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BECKER'S

Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

March/April 2012 • Vol. 2012 No. 3

Healthcare Reform: Two Years Gone, Now What's on the Horizon?

By Bob Herman

President Barack Obama signed the landmark healthcare reform bill, the Patient Protection and Affordable Care Act, into law in March 2010, and now here we are, two years later, trying to absorb the ramifications of the past and prepare for the future.

It's not easy to remember or grasp every section of the bill — the 974-page piece of legislation is not your typical light reading. However, it's important to look back and reflect on how the healthcare environment has changed in the past two years and to see the new initiatives and challenges that lie ahead.

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7 Steps for Building a Top-Tier Cancer Center

By Sabrina Rodak

Many hospitals are building or upgrading oncology centers to more efficiently and effectively treat cancer patients. For example, the University of Nebraska Medical Center and The Nebraska Medical Center, both in Omaha, recently announced preliminary plans for an estimated \$370 million cancer center. In addition, UC San Diego Health System recently acquired the Nevada Cancer Institute in Las Vegas. Through these significant investments, hospitals aim to provide the latest and best oncology care. However, a building alone cannot guarantee top-rate cancer services. Here are seven steps hospitals can follow to develop a successful cancer center.

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Despite Distressed Assets, Private Equity Firms See Value in Healthcare

By Kathleen Roney

During 2011, healthcare mergers and acquisitions saw 980 deals worth a total of \$227.4 billion, an 11 percent increase from \$205.6 billion in 2010, according to an Irving Levin Associates report. The upswing in healthcare mergers and acquisitions is likely to continue into 2012 and even 2013. In light of national healthcare reform, hospitals and health systems are looking to cut costs and integrate services. As a result, the sectors of home-health, ambulatory surgery centers and physician practice groups may see the largest amount of consolidation and acquisition.

According to Brent Hill, JD, healthcare transactional attorney at Waller Lansden Dortch & Davis in Nashville, Tenn., decreases in healthcare reimbursement rates and the Patient Protection and Affordable Care Act are placing downward

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- Key Thoughts on Budgeting in Times of Uncertainty - John R. Zell, VP of Finance and CFO, OSF St. Joseph, Henry Brown, CFO, Internal Fixation Systems, Joseph Guaraccino, Senior Vice President & CFO at The Brooklyn Hospital Center, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP
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Correction: The February Special Issue incorrectly identified David Strong, of Rex Healthcare, as David Shaw. We apologize for the error.

Publisher's Letter

Inside This Issue; 2012 Becker's Hospital Review Annual Meeting — May 17-18, Chicago

March/April Issue. We are pleased to share with you the March/April issue of *Becker's Hospital Review*. This issue includes several in-depth feature articles including a review of changes in healthcare since the signing of the Patient Protection and Affordable Care Act, which has just reached its two-year mark. Our annual list of 70 Hospitals and Health Systems With Great Oncology Programs is also included, as is the complementary story, "7 Steps for Building a Top Tier Cancer Center," featuring leaders from the Siteman Cancer Center at Barnes-Jewish Hospital in St. Louis and the Seidman Cancer Center at University Hospitals in Cleveland. The issue also includes a one-on-one interview with Dr. Elizabeth Nabel, president of the renowned Brigham and Women's Hospital in Boston. In the article, Dr. Nabel discusses the importance of turning challenges into opportunities within the context of the ever-changing healthcare environment.

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Healthcare Reform: Two Years Gone, Now What's on the Horizon? (continued from page 1)

What has transpired

When the PPACA became law on March 23, 2010, immediate changes took place within healthcare. For example, starting in September 2010, young adults were allowed to stay on their parents' health plans until they turn 26 years old. The PPACA also instituted an option for states to offer health plans for those with pre-existing conditions who were turned down by other health insurers. While these provisions helped the national healthcare system at large, they did not have monumental impacts on how hospitals and health systems went about their business.

Last year saw more substantive change, both for the general American populace as well as for the hospital and health system sector. In 2011, the PPACA enforced the medical loss ratio, which required health insurers to spend 80 to 85 percent (depending on their market) of premium dollars on medical care as opposed to administrative costs and profits. If insurers do not spend the required amount, they must send rebates to consumers. The MLR requirement has led to a new era of stringent price negotiating and managed care reimbursement talks between hospitals and health insurers.

Pauline Rosenau, PhD, professor of management, policy and community health at the University of Texas School of Public Health in Houston, has written extensively on healthcare reform. She says the regulation of commercial payors was a big step in helping advance the U.S. healthcare system to that of other countries. "The biggest element is the increased regulation of the insurance agencies," Dr. Rosenau says. "It's new to the United States, but this level of regulation is common to other industrialized nations around the world."

Primary care physicians and general surgeons also benefited from the PPACA, as they received reimbursement increases of 10 percent from Medicare in an effort to emphasize preventive care. Other major measures of the PPACA that have come to fruition include:

- Pharmaceutical companies must provide a 50 percent discount on all name-brand prescription drugs to Medicare beneficiaries who fall in the Part D drug plan coverage gap, or the "doughnut hole." The Department of Health and Human Services estimated that Medicare beneficiaries who fell in the doughnut hole saved a combined \$2.1 billion on prescription drug costs in 2011.

- Medicare Part C plans, which are the privatized health plans known as Medicare Advantage, can no longer raise cost-sharing requirements for certain benefits. Additionally, MA payments and premiums will be set at increasingly smaller percentages than traditional fee-for-service Medicare plans.

- Medicare enrollees can now receive certain preventive services, such as annual check-ups, for free without co-payments.

Jeffrey Steinberg, MD, CEO of Weiss Memorial Hospital in Chicago, says what has actually been enacted so far is only the tip of the iceberg, as the U.S. healthcare system is just beginning a wholesale change to value-based care. "Right now, we are in a fee-for-service world," Dr. Steinberg says. "It's a world where the more we do, the more hospitals and physicians make. But that's changing. There are a lot of innovation models from CMS, and we're at the front end of the changes."

Those models include accountable care organizations, shared savings programs, bundled payments, readmissions reductions and an overall shift toward accentuating primary and preventive care, which are going to be a bigger part of 2012. "What I see happening globally is that there's a realization in the industry there are things that need to happen to take care of patients in the community," says Jay Fathi, MD, director of community health at Swedish Medical Center in Seattle. "That hasn't been reimbursed before. We're going to start rewarding systems for things that haven't been done optimally in the past."

However, the PPACA hit a major speed bump in October 2011 when HHS Secretary Kathleen Sebelius and the rest of the Obama administration agreed to terminate part of the law: The Community Living Assistance Services and Supports Act, which would have been a long-term care insurance program that provided cash benefits to adults who became disabled. Although the CLASS Act would not have impacted acute-care hospitals much, it was an ominous sign that the healthcare reform law may have to fight bigger challenges down the road.

Finally, the two biggest — and most controversial — components of the healthcare law that made ripples in 2011 actually won't go into effect until 2014: the individual mandate in which most Americans will be required to buy health insurance through their employer or health insurance exchanges and the expansion of the Medicaid program. The Supreme Court decided last year it will hear and discuss the constitutionality of those two provisions in 2012 after a maelstrom of criticism and lawsuits swept the country, which will make this year even more important for the hospital and healthcare industry.

What 2012 means

Healthcare reform is coming to a fork in the road this year. Either it will move on unimpeded, or it will hit figurative blows to the head from the judicial and political systems. There are four main components surrounding the healthcare law that will define 2012.

1. Supreme Court ruling. When it comes down to it, nothing will be more important to the healthcare industry than the Supreme Court's constitutional ruling of the PPACA. It is expected the Supreme Court will issue a decision by the end of June.

The individual mandate requiring most people to obtain health coverage and the expansion of Medicaid are the main policies at the center of the debate. The Supreme Court can rule in several different ways. It can strike down the entire law, which would send the healthcare industry into a legislative chaos of sorts after two years of implementation. It could also rule that only the two provisions in question are unconstitutional, but the rest of the law may stand. This could still create a stir as removing those provisions could water down the impact of the PPACA, Dr. Rosenau says.

The Supreme Court could also say the challenge of the individual mandate and Medicaid expansion cannot be heard because it has not yet gone into

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effect, thus not causing any damages. "There is a loophole in consideration: You can't really sue for damages unless you've actually suffered damages," Dr. Rosenau says. "Until you've started requiring people to buy insurance, you may not be able to bring the case to the Supreme Court."

Regardless of what the Supreme Court decides, the mere uncertainty around the law is enough to give hospital executives and all others in healthcare an unsettling feeling, Dr. Steinberg says. Additionally, Dr. Rosenau says these legislative challenges are hindering hospitals and their main goals: providing healthcare. "If I'm a hospital administrator, I'd be staying up all night pulling at my hair because no one knows for sure if [the PPACA] is going to be ruled as constitutional or not," Dr. Rosenau says. "This is not good for hospitals or insurers or any other healthcare provider because you want to get on with the business of providing healthcare with the lowest costs and best outcomes, and it's a major vulnerability for those who expect an increase in access."

2. Provisions that are rolling out. Before getting too caught up in the ramifications of a Supreme Court ruling, the healthcare industry still has to be prepared for the full implementation of the PPACA. There are several provisions rolling out this year, and there are three in particular that have the potential to restructure how hospitals operate.

- *Accountable care organizations.* One of the most highly advertised policies of the PPACA that aims to help hospitals, physicians and other providers improve quality while reducing costs is the Medicare Shared Savings Program. This program went into effect Jan. 1 and established the parameters of what an ACO looks like and how it could be the future model for care management and reimbursement. However, because the program is barely off the ground, there is still uncertainty as to what this component of the PPACA will look like

down the road. "ACOs are like unicorns," Dr. Fathi says. "You know what they look like, but you've never seen one before."

A related program is the Pioneer ACO initiative. Under this five-year initiative, Medicare will reward experienced groups of hospitals, primary care physicians, specialists and others to provide better, more coordinated care for Medicare beneficiaries. The first performance period of the Pioneer ACO program began Jan. 1, and there are 32 healthcare organizations that are giving it a go.

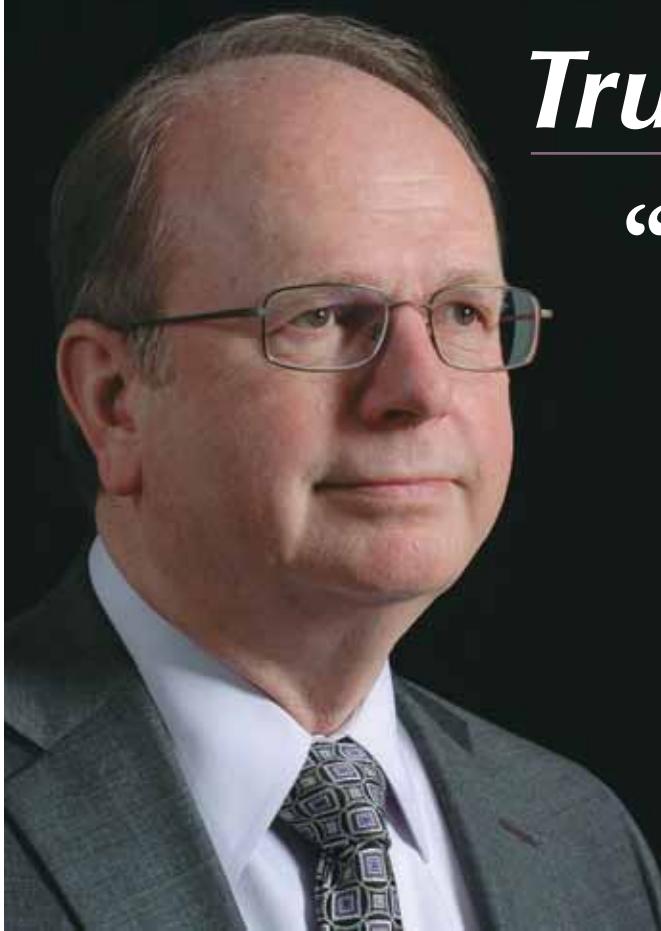
• *Bundled payments.* The Bundled Payments for Care Improvement initiative, which got under way last year, aims to reimburse healthcare providers a lump sum on the expected costs for the spectrum of a patient's care. Participants in these models would be paid for their services under the original Medicare fee-for-service system but at a negotiated discount. Then, total payments would be compared with the target price at the end of the patient's episode of care, and those providers would share any of those savings with Medicare.

There are three models that will be highlighted in 2012, and applications for Models 2, 3 and 4 are due to CMS by no later than March 15. In Model 2, bundled payments include the inpatient stay as well as post-acute care, and the hospital decides the scope of DRGs to be included. Model 3 focuses only on post-acute care, while Model 4 focuses only on the inpatient stay. Model 4 is different from the others because it involves prospective payments, which are when hospitals agree to a price upfront on a particular DRG, and CMS pays that specific bundled price to the hospital. Models 2 and 3 are retrospective payments, where hospitals receive the usual fee-for-service payment, but there is a retrospective comparison with the previously determined target price.

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- **Value-based purchasing.** Starting Oct. 1, 2012 (fiscal year 2013), Section 3001 of the healthcare law establishes the hospital Value-Based Purchasing Program for Medicare. The VBP Program will distribute an estimated \$850 million in incentives to hospitals based on their overall performance on a set of quality measures, such as clinical processes of care and patient satisfaction from the Hospital Consumer Assessment of Healthcare Providers and Systems survey. Examples of the care processes included in the measures are how quickly heart attack patients receive potentially life-saving surgery on their arteries and how often patients with heart failure get proper discharge instructions.

From there, hospitals will be scored based on their performance on each measure compared with other hospitals, and higher scores lead to incentive payments. Hospitals will still receive regular payments for providing care to Medicare patients based on the Medicare Inpatient Prospective Payment System, but those payments will decrease by 1 percent across the board starting in FY 2013 to fund the new value-based payments.

"These are fairly basic initiatives," Dr. Fathi says. "It's giving patients good education about congestive heart failure diagnoses, who to follow up with, where to get prescriptions, basic things. This is not about high-tech implantable devices — it's making sure people have the basics they need to stay well. There hasn't been a financial incentive to do these things in the past, but now with ACOs and bundled payments, there is. And that's a good thing."

However, part of the problem with these initiatives is combining the value-based desires of the future while still maintaining a solid revenue stream in the current fee-for-service system. "We're in a very tricky place right now because you want to be innovating and experimenting, but at the same time, you have to look at the current system," Dr. Fathi says. "Of course, we're all trying to maximize revenues. You have to straddle a fine line."

3. State legislative decisions. The PPACA gives states several freedoms in how they want to implement certain parts of the law — these include high-risk pools, Medicaid eligibility and, most notably, the creation of the health insurance exchanges and the right to design the benefits package for the various health plans that will be offered in the exchanges. David K. Jones, a PhD candidate within the University of Michigan Department of Health Management and Policy and the Department of Political Science, recently wrote in the *New England Journal of Medicine* that these 2012 state sessions are so important because they are the last chances for states to control their

fate. For example, if states do not establish health insurance exchange guidelines by January 2013, the federal government will step in and create the exchanges.

4. The presidential election. The 2012 presidential election is still relatively far away (Nov. 6), but the buzz surrounding it has already dominated the airwaves. President Obama will face off against one of four contending Republican candidates — Newt Gingrich, Ron Paul, Mitt Romney and Rick Santorum — and much of the GOP rhetoric has decried a full repeal of the PPACA should they take the presidency. However, Dr. Rosenau says regardless of who wins the election, the odds of a repeal are slim. If President Obama is re-elected, the law would obviously stay enacted, but even a Republican presidential victory would not doom the healthcare law because a consensus would still be needed in the other branches of Congress. "The chance of a full repeal is very, very low," Dr. Rosenau says. "It doesn't mean it couldn't be amended, but I do believe the Supreme Court's considerations are much more likely to lead to substantial change than what happens after the election."

What the future holds

While 2012 will decide the fate of the health law, 2014 and beyond will dictate how effective these changes will actually be.

By 2014, most people will be required to have some form of healthcare coverage through the individual mandate. However, due to gaps and loopholes in the PPACA, there would still be about 26 million uninsured people if the mandate stands. Dr. Steinberg says the concept of providing more access to care is a no-brainer, but the problem remains in how everything will be funded. "I agree every patient must have insurance and equal access to care," Dr. Steinberg says. "That's just a human right. That's our responsibility to deliver it. How we pay for that care, though, is changing radically."

Dr. Rosenau says if the healthcare system is looking for a source of funding, it should look to cut billing and administrative costs, which waste an estimated \$360 billion per year. The PPACA will institute new standards for electronic funds transfer in healthcare, and this is expected to save up to \$4.5 billion. However, hospitals and health systems will have to do more on their own. "Administrative costs are where the U.S. [healthcare system] is different from other countries," Dr. Rosenau says. "It's a lot of pushing paper, and that spends a lot of money. That's the place to look for really easy cuts. If I'm a hospital administrator, that's the first place I'd look."

However, there is more to healthcare reform than only the PPACA, Dr. Fathi says. He notes most people think of the federal legislation when the phrase "healthcare reform" is used colloquially, but for hospitals and other organizations, healthcare reform is and has been an ongoing process. "There are market-driven reforms and system improvements that are kind of taking place as a parallel process," Dr. Fathi says. "People like to talk about the healthcare legislation, and acknowledging that is important. But there is a healthcare system improvement occurring in real time that is independent of the legislation process."

Whether the PPACA, ACOs and every other acronym stays as part of federal healthcare legislation is murky, but one item remains fairly evident: The days of the regular, volume-based, inpatient acute-care hospital are winding down. "Theoretically at least, less will be uninsured and more will have insurance through the exchanges, but hopefully they will also be getting preventive care," Dr. Fathi says. "The poor, the uninsured — everyone needs follow-up and preventive care and stabilization to stay out of the hospital. It's easier to go into the ER, and a lot of patients don't have a disincentive to go in there. Our system needs to right itself to offer more robust access to primary care for everybody." ■



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7 Steps for Building a Top-Tier Cancer Center (continued from page 1)

1. Articulate a vision. Hospitals should start building a cancer center by developing and articulating a vision for the service, according to Timothy Eberlein, MD, director of the Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine in St. Louis. Hospital leadership needs to agree on a vision for the center that includes the size of the center, its mission and its goals in patient care. Barnes-Jewish Hospital's vision was to develop an integrated, multidisciplinary cancer center that would work towards achieving world-class status for quality of care. Now, the Siteman Cancer Center has the third largest oncology center in patient volume in the United States, according to Dr. Eberlein.

2. Gain support for the vision. The second step is garnering support from various stakeholders for the vision. Dr. Eberlein says gaining buy-in to the vision and strategic plan was one of the biggest challenges when developing the Siteman Cancer Center. Before Siteman was built in 1999, oncology care at Barnes-Jewish and Washington University was not integrated, but was instead departmentally-centered. Gaining buy-in for the vision thus meant persuading stakeholders to support a shift in the delivery of care. "This was new; it was a different paradigm," Dr. Eberlein says. "Our strategy in the institution had been to support the departments. And of course, that's almost the antithesis of a cancer center, which is a multi-departmental, integrated model."

One way the hospital gained buy-in was by setting smaller goals that would eventually lead to a more ambitious plan. "Rather than say our goal is to be the third biggest cancer center in the United States, we chose to say we want to progress towards being a world-class cancer center," Dr. Eberlein says. "If we had made [being the third-largest center] our goal, we would have had a very difficult time convincing leadership to make that large of an investment. We took incremental steps, but each of the steps was toward a goal of excellence."

3. Develop a strategic plan. Once leaders of the hospital and service line support a common vision, they need to develop a strategic plan. Barnes-Jewish Hospital began with a three-year strategic plan that outlined how the institution would build a successful cancer center. They then followed the plan "pretty religiously," Dr. Eberlein says. Once the center was built and received designation as a National Cancer Institute cancer center, the hospital then created another three-year strategic plan, this time to be designated a comprehensive cancer center by the NCI. Creating incremental strategic plans allowed the hospital to gain leadership support, follow the plan closely and achieve its goals.

4. Create specialized teams. To begin staffing a cancer center, hospitals need to recruit multidisciplinary skilled clinicians. One of the keys to a successful cancer center is having several teams that specialize in a specific type of cancer, according to Nathan Levitan, MD, president of the University Hospitals Seidman Cancer Center in Cleveland. For example, UH Seidman Cancer Center has 10 teams representing 10 major types of cancer, such as brain and spine cancer, breast cancer and lung cancer. This structure allows physicians to "keep up with the furious pace of new developments because they don't have to master everything for every cancer," Dr. Levitan says.

Specialized teams can also provide patients with a single recommendation that has been agreed upon by multiple individuals. He says, "When we think of state-of-the-art care, we think of having subspecialty physicians that have real expertise in one or two types of cancer, and we think of teams [in which] the doctors will actually discuss and debate among themselves what the best treatment is and provide that recommendation."

These teams should include medical and surgical oncologists, social workers, nutritionists and nursing staff, according to Paul Okunieff, MD, director of University of Florida Shands Cancer

Center in Gainesville and chair of the UF Department of Radiation Oncology. An academic medical center may also consider adding scientists to the teams, Dr. Okunieff says, so they can "understand the clinical needs, focus their research to overcome barriers and create logically and economically viable implementation plans." He suggests the teams go on a retreat intermittently to self-examine and discuss how they can improve patient care as a team.

5. Invest in advanced technology. Hospitals building cancer centers also need to invest in advanced technology that has been shown to improve outcomes. For example, some centers are using robotic surgery because it is associated with less recovery time. Dr. Levitan says intraoperative MRI is useful when operating on brain tumors because it allows the surgeon to detect, during surgery, any part of the tumor that was not taken out in the initial procedure and remove the tumor. New diagnostic technology, such as PET-MRI scanners and breast tomosynthesis, and radiation therapy technology, such as CT scanners that re-calibrate its beam to avoid treating healthy tissue, can also benefit patients, Dr. Levitan says. Some hospitals and health centers, such as Rochester, Minn.-based Mayo Clinic and Boca Raton (Fla.) Regional Hospital are spending upwards of \$120 million on centers for proton therapy, a new treat-



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ment designed to more precisely target cancer. There is debate, however, concerning the efficacy and cost-effectiveness of this therapy.

6. Offer clinical trials. After establishing a robust clinical program with specialized teams and advanced technology, hospitals should consider offering clinical trials as a way to increase treatment options for patients. "A clinical trials program is a very important part of a state-of-the-art cancer center because it gives patients access to drugs that might not otherwise be available because they're not FDA approved," Dr. Levitan says. Dr. Okunieff says UF Shands Cancer Center tries to get as many patients as possible on clinical trials because it gives them the opportunity to try new medications and therapies that may result in better outcomes.

7. Focus on the patient experience.

As an additional step, hospitals that aim to be recognized for strong cancer services need to focus on the patient experience when delivering care. A patient's experience is shaped by everything and everyone in the care environment. "Every interaction cancer patients have, whether with someone who is transporting them, someone who is delivering a meal — anything that touches the patient — is a healing interaction. And depending upon how these individuals approach the patients, they can really be a part of the healing environment or not," Dr. Levitan says. The UH Seidman Cancer Center, which opened a new free-standing 120-bed cancer hospital in June 2011, was designed to create a healing environment

for the patient, according to Dr. Levitan. "The environment of care is as important to the healing process as are the drugs or the surgery or the radiation."

Dr. Okunieff also emphasizes the role of patients' experiences in their overall care. "There has to be a culture of the patient comes first," he says. "You need care and caring, because without the latter, you'll never get to do the former." He suggests that if the provider does not behave or speak compassionately, the patient may not return to the center regardless of its clinical quality. One way physicians can demonstrate their caring is to make themselves easily accessible to patients, Dr. Okunieff says. "Give patients your cell phone number, they won't abuse it. Just make sure people know that you care." ■

Despite Distressed Assets, Private Equity Firms See Value in Healthcare (continued from page 1)

pressure on the healthcare sector, which is most likely causing the industry's increase in mergers and acquisitions.

Industry experts believe healthcare M&A will continue to see significant numbers in 2012, whether the transaction involves a hospital, a health system or another health organization. "There are many of areas ripe for consolidation," says Mr. Hill.

While hospitals will still see M&A transactions due to physician acquisition opportunities, hospital executives may be more focused on service integration causing increased acquisitions. More specifically, Mr. Hill believes four general areas may lead the industry in 2012 M&A dealings: ambulatory surgery centers, physician practice groups, urgent care and the home health industry. Additionally, Mr. Hill says it is likely that hospitals, healthcare companies and private equity firms will be purchasers of these organizations.

There have been more private equity firms investing in healthcare in 2010 and 2011 than in years past. Private equity players have been active in the hospital industry for many years, and in 2012, we should expect private equity to continue to be active in the hospital space and in home health and urgent care. Both the home health and urgent care industries are fragmented and ripe for consolidation.

In order to understand where private equity in healthcare may lead, it is important to know its past.

Two notable players are New York-based Cerberus Capital Management and The Blackstone Group. Cerberus Capital owns Boston-based Steward Health Care System and Blackstone Group holds majority equity in Tenn.-based Vanguard Health Systems.

Steward Healthcare System

Typically, Cerberus has not invested in healthcare. The company is better known for investments in pharmaceuticals, paper products, transportation and retail. For instance, in 2007, Cerberus purchased an 80 percent stake in auto manufacturer Chrysler.

Cerberus made its first healthcare investment with the purchase of Caritas Christi Health Care for \$900 million in November 2010. Caritas was converted into a for-profit system and renamed Steward Health Care System. With the purchase of Caritas, Cerberus infused capital into the financially struggling health system.

According to Dan Grauman, MBA, president and CEO of DGA Partners, a healthcare finance and management consulting company, one reason private equity firms invest in healthcare is because they have multiple sources of readily available capital to satisfy the capital needs of hospitals and health systems. More and more, hospitals and health systems have been in need of capital. Private equity firms like Cerberus and Blackstone, can meet that need, hence, an influx in private equity healthcare investments.

As part of the Caritas Christi purchase, Cerberus provided \$400 million in capital for infrastructure and technology improvements. Thus far, Steward is fulfilling the capital improvement pledge.

First, Carney Hospital in Dorchester, Mass., completed construction of a \$10.2 million surgical suite consisting of three operating rooms in August 2011. And, Saint Anne's Hospital in Fall River, Mass., opened its new 13,000 square-foot emergency department in early February.

Following the conversion of Caritas Christi into Steward Health System, the system quickly expanded its reach in the region.

In December 2010, Steward completed a \$21 million acquisition of two Massachusetts community hospitals: Merrimack Valley Hospital in Haverhill, Mass., and Nashoba Valley Medical Center in Ayer, Mass. Steward also pledged \$19 million in capital improvements at the two hospitals.

Steward then tried its hand in the healthcare insurance arena with an insurance plan for use with Steward-affiliated physicians and facilities. Steward worked with non-profit Tufts Health Plan in Watertown, Mass., the third largest health insurer in Massachusetts, to create Steward Community Choice. The Massachusetts Division of Insurance approved the insurance plan in December 2011.

Finally, Steward is currently in the midst of acquiring Landmark Medical Center in Woonsocket, R.I. Approval of the deal has been complicated after state regulators deemed the Steward's first application submission incomplete.

Vanguard Health Systems

For-profit Vanguard, backed by The Blackstone Group, also invested in healthcare organizations. Vanguard acquired eight-hospital Detroit Medical Center in December 2010.

As part of the DMC deal, Vanguard took on \$391 million in DMC's debt and assumed its unfunded pension obligations and malpractice liabilities estimated at \$335 million. Vanguard also pledged \$850 million in capital improvements for DMC.

This January, DMC broke ground on a \$78 million cardiology facility. In November 2011, DMC's Huron Valley-Sinai Hospital in Commerce, Mich., opened a \$7 million private-room orthopedic and neurosurgery unit. Both projects represent forward movement of Vanguard's \$850 million pledge.

In June 2011, Vanguard was taken public in an IPO at \$18 per share, bringing additional capital to fuel the hospital operator's aggressive acquisition strategy. As of February 2012, Vanguard was trading at \$10.69 a share.

Vanguard Health also owns three health plans: Phoenix Health Plan, a Medicaid managed health plan; Abrazo Advantage Health Plan, a managed Medicare and dual-eligible health plan; and MacNeal Health Providers, a preferred provider network.

Blackstone Group's investments through Vanguard appear successful based on 2012 fiscal year earnings thus far. Vanguard's 2012 fiscal year began July 1, 2011. Vanguard's acquisitions increased their total earnings for the 2012 fiscal year by 61 percent from their 2011 fiscal year. The increase was largely due to patient revenue from its acquisition of Detroit Medical Center. Vanguard also recorded net income of \$12.9 million in the quarter ended Dec. 31, 2011, compared with a net loss of \$4.2 million in the second quarter of last year.

Cerberus and Blackstone appear to have been successful thus far, but the question remains — are they following a strong strategy that has escaped struggling facilities simply due to lack of access to capital, or are they an exception to the rule?

Mr. Grauman believes there are two reasons private equity firms invest in healthcare. First, private equity firms have multiple sources of readily available capital to satisfy the capital needs of hospitals and health systems.

Second, despite the challenges of distressed assets and variability in hospital performance across the U.S., private equity firms can see down the road to when an investment in healthcare may turn profitable. "Investors and private equity firms are attracted to the healthcare industry because of the growth that the healthcare reform law and expanding healthcare coverage is fueling," says Mr. Grauman.

There is also one overarching demographic trend down the road, which suggests movement towards increases in healthcare service demand: the

aging of baby boomers. "Private equity firms can focus on the bigger picture and see longevity in hospitals and health systems," says Mr. Grauman. "Conventional wisdom is that with the increased consolidation in the healthcare industry, if you pick the right investment it will be attractive in the future," he says. A private equity firm can weather turn-around time and losses, so that a hospital investment has a high return in a few years — when the U.S. patient population is at a peak.

However, only some hospitals suggest a promising investment to private equity firms. The fundamentals for hospital operations need to be available in the market. According to Mr. Grauman, "the four M's" — market, medical staff, money and management — are elements a private equity firm would consider when evaluating a hospital or health system. "[Market, medical staff, money and management] need to be present for a hospital to operate successfully. The private equity firm needs to see that there are enough available physicians in the area and that the market has a sufficient patient population," says Mr. Grauman. "There needs to be a reasonable opportunity for the hospital to succeed."

While Boston and New England have no shortage of competition with providers such as Partners HealthCare in Boston and Johns Hopkins in nearby Baltimore, Steward may have been drawn to the market's ability to attract and produce high quality physicians and perhaps the competitive advantage of offering lower-cost care when compared to the big AMCs.

Most often hospitals face distress for a small number of reasons such as management decisions, lack of insight into future trends or an absence of technological investments. Hospitals that would operate efficiently under alternate circumstances are better able to regain lost capital and are smart investments. Private equity firms, like Cerberus and Vanguard, can visualize the hospital's potential for a strong turn-around, says Mr. Grauman.

Whether a private equity firm is looking for a promising return or merely wants to meet the needs of the healthcare industry, private equity investments seen recently in the healthcare industry are likely to continue. The future is ripe for healthcare transactions as healthcare reform and increases in health coverage continue. With Cerberus Capital's Steward Health and Blackstone Group's Vanguard Health as precursors, time will tell if they have paved the way for other private equity firms or if they are merely an exception. ■

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70 Hospitals and Health Systems With Great Oncology Programs

By Molly Gamble

Hospitals and Health Systems With Great Oncology Programs

Becker's Hospital Review has named "70 Hospitals and Health Systems With Great Oncology Programs." These hospitals are on the cutting edge of cancer treatment, prevention and research, and the *Becker's Hospital Review* editorial team selected them based on clinical accolades, quality care and contributions to the field of oncology.

These hospitals have been recognized for excellence in this specialty by reputable healthcare rating resources, including *U.S. News & World Report*, HealthGrades, Thomson Reuters, the National Cancer Institute, the American College of Surgeons and the American Nurses Credentialing Center. They have demonstrated continual innovation in treatments and services, patient-centered care, and the achievement of clinical milestones and groundbreaking discoveries.

Note: This list is not an endorsement of included hospitals or associated healthcare providers, and hospitals cannot pay to be included on this list. The following content should be used for informational purposes only and is not intended to substitute professional medical advice. Hospitals are presented in alphabetical order.

Atlantic Health Carol G. Simon Cancer Center (Morristown and Summit, N.J.). Atlantic Health System is a major clinical research affiliate of the Cancer Institute of New Jersey, which includes 16 hospitals across the state. It is one of the only hospitals in the region to offer the Prostate Navigate Program — a patient-centered, multidisciplinary consultation service that helps patients select their preferred method of prostate cancer treatment. The center has received the American College of Surgeons Outstanding Achievement Award for cancer care, which is awarded to less than 15 percent of hospitals in the country.

Barnes-Jewish Hospital (St. Louis). The Alvin J. Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine was named a Comprehensive Cancer Center by the National Cancer Institute in 2005. Siteman offers approximately 250 clinical trials for patients, and more than 150 families visit the center's hereditary cancer program each year, which helps people with a family history of cancer assess their risk. In August, Siteman celebrated its 5,000th bone marrow transplant since 1982.

Dan L. Duncan Cancer Center at Baylor College of Medicine (Houston). The Dan L. Duncan Cancer Center at Baylor College of Medicine is a consortium made up of Baylor College of Medicine and its three primary teaching hospital affiliates — Ben Taub General Hospital, Michael E. DeBakey Veterans Affairs Medical Center and Texas Children's Hospital. It's one of three cancer centers in Texas recognized by the National Cancer Institute. With an office of outreach and disparities, Baylor works to enhance the enrollment of under-represented minorities in clinical trials and to reduce disparities in cancer care.

Beth Israel Deaconess Medical Center (Boston).

The Cancer Center at Beth Israel Deaconess Medical Center includes 19 specialty programs in oncology along with eight multidisciplinary clinics that use a team-based approach. It is one of only 34 centers in the country to receive the Outstanding Achievement Award from the American College of Surgeons Commission on Cancer. BIDMC's Pier Paolo Pandolfi, MD, PhD, received the 2011 International Award for Cancer Research from the Pezcoller Foundation-American Association of Cancer Research for the advancements he made in cancer genetics.

Carolinas Medical Center (Charlotte, N.C.).

The Blumenthal Cancer Center is nationally accredited by the American College of Surgeons and received the Outstanding Achievement Award from the American College of Surgeons Commission on Cancer in May. The cancer program of Carolinas Medical Center is now organized within the Levine Cancer Institute, an entity Carolinas Healthcare System formed in 2010 to combine cancer programs across its hospitals. It is headquartered on the Carolinas Medical Center campus, and the facility is expected to open in fall 2012.

Cedars Sinai Medical Center (Los Angeles).

The Samuel Oschin Comprehensive Cancer Institute at Cedars Sinai offers multidisciplinary teams, with many of the center's physicians being published authors and prominent researchers in oncology. The center uses disease-specific tumor boards to help patients design their treatment plans. Cedars Sinai includes a 24-hour outpatient center, which sees more than 9,000 patients each year. The center is home to basic and clinical oncology research along with clinical trials. It recently partnered with a research institute in Arizona to offer joint clinical trials for new anti-cancer therapies aimed at molecular cancer targets.

City of Hope Comprehensive Cancer Center (Duarte, Calif.).

City of Hope was founded in 1913 and has performed more than 10,000 bone marrow and stem cell transplants, making it one of the largest such programs in the world. More than 3,000 clinical trials are held at City of Hope at any given time, and roughly 40 percent of patients participate in them — compared with a national average of less than 5 percent. City of Hope is currently the only institution in the world to hold clinical studies with genetically engineered T-cells to recognize glioma, a terminal form of brain cancer.

Cleveland Clinic (Cleveland).

With a focus on the patient experience, patients visiting the Taussig Cancer Institute at Cleveland Clinic can participate in support groups, art therapy and even high tea as a pleasant diversion from their rounds of treatment. Taussig is a partner with Case Comprehensive Cancer Center in Cleveland, which is a National Cancer Institute-designated Comprehensive Cancer Institute. In May, Cleveland Clinic researchers made strides in the first-of-its-kind vaccine

to prevent breast cancer, a groundbreaking development in oncology. Enrollment in human trials for that vaccine may begin in 2012.

Dana-Farber Cancer Institute (Boston). Dana-Farber was founded in 1947 and collaborates with Brigham and Women's Hospital for oncology services and is a teaching hospital affiliated with Harvard Medical School. It recently opened its Yawkey Center for Cancer Care, a new 14-story facility with 104 exam rooms and 139 infusion chairs — about a 30 percent increase the current capacity on Dana-Farber's main campus. Dana-Farber's clinical reach is quite extensive: It sees more than 300,000 patient visits each year and offers roughly 700 clinical trials. Dana-Farber is a Comprehensive Cancer Center as designated by the National Cancer Institute.

Dartmouth-Hitchcock Medical Center (Lebanon, N.H.). The Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center includes more than 200 oncologists and 135 research investigators and offers at least 100 clinical trials to patients at any one time. Multidisciplinary teams develop treatment plans individually for each of the 31,000 patients that visit Dartmouth for oncology services each year. In October, the center earned a five-year, \$6.1 million grant from the National Cancer Institute for research at its breast cancer screening center — one of three such facilities in the nation.

Duke University Hospital (Durham, N.C.). Duke Cancer Institute serves nearly 6,000 new cancer patients each year and has clinical research partnerships in India, China, Singapore and throughout the United States. It is a comprehensive cancer center as designated by the National Cancer Institute and is also part of the National Comprehensive Cancer Network, which is comprised of 21 cancer centers across the country. The center is home to more than 300 researchers and oncologists. Duke scientists recently found a protein in breast cancer cells that may fuel aggressive tumors and could make an effective target for new drugs.

Emory University Hospital (Atlanta). Emory's Winship Cancer Institute is the only National Cancer Institute-designated cancer center in the state of Georgia. It was founded in 1937 through a donation from the then-president of Coca-Cola, Robert Woodruff, who lost his mother to cancer that same year. The center takes a multi disciplinary approach to cancer treatment and teams of experts meet every day to plan the most advanced care for patients. In 2011, it partnered with Advance Particle Therapy to develop the Georgia Proton Therapy Center — the state's first proton therapy facility.

Fox Chase Cancer Center (Philadelphia). Fox Chase was founded in 1974 and was designated by the National Cancer Institute as a Comprehensive Cancer Center that same year. In a move reflecting its transparency, Fox Chase recently became one of the first cancer centers in the country to publish its clinical outcomes for breast, colorectal, lung and prostate cancer. In nearly all five categories, the outcomes are better compared to those of large and small community hospital cancer programs. Scientists at Fox Chase have cataloged and cross-indexed the actions of 178 candidate drugs capable of blocking the activity of one or more of 300 enzymes, including enzymes critical for cancer.

Froedtert Hospital (Milwaukee). Froedtert Hospital's Clinical Cancer Center includes more than 200 oncologists, physicians and scientists in 13 disease-specific cancer programs. The center operates under a patient-centered "hub model," where physicians are grouped by the kinds of cancer they treat, not the type of service they provide. It was recognized as a regional leader in cancer care in *U.S. News & World Report's* 2011 Best Hospitals list. The hospital, which uses tumor boards to develop patient-specific treatment plans, is also part of a cancer care network with two other local hospitals.

Geisinger Cancer Institute (Danville, Pa.). The Geisinger Cancer Institute employs a multidisciplinary and team-based approach to cancer care, providing patients with access to several physicians at once. Geisinger is a National Cancer Institute Community Cancer Centers Program site, of

which there are only 30 in the country. These organizations receive funds from NCI to advance cancer care in rural or underserved populations. Geisinger's teams focus on symptom management, and nurse navigators are assigned to patients to help them along the continuum of cancer care. There are roughly 100 Phase I-III clinical trials open to Geisinger patients at any one time, and the institute recently found an advanced radiation treatment that can drastically shorten radiation treatment time for some breast cancer patients.

Georgetown University Medical Center (Washington, D.C.). The Georgetown Lombardi Comprehensive Cancer Center was established in 1970 and named after the late football coach Vince Lombardi, who received treatment for colon cancer at Georgetown. As the only National Cancer Institute-designated Comprehensive Cancer Center in the Washington, D.C.-area, it recently led a large national study that found screening current or former heavy smokers with a CT scan can reduce deaths from lung cancer by 20 percent.

Hackensack (N.J.) University Medical Center. The John Theurer Cancer Center at Hackensack University Medical Center has 14 specialized divisions for oncology with teams of experts that treat each specific type of cancer. It currently offers more than 150 clinical trials, both those conducted independently with others held through partnerships and research consortiums. Hackensack's new \$130 million cancer facility opened in 2011, featuring generous amounts of natural sunlight and a 24-foot waterfall in the lobby. It also offers extensive patient support services, including free yoga classes to complement chemotherapy and group cooking classes taught by nutritionists.

Hoag Memorial Hospital Presbyterian (Newport Beach, Calif.). Hoag Cancer Institute is the largest cancer program in southern California outside of Los Angeles County. It treats more than 2,200 new cancer patients each year and continues to include some of the most cutting-edge oncology services in the state. For instance, Hoag includes the first breast care center in California and one of only a handful in the country to offer 3-D digital breast tomosynthesis for breast cancer screening.

Hospital of the University of Pennsylvania (Philadelphia). The Abramson Cancer Center of the University of Pennsylvania has been continuously designated as a Comprehensive Cancer Center by the National Cancer Institute since 1973. In addition to its physicians, the center is home to more than 400 basic, translational and clinical scientists. In the past decade, the Abramson Cancer Center has made important breakthroughs in

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stem cell maintenance and the use of MRIs for breast cancer screening. The center has received extensive recognition for its breast cancer program, including recognition by the National Accreditation Program for Breast Centers.

Indiana University Simon Cancer Center (Indianapolis). The IU Simon Cancer Center was founded in 1992 and has been a National Cancer Institute-designated institution since 1999. The center's physicians, who are primarily faculty of the IU School of Medicine, lead approximately 300 clinical trials for pediatric and adult patients. It also established the Indiana Cancer Consortium in collaboration with the American Cancer Society and Indiana Department of Health. Cancer advocate Lance Armstrong received treatment for testicular cancer at IU Simon in 1996 and proceeded to win the Tour de France seven times.

Johns Hopkins Medicine (Baltimore). The Sidney Kimmel Comprehensive Cancer Center opened in 1973 and was one of the first facilities designated as a Comprehensive Cancer Center at Johns Hopkins by the National Cancer Institute. The center used a \$30 million gift from the Commonwealth Foundation for Cancer Research to establish its Center for Personalized Cancer Medicine, which accelerates the development of cancer therapies based on patients' individual genetic "fingerprint." Recently, scientists from Kimmel Cancer Center revealed the cause of tumors when they completed a map of genetic mutations occurring in the oligodendrogloma form of brain cancer.

Loyola University Medical Center (Maywood, Ill.). Loyola's Cardinal Bernardin Cancer Center is named after Joseph Bernardin, the former Archbishop of Chicago who received treatment at Loyola before dying of pancreatic cancer in 1996. Loyola's head and neck cancer program is one of five of its kind in the country, and its bone marrow transplant program is one of the largest in the nation. Since 1994, patients have participated in more than 200 clinical trials for cancer at Loyola, allowing them to receive therapies not yet available at community hospitals. In 2012, Loyola will kick off a new cancer research program on immune system therapy for metastatic melanoma — the only one its kind in the Midwest.

Massachusetts General Hospital (Boston). Massachusetts General Hospital Cancer Center was founded in 1986 and is now comprised of 18 clinical oncology programs. Multi-disciplinary teams of physicians, nurses, social workers and other health professionals help tailor patients' treatment and make their care experience seamless. Massachusetts General is a member of the research consortium and National Cancer Institute-designated Comprehensive Cancer Center known as DF/HCC, which includes Dana-Farber and Harvard Cancer Center.

Mayo Clinic (Rochester, Minn.). Mayo Clinic Cancer Center's three campuses — Rochester along with Jacksonville, Fla., and Phoenix — extend its geographic breadth and boost patient access for the more than 19,500 new cancer patients who visit Mayo Clinic each year. As a National Cancer Institute-designated cancer center, Mayo receives more than \$100 million in competitive peer review grants and hosts hundreds of clinical trials. Last year, Mayo announced plans to establish a proton beam therapy program, which will include rare and state-of-the-art pencil beam scanning.

Moffitt Cancer Center (Tampa, Fla.). H. Lee Moffitt Cancer Center opened its doors in 1986 and was designated by the National Cancer Institute as a Comprehensive Cancer Center in 2001. Moffitt uses a holistic approach it calls Total Cancer Care, which provides individualized, evidence-based treatment decisions based on the large-scale integration of information technology, clinical research and health outcomes. Moffitt also extends a large amount of services to preventive care, such as its center dedicated to cancer screening and prevention, including genetic counseling.

Montefiore Medical Center (Bronx, N.Y.). The Montefiore Einstein Center for Cancer Care is partnered for research with the Albert Einstein Cancer Center, which was one of the first cancer centers to receive National Cancer Institute designation in 1972. Current Phase I studies for Montefiore patients include examining the use of Taxol, a drug that has already received FDA approval to fight breast cancer and ovarian cancer, to treat different types of cancer.

Nebraska Medical Center (Omaha). Nebraska Medical Center is a founding member of the National Comprehensive Cancer Network. Its oncology program has received accreditation from the National Cancer Institute and the American College of Surgeons Commission on Cancer, among other organizations. Nebraska Medical Center also offers extensive support services to patients, such as its survivorship program for patients who have completed treatment and need assistance in the transition back to a primary care routine and everyday life.

NewYork-Presbyterian Hospital (New York). The Cancer Centers of NewYork-Presbyterian Hospital include two institutions — the Herbert Irving Comprehensive Cancer Center at NewYork-Presbyterian/Columbia University Medical Center; and the Weill Cornell Cancer Center of NewYork Presbyterian/Weill Cornell Medical Center. Weill Cornell physician-scientists have been responsible for many medical advances in oncology, such as the development of the Pap test for cervical cancer. The cancer centers currently receive more than \$33 million from the National Cancer Institute for research, with another \$95 million going toward peer-reviewed cancer research funding.

NorthShore University HealthSystem (Evanston, Ill.). NorthShore Kellogg Cancer Center has three sites in Chicago's northwest suburbs. An academic affiliation with the University of Chicago Pritzker School of Medicine enables NorthShore, a teaching hospital, to further align research efforts and clinical trials with one of the country's most prestigious medical schools. The center uses a multidisciplinary approach to create tailored cancer care plans, and its Guided Patient Support Program provides new patients with nurse navigators, financial advocates, nutritional counselors and other medical practitioners to ease the care process.

Northwestern Memorial Hospital (Chicago). Northwestern Memorial is affiliated with the Robert H. Lurie Comprehensive Cancer Center of Northwestern University, a National Cancer Institute-designated center founded in 1974 and located on the hospital's campus. It treats more than 10,000 new cancer patients each year and was the site at which the late Maggie Daley, wife of former Chicago Mayor Richard M. Daley, received treatment for metastatic breast cancer. Ms. Daley died in November after a nine-year battle — triple the average survival rate for that type of cancer. The Maggie Daley Center for Women's Cancer Care at Northwestern continues to thrive in her honor.

Norton Hospital (Louisville, Ky.). More than 50,000 cancer patients visit Norton Cancer Institute each year. The institute was recently selected as one of 14 new pilot sites — one of 30 sites throughout the country — to participate in the NCI's Community Cancer Centers Program network. The network aims to reduce cancer care disparities and increase patient participation in clinical trials. Norton also offers a behavioral oncology program to deal with cancer-related distress, a survivorship program and patient navigation system to enhance and streamline the patient experience.

NYU Langone Medical Center (New York). Part of NYU Langone, the NYU Cancer Institute is a National Cancer Institute-designated cancer center in Manhattan that offers state-of-the-art care and services. It includes programs focusing on the social disparities in cancer care and molecular-targeted therapy, among other innovative initiatives. In November, researchers from NYU Cancer Institute discovered a new potential therapeutic target for diffuse large B-cell lymphoma, an aggressive and common type of blood cancer in adults.

Ohio State University Medical Center (Columbus, Ohio). The Ohio State University Comprehensive Cancer Center—Arthur G. James Cancer Hospital was established in 1973 and received NCI designation in 1976. As Ohio's only freestanding cancer hospital, OSUCCC—James is expanding its reach even further as it began a \$1 billion expansion of its facilities in

2009. It is one of seven centers in the country funded by the National Cancer Institute to conduct phase I and phase II clinical trials for new anti-cancer drugs.

Oklahoma University Medical Center (Oklahoma City). The first patients received treatment in Oklahoma University Cancer Institute's new Peggy and Charles Stephenson Cancer Center facility in July. The new building features a healing garden, wig salon, game rooms and a pager system where patients' families can be notified via pager when treatment has ended. In addition to the Peggy and Charles Stephenson Cancer Center facility, there is also a new branch of the Cancer Center on the OU-Tulsa Schusterman Center campus. OUCI offers the state's only Phase I clinical trials center for cancer patients — the second-closest location is MD Anderson in Houston, nearly 500 miles away.

Providence Regional Medical Center (Everett, Wash.). The cancer program at Providence Regional Medical Center is a partnership between the hospital and three medical groups: The Everett Clinic, Western Washington Medical Group and Northwest Washington Radiation Oncology Associates. The Cancer Partnership, as it's called, formed in 2007 and is accredited by the American College of Surgeons Commission on Cancer. The hospital offers 20 clinical trials for patients, and it recently invested more than \$10 million in groundbreaking cancer technology.

Robert Wood Johnson University Hospital (New Brunswick, N.J.). Robert Wood Johnson University Hospital has dedicated an entire 123-bed hospital to its cancer program: The Cancer Hospital of New Jersey. The hospital is also the flagship hospital of the Cancer Institute of New Jersey, a hub for innovative oncology research that receives more than \$80 million each year in grants. RWJU Hospital is the only organization in the state with a National Cancer Institute-designated Comprehensive Cancer Program. It has also been accredited by the American College of Surgeons Commission on Cancer.

Ronald Reagan UCLA Medical Center (Los Angeles). The Jons-son Comprehensive Cancer Center at UCLA Medical Center is one of the largest National Cancer Institute-designated Comprehensive Cancer Centers in the country. It includes more than 240 physicians and scientists and sees upwards of 20,000 patient visits each year. President Barack Obama recently named UCLA cancer researcher Owen Witte, MD, to the President's Cancer Panel, which monitors the National Cancer Program's progress. UCLA's care spans beyond cancer treatment to encompass the entire cancer experience. In partnership with the Lance Armstrong Foundation, the UCLA-Livestrong Survivorship Center of Excellence provides a plethora of resources to cancer survivors.

Roswell Park Cancer Institute (Buffalo, N.Y.). Founded in 1898, Roswell Park was the country's first cancer center and remains the first and only facility in upstate New York designated as a Comprehensive Cancer Center by the National Cancer Institute. It's accredited by the National Comprehensive Cancer Center Network, the American College of Surgeons Commission on Cancer and several other oncology-related organizations. Its patient satisfaction scores are consistently well-above the national average. In the past 10 years, the center has added more than 1,000 new jobs, dedicated an entire hospital facility to Phase I cancer research and formed international strategic partnerships with researchers.

Rush University Medical Center (Chicago). The Rush University Cancer Center, which has been approved by the American College of Surgeons Commission on Cancer, recently completed its outpatient cancer center with an expanded chemotherapy space and more rooms for complementary therapies. The center includes comprehensive clinics for eight specific types of cancer, where patients can receive the full spectrum of care from diagnosis to treatment and supportive services. The center also includes an integrative medicine program, which provides complementary therapies for patients such as counseling, yoga, acupuncture and massage therapy.

Sanford Health (Fargo, N.D. and Sioux Falls, S.D.). Comprising Sanford Cancer, Sanford Cancer Center is in Sioux Falls while Roger Maris Cancer Center is in Fargo. Sanford Cancer was recently selected by the National Cancer Institute to participate in its NCI Community Cancer Centers Program to expand oncology research and reduce disparities in care. Sanford recently launched its Edith Breast Cancer program, which has been recognized by the National Accreditation Program for Breast Centers. It will be housed in a new facility on the Roger Maris campus that is still underway, but the program will be integrated to both locations in Fargo and Sioux Falls.

Shands at the University of Florida (Gainesville). The University of Florida Shands Cancer Center is home to more than 250 researchers and clinicians from the University of Florida and Shands HealthCare. Approximately 3,000 new cancer cases are diagnosed at Shands each year. In 2010, the UF Breast Center became the first program in the state to use an Intrabeam radiation treatment system. It also teamed up with Moffitt Cancer Center to study fertility concerns for young cancer patients and earned accreditation from the American College of Surgeons Commission on Cancer.

Skyline Medical Center (Nashville, Tenn.). Skyline Medical Center is part of the Sarah Cannon Cancer Center Network, which consists of eight medical facilities in Tennessee caring for cancer patients. Skyline's program has earned a national three-year-accreditation from the American College of Surgeons Commission on Cancer, and its network program includes more than 100 multi disciplinary oncologists. It's also affiliated with the Sarah Cannon Research Institute, which allows patients to participate in oncology clinical trials.

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Stanford Hospital and Clinics (Palo Alto, Calif.). Stanford Clinical Cancer Center operates on a multidisciplinary approach, where patients can request their care be discussed by a tumor board. This group, comprised of several specialists, surgeons and pathologists, collectively designs the best treatment plan for each patient. Medical teams are involved in more than 300 clinical trials at Stanford, and the center offers a patient-centered approach to care such as valet parking and concierge services. Stanford's Edward Damrose, MD, has successfully removed cancer from patients' larynxes while preserving their voice, making him one of the nation's few experts to master the surgical procedure.

Thomas Jefferson University Hospital (Philadelphia). With National Cancer Institute-designation, the Kimmel Cancer Center at Jefferson includes surgeons who have received the highest possible recognition from the American College of Surgeons Commission on Cancer. Jefferson was the first hospital in the country to receive FDA approval for the use of a new diagnostic tool that tests melanoma patients for a certain type of gene mutation. It offers progressive treatment options and more than 120 clinical trials to patients at any one time, along with services to support their emotional well-being — such as its wig program to help patients ease embarrassment caused by hair loss.

University of Pittsburgh Medical Center. UPMC partners in cancer care with the University of Pittsburgh Cancer Institute,

which combines UPMC's medical expertise with the academic research at the University of Pittsburgh. UPMC Cancer Centers include more than 1,700 physicians, scientists and other healthcare professionals in 14 areas of expertise on specific types or treatments of cancer. The Hillman Cancer Center, a five-story facility located on the UPMC Shadyside campus, is the flagship facility for the UPMC Cancer Centers network. UPMC received nearly \$174 million in government funding for cancer research in 2011, making it the National Cancer Institute's 12th most-funded research institution.

University Hospitals Case Medical Center (Cleveland). University Hospitals Seidman Cancer Center recently opened in spring 2011, combining all of the departments of UH Ireland Cancer Center under one roof with 120 beds. It has 12 multidisciplinary teams to treat specific types of cancer and is a National Cancer Institute-designated Comprehensive Cancer Center, offering more than 300 clinical trials to patients. Phillips Healthcare, an imaging manufacturer, has pledged to invest in UH Seidman, and the hospital will house one of the world's first PET/MRI machines as a result.

University of Alabama Hospital at Birmingham. The UAB Comprehensive Cancer Center is the only National Cancer Institute-designated Comprehensive Cancer Center within a six-state region including Alabama, Mississippi, Louisiana, Arkansas, South Carolina and Georgia. The center is home to more than 330 on-

cologists, physicians and researchers and treats approximately 5,000 new cancer patients each year. In 2010, the center received more than \$110 million from NCI for cancer research. It is also a founding member of the National Comprehensive Cancer Network.

University of Arizona Medical Center (Tucson). University of Arizona Medical Center is the clinical affiliate of University of Arizona Cancer Center, a National Cancer Institute-designated Comprehensive Cancer Center established in 1976. ACC patients receive inpatient and outpatient care from the UA Medical Center physicians. ACC is home to more than 300 oncologists and scientists, and it was recently awarded more than \$19.5 million in grants to study skin cancer and colorectal cancer. It also offers the only genetic counselor in Tucson who specializes in cancer.

University of California, Davis Medical Center (Sacramento). UC Davis Cancer Center is the only National Cancer Institute-designated center serving California's Central Valley region of roughly 6 million people. More than 9,000 adults and children visit the center each year for cancer care and the opportunity to participate in any of more than 150 clinical trials. UC Davis was the first cancer center to partner with a national laboratory, Lawrence Livermore (Calif.) National Laboratory, and it receives approximately \$134 million in annual research grants.

University of California, Irvine Medical Center (Irvine). The Chao Family Comprehensive Cancer Center at UC Irvine is a National Cancer Institute-designated Comprehensive Cancer Center. UC Irvine also is one of only eight institutions nationwide to be named part of the NCI's Cancer Genetics Network, which examines complex interactions between genes and cancer. It has organized its translational research efforts into four areas of cancer — prostate, melanoma, cervical and breast — with multidisciplinary teams working on each. The center saw roughly 50,000 outpatient visits from 2010 to 2011 and receives approximately \$15 million in NCI funding each year.

UC San Diego Medical Center (San Diego). The UC San Diego Moores Cancer Center was established in 1979 and received designation from the National Cancer Institute as a Comprehensive Cancer Center in 2001. Moores Cancer Center emphasizes a shared focus on bench-to-bedside research, preventive care and multidisciplinary treatment and has made waves in the field of cancer care. Its researchers pioneered intraperitoneal chemotherapy, which delivers high doses of anti-cancer drugs directly to ovarian tumors. In 2006, the federal government named that procedure, IP chemotherapy, as the new standard of treatment for ovarian cancer.

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UCSF Medical Center (San Francisco). The Helen Diller Family Comprehensive Cancer Center at UCSF Medical Center received National Cancer Institute-designation as a Comprehensive Cancer Center in 1999, and it has attained the highest level of research funding from the NCI among cancer centers in the state. The center's contributions to cancer care, research and prevention go back decades. In 1989, two UCSF physicians earned the Nobel Prize in Medicine when they discovered the existence of cancer-causing oncogenes — a significant development in the genetic causes of cancer.

University of Chicago Medical Center (Chicago). The University of Chicago Comprehensive Cancer Center offers services not commonly accessible to patients, such as a childhood cancer survivors' center. The center includes more than 200 oncology specialists, offers the most cancer clinical trials in the state and receives the most funding from the National Cancer Institute out of any organization in Illinois. President Obama awarded the Medal of Freedom — America's highest civilian honor — to University of Chicago's Janet D. Rowley, MD, in 2009. Dr. Rowley was the first scientist to identify chromosomal causes of leukemia and other cancers.

University of Colorado Hospital (Aurora). University of Colorado Cancer Center at UCH is the only National Cancer Institute-designated Comprehensive Cancer Center in the greater Denver area. Its five-year survival rates for patients with lung cancer, breast cancer, prostate cancer and melanoma exceed state and national averages. The center includes a Radiation Oncology Clinic, a multidisciplinary treatment program that specializes in minimally invasive radiation treatments. Washington State Sen. Andy Hill is receiving treatment for stage IV lung cancer at UCH's cancer center and is enrolled in a clinical trial in the hospital's Thoracic Oncology Program.

University of Iowa Hospitals and Clinics (Iowa City). University of Iowa Holden Comprehensive Cancer Center was founded in 1980. It's the only center in the state that has been designated by the National Cancer Institute as a Comprehensive Cancer Center, a title it has held since 2000. In 2009, it received \$74.2 million in cancer-related research funding and opened 221 clinical trials for cancer patients. Researchers from Holden have made major contributions to the field of oncology, such as a vaccine currently in clinical trial to treat and prevent prostate cancer.

University of Kansas Medical Center (Kansas City). The University of Kansas Cancer Center has earned the Outstanding Achievement Award from the American College of Surgeons Commission on Cancer. The center is partnered with the Kansas Masonic Cancer Research Institute, which is furthering KU Cancer Center's cause to achieve designation by the National Cancer Institute, for which it has

already applied. Researchers at the center have recently started a clinical trial targeting the most common form of adult leukemia with a drug that was first approved to treat arthritis more than 25 years ago.

University of Maryland Medical Center (Baltimore). With roots stemming back to 1965, the Marlene and Stewart Greenebaum Cancer Center is a National Cancer Institute-designated cancer center and is also accredited by the American College of Surgeons Commission on Cancer. The center also has major partnerships with the state of Maryland, the American Cancer Society and other cancer organizations in the private industry. In March 2011, Director Kevin J. Cullen, MD, was named to serve a six-year appointment on the National Cancer Advisory Board by President Obama. Dr. Cullen led a landmark study that linked HPV to racial disparities in survival rates for head-and-neck cancer.

University of Michigan Hospitals and Health Centers (Ann Arbor). The U-M Comprehensive Cancer Center has been recognized by the National Cancer Institute as a comprehensive institution. It was also a founding member of the National Comprehensive Cancer Center Network, which is comprised of 21 cancer centers around the country. In 2010, the center saw nearly 84,000 outpatient visits. More than 350 U-M faculty members provide care to patients while also collaborating on oncology research. Each year, the institute receives about \$79.5 million in grants from various cancer agencies.

University of Minnesota Medical Center (Minneapolis). University of Minnesota

Medical Center is partnered with the university's Masonic Cancer Center, which was founded in 1991. As a National Cancer Institute-designated Comprehensive Cancer Center, Masonic is a leader in cancer research — the world's first successful bone marrow transplant for Burkitt's lymphoma was performed here. The center was recently qualified in the National Cancer Institute Centers of Quantitative Imaging Excellence program, meaning its imaging services are advanced enough for use in NCI clinical trials.

University of North Carolina Hospitals (Chapel Hill). The N.C. Cancer Hospital is the clinical home to UNC Lineberger Comprehensive Cancer Center, a National Cancer Institute-designated Comprehensive Cancer Center that was established in 1975. N.C. Hospital was completed in 2009 and is now home to 110 faculty physicians, all of whom are members of UNC Cancer Care. The hospital sees more than 100,000 patient visits each year. It offers more than 225 clinical trials and more than 300 scientists who help translate research into treatment options for patients.

University of Rochester (N.Y.) Medical Center. Radiation oncology experts at University of Rochester's Wilmot Cancer Center were the first to successfully take a new brain cancer treatment — shaped-beam radiosurgery — and apply it to patients suffering from cancer that spread to the lungs and other organs. Scientists from the center also discovered a method to protect against HPV strains, which led to the first anti-cancer and HPV vaccine approved by the FDA in 2006. The National Cancer Institute recently awarded Wilmot a five-year grant of \$2.6 million to help young smokers quit.

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USC Norris Cancer Hospital (Los Angeles). The USC Norris Comprehensive Center includes approximately 200 basic and scientists and physicians from the Keck School of Medicine at the University of Southern California. It has held National Cancer Institute designation as a Comprehensive Cancer Center since 1973, when it was one of only eight in the nation. The center currently holds roughly \$134 million in oncology research grants. It includes USC Norris Cancer Hospital, one of only a handful facilities in Southern California built exclusively for cancer patient care. In November 2011, the American Cancer Society awarded the cancer center's director, Peter A. Jones, PhD, the Medal of Honor for his research into the epigenetics of cancer.

University of Texas MD Anderson Cancer Center (Houston). MD Anderson ranks first in the country for number of grants awarded and total amount of grant dollars from the National Cancer Institute. Some of the largest strides in cancer research have occurred within the walls of MD Anderson. In the 1970s, researchers proved that metastasis is a non-random process. The center also pioneered chemotherapy in outpatient settings in the 1980s and early 1990s — a practice that is widely followed today and is more cost-effective for patients.

University of Washington Medical Center (Seattle). UW Medicine is part of the Seattle Cancer Care Alliance, which affiliates UW

Medicine, Fred Hutchinson Cancer Research Center and Seattle Children's for oncology-related and cancer services. The alliance is accredited by the American College of Surgeons Commission on Cancer along with several other oncology-related agencies. In 2011, researchers conducted the first complete genome mapping of lethal prostate cancers to discover a series of recurrent genetic errors and patterns. Construction of a proton therapy center on the center's Northwest Hospital campus is under way and slated to open in 2013 for adult and pediatric patients.

University of Wisconsin Hospital and Clinics (Madison). The University of Wisconsin Carbone Cancer Center was formed in 1973 and is the only National Cancer Institute-designated Comprehensive Cancer Center in Wisconsin. It includes more than 280 physicians and scientists who translate research into treatments for the more than 30,000 patients who visit UW Carbone each year. UW Carbone developed tomotherapy, which is a specialized form of radiation that targets cancer cells while avoiding healthy cells and organs. It was also the sponsor of the country's first telephone-based helpline for cancer patients. That has since become the National Cancer Institute's Cancer Information Service.

University of Virginia Medical Center (Charlottesville). The Emily Couric Clinical Cancer Center at University of Virginia Medical Center opened its doors to patients in April

2011. It's the first center in the country to offer the latest version of tomotherapy. The center is a National Cancer Institute-designated cancer center, and its new facility also offers extensive patient amenities, such as a positive-image boutique that carries mastectomy garments, wigs and special skin care products.

Vanderbilt University Medical Center (Nashville, Tenn.). Vanderbilt-Ingram Cancer Center was established in 1993. It's the only National Cancer Institute-designated Comprehensive Cancer Center in Tennessee and also a member of the National Comprehensive Cancer Network, an alliance comprised of 21 centers across the nation. More than 300 researchers and 120 clinicians meet the needs of the 4,500 new cancer patients who visit Vanderbilt each year. The center's director, Jennifer Pietenpol, PhD, was invited to join the President's National Cancer Advisory Board in 1998.

Virginia Commonwealth University Medical Center (Richmond). VCU Massey Cancer Center was designated by the National Cancer Institute in 1974 and has kept that recognition since. Roughly 14,000 patients visit VCU Massey each year, where more than 400 clinicians deliver care and develop treatment plans in a team-based approach. Patients have access to more than 100 clinical trials offering innovative treatments for more than 20 types of cancer. VCU Massey researcher Steven Grant, MD, was recently asked to serve on the NCI's Investigational Drug Steering Committee.

Wake Forest Baptist Medical Center (Winston-Salem, N.C.). The Comprehensive Cancer Center at Wake Forest Baptist is home to more than 120 clinicians and oncologists with expertise in all aspects among the cancer continuum. The center is the first in the region to be fully accredited by the National Accreditation Program for Breast Centers, and the National Cancer Institute has also designated Wake Forest as a Comprehensive Cancer Center. In the past, the Department of Defense has awarded physicians from Wake Forest with fellowships to study the effect of carbon nanotubes on breast cancer stem cells.

Yale-New Haven (Conn.) Hospital. The Smilow Cancer Hospital at Yale-New Haven treats more cancer patients than any hospital in the state. It's partnered with the Yale Cancer Center, which has been accredited by the National Cancer Institute, and Yale School of Medicine. Yale-New Haven has dedicated an entire program to cardio-oncology, which addresses any cardiovascular complications from cancer or treatment. Yale School of Medicine was the first in the country to establish an academic-based oncology division, and Yale-New Haven was also the first hospital to successfully use chemotherapy in 1942. ■

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Turning Challenges Into Opportunities: Q&A With Brigham and Women's Hospital President Dr. Elizabeth Nabel

By Sabrina Rodak

Increasing pressure to reduce costs and improve quality can be overwhelming for hospital leaders. Elizabeth G. Nabel, MD, president of the Brigham and Women's/Faulkner Hospitals in Boston, says she approaches this challenge, like others she has faced, as an opportunity. Here, she describes how Brigham and Women's plans to continue to innovate and provide quality care while reducing costs.

Q: What are the biggest challenges you are currently facing as president of Brigham and Women's Hospital, and how are you working to overcome them?

Dr. Nabel: One of the biggest challenges that we are currently faced with is driving down the cost of healthcare while maintaining quality, safety and the patient experience. In 2010, we set a three-year goal to reduce our base expenses by \$160 million. I am proud to say that we are \$125 million toward our goal, and that we have developed plans for the final \$35 million, which we will implement over 2012 and 2013. We will work to create efficiency while being ever mindful that quality outcomes, patient safety and the patient experience cannot be sacrificed. To do this, we are working together as a multidisciplinary team and asking those closest to the patients how to make changes to improve care while cutting costs.

In 2011, we also completed a strategic plan which articulates our strategic commitments. The plan is centered on the following "truths:" The care we deliver must be the best and must provide more value to patients and families, specifically through our efforts to push the boundaries of innovation, research and education. We have to continually prove our value to all those we serve — patients, families, referrers, payors and community and government partners. We must optimize the use of our assets and match patients'

healthcare needs with the appropriate level of resources, both inside the walls of our academic medical center and with our partner institutions. Our work across our mission areas must be integrated and coordinated, and we must be able to adapt quickly as the environment in which we live and work changes.

Q: How do these challenges compare to those you have faced in the past?

EN: As a physician, scientist and leader, I have approached challenges throughout my career as opportunities to innovate, and in that way this challenge is quite similar. The Brigham has a history of transforming the future of healthcare — performing the first organ transplant, launching the world's first intraoperative MRI system, conducting the Nurses' Health Study, America's first study of women's health, and more recently performing the nation's first face transplant — and we intend to continue to do so as we shape how we will provide the highest quality patient- and family-centered care going forward. The challenge is to provide the right care at the right location with the right expertise, which will contain costs and improve the patient care experience.

That being said, many of the challenges in healthcare are different now than they were even five years ago. Delivering high-quality, affordable, safe care consistently requires diligence in setting priorities and taking advantage of efficiencies. Going forward, we will focus on co-ordinating care across the continuum, making appropriate and better use of our varied sites of care and further integrating and aligning our research, education, clinical and community mission areas.

Q: How do the challenges you deal with as a hospital leader shape your leadership style and your approach to healthcare?



EN: My leadership style as president of Brigham and Women's Hospital is focused on collaboration. I learned very early on in my career as a physician and a scientist that most often teamwork yields the best outcome. I encourage those on the front lines and staff across the organization at all levels to share their thoughts and ideas. I have established open forums to interact with our staff and encourage all employees to send me their ideas and concerns via an email forum that I've established for this purpose. I've found that this approach — encouraging participation — allows us to capture the creativity of our workforce and implement ideas that improve the quality, safety and efficiency of the care we provide.

Q: What are the most valuable lessons you have learned as president of Brigham and Women's Hospital, and how have you learned from them?

EN: In my time as president of Brigham and Women's Hospital, as well as during my career as a practicing physician and a scientist, I have learned the value of being flexible and adaptable. This is also something I learned from my father, a scientist for 3M, very early on. By anticipating changes in our environment and by committing to being nimble while staying true to our four-part mission of providing exceptional clinical care, innovating through research, training the next generation of caregivers and promoting health equity for our community, both locally and globally, we, as an institution, have been able to continue to be successful while planning for the future. ■

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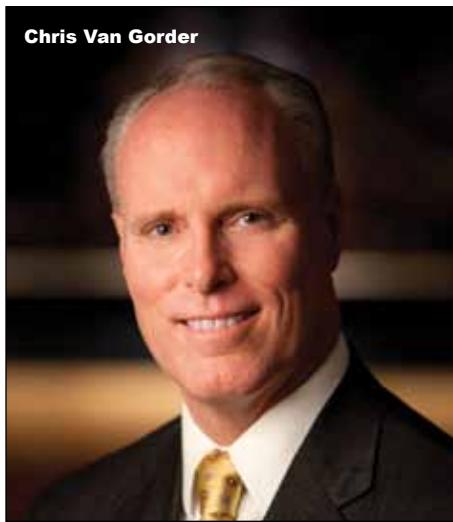
5 Hospital and Health System CEOs: What “Top Performance” Looks Like to Me

By Molly Gamble

What does it mean to be a top-performer, exactly? The phrase is often spoken with implicit meaning, but ask any two people and you'll likely hear different definitions. To help clarify what "top performance" looks like in healthcare right now, five hospital and health system CEOs from around the country deconstructed the term into five realms: clinical quality, finance, patient satisfaction, employee and physician morale, and leadership. Here is how a handful of our country's healthcare leaders are describing — and working toward — top performance within their organization.

Clinical quality

"Hospitals and systems need to engage closely with every member of the healthcare team — physicians, clinical and non-clinical employees — to reduce variation in operations and quality. Clinical dashboards should be developed to identify the organization's performance in clinical areas, with organization-wide action plans developed to evaluate and improve any area of concern. Improvement in quality and safety is difficult and complicated, as it takes changes in the way we deliver care to improve the care. Again, there are many external metrics to use to compare the organization's performance, and those should be used to target top performance." — Chris Van Gorder, president and CEO of San Diego-based Scripps Health



Chris Van Gorder

"First, as the people in an organization are a major determinant in the care hospitals provide, it's important to focus on the recruitment and retention of staff. You want people who are skilled at the highest level, regardless of their role, and

who are committed to working together as a team to contribute to the growth of the institution. Second, care is generally not delivered by an individual but by teams, so systems need to seamlessly come together to achieve needed outcomes. It's important to pay attention to patient flow and processes that enable care delivery. Appropriate use of information technology can enable systems and processes to work efficiently with the goal of improved outcomes." — Louis Shapiro, president and CEO of Hospital for Special Surgery in New York

"Hospitals at the top of the quality spectrum see quality as something that's never 'done' — there is always a new benchmark to achieve and process to be improved. The best hospitals have highly engaged and committed clinical staff who strive to serve each patient and the other providers caring for that patient — which, for academic medical centers like ours, always includes the referring physician. We embrace the Joint Commission's concept of a culture of safety and 'collective mindfulness' of safety. Clinical leaders at top-performing hospitals set clear goals for quality, safety and patient experience using guidelines and evidence-based medicine, and they communicate and inspire their staff to embrace these goals. They also embrace information technology as a tool to track and improve processes and outcomes." — Eric J. Beyer, president and CEO of Tufts Medical Center in Boston



Eric J. Beyer

"This is where the best hospitals are at the top of their game. They've engaged physicians, staff and support systems to focus on the ultimate outcomes of care. This is the best of times and the worst of times for quality in healthcare. We have far more data and trans-

parency than ever before, and that is gradually raising the bar for all — which is a great benefit to our patients and our organizations over time. The downside is there are way too many measures out there, many requiring more data than the value they create. We have a long way to go, and it will be nice when we can move from mostly counting errors to measuring successful outcomes of care." — Ted Townsend, president and CEO of St. Luke's Hospital in Cedar Rapids, Iowa

"You need to identify best practices for patient types, patient conditions and patient diagnoses. If you implement best practices and use them as a starting point, then you can adapt as you go on an individual basis." — Brock Nelson, president and CEO of Regions Hospital in Saint Paul, Minn.

Finance

"Hospitals and health systems must find a way to perform financially even though reimbursement is trending down, particularly from federal and state programs. To identify a top-performer financially, one only needs to look at the ratings given to the organization by the rating agencies — Moody's, S&P and Fitch. The metrics for those various ratings are published by each rating agency, and those are the targets for the healthcare organization to achieve. Then it's simply a matter of execution — managing costs and revenue in such a way to create value for the patient and community while remaining viable as a business enterprise." — Chris Van Gorder, president and CEO of San Diego-based Scripps Health

"Clinical quality at the highest possible level is needed for financial health. Does your hospital deliver the highest possible quality of care and create an exceptional experience for patients? What makes a hospital a top performer in clinical quality — staff and efficient processes — are also key ingredients in maintaining strong financial growth. In today's environment with constrained resources, hospitals are looking at lessons from other industries, such as lean production. Growth is also an important factor contributing to the bottom line." — Louis Shapiro, president and CEO of Hospital for Special Surgery in New York

"Top-performing hospitals need to be able to access capital. In order to do that, they need to demonstrate — to the financial community — an ability to repay their debts. That's increasingly challenging for hospitals in this health reform environment, where there's tremendous

downward pressure on reimbursement. Last year, Tufts Medical Center achieved a BBB rating and was able to issue \$195 million in debt. This enabled us to retire older, more expensive debt and to fund some key capital investments needed to further enhance our clinical programs. In order to accomplish the debt offering, we had to demonstrate to the financial community that we had positive cash flow and a solid strategic plan that would lead to continued financial success in this challenging healthcare environment.” — Eric J. Beyer, president and CEO of Tufts Medical Center in Boston

“[Hospitals] need to show profitable performance in the short-run and a sufficiently strong balance sheet to weather whatever reimbursement storms come out of the Patient Protection and Affordable Care Act, or deficit reduction. This is a crucial reason why many remaining single-site independents are looking for system alignment. From a debt financing standpoint in particular, bondholders are looking for historical track records and access to a deep pocket to deal with whatever comes.” — Ted Townsend, president and CEO of St. Luke’s Hospital in Cedar Rapids, Iowa

Ted Townsend



“A hospital needs to have its expenses run commensurate with its revenue. When those two are not linked, it's a recipe for a lack of success. That ability to run your expenses with your volume is so vital to a hospital's financial health.” — Brock Nelson, president and CEO of Regions Hospital in Saint Paul, Minn.

Patient satisfaction

“Improvement in patient satisfaction is not the end result of a ‘smile program,’ although courtesy is always important. Sustainable improvement requires changes in systems that have been designed for the convenience of the providers — not necessarily our patients. It can also require facility and operational changes in addition to having all staff focus on the total well-being of the patient and their family.” —

Chris Van Gorder, president and CEO of San Diego-based Scripps Health

“At Tufts Medical Center and Floating Hospital for Children, we have a motto: ‘Every Patient, Every Time.’ We know that every interaction with a patient is an opportunity to create a superior experience or a disappointing one. After patients are discharged, they are surveyed on their level of satisfaction with the care they received here. Those results are posted on national websites for the public to review and use in making decisions about their own healthcare. In addition, any patient at any time can instantly communicate with his or her entire social network about the care they received from us — great or not-so-great. It is critical for hospitals to educate their employees about the aspects of patient care on which we're officially and unofficially judged, and to communicate feedback we receive to frontline staff in ways that enable them to take action.” — Eric J. Beyer, president and CEO of Tufts Medical Center in Boston

“First, hospitals need to place a high value on patient satisfaction as a strategic priority. Hospital for Special Surgery has been at the 99th percentile for ‘likelihood to recommend’ for 14 consecutive quarters when benchmarked against other facilities in the Press Ganey Magnet Peer Group. It's a number one strategic priority for everyone in our institution. Second, patient satisfaction is directly linked to employee morale. Employees are 100 percent committed to what we're trying to accomplish as an organization, and they view themselves as owners [of that mission]. Patient satisfaction needs to be hardwired into your organization. For example, we implemented hourly rounding for our nurses to reduce the need for patients to use their call bell. By anticipating our patients' needs, we improved their satisfaction and made nurse workflow more efficient. Now that is part of how our nurses work every day.” — Louis Shapiro, president and CEO of Hospital for Special Surgery in New York



Louis Shapiro

“Patient Satisfaction is the ‘other side of the coin’ for quality. Doing the right things clinically is a start, but if we don't do it the right way or with a caring attitude, then we've not served the patient well. High-performing hospitals have learned how to make sure that the first thing their associates do is care about ‘the person’ before they start providing care to ‘the patient.’ And they do it time after time.” — Ted Townsend, president and CEO of St. Luke's Hospital in Cedar Rapids, Iowa

“Have a plan. Be consistent. You need to learn what satisfies patients. Most importantly, make sure everyone in the hospital contributes to the cumulative result of all the patient interactions, from the parking attendants to the food service people to the medical staff. Everyone needs to be engaged.” — Brock Nelson, president and CEO of Regions Hospital in Saint Paul, Minn.

Brock Nelson



Employee and physician morale

“Healthcare delivery is hard work — both emotionally and frequently physically. But, fortunately, healthcare attracts wonderful people who are dedicated to the care of our patients and our missions. Therefore, it's important for organizations to find ways to support — in every way legally possible — their employees and physicians by creating secure employment for employees and a supportive workplace for physicians. We need to provide competitive salaries and benefits, opportunities for education and advancement, and the opportunity to grow as a healthcare professional. But in an era of significant change and maybe even fear, job security is important as is engagement. Organizations with the right culture and engagement with staff and physicians will thrive even with the significant changes ahead.” — Chris Van Gorder, president and CEO of San Diego-based Scripps Health

“The most important factors are involvement, communication and environment. People are what enable the organization to perform at the

highest possible level, and people want to be involved in decision-making and improvement efforts. Communication goes hand-in-hand with involvement, feedback and follow-up. People need to feel that their opinions count. This means paying attention to and following up on their suggestions for improvement. It's important to communicate what is happening at the hospital so that employees don't feel inhibited or disconnected. Finally, everyone needs to have the tools to do their job, feel the organization is investing in their development, and know what's expected of them — then they're operating in an environment that lets them work at their highest possible level." — Louis Shapiro, president and CEO of Hospital for Special Surgery in New York

"I believe physicians and employees are attracted to hospitals that have great reputations for high clinical quality. At Tufts Medical Center, we not only have a great reputation for quality but for being warmer, more collegial and more nimble than many of our competitors. This culture appeals to physicians and employees alike. For physicians, this means they have opportunities to be entrepreneurial and that they'll be supported as they grow their clinical and research careers. Being somewhat smaller than many academic medical centers also means that individual physicians and employees really can make a difference here. We also support our physicians' practices with a strong community physicians' network and a network of affiliated community hospitals. We support our employees with strong managers who provide feedback and recognition and encourage employees to use their skills at the highest level." — Eric J. Beyer, president and CEO of Tufts Medical Center in Boston

"High-performing hospitals have taken the 'us/ them' out of patient care and moved aggressively to make both their associates and medical staff

part of a single team. From employed hospitalists to more engaged independent physicians, the best hospitals are finding ways to not just to align incentives but have also built strong cultures of mutual respect for each other as the best place to start the focus on achieving best practices." — Ted Townsend, president and CEO of St. Luke's Hospital in Cedar Rapids, Iowa

"Make sure everyone is engaged — involve all employees. Communicate often and talk straight. Create messages everyone across the organization can understand. Everyone should have the same ultimate goals in mind, and it should be clear what those goals are." — Brock Nelson, president and CEO of Regions Hospital in Saint Paul, Minn.

Leadership

"I don't believe there is any shortage of great leaders and potential leaders in healthcare. But organizations need to create opportunities for staff and physicians to gain experience in leadership, management and co-management so they can advance to leadership roles within the organization. Success in leadership is due to a combination of education and experience — with the emphasis on experience. So organizations need to constantly develop leaders from within the ranks." — Chris Van Gorder, president and CEO of San Diego-based Scripps Health

"Walk the talk. Be visible and approachable. Make sure people know you. Don't lose your connectivity to what is happening on the frontline with the people doing the real work in the organization." — Louis Shapiro, president and CEO of Hospital for Special Surgery in New York

"Executive and board-level leaders at hospitals have never had to think and act more strategically than they do now. It's not enough to offer

great patient care, cutting-edge medicine and do it in a way that makes patients feel welcome and families feel included — although all of that is imperative. We have to be extremely cognizant of changes in the market and stay ahead of them. Some years ago, big AMCs were adding lots of beds and trying to drive as much volume to their hospitals as possible. Tufts Medical Center has developed strong clinical partnerships at community hospitals where our [physicians] spend time, helping [those hospitals] expand their clinical offerings and improve quality. In turn, they send us more of their tertiary cases. We stay in close communication with referring physicians to ensure patients get seamless care. It's been a win-win for our partners, our medical center and most importantly for patients. We think this is the right model for the direction health reform is taking — in effect, we are operating as an accountable care organization." — Eric J. Beyer, president and CEO of Tufts Medical Center in Boston

"The best hospital leadership teams learned a long time ago to invert the pyramid. It's about meeting the needs of others, establishing a culture of mutual respect, listening and learning, as well as being able to translate a vision into, 'What does it mean to me?' Today more than ever that means having the ability to look over the horizon to see what's coming in healthcare and to be able not just to establish a direction but to communicate to each member of the care team in such a way that they can see their own way to the future." — Ted Townsend, president and CEO of St. Luke's Hospital in Cedar Rapids, Iowa

"Consistently keep one thing in mind: Always do what is best for the patient. Be authentic. Be relentless. Be without guile." — Brock Nelson, president and CEO of Regions Hospital in Saint Paul, Minn. ■

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"Everyone Rowing Together": Q&A With Vanderbilt Heart and Vascular Institute Executive Director and CMO Dr. Keith Churchwell

By Kathleen Roney

Keith Churchwell, MD, was named executive director and CMO of Vanderbilt Heart and Vascular Institute in July 2009.

Vanderbilt University Medical Center, which includes the Vanderbilt Heart and Vascular Institute, was one of the top-grossing hospitals in 2011 with \$4.52 billion in total patient revenue, according to CMS cost report data analyzed by the American Hospital Directory. Additionally, *U.S. News & World Report* ranked Vanderbilt University Medical Center amongst the top 40 on its Best Hospitals for 2011-2012 List.

Dr. Churchwell's background as a clinician and cardiologist guides his open door and humor-filled management style. Here he discusses his goals in the face of healthcare reform and innovation, his desire to surround himself with hard-working, collaborative individuals and his grassroots approach to executive leadership.

Q: What goals do you have for the Vanderbilt Heart for 2012?

Dr. Churchwell: One of the major goals for this year and for the whole medical center centers on financial issues. We are working to maximize our financial margin so we can fund innovative projects and prepare for what is down the road. Within the Vanderbilt Heart and Vascular Institute, we are looking closely at key projects surrounding acute episodic care for cardiovascular disease that improves and enhances our care model. The goal is to maximize our opportunity to use novel approaches to patient cardiovascular care that achieve the goal of better outcomes and greater efficiency. We want the care to be a win for VHVI and for the patient. We would like to enhance the whole package, which includes minimizing costs and maximizing outcomes.

Another major goal is to truly "bundle" the patient's cardiac care under one care plan. We have spent the last 10 months working on this key project at VHVI. At Vanderbilt, we take care of very ill patients providing surgical procedures that are remarkable in righting the wrongs of the patient's cardiovascular problem. However, that is only part of what we do. Our goal is to look at the totality of patient care. It is essential that the patients understand their disease process. We need to ensure that patients are taking their medicine and that we are taking steps to help put the patient back on the right track from both a physical and mental standpoint. We want to communicate with the patient's local physicians and care providers so they are also a part of this plan and give the patient the best chance for a full recovery.

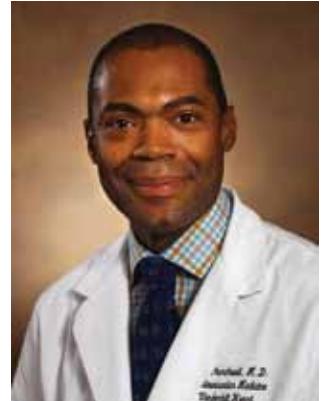
Q: How are you working toward achieving those goals?

KC: The first level of achieving any goal is making sure we have the right staff to get that done. Do we have the appropriate people to maximize care within the hospital environment? We really need to understand the day-to-day work of the hospital; what are the appropriate interlocking parts from a personal and technological standpoint? Once we have those key parts identified, the next question is how do we use them to the best of our ability?

We also need to determine if there is excess in the system. If so, where is it? Is there a better way to use our people, and if there is waste, how can we get rid of it? Where are we not placing enough resources, and how are those deficits leading to problems in care? How can we prevent those rollbacks from occurring, and we are encouraging and receiving the best work out of our staff?

Q: What are your biggest challenges as CMO?

KC: The first challenge is that Vanderbilt is such a large, extensive system. To overcome this, I like to encourage the idea of teamwork. All the staff — support staff, cardiologists, nursing and tech support staff — are a part of what makes Vanderbilt a great medical center and medical school. I want to encourage the staff to act and work in a way that represents Vanderbilt in the best light — a "they are we, we are they" mentality. Thinking in that mindset is extremely important because if not, we are disparate in our approach to problems, and we will not be as effective.



Additionally, it is important to ask for innovation in our thinking about issues that arise so problem solving becomes an opportunity to improve. I want the atmosphere to be "everyone rowing together, in the boat, in the same direction."

Q: How do you try to encourage that mentality and environment of "everyone rowing together"?

KC: We set meetings with all the parts of the staff at VHVI on a regular basis. Sometimes that is not as successful, but I still try. Face time is extremely important. I want to be transparent with questions, concerns and new initiatives. It is essential to get input from all the people who have ideas to share. When I understand their issues, I can handle the big questions, keeping their perspective in mind.

Q: It sounds like you utilize a grassroots strategy. What helps you accomplish that?

KC: Having an excellent administrative staff is essential. Then, realizing that part of my job is being a cheerleader and supporting my staff. It is important that I am able to look at the larger picture, the whole picture, as well as work with the staff and gather their ideas. I have a unique position because I am a clinical cardiologist as well as have responsibilities with senior management. I can see from the ground level what has been and is effective, and then I can talk with executives and partners and see their perspective. The view from both levels is very helpful.

Q: We were discussing challenges for this year. I would imagine that other challenges might revolve around healthcare innovation through technology. What is your strategy for incorporating new healthcare technologies?

KC: Well, you are right in that healthcare technology can be a challenge to integrate. Currently we are in another renaissance with cardiovascular technology and the ability to care for patients. In the late 1970s, there was a new age of revascularization with angioplasty. We are now looking at the age where diagnostic and therapeutic techniques are taking another significant leap forward. As an example, cardiologists and cardiac surgeons can now replace an aortic valve without opening the sternum — a tremendous advance — which will usher in other technological advances and also new care models that should be more efficient, less costly and better for our patients.

With my staff, we are closely evaluating how to continue to integrate the findings of new cardiovascular research and translate those advances into our daily work. What are the results in terms of outcomes from a therapeutic standpoint? We also evaluate the technologies from a financial standpoint — what is the cost to Vanderbilt? What is the cost to the patient? How is it being paid for? How can we be sure that reimbursement is in line with the cost of the procedure and the results? Right now, these questions are key points in conversations at Vanderbilt and on a national level.

Q: You are rounding out your third year as CMO. What is your proudest accomplishment?

KC: I can't think of one single accomplishment, but I am proud of helping to keep the idea of an interlocking, interdisciplinary institute all together and that everything is still moving forward.

Vanderbilt Heart has been able to integrate mature, successful cardiologists who have been in practice for a significant period into an aggressive academic and clinical model of care. The newer cardiologists have thrived and joined successfully with cardiologists who have grown up on this campus. I am proud of that — of our ability to retain physicians and grow careers.

Q: Hospital-physician relationships are very important to healthcare. Why do you think Vanderbilt has such great relationships with its physicians?

KC: Again, we have great administration, from the chairman of cardiac surgery, John Byrne; the chief of cardiovascular medicine, Douglas Sawyer; Robin Steaban, our CNO for Vanderbilt Heart and many others — are all examples of hardworking, dedicated people to this work. They have created a productive, collaborative environment. The physicians and cardiologists respond well to that, and thus far, there has been no burning of torches at the barricades.

Q: How would you describe your management style?

KC: I hope that my style has a bit of humor. I try to be open, firm and more than willing to hear and incorporate other viewpoints. I try to give those who have expertise and who want to grow the opportunity to do so.

The meetings I run are never terribly serious. It is okay for me to be the butt of the jokes if that puts people at ease as they go forward.

I try to make it my role to ensure that I hear everybody's viewpoints, from around the room, during a meeting. When I find I am the only one speaking for an extended period, I try to take a step back. I find the most benefit derives from meetings when thoughts and ideas percolate.

Q: What is the best piece of advice you have been given?

KC: My father, who passed away three years ago, gave me some advice when I was offered the position of CMO: "You need to [take the position] while you are young and use that youth to your advantage! Work hard as CMO; use your energy to do the best job possible and to see what you can make of the position."

I think that is great advice because sometimes one may hesitate when they take on a significant responsibility. The best way to grow as an individual intellectually and emotionally is take on responsibilities like [being CMO]. It is important to remember that others saw qualities within you that may be extremely helpful for moving a bigger agenda forward — it is important to take advantage of that. Be self-reflective throughout the whole process. Ask yourself if you are doing the right thing — have I made the right decision? What would I do differently next time? Be open to critical thinking. Ask those you trust what they think of your decisions. Ask people who can be honest. Surround yourself with people who will challenge you and tell you the truth. ■

Hospital

This is the Worst Time for Healthcare CEO Paralysis

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

I speak to at least one healthcare CEO every day and I have to tell you: From coast to coast, I am seeing something akin to panic right now. Highly experienced, talented and smart leaders, who used to move ahead of the curve, seem completely paralyzed. They are telling me they don't know where healthcare is heading, and many of them are holding off on making any major decisions about the future. That is a mistake.

Granted, the healthcare landscape of today is not a pretty picture. Many hospitals have a flat or declining inpatient census, due to the effects of the Great Recession, and future funding looks problematic. Medicare and Medicaid are projected to have shortfalls of \$25 trillion and \$30 trillion, respectively, over the next few decades. During recent negotiations of the Congressional super committee, the skies looked pretty dark. The federal budget is still pushing \$1 trillion, and our national debt is literally out of sight, a number we can't rationally contemplate.

It will take a stable federal government to solve healthcare funding problems, but all we have right now is political infighting at every turn — and no clear prospect of moving beyond the current game of partisan point-scoring. Here is the scenario as we enter this election year: The Supreme Court will review ObamaCare, the U.S. Senate is up for grabs and nobody can predict where the presidential race is headed.

As a healthcare executive, you have to deal with a lot of the unanswered questions ahead, but the worst thing you can do is just stop and wait to see which way the wind blows. You need to be preparing your institution for the future, because the future will come sooner than you think.

Many executives, however, believe they don't know where to start. Take ObamaCare. Will the Supreme Court strike it down — throwing out all of its myriad provisions, from expanded insurance coverage to accountable care organizations? Well, I don't think so. My read is that the Court is feeling gun-shy about interceding in yet another presidential election, as it did in Bush v. Gore. Yes, there is a possibility the court will strike down the individual mandate, but I believe they will basically leave ObamaCare intact.

Expect fundamental change

The Affordable Care Act faces more challenges beyond the Supreme Court decision, of course. If we put a Republican president and Con-

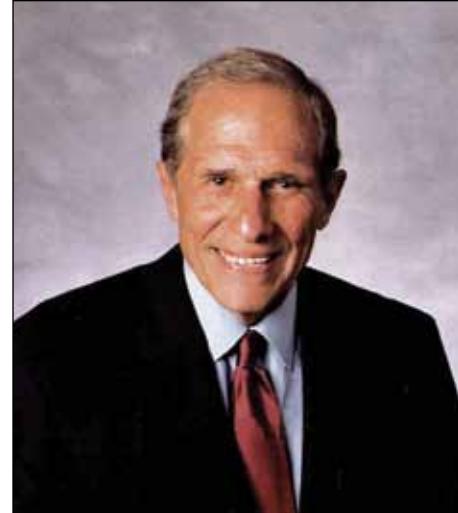
gress into office, they will likely take the axe to the ACA. But even if ObamaCare is repealed, healthcare reform is still inevitable. The system simply cannot continue in its current form and still satisfy both parties' concerns about fiscal solvency, quality and availability. With no ACA, changes could still come through other channels, such as the marketplace and the competition it creates. At a time when people are paying much more out-of-pocket for their care, they are becoming more attentive about getting quality care. For example, the Internet has become a key tool in finding out more about physicians and hospitals. The younger generations are going to be even more computer-savvy.

Whatever happens to ObamaCare, accountable care organizations will move forward, in one form or another. In spite of the furor over federal rule-making for ACOs, a lot organizations are looking to join them in one capacity or another. A *USA Today* survey in late July of executives at 1,800 hospitals found that a third of respondents' organizations were "extremely likely" to become part of an ACO. These organizations are about knitting together hospitals, physicians and post-acute care to manage population health, meet many more standards for quality and share in savings. I don't know exactly what form ACOs will take, but the model of tight integration is here to stay.

Be open to change

There are truly unprecedented challenges for healthcare right now — more than I have seen at any time since Franklin Roosevelt was president. And whenever there are major challenges, a good number of us want to dig in, resist change and be vocal about it. In healthcare, we are world-class in many ways, but perhaps the most refined skill we have is bemoaning the state of our industry.

When President Kennedy proposed Medicare, I was director of communications at the American Medical Association. The leadership of that august organization seriously believed that the sky was about to fall. A lot of doctors believed the practice of medicine would die out. In 1962, right after President Kennedy proposed Medicare in a speech in Madison Square Garden, the AMA rented out the space and the AMA president gave a speech warning of the decline of healthcare if Medicare should ever be passed into law. Well, Medicare was passed a few years later. Although I am a Republican, I have to say that this reviled program turned out to be a reliable payor — for many years,



at least — and even now, doctors recoil at any significant changes to it.

Then, 20 or so years after Medicare started, DRGs came along. At the time, I was publisher of *Modern Healthcare* and, oh, what a furor there was among hospital executives. But when all was said and done, hospitals dealt with DRGs and they prospered. Then in the late '80s and '90s came managed care, which was supposed to be the end of everything good in the world. And we dealt with that, too.

New pressures before us

Now we have new problems to grouse about — such as health IT, ACOs and readmissions policies — and new challenges to meet.

Readmissions are a perfect example of the stark choice that healthcare executives face today. Lowering readmissions means fundamentally changing a hospital's financial outlook. Hospitals that profited from readmissions will soon get dinged as much as 3 percent of payments if you don't reduce them. But even if ObamaCare is repealed and the readmissions disincentive goes away, which is unlikely, don't expect that we are not going to set the clock back again. The old system of fee-for-service reimbursements that encouraged high readmissions doesn't have a future. We are headed into a new way of managing population health, with payment based on meeting standards for quality of care, patient satisfaction and outcomes.

This new system will require investment in healthcare IT systems that can deal with huge amounts of data. In the economic stimulus bill, the federal government even sweetened the pot by offering substantial incentive payments for

hospitals that comply with meaningful use standards. I am amazed about how many hospitals haven't taken part yet. CMS paid out only a small portion of the \$2.8 billion in incentives on the table for stage 1 meaningful use in fiscal 2011. Many providers were glad that stage 2 was delayed, but I have to ask: What in the world are they waiting for? If you don't have a robust IT system, you can't compete. You can't manage costs by DRG, by physician, by service line. It's as simple as that.

Yes, the new programs spawned by the health reform and stimulus laws are still experiments. We really don't know whether they will succeed the way they are set up, but we have to try. If people like Mark McClellan, MD, the former CMS head under President George W. Bush, are right, these programs will soon become the new normal in healthcare. They will then be expanded in a much bigger and broader scale. Joining this experiment now means becoming part of a new system of care at the ground floor.

Time to get out of denial

Despite all the evidence, plenty of executives are still wondering whether any of the changes before them will come to pass. I think they are in

denial. I think they want to return to the good old days, when life was simpler. But this is wishful thinking. The world has changed and healthcare is changing with it, and whoever lives in this bubble is due for a rude awakening.

Sure, there are a lot of challenges ahead, but there is also an incredible number of opportunities. Despite all the problems we face, healthcare is an industry with a strong future. The glut of babyboomers reaching retirement will need a lot of healthcare. Even though Medicare will probably undergo revolutionary change, it is not going to go away. The payment system of the future will reward value-driven care, not just volume.

This is not a time for the faint-hearted. As with anything worthwhile, there will be winners and there will be losers. But for those who are dedicated to healthcare as a calling and are willing to embrace change, this is a thrilling time. Becoming a success will take all your skills, ingenuity, smarts and not a little bit of luck. But you can survive the test of today, and wind up with more than just a T-shirt for your troubles. ■

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.

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Webinar

Bridging the Gap Between Fee-for-Service and Value-Based Care Starts With Physician Feedback

By Lindsey Dunn

As hospitals and health systems across the country work toward coordinated and integrated care, most will need to alter their relationships with physicians. How a health system aligns its priorities with physicians is critical. That's because physicians have such an impact on cost and quality of care — both of which are the key goals of the Patient Protection and Affordable Care Act.

"Across the country, there are very few healthcare markets where the relationships between physicians and hospitals aren't in some type of change process," says Quint Studer, founder of Studer Group. "Closer clinical integration is achieved by a number of different models, including employment. What we're finding, however, is no matter what strategy you pick, the real challenge is the execution of the strategy — not only in the first year but the years thereafter."

Over the past few years, the fear of significant reimbursement changes has caused many physicians to "run for shade" by seeking hospital employment, explains Mr. Studer. Hospitals, in return, have welcomed them — often because of an overarching integration strategy.

Yet, there are certain hurdles that need to be overcome before the relationship between healthcare organizations and physicians can be optimized.

Misaligned incentives

Lessons of the 1990s taught hospitals they must achieve certain levels of performance from physicians in an employment model. As a result, the majority of physician contracts today are productivity or collection based. In contrast, the future of healthcare delivery is value-based — and the shift from one compensation model to another cannot happen overnight.

"When most physicians are brought into employment by a hospital, the hospital isn't totally at risk," explains Mr. Studer. "Physicians' salaries are determined by a productivity model based on either relative value units (RVUs) — i.e., productivity — or percent of total collections. Yet, the heart of the Patient Protection and Affordable Care Act challenges that type of reimbursement."

While it is true that a growing number of systems do provide incentives for meeting certain quality and/or patient satisfaction goals, these measures often impact only a small portion of the total compensation a physician receives.

Therefore, the biggest challenges in physician integration could lie ahead. When hospitals

bring physicians on board they do so hoping to eventually achieve lower-cost, higher-quality care. Unfortunately, the contract they forge with physicians doesn't incentivize them to prioritize these goals. It incentivizes quantity, not quality. This situation creates a gap that hospital leaders must find a way to bridge.

So how can leaders bridge the gap? The answer involves educating physicians on the coming shift, providing them with a mechanism for feedback and using a tiered approach to introducing new payment structures.

Do physicians know where the organization is headed?

Hospitals leaders should first make sure all physicians understand the shift toward value-based care and how it will impact the health system's overarching strategy. "They need to truly understand what goals — both clinical and financial — the organization must meet in order to be successful," says Mr. Studer.

For example, if the organization has set a certain HCAHPS score or utilization rates as overarching goals, physicians need to understand what the goal is, why it has been set and their role in helping to achieve it.

Traditionally, physicians have trained to have an individual mindset. This mindset, combined with physician contracts that reward individual productivity, may create a situation in which physicians are not aligned with the organization's larger goals. Leaders must help physicians to understand that they will soon have to move away from the old paradigm and into a new one — and to understand how it will translate to the system's goals as well as their individual performance goals.

Leaders, however, have to be careful not to dictate these goals to physicians. "Physicians want to have input into and influence on decisions," says Mr. Studer.

This means a hospital should involve the physicians — through committees or other avenues — in helping set new performance measures. For example, if an organizational goal is to receive a specific HCAHPS score, a certain percent of each individual physician's compensation could be determined by his or her scores on the physician communication measure.

"Give the physicians a menu of metrics and let them select which metrics they need to see regularly to meet performance expectations," suggests Mr. Studer.



When introducing these performance-based measures into compensation, Mr. Studer recommends a step-wise approach: introducing a few new measures each year and expanding that as value-based payments become more prevalent. As the organization grows more sophisticated, it can begin to weight the most important measures to ensure they are a core focus of the physicians.

Provide feedback

Next, the organization needs to provide feedback to physician on how they are performing — before it impacts their pay. Physician leaders or an administrator can track physician performance on all indicators that align with organizational goals and regularly provide reports on how each physician stacks up compared to the benchmark as well as to other physicians.

Mr. Studer recommends this feedback be provided in a one-on-one meeting, so the physician doesn't feel publicly shamed if performance falls below the standard. During this meeting, the administrator or physician leader should also solicit feedback from the physician on what barriers may be keeping him or her from achieving those results. If those barriers are operational, leaders should be prepared to quickly address them.

He also recommends healthcare leaders be prepared to provide skill development and training to physicians. "Once they know they're evaluated and data is transparent, they become very hungry to improve their skill sets in those areas," he says.

In the end, the transition from fee-for-service to pay-for-performance is about finding the right speed of change and explaining why this shift is beneficial.

"Value-based payment is actually much more balanced for doctors," explains Mr. Studer. "Items most important to the doctors — patient care and access, for example — begin to more greatly influence how they are compensated for the work they do." ■

7 Best Practices for Hospitals Implementing a Health Information Exchange

By Sabrina Rodak

Health information exchange is a key goal of the HITECH Act and meaningful use program, as it is designed to enable the secure transmission of data between healthcare providers. The American Health Information Management Association named HIE as one of the seven initiatives it will focus on in 2012, and the Office of the National Coordinator for Health Information Technology placed achieving HIE as one of its top goals in its 2011-2015 strategic plan. In addition, a CapSite report found that 74 percent of U.S. hospitals plan to purchase new HIE solutions. Here are seven best practices for hospitals implementing HIEs.

1. Define goals. The first step in developing an HIE, as with many projects, is to define the goals. "Determine strategic objectives, [and] how those are going to be measured. Then determine what's feasible [and identify] top priorities," says Marshall Maglothin, MHA, principal at Blue Oak Consulting, a healthcare firm specializing in electronic medical record implementation, among other areas. He says primary goals should be related to quality, such as preventing readmissions and reducing medical errors.

Other goals, however, will differ between hospitals. For example, Ralph Johnson, CIO of Franklin Memorial Hospital, a rural referral center in Farmington, Maine, says one the hospital's motivations for joining an HIE was to facilitate follow-up with patients after referrals. FMH has participated in HealthInfoNet, a statewide HIE, since 2006. "A large number of our patients will be referred out because we don't do open-heart surgery and we're not a trauma center," Mr. Johnson says. "We're constantly sending patients out of our network. [But] it's almost like a black hole — we don't get feedback on what happened to those patients. Now HealthInfoNet gives us that data."

2. Meet with physician stakeholders. Mr. Maglothin suggests forming a physician advisory board consisting of physician champions, physicians who have reservations about HIE, clinical medical directors of major departments and executives such as the COO, CMIO and CIO. Creating this board will facilitate communication between hospital leaders and physician stakeholders as well as understanding of any resistance to implementing the HIE. "Understand what the reservations and real barriers are," Mr. Maglothin says.

It is important for hospital leaders to understand the HIE initiative from a physician's point of view to be able to identify potential issues and solve them before implementation. For example, Mr. Maglothin says from a physician's standpoint, the

number of log-ins required is important because it affects workflow and productivity. Multiple log-ins may take only 30 seconds for each patient; however, when considering the number of patients seen a day, log-ins could account for up to 43 hours per year of unproductive time, Mr. Maglothin says.

Mr. Johnson said minimizing log-ins was one of FMH's goals when implementing HIE technology. The hospital established a system that allows providers to pass directly from the hospital's EMR to the patient's record in HealthInfoNet without a second log-in. "We wanted to keep the patient in context going between the local EMR in the hospital and at the statewide HIE," Mr. Johnson says.

3. Encourage physician champions. "The primary point of strength of a hospital HIE is physician stakeholders," Mr. Maglothin says. A hospital can benefit from "a visionary physician who has experienced medical records and understands the potential for improving healthcare," he says. He says physician champions should drive implementation of the hospital HIE and "[tell other physicians] This could be an extremely significant tool to leverage our EMR investment to improve patient care across the board."

4. Gain physician buy-in. Gaining physician buy-in is essential to the success of an HIE because an HIE's value depends on the number of users. "Getting the enthusiasm to the end users to use the system is really [when] the benefits [occur]," Mr. Johnson says. While critical to the process, hospitals cannot rely on physician champions alone to achieve the organization's goals through HIE. "The purpose of a hospital HIE is to improve quality of patient care and reduce unnecessary costs. That can only be done if not only physician champions are using it, but also those with reservations," Mr. Maglothin says. He suggests gaining buy-in from physicians with reservations by listening to their concerns and addressing to them.

Mr. Johnson says physicians respond to HIE plans when they learn of the potential benefits, such as faster transmission of data and the reduction of duplicate tests. For example, Mr. Johnson says when he was training a hospitalist to use the HIE he pulled up a patient's chart in the system, which revealed the patient had recently been admitted to a different hospital — information the patient forgot to tell the hospitalist. This information led the hospitalist to determine the reason for the patient's back pain and immediately intervene to reduce the pain.

5. Include other practitioners. Since the benefits of HIE increase in proportion to the number of users, hospitals should include prac-

titioners other than physicians. "When you focus solely on doctors, you're missing a tremendous opportunity for the entire care team to have information they need to take care of their patients," Mr. Johnson says. He suggests extending the HIE to nurse practitioners, nurses, physician assistants, therapists and other professionals involved in the care of a patient. FMH is roughly one-tenth the size of the largest hospital in Maine, but its HIE usage is nearly the same as the utilization of the largest hospital, Mr. Johnson says. "I think [this] is primarily because we expanded; we were not focused on just emergency department doctors using the system. We introduced it to a larger portion of the care team."

6. Work towards interoperability within the hospital. "The obstacle many are reaching now is they still have a number of significant siloed data repositories, diagnostic systems, for example, that collect extensive data, produce a report, but are not necessarily interfaced with other [systems]," Mr. Maglothin says. Hospitals can make best use of the HIE if hospital systems that collect data are interoperable and can thus create one comprehensive database. For example, Mr. Johnson said before implementing the HIE, FMH established interfaces so the HIE could normalize the hospital's data in various forms, such as radiology exams and ICD-9 codes.

7. Don't limit the organization to one HIE. "Hospitals won't [use] one or the other," Mr. Maglothin says. "Large health systems will have possibly their own internal HIE as an internal resource, and also exchange data with a state or regional HIE." Mr. Johnson says when examining a patient, FMH usually begins with the hospital's EMR and then references the HIE to include statewide data. Participating in both an internal and external HIE can enable the hospital to better organize data within the organization and be able to share that information via the regional or statewide system. ■

HIE Statistics to Know

- 70% of healthcare organizations are planning HIEs
- 42% of healthcare executives believe HIEs will improve patient outcomes
- 67 % of healthcare executives believe HIE will increase patient accessibility

Source: Beacon Partners

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PROGRAM SCHEDULE

Conference – Thursday, May 17, 2012

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

Conference – Friday, May 18, 2012

7:00am – 8:00am	Registration and Continental Breakfast
8:00am – 5:10pm	Conference, Including Lunch and Exhibit Hall Breaks
5:10pm – 6:30pm	Reception, Cash Raffles, Exhibits

Thursday, May 17, 2012

7:00 – 9:00 am
Registration

9:00 – 9:45 AM

A. Developing a Strategy for Your Hospital and Health System

Stephen Mansfield, PhD, President and CEO, Methodist Health System, Charles "Chuck" D. Stokes, MHA, Chief Operating Officer, Memorial Hermann, M. Michael Shabot, MD, Chief Medical Officer, Memorial Hermann, moderated by Bill Woodson, Senior Vice President, Sg2

B. Physician Compensation - A Review of Compensation Metrics for 5 Key Areas; Primary Care, Cardiology, Oncology, Orthopedics and Neurosurgery

Timothy Reed, Physician Practice Valuations Practice Leader, Sullivan Cotter and Associates, Inc.

C. Exploring the Facts and Fantasies of Physician Hospital Integration: Real World Examples of What Works, What Doesn't and Why

Peggy Naas, MD, MBA, Vice President, Physician Strategies, VHA Inc., Lani Berman, MBA, Vice President, Performance Services, VHA Inc.

D. Key Concepts for Successful Clinical Integration

Eric T. Nielsen, MD, Vice President, The Camden Group, and Teresa Koenig, MD, The Camden Group

9:50 – 10:30 AM

A. Key Strategies to Align Independent and Employed Physicians

Paul Summerside, CMO, BayCare Clinic, Chris Karam, President & CEO, CHRISTUS St. Michael Health System, Allan Fine, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, moderated by Kristian A. Werling, Partner, McGuireWoods LLP

B. Key Thoughts on Budgeting in Times of Uncertainty

John R. Zell, VP of Finance and CFO, OSF St. Joseph, Henry Brown, CFO, Internal Fixation Systems, Joseph Guaracino, Senior Vice President & CFO, The Brooklyn Hospital Center, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Hospital Physician Alignment: Implications on Profits and Performance

Alex Hunter, Managing Director, Navigant, Michele M. Molden, Executive Vice President and Chief Transformation Officer, Piedmont Healthcare

D. What's New, Next and Best in Healthcare Strategy, Marketing and Communications

Rhoda Weiss, PhD, National Healthcare Consultant, Speaker, Author & Editor, Marketing Health Services Magazine

10:35 – 11:10 AM

A. Payor Provider Integration - A Case Study

Bob Edmondson, Vice President of Strategic Planning and Business Development, West Penn Allegheny Health System

B. Managed Care Negotiation Strategies 2012

Gregg P. Leff, Executive Vice President, Med Metrix

C. Developing a High Reliability Organization - Learning from Other Industries

Charles "Chuck" D. Stokes, MHA, Chief Operating Officer, and Michael Shabot, MD, Chief Medical Officer, Memorial Hermann

D. The Evolution of Service Line Co Management Relationships, Best Practices

Gerry Biala, SVP of Perioperative Services, Surgical Care Affiliates, and Matthew Kossman, Senior Director, Surgical Care Affiliates

11:15 – 12:00 PM

A. Key Thoughts from Center of Medicare and Medicaid Innovation

Valinda Rutledge, Director of Patient Care Models Group, Center for Medicare/Medicaid Innovation

B. Sustainable Physician Compensation Model Design: Critical Success Factors for Building Productivity-Based Compensation Models

Marc D. Halley, President & CEO, and William Reiser, VP, Product Development, Halley Consulting

C. Core Strategies to Succeed as an Independent Hospital

Kerry Shannon, Senior Managing Director, FTI Consulting , Alan H. Channing, President & CEO, Sinai Health System, Joseph Guaracino, Senior Vice President & CFO, The Brooklyn Hospital Center, moderated by Kate Carow, Principal, Carow Consulting

D. Valuing Practices for Acquisitions - Assessing Acquisition Price and Compensation

Jon O'Sullivan, Senior Partner, Jonathan Helm, AVA, Manager, VMG Health

12:00 – 12:45 PM

Networking Lunch & Exhibits

12:50 – 1:30 PM

A. Developing an Outstanding Group Practice, Financial Sustainability, Culture and Other Issues

Jeff Mason, CEO, BayCare Clinic, Marc D. Halley, President & CEO, Halley Consulting, Joseph Golbus, MD, President, NorthShore University Health-System, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Consolidation - Strategic Thoughts for Consolidations and Independent Hospitals

Carsten Beith, Co-Head of Tax-Exempt M&A, Cain Brothers, Anu Singh, Senior Vice President, Kaufman Hall, Victoria Poindexter, Principal, H2C, LLC, moderated by Adam Lynch, Vice President, Principle Valuation

C. Building a Leading Neurosurgery and Spine Program

Casey Nolan, Managing Director, Navigant

D. Using Co-Management Effectively to Improve Results

Jen Johnson, CFA, VMG Health, Michael Piver, Director Orthopedic & Spine Services, Tanner Health System

1:35 – 2:20 PM

A. The 5 Best Ideas for ACOs, PHOs and Shared Savings Agreements

Charles "Chuck" Peck, President & CEO, Health Inventures, LLC, H. Scott Sarran, MD, MM, Chief Medical Officer, Blue Cross Blue Shield of IL, Mike Kasper, CEO, DuPage Medical Group, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Strategy, Quality and Efficiency

Imran Andrabi, President & CEO, Mercy St. Vincent Medical Center, Samantha Platzke, Sr. Vice President Operations & Systems Effectiveness, Catholic Health Partners, and Ben Sawyer, Executive Vice President, Care Logistics

C. Bundling Orthopedics and Other Key Concepts to Improve Orthopedic Volumes

John D. Martin, President & CEO, OrthoIndy, Julie Fleck, COO, Parkview Ortho Hospital, Doug Garland, MD, Medical Director of Orthopedics, Long Beach Memorial Medical Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP

D. Replacing Revenue for a Hospital When Developing Ambulatory Businesses

Robert Zasa, MSHHA, FACMPE, Founder, ASD Management

2:25 – 3:05 PM

A. Key Concepts to Be a Great Hospital CEO - How to Succeed and Develop Raving Fans

Paul R. Summerside, MD, Chief Medical Officer, BayCare Clinic, Peggy Naleppa President & CEO, Peninsula Regional Medical Center, Angela Marchi, Division Division CEO, Health Management Associates, moderated by Kristian A. Werling, Partner, McGuireWoods LLP

B. Key Strategies for CFOs

Gary E. Weiss, CFO, NorthShore University HealthSystem, William T. Cusick, Executive Vice President/CFO, St. Mary's Hospital, Henry Brown, CFO, Internal Fixation Systems, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Musculoskeletal Programs and Physician Alignment For Hospitals

Jeff Leland, CEO, Blue Chip Surgical Center Partners and Megan Perry, CEO Sentara Health System

D. Keys to Successful Implementation of Physician Alignment Initiatives

Charles "Chuck" Peck, President & CEO, and Christian D. Ellison, Vice President, Health Inventures, LLC

3:05 – 3:20 PM

Networking Break & Exhibits

3:20 – 4:10 PM

A. Keynote Panel - The Unintended Consequences of the Affordable Care Act

Ken Hanover, CEO, Northeast Health System, Andrea Price, CEO, Mercy Northern Region, Stephen Mansfield, PhD, President & CEO, Methodist Health System, moderated by Charles S. Lauer, Author, Consultant, Speaker and Former Publisher of Modern Healthcare Magazine

B. Panel Discussion - Key Thoughts on Hospital Restructuring and Turning Around Hospitals

Paul Rundell, Managing Director, Alvarez & Marsal Healthcare Industry Group, Michael R. Williams, MD, CEO, Hill County Memorial, moderated by Barton C. Walker, Partner, McGuireWoods LLP

C. The Radiology Department of the Future -Maintaining Profits From Imaging as the World Evolves

Phillip Heckendorf, CEO, and David Walker, COO, RadCare

D. Valuing and Assessing Co Management Relationships

Scott Safran, MBA, AVA, Partner, HealthCare Appraisers, and Amber McGraw Walsh, Partner, McGuireWoods LLP

4:15 – 5:00 PM

KEYNOTE – Leadership and Management in 2012

Mike Ditka, Legendary NFL Player and Football Coach

5:00 – 7:00 PM

Networking Reception, Cash Raffles & Exhibits

Friday, May 18, 2012

7:00 – 8:10 AM –

Registration and Continental Breakfast

8:10 – 9:00 AM

KEYNOTE – From Nixon to Obama

Bob Woodward, Legendary Political Journalist & Associate Editor, The Washington Post

9:00 – 9:45 AM

A. Keynote Panel - The Best Ideas for Health Systems and Hospitals Now

R. Timothy Stack, President & CEO, Piedmont Health System, Stephen Mansfield, PhD, President & CEO, Methodist Health System, Michael O. Ugwueme, CEO, Methodist Healthcare North and South Hospitals, Charlie Martin, CEO, Vanguard Health System, moderated by Charles S. Lauer, Author, Consultant, Speaker and Former Publisher of Modern Healthcare Magazine

B. The Current State of the Healthcare Credit Markets

Shane Passarelli, Senior Vice President, Healthcare Finance Group, Kevin Vermeer, CFO, Iowa Health System, Don Ensing, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Healthcare Reform - Future Thoughts on Success

Alan Sager, PhD, Professor of Health and Policy Management, Boston University School of Public Health

D. Patients Come Second, Employees Come First

Paul Spiegelman, CEO, The Beryl Companies, and Britt Berrett, CEO of Texas Health Presbyterian Hospital in Dallas

9:50 – 10:30 AM

A. Developing an ACO and Alignment Strategy for Your Health System

Marty Manning, President, Advocate Physicians Partners

B. What Should a Hospital CEO and CFO be Paid?

Paul Esselman, Executive Vice President and Managing Principal, Rebecca Kappahn, Engagement Manager, Cejka Executive Search

C. A Perspective on the Medical Staff of the Future

Ron Greeno, MD, CMO, Cogent HMA

D. Fixing Physician Hospital Joint Ventures That are Struggling

Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America

10:30 – 10:45 AM

Networking Break & Exhibits

10:45 – 11:30 AM

A. Keynote Panel - Great Leadership

Moderated by Suzy Welch, Author, Television Commentator, Business Journalist, Panelists: Kristine Murtos, President, Skokie Hospital, Melissa Szabad, Partner, McGuireWoods LLP, Teri Fontenot, CEO, Woman's Hospital, Pamela Stoyanoff, EVP & COO, Methodist Health System

B. 5 Key Financial Ratios That Providers Should be Tracking

Kate Guelich, Senior Vice President, Kaufman, Hall & Associates

C. The Financial Return on Different Physician Alignment Strategies - How to Assess the Financial Implications of Different Alignment Strategies

Luke C. Peterson, Partner, Strategy, and Kate Lovrien, Partner, Strategy, Health System Advisors

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

Tom Stallings, Partner, McGuireWoods LLP

11:35 – 12:20 PM

A. Keynote Panel - Evolving Strategy - Thinking 10 Months and 10 Years Into the Future

Moderated by Suzy Welch, Author, Television Commentator, Business Journalist, Panelists: Cathy Jacobson, President, Froedtert Health, Donna Katen-Bahensky, President & CEO, University of Wisconsin Hospitals and Clinics, Tammie Brailsford, RN, COO, MemorialCare Health System, Amber McGraw Walsh, Partner, McGuireWoods LLP

B. The Importance of Data and Analytics in a Bundled Payment Approach

Bob Kelley, Senior Vice President, Center for Healthcare Analytics, Thomson Reuters

C. Ideas and Concepts to Improve Cardiovascular Program Profitability

Andrew Ziskind, MD, Managing Director, Clinical Solutions, Huron Healthcare, and James Palazzo, Managing Director, Navigant, moderated by Molly Gamble, Writer-Assistant Editor, Becker's Hospital Review

D. Key Concepts to Police, Improve and Measure Quality

Kathleen Crawford, MSN, MBA, FACHE, Chief Operating Officer, Ashtabula County Medical Center, HFAP Nurse Surveyor, Linda Lansing, SVP of Clinical Services, Surgical Care Affiliates, Marion Martin, RN, MSN, MBA, COO, The Center for Quality, Innovation and Patient Safety, Roper St Francis Healthcare

12:20 - 1:05 pm
Networking Lunch and Exhibits

1:05 – 1:45 PM

A. ACOs in Action

Andrew Ziskind, MD, Managing Director, Clinical Solutions, and Tim Ogonoski, Managing Director, Huron Healthcare

B. Hospital Transaction Preparation and Process Design

Barry Sagraves, Juniper Advisory, Rex Burgdorfer, Juniper Advisory, Martin Machowsky, SVP, Strategic Communications, McGuireWoods Consulting, Kristian A. Werling, Partner, McGuireWoods LLP

C. Generation Y - An Examination of the Mindsets in Employing the Next Generation of Orthopedic Surgeons

Les Jebson, Executive Director, University of Florida Ortho and Sports Medicine

D. Avoiding a Hurricane: How to Evaluate Your Anesthesia Provider and Ensure Your OR's Success

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

1:50 – 2:30 PM

A. Aetna's ACO Initiatives - Our Work With Health Systems to Pilot ACO Initiatives on Hospital Employee Populations

Debbie Lantzy-Talpos, Market Head, Aetna

B. Key Developments in Medicare Reimbursement and Implications for the Delivery of Care

Ken Perez, Senior Vice President of Marketing, MedeAnalytics, Inc.

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

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

D. 10 Keys to Assessing the Short- and Long-Term Sustainability of Your

Hospital and Running a Successful Acquisition or Joint Venture Program

Scott Becker, JD, CPA, Partner, and Barton C. Walker, Partner, McGuireWoods LLP

2:35 – 3:10 PM

A. The Best Ideas on Physician/Hospital Integration - What Works, What Doesn't

Bob Wilson, Executive Director, Health Care Advisory Services, Grant Thornton, I. Naya Kehayes, MPH, Managing Principal & CEO, Eveia Health Consulting & Management, Mickey Bilbrey, Vice President of Eastern Operations, Quorum Health Resources, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Optimizing Resources - Guaranteed New Savings and Revenues

Richard Kunnes, MD, Managing Principal, CEO, Sevenex

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

James M. Palazzo, MBA, Managing Director, Navigant

D. Physician Relations: Best Practices in Leveraging QA Programs to Manage and Affect Positive Change

John DiCapua, MD, Vice President Anesthesiology Services, North Shore-Long Island Jewish Health System, Deputy CEO, CMO, North American Partners in Anesthesia

3:15 – 3:50 PM

A. New Types of Transactions to Deal With the Changing Environment - Payors Acquiring Providers, For-Profit and Not-For-Profit Hospital JVs and Joint Operating Agreements

Carsten Beith, Co-Head of Tax-Exempt M&A, Cain Brothers, Casey Nolan, Managing Director, Navigant, and Kristian A. Werling, Partner, McGuireWoods LLP, moderated by David Jarrard, President & CEO, Jarrard, Phillips, Cate & Hancock

B. Building a World Class Oncology Program - A Case Study

Gerard Nussbaum, Director of Technology, Kurt Salmon

C. Hospital Strategies for Surviving and Thriving in the Changing Healthcare Environment

Russ Richmond, MD, CEO, Objective Health

D. Clinical Variation, Quality and the Role of the CMO

Bill Mohlenbrock, MD, FACS, Chairman and CMO, Verras

3:55 – 4:30 PM

A. False Claims, Anti Kickback Investigations and Other Common Issues of Litigation

Jeffrey C. Clark, Partner, Angelo M. Russo, Partner, and David J. Pivnik, Associate, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Acquisitions of ASCs, Imaging Facilities and Other Ancillary Businesses - How to Examine Opportunities and How to Assess Pricing and ROI

Matt Searles, Managing Director, Merritt Healthcare

C. 5 Core Concepts on How to Reduce Readmissions

Jasen Gundersen, MD, MBA, CPE, SFHM, Chief Medical Officer, Hospital Medicine, and Eric Heckerson, RN, MA, FACHE, Vice President of Operational Performance, TeamHealth

D. Turning Today's PHO into Tomorrow's ACO

Elizabeth Simpkin, Vice President of Consulting Services, and Carole Black, MD, Chief Medical Officer, Valence Health

4:35 – 5:10 PM

A. Performance Improvement Initiatives for Hospital Affiliated Practices

John McDaniel, MHA, President & CEO, Peak Performance Physicians

B. An EMR for the Revenue Cycle: Documenting the Business Side of Care at Saint Joseph's Medical Center

Rebecca T. Black, Vice President, Revenue Cycle, Saint Joseph's Hospital of Atlanta

C. Personalizing the Management of Atrial Fibrillation - How Cardiac MRI can Improve Your Outcomes and Bottom Line

Jeremy Foterhringham, RN, MHSA, JD, Director, CARMA Center, University of Utah Healthcare

D. 5 Basic PR Tactics That Every Health System Should Remember

Marion Crawford, President, Crawford Strategy

5:10 – 6:30 PM

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Bob Woodward, Author, Associate Editor, The Washington Post – Mr. Woodward is regarded as one of America's preeminent investigative reporters and non-fiction authors. He has worked for The Washington Post since 1971 as a reporter, and is currently associate editor of the Post.

While a young reporter for The Washington Post in 1972, Woodward was teamed up with Carl Bernstein; the two did much, but not all, of the original news reporting on the Watergate scandal that led to numerous government investigations and the eventual resignation of President Richard Nixon. Gene Robers, former managing editor of The New York Times has called the work of Woodward and Bernstein "maybe the single greatest reporting effort of all time. Woodward has authored or coauthored 16 non-fiction books in the last 36 years. All 16 have been national bestsellers and 12 of them have been #1 national non-fiction bestsellers – more #1 national non-fiction bestsellers than any contemporary author.



Suzy Welch, Author, Popular Television Commentator, and noted Business Journalist – Ms. Welch's New York Times best-selling book, *10-10-10: A Life Transforming Idea*, presents a powerful decision-making strategy for success at work and in parenting, love and friendship. *10-10-10*

became an instant success and is now published in 29 countries worldwide, and an updated version has been released in paperback. In addition, she is a contributor for ABC's Good Morning America, and has been widely featured in major media outlets including The Today Show and Time Magazine. Together with her husband Jack Welch, Suzy is also co-author of the #1 international bestseller *Winning*, its companion volume, *Winning: The Answers*, and "The Welch Way," a weekly column on business and career challenges which appeared in *BusinessWeek* magazine from 2005-2009 and was published in 45 major newspapers across the globe by *The New York Times* Syndicate. In 2010, the Welches launched an online MBA program through Chancellor University



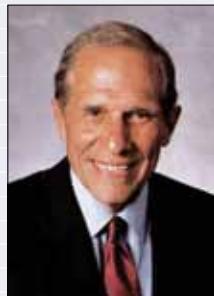
Mike Ditka, Legendary Hall of Fame NFL Football Player and Coach – Pro Football Hall of Fame player and Super Bowl-winning coach Ditka joined ESPN as an NFL analyst in 2004. With a combined 26 years of playing (12) and head

coaching (14) experience, Ditka is an analyst on Sunday NFL Countdown and Monday Night Countdown and makes regular appearances on ESPN Radio and SportsCenter. Ditka also served as a game analyst during ESPN's Monday Night Football doubleheader games in 2007 and 2008, alongside Mike Greenberg and Mike Golic. Ditka boasts a career few can match. He is only the second person to win the Super Bowl as a player (Dallas, 1972), assistant coach (Dallas, 1977) and head coach (Chicago, 1986). He was elected to the Pro Football Hall of Fame in 1988, the first tight end to receive this honor



Valinda Rutledge, Director of Patient Care Models Group, Center for Medicare/Medicaid Innovation – In June 2011, Ms. Rutledge was hired in a senior leadership position as Director of the Patient Care Models Group at the CMS's new Center of Medicare and Medicaid Innovation. Previously, she was the CEO of CaroMont Health in Gastonia, North Carolina. At CaroMont Health, she led the development of the 210 day bundled knee payment arrangement between CaroMont Health and North Carolina's largest health insurer, Blue Cross

and Blue Shield of North Carolina. This initiative was designed to provide value based care leading to enhanced care coordination. Prior to CaroMont Health, Ms. Rutledge was CEO of Bon Secours Saint Francis Health System in Greenville, South Carolina. She was also Senior Vice President of the Bon Secours Health System with responsibility for system-wide physician alignment strategies, as well as market leader for both Kentucky and South Carolina. Rutledge holds two advanced degrees: a Master of Business Administration from Butler University in Indianapolis and a Master of Science in Nursing from Wayne State University in Detroit.



Charles S. Lauer – Mr. Lauer was the publisher of Modern Healthcare for more than 30 years, taking it from a monthly money-losing proposition when Crain Communications purchased the magazine in 1976 to the nation's leading healthcare news weekly. Known throughout the healthcare industry and beyond as a leader, Chuck Lauer is now a healthcare consultant, an author, public speaker and award-winning businessman who is in demand for his motivational messages to top companies nationwide.

Mr. Lauer's career includes early success as a retail representative for Life Magazine at Time, Inc., and later as a drug merchandising manager of Look. The consummate salesman, he served as Midwest Sales Manager for two McGraw-Hill trade publications and was general sales manager for the publications of the American Medical Association where he became the AMA's director of communications. He also held various positions with Family Media, Inc. and Petersen Publishing. He is a graduate of Middlebury College in Vermont. Mr. Lauer served in the United States Army as a corporal during the Korean War and continued his postgraduate education at the Northwestern University Medill School of Journalism in Evanston, Illinois.

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A Culture of Continuous Improvement is Necessary for Success Under Value-Based Care

By Imran Andrabi, MD, Senior Vice President and Chief Physician Officer, Mercy

Transformation. This word is one I've been saying a lot lately. At Mercy St. Vincent, where I served as president and CEO until October, a transformation — in the form of creating a culture of continuous improvement — has been taking place over the last several years. And, healthcare delivery as we know it will soon also experience a major transformation as it moves from fee-for-service to value-based, integrated care. This transformation will require healthcare providers to redesign how they deliver care, in ways both big and small.

On the grander scale, hospital and health system strategy must prepare for integrated, coordinated care along the care continuum. On the smaller scale, this strategy must also create value in more traditional ways — for example, through more efficient operations. At Mercy we have worked to develop a culture of continuous improvement — a culture that allows us to adapt the way we deliver care as we transition to value-based models.

Continuous process improvement

The transformation process we've instituted at St. Vincent involves bringing together a multidisciplinary group from all levels of the hospital to explore ways to make our processes more efficient while maintain the high quality care we are known for. For example, we recently streamlined the transfer process so patients referred to St. Vincent from regional hospitals can quickly be assigned a bed and transported to the hospital. The undertaking began by bringing various staff members who "touch" the transfer process together to map what our current state was as well as what the future state needed to

be — that is, where we want to go. From there, we determined how to streamline and cut duplicate work at each point along the transfer process and identified which measures we needed to improve and track our performance. Then, we implemented and tested the various solutions. Today, St. Vincent has a single hub that receives calls from physicians who wish to transfer patients, and each transfer patient is assigned a bed in 10 minutes or less. Before, transfer assignments took roughly an hour. Also, as a result of the efforts, St. Vincent experienced a 26 percent increase in transfers coming from the region.

Now this same process and principles of performance improvement is being implemented at some of Mercy's rural hospitals, and it will soon be taken out to various regions within our parent organization, Catholic Health Partners. So while the actual improvements may be individual to each hospital, the process is replicable.

Critical capabilities

While continuous improvement alone is important to developing a strong foundation for value-based care, additional capabilities are needed for success as hospitals expand their care continuums post-reform. Here are just a few that will be important.

Eliminating waste. As part of their continuous improvement efforts, providers must continuously examine how they can eliminate waste and remove duplication and rework. If a redundancy doesn't improve safety or quality, then why are we doing it?

Patient-centered mindset. As organizations move toward coordinated, integrated care, they must think in a patient-centered manner. That's easier said than done, of course, but operationalizing processes that do what's right for patients is where the rubber meets the road.

Drill-down benchmarking. Process improvement methodology must include meaningful measures of performance that can be easily reported to employees and staff. This is fairly obvious. However, one thing we learned at St. Vincent is that these measures must be drilled down into more specific measures each employee can impact. We systematically broke down the processes our front line workers could impact in their own domains. For example, for years we were telling nurses to shorten length of stay, but what does that mean to them? Once we drilled down to the



specific ways they could impact LOS, we started seeing improvement. How can nurses impact LOS? They can make sure orders are inputted in a timely manner; they can make sure test results are delivered to physicians quickly; the list goes on.

Health information technology and analytics. Where it's applicable, use technology as an accelerator and as a resource to develop visibility of what you're doing. Also use it to give you data that can be analyzed to improve both clinical and operational processes. If you don't know how you're performing, you don't know what to work toward. These tools also allow us to provide performance data to our various departments by week, day and hour, not by months or years. Transformation requires rapid change in a system, and HIT helps us impact the care delivered at the bedside in real-time.

Transformation, though, is a journey, and it won't happen overnight. The key is to move in the right direction by articulating a vision and have methodology that moves your organization towards it. ■

Imran Andrabi, MD, currently serves as senior vice president and chief physician officer for Toledo, Ohio-based Mercy. Previously, he served as president of Mercy St. Vincent Medical Center in Toledo. He is a diplomat of the American Board of Family Medicine and the American Board of Managed Care Medicine.

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Top 10 Lessons Learned from “Mature” Co-management Arrangements

By **Rebecca Bales, MPA, ASA, Senior Vice President, and Robert Minkin, MBA, FACHE, Senior Vice President, The Camden Group**

Interest in co-management agreements has increased dramatically over the last two years as hospitals explore various forms of physician integration, including bundled care, valued-based payment arrangements and accountable care organizations. Since much of the first wave of co-management agreements began in the mid-2000's, there are many “mature” co-management arrangements from which to learn. Here are 10 lessons learned from those early ventures that paved the way for clinical integration in specific service lines.

1. The improvement in the operations of a co-managed surgical service line, such as orthopedics, had a huge impact on the operations of the OR overall. When the range of on-time starts increased to 80 to 90 percent, and turnover improved, more patients could be accommodated using the same human and capital resources, and both the hospital and physicians benefited financially. The process improvements resulting from co-management spread to other service lines.

2. During the first years of the arrangement, performance standards, targets, tasks and metrics were often adjusted to match those used by accrediting bodies and CMS. Since most co-management agreements have three-year terms, agreements were amended within months of execution. The language in some agreements made this easy, while in others, it was very cumbersome. It is important to have the flexibility to change tasks, responsibilities and hours through amendments, rather than waiting for renewal dates.

3. Most organizations commissioned independent opinions on the fair market value of the payments outlined in the agreement. However, since the mid-2000's, scrutiny from the IRS and CMS has increased regarding the commercial reasonableness of arrangements as well as the compensation paid. Hospitals with co-management agreements (especially those with multiple agreements) have strengthened their compliance to include commercial reasonableness opinions, typically when the contract is renegotiated or extended after the third year. The commercial reasonableness opinion considers the following:

- a. Does the arrangement meet a need of the hospital other than for referrals?
- b. Is there a community and/or patient need for the services in the agreement?
- c. Are the hours reasonable for the services provided?
- d. Is the compensation structure reasonable for the services provided?
- e. Do the credentials of the individuals in the agreement match the services needed?
- f. Are the tasks outlined in the agreement consistent with industry practice?
- g. Is another agreement or party covering the same services?
- h. Is there a formal oversight of the agreement to confirm that the services are being provided?

Hospitals with multiple co-management agreements ran into complications with items c and g, and most had shortcomings in the documentation of item h.

4. Co-management arrangements are more sustainable when they are focused on service lines where the opportunities for quality improvement and/or cost reduction are the greatest. For this reason, many early entrants started with orthopedics or cardiology yielding improvements in supply costs, length-of-stay, readmissions and post-acute utilization. These organizations are now poised to pursue bundled payments and other value-based payment models.

5. In the early agreements, the hours covered in the agreement were typically for physician involvement only. Many agreements were amended to add non-physician services, especially in multi-hospital agreements or those with joint venture managers. Some tasks were delegated to non-physicians working under the direction of physicians. When this occurred, the parties were required to confirm that the tasks and responsibilities were not already performed by hospital paid employees.

6. Many physicians confused co-management with gain-sharing and were surprised to learn that the hospital savings are not shared with physicians. This was especially annoying for physicians in those hospitals that had significant increases in volume over the time of the agreement. Inadequate attention to (and dollars in) the “incentive” payment portion of the fees deflated physician enthusiasm. It should be noted however there will be opportunities for gain-sharing in bundled payment and some value-based payments in the future. All physicians impacted by the co-management agreement should be fully educated on the mechanics and compensation possibilities.

7. Throughout the 2000's, CEOs reported that they spent as much as 50 percent of their time on physician problem resolution. Perhaps that has not improved overall, but CEOs have reported that rather than demanding to see the CEO regarding problems in the OR, surgeons are more likely to work out the issues with the co-management leaders, leaving their interactions with CEOs to more positive and productive topics. This was a lesson for the C-suite and affirmation that clinical integration can improve problem resolution and communication in some hospitals. The specialty liaison committees and site operations committees, in particular, appeared to address physician problem resolution.

8. The success or failure of co-management arrangements in some hospitals confirmed that the culture of clinical integration starts at the top. If the CEO does not include physicians and nurses in senior leadership teams, budget preparation and decision-making processes on a daily basis, then true integration at the service-line level did not come naturally. Opportunities for improvements in patient care and quality were therefore missed. Some hospital executives involved with co-management agreements have increased the exposure of clinicians in all areas of hospital operations and planning efforts.

9. Hospitals with a healthy compliance culture seemed more successful with co-management arrangements. When hospital management was fluent in language that described Stark and IRS excess benefit concerns, there was better acceptance of the constraints on compensation, and the expectations for incentives were more clearly communicated. Hospitals with good compliance were also better at defining roles and responsibilities, which ultimately reduced conflict in their arrangements.

10. As the payors continue to seek greater value, more extensive clinical metrics have been imposed upon healthcare entities, and the pressure to reduce costs is escalating. As a result, most co-management agreements will need to address these higher standards as a part of their deliverables, and accountabilities and responsibilities between the parties must be clearly established. Many co-management agreements

are structured to include some or all of the following: leased employees, service line management, supply standardization and control, capital equipment and medical direction. The physician-led co-management company must assume some or all of these responsibilities in a service line in order to perform to expectations. Hospital executives need to learn to "let go" and share the decision-making while not relinquishing the responsibility for the outcome. This is the most

difficult behavior change, along with selecting the right combination of physicians who also can lead their colleagues in practice change.

Co-management appears to be a good first step to greater levels of physician/hospital integration. Utilizing this tactic can build success and trust which are necessary ingredients for all future relationships. ■

CBO: Most Demonstration Projects Don't Curb Medicare Costs

By Molly Gamble

After reviewing the outcomes of 10 major Medicare demonstrations, the Congressional Budget Office has found most produced little or no savings to the federal health insurance program.

The CBO reviewed six disease management and care coordination demos, and four-value based payment demos.

The first group of six disease management and care coordination demos comprised 34 programs operated by disease management companies. In nearly each of these demos, spending remained stagnant or increased at the same rate it would have without the program in place.

Programs in which care managers had more direct contact with physicians and patients were more likely to reduce costs than other programs. For instance, hospital admissions fell by an average of 7 percent and regular Medicare spending declined by an average of 6 percent for programs with more direct contact. Still, these savings are not enough to offset fees — programs would have to achieve savings of 13 percent to do that.

Value-based payment demos had mixed results. Only one of the four — bundled payments covering all services related to heart bypass surgeries — reduced Medicare spending at all. It cut costs by about 10 percent. The three other demos produced little or no savings. These include the Physician Group Practice demo, Premier Hospital Quality Incentive and Home Health Pay-For-Performance demo.

The CBO has concluded that the key factor associated with demos' success is the nature of the incentive offered to providers. Demos that paid bonuses to providers based on quality scores, estimated savings, or both, produced little to no savings. The success of the bundled payment demo was largely attributed to the competitiveness of hospitals' local markets and providers' strategic decisions — factors that influence the size of the discount offered to Medicare in bundled-payment rates. ■

Survey Suggests Joint Ventures With Physicians Most Popular Alignment Strategy, Among Other Findings

By Lindsey Dunn

The results of a recent survey of more than 200 healthcare leaders by Jarrard, Phillips, Cate and Hancock published in the firm's *Inside Baseball* newsletter suggests that joint venturing with physicians is the most popular current physician alignment strategy (49.8 percent of respondents indicated using this strategy), compared to aggressively acquiring practices (26.3 percent), traditional credentialing and medical staff relations (15.1 percent) and "keeping [physicians] at bay" (8.8 percent).

In terms of how healthcare organizations are facing reform, 42.8 percent of respondents reported "becoming strange bedfellows with... competitors" through ACO or joint venture development. Additionally, just over 20 percent of respondents reported they plan to wait until after the presidential election to embrace reform, 11.2 percent plan to orchestrate or sale or purchase, and 10.2 percent plan to start a new managed care business.

In regard to the election's impact on reform, the majority (53.5 percent) say it's "unstoppable" and market-driven, while 42.5 percent believe if President Obama loses the election, the intensity and direction of healthcare reform will dramatically change. ■

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11 Common Ailments With Physician Practice Valuation

By Nicholas J. Janiga, Manager, and Jason L. Ruchaber, CFA, ASA, partner, HealthCare Appraisers

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Over the past 24 months, HealthCare Appraisers has performed valuation services in connection with over 100 physician practice acquisitions across the country. In connection with these acquisitions, HAI is frequently asked to review or rebut competitors' valuation reports, typically as a result of one of three scenarios: i) HAI is asked to review an analysis that a party to the acquisition does not understand or agree with; ii) HAI is asked to refute or temper the work performed by a valuation firm or consultant that is willing to push past the limits of fair market value (e.g., potentially in violation of Stark Law or Antikickback Statute); or iii) HAI is asked to correct another appraiser's mistakes.

From these experiences, HAI has compiled the following list of 11 common ailments observed with physician practice valuation.

1. Mistaking investment value for fair market value. In the healthcare industry, regulations such as the Stark Law and Antikickback Statute mandate that permissible transactions involving parties who are in a position to refer patients (e.g., physicians) must be priced at fair market value. FMV is defined by these regulations¹ in a manner that is more nuanced than the standard definition of FMV², and may preclude consideration of economic benefits that might otherwise be priced into a transaction.

Though the specifics of these laws and definitions are beyond the scope of this article, it is common to encounter investment banking, accounting, consulting and general valuation firms (i.e., valuation firms not specialized in healthcare) who incorporate significant levels of synergies into their FMV opinions (these synergies result in an investment value opinion which is not consistent with FMV). Common synergies include adjustments involving the following: increased reimbursement under provider-based billing, downstream revenues, improper ancillary carve-outs, lower expenses achieved by the acquirer, indirect consideration of referrals and others. The result of incorporating the aforementioned synergistic adjustments is a change to the standard of value and, therefore, an unusable valuation opinion.

2. Failing to analyze operational data. Appraisers unfamiliar with healthcare frequently fail to consider and analyze key operational data. Operational data includes detailed CPT code reports, provider mix, payor mix, place of service, patient zip code and other related reports. These reports allow valuation analysts to analyze historical trends, prepare a Medicare (or new commercial fee schedule) impact analysis, understand revenue concentration, project changes in revenue, benchmark the subject practice to the industry, analyze relative value units of the subject physicians, assess unsystematic risk and many other supplemental analyses. Without these schedules it is difficult, if not impossible, for the valuation analyst to properly value the subject physician practice.

3. Forgetting the impact of an electronic health record system. Many physician practices have implemented or are in the process of implementing an electronic health record system. Significant direct and indirect costs are incurred during the implementation process, with physician practices expecting to achieve both direct and indirect benefits from the undertaking. The main direct financial benefit includes CMS' subsidy revenue of \$44,000 per physician (paid over five years at \$18,000, \$12,000, \$8,000, \$4,000 and \$2,000 per year), which is subject to current stage one meaningful use requirements and future implementation achievements (CMS intends to propose, through future rulemaking, two additional stages of the criteria for meaningful use). In addition to the expected direct revenue over

the first five years after implementation, many valuation analysts forget to analyze the potential lost productivity during implementation and potential improved productivity going forward.

On the expense side, many valuation analysts forget to examine changes in operating expenses during and after the implementation of an EHR system. An example of this is forgetting to analyze historical consulting and other one-time implementation expenses that should not be projected going forward. Another example is forgetting to project the full amount of increased software, server, computer, hardware and maintenance expenses that will be incurred to maintain the EHR system at the subject physician practice. A final common error, assuming the subject physician practice has implemented voice recognition hardware, is the valuation analyst forgetting to project a decrease in transcription expense (either in-house or contracted service). All of the examples illustrated in the previous paragraphs have an impact on a subject physician practice's future cash flow and, thus, impact the concluded FMV of a subject physician practice.

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4. Failing to analyze local demographics, industries and economies. Valuation analysts may determine that the subject physician practice has the capacity to further grow revenue, whether it is through increased productivity or expanding services, but this does not always mean they have the ability to do so. The ability of a subject physician practice to grow, or even maintain existing productivity levels, is highly dependent on factors within the local demographics and economies. Healthcare is geographically constrained by a patient's willingness to travel and, therefore, local healthcare demand should be analyzed thoroughly, including analyses of historical and projected changes in population, age, workforce, income levels, major employers and industries, prevalence of disease and other factors applicable to the subject physician practice's region.

5. Disaggregating business and compensation valuations. In the valuation of physician practices, physician compensation and business value have an inverse relationship. To the extent physicians are going to receive an *increase* in compensation relative to historical levels, the result is a *decrease* in projected cash flow and, thus, a *decrease* in value (and vice versa). It is common to review valuation reports in which the valuation analyst or client has disconnected the business and compensation opinions either through the use of multiple appraisers or a compartmentalizing of information. A business appraisal that fails to account for a 20 percent increase in compensation post acquisition does not properly impact projected cash flows and overstates the conclusion of value for the subject physician practice. This is akin to someone winning the lottery and choosing to receive the upfront payment and the annuity payments for 20 years (i.e., have your cake and eat it too).

6. Erroneously valuing in-office ancillaries. Many physician practices have both professional collections related to physician services and technical collections related to in-office ancillaries such as diagnostic imaging. In certain instances it may be appropriate to value these separately; however, there is a correct and an incorrect way of separately valuing in-office ancillaries. Similar to disaggregating business and compensation valuations, many valuation analysts create unsustainable business models and do not account for the portion of physician compensation that is generated from in-office ancillaries.

An example is valuing the in-office ancillaries of a cardiology practice where the cardiologists generate a significant portion of their compensation from in-office diagnostic imaging (e.g., as high as 50 percent of total compensation). If the in-office ancillaries are sold, the cardiologists will no longer be able to bill for these services and, as a result, the subject physician practice will have to pay the cardiologists a reduced level of compensation based solely on professional collections. Valuation analysts cannot simply use survey data (e.g., MGMA, AMGA, etc.) via the market approach for determining physician compensation, as the survey data does not adequately bifurcate compensation related to professional services and in-office ancillaries. Thus, after adjusting for the impact of in-office ancillaries, a distributable earnings method or pre-compensation earnings method should be used in determining the appropriate physician compensation.

7. Benchmarking improperly. Valuation analysts should benchmark the subject physician practice to industry metrics. Failure to do so generally results in unsupportable business models and provides very little value-added to the acquirer. Through the use of published surveys, such as the MGMA Cost Survey, and through reviewing previous valuations of similar entities, the valuation analyst should be able to identify certain revenue and/or expense abnormalities as well as adjustments that a normal operator would be able to achieve. Common adjustments include poorly (or absently) negotiated payor contracts that result in below-market reimbursement; excess (or insufficient) staffing levels; excess (or insufficient) leased space; underperforming in-office ancillaries (i.e., negative income and cash flow); and non-operating and non-recurring items.

While some valuation analysts do not benchmark the subject physician practice to the industry, others develop unreasonable financial statement adjustments through assuming all physician practices can achieve "median performance levels." These valuation analysts fail to truly analyze the unique characteristics of the subject physician practice relative to what is "common" within the industry. An example is adjusting clinical support staffing levels to a "median level" for subject physicians that achieve productivity above the 90th percentile. This may be obvious to most, but the subject physicians likely need clinical support staffing levels at the 90th percentile (or above) in order to be so productive.

8. Incorrectly utilizing the market approach. The comparable transaction method of the market approach is the most commonly misused method in determining the FMV of a physician practice. Many valuation, consulting and investment banking firms attempt to apply valuation multiples from closed transactions in valuing a subject physician practice, particularly multiples of revenue. There are a number of downfalls to this approach, including the following: the transactions may not represent FMV; the transactions could involve the subject physicians receiving a pay raise (or pay cut) that is not reflected in the deal data; the inclusion or exclusion of specific assets or liabilities in the transactions that is not reflected in the deal data; and unknown levels of ancillaries, mid-level providers and other important information. Furthermore, assuming the valuation analyst has enough information about a set of closed transactions, it may be inappropriate to apply valuation multiples from closed transactions that have occurred outside of the local market of the subject physician practice. Given the local nature of healthcare services, particularly physician practices, there can be many differing factors across market areas (e.g., reimbursement).

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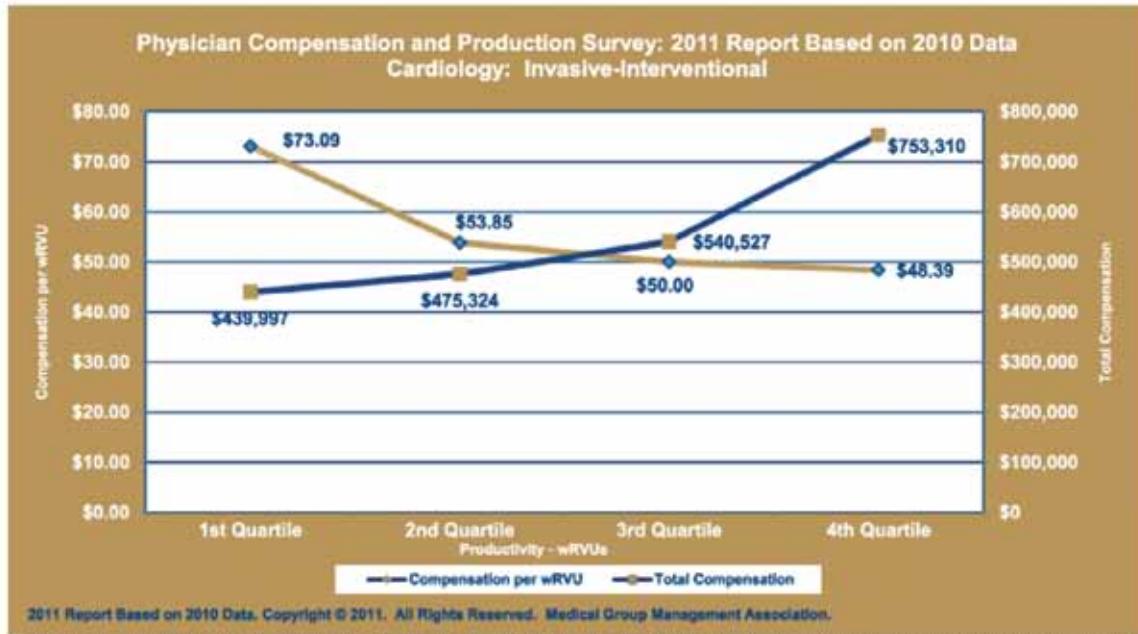
9. Assuming statistically flawed levels of physician compensation. Certain valuation firms, consulting firms, acquirers and attorneys believe every physician practice should be compensated at or above the median compensation per work relative value unit reported in published surveys (even when the subject physician practice has not been able to historically generate such levels of compensation per wRVU). By definition, a median value reflects the midpoint of a data set. Accordingly, 50 percent of physicians make less than and 50 percent make more than the median reported compensation per wRVU rate.

It is also important to understand what the data in these surveys reflect and how the data is intended to be used. For example, MGMA has specifically addressed the fact that for the majority of physician specialties there is a declining compensation per wRVU rate as overall productivity increases. Generally, this indicates that physicians who produce at the 75th percentile should not be paid at the 75th percentile rate per wRVU. There are many factors that contribute to this relationship, and even with a declining rate per wRVU as productivity increases, physicians still have increasing total compensation in all reported quartiles, as illustrated in the following graph.

acquired assets (and liabilities to the extent that any are transferred) when using the income approach.

Using debt-free cash flow under the income approach, an analyst develops a conclusion of the market value of invested capital. From the concluded market value of invested capital, the valuation analyst has to subtract assets that are not going to be transferred. Typical adjustments include the exclusion of net working capital, inclusion of inventory and inclusion of debt on transferred fixed assets. Once the deal terms are known, the appraiser should be consulted to verify that the purchase price is reconciled for the inclusion or exclusion of any assets and liabilities.

11. Failing to go on-site to visit with management and physicians. There is only so much information that can be gleaned from financial and operational reports. Valuation analysts who do not go on site to meet with the administrative team and physicians have a higher propensity to miss certain nuances of the subject physician practice or bury themselves in the numbers and forget the big picture. In meeting with the administrative team and physician group, an appraiser can gain insight into the practice patterns of the subject physicians, condition of the office



Every physician practice has its own unique operating characteristics and levels of technical and other service revenues. Some physicians use more resources (e.g., clinical support staff, space, etc.) in generating wRVUs, have more ancillary utilization and generate higher levels of other service revenues (e.g., on-call, directorship, co-management, interpretation, etc.). These operational characteristics and additional revenues impact a physician practice's compensation per wRVU rate. As a result, it is possible to have two physician practices across the street from each other that realize disparate compensation per wRVU rates.

and ancillary equipment, depth and quality of the administrative team and other information important to the valuation. Although a site visit can be dependent on the scope and timing of the engagement, conducting a site visit is an integral part of the valuation process

Conclusion

As evidenced in the list above, there are many areas where valuation analysts err in valuing physician practices. Acquirers must be very careful in selecting a valuation firm to help determine the FMV purchase price of a physician practice; an interview process is necessary in order to appropriately vet the hiring of a valuation firm. ■

Footnotes:

1. See 42 U.S.C. § 1320a-7b(b) and 42 U.S.C. § 1395nn

2. See the International Glossary of Business Valuation Terms

10. Failing to understand what is reflected in the FMV opinion. Acquirers of physician practices are typically structuring the purchase as an asset deal (instead of a stock deal). The acquirer frequently relies on the valuation firm to help determine the FMV of acquired assets (and liabilities to the extent that any are transferred). Under the asset approach, it is fairly simple to analyze and adjust the FMV balance sheet to include only the assets and liabilities that are expected to be transferred. It is common for valuation analysts to make mistakes when analyzing the FMV of

St. Vincent's HealthCare CFO Mark Doyle: 3 Burning Questions Right Now

By Bob Herman

Sitting in the healthcare "hot seat" is a turbulent experience right now for any hospital CFO. It's similar to the game show "Who Wants to Be a Millionaire?" in that the personal pressure builds the further along someone goes, and there is gradually more on the line, financially speaking. However, healthcare does not have any multiple choice options, 50/50 lifelines or Regis Philbin's calm demeanor.

Mark Doyle, CFO of St. Vincent's HealthCare in Jacksonville, Fla., lays out three questions that are at the forefront of any hospital CFO's mind right now. And unlike a game show, there are no easy answers.

1. How will Medicaid cuts impact my hospital? Medicare, Medicaid and commercial payors are the three main revenue sources of most hospitals. There are, undoubtedly, pressures on all three. Medicare reimbursement rates have an anemic growth rate — the Medicare payment adjustment actually fell behind inflation rates this past year. Hospitals also may have to barter more with commercial payors to make up for the declining governmental payments.

Medicaid, though, has become a growing concern for hospital CFOs because the impact of Medicaid cuts depends solely on what state the organization is located in.

Medicaid spending for the entire country for fiscal year 2011 was around \$398.6 billion, a 10.1 percent increase from FY 2010, according to a report from the National Governors Association and the National Association of State Budget Officers. That total accounted for almost 24 percent of state spending — the single largest element of state spending. At the same time, many state officials are enacting austerity measures on state budgets, and Medicaid reimbursement is one of the biggest items on the chopping block.

More than a dozen states have already sliced Medicaid payments to hospitals and physicians. For example, Arizona cut Medicaid reimbursement to hospitals and other providers by 5 percent this past year. South Dakota (11.5 percent cut to hospitals), Oregon (11 percent cut to hospitals), Washington (10 percent cut to hospitals), North Carolina (7.3 percent cut to hospitals) and many others have also reduced Medicaid rates.

St. Vincent HealthCare in Florida faces roughly \$2 billion in Medicaid cuts for the 2012 to 2013

fiscal year, which amounts to a 12 percent average cut to Medicaid reimbursements for hospitals, and Mr. Doyle says those types of reductions will hurt his state's struggling program even more. "Funding for Medicaid has taken a huge bite out of reimbursement, and every patient of Medicaid will be a significant loss for each hospital," Mr. Doyle says.

Hospital CFOs looking to stay on the offensive have to consider areas that can compensate for this lost Medicaid revenue. For some, this may require an analysis of service line productivity. "This will force a lot of hospitals that are standalone and don't have [market] leverage to probably close their doors or choke off less profitable service lines," Mr. Doyle says. "Hospitals won't be able to keep up the level of services. In the past, it's been you pass the lack of reimbursement onto the backs of the commercial payors and the HMOs. In the future, I don't think we'll be able to do that — or at least not like 10 years ago."

Additionally, Mr. Doyle says hospitals need to constantly review production metrics, become more persistent in payor negotiations, manage the supply chain as efficiently as possible and control every other type of cost (e.g., energy, labor, etc.) down to the penny. "That's the only way right now, absent of rate increases, that we'll be able to survive," he adds.

2. Will ACOs and bundled payments be beneficial? The Medicare Shared Savings Program set the parameters for accountable care organizations, and the Bundled Payments for Care Improvement Program created guidelines for a bundled payment system focused on the continuum of care. Both initiatives, part of the Patient Protection and Affordable Care Act, are under way, but concrete financial benefits will not be seen for quite some time. Mr. Doyle says although his organization is analyzing the new programs, they are not moving full-force until more large-scale financial ramifications become clearer.

However, St. Vincent's HealthCare has submitted an application for Model 2 of the Bundled Payments for Care Improvement Program. Model 2 focuses on bundled payments for both the inpatient stay as well as the post-acute setting, and the hospital decides the scope of diagnosis-related groups to be included in the bundled payments. In this instance, Mr. Doyle says the organization plans to focus on ortho-



pedics and cardiology for the bundled payments, but St. Vincent's HealthCare has not necessarily committed to anything yet.

Mr. Doyle believes the success of these programs will largely be dependent on one component: physician alignment. About a year and a half ago, St. Vincent's HealthCare employed five physicians. Now, the health system has 92 employed physicians. Regardless of how the PPACA programs shake out, there is a shift to congregate physicians and make them a more integral part of the health system's financial solvency. "You can see a rapid expansion for physician alignment, and it's all to manage the entire spectrum of a patient's health," Mr. Doyle says.

3. What exactly is going to happen with the healthcare reform law? This is the million-dollar question. The Supreme Court is scheduled to hear arguments on the PPACA this March, with a final ruling expected in the summer. Parts of the healthcare reform law being questioned include the individual mandate for health insurance and the expansion of Medicaid. However, because the law is in a legal limbo of sorts, it makes it difficult for hospital CFOs and other executives to make definitive short-term plans for their organizations. "It has to be all or nothing," Mr. Doyle says of the potential ruling. "You need the first domino to fall for the rest to come into play."

The early indicators vary on how the Supreme Court will rule. Many healthcare experts think because so much of the PPACA has been ruled constitutional elsewhere — and because so much has been implemented — it will be unlikely there will be a full repeal or even a repeal of the individual mandate, which is one of the biggest hot-button issues. However, in an election year, nothing is for certain. Mr. Doyle, who believes the funding of the PPACA appears to be unsustainable in the future, says it is that uncertainty that is making things so difficult for the healthcare sector. ■

7 Best Practices for a Smooth Hospital Tax Process

By Bob Herman

As Benjamin Franklin famously quipped, “In this world, nothing can be said to be certain, except death and taxes.”

The certainty of taxes has become increasingly involved for hospitals, as the Internal Revenue Service as well as state and local governments are making sure the healthcare systems in this country are properly paying their fair share in an era of tight budgets. As the tax season now starts to hit full stride for most people in the United States, here are seven best practices for hospitals and their financial teams in order to manage their tax processes smoothly year-round.

1. Understand the new Form 990. For non-profit, tax-exempt hospitals, nothing is more important than the Form 990. It is the Holy Grail of tax documents, and the IRS released the 2011 version of the Form 990 (for tax years beginning in 2011) last month.

Milt Cerny, JD, counsel at McGuireWoods, and Rick Speizman, national partner-in-charge of the exempt organization tax practice at KPMG, say this year's Form 990 has added new reporting requirements, with those involving Schedule H as the most important for hospitals. Section 501(r) of the Internal Revenue Code, part of the Patient Protection and Affordable Care Act, imposed new tax exemption requirements on non-profit hospitals. These new requirements in turn led to new reporting on Schedule H, beginning with the 2010 Form 990. Much of the new reporting was optional for filers of the 2010 form, but it is now required for filers of the 2011 form. Here are four of the most pertinent items hospitals need to know about this year's Form 990.

- *Facility information.* Part V, Section A now requires hospitals and health systems to list each of their hospital and non-hospital healthcare facilities, including those operated indirectly through a “disregarded” entity like a limited liability company or a joint venture. “There is more reporting in this form, and it also requires a separate set of responses regarding policies and practices for each hospital’s practices and facilities,” Mr. Cerny says.

- *Community health needs assessment.* Part V, Section B, lines one through seven, provide new reporting obligations for hospitals, as well. Mr. Speizman says the community health needs assessment requirement of Section 501(r) is a major new tax requirement for hospitals. If hospitals want to remain tax-exempt, they have to conduct community health needs assessments, which essentially detail how a hospital is meeting the health needs of the community it serves.

The community health needs assessment is optional for tax years beginning before March 24, 2012, but many hospitals are working on this section of Schedule H now to stay ahead of the game. Examples of detailed questions in this section include how hospitals obtained data and how the assessment was made available to the public.

- *Financial assistance and billing/collections policies.* The financial assistance and billing/collections policy questions are still within Part V, Section B on Schedule H, and these reporting requirements essentially ask hospitals to outline the standards they apply in offering financial assistance to patients, what type of financial assistance they offer and how they publicize their policies. Mr. Cerny, however, says this section has expanded and added different terminology. “It’s interesting because [the IRS] eliminated the term ‘charity care’ and replaced it with ‘financial assistance,’” Mr. Cerny says. “That’s basically asking about policies that applied to the largest number of patients.”

- *Compensation.* Hospitals must record the compensation of top executives in their Form 990 (this is outside of Schedule H). Although the compensation reporting requirements are not new, they still are considered to be one of the most heavily scrutinized facets of the entire form. “Compensation is always going to be looked at by the IRS,” Mr. Cerny says. “That’s something hospitals really need to make sure they have done the due diligence for determining compensation.”

Hospital financial teams should always review the compensation packages of top executives and other “insiders.” “Look at the compensation of executives and see how it matches up against executives at other organizations,” Mr. Speizman says. He also notes that proper reporting of compensation on Forms 990 can be difficult “because of the increased and more detailed reporting — retirement benefits, fringe benefits. A great deal of data needs to be collected. This is always a lot of work,” he says.

Mr. Speizman also recommends that as a best practice, healthcare providers should give their full board of directors an opportunity to review the Form 990 in its final form before it is submitted to the IRS. Because the Form 990 is available in the public sphere, prudence and meticulous evaluation must reign supreme. “In the tax-exempt world, we’re concerned about a lot more than the income tax we might owe,” Mr. Speizman says. “This is information that is being looked at by the IRS, the public, potential donors, labor unions, competitors, the press — everybody. It’s worth putting the proper investment into preparing Form 990 because it really is the face of your organization and continues to get more complicated as the government adds more rules and more reporting requirements.”

2. Have an efficient and effective tax compliance team. The Form 990 is a major undertaking for non-profit hospitals and health systems, but every hospital — regardless of tax status — needs to have a focused tax team, says Monica Coakley, national tax leader for healthcare at KPMG.

Getting all tax filings completed on time should be a given, but being proactive and well-organized along the way is the challenge. “You need to make sure that your [hospital] has an efficient and effective tax compliance team that is planning ahead and executing a proper project management plan,” Ms. Coakley says. “The company should have a clear timeline, from gathering all relevant information through any internal and external reviews and electronic submission. The planning and information gathering process should be ongoing throughout the year.”

3. Evaluate the tax processes on a periodic basis. Hospital CFOs and other financial officers should evaluate periodically how they gather tax data and how they are meeting compliance obligations, including whether they have the right, robust tax technology in place. “Tax technology can make a big difference in the cost effectiveness and accuracy of the tax compliance process,” Ms. Coakley says. “Having strong systems and controls in place is one of the keys to effective tax risk management.”

4. Be proactive on gathering investment information. Many of the larger non-profit hospitals and health systems have substantial investment portfolios these days, and they are making very diverse investments, such as real estate, private equity funds and hedge funds.

However, compiling and retrieving the slew of information from those investments is not always easy. “Typically, those organizations are reliant on receiving forms and disclosures of information, but sometimes that information is hard to get,” Mr. Speizman says. He recommends hospital

financial officers stay on the offensive and be proactive about receiving timely and complete investment statements and Forms K-1 from all of the accounts and funds in which they invest.

5. Don't narrow the focus to only federal income taxes. Both non-profit and for-profit hospitals need to devote appropriate resources to state income taxes, sales taxes, property taxes and escheat taxes, which is another term for unclaimed property taxes. "It's important to not fall into the trap of allocating all of your attention and resources to the federal income tax return, although that's a large component," Ms. Coakley says. "State auditors have become increasingly aggressive as they look to close state budget shortfalls."

6. Stay on top of IRS guidance. Both non-profit and for-profit healthcare providers stand to gain a lot by staying "in the know" with IRS — as well as state and local — tax law developments. The IRS website provides updates to the federal tax code and offers official tax guidance.

Ms. Coakley says there are a number of important recent tax developments that affect taxable healthcare providers. For example, this past fall, the IRS introduced a new safe harbor for the nonaccrual-experience method of accounting, which is a special way for taxable entities to determine when certain income related to healthcare services must be recognized. The less-

son? There will always be complicated rules to the tax code, and doing the research pays off in the long haul. "The rules for the nonaccrual experience method of accounting are very complex, and the previously provided safe harbors are also very complex," Ms. Coakley says. "It's important that for-profit healthcare providers work with their tax advisors to determine how these rules are going to apply to them."

7. Acknowledge that taxes are a year-round endeavor. For the normal taxpaying American citizen, the nuts and bolts of returns are really only considered at the beginning of the year, when tax returns need to be filed. For hospitals and other large organizations, taxes need to be a year-round concern because the organization's bottom line is at stake. "Any CFO should know that taxes are an integral part of the economics of their business," Ms. Coakley says. "Tax implications and planning opportunities should be considered at the forefront of any business undertaking. Taxes shouldn't be something that only comes to mind when it's tax return filing season."

Ms. Coakley adds hospitals that are adroit in their tax planning are actually putting the organization in a better position for future success. "Tax efficiency can contribute to the bottom line," she says. "Because of the prevalence of tax credits, tax incentives, tax exemptions and other opportunities, attentive tax planning can actually create significant value for an organization." ■

7 Ways Hospitals Can Trim Their Labor and Operational Costs

By Bob Hermann

When it comes to a hospital's finances, most CFOs are awaiting decisions on just how much Medicare or Medicaid reimbursements will be cut. While cuts to those government-sponsored programs are out of the hospital's control, there are ways a hospital can make its ledger trimmer from its own cost-saving initiatives.

Mark Bogen, vice president of finance at South Nassau Communities Hospital in Oceanside, N.Y., says there are numerous areas where a hospital can manage and reduce its costs without thinking about Medicare or Medicaid, and he shares seven ways hospitals can save money within two of the most prominent areas: the labor force and the backend operations.

1. Monitor overtime pay. Mr. Bogen says a hospital's labor force is the single largest item that impacts the hospital's budget. At South Nassau, the payroll is \$180 million per year, which is more than 50 percent of its total operating budget. Even if the payroll is off by one tenth of one percent, it would still lead to \$180,000 in wasted money, he says. One way to keep the payroll in check is by monitoring overtime pay. Hospitals are working at all hours of the day, but over-scheduling staff members can lead to higher-than-desired overtime wages and empty work hours. "What you find in most hospitals is that it's easier to staff up when volume goes up than it is to staff down when volume goes down," Mr. Bogen says. "Staffing is certainly an

area that needs to be managed, especially in light of the fact most hospitals today have static or reduced inpatient admissions."

2. Review on-call and all formal pay policies. Hospitals naturally have to have all clinicians on-call. If on-call pay policies have not been reviewed in a while, though, a hospital may want to assess and adjust them to reflect the hospital's current needs. "One of our departments had an on-call policy where if you have to call someone in, as long as they work a minimum of an hour, they got paid for four hours of time," Mr. Bogen says. "It's really important to review not only what the formal pay rules are, but also why the particular pay rules were established years ago."

3. Find the right mix of staff members. Layoffs have been rampant throughout the hospital industry, as there were 13 mass layoffs in August alone. However, hospitals do not have to lay employees off to save the labor budget, Mr. Bogen says. Having more per diem and part-time employees could keep employment figures steady, but it would guard against both staff shortages and superfluous overtime pay.

4. Renegotiate inbound shipping rates. Mr. Bogen says South Nassau's inbound shipping costs averaged around \$500,000 per year, with \$300,000 of that related to deliveries for operating room supplies. Hospitals should work with their materials management team to



find different vendors and suppliers to lower shipping rates. South Nassau was able to save \$75,000 by leveraging its buying power. "The problem is [shipping] doesn't get separately coded, and it gets buried in hospitals' general ledger, so you don't have a good idea of how much you're spending on in- and outbound delivery," Mr. Bogen says. "But you need to take advantage of those situations where vendors are having difficulties closing sales. If they ain't crying, we ain't buying."

5. Reduce overnight shipping in the OR. ORs are unique parts of the hospital that require very specific supplies and par levels, but that doesn't mean its inventory process should get out of hand, Mr. Bogen says. Reducing over-

night charges on shipping is one way hospitals can minimize costs, but this is a point that has to be talked over with surgeons, nurses and all other OR staff.

6. Try to standardize supplies. Physicians, nurses and other clinicians all prefer certain supplies and products over others, but standardizing certain supplies to reduce costs can make the inventory process much simpler

and cheaper, Mr. Bogen says. "Try to make things standardized, maybe things that a particular nursing unit prefers, for example, unless there's some big clinical rationale to go outside that standardization," he says.

7. Train the revenue cycle team to be "pit bulls" with managed care contracts. Backend collections are critical for any hospital, and Mr. Bogen says having a persis-

tent team that understands what needs to be collected — and who is responsible for payment — will lead to less bad debt and more accountability. This is especially important for managed care contracts, which he says can be very convoluted. "Have your revenue cycle team be pit bulls who won't let something go until it's adjudicated in a fair and timely manner," Mr. Bogen says. ■

The War Over ICD-10

By Bob Herman

This past November, the American Medical Association and its House of Delegates voted to "work vigorously to stop implementation of ICD-10." This was, in a way, one of the biggest shots in the battle over ICD-10 — a battle that has raged on for more than a decade. Now, almost exactly three months later into the wintery months of 2012, the Department of Health and Human Services has bowed, announcing it will delay the Oct. 1, 2013, compliance date for certain healthcare entities.

HHS Secretary Kathleen Sebelius said HHS and CMS would go through a formal rulemaking process to re-establish a timeline for the implementation of ICD-10, although no new compliance dates have been provided as of February.

However, this war over ICD-10 does not rest on ICD-10 alone. ICD-10's prerequisite, Version 5010 electronic transaction standards, has also been a factor.

One day after the AMA declared in November it would do everything in its power to stop ICD-10, CMS' Office of E-Health Standards and Services announced it would not initiate enforcement of Version 5010 for HIPAA-covered entities until March 31, 2012 — a delay of 90 days from the Jan. 1, 2012, target. The Medical Group Management Association-American College of Medical Practice Executives also recently said the current problems with the transition to Version 5010 could force physicians to close their practices and should be further delayed to June 30.

In January and February, AMA took their efforts one step further. They sent letters to House Speaker John Boehner and Sec. Sebelius urging the ICD-10 initiative be halted. The AMA has argued the costs of ICD-10 will be onerous and crippling to physician practices, estimating it could cost physician practices from \$83,290 to more than \$2.7 million depending on the size of the practice. The AMA has not indicated a date of when ICD-10 should be mandated, but rather suggested HHS should call "on appropriate stakeholders, including physicians, hospitals and payors, to assess an appropriate replacement for ICD-9 within a reasonable timeframe," according to AMA CEO James Madara, MD.

However, not all healthcare groups have opposed the ICD-10 transition. The American Health Information Management Association, one of the main advocacy groups for HIM and the advancement of health information standards, urged the healthcare community to "keep moving on the ICD-10 transition" because a wait-and-see approach will force providers to inevitably miss the compliance date. The College of Healthcare Information Management Executives also wrote a letter to Sec. Sebelius, whose mailbox is seemingly overflowing these days. CHIME urged that HHS "move quickly and decisively in setting a new compliance date" and to keep physicians and hospitals on the same compliance date.

The American Hospital Association's Central Office also believes the transition to ICD-10 will be ultimately beneficial and will "allow for precise diagnosis and procedure codes, resulting in the improved capture of healthcare information and more accurate reimbursement." Although AHA said

it recognizes there are several overlapping health IT initiatives, its members still support the adoption of ICD-10.

Paul Spencer, compliance officer for Fi-Med Management, says when he first became a certified coder in 1998, he was told ICD-10 would probably be coming in two years. Now, due to the temporary delay of ICD-10, that time will be coming more than 15 years after his certification. "The reason it was delayed was related to lobbying dollars to make sure it never saw the light of day," Mr. Spencer says. "Throwing lobbying dollars is not going to change this reality."

This newest postponement of ICD-10 is the second such delay. Previously, ICD-10 was supposed to go live on Oct. 1, 2011, but after earlier resistance, HHS pushed back ICD-10 to the Oct. 1, 2013, "go-live" date. This recent delay also flies in the face of HHS and CMS, which repeatedly said there would be no more delays and no grace period.

Although the AMA and other healthcare providers have won in the most recent ICD-10 battle, there are several hospitals and physician practices that have heavily invested millions of dollars into the system. While those groups are still well on track to be compliant with ICD-10, groups who lag behind will have some breathing room. But in the end, healthcare providers will all eventually have to convert to ICD-10, regardless of this most recent delay. The most important question left for hospitals and others is this: How will ICD-10 ultimately affect my productivity and bottom line, and is it worth waiting any longer? ■

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Faster, Better, Stronger: Reinforcing Ties Between Hospitalists and Emergency Medicine

By Molly Gamble

As the hospital industry continues to push collaborative care to the forefront of the agenda, hospitals may be underestimating two critical providers in these conversations: emergency department and hospital medicine providers. “I don’t think people have really looked at the role of emergency medicine and hospital medicine in care transitions as much as they should,” says Jasen Gundersen, MD, CMO of TeamHealth Hospital Medicine, based in Knoxville, Tenn. “We’re working very hard as an organization to change that.”

TeamHealth specializes in the management of both emergency medicine and hospital medicine programs, a dual-focus that helps repair barriers between the care settings and ensures more seamless transitions between the two. “We are dealing with a patient across a continuum of care, not an episode,” says Oliver Rogers, president of Hospital Based Services at TeamHealth. “To be successful, we need to streamline the entire process and create a sense of urgency in every team member who interacts with the patient.”

When problems abound

As with any two specialties, providers in emergency medicine and hospital medicine providers have a few nuances in their workflows and perspective. For instance, emergency physicians are likely to exert sharper focus on patients’ immediate needs to ensure they are stable and comfortable. Emergency physicians are also accustomed to operating on working diagnoses as test results come back and the patient continues to undergo assessments.

In the inpatient setting, hospital medicine providers tend to think more in the long-term. They may focus more intensely on diagnoses and consequences of patient admissions. Detailed and specific patient data helps HM physicians determine the severity and volume of the care that will need to be delivered when the patient is admitted under their supervision.

These subtle differences in priorities and concentration may lead to communication breakdowns that carry operational repercussions. For instance, HM physicians might ask the ED to order a certain type of imaging test. Though the ED will order the scan, it can later become ambiguous as to who will follow up on the results. This causes delays in care delivery that can eventually harm patient satisfaction, hospital finance and patient safety.

“The ED and hospital medicine department usually have a good relationship,” says Dr. Gundersen. “When things break down, it’s often due to a lack of communication. This relationship is really a trio — it’s the ED, HM and the hospital itself.” Operational issues within the system — such as problems with testing services, the availability of equipment or poor throughput — can trigger communication glitches between the two providers and affect numerous other aspects of hospital operations and business.

The repercussions of poor communication

Beginning in October 2013, hospital readmissions can pose a significant threat to hospitals’ reimbursement. Under the Patient Protection and Affordable Care Act, Medicare will penalize hospitals if heart attack, heart failure or pneumonia patients return frequently. High readmission rates could cost hospitals up to 3 percent of their regular Medicare reimbursement by 2014.

To avoid these potential setbacks, hospitals are implementing a range of strategies to strengthen patient handoffs and other transitions. One of the most proactive strategies is to tighten communication, hand-offs and collaboration between emergency physicians and hospitalists.

In a study¹ published in the *Annals of Emergency Medicine*, researchers analyzed the communication patterns of emergency physicians and hospitalists during patient handoffs. Researchers

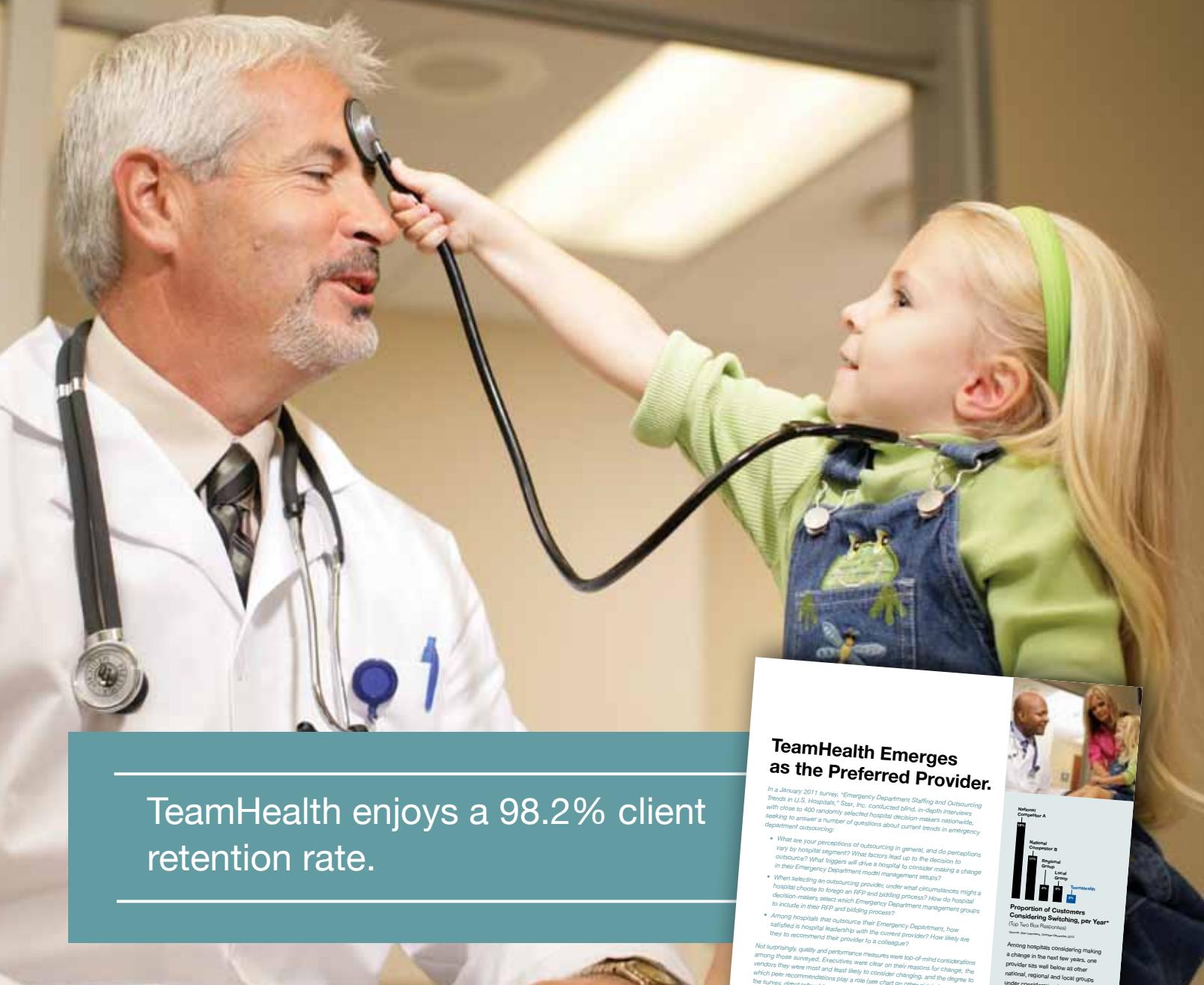
8 Common Communication Failures in Patient Transfers

The most commonly cited communication failures in emergency departments and internal medicine patient transfers include¹:

- Inaccurate or incomplete information, especially of vital signs
- Cultural and professional conflicts
- Crowding
- High workload
- Difficult in accessing key information, such as vital signs, pending data, ED notes, ED orders and the identity of the responsible physician
- Non-linear patient flow
- ED boarding
- Ambiguous responsibility for patient sign-out or follow-up

¹“Dropping the Baton: A Qualitative Analysis of Failures During the Transition From Emergency Department to Inpatient Care,” published in the *Annals of Emergency Medicine*, Volume 53, Issue 6, Pages 711-712, June 2009.

found emergency physicians talked more than hospitalists during the handoffs. Discussions often centered on the patient’s presentation, the professional environment and the patient’s assessment. The interaction between emergency physicians and hospitalists did not qualify as a question-and-answer dialogue by most means, as the form of the conversation was prevalently information-giving with very few questions asked.



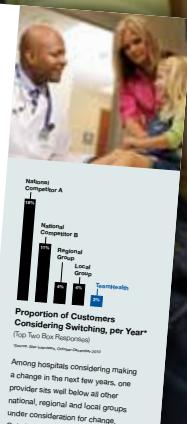
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In a January 2011 survey, "Emergency Department Staffing and Outsourcing Trends in U.S. Hospitals," Dax, Inc. conducted blind, in-depth interviews with close to 400 randomly selected hospital decision-makers nationwide, seeking to answer a number of questions about current trends in emergency department outsourcing:

- What are your perceptions of outsourcing in general, and do perceptions vary by hospital segment? What factors lead up to the decision to outsource? What triggers will drive a hospital to consider making a change in their Emergency Department model management teams?
- When selecting an outsourcing provider, under what circumstances might a hospital choose to forego an RFP and bidding process? How do hospital decision-makers select which Emergency Department management groups to include in their RFP and bidding process?
- Among hospitals that outsource their Emergency Department, how satisfied is hospital leadership with the current provider? How likely are they to recommend their provider to a colleague?

Not surprisingly, quality and performance measures were top-of-mind considerations among those surveyed. Executives were clear on their reasons for change; the vendors they were most and least likely to consider changing, and the degree to which peer recommendations play a role (see chart on other side). According to the survey, direct referral from another hospital is the most frequent reason why hospitals consider switching providers.



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*Based on a 2011 independent national survey of hospital executives.

Such imbalance in conversation may not be very noticeable to practicing providers, but it can create problems down the line and fragment care. "Nothing is more concerning to a patient than having an emergency physician tell you one thing and having a hospitalist tell you something different," says Dr. Gundersen. "Having those groups work closely together and manage those communication issues is important, otherwise it can hurt readmissions."

Another study² published in the *Annals of Emergency Medicine* examined handoff communication problems in more detail and found how dangerous breakdowns in ED and HM communication can become. In the study, 40 of 264 provider respondents reported that a patient of theirs had experienced an adverse event or near miss after an ED to inpatient transfer.

Reported incidents included errors in diagnosis, treatment or disposition resulting from communication issues between the providers, such as inaccurate or incomplete information, cultural and professional conflicts, crowding and high workload. Difficult access to patient information, boarding in the ED, confusion over responsibility for sign-out or follow-up and non-linear patient flow were also cited as factors. It doesn't take a full-on hospital crisis or grave error to put a patient's safety at risk — many of these cited incidents, such as high workload, are ordinary circumstances for physicians.

Best practices to reduce siloed mentalities

The following best practices can help hospitals strengthen the relationships and collaborative spirit between their emergency medicine and hospital medicine programs.

- Go to great lengths to build rapport between providers — even outside of the hospital.**

Sometimes it's simply a matter of understanding other providers' perspectives and personalities. By encouraging regular and casual communication through joint meetings, social outings, newsletters and email blasts, hospitals can strengthen a team spirit between emergency medicine and hospital medicine departments. "The more emergency medicine understands how

the hospital medicine department works, and vice versa, the better those two systems will interact," says Dr. Gundersen.

Further, joint metrics and incentives foster common goals between the emergency medicine and hospital medicine departments. The departments can work to overcome operational or communication hurdles that prevent them from reaching their shared performance goal. Once that metric or goal has been met, Mr. Rogers recommends hospitals jointly celebrate and reward the departments' success as a team. These shared incentives can reinforce a culture of cooperation, collaboration and engagement in both the ED and HM departments.

- Implement daily interdisciplinary rounds.** "A good hospital medicine program has daily interdisciplinary rounds as a cornerstone of their operating model," says Mr. Rogers. "Expand the group to include ED providers and nursing staff on occasion. This will educate them about downstream problems their actions might create." If problems are identified, EM and HM leaders can meet to develop improvement action plans.

Rounds are one strategy to help avoid problems linked to hospital flow. Wait times and boarding are especially crucial to ED operations given the links between wait time, patient satisfaction and hospital finances. "It's really important that we focus on communication," says Dr. Gundersen. "That way, people will have a more seamless experience. They won't come into the ED as patients and face long wait times or providers resisting one another from different departments."

- Emphasize shared decision-making.** Under TeamHealth's management model, EM and HM leaders develop and standardize order sets for patient transfers.

These shared expectations among ED and HM physicians help expedite patient care and also increase cost-efficiency by coordinating orders and tests. "In today's envi-

3 Things to Know About ED-to-Hospital Handoffs

- Emergency physicians talk more during handoffs. Emergency physicians are responsible for 68 percent of the dialogue, whereas hospitalists speak 32 percent of utterances.
- Most conversation content focuses on patient presentation (43 percent), professional environment (36 percent) and assessment (20 percent).
- More than 90 percent of the dialogue consists of information-giving, including descriptions, explanations and rationale. Questions account for less than 10 percent of all handoff conversations.

Source: "Exploring Emergency Physician–Hospitalist Handoff Interactions: Development of the Handoff Communication Assessment," published in the *Annals of Emergency Medicine*, Volume 55, Issue 2, Pages 161-170. February 2010.

ronment, observation and clinical decision units are a must-have," says Mr. Rogers. "These can either further evaluate new conditions or manage acute episodes of chronic disease that can be effectively stabilized in short-stay environments. These units involve both hospital medicine and ED providers in the development of protocols and management." ■

Footnotes:

1 Exploring Emergency Physician–Hospitalist Handoff Interactions: Development of the Handoff Communication Assessment. Julie Apker, Larry A. Mallak, E. Brooks Applegate, Scott C. Gibson, Jason J. Ham, Neil A. Johnson, Richard L. Street. *Annals of Emergency Medicine*, Feb. 2010 (Vol. 55, Issue 2, Pages 161-170).

2 Dropping the Baton: A Qualitative Analysis of Failures During the Transition From Emergency Department to Inpatient Care. Leora I. Horwitz, Thom Meredith, Jeremiah D. Schuur, Nidhi R. Shah, Raghavendra G. Kulkarni, Grace Y. Jenq. *Annals of Emergency Medicine*, June 2009 (Vol. 53, Issue 6, Pages 701-710).



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11 Evolving Issues in Healthcare and Business

By Scott Becker, JD, CPA, Drew McCormick, JD, Allison Harms, JD, and Samuel Bernstein, JD, McGuireWoods

This article briefly discusses eleven different healthcare and business issues. We have divided the article into three key sections. The first focuses on hospital and physician issues. Second, a brief observation on urgent care and sleep labs. Third, a brief discussion of key business issues, focusing largely on a new book by Jim Collins.

I. ACOs, Hospitals, Physicians and Physician-Hospital Relationships

1. Pioneer ACOs. The Pioneer ACO Model is a CMS Innovation Center initiative designed to support organizations with experience operating as accountable care organizations or in similar arrangements. The Pioneer ACO model will test the impact of different payment arrangements in helping these organizations achieve quality and cost goals. After a weak start, 32 provider organizations ultimately enlisted in the Pioneer ACO Project. Many of the ACO participants are very prestigious systems, such as Allina Hospitals and Clinics, Beth Israel Deaconess Physician, and the University of Michigan Health System.

The U.S. Department of Health and Human Services made a wise decision by making the process of testing the ACO model more manageable for health systems. An article entitled "Pioneer ACOs: Promise and Potential Pitfalls," posted by Steven Lieberman on Dec. 29, 2011, in *Health Affairs Blog* states:

"The 32 Pioneer ACOs selected by CMS will operate in 18 states for up to 5-year periods. Hospitals are key players in 22 (69 percent) of the Pioneer ACOs, with 16 integrated delivery (or healthcare) systems, 4 hospitals-physician partnerships, and 2 individual practice associations (IPAs) named for hospitals where the physicians have affiliations (or employment). The remaining 10 Pioneer ACOs (31 percent) are predominately IPAs, with one identified as an alliance of 5 multi-specialty medical groups. (The Leavitt Partners survey reported hospitals sponsored 99 (60 percent) of ACOs, with 38 (24 percent) sponsored by IPAs, and 27 (16 percent) sponsored by insurers, a category not relevant for Medicare ACOs.) In addition to urban entities, the selected Pioneer sites include ACOs that serve rural areas."

Time will tell whether the ACO will endure as a significant part of the healthcare landscape.

2. Exclusive relationships between hospitals and payors.

Recently, hospitals and health systems with great market positions are looking again at exclusive relationships with payors. This again threatens to become a substantial issue for independent surgery centers, physician practices and competing hospitals. One of the earliest exclusive agreements was struck between Boston-based PartnersHealthcare and Blue Cross Blue Shield of Massachusetts in 2000. BCBS gave Partners increased reimbursements in exchange for Partners' promise to seek similar pay increases from Blue Cross competitors. Since 2000, Partners has received a 75 percent increase in payments from Blue Cross, but health insurance premiums have also risen by 78 percent since that agreement. There is some evidence that the government is monitoring the anticompetitive effects of such behavior. For instance, in February 2011, the Department of Justice took an aggressive stance against a health system under Section 2 of the Sherman Antitrust Act in *United States v. United Regional Health Care System* (No. 7:11-cv-00030-O (N.D. Tex., Feb. 25, 2011)). In *United Regional Health Care System*, the DOJ alleged that United Regional Health Care System possessed monopoly power in the sale of both inpatient hospital services and outpatient surgical services to commercial health insurers.

3. Community hospital sales and consolidation.

Given the changing healthcare environment, we are seeing frightened looks on the faces of the boards of community hospitals. This has led to an unprecedented willingness to engage in potential sales of hospitals to national chains or larger systems. On the flip side, buyers may often obtain substantial market benefits from consolidation (see, e.g., "Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About," *Forbes*, by Avik Roy, Aug. 22, 2011; "Hospital Merger Mania on the Rise Across the U.S.," *Next Hospital*, by Katherine Rourke, April 30, 2011). The occurrence of hospital mergers and acquisitions increased by 33 percent in 2010 compared with 2009. The dollar volume of transactions also increased substantially in 2011.

4. Physician independence.

Notwithstanding the talk of physician practice acquisitions and physician integration with hospitals, we are hearing from several large independent physician practice groups that they have remained very busy despite the fact that systems they once worked with are acquiring competing practices. In orthopedics, for example, it is com-

monly discussed that almost 12.5 percent of the healthcare budget is spent on orthopedics in total. This means that many systems must have a large orthopedic presence and compete aggressively to employ orthopedic surgeons. Despite the hospital pressure to accept employment, the independent orthopedists seem to be weathering the changes fairly well.

A 2011 survey conducted by PricewaterhouseCoopers found 56 percent of physicians want to more closely align with a hospital in order to increase their income, yet 20 percent of physicians surveyed said they don't trust hospitals and another 57 percent "sometimes" trust hospitals.

5. Professional services agreement.

Once again, a number of systems have been considering professional services agreements with physicians and physician groups. Such arrangements are a middle ground between the acquisition of a physician practice and subsequent employment of its physicians, and other kinds of relationships between health systems and physicians. As such, professional services agreements are growing in popularity as an option for increasing integration with a number of specialties, while enabling the physicians to maintain private practice. In the article, "When PSAs Are the Right Choice," (*Health Leader Media*, July 13, 2010) author Karen Minich-Pourshadi writes:

"Physician compensation expert Max Reiboldt, president and CEO for The Coker Group, an Alpharetta, GA-based healthcare management consulting firm, refers to these PSA arrangements as 'employment lite'—and he says they can offer a good opportunity for both hospitals and physicians. Unlike traditional service agreements, in which a person is hired for a specific function or for limited service, PSAs allow the facility to work with the doctors, allowing them to keep their independence while the hospital can build in quality measures to help create greater alignment for the physician with the hospital's goal."

"A PSA takes the shape and look of employment, but the physician or practice retains its independence, and if the deal doesn't go well, then the doctor can go back to private practice," he says.

In a professional services agreement model, a health system will typically purchase a substantial amount overall of a physician's time but will not acquire the physician's practice. We will see whether or not this becomes a sizable part of the physician-hospital universe or, whether in-

stead the popularity of the professional services agreement model is merely a stop gap measure for certain systems. The challenge with the physician services agreement model is that it is much more difficult to fit payments to physicians within various Antikickback safe harbors and antitrust safety zones than in the practice acquisition and subsequent employment model.

6. Opting out of Medicare. Notwithstanding the difficult economy, we are hearing from more and more physicians that they have decided to opt out of Medicare. This is occurring more frequently in certain specialties in which physicians are not overly reliant on Medicare business or hospital referrals. For instance, of the 93 internists affiliated with NewYork-Presbyterian Hospital, only 37 accept Medicare, according to the hospital's website. Further, we typically see the decision to opt out of Medicare with physicians who have built tremendous brands and franchises and who can afford to not take Medicare patients. Interestingly, despite opting out of Medicare, many of these physicians nevertheless continue to see Medicare patients on either a pro bono basis or through other means (see, for example, "Doctors are Opting Out of Medicare," by *New York Times*, by Julie Connally, April 1, 2009).

7. Privileges and disputes. We have observed an increase in the number of privilege and peer review disputes involving physicians and hospitals. We are not exactly sure what is driving increased clinical reviews. However, an article was published in 2011 on the concept that the Health Care Quality Improvement Act has resulted in abuses of the peer review system through the courts. The article, entitled "How Courts are Pro-

tecting Unjustified Peer Review Actions Against Physicians by Hospitals," (*The Journal of American Physicians and Surgeons*, by Nicholas Kadar, Volume 16, Number 1, Spring 2011) states:

"Nevertheless, the courts have disregarded the legislative history of HCQIA in the [House Committee on the Judiciary], and have interpreted and applied HCQIA in a way that protects unjustified peer review actions against physicians by hospitals against Congress's expressly stated contrary intent."

As a result, according to Kadar, the courts improperly review motions for summary judgment based on HCQIA immunity and improperly dismiss cases on summary judgment before a physician has an opportunity to present the merits of his or her case.

II. Urgent Care and Sleep Labs.

1. Urgent care. The number of urgent care sites is growing tremendously. For instance, the number of facilities has now grown to 9,200, including approximately 600 new facilities this year. The development in the urgent care arena includes traditional urgent care clinics as well as clinics inside retailers such as Wal-Mart, Walgreens and CVS. The growth in urgent care sites has occurred in response to a direct consumer desire to be able to see physicians at the consumer's convenience (see, e.g., "Health Law May Accelerate Growth in Urgent Care Centers," *Kaiser Health News*, by Phil Galewitz, Dec. 7, 2011). Interestingly enough, in response to the increase in urgent care, many large practices and systems have substantially improved their own customer care and their speed at which they are able to see patients.

2. Sleep labs. We continue to see the evolution of sleep labs and sleep lab relationships. Various structures for sleep labs include independent diagnostic testing facilities, extensions of a physician's practice, hospital-based sleep labs, hospital-owned freestanding sleep labs and joint ventures, to name a few. We often query the method by which sleep labs are structured. As of late 2010, there were about 2,100 accredited sleep labs with an approximate growth of 10 percent per year.

III. Great Business Issues.

1. Great leaders. We continue to be cognizant of the import of great (and poor) leadership on organizations. In health systems as well as in great companies and charitable foundations, there seems to be nothing more important than strong leadership that is truly concerned about the organization (see, e.g., "4 Great CEOs and 1 Who Missed the Boat," *Motley Fool*, by Molly McCluskey, Nov. 11, 2011).

In the article, "The Best Performing CEOs in the World," (*Harvard Business Review*, January 2010) authors by Morten T. Hansen, Herminia Ibarra and Urs Peyer write: "Our data highlights the great extent to which CEOs account for variations in company performance beyond those due to industry, country and economic swings."

As we read articles about the overpayment or compensation to leadership we come away with the conclusion that it is not so much that great leaders are overpaid, it is rather all the other CEOs are not worth what they are paid. In essence, it is hard to place a value on a great CEO but many organizations that do not have great CEOs have been paying as though they do.

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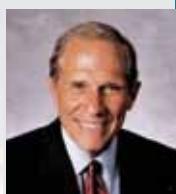
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2. Great Business Book — “Great by Choice.” In reading the most recent book by Jim Collins, “Great by Choice,” we continue to believe that he has more clarity on what it takes to be a great organization than almost anybody else. His core philosophy is the concept that putting great people in place (i.e., the “who” issue) remains the most important issue in creating successful organizations. We agree strongly with this sentiment. Collins also has several other insightful concepts in the book. For example, he speaks of testing concepts (bullets vs. cannonballs), consistent discipline and a core set of business concepts or a blueprint to guide the organization.

On testing, Collins states:

“Amgen’s early days illustrate a key pattern we observed in this study: fire bullets, then fire cannonballs. First, you fire bullets to figure out what’ll work. Then once you have empirical confidence based on the bullets, you concentrate your resources and fire a cannonball. After the cannonball hits, you keep 20 Mile Marching to make the most of your big success.”

On people, he notes:

“Microsoft used extreme standards to select the right people for Microsoft, with Gates summing up in 1992, ‘Take away our 20 best people and I tell you that Microsoft would become an unimportant

company.’ Biomet paid fastidious attention to getting the right people in every seat, using stock options at all levels to attract and retain the best talent. All the 10X companies cultivate cult-like cultures wherein the right people would flourish and equally, where the wrong people would quickly self-eject. The 10X study is predicated on the premise of unending uncertainty, which increases the importance of First Who; if you cannot predict what’s going to happen, you need people on the bus who can respond and adapt successfully to whatever unforeseen events might hit.”

Finally, on the concept of constant performance he spoke of the consistent achievement of goals rather than sporadic phenomenal growth:

“John Brown understood that if you want to achieve consistent performance, you need both parts of a 20 Mile March: a lower bound and an upper bound, a hurdle that you jump over and a ceiling that you will not rise above, the ambition to achieve and the self-control to hold back. The 20 Mile March is more than a philosophy. It’s about having concrete, clear, intelligence, and rigorously pursued performance mechanisms that keep you on track. The 20 Mile March creates two types of self-imposed discomfort: (1) the discomfort of unwavering commitment to high performance in difficult conditions, and (2) the discomfort of holding back in good conditions.” ■

Hospital & Health System Transactions

Ashland (Ore.) Community Hospital considered proposals from five health systems to partner or form an alliance.

Auburn (N.Y.) Memorial Hospital announced a potential affiliation with **Rochester (N.Y.) General Health System**.

Community Health Systems, in Franklin, Tenn., and its subsidiaries signed a definitive agreement to acquire **Memorial Health Systems**, in York, Pa.

Community Health Systems, based in Franklin, Tenn., announced the formation of a regional healthcare system, **Commonwealth Health**.

Geisinger Health System of Danville, Pa., acquired **Community Medical Center** in Scranton, Pa., and its affiliates.

Hartford (Conn.) HealthCare, Hartford Hospital’s regional care network, announced a potential affiliation with **Backus Corp.**, parent company of **Backus Healthcare System**, based in Norwich, Conn.

Huntsville (Ala.) Hospital announced plans to purchase 150-bed **Hartselle (Ala.) Medical Center**.

Nashville, Tenn.-based **Hospital Corporation of America** acquired **Galichia Heart Hospital** in Wichita, Kan.

Howard Regional Health System in Kokomo, Ind., and **Community Health Network**, based in Indianapolis, announced a formal affiliation.

Integris Health in Oklahoma City executed a definitive agreement with **Health Management Associates** in Naples, Fla., to enter a joint venture with five Oklahoma hospitals.

Jersey City (N.J.) Medical Center collaborated with **Community Healthcare Associates** in Bloomfield, N.J., to offer a \$104 million bid on **Christ Hospital** in Jersey City, N.J.

Johnson Memorial Medical Center in Stafford Springs, Conn., and **St. Francis Hospital** in Hartford, Conn., finalized an affiliation agreement.

Lovelace Health System, based in Albuquerque, N.M., completed its purchase of the assets and operations of **Roswell (N.M.) Regional Hospital** and its **Family Care Clinic** in Roswell.

McKenzie County Healthcare Systems of Watford City, N.D., affiliated with **St. Alexius Medical Center** in Bismarck, N.D.

Louisville, Ky.-based **Merit Health Systems** finalized the sale of its **Nix Health Care System**, based in San Antonio, to **Prospect Medical Holdings** in Los Angeles.

Peoria, Ill.-based **OSF Healthcare System** signed a definitive agreement to acquire Ottawa (Ill.) **Regional Hospital & Healthcare Center**.

Poudre Valley Health System in Fort Collins, Colo., and **University of Colorado Hospital** in Aurora, completed a joint operating agreement, creating **University of Colorado Health**.

Ontario, Calif.-based **Prime Healthcare** withdrew its offer to purchase **Christ Hospital** in Jersey City, N.J.

Providence Health & Services, based in Renton, Wash., and Seattle-based **Swedish Health Services** finalized their affiliation.

Sanford Health, based in Fargo, N.D. and Sioux Falls, S.D., signed a definitive agreement to purchase **Clearwater Health Services** in Bagley, Minn.

Skaggs Regional Medical Center in Branson, Mo., announced plans to seek a strategic partner.

Sparrow Health System in Lansing, Mich., and **Hayes Green Beach Memorial Hospital** in Charlotte, Mich., are working to develop a non-exclusive affiliation.

St. Joseph Medical Center in Towson, Md., narrowed its search for a strategic partner to three candidates.

St. Luke’s Hospital and Health Network, based in Bethlehem, Pa., and **Warren Hospital** in Phillipsburg, N.J., officially merged.

Twin County Regional Healthcare in Galax, Va., announced a definitive agreement with **Duke LifePoint Healthcare** of Brentwood, Tenn., for joint ownership of the hospital.

Pittsburgh-based **West Penn Allegheny Health System** announced it expects approval of its affiliation with **Highmark**, also based in Pittsburgh, by fall.

Hospital & Health System Executive Moves

Ascension Health of St. Louis, Mo., named **Charles Barnett** as president of healthcare operations and COO.

Mission Health in Asheville, N.C., named **Lynn Boggs** president and CEO of The McDowell Hospital in Marion, N.C.

Morgan Memorial Hospital in Madison, Ga., named **Ralph Castillo** CEO.

Brian Cook was appointed CEO of Capital Regional Medical Center in Tallahassee, Fla.

Pauls Valley (Okla.) General Hospital named **Bridgette Cosby** CEO.

Wake Forest Baptist Medical Center in Winston-Salem, N.C., accepted **Doug Edgeton's**, MBA, MPH, resignation as COO and executive vice president.

Roger Forgey was named the new president and CEO of Erlanger at Hutcheson Medical Center in Ft. Oglethorpe, Ga.

Alyson Giles, president and CEO of Catholic Medical Center in Manchester, N.H., stepped down, and Joseph Pepe was named interim CEO.

UHC, an alliance of non-profit medical centers based in Chicago, appointed **Scott Glasrud** as executive vice president and CEO.

St. Luke's Health System in Sioux City, Iowa, promoted **Jim Gobell** to CFO.

Brandon (Fla.) Regional Medical Center appointed **Bland Eng** CEO.

Intermountain Healthcare, based in Salt Lake City, appointed **Laura Kaiser** as executive vice president and CEO.

Adrienne Kirby joined Cooper University Health in Camden, N.J., as COO.

Max Long, CEO of Walter Knox Memorial Hospital in Emmett, Idaho, announced his impending retirement.

Sherry Perkins, PhD, RN, was promoted to the position of COO of Anne Arundel Medical Center in Annapolis, Md.

Stormont-Vail Healthcare in Topeka, Kan., appointed **Randall Peterson** as the system's president and CEO.

Indiana University Health Morgan Hospital in Martinsville, Ind., appointed **Doug Puckett** CEO.

Porter Health System, based in Valparaiso, Ind., appointed **Brian Sinotte** COO.

Hawaii Pacific Health in Honolulu appointed **Raymond Vara** president.

Stanford Hospital & Clinics in Palo Alto, Calif., named **Margaret Vosburgh** COO.

Cambridge (Mass.) Health Alliance named **Patrick Wardell** its new CEO.

UT Southwestern Medical Center in Dallas announced **John Warner** as the new CEO of its hospitals.

Patricia A. Warner, executive director of University of Michigan Health's C.S. Mott Children's Hospital and Von Voigtlander Women's Hospital, announced she will retire.

Tomball (Texas) Regional Medical Center named **Bud Wethington** CEO.

The Cleveland Clinic named **Joanne Zeroske** president of Marymount Hospital in Garfield Heights, Ohio.

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