Health Reform in 2013: What’s Happened, What’s Left & What It Means for Providers

By Jim McLaughlin

With just one year remaining before the largest parts of the federal health reform law take effect, 2013 will be a busy year for hospitals as they prepare for the biggest changes in healthcare since Medicare was introduced in 1965.

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What Makes a Hospital Attractive to Employers?

By Molly Gamble

Population health management has become a mainstay in the American healthcare landscape, but many hospitals and health systems are still determining what “population health” looks like for their organization. Most recently, physician groups, hospitals and insurers have become hyper-focused on accountable care organizations, patient-centered medical homes and other performance-driven models.

But as providers and payors partnered for these initiatives, one major player seemed to be missing from the broader picture: employers. And right now, as large employers face pressures to trim healthcare costs, better manage employees’ health coverage or completely revise their benefit plans, companies are eager to engage in partnerships.

“It’s a relatively new phenomenon, starting with large national employers who are pushing the envelope,” says Warren Skea, PhD, director in PwC’s health enterprise

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**Publisher’s Letter**

**March Issue; 2013 Annual Meeting**

**March issue.** The March issue of *Becker's Hospital Review* includes a special focus on compensation issues for hospital and health system executives as well as physicians across all specialties. Compensation-focused articles in this issue include “Hospital and Health System Executive Compensation in 2013: 8 Trends” and “200 Statistics on Physician Compensation,” among other stories. Additionally, the prevalence of hospital acquisitions of medical groups and subsequent employment of physicians is a key trend discussed in “7 Trends in Hospital-Employed Physician Compensation,” another great article you’ll find in this issue.

This issue also contains our annual list of “100 Hospital and Health Systems With Great Oncology Programs” as well as content on hospital-physician relationships and accountable care organizations, hospital finance, and hospital and health system transactions.

**4th Annual Becker’s Hospital Review Meeting.** The 4th Annual Becker’s Hospital Review Meeting will take place on May 9-11, 2013, in Chicago at the Westin Michigan Avenue Hotel. We have expanded the 2013 event to a two-and-a-half day affair with even more speakers and panels, and the event will feature 85 health system executives as speakers. Keynote speakers include Lou Holtz, former college football coach and a sportscaster and author, and Patrick Lencioni, founder and president of The Table Group and author of 10 best selling books including “The Five Dysfunctions of a Team.” Bret Baier of Fox News’ “Special Report with Bret Baier” will also headline the event, serving as moderator for the meeting's keynote panels. To learn more about the event, visit [www.beckershospitalreview.com/4th-annual-beckers-hospital-review-meeting.html](http://www.beckershospitalreview.com/4th-annual-beckers-hospital-review-meeting.html). To register, call (800) 417-2035 or email registration@beckershealthcare.com.

At the Annual Meeting, we will also announce winners of the 2013 Becker’s Healthcare Leadership Awards. Nominations are now being accepted. To nominate yourself or another industry leader, contact me at sbecker@beckershealthcare.com or Associate Editor Molly Gamble at mgamble@beckershealthcare.com.

Should you have any questions or if I can be of help in any manner, please do not hesitate to contact me. I can also be reached at (800) 417-2035.

Very truly yours,

Scott Becker
Health Reform in 2013: What’s Happened, What’s Left & What It Means for Providers (continued from page 1)

The Obama administration has embarked on a comprehensive overhaul of the way Americans deliver and pay for healthcare, aiming to make care more affordable through eliminating waste, incentivizing efficiency and requiring more recipients to pay in. It plans to achieve those goals at the cost of the traditional funding mechanisms and levels that providers have come to rely on, which could spell disaster for the unprepared.

Being prepared requires providers to not only know and adapt to what’s coming, but also to be able to explain what has changed to their patients and business partners. The Patient Protection and Affordable Care Act represents enormous upheaval to the healthcare industry’s status quo, so here is a recap of what’s happened, what’s to come, and what hospitals should be doing to ready themselves for the PPACA.

Reform so far

President Barack Obama signed the PPACA into law March 23, 2010, but the lead-up to its passing was a hard-fought battle. There were rumors of “death panels” enabling government-sponsored euthanasia resulting from rationed funding for healthcare. A public health insurance option intended to compete with private insurers was rejected twice. And although the Supreme Court upheld the constitutionality of the law’s contentious individual health insurance mandate in June 2012, it struck down the requirement for all states to expand their Medicaid programs, relegating that part of the law as optional for each state.

Much of the law so far has begun to turn the wheels of the health industry in the direction of growing primary care, promoting and protecting consumers’ access to coverage and introducing funding models that share payers’ risk and gains with providers.

2010 — Expanding access to more people, the 2010 law immediately began to disburse tax credits for small businesses’ health plans and rebates to seniors for prescription drugs. Children could no longer be denied coverage due to pre-existing conditions, and some state and federal insurance plans were created for adults with pre-existing conditions who had been uninsured for six months or more. Young adults under 26 not offered insurance from their employer were permitted to stay on their parent’s plan. Anticipating the boost in demand, education assistance was established to attract more primary care nurses and physicians into underserved areas.

Within the health plans themselves, types of preventive care became covered without charging a copay or deductible, and no lifetime limits on hospital stays or other essential benefits can be imposed. More assistance was given to seniors buying Medicare Part D-covered drugs and receiving preventive services, and at the same time the Obama administration added defenses against corruption and unreasonable business practices. Extra funding was pumped into fraud-busting programs to cut unlawful billing of Medicare, Medicaid and CHIP, and into state groups with authority to review or regulate insurance premium increases.

2011 — In 2011, a major limit on insurance companies was imposed that required them to spend at least 80 to 85 percent of premium dollars on healthcare or quality improvement, rather than administrative costs or profits, or else send rebates to customers. Gradual reductions to insurance companies in the Medicare Advantage program began, slowly shrinking the $1,000 bonus paid per beneficiary on average compared with traditional Medicare.

Elderly and disabled beneficiaries gained a wealth of new services designed to decrease the amount of time they spent hospitalized, free preventive care for certain services, assistance designing care plans and coordinating support services when they were discharged from a hospital visit, and freedom for states to use Medicaid funding to pay for cheaper at-home care versus nursing home admittance. Medicare beneficiaries also began to receive a 50 percent discount on Part D-covered brand-name prescription drugs.

Money was granted to public health programs and services to help Americans purchase sensible private insurance. Efforts to build and renovate community health centers gained new financial support, and payments for rural providers went up.

2012 — Last year saw a swath of changes, including the advent of accountable care organizations established in order to design cost-effective approaches to care delivery in exchange for sharing in CMS’ savings.

In October 2012, hospitals meeting certain benchmarks for electronic health records became eligible for incentive payments as part of provisions included in the American Reinvestment and Recovery Act. That same month, CMS began its Value-Based Purchasing program, which alters how much it pays hospitals through Medicare depending on its performance on various quality measures including patient satisfaction and hospital readmission rates.

2013 — Beginning this year, funding changes to Medicaid will reimburse primary physicians at Medicare rates through 2014. The federal government will also increase funding to states that craft Medicaid programs with better benefits for preventive care. And a national pilot program to promote bundled payment models has gone into effect, which would allow providers to take on risks and profit potential from efficient use of Medicare funds.

Coming soon

There’s more to come from the law, especially next year in 2014. That’s when nearly all adults and children must obtain health insurance or pay a fine, which will be the greater of 1 percent of income or $95 per adult ($285 for a family) next year but will balloon to the greater of 2.5 percent of income or $695 ($2,085 per family) by 2016. Penalties for much wealthier families can grow as high as the average basic-level government-approved health plan’s annual premiums. Employers of more than 50 full-time workers will need to offer minimum essential coverage or pay a fine for each eligible worker above a threshold who is not offered coverage.

Each state will have an online health insurance marketplace, referred to as an exchange, that will offer qualified private plans for individuals and small businesses, and screen customers to see if they are eligible for subsidies, tax credits or Medicaid. Enrollment for these begins in October this year, with coverage going live Jan. 1, 2014. All but a few Republican states have shunned the idea of running their own exchanges, opting instead for the federal government to take on the job. Supporters say the marketplaces increase competition and will benefit consumers, thus creating less need for government insurance programs.

One of the most hotly contested features of the PPACA, even today, began to receive funding in 2011. The Independent Payment Advisory Board, an appointed panel of healthcare experts, will be charged with making binding cost-cutting plans for Medicare payments beginning in 2015 that Congress can override only through new legislation that achieves the same level of savings. Republicans have vowed to eliminate the IPAB, and even some Democrats have raised an eyebrow at the concept.

Originally, the law intended for all states to be required to expand Medicaid to more poor and childless adults at 133 percent of federal poverty line. But when the Supreme Court nixed that mandate, the Obama administration fell back on incentivizing states to volunteer to expand Medicaid with a guaranteed three years during which the increased cost of the expansion will be covered entirely by the federal government. After that, states will only contribute 10 percent of the extra cost.

Medicare disproportionate share hospital payments, the lifeblood of some critical access and safety-net hospitals, will plummet 75 percent in October, but they’ll be offset by larger payments based on a hospital’s proportion of uninsured served and uncompensated care provided.
What hospitals can do to get ready

It’s going to take strong hospital leadership to weather what could either be a windfall or a typhoon. Following is some advice from healthcare leaders and experts for how to prepare for the flood of changes and regulations.

Expect upfront costs. The law’s goal is to lower healthcare costs over the long term, but in the short term, most will feel the changes in their checkbooks. Doug Fenstermaker, a former hospital CFO now serving as managing director and vice president of healthcare at Atlanta-based Warbird Consulting Partners, says he’s skeptical of significant savings for providers in the near future, because the cost of implementing the law has a lot of upfront cost.

“It is hard to tell whether the PPACA will result in a lower amount of GDP being consumed by healthcare and if costs will actually decline. In the short-term, that is not at all likely, as investments in infrastructure to make it all work will skyrocket,” he says.

While the law aims to improve coordination in the delivery of care and better use of ramped up technology to lower costs, the initial capital cost of that infrastructure will take time to be paid off.

Preserve margins with more savings, not more revenue. Bundled payments, Medicare Advantage and shared savings programs with CMS and private insurers can be lucrative for health systems, especially if fewer patients are uninsured. True, that may bring a flood of new patients, says Aurelio Fernandez, executive vice president and chief operating officer of Memorial Healthcare System in Hollywood, Fla., but political instability in his state and the country alike means he’s not counting on seeing revenues rise.

“I’m not basing our future on the ability of generating [additional] revenues, but on having cost-efficiency,” Mr. Fernandez says.

Back in 2011, he says Memorial’s leaders did a study and learned its cost structure was too high. So in 2012, he says they embarked on a cost reduction initiative that looked at contractual arrangements, staff reductions and eliminating unnecessary services through partnerships. They set a system-wide cost reduction goal of 5 percent, in excess of $75 million, by the end of their fiscal year which ends this April. So far they’ve reached 85 percent of that goal, even after realizing costs to implement their electronic health record system this year.

Track your performance. The sharp drop in Medicare DSH funding will be a blow to systems like Dignity Health. The San Francisco-based organization’s Vice President of External and Government Relations Wade Rose says since Dignity Health is among California’s largest providers of Medicare services, the cuts will be a challenging obstacle. He and his system’s leaders support the law overall, but he acknowledges that expectations are quite high on providers to fix inefficiencies that are easy to identify but difficult to improve because of changes that must be systemically implemented. “The reality on the ground can be very different than the elegant logic of the bill,” Mr. Rose says.

In response, his team is gathering and analyzing copious amounts of data to learn where they can be more efficient, from speeding up imaging tests to designing a nurse’s station to maximize productivity, and tracking the impact of these changes on performance.

Mr. Rose says that’s why this law might be more successful than efforts of the past — he says 95 percent of the bill has to do with delivery system change, rather than mere funding changes.

Look beyond a hospital’s four walls. Some of the greatest cost inefficiencies occur after elderly patients leave providers’ care. Not following physicians’ orders after being discharged from the hospital can lead to higher readmissions, which the health reform law now penalizes through lower reimbursement rates. As a result, many hospitals have focused much of their efforts into transitioning seniors from the hospital to the home, helping them help themselves stay healthy.

Nathan Anspach, CEO of Phoenix-based John C. Lincoln Health Network’s accountable care organization, says his organization’s solution was to collaborate with physicians, clinicians and pharmacists within the ACO to design a systemwide formulary plan. “We see a pretty significant dollar savings,” he says.

“We’re all about the 5 to 60 rule — 5 percent of our members will use 60 percent of the resources of our ACO,” Mr. Anspach says. He and his team have addressed that with greater attention on patients with chronic conditions like congestive heart failure and diabetes.

Keep patients satisfied. Among other metrics, hospitals have begun to see patient satisfaction account for a rise or deduction of up to 1 percent in their Medicare reimbursements. In an era where providers’ margins are shrinking for a number of reasons, hospitals can hold on to what’s theirs with a focus on patient experience, says Kristin Baird, a registered nurse and CEO of Baird Group, a Fort Atkinson, Wis-based healthcare consulting firm.

“Patient satisfaction, once seen as fluffy or soft, is now an important measure that cannot and should not be ignored,” Ms. Baird says. “Consumer Assessment of Healthcare Providers and Systems surveys have leveled the playing field and give the consumer a voice along with other important outcomes. Healthcare organizations recognize now, more than ever, that providing good service directly impacts the bottom line. That realization has not been so clear before.”

Partner to absorb risk. It’s no secret that hospitals are employing more physicians, and that trend of employing or contracting with physicians is likely to continue, says Adam Powell, PhD, a health economist and president of Boston-based healthcare consulting firm Payor+Provider Syndicate.

“In 2013, I expect to see acceleration in the wave of payor-provider integration and hospital consolidation that began in 2012. The recent merger between Baylor Health Care System and Scott & White Healthcare is just one example of how integrated delivery systems are expanding by merging with hospital systems. Hospitals are increasingly being asked to own their risk, and merging with payors and integrated delivery systems provides them the know-how to do so,” Dr. Powell says. “Providers are hoping that mergers will provide them with more leverage in negotiating with payors and economies of scale that will enable them to lower their costs.”

As scrutiny builds over unnecessary inpatient care, Mr. Fenstermaker says hospital systems are likely to divest specialties that aren’t core to the business in favor of integrating those services with other systems. For this reason, he says he expects rural hospitals will begin to operate more like ambulatory care clinics and transfer more patients to larger hospitals’ specialty centers.

The current number of primary care physicians will struggle to meet the anticipated demand brought on by the newly insured, so Mr. Fenstermaker predicts the industry will rely more heavily on physician assistants, practical nurses and technology to compensate for the physician shortage.
What Makes a Hospital Attractive to Employers? (continued from page 1)

growth practice. “We have seen partnerships occurring in markets where there is a large employer, and they see inefficiencies and redundancies in care. They proactively go to a provider and say, ‘It’s important we manage our healthcare costs. We’re going to partner with somebody.’”

A major question has been whether large employers will drop coverage in 2014, sending employees to insurance exchanges. But a July 2012 study from Deloitte found 81 percent of companies with 50 or more employees planned to continue providing benefits in the next one to three years. This suggests many companies are still looking to optimize their benefit programs rather than abandon them.

This article explores providers’ direct contracting relationships with self-insured employers, such as bundled payments and narrow networks, and discusses factors that can make or break a provider’s chance to be involved in those programs.

Lessons from Cleveland Clinic’s ties to employers

Cleveland Clinic has blazed a trail with its employer partnerships. In 2010, the system struck a direct-to-employer deal with the home improvement giant Lowe’s, based in Mooresville, N.C. Under that agreement, more than 225,000 employees and their dependents enrolled in Lowe’s self-funded health plan can travel to Cleveland Clinic for heart procedures. Lowe’s then covers all medical deductibles, coinsurance payments, travel costs and lodging for the patient and a companion.

It was an innovative partnership at the time, according to Michael McMillan. As executive director of market and network services for Cleveland Clinic, Mr. McMillan and his team are the architects of Cleveland Clinic’s direct-to-employer program, called the Program for Advanced Medical Care. “It was a unique and innovative approach to solving a couple of problems that, in this case, a large, multi-state employer had.”

Prior to striking the deal, Lowe’s observed variability in outcomes among its employees’ heart care, as roughly a quarter of a million Lowe’s staff throughout the country visited different physicians and hospitals. Furthermore, a “very small percentage” of its workforce was generating a large portion of costs, says Mr. McMillan. If Lowe’s could get employees who needed highly specialized care to an organization that demonstrated the best outcomes, health costs might decline while employee health improved, along with gains in productivity.

Cleveland Clinic, rated first in the country for cardiac care by U.S. News & World Report since 1994, was an attractive partner for Lowe’s. Cardiac surgery is a big-ticket procedure, which justifies the company’s reimbursement for airfare and other travel costs. Since that first deal, Cleveland Clinic has continued forming relationships around its centers of excellence with an array of large employers.

In October 2012, the system was one of six across the country to partner with Bentonville, Ark.-based Wal-Mart. Under that bundled payment program, 1.1 million employees and their dependents covered by Wal-Mart’s health plan can travel to Cleveland Clinic for cardiac surgery with the employer covering deductibles and travel costs for the patient and a companion. The clinic also struck a deal with Seattle-based Boeing that same month, under which roughly 200,000 of the aerospace corporation’s employees, retirees and dependent family members can receive heart care at the health system for a fixed price.

“We’re in active discussions with a lot of employers, and we anticipate having many more relationships,” says Mr. McMillan. “For this line of business, the idea is that not every patient needs to travel — we look for services for which travel makes most sense. So we anticipate a number of these arrangements.”

What makes an attractive health system partner?

Generally, the employer approaches the provider for potential partnership programs, but experts say health systems can and are becoming more proactive in these discussions. Large employers seek certain traits in a provider partner, and health systems should be prepared to demonstrate these critical qualities to further their partnership opportunities.

Value is at the intersection of a provider’s outcomes and its costs, and is the most significant driver for any joint provider-employer initiative. As employers become more sophisticated in their understanding of healthcare costs, they will pursue systems that demonstrate quality outcomes, aligned incentives, transparency and the proven ability to manage population health.

Outcomes and transparency. Demonstrated positive outcomes are the biggest selling point for providers, but how a system opts to share its outcomes is nearly as important as the data itself. Employers and companies are likely to expect this information to be made available in the next few years, especially as they work to get healthcare costs under control. In the July 2012 Deloitte survey, 37 percent of large employers, or those with more than 2,500 employees, said their core strategy to manage healthcare costs was analyzing costs and outcomes for local physicians and hospitals.

In many ways, Cleveland Clinic has led the way in measuring and publicizing its outcomes. CEO Delos “Toby” Cosgrove, MD, is credited with developing the system’s “outcomes books” when he served as chief of cardiac surgery. The system publishes outcomes data in book format for its centers of excellence and makes it available by request, treating these outcomes books as a major investment. The information shows the clinic and its physicians can deliver reliable outcomes with little variability, which is just what employers want in a direct partnership.

Aligned incentives. The terms of the partnership, such as Cleveland Clinic’s bundled payment arrangements with employers, will be critical in aligning incentives. Through bundled payments, providers are incentivized to reduce variations and deliver care more efficiently while still delivering superior outcomes.

But employers want a partner who has some skin in the game, and a large part of this can also come down to how physicians are paid. Like some other large, integrated systems, Cleveland Clinic has a unique advantage with salaried physicians. This eliminates a host of concerns about unnecessary or duplicative care — extra services that would come at the employer’s expense.

“I think that offers an advantage to employers in that, not only is it one-stop shopping with all services in one box, but because doctors don’t have direct financial incentive to do one thing or another aside from what is in the best interest of the patient,” says Mr. McMillan.

Roger Merrill, MD, is CMO of Salisbury, Md.-based Perdue Farms. The poultry company has contracted directly with physicians and hospitals for more than a decade, penning up to roughly 15,000 contracts for more than 30,000 employees and dependents, according to an American Medical Association News report.

Leaving the payor out of the mix has worked for Perdue, as its healthcare costs for employees have clocked in at less than half of the national average. “We believe the patient and provider are not the same goal,” Dr. Merrill said in the news report. “We all want to maximize the health of the patient. Typically, large insurance companies do not have that same goal.”

Geography and access. A provider’s employer partner might be located just down the street, across the state, or even halfway across the country — depending on the service. The cost of cardiac surgery justified the price involved for Lowe’s to fly employees to Cleveland for care. And a stream of out-of-state patients is not unusual for Cleveland Clinic, since about 50 percent of its 4,200 annual heart surgeries are performed on patients from outside Ohio. The system might expand some of its employer partnerships to include orthopedic procedures, since many of those services fall into the big-ticket category as well.

The geographic proximity for these partnerships, or how far employers are willing to send workers for care, comes into question depending on the complexity and cost of the service in question. High-risk procedures might be worth the travel if a provider can demonstrate best
outcomes. “Other things might be more local,” says Mr. McMillan. “If you provide a direct relationship with an employer for obstetrics services or occupational medicine, those would be more of a local situation.”

**Infrastructure.** When payors are involved in population health models with employers or providers, they can meet an administrative need and handle claims adjudication. “But we’ve also seen models just between the providers and employer directly, cutting out the middle man,” says Dr. Skea from PwC. “More often than not, those are typically [relationships] with a provider that has an insurance license and experience with population health.”

Employer-provider relationships do not have to come in parties of three, according to experts. While some models do have a payor involved, it’s not a necessary component. But providers that do enter direct employer strategies may need insurance licenses, which can create complexity and extra planning, as the process can take up to 18 months.

“One thing that holds promise for shared savings is attractive to employers,” says W. Yale Miller, executive vice president of Nashville, Tenn.-based Aegis Health Group. “I think providers have an opportunity to step into what might be an information void as opposed to saving that conversation for payors. If [providers] are proactive in talking with major employers, they stand to be in better position.”

**Providers with prior experience have an advantage, but it’s not too late**

Employers are well-suited to approach health systems that have demonstrated success with previous employer partnerships. Cleveland Clinic is exemplary in this respect, but smaller systems or hospitals may have fewer resources, still operate on fee-for-service payment models or are located in highly competitive markets. Not to fear, say experts. Even health systems with limited experience with employers haven’t missed the boat.

“In a funny way, even hospitals that haven’t historically had employer-facing efforts are still well positioned at the end of the day. After all they too are employers, most of them large ones, facing the same health cost issues,” says Pearson Talbert, president and CEO of Aegis Health Group, a hospital business development firm. “It’s about refocusing from sick care to healthcare and then re-messaging what you already do.”

One of the richest opportunities for systems looking to expand relationships with employers is to begin with their own workforces. The Deloitte survey found 62 percent of employers anticipate increasing their wellness and preventive health programs as part of their benefits strategy in the next three to five years. Companies will be more attractive to hospitals that have done the same and can point to the improved health of their own population.

This is a multidimensional task, as hospitals have some of the least healthy employees in the country. A 2012 study by Truven Health Analytics found hospital employees are less healthy than the general workforce and cost more in healthcare spending. But by establishing a wellness program or other population health initiatives, systems can learn initial lessons about population management, fine-tune care processes and use the experience as a foundation for their population health strategy.

There are other avenues for health systems that are relatively green in employer relationships. A hospital’s occupational health department can serve as a natural extension to managing employees’ health, according to Mr. Miller. “Second, if they’re doing some sort of community-based education or health screenings, hospitals can think about re-deploying those assets to some key employer groups and providing feedback to employers and their workforces. That’s mutually beneficial sharing of information.”

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Strong Culture Can Lead to Lasting Change: Q&A With Randy Oostra, CEO of ProMedica

By Heather Punke

Randy Oostra has served as president and CEO of Toledo, Ohio-based ProMedica since 2009 and has been with the system since 1997. After 15 years in the system, one might think that Mr. Oostra would already know how staff and physicians feel about ProMedica’s culture.

But he’s not afraid to admit that he doesn’t always. In fact, he welcomes input on everything from the system’s mission statement to its strategic plan to ensure everyone in ProMedica is on the same cultural page.

Here, Mr. Oostra discusses how cultural awareness and flow of communication has led the system to be successful with changes made under healthcare reform and what advancements have him excited about the industry.

Question: To start off, can you look back and attempt to sum up 2012? What were some highlights of the year for you, both at ProMedica and across the national healthcare landscape?

Randy Oostra: 2012 felt like a long year because of the massive amount of change happening in healthcare. Nationally, there is a lot of uncertainty and acknowledgement that the current model is not sustainable. It’s exciting, and I think some things we put in motion will provide success in coming years.

From a ProMedica perspective, it was an exhausting year but one of the best, if not the best, years we’ve had based on our metrics. We did multiple things to prepare our staff for healthcare reform. We did culture workshops where we used interactive sessions to prepare the staff on where we were in healthcare and how we needed to change. About 12,000 people went through those facilitated sessions. We also had our whole staff focus on patient satisfaction.

We did a lot of work in IT last year. As a system, we had 30 major go-live events including physician order entry. It’s astonishing to do that many go-lives in one year.

ProMedica was also selected by Medicare for the Shared Savings Program and our health plan was selected to be a state-wide provider of Medicaid. We also had some growth; we added physicians and added a hospital last year.

Q: As someone who has been with ProMedica since 1997, how do you think that longevity affects your leadership style?

RO: Longevity can be good and bad. The good part is that it allows for perspective. As you have longevity in careers and institutions, you gain a perspective and a balance. Our team has been together for a long time. Everyone understands their roles and responsibilities and knows what everyone is doing. In times like now, it’s very effective because you know people will do their job and take on their responsibilities.

It’s challenging to think about leading and facilitating change in an institution because you have to work with the board and community to explain changes. Having familiarity helps in that area. It all gives you perspective. My 15 years here are helpful as we think about the next decade.

Q: You’re a huge advocate for culture improvement. How has culture at ProMedica changed under your watch?

RO: Culture is incredibly important, especially in times of change. We looked at incredible changes from financial pressures, electronic medical records, the Patient Protection and Affordable Care Act, ACOs and population health management expenses and workforce and recruitment issues. These are the times to step back and go to the basics of what we believe and [form] a sense of unity.

When you look at culture, there are different cultures in the workforce, and they deal with life differently and different things motivate them. For example, cultural differences affect marketing strategy. There are board members that like to look at the newspaper and want to be advertised there, and the young medical group wants social media marketing. If you have the same message for everyone, it doesn’t work. We need to communicate and work with each group differently. If we don’t do that, we won’t be successful in healthcare. When you think about driving teamwork, working with physicians and sharing and navigating decision-making, we want to make sure everyone is together and going about it similarly.

Culture has a huge impact, and we focus on participation and making sure everyone gets an opportunity to voice their thoughts. We do that routinely through webcasts, and we also go on the road to different facilities where we talk with our staff. We make it a point to ask for input on everything we do, like evaluating our mission statement, values and strategic plan. We did that through an online survey, and we got great thoughts on what the staff would like to improve.

We also do executive sessions during all of our board meetings and try to make sure people feel comfortable sharing their thoughts. During those, we focus on dialogue and communication.

Those are the biggest things we’ve done over the last few years, having free-flowing communication.

We coupled all of that with a huge push in employee wellness. We want to show that healthcare organizations should be different from other organizations in employee wellness. We sponsor programs for people to lose weight, and we offer fitness club membership for employees. We have signs that show nutrition for what we serve in our cafeteria and vending machines, and we got rid of sugary beverages. We also don’t hire tobacco users.

Some facilities now have stand-up desks. Instead of people sitting all day, we put in hundreds of these desks in the system’s facilities so people can stand. The desks work well for people with back problems, and we’ve had a strong response.

From a wellness perspective, we believe we have to have a role in doing things differently. We should be different and a model for health and well-being. All of these things are the right things to do for healthcare organizations.

There has also been an emphasis on leadership development. We’ve been getting input from physicians and putting them on boards and in senior leadership positions. All that changes culture from top-down to being based on participation and teamwork.
Q: “Culture” can really be an ambiguous term, encompassing a range of workplace issues. Where should a health system CEO start if he/she wants to drive serious, lasting improvement?

RO: The first thing to think about is the direct impact culture has on change in healthcare. When culture wasn’t aligned with changes in the past, those changes failed. Culture is not a soft, fuzzy thing, but it’s important when you think about what type of environment you want to create to work in.

If you’re interested in culture, start with conversations. Get others’ perspectives on employee, patient, physician satisfaction. If the results are not doing the things we aspire to do. Start small, with a series of conversations, and see if your perceptions align with everyone else’s. Talk to people, with a series of conversations, and see if your perceptions align with everyone else’s. Talk to people, deal with misconceptions, and use that to address cultural issues in the organization.

Q: What is it about healthcare that excites you most right now?

RO: It is a very interesting time to be in healthcare. In some ways, it’s very challenging, but it is still very, very exciting. When you begin to look at the need to change — the fact that healthcare is not sustainable, a lot of people are getting added to Medicare and Medicaid and dealing with cost issues while providing high-quality care — the challenge alone is very exciting.

One interesting thing is the advances we’ve seen, like the adoption of EMR and physician and nurse order entry and the fact that we’re talking about ACOs and global issues of health. Addressing community need and access is not dull by any means — it’s very exciting. Who is better to solve the issue in the community than mission-based, community-focused non-profits? It’s a great opportunity for healthcare institutions to address community needs.

At ProMedica, we became interested in personal determinates of health, and specifically hunger as a health issue. When you look at the mission statement, [editor’s note: ProMedica’s mission statement is “Our Mission is to improve your health and well-being”] it doesn’t mean we only take care of people in our four walls, we need to go outside our four walls to deal with health and well-being in the community. For example, we’re working with Share our Strength’s No Kid Hungry® campaign to help end childhood hunger in communities across the country. We’re excited about it because it’s a little non-traditional. It is something we feel excited about.

Q: Any New Year’s resolutions you can share?

RO: I think any time you go through a lot of change and challenge, it’s good to come back to focusing on what’s important on a work and personal basis. Personally, mine is to have more balance in life over the next year. Professionally, it is to keep balance and take time to step back and think globally and strategically about the things we do.

**Finding Value in Your Organization: Q&A With Baylor Health CFO Fred Savelsbergh**

By Bob Herman

Fred Savelsbergh is not a typical CFO in today’s hospital and healthcare industry.

Since he graduated from North Texas State University in 1982 with a double major in accounting and economics, Mr. Savelsbergh has worked at Baylor Health Care System, based in Dallas. He worked his way up from staff accountant to CFO, a position he has held since 2009.

It’s rare for a person to stick with one organization throughout his or her professional life these days, but Mr. Savelsbergh says he has enjoyed every second of it. A major reason he’s found personal satisfaction at Baylor is because he works for an employer with similar values to his own — and he also happens to be in a position that demands vast amounts of change, which always keeps things interesting.

Here, Mr. Savelsbergh talks about his tenure at Baylor, how the healthcare system has evolved during his time there and what ideas hospital and health system CFOs need to encourage if they want their organizations to be successful in an era of big data and quality outcomes.

**Question:** You’ve been with one employer for your entire professional career. That experience is few and far between these days. How have you been able to maintain such a long, stable tenure at Baylor Health Care System?

**FS:** When I first came to Baylor, it actually had only one other affiliated hospital besides Baylor University Medical Center in Dallas. [There are now 30 hospitals owned, operated, joint ventured or affiliated with Baylor Health Care System.] It was a very small healthcare system.

If you think about where healthcare was in 1982, it was talked about in the purest sense of business, as it was just starting to develop a hub-and-spoke strategy. We did this through years of relationships with other community medical centers. That, in and of itself, is quite remarkable.
Now think about where healthcare is going — focusing on the continuum of care, so a hospital is more like a short-stay urgency center. But at the center of everything we do are patients. We have to think about the continuum of care and all those stops on the continuum of care. It’s about chronic disease management and primary care medical homes, in particular. Our HealthTexas Provider Network is an example of that with more than 600 physicians and extenders.

Q: As you mentioned, Baylor Health Care System has grown significantly over the past several decades, even the past several years. Mergers and acquisitions are becoming more prominent than ever before. How do you see this evolving in the short term, and how big of a role should CFOs have in the M&A process?

FS: Consolidation is going to continue to occur on the provider side — and it is happening on the payor side, too. Size and scale can be a shock absorber when you’re managing transition risk, and you have to have balance sheet strength. Days cash on hand is an example of an important metric to watch.

Baylor Health Care System is in a highly competitive environment, and the reason why we have such a diversity of business models at this point in time is although the market has settled down, the national healthcare environment hasn’t. There are more changes coming in 2014 [due to the Patient Protection and Affordable Care Act]. For example, our state government has said it will decline participation in the Medicaid expansion. What is that going to look like? Those are business models that have to be evaluated, and we are doing that. But right now, there are still too many unknowns to define further M&A movement.

Q: Texas Gov. Rick Perry, as you said, has indicated Texas will not expand its Medicaid program. Essentially for hospitals and health systems in Texas, and other states declining Medicaid expansion, this means continued uncompensated care for patients who could have at least received Medicaid coverage. Texas will also not design its own health insurance exchange. What are your thoughts on how Texas is handling the big PPACA elements?

FS: When the [PPACA] was passed, Texas had the highest rate of uninsured people. The exchanges and Medicaid expansion would provide an option for the uninsured, and it would help the situation in Texas. There are significant healthcare access issues in Texas that have to be addressed.

I think this whole situation around exchanges will come down to benefit design. What are the payments to physicians and to providers who take exchange patients? If I look at it right now, only 37 percent of physicians in Texas take Medicaid, and 70 percent said they will take Medicare. This is a big concern for the state of Texas.

Q: If there’s one important point you’d like to relay to other hospital and health system CFOs out there, what would it be?

FS: One is cost structure. It’s really where payments are going. It’s about managing transition risk between the top line and cost base and trying to maintain that parity between where the top line is changing and pulling costs out of the organization.

One example is our STEEEP governance council, which stands for safe, timely, effective, efficient, equitable and patient-centered care. We have brought together myself, our CMO, COO, chief quality officer, chief safety officer and clinicians, and we look at the finance, quality and clinical care from an efficiency standpoint. That’s one of the structures we’re looking at for our Medicare break-even strategy.

Basically, we’re trying to right-size the cost structure to where we think the puck is going to be, and we want to take $680 million in costs out of Baylor Health Care System over a five-year period. We are in our third year of the journey. We re-evaluate this every year as part of our strategic financial budgeting process. We also track it on a monthly basis and then we measure whether we are accomplishing our goals.

Q: Any final thoughts as we head into 2013?

FS: Over the last 10 years, there have been a lot of acquisitions of freestanding ASCs and short-stay hospitals. We are doing acquisitions as well. With that growth, it will be highly competitive, but you have to invest in those new models.

Back to the STEEEP committee, Baylor Health Care System made a decision to establish a quality institute to look to the future and look at big data. Through [Baylor's Chief Quality Officer] David Ballard, MD, PhD, a large group of physicians and others, they can analyze our data and quality outcomes. That is part of how you compete in the future. You need to have data to continuously improve your organization and prove your outcomes. That was something Baylor invested in years ago, and we are in a position to capitalize on that.

And I’ll leave you with this — providers have to find a financing vehicle. In order to compete, you have to have a financing vehicle because that gives you another source of big data.

Q: When you say “find a financing vehicle,” do you mean hospitals should start their own health insurance plans?

FS: They could start a health plan, acquire a health plan or partner with the payor. Why is that important? Because you’ll be responsible for bundled payments, or any variation of capital or payments based on outcomes. Having a financing vehicle and having covered lives is very important form a competitive advantage standpoint.
Healthcare and Seniors Housing Valuations

Owners and lenders across the country seeking to obtain financing, comply with governmental reporting requirements, or strengthen financial position confidently trust Principle Valuation for valuation and advisory services. Our experienced professionals can expertly handle every facet of your valuation needs. We provide services for all healthcare entities, from valuations of physician practices to allocation of purchase price for hospital systems. We invite you to contact us, and to learn why your valuation and advisory needs are truly a matter for Principle.
Becker's Hospital Review has named “100 Hospitals and Health Systems With Great Oncology Programs.” These hospitals are on the cutting edge of cancer treatment, prevention and research, and the Becker's Hospital Review editorial team selected them based on clinical accolades, quality care and contributions to the field of oncology.

These hospitals have been recognized for excellence in this specialty by reputable healthcare rating resources, including U.S. News & World Report, Thomson Reuters, the National Cancer Institute, the American College of Surgeons, the American Nurses Credentialing Center and CareChex. Each organization has demonstrated a focus on patient-centered cancer care and emphasis on continual innovation in treatments and services. Many of these organizations also have a place in the history of cancer prevention and research, as they’ve driven groundbreaking discoveries and made clinical milestones.

Note: This list is not an endorsement of included hospitals or associated healthcare providers, and hospitals cannot pay to be included on this list. The following content should be used for informational purposes only and is not intended to substitute professional medical advice. Hospitals and health systems are presented in alphabetical order.

**Advocate Good Shepherd Hospital (Barrington, Ill.).** The Center for Cancer Care at Advocate Good Shepherd Hospital provides patients with a multispecialty team of oncologists, surgeons, oncology nurses, spiritual counselors and complementary specialists. The hospital is accredited as a Comprehensive Community Cancer Program by the American College of Surgeons Commission on Cancer. Advocate Good Shepherd Hospital offers patients access to clinical trials and advanced treatments, and it has the third highest volume in the metro Chicago area for prostate cancer treatment with the da Vinci Robot.

**Aultman Hospital (Canton, Ohio).** Approximately 1,600 new cancer cases are diagnosed at Aultman Hospital or Aultman Cancer Center each year. Patients have access to nearly 75 clinical trials for cancer treatment, as Aultman is a teaching hospital affiliated with the Northeastern Ohio Medical University. The hospital's cancer program has retained its accreditation by the American College of Surgeons Commission on Cancer since 1986.

**Aventura (Fla.) Hospital & Medical Center.** The Aventura Comprehensive Cancer Center is recognized by the American College of Surgeons as a Comprehensive Community Cancer Program. The headquarters of the Columbia Cancer Research Network, a hospital-based research organization that offers clinical trials, are located in the cancer center, which bolsters physicians’ access to cancer research and the advancement of prevention. The center also provides patients with a cancer care coordinator, who is an oncology social worker, to assist them through the care continuum and navigate the center’s various support services.

**Banner Gateway Medical Center (Gilbert, Ariz.).** In September 2011, Banner Health formed an affiliation with The University of Texas MD Anderson Cancer Center in Houston to open the Banner MD Anderson Cancer Center, which is located on the Banner Gateway campus. The center acts as a cancer hub in Arizona, combining clinical treatments with access to MD Anderson’s renowned research. A multidisciplinary clinic acts as the cancer center’s core. There, physicians from all cancer specialties collaborate and streamline patients’ diagnoses, consultations and treatment plan development.

**Barnes-Jewish Hospital (St. Louis).** Researchers and physicians at the Alvin J. Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine care for more than 8,000 newly diagnosed cancer patients each year. Patients have access to more than 250 therapeutic clinical studies at the center, as well as services in a state-of-the-art outpatient facility on the hospital campus. Siteman Cancer Center is the only site of its kind in the state to hold Comprehensive Cancer Center designation from the National Cancer Institute, which it received in 2001.

**Beth Israel Deaconess Medical Center (Boston).** The cancer center at Beth Israel Deaconess Medical Center is aligned with Harvard Medical School, allowing patients access to some of the most innovative diagnostic procedures and therapies. The center offers roughly 140 clinical trials and recently conducted trials that led to FDA approval for therapies for melanoma and metastatic renal cancer. Beth Israel’s cancer program is the only one in Massachusetts and one of 34 in the country to receive the Outstanding Achievement Award from the American College of Surgeons Commission on Cancer.

**Boca Raton (Fla.) Regional Medical Center.** The Eugene M. & Christine E. Lynn Cancer Institute, one of the largest cancer centers in South Florida, is accredited as a Comprehensive Cancer Center by the American College of Surgeons. More than 20 oncology physicians at the center treat upwards of 3,000 cancer patients each year. The institute includes the Morgan Pressel Center for Cancer Genetics, where specialists determine if an individual has a hereditary predisposition to certain types of cancer. The institute also uses the latest imaging technology, such as helical computerized tomography or spiral CT, to detect lung masses at their earliest and potentially most curable stage.

**Boone Hospital Center (Columbia, Mo.).** Boone Hospital Center’s oncology program, which is accredited by the American College of Surgeons, treats ap-
proximately 2,000 patients for primary or secondary cancer diagnosis each year. The hospital, which received Magnet accreditation for nursing excellence, is affiliated with St. Louis-based BJC Healthcare and its program is also part of the national Association of Community Cancer Centers. Nine board-certified oncologists, five radiation oncologists and board-certified surgical specialists in the fields of general surgery, colorectal surgery, urology, neurosurgery and gynecologic oncology lead the cancer program at Boone.

Carolina Medical Center (Charlotte, N.C.). At the Levine Cancer Institute at Carolinas Medical Center, patients receive care from their primary care physicians, oncologists, patient navigators, counselors, geneticists and other healthcare professionals focused on numerous aspects of cancer. Established in 2010, the center includes 12 cancer care locations across the Carolinas and also provides patients with access to cutting-edge research. The Levine Cancer Institute recently re-located to a new state-of-the-art facility that features nine cancer clinics, infusion therapy, radiation therapy, palliative care and a Phase I clinical trials center under one roof.

Cedars Sinai Medical Center (Los Angeles). The Samuel Oschin Comprehensive Cancer Institute at Cedars Sinai offers patients a hub model comprised of multidisciplinary teams. Tumor boards, organized by specific types of cancer, help patients design treatment plans. Patients also have access to Cedars Sinai’s 24-hour outpatient cancer center, which treats more than 9,000 patients each year. The center is home to basic oncology research, along with clinical trials. In October, it launched a project in partnership with Baltimore-based Johns Hopkins Medicine that allows all men diagnosed with prostate cancer to have their disease tracked in a secure and interactive online patient portal.

Christiana Care Health System (Wilmington, Del.). Christiana Care’s Helen F. Graham Cancer Center takes a multidisciplinary, team-based approach to cancer care, in which each patient meets with a nurse navigator and team of cancer specialists in consultation with primary care physicians. The center was one of the first to be selected for the National Cancer Institute Community Centers Program. A collaboration with the University of Delaware helped the Graham Cancer Center expand to include its Center for Translational Research, which includes a familial cancer registry.

Christus Santa Rosa Hospital (San Antonio). The cancer program at Christus Santa Rosa Hospital provides inpatient and outpatient services for patients, driven by multidisciplinary teams of oncologists, hospitalists, registered nurses, dieticians, social workers, physical therapists and chaplains. The hospital has a Center of Excellence for High Dose Biotherapy Interleukin-2, which is a protein found naturally in the body that stimulates the immune system, which in turn kills cancer cells. In 2013, the hospital was named one of America’s Top Quality Hospitals by CareChex.

City of Hope National Medical Center (Duarte, Calif.). City of Hope National Medical Center, an independent medical and research center, was founded in 1913 and is located about 20 miles outside of Los Angeles. It’s one of 41 National Cancer Institute-designated Comprehensive Cancer Centers and a founding member of the National Comprehensive Cancer Network. Several breakthrough cancer drugs, including Herceptin and Avastin, are based on technology that was pioneered by City of Hope, and the center’s division of clinical cancer genetics has been instrumental in understanding cancer’s genetic roots.

Cleveland Clinic. More than 14,000 cancer patients visit the Taussig Cancer Institute at Cleveland Clinic each year. Physicians and specialists collaborate across the institute’s six cancer departments to deliver seamless, multidisciplinary care for patients. U.S. News & World Report ranked Cleveland Clinic sixth in the country for its cancer care in its 2012-2013 rankings. The institute is also extending its geographic reach across the Midwest, as it formed an adult oncology affiliation with Winfield, Ill.-based Cadence Health in February 2012.

Community Medical Center (Toms River, N.J.). The J. Phillip Citra Regional Cancer Center has retained accreditation from the American College of Surgeons Commission on Cancer as a Community Hospital Comprehensive Cancer Program since 1986. It includes a 31-bed inpatient oncology unit as well as an outpatient infusion center with private rooms. The hospital is a member of the Penn Cancer Network, which is a group of community hospitals throughout three states that collaborate with Abramson Cancer Center at the University of Pennsylvania in Philadelphia.

Covenant Medical Center (Waterloo, Iowa). The Covenant Cancer Treatment Center at Covenant Medical Center treats approximately 650 newly diagnosed cancer patients each year. Every week, physicians and cancer care team members hold tumor board conferences at the hospital to develop multidisciplinary treatment plans for patients. The center also drives local population health maintenance through its cancer registry, which tracks all cancers diagnosed and/or treated at the center and shares this data with the State Health Registry of Iowa. Covenant Cancer Treatment Center is accredited by the American College of Surgeons Commission on Cancer.

Dan Duncan Cancer Center at Baylor College of Medicine (Houston). The Dan L. Duncan Cancer Center at Baylor College of Medicine is comprised of three hospital affiliates: Ben Taub General Hospital, Michael E. DeBakey Veterans Affairs Medical Center and Texas Children’s Hospital. The center, which includes the Lester and Sue Smith Breast Center and Ellkins Pancreas Center, is one of three in the state to receive National Cancer Institute designation as a Cancer Center. It has received more than $71 million in funding from the Cancer Prevention and Research Institute of Texas since the institute began awarding grants in 2010.

Dana-Farber Cancer Institute (Boston). Dana-Farber Cancer Institute was founded in 1947. Each year, more than 300,000 cancer patients visit the center, which collaborates with Brigham and Women’s Hospital in Boston for oncology services and is also affiliated with Harvard Medical School. For its 2012-2013 rankings, U.S. News & World Report ranked Dana-Farber and Brigham and Women’s Cancer Center the top cancer center in New England and fifth overall in the country. In 2012, Dana-Farber opened a new community cancer clinic in Boston’s Roxbury neighborhood, which is believed to be the country’s first dedicated oncology space in an inner-city clinic.

Dartmouth-Hitchcock Medical Center (Lebanon, N.H.). Physicians at Dartmouth-Hitchcock Norris Cotton Cancer Center provide care and treatment to roughly 31,000 patients each year through multidisciplinary oncology teams of specialists and oncology nurses. In addition to its clinical care, the Cotton Cancer Center is also a pillar for cancer research. It’s designated as a Comprehensive Cancer Center by the National Cancer Institute and is home to roughly 250 active research projects led by 135 cancer research scientists. The center’s research efforts are supported by more than $68 million in grants.

Duke University Hospital (Durham, N.C.). The Duke Cancer Institute, which is designated as a Comprehensive Cancer Center by the National Cancer Institute, is home to more than 300 cancer researchers and physicians. The center is part of the National Comprehensive Cancer Network, which is an alliance of 21 cancer centers dedicated to further oncology research. This past year, Duke researchers identified the structure of a certain molecule that transports chemotherapy drugs into cells, a finding that could help create more effective cancer treatments with fewer side effects.

Eisenhower Medical Center ( Rancho Mirage, Calif.). The Eisenhower Lucy Curci Cancer Center, a recipient of the Outstanding Achievement Award from the American College of Surgeons Commission on Cancer, treats roughly 3,000 newly diagnosed cancer patients each year. The center includes specific centers for prostate cancer, breast care and cancer, infusion services and radiation oncology. Through its affiliation with Stanford Cancer Center, Eisenhower Medical Center also offers patients access to National Cancer Institute-endorsed Phase III clinical trials.
Emory University Hospital (Atlanta). Cancer care at Emory University Hospital is integrated with and coordinated through the Winship Cancer Institute at Emory University, which opened in the 1930s to advance cancer treatment and research. Emory University Hospital earned the Outstanding Achievement Award by the American College of Surgeons Commission on Cancer in 2011 and the Winship Cancer Institute earned designation from the National Cancer Institute in 2009, making it the first and only center in Georgia to do so.

Fox Chase Cancer Center (Philadelphia). Founded in 1904, Fox Chase Cancer Center was the first cancer center in Pennsylvania. In the 1930s to advance cancer treatment and research. The center’s Research Institute for Cancer Prevention was the first comprehensive program of its kind in the country, featuring labs dedicated to prevention-oriented research. In 2012, this 100-bed hospital expanded access to cancer care and research through an affiliation with Temple University Health System and Temple University School of Medicine, both in Philadelphia.

Froedtert Hospital (Milwaukee). The Clinical Cancer Center at Froedtert & The Medical College of Wisconsin opened in 2008. The center and its 200 physicians operate on a hub model, with 13 disease-specific teams of providers who help patients through their treatment and a quality of life center that offers a full range of support services. In addition to the center’s comprehensive cancer care, Froedtert patients also have access to approximately 130 clinical trials devoted to cancer each year.

Geisinger Medical Center (Danville, Pa.). The Geisinger Cancer Institute at Geisinger Medical Center is home to 14 specific cancer programs and more than 100 clinical research trials focused on cancer prevention, detection and treatment. Last fall, the center received Quality Oncology Practice Initiative Certification from the American Society of Clinical Oncology — a recognition reserved for 150 cancer centers in the country committed to delivering the highest quality of cancer care. The cancer institute also offers a nurse navigation program to provide patients with customized assistance, including financial support, transportation and records coordination.

Georgetown University Medical Center (Washington, D.C.). The Georgetown Lombardi Comprehensive Cancer Center was established in 1970 and named after Vince Lombardi, the former coach of the Green Bay Packers who received cancer treatment at Georgetown. The center is the only one of its kind in the Washington, D.C., area to hold Comprehensive Cancer Center designation from the National Cancer Institute. Louis M. Weiner, MD, director of the cancer center, was appointed to the Board of Scientific Counselors for Clinical Sciences and Epidemiology for the NCI in December 2012. This is the only body aside from scientists to review the NCI’s entire intramural program and advise the institute’s scientific director.

Greater Baltimore Medical Center. The Sandra & Malcolm Berman Cancer Institute includes comprehensive outpatient, inpatient, home care, hospice and survivorship programs that are driven by a multidisciplinary team of oncology experts. The institute’s comprehensive, multidisciplinary cancer program is one of only two cancer programs in Maryland to have received the Outstanding Achievement Award from the American College of Surgeons Commission on Cancer. The program offers patients access to more than 60 clinical trials through partnerships with the Johns Hopkins Clinical Research Network.

Hackensack (N.J.) University Medical Center. The John Theurer Cancer Center at Hackensack University Medical Center is comprised of 14 specialized divisions for cancer care and offers patients access to more than 200 clinical trials. U.S. News & World Report ranked the John Theurer Cancer Center as one of the top 50 centers for cancer care across the country in its 2012-2013 rankings. HackensackUMC researchers have spearheaded cancer research initiatives, as they played leading roles in studies in 2012 that focused on a medication that blocks the actions of certain proteins cancer cells need to survive and multiply. Their findings were later published in Blood.

Hartford (Conn.) Hospital. Each year, more than 50,000 patients visit The Helen & Harry Gray Cancer Center at Hartford Hospital. The center is one of 30 across the country to participate in the National Cancer Institute’s Community Cancer Centers Program, which helps hospitals translate research into treatment and address disparities in cancer care. The hospital also has its own cancer registry that dates back to 1928. As one of the oldest in the country, the registry contains information for roughly 92,000 patients and can identify the most effective cancer treatments, where cancer rates are spiking and patients’ progress through survivorship.

Henry Ford Hospital (Detroit). The Josephine Ford Cancer Institute at Henry Ford Hospital treats more than 14,000 patients each year and offers more than 200 clinical trials for advanced treatment options. The institute offers a number of innovative treatments and therapies, including the exercise and cancer integrative therapy education program, which is a special exercise program for cancer patients based on collaborative research from radiation oncology researchers at the cancer institute and Henry Ford Heart & Vascular Institute. The institute is accredited by the American College of Surgeons Commission on Cancer.

Hoag Memorial Hospital Presbyterian (Newport Beach, Calif.). The Hoag Family Cancer Institute, a recipient of the Outstanding Achievement Award from the American College of Surgeons Commission on Cancer, treats more than 3,300 newly diagnosed patients each year, making it the largest-volume provider in Orange County. This past spring, Hoag began enrolling patients in a new late-stage clinical trial for glioblastoma multiforme, an aggressive form of brain cancer. Each year, more than 400 patients participate in the center’s hereditary cancer program, which helps patients assess their cancer risk through genetic testing.

Hospital of the University of Pennsylvania (Philadelphia). The Abramson Cancer Center at the University of Pennsylvania was established in 1973, which is the same year it received Comprehensive Cancer Center designation from the National Cancer Institute. Translational and clinical researchers at the cancer center currently hold more than $145 million in grants, and more than 100,000 cancer patients visit the center for inpatient and outpatient care each year. Last year, Penn researchers discovered four genetically distinct types of breast cancer — a finding expected to drive new treatment developments.

Indiana University Simon Cancer Center (Indianapolis). The Melvin and Bren Simon Cancer Center at Indiana University was established in 1992. As the only site of its kind in the state to receive Cancer Center designation from the National Cancer Institute, IU is home to a range of clinical milestones and oncology research that has altered numerous treatment
Memorial Hermann-Texas Medical Center (Houston). Memorial Hermann includes seven cancer center sites at each of its hospitals in southeast Texas, but the Cancer Center at Memorial Hermann-Texas Medical Center is the newest within the system, as it opened in March 2012. The center is credentialed as a Teaching Hospital Cancer Program by the American College of Surgeons Commission on Cancer. Memorial Hermann-TMC oncologists work with researchers from The University of Texas Health Science Center at Houston Medical School to advance cancer treatments and offer patients personalized therapies. The hospital is also Magnet accredited by the American Nurses Credentialing Center.

Memorial Sloan-Kettering Cancer Center (New York City). Each year, physicians and experts at Memorial Sloan-Kettering Cancer Center treat more than 400 subtypes of cancer and lead more than 500 clinical trials for pediatric and adult cancers. A National Cancer Institute-designated Comprehensive Cancer Center, Memorial Sloan-Kettering recently partnered with IBM to collaborate on the development of a tool built upon IBM’s Watson that will provide medical professionals with improved access to comprehensive cancer data and practices.

Methodist Hospital (Houston). The Methodist Cancer Center is one of Methodist Hospital’s seven centers of excellence. Magnet-designated by the American Nurses Credentialing Center, Methodist’s cancer center was ranked as one of the top 50 in the country by U.S. News & World Report for 2012-2013. The hospital is academically affiliated with Weill Cornell Medical College and NewYork-Presbyterian Hospital in New York City, along with Baylor College of Medicine and other Texas institutions. In December 2012, Methodist Hospital entered into an exclusive agreement with a biomedical institute to develop an investigational drug for glioblastomas, the most malignant type of primary brain cancers.

Mission Hospital (Asheville, N.C.). The Mission Cancer Center delivers comprehensive cancer care in western North Carolina and offers a range of support and navigational services to patients. The center is affiliated with the UNC Lineberger Comprehensive Cancer Center, which provides access to more than 160 clinical trials and more than 300 cancer scientists. In December 2012, Mission also affiliated with Hope Women’s Cancer Centers for enhanced gynecologic and breast cancer care. Mission Hospital’s cancer program is also part of the Southeast Cancer Control Consortium, which is a Community Clinical Oncology Program funded by the National Cancer Institute.

Missouri Baptist Medical Center (St. Louis). The cancer center at Missouri Baptist Medical Center is committed to offering its patients advanced treatment options and a multidisciplinary medical team. The center’s Heartland Cancer Research Program is a National Cancer Institute-designated Community Clinical Oncology Program, which makes Missouri Baptist Medical Center one of only 63 community hospitals in the nation to be granted this designation. In 2011, the cancer center at Missouri Baptist was also one of six community oncology centers in the state to receive the Clinical Trials Participation Award presented by the Conquer Cancer Foundation of the American Society of Clinical Oncology.

Moffitt Cancer Center (Tampa, Fla.). Moffitt Cancer Center was created by the state legislature to address cancer research, prevention and treatment, and is named after H. Lee Moffitt, the former speaker of the Florida House of Representatives. It opened in 1986 on the campus of the University of South Florida and has since become a staple in American cancer care. The center is a National Cancer Institute-designated Comprehensive Cancer Center, and U.S. News & World Report has ranked Moffitt within the top 50 hospitals for cancer care each year since 1999. The center, which includes one of the largest blood and marrow transplant programs in the southeast, uses sophisticated technology to identify and analyze genetic codes unique to each patient’s tumor.

Montefiore Medical Center (New York City). The Montefiore Einstein Center for Cancer Care is affiliated with Albert Einstein Cancer Center, a National Cancer Institute-designated Cancer Center, for research and clinical trials. Montefiore focuses on multidisciplinary and team-based care delivery that is centered around the patient. Upon their initial referral, patients are matched with a nurse navigator who helps coordinate and guide each step of the care process. This past year, a study led by a researcher at Montefiore Einstein Center for Cancer Care found women who are obese or overweight and were diagnosed with estrogen receptor-positive breast cancer, the most common form of the disease, have a significantly higher risk of recurrence than thinner women.

Mount Sinai Medical Center (New York City). The Tisch Cancer Institute at The Mount Sinai Medical Center was established in 2007. The institute includes an ambulatory treatment center and breast center, which opened in 2011 as one of the first sites to offer 3D mammograms. Mount Sinai is one of the few places to offer minimally invasive robotic surgery for head and neck cancer, which allows patients to return to their daily routines within days. U.S. News & World Report ranked Mount Sinai as one of the top 50 cancer programs in the country in its 2012-2013 rankings.

Nebraska Medical Center (Omaha). Nebraska Medical Center is a founding member of the National Comprehensive Cancer Network, which is comprised of 21 cancer centers across the country. The hospital’s cancer program is also accredited by the American College of
Surgeons Commission on Cancer. The hospital extends its cancer care through an extensive survivorship program, which transitions patients from the care of specialists and oncologists back to their primary care provider.

NewYork-Presbyterian Hospital (New York City). The Cancer Centers of NewYork-Presbyterian Hospital are comprised of two institutions — the Herbert Irving Comprehensive Cancer Center at NewYork-Presbyterian/Columbia University Medical Center; and the Weill Cornell Cancer Center of NewYork Presbyterian/Weill Cornell Medical Center. Each year, the centers treat more than 7,000 newly diagnosed cancer patients. In its 2012-2013 rankings, U.S. News & World Report ranked NewYork-Presbyterian Hospital 17th in the country for cancer care.

NorthShore University HealthSystem (Evanston, Ill.). The NorthShore Kellogg Cancer Center has sites at all three NorthShore hospitals in Chicago’s northwestern suburbs. Combined, Kellogg physicians treat roughly 3,700 newly diagnosed cancer patients each year, a significant portion of which are breast cancer patients. Kellogg is well-connected for cancer research and clinical trials through its ties with NorthShore University HealthSystem Research Institute and an academic affiliation with the University of Chicago Pritzker School of Medicine. The center is accredited by the American College of Surgeons Commission on Cancer and offers a National Cancer Institute-funded Community Clinical Oncology Program.

Northwestern Memorial Hospital (Chicago). The Robert H. Lurie Comprehensive Cancer Center at Northwestern University is home to nearly 10,000 newly diagnosed cancer patients each year. The center is home to the Northwestern Brain Tumor Institute and the Maggie Daley Center for Women’s Cancer Care, and all Lurie Cancer Center physicians are also full-time faculty at Northwestern University’s Feinberg School of Medicine.

Norton Hospital (Louisville, Ky.). The Norton Cancer Institute at Norton Hospital provides treatment for all types of cancer and offers extensive services for cancer’s effects on patients’ overall wellbeing, such as a behavioral oncology program that provides psychological care to cancer patients. The Norton Cancer Institute gained approval in 2012 to participate in the National Comprehensive Cancer Network clinical trials program. It was reaccredited with commendation by the American College of Surgeons Commission on Cancer in 2012.

NYU Langone Medical Center (New York City). Part of NYU Langone Medical Center, the NYU Cancer Institute is a translational cancer center that was named to the 2012-2013 list of top-ranked hospitals for cancer by U.S. News & World Report. Recently, the institute began launching programs in cancer healthcare disparities, targeted cancer therapies and melanoma, and it is also developing a personalized medicine laboratory to define unique molecular signatures underlying each patient’s cancer. While research into the field of personalized medicine for cancer is growing, few cancer centers have set up laboratories to delve into the field themselves.

Ochsner Medical Center (New Orleans, La.). Ochsner Medical Center’s cancer team treats nearly 2,000 new cancer patients each year, and the medical center is expanding its reach through the Gayle and Tom Benson Cancer Center. Phase one of the new center opened in 2010, and phase two is due to open in the near future. Ochsner is designated as a Community Clinical Oncology Program by the National Cancer Institute. In 2012, the medical center received the Everest Award from Thomson Reuters.

The Ohio State University Wexner Medical Center (Columbus). The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute is the adult patient care component of The Ohio State University Comprehensive Cancer Center. Known as “The James,” the center is one of the only freestanding cancer hospitals in the Midwest and one of seven centers in the country funded by the National Cancer Institute to conduct Phase I and Phase II clinical trials for new anti-cancer drugs. The Ohio State University Wexner Medical Center was also named to the 2012-2013 list of top-ranked hospitals for cancer care by U.S. News & World Report.

Oklahoma University Medical Center (Oklahoma City). The Peggy and Charles Stephenson Cancer Center at the Oklahoma University Medical Center is a National Cancer Institute-designated Comprehensive Cancer Center. In 2012, Stephenson Cancer Center began offering proton therapy with the MEVION S250, which is newly approved by the FDA. The center is also accredited by the American College of Surgeons Commission on Cancer.

Palmetto General Hospital (Hialeah, Fla.). The 19,000-square-foot Oncology Treatment Center at Palmetto General Hospital has been serving cancer patients since 1994. The center offers personalized cancer care and oncology services, such as its “Just For Women” diagnostic center, which offers all-digital mammography and bone densitometry. The hospital was named one of America’s Top Quality Hospitals in 2013 by CareChex.

Peninsula Regional Medical Center (Salisbury, Md.). The Richard A. Henson Cancer Institute at Peninsula Regional Medical Center offers comprehensive cancer services as well as minimally invasive da Vinci robotic surgery. The institute holds an annual conference dedicated to the diagnosis and management of lung cancer, and the American College of Surgeons Commission on Cancer awarded accreditation with commendation to the institute in 2010.

Pocono Medical Center (East Stroudsburg, Pa.). The $31-million Dale and Frances Hughes Cancer Center at Pocono Medical Center opened in 2012 and offers a full range of cancer services. The center was one of the first few in the nation to offer intensity modulated radiation therapy, a treatment in which radiation beams target...
are conformed to the shape of the tumor. Pocono’s cancer center has been accredited by the American College of Radiation Oncology.

Providence Regional Medical Center ( Everett, Wash.). Providence Regional Medical Center’s cancer services are run through the Providence Regional Cancer Partnership, which was founded in 2007 as the result of a collaboration among Providence Regional Medical Center Everett, The Everett Clinic, Western Washington Medical Group and Northwest Washington Radiology Oncology Associates. The partnership provides patients with access to experts from all four medical groups. The Providence Regional Cancer Partnership is accredited by the American College of Surgeons Commission on Cancer.

Robert Wood Johnson University Hospital (New Brunswick, N.J.). The Cancer Hospital of New Jersey at Robert Wood Johnson University Hospital is the only National Cancer Institute-designated Comprehensive Cancer Center in the state. The 103-bed hospital is the result of a partnership between Robert Wood Johnson University Hospital and the Cancer Institute of New Jersey in New Brunswick, which provides patients with access to clinical trials. The hospital has received Magnet accreditation for nursing excellence from the American Nurses Credentialing Center.

Ronald Reagan UCLA Medical Center (Los Angeles). Jonsson Comprehensive Cancer Center at Ronald Reagan UCLA Medical Center has more than 240 researchers and clinicians. Some successful targeted therapies — treatments that inhibit the growth mechanisms in tumors — like Herceptin were developed based on research conducted at the center. The center has maintained its designation as a Comprehensive Cancer Center by the National Cancer Institute since 1976.

Roswell Park Cancer Institute (Buffalo, N.Y.). Founded in 1898, the 123-bed Roswell Park Cancer Institute offers a multidisciplinary approach to cancer care. In 2011, the institute had 5,394 admissions. Roswell Park is one of the oldest National Cancer Institute-designated comprehensive cancer centers in the United States and one of five centers in New York to be designated a Blue Distinction Center for complex and rare cancers by the BlueCross BlueShield Association.

Rush University Medical Center (Chicago). The Rush University Cancer Center comprises all of the cancer-related clinical, research and educational efforts at Rush University Medical Center. The center includes 45 exam rooms, 56 infusion stations and three procedure rooms. Rush’s researchers and physicians have long been innovators in cancer care. In 1975, Frank R. Hendrickson, MD, a radiation oncologist at Rush, helped found the Fermilab Cancer Therapy Facility, which is involved in groundbreaking clinical trials involving the use of neutrons in cancer therapy. The center has also received Magnet designation from the American Nurses Credentialing Center.

Sanford USD Medical Center (Sioux Falls, S.D.). Sanford USD Medical Center’s cancer services are run through Sanford Cancer Center. In 2007, the medical center was selected as a participating site in the National Cancer Institute Community Cancer Program, which marked its fifth year of operations with the NCCCP. The Sanford Cancer Center has been accredited by the American College of Surgeons Commission on Cancer.

Shands at the University of Florida (Gainesville). The University of Florida Shands Cancer Center includes more than 250 researchers and clinicians. The cancer center collaborates with dozens of University of Florida multidisciplinary centers such as the McKnight Brain Institute, Genetics Institute and Proton Therapy Institute — one of only seven such facilities in the nation. Shands Cancer Center was named one of the top 50 cancer programs in the country by U.S. News & World Report in its 2012-2013 rankings.

Sierra Providence Health Network (El Paso, Texas). The Sierra Providence Health Network is comprised of four acute-care hospitals, and its cancer program is led by cancer specialists including medical oncologists, radiologists, oncology nurses, administrators from the health system’s hospitals and representatives from the American Cancer Society. The program is accredited by the American College of Surgeons as a Network Cancer Program.

Sinai Hospital (Baltimore). The Alvin & Lois Lapidus Cancer Institute at Sinai Hospital provides patient-centered oncology care. Its physicians actively participate in clinical research studies and, in 2012, the hospital was one of six hospitals to join an American College of Surgeons Commission on Cancer national pilot study. The study aims to promote evidence-based evaluation and treatment standards for patients with non-small cell lung cancer who are candidates for surgical lung resection. The hospital was also named one of America’s Top Quality Hospitals in 2013 by CareChex.

Skyline Medical Center (Nashville, Tenn.). The medical center is a part of the TriStar Sarah Cannon Cancer Center Network, which comprises more than 100 medical oncologists, OB/GYN oncologists, hematologists, pathologists, surgeons and radiation oncologists. TriStar Sarah Cannon is the largest community-based, privately funded, diagnostic and treatment center in the country. Its patients have access to clinical trials offered by the Sarah Cannon Research Institute, a global strategic research organization with a network of more than 700 physicians in the United States and United Kingdom.

Southcoast Center for Cancer Care (New Bedford, Mass.). Southcoast Centers for Cancer Care provide cancer patients in the South Coast region with clinical expertise and the latest technology in cancer care, including image-guided radiation therapy and cancer support services, such as patient navigators. The physician-in-chief of Southcoast Centers for Cancer Care, Therese Mulvey, MD, FASCO, was elected to the American Society of Clinical Oncology’s board of directors for a three-year term starting in June 2013. The center also received certification from the Quality Oncology Practice Initiative Certification Program — a self-assessment and improvement program — which is an affiliate of the American Society of Clinical Oncology.

St. Vincent Indianapolis Hospital. St. Vincent Cancer Care offers a full range of comprehensive oncology services and a team of approximately 200 oncologists and cancer care professionals. The hospital and cancer program offer specialized oncology rehabilitation services, such as debilitation risk reduction, which helps minimize functional decline during treatment. St. Vincent Cancer Care is accredited by the American College of Surgeons Commission on Cancer.

Stanford (Calif.) Hospital & Clinics. More than 300 physicians participate in cancer care, translational medicine and clinical research at Stanford Cancer Institute, which offers more than 250 active clinical trials. The institute is currently recruiting for a clinical trial that aims to identify and characterize novel proteins and genes in head and neck cancer. Stanford Cancer Institute is a National Cancer Institute-designated Comprehensive Cancer Center — one of approximately 40 in the country.

Texas Health Harris Methodist Hospital Fort Worth. The Klabzuba Cancer Center at Texas Health Harris Methodist Hospital Fort Worth provided multidisciplinary care to more than 2,500 newly diagnosed cancer patients in 2011, according to the most recent data available. The center has an inpatient oncology unit with 36 private beds and it maintains a cancer registry for state and federal government reporting. Texas Health Harris Methodist Hospital has also received Magnet status for nursing excellence from the American Nurses Credentialing Center.

The Toledo (Ohio) Hospital. The oncology program at The Toledo Hospital is run by the ProMedica Cancer Institute, which has created the largest cancer registry in northwest Ohio and is accredited by the American College of Surgeons Commission on Cancer. At any one time, more than 150 Phase II and Phase III cancer clinical trials for children and adults are actively conducted at ProMedica. To ease the impact of cancer on children and families, ProMedica offers a three-day camp for children who have loved ones with cancer each summer. The Toledo Hospital was named one of America’s Top Quality Hospitals in 2013 by CareChex.
Thomas Jefferson University Hospitals (Philadelphia). Opened in 1993, The Kimmel Cancer Center at Thomas Jefferson University Hospital has consistently emphasized the transformation of scientific discoveries into patient care. At any given time, patients have the opportunity to take part in one of more than 120 clinical trials conducted at Jefferson. The center at Jefferson is a National Cancer Institute-designated Cancer Center, and it was named to the 2012-2013 list of top-ranked hospitals for cancer by U.S. News & World Report.

UH Case Medical Center (Cleveland). UH Case Medical Center offers comprehensive cancer care through the University Hospitals Seidman Cancer Center. The center has 120 beds and state-of-the-art technology, including one of the world's first PET/MRI machines. The center also provides its patients with access to more than 300 clinical trials. In 2012, the results of a first-of-its-kind clinical trial, which was conducted at the center, showed encouraging results for the use of stereotactic radiosurgery — a noninvasive technique — to treat kidney cancer. The center is accredited by the American College of Surgeons Commission on Cancer.

University of Alabama Hospital at Birmingham. The UAB Comprehensive Cancer Center has a faculty of more than 330 researchers and physicians who treat approximately 5,000 newly diagnosed patients every year. The UAB Comprehensive Cancer Center is recognized around the world as a leader in developing innovative monoclonal antibody approaches to cancer therapy. The center is a National Cancer Institute-designated Comprehensive Cancer Center.

University of Arizona Medical Center (Tucson). The University of Arizona Cancer Center was established in 1976 and has a staff of more than 300 physicians and scientists. It has 73 research labs, and its scientists are currently involved in more than 200 clinical trials. The center is one of six in the nation with a National Cancer Institute Specialized Program of Research Excellence grant for gastrointestinal cancers. University of Arizona Medical Center was also named one of America’s Top Quality Hospitals in 2013 by CareChex.

University of California Davis Medical Center (Sacramento). The University of California Davis Cancer Center focuses on both clinical care and research. In 2012, UC Davis researchers discovered a new target for lung cancer treatment. The cancer center is also dedicated to understanding why cancer affects people differently, and it established a Population Sciences and Health Disparities Program to further its findings. The University of California Davis Medical Center was named to the 2012-2013 list of top-ranked hospitals for cancer by U.S. News & World Report.

University of California San Diego Medical Center. The University of San Diego Moores Cancer Center, established in 1979, is comprised of two structures — a three-story facility for clinical services and a five-story research tower. The center is one of only 41 National Cancer Institute-designated Comprehensive Cancer Centers in the country, and the University of California San Diego Medical Center was also ranked among the top 30 hospitals nationwide for cancer care in 2012-2013 by U.S. News & World Report.

University of California San Francisco Medical Center. In 2011, the University of California San Francisco Helen Diller Family Comprehensive Cancer Center diagnosed 6,453 individuals with cancer, and its investigators led 262 interventional trials, according to the most recent data available. The center has more than 370 medical professionals, including faculty investigators in laboratory, clinical and population-based research. The center is a member of the Association of American Cancer Institutes, a group made up of leading research centers in the nation that focus on cancer treatment, patient care and community outreach, as well as the National Comprehensive Cancer Network, an alliance of 21 of the world’s leading cancer centers.

University of Chicago Medical Center. The University of Chicago Medicine Comprehensive Cancer Center has a dedicated team of more than 200 cancer specialists. In 1942, the cancer center's Charles Huggins, MD, was the first to use hormone therapy for cancer patients, which has now become a mainstay of cancer care. He was awarded the Nobel Prize in 1966 for this finding. The center is a leader in Phase I and other early-phase clinical trials, and it is one of only two National Cancer Institute-designated Comprehensive Cancer Centers in Illinois.

University of Colorado Hospital (Aurora). University of Colorado Comprehensive Cancer Center at University of Colorado Hospital is the only National Cancer Institute-designated Comprehensive Cancer Center within an 850-mile radius of the Denver area. Approximately 400 physicians and research scientists work in the center’s labs, clinics and community to diagnose, prevent and treat cancer, and the center receives roughly $143 million in direct annual cancer research funding. In its 2012-2013 rankings, U.S. News & World Report ranked University of Colorado Cancer Center within the top 50 hospitals for cancer care in the country.

University of Iowa Hospitals and Clinics (Iowa City). The Holden Comprehensive Cancer Center at University of Iowa Hospitals and Clinics is the only National Cancer Institute-designated Comprehensive Cancer Center in the state — a designation it has held since 2000. Each year, there are more than 150,000 patient visits to UI Health with a primary diagnosis of cancer. The center also spearheads “bench to bedside” cancer research with more than $74 million in annual cancer related research funding and accessibility to 220 clinical trials.

University of Maryland Medical Center (Baltimore). The Marlene and Stewart Greenebaum Cancer Center at the University of Maryland Medical Center treats 41,000 patients annually and is home to 215 physicians and researchers. The center also offers its patients access to 215 active clinical trials. The center, which has partnerships with the state of Maryland and the American Cancer Society, is a National Cancer Institute-designated Cancer Center. It held the 11th spot in U.S. News & World Report’s 2012-2013 rankings for the best cancer programs in the country.

University of Michigan Hospitals and Health Centers (Ann Arbor). University of Michigan Comprehensive Cancer Center provides clinical care and conducts cancer research. In 2012, the center performed 51,884 infusion treatments, and in 2013, researchers at the center identified the genetic mutation for solitary fibrous tumor, a rare cancer seen in only a few hundred people each year. The center is a member of the Michigan Cancer Consortium, a private-public partnership that aims to reduce the burdens that cancer imposes on families. The University of Michigan Hospitals and Health Centers was named one of the top-ranked hospitals for cancer care in 2012-2013 by U.S. News & World Report.

University of Minnesota Medical Center, Fairview (Minneapolis). The University of Minnesota Medical Center, Fairview’s cancer program is run through the University of Minnesota Physicians Cancer Care at Fairview, which is a specialized team of physicians and nurses dedicated to providing cancer care. The center has consistently made contributions to cancer research and prevention, such as pioneering the identification of cancer-causing substances in tobacco. The University of Minnesota Medical Center, Fairview was named to the 2012-2013 list of top-ranked hospitals for cancer care by U.S. News & World Report.

University of North Carolina Hospitals (Chapel Hill). The University of North Carolina Lineberger Comprehensive Cancer Center has more than 135,000 patient visits every year and offers access to more than 250 clinical trials. Its clinical home is the N.C. Cancer Hospital, which includes 110 physicians who specialize in cancer care. As the state’s only public cancer hospital, it includes 50 inpatient beds for medical oncology and bone marrow transplants. The University of North Carolina Hospitals was named one of America’s Top Quality Hospitals in 2013 by CareChex.

University of Pittsburgh Medical Center.
The University of Pittsburgh Medical Center Cancer Center provides cancer care to the 74,000 patients treated at its facilities every year. It partners with University of Pittsburgh Cancer Institute, which comprises the academic and research activities of the University of Pittsburgh and UPMC, to provide care. The institute is the only National Cancer Institute-designated Comprehensive Cancer Center in western Pennsylvania.

University of Rochester (N.Y.) Medical Center. The James P. Wilmot Cancer Center, part of University of Rochester Medical Center, provides patients with a range of surgical, medical and radiation oncology services under one newly completed roof. URCMC completed its $60.1 million cancer center expansion this past year, unveiling a facility that was designed based on patients’ input. Researchers with University of Rochester Medical and radiation oncology services under one of the top teaching hospitals in the country. Over the years, it has been responsible for many important scientific advances in cancer research, including clarifying the links between steroid hormones and breast and prostate cancer. More recently, research identifying certain genes that have to be turned off for cancer cells to survive, conducted at the center, was named one of the 20 major advances in cancer research in 2012 by the American Society of Clinical Oncology.

USM Hospital at Arlington (Texas). The cancer program at USM Hospital at Arlington are run through the Center for Cancer & Blood Disorders that recently opened a new location inside the hospital. The center includes more than 20 specialists and more than 100 healthcare professionals. In 2010, all 10 of the center's locations were certified as one of 23 oncology practices in the nation to meet the quality standards for the Quality Oncology Practice Initiative Certification Program, a new program offered as an affiliate of the American Society of Clinical Oncology. The USM Hospital at Arlington was named one of America's Top Quality Hospitals in 2013 by CareChex.

University of Virginia Medical Center (Charlottesville). The Emily Couric Clinical Cancer Center at the University of Virginia Health System features a gynecologic oncology clinic, infusion center, neuro-oncology center and a radiation oncology center. The center is named after Virginia State Senator Emily Couric, who died from pancreatic cancer in 2001. It was the first center in the nation to purchase and install the first TomoTherapy TomoHD, a radiation treatment system that allows for two types of beams to target the tumor. The center is a National Cancer Institute-designated Comprehensive Cancer Center, one of roughley 40 in the country.

University of Washington Medical Center (Seattle). The University of Washington Medical Center partners with the Fred Hutchinson Cancer Research Center in Seattle and Seattle Children's through the Seattle Cancer Care Alliance. In 2011, with more than 300 oncologists, radiologists, pathologists and research physicians, SCCA treated more than 5,500 patients, according to the most recent data available. The University of Washington Medical Center has also been awarded Magnet designation from the American Nurses Credentialing Center for nursing excellence.

Virginia Commonwealth University Medical Center (Richmond). The Virginia Commonwealth University Massey Cancer Center treats approximately 13,800 patients every year. Scientists and physicians collaborate at Massey to find better ways to prevent, diagnose and treat cancer, and the center offers more than 150 clinical trials. In 2012, Massey headed a clinical trial that used a radiation device, called the Contura Multilumen Balloon, to treat breast cancer. The trial is currently in its second phase. The Virginia Commonwealth University Medical Center has received Magnet designation from the American College of Surgeons Commission on Cancer.

WellStar Kennestone Hospital (Marietta, Ga.). The cancer program at WellStar Kennestone Hospital aims to combine individualized cancer care with the latest technologies, such as video-assisted thoracic surgery and laparoscopic colon cancer surgery, a minimally invasive procedure. The program, which has been accredited by the American College of Surgeons Commission on Cancer, was the first in Georgia to use the CyberKnife radiosurgery system.

Winthrop-University Hospital (Mineola, N.Y.). The Institute for Cancer Care at Winthrop-University Hospital is committed to both clinical care and research, and it offers a number of clinical trials. Physicians at the center performed more than 1,343 treatments of CyberKnife radiosurgery and approximately 1,300 treatments of intensity-modulated radiation therapy in 2010, according to the most recent data available. Winthrop-University Hospital was named one of America's Top Quality Hospitals in 2013 by CareChex.

Yale-New Haven (Conn.) Hospital. Yale-New Haven Hospital's cancer services are run through the Smilow Cancer Hospital, which is affiliated with the Yale Cancer Center, part of Yale School of Medicine. Smilow has 12 multidisciplinary cancer teams to provide individualized care to its patients, who have access to clinical trials conducted at the Yale Cancer Center, which is a National Cancer Institute-designated Comprehensive Cancer Center. Smilow builds on the scientific traditions of the Yale University, as the medical oncology section of the university was the first to successfully use chemotherapy at Yale-New Haven Hospital in 1942.
In July, New Hampshire shined the magnifying glass on non-profit hospital CEO pay. The independent New Hampshire Center for Public Policy found that average compensation of state non-profit hospital CEOs grew by roughly 18 percent between 2006 and 2009, which was much higher than the growth of private sector wages.

For-profit hospital companies also made news after public records showed CEOs at the largest operators made anywhere between $3.7 million and $21.6 million in total compensation in 2011.

Hospitals and health systems have a lot on their plates, from healthcare reform initiatives to ensuring their balance sheets will be black in the next quarter. Adjusting executive compensation packages has made its way into those discussions as well, and innovative organizations are continually assessing whether and how to incorporate the latest practices.

As hospitals and health systems look to stay at the forefront of innovative and reasonable compensation packages for their executives, here are eight trends regarding healthcare executive compensation based on expert analysis within the field.

1. Executive compensation arrangements will be simpler.

Several years ago, it was common for hospital and health system executives to have elaborate compensation agreements, which were built and constructed by the board’s compensation committee. However, organizations are ditching contracts with confusing language and complex bonuses, incentives and benefits.

“Hospitals are getting away from ‘smorgasbord’ compensation,” says Tom Flannery, PhD, partner with consulting firm Mercer. “The reason is the design of those types of compensation programs can be very complex, making administration cumbersome.”

Dr. Flannery explains there is another reason why compensation arrangements no longer look like labyrinths: Hospitals have to explain their rationale for compensation usually does not exceed the $1 million benchmark. Standalone hospital CEOs are also seeing high pay totals, but their total compensation is substantially, says Deedra Hartung, senior executive vice president and managing director of Ceja Executive Search. “But healthcare reform is changing the goals and objectives that incentives are tied to as the system moves away from volume-based to value-based payment models. For example, metrics based on the degree of physician alignment would play a greater role.”

Dr. Flannery adds that hospitals must also justify how they choose their market data for executive compensation. For example, if a hospital wants to pay the CEO in the highest compensation brackets, the performance must justify decision.

“If you’re going to be paid at the 75th percentile, you have to demonstrate 75th percentile performance,” Dr. Flannery says. “There is much more pressure on making sure there is a causal relationship between pay and performance.”

Consequently, boards are more likely to have clearer expectations in their compensation meetings, and objectives are more likely to be focused on quality of care, safety, patient satisfaction, physician satisfaction, employee satisfaction, reputational image and cost of care efficiency.

3. Compensation for health system CEOs will routinely hit seven figures.

According to Mercer’s 2012 integrated health networks compensation survey, hospital and health system presidents and CEOs continue to record the highest salaries and cash compensation totals in the industry.

Health system presidents and CEOs continue to make the most of any C-level position. Health systems that want to pay their CEOs in the 75th percentile are looking at a total compensation package around $1.46 million. Health system CEOs in the 25th percentile are making just shy of seven figures.

Standalone hospital CEOs are also seeing high pay totals, but their total compensation usually does not exceed the $1 million benchmark. Standalone hospital CEOs at organizations with more than $500 million in annual revenue—in some of the highest earners at standalone hospitals—earned roughly $962,600 in the 75th percentile for 2012. Across all-sized organizations in Mercer’s survey, standalone hospital presidents and CEOs still made $480,000 in the 25th percentile.

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4. Compensation for critical C-suite positions will climb, too.
While presidents and CEOs take home the biggest paydays at hospitals and health systems, other executive positions are holding steady with six-figure payouts. CFOs, CIOs and CNOs at high-grossing hospitals and systems normally make between $340,000 and $650,000.

Mercer’s analysis examined compensation data for 2012 for three non-CEO hospital executive positions: CFO, CIO and CNO. CFOs at hospitals and health systems with more than $1 billion in total revenue earned anywhere from $310,800 to $649,300 — the highest of the three non-CEO positions studied at the largest of health systems. Even across all organizations, CFOs can expect to record total cash compensation between $171,800 and $335,000.

However, CIOs actually made more than CFOs, on average, across all-sized organizations. Total cash compensation for CIOs ranged from $250,700 in the 25th percentile to $415,400 in the 75th percentile. Base salaries reached as high as $362,400 for CIOs across various-sized hospitals and health systems.

For chief nursing executives, salaries and total cash compensation are among the lowest of non-CEO executive positions. However, depending on the size of the hospital or health system, CNOs could earn up to $340,300. Middle-of-the-road salaries for CNOs hover between $171,700 and $236,600, while total cash compensation for CNOs in the 50th percentile could hit anywhere between $187,500 and $282,800, according to Mercer’s survey.

5. Retaining key talent will be an element of many compensation programs.
In order to keep highly qualified executives and prevent turnover during a hectic period of reform, many systems are installing retention devices in their compensation plans.

For example, Dr. Flannery says hospitals may award a CEO a bonus of 30 percent of base pay, if all performance criteria are met. However, half of the bonus may be paid immediately, while the other half may be deferred over five years. That could scatter tens of thousands, or hundreds of thousands, of dollars over several years, and if the CEO left during the deferment period, the bonus may be forfeited. This may make someone reconsider before leaving, Dr. Flannery says.

Michael Dunford, executive vice president and managing principal at Cejka Executive Search, agrees. He says some of the most forward-thinking and innovative compensation contracts he has seen involve “attractive, performance-based, deferred packages that are meaningful and tie in retention” in order to receive full value.

6. Perks are becoming a thing of the past.
Steven Slutsky, JD, director and executive compensation consultant in PwC’s Philadelphia office, says many popular perquisites of the past are quickly on the decline now, even more so than last year. Cars, country club dues, home office equipment, spousal travel and others are fading away due to their negative perception.

Instead, hospitals and health systems are rolling perquisites into total cash compensation, which hospitals can more easily defend.

“[Giving out perquisites] can look horrible: You’re giving the CEO an automobile, but not employees? Don’t executives make enough to pay for their own car?” Dr. Flannery says. “Organizations do not want the distraction of those arguments. Have compensation that is appropriate, competitive and reflects the performance of the individual executive as well as the collective performance of the executive team.”

7. Executives behind CEOs will be in high demand — and compensation will follow.
Dr. Flannery explains that as healthcare reform continues to chug along, there are still only a select group of hospital and health system CEOs that have helped initiate major projects, like accountable care organizations. “If you think about the organizations that have already done that, the CEO is probably not going to leave in the middle of the project,” he says.

However, executives who are second- or third-in-command, such as the COO or CFO, who have successfully helped with ACOs and other healthcare reform efforts have created a new market for themselves.

“Those people now become in high demand because they have demonstrated the skills to do all the complex work that is necessary, and they have the hands-on experience,” Dr. Flannery says. “There’s likely to be a bump in their compensation, particularly for those who have demonstrated success.”

8. Physician executives will continue to attract unique compensation packages.
Because hospital executives will increasingly be paid on value and performance rather than market rates and profitability alone, there is one subset of executives that may have an advantage in terms of experience: physician executives.

Physicians who have turned to the C-suite may already be very familiar with value-based purchasing, as well as inner workings of an organization’s clinical setting, and this places a premium dollar on their availability.

“Physician executives with experience and working knowledge of various payor contracting systems have been in high demand and are well-positioned for senior leadership roles,” says Paul Esselman, executive vice president and managing principal at Cejka Executive Search. “In this environment, those physician executives with the ‘triple-threat’ skills and experience in clinical practice, system engagement and managed care administration are in a unique position to tie the clinical outcomes to reimbursement, thereby maximizing their value and compensation opportunity.”

As hospitals work to integrate their services, shrink their total cost of care, raise patient satisfaction and drop their readmissions, employing or aligning with physicians of all specialties is in hospitals’ sights.

Staying knowledgeable on competitive compensation trends is important for health systems to be able to attract the talent and services they need to grow and improve, while ensuring compensation is appropriate to maximize financial resources. Although a few specialties experienced big pay increases over the last year, several median base salaries saw slight declines.

### Highest-paid specialties
Cardiac and surgical specialties top the list for highest median compensation. Orthopedic, cardiac and thoracic surgeons and invasive cardiologists pulled in median salaries above $500,000, according to data from the American Medical Group Association’s 2012 Medical Group Compensation and Financial Survey, based on 2011 data. Specialists with compensation of $400,000 and up also included diagnostic radiologists, non-invasive cardiologists, gastroenterologists and urologists.

Dermatologists earned just shy of $400,000, followed closely by otolaryngologists, ophthalmologists and general surgeons, with median base salaries at $370,000 and higher. Few specialties can hold a candle, however, to neurosurgeons, whose average starting salary is a whopping $699,000.

### Lowest-paid specialties
Primary care physicians such as pediatricians and hospitalists continued to be paid much less than many other specialties, but psychiatrists held the lowest median base pay at $217,194, according to the AMGA report. Also low on the list were endocrinologists, non-surgical neurologists, nephrologists and rheumatologists, all with salaries between $219,000 and $277,000.

### Other trends
Overall, the weighted average compensation growth for all types of physicians was 2.8 percent between 2010 and 2011. Primary care increased an average of 4 percent, surgeon pay grew 3.4 percent and other specialties climbed 2.8 percent.

Hematologists and medical oncologist compensation exploded with a 7.13 percent boost, and nephrologist pay skyrocketed 6.99 percent. Family medical physicians’ paychecks leaped 5.13 percent.

But some specialties took a hit, namely endocrinologists at a 4.98 percent drop, and intervention- and non-interventional diagnostic radiologists at 1.39 percent and 0.45 percent, respectively. Additionally, rheumatologists’ pay fell 1.09 percent and otolaryngologists’ decreased 0.81 percent.

### Physician statistics — 2013
Compiled from the most recent market research data available, here are 169 statistics on physician compensation trends over the last year. Data from 27 specialties includes median base salary, highest and lowest offered base salaries, median growth from 2011, median work RVUs, median gross charges and female physician pay as a percentage of male physician pay.

Note: Some of the statistics may seem higher or lower compared with others in each specialty. A collection of physician surveys was used to compile information. In addition, every specialty does not contain the same number of statistics, as some data was not available for each specialty. Please read the following to understand where the statistics came from:

- Median salary, salary growth from 2011, work RVUs and gross charges are from the American Medical Group Association’s 2012 Medical Group Compensation and Financial Survey, a 2012 report based on 2011 data. The survey collected responses from 225 medical groups that represent approximately 55,800 providers in total during the first quarter of 2012. An exception to this is the data for neurosurgeons, which was not included in the AMGA’s report. The median salary and salary growth from 2011 statistics for neurosurgeons were taken from the Medicus Firm’s 2012 Physician Compensation Survey, which collected responses from 2,582 physicians between April and May 2012.

### Anesthesiologists
- Median salary: $377,375
- Median salary growth from 2011: 1.24 percent increase
- Median gross charges: $1,268,671
- Employed medical director hourly rate: $125.00
- Independently contracted medical director hourly rate: $130.00

### Cardiac and thoracic surgeons
- Median salary: $544,087
- Median salary growth from 2011: 2.16 percent increase
- Median work RVUs: 9,500
- Median gross charges: $1,735,543
- Employed medical director hourly rate: $220.00
- Independently contracted medical director hourly rate: $207.50

### Cardiologists
- Median salary: $430,316
- Median salary growth from 2011: 1.75 percent increase
- Median work RVUs: 6,934
- Median gross charges: $1,400,210
- Female physician pay as a percentage of male pay: 75.7 percent
- Highest offered base salary (not including bonuses): $600,000
- Lowest offered base salary (not including bonuses): $275,000
- Employed medical director hourly rate: $200.00
- Independently contracted medical director hourly rate: $160.00

### Cardiologists – Invasive
- Median salary: $524,731
- Median salary growth from 2011: 4.09 percent increase
- Median work RVUs: 8,298
- Median gross charges: $1,641,227
- Highest offered base salary (not including bonuses): $650,000
- Lowest offered base salary (not including bonuses): $400,000
- Employed medical director hourly rate: $197.86
- Independently contracted medical director hourly rate: $196.98

### Dermatologists
- Median salary: $397,375
- Median salary growth from 2011: 2.93 percent increase
- Median work RVUs: 7,282
- Median gross charges: $1,459,936
- Female physician pay as a percentage of male pay: 80.5 percent
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Median Salary</th>
<th>Median Salary Growth from 2011:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic radiologists</strong></td>
<td></td>
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<tr>
<td>(Interventional MDs)</td>
<td>$485,277</td>
<td>1.39 percent decrease</td>
</tr>
<tr>
<td>(Non-Interventional MDs)</td>
<td>$459,186</td>
<td>0.45 percent decrease</td>
</tr>
<tr>
<td><strong>Emergency medicine physicians</strong></td>
<td>$297,500</td>
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<tr>
<td><strong>Endocrinologists</strong></td>
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<tr>
<td><strong>Family medicine physicians</strong></td>
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<tr>
<td><strong>Gastroenterologists</strong></td>
<td>$435,120</td>
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<tr>
<td><strong>General surgeons</strong></td>
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<tr>
<td><strong>Hematologists/medical oncologists</strong></td>
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<td><strong>Internal medicine physicians</strong></td>
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<tr>
<td><strong>Nephrologists</strong></td>
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<td><strong>Neurologists</strong></td>
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<tr>
<td><strong>Neurosurgeons</strong></td>
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<td><strong>Obstetricians/gynecologists (general)</strong></td>
<td>$303,350</td>
<td>0.24 percent increase</td>
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<tr>
<td><strong>Hospitalists (internal medicine)</strong></td>
<td>$236,500</td>
<td>3.14 percent increase</td>
</tr>
<tr>
<td><strong>Special Compensation Section</strong></td>
<td></td>
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</tr>
</tbody>
</table>
Independently contracted medical director hourly rate: $150.00

Ophthalmologists
Median salary: $371,987
Median salary growth from 2011: 4.39 percent increase
Median work RVUs: 8,649
Median gross charges: $1,665,174
Female physician pay as a percentage of male pay: 73.2 percent
Highest offered base salary (not including bonuses): $450,000
Lowest offered base salary (not including bonuses): $145,000

Orthopedic Surgeons
Median salary: $515,759
Median salary growth from 2011: 2.78 percent increase
Median work RVUs: 8,026
Median gross charges: $1,916,904
Female physician pay as a percentage of male pay: 73.6 percent
Highest offered base salary (not including bonuses): $750,000
Lowest offered base salary (not including bonuses): $400,000
Employed medical director hourly rate: $200.00
Independently contracted medical director hourly rate: $163.00

Otolaryngologists
Median salary: $374,387
Median salary growth from 2011: 0.81 percent decrease
Median work RVUs: 6,891
Median gross charges: $1,532,766

Pathologists (combined)
Median salary: $363,559
Median salary growth from 2011: 2.43 percent increase
Median gross charges: $1,376,262

Pediatricians (general)
Median salary: $220,644
Median salary growth from 2011: 3.40 percent increase
Median work RVUs: 5,111
Median gross charges: $808,399
Female physician pay as a percentage of male pay: 76.1 percent
Highest offered base salary (not including bonuses): $220,000
Lowest offered base salary (not including bonuses): $130,000
Employed medical director hourly rate: $104.07
Independently contracted medical director hourly rate: $125.00

Psychiatrists
Median salary: $217,194
Median salary growth from 2011: 0.01 percent increase
Median work RVUs: 3,381
Median gross charges: $448,757
Highest offered base salary (not including bonuses): $300,000
Lowest offered base salary (not including bonuses): $160,000
Employed medical director hourly rate: $115.27

Pulmonologists
Median salary: $304,90
Median salary growth from 2011: 0.59 percent increase
Median work RVUs: 6,057
Median gross charges: $929,103
Female physician pay as a percentage of male pay: 89.1 percent
Highest offered base salary (not including bonuses): $415,000
Lowest offered base salary (not including bonuses): $180,000
Employed medical director hourly rate: $132.45
Independently contracted medical director hourly rate: $131.25

Pathologists
Median salary: $217,194
Median salary growth from 2011: 0.01 percent increase
Median work RVUs: 3,381
Median gross charges: $448,757

Rheumatologists
Median salary: $229,051
Median salary growth from 2011: 1.09 percent decrease
Median work RVUs: 4,662
Median gross charges: $738,967

Urologists
Median salary: $415,598
Median salary growth from 2011: 0.45 percent increase
Median work RVUs: 7,456
Median gross charges: $1,850,017
Female physician pay as a percentage of male pay: 80.8 percent
Highest offered base salary (not including bonuses): $650,000
Lowest offered base salary (not including bonuses): $330,000

7 Trends in Hospital-Employed Physician Compensation

By Bob Herman

Salaries and compensation packages of hospital-employed physicians have become a burning topic in recent years, mostly due to the upsurge in hospitals acquiring physician practices and subsequent employment of physicians.

Today, roughly 25 percent of all specialty physicians who see patients at hospitals are employed — a sizable increase from the 5 percent of specialists who were hospital-employed in 2000. The number of employed primary care physicians has doubled to roughly 40 percent during the same time span.

As more physicians become hospital and health system employees, it has become paramount to tackle the sometimes difficult process of benchmarking physician pay. In 2010, the MGMA-ACMPE reported the 25 highest-paid specialties among hospital-employed physicians included orthopedic surgeons, spine surgeons, neurosurgeons, cardiovascular surgeons and specialty pediatric surgeons, among others. The salaries of those 25 high-paid specialties ranged from a low of $465,543 for dermatologists to a high of $714,088 for orthopedic spine surgeons.

With those figures in mind, here are seven trends regarding hospital-employed physician compensation that have emerged over the past several years.

1. For physicians, earning power is greater in a hospital-based setting than private practice. Tom Flannery, PhD, partner with consulting firm Mercer, says there is a general belief in the healthcare environment that physicians in private practice can earn higher incomes than those who decide to become hospital employees. However, that may not always be the case, he says.

After factoring out malpractice costs, health insurance, overhead and other operating expenses, Dr. Flannery believes hospital employment offers greater earning potential for physicians, especially those looking for more stability.

“When everything is considered, including the hassles of running your own practice, the earning power [physicians] have can actually be higher in a hospital-based practice,” Dr. Flannery says. “But there’s still a perception that private practice physicians can earn more. [That] is more to do with the freedom to act as opposed to earning power.”
2. High-paid specialties to watch include noninvasive cardiology, ophthalmology, general orthopedic surgery, neonatal medicine pediatrics and neurosurgery. Mercer recently completed its 2012 Highly Compensated Physician Survey, which collected salary and cash compensation data for the highest-paid employed physician specialties. Mercer analysts highlighted five specialties in particular: noninvasive cardiology, ophthalmology, general orthopedic surgery, neonatal medicine pediatrics and neurosurgery.

Of those five hospital-based specialties, ophthalmologists recorded some of the highest pay packages. Total cash compensation of hospital-employed ophthalmologists in the 75th percentile averaged $779,290, according to the survey. Neurosurgeons recorded the next-highest total compensation average in the 75th percentile at $778,890.

In the 50th percentile, all five specialties averaged more than $500,000 in base salary alone. Here are market base salary averages in the 50th percentile for each specialty:

- Neurosurgery: $663,760
- Ophthalmology: $628,260
- Noninvasive cardiology: $575,000
- General orthopedic surgery: $538,970
- Neonatal medicine pediatrics: $505,000

boost in benefit plan costs, hospitals have traditionally encouraged higher levels of productivity. However, the fee-for-service environment is becoming a thing of the past. Focusing on volume is not a silver bullet in an increasingly value-based environment, but at the same time, hospitals cannot just “let physicians do what they want in terms of productivity,” Dr. Flannery says.

Therefore, in compensation plans, hospitals are incentivizing physicians to focus their energy and efforts on high-level cases instead of “churning numbers.” Instead, advanced practice clinicians, such as nurse practitioners and physician assistants, are helping with simpler cases, a process that has boosted their compensation as well.

“Physicians have to practice at the top of their skill level, and that’s not happening,” Dr. Flannery says. “When we see physicians operating at the top of their skill level, pediatricians aren’t seeing strep throat and ear infections — those are being seen by nurse practitioners. Therefore, nurse practitioners need to operate at the top of their skill level, too. When the value goes up, compensation goes up, and it frees up time for more complicated cases [for physicians].”

5. Hospital-affiliated primary care physicians will eventually see their salaries increase more. Primary care is a major emphasis within the healthcare reform law, and Dr. Flannery predicts primary care physicians will receive higher pay in the process.

3. Benefits for physicians mirror the general hospital employee base, not the C-suite. Physicians who are added to the hospital payroll are increasing the hospital’s operating expenses with higher benefit plan costs. However, Pat Kopacz, principal at Mercer, says Mercer’s Highly Compensated Physician Survey showed most physicians — even those who become heads of a service line or department — receive the same health benefit plans and retirement options as nurses, frontline staff and other frontline hospital employees. The hospital’s executive team usually has its own benefit program, she says.

4. Hospitals are emphasizing value over productivity. In order to combat increased financial pressures such as the aforementioned

For example, in November, CMS released a final rule that said primary care physicians in the specialties of family medicine, general internal medicine or pediatric medicine (and related subspecialties) will be paid Medicare rates for Medicaid primary care services for this year and 2014. In addition, qualifying physicians will receive higher payments if primary care services are rendered by certain physician extenders — such as nurse practitioners — who work under the qualifying physicians’ supervision.

“The literature is starting to say there’s going to be a change in the economics. We’re going to see an increase in primary care physician compensation because the value of primary care is high now and will be higher over the next several years,” Dr. Flannery says.

Dr. Flannery adds that specialists will still remain in high demand and command high salaries due to a general shortage of physicians and the fact that “unhealthy nations are going to need cardiologists, orthopedists and neurosurgeons left and right.”

6. The highest-paid physicians at hospitals have the highest expectations, especially those in administrative roles. Ms. Kopacz says hospital-employed physicians who earn the most — such as CMOs, department heads and other physicians who have additional administrative roles — have higher expectations now. If a physician is making more than $700,000 per year and is a department chair, for example, he or she will be expected to maintain clinical quality and also become a “manager” who helps operate the department.

“Physicians are [being] asked to play multiple roles within an organization — not just clinical, but administrative as well,” Ms. Kopacz says. “That’s something we expect to see more and more. Physicians are going to have to be clinical leaders as well as part of the administration.”

7. Compensation arrangements between hospitals and physicians involve quid pro quo elements. Although some may view compensation negotiations between hospitals and physicians as a Wild West showdown, that is generally not the trend, Dr. Flannery says. Both sides usually are open to a “this for that” mentality.

Of course, hospitals must pay physicians fair market value, but there are certain quid pro quo elements. For example, physicians will receive various benefits outlined in the hospital benefit plan, but it may not be as extensive as benefit plans in other industries. Dr. Flannery views that situation as hospitals offering a perk that physicians may not have had before, and although it’s not as much as other industries, physicians will not have to be on call 24/7, as they would be in private practice.

Another example is tuition and student loan forgiveness. A hospital may offer a physician a sizable sum of money to help pay down medical school loans, but the hospital may ask that physician to commit to work at the hospital for a predetermined amount of time.

“Think about the economics of having to recruit physicians,” Dr. Flannery says. “You have to pay a headhunter, pay relocation, get [physicians] to productive levels — you’re talking potentially the equivalent of 12 to 24 months compensation. It’s a short payment to give them a couple hundred thousand [in student loan forgiveness] to have them agree to stay for five to seven years and not having turnover every two years.”
Healthcare providers are preparing for the reality of the post-reform environment that will require hospitals and physicians to be more accountable for the delivery of higher quality and more efficient care delivered at a lower cost. As hospitals and physicians navigate through the challenges of planning for this future, they also have to remain focused on current operations that are threatened by thinning margins due to an increased cost structure and reimbursement declines in the current fee-for-service environment.

To effectively position for the future realities of healthcare while maintaining focus on current operations, many hospitals and physicians are turning to clinical integration as a viable option to (1) increase quality, (2) reduce cost and waste in the current system to maintain margins, (3) sustain independence for physicians not ready for hospital employment and (4) position providers to take on higher levels of accountability to effectively manage utilization and the health of populations in the future.

CI is commonly defined as a health network working together, using proven protocols and measures, to improve patient care, decrease cost and demonstrate value to the market. Once the CI network can demonstrate a value proposition, payors and large employers are approached to support the network and other incentives that are based on achieving defined results. In most cases, CI networks and the initial conversations with payors are initiated by health systems. However, to be successful, CI networks must become physician-led, professionally managed organizations.

Organizations should keep the Federal Trade Commission’s clinical integration definition and requirements in mind during CI program development and implementation. In 1996, the Department of Justice and the FTC defined CI as an active and ongoing program to evaluate and modify practice patterns by the CI network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. Generally, the FTC considers a program to be clinically integrated if it performs the following:

1. Establishes mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality of care.

2. Selectively chooses CI network physicians who are likely to further these efficiency objectives.

3. Utilizes investment of significant capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

7 Components
To effectively implement CI, the network should understand the relevance and the possible options for each of the seven components discussed below:
of a Clinical Integration Network

By Dennis Butts, MBA, Michael Strilesky, Manager, and Matthew Fadel, MBA, MSM, Senior Associate, Dixon Hughes Goodman

1. Legal options. To legally implement CI, the health system and physicians are required to organize in a structure that supports program objectives. With the exception of an employment-only model, a CI network can primarily be created within a (an):

- Physician-hospital organization — A joint venture between a health system and its medical staffs.
- Independent practice association — Owned and operated by only physician partners.
- Subsidiary of the health system — The health system is the sole corporate member of the subsidiary entity and member physicians sign separate legal agreements to participate.

Traditionally these structures have been used to negotiate and handle managed care contracts (HMO, fee-for-service, etc.) for a defined network of providers and they are now being utilized as the vehicle to implement CI networks by achieving the following objectives:

- Establishing a network of providers that enables enhanced coordination of care.
- Creating a new partnership model with employed and independent physicians that includes defined roles for physician leadership.
- Defining performance improvement initiatives to provide demonstrated value to the market.
- Providing a platform for joint contracting to support care redesign and performance improvement initiatives.
- Negotiating with potential partners for risk-based contracts.

Each legal option is capable of achieving these CI objectives and they differ in ownership structure and capitalization requirements. Some hospitals and physicians already have a PHO or IPA in place and are using those entities as the foundation for their CI programs. For example, a four-hospital system in the Midwest chose to utilize a PHO as their vehicle for CI because the business entity was already created. Although the infrastructure was not entirely created to support a fully-functioning CI network, the PHO created an opportunity for ownership, access to resources, strong public perception and the analytics staff to support quality programs. However, to limit physician costs while still allowing physicians to have a significant leadership role in the network, a four-hospital system in the southeast created a subsidiary of the health system to launch its program.

2. Physician leadership. Integration in the post-reform era requires a high degree of physician-hospital alignment that is based on trust and transparency. Health systems willing to pursue CI must empower physician leaders to have an influence on the future direction of the CI network. This will help to integrate the physician’s clinical expertise into hospital operations and also increase cooperation and credibility of the CI network. Furthermore, dedicated physicians and administrative leadership will be required to successfully implement a major change project of this magnitude.

A vital step to physician engagement and leadership is a robust communication strategy across the network and its partners. Clear goals and objectives by both employed and independent physicians will encourage dialogue and partnership formation as the strategy is implemented.

Once the CI network is created, a governance structure should be developed. Physician leaders should participate on the CI board and provide leadership to committees formed to achieve program objectives. Other participating physicians may lead and/or participate on sub-committees supported by the CI network or health system. CI committees may merge with existing committees in place within the health system (i.e., executive committee, quality committee and contracting committee).

3. Participation criteria. Member physicians or groups in the CI network must sign a participation agreement. This agreement outlines the expectations and requirements for participation in the CI program. In the initial stages of the network, it is very critical that member physicians adhere to program guidelines to help ensure that stated objectives are met and the network’s value proposition is able to be demonstrated to the market.

Recognizing this, one large CI network in the Southeast included information technology adoption in the participation criteria to ensure that the network was able to demonstrate the value of enhanced coordination between providers following evidence-based guidelines. To ingrain IT utilization into the culture, not only did the CI network initially include IT adoption and utilization in the participation criteria, but the network also designated a portion of the performance incentive dollars to this area to increase compliance.

As the network matures and the participation criteria is solidified into the culture, incentive payments are not typically awarded for compliance. However, to keep physicians focused on program requirements, physician eligibility in the incentive program may be tied to meeting the participation criteria.

Sample participation criteria include:

- Maintaining the appropriate IT infrastructure.
- Logging into the CI Network website to view network and individual performance.
- Compliance with clinical protocols and care pathways developed by the network.
- Participation in all network contracts.

4. Performance improvement. Clinical quality and operational improvement projects are necessary components of a CI program. CI provides a vehicle that engages physicians in determining how quality is defined and measured. CI also allows physicians to take an active role in care redesign and protocol development to increase quality, more effectively manage costs, reduce variation and eliminate unnecessary waste within the delivery system. The performance initiatives span across specialties and sites of care.

To achieve performance improvement, the CI network works to define baseline performance and identify areas where the network can demonstrate quality and operational efficiencies to the market. It is critical that physicians play an active role in selecting metrics for the performance improvement initiatives. CI networks should select performance improvement initiatives based on the (1) feasibility of capturing sufficient data to monitor performance, (2) improvement opportunity, (3) payor, employer and/or hospital interest in the program and (4) the ability of participating physicians to impact the targeted metrics.

Performance improvement initiatives can be complex and difficult to monitor effectively based on the sophistication of the network’s IT system and the capacity of the network to manage multiple initiatives effectively. Recognizing this, one large multi-hospital system in the Midwest implemented their initiatives in a phased approach over time and ensured that all metrics
were consistent across contracts. Individual metrics were then reevaluated and updated on an annual basis to help ensure that the initiatives continued to demonstrate the value of the network. Performance improvement initiatives are typically developed in the following categories:

- Variance and cost reduction — Improving operational efficiencies.
- Clinical efficiency — Reducing avoidable, unproductive and duplicative services.
- Care redesign — Ensuring treatment in the most optimal setting and by the right provider.
- System optimization — Shifting focus to preventive care and population health.
- Patient experience — Objective and meaningful comparisons between providers of care.

5. Information technology. If you do not measure it, you cannot improve it. IT is the backbone of the CI network’s value proposition and is critical to improving coordination and connectivity between providers of care. Early adopters of CI would manually input data and transfer information by Excel template report cards. Today the industry is inundated with tools to assist with monitoring and reporting the care provided to a patient. Since providers will be affected most by a change in technology, they must be heavily involved in choosing the correct vendor. Two types of data sharing sources being used most by hospitals are electronic health records and patient registries. However, health information exchanges are becoming more popular and could eventually become robust enough to support clinically integrated initiatives.

An EHR is a medical record for a patient in a physician office, hospital, ancillary care facility or ambulatory care facility. The EHR is intended to replace paper-based patient records for recording encounter-based information on each patient who receives care from the provider entity and includes electronic: data entry, order entry, prescribing and transcription.

A patient registry is a repository that holds clinical information specific to a disease, disease process, implant, drug, etc. A cancer registry is an example of a disease-specific database. The registry is intended to track (1) patients and their compliance with specific chronic disease- (or wellness-) based guidelines across populations, (2) physician compliance with those guidelines and (3) outcomes for specific interventions. A data registry differentiates itself by interfaces with multiple data sources to provide sufficient data at the point of care provided to a patient, which is why many CI networks are utilizing data registries as opposed to the electronic medical records approach.

6. Contracting options. The purpose of CI is to provide higher quality care. Creating a CI network for the sole purpose of negotiating better rates is not the purpose of CI. However, CI networks are rewarded for demonstrated value, which is defined as the highest quality care at the lowest cost.

The CI network can contract with payors, employers or health systems. These contracts can range from a specific procedure to a population of patients. Many hospital systems have reported that payors are not requiring that CI contracts include downside risk for the network. A six-hospital system in the Southeast reported that a major payor has approached them with a contracting model that would reward their network for demonstrated performance in the following ways:

- Premium base rates — Increased fee-for-service rates based on expected performance.
- Performance incentives — Incentive payments made for performance improvement initiatives.
- Shared savings — Savings shared based on a reduction in the cost of care.

Some hospitals have also contracted with their own CI network to realize cost saving opportunities and to more effectively manage cost within their own health plan. A hospital system in the Southwest has implemented this strategy. The savings that are generated by the network are shared to fund the CI program and to make distributions to member physicians.

7. Flow of funds. Calculation and distribution of CI incentives to physicians and to the health system occur after performance is achieved. A distribution of funds will typically be realized through cost savings, quality and efficiency programs negotiated by the CI network and its partners. Funds are distributed based on meeting performance objectives and performance can be defined in a variety of ways. For example, some CI networks reward simply for global network compliance of the CI agreement while other CI networks reward based on site (multiple hospital systems), specialty and individual performance.

Regardless of how the funds flow to the members of the CI network, the methodology should be transparent and easy to understand. Key considerations for CI network distribution methodologies include:

- Distribute rewards based on measurable performance.
- Reduce complexity of distribution methodology.
- Increase transparency across the network.

Conclusion

Health systems and physicians are implementing CI networks across the nation to respond to changing healthcare dynamics that are holding providers more accountable for quality and outcomes. Each CI network needs to create a disciplined approach to assessing and developing the key components of their network to create a sufficient value proposition for the health system, physicians, payors and employers. As CI becomes a strategic imperative in most markets, organizations should keep the following critical success factors in mind to accelerate the implementation of a successful and sustainable CI network:

- Align your health system objectives with the CI vision and strategy to avoid conflicting messages in your market.
- Involve physician leaders in the CI development process to gain physician buy-in for program objectives.
- Express a willingness to create a new partnership model with employed and independent physicians that includes defined roles for physician leadership.
- Maintain systems that can track and monitor clinical data across the continuum of ambulatory, acute and post-acute services.
- Utilize a scaled approach to develop a comprehensive list of metrics that provide value to multiple stakeholders and positions the CI network for greater levels of accountability.
- Create an effective communication strategy across all stakeholders to increase understanding of the key issues of CI.
- Commit to approach payors in the market as a combined network.

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In the 1980s, Henry Hood, MD, decided it was time for his health system to make a change.

The late Dr. Hood was a neurosurgeon and CEO of Danville, Pa.-based Geisinger Health System, then known as Geisinger Medical Center. During the 1980s, the United States began to unfurl its first wave of managed care — that is, coordinating patient care within a specific network in an attempt to improve quality and decrease costs. Dr. Hood wanted to be part of the growing demonstration, which resulted in the formation of the Geisinger Health Plan.

Duane Davis, MD, a board-certified internist and rheumatologist who now heads the Geisinger Health Plan, says the health insurance arm was the beginning of Geisinger’s own reform. “Dr. Hood basically said to all of us, ‘Managed care is the beginning, and the financing of care is changing. Healthcare delivery will change, and we really need to learn how to do this,’” Dr. Davis recalls. “If you look back on it now, it was pretty visionary. That’s kind of how it started for us.”

A handful of health systems like Geisinger have successfully played the role of both provider and payor for the past 30-plus years, and it is one of the reasons President Barack Obama has heralded Geisinger as an exemplary system of healthcare delivery. As healthcare reform continues to evolve, more hospitals and health systems are exploring the option of starting their own health plans and insurance divisions. But managing care as both provider and payor is no easy task — and taking the wrong steps could be detrimental to an organization.

Déjà vu from earlier decades?

In the 1990s, managed care, which included HMOs, PPOs and other insurance vehicles, began to proliferate throughout the healthcare system. Managed care, for better or for worse, became synonymous with U.S. healthcare. Some hospitals and health systems hopped on the health insurance/HMO bandwagon right away and decided to try their own hand at starting a health plan. Geisinger, Intermountain Healthcare in Salt Lake City, Henry Ford Health System in Detroit, Kaiser Permanente in Oakland, Calif., and University of Pittsburgh Medical Center are some of the most notable systems with longstanding, successful health plans.

However, not all hospital-based health plans lasted, as many could not back up the financial risks associated with health insurance. As the 2000s evolved, several hospitals began to divest their health insurance arms like they did with their physician practices.

Now, under President Obama’s Patient Protection and Affordable Care Act, there is a renewed emphasis on managing the continuum of care with better quality and decreased costs. In some instances, such as accountable care organizations and bundled payments, hospitals will be viewed as provider, insurer and care manager.

“Through payment changes, the [PPACA] is creating incentives for provider systems to manage the entire process of care,” says Peter Weiss, MD, president of Concert Health Plan, which started offering commercial group health insurance through the Florida Division of Adventist Health System in 2010. “This is easier when the provider system is also the insurer and can align the incentives of all parties around the health of the member.”

Lisa Goldstein, an associate managing director at Moody’s Investors Service, agrees, saying healthcare reform has inspired a renaissance of hospitals wanting to dip their toes back into the health insurer realm in order to comply with the goals of federal healthcare reform.

“Historically, we’ve seen this trend before,” she says. “[Healthcare] is a very cyclical industry. In the mid-1990s, many health systems became vertically integrated. The hospital was the core business, but management also decided to go into the insurance business like we’re seeing today.”

However, in the 1990s, the practice of hospitals doubling as insurers was more experimental than anything else, especially as the healthcare system tried to grapple with the concept of managing and financing the care of select groups of people.

Now, Ms. Goldstein says hospitals want to start their own health plans because healthcare reform demands population health management — and what better way to manage the care of a population than by becoming that population’s financing vehicle?
Revenue is under pressure, and healthcare reform is coming — that's a fact now,” Ms. Goldstein says. “In order to reduce costs and gain efficiencies, many [hospitals] are exploring getting back into health insurance business, either on their own or with a well established health plan. It’s back to the future with this.”

## Knowing the pros and cons

One of the clearest benefits for hospitals starting their own health plans is the alignment of goals associated with healthcare reform, as previously mentioned. If hospitals provide the care and finance the care, it makes the delivery process more efficient without having to deal with a third-party intermediary.

Consequently, hospitals that add a health plan will generate more revenue, which allows for more reinvestment within the community, the system and a growing patient base. For example, Geisinger Health Plan, one of the nation’s largest rural HMOs, covers more than 300,000 people and brings in roughly $1.3 billion in annual revenue to Geisinger Health System. Geisinger Health Plan is somewhat of an exception, due to its longevity, but CEO Dr. Davis says the increase in revenue allows the health system to better “re-engineer our care to get better outcomes.”

Daryl Tol, CEO of Florida Hospital Volusia/Flagler, which recently announced it would launch its own health plan in 2014, says hospitals that offer health plans to their patients also keep care decisions more “local.”

“We didn’t have the infrastructure or [health insurer] talent, and that concerned us,” Dr. Arbuckle says. “This initiative will help us keep healthcare decisions in our community.”

However, challenges associated with starting a health plan can also be daunting. Last November, Fountain Valley, Calif.-based MemorialCare Health System announced it will launch its own health plan, Seaside Health Plan. Barry Arbuckle, PhD, CEO of MemorialCare, says many questions crossed his and other leaders’ minds before they moved forward with their decision.

“We didn’t have the infrastructure or [health insurer] talent, and that concerned us,” Dr. Arbuckle says. “This is very different from what we’ve done. Playing in the insurance space is very different.”

Ms. Goldstein of Moody’s adds that hospitals looking to enter the health insurance business have to understand how complex it can be. Hospitals cannot flip a switch to go from a provider to an insurer, and state and insurance business have to understand how complex it can be. Hospitals that add a health plan will generate more revenue, which allows for more reinvestment within the community, the system and a growing patient base.

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Best practices going forward

For hospitals and health systems looking to venture into a world of self-owned HMOs and health plans, there are many things to consider. Here are three best practices that are essential for any health systems to become integrated with a health plan.

### Outline specific goals and strategies.

Dr. Davis has been with Geisinger Health System since 1978 and was previously the CMO of Geisinger Health Plan before he was named CEO last May. As a physician and now an executive, he has learned a lot within the insurance space, and he reiterated one tip to those who may want to launch a health plan of their own: What's your goal and strategy for having a financing arm in your system?

“If you’re thinking about getting a health plan, are you really clear on what you’re using it for?” Dr. Davis asks. “What you should not be using it for: keeping traditional beds full and buy more hospitals — that’s probably not a long-term strategy.”

Instead, Dr. Davis says hospitals and health system should view a self-started health plan as a laboratory to ask, “What would be the most optimal way to take care of this membership?” — a question that is at the forefront of healthcare reform.

Then can we re-engineer care in a way to get that done?” Dr. Davis continues. “How do you create a payment model that will sustain and support that value-based re-engineering?”

Dr. Arbuckle of MemorialCare says his health system asked many of those same questions.

“I would encourage others to follow the initial process we did: What will you have?” Dr. Arbuckle says. “This is not a business you know very well, so go through that deliberate process.”

### Conduct the appropriate research, and know your options.

Dr. Arbuckle says MemorialCare evaluated and weighed all of its options before deciding on starting Seaside Health Plan, which will eventually offer health coverage initially to 17,000 Medicaid and CCS beneficiaries with substantial growth expected in the future. (California Children’s Services, or CCS, focuses on children with chronic and ongoing medical needs.) He says the health system had three main options: Start its own health plan from scratch, partner with a payor or acquire an existing health plan.

Dr. Arbuckle and MemorialCare leaders ultimately mixed the first two options. Starting a health plan from scratch in California would have taken up to 18 months, while partnering with a current health insurer on a new health plan “didn’t seem like a viable option” because they didn’t know how other health plans would react, he says.

Instead, MemorialCare went with option number three: It will acquire certain health plan operations and assets of Universal Care and has filed an application to become a California licensed health plan. According to Dr. Arbuckle, this was one of the quickest options, and it allowed MemorialCare to keep on the talent and staff of Universal Care, for which MemorialCare did not have the infrastructure.

Ms. Goldstein of Moody’s says the type of analysis exhibited by MemorialCare is what every health system should expect to conduct before starting its own health plan. In some states, insurance departments require certain levels of reserves, and it is paramount health systems can answer questions such as, “Will you have enough funds on hand to cover future medical expenses?” and “How will you price your product?”

In addition, hospitals should be prudent and see if their health plan would invade on another payor’s market space. While Dr. Arbuckle says his pending health plan does not cross into the coverage of any of his area’s major insurers, hospitals must look at it on a market-to-market basis.

### Have the right governance.

At Geisinger Health Plan, Dr. Davis serves as president and CEO, but the health insurance responsibilities are not his alone. The health plan is part of Geisinger Health System, and he reports to system CEO Glenn Steele Jr., MD, and the rest of the C-suite team. A hospital’s health plan needs its own executive leadership, but it cannot be left alone. It needs molding and support just like any other branch of an integrated delivery network.

“We have a combined governance, and that has been one of the keys to our success,” Dr. Davis says. “The health plan is not something on the side — this is something we’re all responsible for, and we do well by aligning with our mission, which is the triple aim.”

Ms. Goldstein of Moody’s agrees, saying the most successful U.S. health systems that have health plans mirror what Geisinger does from a management perspective.

“At [successful IDNs], their management structures are such that there is a corporate-level CEO, CFO, etc. As you go down into the health plan division, there is a CEO and CFO with health plan expertise who report up to the system CEO and CFO,” Ms. Goldstein says. “They have management at each of the operating companies, and it rolls up into senior management. That’s a key reason to why some health plans have worked at these longstanding systems.”

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4 Things Executives Should Know Prior to a Hospital-ASC Joint Venture

By Kathleen Roney

All parties in a hospital-ambulatory surgery center joint venture stand to benefit in many ways. Hospitals may gain new relationships with physicians while ASCs could receive a bump in reimbursement and gain access to the hospital’s insurance product and additional capital.

However, just because the potential benefits are plentiful that does not mean that a joint venture will be easy to set up or run smoothly once established. Hospital executives in particular need to be fully aware of what a hospital-ASC joint venture entails. Here are four things hospital executives should know before pursuing such a venture.

1. Financial situation. It is imperative that hospital executives have a good grasp on their hospital’s financial situation before moving forward with an ASC joint venture. According to Brent Lambert, MD, co-founder of ASCOA, his team has run into executives who were not fully aware of their hospital’s financial condition. This lack of knowledge could cripple the joint venture.

“If you build a surgical center and you are a part owner, it requires you to be able to put up money to build out the surgical center, to equip it and to have working capital. It’s important the hospital have the capacity to do that,” says Dr. Lambert.

If a hospital can’t contribute money toward the surgery center, many times the discussions end there. “Each party has to ante up for their equity portion. They have to be aware that it is going to cost them money,” says Dr. Lambert.

2. Capacity of operating rooms and case volume. Hospital executives need to have detailed knowledge of the hospital’s operating room capacity and case volume so they know whether they are operating at or near capacity, says Dr. Lambert. One of the prime reasons hospitals seek a joint venture with an ASC is due to a capacity problem: They do not have enough OR capacity to accommodate their staff and their surgical needs. A joint venture is an extremely attractive option to deal with that issue.

“It is always surprising to me to find that CEOs are not really sure about the hospital’s operating room capacity. They need to check on that,” says Dr. Lambert. “If they are looking to decant some cases to an ASC, they need to have a clear understanding of their operating room capacity and what it looks like in years to come so there are no surprises down the road.”

3. Strategy. It is imperative for a hospital CEO to have a clear understanding of the hospital’s strategy, especially in relation to the hospital’s competition. This is because the goal of a joint venture is to generate high profits and help a hospital retain as well as attract highly valuable surgeons, says Dr. Lambert. “[In addition], if done strategically, [a joint venture] can increase market share and expand service area,” he says.

Be aware of the competition

Realizing what the competition is doing is a key part of a hospital’s strategy in the ASC-joint venture arena. According to Dr. Lambert, if a hospital realizes it is losing out to its competitor, then it can strategize how to use a joint venture to gain a leg up.

“For example, [ASCOA] met with a hospital whose competitor had recently built a new hospital exactly two miles north of its facility, and by doing so, had effectively cut off the whole northern county [of its service area]. In effect, the hospital we met with was only getting cases from half of the county,” says Dr. Lambert. “I said ‘let’s put an ASC center north of the competitor’s new hospital. Then we would be the first stop in terms of surgical care for people in the north.’ Those kinds of considerations are useful, especially if the hospital CEO has thought strategically and tactically about how to beat the competition.”

If executives get wind that a competitor is trying to recruit physicians for an ASC, it’s a signal to them: they need to get going because they can’t have a “me too” element to their physician recruitment, says Dr. Lambert.

Know the physician landscape

Knowledge of the physician landscape around a hospital is closely tied to competitor awareness: Hospital executives need to understand the physician landscape in great detail in order to set up a successful ASC.

“Executives need to know who their valued surgeons are, what surgeons are available in the community and what surgeons are with the competitors. Those are the ones you want to highlight and go after when you do a joint venture,” says Dr. Lambert. “Executives need to understand [their] marketplace in great detail so they can place the ASC in the most propitious place that will play into the hospital’s long-term strategy.”

4. Each party’s responsibility. The hospital, the ASC company and any other party involved in the joint venture needs to be fully prepared to fill their role. According to Dr. Lambert, the primary function of the hospital in the joint venture is to increase reimbursement over and above what an ASC could achieve on its own. On the other hand, it is the responsibility of the ASC — the company and/or the physicians — to run operations in a highly efficient way.

“Each equity partner — the hospital, the ASC company and the physicians — have to do their part. If so, everyone is happy. If one of them shirks their responsibility, then it’s a mess,” says Dr. Lambert.

A hospital-ASC joint venture can be profitable for each party involved. However, success is not guaranteed. Hospitals need to be aware of the four elements above in order to benefit from the deal. Just because a deal has potential does not mean it is guaranteed.
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Hospitals are increasingly looking to partner with physicians on surgery center projects, hoping to build relationships with providers in the community and strengthen their market share. Here are 10 hospitals that planned or opened surgery center joint ventures in the last several months.

1. Texas Guadalupe Regional Medical Center. Guadalupe Regional Medical Center in Seguin, Texas, has authorized CEO Robert Haynes to negotiate with the owners of South Texas Surgical Center regarding a potential acquisition. The GRMC board unanimously approved the motion to pursue negotiations for the purchase of the surgery center’s business and leasing of its building. Mr. Haynes said negotiations might be completed by April 1. South Texas Surgical Center is an 18,000-square-foot facility with four operating rooms and two procedure rooms.

2. Cheyenne Regional Medical Center. Cheyenne (Wyo.) Regional Medical Center will soon open a new surgery center on its campus, a merger of Yellowstone Surgery Center and Cheyenne Surgical Center. The High Plains Surgery Center will be formed by the merger of the two ASCs and located on the second floor of the medical office building at CRMC. Cheyenne Regional, which was formerly a shareholder in the Yellowstone Surgery Center, will be a co-owner of the new center. A group of 25 physicians will retain ownership of the rest of the center.

3. Geisinger Community Medical Center. Geisinger Community Medical Center in Scranton, Pa., has announced a joint venture with North East Surgery Center. The North East Surgery Center has 38 surgeons and performs general, orthopedic, plastic, colon, rectal, vascular, podiatric, urologic and ENT surgery, as well as pain management procedures. The center has three operating rooms and two procedure rooms. Hospital administrators said the partnership overlaps with the system’s mantra of providing appropriate care at the right time and location.

4. Munroe Medical Center. Munroe Regional Medical Center in Ocala, Fla., has agreed to purchase a 20 percent share of Surgery Center of Ocala’s business. The new partnership will give the non-profit, 421-bed hospital access to the surgery center’s four operating rooms, two procedure rooms and 6 percent of the market share that the facility controls. The surgery center performs around 4,200 procedures annually.

5. Glen Falls Hospital. Construction crews have begun site work for a new ophthalmology surgery center in Wilton, N.Y. Local ophthalmologists and Glens Falls (N.Y.) Hospital are collaborating on the eye surgery center. The physicians formed North Country Eye Surgery Center, a company that will own 70 percent of the facility. The hospital will own the remaining 30 percent. North Country Eye Surgery is spending around $1.2 million for equipment. It will provide the staff and handle billing, while the hospital is spending $1.2 million, and will own the building and land.

6. HCA Virginia Health System. OrthoVirginia and the HCA Virginia Health System recently opened a 70,000-square-foot medical facility that includes an outpatient surgery center. The OrthoVirginia/HCA facility brings orthopedic specialists in hand, knee, hip and spine together with pediatric services and sports medicine physicians. The sports medicine facility, dedicated to musculoskeletal diagnosis and repair, houses the privately owned orthopedic surgery practice OrthoVirginia, along with HCA’s CJW Sports Medicine program and a jointly owned surgical center.

7. Catholic Health Initiatives and Adventist Health. St. Rose Ambulatory and Surgery Center in Great Bend, Colo., will join Centura Health Initiatives, a Denver-based healthcare group. Centura is jointly operated by Catholic Health Initiatives and Adventist Health system. St. Rose currently belongs to Catholic Health Initiatives, which will integrate its facilities in Colorado and Kansas into one regional group through this move.

8. Middlesex Hospital. Middlesex Hospital in Middletown, Conn., is proposing to acquire a nearby ambulatory surgery center that exclusively performs gastroenterology and colonoscopy procedures. The hospital has submitted a proposal with the Office of Health Care Access.

9. Hackensack University Medical Center. Hackensack University Medical Center has announced a joint venture partnership with United Surgical Partners International and community physicians in the acquisition and operation of two ambulatory surgery centers.

10. Scottsdale Healthcare. Scottsdale Healthcare and its joint venture partner Sovereign Healthcare have completed a transaction, acquiring majority ownership of Biltmore Surgical Center in Phoenix, Ariz. The transaction allows Scottsdale Healthcare to expand patient access to off-campus outpatient surgery services and strengthen alignment with physicians.

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As patient satisfaction continues to become a focal point of how hospital performance is measured and reimbursed, reform readiness is crucial. With 32 million newly insured Americans looking for hospital networks and physicians under Patient Protection and Affordable Care Act, it is important to navigate patients to the proper point of care through streamlined coordination and align staff strategically to help manage the increased traffic and demand for services.

As patient volumes increase, medical and nursing staff resources are at an alarming shortage to meet the care and communications needs of patients, while also attempting to maintain positive experiences that yield high satisfaction and optimal reimbursement. In fact, it is estimated that there will be a shortage of 63,000 physicians by 2015 alone.

Additionally, accountable care organizations are popping up around the country, and systems are faced with additional gaps in executing the new models — from member communications focused on patient education, outreach and management of chronic disease to access to primary care and follow-up communication to ensure compliance. Everywhere you turn, patients and physicians are faced with a web of communication touch points that are begging to be connected.

So how do hospitals who haven’t yet tackled the ACO initiative take on more patients, with already bruised funding, an overworked staff, and yet increase the quality of care and customer service delivered? And how do established or forming ACOs prevent fragmented care and communications? Below are six tips to effectively engage patients throughout a streamlined care continuum, while also improving employee satisfaction.

**Improve patient access**

Patient access deficiencies often stem from gaps in business and operational procedures and capabilities. From front-office staff to technology systems, hospitals and physician groups aren’t always equipped with the optimal tools, data or communication and service levels that yield a positive experience. Even if your hospital staff is delivering the highest quality medical care in your community, remember that consumers aren’t always recommending based on the quality of medical staff. Most changes can cost little to no money, and may just be a matter of staff training.

**Boost employee morale**

With an already exceedingly stressful role, additive pressure can lead to serious and fast employee burnout. Before the hospital is able to implement new processes or ask the staff to change the way they deliver care and an experience, it’s key to check in on their current state. After all, if caregivers feel under appreciated and exhausted, they are more likely to be unreceptive. To boost employee satisfaction, simple initiatives can be implemented to secure morale such as establishing a recognition program, developing a cohesive process for setting and communicating expectations, creating a people-centric workplace culture, and reinforcing a commitment to accountability.

Find an innovative approach to improvement through looking at other industries: Solving the complexities of healthcare is really no different than other companies outside of the healthcare industry faced with similar business challenges. For example, Starbucks focuses intensely on the “experience,” not just selling coffee. By doing so, they have been able to sell coffee at a premium price during a time of economic downturn.

**Details matter**

Disney teaches us to focus on the infinite attention to detail. Every detail that you can imagine in an experience will not be noticed by each person who comes into contact with your system, but the one person in a million who notices a well-thought-out and executed touch will remember you most and likely rank you higher in satisfaction and quality. If you have considered and implemented a solution to something patients and families don’t even know they need, you have succeeded at focusing on detail.

**Change perceptions**

A recent study published in *Psychological Science* showcases what happens when you become desensitized to the obvious in your work environment. In short, when we are too close to something, often we can miss the obvious. Maybe that stained ceiling tile becomes less obvious to the eye, but it can jolt the patient’s opinion about the quality of care they are receiving.

Also consider how missing the obvious can impact care delivery. A call-light could be missed due to the distracting environment that has desensitized caregivers. This doesn’t mean the oversight is caused by human incompetency; it means staff is surrounded by blinking lights and beeping noises all day. They’re too close; they’re missing the obvious.

**Have You Assessed Your Reform Readiness? 6 Tips to Enhance Your Care Continuum**

*By Nicole Nicoloff, Vice President Market Strategy and Innovation, BerylHealth*
Changing perceptions is cost-efficient and is as easy as taking a step back, walking the hospital with fresh eyes, and imagining what you as a patient would perceive just by looking around or what you as a caregiver or administrator could do to refresh the working environment.

**Over communicate with patients**

Feeling “in the loop” can help patients feel more at ease. By explaining your role as a clinician in relation to others providing care, detailing the referral process and noting when a patient’s question falls outside of your expertise, you’re keeping patients in tune with what they need to know and making them more comfortable.¹ Being that patients are ill, in a new environment and don’t speak the jargon, they are at the most vulnerable state. Patients are often too scared or not comfortable enough to ask questions; by being forthright with information, you are educating them and helping them understand and become more responsible for their own care.

**Follow-up**

Direct and swift follow-up with patients, either post-discharge or release from the emergency department, is one of the most crucial tactics in managing patient populations, chronic disease and patient perceptions. While it may seem cumbersome, scaling patient populations by risk and acuity can help make the workload more feasible. Following up works to boost patient medication and instruction compliance, improve the post-discharge patient experience, manage care coordination and prevent unnecessary readmissions, all of which aids in improving patient satisfaction and quality care measures, and in turn shields reimbursements. One of the most valuable outcomes follow-up calls provide is the opportunity your organization has to gather qualitative comments and feedback about patients’ stay experience.

Improving patient access, boosting morale, finding innovative improvements, changing perceptions, overly communicating and following-up consistently throughout your hospital, system or ACO can largely aid inpatient and employee satisfaction, engagement and perception. Empower your hospital to care for the care-giver and empower staff to think how they can innovatively do the best possible. Reform calls for reform. Have you assessed your readiness?

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**Footnotes:**


Nicole Nicoloff is vice president of market strategy and innovation at BerylHealth, a technology-based patient experience company. Previously, she served as the Network director of exceptional patient experience and family experience at Community Health Network.

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Executive Briefing: Using Outsourcing to Transform HR

Staying Nimble, Saving Money: Considerations for Outsourcing HR

By Heather Punke

Recently, hospitals and health systems have begun to hone in on improving efficiency and reducing costs in order to survive and thrive in the new era of healthcare under reform. One area where many healthcare organizations can stand to make great strides in both improved efficiency and cost reductions is human resources.

Historically, hospitals and health systems have fairly complicated human resource departments, since they have fairly stringent requirements to follow when it comes to human resources. For example, nurses, physicians and staff track their time in different ways, which can be difficult to coordinate, causing inefficiencies. On top of, and partly because of, that unique aspect of healthcare organizations’ human resources, hospitals tend to patch together human resource software services and processes, which also leads to issues.

“Most...healthcare organizations in particular have a lot of technology and service providers that are involved in the delivery of human resource functions,” says Terrence McCrossan, division vice president of ADP Strategy, a provider of business outsourcing solutions. “That creates inefficiency.”

That was precisely the case at Pacific Hospital of Long Beach (Calif.). “We actually had three separate vendors involved with time collection and payroll,” Tia Schiller, the hospital’s vice president of human resources, said in a report. “One handled the time and labor information. Another processed the payroll. Still another printed the checks. It was all very strange, very complicated and extremely error-prone.” Those problems and inefficiencies can be solved by outsourcing.

When it comes to human resources, outsourcing can mean a variety of things. “People picture a surrender of control,” says Mr. McCrossan. “It generally isn’t what organizations get out of a service partner.” In fact, outsourcing can involve as little as relying on a partner for payroll processing and tax filing. In most instances, outsourcing means leveraging technology and infrastructure along with administrative efficiency such as tax filing or garnishment processing. Pacific Hospital of Long Beach ended its human resources madness by outsourcing to a single-source provider, ADP.

Benefits of outsourcing

Outsourcing some or all human resource functions to a single vendor can have a major impact on hospitals’ and health systems’ balance sheets, opportunity costs and future successes.

Saving money. First and foremost, outsourcing human resource duties to an outside vendor can save hospitals and health systems money. Currently, the average hospital or health system spends anywhere from $1,400 to $2,000 annually per employee for in-house administration of payroll, workforce administration, time and attendance and health and welfare benefits, according to a PricewaterhouseCoopers report, The Hidden Reality of Payroll and HR Administration Costs.

The report, published in 2011, shows that organizations have, on average, a human resources total cost of ownership that is 32 percent higher when managing these functions in-house via multiple platforms as compared to those that outsource to a vendor via a common platform. “Leveraging a service provider, when considered in conjunction with technology, overall is the most optimal way to achieve gains,” says Mr. McCrossan.

Opportunity costs. When hospital and health system employees spend time on administrative human resource tasks, they are not able to spend that time on strategic aspects of running and growing a facility. “The more time you spend on administrative tasks, the less time there is for strategic tasks,” explains Mr. McCrossan. “[ADP] look[s] to take as much of the administrative tasks as possible so organizations can focus on the strategic tasks.”

The staff at Pacific Hospital Long Beach found more time on their hands thanks to outsourcing. “Increased automation means less paper,” Ms. Schiller said. “The automation relieves your people of repetitive tasks.”

Staying nimble. Healthcare-regulating legislation is anything but static. Healthcare organizations need to keep up with fluctuating laws, whether it be changing tax rates or general employment law. “Most [organizations] don’t have that expertise in-house,” says Mr. McCrossan. “Leaning on a company that does that full time is a major benefit for these organizations.” By outsourcing human resource functions, hospitals and health systems can adhere to change without using their own time and manpower.

Partnering up

Finding the right vendor to outsource to can seem like a daunting task, especially because there is no outsourcing silver bullet that will work perfectly for every organization. However, there are two traits Mr. McCrossan recommends honing in on when choosing a human resources outsourcing partner.

A sliding service continuum scale. While outsourcing human resources can certainly help most hospitals and health systems, deciding on the right level of outsourcing can be difficult. “Every organization has a mix that is optimal for them in terms of internal risk profile or budget or strategic road map,” says Mr. McCrossan. Therefore, they should partner with an outsourcing company that allows them to slide along the continuum of outsourcing options without locking in to just one option. That way, as the organization grows and evolves, the outsourcing company can grow or evolve with it.

Future-proof technology. Technology and software are constantly changing and updating, so a human resources outsourcing partner should be able to do the same. “Pick a partner that will keep pace with change,” Mr. McCrossan urges. The partner should be able to integrate technology and not corner the hospital or health system into a software model or version that will limit them down the road.

Generally, the right vendor “should allow you to slide on the continuum but also bring breadth and depth of technology that allows you to grow and evolve,” says Mr. McCrossan.

Ms. Schiller appreciated ADP’s ability to adapt to her hospital’s future needs. “Their functionality and scalability are enormous features. We know we can count on those solutions to help us efficiently pay and manage our people, whatever the future might bring.”

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The Shameful State of Our Hospitals

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

I just finished reading the book, “Unaccountable,” and I have got to say, I was blown away. Written by Marty Makary, MD, this is an incredibly powerful indictment of hospitals and the doctors who work in them. It presents a stark portrait of a healthcare system that has clearly lost its way.

It’s a book that should have a great deal of impact, because its author is a surgeon with a sterling reputation. On staff at Johns Hopkins Hospital in Baltimore, Dr. Makary is a dedicated proponent of patient safety and helped develop a widely used patient safety checklist.

For more than a decade, ever since the landmark 1999 “To Err is Human” report from the Institute of Medicine, hospitals have talked a lot about instilling a “culture of safety.” With all the activity that has taken place, it’s a real shock to see that errors rates have not budged for the most part.

The book presents some bleak statistics. One in four hospital patients is the victim of a medical mistake. Thirty to 40 percent of our healthcare dollars pays for fraudulent or unnecessary care. Ten to 15 percent of patients are not given all their options for care. And a surgeon operates on the wrong body part 40 times each year.

A Harvard study published in The New England Journal of Medicine in 2010 found that as many as 25 percent of all patients are harmed by medical mistakes. These mistakes are the fifth leading cause of death in the nation.

A culture of silence

Stubbornly high error rates, Dr. Makary submits, are the result of unbridled arrogance and a lack of transparency in our healthcare system. “Healthcare’s closed-door culture feeds complacency about its problems,” he writes.

In stunning detail, he takes us on a tour of incompetent surgeons, unnecessary surgeries and a culture of silence that punishes staff who speak out about patient safety. Dr. Makary notes that some of America’s most prestigious hospitals have worse patient outcomes than many community hospitals.

We meet a Harvard teaching physician from many years ago called “Dr. Hodad” — not his real name, but one given by his residents, as shorthand for “Hands of Death and Destruction.” Dr. Makary, a medical student at the time, recalls that Dr. Hodad’s operating skills were “hasty and slipshod,” and his patients often had complications, but his bedside manners were impeccable. “Celebrities requested him for operations,” he writes. “His patients worshiped him.”

He believes there are Dr. Hodads at virtually every hospital across the country.

It is not easy to report someone like Dr. Hodad. Had he done so, Dr. Makary believes he would have been ostracized. There was — and still is, to a great extent — a code of silence against reporting physicians’ mistakes. Furthermore, a physician can be excellent at doing one type of procedure and awful at another, but colleagues will cover up for him because of his fame. The book reports that Michael DeBakey, MD, the world-class heart surgeon who died in 2008, was a miserable stomach surgeon. When he performed spleen surgery on the Shah of Iran, Dr. DeBakey mistakenly cut the Shah’s pancreas. The shah’s death from complications of that surgery at the start of the Iranian Revolution changed the course of history.

Fred Flintstone care

The book presents some alarming oversights in hospital ORs, which are especially frightening for those of us intending to have surgery in the near future. Dr. Makary introduces us to “Fred Flintstone care” — outdated medicine performed by older, often highly respected physicians. These grey eminences haven’t kept up with a recent breakthrough like minimally invasive surgery, which is incontestably safer than the old way of open surgery. But because these doctors are so beloved, so well protected and so hungry for more income, their patients will likely never know they had another option.

Dr. Makary tells us of a politician who had a small abdominal tumor and was under the care of the chief of surgery emeritus at his hospital. The surgeon, who had never learned minimally invasive surgery, took out the tumor the old-fashioned way. This no doubt forced the patient to suffer more pain, have a longer hospital and go home with a bigger bill, and all the while face a higher risk of infections and possible follow-up surgery.

Covering up mistakes

Rather than own up to medical errors, hospitals and practices seem to have become more proficient at covering them up. For example, the book says the patient form we fill out in the waiting room increasingly has a “gag order” in it. That is, we agree never to speak about a medical mistake, if one occurs. Dr. Makary thinks gag orders should be banned. “They are utterly contrary to a patient’s right to know and to the concept of learning from our errors,” he writes.

The book also targets misleading quality claims made by some hospitals, which can ensnare unsuspecting patients in nighmarish medical complications. Hospital marketing departments can make even wildly over-the-top claims vague enough to escape violation of truth-in-advertising laws. Dr. Makary recalls a young patient who was treated in a hospital that had designated itself a “Comprehensive Breast Cancer Center,” even though it lacked necessary equipment and skilled surgeons. The result was her reconstructed breast was permanently disfigured.

A lot of quality concerns have to do with greed, such as when hospitals routinely pressure doctors to perform more procedures so they can make more money. Doctors often get bonuses for productivity, but not for quality, the book reports. It’s an “eat what you kill” approach — the more procedures you can churn out, the more you’re paid. One of Dr. Makary’s physician colleagues got a note from his hospital saying: “As we approach the end of the fiscal year, try to do more operations. Your productivity will be used to determine your bonus.” Performance, in this case, was “certainly not based on improved patient outcomes and lower rates of medical errors,” Dr. Makary writes.

Bloated salaries

The book shows that children’s hospitals make a great deal of money pulling the heartstrings of donors, and much of it goes into the pockets of their executives. Some CEOs of children’s hospitals make more than $5 million a year and have perks like their own company cars, first-class travel, country club memberships and retirement packages worth millions, according to the book.

Dr. Makary writes that while the CEO of National Children’s Hospital in Washington, D.C., cut the budget, he increased his own salary to $2.1 million, plus benefits. “This small, 300-hundred-bed hospital was paying its CEO far more than the CEO of our mammoth, 2,000-plus-bed John Hopkins Health System,” he states.

Mind you, these are non-profit institutions that don’t have to pay any taxes and continue to tug at donors’ sleeves for donations. The book points out that the millions earned from these fundraising drives could be used to address mistakes in medications, which disproportionately affect children and
are very expensive to fix. This cache of donations might also go toward raising the salaries of pediatrics caregivers, who are at or near shortage because they are paid relatively little. Pediatricians have a starting salary of around $110,000, compared with $500,000 for orthopedic surgeons, and the average pediatric nurse at one children’s hospital gets 40 to 50 times less than what its CEO gets, the book says. What kind of message does that send out?

The solution is transparency

The best way to tamp down all the greed and improve healthcare outcomes, Dr. Makary maintains, is to end the secrecy at U.S. hospitals. Rather than micromanaging with excessive regulations, the simple act of transparency would revolutionize our whole healthcare system. If hospitals had to prove their claims of superior outcomes with real data, they would have to be more serious about meeting higher standards, and the healthcare system would be well on its way to recovery.

Dr. Makary wants hospitals to keep precise records on a variety of measures, including surgical outcomes, hospital-borne infections, readmission rates, payments to doctors, patient volume for each condition and clinicians’ use of best practices.

The message is simple: When hospitals have to provide solid outcomes data, their performance improves. The book notes that when New York State began requiring hospitals to disclose death rates from coronary artery bypass surgeries, the ones with high mortality rates suddenly felt the pressure to make improvements.

The results of the New York program are remarkable. Statewide deaths from heart surgery fell by 41 percent in the first four years of the program. When leadership at one hospital saw that the mortality rate of a particular surgeon was bringing down its score, he was ordered to stop doing heart surgery. The Dr. Hodads were no longer protected.

Dr. Makary is taking further steps toward transparency in his own practice. He has started asking patients to review the notes he took on them for their office visits. Patients began correcting important data that he had gotten wrong in the interview.

He also recommends what is perhaps the ultimate form of transparency—recording medical procedures on videotape and playing them back for the surgical team to evaluate. He adds that installing cameras at hand-washing stations in North Shore University Hospital on Long Island improved hand-washing compliance by more than 90 percent.

Signs of hope

There are signs of hope that Dr. Makary’s vision could yet become reality. The book says young physicians, medical schools and medical societies seem less willing to protect their poorly performing peers, and some hospitals have even taken a pledge of transparency.

Trust, integrity and forthrightness all go hand in hand, and they should be the basis to revive our great American healthcare system. Transparency “can restore the respect of the public in what many perceive has become a secretive, even arrogant industry,” Dr. Makary writes. “With accountability, medicine can address the cost crisis, deliver safer care, and earn once more the trust of the communities we serve.”

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

Ardent Health Services, a for-profit health system based in Nashville, Tenn., and Amarillo, Texas-based Baptist Community Services finalized their purchase of Baptist St. Anthony’s Health System, also in Amarillo.

St. Louis-based Ascension Health and Los Altos, Calif.-based Daughters of Charity Health System signed a formal affiliation agreement, under which Daughters of Charity’s six hospitals will operate under the largest Catholic health system in the country.

Atlanta Medical Center and South Fulton Medical Center in East Point, Ga., consolidated into one hospital on two campuses.

Aurora Medical Center in Mexico, Mo., entered into exclusive talks with St. Louis-based SSM Health Care for an alignment, which would include SSM Health Care operating and managing Aurora Medical Center.

Care New England Health System in Providence, R.I., and Memorial Hospital of Rhode Island in Pawtucket reached a definitive agreement to establish Memorial Hospital as a partner in the CNE system.

The New York State Department of Health approved the affiliation between Champlain Valley Physicians Hospital Medical Center in Plattsburgh, N.Y., Elizabethtown (N.Y.) Community Hospital and Fletcher Allen Partners in Burlington, Vt.

West Chester, Pa.-based Chester County Hospital and Health System signed a non-binding letter of intent to join the University of Pennsylvania Health System in Philadelphia.

Naperville, Ill.-based Edward Hospital & Health Services and Elmhurst (Ill.) Memorial Healthcare announced plans to merge, which would create one of the larger integrated health systems in the state.

Frederick (Md.) Regional Health System, Meritus Health in Hagerstown, Md., and Western Maryland Health System in Cumberland, Md., signed a memorandum of understanding to enter into strategic discussions for an affiliation.

A new integrated health system was finalized in Minnesota, as HealthPartners in Bloomington, Minn., and Park Nicollet Health Services in St. Louis Park, Minn., completed their merger agreement.

Henry Ford Health System in Detroit and Beaumont Health System in Royal Oak, Mich., formed a Merger Integration Task Force to lead the due diligence and integration process for the merger of the two systems.

Hillsboro (N.D.) Medical Center and Sanford Health, based in both Dakotas, finalized their merger agreement, and Hillsboro Medical Center is now known as Sanford Hillsboro Medical Center.

Holy Cross Hospital joined Sinai Health System, both of which are based in Chicago.

Integris Health announced it is the majority owner of Lakeside Women’s Hospital, both of which are based in Oklahoma City.

Ivinson Memorial Hospital in Laramie, Wyo., is an affiliated hospital of the newly formed University of Colorado Health, based in Aurora.

Jordan Health Systems in Plymouth, Mass., and Boston-based Beth Israel Deaconess Medical Center announced plans for JHSI to become part of BIDMC.

Lake Charles (La.) Memorial Hospital, along with its partner West Calcasieu Cameron Hospital in Sulphur, La., entered into a partnership with W.O. Moss Regional Medical Center in Lake Charles.

Rochester, Minn.-based Mayo Clinic announced that Billings (Mont.) Clinic has been selected to be a member of the Mayo Clinic Care Network.

Mercy Health System of Maine in Portland and Eastern Maine Healthcare Systems in Brewer signed a definitive agreement to form a strategic alignment in which Mercy and all of its units will integrate into EMHS.

A U.S. bankruptcy judge approved Bronx, N.Y.-based Montefiore Medical Center’s bid to acquire New York Westchester Square Medical Center in the Bronx.
Northeast Alabama Regional Medical Center in Anniston, Ala., and Franklin, Tenn.-based Capella Healthcare signed a definitive agreement for RMC to acquire Jacksonville (Ala.) Medical Center from Capella.

Northwest Community Hospital in Arlington Heights, Ill., confirmed that it is exploring affiliation with Berkshire Health Systems in Pittsfield, Mass.

Norwalk (Conn.) Hospital and Western Connecticut Health Network in Danbury signed a final agreement to affiliate.


Prime Healthcare Services in Ontario, Calif., donated Huntington Beach (Calif.) Hospital to its non-profit affiliate Prime Healthcare Foundation, and in a separate transaction, Prime Healthcare Foundation obtained a controlling interest in Knapp Medical Center in Weslaco, Texas.

RegionalCare Hospital Partners, a for-profit hospital operator based in Brentwood, Tenn., and Sierra Vista (Ariz.) Regional Health Center announced the signing of a letter of intent to build a new 100-bed hospital with RegionalCare as the operator.

The Regional Health Network of Kentucky and Southern Indiana, a joint venture of Louisville, Ky.-based Norton Healthcare and Brentwood, Tenn.-based LifePoint Hospitals, finalized its acquisition of Scott Memorial Hospital in Scottsburg, Ind.

Rutherford Regional Health System in Rutherfordton, N.C., and Mission Health System in Asheville, N.C., signed a non-binding memorandum of understanding for RRHS to become a member of Mission Health.

Hartford, Conn.-based Saint Francis Care and St. Louis-based Ascension Health Care Network signed a letter of intent for a potential integration of Saint Francis into Ascension in order to build a statewide healthcare delivery system.

The boards of Shore Health System in Easton, Md., and Chester River Health in Chestertown, Md., agreed to merge their hospitals into a single entity.

Dallas-based Tenet Healthcare announced the formation of a joint venture partnership between its San Ramon (Calif.) Regional Medical Center and John Muir Health in Walnut Creek, Calif.

### Hospital & Health System Executive Moves

Russell Armistead, MBA, was named CEO of Shands Jacksonville (Fla.) Medical Center.

St. Joseph Healthcare in Nashua, N.H., named Richard Boehler, MD, MBA, FACPE, president and CEO.

James Brexler was named president and CEO of Doylestown (Pa.) Hospital.

Pikes Peak Regional Hospital and Surgery Center in Woodland Park, Co., named Terry Buckner CEO.

Norfolk, Va.-based Sentara Health System named Mike Burris, CPA, vice president and CFO of its Blue Ridge Region, which includes RMH Healthcare in Harrisonburg, Va., and Martha Jefferson Hospital in Charlottesville, Va.

Mount Carmel Health System in Columbus, Ohio, named Keith Coleman CFO.

Genesis Health System in Davenport, Iowa, named Wayne Diewald as its first COO.

John Halfen, CEO and CFO of Northern Inyo Hospital in Bishop, Calif., announced plans to retire in July 2014.

Soldiers and Sailors Memorial Hospital in Wellsville, Pa., named Janie Hilfiger president.

Eric Jensen, FACHE, was named CEO of Valley General Hospital in Monroe, Wash.

North Hawaii Community Hospital in Kamuela named Lowell W. Johnson interim CEO.

Cone Health in Greensboro, N.C., named Jeffrey Jones, MBA, CFO.

Via Christi Hospital in Pittsburg (Kan.) named Mike Joy CFO.

Wayne Keathley resigned as president and COO of The Mount Sinai Hospital in New York City, and David Reich, MD, was named interim president.

Ben Kolman, CEO of Lafayette Regional Health Center in Lexington, Mo., became CEO of Lakeview Regional Medical Center in Covington, La.

Isaac Mallah, president and CEO of St. Joseph’s-Baptist Health Care, a Tampa-based, five-hospital system that is part of BayCare Health System, announced plans to retire in April.

Bartow (Fla.) Regional Medical Center named Philip Minden CEO.

Amy Perry was named president of Sinai Hospital in Baltimore and executive vice president of Baltimore-based LifeBridge Health, Sinai’s parent company.

DeKalb Health in Auburn, Ind., named Fred Price, MBA, president and CEO.

Benson (Ariz.) Hospital named Richard Polheber CEO and Ken Gorason CFO.

HighPoint Health System in Gallatin, Tenn., named Kevin Rinks CFO.

George Rohrich resigned as CEO of The Memorial Hospital in Craig, Colo.

Oklahoma City-based Oklahoma University Medical System named Charles L. Spicer, Jr., FACHE, president and CEO.

Paul Steinke, DO, replaced the retired Ed Andersen as president and CEO of CGH Medical Center in Sterling, Ill.

Porterville, Calif.-based Sierra View District Hospital’s board fired CEO Joe Stewart and named Donna Hefner interim CEO.

Michael Ugwuueke, MPH, DHA, FACHE, was named executive vice president and COO of Memphis, Tenn.-based Methodist Le Bonheur Healthcare.

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