Becker's Hospital Review Names America's 10 Best Hospitals for 2009

By Leigh Page

Becker's Hospital Review has named the 10 best hospitals in America for 2009. These organizations are leaders in all elements of quality care, drivers of innovation and trendsetters. Their success is recognized by the likes of U.S. News & World Report, Thompson Reuters, HealthGrades, Leapfrog, their communities and industry associations. They are models businesses and establish the bar for excellence.

Here are the hospitals, in alphabetical order.

Duke University Hospital (Durham, N.C.)
Duke University Hospital is one of noblest of hospital award-winners and you might even think of it as close to being king. This is one of a rare breed of institutions to place in the honor rolls of both major hospital ratings systems. This year it was named on U.S. News & World Report's Honor Roll for its 21 Best Hospitals and won the Everest Award, given to Thomson Reuters' top 25 hospitals. Only one other hospital, Vanderbilt,

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9 Ways Hospitals Can Still Make Money

By Leigh Page

As the recession continues to beat up on the industry, we asked a number of hospital executives where they expect to still make a profit in 2010. Here are nine ways they suggest.

1. Attract paying patients
Hospitals that want to be profitable need more private-pay patients, but some institutions don't have many private-pay patients willing to come to the hospital, so a hospital's first goal needs to be attracting these people back. “We have chased all of our paying patients away by our very inefficient systems,” says Michael Young, CEO of financially ailing Grady Healthcare System in Atlanta. “The only people who would put up with it are people who have no other choice.”

Mr. Young, who took the helm at Grady in July 2008, is trying to make its flagship, 953-bed Grady Memorial Hospital, a reasonable option for paying patients again. Toward that aim, he is reducing waiting times in the ED, introducing new equipment and expanding services that the hospital does well, such as acute surgery and care for stroke and HIV patients.

However, even Medicaid payments can be workable, if care is managed well and the hospital is paid a relatively good rate, says Catherine Jacobson, CFO and treasurer at 671-bed Rush University Medical Center in
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2009 was a year of hospitals trying to make sure costs and headcounts were in line with business and trying to make sure payor relationships and revenues stayed solid. 2010 is looking like a more strategic year — a time in which hospital systems will aggressively try and grow specific service lines, acquire and employ physicians and look at more global initiatives. We see 2010 as shaping up to be a really interesting year.

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1) The Politics of Healthcare Reform – Ron Brownstein, Political Director, Atlantic Media Company

2) The Best Ideas For Hospitals Now – Chris Karam, FACHE, President & CEO, CHRISTUS St. Michael Health System, Dan Moen, CEO, LHP Hospital Group, Inc, Paul Summerside, MD, Chairman of the Board, Aurora BayCare Medical Center, Alex Rintoul, CEO, Medical Center at St. Elizabeth Place, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

3) The 5 Things Hospital Should Look for In a Partner – Dan Moen, CEO, LHP Hospital Group, Inc.

4) Developing a Sustainable Physician Strategy – Walter Morrissey, MD, Vice President, Kaufman Hall

5) Five Key Concepts for Growing Profits in a Challenging Economic Environment – Chris Karam, FACHE, President & CEO, CHRISTUS St. Michael Health System

6) Hospital Transactions, Current Market Analysis and Valuations – Greg Koonsman, Senior Partner, and Jon O’Sullivan, Senior Partner, VMG Health

7) Strategies for Competing With a Dominant Hospital – Alex Rintoul, CEO Medical Center at St. Elizabeth Place

8) A Prescription for the Free Standing Emergency Department – Kimberly Nealon, Site Director, St. Vincent’s Medical Center, and John Marshall, Executive Director, Business Development Midwest, Bremner Duke

9) How Doctors Think, Why Doctors Are Different: Suggestions, Ideas and Tips for Partnering with Physicians – Jeff Leland, Managing Director, Blue Chip Surgical Center Partners.

10) An Analysis of What Works, What Doesn’t: Key Thoughts From 10 Great Partnerships With Management Companies and Hospitals – Joe Clark, EVP and Chief Development Officer, Surgical Care Affiliates

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11) Physician Hospital Relationships: A Review of Evolving Problems and Opportunities – Paul Summerside, MD, Chairman of the Board, Aurora BayCare Medical Center

12) Using Metrics to Analyze Hospital Financial Performance – Zach Hafner, Vice President Strategy and Financial Planning, Kaufman Hall

13) The Best Ideas for Hospital CFOs Now – Faye Deich, COO, Sacred Heart Hospital, David Felsenthal, Senior Partner, Principle Valuation, John Thomas, EVP Healthcare REIT, Moderated by Claudia Gourdon, Senior VP, National Marketing Manager, Healthcare Finance Group

14) Data Transparency and Quality in Healthcare – Holly Hampe, Director, Patient Safety and Quality, and Mary Beth Lange, Senior VP, Averinet

15) Best Practices to Reduce Costs – Angie Blankinship, Director of Surgery Services, San Luis Valley Regional Center

16) Monetization of Non-Core Assets and Outsourcing Facility Development – Michael Bryant, CEO, Methodist Medical Center, and Gordon Soderland, SVP, Strategic Relationships, DASCO Companies

17) Moving Outpatient Surgery Out of the Hospital – Joseph Bosco, MD, Vice Chair, Clinical Affairs, Department of Orthopedic Surgery, NYU Hospital for Joint Diseases, and Joan Dentler, MBA, Managing Partner, ASC Strategies

18) A New Model in Cancer Care – John Marshall, Executive Director, Business Development Midwest, and Deeni Taylor, Regional Executive Vice President, BremnerDuke

19) 4 Core Ideas and Concepts to Improve Oncology Program Profitability – Lisa Slama, PhD, Director, Sg2

20) Developing Hospital Physician GI Joint Ventures – John Poisson, Senior Vice President, Physicians Endoscopy

21) Maintaining Profits, Containing Costs and Patient Care Success in a Recession – Nicola Hawkins, MA, RN, RNFA, NP, CEO & Founder, SpineSearch

22) ASCs as a Physician Engagement Tool for Hospitals and Health Systems: How Does a Hospital Assess the Financial Impact? How Do You Ensure Physician Engagement? How Should You Measure Hospital Success? – David Thoene, CEO, Medical Surgical Partners, LLC

Should you have any questions about the conference, please feel free to contact myself or call (800) 417-2035. Also, if you register by Jan. 31, 2010, you are welcome to deduct an additional $100 off the price of admission to the conference.

Scott Becker

Should you have any questions, please contact me at sbecker@mcguirewoods.com or (312) 750-6016.

Very truly yours,

Scott Becker

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achieved this distinction, showing just how different rating systems can be. Both *U.S. News* and Thomson Reuters examine measures such as mortality and patient safety, but while Thomson Reuters also looks at business concerns such as length of stay, expenses and profitability, *U.S. News* bases one-third of its score on physicians’ opinions.

Duke placed 11th on *U.S. News*’ list and was among the top 10 in *U.S. News*’ specialties of gynecology, geriatrics, orthopedics, respiratory disorders, urology, ophthalmology, heart and heart surgery and cancer. The hospital also has won the Leapfrog Award and a citation from the AHA-McKesson Quest for Quality, reflecting the success of Duke’s Safe Choices program, which empowers staff to improve safety by understanding the importance of behavioral choices in everyday patient care.

The 924-bed academic medical center has 10,412 full-time employees, of which about 15 percent have a medical degree, doctoral degree or both. Among recent technological breakthroughs, Duke became the first hospital to establish a center dedicated exclusively to cardiovascular MRIs, in 2001.

**Johns Hopkins Hospital (Baltimore)**

Think of Johns Hopkins as the brightest kid in your class. You thought you had aced the physics midterm but Johns Hopkins did much better — as usual. In 2009, the Baltimore teaching hospital topped *U.S. News*’ list of Best Hospitals in 2009, and it has done so every single year since 1991. This year, *U.S. News* rated Hopkins No. 1 in otolaryngology, rheumatology, urology and geriatrics; No. 2 in gynecology, neurology and neurosurgery, ophthalmology and psychiatry; No. 3 in cancer, digestive disorders, diabetes, heart and respiratory; and No. 5 in orthopedics.

However, just as math geniuses may not be so outstanding outside of math class, Johns Hopkins doesn’t shine quite as much in other hospital rankings. Still, the *U.S. News* rankings are probably the most sought-after, and the 982-bed academic medical center has a rich reputation in academic medicine. It practically invented the concept of the teaching hospital, having coined such terms as residents, rounds and house staff. Hopkins researchers won the Nobel Prize for discovering restriction enzymes that began the genetic engineering industry and they developed the first “blue baby” operation, which opened the way to modern heart surgery.

But rather than rest on these grand laurels, Hopkins has also attended to the day-to-day challenges of running a hospital, such as rewarding its nursing staff and treating patients like human beings. Hopkins received Magnet Recognition for nursing excellence and innovations in nursing practice from the American Nurses Credentialing Center in 2003. And in 2009 it won the National Research Corporation’s Consumer Choice Award as the hospital highest-rated by patients in the Baltimore area.

**Lehigh Valley Hospital (Allentown, Pa.)**

Billy Joel sang, “they’re closing all the factories down” in his 1982 hit, “Allentown.” Those lyrics hit home again this year, as Mack Trucks moves its headquarters from Allentown to Greensboro, N.C., taking another 1,000 jobs away. But throughout these travails, Lehigh Valley Hospital has not only survived but thrived at a high-quality level, making it a beacon for every hospital as we face the current recession.

Lehigh Valley is living proof that a hospital does not have to be a huge academic medical center to perform at the highest levels. This 514-bed hospital is a clinical campus of Penn State University College of Medicine and has 1,100 physicians on staff, including 400 who are employed by the health network. With 10,000 employees, the hospital operates the state’s third largest heart surgery program, with more than 1,200 open-heart procedures a year and the fourth-largest cancer program in the state. It offers a regional referral burn center for critical care burn patients and maintains national certification as a primary stroke center.

The hospital has placed in the *U.S. News* rankings for 14 consecutive years, including eight times for heart care and heart surgery. In 2009 it ranked in *U.S. News*’ specialty roster in geriatric care and urology. It also appeared on HealthGrades’ list of 50 Best Hospitals, a distinction that none of the hospitals on *U.S. News*’ Honor Roll achieved, although several of these big names were on HealthGrades’ list of Distinguished Hospitals for Clinical Excellence, as was Lehigh Valley. The hospital also won NRC’s Consumer Choice Award for its region, was a Leapfrog Top Hospital in the Nation in 2008 and received Magnet Recognition by the American Nurses Credentialing Center in 2002. The hospital’s parent, Lehigh Valley Health Network, was named one of the “100 Best Companies to Work For” in the nation by *Fortune* magazine this year, for the third consecutive year.

**Massachusetts General Hospital (Boston)**

You can ignore the genuflections at Massachusetts General Hospital, the third-oldest hospital in the nation, for its Bullfinch Building and its “ether dome,” because this Boston behemoth is achieving plenty of honors in the here and now. It is the major teaching hospital of Harvard University, with one of the largest hospital-based research budgets in the world. Its researchers have many recent achievements, such as creating a strip of pulsing heart muscle from mouse embryonic stem cells, which is an important step toward growing replacement parts for hearts damaged by cardiovascular disease. Mass General is leading hospitals into the digital age, achieving 100 percent implementation of computerized order entry and convincing the great majority of its physicians to switch to electronic medical records.

Mass General is so big and influential that it has been called, in jest, “the medical industrial complex.” The 900-bed medical center has more than 10,000 employees, making it the largest non-governmental employer in Boston. It admits 47,000 inpatients, handles nearly 1.5 million outpatient visits and performs 37,000 operations annually.

*U.S. News* ranks it fifth among hospitals overall, with the following specialties in its top 10 rankings: psychiatry, diabetes, orthopedics, digestive diseases, geriatrics, heart, kidney, neurology and neurosurgery, ophthalmology, respiratory diseases, rheumatology, cancer and gynecology. This important teaching hospital can also compete on an attribute often identified more with small, cozy community hospitals: friendliness. This year *U.S. News* identified Mass General as one of the 17 hospitals in the nation with the friendliest nurses. The Boston hospital also won the American Nurses Credentialing Center’s Magnet Hospital award in 2003.

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Mayo Clinic (Rochester, Minn.)

While Mayo Clinic is often thought of as a large multispecialty practice, it is very much an inpatient operation, using two major facilities — 1,265-bed Saint Marys Hospital and 794-bed Rochester Methodist Hospital. As a world-famous clinic with a rich history, Mayo promotes its own set of traditions, such as no “the” before its name, no apostrophe in St. Marys Hospital and, no, its name is not “Mayo’s.”

Mayo has been running a very close second to Johns Hopkins for almost two decades in the U.S. News rankings. This year, Mayo ranked No. 1 in diabetes, digestive disorders, neurology and neurosurgery and orthopedics; No. 2 in heart and heart surgery and respiratory disorders; and No. 3 kidney disorders, gynecology and urology. Back in 1990 was the last time that Hopkins lost U.S. News’ No. 1 spot, and it was to Mayo. Both institutions are so close in quality that the difference is well nigh imperceptible, but being No. 2 can still be exasperating. “We appreciate the U.S. News recognition, but what the magazine doesn’t capture is how those ‘players’ work together as a team,” Mayo CEO Glenn Forbes, MD, wrote of this year’s listings.

But the clinic’s team-based approach, the “Mayo Clinic Model of Care,” has gained favor with President Obama and other health reform advocates. This approach, melding inpatient with outpatient care, has been shown to reduce costs and uphold quality. “We should ask why places like the Mayo Clinic in Minnesota, the Cleveland Clinic in Ohio and other institutions can offer the highest quality care at costs well below the national norm,” the president wrote in a letter to Senate leaders in June.

NYU Langone Medical Center (New York)

NYU Langone has the kind of exceptional quality that attracts grand gifts. This New York medical center’s new name, unveiled last year, honors Home Depot founder Kenneth Langone, who has honored it with more than $200 million. The center’s 726-bed Tisch Hospital honors another benefactor, the late billionaire and former CBS-owner Laurence Tisch. Even with the recession ripping through many a New York fortune, the hospital keeps attracting more gifts. When it received a $100 million donation this June, it was the fourth nine-figure gift in 15 months.

The generosity is being put to good use. The June donation is targeted for a state-of-the-art neuroscience institute, and this summer the medical center launched a Center of Excellence on Urologic Disease, using a $5 million gift for a new prostate cancer center and a $1 million gift to study innovative diagnostic technology. Moreover, this largesse hasn’t diverted the hospital from making the small, incremental achievements that make a hospital great. Employees created a guide for discharge instructions that led to improved patient satisfaction and they reduced flash sterilization of equipment from 60 percent to fewer than 20 percent. They revamped breast implant procedures, cutting back serious infections from 5 percent to 1.25 percent. The hospital also increased specialty-certified nurses to 33.8 percent in 2009 from 27.6 percent in 2008.

These kinds of accomplishments have generated a long list of distinctions. This year NYU Langone placed 17th on the U.S. News Honor Roll, scoring within the top 21 slots in rehabilitation, orthopedics, neurology and neurosurgery, heart and heart surgery, psychiatric care, geriatrics and urology. It achieved Magnet Recognition by the American Nurses Credentialing Center in 2005, was a Leapfrog Top Hospital for Patient Safety in 2008. In addition, NYU’s Hospital for Joint Disease has been designated a UnitedHealth Premium Surgical Spine and Total Joint Replacement Specialty Center for 2007-2009.

Ronald Reagan UCLA Medical Center (Los Angeles)

Like its presidential namesake, the Ronald Reagan UCLA Medical Center’s reputation just seems to get better. This year the hospital placed third in U.S. News’ rankings, edging out luminaries like the Cleveland Clinic and Massachusetts General Hospital. In U.S. News’ rankings by specialty, Ronald Reagan placed in the top 10 in an astounding breadth of categories: geriatrics, urology, psychiatry, digestive disorders, ophthalmology, rheumatology, kidney disorders, neurology and neurosurgery, ear, nose and throat, gynecology and heart and heart surgery.

The 520-bed medical center is brand new, having been totally rebuilt in accordance with the latest California seismic safety requirements, reopening in June 2008. The one million-plus square-foot structure, soaring 10 stories, was designed by the renowned architect I.M. Pei and his son, C.C. Pei. It features large, sunny, private patient rooms with terrific views and daybeds for family members, wireless Internet access for patients and guests and outdoor play areas.

In addition to the U.S. News distinction, the hospital received Magnet Recognition by the American Nurses Credentialing Center in 2005 and was a Leapfrog Top Hospital for 2007. The National Cancer Institute designated Ronald Reagan’s Lung Cancer Program a Specialized Program of Research Excellence. The Integrated Healthcare Association ranks UCLA Medical Group one of California’s top performing physician organizations in 2009, for the fifth straight year. UCLA Medical Group is also a qualified data registry under the 2009 Physician Quality Reporting Initiative (PQRI), a Medicare pay-for-reporting program.

University Medical Center (Tucson, Ariz.)

University Medical Center pushes the quality envelope in many directions. It oversees a large, high-tech research enterprise that recently developed a two-drug therapy to reduce the risk of recurrent colorectal polyps, and yet it is also the home of Andrew Weil, MD, the bearded founder of integrative medicine, which prefers botanical medicines rather than prescription drugs.

While UMC Tucson barely placed in U.S. News’ 2009 specialty rankings, which lean heavily toward long-established university centers, this 38-year-old hospital — comparatively young, as teaching institutions go — fared much better in Thomson Reuters’ survey, which gives more weight to objective measures than U.S. News. Thomson Reuters recognized UMC Tucson this year as one of only 15 major teaching institutions on its list of Top Hospitals and gave it the elite Everest Award, which goes to the top 25 on its overall list. As further proof of this hospital’s coming of age, it won the University HealthSystem Consortium’s Quality Leadership Award this year. UMC Tucson also won the Consumer Choice Award for its region from the National Research Corporation in 2009 and the Magnet Recognition by the American Nurses Credentialing Center in 2003.
The 355-bed hospital is part of the Arizona Health Sciences Center, adjacent to the University of Arizona Colleges of Medicine, Nursing, Pharmacy and Public Health. The medical center was part of the university when it was founded in 1971, but is now a separate, non-profit organization, though it still keeps strong ties with the university. The center, Arizona’s only academic health sciences center, maintains a growing presence on the Phoenix Biomedical Campus.

University of Michigan Hospitals and Health Centers (Ann Arbor)

Research spending at the University of Michigan exceeded $1 billion for the first time this year, and 41 percent of those funds were NIH grants for studies on new anticancer drugs, brain tumors and heart disease, to name a few. While the university is one of the nation’s top five research centers in R&D expenditures, U-M Hospitals and Health Centers pay close attention to basic patient safety measures. Among process measures that hospitals report to CMS, U-M scored 100 percent for testing heart failure patients to measure the ejection fraction of the heart’s left ventricle and for giving heart attack patients an aspirin upon arrival and discharge.

U-M Hospitals and Health Centers is a sprawling enterprise in Ann Arbor, including University Hospital, C.S. Mott Children’s Hospital, Women’s Hospital, 120 outpatient clinics and some 40 health centers. In 2008, it counted 2,707 physicians, 1,074 residents and 3,800 nurses, serving 930 beds and 66 ORs that generated 44,683 total surgical cases. It has 179 ICU beds, one of the highest numbers in the country, and its Michigan Transplant Center is one of the busiest in the country, having performed over 7,100 solid organ transplants since 1964.

U-M has been a top performer in several best hospital contests, which tend to have very different slates of winners. It was on U.S. News’ Honor Roll this year, placing 14th overall and scoring within the top 21 hospitals for ear, nose and throat, rheumatology, urology, heart and heart surgery, ophthalmology, diabetes and endocrine disorders, kidney disorders, cancer and rehabilitation. It is also named as one of 15 major teaching hospitals in Thomson Reuters’ 100 Top Hospitals this year and it was one of the Leapfrog Top Hospitals in 2008. It received the 2008 Lindberg Bell Award from the International Association for Healthcare Security & Safety. This year it was the highest-ranking healthcare organization in the Detroit Free Press’ list of “Top Workplaces 2009.”

Vanderbilt University Medical Center (Nashville, Tenn.)

One challenge for Vanderbilt University Medical Center’s new Critical Care Tower, which is just opening, is making sure it would have enough space for medical innovations 10 years hence. In addition to 141 new acute-care beds and 12 operating suites, the $169-million tower has three shelled floors, for future growth. That’s not overly optimistic for a great institution like Vanderbilt, which is constantly on the move. This 832-bed teaching hospital ranks No. 10 among U.S. medical schools in NIH funding. It houses one of the largest DNA databases in the world, but it can also deliver basic primary care, operating more than 50 satellite clinics in Tennessee and Kentucky. The campus includes Vanderbilt University Hospital, a twin-towered building with more than 600 beds, Monroe Carell Jr. Children’s Hospital and the Vanderbilt Clinic.

Vanderbilt has the distinction of being one of only two hospitals, with Duke, to be highly rated in the two major ratings systems. Vanderbilt came in 16th on U.S. News’ list of Best Hospitals and was one of U.S. News’ top 21 hospitals in kidney disorders, urology, cancer, diabetes, ear, nose and throat, gynecology and heart and heart surgery. It also reapplied the nursing Magnet award in 2006 and the Consumer Choice Award for its region in 2009, and it was named this year as one of Fortune magazine’s top 100 companies to work for.

Vanderbilt has one of the most sophisticated electronic medical records systems in the nation. The medical center pioneered EMR 10 years ago and its homedown system is now commercialized as CareAlign. Clinical and research faculty use the system to improve medical outcomes, prompting Vanderbilt’s designation in 2007 as an evidence-based practice center by AHRQ, the federal agency that studies quality of care.
2. Become consumer-friendly

Hospitals have come to realize that improving market share for private-pay patients means becoming more consumer-friendly, says Kevin C. Nolan, a managing director at Navigant Consulting, based in Washington, D.C. But one aspect of consumerism often overlooked is quoting the prices of services. Even as people are thrown out of work and have to closely watch their dollars, many hospitals still aren’t able to field questions about what patients will have to pay, he says.

“If someone who calls up and asks for a price is likely to get passed around a lot,” Mr. Nolan says, “and chances are they’ll end up with someone who says, ‘It depends.’ ” In fact, he says, it is quite easy now to find an exact price for a specific patient, but “no one in the billing department is trained to quote prices.”

He says hospitals that are successful with service lines are making fundamental changes, such as reorganizing them into areas of care, which could mean bringing cardiologists and cardiac surgeons together or matching orthopedic surgeons with physiatrists for patients with back pain. Imaging and labs can be brought together with clinical care for a kind of one-stop shopping. For example, Rush University Medical Center recently opened a $75 million orthopedic building that brings together services that were scattered across its campus into 220,000 square feet of space.

Ms. Jacobson, the Rush CFO, says making sure orthopedic patients are happy is essential because the specialty, as a mostly elective service, allows for consumer choice. “Elective procedures are particularly conducive to comparison shopping because the patients have the time to look around,” she says. In some cases, she adds, elective procedures are losing volume because people affected by the recession are deferring services, but that has not happened at Rush.

Service lines like orthopedics can be a profitable if the process is well managed, said Sid Ramsey, vice president for business development at Iowa Health, a Des Moines-based system with three hospitals and many clinics. “If you can be more efficient and manage turnaround times in the OR, it can work,” he said. “We are working very hard at improving turnaround times and now it’s beginning to pay off.”

4. Develop niche services

Competing hospitals may cancel each other out by vying for the same finite number of patients in major service lines, observes Ms. Jacobson, who, in addition to being CFO at Rush, is national chair for the Healthcare Financial Management Association. As an HFMA leader, she is acquainted with smaller hospitals that have focused on niche services that may not be as lucrative as the traditional service lines but still can bring profits through higher volume.
As examples of these niche services, Ms. Jacobson points to high-volume areas such as pediatrics and women’s health. “It’s generally accepted that women make the most choices in healthcare, so focusing on women can mean gaining a foothold in other areas,” she says. For instance, a hospital can focus on women’s heart services or women’s cancer services. She says women’s services should be patterned to the community. If the population is younger, the hospital might emphasize obstetrics; if it is older, it might emphasize cancer and heart services.

5. Focus on outpatient services
Many hospitals can still make money on outpatient services such as clinics, ASCs and imaging centers. “For most community hospitals today, it’s not unusual to see them make all of their profits on the outpatient business,” Mr. Nolan says.

Tom Timcho, CEO of 373-bed Jefferson Regional Medical Center in Pittsburgh, says despite high unemployment in the area, he still expects to make a profit in outpatient services, specifically in a hospital-owned ASC and two imaging centers. “When outpatient services are on the main campus, it is not a good experience for the patient,” Mr. Timcho says. Patients often have to pay to park, walk from the parking lot to the service area and then they may be bumped by a patient from the ED. “When that happens, it’s the last time they visit us,” he says. “They have plenty of other choices in Pittsburgh.”

6. Make ED services more efficient
Hospitals get many of their best-paying patients through the ED, but the ED can lose money if it has to deal with high volumes of non-paying patients who use it for non-emergency services, a growing problem in this recession. For example, in the past 12 months, Grady Hospital has provided $60 million in additional free care, most of it coming through the ED, Mr. Young says. Out of 110,000 visits to the ED, he says 40,000 simply want primary care that could be provided in a clinic and many of them don’t have the means to pay their bills.

To divert these primary care patients from the ED, Mr. Young opened three new community health “super centers,” designed for primary care patients. He also hopes the new centers can attract more paying patients. Meanwhile, Mr. Young set out to make the ED more efficient by removing bottlenecks that slowed down patient flow. As a result, waiting times in the ED have been reduced from 12 hours to six hours.

The University of Chicago Hospital has tried a similar approach, announcing earlier this year that it would divert patients to two dozen health centers and two community hospitals. But local politicians and some physicians charged the 570-bed hospital with patient dumping, which the university has denied. Ms. Jacobson, viewing the brouhaha from several miles away at Rush, said she can see the rationale behind the University of Chicago’s plan. “If done right, controlling utilization in the ED can be a good idea,” she said.

Loma Linda University Medical Center has had success in reducing unnecessary use of its ED by convincing non-emergency patients to use a new urgent care center instead. Steve Mohr, vice president for finance at the 433-bed hospital, says the hospital has invested in placards and direct mail advertising to steer patients to the center. He says the facility saw a 300 percent increase in patient volume in the first year. The next step, Mr. Mohr says, might be to put up an electronic sign showing current waiting times for non-emergency patients at the ER and at the urgent care center. The difference, which can be several hours, could be quite convincing, he thinks.
7. Staff plenty of physicians, and keep them busy

Mr. Mohr says the profitability of a hospital — and especially of a service line — depends on successful physician recruitment of specialists and good relationships with referring physicians. “We are encouraging more orthopedic surgeons to use our orthopedics ORs,” he says.

Orthopedic surgeons who already use Loma Linda’s ORs are being asked to develop contacts with referring primary care physicians so that volume stays strong. “One way to boost referrals is to create relationships,” Mr. Mohr says. For example, Loma Linda has strengthened ties with Beaver Medical Group, the largest multispecialty group in the area, partnering with Beaver on such projects as a new multispecialty ASC.

Mr. Young says Grady already has enough specialists in many areas and the chief problem is keeping them busy. “Since we have the trauma surgeons, we want to fill their time as much as possible,” he says.

8. Purchase state-of-the-art equipment

Mr. Young says future profits lie in new equipment. When he arrived at Grady one and a half years ago, “our equipment was so bad you couldn’t even use it,” he says. “The cath lab was 15 years old.” The restructuring of the hospital that brought him in established a $300 million fund, which he is using to purchase new equipment. For example, the hospital is installing an electronic medical record system.

Stephen F. Ronstrom, CEO of 344-bed Sacred Heart Hospital in Eau Claire, is another believer in new technology. “Technology can deliver higher market share and patient volume,” he says. “If you make investments in technology, it pays off in volume.” For example, urologists using the hospital’s new da Vinci robot are more likely to perform initial surgery there as well. He adds that new technology, such as the hospital’s Smart OR for brain surgery, lowers reoperation rates, which improve reimbursements. “Our costs per case are being properly controlled,” he says.

9. Avoid readmissions

Ms. Jacobson, the Rush CFO and HFMA leader, says lowering readmissions is rapidly becoming critical to protecting hospital profits. For example, CMS’ Hospital Compare Web site this year began to post each hospital’s rates for Medicare heart and pneumonia patients readmitted within 30 days. And both Pres. Barack Obama’s budget plan and the Senate health reform bill would cut Medicare payments for hospitals with high readmission rates starting in 2012.

“Hospitals will need to make sure that a bounce-back doesn’t happen,” says Ms. Jacobson of readmissions. This means improving discharge planning, coordinating care with other providers who see the patients after discharge and focusing on issues like compliance with medications, she says. Rush has assembled a task force to examine what the hospital should be doing about readmissions.

Mr. Young at Grady is also considering what should be done to control readmissions. He says he is impressed with the success of “patient navigators,” who are extensively used in oncology. The navigators help patients identify resources for financial assistance, medication needs, home health care, insurance questions and transportation.

Contact Leigh Page at leigh@beckersasc.com.

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Community Hospitals across the country face a large degree of uncertainty in 2010. In order to deal with these uncertainties, hospitals must operate efficiently, with patient and physician satisfaction at the top of their list of priorities. David Fox, CEO of Advocate Good Samaritan Hospital in Downers Grove, Ill., shares his thoughts on the challenges, opportunities and future for community hospitals.

Challenges

Softening demand for healthcare, increased bad debt. One of the largest and most immediate challenges for all hospitals is financial uncertainty due to the present state of the economy and high levels of unemployment, which threatens both healthcare spending and coverage.

“What we’re experiencing in the Midwest is very high levels of unemployment of about 10 percent,” says Mr. Fox. “As this extends over time, more and more people will begin losing their COBRA insurance, which will lead to: No. 1, a softening of the demand for healthcare, and No. 2, an increase in bad debt and charity care as people without insurance use the system,” says Mr. Fox.

Hospital leaders should anticipate both a softened demand for care and increased bad debt and should take steps to ensure hospital financial stability in light of these conditions.

Mr. Fox says that Advocate Good Samaritan has already instituted a capital freeze, which he expects to continue through the majority of 2010. The hospital also works to continually “manage the enterprise very tightly” by monitoring patient volumes and cost and labor productivity metrics, he says.

Healthcare reform. Healthcare reform is likely to significantly change the structure of healthcare, and community hospitals face uncertainties about how this new vision of healthcare will be structured and its affect on reimbursement, says Mr. Fox.

“The real reform is going to happen at the local level among doctors and hospitals,” says Mr. Fox. “The structure of healthcare is going to change, the number of insured is going to improve and how healthcare providers get paid is going to change. At the local level, the question becomes, ‘how are we really going to be able to work together to provide better, more integrated care?’”

Current healthcare reform legislation includes provisions that would eliminate reimbursement to hospitals and physicians for patients who are readmitted within 30 days of discharge. If such provisions are enacted, hospitals will need to work more closely with physicians to integrate care and reduce avoidable readmissions in order to ensure financial sustainability. Advocate Good Samaritan already works collaboratively with physicians to reduce avoidable readmission through a unique compensation program that rewards physicians for patient outcomes.

Opportunities

Increased focus on the patient. Although community hospitals face a number of challenges in the coming years, a continual focus on the patient while improving efficiency is one of the surest ways to help improve viability in a difficult environment. Advocate Good Samaritan boasts patient satisfaction scores above the 90th percentile for nearly all of its departments and has seen its volume grow in a time when most hospitals’ volumes are declining.

“We have a track record of very high patient care and customer experience, and, as a result, patient customers are choosing to come to us,” says Mr. Fox. “By focusing on high-level service to both patients and physicians, we have the opportunity to earn more referrals.”

In addition, the hospital plans to continue to focus on becoming a leaner organization. “We can continue to provide great clinical care but do it less expansively,” says Mr. Fox.

Work collaboratively with physicians. Hospitals must also focus on their relationships with physicians. Hospitals need to keep physicians satisfied and align physicians with their needs in order to be successful.

Advocate Good Samaritan has one of the nation’s few programs that reward non-salaried physicians for meeting outcomes and efficiency targets. The “clinical integration program,” as the hospital calls it, provides additional reimbursements to physicians who meet certain goals developed by the hospital leadership team.

“No matter what type of healthcare reform we end up with, in the future, it will become critical for healthcare providers to work more powerfully together,” says Mr. Fox. “Our clinical integration program is a wonderful way to achieve alignment.”

Attract and retain the highest-quality staff. In a challenging environment, attracting and retaining the highest-quality staff is critical for the long-term success of hospitals.

“The key to success for community hospitals today and in the future is being able to attract and retain the highest-quality healthcare workers,” says Mr. Fox. “There is a growing shortage of nurses, pharmacists and respiratory therapists, and we are determined to be the destination hospital for people that work in healthcare.”

Mr. Fox says that attracting and retaining top staff requires competitive salaries and benefits, a high level of collaboration among healthcare staff and physicians and an environment that allows employees to grow, develop and enhance their skills.

Future of community hospitals

Despite the challenges that community hospitals face, Mr. Fox believes that providing quality care at the local level will allow many of these hospitals to survive. Independent hospitals that are not part of an integrated health system, like Advocate, might find meeting the changes brought on by healthcare reform more difficult due to increased regulation but there will always be successful independent hospitals in America, according to Mr. Fox.

“I think that there will always be independent hospitals that do well in America, but there are some advantages, including increased efficiencies, to being part of a healthcare system,” says Mr. Fox.

Mr. Fox has served as CEO of Advocate Good Samaritan since 2003. He earned a graduate degree from the University of Chicago in healthcare management and previously served as president of Central DuPage Hospital in Winfield, Ill.
Hospital CEO Stephen Ronstrom’s Plan for Success in a Rapidly Changing and Challenging Economy

By Leigh Page

As president and CEO of the Western Wisconsin division of Hospital Sisters Health System, Stephen F. Ronstrom oversees two hospitals, 344-bed Sacred Heart Hospital in Eau Claire and 150-bed St. Joseph’s Hospital in Chippewa Falls. The Hospital Sisters Health System is a 13-hospital Catholic system based in Springfield, Ill.

Mr. Ronstrom has more than 25 years experience as a hospital executive, including more than 10 years at the helm of Sacred Heart Hospital. He was recently appointed to the board of the Wisconsin Hospital Association.

He discusses how his hospitals have thrived in the challenging economic climate.

Q: In these difficult economic times, has it still been possible for you to keep a positive operating margin?

Stephen Ronstrom: My two-hospital division had a double-digit operating margin for last fiscal year and this year we’re setting a pace for a record year. We are the most successful division in our health system. However, we are taking the recession very seriously and continue to tighten operating costs. For example, we are working with our health system to control purchasing expenses.

Q: Your high operating margins have allowed you to invest in a level of medical technology that is rarely seen outside of a large academic medical center. You have some expensive, cutting-edge equipment such as the iMRi in your Smart OR and the da Vinci robot. Can you tell us a little about the strategies behind your use of high technology?

SR: While a lot of other hospitals are trying to pull back on technology, technology has been fundamental for our mission. If you make investments in technology, it pays off in volume. For example, if the urologists in our area uses our da Vinci robot, they are more prone to do initial surgery in our hospital OR than in a freestanding one.

Technology can deliver higher market share and patient volume. It can also save money. For example, our Smart OR has lowered reoperation rates for brain tumor surgery. Our costs per case are being properly controlled.

Q: For a hospital that is not within a major metropolitan area — Minneapolis is a two-hour drive away — you have had a great deal of success recruiting physicians. How did you do that?

SR: The longer I’m at this job, the more important recruitment seems to me. It’s really the key to this business. Your success is based on who you hire. Technology is a big lure for physicians. For example, we recently recruited two urologists because we could offer them robotics. This strategy is especially effective in attracting young physicians who are just coming out of training and want to use the technology they had in their programs.

When recruiting, we look for quality. Once you have brought in a few highly regarded doctors, it gets easier to attract more physicians. Bringing in one great neurosurgeon attracts other great surgeons. To get the best physicians, you have to meet them on their terms. Generally, we’ll go along with whatever works for them, whatever meets their needs. For example, a lot of physicians want to keep their autonomy. Rather than integrating physicians into the hospital, we have let them join single-specialty groups independent of the hospital.

This kind of strategy requires a great deal of flexibility, which puts us at an advantage over a large academic medical center, where everyone is bound by particular ways of doing things. A smaller organization is better able to configure policies more flexibly. We can create innovative joint ventures. We can be entrepreneurial.

We also want to recruit more primary care physicians. Primary care physicians are leaving small towns. If coverage is extended under health reform, there won’t be enough primary care physicians to take care of everyone. We used to recruit physicians from Canada; now we’re looking at Africa.

Q: Many hospitals have been hard pressed to maintain efficiency, such as low OR turnaround times. You’ve had a great deal of success with this. How did you do it?

SR: We worked very hard at improving turnaround times, and now it’s paying off. Our surgical caseload has increased by 15 percent. We have also improved processes in the ED. We had
a flow problem there because of some longstanding bottlenecks. For example, in the past, oftentimes it would take a while for us to move patients from the ED into the hospital itself. Making these changes takes organizational discipline. We’ve come a long way but we can still get better at it.

Q: You have also been a strong proponent of keeping staff trained.

SR: One of my real passions is educating our staff. We use “just-in-time” training with neurosurgery and heart surgery staff, which involves working with the individual as they go about their tasks. You can see where the employee needs some help and give instruction right then and there. We have a full-time educator and an education center where employees can use computerized programs and go onto the Internet.

Q: What do you think the future looks like for hospitals?

SR: I believe the recession is a prelude of what things will be like for hospitals. We are going to have to do more with less. We’re going to have to make do with lower levels of reimbursements.

I see a real shakeout ahead for this industry. You’re going to see a greater discrepancy between successful and the less successful hospitals. Hospitals are going to have to focus on growth, not price. You won’t be able to raise your rates, which means you’ve got to add volume and market share if you want to increase your revenue streams.

Whatever kind of health reform we get, hospitals will need to respond by being innovative. I believe some of the old restrictions on hospital improvement, such as the antikickback laws, will be loosened up a bit, so that we can work more closely with our doctors.

This is such an exciting time now. We’re right on the cusp of a golden age in medicine, with innovations such as genetics, medical technology and telemedicine. I see a whole new wave coming at us.

2009 Median Compensation for Hospital Executives

Here are statistics on the 2009 cash compensation earned by hospital executives, by job title, according to Integrated Healthcare Strategies’ 2009 National Healthcare Leadership Compensation Survey.

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Integrated Healthcare Strategies offers comprehensive human resource consulting services to the healthcare industry. These services include physician services, executive total compensation, executive search, governance and leadership consulting and human capital management consulting services. For more information or to learn more about their surveys, please contact David Bjork, senior vice president, or Mick Schoenberger, vice president, at Integrated Healthcare Strategies at (800) 327-9335 or e-mail david.bjork@ihstrategies.com or mick.schoenberger@ihstrategies.com.

2009 Median Compensation for Health System Executives

Here are statistics on the 2009 cash compensation earned by health system executives, by job title, according to Integrated Healthcare Strategies’ 2009 National Healthcare Leadership Compensation Survey.

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Becker’s Hospital Review Names the 32 Best Physician-Owned Hospitals in America

Physician-owned hospitals have a long history of providing effective, quality care. Here are 32 of the best physician-owned hospitals in the United States. They are recognized for their commitment to patient safety and quality by their patients, staff, communities, industry associations and leading healthcare publications and ratings resources. To view profiles of and learn more about these organizations, visit www.BeckersHospitalReview.com. Note: Hospitals are listed in alphabetical order.

Animas Surgical Hospital (Durango, Colo.)
Arizona Spine and Joint Hospital (Mesa, Ariz.)
Aurora Baycare Medical Center (Green Bay, Wis.)
Baylor Medical Center at Frisco (Frisco, Texas)
Black Hills Surgical Hospital (Rapid City, S.D.)
Cache Valley Specialty Hospital (North Logan, Utah)
Doctors Hospital at Renaissance (Edinburg, Texas)
Edgewood Surgical Hospital (Transfer, Pa.)
El Paso Specialty Hospital (El Paso, Texas)
Foundation Surgical Hospital (Bellaire, Texas)
The Indiana Heart Hospital (Indianapolis)
Indiana Orthopaedic Hospital (Indianapolis)
Kansas City Orthopaedic Institute (Leawood, Kan.)
Kansas Spine Hospital (Wichita, Kan)
Lafayette Surgical Specialty Hospital (Lafayette, La.)
Lincoln Surgical Hospital (Lincoln, Neb.)
Nebraska Orthopaedic Hospital (Omaha, Neb.)
North Carolina Specialty Hospital (Durham, N.C.)
Northwest Specialty Hospital (Post Falls, Idaho)
OakLeaf Surgical Hospital (Eau Claire, Wis.)
Oklahoma Heart Hospital (Oklahoma City, Okla.)
Oklahoma Spine Hospital (Oklahoma City, Okla.)
Oklahoma Surgical Hospital (Tulsa, Okla.)
Orthopaedic Hospital of Wisconsin (Glendale, Wis.)
P&S Surgical Hospital (Monroe, La.)
The Physicians Centre Hospital (Bryan, Texas)
Sierra Surgery Hospital (Carson City, Nev.)
Sioux Falls Surgical Hospital (Sioux Falls, S.C.)
South Texas Spine and Surgical Hospital (San Antonio, Texas)
Stanislaus Surgical Hospital (Modesto, Calif.)
Texas Health Harris Methodist Hospital Southlake (Southlake, Texas)
Texas Spine & Joint Hospital (Tyler, Texas)

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Program Schedule

Conference – Tuesday, April 13, 2010
11:30am – 1:00pm Registration
1:00pm – 1:05pm Introductions
1:05pm – 2:40pm The Best Ideas for Hospitals Now
Chris Karam, FACHE, President & CEO, CHRISTUS St. Michael Health System, Dan Moen, CEO, LHP Hospital Group, Inc, Paul R. Summerside, MD, Chairman of the Board, Aurora Baycare Medical Center, Alex Rintoul, CEO, Medical Center at St. Elizabeth Place
Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

2:45pm – 3:25pm A - The 5 Things Hospitals Should Look For In A Partner
Dan Moen, CEO, LHP Hospital Group, Inc.

B - Developing a Sustainable Physician Strategy
Walter Morrissey, MD, Vice President, Kaufman Hall

3:25pm – 3:40pm Break

3:45pm – 4:15pm A - 5 Key Concepts for Growing Profits in a Challenging Economic Environment
Chris Karam, FACHE, President & CEO, CHRISTUS St. Michael Health System

B – Hospital Transactions, Current Market Analysis and Valuations
Greg Koonsman, Senior Partner, and Jon O’Sullivan, Senior Partner, VMG Health

4:20pm – 4:50pm A – Strategies for Competing with a Dominant Hospital
Alex Rintoul, CEO, Medical Center at St. Elizabeth Place

B – A Prescription for the Free Standing Emergency Department
Kimberly Nealon, Site Director, St. Vincent’s Medical Center, John Marshall, Executive Director, Business Development Midwest, BrennerDuke

4:55pm – 5:25pm A – Making Employed Physician Models Profitable
Marc Halley, MBA, President & CEO, Halley Consulting Group

B – How Doctors Think, Why Doctors Are Different – Suggestions, Ideas and Tips for Partnering with Physicians
Jeff Leland, Managing Director, Blue Chip Surgical Center Partners

5:25pm – 7:00pm Cocktail Reception

Conference – Wednesday, April 14, 2010
7:00am – 9:00am Registration and Continental Breakfast
9:00am – 5:15pm Conference, Including Lunch and Exhibit Hall Breaks
5:15pm – 7:00pm Reception, Cash Raffles, Exhibit Hall

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Wednesday, April 14, 2010

7:00 am – 9:00 am
Registration and Continental Breakfast

9:00 am – 9:40 am
Physician Hospital Relationships – A Review of Evolving Problems and Opportunities
Paul Summerside, MD, Chairman of the Board, Aurora BayCare Medical Center

9:45 am – 10:15 am
A – The Best Ideas for Hospital CFOs Now
Zach Hafner, Vice President Strategy and Financial Planning, Kaufman Hall

10:15 am – 10:45 am
Break

10:45 am – 11:15 am
A – Using Metrics to Analyze Hospital Financial Performance
Larry Taylor, President, Practice Partners in Healthcare

11:15 am – 11:45 am
Break

11:45 am – 12:15 pm
Scott Saffire, MBA, AVA, Principal, Healthcare Appraisers, Kristian Werling, JD, Attorney, McGuireWoods, LLP

12:15 pm – 12:45 pm
Break

12:45 pm – 1:15 pm
C – An Analysis of What Works, What Doesn’t – Key Thoughts from 10 Great Partnerships with Management Companies and Hospitals
Joe Clark, EVP and Chief Development Officer, Surgical Care Affiliates

1:15 pm – 1:45 pm
Break

1:45 pm – 2:15 pm
B – 4 Key Ideas and Concepts to Improve Cardiovascular Program Profitability
Ted Winslow, MD, Sg2

2:15 pm – 2:45 pm
A – Key Steps to Contain Costs
Faye Deich, Chief Operating Officer, Sacred Heart Hospital, Regional Director, Hospital Sisters Health System

2:45 pm – 3:15 pm
Break

3:15 pm – 3:45 pm
B – Clinical Integration Models and How to Affiliate for Managed Care Contracting
Brian Silverstein, MD, Senior Vice President, The Camden Group

3:45 pm – 4:15 pm
C – Ancillary Facilities Financing Challenges
Peter Myhre, Senior Vice President, Wells Fargo Equipment Finance

4:15 pm – 4:45 pm
Break

4:45 pm – 5:15 pm
A – Monetization of Non Core Assets and Outsourcing Facility Development
Michael Bryant, CEO, Methodist Medical Center and Gordon Soderland, SVP, Strategic Relationships, DASCO Companies

5:15 pm – 5:45 pm
Break

5:45 pm – 6:15 pm
B – A New Model in Cancer Care
John Marshall, Executive Director, Business Development Midwest and Deeni Taylor, Regional Executive Vice President, BremnerDuke

6:15 pm – 6:45 pm
C – Distressed Hospital Financing Issues
Shane Passarelli, Senior Vice President, Healthcare Finance Group, and Gary Samson, Partner, McGuireWoods, LLP

6:45 pm – 7:15 pm
Break

7:15 pm – 7:45 pm
A – How to Work With Physician Owned Hospitals
Tom Michaud, Chairman/CEO, Foundation Surgery Affiliates

7:45 pm – 8:15 pm
B – 4 Best Practices for Hospital Spine Programs
Ted Michalke, Managing Partner, NeuStrategy, Inc.

8:15 pm – 8:45 pm
Cocktail Reception

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Angela L. Blankinship, Director of Surgery Services, San Luis Valley Regional Center

Joseph Bosco, MD, Vice Chairman Clinical Affairs, Dept of Orthopedic Surgery NYU

Ron Brownstein, Political Director, Atlantic Media Company

Michael Bryant, President & CEO, Methodist Health Services Corporation

Joe Clark, EVP and Chief Development Officer, Surgical Care Affiliates

Faye Deich, Chief Operating Officer, Sacred Heart Hospital, Regional Director, Hospital Sisters Health System

Joan Dentler, MBA, Managing Partner, ASC Strategies

David Felsenthal, Co-Founder, Principle Valuation

Claudia Stone Gourdon, SVP, National Marketing Manager, Healthcare Finance Group

Zachary Hafner, VP Strategy and Financial Planning, Kaufman Hall

Marc Halley, President/CEO, Halley Consulting Group

Holly Hampe, Director, Patient Safety & Quality, Amerinet

Nicola Hawkinson, CEO & Founder, Spine Search

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John R. Zell, CPA, MBA, CFO, OSF St. Joseph Medical Center

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30 of the Best Physician Leaders of Hospitals and Health Systems

Becker’s Hospital Review announces 30 of the best physician executive leaders of hospitals and health systems. These are physicians who excel on the leadership side of healthcare in an extraordinary manner. Note: Visit www.BeckersHospitalReview.com to see expanded profiles of these leaders.

Ron Anderson, MD. (Parkland Health & Hospital System, Dallas). Dr. Anderson is president and CEO of Parkland Health & Hospital System in Dallas. He has served as a CEO for 26 years and a practicing physician for 35 years. Dr. Anderson became CEO of Parkland in 1982 and previously served as Parkland’s medical director for ambulatory care and emergency services.

Warren Brown, MD. (California Pacific Medical Center, San Francisco). Dr. Brown is CEO of California Pacific Medical Center in San Francisco and an adjunct professor of medicine and epidemiology and biostatistics at the University of California, San Francisco, School of Medicine. He received his medical degree from the University of California, San Francisco and his master’s in public healthcare in epidemiology from the University of California, Berkeley.

Delos M. “Toby” Cosgrove, MD. (Cleveland Clinic Foundation, Cleveland). Dr. Cosgrove is president and CEO of the $4.6 billion Cleveland Clinic Foundation, which includes the Cleveland Clinic. Dr. Cosgrove has served as the top leader at Cleveland Clinic since 2004. He previously served as chairman of Cleveland Clinic’s Department of Thoracic and Cardiovascular Surgery, which was ranked as the top cardio program in the country for 10 years in a row by U.S. News & World Report under his leadership.

Melinda Estes, MD. (Fletcher Allen Health Care, Burlington, Vt.). Dr. Estes became president and CEO of Fletcher Allen Health Care in Oct. 2003. She is a neurologist and neuropathologist who also holds an MBA from Case Western Reserve University. Prior to joining Fletcher Allen, Dr. Estes spent most of the previous two decades in the Cleveland Clinic healthcare system, holding a variety of positions of progressive responsibility including CEO and chair of the board of governors of Cleveland Clinic Florida.

Joseph Golbus, MD. (NorthShore University HealthSystem Medical Group, Evanston, Ill.). Dr. Golbus is president of the NorthShore University HealthSystem Medical Group and an associate professor of medicine at the Northwestern University Medical School in Evanston, Ill. He earned his medical degree from the University of Illinois Abraham Lincoln School of Medicine.

Larry J. Goodman, MD. (Rush University Medical Center, Chicago). Dr. Goodman is president and CEO of Rush University Medical Center in Chicago. Prior to being named president and CEO, Dr. Goodman was senior vice president for medical affairs at Rush and the Henry R. Russe Dean of Rush Medical College. He is also a professor of medicine at the college. Before accepting the position of senior vice president in 1998, he was medical director of Cook County Hospital, also in Chicago. Dr. Goodman received his medical degree from the University of Michigan Medical School.

David Feinberg, MD. (UCLA Hospital System, Los Angeles). Dr. Feinberg is the associate vice chancellor and CEO at UCLA Hospital System in Los Angeles. Prior to assuming the CEO role for the UCLA system, he was the medical director of the Resnick Neuropsychiatric Hospital at UCLA, considered to be one of the premier psychiatric hospitals in the Western United States. Dr. Feinberg earned his medical degree from the University of Health Sciences/The Chicago Medical School and his MBA from Pepperdine University.

Gary L. Gottlieb, MD. (Partners HealthCare, Boston). Dr. Gottlieb was recently appointed president and CEO of Partners Health System in Boston, succeeding James Mongan, MD. Dr. Gottlieb will serve as president at Brigham and Women’s Hospital until the end of 2009. He is a professor of psychiatry at Harvard Medical School and focuses his attention on workforce development and disparities in healthcare.

Roberta Luskin-Hawk, MD. (Saint Joseph Hospital, Chicago). Dr. Luskin-Hawk was appointed CEO of Resurrection Health Care’s Saint Joseph Hospital in Chicago in Sept. 2009. Dr. Luskin-Hawk founded Lakeshore Infectious Disease Associates, and has operated the practice for 24 years while serving on the Saint Joseph’s medical staff since 1985. She has served as chief of the section of infectious diseases, director of graduate medical education and chairperson for the department of medicine for the hospital.

Rodney Hochman, MD. (Swedish Medical Center, Seattle). Dr. Hochman is president and CEO of Swedish Medical Center in Seattle and has served in the position since April 2007. Before joining Swedish, Dr. Hochman had been executive vice president of Sentara Healthcare in Norfolk, Va. Prior to that position, he had served as Sentara’s chief medical officer and senior vice president.

Gary Kaplan, MD. (Virginia Mason Medical Center, Seattle). Dr. Kaplan is chairman and CEO of Virginia Mason Medical Center in Seattle. Dr. Kaplan joined Virginia Mason in 1981 as chief resident of internal medicine and is board-certified in internal medicine. During his time at Virginia Mason, he has served as a section head at Virginia Mason East in Kirkland, Wash.; deputy chief of medicine; and chief of the Department of Satellites.

John Koster, MD. (Providence Health and Services, Seattle). Dr. Koster is president and CEO of Providence Health and Services in Seattle. He previously held primary responsibility for system operations since joining Providence in 1997. Prior to Providence, Dr. Koster served as vice president for targeted member services at VHA in Irving, Texas, and was vice president of Presbyterian Healthcare Services in Albuquerque, N.M.

Brent Lambert, MD. (Ambulatory Surgical Centers of America, Hanover, Mass.). Dr. Lambert is the chairman of the board and a founder of Ambulatory Surgical Centers of America, an ASC management and development company. Dr. Lambert is a board-certified ophthalmologist and a graduate of Harvard College, Columbia University College of Physicians and Surgeons, Harvard Medical School and Massachusetts Eye & Ear Infirmary residency program. Prior to the founding of ASCOA, Dr. Lambert was the developer and owner of three ASCs, including the first eye ASC in New England.

Mark Laney, MD. (Heartland Health, St. Joseph, Mo.). Dr. Laney serves as president and CEO of Heartland Health in St. Joseph, Mo., a position which he began on Aug. 3, 2009. Prior to this role, Dr. Laney served as president of Cook Children’s Health Care System in Fort Worth, Texas, one of the largest pediatric multi-specialty practices in the United States.

Roger Longenderfer, MD. (Pinnacle Health System, Harrisburg, Pa.). Dr. Longenderfer is president and CEO of four-hospital Pinnacle Health System in Harrisburg, Pa. He was named head of the Pinnacle system in 2001. He earned his degree in medicine from Hahnemann Medical College and completed his residency in family practice at Geisinger Medical Center. He later went on to complete his master’s degree in business administration at Oklahoma City University.
Edward D. Miller, MD. (John Hopkins Medicine, Baltimore). Dr. Miller is CEO of Johns Hopkins Medicine, dean of the Johns Hopkins University School of Medicine and vice president for medicine of The Johns Hopkins University. He has held these positions since Jan. 1997. An anesthesiologist who has authored or co-authored more than 150 scientific papers, abstracts and book chapters, Dr. Miller joined Johns Hopkins in 1994 as professor and director of the Department of Anesthesiology and Critical Care Medicine.

Edward Murphy, MD. (Carilion Clinic, Roanoke, Va.). Dr. Murphy is president and CEO of Carilion Clinic in Roanoke, Va., and Professor of Medicine at the newly organized Virginia Tech Carilion School of Medicine. Prior to his affiliation with Carilion Clinic, he served as president and CEO of Seton Health System in upstate New York. Dr. Murphy obtained his medical degree from Harvard Medical School, graduating cum laude.

Elizabeth G. Nabel, MD. (Brigham and Women's/Faulkner Hospitals, Boston). Dr. Nabel will become the president of Brigham and Women's Hospital and Faulkner Hospital in Boston in Jan. 2010. She previously served as the director of the National Heart, Lung and Blood Institute at the National Institutes of Health. Dr. Nabel is a board-certified cardiologist and served as the director of the National Heart, Lung and Blood Institute at the National Institutes of Health in Chapel Hill, N.C., and dean of the UNC School of Medicine. He also previously served as program director and the family medicine associate chair at Aurora St. Luke's Medical Center.

Stephen L. Newman, MD (Tenet Healthcare Corp., Dallas). Dr. Newman is COO of Tenet Healthcare Corp., in Dallas. He is responsible for the operational oversight of Tenet's 50 acute-care hospitals in 12 states, as well as the company's ASCs and diagnostic imaging centers. He previously served as CEO for Tenet's California operations.

Herbert Pardes, MD. (New York Presbyterian Health Care System, New York.). Dr. Pardes is president and CEO of the New York Presbyterian Health Care System in New York. He served as U.S. Assistant Surgeon General and was director of the National Institutes of Mental Health during the Carter and Reagan Administrations. He also served as vice president for health sciences at Columbia University and dean of the faculty of medicine of Columbia's College of Physicians and Surgeons, positions he held while he was chairman of Columbia's Department of Psychiatry.

Jonathan Perlin, MD. (Hospital Corporation of America, Nashville, Tenn.). Dr. Perlin is chief medical officer and president of the clinical services group for Nashville, Tenn.-based HCA. He provides leadership for clinical services and improving performance at HCA's 163 hospitals and 112 outpatient centers. Before joining HCA in 2006, Dr. Perlin was Under Secretary for Health in the U.S. Department of Veterans Affairs.

Patrick J. Quinlan, MD. (Ochsner Health System, New Orleans). Dr. Quinlan is CEO of Ochsner Health System in New Orleans and is responsible for all operations and strategic growth for the health system. He previously served as chief medical officer for Ochsner and was chief medical officer at Lovelace Health Systems in Albuquerque, N.M. Dr. Quinlan earned his medical degree from the University of Texas Medical Branch at Galveston.

Prem Reddy, MD. (Prime Healthcare Services, Victorville, Calif.). Dr. Reddy is chairman and founder of Prime Healthcare Services, which oversees 13 acute-care hospitals in California. He is board certified in both internal medicine and cardiology. During his 25 years serving the High Desert region of California, he has built several practices and hospitals from the ground up, including the Desert Valley Medical Group and Desert Valley Hospital.

William Roper, MD. (University of North Carolina Health Care System, Chapel Hill, N.C.). Dr. Roper is CEO and vice chancellor of medical affairs for the University of North Carolina Health Care System in Chapel Hill, N.C., and dean of the UNC School of Medicine. He also is professor of health policy and administration in the School of Public Health and is professor of pediatrics in the School of Medicine at UNC. Prior to joining UNC, Dr. Roper was vice president of Prudential Health-
Chip Kahn, President of the Federation of American Hospitals, Looks at Health Reform 17 Years After ‘Harry & Louise’

By Leigh Page

Chip Kahn has been a major player in Washington for many years — as a health policy adviser to key Republican Senators, a representative of the health insurance industry and now as president for the past eight years of the Federation of American Hospitals. Here Mr. Kahn talks about the prospects of health reform and how it would affect the nation’s hospitals.

Q: You campaigned very aggressively against Bill Clinton’s health reform proposal 17 years ago, but now you are a strong supporter of many aspects of the Democrats’ current health reform initiative. Why is that?

Chip Kahn: U.S. hospitals and the healthcare they deliver are at a pivotal point. The healthcare system is in dire need of fixing. If we in this country continue down the same road we are on now, there will be more erosion of health coverage, which is not good for patients and not good for hospitals. Health reform has been on the association’s agenda for some time. More than two years ago, before the current debate in Congress started, the federation produced a health reform proposal, called the Health Coverage Passport, which spelled out in great detail what we thought health reform should be like.

Q: Your views seem to have evolved since you were executive vice president of the Health Insurance Association of America. Back then, HIAA ran the “Harry and Louise” ads, which are seen as a major factor in the defeat of Pres. Clinton’s health reforms.

CK: People usually have the misperception that the HIAA was against health reform. That is not so. HIAA was against the Clinton brand of health reform. The Clinton proposal was devised in secret, without input from Congress, and it would have destroyed the business model for health insurers.

Q: One major thrust of the health reform bills is to move U.S. healthcare toward universal coverage. Why do you support universal coverage?

CK: Unlike the public option, universal coverage is something that most of us can agree on. Specifically, it would be good for hospitals. Rather than showing up at an emergency room for essentially charity care, everyone would be covered by an insurer and the hospital would be paid-for care.

Q: The federation does not support all aspects of the reform bills. What aspects does it not support?

CK: There are a few provisions we do not support. For example, we don’t favor a public insurance option. If it were to be included in the final version of the bill, it would be a bad thing for hospitals. That’s because payment rates in the public option would be tied to Medicare rates, and Medicare rates are lower than private insurance rates. Furthermore, my suspicion is that supporters of the public option view it as the first step toward a single-payer health system, which would be a path to destruction of the healthcare system as we know it. It’s a shame that the left decided to define health reform in terms of having a public option rather than in terms of universal coverage.

Q: As the bills stand now, how would they affect hospitals?

CK: As the legislation stands now, hospitals would probably feel comparatively little impact in the first three years. Provisions such as lowered disproportionate share payments would begin after the third year. In the first three years, there would be some reductions in payments in the marketbasket update for hospitals, but they would be fairly minor.

However, as the bills read now, there would be a number of demonstration projects such as post-acute bundling and pay-for-performance. Post-acute bundling involves combining payments to hospitals with post-acute providers such as rehab hospitals and long-term care facilities. If the provision passes, how it functions still needs to be worked out. It’s a good concept, but the problem with a good concept is that it’s still a concept. So the jury is still out on this provision.

Q: Can you offer any insights into the Republicans’ position in the current health reform debate?

CK: For many years I worked in the Republican Party, but I am not following the Republican Party on this issue. I work for hospitals, and hospitals have a strong stake in the health reform process. That said, I understand the Republicans’ point of view on health reform. Their objections to the Democratic proposals are based on deeply held principles, such as keeping big government in check.

Q: Why do all but a few Republicans oppose the Democrat’s health reform bills?

CK: Republicans in Congress have not been signing on to the Democrats’ reform proposals, and from their perspective I don’t blame them. Participating in health reform doesn’t do Republicans any good. Bipartisanship only serves the majority. Let’s say something gets passed. It will be viewed as legislation passed by Democrats in Congress, with the president’s signature on it. The Republicans are not going to win any political points helping out the Democrats.

Learn more about the Federation of American Hospitals at www.fah.org.
Assessing Alignment, Action and Accountability Within Your Hospital With Quint Studer of the Studer Group

By Lindsey Dunn

According to Quint Studer, founder of the Studer Group, the success of a hospital is dependent on leadership’s performance in three core areas — alignment, action and accountability. In order to improve the performance of a hospital, leaders must assess themselves and their facilities in these three areas and then work aggressively to improve any gaps.

Mr. Studer discusses each of the three areas, provides questions that can be used to survey employees and assess an organizational performance and offers tips to improve performance in each area.

Alignment Successful alignment means that all levels of hospital staff share the same goals and understanding of the healthcare marketplace. According to Mr. Studer, many hospital CEOs see the external environment differently than frontline supervisors because leadership is constantly looking to the future while frontline supervisors are more often focused on the immediate needs of their departments.

“There can be a gap here. The rest of the organization may not understand the need for urgency at the same level as the C-suite sees it. The C-suite knows about the challenges facing the industry, but they fail to communicate that information to frontline managers and employees so others understand the impact of the changes and actions that need to be taken,” says Mr. Studer.

A recent survey by Studer Group asked C-suite executives and frontline supervisors at several health systems the following question: “If leaders in your organization continue to perform exactly as they do today, will your results over the next five years be much worse, somewhat worse, better, the same or much better?” The survey found that the majority of senior leaders felt that their organization would be much worse if nothing changed, while 63 percent of frontline supervisors thought that the organization would perform about the same.

These results indicate that many hospital leaders need to better job communicating and explaining the external environment to their staff through regular, transparent and cascading communication, Mr. Studer says. He recommends that internal newsletters include information about the healthcare environment, including summaries of reform and other external pressures and the impact of these pressures on their facility. Leaders should then ask their frontline supervisors if they read the newsletter, which can often be done when rounding on the various supervisors, and encourage each supervisor to ask questions about the future of the hospital.

Action Action refers to the ability of the organization to respond to pressures from the external environment effectively, says Mr. Studer. Leaders can assess their organization’s ability to take proper action by asking questions such as: “Are our leaders getting the training they need to ensure they have the skills sets needed to respond to the external operating environment?” and “How well does current leadership prepare you to be a leader?” Hospitals with survey results that reveal potential gaps in these areas should begin by ensuring that their leaders and supervisors receive adequate training on running a meeting, how to select, hire and retain the best talent, how to develop leaders and how to improve or fire low-performers. All of these skills are critical to ensuring a hospital can successfully respond to a difficult external environment, says Mr. Studer.

Action also includes the ability of an organization to move best practices from one area to another. “This is just an overall weakness for many hospitals. We are able to spot a high-quality leader, but we are unable to transfer his or her best practices to other areas,” says Mr. Studer.

Organizations must identify these best practices, break them down and then ensure that leaders in other areas of the hospitals have both the training and the willingness to implement them in their own departments or service lines.

Accountability Accountability means holding leaders and employees responsible for job performance. Research by the Studer Group suggests that healthcare organizations over-evaluate employees, meaning supervisors provide evaluations that overstate the employee’s level of performance. This practice inhibits organizations truly evaluating employees and makes it more difficult for organizations to fire employees who fail to perform, says Mr. Studer.

“In a recent survey we completed, we found that supervisors report that, on average, 1.8 of the employees under their supervision were not meeting performance expectations. However, only 0.8 of their employees were in some sort of performance improvement or counseling program,” says Mr. Studer. “How can we expect high-quality organizational performance if we have a group of employees with performance issues that are not being addressed?”

Hospitals should ask employees questions such as “How well does your organization’s evaluations hold people accountable?” and “Are evaluations objective and not subjective?” to assess performance in this area.

A strong evaluation should use objective measures to assess leaders in up to five key areas — quality, expense management/revenue enhancement, employee management/development, service line growth and service, says Mr. Studer.

Quint Studer is a recognized leader and change agent in the healthcare industry and has more than 20 years of healthcare experience. Learn more about assessing and improving these three core areas in Mr. Studer’s new book, “Straight A Leadership: Alignment, Action & Accountability.”
University of California, San Diego Medical Center named Thomas Jackiewicz as its new CEO in Dec 2009. Mr. Jackiewicz will oversee the UCSD’s 440-bed hospital in Hillcrest, 108-bed hospital in La Jolla, Moores Cancer Center, Shiley Eye Center and the Sulpizio Family Cardiovascular Center, scheduled for completion in the spring of 2011.

Rickie Ressler, president of 274-bed Allina Hospitals & Clinics’ Unity Hospital in Fridley, Minn., announced that he will retire in early 2010.

Community Health Systems’ Brandywine Hospital in Coatesville, Pa., named Bryan Burklow as its new CEO in December. Mr. Burklow replaces Mark Benz who resigned to pursue other opportunities.

Mike Poore was appointed CEO of MedWest Health System in Clyde, N.C., effective Jan. 1. In his new position, Mr. Poore will oversee the newly formed health system, formed through an affiliation of Haywood Regional Medical Center, Harris Regional Hospital and Swain County Hospital. Mr. Poore currently serves as CEO of Haywood Regional.

President and CEO Don Beeler of CHRISTUS Santa Rosa Health Care in San Antonio, Texas, announced that he will retire on Jan. 29.

St. Mary’s Medical Center in Blue Springs, Mo., named Annette Small, RN, as its new CEO in December. Ms. Small served as interim CEO for the hospital after the departure of Robin Schluter in July.

Greg Pivirotto, president and CEO of University Medical Center in Tucson, Ariz., announced that he will retire on Jan. 31. Kevin Burns, CFO of UMC, will succeed Mr. Pivirotto as CEO and president.

Chandler (Ariz.) Regional Medical Center named Patty White as its new president and CEO. She began her new position with the hospital on Nov. 30, 2009.

Walter G. Beck was named the new CEO for Banner Churchill Community Hospital in Fallon, Nev. Mr. Beck began his new post on Dec. 7, 2009.

Sisters of Charity of Leavenworth (Kan.) Health System named Joe Jeans as CFO for Providence Medical Center in Kansas City, Kan., and Saint John Hospital in Leavenworth in November. Mr. Jeans succeeds Juanita Roy, who was promoted to the hospitals’ chief operating officer.

Rob Cooper, CEO of Marshalltown (Iowa) Medical & Surgical Center, announced his retirement, effective Jan 1. Mr. Cooper was the longest presently-serving hospital CEO in Iowa at the time of his retirement.

Tenet Healthcare Corp’s Creighton University Medical Center in Omaha, Neb., named Gary Honts as its new CEO. Mr. Honts had served as interim CEO for CUMC since May.

Anthony A. Armada, president and CEO of Henry Ford Hospital and Health Network in Detroit, announced his resignation in October to become president of Advocate Lutheran General Hospital in Park Ridge, Ill.
Hospital and Health System Transactions

The merger between Roger Williams Medical Center and St. Joseph Health Services of Rhode Island, both in Providence, R.I., has been approved by Attorney General Patrick Lynch, and the two groups will form CharterCARE Health Partners. Integrated operations are expected to begin in Jan. 2010.

Health Management Associates, based in Naples, Fla., has acquired the 492-bed Sparks Health System, located in Fort Smith, Ark.

Novant Health and Wake Forest University Baptist Medical Center have reached an agreement which may lead to both institutions completing community hospitals four miles apart in Clemmons and Advance, N.C. Novant and Wake Forest have been contending each other's hospital plans since Sept. 2007, and the agreement is seen as a step forward for both hospitals' projects.

The North Dakota Attorney General has approved merger plans between MeritCare, a health system based in Fargo, N.D., and Sanford Health, a health system based in Sioux Falls, S.D.

Tyler Memorial Hospital in Tunkhannock, Pa., is merging with Mercy Health Partners as of Jan. 1, 2010. Both facilities said operations would remain the same at first and both boards would focus on expanding staffing and facilities.

Olean (N.Y.) General Hospital and Bradford (Pa.) Regional Medical Center have merged to form Upper Allegheny Health System.

Potomac Hospital in Woodbridge, Va., is finalizing a merger with Sentara Healthcare. The two systems signed a letter of intent in June and are awaiting for final approval from the Virginia Attorney General.

Chicago-based Resurrection Health Care signed a non-binding letter of intent to sell Westlake Hospital in Melrose Park, Ill., West Suburban Medical Center in Oak Park, Ill., and Resurrection outpatient facilities in River Forest, Ill., to Nashville, Tenn.-based Vanguard Health System. The sale will be finalized once approval is received from Illinois state officials.

Memphis, Tenn.-based Baptist Memorial Health Care Corp. is planning to sell its Baptist Memorial Hospital-Lauderdale in Ripley, Tenn., to Kansas City, Mo-based HMC/CAH Consolidated. This marks HMC/CAH's tenth acquisition.

The Rothman Institute, a 62-physician orthopedics practice in Philadelphia, opened the Bucks County Specialty Hospital in Bensalem, Pa. The six-OR, 24-bed hospital is a partnership between the physicians a Leawood, Kan.-based Nueterra Healthcare.

Martin Luther King Jr. Hospital in Los Angeles will undergo a $350 million renovation and reopen in 2013 with 120 beds, down from 233 when it was shut down two years ago.

Cape Fear Valley Health System, based in Fayetteville, N.C., and FirstHealth of the Carolinas, based in Pinchurst, N.C., have received state approval to build new hospitals in and near Hoke County. FirstHealth, which is also waiting on approval to build an outpatient surgery center, plans to build a $30-$35 million, eight-bed facility in Raeford, N.C., while Cape Fear Valley plans to build a $79 million, 41-bed facility just outside Hoke County.

10 Hospital CEOs Age 40 or Younger

By Leigh Page

Chad Aduddell, Bone and Joint Hospital (Oklahoma City, Okla.). Mr. Aduddell, now 36, became president of 102-bed Bone and Joint Hospital in March 2007. His key goal is to develop an environment of patient-centered care, upholding clinical excellence. He has 12 years experience in healthcare, having served as senior practice administrator at St. Anthony Hospital in Oklahoma City, where he oversaw primary care clinics and graduate medical education programs. Mr. Aduddell received an MBA from Oklahoma City University.

Mark Baker, Hughston Healthcare (Columbus, Ga.). In October 2009, Mr. Baker, 40, was appointed CEO of Hughston Healthcare, which consists of Hughston Clinic, a 20-physician orthopedics practice with nine locations in Georgia and Alabama, and 62-bed Jack Hughston Memorial Hospital. He had been serving as interim CEO of the hospital since February and since 2004 had been COO of Hughston Clinic. Mr. Baker has been working to unify the culture at Hughston Clinic and Jack Hughston Memorial, which the clinic acquired in 2007.

Jeremy Biggs, St. Mary’s Medical Center North (Powell, Tenn.). Mr. Biggs, now 38, helped plan and develop 72-bed St. Mary’s Medical Center North, part of Knoxville-based Mercy Health Partners, and became its first chief administrative officer when it opened in July 2007. Mr. Biggs’ first healthcare job was working as a college student in a blood center in the early 1990s. He then earned a master's degree in health administration and joined Mercy. “I had a lot of folks say, ‘Look how young you are and look how fast you’ve gotten to where you are,’” he told Knoxville Biz in 2007. “I’ve been given opportunities at the right place at the right time and I’ve done my homework.”

Damond Boatwright, Lee’s Summit (Mo.) Medical Center. Mr. Boatwright, now 37, became CEO of the new Lee’s Summit Medical Center, an HCA hospital, in Jan. 2008. He previously served as an assistant administrator at Colleton Medical Center and CJW Medical Center and COO at Hentico Doctors Hospital. “Damond is a dynamic young leader,” HCA’s Midwest division president told the Lee’s Summit Journal. “He is
engaging and warmly accepted by his executive peers, physician leaders, his employees and the patients that he works tirelessly to satisfy.”

Barry Bondurant, Baptist Memorial Hospital-Tipton (Covington, Tenn.). Mr. Bondurant, 34, has been administrator and CEO of 100-bed Baptist Memorial Hospital-Tipton since 2008. He previously served as an assistant administrator at Baptist Union City (Tenn.) since 2005 and before that he was a hospital director of wellness and cardiovascular rehabilitation. Mr. Bondurant, whose nickname is “Skipper,” has a master’s degrees in business from Union University and exercise & sports medicine from the University of Memphis.

George Gaston, Memorial Hermann Southeast Hospital (Houston). George Gaston, now 38, became CEO of 274-bed Memorial Hermann Southeast Hospital in 2007. He joined 11-hospital Memorial Hermann as an administrative fellow in 1996, was named administrative director at Memorial Hermann Northwest Hospital in July 1998 and assistant vice president of hospital operations at Memorial Hermann Southwest in 2003. Mr. Gaston said his experiences at age 30 with a cyst, later found to be benign, helped him relate to patients, he told the Fort Bend Sun.

Talitha Glosemeyer, Norman (Okla.) Specialty Hospital. Ms. Glosemeyer, 38, is administrator and CEO of 50-bed Norman Specialty Hospital, which can meet a wide range of acute-care needs including internal medicine, pulmonology, wound care, nephrology, neurology, cardiology, podiatry and psychiatry. “I have the opportunity to touch the lives of individuals who are going through life-altering medical events that may change their lives as they know them forever,” she told OKC Business. Ms. Glosemeyer holds a master’s of health degree in health administration and policy from the University of Oklahoma.

Ben Koppelman, St. Joseph’s Area Health Services (Park Rapids, Minn.). Mr. Koppelman, 36, is president and CEO of St. Joseph’s Area Health Services, 50-bed community hospital owned by Catholic Health Initiatives. “It was a big jump, coming right out of college into my first administrative position,” Mr. Koppelman told the Pilot-Independent, recalling his start as administrator of a 17-bed, financially troubled hospital in Albany, Minn., in 1995. Within years, the hospital was making money. “For a young healthcare administrator, it was a unique opportunity to run both a hospital and a clinic,” he told the Pilot-Independent.

Michael Lutes, Carolinas Medical Center-Union (Monroe, N.C.). Michael Lutes, now 38, became CEO of 157-bed Carolinas Medical Center-Union in Feb. 2008. He has worked in healthcare for 13 years, including stints as CEO of Greenbrier Valley Medical Center in West Virginia and COO of Mary Black Memorial Hospital in Spartanburg, S.C., and Abilene Regional Medical Center in Abilene, Texas. His goals for Carolinas-Union have been to make the hospital as friendly a place as possible, expand services and deliver healthcare on a more local level.

Kevin L. Unger, Poudre Valley Hospital (Fort Collins, Colo.). In less than a decade, Kevin L. Unger, now 40, went from being a chauffeur to president and CEO of 241-bed Poudre Valley Hospital, according to an homage from his alma matter, University of Colorado Denver Business School, published in the school’s 4th Street Journal. He won the American College of Healthcare Executives Robert S. Hudgens Memorial Award for 2009 and his organization won the 2008 Malcolm Baldrige National Quality Award. During his tenure, the hospital has significantly raised patient and physician satisfaction and lowered medical error and infection rates.

Contact Leigh Page at leigh@beckersasc.com.

By Renee Tomcanin

Physician ownership and management of hospitals is not a new concept in the United States, although it has seen peaks and valleys in popularity over the years. Recent ratings from *Consumer Reports* put some physician-owned hospitals at the top of the nation's hospitals when it came to quality and patient satisfaction. However, members of Congress, particularly those involved intimately with healthcare reform, have rallied to try, once again, to limit or eliminate physician ownership.

Brett Gosney, CEO of Animas Surgical Hospital in Durango, Colo., and president of Physician Hospitals of America, discusses some of the political history of physician-owned hospitals in the United States, the proposed restrictions in healthcare reform and the potential impact these restrictions could have on healthcare in America.

**History of physician ownership**

Through the first half of the twentieth century, it was common for physicians to own and manage hospitals, stemming from the practice of physicians caring for patients in their own homes. In-home care soon moved toward larger institutions, and some of the most influential institutions today, such as Mayo Clinic and Cleveland Clinic, were originally founded and managed by physicians.

However, in the 1940s and 1950s, many physicians abdicated the control and ownership of the hospitals and large medical institutions. This, according to Mr. Gosney, was a miscalculation. "Success of a practice depends on the physicians' efficiency and control of quality in the hospital," he says. "By giving up this control, physicians were less able to regulate efficiency and ensure quality, and that could be considered a misstep."

From the 1940s through the 1980s, other hospital models began to emerge, according to Mr. Gosney, including large religious and secular non-profits and the corporate for-profit model. Then in the late 1980s, physician ownership started to re-emerge. Mr. Gosney says that this was due to two drivers: specialization and efficiency.

"The general hospital model was monolithic and could not meet needs on a provider level as more physicians moved into specialty and sub-specialty practices," Mr. Gosney says. "Hospital support systems were generally focused and could not meet the needs of these physicians.

"As far as efficiency, specialists found it difficult to be efficient inside the chaos of the general hospitals, so surgical specialists soon opened the way for physician-owned surgical specialty hospitals," he adds. "They followed a focused factory model of doing one thing and doing it well, with lower complications, better outcomes at a lower cost."

From the 1980s until the late 1990s, Mr. Gosney says surgical hospitals were well thought of and went fairly unnoticed, until larger systems, led by the major hospital lobbying groups, started to see surgical hospitals as competition and a threat.

**Efforts to limit physician ownership**

Mr. Gosney sees the battle between large hospitals represented by the AHA and FAH and physician-owned hospitals as a David and Goliath situation. He notes that efforts to limit the reach of smaller, "disruptive innovators," have not been limited to healthcare, as seen with Japanese car makers in the 1970s, in the computer industry in the 1980s and currently in satellite cable television.

"[Lobbying against disruptive innovators] usually happens when larger industries that do good work and mean well don't respond positively to changes or new models," Mr. Gosney says. "For them, the cheapest and easiest way to deal with small industry is to go to Congress and say, "These are the bad guys; shut them down."

In Mr. Gosney’s opinion, this is how the movement to limit physician ownership began. “It didn't come from patient complaints or an organic, grassroots opposition,” he says. “The hospital lobbies raised a lot of money and have succeeded in getting some sympathetic voices in Congress.”

According to Mr. Gosney, the two sides of the story presented to Congress regarding physician-owned hospitals are: 1) physician-owned hospitals require patients to have “gold bars” to receive treatment, don't address indigent care issues and cause harm to community hospitals; and 2) physician-owned hospitals were formed because general hospitals couldn't meet the needs of physicians and their patients, they perform quality, cost-effective care and they bring much needed competition to community hospitals.

Because of the money and lobbying efforts, the 200-plus physician-owned hospitals have struggled to address the legislative threats posed by industry groups representing the roughly 5,800 general hospitals in the country.

However, most of these efforts have failed to pass Congress, as eight government studies have been commissioned to look into accusations by the lobbying groups, and so far physician hospitals have, for the most part, been vindicated, according to Mr. Gosney.

**Effects of healthcare reform on physician ownership**

In the House healthcare reform bill that was passed in November and in the Senate bill still under debate as of this story, language exists that would severely limit physician ownership of hospitals, according to Mr. Gosney.

The restrictions would affect physician-owned hospitals in every stage of development.

1. **Hospitals already open and operating with Medicare certification.** Physician-owned hospitals that are currently open and have Medicare certification would be grandfathered in and allowed to continue to operate. However, Mr. Gosney calls this an illusory protection as growth would be severely limited. “Few hospitals will be allowed to grow, and most will not be allowed to add additional ORs, inpatient beds or procedure rooms,” he says. “In the foreseeable future, hospitals will effectively close because without growth, they will be unable to compete.”

Another restriction for physician-owned hospitals will be that physician ownership can never exceed the current aggregate percentage as of the date of enactment. Therefore, new physician owners can only be added when others leave the hospital, thereby limiting recruitment efforts.

2. **Hospitals under development.** Under the House bill, hospitals under development that did not receive Medicare certification prior to Jan. 1, 2009, would not be certifiable by CMS.
The Senate bill pushes this deadline back to the date of enactment, according to Mr. Gosney. This restriction applies to all hospitals under development, from those that are seeking initial zoning approvals to those that are a week away from opening.

“Technically, this restriction only pertains to federally-funded insurance programs, but it will have far-reaching implications,” Mr. Gosney says. “If you can’t get Medicare certification, third-party payors are likely not to get on board.”

Nearly 90 hospitals currently under development would be affected by the restriction, which translates into billions of dollars and tens of thousands of jobs lost, according to Mr. Gosney. “It will be a huge disaster if this gets passed,” he says. “The day of enactment is bad enough, but if restrictions are retroactive, it will be even worse.”

3. Future physician-owned hospitals. The bills in both houses of Congress completely disallow the establishment of future physician-owned hospitals, according to Mr. Gosney. Therefore, those hospitals that are effectively closed by the bills will not be replaced by new facilities.

Impact on healthcare
Advocates of physician-owned hospitals have long touted the facilities as an integral part of the solution when it comes to changing healthcare. “We need them,” Mr. Gosney says. “They provide great care, and make their competitors better. They provide great outcomes while re-engaging the physician into the hospital.”

In Mr. Gosney’s opinion, the restrictions are an unfortunate part of healthcare reform, and rather than provoking “real change and reform,” they support an ineffective system that isn’t consumer-oriented.

“Healthcare reform should move toward innovation, decentralization, efficiency and competition,” Mr. Gosney says. “With limitations on physician ownership, there will be a worse response of division, with the hospitals on one end and physicians on the other. The incentives are not aligned. Physician ownership aligns incentives, which is critical to high-quality healthcare.”

Mr. Gosney is the CEO of Animas Surgical Hospital in Durango, Colo., and president of Physician Hospitals of America. Learn more about Animas Surgical Hospital at www.animassurgical.com.
Amy Floria, CFO of Goshen Health System, Shares Goals for 2010

By Lindsey Dunn

Amy Floria, CFO of Goshen (Ind.) Health System, discusses the health system’s goals and challenges for 2010.

Q: What are the top overall goals for Goshen Health System in 2010?

A: In terms of overall goals, we are looking at three key service areas to expand in 2010 based on various forms of feedback from physicians, patients and community members. Goshen will offer highly-specialized wound care, which will be particularly beneficial to our diabetic patients. A new wound clinic will open in December 2009. We are also looking to expand our cardiovascular program by working with our cardiologists to continue to develop our cardiology services. Finally, we are looking at the community’s needs for obstetric and gynecological services.

Q: How will your system go about reaching these goals?

A: In order to expand those areas, we certainly will need to focus on physician recruitment. We also have immediate recruitment needs in our oncology program and in pediatrics. We’re also focusing on our market share. We are seeing where our patients are going for their care and seeing how we can meet those needs locally. This need for local services is directly linked to the service lines we are planning to expand.

Q: What will be the biggest financial challenge for your system in 2010?

A: The biggest issue is the dreadful economy in our community. Elkhart County has one of the highest unemployment rates in the country. In addition, the three counties in the state with the highest unemployment rates are in our service area. There are a lot of uninsured patients in our community because of the unemployment problem. The biggest challenge is protecting our profit margin while continuing to meet the needs of our community members when their ability to pay is lower. Regardless, Goshen is committed to overcome this daunting task.

Q: How will Goshen deal with the need to protect profit margins while continuing to provide care for a growing number of patients in need?

A: Our colleague population (editor’s note: Goshen refers to all employees as ‘colleagues’) never ceases to amaze me in their ability to accept our challenges and exceed our expectations. Because of delayed elective procedures due to the economy, lower volumes in 2009 are a huge challenge for Goshen. We asked our colleagues to implement ideas and streamline processes to save the organization $3.5 million, and as of September, they have already generated $3.9 million in annualized savings. We are dedicated to our colleagues and are concentrating on improving processes by working closely with physicians and other healthcare providers in the area to provide the exceptional care in the best way possible.

Q: If you could make one thing happen for Goshen in 2010, what would it be?

A: If our local economy continues to improve — the unemployment rate is now down from 19 percent earlier this year to 16 percent — it would have a large domino effect for Goshen. When a person’s inflow of money is tight, you put off medical care including elective procedures. If the economy bounces back, the citizens of our community could get the care they really need. The effect on our hospital would be quite large. It would also take some of the stress off our colleagues who have voluntarily agreed to certain deferrals to keep our health system viable during these challenging times.

Learn more about Goshen Health System at www.goshenhealth.com.

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