Healthcare Reform: One Year Later
By Rachel Fields

On March 21, 2010, the House of Representatives passed President Barack Obama’s sweeping healthcare reform bill, signaling the beginning of a watermark decade for the healthcare industry. In the wake of the bill’s passage, hospitals and health systems are struggling to adapt to a variety of changes including planned Medicare and Medicaid reimbursement cuts, additional requirements and regulations, the beginnings of ACO development and a move from fee-for-service to pay-for-performance for providers nationwide. To mark the anniversary of the passage of reform, four healthcare leaders discuss the state of the healthcare industry one year later.

1. Problem: Too many avoidable patient days.
Suggestions: When Ms. Ubbing brought in an outside group to look at her hospital’s inefficiencies, the group found that the number one opportunity for cost-cutting was in avoidable patient days. Patient days can add up quickly if providers aren’t focused on moving patients to other facilities or their homes.

It is time to accept inevitable changes
Tom Strauss, president and CEO of Summa Health System in Akron, Ohio, says the time for griping about healthcare reform is over. The mostly

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50 Best Hospitals in America
By Leigh Page

Becker's Hospital Review has named the 50 best hospitals in America, which cover a wide spectrum from well-known academic medical centers to less widely recognized community hospitals that have reached greatness. Each of these organizations has put patients’ needs first, driven a variety of innovations and helped to set the bar for high-quality care. Each hospital has an impressive list of achievements and a story to tell. Here are the hospitals, in alphabetical order.

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5 Common Hospital Problems — and Suggestions for How to Fix Them
By Rachel Fields

Talk to hospitals around the country, and you’ll hear about the same problems: crowded halls, provider shortages and sloppy patient hand-offs. Mina Ubbing, president and CEO of Fairfield Medical Center in Lancaster, Ohio, and chair of the board of trustees at the Ohio Hospital Association, discusses five common dilemmas facing U.S. hospitals and some suggestions to combat them that worked for her hospital.

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Publisher’s Letter

We hope you find the content of this March/April issue of *Becker's Hospital Review* valuable. The issue includes several feature articles such as:

1. The 50 Best Hospitals in America — This annual list names the 50 best hospitals in America. The list features a wide range of facilities including small community hospitals and large, world-renowned academic medical centers.

2. Shifting From a Hospital-Based to Community-Based Mindset: Q&A With Valinda Rutledge, CEO of North Carolina’s CaroMont Health

3. Planning for an Uncertain Future: Q&A With Gene Michalski, CEO of Michigan’s Beaumont Hospitals

4. Engaging Physicians With IT From Stephen Ronstrom, CEO of Sacred Heart Hospital, Eau Claire, Wis.

5. Healthcare Reform: One Year Later — This article explores the implementation of and controversy surrounding the Patient Protection and Affordable Care Act one year after its passing. The article explores how hospitals are coping with the new law and features insight from the CEOs of Summa Health System and Scripps Health.

The issue also includes the brochure for the *Becker’s Hospital Review* Annual Meeting. This meeting is May 19th – 20th, 2011 in Chicago and features 53 sessions and 80 speakers discussing key business and legal issues facing chief executive officers and chief financial officers today.

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

Very truly yours,

Scott Becker

P.S. Should you have an interest in receiving more information on the conference or to receive a free E-weekly subscription for *Becker's Hospital Review*, please go to www.BeckersHospitalReview.com, email me at sbecker@mcguirewoods.com or call (800) 417-2035.
Healthcare Reform: One Year Later (continued from page 1)

amicable tone at the State of the Union gave pause to those who still see healthcare reform as a battle between two opposing parties. “The question now is really whether we can work together tomorrow,” he says. “We believe at Summa that this healthcare industry we find ourselves with is seriously flawed and unsustainable.” He says despite the controversies over individual measures, healthcare reform moves the industry in a generally positive direction: away from a system where physicians are only paid to treat sick patients. “[That system] doesn’t lend itself to collaboration, integration or a multidisciplinary approach to care,” he says. “As an example, if we have a good flu season, the hospitals are all full and we all make a lot of money. What’s wrong with that picture?”

Chris Van Gorder, president and CEO of Scripps Health in San Diego, Calif., agrees that healthcare reform is in many ways a representation of an already-existing movement. “Healthcare reform probably didn’t change the direction our organization was going, but it increased the speed of the changes we wanted to put in place,” he says.

“It became a catalyst to align our physicians and our managers under what were radical changes we needed to make in our structure and organization.” For the last 11 years, Scripps Health has been working to change its system from a group of silo hospitals, ambulatory networks and pluralistic medical staff to a system of integrated physicians and hospitals. With extra incentives for integration in place due to healthcare reform, the system has sped up that change, moving from a largely vertical structure to a horizontal structure starting in Oct. 2010. He says he believes the horizontal structure will be essential for implementing “reduction of variation in how we work, reduction of variation in quality and cost and reduction of variation in safety.”

Tort reform will play a larger role in 2011

In a nod to supporters of tort reform in Janu-

ary’s State of the Union, President Obama said he was “willing to look at other ideas to bring down costs, including one that Republicans suggested last year — medical malpractice reform to rein in frivolous lawsuits.” The statement followed the introduction of a tort reform bill on Jan. 24 that would cap noneconomic damages in malpractice cases at $250,000 — similar versions of which have been introduced on a regular basis by House Republicans since 2002 and have repeatedly failed to pass in the Senate. At a Jan. 27 Senate Health, Education Labor and Pensions Committee hearing, Secretary of Health and Human Services Kathleen Sebelius said she plans to outline the parameters of medical malpractice reform.

Mr. Strauss says he expects tort reform to be discussed in greater detail in 2011. “We think [the tort reform bill] is a great first step,” he says. “In the past, those efforts have been stalled in the Senate and President Obama has opposed those caps.” He says the need for tort reform to prevent “frivolous lawsuits that cause doctors to overtreat patients” is even more pressing as the healthcare industry focuses its attention on decreasing costs.

Congressional Democrats have traditionally opposed caps on noneconomic — or “pain and suffering” — damages because they feel they could usurp the power of the jury system. President Obama’s statement on tort reform represents a significant success for Republicans, though the future of noneconomic damages remains to be seen.

Collaboration between systems is essential for ACO development, new payment models

Healthcare reform introduces several methods aimed at “bending the cost curve,” the most relevant of which for hospitals may be the development of accountable care organizations and the bundled payment pilot.

If successful, accountable care organizations will assist in decreasing unnecessary cost by bringing together physicians and hospitals to share responsibility for patient care. The Congressional Budget Office estimates that ACOs could save Medicare at least $4.9 billion through 2019 by giving providers strong incentives to cooperate and save money. According to Mr. Van Gorder, ACOs put the healthcare industry on the right track regarding communication and cooperation between providers. Mr. Van Gorder says a challenge for providers will be helping patients navigate a complex healthcare system with multiple gateways and providers.

“We have started thinking about patient navigators to be the key person a patient can contact to help bridge [the gaps] between physicians and ask questions about the system,” he says. “We have patients who are terminal and who have a difficult time trying to figure out what care they get in the acute setting versus hospital setting versus home setting.” He says while Scripps has not come up with a perfect solution to improve provider-patient communication — a “patient navigator” could help give patients a point of contact when they feel lost.
The Patient Protection and Affordable Care Act is expected to introduce a pilot on payment bundling in Jan. 2013, expanding CMS’ ongoing Acute Care Episodes Demonstration Project. The bundled payment approach reimburses multiple providers with a single sum of money for all services related to an episode of care, such as a hospitalization and a period of post-acute care — rather than the traditional payments for each individual service. If the costs of an episode of care are less than the bundled payment amount, providers can keep the difference, hopefully incentivizing providers to decrease cost by reducing unnecessary procedures. While the current ACE demonstration project covers only acute-care services, the bundled pilot will expand the length of time covered to include pre- and post-acute services, which span three days before and 30 days after an acute-care episode. The pilot will also expand the types of conditions covered by bundled payments; the ACE demonstration covers only certain acute-care episodes related to cardiac and orthopedic surgical services. Experts expect the pilot to include a mix of chronic and acute conditions as well as medical and surgical conditions.

If hospitals are to offer pricing that covers costs for care 30 days after discharge, they must start working immediately with post-acute providers to determine that cost, say Mr. Strauss and Mr. Van Gorder. Mr. Strauss says without standardized practices across different types of facilities — hospitals, nursing homes, rehab facilities and others — patients can undergo expensive and unnecessary procedures that actually decrease quality of care. The expected focus on chronic disease will be important, he says, as chronic disease represents the majority of healthcare spending in the United States.

Everyone in the healthcare industry seems to be talking about ACO development, though the official regulations had yet to be released at the time this article was published. Mr. Strauss says his system defines accountable care as “a group of healthcare providers who come together to define a patient population’s care in coordination with each other and are rewarded for not only improving quality and safety but for controlling the total cost of that population.” Summa Health System launched its ACO in January and has taken steps to evaluate evidence-based models of care to create new reimbursement models for improving quality and decreasing cost. “We have basically 100 people across our system for the last year and a half, working on developing areas of information technology, provider network components, financial models and care delivery models,” he says. “We’re starting with a pilot program around the biggest one, which is congestive heart failure, and we’re kicking off this month to fine tune all the components — hospitals, physicians and insurance, as well as acute home health care — that need to come together to improve the health of that population.”

He says because accountable care is such a large undertaking, health systems have to work together to exchange “best practices” and plans around ACOs. Mr. Strauss recently met with heads of such systems as Geisinger Health System in Danville, Pa., Baystate Health in Springfield, Mass., and University Hospitals in Cleveland, Ohio, to discuss various ACO prototypes. Mina Umbing, president and CEO of Fairfield Medical Center in Lancaster, Ohio, says systems in Ohio are beginning to look at what can be accomplished through ACOs, “not just at the Medicare ACO level, but at the broader idea of what you can do with a network and what alignment you need for services beyond the scope of your own facilities,” she says.

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once appropriate. She says the hospital took several approaches to decrease patient days. They worked with nursing homes and extended care facilities to make sure patients could be transferred on weekends, to avoid keeping a patient in the hospital until Monday when they were ready to be moved on Saturday. The hospital also worked with physicians on length of stay and showed data that demonstrated how each physician stacked up compared to his or her peers.

Ms. Ubbing says the hospital’s nurse leaders also introduced a concept called “full capacity protocol.” A hospital might be at “full capacity” for various reasons: Perhaps so many patients are in isolation that second beds in semi-private rooms are unavailable, or perhaps all the beds in the hospital are actually full. Sometimes a patient waiting for discharge will occupy a bed when there is no medical necessity — simply because it’s easier to stay in the bed than to go home. “What we do is we move the patient awaiting discharge to a hall bed, and we put the sicker patient in the room to begin care there,” she says. “It’s pretty amazing how soon that patient awaiting discharge finds a way home.”

2. Problem: Desire for physician integration but very few employed physicians.  
Solutions: Ms. Ubbing’s hospital employs around 10 percent of its physicians, meaning the vast majority of the facility’s providers are independent. This echoes the traditional model of physician practice, but it can mean hospitals struggle to integrate physicians in order to take advantage of bundled payments. Ms. Ubbing says the hospital may eventually move toward a greater percentage of employed physicians, but for now, she uses co-management of hospital service lines to involve her independent physicians in hospital operations. The hospital first implemented co-management of the orthopedics service line and then moved to the cardiovascular and thoracic service line.

When structuring the co-management of the cardiovascular line, Ms. Ubbing says the hospital brought together diagnostic and interventional cardiologists, thoracic surgeons and radiologists — but also primary care physicians and nephrologists, two groups that might seem out of place. “If you step back and think about it, and look at 30-day readmissions, the care between hospitalizations rests in those [primary care] offices, not in the hospital,” she says. “That’s where primary care comes in, and that’s where nephrology comes in with vascular cases.”

She says the hospital placed its trust in the independent physicians by saying, “If you want to run how clinical care is delivered in our hospital, come on down.” Co-management helps integrate physicians with the system, she says. “Unlike the independent physician, who’s doing his care for his patients the way he wants to, he [now] has the opportunity to be part of an institute where the incentives are for the whole group to perform at the highest level,” she says.

3. Problem: Unhealthy community.  
Solutions: Under the healthcare reform law, FMC is required as a non-profit hospital to perform an annual healthcare needs assessment of its community. “One of our big issues is around healthy lifestyles, and more specifically, obesity and the disease stream it leads to,” she says. Even as the insurance coverage expands, she says community members still have to make the effort to visit a physician and keep themselves healthy. In 2010, the hospital targeted drug and opiate addiction in the community, and in 2011, the hospital plans to target obesity. To fight drug addiction issues, the hospital required every employed physician to register with the Ohio Automated Rx Reporting System, an Ohio database that shows physicians a patient’s prescription drug history. “There are some pretty persuasive stories that show you don’t know what you don’t know,” Ms. Ubbing says. “One surgeon got a referral from a primary care physician for surgery, and when [he looked up the patient in OARRS], he found the patient didn’t have one doctor — he had two. He was getting identical prescriptions from both.” The hospital also dedicated a newsletter to issues around drug abuse and provided copies to anyone who wanted them.

In 2011, the hospital will focus on obesity, a huge problem for many communities in the United States. The community has raised money to sponsor local residents to ride their bicycles at designated events where the courses run from 5-100 miles. Because the hospital is located in a farming area, administration is trying to bring more local, fresh produce to community members and ensure nutritionally balanced meals in the hospital cafeteria. Ms. Ubbing has been amazed by the willingness of community members to participate in these initiatives: “People have come forward and said, ‘I want to be part of this,’” she says.

4. Problem: Poor communication between providers.  
Solutions: Fairfield Medical Center recently added a new role to its facility: clinical nurse leader. “A clinical nurse leader is the first new role in nursing in 40 years, and this is a post-masters trained nurse who is on track like an advanced practice nurse, except their training puts them in the hospital at the bedside,” Ms. Ubbing says. She says the hospital has assigned a clinical nurse leader to micro-units of around 12 beds throughout the hospital, where the CNL acts as a liaison between physicians and patients and mentors other nurses. “[We think] this will reduce length of stay, eliminate some rework and get better information flowing faster for decisions to be made,” she says. By installing a nurse leader to increase communication between providers, she thinks patients will have a better healthcare experience with fewer redundancies, and physicians will have a better understanding of what happens to a patient when another provider takes over.

Solutions: Hospitals across the country are preparing themselves for predicted provider shortages. To offset physician and nurse shortages in southeastern Ohio, Fairfield Medical Center has partnered with Mount Carmel Health System in Columbus, Ohio, to bring a satellite college of nursing campus to the Fairfield facility. “[Mount Carmel] has a college of nursing that rewards a BSN degree, among others, and they ran out of bricks and mortar space. The cost of that is expensive,” Ms. Ubbing says. “They came to us because of the vast majority of their students outside Columbus come from here — Fairfield County.” Together, the hospitals installed a branch campus of Mount Carmel’s nursing school at FMC.

About two miles away from FMC, Ohio University runs a branch campus — Ohio University Lancaster. Ms. Ubbing says the nursing students from Mount Carmel do their first year of classroom work at OU Lancaster and spend the next three years doing clinical work at FMC. “There are up to 24 allowed in the class, and we’re on our third class this year,” she says. “We have the benefit of developing more nurses, and we have a three-year relationship with those nurses [by the time they graduate].” The project benefits everyone: Mount Carmel doesn’t have to build more space, Fairfield County students avoid a 50-mile drive and FMC has the opportunity to “grow their own” nurses.

The hospital has employed a similar tactic to “grow” future physicians. The hospital currently has a family practice residency program and is hoping to build an internal residency program as well.
Planning for an Uncertain Future: Q&A With Gene Michalski, CEO of Michigan’s Beaumont Hospitals

By Rachel Fields

Gene Michalski, the fifth CEO in Michigan’s Beaumont Hospitals’ 55-year history, answers questions on the future of private practice, addressing the provider shortage and his biggest success as a healthcare leader.

Question: The next few years bring a flurry of issues to the healthcare industry. What do you see as hospitals’ top priorities over the next year?

Gene Michalski: We know health reform legislation passed only this year … so we’re barely seven months into this journey; and much of the legislation has yet to be written. We have another political party that is going to assert its political prerogatives in the coming session of Congress. To that extent, much remains uncertain in terms of the details. There’s still a lot of uncertainty on what a successful ACO is going to look like, what stakeholders are involved and what legal and other structures are going to be involved.

With that as a backdrop, let me simply say that I personally feel our organization is centered around two things that we think are important in any scenario we could conceive of. I would call these “no regret strategies.” The first one is to strengthen relationships and collaboration with the various physician stakeholders who are a necessary partner in any structural changes under health reform, regardless of what that health reform structure might look like. Let me give you an illustration. We’re a predominantly private practice hospital, with 80 percent private practitioners and 20 percent employed. We have a couple of physician organizations that are contracting entities that include both of those kinds of physicians. Further, there are non-academic physicians and physicians who are academics and researchers. So it is our belief — my belief — that we need to find a model that will provide a successful opportunity for every one of those physicians, regardless of their private or employed relationship or if they’re primarily a clinician or primarily an academician.

Our other “no regret strategy” is to position ourselves for payment for value, not payment for volume. That is aimed at pay-for-performance. For us, that means we need to continue to strengthen our quality, safety and service formulas … and provide value at an increasingly lower cost. I’ll couch this in two forms of cost: the unit cost, which is the per-case or per-procedure cost for a patient experience, and the number of units of service, which would be how many CT scans I perform, [for example]. If you have appendicitis, am I going to do an ultrasound and then a CAT scan and then a CAT scan with contrast, or will I go straight to the CAT scan with contrast and cut out the middle man?

Q: Many hospitals are struggling with the challenge of providing the best possible quality at the lowest cost. How do you plan to do that?

GM: There’s only one way you can do it effectively. It’s what we call clinical effectiveness, and the only way to do it effectively is provide the information technology platform that will assist the physician in using best evidence-based outcomes and methodology. There’s nobody that can carry that amount of information in their heads.

Q: Where are you currently in the process of implementing that IT platform?

GM: We have invested $100 million in a clinical enterprise platform, the center of which is the Epic suite of products. That’s by no means the only product, and there are a number of other “best of breed” systems plugged into Epic and Oracle that give us the capabilities of doing that. We just completed launching clinical practitioner order entry at all three hospitals and are launching a suite of products in the ambulatory setting that will include allowing the patient to keep a chart.

Q: In your experience, how does IT assist in promoting healthcare quality?

GM: You obviously have to be able to “connect the dots” and “connect the docs.” You have to manage the experience of care over multiple venues of care. You’ve got hospitals that are reimbursed separately from nursing care and from outpatient care, and the challenge is connecting the silos with a system of bridges.

Q: Are there other ways you’re connecting providers, aside from through an EMR?

GM: The other way we’re doing it — and you have to do it in multiple ways — is by remodeling the management of the health system. Instead of managing the system by facility, we’re managing by “center of excellence” or clinical condition. If you manage the organization by hospital, by nursing home, by home care, by outpatient care, then you’re connecting silos and you’re having to manage across silos. You can only do so much with information technology to connect those silos.

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state, value stream mapped the better state and involved the patient in the conversation.

So you organize your clinical experience first, you organize your managerial experience second and then you put an infrastructure in place that supports the clinical and administrative experience.

**Q: Michigan, like many other states, expects a physician shortage over the next several years. What are you doing to prepare for that shortage?**

**GM:** Let me tell you what we’re already doing and what we’re going to enhance. We’re already training some 400 physicians and fellows right now in our graduate medical education programs at our Royal Oak campus and probably a couple dozen family medicine physicians at two other locations. That’s right now.

For undergraduate medical education, we have 600 clerkships right now at our Royal Oak hospital filled with students attending medical schools in the area who are in the pipeline, so to speak. We’re also partnering with Oakland University to launch a new medical school to train undergraduate physicians. We’ve received preliminary accreditation and the new medical school will start its first class of 50 students in August 2011. Over the next several years, we’re going to increase the number of undergraduate medical education students by 150. As physicians age and retire in our community, this is our strategy to provide a replenishment of physicians.

**Q: How do you think those physicians will be distributed throughout areas of need in your state? Is there a way to staff those areas that traditionally suffer from more severe shortages?**

**GM:** Well, I wish we could control where physicians select and choose to practice. It’s often driven by personal talents and skills, influenced by what their passions are and certainly influenced by economics and lifestyle. We can have some influence over that, but of course, usually it’s lifestyle and economics that have a huge impact. I think until the reimbursement systems encourage more primary care and less specialty care, we can only do so much. We have some influence to the extent that we have a balanced approach to training undergraduate physicians. There is a shortage of every kind of specialty in the state of Michigan, but everybody points to primary care. Pragmatically, a shortage in family practice physicians will mean the use of more physician extenders.

**Q: Beaumont Hospitals has 80 percent private practitioners and 20 percent employed physicians. Do you expect that to change or shift toward employment in the future?**

**GM:** I think we have to be flexible. There are a lot of pundits who would say the future of medicine is to employ more doctors. Seventy percent of the hospitals in this country are still primarily private practice, and while a great many folks in ACOs say it’s best done with employed physicians, I hasten to remind everybody that 20 years ago, the same vision was put forth as a solution under capitation. It did not occur.

Sociodemographic conditions have changed, many more women are employed and lifestyles have changed, so the chances of more physicians seeking employment will continue. But we have to remain open to having relationships with every kind of physician.

I was at a private practice physician office, and they said, “We don’t want to be employed. If you came to us with an offer of employment, we wouldn’t be interested. What we are interested in is connectivity, and we want support for that connectivity. We want to be part of your health plan in terms of taking care of your people, and we want to make sure your facilities take good care of our patients when we need facility care.”

**Q: What has been your biggest success at Beaumont Hospitals?**

**GM:** From a technical standpoint, it was probably helping Beaumont build many of the elements of the continuum of care. I helped launch the ambulatory care network and home health services, and we’ve expanded and nurtured the nursing home partnership that has given us skilled nursing facility beds and long-term beds. And of course, the growth of both hospitals and the acquisition of a third [has been a success]. From a technical standpoint, maybe [my biggest success] has been putting the puzzle pieces together regarding the continuum of care under healthcare reform.

What I’m most proud of, though, is staying grounded in keeping focus around the most important thing, and that is to remember why we’re here. We’re here to take care of people. All these other things are just the means to a larger end, and the larger end is to help sick people get well, help well people stay well, and, to the extent that we can, give them a seamless and flawless experience in doing that. That’s what drives me and gives me my passion for handling some of the business challenges we have. It’s really very personal.

I was just up in the hospital visiting a patient, a gentleman who had open heart surgery. He had his family at his bedside, and they’re all going through a tough time right now. To the extent we can help that gentleman and his family get through the surgical process and recovery process and get back to enjoying life, that’s the important part.

**Q: It’s an interesting and challenging time to lead a major hospital. What advice would you give to other healthcare leaders?**

**GM:** My advice would be stay grounded in why we’re here, and that’s to help people. Since I stepped into my role as CEO, I don’t have lunch with any of the business leaders in the organization. I dine with doctors, patients, family members and staff. People can tell you that I go to lunch and grab a tray and introduce myself to any one of those important people and ask if it would be okay if I joined them for lunch. I ask them what their concerns are.
Shifting From a Hospital-Based to Community-Based Mindset: Q&A With Valinda Rutledge, CEO of CaroMont Health

Valinda Rutledge was named CEO of Gaston County, N.C.-based CaroMont Health System, parent of Gaston Memorial, in Aug. 2009, resigning her previous position as CEO of Bon Secours St. Francis Health System in Greenville, S.C., part of the national Bon Secours system. The unusual move, says the former nurse, gave her a greater opportunity to impact the health of an entire community — a goal she has had for her entire career. Here she discusses her achievements at CaroMont, the system's plan for the future and why hospital leaders need to take a community-based approach to health, rather than just a hospital-based one.

Q: Gastonia is a very different community than Greenville and CaroMont a very different health system. What attracted you to your new position?

Valinda Rutledge: A passion of mine throughout my life has been to improve health. I saw an opportunity at CaroMont to create an innovative health system that would improve the overall health of the community. The hospital has had superb quality for many years with clinical outcomes in the top 5-10 percent nationally and Magnet status. The clinicians and physicians are excellent, the board has a strong commitment to the community and there is tremendous community loyalty to the hospital. [Gaston Memorial] is also the only hospital in the county. We are the safety net, so if a patient is discharged and then readmitted, he or she will come right back to us. All of this creates a great foundation and a great opportunity for the hospital to move from hospital-centric to community-centric.

Q: Why is the idea of expanding the boundaries of a hospital’s responsibility for health beyond its own walls so important to you?

VR: Hospitals have to move away from being hospital-centric to being community-centric, and health reform has created a greater impetus for that. Hospitals have to get more involved in the community and better understand its health status. It's not only an issue of health, but also, integral to the economy. On the local level, it's one of the fastest growing expenses for employers, which is especially challenging for small employers. Our county was hard hit in the 1990s by the loss of many textile jobs that used to support many of the residents of the community, and these jobs have since moved to other countries. Overseeing population health and keeping costs down is an important part of supporting the community and its businesses.

Q: What are some of the things you’ve done at CaroMont so far to move toward this idea of improving the health of an entire community?

VR: Almost immediately, I began to implement the “triple aim” goals of better quality, better health for the community and reduced per capita costs. The goal related to community health was new to the system, and we came up with a new mission statement to reflect this new focus: To be a nationally recognized leader and valued partner in promoting individual health and vibrant communities.

One of the first things I did to move us toward meeting these goals was to reorganize the structure [of the health system]. We created a position of executive vice president of operational integration, EVP of clinical integration and a vice president of wellness and VP of chronic disease. I also developed six physician-led councils (organized by service line, including primary care) to examine hospital readmission rates. The councils were unique because they also included community leaders, such as public health department officials and human resource representatives from employers in the area.

The main purpose of the restructuring effort was to create a methodical approach to analyze data on the community’s health and begin to determine ways to improve while reducing costs. In order to impact the health of a community, you must look outside of the hospital.

Q: Analyzing health data and developing evidence-based protocols involves a great deal of physician improvement. Did you have any difficulty getting your hospital’s physicians on board for this type of commitment?

VR: While we employ about 60-65 percent of our physicians, 35 percent are not employed. We have made a commitment to support these doctors within independent practice, and we need them to commit to improving population health as well. Three of the six physician councils are led by non-employed physician chairs. We also recently started a year-long course for physicians on how to analyze disease data, identify trends and become more facilitative leaders. Forty-seven physicians (both employed and independent) voluntarily enrolled in this year-long course.

Q: What are some initial steps hospitals can take to move toward the goal of improving population health and better controlling costs?

VR: First, hospitals have to partner with physicians and get them on board. They are the only ones who can help redesign the processes of care. Hospitals need to provide leadership and educational opportunities for physicians on population health and use data to drive their decisions.

Hospitals should also partner with community agencies, such as the health department and employers. They should be seen as equal partners. Hospitals shouldn’t think they have all the answers. Partnerships should be respectful of the existing knowledge and expertise of these agencies. Also, hospitals need to be part of the solution to fix the economy and not part of the problem. We need to be willing to reduce costs, especially to employers, and we need to do that even if it means taking a financial hit. We should do it because it’s the right thing to do as community leaders.
If the hospital is a large employer in the community, as CaroMont Health is, it can first focus on improving the health status of its own employees. Our CaroMont leadership team now receives incentives for meeting certain benchmarks for employee health. For example, leaders will receive a financial incentive this year if a certain number of employees with chronic disease enroll in a disease management program. Next year the incentive might be to reduce the average blood pressure reading or BMI (Body Mass Index) for our employees by a certain percent.

Hospitals have to focus on chronic disease. Ninety-six percent of Medicare dollars are spent on patients with four or more chronic diseases. The answer to reducing costs comes down to better management of chronic disease, which requires a more integrated system of care.

Q: You have been in healthcare for 30 plus years both on the clinical and administrative side. Given this breadth of experience, what have you found most important to keep in mind for successfully leading a hospital?

VR: Leadership, for me, means providing a vision and always being a dealer in hope. We get so busy in the day-to-day work that we sometimes lose sight of why we're doing what we do. One of my favorite poems, “The Contract” by William Ayot, talks about how leaders are there for people when they have doubts. They give us trust and only ask that we stay true. “Staying true,” for us, means being true to our mission and our community. As leaders, we have to be good stewards of that mission. For a non-profit healthcare system, we have to continue to work on improving the health status of our community, which can only be done by rising up and taking on hard issues.

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In healthcare, we require appointments for test results, even though we could relay them privately over phone or email. We recommend preventive care, but we don't follow up to ensure the appointment is made or arrange transportation help. We limit office hours to be convenient for the provider, not for the people who need care. In general, we put provider needs ahead of those who need our services — something no other industry would dream possible.

By moving toward accountable care, we can change this dynamic. Based on lessons learned from the Accountable Care Implementation Collaborative, the Premier healthcare alliance has developed five steps to putting people first in healthcare.

1. **Involve people in decisions.** First and foremost, providers should not think not in terms of “patients,” but in terms of “people” to keep the focus on the needs of all individuals in the community — whether they have accessed care (“patients”) or are part of a health plan (“beneficiary”). The choice is important. It highlights how ACOs are accountable for the population, including those who have not sought care.

To increase engagement, people should be empowered to understand their options and make informed decisions about their health. A best practice for involving people in care comes from Billings Clinic. At Billings, diabetics are given a scorecard recommending all the measures that must be tracked to keep the condition in check. This scorecard is kept on file at Billings, and provided to the individual so both are accountable. In this way, Billings gives people tools to ask for the care they need, rather relying on providers to tell them what to do.

2. **Improve access.** Without access to care after hours, people seek care from the only available places — emergency departments or other expensive, inconvenient settings. Rather than providing services during the hours providers want to work, we need to provide care 24/7.

This starts with scheduling. Physician practices should consider open access or same-day scheduling to ensure people can be cared for before conditions worsen. These can be group appointments with people who share a chronic condition, or systems that leverage physician assistants and nurse practitioners. Similarly, providers should explore new care technologies, such as those leveraged by Fairview Health Services, which allows people to be diagnosed via phone or Web camera.

3. **Taking responsibility.** Many 40-year-old women get mammogram reminders. But the measure of success shouldn’t be the number of reminders mailed, it’s the number of women who get the test.

One way to make people accountable partners for their health is through personal health records, which contain records as well as care and wellness options. With a PHR, people can access lab test results, prescriptions and care plans, as well as input information on appointments made or weight or blood glucose levels. With a record, people can see what’s been done and track it against their care plan.

Other strategies include insurance benefit design to encourage healthy choices. Health Partners, an insurer, offers lower premiums, co-pays and deductibles for people who participate in wellness programs. Similarly, Marriott offers reduced co-pays for medications treating high blood pressure, diabetes and high cholesterol.

4. **Address individual needs.** Today, providers may not being able to control unhealthy eating habits. But they can expand their influence if they understand individual needs and challenges. People struggling with weight may have challenges that lead them to unhealthy choices, including access to money, healthy foods, safe walking environments, knowledge about healthier lifestyles or even depression. Once the need is known, providers can coordinate and connect people to services that keep them healthy.

But, with so many elements of a people-centered paradigm, it must be personal to target individual needs. A good example is the Health Risk Appraisal from the University of Michigan. This questionnaire provides a health assessment based on lifestyle choices. It recommends behavior changes for each individual’s top three personal health risks based on age, gender and risk level, as well as resources for addressing each.

5. **Measure and improve the experience.** ACOs striving to improve the care experience need to measure opinions and implement processes for improvements.

ACOs should select measures, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or the Patient Activation Measures (PAM), and survey people via mail, online, in person and phone. Once collected, providers should review data, trend results and develop improvement plans. To build trust, results should be publicly disclosed — both positive and negative — with clear plans for improving the experience.

In healthcare today, provider convenience is often put ahead of people seeking care. But, we live in an on-demand world for shopping, banking, entertainment and information, and every other sector of the economy caters to individual needs. It’s time for healthcare — our most personal service — to follow suit.
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4 Points on Exclusivity, Market Power and Transparency in ACOs

By Molly Gamble

Accountable care organization guidelines have yet to be released by the Department of Health and Human Services, Federal Trade Commission and Department of Justice, but many providers are nervous to see how the topics of physician collaborations, exclusivity and transparency will be treated when the waivers and safety zones finally are defined.

In the recent New England Journal of Medicine article “ACOs and the Enforcement of Fraud, Abuse, and Antitrust Laws,” Robert F. Leibenluft, JD, discussed the complications surrounding physician collaboration, exclusivity and transparency in terms of ACOs. Here is an expansion on each of these topics and how they may impact ACO development.

1. Proponents and opponents of exclusivity. Some antitrust enforcers have suggested ACO physician networks be nonexclusive, permitting physicians to participate in other networks or contract with health plans directly. Generally, antitrust enforcers oppose exclusive arrangements because they see them as anti-competitive.

On the other hand, exclusivity may ensure physicians remain engaged in the ACO. It may also help prevent other networks from freeloding, or benefiting from the ACO’s improved care without paying associated costs. Exclusivity would also allow an ACO to have more volume with the same number of providers, helping it pay for the high start-up costs.

2. Physicians, particularly specialists, present challenges to geographic markets. Physician collaboration is another point complicating ACO guidelines. Since there are fewer specialists than primary care physicians, specialists could easily manipulate the market if they align with only one ACO. Also, each separate market must be defined by each specialty, but there are disparities between them. Cardiac surgeons often compete in broader geographic markets than obstetricians, for instance.

3. Shifting focus for federal regulators. Additionally, as more physicians merge practices, seek hospital employment and form networks, antitrust enforcers may focus on whether arrangements result in undue market power. Agencies have done this with hospitals in the past two years, defining markets and the effects of competition, but have had little success since courts defined geographic markets broadly, according to the NEJM report.

4. Transparency on how guidelines are created. The issue of transparency in regards to antitrust enforcement and the analysis of arrangements has not received as much attention as the actual guidelines themselves. However, by sharing how the safe harbors and guidelines were drafted, providers will have more guidance on how to collaborate and abide by antitrust law.

Almost Half of Physicians Don’t Know What an ACO Is

By Lindsey Dunn

At a time when hospitals seek alignment with physicians to build accountable care organizations, 45 percent of physicians in a recent survey indicated they did not know what an ACO is, according to a report by HC-Plexus.

Also in the Thomson Reuters National Physicians Survey, which HC-Plexus conducted, 65 percent predicted the quality of healthcare would deteriorate in the next few years, as ACOs and other provisions of the healthcare reform law got into effect.

Most of the physicians believed reimbursement would become less favorable for them. They also indicated that mid-level providers, who are expected to take on more prominent role due to more patients and a growing physician shortage, are not as well qualified as they are.

Physicians had mixed feelings about electronic medical records but only 24 percent believed EMR would have a negative effect on patient care. Practitioners who cared for patients longitudinally and were less procedure-oriented were more positive about EMRs.

45% of Employers Want ACOs

By Molly Gamble

A recent national employer survey has found more than 45 percent of all and 52 percent of large employers want to develop accountable care organizations, according to a Midwest Business Group on Health news release.

The online survey was conducted by MBGH after midterm elections on the intentions and perspectives of employers concerning the Patient Protection and Affordable Care Act. There were approximately 430 respondents, with 43 percent representing employers with more than 500 employees.

Other key survey findings include:

• Fifty-three percent of all employers and 67 percent of large employers say they do not plan to drop health benefits.
• Nearly 60 percent want to replace the fee-for-service with bundled payments.
• More than half of survey respondents want to continue developing the medical home concept.
• Nearly 60 percent of all employers stated that they will expand wellness programs in light of increased incentives allowed.
• Sixty percent of all employers and 50 percent of large employers believe the intention of health reform is to eliminate the employer-based system and move to a single-payer system.

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we saw a great deal of physician hospital integration activity during 2010. The integration activity centered around practice acquisition and employment, service line management and co-transactions involving surgery centers and other physician-owned facilities and a number of other physician hospital relationships.

1. Hospital-physician alignment efforts. We continue to see a great deal of physician-alignment activity and almost everybody is looking at new and emerging physician-alignment models. There was a large uptick in hospital efforts to acquire practices and employ physicians in 2010. This effort may peak in 2011. There has been a slowdown in development of hospital-physician joint venture ASCs. Hospitals are increasingly looking to acquire a 100 percent interest in ASCs. There is also an increase in national companies trying to buy into hospital-physician joint venture ASCs. It is an interesting time to question whether there has been a cresting of the wave of physician practice acquisitions by hospitals. We have talked to one hospital CEO this week who essentially said, “Look, if I continue to cater to our independent practice acquisitions by hospitals. We have talked to one hospital CEO this week who essentially said, “Look, if I continue to cater to our independent physicians and we do not have to pay the freight of employing the physicians, that is a great place to be.” Based on that mindset, the CEO has pushed the internal team to make extra efforts to treat the independent physicians as well as the employed physicians.

2. Co-management. On the co-management side, we are seeing a lot of activity as hospitals look to align with physicians in ways outside employment. Two key points are as follows:

• Co-management agreements need to be based on fair market value and they need to be truly needed. A high quality valuation firm needs to be able to support the fair market value nature of the agreement and the actual need for the agreement should be documented very closely internally. There is some skepticism that certain agreements are entered into to help tighten relationships or lock in referrals and not because they are truly needed for management purposes. We see some of the co-management deals done as part of an acquisition of a surgery center, and many co-management agreements are entered into independently of transactions to help manage a service line for hospitals such as oncology, orthopedics or cardiovascular.
• These relationships are often fixed, in part, with a variable component as well. It is critical that the variable component not be based on or tied to volume or value of referrals. Finally, there are significant questions as to how to split up the dollars within the groups that are providing co-management services. Much of the dollars are often allocated to actual specific services provided by individuals that are part of the co-management group. Other dollars are often paid and split by the co-management entity as a whole for the overall services being provided. In each situation, the total dollars must not be based on the volume or value of referrals and the dollars allocated to any specific person may not be based on the volume or value of referrals.

3. Increased interest in acquiring ASCs. McGuireWoods and I helped surgery centers complete approximately 8 different transactions in the last quarter of 2010. In the ASC sector, the pricing generally ranged from six to eight times earnings for majority interest transactions with a few outliers. An interesting trend is that half of these transactions involved hospitals acquiring surgery centers and half were national companies acquiring surgery centers. Some of the specifics on pricing of these deals were as follows:

• Multi-specialty center, heavily in-network, hospital purchaser, with no co-management agreement, approximately 8 times EBITDA.
• GI center heavily in-network, hospital purchaser, no co-management agreement, approximately 6 times EBITDA.
• Multi-specialty center, entered into co-management agreement as part of the transaction, some out-of-network, hospital purchaser 5.75 times EBITDA.
• Multi-specialty center, in-network, hospital purchaser, some co-management arrangement, approximately 7 times EBITDA.
• Hospital purchaser, a very high multiple, mostly due to the fact that there was a significant drop in income in 2010 and 2011, was not indicative of continued income, approximately 9 times EBITDA.

Where the hospital is also entering into a co-management agreement with the physicians, there will often be a lower price due to the reduction of the expected earnings in connection with the payments for co-management services. Pricing is higher where there is a strong probability of continued earnings, a strong physician base and the center is heavily in-network.

4. Healthcare economics. Over the last few years, the healthcare economy has not seen significant dollars taken out of the economy. For example, 30-40 percent of the dollars, (i.e., the Medicare dollars) have been relatively stable. Further, the shift in unemployment — which has led to an approximately 2-3 percent increase in unemployment over the last five years — has not meant a complete a shift of 2 to 3 percent from commercial patients to Medicaid or no-pay patients. Rather, a smaller fraction of that has shifted payors and moved to a lower payment situations. The greatest reduction in reimbursement has come from the commercial sector, but it is less the day-to-day reimbursement and more the bigger ticket reimbursement that people are finding in certain situations that is no longer readily available. Thus, the overall amount of dollars being spent in the healthcare sector remains fairly stable. Within that, there are changes in practice patterns and changes in reimbursement that are shifting dollars between sectors. In terms of prognosis, we anticipate that the total number of dollars within healthcare will stay relatively steady over the next 3 to 5 years. There will be, however, continued shifting between sectors.
The Physician Hospital Enterprise: 
Physician Leadership Forges New Alliances 

By B.J. Millar, Director, Physician Practice Management, QHR

Is your organization prepared for this new era of joint accountability and quality improvement? Are you well-positioned to achieve successful hospital-physician alignment?

We are at a critical time in healthcare; issues of payment reform, clinical integration and improved quality are driving significant change in the delivery of care. The most successful healthcare institutions are those that find a way to cooperatively and strategically align the two most critical pieces of the healthcare equation: the hospital and the physician.

The evolving physician/hospital relationship

For most of the 20th century, the physician/hospital relationship was informal, based on medical staff privileges, practice locations and previous referral patterns. It was an implicit relationship that involved no contracts, compensation or employment. In short, it was a relationship that was rarely strategic — and often adversarial. But since the arrival of managed care in the 1990s, that relationship has been dramatically transformed. Today's physician/hospital relationships are often a more formal arrangement based on the hospital's economic and strategic mission, the competitive marketplace and evolving payor relationships.

These explicit relationships now include:

- Employment – both primary care physicians and specialists
- Service contracts – directorships; call coverage for ED physicians, anesthesiologists, etc.
- Equity partnerships – joint ventures where physicians and hospitals share in the cost of imaging centers, surgery centers, etc.
- Strategic alliances – coordinated marketing campaigns and co-branding; centers of excellence

Although there's a sense of partnership in these arrangements, the overall tone is often one of reluctant collaboration.

How healthcare reform changes the relationships

The recently enacted healthcare reform bill in reality is payment reform. The aim is to move reimbursement in the direction of rewarding quality and outcomes instead of volume. The legislation shifts the payment focus from individual productivity to joint accountability. And the reform bill attempts to align incentives across and among the silos of the delivery system.

The old paradigm, in which each primary player acted independently, is disappearing quickly.

The physician/hospital relationship is moving inexorably toward clinical integration, where all providers — physicians, hospitals, post-acute care, pharmacy/drug vendors and therapy facilities — work together in an interdependent fashion so they can:

1. Pool infrastructure and resources
2. Develop, implement and monitor protocols, “best practices,” and other processes
3. Furnish higher quality care in a more efficient manner than can be achieved independently

Source: Leary, Leibenluft, Pozn; Guidance for Clinical Integration, AHA, Washington, D.C.
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The challenge of “split focus”
It’s important to note that we’re moving incrementally from the volume/growth model to the new paradigm that focuses on joint accountability and quality improvement. Most physicians and hospitals are still being compensated for pay-for-service and productivity rather than for improved outcomes and higher quality. It's essential to maintain a “split focus” that keeps a careful eye on volume and growth as we evolve toward clinical integration.

Compensation based on quality improvement
Here’s an example of how the volume/growth model can be adjusted to provide fair compensation for higher quality and improved outcomes:

A large hospital in the Northwest asked some of the leading corporations in the region to identify areas where service could be improved. One company felt it was paying too much for lower back pain treatment. The hospital reviewed its courses of treatment and discovered that patients went through expensive CT/MRI scans and pain management upfront, yet 95 percent of them ended up in physical therapy. So the hospital revised the treatment plan. They screened initially for neurological problems (which accounted for the other 5 percent), then sent the other patients directly to physical therapy. The company reported that employees returned to work much faster and had significantly less pain.

The hospital then asked the insurance company to change the compensation policy, but was flatly denied. That’s when the large corporation got involved to help establish a payment policy that rewards quality and outcomes, not volume.

But keep in mind: this arrangement wouldn’t have been possible without the direct intervention of a Fortune 500 company. Many smaller companies are still tied to the current compensation system.

The physician/hospital enterprise
We often hear the term “enterprise” yet fail to grasp that it’s a word that connotes difficulty, risk and a shared sense of purpose. Here are the four definitions you’ll find in the dictionary:

1. A project or undertaking that is especially difficult, complicated or risky
2. Readiness to engage in daring or difficult action
3. A unit of economic organization or activity
4. A systematic, purposeful activity

The emerging physician/hospital enterprise is the tool that will enable us to achieve clinical integration, but it cannot succeed without strong physician leadership. Doctors are trained to diagnose, and they can help diagnose and solve a wide array of problems — both strategic and financial — if they’re integrally involved in the process. There’s a different playbook for physicians and hospitals, much like those for American football and Australian rules football. That’s why it’s vitally important to get physicians involved in key hospital committees: operations, quality, recruiting, etc. When they’re involved in hospital governance, they develop a thorough understanding of both playbooks.

When physicians and hospitals work as allies, they can create solutions tailor-made for their unique circumstances. This eliminates the stalemates that can arise when a hospital is willing to employ but the physicians aren't interested, and vice versa.

Example 1: When employment makes sense
A group of four hospitals in the Western U.S. was being challenged by a proverbial “800 pound gorilla” — a huge integrated healthcare network employing many physicians. The four-hospital group felt its cardiac services line was in jeopardy, so they reached out to four cardiology groups and two cardiac surgery practices. In the new enterprise, it made sense to employ the cardiac surgeons and align the cardiology practices more closely with the four hospitals. This physician/hospital enterprise has prospered by establishing a center of excellence to share best practices and utilize strategic marketing and co-branding.

Example 2: When contracts make sense
A small, county-owned Critical Access Hospital has a staff of 14 providers. Both the physicians and hospital management agreed that it would be a nightmare trying to recruit and retain medical personnel as county employees. So they came up with a solution that worked for all parties: the physicians formed a corporation and contracted their services to the hospital.

Three generations of physicians
A successful transition to clinical integration depends in large part upon a better understanding of the three generations of physicians:

The “Maverick” has the entrepreneurial, independent mindset of an owner. The Maverick lives to work, is a pillar of the community, and views the hospital as a competitor.

The “Survivor” is the private partner who is reluctant to be either an owner or employee. The Survivor works to earn, shifts risk, and sees the hospital as a resource. Most Survivors simply want to practice medicine successfully until their careers end.

The “Newbie” is from the Millennium generation. Newbies actively seek employment, embrace change and are willing to take risks. Although they lack the experience of Mavericks and Survivors, Newbies have a strong sense of purpose and are lifestyle-focused. Newbies are not interested in working 80-hour weeks, and they’re often willing to take less money if there’s greater fulfillment.

Anyone can be a catalyst
The “Catalyst” is the dynamic profile that will dominate the next decade. These physicians are typically employed partners with a stewardship mindset. Catalysts are change agents who are outcome-focused and believe in sharing risk. They view the hospital as a strategic partner.

The Catalysts will transform the physician/hospital relationship because they’re enterprise-minded, IT savvy and patient-focused. Many are cross-trained in other fields like law or business, so they’re excellent problem-solvers.

Although most Catalysts come from the Newbie category, don’t assume that every Newbie has the operational experience to be an instant change agent. And don’t overlook the Mavericks and Survivors who have the potential to become powerful Catalysts.

How a Maverick became a Catalyst
A cardiac surgery group in a large metropolitan area was acquired by a regional health network to become part of its physician division. One of those surgeons was a classic “Maverick” who had built his own practice from scratch twice.

The regional network decided to add a heart surgery and cardiology program to its southern hospital because of the influx of many retirees. So even though the Maverick surgeon was an employee, the network asked him to help design and build the new program.
Is balancing Physician Alignment Strategy, Readmissions Reduction, ACOs, Reimbursement Reduction, and EHR Implementation keeping you from effectively operating your hospital? QHR consultants can help you successfully respond to the evolving Health Reform challenges.

Go to www.QHR.com/PhysicianHospital to download our white paper "The Physician/Hospital Enterprise: Physician Leadership Forges New Alliances" or call 866-371-4669 to speak to a QHR consultant now.
He immediately got involved with the architects and engineers in the design of the operating suites and recovery rooms. He hired his two former partners, and trained the anesthesiology and perfusion staff. He even worked as a liaison with the cardiology group that came on board.

The heart program became so successful that it’s now getting patients from other nearby cities because surgeons can perform procedures at 50 percent of the cost of Las Vegas facilities.

Clinical integration: Measuring your progress
Here’s a practical checklist for assessing your organization’s readiness to achieve clinical integration.

1. Determine the prevailing business structure of your staff: 
___% What percentage of your staff are in private practice?
___% What percentage are employees of the hospital system?
___% What percentage are contracted hires?

2. What’s the generational composition of your staff?
___% What percentage of your staff are Mavericks?
___% What percentage are Survivors?
___% What percentage are Newbies?
___% What percentage are Catalysts?

3. Who are your physician leaders?
List by name the formal and informal leaders on your staff. How many of them are Catalysts?

4. Are any hospital organizations in your service area gaining strategic advantage by achieving clinical integration/alignment?

5. Which physician leaders on your staff fully understand the benefits of achieving clinical integration — and the consequences of not achieving it?

Seeing physician contracts in a new light
Both Newbies and Catalysts are looking for flexibility and options in physician contracts. That’s why your staff needs a comprehensive approach to contract terms, payment rates and a host of other issues.

QHR consultants have extensive experience in the complex world of physician contracts. We understand not only today’s best practices, but the “red flags” that can alert you to contract problems on the horizon.

Dual focus for success
Here are the keys to keeping your physician/hospital enterprise on a steady path toward clinical integration:

Maintain a split focus — Keep a watchful eye on volume and productivity in the near term while looking for innovative solutions that reward quality and joint accountability.

Know the generational differences and act accordingly — Each group has unique qualities that can make them effective Catalysts.

Identify, recruit and invest in physician leaders, especially Catalysts who understand the importance of moving toward clinical integration.

Empower providers by tracking outcomes so that the enterprise can remain patient-centric.

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- Leslie R. Jebson, Executive Director, University of Florida Orthopedics and Sports Medicine Institute, Program Director, University of Florida Graduate Program in Physician Practice Integration
- Paul R. Summerside, MD FAAEM, FACEP, MMM, Chief Medical Officer, BayCare Clinic
- Andrew Hayek, President & CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee
- Alan Channing, President & Chief Executive Officer, Sinai Health System, Chairman Elect, Illinois Hospital Association

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**PROGRAM SCHEDULE**

**Conference – Thursday, May 19, 2011**

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<tr>
<td>7:00 – 9:00 am</td>
<td>Registration</td>
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<td>9:00 – 12:00 pm</td>
<td>Exhibitor Set-Up</td>
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<tr>
<td>9:00 am – 9:30 am</td>
<td>A - ACO Partnerships - A Case Study</td>
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<td>Bob Edmondson, Vice President, Planning, West Penn Allegheny Health System</td>
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<tr>
<td>9:35 am – 10:20 am</td>
<td>A - Commercial Payors and Health Reform - Manage Payor Efforts to Slow Costs and Drive Favorable Outcomes</td>
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<td>Lawrence Nall, Vice President, Managed Care, Quorum Health Resources, LLC</td>
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<tr>
<td>10:25 am – 10:55 am</td>
<td>A - An Overview of the Leading Investor Owned Hospital Chains, HCA, CHS, Vanguard and More</td>
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<td>Anu Singh, Vice President, Kaufman, Hall &amp; Associates</td>
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<tr>
<td>11:00 am – 11:45 am</td>
<td>A - The Best Ideas for Hospitals Now</td>
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<td>Tom Hearn, Senior Vice President Ambulatory Care, Novant Health, and Barbara Gray, Vice President, Accountable Care Collaboratives, Premier, Inc. Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP</td>
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</tbody>
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**Thursday, May 19, 2011**

**B - Orthopedics, An Overview of the Next Five Years**

John Cherf, MD, MPH, MBA, President, OrthoIndex, Clinical Advisor, Sg2, Orthopedic Surgeon, Chicago Institute of Orthopedics

**B - Achieving Success as an Independent Hospital, A Case Study Approach**

Darin Morgan, Manager, Healthcare Strategy Practice, Kurt Salmon Associates

**C - Replacing Revenue for a Hospital When Developing Ambulatory Businesses**

Robert Zasa, MSHHA, FACMPE, Founder, ASD Management

**Conference – Friday, May 20, 2011**

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<th>Time</th>
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<tr>
<td>7:00 am – 8:00 am</td>
<td>Registration and Continental Breakfast</td>
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<tr>
<td>8:00 am – 5:00 pm</td>
<td>Conference, Including Lunch and Exhibit Hall Breaks</td>
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<tr>
<td>5:00 pm – 6:30 pm</td>
<td>Reception, Cash Raffles, Exhibits</td>
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**Conference – Friday, May 20, 2011**

**C - What’s New, Next and Best in Healthcare Strategy, Marketing and Communications - How to Build Market Share**

Rhoda Weiss, Ph.D., National Healthcare Consultant, Speaker, Author & Editor, Marketing Health Services Magazine

**B - The Evolution of Service Line Co-Management Relationships, What Services, What is Fair Market Value, How to Pay for It**

Scott Safriet, MBA, AVA, Principal, HealthCare Appraisers, and Krist Werling, JD, McGuireWoods LLP

**C - Strategic and Capital Alternatives/Opportunities for Hospitals and Other Providers to Prosper under Healthcare Reform**

Shane Passarelli, Senior Vice President, Healthcare Finance Group, Gary D. Samson, Partner, McGuireWoods LLP and Carsten Beith, Managing Director, Cain Brothers

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**C - ASCs as a Physician Alignment Tool**
Charles “Chuck” Peck, MD, President & CEO, and Christian D. Ellison, Vice President, Health Ventures

11:45 am – 12:30 pm
Networking Luncheon & Exhibits

12:30 pm – 1:15 pm
A - Developing an Outstanding Group Practice, Financial Sustainability, Culture and Other Issues
Joe Golbus, MD, President, NorthShore University HealthSystem, Paul R. Summerside, MD, FACHE, FACP, FACEP, MMM, MD, Chief Medical Officer, BayCare Clinic, Moderated and led by Walter W. Morrissey, MD, Vice President, Kaufman Hall

B - Key Strategies to Maintaining A Great Independent Hospital
Sean M. Fadale MBA, FACHE, Vice President, Business Development, Nicholas H. Noyes Memorial Hospital, Virginia Tyler, M.Div, FACHE, President, Tyler Consulting, Katie Carow, MBA, Principal, Carow Consulting

C - Valuing Practices for Acquisitions - Assessing Acquisition Price and Compensation
Vincent M. Kickirillo, CFA, AVA, Partner, VMG Health, Greg Koonsman, Senior Partner, VMG Health

1:20 pm – 1:50 pm
A - Developing a Sustainable Physician Strategy
Kenneth H. Cohn MD, MBA, FACS, CEO, Healthcare Collaboration

B - Whole Hospital Joint Ventures Between For Profit Hospital Companies and Not For Profit Hospitals
Pete Lawson, Executive Vice President Development, Health Management Associates

C - The Re-emergence of Orthopedic Surgery Employment
Leslie R. Jabson, Executive Director, University of Florida Orthopaedics and Sports Medicine Institute, Program Director, University of Florida Graduate Program in Physician Practice Integration, Mark S. Thomas, Senior Attorney, Dell Graham

1:55 pm – 2:35 pm
A - Using a PHO as the Foundation of an ACO
Eric P. Norwood, FACHE, President & CEO, DeKalb Regional Health System, Inc., Albert Wildstein, MD, Chairman, DPHO, Inc., Susan L. Helton, Executive Director, DeKalb PHO

B - Maximize OR Performance: How to Align Perioperative, Anesthesia, and Surgical Staff to Drive Efficiency in Your Largest Revenue Center
Timothy Dowd, MD, Managing Partner, North American Partners in Anesthesia

C - Physician Employment and Compensation: Develop and Implement Physician Compensation Models That Work
BJ Millar, Director Physician Services, Quorum Health Resources, LLC

2:35 pm – 2:50 pm
Networking Break & Exhibits

2:50 pm – 3:30 pm
A - The 5 Best Ideas for ACOs
Joseph A. Scopelliti, MD, Co-CEO, Medical Affairs for Guthrie Health, President & CEO, Guthrie Clinic

B - Contracting with Hospital-Based Physicians - Direct Contracting vs. Outsourcing
Alan Channing, President and CEO, Sinai Health System, Chairman Elect, Illinois Hospital Association, Lynn Massingale, MD, FACP, Executive Chairman, TeamHealth Moderated by Scott Becker, Partner, McGuireWoods LLP

C - Operational Ideas to Improve Surgical Department Efficiency
Larry Teuber, MD, President, Medical Facilities Corporation

3:35 pm – 4:25 pm
KEYNOTE PANEL - The Best Thoughts on Physician Alignment
Charles S. Lauer, Former Publisher of Modern Healthcare Magazine, Consultant, Speaker, Moderator, Michael D. Israel, President & Chief Executive Officer, Westchester Medical Center, Joseph A. Scopelliti, MD, Co-CEO, Medical Affairs, Guthrie Health, President & CEO, Guthrie Clinic

4:30 pm – 5:15 pm
KEYNOTE - Perspectives on Healthcare Reform
Charles N. Kahn III (“Chip”), President, Federation of American Hospitals

5:15 pm – 7:00 pm
Networking Reception, Cash Raffles and Exhibits

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**Friday, May 20, 2011**

7:00 am – 8:00 am
Registration

8:00 am – 8:55 am
KEYNOTE - The Impact of Healthcare Reform on Payors and The Consequences for Health Systems
Peter R. Kostvedt, MD, FACP, Principal, P.R. Kostvedt Company, LLC, Author, and Senior Health Policy Faculty Member in the Dept. of Health Administration and Policy at George Mason University

9:00 am – 9:35 am
KEYNOTE - An Overview of Washington DC and AHA Priorities
Richard J. (“Rick”) Pollack, Executive Vice President, Advocacy and Public Policy, American Hospital Association

9:40 am – 10:20 am
A - ACOs - A Panel Discussion
Martin Manning, President, Advocate Physician Partners, Brian J. Silverstein, MD, Senior Vice President, The Camden Group, and Eric T. Nielsen, MD, Vice President, The Camden Group Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B - 10 Key Financial Questions for Healthcare Executives
Gary E. Weiss, Chief Financial Officer and Treasurer, NorthShore University HealthSystem

C - Anesthesia Relationships - Current Trends and Issues
Marc E. Koch, MD, President & CEO, Somnia Anesthesia

10:20 am – 10:35 am
Networking Break & Exhibits

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10:35 am – 11:15 am
A - Assessing Healthcare Outcomes; A Roundtable on Industry Trends
Peter R. Kongstvedt, MD, FACP, P.R. Kongstvedt Company, LLC, Andrew Hayek, President and Chief Executive Officer, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee, Moderated by Gordon A. Soderlund, Senior Vice President, Strategic Relationships, The DASCO Companies LLC

B - Roundtable Discussion on Physician-Hospital Joint Ventures
Allan Fine, Senior Vice President, Chief Strategy & Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President of Development & Acquisitions, Ambulatory Surgical Centers of America

11:20 am – 12:00 pm
C - Key Concepts to Combine the Efforts of Great Orthopedic Groups with Hospitals to Achieve Greatness and Profits in Orthopedics
John Phillips, Regional Chief Operating Officer, CHRISTUS St. Michael Health System, and Bob Kahn, Chief Executive Officer, Orthopedic Specialists of Texarkana, PLLC

1:30 pm – 2:10 pm
A - Making Employed-Physician Models Profitable
Gary E. Weiss, Chief Financial Officer and Treasurer, NorthShore University HealthSystem, Andrew D. McDonald, FACHE, Senior Manager, Healthcare Consulting, LBMC Healthcare Team, Moderated by Amber Walsh, JD, Associate, McGuireWoods LLP

2:15 pm – 2:50 pm
A – The Future of Physician-Owned Hospitals Under Health Care Reform
Mike Russell, MD, Texas Joint and Specialty Hospital

2:50 – 3:05 pm
Networking Break and Exhibits

3:05 – 3:40 pm
B – Key Strategic and Tactical Steps to Physician-Hospital Financial Relationships
Scott Becker, JD, CPA, Partner, David J. Pivnick, JD, BBA, Associate, and Lainey Gilmer, JD, MBA, McGuireWoods LLP

3:45 pm – 4:20 pm
A - Physician-Hospital Relationships - 5 Key Concepts on Price and Compensation
Scott Becker, JD, CPA, Partner, David J. Pivnick, JD, BBA, Associate, and Lainey Gilmer, JD, MBA, McGuireWoods LLP

4:25 – 5:00 pm
A - Ten Key Legal Steps for JVs and Physician-Hospital Financial Relationships
Scott Becker, JD, CPA, Partner, McGuireWoods LLP

5:00 pm – 6:30 pm
Networking Reception

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- Keynote panel moderated by Charles S. Lauer, Former Publisher of Modern Healthcare Magazine, Consultant, Speaker, and featuring Michael D. Israel, President & Chief Executive Officer, Westchester Medical Center, Joseph A. Scopelliti, MD, Co-CEO, Medical Affairs, Guthrie Health, President & CEO, Guthrie Clinic
- Keynote presentation by Richard J. (“Rick”) Pollack, Executive Vice President, Advocacy and Public Policy, American Hospital Association

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Editor’s note: This list focuses on acute-care, multispecialty academic medical centers and large community hospitals. This list does not focus on specialty hospitals or smaller community hospitals. To view lists recognizing these hospitals, please look in upcoming issues for our lists of 100 Great Places to Work in Healthcare (appearing in the May/June issue), 50 of the Best Specialty Hospitals, 30 of the Best Community Hospitals, 20 Hospitals With Great Orthopedic Programs, 20 Hospitals With Great Heart Programs and more.

This list is sponsored by Cjeka Search and MED3000.

Advocate Illinois Masonic Medical Center (Chicago)
Illinois Masonic derives its name from members of the Eastern Star freemasons, a fraternal order that bought a hospital in 1921 and raised millions for an ambitious expansion campaign. The 408-licensed bed teaching hospital is now part of Oakbrook, Ill.-based Advocate Health Care. The hospital has more than 880 active physicians representing more than 40 specialties and is one of four Level I Trauma Centers in Chicago. Advocate Health Care has an Aa2 bond rating from Moody’s Investor Services and recently entered talks with M.D. Anderson Cancer Center in Houston about a partnership.

Akron (Ohio) General Hospital
Vincent McCorkle, the new president and CEO of the hospital’s parent, Akron General Health System, is fond of saying, “culture eats strategy.” Rather than mandating changes, he prefers a participatory process, where everyone has a role. In a hotly contested market, not that far from heavy hitters like the Cleveland Clinic, 511-bed Akron General has had to stay nimble. The health system, which includes a community hospital and Partners Physician Group, posted a 1.4 percent positive margin on operating revenue of $553.4 million in 2009, after losing money in 2008. Arriving in July 2010, Mr. McCorkle hired back Alan Papa, a former Akron General executive, as president of the medical center and continued physician recruitment by acquiring a five-cardiologist group.

Barnes-Jewish Hospital (St. Louis)
This huge institution, the largest private employer in the St. Louis area, was formed by the 1996 merger of Barnes Hospital, founded in 1914, and the Jewish Hospital of St. Louis, founded in 1902. With 1,258 beds, it is the largest in Missouri. It is the teaching hospital for Washington University School of Medicine. Barnes-Jewish is part of BJC Health System, which has an Aa2 bond rating with Moody’s Investor Services. The old Barnes Hospital was one of the first to treat diabetic patients with insulin and the first to install an electronic data processing system in a hospital.

Beaumont Hospital (Royal Oak, Mich.)
In Oct. 2010, the hospital opened a new cardiovascular center, which is offering “7 tests for $70,” screenings for people at risk of heart disease. This 1,061-bed hospital, the flagship of three-hospital Beaumont Hospitals, operates highly regarded interventional cardiology and community clinical oncology programs. It is a leading center for treating liver disease, hepatitis, ulcers and related disorders and for conducting research in incontinence and interstitial cystitis. The inaugural class of the new Oakland University William Beaumont School of Medicine will begin instruction in Aug. 2011.

Brigham and Women’s Hospital (Boston)
The Brigham, as it is affectionately called, is a teaching affiliate of Harvard Medical School and cofounder, with Massachusetts General Hospital, of Partners HealthCare, which has an Aa2 bond rating from Moody’s Investor Services.
bond rating from Moody’s Investor Services. Its Boston Hospital for Women, with 750 beds, is a leader in women’s health services. It is a top recipient of research grants from the National Institutes of Health with an annual research budget of more than $537 million. In addition to other awards, it won the NQF National Quality Healthcare Award in 2009.

Cedars-Sinai Medical Center (Los Angeles)
Cedars-Sinai Medical Group and Cedars-Sinai Health Associates was one of the top 10 physician groups in Southern California listed by Integrated Health Care Associates. The hospital has 10,000 employees and more than 2,000 physicians in almost every specialty. More than 350 residents and fellows participate in more than 60 programs. Last year, Cedars-Sinai opened a 30-bed inpatient unit to provide advanced heart failure patients using an intensive, multi-disciplinary approach.

Central DuPage Hospital (Winfield, Ill.)
The hospital, located in the growing western suburbs of Chicago, boasts the second busiest surgical center in the state. Opening in 1964 with 113 beds, it now has 361 beds. It operates a physicians group with more than 50 physicians at 17 locations at last count. In Dec. 2010, the hospital signed a definitive agreement to merge with 159-bed Delnor Health System in nearby Geneva, Ill., pending regulatory review. Previously, Central DuPage signed an affiliation agreement with Cleveland Clinic’s cardiac surgery program to improve heart care and refer complex cases to Cleveland Clinic.

The Christ Hospital (Cincinnati, Ohio)
With a staff of more than 1,000 physicians, this 555-bed hospital boasts major services lines in cardiovascular care, spine treatment, women’s health, major surgery, cancer, behavioral medicine, orthopedics, emergency care and kidney transplants. The Carl and Edyth Lindner Center for Research and Education at The Christ Hospital has participated in more than 1,000 clinical research trials, including 130 active trials. Among other distinctions, the hospital was the 2010 Top Workplace in Greater Cincinnati and Northern Kentucky by Cincinnati.com.

Christiana Care Health System (Wilmington, Del.)
Christiana Care is a teaching hospital with two campuses, more than 1,100 beds and more than 240 residents and fellows. The system has launched two health IT initiatives on meaningful use standards, utilizing its computerized provider order entry system and the nation’s first statewide health information network. It has an AA3 bond rating with Moody’s Investor Services. In addition to other recognitions, Christiana Care received a three-star rating from the Society of Thoracic Surgeons in 2009 and the Ernest A. Codman Award from the Joint Commission in 2007.

Cleveland Clinic (Cleveland)
The Cleveland Clinic is always on the move. In recent months, it signed an affiliation agreement with Central DuPage Hospital, announced it would help a group of physicians in the Washington, D.C., area turn their ideas into marketable inventions, began planning a Medical Mart in Cleveland and completed a $163 million expansion of its Hillcrest Hospital in Mayfield Heights, Ohio, ahead of schedule and under budget. This year, the clinic plans to launch the Center for Personalized Healthcare, which will create tools to help physicians develop care plans based on the individual characteristics of each patient.

Duke University Medical Center (Durham, N.C.)
With 924 licensed beds, this academic medical center has more than 10,000 full-time employees, of which about 15 percent have a medical or doctoral degree, or both. It is part of three-hospital Duke University Health System, which has an AA2 bond rating from Moody’s Investor Services. In Dec. 2010, the hospital began an $800 million expansion project, including a cancer center and a new hospital tower adding 20 percent more beds. Recently Duke initiated a community care model to reduce unnecessary ED visits in partnership with a local federally qualified health center.

Evaston (Ill.) Hospital
Evaston Hospital is the flagship of four-hospital NorthShore University HealthSystem, which has an AA2 bond rating from Moody’s Investor Services and annual revenue of more than $1.5 billion. With 775 beds and a staff of nearly 9,000, the hospital boasts a cancer center, cardiovascular care center and medical genetics program. “We stress the fact that we are a system of care, not just one place of care,” said NorthShore President & CEO Mark R. Neaman. NorthShore was an early adopter of electronic medical records in 2003. Formerly known as Evanston Northwestern Healthcare, the system changed its name when it switched affiliation from Northwestern University to the University of Chicago Pritzker School of Medicine. One of NorthShore Medical Group’s most recent acquisitions is 12-physician North Shore Cardiologists.

Hackensack (N.J.) University Medical Center
The medical center campus boasts one of the largest ambulatory facilities in the country, housed in a nine-story, 276,000-square-foot tower. This 775-bed teaching and research hospital is affiliated with the University of Medicine and Dentistry of New Jersey-New Jersey Medical School. It is the largest healthcare provider in the state, both in inpatient and outpatient services. In Jan. 2011, it opened a $130 million cancer center and a $25 million cardiac and vascular “hospital within a hospital.” It also formed an affiliation with 111-bed Hackettstown (N.J.) Regional Medical Center to provide expertise there and send Hackettstown’s more complex medical cases to Hackensack.

Hamot Medical Center (Erie, Pa.)
In Jan. 2011, the board of Hamot Health Foundation, the hospital’s parent, voted to integrate into the University of Pittsburgh Medical Center. As part of the deal, UPMC has agreed to give Hamot $300 million to support expansion and improvements of medical services. The hospital has 417 physicians on staff, 3,159 employees and 375 beds. In addition to other awards, the American Heart Association and American Stroke Association honored Hamot with their “Get With The Guidelines” Stroke Gold Plus Performance Achievement Award and Highmark Blue Cross Blue Shield named it a Blue Distinction Center for cardiac care, bariatric surgery, and knee and hip replacement.

Henrico Doctors’ Hospital (Richmond, Va.)
This 340-bed hospital, part of the HCA Virginia Health System, derives its name from Henricus, an early settlement massacred by Powhatan Indians in 1622, then rebuilt nearby as Virginia’s new capital. The hospital was called Henrico Doctors’ Hospital-Forest until Feb. 2009, when the name was simplified. The opening of a cardiac medical intensive care unit and a new ED in Jan. 2011 is the latest phase of its five-year, $100 million renovation. An intra-operative MRI suite opened in April 2010 and the hospital will open a new lobby, a pre-admission testing area, a laboratory and a satellite pharmacy in fall 2011. The hospital was the first in central Virginia to receive patient data via Wi-Fi. Among many distinctions, the hospital received the outstanding achievement award from the American College of Surgeons Commission on Cancer, an award given to less than 20 percent of all cancer centers.

Hospital of the University of Pennsylvania (Philadelphia)
The hospital recently announced plans to begin a hand transplant program limited to people who have lost both hands. It is the flagship of Penn Medicine, which includes University of Pennsylvania School of Medicine, two other large hospitals, primary care and specialty groups, and affiliations with 11 community hospitals. Penn Medicine has nearly 2,100 physicians on staff (including more than 1,800 full-time faculty), more than 1,000 residents and fellows and 18,000 employees. In addition to other recognitions, the hospital won the 2010 Delaware Valley Patient Safety Award.

Inova Fairfax Hospital ( Falls Church, Va.)
With 904 beds, Inova Fairfax Hospital is the largest hospital in Northern Virginia and the biggest hospital in greater Washington D.C., based on revenue. It is part of Inova Health System, which has had an AA2 bond rating from Moody’s Investor Services. Inova is partnering with Virginia Commonwealth University to create VCU School of Medicine Inova Campus. In Dec. 2010, the system announced plans to add up to 250 primary care physicians to its medical group, more than doubling its size. In addition to other distinctions, it received a three-star cardiac ranking by the Society for Thoracic Surgeons.
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Jersey Shore University Medical Center (Neptune, N.J.)
This institution started in 1904 as a 50-bed convalescent home for women and children. It is now a 502-bed academic medical center affiliated with Robert Wood Johnson Medical School. Jersey Shore is part of Meridian Health, a five-hospital system that completed a merger with Bayshore Community Hospital and Health Services in Holmdel, N.J., in Sept. 2010. A $300 million expansion project at the medical center, completed in 2009, added 136 beds, a new ED and trauma center, surgical suites and an expanded outpatient pavilion. The medical center has been a winner of the John M. Eisenberg Award for Patient Safety from the National Quality Forum.

Johns Hopkins Hospital (Baltimore)
The 1,025-bed facility is in the middle of a $1 billion redevelopment, scheduled to open in 2012, that will feature 560 private rooms, 33 new ORs and a large ED. It is part of Johns Hopkins Health System, which grew from two to six hospitals in just three years. “We did not go out searching for hospitals,” said Edward D. Miller, CEO of Johns Hopkins Medicine, who oversees the system. These hospitals sought out Johns Hopkins. The system’s flagship has a venerable history, having practically invented the concept of the teaching hospital and coining such terms as “residents,” “rounds” and “house staff.”

Lehigh Valley Hospital (Allentown, Pa.)
Part of two-hospital Lehigh Valley Health Network, this 514-bed hospital is a clinical campus of Penn State University College of Medicine and has 1,100 physicians on staff, including 400 employed by the health network. In addition to other recognitions, the hospital won the 2010 Quality Leadership Award from the University HealthSystem Consortium. It operates the third-largest heart surgery program and the fourth-largest cancer program in the state.

Massachusetts General Hospital (Boston)
The third-oldest hospital in the nation, Mass General is celebrating its bicentennial this year. This summer it will open a $579 million, 10-story expansion project at the medical center, completed in 2009, added 136 beds, a new ED and trauma center, surgical suites and an expanded outpatient pavilion. The medical center has been a winner of the John M. Eisenberg Award for Patient Safety from the National Quality Forum.

New York-Presbyterian Hospital of Columbia and Cornell (New York City)
This huge hospital is made up of two institutions: NewYork-Presbyterian Hospital/Columbia University Medical Center and NewYork-Presbyterian Hospital/Weill Cornell Medical Center. It is affiliated with Columbia University College of Physicians and Surgeons and Weill Cornell Medical College. Two of its physician-scientists, Mehmet Oz, MD, and Nicholas Schiff, MD, ranked in Time Magazine’s annual list of the top 100 most influential people in the world.

Northeast Regional Medical Center (Kirksville, Mo.)
Northeast Regional, part of Franklin, Tenn.-based Community Health Systems, is closely affiliated with Kirksville College of Osteopathic Medicine, the birthplace of osteopathy, where osteopathic-founding Andrew Taylor Still’s original office is on display. With 115 beds, it has with more than 130 physicians on staff in 26 specialties and sub-specialties, and 123 full-time registered nurses. It logs 4,243 admissions, 1,390 inpatient surgeries and 77,764 outpatient visits a year. Among its distinctions, Northeast Regional is the only Missouri hospital to be named an Everest winner by Thomson Reuters and won the Quality Respiratory Care Recognition award in 2010.

Northwestern Memorial Hospital (Chicago)
A new 897-bed facility for Northwestern Memorial opened in 1999, located in two towers in Chicago’s posh Streeterville neighborhood. Northwestern Memorial has a medical staff of more than 1,500 physicians who are faculty at Feinberg School of Medicine at Northwestern University. The hospital has an AA2 bond rating from Moody’s Investor Services. Northwestern’s parent, Northwestern Memorial HealthCare, opened the $500 million Prentice Women’s Hospital near Northwestern Memorial in 2007. In 2010 NMH acquired 215-bed Lake Forest (Ill.) Hospital and outpatient center in Grayslake, Ill.

Ochsner Medical Center (New Orleans)
With 473 beds, the medical center is the offspring of the fabled Ochsner Clinic, founded by surgeon Alton Ochsner in the 1942. It is the flagship of Ochsner Health System, which owns eight hospitals after purchasing 165-bed NorthShore Regional Medical Center in slidell, La., in April 2010. To reduce crowding, the medical center’s ED created a protocol called QTrack separating out the sickest patients and speeding up care for the others. Ochsner is one of the largest non-university based physician training centers in the nation, with more than 200 medical residents and more than 300 medical residents from affiliated programs. Among many distinctions, it won the Emergency Medicine Excellence Award and Kidney Transplant Excellence Award from HealthGrades in 2010.

Ohio State University Medical Center (Columbus, Ohio)
This 900-bed academic medical center is on a growth track. It won a $100 million federal construction grant in Dec. 2010 to add advanced radiation therapy for its new cancer center, boosting the budget for its planned expansion to $1.1 billion. A $649 million, 420-bed critical care and cancer hospital is expected to open in 2014. OSU Medical Center will spend $102 million on an electronic health record system over the next five years and its physicians and hospitals expect to win back $25 million in federal payments for meeting meaningful use standards for EHRs. The medical center’s signature programs are in cancer, critical care, heart, imaging, neurosciences and transplantation. The medical center also operates Ohio State University Hospital East, which it purchased in 1999.

Poudre Valley Hospital (Fort Collins, Colo.)
This 241-bed hospital, the only one in Fort Collins, specializes in orthopedic surgery, neurosurgery, cancer, bariatric weight-loss surgery, and women and family services. In 2008 its parent, two-hospital Poudre Valley Health System, which, among other distinctions, won the Baldrige Award, recognizing a handful of organizations across industries for performance excellence each year. In June 2010, the system announced it is partnering with Longmont (Colo.) United Hospital on a medical facility in Frederick, Colo. The hospital has received an American Nurses Association teaching hospital award for outstanding nursing quality three times in a row.

Presbyterian Hospital (Charlotte, N.C.)
This 531-bed hospital heads the Presbyterian Healthcare group, which operates two nearby community hospitals and is planning a third one. In turn, Presbyterian Healthcare is part of Novant Health, which operates a dozen hospitals
with more than 3,000 beds. The Novant Medical Group consists of almost 1,100 physicians in 359 clinic locations seeing 3.9 million patients a year. Novant also operates outpatient surgery centers and 100 outpatient diagnostic imaging centers through its MedQuest subsidiary. Among other distinctions, Novant twice won the Ernest A. Codman Award from the Joint Commission for improving system-wide quality and safety.

Providence Hospital and Medical Center (Southfield, Mich.)
This 365-bed hospital is part of St. John Providence Health System and is home to 20,000 employees, 3,200 physicians, 175 medical offices and 10 hospitals in six counties. The system is part of Ascension Health, a Catholic organization that is the largest non-profit health system in the nation. Providence Hospital has more than 3,400 staff members, 1,500 physicians and about 150 residents in 19 residency programs. After more than 100 years in Detroit, the hospital moved to the suburbs in 1965. A few years ago, it opened a sister hospital, 200-bed, patient-friendly Providence Park Hospital in a 200-acre wooded campus in Novi, Mich.

Providence Regional Medical Center (Everett, Wash.)
Providence Regional is the third-largest hospital in Washington, with two campuses. It is currently building a $500 million, 368-bed tower, which will double capacity. In 2008, the medical center decided to grow Providence Physician Group to about 100 members over the next three years. To reach this goal, it has increased physicians’ involvement in decision-making, such as giving them half the membership in a committee establishing priorities for its capital plan. The 268-bed hospital runs the largest musculoskeletal program in northwest Washington. It is part of Providence Health & Services, one of the nation’s largest Catholic healthcare organizations, which has been adding hospitals and physician practices and becoming more integrated. Providence Health System has an Aa2 bond rating from Moody's Investor Services.

Rex Hospital (Raleigh, N.C.)
Part of UNC Healthcare, Rex has 4,600 employees, more than 1,100 physicians on staff, and 665 beds and treats nearly 34,000 inpatients each year. Rex Physicians, its group of employed physicians, works closely with UNC Physicians & Associates and UNC Healthcare on managed care contracts. In July 2010, state regulators approved Rex's certificate of need application to build a $60 million cancer hospital that will open in 2014. In addition to other distinctions, it received the Five Star Performer Award from Professional Research Consultants for Best Overall Quality of Care in 2010, for the third consecutive year.

Ronald Reagan UCLA Medical Center (Los Angeles)
This 520-bed medical center was totally rebuilt to conform to the latest California seismic safety requirements and reopened in 2008. In Sept. 2010, the Integrated Healthcare Association rated the affiliated UCLA Medical Group, with more than 1,000 physicians and 72 ambulatory practice sites, as one of California’s top medical groups, meaning it had one of the highest overall performance in 2009 based on statewide pay-for-performance program measures. In addition to other distinctions, the medical center won the AHA Award for Heart Failure Care in Dec. 2010.

Rush University Medical Center (Chicago)
Rush, with 676 beds, operates its own medical school and is currently building a $617 million, 14-story acute and critical care tower, which will bring its total bed count to 720 when it opens in 2012. In 2009, the hospital and its affiliated orthopedic surgery group opened a five-story, $75 million orthopedic building. Under a federal grant for medical tourism, Rush is working with University HealthSystem Consortium to identify strategies to attract more foreign residents to seek care in the United States. Among Rush’s many awards, the hospital’s comprehensive stroke program won the Gold Performance Achievement Award.
Are Your OR Expenses Putting Your Hospital Under Water?

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Saint Alexius Medical Center
(Bismarck, N.D.)
Founded in a hotel in downtown Bismarck by an order of Roman Catholic nuns in 1885, Saint Alexius treated both President Teddy Roosevelt and the son of the Sioux chief Sitting Bull. Since then, the medical center has grown to serve a vast region including central and western North Dakota, northern South Dakota and eastern Montana. It has 2,379 employees, including 100 physicians and mid-level providers. In addition to its 306-bed medical center, St. Alexius owns and operates two hospitals and several primary care clinics in North Dakota and manages a hospital in South Dakota. The medical center is sponsored by the Sisters of St. Benedict of the Annunciation Monastery.

St. Luke’s Episcopal Hospital (Houston)
St. Luke’s operates within the famed Texas Medical Center and is affiliated with prestigious Texas Heart Institute. It is the 948-bed flagship of five-hospital St. Luke’s Episcopal Health System, operated by the Episcopal Diocese of Texas. Almost two-thirds of more than 600 physicians on the hospital’s active medical staff have teaching appointments at Baylor College of Medicine or the University of Texas Medical School at Houston. In 2002, the system acquired the Kelsey-Seybold physician group. In Nov. 2010, it acquired 51 percent of 61-bed Patients Medical Center, a physician-owned hospital in South Pasadena, Texas. In addition to other recognitions, Modern Maturity Magazine named St. Luke’s Episcopal one of the 50 Top Hospitals in the U.S.

Saint Thomas Hospital (Nashville, Tenn.)
The hospital, with 541 beds, is part of four-hospital Saint Thomas Health Services, a member of Ascension Health, a Roman Catholic organization that is the largest not-for-profit health system in the nation. In 2010, Saint Thomas Health Services announced plans to double the number of outpatient rehabilitation clinics it operates in the next 18 months. In 2009, it announced an expansion of its neurosciences division. The hospital has 1,800 employees and 750 physicians on staff. Among many distinctions, the hospital won the American Stroke Association’s “Get With The Guidelines” Stroke Performance Achievement Award in 2009.

St. Vincent Indianapolis Hospital
(Indianapolis)
This 747-bed quaternary-care hospital is part of St.Vincent Health, one of the largest employers in the state, with more than 11,500 employees and 2,500 physicians. In 2010, the Care Group, the largest cardiology practice in the nation, with 135 physicians, joined St. Vincent Health. The system also owns three tertiary-care hospitals, seven critical access hospitals, seven specialty hospitals, several joint-venture partners and clinical affiliates. In Nov. 2009, it acquired minority ownership in Indiana Orthopedic Hospital from OrthoIndy, a physician-owned company. St.Vincent Health has been working with orthopedic surgeons to create a management company providing orthopedic services to hospitals across Indiana.

Sanford USD Medical Center
(Sioux Falls, S.D.)
With 545 licensed beds, the hospital is the flagship of Sanford Health, the largest employer in the Dakotas, with 30 hospitals and a network of clinics serving five states. It changed its name from Sioux Valley Hospitals & Health System in 2007 upon receiving $400 million gift from businessman T. Denny Sanford. In 2010, Sanford recruited 75 physicians, announced plans to acquire an 80-bed hospital in Minnesota, build...
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a new clinic in North Dakota and open two new hospitals in Minnesota and North Dakota. Among other distinctions, the medical center received national recognition for hip and knee replacement excellence from the Blue Cross and Blue Shield Association in 2010.

**Spectrum Health Butterworth Hospital (Grand Rapids, Mich.)**
The hospital dates back to 1846, when the Female Union Charitable Association was formed to ease the human suffering in the small frontier village of Grand Rapids. The primary care offices of Spectrum Health Medical Group have been designated patient-centered medical homes by Blue Cross Blue Shield of Michigan. Spectrum Health, the hospital’s parent, is the largest not-for-profit health care system in West Michigan, with nine hospitals, more than 170 service sites and 1,881 licensed beds. Spectrum is the 9th most integrated health system, according to U.S. News & World Report. It is one of only 38 health systems in the nation with an AA3 rating by Moody’s Investors Service.

**UCSF Medical Center (San Francisco)**
The medical center, the first in the University of California system, was founded a year after the devastating 1906 earthquake and fire in San Francisco, which exposed the lack of healthcare services for the city. Affiliated with the University of California at San Francisco, the medical center has 600 beds, 7,000 employees and outreach clinics throughout Northern California. It includes UCSF Medical Center at Parnassus, UCSF Medical Center at Mount Zion and a planned 289-bed, $1.5 billion medical center in the Mission Bay district near downtown San Francisco, scheduled to open in 2014.

**The University of Chicago Medical Center (Chicago)**
Michelle Obama, who headed the medical center’s community and external affairs department for seven years, helped found an ongoing collaborative to create medical homes for people on Chicago’s South Side. The medical center has 332 beds, more than 9,500 employees, more than 700 attending physicians, nearly 900 residents and fellows and more than 1,500 nurses. University of Chicago Medical Center has an AA3 bond rating with Moody’s Investor Services. Affiliated with the University of Chicago Pritzker School of Medicine, it is staffed by more than 700 physicians from the University of Chicago Physicians Group.

**University of Iowa Hospitals and Clinics (Iowa City)**
This institution traces its roots back to 1873, when the University of Iowa’s medical department signed an agreement with the Sisters of Mercy to operate a small hospital in the community. Today, it is a 762-bed institution that also includes University of Iowa Physicians, the state’s largest multi-specialty medical group, with more than 650 physicians in 19 clinical departments. The hospital also employs 720 resident and fellow physicians and dentists, 1,671 nurses and nearly 5,000 other professional and support staff. The organization announced last year it was hiring 142 more nurses, citing an increase of in its daily inpatient count from about 50-70. It has an AA2 bond rating from Moody’s Investor Services.

**University Medical Center (Tucson, Ariz.)**
Besides saving the life of critically injured U.S. Rep. Gabrielle Giffords (D-Ariz.) following a senseless shooting on Jan. 8, University Medical Center has been very busy in the past year. In 2010, the hospital opened 116-bed Diamond Children’s Medical Center, a partnership with the University of Arizona Steele Children’s Research Center, merged with the physician practice of the University of Arizona College of Medicine and replaced Greg Pivrotto, who had been CEO for 21 years, with Kevin Burns, the former CFO. This year, the 487-bed hospital, on the campus of the Arizona Health Sciences Center, plans to complete its merger with University Physicians Hospital and the University of Arizona College of Medicine to form UA HealthCare.

**University of Michigan Hospitals and Health Centers (Ann Arbor, Mich.)**
Physicians in UMHS saved $15 million in the first four years of the Medicare Physician Group Practice Demonstration Project, the precursor to ACOs, mainly by focusing on transitions of patients coming in and out of hospital. With 930 beds, 179 ICU beds, and 66 ORs, UMHS generates 44,683 total surgical cases a year. Moody’s Investor Services gave University of Michigan Hospitals an AA2 bond rating. Among many distinctions, the HHS Hospital Compare Report gave UMHS high marks in care in heart attack, heart failure, pneumonia and surgical infection prevention.

**University of Pittsburgh Medical Center Presbyterian (Pittsburgh)**
Presbyterian Hospital, founded in 1893, took over a small medical school in 1908 and renamed it the University of Pittsburgh. Today, this 1,602-bed hospital is a leading center for organ transplantation, cardiology and cardiothoracic surgery, critical care medicine, trauma services, neurosurgery and cancer. The hospital is the flagship of UPMC, with 20 hospitals, 400 outpatient sites and physicians’ offices and an insurance plan. UPMC had a $77 million increase in operating revenues in summer 2010. Overseas, the system operates in Italy, Ireland and Qatar, and plans to enter China. UPMC recently announced plans to integrate 375-bed Hamot Medical Center in Erie, Pa.

**UW Medical Center (Seattle)**
The medical center is the flagship of UW Medicine, which owns or operates three hospitals and is affiliated with the University of Washington School of Medicine. Its parent, UW Medicine, also operates Harborview Medical Center. The medical center acquired Northwest Hospital & Medical Center in Seattle in 2009 and is now discussing an affiliation with Valley Medical Center in Renton, Wash. The medical center has 450 licensed beds, 4,311 employees and 1,823 physicians on staff. In 2009, it broke ground on a project to provide additional space for premature babies, oncology programs and diagnostic imaging.

**Vanderbilt University Medical Center (Nashville, Tenn.)**
The medical center owes its name to Cornelius Vanderbilt, a New Yorker and once the wealthiest man in America, who bequeathed $1 million for Vanderbilt University at his death in 1877. Today the 832-bed medical center includes Vanderbilt University Hospital, with 600 beds, a children’s hospital, cancer center, psychiatric hospital, rehabilitation hospital and more than 50 satellite clinics. The medical center pioneered electronic medical records 10 years ago and its homegrown system is now commercialized as CareAlign. In Oct. 2010, the medical center announced plans to build a new $200 million medical campus in Franklin, Tenn., to attract fully insured patients in the suburbs.

**Yale-New Haven (Conn.) Hospital**
This institution, the birthplace of President George W. Bush, is the 944-bed flagship of three-hospital Yale-New Haven Health System, which commands a 20.5 percent market share for the whole state. It has a medical staff of 2,200 physicians and more than 500 residents and fellows training in more than 100 specialties and subspecialties and provides services to more than 503,000 outpatients a year. Among other distinctions, Yale-New Haven received the Connecticut Hospital Association’s 2010 award for excellence in the delivery of healthcare through the use of data. ■
A key goal for all hospitals in the next few years is using healthcare IT to create an integrated care system. Achieving this will help break down the barriers between physicians and hospitals as they link their services and prepare for new payment methodologies on the horizon, such as accountable care organizations.

The great majority of U.S. hospitals and practices still have a long way to go, including the two hospitals I run, Sacred Heart and St. Joseph’s, part of Hospital Sisters Health System. Whether we reach our goal will depend on strong cooperation from physicians and how easy it is for them to adopt healthcare IT.

Look to the Heartland for solutions

Providing the leadership for such strategies won’t be limited to hospitals on the West Coast or in the Northeast. Indeed, I believe many of the breakthroughs will come from the Heartland. There are several reasons for this.

The Upper Midwest, in particular, tends to have larger medical groups, which have strong organizational frameworks to adopt these new approaches. Also, our progressive tradition keeps us open to new solutions and we have a strong appreciation for technology. Up the road from us in Chippewa Falls, Wis., Seymour Cray developed the Cray supercomputer back in the 1960s and 1970s. Our embrace of IT solutions is documented in a recent CDC survey on installation of a “basic” EMR system in physicians’ offices, with components like patient history and demographics, clinical notes, computerized order entry, and viewing lab and imaging results bears this out. While 25 percent of office-based physicians offices nationwide had access to a “basic” EMR system, 50 percent or more had it in Wisconsin, Minnesota, North Dakota and just a few other states.

Sacred Heart, St. Joseph’s and the rest of Hospital Sisters are currently in the throes of implementing EHR in the hospital and in physicians’ offices. My two hospitals went live with a Meditech system on Sept. 1, 2010. It will take a year to get the bugs out, but overall the start-up went well.

Involving physicians is key

The key to our current success, I believe, was getting physicians involved in planning from the very start. We wanted a highly collaborative approach and a shared vision, so we created a physician advisory committee to guide us. We also chose a physician champion and paid that person real money for his services. The other hospitals in our system did not pay their physician champions and saw more problems with EHR implementation than we had. A fully involved physician champion can drive installation and help our IT people create the interfaces physicians will use.

Physicians often complain that their EHR systems were “designed by geeks” who did not understand their workflow. This means you need your physicians to help design user interfaces that reflect how they work and what they need to know first. Only a physician can tell you what should go on page one of the interface. Your physician-advisers can tell your IT staff, “I really don’t need that bit of information, but I always need this bit,” or, “I would like the nurse to be able to see this bit right away.”

One thing we emphasized was making sure physicians were well trained in the new system. Physicians who don’t know how to use EHR will get frustrated and won’t want to use it. Every one of our physicians completed EHR training in early August before implementation. We focused on training the late adapters who were less enthusiastic about the switchover.

We made it clear that healthcare IT was very important to us by holding a day-long information forum a week before we went live. We brought in Howard Messing, the president of Meditech, to speak at the event. I went to Boston to ask him to come. Presentations at the forum included such topics as the future of technology and its role within healthcare reform, meaningful use standards and other innovative clinical technologies.

Other ways to improve IT networks

We are also helping employed and independent physicians set up their own office-based EHR systems. The AHA reports that 30 percent of hospitals are putting in IT systems for employed and independent physicians. In our case, we are offering the Allscripts Electronic Health Record and Practice Management solution for both employed and independent physicians over the next three years. HHS granted Stark law exceptions and anti-kickback safe harbors for this activity through Dec. 31, 2013, to encourage hospitals to help independent physicians with EHR. Hospitals are very interested in helping their physicians with IT. A July 2010 study by the consulting firm CSC found one-third of hospitals had offered financial assistance to physicians for EMRs.

However, even when hospitals and practices have EHR, they are often stymied by a lack of interoperability that reduces the systems’ usefulness and discourages physicians. Without interoperability, systems must be called up separately, and data cannot easily be transferred. This is somewhat akin to having too many remotes in your living room — one for the TV, one for the satellite connection, another for the DVD player — and not knowing how to use any of them. A 2009 study by the Robert Wood Johnson Foundation found that poor interoperability “reduces the potential value of these systems and may have a dampening effect on adoption.”

We have been using Novo Grid by Medicity to create interoperability. The software builds a local exchange connecting the hospitals, physicians and other sources of care. The goal is to be able to view information all at once rather having to log into multiple systems. Physicians in our system were really impressed when they could immediately go from viewing a report to viewing a related image on a separate PAC system. This kind of amen moment can help turn skeptical physicians into believers.

Another looming problem is the need for ultra high-speed broadband for some healthcare IT transmissions such as PACs. A federal grant, announced Aug. 2010, provides $11.5 million to Western Wisconsin organizations, including Hospital Sisters, for a demonstration project to construct more than 200 miles of fiber-optic cable that can be used for ultra high-speed transmissions. Work on the fiber-optic lines began this year and could be completed within three years.

We expect many benefits will flow out of all our efforts to create a reliable IT network. First, the experience of working together on these IT projects will help us to become more aligned. Second, once physicians feel comfortable using the new systems, they will appreciate the advantage. Third, these systems will make us more efficient and are essential for new payment systems like ACOs. And finally, and most importantly, they will improve quality of care.

Stephen F. Ronstrom has more than 25 years of hospital leadership experience, having served for the past 12 years as an executive in the Hospital Sisters Health System. He is currently president and CEO of the Hospital Sisters’ Western Wisconsin division, which includes 344-bed Sacred Heart Hospital in Eau Claire, Wis.
10 Lessons From Leaders Who Have Merged or Acquired Hospitals

By Molly Gamble

There is no instruction manual when it comes to hospital mergers, acquisitions and affiliations. Sometimes it is simply most helpful to hear from leaders who have been through these transactions speak on what they’ve learned. Here, three hospital and healthcare executives dispense advice, findings and lessons learned from their experiences in acquiring, merging or affiliating with other providers.

1. Consider an engagement before marriage. There is often a misunderstanding regarding possibilities for hospitals and health systems pre-merger. For instance, some hospitals agree to let the acquiring facility manage a handful of services for a couple of years. This can illuminate any cultural setbacks that may lie ahead while allowing both entities to see if an extended relationship is in their best interest.

Jeff Rooney, CFO of Saint Agnes Medical Center in Fresno, Calif., was CFO at St. Vincent’s Health System in Birmingham, Ala., which expanded to four hospitals as the result of a merger. He encourage management or other affiliation models before jumping the gun on a sale or merger. “You don’t need to go from zero to 60,” says Mr. Rooney. “I’ve seen successful models where boards discuss, and say, ‘We’d like to merge. We think it will happen, but let’s get engaged before we get married.’”

2. It makes sense to integrate some things immediately. If hospitals have made the decision to merge or affiliate, some components of each hospital can be integrated immediately or pre-merger. For instance, Mr. Rooney says he has worked with hospitals that have centralized their staff prior to the merger and also worked to integrate their revenues. “The vice president of revenue cycle took the teams from each hospital and relocated them into a centralized business office,” says Mr. Rooney.

3. Many integration issues aren’t operational, but cultural. Mergers often begin with a keen focus on the strategic reasons behind it, which can then fall to the backburner as operational tasks grow in number and importance. “Strategic thinking has to continue post-merger,” says Mr. Rooney. Integration is often pursued as a list of tasks, but so many integration issues are not operational but cultural. By keeping an eye on the transaction’s strategic vision, and making it available and known, the hospital can build support from both employees and community members.

4. Benefits to each side should be balanced and recognized throughout the transaction. Hospital mergers or acquisitions are a delicate relationship. To solidify it and prevent distrust or apprehension, both parties should be reminded of the balance of benefits as they move through the transaction. It sounds simple in theory, but benefits can become misunderstood as the transaction gains speed and tasks build.

Russ Guerin, the executive vice president of business development and planning for Carolinas HealthCare System, which includes 33 affiliated hospitals in North and South Carolina, says it’s important for both parties to feel there is balance between the benefits of an acquisition, merger or affiliation — whether financial, economical or clinical. “We bring a size and depth that many hospitals cannot get on their own,” says Mr. Guerin. “But we also benefit from it as well — it helps us diversify.” The more balance, the more each party will need one another.

5. A hospital’s communication team is often put to the test. Consolidations or transactions can spur strong community reactions, and thus public relations concerns for hospitals. An excellent communication staff, however, can prevent roadblocks by recognizing community leaders and engaging their involvement. For instance, an effective communications team will identify 10 key leaders the CEO needs to communicate with about the merger or sale — and quickly. “Community leaders and members like to be informed and know they’ve had a chance to voice their opinions or concerns,” says Mr. Rooney.

6. Cultural shifts won’t occur overnight, but subtle changes help staff transition. There are various approaches to take when it comes to cultural changes, with each being situation-dependent. Some systems mandate change and implement it from the start, whereas other hospitals may choose to subtly introduce changes to medical staff, employees and patients.

For example, Mr. Rooney was acting CFO for a Catholic hospital that acquired secular facilities and slowly introduced change. “We built chapels in those hospitals. We made sure Sisters were present regularly in them. You don’t go overnight into absorbing the culture of a Catholic hospital,” says Mr. Rooney. “It takes time. Start with the basics and begin building that identity.” For this delicate transition, an organizational development leader needs to help people in the individual hospitals understand what it means to become part of a Catholic system.

7. Be weary of the word “synergy.” Mergers can be oversold for their “synergistic” benefits, such as lower costs, expense savings or operating leverage. “When you look at a sale, some people expect to see lower costs. But on a pure dollar basis, expenses may be higher but performance is through the roof. Productivity was more important than synergy,” says Mr. Rooney. In the short-term, post-merger, there are few synergies — or financial gain — within 12 or 24 months, according to Mr. Rooney. Rather, a consolidation or transaction has much more to do with creating a larger force in the local market during that time.

8. There’s been a focus shift to quality measures rather than financial advantages. Focus has recently shifted from financial advantages to the quality arena. Hospital boards are increasingly looking at quality results and turning to larger systems to help improve them, according to Mr. Guerin. “Quality in healthcare has become a much more visible component than it was in the past. There is a lot more transparency in quality than there used to be,” he says.

Mr. Guerin also mentioned that most acquirers, including Carolinas, do not pursue mergers or transactions for financial gain, but rather how they may expand services into communities in need. Therefore, a struggling hospital with poor financial results is not necessarily off the market.

9. A successful merger experience can be a selling point for future hospital relationships. When choosing a partner or acquirer, hospitals will want to know what expertise candidates have in hospital transactions. Carolinas, which has acquired many facilities, often points out the fact that few hospitals have divorced from the system since they joined. Experience and expertise in hospital mergers, acquisitions or other affiliations can be a selling point in itself. Other aspects that prove an organization is skilled in transactions include an integration team whose core competency is integrating hospitals, which Carolinas also offers.

10. Physician relationships are a determining factor. Hospital-physician relationships have been discussed as a criteria or influential factor when hospitals go to market. Jeff Nelson, a partner at Tatum who helped prepare the two-hospital system Empire Health Services in Spokane, Wash., for its acquisition by Community Health Systems, confirmed this piece of advice from the buyer’s perspective as well.

“Buyers or partners will look at the number of physicians referring patients to hospitals and consider what kind of relationships they have. They want to see how engaged these physicians are with that hospital or how it can be improved,” said Mr. Nelson. With a focus on integrated health, where hospitals and physicians work to improve quality and lower cost, hospital-physician relationships will continue to be a large criterion when it comes to successful mergers, affiliations or acquisitions.
Hospital M&A Continued to Grow in Second Half of 2010

By Leigh Page

Hospital merger and acquisition activity continued grow in the second half of 2010, which accounted for 62 percent of activity in the full year, according to a release by Irving Levin Associates.

Last year's total of 77 deals was 33 percent higher than in 2009, when there were 52 deals, and represented the highest number since 2001, when there were 82 deals.

In 2010, there were nine deals in the first quarter, 20 in the second quarter, and 24 each in the third and fourth quarters.

Last year, $12.6 billion was committed to hospital M&A, an 86 percent increase from the $1.8 billion committed in 2009. The 2010 level was the second highest in the decade, behind 2006, which logged $35.5 billion.

“‘The M&A market continues to recover from the wake of damage left by the Great Recession,’ the report states. ‘‘If the second half of 2010 is any indication, it seems the hospital sector is heading for an active 2011.’”

Largest transactions of 2010

The five largest hospital transactions reported in 2010 were:

• Community Health Systems (proposed) for Tenet Healthcare, $7.3 billion offered in Q4.

• Vanguard Health Systems for Detroit Medical Center, $1.3 billion in Q2.

• Cerberus Capital Management for Caritas Christi Health Care, $830 million in Q2.

• Prospect Medical Holdings, a management buyout, $363 million in Q3.

• University Community Health for Adventist Health Systems, $355 million in Q3.

Yearly hospital mergers and acquisitions, 2001-2010

2001: 82 deals with $3,108,119,000 committed
2002: 56 deals with $3,403,681,000 committed
2003: 37 deals with $2,341,550,000 committed
2004: 59 deals with $9,706,390,000 committed
2005: 50 deals with $2,905,729,000 committed
2006 55 deals with $35,533,500,000 committed
2007: 61 deals with $9,257,130,000 committed
2008: 60 deals with $2,580,600,000 committed
2009: 52 deals with $1,678,800,000 committed
2010: 77 deals with $12,611,395,000 committed

Total: 589 deals with $83,126,894,000 committed

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5 Common Mistakes Hospitals Make When Investing in Surgery Centers with Physicians

By Leigh Page

Hospitals are increasingly building new ambulatory surgery centers in partnership with surgeons. It is a strategy that can help the hospital strengthen relationships with physicians, prepare for reimbursement changes and defend against competing health systems, says Brandon Frazier, vice president of acquisitions & development at ASCOA. But he warns that hospitals need to be careful they don’t fall victim to five common mistakes surrounding such arrangements.

1. Insufficient equity for surgeons. Surgeons need to have sufficient equity for them to have a sense of ownership in the center. “They need to feel it is their center,” Mr. Frazier says. “One of the reasons ASCs operate so efficiently is that surgeons have a vested interest in making the center efficient.” For example, when tardy surgeons are shown that OR time in their center is worth $18 per minute, they don’t show up late any more. The same applies to prices for equipment and supplies. “Surgeons tend to be much more judicious when the money is coming out of their pockets,” he says.

2. Running the center like a hospital. “Bringing the hospital bureaucracy into the ASC is a death sentence for the center,” Mr. Frazier says. Surgery centers operate differently from acute-care hospitals. “Surgeons are attracted to ASCs because of the efficiencies they provide,” he says. “If ASCs turn into a smaller model of the hospital, they will be very frustrated.” They will disenfranchise existing surgeons, and it will be difficult for the center to attract new surgeons.

3. Overbuilding the facility. “I see this all the time,” Mr. Frazier says. “It is the most common error hospitals make when building an ASC from scratch.” The hospital puts in a big conference room and spacious lounges. “This is wasted space that is expensive and doesn’t generate revenue,” he says. The added expense will increase the monthly debt payment for the ASC and delay the time when earnings can be distributed to physicians, which is a huge negative. Distributions help make the physicians more engaged. Mr. Frazier advises scaling the center to the number of cases the physician investors will bring. He uses a benchmark of 2,000 cases per OR, per year for a multi-specialty center. Excess capacity of 20-30 percent can be built in for future growth.

4. Not using the ASC as a recruiting tool. Hospital executives are often concerned the ASC would cannibalize cases that would otherwise go to hospital ORs, but they fail to realize that a new ASC can help increase their inpatient volume, Mr. Frazier says. Typically, more than 50 percent of cases in the new surgery center come from competing hospitals. “A new center can be a powerful marketing tool to attract surgeons from surrounding hospitals,” he says. “They have seen an increase in inpatient cases in addition to the cases they have recruited to the ASC.” A hospital executive who had come to appreciate this advantage calls it the “halo effect,” Mr. Frazier says.

5. Running an unprofitable center. “The most important factor affecting the relationship between a hospital and its surgeons is the profitability of the ASC,” Mr. Frazier says. While making surgeons financial partners in the ASC can help build relationships if the ASC is profitable, it is a huge disadvantage if the center is unprofitable. “If they end up with no distributions or, worse yet, cash calls to cover an ASC’s losses, they are going to be unhappy,” he says. This happens all too often. It is estimated that about a quarter of all ASCs are making cash calls and another quarter simply break even. To help ensure healthy profits, the hospital may want to include a corporate partner who specializes in running ASCs.

3 Current Trends Impacting ASC Transactions

By Caitlin LeValley and Rob Kurtz


1. Hospitals are more interested in surgery centers. Three years ago, hospital interest in surgery centers was nowhere near the level it is today, says Mr. Lambert. Hospitals are now looking to acquire ASCs and further consolidate their markets. “Hospitals have always had a big piece of the pie, but now they’re starting to buy up surgery centers, physician practices and other healthcare entities,” he says.

2. Out-of-network centers aren’t selling. Buyers are afraid of ASCs with a high percentage of out-of-network cases. As a result, traditional buyers won’t make high offers for these ASCs and their owners are surprised by the low offers. “There’s a gap between what buyers will pay and how much physicians will sell for,” says Mr. Lambert. “So, few transactions are happening with OON centers.”

3. Economy forces quick solutions. Given the tighter credit conditions of the last few years, ASCs must find solutions to financial problems quickly as failure to do so could impact the life of the facility, says Mr. Lambert. In the past, lenders and physician-investors were more tolerant and willing to keep supporting a troubled center as it worked to right itself. Today they take a much more critical look. Lenders are quicker to stop cashflow and for physicians, “there has to be a quick path to profitability or they close it down and shift attention to something better,” Mr. Lambert says.
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ASC Transactions and Pricing During 2010: 4 Key Concepts

By Scott Becker, JD, CPA

2010 saw a significant increase over 2009 in surgery center transactions. During 2010, the pricing of transactions tended to increase from 2009. This article provides examples of pricing seen in various transactions.

1. ASC mergers and acquisitions. McGuireWoods and myself helped surgery centers complete approximately eight different transactions in the last quarter of 2010. In the ASC sector, the pricing generally ranged from six to eight times earnings for majority interest transactions with a few outliers. An interesting trend is that half of these transactions involved hospitals acquiring surgery centers, and half were national companies acquiring surgery centers. Some of the specifics on pricing were as follows:

   • Orthopedic-focused surgery center that was mostly in-network, national chain purchaser for approximately 7.3 times EBITDA.
   
   • Multi-specialty center, heavily in-network, hospital purchaser, with no co-management agreement, approximately 8 times EBITDA.
   
   • GI center heavily in-network, hospital purchaser, no co-management agreement, approximately 6 times EBITDA.
   
   • Multi-specialty center, entered into co-management agreement as part of the transaction, some out-of-network, hospital purchaser 5.75 times EBITDA.
   
   • Multi-specialty center, in-network, hospital purchaser, some co-management arrangement, approximately 7 times EBITDA.
   
   • Multi-specialty orthopedic-focused center, mostly in-network, national chain buyer approximately 7 times EBITDA.
   
   • Multi-specialty surgery center, some orthopedic and spine focus, in and out-of-network, national chain purchaser, for 5.65 times EBITDA.
   
   • Hospital purchaser, a very high multiple, mostly due to the fact that there was a significant drop in income in 2010 and 2010, was not indicative of continued income, approximately 9 times EBITDA.

Where the hospital is also entering into a co-management agreement with the physicians, there will often be a lower price due to the reduction of the expected earnings in connection with the payments for co-management services.

Pricing is higher where there is a strong probability of continued earnings, a strong physician base and the center is heavily in-network.

2. Hospital interest in ASCs. We continue to see a great deal of physician-alignment activity, and almost everybody is looking at new and emerging physician alignment models. While there has been a slowdown in the development of de novo joint venture ASCs, 2010 experienced an increase in hospitals acquiring a 100 percent interest in ASCs. We also saw an increase in national ASC companies trying to buy into hospital-physician joint venture ASCs.

3. Co-management. On the co-management side, we are seeing a lot of activity. For co-management arrangements around a hospital-owned surgery center, keep in mind the following:

   • We see some of the co-management deals done as part of an acquisition of a surgery center. Co-management agreements need to be based on fair market value and they need to be truly needed. A high quality valuation firm needs to be able to support the fair-market-value nature of the agreement and the actual need for the agreement should be documented very closely internally. There is some skepticism that certain of the agreements are entered into to help tighten relationships or lock in referrals and not that they are truly needed for management purposes.

   • These relationships are often fixed, in part, with a variable component as well. It is critical that the variable component not be based on or tied to volume or value of referrals. Finally, there are significant questions as to how to split up the dollars within the groups that are providing co-management services. Much of the dollars are often allocated to actual specific services provided by individuals that are part of the co-management group. Other dollars are often paid and split by the co-management entity as a whole for the overall services being provided. In each situation, the total dollars must not be based on the volume or value of referrals and the dollars allocated to any specific person may not be based on the volume or value of referrals.

4. Healthcare economics. Over the last few years, the healthcare economy has not seen significant dollars taken out of the economy. For example, 30-40 percent of the dollars, (i.e., the Medicare dollars) have been relatively stable. Further, the shift in unemployment — which has led to an approximately 2-3 percent increase in unemployment over the last five years — has not meant a complete a shift of 2 to 3 percent from commercial patients to Medicaid or no pay patients. Rather, a smaller fraction of that that has shifted payors and moved to a lower payment situation. The greatest reduction in reimbursement has come from the commercial sector, but it is less the day-to-day reimbursement and more the bigger ticket reimbursement that people are finding in certain situations that is no longer readily available. Thus, the overall amount of dollars being spent in the healthcare sector remains fairly stable. Within that, there are changes in practice patterns and changes in reimbursement that are shifting dollars between sectors. In terms of prognosis, we anticipate that the total number of dollars within healthcare will stay relatively steady over the next 3 to 5 years. There will be, however, continued shifting between sectors.
Executive Briefing: Hospital - ASC Joint Ventures

Setting Standards for Your Hospital-ASC Joint Venture: 15 ASC Benchmarking Statistics

Here are 15 ambulatory surgery center benchmarking statistics, based on the number of operating rooms in the ASC. These statistics are intended to help hospitals compare and benchmark ASCs when considering a potential hospital-ASC partnership. Data comes from VMG Health’s Multi-Specialty ASC Intellimarker 2010.

ASCs with 1-2 operating rooms
Net revenue: $3,826,000
Operating expenses: $2,703,000
EBITDA: $958,000
Total liabilities and equity: $1,650,000
Working capital: $787,000

ASCs with 3-4 operating rooms
Net revenue: $5,998,000
Operating expenses: $4,986,000
EBITDA: $1,388,000
Total liabilities and equity: $2,770,000
Working capital: $816,000

ASCs with more than four operating rooms
Net revenue: $8,699,000
Operating expenses: $6,630,000
EBITDA: $1,960,000
Total liabilities and equity: $4,988,000
Working capital: $1,392,000

VMG information comes from VMG Health’s Multi-Specialty ASC Intellimarker 2010 benchmarking study. VMG Health is a leading valuation and transaction advisory firm in healthcare. To receive a complimentary copy of VMG Health’s 2010 Multi-Specialty ASC Intellimarker, click here.

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4 Best Practices to Reduce Costs in Hospital-Owned ASCs

By Rob Kurtz

There are four best practices for hospitals to help reduce costs in their ASCs, according to Joseph W. (Woody) Hubbard, vice president of ambulatory care for North Carolina-based Novant Health.

1. **Don’t assume your hospital is getting the best price on supplies for its surgery centers.** Just because your hospital has volume contracts in place, don’t assume that this is beneficial to the ASC. Hospitals are finding that surgery center-focused GPOs can offer less expensive items, some as much as 20 percent lower.

2. **Borrow equipment from the hospital.** Use the resources of the hospital when it comes to needing instruments, equipment, etc. Don’t buy new when you can borrow or buy excess at book value.

3. **Use the power of the physician.** Involve physicians to negotiate capital equipment purchases, especially when the physicians are aligned via joint venture or management agreement.

4. **Introduce ASC metrics.** We removed $1.5 million in construction and equipment costs in a newly planned ASC by introducing metrics common to independently-owned ASCs. Hospitals tend to build their ASCs too large and with equipment specs better suited for inpatient operating rooms and PACU.

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7 Points on Developing Surgery Centers in Highly Regulated States

By Leigh Page

Tyler Merrill, vice president of acquisitions & development at Ambulatory Surgical Centers of America in Hanover, Mass., makes seven points about developing surgery centers in highly regulated states with strict CON laws.

1. **CON states still have room for ASCs.** The ASC market hasn’t become oversaturated in states with strict CON laws such as New York, Virginia, North Carolina, Georgia and Connecticut. This means new ventures are more likely to attract efficient surgeons not yet aligned with an ASC and achieve high volumes. Even in less populous areas of these states, Mr. Merrill figures a community of 60,000 people could support an ASC.

2. **ASCs without a hospital face high barriers.** Physicians who do not partner with a hospital on an ASC face very steep challenges in CON states, Mr. Merrill says. For example, ASCOA and partnering physicians just opened an ASC in New York that took five years develop because of the stringent and litigious nature of the CON process.

3. **Hospital is a key partner in CON states.** Because of the challenges of the New York project, ASCOA has no plans to join another de novo project in the state without a hospital partner. But the company is involved in several physician-hospital joint ventures in the state because it is “the most expeditious way to get through the approval process,” Mr. Merrill says.

4. **Hospitals more open to partnerships.** As in the rest of the country, hospitals in strict CON states often see ASCs as a way to prosper under upcoming payment models, such as accountable care organizations, that emphasize savings. “Having a low-cost, high-quality surgical alternative that focuses on efficiency will be an important tool to help hospitals succeed,” Mr. Merrill says. While a hospital might earn a 6 percent profit from its ORs, an ASCOA-managed ASC makes a 40 percent profit. “Even with reduced outpatient reimbursements, the advantage of an ASC with a proven partner is clear,” he says.

5. **A hospital partnership benefits from a third party.** While there are many reasons for hospitals and surgeons to partner in strict CON states, surgeons would probably be rebuffed if they approached a hospital with a partnership plan on their own. “The hospital would most likely try to block the project,” Mr. Merrill says.

6. **Physicians should own biggest share.** Inside or outside strict CON states, physicians who partner with a hospital need to have the largest share in the ASC so they cannot be dictated to. “It gives them autonomy so that they can make decisions,” Mr. Merrill says. ASCOA’s hospital-physician partnerships are typically owned 50 percent by physicians, 25 percent ASCOA and 25 percent by the hospital.

7. **OON fading in states like New York.** While highly regulated states can yield high volume, states like New York provide relatively low per-case payments because the out-of-network option is fading. When United Healthcare sued OON centers in New York for waiving the patient’s co-pay and deductible, many ASCs in the state signed contracts with payors and went in-network. Since in-network rates are lower, New York centers need to achieve higher volumes to maintain profitability.

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Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, New York Eye and Ear Infirmary
Here are ten big anti-kickback statute and Stark law cases involving hospitals that made headlines in 2010.

1. Former owners of Los Angeles-based City of Angels Medical Center pay $10 million for paying illegal kickbacks — In January, Robert Bourseau and Rudra Sabaratnam, MD, pleaded guilty to their roles in a scheme to pay patient recruiters illegal kickbacks for the recruitment of homeless patients. The recruited homeless patients underwent a variety of medical treatments, many of which were not medically necessary and were billed to federal healthcare programs.

2. Christiana Care Health System in Wilmington, Del., agreed to pay $3.3 million to settle a whistleblower kickback lawsuit — In March, the health system agreed to pay $3.3 million to settle kickback allegations. According to the charges, Christiana Care overpaid physicians at Neurology Associates for in-hospital readings of EEGs allegedly as a “reward” for referring patients to the hospital. The court documents note the payments were part of a contract dating to 1989, prior to the enactment of the current Stark Act and Delaware Anti-kickback Statute. Christiana Care said they put the contract out for rebid in 2003, when it terminated Neurology Associates’ contract under the Stark Act, but the practice won the contract back in 2003. The health system denied any wrongdoing in the case.

3. Tuomey Hospital in Sumter, S.C., pays $49.4 million for violating Stark Act — In April, a federal jury ruled Tuomey Hospital violated Stark Act in regards to employment contracts it held with physicians at its Outpatient Surgery Center. Federal prosecutors also alleged Tuomey violated the False Claims Act by submitting claims resulting from referrals that violated self-referral law, but the jury dismissed this claim, clearing the hospital of Medicare fraud charges. The health system has since appealed the judgment that awarded the government money for its equitable claims, arguing the system’s behavior was consistent with guidance by CMS for complying with Stark Law. The American Hospital Association has joined in Tuomey’s cause by filing an amicus brief in support of the health system.

4. Health Alliance of Greater Cincinnati and The Christ Hospital in Mount Auburn, Ohio, pay $108 million to settle accusations they violated the anti-kickback statute and the False Claims Act — In May, the organizations were accused of illegally paying physicians in exchange for referring cardiac patients to The Christ Hospital, a former member hospital of the Health Alliance of Greater Cincinnati. The Christ Hospital allegedly limited the opportunity to work at the Heart Station — a center where patients receive non-invasive procedures such as electrocardiograms and stress tests — to those cardiologists who referred cardiac business to The Christ Hospital.

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Cardiologists were also allegedly rewarded with a percentage of time at the Heart Station based on their contributions to the hospital's yearly gross revenues, and these physicians could earn additional income for treating patients at the facility.

5. St. Jude Medical, Parma (Ohio) Community General Hospital and Norton Healthcare in Louisville, Ky., settle false claims allegations for $3.9 million — The heart device manufacturer was accused of paying kickbacks to the two hospitals in order to obtain heart-device business. The illegal kickbacks allegedly included retroactive rebates that were paid based on the hospital's previous purchases of St. Jude heart devices and rebates to induce future purchases of devices from St. Jude. In June, it was agreed that St. Jude will pay $3.725 million. Parma Community and Norton will pay $40,000 and $133,300, respectively.

6. Physician-owned lithotripsy provider reaches $7.3 million settlement in anti-kickback lawsuit — In July, Chicago-based United Shockwave Services, United Prostate Centers and United Urology Centers entered into a $7.3 million settlement with the OIG to resolve allegations of soliciting and receiving payments from hospitals in exchange for patient referrals. Specifically, OIG alleged that United, and some of its physician-owners, leveraged patient referrals to obtain contract business from hospitals in Illinois, Indiana and Iowa and caused certain hospitals to submit claims for designated health services as a result of the prohibited referrals.

7. Health Management Associates files motion to dismiss lawsuit alleging kickbacks and false claims — Mike Mastej, former CEO of Physicians Regional Medical Center in Naples, Fla., filed a whistleblower suit against HMA, alleging the hospital operator provided kickbacks to physicians for referrals in the form of on-call payments, reduced or free office space rentals and trips to the Masters Golf Tournament and then billed Medicare for services from these physicians. In September, HMA argued the lawsuit failed to provide enough evidence to prove any false claims or anti-kickback violations. The Department of Justice initially investigated the original whistleblower case but chose not to intervene. Scott Becker, JD, CPA, a partner at McGuireWoods, said the success of qui tam lawsuits is much lower when the government chooses not to intervene.

8. Marion (Ohio) General Hospital pays $1.2 million to resolve allegations of Stark law and anti-kickback violations — The violations, which were self-reported by the hospital in October to the U.S. Attorney General’s Office, included a number of financial relationships with physicians that did not involve a written contract. Specifically, the hospital provided an after-hours answering service and medical waste disposal services to independent physicians at below-market rates and provided payment without a written contract to independent physicians who treated uninsured patients, among other violations.

9. Towson, Md.-based St. Joseph Medical Center pays $22 million to resolve lawsuit involving alleged False Claims Act and anti-kickback violations — The November settlement resolves allegations of the payment of kickbacks to Pikesville, Md.-based MidAtlantic Cardiovascular Associates under the guise of professional services agreements in return for the group’s referrals to the medical center. The settlement specifically resolves issues related to 11 professional services agreements, covering the period of Jan. 1, 1996 to Jan. 1, 2006, which were being investigated for being above fair market value, not commercially reasonable or for services not rendered.

10. Bradford (Penn.) Regional under fire for allegedly violating the anti-kickback statute — In November, a federal judge found BRMC guilty of violating the federal Stark Act by entering into an illegal financial relationship with two physicians and their medical practice and submitting claims to Medicare based upon referrals from them. According to the prosecution, a lease agreement between the hospital and the two physicians was not a bona fide sublease of equipment needed by the hospital, which already had its own nuclear camera, but was instead a disguised attempt to pay the physicians for patient referrals. A jury must decide whether the defendants possessed the necessary intent to be liable under the anti-kickback statute. While no decision has yet been made as to whether BRMC indeed violated the anti-kickback statute, the presiding judge in the Stark Act case stated the hospital will find it difficult to prove they did not possess intent.
24 Statistics on Specialty Physician Compensation

By Rachel Fields

Here are 24 statistics about specialty physician compensation by region, based on data from MGMA’s Physician Compensation and Production Survey.

Anesthesiologists
- Eastern: $360,192
- Midwest: $448,663
- Southern: $493,798
- Western: $387,315

Orthopedic surgeons
- Eastern: $416,785
- Midwest: $536,317
- Southern: $464,559
- Western: $466,306

Invasive cardiologists
- Eastern: $414,000
- Midwest: $452,929
- Southern: $535,780
- Western: $407,273

Neurologists
- Eastern: $234,766
- Midwest: $245,923
- Southern: $239,786
- Western: $228,591

General surgeons
- Eastern: $285,256
- Midwest: $364,068
- Southern: $316,228
- Western: $346,501

Gastroenterologists
- Eastern: $440,584
- Midwest: $507,717
- Southern: $482,700
- Western: $432,371

20 Statistics on Employed Physician Revenue vs. Salary by Specialty

By Rachel Fields

Here are 20 statistics about revenue generated by physicians for hospitals versus average employed physician salary, based on physician specialty. Data comes from 2009 Merritt Hawkins’ Review of Physician Recruiting Incentives and Merritt Hawkins’ 2010 Physician Inpatient/Outpatient Revenue Survey. The latter survey shows net annual revenue generated by physicians in various specialties on behalf of their affiliated hospitals.

Neurosurgery
- Average revenue: $2,815,650
- Average salary: $571,000

Invasive cardiology
- Average revenue: $2,240,366
- Average salary: $475,000

Orthopedic surgery
- Average revenue: $2,117,764
- Average salary: $481,000

General surgery
- Average revenue: $2,112,492
- Average salary: $321,000

Internal medicine
- Average revenue: $1,678,341
- Average salary: $186,000

Family practice
- Average revenue: $1,622,832
- Average salary: $173,000

Gastroenterology
- Average revenue: $1,450,540
- Average salary: $393,000

Non-invasive cardiology
- Average revenue: $1,319,658
- Average salary: $419,000

Pediatrics
- Average revenue: $856,154
- Average salary: $171,000

Ophthalmology
- Average revenue: $842,711
- Average salary: $282,000

Hospital-Employed Physician Salaries Could Jump 2.3% in 2011

By Rachel Fields

Physicians employed by hospitals and health systems could experience a 2.3 percent increase in base salary in 2011, according to a survey by management consulting firm Hay Group.

Hay Group predicts a 2.6 percent pay increase for all healthcare employees in 2011, up from 2.3 percent in 2010. Salaries for employed physicians will increase slightly less than nurse salaries, which could be in for a 2.7 percent boost.

“Healthcare providers have felt the pinch, but salary budgets are beginning to move upward, mirroring the slow ascent in the broader economy,” said Ron Seifert, vice president and executive compensation practice leader for Hay Group’s healthcare practice in a news release.
6 Predictions on Stage 2 Meaningful Use

By Jaimie Oh

The HITECH Act under the American Recovery and Reinvestment Act of 2009 allows eligible healthcare providers to receive incentive payments upon demonstrating “meaningful use” of electronic health records. In order to meet meaningful use, providers must meet a set of criteria provided by the Office of the National Coordinator. The criterion is published in three phases, with Stage 1 going into effect this year. There has already been a significant amount of buzz and debate around Stage 2 requirements to meet meaningful use, but not much has been said about specific measures and requirements. Here, healthcare industry experts share six predictions on possible Stage 2 meaningful use requirements.

1. Increased measures from Stage 1. Stage 1 meaningful use requirements include a subset of clinical quality measures. For Stage 1, although all eligible hospitals must report on all 15 clinical quality measures, some healthcare experts, including Russ Branzell, CIO and vice president of Poudre Valley Health System in Fort Collins, Colo., who is part of the ONC’s tiger team for Stage 2 meaningful use that works on quality measures, predicts these clinical quality measures will likely be heightened in Stage 2.

“If you look at it from a building block perspective, the intent of Stage 1 meaningful use is so that the basic components of an EHR are in place and the hospital has the ability to support those metrics for quality outcomes,” Mr. Branzell says. “As we move into Stage 2, what we’re going to see is not new standards but rather fully implemented standards from Stage 1.”

In one such example, Mr. Branzell cites a Stage 1 clinical quality measure that will likely undergo expansion in Stage 2: computerized physician order entry. Stage 1 meaningful use requires more than 30 percent of all unique patients with at least one medication in their medication list admitted to the eligible hospital’s inpatient or emergency department have at least one medication order entered using CPOE. Mr. Branzell says the industry can safely expect this requirement to dramatically increase to 80-90 percent in Stage 2.

Charles W. Jarvis, FACHE, vice president of healthcare services and government relations for NextGen Healthcare, a provider of health IT and EHR solutions, agrees with that notion.

“It’s going to be challenging at this point to make any predictions on Stage 2 because we don’t even have the recommendations from the ONC Health IT Policy Committee, but what we do expect from preliminary comments made by Dr. Blumenthal and ONC is that there is going to be much higher bars for performance,” Mr. Jarvis says. “In fact, we expect most, if not all, measures will be at 100 percent in Stage 2.”

2. New focus on patient safety measures. The five core concepts for Stage 2 clinical quality measures are patient and family engagement, clinical appropriateness/efficiency, care coordination, patient safety and public health. Mr. Branzell says other work groups that are part of constructing meaningful use requirements have been focusing on subdomains to fall under the category of patient safety. Among these, he says it is likely Stage 2 patient safety measures will include some measures on medication safety, hospital-associated adverse events such as infection rates as well as patient identification.

“Falls are another patient-safety factor hospitals may be required to start measuring,” Mr. Branzell says. “That includes close monitoring and having the predictive modeling to follow and reduce serious falls occurring in hospitals.”

Monitoring of medication administration through bedside medication verification is another patient safety measure the work group has felt strongly about including in Stage 2 meaningful use. “There should be an ability in a hospital’s EHR system to report what percentage of drugs are administered with the right route, right patient and right dose,” he says.

3. Introduction of evidence-based order sets. Evidence-based order sets have emerged in the healthcare arena as a means to reduce medical errors and care variation. Such orders are typically created through collaboration among physicians, nurses and other health practitioners who use evidence and medical literature to establish the best treatment protocols for various illnesses and conditions. Mary Anne Leach, CIO and vice president of The Children’s Hospital in Aurora, Colo., says hospitals may find the introduction of evidence-based order sets as part of Stage 2 meaningful use requirements.

“Evidence-based order sets are essentially best-practice treatment, as defined by evidence,” Ms. Leach says. “What does the evidence tell us is the best set of medications or procedures related to a specific kind of disease? In some cases though, such as with complex pediatric patients, there is a challenge with those kinds of approaches because many children have some very complex and sometimes multiple problems. There isn’t always a straightforward protocol.”

4. Introduction of structured and discrete physician documentation. Ms. Leach says although she doesn’t suspect Stage 2 require-
ments will require a 100 percent inclusion of structured and discrete physician electronic documentation, the topic may very well be introduced. Currently, there is still a significant amount of dictating and transcribing of physician-reported data occurring in hospitals, which, while efficient for the physician, does not give the overall organization or the physician the discrete data elements required to support quality reporting, coding or clinical analytics.

“This is likely to start out as a menu set rather than a required reporting requirement,” Ms. Leach says.

5. Introduction of patient-contributed, structured data into EHRs. Many hospitals are moving toward incorporating a patient portal with their EHRs to help patients more quickly and directly connect with their healthcare providers. However, as many systems function today, most patient portals do not allow a very wide array of patient feedback regarding their own personal health information. Ms. Leach says hospitals could possibly see the introduction of patient-contributed data as a possible menu item in Stage 2.

“Many organizations offer what they are calling a ‘patient portal,’ but oftentimes those systems cannot accept patient-contributed data, such as over-the-counter medications, readings from home glucometers or corrections to their personal information,” she says. “It will be important for hospitals and physicians to anticipate eventual integration of provider-tethered EHRs with patients’ own online personal health records.”

Online personal health records allow comprehensive, integrated up-to-date view of data to be available and also allow patients, families and consumers to participate and be accountable for their own health, she says.

6. Move toward true “meaningful use.” The stages of meaningful use takes providers from initially simply collecting and reporting various measures in Stage 1 to eventually using that collected information to make meaningful decisions about the delivery of healthcare to patient populations in Stage 3. Although Stage 3 won’t be enacted until 2015, hospitals can generally expect Stage 2 to begin the move toward connecting the dots between reported data and healthcare decision-making.

“Another progressive requirement that we’re going to start seeing in Stage 2 is making that connection between the use of health IT and improved outcomes, reduced costs and improved population health,” Ms. Leach says. “Stage 2 and 3 requirements for quality and population management will progressively require this evidence to be electrically reported as a direct by-product of EHR use. This will help move us forward toward true ‘meaningful use.’”

Mr. Jarvis agrees that it is this very idea that will separate providers who are able to meaningfully use EHRs and those who simply have a knack for collecting information and adopting health IT.

“There will eventually be a requirement for 100 percent electronic sharing of data, and I think that is going to clearly delineate those who are able to meet Stage 1 and those who can effectively use health IT to change patterns of care in Stage 3,” he says. “It will be much more outcomes-oriented rather than process-oriented.”

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**2011 Education & Networking Events**

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Visit [www.chefchicago.org](http://www.chefchicago.org) for the full 2011 calendar of events.
Lessons for Hospital Leaders From ‘Undercover Boss’

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

Every so often I watch the show “Undercover Boss” on CBS. It’s about CEOs working incognito in low-ranking jobs within their own companies. The work is often stressful. Supervisors get exasperated with them and sometimes they are fired.

I’ve even seen undercover bosses break down and cry. It’s both wrenching and fascinating, as any good reality show should be. But apart from the voyeurism, “Undercover Boss” is something C-suite executives would do well to watch and emulate.

When employees see the big cheese subjugating his or her own ego, something magical happens. Here is the CEO actually trying to understand the employees’ working environment. The undercover boss comes away with an invaluable perspective on day-to-day operations.

Simple stuff, really, but how many CEOs and C-suite execs would be willing to become floor nurses, paramedics or surgical assistants for a week? Actually, CEO-friends of mine have done this. They were glad of it and came away with a much better understanding of how their institutions function.

An alternative to going undercover

However, if going undercover doesn’t appeal to you, there are other ways to get the same kind of insight into your organization. For example, I am a great believer in walk-around management. It lets people know you care about what they do. True leaders are involved and intimately engaged with their people. They don’t sit upstairs, aloof from ordinary, everyday challenges in their institution.

When you really know your employees, you can help them be more effective. True leaders don’t fire people; they make them stronger through encouragement and training. To fire a person because they are miscast is a waste of time and morale. Finding out what their strengths are and giving them the opportunity to grow in another assignment is true leadership. You need to be totally focused on that person to assess his or her needs and then provide that to them.

It sounds like a lot of apple pie, doesn’t it? Just terrific stuff but impossible to carry out with any degree of success? Not true, by any means! This sort of work is standard practice in the military. Officers in the United States Marine Corps, for example, are instructed to take care of their soldiers first and meet their own needs last. That’s what leadership basically is all about. Helping others achieve success, and, therefore, help the organization reap the dividends from productive and competent employees.

A need for leaders

The economy is just beginning to show some signs of recovery and people seem more relaxed about their futures. But one thing is missing, The nation in general and healthcare in particular need leaders. We need people who are dedicated to their workers and to getting things done. We need people willing to take risks to improve the capabilities of their organizations.

Some leaders are already doing these things, but we need more of them. Enlightened leadership is the responsibility of all CEOs. They have to mentor future leaders in their respective organizations. It takes time, patience and sacrifice. But if it isn’t done and done soon, healthcare may go the way of so many other industries and wallow in an ocean of mediocrity.
Executive Moves

Tim Puthoff was named CEO of Gateway Medical Center in Clarksville, Tenn. Mr. Puthoff has served Gateway’s interim CEO since March 2010. He replaces Mike Mullins, who went on a leave of absence in Jan. 2010 while serving on active military duty in Afghanistan.

Saint Louis University Hospital named Philip Sowa as CEO.

G. Richard Hastings, president and CEO of Kansas City, Mo.-based Saint Luke’s Health System, announced his July 31 retirement. Mr. Hastings has been CEO since 1996 and has worked with the St. Luke’s system for more than 35 years. An internal and national search is underway to find his replacement.

Bill Walczak, CEO of Codman Square Health Center in Dorchester, Mass., will leave to become president of Caritas Christi’s Carney Hospital in Dorchester.

Akron (Ohio) General Health System appointed Stephen M. Gary as senior vice president and CFO. He will join the system on Jan. 31, replacing Debbie Gorbach, who served as interim CFO since Nov. 2007.

David C. Hogan, COO of Memphis-based Baptist Memorial Health Care, will retire at the end of the month after 29 years with the system. Mr. Hogan will be replaced by Jason Little, who has served as CEO and administrator at three BMHC hospitals.

Leo Brideau, president and CEO of Milwaukee-based Columbia St. Mary’s Health System, accepted a senior position at St. Louis-based Ascension Health. Mr. Brideau will be replaced by Mark Taylor, the president and CEO of Genesis Health System, which is based in Grand Blanc, Mich., and part of Ascension. Mr. Taylor begins his new duties on Feb. 15.

Houston Physicians’ Hospital in Webster, Texas, appointed Michele Dionne as CEO.

Boston-based Steward Health Care System hired Jeffrey Liebman as president of Good Samaritan Medical Center in Brockton, Mass. Most recently, Mr. Liebman was president and CEO of the Beth Israel Deaconess Health care campus in Needham, a position he held since 2003.

Finley Hospital in Dubuque, Iowa, hired David R. Brandon as president and CEO. Mr. Brandon will begin his new position at the 126-bed hospital by mid-February, according to the report. He will replace John Knox, who left Finley to become president and CEO of Allen Hospital in Waterloo, Iowa.

John McGee, president and CEO of Solaris Health System, left the Edison, N.J.-based organization to pursue other opportunities. Mr. McGee had been with Solaris, the non-profit parent company of the 399-bed JFK Medical Center in Edison, for 25 years.

Luke Gregory was named permanent CEO of Monroe Carell Jr. Children’s Hospital at Vanderbilt in Nashville, Tenn. Mr. Gregory’s position is effective immediately since he has been serving as interim CEO of the 238-bed hospital since Sept. 2010.

Sharon O’Keefe, president of Loyola University Medical Center in Maywood, Ill., was named president of University of Chicago Medical Center. Ms. O’Keefe’s position is effective Feb. 23. She will replace Ken Sharigian, who has been serving as interim president of UCMC.

Brenwood, Tenn.-based LifePoint Hospitals named David M. Dill as president and COO of the company. While Mr. Dill will serve as president in addition to his current role as COO, William F. Carpenter III will continue to serve as LifePoint’s CEO and chairman of the board of directors.

Calvin “Cal” Knight was named president and CEO of California’s John Muir Health, which has two hospitals in Walnut Creek and Concord, Calif. Mr. Knight’s position with JMH is effective April 4. He will succeed longtime CEO Ken Anderson, who plans to retire March 31 after 36 years with the system and 14 years as president and CEO.

Transactions

Community Hospital of Long Beach (Calif.) will explore a merger with Long Beach Memorial Medical Center. As part of the merger, Long Beach Memorial, which is part of MemorialCare Health System, will take over Community Hospital’s operations while due diligence is performed. This is expected to take up to a year.

Goshen (Ind.) Health System announced it changed its name to Indiana University Health Goshen following a partnership between the health system and IU Health. The partnership will provide research opportunities through IU’s School of Medicine, and is not expected to change the level of service offered at Goshen facilities.

Marlton, N.J.-based Virtua, which operates hospitals and other healthcare services throughout South Jersey, has announced a partnership with Children’s Hospital of Philadelphia for pediatric services at Virtua’s facilities in Mount Holly and Voorhees, N.J.

Lewiston, Maine-based Central Maine Health Care is partnering with Massachusetts General Hospital in Boston to offer telemedicine programs.

Houston-based Signature Hospital Corporation announced plans to sell two more hospitals in Texas: Pampa Regional Medical Center and Gulf Coast Medical Center in Wharton will be put to market, with SHC officials attributing the sales to current economic conditions and impending healthcare reform.

Upstate University Hospital, which is affiliated with SUNY Upstate Medical University in Syracuse, N.Y., could take over Community General Hospital in Syracuse as early as July. The hospitals began exploring a merger six months ago. Community General lost approximately $2 million last year.

The Federal Trade Commission has approved an affiliation between Hartford (Conn.) Healthcare and The Hospital of Central Connecticut in New Britain, Conn.

Children’s Hospital & Research Center Oakland (Calif.) and Lucile Packard Children’s Hospital in Palo Alto, Calif., are exploring a merger or strategic alliance. Both hospitals have been struggling to develop financially viable plans to meet California’s seismic standards for hospitals.

The Beaufort Regional Health Authority Board of Commissioners voted to lease Beaufort Regional Health System in Washington, N.C., to University Health Systems of Eastern Carolina.

Valley Medical Center in Renton, Wash., and UW Medicine in Seattle have signed a non-binding letter of intent to explore a strategic alliance. Valley Medical Center, which is operated by a public hospital district, could join UW Medicine,
which includes Harborview Medical Center, UW Medical Center, Northwest Hospital & Medical Center, UW Neighborhood Clinics, UW Physicians, UW School of Medicine and Airlift Northwest.

Denver-based HCA-HealthOne is continuing to pursue Memorial Health System in Colorado Springs, Colo., despite a recommendation by an independent commission to transition the system to a community non-profit.

Saint Agnes Medical Center in Fresno, Calif., will acquire Fresno (Calif.) Surgical Hospital on March 31. Both parties have signed a letter of intent to partner. SAMC will acquire a 51 percent interest in FSH, but each will operate under a separate license. A joint operations board will oversee the acquired hospital.

In its fourth attempt to sell in nearly two years, Brown County General Hospital in Georgetown, Ohio, accepted Scottsdale, Ariz.-based Southwest Healthcare’s proposal.

Pikeville (Ky.) Medical Center announced an affiliation with Cleveland Clinic in cardiovascular disease.

The board of trustees at Shawano (Wis.) Medical Center approved an agreement to integrate with Appleton, Wis.-based Thedacare. ThedaCare’s board approved the agreement last week, which will be effective Jan. 30.

HCA’s Mainland Medical Center in Texas City, Texas, and Clear Lake Regional Medical Center in Webster, Texas, will soon merge under the Clear Lake Regional umbrella. No jobs are expected to be lost when Clear Lake Regional’s license is extended to Mainland Medical.

Arnot Ogden Medical Center and St. Joseph’s Hospital, both located in Elmira, N.Y., signed a formal agreement to merge into a single regional health system. While the agreement awaits approval from the New York State Health Department, Arnot Ogden will manage St. Joseph’s operations under an interim agreement.

Ralph de la Torre, CEO of Steward Health Care System, has revealed plans to replicate the company’s community hospitals in Massachusetts on a national level. Steward, the new company created by the new owner of Caritas Christi Health Care hospitals, owns six Catholic hospitals in Massachusetts. Steward is owned by Cerberus Capital Management, a New York investment firm.

The board of Erie, Penn-based Hamot Health Foundation unanimously approved an affiliation with Hamot Medical Center with the University of Pennsylvania Medical Center.

An affiliation between All Children’s Hospital in St. Petersburg, Fla., and Johns Hopkins Health System is expected to be complete by March. Under the deal, All Children’s will become part of JHHS.

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