SPECIAL LISTS ISSUE: See statistics on the largest hospitals, top grossing hospitals and more. p. 14

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INSIDE

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5 Best Practices for Hospital Employment of Physicians

By Lindsey Dunn

Hospital employment of physicians has become increasingly popular in recent years and is only expected to continue. Most industry leaders predict that reimbursement will increasingly favor quality over quantity, and organizations most poised to profit under this type of system are those that are part of integrated delivery systems or other similar arrangements.

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Roles and Compensation of Physician Leaders in Hospitals Growing

By Barbara Kirchheimer

From medical directors to department chairs and vice presidents of medical affairs, physicians who have leadership roles within hospitals are being asked to do more, and their levels of compensation are rising along with those demands, say executive and physician compensation experts.

Part of this trend is driven by community hospitals and systems increasingly linking up with academic institutions, says Steve Rice, the executive vice president and practice leader of Integrated Healthcare Strategies' Physician Services practice. Healthcare reform is likely to accelerate this trend as more organizations adopt more fully integrated models such as accountable care organizations, he says.

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30 of the Most Powerful People in Healthcare

By Rachel Fields

As health reform law shapes policy and inspires heated debate, 2010 continues to be a remarkable year for healthcare. Here are 30 people who have played a major role in the healthcare industry this year.

Max Baucus (D-Mont.). Sen. Baucus is the chairman of the Senate Finance Committee and has played an influential role in the debate over healthcare reform in the United States. Mr. Baucus called the first Senate meeting of interested parties before the Senate Finance Committee to discuss healthcare reform, inviting representatives from pharmaceutical groups, insurance companies and HMOs. He has said that America is not yet ready for single payor healthcare and believes that health reform must strive for a "uniquely American solution." In response to Mr. Baucus' work on the Senate Finance Committee bill, AMA president J. James Rohack said, "The AMA applauds Chairman Baucus and his colleagues for their hard work and important contribution toward our mutual objective of comprehensive health system reform. Expanding coverage through tax credits,

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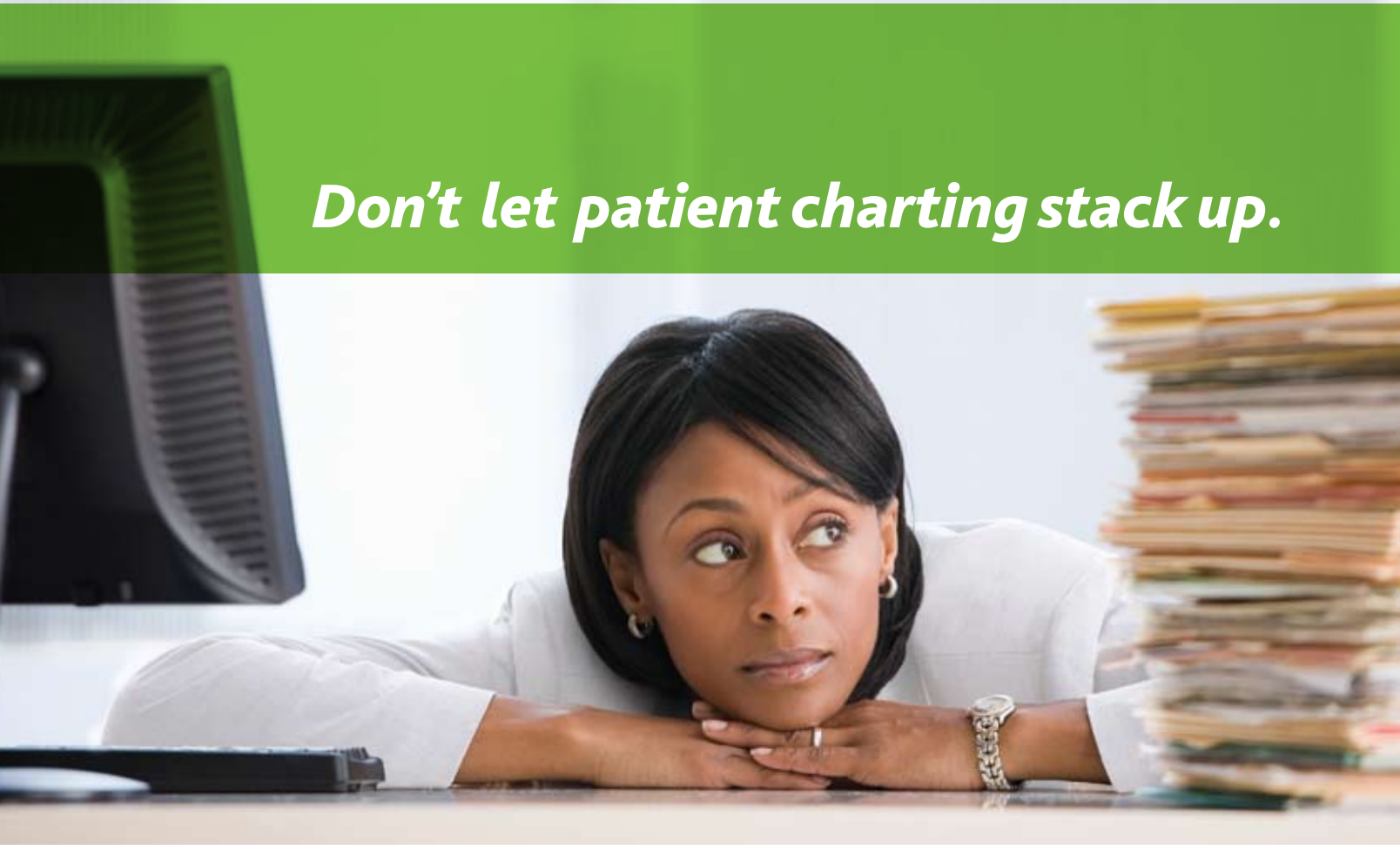

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FEATURES

Publisher's Letter

Thank you for reading the *Becker's Hospital Review*. The *Hospital Review* focuses heavily key and evolving issues for hospital CEOs and CFOs. These include areas such as accountable care organizations, healthcare reform, physician-hospital integration, financial and business issues, the most profitable areas for hospitals and anti kickback, qui tam and other laws and regulations impacting hospitals.

This issue focuses on the most interesting statistics and lists applicable to hospitals, and we continually strive to cover the most interesting people in healthcare and provide useful and teachable information.

Should you have questions about the *Becker's Hospital Review*, please contact Scott Becker at sbecker@mcguirewoods.com or Lindsey Dunn at lindsey.beckersasc@gmail.com.

Very truly yours,

Scott Becker

P.S. To sign up for the free Becker's Hospital Review E-Weekly, please email me at sbecker@mcguirewoods.com, or visit www.BeckersHospitalReview.com.

Insights From the Model for ACOs: Q&A With Harold Dash of Everett Clinic on the Medicare Physician Group Practice Demonstration Project

By Leigh Page

Harold Dash, MD, a cardiologist, is president of the Everett (Wash.) Clinic, a group practice with more than 300 physicians. Here Dr. Dash discusses Everett's participation in the Medicare Physician Group Practice Demonstration Project, the model for the accountable care organization, a new system that bundles charges for hospitals, physician and other providers.

Q: What was the goal of the Medicare Physician Group Practice Demonstration?

Harold Dash: The goal was to lower costs and improve the quality of patient care. It involved 10 large physician groups across the country serving a total of 223,203 Medicare fee-for-service patients. Some of the practices are freestanding like Everett and some are integrated into health systems. The project lasted five years, ending this spring. Participants received the usual fee-for-service payments and then were eligible for cost performance payments and quality performance payments.

Q: How were the cost performance payments calculated?

HD: Participating groups were awarded payments for savings they generated, as compared with charges of a control group in the community. To qualify for these payments, a group's savings had to exceed the target expenditure level by 2 percent. Of that amount above 2 percent, 80 percent went to the practices and Medicare retained the remaining 20 percent.

Q: How much did participants earn?

HD: All groups received payments for improved quality measures but only four groups received performance payments. Everett was one of those groups, but it only received a relatively small payment in the second year. [For cost performance in the second year, Dartmouth-Hitchcock Clinic received $6.69 million, Marshfield Clinic received $5.78 million, the University of Michigan Faculty Group Practice received $1.24 million and Everett received $129,268. Added to $127,021 it received for quality measures, Everett received a total of $256,289 in the second year. Payments for the full five years have not been calculated yet.]

Q: What prevented Everett from making more money?

HD: We are in a very low-cost area in Washington State to begin with, so it was difficult to bend the savings curve. Also, we were not coding properly for severity of illness when there were two diagnoses, such as complicated diabetes with kidney disease. But we've learned a lot in the last 1½ years.

Q: What measures did Everett take in the five-year program?

HD: A nurse coach met in person with patients before discharge to review instructions with them and make follow-up physician appointments. Primary care physicians followed up with patients within five days of hospital discharge to address unsolved or new healthcare problems. Palliative care programs were deployed in physicians' offices to improve end-of-life care for 800 patients. Primary care physician physicians received electronic patient reports on diabetes, heart disease, hypertension, as well as mammogram and colonoscopy screening results. We implemented evidence-based guidelines for ordering imaging tests.

Q: Do you see any flaws in the demonstration program?

HD: It presented a number of challenges. There was no credit for upfront infrastructure costs and it cost Everett more than $1 million to put together the program. Savings had to exceed the 2 percent threshold before groups could be paid, which meant participants did not receive a good deal of the money they saved. [In the project's second year, for example, all 10 participants saved Medicare a total of $34 million for participating beneficiaries, but CMS recognized only $17 million in savings due to the 2 percent threshold.]

There were no aligned incentives between the Everett Clinic and other providers, such as nursing homes, and we didn't know who our patients were. It was not clear which of our patients were in the program. Also, the program was very slow to provide feedback data. We didn't receive data back until a year later. It's hard to act on information when it comes that late.

Q: Is Everett planning to launch an ACO?

HD: We all would love to participate in an ACO, but it needs to be practical. I don't think any of us know exactly what an ACO is going to be. All we have so far are the bare bones of the program as stated in the healthcare reform law. We need to see the regulations. Also, there may be practical limitations not mentioned in the bill. For example, the bill says an ACO needs a minimum of 5,000 patients to run an ACO, but we believe it probably needs 10 times that amount to be financially feasible.

Q: Who is best positioned to run an ACO, a group practice or a hospital?

HD: Hospitals have different incentives than physicians. They have to fill their beds. On the other hand, hospitals are beginning to control a large number of group practices. That may change the dynamic. Also, starting an ACO is expensive and group practices generally don't have access to funds because earnings are distributed every year. Everett is an exception, however. Our goal is to put 5 percent of earnings back into the organization every year. We've achieved this for most years but it's going to be a challenge this year. ■

5 Best Practices for Hospital Employment of Physicians
(continued from page 1)

While integrated delivery systems can take many forms, employment of non-hospital based physicians is one of the more common ways hospitals and health systems are choosing to align with physician groups. Although similar efforts failed in the 1990s due to hospitals financially over committing to these acquisitions, the employment practices today are markedly different than those of 20 years ago, and many say, better positioned for success.

Hospitals employ physicians for a variety of reasons, such as growing market share through referrals or ensuring access to services in areas where physician recruitment is difficult. While the reasons behind employment differ, many of the best practices for successful hospital-owned practices are actually quite similar.

1. Maintain the culture of private practice. Successful hospital-owned practices maintain the culture of accountability that exists in independent practices.

Northwestern Memorial Physicians Group, the subsidiary physician group of Northwestern Memorial Hospital in Chicago, has been in place for more than 15 years, and now employs more than 100 physicians and other mid-level providers, most of them primary care providers. Daniel Derman, MD, president of NMPG, says that the group's success has been due largely to physician's involvement in the strategic direction of the practice, beginning from the group's onset. "I think our practice very closely mirrors private practice," he says. "We took the best of private practice and rolled it into hospital ownership."

Summa Health System in Akron, Ohio, has been employing physicians since 2005 and currently is home to more than 240 physicians in 30 specialties. Summa's vice president of clinical services, Cliff Deveny, MD, says that when employing various specialists, respecting the unique cultures of different groups is an important part of maintaining the private practice mindset. "We respect the cultures of the different groups rather than transferring them into a monolithic way of doing things," he says. "Respect the cultures of groups already in existence, or if you're starting an entirely new group, let [the culture] develop naturally." While the hospital requires some standardization of processes, such as front desk check-in, it defers to the practice's way of doing things in many other areas.

So what does maintaining the private practice culture entail? In a nutshell it means letting physicians maintain control, which may include involving them in governance and operations and allowing them to be the drivers of their compensation.

2. Involve physicians in governance. Giving physicians some control over the governance and strategic direction of the practice holds physicians accountable for the success of the practice, rather than relying on the hospital to make it successful.

NMPG has a separate board which includes three representatives from the physician practice group (its president, medical director and one other physician) and four hospital representatives, which allows the physician leaders of the practice to weigh in on the strategic direction of the group as well as its day-to-day operations. NMPG's approach to physician involvement in governance seems successful — the practice has experienced very little turnover among its physicians, and nearly 75 percent of its original management remains in place.

Kevin McCune, MD, chief medical officer and vice president of medical management at Advocate Medical Group, the 800-physician group practice of Oakbrook, Ill.-based Advocate Health Care, says that its physicians are

actively involved in the group's governing council as well as the five committees that report to the council, which oversee health outcomes, strategic planning, finance, compensation and physician engagement. "Our structure is based on the idea that we need the support of physicians, and their support is ultimately in the best interest of Advocate," he says. "It's a very collaborative process with the administrative team working with physicians."

3. Productivity-based compensation. Employed physician compensation should be based, in part, on productivity or other outcomes to ensure physicians earn their keep. Hospital should avoid providing high salaries with little accountability — a major mistake hospitals made when employing physicians in the '90s.

Most successful employed physician compensation models include a formula based on productivity. They no longer include large signing bonuses or goodwill payments, as was common in the past. "Handing someone money doesn't mean you gain their loyalty," says Dr. Deveny.

Summa provides its physicians a base salary of 85 percent of the national median for compensation based on benchmarks provided the Medical Group Management Association in return for the physician generating work relative value units (RVUs) equal to the 85th percentile of median annual RVUs for physicians in the specialty. Physicians with more RVUs earn bonuses, and those below it risk a 10 percent decrease of their base salary, among other sanctions. This method uses both a "carrot and stick" approach, meaning contracts include provisions to reward productive physicians but also include language that reduces compensation for physicians who do not meet contract obligations.

Other systems have similar arrangements. Northwestern's employed physicians use an "eat what you treat" formula, but NMPG bases compensation on true receipts rather than RVUs, says Dr. Derman. Physician contracts provide a minimum base salary in return for a minimum number of hours work, and provide bonuses for additional productivity. Northwestern requires 36 hours of direct patient contact as a minimum. Bonus programs don't have to be huge to be effective either; often as little as 10 percent of total compensation is enough to drive physicians toward desired behaviors, sources say.

While most hospital-owned practices currently only provide bonus opportunities for productivity, the next iteration of compensation packages is likely to include bonus opportunities for quality indicators, such as readmission rates, patient satisfaction and adherence to evidence-based medicine. Advocate Health Care already provides bonus opportunities for high patient satisfaction scores. Physicians who are rated in the top quartile of all physicians for patient satisfaction receive a bonus. Seventy percent of Advocate physicians score in the top quartile and one-third score in the top 5 percent. The health system also has incorporated measures for quality and efficiency into its compensation structure through its nationally recognized clinical integration program, says Dr. McCune.

4. Dedicated management team. Successful physician-owned practices often have dedicated practice managers. Dr. McCune says that a great deal of AMG's success is due to having its own dedicated management team, including its own CFO, COO, business development executives and human resources department. "We're not a hospital that's running physician practices," he says. "Our team understands the nuances of managing physician practices and managing their needs."

Practices should also consider tying the compensation of their administrative and physician leaders to outcomes. For example, Dr. McCune says that 15-20 percent of his pay is determined by meeting certain measurable targets, such as certain patient satisfaction scores, growth and recruitment goals and patient safety event reporting.

5. Clear and transparent objectives. Finally, hospitals should define the goals and objectives for their practices to ensure they perform as desired, says Dr. Derman. Because primary care practices often lose money, defining goals beyond those purely related to direct practice revenue is critical for these practices to be successful. "Is the goal to increase market share by having a group of captive physicians, or is it to get ready for an ACO?" says Dr. Derman. Leaders may need to educate board members about the losses a practice may incur, while countering that these losses can be made up by downstream revenue or shared savings due to better coordinated care, depending on the goal. Then, specific objectives can be outlined for the practices on how progress toward the goal of "better coordinated care," for example, will be measured. ■

Contact Lindsey Dunn at lindsey@beckershealthcare.com.

Roles and Compensation of Physician Leaders in Hospitals Growing
(continued from page 1)

"I think we're going to see some jumps right now, but I think we're going to see some pretty major movement in the department chair area over the next three to five years, and I think what's going to drive that is many community-based health systems that want to have that academic affiliation and have someone as a department chair with both clinical and academic appointments," he says.

Evolving responsibilities

Department chair roles are becoming more fully developed and time-consuming than in the past, incorporating the financial aspects of the department, physician recruitment, coordination with academic medical centers, quality and marketing roles, Mr. Rice says. "I just think these roles, in particular the roles of the chairs of departments, are going to explode [from a compensation perspective]," he says.

Kim Mobley, principal at compensation consulting firm Sullivan, Cotter and Associates, makes a distinction between the roles of department chairs, who might oversee a broader medical area, and the medical director/chief of a narrower specialty.

Compensation for these roles currently varies widely by specialty, Ms. Mobley says, but she suggests compensation may shift somewhat over time to correlate more with an organization's size as these positions become more strategically focused for hospitals.

"These people can really help drive your business," she says. "You want to make sure you get the right person into that role and responsibility. It's not always your best surgeon or your best internist. It's somebody who has an understanding of how to pull all the pieces together, of working within the organization to really understand what the strategic objectives of the organization are. Those are unique people."

Where historically department chairs spent half of their time in private practice, today it is much

more common for chairs to spend most of their time committed to their work with the hospital, perhaps taking one day a week to see patients to keep up their clinical skills, Mr. Rice says. "I think that's the trend; there is more pressure put on these physicians to have pretty significant time commitments," he says.

In the vice president of medical affairs role, the physician leader oversees the medical staff. VPMAs typically are very seasoned physicians from within the community, Mr. Rice says. They must juggle their internal role — being a liaison with the medical staff and dealing with staff privileging and other medical affairs issues — with external roles within their hospital's community.

Jim Nelson, managing principal at SullivanCotter, says the vice president of medical affairs is typically included in an organization's top executive ranks for compensation purposes. As healthcare reform and other trends lead to more value-based compensation, VPMAs will need to be more sophisticated in their dealings with the medical staff and hospital and system boards. "They will be focusing on process improvement, efficiency and improving quality outcomes," he says. Also, as consolidation increases within the industry, they will be asked to oversee physician employment arrangements, integration of new physicians into their organizations and the creation of new partnership models with medical groups.

No more soft landing

In the past, chief medical officer and VPMA roles were sometimes viewed as a landing place for physicians who were nearing retirement age and wanted to transition out of private practice, Mr. Nelson says. That is no longer the case. The complexity of the job now requires these physicians to have a much more business-oriented skill set. Hospitals are responding by investing more in improving their physicians' leadership, business and communication skills, he says.

"In the past, maybe some of these were more titular than operational," Mr. Rice says. "Now what's happening is the organizations are saying we want this to be an active part of what we're doing from a health system delivery standpoint. We want you to do these things, and we're going to pay you for them, but the requirement is you're going to have to do certain things and put in a certain amount of time to get the payment." Physicians have driven some of this change as well, pushing for on-call pay and other compensation for their time, he says.

Dollars and cents

When trying to figure out an appropriate compensation level for these positions, hospitals should first consider the time commitment and duties that will be required of the physician, which is what drives the valuation amount, according to Mr. Rice.

Median Compensation for Vice Presidents of Medical Affairs

Here are the median compensation rates from 2005-2009 for vice presidents of medical affairs at hospitals around the country, according to Integrated Healthcare Strategies' *Medical Director Survey.*

2009: $312,760
2008: $262,650
2007: $252,472
2006: $264,790
2005: $258,000

For productive physicians, a hospital might need to offer an amount in the 75th percentile of comparable organizations for the physician to want to make the change in practice that would be necessary to take on these hospital roles, Mr. Rice says. Still, Ms. Mobley notes, physicians are not likely to take on a hospital leadership role for the compensation alone, given that they can likely earn as much or more in full-time practice. "It's a career choice, not an economic choice," she says.

Mr. Rice says hospitals need to have a firm idea of what they want their physician leaders to help them achieve. "Instead of starting with the compensation, hospitals need to start by deciding what they want from the position, and identify real, specific duties, responsibilities, outcomes and around that structure how that position is going to function, including if you're going to include at-risk components," he says. "Before you start with the money, start with what you want and how it relates to what you're trying to accomplish as an organization." ■

Average Compensation for Department Chairs

Here are the average compensation rates for department chairs at academic medical centers for four specialties, according to data compiled by Integrated Healthcare Strategies. The numbers below represent the average of the most recent MGMA, AAMC and Sullivan Cotter and Associates data on academic medical centers.

2007
Internal Medicine: $312,700
General Surgery: $480,300
General Pediatrics: $310,800
Family Practice (w/o OB): $235,600

2008
Internal Medicine: $369,100
General Surgery: $492,400
General Pediatrics: $322,300
Family Practice (w/o OB): $256,300

2009
Internal Medicine: $380,400
General Surgery: $558,100
General Pediatrics: $337,400
Family Practice: (w/o OB): $282,700

The Future of Healthcare Delivery and Your Hospital: Q&A With John Hopkins Medicine CEO Dr. Edward Miller

By Lindsey Dunn

Edward D. Miller, MD, has led John Hopkins Medicine, the $5 billion enterprise that unites physicians and scientists of the Johns Hopkins University School of Medicine with Johns Hopkins Health System, since 1997. As leader of one of the most respected healthcare institutions during one of the most revolutionary times in healthcare, few are better poised to discuss the changes healthcare providers will face in coming years and how health systems must adapt to succeed in light of these changes.

Q: Johns Hopkins has consistently supported the new healthcare reform law and its extension of coverage, and you publicly advocated for better coordinated care and a revamped payment system that does away with fee-for-service. Do you think the law does enough to address all of these issues?

Dr. Edward Miller: Our view was that continuing on the same path year after year was not going to get us anywhere. It's certainly not a perfect bill, and a lot of pieces have yet to be defined until specific rules and regulations come out of CMS and HHS. That said, having 32 million uninsured Americans is a significant problem, and it was only going to get worse. We felt it was time to tackle these problems. We pushed hard for health innovations like the Healthcare Innovation Zone concept and accountable care organizations as a way to cost-effectively care for a population of individuals. In our experience, it's really the only way to bend the cost curve. Priority Partners, our managed care organization for Medicaid patients that cares for 175,000 members, is paid per member per month and manages to make money.

However, the legislation fell short in two key areas. It did nothing to address tort reform or how to increase the workforce to care for the 32 million additional people coming into the system. Both of these will be big stumbling blocks to success. I would have liked to see an increase in the number of slots for residents. There has been a lot of talk about increasing the size of medical school classes, but once medical school is over, [the graduates] have to go out and find residencies. Last year, 200 students did not match for a resident slot. The number of residencies has been

flat for several years, and the legislation didn't address this despite it being a relatively quick fix.

Q: Medicare will allow ACOs to share in cost savings they create for Medicare beneficiaries beginning with a pilot program in 2012. What impact do you think this will have on our fee-for-service system?

DM: I think it's probably going to be very different in different regions of the country. It seems that some organizations are pretty far ahead, but a lot of organizations are not. Providers in rural areas are going to have a more difficult time; distance becomes an issue when you are trying to integrate care for a population. I think in many areas you'll see ACOs driven by academic medical centers. Hopkins has managed care for 175,000 Medicaid patients, a group of 32,000 military retirees and their families and our own employees through our hospitals, 25 ambulatory sites, pharmacies and hospice care relationships. We're able to take care of a full gamut of patients and conditions, and we have a wide reach. In other areas, ACOs could be driven more by insurers partnering with providers. I think success [under a medical home reimbursement model] depends on the degree of integration in a system. Providers incur risk in these type of arrangements, and a big factor is the amount of risk an ACO is willing to take on. An academic medical center with a 2-3 percent profit margin does not have a lot of room for error.

Q: That's a good point. How would a health system go about determining if a bundled or capitated fee offered by a payor is a fair price for services?

DM: The most important question here is "Do you have the data?" Since we're an insurer, we have the data. We have inpatient, outpatient and pharmaceutical data on every patient — all 175,000 — in Priority Partners. We can analyze the data and determine the cost of their care in a given year. The same rule would hold true for other populations of patients, like diabetics. For example, if the average cost of care for a diabetic patient is $5,000 and a payor offers $4,000, that's a bad deal. It all comes back to having the data.

Q: It sounds like integrated systems need to be in place for a few years, then, before an ACO could accurately predict their costs. Would you agree?

DM: Yes, I think there needs to be a system in place for a few years in order to have that kind of data. This is where people will get burned if they don't know the true cost of their care. Organizations that wing it and accept rates without knowing their true costs could be in real trouble. However, those with a good grip on costs and are strong negotiators have the potential to do really well.

Q: Large health systems and academic medical centers seem the best situated for financial success under the medical home model. What's the role of the community hospital in all of this?

DM: There are two responses for these small community hospitals. They first need to determine if they can make it as a standalone facility any longer or if it would be better to come into a system. It's an important decision that trustees of hospitals have to face. Hospitals that once thrived are having much more difficulty in this economic climate with increased rules and regulations. Two hospitals — Suburban Hospital in Bethesda and Howard County General Hospital in Columbia — recently joined John Hopkins Medicine because they didn't want to go it alone anymore. Instead of putting their facilities up for sale, they gave their resources to the system and in return are able to take advantage of our infrastructure. They remain community providers, and the board members are kept local. They are the ones embedded in the community and can best help the bigger system understand local issues and identify issues we might not see.

A second way is to establish a meaningful affiliation with a system. For example, we have affiliations with Greater Baltimore Medical Center and Anne Arundel Medical Center in Annapolis. We work closely together, running some of their programs and clinical trials for their facilities.

Q: What are the biggest opportunities for hospitals in the wake of reform?

DM: I think the biggest opportunities to drive change are these pilots. Some are going to work and some are not. Insurance companies don't want to be left out either, so I think we'll see relationships forged between insurers and providers we've never seen before. I also think large employers are going to wake up and realize they have to do something to combat rate increases of 12, 15 or 20 percent. They will start to look at other ways to provide health coverage to their employees. If providers can say, 'we'll take care of your employee population for this amount of money,' it could be a great opportunity. Maybe there's a way to figure out how much the ACO is willing to be at risk and how much the employer will risk, and maybe there's a way both can share in any savings created. A key here would be measuring patient satisfaction at the same time. In the era of HMOs, patient satisfaction dropped to zero because a gate keeper was preventing them from [receiving] care. That's not the goal here. It's about getting the appropriate care at the right time from the right provider.

Q: Hospitals have agreed to $155 billion in cuts over 10 years in return for more insured Americans. Do you think hospitals will net positively from this deal or should they be preparing for decreased revenue?

DM: I personally was not a big fan of this to tell you the truth. It still remains unclear if it will truly provide an offset. When someone first gets an insurance card, they use a lot of resources in the first year or two, and the added cost of that is yet to be determined. If hospitals are seeing more admissions and reduced reimbursements, it could be a double hit. A hospital running at 50 percent capacity would experience increased revenue, but a hospital that's running full like ours could suffer by treating the nearly the same number of patients for less payment.

Another concern is how the cuts will be factored into a medical home payment model. I think it's all about timing here. We are concerned about not getting too far ahead of the curve if payment is behind us. If everyone else is still under a fee-for-service model and we're taking care of a Medicare population, we don't want to get burned.

Q: You are in a very high-profile position at a very remarkable time in healthcare. What has been your greatest accomplishment so far?

DM: My biggest accomplishment has been recruiting a great group of chiefs here throughout the clinical sciences. I think I have the best directors you could ask for and the best group of leaders in John Hopkins. It's really the people who are important in the success of an organization.

Q: What has been your biggest challenge?

DM: It's a challenge to truly understand how quickly change should be instituted. You have to gauge the pace [at] which you can make change. If you do it too quickly you'll fail, and if you do it too slowly, you'll fail. Culture eats strategy everyday for lunch. Communicating the need for change to a group as large and broad as an organization like John Hopkins is challenging, but it's one of the duties of someone in my position and [it's] what leadership is all about.

Q: What is one piece of advice you would give other hospital leaders?

DM: In this job there are a tremendous number of opportunities that come along, and you cannot be so narrowly focused that you dismiss an opportunity because it doesn't quite fit your organization's strategy. You need to explore those opportunities and partnerships. If we stayed the way we were 20 years ago, we would have shot ourselves in the foot. Take workplace development and who provides care as an example. With physician shortages looming, we have been able to use nurse practitioners as true partners in caring for our patients. Being open to new ideas and new ways of doing things is the one thing I would ask of those leading hospitals. ■

Dr. Miller is an anesthesiologist who joined Johns Hopkins in 1994 as professor and director of the Department of Anesthesiology and Critical Care Medicine. He was named interim dean of John Hopkins School of Medicine in 1996.

40 Leading Non-Profit Health Systems

Here are 40 leading non-profit health systems in the United States, by the number of hospitals in the system.

1. **Catholic Health Initiatives (Denver, Colo.) — 75 hospitals**
2. **Ascension Health (St. Louis) — 65 hospitals**
3. **Trinity Health (Novi. Mich.) — 45 hospitals**
4. **Catholic Healthcare West (San Francisco) — 41 hospitals**
5. **Kaiser Foundation Hospitals (Oakland, Calif.) — 36 hospitals**
6. **CHRISTUS Health (Irving, Texas) — 35 hospitals**
7. **Catholic Health East (Newtown Square, Pa.) — 34 hospitals**
8. **Carolinas HealthCare System (Charlotte, N.C.) — 29 hospitals**
9. **Sanford Health (Sioux Falls, S.D., and Fargo, N.D.) — 29 hospitals**
10. **Avera Health (Sioux Falls, S.D.) — 27 hospitals**
11. **Iowa Health System (Des Moines, Iowa) — 26 hospitals**
12. **Providence Health & Services (Renton, Wash.) — 26 hospitals**
13. **Sutter Health (Sacramento, Calif.) — 25 hospitals**
14. **Baylor Health Care System (Dallas) — 23 hospitals**
15. **Intermountain Healthcare (Salt Lake City) — 23 hospitals**
16. **Banner Health (Phoenix) — 22 hospitals**
17. **SSM Health Care (St. Louis) — 20 hospitals**
18. **Sisters of Mercy Health System (Chesterfield, Mo.) — 19 hospitals**
19. **Bon Secours Health System (Marriottsville, Md.) — 18 hospitals**
20. **ETMC Regional Healthcare System (Tyler, Texas) — 15 hospitals**
21. **North Shore-LIJ Health System (Great Neck, N.Y.) — 14 hospitals**
22. **St. Joseph Health System (Orange, Calif.) — 14 hospitals**
23. **Texas Health Resources (Arlington, Texas) — 14 hospitals**
24. **Advocate Health Care (Oak Brook, Ill.) — 13 hospitals**
25. **Hospital Sisters Health System (Springfield, Ill.) — 13 hospitals**
26. **Aurora Health Care (Milwaukee) — 13 hospitals**
27. **Integris Health (Oklahoma City) — 13 hospitals**
28. **BJC Healthcare (St. Louis) — 13 hospitals**
29. **Novant Health (Winston-Salem, N.C.) — 12 hospitals**
30. **Saint Luke's Health System (Kansas City, Mo.) — 11 hospitals**
31. **Memorial Hermann Healthcare System (Houston) — 11 hospitals**
32. **Partners HealthCare (Boston) — 10 hospitals**
33. **Carilion Health System (Roanoke, Va.) — 8 hospitals**
34. **OhioHealth (Columbus, Ohio) — 8 hospitals**
35. **ProMedica Health System (Toledo, Ohio) — 8 hospitals**
36. **Sentara Healthcare (Norfolk, Va.) — 8 hospitals**
37. **OSF Health Care (Peoria, Ill.) — 7 hospitals**
38. **Presbyterian Healthcare Services (Albuquerque, N.M.) — 7 hospitals**
39. **Caritas Christi Health Care (Boston) — 6 hospitals**
40. **Covenant Health (Knoxville, Tenn.) — 6 hospitals** ■

20 Largest Non-Profit Hospitals in the United States

Here are the top 20 largest non-profit, acute-care hospitals in the United States, in order of number of beds, according to data from the American Hospital Directory. *Editor's Note: The hospital bed counts reported here include all medical/surgical and special card beds as reported to CMS by the hospitals in their most recent cost reports.*

1. **New York-Presbyterian Hospital/Weill Cornell Medical Center (New York City) — 2,236**
2. **Florida Hospital Orlando (Fla.) — 1,972**
3. **University of Pittsburgh (Pa.) Medical Center Presbyterian — 1,602**
4. **Montefiore Medical Center-Moses Division Hospital (Bronx, N.Y.) — 1,427**
5. **Baptist Medical Center (San Antonio) — 1,402**
6. **Orlando (Fla.) Regional Medical Center — 1,376**
7. **Barnes-Jewish Hospital (St. Louis) — 1,283**
8. **Methodist University Hospital (Memphis, Tenn.) — 1,273**
9. **Buffalo (N.Y.) General Hospital — 1,241**
10. **Mount Sinai Medical Center (New York City) — 1,223**
11. **Norton Hospital (Louisville, Ky.) — 1,150**
12. **Cleveland Clinic — 1,142**
13. **Memorial Hermann Hospitals (Houston) — 1,136**
14. **North Shore University Hospital (New York City) — 1,082**
15. **Christiana Hospital (Newark, Del.) — 1,081**
16. **Beaumont Hospital, Royal Oak (Mich.) — 1,061**
17. **Spectrum Health Medical Center (Grand Rapids, Mich.) — 1,033**
18. **Jewish Hospital (Louisville, Ky.) — 1,025**
19. **Albert Einstein Medical Center (Philadelphia) — 1,018**
20. **Beth Israel Medical Center – Petrie Division (New York City) — 1,004** ■

To view full profiles on each of these hospitals, visit www.beckershospitalreview.com.

15 Leading For-Profit Hospital Chains

Here are the 15 leading acute-care, for-profit hospital companies operating in the United States. *Note:* Companies are listed in order of the number of hospitals, according to the company's website.

Healthcare Corp. of America (Nashville, Tenn.)
Number of hospitals: 163
CEO: Richard Bracken
2009 revenue: $30.05 billion

Community Health Systems (Brentwood, Tenn.)
Number of hospitals: 123
CEO: Wayne Smith
2009 revenue: $12.1 billion

Health Management Associates (Naples, Fla.)
Number of hospitals: 54
CEO: Greg Newsome
2009 revenue: $4.6 billion

Tenet Healthcare Corp. (Dallas)
Number of hospitals: 51
CEO: Trevor Fetter
2009 revenue: $9.0 billion

LifePoint Hospitals (Brentwood, Tenn.)
Number of hospitals: 48
CEO: William Carpenter III
2009 revenue: $3.0 billion

Universal Health Services (King of Prussia, Pa.)
Number of hospitals: 22
CEO: Marc D. Miller
2009 revenue: $5.2 billion

IASIS Healthcare (Franklin, Tenn.)
Number of hospitals: 15
CEO: David Whilte
2009 revenue: $2.4 billion

Vanguard Health System (Nashville, Tenn.)
Number of hospitals: 15
CEO: Charles Martin, Jr.
2009 revenue: $3.2 billion

National Surgical Hospitals (Chicago)
Number of hospitals: 14
CEO: John Rex-Waller
2009 revenue: Not available

Capella Healthcare (Brentwood, Tenn.)
Number of hospitals: 13
CEO: Daniel Slipkovich
2009 revenue: Not available

Prime Healthcare Services (Inglewood, Calif.)
Number of hospitals: 13
CEO: Lex Reddy
2009 revenue: Not available

MedCath (Charlotte, N.C.)
Number of hospitals: 10
CEO: O. Edwin French
2009 revenue: $602.0 million

Ardent Health Services (Nashville, Tenn.)
Number of hospitals: 7
CEO: David Vandewater
2009 revenue: $1.8 billion

Foundation Surgical Hospital Affiliates (Oklahoma City)
Number of hospitals: 2
CEO: Thomas A. Michaud
2009 revenue: Not available

LHP Hospital Group (Plano, Texas)
Number of hospitals: 2
CEO: Dan Moen
2009 revenue: Not available ■

20 Largest For-Profit Hospitals in the United States

Here are the 20 largest for-profit hospitals in the United States, in order of number of beds, according to data from the American Hospital Directory. *Editor's Note: The hospital bed counts reported here include all medical/surgical and special card beds as reported to CMS by the hospitals in their most recent cost reports.*

1. Methodist Hospital (San Antonio) — 1,414

2. CJW Medical Center – Chippenham Campus (Richmond, Va.) — 758

3. Henrico Doctors' Hospital (Richmond, Va.) — 692

4. Medical City Hospital (Dallas) — 677

5. Sunrise Hospital & Medical Center (Las Vegas) — 640

6. Brookwood Medical Center (Birmingham, Ala.) — 586

7. McAllen Medical Center (McAllen, Texas) — 572

8 (tie). Centennial Medical Center (Nashville, Tenn.) — 555

8 (tie). Oklahoma University Medical Center (Oklahoma City) — 555

10. Saint Francis Hospital (Memphis, Tenn.) — 531

11. West Florida Hospital (Pensacola, Fla.) — 520

12. Providence Memorial Hospital (El Paso, Texas) — 508

13. Hahnemann University Hospital (Philadelphia) — 478

14 (tie).Delray Medical Center (Delray Beach, Fla.) — 465-bed

14 (tie). Saint Mary's Medical Center (West Palm Beach, Fla.) — 465

16. Doctors Medical Center of Modesto (Modesto, Calif.) — 449

17 (tie). JFK Medical Center (Atlantis, Fla.) — 448

17 (tie). Park Plaza Hospital (Houston) — 448

19. North Shore Medical Center –FMC (Fort Lauderdale, Fla.) — 444

20. Carolinas Hospital System (Florence, S.C.) — 431 ■

To view full profiles on each of these hospitals, visit www.beckershospitalreview.com.

Top 20 Grossing Non-Profit Hospitals in the United States

Here are the top 20 grossing non-profit, acute-care hospitals in the United States, in order of annual gross patient revenue, according to CMS cost report data from the American Hospital Directory.

1. University of Pittsburgh (Pa.) Medical Center Presbyterian — $9.85 billion
2. The Cleveland Clinic — $7.74 billion
3. Cedars-Sinai Medical Center (Los Angeles) — $7.22 billion
4. New York-Presbyterian Hospital/Weill Cornell Medical Center — $6.81 billion
5. Florida Hospital Orlando (Fla.) — $6.13 billion
6. Stanford (Calif.) Hospital — $6.0 billion
7. Temple University Hospital (Philadelphia) — $5.45 billion
8. Hospital of the University of Pennsylvania (Philadelphia) — $5.40 billion
9. Montefiore Medical Center – Moses Division Hospital (Bronx, N.Y.) — $5.36 billion
10. Orlando (Fla.) Regional Medical Center —$5.26 billion
11. Massachusetts General Hospital (Boston) — $5.11 billion
12. Crozer-Chester Medical Center (Upland, Pa.) — $4.57 billion
13. Hackensack (N.J.) University Medical Center — $4.37 billion
14. Brigham and Women's Hospital (Boston) — $4.33 billion
15. Thomas Jefferson University Hospital (Philadelphia) — $4.0 billion
16. Vanderbilt University Medical Center (Nashville, Tenn.) — $3.98 billion
17. The Methodist Hospital (Houston) — $3.87 billion
18. Northwestern Memorial Hospital (Chicago) — $3.84 billion
19. Tampa (Fla.) General Hospital — $3.81 billion
20. Norton Hospital (Louisville, Ky.) — $3.57 billion ■

Top 20 Grossing For-Profit Hospitals in the United States

Here are the top 20 grossing for-profit, acute-care hospitals in the United States, in order of annual gross patient revenue, according to CMS cost report data from the American Hospital Directory.

1. Methodist Hospital (San Antonio, Texas) — $3.89 billion
2. Hahnemann University Hospital (Philadelphia) — $3.04 billion
3. CJW Medical Center –Chippenham Campus (Richmond, Va.) — $2.60 billion
4 Doctors Medical Center of Modesto (Calif.) — $2.5 billion
5. Brookwood Medical Center (Birmingham, Ala.) — $2.24 billion
6. Sunrise Hospital & Medical Center (Las Vegas, Nev.) — $2.22 billion
7. Medical City Hospital (Dallas) — $2.15 billion
8. JFK Medical Center (Atlantis, Fla.) — $2.08 billion
9. Henrico Doctors' Hospital – Forest Campus (Richmond, Va.) — $1.79 billion
10. Good Samaritan Hospital (San Jose, Calif.) —$1.73 billion
11. Memorial Hospital (Jacksonville, Fla.) — $1.7 billion
12. Centennial Medical Center (Nashville, Tenn.) — $1.62 billion
13. North Florida Regional Medical Center (Gainesville, Fla.) — $1.61 billion
14. Edinburg (Texas) Regional Medical Center —$1.55 billion
15. Providence Memorial Hospital (El Paso, Texas) — $1.52 billion
16. Riverside (Calif.) Community Hospital — $1.51 billion
17. Brandon (Fla.) Regional Hospital — $1.5 billion
18. Swedish Medical Center (Englewood, Colo.) — $1.49 billion
19. Wesley Medical Center (Wichita, Kan.) — $1.43 billion
20. Clear Lake Regional Medical Center (Webster, Texas) — $1.36 billion ■

Independent Medical Practice: Does Healthcare Reform Mark the Beginning of the End?

By Barbara Kirchheimer

Declining reimbursements, uncertainties about the future and the hassles and costs of running a practice have all combined to make many of today's physicians yearn for some sense of security. In a growing number of cases, they have found it by giving up their independent practices in favor of employment arrangements.

With this trend already established, some observers say healthcare reform, while perhaps not driving the independent physician into extinction, will make it a lot more difficult or unappealing to practice medicine in the traditional way. The law's focus on quality, efficiency and accountability make alignments with hospitals more appealing and may make life even more difficult down the road for those doctors who choose to go it alone.

"I think the independent small medical practice, given the need for integration into delivery systems, given the expense and need for healthcare IT, will not be able to afford to exist," says Patrick Breaux, MD, president of the Louisiana State Medical Society. "I think those will be a thing of the past."

Cardiology takes a hit

Dr. Breaux, a cardiologist and internist whose multispecialty group practice was lost in Hurricane Katrina, now is employed by Ochsner Health System and says many of his colleagues, especially those in cardiology, are joining integrated systems like his. "Within the last year, lots of doctors have been giving up independent practice," he says. "The cost and expense of running a cardiology practice is huge."

Recent Medicare reimbursement cuts to various cardiology procedures, especially those involving imaging, threaten to cut physicians' payments by 10-40 percent, according to the American College of Cardiology. This has led many cardiologists to join hospitals just within the past year. In fact, roughly half of cardiology practices have now migrated into hospitals, says ACC spokeswoman Amy Murphy. "Practices are going away, hospitals are gaining cardiologists, but the costs of the same procedure are higher in the hospital setting than in the practice setting," she says, which leads to higher costs to payors and higher co-pays for patients.

Cardiologists are not the only physicians embracing employment models. In 2003, 8 percent of the Medical Group Management Association's members were in hospital-owned practices. In 2008, that figure rose to 10 percent, a 25-percent increase, according to MGMA data. In that same time period, the size of hospital-owned practices grew from a mean of 64.3 physicians to 76.3 physicians.

Specter of accountability drives alignments

This trend is likely to accelerate under healthcare reform, especially among specialty surgeons such as gastroenterologists, orthopedic surgeons and other major users of ancillary services, predicts David Gans, MGMA's vice president of innovation and research.

Also of note, he says, is healthcare reform's promotion of so-called "accountable care organizations." In one policy brief by Urban Institute researchers Robert Berenson, MD, and Kelly Devers, PhD, an ACO is defined as a "local health care organization and a related set of providers (at a minimum, primary care physicians, specialists and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population."

Under healthcare reform, ACOs will likely be able to share in the cost savings to Medicare that they achieve. A hospital-physician integrated system is better positioned to take advantage of such opportunities than the independent physician, Mr. Gans says. "They already have the governance in place, the methodologies in place, and could take care of cost sharing and have a single contractual relationship with the government," he says.

Primary care physicians join hospitals

Kenneth Bertka, MD, FAAFP, CPHIMS, a director of the American Academy of Family Physicians, went from being in a small group practice for 20 years to becoming the chief medical information officer for the Northern Division of Catholic Healthcare Partners, a 34-hospital system based in Toledo, Ohio.

While Dr. Bertka says he is still "very passionate about private practice," he found he was able to better satisfy his interests in larger reform issues and engage in leadership roles within the AAFP by joining a system. Juggling these responsibilities and interests would have been far harder had he stayed in a small practice environment, he says.

While Dr. Bertka does not see independent medical practice going the way of the dinosaur, he says evidence suggests that 40 percent of primary-care physicians will be employed by hospitals or systems within the next two years, up from "the mid to upper 20s" today.

"The government and the private side want to switch from paying for procedures and volume to paying for outcomes and value," he says. "To do that you really need that team approach and clinical integration."

The current physician shift is partly the result of "psychological" factors such as uncertainty about the future, says Tommy Bohannon, the vice president of hospital-based recruiting at Merritt Hawkins, a physician search and consulting firm. "We don't really know what's going to happen, and it's going to be a long time before we do, so maybe it's better to be in a seemingly more stable environment with a hospital," he explains.

His firm got caught in the middle when it was hired to recruit for an independent physician practice that switched gears midstream and decided to align with a hospital. "Between the time we found (a candidate) and the interview a week later, the group had decided to enter into discussions with a hospital to acquire the practice," he says. "We had to change the spin to the candidate."

Jeffry Peters, chairman of the board of Health Directions, a consulting firm that focuses on hospital-physician strategies, says the combination of the expense of ancillary services, the sophistication of billing and collections processes, the depth of healthcare IT systems and increasing staff costs have driven physicians to seek out new models. Some 75 percent of all physicians coming out of medical school are looking for employment opportunities, and he expects private practice eventually to drop to less than 25 percent of all physicians and practices.

While independent practice may not become totally extinct, Mr. Peters offers another possible analogy. "It's going to go the way of independent grocery stores," he says. "They're still there, they still have a place, but it ain't what it was 20 years ago." ■

Strategies for Hospital Leadership – Identifying Strengths, Allocating Hospital Resources and Focusing on Profitable Niche Leadership

By Scott Becker, JD, CPA, and Barton Walker, JD

This is a great time for hospital leadership and boards to reevaluate their strategies. This article contains eight core thoughts and concepts on strategic planning for hospitals.

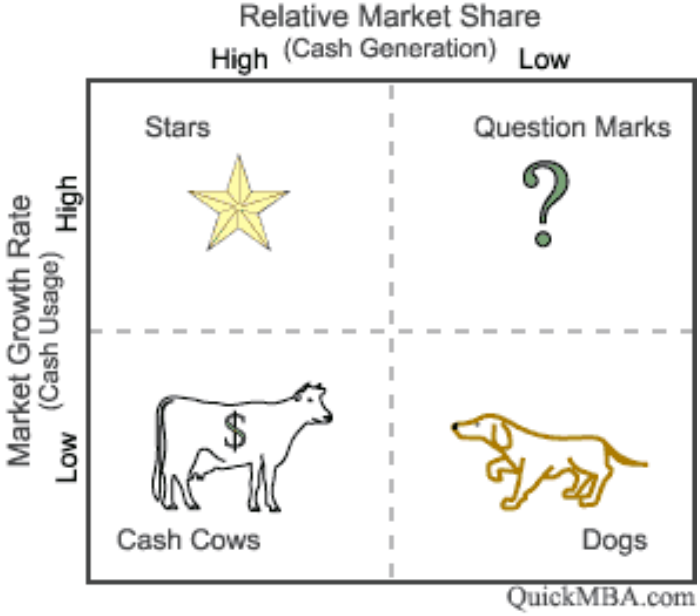
1. Development of a strategy and strategic framework. There are several different frameworks that can be used to build a strategy. Hospitals need to assess their overall strategy. One concept as to strategic approach proclaims that an organization should make a clear choice as to (1) whether an organization wants to be a low cost leader, (2) whether it wants to be dominant in a specific niche or area, or (3) whether it wants to be a leader in being customer centric. Michael Porter, noted author of *Competitive Strategy*, uses a similar framework and groups strategies into three generic strategies (i.e., strategies that are applicable across industries): cost leadership, differentiation and focus. Porter argued that to be successful over the long term, a firm must select only one of these strategies. Otherwise, a firm will be "stuck in the middle" and will not achieve a competitive advantage.

He also states, "These generic strategies are not necessarily compatible with one another. If a firm attempts to achieve an advantage on all fronts, in this attempt it may achieve no advantage at all. For example, if a firm differentiates itself by supplying very high quality products, it risks undermining that quality if it seeks to become a cost leader. Even if the quality did not suffer, the firm would risk projecting a confusing image."

Then, as a hospital starts to assess and implement its strategy, it must focus as much of the organization's resources and energies as possible toward accomplishing these strategies and goals. In terms of evaluating which strategy to pursue, hospital leadership may often use a tool such as a traditional BCG matrix (pictured below) whereby a leadership team maps out areas into four quadrants: (1) their current strongest cash generating businesses (e.g., imaging, spine, orthopedics, oncology, etc.); (2) areas in which they have high growth opportunities and the potential to have a high market share; (3) areas in which they do not currently have high market share, but there is a possibility for high growth (possibly, e.g., an evolving area or a specialty program (i.e., attempting to understand where the future revenue opportunities are)); and (4) areas in which there is low market share and low growth, in essence, areas that BCG traditionally refers to as dogs

The hospital leadership should combine the mix of looking at the business lines through the BCG matrix, and also assess such questions as Porter would set forth. Do you, i.e., want to choose to be one of the three items outlined above: (1) a cost leader (traditionally in healthcare, this has not been the best position); (2) dominant in a specific niche (for example the hospital with the best orthopedics program and/or the best oncology program, or some other high value high growth area); or (3) do you simply want to be extremely customer centric. In assessing these questions, one may also assess (1) how achievable is the goal — how competitive is it — how well-situated is the system to achieve leadership in the area; and (2) if achievable, is it worth achieving? Is there sustainable profit and leadership? For example, if one of the cash cows of the business is a relationship with a specific payor or a specific physician group, a core part of the strategy might be to model the organization such that they can remain very, very close to that payor or that provider.

Boston Consulting Group Matrix



A hospital can also choose to be dominant in a few different niches and combine this with the concept of being outstanding to a certain group of customers. It can also help clarify its strategy by making sure it understands what it is not. Stanford Hospital Chief of Staff Brian Bohman, MD, for example, informed his team members that Stanford is "not a low cost hospital and [is] not likely to be a low cost leader in the near future." He said, "It's thus even more critical that we be a high quality and high satisfaction hospital."

Many strategists state that you have to pick one clear area where you want to focus. We tend to believe that you can be both dominant in several niches and still very customer centric. It is very hard, however, to choose to be both dominant in several niches and/or truly customer centric, and at the same time a cost leader. In essence, the resources needed to be truly customer centric or to be dominant in a certain niche area typically don't line up well with also being a complete cost leader in an area.

One can counter that if a very close payor relationship is a key goal, then being a cost leader may in fact be in sync with that type of customer centric notion. However, even with the concept of being a leader for a payor or dominant in such an area that you could drive down supply and equipment costs, we generally perceive that a goal would be to normalize costs but not to be a cost leader.

As a further note on choosing price leadership, please note the following. Differentiation based on price in healthcare traditionally has had limited success due to (1) the actual or perceived reluctance of patients to sacrifice any significant measure of quality for corresponding cost savings, (2) the lack of information available to compare cost and quality, and (3) the disconnect between the consumer of the service and the party who pays for the service. For example, where the consumer is insulated from the true

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cost of providing the service, as is the case with a great deal of health care services, the consumer has very little incentive to economize. A growing category of exceptions, however, revolves around insurance plans which differentiate in cost sharing and drive patients to be more inquisitive regarding costs and their share of costs.

2. Understand where your revenue is coming from. On a macro level, it is critical for a system to understand by service line — both by areas of care and often by referral source or generator of business — what are the key sources of revenues. [1] If a system has four service lines that comprise 85 percent of the business, a first goal of management is to align resources toward continuing to focus efforts on those four service lines. Often, this means deepening the strength in those areas and continuing to grow those areas. In a webinar on strategic planning for hospitals and ASCs, Bain & Company partner David Fleisch recommended that hospitals invest in their core service lines before expanding to new services. He said hospitals that expand new services without ensuring their core services are bound to face challenges in the future. At the same time, with the knowledge that the profitability of service lines changes over time, leadership also needs to have a keen eye on which areas are potential growth areas, then pick and determine a few of those areas to really concentrate a second set of resources on. Finally, there is a school of thought that essentially says a management team wants to spend zero or very little time on those areas that are true weaknesses and/or low growth and low revenue areas, and to not divert its time from its core cash flow generating activities and high growth potential areas. This kind of discipline can be hard to manage in practice where you see leadership focus on non-core outside efforts such as a market 70 miles away from a hospital's home base or a specialty with very little revenue potential for the system, but that seemingly somebody cannot help themselves but be focused on. However, the results that come from such efforts are not nearly worth the cost and time that would have been better spent on the cash generating activities of the organization and the potential high growth areas for the organization. An example of abandoning a "dog" may include dropping a service area where your hospital has only one physician and loses money, or dropping entirely a low volume, low paying payor.

In assessing strategy, we are big believers in exploiting existing strengths of the practice first. For example, a system might first add existing depth and strength to its strongest areas. E.g., if the system's profits come from oncology, orthopedics and imaging, it might spend a great deal of its time and dollars investing to strengthen and grow these areas. This may mean that available resources are used to fund new equipment, physician recruitment and marketing in these areas. Second, the hospital may diversify in possible high growth areas and where the system has had some success to date. At one hospital, they made the effort to develop leading service lines in neurosurgery and pain management, while the hospital reduced spending in other areas. Here, it became the regional leader in neurosurgical services. Its CEO told *Becker's Hospital Review* that the hospital decided to be the one and only hospital in the area to really focus on this area. It added neurosurgeons, developed call coverage arrangements with other hospitals, invested in technology to support the neurosurgical practice and developed a substantial leadership position.

Here, a health system that is building on its strengths would also examine areas that are immediately adjacent to it strongest areas. This concept of building out from strengths to adjacent areas is articulated extensively by Bain & Company, Inc. in a well-noted book titled "Profit from the Core" by Chris Zook. Bain and Zook note that successful companies focus on: (1) reaching full potential in the core business, (2) expanding into a logical adjacent business surrounding that core, or (3) preemptively redefining the core business in response to market turbulence. Instead of focusing on taking advantage of the next "hot industry," Bain directors recommend that companies focus on strategy, competitive position, reinvestment rates and execution. They cite the example that the most successful sustained growth companies specialize in goods with lower growth, such as energy (Enron), beverages (Starbucks), and athletic gear (Nike).

In sum, a hospital must first decide, with thorough examination of its current businesses and opportunities, what it desires to excel in, and then dedicate a great majority of its resources to such efforts.

3. Normalize costs. In all areas, a system needs to make efforts to normalize costs. Even if a system does not intend to be the cost leader, it is critical that its employee costs, supply and equipment costs, and other types of costs, are in line with benchmarks. Often in healthcare there is a certain amount of economies of scale to achieve a required baseline cost curve for either employee/wage costs as a percentage of revenues or other costs as a percentage of revenue. In essence, in some situations, there is very little ability to amortize staffing costs, leadership costs, IT costs or other costs (if you want to have top quality leadership and top quality staff) unless you have a substantial enough operation to be able to spread those costs over a reasonably sized revenue base.

One tool that almost every hospital uses to control equipment, supply and other costs is the group purchasing organization ("GPO") model. Some of the largest and most well-known GPOs are Premier, Inc., HealthTrust Purchasing Group, VHA and MedAssets. A recent study estimated that GPOs save the U.S. healthcare industry approximately $36 billion each year. [2] A recent increase in hospital consolidation activity highlights the need to minimize the cost structure supporting a hospital's revenue stream. Hospitals are consolidating in order to achieve these economies of scale as a way to compensate for continual downward pressure on their reimbursement rates. Increases in internal efficiency and productivity can only counterbalance falling marginal revenue for so long before other means of cutting marginal cost are required. Although most studies have shown that economies of scale are achieved with increasing hospital size to 200 beds and beyond, some studies have also tied hospital consolidation to increased prices (see chart below). An alternative explanation for increases prices is an increase in quality, which can occur to due to an overall increase in patient volume or a focus on quality over costs differentiation, as noted above.

4. Excel in billing, collections and managed care contracting. Many hospitals do not have leading managed care contracting capabilities internally. If your system is not large enough to maintain strength in this area internally, it may use

Figure 1. Trends in Hospital Consolidation and Pricing, 1994-2008

Sources: Hospital deals are the number of publicly announced mergers and acquisitions, as reported by Irving Levine Associates, http://www.levinassociates.com/. Hospital price index is from the Bureau of Labor Statistic's Series 62211A6, "General Medical and Surgical Hospitals, All Payers Other than Medicare and Medicaid." http://data.bls.gov/

Source: William B. Vogt, PhD, Senior Economist, RAND Corporation, *Hospital Market Consolidation: Trends and Consequences,* EXPERT VOICES, National Institute for Health Care Management (November 2009).

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outside consulting firms to obtain the best results on managed care contracting. Relative bargaining strength also tends to vary greatly with critical mass in a particular area. For example, in some areas of the country one payor dominates the market and smaller providers have very little ability to negotiate rates or terms. In addition to outside expertise, a larger scale can also help with these negotiations. For a large number of providers, Medicare reimbursement only covers a portion of the cost of providing services. Treating a Medicare patient is a money-losing proposition. As a result, commercial payor reimbursement rates become even more critical to financial success.

On billing and collections, most systems above a certain size will internalize billing and collections. Excellence in billing and collections is critical to financial success. In May, South Carolina's Greenville Hospital installed a new billing system to help close a $10 million budget gap and improve collections. In another example, by centralizing Catholic Health Initiatives' billing system, COO Michael Rowan helped save the organization $10 million in the last six months of FY 2009. Others have chosen to outsource billing and collections functions or to partner with a larger health system for administrative services and management.

5. Acquisitions and substantial investments. At this time, substantial acquisitions and investment must be measured very clearly against the core strategy of the organization. Does the investment help the system become dominant in an area that it desires to be dominant in, or does this acquisition or investment allow the system to be substantially more customer-centric? An example of a hospital that has implemented acquisitions successfully is Scott & White Memorial Hospital in Temple, Texas. Under the leadership of CEO Alfred Knight, M.D., Scott & White has aggressively expanded through mergers acquisitions, and investments. Mr. Knight said the key is to ensure that everyone is on the same page about the hospital's best interests. "The lack of coordination in healthcare … creates redundancy and extra cost," he said in 2005. An acquisition in certain situations can also help bend the system's cost curve. Moreover, in looking at this from a BCG matrix perspective, one would want to spend a great deal of their investment dollars in areas that they view as high growth areas where they can obtain a high market share.

There is also often a need to reinvest in high market share areas that are lower growth. In most situations, the first dollars invested in bigger acquisitions and investments should be spent very strictly in either protecting the cash cows of the organization or high growth, high possible market share areas. A secondary tranche of expense and resource allocation would go into promising question mark areas. On the flip side, unless there is some way to really focus resources on what is termed "a dog," a low growth and low market share area, it generally makes sense to abandon efforts all together with respect to such area and sector.

Over the long term, in a changing reimbursement environment that is most likely to be a negative reimbursement environment, it is critical that the parties are cautious on their overall debt and leverage levels. This means very careful allocation of investment and acquisition dollars.

6. Stand alone systems. Unless a stand alone system has a clear reason for being — such as great dominance in an area and some level of substantial size — it may be very hard over the next 10 years to survive as a stand alone system. This is due to the need to allocate capital for reinvestment in systems and facilities, to physician integration, and potentially into new models of managed care and accountable care organizations. Many small stand alone systems do not have sufficient resources to allocate dollars to key objectives, because the investment required can be so substantial compared to the size of the system that it readily places the entire system at risk. In a Trustee magazine study of hospital long-term viability, Ryan Gish of Kaufman, Hall & Associates, Inc. stated that stand alone hospitals strain to remain strategically and financially competitive. According to the report, hospitals often enter into partnerships because they cannot offer state-of-the-art technology and attractive services on their own. According to AHA data, the United States has more than a thousand fewer hospitals today than it had in 1990, because of mergers, acquisitions, and closures – all of which are becoming increasingly commonplace.

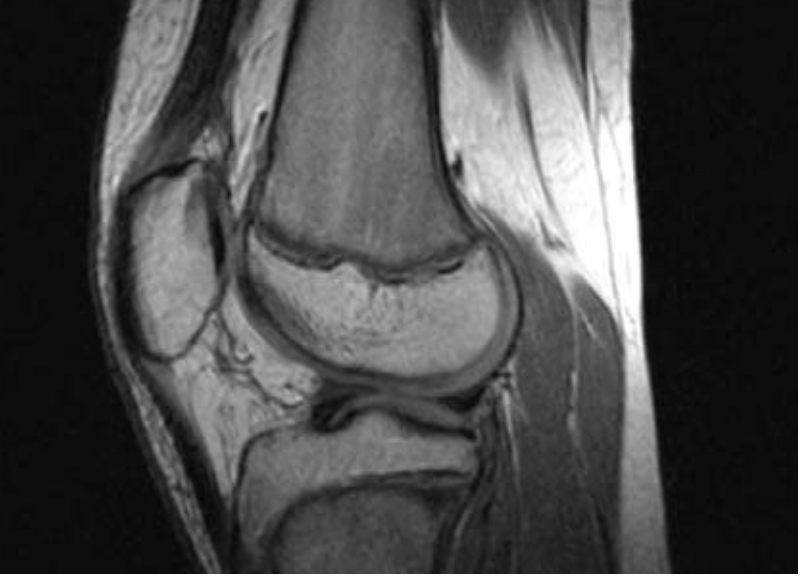
7. Pension funding. Many larger systems with defined benefit plans have found themselves substantially underfunded over the last few years. The amount of money that needs to be funded for the unfunded benefit plans is really substantial and can create serious financial challenges to the stability of many institutions and their ability to refinance, and invest in new and important initiatives. Many systems will need to eliminate defined benefit plans and switch to other types of retirement plans as soon as possible. As a recent example, the high level of pension liabilities (along with overall debt load) was one of the primary factors in the decision of Caritas Christi Health Care to agree in principle to sell its operations to Cerberus Capital Management. Overall, the system has about $230 million in pension liabilities.

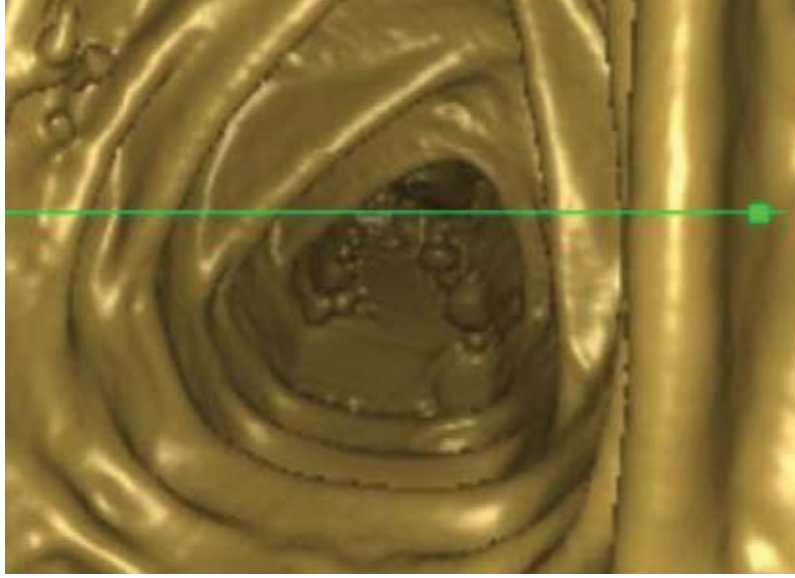
8. Physician integration. Most systems will have no choice but to use a mix of physician alignment strategies. These alignment strategies will include employing specialists and primary care physicians, joint venturing with specialists, and several types of arrangements that are in between these two models. This can include compensation relationships with physicians that are not employment relations or joint venture relations. Virginia Dempsey, president of Saint Joseph in London, Ky., told B*ecker's Hospital Review* in May that alliances with physicians will be even more important under health reform. C. Duane Dauner, president of the California Hospital Association, agreed, saying that the lack of alignment between hospitals and physicians will cause major problems for hospitals who do not pursue a variety of strategies. We believe that most systems will need to have at least some significant number of employed physicians, if not as an offensive mechanism, as a defensive mechanism in a case where the market may quickly turn to an employed market model. They need to have the experience with employing physicians in case they need to have an infrastructure to do so. If they have to develop the infrastructure after a market has already moved toward the physician employed model, it can be very hard to catch up. One system we see made a substantial investment early on in an employed model, and now can bring in physicians by and large without having to create special deals for each group that joins the system. They have also developed a very distinct compensation fund and method of working with physicians such that they are now avoiding the concept of experimenting with every single group. The more experience a system has with this type of model earlier on and before it is needed, the better position the system is in to then adopt and work with such a model.

Another factor that will likely influence the move towards greater physician integration is the advent of formal accountable care organizations. In this model, the full spectrum of healthcare providers (primary care physicians, specialists and hospitals) partner with payors (Medicare and commercial payors) to manage overall cost and quality of care. Beginning in 2012, certain incentive payments will be available for those providers who are able to organize themselves into ACOs. A number of pilot programs and collaboratives are currently underway to start the process of integration. ■

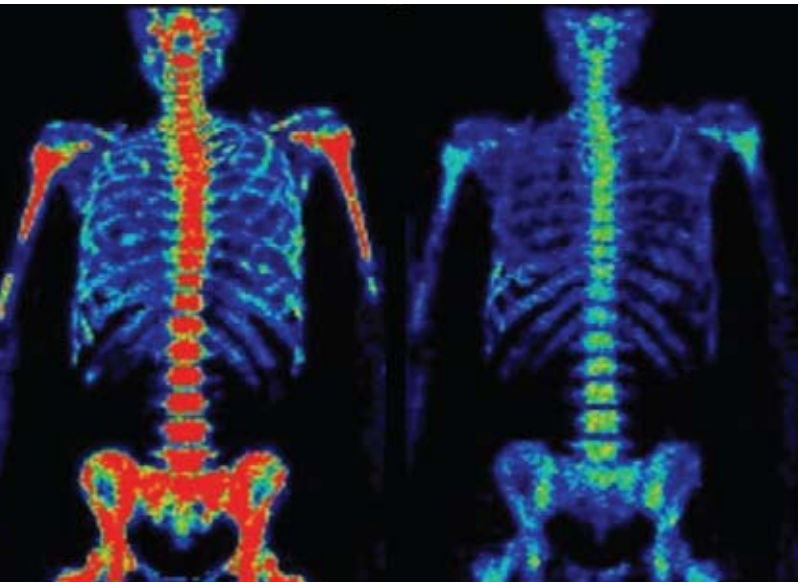
[1] A hospital should also examine which revenues are most at risk – by payor, by service line and otherwise.

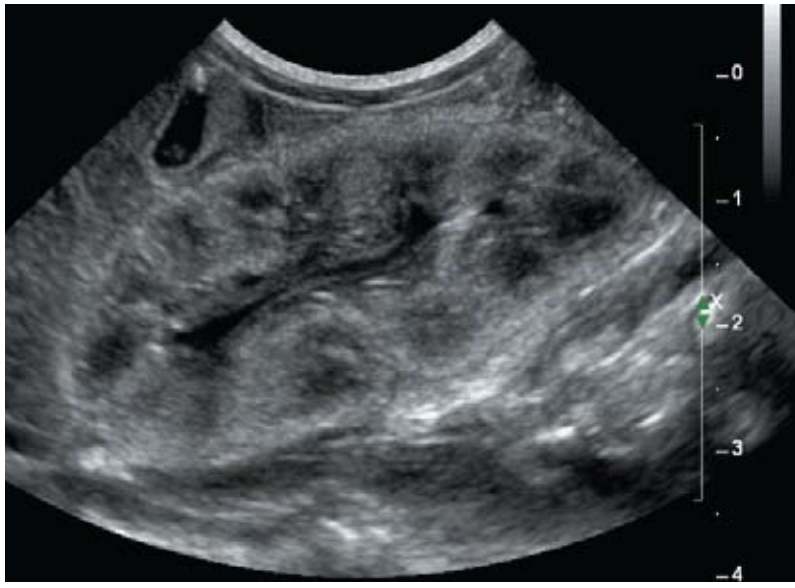
[2] Eugene S. Schneller, Ph.D, *The Value of Group Purchasing - 2009: Meeting the Need for Strategic Savings*, April 2009.





Getting the Quality and Economics Right





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6 Key Trends in Compensation of Hospital-Based Physicians

By Leigh Page

While the care and feeding of hospital-based physicians is not a new topic, there are some new trends and strategies for this group, which includes anesthesiologists, radiologists, pathologists, emergency physicians and hospitalists. Here are six of those trends.

1. Trend toward employment. Hospitals have been moving away from contracting with independent groups for hospital-based services and toward physician employment. "The current trend is toward employment," says Kim Mobley, principal of Sullivan Cotter and Associates. Anesthesiology is a good example of this trend. While hospitals traditionally contracted with anesthesiology groups, 44 percent of anesthesiologists were salaried employees in 2009, while 32 percent were owners or partners in different types of practices and 19 percent were locum tenens or contractors, according to LocumTenens.com.

"Usually the hospital provides employment only when there are no other options," says Will Reiser, vice president of product development and decision support at Halley Consulting. This often happens because anesthesiologists are in short supply, though the recession has somewhat slackened demand for them.

Mr. Reiser says the employment model for anesthesiologists is particularly common in rural areas, where independent anesthesiology practices often cannot find enough volume to survive on their own reimbursed income. "The group approaches the hospital and says, 'Look, we can't make it on our own. We're going to need your help or we'll leave town,'" he says.

However, Mr. Reiser advises hospitals to buck the trend toward employment and continue outsourcing their anesthesiology services in most cases. "Employing anesthesiologists hasn't been a strategic advantage for hospitals," he says. Halley Consulting worked with a hospital that hired its independent group of anesthesiologists, hoping that the arrangement would cost less, but its anesthesiology costs didn't change much. "The hospital expected to get more control but anesthesiologists' time off actually increased," Mr. Reiser says.

2. Evolving payment formulas. Hospitals have been developing new and more complicated payment formulas, based on ever-richer data, such as relative value units (RVUs) and quality measures. Ms. Mobley says the variables used in determining a physician's base salary include specialty area, the physician's experience and credentials, the type of compensation approach and the amount of compensation that is at risk. In the past several years, she says, physicians' salaries have been tied to productivity, which is usually the base salary plus extra compensation based on productivity as measured by RVUs or, in the case of anesthesiologists, ASA units.

Some key factors to identify in the payment formula are the clinical services provided, any administrative services performed by the group and any call coverage, Ms. Mobley says. She identifies some other factors:

Quality measures. "Many organizations are beginning to include elements of compensation that include some type of quality metric," Ms. Mobley says. Usually each organization designs its own quality metrics, which still tend to focus on process rather than outcomes.

Strategic objectives. "As healthcare organizations move toward alignment, we have started seeing measures tied to strategic objectives of the organization or the service line," she says.

Professional fees. What is the group receiving in collections for professional services? Ms. Mobley says this is especially difficult to figure out in pathology because of bundled payments.

3. Paying hospitalists. Although some hospitalists are in large group practices that contract with hospitals, hospitalists tend to be employed by the hospital. Mr. Reiser says this is because hospitalist programs are often built from in-house internists who decide to switch careers.

"The problem with hospitalists is that at night and on weekends, they have nothing to do," Mr. Reiser says. "They work hard on the day shift, but at night they are starved for work, so a pure work RVU formula doesn't fit the model well," he says. "One way to handle this is a combination of an RVU for daytime work and paying them on an hourly basis shift work at night. Another way is to give them a minimum guarantee and if they work hard they get paid more." The minimum payment might be $150,000 to $160,000, then add a payment based on their RVU, he says.

Another method, Mr. Reiser says, is to balance productivity among a few providers. "Say you need four providers. Then structure compensation for that," he says. "This keeps them productive. Put the threshold level, the trigger, at the average number of RVUs expected." Above that they get extra. But he cautions that any push for greater workloads must be balanced by checking for quality. "You need to put in quality factors; you can't have overwhelmed doctors," Mr. Reiser says.

4. Paying emergency physicians. Ms. Mobley says emergency physicians tend to be paid like hospitalists. Hospitalists and emergency physicians do shift work, sometimes on an hourly basis, with incentives for production and quality, she says. In smaller facilities, emergency physicians may be employed by a 24/7 ED that contracts with the hospital, she says.

5. Radiologists and pathologists. Radiology and pathology payments usually involve a salary component, Ms. Mobley says. The salary component might amount to 60-75 percent of total pay, plus a productivity component of perhaps 25-30 percent and 5-10 percent for quality, she says. Mr. Reiser says the typical hospital needs only one pathologist, and the payment formula is straightforward because they don't need to be available around the clock.

6. Use of stipends. Contracted anesthesiology groups in particular have been asking hospitals for stipends to supplement their income. In a 2004 survey sponsored by the American Association of Anesthesiologists, 57 percent of the hospitals provided at least one type of stipend to their contracted anesthesiology group, up from about one-half in 2000. Negotiating clout matters. While 75 percent of larger anesthesiology groups were receiving stipends, only 38 percent groups with fewer than 10 providers did so.

Mr. Reiser cautions that groups who need stipends should have to demonstrate their need with data. "A business case analysis needs to be done, identifying the practice revenue and justifying it with data." Has the practice done all it can to optimize its billings and collections? Has it attempted to cut expenses without jeopardizing service or patient care? The practice must be willing to share its financial data, he says.

The federal anti-kickback law requires that payments to physicians should at the "fair market value," he says. The figure is based on surveys on physician income provided by groups like MGMA, AMGA and Sullivan Cotter. "It's a fairly wide definition, but if you are paying five, six, seven times what the service could generate, that would be out of line," Mr. Reiser says.

Both sides must agree on what services the stipends will cover. Services might include call coverage, medical directorships, participation in hospital committees, administrative duties or participation in process improvement initiatives. In the ASA survey, the most common anesthesiology stipends were for call coverage (35 percent), medical directorship (33 percent), general obstetrical (28 percent) and trauma (21 percent), while 20 percent of stipend arrangements involved income guarantees, an emerging trend. ■

Contact Leigh Page at leigh@beckersasc.com.

Hospital Takeovers: Will Your "Golden Parachute" Protect You?

By Leigh Page

As more hospitals are being sold, top hospital executives need to make sure they have "change of control" agreements in place, says Paul Creasy, a partner in Organizational Consulting Group in Avon, Ohio. The agreement, also known as a "golden parachute," provides a payout to a hospital executive in the event of a takeover. Here Mr. Creasy offers some pointers on these agreements.

1. Get an agreement in advance of sale. It is better to have a change of control agreement in place before the hospital is put up for sale. CEOs who do not have an agreement should approach their board and ask for one.

2. Non-CEOs also can have agreements. Other executives in the C-suite can also have agreement, but instead of approaching the board, they would approach their CEO to get one. "The further you go down the food chain, the less likely it is to have this agreement," Mr. Creasy says.

3. If the sales process has already started. If executives do not have a change of control agreement by the time the sale is being negotiated, they should try to get one inserted in the sales agreement during negotiations.

4. Establish a reasonable payment. The agreement establishes the payment level, expressed as a multiple of the executive's base salary. Hospitals have to be careful about setting the payment too high and risking Internal Revenue Service sanctions. Mr. Creasy has researched severance payments at not-for-profit hospitals, as reported on IRS 990 forms, and found a wide variation in the multiples, ranging from half to seven times of the yearly salary.

5. Establish triggers. A single-trigger agreement simply pays out in the event of a change of control. A double-trigger agreement assumes that the executive would stay under the new regime, and it would pay out only in the event of second trigger, which could cover events other than just the dismissal of the executive, such as a downgrading or being asked to move more than 100 miles. ■

Learn more about Organizational Consulting Group.

3 Trends in Cardiology Compensation and Workload

By Rachel Fields

Cardiology practices are facing increased pressure on revenues due largely to significant cuts in the Medicare fee schedule for these services. Such cuts threaten the profitability of practices, making benchmarking and performance monitoring even more critical for cardiology practices today than in the past. MedAxiom, a cardiology practice benchmarking and consulting firm, collects data annually from 150 cardiology practices around the country on compensation, overhead costs, patient load and overall performance. Patrick White, president of MedAxiom, shares three trends in cardiologist workload and compensation.

1. Decreased compensation. According to Mr. White, cardiologist salaries dropped slightly in 2009, from $472,000 to $460,000 — a decrease that will be even more pronounced in 2010, he predicts. The decrease in compensation is caused by a number of factors, but MedAxiom reports show that the driving force is the "tremendous cuts in the fee schedules." In the last year, fees for cardiology services were lowered, and many CPT billing codes were bundled so that a procedure that might have used three CPT codes in the past now only needs one.

According to Mr. White, it is becoming increasingly more difficult to survive as a cardiologist in private practice. "The threat to working in a private environment is so significant that they're saying, 'I'm going to partner with my hospital, sell or lease to that organization.'," says Mr. White. "Trying to survive as an independent practice and buy equipment and hire staff is difficult when you don't know how much you're going to make that year."

2. Fewer cardiologists and more patients. Mr. White says that as the baby boomer generation hits the age when cardiovascular disease becomes prevalent, more patients are meeting a shortage of cardiologists. According to the MedAxiom 2009 report, 43 percent of cardiologists are over 50, meaning that almost half the cardiologist population will be retiring in the next 20 years. New patients coming to hospitals for cardiology services rose from 630 to 645 per physician last year, and return visits, including long-term care for heart failure and lipid disorders, rose too. "It used to be that cardiology was a consultative practice, where a primary care physician would send me a patient and I'd send him back," Mr. White says. "Now cardiologists hang on to patients, and patients keep coming back to be managed."

The culture of the baby boomer generation also had an effect on the spike in patient visits, according to Mr. White. "This new generation of baby boomers is different from our parents and grandparents," Mr. White says. "We are more likely to understand that if we have chest pains, we should get to the doctor right away."

The current shortage of cardiologists is exacerbated by lower numbers of medical students choosing cardiology as a specialty.

3. Cardiologists working harder and more efficiently. Mr. White says that in this economic climate, cardiologists are being forced to work longer hours, accept more patients and streamline their practices. While physician overhead dropped on average in 2009 — the first year that it has done so since 2002 — cuts in fee schedules and bundled CPT codes mean that overall compensation is down.

According to Mr. White, cardiologists are working hard to make their practices more efficient. This sometimes means whittling your practice down to a strong core team of people instead of hiring a lot of extraneous help. As a specialty, cardiologists have also adopted EHR and EMR more quickly than other providers. While this might cause inefficiencies during the implementation process, Mr. White says "once providers have achieved efficiency with the system, it helps significantly to be involved in e-prescribing and PQRI."

At this point, about 60 percent of MedAxiom's 150 cardiology practice clients are using an EMR, says Mr. White. ■

Hospital Executive Salary Growth Slows

By Rachel Fields

A study by the Hay Group revealed that salary growth of hospital executives has slowed, and interestingly, turnover among executives has slowed with it.

Compensation based on same hospital comparisons indicated that pay increases were 1.5 percent for base salary and 1.7 percent for total cash compensation for all jobs. On a same incumbent comparison — actual person in the position, not just the position itself — base salary increased by a rate of 2.5 percent, a decrease from 4 percent in 2009. Total cash compensation increased by a rate of 3 percent in 2010, slower than the 4.5 percent increase in 2009.

The 2010 study also shows the number of CEOs receiving at least a 6 percent increase in base salary has dropped to 22 percent, its lowest level in 10 years.

The study also reports ongoing merger, acquisition and consolidation activity. For the first time in a significant period, turnover rates for CEOs, CFOs and COOs have decreased. ■

Building an Accountable Care Organization

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

A glance at the headlines shows how badly healthcare needs to become more efficient. Healthcare spending in the United States rose 5.7 percent in 2009, to $2.5 trillion. It now commands 17.3 percent of the gross domestic product, up from 16.2 percent in 2008. That's the fastest one-year increase since 1960.

Our healthcare system is galloping away from us. We spend more than $7,000 per person on medical care, much more than any other country we compete with in the global market. China, for example, spends $600 a year. How can we as a nation keep this up? The economic burden of our healthcare system is simply unsustainable.

Enter the Accountable Care Organization

Hospitals need to become more efficient and control costs. I believe this can be done through accountable care organizations. ACOs will coordinate all the care a patient receives, both inside and outside the hospital, in a certain region. For example, an ACO in my part of Wisconsin might serve 800,000 to 1 million people. The ACO would bring together hospitals, physicians and other providers into coordinated systems that can be more efficient and safer, too.

If you're interested in organizing an ACO, begin planning now. Someone else in your region may already have started. Things are moving fast. These organizations need to be up and running by Jan. 1, 2012, when CMS, as directed by the Patient Protection and Affordable Care Act, will begin assigning Medicare beneficiaries to these organizations and allowing ACO providers to begin sharing any Medicare cost savings they achieve. Some private payors will quite likely use these same organizations for their own payments.

A physicians' group or any kind of hospital can build an ACO, but I believe the not-for-profit hospital is in the best position to do so. The not-for-profit hospital has links to the whole community through its board of trustees. It already deals with many providers who will participate in the ACO, such as social service agencies, mental health services, aging services and the public health department.

Physicians will be the ACO's key target group. The hospital will need to be fully aligned with doctors to function smoothly. With this goal in mind, Sacred Heart is offering an electronic medical record to independent doctors. We are also developing a web portal to connect with an existing EMR system at Marshfield Clinic, which has 775 physicians working at 48 locations in central and western Wisconsin. Aligning with doctors means getting their commitment to evidence-based measures for improving patient care, but this work is getting easier. The scientific evidence behind the care measures has become more convincing, and doctors are more comfortable using them.

ACOs will start slowly. CMS will continue making fee-for-service payments to each provider, supplementing ACOs showing high quality and efficiency with relatively small payments. But the new payments are likely to become more important over time and may well eclipse fee-for-service reimbursement. This new source of funding, covering the entire continuum of care, reminds me of capitation — the per-member, per-month payments to risk-bearing organizations that were the wave of the future 20 years ago. Capitation failed, but ACOs take a different tack. Members of the classic HMO were assigned to a gatekeeper, who controlled all their care. Although ACOs will assign patients to a "medical home" with a primary care physician, patients will have access to any physician they choose, without a referral. It will be up to the ACO to keep them happy and loyal.

Many details about ACOs still have to be worked out — by HHS in proposed rules and also by each ACO on its own, as it works out the specifics of its structure and approach. At Sacred Heart, we are planning three ACO pilot projects using different models of physician alignment. The first involves a small group of independent physicians in a medical home; the second, a larger medical group that has an infrastructure in place; and the third, physicians in a midsize group practice. We will then pick the most successful strategy and use that as a model.

One problem ACOs face is having sufficient numbers of physicians to make the system work. We don't have enough doctors in this country right now, much less when 32 million newly insured people enter the system under health reform. I believe we'll need to make it easier for mid-level providers, such as physician assistants and nurse practitioners, to step in for doctors where appropriate. This will involve changing state licensing requirements and increasing positions at professional schools. Right now, there are so few available slots for applicants at PA schools that it's as hard to get into these institutions as into some medical schools.

Obviously, the transition to this new world of healthcare won't be easy, but we have no choice — neither as a nation, trying to fix its broken healthcare system, nor as a single hospital, caught up in the tide of change. Each hospital and health system will have to transform itself, and it is up to each one of us to decide how that will be done. ■

Stephen F. Ronstrom has more than 25 years of hospital leadership experience, having served for the past 11 years as an executive in the Hospital Sisters Health System. He is currently president and CEO of the Hospital Sisters' Western Wisconsin division, which includes 344-bed Sacred Heart Hospital in Eau Claire, Wis. Learn more about Hospital Sisters Health System.

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PROGRAM SCHEDULE

Pre Conference – Thursday October 21, 2010

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

Main Conference – Friday October 22, 2010

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:40pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:45pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 23, 2010

7:00am – 8:10am	Continental Breakfast
8:10am – 1:00pm	Conference

Thursday, October 21, 2010

Session A – Turning Around ASCs, Ideas to Improve Performance and Benchmarking

1:00 – 1:40 pm
ASC Strategies for the Foreseeable Future - A View of The National Landscape Trends Through the ASC Prism - Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, and Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America

1:45 – 2:25 pm
Selling Shares and Resyndication - Larry Taylor, CEO Practice Partners in Healthcare and Melissa Szabad, JD, Partner, and Elaine Gilmer, McGuireWoods, LLC

2:30 – 3:05 pm
10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them - Brian Brown, Regional Vice President, Operations, Meridian Surgical Partners, and Reed Simmons, Administrator, Treasure Coast Center for Surgery

3:10 – 3:45 pm
5 Steps to Have Your ASC Maximize its Profits - Chris Bishop, SVP, Acquisitions & Business Development, Blue Chip Surgical Center Partners

3:50 – 4:25 pm
What Every Surgeon Should Know; What Really Matters to Your Manager? - Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

4:30 – 5:30 pm - KEYNOTE
Leadership and Motivation in 2010 - Coach Bob Knight, Legendary NCAA Basketball Coach

Session B – Spine, Orthopedics, Pain and General Surgery

1:00 – 1:40 pm
Business Planning for Orthopedic and Spine Driven Centers - Jeff Leland, CEO, Blue Chip Surgical Center Partners

1:45 – 2:25 pm
Keys to Great Success with Outpatient Spine Surgery in ASCs - Richard Wohns, MD, Founder Neospine and South Shore Surgery, Introduced by Michael Weaver, VP Acquisitions & Development, Symbion, Inc.

2:30 – 3:05 pm
Assessing and Improving the Profitability of Orthopedic, Spine and Pain in ASCs - Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America

3:10 – 3:45 pm
Building Outstanding and Profitable Pain Management Programs, Making Pain Profitable - Stephen Rosenbaum CEO, and Robin Fowler, MD, Medical Director, Interventional Management Services

3:50 – 4:25 pm
General Surgery in ASCs - What you Can and Can't Do - Bob Scheller, Jr., CPA, CASC, Chief Operating Officer, and Tom N. Galouzis, MD, FACS, President & CEO, Nikitis Resource Group

Session C – GI, Ophthalmology and Management

1:00 – 1:40 pm
GI - Centers What to Expect for the Next Five Years - John Poisson, EVP & Strategic Partnerships Officer, Physicians Endoscopy

1:45 – 2:25 pm
Benchmarking for GI Centers - Barry Tanner, President & CEO, and Karen Sablyak, EVP, Management Services, Physicians Endoscopy

2:30 – 3:05 pm
Using Ophthalmology as the Beach Head of a Center - Cataracts, Retina and IOLS Ophthalmologists as Leaders - Carol Slagle, Administrator, Specialty Surgery Center of New York, John Fitz, MD, Medical Director, Precision Eye Care, Joseph Zasa, JD, Partner, ASD Management, Moderator

3:10 – 3:45 pm
Dealing With Difficult Physicians - John Byers, MD, Medical Director, Surgical Center of Greensboro, Orthopaedic Surgical Center, Introduced by Holly Ramey, Vice President of Operations, Surgical Care Affiliates

3:50 – 4:25 pm
Tomorrow is Now, Prepare Your ASC for an Uncertain Future, Rajiv Chopra, Principal and CFO The C/N Group, Inc.

Session D – General Management and Accreditation

1:00 – 1:40 pm
How to Reduce Costs and Hours Per Case - Joyce Deno Thomas, RN, BSN, SVP Operations

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& Corporate Clinical Director, Regent Surgical Health and Nap Gary, Chief Operating Officer, Regent Surgical Health

1:45 – 2:25 pm
We Don't Need a Hospital or Management Company - Thriving as an Independent ASC - Keith M. Metz, MD, Great Lakes Surgical Center

2:30 – 3:05 pm
How to Recruit and Retain Great Talent - Doug Smith, President, BE Smith

3:10 – 3:45 pm
The Most Common Accreditation Problems - Raymond E. Grundman, MSN, CASC, former President, AAAHC, Edward Glinski, D.O., MBA, CPE, Heritage Eye Surgicenter of OK, moderated by Debra Stinchcomb, Progressive Surgical Solutions

3:50 – 4:25 pm
Infection Control in ASCs - Best Practices and Current Ideas - Cassandra Speier, Senior Vice President of Operations, NovaMed

Session E – Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Opportunities and What it Takes to Expand Services via a Collaborative Effort with the Payor - I. Naya Kehayes, MPH, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management, and Anna Gimble, VP Ancillary Services-West, United Healthcare Services, Inc.

1:45 pm – 2:25 pm
Information Technology - Key Ways to Improve Your Centers Operations - What are the Best Solutions? - Jennifer Brown, RN, Nurse Manager, Gastroenterology Associates of Central Virginia

2:30 – 3:05 pm
Meeting Today's Reimbursement Challenges: "A Case Study for Success" - Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing, and Nancy Easley-Mack, LPN, Business Office Manager, Short Hills Surgery Center

3:10 – 3:45 pm
The Top 10 Reasons Claims are Being Denied - Lisa Rock, President, National Medical Billing Services

3:50 – 4:25 pm
EMR What Should It Cost; What System Should our ASC Adopt? Best Practices; Policies and Implementation - Patrick Doyle, VP Sales, SourceMedical

Session F – Valuation and Transaction Issues

1:00 – 1:40 pm
ASC Transactions, Current Market Analysis and Valuations - Greg Koonsman, Senior Partner, VMG Health and Jon O'Sullivan, Senior Partner, VMG Health

1:45 – 2:25 pm
Selling Your ASC - A Process and Plan - What Can you Expect? - Evelyn Miller, CPA, VP Mergers & Acquisitions, United Surgical Partners International, Inc. Michael Weaver, VP Acquisitions & Development, Symbion, Inc., Tom Chirillo, SVP Corporate Development, NovaMed, Jon O'Sullivan, Senior Partner, VMG Health, Scott Downing, JD, Partner, McGuireWoods LLP, Moderator

2:30 – 3:05 pm
Co-Management Relationships With HOPDs - Krist Werling, JD, McGuireWoods, LLP and Scott Safriet, MBA, AVA, Principal, Healthcare Appraisers

3:10 – 3:45 pm
ASC and Healthcare Transactions - The Year in Review - Todd Mello, ASA AVA MBA, Principal & Founder, Healthcare Appraisers, Inc.

3:50 – 4:25 pm
ASC Litigation, Non Competition, Employee Litigation and Other Kinds of Litigation, Key Thoughts - Jeffrey C. Clark, Partner and David J. Pivnik, Associate, McGuireWoods, LLP

5:30 pm
Cocktail Reception, Cash Raffles and Exhibits

Friday, October 22, 2010

8:00 am
Introductions - Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

8:10 – 9:00 am - KEYNOTE
Politics, Healthcare Reform and the 2010 Election - Tucker Carlson, Contributor, FOX News, Editor-in-Chief, The Daily Caller and Senior Fellow, The Cato Institute

9:05 – 9:45 am
The State of The ASC Industry - Andrew Hayek, President & CEO Surgical Care Affiliates

9:50 – 10:30 am
Healthcare Reform and Its Impact on ASCs - Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, Tom Mallon, CEO & Founder, Regent Surgical Health, Marian Lowe, Partner, Strategic Health Care, Moderated and Led by David Shapiro, MD, Director of Medical Affairs, AMSURG

10:30 – 11:20 am
Networking Break & Exhibits

11:25 – 12:10 pm
General Session A
Developing a Strategy for your ASC in Challenging Times - Larry Taylor, President & CEO, Practice Partners in Healthcare, Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners, Joseph Zasa, JD, Partner, ASD Management, William G. Southwick, President & CEO, Healthmark Partners, Inc.

General Session B
Orthopedics - The Next Five Years - John Cherf, MD MPH MBA, President, OrthoIndex

11:25 – 1:00 pm
General Session C
An 80 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, Chief Financial Officer, Susan Kizirian, Chief Operating Officer, and Ann Geier, RN MS CNOR CASC, SVP of Operations, Ambulatory Surgical Centers of America

12:15 – 1:00 pm
General Session A
The Best Ideas to Immediately Improve the Profitability of Your ASC - Thomas S. Hall, Chairman, President & CEO, NovaMed, I. Naya Kehayes, MPH, Managing Principal & CEO, Eveia Health Consulting & Management, Jeff Leland, CEO, Blue Chip Surgical Center Partners, Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing

General Session B
What Works and What Doesn't in Hospital JV's - Brett Brodnax, EVP and Chief Development Officer, United Surgical Partners International, Inc. and Scott Nordlund, Vice President, Catholic Healthcare West

1:00 – 2:00 pm
Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E, F

Session A – Ideas to Improve Profits

2:00 – 2:35 pm
The Best Procedures for ASCs and What an ASC Should Get Paid - Matt Lau, Director of Financial Analysis, and Mike Orseno, Revenue Cycle Director, Regent Surgical Health

2:40 – 3:15 pm
Practical Tips for Recruiting Physicians - Dale Holmes, Administrator, Warner Park Surgery Center

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
10 Steps to Reduce Costs in ASCs - John Snyders, VP Operations and Anita Lambert-Gale, VP Clinical Services, HealthMark Partners, Inc.

4:30 – 5:05 pm
A Checklist Guide - 7 Steps to Take to Improve Profits Today - Kyle Goldammer, SVP Finance, Surgical Management Professionals

5:10 – 5:40 pm
Should 2 ASCs Merge? The Pros, the Cons and the Next Steps, Can 1+1 Make 3? - A Case Study Review - Tom Yerden, CEO & Founder, TRY HealthCare Solutions

Session B – Orthopedic and Spine ASC Issues

2:00 – 2:35 pm
Handling Complex Spine Cases in an ASC, Clinical and Financial Issues - Marcus Williamson, President, Symbion Neospine Division

2:40 – 3:15 pm
Orthopedics in a Changing Market - TK Miller, MD, Medical Director and Orthopedic Surgeon, Roanoke Orthopaedic Center and Joseph Zasa, JD, Partner, ASD Management

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Current Issues and Advances in Orthopedics - Jack Jensen, MD, Athletic Orthopedics and Knee Center, Michael R. Redler, MD, The OSM Center, John Cherf, MD MPH MBA, President, OrthoIndex, and Elaine Gilmer, JD, McGuireWoods, LLP, Moderator

4:30 – 5:05 pm
Key Thoughts on Urology, Orthopedics and Partners – Bryan Zowin, President, Physician Advantage, Inc., Rob Carrera, President, Pinnacle III, Herbert W. Riemenschneider, MD, Riverside Urology, Inc., Moderator Barton C. Walker, JD, McGuireWoods LLP

5:10 – 5:40 pm
Key Steps to Reduce Implant Costs - John Cherf, MD MPH MBA, President, OrthoIndex, John Seitz, Chairman & CEO, Ambulatory Surgical Group, and Kendra Obrist, SVP, Marketing & Product Development, Access MediQuip

Session C – GI, Opthalmology, ENT, Urology and Pain Management

2:00 – 2:35 pm
GI - How to Thrive in a Declining Reimbursement Market, Barry Tanner, CPA, President & CEO, Physicians Endoscopy

2:40 – 3:15 pm
Ophthalmology, ENT and Pain Management in ASCs - Current Ideas to Increase Profits- Tammy Ham, President, Surgical Specialty Division, and Reed Martin, Group Vice President, Nueterra Healthcare

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Taking Bold Steps to Build Case Volume - Our Direct Access, Screening Colonoscopy Program A Great Case Study - Cindy Givens, Executive Director, and Christine Corbin, MD, Medical Director, Surgery Center at Tanasbourne

4:30 – 5:05 pm
Using Anesthesia to Improve the Effectiveness of Your OR's, Marc E. Koch, MD, MBA, President & CEO, Somnia Anesthesia

5:10 – 5:40 pm
The Cost Benefit to Outsourcing Your Back Office Operations - What Can You and Can't You Outsource? - Tom Jacobs, President & CEO, MedHQ

Session D – Physician Owned Hospitals, Other Models of Physician Hospital Integration

2:00 – 2:35 pm
Healthcare Reform and Its Impact on Physician Owned Hospitals - What Does One Do Now? What are the Alternatives? - Brett Gosney, MD, CEO, Animas Surgical Hospital, and Molly Sandvig, JD, Executive Director, Physician Hospitals of America

2:40 – 3:15 pm
Adjusting to Married Life - Stories of JV Integrations with ASC Partners - Monica Cintado-Scokin, SVP Development, United Surgical Partners, Inc., and Michael Stroup, VP Development, United Surgical Partners

3:15 – 3:45 pm
Networking Break and Exhibits

3:50 – 4:25 pm
Lithotripsy Models and Current Issues with Lithotripsy ASC Relationships - Jay Sweetnich, NovaMed, Inc., Todd J. Mello, ASA, AVA, MBA, Principal, Healthcare Appraisers, Inc.

4:30 – 5:05 pm
Co-Management Arrangements - Valuation and Other Issues- Jen Johnson, CFA, Managing Director, VMG Health and Melissa Szabad, JD, Partner, McGuireWoods, LLP

5:10 – 5:40 pm
Partnership Restructuring A Case Study - Danny Bundren, CPA, JD, Symbion Healthcare

Session E – Managed Care, Revenue Cycles and Reimbursement Issues

2:00 – 2:45 pm
How to Assess if Your ASC Should be In or Out of Network - I. Naya Kehayes, MPH, Managing Partner & CEO, Eveia Health Consulting & Management, and Melissa Szabad, JD, Partner, McGuireWoods, LLP

2:40 – 3:15 pm
How to Handle New Pressure from Payors on Out of Network Issues - Tom Pliura, MD, J.D., zChart

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Ambulatory Anesthesia - Using a Management Company versus Employing an Anesthesia Team - Gregory Wachowiak, MHA, Co-Founder & President, Anesthesia Healthcare Partners

4:30 – 5:05 pm
Key Steps to Improve Billing and Increase Collections - Bill Gilbert, VP Marketing, AdvantEdge Healthcare Solutions

5:10 – 5:40 pm
10 Ways to Improve an ASCs Coding - Document Deficiencies, Financial Impacts and How to Work with Physicians - Cristina Bentin, CCS-P, CPC-H, CMA, Founder, Coding Compliance Management, LLC

Session F – Leadership, Competition and Legal Issues

2:00 – 2:35 pm
What Great Administrators Should be Paid and What They Should Do to Excel? - Greg Zoch, Partner & Managing Director, Kaye Bassman International

2:40 – 3:15 pm
The Most Common Medical Staff Issues and How to Handle Them - Thomas J. Stallings, Partner, McGuireWoods LLP

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Medical Director 101 - What it Takes to be a Great Medical Director - Dawn McLane, RN, MSA, CASC, CNOR, Chief Development Officer, Nikitis Resource Group, and Jenni Foster, MD, The ASC at Flagstaff

4:30 – 5:05 pm
How to Develop a Successful ASC Joint Venture with a Hospital - Robert Zasa, MSHHA FACMPE, Founder, ASD Management

5:10 – 5:40 pm
How to Value and Sell an Under Performing ASC - Chris Bishop, SVP, Acquisitions & Business Development, Blue Chip Surgical Center Partners

5:45 – 7:00 pm
Cocktail Reception, Cash Raffles and Exhibits

Saturday, October 23, 2010

8:10 – 8:50 am
ASCs and Healthcare - An Overview of the Key ASC Trends and Large ASC Chains -Tom Mallon, CEO and Founder, and Vivek Taparia, Director of Business Development, Regent Surgical Health

8:55 – 9:40 am - KEYNOTE
Peak Performance - How to Achieve Peak Performance as a Person and an Organization - Lt. Colonel Bruce Bright, President & CEO, The Bright Consulting Group

Concurrent Sessions A, B, C, D, E

Session A

9:45 – 10:45 am
Physicians, Hospitals, and Management Companies - What it Takes to Make a Winning Partnership and ASC - Jeffrey Simmons, Chief Development Officer, Nap Gary, Chief Operating Officer, Regent Surgical Health

10:50 – 11:50 am
How to Start a Spine Focused Center - Jeff Leland, CEO, Blue Chip Surgical Center Partners

Session B

9:45 – 10:45 am
10 Keys to Great Performance as a DON - Sarah Martin, MBA, RN, CASC, Regional Vice President of Operations, Meridian Surgical Partners, Lori Martin, RN, BSN, RT(R), Administrator, Summit Surgery Center, Anne M. Remm, RN, BSN, Administrator, Miracle Hills Surgery Center

10:50 – 11:50 am
Accreditation 101, Everything You Need to Know About ASC Accreditation - Marilyn K. Kay, RN, MSA, HFAP Nurse Surveyor, fomerly Vice President of Patient Care Services and Chief Nursing Officer, Henry Ford Bi-County Hospital, HFAP

Session C

9:45 – 10:45 am
Why Develop an ASC and Why Now is a Great Time to Do So? Key Steps for Development - John Marasco, AIA, NCARB, Principal & Owner, Marasco & Associates, and Rob McCarville, MPA, Principal, Medical Consulting Group

10:50 – 11:50 am
Can You Split Up Shares Based on Value of Cases; Can you Redeem 1 Non Safe Harbor Doctor and Keep Others in? Can You Amend Your Operating Agreement to Require Safe Harbor Compliance - Scott Becker, JD, CPA, Partner, Elissa Moore, JD, Gretchen Townshend, JD, and Sarah Abraham Chacko, JD, McGuireWoods, LLP

Session D

9:45 am – 10:45 am
Making the Best Use of Information Technology in ASCs - Marion Jenkins, Founder & CEO, QSE Technologies, Inc., Todd Logan, VP Sales, Western Region, Ron Pelletier, Director of Development, SourceMedical

10:50 – 11:50 am
Should You Sell Your Practice to a Hospital? What Will the Agreement Look Like? What are the Key Issues? - Stephen Peron, Partner, AVA, and Todd Sorenson, Partner, AVA, VMG Health

Session E

9:45 – 10:45 am
Billing and Coding - A 60 Minute Workshop to Maximize Reimbursement - Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing

10:50 – 11:50 am
How to Improve Coding for ASC Procedures - A Discussion of Orthopedic, Spine, GI and Ophthalmology Procedures - Stephanie Ellis, RN, CPC, President, Ellis Medical Consulting, Inc.

General Session

12:00 – 1:00 pm
10 Key Legal Issues for 2010 - 2011 - Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

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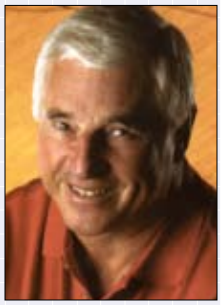
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- Tucker Carlson, Political Commentator
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Danny Bundren, VP Acquisitions and
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John Byers, MD, Medical Director,
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30 of the Most Powerful People in Healthcare (continued from page 1)

insurance market reforms that protect patients if they get sick or lose their job and offering more affordable choices through new health insurance exchanges will significantly improve our healthcare system." Mr. Baucus has been vocal on many issues concerning healthcare, including protecting Social Security and Medicare and expanding healthcare programs. Born and raised in Montana, Sen. Baucus was first elected to the U.S. House of Representatives in 1974 before being elected to the Senate in 1978, where he has served consecutively ever since.

Richard Bracken. Mr. Bracken currently serves as chairman and CEO of Hospital Corporation of America. He began his career with HCA in 1981 and has held various executive positions with the company, including CEO of the Green Hospital of Scripps Clinic and Research Foundation in San Diego, and CEO of Centennial Medical Center in Nashville, Tenn. Mr. Bracken also served as president of HCA's Pacific division. Mr. Bracken received his master's degree in hospital and healthcare administration from the Medical College of Virginia in Richmond. He has served on numerous community and professional boards, including the California Hospital Association and the United Way of Metropolitan Nashville. Upon his second retirement from the position of HCA chairman in 2009, former chairman Jack Bovender said he "could not envision a better successor or more qualified guardian of our company's legacy" than Mr. Bracken.

Mark Chassin, MD. Mark Chassin, MD, is president of The Joint Commission, where he oversees the body responsible for accrediting a majority of the nation's facilities and helps set healthcare standards that are then implemented nationwide by the Commission's member organizations. After Dr. Chassin's appointment to The Joint Commission in 2008, State Health Commissioner Richard Daines, MD, said about his colleague, "[He] is a highly respected physician and leader in healthcare quality initiatives. He has experience in both the public and private sectors and is a great choice to head the Joint Commission." Before joining The Joint Commission, Dr. Chassin was the Edmond A. Guggenheim Professor of Health Policy and founding Chairman of the Department of Health Policy at the Mount Sinai School for Medicine, New York. Dr. Chassin has contributed to the field of quality improvement through The Joint Commission and his work at Mount Sinai Medical Center, where he built a nationally recognized quality improvement program focused on achieving gains in quality of care, patient safety, clinical outcomes, family experience and working environment. A board-certified internist and experienced emergency medicine practitioner, he also served as Commissioner of the New York State Department of Health.

Francis S. Collins, MD. Dr. Collins became the 16th director of the National Institutes of Health in August 2009. A physician-geneticist noted for his discoveries of disease genes and his leadership of the Human Genome Project, Dr. Collins served as director of the National Human Genome Research Institute at the NIH from 1993 until 2008. After the international project culminated in 2003 with a finished sequence of the human DNA instruction book, Dr. Collins was awarded the Albany Medical Center Prize in Medicine and Biomedical Research. His own research laboratory has discovered several important genes, including the genes responsible for cystic fibrosis, neurofibromatosis, Huntington's disease and Hutchinson-Gilford progeria syndrome. The head of the Association of American Universities, Robert M. Berdahl, told *The Washington Post* that Dr. Collins "is acutely aware of the public policy and ethical implications of medical science." Dr. Collins has long been interested in the relationship between science and faith and has detailed his views in *The Language of God: A Scientist Presents Evidence for Belief*. He received his medical degree with honors from the University of North Carolina at Chapel Hill and spent nine years on the faculty of the University of Michigan, where he was a Howard Hughes Medical Institute investigator.

Kent Conrad (D-N.D.). Sen. Conrad has represented North Dakota in the U.S. Senate since 1986 and is a member of the Senate Finance Committee. He has written healthcare policy that ensured continued access to hospitals in rural areas and sponsored the Patient-Centered Outcomes Research Act of 2009, which would establish a research institute with the mission of generating evidence for physicians and patients on effective treatments of diseases, disorders and other health conditions. He strongly opposes a public option and voted with Senate Finance Committee Republicans in Sept. 2009 against an amendment that would have provided for a public insurance option. About Sen. Conrad, Obama campaign manageer David Plouffe said in a statement, "[He] is obviously someone who knows what it takes to get elected in a red state. He is a respected voice for the middle class, for rural America." He was also supportive of the Stupak-Pitts Amendment, which placed limits on taxpayer-funded abortions. Sen. Conrad also serves as chairman of the Senate Budget Committee.

Delos M. "Toby" Cosgrove, MD. Dr. Cosgrove, a thoracic surgeon, became CEO of the Cleveland Clinic in 2006 and has put the world-class institution front-and-center since. He re-organized clinical services into institutes, based on organs and diseases, and has taken many steps to improve the health of his 40,000 employees by refusing to hire smokers and introducing a subsidy for employees to enter Weight Watchers and fitness programs. He has also been a vocal critic of U.S. healthcare. Dr. Cosgrove joined the Cleveland Clinic in 1975 and was named chairman of the Department of Thoracic and Cardiovascular surgery in 1989. As CEO, Dr. Cosgrove presides over a $5 billion healthcare system comprised of the Cleveland Clinic, 10 hospitals and 15 family health and various ambulatory surgery centers. After Dr. Cosgrove's appointment as CEO, former Cleveland Clinic CEO Floyd Loop, MD, called his successor a "proven leader" in a statement. Dr. Cosgrove also has made a name as a heart surgeon, having filed 30 patents for products used in surgery. Dr. Cosgrove earned his MD from the University of Virginia School of Medicine in Charlottesville and completed his clinical training at Massachusetts General Hospital, Boston, and Brook General Hospital in London. He was also a surgeon in the U.S. Air Force during the Vietnam War, serving in Da Nang. Dr. Cosgrove was featured on the *Becker's Hospital Review* list of 60 notable physician leaders of hospitals and health systems.

Nancy-Ann DeParle, JD. As the director of the White House Office of Health Reform under President Obama, Ms. DeParle leads the administration's efforts on healthcare issues. Ms. DeParle, who worked with the Clintons on their health reform efforts of the 90's, is an expert on Medicare and Medicaid and helped the Obama administration expand those programs in pursuit of universal coverage. Healthcare lawyer and lobbyist Frederick Graefe commented on the appointments of Ms. DeParle and Ms. Sebelius to *The Washington Post*, saying that, "[They] are an outstanding team not only for the president but for the nation … they are both very smart and very well respected on the Hill by members of both parties." Prior to joining the Obama administration, Ms. DeParle worked in the private sector as a senior

adviser to JPMorgan and then managing director to CCMP Capital Advisors. She also taught health policy at the University of Pennsylvania's Wharton School of Business. She has sat on the boards of many health companies, from medical treatment producers to hospital systems, and her industry knowledge gives her a unique insight into the needs of various stakeholders in the healthcare debate. Ms. DeParle is a Rhodes Scholar who earned her JD from Harvard University and her master's from Oxford University.

Trevor Fetter. Mr. Fetter has served as president and CEO of Tenet Healthcare Corp. since Sept. 2003 and also serves as a member of the company's board of directors. During Mr. Fetter's tenure, he has helped achieve a peace accord with organized labor and resolved all major litigation facing the company. USC senior vice president for medical care Stephen Ryan said in a statement that "Tenet needs and deserves the talented leadership team of Trevor Fetter as President and CEO and Edward Kangas as chair of the board. We have come through difficult times in the past … I am confident that with the focus on the quality of our faculty physicians, we will continue to have great success in the future." Mr. Fetter previously served as the chairman and CEO of Broadlane, a leading provider of cost-management services to both investor-owned and non-profit hospitals. He also currently serves as the chair of the board for the Federation of American Hospitals. Mr. Fetter holds a bachelor's degree in economics from Stanford University and an MBA from Harvard Business School. He began his career with Merrill Lynch Capital Markets, where he concentrated on corporate finance and advisory services for the entertainment and healthcare industries.

Newt Gingrich. Newt Gingrich is an American politician who served as the Speaker of the U.S. House of Representatives from 1995 to 1999. During his tenure as Speaker, he represented the Republican Party in opposing President Bill Clinton and led the Republican revolution that ended 40 years of a Democratic majority in the House. He has been a vocal critic of President Obama, saying that the universal healthcare reform plan is leading America towards authoritarianism, totalitarianism and the end of democracy. Chip Kahn, who met Mr. Gingrich when he was a graduate student at Tulane, in New Orleans, told *Mother Jones*, "He always thought big thoughts. We would talk for hours about what being a leader was all about, what leadership meant, what politics were all about." Mr. Gingrich now works with the Center for Health Transformation, a collaboration of public and private sector leaders dedicated to the creation of a health system that "saves lives and saves money." According to its website, the Center advocates a "system-wide transformation" to provide cheaper, individual-centered healthcare. Mr. Gingrich is also a member of the advisory board for the Agency for Healthcare Research and Quality and sits on the Board of Regents at the National Library of Medicine.

Gary Gottlieb, MD. Dr. Gottlieb has served as president of Partners HealthCare System, one of the most visible jobs in medicine, since the beginning of 2010. Partners is the largest private employer in the state of Massachusetts with 50,000 employees and has become a potent force in healthcare. Dr. Gottlieb had a national reputation for his work in geriatric mental health when he was recruited by Partners in 1998 to become head of psychiatric services and the interim head of North Shore Medical Center in Boston. Prior to becoming president of Partners HealthCare System, Dr. Gottlieb served as president of Partners' Brigham and Women's Hospital for eight years. He has also served as co-chair

of the Mayor's Task Force to Eliminate Health disparities and as chair of the Private Industry Council, a civic workgroup that helps build the Boston healthcare workforce. About Dr. Gottlieb, Partners trustees chair Jack Connors said, "At Brigham and Women's, Dr. Gottlieb has been a strong advocate for advancing patient care and safety initiatives, supporting the hospital's research community as it opens new doors of discovery in medicine, and guiding an exceptional educational program that will lead the next generation of healthcare providers."

Chuck Grassley (R-Iowa). Sen. Grassley is a member of the Senate Finance Committee, where he serves as the Ranking Member, and has worked on creating policies to make healthcare more affordable and accessible. In 2003, he steered through Congress the first-ever comprehensive, voluntary Medicare prescription drug benefit. Sen. Grassley has been active in healthcare reform and has been helping to negotiate a bipartisan agreement on this issue. He opposes a public option and told *The Wall Street Journal*, "Government is not a competitor, it's a predator. We'd have 120 million people opt out [of private insurance], then pretty soon everyone is in healthcare under the government and there's no competitor." He has also been a staunch advocate of compliance and began an investigation about unreported payments to physicians by pharmaceutical companies. He also received the "Health Policy Hero" award from the National Research Center for Women and Families for his 2004 oversight of legislative reforms and the accountability of the U.S. Food and Drug Administration. Sen. Grassley was elected to the U.S. House of Representatives in 1974 and was elected to the Senate in 1980, where he continues to serve.

Glenn M. Hackbarth, JD. Mr. Hackbarth is the chairman of MedPAC, the commission that advises Congress on Medicare issues. He has experience as a healthcare executive, government official and policy analyst. In a news release regarding Mr. Hackbarth's appointment to MedPAC, Commonwealth Fund board chair James Tallon said, "Mr. Hackbarth is a nationally recognized leader working to move U.S. healthcare toward a high performance health system, and his diverse experiences as a healthcare executive, government official, and policy analyst will certainly enrich the board's deliberations." Mr. Hackbarth served as CEO and was one of the founders of Harvard Vanguard Medical Associates, a multispecialty group practice in Boston that serves as a major teaching affiliate of Harvard Medical School, and previously served as senior vice president of Harvard Community Health Plan and president of its Health Centers Division. Mr. Hackbarth has held various positions at the U.S. Department of Health and Human Services, including deputy administrator of the Health Care Financing Administration (now known as CMS). He currently serves as the vice chairman of the board of the Foundation of the American Board of Internal Medicine and is a board member at the National Committee for Quality Assurance and at the Commonwealth Fund.

George Halvorson. George Halvorson is the chairman and CEO of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, headquartered in Oakland, Calif. As Kaiser's CEO, Mr. Halvorson oversees the nation's largest non-profit heath plan and hospital system, which serves about 8.6 million members and generates $42 billion in annual revenue. Halvorson serves on numerous medical boards and committees, including the board of the America's Health Insurance Plans, the board of the Alliance Community Health Plans and the American Hospital Association's Advisory Committee on Health Reform. He has also served as an advisor to the governments of Uganda, Great Britain, Jamaica and Russia on issues of health policy and financing. He is deeply committed to diversity and inter-ethnic healing and is currently writing a book about racial prejudice around the world. In a statement online, Kaiser vice president and chief diversity officer Ronald Knox said that Halvorson "leads diversity by example. He holds himself and his senior executive colleagues accountable for results." Before joining Kaiser Permanente, Mr. Halvorson was president and CEO of HealthPartners in Minneapolis. He has over 30 years of healthcare management experience and has held several senior management positions with Blue Cross and Blue Shield of Minnesota. Mr. Halvorson completed his graduate studies at the University of Minnesota and earned his MBA at the University of St. Thomas in St. Paul, Minn.

Mary Kay Henry. As president of the Service Employees International Union, Mary Kay Henry has improved jobs and quality of care for American workers, as well as advocated for a more humane healthcare system. Ms. Henry began working with SEIU in 1979 and was elected to the International Executive Board in 1996. She was elected president of SEIU in May 2010 and has said that her major priorities as president are to advocate for labor rights, immigrants' rights and LGBTQ rights. In a 2008 editorial on accessible healthcare, Ms. Henry said, "Our challenge in solving this problem is not a lack of ideas, but a lack of political will. That's why SEIU is working to mobilize our nation for change: We're pulling together coalitions of business, labor, civic, and faith leaders … and we're galvanizing people across the country to elect leaders committed to fixing healthcare." After passing the position of SEIU president to Ms. Henry, former president Andrew Stern said in a statement, "I have worked side by side with Mary Kay Henry and witnessed her extraordinary passion for justice and the natural gift that can only be called her way with people." Ms. Henry received her degree from Michigan State University and joined the SEIU as a researcher just one year after graduation. During her time at SEIU, Ms. Henry has also helped provide healthcare for millions of children and strengthened the State Children's Health Insurance Program.

Karen Ignagni. Ms. Ignagni is the president and CEO of America's Health Insurance Plans, the trade association that represents the country's insurance providers. She was the leader of the American Association of Health Plans before it merged with the Health Insurance Association of America to form AHIP. Former Medicare administrator Tom Scully told MSNBC that Ms. Ignani is "always on her game and knows her substance. Health insurance CEOs come and go, but Karen has always been a constant." Ms. Ignagni also directed the AFL-CIO's Department of Employee Benefits and served as a professional staff member of the U.S. Senate Labor and Human Resources Committee. She has authored more than 90 articles on a wide range of healthcare policy issues and appears regularly before congressional committees and on national newscasts. Ms. Ignagni sits on numerous boards and advisory groups, including the Board of the National Academy of Social Insurance, the Partnership for Prevention and the Bryce Harlow Foundation, an organization that rewards individuals who work to advance business-government relations.

Charles "Chip" Kahn III. Mr. Kahn is the president of the Federation of American Hospitals, the national advocacy organization for investor-owned hospitals and health systems, and is an expert on health policy, Medicare payment, healthcare financing and the uninsured. He currently directs a lobbying group that supports access to healthcare coverage by expanding government programs and offering subsidies to those who don't quality. In March 2010, he drew attention to hospital support of healthcare reform legislation by

praising President Obama's efforts—a markedly different stance than the one he took to the Clintons' healthcare reform efforts in the 90's. He explained to *Newsweek* that there is now wide acknowledgement that quality of care has eroded since 1994 and something needs to be done. "Things are different today," Mr. Kahn said. Mr. Kahn was appointed to the governing board of the National Quality Forum and serves as a principal in the Hospital Quality Alliance. Prior to coming to the FAH, Mr. Kahn was president of the Health Insurance Association of America and focused national attention upon the plight of the uninsured during his tenure.

Michael Maves, MD. Dr. Maves serves as executive vice president and CEO of the American Medical Association, the nation's largest physician group. On his first day as executive vice president of the AMA, Dr. Maves pledged in a statement to collaborate with other healthcare organizations and industry leaders to provide the best possible patient care. "You can look at examples in American business … of times being tough and a leader or a group of leaders—and in our case, I do think this is a group exercise—coming together and saying there's a pressing need that's bigger than any of us," he said. Before joining the AMA, Dr. Maves was executive vice president of the American Academy of Otolaryngology from 1994 to 1999 and head of the Consumer Healthcare Products Association in Washington, D.C. He has served as a specialty society representative and alternate delegate to the AMA House of Delegates, as well as a governor of the American College of Surgeons. In the field of otolaryngology, Dr. Maves has distinguished himself as an accomplished academic, having held faculty positions at the Saint Louis University College of Medicine, the University of Iowa Hospitals and Clinics and Indiana University School of Medicine. He is currently an adjunct professor at the Saint Louis University School of Medicine.

Edward Miller, MD. Dr. Miller has served as CEO of Johns Hopkins Medicine since 1997. Under his leadership, The Johns Hopkins Hospital and the School of Medicine have consistently ranked among the best in the nation in *U.S. News & World Report*. Dr. Miller is currently implementing a master plan to replace aging facilities on the East Baltimore medical campus and develop a life sciences park adjacent to the campus. He also recently established the Center for Innovation in Quality Patient Care to ensure that Johns Hopkins Medicine leads the field in patient protection. About Dr. Miller's appointment to Millennium Pharmaceuticals board of directors, Millennium CEO Mark Levin said, "Dr. Miller's expertise in the area of healthcare policy, his involvement with the FDA regulatory process, and his clinical expertise at one of the world's most renowned research and medical [are] extremely valuable." A noted anesthesiologist, Dr. Miller joined Johns Hopkins as a professor and director of the Department of Anesthesiology and Critical Care Medicine in 1994. Before joining Johns Hopkins, he worked as a professor and chairman of the Department of Anesthesiology in the College of Physicians and Surgeons at Columbia University in New York. He received his MD from the University of Rochester School of Medicine and Dentistry and completed his surgical internship at University Hospital in Boston and his residency in anesthesiology at Peter Bent Brigham Hospital in Boston.

Gary Newsome. Mr. Newsome was appointed president and CEO of Health Management Associates in 2008 after spending five years in management positions at the hospital operation from 1993 to 1998. HMA owns and operates 56 hospitals, with approximately 8,000 licensed beds, in non-urban communities located through the United States. Before he began his work as president of HMA, Mr. Newsome was president of hospital operations for the division of Community Health Systems that includes hospitals in Illinois, New Jersey, Pennsylvania, Tennessee and West Virginia. William Schoen, chairman of the board of HMA, said about Mr. Newsome in 2008, "Throughout his career, including his tenure at HMA, Gary has distinguished himself as one of the hospital industry's most outstanding operating executives." Mr. Newsome began his career in hospital operations with Humana and received his master's in business administration from Butler University in Indianapolis.

John Noseworthy, MD. John Noseworthy, MD, became president and CEO of Mayo Clinic in May 2009. He previously served as the medical director of the Mayo Clinic Department of Development and a professor in the Department of Neurology. He is a vice chair of the Mayo Clinic Rochester Executive Board and led the "Mayo Clinic 2020" task force to help establish long-term institutional direction. Of his successor's appointment, former Mayo CEO Denis Cortese, MD, said in a statement, "Dr. Noseworthy is the perfect choice to continue our commitment to building on the solid foundation of our heritage as we look at providing the Mayo Clinic model of care to new people in new ways." Dr. Noseworthy specializes in multiple sclerosis and contributed to the research field for more than two decades by designing and conducting controlled clinical trials. He helped found the Sylvia Lawry Centre for Multiple Sclerosis Research in Munich, Germany, for the purpose of advancing research into effective therapies for the illness. He also served as the editor-in-chief of *Neurology*, the official journal of the American Academy of Neurology. In December 2009, Dr. Noseworthy announced his attention to keep Mayo Clinic involved in the discussion on national health reform, contending that health reforms need to reward systems that provide quality healthcare at reasonable prices. Dr. Noseworthy has an MD from Dalhousie University, Nova Scotia, Canada and completed his neurology training at Dalhousie University and the University of Western Ontario and a research fellowship at Harvard Medical School.

Barack Obama. President Obama is the 44th and current President of the United States and the first African American to hold the office. A Democrat, President Obama served as the junior United States Senator from Illinois from 2005 until 2008. He graduated from Columbia University and Harvard Law School and worked as a civil rights attorney and constitutional law professor at the University of Chicago Law School. In 2009, Obama called for Congress to approve a 1,017-page plan that would overhaul the U.S. healthcare system by adding a government insurance plan to compete with the corporate insurance sector, making it illegal for insurers to deny coverage because of pre-existing conditions and requiring every American to carry health insurance. The healthcare bill passed in the Senate without the public option in Dec. 2009, and President Obama signed the bill into law on March 23, 2010. Several states have questioned the constitutionality of the bill, and it remains to be seen whether the American public will embrace the plan. In a conference on the Affordable Care Act yesterday, President Obama said, "On July 1st, uninsured Americans who've been locked out of the insurance market because of a preexisting condition will now be able to enroll in a new national insurance pool where they'll finally be able to purchase quality, affordable healthcare—some for the very first time in their lives."

Peter Orszag. Mr. Orszag is the director of the Office of Management and Budget, which assists the President in overseeing the preparation of the federal budget and to supervise its administration in Executive Branch agencies. He served as the director of the Congressional Budget Office from Jan. 2007-Dec. 2008, and under his leadership, the agency significantly expanded its focus on healthcare. He repeatedly drew attention to the role of rising healthcare expenditures in future U.S. fiscal problems and told The American Prospect, "I have not viewed CBO's job as just to passively evaluate what Congress proposes, but rather to be an an analytical resource. And part of that is to highlight things that are true and that people may not want to hear, including that we need to address healthcare costs." Mr. Orszag served as special assistant to the President for Economic Policy, as a staff economist and as senior advisor and senior economist at the President's Council of Economic Advisers. He was the Joseph A. Pechman senior fellow and deputy director of economic studies at the Brookings Institution in Washington, D.C. Mr. Orszag recently announced that he will step down from his position in July. Commenting on his departure, White House press secretary Robert Gibbs said, "I would say obviously Peter has served alongside a valuable and within a valuable economic team that has faced the greatest economic crisis that any President has faced since the Great Depression. It has taken—it's an enormous task."

Nancy Pelosi (D-Calif.). Nancy Pelosi is the 60th and current Speaker of the U.S. House of Representatives and the first woman to hold the position. A Democrat, Ms. Pelosi was instrumental in the passage of the Patient Protection and Affordable Care Act of 2010. In 2010, Ms. Pelosi said about her determination to ensure passage of the healthcare reform bill, "We will go through the gates. If the gate is closed, we will go over the fence. If the fence is too high, we will pole vault in. If that doesn't work, we will parachute in. But we are going to get health reform passed." Ms. Pelosi was also a key figure in convincing President Obama to push for healthcare reform after the election of Republican Sen. Scott Brown, Mass. After the healthcare bill was passed in the House, House majority leader Steny Hoyer praised Ms. Pelosi in a post-vote press conference, saying she is set apart from other politicians by "her focus, her vision, her tenacity, [and] her energy." Ms. Pelosi has also worked on accelerating the development of an HIV vaccine, expanding access to Medicaid for HIV victims and securing health insurance for people with disabilities. Before being elected Speaker, Ms. Pelosi was the House Minority Leader from 2003 to 2007 and has been a member of Congress since 1987. She represents California's eighth district in the House of Representatives, an area that includes most of the city of San Francisco.

Karl Rove. Karl Rove, senior advisor and deputy chief of staff to former President George W. Bush, is a vocal critic of President Obama's plan for healthcare reform. In June 2010, he published an op-ed in *The Wall Street Journal* called "The Bad News About ObamaCare Keeps Piling Up," in which he said that millions of Americans will lose their existing coverage under the new law. He also said that "families making less than $30,000 and individuals making less than $15,000 a year will be dumped into Medicaid, widely viewed as second-class healthcare." While at the White House, Mr. Rove headed the Office of Political Affairs, the Office of Public Liaison and the White House Office of Strategic Initiatives. Though Mr. Rove is often the target of criticism, the people who know him personally paint a gentler picture of the controversial politician. "You expect a partisan who's on stage all the time, and it doesn't function that way in real life. You get a father and husband," said David Dreyer, the former deputy communications director in the Clinton White House. "I think it's sad … that we so often have such an extraordinarily one-dimensional view of people, of our fellow human beings." Since leaving his position in the Bush administration, Mr. Rove has worked as a political analyst and contributor for Fox News, *Newsweek* and The *Wall Street Journal*. He has also worked as a Republican political consultant and strategist and was credited with George W. Bush's successful 1994 and 1998 Texas gubernatorial victories and 2000 and 2004 presidential elections.

Kathleen Sebelius. Ms. Sebelius serves as the 21st Secretary of the U.S. Department of Health and Human Services, which oversees CMS, and is the principal agency for protecting the health of all Americans. Ms. Sebelius previously served as the governor of Kansas and has been a leader on healthcare issues for over 10 years. As governor, Ms. Sebelius worked to ensure every child in Kansas had healthcare, increased newborn screenings and put a renewed emphasis on childhood immunization. She was named by *Time* magazine as one of the nation's top governors in 2005. On her appointment to Secretary of the Department of Health and Human Services, Oregon governor Ted Kulongoski said, "Governor Sebelius is a proven leader and expert in the healthcare arena and has worked tirelessly as the governor of Kansas to improve and streamline their healthcare system, resulting in greater healthcare coverage and affordability for the citizens of her state." Ms. Sebelius was elected to the Kansas House of Representatives in 1986 and left in 1994 to run for state Insurance Commissioner. In this role, she blocked the proposer merger of Blue Cross Blue Shield of Kansas, the state's largest health insurer, with an Indiana-based company, marking the first time the corporation's acquisition attempts had ever been rebuffed.

Scott Serota. As president and CEO of the Blue Cross and Blue Shield Association, Mr. Serota helps oversee a national federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies. The Blue System is currently the nation's largest health insurer, covering 100 million people—one in three Americans. Mr. Serota was named president and CEO of BCBSA in 2000 after serving as a senior executive and executive vice president for system development. "Our mission is to progress the constancy of these proven, proof-based treatments at hospitals across the nation," said Mr. Serota in a statement. "Making this knowledge work to advantage providers, employers and consumers is the founding principle of the Blues' vision for better health insurance quotes." Prior to joining the BCBSA, Mr. Serota was president and CEO of Chicago-based Rush Prudential Health Plans, where he led the integration of Rush-Presbyterian-St. Luke's Medical Center Health Plans and The Prudential. Mr. Serota was appointed by President George Bush to the Policy Committee of the White House Conference on Aging, the administration and congress on policies, programs and services affecting the nation's senior citizens.

Wayne Smith. Mr. Smith has been president and CEO of Community Health Systems since 1997 and has helped the company grow from $742 million to more than $12.1 billion in net revenue. He graduated from Trinity University with a master's degree in hospital administration. Mr. Smith spent 23 years working for Humana, where he progressed from hospital administration to president and COO. While at Humana, he was tasked with turning around a financial crisis brought about by a flaw in the company's Humana Health Plans, which he successfully accomplished in two years. "Humana almost had to shut the Health Plan down, but Wayne came over and took the right amount of time to look at it and understand it," said Vicky Gregg of Blue Cross Blue Shield of Tennessee, who ran Humana's Louisville market at the time, in an interview with *BusinessTN*. "Wayne can take a very complicated situation, simplify it and make it successful." In 1997, Mr. Smith became president and CEO of CHS, where he focused his attention on purchasing non-urban, not-for-profit hospitals. CHS merged with Triad Hospitals in 2007 and is currently counted as the second largest acute-care hospital chain in the United States.

Anthony Tersigni, PhD. Mr. Tersigni has served as president and CEO of Ascension Health, the nation's largest Catholic and largest non-profit health system, since 2004. Prior to working at Ascension Health, he was president and CEO at St. John Health, Detroit, Ascension Health's largest integrated health system. Upon his appointment to president and CEO of Ascension, Mr. Tersigni said in a statement, "It's a privilege for me to lead this outstanding organization with the mission of serving the poor and vulnerable. We have a strong team with a bold agenda to take a leadership role in the transformation of healthcare." He also served the St. John system as executive vice president and COO from 1994 to 1995. He has held various senior leadership positions in other healthcare organizations, including the Sisters of St. Joseph Health System, Ann Arbor, Mich. and the Detroit Medical Center, Detroit. He also worked as a clinical professor of health and behavioral science at Oakland University, Rochester, Mich. Mr. Tersigni holds a doctorate in leadership and organizational development from Western Michigan University. He serves as the chair-elect of The Catholic Health Association of the United States. In a statement in response to the recent healthcare reform legislation, Mr. Tersigni pushed Ascension Health to "continue to be a voice in ensuring all Americans have access to quality healthcare so that we have a society that provides 'healthcare that leaves no one behind'"

Richard Umbdenstock. Mr. Umbdenstock is the president and CEO of the American Hospital Association, the national organization that represents hospitals, healthcare networks and their patients and communities. He was also past chair of the AHA board of trustees and served on the executive committee, chairing the operations committee. Mr. Umbdenstock said in an interview with *AHA News Now* that hospitals should be "performance-driven" and that the system's "philosophy is not about cost-containment. The philosophy is higher-quality care for our patients, driven by what they want." He also served on the Circle of Life committee and chaired the Task Force on Coverage & Access. Mr. Umdenstock has 11 years of experience as an independent consultant for voluntary hospital governing boards in the United States and Canada. He also served as executive vice president of Providence Health & Services, an integrated healthcare system formed through the merger of Providence Services and Providence Health System, and he served as president and CEO of the former Providence Services, based in Spokane, Wash. ■

15 Fraud and Abuse Cases Making Headlines in 2010

By Rachel Fields

The beginning of 2010 has been marked by numerous fraud and abuse investigations, cases and settlements. Here are 15 notable cases from the last six months.

1. Health Alliance of Greater Cincinnati and Christ Hospital kickback investigation settlement. The Health Alliance of Greater Cincinnati and The Christ Hospital in Mount Auburn, Ohio, agreed to pay $108 million in May to settle claims they violated the Anti-Kickback Statute and the False Claims Act. The organizations were accused of illegally paying physicians in exchange for referring cardiac patients to The Christ Hospital, a former member hospital of the Health Alliance of Greater Cincinnati. The government further alleged that cardiologists were rewarded with a percentage of time at the hospital's Heart Station based on their contributions to the hospital's yearly gross revenues, and these physicians could earn additional income for treating patients at the facility. The government claimed The Christ Hospital's use of Heart Station panel time to induce lucrative cardiac referrals violated the federal Anti-Kickback Statute and further alleged the claims submitted by The Christ Hospital to Medicare and Medicaid as a result of this illegal kickback scheme violated the False Claims Act.

2. Tuomey Hospital Stark Act violation guilty verdict. A federal jury found Tuomey Hospital in Sumter, S.C., part of Tuomey Health System, guilty in April of violating the Stark Act for providing kickbacks to physicians in return for referrals at the hospital. Federal prosecutors alleged that beginning in 2004 the hospital violated federal healthcare law by offering part-time and other employment contracts to physicians that exceeded fair market value and were nothing more than vehicles to reward referrals. Federal prosecutors also alleged Tuomey violated the False Claims Act by submitting claims resulting from referrals that violated self-referral law. However, the jury dismissed this claim, clearing the hospital of Medicare fraud charges. Tuomey was ordered in June to pay the federal government $44.9 million plus interest — and may face a new trial on an alleged False Claims violation. The case is reflective of both increased efforts by hospitals to align with physicians and increased efforts by the federal government to assure such arrangements comply with the Stark and Anti-Kickback statutes.

3. Los Angeles' City of Angels Medicare fraud consent judgement. Intercare Health Systems, formerly doing business as Los Angeles' City of Angels Medical Center, agreed to a $10 million consent judgment in May to resolve a civil lawsuit against Intercare by the United States and the state of California for a Medicare and Medi-Cal fraud scheme, according to a U.S. Department of Justice news release. City of Angels was accused of violating the False Claims Act and Anti-Kickback Statute by paying illegal kickbacks to recruiters employed at Los Angeles homeless shelters to deliver homeless patients by ambulance to the hospital for medical treatment regardless of whether their clients in fact needed or requested such treatment. City of Angels would then bill the Medicare and Medi-Cal programs for a variety of medical services allegedly rendered to the homeless patients, many of which were not medically necessary.

4. Kyphoplasty-related false claims allegation settlements. Nine hospitals in seven states agreed to pay the United States more than $9.4 million in May to settle allegations that they submitted false claims to Medicare related to kyphoplasty procedures performed between 2000 and 2008, according to a U.S. Department of Justice news release. The hospitals were accused of performing kyphoplasty, a minimally invasive procedure used to treat certain spinal fractures, as an inpatient procedure in order to increase Medicare billings when many of the cases could have been performed on a less-costly outpatient basis. The top-paying hospitals were Ball Memorial Hospital in Muncie, Ind., which paid $1,995,431, Huntsville (Ala.) Hospital, which paid $1,992,756 and Palmetto Health in Columbia, S.C., which paid $1,861,083.

5. Robert Wood Johnson University Hospital Hamilton $6.35 million Medicare fraud settlement. Robert Wood Johnson University Hospital Hamilton (N.J.) agreed to a $6.35 million settlement in March to resolve allegations that it inflated charges to Medicare patients to obtain higher reimbursements from the federal program. Medicare provides supplemental outlier payments for cases that involve unusually high costs to providers. Two whistleblower lawsuits against the Hamilton hospital alleged it inflated charges to obtain these supplemental outlier payments for cases that were not overly costly and that should not have been eligible for outlier payments. The federal government intervened in the lawsuits in Jan. 2008. As part of the civil settlement, the whistleblowers received $1.1 million of the settlement amount.

6. Five-Physician Sacramento Medicare fraud scheme. Five physicians and six others were indicted by a grand jury in June for their roles in running an alleged $5 million Medicare fraud scheme. From Feb. 2006-Aug. 2008, physicians and staff at three clinics in and around Sacramento, Calif., allegedly billed Medicare more than $5 million in fraudulent claims for treating patients who were not sick. Vardges Egiazarian, MD, the alleged leader of the scheme, admitted healthy patients were paid $100 per visit in exchange for allowing the clinic to bill for its services. In some cases, services were billed for dates when the beneficiary was deceased, according to the report. Dr. Egiazarian and another physician at the clinic, Derrick Johnson, MD, pleaded guilty last year. Dr. Egiazarian was sentenced in November to six-and-a-half years in prison and required to pay $1.5 million in restitution. A grand jury extended healthcare fraud charges to five additional physicians and six others who knowingly committed healthcare fraud.

7. Christiana Care whistleblower kickback claims settlement. Christiana Care Health System in Wilmington, Del., agreed to pay $3.3 million in March to settle claims made by a whistleblower that the health system allegedly paid kickbacks to neurologists for referring patients to its Wilmington hospital. According to the charges, Christiana Care overpaid physicians at Neurology Associates for in-hospital readings of EEGs allegedly as a "reward" for referring patients to the hospital. The court documents noted the payments were part of a contract dating to 1989, prior to the enactment of the current Stark Act and Delaware Anti-kickback Statute. Christiana Care denied any wrongdoing in the case and settled to avoid lengthy legal action. The whistleblowers in the lawsuit were a group of physicians from a competing neurology group and will receive $190,000 in the settlement.

8. Brookhaven Memorial Hospital Medical Center Medicare fraud settlement. Brookhaven Memorial Hospital Medical Center, on Long Island, N.Y., agreed to pay $2.92 million plus interest to settle allegations that the hospital inflated charges to obtain supplemental outlier payments. The U.S. Justice Department intervened in the suit and alleged the hospital defrauded Medicare by inflating its charges to Medicare patients to obtain the supplemental reimbursements, also called outlier payments. These payments are intended for cases in which the cost of care is unusually high, but the cases for which Brookhaven received outlier payments were not extraordinarily costly and should not have merited them, the government alleged. Under the civil settlement, the whistleblower received $613,000 plus interest, out of the proceeds.

9. Health Alliance and Ohio hospitals anti-kickback investigation. The Health Alliance of Greater Cincinnati, two of its member hospitals — Fort Hamilton Hospital and University Hospital — and University Internal Medicine Associates agreed to pay the United States $2.6 million in June to settle claims that they violated the Anti-Kickback Statute and the False Claims Act. The groups allegedly participated in a scheme to refer patients to UIM Associates in return for the practice providing coverage for Fort Hamilton's limited cardiology services. Under state law, Fort Hamilton could only perform the interventional cardiology procedures if it participated in a particular clinical trial involving those procedures. UIM Associates allegedly offered to provide the interventional cardiology coverage that Fort Hamilton needed for the clinical trial, but only if the hospital agreed to refer cardiology patients and procedures to the physician group on a preferential basis. The government contended that the preferential referral arrangements sometimes resulted in patients being transferred to University Hospital, or being seen by cardiologists with University Internal Medicine Associates, rather than the hospital or cardiologist of their choosing.

10. New York's Oswego Hospital $2.1M settlement for alleged Stark violations. Oswego (N.Y.) Hospital agreed to pay more than $2.1 million to the Office of Inspector General for the United States Department of Health and Human Services and the New York State Office of the Medicaid Inspector General to settle allegations that it violated the Stark Law. Oswego Hospital voluntarily contacted HHS and the state Medicaid program in March 2008 when it was discovered that a number of the hospital's business transactions from 2002 to 2007 may not have complied with Stark Law. The hospital has since implemented policies and procedures to ensure that all hospital transactions comply with Stark Law.

11. Former Massachusetts Hospital executive $500,000 kickback scheme. Former Beverly Hospital associate vice president Paul Galzerano was indicted in July in a bribery and kickback scheme that brought him nearly $500,000 in profits. Prosecutors said that Mr. Galzerano solicited and received kickbacks and bribes from contractors on a $50 million expansion project. Two contractors on the hospital project submitted inflated proposals for work on the hospital and paid the difference to Mr. Galzerano through payments on his mortgage and credit card bills, prosecutors allege. Mr. Galerzano also removed antiques, including a $10,000 century-old grandfather clock, paintings and other valuables, from the hospital and put them in his home, which he planned to sell. Mr. Galzerano was indicted along with three contractors. He and his co-defendants are scheduled to be arraigned in Salem Superior Court on July 22.

12. Texas state representative's Medicaid fraud scheme. Texas State Representative Tara R. Rios Ybarra, DDS; Diana Woo Paparelli, DDS; and Colbert J. Glenn, DDS, were indicted in June on charges that they allegedly illegally referred Medicaid beneficiaries to a Gary Morgan Schwarz, DDS, MSD, a McAllen, Texas dentist. The three dentists were charged together on a 22-count indictment. State Sen. Rios Ybarra was charged with three of the counts, which allege that she referred Medicaid beneficiaries to Dr. Schwarz in return for 15 percent of all Medicaid payments made to him for the referred beneficiaries. Dr. Paparelli and Dr. Glenn were charged similarly with three counts of the indictment. All three defendants surrendered themselves to U.S. Marshals and each currently faces prison time and a fine of up to $25,000 for each count if convicted. In late June, Sen. Ybarra was in federal custody awaiting an initial court hearing.

13. Michigan Neurologist false diagnosis accusation. Yasser Awaad, MD, a Dearborn, Mich.-based pediatric neurologist was accused in June of diagnosing patients with epilepsy when in fact the patients were healthy in order to increase the volume of tests he performed at Oakwood Hospital & Medical Center in Dearborn. A lawsuit by seven patients against Dr. Awaad and Oakwood accused Dr. Awaad of misdiagnosing patients because his earnings were tied to procedure volume. Patients diagnosed with epilepsy undergo regular testing to monitor their condition. The hospital denied tying Dr. Awaad's compensation to volume.

14. UT Southwestern's fraudulent billing charges. Federal investigators announced in June plans to further examine the billing practices at Dallas' University of Texas Southwestern Medical Center and Parkland Memorial Hospital, after previous investigations discovered the hospitals had billed the government for services provided by faculty physicians when they were performed by unsupervised residents. Internal audits have identified failure by the UT Southwestern to prevent fraud and to comply with billing laws, in spite of a decades-long investigation and several internal memos encouraging faculty physicians to ensure residents were not fraudulent in their billing practices, according to the report.

15. Federal intervention in qui tam suit against Georgia's Satialla Regional Medical Center. The United States intervened in a False Claims Act lawsuit in April alleging that Satilla Regional Medical Center in Waycross, Ga., and Najam Azmat, MD, submitted claims for medically substandard and unnecessary services to Medicare and Medicaid. Specifically, the complaint alleged, among other things, that the defendants submitted claims for medical procedures performed by Dr. Azmat in Satilla's Heart Center that the physician was neither qualified nor properly credentialed to perform. As a result, at least one patient died and others were seriously injured. The complaint stated that Satilla placed Dr. Azmat on staff even after learning that the hospital where he previously worked had restricted his privileges as a result of a high complication rate on his surgical procedures. The complaint also stated that after Dr. Azmat joined the Satilla staff, the hospital management allowed him to perform endovascular procedures in the hospital's Heart Center even though he lacked experience in performing such procedures and did not have privileges to perform them. ■

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Monitoring Your Hospital's Revenue Cycle: Six Metrics to Review Each Month

By Leigh Page

Automated systems can give a hospital a great deal of insight into many aspects of the revenue cycle by providing metrics to monitor the performance of the entire cycle, from beginning to end. It is important to review these metrics concurrently and then conduct retroactive reviews to determine ways to improve the system, according to Valerie Barckhoff, revenue cycle practice leader at Quorum Health Resources.

Concurrent review is crucial because it allows errors to be fixed before claims are sent out, but not all revenue cycle software systems offer this function, Ms. Barckhoff says. Hospitals should ensure their software either incorporates the function or provides the capability as a bolt-on.

In addition to concurrent review, retroactive review should be carried out by a revenue cycle steering committee composed of directors of the revenue cycle departments as well as clinical leadership, particularly in outpatient settings such as the ED or surgery center, recommends Ms. Barckhoff. The committee should meet regularly, probably on a monthly basis, and review 20-25 key metrics in the following areas:

1. Patient access. How accurate is registration of patients? Reporting errors in real time is important here, because you have the patient right in front of you to provide information. Another metric to look at in this area is percent of scheduled patients who are pre-registered. Pre-registration makes it easier to obtain out-of-pocket payments at the time of visit.

2. Case management. How many hospitalized patients are reviewed within one business day of admission to determine the medical necessity of their stay? This needs to be done as soon as possible to make sure the hospital will be paid.

3. Medical records. How well is the hospital capturing data on complications or co-morbidities? And how many days does it take to code for a particular encounter?

4. Charge capture. Is clinical staff entering tasks, such as blood drawing, into the medical record in a timely manner? This metric measures charges not entered within three days of service.

5. Business office. Metrics include days in accounts receivable and the "first-pass" rate, which measures how many claims go through the billing system without having to opened up and examined due to an edit. The pass-through rate should be above 90 percent. Examine what types of claims have to be opened up and find out the reason. Is there some why the process can be improved?

6. Denials by payors. Separate denials between those involving clinical issues and those involving administrative issues, such as not meeting a deadline for submission. Find out what can be done to prevent denials from occurring. ■

4 Trends in Hospital Revenue Cycle Management

By Leigh Page

Suzanne Lestina, director of revenue cycle at the Healthcare Financial Management Association, discusses four trends in revenue cycle management.

1. Integration with overall goals of the hospital. In the past five to 10 years the goals of revenue cycle management have become more closely intertwined with the larger goals of the hospital. As a result, the vice president for revenue cycle has been given expanded responsibilities, such as oversight of managed care contracting. A close working relationship with managed care helps in many ways, including making it possible to provide price estimates to patients at the point of service.

2. More focus on self-pay receivables. Out-of-pocket payments are growing in two ways. Hospitals are seeing a long-term increase in out-pocket payments by insured patients and a short-term increase in the number of uninsured patients. Effective point-of-service-payments have to overcome many barriers, such as lack of data on what the patient owes and reluctance of staff to begin the conversation.

3. Preparing for ICD-10-CM system. The ICD-10-CM diagnosis coding system, which will be adopted on Oct. 1, 2013, will be substantially more robust than the current ICD-9 system. Using optional sub-classifications, ICD-10 codes can be expanded to over 16,000 codes. Physicians and clinical coders will need extensive consultation and review, and hospitals will have to meet HIPAA 5010 requirements for electronic healthcare transactions, which will be implemented in 2012.

4. Upgrading information technology. While information technology is frequently linked to clinical data, it is just as essential for efficient oversight of the revenue cycle. Hospitals should be undertaking a thorough review of information technology to make sure it meets standards like "meaningful use," which are required to receive federal IT payments under the stimulus bill. ■

Six Revenue Cycle Inefficiencies: Key Learnings From Abbeville Area Medical Center

By Leigh Page

Abbeville (S.C.) Area Medical Center recently underwent a revenue cycle review that identified inefficiencies that, if addressed, would increase revenues by $200,000 a year, a big improvement for this 25-bed critical access hospital.

Tim Wren, CFO of the hospital, says drops in elective procedure volume spurred the hospital to examine the efficiency of its revenue cycle. "People are holding back on elective surgeries and that was a great source of income," he says. Volume fell in 2009 and has fallen 5 percent more this year.

Although Abbeville is a county-owned hospital, it is not supported by tax dollars and has to balance its budget. In 2009, Abbeville laid off 13.5 FTEs, an 8 percent reduction out of 280 employees. Despite the continued fall in volume, "we've been having a better year than last year," he says. This year, the hospital has hired back three people and no more layoffs are expected this year.

The intensive analysis, which was performed by Quorum Health Resources, helped Abbeville identify key inefficiencies in its revenue cycle. The learnings it provides can be applied to other, larger hospitals because revenue cycle does not change much with size, says Mr. Wren. Here, are six key inefficiencies identified by the analysis.

Under-coding in the ED. The review found the hospital's emergency department was not coding claims high enough for services. "We were performing the service and not billing the right level of four levels," Mr. Wren says. "We were meeting all criteria for level 3 and billing at level 2. We'd always done it that way and no one had really questioned it before." Fixing this problem alone is expected to increase revenues for the hospital by $100,000 a year, or about half of the total revenue increases expected from the review.

Not collecting at point of service. As more people move to high-deductible plans, collecting from the patient at the point of service has become more important. As at many hospitals, these changes snuck up on Abbeville and, as a result, "We didn't do well in this area," Mr. Wren says. "If you don't collect it at the point of service, you have to wait 60-90 days for the payment to be processed."

Collecting co-payments will encounter patient resistance, Mr. Wren says. Patients are going to say, "Why is the hospital going to ask me for the money when I have insurance?" The hospital is considering an ad campaign. "We really need to get the word out that we are going to be asking for payment," Mr. Wren says.

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Taking too long to code. The study found it took an average of 8.19 days after discharge to code the bill, compared with the benchmark of four days. Mr. Wren says coders will have to be held accountable to a higher level of productivity. "We've got good people," he says. "We want to get them up to a higher level of efficiency and we believe they can do it."

Taking too long to send out bills. The average time it took to send out bills after discharge was three times the best practice. There was a wide variation among types of payors in the amount of time it took to get the bills out. For example, it took an average of 20.13 days to send out a Blue Cross bill, the best rate, compared with 13.31 days to send out a Medicare bill, and 23.14 days to send out a self-pay bill. The hospital is still investigating why that is.

Gaps in case management. The hospital's one case manager works five days a week and when patients are admitted on the weekend, the physician on duty has been putting them on observation. "The patient is in a holding pattern," Mr. Wren says. "Nothing gets started until Monday." No labs, x-rays, respiratory and other services are performed, even though those services are available on weekends.

To address the gap, the hospital plans to hire a part-time case manager for weekends and other times the case manager is away from the hospital. This 0.4 FTE job should pay for itself and would be easy to fill by a case manager moonlighting from one of the larger hospitals in the area. The hospital also plans to educate its physicians on the importance of placing patients appropriately and only using observation status when it is truly the best course of action for the patient. "Physicians need to understand the financial end of the process," Mr. Wren says.

Too little charity care. The study found low-income patients who should have been identified as charity care recipients were being billed and ending up in the hospital's bad debt rate.

High days in accounts receivable. While the hospital has a good score on the average number of days a bill stays in accounts receivable, "we could probably do even better," Mr. Wren acknowledges. "We might be able to pick up four or five more days at the beginning of the process, by getting our coders to improve their processes and procedures."

Looking forward

It will take a year to implement all the recommended changes, but once they are in place, the extra revenue realized from those changes will help the hospital's bottom line.

"I'm cautiously optimistic about the future," Mr. Wren says. In the past couple of years the hospital has hired three new physicians, a general surgeon and two internists, who can bring in volume to counteract lower demand for services. ■

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5 Tips on Preparing to Meet Meaningful Use Regulations

By Rachel Fields

After the July 13 release of the final rules of meaningful use, providers all over the country are examining the 15 core regulations and 14 "a la carte" regulations to determine how and when they will quality for incentive payments. Here are five tips from three experts in meaningful use for preparing to meet these regulations.

1. Focus on the long-term benefits, not the short-term incentives. Providers seem to agree that a hospital or health system that focuses on implementing an EMR to achieve incentives, rather than to reduce error and improve quality of care, is doomed to continuously be behind the curve on implementation. Don't settle for the minimum amount of effort required to meet standards. Instead, accept that EMR is an integral part of the future of healthcare and will eventually provide great benefits to your administrators, physicians and patients — even if it doesn't seem that way during implementation.

"I think we do a lot of things that improve care and advance care, but very little of it really saves money," said John Connolly, MD, CEO of Castle Connolly, a healthcare research, information and publishing company that identifies the top doctors and hospitals in America. "I think the real savings will be in the management of chronic diseases, preventing duplicate tests and being able to access a patient's entire medical history. Obviously that's going to result in better care. I'm not optimistic about cost savings. I think improved quality should be the focus."

Karen Burton, in-house healthcare expert for integrated information and technology solutions provider Logicalis, says that the hospitals who are struggling with implementation are those who "only started on it because of the regulation." At first, she says the hospital administrations looked at the requirements for incentive payments and asked, "What can we do with the limited funds we have?" They failed to note that the less they did to implement a successful EMR, the more it would cost them in reimbursements every year from 2011 to the foreseeable future. It's not just about the payments in 2011; make your implementation as thorough, permanent and successful as possible to guarantee the highest reimbursements from here on out.

Focusing on long-term benefits means getting your organization's leadership team on board with EMR for the long haul. "No EHR implementation is going to be successful just because there's a regulatory or reimbursement reason," says Randy Thomas, vice president of integrated product management and marketing for Premier healthcare alliance, a performance improvement alliance of 2,300 non-profit hospitals.

2. Build pockets of connectivity. Ms. Thomas says that while it may not be obvious now, connectivity between EHR systems is happening incrementally all over the country. "With each additional connection point, it begins to get to that tipping point for greater and greater connectivity," she says. "We're not going to flip a switch five years from now and suddenly connect everyone, but one of these days we'll look at the big picture and see that a lot of connectivity has been built over [these gradual implementations]."

Ms. Burton also recommends that facilities plan to submit data to state and local health information exchanges. By submitting data to an HIE, an organization can move clinical information among disparate healthcare information systems and help more organizations provide safer, timely, patient-centered care. The 2012 core meaningful use regulations require organizations to electronically submit clinical quality measures to government agencies, and getting used to sharing data electronically can prepare your organizations for these kinds of requirements.

In addition, hospitals should extend their EMR to their affiliated physicians and to their patients. The core regulations for EMR use require providers to "implement capability to electronically exchange key clinical information among providers and patient-authorized entities."

3. Plan for the staged deadlines. Don't plan your implementation around the requirements for 2011 and assume that the work is over. "The thing that people need to understand is that the requirements are fairly minimal for 2011 and then they get much tougher in 2013 and much, much tougher in 2015," says Ms. Burton. For example, she says, imaging for radiology and cardiology is not required to be integrated until 2015, but Logicalis recommends that hospitals start thinking about it now. "It's a pretty complicated thing to do, and there's some technology infrastructure that needs to be in place so that you can do it effectively."

In determining how your organization should plan its implementation to meet meaningful use requirements by 2011, Susan Kanvick, healthcare knowledge leader for Point B's healthcare practice, says you should read over the list of "a la carte" regulations and pick those that are easiest to meet by the first deadline. "I recommend prioritizing by level of effort required to meet and have at least one or two as contingency," said Ms. Kanvick. "It also depends on timing. If they are delaying to the last possible time frame to meet "meaningful use" regulations, they might want to consider getting as close as they can to all ten, because they will become part of the core regulations in the next stage."

4. Look at your existing quality reporting processes. Quality reporting will be an integral part of meeting meaningful use requirements, as providers will be required to report clinical quality measures to state or federal organizations through attestation in 2011 and electronically in 2012. Ms. Kanvick recommends examining your existing reporting functions. "They are likely by necessity fairly reactive and distributed through the organization," she says. "Consider how to better approach the collecting, interpretation of and reporting on quality data."

5. Choose a vendor that will help you get to meaningful use. Don't get too bogged down in the details of how to meet each requirement that you lose sight of your plan, Ms. Burton says. In her experience, many hospitals that started with a "best of breed" system, in which several different applications are used for different hospital needs, are taking a look at their eventual goals for meaningful use and instead deciding to spend the money on an integrated system. "Highly integrated enterprise EMR applications kind of guarantee you'll get to meaningful use," she says.

When picking a system, Dr. Connolly says it's important to pick a system that seems to have the potential be compatible with other systems. "Choosing carefully is very important," says Dr. Connolly. "You want to choose a system where you can connect hospitals to community-based physicians and to patients and to other hospitals." ■

To view a complete list of the core and a la carte regulations visit: https://www.cms.gov/EHRIncentivePrograms/Downloads/NPRM_vs_FR_Table_Comparison_Final.pdf

CMS Launches Official Website for EHR Incentive Programs

By Rachel Fields

The Centers for Medicare & Medicaid Services has launched the official website for the Medicare & Medicaid electronic health record incentive programs. These programs, established as a result of the Health Information Technology for Economic and Clinical Health Act, will provide incentive payments to eligible professionals and hospitals who adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

The CMS incentive program will involve a set of rules that determine whether hospitals are paid for their EHR use. CMS is currently developing the final rules for release.

Visit the http://www.cms.gov/EHRIncentivePrograms to learn more about program eligibility, how to register, meaningful use and EHR training events. ■

Two EHR Giants to Merge, Anticipating Federal IT Payments

By Leigh Page

Allscripts and Eclipsys, two major providers of electronic health records and other healthcare IT, announced plans to merge and create a universal EHR, according to a release from both companies.

The companies said the merger would help clients qualify for $30 billion in federal funding for hospitals and physicians who adopt of electronic health records. The EHR funds were earmarked in the stimulus bill, the American Recovery and Reinvestment Act, and begin in 2011.

The companies cited a Congressional Budget Office report predicting EHR adoption by physician practices would grow from 12 percent to 90 percent by 2019.

The merger is worth $1.3 billion in stocks. The combined companies' client base includes more than 180,000 physicians, 1,500 hospitals and almost 10,000 nursing homes, hospices, home care and other post-acute organizations. ■

Survey Shows CIOs Feel Unprepared To Meet Meaningful Use Requirements

By Rachel Fields

Eight in 10 hospital CIOs surveyed said they are concerned or very concerned that they will not be able to demonstrate "meaningful use" of electronic health records before the federal deadline in 2015, according to a report by PricewaterhouseCoopers titled *Ready or not: On the road to meaningful use of EHRs and health IT*.

The American Recovery and Reinvestment Act allocated billions of dollars in 2009 to help hospitals purchase equipment to computerize patient records. The deadline is five years off, but even state-of-the-art hospitals are struggling to meet meaningful use requirements, according to the survey of 120 hospital CIOs.

The survey found that only half of CIOs surveyed say they expect to meet the first set of requirements in 2011. According to the report, the biggest obstacles to meaningful use for hospitals are lack of clarity on guidelines for system certification, shortage of skilled IT staff and existing infrastructure capabilities.

The survey found that health systems that involve patients, physicians and other team members in EHR planning are more confident about meeting requirements. In order to improve their organizations' successes with EHR, 63 percent of CIOs said they are already working with physicians around meaningful use issues or plan to do so within the next six months. ■

Chuck Lauer: 10 Points on Leadership

By Chuck Lauer, former publisher of *Modern Healthcare* and an author, public speaker and career coach

1. Leading is not the same as managing. There is a huge difference between managing and leading. "Leaders do the right thing and managers do things right," it has been said. While managers focus on working toward the organization's goals, orchestrating resources in an effective and efficient manner, leaders need to engage in strategic thinking. They need to pay less attention to details and focus on the big picture.

2. Don't live in a bubble. Great leaders listen to their people, obtaining a variety of perspectives from a variety of sources. This helps them distill their own decision-making. They ask employees what they think and probe them on the pros and cons of a proposal. This not only shows employees that they are valued but also gets the leader closer to the best solution.

3. Cherish and respect employees. Leaders function as enablers, helping employees perform their jobs to the nth degree. A leader can only get work done through other people. Employees who get respect will produce at their highest capacity and make the leader look good. Make sure people have the tools to do their jobs — and the freedom to make mistakes!

4. Choose a clear mission. Leaders make sure the mission of their organization is plainly articulated and followed day in and day out. A mission statement can sound nice and look really good, but it has to be more than a bunch of words. It should be the very heart and soul of what the organization is about. It should inspire and direct.

5. Demonstrate integrity. Successful leaders recognize that the way they behave reflects the principles and ethics of the organization. Integrity and ethics are essential for any leader. A leader cannot just be "one of the boys." Leaders need to stand above the rest and show the way.

6. Be transparent. Great leaders don't believe in secrecy or closed-door meetings. They must conduct themselves with transparency and openness so that rumors don't start and employees don't feel shut out. Leaders who are frank rather than evasive — even about difficult issues — will be able to win employees' trust.

7. Embrace responsibility. Outstanding leaders come in all shapes and sizes, from a variety of backgrounds, but what really sets them apart is their enjoyment in taking on responsibility and willingness to make tough decisions when necessary. Leaders don't waffle or equivocate. They make sure their decisions are fair-minded and balanced.

8. Share credit. Leaders know the value of giving credit to others, even as they step forward immediately to take the blame for losses, so that their people are protected and valued. "A leader is best when people barely know he exists," the Chinese philosopher Lao Tzu said. "When his work is done, his aim fulfilled, they will say, 'We did it ourselves.' "

9. Leadership isn't for everyone. Not all that many people want to take the hard hits that leaders have to absorb, regardless of whether they run a hospital, a clinic or a restaurant. A study of graduate students several years ago showed that well over 60 percent did not want the responsibility of being a leader. While there are many talented people, only a select few will embrace a leadership role.

10. Have courage. Leadership requires courage. Leaders have to go beyond just taking care of their own careers. They need to engage in calculated risks that will secure the future of the whole organization. This is especially important in these trying times, when healthcare is faces so many enormous challenges. ■

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

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The Current State of Infection Control

By Leigh Page

Reported cases of hospital-acquired infections have been increasing, moving from ICUs to general beds, and these infections are causing more deaths, higher costs of care and more litigation against hospitals.

For example, there were 94,000 cases of HAIs from methicillin-resistant *Staphylococcus auerus* in 2005, and nearly one in five infected patients died from it, according to a white paper from TeleTracking, a software company that offers patient flow automation solutions.

Hospitals are feeling the financial impact. TeleTracking reports MRSA-related hospital stays tripled since 2000. HAI patients have an average length of stay of 20.6 days, compared with 4.5 days for other patients. What's more, the typical hospital is named in seven HAI-related lawsuits each year, each with an average settlement of $1.5 million, the white paper says.

"We live in a world of germs, and hospitals are no exception," said Susan Sewell, RN, vice president of patient management at Methodist Healthcare System in San Antonio.

What is being done

"Bloodstream infections from catheters are nearly 100 percent preventable with clear, actionable steps," said Cathryn Murphy, RN, president of the Association for Professionals in Infection Control and Epidemiology.

APIC reported hospitals that use advanced technology for healthcare-associated infection surveillance are more likely to implement best practices for infection prevention. And yet in a recent APIC survey of infection control professionals, only 30 percent reported their leaders were willing to budget for preventive measures.

The Obama administration is offering $50 million to states to promote quality initiatives and will begin penalizing hospitals with high infection rates beginning in 2015. Meanwhile, 27 states now require hospitals to report data related to hospital-acquired infections and most of them publicly report the results, which could lead to more lawsuits against hospitals.

In June, the Ohio Hospital Association reported 53 Ohio hospitals working together reduced central line-associated bloodstream infections in ICUs by 48 percent over six months. The project aims to reduce the mean the infection rate to less than one per 1,000 catheter days over 18 months. ■

Using Automated Systems to Reduce Infection and Contamination Risk in Your Hospital

By Renee Tomcanin

The increasing rate of hospital-acquired infections costs U.S. hospitals up to $45 billion annually, says the Centers for Disease Control and Prevention, and the average cost per infection case is $15,275. Another troubling fact is that hospital-acquired infections, such a methicillin-resistant *Staphylococcus auerus*, are moving from ICUs into general wards.

Using automated systems is one way hospitals can better monitor and document isolation beds to reduce infection risk. Methodist Healthcare System in San Antonio, was able to employ these systems to cut down on infection risk to patients as well as staff at their facility. In this article, several experts involved in Methodist's effort discuss the benefits of using automation to reduce infection risk.

Lack of communication

Documenting and designating isolation rooms were the biggest challenges for Methodist Healthcare System when it came to preventing the spread of infection. Susan Sewell, RN, vice president of patient management, says lack of communication led to the breakdown. "Often in the hospital setting, we are good at communicating in a silo, and we often forget that other people need to know specific data about a patient. A patient may be well documented as an infection case within the unit, but transportation personnel may not be told when moving someone to, say, radiology," she says. If they aren't aware, the transporter will move along to the next floor taking the dirty wheelchair, and the infection, with them.

Ms. Sewell says unit staff was also documenting isolation beds and infectious patients on paper for their specific area; however, this information was not communicated to key stakeholders throughout the organization, making it an ineffective approach. "We also tried to include stickers on patient charts and signage in a room if a patient was an infection risk, but often the documentation was taken down before housekeeping came to clean the room putting them at risk; if signage did remain and was seen by the housekeepers, housekeeping staff had to return to their housekeeping department to retrieve all the necessary supplies to appropriately clean the room — adding valuable minutes to the bed turn time and further delaying patient flow," she adds.

Methodist Healthcare System decided in order to cut the risk to both patients and staff, it needed to find a better way to communicate about at-risk patients.

Building a team

Methodist Healthcare System chose to work with Pittsburgh-based TeleTracking Technologies to develop its bed tracking management system. "We integrated the TeleTracking bed tracking system with our existing ADT system, so we can recall patient history data and use it in our patient flow technology," Ms. Sewell says.

Bed management is crucial to minimizing infection risk. TeleTracking's system includes a HIPPA compliant electronic bedboard, which displays patient information, including infection status. "The system tracks patients throughout every move in the hospital, and the patient boards help to educate patients and patient placement coordinators," Ms. Sewell says.

Housekeeping and transportation are also included in the loop, as information related to infection status is communicated electronically and proactively to each department. "The system has created increased awareness among staff members. Now everyone can know infection status and feel like part of the team. Before, housekeeping and transportation didn't know until they were already in the room," Ms. Sewell says.

Micki Lerch, FACHE, patient flow specialist with Avanti, a division of TeleTracking, says, "The transparency of an automated system enables other employees to help nurses in the process. It saves time. They are already at the admit board and can access the system."

Methodist Healthcare System took infection control through the system one step further by including a field for isolation need in its bed request system. Starting July 1, the isolation field must include an attribute or indicate "none" in order for the patient to be placed in a bed. This assures that isolation status is addressed in all admission source areas.

Ms. Sewell says, "We struggled when we first started the system to include that field when placing patients in beds. Now, we have made infection control one of the top priorities, supported by placing a hard stop on bed requests before infection status is known."

Once the bed request is put through, the system searches for available beds at any of Methodist Healthcare Systems' six hospitals that fit the attributes included with the patient, starting first with private rooms and then looking for other patients with similar diseases or attributes. "It creates a cohort of patients within the hospital," Ms. Sewell says.

Using data to cut infection risk

Even with an automated system, infections can still break through. Methodist Healthcare System has been able to leverage its system to prevent a repeat event.

"If there is an infection that gets through, staff members can go back and perform an audit and see the points where the patient has been as well as what assist staff has been in contact with the patient," says Joy Avery, RN, MSN, CEN, patient flow specialist with Avanti.

Ms. Sewell notes that data can be broken down even further. "It is important to have a system that is user friendly, so you can go in and adjust and add available alerts, such as dirty beds and infection status changes, to the system." The automated system also pulls key metrics, such as bed turnover time and patient flow data, which can be shared with nursing directors and senior leadership. "We are able to monitor every step in the process on a hospital-wide and unit-by-unit basis," Ms. Sewell says. "For instance, certain areas are an increased risk to patient safety if patients are held there, so we look at the system and track the time it takes us to place patients. By improving the process, we improve patient satisfaction, patient safety and patient flow."

A good automation system should allow the end users, typically nurses, to be comfortable with the system, so that they can easily input and access data. Ms. Lerch says, "You need to have the ability to easily identify what flow metrics you want to measure and to report these metrics. If they can see the metrics, it adds to accountability throughout the process."

Bringing the C-suite on board

A key strategy to improve patient flow efforts including infection control knowledge is the buy-in and support of senior leadership "You need buy-in from the top down," Ms. Sewell says. "We had reluctance when we decided to put a full-stop on patient placement before infection attributes were defined, but when we made the senior leaders and nursing directors aware of the impact, they supported our decision."

Ms. Avery agrees. "It takes senior leadership buy-in [to be successful] throughout the system, otherwise effect change and efficiency will not take place. Engagement is key," she says. ■

Learn more about TeleTracking at www.teletracking.com.

Hospital-Acquired Infections by the Numbers

Deaths. Based on the current infection rate, the average 500-bed hospital sees 194 unnecessary deaths a year. Nearly one in five patients infected with methicillin-resistant *Staphylococcus auerus* patients die from it, a toll greater than deaths from AIDS.

Costs. HAIs cost hospitals up to $45 billion a year and the average hospital incurs $28 million in unnecessary costs per year due to HAIs. Surgical-site MRSA infections alone cost as much as $60,000 per case and the average case costs $15,275.

Litigation. The typical hospital is the target of seven HAI-related lawsuits per year with an average settlement of $1.5 million, for a total of $10.5 million per hospital. Now that 27 states require hospitals to report incidence of HAIs, the number of awards is expected to rise.

Source: "Overlooked and Under-Protected," a white paper on HAIs developed by TeleTracking Technologies.


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TeleTracking's solutions protect against inadvertent exposure by automatically communicating information about isolation to those employees in real-time. It's part of a comprehensive on-line patient flow process which registers "blocked" rooms immediately and offers a host of reports and auditing tools to aid in infection control, from bed history to transport history.

If your infection-control nurses still prepare blocked room lists manually, consider that isolation only works if everyone knows about it. Inadvertent exposure can defeat even the best hand-washing compliance behavior.

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Electronic Infection Monitoring Shown to Improve Adherence to Infection Prevention Best Practices

By Jaimie Oh

Research conducted by the Association of Professionals in Infection Control and Epidemiology has found that hospitals that use advanced technology for healthcare-associated infection surveillance are more likely to put in place best-practices for infection prevention than those hospitals that do not, according to an APIC news release.

APIC's study examined 241 acute-care hospitals in California and looked at the relationship between hospital use of automated surveillance technologies and implementation of evidence-based infection control practices.

The final results showed that hospitals that relied on computer technology to detect HAIs (currently one-third of hospitals in the state) were able to better apply evidence-based prevention practices to help reduce infections, such as MRSA infection and ventilator-associated pneumonia, more than those that implemented manual practices.

Automated surveillance technologies or data mining systems are computerized systems designed to collect infection data, thereby allowing infection preventionists to better protect patients by identifying and investigating potential clusters of HAIs in real time. Electronic surveillance streamlines the review and collection of infection data, provides a larger amount of information than manual methods and reduces staff time spent on surveillance and clerical tasks, allowing infection preventionists to devote more time to activities that protect patients. ■

APIC Study: Hospitals Still Struggle With Infections

By Jaimie Oh

Healthcare-associated infections continue to be an obstacle that hospitals struggle to overcome, according to a study by the Association for Professionals in Infection Control and Epidemiology.

More than half of the surveys respondents said catheter-related bloodstream infections remain a persistent problem due to lack of time directed toward prevention, improper equipment maintenance, lack of time to adequately train staff, inability to reinforce use of best practices and use of time-consuming paper-based system.

Although half of the respondents agree their leadership acknowledge the problem of infections, only 30 percent report that their leaders are willing to spend the money for preventative measures.

"Bloodstream infections from catheters are nearly 100 percent preventable with clear, actionable steps," said APIC President Cathryn Murphy, RN, PhD, CIC, in an APIC news release. Yet, approximately 80,000 patients in the U.S. become infected by CRBSIs, with about 30,000 of those patients dying as a result of those infections. ■

Michigan Hospitals' Infection Control Program Spreading to Other States

By Barbara Kirchheimer

A Michigan program to reduce hospital-associated infections is catching on nationwide as the Obama administration offers $50 million to states to promote quality initiatives and will begin penalizing hospitals with high infection rates beginning in 2015, according to a report in the *Detroit Free Press*.

The Michigan program — which includes new oral hygiene regimens and staff checklists to help prevent catheter, ventilator and central-line infections — has been cited by three federal agencies as a way to reduce infections in other states. It is currently used in 118 Michigan hospitals, according to the report.

Part of the program's funding has been provided by the Keystone Center for Patient Safety & Quality, part of the Michigan Health & Hospital Association, which says it reduced statewide central line infections in 2008 to 1.2 cases per 1,000 days of patient use, compared with 2.4 cases nationwide, according to the report. ■

PHA President Brett Gosney: The Future of Physician-Owned Hospitals

By Rachel Fields

Following the March 2010 passing of the health reform bill, the future of physician-owned hospitals is uncertain. Starting in 2011, the law prohibits existing physician-owned hospitals from expanding and prevents new ones from being built. Here, Brett Gosney, president of Physician Hospitals of America and CEO of Animas Surgical Hospital in Durango, Colo., discusses the effect of the health reform law on physician-owned hospitals and how physician-owned facilities can respond.

Impact of reform

Existing hospitals cannot expand. The legislation will allow existing physician-owned hospitals to keep doing business, with a few notable exceptions: starting in 2011, they can no longer expand the number of inpatient beds or operating rooms or increase the percentage of physician ownership. For example, if a physician-owned hospital is 50 percent physician-owned at the date of enactment, it will not be able to exceed 50 percent from there on.

Hospitals under development must be completed and Medicare certified by the end of December. Under the new health reform law, physician-owned hospitals currently under development will not be allowed to open if they have not achieved Medicare certification by December 31, 2010. "This is where the bill is extremely damaging financially," Mr. Gosney says. "We estimate there are over 100 hospitals under development, and about half of them can be Medicare certified by the end of the year." Mr. Gosney predicts that physicians will be forced to sell their interest in the hospital to a non-physician entity so that the facility can open instead of defaulting on loans and on its lease.

No new physician-owned hospitals. This part is very simple, Mr. Gosney says: after December 31, 2010, the only physician-owned hospitals will be those that already exist.

How to respond

There are three basic ways that physician-owned hospitals can proceed to fight the existing legislation or pursue other options, according to Mr. Gosney

File a lawsuit. Mr. Gosney's hospital, along with Texas Joint and Spine Hospital, has filed a lawsuit in federal district court claiming that the health reform law's regulations on physician-owned hospitals are unconstitutional. According to Mr. Gosney, the lawsuit says that the health reform law specifically targets physicians as being unable to own a hospital in America. "A businessman from Thailand could own a hospital, a church could own a hospital – anyone could own a hospital except a doctor," he says. The lawsuit also claims that the language on physician-owned hospitals in the healthcare bill —only one and a half pages out of 3,000 — is capricious, vague and arbitrary and therefore unenforceable.

Continue the legislative battle. According to Mr. Gosney, the Physician Hospitals of America has tackled numerous bills attempting to ban physician-owned hospitals in the last 10 years. The PHA will continue the legislative battle on Capitol Hill and use its government contacts to try and amend the language.

Explore alternative physician ownership structures. "The reason doctors get involved with physician-owned hospitals is so they can better serve practices and patients," Mr. Gosney says. For this reason, he says that his hospital is exploring ownership structures that will deliver the benefits of pure physician ownership. "Nothing quite as satisfying, clean and good for the patient as physicians owning facilities, but some kind of agreement where the physician would still have a vested interest in the success of the facility." ■

JAMA Article Suggests Many Physicians Fail to Report Impaired Colleagues

By Lindsey Dunn

An article appearing in the latest issue of the *Journal of the American Medical Association* suggests that more than a third of physicians may fail to report an impaired or incompetent colleague.

The study, led by researchers at the Mongan Institute for Health Policy at Massachusetts General Hospital in Boston, found that while 64 percent of surveyed physicians agreed with the professional commitment to report physicians who are significantly impaired or otherwise incompetent to practice, 36 percent did not agree with the statement in all cases.

According to the study, 17 percent of physicians had direct personal knowledge of a physician colleague who was incompetent to practice medicine, but of these, only 67 percent reported the colleague to a relevant authority. The study found that most often physicians do not report colleagues because they believe someone else will do so or nothing would happen as a result of the report.

The lead author of the study, Catherine DesRoches, told the *Wall Street Journal Health Blog* that self-regulation of physician competency could use improving, and physicians likely need more education about how and when to report impaired colleagues. ■

High Readmission Rates Not Necessarily Connected to Poor Hospital Quality

By Jaimie Oh

Research done by Cleveland Clinic shows that, contrary to popular belief, high readmission rates may not necessarily equate to substandard hospital care, according to a report published by the U.S. Department of Health and Human Services.

In fact, the researchers, using data from more than 3,000 U.S. hospitals, found that a higher rate of readmissions for heart failure was connected to a lower 30-day mortality rate.

The researchers suggest that improving patient survival rates past the one-month mark may require extra physician visits, procedures or surgery, which consequently increases the 30-day readmission rate.

Cleveland Clinic researchers began to examine high readmission rates when they noticed their 30-day readmission rate, at 28 percent, was worse than the national average of 24.7 percent. Yet, their 30-day death rate for Medicare patients with heart failure of 8.8 percent is better than the national average of 11.2 percent. ■

One-Quarter of Hospital Patients Readmitted Within Two Years

By Lindsey Dunn

One-quarter of all hospital patients were readmitted one or more times for the same condition within a two-year period, according to a release by the Agency for Healthcare Research and Quality.

Several conditions showed even higher rates in AHRQ's analysis of data on 15 million patients in 12 states from 2006-2007. More than one-third of atherosclerosis patients, 30 percent of patients with uncomplicated diabetes and 28 percent with high blood pressure were readmitted within two years.

Broken down by insurance status:

- For Medicare patients, 42 percent had multiple hospital admissions and 38 percent multiple ED visits.
- For Medicaid patients, 23 percent had multiple hospital admissions and 50 percent had multiple ED visit.
- For uninsured patients, 22 percent had multiple hospital readmissions and 38 percent had multiple ED visits.
- For private payor patients, 19 percent had multiple readmissions and 29 percent had multiple ED visits. ■

HHS Adds Hospital Outpatient and ED Quality Data to Public Websites

By Lindsey Dunn

The Department of Health and Human Services will now include quality information about outpatient and emergency department care at hospitals across the United States on its HealthCare.gov website as well as CMS' *Hospital Compare* website (www.hospitalcompare.hhs.gov), according to an HHS news release.

Previously, the sites only included quality data for inpatient services. New outpatient and ED measures include:

- Rates of outpatient MRIs for low back pain;
- Rates of outpatient re-tests after a screening mammogram;
- Two ratios that explain how frequently outpatient departments gave patients "double" computed tomography scans when a single scan may be all that is needed;
- Measures that show whether outpatients who are treated for suspected heart attacks receive proven therapies that reduce mortality such as an aspirin at arrival; and
- Measures to determine how well outpatient surgical patients are protected from infection.

"Adding outpatient quality measures to *Hospital Compare* will give consumers a more complete picture of the quality of care available at local hospitals," Barry M. Straube, MD, CMS chief medical officer and director of the Agency's Office of Clinical Standards & Quality, said in the release. "In particular, the heart attack and surgical care outpatient measures can be viewed alongside of the inpatient data we already report for these conditions, thus providing a comprehensive look at what facilities in your area are doing to provide high-quality, high-value care."

In addition to outpatient care measures, CMS has updated data for outcomes of inpatient hospital care, including new 30-day mortality rates and thirty-day readmissions rates for inpatients admitted with heart attack, heart failure and pneumonia. ■

Medical Errors Cost $19.5B in a Single Year

By Jaimie Oh

The Society of Actuaries' Health Section has published a research report measuring the annual frequency of medical errors in the United States and the total measurable cost to the United States economy because of these errors, according to a news release by SOA.

Analyzing data from 2008, the report found that of 6.3 million measurable medical injuries, approximately 1.5 million were associated with a medical error. The total cost per error was estimated to be approximately $13,000, resulting in a total cost to the United States economy of $19.5 billion.

Eighty-seven percent, or $17 billion, of that amount is due to medical costs of providing inpatient, outpatient and prescription drug services to individuals who were affected by the medical errors.

An additional $1.4 billion of the total amount was due to indirect costs of increased mortality rates, and another $1.1 billion was related to lost productivity due to short-term disability claims. ■

Study Finds Financial Incentives and Public Reporting Improve Quality of Care

By Lindsey Dunn

A recent study by RAND Corp. found that performance-based accountability systems do indeed increase performance throughout the public sector, including healthcare.

The study, "Toward a Culture of Consequences: Performance Based Accountability Systems for the Public Sector," examines the use of performance-based accountability in five public sectors — child care, education, public health emergency preparedness, transportation and healthcare. Researchers found that in optimum circumstances, these systems — which link financial or other incentives to measured performance — are an effective way to provide better public services.

Within the healthcare sector, researchers found that "pay-for-performance programs," which typically include small financial incentives — frequently combined with public reporting — have modestly improved the quality of care delivered.

However, the study also found that creating an effective performance-based accountability system requires careful attention to choosing the right design for the system, which must be monitored, evaluated and adjusted as needed to meet performance goals.

The study, co-authored by 10 RAND researchers whose collective expertise spans all of the five sectors examined, makes several recommendations to developers of performance-based accountability systems, including:

- Realize that performance-based accountability systems are not always the best option for improving performance. Designers must consider those factors that may hinder or support a system's effectiveness.
- Determine if the performance measures are at the individual, department or organizational level.
- Make the performance rewards large enough to matter, but not larger than the actual benefit of the improved performance.
- Create measures that people can influence. Do not hold people accountable for problems outside of their control.
- Implement the program in stages to allow for opportunities to modify the program as needed, and to identify and fix shortcomings in the program.
- Monitor and evaluate the program. This is the only way to detect problems and improve the accountability system over time. ■

6 Key Issues and Trends Impacting Outpatient Services and Physician-Owned Facilities

By Scott Becker, JD, CPA, and Barbara Kirchheimer

This article briefly addresses six key issues impacting outpatient services and physician-owned facilities.

1. Covering more people will lead to the reallocation of limited healthcare dollars. With the goal of bringing insurance coverage to an estimated 30 million people, the healthcare reform law will necessarily reallocate some of the dollars spent within the healthcare system.

The individuals who will gain insurance coverage under the new law are likely to be low-paying, which means the system will have to absorb a great number of additional covered lives with very little additional aggregate reimbursement. Most new patients will be covered at amounts close to Medicaid reimbursement rates.

Over the next three to five years, the new law does very little to take dollars out of the overall system. However, in the longer term, the reallocation of dollars from this influx of newly covered individuals is likely to increase the pressure to cut costs. The likely scenario five years out is a very different distribution of healthcare dollars and potentially significant tax increases.

2. Erosion of independent medical practice. Against this backdrop, the independent practice model is losing its appeal for many physicians. While aligning with a hospital does not directly reduce physicians' overall outpatient workload, it does affect the entrepreneurial side of their outpatient business.

Available statistics vary on the percentage of physician practices currently owned by hospitals, but it is clear that the number of physicians seeking hospital employment is on the rise.

Physician search firm Merritt Hawkins indicates the percentage of physician search assignments it conducted involving hospital employment rose to 45 percent in 2009 from 23 percent in 2005. Tommy Bohannon, Merritt Hawkins' vice president of hospital-based recruiting, says he expects that figure to jump to more than 50 percent on the firm's next annual survey.

In certain sectors, such as cardiology, the trend is even more pronounced. In his blog, *The Lewin Report*, American College of Cardiology Chief Executive Officer Jack Lewin, MD, took an informal poll asking whether cardiologists had integrated their practices with a hospital in 2009. Some 12 percent responded that they had, while another 21 percent said they had concrete plans to integrate and another 50 percent said their practice was thinking about doing so within the next two years.

"A cardiologist that's part of a hospital system, the revenues they can produce for that system can be very, very good because of the use of ancillary services," says David Gans, MSHA, FACMPE, vice president of innovation and research for the Medical Group Management Association. "Consequently the hospital can support the physician well."

These shifts are likely to affect the prospects for physicians' entrepreneurial business endeavors. Independent practitioners have generally been the lifeblood of ASCs, physician-owned hospitals and other types of freestanding healthcare entrepreneurial ventures. Even slight changes in the total number of independent physicians can have a huge impact on the economies of scale of surgery centers and physician-owned hospitals. These businesses, like any type of business, work with a fairly fixed set of costs. A large portion of their profit accrues after a base number of cases are brought in to cover basic fixed costs. Thus, incremental cases drive their profitability. If the incremental cases are taken somewhere else through employment arrangements with hospitals and other systems, the physician-owned facility is left in a much tougher position.

Several factors are driving this trend in physician employment. The top four are:

Money: Hospitals can afford to pay physicians well due to the technical fees the physicians generate for hospitals. "The hospital can legitimately preclude its competition and bring those doctors in as admitters and users of ancillary services, so these are the same practices that are better revenue-generators for the hospital," MGMA's Mr. Gans says

Money: Physicians are very concerned about the uncertainty of future reimbursements.

Money: Many physicians took a significant hit in the stock market and real estate crash and are seeking a perceived lower-risk practice environment.

Work-life balance: Many physicians who graduated over the past decade seem more focused on work-life balance and more predictable hours than a business owner would have.

Scott Gottlieb, MD, a practicing internist, former CMS official and current fellow at the American Enterprise Institute noted this trend in a recent opinion piece in the *Wall Street Journal*. "Doctors, meanwhile, are selling their practices to local hospitals," Gottlieb wrote May 18 in the *WSJ*. "In 2005, doctors owned more than two-thirds of all medical practices. By next year, more than 60 percent of physicians will be salaried employees. About a third of those will be working for hospitals, according to the American Medical Association."

Dr. Gottlieb goes on to mention that a hospital with which he is affiliated recently formed a new subsidiary to purchase local medical practices. "Nearby physicians are lining up to sell — and not just primary-care doctors, but highly paid specialists like orthopedic surgeons and neurologists. Similar developments are unfolding nationwide."

According to Dr. Gottlieb's analysis, salaried physicians and further consolidation of medical practices will leave patients with fewer options and longer waiting times.

3. There are roughly 5,200 Medicare-certified ASCs. While the number of Medicare-certified ASCs increased by over 50 percent from 2001-2008, the rate of growth has slowed significantly. According to MedPAC's June 2009 Data Book, there were 5,174 Medicare-certified ASCs in 2008, up only 3.7 percent from 4,991 in 2007. By contrast, in 2007, the number grew 6.2 percent, in 2006 it grew 5.8 percent, and in 2005 it grew 7.3 percent.

An industry expert and founder of a leading ASC company recently hypothesized 2010 might be the first year in which there is a net loss in the total number of ASCs across the country. Of the nation's Medicare-certified surgery centers, 20 percent to 35 percent have a hospital partner, and another 20 percent to 30 percent are rumored to be losing money at any given time.

4. Revenues for outpatient services will be under tremendous pressure. As discussed above, the erosion of the independent medical practice will likely lead to either a deceleration in or actual reduced case numbers, which will contribute to the pressure on revenue for outpatient services. In addition, reimbursements for services from commercial payors and Medicare will face significant downward pressure.

The hospital industry and the pharmaceutical industry are among the projected winners in the healthcare reform legislation. Each have secured a substantial portion of the healthcare budget for the foreseeable future and are somewhat protected from significant reimbursement risk. Here, the Federation of American Hospitals and PHRMA made big bets that healthcare reform would pass, paid big dollars to hire Chip Kahn and Billy Tauzin to negotiate their positions with the White House and Congress and by all accounts seem to have succeeded in their efforts. That leaves other healthcare sectors more vulnerable to reductions as these big areas remain somewhat protected.

Insurance companies will also be exercising more authority over physicians. As Dr. Gottlieb notes in his *Wall Street Journal* opinion piece, the pending standardization of minimum insurance benefits in 2014 and mandates on insurers to fully cover certain primary care services will make it harder for them to control their expenses.

"One of the few remaining ways to manage expenses is to reduce the actual cost of the products," Dr. Gottlieb writes in the *WSJ*. "In healthcare, this means pushing providers to accept lower fees and reduce their use of costly services like radiology or other diagnostic testing."

5. Co-management arrangements on the rise. These alternatives to traditional hospital-physician joint ventures seem to be gaining momentum as a way for hospitals to align themselves with independent physicians. Under these arrangements, hospitals either hire physicians or groups to manage service lines or they actually buy a business line from physicians and then have the physicians manage the area. For example, a hospital may buy up an ASC from physician-owners (or develop one) and convert it to a hospital outpatient department. The HOPD then commands higher reimbursement rates. Physicians give up equity but take on less financial risk.

It is not clear how long these co-management arrangements will continue to be the new hot thing. It is likely they will remain important for some time to come.

Co-management arrangements also carry with them some legal concerns. Those that are structured with "aggressive" payment arrangements may well need to be rethought and possibly restructured if the federal government intervenes and raises objections.

6. Great management. It is likely that well-managed firms will continue to thrive even in a much tougher economy for surgery centers, free-standing imaging facilities and other physician-driven businesses. Several leaders have show that it is possible to thrive in a tough business line. One of the largest imaging companies, for example, continued to thrive at a time when most other imaging companies struggled to survive. At this time, it is more important than ever to hire great leadership and bring in top level management team. ■

10 Simple Ways to Contain Costs: How Sacred Heart Hospital Saved $5M

By Lindsey Dunn

When $7 million of Eau Claire, Wis.-based Sacred Heart Hospital's revenue was threatened by the opening of a competing outpatient facility, its leaders devised a plan to recoup $5 million of the lost revenue by reducing expenses — the remainder could be made up through increased volumes. Guided by the work of Michael Rindler and his book "Strategic Cost Reduction," leadership launched the Strategic Performance Improvement Initiative. As part of this initiative, unit directors were assigned to performance improvement groups and were asked to examine every expense, identifying key areas for reducing costs.

"We created diverse groups of directors that traditionally wouldn't work together," says Faye Deich, COO of 344-bed Sacred Heart Hospital and senior vice president, division operations for HSHS Western Wisconsin Division. "This brought a new set of eyes asking questions such as 'why is that this way?' or 'why do you spend so much on that?'"

All departments were asked to cut the same percent from their budgets, which was then translated to a specific dollar amount to better guide the performance groups. "Cuts were made evenly across departments and everyone had to contribute. No department was given a pass," says Ms. Deich.

The groups successfully identified $5.7 million in savings, with $3.3 million coming from non-labor expenses. After just six months of its SPI program, the hospital achieved a savings of $5.1 million, with $2.7 million of that not related to labor. How was Sacred Heart able to achieve such significant savings in such a short period of time? Namely through evaluating and renegotiating vendor contracts, reports Ms. Deich.

"How we do business has really shifted," she says. "Leaders more closely scrutinize costs and what vendors offer, and we've really tried to create a culture where paying attention to costs is a regular part of life."

Here are 10 of the areas Sacred Heart was able to create a significant reduction in its costs.

1. Knee/hip implants — $500,000 saved. Sacred Heart's surgical department successfully negotiated the cost of its knee and hip implants down $500,000 without switching vendors. "Part of what we learned was that many of our leaders came from the clinical side and didn't have training in the art of contract negotiation," says Ms. Deich. "They learned to be much firmer on what they'd accept for pricing and communicated their position with surgeons. You don't want to walk away from a vendor if you're surgeons won't back you up."

2. Blood — $226,000 saved. "We thought we were possibly paying too much for our blood services, but the contract was due, so we told the vendor we'd sign for one year and then do an RFP the following year," says Deich. "The next year, the vendor dropped the price dramatically."

3. Thrombin waste — $120,000 saved. Sacred Heart realized its surgical department was wasting a considerable amount of Thrombin, a very expensive coagulation medication used in neurosurgical procedures. "Neurosurgeons had nurses open a certain number of vials and put it in a sterile basin. If it wasn't used, it was tossed," says Ms. Deich. "We talked to the neurosurgeons about changing this process. If you make sure your physicians understand the cost of what they're using, they are typically very willing and supportive of the change."

4. Syringe preservative change — $60,000. "Our pharmacy took a look at the costs associated with PCA [Patient-Controlled Analgesia] pumps given to patients after surgery. We learned the syringes we were using were designed for a very long shelf life of 90-100 days," says Ms. Deich. "We evaluated how frequently the turnover of our PCA syringes were and realized we were using most within 10 days, so we could switch to a different preservative with a shorter shelf life and realize significant savings."

5. Online journal subscriptions —$46,000. Sacred Heart switched the subscriptions to medical and other educational journals it covers for staff from print to online subscriptions, which created nearly $50,000 in savings.

6. Office supplies — $42,000. Before cost savings measures were put into place, employees could order any items he or she wanted from the office supply vendor. In order to address costs in this area, the hospital began to restrict supply requests to an approved, standardized list of products and required a supervisor to approve any request beyond the approved list. "We had no idea how many little things were being ordered and how quickly they added up," says Ms. Deich.

7. Contrast standardization — $36,000. Sacred Heart worked to standardize the contrast medication given to patients undergoing radiological imaging. "We worked with a GPO to get the medication and a lower rate and worked with radiologists to convert more patients, when medically appropriate, to the same contrast medication," says Ms. Deich. "That allowed us to leverage our volume for lower rates."

8. Soft drinks — $24,000. "We had stocked our physicians' lounge with bottles of soda, and they would grab a bottle," says Ms. Deich. "We switched to fountain drinks, and saved $24,000 in one year." The switch reduced waste and brought about significant savings.

9. Electronic pay notification — $16,800. Sacred Heart stopped printing and mailing pay notifications to employees and instead provided electronic pay notifications via e-mail to employees enrolled in direct deposit. This saved the hospital $16,800 on printing and postage costs.

10. Trash liners — $15,000. By simply switching to a new vendor, the hospital saved $15,000 in one year on trash can liners alone. "While $15,000 isn't a lot, the little things add up," says Ms. Deich. "The bigger message is you have to be willing to look at every detail to find every opportunity for savings." ■

Hospital & Health System Executives Moves

Bob Allen, CFO of 350-bed Valley Presbyterian Hospital, is leaving the Van Nuys, Calif.-based hospital to take up a new job as CFO of Catholic Healthcare West's California Hospital Medical Center in Los Angeles and Glendale (Calif.) Memorial Hospital.

Scott Cihak was appointed the new CEO of 250-bed Columbia Hospital in West Palm Beach, Fla.

Michael A. Clark signed on as Salt Lake City-based Intermountain Healthcare's Logan Regional Hospital's new CEO.

Laurie Ebertst, founding president and CEO of Mercy Gilbert Medical Center in Gilbert, Ariz., is leaving the Catholic Healthcare West hospital for a position at a sister hospital in California.

David Fikse is stepping down as CEO of Southside Regional Medical Center in Petersburg, Va., for an executive position at Community Health Systems in Franklin, Tenn.

Garden City (Mich.) Hospital appointed **Tim Jodway** as the new vice president and CFO.

Bill Leonard has taken on the role of president at Carolinas Medical Center-University in Charlotte, N.C.

Tim Noakes, CFO and interim CEO of Sonoma Valley Hospital in Sonoma, Calif., left his post for a new career opportunity in Central Valley, Calif. The hospital later named **Kelly Mather** as its next CEO.

Mike Patterson will act as the interim CEO of Colorado Plains Medical Center in Fort Morgan, Colo.

Mission Health System of Asheville, N.C. appointed **Ronald Paulus, MD**, as its new president and CEO.

H.L. Perry Pepper, president of the Chester County Hospital and Health System in West Chester, Pa., announced his retirement. Mr. Pepper had been the longest-tenured hospital president in the Philadelphia area.

Megan Perry was named corporate vice president of Northern Virginia for Sentara Healthcare and president of Sentara Potomac Hospital in Woodbridge, Va.

Rich Robinson is named the CEO of Yakima Regional Medical & Cardiac Center in Yakima, Wash.

David Shulkin, MD, was appointed the new president of Atlantic Health's Morristown Memorial Hospital in Morristown, N.J., where he will also act as the vice president for the hospital.

Scott Smith has been appointed the new CEO of Lake Wales Medical Center in Lake Wales, Fla.

St. Petersburg, Fla.-based All Children's hospital appointed **Nancy Templin** as its new CFO.

Detroit Receiving Hospital President **Iris Taylor** was named the new chief business officer of 2,000-bed Detroit Medical Center. ■

Hospital and Health System Transactions

All Children's Hospital and Health System of St. Petersburg, Fla., has signed a letter of intent to integrate with Johns Hopkins Medicine.

New Smyrna Beach, Fla.-based **Bert Fish Medical Center** has officially merged with **Adventist Health System**.

Richmond, Va.-based **Children's Hospital of Richmond** officially joined **VCU Health System** of Richmond.

An affiliation agreement has been reached between **Cleveland Clinic**'s cardiac surgery program and **Central DuPage Hospital** of Winfield, Ill.

A merger agreement has been finalized between **Covenant Health** of Knoxville, Tenn., and **Morristown-Hamblen Healthcare System** in Morristown, Tenn.

Emory Healthcare of Atlanta and **Hospital Corporation of America** have decided to end their partnership over Emory Johns Creek Hospital, which Emory will take over, and Emory Eastside Medical Center, which HCA will take over.

Fort Hamilton Hospital of Hamilton, Ohio, has officially joined Dayton, Ohio-based **Kettering Health Network**.

Jewish Hospital & St. Mary's Healthcare of Louisville, Ky., rejected a $1 billion offer from **Community Health Systems**.

Marion (S.C.) Regional Healthcare System has officially been acquired by **Community Health Systems**.

Marquette General Hospital of Michigan and **Bell Hospital** in Ishpeming, Mich., have agreed to affiliate and now form Superior Health Partners.

The city of New Orleans has offered to pay Universal Health Services $16.25 million to acquire **Methodist Hospital**, which has been closed since Hurricane Katrina.

Scott & White Healthcare of Temple, Texas officially announced a partnership with **Trinity Medical Center** of Brenham, Texas.

Spectrum Health of Grand Rapids, Mich., and **Zeeland (Mich.) Community Hospital** are exploring a merger.

Edmonds, Wash.-based **Stevens Hospital** and Seattle's **Swedish Hospital** agreed to a merger, which will give Stevens Hospital up to $6 million each year for health programs.

St. Joseph's Health System in Atlanta and **Piedmont Healthcare** stopped merger discussions because the two groups could not agree on how to structure the deal.

Washington, D.C., has acquired **United Medical Center** for $20 million. ■

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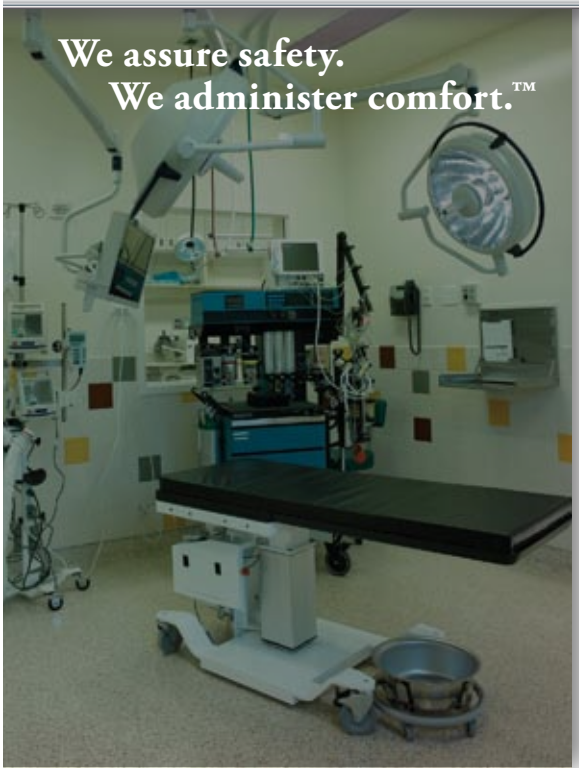

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