SPECIAL BEST PLACES TO WORK ISSUE: Read our list of the 100 Best Places to Work in Healthcare, learn tips for creating an engaged workforce and more.

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BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

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100 Best Places to Work in Healthcare

Becker's Hospital Review/Becker's ASC Review has announced its list of the "100 Best Places to Work in Healthcare." The 2011 list was developed through nominations and research, and the following organizations were selected for their demonstrated excellence in providing a work environment that promotes teamwork, professional development and quality patient care.

For a variety of reasons, the editors ultimately determined to focus the list on hospitals, health systems, surgery centers and large physician

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12 Best Practices for Making Hospitals Great Places to Work

By Leigh Page

It is time to re-engage hospital staff. According to a 2010 report by Press Ganey Associates, 45 percent of hospital employees consider themselves "distanced from or discontent with their current work." Here are 12 best practices to turn that sad statistic around and nurture a fully engaged workforce.

1. Culture eats strategy. Vincent McCorkle, president and CEO of Akron (Ohio) General Health System, is fond of saying that "culture eats strategy." He means that while strategy is key for a successful organization, it can only produce short-term compliance if there is no strong employee culture. All the strategic planning, launching of new initiatives and use of sophisticated metrics in the world won't be successful without a fully engaged workforce.

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50 Things to Know About the Proposed ACO Regulations

By By Scott Becker, JD, CPA, R. Brent Rawlings, JD, Barton Walker, JD, and Lindsey Dunn

This article briefly outlines 50 things to know about the Medicare Shared Savings Program proposed rule — which established Medicare accountable care organizations — released by the U.S. Department of Health and Human Services on March 31. The article begins with a summary of key 45 provisions included in the proposed regulations and then provides five general observations regarding the ACO program, as established by the regulations.

45 key provisions in the proposed ACO regulations

1. ACO Participants cannot participate in other Medicare shared savings programs. A Medicare provider cannot participate in the Shared Saving Program as an ACO participant if it also participates in the independence at home medical practice pilot program or other Medicare programs that include shared savings.

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FEATURES

Publisher's Letter

Accountable Care Organizations: 10 Observations - Orthopedic, Spine and Pain Management Driven ASC Conference June 9th – 11th — How Can ASCs and Practices Thrive in Changing Times; How can Hospitals and ASCs Align?; Meet Every ASC Buyer; What Will ACOs Mean for ASCs and Specialists? Deduct $200 from the Registration Fee

I. ACOs - 10 Observations. We have studied closely the accountable care organization proposed rule, which was released at the end of March. Ten of our core observations are as follows:

1. The ACO regulations place a large administrative burden on CMS and related federal agencies. The regulations articulate, notwithstanding the very substantial regulatory framework CMS and federal agencies must put in place, that the Department of Health and Human Services expects approximately 5 million Medicare beneficiaries to enroll in ACOs.

2. It will take a substantial amount of operational leadership, information technology and overall know-how to establish and operate an ACO. CMS estimates it will cost $1.7 million to establish an ACO. We believe, however, that this far underestimates the actual costs that will be required to put all of the parts in place to operate, and have a chance of succeeding, as an ACO. In reality, the amount of real cost to build out an integrated system or a network that can handle an ACO will require a great deal more money and expenditure than the $1.7 million projected.

3. The first ACOs will be enrolled beginning Jan. 1, 2012. Because this date is fast-approaching and so few organizations are really prepared for this, we believe that many will not be able to enroll in the first effort and will wait and see how the process plays out for at least a year or more.

4. Large integrated delivery systems will be the beachhead of ACOs. They are much better prepared to enter into this type of arrangement, take the risk, measure the risk and possibly succeed as an ACO. In both the short- and long-term, it will be very hard to cobble together networks to operate as ACOs without a serious IDS as the beachhead. The overall advantage, in terms of the new regulations and the evolving system, weighs strongly in favor of large and heavily integrated delivery systems. However, the flip side is that many of these heavily integrated systems are accumulating large carrying costs in physicians and others. It is unclear whether they will be able to sustain those costs.

5. A handful of systems, some of which have already gotten out in front of ACO development, will be the most successful in first entering into ACO contracts. There is a great deal of uncertainty about how payments will be made and how much benefit there will be from being a Medicare ACO. Thus, as stated above, until CMS issues more information, many healthcare organizations will likely remain quite cautious about engaging as ACOs.

6. Given the former history with PHOs and multi-provider networks and the fact that CMS estimates that only 5 million people will enroll, a core question that many systems, surgery centers and individuals will ask is "can you ignore this development? — i.e., ACOs." Generally, we think the risk is too great that ACOs will become key healthcare entities for Medicare or for commercial payors to ignore them. Further, it will continue to impact how healthcare is delivered and how pieces are put together. Historically, when Medicare funds a program, it often becomes a significant driving force as to provider initiatives and efforts.

7. The ACO dialogue places a tremendous amount of faith in a care management model. However, there are still great questions about whether there are sufficient primary care physicians engaged to be able to really handle what is expected under the ACO regulations, as well as whether they have the drive, desire and skills to fulfill those expectations.

8. The ACO regulations appear to view specialists, surgery centers and business interests as necessary evils at best. The regulations limit the percentage of interest that business interests can have in an ACO and, essentially, state that ACOs are aimed at reducing the use of specialists.

9. Many of the ACO concepts are quite aspirational in nature. The regulatory dialogue is very negative toward the current system and idealistic as to how ACO-driven case management can work and how ACOs can offset the fragmenting of care.

10. In terms of pursuing success in this new mode of delivery, most systems have to work through competing agendas. They still must profit in the fee-for-service world but have to be prepared to also live in a managed care environment. This can create conflicting motives, particularly as fee for services is still relied on to keep the lights on.

II. 9th Annual Orthopedic, Spine and Pain-Management Driven ASC Conference - "How should ASCs, hospitals and orthopedic, spine and pain practices align?"; How can ASCs and practices thrive in the next few years?; Meet every ASC buyer; What will ACOs Mean for specialists? June 9th to 11th; Chicago, Illinois, Michigan Avenue.

This year's Orthopedic, Spine and Pain Management-Driven ASC Conference will focus on several issues that are emerging as critical for orthopedic physicians, spine specialists and pain management physicians. These include issues such as:

- Should you sell your ASC and/or practice or not? How should you align with ACOs? How should ASCs, specialists and hospitals align?
- How can independent surgery centers and practices thrive?
- What is and is not legal with respect to a wide range of issues, including out-of-network issues, anti-kickback safe harbors, recruiting and more.
- What ancillaries can your practice profit from? What are the best practices for co-management arrangements?

If you are joining us, please register by May 1, 2011 and take a discount of $200. Please note "discount per Scott Becker" on the registration.

We look forward to speaking with you soon. Should you have any questions, please contact me at 312-750-6016.

Very truly yours,

Scott Becker

12 Best Practices for Making Hospitals Great Places to Work
(continued from page 1)

2. Draw from a 'well of credibility.' Any effort to engage employees should be treated as a valuable investment, says Kevin Haeberle, senior vice president and senior advisor at Integrated Healthcare Strategies in Kansas City, Mo. "Whenever you are engaging in mutual trust, you are putting water into the well," he says. "How deep that well is begins to matter when you need to take water out." For example, you have to postpone annual pay increases, cut back on benefits or make some other unusual demand that is going to be trying on your staff. "If you hit hard times and your well is shallow," he says, "you'll be in for a major negative reaction."

3. Be available. "When the hospital starts losing money, do all the top executives hide in their offices, no longer to be seen by anyone?" asks Brad Federman, president of Performancepoint in Memphis, Tenn. This is poisonous for employee morale, he says. Left without any information, employees start getting fearful, invent scenarios and are distracted from their work. To keep in touch, Mr. McCorkle holds regular "town hall meetings" for all shifts at his hospital. "We talk about aspirations and achievement in there," he says.

Availability is crucial up and down the chain of command, says Vicki Hess, RN, an employee engagement expert in Owings Mills, Md., and author of "The Nurse Manager's Guide to Hiring, Firing & Inspiring." A common complaint from employees is, "My boss is in meetings all the time," Ms. Hess says. She advises managers to maintain an open-door policy and spend time with the staff. When the manager cannot always be personally available, there should be other ways to keep in touch with the staff, such as calling in or stopping by between meetings, she says.

4. Provide achievable goals. "People respond to goals," Mr. McCorkle says. For example, orthopedic surgeons are famous for ignoring requests to consider less expensive implants, but if they were told, "Saving x-amount of money on implants means we would be able to fund these specific projects," they would more likely respond. Having something to work toward "narrows the gap between itch and scratch," Mr. McCorkle says. He wants all goals to be ambitious, adding: "If we don't set high goals we will never achieve them." For example, the proper policy for dealing with patient falls is to set a goal of absolutely no falls with injuries.

5. Be transparent. Mr. Haeberle says the traditional approach is for management to be secretive. "If you were going to lay off people, you would announce it just before it happened," he says. The reasoning was people would stop working hard if they knew, but in fact, most people will continue to do their jobs well, he says. Indeed, Mr. Federman found that hospitals in financial straits during the recession fared better if they were very open about it.

When Mr. McCorkle meets with employees at Akron General, he gives them "total amnesty" to talk about anything they want, even if they don't like his policies. "Transparency is essential," Ms. Hess says, adding that when staff know and understand management's objectives, they will be more likely to share them. For example, a nurse who is tempted to give away medical supplies to patients when they go home might not do so if she knew her department was struggling to balance its budget. "Shared knowledge can be a powerful tool," Ms. Hess says.

6. Nurture mutual respect. Under an older management style, the CEO says, "I expect you to respect me," Mr. Haeberle says. But if workers are treated as equals, they are more likely to be engaged, he says. "When I respect who you are, I try to understand why you think the way you do," he says. At Akron General, Mr. McCorkle insists that employees call him "Vince." He thinks they are more likely to be frank and open that way. "If someone can say, 'Hey, Vince,' they are going to tell you what's on their mind," he says.

7. Be supportive. A big part of nurturing respect is being supportive. Ms. Hess says managers should assume employees are doing the right thing until proven otherwise. For example, when a patient complains about an employee, assume the employee is innocent until proven otherwise, but all the while seriously check into what was going on. "You have got to ask questions and find out what happened," she says.

8. Link employees to the mission. "Employees need to feel that what they do connects to the overall goals of the organization," Ms. Hess says. "If the manager tells me, 'You have to do this because it's our new rule,' that doesn't make me feel good about it," she says. She advises using the vision and values of the organization as a roadmap to guide employees.

Mr. McCorkle tells this story about the power of the mission: A janitor sweeping the floor at Cape Canaveral at night is asked what he is doing. "I'm helping to put a man on the moon," he says. "Healthcare is a calling. It means embracing something bigger than yourself," McCorkle says. "There needs to be a passion and an energy for all the things that the mission is about."

9. Create an effective team. Healthcare relies on relationships within a team, Ms. Hess says. The manager's guidance can make the team more productive. "Managing an effective team means promoting a high level of trust and comfort with conflict," she says. To be effective, team members need to speak up, identify their differences and work through them without hostility.

10. Let employees do their work. Ms. Hess says the hospital's goal should be helping each employee find his or her "professional paradise," where they are satisfied, energized and productive. Mr. Haeberle says managers who respect employees' opinions recognize there can be a variety of ways to accomplish a task. He advises management to get out of the way and let employees do their work. "When I ask you to do something, I'm going to assume it's going to get done," he says. If the employee doesn't do what he said he'd do, the pact is damaged. "The mutual trust has declined," he says.

11. Give employees choices. Employees who are given choices are going to be more invested in the work they do. It's not always possible to do this in a hospital environment where work is often based on prescribed protocols, but there are still many opportunities, Mr. Federman says. Rather than saying, "We can't do that," leaders should be saying, "How can we do this and still follow the regulations?"

"If there is a way to meet employees' pressing concerns, use it, even if it's a little unconventional," Ms. Hess says. For example, employees may prefer to work extra hours rather than use locum tenens nurses, but taking over one eight-hour shift may be too daunting for a full-time employee. One solution might be to cut the shift into two four-hour blocks, which full-timers would be more likely to accommodate.

12. Lead by example. Every two weeks, Mr. McCorkle has a meeting with his top-level managers. "We talk about barriers and roadblocks," he says. "People commit to a goal by signing a pledge." When his staff meets with more people down the organizational chain, they apply the same principles. He says top management's example is like a wave going through the whole organization. ■

Finding the Model Healthcare Executive

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

A lot of sports or business legends exhibit great courage and expertise, but their personal lives reveal things that are anything but exemplary. You might even call these legends phonies with feet of clay. But no one seems to care as long as they score touchdowns, slam the puck into the net or close a fantastic deal.

There are a few people, though, who combine courage, expertise, integrity and honor in one package. When you come across them, you realize how fortunate you are. My own example is a healthcare executive.

Edward A. Eckenhoff retired in 2009 after 28 years as CEO of the National Rehabilitation Hospital in Washington, D.C.

In high school, he was captain of the track team and a fullback on the football team. He took a year off after graduating to study piano in Germany. His life changed forever, though, when he came back to the states and entered college. He was passenger in his roommate's MG sports car in 1963 when it crashed, killing the roommate and throwing Ed Eckenhoff from the car.

Catapulted onto his back, he suffered a spinal cord injury and ended up permanently paralyzed from the waist down. Spending months in rehabilitation, he rethought his life and eventually opted for a career in hospital administration. "There is something about a disability that wakes us up," he said many years later. "I don't know whether we begin overcompensating or we realize we have fewer options for success. I do know it made me rethink my future, and I have observed this with a lot of people who suffered disabilities."

Joining the Rehabilitation Institute of Chicago, he worked his way up to become vice president of administration. Then, seeing a need for similar services in our nation's capital, he moved to Washington and founded the National Rehabilitation Hospital in 1984.

Combining empathy and courage

There are many things that make Ed Eckenhoff

exemplary. One of the most obvious is his empathy for his disabled patients. Empathy is an important trait for all executives to have. He could understand his patients because he had gone through exactly what they were going through. "When I was injured, I spent months in the hospital," he said. "When I began my career as a rehab hospital

administrator, I wanted to see that time reduced, and it has." Partly due to his efforts, length of stay is shorter and equipment for people with disabilities has become much lighter, helping them to be more mobile and become more a part of society.

Another outstanding trait of Ed Eckenhoff is his courage in the face of adversity. "Honestly, in retrospect if I could change anything, I don't think I would," he recently said of his injury. "I do know that it actually was a great life experience. I know myself better and I've been able to use the experience to an advantage and hopefully to help others."

I am proud to know him. He is everything you would want in a friend. He's caring, generous and listens to you. He has a great sense of humor and occasionally likes to have a "toddie." He's a great golfer. Swinging a golf club with one arm and using the other to hold his crutch and balance himself, his scores are in the 80s and lower 90s.

Ed Eckenhoff has been married for 34 years to a wonderful soulmate. How he and Judi met is an interesting story. He was still running the Rehabilitation Institute of Chicago and she was one of his department heads there. He met her in an elevator and eventually asked her out. In today's workplace environment, that might be grounds for harassment because he might have exercised his power as her boss. But that didn't happen.

Dedication to mentoring

He is an articulate man who would have made a great sports broadcaster. As a boss, he took the time to mentor his people so they could do their jobs more efficiently and productively. That alone is an almost lost art in healthcare today. It almost seems as if nobody has the time nor inclination to help others do their jobs better by giving them advice and counsel.

Whenever I visit a hospital, I ask the executives how they are doing with mentoring. They tell me they try but it takes a lot of time and, regrettably, they can't do very much of it. But Ed Eckenhoff did find the time for mentoring and his people were delighted.

His leadership style was to be completely transparent with staff, physicians, board and patients. Everything was on the table and no secrets were allowed!

He never forgot that the hospital CEO's mission is to put patients first and all else second. As far as Ed Eckenhoff is concerned, patients are what healthcare is all about. After all, without patients there would be no need for hospitals.

He saw his mission as healing patients' broken bones and their broken hearts. That's why he was such a wonderful leader all those years. In my 33 years as publisher of *Modern Healthcare* magazine, I met many great leaders in healthcare but Ed Eckenhoff stands out as one of the very best, combining integrity, honor, courage and character. That has made all the difference. ■

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

Physician Integration: Hospital Medical Leaders Share Challenges, Strategies

By Sabrina Rodak

Healthcare leaders are finding that physician integration will be critical for achieving the increased efficiencies and coordination necessary for meeting healthcare reform standards and for producing savings. Although integral to the formation of accountable care organizations, hospitals are pursuing physician integration regardless of plans to create an ACO because of the changing landscape in healthcare. While these changes are just beginning, several chief medical officers and medical affairs executives share challenges and strategies to establish a successfully integrated system.

Education

A common challenge noted among leaders is the lack of specific information regarding ACOs and other models for physician integration. Sharing knowledge and educating others is thus key to beginning to align physicians with a health system. **Kersey Winfree, MD, CMO of Oklahoma City-based SSM Health Care of Oklahoma**, says education is needed at both the basic level — what integration means — and at a higher level, addressing the implications of integration and other changes in healthcare delivery.

Simply teaching fact-based information will not itself lead to success, however. Dr. Winfree says, "It's not just getting physicians to comply with a set of rules; you need to get them to commit to and transform practices." For instance, physicians will have to shift from a volume- to value-based system of care. **Alan Pope, MD, vice president of medical affairs and CMO of Camden, N.J.-based Lourdes Health System**, says one challenge is transferring physicians from an independent model in which they have control of a person's care to a team approach in which they represent one component of the patient's care.

Dr. Winfree echoes this idea: "Historically, physicians have not been part of any employed workforce. They have been independent practitioners or in group practices that might have a non-hospital employer." He says physicians will have to learn how to operate as part of a labor force and hospital leaders will have to learn how to manage this new force.

Governance structure

A second challenge to physician integration is deciding what governance structure to use when aligning physicians with hospitals' missions. **Michael Nochomovitz, MD, president and CMO of Cleveland-based University Hospitals medical practices**, says that for hospitals new to physician integration, "The hardest thing is creating an appropriate structures for physicians with which hospitals can interface."

Many healthcare leaders say including structures other than employment is helpful in integrating physicians. In Alexandria, Va., **Inova Mount Vernon Hospital's Vice President of Medical Affairs Donald Brideau, MD**, says that while potentially more complicated, establishing a model that does not force physicians to become employed may attract more physicians. "One strategy is not trying to make all physicians become employed, [but to] develop much more sophisticated measures of partnership," he says.

Larry Donatelle, MD, vice president of medical affairs at Affinity Health System's St. Elizabeth Hospital in Appleton, Wis., also says that while perhaps easier to align incentives when physicians are employees, hospitals should not exclude other more inclusive models. Affinity Health, for instance, has a medical group separate from the hospital and governed by physicians. Springfield, Mo.-based St. John's Clinic, which is part of the Sisters of Mercy Health System-St. Louis, is a physician-led professionally managed multispecialty organization with its own governing body and hierarchy. **Fred McQueary, MD, president of the clinic**, says the clinic and hospital work together to solve issues. "One is not subservient to the other; they are incentivized to be working towards the same [goals]."

Baptist Memorial Health Care in Memphis, Tenn., has also created an autonomous physician organization as part of their plan for integrated care. **Richard Drewry, Jr., MD, vice president and CMO of BMHCC**, says "The most important part of the relationship is in the first 90 days. How do we interact with [physicians]? Do we interact as a large health system, or do we interact with them in a way that's flexible and willing to look at different ways of doing things?"

Part of being flexible is allowing physicians not employed by the hospital to become integrated. Dr. Nochomovitz says in addition to a base of employed physicians, University Hospitals includes independent physicians through its institutes, which include the Digestive Health, Eye, Harrington-McLaughlin Heart and Vascular, Neurological, Transplant and Urology Institutes. The only criteria for physicians to align with University Hospitals are that they meet quality measures, use certain protocols and share data. Dr. Nochomovitz explains a possible motive for hospitals to want to limit their integration plan to employed physicians: "Sometimes organizations find it difficult to deal with independent physicians. They feel they need to control physicians. We don't believe that; we don't view them with trepidation, [but instead] see as it as an opportunity." This system offers both independent and employed physicians the ability to integrate with University Hospitals.

Physician leadership

Besides choosing a system of interacting with physicians — employment, partnership, etc. — hospital leaders need to decide how to involve physicians in leadership positions to achieve success in integration. Although several hospitals described above have physician organizations separate from the hospital, they all ensure that physicians work closely with hospital administrators in decision-making. Dr Winfree says, "Physician leadership is going to be critical to the success of integrated models."

Because many physicians aligning with hospitals previously worked in independent practices, providing physicians with a level of control is essential in getting them to buy into the system**. Jim Boswell, CEO and vice president of physician services of Baptist Memorial Medical Group**, an affiliate of BMHCC, says, "One of the biggest challenges in physician integration is for physicians to realize they have a voice, they still have autonomy."

One model that allows hospitals to involve physicians in leadership is a co-management agreement in which a physician is paired with a hospital administrator. Dr. Pope says Lourdes Health System uses this model. He explains the benefits of physician leadership: "Physicians are the ones in the trenches day to day, seeing and caring for patients across the continuum of care. Many hospitals recognize that if physicians have the interest and ability to provide leadership, they can often be very strong champions as well as critical thinkers for designing a better healthcare system." To identify physician leaders, Dr. Winfree says SSM Health Care of Oklahoma is surveying physicians about their interest in leadership positions.

Hospitals that combine hospital administrator and physician perspectives may be able to more easily create efficiencies compared to those that don't. Dr. Brideau says, "Physicians get trained in one particular way and managers get trained in a very different way. Yet, you need both sets of skills." Simply adding physicians to a system is insufficient to cut inefficiencies and costs; partnering physicians at the leadership level will help the system create a more coordinated organization.

St. John's Clinic is led by practicing physicians, according to Dr. McQueary. "A driving factor behind our success as an organization is any physician involved in administration is a practicing physician. [He or she] is still 'in the trenches.' [The leader is] able to relate to physicians on a professional and peer level, which

helps drive understanding and trust," he says. Dr. McQueary believes that ensuring physician leaders are practicing physicians increases their believability as leaders. These physicians practice half time and are individually partnered with a professional administrator to complete the administrative team. Similarly, Dr. Brideau says that a message to physicians by physician leaders resonates more than the same message delivered by hospital administrators.

Placing physicians in leadership positions may also help physicians invest in the system. Dr Drewry says physician integration "should be a relationship, not just a transaction." An important part of building a relationship is fostering trust among physician and hospital leaders. Dr. Donatelle says that Affinity Health System's transparency with its plans and engagement with physicians has helped build trust and strengthen their relationship. The hospital has established a physician advisory council to share "information about our current operations and growth strategies for the future" with primary care, specialty, and subspecialty physicians.

As hospitals continue to work towards physician integration, it may be helpful to spend resources developing strategies for education, governance structures and physician leadership. While tangible products like electronic medical records are also essential, working on abstract elements that require communication and trust-building may ultimately drive the success on an integrated system. ■

Physician Integration May Be "Tipping Point" for Success of ACOs

By Sabrina Rodak

The success of physician integration may be the "tipping point" for the development of an accountable care organization, says Michael McKenna, MD, VP of Medical Management at Advocate Lutheran General Hospital in Park Ridge, Ill.

"An ACO is a mechanism by which you can deliver care and the only way it will be effective is to have the hospital and physicians aligned to provide the best outcomes for its patients. If you don't have alignment, it's going to be very hard to become an effective ACO," he says.

For the past 15 years, Lutheran General has been working on a physician integration strategy through Advocate Physician Partners, an organization jointly owned by Advocate and physicians that aligns physicians with hospitals. According to Dr. McKenna, the last five years in particular have shown yearly improvements in physicians' performance.

"This has led to improvement in our community's health and also to improvement in the financial health of both the physicians and the partner hospitals," he says.

Quantifying success

In the midst of uncertainty and a lack of definitions regarding ACOs, Lutheran General and APP have created measures to improve outcomes, which have led to great success in their physician integration program.

At the beginning of the year Lutheran General and Advocate Physician Partners set standards by which physicians will be measured. There are over 140 measures related to clinical integration, but each individual physician is accountable for only a portion of these measures, depending on his or her specialty.

The performance on these measures is then scored, which provides several benefits, including:

1. An evaluation of physician alignment with hospital goals
2. A method for distributing incentives earned through clinical integration
3. An effective tool for communication between the physician and APP, leading to improved outcomes

Dr. McKenna attributes part of the success of Lutheran General's physician integration program to this creation of "accountability systems with measures that we are constantly feeding back to physicians that describe their performance. At the end of the year, their share of the incentives is determined by their clinical score."

He suggests that both physician and hospital leaders jointly decide the distribution of payment for physician incentives. Giving physicians an equal part in this decision builds trust between the physicians and hospital, a key to successful physician integration.

Dr. McKenna adds, "Too many hospitals or systems now think the solution is employment of physicians; to be effective in today's environment, organizations need to be able to deal with different physician practice platforms."

Advocate Physician Partners has helped Lutheran General partner successfully with both independent and employed physicians. ■

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5 Opportunities for Physicians and Hospitals to Realign in Preparation for ACOs

By Molly Gamble

Accountable care organizations may still be clouded with uncertainty, but one facet of the model is becoming clearer: redefined relationships between hospitals and physicians. Shifting from the tense environment of the 1990s, hospitals and physicians are now looking to one another as integral components of a successful ACO. "More commonly, hospitals are recognizing the need to communicate and give voice to physicians, and physicians see the stability of hospitals," says Clayton Harbeck, chief development officer at MedSynergies, an Irving, Texas-based company that partners with healthcare organizations and physicians to align operations.

Since physicians have been called the fundamental driver of ACO success, hospitals are revisiting their relationships and alignment strategies. Here are five ways the hospital and physician relationship will evolve in the wake and preparation of ACOs.

1. A revised culture may mean the expiration of traditional bureaucracy. It may rarely make headlines, but a number of physician integration projects around the country end up failing, with historic bureaucracy hindering the development of successfully governed entities. Even though care delivery models are different in every market, there are commonalities in failing and successful integration projects that serve as best and worst practices.

Failing systems usually leave physicians reporting under the hospital president, limiting their voice and influence in how healthcare is delivered within hospital walls. A thriving integration model, however, will establish a separate entity for the physician practice, with physicians reporting to the leader of the medical group who then reports to the health system CEO. "Successful models have governance or written communication with penalties for noncompliance and awards for adherence," says Mr. Harbeck. "When we see that model, we know it works. But it's very rare."

2. Physician and hospital leaders need to have "crucial conversations" for ACOs to work. Thomas D. Gordon is the CEO of that type of "rare" albeit successful model at Cedars-Sinai Medical Delivery Network in Beverly Hills, Calif. The group, which was formed in 1985, now includes more than 830 physicians: 117 physicians originally from Medical Group of Beverly Hills, which Cedars-Sinai Medical Center purchased in 1985; a 17-physician hospitalist company; a 7-physician pre- and post-transplant cardiology group; and an IPA with more than 700 physicians.

Mr. Gordon attributes much of the medical group's success to his integrated and trusting relationship with the Thomas M. Priselac, CEO of Cedars-Sinai Medical Center. "I must give him a lot of credit. He's worked with me every step of the way when things weren't going right, whether financially or strategically," says Mr. Gordon. "People often think physicians and hospitals are shoes and socks, but they're not. They're essentially fighting for the same dollar. But we approached this as a health system. If you have the crucial conversations, you can make it work," he says.

3. Independent physicians will be able to form new affiliations with hospitals. Cedars-Sinai Medical Group is planning to reach out to independent physicians and incorporate them into ACO-aligned goals, such as population health management. "For some independent physicians in this community, population health may not be on their radar. But we're going to do our best to include them in everything we're doing in population health," says Mr. Gordon.

Healthcare providers may offer high-quality patient care, but relationships with physicians outside the hospital walls — such as outpatient clinics, palliative care, specialty services and home care services — are now major determinants in ACO success. Also, hospitals should not lose sight of an important ACO cornerstone: patient centered medical homes. "Payors are working directly with physicians or physician groups, registering them under key evidence-based medicine criteria, and many hospitals aren't participating in that process. As a result, the payor has the most ability to negotiate," says Mr. Harbeck. "This is a huge mistake." Mr. Harbeck recommends hospitals aggregate physicians and push for registration under these standards, renegotiating contracts based on that success.

4. Hospitals and physicians can strengthen ties through a variety of models. Although more hospitals are acquiring independent practices in order to become ACOs with employed physicians, hospitals and independent providers can still establish affiliations short of full-out acquisitions.

Co-management agreements are gaining popularity as alternatives to employment, with 51 percent of physicians interested in pursuing co-management in the next two years and 24 percent of physicians already aligned in this model, according to a PricewaterhouseCoopers survey. This agreement between hospitals and physicians is one way for both parties to share responsibility, manage the operations of a service line and develop clinical protocols. This type of affiliation carries great potential for incentives, with physicians being paid for administrative components of non-patient care, which will be plentiful during ACO formation.

Another popular approach is clinical integration, which is considered to be the interim model before ACOs. Participation is selective and physicians must opt to comply with set clinical protocols and outcome measures. Physicians individually contract to serve on committees, follow evidence-based guidelines and be involved in measuring outcomes or practice data. Providers participating in this type of model work across a continuum — the hospital, physicians, outpatient services and pharmacy, for instance, all work to manage chronic disease and coordinate care.

5. Physicians will have new leadership positions and opportunities. Physicians are responsible for the evidence-based care decisions that will determine an ACO's success. This shift from fee-for-service to a culture focused on quality and outcomes will require change in clinical patterns, and few people can change physician behavior more effectively than other physicians.

To increase engagement within the ACO at all levels, hospital leaders and administrators may want to designate more responsibility to physicians. Many experts have said the new model is fundamentally physician-led, but hospitals first have to lend physicians opportunities to lead rather than merely expecting them to take charge. ACOs have stressed need for physicians who can excel in standardization, developing clinical protocols and measuring outcomes, among other skills. ■

ACO Pioneers: Q&A With Leaders From The Nebraska Medical Center and Atlantic Health

By Molly Gamble

Sometime between now and their seven-page inclusion in the Patient Protection and Affordable Care Act, accountable care organizations have been pinned as the unicorns of healthcare. While proposed regulations have been released, many providers have yet to see an ACO or fully understand what ACOs will be like.

Glenn Fosdick, FACHE, and David Shulkin, MD, do know what ACOs look like: they head them. Mr. Fosdick is the president and CEO of The Nebraska Medical Center in Omaha, which launched an ACO with Methodist Health System in Feb. 2010, making it the first ACO in the nation to be led by two competing hospitals. The Accountable Care Alliance, as the systems have named it, is led by a 12-member board of directors, mostly physicians, with six representing The Nebraska Medical Center and Methodist Health System.

Dr. Shulkin is the president of Morristown (N.J.) Memorial Hospital and vice president of Atlantic Health, the hospital's parent company that formed an ACO in Dec. 2010. More than 300 physicians participate in Atlantic's ACO, which serves a seven-county area in New Jersey. The system is comprised of 658-bed Morristown Memorial and 504-bed Overlook Hospital in Summit, N.J. Atlantic Health expects its ACO to be ready to work with various populations, including Medicare patients, by Jan. 2012. Here, Mr. Fosdick and Dr. Shulkin answer questions and discuss their respective experiences launching an ACO.

Q: Your organizations were rather ahead of the curb when they launched their accountable care organization. Can you provide some insight on how you knew the time was right for your hospital to proceed and enter ACO agreements?

Glenn Fosdick: I think for the last three years or more, because of healthcare reform and the discussions taking place in Washington, D.C., we recognized some things had to change. We knew we would not be paid the way we are today, and it was obvious we had to do something. More than a year ago, we launched our ACO, called the Accountable Care Alliance. The ACA is a partnership between Methodist Health System, The Nebraska Medical Center and their affiliated physicians. The collaboration of these two competing health systems is meant to form a best practices network to share quality improvement strategies, improve care coordination and efficiency, and find opportunities to reduce costs.

David Shulkin, MD: The ACO concept is certainly not a new one. Many of us who have worked on improving the healthcare system have long believed in integrated care delivery systems and coordinated care as strategies to improve value. What has really happened is that we have run out of other alternatives than what we need to do now: tackle the fragmentation of our healthcare system. ACO principles are actually long standing principles, and the ACO really represents a repackaged term. In fact, some call this craze — the "ACO" that is — "Another Consulting Opportunity." In reality, it is not something new but returns us to basic concepts of care management.

Q: Many industry experts have labeled 2010 as the year of "ACO fever," with many healthcare organizations panicking over the race to a new model. Was your organization able to resist that panic? Do you think 2011 will present similar uncertainty or panic?

Mr. Fosdick: We're very comfortable with the work we're doing with our ACO right now to create better clinical care for our patients. This type of work wouldn't change, regardless of the types of regulations that may or may not be created in Washington, D.C.

Dr. Shulkin: We certainly are not part of the ACO rush. We understand that a commitment to an ACO is long-term and requires foundational change in the medical marketplace. Change in healthcare is never quick, especially when it challenges some current economic principles in the market. However, I also believe that some "ACO fever" is a good thing. There is often so much inertia in healthcare that it takes a certain urgency and competitive push to prompt organizations to make commitments, both in terms of resources but, even more importantly, in terms of vision and leadership attention. Maybe catching the fever will accelerate these changes.

Q: What type of infrastructural changes did your systems make to foster ACO development? Can you speak on the costs associated with these changes?

Mr. Fosdick: Our ACO started by identifying a group of strong physician leaders from Methodist Health System and The Nebraska Medical Center who were sold on the ACO model for identifying ways to provide high-quality, cost-efficient care. These 10 physicians (five from each hospital) and the hospitals' CFOs make up the ACA board. The largest cost has been enhancing our medical system so we can more easily share information. We were planning to change our electronic medical record system regardless, but the ACO gives us another reason. Now we will be able to more easily share information with providers within and outside of our system. There have also been some legal fees, which we've been splitting 50-50 with Methodist.

Dr. Shulkin: The infrastructure needed is easy to talk about and hard to develop. Infrastructural changes include developing a governance structure that allows clinicians and patients to design healthcare strategies that work in the community; providing an IT backbone to facilitate information sharing; allowing patients to participate in their care plans; measuring outcomes and improvement strategies; and creating an economic and clinical alignment. The cost of that, in the long-run, is priceless.

Q: Can you discuss a few of the challenges your organization encountered while implementing this model?

Mr. Fosdick: There have been some challenges in educating the physicians on why we are forming an ACO, but we are at the point where the physicians are very much engaged. Still, there is a large segment of physicians who are not involved, so we have plans to educate them and encourage their participation. In addition to that, there are voices in both organizations (Nebraska and Methodist) that are concerned. "Aren't we competitors with each other? Why are we doing this?" As we expand into different specialties and work on best practices and core results, it will probably be challenging to get people who are still in "competition mode" to sit down and work towards a greater good for the community and for themselves.

Dr. Shulkin: Our biggest challenge to date has been to find clinical leadership that is ready to innovate and take the risk of new models for care delivery.

Q: On that note, can you share a few of the benefits or positive changes you've noticed from the ACO?

Mr. Fosdick: In order for an ACO to be successful, the hospital administration needs to have a more collaborative arrangement with medical staff — more collaborative than they've

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had before. It is essential to allow increased physician involvement in decision-making. The real focus is to improve the health of the population we serve — to keep people healthier so they don't come to the hospital to manage their chronic conditions. They can have a better quality of life because of this.

Dr. Shulkin: Our biggest benefit has been in finding these clinical leaders and then engaging in the real work of improving population based approaches to care. Once engagement in these discussions begins, this redefines the relationships and dialogue between physicians, hospitals and payors and eliminates a lot of the traditional barriers that have been in the way in our traditional structure of healthcare delivery.

Q: You are among a few select leaders who have led a system through this major development. What leadership skills came to the forefront during ACO-development that may not have been as evident in past healthcare experiences?

Mr. Fosdick: It is important to have an open mind to doing things differently than you have in the past. It's also important to concede some of your responsibilities to physician leadership. Work with them as they implement new clinical protocols.

Dr. Shulkin: The leadership skills that are most important are not too surprising. They are what people want from their leaders: trust, values and transparency. This is about building relationships and pursuing paths because you can make a difference in working with others. Another key leadership attribute is admitting that you alone don't have all of the answers. Be able to say, "I really don't know, but we can find out." A sense of humor doesn't hurt, either. ■

10 Recently Formed ACOs

Here are 10 providers that have recently formed accountable care organizations, beginning with the most recent.

Anthem Blue Cross, **Sharp Community Medical Group** and **Sharp Rees-Stealy Medical Centers** — all based in San Diego — will pilot an ACO. The ACO, for select Anthem PPO members, will emphasize coordination of care among providers, focusing on preventive care and chronic care management.

Morristown, N.J.-based **Atlantic Health** formed an ACO with more than 300 participating physicians. Atlantic Health is one of the largest nonprofit health systems in New Jersey, operating Overlook Hospital in Summit, N.J., and Morristown Memorial Hospital.

Blue Shield of California is teaming with five healthcare providers to form two ACOs, which begin July 1 to benefit HMO members of the San Francisco Health Service System. Blue Shield, **Brown and Toland Physicians Group** and **California Pacific Medical Center** will form one ACO to serve 21,000 HSS members assigned to Brown and Toland. California Pacific Medical Center's four campuses — California, Davies, Pacific and St. Luke's — are included in this ACO.

Roanoke, Va.-based **Carilion Clinic** and Hartford, Conn.-based **Aetna** have collaborated to form an ACO. As an ACO, Carilion would buy administrative services through Aetna and Aetna would become the administrator of Carilion's employee health benefits plan. However, Carilion Clinic will continue to participate in existing health plan provider networks and accept Aetna and other private insurance plans.

Mishawaka, Ind.-based **Franciscan Alliance** announced it formed an ACO to improve care delivery and reduce medical costs. Catholic Franciscan Alliance operates 13 hospitals in Indiana and Illinois and employs more than 550 physicians.

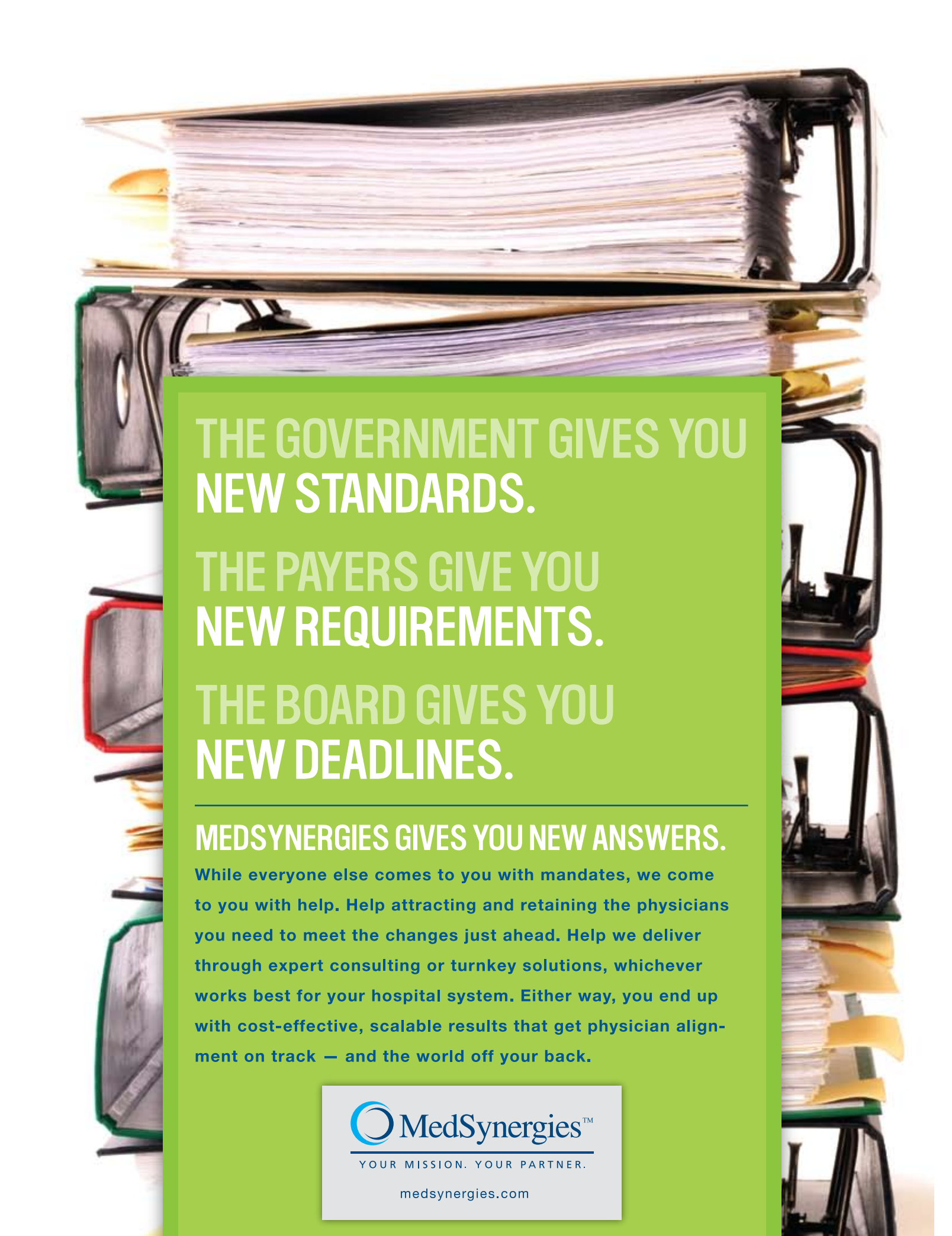
Middletown, Conn.-based **Medical Professional Services** — a group of over 400 physicians — plans to join with other physician groups and hospitals to form an ACO. The ACO plans to cut costs by evaluating doctors' performance, patient satisfaction, and MPS' strategies. The group will use one system of electronic records to integrate care.

Montefiore Medical Center in New York City expanded its contract with insurer **EmblemHealth** to explore an ACO. As part of the agreement, Montefiore will explore arrangements for EmblemHealth's fee-for-service patient population among the lines of an ACO. The contract commits the parties to launch projects that improve quality and cut healthcare costs.

Louisville, Ky.-based **Norton Healthcare** and insurer **Humana** joined to create the first ACO in the Louisville area. The ACO is expected to include approximately 10,000 Humana members, whose employers have agreed to participate in the pilot.

Dearborn, Mich.-based **United Outstanding Physicians**, a physician organization with more than 1,000 physicians, launched an ACO. The ACO has designated 1,020 shares of stock to 720 physicians. Primary care physicians received two shares of the stock, while specialty physicians received one share. Sixty thousand other shares remain available and will either be retained by the company or made available to new physicians. The organization has approached several local health systems to provide inpatient care for patients assigned to its ACO.

Two independent practice associations in New Jersey — **VISTA Health System** in Summit and Central Jersey Physician Network — will form an ACO called Optimus Healthcare Partners. The ACO will enroll physicians from the combined 650 physician membership of VISTA and CJPN before expanding throughout the state to include other physician groups. Both IPAs will continue as separate operations as well. ■



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5 Ways to Improve Pay-for-Performance

By Rachel Fields

In 2002, Oak Brook, Ill.-based Advocate Health Care's major payor indicated it was only interested in giving increases if they were related to demonstrated value. In response, Advocate Physician Partners leadership created a clinical integration program and asked the payor to fund a pay-for-performance program for physicians confident that it would demonstrate value. The program evolved to include other major payors in the Advocate market over the next few years. Over the last seven years, Advocate Physician Partners has used the program to create alignment between the health system and its physician population.

Here Jim Skogsbergh, president and CEO, Bill Santulli, executive vice president and COO and Lee Sacks, MD, executive vice president and CMO, discuss five strategies for building a quality pay-for-performance program.

1. Limit and tailor physician quality measures. Most pay-for-performance systems are based on a number of quality measures that hold physicians accountable for improving readmissions, turnover times and many other hospital processes. The Advocate leaders recommend limiting the number of measures per physician, as well as tailoring the measures for each specialty. At Advocate, while the entire system set 116 benchmarking measures in 2010, each physician had no more than 30 measures. For subspecialties, the number was even lower, at around 10 measures per physician. The key here is to concentrate your physicians on measures they can accomplish without feeling overwhelmed.

Dr. Sacks and Mr. Skogsbergh say Advocate also standardizes measures for each specialty. They say the system has seen dramatic improvement in chronic disease management for Advocate's patient population, due in part to the way the system incentivizes physician teams to work together. "It takes a team to manage a patient with chronic disease. It's not an individual physician who's responsible," Dr. Sacks says. "It really has gotten physicians to use our chronic disease registry and make every encounter a chance to optimize chronic disease management."

Because measures are standardized by specialty, measures for a cardiologist would be different than those for a general surgeon. For emergency medicine physicians, all the "individual measures" are measures that span the respective emergency medicine group at each hospital. "Most of those measures are related to work processes, and it's less about an individual physician doing things than the fact that they've set up the right checklist and processes and protocols," Mr. Skogsbergh says.

2. Hold under-performing providers to high standards. Holding physicians accountable for improving hospital outcomes only works if you stay true to your word, the Advocate team says. In 2009, one of Advocate's goals was to improve radiology turnaround times, which could enhance patient throughput, but was an issue that caused frustration with primary care physicians. The system created a group incentive for the physician hospital organization, and at the end of the year, all but one site had met the goal of improving radiology turnaround times.

When that site's PHO board met in February, the board passed a resolution to tell the hospital president that because the radiologists missed the turnaround time goal, the physicians had lost money in their pay-for-performance incentive. "The board asked the hospital president to cooperate and they said if that happened again in 2010, the hospital should get a new radiology group to be more in tune with system improvement," Mr. Skogsbergh says. "By April, the radiologists were already better than [the set] target."

When a certain hospital or department falls behind on meeting their goals, your board should take immediate action. Don't let the poor performance become a habit.

3. Release annual report cards along with physician incentive checks. Many hospitals and health systems struggle to achieve physician buy-in when they first implement pay-for-performance. Physicians who are used to traditional payment structures may be hesitant to accept a "new era" of payment models. "I think it's fair to say that the first year, most of the physicians didn't pay any attention to quarterly report cards until the final one came out with checks," Mr. Skogsbergh says. "When people realized some people got much bigger checks with their report cards, there were lots of comments."

By pairing physician pay-for-performance checks with final report cards, Advocate helped physicians see the direct impact of their efforts to improve outcomes. Once physicians realized the financial benefits they could reap, they started flooding Advocate administrative offices with input on data and possible changes.

At this point, Dr. Sacks says Advocate physicians are very excited about the success they've had with quality improvements. "They're feeling really good about making improvements on behalf of their patients, and we appreciate the fact that we have data that can document and support the impact," Dr. Sacks says. "Before this, nobody could think about the impact on our 10,000 [diabetic patients]."

4. Stand behind physicians in payor disputes. During contractual negotiations, your system should take steps to build physician trust. If you don't start out by showing your support for physicians, you will probably have more trouble convincing them to participate in integration initiatives. "We've had a couple of moments of truth where you could either go backwards or go forwards," Dr. Sacks says. "I'm thinking about contractual negotiations where we walked away from a major player when our physicians were disadvantaged. We would forego the lucrative contract on their behalf."

In one drawn-out payor dispute, Advocate stood behind physicians for four years while ultimately winning a difficult arbitration trial. The negotiation process is difficult, and your system may have to endanger some payor relationships, but ultimately the struggle will pay off. Today, Advocate has a good relationship with the payor involved in the arbitration trial. "Those events are referenced frequently by the physicians in terms of why they feel confident about the changes we're about to embark on in 2011," Dr. Sacks says.

5. Retire measures when you reach your goal. Don't keep the same measures once you've met your desired targets, the Advocate team says. Obviously you want to aim for continued improvement, but if your system has reached 99 percent for high patient satisfaction scores, it's likely time to concentrate your efforts elsewhere. "In some cases, [measures] become a membership criteria [for physicians] and it's just a given that they have to do them to stay in the organization," Mr. Skogsbergh says. "In other cases, they're retired because there are only so many things you can focus on." Review measures carefully on an annual basis to make sure they still represent your system's goals. ■

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8 Steps to Building a Truly Transparent Hospital

By Rachel Fields

As state repositories demand data on hospital quality outcomes and patients exercise their ability to research and pursue the best possible care, hospitals are recognizing the importance of transparency both internally and externally. Three hospital leaders discuss how their hospitals used transparency and data distribution to improve finances, satisfaction and clinical outcomes at their facilities.

1. Institute a "no blame" culture. For transparency to be truly effective, hospitals must embrace a blame-free culture," says Judith Canfield, director of surgical services at Providence Regional Medical Center Everett (Wash). In this type of environment, a hospital staff will respond to the publication of negative outcomes by thinking of ways to improve, rather than pointing the finger at an individual department or team member. "Once you take away the blame, people are more likely to immediately give you information on something [negative] that happened," Ms. Canfield says. "I know two or three years ago, people at our hospital weren't as forthcoming as they are today. If something happens in the course of a surgery, the patient will find out very rapidly."

A cultural shift of this nature is not easy, but it is possible if administration gets involved in encouraging providers and staff to disclose information. At Providence Regional Medical Center, if an unexpected surgical event occurs, the team notifies the patient as soon as possible and explains what happened. In order to implement this policy, the hospital initiated a training course that taught physicians and leaders how to disclose adverse information. "All our leaders are trained in disclosure, so if we have a physician who doesn't feel comfortable, all they have to do is call one of the quality leaders [who] work with the physician to do it," she says. If physicians understand that disclosing adverse information doesn't equate to "getting in trouble" with hospital administration, they will be more likely to participate.

2. Improve access to data across the organization. If you want your staff to engage with your benchmarks and outcomes, you have to make the data accessible. This means posting the data in a place where employees congregate or visit on a regular basis rather than hiding it on a little-visited section of your website. Ms. Canfield says her hospital posts data on bulletin boards and in employee newsletters. "We also have staff meetings once a month and review the information so that staff can see and understand it," she says. Dave Fox, CEO of Advocate Good Samaritan Hospital in Downers Grove, Ill., says hospital "report cards" are available on the hospital and health system's intranet. "We can all look at each other's performance and see how we're doing — and even more importantly, we can see where we're struggling and not getting it done," he says.

Jerry Royer, MD, CMO of San Joaquin General Hospital in French Camp, Calif., says his organization shares information on quality improvement projects by asking every department to report to a standards committee on a regular basis. The standards committee collects information on which departments are participating in quality improvement projects. This reporting policy improves awareness across the hospital of how departments are working to improve their outcomes and meet benchmarks.

3. Set high goals. Even if your organization consistently meets industry benchmarks — and especially if it doesn't — your administration should set high goals for improvement. As data becomes more publically available, hospitals may be held to a higher standard, and case volume may drop for facilities with unimpressive satisfaction scores or troubling infection rates. Improvement is also essential for improving employee and physician satisfaction. Good outcomes mean better job security for your staff and providers, and employees will likely be happier if they know the hospital is striving to improve and therefore secure their paychecks. Advocate Good Samaritan boasts very impressive benchmarking rates now — but Mr. Fox says it hasn't always been that way. The hospital's success is based on a policy of transparency and constant improvement. "I can go back to July 2004, when our outpatient satisfaction was at the seventh percentile," he says. "Over a 24-month period, we moved it up to the 99th percentile. We decided to get serious about patient satisfaction." In July 2004, the hospital launched an initiative called "Good to Great," which sought to make Good Samaritan the best facility for patients, associates and physicians.

4. Give staff responsibility for improving hospital processes. In order to build a transparent organization, Ms. Canfield says staff members need to understand organizational goals and trust that you have faith in their ability to meet them. If you don't establish a foundation of trust, publicized data can feel punitive rather than instructive, and employees may feel discouraged when the organization does not meet its targets. She says Providence Regional Medical Center builds that level of trust by giving employees the accountability for improving their individual areas of the hospital. When the hospital started planning its new 12-story patient tower, due to open in June 2011, she brought together teams of staff from the cardiac cath lab, interventional radiology and operating rooms to discuss how the divisions would work together in the new building. "These areas are separate right now and don't relate to each other, but are going to be physically located on the same procedural floor. A key element of these cultures coming together is that all the IR, CVL and OR staff members developed the processes of patient flow and how the patient's care would be delivered in this unit," she says. "I have a book of 12 pages of decisions and agreements that they've made regarding how they are going to work."

She says the administration stood back from the collaboration to allow the departments to work together. When each division could explain their processes and challenges to the other divisions, staff members were able to work together and find a solution. By developing a booklet of agreements, the staff members were able to standardize processes and increase transparency as to what was expected across the unit.

5. Give physicians credible data. In order to involve your physicians in improvement efforts, give them data that clearly demonstrates how their efforts affect quality and cost. If physicians understand that their clinical waste negatively affects the hospital's bottom line, they will be motivated to change their practices — especially if you point out that other hospital physicians have seen better results. At San Joaquin General Hospital, physicians in certain departments gather to discuss metrics and compare results.

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In some cases, Dr. Royer says physicians point out that the data is unreliable because of a certain variable. "For gall bladder surgery, we'll have eight or 10 physicians who are doing surgery, and they all have different lengths of stay and different tests that they order," Dr. Royer says. "When you come together and share these, especially if you have 10 physicians in the room who are identified by letter, it's not very long until someone says, 'I'm letter E and my costs are greater because my patients typically come from the emergency room, and therefore the initial ultrasound shows up on my profile." In this case, sharing data with physicians can alert the hospital to compounding factors that may skew data. In other cases, physicians will come up with 'best practices' based on the shared results. Dr. Royer says when physicians at his hospital shared information on medication use for heart procedures, they were able to come to a consensus about which medication provided the best outcomes. He says the key is to gather a small, specialty-specific group in a room and ask them to speak openly about the data you provide.

6. Follow up quickly with underperforming departments. If you want your data to spur improvement in your facility, you have to follow up with struggling departments as soon as possible after results are released. If benchmarking data shows that a certain department is trailing the industry standard and hospital administration does not respond, staff members will probably think the data is not taken seriously. Advocate Good Samaritan promotes transparency by grading its facility on 25 organizational goals, some of which are published on a monthly or weekly basis to track progress. Every Tuesday the organization publishes and discusses patient satisfaction, Mr. Fox says. "If there's a particular department of service that isn't having good results that month, we drill down to understand why." He says the same holds true for net revenue (actual vs. budget), which is reported every Monday. If the hospital is not meeting its budget on net revenue, administration immediately responds to determine where revenue can be increased or spending can be cut.

Hospitals should also respond quickly in departments where data fluctuates over time and affects hospital costs. Ms. Canfield says her hospital benchmarks a productivity report against 400-500 other hospitals to make sure each department is appropriately using the resources of the organization."A good example is Christmas week and New Year's week, where cases are usually low," she says. "We're always flexing up and down with our staffing, so we're not sitting there with a whole board of staff for half the cases." Looking at data on a regular basis can help you respond in time and save money that would otherwise be wasted.

7. Collaborate with outside providers to benchmark physicians. If your hospital uses an anesthesia provider with its own review process, make sure to collaborate with the provider to benchmark anesthesiologist performance. This collaboration will save your hospital time and money, and the provider may give you data on measures you would not have otherwise considered. Ms. Canfield says her hospital's collaboration with Somnia Anesthesia has improved the process of determining how adverse events occur in the operating room. "When a clinical patient issue is involved with a quality issue, anesthesia is always involved as they're part of the team," she says.

"The team participates in root cause analysis to further examine elements that can be improved." If your anesthesia provider has its own peer review process, you can also depend on the provider for information about anesthesiologist performance, satisfaction and global issues in the anesthesia department.

8. Understand that as the industry improves, you will have to improve too. Although Advocate Good Samaritan Medical Center sits comfortably in the top decile on many of its benchmarks, Mr. Fox understands that the hospital cannot be complacent about its high scores. "Everybody is getting better, so you have to get better in order to maintain your percentile ranking in patient satisfaction or Medicare core measures," he says. "If you're standing still with your results, you're probably going to slip behind in terms of percentile." For example, Advocate Good Samaritan's outpatient satisfaction score two years ago put the hospital in the 90th percentile nationally; today, that same score would put the hospital in the 75th percentile, he says. ■

Consumer Access to Hospital Data Places High Expectations on Facilities

By Rachel Fields

We are entering the age of the informed healthcare consumer: While hospitals promote internal transparency to keep employees aware of strategic decisions and financial hurdles, government and commercial resources are expanding the breadth of information available to patients. The availability of information means hospitals must concentrate their efforts on true improvement rather than just marketing. In the past, hospitals and other healthcare facilities could rely on a referring physician to bring a steady stream of patients, but as consumers become more involved in the research process, they may demand more control over where they receive their care.

Several resources, both governmental and commercial, provide information on quality, cost and satisfaction to consumers. CMS' Hospital Compare website provides data in several areas: process of care measures, provided by hospitals to show whether facilities provide recommended care for various diagnoses; outcome of care measures, compiled by CMS to show 30-day risk-adjusted death and readmission rates for Medicare patients; and patient hospital experience results, compiled from the HCAHPS survey to provide a standardized set of data around patient satisfaction. The website also displays Medicare inpatient hospital payment information, giving a resource to cost-savvy customers looking to avoid inflated prices for common procedures.

While state public reporting initiatives are by no means standardized across the country, various states have taken steps to provide hospital quality data to their residents. According to a 2010 article published in *Health Affairs,* 25 states had programs that reported hospital quality, though information varied considerably from state to state.

Unsurprisingly, commercial organizations are in on the action as well. HealthGrades and Consumer Reports, two of the most well-known ratings organizations that publicize data on hospitals, provide quality and cost information for thousands of facilities across the country. The inclusion of hospitals and providers on Consumer Reports indicates that the healthcare industry — long exempt from the cost and service expectations of other sectors — is now receiving equal scrutiny.

The ease of access to these resources may prove frightening for under-performing hospitals. If consumers are expected to slog through pages of dense documents to uncover outcomes information, hospitals can assume the number of knowledgeable patients will stay small. On these websites, however, patients can enter the name of a hospital or location and quickly see telling numbers on infection rates and patient experience. To remain competitive, hospitals must prepare for the coming era of the savvy healthcare consumer. ■

Involving Anesthesia in Transparency and ACOs: Q&A With Somnia Chief Medical Officer Dr. Rob Goldstein

By Rachel Fields

Q: What is the role of transparency in an accountable care organization?

RG: An ACO is comprised of clinicians who transparently share in the decision-making process and are thereby willing to be accountable for true patient-centered care. The concept of an ACO centers on the idea that everyone wants to understand the care that is provided, what it costs and what quality outcomes it produces. Organizational relationships and all relevant clinical, legal, and administrative processes within the ACO should be clearly defined and transparent to physicians, other healthcare professionals, and the public. One way to improve transparency is by collecting and providing data to those it impacts. Transparency also requires that expectations are clear to all stakeholders. This is an element of the process that often gets lost in translation.

Q: What is the value and importance that anesthesia will play in an accountable care organization?

RG: Anesthesia is extremely important to accountable care organizations because as a specialty, we impact so many different care areas throughout the facility. Whether it's in ambulatory care, inpatient care, the OR, ICU, obstetrics or the radiology or GI suite, almost every element of the hospital is impacted or touched by anesthesia.

If an accountable care organization wants to understand how a facility is performing, anesthesia will play a critical role in that assessment. In order for the hospital to be comfortable and confident in reporting on what and how they're doing, they need an extraordinarily sophisticated and professionally managed anesthesia group. The group should be transparent on how they're performing and understand the hospital's expectations.

Anesthesia can provide the ACO with essential operational support and fiscally-sound decision-making through what we are calling an Accountable Anesthesia Organization or AAO. An Accountable Anesthesia Organization serves as a transparent, collaborative partner in the delivery of high-quality and cost-effective anesthesia care.

Q: What is the value of an Accountable Anesthesia Organization™ (AAO) to its patients? What is its value to the facility or facilities it serves?

RG: An AAO's primary focus is improved quality of care and cost-efficiencies. AAOs need to quantify the quality of care and lower cost; they need to be patient-centric and measure the success of that approach; and they need to make evidence-based decisions about care.

Quantifying quality of care means going beyond regulatory and accreditation compliance. The facility should measure performance and outcomes and feed that information back to clinicians so they can strive for higher outcomes and better performance. There also needs to be alignment as it relates to cost of care. Anesthesia departments are often misaligned because someone else is managing the department's budget. As a result, Anesthesiologists may forego less expensive options for the delivery of safe and effective care simply because they are not aware of the cost. They're not matching evidence-based protocols and cost to improve overall utilization of resources.

Anesthesia departments need to get feedback from hospitals in the form of satisfaction surveys. HCAHPS surveys now require performance evaluations of departments of surgery and anesthesia, and that evaluation has a big impact on the hospital bottom line. There needs to be processes to evaluate and capture that data to then improve the patient experience. In the ideal continuum of care, the anesthesiologist takes care of the patient before they arrive in the hospital through a pre-op clinic, then continues care through surgery and manages care post-operatively. We need to know how well we're doing and how our actions impact the bottom line throughout that continuum. Evidence-based protocols are very important to overall cost and quality.

Q: What is the potential impact on the clinicians employed by an AAO?

RG: There is an element of uncertainty in the community because a lot of anesthesia groups are being asked to be accountable, but they don't know what that means. The clinicians don't fully understand the standard or how to meet it, so they get defensive and meet the minimum standard thrust upon them rather than being proactive. The benefit of an AAO is that it provides an "aha!" moment where the clinicians realize they don't have to be defensive. Instead, there's a framework they can use to improve patient care and patient outcomes while containing cost. The clinicians can collaborate with the department and the hospital because everybody's goals are aligned.

For physicians, AAOs will increase coordinated care and offer a complete view of the patient. As a result, clinicians are more professionally satisfied and more productive. The work environment improves. Anesthesia departments are strained and stressed about the idea of being "accountable," so AAOs are very comforting to clinicians because they dispel the myth that accountability will disrupt clinical practice. Having Somnia involved also gives clinicians greater job security, which is really important. If your department of anesthesia is underperforming, your job is at risk. When you have a partner to improve clinical outcomes and save money, you can enjoy greater job security. ■

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Putting Communities in Charge of Hospitals' Future

By Steve Ronstrom, CEO, Western Wisconsin Division of Hospital Sisters Health System

It's getting clear that government can no longer support healthcare in the manner to which it is accustomed. As federal and state governments stagger under huge deficits, payments from entitlement programs such as Medicaid and Medicare are being cut back.

To thrive in the future, hospitals will have to reinvent themselves. A key resource to do so will be their local communities. Granted, non-profit institutions, including Catholic facilities like my own two hospitals, are already deeply committed to their communities. But hospitals can do much more with their communities.

My two hospitals in western Wisconsin started going down this road last year. We had been discussing our next five-year strategic plan and I was getting tired of plans with no soul, focusing on a lot of quantitative data. We already had been hitting all of our financial targets, and I felt it was time to look beyond that. It was time to go beyond charts and graphs.

We came up with a plan called "Imagining the Future: 2016." Our goal was to move in a new direction. We wanted to discover what really matters for our community. We wanted to reach out to everyone in it and have a conversation on what healthcare means to them and their families, with the goal of improving the healing experiences of every patient we see.

We found an outstanding resource to guide us through this process. Pamela Wible, MD, a family physician, pioneered the community approach when she was planning a new practice in Eugene, Ore. In a series of meetings she asked the local community to tell her what her new practice should be like and they came up with all kinds of useful, innovative ideas. We wanted her to help us do the same thing on a larger scale with our hospitals.

Asking people to dream

Dr. Wible asks people to "dream" – to talk about their deepest aspirations for their own healthcare without worrying about costs, planning or anything else. We just wanted them to tell us what they wanted to see and our role would be what I call "deep listening." We took every idea seriously, even when people suggested very unusual approaches, such as bartering for healthcare services.

We started from the premise that each hospital's community is different, with its own needs. For example, we have an Amish community nearby. The Amish, who spurn cars in favor of horse-drawn buggies, do not believe in buying health

insurance. That poses an interesting challenge for payments and it is what pushed the conversation toward bartering. The Amish grow crops that we might use in our cafeteria.

Dr. Wible came for two days last October and met with a variety of groups. We had more meetings after she left, seeing a total of 1,600 people. We met with priests and parishioners, seniors in an assisted living facility and school kids in kindergarten, fourth and eighth grades. We reached out to people who are often ignored, such as chemical dependency patients, the Amish and Hmong people, refugees from Southeast Asia who settled in the area in the 1970s.

What we found out

People really opened up to this approach. To date, we have collected 100 pages of testimony involving 2,830 pieces of data. A committee representing the hospital and the community has identified 700 recurring themes that we wanted to focus on. More than anything, people wanted to be heard, understood and cared for. Rather than just run a bunch of tests, they wanted us to look at patients' needs.

We learned how the attitudes of different groups affected their healthcare and we discussed what we could do about it. For example, Hmong people have a taboo against children discussing their parents' deaths, so we followed up by translating our advanced directives into Hmong. And the Amish, lacking health coverage, board trains and travel to Ohio and Mexico to find lower-cost elective surgeries. It bothered me that they had to leave the community for this. We considered possible expansion of our free clinic, in addition to bartering, as a way to help them.

While many of the suggestions might have eluded traditional hospital planners, they made a lot of sense. For example, some people wanted massages as a way to calm patients and acclimate them to the hospital. Now we are thinking of providing hand or foot massages to ED patients. In addition, Hmong people saw no familiar faces when they come to the hospital, so we are planning to station Hmong greeters there.

What comes next

Many solutions could be undertaken at little expense. For example, our translating advance directives into Hmong was at a very small cost. Also, the chemical dependency patients told us they needed positive distractions such as books, so we organized donations of books.

More suggestions are under review and we plan a lot more forums in the future. We are in the process of reaching out to more constituencies, such as employers who pay healthcare bills. Local governments, for example, want more wellness programs, such as smoking cessation programs for its snowplow drivers.

This new initiative has created a great deal of trust inside the community. While people may expect more from the hospital than before, they also seem willing to give more in the form of donating their time as volunteers. Although the fall initiative was not meant as a marketing tool, our census has been rising and when this was being written, all hospital beds had been full for two weeks. There is also evidence that people who have stronger ties to the hospital are more likely to pay their bills and are less likely to sue.

CEOs at several other hospitals have been contacting me about our initiative. We are very happy with the results. What we have learned from the community has the potential to fundamentally change the way we operate and help us thrive in the future. ■

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 comprises 344-bed Sacred Heart Hospital in Eau Claire and 193-bed St. Joseph's Hospital in Chippewa Falls.

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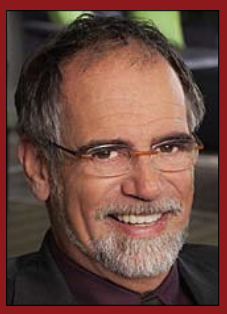
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PROGRAM SCHEDULE

Pre Conference – Thursday, June 9, 2011

11:30am – 1:00pm	Registration
12:00pm – 4:30pm	Exhibitor Set-Up
1:00pm – 5:40pm	Pre-Conference Workshop • Concurrent Sessions A, B, C, D, E, F
5:40pm - 7:00pm	Reception, Cash Raffles and Exhibits

Main Conference – Friday, June 10, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:20pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:20pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday, June 11, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:10am – 1:00pm	Conference

Thursday, June 9, 2011

Track A – Turning Around ASCs, Ideas to Improve Performance, and Benchmarking

1:00 – 1:40 pm
Key Concepts to Fixing Physician Hospital Joint Ventures Gone South - Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, ASCOA

1:45 – 2:15 pm
How to Determine When to go In Network vs. Out of Network, Thomas J. Bombardier, MD, FACS, Principal & Founder, ASCOA

2:20 – 2:50 pm
How to Add Spine and Orthopedics to an Existing ASC - Best Practices - Mike McKevitt, Senior Vice President, Business Development and Bo Hjorth, Vice President Business Development, Regent Surgical Health

2:55 – 3:25 pm
10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them - Brian Brown, Regional Vice President, Operations, Meridian Surgical Partners

3:30 – 4:00 pm
Grow Your ASC's Profits 10% or Greater in 1 Year - Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgical Center Partners, Introduced by Melissa Szabad, Partner, McGuireWoods LLP

4:05 – 4:35 pm
ASC Turnarounds - 5 Key Steps for Success - Kenny Spitler, SVP Development and Robin Fowler, MD, Founder, Interventional Management Services, Introduced by Barton C. Walker, Partner, McGuireWoods LLP

4:40 – 5:40 pm - Keynote
Leadership and Management in 2011 - Mike Ditka, Legendary NFL Player and Football Coach

Track B – Spine and Orthopedics

1:00 – 1:40 pm
Business Planning for Orthopedic and Spine Driven Centers - Jeff Leland, CEO, Blue Chip Surgical Center Partners

1:45 – 2:15 pm
Key Tips for Success - Orthopedics in ASCs - What Works and What Doesn't - Greg Deconciliis, Administrator, Boston Out-Patient Surgical Suites

2:20 – 2:50 pm
Navigating an Orthopedic Practice and its ASCs Through a Changing Healthcare Environment - David Fitzgerald, CEO, Proliance Surgeons, Inc.

2:55 – 3:25 pm
Minimally Invasive Spine Surgery in ASCs - Greg Poulter, MD, Peak One Surgery Center, and Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

3:30 – 4:00 pm
Keys to Successfully Establishing and Growing a Premier Spine Center - Why Partner With a Management Company, Why Partner With a Hospital, Challenges and Opportunities - William Tobler, MD, The Christ Hospital Spine Surgery Center, and Michael Stroup, Vice President Development, United Surgical Partners International, Inc.

4:05 – 4:35 pm
Key Thoughts on Hand and Knee Surgery in ASCs - What Makes Sense Financially - David J. Raab, MD, President, Board of Managers, and Jeffrey L. Visotsky, MD, Member, Board of Managers, Illinois Sports Medicine & Orthopedic Surgery Center

Track C – Pain Management, Joint Ventures, Legal Issues

1:00 – 1:40 pm
Managing Pain Practice-Protocols, Branding and Other Tips to Improve Profitability - Vishal Lal, CEO, Advanced Pain Management

1:45 – 2:15 pm
Pain Management, The Best Practices in Office and ASCs - Nameer R. Haider, MD, Spinal & Skeletal Pain Medicine

2:20 – 2:50 pm
Best Practices for Pain Management in ASCs - Business and Clinical Issues - Marsha Thiel, RN, MA, CEO, Medical Advanced Pain Specialists

2:55 – 3:25 pm
Interventional Pain Management - New Concepts to Reduce ER Visits, Hospitalizations and Re-Admissions - Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago

3:30 – 4:00 pm
Successful Three Party Joint Ventures - Christian D. Ellison, Vice President, Health Inventures

4:05 – 4:35 pm
6 Top Legal Issues for ASCs - Scott Becker, JD, CPA, Partner, and Melissa Szabad, Partner, McGuireWoods LLP

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Track D – Valuation and Transaction Issues

1:00 – 1:40 pm
ASC Transactions, Current Market Analysis and Valuations - Greg Koonsman, Senior Partner, VMG Health

1:45 – 2:15 pm
A Step by Step Plan for Selling Your ASC - How to Maximize the Price, Terms and Results and How to Handle the Process - Luke Lambert, CFA, MBA, CASC, CEO, ASCOA, Introduced by Scott Downing, Partner, McGuireWoods LLP

2:20 – 2:50 pm
Co-Management Relationships With HOPDs - Scott Safriet, MBA, AVA, Principal, Healthcare Appraisers, and Kristian Werling, JD, Partner, McGuireWoods LLP

2:55 – 4:00 pm
Selling Your ASC - A Process and Plan - What Can you Expect? - Evelyn Miller, CPA, Vice President, Mergers & Acquisitions, United Surgical Partners International, Michael Weaver, Vice President Acquisitions & Development, Symbion, Inc., Thomas J. Chirillo, Senior Vice President, Corporate Development, NovaMed, Inc., Jon O'Sullivan, Senior Partner, VMG Health, and Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

4:05 – 4:35 pm
ASC and Healthcare Transactions - The Year in Review - Todd J.Mello, ASA, AVA, MBA, Principal & Founder, Healthcare Appraisers

Track E – Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Keys to Transforming Surgery Centers Into a Profitable Business - Jim Freund, Senior Vice President, GENASCIS and Matt Searles, Managing Partner, Merritt Healthcare

1:45 – 2:15 pm
Operational Best Practices - Sarah Martin, MBA, RN, CASC, Regional Vice President, Operations, Meridian Surgical Partners

2:20 – 2:50 pm
Coding Tools to Capture, Code and Improve Billings in the High Volume Orthopedic Center - W. Harwood Runner, CEO, Kerlan-Jobe

2:55 – 3:25 pm
Supply Chain Management - How to Work with Suppliers - Scott McDade, Vice President, Surgery Center Sales McKesson Medical, Jim Ricchini, Marketing Manager, Ambulatory Surgery & Oncology Markets, B. Braun

3:30 – 4:00 pm
How to Combine in Network and Out of Network Reimbursement, Caryl Serbin, RN, BSN, LHRM, Executive Vice President and Chief Strategy Officer, Source Medical Solutions, Inc. and Nancy Easley-Mack LPN, Business Office Manager, Short Hills Surgery Center

4:05 – 4:35 pm
Value Priced Implants for Orthopedic and Spine Surgery - Richard A. Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute, and Blair A. Rhode, MD, Orland Park Orthopedics

Track F – Quality, Infection Control, Accreditation, Management

1:00 – 1:40 pm
Dealing with Difficult Physicians - Michael R. Redler, MD, The OSM Center, Introduced by Holly Ramey, Vice President of Operations, Surgical Care Affiliates

1:45 – 2:15 pm
How to Effectively Measure and Track Patient Quality - David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

2:20 – 2:50 pm
Most Common Accreditation Problems in Orthopedic, Spine and Pain-Driven ASCs - Raymond E. Grundman, MSN, MPA, Senior Director, External Relations, Accreditation Surveyor, AAAHC

2:55 – 3:25 pm
Infection Control in ASCs - Best Practices and Current Ideas - Cassandra Speier, Senior Vice President of Operations, NovaMed, Inc.

3:30 – 4:00 pm
TBD

4:05 – 4:35 pm
TBD

5:40 - 7:00 pm
Cocktail Reception, Cash Raffles and Exhibits

Friday, June 10, 2011

7:00 – 8:00 am
REGISTRATION and CONTINENTAL BREAKFAST

GENERAL SESSION

8:00 am
Introductions – Scott Becker, JD, CPA, Partner – McGuireWoods LLP

8:15 – 8:55 am - Keynote
The Changing Face of Healthcare Delivery - What to Expect Over the Next Ten Years - Joe Flower, CEO, The Change Project

9:00 – 9:35 am
The State of The ASC Industry - Andrew Hayek, CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee

9:40 – 10:15 am
The Best Ideas for Orthopedic, Spine and Pain Management-Driven ASCs - Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners, Larry Taylor, President & CEO, Practice Partners in Healthcare, Jeff Leland, CEO, Blue Chip Surgical Center Partners, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

10:15 – 11:00 am
Networking Break & Exhibits

Track A

11:00 – 11:40 am
Key Priorities for the ASC Association - William Prentice, JD, Executive Director, ASC Association

11:45 – 12:30 pm
Healthcare Reform and Its Impact on ASCs and Healthcare Delivery - Paul Savoca, M.D., Fairfax Colon & Rectal Surgery, Brent W. Lambert, MD, FACS, Principal & Founder, ASCOA, William Prentice, JD, Executive Director, ASC Association, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track B

11:00 – 11:40 am
Spine Surgery - The Next Five Years - James Lynch, MD, Surgery Center of Reno, Introduced by Chris Zorn, Vice President, Sales, Spine Surgical Innovation

11:45 – 12:30 pm
Key Concepts to Improve the Profitability of Spine Programs - John Caruso, MD, FACS, Neurosurgeon, Parkway Surgery Center and Jeff Leland, CEO, Blue Chip Surgical Partners

Track C

11:00 – 11:40 am
Orthopedics - The Next Five Years - John Cherf, MD, MPH, MBA, President, OrthoIndex

11:45 – 12:30 pm
ACO's - An Overview of What to Expect and How to Prepare - Andrew Hayek, CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee

Track D

11:00 – 11:40 am
Keys to a Successful Turnaround of a Physician/Hospital Joint Venture ASC - Robert Carrera, President, PINNACLE III, Peggy Price, Vice President & Chief Operations Officer, Exempla Lutheran Medical Center, Diane Lampron, RN, BSN, CNOR, Administrator, Lutheran Campus ASC, and Director of Operations, PINNACLE III, Nelson Mozia, MD, President, Board of Managers, Lutheran Campus Ambulatory Surgery Center

11:45 – 12:30 pm
Hospital Within A Hospital Joint Venture - Case Study - Dennis Martin, Senior Vice President of Health Systems, Health Inventures, LLC and, Eric Burke, VP Business Development, Health Inventures, LLC, and Troy P. Stockman, CEO, Nebraska Spine Hospital, LLC

Track E

11:00 – 12:30 pm
A 90 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, CFO, Cathy Rudisill, RN, MHA, CNOR, CASC, BSN, Senior Vice President of Operations, and Ann Geier, Senior Vice President of Operations, RN, MS, CNOR, CASC, ASCOA

12:30 – 1:30 PM
Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E, F

Track A – Orthopedics and Spine

1:30 – 2:00 pm
Assessing the Profitability of Orthopedics and Spine Cases - Vivek Taparia, Director of Business Development, and Matt Lau, Director of Financial Analysis, Regent Surgical Health

2:05 – 2:35 pm
The Future of Minimally Invasive Spine Surgery - Why a Spine-Focused ASC is Important - Richard Hynes, MD, Orthopedic Surgeon, Melbourne, FL

2:40 – 3:10 pm
Everything You Need to Know to Successfully Perform Spine Surgery in an ASC - Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center

3:10 – 3:40 pm
Networking Break & Exhibits

3:40 – 4:10 pm
How To Achieve Great Results for Spine Surgery/Neurosurgery in an ASC - Joan F. O'Shea, MD, Neurosurgeon & Orthopedic Spine Surgeon, The Spine Institute of New Jersey

4:15 – 4:45 pm
Minimally Invasive Outpatient Lumbar Fusions and Multi-Level Outpatient Cervical Disk Replacements - Robert Nucci, MD, Citrus Park Surgery Center, Tampa, FL

4:50 – 5:20 pm
Is There a Place for Orthopedics in ACOs? - Michael Redler, MD, The OSM Clinic

Track B – Orthopedic and Spine ASC and Clinical Issues

1:30 – 2:00 pm
Current Issues in Orthopedics and ASCs - Michael Redler, MD, The OSM Clinic, and John Cherf, MD, MPH, MBA, President, OrthoIndex

2:05 – 2:35 pm
Establishing and Operating Successfully in a Small Market - Robert Zasa, MSHHA FACMPE, Founder, ASD Management

2:40 – 3:10 pm
Handling Complex Spine Cases in an ASC, Clinical and Financial Issues - Marcus Williamson, President, Neospine Division, Symbion, Inc.

3:10 – 3:40 pm
Networking Break & Exhibits

3:40 – 4:10 pm
Key Developments in Cartilage Restructuring - Brian Cole, MD, MBA, Professor, Department of Orthopedics, Department of Anatomy and Cell Biology Section Head, Cartilage Restoration Center at Rush Division of Sports Medicine, Rush University Medical Center

4:15 – 4:45 pm
Biologic Joint Replacement: The Future of Joint Replacement Surgery Using Stem Cells Paste Grafting, Meniscus Allografts, Shell Grafting and Allo and Xenograft Ligaments - Kevin R. Stone, MD, The Stone Clinic

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4:50 – 5:20 pm
Hand Surgery in ASCs - Key Concepts for Clinical and Financial Success - R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

Track C – Joint Ventures, Co-Management, Orthopedic and Pain Management

1:30 – 2:00 pm
Role of Workers' Compensation in a Spine Focused ASC - John DiPaola, MD, Orthopedist, Oregon, and Scott Gibbs, MD, Neurosurgeon, Cape Girardeau, MO

2:05 – 2:35 pm
Developing a Spine Driven ASC: The Essentials for Success- Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

2:40 – 3:10 pm
Getting Started with Endoscopic Spine Surgery: Mitigating the Learning Curve and Risk - Bryan Massoud, MD, Spine Centers of America

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Co-Management Arrangements - Stuart Katz, Executive Director, FACHE, CASC, Tucson Orthopedic Surgery Center

4:15 – 4:45 pm
A Roundtable on Joint Ventures - Allen Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President Development & Acquisitions, ASCOA

4:50 – 5:20 pm
Business and Financial Relationships with Hospitals - Co-Management, Joint Ventures and Employment - Ed Hetrick, President & CEO, Facility Development Management

Track D – Physician Owned Hospitals, Orthopedic Practices

1:30 – 2:00 pm
The Best Ideas Now; 3 Ways to Improve Physician Owned Hospital Profits - Tom Mallon, CEO, Regent Surgical Health, Paul Kerens, Senior Executive Officer, Kansas City Orthopaedic Institute, Michael J. Lipomi, Surgical Management Professionals

2:05 – 2:35 pm
Reducing Implant Costs - Terry L. Woodbeck, CEO Tulsa Spine and Specialty Hospital

2:40 – 3:10 pm
Physician Owned Hospitals - A Prognosis and Plan for the Next Four Years - Brett Gosney, CEO, Animas Surgical Hospital

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Key Legal Issues Facing Physician-Owned Hospitals - Scott Becker, JD, CPA, Partner, and Amber Walsh, Partner, McGuireWoods LLP

4:15 – 4:45 pm
Key Ideas for Improving Orthopedic Practice Profits - David Wold, Chief Operating Officer, Illinois Joint & Bone Institute

4:50 – 5:20 pm
Orthopedic Practices - How to Explore Strategic Options - Stay the Course or Sell - Marshall Steele, MD, CEO, Marshall Steele

Track E – Managed Care, Reimbursement and Syndication Issues

1:30 – 2:00 pm
Orthopedic and Spine Contracting - A Review of Cost Analysis for Orthopedic and Spine and How to Present and Negotiate with Payors - I. Naya Kehayes, MPH, Managing Principal and CEO, and Matt Kilton, MBA, MHA, Princpal and Chief Operating Officer, Eveia Health Consulting & Management

2:05 – 2:35 pm
Best Practices in Physician Syndication - Michelle Trammell, President, and Chase Neal, Vice President, The Securities Group, Larry Taylor, President & CEO, Practice Partners in Healthcare

2:40 – 3:10 pm
Key Concepts for Conducting Internal Investigations - Scott Becker, JD, CPA, Partner, David J. Pivnick, Associate, and Lainey Gilmer, Associate, McGuireWoods LLP

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Improving Managed Care, Contracting Results - A Case Study Step by Step Approach - I. Naya Kehayes, MPH, Managing Principal and CEO, and Matt Kilton, MBA, MHA, Princpal and Chief Operating Officer, Eveia Health Consulting and Management

4:15 – 4:45 pm
Billing Process Improvement 101 - Bill Gilbert, Vice President Marketing, AdvantEdge Healthcare Solutions

4:50 – 5:20 pm
10 Ways to Improve an ASCs Coding - Document Deficiencies, Financial Impacts and How to Work with Physicians, - Kelly Webb, Director, ASC Billing

Track F – Reducing Costs, Market Consolidation, Hiring, and Golf

1:30 – 2:00 pm
Avoiding Critical ASC Mistakes: Hiring Great Staff, Reducing Hours Per Case, Physician Utilization - Joyce Deno Thomas, RN, BSN, Senior Vice President, Operations, and Robert Welti, MD, Senior Vice President, Operations, Regent Surgical Health

2:05 – 2:35 pm
Can an ASC Improve Profits Through Market Consolidation - William J. L. Kennedy, MBA, SVP Business Development, NovaMed, Inc., and Michael Weaver, Vice President, Symbion, Inc.

2:40 – 3:10 pm
Three Ideas to Streamline Costs and Improve Profits - Jeff Blankinship, President, Surgical Notes, Tom Jacobs, President & CEO, MedHQ, Jon Hamrick, Executive Vice President, Networking and Sourcing, Access MediQuip

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Top Traits of ASC Leaders and How to Recognize Them - Greg Zoch, Partner, Kaye-Bassman

4:15 – 4:45 pm
How to Immediately Improve Your Golf Swing, Aaron Bergman, PGA Golf Pro

4:50 – 5:20 pm
Hiring Winners Not Whiners - Tracy Hoeft-Hoffman, Administrator, Hastings Surgical Center

5:20 – 7:00 PM
Cocktail Reception, Cash Raffles and Exhibits

Saturday, June 11, 2011

7:00 – 8:10 am – Continental Breakfast
General Session

8:10 – 8:55 am
Leveraging Ideas from Other Industries to Improve ASC Profits - W. Michael Karnes, Chief Financial Officer, Regent Surgical Health, and Michael Rucker, EVP and COO, Surgical Care Affiliates

Track A

9:00 – 9:45 am
Buying and Selling ASCs - HOPDs and National Companies, Co Management and ACOs - Current Market Trends - Scott Becker, JD, CPA, Partner, Scott Downing, JD, Partner, and Amber Walsh, Partner, McGuireWoods LLP

9:50 – 10:50 am
How and Why Might Orthopedists and Neurosurgeons Team and Partner to Create Musculoskeletal Centers of Excellence - John Caruso, MD, Neurosurgeon, Parkway Surgery Center

10:55 – 11:55 am
Lessons Learned - What Did I Do Right and What Might I Do Differently When Creating a Spine ASC? - John Caruso, MD, Neurosurgeon, Parkway Surgery Center, Scott Gibbs, MD, Neurosurgeon, Cape Girardeau, MO, Richard Hynes, MD, Orthopedic Spine Surgeon, Melbourne, FL, and John DiPaola, MD, Orthopedist, Oregon, Moderated by Jeff Leland, CEO, Blue Chip Surgical Center Partners

Track B

9:00 – 9:45 am
New Advances in Sacroiliac Joint Problems - Richard A. Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute

9:50 – 10:50 am
Pain Management in ASCs - Current Ideas to Increase Profits - Amy Mowles, President & CEO, Mowles Medical Practice Management

10:55 – 11:55 am
Threats to Physicians and Strategies to Protect Your Practice and Investment - Robert M. Schwartz, Executive Director, Proliance Surgeons, Inc.

Track C

9:00 – 9:45 am
Clinical Excellence Every day: Director of Nursing 101; Lesson Learned from Overseeing 100 Plus Centers - Linda Lansing, Senior Vice President of Clinical Services, Surgical Care Affiliates

9:50 – 10:50 am
Accrediation, A 60 Minute Workshop – HFAP

10:55 – 11:55 am
Given the Economic Downturn, Why Now is Actually a Great Time to Develop a Facility - John Marasco, AIA, NCARB, Principal & Owner, Marasco & Associates

Track D

9:00 – 9:45 am
The Best Ideas to Immediately Improve ASC Profits - Sandra Jones, MBA, MS, CASC, FHFMA, Chief Executive Officer, Executive Vice President, ASD Management, Monica Ziegler, Administrator, Physicians Surgical Center, Susan Glendon-Bealieu, RN, LHRM, Administrator, Surgical Center for Excellence, Kara Vittetoe, Administrator, Thomas Johnson Surgery Center, ASCOA

9:50 – 10:50 am
Physicians, Hospitals, and Management Companies - What it Takes to Make a Winning Partnership and ASC - Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

10:55 – 11:55 am
Short and Long Term Strategic Planning and Setting Annual Goals and Objectives - John Goehle, CASC MBA CPA, Ambulatory Healthcare Strategies, LLC

Track E

9:00 – 9:45 am
Information Technology for Surgery Centers – Achieving Positive Outcomes and Avoiding Complications - Marion Jenkins, PhD, Founder & CEO, QSE Technologies, Inc., Todd Logan, Vice President Sales - Western Region, and Ron Pelletier, Vice President, SourceMedical

9:50 – 10:50 am
ASC Litigation, Non Competition, Employee Litigation and Other Kinds of Litigation, Key Thoughts - Jeffrey C. Clark, Partner, and David J. Pivnick, Associate, McGuireWoods LLP

10:55 – 11:55 am
Coding Inaccuracies That May Put an ASC or Practice at Risk With the OIG and RACs - Pain Management Medical Necessity/Over-Reporting, Orthopedic Incorrect Reporting on Knees and Shoulders, Spine Overstating Work/Unbundling - Cristina Bentin, CCS-P CPC-H CMA, President Coding Compliance Management

GENERAL SESSION

12:00 – 1:00 pm
ASC Safe Harbor Redemptions, Physician Compensation Compliance, Internal Investigations, and Increased Government Investigations - Scott Becker, JD, CPA, Partner, Gretchen Townshend, Associate

1:00 pm - Meeting Adjourns

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100 Best Places to Work in Healthcare (continued from page 1)

practice. The list excludes advertisers. Companies do not pay and cannot pay to be selected as a best place to work. All organizations that are placed on the list undergo a substantial review with other peers and through our own research. *Note:* Companies are listed alphabetically by name.

ACMH Hospital (Kittanning, Pa.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: ACMH Hospital is a 174-bed non-profit facility that leads Armstrong County employment with approximately 857 full-time employees. The hospital's benefits program includes the usual — health, dental, short/long-term disability and retirement — as well as the creative — free parking, discounts at area businesses, employee recognition dinners for years of service and personal days. Along with benefits, staff members are encouraged to pursue professional development through continuing education opportunities and tuition reimbursement. The ACMH Hospital School of Radiology, which offers a 24-month certification program, recently celebrated its 50th graduating class.

Advocate Health Care (Oak Brook, Ill.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Advocate Health Care is one of Chicagoland's largest employers, with more than 30,000 associates, including 6,000 affiliated physicians and 9,000 nurses. Every year, the system holds an Associate Appreciation Week with a variety of activities to thank employees for their work. For employees and covered spouses who participate in the Advocate Medical Plan, the system provides incentives to improve health and manage healthcare expenses. In terms of employee development, Advocate provides 100 percent reimbursement for pursuing specific certification, degrees and licensure in high-demand areas, as well as in-house education.

Agnesian HealthCare (Fond du Lac, Wis.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: As an integrated, comprehensive, non-profit healthcare delivery system, Agnesian HealthCare is comprised of 2,750 employees and six ministries. The system's new benefits plan includes an on-site child care center, a fitness facility staffed with personal trainers and a wellness program that encourages smoking cessation, exercise and healthy food choices. Agnesian also helps employees build their skills through career ladders with corresponding pay increases, increased tuition assistance benefits, cross-training between entities and partnerships with several colleges and training programs in the area. Since 2000, overall employee turnover at the health system has declined by 50 percent to a favorable nine percent overall turnover rate.

Akron General Medical Center (Akron, Ohio)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Akron General serves more than 1.2 million people in five Ohio counties and has been named one of the 99 best places to work in Northeast Ohio by the Employers Resource Council. In addition to benefits such as adoption assistance, tuition reimbursement, dependent life insurance and retirement plans, Akron General offers a host of perks. Employees can use on-site dry cleaning pick-up, as well as film developing and discounts on local family entertainment and area businesses.

Ambulatory Endoscopy Center of Dallas (Dallas, Texas)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Employees at Ambulatory Endoscopy Clinic of Dallas reap the benefits of the ambulatory surgery center's partnership with HCA, now in its 15th year. Staff members receive many benefits, including health, dental and vision insurance, a 401k plan and tuition reimbursement, according to Jennifer Cahill, business office manager for the ASC. The ASC employs a very tight-knit group of 21 people who often share lunch together and offer support to one another, which has translated into happy employees, says Ms. Cahill.

Ambulatory Surgery Center of Stevens Point (Stevens Point, Wis.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Since the Ambulatory Surgery Center of Stevens Point opened in 2006, the owners have been committed to choosing the right team for the center's success, says administrator Becky Ziegler-Otis. Since 2006, the Ambulatory Surgery Center of Stevens Point has seen only one employee resign. In 2010, the center developed a wellness committee and has seen nearly 100 percent employee participation in various fitness and wellness campaigns. In addition to health, dental and other "usual" benefits, the center also provides less typical benefits, such as a monthly recognition lunch, free soda and cookies, ergonomic assessments to prevent workplace injuries and an annual Christmas party.

Andrews Institute Ambulatory Surgery Center (Gulf Breeze, Fla.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Andrews Institute Ambulatory Surgery Center opened in 2007. Like many ASCs, Andrews Institute provides flexible scheduling for its employees, and staff never has to work holidays or weekends. Employees are encouraged to submit their ideas in staff forums, department meetings and daily stand-up meetings. According to Barbara Holder, RN, QA coordinator, benefits at AIASC include a generous PTO package, an employer-matched 401(k) plan, various medical, dental, vision and flexible spending plans, short- and long-term disability and an employee bonus plan.

Animas Surgical Hospital (Durango, Colo.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: This multi-specialty hospital and its physician owners strive to provide surgical excellence, an effort recognized by Consumer Reports, which ranked the hospital as the best in the state of Colorado. Animas offers competitive benefits, including health and dental insurance, vision benefits, paid vacation for full and part-time employees and a 401(k) plan. The hospital maintains a low employee turnover rate due to its competitive salaries and family environment, employees says. The hospital touts a high nurse-to-patient coverage ratio and high employee satisfaction, which administrators attribute to the lack of bureaucracy present in a physician-owned hospital.

AtlantiCare (Egg Harbor Township, N.J.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Employees at AtlantiCare join a system of 5,000 staff members contributing to the health of Southeastern New Jersey. The system offers a wide array of complimentary development opportunities for staff, including hundreds of e-learning courses and several "tracks" designed to turn staff members into organization leaders. The AtlantiCare LifeCenter features exercise equipment and spa-like amenities, and benefits such as an employee assistance program, an on-site day care center and 104 hours of annual personal time encourage employees to pursue a healthy work-life balance.

Bailey Medical Center (Owasso, Okla.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Bailey Medical Center is a 73-bed acute-care hospital that is owned by Ardent Health Services and physicians. In its most recent employee satisfaction survey, 94 percent of employees said they were "satisfied" or "very satisfied" with their employment, and 95 percent said they would recommend employment at the hospital. Bailey has installed a variety of activities to build employee engagement, including employee lunches, an employee activities committee and an "Above and Beyond" program that recognizes fellow employees. BMC's employee benefits include medical insurance plans, paid time off, tuition reimbursement, extended illness compensation and life insurance.

Baptist Health South Florida (South Miami, Fla.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Baptist Health South Florida was created in 1990, bringing the region's top non-profit hospitals under one name for the first time. Baptist practices a "promote-from-within policy," meaning existing employees will always be considered for open positions if they possess the qualifications and experience appropriate for the job. To help employees become qualified for those coveted positions, Baptist directs its employees to Baptist Health University, which offers more than 1,000 online courses and 500 classroom courses.

Barnes-Jewish Hospital (St. Louis, Mo.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Barnes-Jewish Hospital, a member of the BJC HealthCare system, is one of the largest employers in St. Louis. Hospital employees receive competitive compensation packages as well as medical, dental and vision coverage. The hospital also provides benefits for employee spouses, including domestic partners for same-sex couples. Employees can participate in merit pay programs and employee recognition for staff members who exhibit exemplary performance. For example, the Health Hall of Fame recognizes achievements in lifestyle that improve overall health and well-being, and the Excellence in Leadership Award honors one member of management for demonstration of exceptional leadership.

BayCare Clinic (Green Bay, Wis.)

Type of facility: Specialty clinic

What makes it a Best Place to Work: BayCare Clinic is the largest specialty healthcare clinic in Northeast Wisconsin and Michigan's Upper Peninsula. BayCare is well on its way to meeting its stated goal of being "the most fit company in Brown County." More than a year into its Healthy

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BayCare Health System (Tampa Bay, Fla.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Composed of 10 non-profit hospitals and 20 ambulatory and outpatient centers, BayCare Health System is a leading community-based health system in the Tampa Bay area. In 2010, the organization approved pay raises for every employee, despite the struggle of running a non-profit hospital in a community that is up to 21 percent uninsured. BayCare also distributed annual performance payments for employees who met pre-determined goals. The organization's benefits include wellness programs with incentives for improving employee health, discounts for non-smokers, college tuition programs, online education opportunities and financial assistance for employee hardship.

Baylor Health Care System (Dallas/Fort Worth, Texas)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Twenty-six hospitals, 23 ambulatory surgery centers and 50 outpatient facilities are owned, operated, joint ventured or affiliated with Baylor Health Care System in Dallas. To help employees achieve promotions, raises and job satisfaction, Baylor provides tuition reimbursement for any employee working on a degree in healthcare. The system also owns a gym in downtown Dallas, where employees can go to exercise and work with trainers for free. Baylor Garland will hold special mammography screenings during March and April for employees. Any employee who schedules a mammogram will be given a free box lunch.

Beaumont Hospitals (Royal Oak, Mich.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Beaumont encourages and supports the career and educational advancement of its employees with a variety of programs. Its internal job bidding program helps employees transfer to different departments and apply for promotions within the organization, and educational assistance provides up to $1,200 a year for full-time employees. Staff can also take advantage of Beaumont University, which offers numerous courses to help employees maintain existing credentials or advance their careers. The system also offers nursing internships to graduate nurses or those looking for a new specialty.

Beebe Medical Center (Lewis, Del.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Founded in 1916 by two physician brothers, Beebe Medical Center is a 210-bed non-profit seaside community hospital. Employees receive competitive and generous shift differential as well as generous salaries. An extra nine percent for evening shift, 14 percent for night shift and nine percent for weekend shift is paid for all hourly employees, with an additional 18 percent for weekend evening and 23 percent for weekend night. Regular full-time employees accrue 25 days per year in paid time off, and the center recognizes eight holidays annually.

Berkshire Medical Center (Pittsfield, Mass.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Berkshire Medical Center, a 302-bed community hospital in Pittsfield, Mass., is a teaching facility affiliated with the University of Massachusetts Medical School. BMC has established numerous programs to reward employees for their hard work. In addition to generous earned time and holiday benefits, employees receive both paid educational time and tuition reimbursement benefits and enjoy an annual employee recognition and awards dinner. The hospital's 2010 Fourth of July float was constructed by employees and voted the community's "most outstanding float" for the year.

Black Hills Surgical Hospital (Rapid City, S.D.)

Type of facility: Specialty hospital

What makes it a Best Place to Work: Black Hills Surgical Hospital is an 11-OR specialty hospital that staffs in-house hospitalists and maintains a 3:1 patient to nurse ratio. The hospital offers sizeable discounts on all services provided at BHSH, training and education assistance, holiday cash gifts, frequent catered lunches and a floating paid day off on each birthday as well as a gift certificate to a local restaurant. The hospital's wellness program offers free flu shots and screenings, smoking cessation assistance, CPR training, weight management assistance and a wellness newsletter that provides recipes and exercise tips. Employees are encouraged to submit ideas and concerns to hospital administration via a suggestion hotline and boxes found throughout the facility.

Brigham and Women's Hospital (Boston, Mass.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: The 777-bed Brigham and Women's Hospital, known affectionately as "The Brigham," is a teaching affiliate of Harvard Medical School and part of Partners HealthCare, a 10-hospital network in Massachusetts. Employees are entitled to subsidized memberships at a fully equipped fitness center at a variety of locations in the city and suburbs, and the hospital provides two types of backup child care services for emergencies. The hospital's transportation program applies to all Brigham employees and offers a 50 percent subsidy on all Massachusetts Bay Transportation Authority passes.

Carson City Hospital (Carson City, Mich.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Carson City Hospital is a 77-bed acute-care facility affiliated with Sparrow Health System. Employees say that the hospital's tight-knit community is evident when colleagues join together for special occasions. Administrators and managers served a special Christmas meal on Dec. 21, 2010 to over 300 associates on all three shifts, and the hospital's "brown bag" lunchtime series allows hospital associates to watch audio-visual presentations of their colleagues' recent projects. The hospital's human resources department and executive team regularly monitor the market to maintain a comparable benefit program. An annual benefits fair brings benefit vendors to the hospital to increase awareness of available services.

Catholic Healthcare West (San Francisco, Calif.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Catholic Healthcare West links 60,000 caregivers across Arizona, California and Nevada. Recognizing that compensation is an important aspect of a great job, Catholic Healthcare West strives to offer competitive base salaries as well as performance-based cash awards. The system also conducts an annual review of pay and offers professional growth and development opportunities to employees looking to move up the career ladder. Employees can take advantage of the CHW Learning Institute and benefit from tuition reimbursement for various degrees. The system's wellness program includes healthy eating options in the cafeteria and healthy lifestyles programs that focus on exercise and nutrition.

Cedars-Sinai Medical Center (Los Angeles, Calif.)

Type of facility: Hospital/health system

Cedars-Sinai Medical Center offers employees a competitive compensation and benefits program that allows employees to choose between a defined contribution plan and defined benefit plan retirement programs. The hospital's "Work 'n' Life Matters Program" provides employees with additional support, resources and education as needed. Childcare resource services, including referrals to public or private schools and access to parenting specialists, are available for hospital employees. CSMC also participates in the environmentally-friendly Rideshare Incentives program that incentivizes employees to ride to work with coworkers.

Centegra Health System (Crystal Lake, Ill.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Centegra Health System was formed in 1995, when Memorial Medical Center in Woodstock, Ill., and North Illinois Medical Center in McHenry, Ill., combined their facilities and staff. Today, Centegra is the community's largest employer, with nearly 4,000 associates and 500 volunteers. The system's wellness program has introduced a $20 incentive for health risk assessments, as well as complimentary mammograms, colonoscopies and PSA screenings, a weight management program and a smoking cessation program. Employees can take advantage of nutrition lectures, meditation exercises and activity classes on campus too.

Centennial Surgery Center (Voorhees, N.J.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Centennial Surgery Center houses four surgical suites, two endoscopy suites, two short procedures rooms and features state-of-the-art surgical equipment and technology to help deliver excellent patient care. The 100 percent physician-owned center maintains a high level of employee satisfaction. This is achieved by top-to-bottom prioritization of employee satisfaction. The physician-owners also express their appreciation of employees by dedicating a week every year in September as the "Centennial Employee Appreciation Week." During this time, employees enjoy food, annual gifts and a "blow-out" catered lunch at the end of the week.

Central DuPage Hospital (Winfield, Ill.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: This 313-bed hospital's incentive plan promotes employee engagement by rewarding collective achievement: Goals are established at the beginning of each fiscal year and are funded through improved financial performance. CDH's fitness challenge program offers a cash incentive to employees for regular attendance at select centers, and five area health centers offer discounts to employees who join the facilities. For employees joining the hospital from a graduate program, CDH's loan forgiveness program offers reimbursement for tuition paid during the last year of nursing school.

Central Park ENT & Surgery Center (Arlington, Texas)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Central Park ENT & Surgery Center's seven board-certified physicians provide adult ear, nose, throat, head, neck and allergy care to the Arlington community. The center aims to treat its employees as a family, hosting regular events that encourage employee unity and build a family-friendly environment. Last year, the ASC held a picnic at a local park, where the organization's CEO grilled burgers, brats and chicken to celebrate the Texas Rangers' reaching the World Series. Over the Christmas holidays, the employees took part in a toy drive for a local family shelter. The center features an on-site gym and frequently provides lunch to enable a more efficient focus on patient care.

Children's Healthcare of Atlanta (Atlanta, Ga.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Children's Healthcare operates three hospitals and 17 neighborhood locations across the state of Georgia. Every other month, Children's hosts a baby shower where employees who are expectant parents can receive gifts, prizes and information about childcare, Family Medical Leave Act and benefits. The hospital also offers up to $5,000 in reimbursement every year for expenses related to adoption or infertility, and various wellness initia-

tives — including onsite Weight Watchers meetings, memberships at various fitness facilities and onsite massage therapy — keep employees happy and healthy.

Children's Medical Center Dallas (Dallas, Texas).

Type of facility: Hospital/health system

What makes it a Best Place to Work: The only pediatric academic healthcare facility in North Texas, Children's Medical Center is a 559-bed nonprofit hospital that serves as a major pediatric kidney, liver, intestine, heart and bone marrow transplant center. In its 2010 employee survey, employees listed the most improved areas as employees' perception of work unit staff levels, communication between different levels of the organization and perception of fairness of pay. On a scale from 1-5, Children's employee commitment score sits at a healthy 4.27, above the National Healthcare average of 4.14.

Children's Memorial Hospital (Chicago)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Along with competitive salaries, health insurance and tuition reimbursement, Children's offers new employees 29 days of paid time off accrued per year as well as concierge services to improve employees' work/life balance. Employees also receive 50 percent off hospital charges after insurance has been applied and are eligible for adoption assistance reimbursement of $5,000 per child. Shuttle service is available to the hospital from all major train stations for a discounted fee, and the hospital offers a payroll loan deduction option for the purchase of computer products.

Christiana Care Health System (Wilmington, Del.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Christiana Care Health System, headquartered in Delaware, is one of the country's largest healthcare providers and serves as a major teaching hospital. The system is deeply committed to its nursing population, offering paid nurse internship programs and nursing scholarships to eligible employees. Christiana Care partners with Bright Horizons Family Solutions for operational management of an on-site child care center and also hosts a fitness center on-site.

CHRISTUS St. Michael Health System (Texarkana, Texas)

Type of company: Hospital/health system

What makes it a Best Place to Work: CHRISTUS St. Michael Health System includes a 312-bed acute-care hospital, 50-bed rehabilitation hospital, an outpatient rehabilitation center and an outpatient imaging center. The campus also includes a health and fitness center with an outdoor lap pool. CHRISTUS St. Michael encourages staff members to develop leadership skills through a mentorship program that pairs administrators or CHRISTUS Academy graduates with associates to provide them with tools and support. The health system also has a School at Work program that allows entry-level staff to advance and continue their careers in healthcare by continuing their education through their jobs.

Cleveland Clinic

Type of facility: Hospital/health system

What makes it a Best Place to Work: With 2,000 physicians and scientists and over 4.2 million patient visits a year, Cleveland Clinic is one of the country's most prominent hospitals. Aside from exceptional medical, vision and dental coverage that pays for nearly 100 percent of all costs, the Cleveland Clinic offers free membership to Weight Watchers, Curves and other local workout facilities, employee discounts to sporting events, theaters and restaurants, free courses at the Cleveland Clinic Academy and an employer-contributed pension plan. Since CEO Delos "Toby" Cosgrove, MD, developed a partnership with Weight Watchers in an effort to improve employee health, Cleveland Clinic's employees have lost over 110,000 pounds.

Deaconess Health System (Evansville, Ind.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Deaconess Health System is a system of five hospitals in southwestern Indiana. Deaconess' nursing services division aims to be a regional leader among community hospitals in the area. Employees can also take advantage of Deaconess RN OnCall, which staffs a registered nurse 24 hours a day to answer questions regarding acute illness or injury. The system provides incentives to employees for working straight evening or night shifts in designated areas, as well as incentives for working straight weekends in certain areas. Staff can enjoy a plethora of information at three on-site libraries: the health science library, the holistic resources library and the lighter side library — the latter of which provides books and videos on non-healthcare topics.

Ephrata Community Hospital (Ephrata, Pa.)

Type of facility: Hospital/health system

What makes it a Best Place to work: Ephrata Community Hospital has been serving the community of north Lancaster County, Pa., for over 65 years. Reduced-cost health, wellness and educational programs are available to all employees through the ECH Wellness Center and Center for Women's Health, including CPR training, diabetes programs, smoking cessation assistance, nutrition consults, yoga, pilates, self-defense and massage therapy. Employees also have free use of exercise equipment at any ECH rehab center location across Lancaster County. The hospital will absorb 70 percent of inpatient and outpatient hospital charges not covered by insurance up to a $300 discount per bill, for which employees, spouses and dependents are eligible upon the employee's hire date.

The Everett Clinic (Everett, Wash.)

Type of facility: Physician practice

What makes it a Best Place to Work: The Everett Clinic is the largest medical group in Washington state, with 315 physicians and 40 specialty services. The company is very invested in maintaining an excellent staff. Staff at Everett can take advantage of tuition reimbursement up to $2,000 per calendar year, starting on their date of hire, and the clinic also pays all costs associated with approved continuing education programs. Each quarter, the clinic updates its wellness program with new goals; for each goal an employee meets, he or she is entered into a drawing for prizes. To support work/life balance and encourage staff to take advantage of the Puget Sound area, Everett offers discounts on cultural arts and sporting events, as well as at amusement parks through Magic Kingdom Club/Great America Club. Employees and their dependents can also apply discounts to certain Everett Clinic services not covered by the benefits on their health plans.

The Eye Surgery Center of Michigan (Troy, Mich.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: The Eye Surgery Center of Michigan was developed by local physicians in partnership with St. John Providence Health System. The center features 10 physicians specializing in eye surgery and ophthalmology. When employees notice a staff member going above and beyond in their work, they can write the person a "star" to be placed in the "star employee reward box." Every month, administration holds a drawing and the chosen employee receives a gift card. "That is just one way they show the staff their appreciation for a job well done," employee Rachel Blaszyk says. The Eye Surgery Center is also focused on wellness. Every few months, the center holds a weight loss competition to promote healthy habits. The facility also recycles every bottle to promote going green. "We are all veterans in the healthcare in-

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dustry and recognize The Eye Surgery Center of Michigan's work ethic is hard to come by," Ms. Blaszyk says. "The continuous dedication of the administration and staff makes it the best place to work in the healthcare field."

Fleming Island Surgery Center (Orange Park, Fla.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Fleming Island Surgery Center is keenly aware that the only way to achieve success is to build a strong core of employees. Lindsay Allen, operations assistant for managing partner Borland-Groover Clinic, says FISC is driven to involve employees in the work that affects them and empowers them to take ownership. One recent project employees spearheaded was updating all preference cards to ensure each physician's satisfaction during their tenure at FISC. When BGC took over managing FISC in 2008, new employee benefits were introduced that were previously unavailable, such as an employee incentive program to reward employees for working above and beyond expectations.

Fremont Surgical Center (Fremont, Neb.)

Type of facility: Ambulatory surgery center

What makes it great: Fremont Surgical Center sees an average of 3,800 cases annually with specialties including gastroenterology, pulmonology, orthopedics, pain management, ophthalmology and dental. The center includes two operating rooms. Steve Henry, FSC administrator, ensures that each physician and staff member has clearly outlined duties and responsibilities to make the surgery center run efficiently. The culture of teamwork at FSC is apparent in the results of the center's 2010 patient satisfaction survey: The patient satisfaction rating is 95 percent. The center's employees are also able to enjoy good benefits, including health, dental and life insurance and 401 (k).

Geisinger Health System (Danville, Pa.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Founded in 1915, Geisinger is a physician-led health system, providing service spanning 43 counties of 20,000 square miles and serving 2.6 million people. Geisinger partners with 20 organizations and institutions, including Thomas Jefferson University, Penn State University and King's College, to provide educational opportunities for its employees. Staff members can apply for educational loans from the system. The Geisinger MyHealth Rewards Program is designed to encourage employees to better their health. The program includes a confidential health risk assessment; free medications for hypertension, high cholesterol and diabetes; a wellness program to help employees lose weight, stop smoking and eat better; and an enrollment incentive payment of $200.

Golden Ridge Surgery Center (Golden, Colo.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Golden Ridge Surgery Center is an AAAHC-accredited surgery center that began operations in June 2010 and has since provided care to over 20,000 patients. Melodie Garrobo, the center's administrator, supervises 10 staff members who have been with her center for over seven years, demonstrating the facility's commitment to employee retention. Ms. Garrobo credits the staff's longevity to the bond between physicians and staff members and the center's "bottoms up" approach to governance. This year, the physician owners and ASC leadership decided to focus on developing and maintaining quality relationships, and the center held its first office party with the main physician group. Staff members are also asked to decide their own benchmarks to increase accountability and give employees a voice in the center's improvement.

Griffin Hospital (Derby, Conn.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: This 160-bed hospital has received national recognition for its unique work environment. Griffin's 1,200 employees attend a week-long orientation with the hospital's CEO and receive a monetary incentive to reach departmental and institutional goals through the hospital's Success Reward program, which has been in place since 1999, and its Spot Recognition program, which rewards exceptional work on-the-spot with small gifts. New employees are required to attend a two-day retreat in Madison, Conn., to learn about the hospital's philosophy of care and partake in team building exercises.

Hackensack University Medical Center (Hackensack, N.J.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Hackensack University Medical Center is a private, non-profit academic medical center serving northern New Jersey and the New York metropolitan area. With nearly 8,000 staff members, the center is the largest employer in the city of Hackensack. For a bustling hospital, HUMC's voluntary turnover rate is shockingly low — just two percent in 2009. On the hospital's 2010 employee survey, 90 percent of responding employees agreed with the statement, "I would recommend employment at this organization to a friend." Another 91 percent agreed that they like their coworkers, and 93 percent agreed that they like the work they do.

Hancock Regional Hospital (Greenfield, Ind.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Hancock Regional Hospital was founded in 1951 and has expanded considerably since then, including a 33,000-square-foot fitness facility in 2000. Employees are incentivized to bring more talent to the hospital every year. Associates can receive up to

$1,000 for each successful referral, as well as a $25 thank-you gift card on the referred associate's first day. If HRH nurses wish to live in a local apartment community, Greenfield Crossing Apartments will offer $300 off the first month's rent and waive the move-in fee.

Harborside Surgery Center (Punta Gorda, Fla.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Harborside Surgery Center, a triangular joint venture between Interventional Management Services and the local HMA hospital Charlotte Regional Medical Center, strives to never stray from its mission. The ASC's commitment to patient satisfaction is a critical reason why Charlene Gorrill, RN, director of nurses for HSC, says HSC is an outstanding place to work. The ASC experiences very little turnover and some personnel have worked there more than 15 years. Staff members receive comprehensive benefits packages that include health insurance, 410(k), group life insurance and long-term disability insurance.

Head & Neck Surgery Center (Hattiesburg, Miss.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Head & Neck Surgery Center is Medicare-certified and AAAHC-accredited and has undergone an extensive two-year makeover that was completed last year. It is still undergoing some ventilation updating to improve the air quality, says Chas Pierce, MPH, administrator. To express appreciation to its employees, the center distributes a Christmas bonus and other offerings, such as employee lunches and an "Employee of the Month" award. ENT Properties, of which Head & Neck is a subsidiary, also plans to establish an "Employee Appreciation Week" starting this year.

Henrico Doctors' Hospital (Richmond, Va.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: This 540-bed hospital, part of the HCA Virginia Health System, was called Henrico Doctors' Hospital-Forest until Feb. 2009, when the name was simplified. In addition to health, dental, life insurance and other basic benefits, Henrico Doctors' gives employees complimentary fitness club memberships, massage therapy, yoga classes, phone service and discounts on purchases in the hospital pharmacy and cafeteria. The hospital's Parham campus includes Children's Choice, an onsite child care center for hospital employees that promotes a literacy based curriculum. Part of the facility is also dedicated to the Sniffles & Snuggles program where mildly ill employees' children can come while sick so employees don't have to miss work.

High Plains Surgery Center, LP (Lubbock, Texas)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Partnered with Laurus Healthcare, High Plains Surgery Center features a center designed collaboratively by physicians and staff members. Chad Southard, administrator of High Plains Surgery Center, says while the center is currently working on several projects to improve cost-containment and patient care, input from staff members and physicians is a priority throughout each process. One recent project included making improvements to the facility's layout for improved efficiency and patient satisfaction. Employee turnover at High Plains Surgery Center has been less than 2 percent annually. Not only are employees rewarded with quarterly bonuses and Christmas bonuses, but employees can also enjoy health, dental and vision benefits, life insurance, retirement benefits and a daily lunch provided by the center.

Indiana Regional Medical Center (Indiana, Pa.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Indiana Regional Medical Center opened to the public in 1914 as a 40-bed facility with 13 private rooms. To encourage health and wellness among employees, the hospital offers an annual wellness screening, a financial incentive for improving health, free flu shots and health services to encourage weight management and good eating habits. IRMC encourages employees to seek promotions inside the organization; job openings are posted internally so qualified employees have the opportunity to apply, and continuing education is provided on-site. The hospital also offers a leadership development program to "grow its own" future executives, as well as scholarship and loan forgiveness, certification reimbursement and web-based learning opportunities.

Inova Health System (Vienna, Va.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Inova Health System is one of Northern Virginia's leading non-profit healthcare providers, serving more than 1 million patients every year. In 2008 — for the seventh year in a row — Inova was named one of *Working Mother* magazine's "100 Best companies for Working Mothers." Inova provides generous flextime, before- and after-school care, training through the Inova Leadership Institute and benefits for adoptive parents. In addition to scholarships and tuition assistance for employees, Inova offers awards for employees' children who plan to pursue post-secondary education in college or vocational programs. For employees who seek professional development but cannot commit to graduate programs, the Inova Learning Network offers ongoing classes in various hospital fields.

The Institute for Orthopaedic Surgery (Lima, Ohio)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Established by the physicians of Desert Orthopaedic Center, The Institute for Orthopaedic Surgery provides care for every orthopedic subspecialty. The center has established specific discharge standing orders in a "step-down binder" to make instructions precise for each patient and simplify the post-surgical process. "We tend to make patients feel very comfortable because the atmosphere is relaxing and the staff is cheerful," says Paul F. Jarrett II. "The flow of the surgical process is outstanding!" According to employees, the center is small enough to provide a familial atmosphere and large enough to offer generous benefits.

Iowa Health System (Des Moines, Iowa)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Iowa Health System entities employ the state's largest non-profit workforce, with nearly 20,000 employees. Employees have the opportunity to develop skills through the system's Management Leadership Academy and Physician Leadership Academy; upon completion of the latter, graduation physicians will be close to earning their master's degree. The system remains focused on creating a healthy workforce: The employee health plan includes annual health risk appraisals, and employees can take advantage of an internal mail order pharmacy. Iowa Health System employees are currently participating in a statewide 100-day wellness challenge called Live Health Iowa, an initiative that provides a team-based physician activity, nutrition and weight loss program to staff.

IU Health Goshen Hospital (Goshen, Ind.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: IU Health Goshen Hospital is a community hospital with 150 physicians in almost 20 specialties. For four consecutive years, the hospital has been recognized as one of the best places to work in Indiana by the Indiana Chamber of Commerce. Goshen employees receive their choice of three medical insurance plans, dental and vision coverage and long-term care coverage options. Retirement benefits include 401(k) savings plan where the employer matches up to 2 percent of the employee's contributions. Goshen's more creative employee benefits

include a child care voucher program, designed to help colleagues pay for child care related to their work schedule, and a 529 college savings plan. The hospital offers legal coverage and financial guidance for family and domestic matters when purchasing a home and preparing a will.

Jersey Shore University Medical Center (Neptune City, N.J.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Jersey Shore University Medical Center, a non-profit academic medical center, is an affiliate of UMDNJ – Robert Wood Johnson Medical School. The hospital has been named one of the "Best Places to Work in New Jersey" for seven consecutive years by *NJBiz* and one of *Fortune's* "100 Best Companies to Work For" in 2010 and 2011. Like other Meridian Health facilities, JSUMC distinguishes itself with a set of generous employee benefits that focus on work/life balance, learning and development and work environment. Busy parents can use the hospital's Early Childhood Education Center, accredited by the National Association for the Education of Young Children. Team members and their family members receive discounted memberships at Meridian's three fully-equipped fitness centers, and a resource and referral service provides professional counseling to help manage family and personal issues.

Johns Hopkins Hospital (Baltimore, Md.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Johns Hopkins Hospital is home to more than 10,000 employees, positioning it among Maryland's largest private employers and the largest employer in Baltimore. For example, employees at Johns Hopkins Hospital can receive tuition reimbursement of up to $5,000 annually and support for a dependent's undergraduate tuition, up to 50 percent of The John Hopkins University's freshman undergraduate tuition and reimbursement for children of employees at any college.

Lehigh Valley Health Network (Allentown, Pa.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Lehigh Valley Health Network is made up of 1,100 primary care and specialty physicians, including 400 employed by the health network. The system offers free health insurance to full-time employees, and eligible employees and their dependents receive $700 to use for exercise and fitness programs, weight loss programs and massage therapy. Employee compensation is tied to the organization's performance, so employees receive cash rewards when patient satisfaction and financial goals are achieved.

LifeBridge Health (Baltimore)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Two-hospital system LifeBridge Health, which also includes a geriatric hospital, nursing home and wellness division, was featured both on *Fortune's* list of "100 Best Companies to Work For" and *Baltimore Magazine's* "25 Best Places to Work" for 2010. The health system offers a variety of activity committees that host events for employees; past events have included LifeBridge Idol singing competitions, bowling and basketball tournaments and dance contests. The system also sponsors regular trips to New York City for employees, and the Department of Pastoral Care and Chaplaincy Services sponsors an annual religious trip abroad. The system's 10-week fitness program encourages employees to get in shape with a health assessment and trial membership at LifeBridge Health & Fitness. Employees can also receive up to $5,000 annual reimbursement for higher education courses.

Lowell (Mass.) General Hospital

Type of facility: Hospital/health system

What makes it a Best Place to Work: This 217-bed community hospital offers a particularly healthy work environment. It was recently recognized by the American Heart Association as a 2010 gold level company, meaning the hospital met AHA criteria for employee fitness and is a tobacco-free campus that offers an American Lung Association smoking cessation program. The LGH Earned Time Program allows employees flexibility in scheduling time off, which they accrue through years of services and the number of hours worked. The hospital offers employees a comprehensive medical plan, dental coverage and life insurance. Additional benefits include forgiveness loans for nursing students, dry cleaning services, child care services and discounted tickets for area movies, museums and amusement parks. Appreciation for Lowell employees is voiced through national appreciation weeks for various departments, an employee awards dinner and retirement teas for departing staff.

Massachusetts General Hospital (Boston, Mass.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Massachusetts General Hospital is a 900-bed medical center that includes five multidisciplinary care centers. In 2008, Mass General was honored by multiple organizations for its dedication to employee engagement. In 2010, DiversityInc named the hospital one of the top 50 companies for diversity; Mass General provides numerous programs and support to help promote women and minority scientists and physicians, including the Association of Multicultural Members of Partners, the Office for Women's Affairs and the Massachusetts General Hospital Lesbian, Gay, Bisexual and Transgender Employee Resource Group. Work/life benefits at Mass General include earned time based on years of service and standard hours, access to a full-service fitness center directly behind the hospital's main campus and tuition reimbursement up to $2,000 per fiscal year for degreed program courses.

Mayo Clinic (Rochester, Minn.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Mayo Clinic is the first and largest integrated, not-for-profit group practice in the world. In 2009, U.S. college students named Mayo Clinic as an "ideal employer" for the sixth straight year, according to a Universum survey of more than 56,000 undergraduates. The system has also been ranked a top employer for healthy lifestyles by National Business Group on Health due to its on-site fitness facilities, healthy weight program, nicotine dependence center and LiveWell program, aimed at helping employees find programs to improve health. The system also hosts 25 employee leagues, clubs and events centered on sports and recreation.

Memorial Healthcare System (Broward and Palm Beach County, Fla.)

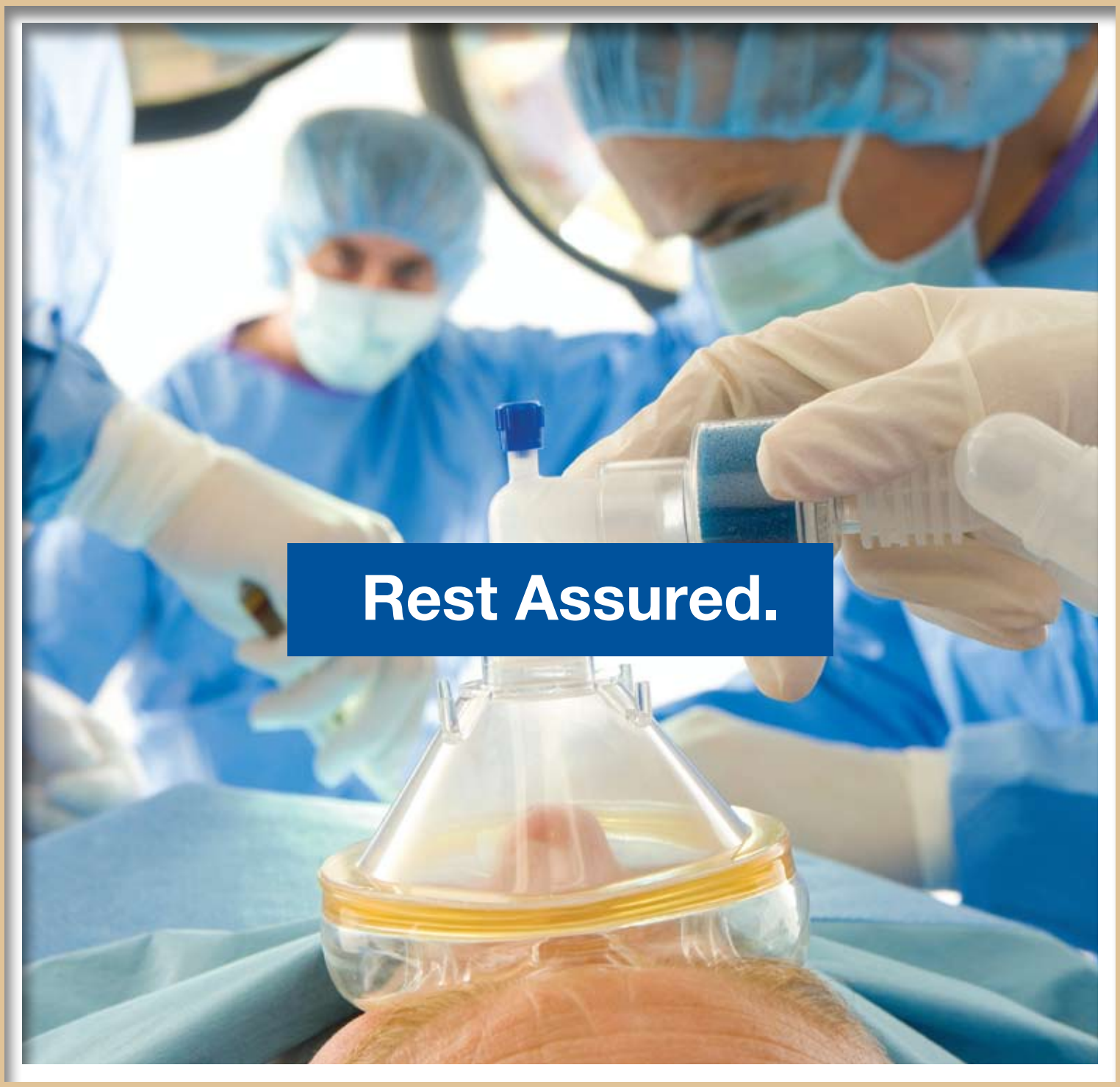
Type of facility: Hospital/health system

What makes it a Best Place to Work: Since its inception in 1953, Memorial Healthcare System has strived to provide high-quality care to South Florida patients. It is currently the fifth-largest public healthcare system in the nation and employs more than 10,000 workers. The hospital's 2010 employee satisfaction survey ranked it in the 96th percentile nationwide, while the physician satisfaction survey placed the hospital in the 97th percentile. Once employees accept a job at Memorial Healthcare System, they are eligible for an attractive sign-on bonus: up to $6,000 for qualified full-time and part-time positions. In addition to generous compensation, the system offers off-site fitness centers, cafeteria discounts, a day care center and premium pay for holiday work.

Methodist Health System (Dallas, Texas).

Type of facility: Hospital/health system

What makes it a Best Place to Work: Methodist Health System is one of North Texas' oldest non-profit health systems. The system's "Team Care = Team Share" incentive program rewards employees $300-$1,000 for meeting organizational goals. The "You Rock" day-to-day recognition program lets employees give a note to any co-worker, volunteer or physician to recognize their



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Missoula Bone & Joint and Surgery Center (Missoula, Mont.)

Type of facility: Physician practice and ambulatory surgery center

What makes it a Best Place to Work: Missoula Bone & Joint Surgery Center has been providing the Missoula community with orthopedics services for 50 years. The center has an extremely low turnover rate — just 3.5 percent — and receives high ratings from staff on every aspect of employment at the center. Employees are invited to join several different committees focused on center improvement, including the process improvement committee and the expense committee, which gives employees input on cost reductions.. In addition to involving employees in process improvement, the center holds regular outings and events to encourage staff bonding. In Dec. 2010, the center held a craft fair for employees to display their work; in Nov. 2010, a barbecue provided a free lunch for employees. Benefits at Missoula Bone & Joint include health insurance paid at 100 percent, a $750 yearly allowance towards dental/vision and other medical expenses, paid time off, life insurance and long-term disability paid by the company and annual continuing education benefits.

Monongalia General Hospital (Morgantown, W.V.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Mon General Hospital, a 189-bed community hospital, is the cornerstone of the Mon Health System. The hospital recently completed a considerable expansion project, upon completion of which, the facility provided a celebration for staff and families. The hospital's "department of the quarter" program recognizes a winning department with an engraved plaque, recognition from administration and small reception for department members. Employees can participate in a wellness program that grants employees points for participation throughout the year. At the end of the year, those who meet the point requirements in three categories are eligible for a wellness cash payout. Staff and their spouses and children can also take part in biometric wellness screenings.

Nanticoke Health Services (Seaford, Del.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Employing 1,100 employees across three entities, Nanticoke Health Services runs a full-service community hospital, a long-term care facility and a network of employed physicians. The system has implemented several tools to communicate with its many providers, including a monthly newsletter, required staff meetings, quarterly town halls and a CEO blog posted on the employee intranet. An objective online performance evaluation tool was introduced to give evaluations a shorter turnaround time and provide clearer, standardized feedback. NHS' active employee activities committee plans regular events to promote staff bonding: Past events have included a bus trip to New York, a Halloween bowling party and employee walk teams at the AHA, ACS and Alzheimer's walks.

Northeast Surgical Care (Newington, N.H.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Northeast Surgical Care, a free standing ASC, recently celebrated its tenth anniversary. Despite a busy schedule, the center maintains a high level of employee satisfaction through growth opportunities as well as benefits, including 401(k) with employer-matched contributions, an annual holiday party and a family summer outing, says Cyndi Harris, administrator at Northeast Surgical Care. Physicians and staff members also make it a priority to give back to the community through frequent service opportunities such as blood drives, road races, golf tournaments, Coats for Kids, Toys for Tots and charity food collections..

North Shore-LIJ Health System (Great Neck, N.Y.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: North Shore-LIJ Health System is the nation's second-largest, non-profit, secular healthcare system, with more than 42,000 team members serving 15 hospitals, ambulatory facilities and physician practices. To encourage employee innovation and creativity, North Shore-LIJ established an "idea forum" that received more than 1,000 ideas from employees over the course of one year. The best ideas were chosen for recognition, and selected employees received $500 and a plaque. North-Shore LIJ offers a host of employee benefits, including a medical plan that covers 100 percent of health services provided at any North Shore-LIJ hospital and facility. The system was recently profiled as a leader in employee engagement in *Closing the Engagement Gap,* a book that highlights exceptional organizations in talent management.

NorthShore University HealthSystem (Skokie, Ill.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: A growing system in the prosperous North Shore suburbs of Chicago, NorthShore has annual revenue of over $1.5 billion and a staff of nearly 9,000. In 2003, it was one of the first hospital systems in the country to successfully launch a system-wide EMR. Since the implementation of the hospital's EMR, NorthShore has invested numerous resources in ensuring employee competency. One-on-one PC coaching and courses in Epic, Kronos and Quantros systems are offered to maintain software skills and increase employee comfort. Good food is never lacking at NorthShore: The system's guest chef program invites famous chefs from P.F. Changs, Wolfgang Puck Café and Maggiano's to work the grill at the hospital cafeteria.

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NorthStar Surgical Center (Lubbock, Texas)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: NorthStar Surgical Center prioritizes service by giving back to the local community and world at large. A number of NorthStar employees volunteer as mentors for local high school students interested in a career in healthcare through the Groundhog Day Shadow Program, and staff members can take medical mission trips with their colleagues to Mexico, Honduras, Africa and Thailand. "This is where I want to end my nursing career," says Vicki Ball, RN, director of nursing. "In my seven years here, I've found this to be the one facility where I can be the best nurse that I can be because at NorthStar we are empowered to be the best we can be."

Northwest Michigan Surgery Center (Traverse City, Mich.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Developed by local physicians in partnership with Munson Medical Center, Northwest Michigan Surgery Center offers a host of services, including orthopedics, plastic surgery, ophthalmology, GI and ENT. According to clinical director Tina Piotrowski, RN, BSN, the physician-owners and Munson Medical Center instituted a 401(k) profit-sharing plan that, in essence, makes each employee a stakeholder in the center's success. To maintain a close-knit team and a comfortable atmosphere, the center staff regularly participates in local events as a team. In 2010, many staff members were involved in community activities such as the National Cherry Festival Run, the YMCA board, career fairs and volunteer events at the State Theatre. "The word is getting out that NMSC is both a top-notch center to receive care and a great place to work," Gayle Bultsma, RN, CAPA, says.

Northwestern Memorial Hospital (Chicago, Ill.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Northwestern Memorial Hospital serves as the primary teaching hospital for Northwestern University Feinberg School of Medicine. The Northwestern Memorial Mentoring Program, launched in 2002 for managers, began with a minority focus and has since expanded to include both minorities and non-minorities. Career development is facilitated through tuition assistance and discounts for full-time employees who attend certain Northwestern University classes. Through the system's training center, NM Academy, employees can take advantage of training sessions, conferences and professional development. Employee health is supported through wellness programs and offerings — such as incentives for successful completion of Weight Watchers — and a confidential disease management program for employees struggling with illness.

OrthoCarolina (Charlotte, N.C.)

Type of facility: Orthopedic practice

What makes it a Best Place to Work: With more than 11 practice locations, OrthoCarolina provides plenty of opportunity for clinical and non-clinical healthcare professionals. The company encourages employees to continue education and pursue career advancement opportunities. OrthoCarolina employees have the opportunity to participate in a 401(k) and profit sharing plan. The practice has been recognized as a Platinum-Level Start! Fit-Friendly Company by the American Heart Association's Start! Movement for healthy employee lifestyles and was honored in 2010 as one of the best places to work by the *Charlotte Business Journal*.

OrthoIndy (Indianapolis)

Type of facility: Orthopedic practice

What makes it a Best Place to Work: OrthoIndy has 14 locations around Indiana and is focused on providing quality bone, joint, spine and muscle care. The practice environment fosters a team approach to providing care and provides opportunities for personal and professional growth for employees. OrthoIndy provides employees with employer-sponsored health insurance, dental insurance and vision discount programs. Employees can also expect a 401(k) pension and profit sharing with matching program, paid time off, life insurance and disability insurance. To promote growth among employees, OrthoIndy offers a clinical ladder program, paid license renewal and other paid continuing education opportunities for full-time employees.

Plastic Surgical Associates of Johnstown (Johnstown, Pa.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Plastic Surgical Associates of Johnson focuses on soft tissue and cancer reconstruction, vein treatment, hand surgery, trauma, skin care and laser hair removal. The center staffs only 18 employees, and each staff member has direct responsibilities and can receive rewards for providing high-quality care. High-performing employees receive quarterly bonuses that equal a 20 percent increase in salary, and base pay scale is above average for all positions to ensure staff continuity. Lunch is provided on all employees' birthdays, and staff members are sent on yearly retreats to improve business practices and strengthen teamwork. Regular company parties involve employees, staff and children and foster a family atmosphere at the center.

Palo Alto Medical Foundation (Palo Alto, Calif.)

Type of facility: Medical foundation

What makes it a Best Place to Work: Since its humble beginnings as a small clinic in downtown Palo Alto in the 1930s, the Palo Alto Medical Foundation has merged three distinct medical groups and currently employs more than 900 physicians. In 2010, PAMF was ranked one of the top 10 places to work in the Bay Area, in the first employee-based survey of Bay Area companies conducted by Workplace Dynamics and published in the June edition of the Bay Area News Group. PAMF placed first as the top non-profit workplace and sixth in the top 10 large companies to work for. The physicians and employees of PAMF organize, support and participate in a wide range of events that promote community health, including community blood pressure screenings, childhood obesity initiatives and parent education programs in local schools.

Poudre Valley Health System (Fort Collins, Colo.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Poudre Valley Health System is a regional healthcare system in northern Colorado consisting of two large hospitals — Poudre Valley Hospital and Medical Center of the Rockies. Poudre Valley Health System prides itself on a low voluntary turnover rate and rewards employee work with a variety of benefits, including birthday gift certificates, on-site massage therapy, a free on-site gym and special employee events. Throughout the year, employees can gather and celebrate PVHS' success at summer picnics, holiday parties, movies, a week recognizing nurses and hospital employees, grill days and themed dress days. If PVHS reaches certain objectives, employees receive a performance bonus tied to the financial and operational success of the system. A reward and recognition program was established to acknowledge employees' individual efforts to improve patient care.

Renown Health (Reno, Nev.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Renown Health is northern Nevada's largest integrated health network, serving a 17-county region and operating four hospitals. The health network's recent expansion features a new child care center for employees and new employee housing to provide convenient living for qualified clinical professionals. Employees are also encouraged to pursue professional development through online learning modules, computer skills training, postgraduate internships and continuing education workshops. Shops at Renown include Starbucks and FreshBerry, and a workplace wellness program and fitness centers help employees stay active and healthy. Staff can also receive public transportation discounts and benefit from a 401(k) savings plan with employer match and a 529 College Savings Plan.

Rex Hospital (Raleigh, N.C.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Part of UNC Healthcare, Rex Hospital has 4,600 employees and more than 1,100 physicians on staff. Rex offers a comprehensive wellness program that tests employee muscular endurance, functional movement, blood pressure and heart rate and personal wellness before designing a personalized plan. Amenities in the wellness facilities would not be out of place in a four-star hotel: whirlpools, indoor tracks, aerobic studios and steam rooms are included. Rex also offers services to manage employee stress, including massage, yoga and stress management. Enrollment at on-site child care is provided by the Rex Child Development Center.

Rothman Institute (Philadelphia)

Type of facility: Orthopedic practice

What makes it a Best Place to Work: In 2010, Rothman Institute was ranked as one of the top places to work in Pennsylvania by *Central PA Business Journal*. The company offers competitive compensation for employees to join its rapidly growing environment. To makes sure each employee knows the importance of their role at Rothman Institute, the company holds superior employee appreciation events throughout the year. This year, 184 team members at Rothman Institute participated in the Arthritis Foundation's Jingle Ball Run/Walk 5K and raised more than $25,000, making the organization the top fundraiser nationwide for the event.

Rush University Medical Center (Chicago, Ill.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Named a top hospital by *U.S. News & World Report,* Rush University Medical Center remains one of Chicago's highest-ranked hospitals. An academic medical center that encompasses a 613-bed hospital, Rush University Medical Center prides itself on a "culture of inclusion," meaning the hospital makes significant effort to promote diversity. Seventy-two percent of employees are women, and 50 percent are minorities, reflecting the diversity of the Chicago neighborhood where Rush is located. The partner and child of any full-time Rush employee is eligible to receive pre-paid tuition for up to nine credit hours in any degree program at the Rush College of Nursing or Rush University.

Sacred Heart Hospital (Eau Claire, Wis.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Sacred Heart Hospital, an affiliate of Hospital Sisters Health System, is a 344-licensed bed acute-care hospital that provides trauma center and regional cancer center services. Each year, the hospital distributes a free frozen turkey to each colleague on staff in the week before Thanksgiving, and each staff member also receives a gift at the hospital's annual Christmas dinner. August means the annual colleague appreciation picnic, where hospital staff and families gather on the hospital's back lawn for ribs, chicken and live music. Each month, the hospital holds a 20-minute recognition ceremony where leaders recognize teams and individuals who have exceeded expectations; one star member is awarded the "employee of the month" special parking space, and others are given certificates and gift cards.

Saint Thomas Health Services (Nashville, Tenn.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Saint Thomas Health Services is a leading faith-based healthcare system in Tennessee and is part of Ascension Health, one of the largest non-profit healthcare systems in the country. Employees at Saint Thomas Health Services benefit from money management assistance in addition to other benefits. The system's partnership with First Tennessee Bank offers an innovative "work perks" program that includes workplace banking, personal services, financial planning advice and free workshops. The system also grants employees free credit consultation and debt counseling. Saving for retirement can start on the first day of employment at Saint Thomas; after one year, STHS begins contributing too.

Scripps Health (San Diego, Calif.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: This five-hospital, non-profit system has more than 12,000 employees and offers unique benefits and employment perks, including phased retirement and flexible scheduling. Along with a wellness program and medical coverage, Scripps offers extensive benefits to its employees, including identity theft protection, pet insurance and career advancement services offered at its Center for Learning and Innovation. More than 25 percent of Scripps employees have been with the health system for more than 20 years, and approximately 10 percent have worked with Scripps for more than 20 years. The health system is also a great fit for older employees, as 28 percent of the Scripps workforce is age 50 or older.

South Nassau Communities Hospital (Oceanside, N.Y.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: South Nassau Communities Hospital is one of the region's largest hospitals, with 435 beds, 2,800 employees and more than 875 physicians. Feedback is encouraged throughout employees' tenure at South Nassau: Every year, the hospital holds an administrative town hall meeting where staff members are invited for a Q&A forum. In 2010, over 1,600 employees participated in South Nassau's employee satisfaction survey. The results indicated that 83 percent were generally or extremely satisfied with working at the hospital. On employee birthdays,

employees receive birthday cards signed by the president and CEO. The hospital will reimburse full-time employees with up to $2,500 of tuition each calendar year; in 2010, South Nassau provided reimbursement for education to employees in the amount of approximately $251,000.

Stanford Hospitals & Clinics (Palo Alto, Calif.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Stanford Hospitals & Clinics supports and empowers its employees to maintain a healthy balance between work and non-work activities. Employees are given a free VTA Eco Pass to use the VTA buses and light rail, access to the system's Health Improvement Program and onsite elder care and child care consultation and programs. The Stanford Center for Education and Professional Development also offers continuing educational courses throughout the year for physicians, nurses and other healthcare professionals with the goal of creating an environment that promotes excellence in patient care.

St. Cloud Hospital (St. Cloud, Minn.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Founded in 1886 by the Sisters of the Order of St. Benedict, St. Cloud Hospital serves a population of more than 650,000 and employs more than 4,300 staff members. The average length of service of nurses at the hospital is 11 years. The clinical nursing ladder program at St. Cloud is designed to empower nurses who want to pursue leadership roles; the program is self-governed by a registered nurse from each hospital area and has been successful in appointing nurse leaders for 15 years. The hospital also promotes nursing research by holding journal clubs, hosting brown bag research presentations featuring hospital RNs and faculty and providing assistance from librarians with literature reviews.

St. Joseph's Healthcare System (Paterson, N.J.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: St. Joseph's Healthcare System is an integrated, multi-disciplinary healthcare system that employs more people than any other organization in Passiac County. The hospital's retention rate sits at 9.8 percent, two percent better the national average of 11.7 percent, and its nursing vacancy rate is less than one percent. In 2011, St. Joseph's employees and their dependents are forecast to pay only 15 percent of their healthcare expenses. The system's Wellness at Work Committee sponsors monthly wellness programs, educational fairs, free screenings and vaccinations. The system's generous tuition assistance program benefitted over 200 employees in 2009-2010, with each receiving an average tuition benefit of $2,000.

St. Jude Children's Research Hospital (Memphis, Tenn.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Ranked the number one children's cancer hospital by *U.S. News & World Report* for the last two years, St. Jude is the first and only National Cancer Institute-designated Comprehensive Cancer Center devoted solely to children. The hospital was ranked one of the 100 best companies to work for by Fortune in 2011. Nursing at St. Jude is particularly well-regarded; nursing benefits include low nurse-to-patient ratios in all units, three weeks paid vacation, a 10-12 week orientation and a four-step clinical ladder advancement program. According to nurse employees, St. Jude's policy of shared decision making gives a voice to every employee by the patient's bedside, rather than giving managers unilateral decision on clinical care. Nurses can contribute opinions by attending staff meetings and serving on support, steering or their particular unit councils.

St. Luke's Hospital (St. Louis)

Type of facility: Hospital/health system

What makes it a Best Place to Work: The employees of St. Luke's are immersed in what they call a FACES Culture: Friendly, Available, Caring, Efficient and Safe. The 493-bed hospital offers competitive and flexible benefit packages, including loan forgiveness for select positions and an employee crisis fund. With a mission to improve the health of the community, St. Luke's has adopted a smoke-free hospital campus and offers smoking cessation classes. It has received recognition for its outstanding employee engagement and job satisfaction scores by HR Solutions, an international management consulting firm, and was also named as a best place to work by the *St. Louis Business Journal* in 2010.

Summit Ambulatory Surgical Centers (Central Maryland).

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: Summit Ambulatory Surgical Centers is the 14-ASC arm of Chesapeake Urology Associates, the largest urologic practice in Maryland and the Mid-Atlantic Region. Chesapeake Urology has just a six percent turnover rate, well below industry averages. This is unsurprising considering the generous employee perks in addition to regular benefits. Employees who pitch ideas which are integrated into operations receive rewards. Offices which exceed patient expectations earn special breakfasts. Employees receive awards for milestone anniversaries with the organization. There's an annual Christmas bonus program and ongoing training and development for staff.

Sutter Alhambra Surgery Center (Sacramento, Calif.)

Type of facility: Ambulatory surgery center

What makes it great: Sutter Alhambra Surgery Center, which is partnered with Surgical Care Affiliates and Sutter Health, has recently achieved re-accreditation by the AAAHC, houses three ORs and has more than 20 orthopedic surgeons using the facility. Staff members attribute their pleasure in working at SASC to the clinical expertise of their colleagues and the surgeons' concern and care for their staff members. SASC ensures employees receive a full package of benefits, including medical, dental and vision benefits and 401(k). Other staff members says the management company's professionalism and willingness to be a "hands-on" company has been another factor in making SASC a great place to work for its staff members.

Texas Back Institute (Plano, Texas)

Type of facility: Specialty clinic

What makes it a Best Place to Work: Texas Back Institute is one of the largest free-standing spine specialty clinics in the United States, offering a range of services to treat back and neck pain. TBI prides itself on its ability to offer flexible hours, allowing employees to take time off work for school activities or sporting events. The facility also attempts to promote from within whenever possible and provide its employees with a strong support system. In Aug. 2008, the facility welcomed its first female spine surgeon, one of the only women to practice spine in the Dallas/Fort Worth area. TBI actively seeks out opportunities to bring team members together: in Aug. 2010, TBI leaders encouraged staff to come together and collect items for victims of domestic violence at a local shelter.

Tulsa Spine & Specialty Hospital (Tulsa, Okla.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Tulsa Spine & Specialty Hospital, a physician-owned specialty hospital, is coming up on its 10th anniversary year. In early Feb. 2011, the facility came together during a record snowstorm and freezing temperatures. Individuals stayed at the hospital for several days without going home, performing duties they had never done before in the absence of food, linen and supply delivery. Employees are invited to participate in profit-sharing, spring and fall cookouts for employee families, assistance with scrub purchases, payroll deductions for cafeteria purchases and an annual Christmas Party. Fundraisers, such as chili cook-offs and raffles, are held throughout the year to raise money for

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the fund; the earnings are then given to employees who experience financial difficulties such as the death of a family member, extensive car repairs or long-term illness.

Thomas Jefferson University Hospitals (Philadelphia)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Thomas Jefferson University Hospitals, a 957-bed academic medical center within the Jefferson Health System, services patients in Philadelphia and the surrounding area. The hospital holds the prestigious MAGNET recognition for nursing excellence from the American Nurses Credentialing Center and provides numerous opportunities for nurses seeking credentialing or higher education. The hospital also offers discounted mass transit passes, a cafeteria meal plan, prescription drug benefits and — perhaps best of all — a farmer's market. The hospital also offers a 12-month administrative fellowship program to individuals pursuing leadership roles. Fellows in the program work side-by-side with senior leaders at the hospital to develop management skills and implement innovative approaches for delivering high-quality care.

UnaSource Surgery Center (Troy, Mich.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: UnaSource Surgery Center is a multi-specialty outpatient facility that offers physicians specializing in cardiology, GI, general surgery, gynecology, otolaryngology, orthopedics, plastics/reconstructive surgery, podiatry and urology. USC was named the 2010 #1 Small Business Top Workplace by the *Detroit Free Press,* marking the third consecutive year USC has made the list. In 2008, the center landed the number two spot on the list; in 2009, it reached number one for the first time. For the past two holiday seasons, the USC staff has taken up a collection and made a donation to a charitable organization and the family of a deceased team member.

University of Chicago Medical Center (Chicago, Ill.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: Affiliated with the University of Chicago Pritzker School of Medicine, the University of Chicago Medical Center has 532 beds, more than 9,500 employees and more than 700 attending physicians. Nurses at UCMC earn among the highest salaries in the greater Chicago area, and employees are encouraged to pursue educational opportunities — everything from safety seminars to the award-winning UCMC Academy to onsite degree completion programs. New full-time employees receive up to three weeks paid vacation per year, plus five paid personal holidays, adding up to essentially four weeks of vacation time. Employees also receive 10 sick days per year.

University of Washington Medical Center (Seattle, Wash.)

Type of facility: Hospital/health system

What makes it a Best Place to Work: UW 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. UW Medical Center employees can take advantage of a variety of wellness services under the umbrella of the UWellness program. For a workout, employees can visit the on-campus health club, golf driving range, waterfront activities center and other facilities; to increase control over their own health, staff can take advantage of counseling and support, classes and educational materials, smoking cessation services and weight management. UWMC also gives its employees free, confidential counseling, financial and legal services, and the Hometown Home Loan Project gives staff assistance with home-buying.

West Bloomfield Surgery Center, d.b.a. Lake Surgery Center (West Bloomfield, Mich.)

Type of facility: Ambulatory surgery center

What makes it a Best Place to Work: West Bloomfield Surgery Center, which services the Detroit metropolitan area, is the highest ranked ASC for employee satisfaction in the National Surgical Hospital family of surgery centers, and was ranked first overall for all of NSH's facilities, according to Anne Hargrave-Thomas, administrator/CEO of the ASC. This high level of satisfaction is reflected in year-over-year improvement in physician satisfaction and the facility's turnover rate, which is below the national average. The leadership team of West Bloomfield Surgery Center, which has four ORs and two procedure rooms, provides numerous opportunities for staff members to share their observations and suggestions through the use of general staff meetings, rounding, departmental meetings and a suggestion box.

The Virginia Spine Institute (Reston, Va.)

Type of facility: Spine center

What makes it a Great Place to Work: The Virginia Spine Institute is a 26,000-square-foot center for spinal healthcare in the Washington, D.C. metro area. To increase its reach in the local community, VSI has developed a formal volunteer program for employees, which encourages the entire staff to donate items and participate in events with the local YMCA, the public school system, little league teams and many other local charities. In 2010, VSI took steps to turn its core values into an integral part of the employee experience, rather than simply "words on a wall." To do so, VSI asked employees to share stories about how the facility's core values — caring, excellence, leadership, teamwork, innovation and comprehensive care — affect day-to-day life in the workplace. Employee benefits include an onsite fitness facility, Pilates classes, personal training and discounted on-site nutritionist and massage therapists.

Yale-New Haven Hospital (New Haven, Conn.).

Type of facility: Hospital/health system

What makes it a Best Place to Work: Yale-New Haven Hospital 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. The hospital has been named one of the 100 best companies for working mothers by *Working Mother* magazine, one of the top 30 companies for executive women by the National Association of Female Executives and one of the best employers for workers over 50 by AARP. The Yale-New Haven Hospital Daycare Center is available to employees with children aged three months to five years, and employees who work 24 hours or more per week are eligible for adoption assistance of up to $6,000 per child. Employees who refer a nursing or allied professional — who is subsequently hired — to YNHH are eligible for a referring bonus of up to $3,000. ■

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50 Things to Know About the Proposed ACO Regulations
(continued from page 1)

2. An ACO may include the following types of groups of providers:
- ACO professionals (i.e., physicians and hospitals meeting the statutory definition in a group practice arrangement);
- Networks of individuals practices of ACO professionals;
- Partnership or joint venture arrangements between hospitals and ACO professionals;
- Hospital employing ACO professionals; and
- Other Medicare providers and suppliers as determined by the HHS Secretary.

3. The regulations provide for a once-a-year start date of Jan. 1. Under the proposed rule, ACOs would apply for the three-year program and, if accepted, would be part of a cohort of ACOs joining the Shared Savings Program every Jan. 1.

4. ACO agreements will be for three years with one-year performance measurement periods.

5. Medicare fee-for-service beneficiaries will be retroactively assigned to ACOs based on primary care utilization during a performance year. "We are proposing to assign beneficiaries for purposes of the Shared Savings Program to an ACO if they receive a plurality of their primary care services from primary care physicians within that ACO."

6. Beneficiaries will not be assigned to more than one ACO.

7. Beneficiaries will not receive advance notice of their ACO assignment. However, providers participating in ACOs will be required to post signs in their facilities indicating their participation in the program and to make available standardized written information to Medicare fee-for-service beneficiaries whom they serve. Additionally, all Medicare patients treated by participating providers must receive a standardized written notice of the provider's participation in the program and a data use opt-out form.

8. CMS expects 5 million Medicare beneficiaries to receive care from providers participating in a shared savings program.

9. An ACO must have at least 5,000 beneficiaries. If an ACO accepted into the program falls short of the 5,000 requirement, it will be placed on a corrective action plan.

10. The board of an ACO must include some Medicare beneficiaries. "Another of the proposed patient-centered criteria discussed previously is the requirement that ACOs provide for patient involvement in their governing processes. We are proposing that, in order to satisfy this criterion, ACOs will be required to demonstrate a partnership with Medicare FFS beneficiaries by having representation by a Medicare beneficiary serviced by the ACO, in the ACO governing body."

11. The ACO board must include representation from all ACO participants. CMS requires this in order ensure all ACO participants are provided "an appropriate proportionate control over the ACO's decision-making process."

12. No more than 25 percent of board seats can be held by non-ACO participants such as entrepreneurial companies. "In order to be eligible for participation in the Shared Savings Program, the ACO participants must have at least 75 percent control of the ACO's governing body."

13. The proposed regulations do not require an ACO to become a separate legal entity with a separate Tax Identification Number. However, CMS recognized not requiring this could make it more difficult for CMS to audit ACO performance. Thus, it is seeking comment on whether all ACOs should be required to be formed as separate legal entities.

14. The ACO can enter into a one-sided or two-sided shared savings agreement. Under the first "one-sided" risk model, an ACO that creates a savings of at least 2 percent would get 50 percent of the money above that threshold, but it would have no penalty if it spent more in the first and second year. Under the "two-sided" model, an ACO could receive 60 percent of the money above the threshold but also would be penalized if it led to higher costs. By the third year of the program, all ACOs would become responsible for losses.

15. Cost targets, from which savings will be calculated, will be based on retrospective review of aggregate beneficiary-level data for the assigned population. Spending targets will be compared to actual spending and any savings above the ACO's minimum savings rate (generally 2 percent), will be shared between CMS and the ACO.

16. CMS will set spending benchmarks based on three years of data. These will be set with a higher weighting on the most recent year and the lowest weighting on the year three years ago (i.e., a 60, 30, and 10 rating). There are several adjustments to the benchmarking.

17. Generally there is no savings shared or costs to be borne unless savings are at least 2 percent above or below the benchmark. The higher the number of beneficiaries, the lower the minimum savings rate. For smaller populations (e.g., 5,000 beneficiaries), the minimum savings rate can be higher (i.e., up to 3.9 percent). However, there are exceptions to the rule for rural ACOs.

18. The ACO entity is responsible for distributing savings to participating entities. Medicare will pay the savings to the ACO, which will distribute it to participants in the ACO.

19. ACOs will be subject to a withhold of shared savings to offset possible future losses. "The ACO will be subject to a 25 percent withhold of shared savings in order to offset any future losses under the two-sided model." If an ACO completes its three-year agreement, it can recoup the 25-percent withhold. If an ACO terminates its agreement before the three-year requirement, CMS will retain any portion of shared savings withheld.

20. To be eligible to receive shared savings, the ACO must also meet certain quality standards. There are five standard measures for quality or areas. These include patient care giver experience, care coordination, patient safety, preventive health and at risk population/ frail elderly health. CMS will designate scoring and measurement concepts. "Each of the [five] domains is equally weighted in determining an ACO's overall quality performance score, regardless of whether the ACO is in Track 1 or Track 2."

21. An ACO must develop a process to promote evidence-based medicine, patient engagement and coordination of care.

22. ACOs must have a patient survey tool in place.

23. ACOs must have a process for evaluating the health needs of the population it serves.

24. ACOs must have systems to identify high-risk beneficiaries and develop individual care plans for target populations.

25. An ACO must report and maintain a database of all ACO participants and their National Provider Identifiers.

26. ACOs must have a compliance plan and conflicts of interest policies and means to screen ACO participants.

27. ACOs must get approval for any changes in ACO participants (i.e., providers) during the three-year contract period.

28. Where an ACO's structure or participants changes during a term, CMS has five different ways it may respond. In some cases, the ACO will be allowed to move forward in the program. In others, it would be required to start over with a new three-year agreement. In some cases, the ACO would no longer be eligible for the Shared Savings Program. (See page 137 of the proposed regulations for the full list of CMS responses.)

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29. Primary care providers may only participate in one ACO. However, a hospital can participate in more than one ACO, as can non-primary care medical and surgical providers.

30. Physicians eligible for primary care provider status include internal medicine, general practice, family practice and geriatric medicine specialists.

31. At least 50 percent of an ACO's primary care physicians must be meaningful EHR users as defined by the HITECH Act and subsequent Medicare regulations.

32. Each ACO will have significant public reporting requirements in a standardized format. Name; location; contact; participating providers; identification of participants in joint-ventures between ACO professionals and hospitals; identification of representatives on the governing body; associated committees and leadership; quality performance standard scores; shared savings information, total proportion of savings distributed to participants; and total used to support quality performance will be reported publicly.

33. ACOs must have a data-use agreement with CMS. However, Medicare beneficiaries assigned to ACOs can opt-out of data sharing. The ACO must supply beneficiaries with a form that allows them to opt-out.

34. CMS will share aggregate population data regarding the ACO's population several times per year. Data from CMS will include financial performance; quality performance scores; aggregate metrics on the assigned beneficiary population; utilization data at the start of the agreement period based on historical beneficiaries; and identification of historically assigned beneficiaries used to calculate the benchmark.

35. CMS may monitor to ensure they are not avoiding at-risk beneficiaries or distributing unapproved marketing materials in addition to a whole range of other issues. In regards to marketing materials, CMS must approve any marketing materials or other communications promoting the ACO.

36. ACOs must agree to be open wholly to audits. "We further propose that, if such data are generated by ACO participants or another individual or entity, or a contractor, or subcontractor of the ACO or the ACO participants, such ACO participant, individual, entity, contractor, or subcontractor must similarly certify the accuracy, completeness, and truthfulness of the data and provide the government with access to such data for audit, evaluation, and inspection."

37. The regulations set forth 16 grounds for termination of an ACO's shared savings agreement with CMS. Examples of these grounds include failure to report quality standards or failure to meet quality thresholds and avoidance of at-risk beneficiaries. (A full list of the 16 grounds can be found on pg. 409 of the proposed regulations.)

38. There are several concepts which are not subject to appeal by an ACO if it is terminated from the program by CMS. (A list of these can be found on pg. 412 of the proposed regulations). ACOs may appeal an initial determination if it is not prohibited for administrative or judicial review.

39. CMS can change the program during a contract term, but can't change the rules regarding the eligibility requirements of an ACO, calculation of the shared savings rate and beneficiary assignment.

40. CMS and the OIG have proposed waivers with regard to Civil Monetary Penalty, Antikickback and Stark laws solely as to relationships wholly related to an ACO. For Stark and Antikickback, the waiver applies only to distributions of shared savings (not any other financial relationships).

41. Preliminary guidance from IRS available. The IRS has issued preliminary guidance to provide tax-exempt entities information on participating in ACOs.

42. Preliminary guidance from antitrust agencies available. The FTC and DOJ have also issued a proposed statement of antitrust enforcement policy as to ACOs. According to the guidance, ACO participants will not be challenged if they have a combined share of less than 30 percent of the common service in each area. If outside the safe zone it can still proceed if less than 50 percent. If more than 50 percent it must receive an approval to participate. If less than 50 percent, it doesn't need a review, but can request one.

43. The core concepts of the ACO program are to achieve better care for individuals, better health for populations and lower growth for Medicare expenditures.

44. Comments on the proposed rule will be accepted for 60 days after the proposed rule is published in the Federal Register (expected April 7, 2011, so until June 6, 2011).

45. The ACO program is scheduled to go into effect on Jan. 1, 2012.

General observations on the ACO program

46. Will require massive bureaucracy. Given the scope of the regulations and the number of actions and approvals to qualify and participate and be accountable as an ACO, the ACO regulations likely will require the establishment of a massive bureaucracy. In some ways, it's a different form with much more integration than providers that manage a Medicare advantage plan system but with arguably even more complexity.

47. Regulations are idealistic. The regulations in many ways speak of what is viewed by CMS as ideal concepts in healthcare, concepts used as platitudes such as "patient-centered care," "patient engagement" and many other terms. It will be fascinating to see how the actual practical hard-nosed implementation meshes with such ideals.

Further, the regulations speak of the kind of leadership expected in ACOs as though government can choose leaders or dictate what they look like in what we know is an imperfect world and where the reality of capitalism and a free market. In reality, who leads such organizations is never going to be as clean and clear as the regulations seem to believe and the leaders won't fit a certain stereotype.

48. Regulations limit business involvement. The program set forth the kind of negative attitude that one might expect from CMS towards business and further tends to reflect CMS' demonization of business and insurance. For example, while some might think business involvement is needed to drive this, the regulations specifically require that business interests cannot makeup more than 25 percent of the board in ACOs.

49. Regulations require beneficiary representation in ACO governance. The program requires a means for equal and shared governance in ACOs and requires beneficiaries to have a say in the ACO governance. Specifically, the proposed regulations require the ACO governing body to include including "a Medicare beneficiary serviced by the ACO."

50. Regulations favor PCPs. The ACO regulations — much like intended reform in the 90s — view the primary care physician as the leader of patients' healthcare and really relegates many other parties to being cost centers. Language regarding PCP roles is somewhat glowing, further suggesting this perspective. ■

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An Examination of Ownership Models of ASC JVs

By Jeff Simmons, Chief Development Officer, and Vivek Taparia, Director of Business Development, Regent Surgical Health

There exist over 5,000 Medicare certified ASCs in the country, up from around 3,000 ASCs a decade ago. Over 90 percent of these ASCs have physician ownership. Around 20 percent of the ASCs have a hospital as an equity partner. Approximately 20 percent of ASCs also have a corporate management partner. Furthermore, a meaningful percentage of these ASCs are three-way joint ventures between surgeons, a management company and hospital.

There are numerous benefits a hospital can accrue in participating in an ASC joint venture, including improved recruitment and retention, enhanced market share and improved operating room capacity. After having made the choice to pursue a joint venture, the choice on the optimal ownership structure given a specific operating environment must be assessed closely.

Three dominant paradigms exist: the hospital minority ownership model, the control model and the co-management agreement.

The joint venture catalyst

The desire to recruit and retain physicians represents the primary impetus for a hospital to incorporate an ASC JV in its delivery network. Major draws for surgeons include the potential economic upside of an ownership interest in the ASC, the enhanced productivity in the ASC environment and the patient experience in the ASC. Further, surgeons recruited to a hospital through an ASC often come from the local market, have established practices and, especially in suburban and urban environments, operate at more than one hospital. As such, through the ASC, the hospital can capture outpatient volume which otherwise goes to competing hospitals. Finally, hospitals involved in an ASC are well poised to shift outpatient volume to the ASC in order free up operating room capacity for both higher acuity and more inpatient

cases in the hospital's main operating rooms. Logically, the hospitals best positioned to deploy such a strategy are those that have operating rooms that are at high capacity utilization.

Minority ownership model

After having validated the benefits of an ASC joint venture, hospitals often seek a minority stake in an ASC. Under this ownership model, three classes of shareholders typically exist. Physicians represent Class A shareholders and own over 51 percent of the ASC. The hospital and potentially a management company, Class B and C shareholders respectively, own the remainder. Because of their majority position, physicians in effect have operational control over all key decisions of the ASC such as credentialing, partnership decisions, budget approvals, capital expenditures and selection of the management company.

There are various instances in which a hospital seeks to have a minority position. For example, in a given market, an ASC has successfully captured the majority of a hospital's outpatient volume. The hospital leadership concludes the hospital is better off with a minority position in the ASC vs. no position at all.

The ASC also seeks to align itself close to the hospital through sale of a minority stake. Often, hospital minority positions in a surgery center originate from majority positions. Hospital majority-owned ASCs often fail due to their inability to meet physicians' needs of administrative authority and financial returns. Hospitals often engage ASC management companies to syndicate their majority position out to surgeons, reducing the hospital's ownership to a minatory stake.

Hospital control model

The hospital control model can represent a superior alternative to the hospital minority ownership model, depending on the specific market environment. In the hospital control model, two classes of shareholders typically exist. Physicians represent one Class A, owning 49 percent or less of the ASC. The hospital and potentially a management company represent Class B shareholders, owning 51 percent or more of the ASC. Furthermore, the hospital owns the majority of the Class B shares. As such, per the ASC's operating agreement, the hospital controls the vote the for all the Class B shares on key decisions which enable the hospital to illustrate its controlling interest in the facility. These decisions include the budget, debt service, contracting and strategic sales. As such, the hospital can represent itself as the majority owner of the facility.

The hospital control model can be optimal if two criteria are satisfied:

1. The hospital has superior insurance contracts to the ASC.
2. The hospital has the ability and willingness to assert its contracting power to benefit the ASC.

Under the control model, hospitals can make a credible statement to payors that the hospital has controlling interest in the ASC. However, it does not necessarily follow that the hospital can procure superior contracts for the facility. Note that Medicare pays hospitals almost 200 percent more than ASCs for the same outpatient procedures. While under the control model, a hospital cannot procure the same hospital outpatient department (HOPD) rates for the ASC. However, hospitals have successfully contracted rates at a 25 percent discount to HOPD rates.

In allowing a hospital to have controlling rights in an ASC, physicians generally will be concerned about the financial downside of less ownership as well as the implications of limited control. Various factors offset these concerns. In terms of ownership, while physicians may own less of the center, if the joint venture executes the Control Model well, physicians will experience higher investment returns than if they were majority owners. With respect to the physicians' concern regarding loss of control, successful JVs under the control model carve out numerous operating decisions to the

physicians, such as choice of management company, hiring of an administrator, admission to the partnership and the anesthesia provider.

Co-management model

As an alternative to joint ventures based on ownership, co-management arrangements are becoming an increasingly common form to structure ASC joint ventures. In a co-management arrangement, the hospital owns 100 percent of the ASC and bills the facility's volume as a hospital outpatient department. The hospital engages surgeons and potentially a management company to provide clinical and operational oversight to the facility and in return compensates these parties at fair-market value for their services.

Typical fees in co-management relationships range between 2 percent-6 percent of net revenues of the facility. In compensating the surgeons, significant attention must be placed on defining performance metrics and determining fair market value in order to remain clear of legal scrutiny surrounding physician self-referral and anti-kickback statues. While the co-management model is largely a nascent structure, but based on discussion with industry practitioners, the model works best at physician-owned ASCs which lacked historical economic success. If physicians earn less in a co-management relationship than as former owners of the ASC, the relationship with the hospital can likely become strained.

Conclusion

In the new era of the accountable care organization, incorporating ASCs, 90 percent of which are physician owned, into healthcare delivery systems will assume increasing importance. Central to the issue of physician alignment is the selection of the appropriate joint-venture structure for the ASC. Depending on the market environment with payors, the Minority Ownership, Control, and co-management models can all generate optimal alignment outcomes.

Case Study: The Surgery Center of Reno - A Minority Partnership Model

The Surgery Center of Reno is an example of restructuring a joint venture to create a minority ownership JV that aligns interests with surgeons and benefits all partners. Prior to 2005, St. Mary's Medical Center, a large hospital in Reno, Nev., owned more than 90 percent of the ASC on its campus.

While the center enjoyed high volume, numerous low paying cases, oftentimes lower than the costs, poor reimbursements due to, at best, average managed care contracts, high labor and supply costs eroded the facility's profitability.

The board contacted a management company to recruit surgeons and restructure the joint venture. A new JV was created with the management company and 19 additional local surgeons, many of whom practiced at the competitor's hospital. The hospital retained a minority share and one seat on the seven-member board. The management company expanded the new partnership from only ENT and orthopedics to include spinal neurosurgery, bariatric surgery, urology and pain management.

During the first year under the new structure, the center generated a 50 percent return on investment; by the end of the 14th month of opening, the facility has had a 110 percent return on investment.

Many of the physician partners moved their practices to St. Mary's campus, which resulted in an increase in activity by these physicians at the hospital. The ASC continues to perform extraordinarily well even after four years of operations. St. Mary's has since opened a second outpatient facility in competitor territory to expand its system's reach.

Ownership Structure

Before: Hospital owned 90 percent and physicians owed 10 percent.

After: Physicians own 74 percent, hospital owns 14 percent and management group owns 12 percent.

Control

St. Mary's and the management group each have one seat on the seven-person board. The physicians have complete operational and clinical control of the facility.

Case Study: Knightsbridge Surgery Center - A Control Model

Knightsbridge Surgery Center opened in 2001 in Columbus, Ohio, but did not produce returns for its physician owners under its initial management company. In 2004, the ASC engaged a new management company which turned around the facility in a few months in part through going out-of-network with key payors. After a few highly profitable years, KSC's payor strategy lost momentum. In 2007, the dominant local health system, OhioHealth, approached Knightsbridge with a partnership offer to buy a controlling interest in the facility. With knowledge that the hospital's contracting ability could benefit the center, the management company structured a transaction in which the hospital would own a 49 percent interest in the facility but would have a 50 percent vote and tiebreaker rights on KSC's key management decisions. In turn, the hospital asserted its contracting ability to benefit the center. Not only did the physicians experience a liquidity event when the hospital purchased a 49 percent interest in the center, KSC's profitability remains at the same peak levels it achieved earlier in the decade. Due to the hospital's contracting ability enabled by the control model, the investment returns for the physicians remain meaningful despite their reduced ownership position.

Ownership Structure

Before: Physicians owned 84 percent and management company owned 16 percent.

After: Physicians own 43 percent, hospital owns 49 percent and management group owns 8 percent.

Control

OhioHealth has two seats, the physicians have four seats, and the management group has one seat on the governing board. OhioHealth has 50 percent voting and tiebreaker rights on key management decisions. ■

athenahealth

8 Problems Surrounding Meaningful Use

By Michael Sinno, Vice President and CIO, Cooper University Hospital, Snehal Gandhi, MD, Director of Medical Informatics, Cooper University Hospital and Molly Gamble

Achieving meaningful use will require extensive training and time, which translates to big costs for providers. Approximately 62 percent of providers who already have or are planning to implement electronic health or medical records will spend more than 20 percent of their yearly IT spending on meaningful use-related projects this year, according to an *InformationWeek* survey. While hospitals are designating dollars for this undertaking, they will still face roadblocks along the way, such as physician resistance, aggressive timeframes and changed workflow. Here are eight problems hospitals may face in their efforts to achieve meaningful use.

1. Problem: Enrollment and attestation process for eligible providers is cumbersome for those with employed faculty.

Explanation: Hospitals with employed physician groups that are also part of a larger healthcare system need proxy access to manage the logistics of enrollment and attestation following the 90 days. The healthcare system has made the investment in an EHR and is ensuring, on the physician's behalf, that meaningful use objectives are met as part of a broader implementation and maturing plan. Without proxy access, it is an unmanageable process to have 400+ physicians enroll individually and attest compared to a centralized process that is completed on their behalf.

Solution: CMS recognizes this gap, but has not committed to a firm timeframe as to when proxy access will be given. Meanwhile, organizations that are ready to enroll and begin the 90-day demonstration period are in a holding pattern, which translates into delays for receiving incentives.

2. Problem: Incentive payments for hospitals and eligible providers cover only 20-25 percent of the overall cost to implement an EHR and achieve meaningful use.

Explanation: The cost of implementing an EHR program greatly exceeds the amount of total reimbursement. The level of investment needed is on the same level and competing for limited capital dollars tied up in initiatives such as strategic facility decisions, purchase of biomedical equipment, ancillary clinical systems, etc.

Solution: Increased level of funding by the government and recognition that hospital-based physicians require ancillary systems that are not native in EHRs, yet are vital to the overall care of the patient. CMS incentives explicitly exclude hospital-based physicians and the focus is around the core EMR systems only. However, in order to build a complete record, investments beyond the core EMR are needed — adding significant costs. These may include a radiology information system, cardiovascular information system, laboratory and pathology system, and digital imaging system, such as picture archiving and communication systems.

3. Problem: Increased demand placed on providers detracts from patient care.

Explanation: While tools such as macros, smart phrases and templates help with ease of electronic documentation, workflow is still slower than a paper-based chart. As a result, a lower volume of patients is seen and/or investments in physician extenders are needed.

Solution: Increased level of funding by the government. Electronics versus paper may slow down workflow, leaving physicians doing less clinical work and more administrative duties. This translates into one of two realities: a lower volume of patients seen, which means less revenue, or added cost to provide physicians with labor to assist them with administrative duties. While EHRs are beneficial for patients, they do add costs that directly impact physicians' bottom line.

4. Problem: The majority of organizations are within the same relative progression phases of EHR implementation. There is a shortage of clinical analysts for whom organizations are competing to recruit, train and retain.

Explanation: A short-term, artificial inflation of labor costs is created due to demand outweighing supply. As organizations reach the end of the maturity model, a surplus of labor will exist, wages will diminish and jobs will be lost.

Solution: Progressive compensation and retention plans, along with employment agreements.

5. Problem: Implementation schedules for new enterprise applications are usually a lot longer than the timeline given for meaningful use.

Explanation: For organizations that began the process as a result of HITECH and meaningful use, the timeframe is extremely aggressive by comparison.

Solution: Given the much shorter timeframe for implementing certified EHR technology to meet meaningful use requirements, an institution would have to accelerate their implementation schedule by ramping up resources while having robust mechanisms in place to ensure quality of care and patient safety are not compromised.

6. Problem: Clinicians may resist the adoption of an EHR, especially if the hospital does not currently have any form of an EMR/EHR in place.

Explanation: Physicians, by virtue of the physician culture, are usually resistant to change and may be difficult to convince when it comes to switching from a paper-based workflow to an electronic workflow. Additionally, there could be significant variations in workflows between units in a hospital, prompting other clinicians' resistance to change.

Solution: Careful, detail-oriented attention must be paid to existing workflows so as to not create cumbersome and inefficient workflows in the EHR. Adequate buy-in must be obtained from the clinical community by recruiting champions from various clinical professions. Standardization is key to successful implementation of an EMR/EHR and this expectation should be set and managed up front.

7. Problem: Maintaining an up-to-date shared problem list may prove to be problematic.

Explanation: One of the requirements of meaningful use is to maintain an up-to-date problem list so organizations can more effectively identify conditions among patient populations. By virtue of how EHRs function, problem lists are shared between all providers, but physicians tend to be territorial about their problem lists, which have been a standard component of medical records since the 1960s. Additionally, in the paper world, charts are usually not shared and each provider maintains his or her own problem list on a patient.

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Solution: Set expectations early with physicians by creating a document that outlines problem list etiquette. Check with your EHR vendor and other institutions that have implemented your brand of EHR to see if they have any solutions to mitigate issues with the problem list.

8. Problem: EHRs have an abundance of data but do not have an abundance of readily available information. Meaningful use requires the reporting of hospital quality measures via use of certified EHR technology.

Explanation: You can essentially find any data you are looking for in an EHR system. The challenge is to extract the data into a meaningful format so providers can submit to meet meaningful use requirements. Also challenging is formatting quality measures and other information off of which stakeholders and end users can base decisions.

Solution: The time is now to ramp up medical informatics and business intelligence at your institution by investing in skilled resources and technology. Technology should be geared towards the ability to deliver meaningful reports and real-time dashboards. ■

Cooper University Hospital in Camden, N.J., is the clinical campus of the University of Medicine and Dentistry of New Jersey — Robert Wood Johnson Medical School at Camden. It has more than 700 physicians in 75 specialties and offers a network of comprehensive services, including prevention and wellness, primary and specialty physician services, hospital care, ambulatory diagnostic and treatment services, and home health care within Southern New Jersey, Philadelphia and the entire Delaware Valley.

Federal Meaningful Use Workgroup Goes to Work on Stage 2 Deadlines and Requirements

By Jaimie Oh

The HIT Policy Committee's meaningful use workgroup is still working toward finalizing recommendations for a timeline and requirements for the next stage of meaningful use.

The workgroup met earlier this week and is expected to make its final recommendations to the committee in May. According to Paul Tang, chair of the meaningful use workgroup, public comments on proposed stage 2 meaningful use measures fell into two categories: those who wanted to stick with the current timelines and those who wanted to slow down stage 2 implementation. Several proposals have been made to address the concern of impending deadlines, including raising the threshold of data measures in stage 2 without adding any new measures or delaying the threshold of data measures under stage 1, according to the news report. ■

8 Steps to Smoothly Achieve Meaningful Use

By Evan Grossman, Vice President Product Strategy, athenahealth

As the rubber meets the road on meaningful use, providers and healthcare organizations are realizing the complexity and administrative work involved in enrolling and attesting. It can indeed be a cumbersome process, one of many "beasts" providers are facing. Here, athenahealth shares eight points for providers to consider when choosing a vendor, integrating the EHR into their organization and achieving meaningful use.

1. Vendors should add value through service and support, such as performance monitoring, automating status updates, enabling dashboard views of how individual providers are performing against measures and performing registration and attestation steps via proxy access.

2. Providers should consider solutions that have low upfront entry fees and charge as a percentage of collections, ensuring the vendor has "skin in the game" in securing meaningful use payments from clients.

3. Consider cloud-based solutions. Software installations weren't designed to handle the kind of rapid response that today's changing healthcare landscape requires. Implementation lag times are out of sync with program requirements, leaving many providers at risk of missing incentives. Cloud-based solutions don't suffer from the same problems. With all users sharing a single instance of meaningful use-certified software, implementations are rapid and users are immediately on a certified EHR.

4. Providers should maintain better visibility into the impact of meaningful use on their individual productivity rather than working off of anecdotal impressions.

5. The most energy will be generated the first time a provider goes live with its EHR. Use that energy to build momentum, using friendly competition to see who can conduct the smoothest go-live.

6. Organizations need to select one or more staff members to receive training in meaningful use, then manage and guide the process. Vendors should complement these efforts with support and expertise, fulfilling the traditional responsibilities of clinical analysts.

7. An EHR that will see widespread physician adoption will allow for multiple documentation modalities so physicians can choose how they chart. It will also distribute the work and documentation in the EHR across all five stages of the patient visit (check-in, intake, exam, sign-off and checkout), freeing the physician in the exam and not slowing them down.

8. The process of meeting meaningful use should not be something satisfied in addition to regular care workflow, but *within* it. EHRs should be built into workflow, surfacing when needed and at the appropriate point in care. Also, vendors should be certified in all Clinical Quality Measures — many are only certified in nine. ■

4 Predictions on the Switch to ICD-10

By Rachel Fields

On Oct. 1, 2013, ICD-10-CM (clinical modification) and ICD-10-PCS (procedural coding system) will be implemented into the HIPAA mandated code, increasing the number of codes from around 13,600 under ICD-9 to around 69,000 under ICD-10. Here are four predictions from various news reports, studies and editorials on the massive coding overhaul.

1. Coders may never regain ICD-9 levels of productivity. ICD-10 will impact productivity of healthcare organizations on many levels, slowing the process of documentation, entering new codes and payor communication, according to an AAPC release. According to the release, documentation is the most obvious and largest area to have an impact on productivity. Providers and physicians will likely need to be queried for additional information when documentation lacks necessary elements for ICD-10 code selection, delaying the submission of claims. The process of entering new codes will also slow down because of the switch to alphanumeric codes rather than simply numeric.

According to a blog post published by Tom Sullivan in *ICD-10Watch*, the real question is whether coders will ever regain the level of ICD-9 productivity with ICD-10. He believes the answer is no: The American Academy of Professional Coders, for example, has said that productivity will not return to normal upon implementation as providers assess how payors interpret the new system. Canadian coding experts have added that productivity in Canada, which has already adopted ICD-10, never returned to ICD-9 levels after implementation. Mr. Sullivan said there may be no way to regain productivity given the extra time it takes to use more codes and more digits.

2. Medical coder demand will increase significantly. The shift to ICD-10 could create thousands of jobs as hospitals and other healthcare facilities adjust to an initial delay in claims submissions, according to a *Tampa Bay Business Journal* report. Because ICD-10 presents a challenge for even experienced coders, coders with in-depth knowledge of the new system will likely find job openings at hospitals struggling to adapt to the change. Coders may also have opportunities to work as billing consultants and training leaders, as every healthcare facility helps its staff members familiarize themselves with ICD-10. States are already seeing a boost in coder training and demand — Minneapolis-area colleges are offering separate ICD-10 classes so that students will have proficiencies in ICD-9 and the new system by the time they graduate, and the Michigan Economic Growth Authority has approved a $2.2 million tax credit to create new medical coding jobs in the area.

3. The move to ICD-10 is expected to cost $1.64B. The Centers for Medicare & Medicaid Services estimate that the transition from ICD-9 to ICD-10 will cost the healthcare industry $1.64 billion, according to a *Wall Street Journal Health Blog* report. The switch is also estimated to increase the number of claims returned for improper coding by 10 percent initially. According to the 22nd Annual HIMSS Leadership Survey, sponsored by Citrix, implementing ICD-10/CPT-10 is the top financial IT priority for healthcare provider organizations in 2011. Forty-eight percent of respondents said ICD-10/CPT-10 were the top priority for their organization, followed by upgrading

patient billing system information (14 percent) and upgrading patient access system (4 percent). Respondents also named implementing medical necessity checking, patient scheduling systems, eligibility transactions with payors and claims transactions directly with payors as priorities.

4. Facilities and practices are stalling on necessary upgrades.
Experts believe hospitals, ambulatory surgery centers and physician practices may be putting off IT upgrades necessary for the conversion to ICD-10, a move that could prove disastrous when the Oct. 1, 2013 deadline arrives. According to an article published in the March edition of Physician Practice Options, physicians should start planning now for the implementation of ICD-10, as the switch to the new coding system is expected to affect every function performed in a medical practice. Rhonda Buckholz, vice president of business and member development for the American Association of Professional Coders, wrote in the article, "Practices will have to revise their super bills or eliminate paper super bills altogether" — a significant undertaking, especially if practices wait until the last minute.

A post in the *Wall Street Journal Venture Capital Blog* pointed out that hospitals and practices that don't meet the Oct. 2013 deadline for ICD-10 will face fines from HHS. Providers making the ICD-10 conversion also have to update the electronic format to transmit claims from 4010A1 to 5010, which is required by Jan. 1, 2012. ■

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Squeezing Water from a Stone

An Executive Briefing

How to Get More From Existing Capacity and Add More to Your Bottom Line

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Squeezing Water From a Stone: How to Get More From Existing Capacity and Add More to Your Bottom Line

By Lisa Romano, RN, MSN, Chief Nursing Officer, TeleTracking Technologies, Inc.

As the health reform law now stands, American hospitals must trim $155 billion in waste over the next decade.

But how will that happen? Job freezes and layoffs are no longer viable solutions. Asking staff to do more with less cannot continue indefinitely. Mistakes cost lives and money. Throw in a projected nursing shortage, an aging population and health coverage for millions more Americans, and you have the ingredients for calamity.

The law will require hospitals to deliver the highest level of patient care or be penalized by extensive losses in reimbursement. According to Moody's analysts, hospitals that can't generate enough efficiency to stay abreast of all the upcoming changes will be forced to make spending cuts and face mergers after 2014.

A PricewaterhouseCoopers report projects that a 300-bed hospital with poor quality metrics could lose more than $1.3 million a year, starting in 2015, and because the results will be published online, losses could snowball with damage to the hospital's reputation.

Hospital executives need a solution that will address overcrowding and produce revenue immediately. Could it be as simple as keeping better track of patients, employees and medical devices?

After decades of cutting staff and services, and implementing industrial efficiency concepts like Six Sigma and Lean Production, hospital executives might do well to consider the roots of those concepts. They were an acknowledgement by corporate leadership that industrial automation alone was not enough. People and technology have to hum along at the same pitch to optimize the overall manufacturing process.

Now a sizable number of forward-thinking hospitals are acknowledging the reverse. After years of focusing on people-oriented efficiency programs, they've realized that people alone can't achieve optimal operational performance. So they have turned to technology.

By incorporating various workflow technologies into their operations, redesigning current operations and involving employees in the changes, these hospitals are speeding processes, eliminating redundancy, getting valuable business intelligence and assigning accountability to help produce incremental but steady performance improvement.

Automating patient flow

One example of this trend is the growing use of logistic control technology in patient flow. Addressing overcrowding exclusively as an ED problem was treating the symptom and not the disease. Without available beds for ED admissions, emergency personnel must split their time between emergent cases and patients who should be moved to the units. Automated patient flow squeezes wasted time out of the bed turnover process, converting that time into space — as much as 20 percent more space without adding a single new bed. By speeding bed turns and transports, patient flow automation can make many more beds available.

Optimizing flow is perhaps the most immediate way to improve operating margin and control increased demand for access. In 2007, The Advisory Board Company quantified the cost of poor patient flow. It said a hospital with poorly managed flow will use its staffed beds about 48.5 times per year. In contrast, hospitals managing their patient flow efficiently will use their staffed beds approximately 62 times per year. For an average-sized hospital of 300 beds with an average contribution margin of $3,000 per discharge, that amounts to a $10 million swing.

With the help of TeleTracking's Avanti consulting division and TransferCenter™ software, Methodist Healthcare System in San Antonio was able to double its transfer volume within one year. The six-hospital system, which provides tertiary services to a large population surrounding San Antonio, accomplished this by automating its existing transfer center and centralizing all enterprise-wide patient flow logistics around it to ensure that all bed capacity within the system was being used effectively.

With federal cuts for hospital-acquired infection-related hospital stays beginning next year, this capability could help hospitals save more than $7 billion in the next decade.

Because systems like TeleTracking automatically trigger communications and alerts to all personnel involved in flow, they can substantially impact the fight against HAI, which is sure to be a key issue under reform. Currently, manual infection control processes can unintentionally create gaps in communication, leaving housekeepers and transporters unknowingly vulnerable to infection by entering an isolation room without warning. Because they are the most travelled employees in a hospital, they can potentially endanger the entire patient population.

However, the real-time nature of patient flow automation permits instantaneous alerts for all appropriate personnel, who can then take measures to greatly reduce the chance of exposure. With federal reimbursement cuts for HAI-related hospital stays beginning next year, this capability could help hospitals save more than $7 billion in the next decade, the total amount the Congressional Budget Office projects the federal government will be withholding.

RTLS and reform

A related technology known as RTLS (Real Time Location Systems) is helping hospitals dramatically reduce search time for medical equipment and decrease capital expenses. TeleTracking's RadarFind asset tracking sensor network enables staff to locate tagged items on a floor plan computer view of the entire hospital or individual patient care areas. The network also yields information on equipment downtime and utilization for better decision-making about the need for purchasing additional equipment.

Southeastern Regional Medical Center in Lumberton, N.C., saved nearly $750,000 in one year by using RadarFind's sensor network to track mobile medical equipment, such as IV pumps and cardiac telemetry devices. Memorial University Medical Center in Savannah, Ga., has slashed costs nearly 40 percent since the RadarFind system went live in May, 2010. The hospital saved more than $300,000 in a year-over-year comparison of asset management costs through August 2010.

The savings multiplies quickly when these technologies are applied enterprise-wide. Methodist recently announced plans to install RTLS across five of its six hospitals.

Complete ROI in a year

RTLS systems can typically pay for themselves in less than a year. So why wouldn't hospitals rush to adopt a low-cost tool that can save hundreds of thousands of dollars and improve patient care?

For one thing, early generation tracking systems were fraught with technical problems which interfered with clinical technologies, but newer technologies have removed the interference issues.

For another, while hospitals generally are quick to adopt treatment technology, they are slow to accept workflow improvement technology because they don't perceive themselves as an "industry."

To overcome those obstacles, it may be necessary to incentivize hospitals so they'll invest the time to become familiar with the many benefits of workflow technology. Federally-budgeted incentives could speed the industry-wide adoption period from several years to several months. Given the examples above, that could be the difference between saving and squandering billions of dollars over the 10-year period stipulated by the White House.

Most importantly, in the context of healthcare reform, these technologies can help ensure that patients have timely access to the kind of care they need at the quality level they deserve. ■

5 Strategies to Improve Patient Flow in a Busy Hospital

By Rachel Fields

By improving patient flow, a hospital can save money on staffing, decrease wait times and boost patient and provider satisfaction. Melinda Noonan, DNP, RN, NEA-BC, director of nursing operations at Rush University Medical Center in Chicago, discusses how her hospital used TeleTracking patient flow software to collect and analyze historical data, improve throughput and plan for the busiest days of the year.

1. Ask every department to participate in promoting efficiency. Patient flow can be disrupted when separate departments and providers do not talk about the hold-ups in each area, Dr. Noonan says. "You really have to be able to have a frank conversation," she says. "Aside from the monthly meetings, environmental services, patient transport and patient placement, get together on a bi-weekly basis and talk about issues." She says the weekly meetings might include discussions on whether nurses are taking reports as quickly as possible. Meeting regularly is essential to breaking down barriers between different departments; otherwise, one department might be blaming another for a throughput problem without understanding the actual cause. "Each person and area only wants to look at their book of business, so you have to have a way of getting everybody to look at their piece in it," she says.

For example, she says Rush is currently working to improve scheduling coordination between different departments. If three separate patients are sent to the same unit from the emergency room, the post-anesthesia recovery department and an outside hospital, the unit may suddenly be bombarded with patients because scheduling times have not been coordinated between departments. While Rush has not yet found a solution to this particular problem, Dr. Noonan says communication between departments is the first step to removing blame and fixing the issue.

2. Use data to predict patterns. Dr. Noonan says Rush uses TeleTracking software to collect and analyze data, which then improves the hospital's ability to predict staffing needs, patient volume and other trends. "People like to say that emergency admissions are random," she says. "They are and they aren't. There is some predictability. Mondays are called 'ER Mondays' all over the country. We actually took historical data and put it through simulation software so we can see that 80 percent of the time, this is what our census is going to be on a given day and shift." She says the ability to simulate patient flow and throughput is essential when mistakes are not an option. "You've got to get matching of staffing and census right now. You can't afford to have mistakes on it anymore," she says. The ability to predict staffing levels on a particular day saves the hospital money by reducing staffing waste and decreases patient wait time by assigning the correct number of providers to the predicted volume.

3. Pay attention to rapidly growing specialties. Because clinical groups do not always grow at the same speed, your hospital may have to adjust beds and staffing over time to keep up with the demands of a certain specialty. "For example, hematology and oncology grew very fast, and we need to designate beds in another area to them," Dr. Noonan says. "Yet you couldn't take the floor away because you still used it for medicine. So we used historical data and fed [timing metrics from TeleTracking] into our simulation modeling software and tested various alternatives." By using simulation software to determine where beds and providers could be expanded, the hospital came up with a plan to use a portion of the medical/surgical unit and train those nurses in caring for non-chemotherapy oncology patients. Certain admission diagnoses were then targeted for the medical unit rather than the oncology unit, where they would have traditionally been placed.

4. Set internal benchmarks based on 'painful' months. In order to create a productivity benchmark, look at the historical productivity in your busiest months and work from there. Dr. Noonan took data from TeleTracking to find out how many patient placements each employee did in a particular month. She looked at June and July 2009, what she calls "the most painful months in the time I've been there." She used those months as a productivity target for busy days and created an internal benchmark for an appropriate staffing level.

5. Examine the biggest portals of entry to your hospital. Like many hospitals, Rush accepts the vast majority of its admissions from the emergency department, surgery, direct admissions from physician offices and outside hospital transfers. "If you're a tertiary center, you're taking in a good number of outside hospital transfers," Dr. Noonan says. To be able to balance patient placement from all four admission sources, Dr. Noonan and her colleagues looked at data on the speed of patient placement from each source. "If outside hospital transfers are placing people really fast, then the ED might be losing some ground," she says. "We look at that on a monthly basis to decide whether we need to slow the outside hospital transfers down." ■

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Hospital & Health System Transactions

Healthcare Management Partners and Memphis-based Dobbs Equity Partners signed a letter of intent to construct a new facility that will merge three existing South Carolina hospitals into one integrated healthcare system. The new system will be called Tri-County Regional Health System. It will be comprised of **Bamberg (S.C.) County Hospital**, **Barnwell (S.C.) County Hospital** and **Allendale County Hospital** in Fairfax, S.C.

The board of **Beaufort Regional Health System** in Washington, N.C., signed a letter of intent with Greenville, N.C.-based **University Health Systems** of Eastern Carolina. As part of the agreement, UHS would manage BRHS and pledge $21 million in capital improvements in the first five years of a potential 30-year lease.

A Circuit Court judge in Florida overturned the merger of **Bert Fish Medical Center** in New Smyrna Beach, Fla., with Adventist Health System's **Florida Hospital** in Orlando. Judge Richard Graham ruled the 21 closed-door meetings surrounding the merger were in violation of the state's Sunshine Law and that the two groups' attempts to "cure" the violations by reholding the meetings were not an appropriate remedy.

Duke University Health System, based in Durham, N.C., is partnering with **LifePoint Hospitals**, a for-profit hospital manager based in Nashville, Tenn., to buy and run community hospitals in North Carolina. Duke and LifePoint announced that their first deal together will be to run 102-bed Maria Parham Medical Center in Henderson, N.C.

Elkhart (Ind.) General Healthcare System and South Bend, Ind.-based **Memorial Hospital and Health System** signed a memorandum of understanding to form an affiliation. Elkhart General and Memorial Health System will form a new regional healthcare system and parent company that includes an equal number of board members from each organization.

Emory Healthcare and **Saint Joseph's Hospital** in Atlanta announced a partnership that will create the largest, most clinically comprehensive health system in Georgia. Emory will hold majority ownership of Saint Joseph's, with a 51-49 percentage split. Saint Joseph's will be involved in governance of the company and retain super-majority voting rights on certain issues critical to its mission and values.

Hospital chain **HCA** signed an agreement to acquire 473-bed **Mercy Hospital** in Miami. HCA plans to continue to operate Mercy Hospital as a Catholic institution.

Franklin, Tenn.-based **Iasis Healthcare** will purchase a 78.2 percent interest in **St. Joseph Medical Center** in Houston. A group of independent investors will retain 21.8 percent ownership interest. The current majority owner sold its interest in the hospital as part of its Chapter 7 bankruptcy process.

Woonsocket, R.I.'s **Landmark Medical Center** signed a nonbinding letter of intent from Brentwood, Tenn.'s **RegionalCare Hospital Partners**. Tenn.-based Capella Healthcare may also make a bid. Lifespan hospital group decided not to pursue an acquisition.

Chicago-based Loyola University will receive $100 million from the sale of its **Loyola University Health System** to Novi, Mich.-based **Trinity Health**. As part of the deal, Trinity will also take over Loyola's debt. In exchange, the health system will pay a $22.5 million annual subsidy to Loyola's medical school.

The merger between Bemidji, Minn.'s **North Country Health Services** and Sioux Falls, S.D.'s **Sanford Health** is official. The health systems now operate as Sanford Health of Northern Minnesota in Bemidji.

Separate votes at Port Angeles, Wash.-based **Olympic Medical Center** and Port Townsend, Wash.-based **Jefferson Healthcare** resulted in unanimous decisions to negotiate nonbinding letters of intent to affiliate with Seattle-based **Swedish Medical Center. Forks (Wash.) Community Hospital** will also vote on a possible affiliation with Swedish.

Peoria, Ill.-based **OSF HealthCare** and **Rockford (Ill.) Health System** are moving towards an "affiliation" that would combine the organizations as OSF Northern Region. After announcing plans to affiliate, OSF HealthCare and Rockford (Ill.) Health System have received second requests for information from the Federal Trade Commission.

Chicago-based **Resurrection Health Care**, which operates six hospitals, signed a letter of intent to explore a merger arrangement with Mokena, Ill.-based **Provena Health**, which owns six hospitals.

Saint Mary's Hospital in Waterbury, Conn., is forming a joint venture with **LHP Hospital Group, Inc.** Under the agreement, LHP and Saint Mary's will have an equally-shared governance structure and LHP will own a majority equity position in the joint venture that will own the hospital.

Boston-based **Steward Healthcare** offered $1.1 billion for Miami's **Jackson Health System**. Jackson failed to respond to Steward's letters of interest by the deadline.

Cincinnati's **UC Health** will acquire the Jewish Foundation of Cincinnati's **Jewish Hospital Medical Campus** in Avondale. The Avondale campus includes the former Jewish Hospital and the Jewish Medical office building.

Texas's **Valley Baptist Health System**, with locations in Harlingen and Brownsville, will merge with Nashville, Tenn.-based **Vanguard Health Systems**. As part of the merger, Vanguard will provide money for Valley Baptist to repay its debts.

Yale-New Haven Hospital and **Hospital of Saint Raphael**, both in New Haven, Conn., signed a letter of intent. They will consider a plan in which 966-bed YNHH would purchase the assets of 511-bed HSR to create one integrated hospital with continued access to both campuses.

Hospital & Health System Executive Moves

Novant Health in Winston-Salem, N.C., promoted **Carl Armato** from executive vice president, the position he held for the past three years, to senior executive vice president and COO.

David Bertauski, CEO of Urbana, Ill.-based Provena Covenant Medical Center, retired and will be replaced by **Mike Brown**. Mr. Brown was named regional president and CEO. He will oversee both PCMC and Danville, Ill,-based Provena United Samaritans Medical Center.

Denver-based HCA-HealthONE named **George Bussey**, MD, as CMO for its continental division. He will lead clinical and quality initiatives across HealthONE hospitals in Denver and HCA hospitals in Oklahoma City, Edmond, Okla., and Wichita, Kan.

St. Louis-based Ascension Health named **Vincent C. Caponi**, CEO of St. Vincent Health in Indianapolis, the new Ministry Market Leader for Wisconsin. Mr. Caponi already holds the position of Indiana Ministry Market Leader.

COO **K. Bobbi Carbone**, MD, MBA, resigned from Royal Oak, Mich.'s William Beaumont Hospital after less than nine months. Beaumont officials have not disclosed the reasons for Dr. Carbone's resignation.

Grant Davies was named CEO of three hospitals within the Sacramento, Calif.-based Sutter Health system: Sutter Medical Center in Santa Rosa, Calif., Sutter Health's Novato Community Hospital and Lakeside Hospital, both in Lakeport, Calif. He succeeds **David Bradley**, who has been named CEO of Sutter's Alta Bates Summit Medical Center in East Bay, Calif.

William Foley is resigning as CEO of Chicago-based Cook County Health and Hospitals System to take a position as president of Vanguard Health System's Chicago market, effective May 15. **Terry Mason**, MD, will serve as interim CEO, effective May 6.

R. Milton Johnson was promoted to president of Nashville, Tenn.-based HCA and will retain his title and responsibilities as CFO as well. His promotion was part of HCA's internal reorganization.

Larry Kaiser, MD, will step down as president of The University of Texas Health Science Center in Houston to become CEO of Temple University Health Systems in Philadelphia. **Guiseppe N. Colasurdo**, MD, will replace Dr. Kaiser as interim president at UT.

Louisville, Ky.-based Jewish Hospital and St. Mary's HealthCare named **David Laird** president and CEO.

Michael Mayo, president of Methodist Dallas Medical Center, and **Michael Arvin**, chief development officer of Methodist Health System, vacated their positions. **Laura Irvine**, FACHE, will become president of Methodist Dallas Medical Center when a replacement for her current position as president of Methodist Mansfield Medical is named. Until Ms. Irvine assumes her new role, Executive Vice President and COO Pam Stoyanoff will head Methodist Dallas.

Eugene McMahon, MD, was promoted from CMO to president and CEO of Elgin, Ill.'s Provena Saint Joseph Hospital. He replaced **Steve Scogna**, who resigned to serve as CFO of Arlington Heights, Ill.'s Northwest Community Hospital.

David Morales, Commissioner of Massachusetts Division of Health Care Finance and Policy, resigned to begin a new role at Boston-based Steward Health Care System. COO and Chief of Staff **Seena Carrington** will take Mr. Morales' place until the Division names a permanent replacement.

Henry Ford Health System in Detroit promoted **Bob Riney** from executive vice president and COO to president and COO.

Irving-based HCA's North Texas Division named **Nathan Scott Robins**, MD, CMO. Dr. Robins previously served as CMO of Lubbock, Texas-based Covenant Health System.

Steve Schultz, CEO of Lexington (N.C.) Memorial Hospital, is resigning effective May 1. A board member will assume CEO responsibilities until a replacement is named.

Charles Stewart resigned from his post as CEO of Hutcheson Medical Center in Fort Oglethorpe, Ga., and **Gerald Faircloth** resigned as the hospital's VP of operations and interim CFO. **Debbie Reeves**, HMC's chief nursing officer, will serve as interim CEO.

Tom Timcho will retire May 31 from his role as president and CEO at Jefferson Regional Medical Center in Pittsburgh. **John J. Dempster** will succeed him.

Irving, Texas-based CHRISTUS Health named **Eugene A. Woods** executive vice president and COO effective no later than June 1. He replaces **Ernie Sadau**, who became president and CEO of CHRISTUS on March 1.

Ellen Zane, CEO of Boston's Tufts Medical Center, is retiring effective Sept. 30. At the request of the board of trustees, Ms. Zane will remain at the medical center for one year as vice chairman of the board and a paid consultant to assist with the leadership transition.

WEBINAR

Maximizing OR Efficiency: Why Most ORs Are Set Up for Failure and What To Do About It

Tuesday, May 10, 2011
2:30 PM - 3:30 PM CDT

Efficiency is defined as the ability to accomplish a job with a minimum expenditure of time and effort. In the OR, efficiency can be an elusive concept when it requires getting anesthesia, perioperative and surgical staff to work in concert each day, 365 days a year. In many cases, the very financial viability of the organization is dependent on it.

This webinar will provide participants the reasons why most ORs are systemically set up for failure as well as provide some insights into how to cure the disease not just treat the symptoms. In addition, Dr. Richard Becker of The Brooklyn Hospital Center, a member of New York Presbyterian Healthcare System, will provide a real life case study on how a community hospital with 464 beds reinvented its organization beginning with the OR resulting in nearly zero case cancellations, high surgeon satisfaction and significantly higher revenue.

Presenters:

Timothy Dowd, MD – Managing Partner, NAPA. Dr. Dowd joined NAPA in 1991 and became Chairman of the Board of Directors in 2003. As Chairman of the Board of Directors, he serves as the Chief Executive Officer of NAPA and has been instrumental in developing and implementing the company's growth model. With regard to Clinical services, Dr. Dowd serves as Chairman of the Department of Anesthesiology at Vassar Brothers Medical Center.

Richard B. Becker, MD – President and CEO of the Brooklyn Hospital Center. Dr. Becker is a member of the New York Presbyterian Healthcare System, and the Brooklyn academic and clinical affiliate of Weill Medical College of Cornell University. Prior to joining Brooklyn Hospital in June, 2008, Dr. Becker spent four years as CEO of The George Washington University Hospital (GW), as well as Assistant Dean of Clinical Affairs. Under his leadership, the hospital experienced new levels of programmatic growth, as well as significant improvement in market share, patient and staff satisfaction, quality metrics and profitability.

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