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

February 2012 • Vol. 2012 No. 2

The Future of Healthcare: 9 Capabilities for Post-Reform Success

By Molly Gamble

As with most things in life, health system success with health information technology is more about quality than quantity. Even the hospital with the most iPads or priciest electronic medical record can falter if it doesn't adapt to rapid change or maintain focus on the "big picture." There's a cluster of capabilities hospitals need to possess in order to monitor population health, reduce care disparities, maintain physician morale and remain the chosen provider for their patients. As the nation's healthcare delivery system evolves, here are nine crucial aptitudes hospitals need to thrive today and throughout 2012.

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Spurring Innovation in Healthcare Delivery: 5 Best Practices of Health System Leaders

By Lindsey Dunn

The system of delivering healthcare services is at a crossroads: While fee-for-service continues as the primary model of reimbursement, a transition to a value-based model is imminent. Even if the healthcare reform law is invalidated, healthcare spending as a share of total national spending is unsustainable. Healthcare leaders must prepare their organizations for this fundamental shift and must do so at an appropriate pace. Moving

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8 Issues for Hospitals to Consider Before an Integration or Sale

By Bob Herman

Consolidation and integration within the hospital sector is undoubtedly on the rise. While overall volume is up over past years, hospitals might not always be prepared for completing these types of transactions, especially as healthcare reform and regulatory bodies are part of the equation.

Krist Werling, JD, partner at McGuireWoods, and Bart Walker, JD, associate at McGuireWoods believe there are two main factors that can complicate a hospital sale: the discovery of regulatory issues and the perception of how those issues will affect the buyer's stance and price. "We're in a regulatory environment where hospitals are being watched by every different regulator," Mr. Werling says. "If you go down the road of selling yourself to a hospital system and a [regulatory] item is discovered days before you're

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5
critical outcomes quantified to help optimize Medicare payment and counting

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- Hospital Strategies for Surviving and Thriving in the Changing Healthcare Environment - Russ Richmond, MD, McKinsey Hospital Institute

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FEATURES

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

Publisher's Letter

5 Core Concepts for Healthcare Providers This Year; 2012 Becker's Hospital Review Annual Meeting — May 17-18, Chicago

Here are five core concepts for healthcare providers this year, as well as observations on key healthcare delivery trends during 2011.

1. Substantial shifting of healthcare providers. 2011 was an absolutely fascinating year in terms of pieces moving around the healthcare map. We saw an uptick in the amount of acquisitions by hospitals of hospitals and practices. Irving Levin and Associates reported that the top 10 hospitals mergers were valued at $5.6 billion in 2011, up from $3.8 billion in 2010. A recent Price Waterhouse Health Research Institute survey reported 46 percent of physicians are interested in hospital employment. This type of interest is consistent with the number of practice transactions we are seeing.

2. Assessing acquisitions, independence. We expect that in 2012 parties will be spending a good deal of time digesting the acquisitions they made last year and making sure that they have met their expectations. We expect independent hospitals and independent practices to take a deep breath and really assess their situation before aggressively moving forward to give up their independence.

3. ASC transactions, out-of-network, going public and more. The surgery center industry also saw a number of transactions involving national companies and hospitals buying surgery centers. We also saw (1) big chains pursue wholly the model whereby they partner with hospitals to acquire centers, (2) a return of big chains buying centers without hospital partners and (3) a couple large chains showing continued interest in acquiring physician-owned hospitals. In this sector, we also continue to see more and more aggressive action by payors as to out-of-network patients and increased effort to scramble for independent physicians to fill slots in surgery centers. We expect a few large ASC chains to test the public markets in 2012.

4. Increased governmental investigations. In 2011, we also witnessed significant increases in governmental investigation on a whole variety of fronts, including physician hospital relationships, false claims and billing and coding claims. With more integration of both providers and of payors, we expect more antitrust claims as well. Further, with more healthcare fraud investigators on the street, there will most likely be increases in anti-kickback and Stark Act investigations. RACs will also have an increasing material impact on hospital net income.

5. 2012 Developments. We expect 2012 to be a very interesting year. There will be (1) a Supreme Court decision on the Patient Protection and Affordable Care Act's constitutionality, (2) a presidential election and (3) a great deal of overall uncertainty in the markets as to the direction of the country, and as to the direction of the healthcare sector.

6. Becker's Hospital Review Annual Meeting — Great Topics and Speakers Focused on ACOs, Physician-Hospital Integration, Improving Profitability and Key Specialties. The Becker's Hospital Review Annual Meeting will be held May 17-18 at Hotel Allegro in Chicago. The two-day event will be co-chaired by Chuck Lauer, former pub-

lisher of *Modern Healthcare,* and Scott Becker, publisher of *Becker's Hospital Review*, and will feature keynote speakers Bob Woodward, Coach Mike Ditka and Suzy Welsh. More than 40 hospital and health system CEOs, CFOs and COOs will be featured among the event's 124 speakers and 74 sessions. Register Today! by visiting www.regonline.com/beckershospitalreviewannualmeeting_1041813. Registrations received before April 1 will receive a discount.

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Very truly yours,

Scott Becker

P.S. If you are interested in exhibiting at or sponsoring the Annual Meeting or advertising in our publications, please contact Jessica Cole at (312) 929-3675 or jessica@beckershealthcare.com for more information.

The Future of Healthcare: 9 Capabilities for Post-Reform Success
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1. Effective change management processes. Though it may sound trite, the most pressing capability health systems and hospitals need for true HIT success is effective change management. A large part of the challenge boils down to connecting HIT-driven shifts in care delivery to reasons why. Without explanations and context, providers may feel their processes and workflow is subject to arbitrary change. Debe Gash, vice president and CIO at Saint Luke's Health System in Kansas City, Mo., said she needs to thoroughly explain the causes behind any changes in her staff's workflow to earn their engagement. "I need the physicians to enter orders electronically," says Ms. Gash. "I have to build a justification for them to change the way they're doing things today, and provide a reason that resonates with them."

Wendy Whittington, MD, a practicing pediatrician and CMO at Dallas-based Anthelio Healthcare Solutions, says it's also critical to refocus the lens and help providers see the big picture when HIT might change comfortable routines. "It's important to remember what it is we're after here and keep your eye on the ball. Sometimes we get distracted and focus too much on one hurdle, like ICD-10," she says. Each of these "hurdles" — such as Meaningful Use, ICD-10, or computerized physician order entry — should be linked to the larger picture of population health, patient-centered care, and evidence-based medicine. This can help providers tap into the logic and meaning behind change that, at the time, might seem high-handed and purely operational.

2. Ability to develop new workflow and processes. By now it's clear that hospitals must do more than install an EMR to see real success. Work flows and processes need to be redesigned to make EMR use more efficient and streamlined with the process of care. Physicians do not want EMR, or HIT in general, to become another patient that requires extensive time and energy. "It takes skills around process design and process improvement to make that [integration] happen," says Ms. Gash.

Many hospitals are currently wrestling with the best ways to redesign providers' care processes around HIT without risking patient safety or employee satisfaction. Ms. Gash, a member of the Healthcare Information and Management Systems Society, mentioned the organization receives many requests from providers across the country asking for best practices to optimize EMR use.

Hospitals can see employee burn out and low morale if these changes in human behavior are not properly addressed. Alan Cudney, RN, an executive consultant with Beacon Partners, has seen these symptoms firsthand. "One thing I see among front-line staff and clinicians is a high level of anxiety and even frustration when they are asked to change their work practices to use clinical software on a computer. The software usually works better and more efficiently than the manual process. The transformation of familiar workflows and giving up 'tried and true' methods can be stressful for clinicians. Sometimes, even the most educated and experienced clinicians react by putting up a barrier. This may be passive resistance or outright rejection," he says It is prudent to involve clinicians in developing the new workflows and software configurations so that they will be more likely to accept the resulting solutions.

3. Data mining to inform clinical decision-making. A governance structure is necessary to manage the implementation of analytics capabilities. This is an effort so vital to HIT strategy that the majority of the hospital's C-level team should be involved. For instance, the CMO and CNO need to specify what information they want and the CIO can make that happen.

At its face, an EMR doesn't help physicians understand population health or arrive at conclusions about trends in metrics. This data should be drawn and arranged with a reference point to enable comparisons and benchmarking, which allows physicians to trace population health and compare hospital performance to national outcomes. Hospitals can save costs only if they leverage the drawn information to make it accessible and recognizable to physicians.

"The understanding and knowledge of business analytics and data governance is crucial," says Ms. Gash. "It's an understanding of how to use that data and find ways to standardize care or minimize variation, which can lead to cost reduction." Even though this capability is the first step to improve quality and cut costs, only 58 percent of healthcare organizations utilize business intelligence tools to help with quality reporting, according to a 2011 HIMSS survey. Another 75 percent of organizations that responded to the survey said they still need more IT resources to fully conduct quality measures.

4. Telehealth services to promote patient wellness and preventive care. Traditionally, telehealth was as a tool used to connect urban teaching hospitals with community hospitals in rural areas that lacked specialists. The services were primarily used for critical care purposes, such as patients in the ICU requiring specialized medical expertise. The case for telehealth services is shifting, however, from critical care and becoming more attuned with patient wellness and preventive care.

"Picture the hypertensive diabetic patient who lives in the middle of nowhere," says Dr. Whittington. "Say she slips her arm in a sleeve to measure her blood pressure, blood glucose and other vitals. Those results are then beamed to an RN in a case management center." A simple process like this could save the hospital and patient transportation costs. It also helps patients remain proactive in their care, as they are more likely to "put off" appointments when the physician is an hour or more away. Telehealth for the management of chronic illnesses and conditions — rather than strictly critical cases — also has large implications for integrated systems with their own payor or within an accountable care organization.

5. Technology to support providers' mobility. Physicians' and other clinical providers' understanding of HIT continues to grow more sophisticated. Now, just as they are accustomed to mobility with their own mobile devices and tablets, physicians are expecting the same in their workplace. Ideally, providers will be able to access patient data anywhere, at any time, on any device.

"What we're hearing is that physicians want to be able to do rounding in the hospital with access to data without having to stop and return to a computer to log in," says Ms. Gash. Providers are beginning to expect more from technology — and the hospital as well. This could include accessing a patient record on an iPad or iPhone, or accessing data in the format they need while outside of the hospital.

6. The adoption and maintenance of updated HIT security measures. A hospital's strides in HIT innovation and adaption are

in vain if it fails to address its security needs. Falling victim to a breach can significantly ding a hospital's reputation. Despite these high risks, 25 percent of healthcare organizations still don't conduct security risk assessments, according to a 2011 HIMSS survey. These are not only required by the Health Insurance Portability and Accountability Act and for meaningful use incentive payments, but are a simple best practice to identify areas of vulnerability.

"If you're going to have mobile solutions, you need encryption technology. If you're providing remote access to an EMR, you may need to have two-factor authentication or adaptive authentication similar to what is used in the banking industry. You may need tools to protect the hospital's perimeter from intrusion," says Ms. Gash. These are just a handful of the protective capabilities hospitals and systems need in order to avoid HIT's pitfalls, like breaches, unauthorized access and data theft.

7. Transparency with employees and patients. Despite the high need for privacy and security around HIT, transparency around the adoption of new technology is vital for employee engagement. There will likely be much more emphasis around the issue of patient access to health information in the coming years. "I think we're in the early stages of information exchange," says Ms. Gash. "Even if you look at Stage 2 of Meaningful Use, there are more requirements for patient transparency to medical records — more patient portals and standards around data exchange between providers."

There has been an increasing amount of attention to the relationship between physicians, patients and health information. There may be more opportunities for patients to adapt active roles in their care as they grow more comfortable with EMRs. A recent study published in the *Annals of Internal Medicine* found 92-97 percent of patients think open visit notes, made accessible through electronic links sent to the patient, are a good idea. Regulatory demands, along with patients' increasing interest in HIT participation, are something for providers to keep an eye on.

8. A governance team that provides the unique perspectives of various stakeholders. A hospital should ideally have a multidisciplinary HIT governance team that includes physicians, members of the executive team and other stakeholders. This variety ensures different departments have a voice in the direction of the hospital's IT strategy and innovation — preventing the silo effect — and gives physicians and other providers a chance to describe their daily processes and workflows.

A balanced governance team can create a sense of shared ownership among stakeholders by allowing them an opportunity to align strategy with IT implementation. "What I'm talking about when I say "governance," is the process where you link your organization's strategy to IT, are make sure both are aligned. Strong and successful [hospitals] will be really good with IT governance," says Ms. Gash.

9. An attitude of innovation. Leaders who embrace change and encourage innovation within their healthcare organization are more likely to rise to the top when it comes to HIT. Along with clinical and technological innovation, hospital leaders should also work to encourage positive attitudes towards change. Or, in other words: less whining.

Dr. Whittington says ICD-10 has been a big source of moans and groans in the industry as a whole. "It's my personal opinion that we have skated the ICD-10 deadline for a long time now," she says. "It's true there are other pressures upon us, but it makes me chuckle when I hear [people] say, 'Let's wait until this storm passes, and then we'll tackle ICD-10.' Well, I'll be amazed if this storm passes in my lifetime!" Linked to the first point, each member of the C-level team should link the steps of HIT implementation back to the broader goals of not only the hospital, but healthcare reform, to prevent begrudging attitudes towards change and innovation. ■

Spurring Innovation in Healthcare Delivery: 5 Best Practices of Health System Leaders
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too slow could leave the system ill prepared for an environment that bundles payments and rewards the prevention of illness, while moving too fast could reduce utilization under a system that financially rewards it, leading to poorer margins.

Kevin Fickenscher, MD, founder and president of CREO Strategic Solutions, a healthcare consulting firm, calls this transition a "reformation" within healthcare delivery. The move toward value means providers will be financially at risk for providing comprehensive coordinated care, which requires integration between physicians and acute, ambulatory and preventive services and a fundamental shift toward preventing healthcare utilization. The level of integration, standardization and information sharing required to achieve this will be a challenge for most healthcare organizations — save the Kaisers, Geisingers and Mayo Clinics of the world — which have not until recently made collaboration with non-acute providers a priority. As the industry evolves toward this new model, healthcare systems will be forced to evolve with it; innovators will flourish and laggards will suffer, and new business models will emerge.

Impactful innovation

While hospitals have instituted performance improvement initiatives for many years as a way to innovate their managerial processes, David P. Hunter, senior managing director and principal at Hunter Partners, a hospital management consulting firm, says hospitals now must focus on driving costs out of clinical processes. "In the late 1990s into the early 2000s, a huge focus of performance work was around more traditional management initiatives — things like productivity and supply chain management," he says. "Today, labor and supply chain management is pretty good. Focus is on the patient-care side. What we're looking for now is innovation that allows for significant improvement in cost and quality through changing professional — that is physician, nurse and other ancillary personnel's — behaviors."

Specifically, health systems must work to remove variation in the practice of medicine, ensuring adherence to the best clinical practices, which requires alignment with physicians and other care providers. "It's amazing the range of variation in practices. Some physicians spend four, five or six times the resources as other physicians for the same or lower outcomes, which creates a huge opportunity to reduce cost and improve quality. "The question then is how can systems get all physicians to use the practices of the physician with the best results?" asks Mr. Hunter. Moving clinicians toward innovation in their care practices can be a challenging one, but the payoff is huge. To ease the process, health systems should keep in mind the following five best practices.

1. Innovation starts at the top. To develop a culture of innovation, especially in clinical practices, innovation must be encouraged by top leadership. These leaders must then ensure a structure is in place to support clinical leadership and innovation. According to Dr. Fickenscher, this means developing more clinical leaders, providing them the training needed to manage other physicians and ensuring physician leadership within ambulatory services are put on the same level as physician leaders of inpatient services — a way of thinking that will be required for success under value-driven delivery models. Dr. Fickenscher also recommends pairing physician leadership with an administrative leader in a dual leadership model that oversees "longitudinal" services lines. For example, the oncology service line would oversee various related disciples, such as medical, surgical and radiation oncology, and would incorporate both inpatient and ambulatory services.

Many large integrated systems have also appointed chief innovation officers to oversee both clinical and non-clinical quality improvement initiatives, notes Dr. Fickenscher. The appointment of such a leader further demonstrates an organization's and its leadership's commitment to innovation.

2. Focus on culture. While support from leadership begins to spur innovation, the health system's culture must also support innovation. "People don't want to change, ever. So, you have to create an environment that encourages change," says Mr. Hunter. "In the old culture of hospitals, the doctors could basically do whatever they wanted to do. The goal now is to work toward a culture of transparency — where the doctors are much more transparent and much more concerned about how they compare to their colleagues."

While a culture of transparency doesn't happen with the flip of a switch, C-suite encouragement for this type of culture and an organizational structure of physician-leader champions can begin to shift the organization. However, these two elements alone won't significantly alter the organizational environment. Incentives are needed.

3. Provide incentives. Both Dr. Fickenscher and Mr. Hunter say financial incentives for providing high value care are critical to bringing about innovation that reduces costs while improving quality. "One of the core issues creating an impediment toward high value care is the current reimbursement system. The system is responding exactly as incentives are telling it to," says Dr. Fickenscher. "Until we start paying people differently, we shouldn't expect to see a lot of innovation."

Mr. Hunter agrees. "People innovate because of rewards. They aren't going to start searching for better ways to do things unless they derive some value out of it," he says. While he does note there are softer incentives — physicians inherently what to do what's best for their patients, for example — organizational-wide change requires more formal incentives. Therefore, hospitals will need to develop a compensation method, such as bonuses for employed physicians or a gain-

sharing model, to reward physicians and other providers for high quality, low cost care. He warns, though, systems must be very cautious when gainsharing with independent physicians due to Stark law and other regulations.

4. Provide high-quality data. After physicians have been given a reason to change their behaviors, they have to be given information about why and how to change their behavior. Without this information, efforts by health systems to change providers' clinical practices will be futile. "The hardest thing for many hospitals, particularly the less sophisticated ones, is the accuracy and cleanliness of the information you're giving the data-driven physicians to work with," says Mr. Hunter. "Hospitals are notorious for data problems. We don't even count things in the same way." Data provided to physicians must be accurate and understandable. If physicians can't make sense of it or have any reason to question its accuracy, they certainly will not rely on it to drive clinical decision-making, says Mr. Hunter.

For many hospitals, arriving at accurate data can be a challenge. "An electronic health record doesn't give organizations much intelligence from a population-health standpoint," says Dr. Fickenscher. Beyond an EMR, systems must have a way to collect, mine and interpret that information, which requires data warehousing capabilities and employees or to analyze the data and report it in an easy-to-understand manner.

One health system well versed in the use of data mining is Salt Lake City-based Intermountain Healthcare. Lee Pierce, director of business intelligence for the system, says Intermountain began pulling data from its electronic medical records, financial and other disparate information systems approximately 13 years ago, to build an Enterprise Data Warehouse. Today the EDW is an "integral part" of the health system's ability to fulfill its mission of providing the highest quality care at the lowest appropriate cost, he says. At Intermountain, data architects pull data from the organization's disparate systems into the data warehouse and then data analysts, or business intelligence developers, as they're called at Intermountain, pull the data and create reports and analysis that can be shared with various service line leaders. At Intermountain, these service lines are referred to as clinical programs. Each clinical program has a physician leader, an operations leader, a data manager and a data analyst who work with the leaders to build structures and tools able to interpret data in a way that is meaningful. For example, surgical services leaders receive reports on physician adherence to the multidisciplinary colon surgery care process model, which has decreased length of stay by 1.5 days and average hospital cost by $1,763 for colon resection patients. This information is then made available to physicians, nurses and administrators to reinforce the efficacy of following the MDCS CPM and used to identify areas for improvement.

For health systems that want to expand their data mining abilities, Mr. Pierce recommends they begin with building an analytics culture through leadership support of data-driven quality improvement initiatives. "It's about leadership and building an analytics culture. It can't just be an IT project. The value comes when IT partners with the business and clinical leaders and staff to deliver analytics," he says. "Start small, one quality improvement project at a time, and build upon those successes to advance analytics efforts in your organization."

5. Let the physicians drive the changes. Finally, allowing the physicians to guide innovation is critically important for success. "You have to provide physician leadership with data and then create an environment — through incentives and executive support — so they'll work with colleagues to improve their colleagues' practices," says Mr. Hunter. "It doesn't work if it's driven by bureaucrats. It has to be driven by the doctors." Hospitals can additionally support the physician leaders with training and development opportunities to help them determine which changes will create the biggest return in terms of value created for resources spent and ensure they have the interpersonal and management skills to drive clinical process coordination.

"How do you get good performers to influence the poorer performers, and how do you get poorer performers to respond?" he asks. "A lot has to do with peer pressure. Share what the great performers are doing, and then have them work with the others to bring them to their level." ■

9 Leading Hospital, Health System CIOs Share Top Goals

By Sabrina Rodak

2012 will continue to be both exciting and challenging for hospital and health system CIOs as they attest to meaningful use stage 1, await the release of meaningful use stage 2 rules and work to integrate technology across the organization. This year many CIOs will also continue or begin to prepare for ICD-10 in addition to pursuing a number of other initiatives, including health information exchange connectivity and expansion. Here, nine of the country's leading hospital and health system CIOs share their top goals for the year ahead.

Ed Babakanian, CIO, University of California San Diego Health System

Some of Mr. Babakanian's top goals involve integration of various health IT systems, such as the emergency department informatics system with the health system's Epic electronic medical records system. "[Another] major effort this year is integrating across the entire revenue cycle — billing, registration, [scheduling]," he says. "Decision support will be implemented across the entire health system, which will connect all clinical and financial information from both faculty practice and primary care as well as the hospitals. They are all going to go into one system that will obviously give us a strategic, competitive advantage," he says.

"We've already achieved Stage 7 [of EMR adoption from] HIMSS Analytics, which means we are pretty much there with the electronic environment," Mr. Babakanian says. "Our focus has been to leverage technology, not just for the sake of technology and implementation of computer systems but to implement [technology] in a way we can help our clinicians improve quality of care, improve patient safety and make the organization efficient. We are implementing technology to be able to achieve our mission, which is patient care, research and education," he says.

Arlyn Broekhuis, CIO, Sanford Health, Fargo, N.D., Sioux Falls, S.D.

"Our biggest goal as an organization for the technology area is to roll out our electronic medical record to all of our facilities. We need to be a meaningful user of our EMR and maximize our stimulus funding from the federal government," Mr. Broekhuis says. "We're [also] doing some work as an organization to develop clinics in different places around the country and around the world — children's and primary care clinics — in underserved areas. We're busy looking for IT solutions that will meet the needs of those clinics."

Mr. Broekhuis also identified preparation for ICD-10 and the development of a data warehouse as top goals.

Maureen Hetu, CIO, Lourdes Health System, Camden, N.J.

"The top goal for 2012 for Lourdes Health System is the deployment of medical record technology to be in a position to meet the requirements for meaningful use. We are also going to be deploying electronic health record technology for our physician practices in 2012. In addition to achieving meaningful use, our team will be focused on preparing for ICD-10."

Greg Kall, CIO, Summa Health System, Akron, Ohio

"First and foremost [we will] continue with clinical system deployment and expansion — an existing strategy around providing our clinicians with tools to create a more effective and safer clinical environment," Mr. Kall says. A second goal is rebalancing the applications portfolio. "We're in the process of deploying an ERP system and an enterprise-wide revenue cycle system. Both of these projects update our portfolio on the administrative system side and facilitate integration across our health system," he says.

In addition, he says, "As meaningful use plays itself out and as healthcare reform plays itself out, the need for us to share information with a wider community becomes more and more important. Over the course of the next couple years we will increase our investments in internal heath information exchange and interoperability technologies so we can move data, not only within our organization better, but to connect with our community better.

"Demand for us to keep our systems functioning properly increases exponentially as we involve more clinicians in this technology, so we're looking at creating a more high availability technology infrastructure. Since we're connecting to more and more people and moving data around a larger community, we'll [also] be making more investments in security infrastructure," Mr. Kall says.

Finally, he says, "I will focus on looking at my own IT organization and at better ways of doing business intelligence and improve the end-user experience. We need to reinvent ourselves to be more reactive to our community of users which is growing ever greater."

Thomas K. Langston, Senior Vice President, CIO, SSM Health Care, St. Louis

"SSM Health Care's information technology goals for 2012 primarily focus on three main areas: improving patient care, demonstrating commitment to our employees and physicians and improving our exceptional financial performance.

"For example, in the area of patient care, SSM's Integrated Health Technologies

will improve patient care through continued implementation of a comprehensive electronic health record. When the clinical portion of the project wraps up in 2013, [the] EHR will be available on more than 19,000 computers at SSM facilities in Wisconsin, Illinois, Missouri and Oklahoma.

"And in the area of financial performance, we will focus on reducing operating expenses while developing a 'Business Intelligence' program that will provide access to data and appropriate analytical tools to improve the capability of SSM senior leadership to improve performance."

Pamela McNutt, Senior Vice President, CIO, Methodist Health System, Dallas

"The top priorities for Methodist Health System in the IT arena would be the continued roll out of evidence-based computerized physician order entry and documentation, ambulatory physician EMR and integration strategies, preparation for new payment methods (ACOs, value-based purchasing, shared savings, etc.), installation of a new quality management system and ICD-10 preparation work. We achieved meaningful use stage 1 at three of our facilities in 2011, with one more to attest to in 2012, so we are keeping a watchful eye on the requirements for stage 2. Finally, the project management team is busy with major expansion projects underway at three of our hospitals, one of which is a replacement facility."

Stephanie L. Reel, Vice President for Information Services, CIO, Johns Hopkins Medicine, Baltimore; Vice Provost for Information Technologies, Johns Hopkins University

"For the year ahead, Johns Hopkins Medicine is preparing for healthcare reform by transforming its healthcare delivery system to become more tightly integrated and patient-focused. To accomplish the vision, our IT organization must manage critical system functions in a more integrated way across the enterprise. We will achieve clinical integration and ensure that the patient is at the center of care. We will also improve access to care and become more efficient so that we can ultimately decrease the cost of healthcare while continuing to improve outcomes.

"We have begun the design and deployment of a new, fully integrated information system that will allow us to achieve standard and consistent use of a fully integrated electronic health record in support of patient care, education and research. This will continue to be our focus in 2012.

"Additionally, our continued focus on patient safety will be supported by greater attention to clinical analytics and data-driven decision-making. We are building a team of analysts who will lead the way in using data in support of patient safety and the science of healthcare delivery, with particular focus on individualized care and population health.

"And as always, our attention and our resources will be focused on innovation, discovery and the creation of new knowledge across Johns Hopkins Medicine and Johns Hopkins University. Through the use of collaboration tools and technologies, we will be focusing on electronically enhanced education and high-performance computing in support of our science and scholarship.

"We will also be attentive to the needs of our faculty, students and staff. Work force development and a commitment to diversity remains a high priority for 2012 and beyond."

Sheila M. Sanders, Vice President of Information Services, CIO, Wake Forest Baptist Medical Center, Winston-Salem, N.C.

One of Ms. Sanders' major goals is to transition Wake Forest Baptist Medical Center to a new electronic medical record system for integrated clinical, billing and ancillary applications. "The EMR project is the cornerstone of the overall IT strategic plan," she says. "It reaches across every line of business at the medical center." The medical center is also planning a merger of its PeopleSoft systems, which manage people and finances. WFBMC will combine the PeopleSoft system of its North Carolina Baptist Hospital with that of the Wake Forest University School of Medicine to unify processes. Another goal is creating a single data warehouse for North Carolina Baptist Hospital and Wake Forest University School of Medicine to facilitate data analytics. "All of these projects are about integration, whether it's integration of our processes, our patient records or our financial information," Ms. Sanders says. "They represent the final pieces of our integration as a medical center."

Rick Schooler, FACHE, FCHIME, Vice President, CIO, Orlando (Fla.) Health

"In the fall of 2009, Orlando Health embarked upon its new multi-year strategy. Built on certain foundational pillars, the strategy also requires information integration throughout our healthcare continuum. Given our own priorities along with those of healthcare reform, we realize it is simply not possible for us to thrive in the future without several key information technologies in place and, most importantly, fully utilized. As such and building upon significant IT investment over the past decade, we have endorsed an additional thirty enabling initiatives which of course must integrate and operate with our existing applications and technology platforms.

"Throughout 2012, we expect to deliver to productive use several of these initiatives. The more significant of those [are] enterprise data warehousing and analytics, health information exchange, a patient portal, a patient self-service platform, physician practice EMRs, telemedicine and patient registries for enhanced care management of populations.

"In addition to these priorities, continued focus will be placed on improving quality and enabling organization efficiencies/cost reduction while meeting the requirements of ARRA/HITECH, meaningful use, e-prescribing and ICD-10/5010. We will also further deploy our various clinical documentation, decision support and surveillance capabilities including extensive growth in physician documentation. We will likely incur modest IT FTE growth, yet overall IT expense budgets will grow to accommodate strategic areas of priority, especially in the realm of physician practice integration and outpatient services expansion." ■

Speaking a Common Language: Q&A With Rex Healthcare President David Strong and CIO Novlet Bradshaw

By Molly Gamble

Rex Hospital in Raleigh, N.C. — a part of UNC Healthcare — is a completely paperless organization. It installed its electronic medical record system in 2007 and has since reached Stage 1 of Meaningful Use and achieved 80 percent adoption of computerized physician order entry. Leading the system's HIT advancement and implementation are Rex President David Strong and Vice President of Information Technology and CIO Novlet Bradshaw, who keep technological advancements at the forefront of the hospital's strategy. In fiscal year 2012, for example, HIT's capital allocation was second only to bricks and mortar investments at Rex.

Here, Mr. Strong and Ms. Bradshaw describe their current initiatives and drive towards meaningful use, describe the most stressful components of HIT and note how the role of the hospital CIO is expanding in today's healthcare environment.

Q: Ms. Bradshaw, CIOs possess an astounding combination of business and technology knowledge. Do you find one skill set emphasized in your role more than the other?

Ms. Bradshaw: No, they are both critical skill sets that have to be successfully leveraged and intertwined daily as the situation or audience dictates.

IT has [evolved] to become a critical success factor in the healthcare industry, especially driven by key initiatives over the past few years. IT involves the delivery of great service, not just technology, and we have to be able to differentiate our hospital business by delivering valued IT services and solutions. We are no longer technologists who sit in the basement, crank out code, take calls from the help desk or orders to fix somebody's computer or reset a password. Because we are now helping to transform business, we also need to transform ourselves into being key business leaders, like a CFO or a COO.

The chief technologist can't speak a language no one understands, so everyone leaves us alone to keep the lights green in the datacenter. It is equally important that I stay abreast of the technology trends and changes in the industry and remain proficient so I can lead the team and work with our IT partners to deliver the most reliable, easy to use and secure IT solutions to the business. That way, I am able to collaborate with our business and clinical partners to realize the Rex vision to deliver compassionate care enabled by technology

Q: Mr. Strong, how has your knowledge of HIT evolved in recent years? Do you find yourself possessing a more sophisticated understanding of HIT? If so, who or what has helped you get here?

Mr. Strong: Information technology is a key component of the healthcare business, and healthcare leaders can't sit on the sideline, abdicate that responsibility and defer their understanding of technology. [As] much as a CEO has to understand and lead in areas such as strategy, finance and operations, the same is now required with HIT understanding.

The role of the CIO is a key seat to fill. This person has to have the right set of technical, business and interpersonal skills that will collaborate with the executive team to deliver IT leadership, education and governance.

Q: Ms. Bradshaw, is there a certain aspect of HIT and healthcare reform that has caused you the most frustration, stress or uncertainty?

Ms. Bradshaw: It's actually both exciting and overwhelming right now. This is a great time to be an IT leader, but it is not for the timid and unmotivated. What is most challenging and rewarding for me right now is to meet the entire project and resulting resource demands driven the healthcare mandates related to meeting meaningful use, performance-based reimbursements and ICD-10 by mandated time frames all occurring over the next couple of years. These are all happening at the same time that the healthcare business is changing, and we have to form alliances with our providers and better integrate our clinical, business, decision support, administrative and IT infrastructure systems across our various entities in the UNC Health Care System.

Our IT users are getting more sophisticated. They're demanding we meet leading edge automation requirements that enable them to use the latest and greatest leading edge mobile computing devices (just like at home) that are not necessarily ready to support enterprise computing natively, securely or safely.

Q: Can you discuss meaningful use a bit more? How is Rex coming along in that area?


David Strong


Novlet Bradshaw

Ms. Bradshaw: We have fulfilled all the requirements and are currently attesting for Stage 1 meaningful use for the hospital per federal requirements. Meeting these criteria set by the government will allow Rex to receive an incentive, and more importantly, avoid millions of dollars in penalties for missing quality- and performance-based measures that could start as early as 2013.

The key to successfully implementing this project was cross organization collaboration among clinicians, administration and IT. Working together for the last 12 month as an organization was a priority. We expect to receive our incentive payment any time after Jan. 2012. We are also executing the activities necessary for our ambulatory physicians, who are eligible providers, to qualify later in 2012.

Q: HIT privacy and data breaches have been a significant concern for hospital administrators and lawmakers. 2011 brought a few major institutions into the limelight for privacy problems. How does Rex try to prevent problems related to privacy, compliance and HIPAA?

Ms. Bradshaw: Our process of keeping our data and infrastructure secure is multi-faceted and is always a top priority, given the strict HIPAA requirements to keep protected health information secure. We have a dedicated team of IT employees whose responsibilities are to make sure we safely manage and prevent unauthorized access to our data. We continuously perform risk assessment, and we have implemented solutions so we have the right controls and audit processes in place to manage access and data loss prevention.

Based on the same risk assessment, we also developed a robust disaster recovery, business continuity and security, and compliance program intended to address all the identified gaps. For example, we are making plans to have a redundant data site for all our critical applications, so they are always available. We also replaced our security software. And we hired independent consultants to periodically and proactively identify any vulnerability so we can address the gaps as soon as they are found.

Q: Mr. Strong, what are some of Rex's goals for HIT in the year ahead?

Mr. Strong: Rex, like other healthcare organizations across the country, has to implement and update our HIT systems and solutions to meet the various healthcare regulatory mandates and initiatives such as meaningful use and ICD-10. We must become prepared to proactively get in front of changing reimbursements and increased recovery audits from the federal government. HIT goals must address these needs and minimize our risks while continuously improving our physicians and clinicians' capabilities in proving safe and efficient patient care. Rex is a member of the UNC Health Care System, which is simultaneously responding to these same mandates while we increase our integration — especially in HIT interoperability. We also have a goal to be in the top 10 percent of healthcare systems across the country and HIT will help us achieve that goal. ■

Ahead of the Meaningful Use Curve: Q&A With CEO Chuck Sted and CIO Steve Robertson of Hawaii Pacific Health

By Bob Herman

CMS' Medicare and Medicaid Electronic Health Record Incentive Program has dished out a lot of money to eligible providers — $1.84 billion as of the end of November, to be exact. Roughly 2,900 eligible hospitals have registered for the meaningful use funds, and one of the first hospitals to receive incentive funds was Honolulu-based Hawaii Pacific Health.

CEO Chuck Sted and CIO Steve Robertson lead the four-hospital system in all things health IT, and the concept of being a "meaningful user" of electronic medical records and "e-healthcare" in general is not anything new to them. Through their different backgrounds, they both knew health IT would become a major part of the future of healthcare in the United States. Here, they explain how the health system stayed ahead of the curve, what major health IT goals HPH has for 2012 and how other health systems should try to prioritize their health IT initiatives.

Q: What are some of the big health IT goals you have for this year?

Steve Robertson: The goals today sound a lot more like business goals than IT goals. And while the healthcare environment is constantly changing, our priorities remain consistent. Our top priority is our sustainable healthcare initiative. It's a program that we essentially started a few years before the hubbub of healthcare reform. Its purpose is to really drive clinical integration and connecting our 350 employed and 700 community physicians. For example, this involves our Epic electronic medical record while really focusing on quality on the inpatient and ambulatory side. HIMSS placed us in the top 3.8 percent of the country of where we are at with our EMR and its capabilities. A key part of that is from developing a dashboard, metrics and quality measures and driving significant improvements in these quality measures.

Our second priority, which supports the first, is our HealthAdvantage CONNECT program. This is an EMR solution for our community physicians. Getting our physicians on our Epic EMR system is a huge benefit to our patients and our community as a whole. Being able to share a common clinical record with everyone is going to make our system a lot more robust. Today we've got 60 independent physicians live and running their practice with our EMR, and we've got another 22 contracted for this upcoming year.

Number three is getting our enterprise resource planning system fully deployed. The ERP is going to replace the general ledger, material management, payroll and other revenue cycle functions. The ERP is the last Holy Grail to put in place to get true system integration across the board.

ICD-10 is number four. We're probably not as far as long as we should be, but we might be farther along than other systems. There's a general reluctance to tie into this thing. Where we are today is each of our facilities has certified trainers for ICD-10, and we've trained portions of our staff. We also have an ICD-10 project charter and a steering committee, and we've done a gap analysis and are defining the budget right now. You need to look at what the financial impact is going to be — it's going to be pretty significant. From a revenue point of view, I don't think we know yet, but from a project-cost point of view, it will be in the $2 million to $3 million range.

Chuck Sted: I spent 18 years in public accounting and was a partner at Ernst & Young. I also was at Bank of America Hawaii for five-and-a-half years. When I came into healthcare 14 years ago, I came in with a healthy appreciation of IT, as it as an enabler of everything else.

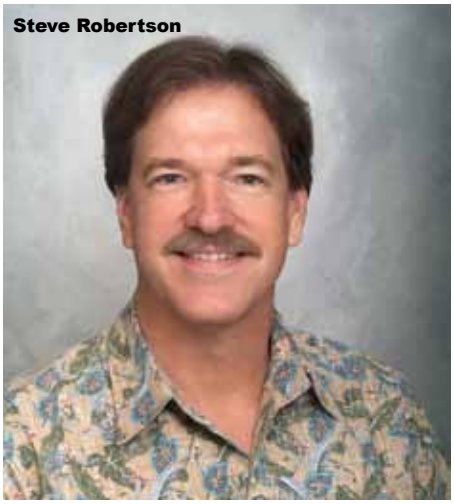
From a CEO perspective, my main responsibility is that we have to make sure we have the right human and financial resources allocated to health IT. Then when we get our leader, Steve, and his team in place along with the teamwork that goes on with all the other business, administrative and clinical people in the organization, then I stay the heck out of the way.

Steve is the CIO, but he's also the head of revenue cycle management. From my point of view, it's really the way to go. You see revenue cycle assigned up to the finance side, but as far as I'm concerned, the revenue cycle is inextricably intertwined with IT.

The other responsibility I have is the pacing. One of our baseline core competencies at HPH is prioritization and managing change wealth. Physician leadership is the second floor. The third floor is Epic, or IT more broadly, and the others are quality, service excellence and employee engagement. My job is to make sure we don't get too much going at one time.

Q: I noticed you didn't mention meaningful use at all, but that's probably also because you are pretty far along with meaningful use goals. Specifically, how far along is HPH with meaningful use, and what are some of the biggest benefits you've seen for being a "meaningful user"?


Chuck Sted


Steve Robertson

Steve Robertson: We're actually one of the first hospitals in the country to be paid by Medicare [for meaningful use]. We received just under $4.4 million for all our hospitals that qualify for the Medicare incentive. We attested in June and were paid in August. As far as the benefits go, we were already on track for receiving meaningful use incentives, so we didn't let it drive our direction. We already set our path a couple years before that came. Meaningful use was more of an administrative thing than anything. The benefit is we received the stimulus money for what we

were going to do anyway, and it actually allows us to invest more to support other parts of our healthcare initiative.

Our physicians haven't been paid yet. However, we've attested for more than 85 percent of the employed eligible physicians, and we expect to get paid early next year. The real challenge has just been the reporting side.

Q: What are some of the ways you help your physicians, nurses and other staff members buy into the health IT wave?

Steve Robertson: That's a great question, but I have to give you a little bit of background. Hawaii Pacific Health is the result of a merger between three different health systems in 2001. All of them were operating independently, and when we made the decision to consolidate systems onto Epic, that was a really disruptive innovation. As we went around and phased the "go-live," we drove the culture by working individually with nurses and physicians, driving to a common system and workflow. It really galvanized relationships and built trust. That sort of back-and-forth, constant communication and teamwork built up a core that helped us gain credibility once systems were installed. There's really no magic to it at all. It's that constant partnership, communication, transparency and really just listening.

Chuck Sted: We've had this conscious engagement from 10 years ago to have a culture of teamwork and to put aside the historical culture in healthcare that many organizations are still burdened with situations where the administration and physicians don't work closely together. If you look at how the Cardinals won Game 6 of the World Series, it's because they played as a team. If you look at how the Red Sox crumbled before the playoffs, it's because they didn't play as a team.

Q: What unique technologies has HPH installed, and how do they improve your system?

Steve Robertson: In terms of technology as a whole, there's nothing really new and exciting. Healthcare is generally 20 years behind the times. HPH is close to being caught up. We are proud of being able to have a web portal [MyHealthAdvantage] to support our patients and engage them.

In terms of infrastructure and networks and bandwidth, there's just nothing special or cool that I could really point to brag about. We built systems that provide complete and total transparency on every workflow we have, and I'm really proud of this. We have revenue cycle systems where data and information is instantly available. I can log into my own portal, and I can spot shifts and trends.

Q: You mentioned ICD-10 is one of your major HIT goals for this upcoming year. How do you see it playing out?

Steve Robertson: [ICD-10] is a major distraction. When you look at what we're trying to achieve, ICD-10 will derail that effort and change the entire focus to only supporting the administrative burden that does nothing to improve care. From the administrative point of view, it enhances recording capabilities, but we have to focus on basics through EHRs.

ICD-10 needs to be delayed two years. If you talk to healthcare CIOs and most healthcare CEOs, I'd be surprised if they wouldn't be supporting a delay of at least two years. It will require a massive change, and it will come at a time when health systems are likely to be weakest.

We're constantly faced with big changes and there's always some resistance, but I think that if ICD-10 came after meaningful use, you wouldn't get the resistance you see today.

Q: What kind of role does mobile technology, such as smartphones and tablets, have within HPH?

Steve Robertson: We have iPhones and tablets that allow physicians to have abbreviated access to medical record portions of patients. They love it, but repeatedly, newer technologies have the tendency to be a fad or a plaything. Wide rollouts are generally not a good idea until you really get it in place and you see how it's used effectively.

Chuck Sted: Everywhere there is an interaction going between the clinician and the patient, there's always a computer. One of the benefits is that the clinical person who is attending to the patient is physically present with the patient more often, that's what patients may want and that gets reflected in the patient satisfaction score. This is at the bedside but also in the primary care physician's office.

If I do go into a PCP's office or a specialist's office, I'm going through the usual routine, nurse checks the blood pressure, initial questions in the exam room, but they are sitting there with the keyboard typing. When the doctor comes in, he is talking with me, making his entries right in front of me, and when our work is finished — when he types his final keystroke — he puts his electronic signature on the note, and he's done. He doesn't have to go back at the end of the day. It's already off to the billing department and available to the next clinician who sees me.

Q: Because HPH is so far along in its health IT initiatives, particularly meaningful use, what kind of advice would you give to other hospitals that may be struggling in their HIT efforts?

Steve Robertson: My response would be it's really important to be steady on course. Given our very hectic [healthcare] environment, distractions are so common. Prioritization is so critical. Take one step at a time and stay focused on getting the job done. There's a lot of different ways to do this: open transparency, partnership, communication are really critical.

If you're an IT guy and you're focused on only IT things, you absolutely fail. From a CIO's point of view, IT and technology aspects should occupy less than 10 percent of your time. Most CIOs would readily recognize that, but we're at a pivotal historic change with health IT. The role of the CIO is radically different than what it was five to 10 years ago. If you're a health system and you're not focused on what's happening with healthcare and enabling that kind of ability to achieve goals, that system is going to fail.

Chuck Sted: I completely agree with Steve. From a CEO's perspective, my advice would be to be very articulate about a strategic plan and make your decision about IT in the context of the strategic plan. Don't let yourself get taken off course by fads. ■

Interested in sharing your experiences with health information technology efforts and meaningful use? Contact Lindsey Dunn, editor-in-chief, Becker's Hospital Review, at lindsey@beckershelathcare.com.

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PROGRAM SCHEDULE

Conference – Thursday, May 17, 2012

7:00am – 9:00am	Registration
9:00am – 5:00pm	Conference
5:00pm – 7:00pm	Reception, Cash Raffles, Exhibits

Conference – Friday, May 18, 2012

7:00am – 8:00am	Registration and Continental Breakfast
8:00am – 5:10pm	Conference, Including Lunch and Exhibit Hall Breaks
5:10pm – 6:30pm	Reception, Cash Raffles, Exhibits

Thursday, May 17, 2012

7:00 – 9:00 am
Registration

9:00 – 9:45 AM

A. Developing a Strategy for Your Hospital and Health System

Stephen Mansfield, PhD, President and CEO, Methodist Health System, Charles "Chuck" D. Stokes, MHA, Chief Operating Officer, Memorial Hermann, M. Michael Shabot, MD, Chief Medical Officer, Memorial Hermann, moderated by Bill Woodson, Senior Vice President, Sg2

B. Physician Compensation - A Review of Compensation Metrics for 5 Key Areas; Primary Care, Cardiology, Oncology, Orthopedics and Neurosurgery

Timothy Reed, Physician Practice Valuations Practice Leader, Sullivan Cotter and Associates, Inc.

C. Exploring the Facts and Fantasies of Physician Hospital Integration: Real World Examples of What Works, What Doesn't and Why

Peggy Naas, MD, MBA, Vice President, Physician Strategies, VHA Inc., Lani Berman, MBA, Vice President, Performance Services, VHA Inc.

D. Key Concepts for Successful Clinical Integration

Eric T. Nielsen, MD, Vice President, The Camden Group, and Teresa Koenig, MD, The Camden Group

9:50 – 10:30 AM

A. Key Strategies to Align Independent and Employed Physicians

Paul Summerside, CMO, BayCare Clinic, Chris Karam, President & CEO, CHRISTUS St. Michael Health System, Allan Fine, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, moderated by Kristian A. Werling, Partner, McGuireWoods LLP

B. Key Thoughts on Budgeting in Times of Uncertainty

John R. Zell, VP of Finance and CFO, OSF St. Joseph, Henry Brown, CFO, Westchester Hospital, Joseph Guarracino, Senior Vice President & CFO, The Brooklyn Hospital Center, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Hospital Physician Alignment: Implications on Profits and Performance

Alex Hunter, Managing Director, Navigant, Michele M. Molden, Executive Vice President and Chief Transformation Officer, Piedmont Healthcare

D. What's New, Next and Best in Healthcare Strategy, Marketing and Communications

Rhoda Weiss, PhD, National Healthcare Consultant, Speaker, Author & Editor, Marketing Health Services Magazine

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10:35 – 11:10 AM

A. Payor Provider Integration - A Case Study

Bob Edmondson, Vice President of Strategic Planning and Business Development, West Penn Allegheny Health System

B. Managed Care Negotiation Strategies 2012

Gregg P. Leff, Executive Vice President, Med Metrix

C. 10 Keys to Assessing the Short- and Long-Term Sustainability of Your Hospital

Scott Becker, JD, CPA, Partner, McGuireWoods LLP

D. The Evolution of Service Line Co Management Relationships, Best Practices

Gerry Biala, SVP of Perioperative Services, Surgical Care Affiliates, and Matthew Kossman, Senior Director, Surgical Care Affiliates

11:15 – 12:00 PM

A. Key Thoughts from Center of Medicare and Medicaid Innovation

Valinda Rutledge, Director of Patient Care Models Group, Center for Medicare/Medicaid Innovation

B. Sustainable Physician Compensation Model Design: Critical Success Factors for Building Productivity-Based Compensation Models

Marc D. Halley, President & CEO, and William Reiser, VP, Product Development, Halley Consulting

C. Core Strategies to Succeed as an Independent Hospital

Kerry Shannon, Senior Managing Director, FTI Consulting , Alan H. Channing, President & CEO, Sinai Health System, Joseph Guarracino, Senior Vice President & CFO, The Brooklyn Hospital Center, moderated by Kate Carow, Principal, Carow Consulting

D. Valuing Practices for Acquisitions - Assessing Acquisition Price and Compensation

Jon O'Sullivan, Senior Partner, Jonathan Helm, AVA, Manager, VMG Health

12:00 – 12:45 PM

Networking Lunch & Exhibits

12:50 – 1:30 PM

A. Developing an Outstanding Group Practice, Financial Sustainability, Culture and Other Issues

Jeff Mason, CEO, BayCare Clinic, Marc D. Halley, President & CEO, Halley Consulting, Joseph Golbus, MD, President, NorthShore University HealthSystem, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Consolidation - Strategic Thoughts for Consolidations and Independent Hospitals

Carsten Beith, Co-Head of Tax-Exempt M&A, Cain Brothers, Anu Singh, Senior Vice President, Kaufman Hall, Victoria Poindexter, Principal, H2C, LLC, moderated by Adam Lynch, Vice President, Principle Valuation

C. Building a Leading Neurosurgery and Spine Program

Casey Nolan, Managing Director, Navigant

D. Using Co-Management Effectively to Improve Results

Jen Johnson, CFA, VMG Health, Michael Piver, Director Orthopedic & Spine Services, Tanner Health System

1:35 – 2:20 PM

A. The 5 Best Ideas for ACOs, PHOs and Shared Savings Agreements

Charles "Chuck" Peck, President & CEO, Health Inventures, LLC, H. Scott Sarran, MD, MM, Chief Medical Officer, Blue Cross Blue Shield of IL, Mike Kasper, CEO, DuPage Medical Group, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Strategy, Quality and Efficiency

Imran Andrabi, President & CEO, Mercy St. Vincent Medical Center, Samantha Platzke, Sr. Vice President Operations & Systems Effectiveness, and Ben Sawyer, Executive Vice President, Care Logistics

C. Bundling Orthopedics and Other Key Concepts to Improve Orthopedic Volumes

John D. Martin, President & CEO, OrthoIndy, Julie Fleck, COO, Parkview Ortho Hospital, Doug Garland, MD, Medical Director of Orthopedics, Long Beach Medical Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP

D. Replacing Revenue for a Hospital When Developing Ambulatory Businesses

Robert Zasa, MSHHA, FACMPE, Founder, ASD Management

2:25 – 3:05 PM

A. Key Concepts to Be a Great Hospital CEO - How to Succeed and Develop Raving Fans

Paul R. Summerside, MD, Chief Medical Officer, BayCare Clinic, Peggy Naleppa President & CEO, Peninsula Regional Medical Center, Angela Marchi, Division Vice President, Health Management Associates, moderated by Kristian A. Werling, Partner, McGuireWoods LLP

B. Key Strategies for CFOs

Gary E. Weiss, CFO, NorthShore University HealthSystem, William T. Cusick, Executive Vice President/CFO, St. Mary's Hospital, Henry Brown, CFO, Westchester Hospital, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Muskoskeletal Programs and Physician Alignment For Hospitals

Jeff Leland, CEO, Blue Chip Surgical Center Partners and Megan Perry, CEO Sentara Health System

D. Keys to Successful Implementation of Physician Alignment Initiatives

Charles "Chuck" Peck, President & CEO, and Christian D. Ellison, Vice President, Health Inventures, LLC

3:05 – 3:20 PM

Networking Break & Exhibits

3:20 – 4:10 PM

A. Keynote Panel - The Unintended Consequences of the Affordable Care Act

Ken Hanover, CEO, Northeast Health System, Michael D. Israel, President & CEO, Westchester Medical Center, Andrea Price, CEO, Mercy Northern Region, moderated by Charles S. Lauer, Author, Consultant, Speaker and Former Publisher of Modern Healthcare Magazine

B. Panel Discussion - Key Thoughts on Hospital Restructuring and Turning Around Hospitals

Paul Rundell, Managing Director, Alvarez & Marsal Healthcare Industry Group, Michael R. Williams, CEO, Hill County Memorial, moderated by Barton C. Walker, Partner, McGuireWoods LLP

C. The Radiology Department of the Future -Maintaining Profits From Imaging as the World Evolves

Phillip Heckendorn, CEO, and David Walker, COO, RadCare

D. Valuing and Assessing Co Management Relationships

Scott Safriet, MBA, AVA, Partner, HealthCare Appraisers, and Amber McGraw Walsh, Partner, McGuireWoods LLP

4:15 – 5:00 PM

KEYNOTE – Leadership and Management in 2012

Mike Ditka, Legendary NFL Player and Football Coach

5:00 – 7:00 PM
Networking Reception, Cash Raffles & Exhibits

Friday, May 18, 2012

7:00 – 8:10 AM –
Registration and Continental Breakfast

8:10 – 9:00 AM

KEYNOTE – From Nixon to Obama

Bob Woodward, Legendary Political Journalist & Associate Editor, The Washington Post

9:00 – 9:45 AM

A. Keynote Panel - The Best Ideas for Health Systems and Hospitals Now

R. Timothy Stack, President & CEO, Piedmont Health System, Stephen Mansfield, PhD, President & CEO, Methodist Health System, Michael O. Ugwueke, CEO, Methodist Healthcare North and South Hospitals, Charlie Martin, CEO, Vanguard Health System, moderated by Charles S. Lauer, Author, Consultant, Speaker and Former Publisher of Modern Healthcare Magazine

B. The Current State of the Healthcare Credit Markets

Shane Passarelli, Senior Vice President, Healthcare Finance Group, Kevin Vermeer, CFO, Iowa Health System, Don Ensing, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Healthcare Reform - Future Thoughts on Success

Alan Sager, PhD, Professor of Health and Policy Management, Boston University School of Public Health

D. Patients Come Second, Employees Come First

Paul Spiegelman, CEO, The Beryl Companies, and Britt Berrett, CEO of Texas Health Presbyterian Hospital in Dallas

9:50 – 10:30 AM

A. Developing an ACO and Alignment Strategy for Your Health System

Marty Manning, President, Advocate Physicians Partners

B. What Should a Hospital CEO and CFO be Paid?

Paul Esselman, Executive Vice President and Managing Principal, Cejka Search

C. A Perspective on the Medical Staff of the Future

Ron Greeno, MD, CMO, Cogent HMA

D. Fixing Physician Hospital Joint Ventures That are Struggling

Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America

10:30 – 10:45 AM
Networking Break & Exhibits

10:45 – 11:30 AM

A. Keynote Panel - Great Leadership

Moderated by Suzy Welch, Author, Television Commentator, Business Journalist, Panelists: Kristine Murtos, President, Skokie Hospital, Melissa Szabad, Partner, McGuireWoods LLP, Teri Fontenot, CEO, Woman's Hospital, Pamela Stoyanoff, EVP & COO, Methodist Health System , Laurie Eberst, President & CEO, CHW Ventura County and St. John's Regional Medical Center

B. 5 Key Financial Ratios That Providers Should be Tracking

Kate Guelich, Senior Vice President, Kaufman, Hall & Associates

C. The Financial Return on Different Physician Alignment Strategies - How to Assess the Financial Implications of Different Alignment Strategies

Luke C. Peterson, Partner, Strategy, and Kate Lovrien, Partner, Strategy, Health System Advisors

D. The Most Common Medical Staff Problems and Issues and How to Handle Them

Tom Stallings, Partner, McGuireWoods LLP

11:35 – 12:20 PM

A. Keynote Panel - Evolving Strategy - Thinking 10 Months and 10 Years Into the Future

Moderated by Suzy Welch, Author, Television Commentator, Business Journalist, Panelists: Cathy Jacobson, CEO, Froedtert Hospital, Donna Katen-Bahensky, President & CEO, University of Wisconsin Hospitals and Clinics, Tammie Brailsford, RN, COO, Memorial Care Health System, Amber McGraw Walsh, Partner, McGuireWoods LLP

B. The Importance of Data and Analytics in a Bundled Payment Approach

Bob Kelley, Senior Vice President, Center for Healthcare Analytics, Thomson Reuters

C. Ideas and Concepts to Improve Cardiovascular Program Profitability

Susan Goldberg, RN, MSN, Director, CV Clinical Program, Aurora Healthcare, Andrew Ziskind, MD, Partner, Senior Executive, Accenture, moderated by James Palazzo, Managing Director, Navigant

D. Key Concepts to Police, Improve and Measure Quality

Kathleen Crawford, MSN, MBA, FACHE, Chief Operating Officer, Ashtabula County Medical Center, HFAP Nurse Surveyor, Linda Lansing, SVP of Clinical Services, Surgical Care Affiliates, Marion Martin, RN, MSN, MBA, COO, The Center for Quality, Innovation and Patient Safety, Roper St Francis Healthcare

12:20 - 1:05 pm

Networking Lunch and Exhibits

1:05 – 1:45 PM

A. ACOs in Action

Andrew Ziskind, MD, Partner, Senior Executive, Accenture

B. Hospital Transaction Preparation and Process Design

Barry Sagraves, Juniper Advisory, Rex Burgdorfer, Juniper Advisory, Martin Machowsky, SVP, Strategic Communications, McGuireWoods Consulting, Kristian A. Werling, Partner, McGuireWoods LLP

C. Generation Y - An Examination of the Mindsets in Employing the Next Generation of Orthopedic Surgeons

Les Jebson, Executive Director, University of Florida Ortho and Sports Medicine

D. Anesthesia Relationships - Current Trends and Issues

Hugh V. Morgan, Director, Quality Assurance, Marc E. Koch, MD, President & CEO, Somnia, Inc.

1:50 – 2:30 PM

A. Aetna's ACO Initiatives - Our Work With Health Systems to Pilot ACO Initiatives on Hospital Employee Populations

Debbie Lantzy-Talpos, Market Head, Aetna

B. Key Developments in Medicare Reimbursement and the Impact on the Delivery of Care

Ken Perez, Senior Vice President of Marketing, MedeAnalytics, Inc.

C. An Analysis of What Works What Doesn't - Key Thoughts for Physician Hospital ASC JVs

Tom Mallon, CEO, Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

D. 10 Keys to Running a Successful Acquisition or Joint Venture Program

Scott Becker, JD, CPA, Partner, and Barton C. Walker, Partner, McGuireWoods LLP

2:35 – 3:10 PM

A. The Best Ideas on Physician/Hospital Integration - What Works, What Doesn't

Bob Wilson, Executive Director, Health Care Advisory Services, Grant Thornton, I. Naya Kehayes, MPH, Managing Principal & CEO, Eveia Health Consulting & Management, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Optimizing Resources - Guaranteed New Savings and Revenues

Richard Kunnes, MD, Managing Principal, CEO, Sevenex

C. Acquiring Cardiology Practices - Key Concepts on Price and Compensation

James M. Palazzo, MBA, Managing Director, Navigant

D. Physician Relations: Best Practices in Leveraging QA Programs to Manage and Affect Positive Change

John DiCapua, MD, Vice President Anesthesiology Services, North Shore-Long Island Jewish Health System, Deputy CEO, CMO, North American Partners in Anesthesia

3:15 – 3:50 PM

A. New Types of Transactions to Deal With the Changing Environment - Payors Acquiring Providers, For-Profit and Not-For-Profit Hospital JVs and Joint Operating Agreements

Carsten Beith, Co-Head of Tax-Exempt M&A, Cain Brothers, Casey Nolan, Managing Director, Navigant, and Kristian A. Werling, Partner, McGuireWoods LLP, moderated by David Jarrard, President & CEO, Jarrard, Phillips, Cate & Hancock

B. Building a World Class Oncology Program - A Case Study

Gerard Nussbaum, Director of Technology, Kurt Salmon

C. Hospital Strategies for Surviving and Thriving in the Changing Healthcare Environment

Russ Richmond, MD, CEO, McKinsey Hospital Institute

D. Clinical Variation, Quality and the Role of the CMO

Bill Mohlenbrock, MD, FACS, Chairman and CMO, Verras

3:55 – 4:30 PM

A. False Claims, Anti Kickback Investigations and Other Common Issues of Litigation

Jeffrey C. Clark, Partner, Richard Greenberg, Partner, and David J. Pivnik, Associate, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Acquisitions of ASCs, Imaging Facilities and Other Ancillary Businesses - How to Examine Opportunities and How to Assess Pricing and ROI

Matt Searles, Managing Director, Merritt Healthcare

C. 5 Core Concepts on How to Reduce Readmissions

David Grinbergs, MD, FACEP, President of Emergency Services, and Eric Heckerson, RN, MA, FACHE, Vice President of Operational Performance, TeamHealth

D. Turning Today's PHO into Tomorrow's ACO

Elizabeth Simpkin, Vice President of Consulting Services, and Carole Black, MD, Chief Medical Officer, Valence Health

4:35 – 5:10 PM

A. Performance Improvement Initiatives for Hospital Affiliated Practices

John McDaniel, MHA, President & CEO, Peak Performance Physicians

B. An EMR for the Revenue Cycle: Documenting the Business Side of Care at Saint Joseph's Medical Center

Rebecca T. Black, Vice President, Revenue Cycle, Saint Joseph's Hospital of Atlanta

C. Personalizing the Management of Atrial Fibrillation - How Cardiac MRI can Improve Your Outcomes and Bottom Line

Jeremy Foterhringham, RN, MHSA, JD, Director, CARMA Center, University of Utah Healthcare

D. 5 Basic PR Tactics That Every Health System Should Remember

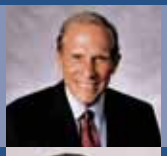
Marion Crawford, President, Crawford Strategy

5:10 – 6:30 PM

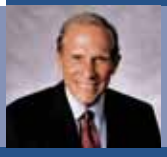
Networking Reception, Cash Raffles & Exhibits

SCHEDULE-AT-A-GLANCE
Becker's Hospital Review Annual Meeting

Thursday | May 17

7:00 - 9:00 AM	Registration and Exhibitor Set Up - Green Room and Walnut Foyer	
	WALNUT BALLROOM	SCREENING ROOM 1
CONCURRENT TRACKS 9:00 AM- 4:10 PM	**CEOS, ACOs and Physician Hospital Integration**	**Improving Profitability - CFOs, and Business and Legal Issues**
12:00 - 12:45 PM	NETWORKING LUNCH AND EXHIBITS IN GREEN ROOM	
3:05 - 3:20 PM	NETWORKING BREAK AND EXHIBITS IN GREEN ROOM	
3:20 - 4:10 PM	 Keynote Panel - The Unintended Consequences of the Affordable Care Act -	
4:15 -5:15 PM	 Keynote - Leadership and Management in 2012 - Mike Ditka, Legendary	
5:15-7:00 PM	Coctail Reception, Raffles and Exhibits Open in Green Room and Walnut Foyer	

Friday | May 18

7:00-8:00 AM	Registration and Continental Breakfast in Green Room	
General Session - Walnut Room 8:10-8:45 am	 From Nixon to Obama - Bob Woodward, Legendary Political Journalist	
	WALNUT BALLROOM	SCREENING ROOM 1
CONCURRENT TRACKS 9:00 AM- 5:10 PM	**ACOs and Physician Hospital Integration**	**Improving Profitability - CFOs, and Business and Legal Issues**
9:00 - 9:45 AM	 Keynote Panel - The Best Thoughts on Physician Alignment - moderated	
10:30-10:45 am	NETWORKING BREAK AND EXHIBITS	
10:45 - 11:30 AM	 Keynote Panel - Great Leadership - Moderated by Suzy Welch, Author,	
4:15 -5:15 PM	 Keynote Panel - Evolving Strategy - Thinking 10 Months and 10 Years	
12:20 - 1:05 pm	NETWORKING LUNCH AND EXHIBITS	
5:10 - 6:30 pm	Coctail Reception, Raffles and Exhibits Open in Green Room and Walnut Foyer	

CINEMA ROOM 1

Key Specialties and Related Issues - Orthopedics, Neurosurgery, Cardiology, Oncology and Radiology

PRESS ROOM

Co-Management, Clinical Integration, ACOs and Quality

moderated by Charles S. Lauer, Author, Consultant, Speaker, Former Publisher of Modern Healthcare Magazine

NFL Player and Football Coach

& Associate Editor, The Washington Post

CINEMA ROOM 1

Key Specialties and Related Issues - Orthopedics, Cardiovascular

PRESS ROOM

Physician/Hospital Joint Ventures, Quality and Anesthesia

by Charles S. Lauer, Former Publisher of Modern Healthcare Magazine, Consultant, Speaker

Television Commentator, Business Journalist

Into the Future - Moderated by Suzy Welch, Author, Television Commentator, Business Journalist

CONFERENCE SPEAKERS

Great Topics and Speakers Focused on ACOs, Physician Hospital Integration, Improving Profitability, and Key Specialties - 74 Sessions - 124 Speakers

Imran Andrabi, President & CEO, Mercy St. Vincent Medical Center

Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Carsten Beith, Co-Head of Tax Exempt M&A, Cain Brothers

Britt Berrett, CEO, Texas Health Presbyterian Hospital in Dallas

Gerry Biala, SVP of Perioperative Services, Surgical Care Affiliates

Carole Black, MD, Chief Medical Officer, Valence Health

Rebecca T. Black, Vice President, Revenue Cycle, Saint Joseph's Hospital of Atlanta

Tammie Brailsford, RN, COO, Memorial Care Health System

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Allan Fine, Chief Strategy and Operations Officer, The New York Eye and Ear Imfirmary

Julie Fleck, Chief Operating Officer, Parkview Ortho Hospital

Teri Fontenot, CEO, Woman's Hospital

Jeremy Foterhringham, RN, MHSA, JD, Director, CARMA Center, University of Utah Healthcare

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Ken Hanover, CEO, Northeast Health System, Inc.

Phillip Heckendorn, CEO, RadCare

Eric Heckerson, RN, MA, FACHE, VP of Operational Performance, TeamHealth

Jonathan Helm, AVA, Manager, VMG Health

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Bob Kelley, SVP, Centers for Healthcare Analytics, Thomson Reuters

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Teresa Koenig, MD, The Camden Group

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Andrea Price, CEO, Mercy Northern Region

Timothy Reed, Physician Practice Valuations Practice Leader, Sullivan Cotter and Associates, Inc.

William T. Reiser, VP Product Development, Halley Consulting

Russ Richmond, MD, CEO, McKinsey Hospital Institute

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Is Your EHR Implementation in Trouble? 10 Things to Check

By Bob Herman

Electronic health records — they are the wave of the future for all hospitals but a headache for some as well. The Health Information Technology for Economic and Clinical Health Act provides federal incentives to hospitals and physician organizations that are meaningful users of the technology systems, but in the rush to meet the meaningful use stages, providers might be encountering problems during their EHR implementation projects.

So what should providers be evaluating if their EHR projects are hitting snags and speed bumps? Dave Vreeland is a partner at Cumberland Consulting Group, a health IT project management firm that helps healthcare providers with EHR implementation projects. He gives a checklist of 10 things all hospitals should check as they undergo those EHR implementation projects, and he notes that if providers can't answer "yes" to the majority of the following questions, they should be concerned their implementation is in trouble.

1. Is the implementation a top organizational priority or one of many? With so many things grabbing a hospital's attention amidst healthcare reform, including accountable care organizations and health information exchanges, Mr. Vreeland says making EHR implementation the number one priority has to occur in order to avoid problems, especially considering EHRs are the building block for almost any health IT venture.

2. Is the project owned by clinical/operational people or IT? The EHR implementation should be led by operational and clinical leadership in conjunction with IT, not managed by IT alone. "These are not simply technology projects; they are clinical and operational transformation projects that have major technological components," Mr. Vreeland says.

3. Is there a clear project director in charge of the implementation? Similar to structured military exercises, an EHR implementation project should have a defined leader. Projects that involve converting to this type of health record system have a defined beginning and a defined end. Mr. Vreeland says it should be very clear who is in charge to guide the project along.

4. Are the top executives in the organization heavily involved? Top executives should not take a hands-off approach, especially in a project as complicated as one dealing with EHRs, Mr. Vreeland says. Just like a hospital CFO should be involved with a revenue cycle replacement, the hospital CEO, chief medical officer and other executives should take an active role to ensure this health IT system is employed correctly and efficiently. In the end, EHRs will be the future technological foundation for all clinical and operational stakeholders in the health system.

5. Are the clinicians heavily involved? Mr. Vreeland says it is a large error if upper management decides to involve the physicians at a later point. They need to be involved in the EHR workflow discussions, walkthroughs, testing, training and — most importantly — the design of the EHR. He adds that the voluntary medical staff should also be included.

6. Have the following documents been developed for the project?

- *Project charter.* This is the broad, overarching document that lays out what exactly the organization is doing relative to the implementation, who is responsible for what tasks and what the time constraints are.
- *Project plan.* Elaborating on the project charter, the project plan is more expansive and explains how the organization is going to carry out the EHR implementation tasks.
- *Communication plan.* When this large of a task is undertaken, communication can get broken up at times due to several moving parts. Establishing a course of action regarding how to best communicate with each team member can assuage any potential lapses in messaging or contact.
- *Clinician adoption/change management plan.* Mr. Vreeland says this document is essential to explain how the healthcare organization is going to take the clinical staff through the process of learning the new information system and how EHRs will impact their day-to-day. The chief medical officer plays a big role in informing the development of this document.
- *Project governance organization chart.* The hospital CEO plays a big role in executing this plan, articulating why the hospital is using its EHR system and outlining the structure of the entire team who will be working on the project.
- *Project team organization chart.* Similar to the communication plan, a flow chart showing who reports to whom is essential to any project, and EHR-based projects are no different, Mr. Vreeland says.

7. Is there a written status report every two weeks? Mr. Vreeland says if there is no sign of a written status report or no meetings regarding the progress of the EHR project, there is a communication glitch. "It ought to be like clockwork [the status report] comes out every two weeks," he says.

8. Is there regular discussion about how and when to implement mandates and changes to medical staff by-laws? When the EHR is finally installed, the physicians, nurses and other hospital staff will be using it to access and input patient data consistently, but there have to be ground rules regarding how to achieve "advanced clinical functionality," or how the clinical and medical staff will actually use the system, Mr. Vreeland says. The rules of being a physician or any other staff member at that particular hospital will have to be updated to reflect the new changes in patient information access. In general, moving to advanced functionality like CPOE and physician documentation will ultimately require the organization to mandate such use.

9. Has the organization articulated the three main reasons for the implementation? While the federal incentives from the HITECH Act are an impetus for hospitals to implement EHRs, Mr. Vreeland says those incentive dollars shouldn't be the main reasons of the implementation. Installing EHRs is still a workflow project, not a technology project, and the core reasons should be clear and made known to all parties involved. Examples of reasons could include: improved patient care through reduced medical errors, improved efficiencies throughout the organization and improved care quality through the use of the tools and information they provide about what interventions work best.

10. Is there measurable progress each month? If meetings show EHR implementation activities are consistently 90 percent done, action needs to be taken to ensure there is full execution of those activities. "If it's 90 percent done, go finish it," Mr. Vreeland says. "Those project management challenges need to be addressed." ■

10 Best Practices for Implementing Telemedicine in Hospitals

By Sabrina Rodak

Telemedicine and telehealth have the potential to increase access to care, improve quality of care and decrease costs. For instance, the American Telemedicine Association proposed legislation that would expand telemedicine and save an estimated $186 million over the next 10 years. In addition, the U.S. Department of Agriculture has devoted significant resources to the development of telemedicine, including recent grants totaling more than $30 million for telemedicine projects throughout the country. Here, several experienced hospital professionals share 10 best practices to build a successful hospital telemedicine program.

1. Conduct a market assessment. "The first step is to do an honest assessment of your capabilities and the needs [of] communities," says Tim Smith, MD, vice president of research for the Center for Innovative Care at St. Louis-based Mercy. Mercy started its telemedicine process with a community needs analysis. The executive leadership engaged the community at different events to find what healthcare services the community needed, according to Dr. Smith.

In addition to direct communication, hospitals can analyze data to assess the needs of the community. "Patient outcomes data can also be very helpful in determining what services to develop and which communities have a high need for a particular service," says Doug Lawrence, telemedicine program manager at Indianapolis-based Indiana University Health. "As an example, if a particular county in a state has poor patient outcomes for stroke and no local stroke-trained physician, developing a telestroke service to provide virtual stroke care to that county is an obvious solution."

2. Conduct a self-assessment. Hospitals need to evaluate their capabilities for providing the service lacking in the community as identified in the market assessment. "You need to be able to speak to your strengths within the service [and] match that with the needs of the community," says Aaron Bair, MD, medical director for the Center for Health and Technology at Sacramento-based UC Davis Health System. "It doesn't make sense to start down the path where the market is already saturated or you do not have specialists available. If want to do pediatric neurology, you better have a certain number of pediatric neurologists interested in providing telemedicine."

Hospitals should decide how to focus their telemedicine programs "based on an analysis of their own market, the anticipated return on investment, whether there are strong clinical champions and the goals for the organization," says Karen Rheuban, MD, medical director of the Office of Telemedicine and director of the Center for Telehealth at Charlottesville-based University of Virginia Health System. She says hospitals should also consider new regulations that may affect service delivery, such as penalties for readmissions.

Furthermore, decisions on telemedicine should be made by a multidisciplinary group of stakeholders. "It is helpful to perform a readiness assessment to determine starting points at each facility," Mr. Lawrence says. "Risk management, legal, IT, telecommunications carriers (in some instances) and clinical leadership should all be involved."

3. Align goals with the organization's mission. "Align the goals of your telehealth program with the mission of your organization," says Shelley Palumbo, chief administrative officer of the Center for Health and Technology at UC Davis Health System. This alignment will help hospital leaders develop a telemedicine program that is strategically valuable for the organization by working towards the hospital's overall goals.

"Consider and define the purpose for developing services," Mr. Lawrence says. "Is the purpose to better manage a disease state or health population within the hospital or health system, improve public health at the statewide level, [serve] as a patient satisfier reducing travel time and costs?" Defining the purpose can guide hospitals toward strategies to meet their goals.

4. Develop a timeline for implementation. Hospitals should organize implementation of a telemedicine system by creating a timeline for key stages of the project. Many factors affect the timeline, including the size of the hospital and the goals of the telemedicine program. "Ample time should be allowed for a market/needs assessment, ordering and installation of equipment, testing and troubleshooting of the equipment, training of clinical and administrative staff, conducting practice sessions with the partnering site(s) and account[ing] for any other issues that might arise during the implementation process," Ms. Palumbo says. Mr. Lawrence suggests hospitals also consider time needed for credentialing, which they say can take up to 120 days.

Less tangible factors such as support of the program by hospital leadership and buy-in from physicians should also be accounted for. "Any time you do something innovative, your timeline is going to be dictated by the level of support you have from the highest level of leadership," says Dr. Smith. "It's amazing how quickly and efficiently you can get things done when you have the support of your organization's executive leadership and when they make this a priority. You can cut months, even years, off of development."

Physician leadership is also key to a streamlined implementation process. "A realistic timeline for development and deployment must be linked to provider engagement, development of institutional champions, a careful analysis of the ROI and the infrastructure needed for the program," Dr. Rheuban says.

5. Gain administrative support. Executive leadership is important not only for a tighter timeline for telemedicine, but also for accessing needed resources, gaining buy-in from physicians and encouraging patients to use the technology. "One of the advantages Mercy brings is strong executive leadership who made this a priority," Dr. Smith says. Mercy's creation of the Center for Innovative Care, which is dedicated to driving innovative

projects, also helps programs like telemedicine succeed.

6. Identify clinician champions. "On-site champions and/or leaders should be put in place to drive development and ongoing support of the service," Mr. Lawrence says. "Physician leadership is a vital component as the physician(s) have to understand and desire the benefits of providing telehealth services and drive the development of the service within the hospital." Dr. Rheuban says hospitals can encourage physician champions by sharing success stories and visiting other successful telemedicine programs to highlight the potential benefits of the program.

One benefit is that seeing patients via telemedicine can enable physicians to delegate their time more efficiently. Dr. Bair says telemedicine allows physicians to spend more time with patients who really need care and effectively manage patients who need less care. For example, physicians can view a patient on video and decide whether that patient needs intervention, potentially saving the patient from traveling to a facility only to be told to continue the current treatment, Dr. Bair says.

7. Train providers. "Training is a key component of a successful program," Ms. Palumbo says. "Telehealth technology isn't that difficult to integrate, but it doesn't eliminate the need for training. Each of our practitioners goes through a hands-on program to learn how to use the equipment prior to seeing patients via telehealth. This enables practitioners to become comfortable with the video and audio components and discuss any remaining questions or concerns," she says.

Mr. Lawrence suggests using telemedicine for planning meetings or educational conferences to familiarize providers with the technology. In addition, IU Health often sets up mock visits or test calls to "alleviate any anxiety," it says.

8. Start simple. Hospitals should begin using telemedicine for simple services before ramping up to complex services such as multi-provider calls and interventions transmitted through the technology, Dr. Bair says. For instance, hospitals can start by using telemedicine for gathering patient history and providing consultations. As programs increase in complexity they can provide services in behavioral health, neurology and endocrinology, Dr. Bair says. "[Telemedicine] is somewhat tiered — starting simple with things that are easy to approach without a lot of additional technology, then higher levels of coordinated, multi-personnel [services] with augmented exam techniques."

9. Analyze outcomes. Hospitals should track outcomes from telemedicine over time to identify any gaps in care or opportunities to expand the service. "It is imperative that health systems that implement this technology and these kinds of programs study what they're doing and report out on that," Dr. Smith says. Studying outcomes and sharing them with others will help hospitals develop additional best practices, he says.

10. Integrate telemedicine with other systems. Dr. Smith suggests integrating telemedicine with other technologies such as electronic medical records to ensure efficiency and to better understand the data. "We are fully integrating all processes to study [data] more systematically and inform improvement process and optimization," he says. While integration is difficult, benefits such as being able to quickly access population health information and having a single database for patient records makes the process worthwhile. "Ultimately you get the best outcomes and best functionality if you can tie [telemedicine and EMR] together," Dr. Smith says. "It takes a lot of work; you have to have the stomach for it. It's much easier to do disconnected work, but in the long run I think most health systems will ultimately want everything

5 Legal Issues Surrounding Electronic Medical Records

By Molly Gamble

Though the technology has been around for roughly 30 years, physicians making the move from paper to electronic medical records may still face some challenges — particularly when it comes to understanding the legal implications of EMRs. In Nov. 2011, the Centers for Disease Control and Prevention reported that the percentage of physicians who've adopted basic EMRs in their practice doubled from 17 to 34 percent from 2008-2011. The percent of primary care physicians using EMRs grew even more, roughly doubling from 20 to 39 percent in that same time frame.

A large portion of EMR implementation revolves around a seamless transition for physicians, nurses and other caregivers, so as to not disrupt workflow or take excessive time out of their day. These systems, however, pose certain legal risks for physicians and healthcare systems that should not go unnoticed.

1. Risk for medical malpractice claims. Although EMRs present significant opportunities for long-term gain, they are quite a thorn in physicians' side at first. Physicians undergoing EMR implementation are at increased risk for medical malpractice during the time of adoption. The risk of error increases during the "implementation schism," or the time between the health system's transition from a familiar system to a new one. While many believe EMRs improve patient safety, their impact on medical malpractice claims remains unclear. A 2010 *New England Journal of Medicine* [1] report was unable to determine whether EMR-use increases or reduces malpractice liability overall — even after the implementation stage is complete.

Beyond boosting the mere risk of lawsuits, EMRs also affect the course of such litigation by increasing the availability of data and documentation that can either defend or prove a malpractice claim. Documentation in electronic form is often organized, detailed and more legible. Under federal law, EMR metadata — which consists of all electronic transactions such as time stamps of clinical activity and the input of orders — is discoverable in civil trials. This ranges on a state-by-state basis, however, and state law governs most malpractice litigation.

EMRs include more detailed patient information than what is required in traditional paper records, according to a report from the Federal Trade Commission. This can either help or hurt the physician's case against malpractice claims. For instance, the FTC report details a case in which a patient was left quadriplegic after surgery. The suit first targeted the surgeon's competence, but further review of EMR metadata revealed a date stamp that signaled suspicion over whether the anesthesiologist was present for the entire duration of the surgery. The availability of such EMR data in pre-trial discovery can heighten the likelihood of prosecutors finding some evidence of wrongdoing among an entire team of providers.

Sometimes basic human behavior, rather than egregious medical errors, is enough to trigger malpractice claims. EMRs provide physicians with clinical decision support, pop-up alerts, clinical prediction rules, or reminders for follow-up — a large variety of resources intended to improve care delivery. Still, while these EMR resources may influence a physician's clinical decision-making, any decisions related to patient care ultimately rest on the physician's shoulders.

"There's human tendency to fall to recommendations coming from literature," says Holly Carnell, JD, attorney with McGuireWoods in Chicago. "But if you read the EMR contract, there are various limitations related to the liability of the EMR vendor. If there's an error related to the accuracy of the clinical content or the manner in which the content is presented to the physician, it's difficult for the patient or hospital to hold the vendor accountable. That increases malpractice risk for the physicians," says Ms. Carnell.

EMRs also present the courts and the industry with previously unaddressed issues, for example, what constitutes the "legal medical record?" In the paper world, a medical record is a folder containing a stack of paper a physician uses as part of his or her basis for a clinical decision. However, in the electronic world, a physician is looking at certain screen shots in a particular order. "There's a big debate on what should be produced when a plaintiff requests a copy of a patient's medical record," says Ms. Carnell. Generally, the "print medical record" function in an EMR generates a report that bears no resemblance to what a physician was looking at when he or she made clinical decisions at the time of treatment.

EMRs are also regularly upgraded and hospitals aren't required to maintain a copy of the old environment, since doing so would be quite costly. Therefore, even if screen shots were produced, if the system had been upgraded between the time of treatment and the time the screen shots were captured, the screen shots may not represent what the physician relied upon to make a clinical decision. While there has not yet been a clear and concise resolution to this issue, it is certainly a matter to keep an eye on as EMRs continue to grow more sophisticated are more commonly adopted by healthcare providers.

2. Likelihood of medical errors. Given the tools available in EMR software, there's a common belief that EMRs can greatly reduce medical errors. But just as a reliance on spell check can leave an email peppered with spelling blunders, too much dependence on an EMR can result in small mistakes that can quickly turn into medical errors.

A 2005 study published in the *Journal of the American Medical Association*[2] found widely-used computerized physician order entry systems facilitated 22 different types of medication error risks. This included pharmacy inventory displays being mistaken for dosage guidelines, inflexible ordering formats that generated wrong orders, and CPOE display screens that prevented a coherent view of the patient's medications. Further, 75 percent of clinical staff surveyed said they encountered these error risks weekly or more often.

The *New England Journal of Medicine* article previously mentioned also pointed out that physicians' overreliance on a simple EMR function like copy and paste can perpetuate mistakes, leaving a long trail of errors less likely to be corrected. The copy and paste function also presents issues when it comes to authorship if a medical record is investigated for legal purposes. Aside from individual errors, EMRs also present the risk of bugs, viruses or other technological inefficiencies — crises that were never an issue with paper records.

Sometimes all it takes is a click of a mouse. Kenny Lin, MD, a family physician practicing in the Washington, D.C.-area, wrote a column in 2010 for *U.S. News & World Report* in which he recalled the time he nearly prescribed a patient the wrong medication for an ear infection due to an accidental click of the mouse. "I knew perfectly well that oral antibiotics — not eardrops — were the best choice and knew which one to prescribe, but had accidentally clicked on the wrong choice in my EMR system, leading to the wrong prescription being printed," Dr. Lin wrote in the column. Fortunately, Dr. Lin caught the mishap in time to still provide the patient with the correct prescription.

3. Vulnerability to fraud claims. The Obama administration's robust focus on healthcare fraud has signaled sharper focus on specific avenues for improper claims or billing, including EMRs. The Office of Inspector General's 2012 Work Plan included a focus on fraud vulnerabilities specifically presented by EMRs, making it the first work plan in which the agency explicitly named EMRs as targets for review. It also outlined plans to review Medicare and Medicaid EMR incentive payments to prevent erroneous payments to providers.

Apart from OIG scrutiny, EMRs present another risk to physicians when it comes to violations of the Stark Law and the Antikickback Statute. Under the Medicare Modernization Act of 2003, the Dept. of Health and Human Services developed safe harbors to promote physicians' adoption of HIT. Under these rules, published in 2006, healthcare systems or hospitals can pay as much as 85 percent of an EMR's cost for physicians in private practice. The physicians, in turn, must pay for hardware, installation and technical support. The safe harbor protects an exchange that would otherwise violate Stark Law — which prohibits monetary or non-monetary exchanges for referrals — and the Antikickback Statute. The rule was finalized under the rationale that the benefit of HIT adoption trumps potential risks of fraud.

Still, despite the safe harbor and exception, hospitals and physicians still risk legal repercussions if agreements are not meticulously crafted. "There are very specific requirements for the Stark Law exception and Antikickback Statute Safe Harbor," says Ms. Carnell. "There needs to be a written agreement carefully structured to avoid running afoul of these laws." A financial relationship between an entity offering designated health services and a referring physician will violate the Stark Law if it does not meet all of the requirements of a Stark Law exception. The Stark Law is strict liability and does not factor intent. "Even a so-called technical error, such as not fully executing the agreement, would be a violation," says Ms. Carnell.

The Antikickback Statute, on the other hand, is an intent-based statute with civil and criminal penalties. The government would examine the donation of EMR technology and determine whether there was intent to induce referrals to the hospital. "Full compliance with the Safe Harbor protects the donor and recipient of EMR technology from liability under the Antikickback Statute," says Ms. Carnell.

The Stark Law exception and the Antikickback Safe Harbor are substantially similar. However, because Antikickback is intent based, failure to meet all of the requirements of the Safe Harbor does not necessarily constitute a violation of the Antikickback Statute. "If the arrangement does not meet all of the elements of the Safe Harbor, and there is intent by the hospital to induce referrals though the EMR agreement, then the donor and recipient risk liability under the Antikickback Statute," says Ms. Carnell.

4. Breaches, theft and unauthorized access to protected health information. The Department of Health and Human Safety posts all data breaches affecting 500 or more individuals on a public website. Since Sept. 2009, there have been 380 incidents reported. The number of patients affected by health data breaches has been on the rise, with 5.4 million affected in 2010 compared to roughly 2.4 patients million affected in 2009. Theft was the most common cause of breaches affecting 500 or more individuals in 2010, the last year for which such data is available. Human error, loss of records and intentional unauthorized access to protected information were also general causes of breaches.

In 2011, Sacramento, Calif.-based Sutter Health was one system to experience a breach when a computer was stolen from its administrative offices and potentially exposed private information pertaining to more than four million patients. HHS and the Office for Civil Rights showed teeth in 2011 when they issued a civil money penalty of $4.3 million against Largo, Md.-based Cignet Health for a HIPAA violation. The fine, issued Feb. 22, was the first imposition of a CMP by the OCR for a HIPAA violation. A mere two days later, the agencies announced Massachusetts General Hospital in Boston had agreed to pay $1 million to settle potential HIPAA violations. A message was sent loud and clear to healthcare providers in those three days: OCR doesn't take HIPAA enforcement lightly.

"That was an interesting week," says Ms. Carnell. Prior to the HITECH Act [part of the American Recovery and Reinvestment Act of 2009], HIPAA was all bark and no bite. Enforcement efforts related to HIPAA were virtually non-existent. Now the government's ability and resources to pursue covered entities and their business associates is vastly enhanced," says Ms. Carnell. Economic factors come into play when it comes to this enforcement, as the administration has recognized HIPAA and HITECH violations as an ample avenue to recover funds and bring money back into a financially-addled government.

The most important steps hospitals can take to protect themselves in this environment of enforcement are thorough preparation and timely and appropriate response to HIPAA related incidents. For example, hospitals should have comprehensive HIPAA policies and procedures and the workforce should be appropriately trained to comply with such policies. Further, in the event of an impermissible use or disclosure of a patient's protected health information, the hospital should analyze the facts and circumstances, determine whether the use or disclosure rises to the level of a breach, take remedial measures to minimize the likelihood of the event happening again, report the incident as required under the HIPAA breach rules, and ensure accurate documentation is retained related to the incident.

"If a hospital is investigated or audited, it wants to be able to show it has taken steps to appropriately respond and remedy the incident. Fines aren't generally imposed unless it's an egregious violation or the violator has not cooperated with the government," says Ms. Carnell. "When a hospital suffers an inadvertent disclosure of health information because of a human error and immediately responds and remedies the situation, we haven't seen many fines." In general, the OCR has expressed a stronger focus on voluntary compliance rather than sanctions, according to Ms. Carnell.

5. Practical tips for healthcare leaders. Given the relative novelty of the EMR, hospital leaders may need to devote more strategy to ensure physicians are well-informed about compliance and legal risks. This starts in the EMR training process, which is not always easy for physicians. Given their traditional modus operandi, hospitals may need to develop certain initiatives in EMR education to make sure employees don't risk legality out of ignorance.

"Physicians are trained to autonomously practice medicine in the care of their patients," says Alan Cudney, RN, an executive consultant with healthcare consulting firm Beacon Partners. "Sometimes physicians and other members of the clinical team don't like to admit it when they don't know things. Sometimes, when teaching them to use new clinical software application, you may have to do so in a private environment. One-on-one training, as well as personalized "at the elbow" user support may be more effective, since physicians may feel less intimidated admitting uncertainties about using the EMR. In these one-on-one settings, physicians can more comfortably think about and discuss impacts of the software on their workflow, including real-life examples of how legal concepts affect their day-to-day routine.

Mr. Cudney also recommends hospital leaders promote cooperation between the hospital's IT department and physicians. The IT department can isolate itself from EMR-users within the hospital and lose touch of the "customer" focus. In this context, physicians are not necessarily customers, but should be treated as so with an emphasis on convenience, user input, reliable support and comprehensive training. When the IT department provides these services, physicians will be more accepting to change and more likely to embrace the new technology, according to Mr. Cudney. At the same time, this focus on the end-user must be balanced with a change control process that reviews all user requests and input against the strategic plan for the EMR and its impact on patient care workflows. Without adequate change control, the IT department could over-accommodate to the point of implementing inconsistent content or conflicting enhancements. To this point, hospital management should consistently evaluate physician-IT relations to ensure balance and cooperation. ■

Footnotes:

1 Sandeep S. Mangalmurti, M.D., J.D., Lindsey Murtagh, J.D., M.P.H., and Michelle M. Mello, J.D., Ph.D. "Medical Malpractice Liability in the Age of Electronic Health Records," New England Journal of Medicine, Nov. 18, 2010.

2 Brian Abaluck, Abigail Cohen, Stephen E. Kimmel, Ross Koppel, A. Russell Localio, Joshua P. Metlay, Brian L. Strom. "Role of Computerized Physician Order Entry Systems in Facilitating Medication Errors," Journal of the American Medical Association, March 9, 2005.

The Care Management Imperative

By Patricia Hines, PhD., RN, The Camden Group, Michael Randall, MHA, Director, Clinical Innovation, Advocate Health Care, Graham Brown, MPH, CRC, The Camden Group

Most providers recognize that the underlying healthcare cost pressures the government, employers and consumers face will inevitably lead to changes in how care is reimbursed, progressing in time toward a new form of managed care that preserves consumer choice and access while creating incentives for providers to improve care coordination and lower cost. Reducing the cost of care while improving quality is the right thing to do — the question really is one of timing, pace, and which model(s) (e.g., medical home, bundled payment, clinical integration, ACO) is most appropriate for the organization given local market dynamics and payor and physician relationships. Each of these integrated models incorporates the importance of case management. Despite all of the models to choose from, the same general concepts can lead to success under each. That is, there are really just a few key messages that every healthcare provider executive needs to know.

- Changing the way that organizations evolve from volume to value-based will be a multi-year journey that will involve a period of time of living in two worlds: volume-based fee-for-service and fee-for-value. Paying attention to the pace of change in the local environment is key to surviving this schizophrenic period.

- Organizations must embrace changes required in this era as a cultural transformation and a radically different way of thinking about how care is organized and delivered — and the role that various stakeholders play (including the patient!). Incentives and compensation are still predominately based on driving more volume and fees.

- Hospitals need to increase market share and reduce their cost base to remain profitable. Survival will require the ability to live on Medicare reimbursement rates or less.

- Improving payment rates will require organizations to achieve quality thresholds or better.

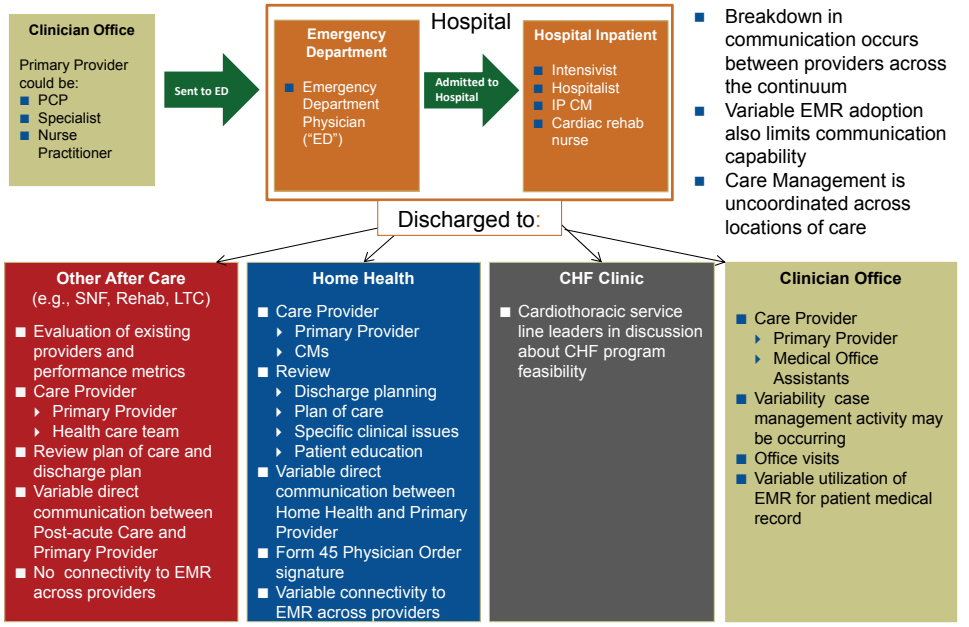
- Starting first with self-insured employees and beneficiaries or a commercial program can be a mechanism for incrementally increasing exposure to shared savings/loss arrangements and risk-based reimbursement while ramping up care management capabilities.

- The care management model design and implementation will differentiate those who succeed from those who fail.

An organization's "care management model" is its approach to coordinating inpatient, post-acute, physician office, and home-based care for patients with episodic and chronic disease management needs. How each of the separate components of the Care Management Model functions independently and with each other to identify patients with gaps in care and "high-risk" patients is the integral component to realizing cost savings. For the theorized cost savings of an organization's ACO financial model (typically 3 to 10 percent) to materialize requires a clear plan that deploys resources around high-yield opportunities for clinical quality outcomes and cost improvement. How well defined this care management model is (i.e., the clinical conditions of focus, the staff resources to coordinate care, and the processes and systems to support care management) determines the winners and losers in a value-based payment world.

In the new world of value-based payment, the care management model may provide the greatest opportunity for organizations to differentiate themselves from their competition to manage costs and improve profitability. Providers will increasingly need to take more responsibility for managing the total cost of care as payments migrate from fee-for-service to shared savings/loss, partial-risk and full capitation. This involves broadening the focus from within the walls of the hospital and adopting a broader definition of how care delivery occurs across the continuum (see Diagram 1).

Diagram 1



Priority areas to address

Roughly 5 percent of the population accounts for 50 percent of the total healthcare cost in America.[1] Conditions that drive a majority of those costs in a non-Medicare population include coronary artery disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease, asthma, mental disorders (excluding dementia) and osteoarthritis. Medicare high cost conditions include many of the same diseases: hypertension, hyperlidemia, heart disease, diabetes, COPD/asthma and osteoarthritis.[2] As healthcare systems manage the care for the patients with chronic diseases, consideration should be given to the cost opportunity of the anticipated outcomes and the timeline to realize those changes.[3] Opportunities for improving healthcare costs generally fall into a handful of categories with varying ability to influence cost-savings improvement and change (see Table 1).

Table 1

Cost Opportunity	Savings Impact	Ability to Influence	Timeline to Realize Change
Reducing Readmissions	High	High	Short
Decreasing ambulatory sensitive conditions	High	High	Medium
Lowering length of stay (per client)	High	High	Short
Variation in Clinical Practice	High	Medium	Long
Decreasing emergency department utilization	Medium	High	Medium
Increasing generic drug use	Medium	Medium	Short
Lowering length of stay (prospective payment)	Low	High	Short

Steps to defining the care model

As an organization undertakes the task of designing a care management model that will coordinate the patient's care across the continuum, there are several key steps that should be considered. These include:

- Analyze historical claims, utilization, cost and clinical quality data to identify the clinical care needs for the target patient population.
- Prioritize the four to five key clinical conditions and multiple co-morbidities of focus. These may be different for commercial versus Medicare versus Medicaid.
- Establish clear clinical quality outcomes and cost-improvement goals.
- Design a care management model that coordinates resources — various care managers, transitions in care, post-acute care facilities and ambulatory care
- A general approach is a blend of the top 10 to 20 percent of high-risk patients and specific programs for clinical conditions (i.e., disease management).
- Identify staff resource roles (i.e., outpatient care management team, including an RN case manager, clinical pharmacist and the patients primary care physician), call centers, home care, home-based monitoring, and psychosocial support.
- Evaluate the impact on physician offices and how the care management resources will work with physicians to coordinate care.
- Determine if there is a role for a catastrophic case manager who can act as a coordinator and liaison between all interested parties, enhancing communication and promoting teamwork for the most positive outcome achievable for the top one to two percent of patients who have high utilization needs.
- Measure the effectiveness of outpatient care management support resources by modeling pre- and post-implementation results.
- Reevaluate patient care and resource needs; consider if staffing levels are optimal to maximize results or if resources should be reorganized.

Transition from today to tomorrow

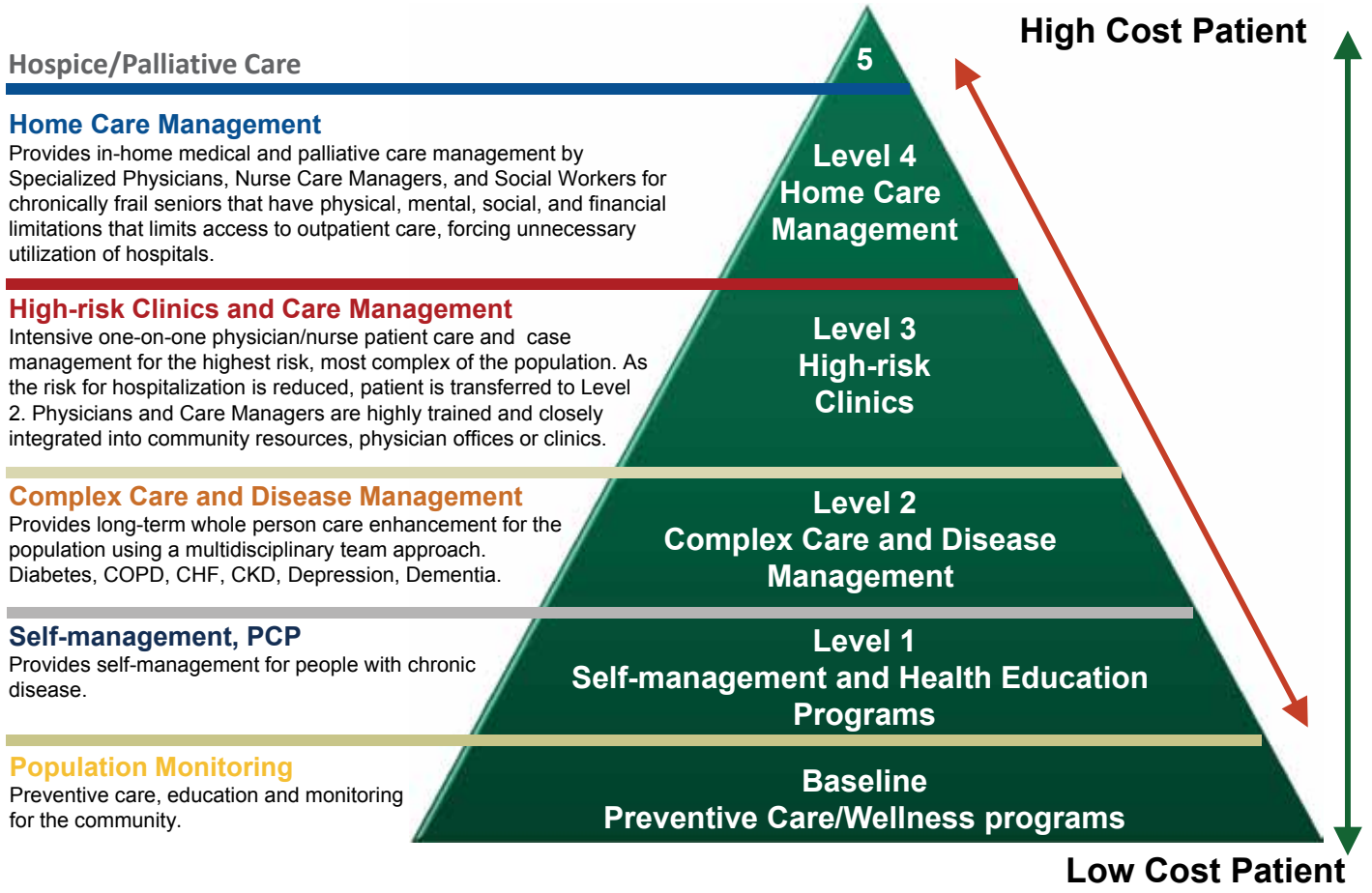
Organizations have seen successful program development by involving key physician and administrative leaders in an assessment, planning, and implementation process. A model for this approach is to establish a steering committee or planning group with the authority to:

- Develop a common vision for coordinating care across the continuum.
- Perform a current state assessment to understand gaps in care and opportunities for improvement and specific program initiatives to be developed in a future state model.
- Define the care model, populations to be served, and how clients transition from one area of service to another depending on their clinical need.
- Establish clinical work groups to prioritize clinical care initiatives and to adapt or adopt evidence-based guidelines to reflect the population characteristics of the communities served.
- Develop a staffing model that supports care delivery in the most appropriate, high quality and cost-effective setting.
- Develop educational resources and a communication strategy to inform physicians, staff and patients on the attributes of the care model, the role of care managers and services that are available to providers and their patients.

Aligning resources around the patient population

Upon initial assessment and when their clinical status changes, patients may be classified into one of five levels of care management need, depending on their clinical care requirements (see Diagram 2). Within any given year, experience suggests that approximately 10 percent of the patients will be high utilizers of resources based on their chronic disease(s). The care coordination for these complex patients' requires the health system to optimize smooth transitions through various communication strategies. Nurse care managers and physicians work with a team of related disciplines, the patient and their supports to modify the care plan for a patient appropriate to their clinical situation. Then they work to implement a plan of care that addresses their current needs, transitioning the patient higher or lower in the level of care needed.

Diagram 2



Case study

HealthCare Partners is one of the nation's largest physician groups serving California, Nevada and Florida. Their approach has been population health aimed at health education and self-management for healthy patients and those with basic chronic diseases. Interdisciplinary teams work intensively to help patients manage complex chronic illnesses.

In recent years, HCP instituted two interventions to support high-need patients at risk of hospitalization. At five Comprehensive Care Centers, multidisciplinary teams care for patients who have just been discharged from a hospital or who have conditions such as COPD or CHF. Homecare Teams of physicians, social workers and case managers visit homebound patients. The goals are to control conditions and return patients to care with their primary care physicians and free up resources for other high-need patients.

Results include Medicare patients use of 800 acute hospital bed days per 1,000 people — roughly one-third the national average. Hospital readmission within 30 days is just 12 percent — half the national average. Patient satisfaction rates are high. Cost savings are $2 million annually for every 1,000 members.

Key lessons for CFOs and CEOs

As organizations engage the healthcare team in designing care management models that are coordinated, seamless and patient-centered, there are few key lessons:

- Communicate and recommunciate the vision about value-based care.
- Understand that redundancy must be removed from the system.
- Build care management competencies today.
- Organizational change of this magnitude requires a cultural transformation and a clear mandate about the patient.
- Provide opportunities to train existing caregivers to new roles with an emphasis on communication, coordination, collaboration and accountability.
- In this era of transparency, the winner will be the organization that best manages the continuum of care for the patient. ■

Footnotes:

1 National Institute for Health Care Management Foundation Data Brief, July 2011.

2 Center for Healthcare Research & Transformation, Health Care Cost Drives Issue Brief, August 2010.

3 Kenneth E. Thorpe, Lydia L. Ogden and Katya Galactionova, Chronic Conditions Account For Rise In Medicare Spending From 1987 To 2006. Health Affairs, 29, no.4 (2010):718-724).

32 Health Systems, Physician Groups to Participate in Pioneer ACOs

By Molly Gamble

Thirty-two healthcare organizations across the country will participate in the new Pioneer Accountable Care Organization program, which is expected to save up to $1.1 billion over five years, according to the Deptartment of Health and Human Services.

The Pioneer ACO model is designed specifically for groups of providers with experience working together to coordinate care for patients. Participating organizations include Partners Healthcare in Boston, Steward Health Care System, also based in Boston and Ann Arbor-based University of Michigan Health System. Together, the participating systems represent 18 states. The names of all 32 participants, which were chosen after a "rigorous competitive selection process," are:

Allina Hospitals & Clinics (Minneapolis)

Atrius Health Services (Newton, Mass.)

Banner Health Network (Phoenix)

Bellin-Thedacare Healthcare Partners (Madison and Appleton, Wis.)

Beth Israel Deaconess Physician Organization (Boston)

Bronx (N.Y.) Accountable Healthcare Network

Brown & Toland Physicians (San Francisco)

Dartmouth-Hitchcock ACO (Hanover, N.H.)

Eastern Maine Healthcare System (Brewer, Maine)

Fairview Health Systems (Minneapolis)

Franciscan Health System (Indianapolis)

Genesys PHO (Grand Blanc, Mich.)

Healthcare Partners Medical Group (Torrance, Calif.)

Healthcare Partners of Nevada (Las Vegas)

Heritage California ACO (Marina Del Rey, Calif.)

JSA Medical Group (St. Petersburg, Fla.)

Michigan Pioneer ACO (Detroit)

Monarch Healthcare (Irvine, Calif.)

Mount Auburn Cambridge Indepedent Practice Association (Brighton, Mass.)

North Texas Specialty Physicians (Fort Worth)

OSF Healthcare System (Peoria, Ill.)

Park Nicollet Health Services (St. Louis Park, Minn.)

Partners Healthcare (Boston)

Physician Health Partners (Denver, Colo.)

Presbyterian Healthcare Services (Albuquerque, N.M.)

Primecare Medical Network (Ontario, Calif.)

Renaissance Medical Management Company (Wayne, Pa.)

Seton Health Alliance (Austin, Texas)

Sharp Healthcare System (San Diego)

Steward Health Care System (Boston)

TriHealth (Northwest Central Iowa)

University of Michigan (Ann Arbor)

The first performance period of the Pioneer ACO Model began Jan. 1, 2012. ■

Survey: 55% of Payors Plan to Participate in ACOs Over Next 3 Years

By Molly Gamble

Fifty-five percent of payors plan to participate in accountable care organizations over the next three years, according to survey results from HealthEdge.

The survey was based on responses from more than 100 payor organizations nationwide. Apart from ACOs, 48 percent of respondents plan to leverage value-based benefit designs, and 51 percent plan to utilize pay-for-performance models.

Despite these plans, the "vast majority" of respondents indicated that their organizations currently lack the technology necessary for these imperatives, according to the release. ■

8 Issues for Hospitals to Consider Before an Integration or Sale
(continued from page 1)

supposed to close, worst case scenario is the buyer might get scared and walk away, but more likely the buyer might lower its valuation of the hospital."

"Every buyer is looking for a reason to pay less," he adds.

If a hospital is preparing to put itself on the market for sale or integration into a health system, there are eight main issues they should carefully evaluate beforehand.

1. Relationships with referral sources. Out of all the issues a hospital must think about before it hits the open market, Mr. Werling says creating an exhaustive list of referral sources is the most important. For example, hospital executives should make lists and categories of physicians who lease space, physician employment agreements, medical director agreements and supply agreements. "It sounds simple, but you'd be amazed at hospitals that don't have comprehensive lists of all of their doctors with whom they have financial relationships," Mr. Werling says.

The U.S. Department of Justice is heavily involved in cases regarding the False Claims Act, Anti-Kickback Statute and Stark Law, which deal with fair market value issues and the prohibition of financial relationships between hospitals and referring physicians. There are several exceptions to the laws, and the onus will be on hospital management to make sure any financial relationships clearly fall within those exceptions. "Your buyers are going to look at that," Mr. Werling says. "The buyer doesn't want to buy themselves a problem with the DOJ."

2. Billing and coding. Medicare recovery auditors, zone program integrity contractors and other audit agencies are closely watching hospitals' billing practices. Occasionally, an audit will come back with negative news, such as overbilling Medicare. In those instances, hospital executives must be willing to show all audits, how they were rectified and perhaps conduct a re-audit to ensure its billing and coding practices are compliant and accurate. "When you're selling a hospital, you don't want to have [audits] just sitting there without an explanation of how you dealt with them," Mr. Werling says. "Buyers are going to say: 'Tell us more. What did you do to fix it? Did you contest it? How do we know it's not going to happen again after we take over?'"

3. Licenses, permits and accreditations. Mr. Werling says most hospitals will reach a point where they must clean up different problems regarding licenses, permits and accreditations. For example, the Joint Commission may provide a list of 10 things the hospital can improve on, and hospitals must remedy those recommendations as soon as possible. "Before you go to market, pull together recent surveys and audits, and just take a look at them to see if there are any that haven't been fully fixed," Mr. Werling says.

Additionally, hospitals must clearly document — even something as simple as an internal memo — how they fixed any issues with their licenses, permits or accreditations because a buyer will want to see that proof and self-auditing practice.

4. Commercial payor relationships. Commercial payors reimburse for a majority of healthcare in the United States, so a hospital executive team must be able to talk coherently to potential buyers about its relationships with those big insurers.

Mr. Werling adds that payor contracts that are on good terms but may expire soon could alter whether a buyer wants to get involved. "Even when you're in a time of calm, just make sure you know what your payor agreement situation is," Mr. Werling says. "If you have 40 percent of revenue coming from Blue Cross Blue Shield, is that up for renegotiation on Jan. 1? If it is, the buyer could be worried about that." In that case, a hospital may want to delay going to market until after a new contract is signed.

5. Contracts. Mr. Walker says the payor contracts offer significant value to any selling hospital, but there are other core contracts that must be considered: financing arrangements, large lines of credit, public bond offerings and, to a lesser extent, vendor contracts. "Commercial payor contracts receive the most focus from buyers because that is where the hospital's margins originate," Mr. Walker says. "Other types of contracts, though, can cause considerable heartburn when you are trying to close a deal."

6. Bonds and debt. Selling hospitals should be familiar with all aspects of their bond and debt documents, such as maturity dates and financing restrictions, but those documents are not the typical lunch-time reading material. Before any hospital prepares for a sale or integration, it must have a thorough understanding of the options under its bonds and debt agreements, and hospital legal counsel should get involved. "Bonds are complex financing instruments for hospitals and are laden with restrictions," Mr. Werling says. "This is a case of dusting those documents off and understanding what they say and what the restrictions are."

7. Culture of compliance. As mentioned earlier, hospitals are deep within a forest of regulations and rules. Any potential buyer in today's market will want to see the hospital endorses and disseminates a culture of compliance throughout the organization. Mr. Walker says hospitals must have an active compliance officer and privacy officer, and the compliance plan must be updated. "Hospitals should be doing [these things] anyway, but it's an area where organizations can get lazy pretty quickly," Mr. Walker says. "You do not want buyers to find the compliance officer asleep at the wheel."

8. Patient privacy. A branch of the culture of compliance that holds extra weight is patient privacy and all HIPAA obligations associated with patient privacy, Mr. Walker says. The updated compliance plan should have an emphasis on patient privacy laws, breach notifications and a specific HIPAA compliance plan. "A big component of this is training," Mr. Walker says. "[Hospitals] should give notices of privacy policies to all patients. In addition, they must have the necessary administrative, technical and physical safeguards in place to protect patient data." ■

CMS Issues Correction to OPPS Final Rule, Payments Decrease 0.1%

By Bob Herman

CMS recently issued a correction to its Hospital Outpatient Prospective Payment system for calendar year 2012 that will change the estimated increase for all facilities and hospitals from 1.9 percent to 1.8 percent.

The decline in payment rates resulted from the CY 2011 threshold models that were paying "1 percent of total payment for outliers rather than 0.93 percent. Therefore, the estimated total increase in payment based on the technical corrections…results in a decline of 0.1 percent."

Furthermore, CMS used an incorrect set of claims data in establishing the median costs. The fixed-dollar outlier for CY 2012 was changed from $1,900 to $2,025.

Table 59, which listed the estimated impact of the changes for the hospital OPPS, was also updated. CMS removed a hospital that had submitted a claim containing a single line for which no payment was made. The total number of hospitals represented in the OPPS data is now 3,894 instead of 3,895. ■

IRS Releases 2011 Form 990

By Bob Herman

The Internal Revenue Service recently released the 2011 version of the Form 990 for tax-exempt organizations, and Schedule H — which is filed by hospitals — has several major changes.

Changes within the 2011 Schedule H include the following:

- Hospital and health systems must list each of its hospital and non-hospital healthcare facilities, including those operated indirectly through a disregarded entity or a joint venture.
- All hospital organizations must fill out the questions in Part V that deal with the organization's financial assistance policy, billing and collections policy, emergency care policy and policy regarding individuals eligible for financial assistance.
- Community health needs assessment questions in Part V line 1-7 are optional for any tax year beginning before March 24, 2012.

Tax-exempt hospitals that are on a calendar-year taxable year must submit their Form 990 by May 15, 2012. ■

To view Form 990, visit: http://www.irs.gov/pub/irs-pdf/f990.pdf.

CMS Shelves RAC Prepayment Review Demonstration

By Bob Herman

CMS recently announced that it will delay its Recovery Audit Prepayment Review demonstration after it was inundated with comments and suggestions.

On Nov. 15, 2011, CMS announced it would launch three different demonstration projects. The RAC Prepayment Review program would allow RACs to review claims before they are paid to ensure the hospital or provider complied with all Medicare payment rules. The RACs would conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments, such as cardiac and orthopedic procedures.

CMS will now give at least 30 days notice before the demonstration begins in the seven states with high populations of fraud- and error-prone providers (California, Florida, Illinois, Louisiana, Michigan, New York and Texas) and four states with high claims volumes of short inpatient hospital stays (Missouri, North Carolina, Ohio and Pennsylvania).

CMS also announced that its Prior Authorization of Power Mobility Devices demonstration will also be delayed until further notice. The Part A to Part B Rebilling demonstration, which will allow hospitals to rebill for 90 percent of the Part B payment when a Medicare RAC denies a Part A inpatient short stay claim, still began on Jan. 1. ■

9 Things Healthcare Organizations Should Do Now to Prepare for ICD-10

By Bob Herman

Come Oct. 1, 2013, the healthcare landscape will be bidding adieu to a friend that has been around for more than 40 years: ICD-9.

Replacing it is ICD-10, which will become the new procedural, diagnostic, coding and billing default of the healthcare landscape for the start of the 2014 fiscal year, much to the displeasure of several groups. The American Medical Association stated in Nov. 2011 that it will "work vigorously to stop implementation of ICD-10," but CMS has repeatedly said that ICD-10 — which has been postponed for more than a decade already — will not be delayed any more.

In anticipation of ICD-9 heading out the door, here are nine things hospitals and health organizations ought to be doing right now to prepare for ICD-10.

1. Clear the Version 5010 hurdle. Currently, all HIPAA-covered entities must be compliant with the Version 5010 transaction standards, but CMS will not initiate enforcement of the standards until March 31, 2012. However, Version 5010 is like the training wheels on a bicycle. If hospitals want to have any success with their ICD-10 implementation, they must first get through Version 5010, which is an essential administrative and technological precursor, says Paul Spencer, compliance officer for Fi-Med Management.

The main reason for this switch to Version 5010 is due to the longer length of the ICD-10 codes. "Right now, ICD-9 stops at five characters, but with ICD-10, depending on the type of code, it can be four to seven characters in length," Mr. Spencer says. "It's important to build billing standards to accommodate that."

2. Align ICD-10 efforts with electronic health record initiatives. ICD-10 will impact a hospital or health system's operations in several areas, including technology, billing, coding and clinical documentation. Since ICD-10 requires certain technological advancements, providers should consider ICD-10 changes in concert with meaningful use and EHR initiatives, which are also required of hospitals and physician practices. For example, it would be futile for providers to upgrade their billing software for ICD-10 without ensuring their EHR is also fully transitioned. There needs to be interoperability between the two. "The bigger EHR vendors have been working on ICD-10 updates for years," Mr. Spencer says. "But there are still a number of physicians who have their EHR and billing separate. You have to look into integration."

The fusion of ICD-10 and EHR software is important beyond meaningful use, as well. Hospitals, in an effort to move toward accountable care organizations or a similar model, are affiliating with and purchasing physician practices at a rapid pace. Transitioning to an ACO-like model will be easier if hospitals and physician practices align their ICD-10 and EHR efforts. "Especially now when dealing with ACOs and hospitals acquiring physician practices, what they really need to do is look at all of billing systems they have," he adds. "If you're picking up a physician's practice with its own billing system, that in and of itself could create a headache."

3. Conduct risk and coding assessments. There are two types of areas in which hospitals should evaluate themselves in preparation of ICD-10: risk and coding. Lori Jayne, director of health information management and privacy officer at The Lahey Clinic, a teaching hospital of Tufts University School of Medicine in Burlington, Mass., says her organization has conducted several risk assessments to see where its coding and technology might be vulnerable in the wake of a tidal wave of new codes.

The Lahey Clinic had a third party assess which specialties involved the most risk of coding, billing or other ICD-10-related issues. In this case, those areas included neurosurgery, cardiovascular, radiology and orthopedics due to their high coding error rates and new and more specific codes. As The Lahey Clinic makes the transition to ICD-10, the HIM team will pay extra attention to those "risk" groups that will be heavily affected by ICD-10. "We did this risk assessment just so we're not chasing a needle in a haystack," Ms. Jayne says. "We have significant volume and complex patients. We identified those critical areas not just because the codes have just expanded but because the technology and approaches to the procedures have changed as well. We don't want our coders to be overwhelmed with all the new coding requirements for all patient types."

Hospitals must also perform a coding assessment. Gloryanne Bryant, regional managing health information management director at Northern California Kaiser Hospitals, said in a recent webinar that hospitals must see where their coders actually stand in their basic knowledge of the four core competencies of coding: medical terminology, anatomy, physiology and pharmacology. This initial assessment of 50 to 150 questions on the basic four competencies should have multiple choice and true/false answers while not allowing resources. This can give a healthcare organization an idea of what type of training and education needs to be provided for the nuts and bolts work of ICD-10. Several organizations, ranging from AHIMA to AAPC, offer those types of coding assessment solutions.

Brian Junghans, partner at Cumberland Consulting Group, agrees that hospitals need to provide refreshers on medical science, anatomy and physiology because the ICD-10 codes require a more specific anatomical reference.

4. Provide foundational and prerequisite education. Completing technological and assessment goals is the vital groundwork of ICD-10 projects, but eventually, hospitals simply have to train and re-educate their staff, particularly their coders and HIM professionals. Ms. Jayne says hospitals should hold 10-week courses that retrain staff members specifically in anatomy and physiology, two of the main core competencies.

Ms. Bryant says an organization should have already performed the coding assessment, and formal training on ICD-10 technology, codes and all other nuances should formally begin by Jan. 2013 at the latest.

5. Experiment with computer-assisted coding. Roughly one year ago, during the infancy of ICD-10 adoption for many hospitals, Ms. Jayne says The Lahey Clinic implemented computer-assisted coding into their coding business process. This technology essentially takes an abstract of rich-text documents, and instead of a coder manually reading a chart, the computer suggests codes, diagnoses and procedures through natural language processing to save coders time. "It takes a good 30 to 45 minutes to do a full coding record cycle, and with the expansion of ICD-10, it could double that time," Ms. Jayne says.

She adds that CAC could help the relationship between coders and clinicians. CAC and its related autosuggestions could prompt coders and physicians to double-check and correctly identify all intended diagnoses and procedures. "Improving your current documentation today is making it more efficient for your providers and coders," Ms. Jayne says. "It's a baby step, but it'll make it so much easier with training and implementation later on."

6. Enhance physician documentation. While coders and frontline staff undoubtedly play an integral role in the implementation of ICD-10, physicians and other clinicians are also a big part of the success and seamless transition to ICD-10.

Educating physicians on ICD-10 may not be the easiest of endeavors, especially as their schedules greatly vary from day to day. However, hospital staff must be dedicated to lay down a "gradual learning" approach for physicians and must understand that not all physicians and clinicians are technologically savvy. Additionally, ICD-10 will most likely affect the daily workflow of physicians and clinicians when the deadline hits, making it all the more important to improve their documentation now. "Clinical documentation is not as obvious a change straightaway, but how people document clinical content and what they need to collect differently to support the more complex code set is pervasive," Mr. Junghans says.

7. Consider installing a reporting and tracking system. Coders and providers each have their own separate challenges, but the two groups can help each other out during the ICD-10 process. Ms. Jayne says her hospitals installed a reporting and tracking technology system that interactively keeps track of a claim from documentation to billing.

Along the way, coders input information, clinical documentation improvement specialists track the information and a physician reviewer monitors the process from the clinician's point of view. Any one of the groups is therefore able to add its input in case there is a coding discrepancy. "In the event where we are questioned by auditors, instead of re-coding or re-evaluating a chart, we can look at all of the dialogue between the coder and provider," Ms. Jayne says.

8. Test functionality with vendors, payors and clearinghouses. Hospitals are expending a lot of energy to prepare internally for ICD-10, but a factor that cannot be left unattended is the testing of ICD-10 compatibility with health IT vendors, payors and clearinghouses, Mr. Junghans says.

Similar to Version 5010 risk mitigation strategies, hospitals should communicate with vendors and trading partners regularly, reach out to a clearinghouse for assistance, establish a line of credit to help cover potential cash flow disruptions from delayed reimbursement claims and take advantage of available ICD-10 testing resources offered by CMS.

9. Understand how ICD-10 will impact a hospital's bottom line. Hospital CFOs are well-aware of the technological challenges ICD-10 presents, and as hospitals wrap up their strategic planning phases, they also know the pending costs. ICD-10 could cost anywhere from a couple million dollars to as much as $100 million for very large, integrated health systems, but if the upfront costs are not swallowed, the future costs due to lost reimbursement and a lagging revenue cycle could be even greater. "The cost [of ICD-10] is going to overwhelming, but it's the cost of doing business," Ms. Jayne says.

Mr. Junghans agrees, adding hospitals must work under the assumption that there will be no more federal delaying of ICD-10. "In order to take full advantage of ICD-10 and to keep a steady state of operations and revenue collection, the sooner hospitals start education and the deeper they get the education entrenched, the better prepared for this transition hospitals will be," Mr. Junghans says. ■

Don't Let Fears About Healthcare IT Mire You in the Past

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

The decision-makers in hospital C-suites have healthcare information technology on their minds these days, but what they are thinking is not all warm and fuzzy. In fact, I detect a certain amount of dread about how it will fit into the future. Even with generous federal incentives for meaningful use of HIT, many hospitals still have not committed to an electronic medical record. Just this past September, HIMSS Analytics, the research arm of the Healthcare Information and Management Systems Society, estimated that only 41 percent of hospitals were ready to meet Stage 1 of meaningful use.

Of course, the high price of implementing EHR has put off a lot of executives, but I believe their concerns run deeper than that. In a Dell Computer survey of hospital executives last March, only 47 percent thought EHRs would be a positive step, and almost 80 percent were anxious about the need to train physicians and staff to use the new technology.

That is not exactly a stunning endorsement of EHR. Hospital executives seem to regard EHR implementation as a long and difficult slog, with uncertain results at the end. We have all heard the horror stories when EHRs' promised magic somehow went horribly wrong. Sometimes physicians and clinical staff had major problems navigating the system and had to stay late to fulfill their new data-entry responsibilities. Clinical care was disrupted, physicians were up in arms and the hospital did not expect a return on its investment for many years to come.

It's time to step up to the plate

All of these problems can happen, but I strongly believe we need to move ahead with EHRs and other technology. Potential problems should not take us off our goal. Rather, they should be instructive examples of how we need to handle EHR implementation better than others did in the past. The advantages of EHR are obvious by now. It can reduce medical errors, improve patient services, increase efficiency, improve workflow and reduce readmissions. A recent study of Philadelphia hospitals, for example, showed that it even reduced readmissions by an average of 7 percent.

Those who ignore EHR will miss the train as it is about to leave the station. The evolution toward advanced healthcare informatics may have been slow in the past, but it is speeding up. The HIMSS Analytics survey I mentioned before found that while still only a minority of hospitals are ready for Stage 1 of meaningful use, that number rose 16 percent from February to September 2011. Healthcare IT is coming sooner than many in this industry care to think!

Put yourself at a competitive advantage

Hospitals and physicians are going to need to adopt EHR and use it, or else they will lose patients to other systems who successfully make the transition. There are all kinds of ways that healthcare IT can help make your hospital more competitive. For example, having a good EHR system in place can help make you eligible for new programs, such as pay-for-performance and accountable care organizations.

Healthcare IT can also help with recruitment of physicians. In a recent survey by Epocrates, maker of point-of-care medical software, 70 percent of current medical students said EHR technology would be an important factor in deciding where they would practice medicine. And last but not least, you can lure more patients to your hospital with a robust healthcare IT system with features such as patient portals. The Dell survey found that 83 percent of hospitals are favorably interested in patient portals and other ways to do business online. While only 18 percent had partially or fully implemented a patient portal, another 62 percent were planning to do so.

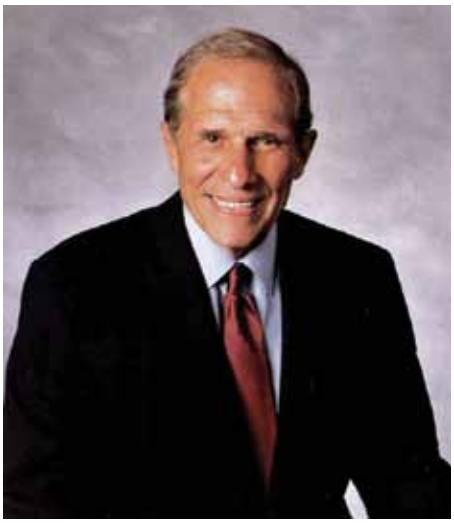
Some steps to keep you safe

If you are still deciding whether or not to implement EHR in the near future, there are ways to keep your institution safe from the perils of healthcare IT. Here, culled from the experiences of other hospital executives, are some steps to take.

Take time to do the groundwork. Most major health systems underestimate the amount of time it takes to implement EHR. You need time to get input from physicians and staff, choose a vendor, plan implementation, train staff and test software extensively before you go live.

Involve physicians and other clinical staff. These key groups should be involved from the beginning, when you are just starting to plan. The EHR system you choose has to fit their needs and be easy for them to use. If they are not on board, your system is likely to fail.

Find the right vendor. The vendor you choose should be responsive, and the system should be flexible enough to allow for improvements and modifications that your primary users identify. Your groundwork should involve performing a workflow analysis.



Hire experienced IT personnel. Seasoned IT personnel can make a huge difference in a successful implementation, but as more hospitals implement EHR systems, the growing demand for them makes it harder to find the right personnel. You may have to pay more to find the right people.

Don't skimp on training. Recognize that people who will be using the system have very different digital abilities and learning styles. Give them as many ways as possible to learn the ropes, including standard classroom training, one-on-one sessions, manuals and online exercises. This rich menu may cost extra, but it's worth it.

Plan for post-implementation snafus. No matter how well you plan, understand that there will be problems. After your go-live date, meet with physicians and staff to evaluate problems and deal with them head-on.

The transition to healthcare IT may seem daunting, but don't be discouraged! EHR is not something you can put off if you want to be a viable player in 2012 and beyond. It's time to move ahead and be part of the future. ■

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

Using HIT to Drive Clinical Integration, Patient and Physician Engagement and Population Health Management

By Kenneth Bertka, MD, Vice President of Physician Clinical Integration at Mercy

Since the passage of the HITECH Act, which was part of the American Recovery and Reinvestment Act of 2009, healthcare providers have been gearing up their healthcare information technology implementation plans to meet meaningful use requirements and gain financial incentives. In addition to providing a "carrot" to providers, the HITECH Act also included a "stick" — providers who do not achieve stage 1 meaningful use by 2015 will have their Medicare payments reduced — propelling many health systems to kick their HIT efforts into high gear.

Towards meaningful use

Mercy began its journey toward electronic health record implementation and computerized physician order entry 10 years ago. Beginning in 2004, we rolled out our EHR and CPOE across our four hospitals. At that time, there were no government mandates for adopting HIT or meaningful use criteria; however, our health system was committed to implementing these technologies because we recognized it was where healthcare was heading, and it was the right thing to do for our patients. While there were challenges surrounding implementation and being a CPOE pioneer, the use of our EHR for CPOE is now well engrained into our culture. All four of our metro-Toledo area hospitals have attested for both Medicare and Medicaid stage 1 meaningful use, and that's something we're very proud of.

The goal behind these efforts has always been to improve access to up-to-date clinical data to guide clinician and patient decision making, thereby improving quality, safety and efficiency of care. We're achieving that. For example, our tertiary care hospital reduced medication errors by 67 percent in the first year after we switched to CPOE and bar coding medication administration. We hope to continue to expand access to data as we further integrate our records with affiliated physician offices and eventually other systems. At Mercy, we plan to not only use our HIT systems as tools to facilitate integration but also to drive patient engagement and population health management — all of which will be core competencies of health systems under healthcare reform.

A key reason for our success has been physician engagement in the process. Decisions around EHR policies, processes and order set development were physician driven. Health system leadership invested in physician involvement by entering into contracts with physicians who participated in the various committees around our HIT efforts. We created a Physician EHR Design Committee to guide CPOE implementation and an EHR Oversight Committee to oversee clinical policies connected to our HIT initiatives. The contracts compensated the physicians for their time and effort but also served as formal mechanism for accountability. These committees required time, effort and "homework" beyond that expected in typical medical staff committees.

Our initial focus was the acute-care environment. However, in Oct. 2011 as part of Catholic Health Partners, Mercy implemented CarePATH (Epic EHR) in all Mercy-owned physician offices and clinics. We strategically decided to launch the ambulatory EHR across all outpatient sites on the same day. The rational was we wanted to have all sites on the same EHR platform rapidly because patients are often served by multiple sites concurrently. The "big bang" implementation of 233 attending physicians and 186 residents in 72 practices/clinics brought us to a "one patient, one chart" environment in record time. Now that each outpatient site is live, we'll work throughout 2012 to optimize CarePATH at each location and to reach meaningful use attestation under the Medicare or Medicaid option. Unlike hospitals, which can attest for both Medicare and Medicaid, physicians must choose between the two. Medicaid payments for meaningful use are higher, so our system will work to determine which physicians are eligible for the Medicaid program and enroll them there.

Integration

In 2012, we will begin the implementation process to replace our current inpatient EHR with CarePATH. Doing this will provide us true integration across inpatient and outpatient environments, thus moving us closer toward our ultimate goal of providing current clinical data when and where it is needed — a goal that should guide every health system's HIT decisions.

Additionally, we plan to make the ambulatory CarePATH EHR available to Mercy's affiliated physicians using a subsidized model. Allowing our independent physicians access to this system is important because it improves our ability to share information and to coordinate patient care. However, we recognize that not all physicians, and certainly not all hospitals, use or will use Epic EHRs. Accordingly, Mercy is working closely with Ohio's statewide health information exchange to

test ways providers across the state can best share medical record data. As we move toward a payment system that rewards value-based, coordinated care across the care continuum, our ability to share and receive information from outside providers will become critical to our success.

Engagement

We also hope to use HIT to increase patient engagement. We currently offer an online patient portal called MyChart, which allows patients to access their medical records and lab results, request refills, send messages to nurses and physicians and make appointments. Patients can access the portal from any computer as well as most tablets and many smartphones. Some within the industry have voiced concern over allowing patients to see this type of information, but at the end of the day, the information belongs to the patients. Our goal has always been to improve access to clinical information, and the patient portal does just that. We have safeguards. For example, certain positive test results are not released to MyChart until the physician chooses to release the information (presumingly after appropriate discussion with the patient).

Consider this scenario: How engaged would you be with an airline that could only be reached from 9 a.m.-5 p.m., is closed during lunch and doesn't have a website? Chances are you'd never consider buying a ticket from them. But this describes a great deal of medical practices today. The patient portal makes it easier for patients to interact with us and offers them the access they need to be engaged in their care. In a future that rewards physicians and health systems for keeping patients healthy, we must do everything possible to engage patients in their health.

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61 Integrated Health Systems to Know

By Sabrina Rodak

61 Integrated Health Systems to Know

Becker's Hospital Review has named "61 Integrated Health Systems to Know" based on organizations' access to care, physician alignment and inclusion of numerous and varied services along the continuum of care. The systems have been recognized for integrated care by healthcare analytics company SDI, peer institutions via nominations and through careful research by the *Becker's Hospital Review* editorial team. *Note:* This list is not an endorsement of included health systems or associated healthcare providers, and health systems cannot pay for inclusion on this list. Health systems are presented in alphabetical order.

Advocate Health Care (Oak Brook, Ill.). Advocate Health Care is the largest integrated healthcare system in Illinois and one of Chicagoland's largest employers, with more than 30,000 employees and affiliated physicians. Advocate includes roughly 6,000 affiliated physicians, making it the state's largest network of primary care physicians, specialists and sub-specialists.

Alegent Health (Omaha, Neb.). Alegent Health is the largest non-profit, faith-based healthcare provider in Nebraska and southwest Iowa, providing care at more than 100 sites. In addition to its nine hospitals, the system has multiple clinics, including nine urgent care clinics, three wellness centers and six pharmacies.

Aurora Health Care (Milwaukee). Aurora Health Care offers care at 15 hospitals; 185 clinics; 82 retail pharmacies; multiple diagnostic, treatment and rehabilitation centers; and home healthcare and social services agencies. As the largest private employer in Wisconsin, Aurora has roughly 30,000 caregivers, 1,400 employed physicians and 3,067 physicians on staff.

Banner Health (Phoenix). Banner Health delivers care in seven states through 23 hospitals, long-term care centers, pediatric facilities and family clinics. Banner has more than 35,000 employees and approximately 7,000 physicians on its hospitals' medical staffs.

Baptist Health Care (Pensacola, Fla.). Baptist Health Care is comprised of more than 6,000 employees, including physicians, making it the largest non-governmental employer in northwest Florida. The system includes four hospitals, two medical parks, a pharmacy and several other centers.

Baptist Health South Florida (Coral Gables, Fla.). Baptist Health South Florida is the largest faith-based non-profit healthcare organization in the region, with more than 13,500 employees and approximately 2,000 physicians. The system consists of seven hospitals and several outpatient facilities offering diagnostic, urgent care and surgical services.

Baptist Memorial Health Care (Memphis, Tenn.). Baptist Memorial Health Care features 14 hospitals, six home care facilities, six hospice locations and four minor medical centers. The system employs 12,000 workers and has more than 4,000 physician providers.

BayCare Health System (Clearwater, Fla.). BayCare Health System has approximately 3,100 physicians on staff and 18,500 employees and serves patients at more than 200 care locations, including 11 hospitals and approximately 70 outpatient facilities.

Baylor Health Care System (Dallas). Baylor Health Care offers care at more than 239 access points, including 27 owned, leased or affiliated hospitals; 26 ambulatory endoscopy centers; 69 outpatient clinics; four senior health centers; 2 retail pharmacies; and 156 access points to the HealthTexas Provider Network. HealthTexas is the largest group of employed physicians in Texas, with more than 450 primary care physicians, specialists and hospitalists.

Baystate Health (Springfield, Mass.). Baystate Health employs nearly 10,000 people and has several care locations, including three hospitals, multiple outpatient centers and 580-physician Baystate Medical Practices. Baystate Health is currently constructing a $296 million, 641,000-square-foot "Hospital of the Future," expected to open in March 2012.

Beaumont Hospitals (Royal Oak, Mich.). Beaumont Hospitals is a three-hospital system with a medical staff of more than 3,700 physicians and 4,000 full-time equivalent employees, making it the largest employer in Oakland County, Mich. The system also includes nursing homes, family medicine centers, rehabilitation facilities and other outpatient centers, home medical equipment stores and hundreds of physicians' offices.

Bon Secours Virginia Health System (Richmond). Bon Secours Virginia Health System consists of Bon Secours Richmond and Bon Secours Hampton Roads with a total of seven hospitals and multiple primary care practices, ambulatory care sites and continuing care facilities. The health system employs nearly 11,000 people, and Bon Secours Richmond's medical group includes more than 200 physicians at more than 70 locations.

Carilion Clinic (Roanoke, Va.). Carilion Clinic is led by multi-specialty physician teams and includes 10 hospitals in addition to numerous other facilities along the continuum of care. Carilion has 600 physicians at 152 practice sites and includes approximately 11,000 employees. The health system offers two health plans — MajestaCare and Carilion Clinic Medicare Health Plan — and in March it partnered with Aetna for an accountable care organization initiative.

Carolinas HealthCare System (Charlotte, N.C.). Carolinas HealthCare System employs more than 1,400 physicians and mid-level providers at more than 600 care locations, including more than 30 affiliated hospitals. Carolinas Medical Center offers residency programs in 12 specialties, serves as an off-campus training site for three additional specialties and features the Carolinas College of Health Sciences as a subsidiary.

Catholic Health System (Buffalo, N.Y.). Catholic Health System includes more than 8,200 full and part-time associates, 1,200 physicians, three hospitals and numerous primary care and imaging centers. Catholic Health has partnered with Mount St. Mary's Hospital in Lewiston, N.Y., and a network of nearly 900 associated physicians to create Catholic Medical

Partners — the largest group of independent practicing physicians in western New York.

Community Health Network (Indianapolis). Community Network has more than 11,000 employees and 1,400 physicians at its numerous sites of care, including six hospitals, several surgery centers, school-based clinics and other facilities. The system's Community Physicians of Indiana includes 200 primary care physicians and nurse practitioners in more than 80 locations.

Covenant Health (Knoxville, Tenn.). Covenant Health employs approximately 10,000 people and has more than 1,000 affiliated physicians who serve at eight hospitals in addition to outpatient centers and other facilities. Covenant Health operates the Fort Sanders Nursing Department, a baccalaureate nursing education program at Tennessee Wesleyan College, located in Athens.

CoxHealth (Springfield, Mo.). As of fiscal year 2010, CoxHealth had nearly 8,800 employees and 500 physicians on staff. The health system provides care in three hospitals, more than 60 physician clinics and numerous urgent care facilities and other outpatient sites.

Fairview Health Services (Minneapolis). Fairview Health Services has 22,000 employees, 2,500 affiliated physicians, more than 40 primary care clinics, 10 hospitals and a variety of other care facilities. The system partners with the University of Minnesota and owns the University of Minnesota Medical Center, Fairview and the University of Minnesota Amplatz Children's Hospital.

Franciscan Health System (Tacoma, Wash.). Franciscan Health System, part of Englewood, Colo.-based Catholic Health Initiatives, includes five hospitals and multiple surgery centers, medical clinics and centers for advanced medicine. The system employs 8,100 people and has approximately 1,400 medical staff members.

Geisinger Health System (Danville, Pa.). Physician-led Geisinger Health System includes 37 community practice sites and numerous hospitals, outpatient centers and other care facilities. Geisinger employs roughly 14,400 people, including 880 physicians/scientists and 470 advanced practitioners.

Genesis Health System (Davenport, Iowa). Genesis Health System includes four hospitals, numerous medical centers and clinics, a home equipment store and First Med Pharmacy, among other resources. The system has more than 600 physicians and 5,000 staff members.

Gundersen Lutheran Healthcare (La Crosse, Wis.). Physician-led Gundersen Lutheran Healthcare consists of three affiliated hospitals, four affiliated nursing homes, 23 medical clinics, three podiatry clinics, eight behavioral health clinics, 12 eye clinics and two sports medicine clinics. The system includes more than 700 medical, dental and associate staff and a support staff of more than 5,500.

HCA Midwest Health System (Kansas City, Mo.). HCA Midwest Health System, the largest healthcare network in the greater Kansas City area, has more than 8,000 employees and 1,500 physicians. Its physician network, Midwest Physicians, includes 230 physicians at 58 practices in 77 locations.

Health First (Rockledge, Fla.). Health First includes four hospitals, one of which — Viera (Fla.) Hospital — was added last April. The health system has the largest multi-specialty physician group in central Brevard, Fla., and Health First is also Brevard's largest commercial health insurer.

Henry Ford Health System (Detroit). Henry Ford Health System, which is affiliated with Wayne State University's School of Medicine, consists of six hospitals, 29 medical centers, 20 pharmacy locations and several medical centers. HFHS includes the Henry Ford Medical Group, one of the country's largest group practices with more than 1,200 physicians.

Inova Health System (Falls Church, Va.). Six-hospital Inova Health System has more than 16,000 employees, including more than 150 physicians in the Inova Medical Group. The health system is engaged in several community initiatives, including Partnership for Healthier Kids, a collaboration of 100 schools and a dozen business and government organizations that provide affordable care for medically underserved children.

Intermountain Healthcare (Salt Lake City). Intermountain Healthcare has 23 hospitals, 165 clinics and a variety of other medical facilities. The health system has more than 32,000 employees and more than 800 physicians and caregivers in its Intermountain Medical Group. In addition, Intermountain offers health insurance through SelectHealth, which includes individual, employer and federal employee plans.

Jackson Health System (Miami). With more than 12,000 employees, Miami-Dade County-owned Jackson Health System serves patients at six hospitals, four primary care centers, 17 school-based clinics and numerous other access sites. In addition to direct care, Jackson offers the JMH Health Plan, an HMO.

Kaiser Permanente (Oakland, Calif.). Kaiser Permanente is comprised of Kaiser Foundation Hospitals and their subsidiaries, Kaiser Foundation Health Plan and The Permanente Medical Groups, a physician-owned and operated practice. As of 2010, Kaiser had 36 hospitals; 533 medical offices; and roughly 15,800 physicians and 167,000 employees.

Legacy Health System (Portland, Ore.). Legacy Health System, the largest non-profit, community-owned health system in the Portland/Vancouver area, includes six hospitals and more than 50 medical clinics, among other facilities. It employs more than 9,500 people and has approximately 2,500 physicians on medical staff.

Lehigh Valley Health Network (Allentown, Pa.). Lehigh Valley Health Network cares for patients in three hospitals, 40 primary and specialty clinics, retail health clinics through a partnership with Geisinger Health System and numerous other facilities. It has 9,500 employees and 1,100 primary care and specialty physicians, 400 of whom are employed.

McLaren Health Care (Flint, Mich.). McLaren Health Care has nearly 150 facilities, including nine hospitals and more than 100 primary and specialty centers. The health system employs 15,000 people — 50 of which are primary care physicians and specialists in the McLaren Medical Group — and has more than 10,000 network physicians.

MedStar Health (Columbia, Md.). MedStar Health consists of nine hospitals and 20 other health-related businesses. The system includes MedStar Physician Partners, a network of more than 100 physicians; MedStar Family Choice, a managed care organization; and MedStar Pharmacy, among other services. With more than 26,000 associates and 5,300 affiliated physicians, it is one of the largest employers and one of the largest health systems in the Maryland and Washington, D.C., region.

Memorial Hermann Healthcare System (Houston). Memorial Hermann Healthcare System is the largest non-profit healthcare system in Texas, with 11 hospitals, 10 surgery centers, 27 sports medicine and rehabilitation centers, 12 diagnostic laboratories, 21 imaging centers and more. The system employs nearly 20,000 people, has more than 4,000 medical staff members and more than 3,500 independent physicians in its Memorial Hermann Health Network Providers.

Mercy (St. Louis). In Sept. 2011, networks of care including St John's Mercy Health Care began a brand change to "Mercy" to more clearly reflect the integration of its facilities. Mercy has more than 400 clinic and hospital locations across seven states, employs 38,000 people and has 1,500 physicians. Mercy Clinic includes thousands of physicians and teams across the Mercy system.

Mercy Health System (Janesville, Wis.). Mercy Health System features 64 facilities, including three hospitals and multiple specialty centers and clinics. The system employs nearly 4,000 people, 285 of whom are physicians. It offers several insurance products, including an HMO, Medicare supplement and Medicaid HMO.

Methodist Healthcare (Memphis, Tenn.). Methodist Healthcare is comprised of seven hospitals and multiple home health agencies and outpatient clinics. It has 10,000 employees, 2,000 physician partners and teaching partnerships with the University of Tennessee and the University of Memphis. The health system also includes Health Choice, a joint venture with MetroCare Physicians, which is the exclusive managed care contracting organization for Methodist Healthcare.

MultiCare (Tacoma, Wash.). With more than 9,300 employees, including 327 physicians, MultiCare is the largest private employer in Pierce County. It also employs more than 1,000 physician specialists. The system has more than 93 sites of care, including four hospitals, 16 primary clinics and many outpatient centers and clinics.

North Shore-Long Island Jewish Health System (Great Neck, N.Y.). Fifteen-hospital North Shore-Long Island Jewish Health System is the country's second-largest non-profit secular healthcare system, based on number of beds. North Shore-LIJ Health System also has more than 9,000 physicians and nursing school affiliations with 15 colleges and universities.

NorthShore University HealthSystem (Evanston, Ill.). NorthShore University HealthSystem has approximately 9,000 employees and 2,400 affiliated physicians, including more than 700 physicians in the NorthShore Medical Group. The health system is also the principal teaching affiliate for the University of Chicago Pritzker School of Medicine.

Northwestern Memorial HealthCare (Chicago). Northwestern Memorial HealthCare includes two hospitals, a physician group, an insurance company and a managed care contractor. Its Northwestern Memorial Hospital employs more than 7,000 people, has approximately 1,600 affiliated physicians and is the primary teaching hospital for Northwestern University's Feinberg School of Medicine. Northwestern Memorial Physicians Group consists of 97 physicians in 15 medical offices.

Novant Health (Winston-Salem, N.C.). Novant Health includes 13 hospitals and a medical group with 1,117 physicians in 360 clinic locations across North Carolina, Virginia, South Carolina and Georgia, in addition to other care facilities. It also offers Novant Health Shared Services, a company that partners with hospitals to improve operations and finances.

OSF HealthCare (Peoria, Ill.). OSF HealthCare has more than 12,000 employees and includes OSF Healthcare System, OSF Medical Group, OSF Home Care Services and other entities. OSF Healthcare System consists of seven hospitals and medical centers, one long-term care facility and two colleges of nursing. OSF Medical Group includes more than 600 employed physicians and other providers at more than 50 office sites and eight LLC corporations.

Presbyterian Healthcare Services (Albuquerque, N.M.). Presbyterian Healthcare Services includes eight hospitals, a health plan and Presbyterian Medical Group. The medical group has more than 500 employed physicians and practitioners at 30 different locations and is the fastest growing medical group in the state.

ProMedica Health System (Toledo, Ohio). ProMedica Health System consists of 306 facilities, including 11 member and affiliate hospitals. The health system has more than 14,000 employees and approximately 1,650 physicians, including more than 315 physicians in its medical practice, ProMedica Physicians.

Providence Health & Services (Renton, Wash.). Providence Health & Services has 27 hospitals, 214 physician clinics, 22 assisted living and long-term facilities and 13 hospice and home health agencies. Spanning five states — Alaska, California, Montana, Oregon and Washington — Providence Health & Services employs nearly 53,000 people, including 1,358 employed physicians.

Roper St. Francis Healthcare (Charleston, S.C.). Roper St. Francis Healthcare has 90 facilities and physician offices, including four hospitals with plans to build another. The health system has nearly 800 physicians and employs more than 5,100 people, making it Charleston's largest non-governmental, private employer. The system also includes Physician Partners, a network of more than 180 physicians, and Wellness Partners, which provides care to businesses' employees.

Saint Francis Health System (Tulsa, Okla.). Saint Francis Health System has approximately 7,000 employees and nearly 1,000 physicians. It consists of five hospitals in addition to other outpatient centers and pharmacies. The health system also includes Warren Clinic, the largest privately-owned physician group in Oklahoma, with more than 210 physicians at more than 40 locations.

Sanford Health System (Fargo, N.D., Sioux Falls, S.D.). Sanford Health is the largest rural non-profit healthcare system in the nation, spanning eight states. The system's care sites include 31 hospitals, 111 clinics and 31 long-term care facilities. The system employs 18,000 people, making it the largest employer in North and South Dakota, and has more than 900 physicians. In addition, Sanford offers a physician-led, non-profit health plan.

Scripps Health (San Diego). Scripps Health includes four acute-care hospitals, more than 20 primary and specialty care outpatient centers and a variety of other facilities. The system has more than 2,600 affiliated physicians and 13,000 employees, and Scripps Clinic includes more than 400 physicians. Scripps Health is affiliated with several medical groups including Mercy Physicians Medical Group, Scripps Mercy Physician Partners, XiMED Medical Group and Connect the Docs.

Sentara Healthcare (Norfolk, Va.). Sentara Healthcare has more than 100 care sites, including 10 acute-care hospitals, six outpatient care campuses, seven nursing centers, three assisted living centers and seven advanced imaging centers. Sentara has approximately 3,400 medical staff members in addition to roughly 380 physicians in Sentara Medical Group. The health system founded Optima Health, the region's first managed-care plan, in 1984.

Sharp HealthCare (San Diego). Sharp HealthCare employs 14,000 people at its four acute-care hospitals, three specialty hospitals, 10 pharmacies and numerous other health facilities. The health system is affiliated with Sharp Rees-Stealy and Sharp Community Medical Group and includes 2,600 physicians.

St. John's Health System (Springfield, Mo.). Six-hospital St. John's Health System, a member of the Sisters of Mercy Health System-St. Louis, has more than 10,000 employees. Physician-led St. John's Clinic is the region's largest multispecialty physician group with more than 470 physicians and 220 mid-level and allied health practitioners in more than 70 offices.

Sutter Health (Sacramento, Calif.). Sutter Health includes more than 20 hospitals, 20 ambulatory surgery centers and numerous outpatient facilities. The system has roughly 47,000 employees and 5,000 affiliated physicians.

TriHealth (Cincinnati). TriHealth has two hospitals, three ambulatory centers and more than 50 other locations. TriHealth is the region's fifth-largest employer with approximately 10,000 employees and has more than 200 primary care and specialist physicians within affiliated physician groups.

University Hospitals (Cleveland). University Hospitals is a network of primary care physicians, outpatient centers and hospitals. The system includes more than 24,000 physicians and employees in its facilities and its partner hospitals, making University Hospitals the second largest private sector employer in Northeast Ohio.

University of Pittsburgh Medical Center. UPMC has three major operating units: provider services, including more than 400 clinical locations; insurance services; and international and commercial services. The system has nearly 5,000 affiliated physicians, 3,000 of which UPMC employs.

WellSpan Health (York, Pa.). WellSpan has more than 40 locations and includes two hospitals, six retail pharmacies, 10 outpatient health centers and 47 physician practices. The system, which has 8,000 physicians, employees, volunteers, board members and auxilians, also includes VNA Home Health and WellSpan Pharmacy.

WellStar Health System (Marietta, Ga.). WellStar Health System includes five hospitals, five urgent care centers, 14 satellite diagnostic imaging centers and more than 100 physician practice locations. In addition to the system's more than 12,000 employees and 1,126 medical staff members, the WellStar Medical Group has more than 500 primary care providers, specialists and advanced practitioners.

Wheaton Franciscan Healthcare-SE Wisconsin (Glendale). Wheaton Franciscan Healthcare in Southeast Wisconsin is the second largest private employer in the state, with nearly 11,000 associates and affiliations with more than 1,300 physicians. The system includes six acute-care hospitals, two outpatient centers, three transitional and extended care facilities and one home health and hospice agency. ■

Using HIT to Drive Clinical Integration, Patient and Physician Engagement and Population Health Management
(continued from page 42)

Population health

CMS and the Institute for Healthcare Improvement share a vision of improving healthcare and improving the health of populations while decreasing the cost of healthcare (or at least bending the cost curve). To start, we hope an integrated outpatient and inpatient EHR combined with a health information exchange strategy will improve care coordination, enhance patient service, aid our affiliated and employed physicians while reducing duplicate testing and overall healthcare costs. Well-built order sets that incorporate evidence-based clinical practices and take into account cost issues (for example, generic drugs are the default option) also improve our position under value-based reimbursement by making the most appropriate clinical decision the path of least resistance for clinicians. We hope to be able to analyze data pulled from our EHRs to adjust clinical pathways and order sets as appropriate. Finally, for Mercy, and other health systems, the CMS and IHI vision challenges us to focus on population and community health. Not only do we plan to use the data gleaned from our medical record systems to help us make better clinical decisions, but we also plan to monitor the health status of the populations and communities we serve.

Looking ahead

Mercy is committed to implementing an HIT system that will help us integrate with other providers, engage patients and improve the overall health of the populations we care for. While it will take us time to get there, we feel we're progressing well. For other health systems interested in what we've learned thus far, I'd say nothing is more important than physician engagement and physician leadership and continuous communication about how HIT will allow physicians and other clinicians to perform the functions that will be required of them in the future. HIT implementation needs to be a clinical project.

Of course, HIT alone isn't going to get us to where we need to be, but it is a major component of the capabilities required to reach the larger goals of reform. The question should never be, "Which HIT product should we implement next?" Instead, the question must be, "How can these tools be used to reach clinical integration, support payment reform, engage patients and manage populations?" ■

Kenneth Bertka, MD, is a family physician and vice president of physician clinical integration at Mercy, a seven hospital and physician group system based in Toledo, Ohio. Mercy is a member of Catholic Health Partners, the largest healthcare system in Ohio.

Hospital & Health System Transactions

Alamance Regional Medical Center in Burlington, N.C., merged with Greensboro, N.C.-based **Cone Health**.

St. Louis-based **Ascension Health** reached an agreement to merge with **Alexian Brothers Health System**, which includes five hospitals and is based in Arlington Heights, Ill.

Broadway Medical Center in Alexandria, Minn., merged with **Sanford Health**, headquartered in Fargo, N.D., and Sioux Falls, S.D.

Nashville, Tenn.-based **Capella Healthcare** and **Saint Thomas Health** signed a letter of intent to form a partnership that will result in joint ownership of some hospitals.

Community Health Systems formed a definitive agreement to acquire **MetroSouth Medical Center**, a 244-hospital in Blue Island, Ill.

Emory Healthcare and **Saint Joseph's Health System**, both located in Atlanta, finalized their partnership.

Ocoee, Fla.-based **Health Central** and **Orlando Health** completed a $177 million asset purchase agreement.

Henry Medical Center in Stockbridge, Ga., is now part of the Atlanta-based **Piedmont Healthcare** system.

Nashville, Tenn.-based **Hospital Corporation of America** completed the sale of **Palmyra Medical Center** in Albany, Ga., to the **Hospital Authority of Albany-Dougherty County**.

Huntsville (Ala.) **Hospital** and Franklin, Tenn.-based **Capella Healthcare** signed a definitive agreement for Huntsville Hospital to acquire Capella's **Parkway Medical Center of Decatur** (Ala.).

Two systems within the initially proposed three-system merger in Kentucky — **Jewish Hospital & St. Mary's HealthCare** and **Saint Joseph Health System** — merged to form KentuckyOne Health. Kentucky Gov. Steve Beshear rejected the merger of Louisville's safety-net University Hospital with the two other systems despite hospital officials' efforts to overcome his objections.

Charlotte, N.C.-based **MedCath** sold its ownership interest in **Harlingen** (Texas) **Medical Center** to Ontario, Calif.-based **Prime Healthcare Services**.

Madison, Wis.-based **Meriter Health Services** partnered with **University of Wisconsin Health**, also based in Madison, for obstetrics and gynecological services at a Meriter clinic in Monona, Wis.

A county judge approved the proposed $152 million sale of **Moses Taylor Healthcare System** in Scranton, Pa., to **Community Health Systems**.

San Antonio-based **Nix Health** is expected to be acquired by Los Angeles-based **Prospect Medical Holdings**.

The **Palm Drive Healthcare District** unanimously approved the affiliation agreement with **Marin General Hospital** in Greenbrae, Calif.

Regional Care Hospital Partners and the **University of Alabama at Birmingham Health System** agreed to partner to improve local healthcare quality.

New Jersey Attorney General Paula T. Dow approved the proposed merger between **St. Luke's Hospital and Health Network**, based in Bethlehem, Pa., and **Warren Hospital** in Phillipsburg, N.J.

Novi, Mich.-based **Trinity Health** agreed to invest up to $150 million in **Mercy Hospital and Medical Center** in Chicago over five years in a deal to acquire the facility.

Underwood-Memorial Health Systems, based in Woodbury, N.J., and **South Jersey Healthcare** in Vineland, N.J., signed a definitive agreement to merge.

King of Prussia, Pa.-based **Universal Health Services** entered into a definitive agreement to acquire **Knapp Medical Center** in Weslaco, Texas.

Hospital & Health System Executive Moves

James K. Beckmann was appointed president and CEO of Tucson, Ariz.-based Carondelet Health Network.

Jim Brexler, CEO of Erlanger Health System in Chattanooga, Tenn., announced plans to retire.

Ruth W. Brinkley was named CEO of KentuckyOne Health, the organization created from the merger of Jewish Hospital & St. Mary's HealthCare and Saint Joseph Health System after University Hospital in Louisville was barred from a previously planned three-system merger.

Eric Buehrens, COO of Beth Israel Deaconess Medical Center in Boston, stepped down for unknown reasons.

Sister Agnelle Ching retired as CEO of Honolulu-based St. Francis Healthcare System of Hawaii.

Naples, Fla.-based Health Management Associates named **Mike Fencel** CEO of its North Florida Division, which includes 11 affiliated hospitals in North Florida.

Mark A. Frey was named president and CEO of the Alexian Brothers Health System, based in Arlington Heights, Ill.

Sandy Gomberg, president and CEO of Temple University Hospital in Philadelphia, stepped down.

Conrad Mallett, president of Detroit Medical Center's Sinai-Grace Hospital, was promoted to the health system's chief administrative officer. As a result of Mr. Mallett's promotion, **Reginald Eadie, MD**, will step down as president of Detroit Receiving Hospital to become president of DMC Sinai-Grace Hospital, and **Iris Taylor**, chief business officer for DMC, will succeed Dr. Eadie at Detroit Receiving Hospital.

President and CEO **Mark J. Moran** of MetroHealth in Cleveland, Ohio, announced he will not renew his contract, which expires in March.

James O'Loughlin, CEO of Carolinas Hospital System in Florence, S.C., will be stepping down.

Barry H. Ostrowsky assumed the position of president and CEO of Barnabas Health, based in West Orange, N.J.

Keith Parrott was promoted to the newly created position of executive vice president and COO of Birmingham, Ala.-based Baptist Health System.

Dallas-based Tenet Healthcare Corporation appointed **Britt T. Reynolds** president of hospital operations.

Paul Rothman, MD, was appointed dean of the Johns Hopkins University School of Medicine and CEO of Johns Hopkins Medicine in Baltimore, effective July 1.

Thomas Royer, MD, was named interim CEO at Parkland Health and Hospital System in Dallas.

Tucson-based Carondelet Health Network named **Dorothy L. Sawyer** senior vice president and CEO for Carondelet St. Mary's Hospital, also in Tucson.

Ted Shaw was named CFO and associate vice president for medical financial affairs for University of Miami Miller School of Medicine and UHealth-University of Miami Health System.

Mark Stensager, president and CEO of Guthrie Healthcare System and co-CEO of Guthrie Health, both based in Sayre, Pa., announced his retirement.

Catholic Healthcare West appointed **Michael Taylor** to be senior vice president of operations for the Greater Sacramento-San Joaquin Service area.

Anthony Tersigni, president and CEO of Ascension Health, will step down to lead the new holding company Ascension Health Alliance. **Robert Henkel**, president of healthcare operations and COO of Ascension Health, will succeed Mr. Tersigni as CEO.

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