The mistakes your hospital is making now may cripple its chances of thriving under healthcare reform and future care delivery requirements. Many of these blunders stem from a lack of urgency to impending policies and penalties. For instance, reform will alter the way a hospital needs to evaluate and forecast financially, along with how physicians, administrators and staff need to interact. Here are eight mistakes your hospital should prevent or repair — stat.

1. Not forecasting correctly. One of the biggest mistakes hospitals can make is to forecast or evaluate incorrectly. In the wake of reform, hospitals should be applying both historical evaluations and new models to predict the future. Failure to do so can lead to financial troubles and missed opportunities. 

2. Underestimating the impact of healthcare reform. Hospitals often underestimate the significance of healthcare reform on their operations. With changes in reimbursement and the growth of ACOs, hospitals need to adjust their strategies to remain competitive.

3. Inadequate preparation for changes in provider status. As physicians become employed by hospitals, the needs of healthcare leadership are shifting. Leaders must adapt to these changes to ensure successful integration.

4. Neglecting the importance of data analytics. Data analytics can provide valuable insights into patient care and financial performance. Hospitals that fail to leverage these tools are at a disadvantage.

5. Insufficient focus on patient experience. Patient satisfaction is becoming increasingly important in the healthcare industry. Hospitals that do not prioritize patient experience risk losing market share and revenue.

6. Overlooking the role of technology. Technology is a critical component of modern healthcare. Hospitals that fail to invest in the right technology may struggle to keep up with the competition.

7. Inadequate planning for hospital closures. In some cases, hospital closures are necessary. However, hospitals that do not plan for these events can face significant financial and reputational challenges.

8. Ignoring the impact of the Affordable Care Act. The Affordable Care Act has had a significant impact on healthcare. Hospitals that do not understand its implications may struggle to adapt.

By Molly Gamble

continued on page 13
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Publisher’s Letter
11 Questions for 2011; Register for the Becker’s Hospital Review Annual Meeting

11 questions for 2011
Here are 11 questions and uncertainties hospital and healthcare leaders will face this year:

1) Will healthcare reform be repealed, revised, and/or implemented?
2) Will there be further consolidation amongst commercial insurers?
3) Will there be significant growth in hospital systems’ commercial payor shared savings and ACO type arrangements?
4) Will there be a continuation or cresting in employment of physicians by hospitals?
5) Will more independent hospitals merge into systems? If so, how extensive will the consolidation be?
6) Will Community Health Systems take over Tenet?
7) How many federal investigations and settlements will evolve as to False Claims, under-billing, RACs, Fraud and Abuse and Stark?
8) Will hospital profits in the aggregate rise or fall in 2011?
9) What will happen with the following five key service areas: cardiology, oncology, neurosurgery, orthopedics and imaging?
10) What new service lines will hospitals profit from?
11) Which areas will hospitals struggle to profit in?

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7 Keys to Developing a World Class Oncology Program

By Molly Gamble

The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins was one of 30 oncology programs recently featured in Beeker's Hospital Review for exceptional cancer research, care and treatment. Terry Langbaum, chief administrative officer of the Kimmel Cancer Center, shares seven characteristics that make the program outstanding.

1. Remarkably focused sub-specializations in cancer diagnostics and pathology. The Kimmel Cancer Center’s sub-specialities in cancer diagnostics and pathology are extremely narrow and specific, with specialists focusing exclusively on certain types of cancer, such as those of the breast or prostate. This has sharpened the staff’s diagnostic abilities, allowing radiologists, for example, to look at a CT scan and tell whether cancer has metastasized in the most subtle of ways. “When you put all that expertise into one place, you end up with better diagnostics and staging, which results in a better treatment plan,” says Ms. Langbaum. A better treatment plan is also one that is more efficient. “That will result in lower cost and better outcomes for the patient,” says Ms. Langbaum.

2. Multiple sets of eyes and minds treating each case. There is power in the number of staff involved in patient care at the Johns Hopkins Kimmel Cancer Center. Due to the fact that it’s a teaching institution, layers of medical professionals are training, learning and participating in the daily activities of the center. For example, there is often more than one technician on a diagnostic machine or piece of radiation equipment, says Ms. Langbaum. Chemotherapy dosages are checked by multiple pharmacists and technicians before ever leaving the pharmacy, and patients often receive the care of an attending physician, fellow, senior resident and junior resident. With multiple sets of eyes and brains, “these environments should be safer in terms of care delivery,” says Ms. Langbaum. Such rigorous enforcement of protocol and a team approach to cancer care can prevent mishaps as benign as a misspelling or as grave as a misdiagnosis.

3. A Comprehensive Cancer Center designation by the National Cancer Institute. There are 40 NCI-designated comprehensive cancer centers in the country, and the Johns Hopkins Kimmel Cancer Center was one of the first to receive that designation in the 1970s. To earn the designation and see its NCI CORE grant renewed, the Kimmel Cancer Center has demonstrated significant depth and breadth in laboratory, clinical and population-based research while providing community outreach. The Kimmel Comprehensive Cancer Center at Johns Hopkins is also a founding member of the National Comprehensive Cancer Center Network, a non-profit alliance of 21 of the world’s leading cancer centers. These centers are responsible for the NCCN Clinical Practice Guidelines, the recognized standard for clinical care in oncology. The guidelines have become the most widely used in oncology, and have been requested by cancer specialists in more than 115 countries.

4. The nursing staff is rigorously trained in oncology care. The Kimmel Cancer Center’s specialization extends beyond pathology and diagnostics to the training and experience of its staff. There are more than 300 nurses, and all of them undergo six months of orientation, receiving intensive education and technical training in oncology before ever administering care independently. Since patients at the Kimmel Cancer Center often have rare and/or complex cancers, the patient population is of a higher acuity than many community hospitals, making the role of the nurse all the more crucial and, at times, challenging. While the center offers a palliative care team, Ms. Langbaum points out that it takes a unique person to want to work around patients who may not survive. “We are choosing people who both want to go into oncology and who have the aptitude and personality to go into it,” says Ms. Langbaum. “We never, ever have a complaint with nursing.”

5. Cancer is seen as a continuum with no room for weak spots. From the diagnostic phase where a patient is thinking “I might have cancer” to the death of a patient, the Kimmel Cancer Center has strengthened its expertise in every facet of diagnosis, treatment, patient care and research. “We’re striving for strength all along the continuum,” says Ms. Langbaum. To measure the quality of care offered at each phase, the staff of the Kimmel Cancer Center examines a variety of factors. They review treatment plans, comparing those from the Kimmel Cancer Center to others offered at community hospitals. The staff also reviews pathology reports to examine how many patients walked into the Kimmel Cancer Center with a diagnosis with which the center’s experts disagreed. “We look at our yearly survival rate compared to the National Cancer Database and compared to other NCI-designated centers. We look at our concordance to NCCN guidelines. You will never have 100 percent concordance, but you want 90 percent concordance or better,” says Ms. Langbaum. The Kimmel Cancer Center also considers Press Ganey surveys and seeks patient feedback and participation in new program planning.

6. Support services recognize patient needs that may not be clinical. The Kimmel Cancer Center extends cancer care beyond the confines of the facility, offering professional financial and social services to patients and families as well as educational opportunities, spiritual support and cancer counseling. The center makes a tremendous effort to alleviate additional burdens cancer patients may encounter. For example, the Hackerman-Patz Patient and Family Pavilion, a 39-suite hotel for adult cancer patients and their families, offers short-term and long-term housing for patients who may have traveled to receive care at Johns Hopkins. The pavilion was completed in Dec. 2008 and funded through philanthropy. The Kimmel Cancer Center also offers an image recovery program, which offers wigs, hats, skin and hair care to patients during cancer treatment.

7. The number and unique nature of clinical trials offered. The findings of Kimmel Cancer Center scientists have become the model for cancer care and research. In 2009, there were 325 therapeutic studies open to patient enrollment. The center also offers an extensive collection of research programs, including those in cancer biology, cancer immunology, cancer virology, female reproductive cancer and brain cancer. The Kimmel Cancer Center is a leader in the development of cancer vaccines, particularly those for cancer of the breast and pancreas. In 2006, the center’s investigators sequenced the cancer genome for colon and breast cancers particularly those for cancer of the breast and pancreas. In 2006, the center’s investigators sequenced the cancer genome for colon and breast cancers and have since developed blood tests to identify inherited genetic mutations that cause a cancer predisposition. The center is constantly releasing new developments in cancer research. In November, scientists identified a compound that could be used to starve cancers of their sugar-based building blocks and may have the potential to be used for many types of primary brain tumors.
Physician Employment & Beyond: The Current State of Physician Integration (continued from page 1)

The goal was to have hardy practitioners who could handle reduced reimbursements by setting up their own ancillary businesses, such as office-based testing, to supplement their income.

But times have changed. When Medicare began reducing reimbursements for office-based procedures, Mr. Crowther sharply changed course and came up with a new physician relationship. Called “systemness,” it involves working tightly together to prepare for accountable care organizations and other payment arrangements.

Many hospital executives like Mr. Crowther are seriously pursuing physician integration, hoping that working closely together can produce savings. They are embracing a variety of strategies, such as employing physicians and acquiring group practices, creating co-management roles for physicians and giving them greater say in governance of the organization.

In today’s fragmented delivery system, “there is tremendous value to hospitals working more collaboratively with physicians,” Mr. Crowther says. “It’s through a system that a hospital and physicians can leverage their experience, knowledge and strengths to achieve a greater good.”

Physician integration requires a profound cultural change for hospitals, says Allen Daugird, MD, a UNC Healthcare executive who is president of a new multispecialty practice for UNC’s employed physicians, called Triangle Physician Network. “There will be a change from a fee-for-service culture that stresses volume of services to a new culture that stresses outcomes and quality,” Dr. Daugird says.

**Employing physicians**

Hospitals are in full physician-hiring mode, and many physicians seem eager to accept. They are being driven to hospitals by lower reimbursements, calls for integration and new administrative requirements, such as installing electronic medical records. A recent PricewaterhouseCoopers survey found that 44 percent of physicians are already employed by some entity, from hospitals to group practices, and 46 percent are interested in pursuing this model in the next two years.

Dr. Daugird is planning for two-thirds of Triangle Physician Network’s employed physicians to be in primary care. “We need primary care physicians to make the system operate,” he says. Acquisitions also follow UNC’s expanding geographical base. “Originally we acquired practices in a 30-40 mile radius,” Dr. Daugird says. “Now our practices are in a 100-150 mile radius.”

Mr. Crowther says Northwest Community Hospital recently acquired Affinity Healthcare, the largest practice on staff at the hospital, with 42 physicians and clinicians in primary care. The PricewaterhouseCoopers survey found that physicians practicing in large groups are two to three times more likely to express interest in hospital alignment than solo practitioners. The survey also found that 63 percent of cardiologists and 48 percent of primary care physicians were interested in hospital employment.

**Beyond employment**

There are many downsides, however, to pursuing an employment strategy, says Mark Grube, managing director at Kaufman Hall in Skokie, Ill. Buying practices is very expensive and typically involves being locked into three-year contracts. He says hospitals have to make sure they are buying for value, instituting work-based payments that ensure employed physicians won’t lose money.

But that’s only the beginning. These practices have to be truly integrated with the hospital. “Just bringing physicians into the employment model won’t accomplish anything,” Mr. Grube says.
Physicians need to develop a common set of goals with the hospital. He advises providing bonus arrangements for compliance with defined protocols and working on quality, cost reduction and “good citizen” points. This may be a challenge. While the PricewaterhouseCoopers survey indicated many physicians seek unemployment, it also found that 20 percent of physicians did not trust hospitals and 57 percent “sometimes” did not trust hospitals.

Many hospitals are looking for relationships beyond employment to align with physicians. “For most organizations, multiple vehicles will be needed to increase the alignment of different segments of physicians,” executives from the consultancy firm of Kurt Salmon Associates wrote in an article for Becker's Hospital Review. “Few hospitals will have the luxury of successfully deploying only one or two alignment tools or structures to partner with all key specialty physicians.”

Co-management

Co-management and similar payment arrangements are catching on as alternatives to employment. The PricewaterhouseCoopers survey found that 24 percent of physicians are currently aligned in this model and 51 percent of physicians are interested in pursuing it over the next two years.

In a co-management arrangement, a physician or group of physicians is paid to carry out management work for the hospital. “Co-management agreements are a great way to align physicians who do not want to be employed by the hospital,” says Mary C. Reed, vice president of the Gateway Group in Cleveland, Ohio. She says the physicians have to be paid for actual work, but the work can include such duties as writing up protocols for establishing a physician-integration model.

“Co-management arrangements are a stepping stone to more expansive relationships, without resorting to physician employment, practice acquisition or other such intrusive endeavors,” wrote the Camden Group in an article for Becker's Hospital Review on Sept. 1, 2010. “They permit a hospital and physicians to work through issues on a small-scale.”

Management service organizations

Ms. Reed also recommends a management service organization as “an inexpensive way to work closely with physicians and win their loyalty.” In such arrangements, the hospital and practices share expenses for functions such as purchasing supplies, practice management services, some aspects of managed care contracting and electronic health records.

Helping physicians set up IT is a good way for a hospital to bring physicians into its system, Ms. Reed says. “EHRs can be very expensive for physicians, so they will appreciate a little help,” she says. Also, the physician becomes part of the hospital’s own EHR network, which is key to integration efforts. She says hospitals are allowed to subsidize physicians’ EMR purchases up to a certain percentage of the cost.

Mr. Crowther is starting to link physicians’ practices to Northwest Community’s EHR system, which was launched in 2004. The newly acquired Affinity Health practice has its own EHR system, which will be fully connected with the Northwest Community system by January. He says this experience will help the hospital connect with other EHR systems of private practices on staff after the Affinity connection is completed.

Governance model

Physicians can also be aligned with hospitals through new governance structures, as is taking place at 430-bed St. Joseph’s Hospital Health Center in Syracuse, N.Y. Kathryn Howe Ruscitto, currently executive vice president and soon to be president of St. Joseph’s, says the hospital has set up an ad hoc coordinating council, made up of physicians that participates in hospital decision-making separate from the hospital medical staff. The hospital recently put the new governance structure to the test by giving physicians a prominent role in compiling its new five-year strategic plan.

“Now that we’ve got the engagement piece correct, the other steps should flow naturally,” Ms. Ruscitto says.

At Northwest Community, Mr. Crowther oversees a similar arrangement, a joint operating committee, with six management people and six physicians. Meetings take place three times a month. Delving into quality and patient satisfaction, physicians become committed to influencing those numbers. “It’s a refreshing form of alignment,” Mr. Crowther says.

Ultimately, Ms. Ruscitto wants committees of physicians to create homegrown best practices of care, called templates, that would be used to coordinate care through the continuum. Applying these templates will require sophisticated IT systems, which St. Joseph’s is in the process of setting up. St. Joseph recently hired a cardiologist to be its director of informatics, and the hospital added 23 people to its IT staff.

The future

Much work still needs to be done. Hospitals and physicians are just beginning to set up bundled payment arrangements with private payors to test whether integration works, and Medicare ACOs are due to begin in 2012.

The ultimate test for each arrangement is whether it is truly integrated and can produce savings. “You can’t have a bunch of siloed provider systems,” Dr. Daugird says. “Physicians will have to sit down and map out an ideal process of care. They would need to create guidelines for care and follow best practices. They would need to be committed to communicating with each other.”

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forecasts of future financial and care delivery innovations to understand where service demand is headed. “Hospitals will need to evaluate historical trends as well as understand where care delivery is going as they move forward to measure broader utilization and cost of care,” says Steve Miff, PhD, VP & General Manager of Clinical Performance Management at Sg2, a healthcare analytics company in Skokie, Ill. With a focus on preventive care and reduced readmissions, hospitals need to reconfigure utilization and cost components, particularly since nearly 75 percent of costs are associated with inpatient stay, according to Dr. Miff.

The development of ACOs and episode-based bundled payments builds on the hospital’s need to understand inpatient and outpatient utilization for services. Technology (such as electronic health records), readmission reductions and outpatient disease management programs also need to be factored in to a hospital’s utilization and financial forecast. Hospitals should modify their evaluation models since traditional forecast models will not reveal the best opportunities for cost savings. Comprehensive forecasting models can be utilized to plan future facility and staffing requirements and analyze what services to contract for population and/or disease management models.

Typically, the vice president of strategic planning is responsible for the forecasting. “We anticipate they will consult and increasingly incorporate a clinical partner as well, like the chief medical officer,” says Dr. Miff. “If you’re trying to evaluate initiatives like reducing readmissions, you need insight from clinical partners to make those decisions.”

2. Not focusing on readmissions. Under healthcare reform, Medicare is deploying financial penalties for low-performance, unnecessary readmissions within 30 days after a congestive heart failure, pneumonia or heart attack admission. Four more diseases will be added to the roster in 2014. It’s easy for hospitals to have a false sense of reality or lack of urgency about how quickly these Medicare readmission penalties go into effect.

Dr. Miff, however, broke it down: the penalties go into effect in 2013, but they will actually begin in Oct. 2012 due to the fiscal year. The penalties will also be based on retrospective data from Oct. 2011. “So, all of a sudden, many hospitals are thinking, ‘Oh wow, we have 10 months to get this right,’” says Dr. Miff. In and of itself, it’s a mistake to have a diminished sense of urgency but particularly around the topic of readmissions since the penalties will be 1 percent of total Medicare reimbursement. This may cost anywhere from $600,000 to $1.2 million in the first year for an average-sized hospital, along with damage to its reputation. “I don’t think a lot of folks have really appreciated the complexity and urgency of it,” says Dr. Miff.

3. Not fully understanding the utilization, quality and cost of post-acute care environments. Post-acute care environments — such as skilled nursing homes, rehabilitation centers, home health services or discharge to home with outpatient physical therapy — need to be weighed and evaluated for their clinical worth as well as their cost, according to Dr. Miff. “Another question to ask is, once you send the patient to one of these centers, how many are coming back and how many are going home?” Unplanned patient returns may double your cost, according to Dr. Miff. The clinical component and cost of each option will become increasingly important as hospitals structure bundled payment programs or ACOs.

“If you’re not fully understanding the options or quality providers in that space, you won’t be able to manage it or have quality,” says Dr. Miff.

4. Ignoring the financial and operational implications of hospital-acquired conditions. HACs clearly have a clinical impact, but their operational and financial implications should not be ignored. A recent study found an average of 25 patient injuries per 100 admissions, including hospital acquired infections and other preventable harms. For cost-reduction purposes, hospitals should keep a close eye on their rates of HACs. The cost of patients with an HAC is anywhere between 100 and 200 percent more, according to Dr. Miff. Additionally, their length of stay tends to double.

5. Not balancing performance across multiple metrics. If performance isn’t balanced across multiple metrics, more problems may be created rather than solved. “More often than not, what we see is a strong initiative in one area only to negatively impact something else,” says Dr. Miff. An example of this imbalance is a hospital initiative to reduce staffing costs. Staffing costs may go down, but length of stay may spike and patient satisfaction may decline as a result.

Another initiative may be the reduction of length of stay. When this is executed without considering the impact to other hospital departments, readmissions may increase, which reflects improper management of coordinated care. “When you focus on the direct cost reduction elements, don’t ignore the impact it may have on the other clinical, operational or financial metrics,” says Dr. Miff.

6. Not focusing on the entire continuum of care — whether your hospital owns it or not. Most hospitals do not own every single piece involved in the continuum of care, but at same time, they need to manage it. Hospitals need to understand their utilization, help patients navigate the maze of care and focus on patient and disease coordination.

“Everybody is either being asked or is looking to take on more accountability. This can come in different flavors and sizes, with ACOs being the most complex and all-encompassing. But if you think about accountability in broader terms, such as bundled payments or medical home models, most health programs are taking on additional accountability. It’s relevant to everybody,” says Dr. Miff.

7. Tense relationships with physicians. The best way for hospitals to profit under ACO principles is by keeping people healthy, and hospitals need to have the efficiencies necessary to offer the best quality and results at a low cost. This requires hospital-physician relationships to become more cooperative. Hospitals also need to put effort into the recruitment of specialists, who can assist primary care delivery by ensuring the right diagnosis the first time, says Timothy Hobbs, MD, CEO of Community Physicians of Indiana in Indianapolis. Dr. Hobbs, who oversees a physician group consisting of more than 200 physicians in more than 70 practices, says specialists help eliminate misdiagnosis and unnecessary care.

Accountabilities are going to develop between physicians, meaning hospitals will need extremely cooperative, team-oriented physicians. “If you bring on a physician who is highly intelligent and skilled but extremely autonomous and won’t work with groups, that’s a disadvantage. What you want to do is find the best and brightest who will help you build your team,” says Dr. Hobbs.

8. Not addressing healthcare reform from the cultural perspective. A hospital may form the most intelligent, detailed plan to deal with healthcare reform, but culture may still eat strategy for lunch, according to Dr. Hobbs. With the focus shifted to healthcare continuums and accountability, hospitals will struggle if unable to execute teamwork with flying colors.

It sounds deceptively simple in theory, since cooperation was a skill many mastered in grade school, but changing a stubborn hospital culture may prove to be one of the most difficult parts of healthcare reform. Hospital administrators need to team up with physicians and other clinicians to establish shared leadership. “I can’t overemphasize this enough,” says Dr. Hobbs. “When you build teams to provide certain levels of care, there is a skill to that kind of teambuilding in itself. Teams don’t just happen.”
2. Hospital employees went on strike. Nurses and other hospital employees across the country went on strike throughout 2010, as contract negotiations between unions and hospitals continued without coming to agreement. Around 1,600 nurses at HCA-owned West Hills Hospital and Medical Center in Los Angeles, Los Robles Hospital and Medical Center in Thousand Oaks, Calif., and Riverside (Calif.) Community Hospital announced plans for a five-day strike beginning on Dec. 23, as SEIU Local 121RN and the hospitals found themselves unable to agree on nurse-to-patient staffing ratios. Around 340 service workers at McKenzie-Willamette Medical Center in Springfield, Ore., went on strike in November for 24 hours, following contention in contract negotiations over proposed changes to wages and benefits.

Harlem Hospital in New York City averted a planned 150-physician strike when it agreed to a new contract on Dec. 16, preventing the transfer of neurosurgery and rehabilitation departments to other hospitals and ensuring that no departments and divisions would be cut.

3. Executive compensation was questioned. As hospitals suffered from slashed budgets and declining volume, employees and the public questioned high executive salaries that seemed incongruous with hospital finances. California Attorney General Jerry Brown announced plans in mid-September to review local government salaries of more than $300,000 and seek legislative reform that would cap public salaries and eliminate pension loopholes, citing as an example the $800,000 in annual compensation paid to the chief administrator of a local hospital. University of California Los Angeles regents faced criticism in September for boosting the annual compensation of UCLA top executive David Feinberg, MD, by $410,000, while the university simultaneously raised employee contributions to its badly underfunded retirement plans.

Hospitals and health systems responded to salary attacks by defending the annual compensation of their top executives. ProMedica Health System, based in Toledo, Ohio, will also stop hiring smokers effective Jan. 1, 2011. If applicants declare they do not use tobacco but their post-offer screening is positive, they will not be hired. Applications who declare tobacco use, as well as those who do not pass the screening, may reapply for a position after 90 days.

ProMedica Health System, based in Toledo, Ohio, will also stop hiring smokers effective Jan. 1, 2011. If applicants declare they do not use tobacco but their post-offer screening is positive, they will not be hired. Applicants who declare tobacco use, as well as those who do not pass the screening, may reapply for a position after 90 days.

5. Hospitals decided to stop hiring smokers. More hospitals decided in 2010 to stop smokers from working at their facilities, according to various reports. Anna Jacques Hospital in Newburyport, Mass., started hiring only non-smokers on Thursday, Nov. 25. The ban is part of a three-step plan. Last year employees were banned from smoking on hospital property, and next year the ban will apply to patients and visitors as well. Starting at the beginning of the New Year, smokers need not apply at Saint Francis Medical Center in Cape Girardeau, Mo. Applicants will be tested for nicotine as part of a pre-employment screening. The hospital website’s “Current Openings” page now includes the nicotine-free hiring policy, to go into effect on Jan. 1. The policy will not affect current employees.

Independent physicians might consider the move to hospital employment for various reasons, including a more predictable income and case volume, better hospital reimbursements and a better work-life balance.

4. More physicians considered hospital employment. According to a 2010 Physicians Foundation Survey, only 26 percent of physicians plan to continue practicing as they have been for the next three years, and many are considering moves to other types of work or retirement. In 2010, 11 percent of physicians were planning to take hospital jobs over the next several years. A survey from the Medical Group Management Association found that 55 percent of practices that responded to its questionnaire were hospital-owned, compared to 50 percent in 2009 and 30 percent in 2003.

More hospitals decided to stop hiring smokers in 2010 to address concerns about workplace smoking and to comply with local smoking regulations. According to various reports, hospitals such as Anna Jacques Hospital in Newburyport, Mass., and Saint Francis Medical Center in Cape Girardeau, Mo., have implemented policies to hire only non-smokers.

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Rising Stars: 25 Healthcare Leaders Under Age 40

By Rachel Fields

Barry “Skipper” Bondurant, 35, joined Baptist Memorial Hospital–Tippton in Covington, Tenn., in 2008, as administrator and CEO.

Damond Boatwright, now 38, became CEO of Lee’s Summit Medical Center, an HCA hospital, in Nov. 2007.

Shane Brophy, 38, first joined Phoenix (Ariz.) Children’s Hospital in 2001 as a strategic planning consultant on the hospital’s turnaround team and now serves as chief strategy officer.

Jim Brown, 35, has served as CEO of Memorial Hermann Sugar Land (Texas) Hospital since June 2007.

Steven Burghart, 36, was appointed COO of Good Samaritan Medical Center in West Palm Beach, Fla., in Dec. 2010.

Jason DeSantis, now 33, serves as division chief information officer of University Hospitals in Cleveland, Ohio.

The St. Mary’s Medical Center administrative team chose its newest member — 35-year-old COO Josh DeTillo — in March 2010.

In his present role as CFO of North Shore Medical Center in Miami, Alex Fernandez, 30, is responsible for promoting the hospital’s mission and executing its strategic plan.

With over 10 years of healthcare leadership experience, Gabrielle Finley Hazle, 33, is responsible for the daily operations of a broad range of medical, surgical and ancillary services as COO of North Shore Medical Center FMC Campus.

At 31 years old, Emory Eastside Medical Center COO Dustin Greene is the youngest hospital chief operating officer in Georgia.

Kevin Joseph, MD, 36, served as interim president and CEO for UC Health West Chester Hospital in Ohio for five months before officially assuming the position in Sept. 2010.

Ben Koppelman, now 37, serves as president and CEO of 25-bed St. Joseph's Area Health Services in Park Rapids, Minn.

Michael K. Lauf, 39, was named president and CEO of the Cape Cod Healthcare System in Dec. 2010, making permanent his previous role as acting president and CEO.

In his current role as assistant vice president of New York City Health and Hospitals Corporation, Haru Okuda, MD, 38, is assisting with new training tools to Health and Hospital Corp.’s 11 acute-care facilities.

Adar Palis, 32, joined Harrison Medical Center in Bremerton, Wash., in 2002 as a network engineer and was later named CIO of the hospital in 2005, becoming the organization’s youngest executive at age 27.

Isaac Palmer, 34, was named COO of three-hospital Florida Hospital Heartland Division in Sebring, Fla., in 2007, after serving as CEO of Adventist Bolingbrook (Ill.) Hospital.

The 34-year-old Carrie O. Plietz, who serves as COO of Sutter Medical Center in Sacramento, Calif., is the 2010 recipient of the Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year, given by the American College of Healthcare Executives.

Kimberly Russo, 39, became COO of The George Washington University Hospital effective April 1, 2009, before which she served the hospital as associate administrator since Aug. 2004.

Jennifer Sinclair, 38, serves as CFO of St. Dominic Hospital in Jackson, Miss. She joined St. Dominic in 2001 as controller and then vice president before assuming the role of CFO.

As COO of HealthONE’s Rocky Mountain Hospital for Children at Presbyterian/St. Luke’s Medical Center in Denver, Colo., Matt Sogard, 31, assumes responsibility for planning and oversight of capital construction projects, including the construction of the new children’s facility on the P/SL campus, management of perioperative services and food and nutrition services and environmental services.

David Stark, 39, currently serves as president and COO of Blank Children's Hospital and executive vice president for Iowa Health–Des Moines.

Fort Hamilton (Ohio) Hospital, the ninth hospital member of Kettering Health Network in Dayton, Ohio, named Jennifer Swenson, 39, its new president on Nov. 19, 2010.

Winjie Tang Miao, 29, joined Texas Health Harris Methodist Hospital as its president in 2007, having worked for Texas Health Resources since 2000.

Nathan Tudor, 31, joined Otto Kaiser Memorial Hospital as CEO in Sept. 2010, having previously served as CEO of 20-bed Stonewall Memorial Hospital in Aspermont, Texas.

At 34, Faraaz Yousuf is one of the youngest top executives at HCA, serving as COO of Good Samaritan Hospital in San Jose, Calif. ■

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System Integration in 2011: Q&A With Gary Campbell, President and CEO of Centura Health

By Rachel Fields

G ary Campbell, president and CEO of Colorado-based Centura Health, discusses the task of leading an integrated health system in a changing industry.

Q: As pay-for-performance replaces fee-for-service, how does Centura plan to organize physicians to receive maximum payments for quality outcomes? How do physicians work together across specialties/hospitals to decrease cost without compromising quality?

Gary Campbell: Centura Health defines value as the confluence of cost, safety [and] quality, service and convenience. Optimal healthcare value requires integrated systems of care across the full continuum of health needs. Truly integrated systems of care in turn require physicians, hospitals, home care agencies, and other providers to be clinically, financially, and philosophically aligned. We believe the key to clinical alignment is an integrated electronic health record that serves pre-hospital, hospital and post-hospital providers.

Financial alignment is arguably easiest through employment of physicians and “ownership” of the continuum of care, but employing physicians is not always practical — nor is there a guarantee that employed physicians and “ownership” of the continuum of care, but employing physicians is not always practical — nor is there a guarantee that employed physicians will be motivated to find ways to reduce cost. We are very intent on fostering the development of patient-centered medical homes and other forms of accountable care organizations or integrated delivery networks as ways to organize ourselves to create integrated systems of care, but the organization structure is not nearly as important as the care processes themselves. We have a variety of efforts underway to work with physicians to identify, acquire and deploy those care processes that are critical to improve health-care value. One of our efforts is to use our multidisciplinary clinical effectiveness groups to identify and deploy standardized care processes that are proven to increase value to the patient.

Q: Centura Health operates 13 hospitals. How do those hospitals work together? What are the challenges in creating bridges between different hospitals, and how do you accomplish it?

GC: Centura Health was formed in 1995 to join the healthcare ministries of Catholic Health Initiatives and the Adventist Health System in Colorado. Over time, [our 13 hospitals and numerous operating entities] have started working collectively to apply a new and innovative way of thinking across the system.

One of the biggest changes has been moving from the mindset of owning and operating hospitals, long-term care facilities, and home care agencies to owning and operating systems of care that address the full continuum of health needs. Internally, we’ve implemented policies to encourage a shift from a singular focus on individual operating units to a much more integrated, holistic and patient-centered focus. Referred to as “disciplined entrepreneurship,” our policies call leaders throughout the organization to work together collaboratively. We align and coordinate our efforts through a process known as “Centurization,” which involves self-managed multidisciplinary teams, including representatives from all involved entities, who work together to create common standards and benchmarks, and ensure we are addressing the health needs of people across the state.

Q: You mentioned the use of EMR to achieve integration. What role does EMR play in achieving hospital integration, in your experience?

GC: Centura Health made the strategic decision to implement a standardized, integrated electronic health record in 2005. We began the journey with one goal in mind: to improve the overall delivery of care.

Early on in the implementation process, we started to see the first signs of integration with teams who had previously worked independently coming together to design our EHR. This inclusive process helped build a foundation of trust that was woven into the fabric of our culture, and as our hospitals went live on the EHR and patient data began to flow across the network, those same teams began talking to each other to leverage best practices to enhance the way we deliver care to our patients. Today, our physicians and clinicians compare clinical effectiveness between facilities and continue to collaborate to improve quality of care across our entire statewide network.

Q: What about rural hospitals? How do you integrate facilities with fewer resources and potentially fewer providers into your network?

GC: Outreach to rural areas is a key component of Centura Health 2020, [which is] our strategic plan that charts the course for the future of healthcare for all Coloradans. Through a clinical integration model, we connect rural partners with our systems of care to bring much-needed resources to their local communities. We operate specialty clinics in partnership with rural facilities, and in partnership with UnitedHealthcare, we recently launched a telehealth pilot project called Connected Care, aimed at delivering specialty care locally through state-of-the-art video technology.

We also work with rural hospitals to determine how strategic affiliations and service agreements between our organizations can expand the scope
of healthcare services offered in the region and enhance the health status of Coloradans. Our affiliations are designed to extend our systems of care into rural communities in a manner that ensures the right care is delivered at the right time and in the right place.

**Q:** What do you see as the most pressing challenges for system integration and alignment over the coming year? How do you plan to meet those?

**GC:** The first challenge is to understand the current environment and have a compelling vision for change. In early 2009, we convened 300 people in a four-month process that culminated in the creation of our plan for the future, called Centura Health 2020. Through this effort, we identified what we believe are the keys to reinvent healthcare delivery and optimize healthcare value across Colorado. Centura Health 2020 is our guide for system integration and alignment. We have planned our work, and now we are working our plan.

Our success in this regard is dependent upon healthcare providers and organizations, both within and outside of Centura Health, coming together to make Centura Health 2020 a reality. The keys are to build trust, think creatively, communicate effectively and keep our focus on the ultimate goal of greater healthcare value.

**GC:** What have been your biggest successes so far in terms of integration, and how did you accomplish those?

**Q:** Centura Health 2020 has become a critical part of our culture and a rallying cry for our own healthcare reform. The process of writing the new standards for how healthcare can and should look has inspired individual associates and physicians to reach higher, to be better and to do more. They feel empowered to help create the future. It’s not just about me, my department or my entity. It’s about how we are all connected across the state and across disciplines. We are encouraged, empowered, and challenged to look at healthcare from the consumer’s perspective. It’s not just about listening — it’s about anticipating. Best practices are shared across our network, from best ways to communicate to transference of clinical excellence, which raises the bar for all of us. It’s about providing the right care, at the right time, in the right place.

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8 Points on Hospital-Physician Integration

By Leigh Page

Catholic Health Initiatives is a faith-based system that includes 73 hospitals and operates in 19 states. Here Stephen L. Moore, MD, senior vice president and chief medical officer at the Denver-based health system, makes eight points about hospital-physician integration.

1. CHI is busy acquiring practices. In the past three years Catholic Health Initiatives has gone from 425 employed physicians to more than 1,500. Two of its past organizations have 350 employed physicians each. The system aims to double the number of employed physicians in the next 2-3 years and reach a level of more than 3,000 providers, including some non-physicians.

2. Integration has been a long-term trend. Physician integration is a well-known strategy for CHI and many other healthcare organizations. “Nationally, the trend toward physician integration is not all that new,” Dr. Moore says. “In the past 15-20 years, hospitals have been solidifying their physician referral base, in some cases aligning with an IDN health plan.” Lately, however, hospitals have seen more specialists wanting to discuss employment.

3. Physicians, hospitals driven closer together. Decreasing reimbursements are, by necessity, driving hospitals and physicians closer together. “We are seeing a perfect storm,” Dr. Moore says. “Both hospitals and physicians have experienced major changes in payments, with drastic decreases predicted to hit within the next 3 years and continuing through 2020.” Recently, cardiologists and oncologists in particular have been seeing large cutbacks in payments for office-based procedures.

4. CHI is progressing with alignment. Healthcare reform will likely increase incentives for physician-hospital alignment, but with no regulations out yet, the impact of reform is “still a little cloudy,” Dr. Moore says. While CHI waits for more specifics, the system is creating centers of physician alignment. “We are looking for care that is much more efficient, more protocol-driven,” he says. “As partners, we will need to drive variations in quality and outcomes out of the organization.”

5. Payment transition is awkward. Hospitals and physicians are transitioning to completely different payment arrangements that call for coordinated care and place less emphasis on the per-unit price. “Hospitals are in an extremely schizophrenic position right now,” Dr. Moore says. “They have one foot in the current payment model and the other in the next model.” Hospitals will be shifting to systems that emphasize population health and disease management.

6. Old “governance” model needs updating. Hospitals and physicians have related to each other through a “governance” model, created 100 years ago for credentialing and peer review. Because patients are sicker, care is more complex and physicians need to cooperate more closely with hospitals, this model alone will not address the new provider relationships necessary for care delivery.

7. Hospitals and physicians need a team approach. “You need a team approach in which the doctor works with other providers,” Dr. Moore says. One example of this is the multidisciplinary approach Johns Hopkins Hospital developed for its ICU. “Physicians, as leaders of the team, will play a guiding role as they transition from the more traditional model of ‘captain of the ship,’ “ he says.

8. Alternatives to employment. In addition to employment, hospitals are pushing for other arrangements such as co-management opportunities for current established practitioners on the medical staff who can manage leadership roles at hospitals. “Within our contracts with hospital-based specialists, we’re looking at increasing operational roles as medical directors and others through co-management and other agreements that better align our mutual goals,” Dr. Moore says.

10 Recently Launched ACOs

By Molly Gamble

Here are 10 hospitals, physician groups, health systems and insurers that have recently formed ACOs.

1. Two New Jersey IPAs will form ACO. Two independent practice associations in New Jersey — VISTA Health System in Summit and Central Jersey Physician Network — will form an accountable care organization called Optimus Healthcare Partners.

2. New Jersey’s Atlantic Health launches ACO. Morristown, N.J.-based Atlantic Health has formed an accountable care organization with more than 300 participating physicians.


4. Illinois’ Advocate Health Care, BCBS announce accountable care agreement. Oak Brook, Ill.-based Advocate Health Care and Blue Cross and Blue Shield of Illinois announced a three-year agreement in which the organizations will operate as an accountable care organization.

5. Massachusetts’s Cape Cod Healthcare partners with local physicians to create ACOs. Cape Cod Healthcare in Hyannis, Mass., partnered with the local physician community to create two organizations with hopes of them evolving into ACOs.

6. Southeastern Wisconsin Health System, IPA launch ACO. Southeastern Wisconsin’s ProHealth Care and local independent physician association Waukesha (Wis.) Elmbrook Health Care formed the first ACO in southeast Wisconsin.

7. Wyoming Medical Center takes first steps toward statewide ACO. Casper, Wyo.-based Wyoming Medical Center is taking the first steps towards creating a statewide ACO.

8. Caritas Christi sale finalized; new for-profit system plans ACO. With the sale of non-profit Caritas Christ Health Care to for-profit Cerberus Capital Management complete, the new system is planning an ACO. The six-hospital system in the Boston area will operate under a Cerberus affiliate, Steward Health Care System.

9. Dartmouth-Hitchcock, Anthem launch pilot for an ACO. Dartmouth-Hitchcock Health, New Hampshire’s largest healthcare provider, and Anthem Blue Cross and Blue Shield launched a pilot payment program to prepare for an ACO.

10. Blue Shield of California, CHW and Hill Physicians create ACO for retired California state employees. Blue Shield of California, Catholic Healthcare West and San Ramon, Calif.-based Hill Physicians launched an accountable care organization to coordinate care for more than 40,000 members of the California Public Employees’ Retirement System.
Quint Studer: 3 Simple Ways to Improve Your Hospital’s Performance

By Lindsey Dunn

Hospitals today are judged on their ability to meet certain performance indicators ranging from clinical outcomes to financial goals. High-level performance has always mattered in healthcare, of course. But over the next several years, as health reform changes go into effect and reimbursement is increasingly linked to performance, it will become even more important.

Improving a hospital’s performance across all indicators can seem like a daunting challenge. But Quint Studer, founder and CEO of Studer Group, says findings from Studer Group’s Learning Lab of nearly 800 healthcare organizations across the country indicate that it is possible. In fact, three simple changes in the way you communicate with employees and patients can have a significant impact on hospital performance.

1. When communicating change, lead with the “why.” When new processes or other initiatives are introduced into an organization with the goal of improving performance, leaders often forget to explain why the change is necessary. “We as leaders spent most of our time on the ‘what’ and the ‘how,’” but the ‘why’ is just important, says Mr. Studer. “If you flip your message to begin with the why, you have a much more receptive audience [for change].”

Mr. Studer says leaders often fail to communicate the “why” because they (wrongly) assume employees understand the implications the major transformation that’s about to occur in the industry. Let’s say, for example, that hospital leadership wants to ensure all patients receive a post-discharge phone call. Any knowledgeable leader would immediately recognize the goal of this is to reduce unnecessary admissions, which hospitals will be penalized for in the future. However, the nurse who sees it as yet another duty to complete in an already busy day might not make the connection.

“Leaders need to explain why this relatively simple practice will improve the hospital’s performance,” says Mr. Studer. “Change your communication to ‘why, what, how’ and you’ll get much better compliance.”

2. Don’t ask if patients have questions. Ask what questions they have. In addition to clinical and financial performance indicators, patient experience measures are becoming increasingly important. For instance, hospitals are now reporting scores from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and a big part of this survey focuses on how well care providers listen and how understandable their explanations are. Most physician and nurses know to ask patients if they have any questions, but many patients fail to come up with any when put on the spot.

“To patients, the question feels like ‘Do you understand this?’” explains Mr. Studer. “They feel like they’re being graded. As a result, patients don’t ask questions. They either call back — which creates more work for the providers — or resort to a web search for information.”

Mr. Studer says that a slight adjustment in how the question is asked will make patients more comfortable and improve their perception of their care as well as the level of concern the doctor had for them. Yes, this may create better HCAHPS results, but more importantly it will create better clinical care.

3. Ensure that follow-up phone calls convey concern. Follow-up calls are near “home runs” for helping reduce readmissions and improving compliance to post-discharge instructions, says Mr. Studer. However, they also present an opportunity for the hospital to further impact the patient’s positive experience of his or her stay.

Mr. Studer offers two sets of “key words at key times” a care provider can use when making post-visit calls. In the first, the caller says something along the lines of, “Hello, I’m calling from the hospital you recently visited. We wanted to call and see how you’re doing and if you have any questions.” If a patient received this call, he or she would likely be surprised and happy to receive it.

However, compare it to the following: “Hi, I’m calling from the hospital you recently visited, as you know we like to call our patients after they leave to see how they’re doing. Your doctor, [insert name], cares about you and wants to ensure you get the best care possible so [he or she] wanted to make sure you weren’t experiencing any issues after you left. We wanted to make sure you understood all your medications and post-discharge instructions. So, how is everything? What questions do you have?”

“The second scenario takes roughly the same amount of time and effort as the first, but it goes a lot further in improving the patient’s perception of the hospital as well as of his or her physician,” says Mr. Studer.

He adds that while improving performance does yield better metrics and boost an organization’s bottom line, it also results in better clinical care — and that’s the most important reason to make it a priority.

“Better metrics are a natural byproduct of a patient-centered culture,” says Mr. Studer. “They’re not the mission. Taking the best possible care of the patient is the mission — and when everything is built around it, performance issues fix themselves.”

Quint Studer is founder and CEO of Studer Group, a recipient of the 2010 Malcolm Baldrige National Quality Award. He is a recognized leader and change agent in the healthcare industry and has more than 20 years of healthcare experience.
Creating Stronger Physician-Hospital Alignment

By Kate Lovrien and Luke Peterson

To create leading healthcare institutions, physicians and hospitals must be aligned in multiple areas over a sustained period of time. However, today, the historical basis for a working relationship between physicians and hospitals has broken down due to increased competition aimed at offsetting reimbursement cuts. This breakdown, coupled with the increasing demands for quality, efficiency and coordination and the payment changes outlined in healthcare reform, has left many organizations wondering how to best rebuild physician-hospital alignment.

Recently, individual economic tools such as employment have been presented as the “silver bullet” solution, but fail to achieve full alignment. Equally misguided is the belief that communication and dialog will be enough to create a durable relationship between physicians and hospitals. Instead, forming durable, collaborative partnerships requires the use of a variety of tools and strategies simultaneously. Given that the success of the hospital’s mission depends on physician alignment, it is incumbent on hospital administrators to define the new collaborative tenor of the relationship between hospitals and physicians and their overall alignment strategy.

As illustrated by Exhibit 1, there are three major elements required for full physician-hospital alignment. This Physician-Hospital Alignment Triangle includes:

- **Clinical Activity Alignment**
  The correlation of the patient care approach, expectations of quality and service, and consolidation of activity in the diagnosis, treatment and rehabilitation of a patient

- **Economic Alignment**
  The correlation of physician and hospital financial returns

- **Alignment of Purpose**
  The correlation of vision, values and energies; creating a shared belief in a single vision/mission, a common culture and an active involvement in the future direction of the organizations

Alignment in one area is not enough to be successful in the future environment. The future post-healthcare reform environment requires much greater integration of the continuum which in turn requires alignment on all three factors.

Unfortunately, most hospitals and healthcare systems are far from full physician alignment. To systematically study the physician-hospital alignment at hospitals and healthcare systems across the country, we developed a quantitative diagnostic tool. This tool, the Physician-Hospital Alignment Diagnostic, allows hospitals to test their specific situation and alignment against others across the country. Over a period of only a few hours per hospital, an organization can rapidly determine where it ranks on physician alignment.

Evaluating the scores of hospitals for which the Physician-Hospital Alignment Diagnostic has been run demonstrates that many organizations have a significant gap in their quest for aligned and integrated physicians.

Taking a sample of 40 hospitals shows some interesting results.

- The total alignment score is measured by adding the scores of the three types of alignment. With a maximum possible full alignment score of 150, the sample scores range from 59 to 106. The mean score is 81.
  - Clinical activity alignment scores range from 19 to 38 of a possible 50 points with a mean score of 27
  - Economic alignment scores range from 12 to 36 of a possible 50 points with a mean score of 27
  - Alignment of purpose scores range from 17 to 36 of a possible 50 points with a mean score of 27
  - The urgency score has a maximum of 50 points. For the sample, the measure alignment urgency range from 22 to 39 with a mean score of 30.

These scores and ranges, which are similar to other hospitals in the database, show the variability of physician-hospital alignment and that, on average, many hospitals are far from garnering the highest score in any one area.

Evaluating a sample hospital (“Hospital A”) shows a typical profile of a hospital in the database. (See Exhibit 2.) This hospital, a 200-bed hospital, has above-average financial indicators and provides strong community care to a growing, affluent, suburban market. The Physician-Hospital Alignment Diagnostic shows that Hospital A has substantially higher-than-average...
alignment of purpose, but average alignment in clinical activity and economic areas. Moreover, market indicators suggest that the urgency of creating stronger physician alignment is lower than average.

Further investigation of Hospital A shows that the hospital’s administration has been actively working to create a common vision with its physicians. This common vision has led to direct physician leadership in setting the strategic course of Hospital A. However, while Hospital A has kept up with the national trends, it has not been overly aggressive at using the tools that might advance clinical activity or economic alignment. For instance, the Hospital A does not employ any physicians, does not pay ER call pay, and has only a very limited number of other contractual and business service activities with its physicians. Given the relatively weaker alignment within clinical activity and economic areas, Hospital A has embarked on investigating the tools that directly impact these two areas of alignment.

In contrast, another hospital in the database (“Hospital B”) is a 250-bed hospital and a sole community provider with financial and quality indicators in line with national averages. Evaluating Hospital B’s physician alignment shows a strong economic alignment, but average clinical alignment and alignment of purpose. (See Exhibit 3.) Their urgency of alignment is lower than others in the sample.

Further investigation shows this hospital uses multiple economic tools—real estate leases, strong information system connections, employment, call pay and medical directorships—to economically align physicians with the hospital. As a sole community provider in a flat market, the hospital needed to mitigate the economic threat posed by physician developing their own facilities and diagnostics to compete with the hospital. However, the tools that led to strong economic alignment did not lead to the same levels of clinical activity alignment or alignment of purpose. To further improve physician alignment, Hospital B needs to deploy the specific tools targeted at clinical activity and purpose.

**Tools to Improve Physician-Hospital Alignment**

There are 20 major tools in four categories that hospitals can use to create the three forms of alignment. (See Exhibit 4.) The four categories each impact alignment differently.
The four categories of physician-alignment tools are not uniformly suited to drive alignment in each area (economic, clinical activity and purpose); instead, within each component of alignment, research indicates particular tool categories are more effective than others at driving alignment. Organizations wanting to improve their physician alignment in a particular area should consider deploying categories of tools according to Exhibit 5.

Within the category, hospitals should deploy tools with the appropriate degree of risk/impact for the situation. (See Exhibit 6.) High urgency scores and low physician-alignment scores indicate that higher-impact tools should be used within the appropriate category. However, because the higher-impact tools entail greater risk, if the situation does not warrant use of high-impact tools (low urgency scores and high physician-alignment scores), lower-impact tools should be deployed. The end goal is to apply the appropriate tools with the right balance of impact and risk to the create alignment.

In the case of Hospital A, the lower urgency of alignment score suggests that Hospital A should use moderate-impact tools with lower risk in the contracts and business services categories. As such, Hospital A is actively working to extend the electronic medical record to all physicians on the medical staff. Moreover, Hospital A is building off its strong alignment of purpose to create a clinical integrated physician network for better care coordination and allowing the physicians and hospital to contract together. Additionally, medical directorships are being reevaluated to ensure they advance the vision of the hospital’s operations and a clinical co-management relationship in cardiology is under development.

In contrast, Hospital B, with lower clinical activity alignment and alignment of purpose, would do well to focus efforts on redefining contracts (e.g., medical directorships) to focus on quality, safety and operational improvement metrics to advance the clinical activity position and create a wide range of structured communications tools to create a common sense of purpose.

While our diagnostic has shown that the level of physician-hospital alignment varies between hospitals, it is clear that most hospitals have the potential for significant improvement in at least one alignment area. Moreover, there is not one tool that will single handedly address all three areas requiring alignment. As physician-hospital alignment and integration become increasingly important to delivering quality and efficient care, it is essential to understand how your organization compares to peer organizations and how to increase alignment in your specific situation. Start this process at www.PhysicianHospitalAlignment.com by taking a free version of the diagnostic and discovering your organization’s performance and steps for improvement.

Kate Lovrien is a senior strategy manager from Kurt Salmon’s Minneapolis office. She has focused her career on advising community and regional referred hospitals and healthcare systems on their strategic and physician alignment challenges. Kate is the lead author of the Physician-Hospital Alignment Diagnostic located at www.PhysicianHospitalAlignment.com. She can be reached at (612) 865-6088 or Kate.Lovrien@kurtsalmon.com.

Luke Peterson is a strategy partner from Kurt Salmon’s Minneapolis office. He has focused his career on advising community and regional referral hospitals and healthcare systems particularly on the physician-hospital relationships and healthcare system organizational structures and rules. He can be reached at (612) 810-8188 or at Luke.Peterson@kurtsalmon.com.

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**Physician-Hospital Alignment Diagnostic**

The Physician-Hospital Alignment Diagnostic is a quantitative tool developed by Kate Lovrien and Luke Peterson at Kurt Salmon to systematically assess alignment between hospitals and physicians in three distinct areas: Clinical Activity Alignment, Economic Alignment and Alignment of Purpose. Additionally, the tool evaluates the quantitative Urgency of Alignment.

Through a series of detailed quantitative questions assessing the indicators of physician-hospital alignment, the tool creates a systematic assessment that can be compared to other organizations and situations across the country.

Each alignment section is scored up to 50 points for a total alignment score of up to 150 points. A higher score indicates greater alignment.

The urgency section is scored up to 50 points with higher scores indicating greater urgency.

A free version of the Physician-Hospital Alignment Diagnostic can be found at:

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Executive Briefing: Physician-Hospital Alignment

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Sources:

2 The 40 hospitals were chosen to provide a cross section of the typical community hospital in the U.S. today. These hospitals all depend heavily on a private practice medical staff, are located in urban and suburban markets and range from 150 to over 500 beds. These hospitals represent typically high-quality, successful organizations.
10 Strategies to Provide Patients With Superior Customer Service

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

1. **Start seeing patients as customers.** Taking care of patients is what healthcare is all about. It may be hard for some people to think of patients as customers, but they definitely are. Their choices bring thousands and even millions of dollars into a hospital’s coffers. In most cases, they don’t necessarily need to use your hospital, even though you have Dr. Brightstar on staff. They may end up at the institution down the street that treats patients better.

2. **Be courteous and respectful.** Always, always, make sure patients are treated with courtesy and respect. I know executives who pretended to be patients inside their own institutions and were shocked by the lack of focus and concern they received. Treating patients has become simply a job for many healthcare professionals. They manifest boredom with their jobs by treating patients indifferently. That’s not professional and it’s bad business!

3. **Never show indifference to patients.** Watch the way patients are treated when entering the ED. It can be quite disappointing at some urban hospitals and even at some suburban settings. If the illness is not life-threatening, patients are virtually given a number and told to sit down and wait. Many otherwise competent and even brilliant healthcare professionals give patients the feeling they are an inconvenience and a bother. Patients should not be made to feel inferior and misinformed.

4. **Don’t contradict, argue or match wits.** Telling patients they are wrong about anything is just plain rude. Even when they have incorrect information, they still should be accorded respect. If you disagree with them, politely explain why their point of view isn’t necessarily correct. Your goal should be to explain and communicate, and then to continue to explain and communicate. Help patients understand what is going on as treatment is being given. Patients should feel they are just important, in the scheme of things, as you are.

5. **Tell patients you appreciate their business.** Everybody likes to be thanked when purchasing an item in a retail store, but in all too many healthcare venues, saying “thank you” is seen as inappropriate. You know as well as I do that saying “thank you” has magic vibes for any kind of relationship. Go ahead and try it! It’s a great way to receive your customers’ repeat business.

6. **Use plain terms and simple explanations.** It may be fun to throw around complicated jargon, but it results in misunderstandings and sometimes errors. Nobody wants errors in today’s healthcare environment. Always make sure your explanations are not clouded with excessive and complicated verbiage. Be brief and to the point. True professionals go out of their way to explain things in simple, declarative sentences.

7. **Good manners will get you everywhere.** Good manners are part and parcel of confidence and competence. Don’t hide the truth even if it creates problems for you. Treat patients the way you’d want to be treated. Saying the appropriate words can show respect. Establishing eye contact is also part of good manners. Go way out of your way to show respect to others! It’s what being civilized is all about, isn’t it?

8. **Keep seeing healthcare as a calling.** Too many professionals begin to see healthcare as a job rather than a calling. There’s a big difference between the two. When healthcare becomes a job, mistakes are not far behind. Today there are so many complicated variables in healthcare that it is easy to get off track. Remember who you are and what your core business is. It might help to recall what brought you into the healthcare field. Was it to take care of people or was it to make a lot of money?

9. **Stay in touch with patients.** Many healthcare professionals don’t think they have the time to stay in touch with patients after care is rendered. They tend to think it’s unnecessary and creates too much stress. That rationale should never be tolerated. Staying in touch with patients, even if it’s an e-mail or a phone call, will pay off.

10. **Keep your promises.** Many promises made to patients are never kept. Things like, “You’ll get the best care here” and “We treat each individual who comes to us with dignity and respect” and also, “You’ll be just fine in a week or so.” The difference between empty talk and promises is that promises must be kept. And if it turns out you overpromised, own up to it. Being honest will pay off later. Any quality business must keep its promises.

Chuck Lauer was publisher of Modern Healthcare for more than 25 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide.
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C - ASCs as a Physician Alignment Tool
Charles “Chuck” Peck, MD, President & CEO, and Christian D. Ellison, Vice President, Health Inventures

11:45 am – 12:30 pm
Networking Lunch & Exhibits

12:30 pm – 1:15 pm
A - Developing an Outstanding Group Practice, Financial Sustainability, Culture and Other Issues
Joe Golbus, MD, President, NorthShore University HealthSystem, Paul R. Summerside, FFAEM, FACEP, MMM, MD, Chief Medical Officer, BayCare Clinic, Chairman of the Board, Aurora BayCare Medical Center, Moderated and led by Walter W. Morrissey, MD, Vice President, Kaufman Hall

B - Key Strategies to Maintaining A Great Independent Hospital
Sean M. Fadale MBA, FACHE, Vice President, Business Development, Nicholas H. Noyes Memorial Hospital, Virginia Tyler, M.Div, FACEP, President, Tyler Consulting, Katie Carow, MBA, Principal, Carow Consulting

1:20 pm – 1:50 pm
A - Developing a Sustainable Physician Strategy
Kenneth H. Cohn MD, MBA, FACS, CEO, Healthcare Collaboration

B - Whole Hospital Joint Ventures Between For Profit Hospital Companies and Not For Profit Hospitals
Pete Lawson, Executive Vice President Development, Health Management Associates

C - The Re-emergence of Orthopedic Surgery Employment
Leslie R. Jebson, Executive Director, University of Florida Orthopaedics and Sports Medicine Institute, Program Director, University of Florida Graduate Program in Physician Practice Integration, Mark S. Thomas, Senior Attorney, Dell Graham

1:55 pm – 2:35 pm
A - Using a PHO as the Foundation of an ACO
Eric P. Norwood, FACHE, President & CEO, DeKalb Regional Health System, Inc., Albert Wildstein, MD, Chairman, DPHO, Inc., Susan L. Helton, Executive Director, DeKalb PHO

B - Maximize OR Performance: How to Align Perioperative, Anesthesia, and Surgical Staff to Drive Efficiency in Your Largest Revenue Center
Timothy Dowd, MD, Managing Partner, North American Partners in Anesthesia

2:35 pm – 2:50 pm
Networking Break & Exhibits

2:50 pm – 3:30 pm
A - The 5 Best Ideas for ACOs
Joseph A. Scopelliti, MD, Co-CEO, Medical Affairs for Guthrie Health, President & CEO, Guthrie Clinic

B - Contracting with Hospital-Based Physicians - Direct Contracting vs. Outsourcing
Alan Channing, President and CEO Sinai Health System, Chairman Elect, Illinois Hospital Association, Lynn Massingale, MD, FACEP, Executive Chairman, TeamHealth Moderated by Scott Becker, Partner, McGuireWoods LLP

C - Physician Employment and Compensation: Develop and Implement Physician Compensation Models That Work
BJ Millar, Director Physician Services, Quorum Health Resources, LLC

3:35 pm – 4:25 pm
KEYNOTE PANEL - The Best Thoughts on Physician Alignment
Charles S. Lauer, Former Publisher of Modern Healthcare Magazine, Consultant, Speaker, Moderator, Thomas J. Sadvary, President & Chief Executive Officer, Scottsdale Healthcare, Michael D. Israel, President & Chief Executive Officer, Westchester Medical Center, Joseph A. Scopelliti, MD, Co-CEO, Medical Affairs, Guthrie Health, President & CEO, Guthrie Clinic

4:30 pm – 5:15 pm
KEYNOTE - Perspectives on Healthcare Reform
Charles N. Kahn III (“Chip”), President, Federation of American Hospitals

5:15 pm – 7:00 pm
Networking Reception, Cash Raffles and Exhibits

Friday, May 20, 2011

7:00 am – 8:00 am
Registration

8:00 am – 8:55 am
KEYNOTE - The Impact of Healthcare Reform on Payors and The Consequences for Health Systems
Peter R. Kongstvedt, MD, FACP, Principal, P.R. Kongstvedt Company, LLC, Author, and Senior Health Policy Faculty Member in the Dept. of Health Administration and Policy at George Mason University

9:00 am – 9:35 am
KEYNOTE - An Overview of Washington DC and AHA Priorities
Richard J. (“Rick”) Pollack, Executive Vice President, Advocacy and Public Policy, American Hospital Association

9:40 am – 10:20 am
A - ACOs - A Panel Discussion
Martin Manning, President, Advocate Physician Partners, Brian J. Silverstein, MD, Senior Vice President, The Camden Group, and Eric T. Nielsen, MD, Vice President, The Camden Group Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B - 10 Key Financial Questions for Healthcare Executives
Gary E. Weiss, Chief Financial Officer and Treasurer, NorthShore University HealthSystem

C - Anesthesia Relationships - Current Trends and Issues
Marc E. Koch, MD, President & CEO, Somnia Anesthesia

10:20 am – 10:35 am
Networking Break & Exhibits

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10:35 am – 11:15 am
A - Assessing Healthcare Outcomes; A Roundtable on Industry Trends
Peter R. Kongsvedt, MD, FACP,
Andrew Hayek, President and Chief Executive Officer, Surgical Care Affiliates, Moderated by Gordon A. Soderlund, Senior Vice President, Strategic Relationships, The DASCO Companies LLC

11:20 am – 12:00 pm
B - Roundtable Discussion on Physician-Hospital Joint Ventures
Allan Fine, Senior Vice President, Chief Strategy & Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President of Development & Acquisitions, Ambulatory Surgical Centers of America

12:05 pm – 12:40 pm
A - ACOs: The Position of ASCs, Hospitals and Physicians
Andrew Hayek, President & Chief Executive Officer, Surgical Care Affiliates

B - The Path to Becoming an Elite Health System - Best Practices from Great Hospitals
Bill Woodson, Senior Vice President, Sg2

12:40 pm – 1:30 pm
Networking Lunch and Exhibits

1:30 pm – 2:10 pm
A - Making Employed-Physician Models Profitable
Gary E. Weiss, Chief Financial Officer and Treasurer, NorthShore University HealthSystem, Andrew D. McDonald, FACHE, Senior Manager, Healthcare Consulting, LBMC Healthcare Team, Moderated by Amber Walsh, JD, Associate, McGuireWoods LLP

B - Using Lean Principles to Reduce Cost and Surplus from the Hospital
Gary Hagens, DMD, Chief Operating Officer and Vice President of Medical Management, Advocate BroMenn Medical Center, Advocate Eureka Hospital

2:15 pm – 2:50 pm
A - The Future of Physician-Owned Hospitals Under Health Care Reform
Mike Russell, MD, Texas Joint and Specialty Hospital

B - How to Have Margin Discussions with Your Physicians
Nick Sears, MD, Senior Vice President, Chief Medical Officer, MedAssets

2:50 – 3:05 pm
Networking Break and Exhibits

3:05 – 3:40 pm
A - Integration Vs. Competition - The Future of Hospital-Physician Relationships
George Economides, President & CEO, Economides Associates, Inc.

3:45 pm – 4:20 pm
A - Physician-Hospital Relationships - 5 Keys Concepts on Price and Compensation
Scott Becker, JD, CPA, Partner, David J. Pivnick, JD, BBA, Associate, and Lainey Scott Becker, JD, CPA, Partner, McGuireWoods LLP

4:25 – 5:00 pm
Networking Reception

5:00 pm – 6:30 pm
C - Squeezing Water Out of a Stone - How Hospitals Can Survive the Coming Reform
Anthony Sanzo, Chief Executive Officer, TeleTracking Technologies, and Lisa Romano, Chief Nursing Officer, Vice President, Teletracking Technologies

3:45 pm – 4:20 pm
A - Physician-Hospital Relationships - 10 Key Statistics to Analyze a Hospital's Financial Performance
Zachary Hafner, Vice President, Strategic, Financial and Capital Planning, Kaufman, Hall & Associates

4:25 – 5:00 pm
Ten Key Legal Steps for JVs and Physician-Hospital Financial Relationships
Scott Becker, JD, CPA, Partner, McGuireWoods LLP

5:00 pm – 6:30 pm
Networking Reception

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Christian D. Ellison, vice president of business development at Health Inventions in Broomfield, Colo., provides eight insights for successful joint ventures between hospitals and ambulatory surgery centers.

1. Know how ASC joint ventures benefit hospitals. Such partnerships can enhance inpatient and outpatient volume, improve working relationships with physicians and encourage physicians to focus on cost management and efficiency, both in the ASC and in hospital operating rooms (ORs).

2. Keep in mind why physicians want to partner. “Ten years ago, the last thing physician-owners wanted was to sell to a hospital,” Mr. Ellison says. But things have changed. “This is an uncertain period for physician-owned ASCs,” he says. For physicians, partnering with a hospital can facilitate better payor contracting support, limit competition, augment physician recruitment efforts, and provide access to capital.

3. Consider acquiring an existing ASC. As opportunities for new ASCs decline, hospitals may want to consider acquiring an existing center. “This is a good strategy in areas where the market is already saturated and there are few physicians who are not aligned with a center,” Mr. Ellison says. “Partnering on an existing ASC also allows you to get to market more quickly. You can access physician relationships and a revenue stream your hospital may have lost at some point in the past.”

4. You may gain new volume. Hospitals are often concerned the surgery center will take volume away from their hospital-based ORs. “Through its ASC partnership, the hospital can access new inpatient and outpatient surgery volume from surgeons that once went to its competitors,” Mr. Ellison says.

5. Spread your net wide at first. If you decide to acquire an ASC, thoroughly evaluate acquisition alternatives in the market and prioritize those, based on how much adds value to your hospital. “The value for you might be a strong future income stream, partnership opportunity with the right doctors, keeping out competitors or gaining access to a new market,” Mr. Ellison says. Once you have narrowed down your choice, contact one of the lead physicians in the ASC to determine physicians’ interest in partnering.

6. Evaluate the ASC. Once you have an interested target, execute a non-disclosure agreement with the ASC so that you can evaluate basic financial and operational information. Once things get serious, you will need an independent valuation to verify price. “An ASC may add additional value to a hospital beyond the incremental income stream and physician integration,” he adds. “It may lower costs and add capacity to a growing hospital or one with an aging infrastructure.

7. Create a business plan. As you evaluate the ASC, begin to create a business plan for the entity, focusing on a five-year forecast for the operation to see if the deal is viable. “Make sure you feel comfortable that the ASC has enough opportunity for growth to support the price you are paying,” Mr. Ellison says. Examine patient volume, physician profiles and reimbursement rates. “An ASC may add additional value to a hospital beyond the incremental income stream and physician integration,” he adds. “It may lower costs and add capacity to a growing hospital or one with an aging infrastructure.

8. Decide your level of interest. “There are a number of considerations in determining what percentage interest to purchase,” Mr. Ellison says. The hospital gains a majority interest, it can be easier to obtain higher reimbursement rates from payors. However, your physician-partners may want to retain majority control. Keep in mind that a controlling interest is more expensive and you may be out of reach for hospitals with capital constraints. Here is how the price for the hospital is determined for an ASC priced at a multiple of earnings. If its earnings are $1 million and the multiple is six, then the total price would be $6 million, less any long-term debt. If the hospital has a 50 percent stake, it would pay $3 million.

5 Best Practices for a Profitable ASC

By Rachel Fields

Five different ASC-focused physicians discuss best practices that contribute to the development and operation of a successful ASC.

1. Fix physicians’ problems to attract them to your ASC. To recruit more physicians to your center, Philip Grossman, MD, FACP, FACG, AGAF, FASGE, CEO and medical director of Kendall Endoscopy and Surgery Center in Miami, advises ASCs to think of the fable of the lion and the mouse, in which the mouse fixed a splinter in the lion’s paw and was later remembered and rewarded. Find out what the physicians in your community are missing, and fulfill that need, he says. “I’ve done a tremendous amount of computer consulting at a variety of levels, including healthcare, and I use that as a driving force,” he says. “Find out the things that are making life difficult for people and then fix them.”

He says these difficulties will vary. “Is it the fact that they go to the hospital and can’t start on time? Is it the fact that they don’t have a particular piece of equipment that would really allow them to distinguish themselves and their specialty?” he says. “Is it that clerical staff can never get a patient registered without 15 follow-up phone
calls?” Physicians will be pleasantly surprised if you fulfill a need they’ve been struggling with for a long time, and will be more likely to bring cases to your ASC.

2. Work with nurses to draw up patient discharge guidelines. According to Thomas Wherry, MD, medical director for Health Inventions and principal with Total Anesthesia Solutions, nursing staff may hold patients longer than necessary after surgery without guidance from an anesthesia provider. “Anesthesiologists should help determine discharge guidelines,” he says. “Without the direction and leadership from anesthesia, I find that the nursing staff may keep a patient an excessively long time. If it’s all on [the nurses’] shoulders, they’ll take the more conservative approach and keep the patient an extra half hour.” He says all these “extra half hours” add up to significant extra staffing hours over time.

To speed up patient discharge, and therefore save money on staffing, Dr. Wherry recommends anesthesiologists and nurses work together to draw up discharge guidelines. He says nurses should be discharging patients based on physiologic criteria rather than time criteria — meaning when a patient is ready, rather than when an hour has passed. “You want the anesthesiologists to work towards coming up with a clear criteria on when the patient can be safely discharged,” he says.

3. Designate a managing partner for an independent ASC. The independent ASC needs a physician-owner who has the interest and the skill set to actively manage the center, says Keith Metz, MD, medical director of Great Lakes Surgical Center in Southfield, Mich. The managing partner does not need an MBA or even training through the business course, but since the job requires a significant amount of commitment, compensation should be in the six-figure range. “You can’t impose this job on anyone,” Dr. Metz says. “It involves a great deal of commitment.”

4. Invest in software to facility quality improvement studies. Investing in software can seem daunting, especially for a smaller facility, but software and technology are essential to conducting quality QI studies. John Dooley, MD, an anesthesiologist and administrator at Mississippi Valley Surgery Center in Davenport, Iowa, says this technology works best when it is specifically tailored to the needs of the facility.

“We bought various software for the staff to use on their desktops so they can produce meaningful information,” says Dr. Dooley. “In some cases, we’ve had staff members save a document to a hard drive and then someone else accidentally deletes it. We’ve had to go to a new software system so that accidental deletion doesn’t happen. Also, sometimes the data gets too large and bulky to manipulate, particularly patient surveys, so spreadsheets don’t work. In that case, we’ve had to switch to a larger database like Microsoft Access.”

5. Pick the right size space for your ASC. Most ASC industry experts agree that getting the size of your ASC right during the development process is absolutely essential to optimum profits. “There are only two ways to make square footage work: either get it right in beginning, or sublet to make it work later,” Jim Reichheld, MD, board-certified gastroenterologist and director of Northeast Endoscopy Center in Lowell, Mass., says. “There are many restrictions on subletting space for other uses, so that can be difficult. Not building a Taj Mahal is critical because your building is a fixed, recurring expense and you can’t change that.”
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10 New ASCs Opened or Under Development by Hospitals and Health Systems

By Rob Kurtz

Hospitals and health systems nationwide continue to lay out plans for and develop new surgery centers. Here are 10 new hospital and health system surgery center projects recently in the news.

1. Rhode Island’s Kent Hospital to Build Surgery Center — Kent Hospital in Warwick, R.I., is expected to break ground soon on a new ambulatory surgery center. The ASC was one of the projects Sandra Coletta, president and CEO of Kent Hospital, was expected to highlight at the hospital’s 60th annual meeting.

2. California’s Palo Alto Medical Foundation to Build Outpatient Surgery Center — Palo Alto (Calif.) Medical Foundation, a Sutter Health affiliate, plans to build a new outpatient clinic in San Carlos, Calif., which will include outpatient surgery. Construction of the 192,260-square-foot San Carlos Center was expected to begin in Jan. 2011.

3. Pennsylvania’s Coordinated Health Plans New Surgery Center for Smithfield Township — Pennsylvania-based Coordinated Health is planning a new surgery center in Smithfield Township, Pa. The health system is proposing a “short stay” medical surgery center; Coordinated Health has received a zoning amendment that allows inpatient and outpatient elective surgery and other medical and dental treatment.

4. Arkansas Health System Applies to Change Hospital to Surgery Center — St. Joseph’s Mercy Health System, based in Hot Springs, Ark., has announced it is applying to the Arkansas Department of Health to change the licensure for St. Joseph’s Mercy Health Center at HealthPark from an acute-care hospital to an ASC. The decision to apply for the licensure change is a result of a merger earlier this year between St. Joseph’s Mercy and HealthFirst Physicians Group. In the merger, Mercy acquired HealthPark Hospital, which had an average daily census of only five patients. St. Joseph’s Mercy can absorb these patients, making it unnecessary to keep the HealthPark facility as an acute-care hospital.

5. New Surgery Center Considered by Ohio’s Kettering Medical Center — Kettering (Ohio) Medical Center is considering building a new ASC on 34 acres of property located near the hospital’s main building in Kettering.

6. New Cleveland Surgery Center Planned for St. Vincent Charity Medical Center — St. Vincent Charity Medical Center in Cleveland will build a new $35 million surgery center in the city. The city of Cleveland is receiving a nearly $2 million grant which will go to clearing a site for the new surgery center.

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7. Ohio Joint-Venture ASC to Become Hospital-Based Surgery Center — Zanesville (Ohio) Surgery Center, currently a joint venture operation with Genesis HealthCare System and community physicians, will be restructured as a hospital-based surgery center. The facility's name will change to Genesis Surgery Center, and the goals of the center will align with Genesis HealthCare’s strategic plan to improve the system’s overall delivery of care.

9. New Jersey Surgery Center Opened by Robert Wood Johnson University Hospital — Robert Wood Johnson University Hospital, based in New Brunswick, NJ, has opened a new outpatient surgery center in New Brunswick. The new Ambulatory Surgical Pavilion is a 13,000-square-foot ASC with four ORs and an endoscopy room. It sees cases in general surgery, gynecology, vascular surgery, plastic surgery, pediatric and retina-vitreous surgery, endoscopy and orthopedic surgery.

10. Sutter Health to Build New California Surgery Center in Elk Grove — Sutter Health, based in Sacramento, Calif., has approved financing for a new ASC in Elk Grove, Calif. The $10.8 million surgery center is scheduled to break ground in May 2011, with completion of the facility targeted for a year later.

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3 Ways Surgery Center Physicians Can Increase Case Volume

By Rachel Fields

Here are three ways surgery center physicians can increase case volume.

1. Aggressively recruit other physicians. The most important contribution ASC physicians can make is recruiting other physicians, says Augusto Alinea, MD, medical director of the Ambulatory Surgery Center of Stevens Point. His surgery center competes with the local hospital for physicians, and some local providers are hesitant to come to the ASC if their practice has a relationship with a competing entity. “By and large, we’ve been able to bypass those roadblocks,” Dr. Alinea says. In order to recruit other physicians, he recommends your current providers keep an eye on the local market and call up physicians without prior commitments to other facilities. “We’re very familiar with the people in the area since we’ve worked with all of them at one time or another,” he says. “We invite them to sit down with us, and we show them the [ASC] and how we practice, which is new to a lot of them.”

Your physicians are the best resource you have for recruiting new partners and providers, says Connie Casey, administrator of Northpoint Surgery and Laser Center in West Palm Beach, Fla. She says her physicians work as a team to bring new surgeons to the center, and they also team up to handle physicians who start taking their cases elsewhere. “That’s what makes my center work,” she says. “I have so many friends who run surgery centers, and their doctors all fight and don’t work with each other. My doctors work as a team.”

2. Add new procedures to existing physicians’ repertoire. Dr. Alinea says his surgery center builds volume by establishing new procedures for existing physicians. “For example, I’m a pain specialist, and instead of just doing one or two types of procedures, I’ve expanded my practice to add new ones,” he says. Take a look at your existing physicians, and determine where your ASC could add cases without having to spend too much money on overhead.

Ms. Casey says when her ASC first opened in 1996, physicians brought in cases indiscriminately and quickly realized they could lose money with that strategy. To make sure the center performed profitable cases, Ms. Casey and her team looked closely at the financials for each potential case and decided to focus the bulk of their volume on the most profitable procedures. Once they established that orthopedics and ENT would bring in the most money, they could tailor their scheduling and recruitment to depend on those specialties.

3. Consider procedures that are new to the outpatient setting. As new technologies develop, more cases become appropriate for the ASC that may have been limited to the inpatient setting in the past. Dr. Alinea says your ASC should watch for cases that have recently moved from the hospital to the surgery center setting. “To increase caseload, we’ve started doing traditionally inpatient procedures as outpatient,” he says. “We started doing total knee arthroplasty.” He says adding a traditionally-inpatient procedure takes some creativity on the part of the ASC administrator and nurse manager, as the center will need new equipment, extended patient care and education and a strict selection process to guarantee all patients are ASC-appropriate.

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10 Traits of High-Earning Hospital CEOs

By Rachel Fields

As short- and long-term incentive plans become more popular and CEO compensation becomes more transparent, hospital CEOs must achieve tangible results to justify their high salaries to the public. Here are the top 10 traits of high-earning hospital CEOs, according to two healthcare recruiting experts.

1. They meet short- and long-term goals. According to Larry Robinson, senior vice president and managing principal of RCG Executive Compensation Group, most hospitals and health systems use short-term incentive plans for their executives. But long-term incentive plans, while relatively uncommon now, are gaining in popularity and are expected to pick up steam in 2011. The highest-earning CEOs over the next few years will sit down with the hospital compensation committee and outline goals for the year as well as the next few years, says John Fulcher, director of healthcare recruiting for Bauer Consulting Group. He adds that while the short-term plan should be tied to quarterly objectives — decreasing readmissions, for example, or increasing patient satisfaction scores — long-term plans might be based on goals such as growing a hospital service line or adding a children’s hospital.

Accomplishing short- and long-term goals impacts a CEO’s current compensation, but it could also impact his or her ability to gain new employment in the future, Mr. Robinson says. “You look for candidates who met or exceeded their goals,” he says, adding that hospitals may be more lenient about accomplishments if the hospital suffered financially due to economic downturn. The most important part of designing short- and long-term incentive plans, he says, is to ensure that all goals are quantifiable, understandable and achievable.

2. They analyze potential employer markets. When a hospital and a CEO work together to design an incentive plan, Mr. Robinson says, generally, the CEO will draw up a list of potential goals, submit them to the board and receive feedback. This process leads to a final decision on the goals for the next year and several years, depending on the compensation model. Mr. Fulcher recommends a new CEO takes a careful look at the hospital’s local market when deciding his or her goals. “Is there a children’s hospital, and will the market support a children’s hospital?” he says. “What’s the hospital’s current market share and the [region’s] current population growth?” He says CEOs should take advantage of public information on population growth and other factors. A CEO should not aim to gain a significant market share if the hospital has already captured a majority of the local market, for example.

3. They take risks with compensation. Most CEO salaries today are made up of several parts that, as a whole, form “total direct compensation.” These parts can include base salary, short-term incentive plans and long-term incentive plans, as well as benefits. Because incentive plan pay is dependent on the CEO meeting a number of pre-determined goals, a higher percentage of incentive pay is a significant risk. However, Mr. Fulcher says the most successful CEOs in the coming years may be those who accept the risk of an incentive plan and embrace the opportunity to achieve that extra money.

More and more, hospitals are unlikely to offer executives large base salaries with small incentive plans. This model means the hospital must accept the risk that the executive will earn a high income without accomplishing pre-determined goals. On the other hand, a compensation model that places too much emphasis on an incentive plan can force the CEO to accept far more risk than the hospital. The smartest CEOs will create a balanced combination of the two sides — enough base salary to guarantee relative financial stability, and enough incentive pay to push them to achieve goals.

4. They stay put. In a culture enamored with quick change and rapid growth, Mr. Robinson says the healthcare industry has remarkably resisted the trend of high turnover among executives. More than ever, hospitals and health systems recruiting new executives value historical longevity with several organizations. “Building a physical plant and maintaining it doesn’t happen overnight,” he says. “We’re all interested in moving to new employment if there’s a higher pay opportunity, but you don’t want to move too quickly. You want to build a strong track record of performance and continuity.”

He says the most attractive CEOs will have spent a long period of time with fewer than five organizations. “One of the first things anyone looks at is: do you see a pattern of sustained employment with one organization and the executive moving up through the company?” he says. “If you see someone moving among a number of different hospitals, that causes concern. Relationships with the board and the community are so important, and you don’t develop those overnight.” He says this trait goes hand-in-hand with the increasing popularity of long-term incentive plans. Hospitals want to know that a new CEO will stay with the facility long enough to implement real change.

5. They prioritize the hospital’s mission. With all the upcoming changes to the healthcare industry, it can be easy for hospital and health system CEOs to get distracted. With so many priorities to focus on — EMR implementation, coding system transition, profitability, regulatory changes and more — CEOs can forget to prioritize the hospital’s mission. Mr. Robinson says this trait is essential for CEOs who want to keep a tight hospital budget. “Many hospitals were founded on the basis of service of the community and its needs,” he says. “There are so many things that are peripheral these days, and the key is to keep focused on the things that are core to the mission of the organization.” This focus could also help hospital profitability, as the CEO will be less likely to recommend spending money on initiatives that don’t fit with the hospital’s core values.

6. They have a background in finance. Mr. Robinson says he has recently seen increased emphasis on candidates with a strong finance background. “To understand the fiscal operation of a large facility takes in-depth knowledge, and when you’re dealing with all the government payment programs and reporting requirements, you really need to have a wide breath of technical knowledge,” he says. 2011’s most successful CEOs will not simply rely on the expertise of their CFOs but bring their own knowledge as well.

7. They get involved with new initiatives. Hospital CEOs who ignore changes through healthcare reform could endanger facility revenue and therefore their own compensation, Mr. Fulcher says. Valuable CEOs should already be involved in local and national initiatives surrounding ACO development, payment reform and physician integration. They should also be up-to-date on changes to coding, reimbursement, regulatory and HIPAA rules, which means a constant “finger on the pulse” of healthcare news.

8. They understand the hospital board’s perspective. It may be too soon to predict an economic recovery, but many believe the worst of the recession is over. In light of this prediction, Mr. Robinson says hospital CEOs should recognize that hospital boards will be increasingly concerned about executive retention. If executives have more employment options, hospital boards will offer increasingly competitive compensation — a boon for hospital leaders.
9. They’re hungry for growth. In any industry, CEOs should hunger for new growth and opportunity, Mr. Fulcher says. “You’ve got to have someone who wants it to be a hands-on director and a hands-on manager, who wants to lead the organization to success,” he says. He says a CEO cannot settle for “good enough” in hospital performance. This hunger will mean more initiatives, projects and ideas that benefit hospital revenue, as well as more frequent achievement of incentive plan goals.

10. They cut costs in simple ways. Cost-cutting in the hospital setting doesn’t have to mean huge effort, Mr. Fulcher says. CEOs who want to make more money should start with their facility, where a gain in revenue or a decrease in cost will most likely mean more money in their own bank account. While personal gain should never be the sole motivator for CEO attention to hospital finances, it can be a nice side effect when a leader puts effort into increasing profit.

Mr. Fulcher says successful CEOs in 2011 will increase revenue through simple measures, such as taking the time to speak with local physicians, tightening up billing and collections processes and looking at data on turn-over times and readmissions.

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**5 Points on Designing a CEO Incentive Compensation Plan**

By Rachel Fields

Hospital incentive plans are increasingly focused on quantifiable measures that are critical for hospital success, meaning only the most focused CEOs can achieve the top financial rewards for their work. Ralph DiPisa, partner of executive healthcare recruiter Phillips DiPisa, discusses five essential traits of an effective CEO incentive plan.

1. Goals should be tiered, not “all or nothing.” Mr. DiPisa says an incentive plan should be made up of several goals, meaning the plan could be partially accomplished and still mean a payout for the CEO. For example, if the hospital sets four equally-weighted goals, and the CEO accomplishes three but fails on the fourth, he or she would receive 75 percent of the incentive payment. This means that a CEO discouraged over one particular goal will not give up on the rest of the goals. It also offsets the impact of the economy, which may make particular goals — increasing hospital revenue or attracting more providers, for example — more difficult.

Incentive plans are formed in many different ways, but hospital boards can also choose to weight specific goals to make them more important. If patient satisfaction is the number one objective in the hospital’s strategic plan for 2011, the hospital board might weight that goal more heavily to direct the CEO’s focus.

2. Incentive goals should combine personal and organizational objectives. Compensation experts agree that most incentive goals should be quantifiable and measurable. That means that at the end of the year, the hospital board should be able to look at the goals and the CEO’s progress and determine very clearly whether those goals were met. Even goals that seem more subjective — creating better relationships with the medical staff, for example — should use physician satisfaction surveys and other data to inform the board’s determination.

Mr. DiPisa says many hospitals choose to combine personal and organizational objectives to encourage a more dynamic CEO. Organizational objectives might include decreasing readmission rates, improving patient satisfaction scores or increasing profit. Personal objectives might include improving the CEO’s knowledge of finance or working on his or her presentation skills. By including personal goals in the incentive plan, hospitals ensure that the CEO continues to grow those personal tools that help accomplish organizational goals.

3. Only the best CEOs should earn 100 percent of their incentive. According to Mr. DiPisa, CEO incentive plans should be designed to really challenge the CEO rather than simply create the semblance of accountability. Compensation specialists discuss incentive plans in terms of a “threshold” and a “target” — the threshold being the minimum amount the hospital expects the CEO to accomplish, and the target being the desired amount. If the CEO has the opportunity to earn 25 percent of his or her base salary by accomplishing a set of goals, the compensation committee might set the threshold at 12.5 percent, meaning half the goals were accomplished. The target would be set at 20 percent, meaning most, but not all, of the goals were accomplished.

The CEOs who are top in their field could earn 100 percent of that incentive. “This is the part that separates the men from the boys and the women from the girls,” he says. Some compensation committees will allow the best CEOs to “take the top off” the incentive plan and actually earn more than 100 percent, assuming they have met all the goals and accomplished extra objectives.

4. Incentive goals should not exceed eight. While a hospital strategic plan might include 68 goals for the year, Mr. DiPisa says a CEO incentive plan should include between four and eight goals. He says he has seen client organizations that divided the plan into four personal goals and four organizational goals. If the CEO’s goals outnumber eight, Mr. DiPisa says there’s a good chance the CEO will accomplish fewer goals and become frustrated with the incentive plan.

Mr. DiPisa, who has served as a hospital CEO in the past, says, “Having run a hospital before, you could be busy every day and all day attending meetings, making presentations and going to small groups. You could do that for a whole year and think, ‘I worked so hard this year’ and have actually accomplished nothing,” he says. Because CEOs are so busy, you need to concentrate the CEO’s attention on several goals and make sure those are a priority next to the hustle and bustle of “making the trains run on time,” Mr. DiPisa says.

5. CEO goals should trickle down. While your hospital staff probably shouldn’t be told the exact financial reward your CEO will receive for accomplishing a specific goal, they should be on the same page about the hospital’s main priorities. The CEO will find it difficult to accomplish his or her goals if the organization isn’t on board. For example, while the CEO can take measures to improve patient satisfaction, the people who most often affect the patient experience are the physicians, nurses and staff members on the “front lines” of the hospital.

He says CEO goals can be spread throughout the facility by implementing incentive plans two or three levels down. “Maybe middle managers would have the opportunity to have a piece of their compensation bonus-based, and they should have the same goals as the CEO,” he says. “The CEO’s goal might be to grow cardiology by a certain percent, and the person two or three levels down might have goals around increasing the number of echocardiograms [or other more granular objectives].”

He adds that while organizational goals should be public, personal goals should probably be kept private.
15 Statistics on Healthcare Executive Compensation

By Rachel Fields

Here are 15 statistics about compensation of various types of hospital leaders, including leaders of non-profit hospitals and CEOs with clinical backgrounds.

Healthcare organization leaders
1. Median compensation of non-physician CEOs in healthcare organizations was $259,302 in 2009.
2. Median compensation of physician CEOs in healthcare organizations was $417,934.
3. Median compensation of CFOs in healthcare organizations was $197,447.
4. Median compensation of COOs in healthcare organizations was $210,000.
5. Median compensation of CIOs in healthcare organizations was $153,087.

Non-profit hospital leaders
Persons listed as “CEO” or “chief executive officer” were treated as top management officials by the survey. If no person was listed in either position, persons listed as “president,” “executive director” or “administrator” were treated as the top management officials.

Average salary by hospital revenue:
6. Revenue under $25 million — $149,700
7. Revenue between $25 and $100 million — $289,600
8. Revenue between $100 and $250 million — $465,300
9. Revenue between $250 and 500 million — $642,100
10. Revenue over $500 million — $877,200

Physician CEOs
11. Median compensation of physician CEOs and presidents working at academic medical centers was $672,000.
12. Median compensation of physician CEOs and presidents working at government facilities was $185,000.
13. Median compensation of physician CEOs and presidents working at health system corporate offices was $400,910.
14. Median compensation of physician CEOs and presidents working at hospitals was $367,500.
15. Median compensation of physician CEOs and presidents working at physician-hospital organizations was $395,000.

Sources:
1-5: 2009 AMGA Medical Group Compensation and Financial Survey.
6-10: Internal Revenue Service’s Exempt Organizations Hospital Compliance Project Final Report.

3 Questions to Ask When Designing an Employed Physician Compensation Plan

By Rachel Fields

Physician employment is becoming more and more prevalent as hospitals look to integrate and align with physicians. C.J. Bolster, national director of the healthcare practice at Hay Group, discusses three questions every hospital leader should ask when designing a physician employment and compensation plan.

1. How do you want to structure your hospital-physician relationship? Determining how to structure your hospital-physician relationship is the first — and probably most important — step in determining how physicians will be employed. “I think the biggest trend in physician compensation is being extremely mindful of where you’re going to go strategically, how you’re going to position the group and the organization’s organizing structure,” Mr. Bolster says.

He says hospitals have several options for how to employ and compensate physicians. Some health systems might choose to manage the physician group as a separate division in the same way as a hospital. “You might manage [the physician groups and hospitals] as a portfolio of companies that has to stand on their own economically,” he says. “There’s a lot of people who think like that.”

He says other hospitals may approach physician employment as integrated, coordinated care organized around a service line such as cardiology. An integrated multi-specialty group practice might place the patients at the center of the model and let the physicians work around the patients rather than based on a particular service line. “There are a lot of nuances to those different types of models,” he says.

2. How will reimbursement structures change over the next several years? If your hospital is redesigning your physician compensation structure, you have to be mindful of how reimbursement will change in the coming years, Mr. Bolster says. Most physicians are currently compensated based on fee-for-service and RVU productivity measures, but those traditional structures may change with the advent of health reform. “You have to be very sensitive to changes in your reimbursement patterns,” he says. “Quality is going to lead because of pay-for-performance. I’ve got
a lot of clients that are still productivity-based, and they’re quite concerned that [productivity-based] compensation is reinforcing a set of behaviors that may not be the best.”

He says because reimbursement will likely not change overnight, hospitals must be flexible about incorporating quality and outcomes measures into existing compensation models. Over the next five years, he expects to see many hospitals adopt a blended approach to physician compensation, using both RVUs and quality outcomes as incentive in addition to base salary.

3. What kind of culture do you want to create? According to Mr. Bolster, integrated systems such as Geisinger Health System have made culture the central piece of their physician employment models. “If you’re a hospital-based system and you want to have a big employed group practice, you are changing the nature of the enterprise to look and feel more like a professional service firm,” he says. “In a professional service firm, people expect to be involved to a higher degree. It’s not as divisionally and organizationally boxed.”

He says physician employment can mean physicians have a large impact on the hospital's operations, through medical directorship positions, committee involvement and board seats as well as clinical practice. “You want to try to be as intentional about this as possible,” he says. “[Physician involvement] will happen, and the more you can be intentional, the more you can affect the kind of culture that is created.”

He says this can mean providing opportunities for emerging leaders who happen to be clinician physicians. Don’t just wait for those leaders to look around for opportunities. Approach them in the initial employment planning stages and involve them in building compensation plans.

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Justice Department Alleges Mayo Clinic Falsely Billed Medicare

By Jaimie Oh

The Department of Justice has accused the Mayo Clinic, based in Rochester, Minn., of violating the False Claims Act by falsely billing federal healthcare programs, such as Medicare, for lab tests that were never performed, according to a report by the Star Tribune.

The allegations stem from whistleblowers David Ketroser, MD, and three former Mayo Clinic patients who claimed the organization billed healthcare programs for thousands of pathology tests that were never rendered over the course of several years. The whistleblower lawsuit was filed in 2007, and the federal government decided to join the lawsuit in September, according to the report.

Dr. Ketroser said he first suspected Mayo’s suspicious billing practices while he was representing patients in malpractice cases against the healthcare organization. After requesting from Mayo a frozen tissue slide for one of his patients, he was told the slide had been thrown out. Later, he found that Mayo had billed for a second test the same day the first test was performed but could not relinquish the test. Dr. Ketroser said that “they didn’t do them” and that he had “encountered it at least 10 or 12 times,” according to the report.

A Mayo spokesman said that the allegations were overexaggerated, that the billings were simply made in error and Mayo has been fully compliant with the law. However, a federal attorney handling the case said an internal memo demonstrates a Mayo official knew the improper billing had been occurring for years. The federal attorney also took issue with Mayo’s stance that it had refunded more than $242,000 to the federal government in 2007 when allegations first arose, saying the organization’s payment does not rectify “the full measure of damages” and that the organization had only moved to repair the situation after the DOJ began investigating, according to the report.

It is yet to be determined how much exactly Mayo might have improperly collected from the pathology tests, according to the report.

St. John’s Mercy Health System and St. John’s Health System Settle Fraud Allegations for $2.2M

By Jaimie Oh

St. John’s Mercy Health Care and St. John’s Health System, both based in St. Louis, have agreed to pay $2.2 million to settle allegations that foot clinics at St. John’s hospitals overbilled Medicare, according to a News-Leaders news report.

In 2009, the Department of Health & Human Services started investigating the St. John’s hospitals when a call was made about a licensed practical nurse who was improperly providing podiatry services. Between Jan. 2005 and March 2010, St. John’s Hospital and five other hospitals allegedly billed Medicare for podiatry services, such as toenail trimmings and callus removals, that were done by nurses and other hospital employees who were not licensed physicians. Medicare does not typically pay for such podiatry services, and federal investigators claimed the provided services were not medically necessary, according to the report.

A St. John’s Hospital spokesperson said that hospital officials believed that claims to federal healthcare programs were being submitted properly and were continuously audited. As part of the settlement, the health systems have also agreed to shut down the six foot clinics and are not admitting to any wrongdoing, according to the report.

Obama Makes Physicians’ Exemption From Red Flags Rule Official

By Jaimie Oh

President Obama has signed the Red Flag Clarification Act of 2010 into law, which clarifies and narrows the definition of a “creditor” and thereby excludes physicians from the Federal Trade Commission’s Red Flags Rule, according to a Healthcare IT News report.

Under the Fair and Accurate Credit Transactions Act, the FTC’s Red Flags Rules required “creditors” and “financial institutions” to implement written identity theft detection and monitoring programs, designed to help business and organizations detect and respond to warnings signs of identity theft. The requirement was met with much disdain, particularly from the American Medical Association, which filed a lawsuit in federal court in May to prevent the rule from applying to physicians because it felt the Red Flags Rule was “arbitrary.”

The Red Flag Clarification Act, which was drawn up and introduced by Sen. John Thune (R-S.D.) and Mark Begich (D-Alaska) on Nov. 30, sought to clarify the definition of a “creditor” based on the reasoning that small businesses, such as physician’s offices, do not offer or maintain accounts that pose any risk of identity theft. The bill narrowed the definition of a “creditor” to include only entities that use consumer reports and furnish information to consumer reporting agencies or to others who extend credit.

The same day the bill was introduced, the Senate unanimously passed the Red Flag Clarification Act, with the House of Representatives following suit soon after in early December. Many societies and organizations, including the AMA, the Medical Society of the District of Columbia and American Osteopathic Association, applauded the passage of the law.
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4 Things to Consider Before Putting Your Hospital on the Market

By Molly Gamble

When selling a hospital, the following factors may either woo or worry potential buyers. Rex Burgdorfer, an M&A banker with Juniper Advisory in Chicago, shares four points to examine before putting your hospital on the market.

1. Quality of the market and the hospital’s market share. Simply put, buyers are paying for the opportunity they see in the market. Buyers will consider the potential changes in a market’s demographic, such as an increase of Medicaid patients as baby-boomers retire.

If consolidators see opportunities to improve a hospital’s market share through relatively small investments, they will be much more inclined to pursue the acquisition further. Small investments or improvements could include the recruitment of specialists to capture lost business when people visit other hospitals in the market (outmigration).

“Buyers may look at a hospital. If they see demand for a service not presently offered, for example an orthopedic group, it dramatically changes their level of interest. A system could acquire the facility and through relatively small investments, recruit specialists and alter the service mix to meet market demand,” says Mr. Burgdorfer.

2. Circumstance of the buyers. It is particularly important to understand the circumstances of potential buyers when entering into a change of control transaction. A couple of years ago, Juniper was advising on a hospital transaction with unique conditions. “We had two companies emerge as logical buyers,” says Mr. Burgdorfer. “When we were going about our analysis, one potential suitor purchased the other.” The two leading candidates suddenly turned into zero, since one no longer existed and the other took on a considerable amount of debt.

Examples such as this speak to the importance of “evaluating all alternatives simultaneously,” according to Mr. Burgdorfer. Alternatives can take form in a variety of transaction models — such as affiliating, leasing, merging, etc. — and within each model are multiple suitors. “If the suitor’s situation deteriorates for some reason, you have options to go another route. Assessing options simultaneously yields vastly better transaction outcomes,” says Mr. Burgdorfer.

3. Regional and national trends. If a hospital is considering going to market either now or 16 months from now, many think now is better, says Mr. Burgdorfer. Since healthcare reform has spurred significant consolidation activity, hospitals approaching the market now will capitalize on the widespread belief that more business combinations are to be expected.

Healthcare reform will greatly impact hospital consolidation by decreasing revenues, increasing costs and rewarding integration. Hospital M&A activity volume for the third quarter of 2010 increased by 20 percent compared to the same quarter in 2009, according to Irving Levin Associates.

“There’s a new group of buyers that did not exist prior to healthcare reform,” says Mr. Burgdorfer. “By assessing options now, hospitals are taking advantage of the capital that group of buyers is willing to expend.”

If hospitals wait, that capital could be put toward other projects, he says, although the fluidity of the market makes it difficult to determine when that may occur.

4. Importance of external, macro factors. Many consultants advise clients to focus on small improvements to boost short term profitability, like cleaning up receivables or collecting accounts payable in a more timely fashion. These minor improvements, however, do not typically sway buyers, according to Mr. Burgdorfer.

“If a hospital is deciding when to sell, it’s more important for them to look at the external macro trends and the circumstances of potential partners rather than focusing on internal metrics,” says Mr. Burgdorfer.

5 Ways to Make Your Hospital More Attractive to a Buyer

By Molly Gamble

It takes hard work to catch buyers’ attention amid the current flurry of M&A activity. Hospitals need to muster an enormous amount of initiative and consider the following strategies to boost their attractiveness. Marisa Manley, president of Healthcare Real Estate Advisors in New York City, and Robert Guenthner, partner of SNR Denton in Chicago, share tips on how hospitals can shift into high gear and garner buyer interest.

1. Be proactive. With a boom in healthcare consolidation, hospitals need to be strategic—not reactive. “If you wait until you’re in a position where you’re cash-strapped and physicians are fleeing the facility, that’s a guaranteed recipe for disaster,” says Mr. Guenthner. He recommends exploring different possibilities, including affiliations, joint- partnerships, mergers and acquisitions.

Part of being attractive is simply being available. Mr. Guenthner stresses the importance of an open mind. “After the round of hospital consolidation we saw in the 1990s, a lot of people thought standalone was the way to go. ‘Big systems are evil, we’re never going to do that.’ That’s not a good business mentality. Keep an open mind about the many types of affiliations that may be available.” Ms. Manley also recommends an assertive attitude when looking for a partner or sale. “You should be able to say, ‘Here’s our plan. We haven’t done it yet, but if you put money in us, we know how we want to use that money. Here’s our timeline, here’s the cost, here are the results.’ Get in the front as much as you can.”

2. Look at your hospital-physician relationships. Physician loyalty to a hospital has a remarkable effect on its marketability. Any hospital buyer is going to examine a hospital’s relationships with physicians, according to Mr. Guenthner. “Look at those relationships and have a recruiting plan for any specialties that may have weak spots or holes,” says Mr. Guenthner. Human resources and marketing support will help the attempt to recruit specialists. Ad-
administration’s responsiveness is a huge factor in hospital-physician relationships. Hospital administrators and executives should have a physician-outreach plan, exercise flexibility with physicians and remain informed of any aspects of the hospital which may be sources of dissatisfaction to physicians.

3. Hone your operational efficiency. When investing in a hospital, buyers want to see stability of operations. Examine the layout of the structure and how it affects the number of patients a provider is able to see within a certain period of time. Small tweaks can lead to noticeable improvements. An adjustment in layout is doable without a complete hospital overhaul. “There are 1950’s hospital buildings that can still have an efficient layout,” says Ms. Manley.

Look for problems that can easily be eliminated, such as wasted space or redundancy. Small, evidence-based design changes may have a significant impact on operational efficiency. For instance, does the hospital have decentralized work stations? Facilities with EBD components are extremely attractive to healthcare professionals, since the design plays such a heavy hand in workflow and workplace satisfaction.

If you know facility changes are required, be proactive. These should be part of the plan you present to any potential acquirer or partner. Be prepared to document how the changes will improve your operations in terms of patient flow and revenue, the likely cost and how long it will take to complete improvements. In connection with any improvements, consider the possibility of “green” upgrades, particularly in connection with heating, ventilating, air conditioning or electrical systems. These appeal to investors, patients and regulators, and may reduce your operating costs, says Ms. Manley.

4. Explore relationships with other healthcare providers. Hospitals will no longer be able to thrive as standalone, autonomous organizations. “Today, every hospital needs to be thinking about the whole continuum of care,” says Mr. Guenther. Ask how your hospital can best fit into a model of care delivery. Of course, it may seem suspicious if a hospital suddenly starts reaching out to other providers for partnerships. “Do what you can internally to put yourself in the best position, along with subtle inquiries,” says Mr. Guenther. Expand into specialties not currently offered at the hospital, such as assisted living or rehabilitation facilities. Joint-ventures or the expansion of services can be accomplished with fairly low degrees of attention.

5. Shape up your payor mix. An attractive payor mix is a key driver for acquisitions. This cannot be tackled overnight, but hospitals should implement strategies to build towards an ideal balance. “No one wants a hospital with a horrible payor mix,” says Mr. Guenther. Even if the mix is not ideal, a potential buyer may consider a hospital more attractive if it has taken initiative to improve it and established a variety of strategies to do so. Steps to do this may include recruiting top physicians or expanding into service lines that are more lucrative. Even if buyers see an opportunity, the hospital may seem more attractive and worth the pursuit. “In a lot of hospital M&A activity, this is something a buyer may look at and say, ‘I think I can improve this payor mix,’” says Mr. Guenther.

"Do what you can internally to put yourself in the best position, along with subtle inquiries," says Mr. Guenther. Expand into specialties not currently offered at the hospital, such as assisted living or rehabilitation facilities. Joint-ventures or the expansion of services can be accomplished with fairly low degrees of attention.

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I’m amazed at how many hospitals today are performing so well, running such strong margins, that they have millions in excess cash on hand. That’s great news as we move closer to “healthcare reform” and the looming changes. The true financial impact of the so-called reform is still not known and many hospitals and systems are “hunkering down” for what may be a mighty blow to their balance sheet.

The disparities between the most successful and efficiently run hospitals and those that continue to struggle just to survive will undoubtedly become much more apparent in the coming months. While you can’t do much about your reimbursement, you can find new ways to control costs, improve efficiencies and redefine your approach to healthcare finance.

Long-term debt has long been a staple in the hospital world. Municipal or commercial bonds in the millions and hundreds of millions of dollars are propping up our nation’s healthcare system. We saw those bonds and the underlying ratings take a solid beating in this economy. Bond holders saw their seemingly “safe” investments undermined by downgrades and failing States and local municipalities.

If you’re going to add a new wing to your hospital, or build an entirely new facility, 15-30 year money makes a lot of sense. The fees are high, and in today’s market you better have a solid investment grade or plan to prop up your rating with insurance by one of the few bond insurers that managed to keep their own credit pristine. Getting a bond deal done in this market, for most hospitals, has been a tall task. Bond financing plays a critical role but you must look at the entire picture. Matching asset life with debt term is paramount to your continuing success. A good deal of your new bond issue will go towards retiring older bond debt. But, and this is where we need to redefine, if you have millions in “excess cash” on hand, why aren’t you paying down that long-term debt?

That “excess cash” is a critical component to how you’ll position your hospital or system for the future. Your choice is to keep your cash on hand, continue paying interest on your long-term debt and use some of the cash to pay for capital equipment purchases. Or, use the cash to pay down a portion of your long-term debt, save thousands or millions in long-term debt interest, reduce your total long-term debt and finance your equipment on shorter term debt at historic low rates and at terms that match your equipment life perfectly.

Carrying the interest full term on long-term bond debt is amongst the most costly expenses on your balance sheet. Simplify the equation and think of your home mortgage. By the time you’ve paid off your house, you’ve paid more than double the original price. Cutting your POs for double the price of all your equipment, disposables and ancillary devices would be unthinkable. So, why are you doing it?

Shorter-term debt is at record low rates. In fact, currently shorter-term debt, 3-5 years, is actually below the rates of most, if not all of your bond debt. There are no fees, or minimal at best, paperwork is simple, you don’t have to move a mountain, but most importantly you’re matching the life of those assets financed with the life of your debt. You’re not paying double the price of those purchases in interest and you’ll begin to improve your bottom line in your first step towards redefining healthcare finance.

How about true healthcare reform; things we can do within our own hospitals and systems to reform how we think about our finances?

Match asset class with debt term. You wouldn’t finance a dishwasher on your home mortgage.

A long-term plan to reduce long-term debt will positively impact your bottom line and bring your hospital or system closer to financial stability through the looming unknown of the insurance reform. If you’re not “hunkering down,” good luck. Nobody anticipated the enormous investment losses that many hospitals suffered in 2008. Non-patient revenue in the negative of millions of dollars impacted your fund balance significantly. You may be running a tighter ship, tightened the budget, put off new equipment upgrades and non-essential spending and just look at that margin you’re running; for many of you, it’s truly a beautiful thing. Running strong profit margins in healthcare, especially for a non-profit hospital or system, is a task worthy of praise.

Here’s the key to really turn those margins into a long term plan to move your facility or system through the turbulence of the current market and prepare it for the next stage of our Nation’s healthcare. Take that excess cash, those excess millions, and start paying down that costly long-term bond debt.

Take advantage of 3-5 year money to finance your capital equipment purchases. Spending “cash” on those purchases can be a deceiving proposition. That cash is there as a result of your management strategy and operating performance. It’s also there in part because of the millions or hundreds of millions in long-term bond debt you’ve carried for the life of your hospital or system. While the bond debt has a definite place in our world as a life sustaining form of capital, it’s important to match asset class with debt term. It’s not truly “excess” cash and you would benefit greatly by using a portion of that to reduce your long-term debt. In fact you may be losing money by the thousands and millions by not rethinking your approach to your debt.

Run a quick analysis of using a portion of your excess cash to pay down your long-term bond debt. Look at the reduced interest and overall reduction in debt. Now add a column for your new short-term debt for capital equipment purchases and compare. The savings will be staggering.

Together we can reform healthcare. We can do it in a more meaningful way, from the inside out. We can work together as an industry to identify best practices, take advantage of IT and state-of-the-art equipment that maximizes our profitable revenue and helps improve our efficiencies. We can tackle process improvement, redefine healthcare finance and deliver quality care. Time to rethink in time for reform.

Shawn J. McBride is a vice president in the Healthcare Financial Services Division at People’s Capital and Leasing Corp., a subsidiary of People’s United Bank and has more than 15 years in healthcare finance. A member of HFMA and ACHE, Mr. McBride has participated in funding nearly $1 billion in the healthcare sector.
CMS Releases Proposed Rule on Value-Based Purchasing

By Leigh Page

CMS has released a proposed rule on value-based purchasing, which involves paying hospitals for performance on quality measures, according to a release by CMS.

Currently, CMS pays hospitals simply for reporting quality measures, as part of the Hospital Inpatient Quality Reporting Program. The new value-based purchasing program, which begins in fiscal year 2013, was mandated under the healthcare reform law. CMS is accepting comments until March 8, and will issue a final rule next year and the program starts on Oct. 1, 2012.

In the proposed rule, CMS had laid out performance measures, standards, a scoring scheme and a methodology for translating scores into incentive payments. Payments would be funded through a reduction in base operating DRG payments of 1 percent in FY 2013, rising to 2 percent in FY 2017.

To measure payments, CMS would use 17 clinical process-of-care measures and eight measures from the Hospital Consumer Assessment of Healthcare Providers and Systems survey on patients’ experience of care. CMS would also adopt three mortality outcome measures, eight Hospital Acquired Condition measures and nine Agency for Healthcare Research and Quality measures for the program.

Under the proposed rules, a hospital would earn 0-10 points for performance on each measure and 0-9 points based on how much its performance improved during the baseline period. CMS would then combine the scores to calculate a Total Performance Score.

Certain hospitals will be excluded for the program, such as those with an insufficient number of patients to measure related conditions.

Premier praised the proposal, saying its Hospital Quality Incentive Demonstration pilot project has shown that “a well designed, value-based purchasing program can achieve better outcomes for patients.”

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5 Hospitals That Closed Their Doors in 2010

By Rachel Fields

Here are five hospitals that closed in 2010, in order from most to least recent.

1. Washington County Hospital in Hagerstown, Md. Washington County Hospital moved its services and patients to Meritus Medical Center on Dec. 12, closing the doors of a facility that opened in 1905. Meritus Medical Center will continue to draw patients from Frederick County and will be better-equipped to deal with emergencies. Meritus Medical Center has paperless, wireless technology throughout the hospital and contains 341 beds. As of yet there are no plans for the old building.

2. Lakeside Hospital at Bastrop in Bastrop, Texas. Lakeside Hospital at Bastrop closed abruptly in late Nov. 2010. The 15-bed rural hospital was owned by Blackhawk Healthcare, which acquired the facility in July 2009. No reason for the closing was offered by the hospital, and hospital patients are now being referred to Smithville (Texas) Regional Hospital.

3. North General Hospital in Harlem, N.Y. North General Hospital closed its doors on July 2, allowing nearby hospitals and new clinics to pick up its patients. The hospital saw 36,000 annual visits to its emergency room and housed 200 beds. A large, government-subsidized walk-in clinic moved into the hospital building immediately to provide care for Harlem residents. North General was around $200 million in debt and had regularly reported losses since its inception in 1979.

4. St. Vincent’s Hospital Manhattan in New York City. The board of St. Vincent Catholic Medical Centers voted in April 2010 to close its flagship hospital in Greenwich Village. The hospital’s Chapter 11 bankruptcy filing showed liabilities of more than $1 billion, following a long battle to turn around the hospital’s failing finances. The parent company of the hospital is currently seeking approval from a bankruptcy judge to sell the Manhattan campus, a sale that could cause controversy in the community if the building is not used to house a hospital.

5. Braddock General Hospital in Braddock, Pa. The University of Pittsburgh Medical Center closed Braddock General on Jan. 31, 2010, despite protests from residents who were concerned about losing local access to care. UPMC said it had been losing $4-$12 million a year on the hospital, due in part to declining admissions. The hospital opened in 1906 and was acquired by UPMC in 1996.
5 Best Practices for Implementing Health IT Across a Large Health System

By Jaimie Oh

As 2011 nears, hospitals and healthcare systems are racing to implement electronic medical record systems in their organizations. The benefits of deploying an EMR system are many — potentially reduced costs, improved clinical outcomes, incentive payments — but implementation is no easy feat, particularly for larger healthcare systems that may need to deploy a system across several facilities. Here, Ron Strachan, senior vice president and CIO of WellStar Health System in Atlanta, shares five ways leaders of health systems can implement an EMR system with fewer complications and in a shorter amount of time.

1. Obtain all-around buy-in. For any health system, half the battle in successful deployment of health IT across an entire enterprise depends on whether there is top-to-bottom buy-in from upper management, physicians and staff members. EMRs and other health IT solutions and applications can only be used meaningfully if physicians and staff can get on board as end-users. Mr. Strachan says WellStar has only occasionally run into some resistance from staff members, but buy-in has improved over time.

“That’s happening less and less because we have conversations with WellStar physicians and staff members on the importance of our projects and why it is important they participate,” he says. “With each successful project, there’s less of a need to convince the rest of the health system to support us and engage in future projects.”

2. Focus on project management. Delegating specific projects out to project managers is a cornerstone to WellStar’s successful deployment of its EMR system and other health IT initiatives. This requires work on both the leadership and project management sides to closely align, effectively communicate and work together toward a commonly shared goal. Mr. Strachan likens the working relationship he has with his staff members to that of a conductor and an orchestra, who must ensure each role player has the right training with the right instrument and plays at the right time.

“There is nothing unique to the success of any given project except making sure you are getting the most traction out of the people that are assigned to work on it,” Mr. Strachan says. “This means making sure staff members are fully engaged, properly trained and given the resources needed to be successful.”

3. Consult industry experts. Not only has WellStar consulted experts on how to use certain IT applications in its initial stages, but it also had the experts come to WellStar facilities and work with hospital staff members side-by-side. This helps the system avoid the need to rely on vendors or other IT companies in case there is a technical issue with one of its servers or applications.

“We’re currently going down the path of successfully adopting server and workstation virtualization, and how we’re doing that is making sure we’re getting industry expertise to help teach our staff how to not only virtualize our environment but also understand the nuances of virtualization,” he says. “What this means for us in the long-term is we’re building up that knowledge on the front-end so the health system itself possesses the competency to maintain the system.”

4. Regularly hold meetings. At WellStar, leadership team meetings are held at least every other week to discuss a wide array of health IT-related issues, including what projects are in need of extra support. Leadership team meetings also give leaders a chance to look into the future and start preparing for other potential health IT projects ahead of time. Mr. Strachan says the health system also has smaller work groups that meet to focus on specific projects.

“For each project, these smaller work groups get together on a regular basis to ensure we are firing all cylinders,” he says. “The work groups sometimes can meet through in-person meetings or even virtual meetings where team members are exchanging thoughts and questions through e-mail or instant message.”

5. Prepare for meaningful use. Health systems will ultimately have to demonstrate to the government that their organizations have deployed health IT and are actively and meaningfully using these systems to improve the health status of their communities. Given that this is the ultimate goal, health systems should keep a clear focus on how all proposed and ongoing projects are going to contribute to the organization’s end-goal of meaningful use. Since it is already a challenge to spread so much time and resources across a multi-facility enterprise, health systems should make it a best practice to keep a discriminating eye on what projects to pursue.

Mr. Strachan says the concept of meaningful use has had an immensely huge impact on WellStar because it has forced the health system to rethink and reprioritize its health IT initiatives.

“First and foremost, if a proposed project is not directly related to meaningful use and [doesn’t] meet at least one of the required criteria of meaningful use, then we can’t afford the time to work on that project,” he says. “We have an organization where the IT staff wants to make people happy, but we want to avoid the fault of saying ‘yes’ too much.”

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Crisis Communication During a Data Breach: 5 Best Practices

By Molly Gamble

A health care data breach can prove costly to an organization's bottom line and its reputation. Here are five best practices for crisis communication during a breach.

1. Do the required risk assessment. When the HITECH Act went into effect in September 2009, it included an expansion on existing HIPAA regulations and required hospitals to conduct a HIPAA security risk assessment. “With the trend in enforcement we’ve seen in the last year, more and more providers are doing the required assessments to understand where their priorities need to be and how they should be best prepared,” says Rosemary Plorin, partner and senior vice president of Lovell Communications in Nashville, Tenn.

The intention of the risk assessment is to help hospitals identify areas of risk and vulnerability — and in the days of thumb drives, smartphones and laptops, there are plenty of opportunities for the use of unencrypted devices to lead to an accidental release of patient data. Laptop theft was recently named the number one cause of healthcare data breaches.

2. Prepare for the worst. Of those organizations that have experienced a breach, many simply had not rolled up their sleeves to figure out plans of action beforehand. “Hospitals need to be prepared to deploy an emergency response team and conduct a root cause analysis just as they would with a clinical issue,” says Ms. Plorin.

Ideally, that team will have already considered a plan of correction in the event of a breach — and communication should be a key component. This plan will include a timeframe for notification of patients, providers, employees, business associates, strategic partners and media outlets. “Timing needs to be as closely synched as it can be,” says Ms. Plorin. The timing of these notifications, however, needs to be carefully planned. A hospital does not want to reach media outlets before contacting those affected by the breach.

3. Go beyond what is prescribed by the government. Patients feel especially vulnerable and uneasy when data breaches occur at hospitals, since those are the same organizations they trust with their health. When it comes time for outreach after a large-scale breach, patients will want to hear from the top of the organization, according to Ms. Plorin. Messages should be created with the expertise of legal and communication professionals to match risk management and patient advocacy needs. “Look at your communication and make sure you’re not being cagey or bureaucratic with your language. A sincere message of regret offered by the organization’s leadership can go a long way toward reassuring patients,” says Ms. Plorin.

Though the federal and state governments have established strict guidelines on what needs to be communicated and when, hospitals need to go beyond that. “Provide as much information as possible to help people protect themselves against identity theft,” says Ms. Plorin. “If financially possible, invest in providing patients with protective services for a year. It’s an extra cost, but it tells the patient you’ll protect them.”

4. Maintain solidarity between departments within your organization. When a breach occurs, departments within the hospital may be looking over their shoulders or seeking someone to blame. “Breaches are very often the result of a systemic weakness. No one is served by pointing a finger at one person or one department,” says Ms. Plorin. Breach experiences, while painful, force hospitals to carefully evaluate their practices and identify all potential gaps in security. “Recovery from a breach should be an opportunity to become a stronger, more compliant organization. Every department, every employee and every person associated with the hospital should be reminded of their responsibility to protecting patient health information and maintaining patient trust.”

5. Make sure all communications and services are consistent with your organization. Organizations tend to exhale once they have mailed the notification letters, posted the news release, established a hotline and launched a website. But it shouldn’t stop there. The hospital needs to go beyond the notification process and maintain strong presence throughout the entire process. An opportunity is lost when hospitals don’t take the breach as a time to express sincere regret and become a staunch advocate for patients.

Offering protection services to patients impacted by a breach is proving to be a gold standard. These services, such as credit monitoring and notification, should be consistent with the hospital’s brand and culture. For instance, hospitals should pay attention to how callers who dial the hotline are treated. “The expectations of a patient are very different from those of a department store customer or credit card holder,” says Ms. Plorin. “It’s a failure if someone e-mails a hospital website after a breach notice and no one responds for a week.”

HIMSS: 22% of Hospitals Can Meet at Least 10 of 14 Core Measurements of Stage 1 Meaningful Use

By Jaimie Oh

HIMSS Analytics has released data indicating that nearly one-quarter of 687 surveyed hospitals are ready to meet 10 or more of the required core measures in stage 1 of meaningful use, according to a HIMSS Analytics news release.

This set of data, which HIMSS Analytics reports with a 99 percent confidence level and a 5 percent margin of error, is the first in a series of data that will be released quarterly starting in Jan. 2011 by the organization.

Other findings from the initial data set including the following:

- Almost 10 percent of participating hospitals indicated they have the capability to achieve 12 core measures for meaningful use.
- 34 percent of respondents have the capability to achieve between five and nine of the core measures for meaningful use.
- Just over 40 percent (40.47 percent) of the market indicated they have the capability to meet five or more of the menu items for meaningful use.
The following statistics are from the PricewaterhouseCoopers 2010 report, “From courtship to marriage: Why health reform is driving physicians and hospitals together.” To inform this report, PwC Health research Institute conducted 15 in-depth interviews with thought leaders and executives representing providers, payors and professional associations. This insight is combined with data collected from a 2010 online survey of more than 1,000 physicians balanced by age, gender, practice type and specialty.

Top five reasons physicians don’t trust hospitals
Of those physicians who do not trust hospitals, there are five main reasons why:

• Competing goals: 60 percent.
• Lack of physician leadership/representation on the board: 56 percent.
• Lack of transparency: 56 percent.
• Lack of communication among physicians and hospital administrators: 50 percent.
• Incentives not aligned: 50 percent.

Top five reasons physicians think hospitals want them
Physicians believe the following reasons contribute to hospitals wanting physician alignment:

• Consolidate market power for payor negotiations: 68 percent.
• Decreased costs and increased efficiency: 66 percent.
• Increased patient and ancillary revenues: 65 percent.
• Improved patient outcomes: 64 percent.
• Enhanced coordination of care across the continuum: 65 percent.

Top five reasons physicians want hospital alignment

• Improved work-life balance: 63 percent.
• Competitive benefits and retirement package: 57 percent.
• Job satisfaction: 57 percent.
• Increased annual income: 56 percent.
• Consistent income: 40 percent.
Healthcare Reform’s Impact on Hospital Emergency Departments: 6 Considerations

By Jaimie Oh

It goes without saying that the new healthcare reform law will have far-reaching implications on hospitals across the country. With many provisions in the healthcare reform law scheduled to take effect in 2011, hospitals and physicians need to refocus their efforts now on enhancing patient care while managing costs. These same expectations apply to emergency departments. As such, it is exceedingly critical that hospitals are prepared for how their respective emergency departments will be impacted by reform. Here, Lynn Massingale, MD, FACEP, executive chairman of TeamHealth in Knoxville, Tenn., shares six thoughts on how healthcare reform will impact hospital emergency departments and what hospitals and physicians can do to prepare for these impending changes.

Healthcare reform’s impact on hospital EDs

1. Reduced reimbursements. In the early stages of formulating healthcare reform, the American Hospital Association agreed to accept $155 billion in reimbursement cuts over 10 years from federal healthcare programs at hospitals across the country. Reduced reimbursements for medical services also apply to emergency care, which will force hospitals to re-think how to contain ED costs as part of their overall strategies to remain financially viable amidst reimbursement reductions.

“A specific provision of the healthcare reform bill mandates reductions in reimbursements to hospitals, some of which can be offset by improvements in productivity,” Dr. Massingale says. “Because of this, hospital EDs will need to focus on improving efficiency in addition to cost-containment initiatives.”

2. Increased coverage. Although approximately 32 million uninsured Americans will be covered under healthcare reform by 2014, the shortage of primary care physicians to accommodate these individuals could result in even more patients flowing through the country’s EDs.

“Even today, a patient with an acute but not life-threatening problem may have trouble getting in to see a primary care physician immediately,” he says. “The shortage of primary care physicians is only expected to worsen in the next five to ten years, causing these patients to rely on the ED for care. We must prepare for that increase.”

3. Repercussions of care provided. Hospitals may need to reassess the way patient care has traditionally been delivered, from a reactive mentality of treating patients as they become sick to a more proactive, longer-term approach of controlling and preventing illness. Dr. Massingale says hospitals could potentially face financial penalties if certain quality indicators, such as readmission rates, do not meet benchmarks defined by federal regulation.

“For hospitals, this may mean considering the use of hospitalists to work with the patient’s family and/or other caregivers on an effective discharge plan so these patients don’t have to return to the hospital for something that could have been prevented,” he says.

Preparing for the changes brought on by reform

4. Implementing standardized evidence-based practices. Physicians, by nature, are wired to research and collect data in order to come to certain conclusions, whether it be related to patient diagnoses or proper treatment protocols. To improve quality and contain costs related to ED visits, physicians must commit to more uniform work-ups and treatments. Dr. Massingale says there is currently too much variation in physician practice behaviors, which will not be affordable or sustainable in the long term.

“Let’s say, for example, a physician orders CT scans on 90 percent of his or her patients with a headache, and another physician orders CT scans for only 10 percent of patients,” he says. “One physician might think more often of migraine and the other suspects early strokes. The difference can mean life or death. Cost and quality suffer unless we tackle this variation in practice behaviors.”

While it may be true there aren’t always clear-cut answers in treatment protocols, physicians should make it a best practice to continuously study and collect data, utilize health IT, investigate areas of wide variance, study medical literature and conclude best treatment practices from that research. “This way, we can better understand which patients truly need the expensive blood test or need the new brand-name antibiotic versus a generic brand. “If we simply study our own data and adjust the medical practice from there, a decrease in variation will follow,” he says.

5. Find simple ways to reduce costs. Exceptional efficiency will ultimately be the key to success in reducing healthcare costs. Dr. Massingale points out that while hospitals may need help identifying ways to reduce costs in this complex environment, some relatively simple methodologies already exist. One method hospitals have adopted to reduce cost is the lean method, which was created in the automotive industry as a means to eliminate waste in order to increase productivity and contain costs. Dr. Massingale suggests that if physicians in a hypothetical ED were able to see 2.2 patients per hour compared to 2.0 as a result of increased productivity and efficiency, hospitals could be spared the need to invest in multimillion dollar expansions to accommodate increased patient volumes.

“Modest changes can have a significant impact on operational and staffing costs,” he adds. “Even actions as simple as arranging every examination room to have medical supplies and equipment placed in identical locations can improve efficiency.”

6. Optimize efficiency with healthcare IT. The market for healthcare IT applications and solutions has rapidly become very sophisticated, more so since the passage of the American Recovery and Reinvestment Act, which incents hospitals that demonstrate meaningful use of electronic health record systems. In addition to electronic medical record deployment, there are ED-focused computer models available today that allow hospitals and physicians to study patient arrival time and acuity, model changes in the flow of patients in the ED, and adjust processes to reduce patient wait times. “Given this kind of technology, hospitals can map out processes over an entire day and predict where bottlenecks will occur,” he says.

In one example, Dr. Massingale describes a hypothetical situation where six patients could arrive at an ED at the same time. “If it takes ten minutes for a nurse to triage each patient, that sixth patient wouldn’t be able to get any medical attention for 50 minutes, but by utilizing computer models TeamHealth has been able to optimize the use of existing space and staff to improve the ED experience,” he says.

“It’s a complex time in healthcare, but with strong physician and administrative leadership, creativity, and a survival instinct, the strongest and most adaptable organizations will succeed and flourish in this new environment,” Dr. Massingale says.
TeamHealth enjoys a 97%

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*Based on a 2011 independent national survey of hospital executives.
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Study Finds Shortage of On-Call Specialists Plaguing ERs
By Lindsey Dunn

A recent study published in *Academic Emergency Medicine* found that emergency departments across the country face significant shortages of on-call specialists.

The study, which surveyed ED directors across the country, found 74 percent of directors reporting on-call coverage problems with specialist physicians. Furthermore, 60 percent reported having lost 24/7 coverage for at least one specialty in the past four years, and 23 percent reported that their trauma center designation level had been affected by on-call coverage.

The authors of the study note the difficulty in obtaining specialty on-call coverage appears to have affected the provision of emergency care.

Rapid Medical Screening Process Improves Patient Flow in EDs
By Jaimie Oh

The implementation of a rapid screening process could improve patient flow during surges in patient volume without affecting rates of return to the emergency department, according to a study published in *Annals of Emergency Medicine*.

The research was conducted during the fall of 2009 when surges in patient volume occurred due to H1N1. Researchers studied how a rapid screening process improved patient flow compared to the previous winter virus season.

The screening process included the use of a new, separate clinic next to the ED. Researchers also used a new preprinted checklist for quick documentation of medical history and physical examination of patients with flu-like illness, “classroom-style” parent discharge information and preprinted discharge prescription and instructions. Patient flow parameters, including waiting time, length of stay, elopement rates and returns to ED within 48 hours and seven days, were closely measured and compared to the previous winter’s measurements.

Results showed the mean wait time decreased from 93 minutes to 81 minutes, overall mean ED length of stay decreased from 241 to 212 minutes and rates of elopement remained unchanged and showed improved responsiveness to high patient volumes. Additionally, rates of return within 48 hours and within seven days stayed the same. Researchers also found the ED was able to accommodate the patient volume increases with only a modest increase in staffing hours.

Researchers Assess Accuracy of Radiology Readings in EDs
By Jaimie Oh

Physicians at Georgetown University and George Washington University, both in Washington, D.C., assessed radiology discrepancies resulting from radiograph interpretations that occur in hospital emergency departments and analyzed the types of errors made by emergency physicians, according to an article published in *The American Journal of Emergency Medicine*.

The researchers consulted an ED quality assurance database that detailed all radiology discrepancies that occurred between emergency physicians and the radiology department from June 1996 to May 2005. During this time period, the ED ordered 151,693 radiographs.

Results showed that approximately 3 percent of radiographs interpreted by emergency physicians are given a different interpretation by the radiology attending. The most commonly missed findings include fractures, dislocations, air-space disease and pulmonary nodes. Researchers suggest continuing education to reduce the incidence of radiology discrepancies.

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Hospital & Health System
Executive Moves

Paul Levy, CEO of Beth Israel Deaconess Medical Center in Boston, announced his resignation.

Newton Square, Penn.-based Catholic Health East has appointed Sister Mary Persico to executive vice president of mission integration.

Franklin, Tenn.-based Capella Healthcare appointed Erik Swensson, MD, FACS, as CMO.

Amy Nachtigal was appointed to CFO of Saint Luke’s Hospital in Kansas City, Mo. Shelby Frigon will replace Ms. Nachtigal as CFO at Saint Luke’s South in Overland Park, Kan.

Savannah, Ga.-based Memorial Health fired Phillip Schaengold, president and CEO.

Volunteer Community Hospital in Martin, Tenn., has appointed Clyde Wood to CEO.

George W. Dawson, president and CEO of Lynchburg, Va.-based Centra Health, announced his plans to retire by the end of 2011.

Bailey Medical Center in Owasso, Okla., named Keith Mason CEO.

Tenn. has appointed Clyde Wood to CEO.

Mark Caton and Chuck Baker assumed the roles of CEO and COO, respectively, of Callaway Community Hospital in Fulton, Mo.

Loyola University Health System in Maywood, Ill., named Robert A. Cherry, MD, chief medical officer and vice president of clinical effectiveness.

Darlene Burns, president and CEO of Rome (N.Y.) Memorial Hospital, will retire at the end of the year.

Allan Atkinson is serving as interim CEO and president of Columbus (Wis.) Community Hospital.

Hill Country Memorial in Fredericksburg, Texas, hired Steve Solstrand as COO of the healthcare organization.

Gary Wages, FACHE, president and CEO of Saint Luke’s Health System in Kansas City, Mo., announced his retirement, effective March 11. Kevin Trimbale, senior vice president and chief nursing officer at SLNH, will succeed Mr. Wages as CEO.

Waterbury (Conn.) Hospital hired Stephen R. Laverty as interim president and CEO of the hospital and its network of affiliates.

Memorial Hospital of Sweetwater County in Rock Springs, Wyo., named Jerry Klein CEO.

Greensburg, Penn.-based Excela Health named Michael Busch executive vice president and COO.

Regina Medical Center in Hastings, Minn., named Ty W. Erickson CEO, effective Feb. 21.

Santa Clara Valley Medical Center in San Jose, Calif., named Linda M. Smith CEO. Ms. Smith will begin work at the 574-bed hospital in February.

The board of directors at Sharon (Penn.) Regional Health System requested and received the resignation of its president and CEO, John Zidansek.

Oregon Health & Science University in Portland hired Lawrence J. Furnstahl as CFO.

Kansas City, Mo.-based Saint Luke’s Health System appointed John Leifer as chief marketing and chief innovation officer.

Crystal Haynes stepped down as CEO of Saint Louis University Hospital in St. Louis to pursue other opportunities. COO Dawn Amuszkiewicz was appointed to interim administrator.

Roseville, Calif.-based Adventist Health named Scott Reiner as executive vice president and COO, effective May 2011.

Medical City Dallas Hospital named Keith Zimmerman senior vice president and chief development officer of Medical City and its children’s hospital.

Akron (Ohio) General Medical Center rehired Alan Papa and named him president.

Oakland, Calif.-based Kaiser Permanente promoted Bernard Tyson, executive vice president, to president and COO.

Adventist Health in Roseville, Calif., named John Beaman vice president of finance. He is relocating to Roseville at the end of the year and orienting into his new role.

Ohio State University Medical Center in Columbus named C. Michael Rutherford as CFO.

Plano, Texas-based LHP Hospital Group named Paul A. Kappelman, FACHE, MHA, division president.

Milwaukee-based Aurora Health Care named Ray Grady senior vice president and chief administrative officer.

Hospital & Health System Transactions

Toledo-based ProMedica Health System said the Federal Trade Commission’s new antitrust challenge of its acquisition of a 198-bed hospital is inconsistent with healthcare reform. ProMedica has been ordered to appear before an FTC administrative law judge for a May 31 trial in Washington, D.C.

Phoebe Putney Hospital, a non-profit hospital in Albany, Ga., plans to complete its acquisition of Palmyra Medical Center, a for-profit also in Albany, in February.

Hoboken (N.J.) University Medical Center signed a letter of intent with HUMC Holdco.

Memorial Health System, which is owned and operated by the city of Colorado Springs (Colo.), is continuing to move forward its plans to convert into a community non-profit.

The board of commissioners for Beaufort Regional Health System in Washington, N.C., approved an affiliation with Franklin, Tenn.-based Community Health Systems, despite a recommendation from its medical staff to affiliate with Greenville, N.C.-based University Health Systems of Eastern Carolina. At least one physician practicing at Beaufort has said he will end his affiliation with the hospital if it moves forward with an affiliation with CHS.

Charlotte, N.C.-based MedCath Corporation completed the sale of the assets of Texsan Heart Hospital in San Antonio to Methodist HealthCare System, also in San Antonio.

Naples, Fla.-based Health Management Associates completed the sale of 140-bed Riley Hospital in Meridian, Miss., to Anderson Regional Medical Center, also in Meridian.
Nashville, Tenn.-based Vanguard Health Systems, a for-profit, completed its acquisition of eight-hospital Detroit Medical Center.

Good Samaritan Hospital in Vincennes, Ind., acquired the Vincennes (Ind.) Surgery Center.

Betsy Johnson Regional Hospital in Dunn, N.C., will merge into Harnett Health System, a new health system that will include Betsy Johnson and a new hospital in Lillington, N.C., which is expected to open in 2012.

Saint Joseph Mercy Health System in Ann Arbor, Mich., completed a merger with IHA, one of the largest physician groups in the Ann Arbor area.

Morgan County officials approved the merger between Morgan Hospital & Medical Center in Martinsville, Ind., and Indianapolis-based Clarian Health.

Columbus (Ind.) Regional Hospital selected Indianapolis-based Clarian Cardiovascular as an affiliate for heart surgeries.

Geneva, Ill.-based Deinor Health System and Winfield, Ill.-based Central DuPage Health signed a definitive agreement to merge.

The commissioners’ court of Llano County, Texas, decided to pursue the transfer of Llano County Hospital Authority to Temple, Texas-based Scott & White Healthcare.

Bloomington, Minn.-based HealthPartners signed a letter of intent to affiliate with Lakeview Health System in Stillwater, Minn., which owns a hospital and multispecialty practice.

Nashville-based, for-profit Vanguard Health Systems will purchase Holy Cross Hospital in Chicago, allowing the Catholic hospital to retain its religious identity.

Kalamazoo-based Bronson Healthcare Group, which operates Bronson Methodist Hospital, signed a letter of intent to acquire a 51 percent interest in Battle Creek (Mich.) Health System.

Maywood, Ill.-based Loyola University Health System confirmed it will consider a partnership with other Catholic health systems.

Steward Health Care System, the for-profit parent company of Boston-based Caritas Christi Health Care, filed an application with the Massachusetts Department of Health to acquire Merrimack Valley Hospital in Haverhill, Mass., and Nashoba Valley Medical Center in Ayer, Mass from Nashville, Tenn.-based Essent HealthCare for $21 million.

Sioux Falls, S.D.-based Avera Health will pay $5.5 million for Creighton (Neb.) Area Health Services, a hospital owned by the city of Creighton, effective Feb. 1.

Tenet Healthcare rejected a $3.3 billion offer from Franklin, Tenn.-based Community Health Systems.

After finalizing their merger, Vancouver, Wash.-based Southwest Washington Medical Center and Bellevue, Wash.-based PeaceHealth will create a non-profit health system with approximately $2 billion in revenues.

Lakeland HealthCare in St. Joseph, Mich., and Community Hospital Watervliet (Mich.) completed the integration of the two organizations in December, ending nearly six months of discussions.

The Federal Trade Commission approved a proposal for Fairmont, W.Va.-based West Virginia United Health System to add St. Joseph’s Hospital in Parkersburg, W.Va., and Camden-Clark Memorial Hospital, also in Parkersburg, to its system.
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