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BECKER'S

Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

July/August 2011 • Vol. 2011 No. 6

10 Predictions on the Future of Hospital Executive Compensation

By Rachel Fields

Stories on hospital executive compensation have littered newspaper headlines in 2011 so far. In April, Salinas (Calif.) Valley Memorial Healthcare System came under fire for the \$4 million retirement package offered to outgoing president and CEO Sam Downing, while Wayne Smith, president and CEO of Franklin, Tenn.-based Community Health Systems saw his compensation nearly double from 2008-2010. While executive salaries are expected to increase as the recession

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Hospital Tax-Exempt Status: Considerations Regarding Maintaining Exempt Status

By Scott Becker, JD, CPA, Milton Cerny, JD, & Anna Timmerman, JD, McGuireWoods

Tax-exempt hospitals (each a "hospital" and, collectively, "hospitals"), and their affiliated tax-exempt faculty or physician practices if applicable, may face concern about retaining their tax-exempt status in the face of the Patient Protection and Affordable Care Act and other changes to tax-exemption requirements. This article provides background, considerations and recommendations for a hospital to consider in maintaining its tax-exempt status, including the following core suggestions:

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Sophisticated and Powerful Consumers: How Transparency Will Change Hospitals

By Molly Gamble

While patients have always been hospitals' consumers, provisions of the Patient Protection and Affordable Care Act paired with increased availability of provider data, ratings and reviews has left the patient more informed and engaged than ever before. Hospitals that adjust their transparency and delivery models to meet sophisticated consumers will fare better as healthcare reform unfolds.

Sources of consumer data

Between word-of-mouth, the CMS' Hospital Compare, HealthGrades and various consumer blogs, patients have seemingly infinite amounts of healthcare data available to them. David Woolwine, vice president of Learning and Organizational Development at Sentara Healthcare, an

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Hospital Review
 BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

July/August 2011 Vol. 2011 No. 6

EDITORIAL

Lindsay Dunn
Editor in Chief
 800-417-2035 / lindsay@beckersasc.com

Rob Kurtz
Editor in Chief: Becker's ASC Review
 800-417-2035 / rob@beckersasc.com

Rachel Fields
Associate Editor
 800-417-2035 / rachel@beckersasc.com

Laura Miller
Assistant Editor
 800-417-2035 / laura@beckersasc.com

Molly Gamble
Assistant Editor
 800-417-2035 / molly@beckersasc.com

Bob Herman
Writer/Reporter
 800-417-2035 / bob@beckersasc.com

Jaimie Oh
Writer/Reporter
 800-417-2035 / jaimie@beckersasc.com

Leigh Page
Writer/Reporter
 800-417-2035 / leigh@beckersasc.com

Sabrina Rodak
Writer/Reporter
 800-417-2035 / sabrina@beckersasc.com

SALES & PUBLISHING

Jessica Cole
President & CEO
 800-417-2035 / jessica@beckersasc.com

Ally Jung
Asst. Account Manager
 800-417-2035 / ally@beckersasc.com

Austin Strajack
Asst. Account Manager
 800-417-2035 / austin@beckersasc.com

Brittney Wichtendahl
Assistant Account Manager
 800-417-2035 / brittney@beckersasc.com

Maggie Wrona
Assistant Account Manager
 800-417-2035 / maggie@beckersasc.com

Cathy Brett
Conference Coordinator
 800-417-2035 / cathy@beckersasc.com

Katie Cameron
Client Relations/Circulation Manager
 800-417-2035 / katie@beckersasc.com

Scott Becker
Publisher
 800-417-2035 / sbecker@mcguirewoods.com

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

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Publisher's Letter

The Compensation Issue; 18th Annual Ambulatory Surgery Centers Conference — Improving Profitability and Business and Legal Issues

The July/August issue of *Becker's Hospital Review* features:

1. Feature Articles on Compensation. Healthcare compensation has grown increasingly complex in recent years as more and more incentives are built into both executive and physician compensation. Non-profit hospitals seem to be criticized routinely by the public for the high levels of executive pay, while the hospitals argue the level of pay is necessary to attract the high level of talent needed to run these complex organizations. At the same time, the growth in physician employment has challenged hospitals to develop physician compensation formulas that encourage productivity, patient satisfaction and quality. Our annual Compensation Issue includes practical guidance and benchmarks for hospital executive compensation, 100 statistics on physician pay and on-call and medical directorship compensation rates and trends.

2. 65 Great Community Hospitals. This issue also features our annual list of community hospitals. Of the nearly 6,000 hospitals in the U.S. today, some 5,000 are community hospitals, according to American Hospital Association estimates. *Becker's Hospital Review's* annual list of great community hospitals recognizes some of these outstanding community facilities and the important role they play in communities around the country.

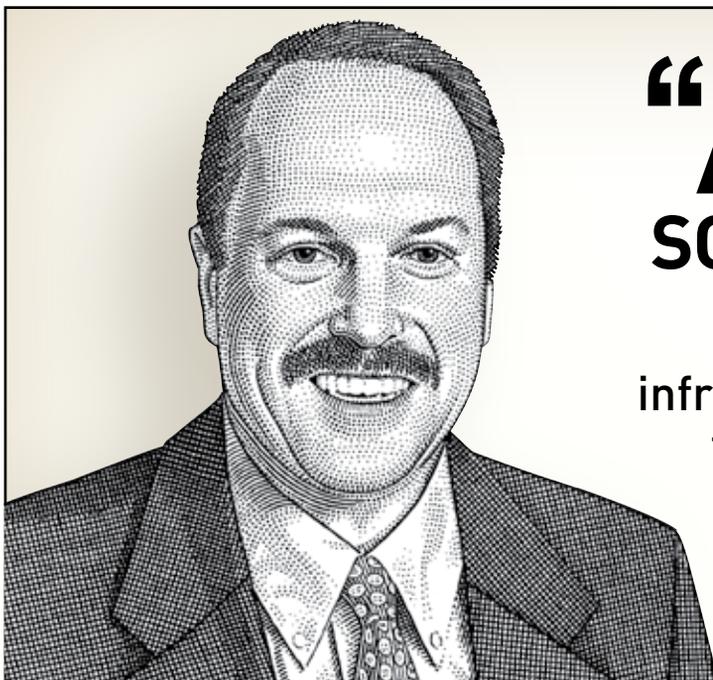
3. 18th Annual Ambulatory Surgery Centers Conference — The Best Annual ASC Business, Legal and Clinical Conference.

Becker's ASC Review's 18th Annual Ambulatory Surgery Centers Conference — Improving Profitability and Business and Legal Issues conference will take place on Oct. 27-29, 2011, in Chicago at the Westin Michigan Avenue. This year's keynote speakers include legendary journalist Sam Donaldson, former NBA star Bill Walton and Adrian Gostick, employee engagement expert and author of "The Carrot Principle." The conference features 85 sessions and 120 of the best speakers on ASC industry issues. To register for the conference, call (703) 836-5904 or email registration@ascassociation.org. More information on the conference is available at www.BeckersASC.com.

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10 Predictions on the Future of Hospital Executive Compensation (continued from page 1)

ebbs, the raises come alongside an emphasis on transparency and accountability, forcing some hospital compensation boards into the spotlight as they defend their decisions. Jim Nelson of Sullivan, Cotter and Associates, Robin Singleton of DHR International and John Fulcher of Bauer Consulting Group discuss 10 trends expected to shape hospital executive salaries over the next several years.

1. Executive salary increases will remain in the 2.5-3 percent range. Mr. Nelson says he expects overall salary increases to stay in the 2.5-3 percent range, mirroring trends that Sullivan, Cotter and Associates has seen over the past several years. “Prior to that, senior healthcare executives might have seen increases in the 4-5 percent range, but salary increases have become more modest and will probably stay that way for the foreseeable future,” Mr. Nelson says. According to Integrated Healthcare Strategies’ Executive Compensation Survey, hospital CEOs earned an average of \$452,400 in 2010, while health system CEOs raked in around \$683,000. Hospital CFOs earned an average of \$268,400 in 2010 and health system CFOs made an average of \$378,000. In addition to a “leveling off” of increases, Mr. Nelson also expects executive salary increases to align more closely with increases in the general healthcare workforce; in other words, if hospital employees receive a 3 percent salary increase overall in 2011, executives are likely to see a similar jump. Mr. Nelson indicated that the overall increase doesn’t preclude boards approving larger increases for higher performers, executives who may be paid lower in the market or executives who receive promotions.

He says several factors are driving this stabilization of salary increases. In an era when “transparency” and “documentation” are the popular buzzwords, compensation committees and hospital boards are becoming less likely to raise executive salaries above the market rate for their size and type of organization. Mr. Nelson says boards are becoming more cautious. There is an increasing preference by boards to link pay to the performance of the organization, so compensation plans are relying more on incentive pay to reward executives versus salary increases. These incentive plans are used to align executive pay with overall organizational performance.

2. Incentive awards will return to higher amounts. Despite the stagnation in executive salary increases, Mr. Nelson expects incentive awards to return to historic levels, signaling a possible return to economic stability. “Over the last couple of years, incentive awards have been lower because of the issues hospitals face during trying economic times,” he says. “Even in some organizations that have performed well, either the executives or the board occasionally decided it might be appropriate to delay payments or not pay them at all.” The use of executive incentives is widespread in the hospital industry, with 83 percent of health systems and 82 percent of hospitals reporting the use of short-term incentives and 35 percent of systems and 22 percent of hospitals reporting the use of long-term incentives, according to Integrated Healthcare Strategies. According to the 2010 Hay Group Healthcare Survey, sponsored by TIAA-CREF, the average annual incentive payment for CEOs of non-profit healthcare organizations is \$335,300; CFOs make slightly less at an average of \$136,300. These incentive payments made up an average of 37.3 percent of total compensation for non-profit hospital CEOs and 29.1 percent of total compensation for non-profit hospital CFOs.

Mr. Nelson says that while high-performing organizations will see a return to robust incentive payments, he notes that along with increased incentive awards, board expectations for executive performance are increasing as well. He says he has seen an increasing emphasis on quality outcomes and community benefit in addition to the traditional financial performance measures in executive incentive plans. “To get the maximum possible award, you have to have outstanding performance in each of the criteria,” he says. Awards are usually based on 5-8 objectives, which are closely aligned with the strategic goals of the organization.

3. Non-traditional executive backgrounds will demand higher salaries. Driven by current demands in healthcare, Ms. Singleton says hospitals are increasingly looking to hire executives with clinical, finance and information technology backgrounds. This means some hospitals are choosing to hire C-suite leaders without a healthcare background. She says because many of these candidates are moving into the healthcare industry from “corporate America” — and leaving high-paying jobs to do so — executive salaries must increase to attract top talent.

The healthcare industry is also seeing an influx of talent from other industries as hospitals create previously non-existent positions to cater to the “patient experience,” says Ms. Singleton. In order to get reimbursed in the future, hospitals and physicians will have to demonstrate accountability on many levels, and they will have to demonstrate patient satisfaction scores and quality scores, she says. “In that case, a new person might come [into the healthcare industry] from the hospitality industry, and that means a higher salary. There’s an increase in salaries of about 15-20 percent when you recruit from corporate America.”

4. Incoming executives will demand higher pay than the leaders they replace. According to an American College of Healthcare Executives report, the hospital CEO turnover rate sat at 16 percent in 2010, a number that Thomas C. Colan, PhD, FACHE, CAE, president and CEO of ACHE said was “too high.” Hospitals losing their executives may agree with Mr. Colan: As long-time CEOs retire, up-and-coming leaders are demanding more money to step into the same roles.

“Those CEOs have been at the hospital a long time and are fairly highly compensated, and they’re pretty maxed out on the internal scale,” Ms. Singleton says. “But in order to replace them with people of their caliber — as well as people who can face the challenges of the future — it’s unbelievable. Hospitals are having to pay much higher.” She says hospitals that want to recruit top talent must pay at the 95th percentile.

The demand for high compensation is exacerbated if a candidate arrives from an area like New York or California, where average salaries are much higher. Mr. Fulcher says states with a higher cost-of-living will also have to pay better salaries, and candidates are unlikely to accept anything less than they made at their last organization. “I haven’t seen any hospitals paying less than what they’re paying the current CEO or less than what the incoming candidate is making,” Ms. Singleton says. “Very few people will move for less than a 3-5 percent salary increase.”

5. Sign-on bonuses and relocation allowances will become more prevalent. More hospitals are offering sign-on bonuses to candidates to offset the cost of relocating and compete with other facilities, Mr. Fulcher says. “If you want to be competitive, you have to pay a sign-on bonus,” he says. “You’ll have sign-on bonuses that are between \$5,000 and \$10,000 and relocation packages that are between \$3,000 and \$10,000.”

Ms. Singleton says she has seen hospitals increase their relocation allowances to help candidates sell their houses and find a new place to live. “Hospitals are having to give candidates a sign-on bonus ... so they can price their house at a much lower sellable price, or they have to give them the money to rent a place and have the cash to make the mortgage payment,” she says.

Mr. Fulcher says some hospitals are choosing to authorize direct billing for candidate relocation, rather than asking candidates to pay for relocation and then reimbursing part of the cost. Direct billing allows the hospital more control over how relocation funds are spent and takes some pressure off the candidate in terms of paying relocation fees.

6. Supplemental benefits will simplify. Non-profit hospitals may simplify supplemental benefits for executives in the next few years, following a decision by the IRS to clarify the way supplemental benefits are now taxed and disclosed on Form 990, according to Mr. Nelson. “While there are supplemental benefits, such as supplemental retirement programs to bring ex-

executive retirement benefits to competitive norms, they're much simpler than they used to be," he says. Supplemental benefits are often required to offset the legislative or contractual caps on group benefits and retirement plans.

For example, more boards are deciding to align the executive level of benefits with the benefits of the general workforce, meaning if an employee receives two times his salary for life insurance, executives would also receive two times their salary for life insurance. However, if caps on life insurance prevent the executive from receiving two times his or her salary (likely a considerable amount more than an employee would receive), the hospital might add supplemental life insurance to bring benefits to a competitive level. But clearly, the rich benefit plans of the past are going away.

7. "Back filling" will mean paying better candidates more money. Ms. Singleton says she predicts hospitals will have to "back fill" positions as they try to undo cuts made during the recession. In order to offset decreased reimbursement and drops in case volume, many hospitals eliminated C-suite roles such as the COO and attempted to spread leadership duties among fewer people. Now that the economy is recovering, hospitals are finding that their leaders are overbur-

dened with work, and some leaders are unable to handle the increasing demands of the industry.

As facilities look to replace or add more talented leaders, they will have to spend more to recruit sought-after candidates. "When you raise the bar and say you want someone stronger in the role that can handle more and has a higher skill set, you'll have to pay more for that," Ms. Singleton says. "That could be anywhere from an 8-12 percent increase."

8. Perquisites will continue to decline.

Mr. Nelson says healthcare organizations are increasingly eliminating perquisites such as country clubs, automobile allowances, tax gross ups and travel expenses that used to serve as an additional compensation for hospital executives. He says the decrease in perquisites is motivated in part by the public perception that executive perks are unnecessary, by tax law changes and by the increasing requirements for reporting of perquisites on IRS Form 990. "There are some perks that are standing the test of time, if they serve a legitimate business purpose" he says. "For some executives, there may be a very legitimate reason to give executives country club dues so they can fundraise and meet with the community leaders. But I think that by and large, boards are challenging perks more than they have in the past."

He says the perks that survive will be those that boards deem necessary for the executive's role: for example, auto allowances for executives who spend a lot of time traveling by car.

9. Past compensation practices will be challenged.

Mr. Nelson says as transparency and documentation become more important, compensation committees and hospital boards are exerting more control over the executive compensation process. "In other words, they're saying, 'Why are we doing what we're doing, and does it still make sense in today's environment?'" Mr. Nelson says. He says in more instances, the full board of directors is involved in overseeing executive pay. There is also a need for non-profit hospitals to clearly document their decisions and be careful to establish that compensation committee decision-makers, as well as their compensation advisors, are independent and do not benefit from the final compensation decisions.

He says the board's review of the analysis of third-party data used to determine executive compensation is also becoming more stringent, as required by the IRS. Instead of viewing market data analysis as a cursory task, boards are expected to think seriously about the hospital's position in the market and calculate how compensation should be awarded based on that posi-

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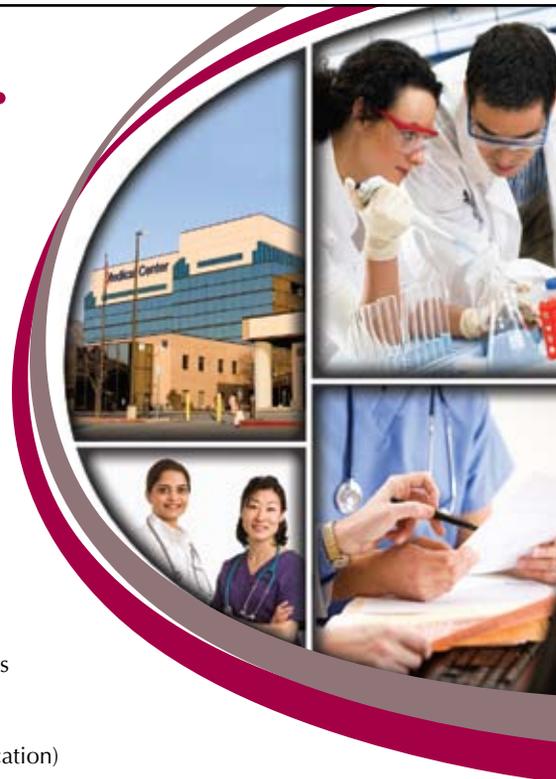
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tion. The boards are also considering whether they are getting data from the right types of organizations. "If the hospital is going to be paying above the median or in the upper quartile for performance, the boards are asking whether the hospital is really performing at those levels," Mr. Nelson says.

10. Severance packages will increase to offset the risk of new positions. As hospitals create never-before-seen positions — "director of patient experience," for example — Ms. Singleton believes severance packages will increase in length. "Severance packages are holding at 18 months, with 12 as a minimum, and some CEO searches are going to 24 months," she says. More robust severance packages can calm the nerves of candidates who are unsure about filling a "non-essential" hospital job — one that was recently created as a new project but may not be necessary in a few years.

These newly-created positions may also pose a problem for recruitment, as hospitals and search agencies may struggle to find suitable candidates. "There could only be three or four people with that title in the country," Ms. Singleton says. "We may have to look at unusual titles, do a lot of original research and go outside healthcare."

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Hospital and Health System Executive Compensation: Statistics to Know

Here are statistics on annual hospital and healthcare executive compensation, based on reports from Hay Group, Integrated Healthcare Strategies and the Internal Revenue Service.

	Hospital CEOs		Hospital CFOs	
	Average	Median	Average	Median
2010	\$452,400	\$440,000	\$268,400	\$256,700
2009	\$472,000	\$434,500	\$270,400	\$260,000
2008	\$497,500	\$490,000	\$281,300	\$271,100
2007	\$394,800	\$365,200	\$208,500	\$186,800
2006	\$285,800	\$275,000	\$175,700	\$160,800
2005	\$278,900	\$262,100	\$167,900	\$161,900
	Health system CEOs		Health system CFOs	
	Average	Median	Average	Median
2010	\$683,000	\$647,000	\$378,000	\$368,000
2009	\$692,300	\$675,000	\$366,000	\$350,000
2008	\$668,100	\$622,300	\$361,800	\$365,000
2007	\$577,500	\$534,600	\$317,800	\$301,300
2006	\$465,200	\$430,000	\$265,100	\$250,000
2005	\$425,200	\$375,000	\$243,900	\$234,100

The following information on non-profit healthcare CEO and CFO compensation is taken from the 2010 Hay Group Healthcare Survey, sponsored by TIAA-CREF (base salary, annual incentive, total annual compensation) and the Internal Revenue Service's *Exempt Organizations Hospital Compliance Project Final Report* (salary by community type and by hospital revenue).

	Non-profit healthcare CEOs	Non-profit healthcare CFOs
Base salary	\$871,700	\$455,800
Annual incentive	\$335,300	\$136,300
Total annual compensation	\$1,111,300	\$574,100
By community type		
High population	\$650,200	n/a
Critical access hospitals	\$152,700	n/a
Rural hospitals	\$289,500	n/a
Other	\$427,500	n/a
By hospital revenue		
Under \$25 million	\$149,100	n/a
\$25-\$100 million	\$289,600	n/a
\$100-\$250 million	\$465,300	n/a
\$250-\$500 million	\$642,100	n/a
Over \$500 million	\$877,200	n/a

Source: Integrated Healthcare Strategies' Executive Compensation Survey, based on 2010 data.

Hospital Tax-Exempt Status: Considerations Regarding Maintaining Exempt Status (continued from page 1)

1. Take steps to develop a rebuttable presumption that all compensation relationships are reasonable;
2. Follow the tax-exemption requirements imposed by PPACA, now codified at Section 501(r) of the Internal Revenue Code (discussed in Section 2 below);
3. Provide, document and review the charitable benefits and charity care the hospital provides to the community on an annual basis;
4. Publicize the hospital's willingness to accept Medicare and Medicaid patients and its services available to indigent patients; and
5. Ensure that any money allocated for community benefit purposes is utilized for activities that actually provide a community benefit, such as research or education of health professionals. The hospital should likely, however, do more than simply allocate certain funds to assure that it can defend that it properly serves community purposes.

Hospitals, as a starting point to assess community benefit, should be aware that case law, particularly state case law, suggests that if the value of charitable services provided each year is 1 percent or less of gross revenues, then the amount of community benefit is not adequate. [1] Under federal law, no specific percentage has been mandated. An IRS study recently found that of the hospitals it surveyed, on average, approximately 9 percent of revenue was spent on community benefit. Twenty percent of hospitals surveyed reported total community benefit spending of less than 2 percent of revenue. In addition, nearly 60 percent of the hospitals surveyed provided less than or equal to 5 percent of revenue on uncompensated care. Similarly, a 2006 Congressional Budget Office report found that non-profit hospitals devoted approximately 5 percent of total revenues to uncompensated care. Thus, it appears that dedicating 3-7 percent of revenue on a variety of community benefit and charity care activities is likely adequate.

Hospitals may also consider that courts have found that if (i) only a very small number of patients are provided free or discounted care, (ii) the dollar value of free care that is provided is minimal, (iii) unpaid bills are immediately referred to collections, (iv) uninsured patients are charged the healthcare entity's full rates, (v) the healthcare entity fails to publicize its Medicare and Medicaid services and indigent patient policies, (vi) the healthcare entity fails to provide apparent benefits to the immediate community it serves, (vii) the healthcare entity does not allocate surplus revenue to research, education and medical training and (viii) the healthcare entity does not promote health for the benefit of its community, the healthcare entity may not be entitled to a tax-exemption [2]. In addition if applicable, then the hospital should ensure that it retains sufficient control over the its related physician practice and its physicians to ensure that the hospital is providing a community benefit throughout the organization.

The remainder of this article addresses the following issues: (i) general tax-exemption key requirements, (ii) new tax-exemption requirements established under PPACA, (iii) potential tax-exemption issues for accountable care organizations, (iv) the IRS's audit focus, (v) hospital operations recommendations and (vi) internal audit considerations.

1. Tax-exemption key requirements. A key to maintaining the tax-exempt status of a hospital is to continually act in furtherance of its community and charitable purpose and to provide community benefits [3]. If a hospital fails to do so, it risks losing its tax-exempt status. While the IRS does not specifically define "community benefit," PPACA established new requirements for certain healthcare entities to maintain their tax-exempt status, as discussed in Section 2 below, which likely may be considered some evidence of community benefit. Other examples of community benefit include providing charitable care, offering health programs to the

public, educating health professionals, and conducting medical research. A hospital does not have to engage in all of these activities, but it must provide enough community benefit to provide the IRS with evidence that the hospital is acting consistently with its charitable purpose. Hospitals will also soon have to begin providing evidence to the IRS of the community benefits that they provide on Schedule H of the Form 990.

There are also three other core areas of exposure for tax-exempt entities, like hospitals, including: excess benefit transactions, private inurement and unrelated business income taxes. According to the IRS, an "excess benefit transaction" is one in which "an economic benefit is provided by an applicable tax-exempt organization, directly or indirectly, to or for the use of a disqualified person, and the value of the economic benefit provided by the organization exceeds the value of the consideration received by the organization."

Similarly, "private inurement" occurs when an individual with significant authority in the organization enters into a transaction or arrangement with the organization in which the individual receives excessive, disproportionate benefits.

Finally, according to the IRS, a tax-exempt organization engages in "unrelated business income" if it participates in an activity that "is a trade or business, it is regularly carried on, and it is not substantially related to furthering the exempt purpose of the organization." Tax-exempt entities generally must pay taxes on unrelated business income.

Hospitals must first be aware of potential excess benefit transactions resulting from, for example, excessive compensation arrangements and non-fair-market-value transactions with certain disqualified persons. [4] Disqualified persons may include physicians, medical directors, officers of the hospital or of the affiliated tax-exempt physician practice, and the board of directors of the hospital or of the affiliated tax-exempt physician practice. Avoiding the provision of excessive compensation or benefits is a core concern in the acquisition and operation of tax-exempt physician practices. Individuals, such as members of the board of directors, may have to pay penalties in the form of excise taxes for engaging in such excess benefit transactions. Examples of excess benefit transactions include:

- Making payments in excess of fair market value for goods and services, such as employment compensation or vendor contracts;
- Providing discounted office space;
- Providing free or discounted billing services; or
- Providing excessive payments for administrative services.

2. New PPACA requirements. PPACA imposes certain new requirements upon tax-exempt, non-profit hospitals in order to maintain their tax-exempt status. These new requirements include:

- Having written, qualified financial assistance and emergency medical care policies publicized and made available to the public;
- Avoiding certain abusive billing and collection practices;
- Limiting charges to individuals eligible for financial assistance; and
- Providing a community health needs assessment report to the IRS for tax years beginning after March 23, 2012.

To implement the new requirements, which are contained in Section 501(r) of the Code, the IRS drafted new annual reporting requirements that certain tax-exempt healthcare entities must complete. Such requirements are set forth in Form 990, Schedule H. In essence, these tax-exempt healthcare entities must show the IRS they are providing a community benefit.

3. Tax-exempt requirements for ACOs. PPACA also established ACOs, which are intended to provide quality healthcare for Medicare beneficiaries and allow the ACO participants to share in the savings from managing care more efficiently. On March 31, 2011, the IRS issued guidance and solicited comments regarding tax-exempt entities' participation in ACOs. The ACO-related tax issues include whether ACOs will themselves be tax-exempt and, if not, how organizations that participate in ACOs will be treated for tax purposes. The IRS intends to look through the ACO and attribute the ACO's commercial activities to the tax-exempt hospital if such arrangements violate tax-exempt purposes. Also, the IRS intends to look at whether the participating tax-exempt hospital has a sufficient level of control over the ACO's activities such that the ACO will serve the hospital's charitable purposes.

4. IRS audit focus. Since all of the healthcare operations of a tax-exempt entity must meet the new PPACA tax-exemption requirements, the IRS has indicated that it may audit the following tax-exempt entity operations:

- Hospital facilities that were operated by the hospital system any time during the taxable year that are licensed, registered or similarly recognized as a hospital under state law, whose principal function or purpose is hospital care without regard to Section 501(r) of the Code (the new PPACA tax-exemption requirements). This information, which is reported on Schedule H of Form 990, may provide additional audit leads for the IRS.
- Non-hospital healthcare facilities operated during the tax year, regardless of whether they are registered under state law. These could include subsidiaries and joint venture operations with physician practices that may lead to further IRS review for unrelated business income and excess benefits.

Failure of an individual hospital or owned physician practice, which is part of a hospital system, to meet the PPACA tax-exemption requirements could affect the tax-exempt status of the entire hospital system. In turn, this could affect the taxability of income from facility-financed, tax-exempt bonds for private use, pension benefits and other government contracts and research grants.

5. Practice operations recommendations. A hospital must ensure that income generated through its affiliated tax-exempt physician practice employees is also tax-exempt and is not derived from any unrelated trade or business income. Thus, in addition to generally providing a community benefit and meeting certain other IRS requirements, a hospital should:

- Publicize its acceptance of Medicare and Medicaid patients and its indigent services to the general public [5];

- Consider other ways that the hospital can provide a community benefit, including allocating money to research and development, measuring how much care is provided to Medicare and Medicaid patients and fulfilling the new PPACA tax-exemption requirements discussed in Section 2;
- Review physician leadership and governance practices on issues including insurance, office space, record-keeping, retirement and health benefits;
- Review fair market value considerations for practice acquisitions and physician compensation with the board of directors, as well as obtain independent assessments of compensation and asset purchase prices;
- Consider and fulfill the compensation practice questions in accordance with Section 6 below; and
- Consider including a provision in the practice physician contracts that requires the practice physicians to act consistently with the charitable purpose of the hospital and consider including language stating that the practice physicians will not discriminate against any patient based upon payor type, including Medicare, Medicaid and self-pay. If many of the practice physicians do not serve Medicare and Medicaid patients, the hospital may consider, assuming it has some significant level of such patients, allocating physician efforts to serving Medicare, Medicaid and indigent patients. Further, a hospital policy may state that physicians shall not discriminate based upon payor.

As noted previously, hospitals may also consider that courts have found that if (i) only a very small number of patients are provided free or discounted care, (ii) the dollar value of free care that is provided is minimal, (iii) unpaid bills are immediately referred to collections, (iv) uninsured patients are charged the health care entity's full rates, (v) the healthcare entity fails to publicize its Medicare and Medicaid services and indigent patient policies, (vi) the healthcare entity fails to provide apparent benefits to the immediate community it serves, (vii) the healthcare entity does not allocate surplus revenue to research, education and medical training and (viii) the healthcare entity does not promote health for the benefit of its community, then the healthcare entity may not be entitled to a tax-exemption [6].

6. Internal audit considerations. A hospital should consider participating in an internal audit of its operations to determine if there are any practices that could negatively affect its tax-exempt status. Generally, in an internal audit, the auditors would review compensation agreements, contracts, information regarding disqualified parties and any information or reports regarding community benefits. A hospital should also be prepared to answer the more specific questions below:

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- Does the hospital have documentation to establish a “rebuttable presumption of reasonableness” for compensation and benefits? When the hospital determines compensation, does it document the proposed compensation compared with compensation paid to similarly situated individuals, which is agreed to and in writing prior to employment? In essence, does the hospital have compensation reports to support the compensation paid in all contracts? How has the hospital documented and assessed incentive compensation that is based on a profit and loss formula?
- Are all transactions fair market value, including those with service suppliers? Are there any disqualified persons or family members or any practice physicians that are in key positions to make decisions for the hospital or the affiliated tax-exempt physician practice? If so, are the contracts signed off on by independent parties?
- How many Medicare, Medicaid and indigent persons are served by the hospital? What percentage of the hospital’s patient population is Medicare, Medicaid or indigent? Does the hospital limit the number of Medicare and Medicaid patients it will serve? Does the hospital turn away patients based upon payor status?
- What percentage of net revenue is uncompensated care? How does the hospital determine who is eligible for free or discounted care? Does the hospital have a written financial assistance/indigent policy? If yes, does the hospital publicize this policy? Is this policy flexible?
- Does the hospital charge its financial-assistance-eligible patients at rates higher than amounts billed to individuals with insurance?
- Does the hospital have a written debt collection policy? What actions does the hospital take before sending a patient to collections? Does the hospital engage in any abusive actions to collect fees?
- What information can the hospital provide regarding its community benefits? Does it provide unreimbursed care? Does it conduct research? Does it educate health professionals? Does it offer health programs to the public? Does the hospital have a community benefit report which lists and describes the community benefit activities the hospital fulfilled on an annual basis?
- Does the hospital participate in any community-building activities, such as providing community health improvement advocacy or making environmental improvements?
- Does the hospital conduct a community health needs assessment? If yes, is this information available to the public?

If a hospital cannot adequately or appropriately respond to the questions above, it should implement changes to ensure that its tax-exempt status is protected.

Scott Becker is a partner in McGuireWoods’ Chicago office. He practices exclusively in the healthcare regulatory and transactional area. He devotes his efforts to surgery center, hospital and healthcare provider related transactions, joint ventures, securities, contracting and regulatory matters.

Milton Cerny serves as counsel at McGuireWoods’ Washington, D.C., office. He represents a broad range of nonprofit organizations including hospitals, private foundations, universities, public charities and trade associations, including U.S. affiliates of foreign charities. He has extensive experience in the application of the federal tax code to nonprofit organizations. He served at the National Office of the IRS in Washington, D.C., where he was responsible for issuing private letter rulings and advising field offices on tax controversies.

Anna Timmerman is an associate in McGuireWoods’ Chicago office. Her practice focuses on healthcare transactional and regulatory matters for a variety of healthcare providers, including hospitals, ambulatory surgery centers and dialysis centers.

Footnotes:

[1] *Utah County v. Intermountain Health Care*, 709 P.2d 265, 274 (Utah 1985); *Provena Covenant Med. Ctr. v. Dep’t of Revenue*, 925 N.E.2d 1131, 1140, 1149 (Ill. 2010).

[2] *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1140, 1149, 1150; *Utah County*, 709 P.2d at 274, 275; *IHC Health Plans, Inc. v. Comm’r*, 325 F.3d 1188, 1196 (3rd Cir. 2003). The IRS does not often revoke tax-exemption status from tax-exempt hospitals.

[3] *IHC Health Plans, Inc.*, 325 F.3d at 1198. *HC Health Plans, Inc.*, a federal case regarding a tax-exempt health plan, stated the following regarding providing community benefit:

An organization cannot satisfy the community-benefit requirement based solely on the fact that it offers health-care services to all in the community in exchange for a fee. [There must be an additional plus.]

...

[Regarding community benefit,] the IRS rulings provide a number of examples: providing free or below-cost services, see Rev. Rul. 56-185; maintaining an emergency room open to all, regardless of ability to pay, see Rev. Rul. 69-545; and devoting surpluses to research, education, and medical training, see Rev. Rul. 83-157.

...

An organization is not entitled to tax exemption unless it operates for a charitable purpose. Thus, the existence of some incidental community benefit is insufficient. Rather, the magnitude of the community benefit conferred must be sufficient to give rise to a strong inference that the organization operates primarily for the purpose of benefitting the community.

Id. at 1197, 1198.

[4] These individuals typically have authority over transactions to the detriment of the charitable purpose of the hospital.

[5] Some courts have found that failing to publicize such policies weighs against upholding a hospital’s tax-exempt status. *Utah County*, 709 P.2d at 274; *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1149.

[6] *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1140, 1149, 1150; *Utah County*, 709 P.2d at 274, 275; *IHC Health Plans, Inc.*, 325 F.3d at 1196. ■

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Sophisticated and Powerful Consumers: How Transparency Will Change Hospitals (continued from page 1)

eight-hospital system based in Norfolk, Va., notes that patients have become more informed over the past few years and have taken a new role in care delivery as a result. “They know the ins and outs of healthcare now,” he says. “They’ve looked at particular diagnoses and can participate in the delivery of their care. People look at quality and service ratings, blogs and all kinds of consumer comments. They are also asking more clinical questions,” says Mr. Woolwine.

Many experts remain split on whether data, such as HCAHPS, word-of-mouth or word-of-mouse — such as blogs or online scores — drive patient decisions more. Before Mary Malone, MS, JD, became president of Malone Advisory Services, she worked at Press Ganey as a senior leader for more than 14 years. Ms. Malone says while data is reliable, patients may still focus on the personal nature of hospitals. “I might be a contrarian on this, but I think you might see a bigger emphasis on word of mouth,” says Ms. Malone. “It seems clear that word-of-mouth is still the number one way we learn about our healthcare or select our physicians and hospitals,” she says.

Word-of-mouth works both ways, helping or hurting a hospital’s place with consumers along with its bottom line. “We recently had a client tell us of a situation where patients cancelled surgeries with a surgeon the hospital recently hired. An investigation found that patient comments on consumer sites — not medical sites — were negative. It turned out that the surgeon only had five ratings, but they were negative and it cost the hospital business,” says John Luginbill, CEO of Indianapolis-based The Heavyweights, an agency that helps healthcare institutions drive patient volume.

Some feel that it takes more than comments on a website to influence the healthcare decisions of savvy consumers, however. “We now have an environment where patients and consumers are very sophisticated,” says Stephanie Goldberg, MSN, RN, NEA-BC, senior vice president of patient care services and chief nursing officer at Hospital for Special Surgery (HSS) in New York City. “There is a lot of information out there and increased transparency. Consumers can go to a website and look at infection rates, HCAHPS data, nursing accreditations and more. In an age of transparency

for consumers, it’s important for organizations to keep their qualitative data at the highest level,” says Ms. Goldberg.

The fine line between quality and amenities

One facet of consumer-driven healthcare that has gained momentum in recent years is the patient amenity, a broad term encompassing perks like back massages, scenic views and world-class food. Hospitals in areas with well-insured patients or markets where competition is fierce are more likely to compete through perks. Research has indicated that improvements in amenities cost hospitals more than improvements in quality of care — but improved amenities led to a greater effect on hospital volume.

This finding does not necessarily mean patients care more about perks than quality of care, according to John Romley, PhD, an economist and faculty member of the University of Southern California in Los Angeles. “It’s very hard for patients to assess quality of care at hospitals. It may be easier for them to assess whether they will get a private room with good food and nice people,” says Dr. Romley. Even if patients do understand hospital data, some may still be willing to trade a little bit of clinical quality for nicer amenities, says Dr. Romley.

There is a fine line, however, between amenities and features of safety or quality. “One feature people focus on is the private, single room. I don’t view that as an amenity,” says Ms. Malone. “It’s a safety feature.” Ms. Malone says hospital perks are not merely hotel-like features intended to draw patients but are supported by research studies showing the features contribute to healing and improved outcomes. These include more natural light, in-room accommodations for family members, individual controls for temperature and light and noise reduction strategies. “I would make the argument that creating a really good patient experience — one that de-stresses the patient and makes them feel more comfortable — is a sign of quality care.”

Executive and staff involvement in the patient experience

Executives may not always be in the nearest proximity to the patient bedside, but they can still ensure the hospital remains focused on patient satisfaction and experience. The practice of walking the halls and visiting patient rooms, or rounding, is commonly advocated by hospital leaders as a method to remain involved in patient experience. Mr. Woolwine says this practice, when widely implemented, is very effective at Sentara and helps executives check the pulse of the hospital. “We don’t just visit with those patients having a challenging visit but patients all over the spectrum,” he says.

Sentara has also introduced smaller measures to gauge patient desires, such as customized white boards in patient rooms that patients use to communicate with caregivers in sharing their unique wants or needs. “It basically has space for the patient to write two or three things that would make their stay more like home,” says Mr. Woolwine. By specifically outlining this and other care information, the white boards help nurses and medical staff attune to patient needs, such as keeping the room bright or dim.

Leadership rounding is also a common practice at HSS. “We pay attention to every single letter and comment,” says Ms. Goldberg. “I would say every minute of the day is spent on patient satisfaction and patient excellence. Our staff lives and breathes patient satisfaction data and we have different structures and committees in place to respond to that data,” says Ms. Goldberg.

The hospital measures patient satisfaction through Press Ganey tools. Every patient is mailed a measurement tool, and HSS sees a very high response rate, according to Ms. Goldberg. Meetings and committee structures allow staff to craft short-term and long-term action plans, such as hourly rounding shifts or adjustments in the delivery of care model, in response to patient satisfaction data. “We respond to that data quickly,” says Ms. Goldberg.

Awards and accreditations

Marketing may take a backseat to quality improvements, but the way in

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which a hospital markets its awards and accreditations still holds weight to consumers. Awards offered by agencies such as Thomson Reuters, *U.S. News & World Report* and HealthGrades are highly publicized by hospitals and are easy for consumers to understand. Healthcare accreditation, such as that of Magnet or the Joint Commission, is also telling of a hospital's quality of care. Many of these rankings or awards also overlap or build on one another. For instance, Magnet status is one criterion for hospitals to be recognized by *U.S. News & World Report* as the country's best.

The American Nurses Credentialing Center has named HSS a Magnet institution, recognizing its excellence in nursing. Approximately 6.6 percent of registered hospitals have achieved this title. "In general, if a hospital is Magnet-accredited, the consumer recognizes the organization for excellent nursing care and quality outcomes," says Ms. Goldberg. Magnet accreditation also serves as a draw for patients, who may choose a Magnet institution over a hospital that is not Magnet-accredited, according to Ms. Goldberg. Along with its appeal to consumers, the attributes of a Magnet-accredited hospital, such as staff participation in clinical decision-making, are attractive to nurses and distinguish HSS from other work environments. "Staff certainly seeks Magnet hospitals, so this designation is also effective as a recruitment strategy," says Ms. Goldberg. "The practice environment also supports nurses to remain at HSS, which only benefits the patient."

Sharing cost information and best practices

While healthcare reform does not require hospitals to post costs for common services until 2014, many providers are stepping in front of the deadline. Hospitals are making price information more transparent to both consumers and fellow providers.

Many healthcare experts say transparency on health prices will eventually eliminate large cost disparities between providers through competition, prompting many hospitals and providers to jump on board before reform's mandates. For instance, Spectrum Health Hospital Group in Grand Rapids, Mich., has posted prices online for approximately four years. About 1,000 visitors visit the site per month for price information alone, and the hospital also offers financial counseling services to help patients better understand the billing process. Last March, a Wisconsin bill went into law, requiring healthcare providers to disclose costs of the most commonly performed procedures in an effort to help consumers determine out-of-pocket costs and compare one provider to another.

Launched in Dec. 2010 by six organizations, the High Value Healthcare Collaborative is a project that compares data on quality, outcomes and cost among healthcare providers. The number of HVHC members has now expanded to 15, with organizations including Cleveland Clinic, Mayo Clinic, University of Iowa Health Care and UCLA Health System, among others. Under the arrangement, Dartmouth Institute for Health Policy and Clinical Practice coordinates data sharing and reports results back to each provider to inform the development of best practices and cost reduction.

Transparency in pricing has delved into payor territory, as legislators push for insurance companies to provide consumers with the costs of services at hospitals. In April, a Missouri Senate bill would require payors to post prices online so consumers could simply type the service they need into a website and see its cost at various medical facilities. The bill's author, Sen. Rob Schaaf (R.-St. Joseph) is a physician who says the bill would increase cost transparency and bring competition into the industry. ■



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5 Trends Affecting the Future of Physician Compensation

By Rachel Fields

Physician compensation is changing as hospitals rapidly acquire physician practices and reimbursement levels decline. To augment their earnings in the face of reimbursement cuts, expensive practice investments and an uncertain future, physicians are looking for new methods of compensation that tie their pay to on-call coverage, medical directorship and quality measures. Here are five trends affecting the future of physician compensation, according to several compensation experts and recent studies.

1. RVU and bonus models continue to be favored over flat salaries. According to Sidney S. Welch, JD, MPH, partner with Arnall Golden Gregory, in the wave of physician practice acquisitions in the 1990s, hospitals generally paid physicians a flat salary for their work. “In this second wave, physicians are being put on a productivity formula in most situations, and typically that is some sort of structure that entails work RVUs,” Ms. Welch says. This means that most physicians now receive base compensation in addition to a bonus depending on their productivity, which can be distributed to individual physicians by the hospital itself or divided up by the practice. Ms. Welch says while work RVUs have become standard in physician employment compensation arrangements, the industry is also starting to see the rise of quality indicators tied to compensation.

According to Jim Farrell with Florida law firm Shutts & Bowen, the danger of basing compensation on work RVUs is that the system is “fraught

with potential gaming.” He says that historically, hospitals have run into problems because “you can get a physician who goes and camps out at the ER all week long and takes care of every indigent patient walking down the street in order to generate RVUs to get a bonus — without generating any money for the facility.” He says bonuses based on quality indicators are more naturally aligned with the hospital’s interests; to earn extra pay, the physician must increase patient satisfaction or improve patient care outcomes. These quality outcome bonuses can also be negotiated with third-party payors, he says. “Hospitals are now able to negotiate with managed care on outcomes for cardiac-related admissions and see some compensation for the third-party payors, which they’re able to turn into bonus structures for the providers,” he says.

2. On-call compensation is more common. Historically, physicians were expected to provide on-call coverage as part of their affiliation with the hospital, says Mark Folk, JD, with Shutts & Bowen. No longer: Physicians across the country have begun demanding compensation for their time on-call, and the trend is spreading rapidly. “As soon as one hospital started paying one subspecialty for call coverage, everybody came down with the flu,” Mr. Folk says.

Mr. Farrell adds that in communities where call coverage is new, the trend generally begins with trauma and neurology coverage. “Neurology was one of the early ones that occurred because while neurologists can do just fine

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with an office-based practice, hospitals desperately need them for stroke patients,” he says. “And now you’re asking the neurologists to come in on the high risk matters. They don’t really want to come to the hospital in the first place, and there’s generally a national shortage of neurologists.” According to Medical Group Management Association’s Medical Directorship and On-Call Compensation Study: 2011 Report Based on 2010 Data, on-call compensation can vary widely by specialty. Invasive cardiologists reported the highest median daily rate of on-call compensation at \$1,600 per day; general surgeons earned a median of \$1,150 per day.

3. Physicians are increasingly involved in administrative duties. As physician employment seeks to align providers more closely with hospital initiatives, physicians are increasingly expected to dedicate some time to administrative duties, says Mr. Folk. The trend has only increased as the physician population ages and older physicians look to move away from clinical duties to physician executive or management positions. Ms. Welch cautions physicians to look carefully at their employment contracts to ensure they are receiving fair market value compensation for their duties “above and beyond” clinical practice, which the hospital may consider part and parcel of their employed compensation. “The hospital is going to be asking or expecting the physicians to do certain things above and beyond as it relates to strategic planning, service line management or on-call coverage,” she says. “That should come with additional compensation and fair market values that would have to be separate from [base compensation].”

Compensation for medical directorships — an increasingly common position for physicians looking to fulfill administrative duties — varies widely based on specialty, according to MGMA’s Medical Directorship and On-Call Compensation Survey. According to the study, the majority of participants reported median annualized compensation levels of less than \$50,000, with only four specialties reporting levels of more than \$50,000. The lowest annualized compensation was reported by internists and pediatricians at \$7,500.

4. Subspecialty and practice size continue to impact pay. Mr. Folk says hospital-employed compensation arrangements can vary greatly based on subspecialty and practice size, as both factors impact how the hospital can expand its ancillary services. “The type of ancillary services you can pack into a physician practice obviously varies by specialty,” Mr. Folk says. “I’ll give you an example: Earlier in the year and late last year, cardiologists were really hurting because their reimbursement under Medicare Part B got cut so drastically, so a lot of groups around the country contacted their local CEO and said, ‘You’ve got to help me or you’re not going to have cardiology at the hospital anymore.’” He says the cardiologists could move their practice ancillary tests into the hospital, where the hospital could receive higher reimbursement for a test than the physician could have received in his individual practice. While the physicians could not share in that ancillary income after the machine was part of the hospital, the revenues could contribute to the sale price of the practice.

Physician compensation can also be affected by the size of a group practice, Mr. Folk says. “Going forward, doctors in a group practice generally fare better under employment with a hospital than the individual physician who operates a physician office in a strip mall,” he says. “Because of what the acquiring entity can do to augment practice revenue by adding ancillary tests, the hospital can share some of that revenue with doctors.” He says the addition of ancillary equipment is more difficult in a small, solo practice with limited space.

5. Hospitals guarantee compensation for up to five years. When hospitals acquire physician practices, they generally guarantee compensation for 2-3 years, according to Mr. Folk. “Obviously the hospitals want to keep the guarantee as low as possible and for the shortest amount of time,” Mr. Folk says. This hesitance to guarantee compensation long-term is due to the uncertainty of reimbursement over the next several years, he says. Fair market valuations are usually unable to predict more

than five years into the future because changes to managed care rates are unpredictable. “We know there are anticipated changes in reimbursement coming from the government, and when there are changes in government reimbursement, there will be changes in managed care rates,” Mr. Folk says. Because of this, compensation levels for hospital-acquired physicians may change significantly over the next several years as reimbursement rates are affected by changes to Medicare. ■

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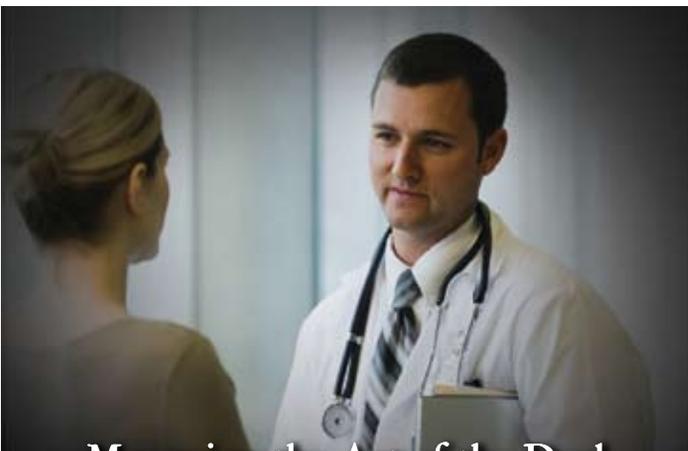
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Trends in Physician-Generated Revenue From 2002-2010

By Rachel Fields

Physician-generated revenue fluctuates as reimbursement levels change, physician shortages impact provider market share and case volume shifts based on economic factors and procedural trends. Here are several trends in physician-generated revenue from 2002-2010, based on data and conclusions from Merritt Hawkins' 2010 *Physician Inpatient/Outpatient Revenue Survey*.

Editor's note: In this survey, hospital CFOs were asked to indicate the combined net inpatient and outpatient revenue generated annually for their facilities by a single, full-time equivalent physician in a variety of specialties through procedures performed through the hospital, tests and treatments ordered, etc. In the case of primary care physicians, survey respondents were asked to determine revenue from direct admissions, procedures performed and lab tests — not indirect revenue primary care physicians may have generated from patient referrals to specialists utilizing the hospital.

Trends in physician-generated revenue

Net annual income generated by physicians has fluctuated over the past eight years, with average 2010 annual net revenue generated by all 17 reported specialties sitting at \$1,543,788 in 2010. This represents a small increase of 3 percent over average annual net revenue generated by all specialties in 2007 (\$1,496,432), a decline of 19 percent from the average annual net revenue generated by all specialties in 2004 (\$1,855,773) and a relatively similar number to the average annual net revenue generated by all specialties in 2002 (\$1,540,181). Approximately \$1.5 million has proven to be a benchmark number for revenue generated by all physician specialties over the last eight years, according to Merritt Hawkins, as three of the four surveyed years produced an average total revenue of close to \$1.5 million.

Despite the recession, the Merritt Hawkins survey found that average net revenue increased in 2010 over 2007 — an interesting finding considering that CFOs participating in the 2010 survey were asked to provide revenue numbers generated by physicians during a period of severe economic recession. While the recession did not appear to take a toll on generated revenue overall, the survey concluded that for some specialties — for example, internal medicine — the recession had an effect. It is possible that general internists, who generally treat a patient population with a high percentage of indigent, geriatric and other poor-paying patients, saw

less revenue during the recession as internists were unable to make up for poor payor mix by providing extra services.

While revenue generated by some specialists decreased in 2010, other specialists saw an increase. For example, pediatricians experienced a revenue increase, a trend that Merritt Hawkins attributed to the expansion of health insurance for children. General surgeons also saw an increase in 2010, perhaps due to the growing shortage of general surgeons. As fewer medical students choose to pursue general surgery, per-physician caseloads could be increasing and driving up per-physician generated revenue, according to the report.

The survey also concluded that the increase in generated revenue could reflect the strengthening bond between physicians and their affiliated hospitals. As more physicians seek hospital employment, physicians may be driving more patients and more work to the hospital rather than to other facilities, such as physician-owned ambulatory surgery centers.

Statistics on physician-generated revenue and compensation

The following data demonstrates trends in physician-generated revenue over the last eight years, as well as the level of compensation physicians receive in comparison to the revenue they generate. Compensation data comes from Merritt Hawkins' 2009 *Review of Physician Recruiting Incentives*.

Neurosurgery

Average 2010 revenue: \$2,815,650
Average 2007 revenue: \$2,100,000
Average 2004 revenue: \$2,406,275
Average 2002 revenue: \$2,364,864

Average salary: \$571,000

Invasive cardiology

Average 2010 revenue: \$2,240,366
Average 2007 revenue: \$2,662,600
Average 2004 revenue: \$2,490,748
Average 2002 revenue: n/a

Average salary: \$475,000

Orthopedic surgery

Average 2010 revenue: \$2,117,764
Average 2007 revenue: \$2,312,168
Average 2004 revenue: \$2,992,022
Average 2002 revenue: \$1,855,944

Average salary: \$481,000

General surgery

Average 2010 revenue: \$2,112,492
Average 2007 revenue: \$1,947,934
Average 2004 revenue: \$2,446,987
Average 2002 revenue: \$1,835,470

Average salary: \$321,000

Internal medicine

Average 2010 revenue: \$1,678,341
Average 2007 revenue: \$1,987,253
Average 2004 revenue: \$2,100,124
Average 2002 revenue: \$1,569,000

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5 Trends Impacting Physician On-Call Compensation

By Rachel Fields

In the last decade, physicians have increasingly expected their affiliated hospitals to provide compensation for on-call coverage, payments that vary by region, physician specialty and local provider shortages. Here are five trends affecting physician on-call compensation in hospitals.

1. On-call pay expenditures have increased. According to Sullivan, Cotter and Associates' *2010 On-Call Pay Survey Report*, 55 percent of survey participants reported their physician on-call pay expenditures had increased in the past 12 months. From 2007-2010, median on-call expenditures reported by trauma centers more than doubled, from \$1.2 million in 2007 to \$2.4 million in 2010. Non-trauma centers also reported an increase, though a less substantial one: Median on-call pay expenditures increased from \$433,849 in 2007 to \$798,000 in 2010.

2. More physicians expect on-call pay than in previous years. According to Kim Mobley, managing principal with Sullivan, Cotter and Associates, the increase in on-call pay expenditures can be partially attributed to the expectation of on-call pay among physicians. The majority (95 percent) of survey participants reported providing on-call pay to at least some non-employed physicians with admitting privileges, and 65 percent reported providing on-call pay to their employed physicians.

Ms. Mobley says expectations around on-call pay have changed over the last decade. While historically physicians were expected to provide call coverage as part of their affiliation with the hospital, physicians are now asking for extra compensation to treat patients outside clinic hours. Ms. Mobley adds that some hospitals have started paying for excess call only, a seeming compromise between the extremes of no compensation and payment for every case. According to the Sullivan, Cotter and Associates survey, around 27 percent of survey participants indicated they use only excess call to pay for coverage.

"For example, [the hospital] would expect a physician to provide so many shifts per month of call coverage, and beyond that, you get the pay," Ms. Mobley says. This arrangement benefits physicians who take call coverage "above and beyond" the expected amount, such as physicians in communities where a shortage of a certain specialty exists.

3. On-call pay depends on physician specialty and shortage. The level of on-call pay depends on physician specialty as well as the number of available physicians in the community. Medical Group Management Association's *Medical Directorship and On-Call Compensation Study: 2011 Report Based on 2010 Data* found that invasive cardiologists reported the highest median daily rate of on-call compensation, at \$1,600 per day on call. General surgeons earned a median of \$1,150 per day, while urologists clocked in at \$520 per day for on-call coverage.

The Sullivan, Cotter and Associates survey also found a significant difference between physician specialty, with a reported median hourly on-call pay rate for stroke neurologists sitting at \$20.83 compared to \$12.50 for ophthalmologists. Ms. Mobley says the difference in pay can be attributed to the amount of call coverage required and the likelihood of being called in. "If you think of a trauma surgeon, when they're on call, there's a pretty good likelihood they'll be called in to provide services relative to perhaps a gastroenterologist or urologist," she says. This also means the level of on-call pay does not necessarily correlate to a specialty's annual average compensation, hence the low rate of \$12.50 per hour for ophthalmologists.

Call coverage payments will also be higher in communities where specialists are in high demand, Ms. Mobley says. A physician who knows he is the only neurosurgeon in a community can demand higher compensation levels because the hospital requires his services to treat emergency stroke patients, for example.

4. Payor reimbursement and type of facility affect pay levels. Payor mix and facility type affect on-call coverage compensation, as physicians are likely to want more payment if they know their reimbursement will be limited. If a physician is providing call to an urban trauma center with an underserved population, he or she may expect a higher on-call pay stipend because reimbursement for the population is lower. In this case, compensation levels will be determined through benchmarking against facilities with similar payor mixes.

5. Payment for telephonic coverage is increasing. In some cases, a physician's consult may be more important than his or her presence at the hospital. According to the Sullivan, Cotter and Associates report, 15 percent of organizations said they provide telephonic call coverage to physicians who are not required to be at the hospital. Unsurprisingly, the decreased strain on the physician providing telephonic call coverage means payments are lower: Around 20 percent of organizations reported they only pay a portion — typically 55 percent — of the normal unrestricted on-call rate, which is typically 55 percent. ■

Medical Directorship Compensation Varies Based on Specialty

By Rachel Fields

Compensation for medical directors varies widely across specialties, with the lowest annualized compensation reported by internists and pediatricians at \$7,500, according to Medical Group Management Association's *Medical Directorship and On-Call Compensation Survey: 2011 Report Based on 2010 Data*.

According to the survey, the majority of participants reported median annualized compensation levels of less than or equal to \$50,000. Only four specialties reported annualized compensation of more than \$50,000.

Compensation also varied by practice ownership. For example, radiologists and neurologists reported greater annualized compensation in non-hospital-owned practices, and family practitioners with and without obstetrics reported greater annualized compensation in hospital-owned practices. Most medical directors spent four to six hours per week on directorship duties, which included developing policies and procedures, attending meetings, clinical peer review, community relations and strategic development. ■

100 Statistics on Physician Compensation

Here are 100 statistics on physician compensation, according to various reports.

Anesthesiologists

Median salary¹: \$370,500

Hospital-owned salary²: \$387,343

Non-hospital owned salary: \$428,580

Male anesthesiologists³: \$335,000

Female anesthesiologists: \$275,000

Highest-paying U.S. region: Southeast (\$340,000)

Lowest-paying U.S. region: Southwest (\$311,000)

Income offered upon recruitment⁴: \$331,000

Emergency medicine physicians

Median salary: \$267,293

Hospital-owned salary: \$258,461

Non-hospital owned salary: \$272,274

Male emergency medicine physicians: \$263,000

Female emergency medicine physicians: \$217,975

Highest-paying U.S. region: South Central (\$314,000)

Lowest-paying U.S. region: Northeast (\$228,000)

Income offered upon recruitment: \$247,000

Family medicine physicians (without OB)

Median salary: \$208,861

Hospital-owned salary: \$183,152

Non-hospital owned salary: \$185,234

Male family medicine physicians: \$165,000

Female family medicine physicians: \$130,000

Highest-paying U.S. region: North Central (\$176,000)

Lowest-paying U.S. region: Southwest (\$140,000)

Income offered upon recruitment: \$175,000

Gastroenterologists

Median salary: \$405,000

Hospital-owned salary: \$484,275

Non-hospital owned salary: \$461,640

Highest-paying U.S. region: North Central (\$542,500)

Lowest-paying U.S. region: Northeast (\$248,000)

General surgeons

Median salary: \$357,091

Hospital-owned salary: \$339,700

Non-hospital owned salary: \$333,497

Male general surgeons: \$300,000

Female general surgeons: \$261,000

Highest-paying U.S. region: North Central (\$341,579)

Lowest-paying U.S. region: Northwest (\$257,500)

Income offered upon recruitment: \$314,000

Internal medicine physicians

Median salary: \$214,307

Hospital-owned salary: \$197,756

Non-hospital owned salary: \$195,883

Male internal medicine physicians: \$188,000

Female internal medicine physicians: \$160,000

Highest-paying U.S. region: West (\$188,000)

Lowest-paying U.S. region: Northeast (\$150,000)

Income offered upon recruitment: \$191,000

Invasive cardiologists

Median salary: \$402,000

Hospital-owned salary: \$570,007

Non-hospital owned salary: \$414,752

Male cardiologists: \$340,000

Female cardiologists: \$249,000

Highest-paying U.S. region: Northwest (\$477,500)

Lowest-paying U.S. region: Mid-Atlantic, Northeast and West (\$275,000)

Income offered upon recruitment: \$495,000

Neurologists

Median salary: \$236,500

Hospital-owned salary: \$240,899

Non-hospital owned salary: \$234,653

Male neurologists: \$207,000

Female neurologists: \$174,750

Highest-paying U.S. region: Southeast (\$225,000)

Lowest-paying U.S. region: West (\$165,000)

Income offered upon recruitment: \$281,000

OB/GYNs

Median salary: \$275,152

Hospital-owned salary: \$288,922

Non-hospital owned salary: \$276,600

Male OB/GYNs: \$245,000

Female OB/GYNs: \$200,000

Highest-paying U.S. region: North Central (\$290,000)

Lowest-paying U.S. region: Northeast (\$210,000)

Income offered upon recruitment: \$272,000

Pediatric physicians

Median salary: \$209,873

Hospital-owned salary: \$195,707

Non-hospital owned salary: \$188,904

Male pediatric physicians: \$170,000

Female pediatric physicians: \$135,000

Highest-paying U.S. region: North Central (\$158,000)

Lowest-paying U.S. region: Northeast (\$135,000)

Income offered upon recruitment: \$180,000

Ophthalmologists

Median salary: \$238,200

Hospital-owned salary: \$338,635

Non-hospital owned salary: \$338,208

Male ophthalmologists: \$285,000

Female ophthalmologists: \$200,000

Highest-paying U.S. region: Great Lakes (\$333,000)

Lowest-paying U.S. region: Southwest (\$170,000)

Orthopedic surgeons

Median salary: \$500,672

Hospital-owned salary: \$516,413

Non-hospital owned salary: \$452,128

Male orthopedic surgeons: \$362,000

Female orthopedic surgeons: \$276,000

Highest-paying U.S. region: North Central (\$537,500)

Lowest-paying U.S. region: West (\$250,000)

Income offered upon recruitment: \$519,000

Urologists

Median salary: \$222,920

Hospital-owned salary: \$410,045

Non-hospital owned salary: \$387,397

Male urologists: \$310,000

Female urologists: \$170,000

Highest-paying U.S. region: South Central (\$357,500)

Lowest-paying U.S. region: Southwest (\$265,000)

Income offered upon recruitment: \$400,000

Footnotes

1. Information on median salary comes from the AMGA Medical Group Compensation and Financial Survey.
2. Information on hospital-owned and non-hospital owned physician salaries comes from Medical Group Management Association's *Physician Compensation and Production Survey: 2010 Report Based on 2009 Data*.
3. Information on salary by gender and region comes from Medscape's *Physician Compensation Report 2011*.
4. Information on income offered upon recruitment comes from Merritt Hawkins' *2010 Review of Physician Recruiting Incentives*.



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9 Leading Hospital CEOs Share Advice for Fellow Hospital Leaders

By Sabrina Rodak



Michael J. Dowling, President and CEO, North Shore-Long Island Jewish Health System, Great Neck, N.Y. “Leadership is always about promoting change. Be transformative, look to the future and be a leading change agent. As healthcare leaders, we should take the position as a leader should: that we have to transform the delivery system. We have to do things very differently than we did in the past, and that has to come directly from the CEO.” To transform the system, Mr. Dowling says leaders cannot

be limited by previous practices or philosophies. “Forget some of the past. Forget the way it was. Break new ground; be optimistic, upbeat and positive.” Helping to build a new healthcare system demands leaders take risks, Mr. Dowling says. “Take some bold steps and take some risks. You can’t be so nervous about failure.” Mr. Dowling says the future offers many opportunities for leaders to make positive changes in the healthcare system. “The next ten years are going to be very exciting. It’s a good time to be in healthcare — take advantage of it. It’s not a time to be pessimistic at all.”



Alexander J. Hatala, FACHE, President and CEO, Lourdes Health System, Camden, N.J.

Mr. Hatala gives three points of advice to hospital CEOs: Be flexible, build relationships and stay mission-focused. “Being a hospital CEO is not for the faint of heart,” he says. “When it comes to healthcare, every day is a new challenge with a new set of rules and regulations, all of which makes an impact on your organization. Being open to change will allow you to make your organization more successful at doing

what it does best.” Mr. Hatala’s second advice centers on relationship-building. “At its core, healthcare is still a ‘people business.’ I encourage all CEOs to create a sense of community by building relationships not only with physicians, nurses and leadership, but with front line staff who are the ‘face’ of your organization. I make a point to learn people’s names. It means a lot and encourages a ‘team’ attitude within the organization.” Thirdly, he suggests hospital CEOs focus on their mission. “At the end of the day, you should always ask yourself, ‘Have I stuck to my mission?’ You should always be able to answer ‘yes.’”



Robert J. Laskowski, MD, MBA, President and CEO, Christiana Care Health System, Wilmington, Del. “Focus on the mission. It’s

easy to get lost in important issues that relate to finances. The basic fact, though, is that the public values health systems for the work our colleagues do in taking care of them. If we stay true to [the hospital’s mission], it not only simplifies decision making, but also acts as a robust strategy to continue to have support that the public currently

has for hospitals and health systems. Keep the fundamental reason why we exist in front of us to help as we get buffeted around by other things.”

Steven L. Mansfield, PhD, FACHE, President and CEO, Methodist Health System, Dallas.

“Be positive, enthusiastic and encouraging as you visibly prepare your organization for the changes ahead for healthcare. There is power in focusing on the opportunities change presents and our organizations need to hear their leaders assure them of our strategy for succeeding in a new paradigm. Personally, I know we can do a better job of healthcare delivery and population health management. Those of us in healthcare leadership owe this to America and I am delighted to be part of the transformation.”

Vincent J. McCorkle, President and CEO, Akron (Ohio) General Health System.

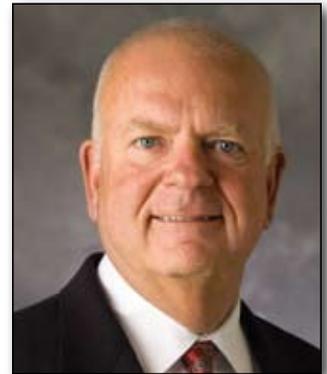
“First, always take your role as CEO and the trust that has been placed in you seriously, but never take yourself too seriously. Second, always remember saying isn’t doing and whatever you do is not only a reflection on yourself and your family, it is a reflection on your organization.”

William A. McDonald, President and CEO, St. Joseph’s Healthcare System, Paterson, N.J.

“Turn operations back over to the clinicians. Deeply involve them in strategy, operations and the results from all their efforts.” He says engaging clinicians in operations makes the hospital “a lot happier place for people to be.” One initiative at St. Joseph’s Healthcare System is improving the clinical service lines. They evaluated the strengths and weaknesses of the service lines, and then included clinicians, managed care professionals and other stakeholders in forming a strategic plan. Through this process, St. Joseph’s was able to successfully expand their orthopedics program to meet the community’s needs.

Charles O’Brien, MD, President, Sanford USD Medical Center, Sioux Falls, S.D.

“Stay patient-focused. The affordable healthcare act gave us a big opportunity to change the cost curve, but we have to at the same time continue to think of the





patients' viewpoint, comfort, experience and expectations." At Sanford USD Medical Center, Dr. O'Brien says they maintain a focus on the patient by "hardwiring" the patients' perspective into every judgment they make. They also include people in decision-making that represents patients' interests.

Amir Dan Rubin, President and CEO, Stanford (Calif.) Hospital & Clinics. "Show true passion, interest and concern for patients, visitors, physicians, staff and community members. To best

serve, try to put yourself in the position of others to best see the world through their eyes."

Sister Mary Jean Ryan, FSM, Chair and CEO, SSM Health Care System, St. Louis. "The best advice I can give to any hospital leader is to keep in mind that it is all about patients. It's why we exist. If we are to be leaders with integrity, it is our obligation to remain faithful to the fact that we must deliver care breathtakingly better than it's ever been before. We should never settle for less than the very best in patient care, and hospital leadership should constantly encourage our partners — employees and physicians — to improve, so that the care hospitals deliver is consistently exceptional in every way." ■



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65 Great Community Hospitals

By Molly Gamble

65 Great Community Hospitals

Becker's Hospital Review has named the 65 great community hospitals, presented in alphabetical order. *Note:* These hospitals include fewer than 550 patient beds and have minimal teaching programs. Hospitals appearing on America's 50 Best Hospitals are not featured on this list.

- American Fork (Utah) Hospital.
- Augusta Health (Fishersville, Va.).
- Aurora BayCare Medical Center (Green Bay, Wis.)
- Baptist Easley (S.C.) Hospital
- Baptist Medical Center East
- Bay Medical (Panama, Fla.)
- Beverly (Mass.) Hospital
- Bon Secours – St. Francis Hospital (Greenville, S.C)
- Cape Cod Hospital (Hyannis, Mass.)
- Carolinas Medical Center – Northeast (Concord, N.C.)
- Chandler (Ariz.) Regional Medical Center
- Chelsea (Mich.) Community Hospital
- Dixie Regional Medical Center (Saint George, Utah)
- Downtown Naples (Fla.) Hospital Campus
- DuPont Hospital (Fort Wayne, Ind.)
- Edward Hospital (Naperville, Ill.)
- The Finley Hospital (Dubuque, Iowa)
- Flaget Memorial Hospital (Bardstown, Ky.)
- Fort Madison (Iowa) Community Hospital
- Franciscan St. Francis Health — Indianapolis.
- Gaston Memorial Hospital (Gastonia, N.C.)
- Holland (Mich.) Hospital
- Howard County General Hospital (Columbia, Md.)
- Hudson Valley Hospital Center (Cortlandt Manor, N.Y.)
- Jackson Purchase Medical Center (Mayfield, Ky.)
- John Muir Medical Center (Walnut Creek, Calif.)
- King's Daughter Medical Center (Ashland, Ky.)
- Lancaster (Pa.) General Hospital.
- Lynchburg (Va.) General Hospital
- Major Hospital (Shelbyville, Ind.)
- Martin Memorial Medical Center (Stuart, Fla.)
- Meadows Regional Medical Center (Vidalia, Ga.)
- Memorial Hermann Katy (Texas) Hospital
- Memorial Hospital West (Pembroke Pines, Fla.)
- Memorial Regional Medical Center (Mechanicsville, Va.)
- Mercy Hospital Clermont (Batavia, Ohio)
- Methodist Medical Center (Peoria, Ill.)
- Middlesex Hospital (Middletown, Conn.)
- Minden (La.) Medical Center
- Newton-Wellesley Hospital (Newton, Mass.)
- Paoli (Pa.) Hospital
- Parkview Huntington (Ind.) Hospital
- Parma (Ohio) Community General Hospital
- Penrose-St. Francis Health Services (Colorado Springs, Colo.)
- Piedmont Fayette Hospital (Fayetteville, Ga.)
- Riverside Medical Center (Kankakee, Ill.)
- Robinson Memorial Hospital (Ravenna, Ohio)
- Russell Medical Center (Alexander City, Ala.)
- Rutherford (N.C.) Regional Medical Center
- Sacred Heart Hospital (Eau Claire, Wis.)
- Saddleback Memorial Medical Center (Laguna Hills and San Clemente, Calif.)
- Saint Patrick Hospital and Health Sciences Center (Missoula, Mont.)
- Scottsdale (Ariz.) Shea Medical Center
- Skyline Medical Center (Nashville, Tenn.)
- St. Elizabeth Boardman Health Center (Youngstown, Ohio)
- St. Elizabeth Community Hospital (Red Bluff, Calif.)
- St. Elizabeth Edgewood (Ky.)
- St. Elizabeth Regional Medical Center (Lincoln, Neb.)
- St. Luke's Hospital (Cedar Rapids, Iowa)
- St. Vincent Carmel (Ind.)
- Stonecrest Medical Center (Smyrna, Tenn.)
- Thibodaux (La.) Regional Medical Center.
- Venice (Fla.) Regional Medical Center
- Woodwinds Health Campus (Woodbury, Minn.)
- Wooster (Ohio) Community Hospital

8 Out-of-the-Box Ways Hospitals Can Cut Costs

By Molly Gamble

Creative cost-cutting is more than alliteration. It can bolster an organization's bottom line, enhance engagement and increase operational efficiency. Thriftiness is not unique to any business, but hospitals face a particularly pressing question: how do they save costs while preserving patient safety and quality of care?

Fortunately, other hospitals are leading by example, revealing lesser-known opportunities for hospitals to save. Some ideas involve a minor tweak to supplies; others require a change in mindset. All, however, serve as inspiration to look within your organization and find the dead weight. Here are eight ideas on methods for hospitals to creatively cut costs and become a fitter workplace.

1. Cut food waste in half by weighing it.

Six Iowa Health System hospitals identified cost-saving opportunities in their kitchens. The hospitals adopted a program to reduce the amount of unused food thrown away, an effort that has sparked lively staff collaboration. By partnering with a food waste tracking company, the hospitals installed ValuWaste tracking systems. Before throwing food away, kitchen staff weighed its submitted reasons for disposal. Staff then tracked the information and adjusted production practices accordingly. Even more impressive, for both financial and economical reasons, is the amount of food saved: Iowa Methodist Medical Center and Iowa Lutheran Hospital in Des Moines, Iowa, have cut their food waste in half since adopting the program in Jan. 2008.

2. Properly sort hazardous from non-hazardous waste.

Approximately 70 percent of hospital waste stems from operating rooms and labor-delivery suites, according to Johns Hopkins researchers. One strategy to cut waste while preserving patient safety is for hospitals to become more stringent when segregating operating room waste. Johns Hopkins researchers say up to 90 percent of red-bagged material, or pathologic waste, does not meet criteria for red-bag waste, which is much more costly to process. By properly separating hazardous from non-hazardous waste, hospitals can decrease waste volume by 30 percent. Washing and reusing surgical scrubs and jackets is another change that can reduce medical waste by up to 20 percent, according to Johns Hopkins researchers.

3. Consider the financial benefits of a smoke-free workplace.

It's a trend sweeping the hospital industry, with some organizations even shifting to smoker-free employment policies. Controversy aside, a nicotine habit does detract from a hospital's bottom line. About one in five Americans smoke, and employees who smoke cost an average

of \$3,391 more per year due to healthcare costs and lost productivity, according to a *New York Times* report. Along with promoting a healthy lifestyle, hospitals may want to consider the financial benefits of adopting a smoke-free campus.

4. Reassess administrative costs.

Since hospitals are facing constrained resources, they do not spend as much time looking at administrative costs. "Hospitals are spending millions on these costs," says Bart Richards, a managing director with The Claro Group, a business consulting firm. Like any commercial entity, hospitals have banking relationships, which can be a source of cost-trimming. "If you can go to the banks in a very focused manner and apply good negotiation techniques, you can reach better deals than what you have in place. Also, this won't directly affect patient care," says Mr. Richards. Other administrative costs that may be trim-worthy include document management. "IT is a great example," says Mr. Richards. "Large organizations spend a lot on IT. To make costs more variable, hospitals may want to consider outsourcing an IT department." Paper management is also an issue: for every dollar a hospital spends on printing, it takes another \$9 to maintain it, according to Pamela Morin of Reliable Technologies. Hospitals may want to consider a managed print services plan, which addresses all costs associated with printers, such as maintenance kits, technician labor and parts.

5. Save money lost on denied claims by making changes over the weekend.

Since denied claims involve real dollars, hospitals may want to examine and categorize them more closely. Jay Arthur, author of *Lean Six Sigma for Hospitals*, helped a hospital save \$380,000 a month by categorizing lost claims. His team first identified the largest group of denied claims: those denied for lack of timely filing within 45 days. He then categorized claims by insurer to find one small insurer accounting for 64 percent of denied claims. With these two findings, the hospital instituted changes over the weekend that eventually helped them save a significant amount of money per month.

6. Make smart switches.

Sacred Heart Hospital in Eau Claire, Wis., made a series of small swaps to save big bucks. By switching from bottled soda to fountain drinks in the physicians' lounge, the 344-bed hospital saved \$24,000 in one year. The hospital saved \$50,000 more by switching its subscriptions to medical and education journals from print to online. Finally, by switching to a new vendor, Sacred Heart saved \$15,000 in one year on trash can liners. The hospital was able to trim costs without interfering with patient safety or employee satisfaction, as

the same materials, services and supplies were still available.

7. Standardize and centralize operating and supporting functions.

Sometimes going back to the basics can be one of the most innovative strategies of all. "Although hospitals and systems formed with the intention of integrating and reducing costs, redundancies often remain in multi-hospital systems," says Joe Kuehn, partner with KPMG LLP's Performance and Technology services advisory practice, who focuses on healthcare. Health systems often do not realize the amount of redundant technology, business processes and organizational structures are still in place within and across their member hospitals. Even standardizing and reducing the number of supply and service vendors remains an opportunity at many hospitals and health systems. Healthcare providers also have additional opportunities to centralize operational and clinical functions, such as nurse scheduling and transcription. "I'd recommend hospital leaders take an internal view and examine three or four different functions in the hospital, says Mr. Kuehn. For example, he suggests hospitals consider how many vendors they use and for what products and services. Can the number of vendors be consolidated and pricing and other terms improved? "By assessing a system's ability to standardize, centralize and eliminate redundancies, hospitals are able to reduce wasted spending and standardize operations," says Mr. Kuehn.

8. Reward and recognize employee ideas for savings.

In 1998, Indiana University Health Goshen kicked off a program called The Uncommon Leader, where colleagues (the hospital's preferred title for hospital staff and employees) submit ideas to improve quality, save costs, generate revenue and improve patient care as part of their annual review. Colleagues then receive a certain percentage of the savings generated by their idea. Since the program began, the hospital has generated more than \$35 million in gain share and cost-cutting ideas. It saved \$6.3 million in 2010 alone. Ideas submitted include changing the type of napkins used on patient trays (saved \$4,000), switching from disposable paper gowns to cloth gowns for patients in the GI department (saved \$22,000) and ordering a large quantity of a generic drug being discontinued to delay the purchase of a higher-cost name brand drug (saved \$460,000). Indiana University Health Goshen's CEO, Jim Dague, says the daily focus on efficiency has strengthened the hospital's adaptability in the wake of healthcare reform, and the hospital has not laid off a "colleague" in 17 years. ■

Becker's Hospital Review Annual Meeting

May 19-20, 2011

On May 19-20, nearly 400 hospital leaders and industry representatives gathered at the Palomar Hotel in Chicago for the second annual Becker's Hospital Review Annual Meeting – ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties.



Wayne Lerner discusses physician alignment challenges at Holy Cross while Benjamin Cutler [left] and Steven Goldstein [right] look on.

Moderator Chuck Lauer introduces the panel.



Attendees listen intently to the panel.

Over the two days, attendees participated in more than 50 sessions featuring nearly 80 different speakers including keynote speakers **Charles "Chip" N. Kahn III**, president of the Federation of American Hospitals, the national advocacy organization for investor-owned hospitals and health systems; **Peter Kongstvedt, MD**, principal of the P.R. Kongstvedt Company and a senior health policy faculty member in the Department of Health Administration and Policy, College of Health and Human Services at George Mason University; and **Richard J. Pollack**, executive vice president of advocacy and public policy for the American Hospital Association. A feature panel moderated by **Chuck Lauer**, former publisher of Modern Healthcare, titled "The Best Thoughts on Physician Alignment" was also a highlight. Panelists included **Benjamin M. Cutler**, chairman and CEO, USHEALTH Group; **Joseph A. Scopelliti, MD, Co-CEO**, medical affairs, Guthrie Health System and president and CEO, Guthrie Clinic in Sayre, Pa.; **Steven Goldstein**, president and CEO, Strong Memorial Hospital in Rochester, N.Y.; and **Wayne Lerner**, president and CEO, Holy Cross Hospital in Chicago.

In the session leaders shared their thoughts on encouraging physician involvement and engagement as a key to aligning hospital and physician interests to succeed post-healthcare reform.

Next year's Becker's Hospital Review Annual meeting is scheduled for May 17-18 at the Allegro Hotel in Chicago.

Joseph Scopelliti addresses the audience.





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- 1) Benefit from the combined efforts of Becker's ASC Review/ASC Communications and the Ambulatory Surgery Foundation to attract attendees and speakers that are among the smartest people in the ASC industry today.
- 2) Take discussion and thinking to the highest levels, focusing on the physician-owners, medical directors, ASC administrators and business minded directors of nursing.
- 3) Access expert views from all sides of the ASC world.

PROGRAM SCHEDULE

Pre Conference – Thursday October 27, 2011

11:30am – 1:00pm	Registration
1:00pm – 5:30pm	Pre-Conference
5:30pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Main Conference – Friday October 28, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:05pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:05pm – 6:30pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 29, 2011

7:00am – 8:10am	Continental Breakfast
8:10am – 12:20pm	Conference

Thursday, October 27, 2011

1:00 – 1:40 pm

A. Key Concepts to Fixing Physician Hospital Joint Ventures Gone South

Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, ASCOA

B. Business Planning for Orthopedic and Spine Driven Centers

Jeff Leland, CEO, Blue Chip Surgical Center Partners

C. Benchmarking for GI Centers

Barry Tanner, President & CEO, John Poisson, EVP, New Business Development, and Karen Sablyak, CPA, EVP Management Services, Physicians Endoscopy

D. How Do You Value Your ASC For Sale? What is the Value in a Majority Sale Transaction? Can Hospitals Pay More if They can Convert to an HOPD or Apply Managed Care Contracts? What is the Value in a Sale of a Small Percentage to a Physician?

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

E. Managed Care Negotiation Strategies - Using Transparency and Case Data to Show Payers How ASCs Save Them Money

I. Naya Kehayes, MPH, CEO & Managing Principal, and Matt Kilton, MBA, MHA, Principal and Chief Operating Officer, EVEIA HEALTH Consulting and Management

F. Infection Control in ASCs - Best Practices and Current Ideas

Phenelle Segal, RN, CIC, President, Infection Control Consulting Services, LLC

1:45 – 2:25 pm

A. Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits

Rob Westergard, CPA, CFO, Susan Kizirian, COO, and Ann Geier, RN, MS, CNOR, CASC, Vice President of Operations, ASCOA

B. Developing a Spine Driven ASC: the Essentials for Success

Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

C. Ophthalmology, ENT and Podiatry in ASCs - Key and Thoughts and Trends

Jeff Peo, Vice President, Development & Acquisitions, ASCOA

D. Should You Sell Your ASC? - A Step by Step Plan for Selling Your ASC - How to Maximize the Price, Terms and Results and How to Handle the Process

Luke Lambert, CFA, MBA, CASC, CEO, ASCOA. Introduced by Scott Downing, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods, LLP

E. Should You Outsource Billing and Collections or Keep It in House?

Caryl Serbin, RN, BSN, LHRM, Executive Vice President and Chief Strategy Officer, Source-Medical Solutions, Revenue Cycle Solutions

F. Effective Clinical Benchmarking and Infection Control

Regina Robinson, Director, Peninsula Surgery Center

2:30 – 3:05 pm

A. 10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them

Reed Martin, Chief Operating Officer, Surgical Management Professionals

B. What Percentage of Key ASC Specialties Will be Employed by Hospitals Within 5 Years - Orthopedics, GI and Ophthalmology

Brian Mathis, Vice President, Strategy, Surgical Care Affiliates, Mike Lipomi, CEO, Surgical Management Professionals, Jimmy St. Louis, III, MBA, Chief Corporate Operations Officer, Laser Spine Institute and CEO, Advanced Healthcare Partners, and moderated by Amber McGraw Walsh, Partner, McGuire-Woods LLP

C. Ophthalmology in ASCs - Current Trends and Issues

Michael A. Romansky, JD, Washington Counsel, VP for Corporate Development, Outpatient Ophthalmic Surgery Society

D. Physician-Hospital Joint Ventures - How to Resolve Conflict and Keep the Venture Thriving

Dawn McLane, Regional VP, Health Inventures, and Tom Yerden, CEO, TRY Healthcare Solutions

E. Being a Great Administrator - Core Concepts to Develop Raving Physician Fans

Joe Zasa, JD, Managing Partner, ASD Management, and Stephanie Stinson, RN, BSN, CASC, Administrative Director, Strictly Pediatrics Surgery Center

F. How to Determine When To Go In-Network vs. Out-Of-Network

Rob Murphy, President, Murphy Healthcare Group

3:10 – 3:50 pm

A. Assessing the Future Demand for ASCs, A Panel Discussion

Barry Tanner, President & CEO, Physicians Endoscopy, Brian Mathis, Vice President Strategy, Surgical Care Affiliates, and Vivek Taparia, Director of Business Development, Regent Surgical Health

B. Impact of Healthcare Reform on Physician Practices and ASCs

Charles "Chuck" Peck, MD, CEO, Health Inventures

C. Key Thoughts From Great Medical Directors - Managing Expenses and Managing Physicians

Alfred McNair, MD, Steve Schuelman, MD, and moderated by Nap Gary, Chief Operating Officer, Regent Surgical Health

D. Anti-Kickback and Stark Act Compliance - Common Issues for ASCs

Scott Becker, JD, CPA, Partner, Melissa Szabad, JD, Partner, and Lainey Gilmer, Associate, McGuireWoods LLP

E. What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements Valuation and Other Issues

Jen Johnson, CFA, Managing Director, VMG Health

F. Meaningful Use, EMR and Other Key IT Issues for ASCs

Marion K. Jenkins, PhD, FHIMSS, Founder, CEO, QSE Technologies, Scott Palmer, President & COO, Ambulatory Surgery Center Division, SourceMedical Solutions, Jeff Blankinship, President & CEO, Surgical Notes, Faris Zureikat, Administrator, North Texas Surgery Center, USPI, Holly Carnell, Associate, McGuireWoods LLP

3:55 – 4:30 pm

A. Orthopedics and Spine - Physician Payor Relationships and Evolving Changes

John Cherf, MD, MPH, MBA, President, OrthoIndex, Steven H. Stern, MD, MBA, Vice President, Cardiac & Orthopaedics/Neuroscience, and Michael R. Redler, MD, The OSM Center, moderated By Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Private Equity's Role in and View of the ASC Market

Joe Clark, EVP & Chief Development Officer, Surgical Care Affiliates, David F. Bacon, Jr., CEO, Meridian Surgical Partners, Geoffrey C. Cockrell, Partner, McGuireWoods LLP

C. Revenue Capture for Endoscopy Centers - Best Practices and Great Ideas

Linda K. Peterson, CEO, Executive Solutions for Healthcare

D. ASC Litigation - Can Non-Competes be Enforced? What to Do When the FBI or OIG Calls? How to Work with Payors

Jeffrey C. Clark, Partner, and David J. Pivnick, JD, BBA, Associate, McGuireWoods LLP

E. What is Great and What is not Great Physician Leadership for Your ASC

Brad Lerner, MD, Summit ASC

F. Evaluating the Return on Investment: Outsourcing Key Business Office Operations

Kim Woodruff, Vice President Corporate Finance & Compliance, PINNACLE III

4:30 – 5:30 pm

Climbing Up the Mountain - One More Time

Bill Walton, Former ABC, ESPN, NBC Basketball Announcer, Hall of Fame NBA Basketball Player

5:30 – 7:00,

Networking Reception, Raffles and Exhibits

Friday, October 28, 2011

8:00 am

Introductions

Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

8:10 – 8:45 am - KEYNOTE

The View from Washington: Politics, Healthcare Reform and the 2012 Election

Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

8:50 – 9:30 am – General Session

ASCs, Healthcare and Washington DC

Brent W. Lambert, MD, FACS, Principal & Founder, ASCOA, Tom Mallon, CEO Regent Surgical Health, Michael E. Russell, II, MD, President, Physician Hospitals of America, Texas Spine and Joint Hospital, Tom Price, MD, U.S. Congressman, Moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

9:35 – 10: 20 am - KEYNOTE

A. KEYNOTE - How the Best Managers use Recognition to Accelerate Performance

Adrian Gostick, Author and Global Thought Leader on Workplace Strategy

B. The ASC Association Legislative Priorities - and What We Will See for the Next Five Years

William Prentice, JD, Executive Director, and Steve Miller, Director of Government and Public Affairs, Ambulatory Surgery Center Association

C. How to Evaluate & Implement New Profitable Services into an ASC

Robert Zasa, MSHHA FACMPE, Founder, ASD Management, and Kenneth Austin, MD, Orthopedic Surgeon, Rockland Orthopedics and Sports Medicine

D. ACOs in Action

11:25 – 12:10 pm

A. The State of the Unions for ASCs

Andrew Hayek, President & CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee

B. Interventional Pain Management - What the Next Few Years Will Look Like

Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians

C. Hospital and Physician Alignment in the Wake of Healthcare Reform - The Expectations for the Next Five Years

Kate Lovrien, Senior Manager, Kurt Salmon and Associates

D. What are the Key Issues Facing Great ASC Administrators

Kara Vittetoe, Administrator, Thomas Johnson Surgery Center, Tracey Hood, Administrator, Ohio Valley Ambulatory Surgery Center, Brooke Smith, Administrator, Maryland Surgery Center for Women, and moderated by Susan Kizirian, COO, ASCOA

12:15 – 1:00 pm

A. Developing a Strategy for Your ASC

Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners, Mike Doyle, CEO, Surgery Partners, Richard E. Francis, Chairman & CEO, Symbion, Inc.

B. Endoscopy Centers - Key Trends and Issues

Barry Tanner, CEO, Physicians Endoscopy

C. Orthopedics and Spine in ASCs - Key Trends and Ideas

John D. Atwater, MD, Steven Hochschuler, MD, Texas Back Institute, Moderated by Jeff Leland, CEO, Blue Chip Surgical Center Partners

D. Anesthesia in ASCs

David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

E. Accreditation 101, Everything You Need to Know About Accreditation

Bernard McDonnell, DO, Healthcare Facilities Accreditation Program

1:00 – 2:00 pm

Networking Lunch & Exhibits

2:00 – 2:40 pm

A. The Best Ideas to Improve Volume and Profits

Bryan Zowin, President, Physician Advantage, Inc., John C. Steinmann, MD, Renovis Surgical Technologies, Robin Fowler, MD, Executive Director and Owner, Interventional Management Services, and Keith Metz, MD

B. ASC Turnaround Case Study, From Zero to Wow!

Joseph Zasa, JD, Managing Partner, ASD Management, and Daniel C. "Skip" Daube, Jr., MD, FACS, Founder, Surgical Center for Excellence, Panama City

C. Is There Still Room for Joint Venture ASCs in the Physician-Hospital Integration Tool Kit - The Pros and Cons to ASCs

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

D. Should You Sell Your Practice to a Hospital? What Will the Agreement Look Like? What are the Key Issues?

Kristin A. Werling, Partner, Geoffrey C. Cockrell, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods LLP

2:00 – 3:25 pm

E. Managed Care Contracting - 1) How Do You Align Your ASC with Physicians 2) Update on CMS Payment System and How it Impacts on Negotiations 3) Fee Schedule Numbers and Ensuring Revenue Collection from Contracts

I. Naya Kehayes, MHP, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management

2:00 – 2:40 pm

F. CMS Inspections Surveys; Are You Ready?

Tracy Hoeft-Hoffman, Administrator, Hastings Surgery Center

2:45 – 3:25 pm

A. The Best Ideas for Physician-Hospital Alignment

Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, Charles “Chuck” Peck, CEO, Health Inventures, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, Robert Boeglin, MD, President, IU Health Management, and moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Surgeon Hospital Partnerships Models

Jeff Simmons, Chief Development Officer, and Bo Hjorth, Vice President, Business Development, Regent Surgical Health

C. Developing an Outstanding ASC Quality Program That Can be Implemented and Makes a Difference

Linda Lansing, Senior Vice President of Clinical Services, Surgical Care Affiliates

D. Physician-Owned ASCs and Hospitals - The Best Strategies for the Next Five Years

Michael J. Lipomi, MSHA, President & Chief Executive Officer, Surgical Management Professionals

F. Governing Body Documentation, Meeting CMS and Accreditation Requirements

Sandra Jones, FHFMA, LHRM, CASC, Ambulatory Strategies, Inc.

4:00 – 4:30 pm

A. Extreme Makeover: Surgery Center Edition - Lessons Learned From a Dozen Turnaround Projects

Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgical Center Partners

B. Ophthalmology in ASCs, Key Issues

Edward Glinski, DO, Healthcare Facilities Accreditation Program

C. Endoscopy Centers - Taking Steps to Prepare an Endoscopy Center for Sale - How to Maximize Your Transaction

Jonathan Vick, President, ASCs, Inc.

D. Helping Large Specialty Physician Groups Navigate the Next Few Years

Marc Steen, Market President, USPI

E. Business and Financial Relationships with Hospitals - Co-Management, Joint Ventures and Employment - Key Valuation Issues

Todd J. Mello, ASA, AVA, MBA, Principal & Founder, HealthCare Appraisers, Inc.

F. Direct Marketing to Patients to Increase Case Volume

Jimmy St. Louis III, MBA, Chief Corporate Operations Officer, Laser Spine Institute and CEO, Advanced Healthcare Partners

4:35 – 5:05 pm

A. Q&A Panel: Will Evidence Based Medicine Kill Spine? Will Practice Acquisitions by Hospitals Kill ASCs? Should ASCs Employ Physicians? Where are the Profits in Pain Management?

Terry L. Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital, Thomas J. Pliura, MD, JD, PC, Physician & Attorney at Law, zChart, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

B. Physician-Owned Distribution Companies - Doing It The Right Way

John C. Steinmann, MD, Renovis Surgical Technologies

C. Urology Issues for ASCs

Herbert W. Riemenschneider, MD, Riverside Urology, Inc.

D. Trends in Buying and Selling ASCs: Mergers and Acquisitions of Surgery Centers

Patrick Richter, Vice President Business Development USPI, Blayne Rush, President, Ambulatory Alliances, Michael Weaver, VP Acquisitions & Development, Symbion, Inc.

E. Key Compliance Risks in ASC Billing

Bill Gilbert, Vice President, AdvantEdge Healthcare, and Bruce Voecet

F. The Most Common Medical Staff Issues and How to Handle Them

Thomas J. Stallings, Partner, McGuireWoods LLP

Roundtable Discussions

2:00 - 2:40 pm

Physician-Owned Ancillaries - Device Companies, Anesthesia, Pathology and Pharmacy and More

Steven Hochschuler, MD, Texas Back Institute, Richard Kube, MD, CEO, Founder & Owner, Prairie Spine and Pain Institute, John C. Steinmann, MD, Renovis Surgical Technologies

2:45 - 3:25 pm

Capital Markets Update - Key Thoughts from Lead Investment Strategists/Managers

Gregory D. Miller, Senior Investment Advisor, and Beata Kirr, Senior Portfolio Manager, Sanford C. Bernstein & Co., LLC

4:00 - 4:30 pm

Metrics and Improving Performance

John Seitz, CEO, Ambulatory Surgical Group

4:35 - 5:05 pm

Are We Profitable? Driving ASC Performance Through Effective Financial Management

Rajiv Chopra, Principal & Chief Financial Officer, The C/N Group

5:05 – 6:30 pm

Networking Reception, Raffles and Exhibits

Saturday, October 29, 2011

8:15 – 9:00 am

A. The 5 Best and Worst Specialties for ASCs - An Outlook for the Next Five Years

Larry Taylor, CEO, Practice Partners in Health-Care

B. Improving Revenue Capture: Best Practices in Coding, Documentation and Charge Capture

Rosalind Richmond, Coding Compliance Officer, and Yvonda Moore, Director of Implementation, GENASCIS

9:05 – 9:45 am

A. The Role of the Medical Director and Physician Leaders in ASCs

John Byers, MD, Medical Director, Surgical Center of Greensboro, Orthopaedic Surgical Center

B. Optimizing Business Office Performance

Paul Davis, CPA, CMA, Amblitel

C. Infection Prevention in ASCs: Looking Ahead - What Does the Future Hold

Marilyn Hanchett, RN, CIC, Senior Director, Clinical Innovation, APIC

D. What Should Great Medical Directors, Administrators and DONs be Paid?

Moderated by Rachel Fields, Managing Editor of Becker's ASC Review, ASC Communications, Inc.

9:50 – 10:30 am

A. The Best and Worst Procedures for ASCs and What an ASC Should Get Paid

Matt Lau, Director of Financial Analysis, Mike Orseno, Revenue Cycle Director, and Vivek Taparia, Director of Business Development, Regent Surgical Health

B. Determining the Exact Cost of a Procedure

Terry Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital

C. Infection Prevention and the CMS Infection Prevention Mandate for ASCs: Key Strategies to Enhance Performance

LoAnn Vande Leest, RN, MBA-H, CNOR, Chief Executive Officer, and Fawn Esser-Lipp, The Surgery Center, LLC

D. How to Improve Coding for ASC Procedures - A Discussion of Orthopedic, GI and Ophthalmology Procedures

Stephanie Ellis, RN, CPC, President, Ellis Medical Consulting

E. The Future Is Now, Preparing You and Your Practice for a Changing Environment

Pedro Vergne-Marini, MD, Founder and Managing Member, Physicians' Capital Investments

10:35 – 11:15 am

A. 3 Core Orthopedic and Practice Group Initiatives - Hospitals and Ancillaries Service Line Management Agreements and Becoming Leaner

John Martin, CEO, OrthoIndy

B. Examining Every Aspect of the Supply Chain to Develop Great Cost Savings

Scott Benglen, CEO, Via Novus Medical, LLC

C. Infection Control

Dotty Bollinger, RN, JD, LHRM, CHC, CASC, Chief Medical Operations Officer, Laser Spine Institute

D. Cataract Surgery for the Revenue Cycle

Bill Phillips, FACMS, CHC, Adjunct Professor, Healthcare Fianca Health Service Management & Leadership

E. Advanced Benchmarking of Financial and Clinical Results

John Goehle, CASC, MBA, CPA, Ambulatory Healthcare Strategies, LLC

11:20 – 12:20 pm

Key Legal Issues and Legal Compliance Boot Camp - The Core Elements of a Successful Compliance Plan

Scott Becker, JD, CPA, Partner, Lainey Gilmer, Associate, and Amber McGraw Walsh, Partner, McGuireWoods LLP

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Sam Donaldson

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Adrian Gostick



Bill Walton

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Growing Future Hospital Leaders: 6 Thoughts From Poudre Valley Health System CEO Rulon Stacey

By Rachel Fields

Forward-thinking health systems are dedicated to building future hospital leaders in their organizations and communities. Everyone benefits from this kind of development: the employee, who gains leadership experience and respect; the hospital, which acquires a pool of capable leaders ready to fill executive positions; and the industry, which sees an influx of great minds even as historic leaders retire. Here Rulon Stacey, CEO of Poudre Valley Health System in Fort Collins, Colo., and incoming chairman of the American College of Healthcare Executives, discusses six ways PVHS grows future healthcare leaders.

1. Meet with every new employee. At the beginning of every employee's tenure, Mr. Stacey meets with the staff member and tells them, "I want this to be the single best job you have ever had in your life." He says the organization is serious about that. "If we don't meet our goal in providing them the best job, it's not realistic for them to provide the best care," he says. Meeting with every new employee in the first days of their employment shows that you are serious about their success with the organization. It also removes perceived barriers between the administration and the hospital staff; if a new lab tech has met the CEO personally to discuss his personal goals, he is more likely to feel that the administration truly wants to see him promoted.

2. Donate to local colleges. Poudre Valley Health System pays hundreds of thousands of dollars to local colleges to help support faculty and instructors set up great programs for students, Mr. Stacey says. "We then give contracts to those students that if they'll go into these programs, we'll help them pay for their schooling if they'll come back and work for us when they're done with school," he says. Investing in the future is essential. Provider shortages are already crippling recruitment across the country, and shortages are only expected to increase as baby boomers hit retirement. If you can help local colleges produce more healthcare professionals by donating money for scholarships, you will benefit down the road when a steady stream of college graduates is familiar with your hospital and ready to join the workforce.

3. Provide funding for training in an employee's field. If your employees want to pursue higher degrees or credentialing, help them make it happen. Many employees want to go back to school but don't have the funds to do so, especially when they're working full-time to pay the bills in the first place. Poudre Valley Health System gives every employee the opportunity to apply for tuition if they go to school in an area that benefits their field. The system's foundation also gives dozens of scholarships to employees for educational pursuits. "We don't train them to go be an auto mechanic, but if it's in their field or it's something the organization needs, we'll pay for it," Mr. Stacey says.

4. Set up a formal mentor program. According to a recent survey by Cejka Search and AGMA, over half of physician groups believe instituting a formal mentor program helps retain providers. If providers and staff members can rely on a more experienced staff member for guidance and advice, they are less likely to become discouraged and more likely to pursue opportunities within the organization. Poudre Valley Health System has instituted a formal mentor program whereby someone in the organization can identify a leader in the organization they would like to learn from. The system monitors the relationship through the human resources department, and the two employees can hold regular meetings and stay in contact as issues come up at work. "It's somebody the person can call and ask, 'Am I doing this right? What is your advice?'" Mr. Stacey says.



5. Help employees understand their weaknesses and strengths. PVHS uses a personality profile tool called The Thomas Concept to help employees understand their strengths and weaknesses. A tool like this can help identify future leaders and give direction to blossoming employees who may need work in some areas. The organization also centers its annual performance evaluation around six strategic organization objectives, which every employee should be able to relate to their personal work, and several behavioral standards that mirror the values of the system. "At the end of every evaluation, every employee fills out a little goal card that has three things every employee can do to promote the vision of PVHS," Mr. Stacey says. "The first thing is to live our behavioral standards, and the second two are blank. Each employee fills in those blank areas as to what they personally are going to do in the coming year to promote PVHS' vision." The employees wear those cards around their necks to promote focus on personal improvement.

6. Extend your succession plan as far down as possible. Mr. Stacey says Poudre Valley Health System's succession plan works down as far as possible through the organization to identify future leaders. "We are always thinking, 'If one of our leaders went away, what are we doing to train a person to take their place?'" he says. This means identifying managers throughout the organization — not just in the very top tier — who have the potential to sit in the C-suite. To build those leadership skills in managers, the system has a leadership program where employees can learn the "building blocks of leadership" and the system's philosophy. "We've specifically and strategically identified people who will work well with our culture, and once they're here, we start to train them," Mr. Stacey says. ■

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As Interest in ACOs Wanes, It's Time to Do the 'Next Right Thing'

By Steve Ronstrom, CEO, Western Wisconsin Division of Hospital Sisters Health System

Like many other hospitals, we had been seriously considering implementing an accountable care organization. It seemed like the right thing to do to meet the needs of patients. The purpose was to make healthcare more efficient by integrating hospital care with that of physicians and other outpatient providers.

But now — like many other hospitals, as well — we have dropped plans for an ACO because the proposed regulations are too complex. However, we have not given up looking at the future or pursuing “the next right thing,” which would incorporate many of the objectives of ACOs without actually becoming an ACO.

To do this, we need to go back to our fundamental goals, which are meeting the needs of the patient and moving toward integration of health services. Hospitals also face the same challenge as before — to become more efficient, because there will be funding cuts. Here are a few examples of the steps hospitals can take to do “the next right thing.”

Focus on patients. As hospitals readjust their goals, the guiding light should be meeting the needs of patients. We should start re-examining the patient experience and match it up with our delivery system. Nationally, the healthcare system is beginning to recognize the positive influence of patient experiences on quality. We need to engage in more patient outreach, such as making sure medications are used, educating patients on compliance and providing support. The goal should be patient literacy.

Study community needs. Paying attention to the needs of the community is fundamental. In fact, this is an obligation for non-profit hospitals such as our own. Our non-profit status brings with it a fiduciary obligation to the community. We need to keep trying to gain the trust of patients and the community at large. With this in mind, our two hospitals have launched a new strategic plan, “Imagining the Future: 2016,” engaging community members in helping create our five-year strategic plan.

Partner with payors. Many hospitals and other providers are working with Medicare Advantage plans to improve efficiency and quality. Providers have also begun working with private payors to create ACO-like arrangements. As part of the deal, hospitals can tap into payors' rich database for metrics, such as how many times

patients have seen their physician or whether the patient got her mammogram on time. The hospital might have some of this information, but it is not as integrated as the data payors have.

Get physicians engaged. Everything I see and hear is about the need to engage physicians. As hospitals employ more physicians, they will need help from us to be more effective. Hospitals need to train physicians on how to operate within the organization and to get decent payor contracts. We also need to streamline management of employed physicians. Instead of managing 100 physicians separately, it's more efficient to organize them into several groups. Hospitals are also setting up medical director agreements to get independent physicians into leadership roles and creating co-management agreements with them.

Create physician-led systems. Hospitals need to go deeper than just making deals with physicians. Physicians should be involved in the highest echelons of hospital leadership and help us create our strategic vision. It's essential to bring physicians into the mission itself and create physician leaders. In the future, physicians will be expected to carry the strategic vision of the hospital or health system. This means more physicians becoming hospital CEOs or working in close partnerships with non-MD CEOs. Making these arrangements successful means choosing the right physicians for leadership roles.

Adopt the medical home. Under the patient-centered medical home, each patient is given a personal physician, providing first-contact, continuous and comprehensive care. The physician assumes responsibility for either directly providing the patient's healthcare needs or arranging care with other qualified professionals. This is a critically important step between going from pay-for-procedure to pay-for-population healthcare.

Help physicians find new models of care. As hospitals and physicians move closer to each other, physicians should still be encouraged to be innovative and entrepreneurial. For example, more physicians are getting involved in “concierge medicine,” which involves charging patients a direct fee and dropping out of Medicare and private insurance. Our health system is also starting to place family physicians at the worksite as a way to help employers reduce emergency and urgent care visits, lower absenteeism and improve employees' overall health status.



Another worthwhile innovation is putting ancillary testing and other outpatient services in the same building with physician offices. This is convenient for the patient. The physician office building can also be a hub for other activities such as expert-led groups on behavior-changing regimens like weight control. Our hospital is involved in planning a physician office building that will include a gym along with several ancillary services. Since 80 percent of the public does not go to a gym, this could be an important step in improving patient wellness.

Improve IT. Hospitals need to keep growing their IT systems. IT has to be linked to outpatient centers and physicians' offices and plugged into insurance information. The data needs to be mined to give physicians information on how to make clinical improvements, which requires a great deal of software to organize the information.

Continue working on centers of excellence. A lot of people are predicting that all tertiary care will go to nationwide centers such as Mayo Clinic, which is only 100 miles away from us. But I believe there will always be a demand for locally grown tertiary care as long as it is of high quality and has sufficient volume. The amount of volume, however, does not have to be as large as some people think. For example, we have expanded our neurosurgery service into full-spectrum neurosurgical care. This involved making substantial investments in state-of-the-art technologies, including two “smart” operating suites equipped with advanced intra-operative imaging and 3-D mapping capabilities.

Put UR front and center. It's time to take utilization review out of the basement of the health system and put it into the executive office. With new requirements like reducing readmis-

sions, UR tasks such as discharge planning are more important than ever. Hospitals need to improve relations with rehab centers, nursing homes and home health agencies for the whole continuum of care. These decisions need close collaboration with the C-suite. The UR director should be in the hospital's leadership group, and the UR department should be regularly reporting to the CEO.

Create new delivery models. As pressures mount to lower costs, we need to come up with innovative models to deliver care. For example, the

least costly venue for care is the patient's home, so it is important to find ways to monitor patients in the home. Home-monitoring technology has been progressing rapidly, and we need to take advantage of it. ■

Steve 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 comprises 344-bed Sacred Heart Hospital in Eau Claire and 193-bed St. Joseph's Hospital in Chippewa Falls. Learn more about Hospital Sisters Health System.

What New Healthcare Leaders Should Know

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

What an honor it would be to speak to a graduating class of healthcare management students and talk about the realities of our work. I would itemize all the skills I think they need to practice in this challenging world. My points, listed below, are pretty basic but could be vital to the success of their careers.

1. Be enthusiastic. I would start off by emphasizing how important it is to be enthusiastic about what you do. There is no greater calling than to help others live healthier and more fulfilling lives. In essence, that is what a meaningful healthcare career is all about. While different people have different ways of showing enthusiasm, they will share the common thread of dedication, thoroughness and loyalty to the mission of the hospital.

2. Take nothing for granted. This warning should be heeded in all echelons of the healthcare profession. True professionals will never be too busy or too tired to check on a system or a patient. You need to take time to make sure everything is in order. If you don't, a patient might die and that would be the greatest sin of all.

3. Be totally engaged. Hold yourself accountable and make sure those around you understand what you are talking about. As a healthcare professional, you should be totally engaged every day with your colleagues. They expect it of you and you expect it of them.

4. Learn to present. Know how to put together a report or outline or even a full-blown presentation that gives you the opportunity to sell a concept to your peers. Don't be shy about presenting your ideas!

5. Learn to write. A critical part of presenting is the ability to write down your thoughts on paper for others to read. Sure, the e-mail way may come in handy occasionally, but putting thoughts down on paper has an even bigger impact on others.

6. Have courage. Stand by your principles and don't let others sway you to their way of thinking. That doesn't mean you act in a stubborn fashion. It simply means adhering to your own set of standards.

7. Have good manners. Show respect for everyone you come into contact with. Everyone loves to be treated with dignity and respect. Patients cannot get enough of it.

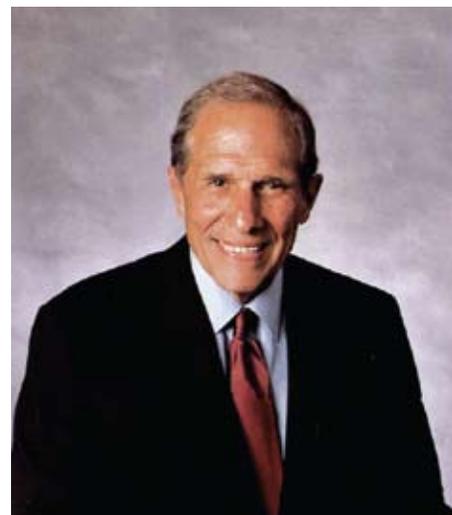
8. Always be there. Always let people know where you are and where you will be. Don't disappear unexpectedly and leave others holding the bag. Be reliable, no matter what the circumstances, and be available when you are needed.

9. Know our organization. Read everything you can about your organization's history, mission and the people who preceded you and made the organization a success. Also read everything that you can about your industry and its future.

10. Listen to others. Learn to listen with your eyes, your ears and your mind. Listening is a powerful tool. Those do it more often than talking usually have greater success than people who spend their time talking. Listen to your bosses, listen to your peers and listen to patients.

11. Learn the art of selling yourself. As you go about your career, you must understand that unless you are willing to step forward, accept responsibility and make sure others see your commitment, whatever you accomplish may go unheeded. It is important that others recognize your abilities.

12. Allow dissent. If you get into a leadership position, do not be afraid to allow others to dissent from your opinions. Too many leaders have too many yes-men around them who care more about their own careers than they do about the success of the organization. Don't be afraid to hear other ideas and objections. It shows maturity on your part.



13. Keep your promises. When you promise anything, always make sure you fulfill it. Keeping promises is a matter of character and integrity.

14. Open your heart. Always—but always—be willing to open your heart and mind to others. Be willing to give a helping hand to a colleague or peer or someone of lesser station in your organization. It's the mark of a true leader!

15. Reach your own judgments on others. Don't listen to ugly rumors or hearsay about another person. March to your own drum when judging others.

16. Be true to yourself. Finally, always be loyal and true to yourself and your organization. Give every day 100 percent, and then some. Don't be afraid to dream your dreams and, better still, to make those dreams come true. Without dreams, life wouldn't be much fun! ■

Chuck Lauer (chuckspeaking@aol.com) was publisher of Modern Healthcare for 33 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide.



Key Issues and Strategies for Physician Integration

By Leigh Page

While most physicians understand the need to integrate with hospitals, many of them seem ambivalent about taking the plunge. For example, a recent survey of physicians by PricewaterhouseCoopers found that just a little more than half of them wanted to align more closely with a hospital, while two-thirds thought hospitals needed physicians to reduce inpatient costs.

Here, several experts cite ways hospitals can improve integration with physicians, and they identify specific integration strategies.

Work with independent physicians

Buying practices can be a useful integration strategy but it also creates new challenges for hospitals, says Peter Young, president of HealthCare Strategic Issues in Ft. Myers, Fla. "I read a vast number of hospital bond disclosures and in nearly all with physicians practices, the column entries are red ink," he says. "Near-term ROI is not there." To make money on practices, hospitals need "a high-powered, innovative practice manager and to reduce the response time for physicians' concerns," he says. In many cases, such as markets with little competition, Mr. Young thinks it's not necessary to buy practices.

Even when hospitals acquire a lot of practices, they still have to reach out to independent physicians, says Mary C. Reed, vice president of Gateway Health, part of the Gateway Group in Cleveland. For this to be successful, "the hospital has to bring something of value or physicians to the table," she says. "The hospital should bring business to the physicians," while still complying with Stark and Antikickback laws. She says the hospital can provide special services to independent physicians such as discounted electronic health records systems or access to databases. Middlesex Hospital in Middletown, Conn., for example, provides independent physicians access to a data repository for laboratory and radiology results.

Work through culture barriers

Paul Keckley, director of the Deloitte Center for Health Solutions, says hospitals that want to integrate with physicians have to work through culture barriers that keep physicians and hospitals apart. "Many physicians are not used to working in teams or exercising leadership," he says. "It's hard sometimes for physicians to be effective leaders."

Mr. Keckley says it is important to establish trust with physicians. St. Elizabeth Hospital in Appleton, Wis., for example, has a physician advisory council to share information about operations and growth strategies for the future with physicians. It is also important to create a common purpose with physicians, he says. Each year, McLeod Regional Medical Center in Florence, S.C., charters a dozen major clinical effectiveness improvement efforts. While the McLeod administration initially proposes a list of measures, a leadership group of physicians makes the final recommendation to the board.

Make physicians accountable

"How do you address behavior of physicians who are not practicing according to guidelines?" Mr. Keckley asks. For integration to work, it has to be more than just voluntary, Ms. Reed says. "Physicians have to take on more structured responsibilities and accountability," she says. "This is possible when physicians are involved in creating and establishing the clinical protocols they will need to use." They can be measured in a variety of ways, such as by patients' ability to access care, hospital readmission rates, mortality data, delays in treatment, patient satisfaction survey data and enhanced patient care coordination across provider settings, according to Kathleen Rausch Henchey, president of Henchey Information Solutions, in an article for the Healthcare Financial Management Association.

Physicians need to be in leadership roles, Ms. Reed adds. "It's more than just having physicians on the board," she says. "They should be on key clinical committees. One of the ingredients in the FIC definition of clinical integration is the ability to demonstrate that physicians are at the table and are actively creating the clinical protocols and the hospital is working with physicians to modify their behavior, if that is needed." At McLeod, for example, leadership specifically invites a physician to lead each major improvement initiative.

Make deals with payors

Even though Medicare ACOs no longer seem workable for many hospitals, private payors are very interested in integrated arrangements with hospitals and their integrated physicians, says Rob Parke, a principal and consulting actuary with the New York office of Milliman. "Private payors offer more flexibility than the federal government," he says. "They can also structure a

number of alternative payment arrangements to choose from, such as sub-capitation, case rates, bundled payments and limited networks." He says health plans are very interested in integrated arrangements because they are anticipating insurance exchanges under healthcare reform. In the exchanges, plans will have to compete head-to-head on price. "Plans have to work with providers to become more efficient and thus offer lower premiums," Mr. Parke says.

Different ways to integrate

Here is sampling of possible integration projects a hospital could take on.

Focus on readmissions. One of the first challenges for integration efforts will be the CMS initiative to reduce Medicare payments to hospitals with excess preventable readmissions, starting in 2012. This will require hospitals to follow up with discharged patients to make sure they do not need to be readmitted. "When you discharge the patient, you need to know you are getting them back to primary care physician and other outpatient services," Ms. Reed says.

Expand outpatient services. "The logical ancillary services to consider are directly related to employed and aligned physicians: outpatient diagnostics, imaging, surgery centers and oncology," Mr. Young says. Ms. Reed mentions partnering with rehabilitation facilities, home health and other outpatient services that could help the hospital provide "seamless care" throughout the continuum of care.

Enhance disease management. Ms. Reed advises focusing on the 20 percent of people who are responsible for 80 percent of costs. The work involves use of nurses and allied health professionals to track patients. "Disease management is not typical for the hospital," she says. "It should involve clinical decisions based on real-time data that results in more cost-effective, efficient delivery of care."

Start with service lines. A natural place to start working closely with physicians is around service lines like orthopedics and cardiovascular. "If these are already successful service lines for the hospital, it is probably due to strong relations with the physicians involved," Ms. Reed says. She adds that because of their relatively high charges, payment arrangements for these services would be very interesting for private payors.



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Agree to bundled payments. Under bundled payments, hospitals and physicians get a single discounted rate for providing all services in a particular episode of care, such as heart surgery or orthopedic surgery. “Figuring out how to manage both the clinical and financial aspects of a bundled payment program and value-based payments is not easily done,” says the consultant Peter R. Kongstvedt, MD. “It is likely that as payment models migrate further in this direction, we will see tighter and tighter clinical integration.”

Set up patient-centered medical homes. Hospitals are beginning to show more interest in this approach, which assigns caregivers to a particular patient. “Motivating the patient is a big part of it,” Ms. Reed says. “It’s getting patients themselves to do what they need to do.” For example, Danville, Pa.-based Geisinger Health System’s medical home program significantly reduced admissions and ED visits for many chronically ill and elderly patients. ■

Optimizing a Hospital-Physician Joint Venture: 4 Tips for a Culture of Partnership

By Molly Gamble

Hospital-physician joint ventures — such as physician-hospital organizations — present an array of opportunities and benefits for both parties. Physicians strengthen their brand and increase their access to capital and clinical resources while hospitals bolster their physician-alignment, service lines and position in the marketplace. Implemented poorly, though, and a joint venture can result in a dysfunctional culture, poor financial results and a weakened reputation in the community. “Very rarely will a joint venture have long-term benefits without a culture of partnership, equal control and valuable leadership,” says Patrick Hampson, chairman and CEO of MED3000.

MED3000 offers practice management and revenue cycle management services, accountable care organization development and business and clinical services, including third-party administration, population health tools and predictive modeling to joint ventures. It also offers sophisticated technology and data analytics services, such as practice management and electronic health systems, electronic recalls systems and data warehousing. Here, Mr. Hampson discusses some of the challenges and best practices for hospital-physician joint ventures.

1. The right sets of knowledge and tools are necessary to expand physician affiliations. To expand affiliations with physicians or other providers in the community, a hospital should have a portfolio of products and services that are needed in the community. “Critical to any and all services is the ability to capture stagnant data and turn it into proactive business and clinical improvement,” says Mr. Hampson. “You have to be able to add value to the delivery of healthcare or you won’t have any long-term traction.” These resources, such as population health or predictive modeling, may be more difficult for physicians to obtain in a small practice setting.

2. Adaptation may be the largest challenge in the first five years. The initial hurdle for hospitals and physicians to overcome in a new joint venture is to embrace change. “Healthcare is not a stagnant industry. It is constantly changing due to market dynamics, changes in regulations or reimbursement, and the economy,” says Mr. Hampson. Successful hospital-physician JVs require leadership that stays ahead of these changes and drives the JV through transitions that are not only related to the new model, but the industry overall.

3. Joint ventures should be offensively driven. Hospitals should not resort to the joint venture model as a defensive tactic to gain or protect market power. “Defense is not a long-term sustainable strategy,” says Mr. Hampson. If used as such, the joint venture will likely dissipate over the years. Instead, leaders should have an offensive strategy that presents growth opportunities for each party involved. If joint ventures happen to be part of this offensive plan, the transaction has a far better probability of turning out successfully.

4. Create a win-win situation. Hospitals should enter joint ventures eager to help partners win. “The most successful joint ventures are those where each party understands the other parties’ goals, objectives and what drives them,” says Mr. Hampson. Understanding perspectives of each provider will help prevent a dysfunctional relationship between the hospital and physicians. A hospital’s first joint venture may very well set precedent for transactions or joint ventures to follow, so organizations should work hard to earn a reputation as a preferred partner, not a partner out of necessity. ■



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Essential Primer: Pioneer ACOs and Proposed Advance Payment Initiative

By Leigh Page

On May 17, CMS unveiled an advanced model for accountable care organizations to start in the summer and is also seeking comment on yet another ACO model that would provide start-up funding, according to a release by CMS.

CMS' announcement came at a time when many well-established integrated delivery systems had been talking about not starting ACOs. In addition to the two new models, CMS announced free learning sessions on ACOs for providers. "These three new initiatives will help give providers new options and incentives to participate in ACOs," the release said.

This Pioneer ACO is "designed to work in coordination with private payors," the release said. The model "provides a faster path for mature ACOs that have already begun coordinating care for patients and are ready to move forward." CMS estimates that care models developed through the Pioneer model could save Medicare up to \$430 million over three years.

The Advance Payment ACO, a second model on which CMS is still seeking comment, "would provide additional up-front funding to providers to support the formation of new ACOs," the release said. It would help organizations "make the infrastructure and staff investments crucial to successfully coordinating and improving care for patients," the release added.

Here is an overview of what is known so far about the two programs.

Pioneer Model for ACOs

1. Limited to advanced organizations. The Pioneer program will "provide a faster path for mature ACOs that have already begun coordinating care for patients," CMS stated.

2. Moves beyond shared savings. The Pioneer ACO Model "will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program." The Center for Medicare and Medicaid Innovation will approve candidates and is now accepting applications for the Pioneer ACO Model.

3. Operates with private payor programs. The model is "designed to work in coordination with private payors in order to achieve cost savings and improve quality across the ACO, thus improving health outcomes and reducing costs for employers and patients with private insurance."

4. Rapid application process. The process moves more rapidly than for traditional Medicare ACOs. CMS originally set the application deadline for July 18, but later extended it to Aug. 19.

5. Implementation in two stages. The program would start as early as this summer. During their first two years, Pioneer ACOs will have "generally higher levels of shared savings and risk" than basic ACOs. In year three, "participating ACOs that have shown a specified level of savings over the first two years will be eligible to move a substantial portion of their payments to a population-based model." Payments to these ACOs would be flexible "to accommodate the specific organizational and market conditions in which Pioneer ACOs work."

6. Must meet key expectations. Pioneer ACOs will be expected to improve the health and experience of care for individuals, improve the health of populations and reduce the rate of growth in healthcare spending. Participating ACOs will be held financially accountable for the care provided to their aligned beneficiaries. CMS estimates that care models de-

veloped through the Pioneer model could save Medicare up to \$430 million over three years.

7. Metrics will be publicly reported. CMS will publicly report the performance of Pioneer ACOs on quality metrics, including patient experience ratings, on its website.

8. Would not require rule-making process. In a news conference, Donald Berwick, MD, said he was "confident" that the new initiatives would not have to go through the rule-making process.

Advance Payment Initiative

1. Would cover start-up costs. The program "would provide additional up-front funding to providers to support the formation of new ACOs," CMS said. The program would pay eligible organizations "a portion of future shared savings." The advanced payment would be "in the form of a monthly payment for each aligned Medicare beneficiary," CMS stated.

2. Responding to providers' concerns. The program would "encourage participation" in the basic ACO program. "Early comments on the proposed Medicare Shared Savings Program rules suggest that some providers lack ready access to the capital needed to invest in infrastructure and staff for care coordination," CMS stated.

3. Still only a proposal. CMS' Innovation Center is proposing this model for ACOs entering the Medicare Shared Savings Program and requested comments on the proposal. Comments were due June 17.

4. Specifics not formulated yet. Basically, "ACOs would need to provide a plan for using these funds to build care coordination capabilities, and meet other organizational criteria," CMS stated. "Advance payments would be recouped through the ACO's earned shared savings." ■

Study Shows ACO Start-Up Costs Can Soar Up to \$26.1M

By Laura Miller

The current estimated start-up and first-year costs to establish and sustain core competencies for accountable care organizations are higher than the original estimate of \$1.8 million by the Centers for Medicare & Medicaid Services in its proposed rule.

A new study prepared for American Hospital Association by McManis Consulting projects the costs to be between \$11.6 million and \$26.1 million, according to the report. The new numbers are based on four case studies of organizations that took steps to manage the care of a defined population, which is similar to an ACO.

The study was completed prior to the release of the ACO proposed rule and doesn't include estimates of the costs of meeting the rule's specific requirements. It does identify 23 different capabilities to be developed across four categories to achieve the transformation in care: network development and management, care coordination, clinical information systems and data analysis. ■

Not Ready to Form an ACO?

Three Value-Based Alternative Models

By Lindsey Dunn

Many providers are finding they don't yet have the resources to participate in or take on the risks associated with accountable care organizations. But it's not an all-or-nothing situation.

In fact, most hospitals would be best served by taking a more measured but deliberate approach to value-based payments, as the U.S. health system moves away from its fee-for-service approach, says Mike Randall, a manager at The Camden Group, a healthcare consulting firm. Three alternative value-based reimbursement models can put hospitals on a path to ACOs, allowing them to develop competencies that will help them succeed with the more sophisticated ACO model.

These alternatives fit along a continuum, with the resources and level of integration necessary to succeed steadily rising. The payment models cannot be entirely separated from changes in care delivery, of course, and thus require increasingly tight hospital-physician alignment. Alignment can be achieved through physician employment, entering into service line co-management arrangements, clinical integration or other methods, notes Mr. Randall.

1. Pay-for-performance. Hospitals and physicians begin by engaging in pay-for-performance programs with payors. This model requires establishing quality performance targets and rewarding providers who meet these targets, typically with bonuses above fee-for-service rates. This model requires less integration and IT infrastructure than other models, enabling less mature networks to participate.

Critical capabilities under this model include establishing clinical quality benchmarks, collecting and measuring results, and reporting. Pay-for-performance is a fundamental stepping stone to more advanced forms of value-based care.

2. Bundled payments. Because care for resource-intensive and complex procedures, such as cardiac and orthopedics, often leads to higher quality and lower per unit cost of care at high-volume hospitals, CMS is testing the effectiveness of offering incentives to consolidate care. Under the CMS' bundled payment model being piloted at a handful of hospitals, a single discounted payment is provided to the hospitals and physicians for an episode of care, such as a surgical or medical DRG. In turn, hospitals may pay physicians up to 125 percent of Medicare fee-for-service rates and share up to 50 percent of savings (not to exceed their annual part B premium, up to \$1,157) with Medicare beneficiaries.

For hospitals interested in trying bundled payments, CMS is expected to expand the pilot at some point. But some providers are not waiting and instead are working with private insurers to develop bundled payment programs for specific service lines. For the CMS pilot, hospitals must be accepted into the program, have the ability to demonstrate superior quality, and successfully align with physicians to lower costs (such as for devices and implants) and improve efficiency. Organizations can prepare for bundled payments by strengthening their ties to their independent cardiologists, cardiac surgeons, and orthopedic surgeons through service line co-management relationships.

3. Medical home. Proven to improve quality and lower costs as much as 20 percent, this primary care-driven initiative focuses on building a team of professionals — the physician, plus RN case manager, medical assistant, and in some cases, pharmacists. The intent is to provide better care coordination, especially for those with chronic conditions, and prevent hospital readmissions and emergency department visits. High functioning medical

homes use electronic medical records, disease registries and central data repositories and require physicians to follow a limited set of evidence-based care guidelines.

To cover the infrastructure costs and staff for care coordination, providers can often negotiate a FFS rate increase or per-member-per-month (PMPM) on top of normal FFS payments. The real pay-off for providers, though, comes in negotiated shared savings arrangements, says Mr. Randall. PMPMs or FFS rate increases generally only cover the added infrastructure and staff resources, so shared-savings can be an enticing incentive because providers doing patient-centered medical homes are often challenged to maintain previous productivity levels.

Hospitals can gain experience with this reimbursement model by forming medical homes with their employed physician groups. They also can provide resources, management and services to physician groups that establish medical homes, although they will not directly receive value-based payments. In both cases, hospitals would benefit from the closer alignment with primary care physicians who will be pivotal to any ACO.

Ready for accountable care?

Once hospitals have built capabilities and gained operating experience with other value-based models, they will be in a stronger position to function as an ACO, overseeing the entire continuum for care for a patient. Under current ACO models, providers are compensated on a fee-for-service basis with the ability to share in savings created. However, the Medicare program also places ACOs at risk if costs rise higher than anticipated.

ACOs also require more resources than any other value-based reimbursement model. Electronic medical records, central data repositories, health information exchanges, evidence-based guidelines across multiple specialties, and clinical decision support at point-of-care are essential elements.

CMS is not and will not be the only option when it comes to accountable care. Other "ACO-like" shared savings models are currently in development. For example, Blue Cross Blue Shield of Minnesota's shared-incentive payment model creates incentives over time for four of the state's largest providers to lower costs and improve healthcare quality. The mechanisms are less defined than those for an ACO, but these organizations will need many of the same competencies including tighter alignment with independent physicians, ability to track and report on quality, evidence-based protocols, and IT systems to coordinate care.

Beyond ACOs

The end game, however, is not an ACO, according to Mr. Randall. Care delivery and payment are moving toward a new form of managed care, he says. It will take some time to get there, but it is clear that once payors perceive that most of the gains from the ACO models have been wrung out of the system, they're only a short step from being able to enter into capitation payment models.

Unlike the 1990s HMO era, however, providers will be ready because they will have added the necessary competencies in care management and population-based analytics. By this point, they will be clinically integrated, have put in place ways to track and measure clinical quality, and created care protocols that are offered at the point-of-care. It won't be much of a leap for hospitals to then devote additional resources to disease management and predictive risk-assessment modeling, Mr. Randall says, which will move health systems toward success in a managed care environment. ■

10 Stark, False Claims and Kickback Lawsuits Involving Hospitals and Health Systems

By Molly Gamble

Here are 10 recent Stark, false claims and kickback lawsuits and settlements involving hospitals and health systems.

1. San Francisco-based **Catholic Healthcare West** agreed in February to pay \$9.1 million to settle allegations that seven CHW hospitals submitted false Medicare claims. The allegations stem back to the 1990s, with the Department of Justice becoming involved in 2001. The settlement resolves charges that three hospitals received overpayments due to Medicare processing errors but did not return the funds when errors were discovered; that three CHW hospitals allegedly submitted inflated costs for their home health agencies and were overpaid; and that one hospital was allegedly overpaid for treating a high percentage of patients with end-stage kidney disease for several years, including two years when the hospital was not eligible.
2. In February, Savannah, Ga.-based **St. Joseph's/Candler Health System** announced it will pay the state of Georgia \$2.717 million in a civil settlement over alleged Medicaid overbilling for inpatient and outpatient services at its two Savannah-area hospitals. The settlement followed an 11-month investigation on SJCHS's billing for cross-over claims, or those made for patients enrolled in both Medicare and Medicaid. SJCHS also agreed to pay an additional \$2,500 to defray the costs of the investigation. The system denied any wrongdoing under the terms of the agreement.
3. In February, **Whidbey General Hospital** in Coupeville, Wash., agreed to forego approximately \$1.7 million in Medicare billings due to physician violations of Stark Law. The hospital self-disclosed the violations in 2008 to the HHS Office of the Inspector General. Whidbey General CFO Joe Vessey said \$4.85 million worth of Medicare billings were affected by the Stark Law and the hospital only expects to be reimbursed 35 percent of the amount billed.
4. Louisville, Ky.-based **Norton Healthcare** agreed to pay the federal government \$782,842 in March to settle allegations that it overbilled Medicare for wound care, infusion and cancer radiation services by adding a separate "evaluation and management" charge that should have been included in the basic rate. The alleged overbilling, which occurred between Jan. 2005 and Feb. 2010, involved outpatient care. The settlement is twice the amount Norton allegedly overbilled.
5. The former CEO and COO of **Tri-Lakes Medical Center** in Batesville, Miss., was accused of involvement in kickbacks and bribery conspiracy in March. Raymond L. Shoemaker of Tupelo, Miss., was charged with conspiracy to commit and committing healthcare fraud, making false claims to the FBI in connection with a federal investigation, making false statements to the U.S. Department of Agriculture in connection with a loan, embezzlement from the medical center and receiving kickbacks for nursing services. If convicted of all counts, Mr. Shoemaker faces up to 80 years in prison and \$2.5 million in fines.
6. In April, **Dartmouth-Hitchcock Medical Center** in Lebanon, N.H., agreed to pay \$2.2 million to settle allegations that it improperly billed various federal health programs. The case began in 2007 when a physician accused the medical center of improperly billing federal programs for services performed by resident physicians without sufficient supervision by staff physicians. The billings in question spanned from 2001-2007. Dartmouth-Hancock denied liability but agreed to settle to avoid the burden, expense and risks of litigation and a trial.
7. In April, California's insurance commissioner filed to intervene in a whistleblower lawsuit accusing Sacramento, Calif.-based **Sutter Health**, a 24-hospital system, of falsely billing for millions of dollars of anesthesia services. Commissioner Dave Jones alleges that Sutter used an anesthesia billing code to charge for services and supplies patients and payors had already paid for through other charges on the hospital bill or anesthesiologist's bill. Commissioner Jones, who said the amount of fraudulent charges is in the hundreds of millions, seeks monetary penalties and damages as well as broad injunctive relief to stop fraudulent billing practices.
8. In April, Dallas-based **Tenet Healthcare** accused Brentwood, Tenn.-based **Community Health Systems** of systematically overbilling Medicare and unnecessarily converting emergency department visits, or observation stays, into inpatient admissions. If treated as false claims, Tenet said CHS' conduct could result in liabilities in excess of \$1 billion for 2006-2009 alone. Federal agencies are coordinating an investigation into CHS' billing practices. CHS has called the lawsuit "baseless" and filed a motion to dismiss the suit April 19.
9. In May, Fort Lauderdale, Fla.-based **North Broward Hospital District** received a subpoena by the Department of Health and Human Services. Agents from the inspector general of the HHS are reviewing contracts given to more than 27 physicians and investigating them for violations of Stark and Anti-Kickback laws. The subpoena was issued in connection with an investigation over possible false claims to Medicare and Medicaid relating to physician reimbursements.
10. In May, a former hospital employee filed a lawsuit accusing **St. Luke's Hospital** in Jacksonville, Fla., of falsely billing Medicare and Medicaid during an 11-month span. The suit claims the hospital falsely billed the government from April 2008 until March 2009. The hospital was allegedly ineligible for Medicaid and Medicare payments because its accreditation allegedly transferred when its former operator, Mayo Clinic, opened a new facility and St. Vincent HealthCare took over St. Luke's. The lawsuit claims St. Luke's continued claiming Mayo's accreditation as its own when it was under St. Vincent HealthCare's ownership. ■

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5 Questions to Determine if Your Independent Hospital Should Sell, Partner

By Sabrina Rodak

Small and medium independent hospitals are facing increasing pressure as health-care organizations form mergers, affiliations and other combined arrangements. Should these independent hospitals join the masses and sell to a larger system or hospital? Two experts in hospital management share questions independent hospital leaders should ask to determine if a sale or affiliation would benefit the organization and if so, how to begin the negotiating process.

1. Have I made the hospital as efficient as possible? Bill Siren, practice leader of Healthcare in the Financial Advisory Services unit at consulting firm AlixPartners, says independent hospitals should exhaust opportunities to improve the facility's efficiency before considering a sale. If the administration has done everything possible to increase efficiency and the hospital is still losing money, "then it's not much of a choice," Mr. Siren says — hospitals should pursue a merger or affiliation.

Mr. Siren suggests one way non-profit independent hospitals can improve their efficiency is to behave like a for-profit hospital. "If non-profit hospitals would begin to operate more like their for-profit brethren, they would see a huge change in their status both clinically and financially. When you look at the best-performing hospitals across the country, many of them are for-profit entities," he says.

2. What are my reasons for forming a merger or affiliation? Mr. Siren says the first step in considering a relationship with another hospital is understanding the reasons for building a relationship, because they may determine what type of relationship — a merger, clinical partnership, etc. — the hospital should pursue. There are a variety of reasons independent hospitals may decide to integrate with another system, including improving efficiency, implementing technology, forming an accountable care organization and gaining profit. Leaders should articulate these reasons so they can form a relationship best suited to the hospital's goals.

Howard J. Peterson, managing partner of the management consulting firm TRG Healthcare, says the underlying reason for considering an affiliation or merger should be helping the hospital follow its mission. "[TRG's] mindset for an independent hospital is that the fundamental fiduciary question for a board is to figure out what the best position is for their hospital to continue its mission of service to the community. Board members often confuse that; they often start

with the premise that their fiduciary responsibility is [for the hospital] to remain independent," he says.

3. What type of transaction would best meet my needs? Independent hospitals have several options when building a relationship with a larger hospital. The hospital can sell, partner for clinical services or partner for capital, among other options. Mr. Siren says independent hospitals may pursue a capital partnership if they are failing financially, but want to keep their administration in place. "There are other ways to access capital and at the same time maintain independence," he says.

One factor in choosing a merger, partnership or other arrangement is the system of governance. Independent hospitals should learn how the leadership of the new relationship will be structured. They should think about who will manage each separate organization and how both teams will interact. "It's not only about local governance for the independent hospital that joins a system, but [also] participation in the system's governance," Mr. Peterson says.

As leaders consider a form of integration, however, they should remember that one option is always to remain independent, according to Mr. Peterson. "Just because you go through a process doesn't mean you've taken independence off the table," he says.

4. What are my decision-making criteria? Mr. Peterson suggests setting decision-making criteria before beginning negotiations with an organization. "Make [them] before you start your process, because boards and management can agree on principles and criteria. But if you wait until the end to figure out how you'll decide, people make criteria to get their preferred outcome," he says. Examples of criteria for choosing a partner or buyer include access to capital, alignment with the hospital's mission, continuation of clinical services and a long-term plan for the hospital's survival.

5. What hospitals and health systems would I consider? Including multiple organizations in the negotiating process is a key to pursuing a merger or partnership, Mr. Peterson says. "If I'm an independent hospital, the last thing I want to do is decide to have a discussion with just one other party. There are two fundamental problems: One, you lose leverage because you don't keep the other choices in the mix. The other problem is that [you] are unlikely to get information on what partnerships could look like

with a variety of parties," he says.

Approaching only one organization reduces the hospital's ability to successfully negotiate because the other organization does not have to compete with another entity. "The best outcomes are from the preservation of a competitive dynamic," Mr. Peterson says. In addition to shrinking the independent hospital's negotiating power, excluding multiple organizations from consideration limits the amount of information the hospital can learn. "[The process] should really be about information gathering for making an incredibly important decision. Gather it from multiple sources," Mr. Peterson says. ■

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5 Changes That Can Increase a Hospital's Value

By Sabrina Rodak

A growing trend in healthcare is for hospitals and health systems to sell, partner or merge to form larger, more integrated organizations. These transactions offer several benefits to all parties involved, including improved efficiencies, cost savings and streamlined services. Hospitals that are selling can optimize the outcomes of the sale by learning how to increase the value of their facility.

The simple answer to increasing value is to increase earnings and decrease costs. But, in a time of declining reimbursements and a slowly recovering economy, manipulating the earnings/costs dichotomy becomes more difficult. Hospital leaders have no control over certain external factors, such as if the state has a certificate of need process, competition, demographics and geography, that influence the hospital's value. Hospitals in states without CONs are likely to have a lower value than those with CONs because there is no limit on where new hospitals are built. If a new hospital is built in the same town as an existing hospital, for instance, the latter will see a decrease in value. However, there are factors leaders have control over that can increase the hospital's value.

1. Proper staffing. Two primary cost containment measures regarding hospitals are salaries,

wages and benefits (SWB) and supplies. Jim Rolfe, managing director of VMG Health's Transactional Services Division, says leaders should evaluate every position in every department to ensure proper utilization and adjust accordingly. "The most efficient and profitable hospitals have SWB running at about 40 percent of net revenue," he says. Leaders can reach this level by downsizing staff and shifting some personnel to part time, according to Mr. Rolfe. However, hospital leaders need to maintain a focus on patient care while reducing costs. "The process of bringing a hospital's SWB to an ideal point should never interfere with quality of care, safety and efficiencies, and needs to be done methodically and over time. The last thing a hospital needs is a mass exit of good, quality staff members," Mr. Rolfe says.

2. Re-evaluate your group purchasing organization contract. "There is a huge opportunity for hospitals, especially non-profits, to evaluate their existing group purchasing contracts, yet they will rarely do it," says Bill Siren, practice leader of Healthcare in the Financial Advisory Services unit at consulting firm AlixPartners. He suggests approaching multiple GPOs to compare cost and then negotiate the lowest possible price for supplies. "Don't be afraid to change GPOs if necessary," Mr. Siren says.

3. Build relationships with physicians.

Strong hospital-physician relationships can increase the value of the hospital. "It's really important that you show a prospective buyer a solid relationship between the hospital and medical staff," Mr. Siren says. CEOs play an important role in building these relationships. Mr. Siren, a former hospital administrator, suggests CEOs take a proactive approach to working with medical staff. "Spend time in physicians' offices instead of waiting for doctors to come in. Spend time in the doctors' lounge engaging with them," he says. In contrast, poor relationships between physicians and the hospital can lower the facility's value. "If there's significant contention between [hospital] management and physicians, the acquisition may become tainted," says Neil Shroff, managing director of the mergers and acquisitions firm Orion Capital Group.

4. Improve efficiencies. Mr. Siren says potential buyers often look at the performance of a hospital in the last 12 months to help determine its value. Thus, Mr. Siren says, as soon as hospitals decide to sell they should start making improvements, such as reducing unnecessary expenses, right-sizing staff and lowering accounts receivable. "One of the specific metrics acquirers tend to seek in hospital acquisitions is low nursing hours per patient. Reducing the average number of hours each nurse spends on any particular patient shows long-term growth and high efficiency," says Mr. Shroff. Making improvements to a hospital will take time, however. Mr. Rolfe says, "If a potential buyer is interested in purchasing a hospital and the expenses have material decrease overnight, the prospective buyer will make adjustments back to higher levels or just walk away."

5. Increase patient satisfaction. Mr. Rolfe says high patient satisfaction can also increase the value of a hospital. "If the patient's experience starts out badly (a long wait time, poor service) then it is hard to regain their satisfaction. Having satisfied patients equals increased volume," he says. "Most hospital patients enter through the ER; it's a big driver for patient satisfaction. Patient satisfaction grows volume," he says. Part of patient satisfaction is also providing services targeted to the community. Mr. Shroff says, "There is a significant amount of segmentation in healthcare and different demographics and geographic regions favor different types of treatment. If you offer the types of medical care that are not aligned with the community, [the hospital] will not demand a higher valuation." ■

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Why Hospitals Need to Start Getting Ready for ICD-10 Now

By Leigh Page

Hospitals have more than two years to get ready for the switch from the ICD-9 to the ICD-10 diagnosis codes, which occurs on Oct. 1, 2013, but coding consultants are urging hospitals to already start preparing.

Some warnings about ICD-10 can sound almost apocalyptic. Eric Mueller, services president of WPC Services in Brentwood, Tenn., states, "The scope of this change is the biggest thing that healthcare has seen." Ray Desrochers of HealthEdge Software in Burlington, Mass., says, "This will be the Y2K of healthcare." Of course, the dire warnings in 1999 about Y2K bringing the economy to its knees never materialized, but Mr. Desrochers argues this was because banks and other institutions took the problem very seriously. He advises hospitals to do the same for ICD-10.

How much on the mark are these warnings? Here consultants and other coding experts explain the ICD-10 system and how it would affect hospitals and other providers.

What the change means

The number of diagnostic codes will rise from 13,000 under the current system to 68,000 and two more digits will be added to the code, moving it from five to seven characters. This will allow for more precise billing information, according to the American Academy of Professional Coders. In fracture care, for example, each particular ICD-10 code differentiates an encounter for an initial fracture, follow-up of fracture healing normally, follow-up with fracture in malunion or nonunion or follow-up for late effects of a fracture, AAPC said.

Very exact information will help hospitals and others mine claims data and improve care delivery, according to *ICD-10 Watch*, an online coding advisor. "Deeper coding creates an opportunity to have a much sophisticated payment platform with more reliable information coming out," *ICD-10 Watch* said. "The result is much more reliable information on outcomes."

But to provide precise billing information, coders will have to study the chart much more extensively and will no longer be able to approximate diagnoses, says Janice Jacobs, director of the regulatory compliance practice at IMA Consulting in Chadds Ford, Pa. Under ICD-10, they can't use unspecified codes to fill in gaps in the chart, as they can do under ICD-9, where there are codes such as "abdominal pain, unspecified quadrant," she says. The quadrant will have to be specified.

Because ICD-10 codes have to be so granular, AAPC predicts they will slow down the process of

documentation, entering new codes and communicating with payors. Coding experts say this will mean lower coder productivity and initially more coding errors and more days in A/R, which they say could last for several years at many hospitals.

Changes for coders

Except for physicians, coders will be the most affected by ICD-10. The new system is more than just an updated version of ICD-9; it represents a whole new coding language, Ms. Jacobs says. "It's a complete change for coders," she says. "In ICD-9, when codes were added it was just sequential. This is completely different."

Even when coders master the new ICD-10 language, they will never be as efficient as before because they will need to spend more time on each chart, Ms. Jacobs adds. To determine the exact code, "coders will have to read the whole chart," she says. "They will never hit the same level of productivity again. If they were doing 50 charts a day, they won't reach that level again."

According to TM Floyd, a coding software company in Columbia, S.C., implementation of ICD-10 in other countries caused an initial 50 percent reduction in coder productivity. Due to lower coder productivity as well as more coding mistakes, "days in A/R will initially go up, and even double in some instances," Mr. Mueller at WPC Services says.

Moreover, to be able to find the exact clinical information in the chart, "the coder is going to need a much more in-depth knowledge of anatomy, physiology and the disease process," Ms. Jacobs says. All of this means extensive training for coders over many months. "But I would not recommend training coders now, because they'll forget what they've learned," she says. "Train them when you get closer to the 2013 implementation date." Identifying the right timing for training will be "a delicate juggling act," she concedes. "I foresee a lot of headaches with it. ICD-9 has been around forever. Coders have to stop cold-turkey and go to ICD-10."

Changes for physicians

Physicians play a pivotal role in the transition to ICD-10. For coders to retrieve exact information from the chart, physicians have to enter the needed information. "The coding is only as good as the chart," says Marcel Handler, CFO for Millin Associates, a coding consultancy in Cedarhurst, N.Y. "The chart is more than just a clinical record," he says. "It is also a billing record. Physicians have to learn what needs to be put there for billing purposes. This is already a problem in ICD-9 and it will be a greater problem for ICD-10."

But unlike ICD-10 training for coders, training for physicians can start right away, because physicians don't actually use the new codes; they just have to provide exact information for them, Mr. Handler says. However, he has found that many physicians don't take ICD-10 seriously yet. Even when a hospital has a certified ICD-10 instructor on staff, he says many physicians are not interested in learning. "My biggest concern is whether physicians will react in a timely manner," he says. "My concern is that they will start looking into it at the last minute."

In helping physicians prepare for ICD-10, hospitals face the familiar problem of trying to persuade mainly independent practitioners to embrace a new system. "There has got to be a 'what's in it for me?'" says Ms. Jacobs of IMA Consulting. "The hospital may have to pay to train physicians, because it would be a good investment." She also recommends phased-in training, which involves identifying physicians who are slow learners and giving them more focused sessions. The hospital could also carry out mini-audits of charts to see which physicians still need more instruction, she says.

Changes in IT systems

To prepare for ICD-10, IT vendors will have to upgrade their systems from the current 4010A1 standard to HIPAA 5010 by Jan. 1, 2012. With that date fast approaching, 48 percent of hospital executives identified implementing ICD-10 as the top financial IT priority for 2011, according to the HIMSS Annual Leadership Survey.

However, "many vendors are not yet up to speed on HIPAA 5100, and they will need to be by January," Mr. Handler says. "Some vendors will make it, but some won't." Hospitals whose vendors don't meet the deadline will have to purchase other systems that do, he says. Likewise, some IT vendors for payors also will have trouble upgrading their systems, Mr. Desrochers of HealthEdge reports. This may impair their ability to process claims, he says.

Changes for hospitals in general

While coders, physicians and IT systems will have the most to do with ICD-10, it will also impact the rest of the organization, Mr. Mueller says. "This new system will affect the workflow and cadences of the entire organization," he says. "Everyone in the revenue cycle, from scheduling through bad debt and collections, is going to experience a huge impact." For example, schedulers who contact the insurer for preauthorization must make sure they are using the right code, he says. If the wrong code was used, the patient might not be covered.

To convey a sense of the new system, he recommends much shorter training sessions for these staff than coders will need.

Ms. Jacobs adds that every paper or digital form in the hospital that will have to be updated for ICD-10. For example, hospital charge tickets and physician practices' encounter forms tend to be quite short, perhaps a page or two, front and back, listing the common codes used. But with ICD-10 vastly expanding the number of codes, the short format will no longer work. "I can't see a physician flipping through a five-page form," Ms. Jacobs says. She thinks hospitals and practices could switch to electronic forms that accommodate more codes by organizing them in a decision tree, for example.

Longer-term implications

Mr. Mueller of WPC Services predicts it will take a few years for hospitals and payors, including Medicare, to get used to ICD-10. "Look at ICD-9," he says. "CMS is still fine-tuning the business rules around code sets and it's now more than 20 years after the implementation."

He also predicts that fraud and abuse allegations against hospitals will rise. "History tells us that whenever there is a new dataset, the number of fraud and abuse cases go up," he says. "Everyone will make mistakes: the payor, the provider, the clearinghouse. It will take a couple of years to work out the kinks."

Increased errors under ICD-10 would also draw the attention for recovery audit contractors, Mr. Desrochers says. "RACs could have a field day here," he says. To guard against this, *ICD-10 Watch*, a respected coding blog, advised hospitals to perform a "RAC data-diving exercise." This involves focusing on highly utilized code sets and determining what kinds of documentation specificity those codes will need. "Once you know your numbers, so to speak, associated with ICD-10, you can drive greater documentation clarity," *ICD-10 Watch* recommended. ■

COMPLIMENTARY WEBINAR Medicare Zero™: An Analysis of Reductions to Medicare's Hospital IPPS and Ways to Improve Medicare Margins to Breakeven or Better

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With so much attention being placed on health reform in general and accountable care organizations, recent proposed reductions to Medicare's Inpatient Prospective Payment System (IPPS) have flown under the radar, relatively unnoticed. The across-the-board reductions to the IPPS are multifaceted, complex and very significant, and in aggregate they will pose a major challenge to hospital finances for years to come. This webinar will present the latest information on these reductions to Medicare reimbursement and suggest strategies to offset the reductions and improve Medicare margins to breakeven or better.

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10 Recent Survey Findings About ICD-10

By Sabrina Rodak

The following findings are compiled from surveys by Contexo Media, J.A. Thomas & Associates and Healthcare Information and Management Systems Society.

1. 63.8 percent of respondents have not started training staff on ICD-10 although 68.5 percent said their staff needs training in anatomy and physiology for the new coding system. *Source: Contexo Media*
2. 52.6 percent of respondents do not have a trainer on staff and 62.8 percent have not had staff attend any ICD-10 seminars. However, only 31.5 percent of respondents said their staff does not need training to meet the new model's increased need for anatomy and physiology knowledge, and only 30.8 percent said they will not train their physicians on ICD-10. *Source: Contexo Media*
3. 74.3 percent of respondents said gaining physician buy-in and then training physicians were their greatest challenge in preparing for ICD-10. *Source: J.A. Thomas & Associates*
4. 50 percent of the respondents who said they are not currently taking steps towards ICD-10 identified other priorities as the reason; 20 percent said ICD-10 preparedness is not currently a priority. *Source: J.A. Thomas & Associates*
5. 71 percent of respondents have formed an ICD-10 Task Force, but only

50 percent have invested in staff training. *Source: J.A. Thomas & Associates*

6. 71.8 percent of respondents said investing in education and training provides the most benefits, with more than half indicating they need help facilitating medical staff acceptance and endorsement of ICD-10 conversion. *Source: J.A. Thomas & Associates*
7. 33 percent of surveyed healthcare IT professionals said their greatest challenge in converting to ICD-10 is a lack of staffing resources. *Source: HIMSS*
8. Other top challenges for healthcare IT professionals included a lack of synchronization between payors and providers (19 percent), a lack of financial resources (15 percent), an inability to test appropriately to ensure compliance with guidelines/regulations (10 percent), changes in regulations from the federal government (9 percent) and inadequate guidelines from health plans and clearinghouses (5 percent). *Source: HIMSS*
9. 48 percent of surveyed healthcare provider organizations said implementing ICD-10/CPT-10 is their top financial IT priority for 2011. *Source: HIMSS*
10. Other top priorities for healthcare provider organizations included upgrading patient billing system information (14 percent) and upgrading the patient access system (4 percent). *Source: HIMSS* ■

AAPC Suggests 16 Steps for Successful ICD-10 Implementation

By Sabrina Rodak

At the Centers for Medicare and Medicaid Services' Code-a-thon on April 26, the American Academy of Professional Coders suggested 16 steps for successful implementation of ICD-10.

AAPC's recommendations include the following:

1. Organize the implementation effort.
2. Develop an ICD-10 communications plan.
3. Conduct an impact analysis.
4. Organize cross-functional efforts.
5. Develop a budget.
6. Design and develop an internal system.
7. Develop a training plan.
8. Contact system vendors.
9. Implement planning.
10. Begin training for Phase I.
11. Perform a business process analysis.
12. Begin education and training for Phase II.
13. Develop policy change.
14. Measure outcomes.
15. Deploy code by vendors to customers.
16. Go live — implementation compliance. ■

Directory Lists Software for Physician ICD-10 Conversion

By Lindsey Dunn

The AMA and the Medical Group Management Association have created an online directory that lists software vendors that can help physicians install HIPAA 5010 connectivity in advance of conversion to the ICD-10 system, according to a release by the MGMA.

In preparation for the ICD-10 conversion, providers will be required to shift from 4010A1 to the HIPAA 5010 system by Jan. 1, 2012.

The two groups' Practice Management System Software Directory identifies features most important to physician practices, such as:

- Price range for the product, excluding implementation costs.
- Current installed customer base for the product.
- Target market for the product.
- Number of years the practice management software has been offered.
- Affiliated electronic health record products. ■

Report: EMR Market Expected to Top \$6B by 2015

By Bob Herman

The electronic medical record market is expected to increase to \$6 billion by 2015, up from \$2.1 billion in 2009, according to a report by marketing research firm Markets and Markets.

Web-based EMR systems are gaining traction with smaller healthcare practices and private physician practices due to lower implementation costs, the report stated, while hospitals and other large healthcare practices typically use client-server based EMR systems, which comprise roughly 76 percent of the EMR software market. The development of interoperable EMR solutions is also the biggest focus among companies in the market.

There are more than 1,000 EMR providers in the market, and Meditech holds the largest hospital EMR segment with an overall market share of 24.9 percent, according to the report. ■

17 States Launch Medicaid EHR Incentive Programs

By Bob Herman

Seventeen total states have launched their Medicaid EHR Incentive Programs, and 11 of them have paid a total of \$114.4 million to qualifying physicians and hospitals, according to a *Government Health IT* report.

Roughly 8,000 healthcare providers in 11 states and 19 hospitals have registered for the program, the report said.

The remaining states yet to launch their incentive programs should have them running by September, with CMS funding states 90 cents for every dollar used toward administrative and oversight costs. The Medicaid EHR Incentive Program differs from the Medicare program as there are no penalties for providers that have not implemented EHR systems and it lasts 10 years. ■

Proposed HIPAA Change Would Allow People to Learn Who Accessed Protected Health Information

By Rob Kurtz

HHS has proposed changes to the HIPAA Privacy Rule which allow people to learn who has electronically accessed their protected health information.

If passed, the revised Rule would allow people to obtain this information by requesting an access report, which would document the particular persons who electronically accessed and viewed their PHI.

Although covered entities are currently required by the HIPAA Security Rule to track access to ePHI, they are not required to share this information with people.

“This proposed rule represents an important step in our continued efforts to promote accountability across the healthcare system, ensuring that providers properly safeguard private health information,” said HHS’ Office for Civil Rights Director Georgina Verdugo, in a news release. “We need to protect peoples’ rights so that they know how their health information has been used or disclosed.” ■

ONC Meaningful Use Workgroup Recommends Pushing Back Stage 2 for Those Attesting in 2011

By Jaimie Oh

The meaningful use workgroup, which advises the Office of the National Coordinator for Health IT, has recommended it push back stage 2 of meaningful use by one year to 2014 in order to ease time restraints for eligible providers who attest in 2011.

In a draft letter addressed to the ONC, workgroup members cited vendors’ and eligible healthcare providers’ concerns that the current time-frame for stage 2 meaningful use “poses a nearly insurmountable timing challenge” for those seeking attestation in 2013.

According to the news report, the stage 2 final rule is likely to be released June 2012. This deadline would make it difficult for vendors to design new electronic health records with the required functionalities by Oct. 2012. Similarly, eligible providers that have attested in 2011 would face the challenge of adopting and demonstrating meaningful use of these systems by Jan. 2013. ■



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Running an Academic Medical Center: Q&A With Johnese Spisso, Chief Health System Officer of UW Medicine

By Sabrina Rodak

Academic healthcare organizations face some challenges that are unique to academic facilities, such as educating and monitoring students and balancing this education with delivering quality care to patients and conducting cutting-edge research. Johnese Spisso, RN, MPA, chief health system officer of Seattle-based UW Medicine and vice president of medical affairs at the University of Washington, describes challenges of running academic health systems and offers strategies to succeed.

Q: What are the challenges of running UW Medicine Health System?

Johnese Spisso: UW Medicine includes seven entities — Harborview Medical Center, UW Medical Center, Northwest Hospital & Medical Center, UW Neighborhood Clinics, UW Physicians, UW School of Medicine and Airlift Northwest. Healthcare today is a very challenging business. UW Medicine experiences the same challenges as many other large academic health systems.

Today, some of the biggest issues in academic centers is how we continue to stay financially viable while delivering the unique mission of improving health for patients through our expert clinical care, teaching the next generation of healthcare professionals and conducting clinical and basic science research that allows us to transform healthcare discoveries into improved

outcomes for patients. UW Medicine also serves as the only academic health system and medical school in a five-state area — Wyoming, Washington, Alaska, Montana and Idaho — operates the only Level I Trauma and Burn Center in this region, is the sole provider of the most complex quaternary care and provides the lion's share of uncompensated care (safety-net care for the entire state of Washington), so we have a huge responsibility to serve our region.

Q: How do you overcome these challenges?

JS: We overcome these challenges through our strategic efforts in integrating our care across health system sites, partnering with our region, implementing rigorous patient safety and quality programs and hardwiring service excellence throughout our system. We have system-wide pillar goals that focus on putting the needs of our patients first and measuring performance against goals on patient satisfaction, quality and safety, employer of choice and fiscal responsibility. We have a leadership team that is very aligned in embracing these goals and the accountability for them.

Q: How do you maintain UW Medicine's success as healthcare reform legislation makes significant changes to the healthcare industry?

JS: Our success is due to our efforts at effective and proactive strategic planning that is an ongoing part of our work every day. We stay focused on our mission and have continued to integrate across the seven entities. We are focusing on further system integration to prepare UW Medicine to serve as an accountable care organization and are working diligently to improve the quality and safety of care while reducing the overall cost and improving value for patients.

Q: What are your short-term and long-term goals for UW Medicine?

JS: Our short-term goals relate to the successful implementation of our annual operating and capital budget plans for the system, completing the investments in some of our new building projects and completing the deployment of IT systems. Our long-term goals relate to continuing to successfully implement our long-term financial and strategic plans that will allow us to continue to succeed in our mission of improving the health of the public and serving patients from all walks of life through our clinical, teaching and



research discoveries. This will allow us to continue to succeed as a world class academic health system that is really changing the world through these efforts, both locally and globally.

Q: What strategies will you use to reach these goals?

JS: Our strategies are based on our strategic plan and pillar goals. These include expanding and strengthening our centers of excellence and core clinical programs, delivering consistent excellent access and services for every patient every time, expanding our strategic partnerships in the region, expanding our network of primary and secondary care, creating more capacity for tertiary and quaternary care and continuing to strengthen our teaching and research programs.

Q: What is the most important lesson you've learned through your work at UW Medicine?

JS: I have learned that our success is due to having alignment of the team, commitment to the core mission of improving health through clinical care, teaching and research and collectively supporting this work as an integrated health system. You also have to empower the team and have the right leaders in the right roles at the right time.

Q: What advice can you give to other healthcare leaders?

JS: Stay focused on your mission, keep strategic planning as a dynamic process so that you can respond to windows of opportunity, be transparent in your communication and be sure everyone knows the key messages at key times and stays engaged in the process. ■

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Academic Health and Hospital Operator Partnerships: Q&A With Dr. Bill Fulkerson and Bill Carpenter of Duke LifePoint Healthcare

By Molly Gamble

Durham, N.C.-based Duke University Health System and Brentwood, Tenn.-based LifePoint Hospitals announced the formation of a joint venture in Jan. 2011. The partnership, Duke LifePoint Healthcare, is designed to strengthen healthcare in the region by providing affiliation options for community hospitals. Since its formation, the joint venture has made strides in North Carolina's healthcare market, with two pending hospital deals – Maria Parham Medical Center in Henderson, N.C., and Person Memorial Hospital in Roxboro, N.C. – and the acquisition of nine cardiac catheterization labs from Charlotte, N.C.-based MedCath.

Bill Fulkerson, MD, executive vice president of Duke University Health System, and Bill Carpenter, Chairman and CEO of LifePoint Hospitals, say this partnership has a unique synergy and makes tremendous sense. Dr. Fulkerson and Mr. Carpenter spoke to *Becker's Hospital Review* about how they found one another as partners, their shared vision for community hospitals and what they believe makes a successful joint venture.

Q: Can you provide some background on this joint venture? How did Duke and LifePoint find one another?

Dr. Fulkerson: We have worked with LifePoint for three or four years. They invited us to come in and strengthen the cardiovascular program at Danville (Va.) Regional Medical Center, which is about 50 miles from Durham and has traditionally been a referral community for Duke. I think over that period of time, we really learned about LifePoint's tremendous commitment to quality, safety and outcomes. This partnership grew out of the affiliation we had in Danville and the positive outcomes that occurred there. There is a fairly unique synergy between LifePoint's management skill and our ability to work with them in clinical program enhancement.

Mr. Carpenter: Many hospitals in smaller communities are struggling and trying to survive and remain relevant in their communities. These hospitals are such viable parts of their communities, and many of them have sought Duke for advice because of the reputation Duke has in the region, and even beyond the region. Our affiliation in Danville let us get to know each other. So, as community hospitals are trying to figure out alternatives and because of the successful af-

filiation we had in Danville, Duke and LifePoint developed this joint venture.

Q: What do you think each organization brings to the venture that would be difficult to achieve independently?

Dr. Bill Fulkerson: We feel there is real synergy around LifePoint's strengths and our strengths. LifePoint's commitment to quality and safety is second to none. Together, we can help community hospitals develop stronger programs than they have historically ever had.

Mr. Bill Carpenter: LifePoint owns and operates 52 hospitals in smaller communities, and we provide a full range of management, financial and operational resources. We provide access to capital so hospitals can invest in new technology. These are the things that are important in small communities that let people feel good about staying closer to home for care. Duke, though, offers hospitals a level of clinical oversight and guidance that is unmatched. It also offers access to highly specialized medical services that simply won't ever be provided in a community hospital.

Q: What advice would you offer to healthcare providers contemplating or launching joint ventures?

Mr. Carpenter: Find a compatible partner. Be clear about roles and goals. Rely on each other's strengths. Be flexible. Going into this, we knew we had a plan, but we also knew everything wouldn't go exactly as planned. From LifePoint's perspective, we've found a compatible partner in Duke. When things don't first go the way we expect them to, we'll discuss it and be flexible.

Q: What are some of Duke-LifePoint's long-term goals?

Mr. Carpenter: Our goal is to acquire, own and operate hospitals in North Carolina and the surrounding region. We don't have a set number in mind. As [Dr. Fulkerson] said, we have announced agreements with two hospitals and the purchase of nine cath labs. What we want to do is build a system of hospitals that will transform healthcare in this region and enhance the services available to people in our communities. We think the Duke-LifePoint partnership is an extremely powerful vehicle to accomplish that.



Dr. Bill Fulkerson



Bill Carpenter

Q: Can you provide some insight as to the challenges community hospitals are facing?

Mr. Carpenter: We're seeing community hospitals around the country struggle with access to capital and have a difficult time recruiting physicians. There have been many changes in the healthcare industry, and much of that has been brought on by healthcare reform and regulatory changes. Community hospitals are really feeling pressure under the HITECH Act, also. They want to know how they can continue to recruit physicians and find capital for

improvements, such as state-of-the-art equipment and technology. With reimbursement decreases and all of these other pressures, community hospitals are seeking the support and security of a partner, and we hope many in North Carolina and the region will choose us to help them meet these challenges.

Dr. Fulkerson: I think independent hospitals, especially smaller ones, are simply going to struggle without the scale necessary to respond to these challenges. Hospitals need the scale that allows them to draw on a system's resources, access purchasing and contracting power and take advantage of infrastructure support for HIT. They also need stability, in regards to physicians and finances, so they can do necessary recruitment. Physicians will migrate to areas they feel are growing and stable.

Q: This is one of the first partnerships between an academic health system and a hospital operator. Do you think we can expect more of these to come?

Dr. Fulkerson: I'd be surprised if similar models aren't developed. Our idea and partnership may be new, but it makes tremendous sense. It leverages both of our talents in a very productive way. I suspect we'll see more partnerships like this around the country.

Mr. Carpenter: We believe the scale achieved in regional areas will be very important in the future. So LifePoint is looking for some more relationships across the country to help our company grow. I do think this is an innovative model, and LifePoint is excited to be part of it. We think this is one of the answers for how to improve healthcare in the future. ■

Quint Studer: Raising HCAHPS Is About More Than Better Service...It's About Better Quality

By Lindsey Dunn

HCAHPS results are playing an increasingly larger role in the financial well-being of America's hospitals.

Since 2007, CMS has required most hospitals to submit HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), a standardized survey tool to measure patient perception of the quality of care received, or face payment reductions. However, beginning in its fiscal year 2013, it will move from a pay-for-reporting system to one based on pay-for-performance. That's when CMS implements its value-based purchasing program, which will reward and penalize hospitals for performance on certain indicators, including certain HCAHPS measures.

Under the proposed value-based purchasing rule, 30 percent of each hospital's total performance score would be based on patient experience indicators as determined by HCAHPS. In the first year, the other 70 percent of the score would be based on 17 core process measures.

However, some have suggested that this weighting creates too much of a focus on patient experience as opposed to clinical outcomes. The American Hospital Association, for example, recently asked CMS to reduce this weighting to 15 percent.

But Quint Studer, founder and CEO of Studer Group, says HCAHPS results and quality are actually two sides of the same coin.

HCAHPS link to quality

Mr. Studer says the HCAHPS survey not only provide an accurate reflection of the quality of

care provided but also gives hospitals a sense of how well they are performing their mission.

While it's true that HCAHPS measures patient perception of quality, many of the results also directly connect to actual quality. Measures on whether patients received information about which medications they are taking and whether they received discharge instructions are two prime examples, says Mr. Studer.

By making sure patients take their medications properly and that they do the right things after they leave the hospital, care providers make it more likely that patients will stay safe and heal faster, he says.

HCAHPS results are also a useful tool in helping hospitals assess whether they are performing in line with their missions.

"I've never met a mission statement — at for-profit and non-profit hospitals alike — that did not mention providing 'excellent care' or 'compassionate care' to the patient," he says. "Well, properly explaining medication or making sure pain is controlled are how care is provided. So asking patients questions about how well you're doing these things completely connects back to the mission and values of an organization."

Best practices for improving HCAHPS scores

The growing importance of the HCAHPS has led many hospitals to begin examining their practices and identifying ways to improve patient experience. Improving scores may be a lot simpler than many hospital leaders think, says Mr.



Studer. Most often, it boils down to consistently providing better communication.

In the new book, "The HCAHPS Handbook: Hardwire Your Hospital for Pay-For-Performance Success," Mr. Studer and co-authors Brian C. Robinson and Karen Cook, RN, offer a variety of tips for improving communication and therefore, patient experience and quality.

The following tips can benefit nurses as well as physicians and all other healthcare professionals who work directly with patients in a hospital setting. While they may seem simple, they go a long way in making patients feel cared for and about.

Upon hospital admission

Manage patient expectations. By this, Mr. Studer means demonstrating to patients that you expect them to receive the highest quality care and best service possible. "Talk about the fact

you want them to receive excellent care and service, and lay out that expectation,” he says.

Provide an “excellent care” hotline. Each patient should be given the name of a person to contact, along with a direct phone number, in case he or she receives anything less than excellent care. Typically the nurse manager for the unit would fill this role, visiting each new patient and providing his or her card and encouraging the patient to reach out if he or she is unhappy with the care received, says Mr. Studer.

During patient encounters

Implement bedside shift reports. Essentially, this tactic means that any time one nurse “hands over” a patient to another — at shift change, for instance — all necessary information is exchanged at the patient’s bedside. This includes information on patient identifiers, safety checks, medications, tests and so forth.

Not only does this make patients feel they are part of their plan — a basic patient right — but it also allows patients to verify that all information is accurate.

“Bedside reporting greatly decreases the likelihood of misses and mistakes,” notes Mr. Studer. “It keeps patients safe. It also improves quality of care, increases nurse accountability and teamwork, and raises the patient’s trust in the organization.”

Practice Hourly RoundingSM and Nurse Leader Rounding. Hourly Rounding essentially means that an organization has a staff member visit every patient every one to two hours, practicing a series of eight very specific behaviors every time. According to the September 2006 *American Journal of Nursing*, this tactic decreases call lights by 37.8 percent, decreases falls by 50 percent, decreases hospital-acquired decubiti by 14 percent and improves patient perception of care by 12 mean points.

Nurse Leader Rounding is a tactic in which nurse leaders (or their properly trained delegates) round on every patient every day. It’s meant to ensure that quality, safe, compassionate care is delivered to every patient, every time, says Mr. Studer.

“Both types of rounding allow you to head off problems at the pass,” says Mr. Studer. “When staff members are constantly in and out of the room,

looking for specific things and asking carefully targeted questions, it’s far less likely that things will go wrong—and far more likely that a patient will have a positive overall experience.”

Show respect. Knock before entering and acknowledge others in the room. This applies to nurses, physicians and any other care provider who enters a patient’s room. “Asking for permission [to enter] suggests a matter of respect for the patient,” says Mr. Studer.

Also, it’s important to acknowledge everyone in the room, he adds. All staff members entering the room should first give their names, roles and what they are there to do. They should also ask the patient’s name and what he or she prefers to be called and should introduce themselves to the family members and visitors in the room.

“Staff members should also ensure the patient is okay with visitors being present while personal health information is discussed,” says Mr. Studer.

Use open-ended questions. All questions should be asked in a way that promotes open-ended responses. This makes patients feel they are being listened to, says Mr. Studer. How you word questions is also important, he says. For example, he recommends not asking patients if they have questions about directions, medications, etc., but rather asking them what questions they have.

Paraphrase patient responses. This demonstrates to patients that providers are listening and that they fully understand what patients are saying. Mr. Studer recommends using language such as, “I want to make sure I heard you correctly” and “Let me understand...”

At discharge

Thank patients. When the time for patients to leave the hospital is approaching, in addition to providing clear discharge instructions, staff members should say thank you.

“Actually, each staff member who comes in contact with the patient throughout the stay should thank him or her for choosing the hospital,” says Studer. “Reinforce at every opportunity that you want to make it a great experience for the patient.”

Quint Studer is a recognized leader and change agent in the healthcare industry and has more than 20 years of healthcare experience. Learn more about Studer Group at www.studergroup.com.

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Hospital & Health System Transactions

Beth Israel Deaconess Medical Center in Boston and 81-bed **Milton (Mass.) Hospital** plan to merge by October. The hospitals have shared a business relationship for eight years and are already clinical affiliates. BIDMC will oversee Milton's operations and finances. Milton will keep control of strategic planning and its own board of trustees.

Franklin, Tenn.-based **Community Health Systems** acquired substantially all of the assets of Scranton, Pa.-based **Mercy Health Partners** from Cincinnati-based **Catholic Health Partners**. The acquisition includes 198-bed Regional Hospital of Scranton (Pa.) and 48-bed Tyler Memorial Hospital in Tunkhannock, Pa., bringing CHS' total number of acute hospitals in Pennsylvania to 13.

Community Hospital Long Beach (Calif.) joined Fountain Valley, Calif.-based **MemorialCare Health System** as its sixth hospital in Los Angeles and Orange Counties. Under the agreement, MemorialCare assumes the lease of Community Hospital from the City of Long Beach.

Lebanon, N.H.-based **Dartmouth-Hitchcock Health** and Bennington, Vt.-based **Southwestern Vermont Health Care** plan to affiliate. The affiliation is part of SVHC's strategic plan to expand the network of physicians and services available to patients. Discussions regarding the partnership should be complete by the fall.

Nashville, Tenn.-based **HCA** completed its acquisition of Miami's 473-bed **Mercy Hospital**. Mercy Hospital is now a campus of HCA affiliate Plantation (Fla.) General Hospital, and has been renamed Mercy Hospital – A campus of Plantation General Hospital. Mercy Hospital will retain its Catholic identity.

Naples, Fla.-based **Health Management Associates** is in negotiations with Knoxville, Tenn.-based **Mercy Health Partners**, part of Cincinnati-based **Catholic Health Partners**, to acquire its seven hospitals. MHP hopes to complete the transaction by this fall.

Naples, Fla.-based **Health Management Associates** completed the transaction to form a joint venture with the current physician owners of the 112-bed **Tri-Lakes Medical Center** in Batesville, Miss. HMA will own a 95 percent controlling interest in Tri-Lakes and will manage its operations.

The FTC approved the sale of MedCath's **Heart Hospital of New Mexico** in Albuquerque to Albuquerque-based **Lovelace Health System**. As part of the deal, Lovelace Health System, which is owned by Nashville, Tenn.-based Ardent Health Services, will pay \$119 million for the hospital.

Long Island College Hospital in Brooklyn, N.Y., is officially part of **SUNY Downstate Medical Center**, also in Brooklyn. LICH has been renamed the University Hospital of Brooklyn at Long Island College Hospital.

Phoenix-based **Maricopa Integrated Health System** has partnered with the **University of Arizona College of Medicine** in Phoenix to become the school's primary teaching, training and research hospital.

A management services and affiliation agreement was finalized between 235-bed **Marin General Hospital** in Greenbrae, Calif., and 83-bed **Sonoma (Calif.) Valley Hospital**. The partnership is expected to allow both hospitals to share more physicians, negotiate more favorable reimbursement rates and possibly reduce IT, billing and marketing services.

The 176-bed **Martha Jefferson Hospital** in Charlottesville, Va., merged with Norfolk, Va.-based **Sentara Healthcare**, becoming the non-profit system's 10th hospital.

Rochester, Minn.-based **Mayo Clinic** has announced plans to acquire 25-bed **Queen of Peace Hospital** in New Prague, Minn. The hospital and its clinics, which are based in New Prague, Belle Plaine, Le Sueur and Montgomery, will be renamed Mayo Clinic Health Systems when the deal is finalized in July.

Asheville, N.C.-based **Mission Health** will manage **Angel Medical Center** in Franklin, N.C. Angel CEO Tim Hubbs compared the management deal to an "engagement" preceding marriage, or a full merger.

Morton Hospital and Medical Center in Taunton, Mass., has filed formal notice with the state attorney general's office of its plan to

be acquired by Boston-based **Steward Health Care System**. The acquisition would convert the non-profit hospital to for-profit status.

Ripon (Wis.) Medical Center is now a member of **Agnesian HealthCare**, based in Fond du Lac, Wis. RMC will retain its name and current services with the addition of specialties.

A merger between **Seton Health** in Troy, N.Y., and Albany, N.Y.-based **Northeast Health and St. Peter's Health Care Services** will result in a new health system with a new name: **St. Peter's Health Partners**. The names of all four acute-care hospitals in the New York system will remain the same under the new system identity. These facilities are Albany Memorial Hospital, St. Mary's Hospital in Troy, St. Peter's Hospital in Albany and Samaritan Hospital in Troy.

Athens, Ga.-based **St. Mary's Health Care System**, part of Newtown Square, Pa.-based **Catholic Health East**, signed a letter of intent to acquire **Saint Joseph's East Georgia** in Greensboro, Ga.

Chapel Hill, N.C.-based **UNC Health Care** rejected Raleigh, N.C.-based **WakeMed Health's** unsolicited offer to purchase **Rex Healthcare**, also in Raleigh, for \$750 million. UNC President Tom Ross said he did not believe divesting UNC Health Care of Rex was in the long-term best interests of the people of North Carolina.

The board of commissioners of Coupeville, Wash.-based **Whidbey General Hospital** unanimously rejected a proposal by Franklin, Tenn.-based **Capella Healthcare** to buy the hospital. Although Capella did not make a specific proposal, they suggested leasing the facility from the hospital district, purchasing it or operating it as a joint venture with 50-50 ownership.

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Hospital & Health System Executive Moves

Wayne Ferch was named president and CEO of Hanford, Calif.-based Adventist Health's Central Valley Network.

Richard S. Freeman was named CEO of the proposed Hackensack (N.J.) University Medical Center at Pascack Valley in Westwood, N.J. The Pascack Valley facility is not open, as LHP Hospital Group, HUMC's partner in the Pascack Valley venture, and HUMC recently filed a certificate of need to reopen former Pascack Valley Hospital.

Michael S. Herman was named COO of Gallatin, Tenn.-based High-Point Health System. He most recently served as vice president of operations of Summerville (S.C.) Medical Center, part of Charleston, S.C.-based Trident Health System.

Lowell Johnson, FACHE, was named interim CEO of Salinas (Calif.) Valley Memorial Healthcare System. He replaced **Sam Downing**, who retired.

Bruce Klockars, FACHE, was named interim CEO of Saint Joseph Health System in Lexington, Ky., and senior vice president of divisional operations for parent company Catholic Health Initiatives. He previously served as president of Saint Joseph Health System's Flaget Memorial Hospital in Bardstown, Ky., and Saint Joseph – Mount Sterling (Ky.).

Kerry Kohnen was named president of Oakland, Calif.-based Kaiser Permanente Georgia. He most recently served as senior vice president of operations for Kaiser Permanente Georgia.

Gordon Larson was named the first CEO of Sanford Aberdeen (S.D.) Medical Center, part of Sanford Health Network, based in Fargo, N.D., and Sioux Falls, S.D. Mr. Larson had most recently served as CEO for Winner (S.D.) Regional Healthcare Center.

Luke McGuinness leads the new system created by the merger of Winfield, Ill.-based Central DuPage Hospital and Geneva, Ill.-based Delnor Hospital. Mr. McGuinness served as president and CEO of CDH. **Michael Vivoda** replaced him as president and became executive vice president of the new system.

Edward Miller, MD, will retire as CEO of Baltimore's Johns Hopkins Medicine and as president and CEO of Johns Hopkins School of Medicine. He has served as CEO of Johns Hopkins Medicine since 1997.

Gary P. Miller was named president and CEO of St. Alexius Medical Center in Bismarck, N.D. He joined the center in 1984 as director of fiscal and information services and most recently served as senior vice president and CFO.

Memorial Health Care System in Fremont, Ohio, named **Wesley Oswald** interim CEO effective April 1. He temporarily replaces **John Yanes**, who left for a position at O'Bleness Memorial Hospital in Athens, Ohio.

Mark Rader was named CEO of 317-bed University Hospital and Medical Center in Tamarac, Fla., part of Nashville, Tenn.-based HCA. In addition to his role at the hospital, Mr. Rader joined the board of directors at the Tamarac Chamber of Commerce.

Keith Richardson was named vice president and CFO of Adventist La Grange (Ill.) Memorial Hospital. He replaced **Paul Ziegele**, who became vice president and CFO of Florida Hospital Zephyrhills (Fla.) after nine years at La Grange.

CEO **Valinda Rutledge** will step down from her post at Gastonia, N.C.-based CaroMont Health to serve as director of the Patient Care Models Group at CMS' new Center for Medicare and Medicaid Innovation.

Randy Safady was named executive vice president and CFO of Irving, Texas-based CHRISTUS Health. He had served as executive vice president

and CFO of Englewood, Colo.-based Centura Health since 2007.

Kevin Schoeplein was named CEO of Peoria, Ill.-based OSF Healthcare System. He replaces **James M. Moore**, who retired after 34 years with the organization.

John Tressa was named CEO of Houston's 444-bed Park Plaza Hospital, part of Dallas-based Tenet Healthcare.

Paul Whelton, MD, resigned as president and CEO of Maywood, Ill.-based Loyola University Health System.

Irving, Texas-based CHRISTUS Health made changes to its leadership team to meet future challenges. **Gene Woods** became executive vice president and COO. **Paul Generale**, who previously served as vice president and chief financial officer for CHRISTUS St. Vincent Medical Center in Santa Fe, N.M., became vice president and senior financial officer of CHRISTUS Health. He is also serving as interim CFO for CHRISTUS Health until the position is filled.

Chris York, MBA, FACHE, was named COO of 276-bed Baylor Regional Medical Center at Grapevine (Texas). He replaces **Scott Peek**, who was named president of the new Baylor Medical Center at McKinney (Texas).

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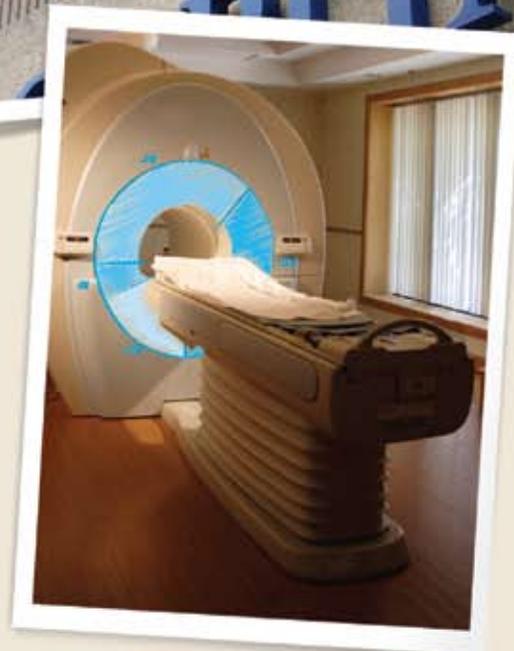
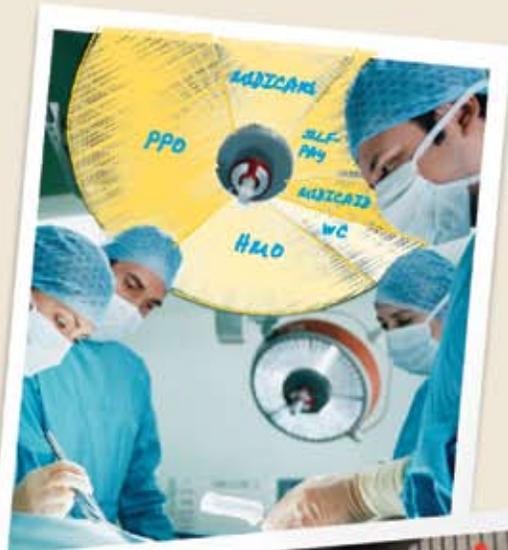
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