See page 20 for the Becker's Hospital Review CEO of the Year

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BECKER'S
Hospital Review
BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

10 Best Practices for Increasing Hospital Profitability

By Lindsey Dunn

Hospitals today face many challenges including an economic recession, increases in uninsured care and growing competition for outpatient services. However, there are still many steps hospitals can take to increase their profitability amid these economic conditions.

Industry experts say that hospitals wishing to increase their profitability can focus on two key areas — reducing costs and increasing reimbursement. Here are 10 best practices for increasing hospital profitability by reducing costs and increasing revenue and reimbursement.

1. Reduce staffing costs by using data to drive staffing decisions. Because labor is the largest single expense for hospitals, it is

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Hospitals and Health Systems: The Best of Times and the Worst of Times (2009)

By Scott Becker, JD, CPA, Elissa Moore, JD, and Renée Tomcanin

Hospitals and health systems, whether general acute care hospitals or specialty hospitals, are attempting to prosper in a challenging time. Last year and in 2007, the nation's hospitals, as a whole, recorded record profits. Many hospitals were examining a multitude of options for debt financing. Nearly 20 percent or more of the nation's hospitals were in the process of renovating, expanding or replacing their current hospitals.

As of 2009, the freezing of the financial markets, the loss of the value in hospital and related foun-

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15 Hospitals and Health Systems With Great Cardiovascular Programs

Allegheny General Hospital (Pittsburgh). Allegheny General Hospital is a 724-bed academic medical center located on Pittsburgh's historic North Side. The hospital, which is home to the Gerald McGinnis Cardiovascular Institute, is recognized both nationally and internationally for its outstanding heart program. Physicians at Allegheny conducted the nation's first echocardiogram, were the first in the state to perform a heart-valve replacement, opened the first freestanding outpatient cardiac catheterization laboratory in the state and conducted Pittsburgh's first FDA-approved ventricular-assist device implant.

The hospital aims to offer outstanding care to its patients through the research and educational

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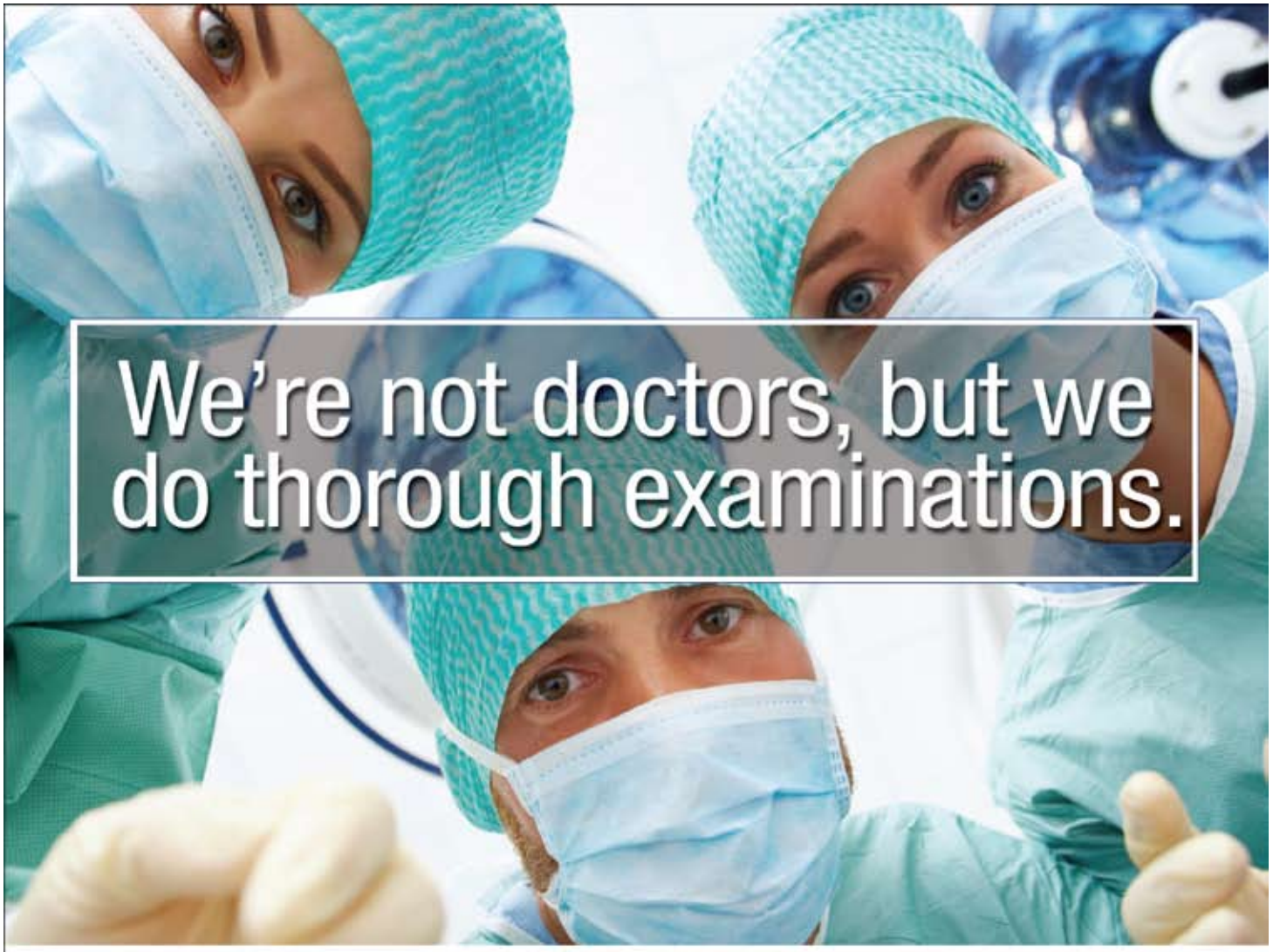

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FEATURES

Publisher's Letter

Healthcare Reform; Hospitals and Health Systems: Improving Profitability of Orthopedic and Spine Programs - Growing Volumes, Assessing Financial Relationships, and Business and Legal Issues – October 7th; 16th Annual Improving the Profitability of ASCs Conference (Oct. 8-10, Chicago) - Special Discounts Available; Free White Papers Available

The first six months of 2009 have been an extraordinary time in the healthcare sector. First, this letter first discusses certain observations regarding healthcare reform. Second, this letter notes new white papers available and provides information on two upcoming conferences.

1. Healthcare reform. The healthcare industry, including both payors and providers, is starting to consolidate its positions against significant healthcare reform. Healthcare reform can briefly be categorized into two distinct parts. First, covering the uninsured. Most parties are wholly for some method of assuring that all people have coverage. With coverage, the core concerns seem to be will coverage lead to reduced reimbursement or to extraordinary national debt. Second, providing an alternative option, a "public option" for insurance, to traditional managed care plans and companies. It is the second part of healthcare reform that has parties greatly concerned.

From a payor perspective, a public option is viewed as government-sponsored competition against them. Further, they have concern that a government-sponsored model will be less expensive, that the government will have to deal with less problems (e.g., can unilaterally set rates and it will be immune from lawsuits) and that it will significantly and negatively impact the number of parties that are covered by the traditional large insurance companies.

From a provider perspective, a public option is concerning because providers get paid, on average, substantially less by governmental plans than they do by commercial plans. For example, hospitals are paid approximately 70 percent by government plans compared with what they get paid by commercial plans. Surgery centers and physicians are generally paid between 70-80 percent on average by governmental plans as compared to commercial plans. Thus, the migration of patients from commercial plans to public plans is viewed by providers as likely to cause a substantial negative direct hit to their revenues. This revenue loss would, in most places, be a direct negative reduction to the bottom line.

Over the last few months and next several months, as the President increases efforts to implement substantial healthcare reform, it will be interesting to see the extent of efforts by parties such as the American Medical Association, the American Hospital Association and the Association of Health Insurance Plans to respond to the President's efforts. At first, these parties tended to give positive lip service to the concepts of healthcare reform. Now that they see that the administration seems quite serious about healthcare reform, the gloves are beginning to come off.

2. White Papers. If you are interested in any of the following white papers, please feel free to e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com and we will be happy to provide them to you.

1) 10 Best Practices for Increasing Hospital Profitability, by Lindsey Dunn.

2) Improving and Maintaining the Profitability of Orthopedic and Spine Practices – 12 Areas of Focus, by Renée Tomcanin.

3) HIPAA Settlements Between Health Care Providers and the Government, by Anna Timmerman.

4) What Hospitals Needs to Know about ARRA and the HIPAA Updates, by Anna Timmerman.

3. E-weekly: Becker's Hospital Review and Becker's ASC Review. If you would like us to add you to the Becker's Hospital Review E-weekly, please e-mail me at sbecker@mcguirewoods.com or go to www.BeckersHospitalReview.com. If you would like to be added to the Becker's ASC Review E-weekly, please go to www.BeckersASC.com or e-mail sbecker@mcguirewoods.com.

4. 16th Annual ASC Conference: Improving Profitability, and Business and Legal Issues. ASC Communications with the ASC Association has two large conferences planned for the fall. First, we have our 16th Annual ASCs Improving Profitability, and Business and Legal Conference on Oct. 8-10 at the Westin Hotel in Chicago. This year we have nearly 97 speakers and nearly 70 sessions. We have great speakers from the surgery center industry as well as outstanding outside speakers such as Bill Lane, long-term speech writer for Jack Welch; Norm Ornstein, a political commentator of American Enterprise Institute; Craig Frances, MD, a leader in healthcare investing from Summit Partners, and several others. To register for the event, please contact the ASC Association at (703) 836-5904. The brochure for the event is also online at www.BeckersASC.com. If you register for the event, and provide a copy of this letter (or reference this letter) with your registration, and register by Aug. 15, please feel free to deduct an extra $100 from the conference registration.

5. Hospitals and Health Systems: Improving the Profitability of Orthopedic and Spine Programs. We have a second conference planned for Oct. 7. This conference is titled Hospitals and Health Systems: Improving the Profitability of Orthopedic and Spine Programs – Growing Volumes, Assessing Financial Relationships, and Business and Legal Issues. Should you have an interest in this program, please contact (800) 417-2035 or e-mail Scott Becker at sbecker@mcguirewoods.com.

Should you have questions about any of the issues raised in this letter, please feel free to contact me at (312) 750-6016 or at sbecker@mcguirewoods.com.

Very truly yours,

Scott Becker

10 Best Practices for Increasing Hospital Profitability
(continued from page 1)

critical that hospitals are not over- or under-staffing their facilities.

Hospitals leaders can consider the use of flexible staffing, such as part-time or hourly employees, and adjust staffing based on patient census data. Leaders should also monitor the efficiency of this staffing by continuously reviewing benchmarking data such as hours worked per case.

Amy Floria, CFO of Goshen (Ind.) Health System, says that her facility monitors patient volume on a daily basis and adjusts staffing accordingly. "We adjust our nursing staffing every eight hours after looking at our inpatient volume and expected discharges and admits," she says.

Kevin Burchill, a director at Beacon Partners, a healthcare management consulting firm, agrees that staffing must be adjusted daily. "The easiest thing that a hospital can do to improve profitability is for the senior management team to assume responsibility for the day-to-day performance of an organization and look at the organization's performance in real time," he says. "You must shift to an emphasis on the day-to-day, not pay-period to pay-period or month-to-month."

It is important that concerns regarding efficient staffing are communicated throughout the organization and that hospital leaders work in collaboration with physicians. Donna Worsham, COO of National Surgical Hospitals, suggests that hospital leaders share staffing efficiency benchmarking data with unit managers and provide feedback regarding the productivity of the unit.

Flexible staffing is especially useful for OR nursing staff. OR managers should review clock-in times versus surgery-start times and determine if their staff is consistently arriving before a surgery actually begins. If this is the case, mangers can utilize flexible staffing to allow nursing staff to arrive later so that when surgeries run over, no overtime expenses are incurred, says Ms. Worsham.

Other facilities are saving in staffing costs by reducing benefits for full-time staff. Goshen Health System, for example, deferred merit increases, reduced paid vacation time and suspended its retirement matching program in response to the current economy, according to Goshen's CEO, Jim Dague. Goshen reduced employee dissatisfaction in response to these cuts by soliciting employee feedback on which benefits to reduce, thereby building organizational support for the changes. In addition, Goshen's executives took a voluntary 20 percent cut in order to help sustain the system through the recession.

Joe Freudenberger, CEO of OakBend Regional Medical Center in Richmond, Texas, agrees that staff must buy in to any reductions in hours and shifts worked that will personally affect them in order for the hospital to remain successful. He says that hospital leaders must communicate the reasoning for these changes to the staff before making them. "If we call off staff, they see it as personally hurting their income when we need to help them understand that it is actually preserving their income by maintaining the financial viability of the hospital," he says. "It may be obvious to us that we're calling them off because we have a significant reduction in patient volume but we need to communicate that to them for them to understand the financial realties we face."

Although some staffing cuts may be necessary, hospitals should be careful not to take a blanket approach to layoffs or cuts in services. Hospital leaders must take a close look at their business before making cuts.

"Don't make the same mistake everyone else does — don't look at bottom line, determine that you need to cut $1 million, for example, and

then cut 10 percent across the board. Doing so will trim some fat but will cut meat and bone in other areas," says Mr. Burchill.

He suggests that hospitals assess each program individually and determine which ones are what are winners and losers. "You do not want to cut areas that you should be doing more of or that are already profitable," says Mr. Burchill.

2. Reduce supply costs by better managing vendors. Hospital leaders can reduce supply costs by working with vendors to improve contracts and encouraging physicians to make fiscally responsible supply decisions.

"When it comes to supply costs, you must drive this expense or the vendor will drive it for you," says Ms. Worsham.

Hospital leaders should not shy away from approaching vendors for discounts. Goshen's IT director recently requested a discount on the health system's contract for IT maintenance due to current economic conditions and successfully received a discount that saved the hospital 15 percent on this contract, according to Ms. Floria.

Hospitals can also reduce supply costs be reducing the number of vendors. Goshen, for example, is in the process of reducing the number of vendors in its surgical suite and aims to eventually scale the vendors down to 4-6 companies. "This action is expected to save us at least a million dollars in supply costs," says Mr. Dague.

Another way in which hospitals may reduce supply costs is by requiring vendors to submit purchase orders for any equipment or implants that are not included in a negotiated, written agreement with the facility. "All of our vendors sign agreements that any purchase orders must be submitted at least 24 hours before a procedure and must be approved by the materials manager or the CEO, or it's free," says Ms. Worsham. "If you don't require this, vendors will drop off the invoice for a pricey piece of equipment or implant after the procedure has already taken place and walk out the back door, which can greatly hurt your profitability."

3. Ensure that your OR is utilized by physicians efficiently. All hospitals can benefit from tightening up the efficiency of their operating rooms, but it is especially critical that less busy facilities ensure that their ORs are used as efficiently as possible.

"Hospitals need to review block time utilization," says Ms. Worsham. "Physicians who are assigned more time than they are using are hurting your profitability."

Ms. Worsham suggests that hospital OR managers work directly with physicians to make OR utilization more efficient.

"When physicians' schedules create gaps in the OR schedule, it effects a hospital's ability to staff effectively, which can create significant labor costs for the hospital," says Ms. Worsham.

4. Involve physicians in cost reduction efforts. Hospitals should work to encourage physicians to become more concerned about the costs of supplies and other activities, such as unnecessary tests and inefficient coding processes that may drive up hospital costs.

"Hospitals today have a unique opportunity to leverage physicians' interest in having hospitals help to stabilize their incomes with the hospitals' needs to involve physicians in cutting costs and improving quality," says Nathan Kaufman, managing director of Kaufman Strategic Advisors, a hospital consulting firm.

Hospitals can encourage the use of products from vendors that are cost-effective, but still high quality, especially in areas such as orthopedic implants, which can be considerably costly for hospitals. In addition, experts say the use of protocol-based care can reduce costs associated with unnecessary tests or treatments.

Mr. Freudenberger says that one of the biggest mistakes hospitals make is not engaging medical staff in profitability. "Physicians have a huge role in maintaining hospital profitability, but unless you give them a reason to be concerned with a hospital's profitability, they will make choices in what and to whom they refer services that will not consider the implications to the hospital," says Mr. Freudenberger. "Hospital leaders should work to help medical staff understand the connection of their referrals to the hospital's viability so that their referral decisions reflect the value they place on the hospital."

5. Consider outsourcing the management of some services. During tough economic times, some hospitals may benefit from outsourcing or partnering with other organizations for certain services, such as food and laundry services, and even, in some cases, clinical services.

"Some hospitals see these economic times as an opportunity to outsource unprofitable services," says Mr. Burchill.

By outsourcing certain services to more efficient providers, hospitals can share the savings with the service provider. However, hospitals must be sure to select truly efficient providers.

"Outsourcing is clearly a smart thing to do if an organization can gain greater efficiency through finding a larger-scale operation; however the provider must be more efficient than the hospital," says Kevin Haeberle, executive vice president, HR capital, for Integrated Healthcare Strategies.

Oftentimes, hospitals outsource services such as laundry, food and nutrition, information technology or human resources because they do not have the capital to invest in the equipment upgrades or training that is needed to increase the efficiency of their internal service. In these cases, the decision to outsource may not directly be related to profitability but instead the "lacking of funds for the investment required to make current services viable," says Mr. Haeberle. However, this decision can improve profitability in the long-run by allowing hospitals to use funds for more profitable services.

Some hospitals have also begun to outsource clinical services such as emergency room staffing and anesthesiology in an attempt to become more efficient. Because these staffing groups employ a large number of specialty physicians, they may be able to provide more efficient services, especially in clinical areas that require around-the-clock coverage where the demand for services is high.

Mike Mikhail, MD, vice president of client services for Emergency Physicians Medical Group, says that hiring an emergency department management company can help to improve the profitability of hospitals whose demand for emergency services exceeds its emergency treatment capabilities. "An emergency management group can help make the emergency department more efficient by introducing management oversight and best practices, allowing more patients to be seen and keeping others from leaving to find another hospital," he says. "Because a majority of hospital admits come from emergency walk-ins, driving more patients through an ER will create more admits, and therefore more profit for the hospital."

6. Consider partnering with local physicians to reduce competition for outpatient cases. An increasing number of hospitals are joint venturing with local physicians and surgery center management companies to offer outpatient services through the development of a surgery center.

According to Clete Walker, vice president of development for Surgical Care Affiliates, hospitals are beginning to focus on the need for a comprehensive outpatient strategy and recognizing the need to partner with doctors to effectively execute on this strategy. Mr. Walker reports that he has seen an increased interest from hospitals in joint venture arrangements for outpatient services.

"More and more hospitals are realizing that their core competency is providing inpatient care; their outpatient cases are more costly per case and take up more of the physician's and patient's time than they do at an ASC," he says. "As a result, hospitals are competing with physicians for outpatient cases. Hospitals with joint-venture agreements, however, do not have to compete with the physicians."

Hospitals can leverage their standing in the community to partner with local physicians to share the revenue generated by efficient outpatient cases.

"We are in lean times, and lean times call for us to rethink our strategies," says Mr. Walker. "It's better for physicians, hospitals and other groups to work together to provide an efficient delivery system for patient care than for the groups to compete."

7. Grow case volume by attracting new physicians to your facility. Identifying and attracting additional physicians to bring cases to your hospital is another way that hospital leaders can increase profits. Physician-owned hospitals can bring in additional physicians as partners, while other types of facilities can recruit new physicians who are willing to perform cases at their hospitals.

"New physicians will bring in more cases and grow your profits," says Ms. Worsham.

Ms. Worsham suggests polling your medical staff for names of local physicians to target and inviting them into the facility. During the visit, Ms. Worsham recommends that hospitals work to "wow" the target physician. "We work tirelessly to promote the services we can offer them," she says.

When a new physician begins performing cases at one of Ms. Worsham's facilities, that physician is assigned a concierge. "We have strong internal programs in place for this first day. A concierge is assigned to each new physician who provides them with a tour facility and walks them through every aspect of their day," says Ms. Worsham.

8. Consider adding profitable service lines. Hospitals may also be able to grow case volume and profits by adding new service lines. However, hospitals need to be careful to do their homework on the expected profitability and ROI for any new lines added, especially in a market where access to the funds required to invest in new service lines may be tight.

"You have to look at what the market needs are and where you're going to get the referrals from," says Ms. Worsham. "Meet with local physicians and interview them about their needs and the number of cases they see that could utilize a new service."

Hospitals should also be sure to examine the competitive landscape for any new service line.

Ms. Worsham reports that her facilities have had great success from adding a hyperbaric service line because few competitor hospitals were offering this service.

9. Consider hiring hospitalists to manage inpatient care. Hospitals that use hospitalists to care for patients can benefit from the more efficient care and better documentation that specialized hospitalists can potentially provide.

"A protocol-based hospitalist program can increase efficiency and help to reduce the length of stay for patients, which can increase case volume without the need for additional beds," says Mr. Kaufman.

Hospitals should consider employing these specialists as a means to improving care and enhancing their bottom lines, according to Mr. Kaufman.

Stephen Houff, MD, president and CEO of Hospitalists Management Group, says that hospitalist groups can provide effective care to patients and possibly increase reimbursement. "Hospitalists may be the most reliable and cost-effective means available for hospital leaders to transform medical delivery in their health system," he says. "Through shared vision, an effective hospitalist team partners with hospital leadership to improve patient safety and access, streamline care, improve patient and family satisfaction, enhance reimbursement via improved clinical documentation and provide seamless transition to post-discharge care."

10. Renegotiate managed care contracts. One of the most important ways that hospitals can improve their profitability is by continually evaluating and renegotiating their managed care contracts.

"Hospitals must demand their fair share of premiums from third-party payors in order to subsidize the underpayment of Medicare and Medicaid," says Mr. Kaufman. "Hospitals need to focus on reducing their cost structure as much as possible to approach breaking even with Medicare reimbursement rates, but that only goes so far."

Mr. Kaufman recommends that hospitals only agree to contracts that reimburse at 130-140 percent of cost. "If a facility is not big enough or strong enough to get these rates, then they should look at merging with a larger facility," says Mr. Kaufman.

Ms. Worsham suggests that hospitals perform a profitability analysis by payor and by procedure in order to determine where a facility is losing money and identify any trends. She also suggests that hospitals evaluate older contracts due to changes in severity-based DRGs and carve out the reimbursement of implants in order to ensure they are reimbursed appropriately for the costs associated with these.

Ms. Worsham also suggests that hospitals evaluate contracts on a quarterly basis, even if the contract is not near expiring. She suggests that hospital

leaders examine the contracts with the following questions in mind:

- Is revenue where we thought it would be given reimbursement rates and volume of policy holders?
- Are we being paid as agreed upon in the contract?
- Are we being paid in a timely manner?

Contracts that are determined to be "high risk" should be renegotiated. Make sure your contracts contain a material harm clause, which will allow you to readdress terms of contracts that have become financially harmful to your facility, according to Ms. Worsham. Renegotiating contracts can be very valuable — one hospital Ms. Worsham advises will gain $500,000 this year due to renegotiations.

Looking forward

Hospitals that focus on enacting these best practices are likely to see improvements in their profitability; however, hospitals can also benefit by using today's economic conditions as an opportunity to improve their overarching approach to business, creating a more sustainable organization in the future.

"When profits were high, hospitals had the luxury of being sloppy in some areas; now we must run a tighter ship," says Ms. Floria. "This will benefit the industry in the long-run."

Hospitals can also use this opportunity to find creative solutions to problems that plague their facilities.

Goshen Health System, for example, recently enacted a program in which the hospital pays the premium required to sustain Cobra benefits for recently laid-off patients seeking care. "We are willing to be creative with our patients," says Ms. Floria. "We pay for benefits when certain patients cannot. The revenue we receive from caring for these patients recoups this cost and provides us with additional cash flows that likely would have been uncollected or written off to charity care or bad debt."

This idea, which was enacted during lean times to improve profitability, will continue to benefit the hospital's bottom line, even when profitable times return. ■

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15 Popular Articles on www.HospitalReviewMagazine.com

Here are just 15 of the most popular articles that recently appeared on www.HospitalReviewMagazine.com and in the *Becker's Hospital Review E-weekly.*

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2. HHS' Inspector General Issues Advisory Opinion on Physician On-Call Coverage
3. Hawaii Hospital Settles False Claims Lawsuits for $2.5M
4. New Jersey Hospital Sues Virtua for Slander
5. Statistics on the Impact of the Economy on Hospital Finances
6. Norton Healthcare's Hiring of University of Louisville Neurosurgeons Could Lead to Legal Action
7. Allina Hospitals Agrees to Reimburse Patients $1.1M to Settle Illegal Interest Rates Claims
8. Lahey Clinic Hospital Pays More Than $840K to Settle Improper Billing Allegations
9. AHA Seeks Federal Help in Refinancing Tax-Exempt Hospital Debt
10. Stronger Bonds With Surgery Centers Through Joint Ventures: The Hospital Perspective
11. "Volume Crisis" To Hit Hospitals, Healthcare Expert George Pillari Predicts
12. Statistics on Physician Compensation
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Hospitals and Health Systems: The Best of Times and the Worst of Times (2009)
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dation portfolios, the underfunding of pension obligations, the movement in a negative direction of payor mix and the delaying of procedures are greatly changing the financial situation for hospitals. While the country's 1,000 healthiest hospitals remain stable, this remains a time of tremendous uncertainty and risk in the hospital industry. This article discusses five strategic and development issues facing hospitals

1. Joint ventures of service lines

Joint ventures can provide substantial benefits to hospitals. There are also severe limitations involved in the use of joint ventures.

Jon O'Sullivan, senior principal and founding member of VMG Health, says, "Physician/hospital joint venture relationships will continue to be a very important part of the healthcare landscape. There are a number of market areas and strategic factors that will continue to drive these relationships."

Mike Lipomi, president of RMC Medstone, agrees that now is an excellent time for hospitals to look into joint ventures. "I think joint ventures will flourish in this difficult economic time," he says. "Joint venturing with a specialized organization supports the focused factory theory of 'faster, better, cheaper.' In addition, the joint venture should result in lower costs, higher efficiencies and increased profitability."

First, in terms of benefits to a hospital, a joint venture provides a means to develop congruent relationships with physicians. When both the hospital and the physicians have vested interests in a venture, it places the parties on the same page; both parties work together to control costs and achieve a profitable venture. It also avoids an employer-employee or boss-servant type of relationship.

Moreover, joint ventures are often less expensive alternatives for hospitals to pursue. Primary alternatives in the past have included, for example, attempting to control patient flow by employing significant numbers of primary care physicians and specialists. It has clearly proven expensive to employ and maintain a primary care–owned network. It is also proving difficult to maintain productive specialists as employees of hospitals or health systems.

A third key benefit to joint ventures is that a joint venture allows for greater freedom for both the hospital and the physician than the traditional employer-employee relationship allows. For example, in a typical joint venture, a majority of physicians maintain an independent practice outside of the joint venture. This type of arrangement allows for congruency in the joint venture between the hospital and physician yet offers the physician a certain amount of freedom outside the joint venture.

There are also challenges and limitations to the use of joint ventures. For example, due to a number of business and regulatory issues, once a hospital invests in a joint venture it is often difficult to modify the number of partners or terminate the joint venture without suffering substantial damages or losses.

Surgery centers may also see the benefits of a hospital joint venture. Mr. O'Sullivan notes that as it becomes difficult for freestanding surgery centers to maximize their revenue through an "out-of-network" approach, many of these centers will look to establishing relationships with their local hospitals. He says, "As more and more managed care payors change their policy towards out-of-network centers, these centers will seek to enter into contracts with those payors in order to continue to serve their patients. Unfortunately, many centers will find that these payors will either not contract with the center or offer a contract with very low reimbursement. These factors will spur many of these centers to joint venture with their local hospital partner who has both the ability to bring better reimbursement through their contracting ability as well as to bring more physicians who might increase the utilization of the center."

Second, in certain types of joint ventures, hospitals receive lower reimbursement if they choose to enter into a joint venture with physicians than they would otherwise. For example, hospitals receive lower reimbursement if they choose to joint venture an ambulatory surgery center with their physicians as opposed to simply receiving hospital-based reimbursement for an outpatient department. Thus, in addition to splitting the profits of the joint venture with the physicians, the venture as a whole will receive lower reimbursement then if operating as a unit owned solely by the hospital.

Third, true joint ventures are not permitted in certain specialties for certain types of services. For example, it is difficult to joint venture various imaging modalities with physicians who are not radiologists. The Stark Act, which prohibits physicians from referring to an entity with which they have a financial relationship, classifies radiology and other imaging services as "designated health services."[1] A financial relationship is defined as any investment, ownership or compensation relationship. Therefore, subject to a rural exception, a non-radiologist physician owner (for example, an orthopedist, a primary care physician or a neurosurgeon) may not invest in a joint venture and generally may only "own" and provide imaging services pursuant to the in-office ancillary services exception, which is a restrictive exception.[2] In addition, states are beginning to limit ownership in imaging by non-radiologists as well. The Maryland Attorney General interpreted the state physician self-referral bill, which is similar to the Stark Act, to specifically exclude magnetic resonance imaging services, radiation therapy services and computed tomography scan services from the in-office ancillary exception.[3] The Centers for Medicare & Medicaid Services has expanded the list of Stark services to include nuclear medicine and positron emission tomography services. This would further limit the ability to enter into joint ventures for such services. There is also increasing scrutiny of imaging ventures set up as quasi-joint ventures as recently highlighted in national newspapers.[4]

Mr. O'Sullivan says, "The dual impact of changes in federal legislation, such as the Stark Act, will prevent certain relationships and increase the need for certain hospitals to implement 'game-changing' strategies in order to remain viable. In many cases, this strategy will take the form of a whole hospital joint venture. Additionally, the prospect of a change in law which might prohibit future or additional whole hospital joint ventures is causing many hospitals to accelerate their thinking of this strategic alternative."

Fourth, a joint venture strategy is limited to certain physician specialists and is difficult to utilize for an entire medical staff. For example, the benefit of a joint venture — congruency between the hospital and physicians, controlled costs, vested interest in profits — becomes too diluted if too many physicians are involved in the joint venture. In short, a joint venture is useful to none if everyone is involved. This means that where a medical staff includes 200-300 physicians, a joint venture may ultimately be a useful option for a small minority of the whole staff.

Mr. O'Sullivan also mentions how some specialty physicians may find the benefit in a hospital joint venture. "Physicians in many specialty areas continue to see their earnings erode. As a result, a plethora of relationships from radiation therapy to co-management agreements are continuously being implemented to provide an ancillary form of income," he says.

The role of joint ventures is likely to continue to evolve over the next three to five years. In general, joint ventures can be expected to proliferate for smaller types of service lines and services facilities, including ambulatory surgery centers, cardiac catheterization facilities and imaging facilities, among a handful of other types of service lines and facilities. In contrast, joint venturing of many large scale projects is not expected. In essence, the development of joint venture specialty hospitals between hospitals and physicians is expected to some degree, and a smaller number of joint ventures of acute care general hospitals are expected between hospitals and physicians.

2. Landmines facing hospitals

Many of the key problems that hospitals may face in the near future have not yet surfaced in part because hospitals are currently experiencing a favorable revenue and business cycle. This favorable business cycle has left many hospital systems insufficiently prepared for dips or downturns in the revenue and reimbursement cycle. Large national payors are pushing back with respect to climbing reimbursement and pricing. On a national level, there is discussion regarding the need to cut back or to reign in Medicare costs and the amounts paid to hospitals. If possible, the government may attempt to limit costs by decreasing reimbursement in niche areas where there is not as much political strength. Hospitals still must be prepared for changes in the revenue cycle.

There are four specific concerns.

First, hospitals have overleveraged themselves. This reflects several different characteristics. On one hand, hospitals remain confident in development plans and are regularly expanding and renovating hospitals to capture or maintain certain types of service lines and revenues. Overall healthcare construction and commitments to construct increased dramatically from 2004-2008. Other entities are investing in information technology while others are pursing deals to merge. On the other hand, however, most hospitals, as not-for-profit, tax-exempt entities, are not forced to make distributions to shareholders. Because hospitals do not have to account to shareholders in that manner, it is easier to find opportunities to invest money in new programs and buildings, rather than prepare for the future by disciplined saving or repayment of loans.

Many hospitals seem to have compensated for the recent economic downturn by better managing their development plans. In a Jan. 2009 report on the financial health of U.S. hospitals and health systems, the Healthcare Financial Management Association (HFMA) reported that 72 percent of hospitals surveyed planned to cut expenditures on new construction

projects over the next three to six months; 37 percent planned to put a hold on all new construction projects. In addition, 77 percent of respondents planned to cut back on information technology expenditures.

Second, a number of the nation's hospitals do not appear prepared for reductions and changes in reimbursement. Many hospitals have benefited from increased Medicare reimbursement and a lack of payor discipline over the last few years. Payors are returning to the zero sum game approach to negotiation efforts with hospitals. The health insurance industry is in a consolidation mode. This generally leads to greater power for the surviving payors and less negotiation leverage for providers. As noted above, all hospitals must be prepared for a slow down in Medicare reimbursement increases and potential reductions in payments from other payors.

Hospitals are also experiencing an upturn in patients seeking treatment who are not covered or covered by Medicaid or other public healthcare programs. A recent report from the American Hospital Association (AHA), *The Economic Crisis: The Toll on the Patients and Communities Hospitals Serve*, showed that 70 percent of the 1,078 hospitals surveyed reported an increase in uncompensated care. A further 46 percent reported an increase in patients on Medicaid or other public or low-income health programs.

Third, many hospitals do not maintain sufficient reserves. Hospital margins are relatively narrow. According to a MedPac report, there has been a decrease in hospital total margins. Total margin was measured by inclusion of all patient care services funded by payors, plus nonpatient revenues. In the aggregate, hospitals saw total margins decrease from 4.4 percent in 1991 to 3.4 percent in 2000. Given the small margins, insufficient reserves to cover losses can be problematic when a hospital faces a downturn in the revenue cycle.[5] Many hospitals in this regard are facing large unfunded pension deficits.

Additionally, the April 2009 HFMA *Healthcare Financial Pulse* report found that 54 percent of all hospitals surveyed reported a negative total margin. In the previous Jan. 2009 study, HFMA found that large to mid-sized hospitals were the most pessimistic about total margins over the next three to six months (35 and 43 percent, respectively). In the April report, 80 percent of the large (more than 500 beds) hospitals reported negative margins.

Although the Jan. 2009 HFMA reported that hospitals were planning on cutting capital spending and considering service cuts if necessary, there was no indication for a long-term solution if margins continued to decrease.

The recent AHA report also showed that hospitals are experiencing a decrease in days cash on hand. Of the respondents, 59 percent experienced a decrease in the amount of days the hospital could continue to meet its financial obligations; of that number, 27 percent considered this decrease to be significant.

Hospitals are also experiencing an increase in days in accounts receivable, further diminishing any reserve funds they may have. According to the AHA report, 36 percent of hospitals reported an increase in days in A/R as compared with last year.

As a result of this loss of revenue, the report showed that nearly half of the 1,078 hospitals surveyed had reduced staff in response to the economic downturn. Eight of 10 had cut administrative expenses, and one in five had reduced services, including behavioral health, post acute care, clinics, patient education and other services that require subsidies.

Fourth, a number of hospitals consistently chase the "next big thing." For example, the "next big thing" a few years ago was an expensive cardiac program. In many situations, the open heart programs proved to be less profitable than expected. This is, in large part, due to improvements in technology and decreases in the number of open heart surgeries performed. Currently, many hospitals are aggressively investing in different types of cancer treatment technologies and new types of buildings and development related to orthopedics and spine. However, if the number of admissions and procedures does not meet expectations, or if reimbursement stagnates or decreases, chasing "the next big thing" may lead to situations where the results for certain programs sorely miss expectations.

In addition, hospitals are unprepared because the economic downturn is hitting them later than other industries. Mr. Lipomi says, "I think the problems facing hospitals are the same problems that all businesses are facing in today's economic crisis. The reason we are facing them later than most is that our industry is highly leveraged by insurance plans and managed care providers making us more of an economic anomaly. We face patients delaying procedures, resisting hospitalization and avoiding physicians' offices and the emergency room for fear of losing their jobs as well as inability to pay co-pays and deductibles. In addition, the co-pays and deductibles are increasing rapidly as the employers are trading premium dollars for higher deductibles."

Mr. O'Sullivan sees hospitals as capable of handling the changes in the market and as even accustomed to facing these challenges. "Unfortunately for weaker hospitals, these changes are part of an ongoing evolution of healthcare and often result in the demise of the weakest participants," he says. "The upside is that the market is often better served as a result of revenue consolidation, greater efficiency and rationalization of the delivery of care (two heart programs in a small market makes little sense). Hospitals will seek alternative mechanisms to survive and thrive in their markets. Some will sell, some will close and some will innovate. The difference will be the ability of management to face these challenges and propose solutions before it's too late."

Mr. Lipomi also sees government intervention as another potential hurdle for hospitals. "We face the threat of government intervention to an even higher level than currently exists," he says. "Threats of a national health plan and the elimination of privatized medicine are on the mind of all healthcare providers. We need to take a close look at countries with national health plans and not only look at outcomes but look at the quality and availability of healthcare."

3. Financing vehicles

Very healthy hospitals still face a plethora of options as to how to finance their investments in facilities and programs. For hospitals in good financial shape, the choice of lenders, from traditional commercial banks to private equity driven financing companies to publicly traded entities focusing on commercial and healthcare finance, is still significant. For a typical project, real estate or equipment driven, a hospital may choose to structure the project through either fixed or variable rate financing options, options not always available in the past. These options often involve captive finance programs from the vendors themselves who may include large equipment companies or real estate entities or middle market lenders that focus on loans ranging from $10-$150 million.

Mr. O'Sullivan says, "Financing is very difficult in the current environment. The inability to gain access to capital will result in hospital sales to those entities that have greater access to capital. In the absence of a strong credit rating and bal-

ance sheet, outside of a sale, there are relatively few options in the current environment."

As a result of this difficult economic environment, hospitals may consider utilizing some of these new financing vehicles.

Certain of these new types of financing choices are intended to improve hospital/physician relationships. For example, the use of participating bonds allows physicians and local community members to hold a part of the debt used by a hospital or a hospital project. It may also include, as noted earlier, the use of joint venture projects which enable participating physicians to share in the capital needs of a venture. In these situations, the cost of these alternative sources of capital can be high in terms of the transaction efforts and fees. At the same time, these options offer a tangible benefit by helping to solidify relationships between physicians and hospitals. Accordingly, hospitals will often utilize a joint venture approach to financing projects even if it may be more expensive in terms of transaction costs and other types of challenges than doing the project alone. Participating bonds are used less often as the transaction costs for such products have proven to be so expensive that many hospitals choose not to use participating bonds unless the project is of such size and scope that the cost will be relatively reasonable in comparison to the total amount being raised. Over the next few years, financing options are expected to continue to proliferate until hospitals, once again, are faced with challenges relating to the financial performance of projects.

The number of the nation's hospitals that are not in strong or even good financial shape has increased significantly in the last 12 months. Whether these hospitals are semi-rural or located in difficult urban environments, these entities face a very significant increased struggle to find financing on any level. According to the Jan. 2009 HFMA report, both hospitals with limited and broad access to capital saw increases in their debt (38 percent of all respondents) and increased difficultly securing other types of financing. Often when financing is available, it is available only at high rates and can be developed only to the extent that there are tangible assets available to serve as collateral for the financing. In contrast, healthy hospital systems can utilize their traditional cash flows and projected cash flows to help obtain financing.

Overall, even though it is becoming more difficult, hospitals are still able to access capital. In the AHA report, 45 percent of respondents said that their ability to access capital was getting worse; however, 51 percent reported that their access to capital was about the same. The report found that most hospitals could gain some type of capital, although they reported that it was somewhat to significantly harder to get.

4. Hospital strategy for the next few years

Hospital planning over the next few years should be driven by three conceptual strategic approaches — an offensive approach, a defensive approach and an allocation method or approach. First, hospitals must play offense. This means constantly seeking new revenue lines. These can be "home run" profit lines, such as the efforts by many hospitals to develop oncology programs or leadership in orthopedics or spine. In contrast, investing smaller amounts in a number of service lines as a way to increase profits and revenues has also benefited hospitals. This may include simply reinvesting in the three to five key programs the hospital sees as its most profitable or to add a few service lines.

Second, hospitals must aggressively play defense. This means not over leveraging the hospital through excessive debt financing or overstaffing of certain programs. It also means preventing erosion of the hospital's revenue base by aggressively challenging or preempting joint venture efforts and market encroachment efforts by other hospitals and health systems.

Finally, hospitals must adopt the concept of allocation as an overriding strategy. Too often, hospitals are significantly over-invested in one service line or one service category. Over the last few years, hospitals that have over-invested in certain types of service lines, such as surgical, imaging, oncology, orthopedic or neurosurgical, have performed very well. However, hospitals are better off allocating their risk by investing in several different service lines. In addition, hospitals must develop a service line or a specialty where they can become known and recognized as a key provider in their community and become the distinct provider of choice. In essence, they must develop some specific reason for existence as revenue lines change and competition unfolds.

Mr. O'Sullivan notes some of the issues when considering developing a specialty hospital. "Migrating services to a specialized facility from an acute care setting is very difficult and can take years," he says. "Importantly, if the opportunity for specialization exists, it will probably take form in a physician driving specialty strategy (heart hospital, short stay hospital, rehab, etc.). The most viable strategy for hospitals in the next five years is to capture market share through enhances relationships with physicians. As such, hospitals are employing physicians at greater numbers, entering into co-management relationships and initiating joint venture strategies. The mix of these varies by market and market conditions."

5. Legal issues, congressional attack and class action suits

Not-for-profit hospitals are facing distinct attacks on several different levels. First, Congress has opened up an investigation as to whether hospitals are actually doing enough to earn and maintain their tax-exempt status. The Senate Finance Committee has delivered extensive questionnaires to ten tax-exempt hospitals and health systems, seeking details on activities ranging from travel to compensation to charity care.[6] In addition, the House of Representatives Ways and Means Committee has held a series of public hearings focusing on the tax-exempt sector, with particular focus on the not-for-profit, tax-

exempt hospital.[7] Second, many states and local communities are making efforts to try to reduce or erode tax exemption.

In the long run it is expected that Congress will take little, if any, action to fundamentally change the way not-for-profit hospitals do business. As a business reality, not-for-profit hospitals are a huge employer in many places, and are vital to many communities. For example, in 2008, tax-exempt hospitals and healthcare organizations controlled approximately $490 billion in assets and received more than $500 billion in gross receipts.[8] Further, the debt markets are extremely important to the national economy and provide great investment opportunities for a whole variety of participants. A challenge to the status of the tax-exempt entities that would result in a reduction of the supply of tax-exempt investments would have a substantial impact throughout the country. While Congressmen may enjoy the investigative aspects of the effort to examine the not-for-profit sector, any changes in tax exempt finance laws and how exempt hospitals function would have draconian and unexpected results throughout the healthcare economy and the national economy as a whole. It is expected, at some point, that politicians will use these types of investigations as a cover to wrestle with real and legitimate cost concerns of the Medicare program. In essence, certain of the negative aspects that come out of the Congressional investigations as to the tax-exempt sector may be used as tools and tactics to provide political cover and to ultimately reduce reimbursement to hospitals and health systems.

However, some believe that Congress should examine problems within Congress before addressing whether or not hospitals still meet tax-exempt status. "I think Congress should examine Congress first," says Mr. Lipomi. He mentions plans like the current stimulus plan could encourage more people to spend money that they don't have and continue this cycle of economic downturn. "This is a very dangerous situation that jeopardizes more than the future of healthcare," he says.

On the state side, there will continue to be state-to-state skirmishes over issues related to the state tax and local tax exemption. This is particularly true in small communities where the hospital has evolved into one of the biggest employers, if not the biggest employer, and particularly if the community has lost some of its tax paying businesses. For example, the Illinois Department of Revenue revoked the local property tax exemption for Provena Covenant Medical Center in Urbana, Ill., following a determination by the local tax board that Provena was not a charitable institution because of the way it treated needy patients.[9] In essence, the manufacturing decreases in many communities and as the taxes are paid by such companies decrease as well, there will be more pressure on local communities to attempt to reap some tax benefits from their local hospitals. ■

This analysis examines five different issues that are facing hospitals and health systems throughout the country. If you would like further information on any of these issues, please contact Scott Becker (sbecker@mcguirewoods.com) at (312) 750-6016 or Elissa Moore (emoore@mcguirewoods.com) at (704) 343-2218.

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Notes

1. 42 U.S.C. § 1395nn.
2. 42 C.F.R. § 411.355(b). In order to satisfy the in-office services exception, a physician has to meet separate supervision, location and billing tests, each of which focus on whether such services are truly ancillary to the medical services being provided by the physician or group practice.
3. Md. Code Ann., Health Occ. § 1-301(k)(1) (2005). On Jan. 5, 2004, the Maryland Attorney General released a legal opinion stating that the law bars a non-radiologist physician from referring patients for tests on MRI machines or CT scanners owned by the physician or his or her practice. 89 Op. Att'y. 10 (Jan. 5, 2004).
4. Armstrong, David, *MRI and CT Centers Offer Doctors Way to Profit on Scans*, *Wall Street Journal*, May 2, 2005.
5. MedPac, "Data Book on Hospital Financial Performance," Appendix D. Table D-15 shows a decreasing trend in hospital total margins. Over the same time frame, urban hospitals saw a decrease in total margins from 4.3 percent to 3.3 percent while rural hospitals saw a decrease in total margins from 5.2 percent to 4.4 percent.
6. See http://finance.senate.gov/press/Gpress/2005/prg052505.pdf for the press release and full text of the detailed questionnaire.
7. See http://waysandmeans.house.gov/Hearings.asp?congress=17 for transcripts of the public hearings relating to the tax-exempt sector and hospitals.
8. Testimony of the Honorable Mark Everson, Commissioner, Internal Revenue Service, before the House Committee on Ways and Means, May 26, 2005.
9. The Champaign County Board of Review, responsible for property-tax assessments, argued that the hospital filed lawsuits and used aggressive debt-collection tactics against patients who didn't pay their bills. As a result of the decision, Provena had to pay $1 million in property taxes. Provena is currently appealing the decision of the Board of Review to the Illinois Department of Revenue.

15 Hospitals and Health Systems With Great Cardiovascular Programs
(continued from page 1)

programs offered by the Institute and offers services to treat a variety of heart problems, including coronary artery disease, congestive heart failure, pulmonary hypertension and aortic disease. The hospital also operates a dedicated Women's Heart Center, which an provides women an overall assessment of their cardiovascular health and offers patients gender-specific action plans for preventing and treating heart disease. Clinicians and scientists at the hospital's Institute are currently working to develop muscle-powered ventricular-assist devices, a project supported by the National Institutes of Health. The hospital also actively participates in a number of clinical trials. www.wpahs.org/agh

Billings Clinic (Billings, Mont.). Billings Clinic is a non-profit 272-bed community hospital, which features a nationally-recognized cardiac care facility. The cardiovascular program was the first in the state to perform open-heart surgery and has been named a "Top 100 Hospital" for cardiovascular care by Thomson Reuter's Healthcare for the past five years. The cardiovascular program uses state-of-the-art technology to diagnose and treat a variety of heart conditions. The program offers patients with heart failure a condition-specific program to integrate services received by a variety of healthcare specialists within the clinic. The hospital also offers telecardiology, a heart-specific telemedicine program that improves access to cardiovascular care to patients outside of the Billings area. www.billingsclinic.com

Good Samaritan Hospital (Cincinnati). Good Samaritan Hospital is a 470-bed facility, which has served the Cincinnati community for more than 150 years. The hospital is home to the recognized Good Samaritan Heart & Vascular Center, which provides comprehensive diagnosis and medical, surgical and interventional treatment of numerous heart conditions. Good Samaritan Hospital performs more than 350 open-heart surgeries annually, along with more than 2,700 cardiac catheterizations and nearly 900 angioplasties.

Good Samaritan has an outstanding electrophysiology program, which focuses on the treatment of heart arrhythmias. The hospital is a regional leader in the treatment of these electrical disturbances and was the first hospital in Cincinnati to implant a pacemaker and the first hospital in the area to perform a catheter ablation. The hospital is also a regional leader in robotic-assisted surgery and was the first in Cincinnati to use robotics in open heart surgery. www.trihealth.com/GSH

Gundersen Lutheran Health System (La Crosse, Wis.). Gundersen Lutheran Health System is a healthcare network that includes a 325-bed teaching hospital and one of the largest multi-specialty group medical practices in that United States. The Heart Institute at Gundersen Lutheran has been home to one of largest and most comprehensive cardiac programs in a three-state region and has been recognized as a "Top 100 Hospital" for cardiovascular care by Thomson Reuter's Healthcare for five years. The hospital has also received five-star distinction from HealthGrades for the treatment of heart attack and heart failure for four years.

The Heart Institute at Gundersen Lutheran performs more than 4,000 invasive procedures and 400 open heart surgeries annually. The hospital has a specialized team dedicated to pediatric cardiology and is a forerunner in the treatment of heart problems in children. Gundersen Lutheran also has a dedicated cardiology research department, which was established in 1997. The

research team is currently pursuing a number of ongoing studies including those examining carotid ultrasound manifestations, external counterpulsation and the effectiveness of cardiac rehabilitation programs. www.gundluth.org

King's Daughters Medical Center (Ashland, Ky.). King's Daughters Medical Center is a non-profit, 385-bed regional medical center serving patients from southern Ohio, eastern Kentucky and western West Virginia. The hospital was recently recognized for cardiovascular care by Thomson Reuter's Healthcare, being named a "Top 100 Hospital" for the specialty. The hospital's Heart & Vascular Center features a specialized cardiology clinic, the first of its kind in the region and a women's heart health program, which aims to lower the hospital's female patients' risk for developing heart attack and stroke. The hospital's cardiothoracic surgery program performs surgeries for aneurysm repair, atrial fibrillation, carotid artery blockages, heart valve repair and replacement in addition to other heart conditions. Surgeons at King's Daughters performed more than 850 open-heart surgeries last year and were first in the region to perform beating heart surgery.

The hospital also has a dedicated cardiovascular nursing unit, staffed with nurses who have completed a cardiac fellowship training program and have achieved certification in Advanced Cardiac Life Support. King's Daughters hosts an annual Cardiovascular Update Conference, where healthcare providers receive information about the latest advances in the treatment of cardiovascular conditions. www.kdmc.com

Loyola University Health Center (Maywood, Ill.). Loyola University Health Center's Center for Heart & Vascular Medicine brings heart and vascular specialists together in one location to collaborate on patient care and treatment options. The center offers initial screenings, non-invasive diagnostic echocardiograms, vascular ultrasound, diagnostic angiography, catheter ablations, pacemaker implantation and vascular and cardiovascular and thoracic surgery. Loyola University Health Center is recognized as a top 30 teaching hospital by Thomson Reuters for cardiovascular care and has been included in Thosom Reuters's "Top 100 Hospitals" list for cardiovascular care for four years. Additionally, Loyola is one of 38 hospitals in the nation and one of two in Illinois to show above-average outcomes for heart failure patients, according to a survey of more than 4,000 hospitals conducted by the U.S. Department of Health and Human Services in 2007.

Loyola was the first hospital in the state, and one of few hospitals in the nation, to staff a Heart Attack Rapid Response Team — a team of board-certified cardiologists and other medical staff who provide 24-hour care, seven days a week, to heart-attack patients, offering potentially life-saving emergency angioplasty treatment immediately upon arrival. Loyola was also the first hospital in the state to perform a heart transplant and was among the first hospitals in the United States to use 3-D ultrasound to guide ablation and to perform minimally invasive cardiac surgery. www.loyolamedicine.org

Maine Medical Center (Portland, Maine). Maine Medical Center is a 606-bed non-profit hospital serving northern New England. The hospital features the Maine Heart Center, one of the most recognized heart programs in the state, receiving five-star ratings for overall cardiac services, cardiology services, coronary interventional procedures, treatment of heart attack and treatment of heart failure by HealthGrades. Maine Medical Center was the first facility in the state to perform bypass surgery and transmyocardial revascularization and was the first to introduce robotic surgery for cardiovascular procedures. The organization's services range from pediatric cardiology to electrophysiology and surgery. The medical center is also a sponsor of the "One Save" program, which provides defibrillation units to public areas in the region in the hopes of saving lives by expanding access to the defibrillation. www.mmc.org

Ochsner Medical Center (New Orleans). Ochsner Medical Center is a 473-bed acute care non-profit, academic healthcare system. The hospital's John Ochsner Heart and Vascular Institute is a comprehensive cardiac and vascular care center that offers a continuum of care unique for the region. The Institute features specialized programs in a number of areas including heart failure and transplant, electrophysiology and vascular medicine. Ochsner was one of the first 10 programs in the United States to perform more than 500 transplants and has performed more than 500 carotid stents in the past 10 years, one of only a few hospitals in the world to do so. The hospital is also currently working on a number of research initiatives and clinical trials. www.ochsner.org

Providence Regional Medical Center Everett (Everett, Wash.). Providence Regional Medical Center is a 468-bed medical center consisting of five campuses. The hospital's Heart and Vascular Institute has received a number of national awards including a top 10 percent ranking for overall cardiac services by HealthGrades. Providence's Cardiac Surgery Single Stay Unit allows cardiac surgery patients to recover in one comprehensive care room for their entire stay and is the first unit of its kind in the state. The Institute features a number of cardiac centers including the Center for Cardiovascular and Pulmonary Rehabilitation and Prevention, the Center for Diagnostic Cardiology, the Center for Interventional Cardiology, Center for Arrhythmia Management and the Center for Surgical Services. www.providence.org/everett

Riverside Regional Medical Center (Newport News, R.I.). Riverside Regional Mecical Center, part of Riverside Health Systems, is a 570-bed hospital with a strong cardiac program. The hospital has been named as a "Top 100 Hospital" for cardiovascular care by Thomson Reuter's Healthcare. The hospital's Heart and Vascular Center provides more than 27,000 incidents of care annually, specializing in cutting-edge diagnostic, emergency and elective heart and cardiovascular care, including open heart surgery. The center also offers the only interventional catheterization lab on the Virginia Peninsula that meets the American Heart Association's guidelines for emergency treatment of heart attacks. www.riversideonline.com

St. Joseph Medical Center (Towson, Md.). St. Joseph Medical Center is a 354-bed acute care regional medical center. The hospital's Heart Institute is well-recognized for outstanding heart care, being named one of the "Top 100 Hospitals" for cardiovascular care by Thomson Reuters Healthcare for eight years. The Institute includes the largest open heart surgery program in the state and an all-digital cardiac catheterization program. The Institute also offers an electrophysiology lab, a cardiac intensive care unit and a cardiac fitness program. St. Joseph is active in cardiac clinical trials and also sponsors "Heart Aware," an innovative heart disease detection program that provides free online heart health evaluations and reduced-price CT scans for participants. www.sjmcmd.org

St. Mark's Hospital (Salt Lake City). St. Mark's Hospital is a 317-bed hospital with an outstanding heart program, which helped earned it the recent distinction of a "Top 100 Hospital" for cardiovascular care by

Thomson Reuter's Healthcare. The hospital's surgeons perform approximately 8,000 cardiac catheterization procedures and 400 open heart surgeries annually. St. Mark's offers dedicated programs for non-invasive cardiac testing, cardiac catheterization, open heart surgery, cardiac rehabilitation and chest pain management. The hospital also opened a state-of-the-art electrophysiology laboratory in June 2008 to better serve patients with heart arrhythmias. www.stmarkshospital.com

St. Vincent Indianapolis Hospital (Indianapolis). St. Vincent Indianapolis Hospital, part of St. Vincent Health, and its cardiovascular Center of Excellence, St. Vincent Heart Center of Indiana, has been ranked by Thomson Reuters Healthcare as a "Top 100 Hospital" for cardiovascular care and is ranked among the top five percent of hospitals nationally for stroke care by HealthGrades. St. Vincent offers programs in minimally invasive heart surgery, interventional cardiology, cardiac catheterization, heart surgery and imaging and testing.

St. Vincent recently announced a new atrial fibrillation Center of Excellence program to address the needs of patients with heart rhythm disorders. The Heart Center also hosts a number of community events to raise awareness about heart disease and prevention and promotes a $99 heart scan for community members as a way help identify early warning signs of heart disease. www.stvincent.org

Vanderbilt Medical Center (Nashville, Tenn.). Vanderbilt Medical Center is a comprehensive healthcare facility with more than 600 beds, serving patients throughout the Mid-South. Vanderbilt's Heart Institute, often referred to as "Vanderbilt Heart," offers dedicated programs in a number of areas including adult congenital heart conditions, electrophysiology, atrial fibrillation, cardiac surgery, heart transplant, interventional cardiology, women's heart disease and cardiac rehabilitation. Vanderbilt's program in heart and heart surgery was recognized by *U.S. News & World Report*, ranking 21st in the nation for the specialty.

Vanderbilt's Heart Institute is a leader in cardiovascular research, recently receiving a $16 million award for research examining thrombosis and the metabolic syndrome and is currently performing research on stem cell therapy, atrial fibrillation and vascular surgery. The Institute also actively works to educate patients about heart health through literature and community programs, such as its annual "Heart Walk" for the American Heart Society. www.vanderbilthealth.com

Venice Regional Medical Center (Venice, Fla.). Venice Regional Medical Center is a 312-bed regional hospital and health system that provides a comprehensive array of healthcare services to the greater Venice area. The hospital has been ranked by Thomson Reuters Healthcare as a "Top 100 Hospital" for cardiovascular care for three consecutive years. Venice Regional's heart program offers medical and interventional cardiology and open heart surgery with comprehensive rehabilitation services for post acute care. The hospital also sponsors a Cardiac Club, which hosts monthly meetings at the hospital and provides information and support to the community. www.veniceregional.net ■

Hospital Cardiology Leaders Offer Practical Guidance for How to Make it to the Top of the Quality Ladder

Written by Mark Taylor

Cardiology services remain among the most profitable hospital services and even marginally successful hospitals tend to make money on this business line. But the upper tier of American hospitals — those achieving top HealthGrades rankings and who crack the *U.S. News & World Report's* "America's Best Hospitals" — has remained there for years, carving longstanding reputations for quality that attracts the top physicians, nurses and patients from around the country and across the globe.

Department leaders at three hospitals ranked in the Top 50 listing and an interventional cardiologist leading heart programs at two Chicagoland hospitals approaching that elite status say getting to the top is hard work, but there is a path and following it religiously will deliver better results and patient outcomes, even if it takes time to reach the top rung.

Maureen Ogden of Tampa General Hospital

Maureen Ogden, vice president of cardiovascular and transplant services for Tampa (Fla.) General Hospital, says 2009 was the first year the tertiary care hospital was ranked by *U.S. News & World Report*, which listed it as number 42 among the Top 50 heart programs nationally. Tampa General, a former public hospital that became a private, not-for-profit academic medical center affiliated with the University of South Florida in 1997, opened its Cardiovascular Center in Bayshore Pavilion in April 2008 for preoperative and postoperative patients. It features six cardiac cath labs and six interventional radiology suites within 77,000 square feet. Tampa General is the eighth busiest heart transplant center in the country. Its stroke program has earned a five-star ranking from HealthGrades and its ventricular assist device program was certified with the Joint Commission's Gold Seal of Approval for quality.

Ms. Ogden says the new facility is successful in part because the hospital involved physicians and staff in the design. Ms. Ogden, who joined the hospital in 1980 as a night nurse in cardiology and has worked there as a nurse, manager and director, says employee commitment and physician involvement are key to climbing the quality ladder. "We have an amazing group of people who really care for the patients here," she says. "Making the *U.S. News & World Report* list wasn't easy or fast. It's a very slow process. When we decided to build the pavilion in 2002, we committed to a new way of doing business. Our goal was to become the employer of choice, to recruit and train the best physicians, nurses and staff."

She says being a regional organ transplant center is a big draw. "We get referrals from many smaller hospitals who don't feel comfortable with really complex patients. All that came together for us. We wanted to get Magnet certification and received it four years ago, which helps us recruit the best nurses. We wanted to receive Joint Commission disease specific recognition and we did. We wanted to work off of national benchmarks and we did."

She says that Tampa General developed its own customer service program after key staff underwent intensive training. "We based our program on the Disney model for customer services and created an educational process in which 100 percent of our staff was trained. We've seen perceptions change."

She says achieving physician buy-in starts with recognizing physician needs. "One of the things you have to do as a leader is to make yourself available at the time best for them. You can't schedule a meeting at 11 a.m., but at 5 a.m. or 7 a.m. You have to respect how valuable a doctor's time is and how difficult it is for them to find time. But physician involvement is critical,"

she says. "You also must provide as much transparency as you can provide to achieve trust on both sides. Physician ease of practice is something we consider very carefully."

She also suggests consistently seeking physician input and giving feedback. "They need to be decision makers in the process. That's crucial to a cardiology department's success. We fully appreciate and value our physicians. They have choices and can take their patients elsewhere."

Ms. Ogden says maintaining elite status is challenging. "It's crucial to stay current with the science and technology and plan for it five years from now. Who's teaching me? My doctors. I seek them out and they keep me current."

Joseph Butz of Sentera Norfolk General Hospital and the Sentera Heart Hospital

Joseph Butz, vice president of the Cardiac and Transplant Program at Sentera Norfolk (Va.) General Hospital and the Sentera Heart Hospital, says that his organization's program unites a longstanding team of cardiac super specialists within an advanced facility "built from the ground up for superior cardiac care."

Sentera was ranked 38th on the *U.S. News & World Report* Top 50 hospitals for heart care. Its Heart Hospital adjoins the level one trauma center and tertiary care hospital, Sentera Norfolk General, and offers an opportunity to house all cardiac services in one area to better focus cardiac patient care. The hospital achieved a ranking of fourth in the nation in mortality for cardiac procedures, with excellent quality outcomes. Mr. Butz points out that half of the heart hospital's volume comes from outside the Norfolk market, serving populations in North Carolina, and Virginia's Eastern Shore and its Upper Virginia Peninsula.

"We defined success for our program to be in the top 10 percent in quality and we've achieved it in most areas," he says. "We believe that good quality medicine is good business. If we can maintain our high quality rankings, we will continue to draw business from outside of our market and do well financially."

Mr. Butz says that the quality of clinicians draws referrals. "Doctors don't want to refer their patients to physicians they don't think are any good," he says. "The quality of those clinicians is important to insurers as well. That's really what makes a preferred hospital provider. Nursing competence is important as well. We've achieved status as a Magnet hospital. Finally, efficiency is a big seller to physicians as well. At Sentera we do joint ventures that help align incentives and work towards a common goal. Physicians, staff and administration together drive quality. The dedication to doing the best medicine drives volume and cost effectiveness."

He says at the Heart Hospital committees select and analyze data to investigate trends and establish best practices and benchmarks. Mr. Butz says one means of achieving high levels of performance is to apply a programmatic approach to care, "to hard-wire quality into everything. That's why the Cleveland Clinic, the Mayo Clinic and Johns Hopkins are always at the top. The program has to be hard-wired so it can survive the departure of an administrator," he says. "I can leave tomorrow and this place will remain a Top 50 hospital. But just because it's hard-wired in doesn't mean it stays. Things change. There needs to be strong infrastructure in place to allow it to continue. You have to keep moving the bar forward. We are constantly looking at programs and making improvements."

Mr. Butz says every healthcare market is unique.

"Hospitals need to figure out what their communities need and how best to meet those needs," he says, pointing out that not every community requires multiple tertiary referral centers. But every community has cardiac service needs and if a hospital is meeting those needs with a strong emphasis on quality, Mr. Butz predicts it will attract that next level of recognition.

"When your CEO says quality is the top goal and making it into the top 10 percent is the measurement, it gets you focused on the right thing, which isn't always volume or cost," he says. "Physicians are instrumental, as is getting everyone on same page. Our physicians are very committed to making this program run better and if it runs better, everyone does better."

Dr. Paul Jones of Mercy Hospital and Franciscan Physicians Hospital

Interventional radiologist Paul Jones, MD, chairman of the department of cardiovascular services at Chicago's oldest continually operating hospital, Mercy Hospital, and medical director of cardiovascular services at Franciscan Physicians Hospital in Munster, Ind., says before hospital executives and their affiliated physicians consider expanding or consolidating heart services, they should crystallize their program's objectives and structure services not just for today's market, but tomorrow's. Dr. Jones says any new program needs to be in synch with the latest technological advances in cardiac care.

"Cardiology program planners should think ahead to make sure the program structures will be where the research and technology are going and the field of cardiovascular disease management is headed," he says. "That's the value of cutting-edge interventional cardiology: having unique tools and some administrative skills to put those two together to structure program ready for what tomorrow's tech will look like."

He says planning for the coming technology isn't enough. "Programs must be quality-based from their inception. They must be structured and programmed with quality in mind and systems for evaluating quality outcomes."

Dr. Jones says CMS and private insurers are increasingly tying reimbursement to quality outcomes through pay-for-performance incentives. "That will become more and more prevalent," he predicts. "The challenge in the years to come will be to convince hospital administrators to grow from a position of quality. I've been fortunate at Mercy and at Franciscan to have had that kind of support over the years."

Mercy has a long history of cardiac quality. He says Mercy's heart program was ranked in Solucient's Top 100 hospitals and achieved status as a Blue Cross and Blue Shield center of distinction.

Franciscan Physicians Hospital, a joint venture between the Mishawaka, Ind.-based Sisters of St. Francis Health Services and physician co-owners, is a relatively young hospital Dr. Jones says is quickly developing a reputation for quality cardiac care. He says he was recruited to develop a cardiac program modeled after Mercy's at Franciscan.

"You have to be honest about the program's weaknesses and strengths and be clear what you want to achieve," he says. "We've developed a continuous quality improvement model that allows us to look objectively at our problems and develop solutions. We want to foster a strong sense of teamwork. The strength of the program does not ride on the shoulders of a single individual, but the quality of the team assembled."

He says he led efforts at Mercy to consolidate heart-related services, including cardiac surgery, into the department of cardiovascular services.

"From a hospital operational perspective it's easier to have of those services all under one umbrella department," he explains. "It also makes us more accountable under our continuous quality improvement program.

"Our endovascular program has received national attention and we've created a program for physicians to train here to perform endovascular procedures," he says.

"Everyone has to understand the true importance of that continuous quality improvement program. People can get complacent about that," he says. "But we cannot let our guard's down."

Chris Thomson of The Christ Hospital's Heart and Vascular Center

Chris Thomson, executive director Heart and Vascular Center at The Christ Hospital in Cincinnati, is a veteran hospital cardiology executive who has led 10 different programs in his career, most recently with St. Thomas Health Services in Nashville, Tenn.

"My career has been building heart programs," Mr. Thomson says. "For collaborative partnerships to work between physicians and hospital leadership there must be a true focus on patient care and quality. The rest of it just happens."

Mr. Thomson says there are numerous effective process programs and analytical tools that work. "What it comes down to is how patients flow through your system and how you analyze that to improve care, how you work together to improve quality. It always comes back to personalities and a commitment to quality. Nothing will happen unless there is a commitment to quality. And people who focus on quality end up with fame and money."

He concedes that some well-intentioned programs do not achieve success, usually because there was no common consensus or unity of vision.

"The reality comes when people don't want to change," he says. "The world around us is changing and what worked in Nashville last year won't work in Cincinnati this year."

He says the vision must be shared top to bottom. "The person cleaning the cath lab is just as important," he says. "If it's only the physicians and administrators, real success won't happen. If you ask the people delivering care what is the vision of the cardiac service line at Christ Hospital, they all can tell you it's quality outcomes, patient satisfaction and physician satisfaction. Everybody throughout the service line has to understand that. And if everyone is going in same direction, you can't help but succeed."

Mr. Thomson says he's seen his share of "one-hit wonders" who appear on the top hospital lists one year and disappear after that.

"Someone came in and shook things up and got them going, but didn't drive down to the lowest level of people to make it stick," he explains. "I can't fix things alone. I can lead toward the fix, but my job is to make sure everyone has the tools they need and understands where they're going.

"They need to bring in someone who makes sure they can follow up and maintain the progress. I'm a builder, not a maintainer. I build it and then move on. It's the responsibility of the builder to figure out how to maintain it and who would be best at that," he says, while conceding: "People can only accept so much change before fatigue sets in. The key to all this is successful collaboration and agreement on the vision driven all the way down throughout the organization." ■

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Statistics on the Compensation of Physicians

Here is a round-up of statistics on the growth and compensation of physicians.

1. There were 633,000 physicians employed in the United States in 2006.
2. The projected number of physicians employed in the United States in 2016 is 723,000, an increase of 14 percent.
3. Here is a list of the median compensation of physicians in 2005 by specialty and years of experience, according to the Bureau of Labor Statistics' *Occupational Outlook Handbook, 2008-09* citing the *Medical Group Management Association, Physician Compensation and Production Report, 2005*.

Specialty	Less than two years in specialty	More than two years in specialty
Anesthesiology	$259,948	$321,686
General surgery	$228,839	$282,504
Obstetrics and gynecology	$203,270	$247,348
Psychiatry	$173,922	$180,000
Internal medicine	$141,912	$166,420
Pediatrics	$132,953	$161,331
Family practice	$137,119	$156,010

Source: Bureau of Labor Statistics' *Occupational Outlook Handbook, 2008-09*.

Becker's Hospital Review Names Its Hospital CEO of the Year and Runner-Ups

David Fox, president of Advocate Good Samaritan Hospital in Downers Grove, Ill., has been named *Becker's Hospital Review's* Hospital CEO of the Year.

Joe Freudenberger, CEO of OakBend Medical Center in Richmond, Texas, and Debbie Hay, president of the Texas Institute for Surgery in Dallas, and were named CEO of the Year runner-ups.

Readers of *Becker's Hospital Review* nominated and voted for candidates.

Learn about the winners

Mr. Fox has been a healthcare executive his entire career. He earned a graduate degree from the University of Chicago in healthcare management and became the president of Central DuPage Hospital, located in Winfield, Ill., in 1997. He joined Advocate Good Samaritan in 2003 and was recently featured in the 2008 Special Report from the Health Financial Management Association. Under his management, Advocate Good Samaritan earned the 2007 Lincoln Foundation for Performance Excellence Silver Award, an award honoring outstanding Illinois hospitals. (Learn more about Mr. Fox below)

Mr. Freudenberger has held several positions in hospital administration, serving as COO for OakBend and as CFO for Memorial Health System of East Texas in Lufkin, Texas. Under Mr. Freudenberger's leadership, OakBend Medical Center received the American Stroke Association's Get With The Guidelines Silver Performance Achievement Award in July 2008. Mr. Freudenberger received his MBA from Tulane University in New Orleans, La. (Learn more about Mr. Freudenberger on p. 22)

Before joining the Texas Institute for Surgery, Ms. Hay served as administrator for a surgery center and as an emergency room nurse and manager. She has initiated a number of green policies while serving as president of the Texas Institute for Surgery, including converting paper patient files to electronic. She has a psychology degree from William Woods University in Fulton, Mo., and a nursing degree from Baylor University in Dallas. (Learn more about Ms. Hay on p. 23)

David Fox, *Becker's Hospital Review*'s Hospital CEO of the Year

By Lindsey Dunn

Transparent is one word that has come to define David Fox, CEO of Advocate Good Samaritan Hospital in Downer's Grove, Ill. While many leaders today put considerable effort into hiding their mistakes, and those of their organization, Mr. Fox believes that sharing and learning from these mistakes is the best way to improve a leader and an organization.

Mr. Fox's unique approach to leadership is one reason why he has been selected as *Becker's Hospital Review*'s Hospital CEO of the Year.

Mr. Fox's transparent leadership style has proven to be extremely effective in improving clinical outcomes, and patient and employee satisfaction, within his facility. His commitment to sharing both his own and the hospital's performance information with hospital leaders, physicians and employees has also led Mr. Fox to be seen as an approachable leader who values the opinions of all hospital employees and believes in the ability of everyone to make noticeable contributions to the hospital.

One colleague praises Mr. Fox for this commitment to the staff. "Dave Fox is known by his first name by many hospital workers, including maintenance, nursing staff and doctors," says a physician at the hospital. "He conducts regular roundtable sessions, open to all, to discuss how to improve the hospital and to provide information. He is professional and accessible, a rare combination."

Mr. Fox's commitment to his staff is apparent in the way he speaks of the successes of the organization, stating that the recent accomplishments that the hospital has achieved, such as being named to Thomson Reuters' list of 100 Top Hospitals for 2008, would not be possible without the invaluable effort that his staff puts forth every day.

According to Mr. Fox, employees, or "associates," as they are called at Advocate Good Samaritan, are one of the most important reasons for the hospital's success. "Our associates are one of our most valuable resources. We greatly value people who choose to work at Advocate Good Samaritan," he says. "We refer to them as associates, not employees, because of the symbolic partnership we see between them and the hospital as a whole."

Mr. Fox's unique leadership style has gained him recognition within the healthcare industry. He was featured by the Health Financial Management Association in its 2008 Special Report for his transparent leadership style. Under his management, Advocate Good Samaritan also earned the 2007 Lincoln Foundation for Performance Excellence Silver Award for "Progress Towards Excellence," which honors outstanding performance by Illinois organizations.

Mr. Fox has served as a healthcare executive his entire career. He earned a graduate degree from the University of Chicago in healthcare management and became the president of Central DuPage Hospital, located in Winfield, Ill., in 1997. He left Central DuPage to join Advocate Good Samaritan in 2003.

Growing Advocate Good Samaritan

The 340-bed Advocate Good Samaritan is affiliated with more than 900 physicians and employs more than 2,500 employees and is part of Advocate Health Care, the largest not-for-profit healthcare system in the Chicago area.

The hospital scores consistently well on measures of clinical excellence as well as patient and employee satisfaction, with Mr. Fox referring to 2008 as the hospital's best year in its 32-year history. The hospital received patient satisfactions score above the 90th percentile from four of the five patient groups it surveys and received employee and physician satisfaction rankings at the 93rd percentile. Additionally, the hospital experienced its best financial performance to date, with admissions growing 5 percent, and a net income of $20 million with an operating margin of 5.5 percent in a year where many hospitals did not fare as well.

Mr. Fox's leadership is respected by colleagues and hospital staff. He treats all hospital employ-

ees equally and values all levels of his staff, according to the hospital's employees.

"It does not matter your title at Good Samaritan; whether you are the head of the hospital or at a lower level, Dave treats you with dignity and respect no matter what," says a Good Samaritan associate.

Mr. Fox says that his primary job as a leader is to set the agenda for the organization and then help all associates understand, as they are called at Advocate Good Samaritan, understand their role in meeting the organization's goals.

"What I aim to do is take complex issues and translate them into relevant and actionable goals so that members of our organization understand how their role affects that goal," he says. "My executive team and I spend a great deal of time formulating organizational goals, which then cascade down through our organization, so that every manager, and eventually every associate, knows how his or her performance is judged," he says.

Focus on benchmarking

Mr. Fox's leadership philosophy, and, as a result, the goals that he sets for the organization are deeply rooted in the importance of measurement and transparency. "You cannot improve what you cannot measure," he says.

One indication of this commitment to measurement is the hospital's extensive use of performance data to set organizational goals.

Mr. Fox regularly informs Advocate Good Samaritan's staff about the importance of a measurement called the mortality index, which measures the number of deaths at a facility against the expected number of deaths as judged by presenting patient acuity. Advocate Good Samaritan's index was determined to be 0.45, which means that only 45 percent of patients who were expected to die due to the severity of their presenting conditions actually passed away. In other words, Advocate Good Samaritan saved more than half of the patients it was expected to lose during the year.

Mr. Fox explains that these type statistics, while very useful, can be difficult for all hospital employees to comprehend. He sees it as his job to translate these statistics into meaningful information for his associates. "I translate these types of figures into something that makes sense, in this case, how many potential deaths were avoided. Using this statistic, I was able to calculate that in 2008, 284 patients that should have died, statistically speaking, survived because of the great care we provide here at Good Sam."

Mr. Fox believes that statistics and other measures of organizational and personal performance are the first step in improving the hospital. "Measurements show you where you stand and can track your progress toward improvement," he says. "Because we measure our performance and do so frequently, we are able to know throughout the year if a certain department or manager is not hitting a goal, and we can work with them early in the year to help ensure that the goal is met."

Mr. Fox personally shares his monthly performance assessment with the entire board of directors, the hospital's management team and the leadership of the medical staff. "It can be embarrassing if I have a bad month," he says "But it ensures that I am accountable for the decisions I make."

Great communicator

Mr. Fox has been identified by his colleagues as a great communicator and leader. He is highly visible in the organization and meets each new employee that begins at Advocate Good Samaritan during new employee orientation.

"Dave Fox is the most visible CEO I've ever met," says a colleague. "He constantly communicates with all levels of staff, holds associate forums and visits nursing units in which he describes his own experiences in a caring and concerned way with the patients and staff."

The employee forums that Mr. Fox hosts quarterly are referred to as "round the clock" associate forums. During the approximately 20 forums, which occur literally around the clock to ensure that employees from all shifts can attend, Mr. Fox responds to questions and concerns that hospital employees have and listens to suggestions from employees to improve the hospital. Colleagues of Mr. Fox say that his being a great listener is yet another reason why he is such an effective leader.

"He truly listens and has the interest and wellbeing of all [in mind]. Good Samaritan Hospital has improved 200 percent during his leadership," says a colleague.

Associates also report that they feel valued by Mr. Fox and that their input effects the organization.

"Dave Fox has been an excellent president for Advocate Good Samaritan," says a colleague. "He has always been sincere and has been able to engage the medical staff and understand their views and solicit their ideas … He has worked very hard to earn everyone's trust and respect, and this helps define him as a great leader."

Concern for people and financial performance

Colleagues also tout Mr. Fox's knowledge of issues affecting hospitals in general.

"In my 30 years as a practicing physician, I have never worked with such a great hospital administrator," says a physician affiliated with the hospital. "Dave Fox has great in-depth knowledge of healthcare issues and a wealth of practical experience. He understands how to relate to people in all levels of the hospital and is able to accomplish things that transform the way people view their jobs. The result is better care for our patients and great pride in our hospital."

Mr. Fox is also respected within the hospital for his concern for the financial performance of the facility.

"Dave does a great job balancing the very difficult task of looking out for the staff at Good Samaritan Hospital and making the very tough financial decisions that have to be made at the present time," says a colleague.

"In my 30 years as a practicing physician, I have never worked with such a great hospital administrator. Dave Fox has great in-depth knowledge of healthcare issues and a wealth of practical experience."

Mr. Fox reports that one of his primary objectives for 2009 is ensure good financials so that the hospital will not be forced to lay off any employees. "My major priority for 2009 is to be proactive in managing expenses so that we can meet our financial goals without losing associates," he says.

Mr. Fox also plans to continue to lead Advocate Good Samaritan toward outstanding clinical outcomes, patient and associate satisfaction and physician support in the coming year.

Quint Studer, a healthcare veteran of more than 20 years and founder and CEO of Studer Group, an outcomes-based healthcare consulting firm, says, "Dave Fox is a role-model healthcare executive. He has the ability to combine technology and advances in medical treatment with the human capital of an organization in order to provide excellent clinical outcomes and an excellent patient experience."

Mr. Fox works every day to create a positive hospital environment where employees are inspired to live out Advocate's core values of compassion, equality, excellence, partnership and stewardship. Although Mr. Fox has already helped his hospital achieve numerous accomplishments during his tenure, he hopes to continue to improve the already outstanding care the hospital provides.

"When I started here as CEO, someone gave me a conductor's baton. I see it as symbolic to what I do here everyday," he says. "A bad conductor can ruin even the most talented orchestra, but a good conductor can get everyone playing from the same sheet of music.

"The hospital is the world's most complex business organization," Mr. Fox says. "My job here is get everyone working together and behind a vision to deliver world-class, compassionate care." ■

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Joe Freudenberger, Runner-Up for *Becker's Hospital Review*'s Hospital CEO of the Year

By Renée Tomcanin

Creating an efficient and successful hospital environment requires more than overseeing day-to-day operations. It requires dedication and a little creativity to change ineffective procedures into profitable ones for the facility.

Joe Freudenberger, CEO of OakBend Medical Center in Richmond, Texas, uses his out-of-the-box ideas to improve operations and create a positive environment at the hospital.

This creativity, among other reasons, is why Mr. Freudenberger is one of the runners-up for *Becker's Hospital Review's* CEO of the Year.

OakBend Medical Center is a 184-bed acute care facility located in Richmond, Texas. It is the only Advanced Trauma Center in Fort Bend County and was recently awarded the Gold Seal of Approval from The Joint Commission as a Primary Stroke Center.

The organization has also partnered with M.D. Anderson Cancer Center to run a state-of-the-art radiation facility. Among other things, OakBend is known for Women's Services which include a birthing center and a Level 2 nursery, while its operating suites and imaging services have the most up-to-date equipment available.

Taking a creative approach to management

According to many of Mr. Freudenberger's OakBend colleagues, he approaches management at the hospital with creativity and the enthusiasm to improve the hospital financially but just as importantly, to make OakBend an efficient and successful place to work.

"Joe is one of the most creative, physician-friendly CEOs I have seen in action," a colleague says.

Another says, "Joe is not afraid to make a decision or take chances and is willing to try new concepts and ideas. He is a positive thinker and believes things will always work out. He is also very open to listen to others and their ideas."

Some other colleagues mention some of Mr. Freudenberger's unique ideas for improving operations at OakBend.

"…Joe is indeed full of creativity and energy and never gives up," one colleague says. "He leads a great group of department directors who work extremely well with each other. Interestingly, an example of Joe's creativity is that some of his leadership team is related, not something most other CEOs would do, and he strongly believes this promotes loyalty, teamwork and community."

Mr. Freudenberger describes his thought process when developing these out-of-the-box techniques by simply saying, "If you aren't achieving your objectives, you have to do something differently."

He says that he'll throw out a radically different idea to his directors in order to "get the creative juices flowing."

"You need to create energy to see how 'we can do it differently,'" he says. "Then you can see a way to change. Small steps might get you to where you need to be."

For example, in order to address the high turnover rates in healthcare, Mr. Freudenberger considered what other organizations in the industry were doing. He came across Medline Manufacturing, a company that decided to keep the production of entire product lines within a single extended family.

"They found that family members do more to hold things together [in a company] than others," he says. "They maintain a level of excellence and are better at internal discipline."

After seeing this example, Mr. Freudenberger thought that it might be a good step for OakBend to take, as noted by one of his colleagues.

"We ask our staff to recommend people they trust," he says of the hospital when trying to fill vacancies. "Often times, they have family members who work out."

As a result, the employee who recommended the family member does his or her best to ensure that the new employee is up to OakBend's standards. "Their reputations are on the line," he says. "They don't tolerate anything that will damage that."

Establishing a presence on the floor

Mr. Freudenberger says two of his other creative management ideas have come from an effort to be more visible in the various departments of the hospital.

"Visibility is important with the community and staff," he says. "You have to get out there at times when people are available."

For example, Mr. Freudenberger and several members of the executive staff held a 1 a.m. town hall meeting for night shift employees so this portion of the staff population could express any concerns they had.

"Seven p.m. would have been convenient for me but not the night shift because that is when they are just beginning their shifts," he says. "Instead, we asked them what time they preferred, and 1 a.m. did work. We had around 30 people come and talk with us. It was very productive."

Another method Mr. Freudenberger has taken to increase his visibility and to motivate staff is to provide a quarterly cash bonus when financial goals are met. Every employee, from housekeeping to clinical staff, receives a $50 bonus if they make their budget each quarter. He makes an effort to personally hand each employee their bonus.

Of this undertaking, one colleague says, "While other bigger facilities in Houston have expanded into our market, Joe and his department directors and board have found a way to thrive and exceed budget month after month. Employees look forward to him personally handing out new $50 bills when budget is beat. Joe values OakBend's employees first of all, and it shows!"

Mr. Freudenberger uses this face time to see how his staff is handling the different issues of the day, such as questioning staff on patient safety goals. This was one technique he used in preparation of The Joint Commission survey.

"[Asking questions] helps to emphasize quality," he says. "I can see if the staff is focused and how they answer questions under pressure so they were prepared for the surveyors."

This technique paid off. The Joint Commission surveyors commented that "OakBend was incredible" and that the staff was "friendly, knowledgeable and did the right things consistently."

Financial success

In addition to his successes with personnel, Mr. Freudenberger has seen financial success and growth over the past year at OakBend. One colleague says, "Joe has turned this organization around both culturally and financially in just one year. He is dedicated, focused and an excellent leader. What we have accomplished in the last year could not have been done without his leadership."

Creating an atmosphere of transparency, honesty and collaboration is what he attributes to this success. Regular communications with employees — letters, town hall meetings, making the rounds — has helped the staff to see what their targets should be and feel proud of their own accomplishments as well as the hospital's.

"Employees should take pride in their work and not just see it as a paycheck," Mr. Freudenberger says. By building a culture of collaboration, he says that OakBend has been able to succeed in this tough economy.

"It is easier to build volume than to cut costs," he says. "We try to maintain a high level of quality and customer service, and then we ask physicians to bring in patients. People do respond to these requests. Physicians are pleased when they are asked to bring in business to help the hospital succeed."

A 'can-do' attitude

Many colleagues note Mr. Freudenberger's can-do attitude. One says, "Joe has demonstrated strong vision and leadership. He is a 'make it happen' CEO with excellent business and market knowledge. Joe has a proven track record of success."

Mr. Freudenberger works to find time to speak with the organization's entire staff about the critical importance of dedication to excellence.

"This is a conversation I have with everyone," he says. "You can do anything if you are committed. I tell my children, 'If you want the A, you must put in more effort." This perspective extends to his professional life.

"I will not accept 'no' as an answer," he says. He says that he will accept "I'm not willing" as an answer, because that means a person won't put in the effort required to accomplish a task. However, in his opinion, "'I can't' doesn't exist."

As a result of this "make it work" philosophy, OakBend is experiencing extensive growth and is expanding to a second campus this year which will feature full service inpatient care as well as a third campus dedicated to comprehensive outpatient services in Fort Bend.

This is impressive, especially since other hospitals across the country have halted or postponed expansions.

"So much in healthcare is tied to financials," he says. "If you don't understand it, you can't come up with and execute solutions. I am able to make quick and efficient decisions."

In addition, Mr. Freudenberger's experience as a COO has helped him see that "it's more than dollars and cents that drive a hospital," he says. "It helped me to see the physician view of operations."

Pride in your work

Most of all, Mr. Freudenberger says that he tries to enable his employees to feel proud to be a member of the OakBend family. "I brag about OakBend all the time to them," he says. "But I also look for opportunities to say, 'You're doing a great job!'"

> "Joe is not afraid to make a decision or take chances and is willing to try new concepts and ideas. He is a positive thinker and believes things will always work out. He is also very open to listen to others and their ideas."

Using past experience as a guide

Mr. Freudenberger's background is in business in finance. He graduated with a bachelor of science in mathematics and economics from Tulane University in New Orleans and received his MBA in finance from Tulane's Freeman School of Business, where he graduate cum laude.

Prior to becoming CEO at OakBend, Mr. Freudenburger severed as a CFO and a COO at another location.

Mr. Freudenberger's experience as a CFO has helped him to become a successful CEO.

By using creative and unique approaches to problem solving, being visible in the hospital and making staff enthusiastic about being a part of the hospital, Mr. Freudenberger has been able to bring success to OakBend.

As one colleague says, "Joe's leadership, experience and commitment have helped our hospital grow and succeed." ■

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Debbie Hay, Runner-Up for *Becker's Hospital Review*'s Hospital CEO of the Year

By Renée Tomcanin

Working well with staff and patients at a hospital is one of the essential steps in ensuring the success of the facility and is a great ability for a CEO to possess. Debbie Hay, president of the Texas Institute for Surgery in Dallas, is one hospital leader who embodies this ability.

In addition to establishing a great relationship with all who work and visit her hospital, Ms. Hay's strong leadership has led to her being voted as one of the runners-up for *Becker's Hospital Review's* Hospital CEO of the Year.

Ms. Hay oversees operations at the Texas Institute for Surgery, a surgical specialty hospital that primarily performs surgical and pain management procedures.

The hospital contains a nine-bed inpatient unit, nine ORs and three specialty treatment rooms. Among its top surgical specialties are orthopedics, pain management and ENT, according to Ms. Hay.

Creating an environment of respect

When describing Ms. Hay's great leadership, one of her colleagues says, "Debbie Hay serves gallantly as president of this small specialty surgical hospital. Her executive leadership skills are great. She's innovative, flexible and always has the hospital and its employees as her first priority."

Another commends Ms. Hay, saying, "Debbie Hay [is an excellent leader] because of her professionalism, quality of care for the facility and employees and patient care. She is personable,

has great character and has a spirit of excellence. She brings out the best in others."

Ms. Hay is modest about her management style, saying that she simply treats everyone equally by being "fair, honest and supportive with people." This approach to management has led many who work at the Texas Institute for Surgery to see Ms. Hay as an effective leader.

For instance, a colleague says, "She always has a willing spirit, will get in there no matter what the department is and get things done and help out when there is a short staff situation. She is very professional, smart and witty and always has an 'open-door policy' to come to her with whatever is needed."

Ms. Hay notes that while she does have an open door, she encourages her staff to use the proper chain of command when they have an issue. "I am available when a staff member feels their concerns aren't being addressed," she says.

Always willing to lend a hand

Before coming to the Texas Institute for Surgery, Ms. Hay has served as the administrator of a surgery center, an ER nurse and manager and has more than 30 years' nursing experience. This clinical understanding is clearly an asset to her when addressing staff problems.

Ms. Hay credits her background with helping her to work more effectively with the hospital staff.

One colleague says, "She is uniquely qualified for her position with the vast years of clinical and administrative experience. Her past experience in the OR raises her credibility with surgeons and staff alike."

"It helps to boost staff and physicians confidence," Ms. Hay says. "I can discuss clinical issues, understand and help resolve them."

Ms. Hay makes sure to commit a significant amount of time in the departments and areas of her hospital. "I frequently ask questions when I'm in the department," she says. "You can find out things that you may not know otherwise."

Often, this helps her to address problems before they become bigger issues and allows her to bring these concerns up with department management.

You can often find Ms. Hay lending a hand in departments that need her, as her colleagues mention. Using her experience as a registered nurse, she is not afraid to step in and assist with the clinical side of the hospital

She also helps out on the business side of operations. She doesn't consider this anything out of the ordinary.

"I help out wherever I can to fulfill the needs of the hospital," she says. "In orientation, I tell every employee that there is no task that is 'not in my job description.' I include myself in that statement. If they need me to serve food in the cafeteria or assist in the clinical area, I'll do it because there is a need."

She sees the benefit in spending times in different areas of the hospital. "By helping out, I'm supporting the fact that we need to have respect for one another's job responsibilities," she says.

Going green

One of Ms. Hay's major projects over the past year has been to encourage her hospital to "go green."

A colleague says, "In addition to electronic medical records, she has speared an amazing effort to 'green' the Texas Institute for Surgery facility — she personally started the effort, and today the program is widely embraced by TIS employees who recycle just about everything possible and has become a model for other hospitals in our area."

Ms. Hay's green campaign consists of "a lot of little things" that a hospital can do.

Some of her "little things" include adding new ground cover and planting trees on the hospital's grounds, converting to EMS, using green housekeeping supplies and monitoring the use of electricity around the facility. This latter technique includes automatic light sensors that shut off the lights and adjusting temperatures in specific areas when they are not in use.

In addition, Texas Institute for Surgery uses green couriers who drive hybrid cars or use bikes if they are close-by.

Ms. Hay's biggest effort when it comes to her green campaign has been in recycling. "The hospital environment is a huge waster of resources because we use so many disposable things that are thrown away," she says.

Her hospital uses a single-stream recycling company that doesn't require them to separate their recyclables. Texas Institute for Surgery recycles everything from bottles to IV bags to tubing to paper products.

"It's had a big impact and has taken the most effort," she says.

Maintaining an excellent staff

Ms. Hay has also managed to maintain an extremely high staff retention rate at her organization. One colleague puts the number near 95 percent. "Our facility attracts great physicians and staff in large part due to the leadership that Ms. Hay has established," the colleague says.

Ms. Hay says that it is important for the staff to know that they have someone within the hospital who will listen to their concerns.

"Finding a good staff that works well together and fits well within the organization has been essential," she says.

She notes that although an employee may be a good worker, it is important that he or she works well with the rest of the staff and within the culture of the hospital.

"Money doesn't solve all problems," she says, in regards to creating an excellent team. "You have to acknowledge situations and be strong enough to say to a person, 'You aren't a good fit.'"

Ms. Hay notes that the process of creating a good team doesn't happen overnight, but working diligently to do so does pay dividends.

According to a colleague, patient satisfaction at the Texas Institute for Surgery is "consistently more than 95 percent," which Ms. Hay attributes to assembling an excellent staff.

"It's the people who maintain patient satisfaction," she says. "A compassionate staff makes patients feel like they are listened to and cared for, and leads to exceptional care."

These many factors have helped the hospital to grow in spite of the current economic situation, and Ms. Hay can't attribute the success to any one element.

"We have an outstanding group of physicians and physician-owners who are concerned with the safety, well-being and happiness of the patients and the staff," she says. "Everyone is on the team." ■

Contact Renée Tomcanin at renee@beckersasc.com.

"[Debbie Hay] always has a willing spirit, will get in there no matter what the department is and get things done and help out when there is a short staff situation. She is very professional, smart and witty and always has an 'open-door policy' to come to her with whatever is needed."

10 Statistics About the Economic Impact on Hospitals

Here are 10 statistics on the impact of the economy on hospitals in the United States, according to a survey by the American Hospital Association.

For the statistics below, the percentages represent the percent of hospitals reporting differences in various aspects of hospital financing during the first three months of 2009, as compared to the same period of 2008.

1. Emergency room visits by uninsured patients — 45 percent of hospitals reported a moderate increase in the number of emergency room visits by uninsured patients; 13 percent reported a significant increase.

2. Uncompensated care — 43 percent of hospitals reported a moderate increase in uncompensated care as a proportion of total gross revenue; 27 percent reported a significant increase.

3. Elective procedures — 41 percent of hospitals reported a moderate decrease in elective procedures; 18 percent reported a significant decrease.

4. Inpatient admissions — 38 percent of hospitals reported a moderate decrease in inpatient admissions; 17 percent reported a significant decrease.

5. Community need — 42 percent of hospitals reported a moderate increase in community need for subsidized services; 11 percent reported a significant increase.

6. Charitable contributions — 31 percent of hospitals reported a moderate decrease in charitable contributions; 9 percent reported a significant decrease.

7. Total operating margin — 26 percent of hospitals reported a moderate decrease in total operating margin; 39 percent reported a significant decrease.

8. Days cash on hand — 32 percent of hospitals reported a moderate decrease in days cash on hand; 27 percent significant decrease.

9. Days accounts receivable — 29 percent of hospitals reported a moderate increase in days A/R; 7 percent reported a significant increase.

10. As a result of these economic conditions, hospitals responded in the following ways:
Administrative expenses — 80 percent of hospitals reported cutting administrative expenses as a result of economic concerns.
Staff reductions — 48 percent of hospitals reduced staff.
Service cuts — 22 percent of hospitals reduced services.
Mergers — 9 percent of hospitals reported considering a merger. ■

Source: AHA's *The Economic Crisis: The Toll on the Patients and Communities Hospitals Serve*, April 2009 (www.aha.org/aha/resource-center/Statistics-and-Studies/studies.html).

Hospitals Across the Nation Announce CEO, CFO Changes

Here is a round-up of 20 of the most recent changes and appointments of hospital CEOs and CFOs from around the country. *Note:* Stories are ordered alphabetically by state.

1. Gadsden Regional (Gadseden, Ala.) announces Stephen Pennington as its new CEO.
2. Jefferson Regional Medical Center (Pine Bluff, Ark.) announces Walter Johnson as new CEO.
3. Mercy Medical Center (Redding, Calif.) CEO Rick Barnett resigns; hospital starting national search for replacement.
4. Jackson Health System (Miami) names Dr. Eneida Roldan as president and CEO.
5. St. Luke's Health System (Boise, Idaho) names Dr. Dave Pate as new president and CEO.
6. Dekalb Memorial Hospital (Auburn, Ind.) CEO Jack Corey resigns.
7. Riley Hospital for Children (Indianapolis) names Daniel Fink as president and CEO.
8. Mercy Regional Health Center (Manhattan, Kan.) names John Broberg as new president and CEO. [http://hospitalreviewmagazine.com/news-and-analysis/business-and-financial/mercy-regional-health-center-names-ceo.html]
9. Norton Audubon Hospital (Louisville, Ky.) names Steven MacLauchlan as new president.
10. Saint Agnes Hospital (Baltimore) names Steve Furniss as CFO.
11. Brockton Hospital (Brockton, Mass.) CEO Norman Goodman resigns.
12. Hennepin County Medical Center (Minneapolis) names Arthur Gonzalez as CEO.
13. Mary Lanning Memorial Hospital (Hastings, Neb.) names Bradley Neet as CEO.
14. Hackensack University Medical Center (Hackensack, N.J.) names Robert Garret as acting president and CEO following resignation of John Ferguson.
15. Robert Wood Johnson University Hospital Hamilton (Hamilton, N.J.) names Anthony J. Cimino as president and CEO.
16. Duke University Hospital (Durham, N.C.) names Kevin Sowers as CEO.
17. Union Hospital (Dover, Ohio) names R. Bruce James as president and CEO. [http://hospitalreviewmagazine.com/news-and-analysis/business-and-financial/ohio-hospital-announces-new-ceo.html]
18. Children's Hospital of UPMC (Pittsburgh) CEO Roger Oxendale resigns.
19. Sumner Regional Health Systems (Gallatin, Tenn.) CEO William T. Sugg resigns.
20. Southwestern Vermont Health Care (Bennington, Vt.) begins search for new CEO. ■

Note: For more information on hospital C-suite changes, visit www.HospitalReviewMagazine.com and sign-up for the free *Becker's Hospital Review* weekly electronic newsletter at www.hospitalreviewmagazine.com/enewsletter.html.

PHYSICIAN-OWNED HOSPITAL UPDATE

Physician-Owned Hospitals and Physician Owners Must Disclose Ownership to Patients

By Scott Becker, JD, CPA, and Amber Walsh, JD

CMS, in the FY 2008 and FY 2009 IPPS regulations, finalized changes relating to hospitals serving Medicare/Medicaid beneficiaries that require such hospitals and their physician owners to disclose physician ownership information to patients. The disclosure requirements became effective June 8, 2009.

The requirements require disclosure by the hospital and by the physician. The hospital must furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital meets the Federal definition of a "physician-owned hospital" and that the list of physician owners or owners who are immediate family members of physicians is available upon request. For purposes of this requirement, the hospital stay or outpatient visit is deemed to begin with the provision of a package of information regarding scheduled preadmission testing and registration for a planned admission/service. The specific requirement is as follows:

> "To furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her case, in accordance with Sect. 482.13(b)(2) of this subchapter. This notice should disclose, in a manner reasonably designed to be understood by all patients, the fact that the hospital meets the Federal definition of a physician-owned hospital specified in Sec. 489.3 and the list of the hospital's owners or investors who are physicians or immediate family members (as defined at Sec. 411.325 of this chapter) of physicians is available upon request and must be provided to the patient at the time the request for the list is made by or on behalf of the patient. For purposes of this paragraph (u) (1), the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service."

The hospitals must also require that each physician owner who is a member of the hospital's medical staff agree, as a condition of continued medical staff membership, to disclose in writing to all patients referred to the hospital that he or she (or an immediate family member) holds an investment interest in the hospital. Disclosure by the physician must be made at the time of the referral. The specific requirement is as follows:

> "To require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the hospital any ownership or investment interest in the hospital that is held by the physician or by an immediate family member (as defined at Sec. 411.351 of this chapter) of the physician. Disclosure must be required at the time the referral is made."

CMS may deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital. Likewise, CMS may terminate a provider agree-

XYZ HOSPITAL
DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in this notice.

1. XYZ Hospital meets the definition of a "physician-owned hospital" under 42 CFR 489.3. The hospital is owned in part by the following physicians.

_____

_____

_____

_____

2. [You have the right to choose the provider of your health care services. Although we believe that XYZ Hospital will be able to meet your needs, you have the option to use a facility other than XYZ Hospital. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedures at an alternative facility if he or she does not maintain privileges at such facility. If desired, your physician or any staff member can provide information about alternative health care providers.]

3. [Disclosure of a physician not on premises 24/7.]

If you have any questions concerning this notice, please feel free to ask your physician or any representative of XYZ Hospital. We welcome you as a patient and value our relationship with you.

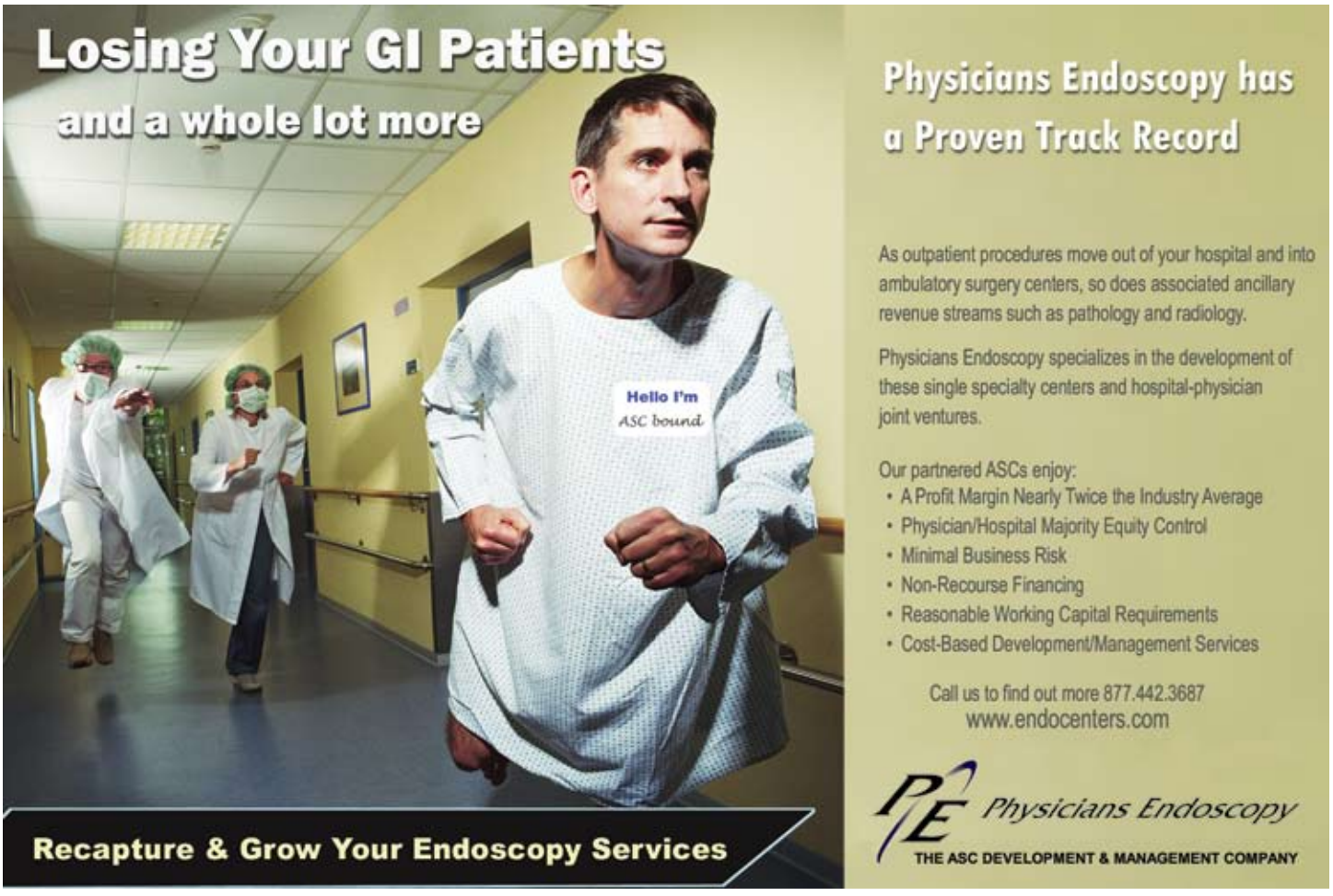
ment with a physician-owned hospital if the hospital fails to comply with the disclosure and medical staff requirements above. The regulation also requires disclosure if a physician is not always on the premise. Here, the specific requirement is as follows:

> "In the case of a hospital as defined in Sec. 489.24(b), to furnish written notice to all patients at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, seven days per week, in order to assist the patients in making informed decisions regarding their care, in accordance with Sec. 482.13(b)(2) of this subchapter. The notice must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition, as defined in Sec. 489.24(b), at a time when there is no physician present at the hospital. For purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient services."

To prepare for the June 8th effective date, physician-owned hospitals should:

1. Prepare a notice of ownership disclosure that would be included in the patient admissions materials and also could be posted on the wall of the waiting room or other public area of the hospital notifying patients that it is physician-owned. Such notice should either a) list the physician owners by name or b) notify patients that they may request the list of individual physician owners. A sample disclosure form that maybe used both in admissions material and as a wall sign utilizing option "a" can be found on p. 26.
2. Notify its physician owners of the requirement that the individual physicians must disclose in writing their ownership in the hospital to patients at the time of the referral and that their compliance with this requirement is a condition for continued medical staff privileges. The hospital should also amend its medical staff bylaws to require such disclosure.
3. Periodically require physician owners to confirm that they are abiding by the disclosure requirements.

If you have any questions about the disclosure requirements please contact McGuireWoods attorneys Scott Becker (sbecker@mcguirewoods.com) at (312) 750-6016 or Amber Walsh (awalsh@mcguirewoods.com) at (312) 750-3596. ■



20 Physician-Owned Hospital CEOs to Know

Mike Bullard (Doctors Hospital Tidwell, Houston). Mr. Bullard is the CEO of Doctors Hospital Tidwell, an acute-care hospital that provides healthcare services to more than 500,000 residents in the medically underserved communities of North Houston. Prior to coming to Doctors Hospital Tidwell, Mr. Bullard was the CEO of Triumph Healthcare in Houston.

Brian Cramer (Orthopedic Hospital of Wisconsin, Milwaukee, Wis.). Mr. Cramer is the CEO of the Orthopedic Hospital of Wisconsin, a specialty hospital that concentrates on the treatment of orthopedic injuries and conditions. He has 23 years of experience in healthcare administration in the U.S. Air Force where he served as director of medical exercises an administrator and COO at bases located globally. Prior to coming to the Orthopedic Hospital of Wisconsin, Mr. Cramer was the executive director of cancer services for Columbia St. Mary's Hospital in Milwaukee.

Rick Ferguson (Oklahoma Surgical Hospital, Tulsa, Okla.). Mr. Ferguson is the CEO of the Oklahoma Surgical Hospital. He is on the board of advisors for the Tulsa Metro Chamber. Mr. Ferguson previously served as COO for the facility when it was known as the Orthopedic Hospital of Oklahoma, and the hospital has since expanded its services to include more than just orthopedic surgery and has added 10 general surgeons on staff.

Thomas B. Flynn, MD (The NeuroMedical Center Clinic, Baton Rouge, La.). Dr. Flynn is the president and founder of the NeuroMedical Center Clinic and has served the Baton Rouge community for more than 40 years. Dr. Flynn received his medical degree from Tulane University and completed a surgical internship and residency at Charity Hospital in New Orleans, followed by a fellowship in neurological Surgery with the Ochsner Foundation in New Orleans. Dr. Flynn retired from medical practice in 2008 continues to serve the NeuroMedical Center as president current president.

Brett Gosney (Animas Surgical Hospital, Durango, Colo.). Mr. Gosney is a founder, partner and the CEO of Animas Surgical Hospital. He currently serves as president of Physician Hospitals of America, a Sioux Falls, S.D.-based trade group that represents physician-owned hospitals and is the director of development for Symbion. Mr. Gosney has a diverse background in healthcare spanning more than 25 years. He has been a paramedic, ICU and surgical nurse, surgical services manager and an ASC and hospital administrator.

John Harvey, MD (Oklahoma Heart Hospital, Oklahoma City, Okla.). Dr. Harvey serves as medical director and CEO at Oklahoma Heart Hospital and Oklahoma Cardiovascular Associates. He is a board-certified physician specializing in cardiac electrophysiology and pacing and has been with Oklahoma Cardiovascular Associates since 1998. Dr. Harvey attended medical school at the University of Oklahoma College

of Medicine in Oklahoma City and completed post-graduate training in general surgery, at Mount Sinai Hospital in New York City and in cardiovascular disease at the University of Michigan in Ann Arbor.

Debbie Hay (Texas Institute for Surgery, Dallas). Ms. Hay serves as president of the Texas Institute for Surgery and previously served as the administrator for a surgery center and as an emergency room nurse and manager. She named as one of the runners-up for *Becker's Hospital Review*'s CEO of the Year this year. Ms. Hay has a psychology degree from William Woods University in Fulton, Mo., and a nursing degree from Baylor University in Dallas.

Michelle Weidner-Jordan (Lewis and Clark Specialty Hospital, Yankton, S.D.). Ms. Weidner-Jordan is the CEO and administrator at Lewis and Clark Specialty Hospital. Prior to assuming the role of CEO, she served as the director of nursing for Lewis and Clark. Ms. Weidner-Jordan has more than 12 years of nursing experience, and she has extensive knowledge of many areas of nursing including medical/surgical, surgery, PACU, endoscopy, manometry, IV sedation, obstetrics, occupational health, oncology and travel nursing. She is a member of her local chamber of commerce, the local leadership and service group, Verve, and is the healthcare representative for the "Shop Local" task force.

Bill Keaton (Baylor Medical Center at Frisco, Frisco, Texas). Mr. Keaton was appointed as CEO of Baylor Medical Center in Frisco in 2001. Under his leadership, the hospital saw a $65 million expansion in 2007. Prior to coming to Baylor Medical Center, Mr. Keaton served as COO of River Region HealthCare System in Vicksburg, Miss., and as CEO of Columbia Panhandle Surgical Hospital in Amarillo, Texas. He currently serves as a board member for Frisco Family Services and Care View Communications and is actively involved with the Frisco Industrial Council and the Sherman Chamber of Commerce.

Jane Keller (Indiana Orthopedic Hospital, Indianapolis, Ind.). Ms. Keller is the CEO and chief nursing officer for the Indiana Orthopedic Hospital where she works with the board of managers to create and implement the hospital's strategic plan and develops and maintains a positive image of the hospital. She serves as the development chair for Indiana's Arthritis Foundation and is an active member of its board of directors. Ms. Keller started at OrthoIndy, the group that owns IOH, as the executive director/nursing director of surgery centers. She is an avid sports fan and can often be found cheering on the sidelines at the sporting events of one of her three children.

For more information or an introduction to any of the following companies, e-mail sbecker@mcguirewoods.com, call (800) 417-2035 or fax with the company circled to (866) 678-5755.

Resources

Anesthesia staffing and practice management

Somnia. Somnia, founded in 1996, is one of the most experienced physician-owned and operated anesthesia management company servicing healthcare facilities nationwide, specializing in building and comprehensively managing world-class anesthesia teams that consistently deliver the highest quality of patient care. Visit Somnia at www.somniainc.com or call (877) 476-6642, ext. 3538.

Superior Medical Services. Superior Medical Services is a full-service medical recruitment firm specializing in permanent and locum tenens placement of anesthesiologists, CRNAs and pain management physicians nationwide. Visit SMS at www.smsanesthesia.com or call (847) 816-9296.

Back-office management, outsourcing and accounting

MedHQ. MedHQ provides accounting, revenue cycle, human resources and credentialing services to clients in 10 states. Learn more at www.medhq.net or call (708) 492-0519.

Debt collections

Affiliated Credit Services. Affiliated Credit Services is a Colorado-based professional account receivables management firm which focuses on increasing businesses cash flow by providing superior collection services. Learn more at www.acscollects.com or call (970) 867-8521.

Health information technology providers

ProVation Medical. ProVation Medical, part of Wolters Kluwer Health, offers ProVation EHR, designed to meet the patient charting and documentation needs of cost-conscious surgery centers; ProVation EHR provides electronic physician, nursing, anesthesia and other documentation combined in a patient-centric system that eliminates printing, transcription and chart storage costs and streamlines workflow. Learn more about ProVation Medical at www.provationmedical.com or call (612) 313-1500.

Hospitalist Services

Hospitalist Management Group. HMG is a nationwide provider of turnkey hospitalists solutions. The company is the largest physician-owned, equal-equity hospitalist group in the country, with more than 400 physicians serving 42 different locations. Learn more about HMG at www.hmgdoc.com or call (866) 464-7497.

Management, development and equity firms

Buxton. Buxton analyzes millions of customer records, both medical and non-medical, to help organizations identify who prospective patients are, where to locate facilities to serve those patients and what level of activity the facilities will ultimately realize. Learn more about Buxton at www.buxtonco.com or call (888) 2BUXTON.

Foundation Surgery Affiliates. Foundation Surgery Affiliates is a healthcare management organization specializing in project development, innovative facility design, partner recruitment and facility operations for surgical hospitals and bariatric hospitals and healthplexes, medical office buildings and surgery centers. More information about FSA can be found at www.foundationsurgery.com or call (405) 608-1700.

Health Inventures. A management and consulting services firm, Health Inventures has been developing and expanding ambulatory surgery care and other outpatient services since 1976. Learn more at www.healthinventures.com or call (720) 304-8940.

MedStone Capital. RMC MedStone Capital combines the strength of several industry standards like Mike Lipomi, Tim Noakes and the Stanislaus Surgical Hospital of Modesto, Calif., with one of the leading real estate companies in Dallas, RM Crowe, to form a very strong team. You can see more information on MedStone at www.medstonecapital.com or call Mr. Lipomi directly at (209) 602-3298.

Physicians Endoscopy. Physicians Endoscopy develops and manages endoscopic surgery centers in partnership with practicing GI physicians and hospitals. Visit the company at www.endocenters.com, e-mail John Poisson at jpoisson@endocenters.com or call him at (215) 589-9003.

Pinnacle III. Pinnacle III specializes in the operational development, management, select management and billing for surgical and specialty hospitals, joint ventures and surgery centers. For more information, visit Pinnacle III online at www.pinnacleiii.com or call Dan Connolly, vice president of development and payor contracting, at (877) 710-3047.

Prexus Health. Prexus Health is a 100 percent physician-owned company that specializes in the development and management of multi-specialty, physician-owned ASCs and small hospitals. For more information, call (513) 454-1414, e-mail Prexus at info@phcps.com or visit www.prexushealth.com.

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VMG Health. VMG Health is recognized by leading healthcare providers as one of the most trusted valuation and transaction advisors in the United States. For more information, visit VMG at www.vmghealth.com, e-mail Jon O'Sullivan at osullivan@vmghealth. com or call (214) 369-4888.

Jack Lahidjani (Miracle Mile Medical Center, Los Angeles). Mr. Lahidjani joined Miracle Mile Medical Center in 2007 as CEO. Prior to joining Miracle Mile, Mr. Lahidjani was the senior vice president and system CFO for a chain of for-profit community hospitals in the urban areas of Los Angeles. Prior to that, Mr. Lahidjani served as the managing director of Hospital Reimbursement Associates, Government Program Specialists and held directorship positions at Jacobson & Associates and Certus Corporation, all healthcare financial consulting firms.

Mark McDonald, MD (Institute for Orthopaedic Surgery, Lima, Ohio). Dr. McDonald is president and CEO of the Institute for Orthopaedic Surgery and is a board-certified orthopedic surgeon, specializing in sports medicine, arthroscopy and total joint replacement. He completed medical school at The Ohio State University College of Medicine and completed his orthopedic surgery residency at the University of Kentucky.

Dr. McDonald also serves as the Team Physician for Bluffton (Ohio) University.

Thomas C. Macy (Nebraska Orthopedic Hospital, Omaha, Neb.). Mr. Macy is the CEO of the Nebraska Orthopedic Hospital, the region's first hospital dedicated to the complete care and treatment of the orthopedic patient. His role at NOH includes oversight for hospital operations, business strategy and development, physician and government relations, and governance. Mr. Macy joined NOH in 2004 as executive director of business operations and was promoted to CEO in 2005. Prior to NOH, Mr. Macy worked in various hospital and physician practice management roles in both Columbia, Mo., and Philadelphia.

Pamala Maher (Arizona Regional Medical Center, Mesa, Ariz.). Ms. Maher is CEO of Arizona Regional Medical Center, which opened in Oct. 2008. Prior to serving as CEO at ARMC, Ms. Maher served as CEO for a number of hospitals in Wyoming, Texas and Arizona and as senior administrator at Advanced Cardiac Specialists, an internal medicine and cardiology practice in Arizona. Ms. Maher served as regional executive for the American Hospital Association from 1995-99 and has served on the Governing Council for Aging and Long-Term Care of the American Hospital Association. Ms. Maher holds an MBA from the University of Idaho.

William May (Black Hills Surgery Center, Rapid City, S.D.). Mr. May joined Black Hills Surgery Center in 2004 as CEO and General Counsel. Prior to that time, he was a senior partner in the Costello Porter Law Offices with extensive experience in commercial litigation, fiduciary duty and health law. Mr. May's role in the hospital includes strategic planning, business development, legal counsel, governmental relations and all operational issues. During Mr. May's tenure, Black Hills Surgery Center has expanded its presence as a surgical center of excellence through a highly focused doctor and patient model of service and care. He was also significantly involved in all legal and transactional aspects of the partial sale of Black Hills Surgery Center to Medical Facilities Corp. of Toronto, Canada, in March 2004.

Timothy J. Noakes (Stanislaus Surgical Hospital, Modesto, Calif.). Mr. Noakes is the CEO of Stanislaus Surgical Hospital and has more than 28 years of experience in the healthcare industry. He joined the management team at Stanislaus as the CFO in 1998 and assisted in the conversion of the facility from an ASC to a general acute care hospital. Prior to joining Stanislaus, Mr. Noakes participated with the company founders in the development and start-up of a private healthcare company, Health Pacific International, and he served as CFO at the Fresno (Calif.) Surgical Hospital. Mr. Noakes is currently on the board of directors at Stanislaus Surgical Hospital and is the registered agent in California for Physicians Hospital Association.

Alex Rintoul (Medical Center of Elizabeth Place, Dayton, Ohio). Alexander Rintoul joined the Medical Center of Elizabeth Place as CEO in March 2007. Previously, Mr. Rintoul served as vice president of ambulatory services division and a director of operations for ambulatory centers for University Hospitals Health System in Cleveland.

Mr. Rintoul also worked as a director of operations for HealthSouth's Ohio surgery centers and served as an administrator for several medical facilities in Ohio, including Western Reserve Medical Center in Kent. Mr. Rintoul served as chairman of the Ohio Association of Ambulatory Surgery Centers from 2004-2006 and holds an MBA from Kent State University.

Tom Schmitt (Kansas Spine Hospital, Wichita, Kan.). Mr. Schmitt is the CEO of the Kansas Spine Hospital and has been at KSH since 2006. Prior to KSH, he held CEO positions at general acute care hospitals in Tennessee and Oklahoma, and has worked with not-for-profit healthcare systems, such as SSM Healthcare and INTEGRIS, and for-profit providers, such as Community Health Systems. Mr. Schmitt is a fellow in the American College of Healthcare Executives and earned his MHA from Saint Louis (Mo.) University.

Stephanie C. Spiegel (Neurologic & Orthopedic Hospital of Chicago). Ms. Spiegel has served as president and COO of the Neurologic & Orthopedic Hospital of Chicago, the only acute care hospital in the United States focused exclusively on neurosurgical, neuromedical and orthopedic services, since 2002. Under her guidance, the hospital has expanded from a start-up venture to a $40 million healthcare facility with 85 beds and more than 200 full- and part-time employees. Ms. Spiegel has more than 20 years of experience in the healthcare industry. Previously, she served as COO for the Chicago Institute of Neurourgery and Neurosearch Medical Group and was vice president of operations for NeuroSource.

Bob Trussell (Foundation Surgical Hospital of San Antonio). Mr. Trussell is the CEO of Foundation Surgical Hospital of San Antonio. Prior to FSHSA, he served as the regional administrator at more than six ASCs in central Texas. He was the associate executive director, hospital finance, for Scott & White Hospital after serving as the CFO for Scott & White Clinic. Mr. Trussell has more than 20 years of experience that covers all aspects of the healthcare industry including the hospital, physician and payor segments. ■

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