Is the Community Hospital a Dying Model, or is it the Future of Healthcare?

By Sabrina Rodak

As the healthcare industry adopts the philosophy of accountable care, large hospitals and academic medical centers may seem to have the upper hand compared with community hospitals, because larger hospitals typically have greater access to revenue and offer more services along the continuum of care. “Academic medical centers offer complex services that for a variety of reasons produce better availability of capital,” says Tim Bateman, executive director of the community hospital network Community Hospital 100 and executive vice president of Lincoln Healthcare Events. However, community hospitals may be

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Are You an Old or New Era Hospital Leader?

By Sabrina Rodak

With the healthcare industry moving towards accountable care, pay-for-performance models, increased quality demands and population health management, hospitals and health systems are experiencing a revolution. The multiple changes in the industry — not only in philosophy but in regulations — require changes in healthcare leaders. To be successful, hospital and health system leaders will need to be collaborative, transparent and flexible. Here, industry experts describe how an “old era” healthcare leader would approach specific areas of healthcare, and how this approach differs from strategies successful “new era” leaders should take.

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Publisher’s Letter

Becker’s Hospital Review Community Hospital Issue;
Annual CEO Strategy Roundtable

July/Aug Issue. We are pleased to share with you the July/August issue of Becker’s Hospital Review. This issue features our annual list of “100 Physician Leaders of Hospitals and Health Systems” and also has a special focus on community hospitals. These organizations face special challenges and opportunities, which are addressed by several articles in the issue, including the cover story “Is the Community Hospital a Dying Model, or is it the Future of Healthcare?”

Also included in the issue are Q&As with two leading hospital executives: Dr. Ralph de la Torre, CEO of Steward Health Care, and Dr. Ronald Paulus, CEO of Mission Health. Both share their insight on challenges facing their organizations and opportunities ahead for healthcare delivery.

Becker’s Hospital Review Annual CEO Strategy Roundtable. The Becker’s Hospital Review Annual CEO Roundtable will be held Nov. 1, 2012, at the Ritz-Carlton Chicago. Come listen to 12 panelists discuss their biggest concerns and how they are addressing them. The panelists include:

1. Larry Anderson, CEO, Tri-City Medical Center
2. Dave Brooks, CEO, Providence Regional Medical Center Everett
3. Teri Fontenot, President and CEO, Women’s Hospital
4. Larry Goldberg, President and CEO, Loyola University Health System
5. Steve Goldstein, President and CEO, Strong Memorial Hospital
6. Dean Harrison, President and CEO, Northwestern Memorial HealthCare
7. Bill Leaver, President and CEO, Iowa Health System
8. Barb Martin, President and CEO, Vista Health
9. Charles Martin, Chairman and CEO, Vanguard Health Systems
10. Megan Perry, President, Sentara Potomac Hospital
11. Jim Skogsbergh, President and CEO, Advocate Health Care
12. Quint Studer, Consultant and Founder, Studer Group

Sessions will be held from 4 to 6 p.m. and will be followed by a networking dinner. For more information or if you are interested in attending, contact Jessica Cole at jcole@beckershealthcare.com. Attendance is limited to 100 people.

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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Are You an Old or New Era Hospital Leader?  
(continued from page 1)

Management  
“Old era” leader  
In the past, hospitals were designed with a stricter hierarchy where there were a few decision-makers tasking others in the organization with carrying out their decisions. “Historically, a lot of [healthcare] organizations have been set up with an executive command and control approach,” says Kevin Fickenscher, MD, president and CEO of AMIA-The American Medical Informatics Association.

“New era” leader  
Healthcare leaders are now moving away from a control model towards a collaborative model of care, according to Dr. Fickenscher. “The top-down system doesn’t necessarily foster the most efficient approach toward care delivery. We have to have an integrated approach; we have to have an approach that recognizes that team models are going to be more effective,” he says. This team will include not only members of the C-suite, but also members of the medical staff, local physician groups and community.

Establishing a collaborative model does not necessarily mean abandoning certain aspects of the command and control model, however. “Healthcare organizations can have very complex political environments that demand comprehensive, deliberate and sound decision-making,” says Dave Mac-Donald, founder and CEO of healthcare consulting firm Adele Advisors. “Any ‘team’ needs to have at least one person [a physician, nurse or administrator] who can step in and make the tough calls.” Successful healthcare leaders today need to balance teamwork with strong decision-making skills.

Hospital-physician relationships  
“Old era” leader  
The level of hospital-physician integration today is a significant departure from past relationships between physicians and hospitals. Previously, hospital executives had limited interactions with physicians at the hospital and often did not include them in strategic planning efforts. “Ten, 20 years ago, there really was sometimes an adversarial relationship between medical staff and the hospital. Physicians were on staff to manage patient care. In many ways the relationship was not very collaborative and inclusive of physicians’ thoughts, thus [not] allowing physicians to become active partners and leaders in the organization,” says Christopher Cornue, vice president of healthcare analytics company Sg2.

“New era” leader  
Today, hospital leaders need to work closely with physicians in developing strategies to improve quality and efficiency in the organization. “Now, with more scrutiny around measurements and outcomes, there needs to be much stronger collaboration between hospitals and physicians because both will be held accountable,” Mr. Cornue says. “New era” leaders will need to engage physicians in ways they never have before. These relationships with physicians will help ensure the organization achieves new metrics that may determine part of a hospital’s payment. Engaging physicians will require hospital leaders to have strong communication skills and effectively communicate with physicians on an ongoing basis. “Strong communication, engagement skills and the ability to motivate individuals at all levels — that’s what will make or break healthcare organizations in the future,” Mr. Cornue says.

Community  
“Old era” leader  
In the past, there was not as much of a focus on population health as there is now, and healthcare leaders may not have proactively reached out to the community to manage patients’ health. “Many old era leaders were focused internally — inside the hospital and sometimes more office based,” says Brian Krehbiel, vice president of B. E. Smith, a leadership solutions company. Leading a hospital in the past may have emphasized ensuring the success of the hospital as a single entity more than building the hospital’s role in the community.

“New era” leader  
Today, as new models such as accountable care organizations and patient-centered medical homes arise, hospital leaders need to partner with community groups and organizations external to the hospital to improve quality and reduce cost. “New era leaders will need to be outward-focused community leaders. They will need to bring the healthcare message into the schools, churches and establishments of everyday life in a way that has not been seen. New era leaders will need to be extraverts who are comfortable in this role,” Mr. Krehbiel says.

One of the ways hospital executives are moving closer to the community is by partnering with retail clinics and building urgent care centers to treat patients in a less costly, outpatient setting. Hospitals are also collaborating with nursing facilities to ensure patients are taken care of after discharge and avoid readmissions. “Healthcare leaders need to recognize that it is no longer about the institution,” Dr. Fickenscher says. “It is more about how we extend the healthcare delivery process into the home.”

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Transparency
“Old era” leader
In the past, financial and clinical performance data on hospitals were not readily available and patients mostly relied on their primary care physicians when choosing a hospital. Hospital leaders and consumers rarely interacted and the hospital’s strategic plan was kept an internal affair.

“New era” leader
Today, CMS and other organizations have made hospitals’ performance data easily accessible to patients, who are becoming more involved in their healthcare decisions. Hospital leaders need to accept and embrace transparency to gain the trust of consumers, their employees and physicians, which is necessary to building lasting relationships. “Healthcare leaders need to recognize they’re working in a transparent world,” Dr. Fickenscher says. “If they can’t tolerate it, they’re not going to survive in healthcare. Openness is crucial.”

In addition, as hospitals begin to partner with community organizations and physicians in reducing readmissions and other initiatives, hospital leaders will be forced to become more transparent about their strategy. “Today, integration efforts by healthcare leaders have had to become much more transparent,” says Heather Kopecky, PhD, senior client partner in healthcare services at Korn/Ferry International, an executive recruitment company. “Organizations have to be able to clearly articulate why an integration strategy is necessary and what the role of the medical group is in this process.”

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The patient experience
“Old era” leader
Years ago, hospital leaders did not prioritize improving the overall patient experience. While they did look at patient satisfaction, improvement efforts focused more on increasing survey scores instead of exploring ways to deliver excellence in patients’ experience from a service perspective as well as in clinical outcomes, according to Mr. Cornue.

“New era” leader
In the current healthcare environment, hospital leaders are becoming acutely aware of patient satisfaction and the patient experience, as payment systems such as value-based purchasing will allocate payments based partly on scores from the Hospital Consumer Assessment of Healthcare Providers and Systems survey. Hospital executives’ efforts are now going beyond increasing the survey score. “They’re really focusing on the broader experience rather than the specific score. When done effectively, the scores will naturally follow,” Mr. Cornue says.

This broader approach requires an assessment of the hospital’s culture and long-term goals. “To achieve lasting success in the future, hospitals first define and then engage staff to execute the target, or ideal experience. They will understand and strive for continuous improvement in delivering the “non-negotiables” — the defining characteristics of experience that should never change,” says Linda Ireland, a partner with global strategy and operational change firm Aveus.

Quality
“Old era” leader
In the past, hospital leaders were not incentivized to improve quality the same way as today. Now, providers are beginning to be penalized for too many readmissions, not following evidence-based standards of care and other quality-related measures. Leaders’ approach to quality in the past was thus different than the approach today. “Quality initiatives often focused on symptoms of a larger problem, not necessarily [the] root cause that could be expensive to remediate,” Mr. Krehbiel says. In addition, hospital leaders tended to punish employees who violated a patient safety or quality standard, according to Dr. Kopecky.

“New era” leader
Now, hospital leaders prioritize quality initiatives and strive to create a culture of quality. They use methods such as Lean and Six Sigma to do a root cause analysis of problems and focus on educating employees and physicians about quality protocols. “Today, healthcare leaders emphasize blame-free environments so that any team member is able to report errors or near errors without fear of retaliation,” Dr. Kopecky says. “Continuous education is used so that team members understand their role in situations where there is high risk and can feel safe speaking up.”

Costs
“Old era” leader
Before healthcare reform, hospital leaders responded to declining reimbursement primarily by focusing on cost containment, according to Mr. Krehbiel. As with quality, they may not have looked at the root cause for high costs and instead made cuts in certain departments’ budgets without understanding the true source of the high costs.

“New era” leader
Today’s leaders have begun trying to reduce costs by decreasing inappropriate utilization of high-cost services, such as encouraging non-emergent patients to seek care in lower cost, appropriate settings outside of the emergency department, according to Mr. Cornue. Hospital leaders will also need to move beyond cost containment and into revenue growth. “Cost containment will be important, but the real winners in the market will focus on driving new revenue, margin and the overall patient and physician experience. Leaders that can accomplish this will avert outward patient migration and will have the revenue needed to continue to enhance the overall patient experience,” Mr. Krehbiel says.
7 Things Hospitals Should Know About Professional Services Agreements (continued from page 1)

achieved without true employment through a variety of strategies, including co-management agreements, medical directorships and joint ventures. One strategy has been gaining momentum and is working its way to the forefront: professional services agreements.

1. Basic tenets of PSAs. A recent whitepaper from the Coker Group described PSAs as “employment lite” because they “serve as an alternative to the primary structure considered under full integration — employment.”

PSAs, in a nutshell, are a form of alignment between hospitals and physicians that falls just short of full employment. “It’s used as ‘employment lite’ because the physician is not directly employed and still maintains some semblance of control,” says Bart Walker, JD, associate at McGuireWoods.

PSAs should not be confused with clinical co-managements, directorships or other professional arrangements — they are their own beast, and they generally fall into four models, according to the Coker Group.

Traditional PSA. A hospital contracts with physicians for certain, outlined professional services, and the hospital directly employs the group staff and takes care of the administrative costs.

Global payment PSA. A hospital contracts with a physician practice at a global payment rate, which includes physician compensation and all administrative expenses, but the practice keeps all management responsibilities.

Practice management arrangement. Although the hospital employs the physicians, the practice structure is retained, and the practice contracts with the hospital for management services. The practice still employs the administrative staff and provides their services in a separate agreement.

Hybrid arrangements. Less common among the options, hybrid arrangements involve various scenarios where hospitals and physicians mix and match contracts for both professional and administrative services.

PSAs could be the right course of action for some hospitals and physicians, according to the whitepaper, because it gives the two groups a cushion to see if they could work as long-term professional partners. In addition, PSAs could lead to easy segues into full employment or enable physicians to transition back into full-fledged private practice.

2. Fair market value. Once hospitals familiarize themselves with the different PSA options, Mr. Walker says the most important component of any deal is fair market value. Regardless of the type of contract or model of productivity, hospitals are required to compensate physicians appropriately for the services actually provided but in a way that is different from full employment.

At the end of the day, some type of productivity metric or work relative value unit per procedure will be used for compensation measures. Amber McGraw Walsh, JD, partner at McGuireWoods, says impartial valuation is essential to maintain fair market value. “Unequivocally, because fair market value is so important, it is really strongly recommended there be an independent, third-party valuation,” Ms. Walsh says. “It’s almost a must in this situation.”

3. Compliance with Stark Law. Between the new regulations of the Patient Protection and Affordable Care Act and older healthcare regulations that span decades, it can sometimes be difficult for both hospitals and physicians to monitor all areas of legal compliance. The Stark Law is no exception, as the possibility of physician benefits from self-referrals for Medicare and Medicaid patients must be rooted out of any PSA.

Ms. Walsh says fair market value is a critical piece of meeting all regulatory and Stark requirements of PSAs, and hospitals and physicians should also be cognizant of all other elements of the available Stark Law exceptions. The available exceptions are those for personal services, physicians practicing in rural areas and possibly the fair market value exception. All elements of at least one exception must be met in order to ensure Stark compliance.

4. Compliance with federal Anti-Kickback Statute. Similar to the Stark Law, physicians and hospitals cannot violate the stipulations surrounding the federal Anti-Kickback Statute. Hospitals and physicians should determine with their legal teams whether they fall under certain safe harbors, such as the personal services/management safe harbor or medically underserved areas. PSAs need to be crafted in a way to ensure there is no direct or indirect kickback from the referrals to the hospital of Medicare and Medicaid patients.

“It’s important to structure PSAs in consideration of the intent of a party to provide good patient care to a section of the hospital where the need is not being fulfilled — and not to [just] generate referrals for hospitals,” Ms. Walsh says.

5. Consideration of state law. The Stark Law and Anti-Kickback Statute cover federal regulatory issues, but Mr. Walker and Ms. Walsh emphasized the buck does not stop there for PSAs. When creating the right “employment lite” contract, hospitals and physicians must confirm they are also in compliance with any state laws that involve physician employment (such as the corporate practice of medicine laws in states like California) or hospital-physician referrals. “Some states have their own modifications in some instances that are stricter than Stark and the Anti-Kickback Statute,” Ms. Walsh says. “Understand and be compliant with state laws as well.”

6. Periodic review of the relationship. Just like regular, full-time employees, hospitals should not rest on their laurels when it comes to their PSAs. There should be consistent review to make sure the agreements are still being met on both sides, that the right amount of work is being completed and that the physicians are still a good match for the hospital and its service lines. Periodic review of PSAs also gives the reassurance that all parties are still meeting the requirements of federal and state healthcare laws.

“It’s critical — because there is ongoing compliance with Stark, Anti-Kickback and state laws — to ensure you are doing periodic reviews of the relationship to ensure services are being provided, that services are still needed, and that parties are operating within compliance of the agreement,” Ms. Walsh says. “If there has been a change in agreement or compensation has changed, then you need to reassess if you should continue the relationship.”

Mr. Walker adds that PSAs could be updated, for example, if a hospital acquires an ambulatory surgery center and converts it into a hospital outpatient department. This will help assure compliance with provider-based status rules and evolving restrictions on physician compensation relationships.

7. Documentation of all aspects of relationship. As an offshoot to periodic reviews of PSAs, Ms. Walsh says every component of the PSA must be recorded and documented to ensure both parties are doing what is expected of them. For example, are physicians turning in documented hours of the services they are providing? Having electronic and hard copies of this information is a legal no-brainer for both hospitals and physicians, especially in today’s intense regulatory environment, she says.

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The Chief of Change: Q&A With Dr. Ralph de la Torre, CEO of Steward Health Care

By Molly Gamble

Ralph de la Torre, MD, gets things done, but he starts by forgetting everything he knows.

In an industry entangled with commentary, red tape and fear of change, Dr. de la Torre has ambitiously forged to the forefront as CEO of Steward Health Care System with the attitude that little is impossible. The young, Boston-based system itself is the result of unlikelyhood: The 2010 sale of Massachusetts’ second-largest hospital chain, the Catholic Caritas Christi Health Care, to Steward, an affiliate of the New York-based private equity firm Cerberus Capital Management. As CEO of Caritas, Dr. de la Torre orchestrated the deal — involving the Catholic Archdiocese of Boston, unions, local communities and a private giant — when it could have easily ended in cacophony.

Steward has moved swiftly. The 10-hospital system has drawn physicians like a magnet, as providers from Massachusetts-based Tufts Medical Center, Partners HealthCare and Beth Israel Deaconess join Steward’s ranks. The system was named a participant in the Medicare Pioneer Accountable Care Organization Program in late 2011, one of the first such 32 in the country, and it recently established a health insurance plan called Steward Community Choice. All this activity may leave some people forgetting an important fact: Steward’s not even two years old.

Behind the progress is Dr. de la Torre, a man who gets little sleep and devotes even less time to naysayers. The MD in his name reflects the time he spent in the operating rooms before the C-suite. He was the youngest chief of cardiac surgery not only at Beth Israel Deaconess Medical Center in Boston, but in the history of any Harvard teaching hospital. In 2007, Dr. de la Torre established the hospital’s CardioVascular Institute, which integrated the program’s medical and surgical specialties and coordinated patient services. Again, he knows how to get things done.

Here, Dr. de la Torre discusses his management style, physician engagement, problems in American healthcare and how he executes big ideas.

Q: How do you choose to deal with naysayers?

RT: If the criticism is credible, I listen and incorporate changes if needed. If it is not, I forge ahead and prove them wrong.

Q: Over the years, what one attitude, belief or notion have you found to be most destructive in the healthcare industry?

RT: The inability to cope with or embrace change. Healthcare is an industry that despises change, but everything changes. Technology changes, culture changes, attitudes change, and we as an industry and as a profession need to learn how to change with the times.

Q: Soon after you were named CEO of Caritas Christi in 2008, you invited the Service Employees International Union to organize employees — something Dennis Rivera, the then-head of the union, said he experienced only twice. Why did you choose to take a proactive approach?

RT: It seemed very logical. When I met with Dennis many years ago and he explained to me his vision of healthcare, his vision of how employees would interact with employers and how caregivers would all unite to provide the optimum care — it seemed completely analogous to my beliefs and the beliefs of Steward as a company. Out of that came the realization that we agree on what needs to be done. We may disagree on some nuances of how to get there, but the end state is one that both parties completely embrace. From there, further discussion followed, and it just happened naturally.

Q: As a fairly new system, how is Steward building rapport and forming ties with physicians in the area? Have you heard feedback from physicians on why they find the system appealing?

RT: Steward is a healthcare company. It’s not a hospital company, and it’s not an insurance company. In many ways, it’s mostly a physician company that happens to operate hospitals and some insurance components. Hence, it is naturally aligned with the way physicians view the healthcare world.

If you look within our structure, many constructs exist for physician empowerment and caregiver empowerment. So why do physicians gravitate towards us? Because in many ways we have designed ourselves to accommodate them and think like they do. Bricks and asphalt don’t take care of patients; a team of people take care of patients.

Q: Many healthcare CEOs have publicly said the Supreme Court ruling on the Patient Protection and Affordable Care Act isn’t significant to them because the law’s values will be instilled regardless. What is your opinion on the matter?

RT: I agree. The main caveat that drives America is the moral imperative not to deny care. Once we as society get to that moral imperative, whether it’s PPACA or state-by-state laws, we’re there. Healthcare reform has occurred.

Q: You’ve been a champion of healthcare innovation — everything from the CardioVascular Institute at Beth Israel Deaconess Medical Center, the Caritas-Steward sale, to redefining America’s community hospitals. What fuels your drive to break the mold in healthcare?

Dr. de la Torre: I must admit, I am a generally inquisitive person who loves to tinker, explore and think about innovative, out-of-the box approaches. On a professional level, I take a different approach than many. I begin by forgetting everything that exists and constructing what I believe to be an ideal structure with an ideal process. Once the ideal is constructed, you simply connect the dots from the present to the future adding layers of details and contingencies.

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Q: Industry experts say Steward is redefining the traditional community hospital. How do you break such a “big picture” initiative down into manageable work?

RT: I think you just hit upon the largest obstacle facing healthcare executives. The challenge can seem daunting. What you have to do is break it up into smaller business plans and smaller tasks. In other words, you create a seven-year plan that is complex and far-reaching, and then you break it down into several components, and you break those components down into further components, and then you break those down into deliverables for a given year, and so on. Then you concentrate on the task immediately ahead of you. If everyone concentrates on their task, you eventually get to the designed end-point.

Q: A Boston Globe report from February 2011 mentioned you average four hours of sleep a night. How do you avoid burnout, or is that not so much an issue?

RT: As a kid, I never slept much. You then superimpose surgical residency training at Mass General Hospital when it was basically every other night, [and I] was trained to sleep even less. You couple that with a healthy dose of paranoia, and you end up at four hours. For awhile, it really bothered me. I thought there was something wrong because I didn’t sleep. Now, except for the occasional 2 a.m. purchase of a Ronco Veg-O-Matic, it doesn’t really bother me.

Q: How might people who work with you describe you as a boss?

RT: I hope people would describe me as demanding but fair. In many ways, it’s a self-fulfilling prophecy. Having been lucky enough to pick the management team now in place at Steward, we are all very similar. We’re all success-driven, hard-charging individuals who in many ways view ourselves to be in a constant start-up mode. The expectations are demanding but fair, [tolerant] of errors of commission, but not omission.

Q: What’s the hardest lesson you’ve had to learn so far?

RT: When you’re a physician and you’re taking care of an individual patient, you can count on everybody trying to do the right thing. They are all honest, hard-working, and want the patient to have a successful outcome. What surprised me is that when you take healthcare from the patient and make it about a million patients or a hundred million patients, a lot of other agendas and objectives come into play, and you lose some of these ideals.

I’ve found that to be a hard lesson because you can’t predict what people are going to do. As a corollary to that, I have been surprised that it is very easy for people to distort the truth and prey on fear in order to achieve an outcome. Those concepts have been very hard lessons for a physician.
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Reinventing a Hospital’s Philosophy: Q&A With Dr. Ronald A. Paulus, President and CEO of Mission Health

By Molly Gamble

Ronald A. Paulus, MD, has big goals and an even “bigger” aim. As the first physician CEO of Asheville, N.C.-based Mission Health, Dr. Paulus oversees a $1.2 billion integrated delivery system — the sixth-largest in the state. Prior to his current role, he served as executive vice president of clinical operations and chief innovation officer at Geisinger Health System in Danville, Pa. Dr. Paulus takes national problems in healthcare delivery and breaks them down to a micro-level, analyzing how they affect the specific region Mission serves and how to most effectively respond.

Shortly after assuming his position at Mission in 2010, Dr. Paulus launched a renewed philosophy for the five-hospital system, called the “BIG(GER) Aim.” The goal? To get each and every patient to the desired outcome — without harm, without waste and with an exceptional experience for both the patient and family. Here, Dr. Paulus shares insight on patient engagement, physician alignment and the philosophies under which he is leading Mission Health.

Q: What are your greatest challenges locally at Mission, and what do you see are the greatest challenges on a national scale?

Dr. Ronald Paulus: I really see the greatest challenges locally as a microcosm of the national landscape. For Mission, our key challenges are our demographics, the regional political landscape and the need to transform from a hospital focused on best-in-class care to a health system focused on meeting the needs of our community to produce the best outcomes at the lowest possible cost.

First, our demographics: Western North Carolina is older, poorer, sicker, less insured and has less access to care than state and national averages. We are the safety-net hospital and health system for the region. More than 75 percent of our patients are covered by Medicare and/or Medicaid, or have no insurance. Given that, along with the obvious federal and state budget challenges, we know that reducing the cost of our care delivery is absolutely essential. But we can’t do that by reducing access or care quality — just the opposite.

Second is the political climate. Western North Carolina is a proud region, fiercely independent and skeptical of outsiders — much like where I grew up, in a similar mountainous area of central Pennsylvania. Many of the difficult changes occurring nationally, like the pressure to reduce costs and the ongoing transformation of physician relationships, have begun much later here, so the timeline for change is shortened and the sense of pain is greater. Nationally, I think the issues are largely the same: How do we do more with less? How do we partner with our physicians to deliver better care at a lower cost? Simply put, how do we not just fix, but actually rebuild the airplane in mid-flight?

Q: Prior to serving as CEO, you served as executive vice president of clinical operations and chief innovation officer at Geisinger. What systems have you introduced to Mission that you implemented at Geisinger?

RP: First, let me say Geisinger and Mission Health are two very different places. Geisinger has a nearly 100-year history as a spin-off from the Mayo Clinic and is one of nation’s premier integrated delivery systems that includes a health plan. Mission Health has a century-long history as a best-in-class hospital. Both are terrific at what they do. That said, there are similarities, and I have introduced some of the same approaches we used at Geisinger.

The first is an absolute focus on quality. Shortly after my arrival, we adopted something we call our BIG(GER) Aim: to get each and every patient to the desired outcome, first without harm, also without waste and with an exceptional experience. That aim guides who we are, what we do and how we do it. My first hire was a remarkable individual, William Maples, MD, an oncologist formerly with the Mayo Clinic [who has] unique quality expertise. Working with Bill and the team, we have already begun to transform our approach with some pretty spectacular results in reducing infections and falls, shortening ICU ventilator days and length of stay, and dramatically improving patient satisfaction.

A second focus is on innovation, with the recognition that what we have done in the past will not get us to where we need to be. Innovation is hard, and it requires the ability to test new ideas and make mistakes. That is counter to much of traditional healthcare. A third emphasis is on hard-wiring process changes via information technology. Recidivism to past behavior, even af-
Q: You’re the first physician CEO at Mission. How has your background influenced your relationships with physicians? How has your physician background helped with your physician alignment at Mission?

RP: I do believe being a physician has been, and will always be, an advantage for me. First, it’s who I am and how I think about myself. I view problems first and foremost from the lens of a clinician [with] the goal of the patient in mind. Those views are not exclusive to physicians, or even clinicians, but it helps me. With regard to physician alignment, physicians are smart, driven and intensely engaged with their patients. It isn’t obvious to them why “aligning” with management is necessarily a good idea. They have to be treated as partners, with joint accountability. That’s the approach I’ve tried to take, and the early results are promising.

Q: You have said engaging patients in their own health and wellness is key to a successful healthcare system and community. How are you doing that at Mission Health?

RP: Yes, absolutely! Engaging patients and their families is a critical part of transforming care. Because we have a less extensive ambulatory network compared to Geisinger, we have begun on the inpatient side. Engagement and empowerment is crucial for our staff as well as patients. We recently kicked off a “Great Place to Work” initiative to empower staff to drive their own success and to meet the needs of our patients. Part of that is to ensure patients are supported, educated and activated. Do they know what drugs are given to them in the hospital? Do they have a daily itinerary? Do they know discharge instructions? Are they willing to speak up if their needs — whether physical, environmental or emotional — are not met?

Most exciting, we have begun to embed patients directly into our redesign teams. We now have patients sitting side-by-side with physicians, nurses, managers and others as we seek to change our care processes and design our campus of the future. Let me tell you, the conversation about what we need to do and how we need to do it is completely different with patients at the table. It’s just a start, but it is exhilarating!

Q: Your background is that of a physician, but you also have an IT background. [Dr. Paulus co-founded CareScience, a company that pioneered the country’s first Internet-based quality management software in 1996 and is now part of Premier Informatics.] How do those two very different skill sets influence what you’re doing at Mission Health?

RP: I view the intersection of clinical care and IT as the quintessential skill set for care transformation. For me, it’s really hard to think about one without the other when seeking to achieve improved quality at lower cost. To re-engineer care, you begin with what can be eliminated entirely, then move to what can be automated, then to what can be delegated; all supported by active patient and family engagement. In each of these steps, IT is crucial. But technology is not an end to itself. As caregivers, we’re here to keep people healthy when we can, heal them when they’re sick and care for them, with grace and dignity, when healing is no longer an option. Technology enables that service with reliability and efficiency, but human trust and touch is the essence that keeps it whole.

Q: How are you, and Mission as a whole, responding to local news reports questioning North Carolina non-profit hospitals’ commitments to charity care?

RP: Each day at Mission, we strive to balance the dual imperatives of providing world-class care for everyone in our community regardless of their ability to pay, with the necessity to operate a sustainable business so that we ensure care for the generations to follow. The issues raised in the article series are all important and merit serious consideration, but rather than focus on any particular issue of the moment, I try to remain focused on our BIG(GER) Aim. It’s our privilege and an honor to serve our community, regardless of our local demographics.

With that said, I do think that in exploring these issues, it is important to paint a more complete picture of any hospital’s charitable care record. In general, it’s important to remember that there are multiple metrics that may be used to measure a hospital’s “community benefit” or “charity care.” In addition, hospitals differ on how they define a “poor person,” which inherently affects their level of “charity care.” Let me give you a few examples of how simple local differences can yield wide variation in these measurements.

One critical factor is whether the hospital operates in a demographically challenged — often rural — or more lucrative market, which is usually urban or suburban. In the poorest communities, more residents qualify for Medicaid coverage. By comparison, residents in mixed but overall more affluent communities often do not qualify for Medicaid. Yet based on typical “charity care” definitions, services provided to the working poor who can’t pay for medical care do qualify as charity care, but services provided to Medicaid patients don’t qualify — even if one hospital receives more reimbursement from the self-pay patient than the other does from Medicaid.

It’s unfortunate that this Medicaid burden is not included in this definition of “charity care,” because it is incontrovertible that the hospital isn’t paid close to the actual cost of caring for the patient putting aside any “profit.” The same principle is true with Medicare. Medicare does not pay the actual cost of delivering [care] to seniors. So, given that the percentage of patients who have Medicaid or Medicare varies widely across hospitals, even by a factor of two to three times, it simply can’t be true that care provided to self-pay patients is the sole determinant of “charity.”

There is also limited consistency in charity care reporting, so comparisons are often difficult and potentially misleading. This is often the case when comparing smaller “subsidiary” hospitals to larger “flagship” hospitals, where the apparent amount of “charity care” can be a function more of cost allocation methodologies than actual practice. Reporting standards for tax-exempt organizations are set by the Internal Revenue Service via its Form 990. “Community benefit” is a key metric reported on the [form]. It’s broader than the so-called “charity care” item, being an aggregation of a variety of charitable-type expenses, such as charity care, expenses for medical education, community development and other similar items. It is often expressed as a percentage of the hospital’s total expenses or total revenues. Based on IRS data, Mission’s total community benefits expenditures as a percentage of total revenues was above the national median. So again, it depends on which metrics you want to include in your report.

In the end, we believe people should look at a more balanced score card rather than relying on any one metric, such as charity care as a percentage of expenses. We should also compare hospitals against all other hospitals. That way the idiosyncrasies that often result from using a small comparison pool are evened out. As I said before, regardless of these complex issues, it is our privilege and obligation to provide care to our citizens, without regard to their ability to pay.

Q: Can you share one piece of advice or one lesson you’ve learned throughout your career?

RP: Wow, now that’s a hard question. Not to be too simplistic, but I guess I would say the most important thing is to remain focused on what is best for the patients we serve. There are so many pressures and so many challenges that it is easy to be distracted by other factors like costs, the competitive landscape, the political environment and so forth. But we didn’t enter the healthcare profession to serve ourselves — we did it to serve others. Our focus is and must remain on the patient-consumer. If we remember that simple rule, we’ll do the right thing.
B ecker’s Hospital Review has named “100 Physician Leaders of Hospitals and Health Systems” based on leaders’ healthcare experience, awards they’ve received and their commitment to quality care. Many of the leaders were nominated by their peers, and the list was vetted by industry experts. Note: This list is not an endorsement of included hospitals, health systems or associated healthcare providers, and organizations cannot pay for inclusion on this list. Physician leaders are presented in alphabetical order.

David Abelson, MD. President and CEO of Park Nicollet Health Services (St. Louis Park, Minn.). Dr. Abelson joined Park Nicollet as an intern in 1983 and served as chief clinical officer and executive vice president and CMIO before being named president and CEO in 2010. He is a current board member and past chairman of the Institute for Clinical Systems Integration, now called the Institute for Clinical Systems Improvement.

Richard Afable, MD. President and CEO of Hoag Memorial Hospital Presbyterian (Newport Beach, Calif.). As president and CEO of Hoag Memorial Hospital Presbyterian, Dr. Afable oversees two acute-care hospitals, five urgent care centers and seven health centers. He previously served as executive vice president and CMIO of Newtown Square, Pa.-based Catholic Health East. He was also founder, president and CEO of Preferred Physician Partners, an Ohio-based physician practice management company.

Steve Allen, MD. CEO of Nationwide Children’s Hospital (Columbus, Ohio). Named CEO of Nationwide Children’s Hospital in July 2006, Dr. Allen oversees the hospital’s research institute, foundation and the Center for Child and Family Advocacy in addition to the hospital itself. Prior to his current position, he was a physician, scientist, teacher and executive at the Texas Medical Center in Houston. Dr. Allen is board certified in anaesthesiology and critical care medicine.

Steven M. Altschuler, MD. President and CEO of The Children’s Hospital of Philadelphia. Dr. Altschuler has served as president and CEO of The Children’s Hospital of Philadelphia since 2000. He previously held the positions of physician-in-chief and the Leonard and Madlyn Abramson Endowed Chair in Pediatrics at CHOP and professor and chair of the department of pediatrics at the Perelman School of Medicine at the University of Pennsylvania. Dr. Altschuler serves on the boards of several organizations, including the Children’s Miracle Network Hospitals, the Free Library of Philadelphia and University HealthSystem Consortium.

Ken Anderson, DO. Chief Medical Quality Officer of NorthShore University HealthSystem (Evanston, Ill.). Dr. Anderson has served as chief medical quality officer of NorthShore University HealthSystem since March 2008. In this role, he oversees quality and safety at the system’s four hospitals in Evanston, Glenbrook, Highland Park and Skokie, Ill. He also serves as co-chair of the steering committee that governs the system’s Center for Clinical and Research Informatics.

Timothy Babineau, MD. President and CEO of Rhode Island Hospital (Providence). Dr. Babineau, a board-certified general surgeon, is president and CEO of 719-bed Rhode Island Hospital and 247-bed Miriam Hospital. In 1994, the facilities founded the non-profit integrated health system Lifespan, which includes three other hospitals and is governed by a separate management team. Prior to taking his current position in 2008, Dr. Babineau was the senior vice president and CMIO of the University of Maryland Medical Center and School of Medicine in Baltimore. He has also served in leadership positions at Boston Medical Center.

Richard B. Becker, MD. President and CEO of Brooklyn (N.Y.) Hospital Center. Since 2008, Dr. Becker has served as president and CEO of Brooklyn Hospital Center, a 464-bed facility that employs more than 2,700 people. Dr. Becker previously served as CEO of The George Washington University Hospital in Washington, D.C., and as dean of clinical affairs at The George Washington University Medical Center. He is board certified in anesthesiology and critical care medicine, which he taught as an associate professor at The George Washington School of Medicine.

Marc Boom, MD. MBA. President and CEO of the Methodist Hospital System (Houston). Dr. Boom has served as president and CEO of The Methodist Hospital System since January. He was previously executive vice president of the hospital for seven years. He has also served as senior vice president and COO of the hospital, president and CEO of The Methodist Diagnostic Hospital and president, CEO and medical director of Baylor-Methodist Primary Care Associates.

Patrick J. Brennan, MD. Senior Vice President and CMO of the University of Pennsylvania Health System (Philadelphia). As vice president and CMO of the University of Pennsylvania Health System, Dr. Brennan oversees quality of care at the Hospital of the University of Pennsylvania, Pennsylvania Hospital, Penn Presbyterian Medical Center, the Clinical Practices at the University of Pennsylvania, Clinical Care Associates and Penn Home Care. He has served in his current role since 2005, before which he served as chief of healthcare quality and patient safety at the system for four years. Dr. Brennan has been a faculty member at Penn since 1998.
David Bronson, MD. President of Cleveland Clinic Regional Hospitals. As president of Cleveland Clinic Regional Hospitals, Dr. Bronson oversees Cleveland Clinic’s Euclid, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, Medina and South Pointe hospitals as well as the affiliate Ashtabula County Medical Center. Before being named to his current position in 2010, he was chairman of the department of general internal medicine from 1992 to 1995 and chairman of the Division of Medical Regional Practice from 1995 to 2007. Dr. Bronson, who also practices internal medicine at Cleveland Clinic, is the president of the American College of Physicians for the 2012 to 2013 term.

George J. Brown, MD. President and CEO of Legacy Health System (Portland, Ore.). Dr. Brown, a gastroenterologist, has nearly 40 years of healthcare experience. He has served as president and CEO of Legacy Health since August 2008 and previously served as COO of Tacoma, Wash.-based MultiCare Health System. He was also a brigadier general in the U.S. Army.

John R. Brumsted, MD. President and CEO of Fletcher Allen Health Care (Burlington, Vt.). Dr. Brumsted became president and CEO of Fletcher Allen Health Care and Fletcher Allen Partners — the parent organization of the health system and Central Vermont Medical Center — in February after having served in an interim role since August 2011. His relationship with the health system began in 1981 when he was a resident, and it has continued as he became CMO and chief quality officer. Dr. Brumsted is board certified in obstetrics, gynecology, reproductive endocrinology and infertility and is a member of the Vermont Medical Society Council.

John Cacciamani, MD. CEO of Chestnut Hill Hospital (Philadelphia). Dr. Cacciamani, a board-certified internist and geriatric subspecialist, was named CEO of 135-bed Chestnut Hill Hospital at the end of March. He previously served as chief of clinical operations and informatics for Temple University Hospital in Philadelphia. He is also a past president of the Philadelphia Medical Society.

Jeffrey Canose, MD. President of Texas Health Presbyterian Hospital Plano (Texas). Dr. Canose is president of 366-bed Texas Health Presbyterian Hospital Plano, which is a member of the 24-hospital, non-profit health system Texas Health Resources. He was the first physician in the Texas Health Resources system to be named a hospital president in March 2009 after he served as the first COO of Texas Health Plano for two years. He previously served as a clinical department chair, academic program director of anesthesiology and administrator of perioperative services at The Western Pennsylvania Hospital in Pittsburgh.

John B. Chassere, MD. President and CEO of Greater Baltimore Medical Center HealthCare. Dr. Chassere, a pediatrician by training, has served as president and CEO of GBMC HealthCare since June 2010. In this role he oversees 300-bed GBMC; Greater Baltimore Medical Associates, a group of more than 40 multi-specialty physician practices; a hospice organization; and the GBMC Foundation. He previously served as president of Caritas Norwood (Mass.) Hospital, now called Norwood Hospital. Prior to his current position, he was a consultant for regional and national healthcare organizations.

Kevin B. Churchwell, MD. CEO of Nemours/Alfred I. duPont Hospital for Children (Wilmington, Del.). Dr. Churchwell has served as CEO of Nemours/Alfred I. duPont Hospital for Children and senior vice president of Jacksonville, Fla.-based Nemours since December 2010. He previously served as CEO and executive director of Monroe Carell Jr. Children’s Hospital in Nashville, Tenn. He also held other positions at Monroe Carell Jr. Children’s Hospital, including chief of staff, medical director of the Children’s Health and Injury Prevention Program, medical director of Pediatric Critical Care Services and transport director.

Steven J. Corwin, MD. CEO of NewYork-Presbyterian Healthcare System (New York City). Dr. Corwin, a cardiologist and internist, has been CEO of NewYork-Presbyterian Hospital and NewYork-Presbyterian Healthcare System since September 2011. He previously served as executive vice president and COO of the hospital for six years and senior vice president and CMO for seven years. He was named to the faculty of Columbia University College of Physicians and Surgeons in 1986.

Delos “Toby” Cosgrove, MD. President and CEO of Cleveland Clinic. Dr. Cosgrove has served as president and CEO of Cleveland Clinic since 2004. He joined the system in 1975 and became chairman of the department of thoracic and cardiovascular surgery in 1989. He was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam as the Chief of U.S. Air Force Casualty Staging Flight, where he was awarded the Bronze Star and the Republic of Vietnam Commendation Medal. He has received the Cleveland Clinic Innovator of the Year award and has 30 patents filed for developing medical and clinical products.

Kenneth L. Davis, MD. President and CEO of The Mount Sinai Medical Center (New York City). Dr. Davis has served as president and CEO of The Mount Sinai Medical Center since 2003, before which he served as chair of Mount Sinai’s department of psychiatry for 15 years. From 2003 to 2007, he was dean of Mount Sinai School of Medicine. In 2009, Dr. Davis received the George H. W. Bush ‘48 Lifetime of Leadership Award from Yale University in recognition of his research on Alzheimer’s disease.

Ralph de la Torre, MD. Chairman and CEO of Steward Health Care System (Boston). As chairman and CEO of Steward Health Care System, Dr. de la Torre oversees 10 hospitals, more than 14,000 employees and other affiliate entities, such as a home healthcare company. He became CEO of Caritas Christi Health Care in 2008 and continued to lead the system after it was sold to Steward Health Care System in November 2010. He was previously founder and CEO of the CardioVascular Institute at Beth Israel Deaconess Medical Center in Boston and CardioVascular Management Associates and chief of surgical cardiology at BIDMC.

Victor J. Dzau, MD. President and CEO of Duke University Health System (Durham, N.C.). Dr. Dzau, a cardiologist, has served as president and CEO of Duke University Health System and chancellor for health affairs at Duke University since 2004. He is also the James B. Duke Professor of Medicine and director of molecular and genomic vascular biology. Dr. Dzau was previously the Hersey Professor of the Theory and Practice of Physic (Medicine) at Harvard Medical School; chairman of the department of medicine, physician-in-chief and director of research at Brigham and Women's Hospital in Boston; and the Arthur Bloomfield Professor and chairman of the department of medicine at Stanford (Calif.) University.

Reginald J. Eadicie, MD. President of DMC Sinai-Grace Hospital (Detroit). Dr. Eadicie became president of DMC Sinai-Grace Hospital in January after having served as president of Detroit Receiving Hospital for nearly two years. He previously served as vice president of medical affairs at DMC Harper University Hospital and DMC Hutzel Women's Hospital. Dr. Eadicie is a diplomate of the American Board of Emergency Medicine.

Melinda Estes, MD, MBA. CEO of Saint Luke’s Health System (Kansas City, Mo.). Dr. Estes, a board-certified neurologist and neuropathologist, has served as president and CEO of Saint Luke’s Health System since September 2011. She previously served as president and CEO of Fletcher Allen Health Care in Burlington, Vt., for eight years and as CEO of Cleveland Clinic Florida for two years. In addition, she was senior vice president of medical affairs and executive vice president of Metro-Health System in Cleveland.

David T. Feinberg, MD, MBA. President of UCLA Health System (Los Angeles). Dr. Feinberg has served as CEO and associate vice chancellor of UCLA Health for five years. He previously served as medical director of UCLAs Resnick Neuropsychiatric Hospital and chair of the NPH Faculty Practice Group.

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is also a clinical professor of psychiatry at the David Geffen School of Medicine at UCLA.

Donald Fesko, OD, MBA. CEO of Community Hospital (Munster, Ind.). Dr. Fesko has served as CEO of Community Hospital for nine years. He previously practiced optometry with Munster (Ind.) Eye Care Associates. This year he received the Robert S. Hudgens Award for Young Healthcare Executive of the Year from the American College of Healthcare Executives. The award recognizes an ACHE fellow less than 40 years of age who is an exceptional CEO or COO of a healthcare organization and has shown excellent healthcare management skills.

Michael R. Foley, MD. CMO of Scottsdale (Ariz.) Healthcare. Dr. Foley became CMO in 2008 after having served as medical director of academic affairs and chief academic officer for one year. Prior to joining Scottsdale Healthcare, Dr. Foley worked in a perinatal practice and maintains a limited clinical practice in maternal-fetal medicine. He is a past president of the Society of Maternal Fetal Medicine and is a board examiner in maternal fetal medicine.

Steven G. Gabbe, MD. CEO of the Wexner Medical Center at The Ohio State University (Columbus). Dr. Gabbe has served as CEO of the Wexner Medical Center since July 2008. He was previously dean of the Vanderbilt University School of Medicine in Nashville, Tenn., for seven years and chair of obstetrics and gynecology at the University of Washington Medical Center in Seattle.

Patricia Gabow, MD. CEO of Denver Health. Dr. Gabow, a nephrologist, will retire as CEO of Denver Health in September after leading the system for nearly 20 years. She joined Denver Health in 1973 as chief of the renal division and became medical director in 1981. She is an active proponent of indigent care and currently serves as a commissioner on the Medicaid and CHIP Payment and Access Commission. In 2010, she received New England Healthcare Institute’s “Innovator in Health” award for implementing lean management principles in the health system.

R. Wayne Gandee, MD. CMO of Carilion Clinic (Roanoke, Va.). Dr. Gandee became CMO of Carilion Clinic in 2011. He joined the system in November 2006 as chair and medical director of the department of radiology. He also serves as assistant professor of the department of radiology at Virginia Tech Carilion School of Medicine.

Kenneth Garay, MD. CMO of LibertyHealth System (Jersey City, N.J.). Dr. Garay, a practicing otolaryngologist, is CMO of LibertyHealth System, which includes Jersey City Medical Center, an emergency medical services organization and behavioral services. Dr. Garay played a large role in helping JCMC recruit more than 250 private community physicians to the medical staff over the past four years.

W. Brian Gibler, MD. President and CEO of University Hospital (Cincinnati). Dr. Gibler has served as president and CEO of University Hospital since September 2010. He was previously the Richard C. Levy Professor of Emergency Medicine and the chairman of the department of emergency medicine at the University of Cincinnati College of Medicine for five years. He was the executive co-chairman of the national quality improvement initiative called CRUSADE, which aimed to develop hospital-based strategies to reduce myocardial infarction occurrences.

Richard L. Goldberg, MD. President of MedStar Georgetown University Hospital (Washington, D.C.). Dr. Goldberg became president of Georgetown University Hospital in 2010 after having served as interim president for one year. He joined Georgetown in 1968 as a medical student and became a member of the Georgetown faculty in the department of psychiatry. He later served in several executive positions, including dean of graduate medical education, vice president of medical affairs and CMO.

Larry J. Goodman, MD. CEO of Rush University Medical Center (Chicago). Dr. Goodman, an internist, has been president and CEO of Rush University Medical Center since 2002. He also serves as president of Rush University, president of the Rush System for Health — a non-profit organization comprised of Rush University Medical Center, Rush Oak Park (Ill.) Hospital, Rush Copley Medical Center in Aurora, Ill., and Riverside Medical Center in Kankakee, Ill. — and principal officer of the Rush Board of Trustees. Dr. Goodman began the “Rush Transformation,” a 10-year, $1 billion project to rebuild a significant portion of the medical center, in 2006.

Gary L. Gottlieb, MD, MBA. President and CEO of Partners HealthCare (Boston). Dr. Gottlieb, a psychiatrist, has led Partners HealthCare since 2010. He previously served as president of Brigham and Women’s Hospital and Faulkner Hospital in Boston for eight years. He has also held leadership positions at the University of Pennsylvania in Philadelphia, serving as executive vice chair and interim chair of the university’s department of psychiatry and associate dean for managed care of the health system.

Howard R. Grant, MD, JD. CEO of Lahey Clinic (Burlington, Mass.). Dr. Grant has served as president and CEO of Lahey Clinic — which includes two hospitals and multiple primary care and specialty care sites — since November 2010. He was previously executive vice president and CMO of Geisinger Health System in Danville, Pa., and CMO of Temple University Health System in Philadelphia. He is a fellow of the American Academy of Pediatrics.

Robert L. Grossman, MD. CEO of NYU Langone Medical Center (New York City). Dr. Grossman is CEO of NYU Langone Medical Center and dean of the NYU School of Medicine. He joined NYU in 2001 as chairman of the department of radiology and previously served as chief

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of neuroradiology at the Hospital of the University of Pennsylvania in Philadelphia. Dr. Grossman recently received the gold medal of the International Society for Magnetic Resonance in Medicine.

Dean Gruner, MD. President and CEO of ThedaCare (Appleton, Wis.). Dr. Gruner, a family physician, is president and CEO of ThedaCare, a health system that is the third largest healthcare employer in Wisconsin. Before being named to his current position in 2008, he served as senior vice president and CFO of the system for five years. He was also CMO of Touchpoint Health Plan, which was sold to UnitedHealthcare in 2004.

Thomas Hansen, MD. CEO of Seattle Children’s. Dr. Hansen has served as CEO of Seattle Children’s since October 2005 and is also a professor of pediatrics at the University of Washington School of Medicine. He previously served as chairman and CEO of Nationwide Children’s Hospital in Columbus, Ohio. Dr. Hansen is a member of the Seattle Chamber Community Development Roundtable and serves on the board of the Greater Seattle Chamber of Commerce.

Rodney F. Hochman, MD. Group President of Providence Health & Services (Renton, Wash.). Dr. Hochman, a rheumatologist, became group president of Providence Health & Services in February when the system finalized an affiliation agreement with Seattle-based Swedish Health Services. In this role, he is responsible for regional operations and strategic and management services. Dr. Hochman had served as president and CEO of Swedish since 2007. Before then, he was executive vice president of Norfolk, Va.-based Sentara Healthcare.

Kevin Joseph, MD. CEO of West Chester (Ohio) Hospital. Dr. Joseph has served as CEO of West Chester Hospital since September 2010. He also serves as senior vice president of UC Health in Cincinnati, medical director of UC Health emergency medicine and an assistant professor at the University of Cincinnati department of emergency medicine residency program. Before becoming CEO of West Chester Hospital, he was medical director of West Chester’s emergency department.

Larry R. Kaiser, MD. President and CEO of Temple University Health System (Philadelphia). Dr. Kaiser became senior executive vice president for health sciences, dean of the Temple University School of Medicine and CEO of Temple University Health System in February 2011. He previously served as president and Alkek-Williams Chair of The University of Texas Health Science Center at Houston, where he was also a professor of surgery and professor of cardiothoracic and vascular surgery.

Alan S. Kaplan, MD. Senior Vice President and CMO of Iowa Health System (Des Moines). In addition to serving as senior vice president and CMO of Iowa Health System, Dr. Kaplan is president and CEO of Iowa Health Physicians and Clinics — a multi-regional medical group staffing more than 100 clinics. He has held these positions since 2009, before which he served in several leadership positions at Chicago-based Edward Health Services for 15 years.

Gary S. Kaplan, MD. Chairman and CEO of Virginia Mason Health System (Seattle). Dr. Kaplan, a practicing internal medicine physician, has served as chairman and CEO of Virginia Mason Health System since 2000. He is also a clinical professor at the University of Washington. Dr. Kaplan is a founding member of Health CEOs for Health Reform and has served on the boards of several organizations, including the Institute for Healthcare Improvement, the Medical Group Management Association and the National Patient Safety Foundation.

M. Narendra Kini, MD. President and CEO of Miami Children’s Hospital. Dr. Kini, who is board certified in pediatric emergency medicine, has served as president and CEO of 275-bed Miami Children’s Hospital since 2008. In this role, he oversees more than 650 physicians and 3,500 employees. He previously served as executive vice president of clinical operations improvement at Trinity Health in Novi, Mich., for four years.

John Koster, MD. President and CEO of Providence Health & Services (Renton, Wash.). Dr. Koster, an internist, has led Providence Health & Services as president and CEO since 2003. He joined the system in 1997 and was responsible for systems operations. He previously served as senior vice president of Irving, Texas-based VHA and has held leadership positions at Presbyterian Healthcare Services in Albuquerque, N.M., and Rocky Mountain Healthcare Company in Denver.

Paul Kronenberg, MD. President and CEO of Crouse Hospital (Syracuse, N.Y.). Dr. Kronenberg, a board-certified internist, became president and CEO of the non-profit, 506-bed Crouse Hospital in February 2004, shortly after the hospital came out of Chapter 11 bankruptcy. Under his leadership, the hospital has beaten budget targets every year since 2004. Dr. Kronenberg previously served as chief of medicine at the hospital for 20 years.

Mark Laney, MD. President and CEO of Heartland Health (St. Joseph, Mo.). Dr. Laney has served as president and CEO of Heartland Health since 2009. He previously served as president of the Cook Children’s Physician Network at Cook Children’s Health Care System in Fort Worth, Texas, for 15 years. He is also president of the board of the Mayo Clinic Alumni Association. Heartland Health recently joined the Mayo Clinic Care Network, providing the system access to Mayo’s expertise.

Robert J. Laskowski, MD, MBA. President and CEO of Christiana Care Health System (Wilmington, Del.). Dr. Laskowski, a geriatrician, became president and CEO of Christiana Care Health Sys-
James Leonard, MD. President and CEO of The Carle Foundation (Urbana, Ill.). Dr. Leonard is president and CEO of the non-profit integrated health system, The Carle Foundation, and its 325-bed Carle Foundation Hospital. He joined the Carle Clinic Association in 1984 as a primary care physician. He served as vice president of medical affairs of The Carle Foundation from 1997 to 1999 and was a member of its board of trustees from 1994 to 1999. He later held the positions of associate medical director of Carle Clinic and medical director of the employee assistance and sports medicine programs. Dr. Leonard became CEO in 2000 after serving in an interim role for one year.

James Mandell, MD. CEO of Boston Children's Hospital. Dr. Mandell, a urologist, is CEO of Boston Children's Hospital (formerly Children's Hospital Boston), a 395-bed center for pediatric healthcare. The hospital is also home to the John F. Enders Pediatric Research Laboratories, the world's largest research enterprise based at a pediatric hospital. Dr. Mandell is a member of the board of trustees and a senior associate in urology at the hospital, and a professor of surgery (urology) at Harvard Medical School in Boston.

Steve Markovich, MD. President of Riverside Methodist Hospital (Columbus, Ohio). As president of Riverside Methodist Hospital, Dr. Markovich oversees the largest hospital in the OhioHealth system. He joined the hospital in 1996 as a family and emergency physician and has held several positions since, including vice president of clinical services, associate medical director and senior vice president of operations. Dr. Markovich is also a Brigadier General in the Ohio Air National Guard, where he currently serves as chief of staff.

John McCabe, MD. CEO of Upstate University Hospital (Syracuse, N.Y.). Dr. McCabe became CEO of Upstate University Hospital and senior vice president for hospital affairs in August 2009 after having served as interim CEO for two months. He has held several positions at the hospital, including medical staff president, medical director and chair of the department of emergency medicine. He has previously served as president of the American College of Emergency Physicians and the American Board of Emergency Medicine.

John D. McConnell, MD. CEO of Wake Forest Baptist Medical Center (Winston-Salem, N.C.). Dr. McConnell, a urologist, was named the first CEO of Wake Forest Baptist Medical Center in 2008 when the medical center restructured its governance model to create a single CEO and board for North Carolina Baptist Hospital and Wake Forest University Health Sciences. Dr. McConnell previously served as executive vice president of health system affairs at Dallas-based University of Texas Southwestern for five years. He also served as urology department chair, prostate disease center director, vice president for clinical programs and executive vice president for administration at UT Southwestern.

Eugene J. McMahon, MD, MBA. President and CEO of Provena Saint Joseph Hospital (Elgin, Ill.). Dr. McMahon, a board-certified pathologist and surgeon, became president and CEO of Provena Saint Joseph Hospital in March 2011 after having served as CMO for a year. He previously served as CMO of Southcoast Hospitals Group in Fall River, Mass., and vice president of medical affairs at St. Francis Hospital/Covenant Healthcare in Milwaukee.

Nanette Mickiewicz, MD. President of Dominican Hospital (Santa Cruz, Calif.). Dr. Mickiewicz became the first physician president of Dominican Hospital — a member of San Francisco-based Dignity Health — in 2007 after serving in an interim role for seven months. She was previously CMO of the hospital and served on its medical staff, specializing in infectious diseases, for 13 years.

Edward D. Miller, MD. CEO of Johns Hopkins Medicine (Baltimore). Dr. Miller, an anesthesiologist, has served as CEO of Johns Hopkins Medicine and dean of Johns Hopkins University School of Medicine since 1997. He joined Johns Hopkins in 1994 as professor and director of the department of anesthesiology and critical care medicine. He recently oversaw the development of a $1.1 billion new facility. Dr. Miller will retire in June.

Elizabeth G. Nabel, MD. President of Brigham and Women's and Faulkner Hospitals (Boston). Dr. Nabel, a cardiologist, became president of Brigham and Women's and Faulkner Hospitals in Boston in January 2010. She was previously director of the National Institutes of Health's Heart, Lung, and Blood Institute, where she launched new scientific programs in genetics and genomics, stem and progenitor cell biology, translational research and other areas. She is currently on the editorial board of the New England Journal of Medicine.

Harris M. Nagler, MD. President of Beth Israel Medical Center (New York City). Dr. Nagler was named president of the 1,106-bed Beth Israel Medical Center in March 2010. He previously served as chairman of the hospital's department of urology for 21 years. Dr. Nagler is also a recognized clinical expert in male infertility issues.

Robert E. Nesse, MD. CEO of Mayo Clinic Health System (Rochester, Minn.). Dr. Nesse, a family physician, became CEO of Mayo Clinic Health System in March 2010. He joined the system in 1980 and served as residency program director for family practice from 1984 to 1990 and vice chair of Mayo Clinic Department of Family Medicine from 1990 to 1996. Before he was named CEO of Mayo Clinic Health System, he served as president and CEO of Franciscan Skemp Healthcare in La Crosse, Wis., a member of Mayo Clinic Health System.

Kurt Newman, MD. President and CEO of Children's National Medical Center (Washington, D.C.). Dr. Newman, president and CEO of Children's National Medical Center, joined the hospital in 1984 and became surgeon-in-chief and senior vice president of the Joseph E. Robert Jr. Center for Surgical Care in 2003. He was also vice president of the Sheikh Zayed Institute for Pediatric Surgical Innovation in 2009. Dr. Newman is a member of the board of commissioners of The Joint Commission and the board of governors of the American Pediatric Surgery Association.

John H. Noseworthy, MD. President and CEO of Mayo Clinic (Rochester, Minn.). Dr. Noseworthy, a neurologist, has served as CEO of Mayo Clinic since November 2009. He joined Mayo in 1990 and has served in various leadership positions since, including 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.

Charles O'Brien, MD. President of Sanford USD Medical Center (Sioux Falls, S.D.). Dr. O'Brien, who specializes in internal medicine, cardiovascular disease and interventional cardiology, has served as president of Sanford USD Medical Center since May 2007. Prior to that appointment he served as vice president of physician affairs of Sioux Valley Health System — the previous name of Sanford Health.

Steven J. Packer, MD. President and CEO of Community Hospital of the Monterey (Calif.) Peninsula. Dr. Packer has served as president and CEO of Community Hospital of the Monterey Peninsula since January 1999. He previously served as chief of staff and was medical director of the hospital’s intensive care unit for 11 years. Before joining the hospital, he was a partner in a cardiopulmonary practice. In February, Dr. Packer was elected as the 2012 chair of the California Hospital Association Board of Trustees.

L. Reuven Pasternak, MD. CEO of Inova Fairfax Hospital ( Falls Church, Va.). As CEO of Inova Fairfax Hospital, Dr. Pasternak oversees the main campus, Inova Fairfax Hospital for Children and the Inova Heart and Vascular Institute. He previously served as executive vice president and CMO of Health Alliance of Greater Cincinnati, and as the vice dean of the Bayview Campus for Johns Hopkins Medicine in Baltimore.
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David C. Pate, MD, JD. President and CEO of St. Luke’s Health System (Boise, Idaho). As president and CEO of St. Luke’s Health System, Dr. Pate oversees the only Idaho-based non-profit health system. He joined the system in 2009 from St. Luke’s Episcopal Health System in Houston, where he served as senior vice president and CMO, and CEO of St. Luke’s Episcopal Hospital.

Barbara R. Paul, MD. Senior Vice President and CMO of Community Health Systems (Franklin, Tenn.). Dr. Paul, a board-certified internist, became senior vice president and CMO of Community Health Systems in August 2006. She previously served as senior vice president and CMO of Beverly Enterprises and directed the Physicians’ Regulatory Issues Team at CMS. She practiced full-time in northern California for 12 years.

Ronald Paulus, MD, MBA. President and CEO of Mission Health System (Asheville, N.C.). Dr. Paulus joined Mission Health System in September 2010 as president and CEO. He previously served as executive vice president of clinical operations and chief innovation officer of Geisinger Health System in Danville, Pa. He was also co-founder, president and CEO of CareScience, a clinical solutions and data analytics provider that is now part of Premier.

Harold L. Paz, MD. CEO of Penn State Milton S. Hershey (Pa.) Medical Center and Health System. Dr. Paz became CEO of Penn State Milton S. Hershey Medical Center and Health System in April 2006. At that time he also took the positions of senior vice president for health affairs at Penn State University and dean of the Penn State College of Medicine in Hershey. He previously served as dean of the Robert Wood Johnson Medical School and CEO of Robert Wood Johnson University Medical Group in New Brunswick, NJ.

Jonathan B. Perlin, MD, PhD. President of Clinical and Physician Services Group and CMO of Hospital Corporation of America (Nashville, Tenn.). Dr. Perlin has served as president of clinical and physician services group and CMO of HCA since 2006. In this role, he leads clinical services and performance improvement at the system’s 164 hospitals and more than 600 outpatient centers and physician practices. He previously served as under secretary for health in the U.S. Department of Veterans Affairs and CEO of the Veterans Health Administration.

C. Wright Pinson, MD, MBA. CEO of Vanderbilt Health System (Nashville, Tenn.). Dr. Pinson, a liver and hepatobiliary surgeon, is CEO of Vanderbilt Health System and deputy vice chancellor for health affairs and senior associate dean for clinical affairs at Vanderbilt University Medical Center. He is also the program director of the Vanderbilt General Surgery Residency Program. He joined the system in 1990 and has had several leadership positions since, including chairman of the department of surgery, chairman of the medical board and CMO.

Kenneth S. Polonsky, MD. Executive Vice President for Medical Affairs at University of Chicago Medicine. As executive vice president for medical affairs at University of Chicago Medicine, Dr. Polonsky reports directly to the university president and serves as an officer of the university, overseeing the University of Chicago Medicine. He also serves as dean of the division of biological sciences, dean of the Pritzker School of Medicine and the Richard T. Crane Distinguished Service Professor of Medicine. He joined the University of Chicago faculty in 1981 and has served as section chief of endocrinology.

Claire Pomeroy, MD, MBA. CEO of UC Davis Health System (Sacramento). As CEO of UC Davis Health System, Dr. Pomeroy oversees the 631-bed UC Davis Medical Center, the School of Medicine, the Betty Irene Moore School of Nursing and an 800-member physician practice group. She is also an expert in infectious diseases and a professor of internal medicine and microbiology and immunology. She joined UC Davis in 2003 as executive associate dean of the School of Medicine and became vice chancellor and dean in 2005. Dr. Pomeroy is chair of the board of directors of the Association of Academic Health Centers and of the council of deans of the Association of American Medical Colleges.

John Popovich, MD. President and CEO of Henry Ford Hospital (Detroit). Dr. Popovich, a pulmonary disease and internal medicine specialist, became president and CEO of Henry Ford Hospital in July 2010. He joined the hospital in 1975 as a medical intern after he graduated from the University of Michigan Medical School. He also served as division head of pulmonary and critical care medicine for 10 years and chair of the department of internal medicine at the hospital.

Robert W. Pryor, MD. President and CEO of Scott & White Healthcare (Temple, Texas). Dr. Pryor became president and CEO of Scott & White Healthcare in April 2011. He previously served as CMO of the health system for six years and as COO for two years. He is a board-certified pediatrician and is certified in Lean process improvement. Prior to joining Scott & White, Dr. Pryor was CMO of St. Joseph’s Hospital and Medical Center in Phoenix.

Patrick J. Quinlan, MD. CEO of Ochsner Health System (New Orleans). Dr. Quinlan has served as CEO of Ochsner Health System since 2001. He will step down to head the new Ochsner Center for Community Wellness and Health Policy Sept. 1 and will continue to serve on the health system’s board of directors. Dr. Quinlan joined the system in 1998 as CMO.

Paul G. Ramsey, MD. CEO of UW Medicine (Seattle). Dr. Ramsey has served as CEO of UW Medicine since June 1997. He has concurrently held the positions of executive vice president for medical affairs and dean of the School of Medicine at the University of Washington. Dr. Ramsey previously served as acting chair and then chair of the UW department of medicine for seven years.

Roger A. Ray, MD. Executive Vice President and CMO of Carolinas HealthCare System (Charlotte, N.C.). As executive vice president and CMO of Carolinas HealthCare System, Dr. Ray oversees performance improvement in quality and patient safety as well as medical staff services, medical records, the Center for Clinical Data Analysis and the R. Stuart Dickson Research Institute. He joined CHS in 2007, before which he served as chief quality officer of Clearwater, Fla.-based BayCare Health System. Dr. Ray practiced clinical neurology for 10 years before taking on administrative roles.

Craig D. Rhyme, MD. CMO of Covenant Health System (Lubbock, Texas). Dr. Rhyme, a board-certified surgeon, became CMO of Covenant Health System in April 2011. He has served in several leadership roles at Covenant, including trauma medical director and chair of the Trauma Peer Review Committee and the Trauma Section Committee. Dr. Rhyme has also been an associate clinical professor of surgery at Texas Tech University Health Sciences Center since March 1999.

William L. Roper, MD. CEO of UNC Health Care System (Chapel Hill). Dr. Roper is CEO of UNC Health Care System, dean of the school of medicine and vice chancellor for medical affairs. He is also a professor of pediatrics in the School of Medicine and professor of health policy and administration in the UNC School of Public Health. Dr. Roper is a member of the Institute of Medicine of the National Academy of Sciences and serves on the board of trustees for the Robert Wood Johnson Foundation.

Fred Rothstein, MD. President of University Hospitals Case Medical Center (Cleveland). Dr. Rothstein, a pediatric gastroenterologist, has served as president of UH Case Medical Center since 2003. He is also a professor of pediatrics at Case Western Reserve School of Medicine and a gastroenterologist at Rainbow Babies & Children’s Hospital. In January, he was appointed chair of the American Hospital Association’s Section for Metropolitan Hospitals.

Lee Sacks, MD. Executive Vice President and CMO of Advocate Health Care (Oak Brook, Ill.). Dr. Sacks is executive vice president and CMO of Advocate Health Care and president of Advocate Physician Partners. He has been the
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president of the Illinois Academy of Family Physicians and a member of the Commission of Health Care Services of the American Academy of Family Physicians. In 2010, Dr. Sacks received the Robert Graham Physician Executive Award from the American Academy of Family Physicians.

Steven M. Safyer, MD. CEO of Montefiore Medical Center (New York City). Dr. Safyer has served as CEO of Montefiore Medical Center since 2008. He has served in several leadership positions at the hospital, including senior vice president and CMO, since 1985. He is a member of the Hospital Association of New York State and the Association of American Medical Colleges.

Mike Schatzlein, MD. President and CEO of Saint Thomas Health Services (Nashville, Tenn.). Dr. Schatzlein, a cardiac surgeon, was named president and CEO of Saint Thomas Health Services in June of 2010. He is also the Ascension Health ministry market leader for Nashville, Tenn., and Birmingham, Ala., a role in which he promotes alignment and helps direct strategic positioning and operational performance of Ascension’s health ministries in the Nashville/Birmingham market. He previously served as CEO of Lutheran Health Network in Fort Wayne, Ind.

Joseph A. Scopelliti, MD. President and CEO of Guthrie Health (Sayre, Pa.). In March, Dr. Scopelliti became the sole CEO of Guthrie Health after serving as co-CEO of the health system and president and CEO of Guthrie Clinic, a multispecialty group practice. He joined the clinic in 1984 and continues to practice as a gastroenterologist at the clinic. He is also a clinical instructor with the State University of New York Upstate Medical University at Syracuse and the chairman of the Guthrie Graduate Medical Education Committee.

David J. Shulkin, MD. President of Morristown (N.J.) Medical Center. Dr. Shulkin, a board-certified internist, has served as president of Morristown Medical Center and vice president of parent organization Atlantic Health System since July 2010. He is also president of Atlantic Accountable Care Organization, a Medicare-approved ACO. He previously served as president and CEO of Beth Israel Medical Center in New York City, and CMO of the University of Pennsylvania Health System, the Hospital of the University of Pennsylvania and Temple University Hospital, all in Philadelphia.

Peter L. Slavin, MD. President of Massachusetts General Hospital (Boston). Dr. Slavin became president of Massachusetts General in 2003 after having served as chairman and CEO of Massachusetts General Physicians Organization for three years. He previously served as president of Barnes-Jewish Hospital in St. Louis. He teaches internal medicine and healthcare management at Harvard Medical School.

Charles Sorenson, MD. President and CEO of Intermountain Healthcare (Salt Lake City). Dr. Sorenson, a urologic surgeon, became president and CEO of Intermountain Healthcare in 2009 after having served as executive vice president and COO of the system for 11 years. He has also served as vice chairman of the department of surgery, president of the medical staff and a member of the board of trustees of LDS Hospital in Salt Lake City. In addition to his role at Intermountain Healthcare, Dr. Sorenson is an adjunct professor of surgery at the University of Utah.

Jeffrey Sperring, MD. President and CEO of Riley Hospital for Children at IU Health (Indianapolis). As president and CEO of Riley Hospital for Children at IU Health, Dr. Sperring oversees pediatric

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services throughout IU Health, including leading programs at Riley Hospital for Children and providing shared oversight for programs in the community hospitals. A board-certified pediatrician, he serves on the National Association of Children’s Hospitals and Related Institutions Council for Child Health Quality and is a member of the Pediatric Hospital Medicine Roundtable. In addition, Dr. Sperling served as an officer in the United States Navy Medical Corps from 1995 to 2001.

Glenn Steele Jr., MD, PhD. President and CEO of Geisinger Health System (Danville, Pa.). Dr. Steele has served as president and CEO of Geisinger Health System since 2001. He previously served as vice president for medical affairs and dean of the Pritzker School of Medicine as well as professor in the department of surgery at University of Chicago. Dr. Steele is a past chairman of the American Board of Surgery and is well-known for his findings in the treatment of liver cancer and colorectal cancer surgery.

Jeffrey Steinberg, MD. CEO of Weiss Memorial Hospital (Chicago). Dr. Steinberg, a urological surgeon, became CEO of Weiss Memorial Hospital in September 2011. He previously served as senior vice president for health policy and disparity in addition to chairman and director of surgery at Saint Francis Hospital and Medical Center in Hartford, Conn., for five years. He was also chief of surgery at Saint Vincent Hospital in Worcester, Mass.

Ronald W. Swinford, MD. CEO of Lehigh Valley Health Network (Allentown, Pa.). Dr. Swinford, a board-certified dermatologist, has served as CEO of Lehigh Valley Health Network since November 2010. He previously served as the health system’s CMO from 2003. Before joining LVHN, he was chair in the departments of dermatology and internal medicine at the University of Missouri-Columbia.

Kevin Tabb, MD. President and CEO of Beth Israel Deaconess Medical Center (Boston). Dr. Tabb has served as president and CEO of Beth Israel Deaconess Medical Center since October 2011 after having served as CMO of Stanford Hospital & Clinics in Palo Alto, Calif. He was previously chief quality and medical information officer at Stanford. He was also the head of the clinical data services division of GE Healthcare IT.

Jeffrey Thompson, MD. CEO of Gunderson Lutheran Health System (La Crosse, Wis.). Dr. Thompson, a pediatric intensivist and neonatologist, has served as CEO of Gunderson Lutheran Health System since 2001. He is also chairman of the board of governors and board of trustees, both of which he has been a member of since 1996. Dr. Thompson joined the health system — then Gunderson Clinic and Lutheran Health System — in 1984 and served as executive vice president from 1995 to 2001.

Nick Turkal, MD. President and CEO of Aurora Health Care (Milwaukee). Dr. Turkal, a family practice physician, joined Aurora Health Care in 1987 and became president and CEO in 2007. He previously served as a senior vice president and president of Aurora Health Care’s metro region, where he oversaw the operations of the system’s facilities and services in the Milwaukee area.

Stephen L. Wallenbaupt, MD. Executive Vice President and CMO of Novant Health (Winston-Salem, N.C.). Dr. Wallenbaupt, a board-certified cardiovascular surgeon, is executive vice president and CMO of Novant Health. He served as executive vice president for medical affairs of Presbyterian Healthcare in the Charlotte, N.C., region from 2001 to 2006, prior to which he was a partner of Hawthorne Cardiovascular Surgeons for eight years. He has also held the position of assistant professor of cardiothoracic surgery at Wake Forest University School of Medicine in Winston-Salem, N.C.

James Weinstein, DO. CEO of Dartmouth-Hitchcock (Lebanon, N.H.). Dr. Weinstein, a spine surgeon, is CEO of Dartmouth-Hitchcock, a health system that includes Dartmouth-Hitchcock Medical Center; Dartmouth-Hitchcock Clinic, a network of more than 1,200 physicians; the Geisel School of Medicine at Dartmouth; and several other clinics and facilities. Before becoming CEO of the system, he served as president of Dartmouth-Hitchcock Clinic and director of The Dartmouth Institute for Health Policy and Clinical Practice. Dr. Weinstein is also a founding member of the national Collaborative for High Value Healthcare.

Allen S. Weiss, MD. President and CEO of NCH Healthcare System (Naples, Fla.). Dr. Weiss became president and CEO of NCH Healthcare System in 2006. He led a private practice in internal medicine, rheumatology and geriatrics from 1977 to 2000. In 2010, he received a Distinguished Executive of the Year award from the Women’s Bar Association of Florida.

Mark J. Werner, MD. Chief Clinical Integration Officer of Fairview Health Services (Minneapolis). As chief clinical integration officer of Fairview Health Services, Dr. Werner oversees quality, patient safety and patient experience initiatives; medical staff management; and clinical research and education in addition to Fairview Medical Group and Fairview Health Network. Dr. Werner, a pediatrician, has held his current role since 2011 after having served as president of Carilion Clinic Physicians and executive vice president and CMO of Carilion Clinic in Roanoke, Va.

Michael Wiemann, MD. President of Providence Hospital (Southfield, Mich.). Dr. Wiemann, a medical oncologist, is president of Providence Hospital and executive vice president of parent company St. John Providence Health System, West Region. He joined the Warren, Mich.-based health system in December 2007 as executive vice president of medical affairs and CMO. He previously served as senior vice president and CMO of Indianapolis-based St. Vincent Hospitals and Health Care Center, and was a professor at Brown University School of Medicine in Providence, R.I.

Nicholas Wolter, MD. CEO of Billings (Mont.) Clinic. As CEO of Billings Clinic, Dr. Wolter heads a non-profit health system that includes a 272-bed hospital, a surgery center, a multi-specialty group practice and several other facilities. Dr. Wolter, who is board certified in internal and pulmonary medicine, formerly served as a member of the board of directors of the American Hospital Association and the American Medical Group Association. He is also a former Commissioner on the Medicare Payment Advisory Commission.

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Focus on: Community Hospitals

Is the Community Hospital a Dying Model, or is it the Future of Healthcare? (continued from page 1)

able to develop new care models more effectively because they are smaller and closely aligned with the community. Here, several community hospital leaders discuss the biggest challenges they face and what they have to do to thrive in the new era of healthcare.

Advantages and disadvantages of community hospitals

While often seen as a disadvantage, community hospitals’ small size may be an advantage in the drive to reduce costs and improve quality. “The smaller your system is, the easier it is to redesign it,” says John Chessare, MD, president and CEO of Greater Baltimore Medical Center HealthCare, which includes a 281-bed community hospital. “The larger your system is, the harder it is to get standardized work in place. And then you have to ask, is it really a system or just a confederation of units? There are a lot of hospital companies that call themselves a system, but in reality each hospital is operating independently from each other. A community hospital and its medical staff should be able to get to care that is coordinated through the eyes of the patient at a much faster pace than a large hospital company with loosely affiliated physicians.” Small, close-knit community health systems may thus be able to change from a fee-for-service care delivery model to a pay-for-performance system more quickly and easier.

On the other hand, one of the disadvantages of community hospitals is their relatively lower access to medical professionals, partly due to their size and location. “[Academic medical centers] have access to larger pools of qualified medical staff and professionals,” Mr. Bateman says.

Hospital-physician alignment challenges

Recruiting and partnering with physicians is one of the greatest challenges facing community hospitals today. This challenge may drive some community hospitals to work with academic medical centers and other hospitals to increase the number of physicians available to them. Recruitment of primary care physicians is particularly challenging, according to John Federspiel, president and CEO of 128-bed Hudson Valley Hospital Center in Cortlandt Manor, N.Y. “Regarding physician recruitment, we are aggressively facilitating discussions with the major medical schools in the New York region,” he says.

Partnering with physicians is key to improving care while reducing costs, as the hospital and physicians can then align incentives for standardizing processes and reducing waste. “You can’t redesign the system without the physicians being in the lead,” Dr. Chessare says. Community hospitals generally have fewer existing relationships with physicians outside their hospital than larger hospitals and may thus have to work harder to transition to a new coordinated model of care. “We must continue to bring physicians to the table to make certain our partnership efforts are collaborative,” says Barbara Tachovsky, RN, MS, president of 226-bed Paoli (Pa.) Hospital. “Our success depends on taking action together.”

Meeting the community’s needs

In addition to partnering with physicians, community hospitals need to strengthen their engagement with the community to ensure they are meeting patients’ needs and to expand services into less costly and more efficient care settings. “We need to enhance community-provider relationships so care continues seamlessly beyond the hospital and is as focused on preventing illness as it is on treating disease,” Ms. Tachovsky says. “We need to partner with other community providers to address the continuum-of-care and cost-of-care issues for our patients.”

For example, Hudson Valley Hospital Center is working with area nursing homes to reduce hospital readmissions. Mr. Federspiel says the hospital meets with all area nursing homes quarterly to review their readmission activity, giving the nursing homes an opportunity to benchmark best practices.

GBMC is engaging more with the community by moving towards a patient-centered medical home model. Under this model, the health system offers care coordinators, electronic medical records, a disease registry for patients with chronic diseases, after-hour visits, group visits and educational opportunities. The health system is also planning to work with local schools to combat childhood obesity by increasing the amount children exercise.

Bending the cost curve

Community hospitals may have to make significant changes in some processes to create efficiencies and reduce cost. Reducing waste may be particularly important for community hospitals compared with larger hospitals because they typically have less capital resources, meaning less room for error in meeting new quality and cost demands. “They will have to be extremely conscious of their operating and balance sheet positions month by month and year by year moving ahead, build in significant cushions to account for uncertainty and be able to manage revenues and costs service-by-service on a much more granular basis than in the past,” Mr. Bateman says.

At GBMC, each manager does a “waste walk” in his or her assigned area to identify processes that could be streamlined. Dr. Chessare says Maryland’s hospital rate-setting commission decided to increase hospitals’ rates by 0.3 percent, while the increase in inflation is about 2.5 percent. “There is immediate pressure to drive waste down,” he says.

Creating a high reliability organization

Hospitals need to become high reliability organizations, meaning they can consistently deliver high quality outcomes at lower cost by standardizing work and empowering employees to find and remove defects in care, according to Dr. Chessare. As do other hospitals, community hospitals need to implement evidence-based practices to prevent harm and improve quality. For example, GBMC standardized a method for inserting and extracting central lines and has not had a central line-associated bloodstream infection for approximately six months.

Comparing quality outcomes with local and national benchmarks is also important for identifying areas for improvement. “We need to continue to focus on creating a reliable culture of safety. Part of this process is sharing our results with internal audiences so we can plan for continued improvement,” Ms. Tachovsky says.

Looking in the crystal ball

While community hospitals face many of the same challenges faced by large hospitals, such as aligning with physicians, reducing cost and improving quality, they have unique features that bring both advantages and disadvantages. Though community hospitals usually have less access to capital and physicians, they are closely engaged with the community and can use their size to their advantage when redesigning care delivery systems. Overall, which win out — the advantages or the disadvantages?

“I don’t see any future for community hospitals,” Dr. Chessare says. “I think there’s a fantastic future for community health systems. It small standalone hospitals are only doing what hospitals have done historically, I don’t see much of a future for that. But I see a phenomenal future for health systems with a strong community hospital that breaks the mold [of patient care].” Dr. Chessare says the future for community hospitals is to be one part of a system that is focused on improving health. The patient-centered medical home model will be the anchor of this new system.

Similarly, the definition of a community hospital as a facility may change in the future, according to Mr. Bateman. “The physical hospital will matter less in the future than the cumulative assets that the hospital entity brings to the table in the form of engaged, informed and committed medical staff and professionals,” he says.

Whether a hospital, health system or a patient-centered medical home, community healthcare organizations that can align with other providers to reach financial, operational and clinical goals will likely succeed. “The future of community hospitals that stay focused on quality and cost is challenging but very promising,” Ms. Tachovsky says.
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Community Hospital CEO Panel: 3 Leaders Share Insights on the State of Community Hospitals

By Bob Herman

Community hospitals are the lifeblood of most of the communities they serve. They usually are a major employer, if not the largest employer, and people generally look to them as a source of stability — knowing that if something bad happened, the hospital would have its doors open.

That is no longer a given in today’s healthcare economic environment. Hospital layoffs are rampant, and a supreme dependency on sufficient reimbursements has some community hospitals shaking in their boots. In fact, some smaller hospitals — like Scott County Hospital in Oneida, Tenn. — are being forced into closure due to a lack of capital, squeezed payments or an inability to find a strategic partner or buyer.

Three community hospital CEOs — Mike Patterson of 50-bed Colorado Plains Medical Center in Fort Morgan, John Sernulka of 189-bed Carroll Hospital Center in Westminster, Md., and Phil Wright of 90-bed Southampton Memorial Hospital in Franklin, Va. — impart their thoughts and guidance on what small and rural hospitals are going through right now and what they can do to stay alive while maintaining their community-based roots. There is plenty of hope; it just takes the right strategic planning.

Question: What are some of the biggest challenges your community hospital, and community hospitals in general, face today?

Mike Patterson: Something that all hospitals are facing is cuts to Medicare and Medicaid reimbursement. Our state instituted around a 5 percent reduction in Medicaid rates over the last couple years. That puts pressure on everybody.

The Colorado provider fee was implemented here a couple years ago, and it has really helped us, as a rural hospital, in getting a little more reimbursement. It also has helped because it has allowed Colorado to add about 50,000 Medicaid recipients to the rolls. That is in jeopardy right now in Washington, so keeping the provider fee is a big issue for us.

We’re a 50-bed, rural hospital, and our volume fluctuates every day. The low-volume Medicare adjustment also really helps us to keep the staff we need here. Again, that is something that is in jeopardy in Washington. It seems we continually face cuts in payments while at the same time are expected to increase quality.

Another challenge is the recruitment of physicians. We’re combating that by getting out there with many different recruiters. LifePoint Hospitals, who is our parent company, has a recruitment division and is helping us find physicians, as well. Those are our biggest issues right now.

John Sernulka: The biggest challenge facing community hospitals is that we are the safety net for the entire health delivery system in our community. We are the largest employer in the community, outside of the public school system, and we are often seen as the organization with the means to be able to help out with a wide range of challenges — this includes supporting the indigent populations, such as the under- and uninsured. The community hospital is the last bastion of resources to hold a system together.

The other big issue is the current healthcare delivery system is so fragmented. Many organizations operate independently — nursing homes, hospitals, radiology, physical therapy — and there’s no linkage of data between any of these entities. This fragmented system has created a big waste of healthcare dollars, and the economic incentives aren’t aligned with efficiency. The burden of re-engineering the health system is eliminating this fragmentation and creating a seamless, integrated, coordinated system of care. And it is falling on hospitals to take the lead in that role.

Phil Wright: I think one of the biggest challenges for my community hospital is the physician recruitment of specialists. Typically in the past, we’ve done a good job recruiting in some of the primary care areas, but when you talk about specialties and subspecialties, it gets more complicated. Finding qualified, well-skilled physicians in areas like general surgery, cardiology, gastroenterology, urology and orthopedics can be challenging. Most small communities do not have the volume to support these specialists — especially if they are sole providers. Today’s medical students seem to be more interested in their quality of life rather than working long hours and constantly being on call.

Q: How is your hospital bracing for the Patient Protection and Affordable Care Act, and what specific measures are you taking to reform the community delivery system?

MP: The biggest struggle for us is the uncertainty of what is going to happen with the Af-
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In the wake of the Affordable Care Act, we know as an industry we need to change the delivery model, and all hospitals are working on trying to implement the information technology infrastructure that is required to build a better delivery system down the road. We’re also working to position ourselves in the community as a wellness provider, not just a provider that fixes you when you’re sick.

We started a service line that focuses on outreach to businesses. We help them by bringing physicians or dieticians in to talk to their employees about becoming healthier. We also have implemented a phone number their employees can call if they need to see a physician or need a service at the hospital. We try to make it easier for them to navigate through the health system. That’s a huge part of positioning ourselves for affordable care, and that’s driving us to keep people healthy. But the reimbursement isn’t looking at the model yet. Accountable care is pushing us toward the wellness side, and the payment model has to be changed so it’s something that we can actually do.

**JS:** What we’re seeing is healthcare will be driven by provider accountability. Physicians, hospitals, allied health professionals — all providers are accepting the accountability of treating patients more efficiently, focusing on disease management, coordinating and sharing data so we can identify the top 20 percent of patients that are spending 80 percent of the healthcare dollars, and finding a more coordinated way to manage those patients so they stay well.

Another big step is in population health — we will be paid to manage a certain region, and we’re at risk to manage that population with a set amount of dollars, or a capitated payment, no matter where that patient goes for care. We have to be able to monitor those patients even when they are out of state. We call our “accountable care organization” the physician-hospital organization.

**PW:** A lot still remains to be seen. Like many across the country, we’re in a community where we were hit hard by unemployment. We had a major employer, International Paper (that has been the centerpiece of the economy in this area for well over 100 years), shut down in 2010, and that left a huge void — not only for that mill but also a lot of support jobs in the area that supported that mill. It’s made for some tough economic times.

As a result, many people have lost jobs and health insurance. The Affordable Care Act could be good. Theoretically, if there’s a mandate, all of those people could be insured, and that would at least help my hospital gain partial reimbursement for patients we already care for. On the flip side, we can all agree that the present system for healthcare delivery is hugely expensive, and it remains to be seen where the resources will come from. Ultimately we have to be cost-conscious and more creative in how we deliver care. Looking at things like ACOs and some of the other initiatives focused on quality, safety and efficiency are the things every healthcare organization should be trying to do. We want to give the best possible care but do it as efficiently as we can.

**Q:** What must community hospitals do to maintain profitability? And what positive trends have you seen in community hospital service lines, payor mixes and other financial metrics?

**MP:** We are affiliated with LifePoint Hospitals, and LifePoint is a great resource for us to navigate the political, quality and legal issues and get better pricing on supplies. They are there to help, but they still allow us, as a hospital, to determine what our strategies are because there are different needs in every community.

LifePoint has what we call the “High Five Guiding Principles”: Delivering high-quality patient care is the top priority, along with supporting physicians, creating an excellent workplace for employees, strengthening the hospital’s role in the community and ensuring fiscal responsibility. If we continue to follow these principles and use them to guide our strategy, we can remain profitable.

I mentioned quality, and that’s always our number one priority. We’ve focused on our fall rate, hospital-acquired infections and the percentage of patients who are returning with the same admitting diagnosis within 30 days. We’ve been able to reduce fall rates by 40 percent by creating committees, meeting weekly and hearing ideas from different people. Another priority is customer service. We’ve had a significant focus on customer service and have conducted customer service training with our employees. We’ve seen our HCAHPS scores go up to the 94th percentile nationally on the inpatient side.

We’re also always looking to see what the community needs are in the healthcare arena. An example of that was an assessment we did on the need for psychiatric care in our community. We found that there really was no other kind of psychiatric care in northeast Colorado, so we decided to start a geriatric psychiatric unit to meet the needs of the people here and the nursing homes that were begging to have somewhere for patients to go for a short inpatient stay. We opened that unit in 2008, and right now — because of the great need there was, and we are the only one in the area — we pull patients from Nebraska, Kansas and Wyoming. We’re expanding that unit from 10 beds to 14 beds to meet the demand we are seeing. It’s about always analyzing the needs of the community and finding out what we can do to meet those needs so [patients] don’t have to travel long distances for their healthcare.

**JS:** Some hospitals may be profitable where they don’t have a lot of debt or are not building the infrastructure toward accountable care. Here in Maryland where our [reimbursement] rates are tightly regulated, we have to operate within the rates that are set. In Maryland, they actually gave us a 0.3 percent net increase in our rates last year, but we’re finding our costs are going up 10 percent. Obviously, over a period of several years, we’re going to reach a point where it will be difficult to remain a standalone, independent hospital.

**PW:** From a hospital standpoint, it’s tough when you have to look at service lines and figure out if it’s something you can sustain. With decreased reimbursements in certain areas, you are forced into closely monitoring the value of services offered. Honestly, it appears there are very few positive trends in reimbursement for many service lines. Like the saying goes, “volume cures all,” and many of them can be successful if managed well. If you can manage the Medicare and Medicaid population, and the entire population for that matter, and keep within the confines of some of those guidelines the different payors have for you, then you can still do well as a community hospital. Obviously, if volumes are not trending favorably for the hospital, then expense management is paramount. Flexing staff, payroll management and supply costs are all indicators that cannot be ignored. It’s not impossible if these things are managed well.

Additionally, much of it does come down, again, to recruiting and keeping your patients at home instead of choosing a competing hospital down the road. You have to get creative with how you bring some of these physicians to the area and into certain service lines such that it allows them to practice [indepedently] but still gives them a lifestyle they’re looking for.

**Q:** Can a community hospital stay independent in the future?

**MP:** I don’t think it’s impossible, but I think many hospitals are aligning themselves — either actually going out and selling or entering into a management agreement — with a parent company. I’m seeing a lot of hospitals doing that because they need the support.

For example, hospitals around us are struggling with IT implementation. The state of Colorado has tried to help out some of those hospitals. For us, LifePoint has helped us get these systems in place. It’s made it one less headache. Other hospitals in our community are aligning with larger entities to get support. I think it’s going to be tough for small community hospitals to be out there doing it on their own.

**JS:** I do think there is going to be the opportunity for a number of hospitals to stay independent. For example, sole community hospitals in a rural county where you don’t have a lot of hospitals trying to compete for patients in that market. There may be enough volume there to support the costs of running a hospital.

In our case, we’re in a suburban/rural community, but we are also a bedroom community for...
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Jim Skogsbergh, President and CEO, Advocate Health Care
Quint Studer, Consultant and Founder, Studer Group

Many hospitals have to look at consolidating with health systems. Some benefits include centralizing departments like IT, billing and human resources — you can see 5 to 7 percent in savings fall to the bottom line by joining a system. Other hospitals are going to just operate basically at a 0 percent margin. Some of them may have to make tough decisions. An example may be a service line like obstetrics. For most hospitals, that is a service that loses money, and some hospitals may have to decide to close a service line. There isn’t one universal answer to how hospitals are going to keep afloat, but if you’re in a highly competitive area, I don’t see how an independent hospital can make it.

PW: That’s a good question. There’s a lot of activity right now within our own parent company, Community Health Systems. There is a lot of acquisition activity out there. These community hospitals are struggling. If you don’t have the capital resources and technology aligned with a bigger system, it’s easy to get behind, especially in this day of consumerism where the patient has a choice of where they can go. They have easy access to things on the Internet — core measures, clinical indicators, patient satisfaction — all of that is at their fingertips now. If you’re not at the leading edge in those areas, you’ll get left behind.

Q: What is most important for a community hospital to reach clinical and financial success simultaneously?

MP: That really goes back to our High Five. The clinical side is an absolute must. If you’re providing high-quality care, that’s what physicians really care about when they treat their patients. Also, having a great working environment is important. It doesn’t matter how many patients you have if you don’t have a staff to take care of them. The community has to feel it is their hospital, so that’s really what we focus on. The High Five are really our guiding principles that help us reach clinical and financial success.

JS: If you do it right the first time, you don’t have to spend dollars to fix mistakes. A successful organization is one that is really committed to hardwiring, in all of its processes, an experience that is of the highest caliber and care that is evidence-based. If all that is done right, you can really deliver the lowest-cost service and, therefore, increase your chance that savings will fall to the bottom line and have those dollars to reinvest. But that’s what it’s all about — doing it right the first time.

PW: Clinical and financial success comes down to what any other organization wants — and that’s good people. If you have the right people in the right positions — managers and directors that view their respective departments as mini-companies of whom they are the CEO — then you should have a well-run organization. That includes case management cooperating and communicating with physicians to keep length of stay down, supply managers dedicated to purchasing quality items at a great price, nurses committed to patients’ care as if it were their own family member, administrators that effectively communicate, develop and implement the strategic goals of the organization — it really takes a team approach to make sure all of those entities are being held accountable in order to run an efficient hospital. Every function and responsibility in the hospital is important and necessary. If all those functions come together, it will lead to a positive experience, patients will come back to you, and in most cases, the financial reward will be positive.

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Examining the Crossroads of Culture, Engagement and Patient Satisfaction

By Paul Spiegelman, CEO of BerylHealth

Running a company that interacts closely with patients and hospitals, we have a mandate to deliver a consistently high level of service to everyone we touch. We make no secret that our workplace culture is the driver behind that service. The same is true for nearly every consistently successful company in any industry, and that same culture of service is now being required of healthcare providers.

For hospitals and other care facilities, the mandate on culture goes beyond just delivering “great service.” With patient satisfaction scores part of the equation that determines reimbursements, having a highly engaged workforce delivering the best service possible is one of the few factors that you can actively develop and commit to. Just how important is employee engagement for hospitals? Consider this sample of literature, white papers and discussion on the topic:

- “Creating Sustainable Performance” (Harvard Business Review; January/February 2012)
- “Hospitals Leverage Employee Engagement To Increase Patient Satisfaction” (HR.com; May 2012)
- “The Relationship Between Employee Satisfaction and Hospital Patient Experiences” (FORUM whitepaper; April 2009)
- “Engage Your Nurses in Improving HCAHPS” (The Baird Group Blog; April 19, 2012)
- “When We’re Feeling Better, They’re Feeling Better” (Towers Watson whitepaper; n.d.)

While academic study of this topic can supply us with the theoretical and statistical impact of the discussion, it’s the personal impact of the initiatives that add color and create a whole picture of what workplace culture investment means for employee engagement. Here’s a sampling of CEO comments from some of the top hospitals around the country:

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“The only way that we could achieve world-class care was through a dynamic and cohesive team of employees.” — Rulon Stacey, CEO, Poudre Valley Health System, Fort Collins, Colo.

Unifying your employees

“You need a unifying theme. If you focus on culture, especially in the healthcare industry, and you have organizations that are typified by silos, you could focus on engagement, but only within their silo. We try to organize a matrix organization that [is] truly cross functional.” — Wayne Lerner, CEO, Holy Cross Hospital, Chicago

Involvement and transparency

“Give them multiple opportunities to share their input and have the transparency to get back to them and let them know what you did with their ideas. If people believe their voice is heard, they will be more engaged.” — Tony Armada, CEO, Advocate Lutheran General Hospital, Oak Brook, Ill.

“Big connection between employee engagement and patient experience. If they understand the mission and the vision, it trickles over into the patient. Patients will say that despite all of the stuff they were going through, they comment about how kind and helpful the employees were.” — Melody Trimble, CEO, Sparks Health System, Fort Smith, Ark.

“So it’s not just about getting people to do better, behave differently, to do what they’re currently doing in a nicer and better and more efficient manner. That’s not even half the battle. The other piece of it is without an engaged, satisfied, (I want to say excited but that’s probably not the right word), workforce that’s capable of change management and changing the way we do things, we can’t succeed because this industry is broken.” — Elliot Joseph, Hartford (Conn.) Healthcare

Examining the personal perspectives and opinions of CEOs provides a valuable insight and context behind the employee engagement results that many hospitals are able to achieve.

If you’re the CEO of a hospital facing possible repercussions in HCAHPS scores and reimbursements because of low employee engagement, the best opportunity to move forward is to focus on your greatest resource, your people. Make a commitment to culture, and you’ll reap the rewards across many avenues.

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A combination of economic, regulatory and competitive market forces is transforming the healthcare industry. Hospitals and physicians are no longer solely compensated for the volume of sick patients they treat. Rather, new financial incentives encourage providers to work together to improve health outcomes and keep patients well. As providers join forces to deliver the preventive care that payors are emphasizing today, there has been an uptick in hospital and physician practice integration. Nearly 75 percent of the physicians in a recent PricewaterhouseCoopers survey said they are already in financial relationships with hospitals, and more than half say they want to become closer. [1]

This interest in working together is not unprecedented. In the 1990s, hospitals rushed to absorb physician practices in an effort to expand and maximize reimbursement. This experiment ultimately failed when reimbursement models proved not to be as beneficial to hospitals as they had hoped. Hospitals ultimately divested their practices, and the tenuous trust between hospitals and physicians eroded.

Today’s healthcare landscape is once again making integration attractive to hospitals and physician practices. But this time the motivation for integration goes beyond maximizing profits. Enhancing quality of care is a key focus, since new payment schemes have created financial incentives for improved clinical outcomes. Many hospitals believe new care delivery and payment models — including accountable care organizations, bundled payments and value-based payments — are the inevitable wave of the future, making convergence with physician groups part of the solution. The more integrated the care delivery, the thinking goes, the better chance there is of effectively and efficiently managing patient outcomes.

By owning a physician group through purchase — one form of hospital-physician integration — hospitals can team with physicians to drive down medical costs and ultimately be more profitable. But purchasing a physician practice does not always pay dividends. Every deal has some risk and should be examined carefully.

Successful buyers have tailored a robust due diligence process that addresses financial and legal considerations. But other factors such as governance, human resources, compliance and information technology are also key valuation considerations that should not be overlooked. All of these factors should influence a buyer’s financial model and ultimately determine if acquiring a physician group fits into a hospital’s overall growth strategy.

With that in mind, hospital management teams should answer eight important due diligence questions before making a physician practice transaction:

1. **What type of practice is it?** Acquiring a practice must be viewed as a strategic decision that takes into account the mission of a prospective practice, its service offerings and its compatibility with the acquiring hospital or health system. A hospital’s evaluation of a transaction should go beyond financial considerations and also consider how clinical outcomes and continuity of care will improve. Hospitals should ask themselves: Does this group of physicians apply the appropriate care to the appropriate patients in the appropriate venue? Is patient satisfaction measured and taken into account? Do physicians follow evidence-based guidelines? Do physicians work in silos or as part of a coordinated care team?

2. **How can I bridge a practice’s historical financial performance to its forecasted results?** Most buyers perform financial due diligence to analyze the company’s historical “quality of earnings.” This analysis assesses the impact of non-recurring items and non-operating costs and revenues and ultimately should help the buyer form an opinion of the sustainability of revenue and earnings. Common diligence procedures also analyze trends in revenue and margins by specialty. Once past performance is analyzed, it is used to bridge the historical performance to management’s forecast. Prospective buyers should ask themselves: Is this forecast achievable based on the historical results? Has the financial model considered the expected decline in Medicare rates?

3. **What are the practice’s working capital requirements?** A buyer should understand the current working capital needs of a prospective practice by analyzing its historical trends. The overall cash cycle should also be assessed. How long does it take to convert a medical procedure into cash? How much of the actual gross billing can actually be collected? Some physician groups may also own an insurance plan requiring that certain cash levels are maintained for state solvency requirements. Capital expenditures should also be evaluated. Capital investments related to physical locations for urgent care centers, ambulatory centers and information technology — especially electronic health records — will be necessary for physician groups to compete in the new marketplace. In fact, the need for capital investment may be one of the reasons a physician group is inclined to sell.

4. **Should I assume a practice’s debt?** In general, it is not advisable for a hospital to assume the debt of a practice it wishes to acquire. However, some debt takes a while to reveal itself. During diligence it is important to identify these “debt-like” items. They are commitments or contingencies that are not recorded on the balance sheet but may require funding post-transaction. Examples include the cash cost of an unfunded pension liability and change in control payments (triggered upon a transaction). If diligence procedures are not created to uncover these, buyers are putting themselves at risk of inheriting financial obligations they may have not known about. For example, a physician group may be self-insured for professional liability claims and the insurance expense may be recorded on the income statement, but the incurred but not reported claims may not be recorded. Once debt-like items are uncovered, the buyer can try to negotiate these obligations away, or at a minimum incorporate the future cash outflows into their financial model.

5. **How much should a practice’s IT infrastructure be taken into account?** A practice’s IT infrastructure is a critical asset that should be evaluated during diligence. Buyers should assess a practice’s existing IT organizational structure and systems in their entirety to gauge the practice’s suitability as a hospital provider. Hospitals should assess the cost of consolidating and implementing the IT systems needed post-transaction. Many times, physician practices will not have invested in interoperability, making it a guaranteed future cost for the hospital.

6. **How should physicians be compensated?** Many physician groups are structured as partnerships, making physicians their own bosses. If acquired, they will have to adjust to being employees. Naturally, physicians who are acquired expect to maintain or increase their income under their new employer. Eighty-three percent of physicians who are considering hospital employment said they expect to be paid the same or more than what they are earning when they join a hospital’s staff.
Today’s physicians are used to being paid on a fee-for-service basis, which lends itself to a volume-driven business. New compensation program designs may bear little resemblance to what physicians have experienced in the past. Patient outcomes will soon outweigh volume as the measure of a physician’s productivity. In a world of ACOs, value-based purchasing and bundled payments, physicians will have to change long-entrenched perceptions of how they measure their own professional success. Buyers should evaluate a practice’s culture of compensation to determine whether it is open to change.

7. Does the practice have a sound compliance program? Gaining an understanding of a physician group’s discipline around coding and compliance is another important step during diligence. If there is no formal compliance program, or if coding practices seem questionable, it may be a serious red flag. Practices should have sound programs in place, including a compliance officer, training and education programs, and auditing and monitoring processes.

Compliance diligence typically overlaps with financial diligence. For example, buyers should analyze the status of Medicare Recovery Audit Contractor audits. Each state has instituted RAC audits to uncover providers’ possible improper Medicare payments (both overpayments and underpayments). Most companies have some type of reserve for a potential payback to CMS (a debt-like item).

8. What governance roles should newly acquired physicians assume? There is a legacy of “bad blood” between hospitals and physicians that has caused each to view the other with suspicion over the years. When asked by PwC whether they trust hospitals, 20 percent of physicians said no, and 57 percent said sometimes. Trust must trickle down from the top; leadership should create an environment in which hospital management and physicians can regain the “trust factor.” A physician group with no physicians on the acquiring hospital’s management team will most likely disrupt the planned integration. More than 90 percent of the physicians surveyed by PwC said that physicians should be involved in hospital governance activities such as serving on boards, being in management and taking part in performance improvements. Determining how the governance of an acquired entity is going to be structured pre-deal may provide buyers with a competitive edge in a deal process.

As the healthcare industry continues to undergo fundamental change, a well-rounded diligence program is more important than ever when evaluating a physician group for acquisition. While traditional financial and legal diligence is important, buyers should also take into account other variables, such as governance, compliance and IT. These variables can quickly derail an acquisition, and thus are key valuation considerations that should not be overlooked. No deal is perfect, but after robust due diligence, hospitals should know who their new team members are as they work with them to succeed in the ever-changing healthcare environment.

Footnotes:

[1] In 2010, PwC’s Health Research Institute commissioned an online survey of more than 1,000 physicians balanced by age, gender, practice type, and specialty. All of the statistics cited in this article were drawn from that survey.

Mr. Barenbaum is a director in PwC’s Healthcare Transaction Services Practice. He can be reached via email at glenn.p.barenbaum@us.pwc.com.

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Physician Engagement: 20 Survey Findings
By Molly Gamble

Although overall physician engagement took a slight hit last year, more physicians in 2011 believed their organizations would be successful in the coming years compared with 2010, according to results from “The State of Staff Physician Engagement: 2011 in Review” by Morehead Associates.

Survey responses are based on a five-point scale, with a score of one reflecting “strongly disagree” and five reflecting “strongly agree” — the higher the score, the more positive the response. Information is based on an analysis of more than 1.4 million survey responses from physicians in 2011.

The physician engagement in 2011 was 4.12, compared with the 2010 average of 4.17. Here are some key findings from the 2011 survey, including survey items physicians rated highest and lowest.

1. This hospital makes every effort to deliver safe, error-free care to patients: 4.19
2. Overall, this hospital provides high-quality care and service: 4.23
3. I would recommend this hospital to other physicians as a good place to practice medicine: 4.06
4. I would recommend this hospital to family and friends who need care: 4.24
5. I am satisfied with the overall performance of hospital administration: 3.54
6. This hospital treats physicians with respect: 3.83
7. I have confidence this organization will be successful in the coming years: 4.21
8. If I am practicing medicine three years from now, I am confident that I will be practicing at this hospital: 3.94
9. Overall, I am satisfied with this hospital: 4.05

Highest-scoring items from the survey
10. The nursing staff at this hospital is committed to providing compassionate care: 4.28
11. This organization cares about its customers: 4.27
12. This organization conducts business in an ethical manner: 4.24
13. This organization is respected in the community: 4.21
14. I have confidence that this organization will be successful in the coming years: 4.21

Lowest-scoring items from the survey
15. I am satisfied with ambulatory services’ efficiency: 3.09
16. I have adequate input into decisions affecting my medical practice: 3.30
17. Senior management is responsive to physician feedback: 3.37
18. I am satisfied with the ease of the scheduling process for my patients: 3.43
19. I can easily communicate my ideas and concerns to senior management: 3.46
20. The amount of job stress I feel is reasonable: 3.45

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Six Sigma, 10 Years on: Was “the Promise” Realized?

By Ian R. Lazarus, FACHE, Principal, Creative Healthcare

In October 2001, an article appearing in Managed Healthcare Executive announced the arrival of Six Sigma methodologies in the healthcare sector.[1] While manufacturing industries had verified significant gains from Six Sigma, service industries like healthcare were only beginning to understand what Six Sigma was all about. Moreover, the healthcare industry had grown weary from a series of performance improvement methods that were tantamount to the flavor of the month. And when a mysterious term like “Six Sigma” appeared on the scene, it might not be uncommon to hear in the halls of a typical healthcare organization, “What is sigma, and why is it sick?”

As they say, “that was then; this is now.” Both Six Sigma and its close cousin, Lean, are not only commonly practiced in both provider and payer organizations — they have entered the mainstream of the healthcare industry. Indeed, two separate studies, one conducted by the American College of Healthcare Executives and the other by the American Society for Quality both point to the fact that 40 to 50 percent of healthcare organizations have employed Lean or Six Sigma as a strategy to cut costs, increase capacity and improve quality.

Ten years on, are we at the halfway point in understanding the true potential from these methods, and what of the organizations that took a deep dive by implementing robust programs? Exactly how much of the promise has been realized?

“There is no doubt that these methods offer us greater potential to cut costs and increase quality,” notes Ken Davis, MD, who employed Six Sigma while at North Mississippi Health Services and later helped earn that organization the prestigious National Malcolm Baldridge Award. “But this is clearly a case of ‘buyer beware.’ Like any change management initiative, implementation of these methods takes a certain amount of perseverance.” Dr. Davis is now at Methodist Health System in San Antonio and involved in deploying Six Sigma there as well.

Dr. Davis’ acknowledgement of Six Sigma as both a performance improvement method and change management initiative points to the complexity and commitment necessary for effective implementation. Because Six Sigma demands much of an organization, management must remain visibly supportive as staff come to learn about how it will raise the bar on performance expectations. And at the slightest sign that management is ambivalent or inconsistent in their support, employees may similarly withdraw:

Leaning to lean

Over the past ten years, challenges with the implementation of Six Sigma caused many healthcare organizations to take pause. For many, this delay paid off as they discovered quicker gains by implementing waste-reduction strategies inspired by Lean manufacturing. “We found it more productive to lean out our processes and then to call the question about whether a Six Sigma initiative was necessary,” notes Rick Rawson, corporate vice president for the Central California region of Adventist Health System. “We found many performance improvement opportunities did not demand the rigor of a Six Sigma project.”

Battle of Champions in Performance Improvement: Six Sigma vs. Lean

While both Six Sigma and Lean focus on waste reduction as a key aim (recognizing waste comes in many forms), this is the end of any common ground between the methods. Still, most organizations find that in any project, a mix of approaches is necessary for true, breakthrough improvement:

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<th>Attributes of Six Sigma</th>
<th>Attributes of Lean</th>
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<tr>
<td>Strong, data-driven orientation</td>
<td>Data not always necessary</td>
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<tr>
<td>Strong project management framework, “DMAIC” = Define, Measure, Analyze, Improve &amp; Control</td>
<td>More intuitive, loose framework based on “Current State” vs. “Future State”</td>
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<td>Focus on variation in process</td>
<td>Focus on value stream analysis</td>
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<td>Aim is to eliminate defects</td>
<td>Aim is to eliminate waste</td>
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<td>Goal is improved quality at lower cost</td>
<td>Goal is increased speed and efficiency</td>
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Failure to launch

As with any change management initiative, the industry is replete with examples of failed attempts to gain traction in these methods. What do they have in common? “Six Sigma demands reliable data but also the ability to step back from that data and to avoid shooting first, asking questions later,” cautions Mark Mathews, MD, managing partner at Creative Healthcare, a firm that offers training and certification in Lean and Six Sigma. “A little data can be intoxicating to managers, and it’s important to stay focused on finding only those variables in a process that are truly driving performance. It many cases, it will be variables that managers never expected.”

Dr. Mathews points to many cases in which an organization was too quick to blame staff for suboptimal performance, when it was actually the process itself that was poorly designed. “It’s critical that practitioners of Lean and Six Sigma begin with the premise that it’s not about the people, it’s about the process.”

Organizations may also choke on the number of Six Sigma projects undertaken at one time, leaving them overextended and exhausted at the close of their first round of projects. “There is a lot to be said for picking projects that will yield quick wins, and to ensure adequate celebration and recognition for those that deliver improvements in the early stages of deployment,” advises Dr. Mathews.

Checklist: Prescription for a Robust Lean/Six Sigma Program

• Staff trained in both Lean and Six Sigma methods
• Establish ROI expectations from portfolio of projects
• Sponsor training for senior management
• Visibility across enterprise for program and its achievements
• Celebration and recognition for completed projects and project leaders
• Implement formal handoff from project leader to process owner
• Continue running control charts on all completed projects
• Implement specification limits that identify if performance has regressed
• Create governance for program to approve new projects
What is 5S?

5S is a method for organizing a workplace to maximize efficiency. 5 steps, undertaken in order, include:

Sort: Set aside all work-related tools for categorization and possible relocation

Set in Order: Decide which tools are needed daily, weekly, monthly or less often. Organize the proximity of tools based on frequency of use

Shine: Ensure workplace is sterile with adequate visual controls to support rapid identification of where resources are and how they are to be used

Standardize: Leverage this work across the entire workspace. Use one workstation as a prototype, replicate, expand. Use this as an opportunity to standardize all supplies and tools.

Sustain: Delegate ongoing responsibility for maintaining order. Post pictures to support rapid identification if any aspect of the organization effort has been compromised.

* Many healthcare organizations have added a 6th “S” for member “Safety.”

Despite these challenges, reports of savings from Lean and Six Sigma initiatives have been steadily adding to the credibility and potential of the methods:

- 2003: The Murphy Leadership Institute, a Washington DC think-tank, published research that demonstrated a direct link between waste reductions and operating margin, suggesting that for every 4 percent reduction in waste an organization enjoyed a 1 percent boost in operating income.

- 2006: isixsigma.com, an online resource for the Six Sigma community, reported on research findings that revealed a 6:1 return from properly funded Six Sigma programs.

- 2012: Creative Healthcare, with grant funding from the American College of Healthcare Executives, studied 150 projects across 10 healthcare organizations and validated a 7:1 return on investment from Lean and Six Sigma projects.

No shame

There was a time many healthcare executives were downright fearful to introduce the concept of Six Sigma in their organizations, unsure of how staff would respond to the mystery behind the method, or possible accusations it will not succeed. “Call it ‘Fred’ if you need to,” was the advice of one veteran consultant, while making the point that the name of the program is less important than the tools and adherence to the method.

Today, such fears are in the past. Indeed, examples of successful Six Sigma projects abound in today’s environment, and the reader need only visit Google for scores of published case studies. The healthcare section of the ASQ website alone boasts over 15 project reviews submitted by various project leads in the health and managed care space.

First and ten

While Lean and Six Sigma have driven significant improvements for organizations adopting them, it’s fair to say the industry as a whole has merely scored a series of “first downs.” In many organizations, a few scattered “black belts” bemoan the fact the organization’s commitment remains tentative. In others, you can literally witness the DNA of the corporation transforming, as staff grow restless with the status quo because they realize they are capable of breakthrough improvement. To be sure, the next ten years will be interesting to watch as the arrival of healthcare reform demands even higher levels of performance, quality and affordability.

John Desmarais, CEO of Commonwealth Health Corporation in Bowling Green Ky., once warned, “When you implement a Six Sigma program you are going to learn some things about your organization that you did not necessarily want to know.” For organizations still on the sidelines, it’s time to get in the game.

Ian R. Lazarus, FACHE, is founder and principal at Creative Healthcare (www.creative-healthcare.com), a supplier of training, consulting and certification in Lean and Six Sigma.

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Megan Perry, President, Sentara Potomac Hospital

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Don’t Fear Clinical Integration: One Reason Community Hospitals May Have an Edge

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

There is certainly a push for clinical integration among healthcare organizations of all sizes and types today; and for good reason. Clinical integration has been shown to improve quality and patient service and reduce per capita costs all while coordinating care. Clinical integration extends the principles of the patient-centered medical home model of care beyond individual primary care practices to a system of care and is the foundation of accountable care organizations.

But clinical integration can be a daunting task for hospitals that have long relied on independent and fragmented medical staff. Smaller, community-based hospitals (as opposed to larger tertiary hospitals and academic medical centers) face further challenges in this pursuit.

First, capital— in terms of both human capital and financial capital— is often harder to come by. Capital spending on equipment or other upgrades is often prioritized, making it less likely funds will flow down to integration efforts.

Many of these organizations also operate on smaller margins than larger health systems, so considering clinical integration on top of day-to-day operations adds another layer of strain on their resources. There is certainly less of a cushion between financial success and failure if any part of the integration efforts goes awry.

At the same time, their medical staffs are smaller, which means their physicians are already extremely busy and may have less time to devote to serving on new committees or otherwise being involved in integration efforts.

All of this said, many community hospitals have a leg up over their larger counterparts when it comes to one important factor of success for clinical integration: engaged physicians.

Mercy, based in Toledo, Ohio, includes seven hospitals that span a range of sizes. What strikes me about our smaller facilities is the engagement of their physicians. The percentage of medical staff who are active and involved in hospital operations and with administrators is higher than at smaller facilities. At Mercy, we are in the process of implementing an electronic health record system at our two smallest hospitals and the initial engagement of physicians as a percentage of the medical staff has been fabulous.

Why is this the case? Well, for one, physicians who practice at smaller facilities, especially those located in more rural areas are physically at the hospital more because there often aren’t hospitalists to care for their patients.

The smaller community hospital is an integral part of the community. It may be the largest employer, and the physicians, who live in the community, understand its integral connection to the economic and physical health of the people served. There’s often a community spirit around the hospital, especially if it’s the only one in town.

There are also stronger physician relationships across the medical staff. Primary care physicians and specialists are all sharing the same patients and run into each other more often, both at the hospital and outside its walls. The majority of the medical staff know each other professionally and often personally. As an organization moves toward clinical integration, the transformation starts with strong, positive relationships among physicians and administrations. If you already have that, it makes going forward a lot easier.

So how can community hospitals capitalize on this leg up? They must recognize that the future of healthcare delivery really requires physician leadership. Hospital leaders must truly engage their physicians in leadership, finding ways to encourage true leadership roles. At Mercy, we are trying to pair physicians with administrators, at every level, to make joint decisions that are the right decisions for transforming patient care and that support the future success of our physicians and the health system. Rapidly disappearing are the days of physicians being viewed primarily as referral sources to fill hospital beds. Rapidly appearing is a focus on developing physician leaders.

While engaging physicians in leadership may be easier in a smaller facility, it still needs to be a conscious decision on the part of hospital administration and its governance structure to allow physicians to lead in ways they have not led before. Their roles will need to expand beyond credentialing and other common medical staff issues. They must be engaged in answering the key question that will make or break your facility’s reform efforts: How are we going to transition to future models of care and do it together successfully? The answer you arrive upon may involve tough decisions such as service line cuts or other resource reallocations. The best way to approach this process is to sit down and ask, “What is the goal?” Once that is agreed upon, work backwards. If the goal is clinical integration, employment is one way to get there, but it’s not the only way.

Depending on your hospital’s resources, community and culture, a different approach may be a better fit.

The good news for smaller, community-based hospitals is the relationships needed for clinical integration are often present and strong. There may be a number of ways for smaller hospitals to sufficiently develop physician leaders and put in place the processes and infrastructure for clinical integration. Many smaller facilities already have or will pair up with larger systems. Luckily, this can occur in a variety of ways — affiliations, mergers or other partnerships — that best allow the hospital and medical staff to fulfill their mission while transitioning to new models of care under physician leadership.

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.
11 Best Practices for Commercial Payor Negotiations on New Payment Models

By Kathleen Roney

As healthcare moves into the next decade, new payment models like bundled and episodic payments, risk-sharing agreements, value-based payments and accountable care organizations are picking up momentum and changing the way reimbursement functions in the healthcare market. These new models of payment support new models of care intended to achieve efficient, cost-effective and excellent health outcomes. As the industry moves to innovative payments, providers need to be proactive.

“If you are a provider, in the long run you need to manage population health cost-effectively to secure your position in the healthcare market and to be paid reasonably for the services you provide,” says John Harris of DGA partners. “We have reached a tipping point where providers need to be planning for or at least experimenting with innovative payment models to secure their position in the healthcare market in the long run. How much, how quickly, how much risk to allow and who to partner with are all a function of the local market and specific organizational needs.”

For the hospitals and health systems ready to engage in new payment models with payors, the process may seem overwhelming. Since successful payment contracts involve complicated and long-term relationships, it is important for providers to consider the right payor. In doing so, the following four factors need to be considered.

Identifying the right commercial payor

1. Select just a few payors. According to Stephen Thome, senior manager in Ernst & Young’s healthcare advisory practice, providers should only select a few commercial payors for discussions about new payment models. New payment models between a provider and a payor involve a complicated relationship that needs to evolve and mature over time. Thus, it will be difficult for providers to have productive contracts with more than a few payors. “It would behoove hospital and health system executives to be proactive in identifying which payors they want to work with over a long period of time,” says Mr. Thome. “Then, engage those payors in a conversation to get a head start on the process.” To determine which to consider, providers should look at a payor’s footprint and strategic focus.

2. Determine the footprint or geographic dispersion of payor. According to Mike Cohen, principal and leader of the provider strategy practice for Deloitte Consulting, the extent that a payor has a geographic dispersion of membership in an area where the hospital also has strength is important, i.e., the market footprint of the provider and the payor should be compatible. “There should be a mutually aligned member base to supply a population for both parties,” says Mr. Cohen. For instance, if a health system covers an entire metropolitan area, the ideal payor would be strong in that same metropolitan area to provide patients for the provider. “If a health system ends up with only a small number of patients for an ACO, the infrastructure to manage care of those patients will become financially burdensome. A provider needs to make sure the payor can deliver a meaningful number of patients to its physicians,” says Mr. Thome.

Beyond providing the population, a compatible footprint between the provider and the payor can help both organizations to grow. “Providers should look for a payor that would allow them to grow in market share for one of its weaker areas. New payment models are about incubating new lines of business rather than hanging on to established business. If a provider is actively seeking out new payment contracts it should be considering a payor in a market where it would like to see growth,” says Mr. Cohen.

3. Examine strategic, philosophical focus. It is important for a provider to look at the possible payors and choose one that has a strategic focus most aligned with its strategy. “Every payor has a different strategic and philosophical approach,” says Mr. Cohen. “Some payors are more focused on evolving payment models and others are further ahead in that regard. It is best for a hospital or health system to find a payor with a philosophical and strategic approach to new payments that aligns with its own.”

4. Consider competitive market. Providers should consider the competitive market dynamics of area payors when selecting a partner, recommends Mr. Cohen. “Providers can help stimulate payor competition based on who they choose to contract with,” says Mr. Cohen. While providers do not always have multiple partners to choose from, providers that are able to contract with new payors can increase competition in the market, which ultimately benefits the provider. “If I am a provider, I want to see if I can pick a payor to contract with that will create a more fragmented commercial insurance market,” says Mr. Cohen.

The new payment model process

Once healthcare officials have identified a few payors as good fits, the next part of new payment contracts involves reaching out to payors and beginning discussions. It is helpful if healthcare officials know what to expect, what to bring to the table and how to handle negotiations. To engage commercial payors successfully, healthcare officials should use the following seven practices:

1. Gain buy-in and discussions at the executive level. In order for new payment models to be successful, there has to be a high level of executive involvement. According to Elaine Daniels, senior strategic contract consultant for Blue Cross and Blue Shield of North Carolina, senior leadership buy-in is important for an effective and creative payment contract. Ms. Daniels believes the buy-in of senior leadership on both sides improved BCBSNC’s discussions with CaroMont Health in Gastonia, N.C., on a bundled payment arrangement for knee replacement. The arrangement covered the entire knee replacement, including the pre-surgical period of 30 days prior to hospitalization, the surgery itself and most follow-up care within 180 days of discharge from the hospital. “The senior leadership really needs to want to implement a new model. In working with CaroMont for the bundled payment arrangement, it was clear that their senior leadership really felt the payment model was the way of the future. Their attitude and energy paved the way for a successful pilot,” says Ms. Daniels.

Not only is senior leadership buy-in important, all of the discussion needs to include the executives. “A value-based or risk-based contracting relationship is a transformative event,” says Mr. Thome. “It is important to define that transformation at the executive level.”

When the executives discuss the payment relationship there is much greater freedom to define terms and apply creative solutions to sticky problems. For the same reasons, a single negotiation will not suffice for creating a new payment relationship. As mentioned earlier, the relationship is complicated and needs to mature; thus, multiple meetings will improve the agreement over time. “It is more like a marriage than a short-term contractual relationship,” says Mr. Thome.

2. Form a collaborative, trusting relationship. The commercial payors and the providers should approach new payment models collaboratively. “I don’t like to use the term negotiate because everyone needs to be involved in the problem. Negotiating conveys a connotation that
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the final agreement will be a win-lose relationship,” says Chris Day, chief business development officer for Actena Accountable Care Solutions. Familiarity with your partners is important for creating new payment models that really work. In this case, it is ultimately what is best for the patient: cost-effective and quality healthcare services.

“It is more than a matter of getting a good contract or a good rate. If the provider and the payor can work together to create an ACO or a value-based contract, even if it doesn’t exist now, that delivers high-quality and lower cost, it will become a valuable commodity,” says Mr. Thome. “Additionally, the commodity will enhance the marketability and fuel growth for each entity. That is the ideal result of a payor-provider relationship.”

3. Reconcile operational and contracting strategy. Many providers are currently on a continuum when it comes to new payment models. The first group is trying to stay in the existing world of fee-for-service. In the next group down the continuum, the providers have aspirations for new payments but their capabilities are behind their goals. The last group on the continuum includes providers with the capabilities and the ambition. According to Mr. Cohen, where an organization sits on the continuum should dictate how it negotiates its contract. “A provider should reconcile where they are operationally and align that with their contracting strategy,” he says.

A provider in the middle of the continuum — with a bigger appetite for a new payment model than the capabilities to sustain the model — should enter contracts more concerned about funding the investments they need a mindset aimed for experimentation rather than trying to move all their business towards bundled care. Or, they should be willing to take a modest upside in exchange for a less near-term risk. However, a provider with more sophisticated capabilities can challenge themselves. “Now would be the time to exploit their capabilities and take advantage of becoming more accountable. They could handle the higher risk to reap the higher award,” says Mr. Cohen.

4. Begin with the end in mind: Know your “ask.” According to Mr. Cohen, providers need to enter new payment model negotiations with the end in mind. Having a good articulation of a strategic plan is important. “In many cases providers are proactively reaching out to payors. In addition to negotiations of rates and incentives, they are looking for payors to invest in infrastructure and capabilities,” says Mr. Cohen. “Some providers do not think to ask for that, but if they are aware of the possibility and it makes sense for them, it is important to bring it up.” For these reasons, providers need full awareness of what they need so they can bring the accurate “ask” to the table.

Additionally, the payor is going to come to the new payment discussions with a sense of its own strategic and boundary conditions. “They aren’t coming in just to fish; they have an end in mind and range to work within,” says Mr. Cohen. “Providers need to recognize that the payor is coming prepared to make a deal so they can come to the meeting prepared to do the same.” According to Mr. Cohen, it may be useful to leave the mindset of “rates” and think about the strategic, even operational, goals. “Get out of the mindset of rate and think about it more strategically and operationally in terms of what the relationship would do for broader strategy for accountable care or population health,” says Mr. Cohen.

5. Create data-driven value proposition. When a payor comes to payment contract discussions, it will have mass amounts of claims data about the clinical and financial effectiveness of the provider. In expectation of the payor’s data, the health system should aggregate its own data to create a value-based proposition. A value proposition consists of the areas where the provider knows its services and outcomes have been successful — where it can provide the strongest value. Preparing data around its value will give the hospital the information it needs to know the quality and cost levels it can be comfortable with in a new payment model. The value proposition will also help the health system be responsive to what the payor’s claims data might show versus what their own data might say,” says Mr. Cohen.

For instance, according to Ms. Daniels, when Blue Cross and Blue Shield of North Carolina negotiates a new payment contract with a provider, they will take the data they have on the health system and run various algorithms to determine a potentially avoidable complication analysis. “[BCBSNC] takes this analysis and compares it to hospitals in our Blue Distinction category, [an award given by the Blue Cross Blue Shield Association to providers with exceptional care quality], as well as to other hospitals in North Carolina,” says Ms. Daniels. “Then we discuss the PAC analysis with the provider. This analysis breaks out the services that are considered typical for the procedure and those that are considered potentially avoidable. The potentially avoidable services are ones that a care management team would work on reducing. The reduction of complications will reduce the total cost for that service; it will also increase the quality of care rendered to that patient. If the provider is interested in increasing quality and reducing cost we share claims details around the entire episode of care and begin negotiating for the new payment model.”

Other payors may have other ways of analyzing the health system’s data before the initial negotiations. “A payor will most likely analyze the data at a population level to understand utilization and spending patterns,” says Mr. Thome. “They will break the population down into disease categories and a variation of clinical practices.”

Whether the payor looks at avoidable complications or past spending patterns, the health system should aggregate its own data in order to gain a sense of its strengths and weaknesses before negotiations begin. In other words, they should have a value proposition based on data-driven analytics. “It will give the health system a good sense of where it is apt to be successful in terms of sharing savings,” says Mr. Cohen. “A health system should have a good sense of its value proposition so it can enter arrangements that emphasize its strengths and not its weaknesses.”

6. Request data transparency. Although data is often shared at initial discussion meetings, it is important that a provider select a payor who is willing to continue sharing data throughout the process. This is important because if a health system is going to meet a value level, it needs to be able to access actionable information that gives a comprehensive view of the patient, including claims, administrative data and financial data from a health plan. The health system needs to know if patients are using a health risk assessment, if they are accessing their health information online and if they are filling prescriptions. A patient’s behavior could be a deciding factor in how to manage his or her care. If a provider and a payor work together by sharing data to identify value opportunities like disease management, cost reductions and other areas of quality to focus on, both will be more successful.

Even providers that have highly advanced data capabilities do not always have access to all of the data they need to manage populations. In order for a provider to be successful in a new payment model they need to be able to break down the silo walls of healthcare and see what happens to a patient beyond their walls. “Do not work with payors that are not willing to share data. Look for payors that have demonstrated willingness to provide performance-based payments — payors that are interested in a collaborative discussions,” says Mr. Day. “Discussions should start with data sharing and not the ‘old world’ discussions of rate negotiation only.” Sharing of the data should be a daily, weekly and monthly occurrence depending on the type of clinical data being tracked and reported. For instance, the provider and payor may share aggregate population level data monthly to identify trends and design clinical responses to benefit the patient population.

Ms. Daniels also believes transparency of data is important to the new payment contract discussion. “On both the payor and the provider side you need good analytics teams to analyze the data to determine the ap-
Moody’s: The 5 Most Prominent Areas of Focus in High-Performing Hospitals

By Bob Herman

Non-profit hospitals currently face the challenge of doing more with less — providing high-quality care with lower reimbursement rates per unit of service — but there are five high-performance strategies that can focus on becoming high-performing, according to a report from Moody’s Investors Service.

1. New payment models. Non-profit hospitals must redesign their delivery of care to achieve lower costs, and new payment models have slid to the forefront. Accountable care organizations and bundled payments are keys to healthcare reform, but other strategies include transitioning certain services to outpatient from inpatient, closing unprofitable services and condensing all aspects of a patient’s continuum of care.

2. Physician alignment. Similar to the 1990s when physicians sought out hospital employment, non-profit hospitals are re-engaging in physician alignment strategies. However, hospitals and physicians are pursuing different strategies compared with 20 years ago. “Hospital leaders are executing employment contracts with clear productivity standards and, in most cases, no longer paying for goodwill.”

3. Growth strategies. Many hospitals and health systems are looking to gain efficiencies and balance capital needs within the merger and acquisition market. For example, some faith-based organizations are looking to consolidate with secular hospitals, while others are looking for geographic market expansion and placement of ambulatory centers. Executives at high-performing hospitals are also increasing scale and monitoring annual revenue growth to establish a solid credit line.

4. Balance sheet growth. Moody’s analysts said most of their rated hospitals are looking to build balance sheet reserves as a key transition strategy. Revenue cycle management, more conservative capital spending models, restructuring debt portfolios, finding different liquidity sources for variable-rate debt and re-evaluating the affordability of defined benefit pension plans are included in those strategies.

5. Improving governance and management skills. Hospitals are increasing the skill set within their management and board ranks by adding individuals familiar with the manufacturing, engineering and technology industries, and some hospitals and health systems are also growing physician leadership programs to bridge trust between hospital management and the larger physician staff.

AHA Supports Postponing ICD-10 Until 2014

By Bob Herman

The American Hospital Association submitted a letter to CMS Acting Administrator Marilyn Tavenner in May, saying it supported a one-year delay of ICD-10 to Oct. 1, 2014, but that CMS should finalize its proposal soon.

AHA also recommended CMS move forward with both the Clinical Modification and the Procedure Coding System versions at the same time, and the extra year should be used to conduct “extensive testing” on the effectiveness of ICD-10.

In February, AHA conducted a survey among 1,000 of its member hospitals, and 70 percent of respondents thought a short delay in ICD-10 implementation would be helpful. Overall, 41.8 percent of hospital respondents said they have completed an ICD-10 implementation plan, and hospitals with 300 or more beds are more likely than smaller community hospitals and critical access hospitals to have completed an ICD-10 implementation plan.

The American Medical Association wrote a letter to CMS saying the ICD-10 compliance date should be extended two years to Oct. 1, 2015, at a minimum.
Hospital mergers and acquisitions increased 12 percent in 2011, according to a Levin Associates report, with surgery center deals following suit. More healthcare facilities are likely to sell part or all of their business, meaning leaders must understand the factors that impact valuation. Here Jason Ruchaber, CFA, ASA, partner with healthcare valuation firm HealthCare Appraisers, discusses the three levers of valuation — earnings, risk and growth — and 10 steps for a hospital or surgery center to increase its value.

**Earnings**

1. **The more money you make, the more you’re worth.** Mr. Ruchaber says the correlation between earnings and value is pretty straight-forward: The more money you make, the higher your valuation. He says to increase value, a hospital or surgery center should have a solid understanding of their financial position and be able to articulate the steps they are doing to maintain and/or enhance earnings. “When we’re doing financial analysis, we want to see a center or hospital that has a good grasp of what they’re doing financially,” he says. This means creating budgets and analyzing variances, evaluating costs on a regular basis, and understanding the contribution margin of different case types/service lines.

2. **Understand how you compare to others.** Mr. Ruchaber says benchmarking is essential for surgery centers and hospitals to determine if their finances are in line, and a key component of the valuation process. He says when valuing a facility, he frequently asks questions like, “How do your staff costs per case compare to your competitors in the area? How does reimbursement vary by surgical specialty?” He also asks questions about any outliers on the facility’s financial records, such as a month with particularly high or low case revenue or non-recurring expense. He says facilities that are able to explain outliers will generally command a higher value than facilities that do not understand why finances are fluctuating. “Great facilities frequently measure and know where they stand relative to others and understand why variances exist,” he says.

3. **Hire a CPA.** Don’t depend completely on your facility staff to keep your finances in order, Mr. Ruchaber says. He recommends “routinely engaging an accounting firm to assist, compile, review, or in the best case, audit the financial statements.” He says this helps a valuation firm or buyer know that financial information is accurate and reported under generally accepted accounting rules.

4. **Enhance profitability with “quality earnings.”** Not all earnings are created equal, Mr. Ruchaber says. “You want to pursue high-quality earnings that are sustainable and not overly risky,” he says. He says his company looks for earnings that don’t have a risk of substantially changing based on only one or two changes in the environment.

For example, some facilities depend heavily on an out-of-network reimbursement strategy, meaning they don’t contract with payors and instead bill higher out-of-network rates. This strategy may generate significant profits, but due to increased pressure from payors on referring physicians and patients, out-of-network cases are harder to come by. “The reason out-of-network is so risky is that the likelihood it will change is all on the downside,” Mr. Ruchaber says. “Reimbursement for these cases is unlikely to go up. However, when payors stop paying these charges or when a facility transitions to in-network, it’ll have an immediate and material impact on the bottom line.”

**Risk**

1. **Understand why your metrics are changing.** Some aspects of a healthcare facility’s business are unpredictable. “It’s not always possible to predict whether someone’s going to come in with a heart attack, stroke, etc.,” Mr. Ruchaber says. “It’s important to understand the business metrics that show signs of a problem.” He says the main way to mitigate risk is to understand your business: If you can explain why revenue is down or readmissions are up for the month, you will be less susceptible to sudden, unexplained changes that negatively impact the bottom line.

For example, he says a hospital with high readmission rates might actively track the diseases most likely to result in readmissions, then target those diseases to lower rates. Even if readmissions stay high in some areas, you should be able to isolate those areas and say, “We know readmissions are up because of this area” rather than, “We really don’t know what’s going on.”

---

**10 Steps to Increase Value**

1. Increase revenue
2. Compare yourself to competitors
3. Hire a CPA
4. Pursue sustainable earnings
5. Understand risk
6. Diversity sources of revenue
7. Improve payment processes
8. Recruit physicians and outstanding staff
9. Understand potential for growth
10. Be wary of risky growth
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2. Diversify sources of revenue. Mr. Ruchaber says facility risk increases when revenue depends on a few key specialties, physicians or payors. If the majority of a hospital’s business comes from a cardiology service line, the hospital will suffer financially if reimbursement rates drop, a scandal prevents patients from coming to the hospital, or high-volume cardiologists leave.

“From a finance standpoint, risk is really evaluated based on the likelihood that the actual results will deviate from the expected results, and by how much,” Mr. Ruchaber says. He says a strongly diversified facility is less likely to deviate materially from the “expected results” line. Facilities that are not well diversified will be subject to more significant “ups and downs,” which poses greater risk to an investor.

3. Improve payment processes. You may have payors that take a long time to pay claims, driving up your A/R and creating more risk for your facility. Mr. Ruchaber says while most facilities cannot control their payor base, which depends on the employers and major insurance companies in the region. However, they can ensure proper coding and billing processes are in place and work with individual payors to improve contracted rates and payment times. “If an individual payor is taking longer than others, you may be able to improve the true value of your business by improving the efficiency of the payment process and getting your A/R balances down,” he says.

4. Credential dependable physicians and hire great staff. Nothing can hurt a facility’s finances as quickly and irreparably as a bad reputation, Mr. Ruchaber says. If your facility has a scandal surrounding a quality issue, patient volume and physician referrals will drop significantly. If your facility has rude staff, disruptive physicians or other unprofessional behavior, you will lose affiliated physicians and their patients. “Make sure the credentialing process is set up to bring in top-quality physicians,” Mr. Ruchaber says. “Though increased volumes may be desirable, centers need to understand the risk they take in bringing on disruptive doctors.”

He says the facility should also concentrate on patient relations. Most centers believe that they are doing a good job, but few actually take the time to actually evaluate this from a patient’s perspective. When Mr. Ruchaber walks into a facility on a site visit, he first examines the reception and waiting areas for signs of trouble. If possible, he tries to observe interactions between the staff and patients, but he also evaluates his own interaction. “Do I have to wait for ten minutes to talk to the receptionist, or am I greeted quickly? Is the tone pleasant and cheerful or stressed and curt?” he says. He also looks to see if the facility has its front office organized and in good order? “What’s going on behind the front desk can be a reflection of what happens in the ORs,” he says.

He also looks at the cleanliness and condition of the other areas seen by patients. “Surgery is stressful, and when a patient can look around and see that attention is given to the minor details, it adds a level of comfort to the overall experience,” he says. He says good customer service mitigates risk and enhances profit, both of which increase value.

Growth

1. Understand where potential for growth exists. “All things equal, higher growth equals higher value,” Mr. Ruchaber says. “The highest multiples are generally paid for those centers demonstrating strong growth.” Because growth is key to a successful valuation, he says his company looks for facilities that understand where they can expand case volume and recruit physicians. “It’s about understanding the demands of the community and the population base,” he says.

He says he likes to see a facility that puts together budgets and actively pursues different strategic initiatives, whether they’re business, clinical or expansionary. He says growth is also related to the quality of the institution; a facility with high-quality equipment, updated operating rooms and capable staff is more likely to attract physicians and patients than one in need of significant upgrades.

2. Be wary of growth that comes with substantial risk. Not all growth is good growth, Mr. Ruchaber says. He says the three “levers” of valuation – earnings, risk and growth – are so closely interwoven that certain kinds of growth do not result in greater value. “While they’re focusing on the growth lever, they may also be increasing the risk,” he says.

For example, he says some surgery center choose to implement spine procedures because reimbursement rates are high, and the specialty was only recently introduced to ASCs. “Spine takes a bit of capital expenditure and extra training for staff, and the volume may not materialize” he says. “We don’t want to see a surgery center trying to bring in volume at the risk of its patients, spending too much on capital and opening up too many ORs when they don’t have the volume guaranteed.”

He says hospitals and surgery centers should never base growth on the idea of, “If you build it, they will come.” You have to know whether the service is needed and wanted in the community before spending money and time on implementation.
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Community Hospitals Must Lead With Experience, Close With Compassion

By Lindsey Dunn

A s the healthcare industry enters an era of accountable, patient-first care, many hospitals are beginning to focus on patient experience. As a part of this, they are placing great emphasis on conveying compassion. While this can be a great strategy for large urban hospitals and academic medical centers — organizations typically viewed as highly advanced and technically competent, but perhaps a bit impersonal — it could prove a miscalculation for smaller organizations.

Leading with experience, technical capabilities
Several years ago, a 200-bed hospital engaged Studer Group to help improve its patient experience. Essentially, the hospital was concerned with “showing patients it cared,” explains founder Quint Studer. To kick off its efforts, Studer Group tapped Gallup to poll the hospital’s patients. The findings surprised everyone: The patients already knew the hospital and its staff cared about them — but they weren’t necessarily sure the team knew what it was doing.

This is a good lesson for smaller, community-based hospitals, says Mr. Studer. Physicians and staff need to “lead” with their education and skills in order to gain patient trust. This is because, while larger hospitals are often assumed to have the most highly trained and experienced medical staffs and access to cutting-edge technology, the same doesn’t hold true for smaller facilities.

“Many smaller facilities do have tremendously skilled healthcare professionals and high-tech capabilities, but patients don’t always know that,” says Mr. Studer. “They assume they’ll be better off at a larger hospital when that might not be the case. You need to educate them on the experience, skills and technology you do have.”

“In a community hospital, you lead with skill, follow with technology and close with compassion,” he summarizes. “In larger facilities, you go the opposite route.”

So how do you lead with skill? Each physician or technician should be trained to introduce themselves to patients in a way that provides an overview of their professional background. This introduction includes a discussion of the physician or technician’s education, relevant certifications and skills and years of experience.

“Patients might know the physician from little league, but that doesn’t mean they know his or her experience or level of competency,” Mr. Studer says.

Combating out-migration
Like all healthcare organizations, community hospitals face a challenging future. For smaller hospitals in particular, investment capital may be harder to come by.

“Depending on the size of the community, there may not seem to be enough population to create the level of volume needed to pay for new technologies and facility upgrades,” says Mr. Studer. “This can make it tough to justify investing.”

Combating this mindset is why community hospitals must work to make sure every patient stays in their own community, rather than choosing a larger facility that may be miles away.

“If you don’t educate people in the community about your technology and expertise, they may opt out, self-referring to another, bigger facility,” says Mr. Studer. “When patients self-refer out of the community, their dollars go with them. Then, it’s even harder for the community hospital to continue to upgrade and stay viable.”

In an era of transparency, it’s important to tell the “story” of your facility’s advantages. This strategy can be aided by quantitative data. If a community hospital discovers it has great HC-HAPS scores for pain management, for example, it can frame its marketing and external communications around this fact.

“Essentially, the hospital would continually hammer home the message ‘We manage pain better than X, Y and Z hospital, and here’s the data to prove it,’” explains Mr. Studer.

A high performing community hospital may actually be able to draw patients away from larger, more urban communities. According to Mr. Studer, this has happened in own community, the area surrounding Pensacola, Fla. In fact, one community hospital has gained such a great reputation for excellent care and patient experience that people travel there from a 50 mile radius travel — despite the fact larger facilities may be closer.

Ensuring access
Community hospitals that aim to be the first line of care for patients must ensure they provide easy access to their services. In short, people must perceive them as being available when needed.

It’s a good idea for community hospitals to take a look at whether the people who depend on them are able to get care quickly and easily. If the answer is no, it’s important that they do what’s necessary to reduce emergency department wait times, offer more outpatient testing, increase access to physician offices and so forth.

“When people are nervous about a symptom they’re experiencing, the number one thing they look for is access,” says Mr. Studer. “If another facility can see them more quickly, they’ll leave the market. If they have a good experience there, you’ll probably never see them again.”

Once patients are in, of course, the other principles come into play.

“Give them great access, tell them about your skill set, and provide a great patient experience and excellent care,” explains Mr. Studer. “If all of that occurs, it’s likely patients will return to your hospital and tell other community members to as well.”

Once patients feel comfortable with your competence they tend to be quite loyal, adds Mr. Studer.

“There’s something special about community members caring for their own community,” he says. “There’s a built-in sense of compassion that is actually very powerful.”

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Intelligence for the new healthcare
A consideration in the design of the Affordable Care Act (ACA) is the role played by rural patients and their providers. This geographically diverse and misunderstood segment of the healthcare delivery system could provide meaningful insight for developing Accountable Care Organization (ACO) models, and for hospitals dealing with the implementation of the Affordable Care Act.

June 2012

An evaluation of how to effectively align and integrate rural hospitals into ACOs starts with a quantitative understanding of existing payment and utilization patterns, and the historical delivery performance by rural providers from financial, clinical, operational and patient experience perspectives.

Below are summary findings from research conducted by iVantage Health Analytics that shed new, multi-dimensional light on the rural healthcare delivery system using the latest Medicare Shared Savings data files, the first nationwide hospital rating system to evaluate community and rural hospitals including all 1,326 Critical Access Hospitals, and the industry’s largest proprietary rural Emergency Department database.

Based upon this timely analysis of the most current public and proprietary data, rural hospitals have achieved a noteworthy level of comparative performance including demonstrated quality, patient satisfaction and operational efficiency for the type of care most relevant to rural communities. While not all care is equal, and it is understood that much complex care is appropriately referred to tertiary care centers, the findings suggest, and the new law demands, that ACOs must manage populations in a variety of settings. Value in healthcare is created by doing a few things well, not by trying to do everything.

The rural findings may just suggest that by natural selection, rural has figured out what it does well and has optimized those services for the patient’s benefit. The misunderstanding that rural hospitals are more costly, inefficient and have lower quality and satisfaction is empirically challenged. More importantly as providers and developers seek to address the New Healthcare using innovative delivery models, the rural setting must be better understood and included in any strategy for patient-centered care.

“Rural hospitals have achieved a noteworthy level of comparative performance including: demonstrated quality, patient satisfaction and operational efficiency for the type of care most relevant to rural communities. While not all care is equal, and it is understood that much complex care is appropriately referred to tertiary care centers, the findings suggest, and the new law demands, that ACOs must manage populations in a variety of settings.”

John Morrow – EVP and Co-Founder, iVantage Health Analytics, Inc.”
The study recognizes the significant differences between healthcare in rural America compared to urban settings and the unique challenges that many safety net hospitals in sole provider communities face. This study nonetheless finds high value in rural healthcare. The study evaluates key performance measures across physician, outpatient, hospital and emergency department settings. The measures include: beneficiary costs, quality of care, patient safety, patient outcomes, patient satisfaction, facility costs and service pricing, market size, competition and demand growth factors.

Summary of Medicare Beneficiary Payment Findings

• Approximately $7.2 billion in annual savings to Medicare alone if the average cost per urban beneficiary were equal to the average cost per rural beneficiary.

• Approximately $2.2 billion in annual cost differential (savings) occurred in 2010 because the average cost per rural beneficiary was 3.7% lower than the average cost per urban beneficiary.

• Per-capita Inpatient Hospital Service payments for rural beneficiaries are 2% less costly than payments for urban beneficiaries.

• Per-capita Physician Service payments for rural beneficiaries are 18% less costly than payments for urban beneficiaries, and

• Per-capita Outpatient Service payments for rural beneficiaries are 14% more costly than payments for urban beneficiaries.

Summary of Hospital Performance Findings

• Neither the rural nor urban cohort dominates performance across the CMS Process of Care topic areas (PN, HF, AMI, SCIP and OP).

• There is no significant performance variation on 30-day readmission rates at the benchmark levels for the two hospital study groups. There is nominal performance variation on 30-day all-cause mortality rates.

• Rural hospital performance on HCAHPS patient experience survey measures is better than urban hospitals.

• For three of the four price and cost efficiency measures based on Medicare Cost Reports, rural hospital performance is better than urban hospitals.

Summary of Emergency Department Performance Findings

• Rural Emergency Departments experienced a 12% increase in utilization between 2007-2011 compared to the baseline 24% increase in the decade between 1998-2008.

• Patient Acuity in rural Emergency Departments is lower (over 50% of visits are low acuity) compared to published national benchmarks for all Emergency Departments (34% of visits are low acuity).

• 58% of low acuity visits to rural Emergency Departments are during business hours (9 am to 5 pm), compared to one third of all visits to US Emergency Departments, as cited in May 2011 Congressional testimony.

• The median Time to Medical Screening for rural Emergency Department patients (20 minutes) is 11 minutes faster when compared to wait times for all US Emergency Department patients (31 minutes) as reported in a published national benchmark study.

• The median Total Time in the ED for rural Emergency Department patients (100 minutes) is 56 minutes faster when compared to all US Emergency Department patients (156 minutes) as reported in a published national benchmark study.

• Inpatient Admissions in rural Emergency Departments (5%) is less than half the national Inpatient Admission rate (12.5%).

• Transfer rates from the rural Emergency Department to another facility (4%) are more than double the published national benchmarks (1.8%).

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Dave Brooks, Chief Executive Officer, Providence Regional Medical Center Everett

Teri Fontenot, President and Chief Executive Officer, Women’s Hospital

Larry Goldberg, President and Chief Executive Officer, Loyola University Health System

Steve Goldstein, President and Chief Executive Officer, Strong Memorial Hospital

Dean Harrison, President and Chief Executive Officer, Northwestern Memorial HealthCare

Bill Leaver, President and Chief Executive Officer, Iowa Health System

Barbara Martin, President and Chief Executive Officer, Vista Health

Charlie Martin, Chief Executive Officer, Vanguard Health Systems

Megan Perry, President, Sentara Potomac Hospital

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This event is moderated by Chuck Lauer and Scott Becker.

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Chuck Lauer, author and former publisher, Modern Healthcare
Why We Need to Keep Our Community Hospitals Strong

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

Community hospitals are under siege right now. Unlike large medical centers or hospital systems, they do not have the clout to qualify for the highest payor rates or the lowest vendor prices. And these self-standing, non-profit institutions have limited access to financing at a time when we’re stuck in economic doldrums.

As a group, these hospitals seem ill-equipped for the vast changes that are sweeping through our industry: the move to expensive healthcare IT, the demands for care-coordination through structures like accountable care organizations and the continuing erosion of Medicare and Medicaid reimbursements.

However, this is not a time to kiss community hospitals goodbye. I don’t particularly want to enter a brave new world with just large, impersonal health systems where all of us are just cogs in the wheel. Without these community institutions, there would be a large hole in our healthcare system, and I don’t think it could ever be filled.

We’ve never really agreed on the definition of “community hospital,” but for purposes here, I’d like to put the emphasis on “community.” An academic medical center can serve an entire region, and a healthcare system can blanket many states, but a community hospital needs to remain firmly anchored to its roots — the people it serves. Local businesspeople sit on its board, the hospital is the nexus for local healthcare services and the CEO speaks regularly at the Lion’s Club.

The community hospital will be relevant as long as healthcare stays local, and I don’t think that’s going to change anytime soon. In fact, localness and people-power seem more important than ever in what we do. We now talk about “patient-centered care” and hospitals that can align with each physician on staff. A well functioning community hospital commands patient loyalty and binds itself closely to its physicians.

People often forget how important their hospital is until it’s shut down. But you don’t need a closure to remind people how valuable their hospital can be. Even something as dreadful as a natural disaster can show us the deep connections between hospital and community.

When an EF5 tornado tore through the small city of Joplin, Mo., a little over a year ago, it took 160 lives, destroyed more than $2 billion worth of property and completely leveled one of the city’s two hospitals. With 357-bed St. John’s Regional Medical Center out of commission, 407-bed Freeman Hospital suddenly was responsible for coordinating all medical care — at a time when this work was more important than ever before.

Disasters like this are an opportunity for a well-run community hospital to show its stuff. Twenty-two surgeries were performed at Freeman on the night of the tornado; 135 local physicians sprang into action and more than 1,700 patients were treated in the next few days. The Red Cross, FEMA and any number of good Samaritans can come into town, but there is something special about local people helping local people. The best side of everyone comes out.

St. John’s is still operating out of a temporary facility, but a new hospital will be built. Freeman continues to reach out to the community, opening a digestive health center just two months after the tornado and starting a “health academy” to help local kids prepare for healthcare jobs.

When a community hospital closes, people lose a major employer and have to drive many miles to an unfamiliar city for care. My family has a summer place in Detroit Lakes, Minn. If 87-bed St. Marys Regional Health Center were not there, people would have to drive 60 miles to Fargo, N.D. But St. Marys is still alive and strong because it is loved and respected. The doctors and nurses were efficient and friendly every time I’ve been there. It is pleasure to see people who truly love their work and make a difference in their community.

In Naples, Fla., where my family vacations in the winter, Naples Community Hospital is a much larger institution, with 681 beds, but it is still remarkably local. A friend of mine, a retired CEO of a specialty hospital in the Northeast, recently had emergency surgery there and raved about the professional standards and personal attention. “The care I received was first rate and the attitude of everyone in the hospital seems to be totally focused on patient care,” he said. “If they had not performed surgery on me when they did, I wouldn’t be here to talk about my experience.”

As healthcare evolves, community hospitals are going to contend with growing challenges to deliver superior care, but it is still possible for them to succeed, provided they carry out some crucial strategies:

1. **Align closely with physicians.** Maintaining a great relationship with physicians is key to favorable payor contracts, successful quality initiatives and an improved cost structure.

2. **Affiliate with a large system.** Specialists rotating through the community hospital from a far-off academic medical center create a win-win situation: the community hospital gains physicians it could never have recruited on its own, and the AMC establishes a pipeline for new patients.

3. **Engage the community.** Keep a high profile by holding community meetings, producing newsletters and articles in community newspapers, and working with community-based organizations.

4. **Get community feedback.** Gather community members’ views through meetings and focus groups to identify ways to improve programs and expose service gaps.

5. **Become the healthcare hub for the community.** Become indispensable to the community by steps such as holding prevention classes, building a fitness center and partnering with existing ventures in the community.
Backus Corp. in Norwich, Conn., parent of Backus Healthcare System, and Hartford (Conn.) HealthCare signed a memorandum of understanding to move forward with their proposed affiliation.

Emory Healthcare in Atlanta and Southern Regional Health System in Riverdale, Ga., signed a letter of intent for an affiliation.

Fairmont (W.Va.) General Hospital entered into a 60-day period of negotiations with West Virginia United Health System in Fairmont to explore options for a partnership.

Hackettstown (N.J.) Regional Medical Center explored a strategic affiliation to support its continued service growth.

The San Francisco-based medical group Hampton Health and the former president and CEO of Honolulu-based St. Francis Healthcare, Eugene Tiffinak, submitted a letter of intent to acquire the former Hawaii Medical Center facilities from St. Francis Healthcare for an undisclosed price.

Kokomo, Ind.-based Howard Regional Health System’s board of trustees passed resolutions approving the affiliation with Community Health Network in Indianapolis.

The potential sale of Knapp Medical Center in Weslaco, Texas, to South Texas Health System in Edinburg, Texas, the local branch of Universal Health Services in King of Prussia, Pa., halted.

Rhode Island Attorney General Peter Kilmartin approved the sale of Landmark Medical Center in Woonsocket, R.I., to Boston-based Steward Health Care System.

Lifespan in Providence, R.I., one of the state’s largest healthcare systems, and Gateway Healthcare in Pawtucket, R.I., a community behavioral healthcare organization, signed a letter of intent to affiliate.

The Massachusetts Department of Public Health approved the merger between Lowell (Mass.) General Hospital and Saint’s Medical Center in Lowell.

Rochester, Minn.-based Mayo Clinic expanded its network of local hospitals and systems, adding Heartland Health in St. Joseph, Mo., to its year-old Mayo Clinic Care Network.

Georgia Attorney General Sam Olens approved the proposed acquisition of McDuffie Regional Medical Center in Thomson, Ga., by University Health Care System in Augusta, Ga., the parent company of University Hospital in Augusta.

Flint, Mich.-based McLaren Health Care’s purchase of Cheboygan (Mich.) Memorial Hospital officially closed.

Mercy Health in Chesterfield, Mo., entered exclusive acquisition talks with Jefferson Regional Medical Center in Crystal City, Mo.

Mountain View Hospital in Madras, Ore., and St. Charles Health System in Bend, Ore., considered ways to deepen their strategic relationship including a lease agreement, a consolidation of assets or other legal business ventures.

Northeast Health System in Beverly, Mass., completed its review process and accepted the recommendation to affiliate with Lahey Clinic in Burlington, Mass., to form Lahey Health System, an integrated healthcare delivery system serving northeastern Massachusetts.

Queen’s Health Systems in Honolulu signed a letter of intent and confidentiality agreement with St. Francis Healthcare System of Hawaii in Honolulu, enabling Queen’s Health to explore the feasibility of acquiring and reopening the former Hawaii Medical Center-West in Ewa Beach.

Scott Memorial Hospital in Scottsburg, Ind., signed a letter of intent to lease its facility to The Regional Health Network of Kentucky and Southern Indiana, a new joint venture formed by Norton Healthcare in Louisville, Ky., and LifePoint Hospitals in Brentwood, Tenn.

Two Chicago hospitals, Sinai Health System and Holy Cross Hospital, began talks to affiliate.

The merger between South Jersey Health System in Vineland, N.J., and Underwood-Memorial Health Systems based in Woodbury, N.J., should complete this August pending regulatory approval.

Universal Health Services in King of Prussia, Pa., announced a definitive agreement to sell Auburn (Wash.) Regional Medical Center to MultiCare Health System in Tacoma, Wash.

UPMC Hamot in Erie, Pa., signed a letter of intent to enter a strategic affiliation with Dunkirk-based Lake Erie Regional Health System of New York.

Raleigh, N.C.-based WakeMed Health & Hospitals withdrew its hostile $750 million bid to takeover Rex Healthcare, also based in Raleigh, from state-owned University of North Carolina Health Care System, based in Chapel Hill.

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Hospital & Health System Executive Moves

Mark Billings, president of Presbyterian Healthcare in Charlotte, N.C., since 2008, left the system to serve as president of Presbyterian’s parent, Novant Health Shared Services in Winston-Salem, N.C.

Shawn Bolouki is no longer CEO of Tulare (Calif.) Regional Medical Center. MedCentral Health System in Mansfield, Ohio, named current CFO Joe Chamberlain as COO and as the acting CEO upon James Meyer’s retirement.

Ryan Chandler was named CEO of Columbus (Ohio) Regional Medical Center.

Robert Driewer, the CEO of Newman Regional Health in Emporia, Kansas, announced his retirement.

West Oaks Hospital in Houston named Gregory Drummond as CEO.

Fairview Health Services in Minneapolis, a non-profit hospital operator, did not renew president and CEO Mark Eustis’ contract.

Children’s Medical Center of Dayton (Ohio) named Deborah Feldman as CEO.

Margaret Gustafson, CEO of Kewanee (Ill) Hospital, accepted the position of president of Children’s Hospital of Illinois in Peoria.

Advocate Health Care in Oak Brook, Ill., announced Richard Heim as president of its Advocate South Suburban Hospital in Crest, Ill.

PeaceHealth in Eugene, Ore., a non-profit healthcare system, named Jon Hill as CEO of its Oregon region.

Brad Holland resigned as CEO of San Angelo (Texas) Community Medical Center to serve as CEO of Cedar Park (Texas) Regional Medical Center.

Sutter Health in Sacramento, Calif., named Daryn Kumar as CEO of Memorial Medical Center in Modesto, Calif.

Jewish Hospital & St. Mary’s HealthCare in Louisville, Ky., announced CEO David Laird retired from the organization.

Wake Forest Baptist Health in Winston-Salem, N.C., announced the retirement of Donny Lambeth, president of its Lexington (N.C.) Medical Center and Davie Hospital in Mocksville, N.C.

Oak Valley Hospital in Oakdale, Calif., named John McCormick as permanent CEO.

Richmond-based HCA Virginia Health System named Tim McManus as CEO of CJW Medical Center’s Chippenham and Johnston-Willis Hospitals in Richmond.

Simi Valley (Calif.) Hospital named Kim Milstien as CEO.

Redwood Area Hospital in Redwood Falls, Minn., named Keith Muetzel as interim CEO.

Banner Ironwood Medical Center in San Tan Valley, Ariz., named Julie Nunley as CEO.

Hancock Medical Center in Bay St. Louis, Miss., named Robert Pascasio, FACHE, as CEO and administrator.

Patrick Quinlan, MD, stepped down as CEO of Ochsner Health System in New Orleans to head the new Ochsner Center for Community Wellness and Health Policy.

Doug Self submitted his resignation as CEO of Seneca Healthcare District in Chester, Calif.

SoutheastHEALTH, a healthcare system in Cape Girardeau, Mo., named Wayne Smith as president and CEO.

Wake Forest Baptist Health in Winston-Salem, N.C., promoted Steven Snelgrove to president of its affiliate, Lexington Medical Center in Columbia, S.C. Thompson Health in Canandaigua, N.Y., named Michael Stapleton president and CEO.

Martin Tursky, president and CEO of Memorial Hospital of Rhode Island in Pawtucket, announced his resignation to serve as president and CEO of Firelands Regional Health System in Sandusky, Ohio.

University of California San Diego Health System named Paul S. Viviano its new CEO.

Cadence Health in Winfield, Ill., named Michael Vivoda as CEO.

Gary Wages will serve as interim CEO of Cushing Memorial Hospital in Leavenworth, Kan., part of Kansas City, Mo.-based St. Luke’s Health System.

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