7 Strategies to Help Hospitals Break Even on Medicare

By Bob Herman

It’s easy to say that Medicare matters to beneficiaries, hospitals, physicians and pretty much everyone else involved in the delivery of healthcare today, but just how important is the country’s largest payor?

In fiscal year 2012, total gross Medicare spending is expected to top $575.7 billion across more than 47 million beneficiaries, which accounts for roughly 17.6 percent of the country’s gross domestic product — and the aging baby boomer generation will only increase those figures. According to a March budget report from the Congressional Budget Office, Medicare spending is expected to jump to more than $1.058 trillion by FY 2022.

For hospitals, Medicare’s impact is colossal, to say the least. Roughly four out of 10 hospital stays are financed by Medicare, and Medicare constitutes anywhere between 35 and 55 percent of the average hospital’s revenue. Colin McCulloch, JD, associate at Epstein Becker Green, adds that Medicare usually pays 70 to 80 cents on the dollar compared...
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Imagine this:

1. **Design**: The image is a page from a newsletter, titled “Becker’s Hospital Review”, focusing on business and legal issues for health system leadership.
2. **Editorial Section**: This section includes names and contact information for various roles within the company, such as Editor in Chief, Executive, and Conference Manager, along with their respective phone numbers and e-mails.
3. **Features Section**: This section lists various topics covered in the newsletter, including:
   - Publisher’s Letter
   - 100 Great Hospitals
   - 100 Great Places to Work in Healthcare
   - Secrets for Success in the Current Healthcare Climate: Q&A With UW Medicine CEO Dr. Paul G. Ramsey
   - Putting Employees First: How to Improve Patient Experience, Profitability
   - Creating an Environment of Excellence: Q&A With Henry Ford Health System CEO Nancy Schlichting

4. **Physician-Hospital Relationships**: Topics include constructing a strategic roadmap, investment grade, Becker’s Hospital Review annual meeting conference brochure.
5. **Executive Briefing**: Various executive briefings on roles of data analytics, supply chain management, and hospital strategy.
8. **Hospital-ASC Joint Ventures**: Crafting successful joint ventures in 2012, Q&A with Jeff Peo, Donna Greene & Brandon Frazier of ASCOA.
9. **Hospital-Payor Contracting**: Antitrust concerns and most-favored nation clauses.
10. **10 New Surgery Centers Planned or Developed by Hospitals**
11. **100 Great Hospitals**
12. **100 Great Places to Work in Healthcare**

This newsletter serves as a comprehensive resource for leaders in the healthcare industry, covering a wide range of topics from strategic planning to regulatory issues, providing valuable insights and best practices.
Publisher’s Letter

Inside This Issue; 2012 Becker’s Hospital Review Annual Meeting

May/June Issue. We are pleased to share with you the May/June issue of *Becker’s Hospital Review*. The issue contains two of our most popular annual lists, “100 Great Places to Work in Healthcare” and “100 Great Hospitals” featuring outstanding healthcare organizations across the country of all sizes and types that have demonstrated excellence. The issue also features a column by healthcare legend Chuck Lauer on 10 factors to create a positive work environment. Chuck pens a column for each of our issues, bringing a personal perspective to prominent issues facing healthcare leaders. Other can’t-miss content includes interviews with UW Medicine CEO Paul G. Ramsey and Henry Ford Health System CEO Nancy Schlichting, whose organization recently received the prestigious Malcolm Baldrige National Quality Award.

*Becker’s Hospital Review Annual Meeting.* If you are receiving this issue as an attendee at our annual meeting, welcome! The two-day event co-chaired by Chuck Lauer, former publisher of *Modern Healthcare*, and myself, is focused on addressing the most pressing issues facing hospital and health system executives including ACOs, physician-hospital integration, improving profitability and service line strategy. Please don’t hesitate to introduce yourself; I’m always delighted to meet with our readers and hear any feedback about our magazines, E-Weeklies or other offerings. For those of you unable to attend this year, please save the day for our 2013 Annual Meeting in early May of next year.

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

Very truly yours,

Scott Becker
the money,” says Paul Spiegelman, founder and CEO of BerylHealth, a company focused on the patient experience. “People want to feel valued.” In fact, most of the following pillars of success involve abstract concepts that, while difficult to define, may ultimately separate a “good” workplace from a “great” one.

1. Culture. Hospitals and health systems identified by employees as great places to work have developed a culture that reflects the values of the workers and organization. “An overarching cultural tenet of the health system is transparency, inclusiveness and stewardship toward our employees. It’s the overarching cultural component that drives everything else,” says Stephen L. Mansfield, PhD, president and CEO of Dallas-based Methodist Health System.

Similarly West Orange, N.J.-based Barnabas Health focuses on creating a friendly environment to make employees feel welcome and happy. To create this environment, the recently retired Barnabas Health president and CEO Ronald J. Del Mauro encouraged people to always say hello to each other, according to current health system president and CEO Barry H. Ostrowsky.

Just as something simple like saying hello can improve an environment, building a healthy workplace culture generally depends on many small factors rather than one expensive program, according to Mr. Spiegelman. “[It’s about] very small things that simply show people that you care about them and not about doing expensive events,” he says. Sending a note of recognition, for instance, can affect a patient as much as or more than a large, costly party. Dr. Mansfield attributes Methodist Health System’s eight consecutive Dallas Business Journal Best Places to Work awards to a myriad of elements that “become embedded in the culture.”

Creating a culture focused on the organization’s employees is important not only for employee satisfaction, but also for patient engagement. Mr. Spiegelman says healthcare organizations are beginning to realize that “the only way to be patient-focused is to be employee-focused and to start first with developing an environment in which employees enjoy what they do every day.” The organization’s leadership is essential for developing an enduring employee-focused culture.

2. Transparency. Being transparent with employees is critical to gaining their trust and engaging them in their work. Dr. Mansfield says Methodist Health System makes it a priority to notify employees of any major initiatives before they are publicly announced. “The basic premise is let’s not surprise our employees,” he says. “Let them hear what we’re going to do from us. And if possible, before a final decision is made.” Communicating directly with employees instead of indirectly through other sources, such as the media, indicates the system considers its employees key stakeholders in the organization. “We want them to feel like insiders — they are insiders. You should treat them like you treat your board from the standpoint of how you communicate with them,” Dr. Mansfield says. “If you want employees to act like owners, you have to treat them like owners.”

When employees are informed about the hospital or health system, they become more invested in the organization. In addition, keeping
employees up-to-date on changes within the organization ensures they are aware of its goals and can work to meet them. “People want to feel engaged in their work, so they want to understand the mission, vision and values of the organization,” Mr. Spiegelman says. “They want to understand what they stand for, what their part is in helping the organization achieve [its] goals.”

3. Communication. In addition to being transparent with employees, hospitals and health systems should communicate openly with employees on other aspects of healthcare that affect them. For instance, Barnabas Health educates employees on healthcare reform through multiple communication channels. Mr. Ostrowsky says hospital employees get little relief from the topic of healthcare because of its prominence outside the hospital in the media and even among friends and family. The system thus began discussing healthcare with employees to provide them with tools to use when faced with the topic outside of the workplace.

Employees have responded positively to this initiative. “Our employees have become more intellectually inquisitive about the topic — more interested in where we’re going as a society in terms of healthcare. They have the interest and we should be able to capitalize on that by providing effective information and education,” says Mr. Ostrowsky. In addition, Barnabas Health keeps employees updated on the system’s involvement in policy discussions with elected officials and other policymakers “so our employees know we’re advocating on behalf of our enterprise and by extension on their behalf.”

4. Listening. As important as providing information to employees is soliciting information from them through surveys or other discussions. Dr. Mansfield and one or two other senior Methodist Health System leaders meet with all the system’s directors and managers each year. These meetings give employees an opportunity to share their successes and improvements as well as barriers to success. Dr. Mansfield then compiles the responses and assigns a member of the executive team to address any issues frequently cited as a barrier. The progress on addressing those issues is reported to the front-line staff throughout the year.

For example, one year many directors identified IT communication and response times as a barrier. The IT executives then redefined their roles, acting as vendors to the hospitals, which became clients. This new framework spurred the IT team to work with the hospitals directly to meet their technology needs. The next year, the issue was not mentioned as a barrier and was even listed as a success by the directors and managers. “For me, it’s a way to get unfettered dialogue from them to me and me to them,” Dr. Mansfield says. “Making that overt effort to try to get frontline feedback at least once a year from across the enterprise and doing something with that feedback has contributed to our success as a culture.”

In addition to formal discussions, informal interactions with employees can be valuable in gauging employees’ needs. “Just as important as a formal survey and benchmarking year-over-year improvements are informal ways to get feedback during the course of the year,” Mr. Spiegelman says. Rounding on the floors, for instance, can give hospital leaders a real-time view of the employee experience.

5. Caring. Showing employees their leaders and colleagues care for them is important in enhancing job satisfaction and employee reten-
tion. Methodist Health System has a program in which employees can voluntarily designate some of their payroll to a fund for employees in need. A committee of employees determines how to allocate the funds. For example, an employee whose home burned or who lacks the money necessary to pay for medical care may receive some of these funds. “We try to create a sense of family and mutual respect and caring for one another,” Dr. Mansfield says. Barnabas Health has a similar program. Last year, nearly 20 percent of employees contributed a total of $130,000 for employee assistance.

Another way Barnabas Health shows employees it cares was by introducing a dry cleaning service, a full bank branch and an entertainment center into the hospital. “Employees could [order food], rent a movie and leave from work ready for an evening of relaxation,” Mr. Ostrowsky says. “We didn’t make any money renting movies and having a full bank branch, but employees understood that we were concerned [and wanted] to develop something that could make their lives easier and less stressful when they left the job.”

6. Empathy. Empathy takes caring one step further by expressing an understanding of employees’ situation. Making employees aware that their leaders understand the challenges of their job is critical in engaging employees in the workplace. “If you’re going to dedicate your professional life to working in healthcare institutions and supporting families and the sick, you have a personality profile and character that is unique and admirable. What we need to do every day as the employer is to connect with that emotion, that inner spirit that drove a person to want to be employed in the industry,” Mr. Ostrowsky says.

Barnabas Health supervisors, many of whom have been on the frontline before, are trained to support their staff emotionally by expressing an understanding of the difficulty of staff members’ jobs. “You have to start with empathy,” Mr. Ostrowsky says. “It’s not enough to say ‘Thank you for your great work.’ You need to say ‘Thank you and I understand how difficult it is.’ Expounding on that will allow the employee to understand that we really do appreciate what is done on a daily basis.” Supervisors who previously served on the frontline are also encouraged to ask their staff what has changed since they left to gain a sense of new challenges the workers face. “If you miss that connection on the emotional level, then you’re not going to make the workplace attractive to incumbent staff or new staff,” he says.

7. Recognition. Recognizing employees for their efforts significantly impacts employee job satisfaction. Dr. Mansfield believes one important thing CEOs can and should do is to personally acknowledge employee accomplishments and successes. One small thing he does is to drop a personal note to the home of employees who are featured in their weekly system newsletter for achieving a goal such as receiving a certification, award or other accomplishment. This small act creates great value for the employee at little cost to the health system. “That costs nothing, really — just a little time and a stamp, and I love doing it,” he says.

Employee recognition should be timely and continuous, according to Mr. Ostrowsky. He suggests healthcare leaders recognize an employee — whether through a formal award or informal acknowledgment — as soon after the behavior they wish to reward as possible. Responding to employees’ successes in a timely manner demonstrates the leaders’ value of and commitment to employees.

8. Professional development. Professional development opportunities are also central to an attractive workplace because they show the organization’s investment in employees and their desire for them to progress in their careers. Methodist Health System has an emerging leader program for frontline employees identified by a manager as potential leaders for the future. Similarly, Barnabas Health has a management institute that trains employees.

Training healthcare employees may become increasingly important as healthcare reform focuses more on the patient experience, which depends in large part on patients’ interactions with the people in the organization. “In healthcare, people are highly trained in a specific skill set. But they’re not generally trained on what it takes to run a business in terms of personal interaction and team development,” Mr. Spiegelman says. “Providing an environment in which they can learn those skills is critical.”

9. Organizational pride. Mr. Ostrowsky says hospitals and health systems identified by their employees as great places to work are those that make their employees proud of the organization, such as by getting involved in the community. “If the employee doesn’t have a warm feeling about the accomplishments of the overall organization, or the employee doesn’t acknowledge to him- or herself that the organization is trying to accomplish something that’s important, you lose an opportunity to make the employee feel good,” he says.

10. Fun. Becoming a great place to work in healthcare also requires opportunities for employees to have fun, according to Mr. Spiegelman. One way to have fun is encouraging employees to decorate their office space. He also cites the case of one hospital that shows funny videos to staff, schedules dress-up days and has social events outside the facility. “They realize that as serious an environment as a hospital is, they can still find the time to have fun with each other.”
Skilled leaders who fit your culture are your greatest asset. Shaping your leadership team in this era of reform is your greatest challenge. Clients on the forefront of health care reform and the development of accountable care organizations work with us as partners to find and hire top leaders. Our reputation for results has placed us among the leadership resources, featuring our latest presentation on leadership development. Visit www.cejkaexecutivesearch.com/Leadership2012 or call us at 866-346-7125.
By Molly Gamble and Bob Herman

100 Great Hospitals

*Becker's Hospital Review* is pleased to name 100 Great Hospitals of 2012. The following hospitals each have a special place in the story of American healthcare and have demonstrated greatness through clinical accolades, innovation in care delivery, recent capital developments, and the offering of new services, specialty programs or technology. Ranging in size and location, these reputable hospitals each saw noteworthy accomplishments in 2011 and will continue to make strides this year.

Editor's note: This list is not a ranking, and hospitals are displayed in alphabetical order. This list is not an endorsement of included hospitals or associated healthcare providers, and hospitals cannot pay to be included on this list.

**Advocate Good Samaritan Hospital (Downers Grove, Ill.).** Located in a southwest suburb of Chicago, this 333-bed hospital includes nearly 1,000 physicians and is continually expanding affiliations with local providers. A 2010 Malcolm Baldrige Award recipient, Advocate Good Samaritan is Magnet-recognized for nursing excellence and received a 9 or 10 on a scale from 0 to 10. 97 percent of Animas patients gave their hospital a rating of 9 or 10 on a scale from 0 to 10. Aurora St. Luke’s Medical Center in Royal Oak is a 1,071-bed, Magnet-recognized facility that was named to Thomson Reuters’ 100 Top Hospitals in 2011. Beacon Hospital’s parent, Beaumont Health System, recently committed $68 million to a new medical school — Oakland University William Beaumont School of Medicine — to alleviate repercussions of Michigan’s impending physician shortage on the hospital.

**Barnes-Jewish Hospital (St. Louis).** Barnes-Jewish Hospital is the child of a 1996 merger between Barnes Hospital and The Jewish Hospital of St. Louis. The 1,288-bed teaching hospital is affiliated with Washington University School of Medicine in St. Louis. In 2011, U.S. News & World Report ranked Barnes-Jewish as an Honor Roll Hospital and first among hospitals in the St. Louis metropolitan area. The Magnet-recognized hospital is building a new $27.5 million cancer center and opened a 12-story outpatient tower in March.

**Baystate Medical Center (Springfield, Mass.).** The 659-bed Baystate Medical Center is a teaching hospital and affiliate of Tufts University School of Medicine. The hospital has earned Magnet-recognition for nursing excellence and was recognized by CMS. U.S. News & World Report also ranked this Magnet-recognized hospital first in the Phoenix metropolitan area in 2011.

**Barnes-Jewish Hospital**

**Banner Good Samaritan Medical Center (Phoenix).** When it was founded 101 years ago — making it four months older than the state of Arizona — Banner Good Samaritan had 20 patient beds. Today, the 668-bed hospital includes roughly 1,700 physicians and was recently named one of the first 32 Pioneer Accountable Care Organizations in the country by CMS. U.S. News & World Report also ranked this Magnet-recognized hospital first in the Phoenix metropolitan area in 2011.

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**Beaumont Hospital (Royal Oak, Mich.).** Beaumont Hospital in Royal Oak is a 1,071-bed, Magnet-recognized facility that was named to Thomson Reuters’ 100 Top Hospitals in 2011. Beaumont Hospital’s parent, Beaumont Health System, recently committed $68 million to a new medical school — Oakland University William Beaumont School of Medicine — to alleviate repercussions of Michigan’s impending physician shortage on the hospital.

**Beth Israel Deaconess Medical Center (Boston).** In 1996, New England Deaconess Hospital and Beth Israel Hospital — two institutions dating back to 1896 and 1916, respectively — merged to form this 631-bed hospital. A teaching affiliate of Harvard Medical School and the chosen hospital for the Boston Red Sox, Beth Israel Deaconess is a 2011 Thomson Reuters Top 10 Hospital.

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100 Hospital and received a HealthGrades Distinguished Hospital Award for Clinical Excellence in 2011 and 2012. Last year, the hospital announced plans to build a $20 million cancer center.

**Boone Hospital Center (Columbia, Mo.).** Boone Hospital Center, which opened in 1921, is a 400-bed, Magnet-recognized hospital affiliated with St. Louis-based BJHCareHealthcare. It was named to Thomson Reuters’ 100 Top Hospitals in 2011 and also received HealthGrades’ Distinguished Hospital Award for Clinical Excellence in 2011 and 2012. Boone Hospital opened its $89 million patient tower — which features 125 private rooms — ahead of schedule and under budget projections in June 2011.

**Brigham and Women’s Hospital (Boston).** With roots dating back to 1832, Brigham and Women’s Hospital is home to many medical firsts, such as the world’s first successful human organ transplant in 1954. The 793-bed facility is a teaching affiliate of the Harvard Medical School and received the 100 Top Hospitals Everest Award from Thomson Reuters in 2011, which recognizes hospitals with top current performance and the most long-term growth in five years. In 2011, the hospital unveiled a $505 million expansion plan that is expected to be complete by 2016.

**Bronson Methodist Hospital (Kalama-zoo, Mich.).** The flagship of Bronson Healthcare Group, the 404-bed Bronson Methodist Hospital has earned recognition from HealthGrades as a Distinguished Hospital for Clinical Excellence and for Outstanding Patient Experience in 2011 and 2012. The hospital was also named to Thomson Reuters’ 100 Top Hospitals in 2011. Bronson Methodist’s $210 million replacement hospital, completed in 2000, has been studied by hundreds of healthcare experts and architects seeking best design practices for healing environments, optimal patient flow and infection control.

**Carle Foundation Hospital (Urbana, III.).** Located in East Central Illinois and dating back to 1918, Carle Foundation Hospital is Magnet-recognized for nursing excellence and was named one of U.S. News & World Report’s Best Regional Hospitals in 2012. The hospital also earned HealthGrades’ Distinguished Hospital Award for Clinical Excellence in 2012 and 2011. Last summer, the hospital began construction on its $220 million patient care tower to replace buildings constructed in the 1960s.

**Carolinas Medical Center (Charlotte, N.C.).** Since its founding in 1940, Carolinas Medical Center has grown to 874 beds and includes the region’s only Level I trauma center. Carolinas’ Sanger Heart and Vascular Institute is the site of more than 800 open heart surgeries per year, making it one of the largest cardiovascular programs in the Southeast. The hospital was ranked first in the Charlotte metropolitan area by U.S. News & World Report in 2011.

**Cedars-Sinai Medical Center (Los Angeles).** Cedars-Sinai Medical Center dates back to 1902, when the hospital was known as Kaspere Cohn Hospital and had 12 beds. Today, the non-profit academic medical center includes 1,000 beds and more than 2,000 physicians in every medical specialty. Cedars-Sinai Medical Center has earned Magnet recognition for nursing excellence and received the HealthGrades Distinguished Hospital Award for Clinical Excellence in 2011 and 2012.

**Central DuPage Hospital (Winfield, III.).** Central DuPage began with 113 beds and 66 physicians when it opened in 1964. Today this 313-bed hospital includes more than 900 physicians, is Magnet-recognized for nursing excellence and was named a Thompson Reuters Top 100 Hospital in 2011. Central DuPage’s cardiac surgery program is affiliated with the Cleveland Clinic, which has been ranked by U.S. News & World Report as the number one cardiac program in the nation for 16 consecutive years. The partnership allows Central DuPage surgeons to review patient cases and decide on treatment plans with Cleveland Clinic physicians’ expertise.

**The Christ Hospital (Cincinnati).** The Christ Hospital was founded in 1889 by a missionary named Isabella Thoburn, who opened the facility with 10 beds. Today, the 555-bed hospital includes more than 1,000 physicians and has been named one of America’s top 50 hospitals for heart care by U.S. News & World Report. HealthGrades has recognized it with the Distinguished Hospital Award for Clinical Excellence in 2011 and 2012, and also named it as one of the 50 best hospitals in the country. The hospital will begin construction on a $265 million hospital expansion, which will include an orthopedic and spine center, in June 2012.

**Christiana Hospital (Newark, Del.).** Within this 913-bed teaching hospital, staffed by more than 1,400 physicians, is Delaware’s only Level I trauma center. In fact, it’s the only facility of its kind between Philadelphia and Baltimore. Christiana Hospital has earned Magnet recognition for nursing excellence and also received HealthGrades’ Distinguished Hospital Award for Clinical Excellence in 2011. Recently, the hospital was one of the first 250 sites in the country to receive FDA-approval for a heart valve replacement procedure that doesn’t require open heart surgery.

**Cleveland Clinic.** Cleveland Clinic was founded in 1921 by four physicians who, after working in army hospitals during World War I, were impressed by the efficiency of military medicine. The hospital is home to several medical breakthroughs, including the first lung transplant in 1998. The Magnet-recognized Cleveland Clinic has been ranked first in the nation for cardiology by U.S. News & World Report each year since 1994, and it was ranked fourth in the country overall in 2011. Cleveland Clinic recently released a 50-year design plan with sophisticated architecture and green aesthetics that involves the development of 14 new buildings.

**Dartmouth-Hitchcock Medical Center (Lebanon, N.H.).** The only academic medical center in the state, Dartmouth-Hitchcock Medical Center dates back to 1797. Hailed by healthcare experts as a model for integration, the medical center is comprised of Mary Hitchcock Memorial Hospital, physician group Dartmouth-Hitchcock Clinic and Dartmouth Medical School. Dartmouth-Hitchcock, a Magnet-recognized hospital, was selected as one of the country’s first 32 Pioneer Accountable Care Organizations by CMS in December.

**Downtown Naples (Fla.) Hospital Campus.** The Downtown Naples Hospital Campus is a 420-bed hospital with more than 500 physicians. The hospital has been awarded for excellent women’s healthcare services by HealthGrades, along with cardiac care excellence. Downtown Naples’ Shick Heart Center has been ranked among the top 5 percent of cardiac programs in the nation and has a mortality rate less than half of the national average. The first open heart surgery program in Collier County opened at Downtown Naples Hospital Campus in 1996.

**Duke University Hospital (Durham, N.C.).** Duke University Hospital’s roots trace back to 1930, when it was founded with the intention to be the best medical institution between Baltimore and New Orleans. Today, this 924-bed academic medical center has been ranked as one of the top 10 hospitals in the country by U.S. News & World Report. Duke’s innovations in community care and partnerships with local clinics caught the eye of President Barack Obama’s administration, which used them as models for elements of healthcare reform. In 2012, the hospital will open its new $230 million cancer center.

**Edward Hospital (Naperville, Ill.).** Soon after Edward Hospital was founded in 1907 with 45 beds, it treated its first patient — a 23-month-old named Frederich, who had been kicked by a horse. This hospital, which has since grown to include more than 1,000 physicians and 309 beds, is Magnet-recognized for nursing excellence and was named a Thomson Reuters Top 100 Hospital in 2011. It was the first hospital in Illinois to offer all private rooms and is launching a $64 million expansion project in 2012.

**Emory University Hospital (Atlanta).** Emory University Hospital dates back to 1904, when a hospital was founded in an Atlanta mansion that had somehow survived the destruction of the Civil War. U.S. News & World Report
ranked the 579-bed hospital as first in the Atlanta metropolitan area in 2011 and as one of the top 10 cardiology programs in the country nine times. Press Ganey has also recognized Emory University Hospital for high patient satisfaction in its emergency department, which it plans to double in size in 2012.

Evans (Ill. ) Hospital. The flagship of the four-hospital NorthShore University HealthSystem, Evanston Hospital was founded in 1891 with six beds and 12 physicians. Today, the hospital is known as the regional center for high-risk obstetrics, and it also serves as a Level I trauma center. Evanston Hospital was named a Thomson Reuters Top 100 Hospital in 2011. HealthGrades named the hospital one of the 50 best in the nation in 2011 and also awarded Henrico Doctors’ its Distinguished Hospital Award for Clinical Excellence in 2011 and 2012. Earlier last year, Henrico Doctors’ became one of the first sites for minimally invasive da Vinci robotic surgeries in the mid-Atlantic region.

Henry Ford Hospital (Detroit). Henry Ford Hospital is one of four recipients across the country to win the 2011 Malcolm Baldridge National Quality Award. U.S. News & World Report ranked the hospital third in the Detroit metropolitan area in 2011. Henry Ford opened its $12 million Innovation Institute last year to coordinate projects and find best practices and new technologies for hospital services, such as knifeless surgery, virtual breast biopsies and blood tests for brain injuries.

Hoag Memorial Hospital Presbyterian (Newport Beach, Calif.). Founded in 1952, Hoag Memorial Hospital Presbyterian is a 498-bed hospital that includes more than 1,200 physicians. A Magnet-recognized hospital, Hoag received the HealthGrades Distinguished Hospital Award for Clinical Excellence in 2011 and 2012. It opened a hybrid cardiac operating room this year and also formed a commercial accountable care organization with Greater Newport Physicians Medical Group and Blue Shield of California.

Hospital for Special Surgery (New York). Hospital for Special Surgery was founded in 1863, making it the oldest orthopedic hospital in the country. The 205-bed hospital was the first in New York City to receive Magnet recognition for nursing excellence, and it has also achieved the statistically lowest infection rates in the state. It also won HealthGrades’ Outstanding Patient Experience Award in 2011 and was ranked first in orthopedics by U.S. News & World Report for 2011. The hospital’s physicians are team physicians for the New York Giants, New York Mets, New York Knicks and several other local athletic teams.

Hospital of the University of Pennsylvania (Philadelphia). Since it opened its doors in 1765, the Hospital of the University of Pennsylvania has served as the nucleus of Penn Medicine, which is the county’s oldest medical school and includes roughly 2,100 physicians. The Magnet-recognized hospital was ranked within the top 10 hospitals in country overall by U.S. News & World Report for 2011-2012. In November 2011, the hospital announced plans for a $102 million expansion to its Perelman Center for Advanced Medicine.

Indiana University Health Methodist Hospital (Indianapolis). Indiana University Health Methodist Hospital has been an influential healthcare hub in its state, as it was the first hospital in the state to have a motorized ambulance, perform a kidney transplant and implant an artificial heart. This Magnet-recognized hospital was ranked first out of 32 hospitals in the Indianapolis metropolitan area by U.S. News & World Report in 2011. The hospital is also home to the Fairbanks Center for Medical Ethics, one of the only clinically-based medical ethics centers in the country.

Inova Fairfax Hospital (Falls Church, Va.). U.S. News & World Report ranked Inova Fairfax Hospital third in the Washington, D.C., metropolitan area in 2011. The hospital has earned Magnet recognition for nursing excellence and was also named a Premier Top Performing Hospital in 2011. The hospital is in the midst of a five-year, $621 million construction project which involves a new 11-story patient tower and separate building for its women’s hospital on the campus.

Jersey Shore University Medical Center (Neptune, N.J.). Jersey Shore University Medical Center’s roots stem back to 1904 when it was founded as a 50-bed home for women and children and converted to a hospital one year later. This Magnet-recognized hospital is high-performing in six medical specialties, according to U.S. News & World Report, and has been named in Fortune’s 100 Best Companies to Work for three consecutive years. Jersey Shore University Medical Center is the teaching hospital for UMDNJ—Robert Wood Johnson Medical School.

Johns Hopkins Hospital (Baltimore). Johns Hopkins Hospital was founded in 1889 at the bequest of American entrepreneur and philanthropist Johns Hopkins. The 1,051-bed hospital was the first in Maryland to receive Magnet recognition for nursing excellence and U.S. News & World Report has ranked it as the number one hospital in the country consecutively for 21 years. With a $25 million gift, the hospital established a new center to study Lou Gehrig’s disease, or amyotrophic lateral sclerosis, this March.

Loyola University Medical Center (Maywood, Ill.). The 570-bed Loyola University Medical Center, the teaching hospital of Loyola University Chicago’s Stritch School of Medicine, has been caring for patients under the Jesuit philosophy for roughly 35 years. This Magnet-recognized hospital was ranked nationally in four adult specialties
by *U.S. News & World Report*. It includes a Level 1 trauma center and burn center, and announced plans to open a new pavilion in 2013.

**Martin Memorial Hospital (Stuart, Fla.).** When Martin Health System was founded in 1939, its flagship hospital had 23 beds and three physicians. Now the hospital has grown to 316 beds and has made strides in its medical accomplishments, receiving awards and recognition for many of its specialties. Martin Memorial Hospital was named to Thomson Reuters’ 100 Top Hospitals and 50 Top Cardiac Hospitals in 2011. It is also a Blue Distinction Center for three specialty services.

**Massachusetts General Hospital (Boston).** The 907-bed Massachusetts General is the third oldest hospital in the country and in 2011 it celebrated its 200th anniversary. Massachusetts General, home to the largest hospital-based research program in the United States, is consistently publishing major findings and breakthroughs in medicine. Recently, it found that a blood test could accurately diagnose depression. This Magnet-recognized hospital was named one of Thomson Reuters’ 100 Top Hospitals in 2011 and recently struck an affiliation agreement with Cooley Dickinson Hospital in Northampton, Mass., extending its clinical reach.

**Mayo Clinic (Rochester, Minn.).** Mayo Clinic was founded in 1889 after a tornado struck Rochester and the town needed a temporary hospital, which was later made permanent. Now, more than one million people from all 50 states, and roughly 150 countries, visit the hospital each year. It’s Magnet-recognized for nursing excellence was named a Thomson Reuters Top 100 Hospital in 2011. This year, Mayo Clinic is launching capital projects valued at $600 million.

**Memorial Hermann-Texas Medical Center (Houston).** Founded in 1907, this 906-bed hospital was named a Thomson Reuters Top 100 Hospital in 2011, and its parent company, Memorial Hermann Healthcare System, was named to Thomson Reuters’ Top 15 Health Systems as well. The hospital, which is the primary teaching hospital for the University of Texas Medical School at Houston, announced it will open a new cancer center in 2012. Following the 2011 Tucson shooting, former U.S. Representative Gabrielle Giffords spent time here for rehabilitation and therapy.

**Methodist Dallas Medical Center.** Methodist Dallas Medical Center was opened in 1927 by a group of Methodist ministers and civic leaders as a 100-bed facility. Today, the 515-bed hospital has grown to become one of the top teaching and referral hospitals in the area. The hospital includes more than 250 physicians, a staff that continues to grow in number as the hospital recently added 78 physicians in 2011 alone. Last year was the third year in a row Methodist Dallas Medical Center experienced its strongest financial performance in its history.

**The Methodist Hospital (Houston).** The Methodist Hospital, the flagship hospital of the Methodist Hospital System in Houston, has consistently been recognized for its delivery of care. This Magnet-recognized hospital was ranked first by *U.S. News & World Report* in Houston metro area in 2010-2011 and was awarded the HealthGrades Distinguished Hospital Award for Clinical Excellence in 2011 and 2012. Open since 1919, The Methodist Hospital is also a teaching hospital affiliated with Weill Medical College of Cornell University.

**Montefiore Medical Center (New York City).** Montefiore was founded in 1884 by a group of philanthropic leaders in New York’s Jewish community. The teaching hospital for the Albert Einstein College of Medicine, Montefiore has made great strides in care delivery and medical innovation. It established one of the country’s first hospital-based social work departments in 1905 and opened the nation’s first headache unit in 1945. *U.S. News & World Report* ranked the hospital 6th in the New York metropolitan area. Montefiore was selected by CMS to participate in the 2012 Pioneer Accountable Care Organization program.

**Mount Sinai Hospital (New York City).** Mount Sinai Hospital, a 1,171-bed teaching facility in New York City, has delivered healthcare services since 1852. The hospital was recently ranked third in the New York area by *U.S. News & World Report* and 16th of all hospitals in country, earning the hospital Honor Roll Status. In addition to being named one of the state’s safest hospitals by the Niagara Health Quality Coalition, Mount Sinai also boasts a reputable school of medicine, which was ranked 2nd out of 126 medical schools nationwide by *U.S. News & World Report* in 2010.

**Morton Plant Hospital (Clearwater, Fla.).** Founded in 1916, the 687-bed Morton Plant Hospital delivers healthcare in 50 specialties, with centers of excellence for cardiology, oncology, neurosciences, women’s services and orthopedics. Morton Plant Hospital is also the only hospital to be recognized as one of Thomson Reuters’ 50 Top Hospitals for cardiac care in 2011 for the 13th straight year.

**Munson Medical Center (Traverse City, Mich.).** Munson Medical Center was the first general hospital in Northern Michigan after James Decker Munson, MD, a well-known humanitarian and neurologist, donated a boarding house for use as a hospital in 1915. The 391-bed, Magnet-designated hospital is currently the largest hospital in the region and performed the area’s first open-heart surgery in 1990. MMC,
which also has been a Thomson Reuters Top 100 Hospital 13 times and has earned several HealthGrades awards over the past two years, is also the only hospital in Northern Michigan to house a neonatal intensive care unit and inpatient behavioral health services.

NewYork-Presbyterian Hospital (New York City). Heralded as the number one hospital in New York City and nationally ranked in 15 adult specialties and 10 pediatric specialties by U.S. News & World Report, few hospitals compare to NewYork-Presbyterian, the second-oldest hospital in the United States. It was founded in 1771 as The New York Hospital — granted as a royal charter from King George III — and merged with The Presbyterian Hospital in 1998 to create one of the largest academic medical institutions in the country and world. NewYork-Presbyterian, which is partnered with the Weill Cornell Medical College, holds a slew of medical firsts, including the first successful heart transplant in a child and the first hospital to have a female professor of clinical medicine.

Northwestern Memorial Hospital (Chicago). Centered in one of the great hubs of hospital healthcare in the United States, Northwestern Memorial Hospital serves as the teaching hospital for the renowned Northwestern University Feinberg School of Medicine. The Magnet hospital was the sole recipient of the prestigious National Quality Award in 2011, presented by the National Committee for Quality Health Care. Northwestern Memorial has also been active in construction and research trials in the past year: It opened a new, 36-bed cardiology wing in its Galter Pavilion, began presenting plans to construct a 25-story, $344 million medical office building, and partnered with the Northern Illinois Proton Treatment Center to study nuclear medicine and proton beam therapy.

NYU Langone Medical Center (New York City). NYU Langone Medical Center is one of the nation’s premier centers for excellence in healthcare, biomedical research and medical education. It serves as the teaching hospital for the NYU School of Medicine and publishes numerous medical findings year-round, such as when it released a 62-page report on quality and patient care to women and to empower them to manage their health throughout their lives. The hospital was the sole recipient of the prestigious National Quality Award in 2011, presented by the National Committee for Quality Health Care. NewYork-Presbyterian, which is partnered with the Weill Cornell Medical College, holds a slew of medical firsts, including the first successful heart transplant in a child and the first hospital to have a female professor of clinical medicine.

Presbyterian Hospital (Charlotte, N.C.). The 521-bed Presbyterian Hospital is the flagship facility of Novant Health. The hospital started off as a 20-bed facility with a barbershop, fruit stand and saloon underneath it in 1903, and now Presbyterian stands as one of the eminent healthcare institutions in North Carolina. Presbyterian Hospital received the 2011 President’s Award for Quality, indicating clinical excellence and operational efficiency, and it was only one of 21 hospitals to earn this designation. Presbyterian Hospital is also a vanguard for creating a wellness culture by offering physical activity support, increasing healthy eating options at work and promoting wellness initiatives to its employees.

Providence Hospital (Southfield, Mich.). For nine straight years, Thomson Reuters has named Providence Hospital a Top 50 Cardiovascular Hospital, a designation that only two other institutions have achieved. Providence was also recognized by the MHA Keystone Center for Patient Safety and Quality for making Michigan a leader in implementing evidenced-based practices and making healthcare safer. Medical breakthroughs permeate Providence’s history, as it was the first hospital in the United States to treat patients in an aneurysm coil study, and Providence surgeons performed the area’s first FDA-approved brain stent procedure.

Providence Regional Medical Center (Everett, Wash.). The Sisters of Providence had a vision for healthcare in the Northwest, as they purchased the Monte Cristo Hotel for $50,000 in 1905, eventually turning it into the 75-bed Providence Hospital — which is now known as Providence Regional Medical Center. Since then, PRMC has grown into a 372-bed, award-winning facility that serves patients from a five-county region. Last June, PRMC opened its new $500 million medical tower. The 12-story Marshall and Katherine Cymbaluk Medical Tower features 240 patient beds and the latest medical and diagnostic imaging equipment.

Regional Hospital of Scranton (Pa.). For more than a century, Regional Hospital of Scranton has provided healthcare to the residents of Northeastern Pennsylvania. Regional Hospital has been a leader in the region when it comes to cardiac care over the past 40 years. In 1965, it established the area’s first coronary care unit, and it also performed the region’s first open heart surgery. HealthGrades has taken notice of Regional Hospital’s quality healthcare, naming it one of America’s 50 Best Hospitals and bestowing it with the Distinguished Hospital Award for Clinical Excellence for the past three years. Last year, the 198-bed hospital became part of Franklin, Tenn.-based Community Health Systems, and now Regional Hospital is part of CHS’ regional healthcare system, Commonwealth Health.

Rex Hospital (Raleigh, N.C.). Part of UNC Health Care, the 665-bed Rex Hospital is no stranger to innovation in the region and state. Rex Hospital was the first in the region to receive Magnet recognition, the first in the area to implement sentinel node procedures for breast cancer, the first regional bariatric center of excellence and more. More than 1,100 physicians are on the Rex Healthcare medical staff, and this year, the hospital received the Distinguished Hospital Award for Clinical Excellence and 12 other service line excellence awards from HealthGrades.

Riverside Medical Center (Kankakee, Ill.). Cardiology, cancer, neurosciences, orthopedics, women’s health — Riverside Medical Center offers a wide array of medical and surgical services and at a high quality. A 2011 Thomson Reuters Top 100 Hospital, Magnet hospital and recipient of four 2012 HealthGrades awards, Riverside Medical Center was the first in the Kankakee area for nine different medical achievements, such as cardiac drug-eluting stents. The hospital opened a $60 million addition in November, which included 13 operating rooms.

Robert Packer Hospital (Sayre, Pa.). As the first hospital established within its service area, Robert Packer Hospital has earned a reputation for high-quality care at the state and national level. In 2011, it was named a Thomson Reuters Top 100 Hospital and ranked number one overall in the state of Pennsylvania for medical excellence, joint replacement and overall hospital care by CareChex. Robert Packer’s entire cardiology center is devoted to all types of aortic disease. The hospital is the only Level II trauma center in the region and is the leading provider of orthopedic trauma surgery between Danville, Pa., and Rochester, N.Y.
Robert Wood Johnson University Hospital (New Brunswick, N.J.). Clinical quality and medical innovation are the standard at Robert Wood Johnson University Hospital, as Harvard University researchers (in a study commissioned by The Commonwealth Fund) identified RWJUH as one of the top 10 hospitals in the nation for clinical quality. The Cardiovascular Center of Excellence at the Magnet-designated hospital was recently selected to be one of the first sites in the nation to offer transcatheter aortic valve replacement since the procedure received FDA approval. Last year, RWJUH opened its new 13,000-square-foot Ambulatory Surgical Pavilion, and this past February, it announced it would explore a partnership with Somerset Medical Center in Somerville, N.J.

Ronald Reagan UCLA Medical Center (Los Angeles). In terms of great hospitals on the West Coast, none can say what Ronald Reagan UCLA Medical Center can, as it has been ranked the “Best in West” for 22 straight years by U.S. News & World Report. A Magnet hospital, Ronald Reagan UCLA Medical Center leads some of the most innovative hospital services in the nation. In March 2011, surgeons performed the first hand transplant in the Western United States in a procedure that took a 17-member team nearly 15 hours to complete. In total, UCLA physicians and researchers found nearly 60 different medical breakthroughs across all spectrums of healthcare over the last two years.

Rush University Medical Center (Chicago). Considered to be one of the top three hospitals in Chicago by U.S. News & World Report, Rush University Medical Center underwent a massive change this past January when it opened its $654 million state-of-the-art hospital tower. The new hospital has many unique designs, such as its butterfly shape, which puts nurses closer to their patients throughout the unit rather than working from conventional, centralized nursing stations. The new hospital also has operating room-quality air in all patient care areas and is Chicago’s first green, full-service hospital. Rush — a Magnet-designated hospital known for orthopedics, neurosurgery, urology and several other services — also conducts some of the most innovative clinical research trials in the country. It received more than $58 million from the National Institutes of Health in 2011 — a new record for the hospital.

Russell Medical Center (Alexander City, Ala.). Russell Medical Center, founded by Benjamin Russell, first opened its doors in 1923 to provide healthcare for employees of the Russell Manufacturing Company and the residents of Alexander City, Ala., and now the 75-bed hospital has grown just as much as the city, treating patients all around the area just north of Alabama’s capital. In 2011, Russell was named a Thomson Reuters Top 100 Hospital and was also an Everest Award winner for current performance and fastest long-term improvement over five years. Russell formed a joint venture with the University of Alabama at Birmingham this past February to expand its oncology services and use UAB Medicine’s best practices in cancer care.

Saint Alexius Medical Center (Bismarck, N.D.). Known for its several centers of excellence, including neuroscience and cancer care, Saint Alexius Medical Center has remained active in its pursuit to provide leading healthcare in the North Dakota capital. Over the past year, Saint Alexius announced a management agreement with the Wishek (N.D.) Hospital and Clinic Association and affiliated with McKenzie County Healthcare Systems of Watford City, N.D., advising McKenzie on facility construction plans as well as physician recruitment. Last June, the hospital also purchased a building in Bismarck with plans to turn part of it into a new 60,000-square-foot ambulatory surgery center, expected to open in summer 2013.

Saint Thomas Hospital (Nashville, Tenn.). Roughly 113 years ago, Saint Thomas Hospital started as a small initiative to provide healthcare around Nashville. Today, Saint Thomas Hospital provides adult specialty healthcare to the more than 2 million residents of Middle Tennessee, Southwestern Kentucky and Northern Alabama. A 2011 Top 100 Hospital by Thomson Reuters and a recipient of 10 different awards from HealthGrades between 2009 and 2012, Saint Thomas Hospital became the first in the state this past February to open two hybrid operating rooms. It is only the third in the Eastern United States, after Johns Hopkins and the Cleveland Clinic, to have two hybrid ORs.

Sanford USD Medical Center (Sioux Falls, S.D.). Sanford USD Medical Center is the largest hospital in South Dakota with 545 beds and is a teaching hospital for the Sanford School of Medicine at the University of South Dakota. Sanford Research/USD is conducting a new clinical trial to study the safety and effectiveness of a drug treatment on patients receiving radiation and chemotherapy for head and neck cancer. A $75 million Sanford Heart Hospital is also attached to the main facility and began a staggered opening this past March.

Schneck Medical Center (Seymour, Ind.). Schneck Medical Center is a 100-bed, government-owned hospital in a small Indiana town, but it has proven its quality healthcare delivery over the past several years. Schneck is one of four 2011 Malcolm Baldrige National Quality Award recipients, making it the first organization in Indiana to win the award. In addition, the Magnet-designated hospital received the HealthGrades Outstanding Patient Experience Award for three straight years.

Scripps Green Hospital (La Jolla, Calif.). Scripps Green Hospital has served the La Jolla and greater San Diego communities since 1977. Scripps Green had San Diego’s first liver transplant program, and it was one of the nation’s first hospitals to provide stem cell transplants. The Shirley Center for Orthopaedic Research and Education has advanced the field of orthopedics and developed innovative programs to share best practices. Also, the cardiology program of Scripps Green will soon join Scripps Memorial Hospital La Jolla (Calif.), its sister hospital, to form the Scripps Cardiovascular Institute. The new entity is expected to be complete...
by 2015 and will be the largest heart care provider in the region.

**Shands at the University of Florida (Gainesville, Fla.).** As the primary teaching hospital for the University of Florida, Shands at UF continues to be one of the most comprehensive hospitals in the area and a leading referral medical center in the Southeast. The Magnet-designated hospital treats patients from every county in the state and at a high quality, as *U.S. News & World Report* ranked Shands at UF in the top 50 for seven adult specialties and six pediatric specialties. Shands at UF is also renowned for its organizational culture of service and operational excellence, as it was a Stander Group Firestarter hospital in 2008.

**Sharp Memorial Hospital (San Diego).** The new Sharp Memorial Hospital opened in January 2009, and the 368-bed Magnet hospital was designed to house San Diego’s largest and most modern emergency department and 24-hour trauma center. Sharp Memorial was designated as a “Patient-Centered Hospital” by Planetree in 2010, and in 2007, the hospital’s parent system — Sharp HealthCare — received the Malcolm Baldrige National Quality Award.

**Spectrum Health Butterworth Hospital (Grand Rapids, Mich.).** Spectrum Health Butterworth Hospital is the flagship hospital of Spectrum Health, a Thomson Reuters top 10 health system. The Magnet hospital’s history spans several decades and includes several awards, including a Practice Greenhealth Partner for Change with Distinction Award for sustainability and several 2012 HealthGrades awards, including the America’s 100 Best Hospitals Award.

**St. Elizabeth Edgewood (Ky.).** For the past 150 years, St. Elizabeth Edgewood’s parent organization, St. Elizabeth Healthcare, has provided healthcare to some of the neediest people in the greater Cincinnati and Northern Kentucky region. St. Elizabeth Edgewood was the region’s first Magnet hospital, and it has also been a Thomson Reuters Top 100 Hospital for the past five years. HealthGrades awarded the hospital several 2012 awards, including the Distinguished Hospital Award for Clinical Excellence and recognition for excellence in spine surgery, critical care and several other service lines.

**St. Luke’s Episcopal Hospital (Houston).** Cardiovascular medical milestones run aplenty at St. Luke’s Episcopal Hospital, one of the top cardiology and cardiovascular hospitals in the country. The first successful heart transplantation in the United States, the first artificial heart implantation in the world and the first laser angioplasty procedure are only some of those feats. This year, St. Luke’s Texas Heart Institute formed an affiliation with Covenant Heart and Vascular Institute in Lubbock, Texas, to collaborate on cardiovascular care. Under the affiliation, THI and CHVI will transition and coordinate patients with complex thoraco-abdominal aortic aneurysms, patients in need of ventricular assist devices and patients in need of heart and lung transplants.

**St. Vincent Indianapolis Hospital.** At the core of St. Vincent Indianapolis Hospital is its five main centers of excellence: orthopedics, spine, cardiovascular, neuroscience and cancer care. St. Vincent Indianapolis has a bevy of accolades from HealthGrades, including excellence awards in cardiac care, coronary intervention, critical care, gastrointestinal care, neurosciences, spine surgery and stroke care. The hospital also received the 2012 Distinguished Hospital Award for Clinical Excellence and the 2011 Outstanding Patient Experience Award. St. Vincent’s Heart Center of Indiana recently partnered on cardiology services with two other Indiana hospitals to benefit residents in multiple Indianapolis area counties.

**Texas Orthopedic Hospital (Houston).** When it comes to physician-owned hospitals, few are more highly ranked than Texas Orthopedic Hospital. Known for its excellence in joint replacement, spine surgery and total knee replacements, the 49-bed hospital has been ranked as one of the top 50 hospitals in the country in orthopedics from 2009 to 2011, according to *U.S. News & World Report*. Last September, The Joint Commission named Texas Orthopedic as one of the top performers in using evidence-based care processes to improve patient outcomes, and its patient satisfaction scores based on Hospital Consumer Assessment of Healthcare Providers and Systems ranked among the best in the Houston area.
Thomas Jefferson University Hospital (Philadelphia). With Blue Distinction Center status for five different specialties and the first to establish an adult celiac center in Philadelphia, the scope of Thomas Jefferson University Hospital’s healthcare impact is far-reaching in the City of Brotherly Love. The 969-bed Magnet facility is partnered with some of the most experienced orthopedic experts in the country at the Rothman Institute and The Philadelphia Hand Center. This month, Jefferson became the first hospital in the region to perform siadendoscopy, a minimally invasive procedure in which stones are surgically removed from the salivary gland.

UCSF Medical Center (San Francisco). Considered to be the number one hospital in the San Francisco area by U.S. News & World Report, UCSF Medical Center is the second largest recipient nationwide of grants from the National Institutes of Health. In a groundbreaking effort, UCSF Medical Center’s heart failure program helped lower readmissions by 30 percent by providing patients with information and support for post-discharge. CEO Mark Laret was elected to serve as chair of the board for the Association of American Medical Colleges this past November, and his term will run until November 2012. Mr. Laret is also spearheading plans to build a $1.5 billion UCSF hospital complex in the Mission Bay area of San Francisco, which is expected to open in 2014.

University of Arizona Medical Center (Tucson). On Jan. 8, 2011, the University of Arizona Medical Center trauma team took on one of the most daunting and time-sensitive cases at the time, as physicians treated and saved the lives of U.S. Rep. Gabrielle Giffords (D-Ariz., who has since resigned) and others during the 2011 Tucson shooting. UAMC, which has the only Level I trauma center in Southern Arizona, has several instances of innovative care. The hospital has pioneered new treatments for patients with advanced abdominal cancer, and an orthopedic surgeon at the hospital also designed the world’s first artificial wrist in 1976. Almost 20 years ago, UAMC also became one of the first hospitals to use stereotactic radiosurgery to destroy a tumor surrounding the spine.

University of Chicago Medical Center. The University of Chicago Medical Center plays home to some of the most advanced care and established history in the advancement of medicine. UCMC and University of Chicago Medicine have provided medical breakthroughs on almost every front, including hormone therapy for cancer, diabetes treatment, the introduction of the gastroscope, public health studies, organ transplantation and more. UCMC is more than 85 percent complete with its 10-story “hospital for the future,” which will contain 240 inpatient rooms and a hub for complex specialty care dealing with cancer, gastrointestinal disease, neuroscience, advanced surgery and high-tech medical imaging. Last June, the American Medical Association named former UCMC CEO James Madara, MD, as its executive vice president and CEO.

University of Colorado Hospital (Aurora). Clinical care at the University of Colorado Hospital has been recognized as some of the most advanced in both the Western United States and the country as a whole. UCH performed the world’s first liver transplant and was also the first in the country to conduct human cell cloning to study genetics and cancer. The Magnet-designated hospital also contains the only National Cancer Institute-designated Comprehensive Cancer Center in the Rocky Mountain region, and two UCH physicians were recently named Howard Hughes Medical Institute Investigators to study the many areas of biomedical research. UCH completed a joint operating agreement with Poudre Valley Health System in Fort Collins, Colo., this past February, creating the University of Colorado Health.

University Hospital (Ann Arbor, Mich.). University Hospital, part of the University of Michigan Health System, is one of the top hospitals in the Detroit metro area and is one of the first hospitals to be part of the CMS’ Pioneer Accountable Care Organization program. University Hospital, the first university-owned medical facility in the United States, is home to several medical firsts, including the world’s first successful lung removal. University Hospital’s parent system finalized an affiliation agreement with Novi, Mich.-based Trinitas Health this March, and the two systems will collaborate on inpatient hospital capacity, high-complexity care for seriously ill patients and other services.

University Hospitals Case Medical Center (Cleveland). A Magnet-recognized hospital, University Hospitals Case Medical Center is one of the top facilities in Cleveland. The Joint Commission and the Leapfrog Group have recognized UH Case Medical Center among the nation’s top performers on key quality measures and patient outcomes last year. The opening of the Center for Emergency Medicine last July completed UH’s $1.2 billion fundraising and construction project.

University of Iowa Hospitals and Clinics (Iowa City). The University of Iowa Hospitals and Clinics is a focal point in the Midwest for numerous procedures and treatments. The Magnet hospital’s Holden Comprehensive Cancer Center is the only cancer center in Iowa designated as “comprehensive” by the National Cancer Institute. UIHC is one of the most active major transplant centers in the country — it performed more than 515 organ and tissue transplants in fiscal year 2011. UIHC is preparing to open a new $12 million cancer clinic, which will include 37 exam rooms and space for research.

University of Kansas Hospital (Kansas City). Last year, the University of Kansas Hospital received the University HealthSystems Consortium Quality Leadership Award, which recognizes top performance in delivering high-quality care among academic medical centers. In addition, the hospital earned six Beacon Awards for Critical Care Excellence in 2010 — more than any other hospital in the United States that year. In March 2011, KU Hospital partnered with U.S. Oncology’s Kansas City Cancer Center to create an outpatient cancer care organization, and it also opened its new Adelaide C. Ward Women’s Heart Health Center this March.

University of Maryland Medical Center (Baltimore). Within the Baltimore area, Maryland and the country as a whole, the University of Maryland Medical Center has made a lasting imprint in how it delivers quality care. UMMC, which is also one of the most environmentally advanced and responsible organizations as ranked by Practice Greenhealth, was the first institution in the world to receive the Outstanding Facility Achievement Award in Perioperative Nursing from the Association of periOperative Registered Nurses. Last June, UMMC’s surgical intensive care unit sustained a rate of zero central line-associated bloodstream infections for a 25-week period, mainly due to the dedication and oversight of appointed infection control nurses.

University of Minnesota Medical Center, Fairview (Minneapolis). The teaching hospital of the University of Minnesota Medical School, this 1,700-bed hospital has been home to many medical milestones, such as the world’s first open heart surgery in 1952. UM Medical Center is Mag-
net-recognized for nursing excellence and includes roughly 1,600 physicians. U.N. News & World Report ranked the hospital first in the Minneapolis metropolitan area in 2011. The hospital was recently recognized by the Department of Health and Human Services for its work in heart and kidney transplantation, an honor based on one-year post-transplant survival rates of recipients.

University of Virginia Medical Center (Charlottesville). The University of Virginia Medical Center today is vastly different from when it first started to provide patient care and medical education in 1825. UVA Medical Center started as a dispensary and surgery center until 1901, when it finally became a 25-bed hospital with three operating rooms. Now, the UVA Medical Center is 570 beds, has a Level I trauma center and encompasses nationally recognized cancer and heart centers. UVA researchers are also on the forefront of medical advances. This year, they performed the first two stem cell transplants in Virginia by using non-embryonic stem cells from umbilical cord blood.

University of Washington Medical Center (Seattle). Ranked as the top hospital in the Seattle area by U.S. News & World Report, the University of Washington Medical Center has won the Environmental Leadership Circle Award for the past five years from Practice Greenhealth, proving UW Medical Center is a vanguard for both hospital sustainability and top environmental practices in the delivery of healthcare. UW Medical Center physicians established the world's first multidisciplinary pain center and spearheaded the U.S. portion of a World Health Organization pilot project, concluding complications from surgery dropped significantly when medical teams use surgical checklists. The Magnet-designated hospital also broke ground on a larger neonatal intensive care unit, which is expected to open this year.

University of Wisconsin Hospital (Madison). The University of Wisconsin Hospital, part of UW Health and the UW Hospital and Clinics, is lauded for several key hospital specialties, including cardiology, oncology and neurosciences. The Heart and Vascular Care program has been nationally ranked by both Thomson Reuters and the University HealthSystem Consortium, and the Magnet hospital has also been the site for many research developments and medical firsts.

UW spine medicine specialists also performed the first minimally invasive spinal fusion surgery in the world in 1993, and more recently, UW physicians demonstrated that virtual colonoscopy is as effective as conventional colonoscopy in routine screening for colon cancer.

UPMC Presbyterian (Pittsburgh). UPMC Presbyterian is the 1,601-bed flagship institution of the UPMC health system. In 2010, UPMC Presbyterian was one of the top grossing hospitals in America, recording more than $10.18 billion in total patient revenue. The hospital, which is physically connected to the University of Pittsburgh School of Medicine, is a renowned center for organ transplantation and a recognized leader in cardiology, cardiothoracic surgery, critical care medicine, trauma services and neurosurgery. UPMC Presbyterian also is designated as a Level I trauma center and operates around the world in Italy, Ireland and Qatar.

Vanderbilt University Medical Center (Nashville, Tenn.). When it comes to academic medical centers, fewer in the country are as highly esteemed as the Magnet-designated Vanderbilt University Medical Center. A former Studer Group Firestarter hospital, VUMC is one of the top medical schools for National Institutes of Health funding, receiving more than $445 million for a slew of research initiatives for fiscal year 2010. This past September, VUMC affiliated with three other Tennessee hospitals — Maury Regional Medical Center in Columbia, NorthCrest Medical Center in Springfield and Williamson Medical Center in Franklin — to improve the cost-effectiveness of patient care through regional partnerships.

Virginia Commonwealth University Medical Center (Richmond). The 865-bed VCU Medical Center is a regional referral center for the state and is the region’s only Level I trauma center. The Magnet-designated hospital also encompasses the VCU Massey Cancer Center, which was designated by the National Cancer Institute in 1974 and has kept that recognition since. Cardiologists at the VCU Pauley Heart Center have focused their research efforts on novel strategies for protecting the heart from injuries associated with cardiac ischemia. The National Association for Female Executives also named VCU Medical Center’s parent organization, VCU Health System, as a top 10 non-profit organization for executive women.

Wexner Medical Center at The Ohio State University (Columbus). This past February, The Ohio State University Medical Center was renamed Wexner Medical Center at The Ohio State University in honor of benefactor Leslie H. Wexner. Although the Magnet hospital has taken on a new name, it still performs as one of the top organizations in the country. The Wexner Medical Center is one of only five U.S. academic medical centers recognized as a “Top Performer” by the University HealthSystem Consortium. In addition, the hospital has made several medical research breakthroughs in the study of breast cancer treatment, gene therapy for Parkinson’s disease, vascular health and more.

Winchester (Mass.) Hospital. In 2011, Winchester Hospital received a slew of awards for its quality care, including the HealthGrades Outstanding Patient Experience Award and the HealthGrades Patient Safety Excellence Award. Winchester Hospital was also a 2011 Thomson Reuters Top 100 Hospital and earned Magnet designation for nursing excellence. Last May, the hospital broke ground on a new ambulatory surgery center to provide services in orthopedics, urology, gynecology, otolaryngology and other outpatient surgeries.

Yale-New Haven (Conn.) Hospital. Yale-New Haven Hospital, one of the oldest hospitals in the country and the first in the state of Connecticut, is the 966-bed teaching facility of the Yale School of Medicine. Yale-New Haven has a long list of medical firsts, including the first use of chemotherapy as a cancer treatment in the United States and the first development of an artificial heart pump, which is now displayed at the Smithsonian. The Magnet-designated hospital signed an agreement with Yale University and the University College of London this past October in a global effort to improve the human condition through translational medicine. In September, the hospital announced plans to merge with Hospital of Saint Raphael, also in New Haven, to create a hospital with two campuses. The proposed deal would create the state’s largest hospital.
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**100 Great Places to Work in Healthcare**

*Becker's Hospital Review* and *Becker's ASC Review* have announced its annual list of “100 Great Places to Work in Healthcare.” The 2012 list was developed through nominations and extensive research, and the following organizations were chosen for their demonstrated excellence in providing robust benefits, wellness initiatives, professional development opportunities and atmospheres of employee unity and satisfaction.

**Advocate Health Care (Oak Brook, Ill.)**

**Type of Facility:** Hospital/health system

**What makes it a Great Place to Work:** Advocate Health Care is one of Chicagoland’s largest employers, with more than 32,000 associates, including 6,000 affiliated physicians and 9,000 nurses. Advocate’s Health You program provides incentives for completing health activities such as participation in a walking club, taking online assessments or working with a health coach. Employees can also earn credits, if involved in the medical plan and dependent on the type of plan, which convert to a dollar amount, anywhere from $200 to $600, which can be used to pay for health services throughout the year.

**Akron General Medical Center (Ohio)**

**Type of Facility:** Hospital/health system

**What makes it a Great 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, a recognition that honors employers that excel in compensation, benefits, training and education and other services. Employees can use on-site dry cleaning pick-up, as well as film developing and discounts on local family entertainment and area businesses. Akron employees come together every year for the annual employee picnic.

**Arkansas Children’s Hospital (Little Rock)**

**Type of Facility:** Hospital/health system

**What makes it a Great Place to Work:** Arkansas Children’s Hospital is a 316-bed non-profit hospital that treats patients from birth to age 21. As the only pediatric medical center in the state and one of the biggest in the country, ACH employs more than 4,400 people. ACH offers several professional development options, including training modules for leadership development and online educational programs. In addition, the hospital provides many personal development opportunities, including workshops on interpersonal styles, interaction skills, teamwork, computer training and personal finance.

**AtlantiCare (Egg Harbor Township, N.J.)**

**Type of Facility:** Hospital/health system

**What makes it a Great 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. For example, the “Pathways to Leadership” track is designed for front-line staff with high potential for moving into a leadership role.

**Atlantic Health System (Morristown, N.J.)**

**Type of Facility:** Hospital/health system

**What makes it a Great Place to Work:** Atlantic Health System is a four-hospital system with more than 11,000 employees. As the primary academic and clinical affiliate in New Jersey of The Mount Sinai School of Medicine and The Mount Sinai Hospital, located in New York, the health system invests in employees’ professional development. RNs and certain other health professionals have the opportunity to participate in the Professional Advancement Clinical Tracks program, which helps them advance within their current position.

**Aurora Sheboygan Memorial Medical Center (Milwaukee)**

**Type of Facility:** Hospital/health system

**What makes it a Great Place to Work:** Aurora Sheboygan Memorial staffs 150 physicians and provides services more than in 25 specialties to serve Sheboygan County. Full- or part-time employees who have worked for Aurora for at least one year, and who qualify for a mortgage loan, are eligible for the Employee Homeownership Program, which provides a five-year, 0 percent interest forgivable loan of up to $3,000 for the purchase of any new or existing home, including single-family, duplex, multiple-use property or condominium.

**Bailey Medical Center (Owasso, Okla.)**

**Type of Facility:** Hospital/health system

**What makes it a Great Place to Work:** Bailey Medical Center is a 73-bed acute-care, 178-employee 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.

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For the past 20 years, UW Medicine has received top ratings from U.S. News & World Report for its clinical, education and research programs. However, even one of the nation’s leading academic healthcare systems feels the current economic strain and pressure of national healthcare reform. It can be a challenge to improve healthcare quality, safety and access while also controlling and reducing costs.

Paul G. Ramsey, MD, CEO of UW Medicine, executive vice president for medical affairs and dean of the school of medicine at the University of Washington in Seattle, discusses UW Medicine’s current goals as well as the system’s “secrets for success” in the current healthcare climate — measurements and metrics, teamwork, hard work and a clear vision for the future.

Question: What are UW Medicine’s current goals?

Dr. Ramsey: We are in a very exciting and challenging time in medicine. UW Medicine’s primary goals relate to our mission of improving health for all people. It is important for UW Medicine, as a leading healthcare and academic system, to remain focused on improving the quality and safety of care and the overall services to patients and their families. At the same time, substantially controlling and reducing costs in the same areas are important.

Our goals this year encompass our mission of improving health in the work we do — in research to discover new ways to improve health, in our clinical programs by offering the very best care for our patients, and in our education and training programs designed to prepare the next generation of health and science professionals.

Q: How do you go about achieving your goals?

PR: As we focus on improving quality and safety in patient care while improving our services, we use measurement tools to assess where we are now, to monitor our progress and to set goals for making improvements for the coming year. Our research, supported primarily by grants, is oriented toward improving health. For educational programs, we establish measures and benchmarks to track outcomes, such as where our medical students and residents choose to practice after training, what percentage go into primary care and how many students and residents choose practice settings that care for underserved patient populations. Metrics and measurements help us identify and support effective programs and improve our outcomes.

One excellent example of our use of measurement in clinical care is the work done over the past few years in the UW Medicine spine program — Sports, Spine & Orthopaedic Health. This program has integrated activities related to diagnoses and care of patients with back pain. Health professionals from multiple specialties — rehabilitation medicine, orthopedics, neurology, neurosurgery and radiology — have examined best practices in the literature and reviewed results from our own program to develop clinical pathways that are more standardized and cost-effective approaches to managing the very large number of patients with back pain.

As a result of this research and the resulting changes to our care approaches — as well as the outstanding service offered to patients — patients are very satisfied with our spine program. We know this because we ask patients to self-assess their recovery. By continuously using metrics and measurements to document and monitor program results, UW Medicine can apply for funding that furthers the system’s ability to improve patient care.

Q: In your opinion, are there any challenges UW Medicine faces in achieving its goals?

PR: There are major challenges in 2012. Our largest challenges, however, are common to all academic health systems around the United States. The foremost challenge is the economy. The economy is adversely affecting support for medical education, clinical care and research. The negative impact on research comes at a time when research has done so much and could do so much more. It is frustrating to see medical research support decline when the outcomes are so exciting and are directly leading to improved health. In 2012, we have the potential to cure and prevent diseases in many areas that could not be addressed in the past. Just this past year, one of our researchers — Suzanne Craft — tested a nasal insulin spray as a treatment for memory loss and dementia. In a randomized controlled trial, she found significant improvement in patients who used the spray. Without adequate research funding, this very promising discovery will not be translated rapidly into new, cost-effective approaches for treatment. Funding support from the National Institutes of Health is extraordinarily important.

Another challenge common to all systems, including UW Medicine, is the fact that we must control healthcare costs and in some areas reduce costs rather dramatically while also improving quality, safety and access for patients. A business model of “we must do better” comes at the same time that we must control and reduce healthcare costs.

Fortunately, UW Medicine has a large number of hard-working, dedicated and outstanding people, who are working to improve quality, safety, service and access in all of our clinical settings.

Q: What do you believe has helped UW Medicine thrive despite hard economic times and downward pressure on the healthcare sector?

PR: We are financially stable across our very large health system, and I attribute our fiscal stability to hard work by hundreds of leaders across our system. We are fortunate to have a
large number of individuals who are doing their jobs very well. We have also made substantial investments in our financial systems over the last five years, and these investments have resulted in accurate and timely financial information to enable us to make good decisions. UW Medicine has been historically conservative in developing business plans and that approach has served us well in a time of economic turmoil. In short, UW Medicine has thrived because of the outstanding, dedicated individuals who work here.

Q: What could other health systems learn from UW Medicine in terms of addressing current healthcare challenges?

PR: Since we are one of the largest and best health systems in the world, we have a special responsibility to develop solutions that other systems can emulate. We need to be a model for developing and implementing new approaches to treat and prevent diseases. Our leaders, faculty and staff are working to design new approaches to address clinical care — improvements for specific conditions, the best methods to implement known standards of care, and ways to increase the effectiveness of healthcare teams. We are also developing new approaches to using information technology that facilitate the work of our healthcare professionals and that help patients interact with their healthcare providers.

Q: What do you enjoy most about being CEO at UW Medicine?

PR: I enjoy all aspects of my position, but if you are asking me to identify one special area, I would say that it is the opportunity to shape the future of healthcare — to focus on how UW Medicine can advance its mission of improving health for all people. I enjoy leading, planning and developing new programs. I enjoy working with people and I am very fortunate to have a large number of outstanding administrative and academic leaders working with me. UW Medicine has more than 21,000 employees and we have a culture of collaboration and teamwork. It is a great pleasure to follow all of the programs that are delivering excellence in patient care programs, creating new knowledge on a daily basis and preparing the next generation of healthcare professionals and scientists.

Q: What is your leadership philosophy?

PR: Lead by example. Lead by serving others. Lead by being an effective communicator. I try to support the individuals who are doing great work by working hard as well.

Q: What has been your proudest accomplishment as CEO?

PR: Despite the economic turmoil, UW Medicine has remained focused on improving health for all people, putting patients’ interests first and creating active learning for students and trainees. Despite the economy, UW Medicine has continued to achieve excellence in all of our activities.

Q: Do you have any personal goals for leading UW Medicine this year?

PR: My personal goals and aspirations align with UW Medicine’s goals. I receive great satisfaction from those goals because I value and enjoy UW’s overall mission of seeking to improve health for the overall population. I set my own professional goals in relationship to how I spend my time working with faculty, staff and students to achieve the overall goals for UW Medicine.

NOMINATIONS SOUGHT!

100 Great Community Hospitals

*Becker’s Hospital Review* is currently accepting nominations for our annual list of 100 Great Community Hospitals. To be considered, hospitals should provide outstanding patient care for their communities and have a proven track record of quality care. Hospitals must include fewer than 550 patient beds.

To recommend a hospital for consideration, contact Molly Gamble, lists editor, at molly@beckershealthcare.com.

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Putting Employees First: How to Improve Patient Experience, Profitability

By Paul Spiegelman, CEO, BerylHealth

What does it mean to create a culture that focuses on the employee, but finds positive results in all measurable categories including profit? As CEO of BerylHealth, a company specializing in managing patient interactions through multiple touch points across the continuum of care for hospitals and health systems, we found that focusing on culture to drive employees in the critical role they play in our success just may be the answer to the issue of improving the patient experience for hospital systems.

Odds are if you’re reading this, you’re a healthcare executive that faces all the pressures of running a hospital or health system coupled with federal oversight, reduced payments and overcrowded emergency rooms. There’s not a tougher, more scrutinized and often controversial industry out there. So why should you care about culture?

Because of all the burdens you face, culture is one thing you can champion and the one thing that touches every single person in your building equally. It starts with the senior leadership and filters all the way to every single bed in your facility. Culture lays the foundation for the patient experience. Culture engages your stakeholders.

Just like your hospitals, everyone is a stakeholder in our building. We need employees to take a vested interest in the bigger picture, so treat them like stakeholders. When you create an environment in which “jobs” are regarded more like “personal investments,” employees will show up with passion, productivity and focus, with an end result of an employee family that is happy and driven and a company that is profitable.

Treating employees as family and stakeholders isn’t driven by money. It just happens to return a yield that allows us to keep doing great things for our employees and customers. Here are four ways healthcare leaders can develop a culture that breeds engagement along with insights from leaders of some great healthcare facilities on how they apply some of these practices to their own facilities.

Be transparent. We earn the trust of our employees by being active in creating opportunities to get their ideas and by reporting on our company’s financial performance regularly throughout the year. Town hall meetings are an effective medium for communicating this information so that staff can ask questions. Getting on the floor and interacting in their realm is powerful. Whether our performance is good or struggling, we own up to it, and let employees know in person how they can help impact the situation.

According to Alan Channing, CEO of Sinai Health System in Chicago, being visible among all levels of workers improves transparency. “The other thing we’ve worked at is being really visible with the front-line caregivers. Each senior leader has a week on call and is required to round throughout the organization. I’m not on that call schedule, but I’m here almost every weekend walking around. When I don’t come, they say...where have you been? We miss you. Most of the 3,000 employees feel like they have a personal connection with the leadership of the organization,” he says.

Anthony Armada, CEO of Advocate Lutheran General Hospital in Park Ridge, Ill., says allowing employees a way to provide input is critically important. “Give them multiple opportunities to share their input and have the transparency to get back to them and let them know what you did with their ideas. If people believe their voice is heard, they will be more engaged. For example, we have leadership webinars and every associate can participate. We have open forums and town halls that encompass every shift. I still do midnight shift rounds every quarter. This type of consistency is important. It can’t be a flavor of the month. I get love letters from some of our nurses when they can’t be there at midnight shift rounds but they have some ideas they want to share,” he says.

Share the successes. From new clients to awards, any company success provides an opportunity to further engage our employees. After winning a “Best Place to Work” award, we celebrated by renting a limousine and driving to the presentation luncheon with ten coworkers who had either been nominated by their peers to represent the company or won an internal recognition contest. As we were riding back to the hotel in the back of the limo, one employee looked at me and said, “This is the proudest day of my life.”

What does that mean for me as a CEO? I have secured an employee who is delivering top-notch services to clients and who will commit long-term to the company. Best of all, I’ve been part of someone’s life in a meaningful way. What would the same engagement from hospital staff mean for the experience the patient receives? Improved HCAHPS scores? How well the patient follows post-discharge instructions? Celebrate the people in your building. When coupled with the partners and resources that are driven by both compassion and technology, you’ll create a patient experience that delivers levels of care you didn’t know existed.

“How do you recognize people that are doing well? First it has to be genuine. Second, it should be unexpected,” says Melody Trimble, CEO of Sparks Health System in Fort Smith, Ark. “I ask people when they start with us to fill out a survey to tell me how they like to be recognized. I’m a big card person. Everyone tells me I should have stock in Hallmark. I am a giver. I need to be a millionaire because I would have so much fun doing things for other people. Then I have to encourage people to do the same thing I do. I ask them to tell me the last time they wrote a card or recognized someone.”

Focus on the single thing employees do care about most. It’s not salary. There are few things that do more to enlure an employee to an employer than taking care of what matters most to them — their family. At BerylHealth, we aim to include families at events like family field day and “Breakfast with Santa.” Our company magazine, “Beryl Life,” is specifically designed to be read by family members, and even has content for kids. What resources and efforts are part of your hospital’s plans to address what’s most important to your staff?

Prioritize smiles. It sounds simple. And from a senior leadership level, it most likely sounds silly to think that something like “prioritize smiles” is an applicable business practice. But healthcare is a tough environment to work in. Every person who interacts with us is sick or in need. (Most of the time, both apply.) By putting a priority on creating opportunities for happiness as a regular part of our work, employees bond as real people and create a better foundation to deliver an outstanding experience.

“If employees and physicians are happy, you’ll get an increase in volume. If you increase volume, you’ll find a way to decrease cost. With that, you’ll increase margin and be able to invest back in employees,” says Mr. Armada.

At Sparks Health System, fun is celebrated formally each quarter. “Every quarter we try to do something fun. We had 2,000 Easter eggs and 350 kids here for the hunt. And, every month, I do birthday celebrations...I say to them...do you want to have $3 or $5 more, or ‘do you want to have a little fun?’ We’re going to have fun,” explains Ms. Trimble.

Put your employees first and you’ll see that creating a culture focus can bring happier patients, higher quality care, fulfilled employees and a better bottom line.
Creating an Environment of Excellence: Q&A With Henry Ford Health System CEO Nancy Schlichting

By Kathleen Roney

Nancy M. Schlichting is CEO of Henry Ford Health System in Detroit, a nationally recognized $4 billion healthcare organization with 23,000 employees. Henry Ford Health includes the 1,200-member Henry Ford Medical Group, five hospitals, the 600,000-member Health Alliance Plan, 32 primary care centers and many other health-related entities located throughout southeastern Michigan.

In November, Henry Ford was named a 2011 Malcolm Baldridge National Quality Award recipient, one of America's highest honors for innovation and performance excellence. Henry Ford was one of only four 2011 recipients and the only organization awarded in Michigan. Henry Ford was also recently selected by the National Quality Forum and The Joint Commission to receive the prestigious 2011 John M. Eisenberg Patient Safety and Quality Award. Henry Ford is one of two honorees nationwide in the Innovation in Patient Safety and Quality local level category.

In order to lead a large, award-winning health system, Ms. Schlichting, administrators, medical staff and Henry Ford employees work to create and maintain a culture of excellence. They emphasize accountability, transparency and effective communication. Here, Ms. Schlichting discusses how creating an environment of excellence with employee engagement and clinical achievements positions Henry Ford as a top-performing health system year after year.

Q: The Baldridge Award is one of America's highest honors for innovation and performance. It clearly indicates Henry Ford's position as a great health system. What did that recognition mean to you and the Henry Ford system?

Ms. Schlichting: Receiving the Baldridge award was an incredibly powerful experience and an amazing way to recognize our employees. When the Baldridge representatives came to visit, they talked to about 1,200 individuals. You cannot cram for or fake that — the employees were genuinely engaged and excited, they blew the examiners away. Even now, when I talk with physicians, volunteers or board members, the Baldridge is all they talk about because they are so proud. It is like being a part of a University that has a winning basketball team. We do not have a sports team but we do have a Baldridge team.

Q: It sounds as if Henry Ford employees are extremely engaged in the system and proud of their work. What do you think has led to that level of employee buy-in?

NS: To create an environment conducive to high performance, it is important that we grow as an organization and focus on our employees. We like to call it a career for life. Henry Ford is such a large system, it allows employees to come in as a nurse for the hospital and end up working for the insurance company. We try to offer a whole host of opportunities for employees to develop their careers. That is how you get great employee buy-in. When people feel the organization cares about them and communicates with them as individuals, they become more accountable for results. It is important to make people feel good every day and not just by what we say to them, or by what we do for them, but how we make them feel.

You also need to create an environment that allows people to be their very best, no matter what their focus. You create that environment through many methods — how you communicate; how you share the hospital or system’s vision; how you involve employees in the strategic planning process and how you seek employee input on important decisions. You want your staff to feel that they are a very important part of the organization.

Q: Can you elaborate on how you share the vision for Henry Ford and involve your employees?

NS: We communicate in 100 ways. We always say that with communication you are never done and never perfect. Everyone receives communication differently so you need to communicate in a variety of ways — we try to be innovative. We have a daily morning post that gives employees and physicians updates — including news from local media and national media. We also share information through the internet, through the system intranet and through video casts — we try to make it fun and interesting. We also hold town hall meetings and focus groups to gauge the employee understanding and interest.

Q: Beyond employee engagement, what do you think it takes to be a great or top-performing hospital?

NS: Three major things are important. The first is to have a culture of excellence. The second is to create an environment to encourage people to reach their full potential and finally, a very strong focus on performance. We set high goals and aspire to be a top-performing organization. We hire individuals that share that vision and are stimulated and excited by it. [Excellence comes from] the leadership team you put together and the strategies you create to engage people. Setting high goals will drive changes that will improve performance. Incremental goals do not push people to achieve as much. Instead, you should set high goals so you are always seeking to be the very best.

Q: What do you think helped Henry Ford to reach such a high level of performance?

NS: There are many things we have done over the years to achieve this level of performance. Setting high goals for all 30,000 employees, physicians and volunteers is important. At the end of the day, it comes down to everyone’s individual and collective effort. It is about focusing on the needs of the organization and its employees. It is about taking care of the people who take care of people — being attentive and accessible, listening and engaging.

I also believe we have made good strategic investments over the years. All of our investments in the past 10 years have shown a good return. We were able to build a brand new hospital, [West Bloomfield Hospital], in a mature market in an innovative way. I hired [Gerard van Grinsven] from the Ritz-Carlton luxury hotel chain to run the building of West Bloomfield. He saw things in the [hospital’s development] that healthcare leaders may not have seen.
We have also been risk takers. We are in Detroit — not an easy market. Yet, we have made investments in Detroit. We have become a driver for the community through incentivizing employees who live in Detroit. We have also maintained a can-do attitude in a tough economy.

Q: You were with Henry Ford when it underwent a dramatic financial turnaround about 10 years ago. What could organizations currently facing hard times learn from Henry Ford’s experience?

NS: During a financial turnaround, you are dealing with a burning platform. We had to make difficult decisions such as reducing 10 to 15 percent of our work force in core business units. Frankly, the most important aspect of the turnaround was that we never wanted to go through it again. That mindset has been a tremendous motivator for cost-management and our focus on quality and service. No one in the system wants to relive those days during the turnaround. At the time, we had to better align our cost structure with the realities of revenue, which was tough. Sometimes it is alluring to have an optimistic view about revenue — that you can put off tough decisions because it will be better down the road. Instead, we stepped up and dealt with the challenges and the tough decisions.

Q: What is your management philosophy or style?

NS: The essence of my job is to create an environment where my employees can reach their full potential. That idea guides what I do every day. When patients tell me that they have received the best healthcare at Henry Ford and that it changed their life, it is music to my ears. We are a leader in the healthcare industry and that is a privilege.

Q: What is the best piece of advice you have been given?

NS: I have received a lot of great advice because I have had some of the greatest leaders as mentors. In that regard, I remember years ago I ran into Sam Tibbetts, who was the chair of the American Hospital Association where I was completing an administrative fellowship. He asked me, “Nancy, why are you in this field?” I came up with an answer about how I was interested in healthcare and so on. His response to me was, “You know, Nancy, healthcare is all about people.” I have never forgotten that conversation. It has really guided me, the idea that healthcare is all about people. Healthcare professionals work in the most stressful and difficult of jobs. The outcomes of their work affect lives. We take care of people in anxious, life-threatening situations and at the most memorable times in their lives. We have to remember that every day. It is easy to come into the hospital, get into a routine and think it is all normal. However, it is not normal. I have that idea at the core of me and I am grateful it came early in my career.

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Physicians will still influence referrals — that capability is inherent. But the triple aim of healthcare reform — higher quality care, improved population health and reduced per-capita costs — has made primary care physicians a central component to any hospital’s long-term success. Patrick Easterling, president of Health Management Physician Network, based in Naples, Fla., cannot emphasize the role of PCP-alignment enough. “I believe that developing a strong primary care strategy with engaged physicians can be the single most important decision a hospital or health system can make,” he says.

But it’s not necessarily an easy one. Hospitals have a few things working against them in their pursuit of primary care physicians, such as a nationwide shortage of 25,000 PCPs — expected to be exacerbated by healthcare reform to 45,000 by 2020. There are also barriers in thought and culture, including tension in hospital-physician relationships, lack of innovation in alignment strategies and close-mindedness towards the geographic settings of PCP practices. Numerous healthcare experts say the following key concepts can make or break a hospital’s PCP-alignment strategy.

Employed primary care physicians — the critical link to accountable care

A 2010 survey conducted by PricewaterhouseCoopers found 48 percent of PCPs were interested in hospital employment — 3 percent more than specialists. Employment was the most attractive alignment model for both PCPs and specialists, with 46 percent most interested in pursuing that model in the next two years. This alignment strategy is particularly attractive to younger physicians who seek financial security, work-life balance and the familiarity of a hospital setting after serving residencies there.

Hospitals can lose anywhere from $150,000 to $250,000 per year for the first three years they employ a PCP. This is typically attributed to a change in productivity as physicians adapt to management changes or re-establish in new practice settings. Traditionally, hospitals stomached the six-figure loss for the long-term gain of influencing referrals back to the hospital and affiliated specialists, but experts say healthcare reform’s broader need for PCPs has further reduced hospitals’ concerns over initial monetary loss.

“Primary care in a value-based purchasing world should be measured on the ability to reduce costs and help population health,” says Barbara Ladon, managing partner of Denver-based Newpoint Healthcare Advisors. “I don’t think referrals are being ignored, but the difference is that a financial loss — that’s really not where [hospitals are] looking at this point. They’re looking at where the overall costs are in the system and how PCPs can manage the system to reduce those costs,” she says.

Because the PCP is at the core of the value-based purchasing model, they’re the link between hospital quality and the patient experience. Hospitals have to ask, “How do we engage them? How do we make sure they’re in the decision-making process and have a strategic voice in where the hospital is going?” says Carol J. Gefner, PhD, president of Newpoint Healthcare Advisors. “[It’s] a very different mindset from just trying to acquire PCPs to increase referrals.”

Learning from mistakes

That was the mindset a couple of decades ago, however. The 1990s are characterized as years of turmoil between hospitals and physician groups. With high expectations for managed care growth and HMOs, hospitals aggressively acquired PCPs to boost leverage for contract negotiations with payors. By the end of the decade, most hospitals had divested themselves of the practices due to financial losses. Those years left a bad taste in the mouths of hospital executives and physicians, exemplifying a history hospitals don’t want to repeat.

“Hospitals acquired physicians due to capitation, thinking acquisitions were the route to financial security,” says Clint MacKinney, MD, MS, assistant professor with the Department of Health Management and Policy at the University of Iowa. “Even though the concept of HMOs is exactly the right one, that is, health maintenance, the basic tenet was overshadowed in the 1990s by aggressive price negotiations with providers.”

Despite the evident lessons of the 1990s, relationships between hospitals and private practice physicians remain somewhat precarious. Private PCPs may be compelled to pursue hospital employment today for security, but they may remain wary of hospitals’ motives when it comes to integration efforts. A physician who recently authored an op-ed for the New York Times said a health system acquiring local practices feels “like Wal-Mart coming into town.” There is fear that corporate control could decimate the values of traditional primary care, and the idea of giving up autonomy and a time-honored private practice can leave physicians with notably low morale.

Each expert who contributed to this article overwhelmingly encouraged a common management strategy in PCP-alignment — physician participation in hospital governance and decision-making. Sturdy governance models let physicians retain the entrepreneurial spirit so many private practitioners value.

Max Reiboldt, president and CEO of Atlanta-based healthcare consulting firm Coker Group, says physician leadership was the missing key in the 1990s. “When hospitals failed in buying practices, one of the reasons is because they didn’t give physicians any real feel that it was a partnership. You have to give physicians the ability to govern and have a say in how the practice operates — not look down on them as, ‘You’re an employee; go do your job.’”

Mr. Easterling also said hospitals’ rush to out-maneuver competition resulted in incohesive acquisitions. “Neither party really knew how to support each other’s needs. Physicians were told by administrators to stay in their offices and see patients, while physicians would not relinquish any autonomy in their offices that badly needed sound business management.”

Open attitudes to out-of-the-box alignment models

Many PCPs are moving toward hospital employment — the highest level of hospital-physician integration — but this isn’t a uniform solution. Mr. Reiboldt suggests hospitals remain open to the numerous flavors of physician-alignment. He has seen some hospitals quickly rule out innovative alignment structures and attribute their resistance to concerns over the model’s legality.

Really, the model may be perfectly legal, but hospitals only want one type of model and are quick to dismiss anything else, he says. Physicians may be un eager to affiliate with a hospital that insists on one model, as this can spark lingering skepticism of what this affiliation is really about.

“Often, hospitals will lean on the crutch of compliance. Compliance and structuring things within regulatory guidelines is absolutely essential, but many times hospitals — before they even consider a structure that may be slightly different than their in-the-box structure — before they consider it, they’ll say it’s illegal,” says Mr. Reiboldt. “A lot of times it’s nothing but a smoke screen for the fact that they don’t want to do anything other than what they want. The hospitals that are amenable to at least considering these things while staying conservative — you don’t have to go right up to the edge — I think these are the ones to which medical groups are much more receptive.”

Employment isn’t taboo — in most PCP scenarios, it makes sense and is the most preferred option. But Mr. Reiboldt says hospitals should also be familiar with what he has coined “employment lite models.” This reflects a closely aligned hospital-physician relationship that falls just short of “W-2” employment.

These arrangements are formalized and structured through Professional Services Agreements and commonly fall into one of four types: global payment PSA, practice management arrangement, traditional PSA or a hybrid arrangement. Here’s a brief summary of what each of those
employment lite arrangements looks like if full-on employment isn’t the best strategy for a hospital or physicians.

- **Global payment PSA:** The hospital contracts with a physician practice for services in exchange for a global payment rate, which covers physician compensation, benefits and practice overhead costs. The practice, in turn, retains management responsibilities.

- **Practice management arrangement:** The hospital employs physicians, but the practice entity is maintained and still contracts with the hospital for management services. The practice’s administrative staff is not employed by the hospital, since these services are provided through another management contract, for which the practice receives a corresponding fee.

- **Traditional PSA:** The hospital contracts with physicians for professional services, but the hospital employs practice staff and “owns” the administrative structure.

- **Hybrid arrangement:** The hospital either employs or contracts with physicians, and the practice entity is structured into a management service organization or information service organization.

**Geographic placement of physicians**

Once a hospital decides which model makes most sense for them, it then needs to determine where to locate PCPs. Historically, hospitals have lacked a retail mindset, according to Mr. Easterling. “[Hospitals] operate with the belief that if they build it next to the hospital, the patients will come,” he says. This is opposite of the traditional retail mindsets, which suggest providers identify markets and strategically place services, like primary care offices, either where patients live or where they prefer to receive care.

Mr. Easterling says hospitals cannot continue this hospital-centric way of thinking and that the focus needs to be on what is convenient for the patient. “Whether a physician works from a hospital, remotely or from a physician office, it just needs to be simple for the patient,” says Mr. Easterling. “This is why the retail-based clinics, although a small subset, are garnering market share. They are easy to access and the pricing is clear.”

As healthcare delivery becomes more patient-centered, hospitals’ physician-alignment strategies are following suit. There’s increased emphasis on where people want to receive care, especially baby boomers, given their significant healthcare spending. A hospital that factors community feedback into its strategic decisions on a practice’s location can benefit through increased referrals and higher patient satisfaction scores. Yet, despite the long-term gains of collaborative decisions, the geographic placement of physicians can still cause tension in the hospital C-suite.

“The way to do this is to ask the community,” says Dr. MacKinney. “Ask the people you’re serving which care setting is most convenient and comfortable for them. But it’s not always that simple, and I’m going to argue that this may make hospital CEOs uncomfortable. Sometimes the best place to deliver care is not in the hospital,” he says.

Healthcare delivery is occurring in more non-traditional settings, such as clinics in churches, community centers and the home, as providers aim to fill gaps in the continuum of care and keep patients from growing so sick that they need to go to the hospital. It may be an uncomfortable finding for some hospital executives, particularly those who consider a hospital as the hub of community health. “History and tradition need to give way to new thinking,” says Dr. MacKinney. “CEOs often define themselves by [what they’ve brought to the hospital] — the new wing they purchased or how many PET scanners they bought. But that’s not the triple aim. It’s going to be hard when traditional egos or the traditional ways in which we value ourselves as leaders stand in the way of how we deliver care,” he says.

The availability of technology will have a huge affect on these decisions, but Ms. Ladon and Dr. Geffner also recommend hospital leaders keep an open mind and consider where PCPs may be most needed in a community. “One of the most important factors in determining which setting is optimal is the leadership’s ability, and the board’s ability, to really break with past-thinking,” says Dr. Geffner.

**Forces working with and against hospitals’ physician-alignment strategies**

Hospitals in certain markets may need to think in defensive terms when developing physician-integration strategies, especially for PCPs. The impending nationwide shortage paired with healthcare reform’s emphasis on the PCP has made them a desirable employee — not only for hospitals but large medical groups and health insurers. A 2011 survey based on 80 medical organizations found 74 percent planned to hire more or significantly more PCPs within the next year than they have in the past.

Payors are also making moves, either by employing PCPs directly or, in some states, not allowing any more PCPs in their panels. In September 2011, UnitedHealth Group announced its purchase of 2,300-physician Monarch Healthcare — the largest medical group in California’s Orange County. This was one of the most sizable acquisitions to date, but it reflects insurers’ growing interest in controlling costs and the providers who make healthcare decisions.

Despite these competitors, Mr. Easterling says there are far more forces working in favor of hospital-PCP alignment than any other time in history. Physicians are drawn to the access to capital to grow and expand, according to Mr. Easterling. They also want to partner with organizations that understand the shift to outcome-based reimbursement and are prepared for ACOs, bundled payments, patient-centered medical homes and other pilot programs. Robust health information technology is also another draw, as the installation of an electronic medical record can cost six figures and leave a severe dent in the bottom line of private practices.

“At no point in my career has my phone rung more from physician offices looking for a partner,” he says. “What’s more important is the size of the groups approaching hospitals or health systems. I am seeing the 25- to 50- to even 100-plus-physician groups approaching hospitals today. These were the groups that formed to build infrastructure and economies to ensure long-standing independence.”

Footnotes:


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One of the significant trends in healthcare over the past several years has been the steady increase in health system employment of physicians. In fact, for the first time more physician practices in the U.S. are hospital-owned than physician-owned. As may be expected, this phenomenon has been accelerated in some markets more than others, consistent with regional differences often observed in U.S. healthcare.

In those markets for which there are still a number of independent specialists, astute health systems are sharpening their strategic due diligence efforts to ensure their physician employment decisions are “investment grade.”

Employment driver balance
Industry observation suggests that physician employment has historically been largely driven by health system strategy. These strategies have generally coalesced around one of four general rationales:

- **Offensive.** To support volume growth initiatives through pursuit of “splitter” physicians, new services/sub-specialties and new geographies.
- **Defensive.** To protect existing referral sources from competing health systems targeting a hospital’s medical staff and service area.
- **Coverage.** To ensure specialist and sub-specialist availability that would be challenging to secure through other means.
- **Business model transformation.** To prepare for new models of clinical delivery and reimbursement by enhancing clinical coordination.

Lately, an increasing push for employment has come from physicians, driven by a fundamental shift in the underlying business model of their practices. Some of these key drivers include:

- **Changes in reimbursement.** Medicare’s sharp cuts in recent years, which are often followed by similar commercial payor actions, have hit specialists especially hard (e.g., cardiology and gastroenterology).
- **Increasing complexity and cost of operating a physician practice.** This includes increased regulations, impacts of healthcare reform, information technology costs and staffing needs.
- **Physician aging.** As the national physician age increases (today more than 45 percent of physicians are age 55+ compared to just 36.9 percent in 2000), established physicians increasingly seek income guarantees and exit strategies.
- **Next generation physician dynamics.** Many physicians recently out of residency seek the increased predictability that employment brings with respect to patient volumes, compensation and time commitments.

Tough questions, tough choices
The confluence of factors mentioned above has coincided with many health systems recently finding themselves inundated with competing requests from physician groups interested in exploratory employment discussions. Frequently, this involves several competing groups within a single specialty. In some cases, these overtures may represent an “about face” for physician groups that have historically stressed their desire around remaining independent to health system leaders.

The challenges these situations present to health system leaders include: expending significant management time and focus on evaluating these opportunities, responding to time sensitive opportunities (groups may be in simultaneous discussions with competing health systems) and assessing the financial impact of the additional employment and infrastructure costs on the budget. These issues require health systems to reflect upon a number of critical questions to ensure employment decisions are rational and defensible, which may include:

- Is this consistent with our strategic plan?
- How do we prioritize among competing physician opportunities?
- How do such decisions fit with our strategic service line efforts?
- What is the expected return on investment?
- Does capacity exist to realize the ROI?

- External: Market demand and referral patterns
- Internal: Physical capacity and infrastructure
- Are the physician groups “investment grade?”

In some cases, it becomes obvious that a system will not have the bandwidth or desire to employ all physician groups expressing interest. Inevitably, tough choices will have to be made knowing that some physicians may either continue to split cases or ultimately become employees.
of competitors. Therefore, it will benefit health system leadership to
develop a structured framework for setting direction and making some
high-level assessments prior to entering into negotiations. This can help
avoid some of the all-too-common employment rationale cited in retro-
spect, such as the “this was the first group to approach us” or “we had
a great initial meeting.”

It is important to not become stuck in “reactive mode,” or simply delegate
negotiations to a single hospital department or individual. Instead, these
decisions should involve executive leadership and present a clear link to the
organization’s strategic plan.

**Real world example of deploying a specialist employment “roadmap”**

Developing a strategic “roadmap” can aid health systems in proactively
assessing employment and alignment opportunities. As with any road-
map, it will have a starting point, destination and general direction. It does
not have to be, nor should it be, as detailed as “turn-by-turn” navigation.
Rather, it should be flexible enough to be adaptable to a range of future
scenarios that may arise.

Such a roadmap should involve the same thought and analytical rigor as
any organizational planning process, such as the five-year strategic plan, the
capital allocation process, or to draw parallel to another industry, a portfo-
lio manager’s investment decisions. (After all, a health system’s “physician portfolio” is often its greatest competitive asset.)

The remainder of this article illustrates such an approach for a hypotheti-
cal health system (“System”) in a large metro area with several competing
health systems. The figure below depicts the overall roadmap and some of
the obstacles the System may face.

This roadmap can be applied on a specialty-by-specialty basis. To illustrate
its applicability in practice, we explore each of its components in order and
in more detail. ³

**1. Physician manpower study.** The physician manpower study has
been the established starting point for physician strategy development. It
calculates physician full-time equivalent surpluses or deficits for each spe-
cialty within a hospital’s primary service area by subtracting the estimated
demand for physicians from the current or projected supply based on the
demographic characteristics of the PSA. (Generally, market-specific, actu-
arily-based projections are preferable to national physician-to-population
ratios, which can vary widely.)

In this example, the physician specialty exhibits a physician surplus today.
But given an expected reduction in physician supply due to retirements and
increasing demand from an aging population, a physician deficit is expected
within the five-year planning horizon.

This tool is helpful in setting the direction for a physician strategy roadmap
by identifying:

- The magnitude of projected physician surplus or deficits by specialty;
- Patient access considerations;
- Leverage that existing groups within each specialty may have based
on market supply and demand;
- Specialties for which succession planning may be more meaningful
than practice acquisition, given high average age of physicians; and
- The degree to which a market could absorb new physicians without
negatively impacting volumes of existing practices.

**2. Physician landscape assessment.** The physi-
cian landscape assessment is basically a taxonomy of
existing physician groups
in the market and basic in-
telligence on these prac-
tices. This information may
largely exist as a mental list
among key executives and
physician leaders, but health
systems increasingly find it
helpful to document and
continually update this in-
formation — especially in
larger, fluid markets.

This assessment generally
includes the following infor-
mation on each specialty and
practice:

- Physician group name, location, physician names and ages;
- Current affiliations, including employment, joint ventures, ACO par-
ticipation, etc.;
- General percent of volumes/practice time devoted to each health
system within the market (may involve quantitative data from state
market share reports, or qualitative market intelligence);
- Recent practice changes, additions, departures; and
- Summary of recent discussions the System has had with each group
(as applicable), and identification of System liaison.
The table above shows a sample summary. Where available, more detailed practice information, such as actual inpatient admissions or surgery/procedure volume, could be displayed in the boxes. In this example, it is worth noting that many employed groups still perform cases at competing systems. This is an illustration of local market nuances and the overall challenges presented by physician practice patterns, even in an employed model.

3. **Physician capacity calculation.** The physician capacity calculation can be used to assess the System’s level of physician support needed by applying market share targets by service line to the Physician Manpower Study results. This can help avoid over-extending employment offers beyond that which the market dictates.

The figure below shows that the hypothetical System’s required physician support (at 100 percent loyalty) for a given specialty is 15.5 FTEs today and 19.0 five years from now, based on demographic growth and market share targets. With nine employed currently, the System’s maximum additional physician capacity under current circumstances is 6.5 new physicians today and 10.0 within the five-year window. Therefore, given the landscape of “in play” physicians in the market, the system could employ either a) the largest group of eight, b) two of the groups of five or c) one group of five and several smaller groups, as long as the total did not exceed 10.0 newly employed physician FTEs.

Employing physicians beyond the future capacity of 10.0 would create the risk of over-extending resources. In theory, incremental employment beyond this threshold could in turn increase future market share, thus justifying additional employment. However, caution should be exercised in readjusting market share targets to justify employment given that:

- Physician capacity is only one determinant of volume;
- Return on investment of additional recruitment may be subject to the law of diminishing returns;
- Additional physical capacity may be required (e.g., ORs, cath labs) to realize benefits of additional employment;
- Limited capital may exist for employment and related infrastructure, and must be assessed vis-à-vis needs in other service lines;
- Addition of multiple groups could be challenging from operational, cultural and service line leadership perspectives;
- Competing systems’ existing primary care base/referral patterns and patient hospital preferences could limit the effect of realigning their specialist groups; and
• Competing systems may recruit new physicians to the market to retain share, thus shifting the underlying community need and landscape.

4. Physician group prioritization tool. The physician group prioritization tool provides an analytical framework with which to evaluate competing employment opportunities among multiple physician groups within a single specialty. It can be applied to all physician groups within a specialty (regardless of current practice patterns or employment status).

Such a tool may involve scoring groups along several quantitative and qualitative dimensions. Calculating a “composite score” may be helpful in terms of ranking groups for employment, but should be used more to stimulate discussion, rather than make definitive decisions.

In the example below, physician groups were evaluated with respect to the following:

• **Size/market presence.** Should be calibrated with respect to each unique specialty.

• **Practice location.** In some instances, proximity to competitors may be more, rather than less, advantageous to capturing new volume.

• **Volume opportunity.** A high number of cases currently performed outside the system will indicate greater volume opportunity.

• **Dependence on competitor PCP base.** Full realization of employment may not be captured if a specialist group’s cases rely heavily on a competitor-employed PCP base.

• **Quality reputation.** Measurements may include outcomes at System hospitals, patient satisfaction, use of best practices, electronic health records, etc.; a rating of “fair” or “poor” may be a deal-breaker.

• **Shared vision/Cultural alignment.** May be most difficult to measure but consider historical participation in System committees/initiatives/leadership roles.

5. Specialist employment decision tree. The specialist employment decision tree puts the aforementioned tools into action. It can be applied on a specialty-by-specialty basis, starting with the highest priority physician group in each specialty. The decision tree is intended to be applied only after developing the tools described above.

The top branch is designed to require physician employment decisions to pass two critical hurdles: 1) group size vs. System capacity for employment, and 2) a group’s “investment worthiness.” The lower branch comes into play for defensive situations in which employment capacity may not exist within existing parameters, but an employment offer from a competitor may threaten the System’s service line sustainability.

In carrying forward our example, we would start with the five-physician Group E, since it had the highest score of 4.2. Given that we calculated the upper capacity limit for additional employed physicians at 10.0 within the planning period, it makes sense to explore employment with that group first. Assuming successful employment negotiations, the new capacity would be 5.0 (10.0 capacity minus the 5.0 new Group E FTEs that will be employed). The next logical group would be the five-physician Group F, since there appears not to be enough capacity to realistically employ eight-physician Group D, and Group F scores the highest among remaining groups of five physicians or fewer.

This process does not necessarily preclude entering into employment discussions with multiple groups at the same time, but rather it demonstrates likely trade-offs and downstream effects of employing one group over another. In essence, a system’s employment action inherently alters the physician landscape in the market, and thus alters future employment options.
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6. Employment vs. alignment alternatives. Not every physician group evaluated with these tools will pass the hurdles for employment. Yet, the evaluation and discussion process may lead to alternatives to employment that could enhance the symbiotic relationship between a health system and a physician group. While many markets are seeing full employment relationships outpacing other alignment vehicles, a number of alternatives, as shown in Figure 7, appear to remain popular in many markets.

Concluding thoughts
Once intent to employ a particular group has been established, there are a number of activities that should be conducted, including but not limited to:

- Strategic and operational due diligence;
- Financial due diligence;
- Negotiation of terms, including employment terms, purchased goodwill (if any), assets included, continued employment of staff, non-competes, etc.; and
- Expectations around clinical practice, best practices, protocols and clinical IT utilization.

For many organizations, past employment decisions have been based on personal relationships and a “gut feel.” The roadmap is a guided, disciplined approach (or “gut check”) to assess physician alignment decisions within the greater context of the market and the health system’s unique characteristics.

Ryan E. Ross is a Director at FTI Consulting in the Healthcare Strategy & Planning practice. He can be reached at ryan.ross@fticonsulting.com or (317) 846-8486.

Footnotes:
2 The Massachusetts Medical Society 2011 Physician Practice Environment Report, Table 5
3 The numerical values are for illustrative purposes only, rather than actual data.
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Pre Conference – Thursday, June 14, 2012
11:30am – 1:00pm Registration
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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 15, 2012
7:00am – 8:00am Continental Breakfast and Registration
8:00am – 5:20pm Main conference, Including Lunch and Exhibit Hall Breaks
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Conference – Saturday, June 16, 2012
7:00am – 8:00am Continental Breakfast and Registration
8:10am – 12:30pm Conference

Thursday, June 14, 2012

Track A  Improving Profits, Valuation and Transaction Issues
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, Ambulatory Surgical Centers of America

1:45 – 2:15 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

2:20 – 2:50 pm Utilizing Spine Cases to Improve the Profitability of Underutilized Poorly Performing ASCs
Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners,

2:55 – 3:25 pm 7 Keys to Make Orthopedic and Pain-Driven ASCs More Profitable
Larry Taylor, President & CEO, Practice Partners in Healthcare, Inc.

3:30 – 4:00 pm An Integrated Approach to Introducing Direct to Consumer Marketing to Your Practice
How it Can Deliver Superior Financial Results - Jimmy St. Louis, CEO, Advanced Healthcare Partners

Jen Johnson, CFA, Managing Director, VMG Health

4:40 – 5:40 pm – KEYNOTE Leadership and Management in 2012
Lou Holtz, Legendary Football Coach and Analyst, ESPN
1:45 – 2:15 pm  
**Track E – Business and Profitability Issues; Revenue Cycle; Managed Care Billing, Coding and Contracting for ASCs**  
1:00 – 1:40 pm  
**Selling Your ASC; What Price Can You Expect; What Are The Deal Terms?**  
Blayne Rush, MHP, MBA, President, Ambulatory Alliances, Patrick J. Simers, EVP, Principle Valuation, LLC, Thomas J. Charillo, SVP Corporate Development, Surgery Partners, Matt Searles, Managing Director, Merritt Healthcare, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP  

1:45 – 2:15 pm  
**Keys to Transforming Surgery Centers into a Profitable Business**  
Tom Terrien, CEO, TRY Healthcare Solutions, Jimbo Cross, VP Acquisitions & Development, Ambulatory Surgical Centers of America, Jeff Peo, VP Acquisitions & Development, Ambulatory Surgical Centers of America, moderated by Barton C. Walker, Associate, McGuireWoods LLP  

2:05 – 2:35 pm  
**How to Smartly Use Technology to Become More Efficient in Operations**  
Scott McDade, Vice President, Surgery Centers, McKesson Medical  

2:55 – 3:25 pm  
**A Step by Step Plan for Selling Your ASC – How to Maximize the Price, Terms and Results and How to Handle the Process**  
Laker Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America, Introduced by Amber McGraw Walsh, Partner, McGuireWoods LLP  

3:30 – 4:00 pm  
**The Key Legislative Priorities of the ASC Industry**  
William Premence, JD, Executive Director, ASC Association  

4:05 – 4:35 pm  
**Physician Owned Hospitals - Adding Ancillaries, Reducing Costs and Legal Compliance**  
Terry L. Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital, Michael Weaver, Vice President, Symbion, Inc., Amber McGraw Walsh, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP  

2:20 – 2:50 pm  
**Most Common Accreditation Problems in Orthopedic, Spine and Pain-Driven ASCs**  
Nancy Jo Vinson, RN, RBA, CASC, Principal, NJM Consulting, Nurse Surveyor, AAAHC, Accreditation Association for Ambulatory Health Care  

2:55 – 3:25 pm  
**Infection Control in ASCs – 10 Best Key Practices**  
Jean Day, RN, CNOR, Director of Clinical Operations, Pinnacle III  

3:30 – 4:00 pm  
**10 Great Ideas for QI Studies**  
Mary Sturm, SVP of Clinical Operations, Surgical Management Professionals  

4:05 – 4:35 pm  
**TBD**
Track A

11:40 – 12:20 pm
Orthopedics Hospital Joint Ventures, Bundled Payments, 16,000 Cases and Are There Lessons That Can Be Applied to Other Facilities and Systems
James T. Caillo Ket, MD, Surgeon In Chief, Hoag Orthopedic Institute

12:25 – 1:05 pm
Developing a Spine-Driven ASC: The Essentials for Success
Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

Track B

11:40 – 12:20 pm
Key Concepts to Improve the Profitability and Outcomes of Spine Programs
Kenneth Pettine, MD, Loveland Surgery Center, Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Larry Teuber, MD, President, Medical Facilities Corp., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:25 – 1:05 pm
Spine Surgery: The Next 5 Years
David Abraham, MD, Reading Neck and Spine Center, Bob Reznik, MBA, President, Prizm Development, Inc., David Rothbart, MD, FACS, FACP, Medical Director, Spine Team Texas, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track C

11:40 – 12:20 pm
The Best Ideas for Improving the Profits of Pain Management-Driven ASC Centers
Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago, Girish Juneja, MD, West Michigan Pain, Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

12:25 – 1:05 pm
The Important of Measuring Clinical Outcomes for Pain Management
Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

Track D

11:40 – 12:20 pm
The Best Ideas for Orthopedics Now

12:25 – 1:05 pm
Strategies for Transitioning from Out of Network to a Contracted ASC Model
Greg Horner, MD, Managing Partner, Smithfield Surgical Partners, LLC

Track E

11:40 – 1:05 pm
An 80 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits
Robert Wintergard, CPA, CFO, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, Ambulatory Surgical Centers of America

3:10 – 3:45 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

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm
Intraoperative Monitoring for Spine Cases in the ASC Setting “Understanding the Technology and What a Surgery Center Should and Should Not Pay For
Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, President/CEO, Alpha Diagnostics, Intraoperative Neurophysiologic Monitoring Board of Directors, Spalding Surgery Center, Board of Directors, American Board of Neurophysiologic Monitoring

4:50 – 5:20 pm
Minimally Invasive Outpatient Lumbar Fusions – A Study on Clinical Outcomes in the ASC
Alan Villaviciencia, MD, Boulder Neurological & Spine Associates, LLC

Track F

11:40 – 12:20 pm
Physician Engagement and ICD-10: The Role of the Physician in a Succession Transition
Christy A. May, MS, RHIA, and Kathy Lindstrom, RHIT, ProVation Medical

12:25 – 1:05 pm
Comparing the Reimbursement of Spine Procedures; ASCs vs. Hospitals
Richard N. W. Woehn, MD, JD, MBA, South Sound Neurosurgery, PLLC

1:05 – 1:50 PM – Networking Lunch & Exhibits

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

Track A – Improving Profits, Valuation and Transaction Issues
1:50 – 2:30 pm
Physician Hospital Alignment and Business Relationships
Allan Fine, EVP & Chief Strategy and Operations Officer, The New York Eye and Ear Infirmary, Charles “Chuck” Peck, CEO, Health Inventures, and Carole Guinane, Novant Health Ambulatory Care, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

2:35 – 3:05 pm
Assessing the Profitability of Orthopedics and Spine Cases
Andrea Woodell, Managed Care Manager and Matt Lau, Director of Financial Analysis, Regent Surgical Health

3:10 – 3:45 pm
How to Maintain Practice Independence While Effectively Partnering with Hospitals
Charles “Chuck” Peck, CEO, and Christian Ellison, Vice President, Health Inventures, LLC

3:45 – 4:15 pm - Networking Break & Exhibits

4:15 – 4:45 pm
The Best Ideas for Handling Out of Network Patients
Edward Hetrick, President & CEO, Facility Development & Management, moderated by Melissa Seabed, Partner, McGuireWoods LLP

4:50 – 5:20 pm
What Should Great Medical Directors, Administrators, and DONs be Paid?
Greg Zoch, Partner and Managing Director, Kaye/Bassman International Corp., Christopher Collins, RN, BSHCS, Administrator, Metropolitan Surgery Center, moderated by Rachel Fields, Editor In Chief, Becker’s ASC Review

4:50 – 5:20 pm
Pain Management – Is In-Office Pain Management or Outpatient Pain Management the Better Option?
Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

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Saturday, June 16, 2012

7:00 – 8:10 am – Continental Breakfast

Track A

8:10 – 8:50 am
Orthopedic, Spine and Pain Management Practices and ASCs – 6 Defining Issues
Michael Redler, MD, The OSM Center. Richard N.W. Wohns, MD, JD, MBA, South Sound Neurosurgery, PLLC, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

8:55 – 9:30 am
Cervical Myelopathy
Fernando Techy, MD, Adult & Pediatric Spine Surgery, Lutheran General Hospital, UIC Chicago

9:35 – 10:10 am
Building a More Robust Case for Spinal Surgery
Stephen Rothenberg, JD, Consultant, Numerof & Associates, Inc.

10:15 – 10:50 am
Healthcare False Claims and Anti-Trust Litigation
Jeffrey C. Clark, Partner, and David J. Pivnick, Associate, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

10:55 – 11:30 am
The Business of Spine Reimbursement and Coding Changes
Barbara Catalotto, MBA, CPE, CEO, Business Dynamics, Ltd.

Track B

8:10 – 8:50 am
Information Technology for Surgery Centers – Achieving Positive Outcome and Avoiding Complications
Michael Rauh, MD, UB, Orthopaedics and Sports Medicine, Marion Jenkins, PhD, Founder & CEO, QSE Technologies, Inc., moderated by Holly Carnell, Associate, McGuireWoods LLP

8:55 – 9:30 am
10 Key Concepts from Top Performing Pain Management Programs
Amy Mowles, President & CEO, Mowles Practice Management

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Baptist Health South Florida (Coral Gables)
Type of Facility: Hospital/health system

What makes it a Great 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. Each year, Baptist Health’s Scholars Program provides more than 200 nursing scholarships to qualified employees.

Barnabas Health (West Orange, N.J.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Barnabas Health is the largest non-profit integrated healthcare delivery system in New Jersey. Employee tenure is a good indication of the strength of Barnabas’ workplace: 55 percent of Barnabas employees have worked with the system for 10 years or more, 31 percent have 10-20 years of tenure and 24 percent have more than 20 years of service. The health system relies heavily on employee referrals as a hiring resource, hiring 25 percent of new employees directly from employee referrals and paying over $350,000 historically to employees for their referrals.

Barnes-Jewish Hospital (St. Louis)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Barnes-Jewish Hospital, a member of the BJC HealthCare system, is one of the largest employers in St. Louis. 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 Health System (Tampa Bay, Fla.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Composed of 10 non-profit hospitals and 70 outpatient facilities, BayCare Health System is a leading community-based health system in the Tampa Bay area. 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. Employees can foster relationships with each other through holiday celebrations, team-building activities, fundraisers, wellness events and family picnics.

BayCare Health 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. Among its more creative benefits, Baylor offers adoption assistance, an employee trust fund and discounted cell phone contracts. The system also owns a gym in downtown Dallas, where employees can go to exercise and work with trainers for free.

Beaumont Hospitals (Royal Oak, Mich.)
Type of Facility: Hospital/health system

What makes it a Great 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 $2,120 a year for full-time employees. Beaumont stands behind its belief that “a healthy work place starts with healthy people.” myOptimal Health Onsite provides health education, recreational programs and health resources to system employees, and a variety of fitness facilities are available at discounted rates.

Beebe Medical Center (Lewes, Del.)
Type of facility: Specialty clinic

What makes it a Great Place to Work: BayCare Clinic is the largest specialty healthcare clinic in Northeast Wisconsin and Michigan’s Upper Peninsula. According to its leadership, BayCare is well on its way to meeting its stated goal of being “the most fit company in Brown County.” Upon the inception of the clinic’s Healthy Lifestyles Premium Discount Program, 21 percent of participants tested at an “excellent” level of body composition and fitness; one year later, the number jumped to 58 percent, with obesity dropping dramatically.

Berkshire Medical Center (Pittsfield, Mass.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Part of the Berkshire Health System, Berkshire Medical Center, a 302-bed community hospital in Pittsfield, Mass., is a teaching facility affiliated with the University of Massachusetts Medical School. Staff are deeply involved in hospital projects, including the development and construction of a 30,000-square-foot, eight-OR ambulatory surgery center. 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.

Brigham and Women’s Hospital (Boston)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: The 777-bed Brigham and Women’s Hospital 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 fully equipped fitness centers 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.

Carolina Medical Center (Charlotte, N.C.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Carolinas HealthCare System prides itself on diversity and inclusion, a goal demonstrated by its reception of the 2010 Belk Innovation in Diversity Award from the Charlotte Chamber. The hospital’s eXtras Program also provides listings of discounts and incentives available through various area merchants. Carolinas Medical Center provides up to $2,000 in relocation assistance for nursing and allied health professionals.

Cedars-Sinai Medical Center (Los Angeles)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: 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. 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 Great 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. Discounts at Centegra abound: 25 percent off in the cafeteria, 10 percent off in the gift shop, discounts to the Health Bridge fitness center and discounts to hospital services for staff members and their families. The system’s wellness program has introduced a $20 incentive for health risk assessments.

Central Park ENT & Surgery Center
(Arlington, Texas)
Type of facility: Physician practice and ambulatory surgery center
What makes it a Great Place to Work: Central Park ENT & Surgery Center aims to provide its employees with a series of robust benefits, including medical and vision insurance policies for which the center pays 100 percent. The center encourages employee unity through various annual events, including cook-outs where the CEO barbecues, a holiday party where physicians and staff play a laser tag, sporting events, a Halloween costume competition and plenty of birthday and potlucks.

Children’s Healthcare of Atlanta
(Atlanta, Ga.)
Type of facility: Hospital/health system
What makes it a Great Place to Work: Children’s Healthcare of Atlanta is a three-hospital system that specializes in children and teens. Children’s offers several conveniences for employees, including Sittercity — an online database of 3,000 baby, pet and house sitters as well as nannies in metro Atlanta — and tuition discounts for certain childcare centers. The health system also provides concierge services to aid employees in making personal travel reservations, gift and flower orders and dining and entertainment plans.

Children’s Medical Center Dallas (Dallas)
Type of facility: Hospital/health system
What makes it a Great Place to Work: One of the largest pediatric healthcare providers in the nation, Children’s Medical Center is a private, non-profit healthcare facility that serves as the primary pediatric teaching facility for The University of Texas Southwestern Medical Center at Dallas. In addition to a robust health insurance plan, Children’s employees receive a 50 percent discount on outpatient services and a 25 percent discount on inpatient services their children receive at the hospital. The hospital’s wellness program includes tobacco cessation coaching, a healthy pregnancy program, a $10 monthly fitness incentive and Weight Watchers meetings at work.

Children’s Memorial Hospital (Chicago)
Type of facility: Hospital/health system
What makes it a Great 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. Children’s Memorial excelled in its areas of back-up family care, its on-site MBA program and its overall benefits program. 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.

Christiana Care Health System
(Wilmington, Del.)
Type of facility: Hospital/health system
What makes it a Great Place to Work: With more than 10,400 employees, Christiana Care is the largest private employer in Delaware and the 10th largest in the Philadelphia region. Employees can also take advantage of wellness program reimbursement, which gives up to $100 per calendar year for paid athletic or wellness activities. The health system provides an on-site childcare center at Christiana Hospital, on-site financial seminars and assistance for retirement planning, fitness trails, therapeutic massage and an on-site fitness center to assist in healthy living goals.

Cleveland Clinic (Ohio)
Type of Facility: Hospital/health system
What makes it a Great Place to Work: Cleveland Clinic offers free memberships 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.

Cullman Outpatient Surgery Center
(Alabama)
Type of facility: Ambulatory surgery center
What makes it a Great Place to Work: Cullman Outpatient Surgery Center annually provides outstanding care to over 5,000 patients while ensuring superior patient, staff member and physician partner satisfaction. A servant leadership culture positively impacts the surgery center’s 33 teammates, and competitive benefits are provided through association with the center’s parent company, Surgical Care Affiliates. Cullen Outpatient Surgery’s themed celebrations and competitions, such as line dancing, consistently engage teammates.

Deaconess Health System
(Evansville, Ind.)
Type of Facility: Hospital/health system
What makes it a Great 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. 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.

Doctors Hospital of Sarasota (Florida)
Type of Facility: Hospital/health system
What makes it a Great Place to Work: Doctors Hospital of Sarasota, part of HCAs West Florida division, is a 155-bed acute and general care facility. The hospital provides the HCA Hope Fund, a non-profit organization run by employees for employees who are in need of financial assistance due to a disaster or personal crisis. Employees are also recognized for their valuable ideas through the HCA Innovators Award.

Ephrata Community Hospital
(Pennsylvania)
Type of facility: Hospital/health system
What makes it a Great 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 employees through the ECH Wellness Center and Center for Women’s Health, including CPR training, diabetes programs, smoking cessation assistance, nutrition consultations, 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 Eye Surgery Center of Michigan
(Troy, Mich.)
Type of facility: Ambulatory surgery center
What makes it a Great 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.
Fremont Surgical Center (Fremont, Neb.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Fremont Surgical Center sees an average of 3,800 cases annually with specialties including gastroenterology, pulmonology, orthopedics, pain management, ophthalmology and dental. 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 more traditional benefits, including health, dental and life insurance and 401(k).

Harborside Surgery Center (Punta Gorda, Fla.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Harborside Surgery Center is a triangular joint venture between Interventional Management Services and the local HMA hospital Charlotte Regional Medical Center. The ASC experiences very little turnover and some personnel have worked there more than 15 years. Staff members are rewarded for their efforts, with a comprehensive benefits package that includes health insurance, 401k, group life insurance and long-term disability insurance.

Henrico Doctors’ Hospital (Richmond, Va.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: This 767-bed acute care hospital, part of the HCA Virginia Health System, has three campuses offering state-of-the-art medical technology in a community hospital setting. 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 on-site childcare center for hospital employees that promotes a literacy-based curriculum.

Geisinger Health System (Danville, Pa.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: A physician-led system founded in 1915, Geisinger Health System provides service spanning 43 counties of 20,000 square miles to 2.6 million people. 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 of $200.

Golden Triangle SurgiCenter (Murrieta, Calif.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Golden Triangle is a free-standing surgery center managed by Surgical Care Affiliates. Although the center staffs fewer than 35 people, the sense of community and loyalty is evident in the lack of employee turnover: Many staff members have spent more than seven years in their positions. This year, the center began recognizing all teammates with a week-long appreciation celebration, calling out the pre-op/PACU nurses, surgical techs and administrative assistants separately throughout the year.

Hackensack University Medical Center (New Jersey)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Hackensack UMC is a private, non-profit academic medical center that serves the Northern New Jersey and New York City metropolitan areas and employs nearly 8,000 people. According to the hospital, being a best place to work is apparent in its turnover rate: the hospital’s voluntary turnover rate as of Dec. 31, 2011, was 5.56 percent. The hospital’s Colleague-to-Colleague Fund was established to help employees in need; the money for financially needy employees is donated by other staff members, and all employees are eligible to receive assistance from the fund.

Hancock Regional Hospital (Greenfield, Ind.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Employees at Hancock Regional Hospital are incented 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. The hospital-owned wellness center is available for employees for $10 a month, and once an employee visits the center 100 times, they are reimbursed half the membership fee.

High Plains Surgery Center (Lubbock, Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: High Plains Surgery Center features a center designed collaboratively by physicians and staff members. Employee satisfaction is so highly regarded at High Plains that employee turnover at High Plains Surgery Center has been less than 2 percent annually. Employees enjoy benefits including health, dental and vision benefits, life insurance, retirement benefits and a daily lunch provided by the center.

Houston Northwest Medical Center (Houston, Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: A 340-bed hospital and member of Tenet Health, Houston Northwest Medical Center was named one of Achiever's 50 Most Engaged Workplaces in the United States in 2011, the only hospital in Texas to earn the designation. HNMC has the highest level of participation in the Tenet wellness program of Tenet's 50 facilities. The program includes personal health coaching, chronic condition management and prevention and regular “lunch and learn” seminars on stress, work/life balance and personal life.

Indiana (Penn.) Regional Medical Center
Type of facility: Hospital/health system

What makes it a Great Place to Work: Indiana Regional Medical Center opened to the public in 1914 as a 40-bed facility with 13 private rooms. IRMC has been named one of the top five places to work in Pennsylvania by the Best Places to Work in PA program for five years in a row. 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.

Iowa Health System (Des Moines)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Iowa Health System employs the state’s largest non-profit workforce, with nearly 20,000 workers. Employees and physicians have the opportunity to develop skills through the system’s Management Leadership Academy and Physician Leadership Academy, upon completion of the latter, graduated 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.

IU Health Goshen (Ind.) Hospital
Type of facility: Hospital/health system

What makes it a Great Place to Work: IU Health Goshen Hospital is a non-profit community hospital with more than 900 employees. In addition to traditional benefits, IU Health Goshen Hospital offers free annual memberships to the Goshen College Gingerich Recreation-Fitness Center, a child care voucher program to help colleagues pay for child care and an employee assistance program that offers free counseling services.
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Jacksonville Medical Center (Jacksonville, Ala.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Jacksonville Medical Center is an 89-bed full-service hospital. Employees receive a comprehensive and competitive compensation and benefits package, healthcare insurance, paid vacation and a friendly, supportive work environment. Additionally, Jacksonville Medical Center is dedicated to enhancing the professional and personal knowledge and skills of its employees so professional development is strongly encouraged through ongoing education and training.

Jersey City Medical Center (Jersey City, N.J.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Jersey City Medical Center prides itself in its recent improvements in employee satisfaction — moving from “worst to first” in just four years, according to human resources vice president Mary Cataudella. Every employee and candidate signs a Values Commitment Contract, agreeing to abide by the organization’s mission and values. To further these values, CEO Joseph Scott communicates with all staff weekly via his “letter from the CEO,” emailed to all employees and board members on Friday afternoons.

Lakewood Health System (Staples, Minn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Lakewood Health System has achieved significant increase in employee engagement scores — from 36 percent to 72 percent — in just four years. The health system has implemented initiatives such as quarterly employee forums, organizational excellence training sessions, employee feedback surveys for each department and an extensive employee recognition structure.

Lehigh Valley Health Network (Allentown, Pa.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Lehigh Valley Health Network is a non-profit community health system. As the largest employer in the Lehigh Valley, it has more than 9,500 employees and 1,100 physicians, 400 of whom are employed. Forty percent of all new hires come from employee referrals — a sign that LVHN employees enjoy where they work. The health system offers employees and their dependents $700 to use for wellness programs, such as exercise and fitness programs or massage therapy, at their discretion.

LifeBridge Health (Baltimore)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Two-hospital system LifeBridge Health recognizes employees through various programs, including LB points that reward employees for performance and can be redeemed for merchandise, travel and gift cards; employee appreciation days that highlight specific roles; and cash rewards for referring a hired candidate. Employees can also receive up to $5,000 annual reimbursement for higher education courses.

Lovelace Women’s Hospital (Albuquerque, N.M.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: Lovelace Women’s Hospital is New Mexico’s first and only hospital dedicated to women’s health. The 736 employees enjoy a dynamic, quality-focused work environment. Employees also enjoy flexible benefit options, flexible spending accounts and tuition reimbursement. Some positions are eligible for sign-on bonuses, employees receive reimbursement for referring other employees, and returning alumni receive special incentives.

Lowell General Hospital (Massachusetts)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Lowell General 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. Along with its focus on employee health, Lowell General has a structured and balanced governance system with a focus on nursing representation.

Massachusetts General Hospital (Boston)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Massachusetts General Hospital, part of Partners HealthCare, is a non-profit, 907-bed hospital that celebrated its bicentennial in 2011. The hospital offers several professional development opportunities through its Training and Workforce Development office, including English classes for non-native English speakers; human resources courses on conflict communication and other skills; the MGH Leadership Academy for the hospital’s managers; medical terminology classes; and Spanish language classes.

Mayo Clinic (Rochester, Minn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Mayo Clinic is a non-profit health system that has more than 49,000 administrative and allied health staff. In 2012, Mayo was named among the “100 Best Companies to Work For” by Fortune magazine for the ninth consecutive year. Mayo offers several lifestyle benefits to its employees, including discounts for movie passes, special attractions, events and travel; cooking demonstrations; and an annual Heritage Day celebrating Mayo Clinic.

McBride Orthopedic Hospital (Oklahoma City)
Type of facility: Hospital/health system

What makes it a Great Place to Work: McBride Orthopedic Hospital was founded on the philosophy of Earl D. McBride, MD, who said, “Whatever you do, do something for mankind.” High-performing employees are eligible to win financial rewards from $250 to $500, accompanied by a letter from the CEO, and an annual Employee Appreciation Week celebrates staff members’ hard work with trivia contests, hourly giveaways and catered meals.

Medical Center of Lewisville (Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Medical Center of Lewisville pursues a philosophy of “shared governance,” meaning employees have the opportunity to share their opinions in professional practice councils and committees. On-site programs include an employee wellness room, exercise equipment, weight loss programs, monthly on-site massage, an employee lactation room and free flu shots. Employees can also participate in a tuition reimbursement program, as well as an on-site “Grow Your Own” program that assists employees wishing to enter to nursing field.

The Medical Center of Plano (Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: The Medical Center of Plano is a 427-bed acute-care facility with more than 1,300 employees and over 1,000 physicians, serving more than 70 specialties and subspecialties. Employee benefits include financial assistance for any formal job-related education, including up to $5,250 per year for full-time employees and up to $2,625 per year for those working part time and unlimited access to online continuing education courses through Nursing Spectrum and Texas Tech University Health Science Center.
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Melbourne Surgery Center (Florida)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Melbourne Surgery Center, which features four operating rooms and a procedure room, serves the Central Florida Brevard County communities. The center emphasizes a family-oriented environment with its physicians and staff members, which Wanda Coulter, RN, director of nursing, says is a refreshing approach to operating a surgery center. Melbourne Surgery Center has a formal process that allows physicians and staff members to freely come forward to share and implement ideas for improvement.

Memorial Healthcare System (Hollywood, Fla.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Memorial Healthcare System is currently the fifth-largest public healthcare system in the nation, employing 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.

The Memorial Hospital at Craig (Colorado)
Type of facility: Hospital/health system

What makes it a Great Place to Work: The Memorial Hospital at Craig is a 25-bed, critical access hospital that employs 200 staff members and nine physicians. The hospital recently began a working relationship with the Studer Group in order to bring “focused attention to hardwiring behavioral change to make healthcare better,” according to Chief of Organizational Excellence Jennifer Riley. The hospital holds an annual employee barbecue, quarterly cook-offs, pancake breakfasts served by administration during Hospital Week and an annual party at a local establishment.

Methodist Health System (Dallas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Methodist Health System in Dallas was selected through an employee survey in 2011 as a “Best Place to Work” in the Dallas Business Journal for the eighth consecutive year. Employee unity is apparent in the health system’s “30 Minute Club,” which was established in 2005 to support the welfare of Methodist patient and employees by collecting employee donations. In fiscal year 2011, the fund provided over $100,000 to Methodist employees in short-term financial crisis.

Missoula Bone and Joint Surgery Center (Montana)
Type of facility: Physician medical practice and ambulatory surgery center

What makes it a Great Place to Work: Missoula Bone and Joint Surgery Center believes its employees are the “cornerstone of our services,” according to CEO Sami Spencer, CMPE, CMM. The workplace pays 100 percent of health insurance costs for its employees and provides up to $250 per month towards family health insurance benefits. Most positions at the center offer a flexible schedule, with over 60 percent of Missoula Bone and Joint Surgery Center employees working less than 40 hours per week.

Nanticoke Health Services (Seaford, Del.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: With 1,000 employees serving across three entities, Nanticoke Health Services strives for every employee to embody the values in its booklet Standards of Performance. In 2012, Nanticoke Health Services implemented several programs to boost employee satisfaction and retention, including the Employee of the Month Program and a “Hidden Treasures” program that recognizes “behind the scenes” employees.

Nebraska Orthopaedic Hospital (Omaha)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Opened in April 2004, Nebraska Orthopaedic Hospital is the region’s first hospital dedicated to the care and treatment of orthopedic patients. With 400 employees, Nebraska Orthopaedic Hospital has maintained a low employee turnover rate — less than 2 percent — year over year. On a quarterly basis, CEO Tom Macy conducts face-to-face “all staff” meetings, giving staff members a chance to ask questions and interact directly with their CEO.

Neosho Memorial Regional Medical Center (Chanute, Kan.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: One of the largest employers in southeast Kansas, Neosho Memorial Regional Medical Center is a clinical training site for six allied health schools, including a physician’s family medicine program. Neosha Memorial employees receive numerous benefits, including access to free vaccinations, meal discounts, continuing education, a fitness center membership and scholarships for children entering college.

North Coast Surgery Center (Oceanside, Calif.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: The ‘teammates’ at North Coast Surgery Center are part of the Surgical Care Affiliates family, a privately-held company of 100+ surgery centers throughout the United States. Most teammates are full-time with benefits, but other options are available — from one to four days per week. Staff members enjoy a predictable home life with a...
Monday-Friday schedule with weekends and holidays off, and the center provides free breakfast and lunch to each staff member every day.

North Shore-LIJ Health System (Great Neck, N.Y.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: The North Shore-LIJ Health System is the nation’s second largest non-profit, secular health system, with more than 43,000 employees across 15 hospitals. The health system has several programs in place designed to identify, develop, and fast track its top performers and recently launched a wellness program that offers Zumba, yoga, guided imagery, meditation, nutrition and walking classes to employees.

NorthShore University HealthSystem (Evanston, Ill.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: NorthShore University HealthSystem is an integrated health system with approximately 9,000 employees and 2,400 affiliated physicians. NorthShore strives to help its employees achieve a comfortable work/life balance, providing weekly Weight Watchers meetings at many locations and offering “alternative work arrangement” options, such as a compressed work week or a weekend work program for RNs. The health system also partners with PerkSpot to bring employees a one-stop shop for hundreds of online discounts.

Northwest Michigan Surgery Center (Traverse City)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Developed by local physicians and a partnership with Munson Medical Center in 2004, Northwest Michigan Surgery Center staffs 120 employees and cares for over 17,900 patients. Staff members receive up to 208 paid time off hours and local discounts, including 25 percent off AT&T and discounts to dry cleaning and massages. Employees can be reimbursed for pursuing an active lifestyle through gym membership, yoga classes and other paid athletic activities.

OhioHealth (Columbus)
Type of facility: Hospital/health system

What makes it a Great Place to Work: OhioHealth is a non-profit health system that includes 18 hospitals and 21,000 associates, physicians and volunteers. One unique benefit OhioHealth offers its employees is the OhioHealth Research and Innovation Institute, which was created in 2006 and helps make clinicians’ and employees’ ideas become a reality. In the past few years, 75 physicians, nurses and employees have introduced more than 130 new product ideas to the program. These ideas resulted in 11 new companies and seven products in clinical use.

OrthoCarolina (Charlotte, N.C.)
Type of facility: Physician practice and surgical facility

What makes it a Great Place to Work: OrthoCarolina has been honored for its workplace several times in recent years, by the Charlotte Business Journal “Best Places to Work” program in 2010 and 2011 and Charlotte’s Healthiest Employers in 2011. Employees receive discounts on gym memberships, fitness programs, cell phones and Costco memberships, as well as paid time off to volunteer, use of gym equipment at the practice and discounted clinical attire.

OrthoIndy (Indianapolis)
Type of facility: Physician practice

What makes it a Great Place to Work: OrthoIndy is an orthopedic practice with 14 locations around Indiana and is focused on providing quality bone, joint, spine and muscle care. OrthoIndy provides employees with employer-sponsored health insurance, dental insurance and vision discount programs. To promote growth among employees, OrthoIndy offers a clinical ladder program, paid license renewal and other paid continuing education opportunities for full-time employees.

Poudre Valley Health System (Fort Collins, Colo.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Poudre Valley Health System is a non-profit health system consisting of two hospitals, a behavioral health center and multiple outpatient facilities. PVHS offers the FlexibleFit Plan, which allows employees to design their own benefit package from different options. PVHS also offers convenience services on site, including an on-site gym and on-site massage therapy.

Renown Health (Reno, Nev.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Renown Health is a non-profit integrated health system with nearly 5,000 employees and three acute-care hospitals, among other facilities. The health system provides several conveniences to employees on site through its Tahoe Tower. In addition to patient suites and trauma, emergency and surgical spaces, the building houses The Shops at Renown. These shops include Starbucks, a pharmacy for employees, dry cleaning, a mail center and a uniform store.

Riverside Methodist Hospital (Columbus, Ohio)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Located in Columbus, Ohio, Riverside Methodist Hospital has served the central region of the state since 1892. Employee benefits include up to $3,000 toward adopting a child; a child care center; an employee assistance counseling program; tuition reimbursement ranging from $1,500 to $3,500 per year; and full tuition reimbursement for full-time schooling in master’s programs at Columbus State Community College and Capital University.

Rothman Institute (Philadelphia)
Type of facility: Orthopedic practice

What makes it a Great 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 team. 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)
Type of facility: Hospital/health system

What makes it a Great 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. Rush prides itself on a “culture of inclusion,” meaning the hospital makes significant effort to promote diversity. Founded in 1991, the Rush ADA Task Force aims to implement policies for individuals with disabilities and has initiated at least 24 programs for improved access and services, as well as 19 disability training, outreach and education programs.

Saint Thomas Health Services (Nashville, Tenn.)
Type of facility: Hospital/health system

What makes it a Great 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. 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.
Southern Ohio Medical Center (Portsmouth, Ohio)
Type of facility: Hospital/health system
What makes it a Great Place to Work: Southern Ohio Medical Center employees also enjoy free online tutoring, AAA Travel Club discount, discounted theme park and cinema tickets, Sam's Club memberships and cellular phone discounts with AT&T and Sprint.

St. Cloud Hospital (St. Cloud, Minn.)
Type of facility: Hospital/health system
What makes it a Great Place to Work: St. Cloud Hospital is a 489-bed, Catholic, regional hospital. As the largest employer in the St. Cloud area, the hospital employs nearly 4,300 people. Under the Mission Matters program, employees can recognize a coworker for demonstrating the hospital’s mission statement and core values, which include collaboration, hospitality, respect, integrity, service and trustworthiness. Each month one of the employees recognized by colleagues is chosen at random and can select a gift from the Mission Matters online store.

South Nassau Communities Hospital (Oceanside, N.Y.)
Type of facility: Hospital/health system
What makes it a Great Place to Work: South Nassau Communities Hospital is one of the region’s largest hospitals, with 435 beds, more than 900 physicians and 3,000 employees. In 2010, over 1,600 employees participated in the hospital's employee satisfaction survey, and the results showed that 83 percent of respondents were either generally or extremely satisfied with the hospital's mission statement and core values, which include collaboration, hospitality, respect, integrity, service and trustworthiness. Each month one of the employees recognized by colleagues is chosen at random and can select a gift from the Mission Matters online store.

Southern Ohio Medical Center (Portsmouth, Ohio)
Type of facility: Hospital/health system
What makes it a Great Place to Work: In addition to comprehensive medical, dental and vision coverage, retirement programs and financial benefits, employees have access to an employee emergency relief fund, education assistance and adoption reimbursement. Southern Ohio Medical Center employees also enjoy free online tutoring, AAA Travel Club discount, discounted theme park and cinema tickets, Sam’s Club memberships and cellular phone discounts with AT&T and Sprint.

Siouxland Surgery Center (Dakota Dunes, S.D.)
Type of facility: Surgical specialty hospital
What makes it a Great Place to Work: In addition to a generous benefit package that includes health, dental, life, voluntary life and generous PTO accrual, Siouxland Surgery Center employees receive annual profit-sharing from the hospital’s physician owners, free lunch every day and numerous employee outings throughout the year. During employee appreciation week, staff members receive special meals from favorite area restaurants, as well as gift cards and door prizes.

South Nassau Communities Hospital (Oceanside, N.Y.)
Type of facility: Hospital/health system
What makes it a Great Place to Work: In addition to a generous benefit package that includes health, dental, life, voluntary life and generous PTO accrual, Siouxland Surgery Center employees receive annual profit-sharing from the hospital’s physician owners, free lunch every day and numerous employee outings throughout the year. During employee appreciation week, staff members receive special meals from favorite area restaurants, as well as gift cards and door prizes.

St. Joseph Hospital (Kokomo, Ind.)
Type of facility: Hospital/health system
What makes it a Great Place to Work: For nearly 100 years, St. Joseph Hospital, a St. Vincent Health hospital, has been the hometown hospital for Kokomo citizens. Employees can take advantage of tuition reimbursement at all levels of education as well as generous vacation time and the PerkSpot Associate Discount program which offers discounts at nationwide merchants like Best Buy, Southwest Airlines, Panasonic, Dell, Target, Disney, Ann Taylor and Sprint.

St. Joseph’s Healthcare System (Pater-son, N.J.)
Type of facility: Hospital/health system
What makes it a Great Place to Work: St. Joseph’s Healthcare System is comprised of several acute-care hospitals, a children’s hospital and a nursing home in the Paterson, N.J., area. The health system’s employee retention rate is 94.5 percent, and the nursing vacancy rate is also less than 1 percent. In 2012, employees at St. Joseph’s Healthcare System will pay an average of only 22 percent of their healthcare and prescription drug costs, and employees can see physicians and other providers within the health system at virtually no cost.

St. Jude Children’s Research Hospital (Memphis, Tenn.)
Type of facility: Hospital/health system
What makes it a Great Place to Work: St. Jude Children’s Research Hospital has six affiliated hospitals and more than 3,600 employees. St. Jude has a Shared Decision Making program for employees in patient care services. Under this program, patient care services employees attend staff meetings and serve on support, steering or unit councils to provide input in the organization’s policies and procedures.

St. Luke’s Hospital (St. Louis)
Type of facility: Hospital/health system
What makes it a Great Place to Work: St. Luke’s Hospital has been honored as a “best place to work” in St. Louis for the last two years by the St. Louis Business Journal and was recognized as one of America’s 50 Best Hospitals by HealthGrades from 2007 to 2012. St. Luke’s wellness program encourages employee fitness through regular wellness events and an on-site fitness center and track.
Stanford Hospital & Clinics (Palo Alto, Calif.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Stanford Hospital & Clinics and the adjacent pediatric teaching hospital Lucile Packard Children's Hospital employ more than 8,500 people. SHC and LPCH offer a wellness incentive program that rewards employees for working to improve or maintain their health. The most recent incentive awarded employees $100 for completing the Stanford Health and Lifestyle Assessment.

Surgical Center of South Jersey (Mount Laurel, N.J.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: As an affiliate of one of the largest ambulatory surgery center companies in the country, the Surgical Center of South Jersey prides itself on providing outstanding patient care by leveraging the satisfaction and morale of its employees. Each year, the team at the center is recognized during its week long “Teammate Appreciation” initiative. During this time, administration caters to the needs of their team by serving them treats, food and gifts for each day of the week.

Texas Back Institute (Plano)
Type of facility: Hospital/health system

What makes it a Great 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. The Institute's team is made up of more than 150 physicians and staff. 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.

Texas Health Presbyterian Hospital Rockwall (Rockwall, Texas)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Employees at Texas Health Presbyterian Hospital Rockwall are rewarded for their hard work in numerous ways. Patient compliments are routinely distributed throughout the hospital, and high performers are given “rock star” awards, which include hospital-wide recognition as well as a bonus. Texas Health Rockwall also offers employees affordable payroll-deduction options for a variety of services, including already-discounted café meals, gift shop purchases, book fairs, Rockwall auxiliary activities and medical expenses incurred at the facility.

The Everett Clinic (Everett, Wash.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: The Everett Clinic is a physician group practice with 16 locations, nearly 400 physicians and more than 2,000 staff members. The practice encourages employees to participate in wellness programs by providing an opportunity to win prizes for meeting wellness goals. Each quarter, The Everett Clinic begins a new wellness promotion program and sets wellness goals. Employees are entered into a drawing for prizes for each goal they meet.

The Women's Hospital (Newburgh, Ind.)
Type of Facility: Hospital/health system

What makes it a Great Place to Work: The Women's Hospital, owned by Deaconess Health System, provides a complete range of healthcare services to women and infants in a soothing, “spa-like” atmosphere. Women's Hospital offers employees a total compensation program including medical and dental insurance, long-term and short-term disability and options for healthcare expense accounts. Additionally, employees can receive financial reimbursement and 401(k) options, and uniforms are furnished.

Tri-City Medical Center (Oceanside, Calif.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: With 2,300 employees, Tri-City Medical Center operates two advanced clinical institutes and staffs more than 500 physicians practicing in 60 specialties. The hospital works hard to increase patient satisfaction scores on an annual basis: Last year's survey showed employee engagement was up 23 percent, satisfaction was up 9 percent and partnership was up 18 percent from the previous year's survey.

University of Chicago Medicine (Illinois)
Type of facility: Hospital/health system

What makes it a Great Place to Work: University of Chicago Medicine, formerly called the University of Chicago Medical Center, has more than 9,500 employees. Hospital employees benefit from a range of educational opportunities. The University of Chicago Medical Center Academy is an on-site corporate quality university that offers classes in computer skills and business writing, among others. In addition, nurses receive 100 percent tuition reimbursement for a BSN or MSN degree at a nursing school of their choice.

University of Washington Medical Center (Seattle)
Type of facility: Hospital/health system

What makes it a Great 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. 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 assistance.

Upland Outpatient Surgical Center (Upland, Calif.)
Type of facility: Ambulatory surgery center

What makes it a Great Place to Work: Upland Outpatient Surgical Center, managed by Surgical Care Affiliates, also hosts a quarterly teammate town hall to allow staff members to voice their concerns and suggest opportunities for improvement. The center also conducts an annual employee satisfaction survey to hold leaders accountable for meeting employee and physician satisfaction benchmarks.

Vanderbilt University Medical Center (Nashville, Tenn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Vanderbilt University Medical Center hires around 10,000 employees each year, and they receive perks including discounts on apartments, cars, cellphones, computers and gym memberships. This year, the medical center was Vanderbilt University Medical Center awarded a five-year, $20 million federal grant to coordinate a national consortium that aims to advance biomedical research nationwide.

The Virginia Spine Institute (Reston)
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. Employee benefits include an on-site fitness facility, Pilates classes, personal training and a discounted on-site nutritionist and massage therapists.

Yale-New Haven Hospital (New Haven, Conn.)
Type of facility: Hospital/health system

What makes it a Great Place to Work: Yale-New Haven Hospital is the 944-bed flagship of three-hospital Yale-New Haven Health System. 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 can also save money on taxes by electing a pre-tax paycheck deduction of up to $115 a month to apply toward commuting expenses.
Bundled payments are making waves throughout the hospital and healthcare industry for several reasons. Sure, they are innovative, collaborative and require new methods of strategic planning. However, perhaps the biggest reason executives are paying attention to bundled payments is because, simply put, the burden for distributing less money from reimbursement is falling to providers. Hospitals, physicians and other healthcare participants will be paid through a variety of models that include lump sums for multiple providers over an episode of care instead of being paid separately for each service rendered. This is supposed to facilitate better coordination of care and reduce cost that may offer providers the opportunity to share in savings produced by efficiency and improved outcomes.

"The important thing about complying with bundled payments is the testing of innovative payment and service delivery models that are intended to reduce spending. This “testing” is a fairly significant change in the way providers are reimbursed...and it will cut into payments, too" says John Morrow, executive vice president of healthcare business data intelligence firm iVantage Health Analytics. "There are a variety of initiatives in the industry: value-based purchasing for higher patient satisfaction, wellness programs for care coordination, and disease management for improved patient-centered care, but with bundled payments, it is by design an initiative to shift the responsibility and to reduce costs.”

Bundled payments, in theory, seem somewhat simple. CMS or other payors pay a hospital a fixed reimbursement on a particular diagnosis-related group episode, and then the hospital, physicians and other parties provide that care. If the cost of care is less than the bundled payment, everyone gets to share in the savings, and if the cost of care is more than the bundled payment, providers lose money.

Hud Connery, president of iVantage Health Analytics, is a former hospital administrator and “veteran” of the capitation days in the 1990s. He has spent his career building healthcare companies, but now focuses his energy, like Mr. Morrow, on how to help hospitals survive and even thrive in the new era of healthcare reform initiatives. Both say the appropriate, organized and methodical use of data analytics can give hospitals the edge for a successful bundled payment initiative.

Bundled payments: where to begin?
When it comes to bundled payments, hospitals may not know where to begin. Today, hospitals have more access to healthcare data and benchmarking statistics than ever before, but for many executives, it may feel like they are drowning in their own information. “The challenge is that no hospital executive has all the information needed to know where all of costs reside, how episodes of care are put together across all relevant service lines, and whether or not those episodes of care are performing within existing best practice benchmarks,” Mr. Morrow says.

Mr. Connery says hospitals must understand three key concepts about bundled payments, and the three concepts all revolve around initial data gathering:

1. What is the size of the market for my particular service? If a hospital wants to commit to bundled payments on orthopedics, executives must know the specific demand and growth for volumes (e.g., hip replacement procedures, knee replacement procedures, etc.) and what the existing provider service mix needs in the service area.

2. What is the clinical variability in that service? Physician variability and physician performance drive some of the costs associated with service lines, and hospitals must be able to associate the raw clinical data to see which physicians stray from the targets. “For example, cancer patients have extraordinarily wide ranges of cost variation for the same diagnosis depending on whether a particular surgery or chemotherapy was successful;” Mr. Connery says.
And...how are you going to deal with the ‘ah-obs?’” Mr. Connery adds. “What if there are costs that are three, four or five standard deviations from which you modeled the bundled payment? You’re going to have some cases like that, and you have to know how you are going to handle outlier cases and who shares in that risk.”

What are my own costs? Being able to handle those outlier cases stems from how well the hospital executives know their own productivity and efficiency. Hospitals need to know how much it costs to provide care in their targeted service lines and how post discharge care contributes to the episode. There are several fundamental cost metrics hospitals should know, including at a minimum their Medicare break-even point for all service lines, prior to negotiating bundles with any payer.

9 key strategies for better data analytics and bundled payments

With those fundamental concepts in mind, Mr. Connery and Mr. Morrow believe there are nine strategies that will ultimately help a hospital with its own bundled payment initiative, and all of these strategies use better data and analytics as the cornerstone.

1. Understand your market. Mr. Connery reiterated that data are only insightful if hospitals know and comprehend the demand, growth and competitors of services beforehand.

2. Figure out who all of the players are. Bundled payments are not just about hospitals and physicians. Skilled nursing facilities, rehabilitation, psychiatric, ambulatory surgery centers, home health agencies and others all matter within the episode of patient care, and hospitals have to know how they fit into the maze of the market map.

3. Plan for the onslaught of the new insurance exchange customers. Although the effects of the health insurance exchanges under the Patient Protection and Affordable Care Act will not be realized until several years from now, hospitals have to utilize predictive data to see if there could be pent-up demand — and if that could help or hinder a marginal bundled payment strategy.

4. Assemble the longitudinal costs now. Mr. Morrow says patients with co-morbidities are the drivers of excess costs and variability. Hospitals need to factor in this patient population, because these patients are integral with requirements to monitor and manage a whole portfolio of performance lines.

5. Perform clinical and functional benchmarking. Bundled payments are still in their infancy, so hospitals need to know what they do well and what they should do less of to maximize their financial risk.

6. Push to integrate data to monitor progress on key performance indicators. Mr. Morrow says all too often, data are placed in silos. Patient experience data are put in one bin, operational efficiency statistics into another, and so on. Integrating information, through dashboards, visualization technology such as GIS and other performance tools will organize the key data and into intelligible and actionable plans.

7. Integrate your findings to build a scorecard for the community. Hospitals that disseminate information on how well they treat their patient populations could give positive exposure and could help with employers/payers who move to global payments down the line. “It is not only about costs,” Mr. Morrow says. “It is about the sustainable value that providers bring to their communities.”

"You will need payor data, and much more data to be better informed," says John Morrow, executive vice president, iVantage. In addition to holding the key to the data needed to inform the pricing of bundles and the risk associated with them, developing bundled payments is pointless unless a payor agrees to reimburse using them.

8. Seek payors as partners. “You will need payor data, and much more data to be better informed,” Mr. Morrow says. In addition to holding the key to the data needed to inform the pricing of bundles and the risk associated with them, developing bundled payments is pointless unless a payor agrees to reimburse using them. CMS has a formal program in place to test bundled payments, and many private payors are also open to such models. Often, a health system can make a payor receptive by demonstrating just how much bundled payments can save.

9. Find a business intelligence analytics partner. Creating an alliance with others to manage service line data and make data more comprehensible has never been more important for healthcare executives. Making these important decisions on service lines and Medicare reimbursements that are grounded in better data is essential because the U.S. healthcare system is beginning to ask “everyone to change how the game is played, and that’s hard,” Mr. Connery says.

“What continues to resonate with us is that [hospital executives] are inundated with requirements to monitor and manage a whole portfolio of performance metrics,” Mr. Morrow adds. “Their frustration is they can’t manage all of these different performance metrics in a disaggregated form. Our purpose is to pull that disaggregated data and put it into forms for people to make better business decisions — and that will drive success in the new healthcare.”

iVantage Health Analytics provides information products to an expansive healthcare industry, integrating diverse public and proprietary data with innovative delivery platforms to ensure clients timely, concise and relevant strategic action. iVantage Health offers a single source for solutions for market planning, performance improvement, and clinical and functional benchmarking. iVantage Health Analytics — intelligence for the new healthcare.
If you’ve had the opportunity to see the movie “Money Ball,” you learned that the secret to success in baseball is achieving a high on-base percentage. For success in the healthcare supply chain, it is an “on-the-shelf” percentage.

Do your healthcare professionals have what they need at their fingertips when they need it, without stockpiling excessive and costly inventory? Some might suggest this is easier said than done. But these naysayers probably aren’t using sophisticated healthcare analytics.

Armed with real-time product intelligence, today’s supply chain professionals are becoming sophisticated cost engineers and, as such, are often increasingly summoned to the C-Suite to help address growing legislative and financial pressures.

Few would argue that saving your hospital millions is smart business; however, the net result extends far beyond improving operating profit margins. Every dollar saved is a dollar that can be invested in delivering better patient care. In today’s healthcare reform climate, it is not enough to carve out costs; hospitals must simultaneously improve care as well. While that may seem a tall mountain to climb, the availability of sophisticated analytical tools means hospital executives don’t have to guess which path to take.

The analytics advantage

Frequently dubbed “business intelligence,” analytics involves collecting, aggregating and storing vast amounts of relevant and related information in a central repository or data warehouse. Using tools that identify, categorize and classify item, coupled with supply product expertise, data is converted to knowledge, giving users detailed insight into their own utilization patterns while also improving their decision-making process around clinical acceptability and quality.

Ultimately, the best analytics tools give executives an integrated, enterprise-wide comparison that creates a clear picture of pricing and price fluctuations, as well as procurement costs, practice patterns, clinical outcomes and other metrics. Employing a healthcare analytics arsenal using a single or a portfolio of products is often an iterative process that can be effectively accomplished in straightforward, common sense stages.

That said, healthcare analytics tools are not a cure-all but instead, should be applied as part of a more rigorous, integrated approach if you’re seeking to reduce costs, improve margins and deliver better patient outcomes.

Here are three key steps hospitals can take to start climbing the proverbial mountain:

Step 1: Understand your data

Hospital item masters, for example, often contain thousands of line items for hundreds of supplies in virtually countless categories. Often, a single, identical supply item like latex-free gloves or sutures is indicated by multiple identifiers, hindering efforts to calculate an accurate, item-specific supply spend. A first-rate healthcare analytics methodology will help you analyze, scrub, consolidate, categorize and classify your item master supply chain data to improve its quality and accuracy. Once you’ve cleansed your data, you can better determine types and quantities of items you are buying to better understand your supply spend and embark on a more cost-efficient purchasing program.

Having an accurate and up-to-date item master is the foundation of an effective analytics program and provides the basis for optimizing unit-based and organization-wide supply spend. Accurate and consistent data also leads to more efficient operations, reducing logistics expenses and storage-related inventory costs while improving labor efficiencies. In my experience, healthcare organizations that adopt this initial methodology can shrink their annual supply costs by between 1 percent and 3 percent.

Step 2. Link data with decisions

Having accurate, comprehensive and up-to-date data is just the starting point. Knowing how to use it is equally important and ultimately will drive financial and operational excellence.

To test your analytics current capability, ask yourself these types of questions:

1. How quickly can I determine the products that comprise my top 10 supply-chain expenses?
2. How much do I spend on costly physician preference items like defibrillators, hip and knee replacements and devices and products used in cardiac and spine-related procedures? Who are the manufacturers of those products?
3. Where does my organization rank compared to its peer-group facilities, within its geographic region or nationwide on the prices it pays for those supplies?
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Anesthesia Involvement in Hospital Strategy, Leadership Crucial to Department, Facility Success

By Lindsey Dunn

A hospital’s anesthesia department plays a key role in many areas of the facility’s operations including operating room efficiency (on-time starts, recovery time, etc.), patient safety and clinical outcomes and patient, surgeon and surgical staff satisfaction. Despite this level of influence, it’s not uncommon for hospital anesthesia departments to feel and even act slightly like outsiders. This is because in many hospitals — save academic medical centers — anesthesia services are outsourced to a contracted anesthesiology group, rather than provided by employed physicians. Additionally, anesthesia groups may hold a number of contracts in a single market, meaning hospitals may not always have a dedicated anesthesiology team. While it’s clear that anesthesiologists who are engaged and involved in hospital issues outside the OR are beneficial, it’s not always the status quo.

So, how do hospital executives engage their anesthesiology teams? One of the resounding themes I hear from executives is I have a chief and they’re clinically astute, but they don’t have these other qualities or their leadership or culture is undesirable,” says Dr. Koch. “It’s important to understand, though, sometimes good leaders aren’t born, they’re made, and sometimes culture doesn’t appear de novo but develops over time.”

In these cases, hospitals should provide clear expectations for their anesthesia leaders, metrics to evaluate the group’s progress and encourage further training and development in these non-clinical areas.

Dr. Koch recommends hospitals consider the following: “Is there a role with some of the incumbent team or leadership to transform the department to an excellent one?” He encourages hospital leaders to work closely with the anesthesiology group to explore what little or big changes could move toward “an output of excellence.”

“Play Switzerland”

One important characteristic of strong anesthesiology leaders is good communication skills. This is particularly important in the sometimes hostile OR environment. If two surgeons are upset about a case being rescheduled, a proactive anesthesiologist can talk to them and explain why the change was made. If surgeons have all the information — perhaps the cancellation was due to an extremely urgent case — and receive this communication with respect, they are often understanding.

“Sometimes what the hospital is looking for is someone to play Switzerland,” says Dr. Koch. “Nurses often get caught in the middle, and in many cases, this can be avoided by an anesthesiologist clearly communicating with the surgeons.”

Robert Cunnah, MD, chief medical officer at Desert Regional Medical Center in Palm Springs, Calif., and an anesthesiologist, concurs. “For any specialty, someone that is very skilled clinically is important, as [clinical skills] generate the respect of other clinicians,” he says. However, he notes softer skills — diplomacy, conflict management and, perhaps most importantly, communication — are equally important. “There’s no point of being the smartest person in the world if you can’t communicate with the rest of the world.”

Proactive relationships

“Any good anesthesia chief has to be involved with all disciplines,” says Dr. Koch. “If he or she does not have good relations with other departments that are closely linked to the OR — such as radiology and the emergency department, for example — it’s a disservice to the patient and the situation.” After all, strong care coordination can improve outcomes.

The anesthesiology group must also extend its relationships beyond clinical department leaders and physicians to administration as well. “You have to have very good lines of communication with the hospital executive team. It’s not an ‘us’ versus ‘them’ situation,” says Dr. Koch. He recommends the anesthesiology chief schedule regular meetings with the hospital CEO, CFO, CMO and/or vice president of medical affairs and CNO to proactively deal with issues before they become negative.

“If a CFO needs an explanation for a line-item expense on a new anesthetic agent, these meetings can address that before it becomes a thorny issue,” he says. Additionally, meetings with the CNO might uncover information from nurses about patients appearing to be in greater discomfort post-operatively, which could trigger the anesthesiology group to assess their practices. “It really gives the group a chance to fine tune the service and make it exemplary,” says Dr. Koch.

“What I see a lot in the industry, is wanting to skip a meeting because it’s at noon or not wanting to bring in a per diem to cover the room; there’s this mentality that I’ll just meet with the CEO when I’m free,” Dr. Koch says. “That’s not a structured and formal approach that leads to positive outcomes. It’s an ad hoc approach that frankly serves nobody well.”

Roy Winston, MD, chief of anesthesiology at Kaweah Delta Medical Center in Visalia, Calif., agrees that successful anesthesia departments must do a lot more than just administer seda-
Although the integration of Certified Registered Nurse Anesthetists (CRNAs) in the delivery of anesthesia services is now accepted practice in today’s healthcare business model, misconceptions about the role of these mid-level practitioners still persist.

Multiple studies indicate that the utilization of CRNAs in the OR does not negatively impact clinical outcomes. In fact, including CRNAs in the anesthesia care team model has been proven to provide many benefits including improved OR efficiency.

Our latest white paper, CRNAs in the Care Team Model, examines the benefits of incorporating CRNAs in the anesthesia department and describes the history of the nurse anesthetist profession. Download it at www.somniainc.com/CRNA.
Committee involvement

Beyond working closely with other departments and administration, anesthesiologists should be proactively involved in hospital leadership through committees or other avenues. “Being proactive requires taking initiative [to serve the hospital]; it involves more than lip service and requires time, energy and effort,” explains Dr. Koch.

Dr. Cunnah believes anesthesiology’s involvement in areas outside the department are critical to the department’s success. “As a hospital-based specialty, hospitals are essentially an anesthesiologist’s world. In order to be heard and represented within your world, it goes without saying you have to be part of hospital governance,” he says.

Anesthesiologist involvement can range from participation on the governing board, if the opportunity becomes available, to contribution to various committees. “For anesthesia leadership to show interest to serve on the governing board, or to serve if asked, is a significant opportunity and responsibility because it gives them the opportunity to speak on behalf of the department to the whole medical staff and to employees and serve as an advocate for patient care,” explains Dr. Cunnah.

On the committee level, anesthesiologists should get involved in committees that most directly impact quality and patient outcomes, or “picking out the venues best leveraged to improve quality and outcomes,” as Dr. Koch describes it. Hospitals, then, should insist the anesthesiology chief either serve on or thoughtfully delegate a colleague (perhaps another anesthesiologist, a certified registered nurse anesthetist or business office employee) to serve on the following committees: pharmaceutical and therapeutics, peer review, quality assurance, credentialing, pain management and trauma.

“The anesthesia group has to be willing to make a commitment to this, so there is non-clinical time to participate in these committees,” explains Dr. Koch. “If you add up the number of hours anesthesiologists might spend participating in committees or meetings with hospital leaders, you may come up with a .25 to .5 FTE. The anesthesia department has to make the commitment to fund that, which involves the group recognizing that it adds value to the patient and to the hospital.”

Once the commitment is made, a group may need to bring in a per-diem or part-time staff member to cover for the other providers. So, how should anesthesiologists contribute once they join a committee? “Actively sit on those committees and listen to various stakeholders, and contribute to the strategic and tactical initiatives that flow from it,” says Dr. Koch. “This engagement gives the anesthesia department a voice, not just in PACU but in the hospital proper, and often. Having that visibility and impacting the overall strategy and tactical direction demonstrates to hospital leadership and staff [the anesthesiology group’s] commitment.”

Dr. Koch believes that the importance of anesthesiology taking an active role in hospital operations is underscored by the fact that many hospitals pay a subsidy for anesthesia services. “Like anything else, if you pay something you expect to get something for it,” he says.

Educational efforts

Another way anesthesiologists can encourage cross-disciplinary relationships and communication is to offer education to other departments that work closely with anesthesiology. “Education [within hospitals] often occurs in silos. Labor and delivery has in-services, ER and OR have their respective in-services,” explains Dr. Koch. “Because anesthesia is so closely connected with all these groups, they should join or offer in-services. This, in a sense, helps increase the profile of the anesthesia department.”

For example, an anesthesiologist might offer the labor and delivery service staff an in-service on the latest advances for intra- and post-partum pain management. And, the anesthesiologist must take the event seriously. “The educational efforts need to be highly structured, put on a calendar, professionally prepared with a PowerPoint or other deliverables,” says Dr. Koch. “This is something that will have a resonating impact on the department and how it’s perceived and will underscore it’s a critical role across different areas of the hospital.”

“In the old days, an anesthesiologist could show up, take care of the patient and be okay,” explains Dr. Winston. “Today, if you don’t ensure the position of the anesthesia department within the healthcare facility, you’re falling short. Even though you may not be in the GI lab with those physicians or with the cardiologists in the cath lab [who both often administer sedation], you are charged with the overall responsibility for sedation throughout the hospital. In the past it was overlooked, today it must be actively managed.”

Educational opportunities also exist outside the hospital walls and beyond clinical issues. “Hospitals are also part of the community, and depending on the talents and interests of the anesthesia group, there are many opportunities within the community to have a voice and a presence,” says Dr. Cunnah. “Be part of the voice that helps mold healthcare in your local community, state or nationally. There are no limits or boundaries that confine people within anesthesia from breaking out and contributing to the larger picture of healthcare.”

Involvement within the hospital and outside it will become increasingly important to success, predicts Dr. Winston. “We practice in an ever challenging and complicated environment where it’s really important to have things well defined,” he says. “It’s a huge mistake to have people who are building silos versus building bridges. Being a consultative anesthesiologist in the 21st century requires a full and wide range of presence.”

Big impact

In fact, as healthcare shifts from a paradigm of volume to one of value, it is almost necessary that anesthesiologists — and truly all providers — reach beyond their clinical duties (e.g., administering anesthetics) and even their administrative ones (e.g., managing OR throughput) and take part in helping move healthcare in a new, better direction. Anesthesiologists who provide this additional influence, and do so proactively, present a great opportunity to hospital leaders, especially those of organizations that are actively working to better coordinate and integrate care. Accordingly, hospital leaders should work with their anesthesia providers to ensure the group works with hospital leadership, other disciplines and impacts hospital strategy to the greatest extent possible.

“Anesthesiologists can greatly impact quality, not just clinical quality but the overall quality of the experience which is transmitted from the surgeon and staff to the patient,” says Dr. Koch.
How Would You Rate your Anesthesia Team’s Performance?

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with commercial payors, leaving hospitals scrambling to break even. All of these figures are also amidst the upcoming 2 percent payment cuts to Medicare providers via sequestration, the annual Medicare merry-go-round with the sustainable growth rate and frequent talk of overhauling the Medicare program altogether.

Although finding 20 to 30 cents on the dollar in cost savings or revenue increases to break even on Medicare is not a simple endeavor, it is very plausible, and many hospitals get by on Medicare today. Mr. McCulloch says hospitals tend to be capital-intensive and, as such, are really slow at eliminating costs. Cutting off Medicare patients altogether is not a wise choice by hospitals, he says, because although that may eliminate 10 to 20 percent of the cost of treating the patient in the short term, that is a 100 percent loss of revenue. “That’s going straight to the bottom line,” he adds.

As Medicare becomes even more important in the healthcare sector, here are seven strategies that can help hospitals manage their Medicare-related financials and stay more solvent in the process.

1. Know your Medicare data. Although this appears to be too obvious, there is no such thing as “too obvious” in an industry as complex as healthcare.

Mr. McCulloch says before a hospital can jump into a strategy of salvaging or tweaking its Medicare business, hospital executives have to know how much money is actually coming in from Medicare and should produce frequent and updated reports on Medicare claims, revenue and per capita costs. While the statistic that four out of every 10 hospital stays is Medicare-funded provides a backdrop for the overall significance of the governmental healthcare program, it does not describe every hospital.

For example, Steve Bush, CFO of Tucson (Ariz.) Medical Center, says his hospital is very reliant on Medicare because his region and state have a higher proportion of older patients. Many hospitals in Florida are in similar situations. However, TMC is able to cope with the Medicare revenue because he and other executives track the important data, such as reimbursement rates, overall Medicare revenue and comparability data to commercial payors. “We do well on our Medicare population because we are living with the reality that many are going to see in a few years,” Mr. Bush says.

For hospital executives looking for broader Medicare data, Medicare Provider Analysis and Review files, or MEDPAR, provide the most comprehensive far-reaching statistics. MEDPAR files currently contain information — such as total charges, covered charges, Medicare reimbursement, total days, number of discharges and average total days — for all Medicare beneficiaries using hospital inpatient services, and they are broken down by state, diagnosis-related group and DRG description.

2. Benchmark productivity metrics. Mr. Bush has handled CFO duties at TMC for the past two-and-a-half years, and he says one of the basic ways to offset the thinner Medicare margins is by looking within the hospital and making sure all departments are reaching their productivity targets. These include average hourly labor rate, staff overtime pay and several others.

William Cleverley, PhD, president of Cleverley + Associates, points to several other financial metrics, including operating margin, total margin, per capita Medicare cost, net patient revenue per equivalent discharge and more. In total, he says there are 18 essential metrics that both appropriately display non-profit hospital accountability to the public and improve Medicare productivity tracking.

3. Reduce clinical variation through active partnership with physicians. Clinical variation is a key factor for driving up hospital healthcare delivery costs, and for a hospital’s Medicare population, this may be especially true. Mark Dixon, former CEO of Abbott Northwestern Hospital in Minneapolis who is now a consultant, says clinical variation hammered his hospital’s productivity and raised both the labor and supply costs of the specialties that affect Medicare patients the most. “One just needs to go to high-cost, high-volume specialties such as cardiology, orthopedics and spine to find significant variation in resource consumption — implants, average length of stay, pharmacy and others — between providers,” Mr. Dixon says.

In order to reduce unnecessary or unwarranted clinical variation, Mr. Dixon says hospital executives, physicians and all other clinical leaders need to enter friendly, civil discussions on how the hospital’s outcomes can be maximized, especially as value-based purchasing approaches this fall. This also positions physicians more competitively in the market. Ken Perez, director of healthcare policy and senior vice president with Cleverley + Associates, says this means admitting there is a problem while attempting to work collaboratively toward a solution, which is not always the easiest topic to bring up.

4. Look at “big bucket” operations savings. For hospital CFOs, operational buckets might be the most common areas to monitor in order to break even on Medicare. These “big buckets” — outside of labor — include strategic growth, revenue cycle, supply chain and other purchased services such as energy, service contracts, shipping, food and all other areas that keep the hospital going on a daily basis. Creativity is needed to maximize savings in operations. Operational savings can be found by cutting food waste by weighing it, reassessing administrative costs, renegotiating inbound shipping rates and more.

Energy management is another area within operations that could lead to savings. Mr. Dixon was also the South Region president of Fairview Health Services in Minneapolis. While there, he says he challenged his team and health system to reduce their energy expenses by 30 percent over a five-to-seven year span. He focused on energy because reducing costs in the energy bucket was an area most integrated delivery networks had not fully explored. In an age when several energy initiatives are becoming more environmentally friendly and more cost-effective, energy-reducing opportunities could be seen as directly helping out all hospital margins, Medicare especially.

“We were buying more expensive machines that used more energy,” Mr. Dixon says. “You have to ask, ‘What can we do to reduce energy, both in the price we pay and the amount we use?’”

The supply chain, perhaps more than any other outside of labor, is an area that offers some of the most significant savings. Mr. Bush tackles the supply costs by initiating service line agreements with TMC’s physicians. For the past two-plus years, TMC has established service line agreements in cardiology, orthopedics and neuroscience, giving physicians the ability to oversee and manage those specialties. However, because Mr. Bush established a solid working partnership with the clinical staff (which was mentioned earlier), he and the physicians have worked together to choose more cost-effective supplies and implants, saving $10 million over that span. “We really have an active focus on supply costs in partnership with our physicians,” Mr. Bush says. “They are incentivized financially for both the financial performance of the service line as well as quality, and it has reduced our supply costs.”

5. Explore bundled payments. CMS’ Bundled Payments for Care Improvement initiative is under way, and hospitals may want to explore the option of bundled payments as a way to save money on Medicare DRGs that involve a lot of variation, Mr. McCulloch says.

There are several best practices hospitals should consider for bundled payment success, including deciding which DRGs to bundle, analyzing the Medicare data set, designing the gainsharing model and others. In the end, bundled payments will allow hospitals to look at a single DRG, such as hip replacements, and find ways it can deliver quality care to those Medicare beneficiaries while reducing the Medicare overhead in the process.

“The great thing about bundled payments is that hospitals are able to try and get that one DRG right before [they] take on too many,” Mr. McCulloch says. “It gives hospitals a chance to show they are good at something before they have to do it all.” The “all” that Mr. McCulloch is referring to is...
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the accountable care organization design. He says only the most sophisticated providers should be in the ACO environment right now because that involves the assumption of significant patient risk. “The ACO concept is not for the faint of heart,” he adds. “Bundled payments are that evolutionary step for hospitals to practice before they have to take it on as their entire business.”

TMC has been developing its ACO, the Southern Arizona ACO, for several years, and it includes independent physicians and federally qualified health plans. Operations began early in 2012 with a commercial contract for Medicare Advantage beneficiaries and received approval to participate in the Medicare Shared Savings Program. In addition to the ACO, Mr. Bush said TMC is also considering bundled payment initiatives as a step to control its Medicare profits even further.

6. Improve operating room and emergency room operations. Hospitals looking to improve their Medicare margins can immediately look at two of the most important departments of the hospital: the operating room and the emergency room. The OR is the valuable, high-revenue and high-cost center of a hospital, while the ER is usually considered to be a “money loser” due to its high rate of uninsured patients and expensive care. However, Mr. Dixon says those two departments can be improved to offset dwindling Medicare payments. “Generally, there is a lot of waste inside an OR,” Mr. Dixon says. “You typically have more available time, so you have to find ways to use staff [better].”

Mr. Perez says there several ways a hospital’s OR can reduce delays and costs, such as improved scheduling, standardization of processes, operational reporting, throughput, first case percent on-time start and overall OR utilization. For example, variances in OR turnover time, delay incidence rate by surgeon and OR cycle time by procedure are some of the metrics that could be measured and gauged to improve the OR.

In addition, data analytics can be used in the ER to find out where the biggest staffing, space and other cost-absorbing inefficiencies are. “Data analytics can help assess the ER’s supply and drug utilization, use of ancillary testing and perhaps most important, inappropriate usage,” Mr. Perez says. Mr. Dixon adds there are numerous initiatives — such as improving ER throughput, visit coding and staffing — that can allow the ER to run much more efficiently and effectively.

7. Consider affiliations and partnerships with other hospitals. The hospital merger and acquisition market has picked up — in 2011, hospital and health system transactions were up 12 percent from 2010 — indicating that some hospitals that rely heavily on Medicare, and Medicaid, patients cannot stomach all the financial hurdles.

While some hospitals look to full ownership transitions, Mr. McCulloch says others may look at strategic affiliations and partnerships — for example, with certain business and backend operations — to help reduce the administrative costs associated with managing claims of Medicare and other large payors. “When hospitals can no longer fill beds, they will look at strategic partners,” Mr. McCulloch says. “They may outsource the business office to cut their overhead. You’re going to see a lot of unique partnerships.”

MedPAC: Hospital Payments Should Increase by 1%

By Bob Herman

The Medicare Payment Advisory Commission recently released its final Medicare payment policy report to Congress, recommending hospital payment rates for both inpatient and outpatient services increase by 1 percent in 2013.

MedPAC based its 1 percent hospital inpatient increase on three main factors: Most payment adequacy indicators are positive; hospitals’ documentation and coding changes led to overpayments over the past three years; and although some hospitals generated positive overall Medicare margins in 2010, most hospitals had negative Medicare margins.

For hospital outpatient services, MedPAC also proposed a 1 percent increase. Although the volume of outpatient services has been growing significantly, most overall hospital Medicare margins are negative, “suggesting a positive update is appropriate,” according to the report.

In addition to the hospital payment recommendations, which were similar to proposals in December and January meetings, MedPAC said Congress must repeal the sustainable growth rate — Medicare’s method for updating physician payments. It argued that the short-term patches undermine the credibility of Medicare and cause undue frustration among all healthcare providers. MedPAC also recommended Congress repeal the SGR as soon as possible because the cost of repeal is increasing exponentially with every temporary fix, and the costs of the SGR will only become more difficult to offset.

MedPAC said the SGR should be repealed and replaced with specified updates. The updates include a payment freeze at current levels for primary care physicians, and specialist physicians would see annual payment reductions of 5.9 percent for three years followed by a payment freeze.
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Recipe for Growing Market Share Through Data Optimization: Start Simple, Add Physicians

By Sabrina Rodak

Todays healthcare environment presents nearly unending questions for hospital and health system leaders: How will healthcare reform affect my organization? How should I align with physicians? How can I mitigate financial losses? What the industry needs, perhaps more than ever, is more information. At the same time, the proliferation of electronic medical records, computerized physician order entry systems and other technologies seems to capture more data than healthcare providers have ever had access to before.

The trick is converting readily available data into usable information. John R. Thomas, CEO of physician alignment firm MedSynergies, explains how starting simple and aligning with physicians can help hospitals leverage data to gain market share.

Back to basics
The amount of data available to hospitals and health systems from new technology and data analytic firms can be overwhelming for hospital leaders. Organizations have to start somewhere, however, and the best place to start is with existing hospital systems, according to Mr. Thomas. “Use whatever you have now. Data in the hospital is where you have to start because it is the most readily available,” he says. For example, hospitals can capture basic information, such as patients’ age, sex, race and zip code, using existing systems. Similarly, a primary care physician can easily determine the number of patients who have not come in for a wellness exam in the last year; the physician can then use this data to reach out to these patients and identify ways he or she can meet the patient’s needs.

“Most clients we see today are underutilizing existing data,” Mr. Thomas says. Hospitals and health systems do not need to have an electronic medical record or participate in an accountable care organization to begin accessing relevant data to meet the community’s needs. “Regardless of where you are in the life cycle of healthcare evolution, start now,” he says.

Expensive, new technology is not necessarily the key to better information. “One of the issues is that people believe technology alone is going to give them the answer,” Mr. Thomas says. “[People] have overcomplicated healthcare information because everybody wants the perfect answer. There is no perfect answer. They have to get started with high-level manual [processes] in the beginning.”

Eventually, hospitals will move toward a strategy in which existing systems are used in tandem with new technology to look at data through both a bottom-up and top-down process. However, a truly integrated system of clinical, financial and operational data is a long way away based on organizations’ current infrastructure abilities, according to Mr. Thomas. Hospitals have to first master current accounting and management systems before adding more complex technology. “It’s critical to start somewhere and to build incrementally,” he says.

Converting data into information
One of the challenges in using data to gain market share is being able to convert raw data into information. Currently, healthcare has a great deal of data but little information, according to Mr. Thomas. Information systems should provide hospitals guidance in which patients to target based on clinical and financial data. The bottom-up approach of using existing, readily available data can help hospitals translate data into usable information because it is simpler.

More complicated systems may yield very specific data that, while prodigious, may not be valuable to a healthcare organization trying to increase revenue. For example, data that breaks patients down by income level, marriage status, number of children and the children’s medical status in addition to general demographics provide interesting statistics but do not necessarily help a hospital answer the question “How can I more effectively meet the needs of my patients?” Mr. Thomas says.

To answer this question, healthcare organizations should begin by looking at the local population’s demographics and other existing data to identify trends and opportunities to reach more patients. These opportunities may come in the form of calling patients to give or solicit information, such as whether the patient is taking the correct medication. For example, a hospital with a high rate of Medicaid emergency room visits may indicate a need for primary care in the community. To respond to this information, hospitals can consider bringing a primary care practice into the hospital and partnering with a pharmacy or federally qualified health center to educate patients on preventive care, Mr. Thomas suggests.

Optimizing revenue cycle processes
A major source of hospitals’ existing data is the revenue cycle system. Before gathering data from the system, however, hospitals need to first optimize their revenue cycle processes. One of the biggest problems is inconsistency in how providers in the same group use the revenue cycle system. Before gathering data from the system, however, hospitals need to first optimize their revenue cycle processes. One of the biggest problems is inconsistency in how providers in the same group use the revenue cycle system, according to Mr. Thomas.

For example, preregistration processes for acquiring and documenting patient information are often variable and may cause some demographic information or other data to be omitted from the hospital’s records. “You can’t start off looking for information. You have to make certain data processes in the beginning are followed and complete so the information converts in the back and becomes meaningful,” he says.

Once processes are optimized, hospitals should designate someone to be responsible for analyzing data. Mr. Thomas suggests this role should be
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Key Steps and a Practical Example for Leveraging Data

1. Use existing data.
   “Use what you have now. Data in the hospital is where you have to start because it is the most readily available,” John R. Thomas, CEO of MedSynergies, says.

2. Create a data analyst role to guide efforts.
   “Having people ask high-level questions is where we should start. It’s a way to start providing the real value of information,” Mr. Thomas says
   The analyst should ask, “What can we do to help these patients?”

3. Partner with local physicians.
   “Whoever formally aligns with the doctors correctly wins the game in terms of patient market share,” Mr. Thomas says. Physicians’ data reveals that many of the Medicaid patients who visit the ED have not made a check-up appointment in the last year.

4. Respond to data.
   “The impact of providing the right care at the right time is worth a lot of money, especially in the future. You can’t put a dollar value on it,” Mr. Thomas says.
   Call Medicaid patients to encourage primary care visits and offer free health screenings to prevent costly ED visits.

Physician alignment predicts success
A useful source of data besides the revenue cycle is physicians. By aligning with physicians in the community, hospitals can access their data to have a more complete picture of the patient population. Physicians’ data on patients’ appointments, for instance, can reveal trends about what type of patients are likely to miss yearly wellness exams.

This data is important because it can predict which patients will seek the organization’s services, which sets it apart from hospitals’ data, which has less predictive power, Mr. Thomas says. Requiring appointments allows physicians to allocate resources appropriately each day depending on which patients are scheduled to come in and what their medical needs are. Hospitals, in contrast, have less ability to predict what patients will come in on a day-to-day basis.

Whether hospitals employ physicians, enter into a co-management agreement or partner with them in a different way, working with physicians to use existing data is essential to generating valuable information, Mr. Thomas suggests. “Alignment is going to happen either with the health system and doctors, or payors and doctors, or doctors and doctors; whoever formally aligns with the doctors correctly wins the game in terms of patient market share,” he says. “Patient market share is a function of physician and ambulatory care models.”

Data analysis can keep the boat afloat
Analyzing readily available data from the hospital’s revenue cycle system and aligned physicians can enable the hospital to more directly target patient populations for services. In addition, hospitals can leverage data to improve access to care and the quality of care. “The impact of providing the right care at the right time is worth a lot of money, especially in the future,” Mr. Thomas says. “You can’t put a dollar value on it.”

Furthermore, garnering usable information from data may be required for hospitals and health systems as healthcare reform emphasizes health for patient populations and quality improvements. “If a health system can’t manage and track patients through physicians, it’s going to be at a competitive disadvantage,” Mr. Thomas says.
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Joint Venture Surgery Centers Usually Follow One of Two Scenarios.

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Hospitals and physician groups are increasingly partnering on the development or management of surgery centers to stay competitive. For physician groups, a hospital partner offers the chance for higher reimbursement rates, more insulation against hospital competition, and a better ability to achieve certificates of need. For hospitals, a joint venture can improve relationships with community physicians, extend hospital branding and provide extra space for overflow of hospital cases. Donna Greene, Jeff Peo and Brandon Frazier, vice presidents of development with ASCOA, discuss the outlook for hospital/physician ASC joint ventures in 2012.

**Q: What do you see this year in terms of hospital-ASC joint ventures? The last few years have seen an increase in these partnerships — do you see the trend continuing in 2012 and 2013?**

**Donna Greene:** I personally think we’re seeing an increase. I’ve been in this business 25 years; this is my 25th official year, and I’ve definitely seen an increase in hospital joint ventures and believe the trend will continue through 2012 and 2013. Fifteen years ago, it was all about controlling inter—

**Brandon Frazier:** I would agree with what Donna said. We’re seeing an increase in the number of JVs, driven by both hospitals as well as ASCs. Hospitals are looking for a low-cost, high-quality alternative to the acute-care setting. In many cases, we hear hospitals use the term “decant”: They’re trying to decant low case mix index cases that are money losers and backfill that space with higher CMI (more profitable) cases. Savvy hospital executives use the ASC as a tool to attract new surgeons and inpatient cases to their hospital, while gaining profits through the ASC on cases that were money losers or marginally profitable before.

ASCs are looking for hospital partners because they’re feeling vulnerable in the face of declining reimbursement rates and what’s going to happen in the future with commercial payors. There’s a lot of nervousness among ASCs in that respect, and a hospital partner helps provide some security in the minds of physician owners.

**Q: Some experts say hospitals are increasingly looking to own ASCs outright rather than pursue joint ventures. Is that the case in your experience?**

**BF:** I’m definitely seeing it more than in the past, but I still wouldn’t say that it is common. The conditions have to be right for it to make sense. Owning an ASC outright is a strategy that’s typically implemented by a hospital utilizing a physician employment model. If the hospital can direct cases to the ASC, having 100 percent ownership in the surgery center allows them to benefit from Medicare HOPD rates and they can typically assign existing contracts to the ASC from the hospital. I am also seeing 100 percent ownership in markets where there is a significant (70 percent or more) Medicare population. Again, the hospital is trying to benefit from HOPD reimbursement rates in a situation where a JV center may not be financially viable.

**Jeff Peo:** I think most surgery centers look at that model and think, “What does 100 percent hospital ownership give the individual physicians?” There’s not a lot that a 100 percent ownership does for physicians unless they’re getting directorships. The people looking for partners in their surgery center don’t want 100 percent partners unless they’re looking to move somewhere else. The hospitals usually want the physicians to remain financially vested so they bring cases to the surgery center and participate in its management. I haven’t seen a lot of 100 percent ownership by progressive hospitals.

**Q: What are hospitals looking for in the surgery centers they partner with? Do you see hospitals pursuing ‘turnaround” opportunities?**

**JP:** I don’t think that hospitals are looking for turnaround opportunities because they don’t know how to run surgery centers. They know how to run hospitals. They’re usually buying centers that are running well if they know what they’re doing. Some hospitals, if they’re buying into a struggling center, are looking to shut the center down and bring those cases back in house.

**Q: What problems do you see commonly plaguing joint ventures? How would you recommend ASC and hospital leaders tackle or solve them?**

**DG:** I think hospitals tend to move at a slower pace than the outpatient world, and I can say that because I’ve worked in the inpatient and outpatient setting. They’re unaccustomed to the pace at which outpatient negotiations move, and I think that can be very, very problematic. My recommendation would be to put together a timeline of events and share that with all parties so everybody’s working on the same timeframe.

Hospitals have a difficult time understanding the business of the surgery center. It’s not their area of expertise; it’s one cost center they have within the hospital system. There’s a level of education that has to occur with the hospital partner about how things should move, how contracts should be negotiated, what the satisfactory turnover time per case is and how the center should be run.

**BF:** I agree completely with what Donna said. The other thing we’ve seen that’s pretty frequent is that hospitals tend to overbuild surgery centers.
They frequently turn them into mini hospitals. We can build a four OR surgery center at about 10,000 square feet, and I’ve seen hospitals build a four OR surgery center in 25,000 square feet. The facilities are beautiful, with gorgeous art and blown glass, but when it comes down to it, the economics don’t work. You’ve got this huge fixed cost of rent that can’t be overcome, and you’ve got a space that’s massive and less efficient in terms of moving patients around. It’s important that a surgery center be sized properly.

Another one I’ve seen just recently is distrust. One of the reasons a joint venture can fail is that many surgeons have longstanding relationships with the hospital. Sometimes that’s good, but a lot of times there’s baggage that comes along with that. The doctors may not trust the hospital, so having a third party management company is a nice bridge between the hospital and the surgeons so that the focus can be on making the ASC profitable and efficient, not focusing on what’s best for one particular stakeholder. A properly established ASC should align incentives among all of its partners.

**JP:** One thing I’ve seen happen is that the hospital tries to put their own overhead into the ASC financials, so they end up billing the surgery center for things that are “hospital overhead.” This makes for a bad partnership situation. It’s important for people to make sure they’re looking and understanding ahead of time what the expenditures are going to be. Make sure there is a trust level there: If there’s no trust, it’s not going to help to make the hospital part of the surgery center.

**Q:** Could you describe the set-up of some of the most successful JVs you’ve seen? What makes the difference between a decent JV and a great one?

**JP:** The most successful joint ventures occur when you have progressive hospital CEOs that don’t care whether employed physicians join the center or not. They realize they’re building a healthcare community that treats patients where it’s most appropriate, whether that’s the hospital operating room or the surgery center. They encourage everybody that they can to patients around. It’s important that a surgery center be sized properly.

The partnership with the ASC should fit into the hospital’s long-term strategic plan, whether that focuses on reaching out further with branding, building partnerships with surgeons they don’t have relationships with currently or getting cases out of the hospital to avoid extensive hospital expansion. The ASC joint venture should fit in nicely with what they’re already trying to accomplish, so everyone’s incentives are aligned.

**Q:** If an ASC is in a community with several competing hospitals, how can they go about deciding who to partner with?

**DG:** I think it depends on whether it’s a CON state or not. If it is, you want to partner with the hospital that will help you obtain that certificate of need. We’re all familiar with markets like these, and we can use Mississippi as a general rule of thumb. There are five competing hospitals in Jackson, Miss., all with different systems, and Mississippi is a CON state. A surgery center there would want to align with a hospital that could truly help the ASC get that CON.

In a non-CON state, you want to seek out the hospital that’s the best at payor contracting. Do they have an employed physician strategy, and can they push additional business to your center? The surgery center should review each of these aspects individually.

**Q:** If an ASC is in a community with several competing hospitals, how can they go about deciding who to partner with?

**JP:** Donna hit that right on the head for if you’re developing a de novo center. If you’re an existing center and you want to choose between several hospitals, you want to ask: Who lines up best with us? Who’s going to allow us to do what we’ve been doing, and who’s going to help us if we’re not successful? What are our weaknesses as a surgery center, and which hospital can best help us overcome those weaknesses? You need to interview those hospital systems. You need to go to individual hospital CEOs and interview them to see what they can bring to the table.

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**10 New Surgery Centers Planned or Developed by Hospitals**

**By Rachel Fields**

Here are 10 new surgery center projects planned, opened or developed by hospitals, according to various news reports.

1. Expansion of Arizona’s Tuscon Medical Center to include surgery center.
2. New California surgery center for Presbyterian Intercommunity to open in fall 2012.
3. New clinic for Huron Regional in South Dakota to include surgical center.
4. Cleveland Clinic’s Marymount Hospital opens new Ohio surgery center in Garfield Heights.
6. Cook Children’s expansion includes new Texas surgery center in Fort Worth.
7. Oakleaf Surgical Hospital to build new Wisconsin surgery center in Altoona.
8. New surgery center for Indiana University Health Saxony opens in Indianapolis.
9. Wyoming Medical Center’s $40 million expansion to include orthopedic and spine surgery center.
10. New East Texas Medical Center facility in Quitman to include surgery center.

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Hospital-Payer Contracting: Antitrust Concerns Surround Exclusive Contracts & Most-Favored Nation Clauses

By Lindsey Dunn

Hospitals and health systems today operate in one of the most challenging environments in the history of the healthcare industry. Regulatory and reimbursement pressures continue to tax facilities, and the growth of government-sponsored healthcare programs further constrain revenues. In response, many providers have begun to more closely focus on their contracts with private payors, and in some cases, enter into unique agreements, such as exclusive and/or most-favored-nation agreements. While these types of contracts can be attractive to both hospital and payor, Angelo Russo, JD, and Richard Greenberg, JD, both partners in McGuireWoods’ Chicago office, recommend dominant providers enter into such contracts with caution, as they could draw attention from antitrust regulators or plaintiffs’ lawyers.

Exclusive contracts

Under an exclusive contract, a health system or other provider might agree to lower reimbursement rates than it would typically accept (but which could still be among the highest in the market) so long as the payor agrees to contract with none of the system’s competitors in the same market. Most concerning, from an antitrust standpoint, is when this type of agreement occurs between a payor and a dominant or “must-have” hospital or health system in a market, says Mr. Russo. When a dominant provider contracts exclusively with a payor, proponents argue lower prices for consumers result. Opponents, however, contend these contracts allow dominant providers to squeeze out the competition. As such, dominant hospitals must be careful when entering into exclusive contracts and should ensure such contracts don’t increase healthcare pricing or inhibit competition.

United Regional Health Care System in Wichita Falls, Texas, was recently on the receiving end of the regulatory scrutiny surrounding this type of contract. In February 2011, the U.S. Department of Justice and the Texas Attorney General’s office filed a complaint against the health system, which controlled approximately 90 percent of acute-care inpatient services and 65 percent of outpatient surgical services in the market. The government’s complaint alleged United Regional systematically required most commercial health insurers to enter into contracts that prohibited them from contracting with the system’s competitors. Additionally, the DOJ and AG argued United Regional’s average per-day rate for inpatient hospital services offered to commercial health insurers under the exclusive contracts was around 70 percent higher than the rate charged by its closest competitor for the same services.

According to a DOJ statement about the complaint:

“Since United Regional is a must-have hospital for any insurer that wants to sell health insurance in the Wichita Falls area, and because the penalty for contracting with United Regional’s rivals was so significant, almost all insurers offering health insurance in Wichita Falls entered into exclusionary contracts with United Regional. As a result, competing hospitals and facilities could not obtain contracts with most insurers and were less able to compete, helping United Regional maintain its monopoly in the relevant markets and raising healthcare costs to the detriment of consumers.”

Simultaneously with filing complaint, the DOJ and AG proposed a final judgment and settlement, agreed to by United Regional. While the final judgment in this case only applies to United Regional, it sets forth four specific rules for the system that should be noted by other providers, says Mr. Greenberg,

- The health system may not condition pricing offered to an insurer on whether or not the insurer contracted with other hospitals;
- The health system may not refuse to contract with an insurer or terminate a contract because the insurer has contracts with competitors;
- The health system may not prevent insurers from encouraging the use of other medical providers; and
- The health system may not provide “market-share” discounts, or discounts beyond the scope of the system’s services. That is, discounts may not be conditioned on an insurer’s purchases at the health system meeting a specified percentage of that insurer’s total purchases.

“If a hospital has market power or a dominant share of the market, it needs to be conscious of agreements with payors,” says Mr. Russo. “Not every exclusive contract will run afoul [of antitrust regulations], but systems must be cautious of contracts that prohibit competitors’ growth or entrance into a market.”

Mr. Greenberg adds, “An exclusive contract with one small insurer is unlikely to be a problem, but agreements with several insurers could be looked at in the aggregate.”

As such, hospitals should analyze their market share for services as well as the potential market foreclosure that would result from exclusive contracts. Antitrust regulations do not provide a specific threshold of what constitutes an anti-competitive agreement, says Mr. Russo. “In some cases, antitrust complaints have been made against organizations with contracts that foreclose 35-40 percent of the market. Other times it’s a little more or a little less,” he says.

Most-favored nation clauses

Most-favored nation clauses are another type of hospital-payor agreement that may draw regulatory scrutiny. Under a most-favored nation clause, hospitals and health systems agree to offer their most favorable rates to the insurer, and if the hospital later offers a lower rate to another insurer, it must then offer that rate to the most-favored insurer. Proponents of these clauses say they allow insurers to be confident that their rate is no greater than their competitors; however, opponents argue these clauses essentially provide purchasing protection from other competitors, says Mr. Russo. “Using these clauses can chill a hospital’s willingness to provide lower rates or discounts,” he says.

The clauses also stifle new health plans from entering the market. “New payors on the scene often enter a market by offering a lower price,” explains Mr. Greenberg. Hospitals are more willing to offer better rates to higher-volume payors than to lower-volume ones.

Payors are generally more at risk for antitrust action related to most-favored nation clauses. However, a most-favored-nation clause can facilitate coordination among healthcare providers in certain instances where the insurer imposing the clause is provider-controlled. For example, where a provider-controlled insurer has access to the rates of competing providers, it might create a price floor for providers by using a most-favored-nation clause as an enforcement mechanism to monitor and curtail possible price cutting by other providers, explains Mr. Russo. Additionally, hospitals are at risk if a private plaintiff brings charges of conspiracy between the hospital and a health plan, says Mr. Greenberg.
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In October 2010, the DOJ and the Michigan Attorney General’s office filed suit against Blue Cross Blue Shield of Michigan, alleging the insurer violated antitrust regulations by entering into most-favored-nation agreements with several hospitals and health systems in the state. According to the complaint, the agreements required hospitals to charge “significant competitors” of Blue Cross rates at least 25 percent more than Blue Cross paid. BCBS requested the case be dismissed, but in June a federal judge dismissed BCBS’s request, allowing the case to proceed. A number of class-action suits were also filed by private plaintiffs against BCBS and a number of Michigan hospitals that entered into the agreements.

Given the increasing scrutiny from the DOJ and state attorneys general around payor-provider contracting, health systems and other providers should carefully examine all payor contracts for potential antitrust action and be cautious of any agreement that could be accused of reducing competition or protecting prices.

Footnotes:
1 United States v. United Regional Health Care System, No. 7:11-cv-00030 (N.D. Tex. Feb. 25, 2011)

CHS, West Tennessee Healthcare Settle Long-Term Antitrust Dispute

By Molly Gamble

Brentwood, Tenn.-based Community Health Systems and Jackson, Tenn.-based West Tennessee Healthcare have reached an agreement over a long-term antitrust dispute.

Regional Hospital of Jackson, which is owned by CHS, has tried to amend a 1996 Tennessee state law that protects private act hospitals from antitrust litigation. This protection covers Jackson-Madison County General Hospital, owned by WTH, and Regional Hospital said such protection gave it an unfair advantage.

Under the agreement, Jackson-Madison County General will not require that it be the sole provider in Tennessee’s Madison County as a condition of entering network agreements with insurers. Existing contracts are unaffected, but new contracts issued by Jackson-Madison will no longer prohibit insurers from contracting with CHS’ Regional Hospital.

In return, CHS and Regional Hospital agreed to drop the long-term effort to enact legislation to change the antitrust law.

FTC Requests Supreme Court Review of Georgia Hospital Sale

By Kathleen Roney

The Federal Trade Commission has continued its challenge of the sale of Palmyra Medical Center in Albany, Ga., to Phoebe Putney Health System, operated by the Hospital-Authority of Albany-Dougherty County, also in Albany.

Phoebe Putney purchased Palmyra Medical Center from Nashville, Tenn.-based HCA in December 2011 for roughly $198 million. The Federal Trade Commission opposed the sale citing antitrust issues. But, the 11th Circuit Court of Appeals ruled in favor of the acquisition claiming the transaction was protected by state-action immunity and is not subject to federal scrutiny.

The deciding factor in the court’s decision is the state’s Hospital Authorities Law, which was enacted in 1941. Under that law, hospital authorities are granted power to “acquire by purchase, lease or otherwise…” projects, including hospitals. The court ruled this state law gives Phoebe the power to acquire Palmyra.

The court also went against the FTC’s concerns about anticompetitive effects, noting that anticompetitive effects were anticipated at the time when the Hospital Authorities Law was enacted.
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Navigating the Care Continuum: The Next Frontier for Providers

By Farzan Bharucha, Harvey J. Makadon, MD, Shannon Sale, Cole Wheeler and Audrey Yoest, Kurt Salmon

Reforming our healthcare system: Slow but inevitable
The healthcare industry in the United States is among the most fragmented, heavily regulated and inordinately complicated industries in the country. Despite the best efforts of many individuals, attempts to promote greater coordination and integration of care have failed due to a combination of disincentives and inertia. But over the past two years, there has been a growing sentiment that the breaking point has been reached as the cost of care continues to increase without a corresponding increase in quality.

Over the coming decade, the United States will have to provide care to more people for less money. To accomplish this with no adverse impact to quality or service, healthcare providers will have to learn to work together to coordinate treatment, prevent unnecessary testing, manage chronic conditions and provide cost-effective care in the appropriate setting. To be successful, providers must transition from discrete entities to collaborative networks focused on optimizing both outcomes and costs. These networks will likely be fully integrated continuums that provide cradle-to-grave care for defined patient populations.

Understanding key change elements: Quantifying the value of the healthcare continuum
The value of the healthcare continuum can be best evaluated in terms of the clinical or operational improvements it provides to the overall delivery of care. This implies that a more integrated care continuum offers some combination of better quality, better service and lower costs per unit of service.

We believe changes to reimbursement principles will drive disparate providers to work together. Below are four key elements that we believe will drive this change toward coordinated care along the care continuum.

• Reduced reimbursement rates. With legislators desperate to bend the healthcare cost curve, few doubt that reimbursement rates will be cut — in fact, some cuts have already been passed — but no one has accurately predicted the magnitude, allocation or phasing of these cuts.

Given that more than 50 percent of all U.S. hospitals already lose money on Medicare, and that Medicaid rates in nearly every state are lower than those of Medicare, federal reimbursement cuts will intensify the economic pressure on care providers. The distribution of payments between providers along the continuum is also being closely scrutinized — with the current specialist-centric reimbursement model often considered a disincentive toward greater care coordination.

• Bundled payments. Our current fee-for-service model allows, and even encourages, redundant testing and duplication of efforts. Bundled or episode-based payments can cut costs by encouraging providers to coordinate patient care more effectively.

In 2011, the CMS Center for Medicare & Medicaid Innovation announced the Bundled Payments for Care Improvement Initiative, and many private-sector insurers are undertaking similar experiments.

Providers, whether or not they choose to participate in the initiative, will benefit from taking steps to understand how to work more efficiently within the continuum. This includes developing a system to distribute payments to providers across the continuum, evaluating care pathways to ensure coordination and adherence to evidence-based medicine standards and continuing to explore cost-containment and efficiency strategies to ensure shared savings are achieved.

• Value-based purchasing — the quality connection. While significant attention has been paid to the issue of quality, there has been limited demonstrable improvement. The latest federal proposal related to quality improvement, detailed in the Patient Protection and Affordable Care Act, is called hospital value-based purchasing. Buyers of healthcare will hold providers accountable for both the quality and cost of care, in the same vein as pay-for-performance systems. The approach of aligning financial incentives with quality of care ties payment to a set of quality measures on process of care, health outcomes, cost-efficiency, patient satisfaction and information technology.

In FY 2013, inpatient prospective payment system payments will be cut 1 percent across the board. Those savings, an estimated $850 million, will then be used as incentive payments to hospitals based on their performance on select quality measures. In the future, CMS plans to add additional outcome measures that focus on improved patient outcomes and prevention of hospital-acquired conditions.

• Eliminating reimbursement for avoidable readmissions. The ACA will start to restrict Medicare payments to hospitals that have “excessive readmissions” in October 2012. While the definition is still to be defined, it will extend the current law that prohibits payment for a readmission on the same day of the discharge to up to 30 days post-discharge.

Many hospitals are already launching initiatives to prevent readmissions, forcing them to think more about care outside their four walls. This challenge, if successfully tackled, can improve both their bottom line and the health of their patients.

One size does not fit all
Despite the intuitive logic of building an integrated continuum of care from the perspective of rational health policy, it must be developed deliberately. Hospitals must answer several questions as they contemplate their role within a future integrated continuum of care.
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1. How will local market dynamics influence the development of care continuums?

The impetus behind the development of an integrated care continuum must be carefully evaluated in the context of each hospital’s competitive environment. Creating an integrated continuum can be accomplished through a plurality of buy, build or partner decisions. Our research has suggested there are four key dimensions — unique to each market and to each sector along the continuum — that must be evaluated in order to identify the optimal integration strategy.

i. Effectiveness relates to the ability of an existing provider in the market to deliver care effectively and efficiently. If an existing provider can demonstrate superior value, there is an incentive to either affiliate with or acquire them to integrate them into the overall continuum.

ii. Scope of services relates to the overlap in functionality between an existing provider in the market and the hospital itself. For example, if a hospital already provides inpatient rehabilitative services, there is less incentive to acquire another provider that offers a similar service offering.

iii. The level of alignment between the hospital and different care continuum providers in the market is also critical. For example, if the hospital’s medical staff already admits most of its chronic vent patients to one specific skilled nursing facility, it may make sense to strengthen that alignment by developing a closer partnership or making an acquisition.

iv. And finally, if there is not a great deal of competition within the market for a specific sector of the continuum there is often a greater impetus to acquire or affiliate with an entity with a strong market presence — as is being played out in numerous markets between hospitals and large multispecialty physician groups.

The market-specific configuration of the insurance sector has also been shown to influence care continuum integration. In markets where the insurance sector is both heavily consolidated and willing to experiment with new payment models — like Minnesota and Massachusetts — there has been a much greater emphasis on the development of integrated continuums.

2. What is the economic impact to the host institution associated with the development of more integrated care continuums?

The dichotomy of the existing reimbursement paradigm is a huge issue in determining whether any provider is willing to explore the development of integrated continuums when it cannot economically justify a reduced level of clinical activity. Several hospitals participating in pilot programs that have encouraged care coordination and proactively

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**Exhibit 1: Environmental Factors Influencing Continuum Alignment**

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<thead>
<tr>
<th>Effective</th>
<th>Not Effective</th>
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<tbody>
<tr>
<td>Build/Dvlp New</td>
<td>Acquire/Buy</td>
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<tr>
<td>Affiliate/Partner</td>
<td>Build/Dvlp New</td>
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**Exhibit 2: Transitioning from Volume to Value**

**TODAY: Performance Based on Volume**
- Revenue driven; margin impacted more by volume and reimbursement per admission and units of work than cost
- Limited incentives to prevent admissions and coordinate care; quality and safety initiatives are process driven
- Organizational focus is on advancing the position of specific providers/points of care delivery; little or moderate integration across the network and across the continuum
- Focus is on managing episodes of illness and disease

**FUTURE: Performance Based on Value**
- Cost driven; margin impacted more by managing costs—both variable and fixed
- Positioned to optimize quality, safety and patient satisfaction
- Organizational focus is on advancing the network or system of provider partners; high degree of integration across the network/system and coordination across the continuum
- Focus is on prevention and population health
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managed patients outside the hospital in an attempt to lower total costs have been so successful that they have adversely impacted the financial sustainability of the host hospital.

For example, the Park Nicollet system in Minneapolis saved Medicare $12.3 million in 2010 by piloting an innovative care pathway that managed care of heart failure patients across the continuum. Though CMS awarded the institution $5.7 million for their successful demonstration, this was less than half the amount they would have realized had they maintained their old care pathways under the current reimbursement system.

Understanding that the reimbursement paradigm is shifting, hospitals will have to make strategic decisions regarding the financial implications of investing now and getting ahead of the curve versus investing later.

### The dichotomy of the existing reimbursement paradigm is a huge issue in determining whether any provider is willing to explore the development of integrated continuum when it cannot economically justify a reduced level of clinical activity.

#### 3. Which entity is best suited to “control” the delivery of care across the continuum?

Hospitals have traditionally viewed themselves as being at the center of any care continuum, but there are several arguments for saying that the multispecialty physician group, or even the insurance company, may be better suited for that role.

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**Conclusion**

While the political winds are likely to change, the realities of an aging population, cutting-edge treatment expectations, unsustainable delivery costs, fragmented care and a sluggish economy are indisputable. The need to provide care to more people for less money may be deferred by political expediency, but it can no longer be completely ignored.

In a way, there is a silver lining to the fact that we, as a nation, have painted ourselves into this corner. As futurist Joe Flower pointed out in a recent post on “The Health Care Blog,” healthcare in the United States faces its own version of the Nash equilibrium. For decades, the optimal solution for each independent provider has been to sustain the status quo — even though that was not the optimal solution for the system as a whole. But there is no longer enough money in the system to support this equilibrium. Systems are more integrated, information is more readily available, patients are more insistent on transparency. Moving forward, hospitals have an opportunity to lead this evolution by virtue of having many of the resources necessary to organize a system, but this will mean building value-based relationships that will benefit all — regardless of the organizational structure. A great deal of the specifics will depend on the characteristics of their markets and hospitals’ willingness to be proactive. Regardless of how these integrated continuums of care evolve, patients will be the big winners.

Farzan Bharucha, Harvey J. Makadon, MD, Shannon Sale, Cole Wheeler and Audrey Yoest are trusted advisors to the nation’s leading hospitals and health systems. They can be reached at farzan.bharucha@kurtsalmon.com and harvey.makadon@kurtsalmon.com.
North American Partners in Anesthesia (NAPA) is the largest and most respected single specialty anesthesia management company in the United States offering premiere anesthesia services and solutions to a full-range of health care organizations across the country. NAPA's world-class clinicians represent the industry's benchmark by devoting all of their efforts towards providing the highest quality of clinical care to every patient -- every time. Through its extensive experience and sustainable infrastructure, NAPA is able to align with its clients as a strategic partner implementing proven systems and processes for efficient Operating Room management that result in maximized OR performance, reduced costs and consistent surgeon and patient satisfaction – placing NAPA at the top of all anesthesia service providers.

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The term “perioperative specialist” — someone who is able to supervise the entire surgical process — is increasingly used to describe the role of a properly focused anesthesiology leader. According to Steven Gottlieb, MD, CEO of TeamHealth Anesthesia, a perioperative specialist is vital for three key reasons: to ensure the optimal coordination of care for patients, for optimal revenue generation and for cost control.

“With regard to hospitals [and ambulatory surgery centers], the operating room is a significant revenue generator, so it is important that someone manages the entire continuum of care to make sure surgeries start on time, operating rooms turn over quickly for the next case, patients are discharged in a timely manner and unnecessary costs are avoided,” says Dr. Gottlieb.

Anesthesiologists are well suited to the role of a perioperative specialist because they “function as a hub of the surgical wheel,” interacting with all the various clinicians involved in surgical cases, including the operating room nurse manager, the surgeon, the perioperative staff, as well as recovery room and post-operative staff. Anesthesiologists are most familiar with the many players and aspects of the surgical process, giving them a comprehensive platform from which to lead.

However, finding candidates to fulfill the perioperative specialist role may be difficult. Here Dr. Gottlieb discusses three steps for finding a perioperative specialist to increase the operational flow of your hospital or ASC's surgical process.

1. Hiring perioperative specialists. Hospitals and ASCs need a perioperative specialist who is a strong leader because of the high level of responsibility and the “importance” that comes with care coordination and optimization, says Dr. Gottlieb. To be successful, an anesthesiologist must be a “problem-solver” that is “proactive,” organized and “process-driven.” He or she should be able to “focus on the details,” but also understand “the big picture” as it pertains to all three customer groups — hospitals, surgeons and patients.

While leadership skills are important, a perioperative specialist should also have a high level of motivation and excellent communication skills. Dr. Gottlieb recommends an anesthesiology leader be well trained, proactive as well as reactive, easily adaptive and focused. These attributes are important because of the breadth of responsibilities a perioperative specialist manages. They manage a patient’s entire perioperative care process and experience, and interface with all the providers who care for a patient during that patient's stay.

“In today’s constantly changing healthcare environment, ASCs and hospitals need leaders who can adapt while always focusing on delivering service as well as quality,” says Dr. Gottlieb.

Finally, Dr. Gottlieb recommends hiring leaders that are passionate. “As in any profession, you want to hire someone who is really committed and loves what they do,” says Dr. Gottlieb.

2. Recruiting and training perioperative specialists. To recruit the qualities mentioned above, administrators and executives should promote the factors of their hospital or ASC that attract motivated, highly communicative, adaptable, organized and critical-thinking individuals. “[Anesthesia leaders] want an organization that welcomes new ideas, encourages dialogues and will support them in their careers,” says Dr. Gottlieb.

“You need to deliver training, professional development and opportunities for advancement within the organization.”

For instance, TeamHealth Anesthesia offers candidates specific training and development to become well-prepared perioperative specialists. The anesthesiologists are given the knowledge and resources to manage an entire surgical process and meet the needs of hospitals and ASCs. This happens through classroom training, proprietary online learning and on-site training and support.

“We provide the tools required to succeed, and train our anesthesiologists to take ownership and be accountable for managing the entire perioperative process as perioperative specialists,” says Dr. Gottlieb.

With the correct training, anesthesia leaders can assure proper patient pre-assessment and optimization, on-time surgical case starts and surgical turnover improvements. According to Dr. Gottlieb, a perioperative specialist with the right training can increase OR efficiency, reduce length of stay and improve patient and surgeon satisfaction.

3. Developing leadership skills. Ongoing training and development programs are essential to shaping strong anesthesiology leaders. According to Dr. Gottlieb, TeamHealth Anesthesia has made an investment in developing leaders a significant priority, and other organizations should do the same.

There are several different methods or tools for training anesthesia leaders. TeamHealth Anesthesia offers both clinically based programs, like a perioperative fellowship program, as well as classroom-style training and meetings that focus on specific aspects of becoming a strong leader. TeamHealth Anesthesia is a Studer Group partner, a private healthcare consulting group that offers clinical, operational and financial training. TeamHealth provides Studer training and holds regular leadership and educational summits for medical directors and physician leaders.

Dr. Gottlieb recommends combining a variety of methods to create a tailored leadership development program. “Some people are born with leadership skills, others develop these skills over time, but everyone can use some extra training and development to become better, more effective leaders,” says Dr. Gottlieb.

Beyond providing leadership development, it is critical that programs follow an organized framework that allows for the measurement and reporting of individual growth and achievement. “In addition to the mechanisms for teaching anesthesiologists how to lead and perform, every hospital and/or ASC needs to establish well-defined expectations and metrics for measuring success and a consistent means to provide ongoing feedback to leaders on their performance,” says Dr. Gottlieb.

In today’s healthcare environment, reducing costs while increasing efficiencies and quality of care are benchmarks that healthcare organizations need to meet. A great way to run an efficient operating room and surgical process is with a perioperative specialist, a well-trained and motivated anesthesia leader.
Perioperative Efficiency Study: 8-Step Process May Improve OR On-Start Times

Research published in the Canadian Journal of Surgery suggests an eight-step change process may help improve operating room efficiency, particularly on-time surgical starts.

8-Step Process for Leading Change

John P. Kotter, chief innovation officer of Kotter International and professor at the Harvard Business School, is a renowned expert on leadership and transformation. Mr. Kotter developed an “8-Step Process for Leading Change” designed to help organizations successfully implement and maintain change. While the process isn’t designed specifically for healthcare, the researchers in the study sought to apply it to OR start times and assess its impact on on-time starts.

1. Establish a sense of urgency. Healthcare organizations can establish urgency by behaving with urgency every day and finding opportunity during times of crisis. However, organizations must be careful in differentiating between complacency, false urgency and true urgency.

2. Create the guiding coalition. Bringing together the right mixture of leaders is crucial to achieving and maintaining organizational change. The guiding leadership must have the right set of expertise, power, credibility and leadership skills.

3. Develop a change vision. Effective visions must be imaginable, desirable, feasible, focused, flexible and communicable.

4. Communicate the vision for buy-in. Healthcare organizations are complex structures, so effective communication, both verbal and physical, is imperative for successful transformation. Under-communication and communication inconsistencies must be avoided at all costs.

5. Empower broad-based action. In order to engage and empower employees — and consequently yield broad-based action — healthcare organizations must overcome common barriers, including “troublesome” supervisors.

6. Generate short-term wins. Healthcare leaders must be able to lead their organizations to short-term wins that will ultimately lead to long-term change.

7. Never let up. Healthcare organizations must fight every urge to regress on change efforts and maintain momentum toward long-term goals.

8. Incorporate changes into the culture. By this point, healthcare organizations must be able to prove the changes are better alternatives to old behaviors and processes. These changes must take root across the organization in order to sustain long-term success.

OR application

Mr. Kotter’s eight-step process has been reported to help organizations affect permanent change. Accordingly, a group of researchers sought to determine whether this process would help improve start-times at The Hospital for Sick Children in Toronto, Ontario.

Change efforts included establishing a sense of urgency, which was accomplished by conducting formal presentations on the need for change to key stakeholders: nurses, anesthetists and surgeons. Bi-weekly meetings were also conducted to communicate the vision and goals for improved operating room start times. A guiding coalition was comprised of perioperative services chiefs and the operating room executive committee. Another seven-member multidisciplinary task force, co-led by a surgeon and a nurse, was created to more closely oversee multidisciplinary change efforts.

The multidisciplinary team determined several factors contributed to operating room start time delays, including anesthesiologists availability (24 percent), surgeon availability (21 percent), patient readiness (23 percent) and need for midazolam (13.6 percent). The team implemented small changes to help remove these barriers, including a 7:35 a.m. huddle in the operating room and additional staffing in admissions areas to ensure patients were prepared in the preoperative area by 7:15 a.m. and in the operating room by 8:00 a.m. on the day of surgery.

Over a nine-month period, the hospital saw a dramatic increase in operating room on-time starts, from 6 percent of patients in the operating room by 8 a.m. to 60 percent. Broken out by departments, ophthalmology patients saw the best average on-start times, with 71.7 percent of patients present in the operating room by 8:00 a.m. and 94 percent present by 8:15 a.m. Although other departments saw a lower proportion of patients with on-start times at 8:00 a.m., most had at least an 83.5 percent to 90 percent start-time of 8:15 a.m.

In addition, despite some resistance from surgeons and anesthesiologists, the 7:35 a.m. huddle improved nurses’ perceptions of patient safety within the operating room. The morning huddle also increased on-time starts by 16 percent in the month following its implementation, though this effect seemed to have leveled out over the course of the study. Although it did not reach its target goal of 90 percent of cases starting on time at 8:00 a.m., researchers concluded the eight-step change process helped improve operating room efficiency.

Founded and led by board-certified anesthesiologists, TeamHealth Anesthesia is recognized as a premier provider of comprehensive anesthesiology and pain management service solutions to hospitals and surgery centers throughout the United States.
At TeamHealth Anesthesia, better, more efficient care is our goal. The highest customer satisfaction rate is our reward.

At TeamHealth Anesthesia, meeting and exceeding the expectations of our partner hospitals is of the utmost importance. To help us identify opportunities to improve our delivery of anesthesia services, we recently commissioned Stax, Inc., a global consulting firm, to independently research and report our performance and that of our peers. Featuring both raw data and client testimonials, Stax's report, “Voice of the Customer,” provides an objective picture of how we are meeting the needs of the hospitals we serve, and how our metrics compare to local, regional and national anesthesia service providers.

Report Summary & Highlights

Anesthesia outsourcing providers can deliver significant value to their client hospitals and have an impact on clinical, operational and financial performance. Stax looked at numerous performance factors of the highest importance to hospitals—including patient satisfaction, interaction with surgeons and staff, improvement in throughput, and quality of staffing—to assess how TeamHealth Anesthesia is performing in these key areas. Highlights from the report are provided below followed by more detailed findings, including charts and client comments.

• TeamHealth hospitals are more satisfied and willing to recommend their anesthesia group than customers of other national or local competitors.
• The overall satisfaction of customers with TeamHealth is higher compared to its peers and TeamHealth doctors are rated highly in categories of highest importance to customers:
  • driving patient/surgeon satisfaction
  • delivering quality staffing and coverage
  • interacting with surgeons and medical staff
• Physician quality, responsive management and strong cohesion with surgeons are frequently cited as TeamHealth strengths.

Our Clients Recommend Us

One of the best indicators of customer satisfaction is their willingness to recommend a provider. According to the independent research, TeamHealth Anesthesia hospitals are more willing to recommend their anesthesia group than customers of other national or local competitors.

TeamHealth Anesthesia Local Groups

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<thead>
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<th>Willingness to Provide a Recommendation**</th>
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<td>National Groups</td>
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<tr>
<td>TeamHealth Anesthesia Customers are More Willing to Provide a Recommendation**</td>
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*Source: Stax, Inc., July 2011
At TeamHealth Anesthesia, better, more efficient care is our goal. The highest customer satisfaction rate is our reward.*

TeamHealth provides comprehensive anesthesia and pain management services for hospitals, surgery centers and pain management clinics. Our proven anesthesia service platform has been specifically designed to help you maximize operating room performance, while increasing patient and surgeon satisfaction. Call 877.884.5567 or go to teamhealth.com to find out how our customized, cost-effective approach can increase patient and surgeon satisfaction while maximizing your financial performance.
Real-Time Health Reform

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International productivity expert Blanton Godfrey predicts health reform will produce a lot of “big winners and big losers” among the nation’s 5,000-plus hospitals.

Moody’s predicts that hospitals which 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.

It’s clear that hospital executives could use a solution that will address overcrowding and produce revenue immediately. Could the answer be as “simple” as keeping better track of patients, employees and medical devices?

Godfrey, who co-founded the Institute for Healthcare Improvement, recommends hospitals take a page from industry and concentrate on workflow improvement.

With hospitals facing the prospects of tighter payment standards, and with millions of newly insured seeking care, deeper staff cuts and service rollbacks are not a viable means for cost savings.

This year, we will instead see more hospital managers embracing a trend long used by industry and commerce – the “real-time enterprise” – to streamline flow, care for more patients, and drive rapid revenue increases.

The time has come for healthcare systems to embrace real-time capacity management. Optimizing hospital operations is perhaps the most immediate way to improve margin and control increased demand for access. For example, with the help of TeleTracking’s Avanti consulting division and its TransferCenter™ software, Methodist Healthcare System of San Antonio, Texas was able to triple its transfer volume in a year and a half, dramatically improving its bottom line as well as its ability to serve a large rural population. The volume increase was the result of a concerted effort to centralize patient logistics, optimize patient flow and manage all capacity in the eight-hospital system from a single location.

Another logistics control technology, Real-Time Locating System (RTLS), has been documented to save hospitals upwards of a million dollars per year in search time and replacement costs for lost, stolen or hoarded mobile medical devices. The convergence of these technologies is creating an automated environment in which all physical operations can be monitored in real-time. This allows managers to react in seconds to changes which can negatively impact their organization.

Real-Time Capacity Management™, as it is called, is a relatively new concept to healthcare. However, it is a concept whose time has come. With this engine of change, hospitals can place themselves ahead of the game. By becoming smarter – by using information in real time -- they can increase patient throughput and revenue while maintaining high quality, preparing them for the standards of this new era of healthcare.

In the decade ahead, the ability to better use existing resources will be critical. These next-generation systems promise to deliver bottom line impact that may be greater and more immediate than the conversion to EMRs. According to venture capitalist Vinod Khosla, the man widely credited with inventing the term “real-time,” every one percent of revenue spent on real time should return 1.5 to two percent in revenue increases. In healthcare, the payoff also includes better infection control, faster transfers, and most importantly, better patient outcomes.
There are 5 key steps involved in the process of implementing Real-Time Capacity Management™ to improve performance:

- Identify Current Issues
- Define Metrics for Managing Issues
- Take Action to Improve Patient Flow
- Provide Metrics to Others for Review and Education
- Gain Access to Data for Better Understanding

Real-time systems can power live information to the entire hospital in an easy-to-read summary format on such things as patient tracking, staff locating, asset management and critical workflow process improvement.

Everything can be presented on graphics-rich “digital dashboards” that provide executives, managers, and placement specialists with a live “motion picture” of their institution. For example, patients can be tracked from the minute they enter the patient flow process—when they walk in the emergency department (ED) door, for example. Once bottlenecks are identified, they can be relieved before they become ingrained in the process.

Better care and better bottom line

The federal government set aside $19 billion for hospitals to adopt electronic medical records. While it’s encouraging to see the clinical side of healthcare becoming more digitized to pursue its mission, what will it do for the bottom line? How will EMRs help hospitals with their pledge to trim $155 billion in waste under the current reform law?

Three out of four healthcare executives say it won’t help, according to the 2011 HeathLeaders Media “Better Care and the Bottom Line” survey. Seventy-three percent of those surveyed said technology incentives should go beyond EMRs to include operational and system efficiency needs.

The study noted that “there is available technology that can not only address overcrowding, but also reduce other operational inefficiencies and generate additional revenue at the same time.

“Yet, while most hospitals are quick to adopt new treatment technology, they are slow to accept work flow improvement solutions, perhaps because these are perceived as too ‘industrial’.”

But the lines are blurring between clinical and operational technology, in large part because they must. Efficiency is now a matter of survival for many hospitals, regardless of reputation or the quality level of care. Increasing a hospital’s bottom line is just as important as increasing its top line. No matter how good the care, it’s irrelevant if your hospital goes out of business. After all, without a margin, there is no mission.

About TeleTracking

For more than two decades, TeleTracking Technologies has applied innovative, industry-leading logistics principles to hospitals and health systems to enhance patient care, improve financial performance and gain competitive advantage. Along with its Avanti Patient Flow Consulting®, RTLS and Business Analytics divisions, TeleTracking designs and delivers an enterprise-wide computer-automated platform that reduces overcrowding, cuts costs, generates revenue, fights the spread of infection, manages assets, accelerates patient transfers and provides business analytics for continual operational improvement and business development. The result is an end-to-end system that connects patient flow to patient care for better outcomes.
$19 Billion in federal EMR incentives, but what will it do for the bottom line?

It’s great to see the clinical side of healthcare becoming more digitized to improve its mission. Now what can be done about its margin? There is hard proof that an operational platform which drives out waste and sustains operational efficiencies can increase your margin. Real-Time Capacity Management™ gives you tighter operational control, which goes right to the bottom line. So, if you want the patient there as the record arrives, medical devices where you need them, and beds when you need them, give us a call. Because, without a margin, there is no mission.
6 Benefits & Challenges in CMS’ Meaningful Use Stage 2 Proposed Rule

By Kathleen Roney

On Feb. 23, 2012, CMS released its proposed rule for Stage 2 requirements for the Medicare and Medicaid Electronic Health Record Incentive Programs. The Stage 2 rule included criteria eligible professionals, eligible hospitals and critical access hospitals must meet in order to qualify for an incentive payment for adoption and “meaningful use” of electronic medical records.

Shortly after, HHS’ Office of the National Coordinator for Health Information Technology released a proposed rule for certification requirements and associated standards for electronic health record technology, effective in 2014. In a notable revision to the Stage 1 regulations, the ONC proposes that hospitals and eligible professionals be required to have certified EHR technology only for the objectives they use to demonstrate meaningful use under the Medicare or Medicaid EHR incentive program. Other major changes involve new and revised certification criteria and standards for EHRs sold by vendors or self-developed by healthcare providers, including new patient safety criteria for certification.

Both proposed rules were formally published on March 7, 2012.

Feedback from the healthcare industry on the two proposed rules has been mixed. It is clear that hospital executives, physicians, healthcare consultants and electronic health record vendors see areas that need further attention and discussion. However, the effort by CMS to offer more consistency and clarity with the Stage 2 requirements is appreciated.

According to Wendy Whittington, MD, MMM and CMO of Anthelio Healthcare Solutions, a provider of healthcare IT services, a “can-do” attitude came through in the Stage 2 rule. “There seemed to be a reaffirmation in the document that CMS is after patient-oriented, efficient and equitable healthcare and that CMS believes healthcare information technology can be a foundation for real health reform in this country,” says Dr. Whittington. “That was necessary. After Stage 1, I felt it was easy for hospitals and providers to lose sight of the purpose. People were focused on checking off the requirements to receive [incentive payments] and not necessarily looking at the big picture. [Stage 2] has refocused us on the big picture.”

Stage 2 follows most of the existing Stage 1 core and menu objectives while adding new objectives for patient access to health information and increasing expectations for health information exchange and data transfer, among other changes. Certain areas and elements in the Stage 2 rule may benefit hospitals and professionals aiming for, and currently on the way to, meaningful use, whereas others may represent challenges.

Here, Dr. Whittington; Mark Segal, PhD vice president of government and industry affairs for GE Healthcare IT in Barrington, Ill.; and Jack Wolf, vice president and CIO of Montefiore Medical Center in New York, discuss three areas in the CMS’ stage 2 proposed rule they believe could provide benefits and three areas that could cause challenges.

Benefits

1. Stage 1 extension

One big change in Stage 2 is CMS’ proposal of an extension of Stage 1, giving providers an additional year for implementation of Stage 2 criteria. CMS originally established that any hospitals and eligible professionals who first attested to Stage 1 criteria in 2011 would have to meet Stage 2 criteria in 2013 — specifically, Oct. 1, 2012 for hospitals and Jan. 1, 2013 for eligible professionals — and all providers pursuing meaningful use would need to use Stage 2 certified EHRs on that same timetable. The proposed rule delays the onset of Stage 2 for those providers by one year, until 2014, which CMS believes would allow the needed time for vendors to develop and providers to implement certified EHR technology that can meet Stage 2 requirements.

The additional time to achieve Stage 1 objectives has been perceived as critical for vendors, hospitals and professionals and thus, extremely valuable. “Looking at the two regulations, you see why an additional year was essential,” says Dr. Segal. “There was no way, with proposed regulations coming out now and final regulations this summer, that hospitals would have been able to start Stage 2 by Oct. 1, 2012, or professionals by Jan. 1, 2013.”

The additional time for the start of Stage 2 introduces gives providers more time to achieve CMS’ and ONC’s upgraded definition of meaningful use. Dr. Whittington believes extending the deadline gives providers the opportunity to emphasize quality over quantity in meeting meaningful use objectives. “I think it gives hospitals and providers time to ensure that the meaningful use criteria, and nothing more,” says Dr. Whittington. “If providers are not rushed by a short-term deadline, providers may be more thorough in achieving the meaningful use objectives. There could be more time to weave other projects in to produce a truly meaningful outcome.”

2. Clinical decision support and information exchange

The Stage 2 changes for clinical quality measures include an enhanced objective and associated measure to use clinical-decision support to improve performance on high-priority conditions. This is a move from a requirement to use one decision support “rule” relevant to a specialty or a high clinical priority to the use of five clinical support “interventions” associated with a high-priority health condition. There is also a specific requirement to link each decision support intervention to one or more of the clinical quality measures reported on by a provider. Additionally, the objective to “exchange key clinical information” from Stage 1 was enhanced to provide summary of care when a patient transitions from, or is referred to, a healthcare professional. There was also a proposal to have 10 percent of these exchanges be electronic and sent outside of the provider’s organization as well as to a different vendor’s certified EHR, using ONC-designated capabilities and standards. These changes are intended to enhance the value of the clinical decision support and data exchange objectives.

Dr. Whittington believes the Stage 2 objective of using clinical decision support to improve performance on high-priority health conditions is on point. “While most clinicians are in favor of clinical decision support that is meaningful and useful, the alert fatigue and frustration that arises from attempted clinical decision support without real clinical context can be a deal breaker in the clinical world,” says Dr. Whittington. “Allowing doctors to have a say in what matters most in their patient population is highly helpful. As a result, there may be more buy-in and the use of the system is going to be more beneficial, meaningful and safe.”

3. Interoperability between vendors

With the EHR certification companion rule, vendors may be more compelled to collaborate, or at least communicate, with each other to produce more compatible EHR products and systems. In a sense, the ONC is pushing vendors to create a better scenario for hospitals and providers to meet meaningful use objectives for EHRs and data transfer.

The ONC proposed rule includes changes to certification for EHRs sold by vendors or self-developed by healthcare providers, and new patient safety criteria for certification.
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“There have been comments that the interoperability in the Stage 2 rule and the companion rule did not go far enough or that they took a step backwards. We believe that the rule is a solid move in the right direction,” says Dr. Segal.

According to Mr. Wolf, better vendor interoperability could increase the shareability, normalization and integration across different, disparate systems. He believes the rule requires vendors to put more focus on product integration, which could have a direct bearing on patient transition of care — physicians could look up information across systems and across vendor products. “It would give physicians a real leg up,” says Mr. Wolf.

Furthermore, Mr. Wolf believes the Stage 2 objectives for interoperability are one of the immediate benefits for the healthcare industry as a whole. “You can see how CMS is looking long-term at how to improve flow and longevity,” says Mr. Wolf. “As the patient transitions, their information should be able to transition with them. Additionally, interoperability could help providers capture more information in their electronic medical records. The new information could drive quality improvement, which is what CMS envisioned in the first place.”

Although the push for great collaboration between EHR vendors is generally perceived as beneficial for the healthcare industry, reaching the level that CMS and ONC seem to desire may be a challenge. With increased interoperability comes a higher expectation for data transfer and health information exchange. Hospitals and providers may face challenges in reaching the Stage 2 objectives focused on EHRs, data transfer and health information access.

Specifically, Dr. Segal and Mr. Wolf expect comments from vendors, providers and hospitals on the interoperability objectives in Stage 2, because sharing data between certified products and unaffiliated providers may be operationally difficult.

**Challenges**

**1. Electronic data transfer among providers and vendors**

A great benefit of electronic medical records and meaningful use is the exchange of health data that occurs within a hospital or health system and across departments and specialties.

The Stage 2 proposed rule includes core and menu objectives encouraging eligible providers to increase electronic data transfer to meet specific thresholds. The requirements include a higher threshold for e-prescribing; incorporating structured laboratory results into EHRs; and the expectation that providers will electronically transmit patient care summaries to support transitions in care across unaffiliated providers, settings and EHR systems.

According to Dr. Segal, there is a perception that some vendors have proprietary or semi-proprietary exchange requirements. He believes that CMS is trying to cut across, what some may call silos, to encourage exchanges across vendors, across hospitals and across health systems. “While I expect some of the requirements to be modified, I believe the intention was to push healthcare organizations and vendors outside of their existing data exchange flows,” says Dr. Segal.

While data transfer has the potential to create wider access to health information and increase integration of services, CMS and ONC are requiring a high level of vendor transparency. One area of Stage 2 requires vendors to put the prices of their products on all their marketing materials and other communications. “It is understandable why that type of transparency is asked for,” says Dr. Segal. “However, the complexity of selling technology solutions is not conducive to such mandatory public provision of pricing information. It is not how the technology market typically works. I expect many vendors, including GE Healthcare, will comment on that element.”

The requirement to share data among certified EHR products and different vendors may challenge hospitals as well. “For [Montefiore], we are one of two or three provider organizations in the Bronx that has attested under Stage 1 meaningful use. For Stage 2, when we want to integrate and share data with another certified provider, we may have difficulty,” says Mr. Wolf. “In many parts of the country, providers will need to consider, whether they are the only provider in the area who has attested under Stage 1 and if so, how they are going to share data with another certified provider. What is expected is not clear either. These issues need to be drilled into.”

**2. Sustaining health information exchanges**

One of the biggest problems with health information exchanges is their financial sustainability. Unfortunately, the Stage 2 proposed rule does not address the issue. “While Stage 2 has pushed for more information exchange, which is a really great thing, it did not give me a comfort level that it is actually going to happen,” says Dr. Whittington. “It did not designate who is going to be responsible for making sure that health information exchanges have a financial basis. We need to see infrastructure continue to emerge that keeps the patient in the center.”

The lack of direction of financially sustaining HIEs is another challenge for hospitals and healthcare professionals. Stage 2 directs hospitals and providers to engage in health information exchange as a “verb”, focusing on so-called “directed exchange” from one known provider to another. Such data exchange could use both a specialized form of secure, health e-mail called “direct” or other standards-based approaches to exchange through an HIE. Notably, many are concerned the funding sources for HIEs as organizations — which could support more robust, two-way exchange including data queries — remain unclear. “When you look at Stage 2, you might think that individual states, counties or local regions should fund an HIE,” says Dr. Whittington. “But they are not the ones reading the Stage 2 rule. Hospitals, providers and vendors are reading the document — the onus is on them to participate and potentially fund it.”

**3. Patient access to electronic health information**

Another theme within the Stage 2 proposed rule is providing patients with greater access to their health information electronically. According to Dr. Segal, the patient access standard is likely to be a challenge for many providers. “The argument for encouraging patients to access their health information is understandable,” says Dr. Segal. “However, placing the responsibility of whether patients access health information on the providers is a new challenge.”

CMS is incentivizing providers to encourage patients to use technology to access health information. The proposed rule includes core objectives to use EHR technology to identify patient specific education resources; to provide patients the ability to view, download and transmit information about their hospital admissions and their health information online; and to secure electronic messaging to communicate with patients on health information.

The CMS Stage 2 proposed rule is another step toward improving quality, safety, efficiency and reducing health disparities in the U.S. healthcare system by engaging patients in healthcare, improving care coordination and increasing the electronic access, usage and distribution of health information. Achieving meaningful use will not always be easy for hospitals and providers, especially when the standards and objects are challenging. However, CMS’ Stage 2 also offers benefits to eligible providers and their patients so that they may work toward reaping the rewards of meaningful use.
Employee Engagement No Longer a “Soft” Science: 3 Steps to Cultivate More Committed Employees

By Lindsey Dunn

For many years, employee engagement, especially in healthcare, was considered a “soft” science — something leaders thought about only after addressing the “hard stuff” like volume and reimbursement. Leaders who buy into this mindset, however, fail to realize the impact employee engagement actually has on the hard stuff, says Quint Studer, founder of Studer Group — issues like patient safety, patient perception of care, and as a result, volume and financial performance.

Recent research is beginning to support this link, and is causing some leaders to reconsider their view on engagement. For example, the January 2012 issue of Harvard Business Review was devoted to employee engagement and satisfaction. The issue’s cover had the phrase “The Value of Happiness” splashed across it, and a number of articles explored the return on investment that engaged employees provide for organizations.

“More engaged employees are better at improving processes; they really fix things rather than just working around problems,” explains Mr. Studer. “Ultimately they provide better clinical outcomes and better perception of care.”

But what drives employee engagement? And how can healthcare leaders improve it?

Research by Studer Group found a direct correlation between an employee’s level of engagement and his or her relationship with his or her supervisor. The finding may seem like common sense, but many organizations don’t elevate the importance of the employee-supervisor relationship to the appropriate level, says Mr. Studer.

It’s true that facilitating strong employee-supervisor relationships can sometimes be challenging. Still, there are three steps that are sure to have an impact.

1. Select the right bosses. It’s best to implement a careful selection process when promoting or hiring for positions that will supervise other employees. Unfortunately, this doesn’t always happen. “Many times in healthcare, an organization will promote people because they’ve always done a good job,” explains Mr. Studer. “However, the skill set it takes to be a good employee or front-line clinician is very different from the skill set needed to be a good boss.”

Mr. Studer encourages hospitals to assess potential leaders on a variety of skills before putting them in a supervisory role. A formal assessment tests such characteristics as the ability to take feedback, critical thinking skills and maturity, among other areas.

“Promoting someone to a supervisory role impacts a lot of people,” he says. “The cost of testing is a small price to pay when you consider what can happen when you hire without making this investment. At Studer, we believe in a lot of testing — it’s just too important to make sure leaders are a good fit.”

2. Know your organization’s strengths and weaknesses. After the organization has made an effort to ensure it has the right supervisors in place, it should assess engagement across the organization and identify areas of strength and weakness through diagnostic tools, recommends Mr. Studer. Formal, annual employee satisfaction surveys are the foundation of this process, but informal efforts to gain this type of information should also take place throughout the year.

Let’s say, for example, that a survey uncovers that employees don’t understand how their roles fit within the “bigger picture” for the organization — its goals, vision, strategy, and so forth. Leaders will then know they must train managers to have these sorts of conversations with front-line workers. Even just sitting down one-on-one with an employee to connect his or her role back to the organization’s goals could be enough to impact engagement, says Mr. Studer.

“You have to know what you have before you can know what you need to improve,” he adds. “If you don’t assess, you don’t know. If you don’t know, you can’t fix it. If you don’t fix it, you won’t have full engagement.”

3. Invest in development. Finally, Mr. Studer says hospitals and other healthcare organizations must be willing to invest in the skill set of their supervisors. Too many are not — especially in tough economic times.

“As money gets tighter, one of the first things we tend to cut is training and development,” he says. “Yet, training is a critical commitment. To employees, having an organization that is willing to invest in their skill sets is one of the most important elements of employee engagement after his or her relationship with the boss.”

“Plus, when organizations are being held more and more accountable for issues of quality, safety and patient perception of care, great leadership matters more than ever,” he adds. “Great leadership — engaging leadership — requires training. It’s just that simple.”

The keys to engaging employees aren’t all that mysterious, says Mr. Studer. It comes down to hiring good people and training them well.

“When a leader’s main job is to develop their staff, a lot of other good things happen,” says Mr. Studer.

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10 Factors in Creating a Positive Work Environment

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

Over the past few years a new phenomenon has burst upon the healthcare world: the call for a positive work environment for employees. This is a great trend and I hope it will continue forever, but one warning: it is not so easy to accomplish. It takes a lot of hard work and total dedication. Here are 10 basic factors that I believe are essential to create a positive workplace. I believe each and every one of them is tremendously important to the overall health of the hospital and to the morale of the people who work in it.

1. The CEO must be involved. The work environment is not going to improve without total involvement of the CEO. You, the CEO, set the tone and create the culture. If you are enlightened, your employees will be enlightened, too. If you don’t care, everyone else will pick up on that, too. The CEO is the face of the institution. You must exude confidence and energy and be willing to listen attentively to your employees, so that they feel respected.

To free up the time to devote to the staff, the CEO must delegate a great deal of management functions to others, such as a talented COO. Leave the paperwork and meetings to other executive staff so that you can connect with your staff and your patients. Bring all employees together regularly in meetings, so that they feel part of the overall operation of the hospital. Use these meetings to hand out awards to deserving employees. Awards not only boost morale but also help people feel they’re part of a team.

2. Tear down all the silos. One undeniable way to improve morale is to get rid of all the silos that exist in every healthcare organization — yours included. “Silo” is just a new word for “clique,” but I like “silo” because it points to the barriers that cliques create. Silos are endemic in any large organization. When people from the same department spend a lot of time together, they begin to distrust everyone else. In healthcare, there are also a lot of professionals with degrees, who may conclude they are not subject to the same objectives and goals as the rest of us.

Tear down these silos! Everyone in the hospital should have the same objective — to deliver quality healthcare to patients in a timely and efficient manner. From the housekeeper to the top surgeon, they all need to strive for the same goals. And no one should be made to feel they don’t count. Everyone is an essential part of the master plan of the organization. You as CEO can discourage silos by using the bully pulpit. You can also chip away at silo-based thinking by inviting people from different departments to work together on key projects.

3. Understand patients are customers. Every employee in the hospital, no matter what their job is, needs to put the patient first. Too often, patients are ignored as we tackle the paperwork and the bureaucracy, but keep in mind: patients are our customers. Now, many people in healthcare are uncomfortable with the term “customer,” but it’s absolutely the right word. The customer deserves everyone’s undivided attention and respect. No business, including a hospital, can exist without a continued flow of customers. Remember that in the future, reimbursements will recognize the way patients are treated — not just in your hospital, but across the continuum of care.

Every single person in the organization should be on board with the customer concept. But all too often, they aren’t trained to think in these terms. In just about any other field, people are routinely taught how to treat customers with dignity and respect and to make sure they get exceptional service. Eric Chapman, the former president and CEO of OhioHealth, has written a book about how to treat the patient, “Radical Loving Care.” He points out that in the traditional hospital, patients are made to feel like prisoners. They are stripped down, put into a gown and given a number, and visits are regulated. This affects employee morale, because when patients are the prisoners, employees take on the role of prison guards.

4. Include physicians in all decision-making. At a small meeting of hospital CEOs that I attended not so long ago, the subject of appointment physicians to the board came up. One of the CEOs said, “I will never have any one of those guys on my board. They just screw things up.” I couldn’t believe what I heard. I thought he was joking, but he was dead serious. This kind of thinking is all too prevalent. It ignores the fact that without physicians, the hospital couldn’t exist. There would be no patients to care for. Physicians were made CEO and turned the whole place around. Allen Weiss, MD, has done everything possible to open the lines of communication. Now the hospital has won award after award, not only for being a great place to work but for clinical excellence as well. Ed Eckenhoff, the former head of head of National Rehabilitation Hospital in Washington, D.C., recently was hospitalized at Naples Hospital, and told me, “I have never been treated so well in a hospital in my life. The hospital just saved my life.”

5. Empower each employee. Every single person who works in a hospital should be empowered to do what he or she feels is necessary to improve care for the patients. There are all kinds of wonderful stories about people stepping up to help patients cope with their insecurities and fear. Recognize there can be a variety of ways to accomplish a task. As a rule, management should get out of the way and let employees do their work.

6. Train personnel on a regular basis. Empowering employees involves giving them the tools to do their jobs and making sure they don’t develop bad habits. In a busy hospital, the staff has to cope with a great deal of stress and still be patient-friendly. This has to be learned. Someone has to teach them the skills, but most hospitals do not give employees much assistance.

Training is an ongoing effort. Being a great employee takes constant attention. It’s not something you do just once or twice a year. It should occur on a monthly or even a weekly basis. It might simply involve several employees meeting during a lunch break to discuss the challenges of the job. Training sessions should include talking about the mission and vision of the management team and why everyone — no matter how menial their job — is part of the overall effort to deliver quality care to patients.
7. Reach out to staff. To create a positive culture, CEOs have to make themselves visible. This means walking around all departments and talking with employees. Great CEOs always make sure that they are known throughout their organization and not hiding in their offices, away from the daily activities that occur in any hospital. Tim Stack, the president and CEO of Piedmont Healthcare in Atlanta, is a walk-around guy, even though his organization has five different hospitals. And Alan Channing, the CEO of Sinai Health System in Chicago, makes sure everyone knows he cares deeply about his people. The physicians call him by his first name.

When leadership does not reach out, it can be very corrosive. Look at the old Soviet Empire. No one had basic information about what was going on, so people started inventing their own scenarios. When people are cut off, rumors abound, and they get distracted from their work. Being open and transparent means constantly meeting with staff and sizing up their needs.

Employees need to feel that what they have to say is important. And no one should feel they cannot criticize and voice their opinions relative to the operation of the hospital.

8. Take risks to make your organization stronger. All hospitals and health systems will have to do more with less. This means they have to continually explore new ways of delivering quality care to patients. Hospitals have to take risks and try out new systems, new viewpoints and new relationships. Leaders who are not willing to do this are jeopardizing the future of their organizations. Healthcare reform is here to stay, with or without the Affordable Care Act. Executives are going to have to step forward quickly, with innovative and creative ideas. If they don’t, the whole organization will suffer the consequences, and some will even close.

9. Make sure nurses are treated with respect. Nurses often get mistreated in a hospital, which is not just bad for them, but affects the efficiency and morale of the entire organization. Many nurses feel exploited and treated indifferentely, and stories of sexual harassment abound. When they are treated well, they are more likely to be engaged with their work. Nurses deserve to be treated with respect and dignity. When we truly respect someone else, we have to figure out why they think the way they do.

10. Encourage staff to be active in the community. The management team should always encourage employees to be active in their communities, whether it is the local Rotary Club or coaching kids in sports. After all, most hospitals are community-oriented, so the more people in the community are familiar with the people there, the more supportive they will be when it is time for fundraising.

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.

**Hospital & Health System Transactions**

Butler (Pa.) Health System and Ellwood City (Pa.) Hospital announced a five-year management agreement.

Cape Fear Valley Health System in Fayetteville, N.C., finalized its purchase of Bladen County Hospital in Elizabethtown, N.C.

Daughters of Charity Health System, a six-hospital health system based in Los Altos Hills, Calif., announced it signed a memorandum of understanding to merge with Ascension Health, the nation’s largest catholic health system.

Community Health Systems in Franklin, Tenn., announced its acquisition of Metro-South Medical Center in Blue Island, Ill.

The Cooley Dickinson Hospital of Western Massachusetts in Northampton, announced plans to negotiate an affiliation agreement with Massachusetts General Hospital in Boston.

Non-profit Dignity Health, based in San Francisco, is a major contender to buy majority stake in the Bakersfield (Calif.) Heart Hospital.

Evergreen Healthcare in Kirkland, Wash., and Virginia Mason Medical Center in Seattle, approved their strategic partnership.

Hackensack (N.J.) University Medical Center and the North Shore-Long Island Jewish Health System in Great Neck, N.Y., announced an agreement to establish a strategic alliance.

Hackensack (N.J.) University Medical Center announced a clinical affiliation with Palisades Medical Center in North Bergen, N.J.

High Point (N.C.) Regional Health System’s board of trustees approved the search for a strategic partner.

The boards of Lowell (Mass.) General Hospital and Saints Medical Center, also in Lowell, approved a definitive agreement that will lead to a merger of the two organizations.

Marquette General in Marquette Township, Mich., and Duke LifePoint Healthcare in Brentwood, Tenn., announced the signing of a memorandum of agreement toward a Duke LifePoint acquisition.

Mayo Clinic Jacksonville (Fla.) announced the acquisition of Satilla Health Services, based in Waycross, Ga., and re-named the health system Mayo Clinic Health System in Waycross.

The Nassau Health Care Corporation in East Meadow, NY., approved an application, for submission to the New York State Department of Health, to obtain $30 million in funding for strengthening an affiliation with North Shore-Long Island Jewish Health System in New Hyde Park, N.Y.

Norton Healthcare in Louisville, Ky., announced new and enhanced affiliations with Carroll County Memorial Hospital in Carrollton, Ky.; Harrison County Hospital in Corydon, Ind.; Breckinridge Memorial Hospital, part of Breckinridge Health, in Hardinsburg, Ky.; Spring View Hospital in Lebanon, Ky.; and Twin Lakes Regional Medical Center in Leitchfield, Ky.

Pike Community Hospital, a critical access facility in Waverly, Ohio, completed its merger with Adena Health System in Chillicothe, Ohio.

Prime Healthcare Services in Ontario, Calif., acquired Roxborough Memorial Hospital in Philadelphia.

Robert Wood Johnson University Hospital in New Brunswick, N.J., and Somerset Medical Center in Somerville, N.J., agreed to “explore a partnership.”

Saint Clare’s Health System based in Jersey, and Catholic Health Initiatives in Englewood, Colo., announced a decision to seek a new owner for Saint Clare’s Health.

St. Alexius Medical Center in Bismarck, N.D., announced a management agreement with the Wishak (N.D.) Hospital and Clinic Association.

Atlanta-based SunLink Health Systems announced it signed an agreement to sell Memorial Hospital of Adel (Ga.) to the Hospital Authority of Tift County, which operates Tift Regional Medical Center in Tifton, Ga., for $8.3 million.

TPG Capital, a Texas-based private equity firm is considering the sale of Lasis Healthcare Corp., which it acquired for approximately $1.4 billion in 2004.

Ann Arbor-based University of Michigan Health System and Novi, Mich.-based Trinity Health announced the signing of an affiliation agreement.

The Washington Township Health Care District in Fremont, Calif., parent of Washington Hospital Health System, also in Fremont, announced approval a letter of intent to preserve the financially struggling St. Rose Hospital in Hayward, Calif.

Glendale, Wis.-based Wheaton Franciscan Healthcare sold its ownership stake in Menasha, Wis.-based Affinity Health System to Ministry Health Care in Milwaukee.
Hospital & Health System Executive Moves

Macon, Ga.-based Coliseum Health System named Charles Briscoe as its CEO.

Fletcher Allen Health Care in Burlington, Vt., named John Brumsted, MD, as president and CEO.

The Indiana University University Goshen (Ind.) board of directors announced Randall Christopel as president and CEO.

Mercy Health System of Southeastern Pennsylvania in Conshohocken, a regional health corporation of Catholic Health East in Newton Square, Pa., announced David Clark as president and CEO.

June Collison joined San Francisco-based Dignity Health, formerly Catholic Healthcare West, as president of Community Hospital in San Bernardino (Calif.).

Sacred Heart Health System in Pensacola, Fla., named Susan Davis, RN, EdD, as interim CEO.

HCA in Nashville, Tenn., announced the retirement of Jeff Dorsey, president of the company’s continental division, which includes the Denver-based HealthONE system.

Wyoming County Community Health System in Warsaw, N.Y., appointed Donald T. Eichenaier CEO.

Baptist Health Care in Pensacola, Fla., named Mark Faulkner as CEO to replace Al Stubbfield who retired.

Jim Fitzgerald retired from his senior executive role at hospital chain HCA Healthcare.

Cleveland Clinic announced Brian Harte, MD, FACP, as the new president of South Pointe Hospital in Warrensville Heights, Ohio.

SSM DePaul Health Center in Bridge- to assist her son in recovery after a t, Mo., announced the appointment of Sean Hogan as president.

Sterling (Colo.) Regional MedCenter, operated by Banner Health, announced CEO Michelle Joy is leaving to serve as an associate administrator for North Colorado Medical Center in Greeley, Colo., another hospital operated by Banner.

Bethesda Memorial Hospital and Bethesda Healthcare System in Boynton Beach, Fla., announced Roger Kirk as president and CEO.

The newly formed health system created by the merger of Provena Health in Mokena, Ill., and Chicago-based Resurrection Health Care, Presence Health, announced Amy LaFine as president and CEO of Provena St. Mary’s Hospital in Kankakee, Ill.

After more than 20 years at the helm, Thomas J. Lewis retired from his role as president and CEO of Philadelphia-based Thomas Jefferson University Hospitals.

Hospital Sisters Health System in Springfield, Ill., named Julie Manas as president and CEO of Sacred Heart Hospital in Eau Claire, Wis., and as the president and CEO of its Western Wisconsin division.

HCA in Nashville, Tenn., appointed Peter Marmerstein as president of its West Florida division.

Catholic Health Services of Long Island in Rockville Centre, NY, named Lawrence McManus as its new president and CEO.

Ocala (Fla.) Health System, owned by Nashville-based HCA, named Randall McVay as CEO.

Vanguard Health Systems named Joe Mullany president of eight-hospital Detroit Medical Center.


Tenet Healthcare in Dallas announced CFO Biggs Porter left to serve as CFO of Fluor Corp., an engineering and construction company.

Ninfa Saunders, PhD, decided to leave her position as president of Virtua Health Care in Marlton, N.J., to assist her son in recovery after a recent automobile accident.

Catholic Health Partners in Cincinnati promoted Brian Smith as president and CEO of its North Division.

Akron (Ohio) General Health System named Thomas Stover, MD, MBA, as president and CEO.

Banner Health in Phoenix, named Linda Thorpe CEO of its East Morgan County Hospital in Brush, Colo.

Lex Reddy stepped down from his position as president and CEO of Ontario, Calif.-based Prime Healthcare Services.

James Wissler, CEO of Lakeside Health System in Brockport, N.Y., re- signed to take a position with a Pennsylvania healthcare organization.

Universal Health Services in King of Prussia, Pa., announced Barry Wolfman as CEO and managing director of George Washington University Hospital in Washington, D.C.
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