A COs: The Least Agreed-Upon Concept in Healthcare?
By Molly Gamble

Healthcare is one of the country's most heavily regulated industries, one also driven by diagnoses, evidence and clinical expertise. Yet, despite this objectivity, one three-letter acronym has caused quite a divide among healthcare policy experts, physicians, health systems and payors.

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Price Transparency: Why It’s an Issue & Where Hospitals Fit in
By Bob Herman

Healthcare prices have been an enigma within the U.S. healthcare system, especially in light of this year’s TIME exposé on why healthcare and hospital services cost so much. Simply put: More patients are starting to question why their healthcare bills are so high — and why they can’t find healthcare prices at all.

In an effort to clarify the muddied waters of healthcare price transparency, Catalyst for Payment Reform and the Health Care Incentives Improvement Institute released a report in March that quantified how a majority of states have failed to enact comprehensive healthcare price transparency laws. The two groups graded each state on whether healthcare pricing information is available, how accessible it is and the

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What’s Behind the Rash of New Hospital Brands?
By Heather Punke

Hospitals and health systems across the country have been getting makeovers this year — several organizations have changed their name, brand and/or logo in the beginning of 2013. The following 10 healthcare name changes and new brands represent just a fraction of the organizations that have reinvented themselves this year.

• Oakland, Calif.-based Alameda County Medical Center became Alameda Health System.
• Baptist Healthcare System in Louisville, Ky., changed its name to Baptist Health and is rebranding its seven Kentucky hospitals.
• Edward Health Services Corp. in Naperville, Ill., became Edward-Elmhurst Healthcare.
• Gaston Memorial Hospital in Gastonia, N.C., was renamed CaroMont Regional Medical Center, to reflect its relationship with CaroMont Health.

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Publisher’s Letter

Dashboard Observations on 17 Niches and Specialties; 7 Reasons to Worry About the Healthcare Economy; Is a Large Combined System Better?

1. Prospects for markets within the healthcare industry. The dashboard below highlights where we see expansion or slow down in different niches within healthcare. Of course, the success of a specific company or provider within an industry depends a great deal on its individual strengths, and the proficiency of its management team and its available resources.

**Hospitals and health systems**

**Slow erosion to stable.** Political power in part offsets substantial reimbursement risk; reduced in-patient cases; increased risk on patient receivables and increased deductibles; serious pricing pressure if movement of patients to exchanges; continued consolidation across industry. Certain hospitals and health systems that have the best quality, that develop leadership in taking on risk, that have market dominance, or that treat a specialized niche and are very lean in their operations will thrive.

**Ambulatory surgery centers**

**Slow erosion.** Reduced number of available physicians, core specialties remaining fairly independent, pressure on case numbers; reimbursement risk; some access to payor issues. Despite the slow erosion in the overall ASC industry, ASC business remains in the greater context a very good industry and business. It remains remarkable how different the revenue equation can be for ASCs from geographic market to market.

**Dialysis facilities**

**Stable to growth.** Continued increasing patient demand offsets some reimbursement risk; continued consolidation; reduced number of physician-owned facilities.

**Physician practices**

**Slow to moderate erosion.** Reimbursement risk depending upon specialty (see below); pressure on referral base and payor access.

**Medical device**

**Slow erosion to stable.** Political power in part offsets some pricing pressure (e.g., industry relationship with Sen. Orrin Hatch); better international opportunities; patient demand continues to increase; substantial mid- and long-term pressure on domestic pricing.

**Health information technology**

**Stable to slow growth.** Customer budget constraints (increased risk to customer-available capital) offset by need to expand and improve systems in hospitals and health systems.

**Urgent care**

**Growth.** Strong alignment with consumers and payors; slim margins.

**Dental practice management**

**Stable to growth.** Growth dependent on payor mix, with pressure on Medicaid-dependent companies; increased state regulatory pressure.

**Home health**

**Stable.** Little political power; fragmented industry undergoing consolidation; some reimbursement risk.

**Hospice**

**Stable.** Some political power; reimbursement risk; utilization risk constraints; consistent consumer demand.

**Nursing homes**

**Slow erosion to stable.** Reimbursement risks for Medicaid-dependent providers and timing of payment from states impacts cash flow.

**Behavioral health**

**Growth.** High patient demand for services; alignment with payors and consumers.
Anesthesia practice management
Stable to growth. Alignment with payors and hospital sector.

Pain management
Stable. Influx of physicians; increased reimbursement and utilization controls.

Orthopedics
Slow erosion to stable. Reimbursement risk; Mature orthopedic practices seem to be very resilient in terms of their referral base and remain critical to the overall delivery of healthcare (i.e., as to the percentage of total dollars spent in orthopedics and the reliance of all facilities on orthopedics).

Spine care
Slow erosion to stable. Reimbursement risk; increased payor controls on surgery.

Gastroenterology
Stable. While there is some pressure on pricing at all levels, gastroenterologists in many areas remain in very high demand and remain very busy.

2. Hospital and health system mergers.
This remains a fascinating time in healthcare. We are continuing to see small to midsize facilities enter into affiliations and sales transactions. In contrast, we are also seeing some large systems (e.g., systems with $3 billion dollars or more in revenue) looking at merging with each other. Here, many questions arise with respect to whether the merger really makes sense from a cost savings or strategy perspective. Specifically, will the combined system achieve a truly dominant position where payors and employers must have the system in their health plans, or will the merger leave the system so burdened with costs and employees that it will ultimately need to engage in layoffs or other efforts to drastically cut costs? Will it allow for more strategic management or simply lead to a large system without clear priorities? Will the merger allow the health system to better serve managed care payors, deliver quality care and manage costs? Will the depth in revenues allow for better investments in management, outpatient services, information systems and other capital projects?

For more discussion on this issue of whether hospital and health system mergers perform, please see “Is Bigger Always Better? Exploring the Risks of Health System Mega-Mergers” (Becker's Hospital Review, March 18, 2013) and “Point-Counterpoint: Is the Rush to Hospital Consolidation Rash?” (Becker's Hospital Review, March 26, 2013).

3. Healthcare spending. Here are seven observations on the current climate surrounding healthcare providers.

• Government debt and the need to reduce spending. No matter how you slice it — and the sequester seems to be the most simple and obvious example of it — there is an increased recognition that the federal government must rein in its spending. Even those on the tax and spend side seem to view it as such. Through Medicare and Medicaid, the government is responsible for around 30 to 50 percent of the payments healthcare providers receive, and as a result, even small reductions in federal spending could amount to a lot of money coming out of healthcare.

• Increased taxes. Increased taxes on high-earning individuals will only further compound the impact of sequestration by taking more money out of the economy that would be otherwise spent on goods and services, including healthcare. These increased taxes being paid by the largest tax payor blocs will take serious dollars out of the economy that won’t cleanly recycle back in and may just go to service government debt. Where a larger and larger portion of the healthcare bill is paid by consumers, whether via deductibles or other means, this has a significant impact on the economy.

• Tepid economic growth. Even before accounting for the sequester and increased taxes on income and the payroll, the economic growth rate was at 1 to 2 percent. When you then take another 3 to 5 percent out of the economy through taxes and costs reductions, it is hard to see where the country will have any economic growth. In March, the unemployment rate was steady at 7.6 percent. Real job creation was below zero when job growth (an 88,000 increase in non-farm payroll employment) is balanced with those exiting the workforce. Overall, the civilian labor force declined by 496,000 during the month.

• Shifts to health exchanges. As insurance companies raise rates to meet the requirements of healthcare reform, it is increasingly projected that more of the population will move to healthcare exchanges. This shift to exchange-based health plans is concerning for healthcare providers, because the payment rates for these plans are uncertain. Small movements of well-paying health exchanges. This shift to exchange-based healthcare plans is concerning for healthcare providers, because the payment rates for these plans are uncertain. Small movements of well-paying commercial insurance patients to lower paying health plans shift more healthcare cost responsibility to the individual. When patients shift more healthcare cost responsibility to the individual, they may lean to high deductibles or other means of cost-sharing. This is a real concern for providers.

• Tightened spending on healthcare. Economic problems will provide more pressure on employers and employees to cut costs, including what is paid for healthcare. Employees selecting health plans — either offered through their employer or exchanges — may lean toward lower-premium or high deductible health plans with less comprehensive coverage. These plans shift more healthcare cost responsibility to patients, which can create collections difficulties for providers. Similarly, employers looking to cut costs will reevaluate healthcare spend and may elect to cost-shift to employees.

• Provider profitability under pressure. Health systems are starting to report much lower profits in 2012 than in 2011, and the decrease in reimbursement and inpatient cases coupled with the percentage of out-of-pocket healthcare costs patients are responsible for will exacerbate these changes. The loss in some types of cases by systems leads to increased competition for other types of cases by these systems, and more pressure on the providers who survive based on such cases and patients.

• Mergers and acquisitions. Earlier this year, the New York Times reported that the first quarter of 2013 saw the lowest M&A deal volume since Q1 2010 (“Mergers Slowed to a Snail’s Pace in the First Quarter, the Fewest Since 2003,” April 2, 2013). We are still seeing a steady flow of deals in the healthcare sector.

4. Specialty physician practices. We are still seeing many specialty physician practices looking to remain independent. The decision to stay independent is largely driven by concern regarding future income. This concern largely stems from a lack of control over referral patterns and decreasing professional and ancillary reimbursement. Small changes in income lead to an explosion in physician/hospital transactions. For example, we saw a massive migration from private practice to hospital employment when the average cardiologist’s reimbursement fell by about 15 percent. With most other specialties, once reimbursement falls by more than 10 percent, the interest of joining a hospital or health system tends to become significantly more acute. Until that point, practices seem more eager to remain autonomous, particularly if it’s a group that has enjoyed long-term independence. We are also seeing more independent practices evaluate strategies for affiliating with other practices, either through ownership or collaborations designed to achieve increased bargaining power with payors.


• What are the winning aspirations/goals?
• What field or market will you play in?
• What is the best approach to win?
• What capabilities must be in place to win?
• What management systems are required to support the effort?

In exploring various businesses and opportunities with clients, I found the tools and concepts very useful and enjoyed it immensely.

Should you have questions, or we can be of assistance in any way, please contact me at sbecker@beckershealthcare.com.

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Price Transparency: Why It’s an Issue & Where Hospitals Fit In
(continued from page 1)

scope of information available. Overall, 29 states received an “F” grade, and seven states received “D” grades, meaning an overwhelming majority of states do not offer consumers adequate information on healthcare prices.

While the report is an indictment of the lack of healthcare price transparency legislation on the books today, Suzanne Delbanco, PhD, executive director of Catalyst for Payment Reform, says the groups did not conduct the research because they thought laws were the only solution to the problem. Instead, she views price laws as a last resort, and hospitals could be taking two steps on their own to ensure their patients have requisite knowledge to make informed healthcare decisions.

“Number one, hospitals can stop requesting health insurance companies to hide their pricing information from patient members,” Dr. Delbanco says. “It’s a minority that does this, but gag clauses leave gaping holes. Two, hospitals can make it as easy as possible for prospective patients to find out what hospital services will cost. It’s one thing to post the chargemaster, and it’s another thing to work with patients and their health benefits to figure out what they will pay out of pocket. That could help foster transparency when it’s needed most.”

Hospitals and chargemasters

The chargemaster, as mentioned by Dr. Delbanco, has been a lightning rod symbol for price transparency in the new era of consumer-driven healthcare, though few patients actually pay full chargemaster rates. Hospitals in California have already experienced “open book” measures when it comes to these all-encompassing lists of charges. Since 2006, the California Office of Statewide Health Planning & Development has required hospitals to submit a copy of their chargemasters to post online, as well as average charges for 25 common outpatient procedures.

John Bishop has served as CFO of Long Beach (Calif.) Memorial Medical Center, Miller Children’s Hospital Long Beach and Community Hospital Long Beach — all part of Fountain Valley, Calif.-based MemorialCare Health System — for the past three years. He explains that chargemasters are important, but when it comes to the transparency movement, hospitals and health plans both play a role with them. Chargemasters are the result of years of negotiations with health plans that have requested discounts from hospitals’ prices, Mr. Bishop says, and prices that appear to be high or inflated are “an unfortunate byproduct” of the bartering system that has endured for decades.

“Price transparency — and chargemaster price reduction — is a goal of ours, but it must be done in cooperation with the health plans in order for it to be successful,” Mr. Bishop says. “There needs to be an industrywide recalibration of charges as the impact on health plan reimbursement, Medicare and [Medicaid] cost reporting and charity care will all be affected.”

Price transparency — for the good of hospitals and patients

For Robin Gelburd, JD, the movement toward transparent and reliable healthcare price information started many years ago. Ms. Gelburd is president of FAIR Health, a New York City-based organization that maintains a database of healthcare charges across the country. She says healthcare price transparency is vital today because the previous system of “no questions asked” is no longer viewed as effective.

“For so long, the healthcare system, in a sense, worked in the shadows. Consumers had no skin in the game, and almost behind a curtain, the transaction was somehow settled upon,” Ms. Gelburd says. “Cost was not a critical issue, and there was a lot of dust on chargemasters because no one was really looking at those with a bright light. Consumers are much more engaged in healthcare now due to the economic climate and [mechanisms] such as high-deductible health plans, and they have to manage care in a more proactive way.”

While hospitals and other healthcare players work on becoming more transparent in their prices, one hurdle will still remain: Communicating to patients that prices and quality healthcare are two completely separate things.

“We could have complete price transparency, without the help of any laws, if hospitals, doctors and health insurance companies worked together to provide it,” Dr. Delbanco says. “The other challenge is we have to continue to educate American consumers about cost and quality relationship — and the fact there really is none. People assume more expensive care is better. We have to pair cost information with quality information. Otherwise, consumers may assume more expensive care is better.”

Correction

In the May issue of Becker’s Hospital Review, the annual list of “100 Great Places to Work” was missing two organizations. Penn State Milton S. Hershey (Pa.) Medical Center and University of Chicago Medical Center were inadvertently left off the print version of the list due to a technical error. Full-length profiles of the organizations are below. Becker’s Hospital Review regrets the error.

Penn State Milton S. Hershey (Pa.) Medical Center

Type of facility: Hospital/health system

What makes it a Great Place to Work: Penn State Milton S. Hershey Medical Center is committed to keeping its employees well, beyond offering basic health, dental and vision coverage. The medical center has an employee wellness program, called Blueprints for Wellness, that aims to enhance quality of life through education on healthy behaviors and empowering participants to encourage each other in healthful practices. In addition to promoting physical health, Penn State Hershey Medical Center helps employees stay mentally fit through educational assistance. Employees — and their spouse and any dependent children, after one year of employment — can receive a 75 percent discount on tuition at Penn State University. Job-related degree programs offered at other accredited colleges are also eligible for tuition reimbursement.

University of Chicago Medical Center

Type of facility: Hospital/health system

What makes it a Great Place to Work: Along with packages for medical, dental, vision and disability benefits, University of Chicago Medical Center offers employees access to its on-site corporate quality academy that offers a range of education and training courses, including BSN completion programs offered in partnership with two local colleges. Full-time hospital employees are entitled to 50-percent remission for courses taken at the University of Chicago or the lab school, and nurses receive 100 percent tuition reimbursement at the nursing school of their choice. The hospital also offers a generous paid-time off package: New full-time employees receive up to three weeks paid vacation per year, plus five paid personal holidays and 10 sick days.
What’s Behind the Rash of New Hospital Brands?  
(continued from page 1)

• Greenville (S.C.) Hospital System University Medical Center was renamed Greenville Health System and adopted a new logo.
• Huguley Memorial Medical Center in Burleson, Texas, became Texas Health Huguley Hospital Fort Worth South.
• High Point (N.C.) Regional Health System changed its logo and brand.
• Des Moines-based Iowa Health became UnityPoint Health.
• Jefferson Regional Medical Center in Chesterfield, Mo., became Mercy Hospital Jefferson.
• Vancouver, Wash.-based PeaceHealth renamed its four Oregon hospitals, which now include PeaceHealth in their names.

Why now?
Hospitals and health systems have always had reasons to rebrand, like to promote a new affiliation or an expansion of services. However, this recent rash of healthcare rebranding seems to come from widespread industry trends, such as increased physician integration and coordination of care across the continuum, that have picked up steam in the last year.

“It’s no secret that healthcare systems and hospitals are redefining themselves…with healthcare reform prompting population health initiatives, there is a move toward a physician-driven, patient-centered system model,” says Marissa Chachra, a senior advisor with Brentwood, Tenn.-based Jarrard Phillips Cate & Hancock, a healthcare communications firm. “As they’re redefining themselves, they recognize the need to rebrand who they are in order to better reflect what they really do now.”

For instance, Greenville Health System, formerly Greenville Hospital System University Medical Center, decided to rebrand in part because it had added multiple employed physician practices and became more integrated as a system. “From an operational standpoint, we’re becoming more integrated and physician-led,” explains Sally Foister, the system’s director of marketing services. “We were moving forward with the goal of becoming a highly integrated delivery system, and if we were going to be operating as an integrated system, we wanted to look like one as well.”

Bill Leaver, CEO of UnityPoint, formerly Iowa Health System, says his system rebranded for similar reasons. “For four years, we’ve been working on creating a different delivery model. With that in mind, we started thinking about our brand and realized we need to be known as the manager of disease and the care coordinator.”

As part of its rebranding effort, Greenville Health System is bringing all of its employed physician practices under the new brand umbrella to present a unified system, says Ms. Foister. According to Ms. Chachra, that practice is becoming more popular with organizations that are reinventing themselves. “It allows [the organization] to increase its footprint in the community,” she says. “Having practices rolled up underneath the larger brand…broadens the number of entry points that a patient can access a hospital or system.”

So, as hospitals and health systems continue to integrate and redefine themselves to patients and their communities, additional new names and brands are likely to pop up across the country. ■
The ACO, or accountable care organization, may very well be the least agreed-upon concept in healthcare today.

The term ACO was coined in 2006 by Elliott Fisher, MD, director of Dartmouth Institute for Health Policy and Clinical Practice in Hanover, N.H. The concept resembles that of health maintenance organizations, with a focus on cost savings and accountability. One of the largest differences between the two models is ACOs’ size, with ACOs being smaller than HMOs.

The concept was embraced by lawmakers and built into the 2010 Patient Protection and Affordable Care Act. In the first few months — even years — after the passage of PPACA and after the publication of CMS’ long-awaited final ACO rule, it wasn’t uncommon for healthcare experts to call ACOs the “unicorns of healthcare.” Critics said the healthcare law encouraged a model everyone had heard of, but nobody had seen.

The unicorn moniker has since fallen to the wayside. As of January 2013, there were 428 ACOs — sponsored by commercial payors and Medicare — across 49 states. That’s a significant increase from March 2010, when there were just 10 ACOs across the entire country.

From late 2011 to early 2013, Medicare has contracted with more than 250 ACOs nationally with 4 million total Medicare beneficiaries. Another 100 to 200 ACOs are expected to be added in the next two years. The model has spread just as quickly on the commercial side. For instance, last year, commercial insurer Cigna announced its plans to have one million patients enrolled in its ACOs by 2014 — a tenfold increase at the time of the payor’s announcement.

Although the model has grown by leaps and bounds in the past three years, proliferation does not necessarily thwart criticism. ACOs have stirred debate since day one, and they’ve been subject to a few louder critiques as of late.

In February, two professors from Harvard University and a senior research fellow from Innosight Institute, an education and healthcare think tank, published an op-ed in The Wall Street Journal, highlighting what they called “flawed assumptions” that will ultimately lead ACOs to fail. “The ACO concept is based on assumptions about personal and economic behavior — by doctors, patients and others — that aren’t realistic,” the authors wrote.

A month later, Deloitte released its “2013 Survey of U.S. Physicians,” based on 613 responses from primary care physicians, surgical specialists, non-surgical specialists and other physicians. In a somewhat unpromising finding, only one in three physicians reported familiarity with ACOs, episode-based payments and patient-centered medical homes. That meager rate of familiarity was noteworthy, given that ACOs have been part of the healthcare reform law for more than three years now.

To punctuate the dampening events, the 32 Pioneer ACOs sent a letter to CMS, asking the agency to reconsider the quality metrics they are required to report on in 2013. The Pioneer program was designed to be a high-risk, high-reward model with an accelerated track to ACO formation. For the past year, Pioneer ACOs received payment for reporting data on metrics. In 2013, the ACOs are slated to move from pay-for-reporting to pay-for-performance. In year three, Pioneer ACOs that have shown a specified level of savings over the first two years will be eligible to move a substantial portion of their payments to a population-based model.

In their letter, the Pioneer ACOs urged CMS to hold them to reporting status only in 2013, just as they were the previous year. The Pioneer ACOs also asked CMS to delay 2014 payments tied to performance benchmarks. Those benchmarks are being applied this year for the Pioneers, and the 32 organizations claimed that 19 of the proposed “flat percentage” benchmarks were higher than other quality performance targets. In April, CMS denied the Pioneer ACOs’ requests to delay the pay-for-performance period and said performance benchmarks will apply to Pioneer ACOs in 2013.

Here, various experts weigh in on why the healthcare industry has been slow to accept ACOs, the five most common arguments against the model and what it will ultimately take for ACOs to become a proven strategy for population health.

“There is no magic bullet”

Stuart Lockman, Esq., is president of Michigan Pioneer ACO, which is Detroit Medical Center’s ACO. The ACO is managed by the DMC Physician Hospital Organization, which includes approximately 1,100 providers, and it is one of CMS’ Pioneer ACOs.

“ACOs have really proliferated in the past three years or so, considering that this was a concept that was only written about in academic journals around five or six years ago,” says Mr. Lockman. “To have 300 of them up and running already is sort of a remarkable achievement.”

Michigan Pioneer ACO was one of the 32 Pioneers to sign the letter to CMS requesting a change to the quality reporting requirements. The ACOs’ letter said CMS does not yet have mature data for empirical benchmarks, a considerable roadblock, and that CMS’ proposed benchmarks are loftier than those in commercial contracts and difficult to meet. But the problem may stretch beyond the Pioneers. Mr. Lockman says problems around data and measurements are likely to present themselves in any ACO arrangement.

“ACOs are driven by data,” says Mr. Lockman. “The question is the availability and extensiveness of the data with which you have to work. We have our own issues with CMS in terms of the data we receive, and [other ACOs] have data issues as it relates to each commercial payor or insurer. In terms of how to proceed, it almost becomes an individual approach.”

As far as expenses go, cost expenditures on Michigan Pioneer ACO’s 12,900 patients have remained flat compared with the baseline data provided by Medicare. That means the ACO is spending no more or less on its patients than it has historically spent.

Mr. Lockman says he’s hesitant to jump on the bandwagon when it comes to broad criticism of the ACO model. “There is no one magic bullet,” he says. “My feeling is that it took us years to get us to the point we’re at. You can’t expect everything to be changed overnight. ACOs put emphasis where it should be, which is on cost and quality.”

Marc Bard, MD, co-director and physician leader of Tufts Health Care Institute for Health Policy and Clinical Practice in Hanover, N.H., agreed-upon concept in healthcare today.

“Anybody looking at the ACO and saying that it will or won’t be the end-game for healthcare is missing the point,” says Dr. Bard. “It’s an evolutionary stepping stone in building a system of care,” says Dr. Bard.

Five frequent arguments against ACOs

Criticism of ACOs in the past few years has varied in extremity and logic, but there have been a few recurring arguments made against the pay-for-performance model.

1. In the grand scheme of healthcare spending, ACOs’ savings will be slight.

Will juice from ACOs be worth the squeeze? Will incentives be enough to change physicians’ behavior? How many administrative costs will ACOs accrue? These continue to be some of the most pressing questions about the model.

ACOs: The Least Agreed-Upon Concept in Healthcare? (continued from page 1)
Some skeptics have said ACOs involve more work than reward. For example, in November 2011, former Federal Trade Commission Commissioner J. Thomas Rosch said that in even the most optimistic scenario, “the savings to Medicare from the ACO program are no more than a rounding error.”

Unfortunately for ACOs’ defense, it’s still too soon for CMS to point to how much money ACOs will save Medicare — if any. Richard Gilfillan, MD, director of the Center for Medicare and Medicaid Innovation, said more “telling evidence” about CMMI models, including accountable care organizations, would be available this summer. But commercial models have reported some promising results, like Oak Brook, Ill.-based Advocate Health Care’s ACO.

Advocate launched its ACO, called AdvocateCare, in late 2010 with Blue Cross Blue Shield of Illinois. The ACO includes 10 hospitals and covers roughly 380,000 patients. Based on data from the ACO’s first six months, hospital admissions per member decreased by about 10 percent and emergency department visits fell by 5 percent. Year-one data from the ACO showed a 26 percent decrease in readmission rates for AdvocateCare patients with chronic illnesses, due in part to patients’ access to transition coaches. And the 13.6 percent readmission rate for AdvocateCare patients who were sent to nursing facilities was still lower than the national average, 20 percent.

2. ACOs were designed on a premise that overestimated the level of integration in healthcare.

CMS offered the Pioneer ACO program in recognition that a handful of integrated health systems were further along in their clinical integration, coordinated care and shared savings arrangements than others. Healthcare experts often point to those health systems and other highly integrated organizations, like Oakland, Calif.-based Kaiser Permanente or Danville, Pa.-based Geisinger Health System, as what ACOs should ultimately resemble down the line, but these comparisons may be overstated.

Dr. Bard of Tufts says ACOs were founded under the idea that there is a high degree of cohesion between physicians and their community hospitals, something he refers to as “systemness.” The only problem is this assumed level of systemness or integration is not found in many communities in America.

“At the end of the day, if the only successful ACOs are those from [Partners HealthCare], Vanguard Health Systems and Kaiser Permanente, what has society gained?” says Dr. Bard. “These organizations were already operating at the highest levels of confidence in respect to the triple aim.” The triple aim was the concept coined by former CMS Acting Administrator Donald M. Berwick, MD, to improve the health of populations, improve the patient experience and reduce per capita healthcare costs.

Instead of integrated systems operating successful ACOs, Dr. Bard says ACOs’ worth will be proven if they can transform care delivery in organizations and regions that are not prolific healthcare hubs, such as Syracuse, N.Y., or Wichita, Kan.

Gary Thomas, COO of Accountable Care Solutions at Aetna, says he’s seen nuances in how organizations pursue accountable care programs, driven by the level of integration they’ve attained. “Interest in a specific approach seems to be heavily dependent on how prepared an organization is to make this transition — both structurally and culturally. Those [health systems] that are far along in clinically integrating their networks are looking at a range of accountable care models to leverage public and private payor programs.”

He says those health systems that are less advanced are looking for consulting, capabilities and other gain-share programs to push clinical integration and build a foundation for value-based care.

3. ACOs won’t work when healthcare still operates in a fee-for-service system.

Even though ACOs are built on a pay-for-performance reimbursement model, Medicare continues to reimburse hospitals on a fee-for-service model. Medicare also reimburses individual providers and suppliers for specific services just as it did under fee-for-service payment system. Many hospitals continue to use fee-for-service as a way to keep score or determine which physicians have earned what portion of payments and savings. This is still the go-to method for “score-keeping” in some ACOs, according to a 2012 report from the New England Journal of Medicine.

Mr. Lockman of the Michigan Pioneer ACO says he’s observed this inherent tension at DMC, and among ACOs in general. When hospitals and physicians are reimbursed on a fee-for-service model, it can be difficult to incentivize them to reduce utilization rates and spend more time with patients. “Part of the issue is that we are trying to have a pay-for-quality-driven system when we’re still in a pay-for-volume system,” says Mr. Lockman. “It’s very difficult to live in both worlds.”

A 2012 Commonwealth Fund report recommended that ACOs’ compensation models should be locally determined, based on the unique makeup of the physician population, the relationship that exists between providers and payors, and other factors respective to the ACO.

Potential payment models for ACOs include straight salaries, a model Cleveland Clinic has used for years; equal shares, in which income is based on revenue after expenses with expenses divided equally among providers; productivity-based compensation, in which income is based on the percentage of either billings, collections or resource-based relative value scale units; incentive-based compensation, with a portion tied to providers’ performance around core ACO goals; and capitation, in which income is based on distribution of money from payors either equally or based on a predetermined formula.

For ACOs to be successful on a nationwide scale, various approaches to payment need to be tested for effectiveness. Hospitals and health systems will also have to use fee-for-service payments in a more limited fashion. “Bringing Medicare and private-sector payment models into sync, to the extent possible, will facilitate this,” the Commonwealth Fund reported.

4. ACOs will move patients out of hospitals and hurt hospitals’ revenue.

Do ACOs represent hits to hospitals’ revenue? It’s certainly a possibility, but as healthcare strives to incorporate the tenets of the triple aim, declining inpatient admissions may be an unavoidable reality for hospitals.

The potential change to hospitals’ bottom lines comes on top of ACOs’ inherent financial burden, as well. Hospitals have the organizational structure, facilities and capital necessary for ACOs, whereas physicians drive the intellectual capital behind the model, making the most decisions about where healthcare dollars go. So while hospitals and health systems may provide the capital investments and infrastructure necessary for ACO success, it will also be their business model that takes the largest hit from the model as ACOs shift healthcare away from “heads in beds.”

“To achieve the triple aim, care is going to continue its migration out of hospitals and into the ambulatory environment,” says Dr. Bard. “The capital partners that need to make investments in the ACO are precisely those organizations that are likely to experience the greatest negative impact from the ACO — mainly a reduction in hospital volumes.”

Mr. Lockman says the hospital industry faces a challenge today — to build accountable care mechanisms while ensuring hospitals can survive and thrive. “What we want to evolve to is a situation in which we reserve hospitalization for those who really need it,” he says. “That may mean over a period of time, hospitals might get smaller or become more specialized — not any hospital in and of itself but the system as whole.”
Speaking from the payor side, Mr. Thomas says Aetna’s ACOs involve opportunities for hospitals and health systems to tap into new sources of revenue. “For example, many of the ones Aetna is involved with include jointly marketed health plan products, giving health systems and provider organizations an additional way to improve the health of their communities while at the same time grow their patient base,” he says.

5. ACOs take healthcare back to the 1990s. Healthcare leaders have a hard time forgetting the 1990s and emergence of integrated delivery networks. These memories leave many in the industry pointing to ACOs and calling the model déjà vu. Physician-hospital organizations and management service organizations were designed to coordinate care through capitated risk contracts, but overall, they were regarded as ineffective in improving care quality or lowering costs. Those disappointments still linger for some cynics.

There has have also been consistent comparisons between ACOs and HMOs. For instance, some critics say ACOs should allow patients to participate in cost savings. This participation could take different forms, such as patients paying smaller copayments if they choose a physician who is in an ACO. If ACOs make it more expensive for patients to receive care elsewhere — as a strategy to keep patients in the ACO — then it may resemble an unfavorable, network HMO.

Oddly, even HMOs received less flak when they were rolled out. Dr. Bard says the emergence of HMOs in the 1990s did not stir as much controversy as ACOs, largely because HMOs were not as mainstream. “The HMO was an alternative movement. It was voluntary and always a bit of the fringe, whereas managed care was more mainstream,” he says.

One of the most significant differences between ACOs and delivery networks in the 1990s is today’s role of health information technology, data analytics and clinical decision support. But these tools alone will not make ACOs infallible, according to a 2012 study published in Health Affairs, which suggested that information technology is necessary but insufficient to improve outcomes in an ACO. Rather, the study found ACOs will fare best if they are not oversold as silver bullets and if structured to target specific populations.

What will prove ACOs? The healthcare industry is still in a waiting game as far as ACOs’ results. Although a few mature ACOs like AdvocateCare (and it’s important to keep in mind that the term “mature” means that ACO is only about three years old) have reported hopeful results from their first years; other newly launched ACOs are not yet able to disclose results. For Medicare savings, the industry has its eye on the Pioneer ACOs, and results from those 32 organizations are expected this summer.

Either way, whether in regards to commercial or Medicare results, Dr. Bard says people shouldn’t expect dramatic results or a sudden wave of ACO acceptance and implementation.

“What I look for is evidence that as we invest in and improve systemness, with everyone working as a team, playing as far north in their licenses as possible and delivering patient-centered care, outcomes improve. I think it will be a slow, steady momentum.”

Dr. Bard and Mr. Lockman both noted that ACOs have already made changes to the healthcare industry, particularly for providers. Dr. Bard says ACOs have restored a level of professionalism across the industry that has been well-received and healthy, as ACOs have enabled the broader range of healthcare providers — nurses, physicians, dieticians, pharmacologists, social workers and more — to feel needed in the care continuum. “That’s what was lost in the 1990s: dignity and care and all those things that matter so much to those people,” he says.

Mr. Lockman says although it will take time for ACOs to gain broader acceptance, he’s observed a change in the provider-patient relationships within Michigan Pioneer ACO. As more providers begin to notice ACOs’ positive effects and promotion of patient-centered care, Mr. Lockman says the model is likely to catch on.

“One of the things that gives us gratitude is some of the individual experiences patients have in terms of working with care managers and providing the kinds of care transitions that the fee-for-service, episodic care system in a fragmented environment does not provide. When we see patients being grateful for having care manager and providing care transitions — every one of those voices adds to support of program,” he says.

Survey: Majority of Physicians Unfamiliar With ACOs, PCMHs

By Heather Punke

Just one in three of the nation’s physicians reported they were familiar with accountable care organizations, episode-based payments and patient-centered medical homes, according to the Deloitte 2013 Survey of U.S. Physicians.

Last year, more than 50 percent of physicians were familiar with those programs, according to the survey.

The survey’s findings are based off of 613 responses from primary care physicians, surgical specialists, non-surgical specialists and other physicians.

Medicare ACO Results Expected Soon

By Molly Gamble

Richard Gilfillan, MD, director of the Center for Medicare and Medicaid Innovation, said more “telling evidence” about CMMI models, including accountable care organizations, would be available this summer.

Dr. Gilfillan offered some early evidence that other pilot programs like bundled payments and patient-centered medical homes may be helping to lower healthcare costs. In the final quarter of last year, hospital readmissions for Medicare beneficiaries decreased to slightly below the threshold of 18.5 percent to 19.5 percent, which is where the readmission rate had sat for the past five years, according to the report.

Dr. Gilfillan also said there is data suggesting CMMI’s medical home program in Vermont is slowing the growth of healthcare costs, according to the report.
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Becker's Hospital Review has named the following CFOs to its list, “125 Hospital and Health System CFOs to Know.” These men and women help lead renowned tertiary centers, academic medical centers, community hospitals and health systems in all financial matters while balancing quality patient care and innovative healthcare reform strategies. The Becker's Hospital Review editorial team used several resources to develop this list, including nominations, prior Becker's Hospital Review lists and input from industry experts.

Note: Individuals cannot pay for inclusion on the list. Names are presented in alphabetical order.

Clint Adams. CFO of Ardent Health Services (Nashville, Tenn.). Since 2003, Mr. Adams has led the financial operations of Ardent Health Services, which owns and operates three different health systems — Lovelace Health System in Albuquerque, N.M., Hillcrest HealthCare System in Tulsa, Okla., and Baptist St. Anthony's Health System in Amarillo, Texas. Prior to his time with Ardent, Mr. Adams was a senior audit manager for Ernst & Young and staff accountant for Deloitte.

Katherine Arbuckle. Senior Vice President and CFO of Ascension Health (St. Louis). Ms. Arbuckle became senior vice president and CFO of Ascension Health, the largest non-profit and Catholic health system in the United States, in April 2012. She had a prior stint at Ascension from 2002 to 2006 as vice president of finance. Ms. Arbuckle also was CFO of Bon Secours Health System, based in Marriottsville, Md., for more than five years and assistant vice president of finance at St. Vincent Health in Indianapolis.

Charles Ayscue. Senior Vice President of Finance and CFO of Mission Health (Asheville, N.C.). Mr. Ayscue has served as senior vice president of finance and CFO of Mission Health since March 2007, and his healthcare finance career has mostly been based in the Tar Heel State. Prior to Mission Health, Mr. Ayscue was CFO of UNC Health Care in Chapel Hill, N.C., for 20 years, where he helped develop a combined operating expense budget of more than $1.4 billion for the 1,096-bed system. He also served as comptroller and associate director of financial services at The Moses H. Cone Memorial Hospital in Greensboro, N.C.

Jenny Barnett. Executive Vice President and CFO of Catholic Health East (Newtown Square, Pa.). Ms. Barnett is responsible for the financial oversight and stewardship of Catholic Health East, which recently announced a pending merger with Livonia, Mich.-based Trinity Health this past October. She has been at CHE since 2006, and before becoming executive vice president and CFO, Ms. Barnett was CHE’s vice president of finance and chief accounting officer. Prior to CHE, she served as system director of finance and corporate controller of Christus Health, based in Irving, Texas, and director of accounting at Memorial Hermann Healthcare System in Houston.

Talana Bell. CFO of Flowers Hospital (Dothan, Ala.). Ms. Bell started her healthcare career at Flowers Hospital in 1999 as a financial analyst. She served in that role for six months before being promoted to CFO. This past September, Franklin, Tenn.-based Community Health Systems, the parent company of Flowers Hospital, awarded Ms. Bell with an Excellence in Leadership Award, which recognizes hospital leaders who have demonstrated commitment to quality healthcare and operational excellence.

Chris Bergman. Vice President and CFO of The Christ Hospital (Cincinnati). Mr. Bergman, who has more than 30 years of healthcare financial experience, joined The Christ Hospital in December 2008. Previously, he was CFO of the Sparrow Health System in Lansing, Mich., and vice president of finance at Sentara Health in Englewood, Colo. He was a senior audit manager at Ernst & Young before entering the hospital sector. In 2011, the Cincinnati Business Courier named Mr. Bergman as its “CFO of the Year.”

Michael Blaszyk. Senior Executive Vice President, Chief Corporate Officer and CFO of Dignity Health (San Francisco). As senior executive vice president, chief corporate officer and CFO of Dignity Health, one of the largest health systems in California, Mr. Blaszyk oversees the financial affairs and corporate operations for the $13.1 billion integrated health system. He has more than 30 years of experience in managing finances and operations in the healthcare sector, and he previously served as CFO of University Hospitals in Cleveland. Mr. Blaszyk also serves as a member of the finance committees for St. Louis-based Ascension Health, Englewood, Colo.-based Catholic Health Initiatives and Cincinnati-based Catholic Health Partners.

Sally Boemer. Senior Vice President and CFO of North Shore Medical Center (Salem, Mass.). Ms. Boemer never intended to pursue a career in healthcare finance, but that changed after she took an administrative fellowship at Massachusetts General Hospital in Boston in 1993. The fellowship allowed her to rotate through all of the hospital’s operations and finance departments. Ms. Boemer assumed the position of senior vice president for finance at Massachusetts General in 1999. She is currently senior vice president and CFO of North Shore Medical Center, a two-hospital system that is part of Boston-based Partners HealthCare, the parent of Massachusetts General.

Mark Bogen. Senior Vice President of Finance and CFO of South Nassau Communities Hospital (Oceanside, N.Y.). Mr. Bogen has more than 35 years of healthcare financial experience, and before being named CFO of South Nassau Communities Hospital in April 2012, he was the hospital’s vice president of finance for four years. Prior to joining South Nassau, Mr. Bogen was CFO of New York City’s Preferred Health Network before it merged with NewYork-Presbyterian Healthcare System. In 1997, he founded his own
consulting firm, The Bogen Consulting Group, which merged with Besler Consulting in 2004.

Jeff Bolton. CFO of Mayo Clinic (Rochester, Minn.). Mr. Bolton has been CFO of Mayo Clinic since 2003. Previously, Mr. Bolton was CFO at Carnegie Mellon University in Pittsburgh and worked in planning and financial analysis at the University of Pittsburgh. His first professional financial position was as a contract administrator for the city of Pittsburgh in 1979. He has helped Mayo achieve an “Aa2” rating from Moody’s Investors Service, one of the highest long-term credit ratings.

Kevin Brennan. Executive Vice President of Finance and CFO of Geisinger Health System (Danville, Pa.). For roughly two decades, Mr. Brennan has been a top financial leader within Geisinger Health System. From 1997 through 2000, Mr. Brennan served as CFO of the formerly merged Penn State Geisinger Health System, and since 2000, he has held his role as executive vice president of finance and CFO of Geisinger. Before Geisinger, he was the regional vice president of finance and vice president of managed care with Sylvania (Ohio) Franciscan Health, and he was also the vice president of finance for The Germantown Hospital and Medical Center in Philadelphia and Saint Michael’s Medical Center in Newark, N.J.

Bill Brosius. Vice President and CFO of St. Luke’s Episcopal Hospital (Houston). At St. Luke’s Episcopal Hospital, Mr. Brosius has described his leadership style as that of someone who evaluates all requirements, builds support among stakeholders and creates consensus around the shared vision. Before he became CFO of St. Luke’s, he served as the chief financial consultant for hospital operations at The Lane Group, a boutique healthcare consulting firm in Atlanta. He also was a consultant and CFO for Triumph HealthCare, a $300 million long-term acute-care hospital company based in Houston.

Michael Buhl. Senior Vice President and CFO of University of Wisconsin Hospital and Clinics (Madison). In November 2008, Mr. Buhl joined UW Hospital and Clinics as senior vice president and CFO. He previously served as interim CFO of Stanford Hospital & Clinics in Palo Alto, Calif. Mr. Buhl also was CFO for the Mayo Clinic in Scottsdale, Ariz., and Mayo Franciscan Skemp Healthcare in La Crosse, Wis., and for 16 years, he was vice president of finance at Minneapolis-based Fairview Health Services. His professional career started in Minnesota as a staff accountant for PwC and a senior Medicare auditor for Blue Cross and Blue Shield of Minnesota.

Michael Burke. Senior Vice President, Vice Dean and CFO of NYU Langone Medical Center (New York City). Mr. Burke, part of NYU Langone since 2008, oversees operations of finance departments for both the hospital and medical school. In March, Moody’s Investors Service confirmed the “A3” credit rating on the hospital’s bonds, and Mr. Burke helped the academic medical center post a 9.9 percent operating margin in fiscal year 2012. Prior to his time with NYU Langone, he was senior vice president and CFO of Tufts Medical Center in Boston for roughly five years. He also served as CFO of Duke University Hospital in Durham, N.C., for four years.

Daniel Cancelmi. CFO of Tenet Healthcare (Dallas). Tenet named Mr. Cancelmi CFO of its 49-hospital network in September 2012. Previously, he served as Tenet’s senior vice president, controller and principal accounting officer, and he has been a headquarters-level executive at Tenet since 1999. Mr. Cancelmi also was CFO of Hahnemann University Hospital, a Tenet-owned, 496-bed academic medical center in Philadelphia. His healthcare career began with PwC in Pittsburgh and New York City.

Benjamin Carter. Senior Vice President and CFO of Trinity Health (Livonia, Mich.). Mr. Carter’s healthcare finance career has taken him all across Michigan. His hospital experience started at Oakwood Healthcare in Dearborn, Mich., where he spent 20 years and eventually became CFO of the four-hospital system. Mr. Carter then moved to Detroit Medical Center, where he was COO, before joining Trinity Health as senior vice president and CFO in 2010. Trinity Health is currently exploring a mega-merger with Newtown Square, Pa.-based Catholic Health East.

Larry Cash. Executive Vice President and CFO of Community Health Systems (Franklin, Tenn.). CHS recruited Mr. Cash in 1997, and as executive vice president and CFO, he oversees the system-wide finances of the second-largest for-profit hospital chain in the country. From 1973 to 1996, Mr. Cash held executive finance positions at Columbia/HCA Healthcare, now Nashville, Tenn.-based Hospital Corporation of America, and health insurer Humana. Global finance publisher Institutional Investor named Mr. Cash as one of America’s best healthcare CFOs for seven consecutive years, from 2005 to 2011.

Paul Castillo. CFO of University of Michigan Health System (Ann Arbor). Since September 2011, Mr. Castillo has led the finances of U-M Health System, one of the largest academic-based healthcare organizations in the country. Before joining the University of Michigan, he was CFO and vice president of finance at UPMC Shadyside in Pittsburgh, a 520-bed hospital within University of Pittsburgh Medical Center. Mr. Castillo was also the vice president of finance at Saint Vincent Health System in Erie, Pa., in the early 1990s.

Randy Combs. Senior Vice President and CFO of Mercy (Chesterfield, Mo.). Mr. Combs became senior vice president and CFO of Mercy in March 2009, and he has more than 26 years of service with the 32-hospital system. This past year, in addition to his regular CFO duties, Mr. Combs received the added responsibilities of strategic growth. Prior to his time with Mercy, Mr. Combs was vice president of finance for Barnes-Jewish Hospital in St. Louis, and he also was a senior accountant with KPMG in St. Louis.

James Connelly. Senior Vice President and CFO of Henry Ford Health System (Detroit). As senior vice president and CFO of Henry Ford
Health System, Mr. Connelly oversees all fiscal affairs such as capital development and mergers and acquisitions — including the system's pending deal to merge with Royal Oak, Mich.-based Beaumont Health System. Before joining Henry Ford, Mr. Connelly served as senior vice president and CFO of TriHealth in Cincinnati. He also was senior vice president and COO of Cincinnati-based Bethesda North Hospital. Mr. Connelly's executive career began at Arthur Andersen in Detroit as an audit partner.

Mike Connors. Senior Vice President of Finance and CFO of Cape Cod Healthcare (Hyannis, Mass.). Mr. Connors has served as senior vice president of finance and CFO of Cape Cod Healthcare since March 2009, and executives at the two hospital system have said Mr. Connors' knowledge and understanding of expense and revenue cycle management has helped make Cape Cod Healthcare a financially sound institution. Prior to Cape Cod Healthcare, he served as senior vice president and CFO of Signature Healthcare, a long-term care system based in Brockton, Mass. Mr. Connors also was CFO of Lahey Hospital & Medical Center in Burlington, Mass., and vice president of finance at South Shore Hospital in Weymouth, Mass.

Diane Corrigan. CFO of Hospital of the University of Pennsylvania (Philadelphia). Since 2000, Ms. Corrigan has been with the 772-bed Hospital of the University of Pennsylvania — the largest hospital in Philadelphia and flagship facility of the University of Pennsylvania Health System. Before she joined HUP, it had recorded three straight years of losses, but she and others helped the hospital post operating margins above 10 percent from 2007 to 2011. In 2011, the Philadelphia Business Journal named Ms. Corrigan as the city's “2011 CFO of the Year” for an extra-large company.

Thomas Corrigan. Senior Vice President of Finance and CFO of Christiana Care Health System (Wilmington, Del.). Since 2006, Mr. Corrigan has served as senior vice president and CFO of Christiana Care, the largest health system in Delaware with more than $2.1 billion in total patient revenue in fiscal year 2011. Before joining the health system, he was CFO for the ADP Brokerage Services Group in Jersey City, N.J., and was also president of the ADP Investment Center in Wilmington, Del. He also served in various financial roles at Anheuser-Busch.

David Cox. CFO of Marin General Hospital (Greenbrae, Calif.). Mr. Cox was a consultant to the Marin Healthcare District before joining as full-time CFO in 2009. Previously, he held various finance and management positions at Sutter Health in Sacramento, Calif., Fletcher Allen Health Care in Burlington, Vt., and St. Mary's Health System in Waterbury, Conn. Healthcare has been Mr. Cox's primary professional field since he left the U.S. Air Force as a captain in 1982.

Kelly Curry. Executive Vice President and CFO of Health Management Associates (Naples, Fla.). Mr. Curry has been an executive vice president at Health Management since July 2007 and officially became CFO in January 2010. He also served as Health Management's COO and chief administrative officer, and held various other management positions with the for-profit chain during its infancy from 1982 to 1994. Along with his professional financial endeavors, Mr. Curry and his wife founded Foundation in Christ Ministries, a religious organization based in Ireland, in 1995.

Dennis Dahlen. Senior Vice President and CFO of Banner Health (Phoenix). Mr. Dahlen oversees all financial operations of Banner Health, which operates 23 hospitals across seven states and has nearly $5 billion in annual revenue. He started his career at Banner Health in 1983 as an internal auditor and worked his way up the ranks to become vice president of finance in 2000 and senior vice president of finance in 2006 before taking on the CFO role in 2009. Prior to Banner Health, Mr. Dahlen was an auditor for accounting firm McGladrey.

Robert DeMichiei. Senior Vice President and CFO of University of Pittsburgh Medical Center. As senior vice president and CFO, Mr. DeMichiei leads the financial initiatives of one of the top-grossing systems in the country. Before joining UPMC, Mr. DeMichiei held various executive finance roles at General Electric — including manager of finance and global business development for GE Energy and CFO of GE Transportation Systems — and worked for PwC in Pittsburgh for 10 years.

Chris Denton. CFO of Henrico Doctors' Hospital (Richmond, Va.). Mr. Denton has served as CFO of 767-bed Henrico Doctors' Hospital, one of the largest hospitals within HCA Virginia, since October 2007. Before Henrico Doctors’ Hospital, Mr. Denton held various other executive positions at HCA hospitals, including CFO and COO of Parkland Medical Center in Derry, N.H. He also held executive accounting positions at HCA hospitals in Florida and Virginia, and he has 15 years of experience in the healthcare industry.

Roger Deshaies. Senior Vice President and CFO of Fletcher Allen Health Care (Burlington, Vt.). Mr. Deshaies has served as senior vice president and CFO of Fletcher Allen, the only academic medical center in Vermont, since 2008. His healthcare financial experience spans almost 35 years. Before joining Fletcher Allen, Mr. Deshaies served as CFO of Brigham and Women's Hospital in Boston for 10 years.

Stephanie Doughty. CFO of Poudre Valley Health System (Fort Collins, Colo.). Ms. Doughty's healthcare finance career dates back to 1982 after she graduated college with a bachelor's in business administration. Prior to joining Poudre Valley Health in 1998, Ms. Doughty was CFO of St. Anthony's Hospital in St. Petersburg, Fla. She previously worked with Bayfront Medical Center, also in St. Petersburg, for 10 years as the controller and vice president of finance, and with Englewood (Fla.) Community Hospital as the controller.

John Doyle. CFO of IASIS Healthcare (Franklin, Tenn.). Since April 2010, Mr. Doyle has served as CFO of IASIS Healthcare. He has also held other positions within the for-profit hospital company, including vice president, chief accounting officer and treasurer. Previously, Mr. Doyle was a senior manager at Ernst & Young from February 1997 until March 2002, and he was at KPMG from August 1994 to January 1997. Between 1991 and 1994, Mr. Doyle also served as CFO for two community hospitals, one in Tennessee and one in North Carolina.

Ben Dunford. CFO of Texas Regional Medical Center at Sunnyvale. At 36 years old, Mr. Dunford is one of the younger CFOs in the hospital sector. He joined the 70-bed, physician-owned Texas Regional Medical Center in August 2011, where he has improved profitability by roughly 30 percent while lowering accounts receivable days and supply costs. Previously, Mr. Dunford was a senior leader at Bain & Company and an associate at Goldman Sachs in Dallas.

Gordon Edwards. CFO of Gundersen Lutheran Health System (La Crosse, Wis.). Mr. Edwards joined Gundersen Lutheran in February 2011 as CFO and has helped the system garner an “A1” credit rating from Moody’s Investors Service. Before his time with Gundersen Lutheran, Mr. Edwards worked at Legacy Health in Portland, Ore., for eight years. He held a variety of roles, including vice president and controller, acting CFO, vice president of finance, director of finance operations and director of government reimbursement and payor contracting. Mr. Edwards also spent eight years in public accounting firms Arthur Andersen and KPMG.

Marvin Eichorn. Senior Vice President and CFO of Mountain States Health Alliance (Johnson City, Tenn.). Since 1998, Mr. Eichorn has been part of Mountain States Health Alliance, a regional healthcare system with 13 hospitals throughout Tennessee, Virginia, Kentucky and North Carolina. Mr. Eichorn was influential in MSHA’s acquisition of five community hospitals in southwest Virginia throughout the past several years. Mr. Eichorn previously was with Covenant Health, based in Knoxville, Tenn.

Chris Ellington. Executive Vice President and CFO of UNC Health Care (Chapel Hill, N.C.). Mr. Ellington has served as executive vice president and CFO of UNC Health Care since July 2010, monitoring all
John Faulstich. CFO of UAB Health System (Birmingham, Ala.). Before joining UAB Health System in April 2009, Mr. Faulstich had a longstanding tenure as senior vice president of finance and CFO of Cleveland-based Sisters of Charity of St. Augustine Health System. From 1984 to 2008, he led that system — which included five wholly-owned and joint-ventured hospitals in Ohio and South Carolina — in financial governance, strategy, contracting, treasury and merger and acquisition activities. While at Sisters of Charity, he oversaw a 50-50 joint operating venture with Cleveland-based University Hospitals in 1999.

Steve Filton. Senior Vice President and CFO of Universal Health Services (King of Prussia, Pa.). Mr. Filton has been with UHS, which has roughly two dozen acute-care hospitals and more than 170 behavioral health facilities, for more than 20 years, starting with his role as director of corporate accounting in 1985 and working his way up to vice president and controller in 1991. Since 2003, Mr. Filton has been senior vice president and CFO of UHS, which recorded roughly $6.96 billion in 2012 revenues.

Kenneth Fisher. CFO of University of Iowa Hospitals and Clinics (Iowa City). Few hospital CFOs have longer current healthcare careers than Mr. Fisher. He has been CFO of University of Iowa Hospitals and Clinics since June 2007, but he has more than 40 total years of healthcare financial experience. Prior to joining UIHC, Mr. Fisher was a director for Navigant Consulting, where he worked with hospital and health system clients. He has also held executive financial positions at DMC Sinai Grace Hospital in Detroit, Baptist Hospital of East Tennessee in Knoxville and three Charlotte, N.C.-based organizations: Presbyterian Hospital, Charlotte Memorial Hospital and Carolinas HealthCare System.

Michael Freed. Executive Vice President and CFO of Spectrum Health (Grand Rapids, Mich.). For the past 17-plus years, Mr. Freed has been an integral part of the Spectrum Health leadership team. In addition to serving as executive vice president and CFO of the nine-hospital system, Mr. Freed is president and CEO of Spectrum’s Priority Health, one of the largest health plans in Michigan. Previous experience included positions with Central New England HealthAlliance in Leominster, Mass., Saratoga Hospital in Saratoga Springs, N.Y., and HealthAmerica, a Pittsburgh-based HMO owned by Coventry.

John Gantner. Executive Vice President of Finance and CFO of Meridian Health (Neptune, N.J.). Mr. Gantner has been CFO of Meridian Health, one of the largest non-profit health systems in New Jersey, since February 2008. He has more than 35 years of healthcare financial and operational experience, having served as executive vice president of Robert Wood Johnson University Hospital and Health System in New Brunswick, N.J., prior to his current position. Mr. Gantner also was a healthcare consulting partner at Ernst & Young.

John Geppi. Executive Vice President and CFO of Covenant Health System (Knoxville, Tenn.). During his tenure at Covenant Health, Mr. Geppi has kick-started multiple projects. For example, he currently serves as CEO of Central Atlantic Health Network, a group purchasing organization that is part of VHA that has saved Covenant Health an estimated $1 million over two years. Before joining Covenant Health, Mr. Geppi served as CFO of several different hospitals and health systems, including Memorial Health System in Chattanooga, Tenn., and Northside Hospital in Atlanta. Mr. Geppi’s professional financial career started in Baltimore with Arthur Andersen.

Steven Glass. CFO of Cleveland Clinic. Mr. Glass has been CFO of Cleveland Clinic and the Cleveland Clinic Health System since 2005, and he joined the organization in 2002 as the Cleveland Clinic’s controller and chief accounting officer. Prior to Cleveland Clinic, Mr. Glass served as vice president and chief accounting officer of MedStar Health in Columbia, Md. He also was an executive and community hospital CFO at MedStar when Helix Health and Medlantic Health merged in June 1997 to form the modern-day MedStar.

Mike Gleason. Vice President and CFO of Shands Jacksonville (Fla.) Medical Center. Mr. Gleason was the controller at the 695-bed Shands Jacksonville before assuming his current title in 2009. Last year, the Jacksonville Business Journal named Mr. Gleason as a finalist for its “CFO of the Year” title for large non-profit organizations, saying his leadership helped the academic medical center garner a credit upgrade and allowed it to exceed patient cash collection targets. Prior to Shands Jacksonville, Mr. Gleason was a senior financial strategist, manager and CFO of Adesa, an integrated supply chain solutions company.

Robert Glenning. Executive Vice President and CFO of Hackensack (N.J.) University Medical Center. Since 2007, Mr. Glenning has led the financial operations of HackensackUMC as executive vice president and CFO. Under his tenure, the 775-bed hospital generated almost $1.2 billion of net patient service revenue in 2011 with a 2.4 percent operating margin. Also in 2011, HackensackUMC received an “A+” credit rating from S&P, the first time it received a rating from S&P. Before HackensackUMC, Mr. Glenning was CFO of Kaleida Health in Buffalo, N.Y.

Paul Goldstein. Vice President and CFO of Orlando (Fla.) Health. Mr. Goldstein has held his position of vice president and CFO of Orlando Health since June 2005. He has been CFO of Orlando Health, one of the largest health systems in Florida, since 1996. Mr. Goldstein
joined Orlando Health in 1981 and eventually became director of finance in 1985. Prior to Orlando Health, Mr. Goldstein was the controller and director of finance at the former Brookwood Community Hospital in Orlando for three years.

Greg Gombar. Executive Vice President and CFO of Carolinas HealthCare System (Charlotte, N.C.). Mr. Gombar joined Carolinas HealthCare System, one of the largest systems in the Carolinas with roughly three dozen hospitals under its management, in 1984. Before then, he served as an audit manager and healthcare consultant with Arthur Andersen for seven years. Mr. Gombar is actively involved in the North Carolina Hospital Association and is a member of the North Carolina Association of Certified Public Accountants.

Michael Gough. Senior Vice President and CFO of Norton HealthCare (Louisville, Ky.). Mr. Gough's career in healthcare finance stretches back to 1983, when he first worked at several hospitals within Nashville, Tenn.-based Columbia/HCA Healthcare, now known as Hospital Corporation of America. He was CFO of Audubon Regional Medical Center in Louisville, Ky., Medical Center Hospital in Huntsville, Ala., and several other hospitals. Mr. Gough joined Norton Healthcare in 2000 as the vice president of finance and has been system CFO since September 2003.

Misty Hansen. CFO of University of Arizona Health Network (Tucson). Ms. Hansen has been with the University of Arizona Health Network since 2001, where she started out as the academic medical center's chief accounting officer. She was promoted to system CFO in 2010. Before the University of Arizona, Ms. Hansen was an accounting manager at Arthur Andersen. She is a past president and board member of Pima Community Access Program, which operates as a bridge to healthcare for the uninsured.

Gail Hanson. Senior Vice President and CFO of Aurora Health Care (Milwaukee). Ms. Hanson joined Aurora in 2011 and has been on Aurora's board of directors since 2009. Previously, she served as deputy executive director for the State of Wisconsin Investment Board for six years, where she managed more than $83 billion in assets for the Wisconsin Retirement System, the State Investment Fund and several other trust funds. Ms. Hanson also worked at Blue Cross Blue Shield United of Wisconsin for 20 years and spent time with Cobalt Corp., the publicly traded arm of BCBSUW, as treasurer and CFO.

Fred Hargett. Executive Vice President of Finance and CFO of Novant Health (Winston-Salem, N.C.). Since 2003, Mr. Hargett has worked his way through Novant's executive ranks, going from senior vice president of financial planning to executive vice president of finance and CFO. Prior to joining Novant, Mr. Hargett worked as a manager of healthcare consulting with Ernst & Young in Charlotte, N.C., leading several initiatives in strategic planning and financial forecasting.

Mark Hepler. CFO of Munson Healthcare (Traverse City, Mich.). Before becoming CFO of Munson Healthcare in April 2009, Mr. Hepler served as vice president of finance for the eight-hospital system and Munson Medical Center, the 391-bed flagship and regional referral center. In addition to his current responsibilities, which include accounting and finance functions, Mr. Hepler serves as treasurer of Munson Home Health, North Flight, which is Munson's emergency medical services, and the Conservation Resource Alliance, a private non-profit committed to sustaining northwest Michigan's natural habitat.

Todd Hofheins. Vice President and CFO of Providence Health & Services (Renton, Wash.). In December 2011, the 27-hospital Providence Health & Services named Todd Hofheins vice president and CFO. Mr. Hofheins oversees all financial operations of the system, which recorded $8.7 billion in net operating revenue and $5.4 billion in total net assets in 2012. His healthcare career spans more than 20 years. He previously managed a new $500 million medical tower at Providence Regional Medical Center in Everett, Wash., and was CFO of Providence’s Northwest service area.

Paul Ishizuka. Medical Centers Finance Officer at University of Washington Medicine (Seattle). Mr. Ishizuka has been the medical centers CFO at UW Medicine and UW Medical Center, as well as associate vice president for medical affairs, since 1999. He has also served as CFO and controller throughout other hospitals in Washington and California, and he serves on the finance committees of various UW Medicine affiliates.

R. Milton Johnson. President and CFO of Hospital Corporation of America (Nashville, Tenn.). Mr. Johnson has served as president and CFO of HCA, the largest for-profit hospital company in the country, since February 2011. He also was executive vice president and CFO of HCA from July 2004 to February 2011, and he has been one of HCA's directors since 2009. Mr. Johnson joined HCA in 1982 as a tax manager in the research and planning area and eventually became director of tax for HealthTrust, which spun off from HCA in 1987.

Evan Jones. Senior Vice President and CFO of Lakeland (Fla.) Regional Health Systems. Lakeland Regional brought Mr. Jones in as senior vice president and CFO in September 2011. Since then, he has improved the operational income of the 851-bed health system from $8.8 million in FY 2011 to $41.8 million in FY 2012, which has raised the operating margin from 1.4 percent to 6.2 percent. Prior to joining Lakeland, Mr. Evans held several executive positions within Main Line Health, including CFO of Lankenau Medical Center in Wynnewood, Pa., and Riddle Hospital in Media, Pa. From 1980 to 2006, Mr. Evans also was CFO of St. Luke's University Hospital and Health Network in Bethlehem, Pa.

John Kasberger. Vice President of Finance and CFO of Mercy Medical Center (Roseburg, Ore.). For the past eight years, Mr. Kasberger has served as vice president of finance and CFO of 169-bed Mercy Medical Center. During this time, he has helped improve Mercy Medical Center's operating margin from 1.4 percent to 7.2 percent and increased days cash on hand from five to fivefold. Previously, he was assistant vice president of finance at Palos Community Hospital in Palos Hills, Ill., and interim CFO/director of revenue services at Centegra Health System in Woodstock, Ill.

Jack Kaup. Compliance Officer and CFO of Black Hills Surgical Hospital (Rapid City, S.D.). Mr. Kaup has been CFO of Black Hills Surgical Hospital since 1999, a couple years after the 26-bed hospital first opened. He has more than 20 years of experience in finance, accounting and business operations. Prior to joining Black Hills, Mr. Kaup was involved in financial management for a diverse group of industries and served as a certified public accountant at a national firm.

Robin Kilfeather-Mackey. CFO of Dartmouth-Hitchcock (Lebanon, N.H.). Ms. Kilfeather-Mackey has led the financial strategy of Dartmouth-Hitchcock since January 2010, and she has held several other positions within the organization since joining it in 1996. In October 2007, Ms. Kilfeather-Mackey served as vice president of corporate finance, where she controlled audit, tax, accounting, treasury and reimbursement functions. She has also held other executive finance positions at various other healthcare organizations throughout New Hampshire and Vermont, and her career started in public accounting.

Ryan Kitchell. CFO of Indiana University Health (Indianapolis). IU Health promoted Mr. Kitchell to system CFO in February 2012. He joined IU Health in September 2010 as senior vice president and treasurer, and in November 2011, he became president of IU Health Plans, which is a health plan that offers four Medicare Advantage options for beneficiaries living in IU Health’s 32-county service area. Before IU Health, Mr. Kitchell spent time at the Indiana Statehouse as the Indiana public finance director, and he eventually became director of Indiana's Office of Management and Budget for former Gov. Mitch Daniels.

Greg Klugherz. Vice President of Finance and CFO of CentraCare Health System (St. Cloud, Minn.). Mr. Klugherz joined CentraCare in 2008 as its CFO. Previously, he was a vice president for HealthPartners,
an integrated health system in Minneapolis, and CFO of Regions Hospital in St. Paul, Minn. Additionally, Mr. Klugherz was the senior financial executive for HealthPartners Medical Group, controller/treasury director for St. Louis Park, Minn.-based Park Nicolette Health Services, which is now part of HealthPartners, and a finance executive with GE Capital Fleet Services.

Anne Krebs. Vice President of Finance and CFO of Butler (Pa.) Health System. Ms. Krebs has served as vice president of finance and CFO of Butler Health System since January 2011. Her prior experience includes roles as vice president of finance at Mercy St. Louis, vice president of finance at St. Joseph Hospital (now SSM St. Clare Health Center) in Kirkwood, Mo., assistant vice president of finance at Lurie Children's Hospital of Chicago and senior auditor in KPMG's Chicago office. Over the past four fiscal years, Ms. Krebs has helped boost Butler Health System's cash on hand to 177.4.

JoAnn Kunkel. Corporate CFO of Sanford Health (Sioux Falls, S.D., and Fargo, N.D.). Ms. Kunkel joined Sanford Medical Center in 1995 and became CFO of Sanford in 2012. Her responsibilities are to provide system-wide leadership and direction of financial strategies for Sanford, which has 35 hospitals, 140 clinics and roughly 26,000 employees, making it one of the largest non-profit, rural health systems in the country.

Kathy Lancaster. Executive Vice President of Strategy and CFO of Kaiser Foundation Hospitals (Oakland, Calif.). Ms. Lancaster has been with Kaiser Foundation Hospitals and Kaiser Foundation Health Plan since 1998 and has been CFO since 2005. She provides financial leadership for each of Kaiser Permanente's eight geographic regions and also holds the title of executive vice president of strategy. Before Kaiser, Ms. Lancaster held senior leadership positions at insurance company Prudential, where she focused on underwriting and network management for the company's western region.

Phyllis Lantos. Executive Vice President, Treasurer and CFO of NewYork-Presbyterian Hospital (New York City). Since 2000, Ms. Lantos has served as treasurer and CFO of NewYork-Presbyterian Hospital and its parent company, NewYork-Presbyterian Healthcare System. She added executive vice president to her title in 2007. Ms. Lantos previously served as deputy COO of Yale University School of Medicine in New Haven, Conn., and as vice president of financial management services at Montefiore Medical Center in the Bronx, N.Y. She also held advisory roles in the Greater New York Hospital Association and Association of American Medical Colleges, among other organizations.

Todd LaPorte. Senior Vice President and CFO of Scottsdale (Ariz.) Healthcare. Mr. LaPorte joined Scottsdale Healthcare in 2001 as director of finance. He served as associate vice president of finance and vice president of finance before he was promoted to his current position. Mr. LaPorte has helped the system raise its credit profile, which prompted the system to absorb Phoenix-based John C. Lincoln Health Network. Before Scottsdale Healthcare, Mr. LaPorte served as CFO of Dental-Net, the parent company of Arizona's second-largest dental plan, in Tucson for nine years. He also worked at Ernst & Young for eight years.

Dennis Laraway. CFO of Memorial Hermann Healthcare System (Houston). In September 2011, Mr. Laraway was named CFO of Memorial Hermann Healthcare System. Previously, he served as CFO of Scott & White Healthcare in Temple, Texas, CFO of Dignity Health in San Francisco and CFO of Dignity Health’s primary academic medical center, St. Joseph’s Hospital and Medical Center in Phoenix. Mr. Laraway’s healthcare career began in the Empire State, where he was CFO of Seton Health and St. Mary’s Hospital in Troy, N.Y.

Ralph Lawson. Executive Vice President and CFO of Baptist Health South Florida (Coral Gables). Mr. Lawson has been CFO of Baptist Health South Florida, the largest private employer in Miami-Dade County, since 1989. He has overseen the system's acquisitions of South Miami Hospital, Homestead (Fla.) Hospital, Mariniers Hospital in Tavernier, Fla., and Doctors Hospital in Coral Gables, Fla., as well as Baptist Health's $2 billion investment portfolio. Mr. Lawson has more than 30 years of healthcare financial experience. Prior to joining Baptist Health, he spent 17 years at Deloitte. Mr. Lawson is the current national chair of the Healthcare Financial Management Association.

Mike Louge. Executive Vice President and CFO of OhioHealth (Columbus). Mr. Louge has been executive vice president and CFO of OhioHealth since 2000 and is responsible for the health system’s financiers, treasury, managed care, internal audits, information systems, materials management and real estate/construction. Prior to joining eight-hospital OhioHealth, Mr. Louge was CFO of Seton Healthcare in Austin, Texas, and vice president of financial operations at Presbyterian Healthcare System, now known as Texas Health Resources, in Dallas.

Robert Lux. Vice President and CFO of Temple University Health System (Philadelphia). As vice president and CFO of Temple University Health System, a $1.4 billion academic health system, Mr. Lux is responsible for financial reporting, cash and debt management, payroll, managed care contracting and other financial tasks. He has served in this position since July 1996. Previously, Mr. Lux served as assistant controller, controller, associate vice president and CFO of Temple University Hospital, the system's flagship facility. Mr. Lux's career started as a supervisor in the assurance practice for KPMG Peat Marwick.

Richard Magenheimer. CFO of Inova Health System (Falls Church, Va.). Mr. Magenheimer joined Inova in 1987 as vice president of financial operations and was named CFO of the six-hospital system in 1994. Prior to joining Inova, Mr. Magenheimer worked for American Medical International — an investor-owned international hospital management company — for seven years, where he served as vice president of financial controls as well as director of finance and budgeting for its western region.

Stacey Malakoff. Executive Vice President, Treasurer and CFO of Hospital for Special Surgery (New York City). Ms. Malakoff has served as executive vice president and CFO of Hospital for Special Surgery — the oldest orthopedics and specialty hospital in the United States — since August 1998. She also serves as the hospital's treasurer. Ms. Malakoff joined Hospital for Special Surgery in November 1990 as director of reimbursement, and she also held the roles of controller and vice president of finance. Previously, she served as an audit manager at Ernst & Young.

Peter Markell. Executive Vice President, Treasurer and CFO of Partners HealthCare (Boston). As executive vice president, CFO and treasurer of Partners HealthCare, an organization with $8 billion in revenue and assets valued at approximately $10 billion, Mr. Markell oversees payor contracting, materials management, research management and all other financial operations. Before joining Partners in 1999, Mr. Markell was a partner at Ernst & Young in Boston, where he helped clients obtain financing and interacted with the U.S. Securities and Exchange Commission. From 1983 through 1995, Mr. Markell was Ernst & Young's director of human resources and administration.

Tim Maurice. CFO of University of California Davis Health System (Sacramento). UC Davis Health System appointed Mr. Maurice CFO in March 2011. Prior to joining the multibillion operations of UC Davis, he was vice president and CFO of St. John's Regional Medical Center and St. John's Pleasant Valley Hospital, both in Oxnard, Calif., and member hospitals of San Francisco-based Dignity Health. Mr. Maurice has also served as CFO of Good Samaritan Community Healthcare in Puyallup, Wash., and Saint Joseph Mercy Oakland in Pontiac, Mich. His professional experience at academic medical centers also extends to Virginia Mason Medical Center and University of Washington Medical Center, both in Seattle.

Peter McCanna. Executive Vice President of Administration and CFO of Northwestern Memorial HealthCare (Chicago). Mr. McCan-
na is executive vice president of administration and CFO of Northwestern Memorial HealthCare and its principal subsidiary, Northwestern Memorial Hospital, which recorded $1.3 billion in revenue in 2011 — the most of any Chicago hospital. Before joining Northwestern Memorial in August 2002, he was senior vice president and CFO of Presbyterian Healthcare Services in Albuquerque, N.M. Prior to that, Mr. McCanna was senior vice president and CFO of the University of Colorado Hospital in Aurora.

Patrick McGuire. CFO of St. John Providence Health System (Warren, Mich.). For the past 27 years, Mr. McGuire has served in various capacities at St. John Providence Health System and has led all financial operations of the $2 billion, seven-hospital system as CFO since 2004. As CFO, Mr. McGuire has accomplished many feats for the system, the largest within St. Louis-based Ascension Health. He helped all Ascension Health facilities in Michigan negotiate a three-year deal with Blue Cross Blue Shield of Michigan, and he also centralized many reimbursement and revenue cycle functions.

Mary Meitz. Senior Vice President and CFO of Bronson Healthcare (Kalamazoo, Mich.). Ms. Meitz assumed her current position as senior vice president and CFO of Bronson Healthcare in 2004. She handles all accounting, budgeting, investment managing, payroll, managed care contracting and billing compliance for the three-hospital system, as well as for Bronson Medical Group. She has more than 22 years of experience in the hospital and healthcare field. Ms. Meitz currently serves as treasurer of West Michigan Cancer Center, a Bronson collaborative in Kalamazoo.

Wentz Miller. Managing Director of Finance and CFO of Integris Health (Oklahoma City). Since October 1998, Mr. Miller has served as managing director of finance and CFO of Integris Health. Prior to joining Integris, he held several positions with Columbia/HCA Healthcare, now known as Hospital Corporation of America. He was CFO of HCA’s Nashville market for one year and CFO of Tulane University Hospital and Clinic, now Tulane Medical Center, in New Orleans for more than two years. Mr. Miller also served as CFO of St. Mary’s Medical Center in West Palm Beach, Fla., for eight years.

Jennifer Mitzner. Senior Vice President and CFO of Hoag Memorial Hospital Presbyterian (Newport Beach, Calif.). Ms. Mitzner serves as senior vice president and CFO of Hoag Memorial Hospital Presbyterian, and her Hoag tenure spans more than 18 years. Ms. Mitzner joined the Hoag ranks in 1994 working mostly with various internal committees, including the finance and audit committee of Hoag’s board of directors and the investment management committee. Before joining Hoag, Ms. Mitzner worked as a certified public accountant for KPMG Peat Marwick, where she worked mostly with healthcare and health insurance clients on audit and consulting issues.

Dan Moncher. Executive Vice President and CFO of Firelands Regional Medical Center (Sandusky, Ohio). Mr. Moncher, executive vice president and CFO of Firelands Regional Medical Center, has been with the 400-bed teaching hospital since 1997, and he has been instrumental in helping Firelands achieve financial stability. Before he joined Firelands, Mr. Moncher served as regional vice president and CFO of Mercy Hospital in Tiffin, Ohio, and Mercy Hospital in Willard, Ohio. He has more than 25 years of healthcare financial experience.

John Mordach. Senior Vice President and CFO of Rush University Medical Center (Chicago). Mr. Mordach became senior vice president and CFO of Rush University Medical Center in February 2011. Previously, he served as CFO of Loyola University Health System in Maywood, Ill., and vice president of finance at University of Chicago Hospitals and Health System, both top academic medical centers in the Chicagoland area. Mr. Mordach also was CFO of Edward Hospital & Health Services in Naperville, Ill., and vice president of finance for Tufts Medical Center in Boston, formerly known as New England Medical Center. He has more than 25 years of healthcare executive experience.

Daniel Morissette. CFO of Stanford Hospital & Clinics (Palo Alto, Calif.). Mr. Morissette has served as Stanford Hospital & Clinics’ CFO since August 2007 and has helped fortify the medical center’s solid financial profile. Before joining Stanford, Mr. Morissette served for four years as senior vice president of finance and strategy at the University of Toledo (Ohio) Medical Center during the health system’s merger with the University of Toledo. Prior to that tenure, he served in various executive roles at the Herman M. Finch University of Health Sciences at Chicago Medical School for 11 years, including senior vice president and CFO.

Kenneth Morris. Senior Vice President, Treasurer and CFO of Duke University Health System (Durham, N.C.). Mr. Morris serves as senior vice president, treasurer and CFO of Duke University Health System. Before he joined Duke, Mr. Morris served as senior vice president of finance at Mission Health System in Asheville, N.C. He also was vice president for finance and treasurer at Loyola University Health System in Maywood, Ill., and served in the U.S. Army as a commissioned officer.

Dominic Nakis. Senior Vice President, Treasurer and CFO of Advocate Health Care (Oak Brook, Ill.). Mr. Nakis has been with Advocate Health Care since its inception in 1995. After beginning his career in healthcare at Ernst & Young, Mr. Nakis went to Evangelical Health Systems Corp. in 1995, the same year it merged with Lutheran General HealthSystem to create the system known as Advocate Health Care today. As CFO, Mr. Nakis oversees all financial operations of Advocate’s 10 acute-care hospitals, two integrated children’s hospitals and more than 200 other sites of care. In fiscal year 2011, Advocate posted total operating revenue of more than $4.4 billion.

Joel Perlman. Executive Vice President of Finance and CFO of Montefiore Medical Center (Bronx, N.Y.). For the past 25 years, Mr. Perlman has worked at the four-hospital Montefiore Medical Center. As CFO, he manages the financial strategy behind the academic medical center, which recorded $2.98 billion in consolidated operating revenue in fiscal year 2011. Prior to Montefiore, he was CFO of St. Francis Medical Center in Trenton, N.J., from 1980 until 1988. Mr. Perlman was also a supervisor at Ernst & Young for four years and an associate director of financial aid at The College of New Jersey in Trenton for three years.

Scott Posecai. Executive Vice President and CFO of Ochsner Health System (New Orleans). Mr. Posecai joined Ochsner Clinic in 1987 and was named CFO in 1995, continuing in that role until the merger of Ochsner Clinic and Alton Ochsner Medical Foundation in 2001. Upon the merger, he was named CFO of the Ochsner Clinic Foundation, and in 2006, of the Ochsner Health System. Prior to joining Ochsner, Mr. Posecai held various financial positions with oil and gas firms, mainly in accounting, treasury and international tax.

Edward Prunchunas. Senior Vice President of Finance and CFO of Cedars-Sinai Medical Center (Los Angeles). Mr. Prunchunas has held his positions as senior vice president of finance and CFO of Cedars-Sinai, a $2.5 billion academic medical center, since 1998. He has held other roles within Cedars-Sinai, including associate director of finance, director of finance and vice president of finance. Outside of Cedars-Sinai, Mr. Prunchunas was CFO of Northbridge (Calif.) Hospital Medical Center in the late 1980s, and he also worked on the consulting staff of accounting firm Ernst & Ernst, which is now known as Capgemini.

Ann Pumpsian. Senior Vice President of Finance and CFO of Sharp HealthCare (San Diego). Ms. Pumpsian has served as senior vice president of finance and CFO of Sharp HealthCare, a 2007 Malcolm Baldrige National Quality Award Recipient, since 1993. She has been at Sharp her whole career, which started in 1984, and has helped maintain Sharp as a competitive provider in the San Diego area.

Michael Reney. CFO of Brigham and Women’s Hospital (Boston). Mr. Reney was an 18-year veteran of Boston-based Partners HealthCare.
when he was named CFO of Brigham and Women's Hospital and B&W Faulkner Hospital, both in Boston, in May 2008. Mr. Reney began at Brigham and Women's Hospital as an accounting supervisor in 1990. He rose through the ranks as a senior manager and director within Partners over a 10-year stretch before coming back to Brigham and Women's as executive director/controller for the hospital's finances in 2000.

Chuck Robb. COO and CFO of Saint Luke's Health System (Kansas City, Mo.). Since 1991, Chuck Robb has been with Saint Luke's Health System, based in Kansas City, Mo., and he has been CFO of the organization — one of the largest health systems in the Kansas City area — since 1999. When Mr. Robb joined Saint Luke's, he started out as CFO of Saint Luke's Hospital, the 382-bed flagship facility of the health system. Before joining Saint Luke's, Mr. Robb worked at Ernst & Young for roughly 13 years.

Kevin Roberts. Senior Vice President and CFO of BJC Healthcare (St. Louis). In June 2008, Mr. Roberts become senior vice president and CFO of 13-hospital BJC Healthcare from University Hospitals in Cleveland, where he was senior vice president and CFO. During his tenure at University Hospitals, the system accomplished a multiyear financial turn-around that improved profitability by $250 million. Prior to joining University Hospitals in 2001, Mr. Roberts served as treasurer of The Cleveland Clinic Foundation. His financial career started with accounting firm Peat, Marwick, Mitchell & Co., now known as KPMG.

Phillip Roe. Executive Vice President, Treasurer and CFO of Vanguard Health Systems (Nashville, Tenn.). Mr. Roe began serving as executive vice president, CFO and treasurer for Vanguard in November 2007. Before then, he served as Vanguard's controller and chief accounting officer since the company's founding in July 1997. Prior to joining Vanguard, Mr. Roe served as senior vice president, controller and chief accounting officer of OrNda HealthCorp, which would eventually merge with Tenet Healthcare.

Steven Rose. CFO of Conway (Ark.) Regional Health System. For the past 23 years, Mr. Rose has worked at Conway Regional, which includes 154-bed Conway Regional Medical Center. Mr. Rose started as Conway Regional's director of business and fiscal services in 1990, eventually working up to his current position in December 1997. Before joining Conway Regional, he served as assistant administrator of finance for Decatur (Texas) Community Hospital, now known as Wise Regional Health System. Mr. Conway also currently serves as secretary, treasurer and national chair-elect of the Healthcare Financial Management Association.

Richard Rothberger. Corporate Executive Vice President and CFO of Scripps Health (San Diego). Mr. Rothberger has served as corporate executive vice president and CFO of Scripps Health since August 2001. He has 30-plus years of experience in the healthcare industry and has helped Scripps improve its financial operations through better contracting efforts and reducing days in accounts receivable by 30 percent. Before Scripps, Mr. Rothberger served as senior vice president and CFO of Mercy Healthcare Sacramento, a former division of Dignity Health, from 1997 to 2001. He also was Mercy Healthcare's director of finance and decision support and director of management engineering.

C. Michael Rutherford. Senior Associate Vice President for Health Sciences and CFO of The Ohio State University Wexner Medical Center (Columbus). Mr. Rutherford became senior associate vice president and CFO for health sciences at OSU Wexner Medical Center in January 2011. Before taking the reins as CFO of OSU Wexner Medical Center, Mr. Rutherford served as CFO of Summa Health System in Akron, Ohio, for 10 years. He also worked in financial and executive roles at Cleveland-based Sisters of Charity Health System for nine years, with some of those positions including CFO and CEO of the Cleveland market and CFO of 476-bed Mercy Medical Center in Canton, Ohio.

Randy Safady. Executive Vice President and CFO of Christus Health (Irving, Texas). Mr. Safady joined Christus in June 2011 with more than 30 years of experience in finance, accounting and healthcare operations. Prior to his current position, he served as executive vice president and CFO of Centura Health, Colorado's largest health system and a joint venture between Englewood, Colo.-based Catholic Health Initiatives and Altamont Springs, Fla.-based Adventist Health System. Mr. Safady also previously served as senior vice president and CFO of Adventist Midwest Health, a region of Adventist Health System.

Fred Savelbergh. CFO of Baylor Health Care System (Dallas). Since he graduated from North Texas State University in 1982 with a double major in accounting and economics, Mr. Savelbergh has worked at Baylor Health Care System. He worked his way up from staff accountant to CFO, a position he has held since 2009. Mr. Savelbergh oversees all financial functions of the health system, which recorded $5.2 billion in total assets in fiscal year 2011. Other positions he has held at Baylor include CFO and later interim president of Baylor Regional Medical Center at Grapevine (Texas) and CFO of Baylor University Medical Center in Dallas, Baylor's flagship facility.

Robert Shapiro. Senior Vice President and CFO of North Shore-Long Island Jewish Health System (Great Neck, N.Y.). Mr. Shapiro has been CFO of North Shore-LIJ Health System in Great Neck, N.Y., since August 2000. Previously, he was vice president of financial operations and director of finance/assistant administrator for the system, previously known as North Shore Health System, in 1984. He was also the assistant director of finance at Maimonides Medical Center in Brooklyn, N.Y.

Terry Shaw. Executive Vice President, CFO and COO of Adventist Health System (Altamonte Springs, Fla.). With more than $7.3 billion in revenue across 41 hospitals in 10 states, Mr. Shaw oversees the finances of one of the largest faith-based health systems in the South and in the country. Prior to his current positions, Mr. Shaw served as senior vice president and CFO of Adventist's Florida Division. He also was the vice president, assistant vice president and director of DRG management at Florida Hospital Orlando.

Craig Sheagren. Vice President of Finance and CFO of Sarah Bush Lincoln Health System (Mattoon, Ill.). For the past six-plus years, Mr. Sheagren has steered the financial operations of Sarah Bush Lincoln Health System, which has roughly $200 million in net annual revenue and includes 128-bed Sarah Bush Lincoln Health Center. Mr. Sheagren, the lead of Sarah Bush Lincoln's audit, finance and investment committee, has helped the system secure an “A+” bond rating from S&P, one of the few health systems of its size to garner an “A+” rating.

Jeff Sherman. Executive Vice President and CFO of LifePoint Hospitals (Brentwood, Tenn.). Since 2009, Mr. Sherman has led the financial strategy of LifePoint Hospitals, one of the five largest for-profit hospital companies in the country. Prior to his current position, Mr. Sherman served as vice president and treasurer of Dallas-based Tenet Healthcare. He has worked in various capacities for Tenet and its predecessor company since 1990. Mr. Sherman has also served as CFO of several different acute-care hospitals in Philadelphia and throughout the Texas Gulf Coast region.

Eddie Soler. Executive Vice President and CFO of Florida Hospital (Orlando). Mr. Soler is executive vice president and CFO of Florida Hospital, which has more than 2,100 beds across its seven hospitals and admits more patients annually than any other health system in the country. Prior to his current post, Mr. Soler was CFO of Florida Hospital, and he also served as senior vice president and CFO of Adventist Midwest Health in Hinsdale, Ill.

Bernadette Spong. Senior Vice President of Finance and CFO of Rex Healthcare (Raleigh, N.C.). Ms. Spong has served as senior vice
of Deloitte. And CFO. Before St. Luke’s, he was a senior manager in the Boise office and in 2008, Mr. Taylor took on his current role of system vice president named vice president of finance and CFO of St. Luke’s Treasure Valley, Idaho, and Mr. Taylor has helped transform St. Luke’s financial operations (Boise, Idaho).

Michael Szubski. CFO of University Hospitals (Cleveland). In October 2008, Mr. Szubski was named CFO of University Hospitals, which includes the 1,032-bed UH Case Medical Center. He joined the system in 2003 as CFO of UH Case Medical Center and later became CCO of UH’s acute-care hospitals. Prior to UH, Mr. Szubski served as executive vice president and CFO of Novant Health, based in Winston-Salem, N.C. Mr. Swindle also was CEO of the former Concord Medical Center in Baton Rouge, La., and vice president of financial services at Baton Rouge (La.) General Health System.

Jeff Taylor. Vice President and CFO of St. Luke’s Health System (Boise, Idaho). St. Luke’s Health System is the largest health system in Idaho, and Mr. Taylor has helped transform St. Luke’s financial operations from a single-hospital initiative to a five-hospital endeavor with annual operating revenue of more than $1 billion. Mr. Taylor has been at St. Luke’s since 1994, when he was hired as the director of finance. In 2006, he was named vice president of finance and CFO of St. Luke’s Treasure Valley, and in 2008, Mr. Taylor took on his current role of system vice president and CFO. Before St. Luke’s, he was a senior manager in the Boise office of Deloitte.

Lannie Tonnu. Senior Vice President of Finance and CFO of Children's Hospital Los Angeles. Ms. Tonnu joined Children’s Hospital Los Angeles in 1991 and has served as senior vice president of finance and CFO of the 347-bed pediatric medical center since 1993. In fiscal year 2011, Ms. Tonnu helped the hospital record $812.8 million in total revenue and $122.5 million in profit. Before Children’s Hospital Los Angeles, she was an audit senior manager in Ernst & Young’s Los Angeles healthcare practice for roughly 12 years.

Mike Tretina. Vice President and CFO of Mary Greeley Medical Center (Ames, Iowa). Mike Tretina has served as vice president and CFO of Mary Greeley Medical Center, a 220-bed, city-owned hospital, since February 2009, and it has become one of the more vibrant community hospitals in the Midwest. Before coming to MGMC, Mr. Tretina was senior vice president of finance at St. Vincent’s HealthCare in Jacksonville, Fla. He also has held various finance roles at Albert Einstein Medical Center and Heffler, a certified public accounting firm, both based in Philadelphia. Mr. Tretina has more than 25 total years of experience in healthcare finance.

Doug Vanderslice. CFO of Boston Children’s Hospital. Mr. Vanderslice began his tenure as CFO of Boston Children’s Hospital in January, coming from 258-bed St. Louis Children's Hospital. While at St. Louis Children’s, he also served as the financial liaison to the hospital’s parent, St. Louis-based BJCAH. Before joining St. Louis Children’s, Mr. Vanderslice was the director of patient financial services and controller for Children’s Medical Center of Dallas, and his professional finance career started at Deloitte in Dallas.

Kevin Vermeer. Executive Vice President, Chief Strategy Officer and CFO of UnityPoint Health (West Des Moines, Iowa). Mr. Vermeer was appointed executive vice president and CFO of UnityPoint Health, formerly Iowa Health System, in 2009. Before then, he served as CFO for Trinity Regional Health System in Rock Island, Ill., and interim CEO of UnityPoint’s hospital in Muscatine, Iowa. He has also held positions with Allen Hospital in Waterloo, Iowa, and Sisters of Charity hospitals in Colorado.

Kerry Vermillion. Senior Vice President and CFO of Baptist Health Care (Pensacola, Fla.). As senior vice president and CFO of Baptist Health Care, Mr. Vermillion monitors all financial and accounting matters of the system, which includes four hospitals across northwest Florida and south Alabama. He has more than 20 years of healthcare finance experience. Prior to Baptist Health Care, Mr. Vermillion worked at Mountain States Health Alliance in Johnson City, Tenn., and Baptist Health System in Birmingham, Ala.

Nick Vitale. Executive Vice President and CFO of Beaumont Health System (Royal Oak, Mich.). Mr. Vitale was named executive vice president and CFO in June 2011. Before assuming his current position, he had served as Beaumont’s senior vice president of financial operations since 2007. Mr. Vitale joined Beaumont in 2005 as vice president and CFO of Beaumont Hospital, Troy. He also served various financial executive posts at Detroit Medical Center, the Rehabilitation Institute of Michigan in Detroit and Bon Secours Cottage Health Services in Grosse Pointe, Mich.

Monte Ward. Senior Vice President and CFO of Cabell Huntington (W.Va.) Hospital. Monte Ward is senior vice president and CFO of Cabell Huntington Hospital, a 313-bed, acute-care facility affiliated with the Marshall University School of Medicine. He began at Cabell in 1978 as the hospital’s controller, rising to the CFO post in 1982. During his career at Cabell, he has been responsible for every department, except nursing, and he also served as interim CEO. Mr. Ward previously worked in the healthcare division of accounting firm Hayflich and Steinberg as a senior auditor.

Denise Warren. Senior Vice President, Treasurer and CFO of Capella Healthcare (Franklin, Tenn.). Since October 2005, Ms. Warren has been Capella’s senior vice president, treasurer and CFO. She has more than 25 years of financial experience, including time spent as a senior equity ana-
Marvin White. Vice President and CFO of St. Vincent Health (Indianapolis). Mr. White has overseen the materials management, accounting, managed care and other financial services of St. Vincent Health since 2008. Mr. White’s tenure at the 19-hospital St. Vincent Health, part of St. Louis-based Ascension Health, is his only hospital executive experience. Previously, he was executive director and CFO at Eli Lilly & Company’s Lilly USA. Mr. White also served various financial roles at General Motors in Illinois and Hewlett Packard in Atlanta.

Jeanne Wickens. Senior Vice President of Finance and CFO of Allegiance Health (Jackson, Mich.). Ms. Wickens has served as senior vice president of finance and CFO of Allegiance Health, a 480-bed system, since July 2004. She joined Allegiance Health in 2000 as corporate controller. Before Allegiance Health, Ms. Wickens served as controller and director of finance and registration at Battle Creek (Mich.) Health System, which is now part of Kalamazoo, Mich.-based Bronson Healthcare. She serves on the boards and finance committees of several local organizations, including the United Way and Center for Family Health.

John Wilson. CFO of Heartland Health (St. Joseph’s, Mo.). Mr. Wilson’s career at Heartland Health, an integrated delivery system with Heartland Regional Medical Center at its foundation, began in 1986. He started as senior internal auditor and worked his way up to controller. In 1990, Mr. Wilson was promoted to CFO of the system. Under Mr. Wilson’s tenure, Heartland Health has improved its Fitch bond ratings from “BBB” in the 1990s to “A+” in 2012. He also serves on the boards of many community organizations, such as the United Way and the Allied Arts Council.

Kris Zimmer. Senior Vice President of Finance and CFO of SSM Health Care (St. Louis). Since 2003, Mr. Zimmer has led the financial planning, capital management, bond financing and investment activities of SSM Health Care, one of the largest Catholic health systems in the country. Previously, he served as CFO of Norton Healthcare in Louisville, Ky., CFO of Mount Carmel Health System in Columbus, Ohio, and CFO of Southeastern Ohio Regional Medical Center in Cambridge, Ohio. In February, CMS appointed Mr. Zimmer as a four-year panel member of the Advisory Panel on Hospital Outpatient Payment, where he will advise HHS and CMS on ambulatory payment classifications for Medicare hospital outpatient services.

Bert Zimmerli. Executive Vice President and CFO of Intermountain Healthcare (Salt Lake City). Mr. Zimmerli oversees the direction and oversight of all Intermountain Healthcare financial operations, including its health plan, SelectHealth. Mr. Zimmerli has been with Intermountain since 2003, and previously, he was CFO of The Methodist Hospital System in Houston. He also was senior vice president and CFO of Houston-based Memorial Hermann Healthcare System. Before serving as a hospital executive, Mr. Zimmerli was a partner at Ernst & Young’s Houston office for 16 years, specializing in healthcare finance.

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Becker’s Hospital Review CEO Strategy Roundtable

November 14, 2013
The Ritz-Carlton Chicago

Co-chaired by Scott Becker, Publisher, Becker’s Hospital Review, and Chuck Lauer, Former Publisher, Modern Healthcare

To learn more visit www.BeckersHospitalReview.com
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Health systems have been on a physician group-acquiring frenzy in recent years, anticipating more hospital referrals and ancillary service as well as better positioning for population health initiatives, but for many, that comes at a steep price.

Consulting firm Dean Dorton Allen Ford in March released a report titled “In-te-gra-tion: The Challenge of Integrating Physician Group Operations,” which found many hospitals lost $100,000 or more per physician annually, creating a strong incentive for hospitals to learn how to keep their physician groups profitable before an acquisition is finalized.

To be clear, many industry experts agree that employed physicians don’t need to operate in the black in order to contribute to the health system’s bottom line. “In no way do we feel like every [physician group acquisition] needs to have a positive bottom line to be beneficial to hospitals,” says David Bundy, president and CEO of DDAF and co-author of the report. “Our point is not to say you need to make money on them.” Rather, he says, “we’re not sure hospitals are managing these practices as effectively as they can.”

The breakdown often occurs during the due diligence process, in which health systems inadequately negotiate patient volume and wRVU minimums into contracts or agree to compensation levels for physicians that emphasize stability over productivity, says Justin Chamblee, vice president of the Coker Group. Too often, hospitals establish compensation variables within their employment models solely based on market survey data, rather than considering the actual economics of the physician practice.

Keeping an independent mindset
Before a hospital buys it, an independent physician practice is completely dependent on productivity and collections to stay afloat. That doesn’t have to be thrown out the window when they are acquired by a hospital, says Gary Ermers, DDAF associate director of healthcare consulting services and co-author of the report with Mr. Bundy. “Employing doctors doesn’t mean you have an integrated system.”

“We believe, particularly if it’s a competitive market, hospitals really aren’t thinking about the longer term sustainability and are trying to scoop up practices and gain that competitive advantage,” says Jennifer Snider, vice president of operations for the Halley Consulting Group. She and her colleagues “favor an wRVU-based model, largely because it is payor-blind and lets [physicians] focus on productivity and patient care, and lets management focus on the payor mix and collections.”

Mr. Ermers favors physician compensation models that tie directly into the revenue physicians generate. “The model needs to incentivize volumes of patient delivery,” he said, but added, “it needs to also incentivize the payor mix.” Simple wRVU-based compensation pays physicians equally, even for treating less profitable government-insured or self-pay patients. If a physician treats high volumes of those populations, he or she brings less revenue into the practice and therefore receive less in output-based compensation. However, he says that can be offset with supplementary metrics to boost pay for high quality or patient satisfaction ratings. He also recommends that contracts with physician groups include an annual review clause to ensure wRVU levels meet or beat levels from one year prior to the acquisition.

Allowing physicians to focus exclusively on clinical elements wrongly spares physicians from the financial side of the practice, Mr. Bundy says. “Hospitals try to cushion doctors from too many market forces. Hospitals shouldn’t feel they need to keep compensation stable.”
Adding Employed Practices to Your Organization? 6 Ways to Getting Buy-in From the Practice

By Ann Maloley, MBA, Lead Consultant, Barlow/McCarthy

Strong relationships between the hospital and employed physicians start when organizational leaders define their expectations of financial performance and measures of practice success. This sets the stage for others in the organization to launch into practice development efforts. With this understanding on the hospital side, gaining support from the providers and practice staff is a good place to start building confidence in the relationship. Buy-in from the employed practice can make all the difference in the eventual success of a practice development strategy.

Getting the practice team comfortable with any practice development plan begins with an understanding and agreement of the goals. This should start before the contract is signed and reinforced in the early stages of integration. Then, like any team project with a mutual goal, other building blocks include a consensus on the action plan and a clear path for who is responsible for what.

Once everyone agrees that working together is a good idea and the dialogue begins, hospital business development leaders will likely need to continue to earn credibility from the practice. Here are a few ideas to help cultivate this support:

Invite, listen and acknowledge. One of the best things you can do to earn trust with your new practice partner is ask for the physicians’ input. They know their practice dynamics and culture best. Staying true to the practice personality will be important, especially if the practice was successful in the market before it joined the hospital organization. Knowing that hospital leaders genuinely want to understand their perspective and will factor their input into the overall strategy is a great step for getting buy-in to the recommendations later.

Ease into it. Don’t risk alienating a newly employed practice by pushing them to change their brand and practice culture all in one day. Start with understanding the brand elements that are working for them and commit to keeping them true. Then make the brand shift a process by taking small steps and getting agreement at each step. It will make acceptance and action easier.

Strategy vs. tactic. Leaders know physician practices are process-oriented operations. The practice’s objective each day is to provide great patient care, on time and as efficiently and seamlessly as possible. This is an operational and tactical system, and you’ve signed them on because you know they can do this well, or have the potential. So, when it comes time to engage this team in the practice growth plan, think about how they think. Give them a strategic framework, but they will be most interested in the action plan — the tactics, the to-do’s, accountabilities, timelines and expected results. Engage them in the action. Define their roles in their terms.

Regular rounds from executive team. Few things build confidence in a practice-hospital relationship more than an engaged and participative executive team. The executive team will want to have a role in the process and find reasons to have regular interactions with the physicians and practice staff. Attaching the executive team to the practice development efforts can eventually lead to deeper relationships with the physicians.

Talk about “wins.” Look for opportunities to discuss any hospital-related news that will add value to the operational, strategic or clinical functions of the practice. Make the connection. And invite ‘good news’ stories from the practice. Encourage them to share their positive patient experiences, for example, and then find ways to share it with internal stakeholders — from the board of directors, to clinical directors to hospital staff — and through the hospital’s practice marketing efforts.

Show progress to drive ongoing involvement. As the practice development plan gets rolling, share the numbers. Physicians will expect conversations with leadership about the pro forma metrics, but keep them in the loop on a more regular basis about the results of active practice marketing strategies. Strong numbers reinforce the value of the plan, and less-than-desirable numbers will hopefully motivate the team to get better. Establish ways to incentivize the practice to reach satisfaction and quality/outcome metrics and to help create differentiators that then can be marketed.

At the start of the hospital-employed physician relationship, there’s a good chance there will be some anxiety about this new partnership — at least until both parties have time to prove their value as a good partner. Keep the practice engaged and involved, even after the initial phase. Buy-in and support is an ongoing effort.

Ann Maloley, MBA, is a lead consultant with Barlow/McCarthy, a recognized industry authority in hospital-physician relations programs. Having worked in a variety of healthcare settings allows Ms. Maloley to provide her clients with broad industry insight and results-oriented strategies. During her 20-year career in healthcare she has had the opportunity to lead teams through the successful launch of practice marketing initiatives, physician relations programs and service line and brand image campaigns. In addition, Ms. Maloley serves as an adjunct faculty member for a premier Midwest university teaching healthcare marketing.

Physician Turnover at All-Time High

By Heather Punke

Physician turnover has hit its highest rate since 2005, the first year the data was collected, according to the 8th annual Physician Retention Survey from Cejka Search and the American Medical Group Association.

In 2012, the average rate of medical group physician turnover was 6.8 percent, up slightly from 6.5 percent in 2011, but much higher than the 2009 rate of 5.9 percent, according to the survey.

Also, medical groups do not expect a reprieve from losing physicians this year: 36 percent of the groups expect the physician retirement rate to increase in 2013.

The survey reflects responses from 80 physician groups that collectively employ 19,596 physicians.
Executing Population Health Strategy: Q&A With Dr. Mike Schatzlein, CEO of Saint Thomas Health

By Heather Punke

Mike Schatzlein, MD, president and CEO of Saint Thomas Health in Nashville and ministry market leader for St. Louis-based Ascension Health, knows healthcare’s status quo isn’t sustainable.

That’s why the former cardiothoracic and vascular surgeon with 40 years of healthcare experience is making changes at Saint Thomas to improve the quality and efficiency of care provided in his system’s hospitals and other facilities. A big part of that strategy is managing the health of populations.

Here, Dr. Schatzlein discusses why and how Saint Thomas Health is working toward population health management and the leadership skills he uses to make that change happen.

Question: You’ve made some major changes at Saint Thomas Health. What fuels your drive to change your system and healthcare as a whole?

Dr. Mike Schatzlein: Our people deserve better. We have [as a nation] evolved into a system that is episodic in nature and we do a great job taking care of folks who need a major intervention, but then we throw them back into the pond and wait for them to get into trouble again. When we survey people, we find them frustrated with their ability to navigate the system, know what things are going to cost and know whose advice to believe. We’re not serving our neighbors in helping them stay well and understand the importance of maintaining health throughout their lives.

Q: Population health is touted by many as the solution to fixing healthcare. What steps has Saint Thomas taken to better manage population health?

MS: Population health is a holistic concept. When I think of population health, I think, for example, of the patient-centered medical home. For 40 years I’ve been saying everyone needs a personal physician. We’ve gotten away from that as people shop from emergency room to emergency room or specialist to specialist, but medicine is just too complicated today to navigate it without help. With the fee-for-service payment model, there is no good way for providers of any type to be reimbursed to take the time to do care navigation. The patient-centered medical home addresses those issues and it’s the best way I know to help control the burgeoning cost of healthcare. We cannot continue to spend 18 percent of our [gross domestic product] on healthcare in this country — that’s twice what other developed countries spend, and we get outcomes that certainly are not demonstrably better.

This feels really, really right for Saint Thomas Health. We’re a faith-based organization that pursues holistic care, which involves taking care of a person across the continuum and being with them where they are. Taking care of patients across space and time in a loving way is what Saint Thomas Health has done for 100-plus years. Now, the country actually really needs that, and it feels like it’s our time.

In addition to all of the things we continue to do to make acute-care hospitals and outpatient centers accessible and patient-centered, we also established an accountable care organization, MissionPoint Health Partners. MissionPoint has a board with many physicians, some hospital administrators and even a Medicare beneficiary. Beneath the board are a number of committees with physician involvement that are working on the best evidence-based care pathways to help patients get well and stay well.

If you were a MissionPoint member, one of the first things you’d get to do is go to an online marketplace and pick your medical home. In the online marketplace, patients can see which physicians have what hours and what their special interests are, things like that. Members also have access to a cadre of health partners — like nurses, social workers, pharmacy technicians or dietitians, for example. The health partners provide a kind of concierge medicine to members while also looking out for potential health pitfalls.

Underlying MissionPoint is an investment in information technology to bring inpatient and outpatient records together and do predictive analytics to help us make sure we’re achieving the results we want and that we are following best practices.

Q: On that note, what is the goal of implementing electronic medical record systems in Saint Thomas facilities, and how has it been accepted by physicians?

MS: There is no endpoint in EMR development, but we just achieved HIMSS Stage 5 and have the goal of reaching Stage 7.

There’s a range of physician and caregiver acceptance of EMRs, but the only way you can have integrated records is for it to be electronic. I would be lying if I told you all of the 2,000 physicians on the medical staff at MissionPoint are eager to see a new software program pop up. But we exert resources for implementation, optimization and provider training. Some caregivers are frustrated, and we work really hard to help with the learning curve.

The investment is clearly well worth it. There is no other way to maintain a medical record but digitally. Medicine is too complicated for us to have handwritten paper spread all over the country with no ability for the data to interact. There’s also a need for more than one person to access the same record at the same time, and you can’t do that with a paper chart.

Right now, a patient portal is being tested for patients presenting at one of the nine hospitals in Mission-Point, and it will be fully deployed this year. We’ll keep adding functionality. It may initially be for lab test results, scheduling and billing paying, and we can continue to add on to that and we will. Our stated goal is to be the Amazon of healthcare.

Q: How will having a system clinically integrated through EMR promote population health?

MS: You can’t manage the health of a population without it. If we’re going to provide optimum care at optimum cost, we need to know all about the patient before we do anything to him or her. Also, if you back up and look at population, you have to have longitudinal data on its health as well.

Q: Saint Thomas is a large system — how do you lead change that affects staff and physicians at hospitals and numerous other facilities?

MS: I only have one leadership skill and that is that I hire, retain and motivate great people. When I was a transplant surgeon I could do it all myself, and I can’t do that anymore. So it’s mentoring, coaching and sponsoring — it comes down to trusting your team.

I’ve gotten better at it. Certainly, heart surgery is a solo enterprise — there are teams involved but the primary responsibility is certainly assumed by surgeons. Running a health system takes an entirely different skill set, so there had to be some evolution there.

Q: Healthcare as an industry is continually developing and growing. How do you continually develop your leadership skills to keep up?

MS: Being a ministry market leader for Ascension Health is a big boon for that. There are eight of us, and we meet with executive leadership in St. Louis in person or via telepresence. Those people all have vast experience in hospital administration, and all have responsibilities in diverse markets in which Ascension operates all over the country. They would be my first source of ongoing knowledge.

A second source, which is kind of a surprise to me actually, is that I’m sitting here at “ground zero” for healthcare in Nashville. There are so many smart healthcare people here; you can’t go out to dinner without running into some at the next table. I’m also involved in the Nashville Healthcare Council. It’s a function of the Chamber of Commerce, and it’s unique. There’s not one member of that board that I couldn’t learn a lot from.

You can’t help but learn about healthcare just wandering the streets of Nashville. It’s the Silicon Valley of healthcare.
Creating Regional Health Networks: Q&A With LifePoint Hospitals CFO Jeff Sherman

By Bob Herman

For the past four years, Jeff Sherman has led the financial operations of Brentwood, Tenn.-based LifePoint Hospitals, one of the five largest acute-care, for-profit hospital networks in the country.

Last year, LifePoint recorded more than $3.39 billion in total revenue, and this year, the company expects revenues to top $3.65 billion. A major reason behind the optimistic projections is an increase in its hospital base.

Like many other for-profit hospital operators throughout the country, LifePoint has been ramping up its acquisitions of independent community hospitals, many of which are finding it harder to operate in today’s healthcare environment without a parent company for support. Mr. Sherman says mergers and acquisitions in the hospital sector today are a lot more nuanced than before. The financial aspect is omnipresent, but companies like LifePoint are factoring in several other demographic and reform-based reasons as well, such as population growth and high-quality care delivery.

Here, Mr. Sherman sheds some light on LifePoint’s recent spate of hospital transactions, why the hospital M&A market will most likely continue to proliferate and how hospital CFOs today can make the right decisions.

Question: LifePoint is one of the biggest players in the hospital market, and your organization has announced a flurry of acquisitions so far this year: Fauquier Health in Warrenton, Va., Bell Hospital in Ishpeming, Mich., and Portage Health in Hancock, Mich. Can you talk about these transactions and how they fit in LifePoint’s strategy right now?

Jeff Sherman: As a starting point, LifePoint operates 57 hospitals in 20 states. These communities are similar to the communities you just mentioned, and these acquisitions have been announced but not completed.

In Michigan, the two announced acquisitions are very consistent with our strategy to form a regional network to provide the full continuum of care. We acquired Marquette General Hospital in September 2012 through Duke LifePoint Healthcare, our joint venture with Duke University Health System. Marquette is the only tertiary care hospital in the region, serving 300,000 residents in the Upper Peninsula of Michigan, and as we think about developing regional networks, Marquette represents the foundation of that network. The two additional acquisitions that have been announced up there lead to the full continuum of care, from the community level up to the tertiary level, and this represents a very exciting opportunity for us.

Fauquier is another great opportunity. We currently own five hospitals in Virginia, and Fauquier is another outstanding hospital with the potential for growth. This is a state where we have a significant presence, and it makes sense to add to that. It will increase our market leverage.

We are seeking hospitals in faster-growing communities with a more diversified employer base to complement our existing portfolio of hospitals. Our acquisitions over the last four years have been consistent with this approach, while offering clinical, financial and operational resources to help newly acquired hospitals grow and thrive in the future.

Q: What are your general impressions of the hospital M&A market right now, even outside of LifePoint’s moves? It’s been at a feverish pace for the past three years — do you see this continuing? And what are the biggest factors behind it?

JS: As we view it, there will continue to be a lot of activity going forward, especially for small community hospitals that aren’t affiliated with a bigger system. As we think about hospitals and what are their reasons for looking to partner, there are a couple that stand out: accessing capital for growth and expansion and the ability to recruit physicians. LifePoint is recruiting more than 200 physicians per year, and the centralization of our resources for physician recruiting makes it easier for us. We have built the infrastructure to help do that, too.

It’s increasingly difficult for freestanding hospitals to navigate the regulatory environment, including the Affordable Care Act, meeting meaningful use, the ICD-10 conversion — even just daily Medicare and Medicaid changes that are coming out. We believe many hospitals can’t afford the increasingly complex technology demands — HITECH, meaningful use, computerized physician order entry, clinical interfaces. At LifePoint, we have a quality department, an IT department, a compliance department, a revenue cycle department and others with resources to stay on top of these daily demands and changes. All of those factors and changes are continuing to exert pressure on unaffiliated hospitals.

We think we’re well-positioned to benefit from that. With the right emphasis on quality, and certainly with our partnership with Duke, we can help invest in the future. Communities and community hospitals are equally concerned about the acquiring company’s ability to invest in the future. So, with our relatively low leverage and financial strength, we have the resources to compete and expand in those communities.

Q: So does this mean that LifePoint has more acquisitions in mind this fiscal year?

JS: We don’t put out specific numerical targets, but over time, LifePoint will continue to acquire hospitals. It is difficult to predict the timing of when an acquisition will take place with local non-profit boards, county officials and, many times, state’s attorney general involved.

We’re looking to grow both organically in our existing hospitals but also through acquisitions. With more and more hospitals looking for strategic partnerships and alliances, we believe we have a flexible approach that can be tailor-made for an individual hospital.

Q: LifePoint’s revenue topped $3.39 billion in FY 2012, an increase of 12 percent from FY 2011, while profit slipped 6.8 percent to $151.9 million. What do you see as the major
catalysts behind the revenue gains? Conversely, what were some of the major reasons behind last year’s drop in profit?

JS: Acquisitions represented a big piece of the revenue growth in FY 2012 as well as continued growth in outpatient services. We completed a couple acquisitions earlier in the year, and then the Marquette transaction was finalized in September. That was a large acquisition.

The single biggest reason for the decline in operating income was related to a significant increase in depreciation expenses, which were up $27 million. We made significant upfront investments in IT, which are preparing LifePoint to qualify for HITECH funding available by meeting meaningful use requirements. These capital investments typically have shorter lives, meaning they depreciate over a shorter period. In 2012, we made more than $100 million in IT investments, so those upfront investments drove bigger depreciation expenses. We ramped up physician employment, so that also put pressure on our margins in 2012. We also view this as a long-term investment by expanding physician presence in our markets and adding new services, like cardiology and oncology.

Q: What advice would you give to other hospital and health system CFOs right now? What are the biggest differences between being an individual hospital CFO and a system CFO?

JS: I’ve been both — I grew up on the hospital side as an individual hospital CFO, both at smaller and larger hospitals. Whether big or small, CFOs must encourage leaders to act as owners of the business, and the right decisions will evolve over time. The key challenge is you have to be investing for future growth while maintaining current performance. It can be conflicting at times. We’re managing LifePoint for the long term, but we still have to meet our short-term financial objectives while continuing to improve the quality of care and service that we provide.

We operate in many diverse markets with large and small hospitals, so it’s difficult to encapsulate the entire company. Hospitals are driven by local issues, local macroeconomic issues, physician relationships. At times, it is challenging to summarize broad trends because of local dynamics, but it’s critical for the CFO to be a key strategic partner to the CEO and to drive future performance and help hold the organization accountable to performance standards.

Q: What is the most difficult aspect of being a CFO of a large hospital chain? What are some of the toughest decisions you have to make daily, weekly and monthly?

JS: Whether it is systemwide or for an individual hospital, some of the toughest decisions are ones that impact employees. Recently, we decided to adopt a shared services approach and outsource our back office functions to Parallon Business Solutions. This change will allow us to become more efficient and improve our performance in those areas. Some of our employees were hired by Parallon, but it was still a difficult decision because it impacted people across our company. However, we knew it was the right decision for the company. We always weight these types of decisions against the “High Five Guiding Principles” of the company.

Also, with limited capital to deploy, it’s been my experience over 25 years that there is an insatiable appetite for hospitals to spend capital. It’s critical to balance capital investments. How and where to deploy capital are always difficult decisions to make, and you must balance priorities.

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Becker’s Hospital Review CEO Strategy Roundtable

November 14, 2013
The Ritz-Carlton Chicago

Co-chaired by Scott Becker, Publisher, Becker’s Hospital Review, and Chuck Lauer, Former Publisher, Modern Healthcare

To learn more visit www.BeckersHospitalReview.com.
To register, visit www.BeckersHospitalReview.com/novhospitalevent.html
David Parmer is what he and many others would call an experienced U.S. hospital system executive. He has been with Baptist Hospitals of Southeast Texas for 22 years, and he currently serves as CEO of the health system’s Beaumont campus, a 508-bed community hospital. Over those 22 years, Mr. Parmer has seen almost every type of community hospital affiliation possible. BHSET used to be a freestanding system, then tried an integrated delivery system model with Dallas-based Tenet Healthcare and eventually merged, and de-merged, with Houston-based Memorial Hermann Healthcare System. Today, BHSET is owned by Community Hospital Corp., which operates both of BHSET’s hospitals. It’s been a long journey for BHST to reach its current position, and many community hospitals might find themselves in similar positions — unsure of their local situation and somewhat apprehensive as to how healthcare reform will play out. The current hospital merger and acquisition market has indicated that consolidation is here to stay. Although hospital M&A was somewhat down in the first quarter of 2013, the number of smaller hospitals becoming part of larger systems over the past four years has signaled a major shift in industry mindset.

This M&A activity has been driven by several forces — declines in reimbursement, high amounts of uninsured patients and charity care, an increase in the cost of care delivery and general healthcare inefficiencies. However, Mr. Parmer says community hospitals of all geographies and sizes will play a role in healthcare reform over the next five to 10 years, and those organizations must look at all of their options carefully before moving to make a deal.

“Hospitals should be looking at all types of arrangements,” Mr. Parmer says. “There is not one size that fits everyone. We’re not certain that all the bricks-and-mortar mergers make much sense.”

Community Hospitals: Why Their Futures Are More Flexible Than You Think

By Bob Herman

The spectrum of transactions

Mike Williams, president and CEO of Community Hospital Corp., has been in the healthcare industry just as long as Mr. Parmer. Previously, he served as president of the former Baptist Hospital in Knoxville, Tenn., COO of Children’s Medical Center of Dallas and vice president of Baylor University Medical Center, also in Dallas. He agrees there is no silver bullet for every hospital’s management situation. Before hospitals consider a transaction of some sort, Mr. Williams says the entire spectrum of options must be fleshed out. The following gives a general overview of the basic types of affiliations hospitals are pursuing today.

**Total independence.** Sometimes the best transaction is one not made at all, as full independence represents the left extreme of this affiliation spectrum, Mr. Williams says. Despite the rise of healthcare consolidation, there are many hospitals and academic medical centers that have the financial wherewithal, volumes, resources, staff and support to forge ahead on their own.

“Community hospitals have a greater opportunity for success based upon three factors,” Mr. Williams says. “One, if they are geographically essential. Two, if they are clinically strong. And three, if they are operationally efficient.”

“Healthcare is local,” Mr. Parmer of Baptist Hospitals of Southeast Texas adds. “Those individuals who make those decisions know what is best for their organizations, and I don’t necessarily agree that [consolidation] is something everyone has to do.”

**Clinical affiliation.** Just to the right of total independence is some type of clinical affiliation. For example, Jamestown (N.D.) Regional Medical Center, a 25-bed critical access hospital, decided in April to pursue a clinical and technology-based affiliation with Fargo, N.D.-based Sanford Health. The deal allows JRMC’s local board to retain governing powers, but JRMC...
Community hospitals earn strong support from the people they serve. But that’s not enough to ensure their survival. Shaky finances and rusty operations are constant threats to longevity and local control. With nearly two decades of experience protecting and preserving community-based hospitals, CHC offers support as well as solutions including operational and financial improvement, strategic vision, and help with regulatory compliance. Please call CHC today. Because your success is vital to your community.

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patients would have access to Sanford’s cancer care, which offers more expanded chemotherapy treatments.

Mr. Williams says these types of relationships will give local hospitals some name and brand recognition with a larger organization, but they are not as heavily pursued today.

Joint venture. Joint ventures have picked up more steam in the past few years. These deals allow a hospital to maintain as much independence as possible, but the other organization will be put at some risk for the hospital’s performance. For example, in February, Akron, Ohio-based Summa Health System and Cincinnati-based Catholic Health Partners created a “strategic partnership.” Summa Health still retained majority ownership and local control, but CHP became a minority owner.

Creating a new entity. Some non-profit community hospitals could go a step further, Mr. Williams says, and create a new 501(c)(3) organization. For example, several county-owned hospitals could band together and build a new parent entity. The counties would still maintain ownership of their respective facilities, but they could lease them to the newly created organization. Mr. Williams says these types of transactions could be very beneficial if community hospitals are looking to gain managed care clout.

Total sale or full-asset merger. The last option, or extreme on the right of the spectrum, is a full merger or sale. A community hospital can sell to a non-profit organization, such as the April merger between Lehigh Valley Health Network in Allentown, Pa., and Greater Hazleton (Pa.) Health Alliance, or an investor-owned company, such as the March deal between Brentwood, Tenn.-based LifePoint Hospitals and Bell Hospital in Ishpeming, Mich.

Choosing the right path

For hospitals that decide some type of affiliation or restructuring needs to take place, both Mr. Parmer and Mr. Williams suggest leaders take a methodical, well-planned course of action. They recommend hospitals consider these five points when pursuing an affiliation.

1. Mission. First and foremost, Mr. Parmer says any new partner — be it a health system or management company — must have a similar goal, mission and culture.

“We’d make a list of three to four must-haves, and mission and common philosophy were always right at the top,” Mr. Parmer says. “Some hospital groups that haven’t achieved all they hope to — you can see it was a noble idea, but you just had two things getting put in same box that were characteristically different.”

2. Understanding from the board. When a hospital decides to create a new partnership, it must keep the board of directors in the know at all times through a transparent, public process. Decisions of this magnitude cannot be unilateral, and a well-informed board will lead to a better transition.

“Make certain your board is educated, informed and knows exactly which direction you’re going,” Mr. Parmer says. “Board perspective is important.”

3. Physician alignment. Hospital-physician integration today is one of the top priorities for hospital executives under healthcare reform, due to varying projects such as bundled payments and accountable care organizations. However, leaders should not assume the medical staff should only be involved with clinical matters. In order to foster positive relationships with physicians, which will help future physician recruitment, hospital executives have to have open discussions with them.

“You need to think of medical staff and physician alignment,” Mr. Parmer says. “There is not much autonomy in our market, and there are not a lot of clinically integrated structures. You need to have awareness of the medical staff and how to achieve that alignment.”

4. Operational assessment. Hospital CEOs and CFOs have more data available to them now than any other point in their careers. Mr. Williams suggests executives use that data to understand how operationally efficient their hospital is — as well as their potential partner. For example, will financial and operational benchmarks improve if a deal is made? Will labor productivity, revenue cycle, supply chain and IT be strengthened?

5. Readiness for healthcare reform. Hospital affiliations have failed for a variety of reasons in the past, but in order for them to succeed in the future, transactions have to be centered around how this new era of reform — namely, the environment created by the Patient Protection and Affordable Care Act — will affect each party five, 10 and 20 years down the road.

“Hospitals are in a transition period of moving from being attractive to patients by their location in marketplace to competing to be selected for participation in health insurance exchanges and ACOs,” Mr. Williams says. “Those are the things we have to keep in mind.”

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Finance, Revenue Cycle & ICD-10 Issues

In fiscal year 2011, the median operating margin for non-profit hospitals, according to Moody’s Investors Service, was 2.5 percent. The Medicare Payment Advisory Commission has posted similar numbers since 1999: Most hospitals lose money on Medicare, and overall margins hover between 3 percent and 5 percent. Compared with most other industries, those are pretty slim margins, and in today’s current healthcare environment, attaining those figures is not always a given.

Here, five hospital and health system CFOs from all across the country explain how their organizations fared in FY 2012, what financial challenges they faced and what strategies contributed to their positive bottom lines.

Question: How was your organization able to achieve a profitable and successful 2012, and what were the main issues you worked on diligently?

John Bishop, CFO of Long Beach (Calif.) Memorial Medical Center, Miller Children’s Hospital Long Beach and Community Hospital Long Beach: In fiscal year 2012, we had a net income of $42.9 million, which was an operating margin of 4.5 percent. We were able to maintain our bottom line despite shrinking reimbursement through aggressively controlling our expenses, primarily labor, supplies and purchased services. Several years ago, MemorialCare Health System and its six hospitals and outpatient facilities began focusing on four areas to manage our costs. Called PLUC, it stands for productivity and labor management, Lean systems, utilization management, and care model redesign. Our Lean system initiatives, for example, helped us to identify non-value added processes. We also used labor and supply benchmarking tools to help identify opportunities.

An additional area of success is related to our “productivity collaborative.” Across MemorialCare, we’ve asked teams of managers to come together to compare labor cost on a per unit of service basis both internally and compared to other hospitals around the country. We’re able to externally benchmark our performance to learn more about our performance. In many cases we are already performing in the highest quartile as measured by the national database. In other areas, we have access to give our leaders context with the best performers in the data set, so they can gather ideas to enhance performance.

Another example has been the work of our VATs, or value-added teams of representatives from throughout the healthcare system, who work with our physicians to further assess and evaluate supply purchases for numerous clinical and support services. Every little, and not so little, bit counts. And that’s all without impacting quality, physicians or patients — simply from better purchasing coordination and collaboration.
The hospital successfully launched phase one of our electronic medical record, which consisted of computerized physician order entry, at the end of June. [We] qualified for stage 1 meaningful use for Medicare and recorded approximately $5.3 million in other revenue. However, operating expenses related to the post-implementation implementation costs and other infrastructure expenses totaled in excess of $7.2 million, thereby creating an approximate $1.9 million shortfall in operations.

Finally, Superstorm Sandy dealt a significant blow to our outpatient volumes. Most significantly, our ambulatory renal dialysis center located approximately two miles south of the main hospital campus was destroyed and left approximately 140 dialysis patients without a home. We were able to place approximately 20 to 25 patients in our hospital-based dialysis unit but needed to transfer the remaining patients to other neighboring freestanding centers in various communities surrounding the hospital. This loss of revenue for November and December totaled approximately $1 million.

However, South Nassau was successful in expense management related to salary expense. The hospital was under budget by approximately $2.5 million as it continued to monitor staffing and the controlling of unnecessary overtime (nursing OT fell by $420,000 from 2011).

Patricia Gavis, CFO of Ellenville (N.Y.) Regional Hospital: Like most hospitals, Ellenville Regional Hospital is managing the challenges presented by historic changes in our industry as we work to provide quality care and improve financial performance.

Among our key priorities in 2012 was a continued focus on delivering quality patient care and implementing technological advances to meet meaningful use requirements under the HITECH Act by implementing a hospital-wide electronic health record. At the same time, we worked to ensure the accuracy and completeness of EHR data as it translates into charges. As such, in 2011, we automated our chargemaster management processes and were able to increase charge accuracy by 80 percent in the first month of implementation, helping us to meet revenue and compliance goals.

In 2012, we successfully completed a full hospital system conversion, including the implementation of an EHR and attestation for stage 1 meaningful use, 117 days after going live. Ellenville has accomplished significant improvement over the years, going from a hospital on the verge of closure in 2003, to a financially stable and successful hospital by the end of 2012. Our successful improvements in patient safety and quality were also exemplified, as we became the only hospital to be awarded the Northern Metropolitan Hospital Association Quality and Patient Safety Award for a second time.

Dan Harris, CFO of Swedish Health Services in Seattle: When I got here in February 2012, Swedish had a $16.7 million loss from operations through the first two months. We forecasted Swedish was on track to lose $7.5 million per month for the rest of the year. Nothing like a crisis for a CFO to get someone’s attention. That was where we were at, but we ended the year with a $40 million profit. We forecasted a $90 million loss but actually made $40 million, a difference of $130 million.

We created an operations improvement plan and got leadership buy-in. Swedish runs five hospitals with almost 10,000 employees. It’s a big organization. For us, it was about creating a plan that people can buy into, support and then execute.

Our operations improvement plan [last year] was probably more cost reduction and also process improvement, along with some growth initiatives and revenue enhancement projects. The big three, though, are revenue cycle, supply chain and productivity. The filler is volumes, and there are programs that are growing. This was a process that we borrowed from Providence, and at Swedish, we created our own [vision].

Ted Sirottta, CFO of Northwestern Medical Center in St. Albans, Vt.: We are proud of our financial performance in 2012. We achieved a 16 percent year-over-year increase in net revenues, and our total margin was 13.7 percent. Our financial success was driven in large part by our acute admissions, births and Medicare case mix all running higher than budgeted. Because our hospital is managed by Quorum Health Resources, we are able to participate in a large group purchasing organization. Combined with reasonably good cost control, we were able to carefully manage all costs within the organization.

Attention to detail is a must in today’s environment, and we feel even a savings opportunity as small as $1,000 is worth pursuing. To help us manage costs, our senior leadership closely reviews all capital and personnel requests to ensure need. Separately, our cost accounting system helped us identify opportunities to reduce costs and negotiate insurance contracts, and stock market returns on our investments helped drive our total margin.

We cannot achieve the financial success we have had without outstanding patient satisfaction and quality. For example, in 2012, our hospital was recognized for the fifth year in a row with a national special achievement award in patient satisfaction from Avatar. In addition, Northwestern Medical Center was recognized by The Joint Commission as a top performer in the nation for pneumonia care, one of The Joint Commission’s key quality measures.
Hospitals and other providers are nearing the 15-month mark: That is, 15 months until they will be required to use ICD-10.

Last year, HHS finalized the new go-live date of ICD-10 for U.S. providers: Oct. 1, 2014. Over the past several years, a debate has raged throughout the country whether hospitals and physicians should make the transition to ICD-10 for their insurance claims and diagnoses. Most can agree that ICD-9 needs to be upgraded, but not everyone agrees on the path to get there.

ICD-10 opponents, such as the American Medical Association, have argued that ICD-10 will be costly and will burden physicians and other providers with a heap of new documentation requirements. In addition, the World Health Organization is roughly two years away from finalizing ICD-11, meaning ICD-10—a product of the early 1990s—will soon be even more outdated. However, ICD-10 proponents say ICD-10 is a necessary step in getting to ICD-11, and ICD-10 must go forward to improve provider documentation.

While the ICD-10 versus ICD-11 debate heats up, one physician believes it is time to look at the situation from a different perspective.

Jon Handler, MD, is a board-certified emergency physician and the former director of emergency medicine research and informatics at Chicago’s Northwestern University Feinberg School of Medicine. He is currently the chief medical information officer of technology firm M*Modal. Dr. Handler says one major stakeholder is being left out of the ICD-10 discussion: patients.

“The key thing here is physicians and patients don’t have enough time with each other, and that is bad for patient care,” Dr. Handler says. “Perhaps more importantly, something we are not measuring in this [transition to ICD-10] is the impact on patients not being seen.”

**Time to abandon ICD-10?**

Dr. Handler says the physician-patient relationship is already strained through increased documentation and the infusion of electronic health records, and that has led him to pen an idea familiar to many: It’s time for healthcare to abandon ICD-10.

“We have people literally dying in the emergency department waiting to be seen. Anything that makes my efficiency as a physician even less, so patients have to wait even longer for me to see them, it better be great. I don’t see that ICD-10 does that,” Dr. Handler says. “ICD-10 makes you document a whole bunch of details that are arguably important in 1992, but they are not that important now.”

He adds that if payors or others want to move forward with ICD-10, that is certainly fine. It’s the requirement on hospitals and physicians that is burdensome.

“My issue is making the provider side of the equation report data as ICD-10,” Dr. Handler says. “Why force physicians—or EHRs, or coders, or anyone else on the provider side—to report the very same data in two different terminologies? Meaningful use stage 2 says I must report the problem in a problem list using SNOMED-CT, then recode the same problem as a ‘diagnosis’ in ICD-10? That seems nonsensical.”

**Solution**

Instead, Dr. Handler suggests the healthcare system should either wait for ICD-11—which many have argued would take several years after WHO releases the final version—or use compositional SNOMED, SNOMED, or the Systematized Nomenclature of Medicine, is one of the most specific databases of healthcare terminology developed by physicians and is the basis of the upcoming ICD-11 set. Further, compositional SNOMED, according to Dr. Handler, is when providers can string codes to describe diagnoses and is a “simple, better and more useful solution than ICD-10.”

However, some say although SNOMED is the most comprehensive model for healthcare terminology and diagnoses, it doesn’t work as well as a classification system because of how granular it is. Instead, ICD-10 should be used as the temporary stop-gap as the world formalizes ICD-11.

Dr. Handler says that is nothing more than an “unfounded myth.” He says SNOMED can support a classification system because ICD-11 will be based on SNOMED—and its “granularity is what makes it uniquely suited for this purpose.”

He also reiterates that all the effort expended on preparing for the 20-year-old ICD-10 system will make future transitions harder to handle, and he doesn’t think patients should be casualties of the process.

“When you look at the costs, effort, training and impact on patients [of ICD-10], we’ve waited more than 20 years,” Dr. Handler says. “We’ve waited until 2014 before we mandated the use of ICD-10, and less than one year [from then], ICD-11 is going to come up. Nobody is going to have the stomach to move to ICD-11, which everyone can agree is better.”

Dr. Handler is not alone in his belief that ICD-10 should be scrapped for ICD-11 and SNOMED. Last year, five leading U.S. medical informatics experts wrote an article for *Health Affairs* arguing that healthcare may be better served by avoiding the drama surrounding ICD-10 and instead move toward ICD-11 and SNOMED. Like Dr. Handler, the authors wrote that ICD-10 is a major upgrade over ICD-9, but SNOMED and ICD-11 are the gold standards—and they are well within reach.

Many hospitals and physicians still have a long way to go in their ICD-10 transitions—in fact, most providers are still just getting started on their ICD-10 projects—but there are still some who have already invested millions of dollars in their ICD-10 projects. When asked if scrapping ICD-10 would affect those who have already put large sums of money toward ICD-10, Dr. Handler says any existing investments puts providers ahead of the game when it comes to ICD-11, and using SNOMED in the interim “should help their readiness even further.”

However, he adds everything goes back to the most important stakeholder: patients. Providers are bound by the Hippocratic Oath, and he believes money invested in ICD-10 cannot trump potentially damaging effects of lost patient time.

“I’m not worried about physicians, payors, hospitals or any member of the healthcare system other than the patients we are honor-bound and mandated to serve,” Dr. Handler adds. “I don’t care how far along we are, if this is bad for patients, we should not do it.”

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Executive Briefing: Healthcare Transportation

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Healthcare Transportation as an Integration Agent

By Heather Punke

News stories abound on the challenges and opportunities created by national and state healthcare reform. Healthcare executives are responding to reform by expanding the footprint of their health systems through mergers and acquisitions and other strategic partnerships built around a push to increase care outside of the four walls of the hospital. As the reach of a single hospital or healthcare system continues to grow, connecting all of a system’s entities and caregivers becomes more challenging and creates many complex business considerations.

It is extremely difficult to coordinate and implement the integration of an entire health system, given their complexity. Numerous pieces have to fall into place for all the points of care, service lines, clinicians, support staff and administrators to unify as one system.

Some of these integrating pieces are much discussed, such as electronic medical records and governance. However, one aspect of integration is often overlooked, but can have a major impact on the efficiency and future success of an integrated system: logistics. More specifically, healthcare transportation as a part of logistics is especially important. Transportation touches nearly every area of an organization, as it is responsible for the system-wide movement of all patient- and business-critical materials, such as lab specimens, pharmaceuticals, supplies and medical records.

As the reach of a single hospital or healthcare system continues to grow, connecting all of a system's entities and caregivers becomes more challenging and creates many complex business considerations.

Conversely, a strong, centralized transportation network can help clean up the messy logistics brought on by integration efforts and can contribute to the overall success of an integrated health system.

Standardizing operations. A big driver of integration success is standardizing operations and implementing the use of best practices across the facilities of an entire organization. Utilizing a single source for medical transportation facilitates that process. “[Transportation] is a standardizing agent that can move things across an organization more cleanly,” Mr. Crampton says.

Mr. Lubotsky believes that utilizing medical transportation is an important part of unifying the operations of a system. “We are consistently looking at our operations and what we can integrate as a system,” he says of Advocate’s integration efforts. “And [using MedSpeed as the sole provider of transportation services] falls in context of looking for ways to continually integrate and standardize our operations.”

Mercy, too, has experienced the positive effects that a unified transportation system has on a health system’s general integration efforts. “Transportation is such an integral part of an integration practice,” Mr. Moore says.
Done well, healthcare transportation can play a pivotal role in helping disparate organizations successfully integrate into a singular, integrated operating system. Importantly, unifying transportation is not only an end in of itself but also a means to create other opportunities for operational standardization, according to Mr. Crampton. “By leveraging a robust transportation network, systems can move to central labs, central print shops, central distribution and so on – all of which brings greater uniformity to how the system works.”

Culture of integration. Beyond standardizing transportation processes across an organization, implementing a system-wide transportation system can also promote a culture of integration throughout the system’s hospitals, clinics and administrative offices. Before integration became a growing trend in healthcare, there was a culture of facility-based orientation, not system-based orientation, according to Mr. Crampton, and that culture has to change for integration to be successful. “Transportation can be a part of cultural change,” he explains.

A unified transportation system is unique when it comes to promoting a culture of integration because it is visual and touches every element of the operation of a system. Anything from acute-care hospitals, non-acute care physician offices and administration personnel see and interact with healthcare transportation on a weekly or even daily basis. “Because transportation touches everything, it is an especially visible and effective unifying agent,” Mr. Crampton says.

“People get connected to [the people who visit their office every day], and the same thing happens culturally in a health system,” Mr. Moore says. He has seen the cultural impact of a unified transportation system at Mercy. When the same driver comes to deliver supplies or pick up lab specimens, it can become a cultural mechanism to unify the system, according to Mr. Moore.

Value creation. Finally, in addition to unifying the system and giving care providers and administrators a cultural touchstone of integration, using a single source for healthcare transportation can give systems added value through long-term cost savings.

At Advocate, Mr. Lubotsky has seen first-hand the savings that unifying healthcare transportation can deliver. Advocate has used MedSpeed for years, and prior to 2012 was saving on a recurring basis about $360,000 each year on transportation from eliminating inefficiencies and standardizing deliveries through MedSpeed’s services.

Increased healthcare transportation integration can lead to even greater savings, though. Since 2012, Advocate has deliveries dropped off at a central logistics center, instead of individual locations, and MedSpeed delivers the supplies to the various sites from there. “MedSpeed was going out to the clinics anyway, and we can now deliver supplies through MedSpeed for a lot less money,” Mr. Lubotsky notes. Now, the system saves roughly an additional $800,000 each year on transportation.

A big driver of integration success is standardizing operations and implementing the use of best practices across the facilities of an entire operation.

According to Mr. Crampton, these significant savings opportunities can be several times the direct savings on transportation alone. The reason: “because a well-designed centralized network creates the mechanism to utilize network connectivity. The delivery and deployment of all goods and services throughout the network can be affected at zero or marginal incremental cost,” says Mr. Crampton.

The overall impact: A unified, professional transportation system can help a health system physically and culturally integrate while helping achieve significant added value at the same time. In a more complex and pressure-filled healthcare environment, this is more important than ever.
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“If it's not your core competency, outsource it. Healthcare, not transportation, is our specialty.”

Healthcare is more tumultuous than ever. Executives are challenged to be increasingly nimble to more effectively manage change. By offering access to intellectual capital and innovations, reducing operating costs and freeing up capital and human resources, outsourcing can help organizations “let go” of non-core functions in order to enhance overall control. Result: a renewed focus on providing quality, timely patient care.

“We've got 32 different people driving all over the place, crossing each other's paths along the way, totally replicating services.”

As organizations spread out, the movement of critical patient specimens, pharmaceuticals, print, mail and supplies becomes increasingly difficult to manage—and can elevate risk and cause both clinician and patient dissatisfaction. Provider organizations need a solution to address transportation as a vital link that reaches across the enterprise, one that, when optimized, can add significant value by eliminating overlap as it improves quality.

“We are not geared up to deal with the rapid growth environment we're thrust into now.”

Mounting pressure for growth is moving care beyond the four walls of the hospital. Health systems are growing at historic levels through acquisitions and strategic partnerships. But, while merging operations can broaden care services, it can also lead to system dysfunction and waste. Given all the expanding points of care, without effective healthcare transportation, care coordination can become very costly, very quickly.

The healthcare landscape is changing dramatically. As the Affordable Care Act moves toward full implementation, more and more organizations are undertaking initiatives to improve quality and drive down costs. Optimization of every function and elimination of waste and over-servicing are clearly the way forward.
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5 Tips on Moving Away From RVUs for Physician Compensation

By Sabrina Rodak

The speed at which healthcare leaders transition their organizations from a volume-based healthcare model to a value-based system differs widely. While some organizations created accountable care organizations and similar models, many others continue to operate based on volume, which remains the primary metric for commercial and federal reimbursement. In fact, a report from the Catalyst for Payment Reform found only 11 percent of all healthcare dollars paid to hospitals and physicians from commercial payors are tied to performance.

Minneapolis-based Fairview Health Services is one of the early movers. In April 2011, the health system dropped relative value units as a payment model for primary care providers and established a compensation framework that ties payment to performance. The system differs widely. While some organizations created accountable care organizations and similar models, many others continue to operate based on volume, which remains the primary metric for commercial and federal reimbursement. In fact, a report from the Catalyst for Payment Reform found only 11 percent of all healthcare dollars paid to hospitals and physicians from commercial payors are tied to performance.

By Bob Herman

Work relative value units continue to be the most common measure when medical groups create production-based compensation plans for physicians, according to the American Medical Group Association’s 2012 medical group compensation and financial survey. The AMGA defined a production-based plan as a plan where at least half of the medical group’s compensation is distributed based on some type of work or financial contribution. The group surveyed 138 physician organizations on these types of plans.

Here are the top five factors for production-based compensation plans, according to the AMGA survey.

1. Work RVUs: 70 percent
2. Net production: 29 percent
3. Cost accounting: 14 percent
4. Gross production: 4 percent
5. Total RVUs: 1 percent

5 Factors Used in Physician Production-Based Compensation Plans

By Sabrina Rodak

To sign up for the FREE E-Weekly, visit www.BeckersHospitalReview.com or call (800) 417-2035
In March, Pittsburgh Mayor Luke Ravenstahl announced the city was launching a formal challenge to University of Pittsburgh Medical Center's tax-exempt status. The city filed a lawsuit with the Court of Common Pleas of Allegheny County contesting UPMC's exemption from city payroll taxes.

The city is also challenging the tax-exempt status of UPMC's 150 properties in Pittsburgh before the Allegheny County Board of Property Assessment, Appeals and Reviews. That appeal remains before the board.

For the lawsuit filed in March, Pittsburgh-based Strassburger McKenna Gutnick & Gefsky. Mr. Strassburger named a range of activities that allegedly disprove UPMC's compliance with the fifth prong, including the closure of facilities in locations with relatively high numbers of Medicare, Medicaid or uninsured patients; more than 20 UPMC employees receiving at least $1 million in pay in 2011; and global business financial activities that “appear to have little to do with…UPMC's charitable mission…and more to do with trying to attract wealthy patients.”

Will this case sound the alarm?

Mr. Strassburger said he doesn't expect this case to set off a ripple of governmental challenges to hospitals' tax-exempt status. UPMC's enormous organizational structure and business affairs make its standing unique.

“I don't think this is a floodgates situation,” he said. “UPMC is an unusually large, diverse business that is subject to laws of Pennsylvania. There aren't a lot of UPMCs around.”

Mr. Strassburger also presented another side to the argument, comparing UPMC to some other major organizations in Pittsburgh. He named the Pittsburgh Steelers, Pirates and U.S. Steel as just a few organizations that are very beneficial for the community, but that doesn't make them tax-exempt.

In his statement to Becker's Hospital Review, Mr. Wood said, “Any sort of new, discriminatory tax scheme would certainly result in less monies for the region and, while satisfying to some, would be bad public policy resulting in many uninformed citizens, or county or state.

Conclusion

The challenge itself has been a noteworthy development, as non-profit health systems continue to grow in size and scale. Pending on the outcome of Pittsburgh v. UPMC, hospitals and non-profit health systems may need to revisit their financial structures, charity care policies and other business strategies to ensure they meet the appropriate legal requirements in their city, county or state.

Editor's note: On April 19, UPMC filed a 16-page complaint in federal court against the city of Pittsburgh and Mayor Luke Ravenstahl, claiming the city's lawsuit questioning UPMC's tax-exempt status is a campaign to target and damage UPMC. In that suit, UPMC is demanding a monetary judgment against the city for its allegedly “gross violation of the constitutional rights of UPMC.”

Expect continuing coverage on the matter from Becker's Hospital Review.
First Things First: Treat Employees Well

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

I first met Paul Spiegelman about five years ago when he asked me to become a member of the advisory board for his company, Beryl, now BerylHealth. The company is in the patient experience arena, collecting data and generating insights into relationships with the most valued people in healthcare — customers. As I got to know Spiegelman better and became more familiar with his organization, I was impressed with not only him as a businessman but also with the fact he was concerned about values, a passion we share.

His philosophy is a simple one: Treat your employees with dignity and respect, and they in turn will treat customers the same way. Lots of executives talk the talk, but Spiegelman practiced that philosophy with his people, and I was quite taken with it as I saw it pay off first-hand. Every time I had the occasion to interact with Beryl employees, I was struck with their dedication and enthusiasm. I realized I was witnessing a management philosophy in action, one that made eminently good sense but also translated into high productivity and exceptional sales.

In other words, Spiegelman’s philosophy was a winner as far as I was concerned and made all the sense in the world. From time to time, he and I get together, including at dinner in Chicago a few months ago. He was excited about a new book he was working on about hospitals and how they treat patients too often in a less-than-appropriate manner. So I was excited to get a copy of that book recently, entitled “Patients Come Second.”

I knew the title was deliberately provocative, but it isn’t just the familiar assortment of patient horror stories. Instead it is an elucidation of the philosophy Spiegelman practiced at Beryl. He has co-authored the book with Britt Berrett, the president of 898-bed Texas Health Presbyterian Hospital in Dallas. Berrett shares the belief of how people should be treated and is a passionate advocate for excellence in healthcare.

In the introduction to the book, there is a letter from a woman Spiegelman identifies as “Wendy L.” who after hearing his presentation at the Beryl Institute Conference on his book in progress, wrote him to question its title. “I believe your book title is very destruc tive and invites reviews and blog posts that will be unnecessarily negative.”

Spiegelman includes his response: “While the title may seem controversial, once you read the book (and I hope you will), you’ll see that we are all after the same thing: improving the experience for the patient. There was once a popular book called “The Customer Comes Second.” That title could have provoked the same response, but it revealed an important truth that spoke to people in the business world. Let’s face it: Employees in most companies get treated as second-class citizens. If that’s the case, how can we expect them to treat customers well? The same is true for employees in the healthcare field.”

For the rest of the book, Spiegelman and Berrett take us on a journey that shows how enlightened leadership and total engagement can achieve patient-centered...

The theme of the book might best be summarized by a quote the authors received from Ron Swinford, the CEO of Lehigh Valley Health System in Allentown, Pa., who referenced the challenges of the Patient Protection Affordable Care Act by saying: “I really don’t give a damn what model the federal government inflicts on us to deliver care. As long as we as providers care about our patients and one another, we’ll be successful. People will beat down our doors to get here, because they’ll feel it.”

The authors also quote Wayne Lerner, the former CEO of Holy Cross Hospital in Chicago: “The future will not be centered around the hospital experience. It will be the entire patient experience, which includes more than hospitals. Organizations that used to be competitive will now need to work together. Just add that to the list of challenges.”

Spiegelman and Berrett agree. “Today, patient experience is a top-three kind of issue, ranking even higher than cost reduction,” they write. “Yet three-quarters of healthcare organizations have yet to define what patient experience means to them, let alone set aside money to address it. The more progressive executives who have tried to tackle the challenge head-on, however, have gone about trying to solve it in a backward manner. They have plowed money into adding more beds or developing new technology such as electronic medical records, all while overlooking the obvious solution: investing in their employees.”

In a discussion of healthcare employees and their sense of mission, Dan Peterson, the CEO of Emory University Hospital Midtown in Atlanta, is quoted: “The overarching mission of a healthcare organization is an easy one to communicate — most employees and physicians choose their profession based on the mission. Everyone wants to be a part of something bigger than themselves, so even those employees who work in roles not found only in healthcare, and even those of us who came to healthcare later in life, can get excited about making a real difference in the lives of others.”

Tony Armada, the CEO of Advocate Lutheran General Hospital in Park Ridge, Ill., adds this: “A mentor of mine once shared a very simple equation with me: If physicians and employees are happy, you’ll get an increase in patient volume. If you increase volume, you’ll find ways to decrease cost. With that, you’ll increase margin and be able to invest back in employees.”

Many of the lessons in “Patients Come Second” are not necessarily original but are reminders of how important the basics are when people engage with others. Good manners, a smile, a sense of humor, total commitment and focus and the willingness to leave egos at the front door are all part of a basic formula for making people feel special so that they can make others feel just as special as they do. Healthcare leaders have many things on their plates, but nothing is more important than the welfare of their patients. That means if patients are to be treated well, the very people who are engaged with patients have to be made aware of how special they are in the scheme of things.

Healthcare is changing, but giving patients exceptional care should be the prime goal of any healthcare workforce and the leaders who are responsible for inspiring their employees every day. Spiegelman and Berrett have done a great job of providing a very workable plan for achieving excellence in patient care. “Patients Come Second” is a great read and worth the time of anyone committed to achieving excellence in patient care.

Chuck Lauer (chuckspeaker3@aol.com) was publisher of Modern Healthcare for 33 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide.
Hospital & Health System Transactions

St. Louis-based Ascension Health, the largest Catholic health system in the United States, completed its acquisition of Marian Health System, a Tulsa, Okla.-based provider with three regional health systems.

Phoenix-based Banner Health added Arizona Regional Medical Center in Apache Junction, Ariz., to its network, pending approval.

Discussions regarding the acquisition of Bert Fish Medical Center in New Smyrna Beach, Fla., advanced with two proposed Florida buyers: Daytona Beach-based Halifax Health and Naples-based Health Management Associates.

Massachusetts hospitals Beth Israel Deaconess, based in Boston, and Lahey Health, based in Burlington, entered affiliation talks.

Asheville, N.C.-based health system CarePartners Health Services entered into a nonbinding memorandum of understanding to become an affiliated member of Mission Health, also based in Asheville.

Englewood, Colo.-based Catholic Health Initiatives and Vancouver, Wash.-based PeaceHealth agreed to suspend their discussions after signing a nonbinding agreement with intent to affiliate in August 2012.

Naperville, Ill.-based Edward Hospital & Health Services and Elmhurst (Ill.) Memorial Healthcare signed a definitive merger agreement.

Emanuel Medical Center, a 72-bed hospital based in Swainsboro, Ga., signed a joint management and lease agreement with ER Hospitals, a hospital management group based in Salt Lake City.

Tacoma, Wash.-based Franciscan Health System finalized its acquisition of Burien, Wash.-based Highline Medical Center, which operates a 154-bed acute-care hospital, a specialty center and more than 20 clinics.

Greater Hazleton (Pa.) Health Alliance and Lehighton Valley Health Network based in Allentown, Pa., signed a merger agreement, pending regulatory approval.

Hackensack (N.J.) University Medical Center and North Shore-Long Island Jewish Health System in Great Neck, N.Y., approached Long Island College Hospital, part of State University of New York Downstate Medical Center, with competing bids to acquire it.

Naples, Fla.-based Health Management Associates officially launched its joint venture partnership with Bayfront Health System in St. Petersburg, Fla., in which the for-profit hospital chain acquired an 80 percent ownership in the 480-bed Bayfront, with the remaining 20 percent stake owned by the Bayfront HERO foundation, a non-profit subsidiary of Health Management co-governed with Bayfront representatives.

Shands Healthcare, part of Gainesville, Fla.-based UF&Shands, is a clinical partner in the new hospital arrangement.

Hot Spring County Medical Center in Malvern, Ark., chose to enter into an operating sublease agreement with Baptist Health Medical Center-Little Rock (Ark.), pending local court approval, over competing offers from Arkansas Heart Hospital and St. Vincent Health System, both based in Little Rock but owned by out-of-state entities.

The Louisiana State University Board of Supervisors approved plans to lease Interim LSU Public Hospital, better known as University Hospital, in New Orleans and University Medical Center in Lafayette, La., to private operators. Louisiana Children’s Medical Center will pay for the lease to run the New Orleans hospital for two years until a new $1.1 billion medical center is constructed, which LCMC would then lease for 40 years. University Medical Center would be leased to Lafayette (La.) General Health System in a similar agreement.

Officials set a goal to sell Iron County Hospital in Pior Knob, Mo., by June 30, the end of the hospital’s fiscal year. Potential buyers and financial details were not disclosed.

Jamestown (N.D.) Regional Medical Center, a 25-bed critical access hospital, began to pursue a clinical and technology-based affiliation with Fargo, N.D.-based Sanford Health.

Johnston Health, a public health system based in Smithfield, N.C., and Chapel Hill, N.C.-based UNC Health Care entered exclusive negotiations for a strategic partnership.

Passing one of its final bureaucratic hurdles in a year-and-a-half pursuit, the deal for New London, Conn.-based Lawrence + Memorial Hospital to acquire The Westerly (R.I.) Hospital earned the Rhode Island attorney general’s approval.

Portland, Maine-based MaineHealth approved an agreement to add Memorial Hospital, based in North Conway, N.H., to its network after a year and a half of discussions.

Boston-based Massachusetts General Hospital’s plan to acquire Northampton, Mass.-based Cooley Dickinson Hospital met with broad support from employees and community members at a public hearing meant to determine whether a certificate of need would be issued to merge after Cooley Dickinson’s former partnership with the Dartmouth-Hitchcock-Alliance dissolved.

Mecosta County Medical Center in Big Rapids, Mich., will officially become part of Grand Rapids, Mich.-based Spectrum Health after both systems’ boards and the Mecosta County board of commissioners signed off on the deal.

Georgia health systems Memorial Health in Savannah and Evans Memorial Hospital in Claxton formed a clinical affiliation, under which Evans Memorial will remain locally owned and operated.

After several weeks of negotiations, the board of trustees for Munroe Regional Medical Center in Ocala, Fla., chose Naples, Fla.-based Health Management Associates over Brentwood, Tenn.-based Duke LifePoint Healthcare to lease and operate the publically owned, 421-bed hospital.

City officials of North Kansas City, Mo., hired three additional lobbyists to fight the passage of legislation that would end the city’s ownership of North Kansas City Hospital and make the institution independent, effectively blocking some city officials’ hopes of selling the hospital to a for-profit buyer.

Winston-Salem, N.C.-based Novant Health added University Health Care System in Augusta, Ga., to its shared services division.

Peoria, Ill.-based OSF Healthcare affiliated with the Mayo Clinic Care Network in a non-ownership relationship.

Ontario, Calif.-based hospital chain Prime Healthcare Services completed its purchase of two Kansas hospitals from Denver-based Sisters of Charity of Leavenworth Health System. The for-profit chain acquired 400-bed Providence Medical Center in Kansas City, Kan., and 80-bed Saint John Hospital in Leavenworth, Kan.

Ontario, Calif.-based hospital chain Prime Healthcare Services offered to invest nearly $44 million into upgrades of St. Mary’s Hospital in Passaic, N.J., pending regulatory approval.

Rush Oak Park (Ill.) Hospital shed its status as a Catholic hospital as Chicago-based Rush University Medical Center completed its 15-year deal to acquire it.

Denville, N.J.-based Saint Clare’s Health System and its Englewood, Colo.-based, non-profit parent Catholic Health Initiatives signed an asset purchase agreement with Ontario, Calif.-based, for-profit Prime Healthcare Services.
In light of public scrutiny, Fargo, N.D.-based Sanford Health withdrew from merger discussions with Minneapolis-based Fairview Health Services.

Elgin, Ill.-based Scottsdale Lincoln Health Network, expected to merge and become based Scottsdale (Ariz.) Healthcare, signed a letter of intent to merge and become based Scottsdale Lincoln Health Network, expected to be completed by July 31.

Elgin, Ill.-based Sherman Health and Oak Brook, Ill.-based Advocate Health Care signed an agreement to merge, pending regulatory approval.

Massachusetts’ Public Health Council approved a determination of need and license to transfer ownership of South Shore Hospital in Weymouth, Mass., to Boston-based Partners HealthCare System.

The board of directors at Southern Ohio Medical Center in Portsmouth decided not to re-merge with OhioHealth but to remain an affiliate of the Columbus-based system.

In order to keep St. Andrews Hospital’s critical access status after closing its 25-bed emergency department, Boothbay Harbor, Maine-based Lincoln County Healthcare hopes to merge its the Boothbay Harbor hospital with its sister campus, Miles Memorial Hospital — located about 30 minutes away in Damariscotta, Maine.

The Episcopal Diocese of Texas approved a definitive agreement to transfer Houston-based St. Luke’s Episcopal Health System to Englewood, Colo.-based Catholic Health Initiatives. Physicians from St. Luke’s have since filed a motion to halt the system’s sale to CHI.

The board of trustees of Winter Haven (Fla.) Hospital unanimously voted to approve a merger with Clearwater, Fla.-based BayCare Health System.

Chapel Hill, N.C.-based UNC Health Care System and Pardee Hospital in Hendersonville, N.C., expanded their management agreement by 15 years.

Erwin, Tenn.-based Unicoi County Memorial Hospital approved Johnson City, Tenn.-based 13-hospital system Mountain States Health Alliance’s definitive agreement to acquire it.

**Hospital & Health System Executive Moves**

Eastern Maine Healthcare System in Brewer, Maine, announced the resignation of Pittsfield, Maine-based Sebasticook Valley Hospital CEO Victoria Alexander-Lane.

Kevin Brown, formerly CEO at Swedish Health Services in Seattle, was named president and CEO of Piedmont Healthcare in Atlanta.

Lynchburg, Va.-based Centra Health announced the resignation of CEO Michael Bryant.

Cleveland Clinic Innovations Executive Director Chris Coburn resigned at the end of May to take a new position with Boston-based Partners HealthCare.

Central Florida Heath Alliance announced the appointment of Saad Ehtisham, RN, MBA, MHA, as the health system’s new COO.

Spokane, Wash.-based Deaconess Hospital CEO Bill Gilbert announced his resignation.

Julie A. Hester, CEO of Wilmington, Del.-based St. Francis Healthcare, resigned for personal reasons.

Springfield, Ohio-based Community Mercy Health Partners named Paul Hitz, FACHE, market leader and president.

Rod Hochman, MD, became president and CEO of Renton, Wash.-based Providence Health & Services three months earlier than expected.

Bristol (Tenn.) Regional Medical Center, part of Wellmont Health System, announced the resignation of its president, Bart Hove.

Memorial Hospital of Texas County in Guymon, Okla., terminated the contract of CEO Lee Hughes.

Carlisle (Pa.) Regional Medical Center named COO Rich Newell as the new CEO following the resignation of John Kristel.

Thomas Malone, MD, stepped down from his positions as president of two Detroit Medical Center hospitals.

Candace “Candy” Markwith announced plans to retire as CEO of Sierra Vista Regional Medical Center in San Louis Obispo, Calif., effective Sept. 15.

St. Louis, Mo.-based Ascension Health promoted Patricia Maryland, DrPH, to president of healthcare operations and COO, effective July 1.

Four executives stepped down from Reno, Nev.-based Renown Health, including Jim Miller, the system’s president and CEO, after a law firm conducted a comprehensive review of Renown’s acquisition of a cardiology practice that led to an antitrust complaint from the Federal Trade Commission.

Atlanta-based Grady Health System named Christopher R. Mosley, FACHE, DSL, as COO.

Huntington Memorial Hospital in Pasadena, Calif., promoted Jim Noble, senior vice president and CFO, to executive vice president, COO and CFO.

Robert Savage, CEO of Poughkeepsie, N.Y.-based Saint Francis Hospital and Health Centers, resigned.

Clark Regional Medical Center in Winchester, Ky., part of Nashville, Tenn.-based LifePoint Hospitals, appointed Cherie Sibley as CEO.

Eugene Suksi, CEO of Crescent City, Calif.-based Sutter Coast Hospital, resigned.

Thomas Thompson was named CEO at Samaritan Healthcare in Moses Lake, Wash.

Rochester (N.Y.) General Health System named Paula Tincher, CPA, senior vice president and CFO.

St. Louis-based BJC HealthCare named Larry Tracy president of Barnes-Jewish St. Peters (Mo.) Hospital and Progress West HealthCare Center in O’Fallon, Mo.

Sister Margaret Wright, 77, resigned as president and CEO of Palos Community Hospital in Palos Heights, Ill.
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