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Hospital Review
BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

January/February 2012 • Vol. 2012 No. 1

The Year Ahead: 12 Challenges and Opportunities for Hospitals in 2012
By Molly Gamble

It may be difficult to believe, but 2012 means hospitals are only in the second year of healthcare reform. Many call this time one of uncertainty, which is true, but it also presents great opportunity for innovation, change and growth. Some concepts of healthcare reform that once seemed novel

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10 Ways for Hospitals and Health Systems to Increase Profitability in 2012
By Bob Herman

To say hospital and health system operating margins are different today than they were a decade ago is an understatement. Medicare reimbursement reductions, cuts to state Medicaid programs and rising tides of uncompensated care have created an atmosphere where some hospitals, particularly smaller, community hospitals, are simply happy with a break-even balance sheet.

The environment is unlikely to change in the short term. The supercommittee was unable to reach a bipartisan agreement to cut $1.2 trillion over 10 years, and it will cause sequestration cuts of 2 percent to Medicare starting in 2013.

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40 of the Most Powerful People in Healthcare
By Rachel Fields
As some states challenge the Affordable Care Act in court, others are pushing implementation of regulations under the federal reform law. The healthcare industry in 2011 is a fragmented and fascinating place. Here are 40 people who have been instrumental in shaping healthcare policy, trends and debate over the last year.

Mark T. Bertolini. Mark Bertolini is chairman, CEO and president of Aetna, a health insurance company with more than $34 billion in 2010 revenue, a workforce of more than 34,000 and operations in North America, Asia, Europe and the Middle East. A member of the company’s board of directors, Mr. Bertolini assumed the role of CEO in Nov. 2010 and the role of chairman in April 2011. Mr. Bertolini recently described his company as “an evolving technology services company with a big insurance vehicle” in an interview with Healthcare IT News. Aetna has been investing in research and development in the last decade, and its recent $6 billion

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- Key Thoughts on Budgeting in Times of Uncertainty - John R. Zell, VP of Finance and CFO, OSF St. Joseph, Henry Brown, CFO, Westchester Hospital, Joseph Guarracino, Senior Vice President & CFO at The Brooklyn Hospital Center, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP
- Key Strategies to Align Independent and Employed Physicians - Paul Summerside, BayCare Clinic, Chris Karam, President & CEO, CHRISTUS St. Michael Health System, Allan Fine, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, moderated by Kristian A. Werling, Partner, McGuireWoods LLP
- Hospital Strategies for Surviving and Thriving in the Changing Healthcare Environment - Russ Richmond, MD, McKinsey Hospital Institute

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January/February Issue. We are pleased to share with you the January/February issue of *Becker’s Hospital Review*, our annual leadership issue, which contains our annual list of “40 of the Most Powerful People in Healthcare” in addition to interviews with key hospital industry leaders including Mass General’s Dr. Peter Slavin, LifePoint Hospitals’ Bill Carpenter and HMA’s Gary Newsome.

Beginning on page 18, 11 different healthcare system CEOs — from CHI’s Kevin Lofton to Stephen Reynolds, president and CEO of Baptist Memorial Health Care in Memphis — share top goals for their health systems during 2012.

This issue also includes an overview of the 12 “biggest” challenges and opportunities for hospitals and health systems in 2012 and a feature story on 10 ways hospitals can immediately improve their profitability.

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

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or troublesome are now beginning to mature, and the industry is becoming more sophisticated in its approach and implementation of the law.

The year ahead brings a presidential election, a change in leadership for CMS, value-based purchasing and other scheduled changes. Then, of course, there are the forces that ebb and flow, such as consolidation and market competition. All together, here are 12 for ‘12 — a dozen challenges, changes and opportunities facing hospitals this year.

1. Uncertainty surrounding healthcare reform. The 2012 election is one hurdle for President Obama’s Patient Protection and Affordable Care Act. One of the greatest differentiators between the Democrat and Republican parties is whether or not they support the repeal of healthcare reform law. Eyeing the chance that Pres. Obama may not see a second term, many GOP activists are already laying the groundwork to slash PPACA if a Republican makes it to the Oval Office.

Apart from the risk of full-on repeal, the public still saw PPACA wobble in 2011. In early October, the Obama administration scrapped the Community Living Assistance Services and Supports Act, a long-term care insurance program created by PPACA. The CLASS Act, which had been championed by the late Senator Edward M. Kennedy (D-Mass.), would have been financed with premiums paid by workers through voluntary payroll deductions, but it was deemed financially unsustainable.

The decision to repeal the CLASS Act may not directly affect hospitals, but it's symbolic of the uncertainty clouding healthcare reform. “This was the first indication from the government that it might have bitten off more than it can chew,” says Scott Becker, JD, CPA, partner with McGuireWoods in Chicago. “The administration axing a program shows things aren’t as definitive as they might seem.”

Twenty-six states have challenged the constitutionality of PPACA, particularly the individual insurance mandate. The Supreme Court will take up the question of the statute's constitutionality in 2012. If justices agree with the lower court and strike the mandate, the rest of the law may still be able to function and remain intact.

Still, officials from the Obama administration and insurance companies say removal of the mandate would severely tangle other provisions in the law. America’s Health Insurance Plans, representing nearly 1,300 member companies, wrote a Supreme Court brief in which it said “the difference between developing measures to implement a mandate-less [Affordable Care Act] (1) with market reforms intact and (2) without some or many of those market reforms is night and day.”

2. Preparing for value-based care and pay-for-performance mindsets. The concepts of value-based care and pay-for-performance are more than operational models. They’ve become philosophies in the industry, requiring deep-rooted change in the way providers think about healthcare.

Some experts have explained the change by comparing it to American taxes — if the traditional, income-based approach was suddenly swapped and Americans were instead taxed based on their personal character.

Hospitals are facing a similar scenario with Medicare and Medicaid payments as CMS rolls out its value-based purchasing program in Oct. 2012. Under VBP, hospitals will be evaluated on 17 process of care measures, claims-based measures, structural measures and patient experience measures as indicated by the Hospital Consumer Assessment of Healthcare Providers and Systems survey. It will provide hospitals with a direct fi-
nancial incentive to promote patient satisfaction — apart from the perennial motivation to beat out competition — and many organizations are exerting intense efforts to nudge survey scores to their highest.

While hospitals strive for happier patients, they’re also preparing to see less of them. Under healthcare reform, a hospital is evolving from a place people go when they’re sick to a place that helps people maintain wellness. Hospitals are continuing to reduce unnecessary readmissions, and a financial incentive for it will go into place this year. The Hospital Readmission Reduction Program, part of CMS’ Inpatient Prospective Payment System, is slated to begin in the 2013 fiscal year. Beginning Oct. 1, 2012, HRRP will lower payment rates for Medicare discharges if hospitals see a higher-than-average readmission rate for certain conditions, including heart failure, pneumonia and acute myocardial infarction.

Specific programs aside, the point of patient-centered medical homes, accountable care organizations and bundled payments is to streamline patient care and cut out unnecessary tests and readmissions. Many hospital providers have indicated that even if their hospital operations do not fall under one of these umbrella titles — PCMH or ACO, for instance — they will still need to transition toward that philosophy of care to survive.

3. Changes upon Dr. Donald Berwick’s departure from CMS. Dr. Berwick’s tenure as CMS administrator came to an end Dec. 2. Marilyn B. Tavenner, RN, is now the acting administrator and COO of CMS. She is a former Virginia Secretary of Health and Human Resources and spent more than 20 years with Hospital Corporation of America, serving as a hospital executive and president of the company’s outpatient group.

Ms. Tavenner’s combination of private sector and public policy experience may bring a different leadership style into CMS. Some media outlets and analysts have emphasized her experience in management rather than policy. The Washington Post, for instance, has even nicknamed her Medicare’s new “pragmatist-in-chief.”

Rather than focus on the leadership style coming into office, many healthcare and policy experts are still mourning what has left. Some in the medical community have called Dr. Berwick’s departure a loss for integrative medicine, as he started his career as a pediatrician and healthcare researcher at Harvard School of Public Health. He was also an outspoken supporter for the Patient Protection and Affordable Care Act, acting as one of its most durable cheerleaders by constantly reiterating the altruistic virtues behind the law.

4. Decreased cardiology procedures. Research has shown that heart failure-related hospitalization rates dropped nearly 30 percent from 1998-

2008. Some experts have attributed the reduction to improved preventive care and disease management. Today’s population is also more informed about health, such as the effects of tobacco.

While the decline is certainly a stride in clinical outcomes, hospitals’ bottom lines may take a hit from such a large shift in volume. This is particularly a concern for organizations that rely heavily on revenue from the cardiology service line.

“Hospitals can endure hits that are small profit issues and rebound without much of a problem,” says Mr. Becker. “It’s when you’re heavily reliant on a [specialty] that it becomes hard to adjust.” Academic medical centers, for instance, are likely to struggle less with this change in patient volume since they have extremely diverse revenues. Community hospitals, however, may have a more strenuous time adjusting.

5. More competition for particular physicians. Most independent hospitals rely heavily upon their top 25 admitting physicians. Hospitals seeking top-tier, productive talent may experience a more rigorous recruitment process than previous years. Approximately 75 percent of physicians are already in financial relationships with hospitals, according to a recent PricewaterhouseCoopers survey; and more than half indicated the desire to move financially closer. “More physicians will already be tied to a hospital or another organization,” says Mr. Becker. “There are only so many physicians who have proven to be productive.”

This trend exacerbates an already pressing issue facing not only hospitals but the entire health-care industry: physician shortages. By 2020, a shortage of 91,500 physicians is expected in the U.S. This is due to the culmination of a number of factors, including an aging physician workforce, increased demand for services due to more people having health insurance and physicians’ increased desire for work/life balance. Primary care physicians are in especially high demand, given the heightened role they play in accountable and preventive care.

Competing hospitals are no longer the only organizations acquiring physicians, though. Payors are beginning to buy practices and hospitals in an attempt to reign in costs. Experts say this strategy can be expected to emerge more prominently in the next couple of years as deals between payors and providers grow in size and frequency.

For instance, in September, UnitedHealth Group acquired 2,300 physicians through its purchase of Monarch Healthcare — the largest medical group in California’s Orange County. There’s also the deal in Pittsburgh: Insurer Highmark is acquiring cash-strapped West Penn Allegheny Health System and financially reviving it to better compete with University of Pittsburgh Medical Center.

Hospitals are also acquiring physician practices that traditionally held affiliations with multiple hospitals in the area. Nearly every day, there is another news story about a physician practice that picked one hospital out of numerous suitors located in the same city. Physicians who were once “team-players” to several hospitals are becoming employed by one, cutting off a large amount of referrals. This means hospitals are not only losing physicians from the recruitment pool, but may see patients referred into competitor’s hospital beds.

6. Questions over tax-exempt status. Non-profit hospitals have another issue on their radar: their tax-exempt status. Congress has started to question the IRS’ policing of non-profit organizations across sectors, including healthcare. Non-profit hospitals are required to fill out certain forms detailing their charity care, and complaints from the American Hospital Association and certain aspects of PPACA have prompted the IRS to delay requiring hospitals to fill out that portion of the form, according to a New York Times report.

Jane Haderlein, senior vice president of Huntington Memorial Hospital in Pasadena, Calif., has observed increased federal scrutiny over tax-exempt status firsthand. “It’s a rather significant process that we’re reporting that properly,” Ms. Haderlein said. “Unfortunately, I don’t think the federal government has concluded what they want from hospitals. They’ve added a section to IRS reports. There’s so much talk in Washington about what’s appropriate [charity care] and what isn’t appropriate. We’re in the crossfire right now.”

The trend is occurring at the state level as well. In August, the Illinois Department of Revenue moved to revoke the property tax exemptions for three major non-profit hospitals based on their levels of charity care. Those hospitals were Decatur (Ill.) Memorial Hospital, Edward Hospital in Naperville and Prentice Women’s Hospital at Northwestern Memorial in Chicago.

Illinois Gov. Pat Quinn temporarily halted the revocation until state legislature defined adequate levels of charity care. That piece of legislation would require non-profit hospitals to commit 3.5 percent of their annual revenue to charity care, but it has yet to pass.

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7. Heightened concerns over infection control. One of the major ways hospitals can trim spending is by flexing more control over infection rates. Assertive infection control can cut additional costs, such as unnecessary readmissions, and help hospitals avoid fines or penalties for quality problems.

With increased access to hospital infection rates data, the issue is just one more way patients will select which hospital they visit for care. Information on hospital-acquired conditions is now searchable on the HHS Hospital Compare website. Also, for the first time, Hospital Compare will begin reporting data on central line infections from the CDC’s National Healthcare Safety Network. CMS is still considering a hospital-acquired conditions measure for the Value-Based Purchasing Program, which goes into effect Oct. 2012 and will expand with measures added each year.

8. Regulatory challenges. Several prominent health systems were fined, sued or faced other legal action over regulatory issues in the past year. In July, the University of California at Los Angeles Health System agreed to pay $865,500 in a settlement with HHS Office for Civil Rights regarding potential HIPAA violations. In August, Geisinger Medical Center in Danville, Pa., agreed to pay the federal government $1.3 million to resolve allegations of improper Medicare billing. Brentwood, Tenn.-based LifePoint Hospitals also agreed to pay a settlement of approximately $1 million in August to resolve allegations of false Medicare billing at one of its hospitals.

Those are just a few of the reputable organizations that saw regulatory problems in 2011, showing these issues aren’t solely reserved for bad actors. “There will be a continued regulatory overhang into 2012,” says Mr. Becker. “There are only so many profits in hospital systems.” This is the year most hospitals will really experience the bottom-line repercussions of healthcare reform, and a regulatory fine or lawsuit will only exacerbate any decline in revenue.

Hospitals will continue to face recovery audit contractors, which continue to become more aggressive. In the entire fiscal year 2010, RACs recovered $75.4 million in overpayments. In the third quarter of fiscal year 2011 — just from March through June alone — RACs recovered $233.4 million in overpayments. Every quarter continues to bring higher RAC recoveries, and hospitals can expect continued assertiveness into 2012.

The Office of Civil Rights also piloted its HIPAA Audit Program in November. Under that initiative, OCR will perform up to 150 audits until Dec. 2012. Hospitals are required to conform to HIPAA 5010 standards by Jan. 1, 2012. These coinciding timelines may require hospitals to exert extra focus on compliance since the standards will still be relatively new at the time of the audits.

While some have compared hospital consolidation today to the “merger mania” of the 1990s, today’s M&A climate is really rather unexamined. “The range and magnitude of the forces confronting independent hospitals today are unprecedented and unlike those that we saw during the last major hospital consolidation wave of the 1990s,” says Jordan Shields, a vice president at Juniper Advisory in Chicago, an independent investment banking firm exclusively focused on hospital mergers and acquisitions.

“These include flat or declining volumes and reimbursement, increased quality requirements, increased clinical and operational IT spending, increased capital demands related to physician affiliations and employment, increased credit costs and increased demands on management,” says Mr. Shields.

Mr. Shields also says that traditional transaction models are gaining new traction as hospitals seek structures that suit their specific circumstances. “Steward’s success in expanding its network beyond its original Caritas Christi acquisition isn’t a ‘new’ model, but its success is absolutely notable. Duke/LifePoint didn’t create the whole-hospital joint venture model, but by emphasizing reputation and quality it has had remarkable success. I think the range of deals we’re seeing is a symptom of the variety and magnitude of challenges facing independent providers, each looking for a structure that addresses its priorities,” says Mr. Shields.

9. Fewer independent hospitals. For some, mergers and acquisitions are a strategy to expand a hospital’s marketplace, while smaller community hospitals may resort to transactions simply to survive. With these forces combined, fewer independent hospitals will make it through 2012 without striking some type of deal with a larger healthcare system.

Mr. Shields also says that traditional transaction models are gaining new traction as hospitals seek structures that suit their specific circumstances. “Steward’s success in expanding its network beyond its original Caritas Christi acquisition isn’t a ‘new’ model, but its success is absolutely notable. Duke/LifePoint didn’t create the whole-hospital joint venture model, but by emphasizing reputation and quality it has had remarkable success. I think the range of deals we’re seeing is a symptom of the variety and magnitude of challenges facing independent providers, each looking for a structure that addresses its priorities,” says Mr. Shields.

10. Questions over “appropriate” care. Policy experts, lawmakers and consumers continue to blame the healthcare industry for profuse spending in an unsteady economy. As a result, the price tag of services has come under extreme scrutiny. Physicians may find themselves caught in a double-bind between delivering high-quality care that is also cost-effective — a battle that may not be new but is certainly more exacerbated.

The ignorance over price has left many providers frustrated, as these figures are often concealed by private payors or may vary depending on the plan. David A. Rivera, MD, FACOG, an obstetrician from Rockford, Ill., recalls his personal experience with the opaqueness of healthcare prices. “I had a cardiac scan/stress test a few years ago and tried to find out how much it would cost. Someone in the cardiology department said, ‘I don’t know, but I think it is around $500.’ The actual bill was $4,000. A lot of it went for the radioactive tracer they use for the scan,” he says.

While he says it is possible for physicians to learn more about insurers’ pricing, it is still time-consuming and rigorous. “Given time, a physician can figure out what an insurance company pays for any given CPT or evaluation and management code. Add multiple insurers or multiple plans from one insurer, and it becomes a great time waster,” says Dr. Rivera.
An increasing number of hospital leaders and physicians are fighting this practice and trying to reverse the secrecy of health prices. For example, Beth Israel Deaconess Medical Center in Boston designed a 56-item price list to help physicians better understand links between price and value. While 56 items out of thousands may be a small start, trends such as this may indicate a movement to boost transparency — and one that will likely gain more traction and energy in 2012.

11. Relationships with other healthcare providers and community organizations. As “collaborative care” becomes less of a catchphrase and more of a reality, hospitals are refining strategies to build relationships with community organizations to form a continuum of care. Some hospitals are even moving beyond traditional relationships with providers to keep community members healthy. For instance, Huntington Memorial struck a partnership with its local library system — a strategy moving out of the traditional provider-provider relationship.

Ms. Haderlein says Huntington Memorial is trying to keep people well in the community by aligning them with primary care physicians. Since patients can sometimes perceive hospitals as threatening or feel extremely anxious about visiting physicians, Huntington Memorial formed a partnership with its local libraries and stationed nurses in these facilities throughout the week. “It helps patients to be in a neutral place. This also extends our educational efforts and helps patients build relationships with the nurses,” says Ms. Haderlein.

Aside from innovative relationships with community centers, more hospitals are strengthening their ties to post-acute care providers as health systems take on the risk for managing the health of entire populations. Major parts of post-acute care include rehabilitation facilities, nursing homes, long-term acute-care hospitals and home care. Ties with these facilities can help manage patients’ post-discharge care and avoid unnecessary readmissions, among other benefits.

12. ICD-10 adoption. ICD-10 gained national attention this year when roughly 140,000 of its highly-specific and peculiar diagnosis codes were revealed, including “bitten by an orca at oil rig” or “burn due to water-skis on fire.” Jokes aside, implementation of the new coding sets has proven to be rigorous. All healthcare providers are scheduled to operate under ICD-10 by Oct. 1, 2013, but progress has looked dismal throughout 2011.

Hospital executives have agreed that conversion to ICD-10 will have negative repercussions on hospital productivity at first. St. Louis-based SSM Health Care estimated that its health system would need approximately 110,000 hours of ICD-10 education just to make the transition properly. Other healthcare organizations have said hiring and staffing are the biggest barriers to the transition.

A survey released in Nov. 2011 showed less than 10 percent of healthcare providers were more than halfway ready for ICD-10, meaning most organizations were still in the strategy and planning phases of implementation. Judging by this statistic, some organizations may find themselves pressed for time in 2012 — an extremely stressful situation for healthcare leaders. Some have expressed actual terror over ICD-10. At a meeting of the Medical Group Management Association, one healthcare attorney said the 2013 deadline sends “shivers up peoples’ spines.”

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40 of the Most Powerful People in Healthcare

(continued from page 1)

Donald Berwick, MD. Don Berwick, former administrator of the Centers for Medicare & Medicaid Services, oversaw Medicare, Medicaid and Children’s Health Insurance Programs — three programs that collectively provide care to nearly one-third of Americans. Before assuming leadership of CMS, Dr. Berwick was president and CEO of the Institute for Healthcare Improvement, a non-profit organization that aims to reduce readmissions, infections and other patient safety issues around the world. Dr. Berwick strongly believes in the need to redistribute healthcare resources from the rich to the poor and has been criticized for his favorable statements about the British healthcare system. Dr. Berwick has been quoted as saying that “sick people tend to be poorer and … poor people tend to be sicker and … any healthcare funding program that is just, equitable, civilized and humane must, must redistribute wealth from the richer among us to the poorer and less fortunate.” Dr. Berwick celebrated his 65th birthday in Sept. 2011, making him eligible for the Medicare program he oversees.

John Bluford III. John Bluford was named chair-elect of the board of trustees of the American Hospital Association in July 2010 and assumed the chairmanship in 2011. As chair of the board of the AHA, Mr. Bluford is the top elected official of the national organization that represents the country’s hospitals and health systems. Mr. Bluford has served as CEO and executive director of Truman Medical Centers, a non-profit hospital system comprised of two hospitals, a health department and a behavioral health network, since 1999. He has said that a “special area of focus” during his chairmanship for the AHA will be to create a culture of wellness among healthcare employees that will hopefully extend into the communities they serve.

Richard M. Bracken. Richard Bracken, chairman and CEO of Hospital Corporation of America, began his career with the company in 1981 and has since held various executive positions within HCA. He was appointed vice president of HCA’s Pacific Division in 1997, COO in July 2001 and president and COO in Jan. 2002. He was then elected to the HCA Board of Directors in Nov. 2002 and became CEO in Jan. 2009. HCA recently announced the company will pay Bank of America $1.5 billion to buy back more than one-sixth of the hospital operator’s outstanding shares, which have reportedly been battered by a slowdown at operating rooms and worries about Medicare cuts. Mr. Bracken said he views the repurchasing of the common stock as an accretive investment in the company and an opportunity to enhance stockholder value.

Angela F. Braly. Angela Braly is the chair of the board of directors, president and CEO of WellPoint, the nation’s largest health benefits company in terms of membership, with approximately 34 million Americans covered through its affiliated health plans. In 2010, WellPoint generated operating revenue in excess of $57.8 billion and employed around 37,500 associates. Ms. Braly was named president and CEO in June 2007 and assumed the role of chair of the board in March 2010. Under her leadership, the company’s commitment to its mission has been strengthened by diversifying its business portfolio to offer more comprehensive health solutions. Ms. Braly has led the company in the diversification of WellPoint’s prescription benefits management business to Express Scripts, increased transparency through the Anthem Care Comparison tool to provide cost information to consumers and the measurement of progress in improving quality of care through a proprietary Member Health Index.

William F. Carpenter. William Carpenter serves as the chairman of the board, president and CEO for LifePoint Hospitals, headquartered in Brentwood, Tenn. He has served as CEO since June 2006, prior to which he served as executive vice president and chief development officer. Having led the company’s acquisition activities as chief development officer, Mr. Carpenter understands the importance of ensuring a smooth transition between acquiring and owning a hospital. Under Mr. Carpenter’s leadership, the company started a transitional services division that is present at the creation of a deal to work side-by-side with the development team from the moment a deal is struck. LifePoint formed a joint venture with Duke University Health System in Jan. 2011, creating an entity designed to improve healthcare delivery by creating flexible affiliation options for community hospitals. Duke/LifePoint is one of the first joint ventures between an academic health system and a hospital operations company.

Carolyn M. Clancy, MD. Carolyn Clancy was appointed Director of the Agency for Healthcare Research and Quality in Feb. 2003, just after the entity was established, and was reappointed in Oct. 2009. As director of AHRQ, her primary focus has been on reducing medical mistakes, improving consistency of healthcare across disciplines and calculating the financial toll of healthcare decisions. AHRQ has recently funded several successful research projects that promote patient safety, including an initiative to reduce hospital-acquired infections in Michigan. Ms. Clancy told The Hill in Sept. 2011 that researchers saw “dramatic” results by using a basic checklist combined with a different approach from hospital leadership and a system that asked employees to “check and balance” one another. AHRQ is now working with other stakeholders to expand the experiment to other conditions and regions.

Richard L. Clarke, DHA, FHfMA. Richard Clarke, president and CEO of the Healthcare Financial Management Association, has led his organization to significant growth in membership, scope and influence since assuming the post in 1986. He announced his retirement, effective July 31, 2012, early this year. During Mr. Clarke’s tenure, HFMA has grown 40 percent and operating revenue has
grown 408 percent. Mr. Clarke has long supported the viewpoint that the U.S. healthcare system is economically unsustainable, and this conviction led HFMA to launch an examination into the principles and components of a new healthcare system. This examination has taken shape in public and private demonstration projects, as well as in the 2010 healthcare reform law. Mr. Clarke spearheaded HFMA’s Value Project, which gathered the support of 17 leading hospitals and health systems to identify how hospitals can “bend the cost curve” while improving quality. The first Value Project report was released in June 2011.

David Cordani. David Cordani, CEO of Cigna, recently led the Bloomfield, Pa.-based company in rebranding itself for the first time in a generation. The company recently adjusted its brand to market to individuals as well as employers, spending $25 million on a rebranding effort that includes television and print advertising, a new social media presence and a softer, less corporate logo. The company has also dropped the all-capital CIGNA spelling of its name. Mr. Cordani said personalization is important to contemporary consumers, and Cigna wanted to connect better with its customers. Mr. Cordani became president and CEO of the company in Dec. 2009, after serving as president and COO since June 2008. He has held numerous other executive Cigna positions and, prior to Cigna, worked with Coopers & Lybrand in Washington, D.C.

Delos “Toby” Cosgrove, MD. As president and CEO of Cleveland Clinic, Dr. Delos “Toby” Cosgrove presides over a $5 billion healthcare system that includes the Cleveland Clinic, nine community hospitals, 15 family health and ambulatory surgery centers and locations in Florida, Toronto and Abu Dhabi. His leadership at Cleveland Clinic has emphasized patient care and patient experience, including the re-organization of clinical services into patient-centered, organ- and disease-based institutes. Dr. Cosgrove and his health system have made headlines in recent months after he criticized proposed rules for accountable care organizations, saying they create “significant barriers” that would discourage hospitals from adopting the new model. Cleveland Clinic is one of several prominent national health systems that has declined participation in the “pioneer” ACO program, a blow to the Obama administration considering that the program was designed for systems exactly like Cleveland Clinic.

Nancy-Ann DeParle. Nancy-Ann DeParle is the deputy chief of staff for policy in the administration of President Obama, a position she came to after serving as the director of the White House Office of Health Reform. Ms. DeParle was named as one of the new White House chief of staff’s deputies during a major shakeup in White House staffing in early 2011.

Ms. DeParle came to the Obama administration with first-hand knowledge of the push for health reform, having served as the director of the Health Care Financing Administration from 1997-2000. She is an expert on Medicare and Medicaid and has helped the Obama administration expand those programs in the push for universal coverage.

Thomas C. Dolan, PhD, FACHE, CAE. Thomas Dolan is president and CEO of the American College of Healthcare Executives, an international professional society of more than 35,000 healthcare executives. The organization has comprehensive programs in credentialing, education, career counseling, publications and research and serves as one of the healthcare industry’s top professional associations, influencing executive opinion on matters such as acquisitions and mergers, quality and patient safety, CEO performance expectations and board certification. As of Jan. 2011, the organization had 24,184 members. Prior to his appointment as president and CEO of ACHE, Dr. Dolan served as the organization’s executive vice president. Before joining the College, he held a variety of teaching, research and administrative positions at St. Louis University, the University of Missouri-Columbia, the University of Washington and the University of Iowa.

Trevor Fetter. Trevor Fetter is president and CEO of Tenet Healthcare, a position he assumed in Sept. 2003. He originally joined Tenet in 1995, serving as executive vice president, CFO and a member of the office of the president. Tenet made headlines in 2011 over its relationship with Community Health Systems, first for suing the hospital operator for wrongfully billing insurers and second for rebuking CHS’ offer to buy Tenet for $7.25 a share. Mr. Fetter said at the time that Tenet’s business strategy would “deliver greater value than Community Health’s inadequate proposal,” an interesting position considering the pressure on hospital systems to be acquired by larger competitors. In April 2011, Tenet sued CHS for billing insurers for unnecessary patient stays, alleging the hospital operator made between $280 million and $377 million through improperly admitting Medicare patients between 2006 and 2007.

Teri G. Fontenot, FACHE. Teri Fontenot is the president and CEO of Woman’s Hospital, a 356-bed Level III regional referral hospital that serves as the largest birthing and neonatal intensive care facility in Louisiana. The hospital is also the largest freestanding, non-profit women’s hospital in the country. Ms. Fontenot has led the hospital in the development of a $400 million replacement campus, which will open in summer 2012 with increased capacity.
for current services and new growth opportunities. In addition to her work as head of Woman's Hospital, Ms. Fontenot will serve as chairman of the American Hospital Association starting in 2012, becoming the top elected official of the organization that represents America's hospitals and health systems. Ms. Fontenot serves on the American Hospital Association Long Range Policy Committee and chairs the AHA Health Forum board. She also chairs the CEO Committee of the American College of Healthcare Executives and has served as a member of the Advisory Committee on Research on Women's Health for the National Institutes of Health and chair of the board of the Louisiana Hospital Association.

George C. Halvorson. George Halvorson is chairman and CEO of Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, headquartered in Oakland, Calif. Kaiser Permanente is the nation's largest non-profit health plan and hospital system, serving approximately 8.8 million members and generating $42 billion in annual revenue. Mr. Halvorson serves on committees and boards of several industry-leading associations, including the board of America's Health Insurance Plans, the American Hospital Association's advisory committee on healthcare reform and the Institute of Medicine roundtable on value and science-driven healthcare. Kaiser has made $5.7 billion since 2009, and Mr. Halvorson was paid $8 million in total compensation in 2009 alone — a fact that has recently brought the health system under fire as 21,000 employees held a strike against the hospital chain for higher wages. Kaiser officials responded by saying they were “disappointed” by the strike by National Union of Healthcare Workers at such an early stage in contract negotiations.

Stephen J. Hemsley. Stephen Hemsley has been CEO of Minneapolis-based UnitedHealth Group, the parent company of UnitedHealthcare, since 2006. Before joining UnitedHealth Group, he worked for Arthur Andersen as a managing partner and chief financial officer. UnitedHealth Group is the nation's largest insurance company based on revenue, pulling in $87.4 billion in revenues in 2010 and benefitting around 70 million Americans. In Sept. 2011, UnitedHealthcare of Florida signed a contract with the state of Florida, agreeing to provide HMO services in 18 counties. The announcement came after the 1st District Court of Appeal rejected parts of a legal challenge filed by United and declined to issue a stay. The other 49 Florida counties were divided among five HMOs that reached agreements with the state separately.

Charles “Chip” Kahn III. Chip Kahn served as the driving force behind the ad campaign that dismantled Bill Clinton's 1993 healthcare reform plan and he has played a significant role in the debate over President Obama's reform efforts as well. The head of the Federation of American Hospitals, Mr. Kahn acts as an influential lobbyist within the healthcare industry and formerly served on the Senate Health, Education and Labor Committee to hash out healthcare reform before drafting legislation. The Federation of American Hospitals has pushed for universal coverage, including the mandate that individuals carry health insurance. In early Sept. 2011, the FAH issued a news release that commended President Obama for focusing on job growth but expressed concerns about the impact of future federal policies on America's hospitals. Mr. Kahn said in the release that the 2 percent Medicare cuts embedded in the Budget Control Act would lead by nearly 50,000 hospital job losses and $30 billion in lost wages by 2021. He said deeper Medicare and Medicaid cuts would dramatically escalate these losses.

Sister Carol Keehan, DC. Sister Carol Keehan is the ninth president and CEO of the Catholic Health Association of the United States, having assumed her duties in Oct. 2005. She is responsible for all association operations and leads CHA's staff offices at Washington, D.C., and St. Louis. She has worked in administrative and governance positions in healthcare for more than 35 years, most recently as board chair of Ascension Health's Sacred Heart Health System in Pensacola, Fla., and prior to that as president and CEO of Providence Hospital in Washington, D.C. Sister Keehan publicly supported the Affordable Care Act but has criticized Secretary Kathleen Sebelius’ narrow religious exemptions for the provision of contraception. On Aug. 1, 2011, HHS announced that only certain religious institutions could opt out of providing contraception, a move that Sister Keehan said would not “protect our Catholic health providers.”

Jeremy Lazarus, MD. Dr. Jeremy Lazarus, a board-certified psychiatrist in private practice in Denver, was elected president-elect of the American Medical Association in June 2011. Prior to his election, Dr. Lazarus served as speaker of the AMA House of Delegates from 2007-2011 and vice speaker from 2003-2007. He is also a past president of the Colorado Medical Society. He has chaired several AMA task forces on a wide variety of topics, including health system reform. Representing the AMA on the Health Coverage Coalition for the Uninsured, Dr. Lazarus has been one of the organization's chief spokespersons on issues involving the uninsured. He is only the second psychiatrist to be president of the AMA.

H. Stephen Lieber, CAE. Since 2000, Stephen Lieber has served as the president and CEO of the Healthcare Information and Management Systems Society, the largest U.S. cause-based, non-profit healthcare association focused on the optimal use of IT in healthcare. He serves not only on the board of directors of HIMSS and its related corporations, but also on the board of the Certification Commission for HIT and the Health Information Technology Standards Panel, which he co-founded. In his role as leader of HIMSS, Mr. Lieber has established the Society as a global leader on technology standards, IT adoption, IT certification, electronic health records and interoperability. In a Feb. 2011 interview with Mobi Health News, Mr. Lieber said healthcare is on the cusp of a “mobile era,” and the presence of mobile content at the HIMSS conference demonstrated that transition.

Steven H. Lipstein. As president and CEO of BJC Healthcare in St. Louis, Steven Lipstein oversees one of the nation’s largest healthcare organizations, with annual net revenues of $3.5 billion and more than 26,000 employees. During his tenure with BJC, Mr. Lipstein has positioned the healthcare system for the future through the creation of the Center for Advanced Medicine and Alvin J. Siteman Cancer Center. The Center for Advanced Medicine, a cooperative effort between Barnes-Jewish Hospital and Washington University School of Medicine, houses a wide range of outpatient services and consolidates more than 30 locations where services were offered previously. Mr. Lipstein is also one of 21 board members to lead the Patient-Centered Outcomes Research Institute, a federal non-profit organization established by the healthcare reform law in 2010. PCORI conducts comparative effectiveness research to provide quality, evidence-based findings on how diseases and health conditions can be effectively prevented, diagnosed, treated and managed appropriately.

Kevin E. Lofton. Kevin Lofton is the president and CEO of Denver-based Catholic Health Initiatives, the third-largest Catholic healthcare system in the nation with $9 billion in annual revenue and 73 hospitals. According to Mr. Lofton, CHI is developing accountable care organization pilots in four markets and will invest $1.5 billion in EHRs and other IT systems from 2010-2015 to enhance quality of care. The hospital system is in the midst of a potential merger that would put Jewish Hospital & St. Mary’s Healthcare and University Hospital in Louisville under the control of Catholic Health Initiatives by merging the hospitals with St. Joseph Health System of Lexington. The merger has met with controversy because the hospitals have agreed to follow Catholic healthcare directives, including not providing sterilization and birth control. The company also recently acquired therapy services from Applied Medical, a large independent physical and occupational practice in North Dakota.

Farzad Mostashari, MD, ScM. Farzad Mostashari serves as National Coordinator for Health Information Technology within the Office of the National Coordinator for Health Information Technology at HHS. Dr. Mostashari joined ONC in July 2009 and was appointed National Coordinator on April 8, 2011, succeeding David Blumenthal, MD. Dr. Mostashari recently said he supports a delay of stage 2 of meaningful
use, per the suggestions of the Health IT Policy Committee. He said delaying stage 2 of meaningful use to 2014 may encourage providers to attest to meaningful use this year, but those who have already attested should still be rewarded. The Office of the National Coordinator plans to release proposed rules for meaningful use of EHRs by the end of 2011 or early 2012 and will complete the rules in the summer of 2012.

Gary D. Newsome. Gary Newsome became president and CEO of Health Management Associates, a hospital operator based in Naples, Fla., in Sept. 2008. From early 1998 until Sept. 2008, Mr. Newsome was employed by Community Health Systems, which he joined as a group vice president and left as division president. Health Management Associates is a for-profit company that mainly operates hospitals and other healthcare facilities in the southern United States. Despite inclusion of several HMA hospitals on a recent Joint Commission list of the 405 “best” hospitals in the country, shares of the hospital operator fell 34 percent between late July and mid-September. Analysts believe stock prices may have fallen over concerns about the weak economy and possibly cuts to Medicare payments, which could come as a result of a deficit-reduction plan.

John H. Noseworthy, MD. Dr. Noseworthy, a neurologist, became president and CEO of Mayo Clinic in Nov. 2009. Dr. Noseworthy joined Mayo in 1990 and has served in various leadership positions, among them chairman of Mayo’s Department of Neurology and vice chairman of its Rochester executive board. He also served as editor-in-chief of Neurology, the official journal of the American Academy of Neurology. Among other projects, the Mayo Clinic has recently made progress toward the launch of a Center for the Science of Health Care Delivery, which will identify the most efficient best practices in the diagnosis, treatment and care of patients by analyzing data and conducting research into new care delivery systems. Mayo Clinic believes this kind of research is essential as state and federal policymakers continue to struggle with the nuances of healthcare reform. Dr. Noseworthy also recently announced Mayo Clinic’s involvement in an initiative to create global smoke-free workplaces.

Pres. Barack Obama. President Obama is the 44th and current President of the United States and the first African American to hold the office. President Obama graduated from Columbia University and Harvard Law School and worked as a civil rights attorney and constitutional law professor for the University of Chicago Law School before serving as a United States Senator from Illinois from 2005-2008. President Obama’s 2010 passage of healthcare reform continues to make waves in the healthcare community, with some lawmakers pushing implementation of regulations such as health insurance exchanges, and others fighting the Affordable Care Act in court. According to surveys released by Gallup and the National Center for Health Statistics in Sept. 2011, President Obama’s healthcare overhaul has proven effective in reducing the number of young adults without health insurance. One survey estimated that the number of uninsured people ages 19-25 dropped from 10 million in 2010 to 9.1 million in the first three months of 2011.

Thomas M. Priselac. Thomas Priselac serves as president and CEO of Cedars-Sinai Health System in Los Angeles, a position he has held since Jan. 1994. Mr. Priselac has been associated with Cedars-Sinai since 1979, and prior to being named president and CEO, was executive vice president from 1988-1993. The Cedars-Sinai Health system is one of the nation’s leading providers of healthcare services, providing physician services through the Cedars-Sinai Medical Care Foundation, a full-time academic faculty and an active private attending staff. With annual
quires nearly all Massachusetts residents to pur-
chase health insurance coverage and has been her-
alized as the predecessor to federal healthcare
reform. The bill also established means-tested
state subsidies for those who do not have ade-
quate employer insurance and make below an
income threshold. Mr. Romney’s involvement in
the landmark Massachusetts legislation, which
he agreed to after months of negotiations with a
Democratic legislature, has been seen by Repub-
licans as a “black mark” on his record, one that
could make him unpopular with conservative
voters who oppose the federal healthcare reform
law. Like every other Republican candidate, Mr.
Romney has said he would seek to repeal the Af-
fordable Care Act and has said he would issue an
executive order on the first day of his presidency
that would grant every state a waiver from its
enforcement of “Obamacare.”

Paul Ryan. Paul Ryan is the U.S. Represen-
tative for Wisconsin’s first congressional dis-
trict, a position he has held since 1999. He is
a member of the Republican Party and serves as
the chairman of the House Budget Com-
mittee, where he has significant impact on the
Republican Party’s long-term budget proposal.
In April 2011, he introduced a plan titled The
Path to Prosperity as a counter to President
Barack Obama’s budget proposal. The House
passed this plan by a vote of 235-193, but the
bill died in the Senate later in the month.
Among its key features, the plan would have
reformed Medicare and Medicaid by ending
the current Medicare program starting in 2022
and converting Medicaid payments to block
grants starting in 2013. The current Medicare
plan would be replaced with a new program —
still called Medicare — involving voucher-
like “premium support payments” and in-
creasing the age of eligibility. The plan would
also make several changes to the healthcare re-
form law, repealing the requirement that most
residents obtain health insurance and repeal-
ting tax credits for small employers that offer
health insurance.

Kathleen Sebelius. Kathleen Sebelius was
sworn in as the 21st secretary of the Depart-
ment of Health and Human Services in April
2009. Since then, she has led efforts to imple-
ment reforms through the Patient Protection
and Affordable Care Act, including policies that
focus on wellness and prevention, adoption of
electronic medical records, recruitment of more
primary health providers and expansion of in-
surance coverage. In Sept. 2011, Secretary Sebe-
lius reported that the Affordable Care Act has
succeeded in expanding healthcare coverage to
hundreds of thousands of young adults. One
survey, conducted by the CDC’s National Center
of Health Statistics, found that the number of
uninsured Americans ages 19-25 dropped from
10 million in 2010 to 9.1 million in the first three
months of 2011. Upon the announcement, Sec-
retary Sebelius also criticized politicians who
support the repeal of the Affordable Care Act.
“It’s very disappointing to hear some people in
Congress talk about repealing the law and taking
away this security,” she said in a statement.

Peter Shumlin (D-Vermont). Peter Shumlin
is the 81st and current governor of Vermont,
elected during the 2010 election. On May 26,
2011, Gov. Shumlin signed a bill that put Ver-
mont on a path to become the first state in the
country to adopt a single-payer health system.
The federal healthcare reform law would not al-
low Vermont to enact a single-payer system until
2017, but the state is asking the administration
to grant a waiver so that it can establish a system by
2014. Gov. Shumlin has previously criticized the
current health insurance system, saying his expe-
rience as the owner of a successful travel busi-
ness lets him “know firsthand that the biggest
obstacle to job growth is the 10, 20, 30 percent
increases in insurance premiums.” Prior to being
elected governor, Gov. Shumlin represented the
held a Vermont Senate seat for eight terms, from

Wayne Smith. Mr. Smith has been president
and CEO of Community Health Systems since
1997 and has helped the company grow from
$742 million to more than $12.1 billion in net revenue. He graduated from Trinity University
in San Antonio, Texas, with a master’s degree in
hospital administration. Mr. Smith spent 23 years
working for Humana, where he progressed from
hospital administration to president and COO.
While at Humana, he was tasked with turning
around a financial crisis brought about by a flaw
in the company’s Humana Health Plans, which
he successfully accomplished in two years. In
1997, Mr. Smith became president and CEO of
CHS, where he focused his attention on pur-
chasing non-urban, non-profit hospitals. CHS
merged with Triad Hospitals in 2007 and is
currently the second largest acute-care hospital
chain in the United States.

Glenn D. Steele Jr., MD, PhD. Glenn Steele
is president and CEO of Danville, Pa.-based Gei-
singer Health System, a role he accepted in 2001
after leaving the Department of Surgery at the
University of Chicago. Dr. Steele is widely recog-
nized for his investigations into the treatment of
primary and metastatic cancer and colorectal sur-
vrey and serves on the editorial boards of numer-
ous medical journals. Geisinger Health System
recently signed a definitive agreement to join with
Bloomsburg Health System, two months after the
system received final regulatory approval to merge
with Shamokin Area Community Hospital. The
system is also planning a takeover of Community
Medical Center in Scranton, Pa., demonstrating
a nationwide trend of increased mergers and ac-
quisions among large health systems. Geisinger
has been praised as a model of low-cost, quality
healthcare by President Obama, who in June 2009
encouraged providers nationwide to look to the
system and learn from its success.
Anthony Tersigni, EdD, FACHE. Anthony Tersigni was appointed president and CEO of St. Louis-based Ascension Health in June 2004, prior to which he served as executive vice president and COO from Jan. 2001-Dec. 2003. He has also held leadership positions at other health systems, including St. John Health in Detroit, Sisters of St. Joseph Health System in Ann Arbor, Mich., and Sisters of Charity Health Care systems in Cincinnati. Mr. Tersigni is also the immediate past chair of the Catholic Health Association of the United States. As president and CEO of Ascension, Mr. Tersigni heads the largest Catholic healthcare system in the nation — even more so after the acquisition of Alexian Brothers Health System in suburban Chicago. ABHS and Ascension announced the signing of a letter of intent in April and said the goal was to complete a definitive agreement and receive necessary state and federal agency approvals by the end of 2011.

Richard Umbdenstock, FACHE. Richard Umbdenstock became president and CEO of the American Hospital Association in Jan. 2007, following a term as the elected AHA board chair in 2006. His career includes experience in hospital administration, health system leadership, association governance and management and HMO governance. Mr. Umbdenstock recently criticized President Obama’s recommended Medicare and Medicaid cuts, which could reduce beneficiaries’ access to care and eliminate around 200,000 jobs over the next 10 years. He said the president’s plan to reduce federal healthcare spending by $320 billion over the next decade “would mean decreased access to care for our nation’s seniors and could overload emergency rooms, shut down trauma units and reduce patient access to the latest treatments,” according to an AHA statement. Mr. Umbdenstock has also argued in favor of payment extensions for physicians; he testified before a Congressional panel about section 508 wage reclassifications; outpatient hold-harmless payments for rural and sole community hospitals; and reasonable cost-based payment for outpatient clinical lab tests in smaller rural hospitals.

Chris Van Gorder. As president and CEO of San Diego-based Scripps Health since 2000, Chris Van Gorder has led the non-profit health system through a series of financial and culture changes, positioning the system as one of the nation’s leading health providers. When Mr. Van Gorder was appointed CEO in 1999, Scripps Health was losing $15 million a year, and the management had recently received a “no-confidence” vote from its medical staff. Mr. Van Gorder responded to the crisis by implementing a physician leadership cabinet, building strategic alliances and pushing a more transparent management style. Through a joint venture with North American Medical Management California, Scripps Health recently formed an integrated delivery network with seven physician groups in San Diego County that is organized to respond to alternative care management agreements. Mr. Van Gorder also serves as chairman of the American College of Healthcare Executives, a professional society of more than 30,000 healthcare executives.

Robert M. Wah, MD. Robert Wah, MD, a reproductive endocrinologist and obstetrician/gynecologist, began serving as chair of the American Medical Association Board in June 2011. He practices and teaches at the National Naval Medical Center in Bethesda, Md., Walter Reed Army Medical Center and the National Institutes of Health. A nationally recognized expert in health information technology, Dr. Wah is chief medical officer for Computer Sciences Corporation and works with public agencies using technology to deliver better information for better decision-making. When he assumed his board position in June, Dr. Wah wrote in American Medical News that the AMA is working hard to champion medical ethics, oversee medical education, set standards and improve quality for physicians and medical practice. “One of the central questions to be addressed is: What will the medical profession of the future be?” he wrote. “As we answer this question, we will develop the tools, technology and services that physicians will need in the future.”

William C. Weldon. William Weldon is the chairman and CEO of Johnson & Johnson, the sixth chairman in the company’s over 100-year history. Mr. Weldon has spent his entire working life at [J&J], joining as a sales representative in 1971. As CEO, Mr. Weldon has engineered some of the company’s largest acquisitions, including the purchases of Alza and Pfizer’s consumer health product line. Mr. Weldon has instigated significant financial successes during his tenure at Johnson & Johnson, including an 80 percent revenue growth since he took over the company in 2002. Under his leadership, Johnson & Johnson has popularized the concept of a “decentralized” corporate environment, meaning responsibility is given to relatively autonomous leaders in local markets. In a 2008 interview with the Wharton School of the University of Pennsylvania, Mr. Weldon said, “…the problem with centralization is if one person makes one mistake, it can cripple the whole organization. This way, you’ve got wonderful people running businesses.”
11 Leading Health System CEOs Share Top Goals for 2012

The coming year promises to be both exciting and challenging for hospital and health system leaders. With CMS’ release of the final rule for accountable care organizations, many healthcare organizations are looking to align more closely with physicians and other providers to create an integrated delivery of care model. Declining reimbursements have forced leaders to find new ways of saving costs and gaining efficiencies. In addition, federal funding for pilot projects and other initiatives are giving healthcare leaders opportunities to improve quality and safety of care for patients. Here, 11 of the country’s leading hospital and health system CEOs share their top goals for the new year.

Barry Arbuckle, PhD, President and CEO, MemorialCare Health System, Fountain Valley, Calif. “In 2011, MemorialCare Health System expanded our family of providers to deliver more comprehensive healthcare. In 2012, we expect to further our reach into Los Angeles and Orange counties even more. While the heat is on with a challenging economic climate, declining reimbursements and a move by payors to value-based purchasing, we are growing our capacity to provide more integrated healthcare in our communities. We are strengthening our offerings in ambulatory care, increasing the number of our acute-care hospitals and broadening our outpatient programs and facilities.

With the goal of delivering the best value in healthcare on a consistent basis at all sites, we are focused on improving quality and lowering costs. Steadfast fiscal discipline and the constant pursuit of bold goals in clinical and service excellence are essential to our efforts to cultivate new dimensions in healthcare. So, too, is our commitment to stay ahead of the curve, implementing new approaches to ensure patient satisfaction, physician partnership and employee engagement.

“It took courage to get where we are today, and it takes commitment to stay the course and lead the way. Our work to tackle current challenges while creating a dynamic integrated system helps ensure the strength and stability of our healthcare family. Our successes in remaining financially fit, providing superior patient care and service and engaging in initiatives that preserve the health and well-being of our employees all help ensure we can continue to invest in the communities we serve.”

John B. Chessare, MD, President and CEO, Greater Baltimore Medical Center. “Our number one goal is to continue our transformation away from being a transaction-focused system to one that is driven to create better outcomes through the eyes of the patient. We are working hard to build a more integrated system to achieve better health, better care at a lower cost and more joy for those providing the care,” Dr. Chessare says. To achieve better health, the system is building the patient-centered medical home model in its primary care practices and is focused on improving clinical care in its hospital by reducing surgical site infections, catheter-associated urinary tract infections and central line-associated bloodstream infections.

“In the area of better care through the eyes of the patient, we’re using our HCAHPS scores to try to drive better communication with our patients. In the area of lower cost, we’re using improvement tools including lean tools to redesign our system to drive out wasteful use of resources, time and effort,” Dr. Chessare says. The system will work towards more joy for the providers of care through efforts to increase employee and physician satisfaction.

Steven G. Gabbe, MD, CEO, The Ohio State University Medical Center, Columbus. “As an academic medical center, our goals each year center on advancing our mission areas of patient care, research, teaching and community service. Among our priorities for 2012 are:

• Continuing the on-time and on-budget construction of our new 20-story James cancer hospital and critical care tower, including a new radiation oncology floor funded by a $100 million HRSA grant;
• Completing the integration of our medical staff into a single university-based faculty group practice;
• Growing our six signature programs: cancer, heart, neuroscience, critical care, imaging and transplant;
• Completing the activation of all the features of the inpatient electronic medical record and business management software system we installed system-wide this fall, which will be the final step in creating our fully integrated health information system;
• Establishing care coordination processes guided by the highest standards for quality outcomes, patient safety, efficiency and patient satisfaction; and
• Introducing a uniquely innovative medical school curriculum that will train 21st century physicians to lead, serve and inspire their profession and the patients and communities they serve.”

Bob Garrett, President and CEO, Hackensack (N.J.) University Medical Center. Hackensack University Medical Center’s goals include reopening Pascack Valley Hospital, working on several construction projects, continuing a physician alignment strategy and enhancing the network development strategy. Hackensack UMC is planning an ED expansion that will double its size, include fixed private rooms and feature pods — different areas within the emergency department that are devoted to...
specialties such as geriatrics, cardiology and oncology. In 2012, Mr. Garrett hopes to complete construction of the new Heart & Vascular Hospital. In addition, the hospital aims to build a comprehensive wellness center. “It will include a large fitness component as well as wellness programs and community education. It will be the largest fitness and wellness center of its kind in the region,” Mr. Garrett says.

The physician alignment strategy will include employment models for primary care physicians and cardiologists; joint venture opportunities for surgical specialties; and plans to form an accountable care organization. In addition, the hospital plans to continue to affiliate with community hospitals in the region. “We will be enhancing our status as an academic medical center by expanding our current medical residency programs and continuing to partner with medical schools,” Mr. Garrett says.

**Tim Hanson, President and CEO (retiring Jan. 2012), HealthEast Care System, St. Paul, Minn.** “In fiscal 2012, HealthEast will begin to work toward our new milestone goal: ‘Building on our benchmark performance, HealthEast will be a national leader in clinical quality, patient experience and cost effectiveness — the best value — by 2015.’

“This goal reflects HealthEast’s commitment to embrace healthcare reform and value-based purchasing. We are expanding our focus on quality to a broader look at value: that includes clinical outcomes and patient experience viewed across all settings of care combined with the total costs of that care. We will be focused more than ever on the transitions of care from home to clinic to hospital to post-acute care to clinic and back to the home. And we’ll have to be innovative, always looking for new and better ways to do our work collectively to best serve our patients.”

**Kevin Lofton, President and CEO, Catholic Health Initiatives, Englewood, Colo.** “Our goal at Catholic Health Initiatives is to continue to improve the quality of care we provide to our patients and residents and to further underscore the mission of our ministry, which is to build and sustain healthy communities. As a system, we continue to move from “sick care” to “well care,” focusing on the kinds of coordination and integration that will lead to higher quality and lower costs across CHI’s network of 73 hospitals and other healthcare facilities in 19 states. A key element of that long-term goal is OneCare, CHI’s $1.5 billion, system-wide initiative that will create a shared electronic health record for each CHI patient in both hospital and ambulatory care settings. This will help us provide the very best possible care to every patient we serve.”

**Mike Murphy, President and CEO, Sharp HealthCare, San Diego.** “Our goals in 2012 are to continue to build on our strengths and history of our comprehensive integrated delivery system and our commitment to our six pillars of excellence (quality, service, people, finance, growth and community). Together with our physicians, nurses and our entire allied healthcare team, we are focused on extraordinary performance in quality and patient safety and delivering these services in the most cost effective manner possible.

“We are continuing to innovate around the full continuum of care from ambulatory through post-acute while optimizing the use of information technology to enhance clinical outcomes and reduce the overall costs of care. We are committed to providing our patients and their families, our employees and our physicians with the very best experience within Sharp.”

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We are developing new and enhanced care delivery models that further align all healthcare providers and our patients. Additionally, we are focusing on population management and chronic disease management and promoting healthy lifestyles and wellness to our patients and staff.

**Stephen C. Reynolds, President and CEO, Baptist Memorial Health Care, Memphis, Tenn.** “In 2012, Baptist will celebrate 100 years of fulfilling the three-fold ministry of Christ — healing, preaching and teaching. The year 2012 will also mark significant progress toward constructing the first comprehensive cancer center in the Mid-South [and] replacement hospitals in Arkansas and Mississippi and implementation of advanced clinical documentation.

“We will focus on partnering with physicians to advance the quality of care in the communities we serve in Tennessee, Mississippi and Arkansas. We will continue to minister to patients and their families through our pastoral care team and volunteer chaplains across the Mid-South. We will continue our 100-year history of teaching future physicians, nurses and allied health professionals.”

**Amir Dan Rubin, President and CEO, Stanford Hospital & Clinics, Palo Alto, Calif.** “At Stanford Hospital & Clinics we continue to focus on delivering that absolute best in patient care to the next patient who walks through our doors. This includes delivering care which incorporates the best in innovative treatments, care with demonstrated and outstanding performance on quality and service measures, care that is personalized and patient centered, care that is coordinated across providers and care which delivers high benefits and value.”

**Dan Slipkovich, Co-Founder, CEO and Chairman, Capella Healthcare, Franklin, Tenn.** “Capella Healthcare is experiencing a time of exciting growth and unique opportunity and we anticipate a similar environment during 2012. During these next few years, we’ll work closely with our hospitals to provide the resources they need to continue making impressive progress on quality and service initiatives. We’ll invest in our staff, in recruiting needed physicians and in the newest technologies, including our clinical IT initiatives. And, we’ll continue to integrate the newest hospitals that have recently joined our family even as we explore additional community partnerships where Capella can make a difference.

“Our ongoing work — in local markets and at the national level — with our physician and community board leaders will include expanded communication, involvement in strategic planning and education about the changing environment. This approach doesn’t just help us to engage these key stakeholders but is essential in moving each hospital to the next level.

“We will continue to work collaboratively and creatively to manage our costs and invest wisely as we seek to meet the needs of all of the communities we serve. And, we’ll be proactive in our operational strategies to ensure that we come through this time stronger and in a solid position to continue to provide patient care excellence as well as to respond to the unique development opportunities these times will present.

“Our vision is for every hospital in the Capella Healthcare family to be the center point for transforming the quality of life in their communities, focusing first on improving the health and well-being of every individual. During this new era of healthcare, having the financial resources and talent needed to accomplish this will be even more vital. And working collaboratively is how we will best meet each community’s specific needs, provide high quality care for all of our patients, and create even better workplaces for our staff to serve.”

**Ronald W. Swinfard, MD, CEO, Lehigh Valley Health Network, Allentown, Pa.**

Dr. Swinfard says his top goal for the system is “to determine the appropriate innovations and directions relative to healthcare reform.” For example, LVHN is considering collaborating with different payors on new initiatives. By working with different payors, he aims to “hone our skills, because we don’t really know what firm direction CMS will take us. We think it will help us maintain flexibility by getting some experience in various risk-taking [projects] with various payors.” Another focus of LVHN for the new year is what Dr. Swinfard calls “mission possible,” a philosophy of service to patients. “We are appealing to the service mentality that permeates all people who work in the health system regardless of their job,” he says. “We believe that what patients really want is access and a caring environment.”
A Relationship Checklist for Hospital CEOs: 7 Behaviors to Ace

By Molly Gamble

As executives rise through the ranks, relationships grow in number and importance. Lengthy to-do lists and time-pressed schedules cannot obscure a hospital CEO’s focus on his or her professional relationships, particularly with their senior management team, since they are crucial to the well-being of an organization. The following checklist should help CEOs quickly identify any characteristics that may be lacking from their relationships with managers or employees.

Joseph Folkman, PhD, is the president and co-founder of Zenger Folkman, a firm that specializes in strength-based leadership development. Through extensive research, he has identified some of the common traits and strategies that set great leaders apart. Here, he shares some of the behaviors that help build and maintain valuable relationships.

1. Do you communicate honestly, even when the conversation may be uncomfortable? It seems redundant to frame honesty and integrity as a best practice when they should be inherent to a leader, but CEOs need to make extra effort to speak directly with people. Bosses should not merely tell managers or employees what they want to hear.

“Everybody wants you to be honest with them. Nobody wants to be fed a pile of garbage,” says Dr. Folkman. “People want the truth in a considerate way, along with a chance to respond and some empathy.” The message may be difficult or cause tension, but senior managers will appreciate the truth and know they can rely on a CEO’s straightforward nature in the future.

2. Do you encourage your senior leadership team to be straightforward with you? There is a degree of loneliness associated with the CEO position. People are much less likely to speak off-the-cuff to the chief, and they may water down or reframe their thoughts to be more eloquent and innocuous. Furthermore, CEOs are likely to face a shortage of feedback from their management team, and they may feel out-of-the-loop on their own professional performance.

“The key here is to really, really push people to be absolutely honest and straightforward with you,” says Dr. Folkman. This may be challenging, but CEOs will face even greater challenges if they can’t get a straight message from the people they rely upon most.

3. Are you too removed from your team? Some CEOs may opt to be distant and objective with their management team because they think it fosters respect and will ease tension if the CEO has to lay somebody off. This can have serious repercussions and break down trust, causing more damage than good. The most sought-after characteristic of managers is the ability to inspire and motivate others. This is nearly impossible without emotional connection.

“If you are friends with somebody, it’s going to be more difficult to fire them and have blunt conversations. That’s because you care about them. But, what you lose in the process [of being distant] is that emotional connection, which creates engagement in people. It creates more ownership and a more positive work environment,” says Dr. Folkman. In short, don’t throw relationships away for an easier layoff discussion.

4. Have you provided mentorship? “Think about the people that have been mentors to you in the past. How do you feel about them?” asks Dr. Folkman.

Odds are, you have the utmost respect — possibly even a soft spot in your heart — for them. Despite their busy schedules, CEOs should not overlook the importance of mentorship. Leaders who help other managers develop their own skill sets share a unique and strong relationship with those individuals that is likely to be carried on as that mentee moves forward.

5. Are you talking more than you’re listening? Along with listening, the skill of asking thought-provoking questions also helps build rapport with managers. “One of the most fundamental skills in relationship-building is to ask great questions that really get people to think,” says Mr. Folkman. Asking thought-provoking questions not only shows the CEO was listening but also helps managers learn more about themselves and how they feel about various topics.

6. Do you reward, recognize and thank people enough? “When I’m with leaders, I’ll ask them, ‘If I went to your direct reports, your kids, your family and asked them if you reward them too often, would any of them say yes? Would anyone say you go overboard, and it’s sickening? How many people would say yes?’”

Probably very few people, if any, would complain of being recognized too much. While Dr. Folkman says about 2 percent of leaders do go overboard with praise and rewards, the other 98 percent do not recognize or reward their team enough. Leaders can schedule time in their day to thank people and begin to make it a habit. The people who recognize the talents, contributions and accomplishments of others tend to have great professional relationships.

7. Have you prioritized results over relationships? Dr. Folkman focuses on two things when it comes to extraordinary leadership, and he calls the pairing the “powerful combination.” Leaders who drive results and build relationships can accomplish remarkable things, and Dr. Folkman recommends CEOs focus on both of these tasks and not prioritizing one over the other. More than 70 percent of top-tier leaders have mastered the push for results and valuable relationships with their staff.

“When we looked at why people are satisfied or committed employees, the top [response] were things like, ‘My boss inspires me. He/she sets goals that are challenging to achieve,’” says Dr. Folkman. “If you’re debating between push and pull — save the debate. Do both,” says Dr. Folkman. CEOs should build positive relationships while also pushing their organization to accomplish goals, make significant contributions and work hard.

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Building on a Legacy of Exceptional Care: Q&A With Mass General Hospital President Dr. Peter Slavin

By Sabrina Rodak

This year Massachusetts General Hospital in Boston celebrated its 200th anniversary. At the same time, the organization is working to cut costs, improve quality and meet various requirements of the healthcare reform law. Peter L. Slavin, MD, president of Mass General, reflects on the hospital's successes in the past year, the challenges ahead and how he hopes to build on a history of delivering quality care to continue exceeding patients' expectations in the new year.

Q: What are the biggest challenges in the past year you have had to face as president?

Dr. Slavin: One is specific to Mass General Hospital. We’ve been pretty capacity-constrained with limited inpatient beds, operating rooms and the emergency department. Managing the hospital at a time with a very high occupancy and congestion that is frustrating to a lot of people minimizes the opportunity to grow. Fortunately, a few months ago we began opening up a new clinical building that addresses a number of those capacity constraints, so that is making some progress towards addressing those challenges.

The other more broad [challenge] is that clearly as result of the economy and federal budget deficit and state budget deficit challenges, we as an organization need to make a transition from a fee-for-service environment to a more global payment environment and also an environment where rate increases are much more modest than what we’ve received in the past. How you turn this aircraft carrier around in a way that it can thrive and continue to [achieve] its mission in a new reimbursement environment has been a challenge, and it will be a challenge for many more years to come. On top of that, a significant portion of [our research budget] comes from the National Institutes of Health, and the budget for that federal agency is also quite challenged by the federal budget deficit.

Q: How are you working to overcome these challenges?

PS: In terms of financial challenges, we’re doing reasonably well, but we decided this year to go through a budget review process to prepare for the future environment we’re going to be living in in an effort to figure out how we can be more efficient and more affordable going forward. [This is] despite the fact that we are doing better than budget through most of the year — we trimmed expenses by about $40 million dollars a year in an effort to try to better position this organization for a much leaner reimbursement environment. Those efforts will continue this year and for the foreseeable future.

[In our] zero-based budgeting process, we asked all department heads to look at everything they’re doing and identify things they could stop doing or things they could do more efficiently. Senior management and I met with department heads to go over their ideas, organizational charts and mission, and made some decisions about things we thought we could implement immediately. We also have a significantly larger pool of ideas that we’re going to need some more work on to turn into reality.

The clinical building, which is called the Lunder Building, was designed a few years ago to address the capacity issues of not enough inpatient beds or operating rooms or a large enough emergency department. So, those three things make up most of the space in the new building. That building just opened a few months ago, and it is the largest and arguably nicest building we’ve ever constructed. And the staff that is now in there living there and more importantly patients receiving care there are thrilled with the patient-centered aspects of the building. One of our doctors expressed concern that we might see the length of stay go up not because of any operational problems but because the patients might not want to leave.

Q: What were your greatest successes this past year?

PS: The new building would be one. [Also], this is our bicentennial year — our 200th birthday since being established by the state of Massachusetts — and we had a number of activities going on throughout the year that celebrated that bicentennial. We focused not on celebrating the past, but looking forward on having a bigger impact in the next years than in the past 200. For example, we reenacted the signing of the charter on Beacon Hill. A couple years ago we commissioned a book on the history of the hospital that is now out and called Something in the Ether. And we’ve also this year given a significant gift to the community for the privilege of operating here in Boston in Massachusetts. We called it the Bicentennial Scholars program, and it’s aimed at getting 26 high school students into college and through college in the next six years.

[A success] I would also point to this year is that we [were] awarded by the Association of American Medical Colleges the Spencer Foreman Award [for Outstanding Community Service], which is given to the hospital they think has the best community health program in the country. Mass General is renowned for clinical care, research and educational activities. It’s nice to see those things recognized by an organization such as the AAMC.

Finally, several years ago we launched a capital campaign to raise $1.5 billion dollars. This year we raised $270 million dollars, the largest total we have raised in any year in our history. We have about two years left in the campaign and we’re at 85 percent of our goal. So we’re thrilled that despite the economic challenges of today, people are still rallying to support this institution in a very significant way.

Q: How did you achieve these successes?

PS: We are very fortunate to have 23,000 very talented and dedicated employees led by a great group of chiefs and vice presidents. Those are the people who deserve all the credit for what I’ve mentioned to you, and then some.

The quality and dedication of the employees are something that I noticed when I first came here as a medical student in 1983. The people here feel [their work is] much more of a calling than a job. People here are incredibly dedicated to doing whatever is necessary to take the best possible care of patients, and I’m pleased that that spirit I first encountered seems to be very much alive and well. And that spirit is wanting to make a big difference in the lives of people we’re caring for today and a bigger difference in the lives we will be caring for tomorrow and the next year and many years to come. That’s the spirit of this place.

In 1810, there was a letter sent from two physicians to the wealthy people of the Boston area to support this new innovation called Mass General. The most famous line in that letter that received a very [positive] response is, “When in distress every man becomes our neighbor.” That really captures, better than any other words, the
Focus on Hospital Leadership

The spirit of this place — what it stands for and what draws people to work here. In most cases when they work here they never leave. About a week or two ago, we had an employee recognition event for people who’ve been here for 40 years or more and we had close to 1,000 people. Some people were celebrating 60 years on staff. There aren’t many organizations that have that longevity of commitment of the workforce.

Q: How do you encourage this spirit?
PS: What I do personally is I try to celebrate that spirit and reinforce it as much as possible. Since I started almost nine years ago, I’ve sent out a monthly email to everybody who works here and I try as best I can to highlight things going on here recently. That reinforces the spirit. Also since I began about nine years ago, I keep positive letters from family members and patients who have had exceptional care here. At least once a month, I try to visit with the staff people who were mentioned in those letters and thank them personally for delivering great care. [We try to choose the] letters that are the most profound for us, the most special, and try to celebrate the accomplishments of the staff and the appreciation for staff’s great care of patients. I look for every opportunity to reinforce this spirit in person or through more mass communications in the organization.

Q: What do you hope to accomplish in 2012?
PS: The most important thing, which has been the most important thing for almost 200 years, is to exceed the expectations of the 50,000 inpatients and 1.5 million outpatients we will be caring for next year. That is the first and second and third most important responsibility. It’s not only why we’re here and our purpose, but also the most important thing we can do from a business standpoint to be successful in the future. I also hope we continue to advance our other missions: research, education and community health. We need to continue the effort of turning this aircraft carrier, getting it well positioned for what is in all likelihood going to be a much leaner revenue picture than it’s experienced in the past.

Q: What is the best piece of advice you can give to other hospital or health system presidents and CEOs?
PS: I’ve seen over the years many CEOs and other hospitals and health systems get so caught up in whatever the business challenge is of the day — forming a network, becoming an accountable care organization, etc., — that they take their eye off the ball of day-to-day patient care and excelling in it. My most important piece of advice is don’t take your eye off that ball, because not only is that ball what is at the core of what we do, but doing it well is in the long term the most important ingredient for success as a healthcare organization.

Q: What other insights on healthcare in 2012 can you share?
PS: I think we’re entering into an era of unprecedented opportunity in healthcare. There are things going to come out of research that are truly extraordinary. At the same time we’re facing economic circumstances which may make those things, and other things that are already delivered today, unaffordable. We’re in for very challenging and interesting times ahead and I think the best way to get through all of that is if we in healthcare delivery can come up with lots of ways to make better and more efficient care and eliminate as much of the fat in the system as possible so we can afford the existing muscle and the muscle that’s going to come out of the spectacular research in the future.

If we don’t do that, if we don’t innovate and improve care and make it more efficient, I’m fearful that we will be forced to cut into the muscle of healthcare here and across the country, and that would be a very sad state of affairs, not only for the people working in healthcare, but also for the American people.

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Hospital Leadership is a Culture, Not a Person: Q&A With LifePoint Hospitals CEO Bill Carpenter

By Bob Herman

As the healthcare environment changes, hospital leadership must realign their organizations, especially as the healthcare sector prepares for reform and other changes coming in the next few years. Bill Carpenter, chairman and CEO of Brentwood, Tenn.-based LifePoint Hospitals, which owns and operates 54 hospitals in 18 states, thinks that for a hospital to succeed, its leaders must be willing to invest heavily in other people and a positive culture. And it’s up to the CEO to listen and respond to its constituents’ ideas to enact an organization-wide strategy.

Here, Mr. Carpenter also shares his thoughts on how his current tenure at LifePoint has influenced his leadership skills, how other hospitals can develop their own leaders and some challenges associated with for-profit hospital operations.

Q: What leadership traits have you acquired throughout your career at LifePoint, and how have they affected you today?

Bill Carpenter: I don’t believe that any leader has it all. I don’t think any single leader can make an organization successful on his or her own. I think leaders have to surround themselves with talented people in order to be successful and for the organization to be successful. The primary responsibility of a CEO is to establish a culture and strategy that will guide an organization through a period of time. Great leaders help other people understand what their role is, what their contributions are and help keep them focused on the key things that are going to make a difference for the organization. Those are some of the things that I’ve learned.

At LifePoint, shortly after I became CEO, we embarked on a strategic planning process to set up the direction of the company for the next five years. We made sure that we had a thorough process and that our organization had a chance to buy into the direction we were setting. Then we worked hard to let people know how their specific work adds value to the organization and how they specifically fit into the overall strategy.

We created strategies for each of our hospitals designed around recruiting the right physicians in the community, establishing new service lines that had not previously been provided in the community and making appropriate capital investments in the hospital to allow physicians to provide care under these new service lines. Another part of our strategy was to continue to enhance quality care. This aspect ties directly into our focus on growth.

People in communities want to know their hospital is a good choice, so we have strategies around physician engagement in order to work with physicians to enhance clinical outcomes for patients at each of our hospitals throughout the organization. We also have strategies around operational excellence. Under healthcare reform, hospital organizations have to get more efficient. And so we have worked with our hospitals to create better processes that we believe will allow us to be more efficient and improve quality of care.

Q: Are there certain ways that LifePoint develops leaders or leadership principles that other organizations can try to emulate?

BC: We have a leadership development program in place to allow people to become the best they can be. Developing key leaders throughout the organization to implement our strategies is very important to LifePoint. The leadership development program starts with each individual having a plan — that’s the key. Leadership development is so important, particularly in a company with hospitals in smaller communities around the country. We have to identify leaders for our community hospitals who first of all want to live in a small town and who also show leadership potential. Then we can help them achieve whatever goal they have for themselves, but it all starts with a plan.

At LifePoint, many of our hospital C-suite leaders were identified during the succession planning process and have participated in our leadership development programs, which prepared them for the leadership positions they now hold. We have many examples of hospitals leaders who were identified as potential leaders of the future of the company. We have worked with them to develop a plan for their leadership development, and today they serve in roles including CEOs, COOs, CNOs and CFOs of LifePoint hospitals, and that’s an exciting thing for me.

Our leadership model involves basic personal mastery skills, business mastery skills and relationship mastery skills, and those include the basic values of the company grounded in things that you would expect: compassion, respect, trust, integrity, honesty, ethical behavior. Those are important. We also look for leaders who can relate well with others and who people want to follow.

Q: What challenges or mistakes have made your leadership stronger over the years?

BC: I do know that I try to learn from my mistakes. I’ve made plenty of mistakes; we all do. I think it’s important for leaders to admit when they make mistakes. Frankly, I think we ought to be more tolerant of our leaders when they make mistakes. Sometimes, I think if you don’t make mistakes, you may not be trying hard enough. When you do big things and try big things, sometimes you’re going to make a mistake. I love leaders who bring ideas to the table, even if [the ideas] don’t work all the time, and that’s what makes us better. Great ideas make us better.

We certainly learned from our mistakes in the past. One thing we’ve done that is innovative, with regard to the way we acquire hospitals, is we have developed a transition services division, which involves our operations teams in the full scope of the acquisition process. Our transition services team is involved in all aspects of due diligence, strategic planning and integration of a newly acquired hospital, and then that team is responsible for the operations of the hospital for the first few years of LifePoint’s ownership. We started this approach in order to make sure there is not any miscommunication between the people who are doing the deal and the people who are operating the hospital after the closing. We decided to give this approach a try after we saw that we could improve the handoff of newly acquired hospitals. This process allows us to build trust with the partner early on, as they have the opportunity to spend more time with the people who are responsible for operating the hospital after closing.

A while ago, we were involved in the acquisition of a community hospital where we were not able to be involved with broader communication during the process for that acquisition. When the transaction was announced, the community was upset that the hospital was being sold. They didn’t understand the hospital’s financial and operational pressure. To them their community
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A. Keynote Panel - The Best Ideas for Health Systems and Hospitals Now
R. Timothy Stack, President & CEO, Piedmont Health System, Stephen Mansfield, PhD, President & CEO, Methodist Health System, Michael O. Ugwueke, CEO, Methodist Healthcare North and South Hospitals, Charlie Martin, CEO, Vanguard Health System, moderated by Charles S. Lauer, Author, Consultant, Speaker and Former Publisher of Modern Healthcare Magazine

B. The Current State of the Healthcare Credit Markets
Shane Passarelli, Senior Vice President, Healthcare Finance Group, Kevin Vermeer, CFO, Iowa Health System, Don Ensing, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. Healthcare Reform - Future Thoughts on Success
Alan Sager, Ph.D., Boston University School of Public Health

D. Patients Come Second, Employees Come First
Paul Spiegelman, CEO, The Beryl Companies, and Britt Berrett, CEO of Texas Health Presbyterian Hospital in Dallas

10:45 – 11:30 AM
A. Keynote Panel - Great Leadership
Moderated by Suzy Welch, Author, Television Commentator, Business Journalist, Panelists: Kristine Murtos, President, Skokie Hospital, Melissa Szabad, Partner, McGuireWoods LLP, Teri Fontenot, CEO, Women’s Hospital, Pamela Stoyanoff, EVP & COO, Methodist Health System

B. 5 Key Financial Ratios That Providers Should Be Tracking
Kate Guelich, Senior Vice President, Kaufman, Hall & Associates

C. The Financial Return on Different Physician Alignment Strategies - How to Assess the Financial Implications of Different Alignment Strategies
Luke C. Peterson, Partner, Strategy, and Kate Lovriren, Partner, Strategy, Health System Advisors

11:35 – 12:20 PM
A. Keynote Panel - Evolving Strategy - Thinking 10 Months and 10 Years Into the Future
Moderated by Suzy Welch, Author, Television Commentator, Business Journalist, Panelists: Cathy Jacobson, Executive, Accenture, moderated by James Thompson, Senior Vice President, Media & Public Relations, Thomson Reuters

B. The Importance of Data and Analytics in a Bundled Payment Approach
Bob Kelley, Senior Vice President, Thomson Reuters

C. Ideas and Concepts to Improve Cardiovascular Program Profitability
Susan Goldberg, RN, MSN, Director, CV Clinical Program, Aurora Healthcare, Andrew Ziskind, MD, Partner, Senior Executive, Accenture, moderated by James Palazzo, Managing Director, Navigant

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https://www.regonline.com/beckershospitalreviewannualmeeting_1041813
A. Key Concepts to Police, Improve and Measure Quality
Kathleen Crawford, MSN, MBA, FACHE, Chief Operating Officer, Ashtabula County Medical Center, HFAP Nurse Surveyor, Linda Lansing, SVP of Clinical Services, Surgical Care Affiliates, Marion Martin, RN, MSN, MBA, COO, The Center for Quality, Innovation and Patient Safety, Roper St Francis Healthcare

12:20 - 1:05 pm
Networking Lunch and Exhibits

1:05 – 1:45 PM
A. ACOs in Action
Andrew Ziskind, MD, Partner, Senior Executive, Accenture

B. Hospital Transaction Preparation and Process Design
Barry Sagraves, Juniper Advisory, Rex Burgdorfer, Juniper Advisory, Kristian A. Werling, Partner, McGuireWoods LLP

C. Generation Y - An Examination of the Mindsets in Employing the Next Generation of Orthopedic Surgeons
Les Jebson, Executive Director, University of Florida Ortho and Sports Medicine

D. Anesthesia Relationships - Current Trends and Issues
Hugh V. Morgan, Director, Quality Assurance, Marc E. Koch, MD, President & CEO, Somnia, Inc.

1:50 – 2:30 PM
A. Aetna’s ACO Initiatives - Our Work With Health Systems to Pilot ACO Initiatives on Hospital Employee Populations
Debbie Lantz- Talpos, Market Head, Aetna

B. Key Developments in Medicare Reimbursement and the Impact on the Delivery of Care
Ken Perez, Senior Vice President of Marketing, MedeAnalytics, Inc.

C. An Analysis of What Works What Doesn’t - Key Thoughts for Physician Hospital ASC JVs
Tom Mallon, CEO, Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

D. 10 Keys to Running a Successful Acquisition or Joint Venture Program
Scott Becker, JD, CPA, Partner, and Barton C. Walker, Partner, McGuireWoods LLP

2:35 – 3:10 PM
A. The Best Ideas on Physician/Hospital Integration - What Works, What Doesn’t moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Optimizing Resources - Guaranteed New Savings and Revenues
Richard Kunnes, MD, Managing Principal, CEO, Sevenex

C. Acquiring Cardiology Practices - Key Concepts on Price and Compensation
James M. Palazzo, MBA, Managing Director, Navigant

D. Physician Relations: Best Practices in Leveraging QA Programs to Manage and Affect Positive Change
John DiCapua, MD, Vice President Anesthesiology Services, North Shore-Long Island Jewish Health System, Deputy CEO, CMO, North American Partners in Anesthesia

3:15 – 3:50 PM
A. New Types of Transactions to Deal With the Changing Environment - Payors Acquiring Providers, For-Profit and Not-For-Profit Hospital JVs and Joint Operating Agreements
Carsten Beith, Co-Head of Tax-Exempt M&A, Cain Brothers, Casey Nolan, Managing Director, Navigant, and Kristian A. Werling, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Building a World Class Oncology Program - A Case Study
Gerard Nussbaum, Director of Technology, Kurt Salmon

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

D. Clinical Variation, Quality and the Role of the CMO
Bill Mohlenbrock, MD, FACS, Chairman and CMO, Verras

3:55 – 4:30 PM
A. False Claims, Anti Kickback Investigations and Other Common Issues of Litigation
Jeffrey C. Clark, Partner, Richard Greenberg, Partner, and David J. Pivnik, Associate, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Hospital Acquisitions of ASCs, Imaging Facility and Other Ancillary Businesses - How to Examine Opportunities and How to Assess Pricing and ROI
Matt Searles, Managing Director, Merritt Healthcare

C. 5 Core Concepts on How to Reduce Readmissions
David Grinbergs, MD, FACEP, President of Emergency Services, and Eric Heckerson, RN, MA, FACHE, Vice President of Operational Performance, TeamHealth

4:35 – 5:10 PM
A. Performance Improvement Initiatives for Hospital Affiliated Practices
John McDaniel, MHA, President & CEO, Peak Performance Physicians

B. An EMR for the Revenue Cycle: Documenting the Business Side of Care at Saint Joseph’s Medical Center
Rebecca T. Black, Vice President, Revenue Cycle, Saint Joseph’s Hospital of Atlanta

C. Personalizing the Management of Atrial Fibrillation - How Cardiac MRI can Improve Your Outcomes and Bottom Line
Jeremy Foterhringham, RN, MHSA, JD, Director, CARMA Center, University of Utah Healthcare

D. 5 Basic PR Tactics That Every Health System Should Remember
Marion Crawford, President, Crawford Strategy

5:10 – 6:30 Pm
Networking Reception, Cash Raffles & Exhibits
# Becker's Hospital Review Annual Meeting

## Schedule-at-a-Glance

### Thursday | May 17

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:00 - 9:00 AM</td>
<td>Registration and Exhibitor Set Up - Green Room and Walnut Foyer</td>
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<tr>
<td>9:00 AM - 4:10 PM</td>
<td>Concurrent Tracks: CEOs, ACOs and Physician Hospital Integration</td>
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<td></td>
<td>Improving Profitability - CFOs, and Business and Legal Issues</td>
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<tr>
<td>8:10-8:45 am</td>
<td>General Session - Walnut Room</td>
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<td>From Nixon to Obama - Bob Woodward, Legendary Political Journalist</td>
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Concurrent Tracks

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CEOs, ACOs and Physician Improving Profitability - Key Specialties and Related Issues - Orthopedics, Neurosurgery, Cardiology, Oncology and Radiology

Hospital Integration, CFOs, and Business and Legal Issues - orthopedics, neurosurgery, Cardiology, ACOs and Quality

12:00 - 12:45 PM
Networking Lunch and Exhibits in Green Room

3:05 - 3:20 PM
Networking Break and Exhibits in Green Room

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Keynote - Leadership and Management in 2012 - Mike Ditka, Legendary NFL Player and Football Coach

5:15-7:00 PM
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Registration and Continental Breakfast in Green Room

General Session - Walnut Room

8:10-8:45 AM
From Nixon to Obama - Bob Woodward, Legendary Political Journalist & Associate Editor, The Washington Post

Concurrent Tracks

9:00 AM- 5:10 PM
CEOs, ACOs and Physician Improving Profitability - Key Specialties and Related Issues - Physician/Hospital Joint Ventures, Orthopedics, Cardiovascular Quality and Anesthesia

Hospital Integration, CFOs, and Business and Legal Issues - orthopedics, Cardiovascular Quality and Anesthesia

9:00 - 9:45 AM
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5:10 - 6:30 PM
Cocktail Reception, Raffles and Exhibits open in Green Room and Walnut Foyer
CONFERENCE SPEAKERS

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

Imran Andrabi, President & CEO, Mercy St. Vincent Medical Center
Scott Becker, JD, CPA, Partner, McGuireWoods LLP
Carsten Beth, Co-Head of Tax Exempt M&A, Cain Brothers
Britt Berrett, CEO, Texas Health Presbyterian Hospital in Dallas
Gerry Biala, SVP of Perioperative Services, Surgical Care Affiliates
Carole Black, MD, Chief Medical Officer, Valence Health
Rebecca T. Black, Vice President, Revenue Cycle, Saint Joseph’s Hospital of Atlanta
Tammie Bralsford, RN, COO, Memorial Care Health System
Henry Brown, CFO, Westchester Hospital
Rex Burdorfer, Juniper Advisory
Eileen Cardile, President & CEO, Underwood Memorial Hospital
Kate Carow, Principal, Carow Consulting
Alan H. Channing, President & CEO, Sinai Health System
Jeffrey C. Clark, Partner, McGuireWoods LLP
Kathleen Crawford, MSN, MBA, FACHE, Chief Operating Officer, Ashatabula County Medical Center, HFAP Nurse Surveyor
Marion Crawford, President, Crawford Strategy
William T. Casick, EVP & CFO, St. Mary’s Hospital
John DiCapua, MD, Vice President Anesthesiology Services, Deputy CEO, Chief Medical Officer, North Shore-Long Island Jewish Health System, North American Partners in Anesthesia
Mike Ditka, Former NFL Hall of Fame Football Player and Coach
Bob Edmondson, VP of Strategic Planning and Business Development, West Penn Allegheny Health System
Christian D. Ellison, VP, Health Inventures, LLC
Don Ensing, Partner, McGuireWoods LLP
Paul Esselman, EVP and Managing Principal, Cekja Search
Allan Fine, Chief Strategy and Operations Officer, The New York Eye and Ear Infirmary
Julie Fleck, Chief Operating Officer, Parkview Ortho Hospital
Tori Fontenot, CEO, Women’s Hospital
Jeremy Fotteringham, RN, MHSA, JD, Director, CARMA Center, University of Utah Healthcare
Doug Garland, MD, Medical Director of Orthopedics, Long Beach Medical Center
Joseph Golbus, MD, President, NorthShore University HealthSystem
Susan Goldberg, RN, MSN, Director, CV Clinical Program, Aurora Healthcare
Steven Goldstein, President & CEO, Methodist Health System
Richard C. Greenberg, Partner, McGuireWoods LLP
Ron Greer, MD, Chief Medical Officer, Cogetn HMA
David Grinbergs, MD, FACEP, President of Emergency Services, TeamHealth
Joseph Guaracino, SVP & CFO, The Brooklyn Hospital Center
Kate Guelich, SVP, Kaufman, Hall & Associates
Marc D. Halley, President & CEO, Halley Consulting
Ken Hanover, CEO, Northeast Health System, Inc.
Eric Heckerson, RN, MA, FACHE, VP of Operational Performance, TeamHealth
Jonathan Helm, AVA, Manager, VMG Health
Michael D. Israel, President & CEO, Westchester Medical Center
Cathy Jacobson, CEO, Froedtert Hospital in Milwaukee
Liesie “Les” Jieson, Executive Director, University of Florida Ortho and Sports Medicine
Josh Johnson, CFO, Managing Director, VMG Health
Chris Karam, President & CEO, CHISTUS St. Michael Health System
Mike Kasper, CEO, DuPage Medical Group
Donna Katen-Bahensky, President & CEO, University of Wisconsin Hospitals and Clinics
Bob Kelley, SVP, Centers for Healthcare Analytics, Thomson Reuters
Marc D. Koch, President & CEO, Somnia, Inc.
Teresa Koenig, MD, The Camden Group
Matthew Kossman, Senior Director, Surgical Care Affiliates
Richard Kunnes, MD, Managing Principal & CEO, Sevenex
Brent Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America
Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America
Linda Lasing, SVP of Clinical Services, Surgical Care Affiliates
Debbie Lancy-Talpos, Market Head, Aetna
Charles S. Lauer, Author, Consultant, Speaker, Former Publisher of Modern Healthcare Magazine
Gregg P. Leff, EVP, Med Medtrix
Jeff Leland, CEO, Blue Chip Surgical Center Partners
Kate Loverrien, Partner, Strategy, Health System Advisors
Adam Lynch, Vice President, Principle Valuation, LLC
Marty Manning, President, Advocate Physicians Partners
Stephen Mansfield, PhD, President & CEO, Methodist Health System
Angela Marchi, Division Vice President, Health Management Associates
Charlie Martin, CEO, Vanguard Health System
John D. Martin, CEO, Ortholody
Marion Martin, RN, MSN, MBA, Director, Roper St. Francis
Jeff Mason, CEO, BayCare Clinic
John W. McDaniel, MHA, President & CEO, South Nassau Communities Health System
Michele M. Molden, EVP and Chief Transformation Officer, Piedmont Healthcare
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Kristine Murtos, President, Skokie Hospital
Peggy Naleppa, President & CEO, Peninsula Regional Medical Center
Eric T. Nielsen, MD, VP, The Camden Group
Casey Nolan, Managing Director, Navigant
Gerard Nußbaum, Director of Technology, Kurt Salmon
Jon O’Sullivan, Senior Partner, VMG Health
James Palazzo, Managing Director, Navigant
Shane Passarelli, SVP, Healthcare Finance Group
Charles “Chuck” Peck, President & CEO, Health Inventions, LLC
Ken Perez, President, MedeAnalytics, Inc.
Megan Perry, President of Sentara Potomac Hospital, Sentara Health System
Luke Peterson, Partner, Strategy, Health System Advisors
Michael Piver, Director, Orthopedic & Spine Services, Tanner Health System
David J. Pivnik, Associate, McGuireWoods LLP
Samantha Platze, SVP Operations & Systems
Effectiveness, Care Logistics
Victoria Poinexter, Principal, H2C, LLC
Andrea Price, CEO, Mercy Northern Region
Joseph Quagliata, President & CEO, South Nassau Communities Hospital
Timothy Reed, Physician Practice Valuations Practice Leader, Sullivan Cotter and Associates, Inc.
William T. Reiser, VP Product Development, Halley Consulting
Russ Richmond, MD, CEO, McKinsey Hospital Institute
Paul Rundell, Managing Director, Alvarez & Marsal
Valinda Rutledge, Director of Patient Care Models Group, Center for Medicare/Medicaid Innovation
Scott Safriet, MBA, AVA, Partner, HealthCare Appraisers, Inc.
Aran Sager, PhD, Professor of Health & Policy Management
Barry Sagraves, Juniper Advisory
H. Scott Sarran, MM, Chief Medical Officer, Blue Cross Blue Shield of Illinois
Ben Sawyer, EVP, Care Logistics
Matt Sears, Managing Director, Merritt Healthcare
M. Michael Schabot, MD, Chief Medical Officer, Memorial Hermann
Kerry Shannon, Senior Managing Director, FTI Consulting
Elizabeth Sippink, Vice President of Consulting Services, Valence Health
Anu Singh, SVP, Kaufman, Hall & Associates, Inc
Paul Spiegelman, CEO, The Beryl Companies
Tim Stack, CEO, Piedmont Health System
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Melissa Szabad, Partner, McGuireWoods LLP
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Barton C. Walker, Partner, McGuireWoods LLP
Rhoda Weiss, PhD, National Healthcare Consultant, Speaker, Author & Editor, Marketing Health Services Magazine
Suzy Welch, Author, Television Commentator, Business Journalist
Kristian A. Werling, Partner, McGuireWoods LLP
Michael R. Williams, CEO, Hill County Memorial in Fredericksburg, TX
Bill Woodson, SVP, Sv2
Bob Woodward, Legendary Political Journalist, Associate Editor, The Washington Post
Robert Zasa, MSHHA, FACMPE, Founder, ASD Management
John R. Zell, VP of Finance and CFO, OSF St. Joseph
Andrew Ziskind, MD, Partner, Senior Executive, Accenture

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asset was being sold, and they hadn’t had the opportunity to get to know us. I’ve learned that we should be involved in communications with all key constituency groups early in the process. We need to be involved at a deeper level with physicians and the community just to make sure everyone is on the same page. That was certainly a lesson-learned and resulted in the formation of that transition services division.

Q: What are some of the key concepts of hospital leadership you know now that you wish you knew when you first became CEO?

BC: I wish I had understood sooner the power of the title. That may sound a little strange, but after becoming the CEO of LifePoint, even though I was one of the founding employees of the company, I realized that I had to be very thoughtful about what I said to people in the organization. They viewed the CEO — even though I was the same person they had known for several years — in a different way. When I spoke, people listened in a different way, and they responded in a different way by putting whatever I said into action. That was something I learned pretty quickly but wish I had known immediately.

I also learned the importance of strategic communication. It is very important for my messages to be tied to the company’s messages because it can be confusing to people if they hear the CEO or their leadership speaking in a way that may seem inconsistent with the direction that had been previously set.

Q: Do you think different leadership qualities are necessary at for-profit hospital enterprises like LifePoint?

BC: Leadership is leadership, whether you lead a for-profit or not-for-profit organization. Good leaders think strategically and make decisions based on effective strategies. I don’t think there’s much difference. Both types of organizations must create a return-on-investment for the hospital in order to remain viable and to accomplish their mission.

As a publicly traded company, we have an additional constituency group to consider — the stockholders of the company to whom we are responsible. I think it’s important for leaders of for-profit companies to be very clear with stockholders about what the company’s goals are, what our expectations are and how we expect to achieve our stated financial goals. I think it’s very important for leaders of for-profit organizations to convey that following a strategic plan — in our case, our focus is on quality, growth, operational excellence and developing key future leaders — will achieve the desired results. A lot of this revolves around good, straightforward communication, whether you’re talking to employees, community members, physicians or investors.

Q: Healthcare reform and changes within the sector, such as value-based purchasing and hospital readmissions, have spread rapidly. How do you and other leaders within LifePoint manage the mass influx of change within the broader context of your organization?

BC: Hospitals around the country are looking to their leadership for solutions to the types of changes you described — value-based purchasing, readmissions, bundled payments and the many other changes that face hospitals these days. It’s one of the reasons many community hospitals are looking for the shelter of a system because they don’t want to be in the position of all this massive change on their own. And so at LifePoint, we’re working to develop plans to deal with each of these things. Focusing on value-based purchasing and hospital readmissions fits very nicely with our strategic plan on improving quality care and documenting care so that we can be appropriately paid for the care we deliver. We have to get more efficient in the future, and we have to be able to prove that we are providing high-quality patient care.

I do think leaders in the healthcare sector have a great responsibility today to help our organizations stay focused on the key things that can make a difference. This is a time of great change when distractions are easy to come by. Keeping our organizations focused on the key things that will make a difference on long-term success is critically important to what we’re trying to do.

Leadership Lessons From “Little” Failures: Q&A With Health Management Associates CEO

Gary Newsome

By Bob Herman

The state of the hospital organization has changed drastically in the past few decades. Many hospitals now work collaboratively with each other, perhaps sharing resources or service lines, and others have joined forces completely to become part of a larger health system. Gary Newsome, president and CEO of Naples, Fla.-based Health Management Associates, has seen this shift in hospital restructuring firsthand. Health Management, through its subsidiaries, currently owns and operates 66 hospitals in 15 states, and he says for hospital leaders to guide an organization that large to success, they must recognize and utilize all of the different invaluable resources at their disposal.

Mr. Newsome shares his insights on how failure can be a learning moment for hospital leaders, who hospital leaders can learn more from, and how the current healthcare environment lends itself to numerous partnerships between for-profit and non-profit hospital organizations.

Q: What key leadership issues have impacted you the most since arriving at Health Management?

Gary Newsome: It’s interesting, over the span of my career, going from the responsibility of operating one hospital to becoming president and CEO of a healthcare company; it is a quantum leap. All of sudden, the weight and responsibility, the strategic direction — everything is in your lap and on your shoulders. It’s not only your own career in your hands, but you have the
responsibility of a countless number of people and the organization as a whole. The associates throughout the company depend on me, and to a large extent, it made me want to do even better and stretch myself even more. It made me try to understand all of the different aspects of the business and try to steer the company in the right direction.

I was brought in for a reason. There were several years here of lethargic growth, and it was really viewed as a mature company. The past few years, though, there's been a great deal of growth, and that's a lot more exciting. Over the past three years, I've learned to appreciate the talented people I work with even more than I appreciated them before, and I realized it's important to have the best talented people in your organization. With the fast changes in healthcare, the people and the thought processes have to be able to keep up.

**Q: What is the best way to develop other leaders? Have you seen more successful ways to lead than others?**

**GN:** Throughout my career, at every organization I've been at, one of my biggest responsibilities was to develop people. If I did a good job of developing people, that would result in direct and sustained growth in the company. I've always felt I needed to surround myself with great people, but when you have great people, what you can't do is put restraints on them. Obviously, we have to be within the bounds of the regulatory environment, but the best I can do is to give them the big picture direction and let them go. And sometimes people fail, but that's okay. That's when they grow, and that's when I've grown as well. If you're willing to let people fail a little bit, you're going to have a great organization — not that people have failed in a big way, but in little ways.

**Q: What stumbling blocks have made your leadership stronger over the years?**

**GN:** I think probably when I've learned the most is when I failed to make a hard decision that needed to be made in a timely basis. When you're dealing with people and dealing with people's lives, it's hard to make difficult decisions. In reality, to guide an organization of this size, 40,000 associates, you have to make hard decisions sometimes. When I've failed to make difficult decisions, typically it comes back worse. I've learned a lot over the years to deal with difficult situations, and the best way is to hit them head on.

When a new leader comes into an organization, some approach it from the standpoint, “I'm going to bring my team together.” Frankly, when I came to [Health Management], it had some very talented people that were underutilized, and there were others where it was more appropriate they move on to other opportunities. I learned to surround myself with great people here but also have been able to develop people that previously didn't have the opportunities to grow and develop.

**Q: You were named CEO at Health Management a little more than three years ago. What things have you learned in those three-plus years that you didn't realize would be issues going into the job?**

**GN:** In healthcare, I've been exposed to a lot from a management standpoint. One of the things that became very apparent to me that I've learned over time was how to tap into the talent of a very experienced board of directors. It is filled with an array of people with tremendous healthcare and business experience. You must tap into those individuals and use them because they are there and want to help and have valuable insight from a leadership standpoint. I have enjoyed getting to know my board of directors and tapping into their talent.

One of the things that healthcare is noted for, on the clinical side, is that we've always been very innovative in terms of technology and other things, but on the business side of health, I feel we haven't been very innovative. It's been the same structures, same type of focus, and we need to step it up from an innovation standpoint and have innovative people, people from outside of healthcare. For example, using the data and analytics that we have in healthcare, we found out in 2010 that [Health Management] has 3.5 million patient contacts annually. If you think of the data layered in below that, it's just millions of data points that have critical value for running our business. I don't think our business has ever tapped into that, and we've been able to pull out some things that we didn't know we did well for some of these years. Data analytics have helped us on the revenue cycle side, the marketing side — and we can use analytics going forward as other aspects of the [Patient Protection and Affordable Care Act] are being implemented. Bringing people in that understand that data was very important for us.

**Q: Since Health Management is a for-profit hospital operator, are there certain things that are harder to manage than non-profit hospitals? Do you have any examples?**

**GN:** It's quite interesting. My whole career has been on the investor-owned side, so I can't really speak for the not-for-profit side. But I think this is true for not-for-profits and a lot of industries: How you manage short-term expectations and long-term success and growth. That's a dynamic that is sometimes the most challenging for us from the investor-owned side. There are certain short-term expectations we have, and it's important for us to also see where we're going to be down the road. In healthcare, there are certain expectations in terms of same-hospital growth, financial performance, which we've done very well, and it makes it easier when you're performing well on a short-term basis to plan long-term as well.

For example, we're in an era where a lot of hospitals are struggling. They can't handle the rapid pace of change, the complexities associated with the [Patient Protection and Affordable Care Act]. We have not-for-profit partners that aren't able to tap into cheap money, so they can't invest. What it's done for us is we continue to invest in all of the fundamental things that have allowed us to expand our footprint in the marketplace. We've been able to develop great partnerships with not-for-profit partners out there. For example, the Shands hospitals here in Florida: We have a joint venture with three hospitals, and this is recognizing where we have core competencies in running a community hospital. We also just recently announced a letter of intent with Integris Health in Oklahoma. Integris is by far the leading provider of healthcare in the state of Oklahoma. Great performance, great quality. And here's a situation where they have community hospitals, and we're partnering with five of them as majority owners. That, to me, is the long-term opportunity for organizations that have the cultural mindset to be able to partner, and we feel like we have that culture.

We have great results from our partners, and not just on the business side. On the clinical side, we have stroke centers, chest pain centers, and I'm pretty excited about that going forward. It's all about putting process and discipline into what we do, and it all goes back to having people who are innovative and who are thought leaders. And my job is to let them do what they do best.

**Q: What projects or goals are you and Health Management most excited about for 2012?**

**GN:** We're focused on developing and spreading our footprint in the marketplace, and a big part of that is having the right network of physicians. And another one of the most important aspects of any hospital is the emergency room. By far, most admissions, patient contacts, family contacts and physician contacts all surround the ER, and we have to have the environment and experiences in our ERs that will set us apart in the marketplace. You can tie that in with our physician development and marketplace development.

We also will be looking into surgery centers, diagnostic labs, and the key to all that is the physician network and primary care. When you are becoming a place where associates want to work, where patients want to come and where physicians will want to work, you are doing the right things. Health Management has really great people at all levels, and our hospitals and the people at the bedside are doing remarkable things.
10 Challenges Healthcare CEOs Can No Longer Ignore

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

Healthcare presents a number of urgent challenges that executives can no longer afford to put off. I was considering what advice to give CEOs facing this brave new world when I heard a remarkable speech at the National Center for Healthcare Leadership’s annual event. Michael Dowling, the president and CEO of North Shore-Long Island Jewish Health System, made some incredibly prescient points upon receiving the NCHL’s Gail L. Warden Leadership Award.

Mr. Dowling believes we are at a historic crossroads in healthcare that demands not just run-of-the-mill courage, but truly gutsy action. What he said brought tears of recognition to my eyes. The following points incorporate some of his views with some of my own on dealing with a time of fast-paced change that, if you don’t watch out, will knock you off-balance.

1. Don’t live in denial. Healthcare leaders need to step up to the plate and cope with change. Mr. Dowling warned the industry is about to undergo significant change, and I couldn’t agree more. Undertaking a few changes here and there, he said, isn’t going to pass muster. Many of the changes we face will come through the Affordable Care Act — a law that faces many challenges, including a Supreme Court review next spring, followed by an election that could bring a new party into the White House and Senate. Faced with these unknowns, some healthcare leaders are simply not willing to undertake any change at all. They want to wait until they know exactly what new regulations under the law are going to be. They are, sadly, frozen in place.

This is a losing strategy. Whatever happens in the Supreme Court case or even if there is a new administration, many facets of the healthcare law are likely to stay in place. The wind of change is frozen in place. The culture of the institution, whether in the non-profit or for-profit sector, won’t be free from. It is up to the CEO to break the silos down. The culture of the institution, whether in the non-profit or for-profit sector, won’t be enough. This kind of work requires an extraordinary effort. It involves persuading everyone to embrace the mission and vision of the organization, as set by the CEO. You might start by putting up a sign that says, “No silos here!”

2. Take risk and make it your friend. A hospital CEO has to take chances. Great leaders make mistakes and you probably will, too, but it won’t be the end of the road for you or your institution. We’ve all gambled at some point in our careers. Of course, make sure when you take risks you have as much data at your disposal as possible. You want the percentages to work in your favor. But great leaders do not succeed by shying away from risk, and they can’t be afraid to make changes, when necessary. Mr. Dowling argued that some CEOs will have to start all over again, turning their organizations upside down, if necessary. I wonder how many CEOs would have the courage to pull it off. Your watchword should be: “Learn to cope with change.”

3. Break down the silos. No organization can function properly unless everyone is on the same wavelength. It’s easy to stay in your own silo, where we can deal with people just like you, in your own comfort zone. But this won’t move an organization forward. A football team or any kind of sports team has no chance of winning if each member goes off in his or her own direction. The silo mentality is very powerful and hard to break free from. It is up to the CEO to break the silos down. The culture of the institution, whether in the non-profit or for-profit sector, won’t be enough. This kind of work requires an extraordinary effort. It involves persuading everyone to embrace the mission and vision of the organization, as set by the CEO. You might start by putting up a sign that says, “No silos here!”

4. Behave like a CEO. It is up to you to set the tone and the culture of the organization you are leading. That takes intestinal fortitude and a great deal of transparency. Tell everyone in the organization what you intend to do and why you feel it is in their best interests. That sounds rational enough, but many leaders let others take charge while they busy themselves with other matters both inside or outside the campus. Too many CEOs forget the main mission of any hospital or hospital system is to take care of people and make them well. In many cases, this is why they chose the field of healthcare.

5. Treat patients as customers. A lot of people in healthcare are still allergic to seeing patients as customers. Caught up in old-fashioned ways of thinking, they continue to believe healthcare is somehow different from a business. The fact is that when you are ill, you want to be treated with dignity and respect, just like a customer is treated. Too many times, patients are treated like an afterthought and not the main purpose of the institution. All patients should be accorded first-rate service no matter what their station in life. They are human beings who came to your organization for comfort, relief and healing. Customers are the lifeblood of any business. Whether or not we like to think so, what we do is a business. We should all accept that fact.

6. Communicate with everybody. Communicating doesn’t just mean talking to people in the C-suite; it means reaching out to every last person in the institution and keeping in mind every last patient who comes through. Follow the lead of other industries that have learned the art of keeping customers and employees engaged by making sure each patient and each employee is fully informed about everything that affects them. Be honest and forthright with information and let people know what is going on. Secrets, innuendos and muddled communications should be stopped immediately. These channels, though unofficial and unauthorized, can destroy the organization if allowed to flourish. Inspire your people by letting them know how proud you are to be serving them and how you are going to make the hospital the best it can be.

7. Tolerate dissent. Embrace those who would disagree with you. Make sure they know what you are trying to do and how you intend to carry out your strategic plan. Quite often, people who disagree with you simply need to be better informed about what you are trying to do. When you explain yourself to people, it disarms them. Sometimes even your most stalwart opponents become your strongest allies. Always be willing and open to those who oppose what you are trying to do. Make sure they are, if anything, over-informed on matters so they can never say you hid your plans from them.

Having a well functioning workforce means setting your people free. Build strong teams and turn them loose to do their jobs. Mr. Dowling said a true leader understands that without quality people dedicated to the mission of the organization, the goals that have been staked out will never be met.

8. Always be visible. Great leaders never shirk from being visible. Too many CEOs think they should stay in their offices. In fact, they should be doing the exact opposite. The real
Patient Engagement’s Critical Role in Post-Reform Success: 6 Steps to Improve Patient Centeredness

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

As hospitals and health systems grapple with the changes brought on by healthcare reform and other efforts toward healthcare delivery transformation, they may understandably become overwhelmed — a similar feeling our patients may experience when facing a chronic illness or new diagnosis. For health systems, success under our soon-to-be value-based delivery system will require strategic analysis, informed decision-making and careful execution. The same can be said for the processes we use to engage our patients in their own care.

Patient engagement, or the efforts we take to get patients involved in all aspects of their care both within and outside our facilities and physician offices, is more than a nice thing to do. Engaged patients are more likely to comply with their treatment and prevention plans, which results in higher quality care, fewer medical errors and lower cost. If you think about the key goals of the healthcare reform law, improved patient engagement across a population requires more sophisticated efforts. At Mercy, we’re using the following six steps to drive patient engagement, an effort we believe will position us well for both value-based reimbursement and population health management.

1. Expand access. The first step to improving patient experience is to increase their access to care. The most obvious example of this is extended office hours, including early morning, evening and weekend hours. But, access goes beyond that. Increasingly, patients crave electronic, asynchronous ways to communicate with healthcare providers. Earlier this year, a survey by Intuit found that up to 73 percent of Americans were interested in using a patient portal for a variety of physician communications, such as requesting new prescriptions and obtaining lab results. At Mercy, we now offer an interactive patient portal where patients can access health information, make appointments, request refills and email physicians and their staff with questions. We want to offer patients a way to engage with physicians, even if their physicians aren’t physically available at the time they have a question. Our belief is anything we can do to enhance two-way communication improves the likelihood a patient will get engaged.

2. Identify patients to engage. Identifying patients can be very simple when the patient is sitting in front of you or calling to request services, but healthcare reform requires providers to get less compliant patients engaged in their care. Under new models, we can’t wait for patients to make the first move; we have to proactively identify patients who are at risk for not getting care and reach out to them. Doing this is the focus for the patient-centered medical home model and for population management within a clinically integrated system. Going forward at Mercy, for example, we can use our system-wide EHR to identify which of our diabetic patients are lacking standards of care such as hemoglobin A1c testing. Then, using a variety of communication options, including our patient portal, we can work to engage patients in our developing patient-centered medical homes.

3. Assess patients’ ability to engage. Patients’ ability to engage in and self-manage healthcare varies greatly, and clinicians need to assess what obstacles may impact a patient’s engagement as they develop the care plan. For example, a college professor with newly diagnosed diabetes may engage well with a physician-recommended book about diabetes management. However, a patient with a less scholarly personality, perhaps not having graduated from high school, has a lower likelihood of following through on that recommendation. Instead, this
Assessing Leadership in the New Era of Healthcare Delivery: 5 Key Questions to Ask
By Lindsey Dunn

Hospital and health system leaders today face myriad challenges unique to the current healthcare environment that are often more demanding than the challenges faced by leaders of the past. Ten or 15 years ago, healthcare leaders were primarily judged by the operating margins of the facilities they oversaw, and hospitals were less frequently judged by their performance against various clinical and quality performance measures, says Quint Studer, founder of Studer Group. Today, hospital senior executives are juggling a handful or more overall organizational goals, and increased transparency means poor performance is identified and dealt with more quickly.

In order to be as prepared as possible for the obstacles they’ll face, healthcare leaders should assess their capabilities as a leader by asking themselves the following five questions, which reflect key behaviors of successful healthcare leaders.

1. **How well am I able to align the organization toward common goals?** Healthcare executives must be able to set strategy and goals for the organization and then ensure they are executed, which means aligning each and every employee in the organization toward meeting those goals. To successfully align employees, Mr. Studer says leaders should connect desired outcomes to the organization’s values. “If we can connect values to desired outcomes, then it becomes too uncomfortable for employees not to meet the goals,” he says.

Leaders can increase the likelihood of driving the behavioral changes required to meet these goals by explaining the “why” behind the change. “Healthcare employees aren’t robots — nor do you want them to be — who will do some action just because a healthcare leader asks them to,” says Mr. Studer. “They're

5. **Set appropriate goals.** Next, the care team, which includes the physicians, other providers and most importantly the patient, needs to agree on goals. The goals must be measurable and should be achievable, which may mean giving the patient smaller steps. For example, a patient with an A1c level of 14 percent is far off from the 6-7 percent goal that some number in between would be a more achievable starting goal over a defined period of time. When treating patients with multiple comorbidities, the care team should set priority goals. Listing every recommended goal for every condition can be overwhelming and result in patient disengagement.

6. **Establish follow-up protocol.** Finally, the care team must establish protocols to monitor patients’ progress and to maintain engagement. If a treatment regimen is not working as expected, the regimen should be reconsidered but patient engagement, including ability to adhere to the regimen, should also be reassessed. If there is suspicion the patient isn’t engaged in the care, clinicians should back up and restart the steps described here, paying special attention to the assessment of the patient’s ability to engage in self-management of care. Maybe the patient didn’t understand the importance of taking the medication; maybe he or she couldn’t afford it. They key for providers is to cultivate open communication so that our patients feel comfortable sharing these issues with us so we can better personalize their care.

**Rule of thumb**
While each of these six steps are important, they all boil down to a simple guideline: Offer care that provides the highest quality outcomes at the best value and remember to engage the patient at every step. To encourage compliance and deeper engagement, encourage two-way communication and engage patients with providers at all levels, giving the patient even more connection points for their care.

Kenneth Bertka, MD, is a family physician and vice president of physician clinical integration at Mercy, a seven hospital and physician group system based in Toledo, Ohio. Mercy is a member of Catholic Health Partners, the largest healthcare system in Ohio.
smart people; I find most people will adjust behavior or repeat desired behaviors if you explain why the change will help the organization [meet its goals].” For example, nurses that are asked to perform hourly rounds on patients may question the new requirement at first but are likely to become advocates of the change if they learn it improves patient satisfaction scores and are reminded increasing these scores by a certain percent is a core goal for the hospital.

2. Do all employees in my organization have the same urgency toward meeting these goals? While aligning the organization toward goals builds a strong foundation for organizational success, the best healthcare leaders don't stop there. They also ensure all employees have the same urgency as the senior leadership team, says Mr. Studer. “Many senior leaders assume employees see the world in the same way they do,” he says. However, that's often not the case. A recent survey by Studer Group found that 31 percent of front line managers believed that if the organization kept operating the same way it is currently, it would stay the same, be better or much better. This is at odds with senior healthcare leaders, many who understand staying the same is likely to spell disaster for a hospital.

“Leaders need to explain the environment to provide the right amount of urgency. The goal isn’t to paralyze [employees], but to get everyone working at the pace needed to achieve goals in the right amount of time and get the organization where it needs to go,” says Mr. Studer.

3. Are the organization’s goals cascaded down throughout every level of the organization and incorporated into every employee’s individual performance measures? In addition to communicating organizational goals and driving alignment through more macro-level communication, healthcare leaders also need to ensure each employee understands his or her specific role in meeting the organization’s goals. This means larger institutional goals should be cascaded down into individual employee performance measures. For example, a hospital with a goal of decreasing admit times might require its housekeeping staff report to a room within a certain agreed-upon timeframe after a patient is discharged to turn the room over. Employees who fall short on performance measures should be provided with training, resources and other development opportunities to enhance their skill sets. “If someone is not meeting goals, it’s normally not for a lack of trying or passion,” says Mr. Studer. “It’s more a lack of skills.”

Mr. Studer also recommends performance measures for mid- and senior-level healthcare leaders assess performance against standardized “leadership” behaviors, such as performing weekly rounding on departments the leader oversees, which can help keep alignment in check. He also says senior-level leaders need to be very careful about the behaviors they’re modeling. “If I’m not passionate, I bet the people below me won’t be passionate. If I’m not confident we can solve an issue, the issue probably won’t get solved,” he says.

4. Am I adequately mentoring and developing colleagues and others for future healthcare leadership? Development and mentoring cannot be relegated just to the human resources or organization development department, says Mr. Studer. Instead, the best healthcare leaders take an active role in mentoring others within and outside their organization. He shares the following example to illustrate how many leaders have fallen short in mentoring: Senior leaders rank their ability on various leadership skills, such as running a meeting effectively or hiring appropriate candidates, very highly, while the leaders rate those they manage lower and lower as they move down the hierarchy. “Leaders need to ask, ‘Why I haven’t developed the person below me to run a good meeting or hire well?’” he said.

Mr. Studer also recommends healthcare leaders reach out to local healthcare management graduate programs and the Association of University Programs in Health Administration, which he says are always eager for professional contacts and feedback on which skills are most valuable to the students’ future employers.

5. To what extent have I helped the organization achieve its desired outcomes? Most importantly, leaders should assess their ability to ensure the organization meets its strategic goals, an idea Mr. Studer borrows from Jim Collins, author of “Good to Great.” The book describes the highest level of leadership, referred to as a Level 5 leader, who are those leaders that achieve the desired outcomes of the organization. “Leaders should really take this personally,” says Mr. Studer. He encourages leaders to relentlessly pursue organizational goals and refuse to accept pushback from those within the organization who aren’t making the goals a priority.

How to improve

Leaders who are concerned about their answers to the above questions should begin by developing the core skills that are needed to reach these outcomes, such as communication skills, business and financial skills and knowledge of the healthcare environment, by assessing where they are now and identifying one or two core skills to address first. “You can’t do all at one time,” says Mr. Studer. “Pick one or two at a time. For example, if you really focus on communication, that ties in with a lot of issues.” The American College of Healthcare Executives publishes a competencies assessment for healthcare executives that can serve as a good starting point to help leaders decide which areas to target first. It can be downloaded at www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

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CMS to Invest Up to $1B for New Healthcare Delivery, Payment Models

By Molly Gamble

The Centers for Medicare and Medicaid Innovation has launched its Innovation Challenge — a new initiative that will provide as much as $30 million to each of 100 applicants who present new ideas for healthcare delivery and payment models, according to the CMS website.

The challenge is meant to support applicants who will implement the most compelling new ideas to improve care and lower costs for Medicare, Medicaid and Children’s Health Insurance Program.

In a blog post on the White House website, then CMS Administrator Donald Berwick, MD, said the “initiative will invest up to $1 billion in the best projects that [physicians], hospitals, and other innovators propose to deliver high-quality medical care and save money. Projects that win this competition will use healthcare dollars more wisely, help create jobs, and help professionals improve the work they do for patients,” according to the post.

Awards will range from approximately $1 million-$30 million for a three-year period. Providers, payors, local governments, public-private partnerships and multi-payor collaboratives can apply to participate. Potential applicants were required to submit a letter of intent by Dec. 19, 2011.

Dr. Berwick provided an example of innovation in his blog post, citing “the use of personal and home care aides to help the elderly stay in their homes or expanding the use of community-based paramedics to provide basic services to individuals in rural communities,” as projects that can be up and running soon.

7 Ways to Improve Accountability for Care

By Dana Hage, MPH, and Eric R. Abrams, MBA, Numerof & Associates

One consequence of the Patient Protection and Affordable Care Act is that it has shown a spotlight on what’s missing in the current business model of healthcare: accountability — for coordination of care, for outcome measures that are more demanding and meaningful, for evidence-based, cost-effective decision making at all levels. In short, accountability for better care at lower cost.

The release of CMS’s rules on accountable care organizations has dampened enthusiasm for the concept, but it should not distract industry leaders from several underlying truths: 1) the current healthcare model is not delivering value consistent with its cost; 2) current costs are unsustainable; and 3) accountable care is an important part of the solution, with or without an ACO structure.

Accountable care can be achieved through any care model that incentivizes providers to improve quality and efficiency of care. An ACO, as loosely defined in the legislation, is only one organizational construct which theoretically could help organizations increase accountability. It certainly is not the only approach to achieving the objective of better outcomes at lower cost.

Any provider can provide more accountable care

Nothing is (or ever has been) keeping any provider from creating more accountable care. Whether or not an ACO structure is an effective means to achieve this end is irrelevant. Rather than focus on restructuring, organizations should really be thinking about how to ensure they are providing accountability.

With or without an ACO, here’s what it takes to provide more accountability:

1. Establish process metrics. (e.g., costs by procedure, patient cycle time to key behavioral milestones). Use this data real time to manage cost and outcome variability and to identify opportunities to improve efficiency.

2. Establish quality and outcome metrics. Use this data to manage variability as well as to improve quality and outcomes.

3. Explore new reimbursement models. Traditional payment methods create little incentive to increase accountability, making improvements in cost and quality difficult. Alternatives, such as bundled pricing, have been introduced in an effort to create shared financial incentives that encourage providers to improve collaboration, integration and — as a result — accountability across the healthcare continuum.

4. Develop predictive care paths. Mapping out your process for delivering care is essential to promoting collaboration and accountability, managing variability and improving clinical practice across your organization.

5. Develop competencies and incentives that support increased accountability. Providing guidance in process improvement and change management can enable clinicians to be more effective in monitoring, evaluating and improving outcomes while controlling costs. Establishing performance expectations and incentives will encourage greater ownership.

6. Use evidence-based medicine. While achieving behavioral change can be difficult, incorporation of evidence-based practices can support the objective of achieving better outcomes at lower cost. Additionally, external research can serve as a benchmark for your organization’s improvement efforts.

7. Take steps to facilitate provider coordination. Your organization should be a vehicle for effective, efficient and transparent provider collaboration. Developing the IT and system integration capabilities to implement a uniform EHR system will allow providers to communicate with each other seamlessly. These steps are not easy to operationalize. They require an integrated effort and shared accountability between administrative and clinical leaders. They also require organizations to set cost and quality of care goals that go hand-in-hand. They cannot be segregated and addressed independently. All decisions in the care model have to be in the dual context of the economic and clinical value that would result. Accountable care is about improving this dual value proposition.

What are you waiting for?

As we’ve suggested, there isn’t anything holding your organization back. There is, though, a rare market opportunity to seize the initiative and deliver more accountable care. Improving accountability will differentiate your organization in an increasingly competitive market in which cost and quality outcomes are growing more critical to success.

Dana Hage, MPH, is a business analyst, and Eric Abrams, MBA, is a consultant at Numerof & Associates, Inc. N+A is a strategic management consulting firm focused on organizations in dynamic, rapidly changing industries.
While 2012 may appear to be a grim time for hospitals to keep their finances positive, there are several things hospitals can do to go beyond just maintaining solvency. Hospitals and health systems essentially have two options: They can either cut costs or create new revenue streams. Here, several healthcare leaders share their thoughts on how this can be done and offer one recurring theme: Hospital and healthcare leadership needs to evaluate a multitude of planes rather than relying only on across-the-board savings cuts.

1. Focus on the continuum of care. One of the biggest changes occurring in healthcare is the full-scale shift away from fee-for-service and volume-based measures toward accountable care organizations and quality-based measures. Ann Pumpian, CFO of Sharp Healthcare in San Diego, says hospitals will need to look at the entire continuum of care, regardless if they join an ACO, if they plan to stay profitable in 2012 and beyond. She says the continuum of care hospitals need to focus on includes the initial admission, how services are provided within that admission to create the most efficient process for a quick yet appropriate discharge, a discharge to the appropriate post-acute setting and follow-ups with that discharge.

Ms. Pumpian also emphasizes the hospital-physician relationship. Although some states prohibit hospitals from employing physicians — especially primary care physicians. In addition to quality- and value-based principles, healthcare reform is also centered on preventative care, managing chronic illnesses and keeping people healthy before a hospital trip is required. To do that while staying profitable, Mr. Talbert says hospitals must focus on physician alignment and actively engage with the primary care physicians in their communities. “The primary care physician is the air traffic controller for the patient,” he says.

2. Design models to reduce readmissions. Hospitals that realign their goals toward the entire continuum of care can then focus on one of the more pertinent aspects: reducing readmissions. Readmissions negatively impact a hospital’s bottom line in several ways, such as the high costs associated with them and scrutiny from private health insurers and patients. Now part of President Barack Obama’s healthcare reform, hospitals with high levels of preventable readmissions face the potential of losing a portion of their Medicare, Medicaid or other governmental reimbursements. “If [other hospitals] are not gearing up for that now, they are really behind the eight-ball,” Ms. Pumpian says. “They should’ve been doing this years ago.”

She says there are several ways hospitals and their physicians can effectively reduce their readmissions, such as ensuring patients attend post-acute office visits routinely after discharge and overall providing resources to people to ensure they are taking the proper post-discharge steps. “This has proven to be a key indicator to keep readmissions from occurring,” Ms. Pumpian adds.

3. Have a good relationship with payors, and renegotiate managed care contracts. While hospitals cannot control the under-payments from Medicare, Medicaid and other governmental payors, they have a semblance of control over one major outlet: commercial and employer-based payors. Mr. Talbert says private insurance carriers comprise, on average, 35 percent of a hospital’s revenue.

According to Kyle Kobe, principal at healthcare consulting firm Equation, hospitals must take the time to understand existing contracts, benchmark managed care contracts against each other, conduct research to know what percentage of the insurer’s business comes from the hospital, routinely update stagnant and evergreen contracts and look for carve-out opportunities. Hospitals and their managed care departments must be prepared when renegotiating contracts, but at the same time, a level of respectful dialogue must exist — otherwise, fallouts will occur, leading to costly periods of no reimbursement and a public relations nightmare. “Often times, people don’t think about the fact there is a mutual respect that needs to occur with the payor and institution,” Ms. Pumpian says. “That is earned over time in a manner that allows you to help collaborate, design and develop the care delivery models and product designs that those payors will ultimately use.”

4. Manage new service lines to increase market share. When it comes to “creating new streams of revenue” for hospitals, this most commonly refers to adding new service lines. Larry Moore, CFO of Cumberland Medical Center in Crossville, Tenn., agrees increasing market share through new services is the most effective way to deal with any reduction in net payments.

Hospitals should not merely add any service line — for example, orthopedics — because it is historically profitable. Mr. Moore says hospitals need to conduct research and look at the demographics of their locale to determine which service lines are needed, what competitors in the area offer and what services stand to gain the most referrals. For example, roughly 10,000 baby boomers are becoming eligible for Medicare every day, and Mr. Moore says Cumberland, which has a high Medicare population, has been focusing on cardiovascular services. Additionally, he says the surrounding population tends to have a higher concentration of obese patients, and therefore Cumberland is also focusing on enhancing its orthopedic service line.

Conversely, if hospitals want to become or remain profitable next year, they will have to monitor their service lines to see if any are hemorrhaging money. Jack Lahidjani, president of Mission Community Hospital in Panorama City, Calif., says this is especially important for community hospitals, as community hospitals can’t be the healthcare provider for all. “Most community hos-
Hospitals don't create a differentiation between themselves and a tertiary facility or a teaching facility,” Mr. Lahidjani says. “We can't have the same number of programs as a Cedars-Sinai. They can afford to lose money on 10 to 15 programs because they are making money on the other 80. We need to evaluate every program on a quarterly basis and make adjustments accordingly. Hospitals need to be aware of community needs and cater to those needs.”

5. Control labor costs with meticulous data collecting. At most hospitals, more than 50 percent of expenses are related to labor costs or labor-related costs, and Mr. Lahidjani says “if you can't control your labor costs, working on anything else almost becomes immaterial.”

Mr. Lahidjani, who also used to be CEO of the physician-owned and Los Angeles-based Miracle Mile Medical Center and CFO of Los Angeles-based Alta Healthcare System, says his hospitals hold daily “labor control meetings” for 10 minutes. Every department shows up, goes over their respective staffing metrics and manages their labor on a dollar-per-patient-day level. “If we are overstaffed by one nurse in surgery and understaffed by one nurse in the emergency room, can we move the surgical nurse to the ER?” Mr. Lahidjani says. “This type of communication where every manager and operator in the hospital gets on the same page also creates awareness of what's going on in the other parts of the hospital.”

If hospitals do not manage their labor costs or have staff meetings on their labor rolls every day, then he says hospitals should, at the very least, be data-driven on this front on a bi-weekly, monthly, quarterly and annual basis.

6. Reduce supply costs by working with vendors and physicians. After labor costs, supply costs are the second-largest money eater of a hospital's operating budget. Clark Lagemann, vice president of HealthOptions Worldwide, says hospital leaders can reduce supply costs through two main ways: working with vendors to improve contracts and encouraging physicians to make fiscally responsible supply decisions. “A hospital should not shy away from approaching vendors for discounts,” Mr. Lagemann says. “This may help alleviate costs on the purchase product, and in my experience, most vendors are willing to negotiate if the volume of product allows for it.” Additionally, approaching physicians and working together to create a more cost-conscious supply plan for every department can help foster a better working relationship with physicians in addition to supply savings.

7. Improve deficiencies in the emergency room and operating room. Many hospitals consider their ERs and ORs to be two of the most important areas of a hospital because they represent a traditional “money loser” and a traditional “money winner.”

ERs and trauma areas are vital to any community health system, but hospitals have been facing growing numbers of uninsured patients walking into their ERs. This is leading to high amounts of uncompensated care. However, there are ways hospitals can reduce the large costs and pressures associated with the ER and its high volume of uncompensated care. Phil Lebherz, executive director of the non-profit Foundation for Health Coverage Education, says hospitals must actively use the ER to their advantage, as roughly 80 percent of the uninsured patients who come into the ER are eligible for some type of publically funded program. He says hospitals should make it a priority to help ER patients complete applications for publicly funded health coverage like Medicaid. This could make patients more willing to seek preventive care instead of resorting to last-minute, much-needed and highly expensive ER treatment, and it will also directly reduce a hospital's uncompensated care and bad debt.

A hospital's OR is typically one of the most profitable areas of a hospital due to the type of surgeries performed, and Mr. Lagemann says improvements in the OR can help a hospital maintain its levels of profitability. For example, he says future profits lie in new equipment, such as smart ORs and hybrid ORs. Mr. Lagemann adds that new technology, although an investment at first, can eventually lead to higher market share and patient volume, and it can also lower reoperation rates, which could improve reimbursements.

8. Create population health management programs to gather health data analytics on chronic illnesses. The ACO model, or at least its population-health emphasis, is shifting hospitals' thinking of how to be profitable. Mr. Talbert says hospitals are asking themselves if they are in the “healthcare” business or the “sick-care” business, and more often than not, he says they find they are in the “sick-care” business as they wait for patients to become sick before addressing health issues.

To counter this, Mr. Talbert says hospitals will need to create formal population health management programs through which the hospital can reach out and gather health data analytics on its local patients as a way to address potential health problems before they become costly, chronic issues. “If we are going to control costs of healthcare and start bending the curve downward, we have to start looking at things from the perspective of population health management,” he adds. If hospitals are able to see data and cost figures associated with chronic diseases — such as diabetes, cardiovascular disease, asthma, hypertension and others — they can reach out to their communities to start chronic care programs to mitigate costly, long-term health problems.

9. Consider outsourcing some services. Outsourcing services at hospitals is nothing new; but Mr. Lahidjani says eliminating the administrative overhead and farming out functions that are better handled on an independent contractor basis will directly result in bottom line savings. Laundry services, housekeeping, food services, facility maintenance and some biomedical and clinical departments are commonly outsourced services. Mr. Lahidjani says his hospital has also experimented with outsourcing its nurse education. Mission Community Hospital did not want to end its nurse education program, but it also did not know if it could continue to incur the program's operating costs. Currently, the outsourced company has individuals that show up two or three times a month to hold its nursing educational seminars. Mr. Lahidjani says their nurses are still getting quality “know-how,” but their expenses have since been lowered.

A hospital must be prudent when it decides to outsource a service, though, and it must have a contingency plan if the proposal does not work out. “Whenever you outsource a service, you need to be prepared to bring it back in case the relationship disintegrates or if the third party is not able to provide the level of service we expected or anticipated,” Ms. Pumplin says.

10. Revamp the energy cost strategy. “Going green” could be more than just a strategy that positively impacts the environment and reduces reliance on fossil fuels — it could also save on a hospital's bottom line.

Dennis Olson, vice president of facilities at Mayo Clinic Health System in Eau Claire, Wis., says the hospital system has been actively revamping its sustainability and energy cost strategies, and it’s led to significant results. One of the larger projects involves the use of geothermal energy at one of the health system’s dialysis centers under construction. Various pieces of equipment run through the ground and can extract heat or cooling from the natural ground water, which is typically around 45 to 50 degrees Fahrenheit. This extracted heating or cooling can be diverted to warm up the building in the winter and cool the building in the summer. He says a geothermal energy project is fairly expensive up front, but the benefits are in the long-term. Hospitals can expect a payback on its investment within seven to eight years, all while the hospital provides its own, truly natural energy: “You’re not burning any fuel to get heating and cooling sources such as natural gas or oil, and instead, you’re letting the Earth’s resources handle that,” Mr. Olson said.

For hospitals that are not quite ready to tackle a project as large as self-sustaining geothermal energy, Mr. Olson says there are smaller things hospitals can do in their energy savings strategies that can pay off immediately or within a couple years. Mayo Clinic Health System has installed automatic faucets to reduce water overuse, and it also has had low-flow waterless urinals for a year. Both of those smaller projects have cut their water bills significantly, he says. Motion sensors for lighting, shifting to LED lighting, vegetative roof gardens, mass-scale recycling efforts and several other small-scale initiatives can also give any hospital the ability to cut back on its energy costs as well as its BTUs per square foot.
Finances in the Era of Population Health: Q&A With Kevin Lang and Steve Mohr of Loma Linda University Medical Center

By Bob Herman

Loma Linda (Calif.) University Medical Center knows a thing or two about handling finances. In fiscal year 2010, it brought in more than $1.2 billion in total patient revenues and still maintained a net income of $33.9 million — all in a state that some say is experiencing a "healthcare affordability crisis."

Kevin Lang, executive vice president and corporate CFO of Loma Linda University Adventist Health Sciences, and Steve Mohr, senior vice president of finance and CFO of LLUMC, explain that handling the large load of hospital finances certainly has its challenges — but making the right changes during the coming era of accountable care and population health management are key to keeping a healthcare institution solvent.

Q: What are some of the major financial issues LLUMC is dealing with right now?

Steve Mohr: Medi-Cal, our Medicaid program, and Medicare are more than 50 percent of our business. Medi-Cal alone is in excess of 35 percent of the business at LLUMC, and unfortunately, LLUMC is significantly under-reimbursed for costs.

Kevin Lang: California, in terms of Medicaid hospital reimbursement, has the lowest reimbursement of all 50 states. That is documented.

SM: The Kaiser Family Foundation did an analysis of that, and we’re actually 51st, including the District of Columbia. That presents a huge challenge for us. One of the things we’ve had to do is cost shift. But with the current economic environment, that is becoming more and more difficult to do. We are getting squeezed from a revenue standpoint, and we have to look at our expenses very carefully.

KL: Another issue is California requires high earthquake standards in facilities. Our hospital was built in 1967, and it was going to cost too much money to retrofit it. Now we need to build new hospital to the tune of $800 million. There are two earthquake standards, one due in 2013 and one in 2030, and we plan to meet both codes by 2020. It appears [the state] will give us permission to meet the lower-level and higher-level codes by then.

Q: How does LLUMC plan to implement ICD-10?

SM: LLUMC has a legacy billing system which goes back 15 to 20 years, and to modify that system, the costs would be prohibitive. We are actually implementing the Epic system for both electronic health records and billing for our faculty practices and physicians. That is our primary plan right now.

Obviously, there is a significant amount of training that will be required. We will need almost 100 hours of training for each of our coders, which is extremely expensive. We’re definitely concerned. We started this in May of [2011], and the whole project will be implemented within 18 months.

Q: LLUMC is one of the highest grossing non-profit hospitals in the country. What is the pressure like to manage the billions of dollars in revenue that pass through every year?

SM: Our organization has gone through tough times in the past, changes in reimbursements. Being a non-profit, we’ve focused on our people. Kevin and I go home with 13,000 and 7,000 [employees of LLU] on our minds, making sure we are not only providing the highest level of care for our patients but also making sure employees who give their lives to our organizations are well cared for. The community is relying on us, but employees are relying on us as well.

Q: How can hospitals best navigate through the upcoming Medicare and Medicaid cuts, and what kind of initiatives are you taking on to ensure financial solvency and quality care?

KL: This is going to be a real challenge, and the biggest thing is the unknown. We have to prepare ourselves to be proactive on how we can deliver the best overall service in the most cost-effective way. The biggest thing we’ve taken on as an organization is that our physicians are consolidating into one faculty practice group. At the same time, we are focusing on the continuum of care to manage chronic disease. The way we view the future, accountAbility care organizations or what have you, will revolve around population management. Health systems put us in a position to manage populations. We are spending a lot of time to create the right structure and implement the right information systems to support it.

SM: An integrated health system provides a great opportunity to align incentives between the hospital and our physicians in our faculty practice plan. This will reduce overall costs but will increase our quality to our patients at the same time. But it is not easy to implement organizationally competing interests. Aligning those interests is challenging, but our organization is moving strongly in that direction.

We also wanted to reduce the number of [full-time equivalents], but we wanted a plan that was thoughtful of employees. We reduced 240 FTEs without any significant layoffs, saving $28 million on a year-over-year basis, and this was mostly done through attrition and retraining.

Q: What kind of advice would you give to CFOs of smaller hospitals during these fluctuating financial times?

KL: For small community hospitals, they need to be looking at where they can align with other hospitals in the future. I’m not talking about mergers, but just aligning and working together on population management. It is part of the [PPACA] initiative, so they must share information from a quality perspective. That’s a key for long-term success: who your partners are.

SM: Ramp up physician alignment and cost cutting. We hate to be the masters of the obvious, but it’s putting a new spin on old concepts.

KL: I want to add that hospitals need to be a low-cost provider; that’s essential. Quality cost-cutting initiatives are going to be key. Volume drives costs, and to be viable in the long term, the physician alignment and cost-saving initiatives are essential.
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As healthcare organizations continue to merge or acquire, some hospitals are taking a more flexible route and are becoming “strategic partners” to tackle challenges unleashed by healthcare reform.

Colloquially, a strategic partnership may stir ideas of loose affiliations or the simple exchange of best practices, since the arrangement is typically less aggressive than a full-on merger. These arrangements do not necessarily involve transactions affecting hospital governance, management or financial independence, but some hospitals may find this to be more malleable for their organizations in the onset of accountable and collaborative care.

**The benefits of a strategic partnership**

Strategic partnerships vary slightly from organization to organization, but they generally share a few common principles such as the sharing of electronic resources, clinical data, best practices and administrative services. Hospitals can trim costs incurred through duplicate services while extending their geographic reach and solidifying the continuum of care for patients. While collaborating on all of these fronts, however, the hospitals remain independent — one characteristic that makes the strategic partnership especially interesting.

Dan Marino, president and CEO of consulting firm Health Directions, says a strategic partnership can make a lot of sense. “I think it’s a good way to dip your toes in the water without getting wet,” says Mr. Marino. “A lot of health systems and hospitals have cultural implications. You’re not only dealing with a hospital’s leadership, but also with its medical staffs. In some cases, strategic partnerships are a great way for medical staffs to begin testing one another’s culture to see if something more can be aligned.”

**Health systems coupling in Washington**

In October, Renton, Wash.-based Providence Health & Services and Seattle-based Swedish Health Services announced plans for a particularly innovative strategic affiliation. Under the proposed deal, Swedish’s five hospitals will remain non-religious, and Providence’s 27 hospitals will keep their Catholic mission. The systems share the Epic electronic health records platform, which will allow them to join forces on population health management and drive the standardization of best practices.

“Over a year ago, we started considering structures that could respect the Catholic identity while respecting a non-religious relationship with Swedish. We think we came up with it,” says Swedish Health Services President and CEO Rod Hochman, MD. The proposed partnership is still in the early stages of regulatory review.

Shortly after that relationship was announced, two other providers in Washington state also formed a strategic partnership to collaborate on patient care and trim the costs of duplicative services. Virginia Mason Medical Center in Seattle and Kirkland, Wash.-based Evergreen Healthcare have initially identified two areas of immediate collaboration — cardiac services and home care and hospice — and are developing frameworks for future joint efforts. Officials from both systems said the arrangement made sense due to the organizations’ like-minded nature.
Like-minded and complementary partnerships

What makes the proposed Providence-Swedish partnership groundbreaking is the preservation of their respective identities and religious affiliations. The two systems aren’t quite unlike partners, but they certainly have different cultures. Religious and non-religious organizations typically face numerous challenges when it comes to affiliations — either in attaining approval from regulatory agencies or religious authorities. Nonetheless, Providence and Swedish have set out to break the mold.

Mr. Marino says this strategy of pairing complementary institutions is an intelligent move for hospitals today. “It makes sense to strategically partner with a group that has complementary services. For example, if you’re an acute-care hospital, it makes sense to partner with a children’s hospital,” says Mr. Marino. These types of relationships can increase accessibility for patients and help hospitals achieve more sophisticated physician alignment, and Mr. Marino predicts we’ll see more of them in the next few years as providers aim to form ties to improve population health.

Shared EHRs enable big cost-savings

Mike Butler, COO with Providence, expects the proposed partnership to trim costs on the clinical and administrative side. Through the consolidation of certain services, like billing or human resources, the systems can find additional savings and leaner operations. Additionally, Providence and Swedish hospitals may standardize treatments for certain conditions, such as breast cancer, and exchange clinical best practices to trim unnecessary costs.

Those clinical savings will largely be the result of the systems’ shared EHR — one of the largest drivers to cost-savings. A shared EHR platform can be a huge partnership asset by enabling both parties to access the same clinical data and patient histories. “Technical infrastructure is becoming more critical,” says Mr. Marino. “In a lot of areas, you’re seeing community hospitals that can’t necessarily afford to buy IT infrastructure. So they look to a larger hospital so [they] don’t have to build it all from scratch,” says Mr. Marino.

EHR platforms can make or break a partnership, and officials from Providence and Swedish said health IT was a very significant factor in their pursuit for a partner. “Large health systems need to become [information-rich] organizations. The strength of a hospital’s ability to compete in the future will be based on health information,” says Dr. Hochman.

“World-class” partnerships

Partnerships centered around specific service lines can be an impetus for hospitals aiming to develop centers of excellence. For instance, Saint Vincent Health Center in Erie, Pa., and Cleveland Clinic signed a letter of intent in Aug 2011 to join forces over cardiac and neurological services. These types of partnerships — with extremely reputable institutions — make sense, according to John Ortiz, a partner at the executive services firm Tatum.

“If a hospital wants to bring a ‘world-class service’ to their community, then a strategic partnership with an organization considered ‘world-class’ can provide substantial benefit. As an example, there are now numerous hospitals throughout the country that have partnered with MD Anderson Cancer Institute in Houston to enhance their oncology programs and improve access to ‘world-class’ cancer treatment within their community,” he says.

Extending geographic reach

In partnerships, the factor of geography is not so much measured in the distance between headquarters but the harder-to-measure factor of market power. More hospital transactions — not just partnerships — are beginning to span state lines.

In October, Des Moines-based Iowa Health System and Peoria, Ill.-based Methodist Health Services finalized a strategic partnership.

IHS CEO Bill Leaver said Methodist was a natural strategic partner since Peoria is contiguous to one of the system’s markets in the Quad Cities. Under the deal, IHS committed to invest $175 million into strategic capital initiatives for Methodist. Methodist will keep its own board of directors and local leadership team, but the partnership still lets IHS spread its geographic reach to cover more people, according to Mr. Leaver.

Potential problems

While there are compelling benefits to strategic partnerships, the same characteristics that make the arrangement so attractive can also cause their downfall. Some experts think strategic partnerships can serve as a temporary solution to healthcare challenges, but the real, long-term cost savings can only be found in full-on acquisitions or mergers.

The arrangement also raises questions and concerns over governance. Van Conway, CEO of Detroit-based turnaround firm Conway MacKenzie, says it’s hard to imagine an organization excelling with two administrations. “If you have some type of marriage — call it a merger, partnership, acquisition, consolidation or combination — somebody has to be calling the shots.”

If hospitals do choose to pursue a dual-CEO model, it will take an enormous amount of planning and organization to delineate each leader’s responsibilities. “For example, one might focus on health-care services and one on the administrative side of business duties,” says Mr. Conway. “But there really can’t be two CEOs. Some multiple hospital chains have an executive in charge of each hospital, but there is one CEO of the entire system.”

Mr. Ortiz also says there’s a risk when hospitals come together to form a new, multi-hospital entity resembling a hospital system but lack a single leadership group to maintain accountability. “Numerous examples of this approach have failed miserably because of the competitive environment and ownership barriers that infringe on decision-making,” says Mr. Ortiz.

A Partnership That Breaks the Mold:
Q&A With Leaders From Washington’s Providence, Swedish Health

By Molly Gamble

In October, Wash.-based Providence Health & Services and Seattle-based Swedish Health Services announced plans to form one of the most unique healthcare partnerships of the year. Under the proposed deal, each organization will keep its respective name and identity and will continue to operate separately. The 27 hospitals under Providence will keep their Catholic mission, while Swedish’s five hospitals will remain non-religious. Donations made to the Swedish Foundation will only go to Swedish, donations made to Providence foundations will only go to Providence.

Swedish and Providence leaders said they had to think beyond the traditional merger or acquisition to strike this innovative arrangement. Here, Swedish Health Services President and CEO Rod Hochman, MD, and Providence Health Services COO Mike Butler discuss trends in hospital M&A, explain what drew their organizations together and offer advice to hospital leaders considering partnerships.

Q: There are plenty of flavors of hospital transactions — mergers, joint ventures, clinical affiliations, acquisitions and more. Why did a partnership model appeal to you and your organizations the most?

Mike Butler: We chose an affiliation because we felt it appealed to both parties. Our organizations have been serving the Puget Sound area for more than 100 years, and we felt we needed to honor our [respective] heritages. An affiliation also met the needs of our key stakeholders, as well as the Archbishop. It allows us to achieve greater affordability and patient access. This was some of the rationale for an affiliation.
Dr. Rod Hochman: As Mike said, what we looked for is what would fit for both of us. We wanted to be able to manage the organizations together. From our standpoint, that was extremely important. We’ll have one board for the organization, which will be combined with some of the Swedish board members. Whatever name you want to use, [the partnership] allows [a management team] to run the organization under one team concept. [Note: The affiliation is still in the early stages of regulatory review and is not yet final. The systems have not yet finalized the partnership’s proposed governance structure.]

Q: Under the proposed deal, Providence and Swedish will maintain their respective identities: Providence will remain Catholic, Swedish will keep its name and stay non-religious. That’s pretty unique in the world of healthcare transactions. Can you explain how you arrived at this strategic decision?

Dr. Hochman: I serve on the board at Catholic Healthcare West, so a lot of organizations are trying to look at how you [join] faith-based and non-faith based organizations and respect both identities. Over a year ago, we started considering structures that could respect the Catholic identity while respecting a non-religious relationship with Swedish. We think we came up with it. I think it provides a good opportunity for non-Catholic [hospitals] to join together in a well-integrated organization. There are lots of joint operating agreements, but [a partnership] allows them to come together for clinical care in a way that still respects the Catholic and non-Catholic nature of the institutions. As much as I’ve seen, [this is] groundbreaking.

Mr. Butler: We wanted to honor the heritage of both organizations. We’ve been in the state of Washington for more than 150 years, so we wanted to maintain our identity and maintain the Catholic identity on the Providence side. The affiliation will result in a combined vision through clinical and administrative best practices to improve access.

Q: What will be the benefits of this partnership?

Dr. Hochman: We want to lead with clinical transformation. We don’t believe we can achieve cost-effective care by traditional cost-cutting methods, like back office [cuts] or a few FTEs less here and there. That won’t make it where we see healthcare going. The clinical enterprises are where we see opportunity. If we can reduce variation over scale, that’s the way to reduce cost and really improve care. That’s why we’re doing this. That’s the most important part of this partnership.

Mr. Butler: Improved access, quality and cost. We think we can save significant amounts annually through developing clinical best practices and reducing administrative expenses, such as consolidating certain services like billing and human resources. We’ll both be on the Epic IT platform, allowing single medical records to be available for two or three million people.

Q: You’re still in the early stages of this deal, but what single piece of advice would you offer to other hospital CEOs if they pursue a partnership in the next year? What, from this deal so far, has made an impression on you?

Mr. Butler: A couple of things. First, it’s critical that both parties truly understand the business and economic environment we’re in. Secondly, be sure that senior leadership and governance are 100 percent aligned with details in combined strategies to meet challenges and survive in this economic environment. Leadership should be completely aligned on that.

Something that has probably left the biggest impression, or something I’ve been pleasantly pleased by, is the overall positive response by key stakeholders. They’re recognizing that we’re truly trying to improve costs and quality by coming together. There was a nice article in [the local] Everett Herald that really called that out. This is due in part to having real alignment and vision, but also being proactive in the development of a communication and public relations plan to share that vision.

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4 Common Mistakes in Determining Fair Market Value for Physician Compensation

By Jonathan Helm, AVA, Manager, VMG Health

Industry regulations require healthcare organizations to pay fair market value compensation to physicians for their services.[1] Due to the lack of a published set of standards that define a process to establish FMV for physician compensation, misconceptions of what determines and substantiates FMV are common in the market. The following provides a list of four common mistakes that VMG Health, a healthcare valuation firm and my company, has observed.

1. 90th percentile of survey data cannot be FMV. Conservative physician employers may cap total compensation paid through an employment agreement at the 90th percentile of reported survey data. This, however, does not mean that physician compensation at or in excess of the 90th percentile cannot be FMV. Metrics such as services provided, experience, total hours worked and production levels must be collectively considered. If a physician's hours and/or productivity are in excess of the 90th percentile of reported data, it may be reasonable and within FMV to pay compensation levels above the 90th percentile.

2. Relying on median survey data to establish FMV. Median compensation indicates that one-half of the respondents earned less than this rate. With this in mind, it may not be appropriate to rely on compensation at the median as a basis for FMV unless factors are present that support paying the physician a median rate. For example, if a physician is unproductive, has a higher than average expense profile or works less than 40 hours per week, the median may not technically be FMV. This logic is magnified if the 75th percentile is selected as a sole basis for FMV. Some factors to consider when choosing a FMV compensation percentile include productivity (i.e., charges, professional collections, work RVUs, encounters), payor mix, practice overhead, historical compensation, experience and hours worked.

3. Misapplying reported compensation per work RVU data. Productivity-based compensation models based on a dollar per work RVU are prevalent in the market. Often employers assume that if a physician's work RVU volume falls at a certain percentile, then the compensation per work RVU should be consistent with that percentile. This can easily turn into a total compensation payment that is well outside of a FMV range. For example, assume an employed electrophysiologist generates 21,330 work RVUs annually (MGMA 90th percentile[2]) and is paid $64.12 per work RVU (MGMA 90th percentile). This results in annual compensation paid of $1.37 million, which is 62 percent greater than the reported MGMA 90th percentile compensation for electrophysiologists ($844,141). The issue is clear: The physician would be earning much more than the 90th percentile for productivity that is only consistent with the 90th percentile.

4. Relying on one survey establishes FMV. Physician employers may develop an internal compensation plan that relies solely on one published survey. It is important to note there is regulatory guidance suggesting other sources should also be considered. Specifically, Stark law recommends that multiple, objective surveys are considered when determining the FMV of physician compensation:

“Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value.” [3]

Based on this guidance, the sole reliance on one survey alone may be scrutinized by healthcare regulators and may not provide sufficient support to determine FMV.

Footnotes:
[1] Industry regulations include the federal Stark law, Anti-Kickback law, and (for federal tax-exempt organizations) IRS regulations.

Jonathan Helm is a manager in the professional service agreements division of VMG Health, a national healthcare transaction and advisory firm in Dallas.
Delivering integrated care in the operating room will become increasingly important as hospitals work to improve quality and reduce costs. Anesthesiologists play a central role in OR care and have oversight of the entire perioperative experience: preoperative patient preparation, intraoperative care and post-operative care, including pain management. By creating more effective relationships with anesthesiologists, hospitals will see gains in patient care, efficiency, profitability and integrated service delivery.

**Current anesthesia models**

Current models of anesthesia service leave hospitals with one of two choices: outsource to a local group or national anesthesia management company, or directly employ anesthesia providers. While the first option gives hospitals access to skilled anesthesia services, the downside can be higher overhead and misaligned incentives. Having an outside group deliver anesthesia services “is a more challenging platform for integrated OR delivery,” says Howard Greenfield, MD, principal of management and consulting firm Enhance Healthcare.

In addition, an outsourced team often distances anesthesia providers from hospital administration. “When you outsource, you are introducing an intermediary between the hospital and the providers delivering a service,” says Robert Stiefel, MD, also a principal with Enhance Healthcare. “This can create a barrier to streamlined, efficient, affordable care in the OR. Outsourced groups have a business to run with their own objectives, processes, financial goals and internal margin and profit requirements.”

The second option — a directly employed anesthesia model — is currently used by approximately 13 percent of hospitals in an effort to reduce costs, eliminate the intermediary and control anesthesia policies, according to Dr. Greenfield. However, in many cases “hospitals lack experienced, professional anesthesia practice management resources,” he says.

**New anesthesia model**

Drs. Greenfield and Stiefel promote a new anesthesia co-management model they have created in which the hospital employs the anesthesiologists and engages a team of anesthesia management professionals who enhance the “in-sourced” arrangement. The model offers hospitals customized management support uniquely designed for the specialized fields of anesthesiology and OR management, they say. As anesthesiologists with extensive clinical and management experience, Drs. Greenfield and Stiefel have the ability to understand both sides of the complex relationship between the hospital and anesthesia providers. “With a co-managed anesthesia employment model, hospitals receive the best of both worlds — more control, lower expenditures and a long-term partnership assuring expert resources,” Dr. Stiefel says.

Drs. Greenfield and Stiefel share six key strategies they use to integrate the anesthesia group into the hospital surgical delivery system via their co-managed employment model.

1. **Support anesthesia leadership.** Proper anesthesia leadership in the OR is a key element of integrated delivery of care. Dr. Stiefel defines this as “healthcare professionals and supporting facilities working toward one goal: optimized patient care that is more efficient and cost effective.” Integrated care in the OR depends on the coordination of hospital administration, OR staff, surgeons and anesthesiologists. Anesthesia providers’ involvement in all aspects of the OR makes them prime candidates to oversee this coordination. Anesthesia providers are the most consistent component of the entire perioperative experience,” Dr. Stiefel says.

Dr. Greenfield echoes this sentiment: “A proactive anesthesia physician leader will help coordinate the entire perioperative process by effectively becoming the OR’s medical director. An anesthesia leader must possess excellent clinical skills as well as leadership skills to effectively work with all stakeholders — patients, administration, surgeons, OR nursing and anesthesiology peers.” They, however, need access to the tools, support and mentoring needed to define expectations, establish a culture of service and develop those anesthesia leaders.

2. **Align incentives.** Successfully integrated OR care is supported by incentives that are aligned with anesthesia providers. Metrics are important tools for hospitals to achieve this alignment in employed models. The metrics must be related to areas that anesthesiologists can directly affect: quality of care, OR throughput and customer service. By tying anesthesiologists’ performance to their compensation, hospitals will begin to realize greater OR performance. The strategy motivates employed anesthesiologists to work toward common stated goals. Linking compensation to meaningful performance metrics can help hospitals build “a more transparent, efficient and quality-focused system in the new healthcare reform era,” says Dr. Stiefel.

3. **Track metrics.** Gathering data on anesthesiologists’ performance is useful not only as a powerful incentive, but also in analyzing and developing proactive strategies to increase OR efficiency. “As the emphasis begins to shift to proof of quality, efficiency and quantifiable data, we have developed dashboards and methods to track anesthesia output and performance,” Dr. Stiefel says. Some useful metrics include pre-surgical patient evaluations, first case on-time starts, as well as patient and surgeon satisfaction.

4. **Encourage a customer service philosophy.** Successful anesthesia programs also identify customers and develop a customer service culture, say Drs. Greenfield and Stiefel. For all anesthesia groups, patient care is their priority, but surgeons, OR nursing and the hospital are direct customers. “In employed models, the goal is to align anesthesiology services with the expectations of key customers,” Dr. Stiefel says. This alignment helps the OR team deliver more integrated patient care.
Successful hospital-employed anesthesia programs incorporate procedures to ensure surgeons’ needs are met. Anesthesia providers perform this role in numerous ways by evaluating all patients prior to the day of surgery, ensuring timely first case starts, facilitating quick turnover and managing postoperative pain. “Not only is pain control important to surgeons, but it is also a metric which payors are increasingly linking to reimbursement,” says Dr. Stiefel. Additionally, clear communication about scheduling, patient care and other issues contribute to greater satisfaction among surgeons.

5. **Standardize processes.** Implementing standard policies is another way to establish and support a culture of customer service. By aligning processes with surgeons’ expectations, hospitals are better able to provide safe, high-quality care and streamlined workflows. “Hospitals need systems where anesthesia providers, surgeons, support staff and other professionals are all following an integrated playbook rather than functioning as independent parts. At a high level, this is what integrated care strives for, and anesthesia plays a central role,” Dr. Stiefel adds.

Drs. Greenfield and Stiefel say standardization is easier in a co-managed hospital-employed anesthesia group than in most other anesthesia contractual relationships. A co-managed model gives the hospital more direct control and the expertise to manage anesthesiologists effectively. In many outsourced vendor groups, individual physicians “do their own thing clinically and operationally, and may differ dramatically in their approach, which contradicts the objectives of integrated care,” according to Dr. Stiefel. In employed models, facilities should standardize many perioperative anesthesia processes in order to maximize performance on the day of surgery.

6. **Optimize business practices.** Currently, more than 80 percent of hospitals pay subsidies to support the anesthesia coverage they need, according to Drs. Greenfield and Stiefel. Drivers of these subsidies include inefficient anesthesia staffing models, a surplus of anesthesia locations, poor billing and collections practices and a lack fair-market-value compensation.

For hospitals seeking better ways to manage OR resources and performance, it is time to examine the delivery of anesthesia services to patients and surgeons. In the appropriately co-managed employment model, hospital executives and anesthesiologists can become powerful allies who, together, position the hospital for greater efficiency, improved patient care and higher profits.

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**25 Benchmarks for Anesthesiology Practices**

Here are 25 financial benchmarks for anesthesiology practices and groups.

**Anesthesiologist compensation**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average compensation, hospital-employed</td>
<td>$389,351</td>
</tr>
<tr>
<td>Average compensation, not hospital-employed</td>
<td>$407,292</td>
</tr>
</tbody>
</table>

*Source: Medical Group Management Association’s “Physician Compensation and Production Survey: 2011 Report Based on 2010 Data.”*

**Accounts receivable**

- **Total AR/physician**: $186,572
- **Total AR/provider**: $87,218


**Operating costs**

- **Total business operation staff**: $20,879
- **Total front office support staff**: $3,952
- **Total clinical support staff**: $9,490


Enhance Healthcare has created FOCUS, a new co-managed anesthesia employment model to help hospitals boost OR performance. Their seasoned team of anesthesia management professionals partner with hospital executives to transform the perioperative experience and set a new standard for integrated care delivery. To learn how Enhance Healthcare’s customized solutions can reinvigorate the most valuable profit center in your organization, contact info@EnhanceHC.com.
The FOCUS hospital employed anesthesia model creates a successful foundation for integrated surgical care.

The uncertainty that continues to cloud healthcare reform leaves hospital leaders with few definitive guidelines to frame the decision making process. One thing that is certain, healthcare insiders acknowledge that the key to future survival will depend on greater integration of delivery systems.

With regard to surgical services, integrated delivery includes a full spectrum from hospitals and OR information systems to surgeons, OR nurses and hospitalists. Due to the continuity of care they represent in the OR, anesthesiologists must play an essential role. Therefore, hospital executives will benefit by building upon a foundation of an aligned group of anesthesia service providers. Current outsourcing solutions, however, lack the accountability and adaptability necessary to achieve win-win results. Traditional outsourcing adds challenges to operating room success by creating a management layer between anesthesia service providers and hospital leadership (including conflicting goals and agendas) and can also divide members of the OR team.

Industry trends indicate that anesthesia supply/demand is beginning to equilibrate. Compensation has flattened. Providers are more plentiful. With the enterprise-wide imperative for greater integration, the time is ideal to create a new, more responsive anesthesia model.

FOCUS on anesthesia employment

While many hospitals currently employ or are considering employment of anesthesia providers to better integrate surgical service platforms, they often face challenges with the business management of anesthesia groups. Now, hospital leaders have access to anesthesia-specific expertise which will lead to optimized results and properly aligned incentives.

Enhance Healthcare is pleased to introduce the FOCUS Anesthesia Employment Program. This new model pairs our team of nationally-recognized anesthesia service experts with hospital executives to deliver cost effective, integrated delivery systems that enhance your bottom line. This is a unique system designed to help hospital leaders and anesthesiologists develop strategic partnerships that result in dependable quality, financial success and greater productivity.

Executive Brief: FOCUS on Co-Managed Anesthesia Employment

Enhance Healthcare has created FOCUS, a co-managed anesthesia employment model to help hospitals boost OR performance. A seasoned team led by anesthesiologists and Enhance Healthcare principals Howard Greenfield, MD and Robert Stiefel, MD, partner with hospital executives to transform the peri-operative experience, setting a new standard for integrated care delivery.

FOCUS on OR improvement

An employed physician process created with anesthesia and hospital integration in mind will create a solid foundation for OR success. Enhance Healthcare professionals partner with hospital executives to co-manage employed anesthesiologists to ensure your facility is strongly positioned for surgical volume gains. Let Enhance Healthcare help you create the optimal environment for OR performance and integrated surgical care. Contact info@EnhanceHC.com or visit www.EnhanceHC.com.

Maximize anesthesia revenue cycle

- Reduce anesthesia expenses
- Protocols for integrated care delivery
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- Support anesthesia group leadership
- Anesthesia specific policies and procedures
- Develop anesthesia specific standards
- Link compensation to performance
- Evidence based peri-operative protocols
- Customized anesthesia performance dashboards
- OR process improvement expertise
- “Right Size” your OR through efficiency measures
- Establish a framework for integrated delivery of surgical services
- Expand peri-operative focus on system wide efficiencies, customer satisfaction, and improved patient care
- Integrate reporting mechanisms, pricing strategies and quality improvement

Financial Improvement

Operational

Clinical Quality

Utilization

Strategic Integration

This is a unique system designed to help hospital leaders and anesthesiologists develop strategic partnerships that result in dependable quality, financial success and greater productivity.
**FOCUS Anesthesia Employment Program**

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- Protocols for integrated care delivery

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**FOCUS on OR improvement**

An employed physician process created with anesthesia and hospital integration in mind will create a solid foundation for OR success. Enhance Healthcare professionals partner with hospital executives to co-manage employed anesthesiologists to ensure your facility is strongly positioned for surgical volume gains. Let Enhance Healthcare help you create the optimal environment for OR performance and integrated surgical care. Contact info@EnhanceHC.com or visit www.EnhanceHC.com.
Advocate Christ Medical Center in Oak Lawn, Ill., announced its affiliation with MD Anderson Physicians Network.

Catholic Healthcare West chose Community Health Systems as the potential buyer of Saint Mary’s Regional Medical Center in Reno, Nev. The two systems are now in the due-diligence phase.

Central Vermont Medical Center in Berlin and Fletcher Allen Health Care, based in Burlington, Vt., announced that their boards approved a corporate affiliation between the two organizations.

Colorado Attorney General John Suthers approved HCA Holdings’ proposed acquisition of the Colorado Health Foundation’s 40 percent interest in HCA-HealthONE.

Naples, Fla.-based Health Management Associates’ acquisition of Knoxville, Tenn.-based Mercy Health Partners and its seven hospitals went into effect. Mercy system is now known as Tennova Healthcare.

Naples, Fla.-based Health Management Associates announced agreements with Oklahoma City-based Integris Health to joint venture five hospitals in Oklahoma.

Pittsburgh-based Highmark and West Penn Allegheny Health System reached a verbal agreement on the terms and conditions of the payor’s planned acquisition of the hospital system.

The sale of Hoboken (N.J.) University Medical Center to for-profit HUMC Holdco was finalized.

Des Moines-based Iowa Health System and Peoria, Ill.-based Methodist Health Services finalized their partnership agreement.

Henderson, N.C.-based Maria Parham Medical Center is officially part of Duke LifePoint Healthcare after a joint venture agreement was finalized.

Richardson, Texas-based Methodist Health System purchased the hospital facilities currently owned by Richardson Hospital Authority.

After more than a year’s worth of talks, the board of McDuffie Regional Medical Center in Thomson, Ga., voted to sell to University Health Care System in Augusta, Ga.

With its affiliation agreement approved, Olympic Medial Center in Port Angeles, Wash., became the first member of Seattle-based Swedish Health Network.

Person Memorial Hospital in Roxboro, N.C., officially became part of Duke LifePoint Healthcare.

The merger joining Mokena, Ill.-based Provena Health and Chicago-based Resurrection Health Care was finalized.

Renton, Wash.-based Providence Health & Services and Seattle-based Swedish Health Services joined to form a new, unique non-profit system.

Brentwood, Tenn.-based RegionalCare Hospital Partners and Nashville, Tenn.-based Essent Healthcare completed their merger, under which RegionalCare will absorb Essent and operate its seven rural hospitals.

The board of Boise, Idaho-based St. Luke’s Health System approved a merger between its hospital in Twin Falls and St. Benedict’s Medical Center in Jerome, Idaho.

A 2.5-year merger between New York’s St. Peter’s Health Care Services, Northeast Health and Seton Health finally closed Oct. 1.

Atlanta-based SunLink Health Systems and Oklahoma City-based Foundation Healthcare Affiliates have ended discussions to merge, due to “differences in the parties’ respective business models, philosophies and operating assets.”

Tomball (Texas) Regional Medical Center was officially sold to a subsidiary of Franklin, Tenn.-based Community Health Systems.

Greenville, N.C.-based University Health Systems of Eastern Carolina acquired Pungo District Hospital in Belhaven, N.C.

Under a proposed merger plan, Connecticut’s Yale-New Haven Hospital bought the assets of Hospital of Saint Raphael, also in New Haven, to create a single hospital with two campuses.

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#### Hospital & Health System Executive Moves

Daniel Aronzon, MD, president and CEO of Vassar Brothers Medical Center in Poughkeepsie, N.Y., retired.

Freeman Health System in Joplin, Mo., promoted Paula Baker to president and CEO-elect.

Ruth Brinkley, president and CEO of Carondelet Health Network in Tucson, Ariz., stepped down from her post to serve in an advocacy role in Washington, D.C.

Mike Browder joined Brentwood, Tenn.-based RegionalCare Hospital Partners as executive vice president and CFO.

William Brown was promoted to full-time CEO of Westlake Hospital in Melrose Park, Ill.

HealthEast Care System, based in St. Paul, Minn., named Kathryn Correia as the new president and CEO.

Denver Health CEO Patricia Gabow, MD, retired in September after nearly 20 years of serving at the helm of the health system.

Michael W. Garfield was named division I vice president and Tenova Healthcare marker CEO.

Michael J. Goebel was named CEO of Adventist Hinsdale (Ill.) Hospital.

Tener Healthcare appointed John A. Grah CEO of Des Peres Hospital in St. Louis.

Vista Health System, based in Waukegan, Ill., appointed Pamela German Hill CFO.

SSM Health Care-St. Louis named Robert William Hoefer president of SSM St. Clare Health Center in Fenton, Mo.

Tom Jackiewicz, president and CEO of UC San Diego Health System, resigned.

Randall L. Kelley was appointed to serve as president and CEO of CarolMont Health, based in Gastonia, N.C.

Sarah Krevans was named COO of Sutter Health, a 24-hospital health-care system based in San Francisco.

Methodist Healthcare System, based in San Antonio, Texas, named Gay Nord as its new CEO.

Joshua Putter was appointed COO of Steward Health Care in Boston.

Glendale (Calif.) Adventist Medical Center named Kevin Roberts president and CEO.

Anthony A. Scaduto, MD, was named interim president and CEO of Los Angeles Orthopaedic Hospital.

Wake Forest Baptist Medical Center named Steve Snellgrove COO of Wake Forest Baptist Health-Lexington (N.C.) Medical Center and Wake Forest Baptist Health-Davie Hospital in Mocksville, N.C.

Jeffrey Steinberg, MD, was appointed CEO at Weiss Memorial Hospital, a Vanguard Health System-owned facility in Chicago.

Stony Brook (N.Y.) University Medical Center President and CEO Steven L. Strongwater, MD, resigned.

Lifespan, based in Providence, R.I., extended President and CEO George Vecchione’s contract through Dec. 31, 2012.

James Weinstein, DO, was appointed president and CEO of Dartmouth-Hitchcock Health, based in Lebanon, N.H.

Paul Wiles, president and CEO of Novant Health in Winston-Salem, N.C., retired.

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