10 Things the Most Progressive Hospitals Do

By Molly Gamble

It’s been said that there are three types of people in the world: the retrograde, the stationary and the progressive. The same could be said for organizations, particularly in healthcare. There are hospitals that will cling to the ways of the past. There are also organizations that will settle as they are, resisting major change, surviving rather than excelling.

Then there are the progressive ones, the hospitals defying the norm. These hospitals are tackling challenges that surpass the confines of their singular institutions. One hospital vowed to share its prices for common services and, just to add some teeth to it, challenged local competitors to do the same.

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Positive Hospital-Union Relationships: Open Communication is Key

By Heather Punke

Unions in general have been in decline in the United States over the last 20 years. In 1983 the union membership rate — the percent of wage and salary workers who were members of a union — was 20.1 percent, and there were 17.7 million union workers. In 2012, the union membership rate was 11.3 percent, and there were just 14.4 million union members, according to Bureau of Labor Statistics data.

The healthcare industry, however, is swimming against the stream. Last year, 20.8 percent of healthcare workers — people in healthcare practi-

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Da Vinci Robots: Minimally Invasive Miracle or Costly Conundrum?

By Jim McLaughlin

Minimally invasive surgeries have grown in use among surgeons and favor among patients and payers. Roboticy assisted surgery performed using the da Vinci robot is the latest technologic upgrade, but new research is calling its effectiveness — and higher cost — into question.

But, even some healthcare executives skeptical of the da Vinci’s cost-saving potential find the machine indispensable in recruiting physicians and marketing to patients.

Rise of the robots

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Publisher’s Letter
August Issue; Becker’s Hospital Review CEO Strategy Roundtable

August issue. The August issue of Becker’s Hospital Review features our annual round-up of the largest and top-grossing hospitals in America, organized into nonprofit and for-profit categories. The issue also includes a list of the largest nonprofit and for-profit health systems in America, a list that always seems to be changing given the active healthcare merger and acquisition market.

Inside this issue you’ll also find a great feature article on the efficacy of the Da Vinci robot, a costly piece of equipment that is often a must-have for physician recruitment despite the lack of agreement around its ability to improve outcomes across several procedures. The issue also features the article “10 Things the Most Progressive Hospitals Do,” which explores some of the things beyond patient care a handful of forward-thinking hospitals across the country are pursuing in order to adapt their business models to the pressures of healthcare reform.

CEO Strategy Roundtable. The Becker’s Hospital Review CEO Strategy Roundtable will take place Thursday, Nov. 14, 2013 in Chicago at the Ritz-Carlton Hotel at Water Tower Place. The day-long event features three tracks, 23 sessions, 50 speakers and 24 hospital and health system CEOs as speakers. Sample sessions include:

• How to Assess Strategy in a Changing World: Thinking 5 Months and 5 Years Into the Future
• Assessing and Defending the Fair Market Value of High Earning Physician Compensation
• Talent Rules! Creating a Talent Management Process Within Healthcare

• The Best Ideas for Community Hospitals Now
• ACOs: Current Trends and Issues
• Creating an ACO for Your Own Employees
• The State of the Healthcare Future
• Compensation for Health System Leadership
• Hospital Leadership: What Are the Biggest Opportunities for and Threats to Hospitals?
• The Road to Population Health: Key Enablers in Implementing Value-Based Approaches

To learn more or register for the event, visit: http://www.beckershospitalreview.com/beckers-hospital-review-ceo-strategy-roundtable-2013.html.

Should you have any questions or if I can be of help in any manner, please do not hesitate to contact me at sbecker@beckershealthcare.com. I can also be reached at (800) 417-2035.

Very truly yours,

Scott Becker

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When many ASC companies were being formed 10 years ago, ASCOA was already delivering outstanding care to patients and the industry’s best profit margins to its center partners. For freestanding ASCs or Hospital JVs, see why ASCOA is called the Turnaround Experts."
Another health system worked with New York City Mayor Michael Bloomberg to fight rising obesity levels through citywide policy changes.

One health system launched a new entity focused on healthcare innovation, which has since produced clinical advancements and redesigned the traditional hospital patient gown.

Another system partnered with a chain of retail health clinics, a traditional menace to hospitals, for patient education and better management of care.

It doesn’t stop there. Patient satisfaction, collaborative relationships with employers, formalized structures for executive-physician collaboration — progressive hospitals take fresh approaches to the menu of issues they face. Their strategies may be unorthodox, but in most cases, they end up becoming the new tried and true.

Without further ado, here are 10 things progressive hospitals do.

1. They work with lawmakers to address social issues related to healthcare. Hospitals in some of the country’s toughest urban areas have a known track record for a progressive approach to healthcare, such as Montefiore Medical Center in the New York City borough of the Bronx.

Since he assumed his role in 2008, Steven Safyer, MD, president and CEO of Montefiore Medical Center, has led Montefiore to work with local lawmakers and organizations to forward several public health initiatives in the Bronx, which is one of the most financially and health-challenged urban neighborhoods in the country. He has worked with Mayor Bloomberg to unveil his anti-obesity initiative to limit the size of sugary drinks, has been active in the fight to protect Medicare funding for hospitals, and also serves as chair of the Board of Governors for the Greater New York Hospital Association, among other political and policy-oriented initiatives.

“We know that in order to be successful, we need to affect the social determinants of health, including the environment and social-economic factors, in addition to access to quality care,” says Dr. Safyer. “To that end, we’ve supported efforts to address lead paint hazards in the community and have significantly reduced exposure to and poisoning from lead paint. We have worked to reduce the consumption of sugary beverages and stimulate increased physical activity.” Also, in 2006, Montefiore was a key advocate for the New York City’s effort to remove whole milk from public school menus and replace it with low-fat milk. Dr. Safyer says, as a result of these efforts, “we’re seeing obesity rates are starting to decline.”

2. They take a holistic approach to population health. Population health demands hospitals go beyond the traditional beds-in-heads business model through preventive health services, improved post-acute care and accessible wellness initiatives. Progressive hospitals take their mission one step further. They affiliate with organizations that aren’t necessarily healthcare providers to promote healthy living in other realms of patients’ lives. Their presence as a “hospital” exceeds the traditional definition of such. This whole-person approach to healthcare sets these hospitals apart from their traditional purpose as places to visit episodically.

Hospitals that plan to affiliate with non-provider health or community organizations are not rare. In fact, many hospital CEOs have expressed a desire to diversify their organizations’ relationships. An American Hospital Association survey from April 2012 found many hospital CEOs plan to look beyond traditional provider collaborations and form ties with less orthodox entities to improve population health. For example, 67 percent of CEOs said they would explore a partnership with a community, public health or government agency.

But a few health systems have already executed those partnerships and spearheaded interesting programs as a result. Take Truman Medical Centers, a two-hospital safety-net system based in Kansas City, Mo., for example. It set itself apart this past spring when it partnered with a local economic development organization to open an $11.5 million grocery store.

The store stems from the success TMC saw with its farmer’s market, as some physicians would actually write prescriptions for patients to shop at the farmer’s market for fresh food.

Along with its policy-driven initiatives, Montefiore has shown an unwavering dedication to the wellbeing of the Bronx. Dr. Safyer says the system, which is the largest employer in the borough, works with community partners at every level. “This includes everything from very local initiatives like neighborhood health fairs to initiatives like the Collective Action to Improve Community Health program,” he says. “We partner with the New York City Department of Health and Mental Hygiene, the Bronx Community Health Network and other community-based organizations and agencies. We have a depth of real-world experience and see the problems people face.”

3. They promote price transparency. Most hospitals back the idea of more comprehensible and accessible prices in healthcare, but some have taken their support to new levels in recent months. Instead of reiterating their support for price transparency with little to no action, progressive hospitals make tough decisions about price-sharing and follow through.

In May, Steven Sonenreich, president and CEO of Mount Sinai Medical Center in Miami Beach, Fla., was on the air for an interview with a local radio station. During that radio show, Mr. Sonenreich made a public pledge to post the contract rates Mount Sinai pays private payers for diagnoses and treatments. But Mr. Sonenreich upped the ante: He challenged other health systems in the community to do the same.

Mr. Sonenreich garnered national attention for his candid promise and challenge. The event illustrates what may become a more prevalent business strategy in the next few years. Hospitals that make public promises, set measurable goals and execute strategies to share price information can use this transparency as a competitive advantage. If one hospital in a market offers price data while other hospitals withhold, this will undoubtedly send a message to patients. The transparent hospitals will benefit from sustained patient trust, especially in an unsteady economy.

4. They monetize intellectual capital. In addition to care delivery and clinical programs, some hospitals and health systems are using intellectual capital rather than financial capital to drive growth. This includes patents and medical inventions, as well as more fluid items, such as unique business know-how. “This approach has a number of benefits,” says Igor Belokrinitsky, principal with Booz & Company. “It allows an entity to monetize the assets in which it has been investing over a long time, such as research leadership and innovative treatment techniques, while diversifying its revenue streams to broader geographies and new revenue types.”
University of Pittsburgh Medical Center partnered with Washington, D.C.-based consulting firm The Advisory Board this past year to launch its UPMC Advisory Services. UPMC is marketing the services — which are specialized in certain areas of expertise like oncology, information technology, pediatrics and health security — to other health systems and providers, thus creating a new revenue stream for the organization.

In 2011, Detroit-based Henry Ford Health System opened its $12 million Innovation Institute, which is organized as an independent scientific research and educational entity. The health system partnered with its medical group, Detroit’s College for Creative Studies and Wayne State University to launch the institute, which is focused on bench-to-bedside clinical developments, new diagnostic techniques, telemedicine, and the integration of cost data and clinical quality to develop value-based treatment models.

So far, intellectual developments have ranged from clinical advances, such as a Phantom Lung that lets radiation oncologists and physicists better understand lung tumor motion, to enhancements for the patient experience, such as renovated hospital gowns resembling wrap-around robes.

5. **They aren’t afraid of retail health.** Some of the country’s largest retailers, including Wal-Mart, Walgreens and CVS pharmacies, have rapidly expanded into the provider space and will only continue to rattle traditional delivery models. A June report from Accenture forecasted the doubling of retail clinics in the next three years, from the current 1,400 or so locations to more than 2,800.

Traditionally, hospitals have viewed retail health clinics as threats to their referral chains and established physician-patient relationships. But progressive hospitals and health systems have ditched that perspective and no longer view retail delivery settings as opponents. The deluge of newly insured patients under the healthcare reform law will create more demand for healthcare services, and retail clinics can aid hospitals by providing routine, nonurgent and predictable services. By handling these episodes of care, retail clinics can also help hospitals reduce the number of preventable hospital admissions.

Hackensack (N.J.) University Health Network views retail clinics not as competitors, but as partners. “The healthcare industry is moving toward a model of value-based reimbursement with an emphasis on keeping patients well and out of the hospital,” says Robert C. Garrett, president and CEO of HackensackUHN. “As patient care will be delivered more frequently outside the four walls of the hospital in the future, it needs to be accessible and affordable.”

Under HackensackUHN’s partnership with CVS, physicians from the flagship Hackensack University Medical Center serve as medical directors for seven MinuteClinic walk-in locations, located inside CVS pharmacy stores. The health system also partners with the retail clinic for patient education and disease management initiatives, and both are in the process of integrating their electronic medical record systems.

While retail clinics may present the opportunity for hospitals to lose patients and referrals, the HackensackUMC-MinuteClinic partnership does the opposite: The entities refer patients to one another when appropriate. “HackensackUMC accepts patients requiring a level of care not provided by MinuteClinic, while MinuteClinic offers patients walk-in services for common family illnesses and wellness and prevention services, such as health condition monitoring,” says Mr. Garrett.

6. **They include physicians in administrative decision making.** In recent years, there has been an increase in the number of hospital executives with MDs after their name. There are more than 60 joint MD-MBA

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**True Partnerships.**

“Our switch to HFAP was seamless. We began with a collegial and thorough survey process focused on quality and patient safety. Our relationship continues to be a cost-effective and educational partnership.”

*John M. Kosanovich, MD, MBA*  
VPMA / Network Development  
Covenant HealthCare  
Saginaw, Michigan
degree programs now compared to only a handful in the 1990s. While physician executives add a textured expertise to their role and strategic thinking, progressive hospitals go one step further and formalize physician leadership within their governance structures. In meeting rooms, physicians sit side-by-side with the hospital CEO and other executives, creating a finer balance between business and medicine in decision making.

San Diego-based Scripps Health is one system that boosted physicians’ role in decision making remarkably well. When he took the reins in 2000, president and CEO Chris Van Gorder shook up Scripps’ governance model. He established the system’s Physician Leadership Cabinet, which acts as an advisory group and includes chiefs of staff and CEOs from each hospital campus, along with the corporate vice president of nursing. The cabinet strengthens collaboration between Scripps administrators and physicians as they develop strategies to improve quality and efficiency while reducing costs and clinical variation.

In 2011, Scripps adopted a similar cabinet approach for ScrippsCare, which is comprised of Mr. Van Gorder, physician leaders from seven Scripps-affiliated medical groups, the system CMO, community stakeholders and a payer relations executive. These individuals make evidence-based decisions to redesign care delivery and make it more efficient, high-quality and cost-effective. So far, ScrippsCare has standardized procedures for its admissions orders, lab tests, coronary angioplasty treatments and chemotherapy. Redesigns such as those saved $77 million in 2011 and another $66 million in 2012 — a figure Scripps expects to match in 2013.

7. They are serious about hospitality and have chief experience officers in the C-suite. Progressive hospitals are doing more than paying lip service to patient satisfaction. Forward-thinking hospitals are borrowing best practices from the retail, marketing and hospitality industries. Those hospitals are also dedicating more resources and employees to these efforts, including the appointment of “chief patient experience officers,” or CXOs.

CXOs are senior administrators who ensure patient satisfaction improvements are consistent, methodical and prominent throughout the organization. CXOs often lead efforts to educate hospital management and staff on hospitality and patient communication, especially in high-contact moments of care delivery, such as waiting rooms and bedside conversations. Often, the CXO role is part of an entire department dedicated to the patient experience. Cleveland Clinic, which claims to be the first academic medical center to appoint a CXO, was one of the first health systems to launch an Office of Patient Experience.

The PPACA put some fangs into the concept of “patient experience” by tying it to a portion of hospitals’ bonus reimbursement. Patient experience ratings will determine 30 percent of hospitals’ total bonus payments under the federal Value-Based Purchasing program. Those ratings are determined by patients’ answers on HCAHPS surveys, which pose a variety of questions, including one in which they must rank their hospital stay on a scale from 1 to 10.

Denise Beaudoin, vice president of customer engagement, and Sven Gierlinger, vice president of hospitality and service culture, jointly manage patient satisfaction and experience for the six hospitals within Detroit-based Henry Ford Health System. Mr. Gierlinger says it seems every hospital is creating a patient experience department, if it hasn’t done so already.

Ms. Beaudoin says her and Mr. Gierlinger’s roles have allowed Henry Ford to take a more systematic approach to patient satisfaction. “The pressures of value-based purchasing really raise the level of how we should treat patients [and brings it] to the C-suite,” she says. “Before, we could quantify how many patients have left in our system and how much that costs, but [VBP penalties are] literally actual dollars we walk away from.”

More transparent hospital prices will likely help patients cost-compare their options, which will leave a hospital’s patient experience as the deciding factor for patients who are on the fence. Mr. Gierlinger, who has a background in the hospitality industry, says he only expects demand for CXOs to grow. “Attention has traditionally been very much on quality and safety, and the experience aspect continues to rise in importance as social media plays a bigger role,” he says. “Patients are becoming more and more consumers with healthcare services — they are making more decisions and not necessarily going just where the doctors tell them to go.”

8. They partner with employers. Despite how frequently it peppers conversations in healthcare, the term “population health” is still somewhat daunting and undefined for many hospitals. Does it refer to enrollees within an accountable care organization? An entire geographic population? ACOs are one model for hospitals to take on population health, but some health systems are also partnering with employers to improve outcomes, lower costs and reduce clinical variation for a defined group of patients.

Hospital-employer partnerships may proliferate in the next few years as large employers face more pressure to trim healthcare costs, better manage employees’ health coverage or completely revise their benefit plans in light of the PPACA.

One health system pioneering direct contracting relationships with employers is Cleveland Clinic. In 2010, the system struck a direct-to-employer deal with the Mooresville, N.C.-based home improvement giant Lowe’s. Under that agreement, more than 225,000 employees and their dependents enrolled in Lowe’s self-funded health plan can travel to Cleveland Clinic for heart procedures. Lowe’s covers all medical deductibles, coinsurance payments, travel costs and lodging for the patient and a companion.

Cleveland Clinic has struck similar deals with Bentonville, Ark.-based Wal-Mart Corp. and Seattle-based Boeing for cardiac care. A Cleveland Clinic spokesperson said the system is in active discussions with many employers, and it anticipates “many more” direct-to-employer relationships.

9. They let patients have access to their personal health information. Many hospitals have enough difficulties with electronic medical records, but a few pioneers have mastered the technology enough to let patients access their PHI. This can improve patient engagement, transparency, medication adherence, and patients’ understanding of medical issues and their choice of providers.

In May, Danville, Pa.-based Geisinger Health System let more than 100,000 patients access their physicians’ notes for the first time. Patients will be able to view notes from more than 500 Geisinger physicians in primary care, pediatrics and more than 10 specialties.

The initiative stems from Geisinger’s participation in the 12-month Open-
Notes project, which included 24 primary care physicians and 8,700 patients at Geisinger, along with additional patients and physicians from Beth Israel Deaconess Medical Center in Boston and Harborview Medical Center in Seattle.

The pilot found roughly 82 percent of patients opened at least one note in their EMR and felt more engaged when they did so. Furthermore, the project found patients enthusiastically supported seeing their medical notes, and no physicians said they wanted to opt out of the note-sharing routine by the end of the pilot.

Other EMR platforms such as MyChart are revolutionizing data-sharing between physicians and patients. In June, Cleveland Clinic adopted a new version of MyChart to give patients “nearly complete” access to pathology records, X-rays, physician notes and a listing of their current health issues. This will take effect by next year. Currently, any Cleveland Clinic patient can access hard copies of their complete medical record, as well as reports associated with medical images including MRI, CT, ultrasounds and mammograms.

10. They launch residency programs. The shortage of physicians in the U.S. is only expected to worsen, due to aging baby boomers and millions of newly insured Americans under the PPACA. The shortage lies not in how many men and women are pursuing medical degrees — enrollment at medical schools has actually increased. Rather, a large part of the problem is the shortage of medical residencies at hospitals.

The number of residency positions has not responded to medical schools’ increased enrollments, leaving newly minted physicians no place to train. The majority of medical residencies are funded by Medicare’s graduate medical education payments, and Medicare-funded residency positions have been frozen since 1997.

States like Florida and Texas are especially hard-pressed for residencies. Those states have developed four new medical schools combined in the past 10 years but have added few residencies for those physicians-in-training.

Some hospitals are launching residency programs to help reverse this phenomenon. These developments are an indication of hospitals’ commitment to medical education and access to care. Fort Myers, Fla.-based Lee Memorial Health System will launch a residency program with the Florida State University College of Medicine in Tallahassee, Fla., effective 2014. Florida Hospital for Children in Orlando also announced plans to launch and receive accreditation for a pediatric residency program, which will accept its first class of residents in 2014.

Conclusion

Hospitals can adopt untapped strategies to either address challenges or proactively reinforce their values, and those organizations will make waves in healthcare. Declining reimbursement, a transition from the traditional fee-for-service and inpatient model, a physician shortage, a wave of newly insured patients under the PPACA — these are just a few of the pressures hospitals face today. The circumstances are great enough to demand new schools of thought and untapped strategies. Of the three types of organizations — the retrograde, the stationary and the progressive — the healthcare industry will be well-served if it keeps a close eye on the last grouping, the movers and shakers that buck the status quo.
Positive Hospital-Union Relationships: Open Communication is Key (continued from page 1)

There are several reasons more healthcare workers are members of unions. Recently, unions began focusing on healthcare organizations like hospitals and health systems more than ever before. “Unions have had a terrible time with manufacturing,” says David Rittof, president of Modern Management and employee relations consultant. “A lot of that is due to lost manufacturing in the country,” he says. Much of the nation’s once prolific and heavily unionized manufacturing plants have been moved and workers outsourced to other countries, leaving no workers for the unions. On the other hand, “you can’t pick up and move a hospital,” says Mr. Rittof. “It’s a captive audience.”

Even hospitals and health systems that have great relationships with unions sometimes hit a rough patch in the relationship. The reason these relationships can be challenging, says Brandon Edwards, president and CEO of ReviveHealth and founder of Dallas-based Tener HealthCare Corp.’s crisis communication team, is simple human nature. “Any time you insert a third party into anything, like between an employer and an employee, [everyone is] going to be anxious,” he explains. The union is anxious to prove value, and employees every day, in between negotiations. “The tendency…is that communication [to employees] ends up reading like a lawyer wrote it,” says Rory McEvoy, partner at Edwards Wildman Palmer in New York and co-chair of its labor and employment practice group.

The hospital will be suspicious naturally. “The existence of a union in a hospital will fundamentally change the relationship between the hospital and its employees. I’m not saying it’s necessarily all bad, but it’s not the same or as positive.”

“In general, with unions, it becomes a ‘we/they’ or ‘us vs. them’ mentality instead of a team [mentality],” adds Mr. Rittof. “And in healthcare, delivering patient care is all about collaboration.”

**Maintaining an unorganized employee base**

Many hospitals that do not have organized labor would prefer to stay that way, if only to avoid developing the “us vs. them” mentality that often comes with unionization and to make the team dynamic easier to achieve. For hospitals that currently have no unions, maintaining that status is a possibility even with the unions’ newfound interest in healthcare, according to Mr. Rittof. It just takes prepared managers and excellent communication.

**Prepare the leaders.** Managers in hospitals with no current union presence should be constantly on the lookout for unionizing activity and be trained on how to handle it, says Mr. Rittof. Signs of employees thinking about unionization can be as obvious as seeing a flier posted on a bulletin board or as subtle as employees starting to use combative, negative language. If this activity is happening, hospital managers need to be able to have effective conversations about unionization with the employees. “The most powerful tool is first-line supervisor direct dialogue with employees,” Mr. Rittof says. Managers should be able to speak about why unionization would not be ideal for that department or the hospital as a whole.

**Engage the employees.** “The only way unionization tends to work is where employees want it in the first place. They have to be disengaged from the employer,” Mr. Rittof says. Giving employees multiple routes to communicate directly with their employers is one of the most effective ways to facilitate employee engagement and avoid unionization. He suggests employer opinion surveys, lunch events with executives, hotlines for suggestions and an open door policy with human relations and managers as ways to facilitate and track employee engagement levels. Including employees in decision making whenever possible is also effective.

Other simple ways to keep employees happy and the hospital union-free include offering fair and balanced wages and a competitive benefits package, and consistently enforcing personnel policies across all departments, Mr. Rittof says.

**Coming to the table**

Healthcare markets in many states, like New York, have heavy unionization and relationships with unions that are firmly established. “It’s a little late to keep the unions out of the hospital,” says Rory McEvoy, partner at Edwards Wildman Palmer in New York and co-chair of its labor and employment practice group.

Since hospitals negotiate with unions on contract agreement generally only every three or so years, it is especially important for hospitals to build positive relationships with unionized employees every day, in between negotiations. Building positive relationships day to day will make negotiation times easier for both sides.

To do so, Mr. Edwards recommends that hospital administrators in a unionized hospital treat their employees as if there is no union to the greatest extent possible. “In many ways, hospitals need to pretend like the union isn’t there and communicate effectively and continue to treat them that way,” he says.

“The tendency…is that communication [to employees] ends up reading like a lawyer wrote it,” because of the regulated environment in unionized hospitals, Mr. Edwards says, but he encourages hospital administrators to resist that urge. “Continue to treat employees the way [you] did in absence of a union. Care about them, communicate with them effectively.”

From the union perspective, one of the best ways hospital administrators can ensure positive relationships day to day is by simply honoring the contract. “The contract isn’t a cafeteria menu where you can pick and choose the parts…that you honor,” says Deborah Burger, co-president of the California Nurses Association, which is a founding member of National Nurses United. If hospitals follow the contract that is in place, the next negotiation is more likely to be a smooth process.

Even if hospitals do all they can to maintain positive relationships with their unions, contentious negotiations can still occur. Mr. Edwards provides three tips for hospitals to keep the peace with unions during such a time.

**Stick to the agenda.** Before hospital and union officials meet for a negotiation, both parties should agree on a specific agenda. “There’s a tendency…to spend so much time on minutia…and lose sight of the big picture,” says Mr. Edwards. If both sides keep the big picture and agenda in mind, he explains, “it changes the nature of the negotiations” and keeps them moving forward and positive.

**Avoid games.** Hospital officials should be sincere in accommodating the other party and vice versa. “We see this a lot, where one party will provide an offer and say it will expire in six hours, or not reply to an offer for six weeks,” Mr. Edwards explains. Instead of playing games like those, both parties should keep the end goal of the negotiation in mind and “behave accordingly,” he says.

**Align on crucial issues.** Hospitals and unions need to agree on key issues that need to be solved in order to have a successful negotiation. Mr. Edwards recommends that hospital officials be as clear as possible when explaining the issues important to them. It allows union officials to see where the hospital is coming from and limits the union’s ability to project a negative motive onto the hospital’s goals.

Ms. Burger adds one point hospitals should consider during union negotiations: Send the right people to the table. “[Hospitals] are sending human resources people…and sometimes even lawyers, but they don’t really have the authority to change a proposal at the table,” Ms. Burger says. Instead, she says unions would prefer if hospitals sent a person or a team of people who are prepared to listen and engage in a real discussion of the issues and be able to do something after that discussion.

Overall, unionization changes the nature of the relationship between the hospital and its employees. Organizations that are union-free and wish to stay that way should keep their employees happy and engaged. Hospitals that already have a union presence can maintain positive relationships and a team mentality by practicing fair negotiation tactics and continuing to treat employees with respect.
of laparoscopic surgery by controlling mechanical arms and instruments using hand controls, foot pedals and a 3-D high-definition display while seated in a booth several feet from the patient. A single da Vinci unit costs about $1.5 million and can perform a variety of minimally invasive procedures, especially for localized cancers in tough-to-access anatomic regions, including colorectal, prostate and head and neck procedures.

Ingrid Rodi, MD, a surgeon and clinical professor of obstetrics and gynecology at the Geffen School of Medicine at UCLA, said gynecologists in particular can benefit from the da Vinci if they have not yet become proficient at other types of minimally invasive surgery. “I think that gynecologic surgeons today need to have access to a robot to be able to do the highest possible percentage of cases in a minimally invasive fashion,” she says.

Use of the robots in gynecologic surgery has grown rapidly in recent years. In 2007, da Vinci robots performed just 0.5 percent of U.S. hysterectomies, but that jumped to 9.5 percent in 2010, according to a study published in the February 2013 edition of the Journal of the American Medical Association.

However, the JAMA study also noted that while robotically assisted hysterectomies produced slightly fewer hospital stays longer than two days than non-robotic laparoscopic hysterectomies, they performed at about the same level in regards to blood loss and operative complications — and cost about $2,189 more per procedure.

The American Congress of Obstetricians and Gynecologists released a statement in March critical of the device’s appeal among physicians and hospitals, assaying its high price tag and $125,000 annual maintenance cost. The group said the device is “the most expensive approach” to hysterectomies “without any demonstrable benefit” over non-robotic laparoscopic methods.

Intuitive Surgical, the Sunnyvale, Calif.-based company that makes the da Vinci, generated $2.2 billion in revenue last year, but is the subject of 26 pending lawsuits related to the company’s policies or product, according to reports from BusinessWeek and Bloomberg News. In March, the FDA, which approved the robot for surgical use on humans 12 years ago began an investigation into an increase in adverse reports from patients.

Tampa Bay, Fla., resident and uterine cancer survivor Lee Ann Leach had a robotic hysterectomy several years ago that she said left her in extreme pain. Even though she had previously undergone two caesarean sections and one bilateral mammoplasty, she says, “I literally felt like I had been drawn and quartered after the robotic surgery.” She adds, “It seems like the [physicians] are using the da Vinci robot, rather than thinking on the patients’ behalf.”

**Providers’ take**

“It is worth the investment until a less expensive [alternative] comes along,” Dr. Rodi says. “If a hospital wants to attract gynecology patients, a robot is essential” in order for all eligible patients who prefer minimally invasive procedures to receive them, she says.

Marc Smaldone, MD, a urologic oncologist at the Fox Chase Cancer Center in Philadelphia who uses the robot in more than 75 percent of his procedures, says, “It is my own opinion that the robotic platform affords procedures requiring complex reconstruction [such as] cystectomy, partial nephrectomy [and] prostatectomy to be performed in a minimally invasive fashion, but there are certainly strong market forces influencing the decision at the hospital level to purchase the robot which are hard to ignore.”

Those market forces are under special scrutiny lately, as hospitals and health systems place a premium on value-based care and cost savings as they face shrinking reimbursements.

“Providers are meeting increasing pressure to deliver care efficiently,” said Kenneth L. Davis, MD, President and CEO of The Mount Sinai Medical Center in New York City, at a public interview in April. “The da Vinci robot can be highly effective for prostate and some head and neck surgeries. However, it has to be in the hands of a very skilled, well-trained surgeon who has used it in hundreds or thousands of procedures,” he said.

When the da Vinci is used for gynecological procedures, Dr. Davis said, “the surgery takes longer. The cost to the healthcare system is much higher. The outcomes aren’t any better. But the doctors market it because people think, ‘It’s a robot, it must be unbelievable, right?’ Somebody has to have sanity around this.” When patients and payers are calling for reducing the cost of healthcare, Dr. Davis added, it’s difficult to justify spending money on robotic equipment that isn’t proven to be more effective or less expensive.

Robotic surgery has its supporters on the administrative side, as well. Dave Tupponce, MD and interim CEO of Abrazo Health Care’s Paradise Valley Hospital, both based in Phoenix, said its da Vinci robot draws appeal from physicians and patients alike. “If we can provide both conventional and robotic-assisted options, it makes our hospital more attractive to both populations,” he says.

Paradise Valley was fortunate to acquire its da Vinci from an inter-company transfer rather than buying or leasing the robot, Dr. Tupponce says. As for effectiveness, he says he believes the skill of the surgeon coupled with appropriate patient selection is the greatest determinant in robotic surgical outcomes. He adds, “As with any type of surgery, there tend to be good correlations between outcomes and case volume.”

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**In gynecological surgeries, here is where marketing and capitalism and healthcare can all come together to produce a catastrophe,” said Kenneth L. Davis, MD, President and CEO of The Mount Sinai Medical Center in New York City, at a public interview in April. “The da Vinci robot can be highly effective for prostate and some head and neck surgeries. However, it has to be in the hands of a very skilled, well-trained surgeon who has used it in hundreds or thousands of procedures,” he said.**

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The Da Vinci Robot is often a “must-have” for hospitals, at least according to physicians who have been trained on it, but do its benefits outweigh its cost?
Keeping the Patient at the Center: Q&A With Beaumont Health System CEO Gene Michalski

By Anuja Vaidya

Navigating the ever-changing landscape of the healthcare industry is a challenging task. Having to lead a healthcare facility through that landscape is even more difficult. But Gene Michalski, CEO of Royal Oak, Mich.-based Beaumont Health System, believes that the inherent complexity of the healthcare industry is what makes it so exciting.

Since 2010, Mr. Michalski has been at the helm of Beaumont, before which he served as its executive vice president and COO. Mr. Michalski has also previously held leadership positions at Beaumont Hospital, Troy (Mich.). He has served as past president of the Midwest Healthcare Executive Group and Associates, and in 2012, he was named to the Becker’s Hospital Review list of “100 Non-Profit Hospital and Health System CEOs to Know.”

Here, Mr. Michalski talks about some of Beaumont’s strategies, shares the best career advice he ever received and tells us what he wished he had known before assuming the role of CEO.

**Question: What are some of Beaumont’s goals, and how does it plan to achieve them, particularly in light of the merger discussions with Detroit-based Henry Ford Health System that didn’t go through?**

Mr. Michalski: We are at an interesting nexus. We just ended merger discussions with a potential partner and now that those discussions have ended, we are going to take some time to look over our strategic plans.

Three years ago, we put into place a strategy to become one of the foremost high-value providers in the country, and if you look at University HealthSystem Consortium data, we are listed among the top 10 quality leaders among more than 100 academic medical centers in the country. Our focus on high-value care and performance-based payment is going to continue. We have adopted a model of centers of excellence and clinical integration councils, and they support the platform on which we have achieved excellence in value over the last three years. The centers of excellence and clinical integration councils are physician-led, nurse-partnered and administratively supported, and we did that because physicians and nurses are at the forefront of patient care. We, as administrators, support them.

My philosophy at Beaumont is that you either help a patient or you help someone help a patient. One of the new strategies we have implemented is a partnership with United Physicians to create a clinical integration organization called Beaumont United Care Partners. United Physicians will contract for physician fees and we will contract for facility fees. It will help us achieve better clinical integration. We have also developed a set of strategies that we believe are key to the creation of a model health system. These are: 1) To improve the well-being of the people of Michigan and beyond; 2) To serve as a national model for innovative, efficient, high-value care; 3) To attract and retain the highest quality physicians and employees from a national pool; 4) To attract patients to Michigan for destination medicine; 5) To serve as an engine of innovation and economic development for the region.

Healthcare has never been more interesting than it is right now, and we get a chance to shape it.

**Q. What do you think are the biggest challenges facing your organization? How do you plan to overcome them?**

**GM:** One challenge is the reductions in reimbursement. There is going to be less money in the system for everybody. Here’s the way we think about overcoming it. It’s my belief that if you want to achieve an outcome, you need to put a process in place and then you need to have a structure in place to achieve these outcomes. You need to incorporate processes that reduce variation, and then you need to have the structures to support the processes. This will help lower costs but will keep quality high. Also, to combat reductions in reimbursements while improving quality you need to knit together the patient experience so that it is seamless and flawless. In addition, it is my belief, culture drives behavior, which drives outcome. So to be successful, you also need people who care about treating patients as one individual at a time, with dignity and respect. Both the process track and the behavioral track need to be in place to get consistent reliable results.

Physician shortages are another issue. We started a medical school, the Oakland University William Beaumont School of Medicine. It was Michigan’s first new allopathic medical school in 47 years. We attract students from all across the country.

**Q: Is there something you wish you had known when you first assumed the role of CEO?**

**GM:** Yes, I wish I had known more about models of governance and more about the political world that we live in. Policy, ultimately, drives how healthcare is delivered and how it is financed. It is important to know how policymakers are making the decisions that affect how healthcare is delivered in the country.

**Q: What is the best piece of career advice you’ve received?**

**GM:** There are three pieces in my case. The first is that the patient should be at the center of the conversation always. The second is that when thinking about career and career aspirations, think two levels above your current level, not one. Basically, you need to think like your boss’s boss and not your boss. The last one is built around game theory. Keep in mind that people always make the decision that they know what they want, but they don’t know what they don’t want. For each of your alternatives in a decision, ask yourself the question, “What is it that I don’t want?” Sometimes you will find that you will pick the alternative that is more risky but provides greater benefits and opportunities.

**Q: Given the rapid pace of change in the healthcare industry at the moment, what advice do you have for CEOs of other nonprofit hospitals?**

**GM:** Put the patient at the center of all you do, and remember that your job is to support those who care for the patient. Remove barriers that stand in their way. Also, get out of your office and go see what is happening on the front lines. Listen more than you talk.

**Q: What excites you most about healthcare right now?**

**GM:** The complexity. I can tell you, complexity of healthcare delivery and financing in America is one of the most challenging endeavors anyone can undertake, and that is what makes it so exciting. It’s magnificent and meaningful work that we do because we help people.
When it comes to uncompensated care, Cook County Health and Hospitals System, a public health system based in Chicago, feels the sting more than most. “We’re giving $500 million to $600 million away in uncompensated care each year,” says Ramanathan Raju, MD, CEO of CCHHS. The nation’s third-largest county-owned health system serves as a safety-net medical provider for Cook County’s 5 million residents. Sixty percent of its inpatients are uninsured; the same is true for 85 percent of its outpatients. Furthermore, even many of CCHHS’ poorest patients used to not qualify for Medicaid under Illinois’ strict eligibility requirements, which limit adult coverage to the disabled, elderly and parents.

For the few who did qualify, a state-federal agreement allowed CMS to pay its half of Medicaid bills, while the state made a lump sum payment similar to a block grant each year, requiring CCHHS to operate under a de facto capitated model for many of its Medicaid and uninsured patients. However, state budget problems have threatened that block payment in recent years, Dr. Raju says, shrinking from more than $400 million a few years ago to $253 million this year.

That challenging payer make-up in what Dr. Raju calls “an iconic system” led state and federal policymakers to name Cook County one of several areas nationwide to pilot a Medicaid expansion beginning in October 2012, six months before the 26 confirmed states — including Illinois — launch their own next year.

The pilot, dubbed “CountyCare,” broadens Medicaid eligibility for Cook County residents to all residents in households earning at or below 138 percent of the federal poverty line. Under a provision of the Patient Protection and Affordable Care Act, the federal government will fully fund coverage for the newly eligible until 2017, tapering off to not less than 90 percent in 2020 and beyond. Thanks to the CountyCare pilot, CCHHS has already begun receiving that federal funding through capitated payments for enrolled Cook County residents, many of whom the system previously received no direct reimbursement for.

In June, under the pilot, the per member per month gross capitated revenue totaled $13.6 million. Cook County receives half of those payments, with the other half being distributed to other safety-net providers in the county. Therefore, CCHHS netted $6.8 million that month in revenue through the CountyCare pilot. Prior to last October, CCHHS was forced to treat nearly all of those patients without compensation, because they did not qualify for Medicaid under its previous, stricter eligibility requirements.

Piloting the expansion benefits all parties involved, according to Dr. Raju. HHS can gather data and learn best practices for educating and enrolling the newly eligible Americans in Medicare, a challenging and critical lynchpin of the PPACA’s effectiveness. The additional capitated revenue CCHHS receives has allowed it to invest and convert its 18 outpatient clinics into patient-centered medical homes to provide team-based care and wraparound social services for patients. Patients and government payers benefit because increasing access to affordable, comprehensive care sooner means patients who have or are at risk for chronic illnesses, such as diabetes, are able to manage their conditions and help prevent them from worsening, costing significantly less in the long-run, Dr. Raju says.

Since the program took effect last fall, he says the system has been “in better shape because with the same [patient] volume, and [CCHHS] gets twice the money.”

After the pilot year is completed, Dr. Raju says he hopes policymakers will work with CCHHS to convert CountyCare into a permanent low-cost managed care health plan, even after Illinois expands its Medicaid program next year to low-income childless adults and other newly eligible populations.

Dr. Raju, formerly the executive vice president of medical and professional affairs at New York City Health and Hospitals Corp., the largest public health system in the country, says the problems in urban healthcare are the same nationwide: disproportionately high levels of mental illness, substance abuse and social issues complicated by frequent language differences. Although the New York system is five times larger than CCHHS, Dr. Raju says his current role is inspiring.

“We have the opportunity to help a lot of people by offering quality care and making them healthier, and at the same time stabilize the healthcare system, which is in deep financial trouble,” he says. “I look at this time in the healthcare industry as challenging and exciting, and this is a once-in-a-lifetime chance to make things right.”
25 Largest Nonprofit Hospitals in America

By Molly Gamble

Here are the 25 largest nonprofit hospitals in America, listed by number of beds. Figures are based on CMS cost report data analyzed by American Hospital Directory. Data are for short term acute-care hospitals, critical access hospitals and children’s hospitals.

Note: The hospital bed counts reported here include all medical/surgical and special care beds as reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include bed counts from other facilities that share a provider number with the main hospital.

For the purposes of this list, AHD data were stratified to include the following “type of control” categories: governmental hospital district; governmental city; governmental city-county; governmental county; governmental federal; governmental other; governmental state; voluntary nonprofit (church); and voluntary nonprofit (other).

1. New York-Presbyterian Hospital/Weill Cornell Medical Center — 2,292
2. Florida Hospital Orlando — 2,141
3. Jackson Memorial Hospital (Miami) — 1,724
4. University of Pittsburgh Medical Center Presbyterian — 1,590
5. Orlando (Fla.) Regional Medical Center — 1,483
6. Indiana University Health Methodist Hospital (Indianapolis) — 1,462
7. Baptist Medical Center (San Antonio) — 1,422
8. Montefiore Medical Center – Moses Division Hospital (Bronx, N.Y.) — 1,418
9. Barnes-Jewish Hospital (St. Louis) — 1,326
10. Cleveland Clinic — 1,309
11. Methodist University Hospital (Memphis, Tenn.) — 1,293
12. Norton Hospital (Louisville, Ky.) — 1,268
13. Buffalo (N.Y.) General Hospital — 1,230
14. The Mount Sinai Medical Center (New York City) — 1,221
15. Memorial Hermann Southwest Hospital (Houston) — 1,157
16. UAB Hospital (Birmingham, Ala.) — 1,138
17. Christiana Hospital (Newark, Del.) — 1,082
18. North Shore University Hospital (Manhasset, N.Y.) — 1,072
19. Beaumont Hospital, Royal Oak (Mich.) — 1,070
20. Jewish Hospital (Louisville, Ky.) — 1,064
21. Memorial Regional Hospital (Hollywood, Fla.) — 1,017
22. Beth Israel Medical Center – Petrie Division (New York City) — 1,011
23. Spectrum Health Butterworth Hospital (Grand Rapids, Mich.) — 994
24. Saint Joseph’s Hospital (Tampa, Fla.) — 986
25. Ohio State University Wexner Medical Center (Columbus) — 976

25 Largest For-Profit Hospitals in America

By Molly Gamble

Here are the 25 largest for-profit hospitals in America, listed by number of beds. Figures are based on CMS cost report data analyzed by American Hospital Directory. Data are for short term acute-care hospitals, critical access hospitals and children’s hospitals.

Note: The hospital bed counts reported here include all medical/surgical and special care beds as reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include bed counts from other facilities that share a provider number with the main hospital.

For the purposes of this list, AHD data were stratified to include the following “type of control” categories: proprietary corporation; proprietary individual; proprietary other; and proprietary partnership.

1. Methodist Hospital (San Antonio) — 1,536
2. Edinburg (Texas) Regional Medical Center — 816
3. Henrico Doctor’s Hospital (Richmond, Va.) — 812
4. North Shore Medical Center (Miami) — 775
5. CJW Medical Center – Chippenham Campus (Richmond, Va.) — 762
6. Medical City Hospital (Dallas) — 668
7. Oklahoma University Medical Center (Oklahoma City) — 668
8. Plantation (Fla.) General Hospital — 655
9. Sunrise Hospital & Medical Center (Las Vegas) — 642
10. Brookwood Medical Center (Birmingham, Ala.) — 631
11. Clear Lake Regional Medical Center (Webster, Texas) — 627
12. Las Palmas Medical Center (El Paso, Texas) — 599
13. TriStar Centennial (Nashville, Tenn.) — 595
14. McAllen (Texas) Medical Center — 542
15. Doctors Hospital at Renaissance (Edinburg, Texas) — 530
16. Hillcrest Medical Center (Tulsa, Okla.) — 529
17. West Florida Hospital (Pensacola) — 515
18. Providence Memorial Hospital (El Paso, Texas) — 508
19. Wesley Medical Center (Wichita, Kan.) — 507
20. Saint Francis Hospital (Memphis) — 499
21. Hahnemann University Hospital (Philadelphia) — 496
22. Saint Mary’s Medical Center (West Palm Beach, Fla.) — 464
23. Summerlin Hospital Medical Center (Las Vegas) — 454
24. Saint David’s Medical Center (Austin, Texas) — 451
25. JFK Medical Center (Atlantis, Fla.) — 448
25 Top-Grossing For-Profit Hospitals

By Molly Gamble

Here are the 25 top-grossing for-profit hospitals in the United States based on gross revenue, according to CMS cost report data analyzed by American Hospital Directory. Data are for short term acute-care hospitals, critical access hospitals and children's hospitals.

Note: The hospital total patient revenues reported here are reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include patient revenue from other facilities that share a provider number with the main hospital.

For the purposes of this list, AHD data were stratified to include the following “type of control” categories: proprietary corporation; proprietary individual; proprietary other; and proprietary partnership.

1. Methodist Hospital (San Antonio) — $5.13 billion
2. CJW Medical Center – Chippenham Campus (Richmond, Va.) — $3.54 billion
3. Doctors Medical Center of Modesto (Calif.) — $3.14 billion
4. Oklahoma University Medical Center (Oklahoma City) — $3.10 billion
5. Sunrise Hospital & Medical Center (Las Vegas) — $3.07 billion
6. Hahnemann University Hospital (Philadelphia) — $3.03 billion
7. Medical City Hospital (Dallas) — $2.96 billion
8. Brookwood Medical Center (Birmingham, Ala.) — $2.84 billion
9. Las Palmas Medical Center (El Paso, Texas) — $2.81 billion
10. JFK Medical Center (Atlantic, Fla.) — $2.59 billion
11. Good Samaritan Hospital (San Jose, Calif.) — $2.36 billion
12. North Florida Regional Medical Center (Gainesville, Fla.) — $2.31 billion
13. Clear Lake Regional Medical Center (Webster, Texas) — $2.30 billion
14. Henrikos Doctor’s Hospital (Richmond, Va.) — $2.27 billion
15. Riverside (Calif.) Community Hospital — $2.26 billion
16. Plantation (Fla.) General Hospital — $2.13 billion
17. Memorial Hospital (Jacksonville, Fla.) — $2.07 billion
18. Edinburg (Texas) Regional Medical Center — $2.02 billion
19. Swedish Medical Center (Englewood, Colo.) — $1.98 billion
20. TriStar Centennial (Nashville, Tenn.) — $1.95 billion
21. Regional Medical Center of San Jose (Calif.) — $1.94 billion
22. Brandon (Fla.) Regional Hospital — $1.92 billion
23. Orange Park (Fla.) Medical Center — $1.89 billion
24. Saint David’s Medical Center (Austin, Texas) — $1.83 billion
25. Wesley Medical Center (Wichita, Kan.) — $1.82 billion

25 Top-Grossing Nonprofit Hospitals

By Molly Gamble

Here are the 25 top-grossing nonprofit hospitals in the United States based on gross revenue, according to CMS cost report data analyzed by American Hospital Directory. Data are for short term acute-care hospitals, critical access hospitals and children's hospitals.

Note: The hospital total patient revenues reported here are reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include patient revenue from other facilities that share a provider number with the main hospital.

For the purposes of this list, AHD data were stratified to include the following “type of control” categories: governmental hospital district; governmental city; governmental city-county; governmental county; governmental federal; governmental other; governmental state; voluntary nonprofit (church); and voluntary nonprofit (other).

1. University of Pittsburgh Medical Center Presbyterian — $11.87 billion
2. Cleveland Clinic — $10.51 billion
3. Cedars-Sinai Medical Center (Los Angeles) — $9.40 billion
4. Florida Hospital Orlando — $8.81 billion
5. Stanford (Calif.) Hospital — $8.55 billion
6. New York-Presbyterian Hospital/Weill Cornell Medical Center (New York City) — $8.37 billion
7. Hospital of the University of Pennsylvania (Philadelphia) — $7.41 billion
8. Montefiore Medical Center – Moses Division Hospital (Bronx, N.Y.) — $6.96 billion
9. University of California San Francisco Medical Center at Parnassus — $6.88 billion
10. Orlando (Fla.) Regional Medical Center — $6.70 billion
11. Massachusetts General Hospital (Boston) — $6.42 billion
12. University of California Davis Medical Center (Sacramento) — $6.36 billion
13. Temple University Hospital (Philadelphia) — $5.92 billion
14. Vanderbilt University Medical Center (Nashville, Tenn.) — $5.45 billion
15. Indiana University Health Methodist Hospital (Indianapolis) — $5.37 billion
16. Ohio State University Wexner Medical Center (Columbus) — $5.22 billion
17. Brigham and Women’s Hospital (Boston) — $5.10 billion
18. Crozer-Chester Medical Center (Upland, Pa.) — $4.85 billion
19. The University of Texas M.D. Anderson Cancer Center (Houston) — $4.84 billion
20. Hackensack (N.J.) University Medical Center — $4.83 billion
21. New York University Langone Medical Center (New York City) — $4.83 billion
22. University of Michigan Hospitals and Health Centers (Ann Arbor) — $4.83 billion
23. Thomas Jefferson University Hospital (Philadelphia) — $4.78 billion
24. Duke University Hospital (Durham, N.C.) — $4.76 billion
25. Northwestern Memorial Hospital (Chicago) — $4.63 billion
25 Largest Nonprofit Hospital Systems

By Molly Gamble

Here are 25 of the largest nonprofit health systems in the country, ranked in descending order by the number of hospitals in the system. The following list was devised with data from the American Hospital Directory and each health system’s respective website and/or public relations department.

Editor’s note: Figures represent the number of acute-care hospitals in the system, which may include specialty hospitals and children’s hospitals. Outpatient care settings and clinics are not included. This list does not include public or government-owned hospital systems.

1. Ascension Health (St. Louis) — 100
2. Catholic Health Initiatives (Denver) — 86
3. CHE/Trinity (newly merged entity between Trinity Health in Novi, Mich., and Catholic Health East in Newton Square, Pa.) — 82
4. Adventist Health System (Altamonte Springs, Fla.) — 43
5. Dignity Health (San Francisco) — 38
6. Kaiser Foundation Hospitals (Oakland, Calif.) — 37
7. Carolinas Healthcare System (Charlotte, N.C.) — 35
8. Sanford Health (Sioux Falls, S.D. and Fargo, N.D.) — 35
9. Mercy (Chesterfield, Mo.) — 32
10. Providence Health System (Seattle) — 32
11. Avera Health (Sioux Falls, S.D.) — 31
12. CHRISTUS Health (Irving, Texas) — 31
13. UnityPoint (Formerly Iowa Health System) (Des Moines) — 29
14. Baylor Health Care System (Dallas, Texas) — 27
15. Banner Health (Phoenix) — 24
16. Catholic Healthcare Partners (Cincinnati) — 24
17. Sutter Health (Sacramento, Calif.) — 24
18. Mayo Clinic Health System (Rochester, Minn.) — 23
19. Intermountain Healthcare (Salt Lake City) — 22
20. University of Pittsburgh Medical Center — 22
21. Adventist Health (Roseville, Calif.) — 19
22. Bon Secours Health System (Marriottsville, Md.) — 19
23. IU Health (Indianapolis) — 19
24. SSM Health Care (St. Louis) — 18
25. NewYork-Presbyterian Healthcare System — 16

13 Largest For-Profit Hospital Operators

By Molly Gamble

Here are the 13 largest for-profit hospital operators in the country, as of June 2013, including specialty/surgical hospital operators.

Note: Companies are listed in descending order based on the number of hospitals. Figures are based on the company’s publicly filed financial documents and/or information from a company spokesperson. Also, Tenet Healthcare Corp.’s proposed acquisition of Vanguard Health Systems was not finalized at the time of publication. For this reason, their entries are separate.

1. Hospital Corporation of America (Nashville, Tenn.).
   Number of hospitals: 162
   CEO: Richard Bracken
   2012 revenue: $33.0 billion

2. Community Health Systems (Brentwood, Tenn.).
   Number of hospitals: 135
   CEO: Wayne Smith
   2012 revenue: $13.0 billion

3. Health Management Associates (Naples, Fla.).
   Number of hospitals: 71
   CEO: Gary D. Newsome
   2012 revenue: $5.88 billion

4. LifePoint Hospitals (Brentwood, Tenn.).
   Number of hospitals: 57
   CEO: William F. Carpenter III
   2012 revenue: $3.39 billion

5. Tenet Healthcare Corp. (Dallas).
   Number of hospitals: 49
   CEO: Trevor Fetter
   2012 revenue: $9.12 billion

6. Vanguard Health Systems (Nashville, Tenn.).
   Number of hospitals: 28
   CEO: Charles N. Martin Jr.
   2012 revenue: $5.95 billion

7. Universal Health Services (King of Prussia, Penn.).
   Number of hospitals: 23 (acute-care)
   CEO: Alan B. Miller
   2012 revenue: $6.96 billion

8. Prime Healthcare Services (Ontario, Calif.).
   Number of hospitals: 23
   CEO: Prem Reddy, MD
   2012 revenue: Not available

9. IASIS Healthcare (Franklin, Tenn.).
   Number of hospitals: 19 (acute-care)
   CEO: W. Carl Whitmer
   2012 revenue: $2.5 billion

10. Capella Healthcare (Brentwood, Tenn.).
    Number of hospitals: 14
    CEO: Daniel S. Slipkovich
    2012 revenue: $747.8 million

    Number of hospitals: 13 (specialty/surgical)
    CEO: David Crane
    2012 revenue: Not available

12. Ardent Health Services (Nashville, Tenn.)
    Number of hospitals: 12
    CEO: David T. Vandewater
    2012 revenue: Not available

13. Steward Health Care System (Boston).
    Number of hospitals: 11
    CEO: Ralph de la Torre, MD
    2012 revenue: Not available
The Hospital CEO’s Ultimate Dashboard: What to Check Daily, Quarterly and Yearly

By Quint Studer, Founder of Studer Group

The job of a hospital CEO can be overwhelming. There are so many areas to oversee, decisions to make and problems to solve. If you aren’t careful, you’ll spend your whole day responding and reacting instead of focusing on the issues that drive results.

Before you know it, those days turn into weeks turn into months that turn into years. Eventually you come to see that you’ve spent most of your valuable time addressing the symptoms of problems instead of the problems themselves.

The solution to reduce chaos is to create structure. When you consistently and deliberately take aggressive action on the metrics that matter, you are often able to extinguish those problems themselves.

So what are the big issues a CEO should focus on? In my experience, they fall into four “buckets”: productivity, volume, clinical quality and service.

I find it’s helpful to break these categories into specifics and put them into a timeline. There are three categories of tasks — those to do yearly, quarterly and daily. I recommend the following checkpoints:

Metrics and issues to monitor daily

1. Outpatient no-shows. Patient no-shows hurt productivity and cost the healthcare industry billions each year. If you notice your hospital’s numbers are running high, it might be time to tweak your reminder system or switch to a more efficient system.

2. First case start-times. Prompt start times are crucial for preventing delays and bottlenecks, and for keeping the OR running smoothly.

3. Patient volume. How many admissions are in the hospital each day?

4. “Door-to-doc” time in the emergency department. How long does it take from the time the ED physician decides to admit patients to an inpatient bed and the time the patients actually left the ED for that bed?

5. “Door-to-bed” time in the ED. How long does it take from the time the ED physician decides to admit patients to an inpatient bed and the time the patients actually left the ED for that bed?

6. Number of patients who leave without being seen in the ED. Studies have shown LWBS visits are an indicator of ED crowding and are associated with longer ED wait times. Patients who leave the ED without being seen are more likely to report worsened health problems.

7. Agency and overtime costs. You must look at agency costs constantly, because you are paying a premium price for hospital labor. This may be a temporary cost if labor is assigned for a certain project, but most of the time, high agency costs are because the hospital has a turnover issue, a recruitment issue or — most often, in my opinion — a retention issue. All three of these are strongly correlated with engagement issues.

8. Major service issues. Are any patients upset? It’s a good idea to handle these situations personally.

9. Major engagement issues. Are any physicians or employees upset? This is the time to address major issues in employee or physician morale. Employee engagement affects patient safety and process improvement. That one number can impact all sorts of things.

Metrics and issues to monitor quarterly

While most of these issues need to be looked at continually, I recommend an intensive review of them at least four times a year.

1. Quality metrics. How are the hospital’s HCAHPS results? Process of care measures? Outcome measures? Pay-for-performance changes make these benchmarks particularly “hot,” as they are directly linked to the health of hospitals’ operating margins.


3. Physician metrics. This includes referral patterns as well as satisfaction ratings. It’s important to ensure physicians are deeply engaged in hospital operations and that they see your organization as a great place to practice medicine.

4. Philanthropy. While most organizations zero in on philanthropy once a year, quarterly is better in a time when so many hospitals are struggling to sustain themselves. With government funding getting harder and harder to obtain, philanthropy grows more important. Keep an eye on donations. Know when donations increase and decrease, and understand why. A challenge with many hospitals’ fundraising is the tendency to ask for money once a year. I think it’s so powerful if the people who donate money receive regular feedback about where their funds went.

5. Board communication. Make sure this takes place vigorously and often. The end of the year is too late. Most hospital CEOs are never formally measured on board communication. They assume that, because they go to board meetings, they’re communicating fine. If there’s a problem, it festers and will one day explode. The CEO should meet with every board member individually and ask him or her what they define as healthy communication. This is about clarifying expectations and measuring them so the CEO is not surprised when an issue comes to head.

Steps to take annually

1. Hold an intensive leadership assessment. How aligned are your leaders in terms of mindset and resources? Is there a universal sense of urgency regarding the need for constant improvement? Are you taking the right ac-
tions quickly and precisely? What about your systems and processes — do they hold people accountable for executing well? Studer Group offers the Straight A Leadership Assessment to evaluate leaders, but if you don’t use this tool, find another way to measure these vital leadership issues.

2. Audit your evaluation system. How well do leader assessments match up to the results they’re responsible for? If most of your leaders receive a “substantially exceeds expectations” rating, your organization needs to be hitting most, if not all, of its goals. I find this is often not the case. If you’re using a subjective evaluation tool, rather than an objective one linked to hard goals, it may be time to re-think your approach.

3. Evaluate vendor contracts. Look closely at these relationships in two areas: cost and performance. A while back, I was talking to a hospital CEO who was preparing for a reduction in force at his organization. I pulled up the hospital’s HCAHPS scores and saw the organization was in the 12th percentile for cleanliness. The hospital’s environmental services were outsourced. I would have reevaluated that contract in a minute. Monitor the vendor costs — not only the market price but the cost in terms of performance. Hospitals can tie performance into their contracts with vendors. It’s common in certain areas, but could be common in more.

Conclusion
As I was writing this article, I struggled with whether to put “daily” items or “annual” items in first position. I decided on daily, and for a reason. If you are truly monitoring these crucial issues every day — and making smart decisions based on the evidence you’re seeing — your quarterly and annual tasks will be much, much easier. Throughout the year, you will build a solid foundation for your annual tasks, and you’ll be deeply familiar with the issues. Sometimes, hospital CEOs don’t want to measure issues when they anticipate a poor score or outcome. If you sense poor physician morale, you may want to avoid measuring it and validating your fear. Sometimes hospital CEOs avoid taking metrics to avoid conflict with the board. They anticipate the board will not be pleased with the results, and they want job security. But CEOs have to look at these metrics as if they were physicians. Physicians do not simply tell patients they don’t want to measure their blood pressure. It has to be done.

Together, these checklists make up a “dashboard” that will help hospital CEOs steer their organizations confidently through the hurricane of change that’s buffeting our industry.
Clinical Integration & ACOs

Survey: Number of Hospital-Employed Physicians Up 6%
By Anuja Vaidya

More physicians were employed by hospitals in 2013 than in 2012, according to a survey conducted by Jackson Healthcare, a healthcare staffing company.

For the survey, 3,456 physicians were polled between March 7 and April 1, 2013.

When asked which form of employment they chose, respondents reported the following, according to the survey:

- Employed by a hospital — 26 percent reported this in 2013, up by 6 percent from 2012.
- Have ownership stake in a practice — 22 percent reported this in 2013, down by 1 percent from 2012.
- Have a solo practice — 15 percent reported this in 2013, down by 6 percent from 2013.
- Work for physician-owned practice/has no ownership stake in a practice — 15 percent reported this in 2013, up by 3 percent from 2012.
- Employed by practice that is owned by a hospital or health system — 14 percent reported this in 2013, down by 1 percent from 2012.
- Is an independent contractor — 8 percent reported this in 2013, down by 1 percent from 2012.

Out of 85 payer arrangements, more than one-third were for upside-only shared savings, but the upside option was noticeably lacking in commercial markets, according to an analysis by Premier.

Shared savings agreements typically come in two forms. An upside-only agreement involves no downside risk for failing to achieve cost targets. An agreement with downside risk involves providers agreeing to “pay back” any spending over the cost benchmarks.

Fifty-seven percent of upside arrangements fell within the Medicare Shared Savings Program or Medicare Advantage, while 7 percent of upside arrangements were reported within Medicaid, 7 percent with provider-owned health plans and 7 percent with self-insured employers.

Among the accountable care organizations analyzed in the whitepaper, only 21 percent of commercial arrangements offered upside shared savings. Those contracts were clustered in just four markets and they also tended to be smaller in scope, usually for 5,000 covered lives or less. Premier also reported that nearly 70 percent of commercial payment arrangements to date have been limited to either care management fees or downside shared savings models.

Here are some other major findings from the whitepaper, which details various ACO and payer arrangements among 22 health systems that are part of Premier’s Partnership for Care Transformation Population Health Initiative.

Percent of lives covered by model
- Shared savings agreement with upside risk: 41 percent
- Shared savings agreement with downside risk: 26 percent
- Care management fees: 21 percent
- Bundled payment: 9 percent
- Capitation: 3 percent

Range of savings provided to ACOs
- Public payers: The range of savings provided to the ACOs by public payers, such as Medicare and Medicaid, runs between 25 percent and 60 percent.
- Commercial payers: ACO arrangements with commercial insurers typically result in the provider receiving 50 percent to 80 percent of any achieved savings.
- Employer payers: Employers offer some of the broadest arrangements, with anywhere from 100 percent of savings with downside risk, to 50-50 shared savings arrangements in upside-only arrangements.

Report: 36% of Physicians Plan to Leave Medicine Within 10 Years
By Anuja Vaidya

Thirty-six percent of physicians plan to retire or stop practicing medicine in the next 10 years, according to a survey conducted by Jackson Healthcare, a healthcare staffing company.

For the survey, 3,456 physicians were polled between March 7 and April 1, 2013.

The reasons cited for wanting to leave or retire, according to the survey, were:

- Feeling burned out — 60 percent cited this as one of the reasons.
- Not wanting to practice in an era of healthcare reform — 58 percent cited this as one of the reasons.
- Economic factors such as malpractice insurance, overhead, using EMRs, etc. — 50 percent cited this as one of the reasons.
With the increasing use of reimbursement models paying for the longitudinal health status of a patient, health systems’ historical value proposition of simply being the provider of hard assets to the market is becoming less effective. In a fee-for-service environment, growing volumes and effective operations are the hallmarks of creating enterprise value. As the market shifts to more risk-sharing reimbursement models, the ways to create enterprise value require health systems to consider the relevance of their value proposition and create new capabilities. Those that do not make this shift are seeing their assets rapidly commoditized.

Commoditization of the industry’s “sick-care” assets should be a major concern for the asset-centric health systems in the U.S. As with any asset-centric industry segment, once there is a glut of assets, or once assets become commodities, the price commanded by those assets runs down to the variable cost until enough of the assets are bankrupt to bring the cost of building new assets in line with the price of the existing. With the costs of building new hospitals exceeding $2 million per bed, it might be logical to think the existing health systems are safe from being commoditized. However, consider most healthcare assets, be it hospitals or ambulatory centers, are operated at less than full capacity. Moreover, new delivery models are providing lower-cost substitutes for many of the services provided through these expensive assets. As an example of this substitution, consider the growth of free-standing urgent care centers. With now more than 9,000 centers nationwide, free-standing urgent care centers are growing 7 percent or more per year.1 While much of the urgent care volume is siphoning off primary care visits from physician offices, a portion, as much as 17 percent, is volume that would otherwise go to the emergency rooms.2 Even as health systems are building out the urgent care model, the reimbursement is perhaps one-third of what it is in the ER for the same patients.

To combat this commoditization of their core assets, many health systems have shifted their investments from inpatient facilities to outpatient facilities. This is proving to be a good, albeit short-term, strategy. As inpatient and hospital facilities are commoditized, they are typically done so by the lower-cost ambulatory facilities. As a result, ambulatory care utilization has been growing faster than inpatient care over the last several decades. Nevertheless, no sooner does the health system invest in an ambulatory asset as that asset itself becomes commoditized. It is as if the health system leaders have forgotten their core purpose is not to invest in capital assets but develop the efficient means to care for patients.

Regardless of the types of assets being developed, attempting to compete by virtue of providing assets is a recipe for commoditization.

How are health systems competitively positioned today?

Unfortunately, we find the health systems in the U.S. today have redoubled their asset-based value equation in most markets across the county. Since at least the early 2000s hospitals have moved to focus on the core inpatient and asset-centric ambulatory businesses. This overreliance of the healthcare provider industry on capital and assets for competitive advantage has resulted in those that are big becoming bigger and the long-term growth of healthcare systems.

In the wake of the Patient Protection and Affordable Care Act, small systems and independent hospitals scrambled to join systems for the protection size offered. However, studies have shown the advantage offered by a system tends to be only the increase of pricing power vis-a-vis the payers.3 Yet, as is being proven out in markets such as San Jose, Calif., Denver, Seattle and Boston, having a large base of assets does not make systems immune to the commoditization of those assets over
time by insurers and physician organizations. In fact, the same large capital asset base that has made health systems strong can be turned to a liability as systems need volume at any cost above variable cost to maintain their returns.

The solution is to shift the health system’s strategy from a capital asset strategy to a capability strategy. Successful systems are doing this by focusing on building both the systems of care and manage systems of health

**The need to manage systems of care and systems of health**

As more attention and payment is focused on keeping populations healthy, health systems must develop the capabilities to both build systems of care and manage systems of health.

- Systems of care focus on patients seeking medical attention, whether prevention, diagnostic or treatment services
- Systems of health focus on populations seeking ways to prevent, manage and improve health

While building systems of care continues to require capital assets, managing systems of health requires very little capital assets and instead requires a broad set of new capabilities. Moreover, while the revenue model for systems of care can be linked to assets, the revenue models for systems of health must be linked to health, and thus, the ability to maintain health. As such, health systems must begin to shift their value equation from simply providing the assets necessary for systems of care to building the capabilities to coordinate systems of care and manage systems of health.

**Capability strategies**

*Definition: Strategies that create organizational potentiality and ability*

Capability strategies focus on developing the abilities and talent needed to coordinate systems of care and manage systems of health. In the changing environment of healthcare today, adaptability and innovation need to be top of mind for organizations. As Darwin said, “It is not the strongest species that survive, nor the most intelligent, but the ones most responsive to change.” The systems that understand and embrace this concept will be the ones that excel because they focus their energy on creating new capabilities and options.

Capability-based strategies stem from the premise that core competencies derived from distinctive capabilities provide strategic advantage, profitability and sustainability in the market. In the seminal business paper on the topic, Stalk, Evans and Schulman identified four principles that serve as guidelines to achieving capability-based competition:4

1. Corporate strategy does not depend on products or markets but on business processes
2. Key strategic processes are needed to consistently provide superior value to the customer
3. Investment is made in linking across functions and departments
4. Because capabilities cross functions, the strategy must be top-down

Applying a capability strategy framework to health systems causes a radical shift in strategy for most health system leaders. It starts with the envisioning the role of the health system in the future environment and the shift away from sick care towards population health. In this journey there are four roles health systems must play: partner (system of health), innovator (system of health), expert (system of health) and improver (system of care).

**Partner: One that shares**

Developing the partnership capability is critical for success in managing systems of health. To affect populations’ health, a mindset of partnership is the most important capability a health system can have. As most of the population health depends on the individual’s own actions, health systems must create partnerships across a wide range of organizations to create the environment for health.

Moreover, health systems who take on the partner role know the value is not in duplicating services for populations, but the value is organizing, managing and integrating these services into a coordinated offering that individual organizations cannot do on their own. It matters less who owns the services and more that the delivery model across the care continuum works for individuals and results in better health. Partners in systems of health will range from retail partners (e.g., CVS, Walgreens) to technology vendors (e.g., Siemens, McKesson) to employers and payers.
The core capability developed is the ability to integrate the delivery model for populations as they seek care.

**Expert:** One that has, involves or displays special skill or knowledge derived from training or experience

Those health systems that have built a strong relationship with and intimately understand the needs of their communities may already have the capability of expert being developed today. Just as partnering is critical to success, so is the capability to understand and know more about the population and their needs to remain healthy. This expert function is a role that the U.S. healthcare industry has depended on nonprofit health systems for over the last several decades.

As such, health systems who take on the expert role applied to systems of health, strive to understand the needs of the populations intimately. They track data and information about the population not just the patients inside their hospitals. This understanding of populations requires access to data from across the continuum and the capability to collect through partners, analyze with sophisticated predictive modeling and act to preemptively change actions.

The core capability is data analytics and interpretation to prospectively determine what populations will need.

**Innovator:** One that does something in a new way

Healthcare in the U.S. has recently been about providing a service demanded by a population that was generally acutely ill. Innovators were those that created new technology or techniques to treat acute (or soon to be acute) health issues. To succeed in a population health era, the innovative focus of the last five decades needs to be shifted away from only the acute and towards the population’s lifestyles, environment and activities. There is some argument that this cannot be done by health systems and must be undertaken by larger, social networks and governments. However, health systems that do understand their communities and the activities and health lifestyles of their local populations can be a strong influence in developing new thinking and action by populations on maintaining health.

**Improve:** One that enhances quality or value

There is also a new capability that is needed inside the systems of care. It is no longer enough to simply build and provide capital assets to the market. The health systems that successfully develop systems of care do so by improving on the individual parts and creating coordination across elements. It is this improvement through coordination that many health systems have begun to make progress in their capability strategies.

Health systems that do recognize the need to improve (or recreate) the system of care, often are driven by a vision of multi-disciplinary care and coordinated handoffs. Recently these beliefs have led to increased mergers, acquisitions and affiliation/partnership strategies. As an example consider the goal of Mayo Clinic with its Mayo Clinic Care Network. Under this strategy, Mayo has developed the linkages with other clinics and health systems to streamline the referral process and ensure handoffs between the two organizations do not result in gaps in care.

**Where should health systems begin?**

As health systems take on the new roles required of a capabilities based strategy, their organizational structure and outlook must also change. These changes must be driven from the top down as they will shift the priorities and culture of the organization from managers of assets to managers of capabilities. Below are examples of the change:

**How will the provider landscape change?**

The rapid commoditization of traditional hospital-based health system assets is causing a shift away from competing on capital to competing on capability that will accelerate over the coming decade. Capital can be replaced, whereas capabilities must be developed. As the industry comes out from under the fear of the change represented by the PPACA and the specter of significant reimbursement change, health systems that have come together for access to capital are going to experience pressure to split into smaller units.

As a result, we anticipate several visible manifestations to occur in the industry over the coming five years:

1. National systems that cannot make the transition will split into semi or fully-autonomous regional units.
2. Health system management teams will reorganize and move the hos-
Executive Briefing: Population Health

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Key change</th>
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<tbody>
<tr>
<td>Governance</td>
<td>Fiduciary responsibility refocuses on the organization’s development of intellect and innovation</td>
</tr>
<tr>
<td>Organization</td>
<td>Ambulatory, physician and knowledge divisions are on par rather than under the hospital structures</td>
</tr>
<tr>
<td>Finance</td>
<td>NOI rather than EBIDA; ROI incorporates option value and potentiality</td>
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<tr>
<td>Affiliation</td>
<td>Partnership rather than control</td>
</tr>
<tr>
<td>Management</td>
<td>Repeatable processes and consistency</td>
</tr>
<tr>
<td>Strategy</td>
<td>Learning; capability share rather than market share</td>
</tr>
</tbody>
</table>

Capital leadership structure out of the center making it equal with physician, ambulatory and population health management enterprises.

3. Regional health systems will shift their remaining capital investments from inpatient assets to primary ambulatory assets (primary care clinics, urgent care, ambulatory diagnostic and procedural centers).

4. Partnerships between health systems and physicians, insurers, non-traditional providers (retailers, employers) and communities will proliferate as health systems seek to build capabilities to care for a population rather than treat a patient.

5. The community and academic health centers that have not developed a strong capital or capability position will close as they become increasingly irrelevant to the market and not find partners or systems to remain viable.

Conclusion

As with any major industry environment change, the organizations that recognize the change and adapt more quickly will be the winners. For health systems to thrive in the population health environment, an intense focus on building new organizational capabilities is needed. Those that develop the capabilities to partner, innovate leverage expertise and improve processes will be the winners.

Kate Lovrien and Luke C. Peterson are principals at Health System Advisors. Together they have spent more than 25 years advising senior healthcare leaders on their market and organizational strategy. They can be contacted at Luke.Peterson@HealthSystemAdvisors.com.

References:
1. IBIS World “Urgent Care Reports”, 2012
2. Weinick, Burns, and Mehrotra, Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail ClinicsHealth Affairs, vol. 29, no. 9, Sept. 2010, p. 1630-1636

Health System Advisors is a strategy consultancy whose mission is to advise leaders, advance organizations and transform the healthcare industry. For more information contact HSA at (877) 776-3639, or email Kate.Lovrien@HealthSystemAdvisors.com or Luke.Peterson@HealthSystemAdvisors.com.
Becker's Hospital Review Annual Chief Executive Officer Strategy Roundtable
Thursday, November 14, 2013 • 9:00 am - 7:00 pm
3 Tracks, 23 Sessions, 50 Speakers and 24 CEOs Speaking

Breakout Sessions

RITZ CARLTON • CHICAGO, ILLINOIS

Program Schedule

Thursday, November 14, 2013
9:00 - 10:25 am Breakout Sessions
10:25 - 10:45 am Networking Break
10:45 am - 12:10 pm Breakout Sessions
12:10 - 1:00 pm Networking Lunch
1:00 - 2:25 pm Breakout Sessions
2:25 - 2:45 pm Networking Break
2:45 - 4:10 pm Breakout Sessions
4:15 - 6:00 pm CEO Strategy Roundtable
6:00 - 7:00 pm Networking Reception

Please join us for the Becker's Hospital Review Annual Chief Executive Officer Strategy Roundtable from 9 a.m. to 7 p.m. on November 14th at the Ritz Carlton in Chicago.

Come listen to 50 hospital speakers discuss strategy, ACOs and physicians hospital integration and healthcare reform and improving profitability.

A. Strategy
B. ACOs and Physician-Hospital Alignment
C. Healthcare Reform and Improving Profitability

See the full schedule on page 2.

Several business-focused sessions include:

• Hospital Leadership - What Are the Biggest Opportunities for and Threats to Hospitals?
• How to and Rationale Behind Setting Up a Pioneer ACO
• A Step By Step Approach to Physician Hospital Integration
• You've Now Implemented Your EMR - Welcome to the Starting Line
• Physician Alignment Strategies, Co-Management Joint Ventures, Employment and More
• The State of the Healthcare Future
• Should Your Community Hospital Sell or Stay the Course?
• Leadership in Support of Patient-Driven Care
• Assessing and Defending the Fair Market Value of High-Earning Physician Compensation
• Talent Rules! Creating a Talent Management Process Within Healthcare
• How to Assess Strategy in a Changing World, Thinking 5 Months and 5 Years Into the Future
• Developing a Payor-Provider Plan With a Multi-Hospital System
• What is the Impact of Healthcare Reform on ASCs and Group Practices - All Clouds or Silver Lining Too?
• How Urban Systems Find Value in Rural Affiliations
• ACOs Current Trends and Issues
• Driving Perioperative Performance to Improve the Bottom Line

CO Chairs
• Charles S. Lauer, Author, Consultant, and Former Publisher, Modern Healthcare
• Scott Becker, JD, CPA, Publisher, Becker's Hospital Review and Partner, McGuireWoods LLP

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RITZ CARLTON • CHICAGO, ILLINOIS

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THURSDAY, NOVEMBER 14, 2013

**Becker’s Hospital Review Annual Chief Executive Officer Strategy Roundtable**

**Breakout Session Tracks:**
- A. Strategy
- B. ACOs and Physician Hospital Alignment
- C. Healthcare Reform and Improving Profitability

**Concurrent Sessions**
- A. How to Assess Strategy in a Changing World, Thinking 5 Months and 5 Years into the Future
  - Michael Sachs, Chairman, Sg2
- B. Assessing and Defending the Fair Market Value
- C. 7 Key Stark, Anti Kickback and False Claims Act

**A. Hospital Leadership – What Are the Biggest Opportunities for and Threats to Hospitals?**
  - Lynn McCvey, Acting Chief Executive Officer and President, Meadowslands Hospital Medical Center, Jose R. Sanchez, LMSW, LCSW, Chief Executive Officer, Norwegian American Hospital, David DiLoreto, MD, President and Chief Executive Officer, Presence Health Partners, Donald Lovasz, President and Chief Executive Officer, KentuckyOne Health, Partners LLC, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

**B. You’ve Now Implemented Your EMR – Welcome to the Starting Line**
  - Bertram Reese, Senior Vice President and Chief Information Officer, Sentara Healthcare

**C. Talent Rules! Creating a Talent Management Process Within Healthcare**
  - Scott Dimmick, Vice President of Human Resources & Organizational Development, ValleyCare Health System

**Networking Break** • 10:25 AM – 10:45 AM

**A. Physician Alignment Strategies, Co-Management Joint Ventures, Employment and More**
  - Patrick Board, Chief Executive Officer, Union Associated Physicians Clinic, Brent Lambert, MD, FACDS, Principal and Founder, Ambulatory Surgery Centers of America, Scott M. Safriet, MBA, CVA, Partner, HealthCare Appraisers, Brian Silverstein, MD, President, HC Wisdom, Moderated by Lindsey Dunn, Editor in Chief, Becker’s Hospital Review

**B. ACOs Current Trends and Issues**
  - Ted Schwab, Partner, Health and Life Sciences, Oliver Wyman, Jen Johnson, CFA, Partner, VMG Health, Randall E. Williams, MD, Chief Executive Officer, Pharos Innovations, Miles Snowden, MD, MPH, CEBS, Chief Medical Officer, Optum, Moderated by Molly Gamble, Editor, Becker’s Hospital Review

**C. Should Your Community Hospital Sell or Stay the Course?**
  - Joseph R. Lupica, Chairman, Newpoint Healthcare Advisors, Gordon Mountford, Executive Vice President, Huron Healthcare, Greg Koonsman, Senior Partner, VMG Health, Moderated by Bob Herman, Editor, Becker’s Hospital Review

**11:30 AM – 12:10 PM**

**A. Plan/Provider Efforts in the Coming of Age of ACOs, PHOs and Shared Savings Agreements**
  - Scott Sarran, MD, MM, Chief Medical Officer, Government Programs, Health Care Services Corporation, Paul Stewart, President and Chief Executive Officer, Sky Lakes Medical Center, Phillip H. Kamp, President and Chief Executive Officer, Valence Health, Paul Harkaway, MD, Corporate Vice President for Clinical Integration and Accountable Care, Trinity Health, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

**B. Developing a Payor Provider Plan with a Multi-Hospital System**
  - David DiLoreto, MD, President and Chief Executive Officer, Presence Health Partners

**C. What is the Impact of Health Care Reform on ASCs and Group Practices - All Clouds or Silver Lining Too?**
  - W. Michael Karnes, Chief Financial Officer and Co-Founder, Regent Surgical Health, Barry Tanner, President and Chief Executive Officer, Physicians Endoscopy, Greg Koonsman, Senior Partner, VMG Health, Wesley Curry, MD, Chief Executive Officer, CEP America, Moderated by Amber McGraw Walsh, JD, Partner, McGuireWoods LLP*

**Networking Lunch** • 12:10 PM – 1:00 PM

**1:00 PM - 1:40 PM**

**A. How Urban Systems Find Value in Rural Affiliations**
  - Kelby Krabbenhoft, President and Chief Executive Officer, Sanford Health, Hon. Steve Hobbs, President and Chief Executive Officer, Physicians Endoscopy, Greg Koonsman, Senior Partner, VMG Health, Wesley Curry, MD, Chief Executive Officer, CEP America, Moderated by Amber McGraw Walsh, JD, Partner, McGuireWoods LLP*

**B. A Step-by-Step Approach to Physician Hospital Integration**
  - William Cors, MD, MMM, FACPE, Chief Medical Quality Officer, Pocono Health System

**C. 7 Key Stark, Anti Kickback and False Claims Concepts for Senior Leadership**
  - Scott Becker, JD, CPA, Partner, McGuireWoods LLP

**1:45 PM - 2:25 PM**

**A. Leadership in Support of Patient-Driven Care**
  - Paul F. Levy, Former Chief Executive Officer, Beth Israel Deaconess Medical Center

**B. How and Why to Set up an ACO: What OSF Has Learned from its Pioneer ACO**
  - Robert C. Sehring, Chief Ministry Services Officer and Tara Canty, Chief Operating Officer, Accountable Care, Senior Vice President, Government Relations, OSF Healthcare System

**Networking Break** • 2:30 PM – 2:45 PM

**2:45 PM – 3:25 PM**

**A. The Best Ideas for Community Hospitals Now**
  - Bart Bu luxton, President and Chief Executive Officer, McLaren Lapeer Region, Paul Stewart, President and Chief Executive Officer, Sky Lakes Medical Center, Rick Napper, President and Chief Executive Officer, Magnolia Regional Health Center, Jeff Hill, Chief Executive Officer, Steele Memorial Medical Center, Rand Wortman, President and Chief Executive Officer, Kadlec Health System, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

**B. The Road to Population Health: Key Enablers in Implementing Value-Based Approaches**
  - James Stanford, Client Service Executive, Objective Health, a McKinsey Solution for Healthcare Providers

**C. Creating an ACO for Your Own Employees**
  - Brian Silverstein, MD, President, HC Wisdom

**3:30 PM – 4:10 PM**

**A. The State of the Healthcare Future**
  - Charles S. Lauer, Author, Consultant, Speaker, Former Publisher of Modern Healthcare Magazine

**4:15 PM – 6:00 PM**

**A. CEO Strategy Roundtable**
  - Quint Studer, Founder, Studer Group, Catherine Jacobson, President and Chief Executive Officer, Froedert Health, Inc., Philip M. Kambic, President and Chief Executive Officer, Riverside Medical Center, Lynn Nicholas, FACHE, President and Chief Executive Officer, Massachusetts Hospital Association, Larry Goldberg, Chief Executive Officer, Loyola University Health System, Louis Shapiro, Chief Executive Officer, Hospital for Special Surgery, Larry Kaiser, MD, Chief Executive Officer, Temple University Health System, Michael Sachs, Chairman, Sg2, Paul Summerside, MD, FAAEM, MMM, Chief Medical Officer, BayCare Clinic, LLP, Diana Hendel, Chief Executive Officer, Los Angeles County: Long Beach Memorial, Miller’s Children’s Hospital and Community Hospital, Jose R. Sanchez, LMSW, LCSW, Chief Executive Officer, Norwegian American Hospital, Joseph Fifer, President and Chief Executive Officer, Healthcare Financial Management Association, Moderated by Charles S. Lauer, Author, Consultant, and Former Publisher, Modern Healthcare, and Scott Becker, JD, CPA, Publisher, Becker’s Hospital Review, Partner, McGuireWoods LLP

**Networking Reception** • 6:00 PM - 7:00 PM
Becker’s Hospital Review Annual
Chief Executive Officer Strategy Roundtable
November 14th • Chicago
3 Tracks, 23 Sessions, 50 Speakers and 24 CEOs Speaking

EXCLUSIVE CEO ROUNDTABLE SPEAKERS

Joseph Fifer, President and Chief Executive Officer, Healthcare Financial Management Association
Larry Goldberg, President and Chief Executive Officer, Loyola University Health System
Diana Hendel, PharmD, Chief Executive Officer, Long Beach Memorial Medical Center, Miller’s Children’s Hospital and Community Hospital Long Beach
Catherine Jacobson, President and Chief Executive Officer, Froedtert Health
Larry Kaiser, MD, Chief Executive Officer, Temple University Health System
Phillip M. Kambic, President and Chief Executive Officer, Riverside Medical Center
Lynn Nicholas, FACHE, President and Chief Executive Officer, Massachusetts Hospital Association
Michael Sachs, Chairman, Sg2
José R. Sánchez, LMSW, LCSW, Chief Executive Officer, Norwegian American Hospital
Quint Studer, Consultant and Founder, Studer Group
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SPEAKERS

Rex Burgdorfer, Juniper Advisory
Bart Buxton, President and Chief Executive Officer, McLaren Lapeer Region
Holly Carnell, Associate McGuireWoods LLP
Geoffrey C. Cockrell, Partner, McGuireWoods LLP
William Cors, MD, MMM, FACPE, Chief Medical Quality Officer, Pocono Health System
Wesley Curry, MD, Chief Executive Officer, CEP America
David DiLoreto, MD, President and CEO, Presence Health Partners
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Jen Johnson, CFA, Partner, VMG Health
Larry Kaiser, MD, Chief Executive Officer, Temple University Health System
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Greg Koonsman, Senior Partner, VMG Health

Kelby K. Krabbenhoft, President and Chief Executive Officer, Sanford Health

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Rick Napper, President/CEO, Magnolia Regional Health Center

Jeff Peters, President and Chief Executive Officer, Surgical Directions
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Bert Reese, Senior Vice President and Chief Information Officer, Sentara Healthcare
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Scott Sarran, MD, MM, Chief Medical Officer, Government Programs, Health Care Service Corporation
Ted Schwab, Partner, Oliver Wyman
Robert C. Sehring, Chief Ministry Services Officer, OSF Healthcare System
Brian Silverstein, MD, President, HC Wisdom
Miles Snowden, MD, MPH, CEBS, Chief Medical Officer, Optum
Paul Stewart, President and Chief Executive Officer, Sky Lakes Medical Center
Barry Tanner, President and Chief Executive Officer, Physicians Endoscopy
Randall E. Williams, MD, Chief Executive Officer, Pharos Innovations
Rand Wortman, President and Chief Executive Officer, Kadlec Health System

SPEAKERS NOT PICTURED
Patrick Board, Chief Executive Officer, Union Associated Physicians Clinic
Tara Canty, Chief Operating Officer, Accountable Care, Senior Vice President, Government Relations, OSF Healthcare System
Paul Harkaway, MD, Vice President for Clinical Integration and Accountable Care, Trinity Health
James Stanford, Client Service Executive, Objective Health, a McKinsey Solution for Healthcare Providers
MODERATORS

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

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

Scott Becker
Mr. Becker is the publisher of Becker's ASC Review, Becker's Hospital Review and Becker's Spine Review. Mr. Becker received his Juris Doctorate from Harvard Law School and his Bachelor of Science in finance and accounting from the University of Illinois at Urbana-Champaign.

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Compensation

On-Call Coverage for Surgical Specialists Drops 10% in 2012
By Laura Miller

While on-call pay for surgical specialists dropped last year, surgeons are still compensated more highly than primary care physicians for their time on-call.

According to the MGMA Medical Directorship and On-Call Compensation Survey: 2013 Report Based on 2012 Data released last month, 70 percent of all physicians received payment for on-call coverage in 2012, a 10 percent increase over the previous year. Surgical specialists, including orthopedists and neurosurgeons, are most in demand and average daily stipends were reported as $900 in 2012.

Despite receiving more than primary care physicians — who reported on average $250 daily stipend for on-call coverage — surgical specialists saw a 10 percent rate decrease in 2012.

Report: Quality, Patients Will Have Bigger Role in Physician Compensation
By Bob Herman

Last year, primary care physicians and specialists both said quality metrics began to affect their compensation, a trend both physicians and others in the industry expect will tick upward, according to MGMA’s newest physician compensation and production survey.

Primary care physicians said 3 percent of their total pay was based on quality, while specialists said the same was true for 2 percent of their pay. This is the first time MGMA has reported quality and patient satisfaction metrics in their annual physician pay reports.

“Quality and patient satisfaction metrics are not yet dominant components of physician compensation plans right now. However, as reimbursement models continue to shift, the small changes we’ve observed recently will gain momentum,” said Susan Turney, MD, MGMA president and CEO, in a news release. “It’s encouraging to see physician practices invested in patient-centered care and continuing to seek ways to better incorporate quality and experience into compensation methodologies.”

Rural Hospital CEO, CFO Compensation: 24 Statistics
By Bob Herman

Rural CEO compensation
Depending on geography, size of facility and percentiles, a rural hospital CEO made between $120,000 and $392,000 in 2012.

In partnership with the National Rural Health Association, Yaffe & Co., a healthcare compensation consulting firm, released data for its most recent rural hospital executive compensation survey this past April.

Here are 12 statistics on rural hospital CEO compensation, based on Yaffe & Co’s 2012 Executive Compensation Survey for CAH/Rural Hospitals. Note: The survey received responses from 197 rural hospital and critical access hospitals. Sixty-eight percent of responding hospitals had between 25 beds and 100 beds, and median full-time equivalents at responding hospitals ranged from 110 to 495.

Hospital with less than $20 million of net patient revenue
25th percentile: $120,000
50th percentile: $188,698
75th percentile: $225,000

Hospital with $50 million to $100 million of net patient revenue
25th percentile: $249,750
50th percentile: $267,500
75th percentile: $309,644

Hospital with more than $100 million of net patient revenue
25th percentile: $316,865
50th percentile: $358,500
75th percentile: $392,668

Rural CFO Compensation
CFOs are usually the second-highest-paid executives at rural hospitals, and compensation for rural hospital CFOs ranged from $76,000 to $248,000 in 2012.

Here are 12 statistics on rural hospital CFO compensation, based on Yaffe & Co’s 2012 survey. Note: The survey received responses from 197 rural hospital and critical access hospitals. Sixty-eight percent of responding hospitals had between 25 beds and 100 beds, and median full-time equivalents at responding hospitals ranged from 110 to 495.

Hospital with less than $20 million of net patient revenue
25th percentile: $76,210
50th percentile: $92,123
75th percentile: $106,850

Hospital with $20 million to $50 million of net patient revenue
25th percentile: $106,558
50th percentile: $123,698
75th percentile: $150,000

Hospital with $50 million to $100 million of net patient revenue
25th percentile: $143,748
50th percentile: $166,572
75th percentile: $201,400

Hospital with more than $100 million of net patient revenue
25th percentile: $196,255
50th percentile: $214,200
75th percentile: $248,499
7 Forecasts on Hospital Inpatient, Outpatient Volumes

By Bob Herman

Inpatient and outpatient volumes have already begun shifting at hospitals over the past several years, and looking five to 10 years out could help organizations refine their financial strategies.

Sg2, a healthcare analytics firm, has released national and regional forecasts for hospital inpatient and outpatient volumes. Here are seven predictions on long-term hospital volumes.

1. Overall growth. Outpatient volumes are expected to grow 17 percent over the next five years, while inpatient discharges may decrease 3 percent, according to Sg2's report.

2. Bariatric surgery and advanced imaging. Bariatric surgery and advanced imaging are expected to be major drivers of outpatient growth in the next five years. Sg2 predicts outpatient bariatric surgery alone may increase by 75 percent.

3. Cardiovascular. Inpatient cardiovascular discharges have been on the decline at hospitals for many years. Inpatient angioplasties are still expected to drop as more cases shift to the outpatient setting. However, over the next five years, outpatient cardiovascular services are expected to swell by 16 percent. Certain cardiovascular surgeries, electrophysiology and vascular intervention are also expected to grow in both the inpatient and outpatient settings.

4. Cancer. Advanced cancer surgical techniques, such as neoadjuvant treatment, are expected to boost inpatient oncology services.

5. Neurosciences. Admissions for inpatient stroke treatments are expected to stabilize, and admissions for stroke interventions like tissue plasminogen activator treatment could increase up to 59 percent over the next five years.

6. Orthopedics. Orthopedic surgeries have exploded in the outpatient setting, but Sg2 still expects hip replacements and knee replacements will grow 11 percent and 16 percent, respectively, over the next five years in the inpatient setting.

7. Women's health and pediatrics. National neonatal intensive care unit admissions are expected to fall by 2 percent over the next five years.

11 Statistics on Hospital Debt-to-Capitalization Ratios

By Bob Herman

For most hospitals and health systems, debt-to-capitalization ratios fell between 2009 and 2011 as many organizations looked to refinance debt and build cash on hand.

Debt-to-capitalization is the hospital’s long-term debt divided by the sum of long-term debt and unrestricted net assets. This ratio essentially shows how much debt a hospital has compared to the hospital’s overall equity.

Here are 11 statistics on median hospital debt-to-capitalization ratios over the past several years from two credit rating agencies, Standard & Poor’s Ratings Services and Moody’s Investors Service. Note: All data are medians. S&P’s data reflects only standalone hospitals in its portfolio, while Moody’s data reflects standalone hospitals and single-state health systems in its portfolio.

S&P median hospital debt-to-capitalization ratios
2006: 37.4 percent
2007: 36.1 percent
2008: 39 percent
2009: 39 percent
2010: 38.1 percent
2011: 36.9 percent

Moody’s median hospital debt-to-capitalization ratios
2007: 37.6 percent
2008: 41.1 percent
2009: 42.1 percent
2010: 41.6 percent
2011: 40.4 percent

S&P: Cost of Hospital Services Mildly on the Rise

By Bob Herman

The average per capita cost of hospital services covered by Medicare and commercial payers increased 2.02 percent from April 2012 to April 2013, a tick up from the 1.91 percent increase recorded in March, according to Standard & Poor’s Healthcare Economic Indices through April.

Healthcare economic indicators have fallen and stagnated over the past six months. Even though revenue growth rates for hospitals and health systems from payers were up in April, they are still lower than rates recorded in September, when S&P’s Hospital Index hit its lowest annual rate (3.84 percent) since January 2005.

Hospital growth from commercial payers is still at some of the lowest levels in years. Through April, the Hospital Commercial Index was 1.89 percent, a new record low. In September, that index was at 5.1 percent.

Here are the latest S&P healthcare indices through April 2013.

S&P Healthcare Economic Indices (12-month moving average)
Composite Index: 3.16 percent
Medicare Index: 1.06 percent
Commercial Index: 4.54 percent

Hospital Index: 2.02 percent
Hospital Medicare Index: 2.15 percent
Hospital Commercial Index: 1.89 percent

Professional Services Index: 4.23 percent
Professional Services Medicare Index: -0.80 percent
Professional Services Commercial Index: 6.88 percent
Executive Briefing: Emotional Intelligence

There is a growing interest in healthcare, in the role of Emotional Intelligence — a set of behavioral competencies, which impact performance. There is also a growing body of evidence that individual behaviors, including EQ, influence patient outcomes and organizational success. What is EQ? How does it apply to healthcare? How do we use it to improve performance?

Everyone is striving to provide patient-centered care, and to increase quality while reducing costs. Operational strategies like Lean and Six Sigma are helping to design more effective and efficient care models. Information systems make clinical and financial data more useful and enhance efficiency. While these strategies and technologies are widely available, not every organization is successful.

For instance, after intense focus on patient safety over the past few years, a recent report by the Leapfrog Group revealed that most hospitals showed no improvement in safety scores and some even declined. Patient safety, and patient-centered care are, to a large degree, about individual behaviors and interactions between providers and patients and among administrators, physicians, nurses and staff. Ted Kinney, PhD, head of research and development at Select International, summed it up: “At its very core, the patient experience is an evaluative attitude about the level of care that people provided during the treatment cycle. Revisions to process and new technology can provide efficiencies, but, in the end, a patient’s attitude depends on [his or her] interactions with people. Those high in EQ are able to navigate those interactions in a way that leaves a positive impression.”

Emotional intelligence — What is it?

In the 1930s psychological research had identified “social intelligence” skills, distinct from traditional intelligence, that impact work performance. By the 1980s research showed that overall performance was often the result of interpersonal, more than technical, skills. By the 1990s, the term “emotional intelligence” was widely discussed in business circles. Definitions typically include about two dozen social and emotional abilities that are often grouped into five core areas:

- Self awareness
- Self regulation
- Self motivation
- Social awareness
- Social skills

Interest in the concept took off in the 1990s and it continues to have widespread support in the business world, but healthcare has been slow to apply EQ concepts.

Behaviors and outcomes

Efforts to improve quality will always begin with research and training on new diagnostic and treatment approaches. There is a growing body of evidence, however, that individual behaviors significantly influence outcomes.

For instance, relatively simple protocols have been shown to virtually eliminate certain hospital-acquired infections. Some hospitals adopt these protocols but don’t reduce infection rates. Why? John Santa, MD, MPH, director of the Consumer Reports Health Ratings Center, commented on the dilemma: “For the process to work, each individual has to make a commitment to perform each step each time, and have the courage to correct their colleague when they see an error has been made.”1 Success requires staff members who see the value of new procedures and a culture of communication, collaboration and adaptability.

We are learning that behaviors like empathy and compassion not only make for a better patient experience, they actually impact patient outcomes. For instance, provider empathy improves patient satisfaction and adherence to treatment and correlates with fewer medical errors. Empathetic doctors are better at managing chronic conditions like diabetes. Inappropriate behaviors by nurses and physicians are not only disruptive to the work environment but, more importantly, those behaviors can harm patients. EQ might be offered as an explanation for why some practitioners and organizations are better at delivering patient-centered care.2

There is also evidence that EQ can be improved with training. If providers have a better understanding of their behavioral propensities, they can adopt specific behaviors that will improve interactions with patients and colleagues.

Healthcare emotional intelligence

Working with a group of physician leaders at a progressive healthcare system, we heard the following: “We appreciate the connection between EQ and patient care and physician career success, but when we took an EQ assessment, we found the results to be interesting, but weren’t sure what to do with the information.” Traditional EQ measurement tools do not provide practical recommendations for physicians and nurses.

“Part of the problem is that the concept of EQ — how it is defined, measured and used, has not been looked at within the unique context of healthcare.”
Healthcare Emotional Intelligence (HEQ) – A Breakthrough in Training and Development

Select International’s Patient-Centered Care Training provides participants with their unique personality profile. Using the Select C.A.R.E. Assessment, you can examine those behaviors that impact patient centered care and leverage the concept of Healthcare Emotional Intelligence to:

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- Improve patient satisfaction
- Enhance staff adaptability
- Create custom solutions and training

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Executive Briefing: Emotional Intelligence

healthcare context. Healthcare job performance is different than most jobs in the labor market. Physicians, for instance, may score high on traditional measures of EQ, but other behavioral traits can prevent them from displaying the highly collaborative or patient-centered behaviors we’d expect,” says Dr. Kinney.

From our years of working with healthcare organizations, we’ve developed an innovative behavioral construct to patient-centered care that incorporates the concept of “healthcare emotional intelligence.” Where a physician or nurse scores on the continuum for these areas is less important than their ability to understand their behavioral make-up and adapt accordingly.

Compassion. How compassion is measured and how the results presented, are important. For compassion to be useful, it must result in positive action. Providers who are exceptionally high in compassion may struggle separating their feelings from the decision-making process. Even highly factual (vs. feeling) individuals can connect with patients and co-workers if they are aware and able to convey that they are trying to understand the other’s emotional state.

Awareness. The ability to understand a situation and either focus on the details or the big picture, as appropriate, is invaluable to creating a patient-centric culture and to successfully collaborating and working in teams.

Regulation. The ability to moderate emotions allows individuals to problem solve under stress, and to maintain productive, professional relationships. Those who are highly excitable may be at a greater risk for impulsive negative remarks or actions (think about disruptive behavior). Those who are hyper-controlled, however, are often perceived as distant and uncaring.

Emotional intelligence. Your level of “social focus.” Are you so focused on the task at hand that you fail to read the needs of patients and colleagues, or are you easily able to read others’ emotions and use that information to achieve a positive outcome?

Training implications
Traditionally, patient-centered care has involved service excellence programs like those adapted to healthcare from Disney or the Ritz Carlton. These have their limitations.

Imagine a patient with bad reaction to anesthesia. It’s fairly routine but still uncomfortable and unnerving for the patient and the family. One nurse may be highly conscientious and clinically competent and quickly work through the right protocol. The symptoms will resolve, but she doesn’t pick up on the patient’s anxiety or address it. Another nurse may not be quite as conscientious or detail oriented, but she is more comforting; she knows to put a hand on the patient’s shoulder and to assure the family that this is normal. The two patient and family experiences will be very different.

If each of these nurses can learn about their natural behavioral propensities, they can develop behaviors and practices to improve their patients’ experiences. The first can learn to take a minute to read the anxiety level of her patients. The second can learn to be more diligent in administering treatments.

One CEO told us, “We check all the boxes on our service excellence program and pat ourselves on the back, but our patient satisfaction scores have not improved.” The specific, individual behaviors and interactions of every physician, nurse and staff member are what drive patient-centered care. More importantly, people must understand something about their own behavioral make-up so they can learn to modify their behaviors, accordingly.

Dr. Kinney relates his experience: “The key to developing in this behavioral style is self-awareness. If an EQ assessment pinpoints profiles that do not lead to a positive patient experience, then the participant can learn to modify behavior in future situations to be more in tune with the needs of the patient. People learn that by forcing themselves to attend to how they are being perceived, they are able to impact positive outcomes. The most successful patient-centered care training programs will combine service excellence principles with behavioral assessments that provide staff with useful insight into their own behavioral make-up — including healthcare-specific emotional intelligence. It is not possible to train patient satisfaction through a ‘one-size fits all’ training paradigm. Rather, different people have different development needs when it comes to the way they interact with others. Starting a patient satisfaction development program should always be preceded by ‘taking the temperature’ with a well developed EQ measure to understand the participant’s unique challenges in connecting with others.’

Endnotes:


ii See:

• (Emotional intelligence in medicine: A systematic review through the context of the ACGME competencies. Arora, S., Ashrafian, H., Davis, R., Athanasiou, T., Darzi, A., & Sevdalis, N. (2010). Medical Education, 44(8), 749-764)


• Impact and Implications of Disruptive Behavior in the Perioperative Arena, Journal of the American College of Surgeons, July, 2006.)

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It’s no secret that hospitals have been getting much friendlier with one another lately.

Consolidation activity in the healthcare industry has been accelerating for several years, driven by changes in reimbursement, spikes in the rate of the uninsured and major shifts on the horizon in light of government health reforms. That’s led systems small and large to buddy up in partnerships ranging from simple clinical affiliations to corporate mergers and sales. But, one type of transaction may be picking up in popularity: nonprofit hospitals and health systems partnering with private equity firms.

That’s been evidenced by three recent high-profile examples. In 2010, Boston-based Caritas Christi Health System was acquired by Steward Health System, an entity created by private equity group Cerberus Capital Management. In the same year, Nashville, Tenn.-based Vanguard Health Systems, owned by private equity firm Blackstone Group, bought out the ailing Detroit Medical Center. And Catholic health giant Ascension Health, based in St. Louis, formed a funding joint venture in 2011 with Oak Hill Capital Partners, also a private equity firm.

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The appeal of private equity

“The major nonprofit systems around the country are talking strategically. They want to get bigger,” often through partnering with others, says Adam Buchanan, vice president of municipal credit at Ziegler, a specialty healthcare investment bank. “I think the private equity side of it is a little more unique.”

Sometimes the smaller systems seek the big private equity-backed partners in order to stay relevant, as in the case of DMC, or in order to compete in a saturated market like Caritas in Boston, Mr. Buchanan says. But, the larger multistate system’s use of private equity partnerships is for strategic purposes. “The Ascension Health System and Oakhill Private Equity Fund joint venture provides Ascension access to capital to acquire mission-driven smaller facilities and systems,” he says.

That model is one that’s becoming a favorite of nonprofit buyers, says Jonathan Spees, a senior vice president with healthcare management consulting company The Camden Group and the founder and owner of two private equity-backed hospital companies. The for-profit entity buys up hospitals for the nonprofit partner in the joint venture. “Instead of using their own capital, [the nonprofit] gets to acquire ownership and at least some measure of control [over the acquired hospitals],” he explains. The private equity body is the taxpaying entity and pays a share of dividends or proceeds, but is not subject to the same nonprofit regulations. Communities, if they can be assured that charity care and services won’t suffer, may support these agreements for the increased tax base a for-profit can bring.

“Private equity’s biggest draw for nonprofit hospitals is the access to capital made available in such partnerships,” says Patrick Pilch, managing director at BDO Consulting. “Specifically, many hospitals are using private equity capital to secure the appropriate IT platforms, which provide connectivity that is essential under health reform. In addition to enabling significant investments in infrastructure and other capital investments, private equity capital can be particularly attractive because it may assume a system’s liabilities as well as assets.”
What’s in it for private equity?

The latest deals are still new, and there’s not enough historical data of private equity firms throwing their hats into the nonprofit hospital ring to know what a typical return on investment would be, but in other industries returns yield 10 to 20 percent annually to private equity investors, Mr. Spees says. That’s a much higher operating margin than many small nonprofit hospitals clear. “Changes in reimbursement methodologies does make it riskier than in the past, in my opinion,” he says, but “since they’re definitely contributing capital to this industry, they’ve concluded that it’s not too risky.”

Although it would seem nonprofits with charitable missions or uncompensated care requirements would be unattractive investment picks, Mr. Pilch says “Private equity doesn’t necessarily balk at these opportunities because some people will only go to a nonprofit, religious, academic or charitable system.”

The turnaround time for these deals ranges from three to 10 years, with the average falling somewhere between five and seven years, he says. That short turnaround time and high margin means private equity enters agreements with a detailed exit strategy, building the features future buyers will want and pruning what they don’t. That way, when the purchased hospital or system is sold, the short-term private equity partnership can be replaced with a long-term and sustainable one.

For that reason, Mr. Spees says, nonprofits may consider private equity to help dress them for a future partnership deal. “Every nonprofit who’s considering entering into this path establishes the guiding principles that they’ll use to guide a pending transaction, review the proposals they’ll receive, and the transaction is outlined in their guiding principles.”

The case against private equity

But private equity deals are not simply a windfall for failing or cash-strapped hospitals. David Kirshner, director and senior CFO consultant at Warbird Consulting, said he’s skeptical private equity will become a big and growing trend for nonprofit health systems. “Changes in reimbursement methodologies does make it riskier than in the past, in my opinion,” he says, but “since they’re definitely contributing capital to this industry, they’ve concluded that it’s not too risky.”

Selling a hospital’s controlling interest to a private equity firm that aims to earn a tidy profit in a short time horizon may compromise a hospital with a faith-based or charitable mission, Mr. Kirshner says. “Generally speaking, for the trustees, there’s a lot of soul-searching that is done, one reason why it hasn’t been done much yet.”

However, Mr. Pilch of BDO maintains private equity ownership can allow for nonprofit hospitals and health systems to revert to nonprofit status and such an agreement to do so can be made prior to the deal’s closing to maintain the hospital’s mission. Furthermore, agreements can be made before the deal’s closing to maintain the hospital’s mission or even grant original operators commanding governance on some issues.

While nonprofit health systems currently have access to cost-effective capital through the issuance of municipal bonds, Mr. Buchanan notes Moody’s Investors Service downgraded $20 billion of debt in this sector last year. Lower credit ratings make it more difficult and expensive to issue tax-exempt bonds, and capital needs are great. Considering more than 60 percent of the downgrades occurred at hospitals with less than $500 million in top line revenue, and that Moody’s has maintained a negative credit outlook for nonprofit hospitals since 2008, Mr. Buchanan says private equity is likely to remain a consideration for nonprofits looking at partnership possibilities.

“CEOs, CFOs and boards should look at all partners and available sources of capital, assess them and make sure that any arrangements make sense for their hospital, their system and their communities,” Mr. Pilch says. “One size does not fit all. The decision needs to incorporate and address such questions as, ‘What is our strategy, what is our mission and what are we going to be?’

“I do believe private equity-backed firms can offer a viable model for nonprofits to consider. They can be a win-win opportunity where the nonprofit legacy continues to be involved post-transaction,” Mr. Pilch adds. “In many cases, the discipline operationally and capital-wise that’s brought by a private equity firm can be a major factor in keeping the system healthy and sustainable.”

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Most hospital CEOs realize how payment trends affect the surgery department. New payment models are making it more important than ever for hospital operating rooms to increase quality, improve outcomes and control costs. Few hospital leaders, however, understand how surgeon income impacts OR performance. The fact is that changes in surgeon economics will soon have a profound effect on OR revenue.

How? Surgeons have always been key to bringing business to the OR. Today they are also critical to helping ORs thrive under new quality-based payment models. Yet most surgeons are struggling financially in the current environment. Malpractice and clinic costs are escalating, and overall reimbursement is static or decreasing. Hospitals that fail to support surgeons will suffer a double hit — declining OR volume as surgeons move cases to competing facilities and declining payment as the OR struggles alone to address quality shortfalls.

What can hospital CEOs do to protect OR revenue? The first step is to understand how the current surgical services environment affects hospital ORs and their surgeon partners.
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The CMS Value-Based Purchasing program will expand its use of surgical quality metrics in calculating base DRG bonuses and penalties. How VBP Affects the OR

Representatives from anesthesia, nursing and hospital administration. OR. An effective SSEC is led by surgeons and includes representatives from anesthesiology, surgery and hospital administration. How can hospitals harness that management and clinical synergies? Many hospitals have established effective surgeon leadership to optimize clinical safety and outcomes. New Medicare programs are putting ORs on the hook for surgical complications and poor patient outcomes. One core solution is to build quality into the system through standardized preoperative processes.

1. Involve surgeons in OR leadership

Surgeon demands for schedule access, rich staffing and new technology have helped create costly ORs. Yet surgeon-owned ambulatory surgery centers prove that surgeons can run lean, cost-efficient surgery organizations. How can hospitals harness that management skill? Many hospitals have established effective surgeon leadership by creating a surgical services executive committee.

Think of an SSEC as an operational “board of directors” for the OR. An effective SSEC is led by surgeons and includes representatives from anesthesia, nursing and hospital administration. Its mission is to manage OR access, improve OR operations and optimize clinical safety and outcomes.

Hospital CEOs often fear the idea of a surgeon committee running the OR. Will it become just a forum for new demands and increased headaches? These fears are unfounded. Surgeons welcome the opportunity to take greater responsibility for the OR, and well-designed SSECs conscientiously work to optimize department efficiency, resource use, clinical quality and overall financial performance.

2. Create an efficient work environment for surgeons

Surgeons want to be able to access the OR schedule when needed, start their day on time, provide high-quality care and be as productive as possible. At the same time, hospitals need to make the most efficient use of the OR.

In most hospitals, the top priority is to restructure the block schedule system. Block system reform can be complex, but two principles are key:

- Shorter blocks (four to six hours) are less efficient than longer blocks (eight or more hours). Longer blocks maximize efficiency in a vertical manner by creating consistency in the labor and non-labor resources required to improve overall productivity.
- Utilization thresholds are imperative. Most ORs do not require surgeons to use assigned block time efficiently. Well-run ORs set a utilization threshold of 75 to 85 percent as the requirement for maintaining ownership of a block.

Other block system changes help ensure schedule flexibility. In addition, ORs need to examine nursing processes to ensure strong clinical support and efficient turnover. Data-driven decision making is critical to productivity — key stakeholders should have access to clear and transparent performance dashboards and operational metrics. Taken together, these schedule and process improvements allow surgeons to maximize their case volume, sustain their income and improve their lifestyle through greater predictability. They also ensure the optimal use of the hospital’s expensive OR resources.

3. Build quality into the system

New payment models are putting ORs on the hook for surgical complications and poor patient outcomes. One core solution is to build quality into the system through standardized preoperative processes.

How VBP Affects the OR

The CMS Value-Based Purchasing program will expand its use of surgical quality metrics in calculating base DRG bonuses and penalties.

<table>
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<tr>
<th>Year</th>
<th>Surgery-Sensitive Elements</th>
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<td>2013</td>
<td>Calculation includes seven Surgical Care Improvement Project measures, including prophylaxis for infections, blood clots and other surgical complications</td>
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<tr>
<td>2014</td>
<td>Will add outcome measures such as 30-day acute myocardial infarction mortality (includes both surgical and non-surgical patients)</td>
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<tr>
<td>2015</td>
<td>Will incorporate a composite patient safety measure that includes deep vein thromboses, pulmonary embolisms, sepsis and surgical wound dehiscence</td>
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Single-path scheduling. In many ORs, the case scheduling process is disorganized and inefficient. OR staff and surgeons fail to capture complete information on patients for scheduled procedures. Better-performing ORs create a “single pathway” for the scheduling process to ensure quality, remove variability and prevent errors. Develop a standardized fax form (or IT/IS module) with required fields for patient identifier, specific procedure information, patient comorbidities and other critical details. Standardized scheduling processes ensure that OR staff are able to identify and manage all patient risk factors ahead of surgery.

Pre-surgical testing. In most ORs, pre-surgical evaluation is incomplete, expensive or both. In better-performing hospitals, the SSEC creates pre-surgical testing and patient management protocols specific to disease, procedure, comorbidities and other risk factors. Integrating case management, anesthesia and hospitalists into pre-surgical processes is important to improving clinical outcomes. Well-designed testing and preparation protocols help ensure patients are optimized for their procedure and for a speedy recovery.

Daily huddle. In better-performing ORs, a multidisciplinary caregiver group takes 20 to 30 minutes every afternoon to review the next day’s schedule. The purpose of this “daily huddle” is to verify patient preparation, reschedule patients who are not ready for surgery and flag any potential problems with the schedule, equipment, etc. An effective huddle not only improves patient safety, it also reduces case delays and cancellations and ensures the schedule runs as smoothly as possible.

4. Create the systems and culture of safety
For the typical hospital, Medicare HAC penalties could amount to $250,000 or more per year. The key to avoiding errors and preventable complications is to embed safety in OR processes. Tackle the issue from several angles:

Checklists. Implementing the World Health Organization’s Surgical Safety Checklist as part of the universal safety protocols ensures that staff use safe processes 100 percent of the time. In many ORs, safety checklists have been instrumental in reducing sentinel events and improving quality metrics.

Crew resource management. Adapted from the aviation industry, CRM is a set of principles that support clear communication about risks. CRM flattens hierarchies and empowers all staff to take responsibility for patient safety.

Hospital surgery departments also need to foster a “just culture” focused on learning from mistakes, not assigning blame. Modeled by leadership, a just culture allows staff to be honest about quality lapses without finger-pointing and put energy into fixing broken processes. In addition, anonymous error reporting helps ensure that safety events are brought to light so that staff can identify root causes and prevent future recurrences.

Case Study: CarolinaEast
Implementing the four strategies described above can have a significant impact on both a hospital OR and its surgeon partners. CarolinaEast Health System runs a 12-room hospital OR (10 rooms currently operational) and a six-room outpatient surgery center in New Bern, N.C. In 2009, the surgical services department was facing declining case volume and high surgeon dissatisfaction.

In 2010, CarolinaEast took a series of steps to turn around OR performance. Interventions included creating a physician-led SSEC to run the OR, strengthening the block schedule system, creating a protocol-driven pre-admission testing center and implementing a daily huddle. The OR also implemented several safety initiatives.

In less than a year, OR utilization at CarolinaEast increased from 48 to 73 percent. After one year, average monthly case volume had increased approximately 8 percent. Better patient management and safety processes led to improved quality metrics. Patients were better prepared for surgery and length of stay decreased. From the surgeon perspective, schedule access and practice efficiency improved markedly. Surgeon complaints declined, and surgeons started steering more cases to the OR.

Financial synergy
Hospitals like CarolinaEast are well positioned to thrive in the evolving surgery market. Strong surgical quality metrics help maintain revenue under quality-driven payment models. In addition, higher utilization creates a leaner cost structure, enabling ORs to do well under shared savings arrangements.

Surgeons benefit as well. Many well-run ORs have leveraged quality gains to negotiate payer contractual bonuses for surgeons, and efficiency improvements allow surgeons to optimize their productivity. These gains reinforce surgeon satisfaction, engagement and loyalty, driving strong OR revenue and volume. ■

William Panza, MD, is a board-certified anesthesiologist who practices in New Bern, N.C. Dr. Panza is also a consultant with Surgical Directions, a physician-led consulting firm that helps hospital ORs improve clinical outcomes, financial performance and patient and staff satisfaction. Robert Dahl is senior vice president and chief operating officer at Surgical Directions. They can be reached at (312) 870-5600.
Executive Briefing: Specialty Hospitalists

5 Key Ways Specialty Hospitalists Help Hospital-Physician Relationships

By Anuja Vaidya

Hospitals are turning toward hospitalists to help them address physician shortages and ever-growing patient volumes in the inpatient setting. In fact, in 2012, hospitalists were found to be the second most-placed physician specialty, according to physician search company The Medicus Firm.

There are a number of reasons for the growing popularity of hospitalists. According to the Society of Hospital Medicine, hospitalists are physician and non-physician providers who provide medical care for acutely ill patients in a hospital setting. They are generally trained in internal medicine, general pediatrics or family medicine.

Specialty hospitalists, however, are surgical specialists who work exclusively in the hospital setting, taking care of patients in need of emergent and urgent care, according to Gene Krumanocker, COO of Delphi of TeamHealth, a hospitalist physician staffing firm. Delphi of TeamHealth specializes in hospitalists providing orthopedics, general surgery and obstetrics and gynecology services. Specialty hospitalists are typically on-call 24 hours a day and provide emergency department call coverage for their specialty. They also perform surgeries, provide postoperative follow-up and provide inpatient consults.

For hospitals, Mr. Krumanocker says contracting specialty hospitalists has obvious advantages, the largest one being in-
Increasing the satisfaction of physicians who have privileges at the hospital and also have private practices. Another advantage is that the hospital can ensure a specialist is always accessible to ED patients. Contracting specialty hospitalists also acts as an effective tool for recruiting private practice physicians. Specialty hospitalists can help reduce the number of hours physicians with privileges have to be on-call at the ED, allowing the physicians to concentrate on their practices, says Kurt Ehlert, national medical director for orthopedic surgery at Delphi of TeamHealth.

While specialists in private practice sometimes resist the idea of bringing in specialty hospitalists, the resistance evaporates once they see the benefits, says Andrew Lin, national medical director for OB-GYN services at Delphi of TeamHealth. Some of them are afraid of facing competition, and some are wary of losing revenue from not being on-call in the ED, but these fears end up being largely unfounded, says Dr. Ehlert.

There are five key ways in which specialty hospitalists help private practice physicians, and this can help hospitals recruit and retain them:

1. Remove the burden of ED calls. “Specialty hospitalists help private physicians by relieving them of the burden of ED calls, which can be very unpredictable,” says Mr. Krumanocker. They can focus on their own practices and scheduled surgeries without worrying about responding to an ED call, which usually allows them to grow their own practice. “Most private practices experience overall growth after being relieved of ED calls,” adds Mr. Krumanocker.
2. Allow private practice physicians more time at home. Specialty hospitalists take on more ED call time, because of which hospitals do not need to depend on private practice physicians for ED call duties. This gives private practice physicians more free time, which they often elect to spend at home. Having enough time with their family is particularly important for younger physicians, says Dr. Lin, and having a specialty hospitalist program in place may, in fact, help hospitals recruit younger physicians. The fact that physicians do not have to be on-call in the ED due to the presence of specialty hospitalists could become an effective recruiting tool for the hospital, adds Mr. Krumonocker.

3. Help private practice physicians ensure better care for their patients. According to Dr. Lin, specialty hospitalists can enhance patient safety since they can step in and take care of a patient until the private practice physician arrives. This is particularly true in the case of labor and delivery, where patients sometimes need to deliver quickly, he says. Given the fact that most hospital EDs have to deal with high patient volumes and high-acuity cases, hospitalists can provide invaluable services in helping ensure the safety of patients.

4. Allow private practice physicians to focus on their primary interest. As the trend toward sub-specialization continues, private practice physicians sometimes lose interest in general procedures, says Mr. Krumonocker. Procedures involving fractures, for example, are the most common procedures performed by orthopedic hospitalists, he says. Many physicians are more comfortable performing procedures only within their own subspecialty, and specialty hospitalists can help them do so by taking over the fracture procedures, says Dr. Ehlert.

5. Help combat physician shortages. Only 4.8 percent of physicians practice in rural areas, according to a study by researchers at the George Washington University School of Public Health and Health Services. It is harder to retain or recruit physicians in smaller areas, says Dr. Lin, and in communities where hospitalists can help ensure the safety of patients.
where physician shortages exist, specialty hospitalists can reduce the pressure local private practice physicians face to fill the void in the ED. A specialty hospitalist program can also keep an ED from going uncovered in specialties or services for which physician shortages exist, says Mr. Krumanocker.

The presence of specialty hospitalists proves to be advantageous for private practice physicians, resulting in a positive situation for both hospitals and their physicians. Having private practice physicians and specialty hospitalists work together at a hospital is an ideal model, and one that will hopefully become a standard of care in the future, says Dr. Lin.

Specialty hospitalists help private physicians by relieving them of the burden of ED calls, which can be very unpredictable”

— Gene Krumanocker, COO, Delphi of TeamHealth

TeamHealth (Knoxville, Tenn.) (NYSE: TMH) is one of the largest providers of outsourced physician staffing solutions for hospitals in the United States. Through its 18 affiliated regional locations and multiple service lines, TeamHealth’s approximately 8,900 affiliated healthcare professionals provide emergency medicine, hospital medicine, anesthesia, urgent care, and pediatric staffing and management services to approximately 800 civilian and military hospitals, clinics, and physician groups in 47 states. The term “TeamHealth” as used throughout this release includes Team Health, Inc., and all of its related entities, divisions, subsidiaries and affiliated physicians and physician groups. For more information about TeamHealth, visit www.teamhealth.com.
A Look Into the Pressing Need for Health IT Talent

By Anuja Vaidya

With the increase in the adoption and use of health information technology, the demand for skilled workers in the field has increased exponentially. The Bureau of Labor Statistics states that more than 50,000 health IT-related jobs have been created since the enactment of the Health Information Technology for Economic and Clinical Health Act in 2009, according to a fact sheet released in April by CMS and the Office of the National Coordinator for Health Information Technology.

However, there aren’t enough people with the requisite experience and skills to take on these jobs, says Dan Garrett, U.S. healthcare IT practice leader with PwC. Sixty-seven percent of healthcare providers report experiencing IT staff shortages in their organizations, according to a report by PwC’s Health Research Institute released in March.

This shortage of health IT talent is not only slowing down the basic adoption of electronic health records and other technology, but is also leaving the industry lagging with respect to data analysis. According to Paul Browne, CIO and senior vice president of applied clinical informatics for Dallas-based Tenet Healthcare, most healthcare providers are just scratching the surface as far as analyzing data is concerned, and the industry hasn’t reached the value proposition of health IT systems as quickly as it had anticipated.

The issue at present

According to Mr. Browne, part of the problem of filling health IT-related positions is that every healthcare organization is fishing from the same talent pool. Healthcare is a complex industry, and it is difficult to take people with no prior experience in the field and train them in the workflow of health IT systems. “There is no substitute for having worked in a hospital, physician office or a long-term-care facility,” he says. “You can train or mentor them, but part of their skills and expertise is simply the seasoning that comes from working in a healthcare facility.”

Another issue is that healthcare organizations need skilled professionals to maintain the IT systems that are already in place as well those who can update and upgrade those systems. The industry “needs workers with a wide variety of skills,” says Mr. Browne. The government’s meaningful use requirements will continue to focus on demonstrating how the technology is being used, and how the technology is impacting certain quality measures, he says.

The four most important skills to achieve healthcare providers’ IT priorities are clinical informatics, systems and data integration, technology and architecture support and data statistics and analytics, according to the report by PwC released in March. “We need people who can unlock data and create value from that data,” says Mr. Garrett. “We need people who can help increase positive outcomes.”

What healthcare organizations can do

The need for skilled professionals who can help healthcare organizations meet their goals of improving quality and meeting regulatory requirements is going to increase. Healthcare organizations need to find a way to mitigate the lack of skilled IT talent. Here is a two-pronged approach that organizations can take.

1. Create a talent development team.

   Mr. Garrett says that putting together a talent development team that fosters partnerships with outside institutions and engages in IT talent transfer is key.

   This is the tactic that Tenet is employing, says Mr. Browne. “We are looking to third-party organizations, such as Cerner and Dell, to help provide talent to us, and we have an active dialogue with them to find the right people to meet our needs,” he says.

2. Retain current health IT talent.

   Given the fact that most healthcare organizations are fishing for talent from the same pool of limited professionals, it is essential that they hang on to the IT staff that they have. The primary thing is to continue to stress the importance of their work, and how their work has an impact on patients and their families, says Mr. Browne. Mr. Garrett also says that connecting the work that IT professionals do to the mission of delivering healthcare helps generate a more rewarding role for them. “People want the opportunity to make a difference,” he says. “If you give people that opportunity you will see the results in your retention.”

   Another way to retain health IT talent is to create an environment where it can learn and grow, says Mr. Browne. At Tenet, health IT professionals are given the opportunity to have different experiences in different facilities so that they can build expertise. Tenet has also created a structured development program for its clinical informaticists, which includes career progression, skills identification and skills development. Also, ensure that health IT talent is compensated appropriately, adds Mr. Browne, so that employees feel valued for the work that they put in.

With the healthcare industry rapidly aligning itself with health IT, the need for professionals with IT-specific skills is at an all time high. While the lack of skilled talent is a problem at present, it is not an insurmountable one, provided that healthcare organizations work at building teams of health IT professionals and retaining those they have at present.

Report: Telemedicine Patients More Likely to be Urban, Affluent, Educated

By Helen Gregg

Telemedicine users are more likely to have college degrees, be relatively affluent and live in an urban area, according to a report released by the National Telecommunications and Information Administration.

About 8 percent of Internet users in urban areas have used telemedicine services, compared with 4 percent in rural areas. Telemedicine users are also five times more likely to hold a college degree (10 percent) than not have finished high school (2 percent). Additionally, 11 percent of Internet users living in households with annual incomes above $100,000 have engaged in telemedicine activities, almost three times the usage rate of those living in households making under $25,000 (4 percent).

Researchers note that the low overall usage rates show telemedicine is still in its infancy.
A few hospitals are beginning to train their employed physicians to “sell” the hospital, which involves asking referring doctors in the community to send patients their way. It’s an intriguing idea, and I’m not really sure it’s going to work, but the pressure to bring doctors into sales is mounting. Hospitals depend on admissions by primary care physicians, and future prospects are uncertain.

The new health insurance exchanges and state Medicare expansions that start next year could bring a tidal wave of new hospital patients — or maybe not. And all the while, payers are trying to pare back admissions.

Hospitals need a way to keep admissions flowing. It used to be that there were a lot of opportunities to reach out to referring physicians. When they came to the hospital to see their patients, the staff had a chance to tell these physicians about a new CT scanner or service line. Then these physicians would go to the doctors’ lounge and chat with other doctors on staff, who would tell them about all the great specialty services.

But in a lot of hospitals this doesn’t happen. Now hospitalists see the patients, and the referring physician doesn’t come by any more. A crucial communications link has been severed, and hospitals are trying to find ways to restore it.

One tactic is to hire former drug and device reps to visit referring doctors and sell the hospital, just as they used to sell drugs and devices. In 2011, USA Today reported that HCA, Tenet and even the University of Chicago Medical Center were doing this. Tenet told the newspaper that it had doubled its sales force to doctors in the past two years and had increased its base of actively referring doctors by 39 percent.

But these non-physician sales people have limited entry into the physician’s office. They cannot match the doctors, who can comfortably chat with their colleagues, just like in the doctor’s lounge. Also, why pay sales people for this work when hospitals have a growing cadre of employed physicians who could be assigned a few sales duties?

Many doctors, I’m sure, wouldn’t be thrilled with this new assignment. I can just hear them say, “I didn’t go to medical school to be a salesman!” Salesmanship is what other people have to do — drug reps, car dealers, computer companies, restaurants, retail stores — in short, all the rest of us!

But the fact is that doctors and the whole world of healthcare would greatly benefit from sales skills. The heart of great salesmanship is great customer service, and that notion of customer service is sorely lacking in healthcare today.

Some of the worst customer service around can be found in our hospitals and medical practices: inattentive and sometimes rude staff, long waits to get care and then scanty attention when it finally does come. In the rest of the economy, the customer is king, but not in healthcare.

Customer service lies at the core of salesmanship. The Business Dictionary defines salesmanship as satisfying customer needs through a sincere and mutually beneficial process aimed at a long-term relationship. Physicians already have a word for this; it’s called “bedside manner.” All doctors want to have a bedside manner, even if they don’t always quite get there. This means recognizing that the patient — the customer — should always come first.

Physicians should strive to improve their customer service, but will they become great sales people? The jury is still out.

There are a lot of reasons why physicians should get involved in sales. Since they’re peers of the target customers — physicians who could admit more patients to the hospital — they have a kind of access that a sales person would give his eye teeth for. And they definitely understand their customers. They walk in their shoes. They know the clinical challenges, the ins and outs of referrals and the personal pressures these doctors face.

Also, many physicians are very good listeners, which is one of the most effective skills a sales person possesses. When you listen — I mean really listen — to prospective customers, you get all kinds of hints about their needs and what you would need to do to win them over.

There are also many problems, of course, with using physicians as salespeople.

First, physicians are not your typical employees. They spend most of their time seeing patients, doing surgery or providing follow-up care at locations that are often removed from the hospital. Asking them to talk to other physicians takes valuable time away from their core work.

Second, those physicians who have a bad opinion of salesmanship will be set up to fail. When a person who hates to sell meets a person who hates to be sold, it’s a very awkward and messy situation, and nobody wins.

Third, some doctors do not possess the innate talents needed to be good at sales. A sales person needs to have great people skills, but doctors spent their formative years studying, away from people, and some of them never got over that.

Of course, some doctors are extremely outgoing and friendly and are motivated to be great sales people. They understand the need for salesmanship and its notions of good customer service.

I met one of them recently at a meeting in Boston. He gave one of the most enthralling and motivational talks I’ve ever heard. This doctor said we are entering a new era in medicine — one in which physicians will be expected to think of patients as customers, just as anyone operating a business has to do. He said patients must be treated with dignity and respect — not only clinically, but also in the way they are greeted, the way they are listened to, in the food they are served and in their total experience before, during and after they leave the hospital.

However, as I stated before, having to sell means taking a step beyond providing good customer service. I have been a salesman, and I can tell you it requires a special set of skills, including knowing when to open the deal, learning to pick up subtle cues from your potential customer and knowing when to close the deal.

Here are some pointers for a hospital that might want to launch a successful physician sales campaign:

1. Identify physicians with the talent and inclination for sales. Probably the only people who could identify these doctors are those who have actually worked in sales and have been successful at it. You would have to know the traits of solid selling to know who could do it.

2. Help them appreciate the role of a sales person. People who hate sales are usually thinking of “black hat” sales, where the sole aim is to strong-arm prospects into buying something they don’t really want. But a truly effective salesperson tries to find out what the potential client needs and then address that need.

3. Train them in small groups. Many physicians are articulate, bright and have aggressive personalities. They are capable of picking up the rudiments of selling very easily. But even these physicians are still diamonds in the rough. They will need personal, individualized mentoring by sales professionals.
4. **Teach them about body language.** How you comport yourself, including eye contact, seems like a little thing, but it can make all the difference between success and failure. Good eye contact shows that you have respect for the person you are selling to and what they are saying. This is critical in a sales situation! Unfortunately, many physicians start turning to their computers after making initial eye contact, never to look back again! I hear this complaint all the time.

5. **Help them with speaking skills.** The art of selling involves speaking clearly and succinctly without a lot of excess verbiage. No one, particularly a fellow physician, has time to waste on someone who cannot get to the point right away. Being able to tell your story quickly and thoroughly shows respect for the other person.

6. **Have them practice in a mirror.** Practicing what to say to a prospect shows respect for the other person. Be prepared to know the information you will give the prospect in detail. It is not easy to be successful with this. Not only do you need to have a favorable attitude toward sales, but you also have to realize that it’s much harder than it looks. It takes dedication, an outgoing attitude and a willingness to learn.

**Chuck Lauer (chuckspaker30@aol.com) was publisher of Modern Healthcare for 33 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide.**

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### Hospital & Health System Transactions

Downers Grove, Ill.-based Advocate Health Care officially added Elgin, Ill.-based Sherman Hospital, now called Advocate Sherman Hospital, as its eleventh acute-care hospital.

Board members of Alameda (Calif.) Hospital signed a letter of intent to merge with Oakland, Calif.-based public network Alameda Health System.

The City Council of Ashland, Ore., unanimously voted to approve Medford, Ore.-based Health System, now called Asante’s takeover of Ashland Community Hospital, closing a two-year negotiation process.

Dallas-based Baylor Health Care System signed a definitive agreement to merge with Scott & White Healthcare, based in Temple, Texas, to form a new entity to be called Baylor Scott & White Health with a subsidiary service company called Baylor Scott & White Health Service.

Bell Hospital, a 25-bed critical access hospital based in Ishpeming, Mich., signed a definitive agreement to be acquired by Brentwood, Tenn.-based LifePoint Hospitals.

Since the two cash-strapped, New York systems signed a memorandum of understanding to merge in February, The Brooklyn Hospital Center and Interfaith Medical Center, also in Brooklyn, made little progress toward closing the deal, indicating it may never happen.

Elyria, Ohio-based EMH Healthcare may soon merge with Cleveland-based University Hospitals, as the two health systems signed a letter of intent to integrate.

Mishawaka, Ind.-based Franciscan Alliance is accepting prospective partners to acquire or form a joint venture with Franciscan St. James Health, a health system with hospitals based in Chicago Heights, Ill., and Olympia Fields, Ill., and hopes to enter exclusive negotiations this year.

Glendive (Mont.) Medical Center and Billings (Mont.) Clinic officially signed an affiliation agreement.

Grenada (Miss.) Lake Medical Center board members met with officials from Jackson-based University of Mississippi Medical Center to discuss a lease proposal.

Naples, Fla.-based Health Management Associates signed a letter of intent to lease Munroe Regional Medical Center, a 421-bed public hospital in Ocala, Fla.

Pittsburgh-based health insurer Highmark is one step closer to expanding its new integrated delivery network, as the Orphan’s Court of Erie County approved the proposed affiliation between Eric, Pa.-based Saint Vincent Health System and Allegheny Health Network.

Warner Robins, Ga.-based Houston Healthcare and Macon-based The Medical Center of Central Georgia will partner in a formal affiliation while retaining their independence.

New London, Conn.-based Lawrence + Memorial Hospital finalized its acquisition of financially flailing The Westerly (R.I.) Hospital, ending a year and a half of hurdles the ownership deal faced.

Lewistown (Pa.) Hospital and Danville, Pa.-based Geisinger Health System signed a definitive agreement to merge.

The Owosso, Mich.-based Memorial Healthcare board of trustees voted unanimously to cancel its request for proposal agreements with three other Michigan health systems in favor of reviving the terms of the existing RFPs to be less restrictive and attract more potential partners.

Ohio State University Wexner Medical Center and Mount Carmel Health System, both based in Columbus, Ohio, signed an affiliation agreement that will allow the two health systems to work more closely on clinical care and improve care coordination in the area.

OhioHealth continues to expand its footprint in the Buckeye State, as the Columbus-based health system and Athens, Ohio-based O’Bleness Health System signed a memorandum of understanding for O’Bleness to merge with OhioHealth.

Terms of a proposed lease of Paynesville (Minn.) Area Health Care System by St. Cloud, Minn.-based CentraCare Health gained attention at a Paynesville board meeting.

Chicago-based Presence Health plans to expand its footprint in Illinois, as the Catholic health system signed a letter of intent to form an affiliation with Iroquois Memorial Hospital in Watseka, Ill.

A new for-profit hospital company is making its way into New Jersey, as Santa Ana, Calif.-based Prospect Medical Holdings and Perth Amboy, N.J.-based Raritan Bay Medical Center signed a nonbinding letter of intent to join.

Brookton, Mass.-based Signature Healthcare signed off on a partnership between its Brockton Hospital and Beth Israel Deaconess Medical Center in Boston.

Somerset Medical Center in Somerville, N.J., entered merger discussions with the New Brunswick, N.J.-based Robert Wood Johnson University Hospital.

Hartford, Conn.-based St. Francis Care allowed its letter of intent to integrate with St. Louis-based Ascension Health Care Network to expire.

Victory Healthcare, a for-profit community medical center firm based in The Woodlands, Texas, will lease property to reopen and operate The Hospital at Craig Ranch, a 24-bed surgical hospital in McKinney, Texas.
Longview, Texas-based Good Shepherd Health System announced the appointment of Steve Altmiller as president and CEO.

Ketchikan (Alaska) Medical Center announced the August resignation of CEO Patrick Branco.

Howard County General Hospital in Columbia, Md., announced that CEO Victor A. Broccoli will retire on Jan. 15, 2014.

Ashley Regional Medical Center in Vernal, Utah, part of Brentwood, Tenn.-based LifePoint Hospitals, announced that Ben Cluff was appointed its new CEO, effective July 15.

The American Medical Association announced that Ardis Dee Hoven, MD, will serve as the 168th president of the association.

San Joaquin Community Hospital in Bakersfield, Calif., part of Roseville, Calif.-based Adventist Health, named Doug Duffield as president and CEO.

Salem, Va.-based LewisGale Regional Health System president Victor Giovanetti will resign effective July 2013.

Dian Powell stepped down from her role as president and CEO of Roseland Community Hospital in Chicago after hospital officials said she wrongly blamed the state for Roseland’s financial problems.

Plano, Texas-based LHP Hospital Group announced that Daniel R. Ordyna will join its Portneuf Medical Center in Pocatello, Idaho, as CEO.

John Sheehan, COO of UnityPoint Health-St. Luke’s Hospital in Cedar Rapids, Iowa, was appointed CEO of UW Health at the American Center in Madison, Wis.

San Antonio-based CHRISTUS Santa Rosa Health System announced the appointment of Ken Haynes as COO, effective July 1.

Thomas Jefferson University Hospitals System in Philadelphia announced that Stephen K. Klasko, MD, was named president and CEO of the system and president of Thomas Jefferson University in Philadelphia.

Salinas Valley Memorial Healthcare System in Salinas, Calif., announced the appointment of Augustine Lopez as CFO.

Rancho Springs Medical Center in Murrieta, Calif., appointed Brad Neet CEO.

Rockville Center, N.Y.-based Catholic Health Services appointed Dennis Verzi as the system's first COO.

Riley Hospital for Children at Indiana University Health in Indianapolis named Russell Williams COO.

Lakewood Ranch (Fla.) Medical Center CEO Jim Wilson retired.

EASTAR Health System in Muskogee, Okla., announced the appointment of Anthony R. Young as CEO, effective June 17.
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