovery and Reinvestment Act of 2009, healthcare providers are able to qualify for incentive payments upon adopting and demonstrating meaningful use of healthcare information technology, particularly electronic health records. Starting in 2011, these incentive payments will be distributed to hospital applicants that are able to successfully meet 19 requirements as outlined by the first stage of the meaningful use final rule. Here, Stephen Stewart, FCHIME, CIO of Henry County Health Center in Mount Pleasant, Iowa, and Bill Spooner, FCHIME, senior vice president and CIO of Sharp HealthCare in San Diego, share 11 ways hospitals can cash in the maximum amount of incentive payments.

## Tackle the basics

**1. Figure out what your maximum reimbursement is based on formulas in the regulation.** Hospitals, depending on their eligibility under the Medicare fee-for-service, Medicare Advantage and Medicaid programs, should calculate their maximum amount of incentive payment based on the formulas outlined in the final rule and set that maximum amount as a goal. Hospitals should be particularly wary when calculating maximum reimbursement, as incentive payments are not standard across the board. For example, although fee-for-service hospitals are eligible for a base amount of \$2 million with added “discharge related amounts,” critical access hospitals, such as HCHC, follow a different calculation.

“It all starts with having your clinical leaders and IT leaders sit down with the financial leaders and figure out, based on these formulas, what your hospital qualifies for, what it has to do in order to reach that maximum reimbursement and how to continue qualifying for payments in 2013 and 2015,” Mr. Stewart says. “Hospitals also have to remember they are subject to Medicare payment reductions starting in 2015 if they aren’t demonstrating meaningful use in the future.”

**2. Understand the core 14 objectives and the five objectives your hospital chooses from a menu of 10 needed to meet stage 1.** Ultimately, hospitals will have to meet all 24 requirements mandated by the meaningful use final rule, but stage 1 only requires hospitals meet 14 core requirements and five requirements that they are able to choose from a menu of 10 total requirements. In order to meet these objectives, as well as 15 clinical quality measures, 80 percent of patients must have records in the certified EMR technology. A full list of stage 1 objectives and measures can be found on the CMS website.

“When hospitals are looking at the menu list of objectives, they have to carefully scan and select the low-hanging fruit first because you don’t have to do them all in stage 1,” Mr. Stewart says. “Eventually hospitals will have to meet all 24 of the objectives, but for stage 1 if there is one or two items on the menu list that a hospital finds challenging, it shouldn’t select those. Incentive payments are an all or nothing deal, so make sure you can address the core 14 and the easiest five menu items.”

## Encourage meaningful use among users

**3. Implement EMRs in a way that maximizes efficiency.** In order to obtain the maximum incentive funds, hospitals must first begin with re-working work flows so that physicians and other healthcare providers are able to use the EMR system efficiently with minimum impact on productivity. At HCHC, simple changes in work flows, such as asking demographic questions during registration as opposed to during intake with the physician, helps the patient move through the care process faster. This way, the physician is able to save time and maximize productivity, which encourages him or her to continue using the EMR in a meaningful manner.

“Questions to patients, like what their preferred language is, traditionally were asked at intake by clinicians, but we realized that if those questions are asked at registration, all the clinician has to do is confirm the patient’s answers,” Mr. Stewart says. “Our strategy is to work and talk with the physicians, get input from them and build a system that is most efficient for their use.”

**4. Mix learning and adoption methods.** In the same vein as maximizing efficient work flows, hospitals must also make sure the appropriate training is being offered to physicians and staff. Diligent training across the entire hospital is important, and leaders can use a variety of approaches tailored to the learning styles of its physicians and staff. Mr. Spooner says classroom-based or computerized training are the two main options at Sharp Healthcare for training staff on how to use EMRs.

“We’ve used the traditional classroom training and computerized training through Adobe, which uses scripted training to talk users through how to use our EMR and reinforce what they learned in the classroom,” he says. “Organizations, though, are starting to look at computer-based training as a substitute for the classroom because it gives the learner more flexibility and is less expensive since it doesn’t require a human trainer.”

## Establish IT-focused staff

**5. Form a steering committee.** At HCHC, a steering committee comprised of representatives from all clinical and administrative departments ensures all hospital representatives collectively come together to solve issues related to efficient and meaningful use of its EMR system. On a monthly basis, these leaders discuss a wide range of matter, spanning from what changes in work flow need to be made, what new technologies need to be reviewed or acquired and so on.

“The key here is really communication, and having all the constituencies of our hospital represented in this steering committee is really important because all this has a bearing on clinical outcomes, finance, the billing department and so on,” Mr. Stewart says. “Hospitals will also want to make sure they involve the clinical staff because implementing a system is one thing; getting clinicians to use it is another. Ultimately, if you don’t use it, you won’t get the money.”

## 6. Elect an IT medical director and health informatics nurse.

In addition to having a steering committee to quarterback meaningful use issues, hospitals will also benefit immensely from electing an IT medical director and health informatics nurse. The IT medical director at HCHC, who is a permanent member of the steering committee, is responsible for acting as a liaison between hospital staff, IT technicians, medical practices and the steering committee. As problems related to meaningful use of HCHC’s EMR system arise, clinicians voice their concerns to the director who then relays those concerns to the steering committee. “If a clinician has a problem using the EMR system, then everyone goes back to the drawing board because not everything is going to work right the first time,” Mr. Stewart says. “This role helps us to quickly address those issues to mitigate the impact of problems as they occur.”

The health informatics nurse at HCHC, who also serves as a liaison to medical staff, is also charged with spearheading the actual implementation and execution of its EMR system. “The health informatics nurse is really a nurse by training, but she is also highly proficient in technology,” Mr. Stewart adds. “She actually develops flow sheets and electronic forms, sets up applications and tests them and so on.”

## Work closely with outside resources

**7. Meet with your vendor regularly to ensure your EMR is working optimally.** To maximize efficiency and meaningful use, hospital leaders should strive to meet with their contracted vendor partners as often as possible to communicate and rectify IT problems. Mr. Stewart says he meets with representatives of the two vendors HCHC works with at least on a quarterly basis but usually meets with them in the interim.

“You want to be careful in choosing the right EMR vendor partner and foster a true partnership with them,” he says. “I meet with them constantly and ask them what the roadmap to the future is so they can serve us well going forward, especially as these rules start to come out for stage 2 and stage 3.”

## 8. Consider a vendor's implementation recommendations.

Mr. Spooner says hospitals should seriously consider implementation approaches, or structured implementation methodologies, that are being promoted by EMR vendors. Vendors may promote implementation methodology to a hospital and communicate their best practices in a semi-standardized configuration. Mr. Spooner says the advantage in adopting a vendor's recommendations for implementation is that the companies usually compile best practices gleaned from previous successful deployments, allowing your hospital the opportunity to deploy a system more quickly and without the complication of configuring a system from the ground up.

“The previous method for hospitals was working with a vendor with a clean slate and communicating to the company what the hospital wants the system to look like and do, and often trying to configure a system and all its applications like that takes longer and doesn't necessarily make the best use of a system,” he says. “With our first hospital, we chose to adopt the vendor's methodology and deployed in 15 months a system that would have taken us three years to deploy otherwise.”

**9. Reach out to established organizations.** Hospitals should reach out to organizations specializing in healthcare IT or who are keenly aware of the legislation related to meaningful use of EMRs to promote a better understanding of the regulations and criteria for meaningful use. With still so much uncertainty surrounding future criteria and regulations, moving forward with EMR implementation can feel like a risky venture, but Mr. Spooner says that while meaningful use final rules and regulations may seem like a moving target, it is still an achievable one.

“In terms of understanding the rules for meaningful use, there are number of organizations that are good at communicating through e-mail, webinars and other mediums clarification on what those rules are,” he says. “There is an active effort by CHIME and HIMSS to offer educational opportunities for hospitals. There is a lot of reading and listening, but there's plenty of information available to hospitals.”

## Look toward the future

**10. Strategize your approach to meaningful use going forward.** While hospitals are still rushing to meet stage 1 requirements, hospitals will benefit from looking ahead to 2013 and 2015 as well. The Office of the National Coordinator will likely roll out increasingly complex requirements for stage 2 and stage 3 of meaningful use. Although rules and regulations regarding future stages of meaningful use are only speculation at this point, Mr. Spooner says some predictions can still be made to help prepare for those future criteria.

“One area that is less mature is the area of information exchange, and that is still in flux in terms of what the expectations coming out of CMS and ONC will be,” he says. “Although there is still a lot of debate going on in terms of information exchanges, it doesn't seem the HIE requirement will go away, so I advise organizations to get engaged in the community to find effective HIE solutions so that by fiscal year 2014, they are already on the road to operating one.”

Mr. Spooner adds that hospitals should prepare for the changes expected to come out of stage 2 and stage 3 for quality indicators of meaningful use. “Based on all the reading that I do, it appears that while specific indicators may vary or come and go, there are a few things that are pretty solid in terms of expectations for stage 2 and stage 3, and one is quality indicators,” he says. “Hospitals are going to need to possess an automated way of collecting data on quality and show by stage 3 how they are improving clinical outcomes as a result of capturing that data. Looking ahead can really help a hospital maximize its meaningful use.”

Mr. Stewart also predicts that while stage 1 requires eligible fee-for-service or critical care hospitals demonstrate more than 30 percent of unique patients have at least one medication entered using CPOE, that percentage could possibly increase to 60 or 70 percent.

**11. Wait another year to apply, if need be.** If your healthcare organization isn't ready to meet stage 1 requirements for meaningful use, Mr. Spooner suggests waiting another year before applying to make sure all concerns, technical issues and other obstacles are addressed. “One thing organizations should consider, depending on where they are in adoption cycle, is to maybe wait a year. One risk with going ahead and applying is that once you begin the application for fulfilling stage 1 requirements, there is an expectation that you also fulfill stage 2 requirements,” he says. “It might be wise to wait a year to apply for stage 1 because that gives you an extra year to make stage 2.” ■

# Apply Now for Becker's 2011 “100 Best Places to Work in Healthcare”

**Becker's Hospital Review and Becker's ASC Review are now accepting nominations for the “100 Best Places to Work in Healthcare.”**

Applications available on [www.beckershospitalreview.com](http://www.beckershospitalreview.com) or by contacting Rachel Fields ([rachel@beckersasc.com](mailto:rachel@beckersasc.com)). There is no fee to apply.

**The deadline for nominations is January 31, 2011.**

If you are interested in sponsoring the list, contact Jessica Cole ([jessica@beckersasc.com](mailto:jessica@beckersasc.com)).

## CCHIT to Launch EHR Certification for Hospitals

By Jaimie Oh

The Certification Commission for Health Information Technology has announced it will launch a new customized electronic health record certification program for hospitals without certified EHR systems on Dec. 15, according to a CCHIT news release.

The EHR Alternative Certifications for Hospitals program is designed to meet the needs of hospitals that have uncertified healthcare IT software, customized commercial products or have developed their own EHR systems to suit their individual needs. Before the EACH program is launch on Dec. 15, CCHIT will be hosting a Town Call webcast and teleconference on Dec. 1.

Alternative certification is an option for hospitals that have not already adopted an EHR with complete certification or a combination of certified EHR modules that meet the 2011/2012 certification criteria. ■

## CMS in Final Stages of Testing Incentive Management Systems

By Jaimie Oh

The Centers of Medicare and Medicaid Services is in the final stages of testing health information systems that will act as management systems for incentive payments to healthcare providers participating in the meaningful use program, according to a *Government Health IT* news report.

The incentive management systems, which will handle the registration, attestation and payments to participating healthcare providers, are set to go live in January. Healthcare providers who want to apply for the incentives must register through CMS' Provider Enrollment, Chain and Ownership System, which available through the agency's website.

CMS said it will update system throughout 2011 and then going forward as the Office of the National Coordinator continues to release criteria for meaningful use.

After healthcare providers enroll in PECOS and receive national provider identifier numbers, CMS will guide participants to an attestation module which will require providers to perform tasks describing how they meet meaningful use requirements. After the attestation and verification, CMS will issue the incentive payments. ■

**Your organization is under siege.  
Let us protect you.**

Citadel Outsource Group, LLC is a patient financial services company specializing in the collection and resolution of third-party accounts receivable. From full business office outsourcing to providing account representative services by the hour, Citadel has the resources necessary to meet the needs of any size facility.

Call Citadel today to learn how we can help your business.



www.citadelosg.com | 615-757-1017



# Changes to HIPAA in the Interim Rule and Best Practices for Maintaining Compliance

By Jaimie Oh

**A**lthough the passing of HIPAA and its privacy and security rules for patient health information occurred over a decade ago, the HITECH Act passed in 2009 strengthens some of the already existing rules under HIPAA. Following the passing of the HITECH Act, the Department of Health & Human Services released interim final rules regarding the strengthened regulations. As these regulations become stricter and healthcare organizations and providers face greater liability for HIPAA violations, it is important for these entities to be aware of these recent HIPAA changes. Here are some of the most significant developments that modified the already existing HIPAA rules and best practices for maintaining compliance.

## Latest changes to the HIPAA Privacy and Security Rules

### 1. Definition of a business associate.

The definition of a “business associate” has been expanded in the interim final rule. Business associates are defined as companies that perform work on behalf of a healthcare provider or organization and who deal with the use of personal health information. Traditionally, the rule pertained to various healthcare professionals such as pharmacy benefits managers for insurance plans, billing companies and legal services, but it is now expanded to also cover vendors who contract with healthcare providers or organizations to provide personal health records, entities who are in contact with e-prescribing systems and, most importantly, subcontractors who act on behalf of direct business associates. These individuals are now liable for how they handle personal health information, and their uses of such data are associated with stricter monitoring and penalties.

“Let’s say, for example, your hospital sends electronic equipment out to be repaired because you don’t have a huge in-house IT department,” says Jared Rhoads, senior research analyst at IT services and consulting firm CSC. “If [a hospital or other provider] sends out the equipment to an off-site company, that provider is now responsible for monitoring that company’s practices for protecting health information, even though that is out of the provider’s immediate control.” Before the interim rule, if a provider was a covered entity and had a business relationship with a specialty vendor, not all of HIPAA would have extended to that business associate.

**2. Accounting of disclosures.** Healthcare providers and organizations may be required to account for each disclosure of personal health information. What this means is if one caregiver shares a patient’s information with another caregiver, those individuals are required to disclose that exchange to the patient upon the patient’s request. Traditionally, clinicians and organizations were required to keep a detailed list of disclosures dating back six years. Under the proposed changes, but the length of time isn’t as long, says Mr. Rhoads, but the scope of information will be broader so that it includes details about treatment, payment and healthcare operations.

“As the term implies, these caregivers need to account for disclosures. So if a patient shows up one day asking to see a list of all the people who has seen his or her personal health information, there is now a requirement that the organization needs to be able to furnish a detailed list,” Mr. Rhoads says.

Additionally, healthcare providers are subject to new breach notification rules. “The new provisions are especially pertinent in the event of a breach affecting more than 500 individuals,” he says. “If that is the case, then the covered entity is required to notify HHS and the general public through prominent media outlets.”

**3. HIPAA violation enforcement.** As the requirements and rules under the HIPAA act continues to evolve and become more stringent, healthcare organizations, providers and business associates are liable to face stricter penalties for non-compliance. Violation of some HIPAA rules can result in devastating civil and criminal penalties, and the Department of Health & Human Services Office of Civil Right will start recruiting enforcement agents and auditors to watch for such violations, says Linda Ricca, client partner at CSC.

Penalties for even individuals who were not cognizant of the violation they committed can be anywhere between \$100 to \$50,000 per violation. Penalties increase as the type of offense becomes more negligent, including up to \$1.5 million annually as well as prison time. In addition to the monetary penalties, healthcare organizations can face serious damages to their reputation. “The cost of a breach is becoming higher and higher,” says Ms. Ricca. “If a hospital has to go on the media about a breach of personal health information, then you have lost the trust of your patients who might start migrating to other institutions. There’s a significant downstream impact, and the implications can be far-reaching.”

## Best practices for maintaining HIPAA compliance

### 1. Understand preemptive state laws pertaining to security and privacy rules.

Ms. Ricca and Mr. Rhoads write in a white paper on privacy and security enforcement of patient health information that although HIPAA maintains federal privacy protections for personal health information, state laws may be in place that enact stricter privacy and security controls. Healthcare organizations and providers should continually be scanning the legislative realm, both on a federal and state level, to fully comprehend what rules and regulations apply to them.

### 2. Create and review business associate agreements.

Now that the interim final rule has expanded the definition of a business associate, hospitals and healthcare providers would find it in their best interest to go back to all contracts with third-party companies to ensure those business associates are aligned with the updated version of HIPAA rules.

“This means digging up all your current contracts with all the companies you work with, going through each of them to ensure compliance and adding clauses and renegotiating them so they are in line with your organization’s security and protection policy if required,” Ms. Ricca says.

**3. Set up a security office.** Additionally, hospitals should elect a compliance officer and a chief information security officer, who are responsible for monitoring HIPAA compliance and developing a remediation strategy when they find issues. The compliance officer would ideally have a support team or department who would aid him or her in conducting security policy reviews.

“You also have to set up the governance and infrastructure within the hospital, so that might mean having a security officer who is a trusted advisor who monitors and changes business associate agreements to improve security within the infrastructure,” Ms. Ricca says. “The security reviews also have to be ongoing because your hospital’s security may be okay today, but there may be a breach next week. The officer should look at how many touch points there are between information systems. Any time a new system is implemented, all of the systems — including the new system — need to undergo review to minimize security risks.” ■



# 7 Best Practices for Installing Real-Time Location Systems in Your Hospital

By Jaimie Oh

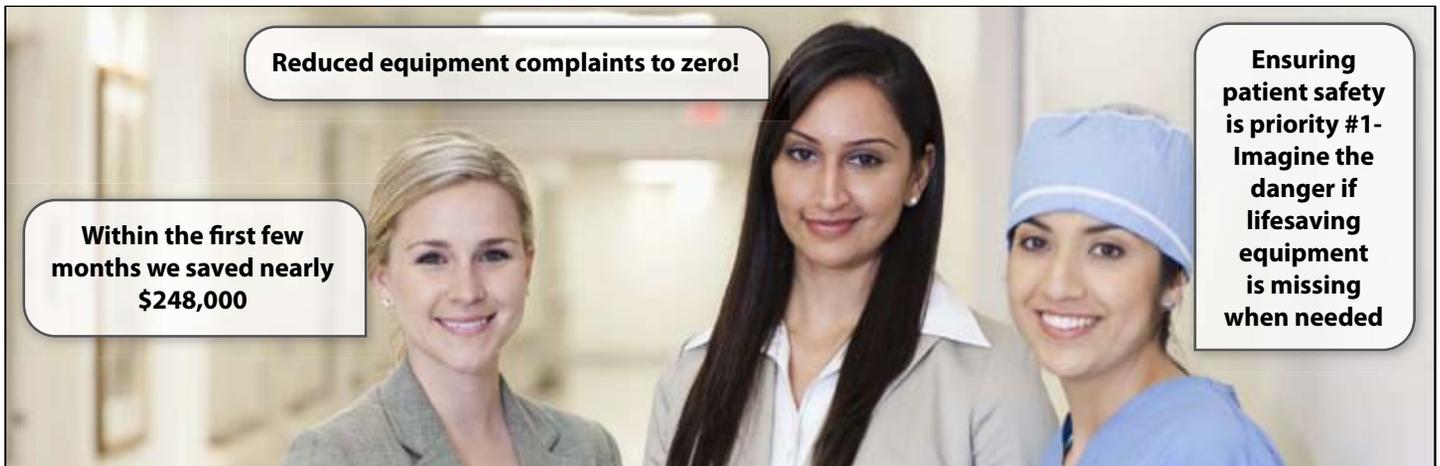
**R**eal-time location systems are an IT solution that has been adopted in many different industries, including the military and healthcare industry, as a way to improve asset management. Specifically in the healthcare setting, RTLS may be installed to better track mobile medical equipment, expensive surgical equipment and other supplies to reduce supply chain expenditures. In other instances, RTLS has also been employed to track patients as a means of improving operational processes that can affect a healthcare organization's efficiency, such as patient throughput, wait times and length of stay. Here are seven best practices for hospitals before fully employing RTLS.

**1. Get organization-wide buy-in.** Valerie Fritz, vice president of marketing for Aware-

point, a real-time solutions company, says it is critical hospitals get all potential end-users on board with the installation of RTLS. This starts by engaging all major stakeholders, departments, physicians, administrative leaders and staff members about why RTLS is the solution for the organization's weaknesses, whether it be poor management of assets or poor patient throughput. "If you go in and just get buy-in and feedback on opportunities for improvement from the biomedical department's perspective, you're going to lose opportunities in other areas, like the OR. What's important from the very beginning is getting key leaders from each department to understand the issues that need to be resolved within the organization and how RTLS fits into the picture," Ms. Fritz says.

Scott Sullivan, business officer for perioperative and imaging services at UC San Diego Health System, says his healthcare organization established a steering committee made up of constituents from multiple departments. The committee meets once a month to collectively decide as a group which assets will be tagged. "There are representatives from all departments, including nursing, our pharmacy, IT department, security, nutrition and clinical educations," Mr. Sullivan says.

**2. Start with a specific objective with the end-goal of expanding.** Ms. Fritz says healthcare organizations should zero in on a specific goal to accomplish, such as seamless asset tracking, with the intent to expand RTLS use over time. This gives healthcare organizations the opportunity to test RTLS on a smaller scale.



Reduced equipment complaints to zero!

Within the first few months we saved nearly \$248,000

Ensuring patient safety is priority #1- Imagine the danger if lifesaving equipment is missing when needed

## The Awarepoint Difference:

Exceptional Quality and Financial Returns the Minute Your System Goes Live

Real-time Location Solutions (RTLS) are analogous to indoor GPS. They offer location, status and movement information to remotely monitor equipment and people in hospitals.

We work with you to determine areas of your hospital which can benefit from the Awarepoint Solution. A customized Impact Analysis summarizes projected quality, efficiency and cost savings value using your hospital's specific data.

**Contact us today for your unique RTLS Impact Analysis and discover The Awarepoint Difference.**



1-888-860-FIND  
(3463)

[www.awarepoint.com](http://www.awarepoint.com)  
[www.awarepointblog.com](http://www.awarepointblog.com)



**Showing 115% ROI  
within 3 weeks-  
we now connect to  
our other hospitals  
to manage inventory  
between sites**

**Addresses asset  
management,  
patient flow, and  
patient care  
challenges most  
important to  
hospitals**

**It's so easy to use  
nurses literally trained  
themselves-  
This has notably  
improved clinical  
workflows**

## **The Awarepoint Difference:**

### **Proven Success in Real-Time Location Systems (RTLS) for Hospitals**

Awarepoint Solutions are used to track and monitor mobile equipment assets and patients, increase efficiency, support quality of care, improve workflows, and collect and make available value process improvement data to clinicians and healthcare administrators.

Our experienced client success team details best practices and provides consulting services vital to realizing hard and soft dollar benefits.

**By definition, there can only be one market leader:** Today, Awarepoint represents the largest enterprise-wide hospital RTLS client base in the industry. Awarepoint is providing its solutions to hospital clients which include prestigious teaching institutions, premier independents, military facilities and members of major integrated delivery networks.

**Contact us to experience Awarepoint's unique client success engagement model and discover The Awarepoint Difference.**



**1-888-860-FIND  
(3463)**

**[www.awarepoint.com](http://www.awarepoint.com)  
[www.awarepointblog.com](http://www.awarepointblog.com)**

However, it is absolutely critical that organizations implement the RTLS network coverage across the entire organization, even if only specific departmental assets are being tracked initially, Ms. Fritz says.

Jim Barnes, manager of the OR support staff at UC San Francisco Medical Center, says his organization first implemented RTLS for his OR suites, which were located on the fourth floor. In the initial stages, RTLS slightly expanded to include six “high use” floors that are most likely to have OR equipment, including the radiology department and delivery unit. A year later, Mr. Barnes says it was clear how necessary it was to install RTLS across the entire system.

“We are the flagship of the health system, so we lend a good amount of equipment to various other areas across the system. RTLS is imperative when you’re looking for a piece of equipment and you find someone from the Orthopedic Institute has it,” Mr. Barnes says.

### 3. Consider what location accuracy your organization needs.

Accuracy can vary, depending on the technology solution you select. The long-term success and full return on investment of many hospital applications hinges on location or positional accuracy, Ms. Fritz says. RTLS zones can range from room-level to floor-level. Ms. Fritz states healthcare organizations must carefully measure the pros and cons and really understand the long-term benefits of RTLS for all stakeholders in the organization.

“Many organizations argue that a general zone level accuracy is better than what they have now, which is no system and staff members running around with no way of knowing a general idea of where hospital equipment is,” Ms. Fritz says. “While that may be true, our argument is that there is a lot of value in having room-level accuracy. Search efficiency, equipment utilization and optimization, rental management and work flow initiatives can only be maximally improved with room-level accuracy.”

### 4. Know what installation and maintenance entails before deploying.

Just like any other technology acquisition, healthcare organizations should diligently research what exactly it will take to install RTLS in their facilities. Beyond the initial question of how much it will cost to purchase RTLS, healthcare organizations should also research the time it will take to install the solution, the implications of installation of RTLS on patient care and staff members’ productivity, ongoing maintenance requirements and so on. Ms. Fritz says one of the most important aspects of RTLS installation that healthcare organizations must closely measure is invasiveness. Will the RTLS solution require a change in the organization’s physical infrastructure? Will patient rooms or other care areas need to be shut down during installation? Will physicians and staff members’ work be impeded by the solution?

## Becker’s Hospital Review Annual Meeting ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

Great topics and speakers focused on key business, clinical and legal issues facing hospitals and health systems —  
53 sessions, 79 speakers

Featuring Keynote Speakers Chip Kahn, President, Federation of American Hospitals; Peter Kongstvedt, Principal, P.R. Kongstvedt Company, and Senior Health Policy Faculty Member, George Mason University; and Richard Pollack, EVP, Advocacy and Public Policy, AHA

May 19-20, 2011 • Chicago, IL  
To register, call (800) 417-2035  
or e-mail [registration@beckershospital.com](mailto:registration@beckershospital.com)  
Register online: <https://www.regonline.com/beckershospitalreviewannualmeeting>

For more information, visit: [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)

“For some RTLS systems, installation can take months and month of time. When you’re talking about patient care areas or operating room suites, hospitals can’t afford exposing sensitive patient areas to an installation process that can cause infection control concerns, or take a long time, especially if installation requires drilling walls or anything just as invasive,” Ms. Fritz says.

In the same vein as invasiveness to work flow productivity, hospitals should consider how the RTLS technology they choose coexists with the facility’s already existing wireless network. Technology has become so sophisticated that there are now technologies that are able to coexist on different planes of wireless connectivity, such as Zigbee protocol, which is a wireless mesh network that operates separately from a building’s wireless network. This way, the wireless network is not slowed down or jammed because of the asset tracking system.

**5. Research what other benefits RTLS can provide.** Hospitals should look to see how various RTLS systems are able to provide tracking abilities beyond the day-to-day asset or patient tracking. Mr. Sullivan says UCSD has applied RTLS to emergency preparedness.

“In 2007, we had two major wild fires that were both headed toward our hospitals, and we were put on possible evacuation alert,” Mr. Sullivan says. “Since we have RTLS, we are able to find the exact location of all our hospital’s gurneys and wheelchairs.”

Both UCSF and UCSD have also applied RTLS as a means for temperature monitoring of refrigerators in their hospitals. For quality purposes, The Joint Commission requires hospitals to regularly log temperatures of all refrigerators. RTLS has given the two health systems a way to continuously monitor and log refrigerator temperatures without the need of a manually logging by a hospital staff member.

**6. Understand the RTLS solution’s interoperability.** As mentioned before, although healthcare organizations may consider RTLS with the starting goal of asset management, hospitals will yield greater successes with the end-goal of leveraging RTLS throughout the entire healthcare system. Given the nature of this end-goal, hospitals should look for RTLS solutions that can integrate with already existing systems at the hospital to capture greater returns on the investment. Ms. Fritz says this can be done with a standards-based solution and an open application programming interface, so that the system can provide the location and status of assets or patients to other third party applications in the hospital.

“Let’s say a hospital already has a software application to manage equipment and preventive maintenance schedules. RTLS could simply augment that existing system so that when a staff member runs the PM schedule, the specific location of each item on the list is displayed. This can save countless hours of search time and improve preventive maintenance completion rates overall,” Ms. Fritz says.

### 7. Choose a vendor whose business model is the best fit for your hospital.

Some companies allow hospitals to rent their RTLS solutions on a month-to-month basis with no upfront costs, which is the simplest and lowest risk business model available. This gives hospitals a chance to test-run RTLS in their facilities without the pressure of a long-term commitment and huge upfront investment. Another factor of the business model is understanding what the vendor provides once the system is installed. To ensure success, a solution provider with experience in RTLS for hospitals can help you summarize projected savings and outline the steps needed to achieve desired outcomes.

“I think one of the biggest challenges is debunking the concept that there’s something magical about technology. It’s not a silver bullet but a tool, and unless you really focus on the people and process changes to fully take advantage of the power of RTLS, at some level, you’re going to fail,” Ms. Fritz says. ■

Reduced equipment complaints to zero!

Within the first few months we saved nearly \$248,000

Ensuring patient safety is priority #1- Imagine the danger if lifesaving equipment is missing when needed

## The Awarepoint Difference:

Exceptional Quality and Financial Returns the Minute Your System Goes Live

Real-time Location Solutions (RTLS) are analogous to indoor GPS. They offer location, status and movement information to remotely monitor equipment and people in hospitals.

We work with you to determine areas of your hospital which can benefit from the Awarepoint Solution, including:

- Gains in staff productivity
- Decreases in inability to locate assets
- Increases in equipment utilization
- Reductions in equipment procurement
- Reductions in rental budget
- Completion of preventive maintenance
- Automation of temperature data collection
- Increases in direct patient care time

A customized Impact Analysis summarizes projected quality, efficiency and cost savings value using your hospital's specific data.

Contact us today for your unique RTLS Impact Analysis and discover The Awarepoint Difference



1-888-860-FIND  
(3463)

[www.awarepoint.com](http://www.awarepoint.com)  
[www.awarepointblog.com](http://www.awarepointblog.com)

# Case Study: Implementing RTLS at Texoma Medical Center

By Jaimie Oh

**R**eal-time locating systems are a health IT solution that many health-care organizations have adopted as a means to reduce waste and improve process efficiency. Gregg Stepp, supply chain director at Texoma Medical Center in Denison, Texas, shares the steps Texoma took to implement and optimally use RTLS and how it resulted in savings in time and money at the organization.

**1. Pinpoint the problem.** Mr. Stepp says Texoma Medical Center has had an on-going issue with missing or hard-to-find movable medical equipment, such as sequential compression devices, PCA pumps, feeding pumps and wound VACs. Members of the materials services department would spend anywhere between 20 to 30 minutes trying to track down and retrieve medical equipment, which impacted the department's ability to spend time tending to their other responsibilities.

"When a request is made for a piece of equipment, our department is responsible for getting it to the floor, picking it up once it was used and cleaning and reprocessing it for the next patient," Mr. Stepp says. "We could find it in our storage spaces and take it to the floor, but we weren't able to find those pieces of equipment once we sent them out. We'd spend time going from room to room trying to track them down."

In addition to losing track of a piece of equipment, the hospital was finding many pieces of equipment were also being accidentally thrown away. After being placed into bags after use, the equipment would sometimes be improperly placed in trash bags or laundry bags, which leads to permanent loss of that asset and creates additional costs for equipment or rentals, Mr. Stepp says.

## 2. Educate staff members on the problem and the solution.

Education has been the key component in the successful implementation of RTLS at Texoma Medical Center. Mr. Stepp says the easiest part was educating others on the problem of missing and hard-to-find equipment. The more difficult part was getting the staff members on board in adopting RTLS as the solution to the problem. Mr. Stepp says there was some resistance from staff members, particularly nurses, who weren't comfortable with the drastic change. Eventually, staff members started coming around to the idea of adopting RTLS after Mr. Stepp revealed the benefits of using such a solution, particularly with temperature monitoring in refrigerators, which is required by Joint Commission.

"With RTLS, each tagged refrigerator reports back temperatures, and we're alerted if for some reason the temperature falls outside of an accepted range, which can lead to something spoiling or freezing," Mr. Stepp says. "What I did was package the information about asset tracking with temperature monitoring and presented that to our staff members, and that was what led us to the joint buy-in."

## 3. Find a system that works well within your organization.

Mr. Stepp says healthcare organizations need to take time to analyze all the possible options for implementing an IT solution for asset tracking. Texoma Medical Center, which uses an RTLS system powered by Awarepoint, incorporated a system that consisted of low-power sensors and ZigBee pro-

ocol, which is a specification for wireless connection. The system includes 250 sensors throughout the building, 50 bridges and a server that is separate from the hospital's own wireless network. Every piece of equipment that is tagged sends a signal to a sensor, which relays that signal through the bridges and then to the server. From the server, staff members can pinpoint where exactly a piece of equipment is stationed or whether it's moving through a hallway.

"Along with that capability, we have the ability to set up a firewall or alert, so if a piece of equipment with a tag goes outside of a set of sensors, it alerts us to know that the equipment is about to leave the building or is headed toward a trashbag," Mr. Stepp says.

Mr. Stepp adds that this particular system was chosen because of its quick installation period of a little over one month and its ability to operate separately from the hospital's wireless connection. "ZigBee protocol is something that I'm not sure very many people are aware of. I think most people are using their traditional wireless connection, which can be a drag on your network."

## 4. Assess your returns on investment.

A thorough assessment of ROI first begins with a healthcare organization deciding which success indicators to measure. Mr. Stepp says his hospital's ROI was focused on soft costs, meaning part of the measured ROI included time saved looking for missing equipment. After determining time spent searching for missing equipment was cut down from 20-30 minutes down to five minutes, that finding was stratified to calculate savings in hourly wages.

"You have to decide ahead of time how you're going to measure ROI, and everyone measures it differently," he says. "We're seeing a lot of the return coming back to employee productivity, which is hard to put a pencil to. I have been short-staffed in the last eight months, and I don't know if we could have ever done our jobs well if we still had all those same responsibilities while spending all that time looking for equipment."

In addition to measuring how much productivity has increased, Texoma Medical Center discovered that huge savings were being reaped from not spending money on rentals or new equipment to replace lost items. "One of our big ROI savings was about \$88,000 because of not buying new PCA pumps. We started analyzing how many PCA pumps we had, and we found we had 75 percent of the pumps available when staff members thought 99 percent of the pumps were unavailable. So instead of spending \$88,000 to buy new pumps, we saved that money because we are able to track our equipment's location and availability much better," he says.

Texoma Medical Center was also able to save approximately \$3,000 each month in rental expenditures. Mr. Stepp says sequential compression devices were one of the bigger ticket items that was going missing frequently, and so the hospital often turned to rentals to compensate for lack of equipment availability. "I have not had to rent a piece of equipment in about seven months because everything we were renting was things we lost or could not find. There is an enormous amount of money being saved just through our rental savings," he says. ■



Awarepoint provides real-time location systems (RTLS) to hospitals. Analogous to indoor GPS, these solutions provide location, status and utilization information of mobile medical equipment, and provide patient and staff workflow intelligence to hospital managers.

# For-Profit Hospital Operators 3Q 2010 Financial Results

## Health Management Associates

Headquarters: Naples, Fla.  
 Number of hospitals: 58  
 Revenue: \$1.27 billion  
 Net income: \$35.3 million  
 Admissions: + 4.9 percent

## Hospital Corporation of America

Headquarters: Nashville, Tenn.  
 Number of hospitals: 163  
 Revenue: \$7.65 billion  
 Net income: \$243 million  
 Admissions: - 0.6 percent

## LifePoint Hospitals

Headquarters: Brentwood, Tenn.  
 Number of hospitals: 52  
 Revenue: \$832.3 million  
 Net income: \$38.8 million  
 Admissions: - 3.7 percent

## Tenet Healthcare Corp.

Headquarters: Dallas  
 Number of hospitals: 49  
 Revenue: \$2.26 billion  
 Net income: \$932 million  
 Admissions: - 3.5 percent

## Universal Health Services

Headquarters: King of Prussia, Pa.  
 Number of hospitals: 25 (acute-care, additional behavior health facilities)  
 Revenue: \$1.32 billion  
 Net income: \$55.6 million  
 Admissions: + 1.6 percent

## Community Health Systems

Headquarters: Franklin, Tenn.  
 Number of hospitals: 126  
 Revenue: \$3.3 billion  
 Net income: \$70.4 million  
 Admissions: - 3.0 percent ■

## Your Healthcare Capital Partner.



Collective staff experience of nearly 50 years, and over \$3 billion in capital solutions.

- Master Lines of Credit
- Commercial Leases & Loans
- Tax-Exempt Leases and Loans
- Leasehold and Tenant Improvements
- Real Estate Financing
- IT and Software Financing

**People's Capital and Leasing Corp.**

A subsidiary of **People's United Bank**

peoples.com/healthcare

©2010 People's United Bank | Member FDIC | Equal Opportunity Lender

## Becker's Hospital Review Annual Meeting ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties

Great topics and speakers focused on key business, clinical and legal issues facing hospitals and health systems —  
53 sessions, 79 speakers

Featuring Keynote Speakers Chip Kahn, President, Federation of American Hospitals; Peter Kongstvedt, Principal, P.R. Kongstvedt Company, and Senior Health Policy Faculty Member, George Mason University; and Richard Pollack, EVP, Advocacy and Public Policy, AHA

May 19-20, 2011 • Chicago, IL

To register, call (800) 417-2035

or e-mail [registration@beckershospital.com](mailto:registration@beckershospital.com)  
 Register online: <https://www.regonline.com/beckershospitalreviewannualmeeting>

For more information,  
 visit: [www.BeckersHospitalReview.com](http://www.BeckersHospitalReview.com)

# Hospital & Health System Executives Moves

**H**ere is a list of notable executive moves that occurred during November and October 2010.

**Jason Barker**, CEO of St. Mary Medical Center in Apple Valley, Calif., announced he would leave the hospital at the end of 2010 to become president and CEO of St. Vincent Healthcare in Billings, Mont.

**John Betjemann**, the man who led Methodist Hospitals in Gary, Ind., for nearly one-quarter century, died in October from complications of Parkinson's disease at age 70.

Ohio-based Premier Health Partners named **Mary Boosalis**, current CEO of Premier's Miami Valley Hospital in Dayton, as the health system's new executive vice president and COO.

Coventry Health Care, based in Bethesda, Md., announced that **Kevin Conlin** would join the company as executive vice president. Mr. Conlin most recently served as president and CEO of Via Christi Health in Wichita, Kan.

Lutheran Health, based in Fort Wayne, Ind., appointed **Joe Dorko** CEO of the health system, making permanent the role he filled on an interim basis since June 2010.

**Jim Gardner**, president and CEO of Northeast Georgia Health System, announced his resignation. Mr. Gardner joined NGHS in March 2004 to fill the vacancy created by the retirement of longtime CEO John A. Ferguson.

Massachusetts-based Partners HealthCare COO **Thomas P. Glynn** announced he would leave the health system at the end of 2010 to teach at Harvard. Mr. Glynn served as the COO of Partners for 14 years.

Longtime hospital executive **Michael Hunn**, CEO of Providence Little Company of Mary Medical Center Torrance (Calif.), was named CEO of Providence Health & Services' California region.

WellPoint executive vice president **Dijuana Lewis** was "terminated without cause" by the Indianapolis-based insurance company. Ms. Lewis served as president and CEO of the company's comprehensive health solutions unit.

Health Choice, a Memphis-based managed care organization, appointed **George Mayzell, MD**, as CEO. Most recently, Dr. Mayzell served as senior vice president and chief patient care officer for Methodist Le Bonheur Healthcare and CMO of Methodist Le Bonheur Germantown Hospital.

IASIS Healthcare in Franklin, Tenn., named **Phillip J. Mazzuca** COO. Mr. Mazzuca formerly served as division president of IASIS.

Sisters of Providence Health System in Springfield, Mass., appointed **Daniel Moen** as president and CEO. Mr. Moen began work at the health system in Jan. 2011, leaving his position at Haywood Hospital in Gardner, Mass., a job he has held since 1990.

St. John Health System in Tulsa, Okla., named **David Pynn** as CEO, according to a system news release. Mr. Pynn previously served as executive vice president and COO for the system.

Stanford (Calif.) Hospital & Clinics appointed **Amir Dan Rubin** as president and CEO, effective Jan. 3, 2011. Mr. Rubin previously served as COO at UCLA Health System in Los Angeles.

Virtua Healthcare System, based in Marlton, N.J., promoted **Ninfa Saunders** to president and COO of the hospital system. Ms. Saunders succeeded Richard P. Miller, who will continue to serve as Virtua's CEO.

Northern Michigan Regional Health System in Petoskey named **Stephen J. Scannell** as CFO. He started at the hospital on Oct. 18.

Lehigh Valley Health Network's longtime president and CEO, **Elliot J. Sussman, MD**, announced his resignation. Hospital trustees appointed Ronald W. Swinfard, MD, the health network's current CMO, as the next president and CEO of LVHN.

**Ronald A. Williams**, chairman and CEO of health insurance company Aetna, announced his retirement, effective April 2011. He was succeeded by company president Mark T. Bertolini, who assumed the CEO role on Nov. 29.

**Kirk Wilson**, CEO of Saint Joseph's Health System in Atlanta, announced his resignation. ■

# Hospital & Health System Transactions

After re-holding merger meetings following allegations of violating Florida's Sunshine Law, board members of Southeast Volusia Hospital District, which operates **Bert Fish Medical Center** in New Smyrna Beach, Fla., voted again to merge with **Adventist Health's Florida Hospital** in Orlando.

A certificate of need was filed with West Virginia Health Care Authority for the proposed merger of **Camden-Clark Memorial Hospital** and **St. Joseph's Hospital**, both in Parkersburg, W. Va. Under the deal, St. Joseph's would join West Virginia United Health System while simultaneously affiliating with Camden-Clark.

With the \$895 million sale of non-profit **Caritas Christi Health Care** to for-profit **Cerberus Capital Management** finalized, the new system is planning an accountable care organization. Under the arrangement, the six-hospital system, formerly Caritas Christi, will operate as a Cerberus affiliate, Steward Health Care System.

**Community Hospital** in Watervliet, Mich., and St. Joseph, Mich.-based **Lakeland HealthCare** signed a letter of intent to merge. Under the deal, the 58-bed Community Hospital will become part of Lakeland Healthcare.

Michigan Attorney General Mike Cox approved the sale of non-profit, eight-hospital **Detroit Medical Center** to for-profit **Vanguard Health Systems** in a deal valued at \$1.5 billion.

**Gundersen Lutheran Health System** in La Crosse, Wis., will manage **St. Joseph's Health Services** in Hillsboro, Wis.

Ocoee, Fla.-based **Health Central** received proposals from the following four hospital operators for a possible partnership: **Hospital Corporation of America**, **Health Management Associates**, **Orlando Health** and **Adventist Health's Florida Hospital**. Health Central is deliberating whether to pursue a sale or a merger.

The city of **Hoboken, N.J.**, and the **Hoboken Municipal Hospital Authority** continue to move towards the privatization of **Hoboken University Medical Center** by reviewing offers from various companies interested in purchasing the hospital.

**Hutcheson Medical Center** in Fort Oglethorpe, Ga., entered partnership negotiations and a 60-day due diligence period with Chattanooga, Tenn.-based **Erlanger Health** in October.

The board of **Long Island College Hospital** in Brooklyn, N.Y., approved a merger with **SUNY Downstate Medical Center**, also in Brooklyn.

Newly formed non-profit **Michigan Rural Healthcare Preservation** will acquire **Cheboygan (Mich.) Memorial Hospital** by the end of the year, pending regulatory approval.

**MedCath** completed the sale of 58-bed **Heart Hospital of Austin** (Texas) to **St. David's Healthcare** for a purchase price equal to \$83.8 million plus retention of working capital.

**Medcath** completed the sale of its minority ownership in **Southwest Arizona Heart and Vascular Center** in Phoenix to the joint venture's physician partners for \$7 million.

**North Shore-Long Island Jewish Health System**, based in Manhasset, N.Y., and **Nassau University Medical Center** in East Meadows, N.Y., are discussing an affiliation.

The Federal Trade Commission approved a merger between **Pen Bay Healthcare** in Rockport, Maine, and **MaineHealth** in Portland. Under the merger, Pen Bay is expected to become a full member of MaineHealth.

**Ripley County Memorial Hospital** in Doniphan, Mo., merged with Cape Girardeu, Mo.-based **Southeast Health**. The hospital will be renamed Southeast Health of Ripley County.

Harrisonburg, Va.-based **Rockingham Memorial Hospital**, part of RMH Healthcare, is on pace to merge with Norfolk, Va.-based **Sentara Healthcare** by the beginning of 2011.

**Shamokin Area Hospital** in Coal Township, Pa., and Danville, Pa.-based **Geisinger Health System** are discussing a merger.

**Shawano (Wis.) Medical Center** approved plans to merge with Appleton, Wis.-based **TheDACare** after six months of negotiations.

**St. Luke's Episcopal Health System** in Houston acquired 51 percent of **Patients Medical Center**, a 61-bed, physician-owned hospital in South Pasadena, Texas.

Officials from the **University of Louisville**, Ky., signed a letter of intent to continue with a 3-way merger between the school's health-care system, **Jewish Hospital & St Mary's Healthcare/Jewish Hospital Healthcare Services** in Louisville, Ky.; and **Catholic Health Initiatives** and its Berea, Ky.-based operation, **St. Joseph Health System**. ■

## Advertising Index

*Note:* Ad page number(s) given in parentheses

**Awarepoint.** [info@awarepoint.com](mailto:info@awarepoint.com) / [www.awarepoint.com](http://www.awarepoint.com) / (888) 860-3463 (p. 48, 49, 51)

**Citadel Outsource Group.** [rshedden@citadelosg.com](mailto:rshedden@citadelosg.com) / [www.citadelosg.com](http://www.citadelosg.com) / (615) 757-1017 (p. 46)

**The C/N Group.** [rajchopra@thecng.com](mailto:rajchopra@thecng.com) / [www.thecng.com](http://www.thecng.com) / (219) 736-2700 (p. 40)

**HealthCare Appraisers.** [info@hcfmv.com](mailto:info@hcfmv.com) / [www.healthcareappraisers.com](http://www.healthcareappraisers.com) / (561) 330-3488 (p. 7)

**Healthcare Facilities Accreditation Program.** [info@hfap.org](mailto:info@hfap.org) / [www.hfap.org](http://www.hfap.org) / (312) 202-8258 (p. 5)

**Health Inventures.** [info@healthinventures.com](mailto:info@healthinventures.com) / [www.healthinventures.com](http://www.healthinventures.com) / (877) 304-8940 (p. 9)

**Image First.** [broberts@imagefirst.com](mailto:broberts@imagefirst.com) / [www.imagefirst.com](http://www.imagefirst.com) / (800) 932-7472 (p. 10)

**Mede Analytics.** [marketing@medeanalytics.com](mailto:marketing@medeanalytics.com) / [www.medeanalytics.com](http://www.medeanalytics.com) / (510) 379-3300 (p. 3)

**MedHQ.** [tjacobs@medhq.net](mailto:tjacobs@medhq.net) / [www.medhq.net](http://www.medhq.net) / 708.492.0519 (p. 41)

**People's Capital--Healthcare Financial Services.** [Shawn.Mcbride@peoples.com](mailto:Shawn.Mcbride@peoples.com) / [www.peoples.com/healthcare](http://www.peoples.com/healthcare) / 678-735-1706 (p. 53)

**Pinnacle III.** [info@pinnacleiii.com](mailto:info@pinnacleiii.com) / [www.pinnacleiii.com](http://www.pinnacleiii.com) / (970) 685-1713 (p. 11)

**Principle Valuation.** [tbaker@principlevaluation.com](mailto:tbaker@principlevaluation.com) / [www.principlevaluation.com](http://www.principlevaluation.com) / (312) 422-1010 (p. 4)

**The Securities Group.** [mtrammell@thesecuritiesgroup.com](mailto:mtrammell@thesecuritiesgroup.com) / [www.thesecuritiesgroup.com](http://www.thesecuritiesgroup.com) / (901) 328-4814 (p. 42)

**Somnia Anesthesia Services.** [sishaq@somniainc.com](mailto:sishaq@somniainc.com) / [www.somniainc.com](http://www.somniainc.com) / (877) 795-5788 (p. 15)

**Veolia Energy.** [contact@veoliaenergyna.com](mailto:contact@veoliaenergyna.com) / [www.veoliaenergyna.com](http://www.veoliaenergyna.com) / (617) 849-6600 (p. 2)

**VMG Health.** [osullivan@vmghealth.com](mailto:osullivan@vmghealth.com) / [www.vmghealth.com](http://www.vmghealth.com) / (214) 369-4888 (back cover)

**West Coast Medical Resources.** [westctmed@westcmr.com](mailto:westctmed@westcmr.com) / [www.westcmr.com](http://www.westcmr.com) / (800) 565-6385 (p. 12)

BECKER'S

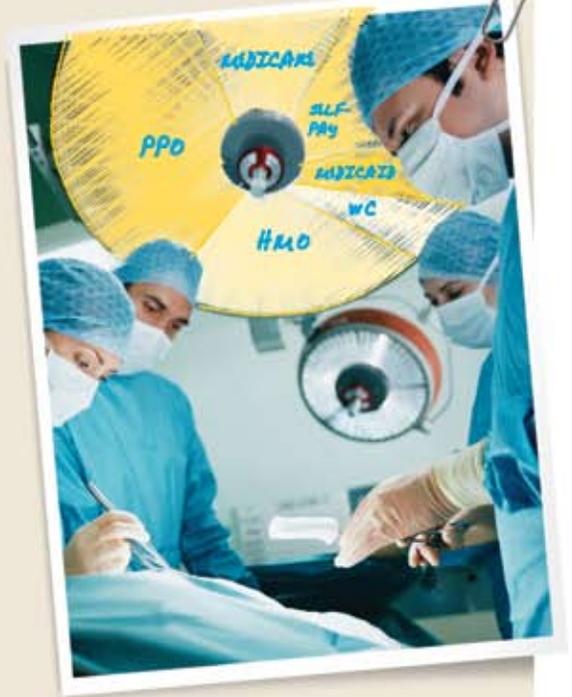
**Hospital Review**

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

**SIGN UP FOR A FREE ONE-YEAR  
SUBSCRIPTION! CALL (800) 417-2035!**

# Experts In Fair Market Value. Focused In Healthcare. Trusted by Clients.

VMG Health is the leader in the valuation of ASC's. No one has more experience and insight into the critical factors that drive the value of a surgery center.



*Visit our website to download  
the 2010 Intellimarker ASC  
Benchmarking Study*

1

[www.vmghealth.com](http://www.vmghealth.com)

2

Three Galleria Tower • 13155 Noel Rd., Ste. 2400 • Dallas, TX  
214-369-4888

3

3100 West End Ave., Ste. 940 • Nashville, TN  
615-777-7300